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The Influence of SI-RS Development and Computer Self-Efficacy on the Implementation of EMR Mediated by Barrier Self-Efficacy at Firdaus Hospital

Erish Harry Angkat [1], MF. Arrozi Adhikara [2],
Wahyuni Dian [3,] Esa Unggul University, Jakarta

erish_1982@ymail.com
arrozi@esaunggul.ac.id
dewani.dian@esaunggul.ac.id

Health technology transformation is realized through development and utilization technology, digitalization, as well as bio-technology. The implementation of health technology transformation that has been carried out by the Ministry of Health is the enactment of Minister of Health Regulation Number 24 of 2022 concerning Medical Records which requires all hospitals to maintain electronic medical records (EMR) no later than 31 December 2023. The aim of this research namely to analyze the influence of the development of SI-RS and computer self-efficiency on the implementation of EMR which is mediated by self-efficacy barriers at Firdaus Hospital. The research method used is an associative quantitative research method. This research was conducted on medical service and examination officers with a population of 261 people. The sample used was 110 people who were calculated proportionally. This research uses path analysis and regression analysis techniques. The results of this study indicate that the simultaneous development of SI-RS and computer self-efficiency have an effect on the implementation of EMR which is mediated by self-efficacy barriers, partial development of SI-RS has no effect on self-efficacy barriers, computer self-efficiency partially influences barrier self-efficacy, barrier self-efficacy partially influences EMR implementation, SI-RS development partially influences EMR implementation, and computer self-efficacy partially influences EMR implementation.

Keywords: *SIRS Development, Computer Self Efficacy, EMR Implementation, and Barrier Self Efficacy*

Correspondence writer: arrozi@esaunggul.ac.id

Introduction

Minister of Health Regulation Number 24 of 2022 concerning Medical Records which requires all hospitals to maintain electronic medical records *(EMR)* no later than 31 December 2023. This encourages all hospitals in Indonesia to switch from conventional medical records *(paper-based medical records)* to electronic medical records. EMR implementation is mandatory *for* every health facility to provide quality health services while increasing hospital profitability (Tsai et al., 2019).

During the transition process from the old SIRS to the new SIRS, conflicts occurred in the adaptation process. This condition is in accordance with the statement by Compeau and Higgins (1995) which states that the critical stage in implementing an information technology system is the condition where the existence of the system is accepted or rejected by the user. This adaptation process is hampered due to the tendency for differences in

perceptions regarding the benefits and ease of operation of the new system. This appears to be due to the tendency for some employees to find it difficult to adapt to the new system.

The success of EMR implementation will be influenced by the suitability of the system implemented by the hospital with the system run by SI-RS (Tsai et al., 2019). This is related to the success of the transition process during the adaptation process to the new SI-RS. Officers will easily adapt if the system running in SI-RS is in accordance with the system already running in the hospital. Significant system differences between what is already running in hospitals and the system implemented in SI-RS will hinder the success of EMR implementation(Devi & Widhiyani, 2020)

Computer self-efficacy also plays an important role in the implementation of SIRS and EMR. *Computer self-efficiency* is seen as an important variable for studying individual behavior in the field of information technology (Agarwal et al. 2000). *Computer self-efficacy* is defined by Compeau and Higgins (1995) as *an assessment of* a person's computer abilities and skills to perform tasks related to information technology. In implementing EMR, *computer self-efficacy* needs to be researched to see the factors within the staff that support the success of implementing EMR at Information Hospital This includes a person's self-confidence to be able to operate information technology devices that support the implementation system in an agency (Devi & Widhiyani, 2020).

In its implementation, the implementation of the new EMR faces various obstacles and challenges that arise during the adaptation process, both technically and human resources. Based on the results of interviews with officers at Hospital 2) There is incomplete information entered; 3) Officers still have difficulty inputting data; and 4) Officers are dissatisfied with the existing system because they are not used to it, thus slowing down the rhythm of work. This is in line with research Delvita dan Mulyanti (2023)which raises a similar problem that in the implementation of EMR there were complaints related to the SI-RS used. Complaints that are often received relate to system quality, information quality and user satisfaction. Other research also reports that many doctors experience technical problems, operational disruptions, data errors, and system compatibility problems (Tsai et al., 2019). This is what causes many officers to feel objections every time the EMR is moved, because of the need to adapt to the new EMR.

