Patient perceptions of electronic medical records use and ratings of care quality

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Introduction

Electronic medical records (EMRs) have significant potential to facilitate information exchange and enable greater patient engagement. To maximize this potential, care must be exercised in the adoption and use of EMRs, to ensure that EMRs facilitate patient-centered communication and health care processes.1–5 Prior research exploring physicians’ attitudes about EMRs6–9 and patients’ satisfaction with physicians’ use of EMRs has yielded mixed results.10–12 Evaluating patient perceptions of provider use of EMR and associated ratings of health care quality is a first step in understanding the impact of EMRs on the patient experience.13–15 Use of EMRs is rapidly increasing; therefore, tracking patients’ perceptions of provider EMR use and assessment of their association with ratings of quality of care is important to understand patients’ perspective on this evolving component of health care.16 Data from a national sample of adults in the USA were analyzed to explore whether patient-reported physician use of an EMR is associated with quality of care ratings.
Methods

Data collection and response rates

Data from the Health Information National Trends Survey (HINTS) (HINTS 4, Cycle 1 and Cycle 2; n=7,390), a nationally representative survey of the US adult population that tracks attitudes, knowledge, and behavior relevant to health communication, were analyzed.\(^1\)

HINTS 4 Cycle 1 and Cycle 2 data were collected in 2011 and 2012 via mailed questionnaires. The instruments used in these data collection efforts were cognitively tested and pilot tested to ensure respondents were able to understand and complete the instruments.\(^1\) Each instrument was also approved by the US Office of Management and Budget to ensure the level of burden for respondents was deemed acceptable.\(^1\) The sample design was a two-stage, stratified sample wherein addresses were selected from a United States Postal Service file of residential addresses, and individual respondents were selected from each sampled household. The final response rate for Cycle 1, was 36.7% and for Cycle 2, was 40.0%.\(^1\) Additional details about the sampling strategies and survey design for HINTS 4 are published elsewhere.\(^1,18\)

Measures

Ratings of health care quality

The following question captured respondents’ quality of care ratings: “Overall, how would you rate the quality of health care you received in the last 12 months?” The response options were given on a five-point scale, ranging from “excellent” to “poor.” To improve interpretation, the scale was treated as interval, scores were reversed, and a linear transformation was applied to create scores ranging from 0–100, wherein higher scores indicated higher ratings of quality.

Electronic medical record use

Respondents were asked the following question to assess whether they believed their health care provider maintained an EMR: “As far as you know, do any of your doctors or health care providers maintain your medical records in a computerized system?”

Health care access

Usual source of health care was assessed with the following: “Not including psychiatrists and other mental health professionals, is there a particular doctor, nurse, or other health professional that you see most often?” Health insurance status was assessed with the following: “Do you have any of the following health insurance or health coverage plans: Insurance through a current or former employer or union; Insurance purchased directly from an insurance company; Medicare; Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or disability; TRICARE [health care program for Uniformed Service members] or other military health care; VA [US Department of Veterans’ Affairs]; or Indian Health Service.” Responses were recoded as “yes” or “no.”

Sociodemographic variables

Sociodemographic variables included sex, age, education, race/ethnicity, annual household income, and employment.

Data analyses

SUDAAN version 10.0.1 (RTI International, Research Triangle Park, NC, USA) was used to account for the complex sample procedure. All data were weighted to provide representative estimates of the adult US population. Mean ratings of quality were calculated and compared by t-test for those who reported their health care providers maintain an EMR and those who reported they do not. A multivariable linear regression model was conducted, regressing health care quality ratings on a set of predictors, including sociodemographic variables, health care access, and perceived provider EMR use.

Results

The vast majority of respondents (86.99%) reported that their health care provider maintained their medical records in a computerized system (Table 1). Significant differences in perceived EMR use were observed by health care access and sociodemographic variables. As summarized in the first data column of Table 1, perceived provider EMR use was more frequently reported by females, younger adults, non-Hispanic whites, those with higher education, higher incomes, health insurance, and a usual source of health care.

