

Cover Story



'Meaningful Use' Hoists Hospital IT to Next Level

By Matthew Weinstock and Suzanna Hoppszallern

Meaningful use. Those two words have so dominated the health information technology marketplace for the past year and a half that it's been difficult to see the forest for the trees.

For most hospitals, the challenge is understanding how meaningful use fits into broader strategic, quality-of-care and patient-safety goals. Chief information officers at the 2010 Most Wired hospitals and health systems recognize that it is not an end, but a guide on the journey to create technology systems that enable clinicians to provide the best care possible.

"For us, meaningful use is a scorecard for where we've been heading for some time," says Russ Branzell, vice president and CIO, Poudre Valley Medical Center, Fort Collins, Colo. "We already had plans to roll out CPOE early next year; it just so happens to coincide with meaningful use. I don't think that is the case for a significant portion of hospitals out there. For some, [HIT adoption] is a necessary evil to get a physician integration strategy; for many it has been a back-burner issue, especially with the economic challenges we've been facing."

Branzell, a former board member for the College of Healthcare Information Management Executives and current chair of CHIME's education foundation, says CIOs themselves are partly to blame for that gap. They didn't always sell IT as a way to improve quality and safety and drive process changes.

"For a lot of organizations, it was approached as an infrastructure build," says Branzell, whose hospital has appeared on the Most Wired list for the past seven years.

As the start time for meaningful use requirements rapidly approaches—and as health reform intensifies the demand for data and evidence-based medicine—Branzell and CIOs at other Most Wired hospitals say it is imperative to talk about IT in those broader terms.

This year's survey reveals continued progress in such patient safety initiatives as closed-loop medication systems: 57 percent of medication orders are placed electronically by physicians and other authorizing providers at Most Wired hospitals, up from 49 percent last year. Fifty-five percent of Most Wired hospitals match medication orders at the bedside through bar coding or radio-frequency identification, up from 49 percent in 2009 and 23 percent five years ago.

"If you don't have [electronic ordering] as part of a closed-loop system, you don't have it as a safety component," says Linda Reed, R.N., vice president and CIO of Atlantic Health in Morristown, N.J.

The Most Wired data also show hospitals moving forward in such areas as evidence-based order sets and security systems, among others, says Chantal Worzala, director of policy, American Hospital Association. But, she notes, there is a lot of ground still left to cover.

Being Most Wired

In some ways, this year marks a new beginning for the 12-year-old Most Wired Survey. In 2008, H&HN staff began to redesign the survey with the goal of increasing the reliability of the data and improving the usefulness of the results. Hospital and health system CIOs were actively involved in every facet of the process (see related article in the foldout section).

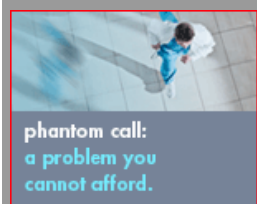
Midway through the redesign, the Obama administration pronounced health IT a national priority. It incorporated meaningful use into the 2009 American Recovery and Reinvestment Act and authorized billions of dollars to help hospitals and physicians go digital—and penalties for those that do not. As 2009 was coming to a close, the Centers for Medicare & Medicaid Services released its proposed meaningful use rule. At press time, the agency had yet to issue the final regulation.

A Most Wired advisory board reviewed the survey with the proposed meaningful use definition in hand. However, there was never an intention to suggest that a Most Wired hospital will meet CMS' threshold.

"We wanted to make sure we were providing a product that was aligned with where meaningful use was going," explains Pamela McNutt, senior vice president and CIO, Methodist Health System in Dallas, and chair of the advisory committee.



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HOSPITAL MERGERS

WHY THEY WORK,
WHY THEY DON'T

Breaking Down Silos

David Blumenthal, M.D., national coordinator for health information technology, in a June 14 blog entry on his office's Health IT Buzz page, contends that health IT will greatly advance the state of patient care. While acknowledging concerns from sectors that think the government is asking for too much too fast, he counters, "Can we make these changes expeditiously enough?"

Blumenthal embraces the notion that IT is a game changer. "I resisted using EHRs while an internist in Boston," he writes. "Over time, however, I found that working with health IT made me a better and safer physician. Most importantly, my patients received better, safer care and improved outcomes.... This is the time to realize the promise of health IT. Information technology has improved every aspect of our lives; we need to channel information technology to improve our health and care."

But to realize the transformation that Blumenthal is talking about—and the one envisioned in health reform—CEOs need to unite disparate parts of their organizations.

