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is trying to convince the VA to rebuild on the campus.

Dr. Michael Kaiser, acting chief medical officer of the LSU Health Care Services Division, said at the field hearing that—before Katrina—the VA bought at least \$3 million in services from LSU annually. Before Katrina, 75 Tulane physicians had joint VA-Tulane appointments, and 120 Tulane residents received training at the VA, said Dr. Alan Miller, interim senior vice president for health sciences at Tulane, at the hearing.

Currently, 40 Tulane doctors provide services and training at VA outpatient clinics, which represents \$2.2 million in physician compensation, he said.

The private Ochsner Health System is vying to have the new VA hospital built across the street from its campus in Jefferson Parish.

At the field hearing, Dr. Patrick J. Quinlan, Ochsner's CEO, noted that the site "is

above sea level and not located in a flood plain."

Because the federal government has not agreed to fund a new campus, Gov. Kathleen Blanco signed an executive order allocating an immediate \$74.5 million for land acquisition and planning. To come up with the additional \$1.2 billion needed, the state will float a series of bonds.

And some stalwarts have not given up on reopening Charity. Last year, the state legislature approved a study by an independent team of investigators to see if the first three floors could be refurbished while a new medical campus is put together.

#### EDs Feel Ripple Effect

The lack of inpatient beds and mental health care, and the shortage of primary care sites are felt most acutely in the area's emergency departments.

Two years ago, the now-shuttered Charity Hospital received 120,000 to 200,000 ED visits a year. Granted, there are fewer

people in the city now, but there are more now who come in the door sicker or in need of basic care, said Dr. Jim Aiken of the emergency medicine department at LSU.

"We do a lot of renewing prescriptions and checking blood pressures," and other primary care types of interventions, he said in an interview.

The Interim Hospital sees about 3,500 patients a month. Although things have improved in the last year, the ED is admitting more patients than before the storm, and "we struggle every day with surge capacity," said Dr. Aiken.

Diversion is not uncommon, but the hospitals in the area now at least have a new communications module that lets them track online what's happening at other facilities in the area.

The lack of adequate mental health care, combined with poststorm stress and anxiety, is having the biggest impact on the ED, said Dr. Aiken. It is not unusual for the hospital to be holding 15 psychi-

atric patients at its 31-bed ED, he said.

Charity also housed a crisis intervention unit where the police could take the mentally ill. With that unit gone, those with psychiatric needs have been spread out around the city.

Before Katrina, there were 578 psychiatric and detox beds in and around New Orleans; that number is now at 236, with only a small portion of them actually in downtown New Orleans, according to Dr. Cerise.

The deteriorated mental health system is "probably in my mind the most critical health care issue in this state since the storm," said Dr. Aiken.

Even the LSU system in Baton Rouge has been affected, said Dr. William "Beau" Clark, president of the Louisiana chapter of the American College of Emergency Physicians.

Emergency rooms in that city have absorbed some of New Orleans' outflow, including psychiatric patients who end up boarding in Baton Rouge, he said. ■

## Only One in Four U.S. Physicians Has Adopted Electronic Medical Records

BY TIMOTHY F. KIRN  
Sacramento Bureau

SEATTLE — Despite the government's push to encourage the development of the electronic medical record system, only a quarter of physicians keep medical records electronically, and only 11% of hospitals have fully implemented them, according to Dr. Karen M. Bell, director of the federal government's Office of Health IT Adoption.

In addition, of the electronic record systems in use, probably fewer than half are fully operational, that is, able to take notes, make lab and pharmacy orders, and get lab results, said Dr. Bell at the annual meeting of the American Geriatrics Society.

"The reality of it is that adoption of really good functionality is really very low," she said.

The barriers to widespread adoption continue to be the lack of good, accepted computer applications, and the time and cost, said Dr. Bell.

While it is thought that the use of electronic health records eventually would result in financial savings, start-up costs continue to be prohibitive, she said.

The cost to get every record interface—every office, laboratory, pharmacy—up to speed with appropriate software and hardware may be \$5,000 for each one, and for the nation as a whole it may cost \$50 billion, Dr. Bell said.

At the same time, those who are using electronic medical records are finding that they are not exactly time saving. In part, that is because there is a learning curve involved.

