Physicians find ways to share data despite system limitations

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PLUS

TOBY COSGROVE HEADS TO GOOGLE
WHAT IT MEANS FOR THE FUTURE OF HEALTH IT

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Direct primary care: the benefits of dropping payers

Using automobile insurance as a parallel, health insurance has done the equivalent of paying for oil changes, tires, and other car repairs in addition to covering collision and liability. But the consumer is already motivated to do those things and will pay out of pocket to maintain their car so as to avoid needing to use their auto insurance at all. Additionally, paying for tires, oil changes, etc., allows these things to have artificially set prices which are unreasonably high (since it’s covered by insurance) and so the cost of routine maintenance goes up.

So, what are the implications of rejecting insurance payment?

THERE IS AN INCREASED FOCUS ON REDUCING THE COST OF CARE.

My patients are paying me, so I am very conscious of trying to give them their money’s worth. If I can give them value (a concept that has become foreign to healthcare), patients are happy with my care and will continue to stay in my practice. It’s in my business’ best interest to do this, so we do a number of things to save patients’ money:

[ ] We offer very low-cost lab testing (using “client billing”), saving people 75 percent or more on labs.

[ ] We dispense medications in the office (legal in most states), also saving people 75 percent or more, and offering a huge convenience to the patient.

[ ] We find the lowest cost for procedures, X-rays, and specialist services. While many of these are covered by insurance, most people have higher deductibles, so the lower cash prices are very valuable to them (not to mention the value to the uninsured).

None of these give significant direct income to the practice, but they all make patients much more reluctant to leave. In truth, these things end up being our biggest marketing tool, as patients frequently brag to friends and family about their doctor “who saves me money.”

To read more, visit: bit.ly/dpc-dropping-payers

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9 ways doctors have it worse than everyone else

Physicians face many obstacles in their quest to provide quality care to patients. Imagine if other professions had to deal with some of the same challenges.

To view, visit: bit.ly/docs-have-it-worse

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Topic Resource Center

HEPATOLOGY

[ ] Hepatitis C epidemic hides within opioid use epidemic

[ ] Hepatitis C virus eradication by direct-acting antiviral agents improves glucose tolerance

[ ] Two-drug direct-acting antiviral combination treats advanced liver disease

For more, visit: bit.ly/MEC-hep-C

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Bloggers

“When policies may harm patients—such as time-consuming prior authorizations—we need to speak out and get involved; we need to advocate for change.”

— Carrie Horwitch, MD, MPH, on reducing physician burnout by increasing advocacy

“As a physician and person, you can’t help anyone if you’re not stable, happy, and growing.”

— Craig M. Wax, DO, on why physicians must care for themselves to truly help others
Connecting practices to **EMERGING TRENDS.**

We're taking the mal out of malpractice insurance. In an ever-evolving healthcare environment, we stay on top of the latest risks, regulations, and advancements. From digital health innovations to new models of care and everything in between, we keep you covered. And it’s more than a trend. It’s our vision for delivering malpractice insurance without the mal. Join us at thedoctors.com

The nation’s largest physician-owned insurer is now expanding in New York.
Americans require a moderate solution to the healthcare crisis

I read with interest the “Your Voice” contribution by Dr. Craig Wax. “To solve the U.S. healthcare crisis, think small, not big.” My fundamental objection to Dr. Wax’s well-articulated position is that he represents an extreme position on healthcare in the United State, and Americans are (present political discourse notwithstanding) not generally an extreme people. Not recognized by Dr. Wax is the existence of the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986. This statute, passed in keeping with the compassionate nature of the American people, requires hospitals that accept payments from Medicare (i.e. nearly all) to provide at least stabilizing treatment to any patient seeking care on an emergency basis. Because of EMTALA, some Americans rely on emergency departments for catastrophic care and eschew expensive health insurance altogether. The latter is not in the patients’, the hospitals’, or society’s best interest. The right position for the country is, per usual, a middle course that will provide the compassionate safety net, encourage individual responsibility for health and its cost, and assure a sustainable future for the providers of care.”

James P. Nataro, MD, PhD, MBA
CHARLOTTESVILLE, VA.

We must challenge the current healthcare dogma

It is refreshing to read an article that challenges the current dogma of our healthcare system. Promoting individual choice and advocating for diminishing the bureaucracy of our current healthcare system is an effort that is long overdue.

I applaud the perspective of Dr. Craig Wax, as well as your decision to publish his thoughts. This side of medical economics has not been adequately discussed.

Craig Hjemdahl-Monsen, MD
HAWTHORNE, N.Y.

Reader poll results

Q: Is it possible to provide quality care via telemedicine?

34% No
66% Yes

Telemedicine coverage in this issue Visit page 17

Source: Medical Economics web poll, Sept. 12, 2018
Physician burnout worse among primary care physicians

Feeling burned out from long hours and administrative burdens is common among physicians. But is the problem worse for particular specialties? The American Medical Association conducted a survey on burnout earlier this year, collecting responses from more than 15,000 physicians from 29 different specialties. Here’s what they found:

**FINDING 1:** The leading cause of burnout is administrative tasks

1 out of 2 physicians said “too many bureaucratic tasks” is the leading cause of burnout.

Other leading responses: Too many work hours, increased computerization of practice and insufficient compensation.

**FINDING 3:** The leading cause of burnout is administrative tasks

**FINDING 4:** Better work schedules and slashing regulations would reduce burnout

When asked how to improve working conditions for physicians they pointed to these steps:

- Provide more manageable work schedule and call hours: 31%
- Slashing government regulations: 27%
- Greater respect from patients: 12%
- More positive attitudes from colleagues: 8%

**FINDING 2:** Many specialists reported the lowest rates of burnout

Physicians that reported the least amount of burnout were:

- Orthopedics: 34%
- Ophthalmology: 33%
- Pathology: 32%
- Dermatology: 32%
- Plastic surgery: 33%

The highest percent of burnout was reported by physicians in:

- Critical care: 48%
- Neurology: 48%
- Family medicine: 47%
- Obstetrics and gynecology: 46%
- Internal medicine: 45%
- Emergency medicine: 45%
In early August, CMS Administrator Seema Verma called for an end to physicians using faxes to transmit patient data by 2020. While those outside of medicine wondered why she would want to ban a seemingly obsolete piece of office equipment, many physicians wondered how they would access patient records without it.

Yul Ejnes, MD, MACP, an internist in Cranston, R.I., uses his fax machine, EHR, secure email, or whatever it takes to get data on his patients. “The ideal scenario is all the EHR and other data sources would be interoperable and all the data would be accessible with a couple of clicks,” he says. “The reality is, depending on where else the patient has been seen determines how we go about getting information that is not generated in my office.”

A fact of life for many doctors is that, despite its inefficiencies, the fax machine is a vital part of getting the information needed to provide quality care. Other doctors may have some level of interoperability through their EHR, which connects them to physicians using the same software, and in some cases, to those using different EHRs. In states with robust Health Information Exchanges (HIEs), doctors may be able to get patient data from a variety of sources—as long as they participate in the system. But for the vast majority of physicians, the fax machine still plays an important role in obtaining patient information.

Getting patient data into their EHR is rated as a major problem by respondents to the 2018 Medical Economics EHR survey. When asked about importing data into their system, 61 percent of doctors rated their software as a five or less on a scale of zero to 10, with 10 being excellent; 14 percent rated theirs a zero.

Even for those fortunate enough to have access to most or all data their patients generate at hospitals, specialist visits or labs, challenges remain. “Not all data is created equal,” says Robert Tennant, MA, director of health information technology policy at the Medical Group Management Association. “If all the information looks the same, you can have trouble discerning what’s critical. Does an emergency room doctor have time to read 500 pages of data created from over a decade of the patient seeing different doctors? No.”

So how are doctors getting the patient data they need when they need it? Medical Economics talked to doctors on the front lines—as well as those working on the technology meant to help them—to find out.

Here are their stories.
Does your EHR keep you tethered to your desk? It’s time to set yourself free. athenahealth’s services for physicians now include praxify, the intuitive, easy-to-use mobile solution that frees up providers to spend less time with their EHR and more time with patients.

Learn more about how praxify is freeing physicians from their desks at athenahealth.com/praxify
For one large health system, Ejnes can access the hospital notes through its EHR, even though it’s not the same one his office uses. But for other area hospital systems, he has to rely on someone to fax him the notes on a patient.

“Some labs and diagnostic imaging can be accessed through the statewide HIE, and in Rhode Island, we have a pretty good one,” he says. “All the labs share data through the exchange.” But he notes that this manual retrieval takes time.

“It’s a matter of opening a browser, logging in with a password, and getting the info,” he adds. “It then has to be printed out and scanned into our records. Even when the data is electronic, you have to use multiple portals and passwords.”

Ejnes estimates 70 to 80 percent of the information he needs can be accessed through his EHR, but the remaining data doesn’t get to his office on its own and requires checking portals or making phone calls to track it down.

