8 top challenges and solutions for making EHRs usable

9/16/2014, 10:00 AM

It's no secret that many physicians are unhappy with their electronic health record (EHR) systems, thanks in large part to cumbersome processes and limited features that get in the way of patient care. Now a panel of experts has called for EHR overhaul, outlining the eight top challenges and solutions for improving EHR usability for physicians and their patients.

This new framework (log in) for EHR usability—developed by the AMA and an external advisory committee of practicing physicians and health IT experts, researchers and executives—focuses on leveraging the potential of EHRs to enhance patient care, improve productivity and reduce administrative costs. Here are the eight solutions this group identified to address the biggest challenges:

1. Enhance physicians' ability to provide high-quality patient care. Poor EHR design gets in the way of face-to-face interaction with patients because physicians are forced to spend more time documenting required information of questionable value. Features such as pop-up reminders, cumbersome menus and poor user interfaces can make EHRs far more time consuming than paper charts.

Instead, EHRs should be designed to enable physician-patient engagement. Technology should fit seamlessly into the practice and be based on work flow needs.

2. Support team-based care. Current technology often requires physicians to enter data or perform tasks that other team members should be empowered to complete. EHR systems instead should be designed to maximize each person's productivity in accordance with state licensure laws and allow physicians to delegate tasks as appropriate.

3. Promote care coordination. Transitioning patient care can be a challenge without full EHR interoperability and robust tracking. EHR systems need to automatically track referrals, consultations, orders and labs so physicians easily can follow the patient's progression throughout their care.

4. Offer product modularity and configurability. Few EHR systems are built to accommodate physicians' practice patterns and work flows, which vary depending on size, specialty and setting. Making EHR systems more modular would allow physicians to configure their health IT environment to best suit their work flows and patient populations. Allowing vendors to focus on specialized applications also would produce the tailored technology physicians need.

5. Reduce cognitive work load. Although physicians spend significant time navigating their EHR systems, many physicians say that the quality of the clinical narrative in paper charts is more succinct and reflective of the pertinent clinical information. A lack of context and overly structured data capture requirements, meanwhile, can make interpretation difficult.

EHRs need to support medical decision-making with concise, context-sensitive real-time data. To achieve this, IT developers may need to create sophisticated tools for reporting, analyzing data and supporting decisions. These tools should be customized for each practice environment.

6. Promote interoperability and data exchange. Data "lock in" is a common problem. EHR systems should facilitate connected health care across care settings and enable both exporting data and properly incorporating data from other systems. The end result should be a coherent longitudinal patient record that is built from various sources and can be accessed in real time.

7. Facilitate digital patient engagement. Most EHR systems are not designed to support digital patient engagement. But incorporating increased interoperability between EHR systems and patients' mobile technologies and telehealth technologies would be an asset for promoting health and wellness and managing chronic illnesses.

8. Expedite user input into product design and post-implementation feedback. The meaningful use program requires physicians to use certified EHR technology, but many of these products have performed poorly in real-world practice settings. EHR systems should give users an automated option to provide context-sensitive feedback that is used to improve system performance and safety.

"Physicians believe it is a national imperative to reframe policy around the desired future capabilities of this technology and emphasize clinical care improvements as the primary focus," AMA President-Elect Steven J. Stack, MD, said in a news release.

As part of its Professional Satisfaction and Practice Sustainability initiative, the AMA will use this framework to work with physicians, vendors, policymakers, health care systems and researchers to drive EHR improvements that can advance the delivery of high-quality, affordable care.

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martin bury
8:47 AM on 9/17/2014
Give me a good old-fashioned dictated S.O.A.P. note any day over this mass of useless redundancy (done, of course, ONLY for the purpose of passing a possible billing audit someday, NOT to enhance patient care)

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rakord
7:49 PM on 9/17/2014
Amen and about time we set some of our own standards.

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magneticmem
7:59 PM on 9/17/2014
I agree whole-heartedly with Dr. Bury. Our practice uses an Alscripts product. Among numerous bottlenecks, poor user interface is a major issue. The inability to toggle back and forth between menus or to have multiple windows open simultaneously (e.g. lab, appointment list, med list, diagnosis list, physical exam, etc., etc.) and return to the note in progress with minimal mouse clicks, markedly slows down note generation. The time taken to generate a meaningful cogent encounter note frequently requires as much time, or more, than the actual encounter did.

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claudia koppelman
10:37 AM on 9/19/2014
Refocus "ALL" to the real purpose of a medical record==> Patient care....
NOT data collection for statisticians and insurance/payers and the quality of care as well as outcomes will improve with resultant decrease in costs.