Mean ratings of quality of health care also differed by perceived EMR status, with significantly higher ratings among those reporting use of an EMR (mean =80.9) compared with those reporting no use (mean =73.6) (t=4.59, P<0.0001). Significantly higher ratings of quality of care were also observed among those reporting provider use of EMR compared to those reporting no EMR use for: males, females, those aged 35–64 and 65 years or older, those earning less than $50,000 per year, Hispanics, non-Hispanic others, those with some college or less, those with health insurance, employed and unemployed persons, and those without a usual source of care (Table 2). Perceived physician use of EMR remained significantly associated with quality of care ratings in the
multivariable model. Respondents who reported physician use of EMR had significantly higher ratings of care quality (Beta = 4.83, standard error [SE] = 1.70, P < 0.01). Having a usual source of health care, increasing age, and higher income were also significantly associated with higher ratings of care quality, in the multivariable model (Table 3).

**Discussion**

Despite their considerable potential for improving health care quality, adoption of health information technologies, such as EMRs requires prudence, to ensure that such tools are designed, implemented, and used meaningfully to facilitate patient-centered care processes and improved health outcomes.1,12-22 We assessed patients’ perceptions of EMR use and associated ratings of quality. Our analyses revealed that the majority of the population believes that their health care providers maintain an EMR. This estimate is strikingly higher than the estimated 55% of a national sample of physicians who reported EMR use in 2011, and somewhat higher than the estimated 69% of physicians who reported EMR use in 2012.16,23 It is important to bear in mind that the adoption of an EMR varies significantly by type of clinical practice. For example, data from the National Ambulatory Medical Care Survey (NAMCS) Physician

### Table 1: Weighted population estimates for perceived electronic medical record status by sociodemographic and health care access characteristics

<table>
<thead>
<tr>
<th>Provider maintains EMR</th>
<th>Yes (N=6,511)</th>
<th>No (N=879)</th>
<th>Chi-square</th>
<th>P-value</th>
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<td>Overall</td>
<td>86.99%</td>
<td>13.01%</td>
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<td>Health insurance</td>
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<tr>
<td>Yes</td>
<td>85.71 (84.60–86.76)</td>
<td>60.06 (54.11–65.73)</td>
<td>42.11</td>
<td>0.0000*</td>
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<td>No</td>
<td>14.29 (13.24–15.40)</td>
<td>39.94 (34.27–45.89)</td>
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<tr>
<td>Regular provider</td>
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<tr>
<td>Yes</td>
<td>68.22 (66.00–70.36)</td>
<td>39.04 (33.49–44.90)</td>
<td>63.96</td>
<td>0.0000*</td>
</tr>
<tr>
<td>No</td>
<td>31.78 (29.64–34.00)</td>
<td>60.96 (55.10–66.51)</td>
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<tr>
<td>Employed</td>
<td>55.82 (53.86–57.77)</td>
<td>57.21 (50.50–63.66)</td>
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<td>0.694*</td>
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<tr>
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<td>44.18 (42.23–46.14)</td>
<td>42.79 (36.34–49.50)</td>
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<td>Sex</td>
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<tr>
<td>Female</td>
<td>52.79 (51.97–53.61)</td>
<td>41.34 (36.55–46.30)</td>
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<td>47.21 (46.39–48.03)</td>
<td>58.66 (53.70–63.45)</td>
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<td>Age</td>
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</tr>
<tr>
<td>18–34</td>
<td>30.11 (29.14–31.10)</td>
<td>34.87 (29.06–41.18)</td>
<td>5.75</td>
<td>0.0003*</td>
</tr>
<tr>
<td>35–49</td>
<td>26.36 (25.67–27.06)</td>
<td>31.42 (27.13–36.06)</td>
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<tr>
<td>65–74</td>
<td>9.73 (9.42–10.05)</td>
<td>5.64 (4.22–7.49)</td>
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<tr>
<td>≥5+</td>
<td>8.08 (7.78–8.39)</td>
<td>5.51 (4.02–7.51)</td>
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<tr>
<td>Income</td>
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</tr>
<tr>
<td>&lt;$20,000</td>
<td>21.40 (19.56–23.36)</td>
<td>32.88 (26.49–39.97)</td>
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<td>$20,000 to &lt;$35,000</td>
<td>15.90 (14.39–17.53)</td>
<td>16.51 (12.69–21.20)</td>
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<td>$35,000 to &lt;$50,000</td>
<td>14.47 (13.26–15.76)</td>
<td>13.63 (9.54–19.11)</td>
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<td>$50,000 to &lt;$75,000</td>
<td>16.53 (14.80–18.46)</td>
<td>19.30 (14.67–24.98)</td>
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<td>$75,000 to &lt;$100,000</td>
<td>12.45 (11.29–13.71)</td>
<td>7.49 (5.41–10.28)</td>
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<td>$100,000 or more</td>
<td>19.24 (17.72–20.85)</td>
<td>10.18 (7.86–13.09)</td>
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<tr>
<td>Hispanic</td>
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<td>23.34 (18.68–28.76)</td>
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<td>0.0000*</td>
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<tr>
<td>NH White</td>
<td>65.30 (64.23–66.37)</td>
<td>48.26 (43.09–53.46)</td>
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<td>NH Black</td>
<td>9.89 (9.29–10.53)</td>
<td>13.87 (10.49–18.12)</td>
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<td>NH Other</td>
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<td>9.32 (6.31–13.56)</td>
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<tr>
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<td>5.21 (3.96–6.82)</td>
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<td>Education</td>
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<td>Less than high school</td>
<td>11.79 (10.80–12.86)</td>
<td>22.68 (18.01–28.14)</td>
<td>7.49</td>
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<td>High school graduate</td>
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<td>24.63 (19.62–30.44)</td>
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<td>Some college</td>
<td>35.21 (33.74–36.71)</td>
<td>29.87 (24.48–35.87)</td>
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<tr>
<td>College graduate</td>
<td>32.02 (31.07–32.99)</td>
<td>22.83 (19.17–26.95)</td>
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</tr>
</tbody>
</table>

