FULFILLING THE EMR PROMISE

BY STEVE MACKES

PERCEIVED BENEFIT VS. REALITY

In recent years, the healthcare industry has been under a lot of pressure to adopt the EMR (Electronic Medical Record). The assumption is that by converting physical documents to a digital system, medical information—patient charts, lab results, etc.—will be easier to access, update, track and share with other medical professionals. The perceived need to transition the industry's information to an electronic format is so great that recent healthcare legislation (HIPAA HITECH) provides both incentives for physicians to adopt EMRs as well as penalties if, within a specified timeframe, they don't.

Theoretically, EMRs have the potential to be an incredible improvement in how healthcare information is controlled and distributed. But in actual practice, the cost-effective, care- enhancing, time-saving benefits of these systems, for the most part, have fallen seriously short of expectations. Here are several reasons why:

- Many EMR systems are unable to share information with one another. Consequently, the electronic record of patients who are seeing multiple physicians may by incomplete or fragmented.
- Electronic records within ERM systems don't seem to be that secure, creating added risk as well as fueling security concerns.
- EMRs can be inefficient. Currently, some systems require logging on to a different system to view images. Physicians, indeed, find that EMRs take a long time to learn and often make them less productive. Physicians also experience specific usability problems when working with EMRs that cause long training times and loss of productivity. Examples of lost efficiency/productivity include: lengthy logins; long system response times; difficulty locating important information; logging in/accessing a second workstation when switching between patiens and exam rooms; lack of information integration can complicate a task and require the accessing of multiple screens; procedures and diagnoses may be based on a different set of codes than what physicians use; screens may contain useless information while lacking important data; screens may be densely packed with information, making it difficult to find what is needed.
- While EMRs appear to significantly improve the accuracy of administrative tasks such as billing and coding, the effects on quality of care is sketchy at best. A National Ambulatory Care Survey that analyzed 750,000 patient records over 2 years found the quality of care with EMRs

superior in one area, worse in another and the same as paper in the 14 other categories evaluated. Better quality care results come from large institutions with internally developed EMR systems, but these systems are not considered broadly applicable, especially to small and medium size medical practices.

- EMRs can perpetuate inaccuracies. Pressed for time, physicians can easily introduce errors into an EMR. Once there, wrong information is unlikely to be questioned, yet quite likely to be copied, pasted and perpetuated by other healthcare professionals.
- EMRs can be costly, requiring significant expenditures in hardware, software and training.
- Switching between patients, which happens frequently in healthcare, often becomes a time-consuming process, requiring logins on multiple workstations, lengthy searches to complete a task and long response times.
- EMRs often limit simultaneous access to the same patient record, even though this is vital to the performing of parallel work between a physician and a nurse.

THE ONLINE RECORD CENTER FOR GRM

Despite these issues, the good news is that GRM Document Management is bringing much- needed help to EMR-challenged healthcare organizations through its Online Record Center service.

GRM's Online Record Center has proven itself to be an effective supplement or even (in the case of such clients as Atlanta's West End Medical Centers) an entire replacement to the EMR.

In either capacity, the GRM Online Record Center gets the job done, provides solutions to the problems listed above and delivers those benefits that made the concept of EMRs so attractive in the first place.

The ORC secures, handles and integrates structured and unstructured data, allowing high levels of workflow automation, management manipulation, tracking and simultaneous, authorized, multiple-user access.

Better yet, as an out-sourced, easy-to-use, web-hosted, on-demand SaaS (Software as a Service) system, the Online Record Center requires little or no upfront capital expenditures or ongoing costs for software upgrades, maintenance, IT and training. As part of the service, GRM can customize the ORC to work seamlessly with an existing EMR or as a completely compliant substitute for one.

The Online Record Center can help EMR-challenged healthcare organizations of virtually any size and at any stage of the EMR transition process. The ORC is ideal for smaller healthcare organizations that need to supplement and enhance their EMR capabilities. It can also provide an effective bridged solution for an organization in the midst of transitioning to an EMR. That's what GRM accomplished recently for a medical center 3 months into an 18-month EMR rollout. Through the Online Record Center, all of the center's charts were scanned and accessible in just 30 days. Then, when implementation of the EMR was complete, the information was quickly migrated to the new system.

While the inter-departmental integration capabilities of the Online Record Center can help cuts costs and improve productivity throughout a healthcare organization, it is a particularly effective solution in such areas as legacy, back office, AP and HR.

The bottom line is that GRM's Online Record Center can assist hospitals, medical centers, physician practices, and other organizations in meeting EMR compliance requirements, overcoming the issues of existing EMRs, and adding supplemental capabilities that fulfill the EMR promise.