

## EMR for the Small Practice: The EMR Conundrum

First in a series of five White Papers for Physicians  
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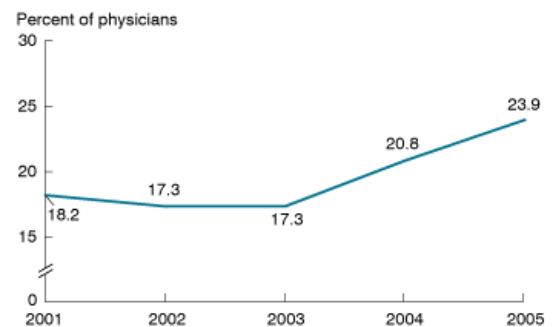
## EMR for the Small Practice: The EMR Conundrum

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As a small-practice physician, you have probably pondered, at least once, whether or not to deploy an Electronic Medical Record (EMR) system. If you are like many, the information you have gathered has raised as many questions as it has answered, and perhaps you are now more confused than you were when you started. When speaking with colleagues who have approached the same issue, you have probably heard some success stories, as well as some horror stories. Some praise EMRs as a practice-saver while others dismiss it as great waste of time, resources and money, abandoning the project and re-embracing paper records. If all of this has left you in about the same place as you started, you're not alone. You've entered "The EMR Conundrum"

Estimates of the percentage of office-based physicians that have a full or partially implemented EMR varies between 15 and 24%. But the actual numbers are much lower among physicians in small practices (ref <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/electronic/electronic.htm>). And it's no wonder. For many physicians in small practices, the kind of ambiguity in approaching EMR mentioned above is all too familiar. And small practices cannot afford to make mistakes. Even the term "EMR" itself is often used interchangeably (and mistakenly) as EHR, or Electronic Health Record. The result is confusion for the vast majority of the more than 500,000 physicians who face this conundrum today, or have had to deal with it in the past. According to industry forecasts, as many as 100,000 physicians and practices may be making decisions on EMR in the next 24 months, as the market reaches the so-called "Tipping Point." The best of the companies are even developing "best practices" in the implementation of EMR systems. And with standards committees, industry groups and regulatory agencies all weighing in on EMR at this very time, there is little reason to doubt the forecast. Especially, it seems, in hospitals, medical centers and large practices, which have IT staff and funds available.

**Figure 1. Percentage of office-based physicians who report using electronic medical records: United States, 2001–05**



NOTES: Trend is significant ( $p < .05$ ). Includes nonfederal, office-based physicians who see patients in an office setting. Excludes radiologists, anesthesiologists, and pathologists.  
SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey, 2001–05

But the question remains: How does a small practice come to a reasonable decision about investing in EMR? How do they feel secure in their decision and ensure that the implementation will be successful? That's the subject we are tackling, and is the first in a series of five white papers that attempt to define the real issues for physicians and small practices across the United States. MediNotes is an EMR software firm that has been working exclusively with small medical practices for more than ten years. Our experience in working with more than 4,000 practices, and over 15,000 users has given us a unique perspective and knowledge of the issues relating to EMRs – particularly in one to five doctor practices.

For physicians wondering about or considering the possibility of deploying an EMR, these papers are aimed at helping you make a more enlightened choice. Transforming the 'conundrum' into an effective process for finding the right answers, and giving you the information you need to move ahead with conviction and confidence.

Subsequent papers in this series for small practices discuss many of the important issues and lessons we've learned over the years about how to implement an EMR. These white papers include:

- "The Seven Hurdles to Making a Go/No Go Decision on EMR"
- "The Five Keys to Successfully Implementing EMR"
- "The Missing Link in the Transition from Paper to Electronic records: The Change Management Process"
- "EMR for the Small Practice: Getting it Right the First Time"

All these papers will help to bring the pieces of the puzzle together and introduce a process for ensuring success.

