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Obtrusive Strategies: Steering Physicians to Adopt IT

EXECUTIVE SUMMARY

Managing doctors is like herding cats goes the old cliché, but when it comes to encouraging physicians to use clinical IT those cats are starting to look a little more herd-like. Given the heavy investment in new clinical systems today and the public imperative to reduce medical errors, hospitals and health systems are becoming more systematic—and more obtrusive—in their efforts to have physicians incorporate IT into their workflow.

Physician resistance to using computers is another cliché that's becoming increasingly less relevant. While it remains a factor—resistance is always an issue with new technology—the question of doctors using IT has become a question of not if but when. That's one of the certainties from our discussion with a wide-ranging group reflecting nearly every spectrum of the healthcare industry.

For this issue of Information Edge on strategies to encourage doctors to use clinical systems we interviewed clinical, IT and operational executives at Orlando, Fla.-based Adventist Health System, Novi, Mich.-based Trinity Health, Boston-based CareGroup, Long Beach, Calif.-based First Consulting Group, Boston-based Massachusetts Blue Cross Blue Shield, Chicago-based Northwestern Memorial Physicians Group, Grand Rapids, Mich.-based Spectrum Health and Beverly Hills, Calif.-based Zynx Health Inc.

It's clear that merely installing any new system is a recipe for disaster. These case studies and commentaries are replete with lessons on how to be successful in more aggressive efforts to turn doctors into electronic knowledge workers.

Physician adoption

Devising strategies to get physician adoption of clinical systems is a priority for First Consulting Group. "We've done a lot of thinking and studies on the subject," says Mitch Morris, MD, executive VP at FCG.

How you approach the issue depends on the nature of the physician group. Is it part of a teaching hospital with lots of interns and residents who are young and subject to taking orders? Is it an employed physician model of a hospital or parent organization? Or is it the polar opposite of these examples with a voluntary medical staff?

"These are some really important variables that determine how you approach the issue of physician adoption," says Morris, adding that the most challenging model is the last

Mitch Morris, MD, executive VP, FCG, Long Beach, Calif.

one, because of the potential for alienating physicians to the point that they sink the effort and shift their patients to other hospitals.

"The most challenging scenario is having lots of individual doctors who are independent and who are accustomed to choice," he says. The key elements of a successful physician adoption program:

1. Physician leadership in order entry must be prominent and tangible;
2. It should not be viewed as an IT project but as a quality initiative;
3. Operational leadership should be from outside IT;
4. It has strong leadership from hospital management;
5. It has strong leadership from clinicians—don't pick physicians who are computer docs, but rather well-respected, busy clinicians who are influential among their peers.

Certifiable

In terms of concrete steps, hospitals can pay one or more physicians for their time working on a clinical systems project. One example is Allina Hospitals and Clinics, which identified six physicians at this 10-hospital system and paid them half-time salaries to devote time to EMR and CPOE. They became certified in EPIC Systems software and continue to spend significant time on the project.

"These are not ad hoc committee positions. These have become formal roles with dedicated support," says Morris.

One way to spearhead a physician-adoption program is to establish the chief medical information officer (CMIO) role. "In general, a very successful tactic is to use a dedicated physician leader who's influential, well respected and a decision-maker. It sends a message to doctors that this is a serious project and that we're putting money behind it. The move also demonstrates that management wants to incorporate the doctor's point of view."

Another key factor: the manner in which a hospital or health system rolls out a clinical systems initiative. One way is the "Big Bang" approach when the system gets turned on all at once across the enterprise. "That's very risky," cautions Morris. A more surefooted approach is to segment the roll-out based on how receptive physician groups are for technology adoption. There are often four groups that can be identified:

1. The small group that loves technology and likes to be different;
2. A larger group of early adopters;
3. A conservative group that must be shown the benefits;
4. A small group of individuals who say, "I'll never change no matter what you do."

Science and art

"If you design an implementation around [the above four groups] and prove the benefit as you go, then by the time you're done,

WELCOME NEW MEMBER

The Scottsdale Institute is proud to welcome new member Truman Medical Centers, based in Kansas City, Mo.

