

EMR update: part 1

Crossing the digital Rubicon: committing to electronic medical record systems

Peter J. Tarr, PhD

The technology is now more secure and more efficient than ever, yet most oncology practices have still not joined the digital age. If you are in that boat, this article and its companion on page 316 could be the last things you need to read before taking the plunge.

What practice would not want to make an investment that improves patient care, manages patient drug regimens, controls in-house drug inventories, provides meticulous documentation of every patient encounter, and automatically generates bills that coincide with services rendered so that charges slipping through the cracks could be captured?

Incredibly, the answer appears to be that fully three-fourths of office-based physicians¹ in the United States have not seen fit to make the investment in question—that is, buying an electronic medical record system, or EMR.

The best of these systems today are capable of integrating all of the disparate procedures and functions of virtually any specialty practice, including those of community-based medical and radiation oncologists. Yet one leading software executive estimates that only one-fourth of US oncology practices, and as few as 1 oncologist in 10, currently uses EMR software.²

What has kept so many American physicians, including oncologists, from crossing the digital Rubicon, even as EMR systems have become more capable? **To answer that and related questions, this article discusses:**

- the barriers to using EMR
- making the decision about investing in an EMR system for your practice
- some developments in the current generation of EMRs.

A companion piece on page 316 addresses:

- choosing a vendor
- what implementing an EMR system is likely to entail

Irrational exuberance

The promise of computerized medical record-keeping and clinical management has been widely discussed since at least 1991, when the Institute of Medicine (IOM) published its influential report, “The Computer-Based Patient Record.” In that forward-looking document, the IOM recommended prompt development and implementation of computer-based patient records to “improve the care of both individual patients and populations and, concurrently, to reduce waste through continuous quality improvement.”³ Not surprisingly, this spawned a new generation of specialty software companies. They offered solutions that many information

KEY POINTS

One of the main barriers to adopting EMR is simple human resistance to change.

Privacy and security issues have been satisfactorily addressed, as has been the question of interfacing with existing practice-management tools.

The cost question persists, and for good reason. EMR systems are unquestionably expensive.

Making the investment may be inevitable: pay-for-performance is coming, and EMR can make it easier to document quality care that is delivered efficiently.

A cautionary tale is included: as you type your clinical notes into the record, be sure to continue engaging the patient sitting before you.

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A dream deferred

IN 1991 THE INSTITUTE OF MEDICINE (IOM) envisioned full-blown **electronic health records**—digitized *patient-centric* records that would contain general health-related information about an individual from multiple sources, including practitioners and healthcare institutions. The somewhat more humble **electronic medical record** (EMR) with which this article deals is organized not around the patient, but around the *work-flow of the medical practice*.

EMRs can be thought of as an evolution of practice management systems that have been adopted by nearly all US physicians—the now-familiar tools such as electronic billing and patient scheduling. EMRs, which seek to “digitize” the clinical chart, integrate

these tools with lab reports, records of drug administration, inventory systems, as well as software through which physicians can fully document the patient encounter in digital format, without dictating or taking notes by hand. In a perfect paperless world, EMRs would consign to oblivion the traditional, free-floating chart, that overflowing manila folder bristling with stickers and paper clips.

For those who advocate the complete digitization of health and medical information, with the record centered on individual patients and not practices, electronic health records remain a distant goal. However, there is a notable exception: the virtually self-contained Kaiser Permanente system (see *Community Oncology*, January 2006, page 51).

technology enthusiasts expected would take the medical community by storm before the end of the 1990s.

That American physicians were not swept off their feet back then probably says more about the pre-millennial exuberance of the US high-tech industry than about physicians’ supposed technophobia. In retrospect, we can say that a classic technofallacy was about to play out: software engineers who envisioned technical solutions to a variety of practice problems failed to consider whether the potential users of EMRs—clinicians and practice administrators—were willing to invest in the systems or change existing procedures in order to integrate EMR into everyday practice.

