Avoid Pitfalls of Electronic Records Implementation

Staff input is essential since these are the people who really know what goes on in your practice.

BY MARY ELLEN SCHNEIDER
Senior Writer

BOSTON — To successfully implement an electronic health record system, set clear and specific goals and involve your clinical and administrative staff in all of the planning, Jerome H. Carter, M.D., said at a congress sponsored by the American Medical Informatics Association.

"You have to plan," said Dr. Carter, chief executive officer of NT&M Informatics, Inc., Atlanta, and the editor of "Electronic Medical Records: A Guide for Clinicians and Administrators," published by the American College of Physicians.

As many as half of complex software implementations fail, Dr. Carter said, and usually for the same reasons: vague objectives, bad planning and estimation, poor project management, insufficient involvement by senior staff, and poor vendor performance.

"This is not the time to experiment with the latest gadgets," he said.

Implementation doesn't start when the organization purchases the EHR products, but, rather, as soon as the group accepts the idea of moving from paper to an electronic system, Dr. Carter said.

The first step is to understand the current problems within the practice, to figure out how the practice should function, and identify what keeps the practice and its current system from working in an ideal way.

Potential EHR buyers should spend at least 3-4 weeks canvassing everyone in the practice to find out the problems and goals and to create a statement to capture those ideas, he said.

The next step is a systems and process analysis to be conducted by clinicians and executive management. This is a chance to figure out if an EHR will help to solve current problems, he said.

The executive management should also assess everyone's job functions. Adding an EHR to a practice will change job functions, and it's important to make sure that all the important duties are still covered, Dr. Carter said.

Once this backgrounding has been done, a request for proposals based on practice needs can be created.

During product review, it's important to have a designated project manager whose only job is to shepherd the project through each stage. In addition, senior executive support—both administrative and clinical—is key since that group will make the final decision on a system.

And staff input is essential since these are the people who really know what goes on in your practice, Dr. Carter said.

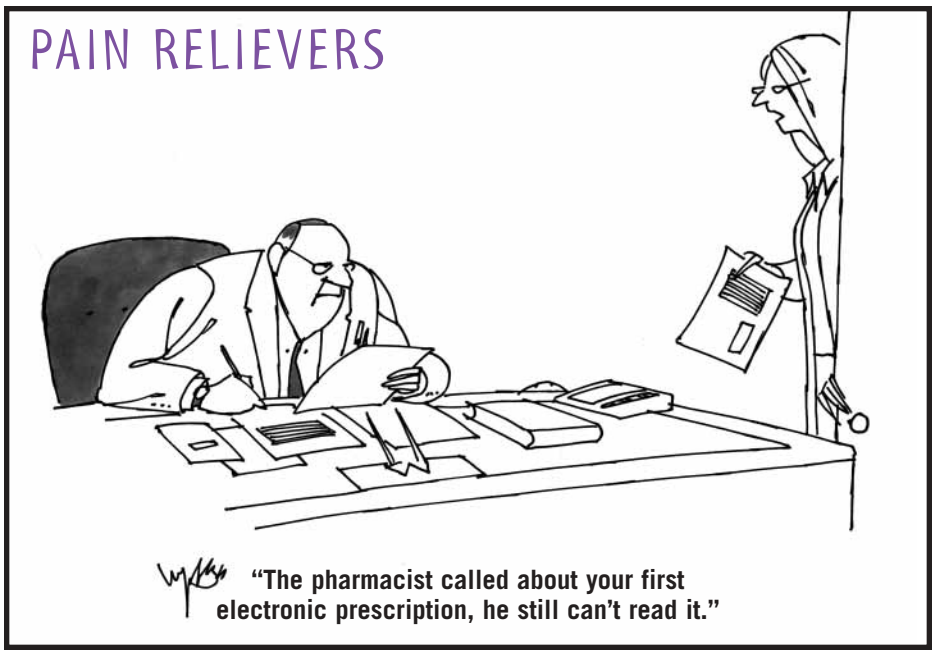
Spend time figuring out what resources will be needed in terms of new personnel, technical support, security, and equipment. "Without that level of estimation and planning, it's very likely you'll be in a situation where you need a critical person and that person is not there," he said.

Consider hardware issues. For example, it's important to consider the types of input devices that will be used, such as tablets, desktop computers, or personal digital assistants (PDAs). Tablet computers are popular but people also tend to drop them and spill coffee on them, he said.

