How Health IT Can Drive a Healthier Clinician Experience

6 Essential Reads for Hospital and Health System Leaders
Physician engagement is critical. Intelligent IT adoption forges the path.

Hospital and health system executives are identifying physician engagement efforts as the most reliable route toward improved performance. Physician engagement is crucial now more than ever as healthcare’s business model shifts to place dual pressure on financial and clinical leaders. Success lies in hospital executives adjusting to these changes and ensuring physicians have a seat at the table to lead the charge.

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Empowering the clinician around the EHR

By Bill Klco, Director of Healthcare, Jive Software

John Steinbeck once said, “Anything that just costs money is cheap.” That time-tested adage has never been more true—especially when it’s applied to the modern US healthcare industry.

Imagine being forced to spend millions of dollars on technology that promises to increase efficiency and profitability only to find yourself spending two to three additional hours each day on data entry, while also enduring 30 percent reductions in both pay and initial productivity. That’s how many hospitals, health systems and clinicians feel about the current state of Electronic Health Record (EHR) systems.

The Health Information Technology for Economic and Clinical Health Act (HITECH), which was part of the 2009 $787 billion economic stimulus, incentivized the “meaningful use” of EHRs to “achieve significant improvements in care.” As a result, EHR vendors are caught between clinician desires for ease-of-use and government mandates. It’s no wonder that the most recent Physicians Foundation study of more than 20,000 clinicians found that, while 85 percent had adopted EHRs, more than four-fifths described themselves as either “over-extended or at full capacity.” Nearly half (46 percent) reported that EHRs had detracted from their efficiency. Another recent survey found the same percentage of physicians described themselves as suffering from “burnout.”

CLINICIAN BLUES

While EHRs certainly fill a necessary role in this digital age, clinician complaints about them range from poor design and lack of interoperability to interruptions in workflows and the resulting reductions in productivity. These usability frustrations unfortunately limit the technology’s ability to help improve care, because they add hours’ worth of redundant tasks each day and require dozens of clicks to review a single note, which infringes on valuable patient interactions. Instead of driving more collaboration between providers, patients and payers, EHRs are building unintended silos.

UNHEALTHY MANDATE

To be fair, most EHRs aren’t designed just to improve clinical care. Instead, they’re engineered to comply with federal regulations such as those mandated by the 1996 Health Insurance Portability and Accountability Act (HIPAA). Among other things, HIPAA has strict security requirements to protect patient privacy. Of course, safeguarding people’s identifiable health information is crucial, which is why the costs of non-compliance are steep — ranging from $25,000 annually to $1.5 million or even prison sentences for the worst offenders. Is it a wonder that EHR vendors are, in the words of one physician, “focusing on qualifying their systems for the next meaningful use.”

THE CATCH-22

Today, clinicians often work across several different hospital systems, which can require them to interact with a number of different EHRs, each with its own set of security features including intentionally complex passwords and two-factor authentication. Doctors and nurses must log in and out of multiple EHRs dozens of times each day as they move between clinics, patient and exam rooms. As one might imagine, all of those extra steps are causing a lot of stress for healthcare workers who would prefer to do the one thing they do best—serve their patients. And, therein lies the catch 22. Improving patient care is one of the primary directives of the 2010 Affordable Care Act (ACA).

PATIENT SUFFERING

The move away from a fee-for-service model toward value-based care is a noble goal that one would think would be a big win for patients. Unfortunately, many patients are feeling the pain as clinicians spend ever-more time dealing with the dizzying array of technological and regulatory burdens. A recent Prophet study found “an alarming 81 percent of consumers are unsatisfied with their healthcare experience.”
“...Ultimately, it won’t be providers or EHR vendors who will determine the future of healthcare technology – it will be the patients themselves. Increasingly, consumers are taking their health into their own hands.”

