

# It's Time to Replace Steam Engine EMRs with AI-EMRs

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## Abstract

What is the message? Historically, replacing one large steam engine with one large electrical engine yielded minimal productivity gains. The industrial revolution came with the redesign of the production process. Modern Electronic Medical Record (EMR) systems are like steam engines in the industrial era – outdated technology poorly suited to leverage the potential of Artificial Intelligence (AI). Modern hospitals need a new AI-EMR built from the ground up to fundamentally transform healthcare delivery, quality, and cost structures. The authors propose that major tech companies like Amazon and Google should partner to purchase a small hospital system to develop a new AI-native EMR.

What is the evidence? The authors cite multiple sources demonstrating how current EMR deployments limit the potential impact of AI. They provide examples of complementary technology, such as mathematical optimization or learning from randomization and experimentation, broadly used in other industries to harness the full potential of AI but incompatible with current EMRs. The paper contrasts healthcare's expensive, fragmented approach to technology with more efficient ecosystems like Apple and Android. The paper describes emerging market movements in this direction, including Oracle's \$28 billion acquisition of Cerner and venture capital investment in healthcare delivery systems targeting technological transformation.

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The invention of the electric motor had relatively little immediate impact on productivity. Initially, companies swapped one large steam engine for one large electric engine. Productivity increased only after factories redesigned the production process in ways made possible by powering machines with many independent electric motors.<sup>(1,2)</sup> As Google continues to announce large language models (LLMs) that extend their lead over physicians in a growing set of clinical tasks,<sup>(3,4)</sup> hospitals are investing in the modern day equivalent of installing light bulbs in a factory powered by one large steam engine, the Electronic Medical Record (EMR). To unlock the potential of Artificial Intelligence (AI) to improve quality and reduce costs will require the development of a new AI-native EMR (AI-EMR). We lay out the potential benefits by drawing on examples from Amazon, Apple, and Google. We propose a roadmap for the development of an AI-EMR by a partnership with the appropriate capital and expertise.

*Figure: A hospital figuratively powered by a steam engine EMR – one large, outdated system on which all the machinery within relies.*



## Potential Benefits

Large language models (LLMs) have drastically improved in their ability to interpret self-contained medical text, aid physician decision-making, and tackle a variety of administrative tasks. Hospitals are racing to adopt LLMs such as: digital scribes, a replacement to Google for medical questions, administrative assistants, and to draft everything from responses to patient messages to prior authorization requests (3-6). The initial results are promising, but the cost, quality, and efficiency of these use cases is fundamentally handicapped by their dependence on the hospital's EMR steam engine.

An AI-first EMR would open the door to complementary optimization technology ubiquitous in other industries; facilitate the creation of a learning health system; improve quality and

reliability; automate low-value patient and provider tasks (which consume the majority of time people spend interacting with the healthcare system); and lower rather than raise costs. Amazon demonstrates the potential efficiency allowed by AI and complementary technology. The Apple and Android ecosystems illustrate the potential of secure, connected data sharing. All of these companies improve productivity rapidly by building randomization into the consumer experience to learn from their own data.

In order to generate value, general purpose technologies such as LLMs require complementary infrastructure.(1,7,8) Mathematical optimization or mathematical programming is a central pillar of this complementary infrastructure in practically all large industries. From early uses in the 1940s to 1960s to solve logistics problems for the U.S. Air Force during World War II and to design pharmaceuticals, mathematical optimization is now widely used by retailers like Amazon and Walmart; all major airlines; electrical grids; financial investment firms; and even The National Football League.(9-11) To generate value from AI-based forecasts of consumer demand, retailers like Amazon and Walmart use mathematical optimization to create efficient shipping schedules for millions of packages per day. The optimizations minimize delivery times and fuel costs.(12)

To generate value from AI-based forecasts of weather patterns, potential delays, and ticket prices, major airlines use mathematical optimization to assign planes to routes and crews to planes. These maximize profits by maximizing revenue and minimizing fuel costs while respecting myriad practical and regulatory constraints.(13) Such optimization is part of the reason that airline productivity and costs have improved over the last 30 years while hospital productivity and costs have not.(14,15) To create a schedule that respects myriad rules such as each team playing every team in their division twice and not flying across the country for consecutive games, the NFL uses mathematical optimization to create a draft schedule that humans revise.(16) There have been hundreds of papers demonstrating how mathematical optimization can complement AI to improve surgical scheduling, nurse staffing, patient clinic appointments, and service-to-unit assignments. However, largely because modern EMRs do not support mathematical optimization, very few such innovations are implemented.(17-20) A new AI-EMR would build in optimization as a complementary technology.

