Adoption of EHRs by U.S. Hospitals Is Low

BY MARY ELLEN SCHNEIDER

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ess than 11% of U.S. hospitals have a “basic” electronic health record system operating in at least one major clinical unit, according to a survey. Even fewer hospitals have a “comprehensive” system, operating in all major clinical units, the survey found (N. Engl. J. Med. 2009;360:1628-38).

The findings shed light on the use of health information technology at a time when the federal government is directing billions of dollars in incentives to physicians and hospitals to begin using those systems to improve quality and cut costs.

The results are based on a 2008 survey of nearly 1,000 U.S. nonfederal acute care general hospitals. About 1.5% of hospitals met the definition of a comprehensive EHR system, meaning that they have implemented 24 functions—including clini- cal documentation, test and imaging results, computerized provider-order entry, and decision support elements—across all major clinical units in the hospital.

Basic EHR systems, on the other hand, are defined as having at least eight functions that had been implemented in at least one major clinical unit in the hospital. Those systems do not include clinical decision support and have fewer results-viewing features and computerized provider-order entry functions than do the comprehensive systems. About 7.6% of hospitals have a basic system that includes functionalities to allow for physician notes and nursing assessments, and 10.9% of hospitals have a basic system that does not include clinician notes.

The comprehensive record definition should serve as a goal for all hospitals, while the basic system standard represents the minimum level of functionality needed to help clinicians improve quality of care for patients, said Dr. Ashish Jha of the Harvard School of Public Health, Boston, and the lead author of the study.

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The goal of the survey was to establish a baseline for EHR adoption in hospital settings. Before the survey, published estimates of EHR adoption by U.S. hospitals ranged widely, from 3% to 59%, reflecting differing definitions of an EHR system, convenience samples, and low response rates.

Cost continues to be a significant barrier, the implementation of EHR systems in hospital settings, the survey found. Among hospitals that had not implemented EHR systems, 74% cited inadequate capital for purchase of a system, 44% had concerns about maintenance costs, and 32% were wary of the unclear return on investment.

But responses from hospitals that had implemented an EHR system indicated that financial incentives could spur adoption. About 82% of hospitals that had adopted EHRs said that additional reimbursement for the use of an electronic system, could help, and 75% said financial incentives for adoption would be a positive step.

“This is really hard work,” said John P. Glaser, Ph.D., vice president and chief information officer of Partners HealthCare System in Boston, which has put such advanced clinical decision support features as computerized provider-order entry into 11 of its hospitals and has implemented EHRs in outpatient settings for about 3,000 physicians.

The implementation of an EHR system in a large multihospital system can cost hundreds of millions of dollars, involves difficult workflow and behavior changes for the staff, and requires sustained leadership, Dr. Glaser said. “These are not triv- ial undertakings,” he cautioned.

Some hospitals may not have access to sufficient capital to purchase and implement a system, while others may be hesitant about their ability to recoup some of the costs. At Dr. Glaser’s institution, they have worked with area managed care companies to build financial incen- tives into the contracts, so their physi- cians are more willing to adopt EHRs, he explained.