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Doctors' 10 Biggest Mistakes When Using EHRs

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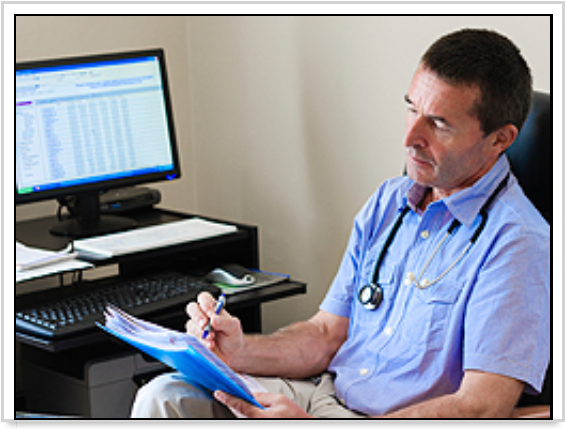
Introduction

Many physicians complain vociferously about electronic health records (EHRs): the difficulty of documenting in them and the resultant loss of productivity. A recent survey of 4279 physicians found that from 2010 to 2012, doctors' satisfaction with EHRs dropped significantly across all specialties and practice settings.[1] Online forums tell the same story: Many doctors attest that EHRs improve neither their efficiency nor their quality of care.

There's no doubt that EHR design flaws contribute to the unhappiness of many clinicians who find them difficult to use. But individual doctors and physician practices also make serious errors that can cause problems, sometimes without knowing why. Here are 10 mistakes that physicians commonly make with EHRs and advice on how to avoid them.

Mistake #1: Thinking a Site Visit Isn't Worth the Effort



Many physicians purchase an EHR without making a site visit to a similar practice that's using the same product, says Ron Rosenberg, a Sausalito, California-based practice management consultant. Not doing that, Rosenberg says, is a big mistake. "If the biggest barrier to successful use is a productivity penalty," he asks, "how can you possibly select a system without knowing exactly what it's going to take to see a patient while you're using that system?"

Rosenberg points out that some EHR vendors interface their products with "horrible practice management [PM] systems." PM systems that are part of integrated systems can also be poorly designed. "You have to evaluate the billing and PM side with as much due diligence as the EHR side, because it's your practice's financial livelihood," he notes.

There are other potential problems with EHR selection: Specialty practices, in particular, may buy an EHR that's not designed for their specialty, or doctors may choose an enterprise product that's inflexible and ill-suited to small practices. But employed doctors may not have a choice, Rosenberg observes.

Mistake #2: Signing an Unvetted Contract

"Never sign the contract the vendor puts in front of you without representation," says Mark Anderson, an EHR consultant in Montgomery, Texas. He advises doctors to use attorneys who can understand the contract from an operational as well as a legal standpoint.

Among the questions to ask vendors: How are you protected if something goes wrong with the EHR? What happens if the vendor doesn't deliver or delays installation? What if the vendor's trainer doesn't understand your problems or your practice? Is an exit strategy spelled out in the contract?

"I've had doctors who have bought products that have been sunsetted and are no longer supported, and they have to pay for them for 5 more years. There's no out for them," says Anderson. They'd still have to pay off their loan, he notes, even if the vendor decides not to get certified for Meaningful Use stage 2 and the physicians have to replace their EHR with a certified product.

The Way the EHR Is Used

Mistake #3: Neglecting to Perform a Workflow Analysis

Many practices neglect to figure out how they're going to get their daily work done with the EHR before they implement it. "It's a matter of configuring the software around their workflow," says Anderson. "But rarely does anybody do that. The practice installs the product and then lets the doctors start using it without asking any questions."

This can have adverse consequences. For example, Anderson notes, if the EHR isn't set up to send normal laboratory results to nurses, the doctors may be swamped by results that they don't need to see. If the EHR's messaging system isn't turned on, or the product doesn't have such a system, the staff may not know how to communicate with physicians and vice versa. Nurses may not even know which patients to room first if the EHR isn't set up to tell them when those patients arrived.

All this should be mapped out in advance before the EHR is implemented. Otherwise, practice managers or IT people may have to reconfigure the EHR while the doctors are trying to see patients -- and then teach everyone how to use the revised features. Anderson urges practices to do the workflow analysis before they train their staff on the EHR.

Mistake #4: Undertraining Doctors and Staff on EHR Use

You can cut training time in half if you do a workflow analysis first, Anderson says. Nevertheless, he observes, "Doctors pay too much for software and not enough for training." A doctor typically receives about 3 hours of EHR training, which is barely enough to learn how to handle a patient visit, he says.

Rosemarie Nelson, a Medical Group Management Association (MGMA) consultant based in Syracuse, New York, agrees that physicians don't receive enough training. Many of them tune out or leave the training session after they've learned how to document a visit -- although that's only a small part of what they need to know, she points out.

"Now they can do a visit, but they don't know how to optimize what happens between them and their nurse all day," Nelson says. "They don't know how to use the inbox. They don't see what all the possibilities are."

Nelson doesn't believe that people can learn how to use the EHR all at once, because there's too much to absorb. A good way to continue learning, she says, is to take the online courses that many vendors offer. Also, she recommends that the technology guru on the staff be authorized to "round" on EHR users once every 3-6 months. By observing what users are doing -- be they staff or doctors -- the guru might be able to show them shortcuts or easier ways to do things, she says.

Mistake #5: Refusing to Purchase a Laboratory or Device Interface

Sure, lab interfaces can be costly. But not having connections with your major laboratories can cost even more in wasted time during patient visits, Nelson points out. If laboratory results are faxed and imported or scanned into the EHR in PDF format, they're stored in a separate part of the EHR.