An AI-EMR could inject experimentation into daily care to generate evidence to help U.S. healthcare attain the long-sought goal of becoming a learning system.(21) For decades,

technology firms have generated improvements from evidence collected by injecting randomization and experimentation into their technology and user experience.(22,23) They have leapfrogged healthcare, where experimentation and standards of evidence go back almost 3,000 years to King Nebuchadnezzar of Babylon.(24) Most clinical trials remain expensive, time consuming, and restricted to small populations with limited potential to generalize.(25) Healthcare has taken promising steps in this direction, such as the inclusion of pseudo-randomization into the standard of care for algorithm-enabled remote patient monitoring of youth with diabetes.(26) However, these are primarily ad-hoc engineering efforts outside the EMR, which is not compatible with the technology. Progress would improve rapidly with an EMR engineered to allow randomization and experimentation as part of the standard of care.

Integrating all relevant information about a patient between the EMR and AI would drastically improve quality and reliability. Recently developed model context protocol (MCP) technology connects LLMs to other software and databases in a standardized way that improves efficiency and reduces hallucinations.(27,28) Only with access to data can LLMs help nurses, physicians, or patients answer common questions like, “Which medications and doses were prescribed?” or “How much out-of-pocket spending will this entail?” or “How long was the ICU stay?” Only with access to data can a digital scribe ensure that it heard a physician in a noisy room say “hydroxyzine” not “hydralazine” or “.2 mg” not “2 mg.” Phone applications that auto-fill passwords, measure a pulse, or allow for conversations with an LLM are possible only with secure, reliable connections to the FaceID, camera, and microphone.

Designing administrative and clinical workflows based on the current capabilities of LLMs, and projections about their improvement, would allow the elimination of numerous low-value tasks that drive burnout and reduce the time physicians and nurses have with their patients. Entire categories of non-clinical work currently done by highly trained people could be eliminated. Nurses could stop scheduling routine appointments and focus on patients with complex needs. Physicians could save hours each day and eliminate pajama time by not documenting billing codes. Experienced nurses could review and approve schedules or nurse-patient assignments generated by AI rather than dedicate half their time to it. Analysts could dedicate time to generating insights about opportunities to improve care or cut costs rather than putting together static dashboards. Apple and Android helped third-party travel applications improve convenience, choice, and competition by letting people compare the costs of rides to the airport, hotel stays, and plane tickets. The operating system makes this possible by providing location

applications, saved payment information, and Bluetooth connections for wireless hotel room keys. Such ubiquitous, time-savings opportunities require a system designed for connectivity, the opposite of today's EMRs designed primarily for data silos.

Perhaps the most pragmatic reasons are lower costs and better security. Current AI productivity improvements raise costs because current EMR deployments are customized to each hospital at the wrong level. Each EMR deployment is customized to each hospital's preferences and needs at the "operational level." Every application is tested by every hospital's security and stability teams, then it is customized to the hospital's operational model and installed in an expensive six- to 18-month-long process. Such installations are often incompatible with user preferences. Each Apple and Google phone is customized to the user's preferences and needs at the "user level." Every app is tested by Google and Apple security and stability teams once, each user installs it with a click, and customizes it to their preferences. The resulting process is efficient and secure. Almost too secure: it took dedicated teams of experts employed by the FBI months to break into an iPhone they had in their possession. In contrast, the fragmented nature of healthcare system deployments makes them expensive and vulnerable to large, costly attacks.

*Table: Potential benefits and uses of AI-EMR technology with examples from other industries*

| Potential benefits of AI-EMR                              | Additional technology built into EMR  | Examples from other industries  | Potential hospital uses   |
|---|---|---|---|
| Improve procedure, physician, nurse, and staff scheduling | Mathematical optimization to complement generative AI for scheduling and logistics                      | Amazon, Walmart, airlines, and the NFL use optimization to schedule staff, supplies, and logistics  | Schedule surgical procedures, nurse-patient assignments, and other aspects of operations using patient characteristics combined with physician and nurse experience and preferences |
| Generate evidence for a learning system                   | Pseudo-randomization and experimentation as part of the standard of care                                | Amazon, Apple, Google, and other technology firms generate data by integrating randomization and experimentation into the user experience               | Enable virtual randomized clinical trials as part of the standard of care by, for example, allowing randomization in digital health interventions such as remote patient monitoring |
| Improve LLM clinical decision-support                     | Connections, such as Model Context Protocols, between LLMs and patient history and data                 | LLMs properly integrated into the programming infrastructure significantly improve the speed and efficiency of software development                     | LLMs provide more accurate, relevant answers to care providers by drawing on patient history and data   |
| Fully automate tasks carried out by LLMs                  | Connections, such as Model Context Protocols, between LLMs and EMR functionality                        | Broad adoption of full-service chatbots for low-risk, low-value tasks such as scheduling or providing financial information                             | LLMs schedule non-urgent appointments and answer simple patient questions   |
| Lower adoption and maintenance costs                      | A secure system of permissions for data sharing and functionality between the EMR and new applications. | Apple and Google application environments reduce the initial and ongoing cost to validate new applications and integrate them into the operating system | Low adoption and integration costs for direct access to a large ecosystem of applications such as clinical risk prediction, scheduling, or financial tools                          |