The various obstacles that arise during the process of implementing EMR adaptation are dominated by factors that arise within the officers. Barriers during the EMR implementation process are based on individual promises to adapt to new EMR technology, so that individuals are resistant to existing changes (Afrizal et al., 2019). Many officers show resistance to implementing EMR on the grounds that EMR will hamper work rhythm, doubts about the system used, fear of losing data, ambiguous belief that data is not stored safely, or complaints about the slowness of the system used. However, the reasons expressed by the officers were baseless reasons arising from the officers' lack of confidence in the system currently used (Wikansari & Santoso, 2022). Barriers that arise due to officers' lack of confidence in their own abilities in implementing EMR are known as *self-ability barriers*. *Self-efficacy barriers* are one of the potential obstacles that influence the success of EMR implementation in hospitals (Afrizal et al., 2019).

Research methods

This research is a quantitative associative (causality) research which aims to review the causal relationship between two or more variables. Quantitative research is research with basic data in the form of numbers with analysis according to statistical rules. Meanwhile, associative is intended to determine the relationship between 2 or more variables regarding the phenomenon raised in the research problem. This research uses one dependent variable, namely EMR implementation, one intervening variable, namely *barrier self-efficacy*, and 2 independent variables, namely SI-RS development and *computer self-efficacy*. Researchers want to analyze the influence of the development of SI-RS and *Computer Self-Efficacy* on the implementation of EMR with *Barrier Self-Efficacy* as an Intervening variable. Where study carried out using data sources and information obtained from respondents as samples study with use questionnaire Which spread in a way brave use Google Form as instrument Meeting data. Total statement from all variable There is 18 statement. Population Which researched for example all employees of Hospital X Class C in North Jakarta who are directly involved in medical services and

maintenance, namely doctors, nurses/midwives, laboratories, radiology, pharmacy and medical records.

Measurement of EMR implementation variables using dimensions (Peiwen Li et al. (2022) Which consists from *Performance expectations*, *Effort hope*, *Social influence*, *Facilitating conditions*, *Severity of sanctions*and *Certainty of sanctions*. measurement of SIRS development variables using dimensions from (Fishbein & Ajzen, 2011), namely: *Perceived usefulness*, *Perceived ease of use*, *Attitude towards technology use* And *Real use of technology*. Measurement *of computer self-efficacy* variables using dimensions (Compeau & Higgins, 1995)namely: *Magnitude* , *Strength* and *Generalization* . measurement variable *Self-efficacy barriers* to use dimensions (Afrizal et al., 2019) Which consists from *Lack of knowledge, Unfamiliarity, User resistance, Lack of willingness to learn new skills and Limited* Awareness.

In study This data validity test uses a validity test and a reliability test. The validity test according to Ghazali (2017) the significance test is carried out by comparing the calculated r value with the rt table for *degrees of freedom* (df) = N-2. in this case n is the number of samples, with the result: If the value of r calculated by *the Pearson correlation* > r the table is declared valid. If the calculated r value *of the Pearson correlation* < r the table is declared invalid. Reliability test according toGhazali (2017) Ghazali (2017) A research variable is said to be reliable if it meets the following criteria: If Cronbach Alpha > 0.6 it is declared *reliable.* If Cronbach Alpha < 0.6 it is declared unreliable .

In this research, the data analysis technique uses descriptive statistics, three box method, normality test, hypothesis test and intervention test. This research uses 110 samples, so that each sample can provide a score for each statement item from score 1 to score 5. Thus the *three-box method calculation* (Ferdinand, 2006) is as follows: Upper limit score: (110 x 5) / 5 = 110 and lower limit score: (110 x 1) / 5 = 22.

The normality test uses the *Kolmogorov-Smirnov (KS) technique* with the help of SPSS data analysis *software from Windows*. The normality test value limit set is > 0.050. If the KS value obtained is > 0.050, then the research data is declared normally distributed. Meanwhile, if the KS value is <0.050 then the research data is indicated as abnormal. Hypothesis testing in this study used multiple linear regression analysis methods with the help of *SPSS ver. 25* . Regression analysis is a statistical technique that is useful for examining and modeling relationships between variables. For regression where the independent variable consists of two or more variables, it is called multiple regression. Because this research consists of two independent variables, the analysis uses multiple linear regression analysis. Intervention tests were carried out to determine whether there was an influence of mediating variables in the research model. The intervention test aims to see whether mediation occurs or not in the research model carried out.