Truman Medical Centers is the primary teaching hospital for the University of Missouri-Kansas City Schools of Health Sciences. Truman Medical Center Hospital Hill and Truman Medical Center Lakewood are the two hospitals at the core of the TMC system.

Hospital Hill is best known for its trauma and emergency departments. Other specialties include women's health, asthma, diabetes and high risk OB.

TMC Lakewood provides primary care to residents of Eastern Jackson County. Specialties include diabetes, rehabilitation services, geriatrics, obstetrics and women's health. Combined the two hospitals have more than 300,000 patient visits per year.

welcome new member continued on next page

you will be 90% to 95% complete. You'll then be able to require the small group of remaining physicians to use the system. There are complexities such as running two systems in parallel—the existing system and the new one—but the benefits of such a phased-in approach are really significant," Morris says.

"This is part science, part art," he says, adding that multiple factors shape an implementation such as whether it involves one or 10 hospitals, is ambulatory or inpatient. There's also a personal component. For example, the doctors in a particular clinic might be gung-ho for a system, making it much easier to implement. Or there might be an active hospitalist program which becomes the focal point for the effort.

Sometimes a critical safety issue can drive an implementation. For example, a pediatric ICU that recently incurred safety-related injuries was motivated to act as the platform upon which to build an entire clinical system.

Launching an EMR in Florida

Adventist Health System is a large integrated delivery system that has developed a strong program for physician use of IT. The organization is rolling out its EMR to 34 separate hospital sites over the next three years. "So far, we've brought one site up," says Loran Hauck, MD, CMO at Adventist. "We did a big bang," rolling out 19 applications at once, including registration, scheduling, results viewing, pharmacy, eMAR, emergency department, surgery and nursing documentation at 7:00am one Sunday last spring.

ADVENTIST HEALTH SYSTEM

Previously, the pilot-site hospital's medical executive committee had decided that if physicians were going to work there, they would be required to use the new system, a decision strongly supported by an executive team that included the CEO, CNO and other senior executives.

Four physicians—two from Adventist and two from the IT vendor—were on site at the launch for physician support and training. "It went amazingly well. I had quite a bit of apprehension," says Hauck. "A handful of doctors were very vocal in questioning the new system, but we stayed on message. We said to them, 'If you can you do email and buy airline tickets online then you can learn to use this system.'"

Despite having had advance training and plenty of heads-up for the launch, many doctors were still taken aback when they arrived at the hospital the day of go live. The key factor that carried the day, he says, was the strong joint support of the medical executive committee and senior management team. The hospital—Huguley Memorial Medical Center in Fort Worth, Texas—is in a competitive hospital market and doctors could have referred patients elsewhere if they didn't like using the new system, but they kept their patients at Huguley.

welcome new member continued

Over the past five years, TMC has risen to the top of the University HealthSystem Consortium's clinical quality ratings in the areas of patient safety, performance improvement and select measures for adults in an intensive-care-unit setting. In addition, TMC also has been recognized as a top performer in the Missouri quality initiative rankings for heart attack and heart failure treatments.

TMC Lakewood has been recognized by Solucient as one of the top 100 hospitals with the highest rates of improved patient outcomes and financial performance.

In addition, Truman Medical Centers recently was named one of the nation's "Most Wired" or technologically advanced hospitals in a survey by Hospitals & Health Networks magazine.

Welcome John W. Bluford, III, president & CEO, Catherine D. Disch, executive VP & chief operating leader of Hospital Hill facility, William K. McQuiston, CIO, and the entire management team at Truman Medical Centers.

Care and feeding

Conducting training sessions in advance helped, as did training of Super Users—Huguley physicians taken from a pool of clinical thought leaders from ED, pathology, medical specialties, surgical specialties and other diverse clinical areas. Other helpful strategies included the use of publicity in the form of banners, posters and flyers in the cafeteria, nursing units and the doctors' lounge. On Thursdays prior to go live a special buffet lunch was provided to medical staff while a trainer buttonholed physicians for five minutes at a time to demo the new system.

"There was a gradual building of momentum for 12 months prior to go-live," says Hauck. One lesson learned was to make a greater effort to get physicians into a three to four-hour formal training session ahead of go-live. "Having to do that much on-the-fly training was hard."

