



Building Physician Engagement During an EHR Implementation

The Case for an Interim CMIO at Safety-Net Hospitals and Other Hospitals with Uncompensated Care

Executive Summary

Electronic health record (EHR) implementations are among the most disruptive events a hospital can undergo. For safety-net hospitals, the disruption can be particularly acute because these organizations frequently operate under financial constraints while caring for disproportionately uninsured, underinsured, and medically complex populations. Research has shown that hospitals with high levels of uncompensated care often experience lower operating margins compared with other hospitals, creating additional challenges when undertaking major technology transformations.

This white paper examines a common and instructive scenario in healthcare IT: a safety-net hospital facing increasing physician skepticism and engagement challenges during an EHR rollout, and its decision to bring in an interim Chief Medical Information Officer (CMIO) to stabilize the transition. Our client was a safety-net hospital with ~150 beds that served ~300,000 residents across six zip codes within a large inner-city setting in the Midwest.

The narrative is otherwise intentionally generalized (i.e., it does not describe any single vendor, platform, or institution) because the pattern it illustrates recurs across the industry regardless of which EHR is involved. The purpose is to give hospital executives, medical staff leaders, and healthcare IT professionals a practical framework for recognizing the warning signs of physician disengagement and for using interim clinical informatics leadership as a deliberate, time-bound intervention rather than a last resort.

While this white paper uses a safety-net hospital case study as its example, the patterns described are not unique to safety-net organizations. Similar challenges can arise in rural hospitals, critical access hospitals, community hospitals, and other healthcare organizations operating with constrained resources, physician shortages, or limited clinical informatics leadership during periods of significant transformation.

Physician engagement is a strategic imperative. A 2026 AMA survey reports that approximately 42% of physicians continue to report one or more symptoms of burnout, and administrative burden remains a significant contributor.¹



1. The Setting: Safety-Net Hospitals and the Weight of EHR Transitions

Safety-net hospitals operate under constraints that shape every technology decision they make. Margins are thin. Philanthropic and grant funding often has to substitute for the capital reserves that better-resourced health systems draw upon. Physician staffing is frequently a mix of employed providers, perhaps residents, and community physicians with varying degrees of institutional loyalty. Turnover in the C-suite (including the CMIO role itself if there is one) is common because the job is demanding and the resources to do it well are frequently scarce.

These pressures are occurring at a time when hospitals face workforce shortages, rising labor costs, and increasing demands for technology investment. In 2026, the American Hospital Association reported that many hospitals remain under financial strain despite recent stabilization in operating margins.² Safety-net hospitals are especially vulnerable, as 2025 federal Medicaid policy changes under H.R. 1 are expected to further increase uncompensated care and tighten resources at organizations that already operate with limited financial flexibility.³

An EHR implementation can land like a hurricane in this environment. Workflows are often rebuilt from the ground up, or worse, “copied” from the old EHR system. Order sets, documentation templates, and clinical decision support all have to be reconfigured in the new EHR system, and someone has to make hundreds of small clinical judgment calls about how care should be structured inside the new system. When that “someone” is a vacant CMIO seat, or a rotating cast of interim administrators without clinical credibility, physicians notice immediately.

2. Warning Signs: When Physician Engagement Erodes

Physician frustration during EHR transitions is not simply anecdotal. KLAS Arch Collaborative research found that one-third of physicians report some degree of burnout, and the EHR is cited as a contributing factor by more than 60% of burned-out physicians. Those who report poor EHR experiences also demonstrate significantly higher turnover risk and lower organizational loyalty.⁴

In the case examined here, the warning signs were not subtle, and they will be familiar to anyone who has lived through a difficult go-live:

Order set adoption stalled.

Physicians reverted to free-text orders and workarounds rather than using the build that had been configured for them.

Help desk tickets piled up faster

than they could be triaged, with many describing the same handful of unresolved workflow problems.

Turnover risk rose.

Several physicians, particularly in high-acuity specialties, began discussing whether to leave for organizations with more mature systems.

Governance meetings lost quorum.

Physician advisory committees for the EHR project saw attendance drop, and decisions began to be made without meaningful clinical input. Organizations should view declining participation in governance activities as a meaningful warning sign. KLAS research has demonstrated that physicians who believe their input is valued report substantially higher satisfaction with the EHR and organizational support than those who feel ignored.⁵

Informal complaints outpaced formal ones.