Number of samples studied 110 respondents. Method The data measurement used is a Likert scale with a scale interval of one to five. Analytical tools used that is *SPSS* .

Results and Discussion

Table 1
Description of Research Data

No	Kategori	Keterangan	Jumlah	Presentase	Presentase Kumulatif
1	Jenis Kelamin	Laki-laki	22	20%	20%
		Perempuan	88	80%	100%
		Jumlah	110	100%	
2	Pendidikan Terakhir	D3/Sederajat	68	62%	62%
		S1/D4/Sederajat	21	19%	81%
		Program Profesi	14	13%	94%
		Magister/Spesialis	7	6%	100%
		Jumlah	110	100%	
3	Jabatan/Posisi	Dokter Spesialis	8	7%	7%
		Dokter Umum	9	8%	15%
		Perawat	57	52%	67%
		Bidan	9	8%	75%
		Laboratorium	7	6%	81%
		Radiologi	4	4%	85%
		Farmasi	11	10%	95%
		Rekam Medis	5	5%	100%
		Jumlah	110	100%	
4	Usia	<20 Tahun	3	3%	3%
		21-30 Tahun	70	64%	67%
		31-40 Tahun	29	26%	93%
		41-50 Tahun	8	7%	100%
		>50 Tahun	0	0%	100%
		Jumlah	110	100%	
5	Masa Kerja	<1 Tahun	30	27%	27%
		1-3 Tahun	44	40%	67%
		4-6 Tahun	22	20%	87%
		7-9 Tahun	14	13%	100%
		>9 Tahun	0	0%	100%
		Jumlah	110	100%	

Sumber: Data Hasil Kuesioner, Peneliti (2023)

The number of samples used was 110 medical officers at Hospital X class C, North Jakarta. The research instrument used was a questionnaire which was given directly to respondents. Death questionnaires from April 2023 to June 2023. The total number of deceased questionnaires in this study was 110 questionnaires. Of the 110 questionnaires distributed, 110 (100%) questionnaires were received back, 110 (100%) could be processed. In table 1, you can see a description of gender, last education, title/position, age and length of service.

Based on gender, 22 respondents (20%) were male while 88 respondents (80%) were female. Based on the latest education, it is known that 68 respondents (62%) have an educational background at the D3/Equivalent level, 21 respondents (19%) have an educational background at the Bachelor/D4/Equivalent level, 14 respondents (13%) have an educational background at the equivalent level. professional program, and as many as 7 respondents (6%) had an educational background at master's/specialist level . Based on job titles/positions, researchers identified 8 functional positions/positions, namely specialist doctors, general practitioners, nurses, midwives, laboratories, radiology, pharmacy and medical records. as many as 8 respondents (7%) are specialist doctors, as many as 9 (8%) are general practitioners in the emergency room/room, as many as 57 respondents (52%) are nurses, as many as 9 respondents (8%) are midwives, as many as 7 respondents (6%) are %) are laboratory analysts, 4 respondents (4%) are radiographers, 11 respondents (10%) are pharmaceutical technical personnel, and 5 respondents (5%) are medical records personnel . Based on age, this study was divided into 5 groups, namely <20 years, 21-30 years, 31-40 years, 41-50 years, and >50 years. as many as 3 respondents (3%) aged <20 years, as many as 70 respondents (64%) aged 21-30 years, as many as 29 respondents (26%) aged 31-40 years, as many as 8 respondents (7%) aged 41-50 years , and there were no respondents (0%) aged >50. Respondents in this study were dominated by officers aged 21-30 years. Based on work period, this study categorizes work period into <1 year, 1-3 years, 3-6 years, 6-9 years, >9 years. as many as 30 respondents (27%) had a work period of <1 year, as many as 44 respondents (40%) had a work period of 1-3 years, as many as 22 respondents (20%) had a work period of 4-6 years, as many as 14 respondents (13%) had a service period of 7-9 years, and no respondents (0%) had a service period of >9 years. This research was dominated by officers with 1-3 years of service.

Validity test

The validity test shows the extent to which the measuring instrument is able to measure what it wants to measure. The validity test is useful for finding out whether there are questions in the questionnaire that should be removed/replaced because they are considered irrelevant.

