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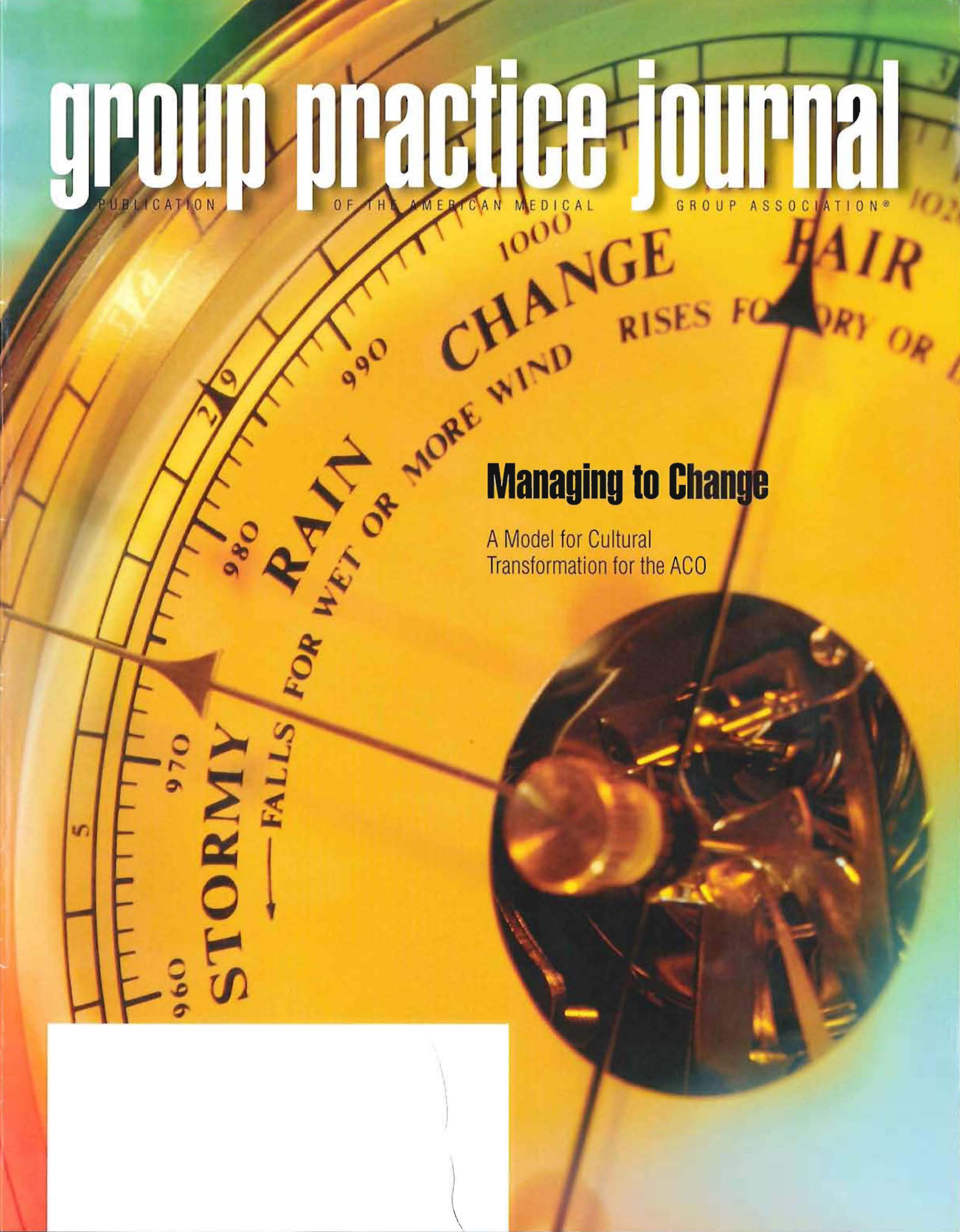

