Healthcare Reaches the EHR Tipping Point: Examining the HIM Implications and Expectations Now That A Majority of Us Providers are Using EHRs

By Mary Butler

Sometimes one must call back into the past to understand the present and future.

When it comes to current challenges and successes with electronic health records (EHRs), the ongoing countrywide implementation mirrors that of another revolutionary wired device.

Judy Murphy, RN, FACMI, FHIMSS, FAAN, deputy national coordinator for programs and policy at the Office of the National Coordinator for Health IT (ONC), likens EHR interoperability to advances in telecommunications.

"We've often used the analogy of the telephone," Murphy says. "If you buy a telephone, it's only as good as the other people who have telephones and can call, and so one of the things we're doing with getting EHRs installed is that we're setting up the capabilities and electronically exchanging the information so we can create a patient-centric record."

Even with telecommunications, where cell phone adoption is broad, problems linger. Dropped calls plague even the most robust cellular network providers, and coverage in vast swaths of rural areas can be spotty. When users outgrow or want to upgrade their phone before their contract ends, the costs are high. The infamous "Can you hear me now?" commercial catchphrase is still uttered by more people than most cellular carriers would like to admit. Still, not many would trade their iPhone for a rotary phone. And federal and local health IT and HIM professionals are banking on the fact that healthcare providers will go to EHRs and never look back.

To look at the numbers, EHR adoption has made tremendous progress with the help of federal initiatives such as the "meaningful use" EHR Incentive Program. In May 2013, Department of Health and Human Services Secretary Kathleen Sebelius declared that the country had reached a "tipping point" in the adoption of EHRs, with more than 50 percent of eligible professionals (mostly physicians) and 80 percent of eligible hospitals having demonstrated meaningful use and received an incentive payment. Now that the nation is meeting federal goals and a majority of healthcare providers have EHRs, it's time to examine what's working, what is not, and what still needs to be done with health IT.

Analyzing the Federal Return on Health IT Investment

In October 2013, the Centers for Medicare and Medicaid Services (CMS) announced that it had paid out just under $17 billion in meaningful use incentive payments. Additionally, the agency noted that more than 430,000 eligible hospitals and professionals had achieved meaningful use, with 93 percent of eligible hospitals and 80 percent of eligible professionals registered for the program.

Murphy says those numbers are on track with CMS and ONC goals, but she's also quick to point out the broader benefits of reaching the EHR "tipping point" such as the widespread use of electronic prescribing (e-prescribing or eRx) and clinical decision support. These are new convenience safety features that were just not possible in a paper world. Brian Levy, MD, a practicing hospitalist physician and the senior vice president of health language at Wolters Kluwer Health, sees the benefits of both of these features every day. "With e-prescribing, I don't have to write them up by hand, don't have to worry about patients losing them, have to have the pharmacy call me up because they couldn't read the prescription—I think that's turned into a benefit," Levy says.

Clinical decision support is getting easier for Levy as well. If he's treating a patient with atrial fibrillation, he can research interventions and print out pamphlets for his patient at the point of care. "The goal is to provide the most useful patient-specific information so I don't have to read pages and pages of stuff," Levy says. "That's going to be of immediate value to the clinician and to the patient—getting access to the right information at the right time."

As for whether the government has seen a good return on its investment in health IT, Murphy says it "absolutely" has. She points to the Beacon Communities, regional extension centers (RECs), and the infrastructure now laid for HIEs as the most successful programs the government invested in—many of which helped providers meet meaningful use criteria. For example, the RECs helped providers find, implement, and use their EHRs to meet meaningful use criteria.

"I don't know where they would've gotten that type of resource otherwise. Many cannot afford to hire consultants. Giving a lot of those tools and working with them was really helpful," Murphy says.

But William Bria, MD, co-founder and president of the Association of Medical Directors of Information Systems (AMDIS), says determining the government's health IT return on investment is difficult to quantify. "It's like asking a mother or father 'What you paid for your kid's college tuition, was [it] worth it?'" Bria says. "In some cases, 'Yes!' You definitely catalyzed a transformation. Is it done? Not even close."

The benefits of nationwide EHR adoption, which is the goal of CMS and ONC, are crucial for improving healthcare, says Jill Devrick, MPA, president of the Association for Healthcare Documentation Integrity and product solutions advisor for eHealth documentation solutions at 3M. "I think it's the whole idea of everything being available from a central location," Devrick says. "There aren't going to be issues with there being only one chart and people are waiting for information, and the delays that were inherent in the paper world.