Table 2
Validity test

Variabel	Indikator	R hitung	r tabel	Keterangan
Implementasi EMR	EMR1	0,563	0,154	Valid
	EMR2	0,762	0,154	Valid
	EMR3	0,606	0,154	Valid
	EMR4	0,828	0,154	Valid
	EMR5	0,732	0,154	Valid
	EMR6	0,752	0,154	Valid
Pengembangan SIMRS	SIMRS1	0,836	0,154	Valid
	SIMRS2	0,903	0,154	Valid
	SIMRS3	0,874	0,154	Valid
	SIMRS4	0,748	0,154	Valid
Computer Self-Efficacy	CSE1	0,806	0,154	Valid
	CSE2	0,850	0,154	Valid
	CSE3	0,878	0,154	Valid
Barrier Self-Efficacy	BSE1	0,710	0,154	Valid
	BSE2	0,607	0,154	Valid
	BSE3	0,926	0,154	Valid
	BSE4	0,786	0,154	Valid
	BSE5	0,893	0,154	Valid

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Based on table 2, it shows the results of the validity test using *bivariate comparison with the Pearson product-moment correlation* testing technique which shows that all test results are r calculated > table (r calculated > 0.154) . This indicates that all indicators in the research variables are concluded to meet the validity test requirements and can be said to be valid as indicators in the research questionnaire.

Reliability Test

Reliability is an index that shows the extent to which a measuring instrument can be trusted or relied upon. If a measuring instrument is used several times to measure the same phenomenon and the measurement results obtained are relatively consistent, then the measuring instrument is reliable. In other words, reliability shows the consistency of a measuring instrument in measuring the same phenomenon.

Table 3
Reliability Test

Variabel	Cronbach's alpha	Nilai Rujukan	Keterangan
Implementasi EMR	0,804	0,600	Reliabel
Pengembangan SIMRS	0,863	0,600	Reliabel
Computer Self Efficacy	0,800	0,600	Reliabel
Barrier Self Efficacy	0,850	0,600	Reliabel

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Cronbach's Alpha testing technique. The results of reliability testing show that all variables have a *Cronbach's Alpha value* > 0.600 . This means that all variables in the research questionnaire meet reliability and can be said to be reliable as a research questionnaire.

Descriptive statistics
Three Box Method Analysis

Based on previous calculations, each item statement will have a possible score in the range of 27.5 – 110. The score difference is known to be 87.5, so each box will have a class interval of 27.5. The assessment categories for each indicator and variable in *the three-box method* are as follows:

Table 4
Three Box Method

No	Rentang Nilai	Kategori
1.	22 – 51,33	Rendah
2.	51,34 – 80,66	Sedang
3.	80,67 - 110	Tinggi

Recapitulation of Results Description of Data Variables

Variabel	Rendah	Sedang	Tinggi
Implementasi EMR			82,63
Pengembangan SIMRS			89,10
Computer Self Efficacy			86,20
Barrier Self Efficacy		64,56	

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Based on table 5 values average distribution respondents from variable implementation of EMR is 82.63 which is included in the high category. Average value average distribution of respondents from the SIRS development variable is 89.10 including in category tall, mark average distribution of respondents variable *Computer Self Efficacy* is 86.20, which is in the high category and the average value of the distribution of the *Barrier Self Efficacy variable for respondents* is 64.56, which is in the medium category.

Normality test

The normality test aims to determine whether the differences in the residual values studied are normally distributed or not. Multiple regression testing requires normally distributed data, so that a predictive research model is obtained.

Table 6
One Kolomogorov-Smirnov Example

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Ket
		B	Std. Error	Beta			
1	(Constant)	1.534	.273		5.614	.000	
	BSE	.567	.069	.622	8.264	.000	**H3 Diterima**

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Based on table 6 , it is known that the normality test results show the *Asymp value. signature. (2-tailed)* of 0.200 > 0.050. This shows that the value obtained is greater than the specified limits, so that the research data can be said to be normally distributed.

Hypothesis testing

The partial test (t test) is based on the *statistical t value* and *P value* in the table. The rule for *statistical* tests is that if t count > t table with a significance level of 95% or < 0.050 then it can be concluded that there is a significant influence between exogenous variables on endogenous variables. If t count < t table with a significance level > 0.05 then the variable is declared to have no significant influence between exogenous variables on endogenous variables.