Don't forget to factor in security issues, Dr. Carter advised. For example, practices should be sure that any system they buy is compatible with the Health Insurance Portability and Accountability Act of 1996.

When the time comes, there are a variety of ways to roll out a system, Dr. Carter said. For example, a practice can test all the features at once through a pilot at one site in the practice. Another option is to phase in implementation of the most important features first across the entire organization.

Or a practice could opt to try a "big bang" rollout where all features are implemented across the organization at once. This approach is generally more successful in smaller practices with only two sites and fewer than 10 physicians, Dr. Carter said. ■



Barriers to Sharing Data Between Systems Inhibit EHRs

BY MARY ELLEN SCHNEIDER
Senior Writer

BOSTON — Interoperability is key to the success of electronic health records, but there are barriers to sharing data between systems, said David Brailer, M.D., national coordinator for health information technology.

The major challenges include standards harmonization, unclear data control policies, a lack of uniform security practices, the inability to ensure that products perform as advertised, and the lack of a business model around interoperability, he said.

"At the very basis of this—kind of the DNA of the interoperable electronic health record—is the emergence of harmonized standards," Dr. Brailer said at a congress sponsored by the American Medical Informatics Association.

There are many organizations involved in developing and approving standards, but there isn't a process for harmonizing two conflicting standards.

In addition, there is no unified maintenance or release schedule for standards so that the industry can know what's coming and build investment plans around it, Dr. Brailer said.

Further, there is no means of providing input into the standards process, he said. For example, there isn't a mechanism for taking a problem in health care and distilling that into requirements that could be used by organizations that develop standards.

"Problems don't come well packaged into a standard," Dr. Brailer said.

Harmonized standards are at the core of interoperability, but even with standards there are many other factors in achieving interoperability, he said.

One less well-known obstacle to interoperability is the lack of clear policies about data control. Health care right now lacks even a vocabulary to talk about the control of data, Dr. Brailer said. Deciding on a set of terms and their meanings will be essential to figuring out who decides if information flows from point A to point B, in what way, and who will be notified.

Security standards pose another set of problems, Dr. Brailer said. Currently, it's possible for any two health care organizations to be compliant with the Health Insurance Portability and Accountability Act of 1996 and still have security practices that render their data unable to be shared.

For example, one organization may adopt user names and passwords for authentication while another organization uses a biometric thumbprint.

Some solutions are being developed to bridge the different levels of security. For example, security brokers or other third parties could navigate between two systems. And some states have talked about creating more requirements for uniformity of security practices.

"I think this is a profound barrier to our ability to be interoperable, and standards won't address it," Dr. Brailer said.

Physicians also need to be able to know if the system they purchase will be able to deliver on the vendor's promises of interoperability. The industry is taking a step in that direction with the formation last year of the Certification Commission for Healthcare Information Technology, a group that will certify that EHRs and other products meet minimum standards.

This work is important not just so that EHRs will one day become "plug and play" technology, Dr. Brailer said, but also because it will take some of the risk out of the marketplace.

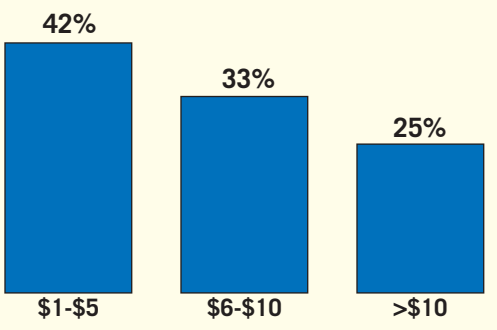
But ultimately, interoperable EHRs can't become successful without a viable business model. The industry is just starting to experiment with the value drivers in this area, such as research, clinical improvement, and transaction simplification compared with paper.

"The government's not going to tell you what the business model is," Dr. Brailer said.

The challenge is not just what the business benefit is but who receives it, he said. And Dr. Brailer predicts that this interplay of costs and benefits will lead to new relationships between providers and payers and other entities. ■

DATA WATCH

What Patients Are Willing to Pay per Month for E-Mail Consultations



Note: Based on a nationwide survey of 2,014 adults from March 27 to April 2, 2002; 37% said they would be willing to pay for e-mail consultations.
Source: Harris Interactive

KEVIN FOLEY, RESEARCH