Some informal training is inevitable. Hauck recalls being available as a Super User at 10:00pm one evening when a pain specialist needed help creating a password. After 30 minutes, the specialist got it and said, "Ok, I can do that."

Offers they can't refuse

Training isn't enough. A lot of persuasion was also necessary. Adventist's CIS Medical Director coined a phrase that characterized the prevalent attitude among physicians: "Radio Station WIIFM" for "What's in it for me?" or "Why should I go to work at a clinical workstation?" Hauck and his team offered them three main reasons:

1. *Remote access*: Using any web browser anywhere in the world physicians can access the EMR using a credit-card-like token that provides authentication. Doctors can make electronic rounds without having to call each nursing floor.
2. *Ease of use of centralized online medical record*: Doctors can easily click on the "Inbox" to call up a list of medical records they need to review; they can make changes required and then electronically sign off.
3. *Increased efficiency*: "We told them eventually this will make you more efficient, but there is a learning curve," says Hauck.

Another key in facilitating physician adoption was having an adequate number of hardware devices, multiple ways to access the chart. From inside the hospital there are two desktop PCs at each nursing station plus wall-mounted, flat-panel workstations along corridors on accordion arms. Also, every nursing unit has four to six "COWs," or computers on wheels, each with an eight-hour battery life. Physicians can also opt for a Hewlett-Packard iPac PDA that allows them to review a patient's vital signs anywhere in the facility.

Hauck says a medical staff tends to go through three phases in an implementation:

1. Why are you making me do this?
2. This isn't so bad.
3. (After 60 days) Please don't take this away.

Upcoming Events

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November 1
New Facility Planning: IT Considerations
- Molly Coye, MD, MPH, CEO, HealthTech, San Francisco
- Ravi Nemana, senior advisor for IT, HealthTech, San Francisco
- Tim Zoph, CIO, Northwestern Memorial Healthcare, Chicago

November 5
Supplies at a Crossroads with Operating Costs: Using Supply Chain Management as a Tool
- Robert Majors, director of materials management, Bloomington Hospital and Healthcare System, Bloomington, Ind.

November 9
Human Factors Considerations in Developing and Implementing an Automated Medical Record System
- Kathleen A. Harder, Ph.D., University of Minnesota, Minneapolis/St. Paul
- John R. Bloomfield, Ph.D., University of Minnesota, Minneapolis/St. Paul

more events on next page

Vision and local governance meet at Trinity

The first step Trinity Health takes in clinical-systems development is to deeply involve physicians in the design and building of applications, while creating a vision for that effort around patient safety. "We stress that it's the right thing to do and we emphasize time and efficiency as benefits for doctors," says Donald Crandall, MD, Trinity's VP for clinical informatics.

Donald Crandall, MD, VP, Trinity Health, Novi, Mich.

Trinity pays physicians a flat rate to participate in workflow design for days at a time with system architects. "We acknowledge to them that we can't pay them what they're worth, but it's still a reasonable fee," he says, particularly accounting for physicians who might incur a loss by helping out because they are under a productivity contract.

Governance is a key element in ensuring physician adoption of a system. Clinical-liaison committees—they include both IT and clinical staff at each hospital—coordinate implementation. Local ownership is further encouraged through clinical advisory committees, comprised of physicians and nurses at each facility, that play critical roles in fitting a new system into a hospital's workflow patterns—and buy into the vision and convey it to peers.

Lots of local owners

"We have a pretty extensive network to link all these processes" of clinical IT implementation, says Crandall. It has to be: Trinity owns or manages 46 hospitals and counts 10,000 physicians under its umbrella, creating a huge challenge for any IT implementation.

Prior to a system's launch, local hospitals set expectations such as the percentage of electronic orders they want to achieve with the new system.

Indeed, local ownership dictates much of Trinity's IT implementation. "We have a slightly different approach than most health systems. Some may opt for the Big Bang, others more incrementally. Ours is more of a local culture thing. We have local go/no-go decisions. Each hospital signs off on all these issues," says Crandall. Each hospital also appoints their own physician champions based on their roles as respected clinical thought leaders, not necessarily because they are IT power users.

Some measure of resistance to any new system implementation is expected, but a strong leadership team and a culture of working together can overcome that obstacle, says Crandall.

