

8 POPULAR EHR MYTHS DEBUNKED

Remove the roadblocks to incorporating EHRs by knowing the facts.

BY CHRISTINE ARCHIBALD



In 2012, almost 72% of office-based physicians reported using electronic health record (EHR) software, a notable 35% increase since 2007.¹ Some physicians, however, are still reluctant to adopt EHRs because of several prominent myths. This article identifies and debunks eight of them.

MYTH

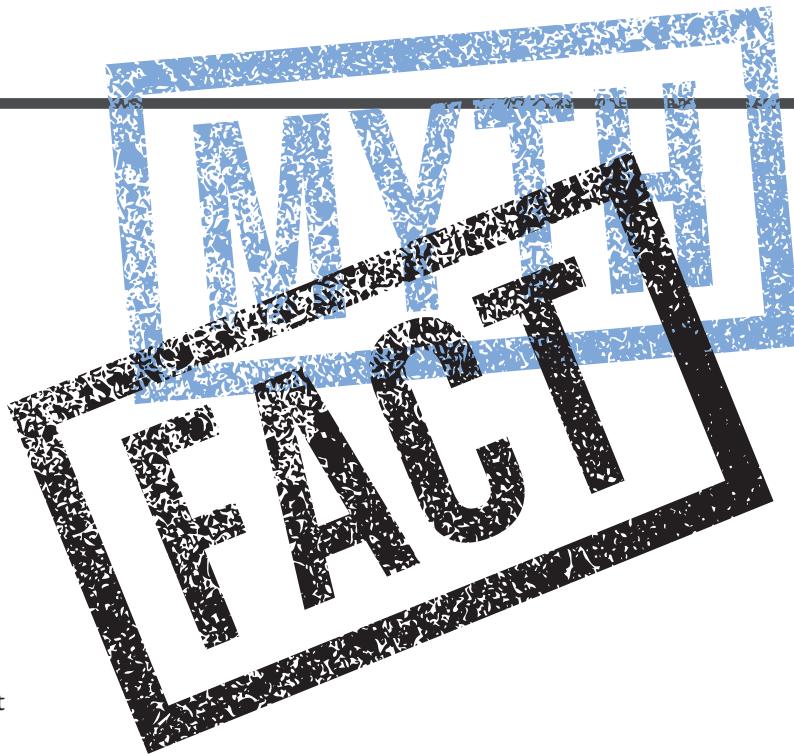
No. 1. EHRs ARE EXPENSIVE

FACT

The cost of EHR software and hardware is comparable to, if not less than, any other investment in medical equipment. "Any imaging acquisition software or machinery that we purchase comes with a lesser degree of computing than what is needed for a server in a workstation, and the prices for medical equipment are always in the tens of thousands of dollars, if not more," said David S. Hoffman, MD, of Summit Eye & Optical in Summit, New Jersey. "Good-quality servers are much less than that."

In addition, EHR systems can improve cash flow, which is a significant benefit in a climate of decreasing reimbursement. "The expression 'time is money' is true in a practice setting, whether it is our time or our patients' time," said Sam Multack, DO, of Multack Eye Care in Olympia Fields, Illinois. "We can accomplish better examinations with better patient safety and better quality of care with a fully integrated EHR [system]. The examination, through time, is much faster. For example, while using paper charts, we would print fundus photography, topography, and more. Now that we have EHRs, we have saved an average of \$1,800 a month on printing paper and ink, let alone time to have someone retrieve the reports, arrange them, and deliver them to the examination room."

"We were also able to lower the cost of our billing services from 6% of collections to 2.9% by integrating a billing component into our EHR," added Dr. Multack. "One contributor to saving money has been communicating more



efficiently with the billing company. We used to fax paperwork to them or hire couriers to drop off billing forms. Now that we have integrated billing with EHR[s], our payments are also received faster, on average 14 to 16 days versus the previous 22- to 32-day window."