## WHY THE CONUNDRUM?

The case for electronic medical records has been debated for close to two decades now. While probably installed at one point or another in tens of thousands of locations over that time, there still appears to be no clear-cut consensus among practitioners of the benefits of EMRs. There are many who will herald the benefits an EMR that has brought to their practice. These improvements include administrative streamlining, reduction in costs (transcription, staff, charting supplies, lost charts, etc.), better coding of procedures, better financial performance, more accurate, legible record keeping and processing, etc. On the other hand, there are probably as many practices that would characterize their attempts to implement an EMR as failures. The most cited reasons for failure when implementing an EMR include technical, cost/financial, product compatibility, staff reluctance and lack of time.

**Figure 2. Percentage of physicians using electronic medical records and using electronic medical record system by practice size: United States, 2005**

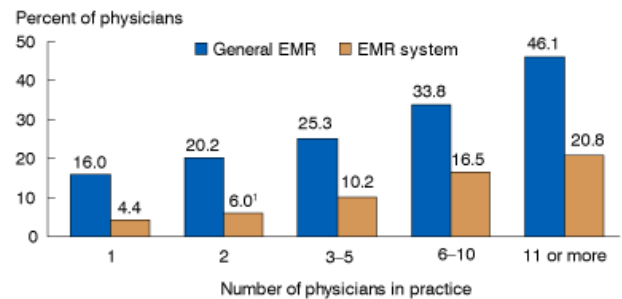


Figure does not meet standard of reliability or precision.  
 NOTES: Both trends are significant (p<.05). EMR is electronic medical record. General EMR is positive response to single question on full or partial EMR use. EMR system is a positive response to four minimal features: computerized orders for prescriptions, computerized orders for tests, test results, and physician notes. Includes nonfederal, office-based physicians who see patients in an office setting. Excludes radiologists, anesthesiologists, and pathologists.  
 SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey, 2005.

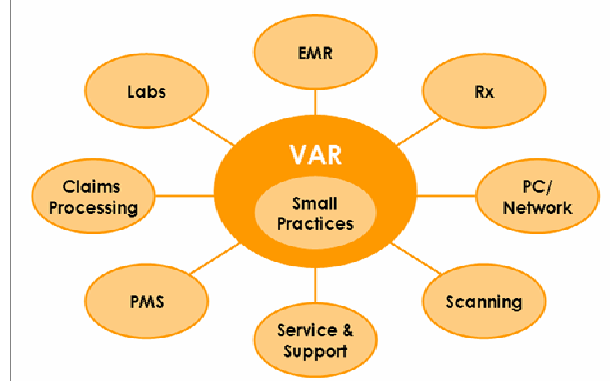
Word-of-mouth plays a strong role in the medical community and both sides of the conundrum are well represented. So, despite multiple studies and even testimony to a congressional subcommittee (<http://www.house.gov/smbiz/hearings/databaseDrivenHearingsSystem/hearingPage.asp?hearingIdDateForMat=060406>) that document both the financial and “soft” benefits of successful EMR adoption in small practices, the vast majority of physicians have resisted the undertaking. Why EMRs succeed for some and fail for others is simply part of “the conundrum.” There have been few formal studies in this area, but anecdotal findings seem to point to the same general areas mentioned above.

Available data suggests that, while overall adoption of EMRs may be around twenty percent (see Figure 1 above), that number varies considerably by size of practice and specialty, as well as between “employed” doctors and independent physicians. In general, the smaller the practice, the lower the EMR adoption rate (see Figure 2, above). As is expected, this is a function of several things including budget, IT expertise, staffing available to support systems, etc. Employed physicians, (those in hospital settings employed by large clinics or HMO’s) also tend to be far more likely to adopt an EMR, especially when those organizations may already have an EMR in place.

The failure rates for attempting to implement an EMR are broadly estimated to be between 40-80%, with little consensus or empirical data to support such findings. Those listed as failures can include abandoned systems that were unable to be used effectively, those removed for technical or functional shortcomings, integration issues that couldn’t be worked out, or other such incompatibilities. It seems that for every set of environmental issues blamed for an EMR failure, there are some nearly identical environments which succeeded. This, too, is part of “the conundrum.”

