



## What's Wrong with EMRs: The Time Bandits

"The lack of time to do a good job is a particularly strong driver of primary care unhappiness" –  
Institute for Healthcare Improvement (1)

### Time Bandits

To understand the problem with most EMRs you must understand this concept of time – "medical time". The amount of time we have with each patient at each visit is fixed. What we do with that time is very important. If we spend too much time on one specific task (documenting with an EMR) it takes time away from other important tasks. Most EMRs are "time bandits". They hassle us, they take time from other tasks and they get in the way of quality care and quality relationships with our patients.

The Institute of Medicine has stated, "the transfer of knowledge is care". Whether that transfer occurs through dialog, the writing of a prescription, the interpretation of a study, or the performance of a procedure, in order to optimize that knowledge transfer the physician must apply the best science available to the specific patient, taking into account not only the patient's drug allergies, laboratory test results, social, family, and medical history, but also the patient's fears, beliefs, socioeconomic status—in essence, everything that makes the patient unique. To do this effectively requires time: time to listen, time to examine, time to think, time to explain, time to operate, time to interpret, time to comfort (1).

Doctors understand this and this is why many are NOT jumping on the EMR bandwagon. They are NOT convinced that EMRs will help them provide higher quality care or more efficient care (**footnoted article**). They are skeptical about the utility of EMRs and they worry that EMRs will steal their time and make their job harder.

This skepticism is well founded and rooted in medical information technology experiences. Doctors have been misled and disappointed many times in the past with technology that was not "ready for prime time". When computers were first available and practice management programs were being used for the first time, the "early adaptors" lost lots of time and money because the computers and the software did not do what the sales people said they would do. Doctors remember this. They remember being burned in the past by computer software companies and their sales people.

EMRs cost a lot of money and they take a long time to install, implement and learn (**footnoted article**). Doctors are being asked to spend the money and take the time to learn the EMR when they are not convinced it is going to help them or their patients. They are concerned that it will make them less productive and they are concerned that it will adversely impact their professional satisfaction and personal lives. In addition, the payers and the "quality control people" derive all the benefits from the doctor's investment of time, money and risk.

Giving physicians more time in their day is neither simply an issue of personal satisfaction with the quality of their professional lives, nor merely an opportunity for them to generate more revenues. Rather, the issue of time is one which itself has a significant impact on quality and outcomes (1).

Doctors need more time if quality is to be improved, not less time. Can you blame doctors for not rushing to buy and install EMRs? Doctors are not sure about the benefits of EMRs, but they are certain that if you steal their time, you will negatively impact their professional satisfaction and the quality of their care. They are not willing to take the huge risk that buying an EMR would entail.



## **Clinical Support Tools**

One of the reasons we are told we need EMRs is because of the point-of-care, just-in-time clinical support tools. We are told that this will help us improve the quality of care we provide. We are told we need this. Many doctors don't think that they need this type of clinical support from EMRs. Doctors have their textbooks, their journal articles and their usual way of obtaining this type of support. For many doctors, this works just fine. Many doctors worry that embedded in the EMR, these tools have the potential to slow them down and interfere with their relationships with their patients at the point-of-care.

Doctors also believe they know how to practice medicine because they have spent 7 to 10 years in medical school and post graduate training programs (residencies and fellowships) learning how to be doctors. Clinical support tools are nice to have and they can be helpful, but they are not necessary and they can be intrusive, demanding and annoying. These type of tools are a nice feature of EMRs but they are not a compelling reason to get an EMR.

## **Quality Improvement and Incentive Payments**

Another reason we are told we need EMRs is because we will be able to better measure, monitor and manage our practice of medicine. We will be able to improve our care and our skills by getting feedback from our EMR and we will be able to earn pay-for-performance incentives from the insurance companies and Medicare.

