EHR dissatisfaction:
A tech or people problem?

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A percolating problem is beginning to boil over: doctors and nurses really don't like their new electronic health records systems. And, as EHR implementations increase ahead of government deadlines for incentive dollars, dissatisfaction among clinicians is growing.

The problem might be that EHR implementation is treated as a purely technological issue when in reality it is a workforce issue. Several years before federal incentives began for healthcare providers to adopt EHRs, leading healthcare informatics organizations strongly recommended that workforce training and readiness must be a top priority in the national transformation from paper to electronic health records.

While the benefits of EHRs to patient care have been established, persistent user issues may be impacting the technology's effectiveness. Many surveys and studies show that user satisfaction with EHRs is headed in the wrong direction. An American College of Physicians survey, released this spring at the HIMSS13 conference, showed that overall EHR user satisfaction fell 12 percent from 2010 to 2012, while those who said they were "very dissatisfied" rose by 12 percent.

A 2012 national survey of 14,000 physicians by Merritt Hawkins conducted for The Physicians Foundation found that half of doctors said their EHR systems had no effect on quality of care, had decreased quality of care, or that any quality of care gains achieved were not worth the cost. A RAND Corp. report in January concluded that the promise of health information technology has not been achieved in part because clinicians find the EHR systems are too hard to effectively use.

The American Medical Association, meanwhile, recently opined that the federal EHR incentive program should "take a breather" for a thorough evaluation of "what went wrong, what went right and what is the best course going forward."

Early warning

On the eve of the EHR revolution, before federal incentives revved up the technological conversion, two medical informatics associations issued a warning. The 2006 publication "Building the Workforce for Health Information Transformation" by the American Health Information Management Association and American Medical Informatics Association stated:

"A workforce capable of innovating, implementing, and using health communications and information technology (IT) will be critical to healthcare's success. Conversely, without such a workforce, implementations will fail or could even cause harm."

A national workforce agenda contained in the report strongly recommended robust efforts to provide training, education and incentives to effectively engage the clinical workforce — not just the technology workforce — in the health IT transformation.

Implementation: The importance of people

Far too often, healthcare systems of all sizes, including physician practices, underestimate the importance of preparing and engaging the clinical staff during system selection, build, testing and pre- and post-go-live support. In too many scenarios, all attention is focused on how well the technology will work, instead of on how well frontline clinicians will work with it.

During the go-live period and 2-5 weeks immediately following, on-site experts are needed who possess both clinical and EHR experience in at least a 1:5 ratio with core clinical staff members. Backfilling with support staff during initial EHR training and embedding specialized EHR clinicians during implementation are important. Otherwise, the result may be growing clinician frustration, extended adoption times and increased costs, often from unbudgeted training and other staff problems. Post-implementation issues often are labeled as technology problems, when in reality they are matters of staff acclimation to technology.

Hospitals average a 15-25 percent drop in staff productivity during the go-live event and up to four weeks afterward; planning ahead for this learning curve on a new system can avoid a decline in efficiency. Lowering patient assignments for nurses and other staff immediately before and after EHR go-live allows staff the time to learn on the job without being forced to shoulder a complex technical burden on top of a normal demanding day.

To fill in the productivity gap, a clinical EHR transition staffing program can provide nurses, physicians and other staff, who are specially trained in the EHR system, to temporarily take on the patient load while also providing support for staff learning on the new EHR.

Quickest ROI

An EHR may be one of the biggest investments a healthcare system will make. A 2007 American Hospital Association study showed that the median cost to implement an EHR in a hospital was $5,556 in capital costs per bed and $12,060 per bed in annual maintenance costs. It may be even more expensive today. A survey last year by KPMG Healthcare found that many organizations underestimated the cost and magnitude of the system-wide effort needed to implement an EHR.

The swiftest path to achieving return on investment and improved patient care from the enormous expense of a new EHR is a smooth implementation that coincides with educating the clinical workforce to use the system effectively. With careful planning and execution, an effective EHR transition and satisfactory levels of staff acceptance are quite possible. But it requires planning for the human transition from paper to pixels, not just the technological change.

Kimberly Martini is division vice president at AMN Healthcare. Her clinical team has completed dozens of EHR implementations at hospitals and physician practices, while individual team members have been involved in hundreds more. She has nurses on her team who actually like to do EHR implementations.