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In recent years, few topics have dominated the conversation in rural hospitals as much as the deployment of electronic health record (EHR) technology.

As the discussion has evolved, the questions have changed, too. Today, we no longer ask, “Will we deploy an EHR system?” or even “When will we deploy an EHR system?” (The answer to the latter question has largely been dictated by federal EHR incentive payments and their requisite deadlines for meeting Meaningful Use standards.)

Rather, the focus in many hospitals has shifted to how EHR deployment will occur in a timely and orderly fashion. Of equal importance is the answer to this question:

“*How can we get physicians to accept and use our EHR system?*”

After all, physician use of an EHR system plays a pivotal role in meeting Meaningful Use standards. It’s also a key ingredient in realizing the many clinical and organizational benefits of EHR technology, including increased patient safety, immediate access to patient information, and, ultimately higher levels of patient satisfaction.

This white paper will concentrate on physician adoption of EHR in rural hospitals and, by extension, in their affiliated physician practices. Specifically, we will address:

- How EHR technology is benefiting physicians and their patients
- The crucial role of physician adoption in fully realizing EHR deliverables
- How hospitals have overcome resistance to EHR use and have achieved a high level of physician participation

This white paper relies primarily on the perspectives of individuals — physicians, hospital executives and information technology (IT) leaders — who have accomplished, or are in the process of achieving, their desired levels of physician involvement with the facility’s EHR system.

It is important to note that no two hospitals cited in this paper have followed exactly the same pathway to physician adoption of EHR. These varied experiences reflect the unique attributes of each hospital, its people and the community it serves.
By sharing these real-world experiences, tactics and tips, it is our goal to help leaders in rural hospitals formulate or fine tune their own plan for gaining physician adoption of EHR technology.

Our Physician Roundtable

We wish to acknowledge and thank the following individuals for sharing their insights and experiences in the creation of this white paper. Each of these individuals has been instrumental in promoting physician adoption of EHR in his or her facility.

Physicians:

- Kenneth Langille, MD, Kane Community Hospital (PA)
- D. Eric Westberg, MD, Glacial Ridge Health System (MN)
- Kim Witkop, MD, Snoqualmie Valley Hospital and Clinics (WA)

Executives:

- James Magee, Administrator, Piggott Community Hospital (AR)
- Mike O’Neal, Chief Executive Officer, George C. Grape Community Hospital (IA)

IT leaders:

- Mark Davis, Information Technology Manager, Piggott Community Hospital (AR)
- Heidi Engle, Chief Information Officer, Glacial Ridge Health System (MN)
- Jay Stewart, Clinical Support Specialist, Glacial Ridge Health System (MN)
- Margaret Twidale, Director of Information Services, Kane Community Hospital (PA)
- Craig Wells, Director of Information Technology, George C. Grape Community Hospital (IA)
Multiple components comprise an EHR system in the typical rural hospital. The inpatient modules used most frequently by physicians and other providers include:

**Clinical documentation** — where physicians and nurses enter vital signs, intake-output values, progress notes and nursing tasks into the patient’s EHR.

**Computerized physician order entry (CPOE)** — provides one-stop order entry, order communications, and other value-add features, such as clinical decision support, medication interaction alerts, access to lab results, and duplicate order checking.

**Provider work center** — a dashboard where physicians can track patient vital signs and manage their workflow, lab results, unsigned orders, and unsigned transcriptions.

Physicians also may use modules for specific departments, such as the emergency room, radiology, laboratory and pharmacy. In addition to the inpatient system, they may use an EHR in their clinic office to document patient encounters, automate many charting tasks, and share information with other providers.

The list of expected EHR benefits to physicians and patients is long, compelling, and well documented. Among the key benefits commonly cited:

- **Improves patient safety** by reducing the potential for medical errors inherent with paper records and by automating critical processes, such as medication interaction checking
- **Anytime, anywhere access** to patient charts via secure, browser-based wireless technology, and portable devices, such as iPads and netbooks
- **Provides a complete view** of patients and their medical histories; integrated systems consolidate information from care delivered in the inpatient, physician practice, emergency room, long-term care, and/or home health settings
- **Enhances consistency in patient care**, thanks to clinical decision guidelines and standard order sets
- **Increases satisfaction among patients**, who no longer have to provide information that already exists in their records
- **Fast, efficient order entry** through templates with pre-populated fields and other shortcut features
Documented EHR Capabilities and Advantages

Our physician adoption roundtable provided insights into the everyday usage and benefits of an EHR system.

At George C. Grape Community Hospital, use of the EHR system has greatly sped up access to patient charts. “We don’t have to wait for our medical records team to produce a paper chart, a process that could take an hour to 90 minutes,” said hospital IT Director Craig Wells. “As information is entered into the system, the patient chart is updated immediately, and it can be accessed from anywhere, 24/7.”

This immediate information access enhances the ability of departments to work together as a patient care team, according to CEO Mike O’Neal. “Everyone is able to see everything all at once. A nurse enters something into the ER system, and almost instantly, it can be brought up in the lab or in radiology.”

