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Adopting Electronic Health Records – the Challenge

By Jon Roberts

A few months back I wrote a column for *FYA* about the "big" changes on the horizon for healthcare. As evidenced by the media, and my own contribution to *FYA*, there seems to be no boundaries on the extent to which this can be discussed. Putting much of it aside, I would like to offer a few thoughts on the adoption of electronic health/medical records (EHR), as the advancement of new technology in healthcare seems to be a major platform of the Obama administration's "plan."

My first observation is that despite the Obama administration's "Change/Hope" platform, with regards to electronic health records, there is no disagreement with the previous administration's view: Electronic health records will streamline care, reduce waste and therefore costs, and reduce errors, thereby improving outcomes for patients. So, this is terrific, because we actually have some agreement about the problems/answers of healthcare.

To the "civilian," that sounds pretty fantastic – "streamline care, reduce waste and therefore costs, and reduce errors, thereby improving outcomes for patients." For those of us working in healthcare, we realize that it is not so simple.

What actually happens is more complicated and the real benefits of a new EHR are often debatable. We spend millions upon millions of dollars on the software and the training. Timelines for training and "go-live" are constantly set back. This takes away from other initiatives that have been designed to improve care. Productivity drops dramatically. Overtime increases. At some places I've consulted, seasoned clinicians decide that the new system is the signal they needed to retire. Ironing out the kinks of the new system takes years, and when that happens, we're operating roughly at the same levels we were before we began this endeavor. During the course of that time, we've often been forced to adopt other technologies that don't "speak" to the new system, and we come to live with these shortcomings because we have to. On the "upside," we've got a system "update" coming along in the not-so-distant future.

Now, that's a pretty chilling assessment, but if you've been around for a while, I'd bet much of that resonates with you. Why is it like that? I always ask my clients: "You're dissatisfied with the IT system that your organization is currently using. What is different now as you prepare to take on this new system? What have you learned that will keep you from being in this same position two years from now?" I get all sorts of answers to this interrogation. Many people cite an insufficient investment in either training or post go-live support. Occasionally I hear that staff are "stuck in the stone age," that is, not willing to learn a new system. One that particularly interests me is, "we involved the clinicians in the design of the system, but when it was finished they weren't happy with it." (I'll have to address that in another column.) The most common

(Continued...)

Adopting Electronic Health Records – the Challenge (Continued)

answer I hear is about the failure of the technology; it just wasn't designed well. We blame the technology. A colleague of mine was discussing this with Greg Daines, founder of Knowligent, an IT consulting and services firm, based in Boston, MA, and Daines said something interesting. "No IT adoption has failed because of a lack of capability of the technology". To some of you, that probably sounds crazy. What if that is true? Let's step back and take a look at how we generally go about implementing a new IT system at a healthcare organization.

First, please forgive me for being overly simplistic in my description here. Traditionally, an IT implementation happens in three phases:

- 1) System build
- 2) Training
- 3) "Go Live" and post "Go Live" support

System build. The major providers of large-scale IT solutions have years and years of experience in helping design and customize systems to meet their clients' needs. Starting with a basic platform, teams are deployed to understand how different teams and departments will need to have the system "tweaked" to suit them. During this phase, frontline staff members have the opportunity to provide input into the design of the system.

Training. Assign a few people from each department to become "super-users." While everyone will get a good deal of offsite classroom training, "super-users" will get extra training so that they can be a resource to regular "end-users" after the system is up and running. Training consists of walking through a user manual and learning the various functions of the system as appropriate. Most often, staff will have spent time allotted to practice using the system in a computer lab on-site, where there will often be "super-users" present and members of the implementation team to help navigate through problems.

Go live and post go live support. A great deal of effort is put into understanding the order in which different departments should be up and running. Some

departments can operate independently, and some cannot. That's pretty complicated stuff. Once each department "goes live," we invest an enormous amount of resources in order to have help available to the end users while they actually use the new system and take care of patients. This is when, as I said above, productivity drops dramatically, and the "hidden" costs of the new system begin to be realized. I've even worked with a few clients that can attribute terrible patient outcomes to the post go-live confusion. It's pretty scary stuff.

