Subject: Why Health Care Tech is Still So Bad_Sunday_NYTimes.com_Wachter_fyi

March 21, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

Interesting read.

http://www.nytimes.com/2015/03/22/opinion/sunday/why-health-care-tech-is-still-so-bad.html?hp&action=click&pgtype=Homepage&module=c-column-top-span-region®ion=c-column-top-span-region&WT.nav=c-column-top-span-region&_r=1

March 21, 2015
Daniel Humiston, MD, FACC (dhumiston@utahcardiology.com)

Thanks Norm,

After living in Utah for nearly 21 years I've let my New York Times subscription lapse. It's comically tragic to read this article after spending most of my Saturday finishing EHR office notes from Thursday and Friday. Documentation that used to average one or two minutes now takes five to ten. My favorite example of EHR insanity was highlighted again this evening when I ordered a Foley for my patient with CHF admitted to our ICU. The default "occurrence" for a Foley catheter placement in my hospital's system is "Q8 hours". Not sure I know many patients that would actually allow this, but it's a poignant reminder that non-medical folks dominate the development and implementation of these now mandated software systems. As the article indicates, clearly the equivalent of Boeing engineers did not test drive these systems either. Ah, but I only have another twelve years before I can retire. Surely all will be well by then!

Dan

March 22, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

Yet, most of us drank the Kool-aid

March 22, 2015
Edward Fry, MD, FACC (fry5@comcast.net)

Norm,

Thanks for forwarding. The negative impact on day-to-day patient care inflicted by EMR's is perhaps more infuriating to clinicians that even SGR and MOC and is certainly more immediately tangible. It is the constant reminder and embodiment of the apparent loss of control the provider community has seen in the past 7 years.

As Dr. Wachter points out, if this were simply the whining of a bunch of curmugeonerly (word?) old docs, the belly-aching would be dismissed as the inflexibility of Luddite practitioners that will fade away quickly over time as new, tech-savvy, adaptable trainees displace them from the ranks of patient care

(remember the average of a cardiologist is 57). But the pain and failings of current EMR systems seem to be age-neutral, although there is some truth to the observation that those coming out of training today, and especially many care team professionals, have known no other way and are wondering what all the fuss is about.

For me, and I doubt I am alone on this, currently available EMR's represent the "Triple-Miss" of health care:

- The "eye off the ball" phenomenon - A misdirected focus on data entry and compliance at the expense of clinical assessment and decision making.
- The "needle in the haystack" phenomenon - Being blinded to perhaps the key piece of clinical information critical to a patient's outcome by the disorganized, unsearchable blizzard of irrelevant data elements collected and displayed for a given encounter.
- The"wedge" that has been driven between provider and patient that undermines what is fundamental to providing patient care as we have known it.

Beyond these failings, present day EMR's also appear to stifle the "Triple Aim":

- Access - Many providers have reduced the number of patients they see in a given time due to the busy work necessitated by data entry.
- Quality and patient satisfaction - Despite Dr. Wacther's optimism, outcomes have not been shown to improve (quality reporting may be better, but not the quality itself). Although patients are increasingly reassured that we are actually moving beyond tablet and chisel in our information management technology, they are as frustrated as we are by the physical and metaphorical barrier placed between them and us each time we bring the laptop into the exam room.
- Cost - It may be too early to reap the benefits of EMR's financially, but when you strip out the Federal Stimulus dollars that are quickly fading, subtract the lost productivity, and add back the fact that 25% of EMR's have been scrapped and replaced, the total added cost coupled with eroding reimbursement is a big loser. Granted, we may yet see benefits, but our health system estimates we invested $4 for every $1 of Meaningful Use money recovered when implementing both in-patient and out-patient EMR's.

Today the myriad of EMR systems has created a medical "Tower of Babel", unintentionally further fragmenting the care of patients who may receive care from multiple health care systems. Our practice has an extensive state-wide outreach program. We have to take into account the "fluency" of each provider with multiple EMR systems we may encounter at different outreach sites when scheduling and deploying physicians to the various locations. There is a limit to how "multi-lingual" we can be.

