8 ways to smooth your CIS install

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Clinical Information Systems

8 ways to smooth your CIS install

Health Management Technology asked select industry experts to respond to the following question:

What are the best ways to minimize the pains associated with selecting and adopting a clinical information system?

Cloud-based systems offer easier EHR deployment
Oleg Bess, M.D., CEO, 4medica

The best strategy to minimize troubles associated with migrating from paper to electronic records is to choose an EHR that fits a hospital’s precise needs and aligns with the level of their clinical, financial and IT resources.

For example, small- and medium-size facilities are better off with a secure cloud-based subscription service (SaaS) EHR solution than an enterprise system. A SaaS application can be deployed rapidly in weeks rather than months or years because it leverages the Internet network and standard industry protocols in conjunction with the hospital’s current IT infrastructure. Clinicians already familiar with how to use a Web browser find a cloud EHR easy to learn and use from the start. SaaS also costs 30 to 65 percent less, since it doesn’t require hospitals to incur big upfront infrastructure, hardware and software investments, as the vendor operates, maintains and upgrades the infrastructure and EHR remotely.

In contrast, enterprise EHRs typically are proprietary systems specifically built to address the needs of large academic medical centers and hospitals. They require at least a year to be deployed and cost over $1 million. Unlike larger peers, smaller facilities lack the nurse and physician informaticists, deep pockets and IT personnel necessary to customize, support and evolve an enterprise EHR.

An EHR that may be right for one hospital may not be right for another. Organizations that take their size, budget and clinical and technical resources into account when selecting a system will have easier implementations; those that fail or adopt a one-size-fits-all EHR will have a rockier ride.

Select a system that meets MU, functionality and business requirements
Paul Pitcher, research director, KLAS

In March 2011, the KLAS “Community Hospital EMRs Maturing for Meaningful Use” report found that 20 percent of community hospitals are looking for a new EHR. Meaningful use (MU) is a primary concern for hospitals seeking a new CIS, both from a system functionality standpoint as well as a physician buy-in perspective for CPOE adoption. One CEO said, “The frustration is with the physician documentation. We know that any physician EMR is going to be troubling for the doctors because they don’t really want to take the time to document.”

KLAS has found that providers aim to select a system that meets MU, functionality and business requirements, as well as provides a workflow conducive to existing clinician workflow. Hospitals also take additional steps to give them the best chance for deep CPOE adoption:

• Involve key shareholders. Physicians, nurses and other shareholders should be involved in the selection process from the very beginning, providing feedback on solutions. Some hospitals even allow their shareholders to vote on the selection and then involve them in the system build.
• Get executive buy-in. Executive involvement and approval of a CIS will percolate down the organization to encourage buy-in from the rest of the organization.
• Solid implementation, go-live support and training. Implementations should include clear communication of timelines and potential delays to manage clinician expectations. In addition, ensuring that there is thorough training and a large support staff to resolve issues eases the transition to the new CIS and improves chances for CPOE adoption.

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CIS is the means to an end
Jon Elion, Chartwise Systems

Whether selecting and adapting an inpatient or an outpatient clinical information system, a little homework can go a long way towards helping to ease the pains of adoption:

- Start by carefully defining your current information environment, followed by a complete description of the functionality that you want (now and in the future). List all systems that create information and all stakeholders that use it. Then you can start looking at vendors, making sure that their systems meet your scenario.
- As you move to the all-electronic medical record, decide how you will handle the components that are still paper based.
- Decide if (and how) you need to migrate or access legacy data.
- Define the interfacing and data needs of each external component in the system, remembering that there are several possible strategies: Standalone (no integration); file-based uploads of patient demographics information; data delivered by HL7 messages; unstructured data (for example, displayable reports) returned via HL7 or other means; structured data returned via HL7; and direct application integration (patient-synchronized applications, portal-savvy apps, direct application plug-ins).
- Identify the information that needs to flow between the inpatient and outpatient settings and how that will happen. This includes connectivity with referring physicians and acquiring data from outside testing facilities.

Do not count on the CIS to magically give you the desired information and workflow; it is just a means to the end. Identify thoroughly where you are headed, then make sure that the software will get you there.

In the midst of implementation, it pays to connect devices
Dave Dyell, CEO and Founder, iSirona

Implementing a new clinical information system (CIS) is a large undertaking. In fact, as Johns Hopkins Medicine stands at the precipice of such an endeavor, it plans to hire more than 60 new strategic positions to ensure a smooth implementation.

True, every hospital is unique; no two implementations are exactly alike. But any hospital in the midst of a CIS implementation has an incredible opportunity for a quick win that delivers immediate results: device connectivity.

Device connectivity automates, or channels, medical device data directly into the CIS or electronic medical record (EMR). The result is a more robust, or “meaningful,” EMR. That said, meaningful-use dollars go a long way in improving the ROI on the CIS investment.

Federal monies aside, it still pays to bring devices online. For one, nursing documentation responsibilities are greatly reduced when hospitals automate data flows. This gives clinicians more time to deliver direct care.

Similarly, data accuracy improves with device connectivity, as human transcription is inherently problematic; it’s also quite slow. Automation solidifies the data chain, leading to timely, accurate data in the EMR.

