CIR VITALS

Fall 2011

Residency in a Digital World: A Look at Health IT

INSIDE THIS ISSUE

PRESIDENT'S REPORT

HILLARY TOMPKINS, MD

Creating a Strong Network of Residents, Online and Off

It is with great excitement that I am writing my first President's Report. I have been actively engaged with CIR ever since I attended medical school at Boston University and have represented my colleagues on the CIR Executive Committee for five years. Throughout my residency and fellowship, I have watched as the practice of medicine and delivery of healthcare has changed on a local and national scale, and so too have we as physicians and as an organization.

We should be active participants in shaping how health care is delivered as residents and throughout our careers.

I'm optimistic about what we can accomplish this year. Led by a smart, enthusiastic and diverse Executive Committee, CIR leaders around the country are vocal advocates of health-care reform, and we continue to speak out on the importance of maintaining Medicare and Medicaid, especially in this time of economic decline.

In July, I had the privilege, along with Massachusetts Regional Vice President Dr. Jessica Eng, to visit the White House and Capitol Building to tell our representatives to stand strong against blanket cuts to Medicare and Medicaid programs. Many of you also helped by signing CIR's petition to our nation's leaders. Thank you! It is important that our voices be heard when decisions about health care are being made and this was never so evident to me as it was during my time in Washington, DC.

As our hospitals and our patients are affected by the economic downturn, cost-conscious medicine and quality improvement are increasingly important. In this edition of *CIR Vitals*, CIR members discuss how they're getting involved in quality improvement initiatives and efforts to extend and improve information technology. We highlighted some of these issues at our national convention this year and continue to engage in opportunities to improve care, such as our participation at the Telluride Patient Safety Educational Roundtable this past summer.

One of CIR's strengths is that we represent residents across specialties and in all different types of hospitals, from highly-networked facilities to small safety-net hospitals that are struggling to implement an EHR for the first time. When we started to look at how technology is used in CIR hospitals, we found a range of answers. One resident at UCSF and San Francisco General Hospital actually developed his own iPhone and iPad application, which you can read about in the Resident Spotlight section. Residents at other hospitals have negotiated for expanded educational funds in order to purchase tablets, and are learning how to integrate those devices into their work. These are just a couple examples of the way health IT is shaping our experience. We would love to hear from you about how this plays out in your hospital or your work life. You can contact me directly at president@cirseiu.org, and also go to www.cirvitals.org to weigh in.

Correction: *In the Summer 2011 issue of* CIR Vitals*, Dr. Matt Vasey was incorrectly identified as a PGY 1 in Emergency Medicine. He is Chief Resident in Emergency Medicine at Lincoln Hospital. We regret the error.*

CIR VITALS

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"May your organization prosper for many years to come! Its purpose and goals are so important to our country."

Dr. Carolyn Koffler

Dr. Carolyn Koffler Honored at 2011 National Convention for a Lifetime of Service

In 1937, resident physicians actually lived in their hospital dormitories. This was long before residents were given a voice in their workplace. Long before most residents were paid for their endless hours on the wards. But in 1937, Carolyn Koffler, MD, DrPH, was one of six interns who negotiated the first salary for resident physicians working in New York City public hospitals.

"I remember spending all of my free time writing letters to the editor, calling assemblymen …. Hospitals weren't well-enough staffed with attending physicians, they weren't available, but the interns were always there. I'd become an expert at dressing so quickly—we were always on call," she said.

Dr. Koffler recalled meeting with Mayor LaGuardia when she and her colleagues lobbied the city government for a fair wage. "[We] begged Mayor LaGuardia to understand how overworked we were, and received no compensation for any of it. He said that 'we should be glad that we weren't being charged' for having such a great experience; we were learning so much."

Despite the Mayor's protests, Dr. Koffler and the Interns Council were ultimately successful in their efforts, and began earning salaries of $15 a month. After completing her residency, Dr. Koffler earned her doctorate from the Yale School of Public Health and continues to this day to advocate for a universal healthcare system. At CIR's National Convention in Chicago this summer, CIR honored Dr. Koffler, now 98, for her pioneering efforts and unrelenting dedication to her mission.

Dr. Koffler wrote to CIR to thank everyone for a wonderful weekend at the convention. "I don't think I'm capable of explaining to you the joy that I experienced as a result of your invitation to me to participate in your convention. To learn of the extensive work you are doing improving patient care and safety, providing better communication among hospital workers, etc., in addition to your efforts to improve housestaff benefits and better working hours is so impressive. May your organization prosper for many years to come! Its purpose and goals are so important to our country."

To watch videos of Dr. Koffler telling her story, visit ***www.youtube.com/cirseiu****.*

ALUMNI CORNER | Dr. Nailah Thompson

In Implementing Electronic Records, Don't Forget the People

The most valuable thing about EHR is the data and the control it gives you. I can see all of my patients, filter for diabetics, filter for those who are uncontrolled and focus on getting them in for screenings. We have easy access to data that was unimaginable with paper but none of it matters if I can't even get my password to work.

Having completed residency training in a largely paper-based hospital, former CIR Executive Vice President Dr. Nailah Thompson reflected on transitioning to her new position in Internal and Preventative Medicine in the fully electronic Kaiser Permanente in Oakland, CA.

When we speak of EHR, we extol its virtues in creating a safer, more efficient patient care setting. Yet one of the greatest barriers to creating this more efficient system is the providers themselves. In addition to cost and technological hurdles, hospitals face the challenge of training physicians and healthcare workers to adopt and be proficient in an entirely different work flow. We asked Dr. Thompson to share her experiences working in a fully electronic health records system. Kaiser Permanente is an industry leader in health IT, recognized by the Healthcare Information and Management Systems Society for its implementation of EMR.

Why did you choose to work at Kaiser?

