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Good afternoon. I'd like to share with you reflections of a practicing primary care provider on the meaningful use of HIT.

For context, I am a general internist at MAC in Dbq, IA, a 115 physician multi-specialty clinic. We've had an EHR for 10 years, our hospital has had a different EHR since 2006, and we have been a Level 3 PCMH since 2008.

Dubuque is a town of 60,000 people. The Dartmouth Atlas identified Dubuque as having the absolute lowest costs of care for hospitalized Medicare patients in the last two years of life of all 360 MSAs. Dubuque has the 2nd lowest global costs of care for the commercial population. And the Commonwealth Fund has identified Dubuque as the 2nd highest performing healthcare system in the country.

As I think of these achievements, I realize that the EHR has been essential, especially for our medical home model.

It allows us to share information with patients and to increase patient engagement. For example, we can provide each patient with an updated medication list at the end of each appointment to lessen the chance of medication errors. We can track every test to ensure nothing falls through the cracks. We want to leave nothing to chance.

It allows us to share information across settings. When a patient calls in the nurse can immediately pull up their information. When I am in the hospital I can access the patient's clinic information, and visa versa, when in the clinic I can pull up hospital records for the patient. This makes it less likely that there will be a blind spot in the patient's care or that tests will be repeated unnecessarily.

Through our web portal we invite patients to communicate with us electronically between visits.

But it would be misleading to imply that the transition has been easy, or that our work is done. In many ways it has been a bumpy road.

Here is a physician in Alaska: "I used to be a doctor, now I'm a typist."

There is this issue of continuous partial attention. Whatever amount of undivided attention we can give to our patients—that is the essence—that is where good things happen. But I am concerned that this essence is being increasingly crowded out by the growing administrative and clerical responsibilities that have been directed to the physician. We risk utilizing the majority of the 15 minute visit for clerical work.

So there is this gap between the promise, and the incredible power of this tool, and the reality we experience on the front lines. The first generation of tools and policies are not yet sufficiently aligned

with new models of care. My nurses and I have developed a strong team-based model of care. But we are daily constrained by the limitations of our EHR and by policies that inhibit teamwork.

There is also an efficiency issue. Over the last several years I've shadowed over 40 primary care physicians and their staff. One of the constants is the need to take home 2 hours of inbox work every night to be done after the kids go to bed. This is a recipe for burnout and a threat to career satisfaction. And because a strong foundation of primary care is essential for a high performing healthcare system, this has implications for the things we value and care about in the US Healthcare system: achieving the 3 part aim of improving experience of care for patients, improving quality and reducing cost.

So the take home message I'd like to leave with you is that the first generation of EHRs and EHR implementations has been both a blessing and a burden. That we would never go back, but we need to keep moving forward.

Some recommendations: This new technology demands a new delivery model and a new type of support staff. I would like to see community colleges ramp up their training of Associates Degree RNs with information management skills to help meet this need.

We need policies and technology that align with a team-based model of care. While I fully endorse Meaningful Use, I am concerned with the provision that prohibits a receptionist from keyboarding in the orders for labs and mammograms, thus adding a new and unsustainable burden onto nurse and physicians.

Finally we need a regulatory and commercial environment that fosters the rapid evolution of HIT in a way that mirrors the pace of improvement in technology in the rest of our lives.

Thank you. I look forward to your questions and comments during the discussion.