Rational resistance

Over the past 15 years, practice management software has made the transition from novelty to nearly uni-

versal acceptance in American medical practices. One reason is that it offers clear advantages—the kind that physicians can bank on. Billing, for instance, is automated; patient scheduling is centralized and coordinated. Why has EMR software not been similarly successful? There are a number of reasons.

“Back in the late ’90s there was an assumption being made, which simply didn’t pan out, about how quickly these applications would mature,” says Bret Brodowy, PharmD, Vice President of Health Information Technology at McKesson Specialty Oncology Services. The feeling lingered that EMRs were a technology whose time had not yet arrived.

Perhaps more important were concerns about how much EMRs would cost and how difficult they would be to implement. The cost question persists, and for good reason. Solo practitioners can spend

anywhere from tens of thousands to hundreds of thousands of dollars to go digital, whereas medium-sized practices (6–14 physicians) usually begin with an investment of hundreds of thousands of dollars. In larger practices, the combination of hardware and on-site personnel training costs sends that figure even higher. Yet, as McKesson’s Dr. Brodowy admits, “the industry as a whole hasn’t done a good job justifying the return on investment. It has not been well documented.” And that has almost certainly discouraged more than a few prospective buyers.

If you are like many clinicians, you may regard the technology as young and unproven, both financially and clinically. And you may be asking these questions:

- How will EMR change the way we conduct our practice?
- How will all the parts of a comprehensive EMR system communicate digitally?
- Will presently installed practice management software have to be abandoned?
- Is it really possible to capture the nuances of the patient encounter without taking a single handwritten note?
- Are all EMR systems able to combine data from the radiation and medical oncology components of a single practice?
- Are the data displayed on a computer screen secure from hackers?
- Will the system function properly if only some of the physicians in our practice use it?

The answers to these questions are discussed below and in the companion piece, that follows.

Making the change

Operationally, many practices “are doing things the same way they’ve been doing them for the past 40 years,” says Rosemarie Nelson, a principal of the Health

Care Consulting Group's Medical Group Management Association. "We make an appointment, the patient comes in, the doctor walks into the exam room with a paper chart, walks back out, and writes a note. The paper system that preps, documents, and bills for this care is not so broken that people are eager to go through difficult changes to make things better."

Beginning in 1996, Mark Thompson, MD, wanted to shred that paper system, making him perhaps one of the first oncologists in the US to have led a medium-sized practice into the digital age. Back then, he began persuading seven colleagues in his Columbus, Ohio, group to make the transition to a Varian Medical Systems EMR. "It's a tough decision," Dr. Thompson admits, "and a big reason is that it involves making some truly fundamental changes in how physicians deal with things day in and day out."

Initially, the plan was to have a

completely paperless office within a year. "It took us about 4 months to see that wasn't going to work," Dr. Thompson recalls. "One of our colleagues, who has since retired, couldn't type. Some people in the office were better computer users than others. So we had some resistance, and we decided to back off, adding a new part of the system every 3 or 4 months." In retrospect, he says, "the hardest thing to 'implement' in an EMR system was the physicians."

David Henry, MD, member of an eight-physician medical oncology practice in Philadelphia, points out that patients themselves sometimes resist EMR technology.

An admitted "computer geek," Dr. Henry was intrigued by the prospect of abandoning the always-hard-to-locate paper chart. His iKnowMed EMR software enabled him to do that. Before walking into an exam room, his EMR presented him with a template that provided patients' vital signs, lab

values, and information on their treatment course. But Dr. Henry's system was configured so that details of the actual exam would not be captured entirely by clicking on various items in drop-down menus. It gave him more latitude, permitting the entry of notes. This flexibility was a plus, he thought. But he soon learned that not every patient saw the beauty of the arrangement. (See box below.)

"The record keeping that EMR makes possible is incredible," he says, "and it provides other benefits. Because I can access my EMR via the Internet, on a Saturday night I can sit down at my home computer and go over things with a patient who has called in. It's wonderful in terms of safety and patient care. The trade-off is that you've got to be typing while you're talking to a patient. It's a difficult skill to learn, especially when a patient is in the room."

