



# EHR Investments: The Value Case for Senior Healthcare Financial Executives

This project is a collaborative effort by Cerner and the Healthcare Financial Management Association.

**You:** I'm going to need your support for a major capital investment that will uproot our processes, may alienate many physicians, and will likely require scrapping many of our expensive IT systems that are currently running well.

**Board Member:** What kind of savings can we expect?

**You:** Well, I can't say for certain.

**Board Member:** What?!?

Such is the possible exchange CFOs face when presenting their boards with the case for electronic health record adoption. Yet as daunting as this situation appears, it is one that the financial executive must be willing to face.

Pay-for-performance programs that require advanced methods to track and report clinical outcomes are popping up across the country. President Bush's funding of health IT demonstration projects as well as the

e-prescribing and interoperability standards mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 are a clear indication of where payer intention lies.

Important, too, is the growing number of healthcare consumers interested in learning about the quality of care their local hospitals provide. So far, limited outcomes information is available through the Centers for Medicare and Medicaid Services web site and some state-sponsored sites. However, as patients continue to take a more active role in selecting their healthcare providers, the availability and significance of such data sources will continue to grow.

These directives for transparency make it strategically imperative for providers to adopt better data tracking and reporting technologies. Those not making the needed investments will put themselves at a great disadvantage when the time comes to respond to government, payer, and patient inquiries.

And this “day of reckoning” is coming soon, according to Robert Brook, MD, vice president and director of RAND Health, and professor of medicine and health services at the University of California-Los Angeles:

*By 2020, 90 percent of all providers in the United States will likely have some sort of electronic health record. That’s assuming the government does nothing to step up the effort, using the best analysis tools based on adoption curves of technology in different industries, and looking at what’s happened in health care to date.*

*There are some wide competence limits around that and they swing plus or minus a few years, but we’re on an adoption course regardless of what Washington does. Some time in the next decade—probably at the end of it—most everybody in the United States will have this thing.*

What should you be doing to help your organization keep pace?

This past March, HFMA convened a meeting of 31 CFOs from around the country to discuss this topic and explore how hospitals should view EHR investments and their benefits and returns. The meeting was generously supported by Cerner Corporation and was conducted in a peer-to-peer roundtable format.

Participants’ experiences showed that key for financial managers will be making the business case for EHR—both from a financial and strategic perspective, supporting a sound clinical and technical migration strategy, and addressing potential difficulties associated with implementation.

## Making the Financial Case

There’s no denying that health IT is costly. Although estimates vary, physician practice EHR systems typically cost more than \$10,000 per physician, with operating costs representing another 25 percent of the total per year. For a large hospital or multisystem provider, an EHR investment can easily exceed \$10 million.

Yet an even greater barrier to EHR adoption than the hefty price tag appears to be the difficulty in quantifying an associated level of return. Many senior healthcare financial executives find it extremely challenging to build a definitive business case based on cost savings.

As an example of value challenges that providers typically face, consider the experience related by James Peppiatt-Combes, CFO, Trinity Health, Novi, Mich.

Trinity is one of the largest Catholic healthcare systems in the country, owning 23 acute care facilities and operating a total of 45. As part of a \$200 million initiative, Trinity hopes to link clinical, revenue cycle, and supply chain management functions throughout the system through a common EHR platform. To date, Trinity has completed implementations at three community hospital systems, has one implementation under way at a Battle Creek, Mich., facility, and plans rollout at four more hospitals this year.

Peppiatt-Combes says some key challenges have developed when staff at individual locations have presented the business case for the project. Although they are able to identify provable savings in the ROI analysis, sometimes the overall costs have actually gone up once the technology is introduced. In other instances, as processes are redefined to prepare for coordination, the efficiencies created have swayed initial estimates. Thus, it sometimes appears as if staff members are giving credit in their electronic record ROI analysis for things that could have been done all along. And perhaps most troubling, even the best ROI estimates are rarely enough to drive change.