MYTH

No. 2. EVERY TEXT FIELD MUST BE COMPLETED DURING AN EXAMINATION

FACT

An ophthalmic examination may require many unique pieces of information. Ninety percent of the examination template is made up of data fields. Users may become anxious at the prospect of having to complete 50 text boxes on 1 page.

Although the template covers the majority of what an ophthalmology examination would contain, each field is optional. In the same way that a doctor would skip over a data field on a paper chart, he or she can take the same approach with EHRs. Just because an EHR has a data field, it does not mean that field must be populated.

"My EHR software does not force any one field to be populated," said Dr. Hoffman. "There are options to automatically populate multiple fields at the same time, usually with normal findings. I can also copy right eye to left eye or import fields from previous visits. Many software programs will suggest or count elements of the patient's history or quantify the decision-making process to allow the user to achieve the highest level of coding. The program doesn't force me to add an element to the history; it only suggests. Some fields such as allergies, medications, and contact lens prescriptions are carried forward from visit to visit, and others must be populated with each visit. These fields can often be determined by the user."



No. 3. IT IS DIFFICULT TO VIEW OLD PAPER RECORDS IN AN EHR



When implementing EHRs, the user does not lose the ability to pull out a paper chart and thumb through the pages. Even more beneficial, if the old records are scanned into the new EHR system, users can scroll through these records electronically. If they want to access one piece of data, it can be pulled and translated into a line graph that reveals how the data have changed over time.

"There are many options for viewing old records," said Dr. Hoffman. "Users can scan all old paper charts into patients' records, which can be stored as attachments and then viewed as a PDF document or similar images when needed. Users can also choose to scan only the most recent paper chart into their records and access older charts for reference. Finally, users can choose not to scan paper charts into patient records, with the exception of unique documents, such as consult letters, and try to be as thorough with the initial EHR visit as possible and refer back to paper records only when needed. My office has chosen this route. We try to get as much information from the most recent paper records into the computer before and during the patient's initial EHR visit. We keep paper charts as backup and have them in the room during the initial EHR visit."

When it is time to look at old records, Dr. Hoffman opts to view his in a narrative format. "This is often easiest during a current examination, because I can see the old examinations printed in another window in a summary format similar to the printed chart," he said. "Furthermore, any field that can be populated gives the option of seeing values that were previously input during other visits just by right clicking in a field and selecting 'previous values.' I also use the graph feature for IOP. This is a quick way to see IOP change over time or trends in IOP and glaucoma management in general."



No. 4. I MUST USE A SCRIBE WITH EHRs



The concept of using a scribe in an ophthalmology practice started many years ago in an effort to move through examinations more fluidly and improve efficiency in a paper environment. Often, doctors who are reluctant to use EHRs will hire a scribe to record patients' information, but if a practice did not use a scribe with paper charts, there is no need to do so with EHRs.

"With EHR [systems], you learn quickly to enter data while you are talking to and examining the patient," said Dr. Hoffman. "The first time you see a patient, it may take a while. However, it becomes easier and takes less time with practice and after each additional patient. This is because most elements don't change. That is reflected in many ways more easily within an EHR record than a paper record, because EHR software has the ability to pull data forward that does not have to be entered again at the follow-up examination. If a patient presents for an examination and nothing has changed other than their eyeglasses prescription or their IOP, it only takes a few clicks of a mouse to indicate that all other data [are] the same and then go to the exception where the variation from the norm occurred. In a paper chart, you may have to draw circles off of preprinted templates or handwrite where the patient is normal."

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No. 5. I WILL NOT BE ABLE TO SEE AS MANY PATIENTS



Ophthalmologists who began their careers using paper charts have perfected this method of record keeping. They worry that, by changing this process, they will no longer be able to move through an examination at the same rate.

"At the very beginning, like [with] everything else that is new, it takes some time to reorganize your workflow, but it doesn't invariably have to lead to a slowdown in the volume," said Dr. Hoffman.