“There’s a lot of old-world stuff that goes on to get the information we need,” he says. Finding the data consumes hours of his staff’s time each day, and if the office doesn’t know about a patient’s ED visit, for instance, they won’t even know to look. “Often, we don’t know something happened until a patient tells us,” says Ejnes.

While he’s hopeful that interoperability improves, he says it’s also important not to forget the human factor. “It has to be embedded in our DNA as physicians to share information with those who need it,” he says. “This has to be of importance to the doctor, hospital, specialist, or urgent care or it won’t happen.”

—YUL EJNES, MD, INTERNIST, CRANSTON, R.I.

Sommer provides telemedicine services to hospitals, and many are not on the same EHR he uses. Accessing the data he needs may require some searching.

“Even within the same health system, a patient may have disparate records,” he says. He focuses on trying to obtain the most relevant information in whatever system it resides, which may require converting data to a PDF format or having someone print out the information and transmit it by fax.

And even if he can locate the appropriate patient record, finding the specific information he needs is often frustrating. “There is so much data and a limited amount of time,” says Sommer. “I might need EKG results and have to search in the cardio tab in one EHR, but now it’s in the procedures tab or some other location in another EHR. Even in one system it can be difficult to gather the information you need.”

Despite the challenges of EHRs, he says that using paper charts wasn’t ideal either. For a patient with complex conditions, a doctor might only have the most recent record and not the whole picture, while today there is a better chance that the attending physician can access either the entire record or the relevant parts of it. But much work still needs to be done to make the software more useful.

“A lot of these systems were created 10 years ago,” he says. “A lot of the systems sold to practices today have had marginal improvements, and I’m not sure we’ll see a dramatic change in the way they are accessed or used.”

—DARREN SOMMER, DO, INTERNIST, JONESBORO, ARK.
The goal may be to eliminate the fax by 2020, but unfortunately I don’t think we are even close to that,” says Linda Delo, DO, a primary care physician in Port St. Lucie, Fla., who says getting patient records from specialists via fax is commonplace.

Delo has had a mixed experience with local hospitals in tracking the care her patients have received. With one hospital, communication of patient data is relatively seamless. “Every time a patient visits the ED, the details are downloaded into our system,” she says. “When they are in the hospital, I get daily notes so I know when to do follow-up and we really have excellent continuity of care.”

One of the reasons she chose her EHR was based on the local hospital’s use of the same system, which helps her stay updated on her patients’ status. The same can’t be said of her experience with another local hospital. “It’s horrible—I’ve had patients come out of there and I cannot get the records.”

Florida has an HIE, but Delo hasn’t used it because it has the same limitations as the hospital portal and would require too much time. Overall, she hasn’t seen much progress on interoperability in recent years.

“I wish I could say there is a portal that we could have on every EHR that is national and you could just click a button and request information.”

—COLE ZANETTI, DO, PRIMARY CARE PHYSICIAN, ARVADA, COLO.

Cole Zanetti, DO
FAMILY MEDICINE
ARVADA, COLO.

Zanetti sees the challenge of getting patient data from both the practice and the IT side thanks to his work with the informatics arm of the American Osteopathic Association.

“The idea of interoperability is frustrating for providers,” he says. “It seems like it would be so easy to lift the veil and share information, but privacy and security are legitimate concerns that make it difficult to do.”

And because of this difficulty, the fax machine still rules the day. “I’ve seen organizations struggle when their fax machine isn’t working. Maybe it’s missing toner or needs maintenance because the volume on the receiving end is so high, but it’s absurd that this is what we need to be concerned about.” Beyond faxing, he says much of the burden falls on the patient to make sure their records get transmitted to their primary care physician.

One of the drawbacks to EHR printouts is that older patients’ records might include as many as a thousand pages. “If someone drops some pages or doesn’t include them, is anyone even going to notice?” says Zanetti. “I wish I could say there is a portal that we could have on every EHR that is national and you could just click a button and request information.”

But even if such a system existed, that thousand-page record presents a new challenge: No one has time to read it all to find the relevant pieces. “AI programs are being developed to read records, but if we don’t have a way to process the data, we certainly don’t have time to read it all. It’s a wicked problem.”

Continued on page 37
Telemedicine’s reimbursement challenges

In healthcare, profitability is driven by reimbursements from government and private payers. When it comes to telehealth, legal policy is the primary factor affecting reimbursements.

Medicare rules
Telehealth services are typically reimbursable only if they are provided for beneficiaries who live in certain rural or underserved areas.

This usually requires the beneficiary who is receiving the telehealth services to be physically located at certain “originating sites,” such as practitioners’ offices, hospitals, rural health clinics, and nursing homes.

Medicare publishes a list of procedures, which are designated by billing codes, that Medicare will pay for if all of the required conditions are met. Medicare has additional rules that must be followed in order for telehealth services to be reimbursable, such as limitations on the type of technology that may be used and what type of practitioner may provide covered telehealth services.

If a telehealth service is covered under the Medicare rules, both the remote practitioner and the originating site may be entitled to bill for the service. The remote practitioner is entitled to bill for the professional service that is provided, and the originating site is entitled to bill for a facility fee.

When submitting claims to Medicare for telehealth services, each provider must add a billing code modifier to identify the service as a telehealth service. The fee is subject to applicable deductibles and coinsurance.

Additionally, Medicare’s fee schedule reimbursements for telehealth services are not necessarily on par with the fees payable for similar in-person services.

Private payer rules
Reimbursement for telehealth services provided for non-Medicare patients depends upon the jurisdiction where the patient is located while receiving the services.

Most states have legal policies governing telehealth services, and there is no uniformity with regard to state telehealth guidance, including in the areas of site-of-service requirements and the types of technology that may be used.

And perhaps even more importantly, there is variation regarding whether commercial insurers are obligated to reimburse for telehealth services.

Most states require commercial insurers to cover telehealth services. However, state laws vary regarding the amounts these payers must reimburse. Some states require private insurers to reimburse for telehealth services “on par” with, i.e. at the same rates that the insurer would have paid if the same service was provided to the patient during an in-person visit.

Other states, such as New York, require commercial payers to cover telehealth services, but either do not require or are silent with respect to parity for reimbursement.

And still other states have some form of reimbursement requirement for telehealth services that does not quite equal on-par reimbursement.

For example, New Jersey requires private insurers to reimburse for services provided through telehealth, but only requires that the rates for telehealth reimbursement may not exceed the rate of reimbursement if the service was provided in person. Finally, some states have no requirement for private payers to cover any telehealth services.

Learn the laws
These varying laws and rules for telehealth can create great difficulties for physicians, especially those delivering telehealth services from different states.

In most jurisdictions, payers have great discretion in determining how much to reimburse for telehealth services, or even whether to pay at all. Physicians should become aware of reimbursement rules for services they will provide for patients in another state before those services are provided.

John D. Fanburg, JD, is chair of the Health Law Practice and managing member and Jonathan J. Walzman, JD, is an associate at Brach Eichler, LLC, in Roseland, N. J. Send your legal questions to medec@ubm.com.
A young physician’s view on EHRs: They don’t work well enough

“I have yet to meet a young physician colleague or trainee who has displayed any emotion greater than lackluster contentment with their medical record system.”

In the brief span of my medical school and residency training I was exposed to 16 different electronic health records (EHRs), as well as paper charting. Ironically, I found that the easiest to use, most comfortable, and best experience was the paper record. Everything else felt clunky, unintuitive, and disruptive to the patient-physician encounter. Digitizing health records increases communication, continuity, and long-term tracking of illness. But for this millennial trainee who is facile with technology and has a background in computer networking, the sum of my experiences with EHRs have left me simultaneously overwhelmed and unimpressed.

And here’s the kicker: Starting my first job as an outpatient primary care physician, I was introduced to my 17th EHR.

**HOW EHRs OBSTRUCTED LEARNING**

In my experience, exposure to the EHR during medical school obstructed both my learning and the training environment. Routinely, I would arrive on my first day of a new rotation to find lack of access to the medical record system and patient information. Obtaining access was always coupled with hours or days of formal training on the nuances of the EHR. In the span of a two- or four-week rotation, this represented precious time away from the bedside. Thereafter, I experienced at least a week of fumbling through a foreign system before understanding the processes, anomalous places to click, and complex orders that almost never paralleled other systems. In effect, the impact of the EHR on my training was more a lesson in responding to change and decoding a dysfunctional medical record system than an actual enhancement of clinical experience.

I was in medical training between 2008 and 2015; my hope is that with EHR consolidation, such experiences are less common. Yet I suspect that EHRs remain disruptive to the training environment. Even the most advanced current EHR systems have incongruous inpatient, outpatient, surgical, and imaging interfaces. Month by month, trainees are still left to contend with the challenge of understanding the computer interface before patient care.

Frustration with EHRs is not limited to senior physicians. It is transgenerational and extends from misapplication of outmoded technology. I have yet to meet a young physician colleague or trainee who has displayed any emotion greater than lackluster contentment with their medical record system.

