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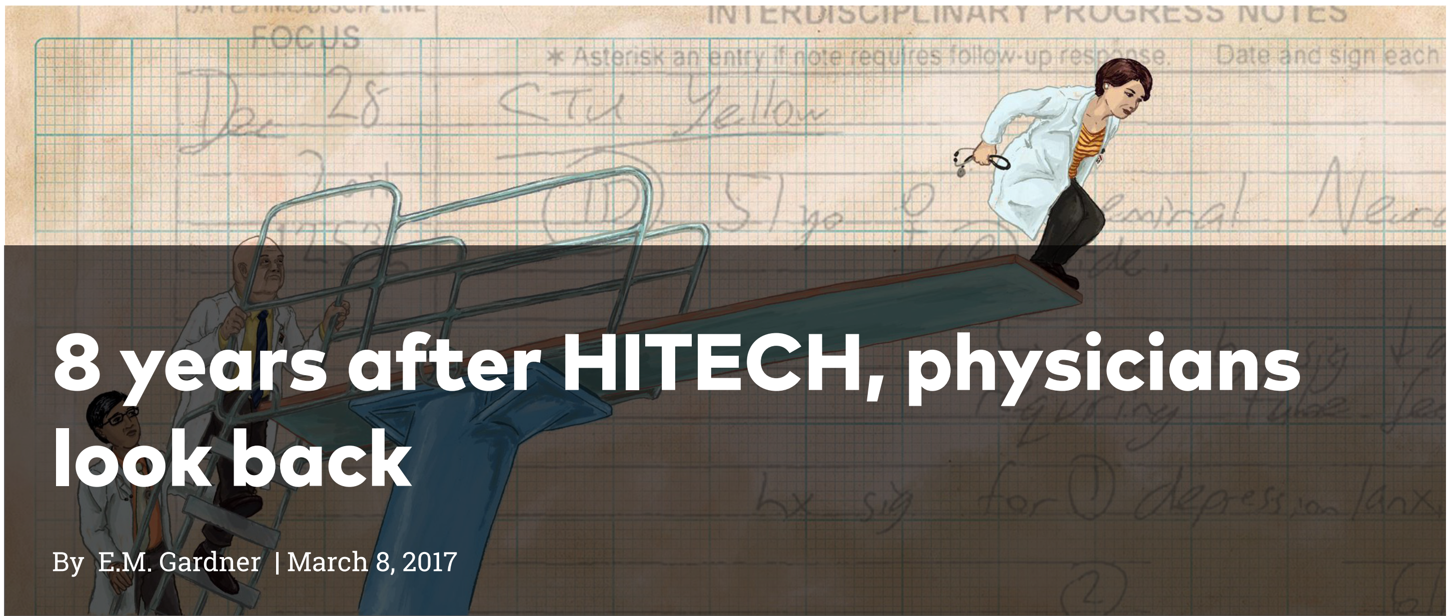

8 years after HITECH, physicians look back

By E.M. Gardner | March 8, 2017

In healthcare, change sometimes comes gradually. So it's worth considering how dramatically medical offices have transformed in the past two decades, as piles of paper have given way to electronic health records.

In the eight years since the federal Health Information Technology for Economic and Clinical Health (HITECH) Act mandated incentive payments for adopting EHRs — and penalties for not doing so — many medical practices are all but paperless. As of 2015, almost 87 percent of physician offices had an EHR and more than half were using their systems effectively enough to qualify for "meaningful use" incentive payments.

It's always a challenge to change longstanding habits. And everyone has heard complaints about screens. But for many providers, nostalgia for the good old days of paper has given way to an understanding of how electronic records can improve care and performance — especially as function catches up with user needs and interoperability collaborations make data sharing easier.

"If we were on paper, we couldn't get data out of our records the way we do, or analyze it, or share it with other entities," says John Kulin, D.O., CEO of the Urgent Care Group in New Jersey. "The major change coming in medicine won't be a new kind of scan, but how we use data to improve care."

Kulin's 34-physician practice, with several locations along the Jersey Shore, has accumulated electronic records on 195,000 patients in the nine years since it made the switch from paper. Kulin says the practice could not function, much less grow, without an EHR.

Using a tablet, he can access patients' prior urgent care records and do medication reconciliation with confidence, so that he doesn't prescribe anything inappropriate.

"If we were on paper, it would be up to our brains to remember, and with how quickly new medications are coming out, I love having all that information right at my fingertips," he says.

Because his practice solely offers urgent care, Kulin looks forward to being able to share information with his patients' primary care providers through a local

health information exchange — an ability he hopes will be in place by summer.

Pediatrician Sally Ginsburg of Pioneer Valley Pediatrics, in Longmeadow, Massachusetts, can't think of anything she misses about paper. The other day, she received a paper chart from another practice in preparation for taking on a new patient.

"You can't read anything," Ginsburg says. "Until I meet this patient, I won't know what's going on."

Women's Specialty Care, an OB-GYN practice with four offices in northern Wisconsin, switched to electronic records in 2009 but still uses a paper billing sheet in the exam room, says Medical Director Herbert Coussons, M.D.

The practice automated its management and clinical functions in 2008 and 2009, respectively. But Coussons says if he had it to do over again, he would diminish the overall pain by switching everything at once.

"The docs don't touch the billing system, and the front desk doesn't touch the clinicals, so it's a fallacy that you have to stage it," he says.

The practice eased into the EHR by scanning in each patient's chart at the first post-EHR visit. Within a year, about 90 percent of the charts were fully electronic, though Coussons says they still have to pull an old paper chart occasionally.

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OrthoAtlanta, a 12-office orthopedic practice with 39 physicians and 38 non-physician clinicians, has had an EHR for 10 years, but is only now getting back to the administrative efficiency it had with paper, says medical director Michael Behr, M.D.

"It used to be you just talked into a Dictaphone and someone at the other end would magically type it up and you were done," he says. "Now, voice recognition technology has improved so dramatically that once again, you're done!"

Behr loves the portability of electronic records, as well as their legibility, but still feels that it takes him somewhat longer to find things in an electronic chart, and even longer to enter data.

"Until you can see a patient in close to the same amount of time that you could with paper, you'll continue to struggle," he says.

Indeed, some clinicians easily make the jump from check-boxes on paper to check-boxes on a screen, but others don't.

"Sometimes it was easier to find things on paper than it is now, but not always, and our EHR search function got better last year," says John Sawyer, M.D., chief medical officer for Hudson Headwaters Health Network, a 17-site federally qualified health center network in upstate New York that has 170 clinicians and takes care of 80,000 patients.

The practice converted to an EHR seven years ago, and Sawyer remembers typing in medications and problem lists for many of his patients during the transfer period.

"The process of note-writing used to be simpler on paper," he says, "but you couldn't read the notes."

E.M. Gardner is a writer based in Chicago.

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