Explains Peppiatt-Combes:

*For the supply chain, it’s not showing up on the bottom line—but we’re sure it exists. In revenue management, it’s showing up on the bottom line, and we haven’t installed the systems.*

*Worse still, the best defensible number we could come to was about 6.5 percent—which is not a number that would necessarily cause you, from a financial point of view, to see it as a place you would normally go. Sure, you can look at some of the clinical measurements, and you can see significant improvements. But the ROI measurements that we’re typically used to seeing, and that we, as CFOs, insist be behind any other initiative, simply aren’t there.*

Still, as elusive as value may be to pin down, the reality is that financial managers need to present a case with dollars. Inevitably, there will be some board members who are going to insist on that.

**Tip!** Not sure how you’ll satisfy training needs at all your sites? To cut costs, one hospital set up a recreational vehicle with personal computer workstations. It could then take this RV “traveling training room” from facility to facility where needed.

## How Can You Make a Better Business Case for EHR Adoption?

**Stagger demonstration of ROI.** Initial discussions of ROI should be based on your best approximation of specific, measurable results. The next level of ROI will occur after a pilot system is installed. At that point, focus shifts to measuring the impact of the system. Data derived from initial programs will form the foundation of discussions with the board on furthering the organization's investment. Quantification and communication of success after the board's initial leap of faith is key.

**Establish data systems to capture aspects of quality.** Your goal should be an electronic format that will allow you to recognize specific patterns in care delivery. Don't just try to tie down the financial side of the analysis; use measures that will help you track performance to a limited number of clinical best practices by caregiver. Once you start capturing these data, you will have a foundation from which you can analyze and redo processes.

**Include satisfaction.** As you begin to knock down process barriers and improve the quality or amount of time physicians and nurses spend with patients, be sure to track customer service metrics. As an

example, quicker response times in the emergency department stemming from efficiency in documentation may lead to fewer diversions, improved scheduling, and faster admission for patients on arrival. These changes are likely to create tangible improvements in customer and physician satisfaction.

**Don't forget charge capture.** When quantifying return on an EHR investment, it may seem like a given to include revenues associated with improved charge capture. Yet all too often, financial managers simply leap straight to clinical benefits.

**Set ROI in a range.** Boards feel more comfortable when there is a planned level of investment risk. Although it may be impossible to zero in on exact figures, setting ROI expectations based on most successful and least successful scenarios using reasonable assumptions will help dispel some concerns.

**During planning, beware of the primary threats that eat away at return.** The most significant financial drains are delays in installation, failure to appropriately assess standardization needs, and unplanned expansions in scope.

One way Trinity Health has attempted to meet this challenge is by selecting measures and reporting experiences and applying them in limited use to help drive the data to make the case for broader application. Key has been setting measures at the beginning of the process so there is a baseline from which it is possible to calculate impact.

*In a lot of the clinical measurements, we had a modestly good baseline we could use. But we didn't have a good baseline in ancillary departments. After our first institution install, the changes in the ancillary departments were just horrible—they appeared to be largely people-dependent or undocumented. One of the things we've done—and it may seem like a waste and it adds a bit to initial cost—is that on each new installation, we sent in a document that we eventually planned to change to be used with the existing system. That may sound a little illogical, because you know you're going to be changing it, but it's necessary to get that base measurement.*

Standard areas cited where adoption of an EHR system will lead to margin improvement include reductions in transcription costs, savings in paper-chart-related costs (supplies, copying, printing, and storage), opportunities for staff efficiency as less time is spent searching for charts and entering charges manually, and revenue enhancements through improved coding and charge-entry accuracy.

Integrating clinical standards and evidence-based protocols into order entry systems also can reduce costs associated with excessive length of stay and medical errors. Studies have shown lower incidence of adverse drug events when appropriate and timely electronic notifications are pushed to clinicians. Further, drug-related costs can be reduced by alerting clinicians to the availability of drugs that are just as efficacious, but less costly than other drugs, and notifying clinicians when a patient can appropriately be switched from intravenous to oral medications.

