Maximizing the value of your EMR

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Get your clinicians on-board or fail. Through the implementation of a dedicated program to ameliorate the commitment of clinicians to utilize technology and people for a more preponderant patient care and outcome.

As health care distribution and financing shifts from a volume-predicated to a value-predicated business model, it offers the promise that provider prosperity will be achieved through offering accommodations with the best possible quality, outcomes and accessing for the lowest possible cost across the continuum of patient care accommodations and sites.

Electronic medical records (EMR) systems are set to enable technology that sanctions providers to pursue more preponderant quality, outcome and patient care. Many surveys of providers exhibiting slow but steady progress in habituating to EMR systems and clear decency in information technology as a paramount implement to provide and amend patient safety, patient care, financial rewards and evidence predicated medicine.

Adopting EMR's is an intricate change. Everyone adopting EMR's goes through kindred cycles of progress and barriers – those organizations that have taken it upon themselves to pursue a program comprised of a set of interventions, policy adjustments and opportunities have shown lower barriers and better adaptation to EMR systems.

Let's review some of the prevalent reported barriers to EMR adoption;

- High up front cost and uncertainty of financial benefits make it difficult for leadership teams in organizations to recognize the benefits and value up front.
- Up front clinicians time in four key underlined areas:
    1. *The build* - if clinicians are the only ones positioned in "the driver seat" during the build it is likely (with the best intentions) to replicate the "paper" process that may not fit in an electronic system and worse it will results in taking the "long cut".
    2. *Technology* – because of the nature of EMR being multi-disciplinary making the learning curve slightly longer, where keeping the "momentum" may be difficult.

3. *Changes\ Customizations & Support* – unfair expectations from clinicians to take the role of “builders,” workflow designers, and technology super-users are causing clinicians to spend a substantial amount of time learning, building and re-working the EMR system, thus delaying the opportunity to impact quality of care using EMR’s.
4. *Electronic Data exchange* – slow systems built by public or private exchanges and delayed adoption by providers underline an ongoing problem of exchanging information in an easy, secure manner resulting in makeshift solutions which are inadequate and non-compliant.

- Physician Attitude: non-champion physicians tend to show less positive attitudes toward EMR and are more easily discouraged by usability problems.
- Shifting the view of physicians from growing volumes and maintaining margins to improving outcomes.

It is no longer a mystery; there is a consistent relationship between electronic documentation, more preponderant quality amendments and financial benefits. Basic utilization of the EMR will likely drive amended legibility and accessibility to progress notes and increment availability of electronic quandary and allergy lists. In advance settings you can expect to find more preeminent opportunities to improve quality of care; for example: quandary-categorical templates with embedded prompts reminding clinicians to ask about particular symptoms, order particular tests and prescriptions, or perform preventive or disease management activities. Also, templates that allow clinicians enter data in coded, rather than free-text form, facilitated more advanced computer-predicated decision support for such tasks as care coordination and chronic disease management.

What strategic framework can be considered to align healthcare organizations with improving patient outcomes through the use of an EMR system?

Improved alignment between hospitals and medicos is essential to transmuting the way care is distributed, enhancing patient and medico contentment and improving on each element of the value equation—quality, outcomes, cost and access. Because medicos are responsible for driving the clinical care of patients, their incentives must be predicated on value and aligned with those of hospitals and health systems.

To achieve the caliber of collaboration that aligns healthcare organizations, hospitals and health systems must lay the needed substructure of financial (investment), clinicians' time, physicians' attitude, improving outcomes, performance targets and medico participation. Implementation of the first four strategies lays that substructure.

Financial \ Investment Strategy:

- **Strategy 1.** Ground medico-integration efforts on a well-defined strategic financial plan with sufficient resources and performance targets.
- **Strategy 2.** Structure efficacious and sustainable emolument programs for employed medicos.
- **Strategy 3.** Document and communicate the caliber of financial commitment required to employ medicos.
- **Strategy 4.** Before employing medicos, model alternative payment

Managing Clinicians time Strategy

- **Strategy 1.** Understand the forces affecting medicos; design, strategic offerings to meet the needs of local medicos.
- **Strategy 2.** Ensure vigorous medico participation, leadership and governance.

Physicians Attitude Strategy

- **Strategy 1.** Manage employed physicians to achieve goals
- **Strategy 2.** Use technology to connect with physicians.

Improving Outcomes Strategy

- **Strategy 1.** Use a disciplined, integrated approach to practice acquisition and employment.
- .**Strategy 2.** Use a structured process to ensure creation of a sustainable venture and consistency over time.
- **Strategy 3.** Ensure objective assessment of organizational readiness for value-predicated care transformation efforts, including a formal clinical integration program.

Hospitals and health systems must achieve efficacious hospital-medico alignments to remain competitively situated. There is no one integration plan that works for all organizations or all medicos. Service areas and medico needs are diverse, so hospitals and health systems must be quick to offer multiple engagement options, accommodating multiple medico constituencies.

The approach organizations considering must align organizational and medico goals cognate to amended quality, efficiency and access within the constraints of current organizational capital

resources. Finding a sustainable balance of strategic and clinical needs, capital constraints, operation capabilities and management competencies is critical.

The organizations most liable to gain and retain close integration with medicos have prevalent attributes that include deep management expertise, shared hospital-medico leadership and a well-developed integration infrastructure. Health care boards and executives should be taking purposeful steps to align their organizations with medicos for sustainable prosperity under a very different care and payment system going forward. Organizations whose bellwethers act early to build these attributes predicated on solid orchestrating and monitoring are poised for future prosperity in their communities.