Physicians voiced frustration in hallway conversations and department meetings but stopped submitting change requests through official channels because they had lost confidence that anything would change.

None of these signs, in isolation, is a crisis. Together, they describe a medical staff that has stopped believing it has a voice in its own clinical technology — which is, at its core, a leadership and trust problem, not a software problem.

3. A Turning Point: The Decision to Bring in an Interim CMIO

Hospital leadership faced a choice common to organizations in this position: continue trying to manage the implementation through a committee structure and vendor project managers, or bring in dedicated clinical informatics leadership, even temporarily, to stabilize the situation.

The hospital chose the latter, engaging an interim CMIO — a physician executive with informatics experience, typically brought on through a consulting or locum arrangement — with a mandate measured in months rather than years.

This decision reflected several judgments that are worth naming explicitly, because they generalize well beyond this case:

Credibility must be clinical.

Project managers and IT directors, however capable, cannot substitute for a physician who can speak peer-to-peer with medical staff about clinical workflow trade-offs.

Speed matters more than permanence in a crisis.

A national search for a permanent CMIO can take six to twelve months. An interim leader can be in place within weeks, buying time for a proper search to happen without the implementation stalling in the meantime.

An outside perspective can be an asset.

An interim leader without ties to prior political battles on the medical staff can make and defend difficult build decisions without being read as taking sides in old disputes.

A defined end date changes behavior.

Because the engagement is explicitly temporary, it is easier for an interim CMIO to make hard calls and hold firm timelines without the incentive to avoid conflict that a permanent hire, worried about long-term relationships, might feel.

The growing strategic importance of clinical informatics leadership reflects a broader evolution of the CMIO role. What was once viewed primarily as an EHR implementation position is now widely recognized as a critical executive function responsible for clinician engagement, workflow optimization, quality improvement, and physician satisfaction.⁶



Why Physician Engagement Matters

- Approximately **41.9%** of physicians report at least one symptom of burnout¹
- The EHR is cited as a contributor by **62%** of burned-out physicians⁴
- Strong governance, personalization, training, and clinical involvement are consistently associated with higher EHR satisfaction⁴
- One-third of burned-out physicians report an increased likelihood of leaving their organization⁹
- Physician replacement costs are often estimated between \$500,000 and \$1 million per physician⁹

4. The Interim CMIO's First 90 Days

Across cases like this one, the first 90 days of an interim CMIO engagement tend to follow a recognizable pattern:

Listening and diagnosis (weeks 1-3)

Before touching the build, the interim CMIO typically spends time in clinical areas, in shadowing sessions, and in one-on-one conversations with department chairs and frontline physicians to understand where the friction actually lives, as opposed to where the project plan assumed it would.

Triage and quick wins (weeks 3-6)

A short list of high-visibility, low-effort fixes (e.g., a broken order set, a misconfigured alert firing too often, a documentation template that duplicated work, etc.) gets addressed quickly and visibly. The goal is not to solve everything, but to demonstrate that clinical feedback now produces action.

Governance reset (weeks 6-10)

Physician advisory structures are reconvened, often with a smaller, more decision-capable membership and a clearer charter. This group has real authority over clinical build decisions, and its recommendations will be honored absent a specific, stated reason otherwise.

Sustained build and change management (weeks 10-13+)

With trust partially restored, harder decisions (e.g., standardizing order sets across departments, retiring workaround processes, tightening clinical decision support, etc.) become possible because physicians believe the process is being run in good faith.

5. Rebuilding Trust: Strategies That Worked

Several practices recur across successful interim CMIO engagements in safety-net settings:

Rounding, not just reporting.

Interim CMIOs who spend time rounding with physicians, rather than managing the project purely through steering committee reports, tend to earn credibility faster. Physicians trust when they see a leader personally engage with them. And KLAS research has shown that high trust in organizational leadership is associated with improved EHR satisfaction.⁷

Closing the feedback loop visibly.

Every piece of physician feedback needs a traceable outcome, even if the outcome is “we heard this and decided not to change it, and here is why.” Silence is what erodes trust; a “no” with a clear rationale rarely does.

Protecting physician time.

At-the-elbow support during actual patient care hours, rather than generic classroom sessions, signals respect for the realities of physicians’ practice. Healthcare organizations that provide workflow-specific EHR education and personalized support consistently report higher clinician satisfaction and stronger perceptions of efficiency than organizations relying solely on standard classroom training.⁸

Aligning informatics decisions with quality and safety, not just efficiency.