"EHRs are going to be very important for individual health systems, but also the idea of them being interoperable and the idea that my record is going to be accessible regardless of where I'm seeking care."

Levy says there's no question EHRs are helping to improve care, although adjusting physician workflows have been a challenge. Also, the lack of interoperability and difficulty to exchange health information has limited EHRs' benefits. As a hospitalist, Levy works at multiple affiliated hospitals in one city where all the hospitals use the same EHR system.

"I'm not able yet to see information from an unaffiliated hospital," Levy says. "But if a patient's had a cardiac cath[eterization] or an echo[cardiogram test] or some other test at an affiliated hospital, I can see that information and I don't have to reorder tests, I know what the results are. I know what the lab tests were in the past."

Levy says he expects to see more of this type of interoperability with stage 2 of the meaningful use program. He's even been able to make the most of functionalities that have been headaches for other physician EHR users. One of the most frequent physician complaints is that EHRs are too time consuming—an issue that correlates to a frequently cited criticism from patients that their doctors always seem to be in a hurry. However, putting computers in hospital rooms to facilitate physician documentation has helped change this perception, Levy has found.

In the past, Levy says, he would spend five or 10 minutes with a patient, and 20 to 30 minutes charting outside of the patient's room, which the patient never saw. "I'm spending 30 minutes with the patient, and the patient is seeing that I'm spending all of this time with them. It gives me more of a chance to interact with the patient," Levy says. "I think it's a very good way to get the computer and EHRs in front of the patient."

Mary Radley, RHIA, director of health information management at Boston Children's Hospital, has led her department through multiple electronic initiatives, such as the implementation of personal health records (PHRs) and patient portals, long before they were driven by federal programs. Radley says this current era is the most exciting time to be working in the field.

Staff engagement with patients at Boston Children's, an initiative in meaningful use, has been high, according to Radley. Part of being responsive to consumers is meeting their high technology expectations. Patient engagement with technology such as PHRs and patient portals at Boston Children's has not been a problem as it has at some clinics and hospitals that serve largely Medicare populations and have lower portal use rates.

This is helpful since pieces of the meaningful use measures call on patients to proactively use health IT systems. "They're asking 'Why can't we do this?' and 'Why can't we do that?" They're used to the 'there's an app for that,'" she says.

Part of Radley's patient population includes adolescents, which brings privacy concerns about parent access to portals for patients over the age of 18 and emancipated minors. Radley has been lucky to have strong physician involvement, which made the use and HIM management of health IT systems easier.

"A lot of committees I work on are high nursing- and physician-based committees dealing with information management," Radley says. "It's been rewarding that they're getting it. They're understanding that when it's electronic, it still needs protections. I never really interacted with physicians in the way we do today when we were [working] with paper records."

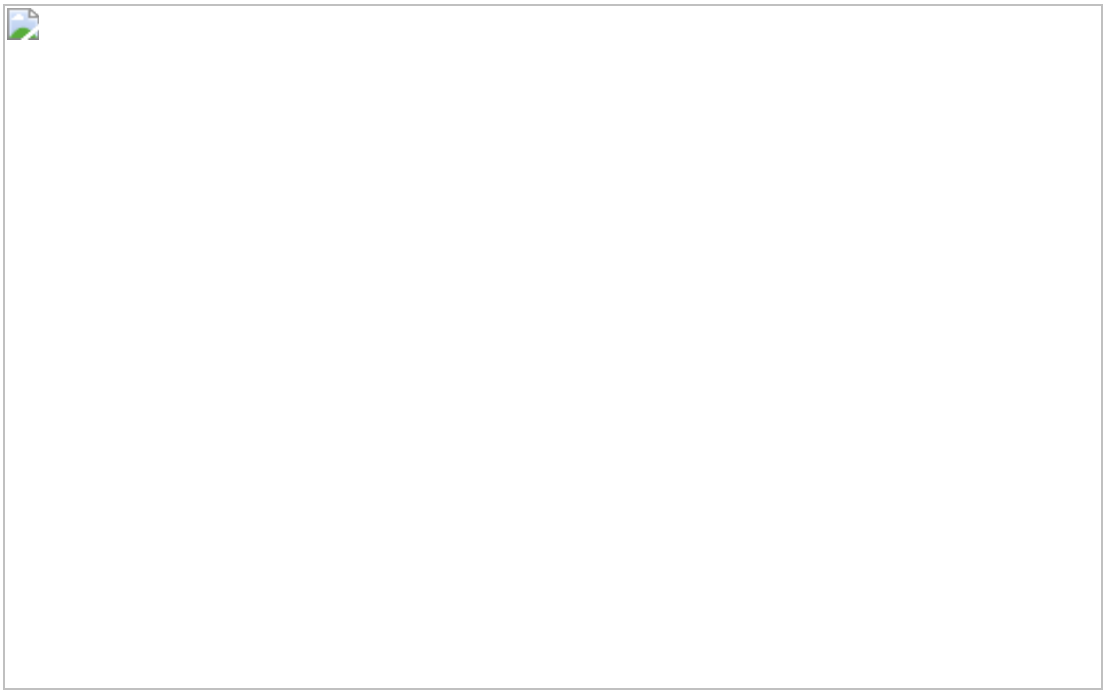
CDC Report Offers State-by-State EHR Adoption Rates

