

Hot, Emerging HCIT Tools and Trends *The Pace Quickens*

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Health systems and clinics of every size are preparing for an accelerated pace for healthcare information technology (HCIT) adoption and implementation, which will increase influence in every part of the clinical, financial, and operational workflow. This article addresses the five emerging tools/trends where acceleration will be most profound and necessary for future viability and participation in quality care initiatives.

1. Analytics and Dashboards (Big Data)

According to the familiar maxim, "What gets measured gets done." (*Note: "What gets measured gets done" has been attributed to Peter Drucker, Tom Peters, W. Edwards Deming, Lord Kelvin, and others.*)¹ Heretofore, analytics and benchmarking were mostly reactions to outdated data manually compiled by the organization's leadership team. In most cases, data was compiled from multiple sources, including the manual abstraction of information from paper sources. Now, emerging analytic solutions, combined with powerful electronic health records (EHR), are capable of extracting "big data" from multiple repositories and caregivers to provide comprehensive insights at the point of care or decision points. For example, these solutions can quickly reconcile all the medications being prescribed to the patient, which can dramatically decrease drug-to-drug interactions. In addition, key performance indicators (KPIs) (or measurements for quality) can be tied to decision support alerts to allow the caregiver to make better decisions while treating the patient.

In the near future, reimbursement will be predicated on delivering quality outcomes, and it will be imperative for providers to demonstrate the value of their contribution on exactly how they are reducing cost. This will be especially true for providers who will participate in quality care initiatives and/or accountable care organizations (ACOs).

KPIs can also be monitored based on role or department. In most cases, an executive dashboard will also reside on the user's computer device so the information can be viewed in real time and in some cases can even predict trends and provide "what if" scenarios by modifying the KPIs.

2. Population Health Management (PHM)

The concept of accountable care requires a group of providers to work together to manage a population of patients in a particular market. EHRs were never built as care coordination tools. Even an enterprise EHR system where there is only one patient record in use does not always have functionality to manage an entire population of patients and/or consumer-driven programming. As data becomes more available, it also becomes more fragmented. PMH solutions act like a funnel, collecting data from various EHRs and health information exchanges (HIEs) to enable care coordination and management of a population of patients and their quality outcomes.

3. Health Information Exchanges

HIE and PHM tools both consolidate data to enable care coordination, but HIEs are generally structured as solutions driven by an entire community or statewide repositories. In most cases, the end user may not interact directly with the HIE. An HIE will likely function as a central repository for both structured and unstructured data. Connection to an HIE is also required for Phase II of Meaningful Use (MU). An HIE is not typically something a physician purchases directly; usually, there is an access fee and/or recurring subscription fee to connect to an existing HIE. Some larger health systems may operate private HIEs across their campus(es) and medical

staff. Ensuring data integrity and security are concerns that should be addressed with the HIE provider prior to participation.

4. Patient Portals

Although patient portals are not new, they are emerging as the primary solution for coordinating care electronically with patients. The increase in popularity has accelerated as a result of participating in MU incentives. Advanced patient portals allow patients to pay their bills online, schedule and reschedule appointments, and even facilitate an electronic visit (e-Visit) for conditions low in complexity. Not all payers cover e-Visits, however. Eligibility should be verified in advance.

5. ICD-10 Enabling Tools

ICD-10 is a massive unfunded mandate that will require every provider, hospital, and payer to convert to on October 1, 2014. This initiative has proved disruptive to existing workflow and processes, especially in the area of clinical documentation and point-of-care charge capture. Going from 14,000 to 68,000 codes will not be an easy task. Most vendors will have ICD-10 codes loaded in their directories, but helping the provider select the correct code and apply the correct documentation will still have to take place at the point of care or soon thereafter. To respond to these challenges, a myriad of ICD-10 enabling tools have emerged to ease the pain of conversion. Some examples include:

- **Computer assisted coding.** Some solutions can apply “Google-like” search engines that will bring up clusters of possible ICD-10 codes to consider based on the content of the clinical documentation. This helps the provider narrow down the 68,000 codes to only those that best fit the patient encounter. While this will reduce search efforts, the documentation also has to correct for this technology to work correctly. ICD-10 documentation will require specific details concerning the reason for visit and treatment plan. For example, something as simple as denoting “ear infection” will no longer be acceptable; ICD-10 will require the provider to document whether the infection is in the left or right ear.
- **Crosswalk solutions.** Some solutions are betting on physicians and hospitals not being ready or fully prepared for ICD-10. Accordingly, emerging solutions will allow a provider to continue using ICD-9, with a feature to crosswalk the code to the closest match in ICD-10. However, much like computer-assisted coding, the matches are not one-to-one, and the documentation will still need to meet the required standards.
- **Clinical decision support tools.** Although clinical decision support tools are not new, especially to those who use an advanced EHR system, they are now being enhanced to incorporate documentation necessary to meet IDC-10 requirements. The caregiver is still responsible for approving the final note, but in some cases a default treatment plan can populate the note to help save time and ensure adherence to the standards. That said, overutilization of “cloned” notes or “boiler plate” can trigger an audit. Defaults should be used carefully and only when applicable.

Disruption and policy changes always drive new solutions into the marketplace to help providers and hospitals meet new challenges. The emphasis on and expectations for clinical outcomes, quality of care, and care coordination will be significant and tied directly to compensation. As HCIT systems evolve to meet these challenges, end users will have to adapt their workflows and procedures accordingly. Greater awareness of where your organization needs to be in terms of participating in quality improvement initiatives will drive today’s decisions and strategies. Staying current on reimbursement policy changes and mandates will also help anticipate the right planning and budgeting processes for keeping up-to-date with the latest tools and solutions.

Investments in emerging technology should also include developing performance-based terms and conditions to ensure these systems work as promised. This is especially critical as you start to build and create dependency on these solutions. For a complimentary list of performance-based contracting terms, please e-mail your request to idaigrepoint@cokergroup.com

Reference

1. R.M. Williamson. 2006. What gets measured gets done: Are you measuring what really happens? Columbia, NC: Strategic Work Systems, Inc. At <http://www.swspitcrew.com/articles/What%20Gets%20Measured%201106.pdf>. Accessed November 13, 2013.

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