Table 7
The simultaneous influence of SI-RS development and *computer self-efficiency* on EMR implementation is mediated by *self-efficacy barriers*

	Mean square	df	Mean Square	F	P value	Kesimpulan
Regression	20.979	3	6.993	30.320	.000[b]	
Residual	24.448	106	.231			**H1 diterima**
Total	45.427	109				

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Table 8
Partial Test of the Effect of SIRS Development and *Computer Self-Efficacy* on *Barrier Self-Efficacy*

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Ket
		B	Std. Error	Beta			
1	(Constant)	.548	.303		1.810	.073	
	SIMRS	.080	.057	.093	1.394	.166	**H1 Ditolak**
	CSE	.777	.072	.715	10.724	.000	**H2 Diterima**

Sumber: Data Hasil Kuesioner, Peneliti (2023)

***Efficacy* on EMR Implementation**

		Unstandardized Residual
N		110
Normal Parameters[a,b]	Mean	.0000000
	Std. Deviation	.78311305
Most Extreme Differences	Absolute	.067
	Positive	.062
	Negative	-.067
Test Statistic		.067
Asymp. Sig. (2-tailed)		.200[c,d]

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Table 10
Partial Test of the Effect of SIRS Development and *Computer Self-Efficacy* on EMR Implementation

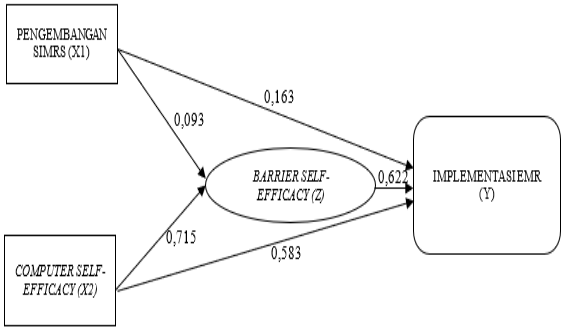
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Ket
		B	Std. Error	Beta			
1	(Constant)	1.056	.316		3.338	.001	
	SIMRS	.127	.060	.163	2.126	.036	**H4 Diterima**
	CSE	.576	.076	.583	7.621	.000	**H5 Diterima**

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Intervention Test

Intervention tests were carried out to determine whether there was an influence of mediating variables in the research model. The intervention test aims to see whether mediation occurs or not in the research model carried out. The test results are presented as follows:

Figure 1
Path Analysis



In *path analysis,* a positive coefficient value indicates that there is a positive relationship between the exogenous variable and the endogenous variable. Meanwhile, a negative coefficient value indicates that there is a negative relationship between exogenous variables and endogenous variables. The results of the intervention tests in this study are presented as follows

Table 11
Intervention Test

No	Keterangan	SIMRS		COMPUTER SELF EFFICACY	
		Pengaruh Langsung	Pengaruh Tidak Langsung	Pengaruh Langsung	Pengaruh Tidak Langsung
1	Barrier Self Efficacy	0.093	0.000	0.715	0.000
2	EMR	0.163	0.093 x 0.622 = 0.0578	0.583	0.715 x 0.622 = 0.4447
		Pengaruh tidak langsung < pengaruh langsung, tidak terjadi mediasi		Pengaruh tidak langsung < pengaruh langsung, maka tidak terjadi mediasi	

Sumber: Data Hasil Kuesioner, Peneliti (2023)

Based on table 10, it can be seen that the coefficient of the direct influence of the SIRS development variable on EMR implementation is 0.163, while the indirect influence of SIRS development on EMR implementation which is mediated by the *self-efficiency barrier* is 0.0578. This shows that the indirect effect <direct effect, which means that there is no mediation by the *self-efficacy barrier variable.*

Based on table 10, it can be seen that the coefficient of the direct influence of the *Computer Self-Efficacy variable* on EMR Implementation is 0.583, while the indirect influence *of Computer Self-Efficacy* on EMR Implementation which is mediated by *Barrier Self-Efficacy* is 0.4447. This shows that the indirect effect <direct effect, which means that there is no mediation by the *self-efficacy barrier variable.*

Discussion

Hypothesis 1: Hypothesis 1: Simultaneous Influence of SI-RS Development and *Computer Self-Efficacy* on EMR Implementation Mediated by *Barrier Self-Efficacy*

H1 which states that there is a simultaneous influence between SI-RS development and *computer self-efficacy* on EMR implementation which is mediated by *the self-efficacy barrier* is accepted**.** The research results show that it is known that the F statistics value is 30.320 with a P value of 0.000 < 0.050 or below 5%. This indicates that SI-RS development and *computer self-efficacy* influence EMR implementation compliance with *the self-efficacy barrier* as a moderator.

