Fixing a Broken EHR: HIM Working in the Spotlight to Solve Common EHR Issues

By Mary Butler

Accounts of mistaken identity, anecdotally at least, seem to happen to everyone at least once in the healthcare realm with both paper and electronic records. But in an increasingly electronic world employing electronic health record (EHR) systems and other health IT where patients are presenting with more complicated cases than ever, small errors have high-stakes consequences.

Even the savviest healthcare consumers are at risk. Julie Dooling, RHIA, CHDA, a director of HIM practice excellence at AHIMA, learned this first-hand when she took her 89-year-old mother to the hospital for a ureteral stent replacement—a procedure she undergoes every 10 to 12 weeks due to kidney failure. On one particular trip to a hospital where Dooling's mother has a long history of being treated, Dooling noticed that the nurse kept addressing her mom as "sister," as if she thought her patient was a nun. Dooling and her mom shared a laugh over this, since Julie has three other siblings. When they informed the nurse of this mistake, the nurse asked if Dooling's mom ever had knee surgery.

"This is when I knew something was wrong and suspected a copy and paste problem," Dooling says. "The nurse said, as she was looking at her computer, 'Oh, there is some information that was 'brought over' that is not right.' I knew then it was a copy/paste issue.

"I asked to see the screen to confirm that everything was right. When she showed me, the wrong information was gone—I am sure she selected the wrong text quickly and deleted it—like she had to do this often," Dooling explains.

For health information management (HIM) professionals, errors such as this one are particularly frustrating since they've seen directly all the work and money that has been poured into making EHRs functional. As of October 2014, more than 418,000 healthcare providers received payment for participating in the Centers for Medicare and Medicaid Services (CMS) "meaningful use" EHR Incentive Programs. In May 2013, CMS announced that more than half of all eligible healthcare providers had been paid under meaningful use.[1] But while EHR adoption has achieved critical mass, with more providers than not having adopted them at this point, HIM professionals are still working to meet increasingly difficult meaningful use criteria, trying to get physicians on board with EHRs, adjusting workflows, and auditing records to ensure document integrity.

Most HIM professionals still stand behind EHRs and believe they will improve healthcare delivery, but do acknowledge that there is plenty to fix before the systems are perfect. The following dives into HIM's current health IT challenges, and examines how HIM professionals are using creative means to solve common problems.

EHRs can Inhibit 'Meaningful' Intentions

There is a widely held belief in the health IT community that the most problematic aspects of EHRs stem from many systems being "slammed in," or implemented too quickly, in the rush to get meaningful use payments. Karen Gallagher Grant, RHIA, CHP, says she has definitely seen this phenomenon. Grant, who is the COO of Medical Records Associates, says that providers who are able to develop EHR systems in-house are more efficient and can do more with the data they gather.

Some vendors, Grant explains, create an EHR system, plug it in, and then leave providers on their own with systems that can only achieve the bare minimum of tasks. "What I'm seeing in new EHRs is that they're designed so that physicians will use it—and they are using it—but it's not doing the other things that need to be done to make it really, really smart," Grant says. "With Big Data and the way we're moving, we're done with plugging in the computer and using it. We have to make it work for us."

HIM is dealing with many EHR errors that are very difficult to correct, if not impossible. While the EHR has advanced healthcare by improving the access and exchange of digital health records, some basic errors that were not present or tolerated in the paper record are rampant in EHRs. For example, a recent incident relayed by an HIM professional to *Journal of AHIMA* staff involved a physician at their facility who somehow was able to get into his EHR documentation template that a patient had colon cancer. According to the HIM professional, who asked to remain anonymous, the physician used that same template for 50 patients, listing colon cancer on each of their records. The kicker—when HIM staff tried to fix the issue the EHR used had no way of deleting that false information.

Compounding many of these EHR issues is the lack of testing and training by HIM professionals and other medical staff during and after system implementations. Issues like copy/paste, a lack of interoperability of systems that inhibits exchange, and basic documentation issues like the above example are causing HIM professionals unnecessary stress and burden.

Physicians are also complaining about EHRs, saying the data entry needed to document patient encounters is taking away time that could be spent helping patients. Because of this, some have turned to using HIM-based scribes as a way to better interface with EHRs (see the sidebar below).