While a paper chart is 'custom-made' and writing in it may seem

An EMR story

David H. Henry, MD | Pennsylvania Hospital, Philadelphia

AROUND THE TIME our practice first installed an EMR system, I started caring for Mr. MB, a 78-year-old male with coronary artery disease who had had a heart attack several years previously. I was treating him for his hematologic problem: moderate anemia from myelodysplastic syndrome.

As is customary, at each visit I would examine him and talk with him briefly. Then I would spend at least as much time looking at the computer and entering the visit data.

A few weeks after his last visit, we received a call from Mr. MB's wife,

telling us that he had died suddenly. When I called her several days later to tell her how sorry I was, she sternly chastised me as "one of his doctors who did nothing for him but talk to the computer." Taken aback by this, I asked her to explain what she meant.

During the past year, she said, her husband often complained that his doctors just stared into the computer and typed. Despite his taking 15 medicines a day, she said, he didn't get any better and now he was gone. I tried to console her but she was too angry to listen. When I hung up the phone, it occurred to me how all this might look to patients, especially dur-

ing a first visit when I type the entire assessment of the visit into the EMR. A clinician, deep in thought, trying to document the visit or provide medical insight for the referring physician, could easily make the patient feel neglected.

I now make a conscious effort to keep talking to the patient as I'm typing in data, reminding him that I'm doing this for accuracy and good record keeping of his (or her) case. I explain that this might well assist another physician, especially one who is on call at night when I am not available, to take care of him.

So far, it seems to be working.

faster than sitting down at the computer and typing, paper is prone to all of the old problems, Dr. Henry notes. "Your writing isn't always legible, and you don't cover everything you really should. On the basis of quality of care alone, EMR is going to be—practically overnight in terms of 'medical time'—the accepted standard all around the country, just as it is at the Veterans Administration (VA) today."

Security and other headaches

Over the past year, the VA has drawn attention to itself by not properly protecting the personal information of millions of veterans in its computer databases⁴ and by failing to utilize EMR-generated medical data on Iraq War vets. According to a recent report in *The New York Times*, lapses in using an EMR system for tracking wounded soldiers led to medical mistakes and delays in care and may even have contributed to the suicide of one soldier. His suicidal ideation, clearly noted in his record, was not consulted until days after he killed himself.

Data captured in EMR systems are regarded as secure by vendors who make the software. Much of it is often stored at practice sites, by users' own servers (see companion piece). EMR users who rely on the Internet are assured that their data are encrypted. Many experts consider data encryption no more of a problem for EMR systems than for computerized banking transactions. Both are protected in similar fashion, often using the same 128-bit encryption standard. Indeed, the software industry and many physician-users now regard the security of patient medical information a solved problem.

However, the VA's inability to consult its own EMR records does raise

the question of whether every member of a practice must go digital in order to make EMR work in that practice. The answer is that physicians can continue to use and generate new paper records. In such cases, information can still be shared, but it will be subject to the inefficiencies that EMRs are intended to address. But paper records will be more likely to generate medical errors.

Making the leap

If you're considering a digital conversion, you may be cheered to learn that many, and possibly even a majority of small- and medium-sized practices that have adopted EMRs, began their installation with less-than-complete participation from their colleagues.

Mandatory use of EMRs is typical in the hospital environment and in community-based practices with multiple locations or satellite clinics. In fact, one of the great advantages of EMRs is the ability to instantly share up-to-the-minute data across different practice sites. In effect, the chart is everywhere in the practice at once and can be accessed simultaneously by different authorized users over encryption-protected lines.