**HOW EHRs WILL IMPROVE**

I envision three major themes for EHR improvement: advancement of usability, care enhancement capability, and supportive infrastructure. The first requires updating technology, revolutionizing interfaces, and easing data entry and extraction. The second theme is already underway in some settings, and involves enhancing digital interaction to extend beyond the documentation of episodic encounters.

Such capability would include integration of population management, digital and remote monitoring of patient data, and real time updating of clinical information and guidelines.

The third major theme involves the systems, people, and processes that are built around EHRs. This supportive infrastructure is responsive to changes in payment, policy, regulation and documentation requirements that are layered into the healthcare system.

One major, yet necessary, fix depends upon coordinating interoperability between systems. In my free time outside of my

BY AARON GEORGE, DO

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Frustration with EHRs is not limited to senior physicians. It is transgenerational and extends from misapplication of outmoded technology. I have yet to meet a young physician colleague or trainee who has displayed any emotion greater than lackluster contentment with their medical record system.

**HOW EHRs WILL IMPROVE**

I envision three major themes for EHR improvement: advancement of usability, care enhancement capability, and supportive infrastructure. The first requires updating technology, revolutionizing interfaces, and easing data entry and extraction. The second theme is already underway in some settings, and involves enhancing digital interaction to extend beyond the documentation of episodic encounters.

Such capability would include integration of population management, digital and remote monitoring of patient data, and real time updating of clinical information and guidelines.

The third major theme involves the systems, people, and processes that are built around EHRs. This supportive infrastructure is responsive to changes in payment, policy, regulation and documentation requirements that are layered into the healthcare system.

One major, yet necessary, fix depends upon coordinating interoperability between systems. In my free time outside of my
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busy medical practice, I can instantaneously video chat a friend across the globe easily, for little cost, and with good fidelity. Yet I am frequently foiled in efforts to garner even simple notation on care from the walk-in clinic across the street from my practice.

Such fragmented communication remains far too commonplace. It cripples continuity, leads to soaring costs and duplicative work, and engenders uncertainty in physician decision making and patient care. I fully appreciate the complexity and challenge in meeting the goals of interoperability, not to mention the cost, but a sane healthcare system demands it.

**THE FUTURE OF EHRs**

I anticipate that we will see a disruptive innovator—the kind that has arrived in almost every other industry—that will be able to provide a better EHR product, at a far more reasonable price and improved ease of use. In terms of the current market, there have been so few new players on the scene, and those that do exist charge kingly prices to implement and maintain their systems. I anticipate we will see an Uber of EHR, given the expansive marketplace, financial possibilities, and creative genius of Silicon Valley and elsewhere. Many should be eager to take advantage of an uninspiring and frequently frustrating healthcare environment.

On the horizon, physicians should anticipate the implementation of voice recognition software with smart learning and artificial intelligence (AI). This will allow audio recording of an entire encounter, with construction of relevant history points, physical exam notations, and assessment and plan into a digestible, structured, and cohesive document.

Imagine immediate creation of a patient handout at the conclusion of any encounter that summarizes and condenses salient points and plans as they are vocally conveyed to the patient in real time. A similarly generated documented summary of the visit in written form can be reviewed by the physician prior to finalizing and signing.

At this very moment Amazon’s Alexa software can instantaneously tell me the score from the 1960 NFL championship game, and provide details of the date, hour and place of the game in the span of a heartbeat. Yet, after nearly 40 hours of personalized voice recognition training, my current clinical dictation software routinely falters and employs essentially no artificial intelligence or capability beyond that of a transcription Dictaphone.

The future of EHRs should look to replace typing and clicking with the ability to simply say: “What was Mrs. S’s most recent hemoglobin A1c?” or respond to the request, “Show me Mr. D’s hospital discharge summary.” Beyond this, imagine the comfort of voice activated ordering: “For Mrs. R, I would like to order a chest x-ray, CBC, CMP, and urinalysis.”

This will eliminate the need for multiple clicks, multitasking, and the current fatigue and mental strain associated with scattered rapid eye movement required to navigate uncoordinated ordering systems. It is my belief that voice recognition software complemented by AI will have the greatest impact on breaking the shackles of the current EHR chains that weigh so many of us down.

I hope my next system, my 18th EHR, will be approachable, intuitive, and connected enough to not require a 19th.

Aaron George, DO, is a family physician practicing in his hometown of Chambersburg, Penn. He was an Andlinger fellow in health policy with the Center for Public Health in Vienna, Austria, and has been awarded both the Bristol-Myers Squibb award for excellence in graduate medical education, and was recently included among the “40 under 40” physicians by the Pennsylvania Medical Society.
Toby Cosgrove heads to Google:
What does his move mean for digital healthcare?

When Delos “Toby” Cosgrove, MD, stepped down from the helm of Cleveland Clinic, where he had served as chief executive officer since 2004, few thought he was ready to exit the healthcare industry altogether.

Still, many were surprised when Gregory Moore, MD, vice president at Google Cloud, announced in a July 19, 2018 blog post that Cosgrove would be joining the company as executive advisor to the Google Cloud Healthcare and Life Sciences team. But in an email to Medical Economics, Cosgrove says Google Cloud’s mission to make healthcare information “accessible, useful, and secure” appealed to him.

“This team is making huge inroads in helping to balance the advances in digital health with the impact on those who provide care,” Cosgrove writes. “I’m thrilled to join them and look forward to continuing Google Cloud’s mission to improve provider efficiency and patient care through the use of technology.”

Cosgrove’s move follows other high-profile moves of individuals prominent in the healthcare industry into technology-related positions. Thomas Insel, MD, left the National Institutes of Mental Health in 2015 to join Google’s Verily, and recently left there to create his own healthcare technology start-up.

Meanwhile, famed surgeon and author Atul Gawande, MD, has taken command of the new Amazon-Berkshire-JPMorgan Chase healthcare partnership. But while these healthcare “defections” make headlines, it’s often unclear what such illustrious physicians have to offer these technology companies. What is the potential impact of Cosgrove’s new role with Google Cloud on the healthcare field—and the company’s position in it?

A MATTER OF TRUST
As noted in a recent IDC Health Insights Survey, among the biggest barriers to cloud adoption in healthcare are concerns over the privacy and security of patient data.

Vince Vickers, MBA, a principal at KPMG Healthcare and Life Sciences, who has conducted cloud migrations for several healthcare systems, says that many organizations may have preconceived notions about Google as a secure cloud provider. Vickers says Google’s success in consumer data mining might make some wary of using them to help secure patient health information.

“Bringing in someone like Dr. Cosgrove,
who is an icon in the industry—someone who has been successful as a physician and as a businessman in the healthcare space and really understands the challenges in this space—goes a long way to building that trust," he says. "It can help make healthcare providers more comfortable with the idea of Google, and what Google Cloud might be able to offer to assist them."

Such an eminent hire, Vickers says, can help healthcare organizations believe that Google Cloud is trustworthy—and can provide the tools to keep patient health information private.

RECONCILING THE PUSH AND PULL OF CLOUD ADOPTION

Lynne Dunbrack, MS, MBA, vice president of research at IDC Health Insights, says that many healthcare organizations have conflicting feelings about cloud adoption.

IDC’s 2018 Cloud Adoption Trends survey suggests that security remains a top concern for healthcare organizations considering cloud adoption—but those same organizations also understand that cloud solutions can help make their organizations more secure. Dunbrack says this seemingly contradictory finding is due to many organizations’ lack of experience with cloud solution technologies. This ambivalence remains a bit of a conundrum for the industry—and one that could use the right leadership to resolve.

Dunbrack says that many organizations feel overwhelmed by cloud offerings—but Cosgrove's hire, and the resulting education and outreach efforts, may help healthcare organizations better balance their worries concerning cloud adoption and find the solutions that will work best for them.

"Cosgrove’s reputation in the industry speaks volumes. The fact that he’s getting behind these initiatives and lending his professional talent and expertise speaks to Google’s commitment to understanding the specific needs involved with healthcare and the needs involved with healthcare cloud in particular. It puts Cosgrove, and Google Cloud, in a really good position to guide others," says Dunbrack.

Cosgrove writes that’s why one of his principal efforts at Google Cloud will be to educate healthcare professionals regarding the benefits of moving to the cloud.

"Google Cloud believes it is important to work with partners across the ecosystem—patients, providers, insurers, and researchers—to unlock important data and deliver it to where it is needed most," Cosgrove explains.

FURTHERING THE HEALTHCARE MISSION

Cosgrove says that his mission at Google Cloud will be to help healthcare organizations simultaneously improve clinician workflow and the quality of patient care using innovative technologies.

"As the executive advisor, my goal is to use expertise to help the Google Cloud Healthcare and Life Sciences team educate healthcare professionals on the benefits of moving to the cloud and how it can improve not only the work experience of clinicians and staff but also patient experiences," he says.

Both Vickers and Dunbrack believe he is in a unique position to do so. Vickers says that Cosgrove's experience will be a boon to Google Cloud as they extend their reach in the healthcare industry.