Patients spend a great deal of time with technicians. Because the technician will gather patients' histories more quickly with EHRs, the technician alone can shave minutes off each examination. As the time freed up accumulates throughout the day and the week, a physician can see even more patients in 1 day.

"The year 2013 was my first full year with an EHR [system], and neither [the] volume of patients nor revenue suffered compared with previous years," commented Dr. Hoffman. "That trend is holding true for 2014 as well."



No. 6. EHR TRAINING IS A ONE-TIME OCCURRENCE



An initial training session will equip a practice to successfully launch EHRs. However, just as continuous training is needed when adopting diagnostic equipment to improve patients' quality of care, it is also needed to ensure that an EHR system's full potential is realized.

Jeffrey L. Girardin, OD, of Horizon Eye Specialists & LASIK Center in Phoenix embraces training as an ongoing process. "As our practice grows into EHRs, both physicians and technicians notice areas where our software could work better for us. We continue to modify our system and train staff to understand those modifications so that we can better treat our patients."

Dr. Multack has access to a portal of training videos that he can watch from anywhere. "Training videos make mastering the system easy," he said. "I recently learned a way to hit two computer key buttons and be able to insert specific sentences I want placed in the chart, which is more efficient than writing or typing it out. It is a time-saving tip that allows me to spend more time with patients."



No. 7. EHR SYSTEMS WILL DECREASE QUALITY OF CARE



A common barrier to implementing EHRs is the fear that doing so will decrease the quality of care by interfering with face-to-face interaction between patients and doctors. According to Dr. Multack, the opposite is true, because doctors are able to spend more time with and obtain more detailed information about their patients.

"[EHRs make] evaluating the patient complete with glaucoma photos, [optical coherence tomography] images, and visual field imaging on the same page with one click of a button," he said. "We have the ability to customize tables to graph and track progress. Cataract patient data [are] automatically incorporated into the EHR, and I can export the data and track my outcomes to constantly see where I can improve on IOL selections, how much astigmatism I am inducing, and use customized surgeon IOL constants. Furthermore, I can access patient records from anywhere—in the hospital or at home when I am called at 2:00 AM. I know all of the patients' details instantaneously."

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Physicians and their staff may at first think that mobile is better, but the amount of data that needs to be entered during an ophthalmic examination would make the process challenging and time consuming with a small device."



No. 8. I CAN OPERATE MY EHR SYSTEM SOLELY WITH MY SMARTPHONE OR TABLET



Physicians and their staff may at first think that mobile is better, but the amount of data that needs to be entered during an ophthalmic examination would make the process challenging and time consuming with a small device.

The best use of the desktop computer is to create content, the tablet to consume content, and the smartphone to connect with others. For example, a surgeon who is advising a patient on an impending cataract surgery might use a tablet to show him or her a video that explains how the surgery will be performed and what to expect. Dr. Multack uses a tablet to show vision simulations to patients to demonstrate how they will see with different lens implants.

In a recent study, it was revealed that medical students predominantly used mobile technology to obtain real-time patient data via EHRs, to access medical resources for learning, and to educate patients. Researchers found that integrating mobile technology was most useful for learning and supporting clinical decisions, further showing that smartphones and tablets are accessories to EHR systems, not sole methods of accessing them.²

CONCLUSION

These common misconceptions are roadblocks to successfully implementing EHRs and realizing their full benefits. By separating myths from facts, practices can increase their success with the technology and, ultimately, improve the quality of care. ■

1. Hsiao CJ, Hing E, Ashman J. Trends in electronic health record system use among office-based physicians: United States, 2007–2012. *Natl Health Stat Report*. 2014;75:1–18.

2. Nuss MA, Hill JR, Cervero RM, et al. Real-time use of the iPad by third-year medical students for clinical decision support and learning: a mixed methods study. *J Community Hosp Intern Med Perspect*. 2014;4(4).

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