EHR REPORT

EHRs Get a Failing Grade on Usability

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 note using their system and that they 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 physicians and their staff 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 collected during a brief encounter and you have a note that takes more time to document than the visit itself. The very fact that vendors require extensive training is proof that these EHRs are neither intuitively designed nor easy to use.

The concept of "usability" is defined as the ease with which people can use a particular product to accomplish defined goals. The lack of usability has been a major cause of dissatisfaction with EHR systems. It has been estimated that one in every three EHR adoptions fail, with poor usability likely a major contributing factor.

Unfortunately, the true experience of an EHR's usability only occurs well after an EHR contract is signed, training has completed, and the 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. This is a common complaint reported by physicians attempting to use notes generated by an EHR.

To add insult to injury, there is an ever-growing list of horror stories reported by physicians who have given up on their EHRs. Unfortunately, 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 of the physicians 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 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.

As physicians recognize the perils of signing EHR contracts before they truly know if an EHR is usable, they will begin to demand usable, intuitive EHRs.

Increasingly, physicians will come to appreciate how financial incentives and initial system costs are dwarfed by the potential reduction in productivity and revenue when a system proves difficult to use.

As they gain more exposure to the EHR market, physicians will start to ask the important questions and demand answers about the critical issue of usability, which ultimately makes or breaks their EHR experience. ■

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Most Uninsured Young Adults Will Get Coverage by 2014

BY JANE ANDERSON

Health reform could benefit young adults more than any other uninsured group, expanding coverage to almost all 13.7 million of them through a combination of insurance reforms, subsidies, and Medicaid expansion, according to a new report from the Commonwealth Fund.

Provisions of the Affordable Care Act that extend coverage of young adults as dependents to age 26 years probably will cover about 1.2 million of that population by the end of 2011. Extending Medicaid eligibility could provide coverage to another 7.1 million young people, beginning in 2014, the Commonwealth Fund report said.

Further, combining premium subsidies with opportunities to purchase coverage via a health insurance exchange will provide the remaining uninsured young adults—defined by the report as aged 19-29 years—a chance to obtain affordable coverage beginning in 2014.

"The benefit of the Affordable Care Act of 2010 for young adults cannot be overstated," Sara Collins, Ph.D., lead author of the report, said during a press briefing. "All told, the provisions have the potential to cover 13.7 million young adults," or the same number that were uninsured in 2008.

However, that figure probably underestimates the current number of uninsured young adults, since unemployment has risen dramatically in that population since 2008.

Health care costs represent a significant problem for this group, whether or not they are insured, according to the report. A total of 76% of uninsured young adults and 37% of those with insurance went without needed care in 2009 because of its cost, the report said. One-third of all uninsured young people and 46% of those both uninsured and with chronic health problems reported that their health declined because they delayed getting medical care.

In addition in 2009, 60% of young adults without insurance had trouble paying medical bills, compared with 27% of their insured peers, according to the report.

Medical debt also is a problem, the report found, with 11.3 million young people paying off medical debt. Half of those had asked family for financial help, while 39% said they were unable to meet other financial obligations such as student loans because of their medical debt.

More than half of the 13.7 million uninsured young adults are in families with incomes that will make them newly eligible for Medicaid under the health care reform law. Another 30% are in families whose incomes will qualify them for health insurance premium subsidies so they will not have to spend more than 3%-8% of their income on health insurance premiums. And 12% live in families whose incomes will qualify them for health insurance–premium subsidies so they won't have to spend more than 9.5% of their income on premiums, the Commonwealth Fund study found.

Fewer than 1 million uninsured young adults are expected to have incomes too high to qualify for premium assistance, the study authors said.

Many of those who will become newly insured through the law's provisions probably will seek care from primary care physicians rather than getting free care from emergency departments, noted Dr. Collins, the Commonwealth Fund's vice president for affordable health insurance. This has the potential to help primary care physicians because "these people will be coming in with insurance cards" that will cover much of their care.

"A lot of people have been getting free care," she said. "Now, providers will be reimbursed for care."

It's not clear whether the new law will lead to a significant shortage of primary care physicians to care for the influx of patients, but Dr. Collins said that the law authorizes a significant increase in funding for community health centers, which could take up some of the slack.

The report, "Rite of Passage: Young Adults and the Affordable Care Act of 2010," was based on federal health insurance data and a national telephone survey of 2,002 young adults. ■

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