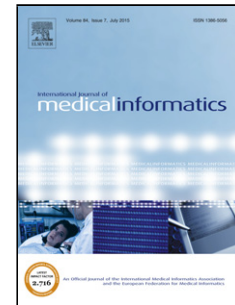


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Successfully implementing a national electronic health record: a rapid umbrella review

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Successfully implementing a national electronic health record: a rapid umbrella review

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Highlights

- Implementation process of Electronic Health Records (EHRs) is critical for success.
- Vast literature available on EHR implementations in different settings and contexts.
- Organizational, Human and Technological factors influence success across settings.
- Dynamic interaction of the identified factors trigger success.
- Consideration of the specific healthcare context and end-users is important.

Abstract

Aim: To summarize the findings from literature reviews with a view to identifying and exploring the key factors which impact on the success of an EHR implementation across different healthcare contexts.

Introduction: Despite the widely recognised benefits of electronic health records (EHRs), their full potential has not always been achieved, often as a consequence of the implementation process. As more countries launch national EHR programmes, it is critical that the most up-to-date and relevant international learnings are shared with key stakeholders.

Methods: A rapid umbrella review was undertaken in collaboration with a multidisciplinary panel of knowledge-users and experts from Ireland. A comprehensive literature review was

completed (2019) across several search engines (PubMed, CINAHL, Scopus, Embase, Web of Science, IEEE Xplore, ACM Digital Library, ProQuest, Cochrane) and Gray literature. Identified studies (n=5,040) were subject to eligibility criterion and identified barriers and facilitators were analysed, reviewed, discussed and interpreted by the expert panel.

Results: Twenty-seven literature reviews were identified which captured the key organizational, human and technological factors for a successful EHR implementation according to various stakeholders across different settings. Although the size, type and culture of the healthcare setting impacted on the organizational factors, each was deemed important for EHR success; *Governance, leadership and culture, End-user involvement, Training, Support, Resourcing, and Workflows*. As well as organizational differences, individual end-users also have varying *Skills and characteristics, Perceived benefits and incentives, and Perceived changes to the health ecosystem* which were also critical to success. Finally, the success of the EHR technology depended on *Usability, Interoperability, Adaptability, Infrastructure, Regulation, standards and policies, and Testing*.

Conclusion: Fifteen inter-linked organizational, human and technological factors emerged as important for successful EHR implementations across primary, secondary and long-term care settings. In determining how to employ these factors, the local context, individual end-users and advancing technology must also be considered.

Key words

Electronic Health Record; Electronic Medical Record; Implementation; Review.

1. Introduction

Capturing and effectively using clinical information and knowledge to ensure a quality, safe and sustainable healthcare service is widely recognised^{1,2} and data from electronic health records (EHRs) have been vital to decision-making on public health policies during the COVID-19 pandemic³. An EHR provides a longitudinal record of information regarding the health status of an individual in computer-processible form across practices and specialists, and enables authorised access to clinical records in real-time^{4,5}. As well as expanding the capacity to utilise clinical data for monitoring of patient outcomes and conducting audits and research^{6,7}, the EHR provides access to patient information in a timely manner, enabling healthcare professionals (HCPs) to spend more time with patients⁸, reducing duplication of tests and work, and improving the safety and quality of care provided^{4,7,9-14}. Additionally, integration of other functions and software, such as clinical decision support and bar code medication administration, further expand its potential benefits^{15,16}.

Electronic patient records (EPRs) or electronic medical records (EMRs) also offer many of these benefits but solely contain the records from an individual organization. Whilst shared or summary care records and patient portals respectively store and facilitate access to specific patient information required by HCPs¹⁷ and patients¹⁸. Despite the number of benefits which can be derived from these systems, challenges have been met in implementing a fully interoperable EHR between primary and secondary care^{13,19}, often attributed to the implementation process as opposed to the product supplied by the EHR vendor^{20,21}. Therefore, the implementation process is critical²² and must be considered as an ongoing process beginning during procurement and continuing throughout each phase of design, development, testing, 'Go Live' and optimization.

Whilst hospital information systems (HIS) in the USA have been in existence since the 1960s²³, HIS are a more recent phenomenon in the Republic of Ireland where public healthcare is managed by the Health Service Executive (HSE) which co-exists with a private health system. The Office of the Chief Information Officer (CIO) has overall responsibility for embedding technology within the health infrastructure²⁴ and to date, EPRs have been implemented in some individual private and public hospitals and the majority of general practitioner (GP) offices (i.e., private primary care physicians often with HSE contracts), as well as for specific cohorts of patients (e.g., maternal and newborn and epilepsy)²⁵. However, many other hospitals and HSE primary care (i.e., community) centres remain largely paper-based. With an EHR in the pipeline^{24,26}, three national projects have been planned by eHealth Ireland; Acute EHR, Community EHR and the Shared and Integrated Care Record. Therefore, this is an opportune time for policy-makers and other key stakeholders to review the learnings from the implementations of health information technology (HIT) both in Ireland and internationally.

However, a vast amount of literature is published on topics such as EHRs which renders it difficult for policy-makers to remain up-to-date^{27,28}, perhaps amplifying the “know-do” gap. Additionally, healthcare is a complex and adaptive system which needs to be recognized and acknowledged when attempting to replicate successes in another context²⁹. The EHR programme in Ireland is also already underway and therefore, it’s critical that knowledge is generated to provide actionable and relevant key considerations in a timely manner aligned with the policy and decision-making cycles³⁰. Therefore, the aim of this review is to identify and explore the key factors which promote a successful EHR implementation across healthcare settings, with active collaboration from key stakeholders in the Irish context.

2. Methods

2.1 Design

A rapid umbrella review was conducted and guided by the World Health Organisation (WHO) practical guide for *Rapid Reviews to Strengthen Health Policy and Systems*³¹. Unlike a systematic review, an umbrella review also known as a review of reviews, compiles evidence from several research syntheses across different healthcare contexts and stakeholder groups^{32,33}. Active collaboration with an expert panel of knowledge users facilitated the acceleration of the systematic review process³⁰ and to facilitate uptake and use of these findings by planners and decision-makers, the synthesized findings were also presented in a report format³⁴.