"This is a guy with an amazing background who really understands the nuances of healthcare," says Vickers. "I think Google Cloud having someone like Cosgrove on board, someone who understands the needs and the challenges, is going to be a big benefit for them—and for cloud adoption in general."

Dunbrack agrees. "There are a lot of benefits to being in the cloud, especially with regards to becoming more agile and bringing new systems online," she says. "Having a high profile executive like Toby Cosgrove on board is certainly going to be very helpful to Google Health as they move forward and demonstrate their commitment to working in healthcare."

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"This team is making huge inroads in helping to balance the advances in digital health with the impact on those who provide care."

—TOBY COSGROVE, EXECUTIVE ADVISOR, GOOGLE CLOUD HEALTHCARE AND LIFE SCIENCES TEAM

[Image of Toby Cosgrove]
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Trapped in an EHR

Five physicians discuss how the performance of their systems affects their workload, careers and ability to treat patients

by JORDAN ROSENFELD  Contributing author

HIGHLIGHTS

- Lack of interoperability means the promised benefits of electronic records go unfulfilled, physicians say.
- Physicians often argue that the computer gets in the way of interacting with patients. Some use scribes to avoid this problem.

Nearly 70 percent of physicians find themselves stuck with EHRs they can’t quit for reasons ranging from cost to lack of better options, according to the Medical Economics 2018 EHR Report.

About 57 percent said they wouldn’t recommend these systems to their peers due to administrative frustrations, lack of interoperability and how they distract from patient care. We spoke to five of the physicians who answered the survey about the EHRs they say they are stuck with.

LIMITED BY THE OPTIONS

A common reason physicians remain stuck in an EHR they don’t like is a sense of limited options. Keith Aldinger, MD, an internist with a large group practice, Living Well Health Center, in Houston, Texas, says, “It’s pick your poison.”

He’s particularly frustrated with the lack of interoperability, which he says was supposed to be the whole point of the original RAND Corporation study that suggested EHRs would improve health benefits and reduce costs.

“They’re not interoperable and the government hasn’t brought pressure to bear on IT vendors to do that, yet they levy penalties against physicians if they haven’t demonstrated meaningful use of the tool,” he says.

While acknowledging that he and his fellow physicians could put pressure on the medical group to change to a different EHR, he says, “I don’t see anything out there worth putting pressure on to change to.”

Aldinger, who was in independent practice before he joined Living Well in January, 2018, has used two different EHRs and says, “I don’t find any of them helpful when you’re entering the room clinically.”

“You spend a heck of a lot more time with the computer than with the patient,” he says. “I don’t think a computer possesses any of the characteristics that help you interview or interact with people better.”

He doesn’t want to bring in a scribe, as some physicians have done, because he feels that having another person in the room can interfere with the patient’s sense of safety or confidence. “It would just be another presence that made the patient uncomfortable in fully discussing what they want to say,” Aldinger says.

Not only does entering data into the EHR distract from communicating with his patients, he dislikes having to sort through what he calls “digital debris”—far more information than he needs—to get to what he’s looking for, particularly when the emergency department sends records.

The records are very lengthy, even for simple clinical encounters. “Someone comes in just for a cold and it’s three to five pages due
to these pre-populated things they want you to do,” he says.

The only improvement he is hopeful about is a possible shift to voice dictation. An affiliated hospital uses a system called Nuance, which Aldinger has tested with success. He envisions this technology replacing manual template box clicking with simple voice commands.

‘CORPORATE MEDICINE’ CALLS THE SHOTS
Edwin Schmidt, MD, a primary care doctor with SSM Medical Group in St. Louis, Mo., feels constrained by his EHR.

“We don’t have any choice in it. It’s corporate medicine. Whoever is on top picks our medical record,” he says.

He dislikes that his EHR adds complexity to once-simple tasks. He says that he and the five other physicians in his office have all adopted different ways of doing the exact same process in their EHR because it’s just not straightforward.

“Even if [IT] corrects the problem later, it’s not worth the time to learn how to do it when you’ve already jury-rigged your own system,” he says.

Despite his frustration, and the extra hour of work it adds to his schedule at the end of each day, he won’t be changing EHRs before his planned retirement in 2020.

Nor is he hopeful that there’s a better option. “The big [vendors] say they have physician input, but those are physician administrators who are more interested in the administrative component than practicing medicine,” he says.

If he had his way, Schmidt says he’d go back to paper “in an instant.”

A NECESSARY EVIL
Scott McLeod, MD, an independent primary care physician in Woodstock, Va., looks longingly back to the time two years ago, when he was using an EHR that he found pretty user-friendly.

But in order to keep up with the shift to quality reporting measures as an independent practice, he joined Privia Health, a practice management and population health company that required him to switch to a different EHR.

“It was a downgrade in terms of ease of use,” McLeod says. Before, he had unlimited templates, which allowed him freedom to customize them as needed. Now he has only 173, and can’t change them easily, he says.

The transition between EHRs was so intensive that he acquired tennis elbow and carpal tunnel syndrome from what he describes as “endless clicking” and felt burned out to the point that he had to take two weeks off during which he did not look at a computer.

But he feels that this EHR is the price of staying independent. As a result, he’s had to reduce his patient load by 20 percent to keep up with all of the administrative work, and his income has decreased.

Having now used the system for two years, he is as comfortable with it as he can get. “I know its ins and outs. I can make it do whatever it can do, but I’m also very aware of its limitations,” he says.

STARTING FROM SCRATCH
Steven Ames, MD, a primary care doctor with Thurston Medical Clinic, in Springfield, Ore., left independent practice to join a medical group to stay in business.

His previous EHR did not interface easily with the new one, and he couldn’t find anyone to help him adapt to the new system because none of the data was standardized. “It was sort of like going from VHS to DVD, so there really wasn’t a way to input data,” he says. As a result, he had to manually transfer data for every patient.

What’s more, information from other sources has to be entered separately. “I call it a bunch of islands instead of anything being integrated,” he says.

He uses a scribe because “It keeps my head out of the computer” but it doesn’t solve all of his problems.

He’s frustrated by how EHRs are primarily “based on how to get reimbursement, how to create a database that then proves to the government what we did and what our value is.”

Ames would like to see a healthcare system where patient information is centralized, not siloed. Patients would have a data card containing everything pertinent: address, birth date, health insurance information as well as doctor visits.

“You’d have one repository of past medical history,” he says.

Of course, he’s aware that this is something of a pipe dream at present. At best, he says, “They just need to develop some

— KEITH ALDINGER, MD, INTERNIST, LIVING WELL HEALTH CENTER, HOUSTON, TEXAS

“[EHRs are] not interoperable and the government hasn’t brought pressure to bear on IT vendors to do that, yet they levy penalties against physician if they haven’t demonstrated meaningful use of the tool.”
interoperability standards so that each system can talk to one another. Right now, it’s like some [EHRs] are on a railroad track, some are on a highway and some are on a dirt road.”

MIRED BY A MERGER
A hospital merger between Scarsdale Medical Group and White Plains Hospital in Harrison, N.Y., brought with it a forced change of EHR for internist and gastroenterologist Malcolm Schoen, MD. Schoen thought his previous EHR was less than perfect, but he calls the new one “a horror show.”

He’s frustrated by how it complicates simple processes. “You can’t just get a spreadsheet of vital signs. You have to go to each individual visit and look it up,” he says.

Additionally, the only way he can enter medications into the patient’s record is if he knows the name of the pharmacy the patient uses. And there are medications missing from the database that he has to call in to the pharmacy himself.

Following the merger, patient information did not transfer to his new EHR and he’s had to come in as much as two hours early to do pre-charting. The added burdens are taking a toll on him. “I’m losing sleep and extremely stressed, but all the doctors in my fifty-doctor group are,” he says.

Still, he hangs a small amount of hope on the possibility that the medical group will consider a better product. “I’m anxious to see what else is out there. They can’t all be like this,” he says.

### SWITCHING

**Q: What are the main reasons your practice switched EHRs in the past?**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changed practice/employment</td>
<td>44%</td>
</tr>
<tr>
<td>Wasn’t user-friendly</td>
<td>21%</td>
</tr>
<tr>
<td>Selected a product linked to other systems (practice management, billing, etc.)</td>
<td>19%</td>
</tr>
<tr>
<td>Wanted better customization of system</td>
<td>18%</td>
</tr>
<tr>
<td>Lack of customer support</td>
<td>15%</td>
</tr>
<tr>
<td>Wasn’t certified for Meaningful Use/MACRA</td>
<td>11%</td>
</tr>
<tr>
<td>Vendor went out of business</td>
<td>9%</td>
</tr>
<tr>
<td>Found a less expensive system</td>
<td>8%</td>
</tr>
<tr>
<td>Other</td>
<td>17%</td>
</tr>
</tbody>
</table>

**Q: What capabilities is your practice looking for in a new EHR system that its current system lacks?**

(Respondents could choose multiple answers)

<table>
<thead>
<tr>
<th>Capability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easier to use</td>
<td>71%</td>
</tr>
<tr>
<td>Improved ability to customize</td>
<td>54%</td>
</tr>
<tr>
<td>Better vendor support</td>
<td>49%</td>
</tr>
<tr>
<td>Improved quality metrics measuring (e.g., Medicare payment reform)</td>
<td>43%</td>
</tr>
<tr>
<td>Better billing capabilities</td>
<td>39%</td>
</tr>
<tr>
<td>Less expensive</td>
<td>36%</td>
</tr>
<tr>
<td>Cloud-based system</td>
<td>28%</td>
</tr>
<tr>
<td>Better population health capability</td>
<td>26%</td>
</tr>
<tr>
<td>Other</td>
<td>19%</td>
</tr>
</tbody>
</table>
Robert Lending, MD, describes himself as a "computer dinosaur." The Tucson, Ariz., internist and clinical lipidologist gets cash from bank tellers rather than ATMs. He doesn’t make online purchases or use social media. And he doesn’t use electronic health records.