While a few health systems are already “using advanced analytics to translate large amounts of data about a patient’s condition and behavior to actually anticipate the need for interventions and revise care plans,” ultimately, it won’t be providers or EHR vendors who will determine the future of healthcare technology – it will be the patients themselves.

Increasingly, consumers are taking their health into their own hands. Consider the following:

- In 2014, more than half of consumers believed mobile devices helped clinicians better coordinate care.
- Nearly half of consumers were willing to communicate with providers online.
- Last year, 58 percent of consumers had a “healthcare, wellness or medical app” on their smartphone (up from 28 percent the previous year and 16 percent in 2013).

Those numbers reflect the growing trend toward more consumerization in healthcare, and are creating opportunities for health organizations that put the patient first.

THE CURE

With the entire system in unprecedented upheaval, some forward-thinking providers are finding efficiencies in the areas they can affect most quickly.

They are supplementing their EHRs with alternative, secure collaboration solutions to streamline communication and knowledge-sharing within their practices, as well as externally with patients, administrators and payers.

It may seem counter-intuitive to suggest that more technology is the antidote for the challenges of EHRs. However, new, secure collaboration platforms excel at easily capturing human conversations, questions, answers and ideas — filling the gaps of today’s healthcare technology, and aligning perfectly with the ACA’s triple aim goals of enhancing the experience of care, improving the health of populations and, ultimately, lowering the cost of healthcare. Other industries have successfully used these types of solutions to improve workflows and engage employees in the ways they work best for years.

By reclaiming efficiencies from the slowdowns that are inherent to complicated EHR implementations, new technologies are creating better outcomes for clinicians and patients alike. But you shouldn’t just take it from me – John Steinbeck also said, “No one wants advice, only answers and ideas — filling the gaps of today’s healthcare technology.”

And in today’s healthcare environment, those are words to live by.

Physicians play a high stakes game to identify quality problems

By Dr. Anthony Oliva, Vice President and Chief Medical Officer, Nuance

Many physicians today are baffled by how quality of care is measured, and how that information makes its way to the public in different ways and with varying degrees of credibility. Not only are hospitals publicly ranked in terms of quality performance, consumers can now read online reviews, and compare hospitals and physicians based on details they probably don’t know much about, such as C-section rates, medication protocols and mortality (whether a death was expected or not).

It used to be clear: If you did a good job healing patients, they were usually satisfied. If they felt you and your care team treated them properly and with compassion, doing the best you could with their health concerns, it usually translated into “quality of care.” Happy, satisfied patients subsequently translated into a solid paycheck, a strong pipeline of referrals and a great reputation.

Not anymore. Nobody is disputing that quality of care is important, or even that it needs to be measured and reported publicly. Physicians and healthcare leaders support rewarding and even emulating top performers, but what they question is the way quality is being measured.

People need to understand how hospitals or physicians get to the top or the bottom percentile of lists published by HealthGrades, Leapfrog or CareChex. And, more importantly, clinicians need to know how to identify and fix problems related to quality — even if it turns out to not be about the care delivered at all.

Today most people in and out of the healthcare industry don’t know what really drives public quality ratings. Healthcare leaders are beginning to understand it has something to do with what physicians are putting (or not putting) into patient charts, but very few know that today these are driven by billing and claims data, and fixing that is not enough.

CLINICAL CATCHPHRASE

Physicians are caught in the game of Catchphrase. You may know the game. There are different teams where one player provides clues while the others try to guess a common word or expression before time runs out. The team that can name the desired “catchphrase” more often before time runs out wins. In a way, that is what’s happening in healthcare today, but the stakes are higher.
"Doctor speak" doesn’t naturally translate into terms that support the business of healthcare (ICD-10 codes, medical necessity) or top quality rankings, and if the catchphrases aren’t there for coders, payers and regulators, then the care doesn’t translate into reimbursement and quality, creating holes that can live in the patient record, impacting future care and hospital metrics. I work with physicians and healthcare leaders to educate teams about how to speak the same language to put this clinically relevant information into patient charts and pull it through the process to improve both the clinical and financial side of healthcare using clinical documentation improvement (CDI). And it works.