Better visibility also means fewer medication errors, Mr. O’Neal continued. “With an electronic system, we have better awareness of potential medication errors, which enables us to take corrective action and increase patient safety.”

Physician D. Eric Westberg, MD, has witnessed EHR’s profound impact on the way healthcare is delivered at Glacial Ridge Health System.

“Electronic health records have changed the way we practice medicine and the expectations for the practice of medicine,” he stated. “It used to be the standard that when people came into the ER, for example, we had to guess what their medications were, if they weren’t able to tell us. Now everybody has access to an accurate list of medications. We’re not reinventing the wheel in terms of understanding what’s happened to a patient before. This potentially allows us to expedite the admission process. Ultimately, the patient is receiving better care right out of the gate.”

One of the biggest changes for physicians is the use of CPOE to place nursing, pharmacy, radiology, and laboratory orders. And, while the transition to CPOE can require time and patience, the physicians on our roundtable clearly indicated that the benefits outweigh any disadvantages. Following is a sampling of their comments:
Dr. Langille:

“CPOE gives us a tremendous advantage, especially in terms of medical ordering. Instead of writing an order on a piece of paper and handing it to at least one intermediary, the order goes directly to the person who’s going to institute it. We’ve reduced the chances of misinterpretation.”

“We’ve also removed the issue of illegibility. Doctors are not particularly known for the quality of their handwriting. I’ve gone back and looked at my own orders and wondered what on earth I was writing. With CPOE, there’s much less opportunity for misinterpretation or someone not having any idea what we’re asking them to do.”

Dr. Westberg:

“I love that I can order labs during patient visits, as I’m talking to them about their care. In addition, I can order labs while sitting next to the patient. I explain why I’m doing each lab and give them the opportunity to provide input. They become a partner in their own healthcare. In addition, I can perform medical necessity checking and get a diagnosis tied to a lab right away. Patients are more satisfied because they’re aware of what Medicare does and doesn’t cover.”

“I appreciate the flexibility of being able to order labs individually or together as a panel. I like the fact that once an order is entered, each department is notified in one fell swoop, whether it involves lab, radiology or nursing. This really has improved workflow, and it has relieved the uncertainty about something getting missed.”

Dr. Witkop:

“A well-structured order entry format prevents items from being forgotten or left out. In other words, we don’t have to go back later and make changes. It also gives us a safety mechanism — we always have essential reminders in front of us, CPOE puts medication alerts at the point of order entry, which spares the pharmacist or nurse from having to contact the ordering physician and resolve a medication interaction. This increases efficiency and helps ensure more rapid delivery of medications to patients.”

“With wireless access, physicians can remotely enter orders, whether they’re outside the facility or in another section of the facility. This saves them from having to go to the patient’s floor to write an order, which is especially important for physicians who
frequently have to go back and forth from hospital to clinic or from floor to floor in larger facilities.”

The importance of physician EHR adoption may be viewed from four perspectives:

- Delivery of high-quality and safe patient care
- Attainment of Meaningful Use standards and EHR incentive dollars
- Patient flow and operational efficiency
- A hospital’s overall success with the EHR system

As described in detail above, physician use of an EHR system can drive positive changes in patient quality of care, patient safety, and patient satisfaction.

Secondly, the more a hospital uses its EHR technology, the greater the likelihood of meeting Stage 1 Meaningful Use standards — the primary requirement for receiving Medicare and Medicaid EHR incentive payments. Stage 1 Meaningful Use includes the following core measures applicable to patients seen by an emergency physician or admitted to the hospital:

- More than 80% of patients must have at least one active diagnosis entry in the EHR (or an indication in the electronic record that no known problems exist).
- More than 30% of patients who are issued medications must have at least one medication entered using CPOE.
- More than 50% of patients ages 2 or older must have height, weight, and blood pressure entered into the EHR.

Under Stage 2 Meaningful Use, the threshold and/or scope of Stage 1 measures will increase, and providers will be responsible for meeting a number of new requirements, particularly surrounding care coordination and patient engagement. While a certain number of hospitals managed to hit their Stage 1 targets without strong physician participation, this will become much more difficult, if not impossible, to do under Stage 2 Meaningful Use.
On a related note, physicians in some rural hospitals have circumvented direct use of an EHR system by delegating data entry tasks to nurses or other support staff. Unfortunately, this practice undermines key advantages of EHR technology. As Dr. Langille indicates above, the potential for error increases when a physician uses a piece of paper to communicate important information to a support staff member, who then enters the data into the EHR. And, of course, the practice of using an “EHR intermediary” is inherently inefficient because these tasks now involve two people instead of just one.

**Patient Flow, Operational Efficiency and Intangibles**

This leads to another area where physician adoption of EHR can benefit the hospital as an organization: patient flow and operational efficiency.

“Looking at the whole process, from admission to discharge, EHR gives us documentation that is more timely and more accurate,” said Grape Community Hospital’s Mr. O’Neal. “We save time throughout the whole process, even though physicians may not recognize time savings at the individual level.”

