H&HN

Executive Dialogue

Technology as an Enabler of Change

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The path to meaningful use remains varied among health care organizations. For some, achieving Stage 1 requirements was a matter of fulfilling the organization's IT strategic plan. Other organizations, however, have had to navigate the complex process of electronic health record adoption from the beginning. Regardless of where organizations are in terms of meaningful use adoption, significant challenges and questions remain about the ability and needs of IT systems to impact population health and adapt to the value-based health care delivery system.

To discuss these issues, Health Forum convened a panel of industry experts Oct. 18 in Indian Hills, Calif., for a roundtable discussion. Health Forum would like to thank all participants for their open and candid discussion, as well as AT&T, McKesson, CareTech Solutions and CHIME for sponsoring this event and the Most Wired Survey.

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MODERATOR (Matthew Weinstock, Health Forum): We're going to start by looking at meaningful use. The Stage 2 rules are finalized. What's your sense of where the field is in terms of adoption and meeting meaningful use criteria?

PAMELA McNUTT (Methodist Health System): We're not as far along as we hoped we would be at this point, and that raises a little bit of a worry. There are still organizations that have not achieved Stage 1 and that has to be a priority for the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health Information Technology. They will continue to look at adoption rates before they start to impose penalties, and continue to look to see if the time frames are reasonable. There already have been adjustments to the time frame and I think more are likely. Stage 2 is really quite a leap from Stage 1 for most organizations.

MODERATOR: Does everyone agree that the hospital field isn't exactly where we thought it would be at this point?

STEPHEN STEWART (Henry County Health Center): It all depends on the relative position of the organization when it got started. Most organizations were really behind in the implementation of the electronic medical record. As a result, they have been faced with a great deal of work in a short period. We had a good start because we implemented computerized provider order entry in 2008. It took us a solid year to do it and we have a small medical staff.

But for organizations that just started after Stage 1 rules were written, it's a much different picture. I can't imagine what it would be like to be in that position.

Progress is being made, though. The end game is to get to the point where we improve care and reduce cost. Moving too quickly into the penalty phase could be a disincentive. Pam hit the nail on the head; being reasonable with the timelines as we go forward and implement these things is critical for everybody. When you combine meaningful use with the coming of ICD-10 in the same time window, there's a massive amount of stuff out there for organizations to do.

The end game is to get to the point where we improve care and reduce cost. Moving too quickly into the penalty phase could be a disincentive.

Stephen Stewart

ALLANA CUMMINGS (Northeast Georgia HealthSystem): That's a really key point. There are many organizations that have met what was required for Stage 1, but now they have to sustain that performance for a year. That's going to be a real challenge for some organizations. It's not about implementation; it's about sustainable performance that drives efficiency. Some organizations will struggle with that and adding requirements for Stage 2 is going to make that increasingly harder.

MODERATOR: What's driving your IT strategy? Is it meaningful use, or is it reform and the need to cut costs? What are the drivers within your organization and what are you hearing from your peers?

JIM GIORDANO (CareTech Solutions): Our clients are starting to get a clear vision of what this will look like in the future. Meaningful use Stage 1 is about getting systems installed. We are now starting to see more attention being paid to outcomes. If there is a silver lining in this cloud, I think it's the fact that a lot of our customers are saying, 'We completed meaningful use Stage 1 and it was a gargantuan effort. The whole hospital came together to make that happen.' But, as the CEO of one of our hospital clients said, 'The good news is, we are ready for Stage 2. It's not like we have to learn to work together as an organization again. That's done.'

The issue of penalties is interesting and is causing people to sit up and take notice. The penalties may not help to achieve meaningful use, but those penalties being used for HIPAA privacy breaches are causing more attention to compliance. The government is serious about this and hospitals need to pay attention. As these penalties increase, we'll see more attention given to security and to risk. Hospitals are going to have to focus on this.

ALBERT ORIOL (Rady Children's Hospital): You are absolutely correct. Although meaningful use is not a driver in and of itself, it's an enabler for many organizations to be able to afford the infrastructure to get us there.

STEWART: It's a partially funded mandate.

PAUL McRAE (AT&T): There's also a great deal of focus right now on integrating mobile solutions into specific workflows. The clients with whom we are working are interested in solutions that are pre-integrated or how quickly existing solutions can be integrated. The solutions being considered not only provide cool tools to monitor the patient, but also increase the opportunity to generate more billable activity.