A new study using public rankings shows that Nuance CDI clients outperform other hospitals in national quality rankings. When clinicians improve the details in their clinical notes, it helps other caregivers get a clearer picture of the patient, especially in today’s EHR-driven world, and their notes support higher quality rankings.

More importantly, this approach to CDI shows caregivers where gaps in quality of care actually exist that impact the patient.

**IS IT A QUALITY PROBLEM OR A DOCUMENTATION PROBLEM?**

This part is not a game. Hospitals need to know when they have a real quality problem vs. a documentation problem masquerading as a quality problem. I work with hospital and physicians to improve clinical documentation and eliminate the gray areas, so they find and attack the root of real quality problems and deliver better patient care.

While words matter, it’s not enough to just find the catchphrase and fix documentation. To truly improve patient care, hospitals and physicians need to make sure their patient records tell the patient’s true story, reflecting the quality of care delivered and ultimately demonstrating that in the rankings that are reported to the public.

Bridging the divide: How the level of physician engagement can make or break your hospital

By Tamara Rosin, Assistant Editor, Becker’s Healthcare

The importance of strong physician engagement is far from new, but hospital and health system CEOs recently elevated it to the most promising means of improving performance, according to The Advisory Board Company’s Annual Health Care CEO survey.

This year, hospital and health system CEOs were twice as likely to rate physician engagement as their best opportunity to improve performance compared with other options — such as redesigning service portfolios for population health, strengthening primary care physician alignment and controlling avoidable utilization, among others — with 90 percent of respondents reporting an interest in physician engagement. Last year, survey respondents ranked physician engagement as the third-best opportunity to improve performance.

Engaged physicians approach their work with energy and enthusiasm, are dedicated to their patients and truly committed to the improvement of their organizations. In contrast, disengagement among physicians can pose a serious impediment to achieving an organization’s goals.

**WHY PHYSICIAN ENGAGEMENT IS CRITICAL NOW MORE THAN EVER**

Stephen Moore, MD, CMO of Houston-based CHI St. Luke’s Health, says numerous external demands have forced physicians’ and administrators’ relationships to evolve to understand physician engagement as a top priority.

Historically, the focus has always been less on physician engagement and more on physician satisfaction, according to Dr. Moore. Giving physicians what they wanted — such as access to the operating room and a supportive nursing staff — is what drove good business. Now, however, there is an opportunity through physician engagement — whether with employed or independent physicians — to improve patient access, customer service, quality and costs.

"Today the business model is shifting to a payment for value as well as value-based contracting with commercial payers," says Dr. Moore. "This change has really forced healthcare to unify operational and clinical leadership."
Establishing a highly engaged physician population allows hospitals to more effectively target the quality and efficiency issues that may help reduce complications, mortality, readmissions and length of stay. It allows the whole hospital business to come together as a team and tackle inefficiencies while addressing the needs of the community and making the patient experience more satisfactory, according to Dr. Moore.

Rob Lazerow, practice manager for The Advisory Board Company, says hospitals that fail to prioritize physician engagement will be left in the dust.

“Physician engagement is critical now because hospitals and health systems are in the midst of pretty major transformation,” says Mr. Lazerow. “They are changing payment models, moving toward population health and providing more affordable care. Hospitals cannot achieve any of this without strong participation from their medical staff.”

Hospital administrators have always focused on how they engage physicians, but the difference is that the stakes are much higher, according to Mr. Lazerow. While improving care delivery and quality is an everlasting goal in healthcare, the risks of getting it wrong and the importance of getting it right are higher than ever before, as clinical outcomes and financial performance become bound more closely together.

**POSITIVE EFFECTS OF ENHANCED PHYSICIAN ENGAGEMENT**

There are numerous benefits of having a highly engaged physician workforce in addition to improved quality, lower costs and better performance overall.