Sources consulted for this article unanimously agreed: the decision to adopt an EMR and convert to digitized medicine ultimately depends upon the individual commitment of partners in a multiple-physician practice. It's likely to be driven by an interest in addressing specific problems in the practice or in discovering how to make the practice safer, more efficient, more profitable, or better able to take part in cutting-edge medicine through clinical trials. (EMRs can make it much easier to compile accurate data for trials, as well as enroll patients.)

"Unless you write it yourself, there is no software out there that's going

to do things exactly the way you are accustomed to," says Mike Cretaro, the information technology director of an 11-physician multisite practice in Syracuse, NY. Mr. Cretaro's group uses an EMR system made by IMPAC. "If you're unwilling to change how you do things, the process will be more difficult," he says. "But if you are willing to do some self-analysis, which is hard for everybody, and you can look at your procedures without fear, then you can do this successfully—usually, within a year."

And of course, there's the inevitable march toward pay-for-performance medicine. EMRs can help generate the kind of documentation of a practice's clinical success rate that insurers and providers like Medicare are likely to demand in the not-so-distant future. Couple that with precise billing for services and improved patient care and you have to ask yourself: how can your practice not make the leap?

On page 316, the second part of this article discusses how to go about choosing a vendor, hardware needed to support the software, and several other key technical issues.

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Peter J. Tarr, PhD, has been a science and medical writer for 25 years. In addition to his writing about oncology, he writes frequently about brain research and biotechnology.

EMR update: part 2

Choosing, installing, and supporting an EMR system

Peter J. Tarr, PhD

You've made the decision to make the leap. Now what? In Part 2 of our report on electronic medical records, we guide you through the steps you need to take and the questions you need to ask along the way as you make this important purchase.

Anyone who has been to a medical convention recently knows that there is no shortage of vendors eager to sell electronic medical record (EMR) systems and other medical software products. And anyone who pays close attention to the business page of the newspaper knows that the medical software industry is in the midst of consolidation in which companies are seeking to add key components or functions to existing but incomplete suites of product offerings.

Where to begin?

With at least 2 dozen major vendors currently serving a marketplace in which as few as 1 in 10 oncologists uses any EMR product, the commercial opportunity is rich. Predictably, though, the parry-

ing of claims and counter-claims is confusing. Every major vendor claims to be able to serve all the needs of every kind of physician-client, no matter the specialty. Needless to say, the devil is in the details: budget, manpower and training requirements, and the technical means by which Vendor X proposes to meet the specific needs of your unique practice. "Every vendor claims their program is specialty-specific, but the content they deliver isn't necessarily robust," cautions Rosemarie Nelson, a veteran EMR consultant and principal of the Medical Group Management Association (MGMA).

Two vendors devote themselves exclusively to oncology clients: Varian Medical Systems and IMPAC. Varian's line of EMR products is called Aria; IMPAC's are called Medical Oncology EMR and Radiation Oncology EMR. But the distinction of serving only oncology clients does not, in itself, indicate the appropriateness of a vendor's product for a particular practice. In compiling data for this report, we spoke with marketers and/or oncologist-users of Varian and IMPAC products, as well as those of other vendors: McKesson (OncoEMR); Allscripts (TouchWorks); US Oncology (iKnowMed); and NextGen (NextGen EMR). EMR consultants we spoke with agreed that all of these products were competitive, and they advise potential purchasers to view product websites, speak with vendor representatives, view their offerings at oncology conventions, and—most importantly—speak with current users of the various products.

Make a rule-out diagnosis

Some practices will consider only an oncology software specialist; others, perhaps thinking of "how much product" they need or can afford, look at a range of offerings and insist on comparing their suitability. Perhaps the best starting point is suggested by the

KEY POINTS

- When deciding on an EMR vendor, oncologists need to assess their objectives and make a "rule-out diagnosis."
- Practices also need to assess their workflow and be willing to change processes that may work well enough today but could be improved by better, more efficient methods afforded by the EMR system.
- A fundamental choice to make is between the different ways data can be stored: on-site or remotely.
- Know that EMR adoption cannot be driven entirely by IT people; clinicians must play a key role.
- Size up vendors' experience and size; talk to their users.
- Don't stint on the training budget; ramp up slowly.