One system director in Tennessee acknowledged his revenue cycles are moving away from his traditional acute model, so now he is focusing on producing the same revenue in an ambulatory model. He has to empower the clinicians who support that strategy with infrastructure that he doesn't have today. Infrastructure requires a lot of initial capital investment, which doesn't exist. In a business model that traditionally has only shown 3 to 5 percent profitability, the only way to find resources to build out the necessary infrastructure will be to cut operational costs. Mobile solutions ultimately can reduce the cost of operations and generate revenue, but still require capital to initiate the strategy.

Meaningful use Stage 1 is about getting systems installed. We are now starting to see more attention being paid to outcomes.

Jim Giordano

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ANDREW MELLIN, M.D. (McKesson): Successful organizations are those that already had the vision and just have to check off the boxes to put meaningful use in place. That's not to say it doesn't take a lot of time and energy to get the infrastructure in place for clinical decision support, but the organization was already moving in that direction. More than 1,900 hospitals have tested for Stage 1 now, which is a fair number. Some are just checking off their requirements to get the money, while others are doing it because it's the right thing to do.

Under Stage 2, the challenges again will be to make sure the quality measures are better aligned with the workflows and the needs of the organizations. But the tools that they are putting in place are absolutely required for survival.

JIM VELINE (Avera Health): The tenor of the conversation has changed at board meetings. Quality indicators are up front in the agenda and very much now part and parcel of monthly discussions in the governing bodies. That's good. That's really where the responsibility of the board belongs, and we have seen that change just in the last 12 to 18 months.

MODERATOR: Are those boardroom conversations around meaningful use incentive dollars, or around that broader definition of meaningful use?

VELINE: I don't want to discount the discussion about incentive payments and penalties, but I think the majority of the discussion has been about how we are doing relative to these indicators and whether we can continue to improve. There's an altruistic benefit in terms of trying to provide care to the patient, but it's now driven home for the boards what their true responsibility is to the patient.

STEWART: It has everything to do with sustainability of the organization and the board should recognize that. They may not have looked at these things before, but they are now.

GIORDANO: That's true for organizations in home health. You just have to have the infrastructure for that to work.

MODERATOR: I want to come back to the quality measures. What are the challenges of being able to capture those quality metrics?

ORIOL: I would expand your question a bit. Many of these measures are designed with 80 percent of the population in mind. When you start looking at the specialty institutions like pediatric hospitals, it makes you wonder if we are measuring the right things. In the end, we're still measuring process metrics, right? The end goal is to get away from process metrics and move to outcomes. Until we can get there, we're kind of stuck. Are we capturing the right things?

PATRICIA SKARULIS (Memorial Sloan-Kettering Cancer Center): We don't qualify for meaningful use, but we feel it is important to continue on with the direction that we are going.

We've put a lot of effort into clinical documentation. What are the types of things that need to be documented? In the end, we think we'll come out ahead having all the data. We

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Jim Veline

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Allana Cummings

need it, certainly, for our own research. There are efforts around the country dealing with natural language processing that may lead people to the same answers. We're not sure, but we're certainly working in that area as well. We've just taken a different approach and hope to get to the same place in the end.

CUMMINGS: One of the challenges is not necessarily measuring the outcomes, but determining what the lead indicators are that can effect change in those outcomes. It's then a matter of structure and the quality of your documentation. That will determine if you are really able to help drive change in the processes.

That is something we're finding. We have opportunities to go back and review decisions around our billing strategy. We may have been collecting a large volume of information, but is it meaningful in helping us actually effect those outcomes? That's where clinical decision support and some of the vendor capabilities to help us structure that data become very important.

SKARULIS: We're also pushing and thinking about patient reports. We're asking patients about the long-term impact of their treatment. In the cancer field, this is a big indicator. How quickly was the patient able to get back to a presumably normal life? One drug may enable patients to get back to work in two months' time, but there may be a more costly option that enables the patient to get back in a much shorter time.

Those are all types of input that we're trying to learn how to gather so that we can figure out our outcomes. We struggle with that all the time.

MODERATOR: And how closely have you worked with your vendor to brainstorm or incorporate those into your systems?

SKARULIS: We're looking at doing it more on our own and pursuing capabilities, potentially Web-based. We're already demanding a great deal from our vendors. We tax them to meet all of these requirements. It doesn't leave them the time to collaborate with us on more innovative things.

STEWART: I couldn't agree with you more. I'm very empathetic to our vendor partners. They have a tall order to try to fill. The rules for Stage 2 were just released in September. Vendors are scurrying to get those into place. There is a tendency on their part to look at what is the minimum needed to become certified and have a system up and running that enables clients to comply; I understand that.

