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Hospitalist Update

The Hospitalist & the Electronic Medical Record

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In January, 2010, the Center for Medicare and Medicaid Services (CMS) released full details of the proposed Electronic Health Record Incentive Program [1]. These proposed rules set initial requirements which hospitals and health care providers must meet in order to qualify for economic incentives under the American Recovery and Reinvestment Act (ARRA). Since the sixty day comment period ended on March 15, 2010, we can anticipate a final version of the rules to be published very soon.

The linkage of hospital reimbursement to the development and utilization of the electronic medical record (EMR) has further escalated the pace at which hospitals are converting their orders and documentation from paper-based to electronic processes. Most hospitals already using EMRs are busy identifying the areas outlined by the CMS rules which will require further adoption in order to reach specified thresholds. As hospital-based physicians, hospitalists find themselves integrally involved in these changes.

Is the acceleration of the rate of EMR adoption good for hospitalists? There is no simple answer to this question, since many hospitalists who have used EMRs admit to ambivalent feelings about these systems. They know that features such as computerized provider order entry (CPOE) have been shown to decrease errors due to poor legibility, reduce adverse drug events and decrease the time for medication delivery; however, the electronic processes also induce opportunities for new types of errors [2]. Many physicians using CPOE have noted a slight increase in time spent writing orders; however, this is usually offset by time savings that occur due to less phone calls and order clarifications [3].

Many hospitalists find that changing inpatient documentation from paper to electronic is the most challenging feature of EMR adoption. The Press-Ganey Corporation recently reported that physician satisfaction with EMRs is decreasing throughout the nation [4]. Although some of this dissatisfaction may be expected during the "learning curve," other factors may include feelings that they have not had an adequate voice in the EMR selection process or the belief that some EMR products (cont)

(cont) need further development before widespread implementation. As an example, University of Iowa Hospitals introduced Epic EMR throughout their system in May, 2009, investing $61 million in the project; many providers have been frustrated by the inefficiency of their system, making it a huge source of dissatisfaction for many physicians [5].

Our hospital recently conducted a survey of staff physicians to determine levels of satisfaction with our EMR. We have had a ten-year history of EMR use at our facility, though a major gap has been the absence of CPOE, which is scheduled to go live in the fall of 2010; about 85-90% of inpatient documentation is now electronic. Several interesting opinions were voiced on the survey by physicians who identified themselves as predominantly inpatient providers:

- 73% felt that the EMR improved communication between inpatient providers
- 58% felt that the EMR improved communication between inpatient and outpatient providers
- Most felt that the EMR provided access to the information that they need for patient care
- Many felt that the EMR enhanced workflow for administrative and educational chart reviews

However, several concerns were also voiced by these inpatient providers:

- Most felt that access to computers to support this documentation was inadequate
- Only 30% stated that it was easy to document their clinical care using the EMR
- Only 24% reported that the EMR facilitated their workflow while documenting care
- Most reported dissatisfaction with the quality of structured medical documentation (generated by checking boxes) that contained little narrative information, whether produced by nurses or physicians

Despite these concerns, the majority of inpatient providers agreed that the EMR enhanced the quality of their work life compared with paper documentation.

How can hospitalists best survive this transition period as hospitals increasingly move to electronic documentation of care? The opinions supplied in our recent survey would suggest that those physicians who are most involved in the adoption and customization of the EMR, and who are best trained to optimize EMR use, are most likely to be satisfied with the product. Specialty-specific documentation templates and electronic summary screens, which automatically compile data from multiple sites in the medical record, have been especially well received by our inpatient physicians. As hospitalists partner with the IT developers, additional tools can be created and deployed to improve management of inpatient information.

Throughout the country, the momentum to move to the EMR has intensified. Ironically, though hospitalists are among the physicians who partner most closely with hospitals when implementing technology changes [6], current guidelines exclude hospital-based physicians from directly benefitting from stimulus (cont)

(cont) funding as an eligible provider [7]. The primary reason for hospitalists to remain involved is to insure that the EMR changes are introduced in ways that enhance safety and quality of care while having as little impact as possible on productivity; to ignore the coming change will almost certainly lead to higher levels of dissatisfaction. By engaging with hospital administrators, IT personnel and physician colleagues who are working to enhance patient care through the EMR, we are more likely to emerge from this time of change with documentation systems that support both good care and reasonable work flow for hospitalists.

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