An organization’s culture is profoundly affected by increasing engagement among physicians and other clinical staff, according to Dr. Moore. Dyad and triad leadership models – in which physicians, nursing staff and executives work together on some level of management – create a trickle-down effect through the rest of the organization, because each group contributes its perspective of the business and can more efficiently solve issues. Additionally, the act of bringing physician and nurse leaders to the table with executives helps flatten the traditional health system hierarchy in which physicians serve as the clinical captains but are not really integrated with broader leadership.

Physician engagement also fosters a sense of connectedness, value and influence among physicians, which is beneficial to any hospital.

“In the past, one could classify even the best of situations as having tension between physicians and administrators,” says Dr. Moore. “A highly engaged physician workforce chews away at the edges of that tension. It renews a sense of purpose for waking up and going to work.”

**TRADITIONAL HOSPITAL CULTURE POSES AN OBSTACLE**

Effectively engaging physicians requires a restructuring in the way various components in healthcare organizations communicate and interact. According to Dr. Moore, until recently, healthcare functioned in a tri-partite parallel structure, in which the administrative leaders, physician leaders and other clinical leaders operated in distinct silos with little coordination and collaboration bridging them together. The recent push for increasing value, lowering costs and improving population health management is driving those parallel silos together, and the systems that most effectively align the interests of all three will be most successful.

Changing the structure and culture required to enable physician engagement does not happen overnight. While there hasn’t been any resistance to the concept of improved engagement, Dr. Moore explains the difficulties lie more heavily on how exactly to achieve it.

“We are almost completely changing a business model that has been present for the last 100 years,” he says.

There are cultural obstacles to overcome when making a systemic change within an organization, such as integrating physician leadership into operations. This is often equally uncharted water for both physicians and administrators, according to Dr. Moore. While everyone sees a need to go there, the process of overcoming the historical working relationship in which administrators wielded majority control requires a concerted effort as well as openness to learning and flexibility.

**BEST PRACTICES FOR PHYSICIAN ENGAGEMENT EFFORTS**

There are several important aspects of successful strategies designed to achieve this alignment and engage physicians.

**Implementing effective incentives.** According to Mr. Lazerow, whether approaching an employee model or not, incentives are an important lever for motivating the right behavior and removing the barriers to higher performance. Compensation models are increasingly important as private practices consolidate with larger health systems and physicians seek hospital employment.

Applying the right compensation models. Incentives based on productivity conflict with value-based care and population health management efforts, according to Mr. Lazerow. Instead, determining compensation models that promote highly efficient, population health-oriented care will reduce barriers to care transformation and may lead to improved engagement among physicians.

**Shifting the focus from contractual to cultural alignment.** Another important aspect of enhancing physician engagement is shifting the focus from contractual alignment to cultural alignment, which includes focusing on leadership, joint decision-making and aligning strategy between physicians and administrators. However, contractual alignment is still vital for supporting the structures that create a unified care model, Mr. Lazerow notes. For example, he explains that
models such as clinical integration can provide a vehicle for bringing together employed and private practice physicians.

**Developing strong physician leaders.** Effectively integrating the clinical and administrative components of physician engagement calls for strong physician leadership and participation in governance roles. According to Dr. Moore, an essential part of this is identifying leadership opportunities and offering formal leadership development programs for physicians. “The idea is to grow a coterie of physicians interested in becoming leaders in their specialties or across the medical staff, as well as involving physicians in operations of the organization, including decisions for purchases and allocation, developing care models and working with administrative leaders to create the quality and efficiency solutions the organization needs,” says Dr. Moore.

**Improving transparency.** Finally, improving performance transparency provides physicians with the means to analyze data on a case-by-case basis and provide better care in the future.