For a doctor to compare current laboratory values with the previous results, he or she has to pull up 2 different documents and find those values, which can be inconvenient when you're seeing a patient. Having discrete laboratory data coming into your EHR is also required for Meaningful Use and can help you move normal results to a patient portal.

Not having interfaces between your EHR and medical devices, such as ECGs and vital sign monitors, can also make your workflow clumsy and inefficient. It's difficult to look at a printout of an ECG while you're viewing other data in the EHR, and scanning in those documents doesn't work well, Nelson notes.

It doesn't have to be expensive to add interface devices, Nelson says. You can buy PC-based devices, and manufacturers provide applets, small software programs, that you can download to connect those devices to your EHR.

The Division of Labor

Mistake #6: Entering Too Much Data Into the EHR

Don't try to enter all patient data into the EHR yourself, Anderson says. Have a nurse put in the vital signs, update the problem list, and perhaps start the history of present illness, and then complete the rest of the note during or after the examination. "Doctors spend way too much time entering data into the record, even though they may not make any clinical sense out of that data," he points out.

In addition, Anderson says, EHR novices should start documenting gradually, perhaps starting with new patients. One reason for this is that when physicians start out with an EHR, they don't have any patient data in the system, and the initial data entry takes so much time that some doctors get frustrated and give up.

There's also nothing wrong with dictating progress notes, says Rosenberg. "For 99% of practices, structured data are worthless. In terms of doing searches for quality improvement, it's not worth what it takes to do it. If you're being required to get an EHR and you can dictate with voice recognition, that's a great way to go." Alternatively, he notes, some doctors successfully use scribes to enter data for them.

Mistake #7: Doing EHR-Related Work Your Staffers Should Do

Rosemarie Nelson agrees that doctors need not do much data entry. She points out that most of the structured data they need, such as problems, medications, allergies and laboratory results, can be entered by staffers, can come in through lab interfaces, or can be generated automatically. For example, the electronic prescribing module in an EHR automatically builds a medication list, although staff may have to enter other medications that patients bring in.

Many EHRs, however, are designed in a way that shifts some of the routine workflow in the practice to the physician. Those tasks include such items as maintaining problem lists and reviewing normal results. Instead of staff members doing these things, which are part of their job, doctors have to do them, which is "absolutely inefficient," she says.

"So you shouldn't allow that work to shift back to you. There has to be an effort in place to make sure everyone in the practice understands what their roles are. Part of the nurse's role is to help make the doctor's day more efficient, and that includes taking on tasks that some EHR vendor thought should be a doctor's, such as data entry."

Mistake #8: Using Shortcuts and Workarounds

Many physicians rely too much on shortcuts, such as EHR code checkers that help them verify that they have done everything required to justify a particular evaluation and management code, Ron Rosenberg says. This is a mistake because the code checkers often don't conform to Medicare's documentation and coding guidelines, he notes. Referring to an ophthalmology EHR, he says, "The way that system generates the note, it's blatantly fraudulent what they say about the review of systems."

It's also not uncommon for doctors to cut and paste sections of previous visit notes into current notes. That may simplify the process of creating the note, but it could land you in a world of trouble, Rosenberg points out. "The Office of Inspector General is really starting to look at that," he says. "Some doctors take the initial visit and keep carrying it forward. You're supposed to change what needs to be changed. But they're clearly documenting things that weren't done."

Moreover, Rosenberg says, this approach leads to suboptimal patient care and can create a "huge malpractice liability."

Keeping Both Paper and Electronic Records

Mistake #9: Creating "Shadow" Paper Documents

A recent study of physicians' EHR "workarounds" found that some doctors who feel uncomfortable with EHRs create paper "shadow" charts.[2] Doctors use these documents to track patient progress or as guides to medical decision-making, believing that they're more accurate and up to date than the EHR information.

Such an approach is understandable, especially if you have an unsatisfactory EHR. But maintaining both paper and electronic records can lead to other problems, such as missing information in one or the other or both.

"Once a patient record has been converted to the EHR, that should be the official document," says Rosenberg. "Having 2 charts is fraught with potential problems."

Another workaround, scribbling notes on pieces of paper, usually results from an IT person configuring the system without input from clinicians, Nelson says. If the EHR prompts and messaging system are set up correctly, there shouldn't be any need for Post-it® notes. She cautions doctors not to use regular interoffice email. Not only is such a system insecure, but it's also not tied to the patient record, she says.

Mistake #10: Accepting Inefficiency as the New Status Quo

What doctors fear the most about EHR adoption is that they will lose productivity for a certain period, or maybe forever. In fact, Medscape's 2012 EHR Report, in which physicians ranked the top EHR systems, showed that 32% of the respondents had not returned to pre-EHR levels of productivity, compared with 20% in 2010.

But the most unfortunate doctor response to this fear is to give up trying to be productive, Mark Anderson says. "Before, they were spending 2 minutes documenting, and now they're spending 10 minutes documenting. And they realize they're seeing 5-6 fewer patients a day. But they just say, 'Well, I have to do it that way.' They kind of give in to the idea that they're going to see fewer patients and make less money. But it doesn't have to be that way."

Among Anderson's recommendations: Don't try to enter all the data, and see what your colleagues who have EHRs are doing and what works for them.

An EHR may be a pain in the neck to learn how to use, and some things may take longer, but it needn't sink your practice. Follow the recommendations of experts, be proactive, and learn new ways of doing things if you want to succeed. Above all, avoid blaming the software for all your problems. Perhaps there's something you need to do to make it work better.

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