MGMA's Ms. Nelson, who has helped many—from solo practitioners to institutions with as many as 500 staff physicians—adopt and implement EMRs. **She advises oncologists to begin with an assessment of objectives.**

“What is it they want the EMR to do for them?” asks Ms. Nelson. “Beyond this, it's a lot like ruling something out with a patient. For instance, if you have users in the practice who say, ‘I won't type,’ that's going to affect which vendors you look at. If the vendor can't do an interface—that is, seamlessly incorporate data—with the national labs, that may be grounds for ruling them out.”

Ruling out vendors will depend upon what sort of practice you have. Is the practice small—fewer than, say, six physicians? Does the practice include both medical and radiation oncologists? Do you have satellite clinics? How much money are you willing to spend up front? And how much are you prepared to spend on routine maintenance, product upgrades, training and retraining?

In addition to these basics are several subjective issues:

- What kind of look and feel do you want the EMR's user-screen to have?
- Will members of your practice demand custom screens to accommodate their particular way of conducting an office visit?
- How much pointing and clicking (or typing) are you willing to do during a patient exam?
- Will you need to adapt exam-room templates to individual users?
- Does the system you're considering have a template editor?

There are also questions to ask yourself about procedures you now have in place:

- Are you satisfied with your present patient-management system?
- Would you like to replace your current billing or lab system with an entirely new, “integrated” product, combining practice management functions with the EMR's “digital chart”?
- Are you interested in an EMR be-

cause you want to integrate scheduling and billing with the patient chart, or because you also want to use a digitized chart to answer specific questions about patient outcomes or the effectiveness of chemotherapy regimens?

- If you are planning on participating in clinical trials or compiling pay-for-performance data, does the EMR system you're considering use the standardized data categories needed to generate comprehensive reports?

Improving workflow

Installing an EMR is going to change the way you practice. The question you will have to answer is how much of your operation you are prepared to subject to review and possible retooling. Some people believe that “if it ain't broke, don't fix it.” But others have a different view. Mike Cretaro, the information technology (IT) Director for Hematology/Oncology Associates of Central New York, says that practices should consider changing what works. “What you have may work because of the way you do things today,” he says, “but that may not be the best way to do things.”

After installing an IMPAC EMR, Mr. Cretaro's practice decided to stick to an old process by which dictated notes were transcribed on paper so they could be faxed to referring providers. Later, a decision was made to try digitally integrating transcribed materials into the electronic chart—something their EMR made possible. “If we had not been willing to change this process, we would have missed a tremendous gain in efficiency,” Mr. Cretaro says.

His group's EMR system is fully integrated and includes the capability to replace existing billing systems. But Barbara Robbins, Director of IMPAC's Medical Oncology Business Unit, suggests that the decision to use the IMPAC billing module should be “a matter of how well the current billing system is working, and whether there is value in having that

and other functions integrated into a single vendor's EMR solution.”

This gets at one of the great selling points of complete EMR packages. “In the medical oncology practice flow, as chemotherapy regimens are assigned, the system also generates appointments,” Ms. Robbins points out, using IMPAC's EMR as an example. This means that in IMPAC and some other products, the scheduling module, like the billing module, draws information from a single database that the clinical functions of the EMR also share. In the old paper-chart system, with different components of the practice managed by a combination of handwritten notes and different pieces of computer software, “those chemo appointments can be missed at the desk, or appointments come in and staff members aren't prepared for them so drugs aren't ordered,” she says. The fully integrated EMR “does bring a tremendous amount of order to the process flow. And with order comes productivity.”

And, it should be added, there is a potential gain in safety afforded by the EMR's use of oncology-specific diagnosis codes and its integration of practice guideline-based treatment tools.

Who houses the data?

One choice is fundamental and comes before all others in choosing an EMR: Do you want the data generated by your practice housed at your place of business or at some remote location, managed by a professional data-management company?

