AAPA

EHR Usage Among PAs

Trends and implications for PAs

April 2019 • A Report from the 2018 AAPA PA Practice Survey

Contents

Methodology

Data were collected in a survey sent to a random sample of 8,678 PAs and PA students, with a response rate of 11.5%. A total of 725 PAs responded to the survey. The overall margin of error is +/- 3.6% at the 95% confidence level. Response rates and margins of error vary by section and breakout.

Data contained within this report represent PA respondents only.

Measures

Only data based on 5 or more respondents are included.

On the tables that follow:
"Median" is the 50th percentile; i.e., 50 percent of responses are above the median and 50 percent are below the median.
"N" refers to the number of respondents and is generally the first column in the data tables.
"%" refers to the percent of respondents who provided a given response.

Notes about the Data

The results of this survey are not intended for public release without prior approval from AAPA Research.

Executive Summary

PAs often cite Electronic Health Record (EHR) systems as a barrier to work-life balance. Despite many benefits, PAs also view EHRs as a new bureaucratic part of healthcare that causes additional workload for PAs and other medical providers. In fact, more than one in four PAs (26.3%; Table 17) surveyed by AAPA recently indicated that they spend more than two hours per day outside of their normal office hours documenting clinical care in their EHR system. Further, more than four in five PAs (81.6%; Table 18) do not have staff support, such as a scribe, to assist in this documentation. With EHR systems the new normal in healthcare, it is important to understand where strengths and weaknesses exist, as well as to identify PA-specific barriers that should be considered and eased.

More than 3 in 4 PAs believe EHRs improve quality of care and medication errors

The Good News about EHRs

Not all opinions are negative when it comes to EHRs, as PAs overwhelmingly agree about several EHR benefits (Table 15). PAs strongly or somewhat agree that the electronic exchange of information to providers outside of their practice improves their practice's quality of care (82.6%), increases their practice's efficiency (77.5%), prevents medication errors (75.0%), enhances care coordination (82.8%), and reduces duplicate test ordering (74.9%). The widespread adoption of EHRs appears to be mitigating some of these very real concerns providers have. Providers also seem to agree that the exchange of EHR information is useful.

Half of PAs say the time spent documenting clinical care reduces their time with patients

The Bad News about EHRs

But current views on the state of EHR systems are not all good (Table 16). This may be due to technological challenges, with more than two in three PAs (68.3%) noting the difficulty of electronic exchange with providers who are using a different EHR vendor. Other challenges pertain to the patient experience itself. Half (51.3%; Table 20) of PAs say the amount of time spent documenting clinical care reduces the amount of time spent with patients. There are other logistical barriers for PAs to effectively utilize EHR systems; some of these may stem from the ways in which EHRs are implemented and used.

According to a 2018 AAPA survey of 10 of the top ambulatory and inpatient EHR vendors, while most vendors indicated their software offers full functionality for PAs and makes no distinction in access or use between PAs and other providers, PAs continue to encounter barriers to effective use resulting from the design of the EHR. Three vendors surveyed by AAPA – Epic, Allscripts, and NextGen – may allow a physician to modify a PA's clinical documentation. More than two in five PAs (41.7%) indicated that they use those EHRs (Table 12). One in ten PAs (10.1%) indicated that physicians can overwrite their documentation or attribute a PA's work as his or her own (Table 2 lists factors that limit PAs' ability to most effectively use their EHR).

One in ten PAs indicated that physicians can overwrite their documentation or attribute a PA's work as their own

Modification of clinical documentation a concern

Modification of a PA's clinical documentation is a significant compliance concern. A physician's ability to attribute a PA's work as his or her own is a potential misuse of EHR technology and increases the risk for fraud and abuse. Hospital and health systems using EHRs that can modify the work of a PA are also at risk of violating Medicare Conditions of Participation, which require assurance of the accuracy, authenticity, and integrity of the medical record. In addition to compliance concerns and potential penalties, the alteration of a PA's clinical documentation may compromise medical-legal documentation. Finally, EHRs that do not safeguard PA clinical documentation can lead to noncompliance and adversely affect patient care.

Data Tables

Table 1. EHR Access

PA Has Full Access and Functionality	N	%
Yes	576	91.6
No	53	8.4
Total	629	100.0

Question: "Do you have full access and functionality of the EHR system you use?"