A January report from the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC/NCHS) confirmed previous rosy federal estimates that electronic health record (EHR) adoption rates for physician practices reached 78 percent in 2013.

The report also revealed potential barriers to successful attestation for office-based physician practices. Though 78 percent reported having any type of EHR system, only 48 percent of physicians reported having a "basic system" able to meet all meaningful use objectives. As stated in the CDC/NCHS National Ambulatory Medical Care Survey, "to qualify for the Stage 2 meaningful use incentives in 2014, eligible physicians must meet all 17 of the Stage 2 Core Set objectives for meaningful use and three of the six Menu Set objectives, using certified EHR systems. In this report, estimates of physicians' readiness to meet meaningful use measures were limited to 14 of the 17 computerized capabilities that support the Stage 2 Core objectives."

Additionally, the report provided state-by-state comparisons demonstrating where states stand on EHR adoption readiness. For example, in North Dakota, 83 percent of eligible physicians reported having a basic EHR. New Jersey physicians ranked the lowest, with only 21 percent reporting basic EHR adoption, according to the report.

State-By-State Analysis of Office-Based Physicians With Basic EHRs



Source: CDC/NCHS. "National Ambulatory Medical Care Survey, Electronic Health Records Survey." NCHS Data Brief no. 143 (January 2014). http://www.cdc.gov/nchs/data/databriefs/db143.pdf.

EHR 'Shock and Awe' Affecting Some Providers

The fact that some physicians are dissatisfied with EHRs was entirely predictable, Bria says, adding that there is still a lot of "shock and awe" among physicians who are alarmed by the disruptions to their workflow and the pace by which changes are happening. However, claims about EHR usability, configuration, ease of workflow, and implementation were oversold to the provider community in many cases, Bria says, and the reality is now settling in.

"We're seeing a lot of marginal systems, for those that are functional, they've been implemented too fast, and for those that haven't been implemented too fast, they've been configured and adjusted too little," Bria says. "I mean, if you think Epic or Cerner or Allscripts [is] one size fits all, it works for every specialty, you're delusional. You're crazy."

Fortunately, that's where HIM professionals can help their clinical counterparts, Bria says. HIM professionals can help by facilitating communication between the IT department, clinical staff, and administrative staff to select proper systems or fix EHR issues. He says too often IT departments are put in charge of choosing the EHR vendor when they are not the staff familiar with documentation and physician workflow.

"HIM really needs to be a source of accurate information," Bria says. "HIM has, in the past, in many places I'm familiar with, ranged from silent and very passive to very active and as much a communicator of legislating and compliance as anything else."

Too often, Bria says, HIM staff is not invited to important system discussions. But with the EHR taking center stage in many facilities, HIM professionals now have the opportunity to say "It's the data, stupid."

"There's an excitement that this may not only be the future career of people who used to push the paper around, but time for a new generation and an especially trained medical records department [that is] far more engaged with the medical community," Bria adds.

While vendors can sometimes be part of an EHR fix, other times they just add more problems. Radley acknowledges some frustration in dealing with big vendors who are unable or unwilling to customize workflows to suit medical specialties, such as pediatrics. One vendor told her that: "If you can get all of the pediatric hospitals to work together on how they would want that to look, you have a better shot at getting the change made because it will benefit all of the pediatric clients. But if you each send in a different spin on it, then none of you will get what you want."

