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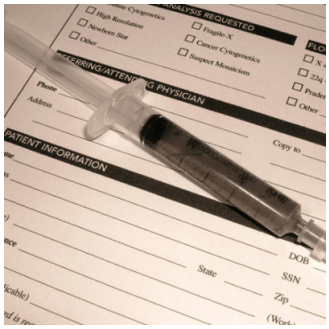
4 in 5 U.S. Hospitals Adopt Basic EHR, But Face Limitations



Electronic health record (EHR) adoption reached 84 percent of hospitals in the U.S., and nearly as many were able to exchange key information with outside providers, new federal data has shown, according to the Healthcare Financial Management Association (HFMA).

The share of acute care hospitals adopting basic EHR has grown from 9.4 percent in 2008—the year before the federal EHR incentive programme was enacted—to 83.8 percent in 2015, according to new data from the Office of the National Coordinator of Health Information Technology (ONC).

“That is a nine-fold increase since 2008,” said Vindell Washington, MD, principal deputy national coordinator at ONC. “At ONC, we believe we're at a critical inflection point, one where technology, policy, and demand are poised to change the way we think about access and use of health information to improve care and advance science and public health.”

However the adoption of advanced EHRs—defined as those with comprehensive levels of functionality above basic electronic records with clinician notes—reached only 40 percent of hospitals in 2015, writes Rich Daly, a senior writer/editor at the HFMA.

Additionally, 96 percent of acute care hospitals “possessed” a certified EHR in 2015. However, “possessed” means only that the hospital has a legal agreement with an EHR vendor and is not equivalent to adoption.

Basic EHR adoption occurred across hospital types, with the lowest adoption rates—80 percent—seen among rural hospitals and critical access hospitals (CAHs). Basic EHR adoption has increased from 36 percent of rural hospitals and 35 percent of CAHs in 2012.

The broad geographic nature of the adoption was reflected by ONC data showing basic EHR adoption occurred among more than 65 percent of hospitals in each state by 2015.

The share of acute care hospitals electronically exchanging laboratory results, radiology reports, clinical care summaries, or medication lists with outside ambulatory care providers or hospitals reached 82 percent in 2015, up from 76 percent in 2014, according to another ONC report.

However, only 46 percent of all acute care hospitals had providers who were able to electronically access necessary clinical information from outside providers or other sources in 2015. That was a slight improvement from 41 percent in 2014.

Less than one-fifth of hospitals reported their providers often used patient health information received electronically from outside their hospital system when treating their patients, while 36 percent said their providers rarely or never used such data in treating patients.

The most common reason for not using patient health information received electronically from outside providers was that the information was not available to view within the EHR. Similarly, the inability of exchange partners to receive data was the most frequently identified barrier to interoperability

Washington described the flow of health information as “critical to many of our national priorities,” like precision medicine or the National Cancer Moonshot Initiative led by Vice President Joe Biden.

The data release came on the same day the Centres for Medicare & Medicaid Services issued a correction to the final rule implementing Stage 3 of meaningful use. The change to Measure 2—which requires hospitals to add to a patient’s record an electronic summary of care document for more than 40 percent of transitions and referrals received and encounters with new patients—deletes the requirement that the source of the summary of care document be from outside the provider’s EHR.

The latest data on information exchange among providers came amid the Obama administration’s ongoing push to lower the barriers to interoperability and data exchange. One part of that push has been an effort to get vendors and providers to pledge not to block the flow of patient data.

Although the vendors signing the pledge provide 90 percent of the EHRs in U.S. hospitals, providers continued to raise concerns that vendors are blocking data.

In contrast, many providers must pay vendors to join a local health information exchange network.

The lengthy ongoing process to develop common interoperability standards also drew criticism from providers.

Meanwhile, David McCallie, MD, a senior vice president at Cerner Corp., warned that the current definition of interoperability is inadequate and will not provide clinicians with “actionable” data.

“We're going to go from having little interoperability to having lots of data flowing and then discover that is not good enough,” he said.

The solution to the lack of actionable data may be the ability to plug an app, like one with a population health manager setting, into a remote system to provide the needed data, according to McCallie.

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