I wanted to work at Kaiser because the position I have now blends primary care and preventative medicine. Its focus on public health provided opportunities to do a lot of community work.

Kaiser Permanente has a fully electronic medical records system. What does that look like on the ground?

Kaiser's EMR is very intergrated. I can have a patient come from any other Kaiser hospital in California and have their information. Everything from the patient's chart to notes from specialists are all immediately available. The entire hospital — radiology to pharmacy to physical therapy — uses the same system.

How does EHR improve your day-to-day work?

During residency [in Internal Medicine at Alameda County Medical Center in Oakland, CA] and at a small community hospital I worked at in Northern California, we were still using paper charts. What really sets my work apart now is the access I have to data. I can look at all my patients, filter for diabetics and for how many of them are controlled. If only 20 percent are, I can focus on getting those patients in for check ups and screenings. That's not possible with paper charts. Not only can you not get these kinds of measures, you often don't even know how many patients you have.

It also makes the doctor's work much more streamlined. You can include prompts for all sorts of measures: blood pressure screenings, mammograms, colon screenings. And the physician doesn't have to commit these to memory. In fact, other staff can be sure to prompt patients for preventive measures as well. You can have reminder messages automatically sent to patients and you can communicate with them through the health net [the hospital's online patient communication system].

How did you adjust to working with EMR?

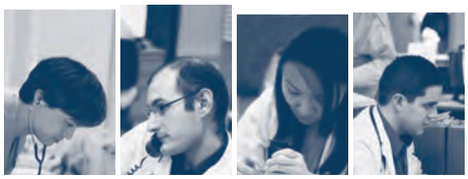
There was definitely a learning curve but what's really helped me adapt quickly is learning from my colleagues. You can't be afraid to ask questions. The hospital has implemented programs like a physician mentorship program and a year-long physician orientation program that create a supportive environment for continued learning.

What factors do you think are most important in creating an efficient EHR system?

Training. We received one full week of training on the system. It's so important because learning on the job just doesn't work. We ran through everything—logging in, checking patient charts, checking email—with the hospital's IT staff. We were able to troubleshoot many of the inevitable problems, so you are not unable to access a patient's medical history because you are sitting in front of your computer trying to get your password to work.

Dr. Nailah Thompson served as CIR Executive Vice President, Regional Vice President and Delegate during her residency and fellowship.

AROUND THE UNION



CIR members at **Santa Clara Valley Medical Center** in San Jose, CA successfully negotiated a new contract in August that provides new gains in future years as well as several non-monetary stipulations in the contract that will improve resident life. At a time when all county unions were being asked for steep cuts and concessions, CIR was able to hold onto many of the key benefits in the contract, such as 100 percent reimbursement on medical license applications for categorical residents, and up to $2,500 for the mandatory AIRP conference for radiology residents. All residents will be reimbursed fully for Step 3 exams. The bargaining committee is also working towards quarterly IT walk-throughs to ensure working computers.

At the **University of New Mexico,** CIR contract negotiations this summer yielded several improvements. Residents won a $100,000 increase to the meal fund over two years and $80,000 for the Patient Care Fund over two years, as well as improved reimbursements for Step 3 and other expenses. The resident negotiating team also negotiated some innovative provisions such as a resident-only meditation/prayer room, which was being completed over the summer, and a new resident and family counseling services provider. They also became the latest hospital to pursue quality improvement in collaboration with the administration. A Joint Quality Improvement Committee was formed with an initial pool of $20,000 allocated for resident incentives if mutually-established goals on quality are met.

Photo Credit: Ivy Quicho/CIR

Counting the ballots: The Santa Clara housestaff ratified a new contract on August 22, 2011.

CIR Mourns the Passing of Former Secretary-Treasurer Dr. Kevin Mack

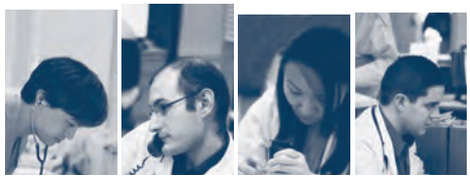
CIR lost a former leader and San Francisco General residents lost a beloved mentor and professor on July 14 when Dr. Kevin Mack was killed in a collision on his way to work.

There was an outpouring of grief at San Francisco General and its affiliate, UCSF, over the tragic death of Dr. Mack, 52. He was a staff psychiatrist at SFGH and an associate clinical professor in the UCSF Department of Psychiatry. He was also Director of Educational Technology and Faculty Development in the UCSF-Berkeley Joint Medical Program, an Advisory College mentor, and a member of the Haile T. Debas Academy of Medical Educators.

Before becoming a faculty member at UCSF, Dr. Mack was deeply involved in CIR as he completed his residency at Cambridge Hospital. From 1998 to 1999, he served as CIR's National Secretary-Treasurer and before that had served as Regional Vice President for Massachusetts.

In a statement by CIR delegates at San Francisco General, they said, "He was a beloved educator and physician and mentored dozens of trainees in all fields of medicine, touching countless students, residents, and peers through his bright, inspiring, committed presence. Dr. Mack's greatest joy came from being an educator, and in his own words, 'from helping people use their own sense of wonder and inquiry to find and fuel their passion...whether that be in science, arts, or something else entirely.'"

Dr. Mack will be sorely missed by CIR members and staff, by his colleagues and his patients. He is survived by his S husband, Naoki Nitta, and his two small children, Chiaki and Nobu. A memorial site has been created at **www.forevermissed.com/kevinmack**.



New Additions to the CIR Executive Committee

CIR welcomes two new Regional Vice Presidents to its leadership: Dr. Jessica Eng and Dr. Rafael Hernandez.