Managing to Change

A Model for Cultural Transformation for the ACO

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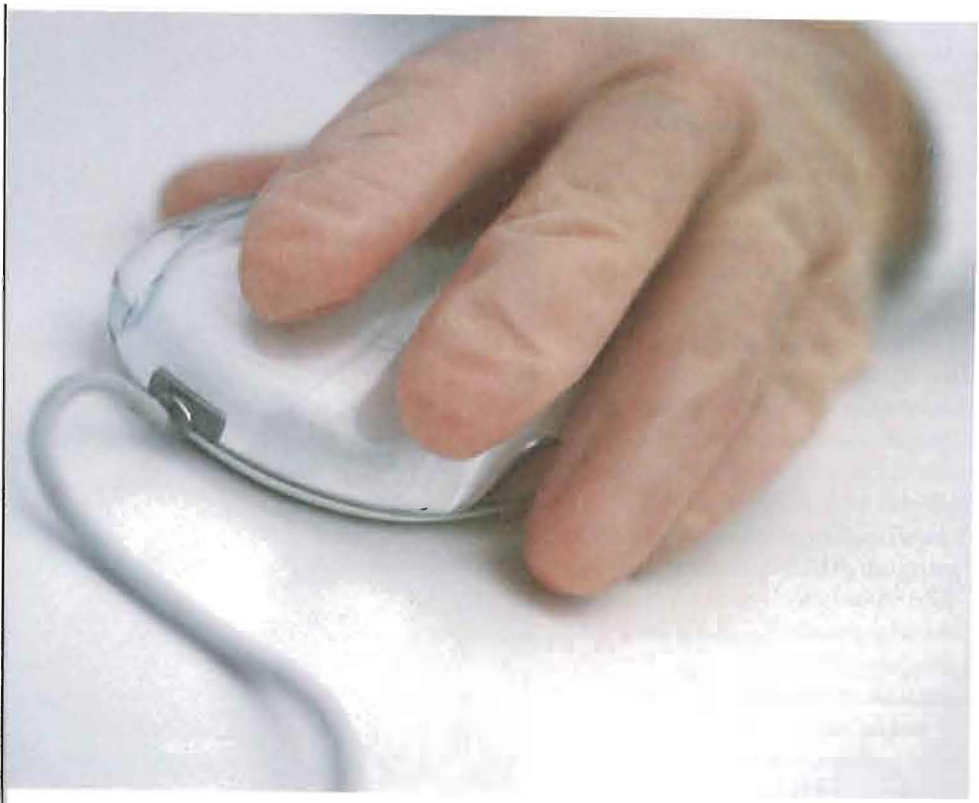
INSIDE: RETENTION SURVEY RESULTS

Return on Effort, Not Investment, Guides Successful EMR Adoption

BY KEITH SLATER



Healthcare professionals attending the 2010 HIMSS conference in March couldn't avoid the clarion cry about electric medical records (EMRs)—not to mention meaningful use, certification, and interoperability. Reminders about the October 2011 qualification deadline for EMR adoption were equally loud.

Yet, conference buzz aside, actual use of EMRs is lagging. In 2008, HIMSS issued a report estimating that only 25-35 percent of small- and medium-sized physician practices, respectively, have begun to implement this soon-to-be-required technology. The low numbers aren't surprising: cost and aversion to change continue to be cited as the greatest impediments to EMR adoption.

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Regardless of the reasons for delay, medical groups can wait no longer to begin the process of vendor selection, staff training, and implementation. Foot dragging not only jeopardizes the opportunity to receive incentive funds, but also increases the risk of penalties that will be levied in just a few years.

At this juncture, savvy medical practices should consider a number of factors to jumpstart their EMR adoption efforts.

Take an honest look at the number of months that may be required to choose an EMR and to get it up and running. Planning is critical to a successful EMR selection and implementation. The larger your organization, the more planning will be required. Keep in mind that the HITECH Act requires 90 days of "meaningful use" reporting (between October and December 2011) to qualify for the initial round of incentive pay in 2012. A reasonable timeline might look like this:

- Now – October 2010: Complete EMR vendor evaluation, selection, and contract negotiations
- June 2010 – November 2010: Perform an in-depth analysis of current paper-based processes
- October 2010 – March 2011: Modify standard EMR templates and workflows
- January 2011 – March 2011: Train super users, as well as other physicians, nurses, and clinical staff
- March 2011 – May 2011: Begin gradual implementation of EMR functionality, perhaps starting with e-prescribing, orders and results, and scanning necessary paper documents

- May 2011 – July 2011: Begin second phase of roll-out with the automation of support staff tasks

- July 2011 – October 2011: Work with physicians to begin using the EMR for all patient encounters

It goes without saying, of course, that this outline assumes everything goes smoothly, with few bumps in the road.

Offer multiple opportunities for training that respect individual learning styles.

Table worries and discussions about return on investment. Instead, focus on "return on effort." There is no question that an EMR is an expensive undertaking, and as yet, there is no formula that guarantees a break-even point when an EMR begins to pay for itself. The true bottom line is that practices must implement EMR if they want to qualify for stimulus incentives and keep up with fast-paced changes in automation and information sharing. As hard as it may be, practices must make the most of the opportunity and invest the necessary time and effort up front to make sure the system supports patients, providers, and the organization alike.

Recognize that the real task ahead is change management—not simply installing a new IT system. Human beings—more or less universally—balk at change to some degree because it forces them out of their comfort zone. Those charged with supervising the change from paper to electronic processes (or, as some put it, the conversion from "what has worked just fine for us" to "what some ivory-tower expert thinks will be better") must recognize that their real responsibility is rewiring the entire practice in a way that makes sense to everyone and after a reasonable period of uncertainty, proves to be a better way. How to accomplish this?