Cardiologists are perhaps the earliest adopters of new technologies and innovation. So, the blow back from EMR adoption is meaningful. Most systems were originally built on a billing, not a clinical, backbone and have been layered with a morass of compliance/MU fields. Clinical utility has almost been a second thought; an add-on, not the fundamental infrastructure. As the Op-Ed piece points out, EMR's were not built by clinicians and certainly were not tested and refined over thousands of hours of testing before subjecting patients to their use. The Great Recession of 2008 and the subsequent Federal Stimulus program necessitated getting cash out the door into the spiraling economy for what were thought to be "shovel ready" projects. It is interesting to speculate how the evolution of EMR's would have been without such dire pressure to roll them out prematurely.

Although the tools we now have are really crude and first generation, it is the work flow redesign that will be key to better application of EMR's and their future design. Dr. Wachter states: "We also need far better collaboration between academic researchers and software developers to weed out bugs and reimagine how our work can be accomplished in a digital environment". True that! But, please do not leave out the clinicians and the entire care team, most importantly the patient, in the re-design process. It is very interesting that the big information and tech companies, such as Google, Apple, Microsoft, SAP,

Oracle, and others, sat on the sidelines in the early days of EMR development, perhaps underscoring the complexity and uncertain ROI in health information management. But all are now showing signs of involvement, which can only be encouraging for the future. As was pointed out, effective use of "big data" can and will transform medical research and care delivery. Many of us may not be in practice long enough to see it in day to day patient care, but may benefit from it ourselves later in life.

Webster defines a tool as "a hand held device that aids in the accomplishing a task". Today's EMR's do not live up to that definition. Far from it. Cardiologists who fluidly move from in-patient to out-patient care, from medical to procedural care, and who are accustomed to developing technologies for the benefit of their patients must help lead the evolution and maturation of health information management to guide creation of better EMR's that effectively support clinical decision making, talk a single language connecting remote sites of care, that improve patient safety, that eliminated redundancy and lower costs, that involve the patient directly, and that are adaptable to the ever changing knowledge of medicine.

Ed

March 22, 2015
KellyAnn Light-McGroary, MD, FACC (kellann-light-mcgroary@uiowa.edu)

Well said Ed. I think though that your last paragraph is the most poignant. I feel we are in the Stone Age of the EMR. In that place where we have tools that have tremendous potential but we have not fully explored how to best incorporate it's functionality into our day to day life. Perhaps more than most physicians, especially within internal medicine, we have the most experience adapting technology into our workflow to achieve the greatest success. Ed is spot on that we must lead the evolution of the EMR so that it enhances the patient-provider experience, not diminishes it. We need to be vocal around innovation and adaptation.

KellyAnn

March 22, 2015
Hector Ventura, MD, FACC (hventura@ochsner.org)

All I want from the people that have designed the EMR is to give money back to us. While everybody is cutting our reimbursement the EMR people are making tons of money. Give us back some!!!!!!!! H

March 22, 2015
Matthew Phillips, MD, FACC (mattphillips1@me.com)

Hi

I was at Capitol Hill 2 weeks ago. We met several senators and congressmen and aides. We discussed EHR

Highlights

1. The summary document given to the patient -reviewed the cases of patients calling nurses in a panic because of diagnoses of cancer (that the patient self reported) and an abnormal anion- gap on their labs. They complain now about he ICD/9 description of tobacco use as abuse -

2. We are getting better at typing

3. Patients need sunglasses to look at the back of some of the cardiologists heads in a lighted room (a mark victor line)

4. We are seeing less patients

5. Still cannot get records from other docs

6. The legislators said they only wanted EHRs to talk

7. They are seeing large groups blow off meaningful use

8. It seems to be a tool to take our fees back

Matt

March 22, 2015
Jay Alexander, MD, FACC (drjay100@aol.com)

Well said, Ed..

March 22, 2015
David May, MD, PhD, FACC (dmay@cvscardio.com)

Perhaps it is time for this type of discussion to move from the tightly held 1S orbital of the BOG atom, becoming an incident photon resulting in Compton scatter elsewhere in the health IT world and beyond?

There are a variety of vehicles open including Cardiosource World News (Straight Talk), Health Affairs blog and others.