2.2 Expert panel of knowledge users

A multi-disciplinary panel of experts and knowledge users (n=10) were engaged and involved throughout the review process to inform its methodology, validate the generalizability and relevance of the review findings³⁵, and ensure it reflects current thinking and is useful²⁷. The panel was convened in January 2019 by the Office of Nursing and Midwifery Services Director (HSE) and comprised of those currently involved in large HIT implementation projects across primary and secondary care at local and national levels in Ireland, as well as clinicians, health service researchers and academic partners from healthcare and health informatic backgrounds (Table 1). Five consultative in-person group meetings and several individual meetings and email exchanges within the group were conducted throughout the review process.

Table 1. Positions held by the members of the Expert Panel (n=10)

National Clinical Information Officer for Nursing and Midwifery, HSE.
Professor of Health Informatics, UCD.
Group Chief Information Officer, Ireland East Hospital Group, HSE.
ICT Project Manager, Office of the Clinical Information Officer, HSE.
Senior Clinical Psychologist, National Rehabilitation Hospital, Dublin.
Clinical Health and Social Care Professional Lead in the Clinical Management System, National Rehabilitation Hospital.
Associate Professor in Physiotherapy, UCD.
Business Manager, National MN-CMS Project Team.

Community EHR Senior Project Manager, HSE.

General Practitioner (GP).

National Co-ordinator of the GPIT Project at the Irish College of General Practitioners.

Senior Professional Officer, Northern Ireland Practice and Education Council for Nursing and Midwifery.

EPR Project Manager, St. James' Hospital, Dublin.

Engagement and Delivery Lead, Informatics Directorate, St. James's Hospital, Dublin.

Physiotherapist.

Note: Some members of the expert panel had more than one position. Health Service Executive (HSE), government-funded organisation responsible for the provision of health and personal social services; UCD, University College Dublin; Ireland East Hospital Group, one of seven hospital groups in Ireland comprising of 11 hospitals and four community healthcare organisations; ICT, Information Communication Technology; Maternal and Newborn Clinical Management System (MN-CMS), an EHR for all women and babies being cared for across maternity and new born services in Ireland; GPIT, General Practice Information Technology; EPR, Electronic Patient Record.

2.3 Research question and search strategy

An initial exploratory scope of the EHR literature in the PubMed database was reviewed by the expert panel and the final research question, methodology and search strategy were developed and agreed. A large number of search terms to describe “*Electronic Health Record*”,

Table 2. Criteria for inclusion and exclusion of identified literature reviews

Inclusion Criteria	Exclusion criteria
Literature review (i.e., provides a comprehensive search and summary of previous research).	Primary studies and editorial discussions.
Reviewed the implementation of an electronic health record (EHR) and/or EHR component including EMRs, EPRs and computer physician order entries.	Not conducted within a healthcare organisation.
Identified factors impacting on EHR implementation including barriers, facilitators.	
Conducted within a healthcare organisation.	

“*Implementation*” and “*Literature Review*” were identified from previous systematic reviews^{7,36–40}, additional literature¹⁷, medical subject heading and controlled vocabulary and via consultation with the expert panel and an experienced information technologist at the Health Sciences Library, UCD [Appendix]. The search string was tailored to the indexing language of each database and in March 2019, it was executed across PubMed, CINAHL, Scopus, Embase, Web of Science, IEEE Xplore, ACM Digital Library, ProQuest and Cochrane, with limitations of English language and published since 2010. Grey literature including reports and conference proceedings were also searched (international Health Informatics Societies, the World Health Organization (WHO), European e-health network, Kings Fund, Gartner and Lenus). Panellists also drew on their expertise to identify any additional relevant sources³⁵.

2.4 Identification of literature reviews

Identified articles were calibrated in the citation management software Endnote version x9.2 and titles and abstracts were screened by one researcher using the inclusion and exclusion criteria agreed with the expert panel (Table 2). Full text articles were then accessed and screened by the same researcher, with any doubts regarding inclusion or exclusion discussed with the panel to overcome any risk of errors or inconsistencies associated with using one reviewer³¹. In line with our chosen rapid review methodology, a quality assessment of identified reviews was not conducted.

2.5 Data extraction and synthesis

A standardized data extraction form was developed and included authors, year of publication, study design, participants, healthcare setting, included studies and findings related to factors impacting on the implementation (i.e., themes and/or paragraphs as required). Following data extraction, a qualitative content analysis of the factors impacting on the EHR implementation was undertaken by the researcher⁴¹. Using an iterative process, a list of codes representing the identified factors from each of the literature reviews was formed⁴². The expert panel reviewed these codes via an adapted nominal group technique, which saw collated appraisals distributed amongst the panellists⁴³ to assess whether they were comprehensive of the literature and their

own experiences, and to determine whether the findings could be transferred to Irish contexts and settings ⁴². Having reached a final consensus regarding the factors for a successful EHR implementation, these factors were further categorized into a theoretical framework ¹⁰ and resulted in the generation of key considerations ⁴².

3. Results

3.1 Characteristics of literature reviews

Of the 5,040 articles retrieved, 27 literature reviews were identified which captured factors deemed important for the successful implementation of EHRs, as well as other HIT implementations (Fig. 1). Fifteen were classified as systematic reviews, whilst the others were umbrella reviews (n=3), scoping reviews (n=2), interpretive review (n=1), literature review with a meta-narrative (n=1) and other non-systematic literature reviews (n=5). Overlap in included publications existed across the literature reviews with 974 unique studies, literature reviews, reports, books and guidelines identified. Perspectives of a variety of stakeholders were captured in these reviews including GPs (or primary care physicians), other doctors, nurses, health and social care professionals, patients, policymakers, vendors and IT consultants (Table 3). Although many literature reviews encompassed studies from a variety of healthcare settings, others were specific to primary care (i.e., community) ^{13,44,45}, long term care ⁴⁶ and mental health settings ⁴⁷ or within specific countries or groups of countries ^{19,48–51}.