However, I hear from our physicians that workflow isn't always taken into consideration. For example, we're in the midst of beta testing a CPOE rewrite because our physicians are telling us that it is the answer to their problems and their complaints. It's going to turn out to be an efficiency game for them. But we weren't able to deliver that with Stage 1 certification, so it's an interim release. Now I think we'll go through another period where, for the next 12 to 18 months, vendors are going to be scrambling to get to 2014 certifications, and then we'll see a round of improvements in those initial offerings. We'll be facing the same thing in 2015.

One of our vendors went from 600 employees in 2008 to 1,600 now to keep up with what they're doing. We saw a marked decrease in the quality of the support we got

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Patricia Skarulis

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Andrew Mellin, M.D.

in 2010, because the experienced representatives moved on to implementation and installations and the new people came in on the support desk. From talking with my peers, I don't think we are the only ones who have experienced that. I am very empathetic to what the vendors are up against. It's a tall challenge for all of us, and it's going to be an interactive process as we work our way through this.

CUMMINGS: We are finding some tools our organization can further leverage in a collaborative care environment. An example is our enterprise visibility tool. Its initial intended use was for basic patient tracking, to provide certain elements of data about where patients were located, such as when a patient leaves his or her room for a diagnostic procedure. We are now leveraging it to provide visible clinical decision support on our patient care units, such as the time of order entry, to be a more proactive tool. We have developed a tool that shows evidence of a patient's declining condition, so we are able to intervene before a patient crashes and a code is called. Organizations need to go back and leverage the technology investments they already have made and use innovation to repurpose the tools that they have for even greater good.

In addition to investing in new technologies, we are trying to focus around optimizing our current technology portfolio and how we can extract more value from it. That's what creates excitement for our team.

MELLIN: One of the things we're passionate about is determining why quality isn't automated better. Many of the quality measures were done years ago and the data are really messy, so a lot of things are glossed over. But there are exciting things happening on three different fronts: The measure creators for the

Resource functions accessible through physicians' portal

	2012 All	2012 Most Wired
View what is in the electronic health record (remote access/consolidated in-house information)	87%	99%
Complete and sign the medical record	83%	99%
Place orders and other real-time transactions	75%	97%
Exchange/see other facilities' results in your portal (Health Level Seven or other point-to-point exchange)	47%	75%
Use portal/EHR to exchange results into others' EHRs (more advanced portals/health information exchanges)	30%	50%
Facilitate orders and scheduling information exchange among providers	42%	72%
Image exchange (centralized viewing for multiple facilities or broker to load PACS images from other facilities electronically)	49%	73%
Communicate with patients (email, alerts)	36%	62%

Source: *Hospitals & Health Networks'* Most Wired Survey, 2012

National Quality Forum, as well as the ONC, are looking for ways to partner better with the vendors and understand workflows. They're building measures that can be done electronically in the real world. From the vendor perspective, we're trying to help our customers create and install systems in which data are captured in a more rationalized manner for clinical decision support; and when that's in place, adding tools for real-time quality dashboards.

We are moving from an environment in which I, as a physician, get a note one month later saying, 'Dr. Mellin, you forgot something.' This doesn't help; we need to receive the information while the patient is still in the hospital.

I see all these things converging now with the ONC and National Quality Forum. Over the next few years, we'll see a real meaningful way to be able to measure quality in real time and be able to understand it analytically.

MODERATOR: A lot of that ties into the move toward value- or risk-based models. Is IT moving at the same pace as the rest of transformation? If not, what needs to happen to make sure that everything is on a parallel path?

McRAE: As a vendor, I've spent most of my time in the IT outsource space. I see an absolute lack of desire from vendors of electronic health records to integrate and share data. In other industries, we're able to come to the table and work together so we are not tripping over each other.

The integration of Health Level Seven International is almost a commodity function at this point and being able to add to that data stack with various devices, mobile machine-to-machine and more patient monitoring will be an absolute necessity in reducing cost. That is a challenge and there's an absence of any kind of governing body. It's going to take an acknowledgment that there's a bigger problem to solve without collaboration.

McNUTT: I disagree that HL7 is a commodity. One of the things that's slowing us down right now with health information exchange is getting normalized data — that can be viewed in a meaningful way — coming in from HL7 transactions. That's still a big challenge. The other piece of clinical integration that's holding us up is getting ahead of IT. One of our problems is that we don't know all the questions that we need to ask about clinical integration.