Viewed from a member perspective, that would be real value and, in my view, strike a resonant cord with the rank and file.

March 22, 2015
Jay Alexander, MD, FACC (drjay100@aol.com)

David,
Absolutely agree this should go out to members and I believe Ed's commentary should go with it..
Jay

March 22, 2015
Lisa Goldstein, ACC Staff (lgoldstein@acc.org)

Governors:

This past Friday, CMS released the proposed regulations for Stage 3 of the EHR Incentive Program. While we are still reviewing the proposed regulations, we wanted to make sure that you were aware of this development. Here is the link to ACC's article on them. Also, attached please find ACC's press statement on the new proposals. The College plans to submit comments on these proposals, as we have done with previous proposals.

Additionally, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing on interoperability this past week. The ACC submitted a statement for the record prepared by the Congressional Affairs team (attached here) that raises concerns regarding the costs vendors are charging for physicians to access their own records, as well as the "check the box" nature of the current EHR program.

Please let us know if you have any questions or concerns.

Lisa

March 22, 2015
Jesse Adams, MD, FACC (jadams03@bluegrass.net)

Norman- thanks for posting and starting this very interesting and important thread.

Ed- spot on wise analysis, as we know would be the case!

Dave- agree completely- helping to improve this issue would be of great value to our members. You had suggested at the BOG steering committee meeting that the ACC create Health Policy Statements to address issues that are of interest to our members. Perhaps this would be a topic that would benefit from such an approach?

Jesse

March 22, 2015
Kim Williams, MD, FACC (kim_a_williams@rush.edu)

Will work with staff on a vehicle for transmission. Blog or leadership page might be appropriate.

Yes, David. Best part of internal conversion to eject an electron is that the atom is left in an excited and positively charged state. Might be just what we need here.

Thanks, Kim

March 22, 2015
John Hirshfeld, MD, FACC (hirshfel@mail.med.upenn.edu)

I have been watching this discussion with interest. My institution was an early Epic adopter so I have a lengthy experience with it. I have experienced all of the frustrations that have been articulately described in this thread.

In particular, I have been frustrated by the poor interface design, inadequate rollout support and the additional time demands required to "feed" the record (and I have good keyboard skills).

Despite all these frustrations, I think it is worth pointing out that EMRs already confer a substantial benefit - namely enhanced access to information. How many of us would prefer to spend time rooting through charts looking for paper documents or to be in a remote location when needing to review a physical chart that is some place else?

Given that I am part of a large health system and see patients who are seen by multiple other doctors in other disciplines, the immediate electronic access to other physicians' records and all laboratory and imaging studies has proved to be a substantial enhancement.

Yes, the current generations of EMR's are primitive. Yes, we have been the frustrated by an immature technology. Yes, many institutions have furnished inadequate support effectively shifting clerical work onto physicians.

However, I think they are here to stay and, hopefully the above deficiencies will resolve over time (hopefully sooner rather than later).

March 23, 2015
Tim Dewhurst, MD, FACC (tdewhurst@comcast.net)

Colleagues, please indulge me with a personal view of EHRs and some thoughts going forward that get at the root of the problem (not all related to EHRs themselves). I believe that there are opportunities for the ACC, BOG and ACCPAC to improve where we are.
Please read to the end before deleting and I apologize if my auto-correction changed EHR to HER (which it wants to do) and I missed it.

Like John I have a decade experience with Epic (in two different institutions) and have developed clinical content templates for both in-patient and out-patient care.

I am not sure if we are ahead or behind the curve compared to other areas of the country, but many of the promises of EHRs *have been realized* in my geographic area and practice.