Dr. Eng, a second year Geriatrics Fellow, was appointed to fill a vacancy in Massachusetts. She brings nearly five years of experience as an active union member and delegate at Boston Medical Center. She is currently involved in quality improvement initiatives and patient advocacy at BMC. About her new role in CIR Dr. Eng says, "CIR has become an integral part of who I am as a doctor and I've really learned a lot throughout my time as a member. As Massachusetts Regional Vice President, I look forward to helping CIR improve resident involvement in additional QI projects."

Dr. Hernandez is a second year Internal Medicine resident at Woodhull Medical Center in Brooklyn, New York.

He joins the CIR executive committee with experience as a delegate and as the chair of his hospital's Housestaff Safety Council. Dr. Hernandez was one of two CIR leaders who attended the Telluride Patient Safety Educational Roundtable this year and has been working closely with colleagues and administrators at Woodhull to implement patient safety measures.

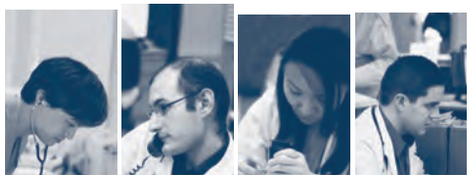
He is filling a Regional Vice President position vacated by Dr. Abimbola Pratt from Methodist Hospital, who resigned earlier this year due to the time demands of his residency program.

CIR Attends Lucian Leape Institute Forum & Gala

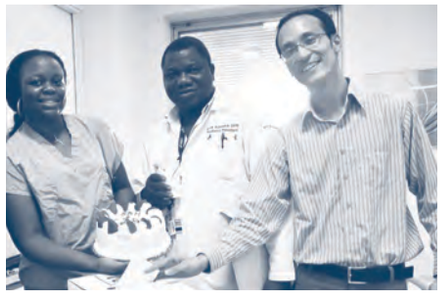
Current and former CIR leaders Drs. Shoaib Afridi, Jessica Eng, Sarah Sloan, Clinton Pong and Bijay Acharya joined CIR President Dr. Hillary Tompkins, Executive Director Eric Scherzer, and Policy Director Sandy Shea in Boston for the Lucian Leape Institute's fourth annual patient safety conference and fundraiser on September 22. Renowned physician and writer Dr. Atul Gawande capped off the event with a talk on the value of coaching—a practice that the world's greatest athletes employ, but most physicians and other professionals do not. "Since I have taken on a coach, my complication rate has gone down," Dr. Gawande said. "We care about results in sports, and if we care half as much about results in schools and in hospitals we may reach the same conclusion."

Policy and Education Initiative Takes Flight

The **CIR Policy and Education Initiative** (PEI) will continue its patient safety work with NYC's Health and Hospitals Corporation (HHC) thanks to a recent grant from the Federal Mediation and Conciliation Service (FMCS). This time the focus will be on medication safety and teamwork. In the last twelve months, the nonprofit organization has also sponsored workshops on alternatives to medical malpractice litigation; hosted AMSA's Health Equity Leadership Institute; and convened a patient safety conference (on reducing hospital-acquired infections) in conjunction with HHC and a number of other healthcare unions. The PEI is also sponsoring a conference on The Art of Medicine: Physician-Patient Communication on November 19 in New York City. To learn more about the CIR Policy and Education Initiative, please visit **www.cirpei.org**.



A New Era as St. Barnabas Housestaff Settle First Contract



On August 10, 2011, St. Barnabas housestaff ratified their first collective bargaining agreement. It afforded them mechanisms to improve patient care, salary increases and a solid platform to address issues jointly with the administration.

It marks a major change since the residents began organizing. In early 2009, galvanized around providing quality patient care and a better standard of living for housestaff, a group of nearly 30 St. Barnabas residents stood outside of the hospital CEO's office with a petition signed by 87 percent of the housestaff, demanding a platform to advocate for themselves and their patients.

"Whenever we'd ask for even the simplest things to improve patient care, we were just told there was nothing we could do about it. We all wanted change," said Dr. Addison Chan, a former Emergency Medicine resident.

The salary and benefits at St. Barnabas lagged behind other hospitals in the region. "As an intern, I remember looking at other programs and seeing they had funding for book allowances and conferences and better salaries.," said Dr. Chidi Ogbonna, a former Podiatry resident. "When I first heard residents talk about organizing, I thought 'finally!'"

The housestaff built the effort through regular interdepartmental meetings. "The cafeteria was our campfire...it was clear that everyone was frustrated. We saw the hospital spending money on cosmetic improvements like building a new entrance...[yet] they were raising the cost of our healthcare. We saw waste and we thought we should have a voice in those decisions," said Dr. Chan.

The residents met resistance throughout the campaign. After presenting the petition, CIR filed for recognition with the National Labor Relations Board (NLRB), which certifies union elections for private sector employees. The St. Barnabas administration challenged the doctors' right to form a union, claiming that they were students, not employees, and therefore ineligible to unionize. Months of NLRB hearings followed.

Dr. Sara Lary, a former Emergency Medicine resident, gave eight hours of testimony before the board. "I never thought about it as a win or loss. It [was] a struggle to do the right thing at the right time," she said.

The regional board affirmed the resident's status as employees; however, the hospital administration disagreed with the ruling and appealed to a higher court. Housestaff voted in a union election but those ballots were impounded and left uncounted while the residents and hospital awaited a federal hearing.

"The most frustrating thing was just getting to the place where we could actually have negotiations...even after we voted the hospital didn't want to recognize us," said Dr. Ogbonna.

On June 21, 2010, the NLRB board announced it would not hear the hospital's appeal and the ballots were counted. Residents had overwhelmingly voted to join CIR by a vote of 117 to 2, paving the way for negotiation of the very first housestaff contract at St. Barnabas. After 11 months of bargaining, the residents ratified their new contract 134 to 7.