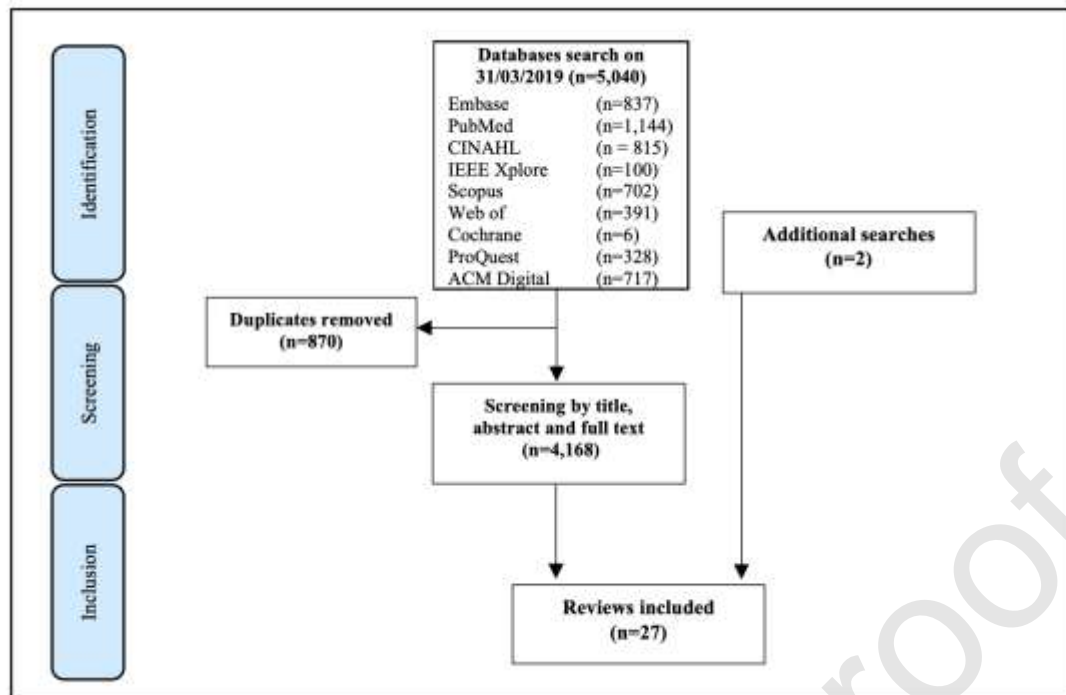


Figure 1. PRISMA Flow Diagram

Table 3. Identified literature reviews which reviewed the key factors for a successful EHR implementation

Author (Year)	Design	Focus	Setting/ participants	Studies	Inclusion criteria	Identified factors		
Ajami and Bagheri-tadi (2013) ¹²	Non-systematic review	Barriers to EHR adoption	Physicians in hospital or community	20	n/a	Governance, leadership and culture Vendor trust & experience Communication among users Training Formal training Support Expert & technical Resourcing Time & cost Workflows Workflow disruption	Skills and characteristics Computer literacy & skill Ability to select & effectively install system Perceived benefits and incentives Lack of incentives Perceived changes to the health ecosystem Concerns about data entry, patient acceptance, security & privacy Interfaces with doctor-patient relationship	Usability Complexity Interoperability Inadequate data exchange Interinstitutional integration Infrastructure Access to computers Reliability, speed & wireless connectivity Physical space
Ben-Zion et al., (2014) ⁵²	Literature review and prescriptive analysis	Success factors for EHR adoption	Any healthcare organisations	55	2001-2013 English	Governance, leadership and culture Firm strategy Scope & project controls Interactions across communities Motivation to collaborate Culture change Knowledge management Process change End-user involvement IT alignment with firm strategy	Support Executive management Process change Training Process change Resourcing IT resources & cost Workflows Process change Perceived benefits and incentives Economic competitiveness	Motivation to collaborate Usability Accessibility & usability Interoperability IT integration with external networks Infrastructure IT innovation System Architecture & Infrastructure Regulations, standards and policies Shared language & narratives IT integration with external networks
Boonstra et al. (2014) ³⁶	Systematic review	EHR implementation lessons	Project team, doctors, nurses, technical & clerical personnel, administrators, IT personnel, psychiatrists, directors, CEOs, CIOs, managers, vendors, healthcare practitioners, pharmacists in hospitals	21	Up until 2013 English Peer-reviewed Empirical	Governance, leadership and culture Large not-for-profit teaching hospital Readiness for change Mature vendor Culture supporting collaboration & teamwork Little bureaucracy & considerable flexibility Comprehensive implementation strategy Interdisciplinary implementation group Champions among clinical staff End-user involvement Participation of clinical staff Training	Support Real-time support Management support Resourcing Financial capabilities Sufficient number of staff Workflows System fitting hospital's needs Creating a fit by adapting technology & work Skills and characteristics Previous experience of HIT Resistance of clinical staff	Perceived changes to healthcare ecosystem Ensuring care activities Usability User-friendly software Adequate safeguards Infrastructure Hardware System reliability (speed, availability & lack of failures) Adaptability Vendor willing to adapt
Boonstra et al., (2010) ⁵³	Systematic review	Barriers to acceptance of EMRs	Physicians in any healthcare organisations	22	1998-2009	Governance, leadership and culture Vendor uncertainty Lack of participation Lack of leadership Organizational size & type Change Process Training Technical training Support Technical support External party support Support from organizational culture, other colleagues & management level	Resourcing Start-up & ongoing costs Time to select, learn & convert patient records Skills and characteristics Lack computer skills Need for control Perceived benefits and incentives Return on investment More time per patient Lack of belief in EMRs Lack of incentives Perceived changes to healthcare ecosystem Time required to enter data	Interference with doctor-patient relationship Privacy or security concerns Usability Complexity Limitations Interoperability Interconnectivity/standardization Adaptability Lack of customizability Infrastructure Reliability Computers/hardware
Castillo et al., (2010) ¹¹	Systematic review	EHR adoption	Physicians inpatients & outpatients in hospitals & primary care	68	1985-2010 English	Governance, leadership and culture Communication among users	Support Technical & expert Workflows Workflow impact	Perceived benefits and incentives User attitude Interoperability Interoperability