Note: *Significant P-value.

Abbreviations: EMR, electronic medical record; NH, non-Hispanic.
Workflow mail survey showed adoption of an EMR to be as low as 29% among solo practitioners to as high as 100% in health maintenance organizations, with increasing adoption and use of EMRs with increasing practice size.\(^6\) With the movement toward group practice, fewer patients are receiving care in the types of care settings that are least likely to have adopted EMRs and increasing numbers of patients are receiving care from the types of settings that are most likely to maintain EMRs.\(^{16,24,25}\) Therefore, the estimates of EMR use obtained in our data may, in part, be a reflection of greater numbers of patients being seen in the larger group model and health maintenance organizations that are more likely to maintain EMRs, although we are not able to discern this from our data.

The higher ratings of quality of care observed among those who reported physician use of EMR, even after controlling for important sociodemographic and health care access variables, underline the potential importance of perceived EMR use on the patient–clinician encounter. Furthermore, among persons without a usual source of care, ratings of quality of care were significantly higher for those who reported that their health care provider maintained an EMR compared with those who reported that they did not, while no differences were observed among persons with a usual

<table>
<thead>
<tr>
<th>Table 2 Weighted mean health care quality ratings by electronic medical record status</th>
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<tbody>
<tr>
<td><strong>Mean rating of health care quality on a 100 point scale (higher score = greater quality)</strong></td>
</tr>
<tr>
<td><strong>N</strong></td>
</tr>
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<td>Overall</td>
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<tr>
<td>Health insurance</td>
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<tr>
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</tr>
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<td>No</td>
</tr>
<tr>
<td>Regular provider</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
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<tr>
<td>Not employed</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Female</td>
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<tr>
<td>Male</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>18–34</td>
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<tr>
<td>35–49</td>
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<td>50–64</td>
</tr>
<tr>
<td>65–74</td>
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<tr>
<td>≥75</td>
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<tr>
<td>Income</td>
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<tr>
<td>&lt;$20,000</td>
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<tr>
<td>$20,000 to &lt;$35,000</td>
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<td>NH Black</td>
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<td>Education</td>
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<td>Less than high school</td>
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<td>High school graduate</td>
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<tr>
<td>Some college</td>
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<tr>
<td>College graduate</td>
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</table>