The records also generally require more information than what went into records previously, as part of an

effort to improve and ensure quality.

The government currently has public policy advisory committees to encourage more adoption and to deal with privacy issues—significant challenges, Dr. Bell said.

In the meantime, her office is continuing to develop an exact definition of what is going to be needed in an electronic health record, she added. "There are no standard definitions for any of this stuff."

Other speakers at the meeting described the significant hardship they went through acquiring a system specifically for geriatrics.

The electronic health record industry and its products are geared to the acute care environment, and when they can be used for a facility that cares for older persons, they need to be modified significantly, the speakers said.

"As I was trying to figure out which electronic health records system we would use for geriatrics, I really ran into a lot of roadblocks," said Dr. Irene Hamrick of the division of geriatrics at East Carolina University, Greenville, N.C. "There really is nothing out there that is very good."

Her institution finally chose General Electric Company's Centricity system because it can be used in many locations, such as the home for health care visits. But, the institution found that it needed to tailor the system for specific geriatric needs, adding records of diet and ac-

tivities of daily living, and changing the physical exam form to include sections for foot and mental status exams.

"Very little out-of-the-box software is user friendly for geriatrics. None is totally acceptable to my mind. If you want to use them, you have to adapt them," Dr. Hamrick said.

**Of the EMR systems in use, probably fewer than half are fully operational, that is, able to take notes, make lab and pharmacy orders, and get lab results.**

When the Gurwin Jewish Geriatric Center of Commack, N.Y., began to look for an electronic medical record system, the institution had no idea it would take so long to find and implement one, said Dr. Suzanne Fields, the medical director.

The center found that there are Web sites (such as [www.providersedge.com/ehr\\_links\\_products\\_services.htm](http://www.providersedge.com/ehr_links_products_services.htm)) that can help one find a system, and that the American Academy of Family Practice has a rating form that one can send to vendors to get information on their systems for comparison.

Moreover, the center found a number of products for long-term care. But, the center has both outpatient day care and clinics, and inpatient beds, and none of the products adequately accommodated both, Dr. Fields said.

They, too, found that they had to adapt a system to their needs. In the end, the center combined two products, one for long-term care and another for physician care. The system is not yet up and running.

"It has to be individualized. That's what I didn't realize," she said. ■

## Pharmacists in the ED Enhance Patient Care, Doctors and Nurses Say

WASHINGTON — A 99% majority of emergency department staff said that a clinical emergency pharmacist in the ED improved the quality of patient care, based on data presented at a conference sponsored by the National Patient Safety Foundation.

Drug-related adverse events in the ED remain a significant public health problem. Reports of the success of clinical pharmacists in other hospital areas suggest that the ED-based clinical pharmacists could improve the quality of patient care; however, ED-based pharmacy programs are relatively rare, and their impact has not been well studied.

To assess the ED staff's perception of their facility's emergency clinical pharmacists, Dr. Roger J. Fairbanks and colleagues at the University of Rochester (N.Y.) surveyed a random sample of ED staff members in a tertiary care academic medical center and trauma center that included an emergency medicine residency program.

Anecdotal reports suggest that ED staff members value clinical pharmacists, but no previous studies had addressed the question, the researchers said in a poster.

They collected responses from 33 doctors and other health care providers and 42 nurses as part of a research program supported by the Agency for Healthcare Research and Quality.

A total of 96% of the respondents said that the emergency pharmacist was an integral part of the ED team. In addition, 93% of the respondents said that they regularly consulted the emergency pharmacist, and 93% reported using the pharmacist more in the ED location than in the pharmacist's previous location.

Overall, 47% of the ED staff (55% of physicians and other providers and 40% of nurses) said that immediate availability for consultation was the most valuable role of a clinical pharmacist. By contrast, slightly more nurses than doctors or other providers reported that attending medical and trauma resuscitations was the most valuable role of an emergency pharmacist (38% vs. 22%, 36% overall). Another 7% of the respondents said that the emergency pharmacist's most important role was reviewing orders, and 8% said that the emergency pharmacist's most important role was staff education.

A Web site hosted by the University of Rochester ([www.emergencypharmacist.org](http://www.emergencypharmacist.org)) provides resources for doctors and hospitals that are thinking of adding an emergency pharmacist to the ED.

—Heidi Splette