Small Offices Underutilize Electronic Records

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WASHINGTON — A growing number of small medical practices are turning to electronic health records to help the office run more smoothly, but few of these practices are using them to directly improve patient care, according to findings from a small study presented at the annual symposium of the American Medical Informatics Association.

Christopher E. West, Ph.D., and his colleagues at the University of California, San Francisco, surveyed 30 doctors, nurses, and physicians' assistants working in solo or small group practices. They were working in 16 offices spread across 14 states.

All but one said they use the electronic health records system for documenting patient care at least 75% of the time, and half said they use it all the time. At least 80% of the respondents said they use the system most of the time for visit coding, writing prescriptions, or viewing lab results, Dr. West reported.

That kind of "basic functionality" of electronic health records software seems to have largely replaced paper in those offices, he said.

But the researchers also found that offices were not as quick to adopt more advanced functions for improving patient care.

Only 13% said they took advantage of functions that can generate lists of patients in need of follow-up care. Only about one-quarter used features enabling patient self-management plans or doctor visit summaries.

"Doctors are still not using electronic health records for quality improvement," Dr. West said.

Still, the study suggests that stubbornness may not be to blame.

Half of respondents said their software came with adequate training, but the other half called their training fair or poor. ■