Lending, 65, calls EHRs “the most dangerous, ridiculous piece of equipment I could ever have conceived of,” adding that his colleagues envy him for the peace of mind and extra time he enjoys from using paper charts.

“You can’t believe how angry they are at computers, at the whole system,” he says. Lending is far from alone. True, physicians’ use of EHRs has soared in recent years, due in part to the financial incentives the government provided through its Meaningful Use program. According to the most recent data from the Office of the National Coordinator for Health Information Technology, 87 percent of office-based physicians were using some form of EHRs in 2015, up from 24 percent a decade earlier.

Still, that leaves a lot of doctors who aren’t using EHRs, despite pressures from the government, payers, and sometimes their own colleagues to do so. Medical Economics spoke with some of them to find out why.

ROBERT LENDING, MD
Since beginning practice in the early 1980s Lending has watched as EHRs have spread throughout the healthcare system.

Now he is among a handful of providers at his large, multispecialty practice who continue to use paper charts. While conceding that EHRs offer some benefits, such as data mining and e-prescribing, for the most part he has not liked what the technology has done to physicians or the profession.

“Most of my colleagues are spending an extra one to two hours per day just doing their records, often at ridiculous times,” he says. “Like they’ll see a patient on Tuesday afternoon and finish the note [for that patient] on the weekend.”

Lending dictates his notes on an iPad during the patient visit, in part because he values the level of detail and accuracy it allows.

“When you’re doing a note four days later it’s hard to remember if it was the second left proximal knuckle or the third left distal knuckle,” he says. “My ability to create a useful, accurate note lessens even a day later.” He e-mails the dictated note in audio format to a medical transcription service.

Lending estimates that the government docks him the equivalent of 2 percent to 3 percent of his Medicare reimbursements for not using EHRs. “But I’m willing to give that money up so I’ll have all my charts done before I leave the office, every script is taken care of, and my desk is clean,” he says.

Similarly, he misses out on a portion of bonuses the practice
VOTED #1 EHR IN THE NATION
receives tied to quality data gleaned from providers’ EHRs. “But that’s another thing I’m willing to give away so that I can just do my thing and be a doctor,” he says.

Lending says that if he were younger and had more years of practice ahead he would probably have gone digital by now because “Who knows, ten years from now it may be illegal even to use paper.” As it is, EHR use now is a requirement for any new provider joining the practice. But he is determined to hold out.

“Why would I want to take the smooth, efficient machine I have in my office and throw this kind of junk [EHRs] in just to be able to be current?” he says. “If my group forced me, that’s when I would quit.”

ASHESH PATEL, MD

For Washington, D.C. internist Ashesh Patel, MD, using paper charts rather than EHRs was more a legacy than a conscious decision. But having started down the paper trail, so to speak, he’s reluctant to turn back.

Patel, 46, began his career in 2000 by partnering with an older physician who didn’t use EHRs. Patel followed his example and continued with paper charts even after his partner retired six years later.

“It was more economically feasible to continue than to convert all those paper charts I inherited into electronic form, especially starting off as a solo practitioner,” he explains.

Since taking over the practice Patel has sometimes considered using EHRs for new patients while continuing on paper with existing patients but has found he likes the simplicity and direct patient contact paper charting affords.

“When I see a patient there’s no computer in front of me so I’m always face to face with that patient,” he says. “I write the note in front of the patient and they like seeing me write what they’re saying and knowing they’re being listened to,” he says.

Patel’s day begins around 7:30 a.m. and most days he’s finished charting by 4 p.m. “So I’m not in the position of many doctors I know who are still charting on their computers for an hour or two after their day is over, which leaves me time to focus on tasks like refills,” he says.

Like Lending, Patel incurs a financial penalty from Medicare for not using EHRs. But since only 20 percent of his patients are on Medicare, it’s a price he’s willing to pay for not spending additional hours completing patient charts.

An unexpected benefit of paper charting, he adds, has been the response of the medical students who rotate through his practice. “I’m the only place they go that has paper charts, and at first they’re a little shocked,” he says. “But once they realize that charting is simple, and they can come here and participate in patient care right off the bat without having to learn a new [EHR] system and password and all that, they really seem to appreciate it.”

His students are also reassured, Patel says, by the fact that he has computers in his office for other purposes, such as scheduling and getting patients’ lab results. “I’m not totally averse to computers, I grew up playing with them,” he says. “It’s just that I’ve gotten used to paper charting and I like it.”

ANN CORDUM, MD

When Boise, Idaho internists Ann Cordum and Kristen Fiorentino began planning to open their own practice in 2015, one of the first questions they debated was whether to use EHRs. Both had used them previously

“There’s a lot of pressure in medicine to use a formal EHR. But so far we have not felt that the pros outweigh the cons.”

—ANN CORDUM, MD, INTERNIST, BOISE, IDAHO
and knew the technology’s advantages and drawbacks. Eventually they chose not to, though the decision was not easy.

“There’s a lot of pressure in medicine to use a formal EHR. But so far we have not felt that the pros outweigh the cons,” Cordum says.

In part, their decision was driven by a desire to keep their practice small and personal and operate it on a direct-pay model, which requires minimizing overhead expenses. And the costs of buying and maintaining an EHR system and keeping its software updated can easily run into tens of thousands of dollars.

“So if I can cut out that piece it allows me to see fewer patients per day and spend more time with them, which was our goal when we started this practice,” Cordum explains.

Moreover, she adds, EHRs require physicians to spend a portion of each patient visit entering often-irrelevant data such as when the patient last had an eye exam or dental checkup. “And the more time spent on all that, the less time the practitioner has to address the patient’s immediate concern,” she says.

“Except when the patient grants permission, the only other person who can see the data is Fiorentino, when she’s covering for Cordum.

When Cordum needs to exchange patient data with another provider or institution she does it the same way the other party does even if they have an EHR: by fax.

“It’s the irony of electronic health records that none of these systems talk to each other,” she says. “So even if I were totally electronic, I’d still be relying a lot on paper.”

Despite their shortcomings, Cordum says she’s not philosophically opposed to using EHRs. “If it’s a tool that will help my patient get better care, I will use it,” she says. “But if it’s cumbersome and not really helping the care, then it just doesn’t work for me and my patient.”

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**Q: Why don’t you use an ambulatory EHR system? (Respondents gave multiple answers)**

- **53%** Interferes with patient relationships
- **42%** Cost
- **40%** Prefer paper
- **40%** Don’t want to invest the time and money
- **36%** Not required for my daily work
- **8%** Don’t accept Medicare patients; no threat of penalties

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“You can’t believe how angry [my colleagues] are at computers, at the whole system.”

—ROBERT LENDING, MD, INTERNIST, TUCSON, ARIZ.
An interoperability breakthrough?

A new health information exchange will include all major EHR vendors. We sat down with Micky Tripathi to learn what this means for physicians.

by AVERY HURT Contributing author

Micky Tripathi

is the president and CEO of Massachusetts eHealth Collaborative. Mr. Tripathi has been a nationally recognized leader in health information technology since his founding leadership of the Indiana Health Information Exchange and the Massachusetts eHealth Collaborative. Tripathi has advised statewide health information exchange projects in Massachusetts, New York, New Hampshire, Missouri, and North Carolina.

In what some are calling a major technological breakthrough for EHR interoperability, Carequality and CommonWell are set to launch a health information exchange that will include all major EHR vendors.

Micky Tripathi, president and CEO of the Massachusetts eHealth Collaborative, sat down with Medical Economics to answer questions about what to expect, how to cope with the additional data, and what lies ahead.

Q: Medical Economics: When will this be available to U.S. physicians and how do they get on board?

Micky Tripathi: We already have some provider organizations in initial production connected via Cerner, Greenway, and Epic, so some physicians are already using this.

By early October, it will be opened up completely to all CommonWell and Carequality vendors. The bridge is built, now we just need vendors to make it available to their customers. We expect that in eighteen months to two years, most vendors will have implemented it with their customers.

Q: ME: How many US physicians will be able to make use of this?

Tripathi: The EHR vendors in Carequality and CommonWell represent about 75 percent to 80 percent of U.S. physicians. I suspect and hope! that as word gets out, physicians will be banging on the door, asking their vendors: “When do I get this?”

