

Chapter 4

Planning for EMR

What is involved in the installation of an EMR system

You should remember that while a good Electronic Medical Records system will do everything as promised, getting underway is more complicated than just having a techie show up one day and download software into your computers.

As you read this guide, you should start thinking about how to avoid confusion and frustration. If you and your staff know what they face, you will have more confidence in your ability to make the transition from paper to computer with a minimum of delay and hurt feelings. To do that, you ought to have key members of your staff and a representative from your vendor write a one-page schedule of what needs to be done and when and who is responsible for each task.

As you read this guide, you should be thinking of your office and clinic and the person or persons best suited to manage the transition. There will be problems; that's inevitable. But with good planning, those will be kept at a minimum.

If your staff looks at the installation of EMR as an odious chore, it will likely be a self-fulfilling prophesy. Do your best to enlist people. Their acceptance of EMR is vital to the practice's success. Give your people some autonomy and authority. And hold them accountable.

On the need to have an EMR specialist in your office

You should designate somebody in your office to monitor the system to make sure that it's working correctly. The vendor can't make fixes and adjustments if you don't tell their technical people that you're having problems.

By the way, the more complicated the software, the greater the odds of minor problems. Even a giant like Microsoft has to send out patches to fix problems.

Have one person manage all the templates and work with a doctor who knows what he or she is doing. If you have a large practice, you'll need to designate person to interact with the vendor to maintain update templates for all the physicians. Having a small EMR Committee might not be a bad idea; that way workflow trumps seniority.

The need to plan for emergencies and contingencies

You need to write contingency plans. What if an ice storm hits, dropping power lines and causing an electrical blackout in your area? Some hospitals have emergency power generators so they can keep lights, operating rooms, respirators, and computers running. The building where your office or clinic is located might not have generators.

In short, you'll need to train people what to do in case of an emergency.

Your contingency plans should have a manual that gives step-by-step instructions about what to do in various emergencies. You should periodically review these plans.

Every once in a while, every six months or so, you should stage a mock emergency, something like a fire drill, to make sure everybody knows what he or she is supposed to do in case electrical failure knocks out the system.

The problem of electrical blackouts does not just affect computers; you should plan for overcoming the problem of electrical interfaces with your other equipment. Do you have a good paper system to document data while your EMR is down? You'll need this so that you can later input data easily and catch up.

If you run your EMR software on your own computers, the system should be designed to record regular backups, but the concern remains. No loss of data is good. Before you agree to buy EMR software, ask about backups. Make sure you get clear, specific answers.

If you run a fee-based EMR system on computers maintained by your vendor, your data should be safe no matter what (make sure your vendor has a generator and duplicate systems). If you have electricity at home, you can work from there until the blackout is lifted in the area of your office or clinic.

Disaster recovery contingencies

Disaster recovery contingencies should be reviewed at least every six months. At a minimum, you should restore your backup cartridge away from your current location. It's best to do this at another doctor's office with similar hardware, but not software. That doctor's computers can check your data. Your computers can check his data. If you don't have a partner physician, your vendor should be able to help you. If your vendor offers ASP facilities—EMR delivered over the internet—you should have a contract to periodically check and restore your data. In an emergency, you can set up or share an office anywhere you have access to the internet with minimal downtime. This is how I see a true backup environment.

What to do about staff members who resist EMR

The problem of mindset is genuine and not to be taken lightly. The usual problem is that of a person who has worked for a physician for years and feels challenged by a younger counterpart who has no problems embracing new technology. If the older employee turns negative, he or she can infect your entire staff with the negative. You don't want that.

What you should do depends on the character of the staff member who feels threatened. You know him or her. Nobody else does. Some general advice is to sit down with the employee and explain the facts of modern life. To save money, the medical professionals in the United States everywhere are going digital; it's impossible to run a modern office or clinic and maintain charts and records on paper. To work in an up-to-date office or clinic, everybody has to learn how to manage charts and records with computers.

What do you do next? One possibility is to give concerned employees advance help in the form of an on-line tutor to walk them through the software and give them some hands-on practice so that when the transition begins they won't find themselves frustrated and embarrassed because they have no idea what to do next. The bottom line? This all has largely to do with confidence and pride.

Remember that most people are resistant to change and will complain about any new program in your office. Thus, the staff member leading the transition to EMR ought to be an upbeat person who will get excited about the new software and pass that excitement on to the rest of your staff. Make sure that you exhibit your excitement and enthusiasm as well.

What to do about older physicians who resist EMR

It's not only the doctors close to retirement who resist EMR. Some of those in their forties or early fifties don't want it. One thing you can do is automate the front desk where patients check in. A nurse, a reception staff or even a patient can fill out the data you need to create a temporary paper chart for those doctors. You'll have to scan those summary pages—the patient's active medications and a summary of the last three or four visits—plus the notes the doctor made. You can put a barcode on those notes to help you scan them into the EMR.

Give them something close to the documents that they already use. You can also give them a digital pen that they wrote onto a screen so that their handwritten notes are beamed into the patient's EMR. The trick is to start slowly without changing a whole lot in their accustomed drill. After a few months, they'll do more things digitally because they know it's not impossible to understand. It makes life easier for them, not harder. It may also be helpful to enlist the use of scribes to assist the physicians.

One estimate is that practices that use EMR are worth as much as four times those that stay with paper. If a doctor cooperates with installing EMR today, there will be more money in his retirement fund later on. Not a bad reason for going with the flow.

What to do with existing paper charts and records

The average doctor has several thousand charts. One thing you can do is scan them into the EMR as a PDF file—that stands for Portable Documents File made popular by the Adobe Reader. The problem there is that labor is expensive. It costs money to scan four or five thousand charts. There are services that can bring a unit to your practice for a few days to scan your entire practice. You have to ask if all files are worth scanning and if it's worth the cost. If you have a service scan your charts, clean up your charts before they start scanning for better images and fewer pages scanned.

Since the space used by those old charts isn't being productive once they're pulled, some doctors scan charts as patients come in. A doctor might just want his staff to scan the last several lab results or the notes of the patient's last half dozen visits. This will vary. What is clinically important depends on the specialty or the patient's particular problem. A cardiologist might have one need, a dermatologist another.

About eighty percent of the doctors switching from paper to EMR are using one of two approaches.

Most charts contain a summary of the patient's medical problem this is usually located at the top of the chart and lists all the diagnoses, the date of the last visit, lab results, and what medications that they're on. You can scan those pieces of information, even if the patient doesn't come in. If he or she calls to have a medication refill, bingo, you can call up the summary.

You can see a patient today using his or her paper chart. You can key the results of this encounter into the EMR. You then add a sticky note on the paper chart telling the nurse or staff member what else from the chart that you want entered on the EMR.

Some practices continue using paper charts for the established patients and EMR charts for any new patients. This is a nice way to transition to EMR without putting extra burden on the staff to scan in charts. You can make the decision to scan in older charts at any time.

You are required by law to keep your charts for seven years or until 18 years of age, whichever is later.