NATIONAL REVIEW of MEDICINE
ESSENTIAL NEWS FOR CANADA'S PHYSICIANS

APRIL 30, 2007 | VOLUME 4 NO. 8

PRACTICE MANAGEMENT

YOUR PRACTICE

Going electronic in six painless steps

Forget the rumours — the switch from paper to computer records doesn't have to be a nightmare

BY SAM SOLOMON

"I'd like to..." laments Dr Kalyani Srinivasan, a GP in Fredricton, NB, about the thought of switching from paper records to a computerized system. "But the cost — in time, money and effort — is tremendous and I don't have any of the above to meet the challenge."

It's a familiar refrain. Ask almost any Canadian physician if they're planning to adopt an electronic medical record (EMR) system and the answer invariably begins, "Sounds great, but...."

In fact, Canadian docs came dead last in EMR use compared to other industrialized nations' physicians in a survey last year by prestigious US-based healthcare charity the Commonwealth Fund. Just 23% of Canadian primary care physicians have computerized their patient files, in stark contrast to Holland's sparkling 98% mark. If those were MCAT scores, the Dutch would walk away with all the big grants and the cushy fellowships — and Canada wouldn't even get into med school. EMR systems have been shown to help reduce adverse events, improve communication between health providers and keep a tighter lid on health record privacy.

Sure, the prospect of going electronic can be intimidating, but it doesn't have to paralyze you. Follow these six simple steps to guide you through the research and implementation of an EMR software system.

1 LEARN WHAT'S OUT THERE

Research, research, research. And then do some more research. That's the advice from Dr Alan Brookstone, a Vancouver GP and the creator of Canadian EMR, an industry-funded project designed to

help Canadian doctors choose EMR software.

Your most important source should be your fellow physicians, he says. (But don't forget to make sure they aren't shareholders or board members of the company they recommend.)

Vendors may offer demonstrations of their products to help you get a better look at them. Or you could go to a nearby clinic to check out their system first-hand.

Don't rely on the internet too heavily; just sifting through the software company's website and separating the gibberish from the gems could take longer than it took to earn your MD.

It's important to include all of your practice's physicians and staff in the decision process to ensure everyone is on the same page, adds Dr Brookstone.

More research sources will soon be available, including a full version of Dr Brookstone's Canadian EMR project, which will feature a comparison tool to allow physicians to look at other physicians' ratings of EMR software based on a number of criteria. (The site, which is not yet fully operational, has a physician-only blog located at emruser.typepad.com.) Canada Health Infoway is also developing a set of standards that it intends to use to certify EMR software.

2 NO PRACTICE IS AN ISLAND

Interoperability has been a buzz word in the medical information technology (IT) community for some time now — it refers to EMR software's ability to interface, or mesh, with other physicians' EMR systems, lab reports, prescription forms, billing information and other computer-based functions. In Canada, however, EMR interoperability is still in its infancy. "Everyone has their own computer systems and we don't have a strategic [national] plan," says U of T health policy professor Kevin Leonard, PhD. "What happens is when a doctor needs to use a system in an ER for instance, they don't have all the information that's relevant because it's stored in somebody else's electronic or even paper files."

One solution that may emerge, suggests Dr Brookstone, is a model based on geography: physicians from one region could pool their resources and purchase an EMR software that they could all use, giving them better bargaining leverage with the EMR company as well as any hospitals or labs that might need to learn to use the software's formatting, as well as the ability to interact electronically with one another when transferring patients or records back and forth. Based on the success of physicians in Auckland, New Zealand, where almost every doctor is on the same EMR program, Dr Brookstone is working with the Vancouver Coastal Health region to coordinate a similar effort. Calgary Health Region also has a collective approach underway now, called Medical Doctor's Electronic Record Association.

EMR Myth #1

IT TAKES TOO LONG

"It won't save any time, at least at the onset," worries Dr Gayle Garber, a GP in Conception Bay South, Newfoundland. But does she think it would lead to a more efficient practice after the system gets going? "I imagine so," she admits. "I guess it's a real time-saver. The list of drugs is right in front of you, up to date, and you can go online at the same time and look up diagnoses." The initial investment of your time during the early going will likely pay big dividends later, once the software is up and running.

3 TECH SUPPORT
One of the most important things to learn during your research is the degree of support the company offers. Larger companies may be able to offer more comprehensive and responsive technical support than smaller start-ups.

Also, be sure to verify that either your current computers can run the software, or that your budget will cover buying new computers. "There needs to be a computer in every exam room," says Dr Sands.

And don't be ashamed to ask for help — that's what the tech support is there for.

