# EMR Adoption 'Awkward,' Remains the Exception

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.

Although 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, etc.—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.

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

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," she added.

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. However, the institution found that it needed to tailor the system for specific geriatric needs, adding records of diet and activities 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.

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) 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.

And, 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. ■

# Hospitals Are Looking to Physicians As Partners Rather Than Employees

BY JOEL B. FINKELSTEIN
*Contributing Writer*

WASHINGTON — Hospitals are getting smart instead of angry about competition from physicians.

"A lot of care is moving from the hospital to the ambulatory sector, some of which is still under the auspices of the hospital, but increasingly into doctor's offices, into physician-owned ambulatory surgery centers, imaging centers, testing facilities," Dr. Robert Berenson, a senior fellow at the Washington-based think tank the Urban Institute, said at a press briefing on health care costs sponsored by the Center for Studying Health System Change.

Physicians often set up these centers in part out of frustration with hospital bureaucracy, but also in response to economic pressures, said Adam Feinstein, a managing director at Lehman Brothers where he coordinates the health care facilities research team.

"Physician incomes have been going down. They have been looking to make up for the lost income, and they're competing more aggressively with the hospitals," he said.

Over the past 10 years, the number of ambulatory surgery centers has doubled to approximately 5,000.

There are now almost as many surgery centers as there are hospitals in the country. By comparison, there are only about 100 specialty hospitals in the United States, despite all the political attention they get.

**'What we have seen over the last 5-8 years is tremendous interest on the part of hospitals and systems to do joint ventures with physicians.'**

Jeff Schaub, who rates acute care hospitals for the international credit rating firm Fitch Ratings, pointed out that when hospital leadership does not focus on "what their physicians are doing and want to do, we have seen dozens of places have their outpatient surgery volumes cut in half because docs have gone out and put up buildings."

To counteract such trends, "what we have seen over the last 5-8 years is tremendous interest on the part of hospitals and systems to do joint ventures with physicians, figuring that they would rather lose half the business than all of it," he said.

Alternatively, some hospitals have tried to integrate physicians into more of the business decisions, hoping to create a more comfortable environment for them to work and minimizing their desire to go off on their own, Mr. Schaub said.

"It is really interesting how things come full circle," said Mr. Feinstein. "Hospitals were letting doctors partner with them back in the mid-1990s, there was a lot of scrutiny over this so everyone stopped doing it, and now here we are again and everyone is doing it."

There are similarities, but some important differences this time around, Mr. Schaub said.

"In the 1990s, everybody was buying practices just because everybody else was buying practices. Now what I see is a much more strategic focus, whether it's service-line related or to head off entrepreneurs splitting off or to focus on a particular geography, hospitals in a lot of markets are being more selective than they were 10 years ago," he said. ■

# *Families Overriding Relatives' Plans for Organ Donation*

ORLANDO — Patient wishes for organ donation were overridden by family members in about 20% of cases, creating "missed opportunities" for organ procurement, according to research conducted at a level I trauma center in Charlotte, N.C.

Dr. A. Britton Christmas and colleagues at the F.H. Sammy Ross Jr. Center at the Carolinas Medical Center reviewed 3 months of organ donation referrals at their center. They estimated that about 17 potential transplant recipients did not receive organs because a patient's previous donation intentions were overridden by family members.

The research was presented in a poster at the annual congress of the Society of Critical Care Medicine.

The researchers examined charts to determine the appropriateness for donation, familial consent or denial for donation, and the number of organs transplanted from each donor. They compared their records with data from the state department of motor vehicles (DMV) related to organ donation designations.

The researchers analyzed information on 84 individuals who had information on file with the DMV and whose families had been approached by hospital staff for organ donation over the 3-month period. According to DMV records, 25 individuals were listed as organ donors, and 59 had not designated organ donation.

For the 25 individuals who had designated themselves as organ donors, 20 consents for donation were obtained from family members. Of the remaining 59 individuals, 22 consents for organ donation were obtained.

Although the organ recovery rate was higher among those who had already specified a desire to be donors (80% vs. 37%), some families chose to override a previous designation of organ donation. With an average of 3.4 organs transplanted from each eligible donor, the researchers estimated that the five individuals whose consent was withdrawn by the families resulted in 17 potential organ recipients who would not receive organs.

**—Mary Ellen Schneider**

*For additional information on organ donation and the donor shortage, visit www.organdonor.gov.*

Pages 48a—48b