## Considering Strategy

Although it's possible to make some level of financial justification, in the end, these issues tend not to lead EHR investment discussions. Focus tends to shift toward the potential for EHR systems to enable better health care through improved nurse documentation, standardization of processes, and reduced workflow. The prospect of a safer and more efficient environment where patients want to go and physicians want to practice—the soft side of ROI—is where the heart of most business cases will lie.

The most convincing business cases typically blend a discussion of return in terms of a best approximation of specific, measurable results with ways in which the technology is likely to affect overall quality of care delivery.

As one CFO describes:

*There are some areas that we thought we could measure—areas like nursing documentation on the floors and documentation for doing initial assessments. We then looked at measurable quality indicators, such as number of patient falls and pressure ulcer sores, and how they affected our length of stay. From there, we moved to standardization and tried to reduce workflow processes and times. We established benchmarks and identified associated savings.*

*However, we knew these efficiencies weren't going to equate to a direct reduction in the work force. In reality, you're not going to lay off nurses, but redeploy them. In other words, some of the time the nurses spent doing documentation would now be devoted to patient care, so the nurses would have the capacity to care for more patients. Such changes in care delivery had derivative savings potential. It might mean reducing the amount of recruitment needed to try to find nurses to fill vacancies, since turnover would likely decrease as nurses felt more satisfied with how their time would be spent.*

### Tip!

After EHR implementation, don't just solicit feedback from senior physicians and nursing staff. Early careerists are the most likely to have been exposed to EHR experiences externally during their training—and may be able to offer key recommendations on how your system or processes can be improved to optimize use.

*This would also mean we could decrease our level of dependence on agency nursing—which is not only costly but less effective than having our own staff.*

*Also important was recognizing the impact of creating a system that could really measure patient errors. Granted, at first the rates would go up as we were able to capture more data, but then six to nine months into it, we expected a reduction in errors as we started to use the data to improve processes—there is some value to that from both a financial and patient quality perspective.*

*Taken in total, these findings translated into the fact that we would have better patient care and become the institution of choice—which would help to fuel our growth.*

In the end, it's not hard dollars so much as strategic significance that will guide most business cases for EHR adoption. Rather than focusing on costs associated with acquiring the technology, discussions begin to center on opportunity costs associated with postponing investment.

In some geographic areas, the strategic significance of EHRs is already being felt. Some CFOs report that failure to acquire the technology is already having a direct impact on their organization's desirability as an employer.

As an example, one CFO from an Illinois hospital that is sandwiched between two larger healthcare systems recently watched as his competitors struggled to adopt an EHR system. At first, the process changes alienated many physicians. As time progressed, however, the clinical case for EHR adoption became hard to dispute.

*Two years ago, our doctors were saying, 'We like you guys, you haven't put us through all this pain and hassle.' Now, as time has passed, the doctors are saying, 'All the pain and hassle, that was a pain for a while, but now we kind of like it. When are you guys going to do it?' They're thinking of it as the core of what they do. They want an electronic record for their offices.*

More pressing for most providers, however, is a need to anticipate demands of payers. As data continue to support the use of EHR systems to improve patient care, insurers will begin to insist on them. Providers unable to adequately document that they can provide the same quality of performance as their competitors are going to miss out on payment.

Greater transparency of performance also is likely to have a significant impact on competition in areas where patients typically have a greater voice in their care, such as obstetrics, orthopedics, and elective procedures. Trends toward consumer-directed health care combined with increased public posting of clinical data can't be ignored.

Providers not only will have to develop the ability to report these data, but they also will need to make sure the data are clean, accurate, and appropriate—that's when having good systems and processes will matter most.

## Developing a Sound EHR Migration Strategy

Obtaining funding approval is just the first hurdle the healthcare financial manager must face. For EHR adoption to be a financial and clinical success, it's also important to support a sound migration strategy.