**SUPPLEMENTING PHYSICIAN ENGAGEMENT EFFORTS WITH TECHNOLOGICAL TOOLS**

Dan Malloy, PhD, executive vice president at Quantia, says the key driver of physician engagement is incorporating physicians’ input into operational agendas instead of merely imposing new strategies over which physicians have no say.

A majority of hospital administrators have very limited experience in managing physicians as employees, according to Dr. Malloy. If administrators’ understanding of what physicians need to be effective is lacking and they have not created the communication mechanisms to hear physicians’ opinions on how they want to be managed, the process of improving engagement could hit a roadblock.

New technology, such as content sources physicians respect, can help support communication between physicians and administrators.

For example, Quantia operates a web-based property called QuantiaMD — an online physician community with 225,000 physician members who use it as a location for self-directed learning and collaboration with peers and colleagues across the industry. Health systems can leverage the platform as a vehicle to facilitate interaction, communication and engagement with their physicians to align their strategic business needs.

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“In building physician engagement programs and strategies, you are talking about people who are fundamentally time-starved,” says Dr. Malloy. “The design of such programs must leverage exchanges of information and dialogue in a concise and efficient way – the way physicians want to interact with and use information.”

The Advisory Board Company offers its own tool for engaging physicians in cost and quality improvements. More than 1,000 organizations participate in The Advisory Board Company’s Crimson Clinical Advantage suite of programs that align the efforts of physicians and health systems to deliver higher quality, cost-effective care to the patients they serve.

The Advisory Board Company develops the Crimson Clinical Advantage’s suite of offerings in partnership with a growing team of progressive health systems, hospitals and physicians. It helps health systems succeed under value-based reimbursement models by combining business intelligence technology with analytics support grounded in best practice research. Among other benefits, member organizations gain a nuanced view into physician practice patterns and payer-specific clinical and financial performance.

The Studer Group offers another variation of a physician engagement resource for hospitals and health systems. Through the Studer Group’s Physician Coaching Partnership program, the Studer Group works with organizations to help them achieve alignment with physicians to drive accountability and further develop physician skills to improve patient outcomes. The Physician Coaching Partnership program begins with an initial survey and needs assessment, and is followed up with a comprehensive physician coaching plan and strategy.

The process of creating a strong physician workforce is a long and challenging one, but patients, payers and financial demands necessitate it. Most importantly, physicians wield the clinical expertise that can inform strategies, improve workflow and lead to better outcomes for patients, in turn improving the hospital’s performance.
How Health IT Can Drive a Healthier Clinician Experience

Saying goodbye to paper: The iPad advantage for healthcare

By Chris Joyce, Director of Healthcare Solutions, Bottomline Technologies

From patient intake to physician diagnosis to final discharge, paperwork maintains a constant presence in every phase of the healthcare process. But given its inherent inefficiencies, paper causes problems from both the healthcare perspective and the patient perspective. Given today’s digital society, the question arises: Can paper be discarded? And, if it can be eliminated in the process, what advantages might that bring to the hospital system?

A PAPER LOGJAM

Paperwork clogs the hospital system in many different ways. For instance, there is the purely physical nature of paper. In many hospitals, employees wheel a cart from room to room with a laptop and scanner, scanning endless forms so that the data enters the Enterprise Content Management system (ECM). These carts often get in the way, creating a physical and emotional barrier between patient and caregiver.

Then there is the “grunt work” that paperwork creates. Consider the path a patient form might take. First, the patient completes the form. A hospital employee then checks the form, returning it to the patient if there are any omissions. The finished form must be scanned. A barcode label may need to be assigned. If any data on the form needs to be searchable and accessible, it will have to be entered manually into the Electronic Medical Record system (EMR). Finally, the form may be checked as part of a quality control procedure to verify that it has been indexed properly.

Patients, of course, find paperwork frustrating. Clipboards with multiple forms can be daunting and confusing, leaving patients uncertain about what information they need to fill out. That frustration mounts if patients are required to complete the same forms more than once to get the treatment they need. For example, they may be required to provide their medical history in several different departments or clinics within a large hospital.

