Docs, Patients, and a Love-Hate Relationship With EHRs
By Joanne Kaldy

More than ever, physicians and other practitioners are using and embracing electronic health records (EHRs) and other technology, but they still see these systems as far from perfect. At the same time, some of these concerns are shared by patients and families as they become more tech savvy.

According to a report from Stanford Medicine, "The role of technology in health care has increased dramatically (63%) of primary care practitioners (PCPs) believe that EHRs have led to improved care and are "somewhat" satisfied with their current system. Most (70%) say EHRs have improved over the last five years. However, 40% say that there are more challenges with EHRs than benefits.

Among other findings from the study:
- 49% of office-based PCPs think that using an EHR actually detracts from their clinical effectiveness
- 71% agree that EHRs greatly contribute to physician burnout
- 8% say the primary value of their EHR is clinically related

Over half of practitioners (59%) think that EHRs are a complete overhaul. Specifically, 72% think that improving the user interface of EHRs could best address the challenges in the immediate future. Elsewhere, 67% think that solving interoperability deficiencies should be the top priority for EHRs in the next decade, and 43% want better predictive analytics to support disease diagnosis, prevention, and population health management. Nine of 10 physicians want EHRs to be more intuitive and responsive.

Only 3% of PCPs don’t see any value in their EHR system. However, they overwhelmingly agree that this technology makes as practice managers is protecting to their administrative burdens, and hurs their relationship with patients.

Recently, he suggested, cybersecurity is part of orientation for new providers. “We address HIPAA and cybersecurity in the first week, and we continue to provide updates on these issues over time as new developments or security threats arise,” he said.

Patients and Cyber Concerns
As stories about health system and organization cyber breaches make headlines, patients and their families are becoming more aware of security issues. At the same time, patient-generated health data from wearable and remote devices present new opportunities for security problems.

In one study from the Harvard T.H. Chan School of Public Health, about a third of patients surveyed said they are “very concerned” that an unauthorized individual or entity will be able to access their private data, and 26% said they are

See DOCS, PATIENTS • page 5

EHRs Talk from page 1 to each other become more problematic. “The 21st Century Cures Act was the first major step toward governmental intervention to promote interoperability,” said Dr. Mahajan. This bill, passed in 2016, was designed to bring medical product and technology innovations and advances to patients who need them faster and more efficiently (U.S. Food and Drugs Administration, March 2018, http://bit.ly/37jKxw).

This move forward is essential because there is no room in new models of care for communication/information gaps that result in adverse events or other problems that increase costs and negatively impact outcomes.

There is a need for longitudinal records that enable practitioners to see what has happened as the patient moves from setting to setting,” said Dr. Mahajan.

The consequences of systems that don’t share information go beyond finances. They can be devastating, even deadly. Dr. Mahajan said, “I tell the story about a patient who was within three months went from living independently to moving through three hospitals and two nursing homes in five different systems.” He added that her living will, do-not-resuscitate order, and other data weren’t transferred to the emergency department, where she was resuscitated and ultimately intubated. She suffered and was denied a peaceful death because her information didn’t travel with her to the next site of care.

“This was my motivation to drive people to work more with technology,” said Dr. Mahajan. He explained, “We treat one patient at a time and have to deal with massive failures in the system because of lack of information. Instead of complaining, I decided to take things into my hands and help vendors work together to come up with interoperable systems that allow information to travel with patients.” He added, “Vendors now have this on their roadmap, but we need more physician involvement.”

Dr. Mahajan hopes that program participants will leave the session prepared to take a proactive role in promoting interoperability. “We are at a critical juncture where we can sit and complain and say we don’t have the information we need. If we can come in and learn how these systems work and why interoperability is important. Then we can go back to the facility and have meaningful and impactful conversations with administrators and others about why they need to push for information exchange between hospital and nursing homes,” Dr. Mahajan said.

As systems become more interoperable, practitioners also will take on greater responsibility for protecting data. “Cybersecurity is very important, and we all have to work hard to ensure we have best practices to avoid breaches,” said Dr. Mahajan. This session will include the basics of cybersecurity and how practitioners can help reduce the chance of breaches. “Physicians need to understand proper security protocols, and how to safely use systems remotely,” he noted.

Senior contributing writer Joanne Kaldy is a freelance writer in Harrisburg, PA, and a communications consultant for the Society and other organizations.

Make the Most of EHR

• Future-proof your practice. The ability to coordinate care instantly and seamlessly via the internet is an emerging giant in the field of medicine and of tantamount importance to the future of health care. Keep ahead of the curve by leveraging your EHR to grow the percentage of patients whose clinical information is shared electronically across care settings.

• Think about your notes beyond what they mean clinically. For practitioners receiving Medicare reimbursements, the Centers for Medicare & Medicaid Services treat progress notes like itemized bills. The notes entered into your EHR today not only need to convey important medical information about patients to other medical staff but also should document the accurate information requested by Medicare.

• Remember that good data entry enables a focus on patient care. Timely, accurate, and robust data entry into your EHR lets the business-minded people in your practice do what they do best and frees the practitioners to focus on providing the best patient care possible.

