COMMENTARY

EHRs Fail on Usability and User Satisfaction

BY JONATHAN BERTMAN, M.D., AND NEIL SKOLNIK, M.D.

Despite the federal government's pledges of financial incentives and eventual penalties, adoption rates of electronic health record (EHR) systems remain stubbornly low. When a product or service is still underutilized, even after being subsidized by public funds, we have to ask ourselves why.

Many vendors advise physicians that extensive training is needed to learn how to document a clinical note, and that the physicians should be prepared to reduce their patient volume throughout the EHR adoption period. This lost patient volume is the direct result of data collection gone awry.

Instead of focusing data collection on key elements required for interaction—checking and billing, for example—most EHR systems require users to codify all data. This means that physicians and their staffs will spend time navigating through multiple windows, drop-down menus, and check-box lists to record something as simple as "3 days of productive cough." Multiply that effort by all the data that are collected during a brief encounter and you have a clinical note that takes more time to document than the duration of the visit itself.

The fact that vendors require extensive training is proof that these EHRs are neither intuitively designed nor easy to use.

The lack of usability has been a major cause of EHR dissatisfaction. One in every three EHR adoptions is estimated to fail, with poor usability likely a major contributing factor.

Unfortunately, the true experience of an EHR's usability occurs only well after an EHR contract is signed, training has completed, and the period of light patient load has ended. That is when the seriousness of poor EHR usability becomes apparent.

To compensate, many physicians end up using templates, macros, and preset lists. This may help alleviate the slowdown caused by an EHR's poor design, and the resulting patient notes may be full of data, but they often lack any real substance. The real story in each patient encounter is frequently lost.

Many EHR vendors do not allow dissatisfied users out of their long-term contracts. Or if a vendor does allow a physician out of the contract at a reduced cost, there are often stipulations.

One physician we interviewed for this article said that he was negotiating an early termination of his contract, but to do so he had to sign a nondisclosure statement, saying that he would never comment on his poor experience with that EHR.

So how can a physician avoid ending up with an EHR that may be unusable?

It is essential to review the experience of those who have already purchased an EHR. The American Academy of Family Physicians' Center for Health IT provides a Web site through which members can rate their own EHR based on a five-point scale measuring quality, price, support, ease of use, and impact on productivity. Sorting the available list of 93 EHR systems by rating provides a clear look at overall user satisfaction (www.centerforhit.org).

User satisfaction studies are another indispensable resource. An October 2009 survey of over 3,700 EHR users published by Medscape.com found that over 30% of respondents would not recommend their EHR (www.medscape.com/viewarticle/709856).

Similarly, "The 2009 EHR User Satisfaction Survey," published in the November/December 2009 issue of Family Practice Management, provides a troubling look at how physicians rate many of the best known EHRs. This survey's final question asked 2,012 family physicians if they agreed or disagreed with the following statement, "I am highly satisfied with this EHR system." Astoundingly, nearly 50% of all respondents said that they would not agree.

With the current rate of physician dissatisfaction, EHR adoption rates will likely remain low despite the government incentives. Perhaps most ironic is that federal financial incentives to adopt EHR systems may contribute to delays in improvements in EHR usability. Rather than allowing competition to reward vendors who produce better software at lower prices, the stimulus money encourages physicians to purchase mediocre software at inflated prices. ■

DR. BERTMAN *is a family physician in private practice in Hope Valley, R.I., and clinical assistant professor of family medicine at Brown University in Providence, R.I. He also is the founder and president of AmazingCharts.com, a developer of EHR software.* DR. SKOLNIK *is associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital and professor of family and community medicine at Temple University in Philadelphia.*

Kaiser Permanente PHR Streamlines Medical Practice

BY ANNE C. ZIEGER

WASHINGTON — Building on the strength of its extensive electronic medical record system, Kaiser Permanente's personal health record has streamlined many daily functions for its physicians and members.

The personal health record (PHR), called My Health Manager, has attracted 3 million Kaiser members to register at KP.org, the site hosting the PHR. Each month, patients refill more than half a million prescriptions, review 1.2 million test results, make more than 100,000 clinic appointments, and exchange approximately 800,000 secure messages with their physicians and other providers.

The PHR effort is closely tied to Kaiser's electronic medical record, HealthConnect, which serves all of its 431 clinics and 35 medical centers.

"Adding the PHR ended up being part of our EMR culture change," Jan Oldenburg, senior practice leader with the Kaiser Permanente Internet Services Group, said at a conference sponsored by the American Medical Association and the IEEE Engineering in Medicine and Biology Society.

At the outset of the PHR program, some Kaiser physicians were afraid that patients wouldn't cooperate, or that they might get too involved in managing their health data.

For example, Ms. Oldenburg said, some physicians argued that their older, sicker patients would never log on. Others feared that if patients were presented with abnormal lab results, their call volume would go through the roof.

However, Kaiser studies have concluded that neither calls nor e-mails to physicians have increased since My Health Manager was rolled out, Ms. Oldenburg said, adding that more than 40% of Kaiser's Medicare population have become active PHR users.

Indeed, the PHR has actually helped physicians run their practices more effectively, according to Ms. Oldenburg. "There have been studies which show reductions in office visits," as well as an improvement in the overall health of the PHR-using population.

My Health Manager is particularly popular with some subsets of Kaiser members, Ms. Oldenburg said, noting that 48% of registered PHR users are 40-64 years old and another 30% are 24-39 years old.

Between 2005 and 2009, the number of patient sign-ins has shot up from 5 million to 51.6 million, Ms. Oldenburg said. ■

HHS Prepares for New Oversight of Health Plans

BY MARY ELLEN SCHNEIDER

The Health and Human Services department has taken the first steps toward greater oversight of the health insurance industry called for by the new health reform laws.

On April 12, HHS officials issued requests for public comment on how to calculate medical-loss ratios for health plans as well as factors to consider in determining whether a plan's premium rate increase is "unreasonable." The comments will be used to help HHS officials develop regulations over the next several months.

Under the Patient Protection and Affordable Care Act, signed into law on March 23, health plans must submit annual reports to HHS on their medical-loss ratios, the percentage of premiums spent on medical care and quality improvement versus the percentage spent on administrative overhead. Beginning on Jan. 1, 2011, if the medical-loss ratio does not meet minimum federal standards, the health plans will have to provide customers with a rebate. For plans in the large group market, the amount of premium revenue spent on clinical services must be at least 85%. For those in the small group and individual markets, the threshold is at least 80%.

HHS is also asking the National Association of Insurance Commissioners to establish uniform definitions and standard methodologies to determine how to define clinical services and quality improvement as part of the medical-loss ratio. The health reform law had called on the organization to develop these definitions by the end of this year, but HHS has asked them to do it by June 1 so that the agency can publish regulations as soon as possible.

The health reform law also includes new oversight of insurance company rate increases. It requires HHS, in partnership with states, to establish a process for the annual review of "unreasonable" increases in premiums for health insurance coverage. As part of this process, insurers have to publicly post and submit to HHS and their state the rationale for any premium increase considered "unreasonable" before the increases goes into effect.

"This increased accountability aims to use transparency and competition to prevent rampant premium escalations," Jeanne Lambrew, Ph.D., director of the HHS Office of Health Reform, said during a press conference. ■