Finally, there is the fact that scanned images are static in nature. The data they contain cannot be searched, accessed, or manipulated. That immobility is completely at variance with the whole tone of technology today, where data is raw material to be analyzed and leveraged to meet defined objectives.

The physicality of paper, the manual processes it necessitates, the patient frustration it causes, and the inflexibility it represents all combine to create a paper logjam blocking the efficient flow of work in the healthcare setting.

ENTER THE IPAD

Now, consider an alternative: replacing paperwork with an iPad-specific healthcare application that would allow all forms to be completed on a mobile device that is nearly universally familiar and has revolutionized the simplicity of how people interact with technology.

Why the iPad? When Apple developed the iPad, they did so with the end user in mind. They created a piece of technology that is basically age- and understanding-agnostic. That is critical for the healthcare environment, where the age-50+ population is growing. Hand an elderly patient an iPad, and they can complete the healthcare form that appears on it without
technical difficulty. Similarly, hospital personnel require only minimal training to use an iPad-based application. It is a truly intuitive tool.

EXPERIENCING DIGITAL VALUE

Moving from paper to virtual forms via an iPad-based application has positive ramifications throughout the healthcare system. Consider these top six value-adds:

#1 Simplicity
Value: starts at the very beginning: with a drag-and-drop method of entering forms that automatically optimizes each form for digital input. Hospitals have innumerable forms. If each form required coding to enter it into the application, the task would be monumental. But drag-and-drop simplicity makes deployment straightforward and swift. Plus, by removing cumbersome coding, forms can be edited, managed and controlled by business users without placing a burden on IT.

#2 Automation
Removing paperwork and automating the forms process has immediate positive effects on hospital personnel and processes:
- Hospital staff are freed up for more strategic roles as scanning, barcoding and data entry are made obsolete
- Manual data entry errors are eliminated
- The correct forms for each patient are always immediately available and can be produced in more than one language if necessary
- Patient data is instantly accessible – there is no delay for scanning and entry into backend systems
- Hospital personnel are better enabled to engage with the patients at the point of care
- Storage of paper documents is eliminated, along with risks associated with lost or stolen files

#3 Standardization
Online forms simplify standardization of document naming conventions, with no coding or programming required. Such standardization then allows the forms to map correctly up to the EMR, creating a truly efficient hyperlink to all content.

#4 Compliance
Healthcare forms must be completed in full since the data they contain carries financial and legal implications. On the financial side, the revenue cycle starts with the patient filling out the appropriate forms. On the legal side, there are often consents that have to be obtained, which may have to be produced if a liability issue arises. An iPad-based healthcare form makes such compliance simple. Areas requiring patient and staff input are color-coded. Omissions are automatically flagged. Patients don’t have to wonder if they “got it all,” nor do hospital staff need to manually check forms for completeness. The application itself notes when the form is finished.

#5 Satisfaction
An iPad application for healthcare forms increases satisfaction for all stakeholders. Hospital personnel can use the application with minimal training due to the intuitive nature of the iPad. Once the application is deployed, they can access any form and capture any consent on the spot. The patient experience is enhanced by making form completion easier and more straightforward. Patient data is then instantly accessible from any location and by any person in the hospital. With less time spent on admitting, staff members have more quality time to dedicate to patients.

#6 Cost Savings
In addition to satisfaction, an iPad healthcare application generates savings for the hospital system. These savings come from many sources:
- The automation of manual tasks
- The elimination of data entry errors
- Increased staff productivity
- The ability to process patient information more quickly
- Streamlining the flow of data through the hospital system
- Enhanced compliance and security
- The empowering of business users to perform tasks formerly requiring IT input

The more a hospital system uses the iPad application functionality, the greater the return on investment they experience.