"We were behind many hospitals in the area and we've begun to catch up. CIR gives us a direct line to the administration to work together to make improvements in the hospital," said Dr. Ernesto Badui, an Internal Medicine intern.

"We believe the agreement works for all parties concerned," said St. Barnabas CEO Dr. Scott Cooper. "We look forward to enjoying a positive and fruitful relationship with CIR for years to come." The hospital has already begun to co-sponsor community health projects with the new CIR chapter.

"What I remember most is how people stepped up. You'd get beat up on a 24 hour trauma call, take a shower, put on a suit, and head right over to meet with elected officials. It was just that important to us. To know what we went through and know that the current residents toughed it out to settle a contract, I'm just really proud of them," said Dr. Chan.

SPOTLIGHT ON Dr. Brad Cohn

CIR Resident Combines Mobile Technology and Medicine

San Francisco General Hospital (SFGH) is a far cry from the high-tech world of Silicon Valley, which is just 40 miles south of the hospital. But a CIR delegate has found a way to harness that innovation and technological advancement to improve medical care at the public hospital.

Anesthesiology resident Brad Cohn co-created MediBabble, a free mobile translation application that's used by more than 12,000 healthcare providers. The app, which launched with five languages and just added a sixth, is free and available for download by anybody with an iPad or iPhone.

San Francisco was a natural place to pioneer the technology, Dr. Cohn said. "Being at UCSF, it's a pretty culturally diverse area. You could walk into the hospital and find 10 different patients who speak 10 different languages."

Dr. Cohn, now a PGY 2 at the University of California San Francisco and a CIR delegate at SFGH, developed the idea for MediBabble while a medical student at UCSF. He and his classmate, Alex Blau, were commiserating over language barriers after a frustrating shift at SFGH. While the hospital offers assistance in more than 65 languages through a combination of staff medical interpreters, a telephone language line and a video medical interpretation system, it's not always sufficient, particularly at night and on weekends.

"You want to bring resources to bear as quickly and effectively as possible for your patients and it's frustrating," Dr. Cohn explained. "That was the motivation for this project, and the more we thought about it the more potential we saw in it."

The concept, although simple, has grown into a fairly sophisticated tool. Currently available in Spanish, Cantonese, Mandarin, Russian, French and Haitian Creole, the app contains thousands of commonly asked questions and instructions, organized by system and symptom to facilitate both comprehensive and targeted medical history-taking.

Drs. Cohn and Blau focused on medical history-taking because most diagnoses come from the patient's self-reported medical history, something that can't be accomplished effectively if there are language barriers. They were fortunate to have the support of Dr. Lawrence M. Tierney, a professor of medicine at UCSF School of Medicine and Associate Chief of San Francisco's VA Hospital. Dr. Tierney is also the author of the

Photo credit: Cindy Chew

seminal text on evidence-based history-taking. The application offers audible translations of common questions, voiced by native speakers. The initial languages were added based on the patient population at UCSF and SFGH. Haitian Creole was added in response to the 2009 earthquake in Haiti, in an effort to support relief workers who didn't speak the language.

Dr. Cohn hopes that the international use of MediBabble will expand over time. His residency program offers a special track in global health, which will offer him four months out of the next two years he can dedicate to the project. "I want to make this available to providers abroad who may not be as connected to the networks that we've been able to distribute it through here." Judging from its application in Haiti, it holds a lot of potential for international and emergency use.

In order to be accessible in resource-poor areas, whether they're safety-net hospitals or disaster-struck areas, MediBabble is fully functional without Internet connectivity, as well as in commonly shielded environments, such as hospitals, emergency rooms and radiology suites. It comes pre-loaded with Spanish and then users can add additional languages as needed.

A question that always comes up is how MediBabble users can understand the responses if the patients answer the questions in their native languages. Dr. Cohn explained that the application "doesn't back translate." It uses yes or no questions, or asks patients to point to the part of their body that's affected.

Acknowledging its limitations, Dr. Cohn said, "It's really only for collecting information. You can't give information, and our greatest concern was misinformation by pressing a wrong button. It won't replace a medical interpreter, it'll just extend the reach."

Dr. Cohn's work on MediBabble is in keeping with the ideals that brought him to the medical field in the first place. A California native, Dr. Cohn went to the University of California at Irvine for college, without a clear idea of what career he would pursue.

"I went abroad to learn Spanish and

see MEDIBABBLE on page 9

Keeping Humanism in Medicine: The Cambridge Intern Oath Project

How do you create a meaningful ritual? The Arnold P. Gold Foundation, devoted to instilling and nurturing humanism in medicine, has some experience. They are credited with establishing what is now a medical school tradition everywhere—the White Coat Ceremony.

Now the Foundation, which mentors medical faculty, sponsors the Gold Humanism in Medicine Honor Society and works to improve physician-patient communication, is piloting a program to establish a residency ritual. In June 2011, interns at the Cambridge Health Alliance in Cambridge, MA—about to embark on one of the most challenging years of their lives—were one of the first intern groups in the country to collectively author an Intern Oath.

Funded by a Gold Foundation grant, CHA faculty Drs. Liz Gaufberg and Maren Bataldin met during orientation with the interns to discuss what promises they would make: to their patients, their colleagues, their family and friends and themselves. Spirited large group discussion and refinement by a smaller group of volunteer wordsmiths produced the first ever Cambridge Health Alliance Intern Oath. The Oath is now a poster displayed on the on-call room suite wall and also reduced to an individual pocket-sized card for each intern.

Interns at Cambridge said they saw the oath as a good reminder to keep them from losing perspective during residency.

"We're starting residency, something very big and requiring lots of hard work, and the oath exercise was a very important process that gave us the opportunity to reflect on and clarify our goals and remind us of our reasons for becoming doctors," said Adam Elias, a psychiatry intern.

