Avoid Common Pitfalls of EHR Implementation

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.

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.

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.

Regardless of the type of rollout, ongoing staff training is critical. It is not a one-time event. Staff will need training on the workflow change and planning aspects and the actual EHR system. Physicians will need additional training on physician-specific issues related to implementation, he said. ■

Coalition to Begin Certifying Electronic Health Record Software in the Fall

BOSTON — A coalition of private sector informatics groups plans to launch a process for certifying electronic health record products late this year.

Certification will bring some predictability into the market for physicians, vendors, and payers, Mark Leavitt, M.D., chair of the Certification Commission for Healthcare Information Technology, said at a congress sponsored by the American Medical Informatics Association.

The commission's initial scope is to certify electronic health record (EHR) products for physician offices and other ambulatory settings. They plan to begin beta testing products as part of a pilot project in September.

By the end of the year, the commission is slated to publish certification requirements and to outline a roadmap for vendors for requirements for the next 1-2 years, Dr. Leavitt said.

The roadmap is a key part of the commission's work because the cycle for getting new features, interfaces, and interoperability functions into a product can be 6-18 months or more. "We need to signal to the industry as to where we are going next, so it has time to respond," he said.

The commission was founded last year by the American Health Information Management Association, the Healthcare Information and Management Systems Society (HIMSS), and the National Alliance for Health Information Technology.

The three groups have provided seed funding and have loaned staff members to the effort. As the process moves forward, the commission will charge fees to the vendors to cover the cost of testing the products. They also plan to seek sustaining grants from other organizations to maintain their operations, said Dr. Leavitt, who is also the medical director at HIMSS.

Under the voluntary certification process, products will either be certified or not certified. "We are not trying to create a competitive rating system," Dr. Leavitt said.

The idea is that the commission will be setting a baseline standard, leaving space for competition and innovation above that standard. And the standard needs to be based on reality, he said, to get participation from vendors.

In the first year of certification, the members of the commission want to be sure that they don't create requirements that will shut down the marketplace. However, Dr. Leavitt said he expects that as the standards become more rigorous in the years to come, the marketplace will evolve to follow the certification process.

Currently, adoption is progressing slowly because the market lacks order and predictability. For example, physicians won't buy EHR systems until costs are lower, their own risk is lower, and the incentives are higher. However, it's hard for vendors to bring down prices when the sales volumes are so low and the sales cycle is so costly.

Payers have expressed interest in offering incentives for the use of EHRs, but many are concerned that if they start to offer incentives, an industry of minimal systems will spring up to capture that money, Dr. Leavitt said.

Certification is a way to take some of the risk out of the process for all the players, Dr. Leavitt said.

Another challenge is to make sure that there isn't a wave of adoption of products that aren't interoperable.

"We want to ensure that these products that get adopted will be interoperable in this emerging infrastructure," according to Dr. Leavitt. "The challenge is the infrastructure isn't there yet, it's emerging."

—Mary Ellen Schneider

For more information on the certification timeline, visit www.cchit.org.