Train and retrain

Clinician-training cycles are critical. "It's absolutely imperative that you train them well and then, after several weeks, retrain," he says, adding that Trinity creates an extensively trained group of Power Users who wear highly visible shirts and badges on each floor. A 25 to 30-person team remains onsite for two weeks to address

Upcoming Events continued

November 10
Web-based Nurse Staffing: St. Peters Case Study and ROI
- Kathy Brodbeck, VP operations, St. Peter's, Albany, NY.

November 15
CPOE Readiness in US Hospitals
- David Classen, MD, VP, FCG, and advisor to Leapfrog Group, JCAHO, and the IOM, Salt Lake City

November 16
Sisters of Mercy Bar Code Implementation
- Shannon Sock, VP, healthcare solutions, Sisters of Mercy Health System, Chesterfield, Mo.
- Rick Cowan, MS, MBA, RPH, executive director, Clinical Departments Genesis Initiative, Sisters of Mercy Health System, Chesterfield, Mo.

November 18
Blended Shore: Models for Healthcare IT Sourcing
- Skip Lemon, VP, FCG, Long Beach, Calif.
- Jim Kuhn,director, FCG, Long Beach, Calif.
- Dan Coate, director, FCG, Long Beach, Calif.

more events on next page

issues like lost passwords and design modifications. Nursing deliberately overstaffs at these times to handle the heavier workload during implementation.

An extensive central command center is empowered to trigger an expedited decision process during a multiple-site installation if it sees, for example, that a software template at one site fails to work at another. Even after a few weeks, Power Users are available to meet physicians at the hospital entrance and accompany them on rounds if they still need assistance.

Crandall sees different challenges depending on the project phase. "In the first week it's, 'How do I get on the system?' The third week, 'Is the information in the right format?' I'm going through all the issues: people, process, technology, culture," he says, having received and categorized 1,800 issues to date. Crandall plans on using the database to help Trinity modify its readiness strategy for clinical IT.

Incentives for employed physicians

Unlike executives at some organizations, Lyle Berkowitz, MD, medical director of clinical information systems at Northwestern Memorial Physicians Group (NMPG), a subsidiary of Northwestern Memorial in Chicago, has undisputed leverage when it comes to persuading physicians to use computers. "We're an employed physician group and we decide as a group whether to adopt clinical systems. Our executives felt that implementing an office-based, paperless EMR connected to the hospital's enterprise system was the right thing to do, and then we developed the strategy to win over our physicians as well."

Northwestern Memorial Physicians Group

Lyle Berkowitz, MD, medical director, Northwestern Memorial Physicians Group, Chicago

It helps that the physicians in the group are demographically younger, but NMPG also made sure that they always kept them updated about the importance of this project and what to expect with the roll-out. They did this via frequent "EMR FAQ Emails" and at least some type of EMR discussion at every physician meeting. Additionally, when they did go live with the system, NMPG chose to provide extra incentives to their early adopters. Dr. Berkowitz notes "since our physician's compensation is based on productivity, then any slowdown from the EMR means decreased salary for them. This slowdown was most obvious for our earliest users, when we were all learning how to implement efficiently, so we gave them a one-time cash bonus to reward them for their extra effort. We decided to continue to give smaller bonuses to all physicians who go live, since EMR conversion is never an easy task".

Berkowitz explained that the early adopters had schedules blocked to 50-60% of their usual in the first two weeks, but got back to 80-90% soon thereafter. However, the last 10% always takes longer, with the pilot physicians not hitting 100% productivity

Upcoming Events continued

December 1
Physician IT Leaders: A New Era
- Lyle Berkowitz, MD, medical director, clinical information systems, Northwestern Memorial Physicians Group (NMPG), Chicago, and assistant professor of clinical medicine, Northwestern University Medical School
- Michael Shabot, MD, medical director, enterprise information systems and immediate past chief of staff, Cedars Sinai Health System, Los Angeles

December 7
P4P: The California Experience
- Tom Williams, vice president, Integrated Healthcare Association (IHA), Walnut Creeek, Calif.

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until after the second or third month. As the EMR system and NMPG's experience at implementation improved, more recent rollouts were about twice as fast as the earlier ones. Additionally, a recent analysis found that the doctors using the EMR system were actually seeing more patients and billing at higher levels of service than those still using paper.

