**Behind Closed Doors: Avoid These EMR Disaster Stories**
Lessons learned from implementations gone bad — as told by the vendors who’ve witnessed them
By Sarah Schmelling

A practice administrator yells at a nurse as she struggles to enter patient data.

A receptionist curses under his breath while attempting to enter a new patient’s insurance information.

One doctor hasn’t spoken to her two physician partners in a week.

A nurse repeatedly tells his colleagues that the chaos his practice is experiencing is “all the administrator’s fault.”

One month ago, the employees in this same practice, though very busy, generally got along quite well. What happened?

They bought an EMR.

The vendors who help practices through the growing pains that often accompany the transfer from paper to paperless have repeatedly witnessed these very human meltdowns.

So we asked several leading EMR vendors to describe some common problems they’ve come to associate with the implementation process in hopes of helping you avoid wrong turns when it’s time to upgrade your practice. Here’s what we learned:

**Lesson #1: The practice that upgrades together stays together**

Ensuring your entire staff climbs on board the EMR train is key to its success; anything less than full cooperation tempts unnecessary trouble.

Paul Stinson, senior vice president of product management for Sage, tells the story of a 10-provider practice that saw nothing wrong with allowing some of its staff to continue using paper while the rest used its newly implemented EMR.

Confusion quickly ensued. “The whole staff has to adopt the new technology,” says Stinson; otherwise, a practice’s work flow gets stuck somewhere between past and present.

An essential element of any effective EMR implementation is to analyze the work flow and processes a practice already has in place. This helps staff understand what modifications should be made before making the switch. “There’s not a consistent work
flow for every medical practice,” explains Stinson. “So it’s very important for customers to understand their own work flow and then see what will change with the EMR.”

Sarah Corley, a physician and the chief medical officer of NextGen, a national provider of practice management software and EMRs, recommends that practices that want to go paperless conduct a comprehensive analysis to evaluate their everyday processes. She emphasizes that practices should examine “every single step that is involved in the process of seeing patients.”

Corley explains that means writing out what happens “when a patient calls for an appointment, when the patient comes in, when the nurse takes a patient to the exam room, the process of gathering their vital signs, getting their medication and allergy lists. You need to look at who does what in the practice and when. Is it done in a central location or in the exam room? How much time is spent doing each step?”

If you look at these steps before implementation and identify areas in which you’re less efficient than you want to be, says Corley, you’ll be better prepared to use your new software to ease your specific problem areas.

Thus, practices often overlook many of the benefits EMRs provide because the software requires offices to modify the way they previously approached common tasks. For example, EMRs allow staff members other than physicians to take a patient’s history, which can give physicians more time with patients that they can use to address other issues. EMRs can also alert staff to needed tests or immunizations. Because such regular procedures are “standing orders” built into the technology, physicians no longer have to manually write out orders for them, freeing up more of their time and helping their support staff become more efficient.

**Lesson #2: A ship without a captain is bound to sink**

Experts agree that a physician should be the final decision-maker when a practice chooses and implements a new EMR. This person should act as a “clinical champion” and chief contact person throughout the entire implementation process. Unfortunately, many practices fail to do this, particularly multiphysician groups.

Stinson recalls one scenario in which this lesson was hard learned. “[This four-provider office] tried to run their implementation like a democracy, where everyone did what they wanted to do,” he says. “There was no one person who was in charge of making decisions.”

With no one at the helm, the practice’s EMR implementation quickly disintegrated into chaos. It was severely impeded by the group’s inability to agree on standardized workflows, processes, templates, and general organization. “They found that they really
needed one person with a plan and a focus who could help them get in the right direction,” says Stinson.

Ideally, the “physician champion” who leads his practice’s EMR transition should be an EMR technology advocate who is prepared to navigate confidently through troubled waters. “Customers have to understand there’s going to be resistance,” Stinson says. “Not everyone’s going to want to adopt this new technology and new change, and change is difficult for a lot of people. That’s when it’s really helpful to have a solid leader on the clinical staff who will encourage their staff to adopt the new technologies and understand the benefits that are going to come from them.”

Donna Frazier, implementation supervisor for Companion Technologies in Columbia, S.C., tells an even more unsettling story about a client who failed to involve a lead physician when attempting to go paperless. In this practice, the cardiac surgeon’s office manager “did everything for him, and she [said that she] absolutely, positively knew what [the surgeon] wanted” regarding the new EMR’s templates, recalls Frazier. “She spent a lot of time building these templates and never asked him to look at them. Then, on the first day of ‘go-live’ … he looked at the templates and blew up.”

The office manager’s tears combined with the physician’s anger equaled “not a good time,” says Frazier. “I can’t tell you how much easier it makes it when you have physicians who participate.”

**Lesson #3: Keep sour grapes at bay**

But in most practices, a spiffy new EMR system will be more or less well received, says Frazier. Expect about half of your staff to welcome the change. Frazier says an additional 25 percent will have an undying, gung-ho enthusiasm for the new technology.