With re-alignment of the "real" purpose we all keep a medical record of our encounters with our patients then the usability and functionality of an ehr will
occur. All of the points set forth by the AMA could be achievable, but ONLY if the REAL reasons others have forced ehr's upon the medical community are ousted.

i.e. Medical professional needs/ethics vs Business community value/money oriented ethics

The one priority requirement of all ehr's must be interoperability with one uniform platform at NO cost to providers. The fact that the "voluntary mandate" from CMS was rolled out without any structure i.e. a free for all for any vendor who wanted to get into the game, supports my opinion that the entire ehr concept was and still is focused on increasing the IT industry economy and employment and data collection entities desire for "data"...regardless of quality of the actual data being collected.

From a purely financial business perspective the cost of implementing, training and maintaining an ehr to be 100% compliant with what CMS mandates is a losing proposition [ongoing deficit] to all who have no means to incorporate the costs into their charges and increased premiums to all who purchase insurance as the costs are being passed on to "consumers" in a "cost of doing business" manner.
In addition, in my opinion, our government/CMS must eliminate the built in penalties if not in compliance with their "voluntary mandate" as it serves to support my theory that it is a built-in savings plan for the government not an 'incentive' to be in compliance with all Stages of what I and many others believe to be "meaningless use" data collection. [Spending $35,000+/physician a year to not be penalized a few thousands is a no brainer financial business decision and only further

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demoralizes and shows disrespect for physicians and the value of our work].
All that the "voluntary" mandates have proven thus far to achieve is further burnout of the physician workforce, early retirement and increased costs to the entire healthcare system and American taxpayers. They have also alienated physicians from one another causing less real time communications as too many colleagues defer to technologies assuming information has been retrieved/accessed/sent etc. to another, which often is not the reality.

So, if the "dream" of having a functional secure seamless ehr environment in America for the benefit of improved patient care is to be realized...then let's pressure the government to mandate vendors incorporate ONE platform for easy interoperability between all and certify products ONLY if proven to show ease of usability by active practicing physicians that are meaningful to provider type...i.e. not one size fits all regardless of pertinence to type of practice.

pjmukti
10:54 AM on 10/4/2014
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One should be able to get data from one EMR to a different EMR with ease.

(e.g. When an older EMR company ceases to exists or when a practitioner's PRACTICE changes)

rachelwest
12:17 AM on 10/16/2014
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it is great to hear the correct people are organizing the conversations about the realities of the her world. I lost soo much obey and frustrated my staff, one who quit after 5 years after canceling 2 emr/ehr that were unusable in reality. plus, dictation was not available in the cloud format, and i was asked to pay more for lab interfaces and every other little need--they were nickel and dining me if i wanted to add electronic ekgs etc. and this was the 1st program recommended by california. then, when i searched for codes, it was like doing a search in 1980 where nothing would show up unless using the perfect term. i am tired, broke from this and burnt out from wanting to go again into this. plus, when i found out it was going to be another thousand to learn how to do reporting, i just cried. i might quit accepting medicare.

rachelwest
12:22 AM on 10/16/2014
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let them simply pay for the whole thing including scribes)like court reporters) if they want this done for data purposes. if judges have court reporters paid for, and lawyers charge for god knows everything, so shall medicine follow

mpaagroup
12:27 AM on 11/6/2014
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Agree on all points. But it should be reitereated that all of these challenges and solutions which you have provided should be considered as early as the planning phase. As suggested in this simple guideline, http://www.mpaagroup.com/document-management/create-effective-change-management-plan/, an EHR implementation and change management plan should be as detailed as possible and these points you provided are a good addition.

troyrjones
8:27 AM on 11/13/2014
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There are hundreds of EHR companies who are competing to provide the best system. The competition is massive and development is going as fast as it can go. But when the government gets involved making all these worthless requirements and regulation, it drives the smaller, less well funded companies, many of which have great ideas and technology, out of business. When the government and the AMA get out of the way development of high quality, fast, and user-friendly systems will be much faster. As it is, these companies are using their money to jump through government hoops rather than developing great systems.

troyrjones
8:47 AM on 11/13/2014
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I actually have an ehr that is fast and makes my office more efficient, helps me provide better medical care, and makes me a better physician. But I don't participate in all the government garbage, and, therefore, I have stopped seeing new Medicare/Medicaid patients---there is life after death!

rclutter
7:57 AM on 7/25/2015
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The Indiana Academy of Family Physicians just passed a resolution this morning directing the AAFP and the AMA to streamline both MU and QA requirements making them less burdensome, and achieve the goal of improving patient quality of care instead of interferring with it, as it does now. The resolution was just passed an hour ago. What a prompt response! Keep up the pressure!

philosopete
9:08 AM on 7/25/2015
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It's very simple--the EHR makes things easier for everyone but the patient and the caregivers.

nscharff
8:02 AM on 10/3/2015
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The worst of the many faults of current EMRs is the difficulty of reading the chart, whether picking up a new patient or reviewing before seeing an old one. First, there's no way to scroll through as with a paper chart (though there could be), and second, the automatically generated text in the note is mostly extraneous and, because it wasn't written for the particular patient, substantially false. In real time, nobody has time for trying to find real data in all that mess.
Nothing was more important in managing real patients than the chart, and nothing could have been more destructive of it.