Berkowitz does acknowledge the advantage of being part of a larger enterprise system. "The truth is that being owned by the hospital corporation makes it easier to do these things. There are economies of scale. Smaller groups are not as protected as we are. We'll see more and more hospital systems subsidizing these systems for physicians."

Fundamental flaw

And unfortunately, there may even be a disincentive to practicing better medicine with IT, notes Berkowitz. "One of the fundamental flaws of our current healthcare system is that incentives are not always well aligned, as quality and efficiency are not rewarded consistently," he says, adding that use of clinical systems might save money for insurers, employers and patients, but physicians are often the ones being asked to pay for them.

"So the question is how do we provide appropriate incentives to our doctors? We have found that early bonuses can be an important way to get over the initial hump, and then we make sure to show our physicians that their improved documentation allows them to code at an appropriately higher level, while also making it easier and quicker for our billing department to review notes online when needed. Eventually, we also believe that quality will become more reimbursable, and so we will be in the driver's seat when that happens. Finally, never underestimate the appeal to a physician's professionalism: They understand more and more that this is the right thing to do."

Train, Support…

On thing NMPG knew from the beginning was to avoid overtraining physicians. There are a few hours of basic training before implementation, and then lots of in-office support, as well as ongoing help desk availability via phone or email. "Having our EMR team onsite with physicians when we go-live has been the single most important factor for our success in implementing the system," states Berkowitz.

…and train again

However, something NMPG has had to learn is the importance of revisits and re-education on a regular basis after the go-live. "A common problem among a lot of EMR implementations is that there is not enough follow-up optimization. There's too much attention paid to initial training and not nearly enough to post-implementation training," Berkowitz says.

NMPG also found that "EMR Pizza Meetings" can be very successful, as both new and experienced EMR users share their experiences and tips with one another. "There is nothing more powerful than listening to how your peers deal with the same situations you face every day, especially when using the established concept of 'See One, Do One, Teach One' to get everyone involved."

There's too much attention paid to initial training and not nearly enough to post-implementation training.

If physicians embrace CPOE and other applications as a strategy, someone should be able to bring them back data demonstrating measurable improvements in safety and quality.

Mass e-prescribing

Some health plans are getting obtrusive in their efforts to encourage physicians to use clinical systems. Earlier this year, Blue Cross Blue Shield of Massachusetts in collaboration with another health plan launched an e-prescribing initiative using primarily hand-held computers, or PDAs. The collaborative effort provides funding for the device, a year's worth of software license fees and six months of connectivity, according to Robert Mandel, MD, VP eHealth.

Robert Mandel, MD, VP eHealth, Blue Cross Blue Shield of Massachusetts, Boston

While there was some initial interest from large IPAs, he says there wasn't as much interest as expected from doctors, "So, we added e-prescribing to our Primary Care Physician Incentive Program (PCPIP)." Physicians with 200 or more BCBSMA members get paid $1 per member per month if they are actively eprescribing in 2004.

"We saw a lot more interest as a result," says Mandel, who adds that physicians who receive the incentives must use the system for at least 51% of their scrips in order to qualify for the program. "You can't just have the hardware in order to get paid," he says.

About 1,100 physicians currently possess the technology, with 300 of them actively using it. Mass Blues plans to expand the program to specialty physicians in 2005 through their Group Physician Incentive Program (GPIP). Anecdotal evidence points to such benefits as a significant reduction in staff time spent on the telephone, Mandel says, adding that it will take another six months' experience with the e-prescribing system to gather quantifiable results.

Quick and intuitive

Software vendors are obviously keen to know what makes physicians and IT click. Scott Weingarten, MD, president of Zynx Health, says that for physicians to use a clinical system like CPOE, it has to be extremely quick, intuitive and not slow their workflow. Hospitals can use helpful strategies like pre-populating CPOE with order sets so that the time spent entering orders decreases.

Scott Weingarten, MD, president, Zynx Health, Beverly Hills, Calif.

"Any time you can reduce physician time, that should be a focus," he says, adding that display screens need to be intuitive and screen "flips" need to be sub-second.