As a result, Radley has quarterly meetings with other pediatric providers to share tips, work-arounds, and strategize about how to lobby vendors for changes.

Number of Providers Paid through Meaningful Use Program

The table below shows how many healthcare providers have received incentive payments through the meaningful use EHR Incentive Program as of September 2013.

	Unique Providers Paid 2011 Program Year	Unique Providers Paid 2012 Program Year	Unique Providers Paid 2013 Program Year	Unique Providers Paid Program To Date
Medicare Eligible Professionals	58,431	187,282	7,047	204,335

Doctors of Medicine or Osteopathy	51,433	167,580	6,592	182,900
Dentists	53	169	6	193
Optometrists	2,578	8,503	158	9,080
Podiatrists	2,915	6,221	210	7,055
Chiropractors	1,452	4,809	81	5,107
Medicaid Eligible Professionals	50,516	65,249	11,571	103,968
Physicians	37,860	47,192	7,151	73,861
Certified Nurse-Midwives	1,103	1,367	188	2,123
Dentists	2,693	5,044	1,431	8,898
Nurse Practitioners	8,213	10,895	2,649	17,889
Physicians Assistants	647	751	152	1,197
Eligible Hospitals	2,316	3,231	759	4,149
Medicare Only	79	156	36	204
Medicaid Only	57	71	22	110
Medicare/Medicaid	2,180	3,004	701	3,835
Medicare Advantage Organizations For Eligible Professionals	10,507	11,340	-	12,672
TOTAL	121,770	267,102	19,377	325,124

Source: Centers for Medicare and Medicaid Services. "EHR Incentive Program: Payment and Registration Summary Overview." September 2013. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/September2013_PaymentandRegistrationSummaryOverview.pdf.

EHRs are In, but Tweaking is Needed

Just because the majority of providers are using EHRs doesn't mean they are using them well. Lingering concerns exist that EHRs were implemented too quickly before proper standards could be put in place, and that initiatives like the meaningful use program lead to vendors slamming in EHR systems with little care that they would actually work for a facility.

"I think there's going to be a lot of movement toward data dictionaries," says Devrick, noting cases where clinicians often use two or three different terms to identify the same thing. "It's getting to the point where there needs to be further standards and discussion about documentation quality, the capture of data, and how are physicians being taught to do the entry."

Although use of EHRs has reached critical mass, they'll be in tweaking mode for a long time. In the near future healthcare organizations are going to be pulling data from EHRs to make decisions about quality improvement and patient care. The lack of standards between facilities will hamper this effort, Devrick says. "If you're comparing apples to oranges, that means you're going to have to go back through and look at standards and look at how the information is being entered to [see] more consistent methodologies where you can make good, valid comparisons," Devrick says.

Another example of a needed tweak to many systems is the unstructured or narrative data that's missing from many EHRs. According to Devrick, although "moving towards more structured data is great from the reporting standpoint, it doesn't paint the full picture of a patient's situation, the context behind why the decisions are being made or why the patient is in the condition that they're in," she says. "There has to be a thought process documented to explain the social history or the family history that led us down this path.

"Obviously people aren't the same and that's where the data comes in. It's really important to treat people as an individual story and not a bunch of data points."

Another area of tweaking for EHRs will involve their functionality for patient-centered medical homes, which some say they are not well configured to support. Medical homes, which are care coordination models that rely on communication between patients and physicians, can pose a challenge when collaborating providers aren't using interoperable EHRs.

Sheila Green-Shook, MHA, RHIA, CHP, director of HIM and privacy officer for Evergreen Health, says organizations are trying to accomplish some of these functionalities by sending coordination of care documents, or summaries of care, that follow patients to their next provider. However, she says, it can be challenging to send bits and pieces of information from an EHR to the recipient in a way that's easy for them to understand.

According to Green-Shook, a challenge in creating and sending out the transition of care summaries has been that it started out as a function handled by their IT department. She predicts, though, that it will likely become a task delegated to HIM.