EHRs let me communicate real time with my PCP and specialty colleagues, and clinical questions are resolved quickly with rare need for phone calls and phone tag interrupting physician-patient time.
I can securely email with my patients, and prescribe to any pharmacy in the country electronically.
When I see a new patient, the old records are complete and on my screen more than 95% of the time.
I can care for more patients, more efficiently with the tools provided in my EHR.
I can provide excellent care while keep patients happy and off the freeways (or in some cases ferries) with virtual care.
I can update my patient’s medication list real time. (My personal OCD focus)

I can click a hyperlink to see radiology studies including nuclear medicine (but not yet echo and cath studies)
After my visit, patients leave with legible instructions and an up to date medicine list both in hand and available on line.
I see significant abnormal labs real time and can act on them efficiently leaving a paper trial of what I did.
I can see medical records from almost all hospitals in my geographic area for a given patient, greatly helpful for ER care follow up.
I can provide specialty virtual consultation to my primary care colleagues, more efficiently seeing those I need to see, and guiding the PCPs in those I do not need to see.
We are able to track and care for patients on amiodarone in an automated way.
We have a great Anticoagulation clinic process with physician oversight and a time in treatment range of 75% (as good as or better then Warfarin trials)
Three months ago my organization released all notes to all patients who want to see them electronically. Of course, all notes have always been passively available to the patient.
In three months I have had only one patient with a comment on the note and it was to correct a somewhat important fact.

My notes are better with an EHR than without.
I know our area is lucky that most hospitals and groups use Epic, but even my hospital practice system (which uses Cerner) uploads to our out-patient Epic system.

What are the problems with EHRs, and what problems are more systemic, and not related to EHRs?

They are expensive in acquisition and maintenance.
Good systems are out of the financial reach of small practices. (Unfortunately, I do not see any way for them to survive in the changes coming without aligning with a large system that will need to provide the EHR)
There are no interoperability standards. (Massive federal government failure, not too late to fix, but now incredibly expensive)
Interfaces are suboptimal and way behind current technology.
There is almost no utilization of AI in how information is presented to the clinician.
The general systems are not specialty friendly and the specific specialty systems are even less interoperable.
Completing notes takes longer than standard dictation.

One of the biggest issues blamed on EHRs, but is not at all the HER's fault, is what I call the "The Emperor Has No Clothes" issue.
EHRs are largely built to satisfy arcane documentation requirements based on insane CMS requirements.
In our crazy current fee for service system, we have blindly gone the path of wasting time by documenting a complete review of systems, comprehensive physical exam, detailed family history so we get paid less than our office expenses for that visit.
We do this to get paid, protect ourselves from legal issues (both malpractice and administrative). It does not add anything to patient care.

Envisage a note that just had pertinent problems, meds, allergies, labs and a readable (and findable) helpful assessment and plan.
Would that be helpful to our colleagues, and patients?
Would it let us spend more time with our patients?
Would it let us spend more time with our families?

What can we do as the ACC BOG?

1) Work with Congress and DSHS to demand complete interoperability of EHRs, at the vendor's cost.
2) Lead the charge to a value based reimbursement system that does not require insane documentation requirements. If the people taking care of the patient can understand the assessment and plan in a note, that is all that should be required. We need to continue to work with the public and policy makers to shed the light on these useless documentation requirements.

Thanks for reading this far. EHRs are inherently good, they need a lot of work to be optimal, but I have seen enough positives to have no interest in going backward.

Tim Dewhurst

March 23, 2015
Victor Ferrari, MD, FACC (ferrariv@mail.med.upenn.edu)

Tim, John

Many thanks for your thoughtful and detailed notes. I agree with you both that - despite their present very apparent deficiencies and glaring limitations - there are many ways that EHR's can get us across the goal line of better patient care and communication. However, I acknowledge the limitation of access issue that others have raised while we invest our own time to create and optimize templates, and to adapt to this uninvited visitor in the exam room. As both have described, poor technical support and planning lead to even greater inefficiency in learning a new system and streamlining tasks, and investing more of our own time to rectify issues. Two questions for Tim:

1. Since health systems should be providing subspecialty physicians with inpatient and outpatient templates (but these are often inadequate for real practicing cardiologists), would you be willing to share your templates/Smartphrases with those who might be interested in seeing what you've done to optimize them for your practice? This could be done offline (off the listserv, that is) and may be one way the BOG can improve members' experiences with EHR's. If this info is proprietary or otherwise not for public distribution, we understand, but even some descriptions of your strategies for various types of patients will be very helpful.