Table 3 continued

Table 3 continued

Cresswell and Sheikh (2013) ⁵⁴	Interpretive review	Organisational barriers to HIT implementation and adoption	Any	13	1997-2010 Systematic reviews	Governance, leadership and culture Open communication channels Senior leadership & “champion” Strong organizational leadership & management Avoidance of “scope creep” Appropriate implementation approach Plan for potentially extreme contingencies End-user involvement On-going involvement of key stakeholders Support	Lead professional support Resourcing Costs & additional time available Workflows Fits in with existing organizational processes Skills and characteristics IT literacy & general competencies of users Personal & peer attitudes Perceived benefits and incentives Offers relative advantages over existing practices	Useful Early demonstrable benefits Usability Perceived ease of use Supports inter-professional roles and working Interoperability Interoperable with existing technology Interoperability considerations Adaptability Testing Field testing of early prototypes
De Grood et al., (2016) ⁵⁵	Scoping review	Barriers to and opportunities for e-health technology adoption	Physicians in any healthcare organisations	74	1995-2015	Governance, leadership and culture Ownership & size of practice Training Support Resourcing Cost	Lack of time & workload Perceived benefits and incentives Pre-analysis of data Proof of utility Productivity Perceived changes to healthcare ecosystem	Privacy & security concerns Liability issues Patient and physician interaction Threatened clinical autonomy Usability Design
Fritz et al., (2015) ⁴⁸	Systematic review	Success criteria for EMR implementation	Hospital or community in low resource countries	47	English	Governance, leadership and culture Political Organizational Training	Resourcing Financial Perceived changes to the healthcare ecosystem Ethical	Usability Functionality Infrastructure Technical
Gagnon et al., (2014)	Systematic review	Barriers and facilitators to implementing electronic prescription	Physicians, nurses, other HCPs, admin, management in primary care	34	Empirical Design Link with primary care	Governance, leadership and culture Other professionals’ performance Developer & vendor Implementation strategies Characteristics of the health structure Influence of leadership Macro organisational elements Professional interaction Support Support & promotion by colleagues Organisational support Resourcing Link Time issues Resources Cost issues	Workflows Work process Skills and characteristics Agreement with e-prescribing Familiarity with technology Patients’ attitudes & preferences Self-efficacy Socio-demographic characteristic Confidence in e-prescribing Perceived benefits and incentives Perceived usefulness Impact on clinical uncertainty Risk–benefit equation Outcome expectancy Time saving	Perceived changes to healthcare ecosystem Privacy and security concerns Patient/clinician interaction Autonomy Impact on professional security Usability Design Content appropriate & satisfactory Generic substitution options Data accuracy & legibility Ease of use Efficiency Patient security Interoperability Infrastructure System reliability or dependability
Gesulga et al., (2017) ⁵⁶	Structured literature review	Barriers to the implementation of adoption of EHR or EMR readiness	Any	38	English Until July 2016	Governance, leadership and culture Change in culture Lack of project planning Implementation issues Number of vendors Competitiveness External factors End-user involvement Involvement in design & implementation Training Lack of education & training Support Administrative & policy support Upgrading & maintaining the system Resourcing Lack of technical expertise Inadequate staff Implementation, maintenance, initial, equipment & training cost Lack of available funding	Increase of nurses & physician’s workload Workflows Communication among users on data entry Reduces productivity & disturbs workflow Skills and characteristics User resistance Lack of computer skills Provider or patients age Illiteracy Physicians’ experience with poor products Lack of capacity Unrealistic expectation about ease of installation Perceived benefits and incentives Lack of awareness of EHR/EMR & importance Concern that system will become obsolete Concern on return on investment Waiting to see if subsidies develop Perceived changes to healthcare ecosystem	Affects physician-patient interaction Concerns about privacy & confidentiality Physicians’ legal liability Usability User access limitation Data accuracy & quality Capacity to use real-time data Infrastructure Centralized healthcare database National health information network Data Security Hardware functionality issues Internet connectivity Network communication infrastructure Network speed Lack of IT facilities & equipment Regulations, standards and policies Lack of health information data standards Health terminology & classification Risk of new regulatory requirements

Table 3 continued

Gill et al., (2017) ⁵⁷	Scoping review	Adoption of EHRs or EMRs	Any	39	Case studies English 2010-2015	End-user involvement Use of stakeholders throughout the process Training	Sufficient time spent on training clinicians Support Executive	Usability System designed & built as per requirements
Kruse et al., (2018) ⁵⁸	Systematic review	Facilitators & barriers to the adoption of an EHR for population health	Public health	55	2012-2017 English	Governance, leadership and culture Communication Support Limited staff support Resourcing Cost Financial assistance Productivity loss Skills and characteristics Resistance to change Perceived benefits and incentives	Disease management Critical thinking/treatment decisions Quality Surveillance Preventative care Decision support Health outcomes Perceived changes to the healthcare ecosystem Privacy concerns Usability	Complex Ease of use Accessibility/utilization Satisfaction Data management / Missing data & errors Efficiency Interoperability Regulations, standards and policies No standards Infrastructure Current technology
Kruse et al., (2016) ⁵¹	Systematic review	Barriers to EHR adoption	Any patient care facility in the USA	21	2012-2016 English	Governance, leadership and culture Need organizational cultural change Facility location Competitiveness Consensus within the practice External factors Eligibility criteria Training Support Technical support Resourcing Initial & maintenance/ongoing costs Insufficient time Effort needed to select system Staff shortages Productivity loss Workflows Workflow challenges	Skills and characteristics Resistance to changing work habits Physician attitude Race & income disparities Provider or patient age User acceptance IMGs less likely to adopt Perceived benefits and incentives Financial incentives Return on investment Perceived usefulness Penalties Medical errors Perceived changes to the healthcare ecosystem Privacy concerns Physician autonomy	Usability Technical concerns Inability to easily input historic medical record data Complexity of system Limitations of system Missing data Interoperability Interoperability Degree of integration Adaptability Agility to make changes Infrastructure Technical infrastructure Upgrades Regulations, standards and policies Clarity of Federal and State policies
Kruse et al., (2016) ⁵⁰	Systematic review	Barriers & facilitators to EHR adoption	Any patient care facility in the USA	36 (31 unique)	2012-2015	Governance, leadership and culture Facility location Implementation issues External factors Organizational cultural change Hospital size Project planning Alignment with strategy Competitiveness Communication Training Support Maintenance Executive management support Resourcing Cost	Time-consuming Lack of tech assistance Staff shortages/overworked Skills and characteristics User/patient resistance Lack of tech experience Provider or patient age Race & income disparities IMGs less likely to adapt Perceived benefits and incentives User perception/perceived lack of usefulness Incentives Long run cost savings Error reduction Improved population health Medical error	Usability Transition of data Missing data Access to patient data Efficiency Privacy & security Interoperability Ability to transfer information Continuity of care document Infrastructure Upgrades Lack of infrastructure & space for systems Adaptability Lack of agility to make changes Regulations, standards and policies Standard protocols for data exchange
Kruse et al., (2015) ⁴⁶	Systematic review	Adoption factors for EHR introduction	LTC	22	2009-2014 English USA-based	Governance, leadership and culture Project planning Facility characteristics Implementation issues Cultural change External factors Training Training Implementation issues	Resourcing Cost Staff retention Perceived benefits and incentives Error reduction Cost savings Health outcomes User perceptions Time savings	Perceived changes to the healthcare ecosystem Usability Implementation issues Clinical and administrative efficiency Security Access & transfer to information Regulations, standards and policies Implementation issues