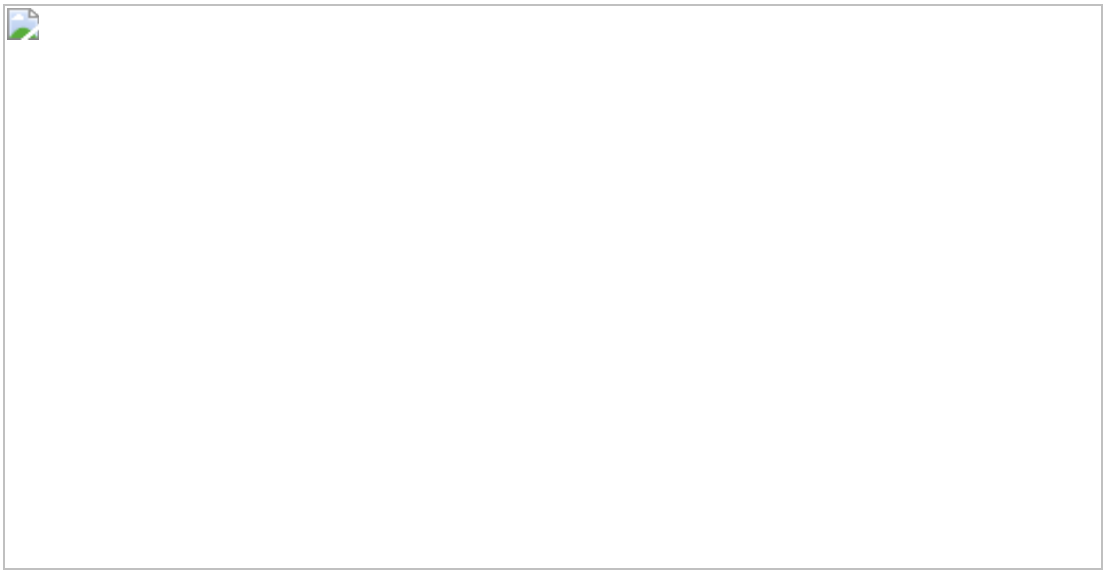
"You've got IT who is driving the technology piece of this and making sure the transition of care document goes out, and the right box is checked so it gets counted for meaningful use, and then you have the other group, HIM, working with physicians and making sure the info contained within the transition of care is actually sent to the provider," Green-Shook says. "That's two different things. You can meet the transition of care [requirement] by sending it out to 10 percent of your patient discharges. But if there's no clinical value, that's not really the intent of having a transition of care document."

ONC's Murphy acknowledges that some EHR product developers did not pay enough attention to functionalities required for patient-centered medical home documentation. "Frankly, though, an EHR is going to be better than trying to do it on your own with paper," Murphy says. "…Even in its most basic element, EHRs support patient-centered medical homes. But then when you start to think about the templates and protocols, some of the other data analytics that are required under patient-centered medical homes, they are just in lockstep with the use of an EHR."

The trend of finding flaws in newly implemented EHR systems could get worse before it gets better, AMDIS's Bria says. He is sympathetic to physicians and HIM professionals who are frustrated with EHRs. "I understand how good people can start to be exhausted and say 'Maybe these things are crap and maybe I should stop defending it,' because again, the machine doesn't have a sensitivity or personality or feelings," Bria says. "[But] exemplars have shown how we could really soar at providing superb care consistently and learn so much more with the use of computer systems. The problem has been there are a lot more partial or poor implementations than there are good ones."

US Office-based Physicians with EHRs by Year

This chart shows a comparison of physician office adoption of "any" and "basic" EHR systems between 2001 and 2013, according to the National Center for Health Statistics.



Source: CDC/NCHS. "National Ambulatory Medical Care Survey, Electronic Health Records Survey." NCHS Data Brief no. 143 (January 2014). http://www.cdc.gov/nchs/data/databriefs/db143.pdf.

Like the Telephone, EHRs will Keep Improving

EHRs and other health IT systems will continue to evolve, just like new generations of the iPhone will keep people lined up at Apple stores. So when will the industry know the hardest part of EHR adoption is over? Devrick has a theory.

"You always want the technology you provide somebody to eliminate stress—or at least not add stress to their job. I think that's the big question out there right now, 'What are we doing to physicians?'" Devrick says. "We'll know we've reached the destination when everyone can sit down at their desk and do their job without being frustrated and feeling like they're having time taken from them by doing the job."

Mary Butler (mary.butler@ahima.org) is associate editor at the *Journal of AHIMA*.

Article citation:
Butler, Mary. "Healthcare Reaches the EHR Tipping Point: Examining the HIM Implications and Expectations Now That A Majority of Us Providers are Using EHRs" *Journal of AHIMA* 85, no.3 (March 2014): 22-27.