"We envision the Oath as a touchstone and we plan to revisit it throughout residency," says Dr. Gaufberg. However, she readily acknowledged, "It is not easy to keep these promises."

To read the Cambridge Intern Oath go to www.cirseiu.org. For more information about the Arnold P. Gold Foundation Intern Oath Ritual (including how to apply for start-up funding), visit www.humanism-in-medicine.org.

Photo credit: Sefra Bell-Masterson/CIR

Cambridge interns Dr. Rebecca Rogers (Medicine) and Dr. Adam Elias (Psychiatry), with the Gold Oath, which they carry around in their white coat pockets.

CHA Facts

Hospital: Cambridge Health Alliance

CIR Chapter: Cambridge House Officers Association (1976) and affiliates with CIR (1993)

Number of Housestaff: 115

Specialties: Internal Medicine, Adult and Child Psychiatry and Podiatry

Academic Affiliation: Harvard Medical School

MediBabble (CONTINUED FROM PAGE 8)

happened to pick a medical-themed program in Ecuador, so early on in this process I was excited by international health work," he said.

Dr. Cohn became involved in CIR during contract negotiations at SFGH and was elected delegate for 2011-2012. He was especially interested in protecting and expanding the Patient Care Fund, which allows residents to purchase critical equipment and fund community programs that benefit their patients.

With all the time pressures of his residency, he estimates he spends 20 hours a week on logistics and marketing for MediBabble. He credits the rest of the team for moving it forward: Dr. Alex Blau; Zhanna Shamis, a user interface designer; David Cairns, software engineer; and Janice Holve, JD, MBA, marketing and legal counsel.

Dr. Cohn feels lucky because not only does he get to continue to be involved with the software as it expands to include new features and new languages (Hindi, Urdu, German, and Gujarati, to name a few), but he actually gets to use the app in his own practice and see it in use by his peers.

"Even this morning I walked into an exam room and saw someone using it," he said.

The Bumpy Road To EHR Implementation
CIR Residents Assess Their Hospitals

It's the new American Dream. A Georgia native, hiking in Utah, suffers a fall and is transported unconscious to the region's community hospital, where the physician on call carefully reviews the patient's allergies and medications in the center's database and modifies the treatment accordingly. Once stabilized, he's transferred to a major hospital in Salt Lake City for a few days before returning to Atlanta, where he follows up with his hometown PCP two weeks later. No papers are exchanged. No faxes. No request for medical records. There are no delays in treatment. The tests aren't duplicated and the results are complete, easy to find and easy to read. This is an America with a universal electronic health records system.

We're not there yet. And the truth is we may never get there. And it's absurdly expensive. But most residents agree: electronic health record systems, however imperfect, are improving patient care.

Congress passed the American Recovery and Reinvestment Act (ARRA), which provides $19 billion for the Health Information Technology for Economic and Clinical Health (HITECH) Act, and thus paved the way for nationwide adoption of EHR systems, offering a minimum of $2 million (and potentially much more) in incentives for EHR technology to hospitals that meet certain "meaningful use" qualifications.

Propelled by government funding and the looming threat of financial penalties to those who don't fully adopt a certified EHR system by 2015, healthcare providers are anxiously shopping around, inundated with sales pitches from technology companies eager to take advantage of this new flush of cash. In the rush to allocate stimulus funding, are the best decisions being made? Well-known healthcare blogger Maggie Mahar wrote recently in *Health Beat*, "In 2020 or 2025 many hospitals may discover that the choice they made in 2014 was less than optimal, and now they must strip out the old system, and install a new one."

What promise does EHR have for CIR hospitals? According to a survey completed by 109 residents at the 2011 CIR Convention, 82 percent use electronic medical records in some fashion, such as physician order entry (74 percent); inpatient records (76 percent); and outpatient records (69 percent).

"It's sold by IT people to IT people, and IT people don't understand what we need."

Raised in the tech generation, residents have taken the lead not only to incorporate EHR tools into their practices, but to improve upon them. CIR residents are participating in their hospitals' Health IT meetings, pushing for the integration of tablets, and taking advantage of the technology to check in on patients from home, fuel their research projects, and document quality improvement measures. *CIR Vitals* spoke to residents throughout the country to see how CIR hospitals are meeting the challenges of implementing EHR systems.

WHERE WE ARE NOW

"For as long as I've been working in a clinical setting, computers have been a tool to help people do things faster. But it all depends on the software that's written. [EHR] software isn't designed with doctors in mind," said Dr. Neeraj Modi, a PGY 4 in Radiology at Bronx-Lebanon Hospital Center. "It's sold by IT people to IT people, and IT people don't understand what we need. Unless you're involved in both sides and understand both medicine and technology, there's going to be hiccups."

Dr. Robert Leviton, Bronx-Lebanon's Chief Medical Information Officer, said, "One of the challenges is to create user interfaces that are easy to use so doctors don't have to become information technologists." Always looking to improve the system, the hospital is a founding member of The Bronx RHIO (Regional Health Information Organization), a health information exchange that enables networked hospitals, individual physicians, and additional healthcare providers in the Bronx to view and share patient information, creating integration between hospital and local physician on a community level. They're encouraging local physicians to take advantage of HITECH funding to set up their own EHR systems that will integrate with Bronx-Lebanon, but while private practices make the digital transition, the hospital also has the technology to auto-fax a patient's records to physicians who still rely on paper charting.

Of course, software is not the only barrier to full implementation of EHR technology. Dr. Michael O'Neill, a PGY 2 in a dual Internal Medicine/Pediatrics program at Jackson Memorial Hospital in Miami, explained that in pediatrics, physicians input orders into their software system, but in IM, physicians handwrite the orders and a nurse inputs them; it's a redundant process that introduces room for error.