EHR Frustrations Bolster Scribe Use

PHYSICIANS WHO TRULY feel that EHRs are costing them serious time spent with patients are increasingly turning to medical scribe services, according to a recent article in the *Journal of the American Medical Association* citing estimates provided by the American College of Medical Scribe Specialists (ACMSS).[4] The ACMSS is the non-profit organization that certifies medical scribes. However, because no federal agencies regulate or monitor scribe services, growth is hard to measure.

Michael Murphy, co-founder and CEO of ScribeAmerica, a scribe outsourcing company, says that adoption of EHRs has driven the growth of medical scribes. ScribeAmerica came on the scene in 2004 and expanded to 32 hospitals between 2004 and 2009. But between 2009 and 2014, the company has placed scribes in 500 hospitals nationwide. Part of this was driven by physicians frustrated with having to take time out of their day to electronically document encounters and other notes in the EHR.

EHRs and meaningful use aren't the only reason for the business boom. Murphy says that forces such as value-based purchasing, accountable care organizations, ICD-10-CM/PCS, and physician quality reporting system (PQRS) initiatives all mean that doctors need to see more patients in a day and better document their encounters in order to ensure proper reimbursement. Scribes make that possible, according to Murphy, by erasing any time spent on documentation typically captured by typing physicians.

ScribeAmerica scribes are trained to be "seen and not heard" by patients and are instructed to document an encounter "in parallel" with the physicians. Scribes do all of the documentation work except the computerized physician order entry (CPOE), and in some cases could eliminate the need for transcriptionists under this delivery model. In the future, Murphy hopes that every physician encounter will also include a nurse, a scribe, and a technology assistant.

Physicians with scribes "can still sit down at the patient's bedside and listen to them," Murphy says. "I think everyone in America can say they've had a bad encounter with a physician or knows someone who has, where the doctor didn't listen or spend enough time with them."

ScribeAmerica only chooses scribes that aspire to work in the healthcare industry, whether they're in nursing school, medical school, or physician/medical assistant programs. They also undergo extensive educational training, both online and in a classroom and receive the same training about HIPAA and patient privacy and security that any hospital employee receives.

Additionally, scribes are trained to be vendor agnostic so that they can work with any EHR vendor a provider uses.

The way physicians use EHRs can vary even within the same practice, a symptom of a lack of training and standards, according to a new study in the *Journal of the American Informatics Association*.[2] That report found that variability among practitioners in their use of EHRs was "high," which has led to various issues.

Some of the top challenges include data integrity issues, like copy forward/copy paste, and an inability to compare data apples to apples in EHR systems. For stage 2 meaningful users, just getting the information out of their health IT systems has been an issue. Some EHRs don't even have the basic tools to pull data for meaningful use, according to recent news reports. In the rush to meet meaningful use, some vendors did an initial set up and then left providers to find later that they can't do everything they need to accomplish in order to meet the more difficult measures of the later stages of the meaningful use program.

While haphazardly installed EHR systems may have allowed some providers to attest to stage 1 of the meaningful use program, achieving the more complex stage 2 has been decidedly more challenging. Initial stage 2 attestation data painted an underwhelming picture. As late as July 2014, only 972 eligible professionals and 10 eligible hospitals had attested, according to CMS data. However, by January of this year, 77 percent of hospitals eligible to attest to stage 2 had done so and CMS officials are optimistic that the number of eligible providers will continue to climb as well.[3]

But that's not to say that stage 2 has been a breeze. The increasingly difficult core objectives did prompt many providers to exit the program—as many as 22 percent of original attesters, according to Medscape's "EHR Report 2014" released in July. The exodus of providers from the meaningful use program has occurred because patient portal and transition of care requirements are too difficult, says Melissa Jarriel, RHIA, CHP, director of HIM services at Georgia Regents Health System. While Georgia Regents is successfully in its second year of stage 2 attestation, Jarriel is sympathetic to providers who've abandoned the program.

When Georgia Regents attested to stage 1 of the meaningful use program they chose to follow the "all emergency department (ED)" option. As defined by CMS, this method allows hospitals and eligible providers to meet meaningful use criteria through hospital emergency department admissions. Because the volume of patients coming through Georgia Regents' emergency rooms was high—about 200 patients every day—they were meeting the computerized physician order entry (CPOE) requirement in stage 1. Due to this success, they kept using the "all ED" option for stage 2 meaningful use.