Because automation funnels patient data to the EMR faster, clinicians (as well as clinical decision-support systems and next-generation alarm-management systems) have access to more up-to-date patient information. This, in turn, leads to better patient care.

In short, if you’re already under the hood implementing a new CIS, it pays to integrate the devices that will, ultimately, populate your system.

Must engage clinicians in selection process
Steve Claypool, M.D., VP of clinical development and informatics, Wolters Kluwer Health

When deploying clinical information systems, the best way to minimize pain is through early clinician engagement. Understanding how these technologies will impact clinical workflows, as well as any expectations and concerns that may affect users’ willingness to adopt, is crucial to developing a comprehensive plan that minimizes disruptions and maximizes satisfaction. This process will also uncover any gaps that must be filled before the new system can meet administrative objectives and clinical expectations.

For example, it is imperative that a sufficient number of evidence-based order sets be available within a CPOE system at-go-live or physicians will likely find it to be too cumbersome. Thus, it is important that a sizable order-set library be built and integrated with CPOE in a timely manner. This gap can typically be closed by investing in an electronic order-set solution to accelerate authoring and integration. A revamp of processes governing order-set development may also be necessary.

Keeping pain to a minimum also requires engaging clinicians in the evaluation and selection process. Encourage their participation in vendor demonstrations and solicit input — positive and negative — on the features and functionality of each system. While it likely isn’t feasible to have every member of the clinical staff actively involved in the evaluation, it is important that each department be represented to ensure their voices are heard and that there is a sense of ownership of the new system.
Vendor partnership is important

Gerry McCarthy, senior VP, product management, McKesson Provider Technologies

With meaningful-use incentives and potential future penalties looming and many other regulatory and payment reform initiatives in play, there is more at stake than ever in the selection of a clinical information system (CIS), but the noise in the market is making it even harder to think through what matters most. The decision now has ramifications across every aspect of a healthcare organization’s ability to achieve its mission.

So, what does matter most? A CIS must be robust and effective at many different levels, from the bedside to the board room. It must meet clinical workflow needs beyond any one discipline, enabling true multidisciplinary, patient-centered care that includes advanced patient safety technology. It must drive clinical quality and operation process improvement through support for comprehensive data analysis and strategic decision making. And a CIS must support the ability to connect the organization to physicians and the larger patient-care community.

Once the selection is made, the adoption process depends as much on internal commitment and motivation as it does on the software itself. That’s when the true value of vendor partnership comes in to play. Organizations need to ensure that the vision of their chosen partner synchronizes with their own, and that the technology will continue to evolve to meet the care requirements of the future. Ultimately, an organization is investing in a partnership that will last a number of years and requires teamwork, mutual trust and a commitment to drive projects toward the achievement of its vision.

Make CIS clinician friendly

Donald M. Burt, M.D., CMO, PatientKeeper

In order to maximize adoption, clinical information systems should be designed and selected with considerable input from the clinicians who will use them. This is especially true for physicians, who historically have embraced all manner of advanced technology in the workplace except for IT.

As an industry, we’re still not doing a very good job giving physicians IT solutions they like. A physician-centric approach to healthcare IT should be grounded in five key tenets:

1. Respect the way physicians practice medicine. Physicians work hard enough caring for patients; don’t force them to adapt workflow to accommodate software design.
2. Ensure IT systems offer physicians a compelling benefit. The absence of a penalty — e.g., “Ordering electronically won’t take you any more time than what you’re doing now” — is not a benefit.
3. Let physicians practice anywhere, anytime. Hospitals must enable physician mobility through hospital information systems, since smartphones and tablets alone (popular as they are with physicians), without the information access, are of limited utility.
4. Don’t change everything at once. Hospitals are wise to take an incremental approach to automating physician workflow, starting with the serious problem areas, such as CPOE, for example.
5. Focus on the parts physicians see first. What matters to physicians is their experience interacting with software applications that directly touch their processes and workflow.

System should let users hit the ground running


Hospitals are bound to experience setbacks when implementing clinical systems. Many hassles can be avoided by ensuring that every constituency is represented on an EHR selection committee and by selecting easy-to-use solutions.

When establishing the committee, recruit informal leaders to evaluate, choose and champion the EHR. These individuals need not hold official leadership positions, but they should be influential and widely respected among their peers. It is critical that they participate in hands-on product demonstrations and ask tough questions to help identify the EHR that best meets the majority of users’ needs.

Also, hospitals should steer clear of products featuring too many menus, screens, pick lists and free text. Those applications will alienate and frustrate end users, harming productivity and affecting EHR adoption rates negatively. If the solution is easy to navigate, users will be much more satisfied and training costs will be lower. In a nutshell, invest in an application that lets users hit the ground running.

Providers should also consider whether they would be better served by an enterprise, best-of-breed or hybrid EHR approach when automating the ED, ICU and other high-acuity areas. Because enterprise EHRs are built for med-surgical areas and best-of-breed solutions are designed to meet the unique needs of specialty departments, the hybrid path offers a smoother transition to automation.

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