When Dr. O'Neill took his concerns to the IM program directors, they introduced him to the logistical nightmare EHRs could create. "You have

to consider: (1) Do we have the physical hardware? Do we have enough computers on the floor, or do we need more, and if so, how are we going to pay for them? and (2) Now we need more training—for both doctors and nurses; and (3) Do the nurses have enough computers [so doctors and nurses can issue and monitor orders at the same time without causing delays]?"

Lack of sufficient equipment is apparently not a new problem; 43 percent of CIR's 2011 Convention survey respondents said waiting for a computer caused work interruptions on inpatient service. LAC+USC even negotiated for 100 additional computers in recent labor management meetings. Because computers are expensive, clunky, and stationary (or, with a little innovation, awkwardly mobile), many hospitals are exploring the functionality of handheld devices, such as iPads.

"It takes time, it takes money, and it takes training. Nothing is ever cut and dry," Dr. O'Neill said. But the systems are always improving. Physicians in IM will soon be inputting orders into the computer themselves, just like pediatrics.

HOW EHR IS IMPROVING PATIENT CARE

"For our patients and our hospital, EHR use is at close to 100 percent. There's a big Medical Records Office with old paper charts that I'd like to see disappear. Having everything readily available so when someone comes in in the middle of the night [accessing old records] isn't an issue," said Dr. Scott Stein, a PGY 3 in Internal Medicine in New York's St. Luke's-Roosevelt Hospital Center, discussing improvements he'd like to see in his hospital's EHR system.

Having discharge summaries online really helps patient care, Dr. Stein said. "It minimizes the detective work we have to do in clinic because many times patients don't know why they're there. Having the EHR pulls up that information immediately."

St. Luke's-Roosevelt has adopted the software eClinicalWorks to expedite the note-writing process. Dr. Stein said, "We can't see the same volume of patients when we're first learning. Every time you talk about expanding EHR you have to incorporate a learning curve. But once you've mastered it, it's better than reading paper charts. It's better than reading horrible handwriting, which is a big problem in the profession."

Adopting new software can be a tedious process, but it usually pays off in the end. Jackson Memorial Hospital's Internal Medicine department has just started using the software PowerNote—a program that enables physicians to quickly document notes by clicking on evolving paths based on previous information entered and selected, so the computer forms prewritten paragraphs. It's particularly useful in departments with significant turnover, such as the Emergency Department.

43 percent of CIR's 2011 Convention survey respondents said waiting for a computer caused work interruptions on inpatient service.

"It's kind of a pain to learn, but a lot of [residents] are really starting to enjoy the benefits of being able to write their notes a little faster," Dr. O'Neill said.

Dr. Jenna Godfrey, a PGY 3 in Orthopaedics at the University of New Mexico Health Sciences Center, said, "The one [bad] thing that happens at our hospital is that it promotes laziness because it's easy to copy and paste your notes from the day before, whereas with handwritten notes you *have* to write them again, and reconsider, 'Did I look at all the new labs? Is the patient in the same condition?'

"Overall the benefits of EHR outweigh any of the drawbacks. It's significantly safer," Dr. Godfrey continued, explaining that EHR had improved patient safety and reduced the rates of medical errors. "There are so many things to remember when you're writing orders …. Having [all medication and dosing options] come up on the computer is really helpful. The decimal point is never misplaced like it can be on illegible handwritten notes. All pharm orders go automatically to the pharmacist who can check for accuracy.

"One of the things we're starting in our department is the SCIP protocol. There's a lot of Medicare and Medicaid regulations we need to meet now, such as, 'How quickly did you get the Foley out? How quickly did the patient get antibiotics?' These reminders and alerts are triggered through EHR, and you can regulate across the departments and hospital. EHR is a huge benefit for [monitoring] those things."

Dr. Leviton at Bronx-Lebanon suggested that tracking patient progress on micro and macro levels would be a huge benefit, both for individual patients and for the entire healthcare industry. "We are able to identify if a patient has been in a hospital in the last 30 days. We can track and trend the number of tests and labs and look back retrospectively and make decisions based on that. We can get

see EHR Implementation on page 12

EHR Implementation (continued from page 11)

alerts and warnings that there are certain tests physicians need to order. Decision-making happens more regularly."

WHERE ARE WE GOING?

"You have to think about health care in terms of the community. Patient, doctor, hospital—and within the hospital several departments, testing, radiology, consultants.… In this connected community, you want to share information among everyone," said Dr. Leviton. "EHR is not just a record, but a tool that can be used by the healthcare system to communicate about a patient."

Patient Portals and The Bronx RHIO are Bronx-Lebanon's answer to physician-community building. Jackson Memorial Hospital in Miami has mandated that all of its campuses and clinics use the same integrated system, and LAC+USC is building relationships with other LA County hospitals and is in the process of giving residents access to the records at their partner hospitals.

"By obtaining access the hope is to be able to provide better quality and more cost-effective care by understanding the workup and treatment that has been done at another county institution and not needing to repeat studies," said Dr. Wendy White, Chief Resident in Emergency Medicine at LAC+USC in Los Angeles. For patients who have been seen at outside hospitals and clinics, they still go the traditional route of requesting medical records, which can delay care or increase costs if studies need to be repeated, and it takes physicians away from other patient care activities, she said.

Like GPS and the Internet, electronic health records have benefited greatly from government initiatives. The VA hospital's EHR system is a case in point. It may not have all the bells and whistles that its private competitors have, but it works simply, efficiently, and seamlessly.

"That's what's so great about the VA," said Dr. Godfrey, who rotates through the VA in Albuquerque. "The VA's EHR system is really basic. But it works the best out of all of the EHR systems. You can connect to their medical records from anywhere in the country. You can find out so much about a patient, what's been done. It's huge. There's all this talk about integrated EHR nationwide. I don't know how feasible that is, but it would be awesome."