Unfortunately, this meant that the HIM department had to enroll new patients into the patient portal during an ED encounter, which proved "virtually impossible" to do, according to Jarriel.

"Just think, we're a Level 1 trauma center and the types of patients we see, and how the whole trauma workflow goes. It's just not appropriate to be going into the room of someone who's been shot and ask if they want to be in the patient portal. It's just not going to work," Jarriel says. "On the surface these objectives don't seem that difficult, but when you get down into the weeds, it is extremely difficult."

Georgia Regents was eventually able to make the program work and attest successfully to stage 2, but only after a lot of extra work designing manual processes to meet the requirements.

According to Anna Orlova, PhD, AHIMA's senior director for standards, part of the disconnect that Grant and Jarriel identified is the result of how the meaningful use program was set up. In March 2014, Orlova attended a CMS workshop event that focused on discussing the meaningful use program's accomplishments. The takeaway from that workshop, Orlova says, is that in developing the meaningful use program CMS officials chose to emphasize the utilization of electronic records—not the usability of health records.

"This was a really strange statement, and I felt like I finally got an understanding about meaningful use and its challenges," Orlova says. "If utilization means pushing complex systems into healthcare organizations, then I think we achieved this goal. If the goal was using that to support health practices in a meaningful way, we definitely didn't achieve that goal."

Orlova explained that the health information community developed over 150 use cases that they hoped EHRs could serve. However, the meaningful use program only addresses 20 of those 150 use cases. This helps explain the trouble meaningful users are experiencing in trying to parlay the program into improved care processes.

Participation in standard-setting organizations will help the industry make the most of EHRs down the road, Orlova says.

"I believe that AHIMA, now, holds the key role in addressing the current challenges of our health record," Orlova says. "And based on lessons learned over the last five to 10 years, I would say, to be able to bring together the industry to move forward with records that work."

Cutting Out Copy/Paste

HIM practitioners on the whole agree that EHRs are worth the trouble it takes to make them function properly. They're also the ones leading their organizations to maximize EHRs benefits, which highlights the need and demand for HIM professionals.

The expansion of EHRs, says Grant, "positions us to where we need to be as a profession. I think the introduction of the EHR offers many opportunities for health information professionals and closes the gap of the old world and the new world." One example of a health IT opportunity for HIM professionals is the patient portal. "Now, patients are looking at their portals and might not understand the medications they're on, and HIM professionals can facilitate discussion between the patient and their primary care physician," Grant says.

Cindy Phelps, RHIA, director of technology services at the Carilion Clinic, based in Roanoke, VA, has had an EHR up and running since 2008. She says that the process of implementing the system increased the visibility of the HIM department in her organization. At Carilion, HIM operations used to report to revenue cycle, but now it falls under IT because that is the department they now collaborate with the most. When she started the meaningful use process she moved a master patient index (MPI) analyst and a transcription team leader over to IT, and has leaned heavily on them.

"They're doing very similar work but more intense. The move has given them the opportunity to learn more and expand their scope," Phelps says.

HIM professionals are also the go-to people for one of the biggest problems with EHRs—the functionality that allows users to "copy and paste" data from one record to another. As Dooling notes through the incident with her mother, copying and pasting within an EHR proliferates because it saves nurses and physicians typing time if they "carry forward" relevant information from a previous encounter with the same patient. But too often, wrong information gets carried forward or copied over from another person's record, leaving clinical documentation improvement (CDI) specialists or transcriptionists to clean up the record.

Joyce Smith, transcription manager, document integrity services at western Michigan-based Spectrum Health, has transitioned at least 15 transcriptionists to the role of document integrity auditors to help correct EHR issues. Smith says that while the volume of work is shrinking for transcriptionists due to the use of EHRs, there is plenty of work to be done in correcting copy and paste habits and correcting basic grammar and spelling in health records.

Additionally, she has trained 13 transcriptionists to become physician trainers who go out on the hospital floor and coach physicians on the best ways to document.

"When we first started this project, the CDI folks were like, 'We're in the chart all the time, we'll just take this on.' But it soon becomes evident that they don't have the time to do the nitpicky stuff that we do," Smith explains.