If it's important to have your data on-site, then you must purchase what is called in the IT business a **client/server** EMR system. Virtually all large institutions and practices of 15 or more physicians insist upon the client/server model. Their top priority is having immediate physical access to the machines in which their information is stored. And they can afford to have the IT staff on hand to configure, program, and network servers with PC workstations and mobile devices, as well as to fix anything

that ails the server. It's a major investment in hardware and staff.

A few large practices and many small ones choose what is called the **application server provider, or ASP**, model. In the ASP model, the EMR application is served up to the practice from afar, over dedicated high-speed Internet lines. Each physician-user pays an annual license fee. The software is maintained, serviced, and upgraded remotely by the service provider. Data generated within the practice are sent out over encrypted Internet lines and stored, typically in server farms—warehouses filled with rack upon rack of storage computers and servers. Large commercial banks rely on such a model to serve users in their often widely scattered branches. So the technology is tried and true.

Even ASPs entail significant investment in hardware. David Henry, MD, an oncologist in a Philadelphia practice of eight, says the number of

“boxes”—by which he means PC-type computer workstations—grew from 10 to “about 60” when the practice adopted the iKnowMed ASP-type EMR. When the whole practice is digitized, every staff member in the group must work on a device connected to the system.

Relying on the Internet to deliver data about a patient now sitting in your office can sometimes impede the smooth operation of a practice, as some users of the ASP model have reported. Page-loading delays are common. Some oncologists, like Dr. Henry, learn to live with this. Others find it intolerable.

The deciders

Understandably, many physicians believe adopting an EMR is an IT project. But, says the MGMA's Ms. Nelson, **“it's not a technology project; it's a change-management project. And it cannot be successfully driven by**

IT people. It needs to be driven by clinical people because it changes the way clinical people interact. IT people don't really understand workflow issues in the practice.”

Mike Cretaro says of his practice, based in and around Syracuse, New York, that it was “the doctors, nurses, and nurse practitioners who provided the input that made our EMR system work well. I did not have the clinical knowledge to anticipate issues that would arise in documenting the patient visit, for instance, or in configuring the system to accommodate dose reductions in chemotherapy. After we reached a certain stage in the implementation, I was the wrong person to be leading the effort.”

Indeed, Mr. Cretaro, Ms. Nelson, and EMR vendors say it is critical to identify a “superuser” in a practice to spearhead implementation and training. The problem being primarily a

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Integrated versus interfaced

EMR VENDORS often boast that their systems are “fully integrated” software solutions. Technically, the phrase should be used to indicate that practice management and clinical “modules” of an EMR system run from a single “integrated” database—in effect, joined at the hip. But “integrated” is potentially misleading in the following sense: while the very purpose of the EMR is to integrate various parts of the medical practice, integration is achieved in different ways.

Not every vendor makes a billing component or a lab component, or one that helps calculate or administer chemotherapy or radiation doses. If not, these “modules” will have to be acquired separately and run off of separate databases. The information must be brought together with that generated by the EMR system. **The question to ask a vendor is what**

functions are included within the EMR solution. If billing or scheduling is not on the list, the vendor might have a business partner that does provide the “module” For example, Varian uses GE's Centricity product to supply billing capabilities. Insist on a guarantee that a good *interface* between the two can be made.

Although we use the word “interface” metaphorically in the preceding sentence, in fact, another key hardware component of many EMR systems is an **interface engine**. Using a common data standard called HL7, an interface engine can make most billing, scheduling, lab systems, and other parts of the practice communicate digitally with the clinical functions of the EMR. Of course, both the “engine” and the know-how to use it come at a monetary cost.

The claim of an “integrated EMR solution” may or may not minimize the

need to “interface” among different systems. Among the half-dozen physicians and IT managers contacted for this story, all used or managed an EMR that was interfaced with one or more modules made by another company. At the very least, you will have to build interfaces between your software and various office machines like the fax, which are used routinely in medical practice and carry information that should be brought into the digitized patient record.