"It would be more comprehensive," Dr. O'Neill said. "Really what should happen is that it should be a government run thing where the government comes up with the best EHR and then everyone uses the government database, but people are afraid of the government running the EHR."

This is perhaps one reason the federal government has not mandated that all physicians use the same system, but physicians will be penalized if they have not yet transitioned to some type of government certified EHR system by 2015.

MEDICINE ON THE GO

UNM's Orthopaedics residents were some of the first physicians at UNM to start using handheld devices, propelled by encouragement from their chairman and

Word from the Wards

Doctors at two CIR hospitals, New York Methodist Hospital in Brooklyn, NY and the University of New Mexico, recently negotiated the right to use their educational funding to purchase iPads. We asked residents, "How are you using mobile technology in your day to day work?"

"Having a handheld device just makes accessing patients' charts so much easier. Sometimes the hospital's system goes down but with an iPad you have access and can still finish your work."

Calvin Spellmon, PGY 1
Pediatrics, UNM

"In the NICU, an iPad is more efficient than a cart. You can have quick access to references like Epocrates, Cerner, online textbooks. It makes a big difference."

Ashok Kottarathara, PGY 2
Pediatrics, New York Methodist Hospital

"I haven't purchased an iPad yet but I plan to. I'm looking forward to downloading the mobile app for Powerchart so that I can view my patients charts when rounding and on the floors."

Laura Waymire, PGY 2
Neurology, UNM

program director, Dr. Godfrey explained. She detailed how residents use their iPads to make case logs, review x-rays, and enter orders from home, which is particularly helpful on home-call.

UNM is one of several hospitals where CIR members recently negotiated for tablets to be covered under the residents' Medical Education Fund. "There has been an exponential increase in iPads," Dr. Godfrey said. Because the Orthopaedics department took the lead in using iPads, they have been helping residents throughout the hospital integrate them into their practice.

"With devices getting so advanced, you can't deny that it would be helpful to use," Dr. O'Neill said. "If something crosses my mind when I go home, or I just want to check my patients' vitals, their blood pressure, make sure they're not fevering . . . . It's very nice to have that capability."

Dr. Edward Dunn, Chief of Performance Improvement at the Lexington VA Medical Center, cautioned that technology was not a catch-all solution to patient care. Residents "have forgotten how to talk to each other. They've forgotten about the telephone, or speaking face to face." Dr. Dunn explained that technology replaced double-loop communication with single-loop communication, and that physicians must relearn to deliver critical alerts in real time.

On the other hand, Dr. Leviton believes devices like iPads can actually improve communication, and envisions a world in which every physician carries an iPad through the wards. iPads would be fully integrated with the EHR system, he said. "All patient information, history, tests, radiology results, nursing summary… everything that a doctor would need to know in that instant. Computers are big and bulky. If every doctor had an iPad, they wouldn't have to sit at a computer in the nursing station getting in the nurses' way. They could be closer to the patients, in the patients' rooms. There's incredible efficiency. With the iPad you can turn it around and show the patient information [about his health] right there."

Dr. Leviton continued, espousing the potential of doctors teaching their patients how to take care of themselves, of improving communication, of improving relationships. As healthcare reform promises to begin pairing payment with quality of care rather than quantity, residents are witnessing in real time a complete overhaul of their chosen profession, and EHR is an increasingly important tool central to that transition. As parents and educators lament the destruction of social and interpersonal skills due to technology, will EHR be the tool that ultimately affords physicians more opportunity to truly sit down with their patients and talk to them?

"This is just the beginning," said Dr. Modi, who is applying for a fellowship in Informatics with the goal of improving Health IT. "More people will get involved. As time moves forward you hope it will get better."

"I plan to buy an iPad for use when workrooms are crowded and no computers are available."
Maria Hamilton, PGY 1, Pediatrics (left)

"I want to use my iPad in call rooms with no computer access and at home for easy access to online journals."
Elizabeth Greig, PGY 1, Family Medicine, UNM (right)

"[Having access to the EHR] can definitely make everybody's life easier —instead of asking patients all these questions again, you can move ahead... The most important thing is, the records have to be organized. The reason it's not intuitive is because it's not doctors who created it.
Erik Ilyayev, PGY 3
Internal Medicine,
New York Methodist Hospital

CIR Residents Advocate for Responsible Reform at Brooklyn's Safety-net Hospitals

CIR residents overwhelmingly work in safety-net hospitals, and it is the patients of safety-net hospitals who suffer the most in an economic downturn. Given the current financial slump and existing and planned cuts to Medicare and Medicaid services, New York's Governor Andrew Cuomo has empowered his Medicaid Redesign Team (MRT) to assess the long-term financial viability of Brooklyn safety-net hospitals with the goal of controlling anticipated failures. One option the MRT is exploring includes the possible closure of some struggling hospitals in North and Central Brooklyn.

CIR residents have stood behind their patients and their hospitals, lobbying the government, signing petitions, and speaking at public MRT meetings, arguing that simply closing safety-net hospitals—which have a high percentage of Medicaid and uninsured patients—won't save money, but will only redistribute the problem and disproportionately affect low-income and minority populations.

"A huge proportion of spending in health care is for the treatment of preventable chronic diseases, like hypertension, diabetes, and lung and heart disease, and especially their avoidable complications," Dr. Jeff Wuhantu, an Emergency Medicine resident at Methodist Hospital, told the MRT taskforce. "A smart, sustainable healthcare system will invest in preventing and managing these diseases. This can only be accomplished by ensuring that medically underserved populations have affordable, accessible primary care options here at home."