Q: ME: More interoperability means more data for physicians to digest. Won’t physicians be flooded with data?

Tripathi: This is one of the challenges of interoperability, but it’s the problem we wanted to have.

I’d rather that people complain about the data they’re getting than get no data at all. However, I realize that physicians can be inundated by too much info, which presents workflow and safety issues as well. Vendors are working with their customers to inte-
grate all this data into their workflow—what fields doctors need to be able to access from which screen, what data they can do without, and so on.

But in order to make this work for you, there is no better channel than loud and frequent feedback to vendors. The more focused feedback you provide, the more they respond.

Q: ME: Is there something that physicians can do on their end to help them sort through the tsunami?

Tripathi: Physicians need to think: “How I am going to use this data? What data do I really need?”

The practice manager, physician manager, or care teams need to look at this in a thoughtful way, see how they can make the best use of it, and set up processes and routines for managing the day-to-day flow. It’s no different than what they’ve already put in place with their postal mail, courier packages, and faxes—it’s just another medium.

Q: ME: What types of information will doctors be able to access beyond Continuity of Care Documents?

Tripathi: Right now all you get is the Continuity of Care Document, which has 22 data elements required by Medicare and Medicaid.

Physicians say, “The CCD! You’re giving me more of the stuff I hate!” For many physicians CCDs seem like 10-15 pages of cut and pasted information with one small piece that they need hiding in there somewhere. I’m sympathetic to these concerns, but once this data is in their system, they can figure out how they want to integrate it into their workflow.

Most physicians can tell you the three or four other clinicians or specialty groups they need information from regularly, and usually three or four types of info they need. They should communicate with their main referral partners to get and set expectations of what they will send and receive through their EHR systems. They can say establish workflows for handling information from their main referral partners, which will account for most of their activity, and a triage process for managing the less frequent, ad hoc information that dribbles in less frequently.

Again, they already do this with their paper processes, they just need to apply that same attention on process to their electronic processes.

Q: ME: So what is the long-term picture?

Tripathi: Over the next few years we should see more functions based on FHIR standards which will provide the ability for more useful interoperability because the data will be more manageable.

The CCD is a document-level standard, meaning that you get the entire medical document with each exchange, not just the specific information (like medications) that you were looking for. FHIR is a data-level standard, meaning that you can ask for and receive specific information (like medications) and just get that back. It’s basically the same technical approach that Amazon and other modern platform companies use today.

Here’s an analogy. Way back in 1998, Sears had a shopping website, but in order to use it you had to download the whole Sears catalog, page through on your computer it to find what you want to buy, and type the information into a box on the Sears website. Now you go to Sears or Amazon and type “21-inch gasoline lawn-mower,” and it gives you back just the information that you asked for, not their entire catalog.

Q: ME: So now we’re at the 1998 Sears website stage?

Tripathi: Right. Is it perfect and elegant? Absolutely not. But we have to start somewhere. We’ll look back in ten years and see that this was the first step toward nationwide interoperability—like the old online Sears catalog. But by then we’ll hopefully have something more like Amazon.
A whopping 83 percent of physician practices report that they have experienced some form of a cyber-attack, including phishing, hacking, and even employee theft of electronic protected health information (ePHI), according to a study from the AMA and Accenture.

Practices typically focus on technological tools and interventions to prevent these incidents. While antivirus software and firewalls do play a critical role in cybersecurity, the human element should not be overlooked, says Uday Ali Pabrai, chief executive officer of ecfirst, a cyber-defense company.

"The journey starts with knowledge acquisition," he says. Most organizations have not done enough to improve individuals’ cyber-literacy, thus weakening practices’ readiness overall, he says.

Before your practice becomes a cyber-crime statistic, consider the following ways to strengthen your defenses:

1. **EXPLAIN THE DANGERS**

"Checking boxes’ without thought ultimately defeats the purpose of what cybersecurity programs are about," says Brian Yeaman, MD, a solo primary care physician in Oklahoma and health IT expert. "It’s really so much more significant in terms of protecting our patients’ privacy and protecting our practice because data breaches and their penalties are serious and severe.”

Practices must convince employees that training is more than a mandatory exercise that takes up their time; it’s integral to protecting patients, the practice, and their jobs.

Even a minor security incident can cause substantial business disruption, notes Yeaman. For example, consider a scenario in which someone gets into a practice’s network with malicious intent and brings down its network or domain. The expense doesn’t end with paying an IT company to rectify the problem, he says. "It’s lost patients, lost revenue, and staff sitting around with nothing to do because without your network, you’re dead in the water.”

And it’s not unheard of for disgruntled patients to make privacy or security complaints without merit, says Kate Borten, a Massachusetts-based security and privacy consultant. "I worked with one office in which a patient angry about his bill made a privacy complaint as a means of wiggling out of financial responsibility," she says.

Because there was a complaint, HHS investigated and therefore required the practice to provide copies of all of its policies, procedures, and evidence of staff training. "Through no fault of its own, the practice was really on the spot [to prove compliance]," Borten says. "Practices have to convey to employees that it doesn’t take much..."
to become involved in an investigation and they need to be prepared.

2 SELECT A SECURITY OFFICER

Success starts at the top. Therefore, it’s crucial that practice leadership and security officials be devoted to protecting the organization from cyber-threats, says Borten.

First, practices of all sizes should recognize that they are required to have a privacy official and a security official. “I’ve seen some backsliding on compliance with this point,” Borten says.

She advises appointing practice privacy and security officers (who can be the same or separate individuals, according to HIPAA regulations) who welcome the role. Physician owners shouldn’t “automatically appoint the practice manager, for example,” Borten says. “You really want somebody who cares, who’s interested in privacy and security, and who will go out and actually seek information to understand his or her responsibilities.”

Security personnel should be provided with some work time to fulfill those responsibilities, Borten notes. Those duties include developing training content, which may be in the form of slides, paper handouts, or other media that can be shown to HHS in the case of an audit or complaint.

“It should be the officer’s responsibility to make sure that training is adequate and meets expectations—and hopefully he or she will become the eternal go-to person for questions, complaints, and education.”

3 KEEP TRAINING SHORT AND STIMULATING

The frequency and content of security training are not spelled out explicitly in federal regulations, says Borten. She recommends that all employees, including physicians, receive comprehensive training upon hire and annually thereafter, with short refreshers on specific topics at least monthly. One way to carve out the time is to include some cyber-training on the agenda of existing staff meetings, she says.

To keep employees engaged, conduct the training using a variety of formats and tools. For example, hold a brief roundtable discussion about ransomware, suggests Pabrai. Or develop a handout focused on a particular area, such as how to report a potential breach of ePHI. “Identify your core topics and circle through them in different ways,” he says. “Keep trainings short, fast-paced, and relevant to current events.”

In addition to keeping training content relevant to current risks, employees must be able to connect the information to their day-to-day work, says Borten.

“Make it personal and directly related to people’s work processes and behavior,” she says. In other words, rather than regurgitating regulatory language, use training to explain what employees should do when they encounter specific situations.

She recommends practices take advantage of numerous training modules available online at little or no cost, many of which are geared toward physicians. Examples include resources from HealthIT.gov and the AMA.

4 REDUCE INTERNAL RISKS

Especially in small practices, the trustworthiness of employees can be easily taken for granted. However, a 2018 survey from Accenture found that 18 percent of healthcare employees said they would be willing to sell confidential data to unauthorized individuals. Furthermore, about a quarter of those surveyed said they knew someone in their organization who had sold their login credentials or similar information.

“We’d all like to think our employees are perfect and would never do that, but the reality is they would and they will at some point in time—so you have to create an environment that protects you,” says Yeaman.

Yeaman recommends, for example, shutting down USB ports on all equipment to prevent individuals from downloading data onto a thumb drive or other device. Network activity monitors should also be set to track any aberrant patterns that could signal inappropriate activity, he adds.

While anonymous reporting of suspected data misuse or noncompliance with security policies can be challenging, it’s essential that leadership supports reporting without retaliation, says Borten.

Reporting procedures should be included in training, she says. Both the HIPAA privacy and security rules require that covered entities have a written process for discovering and reporting even suspected misuse or breach of patient information.
Bullock gets some patient data from his EHR, but he doesn’t get all the notes from specialists or the local hospital, leaving him with an incomplete picture of his patients’ care. “With everyone moving to the electronic world for data, interoperability has not kept up,” he says. “As a primary care physician, I still can’t get my hands on the information that is out there.”

And while Vermont has an HIE with a portal, he has to go into the system and look up the information. “You have to know what you are looking for and go get it instead of the information coming to me,” says Bullock. “I feel like we have benefitted a great deal from electronic records, but the information in the system is not complete nor is it going to be complete anytime soon.”

To fill in the gaps, his staff faxes requests to specialists his patients have seen, but this can require multiple steps and authorizations before the records are finally released, and they actually need to know the patient received care outside the practice. “When you have to ask the patient, it doesn’t make you look informed, it doesn’t make the institution you are asking about look good and it doesn’t build confidence in the system. It’s inefficient.”