Note: *Significant **P**-value.
Abbreviations: EMR, electronic medical record; NH, non-Hispanic; SE, standard error.
Table 3  Independent associations of electronic medical record use and quality of care ratings

<table>
<thead>
<tr>
<th>n=5,576</th>
<th>Quality of care ratings</th>
<th>Beta coefficient</th>
<th>SE</th>
<th>Adj Wald F</th>
<th>P-value</th>
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<td>Provider uses EMR</td>
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<tr>
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<td>8.05</td>
<td>0.0055*</td>
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<td>0.00</td>
<td>0.00</td>
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<td>Health insurance</td>
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<td>0.3319</td>
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<td>0.00</td>
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<tr>
<td>Regular provider</td>
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<td>24.61</td>
<td>0.0000*</td>
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<td>0.00</td>
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<td></td>
<td></td>
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<td>Age</td>
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<tr>
<td>18–34</td>
<td>3.07</td>
<td>0.0200*</td>
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<td>-0.38</td>
<td>1.19</td>
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<td>7.17</td>
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<td>Race/ethnicity</td>
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</table>

Note: *Significant P-value.
Abbreviations: EMR, electronic medical record; NH, non-Hispanic; SE, standard error.

Source of care. Prior research indicates that persons without a usual source of care are less likely to use preventive services, more likely to rate their care unfavorably, more likely to use emergency services, and more likely to experience poor health outcomes. Although not directly discernible from the HINTS data, this finding may suggest that EMRs play a role in continuity of care for those who lack a regular provider. Further research is needed to explore the ways in which EMR capabilities and health information exchange efforts can better support continuity of care, particularly for patients without a usual source of care.

HINTS data are derived from cross-sectional surveys, therefore inferences about causality in observed relationships are not appropriate. The response rate for this survey, although an improvement over declining response rates from telephone surveys, is low. Low response rates can lead to biases in the data. However, significant efforts were made in this data collection to reduce the potential for bias, through modality coverage and sampling. Additionally, recent methodological research suggests that the potential for bias resulting from declining response rates may be less significant than previously assumed.

National survey tools are often constrained by survey length and respondent burden to measuring constructs of interest with only one or two items. In particular, the one-item measure of provider EMR use is relatively blunt, may not elicit accurate reports from respondents, and may fail to capture the functionality and nature of EMRs that may contribute to various aspects of care quality. Although the EMR question followed a series of questions on patient health care experiences that encouraged respondents to consider the health care providers that they had seen in the prior year, it was a broadly stated question and not specific to any one health care provider. A final limitation to note is that the association of perceived provider EMR use and ratings of quality may be confounded by the potential for practices with greater resources to have functioning EMR systems. That is, it may be the case that the greater resources of practices with EMR systems may be the driving factor in patient ratings of quality rather than the EMR itself. This, however, was not assessed and therefore could not be controlled in the analyses.

**Conclusion**

Our analyses revealed higher ratings of general care quality among patients who believed their health care providers maintained an EMR, providing early evidence, from the patient perspective, of a positive evaluation of “meaningful use” of information technology in the health care setting. While EMRs have the potential to facilitate information exchange, enable greater patient engagement, and improve continuity of care, caution must be exercised in adoption and use of EMRs to ensure these tools facilitate, rather than impede, patient-centered communication and care processes. Understanding the patient perspective on use of EMR and associated ratings of health care quality is a first step in evaluating the impact of EMRs on the patient experience.
processes, and health outcomes and to evaluate specific use of EMR functionality to improve patient care.

Disclosure

The authors report no conflicts of interest in this work.

References