CIR residents have felt the impact of hospital closures before. Based on how patient flow and hospital admissions were affected after safety-net hospitals closed in Queens and Manhattan, CIR modeled several Brooklyn hospital closure scenarios and found that the impact on increased travel times, Emergency Department wait times, ambulance deferrals, and excess bed capacity could potentially be catastrophic, even if only half the struggling hospitals closed, and neighboring hospitals would be pushed to nearly 100 percent average occupancy of inpatient beds. Furthermore, 88.5 percent of affected patients would be people of color, and questions arise about patients receiving culturally competent care if they're forced to seek treatment outside of their communities.

CIR analyzed the career paths of New York residents and determined that safety-net hospitals disproportionately train more primary care physicians who go on to practice in Health Professional Shortage Areas like North and Central Brooklyn than non safety-net hospitals, meaning that preserving safety-net hospitals is vital to producing safety-net physicians.

"Looking out for the patients of Brooklyn isn't just about making sure health services are adequate now—it's about making sure we have physicians, nurses, and other health providers who are up to the task of caring for the local needs of our community well into the future," said Dr. Sheena Punnapuzha, an Emergency Medicine resident at The Brooklyn Hospital Center.

The Brooklyn Work Group tasked with assessing the viability of Brooklyn hospitals is expected to release its recommendations on November 1, 2011.

Residents Prepare for Big Changes at UMDNJ

In January of this year, New Jersey Governor Chris Christie signed Executive Order 51 that established an ad-hoc committee to review graduate medical education in the state. The review will largely focus on the University of Medicine and Dentistry which currently hosts about 1,100 CIR members.

A full change of ownership at the UMDNJ-affiliated hospitals is one of the many restructuring possibilities under consideration. Gov. Christie announced his support for an initial recommendation that Rutgers take over three UMDNJ institutions: Robert Wood Johnson Medical School, the School of Public Health and the Cancer Institute of New Jersey.

Saint Barnabas Heath System has indicated a strong interest in taking on the Newark-based programs at The University Hospital but faces some legal and financial hurdles.

It is unclear as of this date, but residents fear that if there is a break-up of UMDNJ, services may be eliminated or there could be changes in faculty and staff, and size and composition of residency programs. For the latest information on UMDNJ, visit www.cirseiu.org.

The Keys to Successful Medical Education

What happens when you take two residents from New York City to a patient safety conference deep in the mountains of Colorado? Drs. Kamal Nagpal, now a PGY 3 surgical resident at Bronx Lebanon and Rafael Hernandez, a PGY 2 internal medicine resident at Woodhull in Brooklyn will tell you their experience in mid-June of this year was transformative.

The Telluride Patient Safety Roundtable was founded six years ago by Drs. David Mayer and Tim McDonald of the University of Illinois Medical Center and Richard Boothman, Esq. of the University of Michigan Health System. All three are national leaders in patient safety and medical malpractice reform The Roundtable brings together patient advocates and experts in patient safety and health sciences education for a unique sharing of perspectives, ideas, and strategies for improving our healthcare system. A central concept is that patient safety and quality care are dependent upon transparent, effective, and honest communications between healthcare professionals, and patients and their families.

CIR Vitals *sat down with Drs. Nagpal and Hernandez to reflect on the lessons they took away from the conference.*

Photo credit: Harry Franklin/CIR

Drs. Rafael Hernandez and Kamal Nagpal with Dr. Lucian Leape at the June 2011 Telluride Roundtable. A retired surgeon, Dr. Leape now teaches at the Harvard School of Public Health. He was lead author of the seminal 1999 Institute of Medicine report "To Err is Human: Building a Safer Health System," and is widely recognized as the founder of the patient safety movement. Dr. Leape's Telluride presentation focused on "the three golden elements of success in any industry: Respect, Appreciation and Support." In searching for the reasons why so little progress has been made in reducing medical errors, Dr. Leape made a compelling argument that disrespect in the healthcare workplace—including pervasive humiliation and bullying—was to blame because it impedes the reporting of unsafe practices and errors, and undermines effective teamwork and communication.

A CULTURE OF RESPECT

KN: Even with a PhD in patient safety under my belt, a lot of concepts were novel to me. During this roundtable, I learned that we have missed important concepts in our education, which include behavior, attitude, and relationships with patients and colleagues.

Disrespectful behavior, humiliation, ego, hierarchy, blame, and fear should not have a place in medicine, as it clouds judgment, impairs thinking, and compromises patient safety. As residents, we need to be aware of the importance of respect, appreciation and support for all members of the healthcare team and for our patients. CEOs and department chairs must also champion this culture change throughout the entire organization.

RH: We need clinical champions—people like you and me that are willing to go an extra step to make a difference. We need to begin creating a "culture of respect" and atmosphere of no blame or shame; an atmosphere that allows us to report or share incidents and near misses with the sole purpose of learning from them and taking out of the equation judgments from peers or unconstructive criticism.

UNDERSTANDING OUR PATIENTS' PERSPECTIVES

RH: I have always known that coins have two sides, that every story changes depending on the perspective of the person that tells it. But I never imagined that listening to other versions would impact my perspective so much.

KN: Health care should be patient-centered. Patients and their families should be actively involved in all the decisions and there should be open discussion. I spoke with a few mothers whose children had an unfortunate outcome in healthcare treatment. It made me realize that some of the outcomes would have been different if they had been actively involved in decision-making and consent had been truly *informed*.

RH: Our goal as healthcare providers should always be to practice medicine with transparency and respect, not only for our patients but also for our patients' family members, as much of the time we make them feel like outsiders.

TREATING THE WHOLE PATIENT

RH: Plato wrote, "The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul; although the two cannot be separated."

During my week in Telluride I can honestly say that my perspective of medicine has changed 180 degrees.

The Telluride Roundtable aims to identify and develop future patient safety leaders. See ***transparenthealth.wordpress.com*** *for more information.*

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