So what is going on here? If, as Greg Daines states, "It's not about the capability of the technology," then what is it? Are many staff members really stuck in the past and unwilling to learn something new? I witnessed an encounter during an IT training session that I really enjoyed. At the beginning of the session, the teacher from the implementation team said to a group of seasoned nurses, "Now, I know it's scary for some of you to learn how to use a computer..." One nurse said, "Don't give me that, we've all been using computers for years. I use computers more than my daughter and she's a high school principle!" So, I don't buy the idea that nurses aren't willing to use technology. Is it a failure to dedicate enough resources? Remember, this is what many of my clients "blame" their "bad" systems on. It's my observation that once underway, large organizations hemorrhage time and money in an attempt to make the transition successful. So if it's not the technology, and it's not your staff or your financial commitment, then what is going on here?

I'm out of space in this column. I will attempt to give these questions proper attention in my next column, which will be titled "A Tale of Two Rollouts." I will leave you with a hint of what's to come: context, problem solving and timing. If you just can't wait to hear the rest, send me an e-mail.

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Time to Care About Primary Care

By Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

Most would agree that the quality of primary healthcare is the cornerstone of a healthcare system since it affects outcomes, efficiencies and costs. And the importance of quality primary healthcare is increasing rapidly as patients age, the incidence of chronic disease increases and patients increasingly seek outpatient care instead of inpatient care. Thus, the direction of primary healthcare can be considered as a bellwether for the direction of healthcare quality.

A 2009 Commonwealth Fund study of primary care in 11 countries provides some helpful insights into the role and usefulness of primary care. The countries studied included Australia, Canada, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, the United Kingdom and the United States. The study is summarized in a November 5, 2009, article in *Health Affairs-Web Exclusive* entitled "A Survey of Primary Care Physicians in Eleven Countries, 2009: Perspectives on Care, Costs, and Experiences," which provides some valuable insights that should be considered as our leaders in Washington, D.C. continue their crusade to reform our U.S. healthcare system. The study, which is the twelfth in a series, focused on access, chronic care management, health information technology and financial and information incentives, all of which have been considered as targets for U.S. healthcare reform.

Consider the following interesting and instructive conclusions from the study:

- "The United States is distinct in its reliance on internal medicine and pediatrics for primary care and its highly decentralized referral systems," whereas the other countries "rely extensively on general or family practice (GP/FP) physicians, often augmented by use of primary care nurses for preventive or chronic care and counseling."
- "In recent years, all but the United States have initiated national reforms, including financial and information incentives, focused on primary care to strengthen or transform the capacity to provide a foundation for high-quality, efficient care."
- The study found a noticeable difference among the countries in the adoption and use of electronic medical records:
 - "In Australia, Italy, the Netherlands, New Zealand, Sweden, and the United Kingdom, EMRs are nearly universal..." whereas physicians in Canada, the

United States and France "lag behind in basic EMRs as well as multifunctional support..."

- EMR capacities differ widely – e.g., "among the seven countries with near-universal EMRs, the majority of physicians reported electronic access to lab results, yet fewer than half of Dutch, Norwegian, and U.K. doctors can order tests electronically." But most doctors with EMRs in most of the countries reported access to electronic clinical notes, routine electronic prescribing and computerized alerts about potential problems with drugs and drug interactions.
- Decision support "appears generally less well developed," with computerized prompts about treatment guidelines, lab test tracking and prompts to provide patients with test results were among the least frequently reported usages.
- Primary care practices were generally regarded as "an entry point into the health care system, as well as, a key source of prevention, essential care, and continuity."
- Especially interesting was the following: "Asked whether their practice had an arrangement where patients could be seen after hours without going to an emergency room (ER), nearly all Dutch, New Zealand, and U.K. doctors said 'yes', compared to just 29 percent of U.S. physicians – the lowest in the survey."
- While a majority of Canadian, German, Italian and Swedish primary care doctors reported long waits for patients to see specialists, "less than 30 percent of U.S. and U.K. doctors reported long waits – the lowest rates in the survey."
- "An increasing share of primary doctors' time is spent caring for patients with complex chronic conditions" and thus "improving outcomes requires transforming primary care to focus on prevention and health and engaging patients and families to manage conditions over time."