THE IPAD ADVANTAGE
Hospitals generate an almost unfathomable amount of data, so any solution that streamlines the generation, transmission and accessibility of that data brings significant benefit to the entire system. Removing paper from the data flow and replacing it with an iPad application does exactly that, beginning with the moment the iPad is handed to a patient.

And the iPad itself, coupled with a consumer-focused application, makes the transition from paper to virtual forms easy. Deployment, training and implementation are simple and straightforward. Hospitals can begin to reap the benefits of the iPad advantage from day one.

“Paper has played a vital role in hospitals for centuries. But now, paper forms can be retired with honor. It’s time for online healthcare forms to take center stage.”
5 steps for engaging physicians in clinical documentation improvement programs

By Tamara Rosin, Assistant Editor, Becker’s Healthcare

Document issues can cost hospitals millions of dollars per year. While reaping physicians to take a greater initiative in clinical documentation improvement efforts can be a feat in itself, there are several strategies hospitals and health systems can use to improve physician engagement.

The average 250-bed hospital leaves an estimated $7.1 million on the table every year, and that number is expected to grow to $12.8 million by 2020 as a result of other external factors, such as ICD-10 and value-based purchasing, according to Edward Hock, managing director of The Advisory Board Company.

Furthermore, about 60 to 80 percent of opportunities to resolve documentation issues are concentrated among 10 to 20 percent of total physicians.

“We took a step back and asked, ‘Does this teach us anything about how hospitals and health systems should tackle this issue of documentation?’” Mr. Hock said at the Becker's Hospital Review 6th Annual Meeting in Chicago.

Hospitals can improve physician engagement in CDI by taking the following steps.

1. Determine which physicians will benefit the most. According to Mr. Hock, hospitals can reap the most substantial benefits in their CPI programs by identifying a select amount of physicians to train. These physicians should have the greatest opportunity for impact, meaning they have plenty of room to improve their documentation, as well as see many patients. However, it is important hospitals “don’t bite off more than they can chew,” said Michael Redman, RN, director of care coordination and clinical analysis of St. Joseph Hospital in Bryan, Texas. If hospitals don’t have the resources or time to train and monitor a large group of physicians, they should reduce the number of participants.

2. Make a compelling case to physicians using evidence-based reasoning. Physicians will be more likely to understand the need to improve clinical documentation if the hospital leadership uses real life examples to show how documentation impacts quality of care.

Mr. Redman said by starting with the big picture with national trends of clinical documentation performance, then narrowing down to the hospital’s performance, department performance and then the individual physician’s performance, physicians take a greater interest in their performance on a comparative level.

3. Educate through a documentation training session. According to Mr. Redman, an intensive training session over the course of a few days is an important first step to initiating behavior change and ongoing documentation improvement.

4. Provide ongoing progress and performance monitoring and support. It is equally important to continue educational efforts and provide support for physicians on an ongoing basis, according to Mr. Hock. The physician and others present during performance tracking meetings, including the CDI staff, coders and the case management director, discuss the physicians’ progress to keep them engaged in the improvement process.

Physicians show the greatest improvement when they are able to see how the quality data they care about – such as mortality rates and patient stays – are tied to clinical documentation.

While many physicians are initially resistant to the idea of blocking off an entire hour every other month for check-ins, Mr. Redman said the participating physicians eventually looked forward to their meetings.

“Physicians came in at first kicking and screaming. They said they didn’t have an hour for their training and meetings to go over their numbers,” said Mr. Redman. “But soon they wanted to see their numbers and the direct impact they were having. We were able to keep that energy going by showing the difference they made and how they were helping their patients.”

5. Involve executives. Involving executives in CDI programs, especially CMOs and clinical integration chiefs, creates a “watercooler effect” by spreading enthusiasm and support of the program to physicians, according to Mr. Redman. Additionally, once physicians became comfortable with the process and started seeing positive results, they would talk to other physicians who would then want to participate as well.
The upside of EHRs: 3 physicians’ perspectives on what they get right

By Max Green, Writer / Reporter, Becker’s Healthcare

EHRs are healthcare’s most popular punching bags. Physicians say the clunky, unintuitive interfaces make their jobs harder. The cost of implementation ranges from hundreds of thousands to millions of dollars, with some systems even planning for $1 billion-plus. Patients also have a problem with EHRs: The more time the physician spends entering data and looking at a screen, the less satisfied patients become, studies suggest.