First, we need to look at the goals of clinical integration and the key behaviors that will drive it, then we can focus on the technology to support it. There's a series of back-and-forth conversations that need to take place. We have a lot of data, now what do we do with it?

With our accountable care project, we're trying to walk before we run, before we spend millions and millions of dollars on various IT tools, but we are waiting to figure out exactly what we need. The good thing about an accountable care organization through the Medicare program is that it's a no-risk proposition for the first couple of years. So we're going to be taking advantage of that. We also have medical home programs and we're learning a lot through those. They are also going be useful for our ACO.

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Paul McRae

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Pamela McNutt

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Albert Oriol

McRAE: I agree. And just in response, the normalization piece is an absolute and, in some respects, should be the responsibility of some governing party. You hope that would have been the direction coming from the federal government, but we don't have that. And that's where we have an opportunity, but not a whole lot is being done.

MELLIN: A lot of good technology exists today that can solve the ACO problem, which is that most organizations don't know where to start. We are starting to see a changing relationship with our hospital customers. They are asking for our help in building a road map. 'What are the 10 things we should do to get started?' That's really been evolving in how we're working with our customers.

GIORDANO: Hospitals tend to be in one of two camps: those that made the decision to put acute and ambulatory on one platform and those who have placed them on separate platforms. More than 50 percent of our customers have different platforms. Health information exchanges are the next big thing. They absolutely have to have it now.

Some of that is being addressed with meaningful use and some of the certification requirements are going to get at the issue. The systems have to be able to talk to each other. Hospitals have spent tens and hundreds of millions of dollars on these platforms. Most are too far down the path to go out and change systems.

McNUTT: Well, we do have a challenge and two separate camps as you mentioned. There's ambulatory and inpatient integration, but in ACOs and medical homes and some of the new payment models, organizations will have to reach out to many more people.

Then there's the whole post-acute issue. How are we going to get that data into the model? We are still blind from a technology standpoint. So, even if you think you've solved the issue of integration between you and your doctors, there are other specialists and other organizations that would need to be brought into the fold.

MODERATOR: Jim, can you comment on that? What's been Avera's experience with the medical home?

VELINE: When we started looking at the concept, we realized that small, community hospitals in rural areas are very close to operating medical homes. Everybody knows everybody. We looked at that environment to figure out what we needed to add to bring it to closure. We looked at a bunch of things and decided to add a health coach or patient navigator to the process to add some accountability for patient follow-up. It's interesting to think about how many similar situations there are across the United States. It doesn't take much to bring that to closure. It's really the more urban, fragmented environments where it's going to take extra work to bring it all together.

Key Findings

1 Organizations are in various stages of achieving and sustaining Stage 1 meaningful use. Moving too quickly to the penalty phase would be a disincentive for many organizations as they work toward meeting the requirements.

2 Organizations need to leverage their existing technology to assist with the capture and meaningful use of quality data.

3 Patient engagement plays an important role in accountable care organizations. A challenge for organizations will be connecting with patients in a meaningful way. Organizations will need to overcome a gap in infrastructure in connecting with patients to achieve medical management and desired quality outcomes.

MODERATOR: Patient engagement is a big part of this. How is that dynamic fitting into your discussions strategically? How is technology changing the patient dynamic?

ORIOL: In our case, 50 percent of our care is provided to Medi-Cal and low-income families. They may or may not have the means to engage electronically with us. In fact, in many cases they don't have the means to engage physically with us.

The ACO world is not so much about medical management as it is about the management of the social issues. Often patients miss their appointments because they don't have a ride to the physician's office, so wherever there is a potential solution to make that easier, the better. The mobile health piece might help, but there's still a gap to fill. There's a basic infrastructure gap in their ability to connect.

It's certainly in the best interest of the health care population to solve it and it might be in the best interest of the provider community to solve it, but I suspect that this is something that's way more pervasive. It does not just affect health care. It affects education and a host of other issues that need to be solved, and we can't solve it.

STEWART: In our case, we're almost 60 percent Medicare. One of our concerns is how we are going to get those patients to be involved. Do they have the resources to communicate electronically with us at home? There are still a lot of people with dial-up Internet connections.

McNUTT: Technology is not going to create a relationship with the doctor in and of itself. In trying to change the whole model of care to influence patients to do things that are in their best interest, then technology can be an enabler.

There has to be a trusting relationship with the physician in which patients feel as though they can share everything that's going on with their primary care doctor, so the physician can effectively manage care. We can't think that technology is going to make that happen all by itself.

ORIOL: We have to remember that this is only a partial solution to the challenges we face. There are larger issues to be addressed.

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