## A Practical Roadmap

Modern patient care is too complex for a group of motivated innovators to build an AI-EMR in their garage. A company or partnership with expertise and capital, such as Amazon and Google, would have to buy a small hospital system; embed clinical, technical, financial, and operational experts in the care teams; and develop the new hospital AI-EMR from the ground up. There would be significant challenges. Fortunately, the resources are available and the potential rewards are attractive.

The market is already moving in this direction. Amazon has made several forays into the space, first through an ultimately unsuccessful partnership with other large companies to create a new firm, the creation of its own online pharmacy, and most recently with the \$4 billion dollar acquisition of primary care provider One Medical.<sup>(29-31)</sup> However, these efforts are not yet targeted at hospitals nor the creation of a new EMR. In 2021, Oracle, a large technology company, purchased Cerner, the second largest EMR after Epic, for \$28 billion and is working to transform it into an AI-powered EMR.<sup>(32,33)</sup> Unfortunately, that effort has run into the problems common to modernizing legacy technology. Venture Capitalists (VCs) have committed to the viability of a similar opportunity. A VC group recently finalized a \$485 million deal to acquire an 8,000-person integrated healthcare delivery system with the goal of using technology to improve its efficiency.<sup>(34,35)</sup>

Purchasing a small hospital system would be a relatively small, low-risk investment for a partnership like Amazon and Google. Google just acquired an 1,800- person cyber security firm, Wiz, for \$32 billion, approximately 100 times Wiz's \$350 million annual revenue. In contrast, hospitals are typically acquired for several hundred million to one billion dollars, approximately .8-3 times their annual revenue. This is a small fraction of what Google spends on electricity each year. Purchasing a hospital system and building an EMR from the ground up may also be safer than purchasing an EMR and inheriting the problems that Oracle is attempting to overcome.

Although the costs of transitioning to a new EMR are high, they could be defrayed by the massive short-term savings made possible by the AI technology Google has just developed and Amazon's expertise with efficient operations.<sup>(3,4,12)</sup> An AI-EMR would embed or reduce the cost of the functionality on which hospitals currently spend hundreds of billions of dollars each year.



Because modern EMRs do not offer any kind of meaningful support for operations, practically every large hospital pays for systems to visualize their data such as Tableau, to schedule their employee such as Kronos, to manage their budgets such as EPSI, to deploy AI point solutions such as scribes, etc. In addition to the licensing fees, hospitals employ massive workforces dedicated entirely to validating, installing, supporting, and maintaining the systems. The costs of the systems are high and the user experience poor, because companies compete based on their ability to sell to and integrate with hospitals, not on the quality of their technology. In contrast, markets with low barriers to entry such as Apple and Google ecosystems, see fierce competition to improve quality and reduce cost. Finally, the value provided by these systems is limited by the difficulty, sometimes impossibility, of sharing data. Nurse scheduling, the top operational expense of most hospitals, would be more efficient if it were powered by mathematical optimization integrated with data on: patient census, scheduled patient admissions, and detailed clinical data such as which patients require care from nurses with specialty skills.(36-38)

## Challenges

The primary risks of the proposed approach would be the clinical complexity of deploying a new EMR during clinical practice, the short-term declines in quality associated with the adoption of a new EMR, and the risk of data blocking and legal action by incumbent EMRs.(39-41) Fortunately, practically every hospital in the United States has adopted an EMR. There is now a large workforce of specialists with experience in multiple EMR deployments and a vast literature of common challenges and strategies to overcome them. The appropriate partnership could acquire this expertise. Amazon has a multi-decade record of successfully acquiring and improving the efficiency of low-tech, labor-intensive companies. Google's forays into AI have yielded Nobel-prize winning improvements in medical technology.(42,43) Both companies have world-class legal teams with decades of experience in litigating intellectual property.

## Conclusion

Those of us working in healthcare have long lamented that Epic is like democracy – it's the worst system for hospital operations, except all the others that have been tried. In an era of breathtaking technological transformation, EMRs remain the expensive, harmful steam engines of an era bygone. The risks of radical transformation are great. The promise of recent advances in AI are worth it.

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