Table 3 continued

Kruse et al., (2014) ⁵⁹	Systematic review	Internal organizational and external environmental factors associated with adoption of HIT	Any	17	1993-2013 English	Governance, leadership and culture Competitiveness Location & size Interdependence Ownership Strategic alliances Communication among users	Physician arrangements Teaching status Support Technical & expert Unity of effort Resourcing Payers Capital expenditure	Workflows Workflow impact Complexity of care Skills and characteristics Patients & users User attitude toward information Computer anxiety Interoperability
Lluch (2011)	Literature review	Organisational barriers to HIT implementation	OECD and EFTA countries	79	2007-2010 English	Governance, leadership and culture Hierarchy Teamwork & cooperation Centre of gravity and autonomy Training Training, IT/HIT skills Support Workflows	Changes in work processes & routines Skills and characteristics Training, IT/HIT skills Perceived benefits and incentives Incentives Perceived changes to the healthcare ecosystem Autonomy	Face-to-face interaction versus new ways of working Trust & liability Accountability to employer & policy makers Interoperability Information & decision processes Regulations, standards and policies Lack of legal framework
Mair et al., (2012) ⁶⁰	Explanatory systematic review or reviews	Factors that promote or inhibit e-health technology implementation	Any	37	Literature reviews 1990-2009	Governance, leadership and culture Coherence Cognitive participation Addressing organizational issues Reflexive monitoring End-user involvement Cognitive participation Training Roles, responsibilities & training Support	Addressing organizational issues Roles, responsibilities & training Resourcing Addressing organizational issues Skills and characteristics Cognitive participation Perceived benefits and incentives Cognitive participation Confidence and accountability Reflexive monitoring	Perceived changes to the healthcare ecosystem Effects on healthcare tasks Confidence and accountability Usability Effects on healthcare tasks Interoperability Addressing organizational issues Regulations, standards and policies Addressing organizational issues
McGinn et al., (2011) ⁴⁹	Systematic review	EHR implementation barriers and facilitators	Physicians, pharmacists, midwives, social workers, patients in health services comparable to Canada	60	1999-2009 Empirical	Resourcing Lack of time & workload Cost issues Skills and characteristics Familiarity & ability with EHR Perceived benefits and incentives	Productivity Motivation to use EHR Perceived changes to the healthcare ecosystem Patient & health professional interaction Design or technical concerns	Privacy & security concerns Usability Perceived ease of use Interoperability Infrastructure Design or technical concerns
L. Nguyen et al., (2014)	Systematic review	EHR impact and issues	Clinicians Patients Doctors Nurses Management Administration Organizations IT staff in primary tertiary secondary LTC ambulatory community	98	2001-2011 English Empirical Peer-reviewed	Governance, leadership and culture Implementation Organizational Adoption rate Systems development End-user involvement Systems development Implementation Training Service quality Implementation Support Service quality Implementation Resourcing Implementation Organizational	Workflows Changes to workflow Skills and attitudes Attitudes Adoption rate Implementation Perceived benefits and incentives Attitude Quality and safety of care Administrative efficiency & cost reduction Changes to workload & productivity Clinical documentation practice & quality Information quality Implementation Perceived changes to the healthcare ecosystem	Clinician-patient relationships Systems quality Usability Systems quality Information quality Adoption rate User satisfaction & use Interoperability Systems quality Implementation Infrastructure Service quality Regulations, standards and policies Systems development Testing Implementation
Nguyen et al., (2014)	Literature review	Organisational success factors for HIT	Any	36	English Peer-reviewed 2001-2013	Governance, leadership and culture Champion Openness of the organization to change & innovation Collaboration with vendors End-user involvement End-user participation Collaboration among administration, IT & clinical functions	Training Support Technical support Resourcing Sufficient resources Workflows Collaboration among administration, IT, & clinical functions	Perceived benefits and incentives Incentives Provision of information System, service & information quality Infrastructure Infrastructure quality Regulations, standards and policies Regulation

Table 3 continued

O'Donnell et al., (2018)	Systematic review and evidence synthesis	EMR adoption	Physicians in Primary care	33	1996-2017	Governance, leadership and culture Organization Implementation Training Implementation Support Quality of information, system & service Resourcing Funding & incentives Workflows	Use & user satisfaction Skills and characteristics People Perceived benefits and incentives Net benefits in terms of care quality, productivity & access Funding & incentives Perceived changes to the healthcare ecosystem Use & user satisfaction	Usability Quality of information, system & service Interoperability Quality of information, system & service Infrastructure Quality of information, system & service Regulations, standards and policies Legislation, policy & governance
Police et al., (2011)	Systematic review	Benefits and barriers to HIT implementation	Physicians in Primary care	119	2004-2009	Governance, leadership and culture Practice-based predictors & barriers External policies & organizational barriers Impact of practice culture Training Educational barriers	Resourcing Financial barriers Perceived benefits and incentives Staff-related barriers Perceived changes to the healthcare ecosystem Technological barriers	Interoperability Technological barriers Infrastructure Technological barriers Regulations, standards and policies External policies & organizational barriers Technological barriers
Ratwani et al., (2016)	Systematic review	EHR safety and usability challenges	Any	55	2010-2016 English Peer-reviewed	Governance, leadership and culture Governance & consensus building End-user involvement Governance & consensus building Training Support Training	Resourcing Cost and resources Workflows Clinical workflow Skills and characteristics Training Usability	Customization Usability testing Adaptability Customization Testing Risk assessment Usability testing
Ross et al., (2016)	Umbrella review	Implementation of e-health	Any	44	2009-2014	Governance, leadership and culture Implementation climate Planning Engaging Reflecting and evaluating Leadership engagement Champions End-user involvement Key stakeholders Support Training Access to knowledge & information	Resourcing Cost Available resources Workflows Compatibility Skills and characteristics Knowledge & beliefs Other personal attributes Perceived benefits and incentives Incentives Reflecting and evaluating	Perceived changes to the healthcare ecosystem Knowledge & beliefs Usability Complexity Interoperability Infrastructure Complexity Regulations, standards and policies External policy Adaptability
Sligo et al., (2017)	Literature review with a meta-narrative	Large scale HIT planning, implementation and evaluation	Any	382	n/a	Governance, leadership and culture Structural/contextual/organizational factors Technical factors End-user involvement Structural/contextual/organizational factors Technical factors Training Human factors Support Structural/contextual/organizational factors	Resourcing Structural/contextual/organizational factors Human factors Workflows Human factors Skills and characteristics Human factors Perceived benefits and incentives Technical factors Perceived changes to the healthcare ecosystem	Human Factors Usability Technical factors Interoperability Technical factors Infrastructure Technical factors Adaptability Technical factors Testing Technical factors
Strudwick and Eyasu (2015)	Literature review	Experiences with EHR implementation	Nurses in mental Health settings	7	English	End-user involvement Skills and characteristics Characteristics of nurses Experience and interest in computers	Perceived benefits and incentives Perceived benefits Perceived changes to the healthcare ecosystem Privacy and confidentiality concerns	Usability Infrastructure Physical space Lack of computers

