

In November of 2001, while installing a network for a local physician office, our company was asked to be a reseller for the electronic medical record (EMR) software the physician was purchasing. We were the *second* reseller of that EMR product, which today has over 250 resellers nationwide and over 3500 physician offices as clients. While five years experience would not be considered a long time in most industries, in EMR circles we are old-timers. We have seen the EMR products and their parent companies evolve and respond to the marketplace as well as a slew of new EMR companies emerge trying to cash in on a new market. Since our company's principals are computer professionals rather than sales professionals, we work very hard to ensure that physicians have realistic expectations when it comes to using an EMR in their practice. In my next couple of articles I am going to go over a few of the rules that have held true year after year regarding using an EMR in your practice, the most important of these being what I call 'doctor buy-in' of the system.

Three years ago a local physician and I wrote an article on implementing an EMR into an existing practice where we cited 'doctor buy-in' as one of the key elements to a successful implementation, and this adage still holds true today. The doctor must be onboard and lead the staff thru the process of changing their workflow and embracing the software as a positive change. That may sound dramatic but it is absolutely true. We have worked with offices where the staff was onboard and doing their part and the doctor did not want to change and eventually decided to scrap the software, necessitating removal of the computers from the exam rooms and going back to paper. Many EMR systems, in response to the perceived difficulty of implementation, have incorporated methods to shorten note completion time while learning the new workflow. These include the ability to use dictation when desired, placing notes on hold (to be finished later), and setting up an encounter form in the software that mirrors the paper encounter form. No matter what method is chosen, it is still imperative that the doctor(s) 'put a stake in the ground' and make a goal of doing every note for every patient in the software instead of on paper. This brings us around to the issue of customization within the EMR software.

Since EMR vendors want to encompass as many disciplines as possible, out of the box there will be hundreds of choices for almost everything, many of these choices are going to be meaningless to you and your office. Some vendors narrow this down by selling content based on discipline but this can end up costing more in a multi-discipline environment and there are still more choices than you will ever use. Others include all content for all disciplines offered and then teach offices how to 'hide' irrelevant content. Either way, it means the software needs to be customized to your practice, *there is no EMR software that will do exactly what you want the way you want right out of the box.* Within the same discipline offices can function very differently, and even within the same office each physician wants to see and manipulate the data in their own way. Vendors have responded to that by allowing extensive customization; adding choices, drugs, verbiage, exams, you name it based on physician login. However, this does mean that someone at the office needs to understand how the software works, how all the pieces work together, and whether the changes will affect one doctor or all doctors in the office before customizing. Keep in mind that with any software package, and this includes Microsoft Word and Excel, there are going to be multiple ways of doing the same thing, it is all a matter of finding which way works for you.