2. Re: your comment "I can see medical records from almost all hospitals in my geographic area for a given patient, greatly helpful for ER care follow up" - this is very interesting. Are the hospitals you're talking about part of your health system, or is there a regional agreement to share EHR material for ER visits, even among "competing" health systems? This would certainly be a step forward in improving health care for all.

Thanks a lot,
Vic

March 15, 2015
Hadley Wilson, MD, FACC (Hadley.wilson@carolinashealthcare.org)

As Smadar said you can give your credit card # and have it deducted at a low painless amount monthly if you choose. Brilliant! Hadley

March 15, 2015
Thad Waites, MD, FACC (thadwaites@gmail.com)

Just a word of warning about the credit card method, it doesn't automatically renew. I believe the team is working on a way to automatically remind you, but to date that's not there, either. I know, because the PAC team was scowling at me the first day or two. No green PAC ribbon attached to my badge ribbon line up. My monthly had lapsed.

Thad

March 15, 2015
Elizabeth Shaw, ACC Staff (eshaw@acc.org)

Dear BOG,

I hope you all are having a wonderful ACC 15, it has been a great meeting so far. I just wanted to forward along the link https://accadvocacy.com to the SGR alert that Dr. Phillips mentioned. I also wanted to remind you that if you would like to take action on a desktop there is a computer at the Advocacy Booth in the Expo Hall and in the ACCPAC Lounge in the Sails Pavilion. Please ask your colleagues to take action as well. Thank you in advance and let me know if you have questions.

Best,

Elizabeth Shaw
Manager, Federal Grassroots
American College of Cardiology
202-375-6404

March 15, 2015
Gerald Blackwell, MD, FACC (jblackwell@mycva.com)

The thread leads me to think that most folks who haven't contributed - don't realize they haven't contributed and/or there is a technical reason.

For those very few who actively choose not to participate - I think it would be critical to understand "why" a BOT or BOG member would choose not to participate.

It should not be a matter of public debate, but it would seems in-bounds for our leadership to know and see if we can learn something.

There is no minimum contribution - so anyone choosing not to must have a philosophical opposition.

The symbolism to our members that there is 100% BOG/BOT participation seems valuable to me.

One ongoing members opinion...

Great meeting by the way.

Jerry

March 15, 2015
Edward Fry, MD, FACC (fry5@comcast.net)

Jerry,

Well said. Doubt there are philosophic "gaps", only informational and technical ones.

When communicating with our leadership peers as well as membership, we need to paraphrase from our friends at ABIM: "Advocating, but not contributing"!

Ed

March 15, 2015
Charles Brown, MD, FACC (Charles.brown@piedmont.org)

How about a targeted individual confidential email to those BOG members who have not contributed. Maybe they overlooked it

March 25, 2015
Garwood Gee, MD, FACC (Garwood.gee@kp.org)

Tim and Ed,

Thanks for your thoughtful and thorough analyses of the everchanging landscape of EMRs.
My experience more closely resembles Tim's, where we are a plan that is on Epic. We started with the same edition as everyone else and dealt with the same shortcomings initially.
However, over the last six years, we have been able to develop content that enhances rather than inhibits your work. To do so, there is a large commitment of resources. We actually have a cardiologist who spends half of his time doing Epic content, and each hospital site has a Technology leader, with bimonthly meetings.
We actually have a separate Cardiology Navigator section, specifically designed to keep cardiology procedure results and reports placed on its own tab, and with workflows and orders built in, to allow cardiologists to work between institutions.
We are only able to do this because we have a cohort of over 200 cardiologists, and enough commitment in an interested cohort to make existing with the EMR bearable. I joke that I can't believe that we pay them, rather than the other way around.
If it helps, I joke to the patients that I'm just a scribe when I make them wait while I enter a computer order.

Garwood

March 25, 2015
John Erwin, MD, FACC (jperwin@sw.org)

Gil-
Thank you for this. Our Baylor Scott & White Health Central Division hospitals have experienced the same issues. It has actually inhibited rapid cycle (PDSA) improvement in trying to mediate a common ground amongst a diverse group of hospital settings. We are gaining some steam now that we are one year out from the rollout, but the added time and effort to rebuild a very generic Epic system to make it work for us has been enormous.
-john