Cybersecurity: Going From Scary to Safe
While the Stanford poll didn’t address practitioners’ concerns about privacy, this is an issue on everyone’s minds. They’ve either read about security breaches that have affected others, or they’ve personally experienced a breach. “One of the most important decisions we have to make as practice managers is protecting patient information and the organization,” said Dr. Swenson. He added, “One appeal of a good EHR is a two-step verification process. That ensures that if a laptop or other device is lost or stolen, we wouldn’t have to worry about patient information being accessed.”

Dr. Swenson stressed, “Protecting patient data should be at the top of our list. These individuals should expect us to protect their information at all costs.”

Thin Line Between Love and Hate
A love-hate relationship with EHRs isn’t uncommon for practitioners, but there are some who love their information technology. What kind of system wins practitioners’ affections? It’s one that involves physicians and other practitioners in its design, is easily integrated into their workflow, enables access to information without multiple clicks or searches, and frees them for direct patient care, said Darren Swenson, MD, the CEO and president of US Post Acute Care in Tacoma, WA.

Features such as voice-to-text interface also are popular. This enables practitioners to focus on their conversation with the patient and lets the system record necessary information. “Rather than searching for a field, you just say the field. Some even have medical libraries built into the application to help ensure accuracy,” said Dustin Baker, security manager and privacy officer at GPM, Inc., in Asheville, NC.

Senior Conference Session
Other sessions at the conference to address EHR and technology-related issues include:

• Electronic Medical Records and Computerized Physician Order Entry in LTC, Conference: Patient or Foe (Friday, April 3)

• Tools of the Trade: A Practical User Guide From Apps to Data Analytics (Friday, April 3)

• An Advanced Care Unit: Using Telemetry and Continuous Vital Sign Monitoring to Reduce 30-Day Hospital Readmissions (Saturday, April 4)

• Expert Consensus on the Use of Telemedicine in the Roles, Tasks, and Functions of the PALTC Medical Director (Saturday, April 4)
Continued from previous page

or specialty admissions nurse, or evening nursing supervisor, depending on the facility’s structure and needs. Exact telephone numbers should be posted at the hospital’s nursing stations. And, of course, the nursing staff at the SNF must be poised to receive these calls and to maximize each call’s value with appropriate questions such as the indication for a Foley catheter or needed details about wounds and wound care.

Implementation of the handoff practice should be two way. The nursing home should provide this same service to the ED whenever a resident is transferred, in addition to whatever standard paperwork is sent. This could be an ideal quality assurance performance improvement (QAPI) project. These calls should be documented as received or performed, allowing for the collection of statistics about performance rates that can be shared with the hospital.

**Record Access**

A second intervention with high potential for success would be to obtain access for one or more clinicians at the SNF to the hospital’s Electronic Health Record, at least on a read-only basis. Most hospitals have mechanisms to provide access to affiliated physicians in their offices, so the extension of this to appropriately qualified professionals in the facility is not a stretch. Obviously, there is no HIPAA issue involved because these are patients for whom you are providing care.

Although these connections might, theoretically, also be achieved through a Regional Health Information Organization (RHIO), the consent mechanisms for many of these have proven slow and unwieldy. With a single major referral hospital, direct access would be much simpler. Among the major clinical benefits that such access provides is the ability to review culture and sensitivity reports, biopsy and other pathology reports, and other complex radiology procedure reports that are often still pending at the time of discharge.

Ironically, PDPM provides an opening to initiate this discussion. Our billing now requires more sophisticated information regarding details of the hospital stay, such as the exact surgical procedure performed and detailed ICD-10 codes for diagnoses. Without these, our Minimum Data Set and finance staffs will be bounding the hospital medical records department for information. Direct computer access would save hospital time and decrease aggravation. Although hospital administrators may see the clinical needs as somewhat theoretical, everyone understands the stark reality of federal billing requirements.

**Common Goals**

Effective communication requires two interested parties. Although some hospitals are highly motivated to be good partners in care, unfortunately this is a low priority for many acute care facilities facing multiple challenges. Small rural hospitals are closing, major tertiary care centers are in brutal competition for better-paying patients with attractive diagnoses, national and state so-called leaders are hiding away at insurance coverage, overworked and short-staffed nurses are threatening to walk off the job as we have already seen in other countries, and high-paying private insurance plans are disappearing. Meanwhile, an aging population leads to sicker geriatric patients in the hospital with the same expected length of stay. We need to offer communication solutions that are easy and quick.

As clinicians, our goal is to provide the best possible quality in a health care system driven almost exclusively by the bottom line. The faults in transfer communications processes are not those of indifferent discharge planners, ignorant hospitalists, or thoughtless administrators. Within the constraints of this system, we need to find innovative ways to provide the informed, quality, person-centered care that our residents deserve.

Dr. Nichols is past president of the New York Medical Directors Association. Read this and other columns at www.caringfortheages.com under “Columns.”

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**Docs, Patients**

*from page 3*

“somewhat concerned.” Further, some patients have expressed worries that data from their health records will be used to deny them health benefits, insurance, or job opportunities.

Dr. Swenson said that, to date, he “can’t think of one patient or family member [in post-acute and long-term care] who has asked me about the security of information.” However, he added, “I think we will see our operators, patients, and families start asking about things such as how we protect patient information and how we communicate and share data.” He suggested that practitioners should start to prepare for such conversations. For instance, he brings his tablet to meetings with new facilities and team leaders and shows them how his practice’s EHR works. He said, “Immediately, they relax and feel more comfortable that we are doing everything we can to protect data and prevent breaches.”

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