EHRs: Are the Benefits Worth It?

BY ELIZABETH A. DAVIS, MD; CRAIG BEYER, DO; WARREN E. HILL, MD; JANE LINDELL HUGHES, MD; AND STEVEN G. SAFRAN, MD

From a provider's standpoint, what has your experience been with electronic health record (EHR) systems, and what are the benefits to you, the patient, and society, both in general and regarding meaningful use in particular?

ELIZABETH A. DAVIS, MD

I believe that, in the future, EHRs will be a significant improvement over paper charts, including but not limited to enhanced efficiencies, coordination of care, easier communication among providers, ready access to records from all providers, and elimination of redundancy in testing and paper waste. We have some hurdles to overcome first, however, including the integration of the multiple different EHR systems that currently cannot communicate with one another, security and privacy issues, management of preexisting paper charts (some quite extensive), and the significant cost to the provider for the purchase and yearly maintenance of such systems. These initial challenges will not be insignificant, but years from now, the end result will be an improved health care system for the benefit of both patients and physicians.

CRAIG BEYER, DO

In January 2012, we licensed an application service provider version of the NextGen EHR system (NextGen Healthcare). After nearly 8 months of problems transferring our previous patient demographic and billing information into the new system, it is finally live. There are several benefits associated with the EHR system. For instance, doctors are directly involved in the coding process and can verify that the claim is submitted. A web portal allows patients to schedule visits online and to enter demographic information as well medical, social, and family histories that digitally populate their medical record. Other forms can be sent automatically to patients once they schedule an appointment. In a refractive surgery practice, the patient portal can be used to capture website leads, categorize them, and then track their status. Thus, we plan to abandon our current refractive contact management software along with the double entries. There is also the option to automatically send specific e-mails at various periods for leads that are not progressing through the sales pipeline. The software is extremely customizable throughout, from the template's design to the HTML design of e-mail.

Of course, there are downsides, too. The customization process is complicated and cannot be delegated to office personnel. There are at least 18 hours of training materials to cover online, and several training conference calls are required to qualify for the rebate. When the occasional glitch occurs, a service order is required to have the problem resolved, meaning there is no immediate help or answer. Unfortunately, I now spend more time facing my computer than the patient. I hope a tablet will help rectify this problem.

WARREN E. HILL, MD

My partners and I have struggled with the idea of going to EHRs for several years. The paper system that we currently have in place is simple and elegant, and we have no problems with legibility or having the right information when we need it. After much thought, we decided to take the hit from Medicare rather than collectively drive over the same EHR cliff as some of our unhappy colleagues. The system that we have is not broken and does not need a disruptive and expensive change.

It should be recognized that, in some practices, individual attention takes the place of high volume. At our practice, there is already meticulous attention to detail that arises out of a single vision for patients' care. To trade templates (even custom made) for default normals and F-key auto-fill-ins for individual physicians' charting has the potential to diminish the encounter with our patients. It is also difficult for the physician both to perform the examination and manage the "medical record" using EHRs.

In my opinion, having one's head down in front of a computer screen is not the best way to interact with a patient, and what invariably ends up happening is that the person doing the examination and the person entering the data are different individuals. I have seen countless examples of medical records that do not match patients' findings.

When something comes along that is actually better than what we are presently doing, I will happily make the change. Until that time, I am reluctant to do something simply because the federal government tells me that it is a better idea.

JANE LINDELL HUGHES, MD

I have no problem with anyone who wants to institute EHRs in his or her practice for personal reasons. Those who do, however, should know that EHR systems are less efficient than paper charts and cost more per patient encounter than a paper record.[1] Mistakes are easily rectified with paper charts and a pen. Many EHRs, on the other hand, have cumbersome methods to rectify mistakes, especially if they are not caught on the same day they are made. With a click of a button, many EHRs fill in the blanks with what may or may not have occurred in an interaction with a patient. I have a problem with the central connection of each EHR to the US Department of Health and Human Services. With full implementation of the Patient Protection and Affordable Care Act, the physician puts him- or herself in moral and ethical jeopardy when he or she gathers privileged information in the sanctity of the examination room and then pushes the "send" button, transmitting information to a faceless government bureaucrat at the office of Health and Human Services, who then approves or disapproves treatment plans and monitors the physician's compliance.

STEVEN G. SAFRAN, MD

EHRs for ophthalmology are inherently difficult, because we speak a unique medical language, have a need for creating drawings and images in the chart, incorporate a great deal of imaging studies and testing in the record to which we need dynamic access, have multiple unique subspecialties, and rely on a lot of numbers that must be entered and referenced quickly and efficiently. Our needs are somewhat special, and none of the vendors in the EHR market has stepped forward at this early stage in the game as the clear industry leader. Most ophthalmology practices that adopt EHRs are taking a leap of faith that requires considerable bravery, considering the horror stories we have all heard from those who have made the switch and compared it to something akin to sharing their hot tub with a snapper turtle.

Clearly, the benefits are greater for larger practices with a greater number of doctors and locations, because there is an inherent advantage to using a "common language" within a practice. The solo practitioner, on the other hand, will recognize and understand his or her own notations and has less to gain by learning to "speak" a new language. As a solo practitioner with a single office location, I have looked at switching to EHRs with trepidation and worry about decreased productivity, increased oversight, distractions from direct interactions with patients, and unforeseen glitches and expense. I know these systems will continue to improve over time, and I hope one or two vendors will become the clear-cut industry leaders. The meaningful use benefits do not offset the potential costs of implementation and lost revenue from decreased productivity. Nor do they mitigate my concerns about increased oversight. I will wait until a program knocks my socks off and, in the meantime, keep my pen and dictaphone handy. ■

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