Kendrick is the CEO of MyHealth Access, a nonprofit health information network focused on ensuring every Oklahoman’s health record is available to those who need it. “On average in Oklahoma, only 30 percent of patients have all their data in one place, and 70 percent have it in two or more,” he says. “When I’m seeing patients, that means I have a 70 percent chance of missing important information if I’m not connected.”

Prior to MyHealth Kendrick, like many doctors, would find out from his patients about an ED visit, often with little detail. “They knew they got medicine, but couldn’t remember what it was,” he says. “We would have the patient sign a release and fax it over to the hospital, wait a couple of weeks for the information, then the patient would get care. If the issue was acute, then I would have to guess and treat them, possibly repeating tests.”

The HIE, which includes about 5,000 doctors and 70 percent of the hospital activity in the state, pushes most data out to the primary care physicians’ EHRs when someone is hospitalized. Kendrick recognizes that doctors need the data delivered to them and shouldn’t have to go looking for it, but not all EHR vendors cooperate in that regard.

“The data should be teed up in the doctor’s workflow,” says Kendrick, but the EHR has to allow data to be downloaded from the HIE, which doesn’t always happen. “I consider that inbound data blocking,” Kendrick says.

While he says tremendous progress has been made toward interoperability across the nation, more work remains, including training doctors to know how to find the information that’s available to them. But regardless, doctors need to be leading the process. “As clinicians, we need to drive the conversation and be clear on what we want and how it should look and vendors should be held to that,” says Kendrick.

“As clinicians, we need to drive the conversation and be clear on what we want and how it should look and vendors should be held to that.”

—DAVID KENDRICK, MD, CEO, MYHEALTH ACCESS

Continued on page 38
UHIN is Utah’s HIE, and connects 92 percent of hospitals in the state to primary care practices, skilled nursing facilities, and even therapists and paramedics. Rivera says the goal of the organization is to get the information providers need with a minimal of effort on their part.

“Where we can connect with their EHR, we want to push the data through that,” says Rivera. “Ideally, when a patient comes to a clinic and registers, their system will call our system and we can push them a summary of all the information we have.”

Before the system, she says fax was the primary method of data exchange. “Trying to get doctors to take the fax out of their workflow is one of the things we work hard on,” she says.

Part of the challenge is that early on, the system didn’t have as many participants as it does today, so physicians may have tried it eight years ago and dismissed it as not meeting their needs. “Because we are adding new data sources every week, it is an education process with them,” she adds.

Rivera recognizes the challenge doctors face with receiving too much data, so they are working on the best way to filter the most relevant data out of a larger health record. “It’s a matter of all data versus important data,” Rivera says. “How can we filter so that it is the right amount of data needed for the physician to treat the patient?”  

C arey is charged with overseeing ConnectVirginia, the HIE system linking all the EDs statewide. The initiative started as a way to track frequent users of EDs to reduce duplicative services and provide ED doctors with all the background information they needed to effectively treat the patient. As the program proved successful, it has expanded.

“Why not move the information down-stream to providers that allow a whole community of care where they are being seen, allowing them to address any red flags there?” says Carey, noting this is exactly what Virginia has done.

The HIE integrates an alert into the EHR, so doctors are notified about ED visits as part of their normal workflow, and all emergency departments are required by law to participate. Carey says the ease of use is why the system has proven so popular. “It is getting the information to the clinician using it, right there when they need it,” he says. “It’s right there, and that’s the key.”

He also credits a design that was focused on the needs of doctors in the ED. “If you design it right, you don’t have to sell the concept to doctors. People will be asking you how to expand it,” he says.

Kotrys says before Health Current, Arizona’s HIE, health records were being exchanged primarily by fax and phone. But as more providers moved to EHRs, the need for connectivity increased. Today, the system has over 500 healthcare organizations participating, representing 95 percent of inpatient discharges in the state.

“Without the information available through the HIE, doctors may not know that certain tests were done in different organizations,” says Kotrys. “From a care coordination standpoint, just knowing their patient is in the hospital or a high-risk patient is visiting the emergency department has allowed doctors to intervene to get them to a more appropriate care setting.”

Health Current uses a combination of alerts that are pushed out to doctors’ EHRs as well as a portal where more detailed information is available.

“In Arizona, we have had a lot of success in bringing together organizations that compete in other aspects, but recognize they shouldn’t compete when it comes to sharing information,” she says. “Sharing improves safety and care and we have a lot of support from the community.”
Q: Overall, how satisfied are you with your EHR system?

- Average satisfaction score: 2.8 out of 5

Q: Would you recommend your current EHR to a colleague?

- Yes: 43%
- No: 57%

Q: Why wouldn’t you recommend your current EHR to a colleague?

- Lack of concern for the physician’s/practice’s time in resolving problems: 69%
- Not meeting current practice needs: 46%
- System didn’t live up to vendor promises: 43%
- Inadequate vendor support (training, customer service, etc.): 42%
- Little or no ability to customize: 42%
- Cost: 37%
- Unable to negotiate better pricing: 10%
- Other: 16%

Q: Overall, what do you think EHR vendors could do to improve their products?

- Make systems more user-friendly: 72%
- Work more closely with their customers when designing systems: 65%
- Take an active role in promoting interoperability: 55%
- Put people before profits: 38%
- Incorporate voice recognition software: 32%
- Nothing, no improvements needed: 1%
- Other: 8%

Q: In your opinion, what is the biggest problem with EHR systems across the marketplace?

- Lack of user-friendliness: 42%
- Lack of interoperability: 26%
- Cost: 11%
- Inability to customize without vendor assistance/add-on: 11%
- Interference with patient information: 5%
- Other: 5%
- None: 1%
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NextGen Healthcare provides software and technology solutions to ambulatory care organizations on an integrated platform, enabling them to target superior clinical and financial outcomes concurrent with improved physician and patient engagement. Founded in 1976, NextGen Healthcare is an established leader dedicated to our clients who range from large multi-specialty to small single-specialty practices and include practice networks such as accountable care organizations (ACOs), ambulatory care centers (ACCs), community health centers (CHCs), independent physician associations (IPAs), management service organizations (MSOs), and physician hospital organizations (PHOs).

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Physicians rate EHR systems

For our exclusive survey, *Medical Economics* polled physicians to gauge how well EHRs function. Physicians were asked to rate their systems on key areas, including system capabilities, customer service and impact on patient care and practice finances.

**EHR USE**

**Q:** Do you personally use an ambulatory EHR system?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>14%</td>
</tr>
<tr>
<td>Yes</td>
<td>86%</td>
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</table>

**Q:** How long have you used an EHR?

Average length of EHR use: 7.1 years

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>≥10 years</td>
<td>24%</td>
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<tr>
<td>5-9 years</td>
<td>40%</td>
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<tr>
<td>1-4 years</td>
<td>30%</td>
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<tr>
<td>&lt;1 year</td>
<td>6%</td>
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</tbody>
</table>

**Q:** How many EHR systems have you personally used?

Average number of EHRs: 2.6 systems

<table>
<thead>
<tr>
<th>Number of Systems</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>≥5</td>
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<tr>
<td>4</td>
<td>14%</td>
</tr>
<tr>
<td>3</td>
<td>23%</td>
</tr>
<tr>
<td>2</td>
<td>29%</td>
</tr>
<tr>
<td>1</td>
<td>22%</td>
</tr>
</tbody>
</table>

No answer: 1%

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**EHR RATINGS (out of 10, with 10 being highest)**

<table>
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<tr>
<th>System</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementation</strong></td>
<td></td>
</tr>
<tr>
<td>Quality of training</td>
<td>5.3</td>
</tr>
<tr>
<td>Amount of training</td>
<td>5.2</td>
</tr>
<tr>
<td>Ease of customization or configuration</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Customer service</strong></td>
<td></td>
</tr>
<tr>
<td>Average wait time on a support call</td>
<td>5.2</td>
</tr>
<tr>
<td>Vendor’s ability to resolve technical problems</td>
<td>5.2</td>
</tr>
<tr>
<td>Quality of communication on resolving issues</td>
<td>5.1</td>
</tr>
<tr>
<td>Response time to resolve an issue</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Productivity</strong></td>
<td></td>
</tr>
<tr>
<td>Ease of moving from one section of EHR to another</td>
<td>5.3</td>
</tr>
<tr>
<td>Ease of navigation through patient visit</td>
<td>5.1</td>
</tr>
<tr>
<td>Importing data into your EHR</td>
<td>4.4</td>
</tr>
<tr>
<td>Frequency of useful pop-ups/alerts</td>
<td>4.4</td>
</tr>
<tr>
<td>Speed of moving to back-up system when main system is interrupted</td>
<td>3.8</td>
</tr>
</tbody>
</table>
**EHR IMPACT ON PRACTICE**

**Q:** Do you feel your EHR has improved or harmed the quality of care your practice provides?

- **45%** Harmed
- **27%** No effect
- **28%** Improved

**Q:** What is your staff’s opinion of your EHR system?

- **50%** Negative
- **26%** Neutral
- **23%** Positive

**Q:** What effect has your EHR selection had on the finances of your practice?

- **51%** Negative
- **30%** No effect
- **19%** Positive

**Q:** In what ways (if any) do you feel your EHR has improved the quality of care your practice provides?

- **60%** Enabled e-prescribing
- **33%** Improved communication with patients via patient portals
- **30%** Made it easier to exchange patient health information with specialists/other providers
- **26%** Improved patient access to their records
- **7%** Other
- **1%** No answer

(Respondents could provide multiple answers)
Q: What have been the disadvantages of your EHR system (if any) to your practice’s daily operations?