4 TALK OUT LOUD
To be on the cutting edge in adding notes to a patient's record physicians used to rely on their handy dictaphone. Doctors would record their notes and a transcriptionist would type them up, then the doctor would certify their accuracy and finally the notes would be appended to the chart. While this may not sound like ancient history to many MDs, the future of discharge summaries is voice recognition software, according to Dr Danny Sands, director of medical informatics at Cisco Systems and professor of medicine at Harvard. Many EMR software programs now offer voice-recognition compatibility as standard, he notes. "I like it better than dictating," he says. "When you're doing a dictation you can dictate wherever you are — sometimes you see doctors dictating their notes in their cars. But if you are doing voice-recognition, you are doing it on the screen in front of the PC — it's great, you get the notes done, signed and you don't wait." Depending on your preference, you might add voice-recognition as a criterion in making your selection.

EMR Myth #2
IT'S SCARY
Dr Srinivasan, the Fredricton GP wracked with doubts about EMR, in many ways represents all Canadian docs' internal struggles about making the switch. In her estimation, the hassle and expense simply don't outweigh the benefits. But is this a classic example of a false dilemma? "You're either with us or against us" — a rhetorical tool as old as time, with adherents as various as Jesus, George W Bush and Darth Vader — is, in fact, a logical fallacy. The best solution, as years of practising medicine and raising children have likely taught you, often lies somewhere in the middle of the spectrum, in shades of grey.

Believe it or not, the majority of Canadian doctors believe that EMR is a good thing in almost every regard, according to the last CMA Physician Resource Questionnaire in 2002. So why don't the majority of Canadian doctors take the plunge? "Doctors are busy and afraid to change," explains Dr Sands. "They're afraid of tipping the apple cart." Nevertheless, he says, the effort will pay off. He compares it to quitting smoking: "Once you have made the jump, you don't ever want to go back — everything is better."

5 SIGN UP AND SET GOALS

After you and your colleagues have narrowed down your shortlist to one final candidate, you are ready to sign the contract. Depending on your situation, grants may be available through Canada Health Infoway, as well as from your provincial government.

Dr Sands recommends you set milestones with the vendor. "Put in guarantees on achievements and service quality," he says. The software companies may not always be amenable to such demands in the contract, but setting goals can make a huge difference in the implementation process, he says.

The specifics of the training should be established in the contract as well. Dr Brookstone offers a tip on training: "Implementation is particularly successful in larger groups where physicians get together on a regular basis" — often without a vendor's trainer present — "and assist one another with the EMR," he says. Training with your colleagues and trading hints and shortcuts about particular features — how to design custom reports, create lists, prescribe more quickly etc. — is often more useful, after you have learned the basics, than receiving further training from the vendor.

6 GRADUAL SWITCH

"At my old institution," says Dr Sands, "we hired someone to go through our paper records and enter stuff on the computer. That was a colossal waste of money — it wasn't cost-effective. A better way to do it is to recognize that paper records will be with you for some time." Once your EMR software is up and running, begin doing all your new documentation on the computer, he says. But don't stress about filling in every bit of information from the paper records right away; instead, when a patient arrives for a visit, he says, add a few new pieces of information.

Dr Brookstone agrees with the partial-fill strategy. He recommends initially inputting some basic patient information: personal and demographic details (which can hopefully be transferred from your electronic billing software), current medications, allergies, significant test results and baseline EKGs, if they are available. "What physicians find is for the first couple of visits they may need the paper record there," he says. "But if the patient is well known to the practice, you may not need the paper record because you'll remember the last few visits. Then, begin to build the record on the computer."

EMR Myth #3

IT'S NOT SECURE

Though many doctors express anxiety about how privacy legislation will apply to electronic records, that worry is largely unfounded, says Dr Sands.

Concerns nevertheless persist. "I'm not sure the companies are doing enough to protect patient records," says Dr Garber. "Every day you read something about somebody hacking into something somewhere. Bank records and social insurance numbers and all that stuff."

Many such stories were shared by participants at an EMR privacy conference in Regina earlier this month. One was the story of Stephanie MacDonald, a medical clerk in Calgary who monitored the records of her lover's wife, an ovarian cancer patient, to make sure she really was sick. She was slapped with a $10,000 fine. Another recounted the case of a healthcare worker who accessed the EMR files of persons he met while working at a tanning salon, scouting for potential dates.

On the bright side, EMR login tracking means that rats like these get caught, whereas there's no proof with paper records. Dr Sands says computerized records are sufficiently protected. "Generally, computer systems do a better job than paper," he says.

Link to original article:

http://nationalreviewofmedicine.com/issue/special_sections/2007/practice_management/4_your_practice_8.html