The success of EMR is based on how much use of EMR can be carried out consistently and integrated. To ensure EMR is implemented consistently, user compliance plays an important role. Many factors influence user compliance in EMR implementation. This can be explained through many theories related to system implementation compliance, one of which is a *compliance-based framework for digital identity management*

Hypothesis 2: Partial Influence between SIRS Development on *Barriers to Self-Efficacy*

H1 states that there is a partial influence between SIRS development against *self-efficacy barriers* **is rejected.** The results of this research show that the statistical t value for the SIRS development variable is 1.394 with a P value of 0.166 > 0.050. This shows that partially the development of SIRS has no influence on *the self-efficacy barrier*. Based on the results of this research, it is known that the magnitude of the direct influence between SIRS development on *the self-efficacy barrier* is 0.093 with a positive correlation direction which shows that the higher the SIRS development, the higher the *self-efficacy barrier* , and vice versa, the lower the SIRS development, the lower *the barrier* . *self-efficacy*. However, the known correlation is not significant, so partial development of SIRS cannot be a factor that influences *barriers to self-efficacy*.

There-box method analysis, the average value for the SIRS development variable is 89.10 in the "High" category. This shows that the development of SIRS has been considered good in supporting EMR implementation. *Barrier self-efficiency* is one of the main problems in EMR implementation. In this study, it was not proven that there was an influence of SIRS development on *self-efficacy barriers*, so the SIRS development coefficient cannot be used to predict *self-efficacy barriers*. Based on the results of this research, it can be seen that partial SIRS development cannot be used as a predictor of *self-efficacy barriers*.

Hypothesis 3: Partial Influence between *Computer Self-Efficacy* on *Barrier Self-Efficacy*

H2 states that there is a partial influence between *computer self-efficacy* on **perceived** *barrier self-efficacy*. The results of this research show that the statistical t value for the *computer self efficiency variable* is 10.724 with a P value of 0.000 < 0.050. This shows that partially *computer self-efficacy* has no influence on *barrier self-efficacy*. Based on the results of this research, it is known that the direct influence between *computer self-efficiency* on *barriers to self-efficacy* is 0.715 with a positive correlation direction which shows that the higher *the computer self-efficacy* , the higher *the self-efficacy barriers* , and vice versa, the lower *the computer self-efficacy* , the lower it is. *self-efficacy barriers*.

The results of this research also show that based on the *There-box method analysis*, the average value for the *computer self-efficiency variable* is 86.20 in the "High" category. Meanwhile, the average value for the *Barrier Self-Efficacy variable* it is 64.56 in the "Medium" category. This shows that *computer efficiency* is in the good category, which means that the majority of respondents have confidence in being able to master the use of information technology in implementing EMR. The existence of good *computer self-efficiency shows that the barrier to self-efficacy* is in the opposite condition. The obstacles to self-efficacy that respondents have are in the medium category, which means that the obstacles encountered can still be controlled.

Hypothesis 4: Partial Influence of *Barrier Self-Efficacy* on EMR Implementation

H3 states that there is a partial influence between *self-efficacy barriers on* **accepted** EMR implementation. The results of this research show that the statistical t value for the variable *self-efficacy barriers* to EMR implementation is 8.264 with a P value of 0.000 < 0.050. This shows that partially *barrier self-efficacy* has an influence on EMR implementation. Based on the results of this research, it is known that the k correlation value between *the self-efficacy barrier* and the application of EMR is 0.622 with a positive correlation direction, which shows that the higher *the self-efficacy barrier* , the higher the EMR implementation, and vice versa, the lower *the self-efficacy barrier* , the higher the lower it is. implementation of EMR.

