EMR and Your Oncology Practice: Another Perspective

by Amanda Patton

An ACCC member institution that is a nine-physician multi-clinic private practice was an early adopter of EMR. Currently the practice has three sites, one of which offers imaging services (CT scanner and film X-ray). In 2004 the practice saw slightly more than 1,800 new analytic cases with breast and lung being the leading cancer sites.

At this practice, the decision to purchase an EMR—made in 2002—was championed by the practice administrator and one physician. According to the practice's CFO, the decision on some level reflects "a recognition that it's something we have to do to continue to provide quality care over the long run. In our case with multiple locations [we were] looking to the new EMR to improve accessibility of information for doctors who didn't regularly see patients [in a particular location]." In addition, the practice had an aging practice management system that was due for replacement.

How They Did It

For this practice, time from initial investigation to implementation was about 18 months. To kick off the EMR hunt, the practice administrator and IT manager visited a trade show. The IT manager is a full-time staff person, who joined the practice in 1999. This staff member attends to network infrastructure issues. As a result of attending the tradeshow, EMR was included as an item in the capital expenditures process.

The practice administrator and IT manager then began the process of narrowing down the vendors. Initially, the physician champion and practice administrator were the main staff involved in the process. Input from other staff occurred later in the selection process.

Interviewing the vendors by phone, the practice was able to narrow the field to two vendors. At this point, the practice arranged for some site visits, and other clinical staff was brought into the EMR selection process.

In assessing the EMR offerings, the practice looked for the following criteria:

- *Commitment to the industry and to oncology and cancer care*. The practice wanted a vendor that understood oncology and had a commitment to develop oncology-related software
- *Stability and service record of vendor.*
- *Accessibility of data*. The practice wanted to determine how easy it would be to query the EMR database and retrieve information and then present it the ways they would need on an ad hoc basis.
- *Technical functionality of software*. Would the EMR system do what they needed it to do?
- *Price*. Cost was a consideration but less important than finding an EMR system that would meet the criteria the practice identified as important.

Return on Investment

The practice's expectation was to realize a return on investment within several years. In reality, the practice began to see some payback on the investment in EMR within 18 months, but the return was not as much as they had initially anticipated.

The practice had calculated on a return on investment in two practice areas: one was related to the billing system and the ability to interface the practice's drug management and billing system. The expectation was that the interface would automate a process that was being done manually. The practice's initial implementation focus was in the practice management side of business operations, e.g., scheduling appointments and billing. This step was achieved within a few months. Here the practice experienced the hoped-for benefits.

The second area of anticipated savings was the potential to reduce medical records staff due to the switch to electronic charting. For this practice, implementation of e-charts has taken longer than anticipated. So, in this area, return on investment is not occurring as rapidly.

The move to e-charting was slowed down, in part, by the need to develop "workarounds" for some pieces of software. Another issue for this busy practice has been finding the time to do all the training and learning associated with e-charting.

The practice is using a two-pronged phased-in approach to adopting e-charting. Two of the practice's physicians have agreed to go paperless for their new patients. At this point, these doctors have about 50 patients whose charts are paperless.

The second prong is to convert certain administrative sections of all patient charts (i.e., insurance information and demographic information) into e-charts. Currently, the practice has in excess of 200 patient charts that have an electronic portion.

Lessons Learned

For this practice, what the vendor has done very well is listen and identify the issues that are important to the practice and get those concerns addressed. In

addition, the practice is happy with the company's upgrades.

Two practical take-home suggestions from this practice—pick off the easiest part of the implementation first and partner staff who are most interested in adopting the new system.

For example, scanning the insurance information is a relatively "easy" first step in EMR implementation. Working with the front office and billing staff, this practice experienced no resistance to change. The practice was able transition without major flow issues and without getting a consensus. They could also show a tangible result. "We had something we could point to and say—the chart is thinner than it used to be," said the CFO.

In addition, partnering staff who are most interested in adopting the new system can help overcome barriers to transitioning to e-charting. This practice identified those nurses most interested in e-charting and paired them with the two physicians who have agreed to go paperless.

But perhaps the most important lesson learned is EMR adoption can take a significant amount of time. "Treat it as a long-term project and give yourself some time to get it all digested," advises the practice CFO. And, he adds, plan for the resources needed to accomplish this effort. These resources include not just the financial ones, but that nonrenewable resource—time. He suggests that practices moving to EMRs need "someone who is a recognized leader; someone who has to take the time and energy to solve all the little problems."

Amanda Patton is associate editor at the Association of Community Cancer Centers in Rockville, Md.