What seems to make the issue more of a hurdle for small practices – generally those under five physicians – is not only limited resources, IT expertise and budget, but less tolerance for risk and more adversity to change. Given the reductions in reimbursements and pressures on finances, physicians in small practices are struggling more each year to see enough patients to keep their incomes from shrinking significantly. This seems to make the decision to implement an EMR more risky, even if the benefits are acknowledged and accepted as

**Fig 3: From Paper to Electronic: Making it all work together in Small Practices:**



many practices fear a drop off of patient through-put and productivity. Such misperceptions are also part of “the conundrum.” But when added to the expected costs of acquiring an EMR plus other start up costs, many practices balk at moving ahead without better understanding of the risks, and making the right software decision. Wrong assumptions and decisions can be very costly.

So, in our experience in helping over 15,000 physicians make the transition from paper to electronic, there are five key reasons for the ongoing “EMR Conundrum.” These reasons significantly limit small practices from undertaking an EMR. Clearing up these issues will pave the way for a clearer process for each practice:

1. **The EMR Process is Confusing:** With a dizzying array of products claiming similar capabilities at a variety of price points, how can a small practice evaluate so many possibilities? And what are the odds of finding the RIGHT EMR for the practice? The key here is for physicians to spend as much effort finding a vendor that brings the right “process” of implementation to the table, as well as finding the right EMR program.
2. **Lack of Thought-out Selection Criteria:** Most practices have not implemented an EMR before. As such, identifying all the right questions at the beginning of the process is crucial. Product, process and vendor-selection criteria are often given less consideration than merely acquisition and start up costs. “Total cost of ownership” (TCO) looks at costs over a three or five year period, not just a purchase price assessment. Vendors who use subscription-based pricing or ASP (remote-hosted) models have an attractive purchase price, however, the costs are almost always higher in the long term. Gathering product information is easy; but making a decision based on the needs, priorities and constraints of the practice with TCO fully understood is more essential to a successful process. Having a process that “starts with the end in mind,” as author Steven Covey suggests, may be the most critical part of the EMR decision. That vision must include TCO and support as important considerations.
3. **Uncertainty of Interfacing with Existing Systems Office Technology:** Some vendors try to convince physicians that it is in their best interest to abandon the current technology in their office in favor of an integrated office solution. Replacing an existing technology such as practice management system (PMS), billing software, etc. can create a variety of problems. First, it means retraining front office staff on a new system in addition to their role with a new EMR. Second, this can often lead to a “rushed” implementation and/or running two systems parallel until fully transitioned. This is a huge burden and a source of great frustration for office staff. In addition, the practice must continue to run smoothly and patient scheduling must be maintained. Third, replacing a practice management system (PMS) often results in lost or inaccurate billing data, corrupted files and accounts receivable inconsistencies. Not only is replacing a PMS that is already performing risky and time-consuming, it may also ultimately result in settling for a new system that isn’t as good as the one you had. All-in-one products have been designed around one application, with the others being far less functional than many “best of breed” products. The vast majority of physicians MediNotes work with prefer to keep their existing PMS systems, and add an EMR (and other systems) that interface with it. With growing HL-7 industry standards and increasing partnerships among healthcare IT vendors, interfacing between multiple programs has already been achieved. This, in turn, enables physicians to select whatever “best of breed” products are best suited to their practice.
4. **Lack of an Implementation and Training Plan:** In our opinion, the chief culprit in the majority of failed attempts at EMR implementation lies in trying to rush the installation and declining formal training. Additionally, there is not a solid implementation plan for every worker in the office. Many physicians labor under the mistaken assumption that EMR described as “easy to use” and “easy to learn” translate to “little training required.” Feature-rich products that are easy to customize require training, as does learning any new technology. This, however is a small price to pay for freedom from dedicated IT staff or constant vendor interference. Still, the key element in having such a powerful, flexible tool that will transform your clinical data-gathering process, is to give extra attention to “process” in the initial stages of implementation. Involving everyone in the office from the beginning and establishing a workable plan will lead to a smooth and successful implementation.
5. **Fear That it is Not Worth the Effort:** Most small practices feel that their “paper process” is working satisfactorily. Many consider occasional administrative glitches and problems tolerable. This is a costly assumption if providers are unaware of the tremendous impact an EMR will have on the three major axes of