- 82% Spending too much time entering data not directly related to patient care/outcomes
- 65% Disrupting practice workflow
- 60% Not allowing eye contact with patients during exams
- 16% Other
- 6% None, no major disadvantages
- 1% No answer

CHRONIC CARE MANAGEMENT

Q: Does your EHR have chronic care management tracking capability?

- Yes: 66%
- No: 34%

ANNUAL SPENDING

Q: How much does your practice spend annually to maintain its current EHR?

Average annual cost: $38,000

- 36% $50,000 or more
- 15% $20,000 to $49,000
- 14% $10,000 to $19,999
- 10% $5,000 to $9,999
- 10% Less than $5,000
- 3% Have not had current EHR for a year
- 12% No answer

Continued on page 46
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DATA SECURITY

Q: Are you concerned about the security of the data contained in your EHR system and the potential for a breach?

- No: 46%
- Yes: 54%

Q: Does your practice have a designated IT department/employee or outsourced IT service?

- No: 7%
- Yes, an outsourced IT service: 33%
- Yes, an in-house IT department/employee: 60%

Q: Has your practice been the victim of a data breach in the last 12 months?

- No: 82%
- Yes: 3%
- Not sure: 14%
- No answer: 1%

TOP REASONS FOR THE DATA BREACH:

1. Ransomware was installed
2. Opened email with phishing scheme
3. Someone hacked the EHR system
had recently finished residency, and I was excited. After years of training, I would finally get to be a general pediatrician in a small community. I was ready to be a children's doctor; one who followed them through years of growth. I had studied and learned tremendous amounts of information. I knew how to pick up abnormal exam findings, notice red flags, and identify and treat illnesses. I had read parenting books and knew tips and tricks that would help parents through difficult phases and situations.

I knew the information that I had was good, I knew how to communicate it, and I was ready to help people.

It was in these early and idealistic days that I had one of my most defining moments as a pediatrician. During a routine well child check, the parents of a young girl complained that she was having a hard time falling asleep. They were frustrated with all the work they were doing to keep her in bed. They were stressed out and needed help, so I gamely reached into my bag of tricks and started making suggestions. Much to my chagrin, they had a ready answer for each statement:

“One thing that might help is...”
“We tried that”
“Have you considered...?”
“It doesn't work”
“You might be able to...”
“She just screams.”

It was an aggravating exchange, and after several minutes of being shot down at every turn, I was nearly out of ideas. Desperately, I came out with my last suggestion, “You might just need to close the door and walk away.” The response came swiftly: “She

“I knew the information that I had was good, I knew how to communicate it, and I was ready to help people.”
doesn’t have a door on her bedroom.”

I was out of ammunition. Defeated, I muttered something along the lines of “Well, I guess you have a problem, then,” and we moved on with the visit.

To my surprise, the parents did not seem upset with my failure to solve their child’s sleep issues, and they were not put out by my comment. The visit ended pleasantly, and the child continued to be my patient. I, however, was unable to put the encounter out of my mind. I was frustrated that I had not been able to solve their problem and even more frustrated that they had been so unwilling to positively respond with any advice I had to offer. What had I done wrong?

After mulling over the experience, I finally came to realize that I had misunderstood the parents’ intentions. Although they had expressed concerns about sleep, they were not actually looking for a solution.

Perhaps all they were really looking for was an acknowledgement of the intensity of what they were living with every night.

Initially this revelation came as a shock. I had thought that my job as a doctor would be to find solutions and fix problems. Through this interaction, however, I came to understand that, while my responsibility as a pediatrician is to present potential solutions to a whole host of parenting dilemmas, my job ends at that point.

This may seem like an odd realization to call a “defining moment,” but I believe that it has shaped my practice in a profound way. Recognizing where my responsibility ends, I offer my advice to parents more graciously. If they choose not to take it, I can smile and see them back at the next visit, ready to interact with any concerns they bring up then.

Over the years, I have found that the beauty of being a general pediatrician is that I do get to follow kids and families through years of growth and development, and families grow and develop, just like their children. So although she might not have a bedroom door at this visit, there’s a chance that, sometime in the future, she will.

As her pediatrician, I’ll get to be at that visit, and we just might be able to get everybody to sleep then.

Judy Black, MD has been practicing pediatrics for 16 years and currently is a partner in a multi-specialty clinic in Grants Pass, Ore.

Paperwork aside, Black says she reaps great satisfaction from her work. Fascinated by the functions of the human body and, in particular, the growth and development of children, she loves watching her patients grow over time and helping them develop into healthy adults.

During her free time, she enjoys knitting, spending time with her husband and children, and traveling. In fact, her retirement plans include touring the country with her husband in an RV. It’s safe to say that she probably will get a lot of knitting done as well.

Her advice for young doctors? “Expect to see a lot of changes in the business of medicine over the course of your career and try to be flexible.”

“arthur that my job as a doctor would be to find solutions and fix problems. Through this interaction, however, I came to understand that, while my responsibility as a pediatrician is to present potential solutions to a whole host of parenting dilemmas, my job ends at that point.”
Medical Economics reached out to physicians, healthcare technology experts, and financial consultants across the United States and asked what factors doctors should consider before investing in technology. Here’s what they said:

Study your workflow
Physicians should determine whether the technology they are considering would compliment and augment their workflow, says William H. Morris, MD, MBA, and senior medical director at Cleveland Clinic Innovations in Cleveland. Even the most compelling, novel technology will fail if it’s burdensome or distracting. “To combat this, be sure to understand the workflow first and ensure that the solution solves a pragmatic problem within it,” Morris says.

Determine if it’s worth the money
When it comes to electronic medical records, physicians should ask themselves if they will gain in efficiency by adopting such a system, says Diane Dewar, president of Dewar Healthcare Consulting in Castle-on-Hudson, N.Y. Electronic medical records can help large, busy practices share patient records among other providers while reducing errors. “But if it’s a small practice with a one-person shop, the technology is expensive and time-consuming to learn, and it may not be worth it for them to go through all that,” Dewar says.

Write a business plan
John Bender, MD, at Miramont Family Medicine in Fort Collins, Colo., says physicians should never invest in technology before writing a business plan. If it takes eight years to pay off the new technology, the investment isn’t worth it, because the equipment or system might not last that long. “If the break-even point is 16 months, that’s reasonable because the equipment will be still be working after 16 months, and it will bring in revenue,” Bender says.

Consider the patient experience
Clinicians should think about how a new technology will affect patients before investing, because often it doesn’t fit seamlessly into the existing workflow or patient experience, says Michael Brookshire, Dallas-based partner with Bain & Co. in Boston. In a best-case scenario, technology can help physicians provide new services, bring in new patients and improve efficiency. “But all too often, a new technology isn’t fully deployed because there isn’t enough patient demand or, even worse, it disrupts a highly functioning practice,” Brookshire says.

Build an implementation team
Bender says he forms an implementation team among his staff before buying new technology. They talk about how they would use the technology, explain it to patients, establish protocols for its use and even secure it at night. “There are a lot of fancy gimmicks out there that doctors can buy and not use very much,” Bender says.

Choose the right vendor
Before investing in technology, physicians should find a vendor that understands the challenges of delivering healthcare and is prepared for the future of healthcare technology, says Mark Janiszewski, executive vice president of product management and corporate development at Greenway Health in Tampa, Fla. “With complex technology available today, it’s crucial to have a partner who provides ongoing guidance, support and training, while also proving their solution is easily adaptable and can meet the organization’s specific workflow and needs on a continual basis,” Janiszewski says.

Bob Sandrick is a contributing author. Send your financial questions to medec@ubm.com.
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"As clinicians, we need to ... be clear on what we want and how [EHR systems] should look."

DAVID KENDRICK, MD, MPH, INTERNIST, TULSA, OKLA.

"There’s a lot of pressure in medicine to use a formal EHR."

ANN CORDUM, MD, INTERNIST, BOISE, IDAHO

45% of physicians surveyed said their EHR has harmed the quality of care they provide in their practice.

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“I’m really starting to worry about the new interface for the patient portal.”

The Money Issue

Physicians are beset from all sides with advice on how to manage their money and save for retirement. But where should you begin? Our cover package focuses on advice from financial experts on what primary care physicians should do to both grow and protect their wealth and manage their practice finances more efficiently.