"We've found that some vice presidents of quality are not fully aware of the quality implications" of meaningful use, says Pam Arlotto, president and CEO of Maestro Strategies, a health care consulting firm in Roswell, Ga., adding that CIOs don't always understand the breadth and depth of what it will take to link IT and quality reporting systems.

At Most Wired hospitals, breaking down those barriers begins by bringing clinicians into the fold early in the process. It adds credibility to a project when physician, nursing and pharmacy leaders take ownership of an IT deployment, says Douglas Abel, vice president and CIO, Anne Arundel Health System.

Physicians at the Annapolis, Md.-based system staff a work group to identify and improve IT initiatives. The group meets regularly to discuss such issues incorporating evidence-based order sets into the IT system as well as changes to improve workflows. Physician leaders also sit on a steering committee alongside hospital administrators to look at big-picture, strategic issues.

As a result of their engagement, physicians have become vested in seeing health IT deployments succeed. For instance, 90 percent of physician medication orders are done electronically following implementation of an electronic medical record and CPOE last December.

"There was a little brute force," Abel says jokingly, referring to the fact that the medical staff, not the administration, changed its bylaws to require physicians—both employed and independent—to show competency in the use of the system if they wanted to practice at the medical center.

Patricia Czapp, M.D., a family practice physician and chair of clinical integration at Anne Arundel, vividly remembers the vote that took place on a cold, dark night in January 2009. The medical center was committed to going digital just 12 months later, in December 2009. She told her colleagues that everyone needed to be held to the same standard.

"I stood in front of them and said, 'This is going to be tough, but this is our commitment.... How will you feel if half of your partners aren't trained and can't take care of patients in the hospital and it falls on you?'" she recalls. "We voted for it immediately."

Extensive training took place and continues today for doctors who need it, says Czapp. The physician work group determines how to handle training and other issues.

Getting it Right

It is not just about physicians, though. Atlantic Health brought pharmacists and nurses together when building its electronic ordering system, realizing that they had different processes and workflows, even patient documentation. Reed says it was an eye-opener.

"No one realized how significant discrepancies in the pharmacy process would impact nursing. Bringing the two departments together was really painful," she says, adding that both nurses and pharmacists have become attentive to what's in the orders.

At NorthShore University Health System in Evanston, Ill., the quality team is involved in creating clinical decision support tools, but that wasn't always the case, says CIO Tom Smith. When the hospital began its electronic journey in 2002, the task fell primarily to physicians in specific disciplines, even though the quality team was more familiar with CMS indicators and reports.

"One thing [the quality team has] helped us with is how often alerts fire and how often they are used," Smith says. "And if they are used, we can see if they made a difference. We can see if clinicians are changing their orders when they get an alert."

Smith says NorthShore has either replaced or improved 25 percent of its alerts with "smarter" ones by working with the quality team.

Building smarter alerts is critical if hospitals are to avoid the dreaded alert fatigue that clinicians so often complain about. Stephen Stewart, CIO at Henry County Health Center, a critical access hospital in Mount Pleasant, Iowa, works with the medical staff committee to build consensus around alerts. This is the health center's third year on the Most Wired list.

Officials at Anne Arundel Medical Center are turning to Leapfrog Group criteria to study its alerts. The medical center is completing the Leapfrog Hospital Survey and has found it valuable in assessing the CPOE system.

"They have a pretty good framework about what classes of alerts we should be using and how to integrate them," says CIO Abel. "We've done a gap analysis and looked at what we can do better and we're beginning to apply those ideas to our clinical

decision support system."

Looking Ahead

Reed suggests that hospitals conduct a gap analysis for their entire HIT systems—where you are now and where you want to be. That will be especially important as meaningful use requirements kick in, but executives shouldn't lose sight of the larger goals of quality and patient safety.

Overall, the AHA's Worzala sees room for growth in several areas, both among the Most Wired and the entire field, with care coordination one of the most prominent. In some instances, the Most Wired are doing well when it comes to sharing information during care transitions. For example, new medication lists are electronically delivered to caregivers and patients 94 percent of the time when a patient is transferred within the hospital, 98 percent at discharge and 86 percent when transferred to another care setting.

On the other hand, electronic medical record functions continue to lag, especially with independent physicians. For the Most Wired, just 43 percent of independent physician practices have electronic clinical documentation, 41 percent have CPOE and 44 percent have decision support.

"Getting to that place where we can share data between the primary care team, the inpatient team and the post-acute care team holds great potential for improving the quality and efficiency of care," Worzala says. "That is an area where a lot of work needs to be done just to figure out what information is even needed."

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This article 1st appeared in the July 2010 issue of HHN Magazine.

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