Note: EHR, Electronic health record; LTC, long-term care; HIT, Health Information Technology; OECD, Organisation for Economic Co-operation and Development; EFTA, European Free Trade Association.

3.2 Synthesized findings

Fifteen common factors were identified and classified as organizational, human and technological. Each of these factors are discussed in detail below as well as how they interact within different contexts.

3.2.1 Organizational factors

Factors relating to the processes by which the EHR was introduced and incorporated into routine care were categorized as organizational⁵⁴. Whilst each of the six factors were important across all contexts, the size and type of organization impacted on how each triggered success during the EHR implementation^{46,53,61}.

Governance, leadership and culture

The governance of the EHR implementation^{13,19,37}, as well as leaders^{7,10,36,44,48,52–54,62,63} and organizational culture, were identified as paramount in ensuring a successful EHR system^{7,10,13,36,45,50–53,56,59,62}. Whilst top-down, middle-out and bottom-up governance structures have been utilised, ongoing political willingness, national policies and some independence at an individual organizational level regarding EHR procurement, development and design, were recommended to promote engagement, usability and interoperability^{13,48,51,62}. It was also important that executive leaders such as CIOs and project management teams establish good and trusting relationships with vendors and consulting firms^{12,44,52,56,63}, and designed the implementation strategy with clear measurable objectives^{10,50,52}, a fitting implementation process (e.g., big-bang or phased)^{44,46,51,58}, and clear roles and divisions of labour^{10,60}. A shift away from the dominance of top and middle management has also been recommended^{10,19,36}, with the appointment of local leaders or *champions*, and supporting of internal and external communication and collaboration^{10,11,19,52,59}, innovation and continual improvement⁵², and patient-centred care¹⁹. This helps create a favourable^{10,36,44,63} and flexible⁵² culture.

End-user involvement

During each stage of the EHR implementation process, end-user involvement was highlighted as important^{7,10,37,47,48,52,54,56,57,60,62,63}, as it helps to ensure that the EHR meets end-users' needs and workflows, as well as promoting a sense of ownership³⁷ and acceptance amongst staff^{10,37,63}. Engaging end-users from each stakeholder group was recommended³⁶, and this has often been done in the form of appointing *champions*. These leaders should be respected amongst their colleagues as well as having the relevant knowledge to act as a bridge between the end-users and IT staff^{60,62,63}. However, *champions* may sometimes need to be shared between organizations¹⁰.

Training

Basic computer and EHR-specific training were identified as key to a successful EHR implementation^{7,10,12,13,19,36,37,45,46,48,50–53,56,57,60,61,63}. However, the effectiveness and resource-efficiency of training depended on the appropriateness of the appointed trainers, training content, timing of training (i.e., as close to *Go Live* as possible³⁶) and methods of training e.g., classroom based versus eLearning⁵⁷. EHR training was also recommended on an ongoing basis for new staff, as well as existing staff to optimize their use of the system^{37,53}.

Support

Expert, technical, executive and external support have been critical to successful EHR implementations^{7,10–13,19,36,37,44,50–53,56–58,60–63}. Expert or peer support, often referred to as *super-users*, reportedly helped end-users to optimize their use of the EHR^{7,11,12,36,53}, whereas

technical support staff helped solve IT issues^{51,62}. During *Go Live* (often first 3-4 weeks³⁷), technical and peer support should be available 24/7 seven days a week in hospitals^{12,36}. However, this may not be feasible or required in primary care centres but channels to obtain support during working hours remain important. Other crucial support comes from an executive or policy level^{19,50,52,53,56,57,60,63} and professional networks or external parties^{19,53}. Although maintenance support for servers and networks was not as evidenced in the identified literature⁵⁰, the expert panel also deemed this as important.

Resourcing

The availability of resources in terms of finance, skilled workforce and time was also important^{7,10,12,13,36,37,44–46,48,49,51–54,56,59–63}. Financial resourcing was often highlighted as a barrier especially by primary care doctors^{12,13} and those in lower income countries⁴⁸, and scope creep of the budget was a common occurrence for larger hospitals^{10,52,54}. Therefore, a cost analysis which encompasses infrastructure, personnel, maintenance and ongoing optimization was critical^{36,62}. Having a skilled workforce in-house who understand the clinical workflows was also recommended^{53,61} as it can reduce dependence on and cost of vendors^{12,36}. However, this may not be feasible for smaller organizations, and larger organizations also reportedly had issues with IT staff retention^{10,13,36,48,51}. Adequate time for end-user involvement and habituation to the EHR was also vital^{7,10,12} to ensure organizational readiness^{7,13,51,53}.

Workflows

Inability of the EHR system to meet the workflows of end-users and organizations was commonly cited as negatively impacting on success^{7,10–12,36,37,51,52,54,56,62,63}, including end-user efficiency, productivity, satisfaction and acceptance of the EHR^{7,11,63}. Although replicating existing paper-based practices may minimize disruptions for end-users^{7,13,19,62}, re-engineering of workflows during digitization to make them safer and more efficient was recommended^{19,62,63}.

3.2.2 Human factors

Ability of healthcare organizations to successfully adopt an EHR system was largely determined by the individual end-users^{10,54}, and three overarching human factors were identified.