There are many problems with this argument. The first flaw in this argument is that many EMRs are unusable. If the EMR is unusable (it takes too much time to use correctly), the information will not get into the EMR properly to be used for all these lofty goals and purposes. Providers will "jerry rig" their systems to get their note done, get their billing done and get their work done. They won't care about the quality improvement reports or the incentive reports that everyone else is so excited about. The quality reports will be garbage because, "garbage in, garbage out".

There are additional problems with this data management argument. First, most insurance companies don't have pay-for-performance plans and there are no plans to implement these programs in the near future. So, why make the huge investment in time, effort and risk for something that does not exist and may never exist.

Second, it is an expensive proposition to try to get these bonuses from the insurance companies and from Medicare. You must collect the data, put the data together in a report and then apply for the money. This takes a great deal of time and effort. Medicare bonuses may not be significant enough (2%) to justify the cost and effort, plus your application might be denied after all that work has been done.

In one major Medicare pilot program (Physician Group Practice Demonstration), 80% of the practices who took the time and effort to earn these incentives were denied their bonus because of rule changes and "small print" exclusions (2). In effect, they were tricked into spending lots of time and money to strive for the bonuses and then cheated out of their monetary reward because of technicalities. Many doctors don't believe that they will actually get the promised incentive compensation from the government or the insurance companies even if they do all the work and fulfill all their obligations. Many doctors do not even believe that doctors will get the money promised in Obama's \$30 Billion EMR Stimulus Package.

There is a complete lack of trust. This skepticism and cynicism is palpable, understandable and justified based upon the past experiences physicians have had with payers and government programs.



The recent bad experience with the Physician Group Practice Demonstration just reinforces physician's feelings and fears. It feels like we are being set up again. Led into a trap where we spend lots of time and effort to accomplish a goal and then the rules are changed halfway through the game when there is no turning back. We do all the work; suffer all the pain, and then the promised monetary reward is withdrawn at the last minute.

### **Granular Data and EMR Design**

Finally, entering information in a "granular manner" using drop down menus and buttons for data mining can be very time consuming and labor intensive. Many EMRs are not user friendly (not easy-to-use or simple-to-use). They think like computer programmers and healthcare executives rather than thinking like clinicians. Doctors who have purchased these systems (or are forced to use them because they are part of a large group or hospital system) wonder whether it is worth the time and effort to enter information in this manner. After all, if you spend a lot of time entering information into the EMR, that "time expenditure" comes at the "high cost" of NOT spending time doing other things for the patient. At the extreme, this type of data entry distracts doctors, forces them to take their "eye off the ball" and could lead to more errors and omissions. Many EMRs have data entry processes that are long, arduous and counter intuitive. These EMRs were designed for the payers and the "quality control people", not doctors. These EMRs adversely affect the quality of care and are bad for doctors and patients.

### **EMRs have to be Time Savers, not Time Bandits.**

EMRs have to make our jobs easier, not harder. Time is THE critical issue. EMRs must help us gather information, chart our notes, issue prescriptions and enter orders in a more time efficient manner. If the EMR can accomplish this task, you will have widespread EMR implementation. Doctors will buy, install and begin using EMRs with zest and enthusiasm. Doctors will even be happy to pay for their EMRs if they bring value to their medical practices and their medical care. It is all about time, quality care and professional satisfaction.

### **The Perfect EMR**

Is there an EMR or a group of EMRs on the market that can accomplish this? The answer is "Yes!" You have to spend the time and do your homework to find them, but they are there. These EMRs are written for physicians. They save time. They help doctors take care of their patients and they enhance the doctor's professional satisfaction. In my next article, I will describe the perfect EMR and show you how to find these awesome clinical tools..

1. Institute for Healthcare Improvement, Engaging Physicians in the Shared Quality Agenda: Innovation Series 2007, page 5-6, [www.ihl.org](http://www.ihl.org).
2. Moore, Pamela L. Pay For What? Physicians Practice, November 2007, page 10. [www.physicianpractice.com](http://www.physicianpractice.com)



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