Table 2. EHR Effective Use

Factors	N	%
Restricted access and/or functionality	64	10.4
Requirement of unnecessary physician co-signatures	117	19.1
The ability of a physician to overwrite part of my documentation or attribute my work as his or her own	62	10.1
Results of diagnostic labs and tests I order not attributed to me and/or results not returned to me	121	19.7
Inability to measure my professional contribution to care	162	26.4
Inability to measure my productivity	185	30.1
Other	52	8.5
None of the above	261	42.5
Total	614	100.0

Question: "What are the factors that limit your ability to most effectively use your EHR? Select all that apply."

Table 3. Target of EHR Limitations

Who Limitations Affect	N	%
Limitations apply to PAs only	38	10.9
Limitations apply to other health professionals	226	64.9
It depends	12	3.4
I don't know	72	20.7
Total	348	100.0

Question: "Do the limitations you have encountered only apply to PAs, or do they apply to other professionals (such as NPs)?"

Table 4. Possibility of EHR Modifications to Remove Barriers for PAs

EHR Modifications Possible	N	%
Yes	157	45.8
No	186	54.2
Total	343	100.0

Question: "Have you spoken with your system administrator regarding whether it is possible to modify your employer's EHR system to remove the barriers for PAs?"

Table 5. Who Can Carry Out System Changes

Response	N	%
Any changes could be carried out in house	27	17.5
Some or all would require changes from the EHR vendor	91	59.1
I don't know	36	23.4
Total	154	100.0

Question: "Could these system changes be carried out in-house, or would you be required to have such changes made by your EHR vendor?"

Table 6. EHR Restrictions: Employer Policy or EHR System Constraints

Response	N	%
All restrictions are a result of employer policy	40	6.6
Most restrictions are a result of employer policy	73	12.0
All restrictions are a result of EHR functionality	71	11.7
Most restrictions are a result of EHR functionality	99	16.3
I don't know	325	53.5
Total	608	100.0

Question: "Are there any restrictions on your use of EHR systems that are a result of your employer's policy, as opposed to EHR system functionality constraints?"

Table 7. PA Involvement in EHR Customization

PA Was Involved in EHR Customization	N	%
Yes	180	29.1
No	438	70.9
Total	618	100.0

Question: "Were you involved in or did you provide feedback on any customization of your employer's EHR system?"

Table 8. EHR System Produced Reports About PA Services

System Can Produce Reports About Services	N	%
Yes	361	60.1
No	240	39.9
Total	601	100.0

Question: "Can your system produce reports regarding services you have provided (e.g. quality metrics, RVUs, revenue collected, etc.)?"

Table 9. Reports Are Based Solely on Claims Submitted Under PA Name/NPI

Response	N	%
Reports based solely on claims data	147	43.6
Reports based on more comprehensive sources of information	190	56.4
Total	337	100.0

Question: "Are these reports based solely on claims submitted under your name/NPI or is information more comprehensive (e.g. includes services rendered but not billed)?"

Table 10. PA Training in the Use of EHR System

PA Received Training	N	%
Yes	532	86.1
No	86	13.9
Total	618	100.0

Question: "Have you received training in the use of the EHR systems you use?"

Table 11. PA Formal Training in the Use of EHR System

PA Received Formal Training	N	%
Yes	422	80.8
No	100	19.2
Total	522	100.0

Question: "Was the training you received part of a formal training (provided during orientation or EHR implementation)?"

Table 12. EHR Systems Used by PAs

EHR System	N	%
Allscripts	35	5.6
Athena Health	29	4.7
Cerner	60	9.6
CPSI (Evident)	1	0.2
eClinical Works	48	7.7
eMDs	4	0.6
Epic	205	32.9
GE Healthcare (Centricity)	13	2.1
Greenway Health (Vitera)	11	1.8
Kareo	1	0.2
NextGen	20	3.2
Other	171	27.4
None of the above	25	4.0
Total	623	100.0

Question: "What EHR system do you use?"

Table 13. Satisfaction with EHR System

Satisfaction	N	%
Very satisfied	109	17.5
Somewhat satisfied	258	41.3
Neither satisfied nor dissatisfied	89	14.3
Somewhat dissatisfied	92	14.7
Very dissatisfied	51	8.2
Not applicable	25	4.0
Total	624	100.0

Question: "Overall, how satisfied or dissatisfied are you with your EHR system?"