There-box method analysis it is known that the *self-efficiency barrier variable* is 64.56 in the "Medium" category. Meanwhile, the average value for the EMR implementation variable is 82.63 in the "High" category. This shows that *the self-efficacy barriers* that are formed are able to influence the success of EMR implementation. However, the *self-efficacy* barriers found can still be controlled. This can

be seen from the results of observations which show that the implementation of EMR is in the good category, which means that the implementation of EMR at the research site can be said to be successful even though it is imagined that there are various obstacles that arise from *self-ability barriers.*

Hypothesis 5: Partial Influence between SIRS Development on EMR Implementation

H4 states that there is a partial influence between the development of SIRS on the accepted implementation of EMR**.** The results of this research show that the statistical t value for the SIRS development variable on EMR implementation is 2.126 with a P value of 0.036 < 0.050. This shows that partially the development of SIRS has an influence on the implementation of EMR. Based on the results of the research conducted, it is known that the correlation value between SIRS development and EMR implementation is 0.163 with a positive correlation direction, indicating that the higher the SIRS development, the higher the EMR implementation, and vice versa, the lower the SIRS development, the lower the EMR implementation. The results of this research show that the relationship between SIRS development and EMR implementation has significant significance. So the development of SIRS is one of the factors that partially influences the implementation of EMR.

There-box method analysis, the average value for the SIRS development variable is 89.10 in the "High" category. Meanwhile, the average value for the EMR implementation variable is 82.63 in the "High" category. This shows that the development of SIRS at the research site is in good condition to support the successful implementation of EMR. This is known from the EMR implementation value which is in the good category, which means that the EMR implementation can be said to be successful in line with the good SIRS development. The results of this study indicate that SIRS development can be a predictor in EMR implementation.

Hypothesis 6: Partial Influence of *Computer Self-Efficacy* on EMR Implementation

H5 states that there is a partial influence between *computer self-efficacy on* **accepted** EMR implementation . The results of this research show that the statistical t value for the *computer self efficiency variable* regarding EMR implementation is 7.621 with a P value of 0.000 < 0.050. This shows that partially *computer self-efficacy* has an influence on EMR implementation. Based on the results of research that has been carried out, it is known that the correlation value between *computer self-ability* and EMR implementation is 0.583 with a positive correlation direction, which shows that the higher *the computer self-ability* , the higher the EMR implementation, and vice versa, the lower *the computer self-ability* , the lower it is also the implementation of EMR.

There-box Method analysis the average value for the *computer self-efficiency variable* is 86.20 in the "High" category. Meanwhile, the average value for the EMR implementation variable is 82.63 in the "High" category. This shows that respondents' confidence in their ability to use technological information is in good condition to support the success of EMR implementation. This is known from the value of EMR implementation which is in the good category, which means that EMR implementation can be said to be successful in line with the high *computer self-efficiency* in EMR implementation. The results of this study indicate that *computer self-efficiency* can be a predictor in EMR implementation.

Conclusion

Based on the research results and discussions that have been presented, the conclusions in this research are as follows:

1. Partial development of SIRS has no influence on *self-efficacy barriers*. This shows that SIRS development is not related to *self-efficiency barriers*. *Barrier self-efficiency* is one of the main problems in EMR implementation. In this study, it was not proven that there was an influence of SIRS development on *self-efficacy barriers,* so the SIRS development coefficient cannot be used to predict *self-efficacy barriers.*
2. *Computer self-efficacy* partially influences *barrier self-efficacy.* This result is due to the existence of good *computer self-efficiency , indicating that the barrier to self-efficacy* is in

the opposite condition. The obstacles to self-efficacy that respondents have are in the medium category, which means that the obstacles encountered can still be controlled.

3. *Self-efficacy barriers* partially have an influence on EMR implementation. This shows that *the self-efficacy barriers* that are formed are able to influence the success of EMR implementation. However, the *self-efficacy* barriers found can still be controlled. This can be seen from the results of observations which show that the implementation of EMR is in the good category, which means that the implementation of EMR at the research site can be said to be successful even though it is imagined that there are various obstacles that arise from *self-ability barriers.*
4. The development of SIRS partially has an influence on the implementation of EMR. This is related to the success of the transition process during the adaptation process to the new SIRS. Users will easily adapt if the system implemented in SIRS is in accordance with the system already running in the hospital, which means that the implementation of EMR can be said to be successful in line with the good development of SIRS. The results of this study indicate that SIRS development can be a predictor in EMR implementation.
5. *Computer self-efficiency* partially has an influence on EMR implementation. This is because EMR implementation will be successful if it is supported by the employee's self-confidence that he is able to use the system well, which means that EMR implementation can be said to be successful in line with the high *computer self-efficiency* in EMR implementation. The results of this study indicate that *computer self-efficiency* can be a predictor in EMR implementation.

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