Skills and characteristics

IT skills as well as personal characteristics of individuals impacted on the success of an EHR implementation^{10,12,50,51,53,56,58,60,62,13,19,36,37,44,47–49}. Assessing computer literacy of end-users enabled provision of basic computer training to those requiring it, prior to effective EHR training^{36,48}. Whilst the research assessing the impact of age, gender and clinical experience on acceptance of the EHR reported in the identified reviews was inconclusive, personal traits such as being open-to-change and a problem-solver appeared to contribute to success^{56,62}. However, resistance to the EHR could also be attributed to unusable technology^{10,51}.

Perceived benefits and incentives

Where individual end-users perceived the EHR to positively impact on patient care and workload, this reportedly facilitated a successful implementation^{10,12,50,51,56,58,60,13,19,36,37,44,47–49}. However, realistic benefits and timeframes specific to the organization should be communicated with end-users^{44,45,62}. Monetary incentives or penalties have also been shown to be important, especially for privately-governed organizations^{13,45,59}.

Perceived changes to the healthcare ecosystem

End-users' concerns with changes to data privacy and security, patient-clinician relationships and their roles and responsibilities, appeared to negatively impact on EHR implementations ^{7,10,51,53,56,58,60-62,12,13,19,36,44,47-49}. These concerns may differ depending on the specific setting and type of sensitive personal information being collected (e.g., mental health) ⁴⁷. Therefore, specific concerns and their causes of concerns should be identified and addressed as soon as possible to mitigate their impact on EHR implementations ^{19,36}.

3.2.3 Technological factors

Six factors relating to the technology aspect of the EHR implementation were identified as critical to its success and were intrinsically linked to the organizational and human factors.

Usability

EHR usability was deemed important across several reviews ^{7,10,11,13,36,37,44,46,47,49,51,52,54,58,60,62}, as it impacted on end-user efficiency, patient-facing time ^{12,13,37,53}, quality of care ¹², patient-clinician relationships ⁵² and safety ³⁷. However, a simple and intuitive system in one setting may not be transferrable to another, and therefore, end-user involvement in development, design ^{10,37,62} and usability testing were recommended at each site ³⁷. Additionally, enabling personalization of the EHR interface ⁵³ and access to legacy paper-based records ^{50,51} as well as consideration of data quality and accuracy ^{13,44,51} with use of health terminologies and classifications ⁵⁶ was recommended. However, usability needs to be balanced with security ⁴⁴.

Interoperability

To enable health information exchange both within and across healthcare organizations, interoperability was identified as critical ^{7,10-13,19,37,44,45,49-52,54,58,60,62}. Local contextual factors within countries such as two tier and fully private health systems, lack of employment of national standards ^{45,53,62}, inconsistent data capture in incompatible formats ¹², have rendered the creation of a fully interoperable EHR as difficult. Therefore, technical standards and communication between organizations were recommended to ensure interoperability was built in from the outset including for legacy and existing health IT systems ⁷.

Infrastructure

Procurement or enhancement of infrastructure, including software (e.g., EHR, anti-viral), hardware (e.g., data-entry devices, Wi-Fi, power outlets) and furniture, accounted for a large proportion of the financial resourcing and were deemed critical for the success of the overall EHR implementation ^{10,12,56,62,63,36,47-53}. The existing and new hardware and software must be compatible with the specific EHR product ⁴⁵, reliable and functional ^{13,36,44,53,56}, and enable sufficient accessibility to the EHR for end-users ^{36,45,52,56}. According to the expert panel and additional literature reviewed, selection of mobile and stationary data-entry devices also require consideration of vendor certification, healthcare setting (e.g., outpatients versus isolation rooms), required functions and workflows (e.g., checklists versus long narrative notes), and end-user preferences for usability.

Regulation, standards and policies

As stated earlier, national and international standards as well as regulation and policies were critical for interoperability and addressing privacy and security concerns ^{7,13,19,45,46,51,52,56,58,60,62,63}. Therefore, messaging and language standards ^{45,52,56}, as well as robust privacy laws and policies ^{13,44,52,56,62} were recommended. Where healthcare organizations were permitted to procure their own EHR product, these standards would likely be especially

important.

Adaptability

Many of the literature reviews reported that adaptability of the software was important to facilitate customization of the EHR software to meet the needs of the end-users and organizations^{10,36,37,50,51,53,54,62}. This reportedly required the software vendors to be open to sharing code development data and willing to adapt their product^{36,37,53}, and the organization to have access to a skilled workforce with the capabilities to adapt the EHR to clinical workflows³⁷. Where interoperability standards exist, the need for adaptations to the software may be reduced³⁷.

Testing

Comprehensive testing of the system was critical to ensure usability and safety^{7,10,37,54}, and was more commonly cited as important by IT staff and management than HCPs⁷. This rigorous, resource-intensive, multi-step testing process of each EHR function needed to be conducted within live environments with actual end-users⁵⁴ and should not be underestimated.

4. Discussion

This umbrella review distilled the large volume of evidence available regarding the successful implementation of a national EHR and these findings were corroborated by an expert panel as being relevant to the Irish healthcare context. Fifteen key organizational, human and technological factors were identified as critical and by synthesizing the findings from several different stakeholder groups and clinical settings, such as doctors in primary or secondary care^{11,13,45,53,58,61} and nurses in a mental health setting⁴⁷, this review of reviews identified that each of these factors were also relevant and important to EHR implementations across different healthcare settings.

However, between country differences including health service management, politics, economics, regulation and socio-culture impact on how the identified factors influence success. This was evident in the literature reviews which largely focused on studies conducted in the largely private health service in the USA where return on investment and productivity were important perceived benefits and incentives^{50,51,56}. Additionally whilst the governance approach was identified as important, a successful approach in one country cannot necessarily be replicated in another, as occurred in the UK where the top-down approach successfully employed in the Netherlands resulted in disengaged healthcare organizations in the UK²². Therefore, these factors need to be employed with consideration of the national context and in the Republic of Ireland this will also require close collaboration and communication across the co-existing public and private health sectors^{64,65}, as well as with Northern Ireland (UK). Additionally, European Union (EU) citizens may avail of healthcare from any members state under the Cross-Border Healthcare Directive (2011/24/EU) and thus, efficient exchange of health data across borders is a major priority⁶⁶ and is a pillar of EU4Health 2021-2027⁶⁷. Therefore, the EU interoperability policies and frameworks¹⁴ as well as standards such as the International Patient Summary, the General Data Protection Regulation (GDPR) and standardised terminologies⁴ to support these frameworks need to be employed.