At the Carilion Clinic, Phelps says that copy and paste is a big problem, and one that CDI specialists and coders work on together. The system formed a steering committee to tackle copy and paste this last summer. The committee agreed that CDI and HIM staff would audit records and make note when physicians improperly copied and pasted or contributed to what Phelps calls "note bloat," which occurs when EHR users chronically pull forward old information on a patient. When physicians do this too frequently, committee members will inform medical staff that this is happening, and then it will be up to the medical staff to sanction the physicians. Therefore, the medical staff is tasked with deciding how much copying and pasting they will tolerate.

Putting the 'Able' in Interoperable

The federal government, in a recent report to Congress, lamented the fact that even though EHR adoption rates are improving, the lack of interoperability between those systems is impeding information sharing as intended.

"Electronic health information is not yet sufficiently standardized to allow seamless interoperability, as it is still inconsistently expressed through technical and medical vocabulary, structure, and format, thereby limiting the potential uses of the information to improve health and care," said the October 2014 report from the Office of the National Coordinator for Health IT (ONC).[5] Some progress was made in February when ONC released a draft of its Interoperability Roadmap aimed at facilitating safe nationwide exchange of health information.

In the absence of federal success with interoperability, some members of the private sector have responded with their own plan. The CommonWell Health Alliance, a non-profit, vendor-led trade group for health IT companies, including EHR vendors, retail pharmacies, and other stakeholders, is working to enable patient data exchange more easily. As the Alliance points out in one of its specification sheets, providers are experiencing "deployment fatigue" and aren't "interested in adopting new solutions that would dramatically change their workflows yet again."

Dan Schipfer, a vice president with Cerner and an Alliance volunteer, says the Alliance is using "our collective experience to bring down barriers to data exchange" through interoperability specifications the Alliance has published and made public.

Schipfer says one of the biggest hurdles to interoperability from provider to provider, or from patient to provider, is the lack of a standard way to identify a patient. The adoption of a tool such as a national patient identifier (NPI) has been unpopular in Congress, so ONC has encouraged groups like the Alliance to solve that problem on their own. That said, in fall 2014 ONC launched a workgroup as part of their "Innovators in Residence" program to address patient identification and matching issues.

The Alliance has also begun to do this by developing a set of specifications that providers and other health data companies can adopt to make data easier to exchange, regardless of whether they are part of a health information exchange (HIE) organization. To make it easier for stakeholders to participate, the Alliance offers a set of four services: an identity management service that helps providers accurately confirm the identity of patients; a record locating service; a consent management service (patients have to give their consent for participation); and a service that provides authentication and auditing in order to facilitate secure data sharing.

"The other thing we wanted to do was manage a patient's consent. If the patient says 'I don't want this information shared,' then it ends there," Schipfer says.

Heal Thyself

How does the healthcare industry fix its EHR issues? Focus less on technology and systems and more on training people and better using current systems, according to some HIM professionals. Healthcare is better off with EHRs, but the systems have a long ways to go before the healthcare industry starts seeing benefits. However, EHRs hold a lot of promise, Dooling says, and the hope is that the healthcare industry will start seeing benefits as people become more comfortable with the systems and interoperability improves.

After all, it would be difficult to imagine going back to a paper health record.

Notes

[1] Centers for Medicare and Medicaid Services. "EHR Incentive Program Active Registrations." October 2014. www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/October2014_SummaryReport.pdf.

[2] Ancker, Jessica et al. "How is the electronic health record being used? Use of EHR data to assess physician-level variability in technology use." *Journal of the American Medical Informatics Association*. November 2014. http://jamia.oxfordjournals.org/content/21/6/1001.

[3] Raths, David. "MU Stage-2 Eligible Hospital Attestation Rate: 77 Percent." *Healthcare Informatics*. January 13, 2015. www.healthcare-informatics.com/article/mu-stage-2-eligible-hospital-attestation-rate-77-percent.

[4] Gellert, George et al. "The Rise of the Medical Scribe Industry: Implications for the Advancement of Electronic Health Records." *Journal of the American Medical Association*. December 15, 2014. http://jama.jamanetwork.com/article.aspx?articleID=2084910.

[5] Office of the National Coordinator for Health IT. "Report to Congress: Update on the Adoption of Health Information Technology and Related Efforts to Facilitate the Electronic Use and Exchange of Health Information." October 2014. www.healthit.gov/sites/default/files/rtc_adoption_and_exchange9302014.pdf.

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