Table 14. Satisfaction with EHR System

EHR System	Satisfied		Neutral		Dissatisfied	
	N	%	N	%	N	%
Allscripts	15	44.1	7	20.6	12	35.3
Athena Health	18	62.1	6	20.7	5	17.2
Cerner	36	60.0	7	11.7	17	28.3
CPSI (Evident)	*	*	*	*	*	100.0
eClinical Works	25	52.1	10	20.8	13	27.1
eMDs	*	*	*	*	*	*
Epic	163	79.5	24	11.7	18	8.8
GE Healthcare (Centricity)	7	53.8	*	*	5	38.5
Greenway Health (Vitera)	*	*	*	*	6	54.5
Kareo	*	*	*	*	*	*
NextGen	9	45.0	*	*	9	45.0
Other (please specify):	85	51.2	29	17.5	52	31.3
None of the the above	*	42.9	*	14.3	*	42.9
Total	367	61.3	89	14.9	143	23.9

Questions: "What EHR system do you use?" and "Overall, how satisfied or dissatisfied are you with your EHR system?" Satisfied = very or somewhat satisfied. Dissatisfied = very or somewhat dissatisfied.
*Data cells with fewer than five respondents are left blank.

Table 15. Electronic Exchange of Clinical Information

Electronically exchanging clinical information with other providers outside my medical organization...	Strongly agree		Somewhat agree		Somewhat disagree		Strongly disagree		Not applicable	
	N	%	N	%	N	%	N	%	N	%
Improves my practice's quality of care	326	54.0	173	28.6	24	4.0	12	2.0	69	11.4
Increases my practice's efficiency	307	50.7	162	26.8	36	6.0	23	3.8	77	12.7
Prevents medication errors	240	40.3	207	34.7	52	8.7	22	3.7	75	12.6
Enhances care coordination	338	56.2	160	26.6	27	4.5	12	2.0	64	10.6
Reduces duplicate test ordering	265	44.0	186	30.9	52	8.6	27	4.5	72	12.0

Question: "Please indicate your level of agreement with each of the following statements."

Table 16. Barriers to Electronic Information Exchange

Barriers	Yes		No		I dont know		Not applicable	
	N	%	N	%	N	%	N	%
Providers in our referral network lack the capability to electronically exchange	280	46.6	168	28.0	112	18.6	41	6.8
We have limited or no IT staff	174	29.0	351	58.6	36	6.0	38	6.3
Electronic exchange involves incurring additional costs	91	15.4	134	22.7	330	55.9	35	5.9
Electronic exchange with providers using a different EHR vendor is challenging	408	68.3	51	8.5	98	16.4	40	6.7
The information that is electronically exchanged is not useful	67	11.2	376	63.0	82	13.7	72	12.1
It is difficult to locate the electronic address of providers	175	29.2	159	26.5	205	34.2	60	10.0
My practice may lose patients to other providers if we exchange information	13	2.2	359	59.8	158	26.3	70	11.7

Question: "Please indicate whether these issues are barriers to electronic information exchange with providers outside your medical organization."

Table 17. Time Spent Documenting Clinical Care Outside Office Hours

Time Spent	N	%
None	133	21.7
Less than 1 hour	127	20.7
1 to 2 hours	192	31.3
More than 2 hours, up to 4 hours	111	18.1
More than 4 hours	50	8.2
Total	613	100.0

Question: "On average, how many hours per day do you spend outside of normal office hours documenting clinical care in your medical record system?"

Table 18. Staff Support in Documenting Clinical Care

PA Has Staff Support	N	%
Yes	112	18.4
No	496	81.6
Total	608	100.0

Question: "Do you have staff support (e.g., scribe) to assist you with documenting clinical care in your medical record system?"

Table 19. Time Spent Documenting Clinical Care Outside Office Hours

Time Spent	N	%
Very easy	130	21.2
Somewhat easy	312	51.0
Somewhat difficult	125	20.4
Very difficult	28	4.6
Not applicable	17	2.8
Total	612	100.0

Question: "How easy or difficult is it to document clinical care using your medical record system?"

Table 20. Perceptions About EHR System

Statement	Strongly agree		Somewhat agree		Somewhat disagree		Strongly disagree		Not applicable	
	N	%	N	%	N	%	N	%	N	%
The amount of time I spend documenting clinical care is appropriate.	87	14.4	224	37.1	171	28.3	99	16.4	23	3.8
The amount of time I spend documenting clinical care does not reduce the time I spend with patients.	117	19.3	157	26.0	177	29.3	133	22.0	21	3.5
Additional documentation required solely for billing, but not clinical purposes increases the overall amount of time I spend documenting clinical care.	236	39.1	212	35.2	63	10.4	25	4.1	67	11.1
Clinical care documentation requirements for private insurers generally align with Medicare requirements.	83	13.9	306	51.1	54	9.0	9	1.5	147	24.0

Question: "Please indicate whether you agree or disagree with the following statements about using your medical record system."