Framing build decisions in terms of patient safety and care quality, rather than purely operational metrics, speaks the language physicians already use to evaluate their own work.

Preparing the organization for permanent leadership.

A well-run interim engagement does not just stabilize the crisis; it leaves behind a governance structure, a documented set of build decisions and their rationale, and a clearer picture of what the organization needs in a permanent CMIO. So, the eventual hire inherits a functioning structure rather than a fresh fire.

6. Illustrative Outcomes

While outcomes vary by organization, improvements in clinician engagement have measurable operational implications. Research suggests that physician turnover can cost an organization between \$500,000 and \$1 million per departing physician, making efforts that improve physician satisfaction and retention financially important as well as operationally necessary.⁹

Every engagement is different, and the metrics below are illustrative of the kind of improvement organizations in this situation typically report — not figures from any single institution:

Indicator	Before Interim CMIO Engagement		Typical Direction After
Physician advisory committee attendance	Declining, often below quorum	—————>	Restored to consistent quorum
Order set / clinical content adoption	Low, high rate of workarounds	—————>	Meaningfully improved
Open help desk tickets tied to clinical workflow	Backlogged	—————>	Reduced and better triaged
Physician-reported confidence in leadership	Low	—————>	Improved, though not fully restored
Physician turnover intent	Elevated	—————>	Stabilized

The consistent theme across organizations that have taken this path is not that every problem gets solved during the interim window, but that the trajectory changes from active erosion of trust to a visible, credible process of repair.

Physician Engagement Recovery Model

A proven 6-step journey to restore trust, reengage physicians, and strengthen healthcare leadership and performance.



7. Lessons for Other Organizations

For hospital executives and boards considering a similar path, several lessons generalize well:

- ✓ Watch for the leading indicators, not just the lagging ones. Declining committee attendance and rising informal complaints precede formal escalation. Waiting for a sentinel event or mass resignation threat means acting too late.
- ✓ Don't treat clinical informatics leadership as optional overhead. A vacant or under-resourced CMIO role during an EHR implementation is a governance gap, not a line-item savings.
- ✓ Interim leadership is a legitimate strategy, not a stopgap admission of failure. Used deliberately, it buys time, restores trust, and improves the odds that a permanent hire succeeds.
- ✓ Vendor-agnostic principles matter more than the platform. The trust deficit described here is rarely about which EHR is installed; it is about whether physicians believe their clinical judgment has a real channel into how the system is built and changed.
- ✓ Plan the handoff from day one. An interim CMIO engagement should be designed, from its first week, to leave behind the governance structures and documentation a permanent leader will need.



Conclusion

Physician engagement is not a soft metric.

It is a leading indicator of patient safety, staff retention, and the ultimate success or failure of an EHR investment. Safety-net hospitals, operating with fewer resources and often thinner clinical leadership benches, are particularly vulnerable to the kind of erosion described in this white paper. Bringing in an interim CMIO is not a concession that an organization has failed; it is a recognition that clinical technology decisions require clinical leadership, and that sometimes the fastest path to restoring that leadership is a dedicated, time-bound engagement built for exactly that purpose.

Organizations facing similar warning signs should treat this paper's contents — diagnosis, quick wins, governance reset, and sustained change management — not as a fixed playbook, but as a starting framework to adapt to their own medical staff, culture, and EHR platform.

About HealthNET Systems Consulting

HealthNET Systems Consulting, Inc. is a healthcare-focused consulting and advisory firm dedicated exclusively to serving healthcare organizations across the continuum of care.

With decades of clinical, financial, operational, and health IT expertise, HealthNET Consulting partners with hospitals, health systems, physician organizations, ambulatory practices, and other healthcare providers to optimize technology, improve workflows, maximize revenue, and advance strategic transformation initiatives. Our consultants bring real-world experience in clinical and financial operations, electronic health record (EHR) implementations and optimization, digital transformation, interoperability, governance, and change management, enabling us to deliver practical solutions that improve both organizational performance and patient outcomes. Because healthcare is our sole focus, we understand the unique regulatory, operational, clinical, and financial challenges our clients face and provide tailored guidance that aligns technology, people, and processes to achieve measurable results. At HealthNET Consulting, we help healthcare organizations navigate complexity, accelerate innovation, and realize the full value of their technology investments while keeping patient care at the center of every engagement.

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