- While the practice is assigning key decision makers to evaluate EMR systems, management should concurrently map out the processes and preferences of all whose jobs will be touched by the EMR: every individual who reads or routes each piece of information currently contained on paper. Likewise, leadership must prioritize the impacts of the transition. These issues will provide focus and context for vendors during the sales cycle, and might include:
  - Fixing current "pain points" within manual processes
  - Ensuring the practice is prepared to respond to increased patient communication needs since they may soon have access to a portal, online appointment requests, email, etc.
  - Planning to convert soon-to-be empty medical records space to revenue-generating uses, such as additional exam rooms or new procedure rooms

- Consider provider proclivities in terms of documentation. Some prefer a narrative style, while others use bullets and abbreviated notations. This information will prove invaluable as standard EMR templates are tweaked or modified. Project managers can determine, for example, if the templates should rely heavily on check boxes, or if free-text entry fields would be more palatable to users. If providers can continue to use a relatively comfortable, familiar approach, buy-in and adoption will be accelerated.

- Have the billing office compile list of the 100 most widely assigned diagnoses and 100 most frequently performed procedures or services. Templates can be customized to make selecting these commonly used codes quick and intuitive. Likewise, the EMR project manager should pull paper charts to get a feel for how providers describe various conditions. What terms do they consistently use when documenting visits with diabetic patients, for example? Templates can then be customized or personalized (within reason). In other words, the primary content of the EMR should parallel the information most typically used on a day-to-day basis.

- Seize the opportunity to evaluate the current quality of data. In reality, EMRs are no more than a tool to house data and produce reports. Make sure that data being entered and extracted meet the needs and expectations of the practice. During initial implementation, personalize the EMR set-up to guide users through a standard requirement for the documentation of patient visits. This will guide quality and consistency in data entry methods, maximizing revenue capture and reducing tendencies to over- or under-code that may lead to audit fines.

Judiciously select super users or EMR champions. A certain subset within each group—physicians, nurses, medical assistants—will require convincing that an EMR represents a more-efficient and more-effective approach to managing information. This persuasion can be accomplished best by a respected peer. Likewise, after implementation, these super users serve as an internal resource, removing some of the help desk burden from administrative staff and providing ongoing process and procedure refinement.

Offer multiple opportunities for training that respect individual learning styles. Enough said.

Consider a "crawl, walk, run"

approach to implementation. Practice leaders who genuinely understand the enormity of the change they are asking of providers and clinical staff find implementation goes much more smoothly. Introducing various functional elements gradually can avoid an impossible "all or nothing" scenario. For instance, the majority of healthcare providers immediately see the value in e-prescribing or electronic orders and results. Plus, these are not complicated tasks and therefore serve as a non-threatening way to get started. A solid second step is to automate the activities of support staff—entering chief complaint, documenting vitals, and logging phone messages, for example.

Make documentation of the patient encounter gradual and as easy as possible. Be responsive to the approach that is most comfortable for the providers. Some may want to begin using full EMR functionality for new patients only, because there are no histories, labs, or imaging studies to merge into the electronic record. Other providers, on the other hand, may want to begin with established patients because they are familiar with the individuals and prefer to incorporate historical considerations during a face-to-face visit. Another approach is to ask providers to use the EMR for only three patients (new or established) per day the first week, six the second week and so on until the full schedule is converted.

Recognize that the roles of some support staff will change—and reassure them that the practice will help them in their transition. Once the EMR is fully implemented, reliance upon medical records personnel and file clerks diminishes rapidly. These individuals can be trained to take on new responsibilities, however—responsibilities that are created by the transition to EMR. The practice will no doubt continue to receive paper documents such as consultation reports, and staff members can be reassigned as scanners. Time gained through automation can be invested by redeploying staff for appointment confirmations, insurance eligibility, and assertive collection efforts.

Recognize that the roles of some support staff will change.

Take full advantage of the vendor's expertise. While implementation of an EMR is a rare event for most practice staff members, it is routine for the EMR vendor. Implementation managers most likely have been through the process dozens of times and have a great deal of subject matter expertise to share. It's important to draw upon this experience to avoid pitfalls and troubleshoot common problems.

Don't view October 2011 as an endpoint; recognize it is only the beginning. The incentive due date is only one milestone of many. New technologies and new opportunities are sure to arise in 2012, 2015, 2020, and beyond—as will new rules and requirements. Vendors will develop updates and innovative tools. Practices themselves will uncover unexpected ways to improve efficiencies and outcomes. It is vital to understand that EMR adoption is a process and that it won't come to a gentle stop in a year or two.

Conclusion

Converting to an EMR is a daunting challenge. But there is no doubt that the EMR is here to stay. In fact, according to a forecast from Global Industry Analysts, the North American market for EMR systems will grow to $5.4 billion annually by 2015, largely due to implementation by physician practices and small and rural hospitals. Although the transition will not be easy, medical groups can simplify the process by planning ahead and striving to implement an EMR that will achieve their overarching goals of providing the highest quality of care in the most cost-effective manner possible.

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Note: *An article authored by Henry Schein's Ajit Kumar, Ph.D., entitled, "New Incentives, New Momentum: The Current State of E-prescribing," appeared in the February 2010 edition of* Group Practice Journal. *The article had been held for a number of months due to space constraints and, sadly, Dr. Kumar passed away shortly before the issue went to press. We apologize for the delay and extend sincere sympathies to Dr. Kumar's family.*