For radiation oncologists, the matter of interfaces is all the more critical. “When you bring those machines in, it's a whole different level of IT,” says Mark Thompson, MD of Columbus, Ohio. “The complexity is huge. We now have an IT manager and three technicians to keep the medical and radiation components of the practice's all-Varian EMR system running smoothly.”

Making quality care transparent with EMR

MANY PHYSICIANS are familiar with the quality-care argument for migrating to electronic medical records (EMRs). Linda D. Bosserman, MD, who heads Wilshire Oncology, a 10-physician oncology practice in Southern California, sees in this EMR selling point a solution to problems with payers that now vex many oncologists across the nation. By adopting EMRs, she says, physicians can make a bid to “take back medicine” from insurers, government payers, and a variety of risk-managing middlemen who, in her view, have turned the ethics of medical practice upside down over the past 15 years.

In her own practice, Dr. Bosserman has had the unnerving experience of being told by insurers that she and her colleagues were giving “too much care.” In effect, she says, “what we have right now in California is not ‘pay-for-performance,’ but rather ‘persecution-for-performance.’” Cost control, she asserts, is driving care, at the expense of both quality and, ironically, cost-effectiveness.

At the heart of Dr. Bosserman’s argument is the notion that over

the long haul, the best care is also the most efficient from a cost perspective. Oncologists, she says, “need to become fully accountable for the care they give.” But they cannot do so, she says, unless and until they are able to fully document and justify their work to payers. And this is where EMRs come into the picture. Recently, Dr. Bosserman helped organize Cancer Centers of Excellence (CCE), 21 oncology practices with 250 physicians, all of whom have committed to using EMRs to deliver and document care according to the latest evidence-based standards. Dr. Bosserman serves as chief quality officer for CCE.

Her thesis is that physicians will be able to regain the upper hand in medical decision making if they band together to adopt the technology that will enable them to show payers that high-quality care can actually save money by producing better outcomes. Dr. Bosserman argues that medical decisions driven by cost-containment yield a lower quality of care, produce inferior outcomes, and ultimately necessitate more care, driving up costs.

The catch is that EMRs are difficult to adopt and require considerable

investment. Dr. Bosserman believes many oncologists will be willing to endure the pains of adoption if they can be assured that they will be compensated fairly for installing EMRs and delivering the high level of care made possible by the technology.

“We’re saying to payers, ‘Pay us to commit to an EMR and practice according to the latest and best evidence. Compensate us for the time it takes to adopt and train personnel to use EMRs, and to enter data properly in the system. Pay us a premium for meeting within the practice regularly to keep our practices in line with the latest guidelines, and for being able to sit down at any time with you, the payer, to show who we treated, how we treated them, why we treated them the way we did, and what the outcomes were.’”

In Dr. Bosserman’s view, “Making quality cancer care transparent with EMR technology has the potential to bring everyone into alignment—doctors, payers, and patients. They all have an incentive. Patients will have better outcomes, payers will save money, and doctors will regain control over the care they provide.”

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human and not a technological one, it’s essential to have at least one—and in some practices, several—users who are fully committed to the transition, and who can hold the hands of the reluctant and persuade the recalcitrant.

Ramp up slowly

Finally, before committing to a vendor, a practice should give careful thought to what the implementation of the EMR will entail, how personnel will be trained, and how long it will take to put the system into daily use.

Barbara Robbins of IMPAC is not alone in advising physicians to implement in phases, for the simple reason that “oncology care is quite complex and in medical oncology especially we touch all areas of the process flow.” Ms. Robbins and MGMA’s Ms. Nelson both stress that if the implementation involves introducing new practice-management software (even if part of a “fully integrated” EMR), “you should not even think of bringing up your EMR for about 6 months, until after the practice-management component has stabilized,” says Ms. Nelson. After all, if you don’t get billing or scheduling just right,

then everything comes to a halt.