Being able to demonstrate results to physicians is also critical. "If physicians embrace CPOE and other applications as a strategy, someone should be able to bring them back data demonstrating measurable improvements in safety and quality. Most doctors will say, 'I'll give it a try, but I hope you'll show me evidence that it does produce

benefits,'" says Weingarten. "Certain physicians will embrace it and others will not. Before one mandates or considers mandating a system, the organization has to be absolutely certain the performance is there."

Spectrum of choice for physicians in Michigan

Spectrum Health is an example of a health system that has aimed to pre-populate its clinical systems with order sets as a way to motivate physicians to use clinical systems.

While Jennie Dulac acknowledges that CIO Patrick O'Hare and Director of Medical Informatics Angel Tebario, MD, do the heavy lifting for clinical applications like CPOE, as senior director of quality improvement she has her hands full with a precursor to CPOE: developing electronic standardized order sets and getting physicians to use them.

As part of Spectrum's Quality Initiative, an interdisciplinary clinical improvement team develops the order sets for admission, course of stay and discharge associated with high-volume, high-risk procedures: AMI; PTCA; CHF; CABG; total lower joint replacement (hips and knees); Cesarean section and vaginal delivery; laminectomies and lumbar fusion; and community acquired pneumonia.

The group is also working on rules and alerts that should "fire" if necessary during use of that electronic order set. "Rules and alerts are frequently employed because they promote standardization of practice based on the scientific literature as opposed to physician opinion," says Dulac. The objective is to send doctors educational information at the point of decision and give them a choice so it's not cookbook medicine.

"It can be very powerful. We try to be very data driven," she says.

Data hungry

Still, it's one thing to develop electronic order sets, reminders and alerts—yet another to get physicians to use them. But Dulac says physicians are hungry for data to help them practice better. "We use the data to attract the physicians to the technology," she says, adding, however, that the organization has learned three key lessons about physicians and computers:

1. Physicians want a single master or sign-on and universal passwords;
2. Speed and turnaround in applications is always an issue;
3. Physicians are always included in the development phase.

Then there's support. Spectrum has developed the "Purple Shirts," a cadre of younger, computer savvy, paid volunteer residents who assist physicians in using clinical systems. Another source of support: nurses trained up front to be Super Users, who can assist everyone from physicians to radiation therapists and dietary staff in using systems.

But Dulac reiterates that physicians at Spectrum have gotten hooked on the data—even in paper form—and are clamoring to get it electronically now. "Doctors

We use the data to attract the physicians to the technology.

are disappointed when they're limited to getting paper quarterly reports for different disease registries. What they want is to have clinical data sets entered into a data warehouse. That would make them very happy," she says.

Conclusion

Until healthcare is completely automated from an information standpoint, hospitals and physician groups will probably continue to brew up a mix of carrot, stick and moral appeal to encourage doctors to incorporate clinical IT into their daily diet. John Halamka, MD, CIO at CareGroup, says his organization's strategies for physician adoption include:

1. *Incentives*—Pay doctors to use systems via payer-based pay for performance strategies. Bridges to Excellence, which pays $50 per patient per month, is one example, as is Mass Blues' approach mentioned above.
2. *Peer pressure*—Doctors who do not use EMRs get fewer referrals because referring doctors want to see the result of the referral in the electronic record.
3. *Requirement*—To maintain staff privileges at CareGroup's Beth Israel Deaconess Medical Center doctors must use CPOE. There's no opportunity to use voice or handwritten orders.

John Halamka, MD, CIO, Care Group, Boston

Halamka says that to be effective incentives must be at least $3.00 to $4.00 per patient per encounter or have to affect 20% of a physician's income. "Doctors say, 'I would stay five minutes longer' if the incentive reached those thresholds," he says, predicting that the federal government will start paying $3.00 to $6.00 per patient encounter to use EMRs. "The Medicare program will spend some money to save money."

Saving physician time is a big carrot, but it's also necessary to explain that there will be a productivity hit for the first three to six months. After that, however, there are numerous opportunities for physician time saving, including, for example, saving a half hour waiting for admitting orders. A great way to motivate doctors to use IT, Halamka says, is to let them know that, as a result of using the new system, "You're going to get home two hours early. You'll love it."

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