With complaints as rich as these, it’s easy to overlook the good EHRs facilitate. Here are three perspectives from physicians on what EHRs have gotten right.

Note: Responses have been edited for clarity, style and length.

Jesse Ehrenfeld, MD
Associate Professor of Anesthesiology, Surgery, Biomedical Informatics and Health Policy at Vanderbilt University School of Medicine (Nashville, Tenn.), Board Trustee for the American Medical Association (Chicago)

“EHRs are obviously here to stay for a lot of reasons, and there are certainly very positive things about them. I think about the things they let me do very effectively, and the things I think most practices around the country that have adopted them find useful. Primarily, they fall into three categories. I think there have been a lot of benefits around e-prescribing. Secondly, some of the drug alerts and clinical decision support built into EHRs have helped us improve quality and safety. Then the ability of multiple clinicians or users to access medical information at the same time. These are probably some of the biggest benefits that, across specialties and practices, physicians find really helpful.

In the operating room, when I have a patient who is under anesthesia, the electronic record gives me a visual representation that allows me deeper insight into what’s happening in the moment. When I talk to my colleagues that have clinic-based practices, they find the same thing. Having a longitudinal view of data that’s pulled together in a way that generates information is probably a huge benefit of these systems. The challenge, of course, is doing that right and well. The AMA has laid out principles around how these things can be best done, and one of the principles is these systems should help reduce cognitive workload and get better insight from information in the patient’s record.”

Anas Daghestani, MD
Internalist at Austin (Texas) Regional Clinic

“We’ve pulled all of the clinical data out of our EHR and combined it with claims data from insurance. That allowed us to have more of a complete picture about what happens within and outside our system. We then looked at our population to see how we compared to the National Committee for Quality Assurance guidelines on different health measures, like cancer screening, management of diabetes and management of coronary artery disease. That allows us to look for areas where we’re doing better and worse, and devote resources, education and awareness on a system level.

At the individual level, we’ve built alerts within the system to alert our physicians at the time of the [patient] visit. So if I have a patient seeing me for an ankle sprain, but they haven’t had a colon cancer screening test done in 10 years and they’re due for one, it’s going to give me an alert within the system.

We’ve built those same alerts on the patient side. Our patients have access to our portals, so we’ve invested a lot of time and energy into promoting access to our system on the patient or customer side so they can log in and see this information the same way we’re seeing it. If I’m a patient at Austin Regional Clinic and I log in, it will show that I’m due for a pneumonia shot or a flu shot, that I’m overdue for a mammogram or a colonoscopy or a blood test. Making that information available to the patient on an individual level and the physician on a system level measures how we’re doing between different providers, different locations and on a population level. We can then decide how we want to invest our resources.

We saw we were having a hard time with screening diabetic [patients] for eye disease. [Screening] rates were low. We looked at national rates and we found them to be as low as ours, so we invested in technology and solutions. We ended up bringing screening equipment in-house, so screenings could be done in the lab at the same time that a patient gets a blood test. We began seeing a dramatic improvement in our screening rate immediately. Before the EHR, we would have not been able to measure that information.”

Monica Williams-Murphy, MD
Emergency Medicine Physician at Huntsville (Ala.) Hospital

“EHRs are going to be part of the solution for having accessible and actionable advance directives. Medical care can be driven by wisely considered patient wishes, particularly near the end of life when patients are often unable to speak for themselves. The era of paper records and paper-based living wills [or] advance care plans will hopefully, sooner rather than later, give way to a much more cohesive care plan informed by patient wishes.”
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