And then there are the naysayers.

Often, these are physicians who want an EMR but were outvoted by their peers regarding which vendor to choose and so have decided not to accept the system, sometimes personally campaigning against it.

“We had one physician who was computer-savvy, but the EMR the practice chose wasn’t the one he wanted,” Frazier recalls. From day one, he warned everyone how terribly it would turn out. “We published the schedule of which physician was going to be trained when, and he would go to each physician before they were trained and tell them, ‘This is going to be bad.’ He was poisoning the well before anyone got there.”

To defuse the dampening effect a naysayer can have on a group, a practice may opt to
train that person first. “They’ll say, ‘If we can get that person up, we can get anybody up,’” explains Frazier.

But she adds that that tactic rarely succeeds. The naysayer will focus on any specific negative aspects he discovers during training to influence others’ attitudes. What’s Frazier’s solution? “Start with the people who want to be doing it first, who will spread the positive and the good, and that makes it a lot easier for that last person.”

On top of this, Frazier says practices should be aware of the “freak-out level,” which sometimes occurs when people fear the new technology will cost them their jobs. One remedy here is to address such fears upfront with all employees, says Frazier. “It’s a reasonable expectation for people to have,” she says. But if you are honest with your employees about it, telling them that the likelihood of their job being eliminated right away is small, you can ease some tension.

**Lesson #4: Don’t skimp on time and training**

Frazier notes that practices often “just assume that by purchasing an EMR, it’s going to be exactly what they want it to be out of the box.”

The result? Failure to set aside adequate training time required for effectively implementing and fully utilizing the new technology.

Allowing sufficient time for training before going live is critical. “It just makes it less stressful,” says Frazier, citing as an example an internal medicine practice with a physician who was “so excited about the EMR, and he was so convinced it wasn’t going to slow him down, not only was he going to book a full schedule; he actually overbooked that day.”

Had it just been him, she says, this approach might have worked. “But practices have to understand [a new EMR] affects everyone in the office.”

Frazier warns practices that during the first days of “go-live,” there are going to be slowness and adjustment issues: “You’re not going to be able to see all the patients you saw the day before when you were working with paper. And everyone needs to recognize it’s a learning experience.”

Going hand in hand with miscalculating training time is underestimating the amount of training required. Glen Tullman, CEO of Allscripts in Chicago, recalls a large practice on the East Coast that gave its entire staff 25 minutes of training before patients started coming in on the day its new EMR went live. Needless to say, says Tullman, “by midday, they were running almost two hours behind.”
Physicians often don’t understand that absorbing the ins and outs of a complex new technology involves a learning curve that arcs differently for each staff member. “Even in the best cases, training takes time,” says Tullman.

Sue Weis, director of PowerWorks Delivery for Cerner Corp. in Kansas City, Mo., concurs. “Physicians also often don’t understand the technology will require ongoing work,” Weis says. “They don’t believe that it will take the time that it does to genuinely understand it. And that weeks after [the installation] they will still be learning it.”

**Lesson #5: Learn from others’ mistakes**

Stinson says these problems are not inevitable and that a reputable vendor will always return to meet with its clients, address unexpected concerns, and get installations back on track when they go awry.

But to avoid falling off track in the first place, practices should begin by analyzing their existing workflow and carefully timing their implementation. Stinson suggests going live during a relative downtime, such as “a week that they’ve reduced the number of patients they see in their schedules.” This gives everyone a chance to absorb the new technology and understand fully the how, why, and when of their new responsibilities.

Training may cost extra, but don’t skimp, vendors say. “Software is expensive, so [practices] feel they can cut costs on training, when training is what makes all the difference,” says Corley. “Even if the software has every feature known to man, if you don’t have good training on the software, you’re not going to do well.”

Forming a committee to discuss possible transition strategies may be a good idea, especially if your practice is large. However, resist joining a growing trend toward making decisions communally, with majority ruling. Experts say this serves only to reduce the lead physician’s sense of personal ownership of the project. “When you have a large group of disparate doctors who’ve been practicing in their own ways and suddenly you’re saying, ‘We’re all going to do things the same way,’ that requires a whole lot of planning ahead of time to get physician buy-in,” says Corley.

“You’ve got to have executive sponsorship — someone in the organization who will say, ‘We will make this work,’” Tullman adds. “A physician champion is very important.”

And remember: EMRs are complex systems; expect their implementation to be complex as well. Unlike earlier types of electronic systems in which clinicians didn’t need to be as involved because the technology was principally used for billing or administration processes, today’s EMRs are integral to a physician’s daily work; hence, their critical involvement. “The higher the involvement, the greater the success for the clinician and the staff,” says Weis.
Once your EMR is up and running, everyone is fully trained, and quality data are improving and speeding up your processes, this new way of conducting business will benefit you, your staff, and your patients. This takes time, but most agree it’s well worth it. “If we could teach everybody something here, it’s that this is not a horse race,” says Weis. “And it’s well worth living through.”

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