Some practices pay the vendor to send specialists on-site to train their personnel. All major vendors offer this service, at a cost. Most vendors also claim to be able to train via online “webinars,” or joint teleconferences, with users. It probably pays to heed Mr. Cretaro’s advice, based on more than a decade of EMR experience: **“The most important thing is, you can never have enough training. Whatever you think you may need, budget more, because it’s very difficult.”** At his practice, nurses, physicians, and nurse practi-

tioners formed a committee and led the effort, which did not end after the system was up and running. It continues, as does the process of tweaking and upgrading the software. ASP users have the advantage of knowing that upgrades will be handled by the “provider,” remotely. Not so users of client/server systems.

Sizing up the vendor

Greg Hammack, Director of Specialty Markets for Allscripts, is one of several large-vendor representatives

who urges buyers to “look at the company,” suggesting that size does matter. “It’s not only a question of the product and its features,” he says, “it’s what kind of people they bring to the table. Do they not just install but also support? How stable is the company? After being in this business for more than 15 years, I can say that one of the most important things to look at is if the company is big enough to make the kind of investments that will take the product forward, so that it’s not just good for today. A company with

a good product but a small user-base may not be there for you 5, 6, 7 years into the future.”

Naturally, smaller vendors will take exception to this. But about one thing vendors both large and small will agree: choose carefully, after consulting with people who actually use the product you are planning to purchase. Most vendors are happy to provide a list of users. Inevitably these users will be satisfied customers, so prospective buyers should also Google unvetted, Web-based user groups.

Community Experience

First-year EMR check-up

We spoke with Patrick Cobb, MD, a medical oncologist in Billings, Montana, 1 year after he and six colleagues began using their IMPAC electronic medical record (EMR) system on a daily basis.

Community Oncology: Why did your practice decide to invest in an EMR system?

A couple of reasons. One is that we are so spread out physically. Although most of our 70 employees are here in Billings, we have sites in Butte, Sheridan, Cody, and Mile City that are 100 to 200 miles away. On weekends, if I’m on call in Billings and I get a call about a patient in Sheridan, it’s awfully hard for me to know what’s going on with that patient. With an EMR, I can just pull up the chart on the computer and consult from home, making things easier for me but also providing much better service for the patient.

Another reason is that we knew we would have to do this eventually to comply with pay-for-performance initiatives. With several other small practices that were considering EMRs, we decided to join the Can-

cer Centers of Excellence collective. Through this consortium we did our due diligence together, and eventually we purchased software from the same vendor in order to get a break on the price.

How did the installation go?

The process began in the fall of 2005, and we were able to go paperless by March 2006. We still have some legacy charts to scan into the system, but we’ve been paperless for a year now. We had been running a version of Medical Manager, but the license was about to expire and we figured it made more sense to keep everything in one system rather than have two systems that might or might not be able to talk to one another. So we went with IMPAC from soup to nuts.

The installation was not smooth. There were a lot of fits and starts. One of the biggest problems was getting the EMR to interface with our lab system. We went through multiple iterations of the software trying to iron out the interface problem. We’ve told others, “Figure it’s going to cost you twice as much and be three times as hard as you thought it was going to be.”

If it’s not going to save you money, do you feel in retrospect that you made a mistake?

It’s difficult to say that a system like ours will save a small practice money. But in a practice like ours, with different locations, being able to get a handle on treatment programs across our five sites is a plus that you really can’t put a price tag on. A top priority for us is trying to standardize treatment across our practice, and the EMR enables us to do that—to practice according to guidelines, based on the latest and best evidence.

At the 1-year mark, what would you tell those considering an EMR?

The main thing is to make sure all of the physicians in the practice are comfortable with the system that you pick. You have to have some consensus about its value for your practice. I would also say that it costs a ton of money, and with the current reimbursement reality for medical oncology, it can be a difficult thing. I’m glad we did it when we did, because I’m not sure we’d have the resources today.