Technical barriers in this regard can be significant. Unlike most technology investments that cross the CFO's desk, clinical information systems that support EHRs have yet to reach maturity. It is difficult, if not impossible, to find a beta site that will use the

technology in the same way as your organization. Therefore, finding a solution for your organization requires more than simply looking to peers who have had successful experiences. As one CFO explained:

*There isn't somewhere to just go and see where it's working. It is still an academic discussion to some extent right now. In some ways, you're betting your career on vaporware.*

One reason it is so difficult to translate EHR experiences from one facility to another is that successful functioning often depends on how well interfaces occur with separate legacy systems in each department.

As one CFO describes:

*As we try to interface our existing 'islands of automation' with the integrated system, we're continually hitting walls. The vendors that support the disparate systems we are using don't particularly have any economic incentive to want to help us, and we're having a very difficult time trying to have them write interfaces for us. The practical decision we're facing is either to scrap a very expensive system and start over, or to do expensive workarounds—and that's a constant source of frustration for us.*

## How Can You Support a Sound EHR Strategy?

**Create structured change management.** Any time you bring in significant technology, you should first have across-the-board education on change management. Hospitals that devoted resources to this area found it easier to anticipate and overcome resistance to change.

**Focus on process improvement first.** You shouldn't simply be looking at how things are being done today and figuring out how to replicate that electronically. You should be trying to install a system that reflects best practices for the area. Also, upfront reengineering processes often can help you optimize the functionality of a particular system.

**Commit the right team.** A strong clinical voice needs to be present not only to achieve the buy-in necessary for process changes, but also to estimate the impact on the user group. Also, don't hold back

on using your best people. To be successful, you will need your best talent committed to the cause—even if that means dismantling or disrupting some areas that currently are running well.

**Establish formal communication opportunities with IT.** Realistic implementation schedules will not occur if the operational team and IT staff are not in sync. The operational group will need to communicate ramifications of the technology and any issues that would impede staff commitment to perform critical functions that have to be done for IT to carry out its related processes. Poor information flow to IT is a frequent source of system delays. By having the operations team commit to regularly scheduled meetings with IT, you can minimize these information gaps.

Another common disconnect exists between operational processes and system functionality. Clinical processes tend to vary significantly among departments and organizations, and the technology isn't always able to adapt.

And in some cases, a strong argument can be made that perhaps the technology shouldn't adapt. Consider the experience of one healthcare CFO whose hospital tried to make the electronic record replicate the organization's paper processes.

*We took a system and tried to customize it to make sure our demographic and intake forms were exactly the same as what we were using. The result was that we ended up creating oodles of forms—many of them picking up the same data element. Not only did we end up entering data more than once, but also, what we created became so unwieldy that the nursing director and physician associated with the project practically gave up. That was probably the nail in the coffin for the system that we were trying.*

Because of these challenges, it is particularly important for providers to commit their top clinical and IT staff to participate in the planning process. These individuals will need to identify operational processes and standards that the technology should incorporate; develop appropriate strategies for interfaces between departments, the organization, and external users; and establish the timetables for associated rollouts.

Although it can be hard making do without your organization's top performers while they are devoted to these tasks, such strong organizational commitment is vital. EHR technology touches every department and influences internal and external interactions in ways that cut to the heart of core care delivery and business functions—a prospect far too important to leave in the hands of a team with less than optimal skills or experience.

**Tip!** Organizational discipline is key to establishing—and maintaining—properly trained staff. One hospital refused to give new hires their sign-on bonuses until they had completed appropriate training classes for the solutions they were going to use. Establishing this firm guideline prevented typical excuses at the department level, such as immediate need for staffing or an ability to get by with “just-in-time” training, from getting in the way of having a fully and adequately trained staff.

One word of caution: When selecting team members, first train appropriate support staff to handle day-to-day responsibilities in their place. A common mistake when dealing with large strategic initiatives is to commit the needed executives and managers to the project without having the necessary backup to handle the tasks that will need to be redirected. It's important to build bench strength *before* stepping into the game.