Despite the expansion in internationally-recognised standards (e.g., HL7 FHIR) and significant regulatory and financial incentives created by the HITECH Act and “Meaningful Use” requirements in the USA, factors such as Usability and Regulations, standards and policies

continue to be highlighted as important for success as opposed to being assumed components of EHR products. Whilst the inclusion of older studies by these reviews is perhaps attributable, it is also likely that standards and requirements alone will not ensure an interoperable and usable EHR. In fact, it is the dynamic interaction between each of the identified factors which promote a successful EHR⁶⁸. However, more emphasis placed on an individual factor can reduce the resources required for others, for example promoting Usability and Standards can respectively reduce the burden of training and support, and adaptability³⁷. Additionally, this may be achieved by advances in evidence and technology such as artificial intelligence (AI) including automated testing⁶⁹, eLearning modules^{70,71}, and personalization of the EHR interface⁷². Therefore, it is recommended that those involved in each aspect of the implementation process communicate throughout if and review the latest evidence regarding technology including peer-reviewed publications and white papers.

At a more local or meso level, the size of the organization, infrastructure, organizational readiness and culture, capabilities and beliefs of the workforce, and available finance^{36,37}, were also identified as important when considering the application of the identified factors. Certain aspects of the internal context can be enhanced to improve the likelihood of EHR success such as employing change management to create a clear and realistic vision of the EHR⁷³ and providing basic computer training^{36,48}. However, the size of the organization and its workforce will likely remain more limited compared to their larger counterparts^{10,37}. Therefore, sharing of resources such as champions, support staff and trainers between larger and smaller hospitals or primary care settings has been recommended, with some countries creating networks or encouraging collaboration between existing regional groups of healthcare organizations^{73,74}.

Strengths and Limitations

Undertaking a rapid qualitative evidence synthesis requires acceleration of many of the research processes, is dependent on the reporting in the original reviews³² and could risk losing the context and complexity of the original research setting^{32,42,75}. Additionally, five of the literature reviews were conducted by the same lead author which could lead to bias of individual study inclusion. However, the inclusion of literature reviews, consideration of the inclusion criteria of each literature review and ongoing collaboration with an expert panel³⁰ provided a degree of confidence regarding the coherence, relevance and adequacy of the findings and their generalisability across healthcare settings⁷⁶. Additionally, actively involving knowledge-users who were undertaking HIT implementations led to the concurrent translation of this knowledge into practice⁷⁷.

5. Conclusion

The key organizational, human and technological factors identified in this review provide policy-makers and other key stakeholders with a foundation for making evidence-based decisions during the implementation of a fully interoperable EHR across primary, secondary and long-term care. However, critical to the application of these factors within an implementation process also requires consideration of the specific contextual influences. Additionally, the end-users, existing technological standards and policies, and advances in technology and research in the area, will impact on how these factors dynamically interact during EHR implementation and will influence success.

Summary points

What was already known on the topic:

- Despite recognition of the huge potential for EHRs to improve the delivery of healthcare, no country has successfully implemented a fully interoperable EHR across acute and community care.
- The implementation process of EHRs is critical to their success and needs to be carefully planned and considered across the complex and adapting healthcare landscape.
- A vast amount of literature exists on EHRs which has been relevant to specific stakeholder groups and healthcare contexts.

What this study adds:

- A comprehensive and clear overview of factors influencing the success of an EHR implementation across primary, secondary and long-term care and different stakeholder groups is presented.
- Validation of these factors for the Irish healthcare context via co-production and transfer of knowledge with key knowledge-users.
- Generation of key considerations for each of these factors for policy-makers and other knowledge-users.

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Declarations of interest

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Appendix Search Strategy
Electronic Health record
Electronic health record*
Electronic Healthcare Record*
Electronic patient record*
Computerized health record*
Electronic medical record*
Online health record*
Digital health record*
Computerized medical record*
Electronic Medical Record
Automated medical records
<i>Electronic health record</i>
<i>Electronic health records</i>
<i>Electronic medical record</i>
<i>Computerized medical records</i>
<i>Automated medical records</i>
Electronic Record System*
Clinical Information system*
Electronic Health Record System*
Medical Information System
Computerized medical systems
Computerized medical systems

Clinical data repositor* Health Records System* Medical Records System* Health information system* Hospital information system* <i>Health Information Systems</i> <i>Medical records system, Computerized</i> <i>Electronic health record system</i> <i>Medical information system</i> electronic prescribing e-prescri* eprescri* Electronic pharmaceutical record Electronic Order Entry computerized ordering Medical Order Entry System* Drug Information System Order comm* Computeri?ed Physician Order Management Computeri?ed Provider Order Entry Computeri?ed Provider Order Management Computeri?ed Physician Order Entry <i>Medical Order Entry Systems</i> <i>Electronic Order Entry</i> <i>Computerized provider order entry</i> Personal health record* Patient health record* Electronic patient record* Patient portal* Shared care record* Summary care record* Patient data repositor* Interoperability Health Care Information Exchange* Medical record linkage* Health Information Exchange <i>Patient Portals</i> <i>Health Information Interoperability</i> <i>Data interoperability</i> <i>Interoperability</i> <i>Health Information Exchange</i> <i>Medical Record Linkage EHR</i> PHR EHCR EPR EMR CIS EHRS DIS CPOM CPOE EPR EHRS HIE
Implementation
Implement* Introduc* Adopt* Develop* Establish* Process* Execut* Employ* Instigat* Launch* Re-launch Commence* Initiat* Uptake* Configuration* Customization* Re-optimi* Optimi* Rollout* Evaluat* Assess* Design Facilitate* Barrier* Challeng* Benefit* Success Failure <i>Systems Development</i> <i>Systems Implementation</i>
Literature Review

<p>Systematic Review</p> <p>Scoping Review</p> <p>Meta Analysis</p> <p>Literature review</p> <p>Systematic review</p> <p>Scoping review</p> <p>Meta-analysis</p> <p>Meta-synthesis</p> <p>Systematic interpretive review</p> <p>Systematic methodological review</p> <p>Systematic meta-review</p> <p>Systematic literature review</p> <p>Qualitative synthesis</p>
<p>Note: *, truncation; ?, wildcard; italicised terms, refer to subject headings which were exploded in the relevant databases.</p>

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