This excellent study provides some interesting insights regarding the role of primary care in healthcare that should be carefully considered as a part of forthcoming U.S. healthcare reform.



I would like to hear your comments.

Send them to:

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Healthcare Reform – What and When

The *Washington Post* reported that the bill the Senate began debating last week could be setting Americans up for disappointment: Some of the main reforms would not take place for several years, and even when they do, some observers say, the bill does too little to make sure they would be enforced.

Until 2014, insurance companies could continue to deny coverage or charge higher premiums based on people's medical history. Another highly publicized reform – banning annual and lifetime limits on coverage – would take effect in 2010, but it would permit significant exceptions.

Even with those rules in place, "there's no power to really hold the insurance companies accountable," said consumer advocate Betty Ahrens, executive director of the Iowa Citizen Action Network. "It's toothless."

Jim Manley, a spokesman for Senate Majority Leader Harry M. Reid (Democrat from Nevada) said the bill was a compromise. "This is not the legislation we would have written in a perfect world, but Senator Reid believes that this bill has the best chance possible to get the 60 votes necessary to overcome a Republican filibuster," Manley said.

Delaying relief until 2014 means that the President could face reelection – and Congress be transformed by two elections – before voters begin feeling the legislation's full effect.

It would also reduce the cost of the bill during the 10-year budget window measured by the Congressional Budget Office.

Deferred until 2014 would be a federal mandate that everyone buy insurance, subsidies to help people with lower incomes pay for it and the creation of marketplaces called exchanges, in which individuals and small businesses could comparison-shop for health plans.

The bill would offer interim relief for some people with preexisting conditions by creating a temporary insurance plan just for them, but only people who have been uninsured for six months could join.

A close reading of the bill reveals other surprises, like the section titled "No lifetime or annual limits," which is intended to protect people from huge out-of-pocket expenses.

Where annual benefits are concerned, the Senate bill bans only "unreasonable" limits. What that means is not spelled out; a Senate aide said the Treasury Department would set the standard.

In addition, the bill says that certain health plans could continue to use annual and lifetime limits. As Timothy Stoltzfus Jost, a law professor at Washington and Lee University, interprets it, those potentially exempt from the ban include companies that self-insure and businesses with more than 100 employees.

Further, the prohibition on lifetime and annual limits applies only to limits "on the dollar value of benefits."

In the past, health plans have gotten around restrictions measured in dollars. In 1996, Congress passed a law that said employers could not set lower dollar limits on mental health coverage than on medical and surgical coverage. Many employers responded by adopting tighter limits on the number of mental health outpatient visits or hospital days, according to testimony the Government Accountability Office gave in 2000. Congress finally closed that loophole in 2008.

What's more, enforcement of the bill's new federal insurance rules would generally be the responsibility of state regulators. With some exceptions, the federal government would step in to police private insurers only if it determined a state was not doing the job.

"Unless an administration is in place in 2014 that is deeply committed to pushing recalcitrant states aside and taking direct action, it is likely that the reforms may never be implemented adequately throughout the country," Jost wrote in a recent blog post.

About



PHNS provides IT services for hospitals, other healthcare providers and businesses. PHNS' IT services include application hosting, co-location and managed services; electronic off-site data back-up and data vaulting; business continuity solutions; disaster recovery services; and systems integration services. PHNS also provides comprehensive business process

solutions for hospitals including admitting, HIM (including medical record management and storage, transcription, coding, release of information and electronic medical record services) and revenue cycle services. PHNS creates business-healthy hospitals by improving operations, enhancing technology and increasing cash on hand, which allows hospitals to focus on their core competency – patient care. PHNS has approximately 1,670 customers, including approximately 400 hospital IT and business process customers and approximately 1,270 IT customers. PHNS is headquartered in Dallas, Texas. See www.phns.com for additional information about PHNS.