## Addressing Barriers to Implementation

Once an organizational strategy is established, focus then shifts to tackling implementation barriers. One of the greatest impediments to successful implementation is lack of initial support from technology users, particularly physicians.

Although point-and-click technologies may save substantial dollars on the back end of the business, leadership can't ignore the extra work that is often created for front-end users. When independent physicians are asked to participate in computerized order entry, they need to be assured that they are not merely data entry clerks.

One way some organizations are addressing this challenge is by highlighting ways that the automated processes are contributing to safety and improved care. Physicians will usually be receptive to using the clinical information system once they see evidence that *not* making use of the technology will make them outliers among their peers. Unfortunately, in most cases, until you implement these kinds of systems, such data will not exist.

In the absence of data, reliance on user champions becomes crucial. Physicians prefer to learn from other physicians. Therefore, system selection, development discussions, and training require a strong clinical component. Some hospitals have found success in getting hospitalists on board EHR adoption first. These physicians are best positioned to relay the importance of the technology and address concerns with the organization's independent physicians.

Also key is creating opportunities for staff feedback. Some hospitals have created clinical process teams consisting of physicians and nurses from each facility and all disciplines that meet frequently to discuss desired functionality as well as challenges and experiences with the technology. Business staff can then use this feedback to rework organizational processes or seek specific functionality from the vendor.

## How Can You Support Smooth Implementation?

**Develop short-term wins.** Whether through pilot projects or designing rollouts to occur in different areas geographically, start small and build on your successes. The sooner people start seeing benefits, the easier it will be to build on the momentum and develop user buy-in.

**Keep expectations in check.** Somebody is always going to be able to do something you can't. Simply put, you won't always have the same preferences and functionality in particular areas as your competitors. Therefore, let users know what the functionality will do and define how they're best going to use it.

**Devote significant time and resources to training.** Not only will everyone need to know how to use the system, but training also has to be kept up so that you really use the functionality. All training should be tracked. You'll need to continue to educate and train; it's not a point-in-time investment that you're making.

In addition, it's critical to accurately assess the number of people in need of training, how many resources (computer terminals, instructors, etc.) will be needed, and how much time will need to be devoted. Although doing so may sound basic, too often organizations are in denial about what it really

will take to accomplish effective training. Experience shows that training is an area where hospitals most frequently underestimate resource needs.

**Choose your vendor rep carefully.** Successful implementations are best facilitated when linking with someone who is an expert on the vendor side. Those who have a proven track record of implementation are in the best position to provide advice and ideas. As one CFO explained, "My worst installation was where the vendor had a new person on the job. This was a second install, and we just bombed."

**Set up milestones for contract payments with vendors.** That way, if things do slip and the deliverable of the next phase is not ready, you're not paying the dollars. Also, it's important to be clear in the contract about your expectations regarding the scope of work.

**Don't let post-implementation lull take over.** It's easy to put all of your focus on the install and lose sight of what happens afterward. The organization should periodically be asking whether it is using the capabilities it purchased and whether there is functionality that hasn't yet been tapped. Asking vendors to critique how effectively you are using their features can be useful.

It's important to note that the first step should be trying to find a product that meets most of the organization's needs and finding ways for staff to adapt to using the solution as it is intended—the way that has already proven some benefits. Only after positive outcomes are gained in this way should the organization tackle trying to customize features.

### Difficult Discussions

When it comes to EHR adoption, healthcare financial managers across the country will be facing many difficult discussions. What is the organization's financial stake in obtaining and operating the technology? How will the organization optimize processes to leverage

use into market distinction? What steps need to be taken to combat implementation barriers and minimize financial risk?

Although these issues present no easy answer, health-care providers who develop an EHR adoption strategy based on sound financial principles and a strong commitment to improve patient safety and care delivery will best position their organizations for competitive advantage.

The industry is poised to change. Those who haven't at the very least engaged in discussions about how to achieve and document quality and safety standards in accordance with peers are putting the very well-being of their organizations at risk.



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