When the technology was in its infancy, many EHR promoters sincerely believed that it would save physicians time and/or make their day shorter. In general, this has not been the case, according to Dr. Westberg. However, “EHR has evolved to help me become better provider, and it has allowed me to get more done in the course of day,” he said.

Moreover, because the system prompts physicians to provide all essential information up front, there is less likelihood that something will be overlooked. “This also improves turnaround times because we’re not having to go back and correct things that were missed when an order was entered.”

Intangibles also come into play when discussing the importance of physician EHR adoption. Piggott Community Hospital Administrator James Magee offered this: “It’s very difficult to do much of anything in healthcare if your physicians are not on board with you. Not only do they have their piece of it, but they have a great deal of influence over nurses, ER employees and others in the organization. They help set the tone for everyone else.”

Of course, the overall attitude of the facility is influenced by others in the organization, including the hospital administrator, director of IT, and nursing director. “However, your job is much more difficult if you don’t have the cooperation of your medical staff,” said Mr. Magee.
Based on the interviews with members of our roundtable, there is no one-size-fits-all solution to the challenges of achieving physician adoption in rural hospitals. Quite simply, the solutions are as different as the hospitals — and the physicians who serve those hospitals.

Many physicians embrace EHR technology. They may be technologically inclined (and a physician’s age is not necessarily tied to this inclination), or they may simply understand the significant benefits of EHR to their patients.

Others resist getting on board with EHR for as long as possible, and when they do, they may require a lot of “hand holding” by a member of their support staff.

Mr. Magee pointed out that physicians do recognize the inevitability of EHR. “Everybody is going to adopt EHR, whether now or in the future. It’s not as if this is a big surprise. Physicians are very much aware that this has to be done.”

It comes down to finding and sustaining the inertia to make it happen.

“People will get on board once they realize how much benefit there really is,” commented Dr. Langille. “There’s monetary benefit. There’s intellectual benefit. There’s the patient safety benefit. There are just so many benefits from using this kind of system. The fact is, no one likes change. You need to get past that hurdle, just realize you have to change, you’re going to change, and you’re going to do it in the fastest, most painless way possible.”

The following tactics summarize the experiences of our roundtable members, whose comments accompany each tactic.
Tactic #1: Involve physicians early in the process

Mr. Davis:

“We included our physician champion in a visit to a hospital that was using the EHR solution we ultimately selected. This physician was instrumental in helping us make our decision.”

Dr. Westberg:

“You can give the speech 100 times about all the benefits of EHR. But until you get out there and starting using EHR and experiencing all the benefits at the personal level, it’s just talk. As physicians continue to use EHR and become happy with it, they’re willing to go the extra mile and make it an even better tool.”

Tactic #2: Start with small wins

Mr. Davis:

“We didn’t just flip a switch and go to the program all at once. In our clinics, we started using EHR with one patient per day, then two patients per day. That way, we didn’t get behind schedule by trying to get every patient into the system. We worked on a partial-patient basis until the system was mastered.”

Mr. Stewart:

“Small wins are huge. One thing we did at Glacial Ridge was to have a facility-wide celebration any time we implemented something. The most important thing is to start small. Any time I can get them to chart something with EHR, I provide positive reinforcement.”

Mr. O’Neal:

“At the beginning, we made it known that we required our physicians to sign off on all orders electronically. That was our ticket into the system.”
Tactic #3: Don’t make unrealistic promises

Dr. Westberg:

“Be honest about the system, in terms of what it will and won’t do.”

Tactic #4: Establish a positive tone at the top

Ms. Twidale:

“The number-one factor is the organization’s leadership. If they’re not on board, the physicians think ‘why should I comply?’ The buy-in has to start at the top; it can’t start anywhere else. Once you have that in place, you need to have people sit down and determine what your goals are. These goals must be part of the hospital’s strategic plan; if the goals are not part of the hospital’s strategic goals, it’s never going anywhere. Then you need to evaluate where you are now, what you have, and what you’ll require to reach your goals.”

Tactic #5: Identify and engage a ‘physician champion’

Mr. Davis:

“Our physician champion is very technologically inclined. We tried to include him, whenever possible, in important discussions and keep him apprised as to the next steps, what to expect and when things will be happening.”

Ms. Twidale:

“You need a physician champion to lead the way, and every department has to have a leader, someone who leads by example.”
**Tactic #6: Identify and engage your most resistant physician**

*Ms. Engle:*

“The idea here is simple: You’re trying to instill the mindset among your physicians that ‘Dr. Doe,’ who has been resistant to EHR, embraces and uses the system, then so can I!”

*Mr. Stewart:*

“For me, working with these physicians is a matter of having patience. EHR is new for everybody, and I try to help our doctors and nurses feel comfortable with new processes. That’s really what it is...new processes.”

**Tactic #7: Provide training on the physician’s terms**

*Mr. O’Neal:*

“Providers need to make time to learn and understand the system’s capabilities. At the same time, it can be difficult getting them to make that commitment. Somehow, you need to make it happen. Maybe it’s during a breakfast, at a lunch and learn, or following a medical staff meeting. Figure out ways to do it without making a physician’s lengthy day even longer.”

*Ms. Twidale:*

“One of the things we did was host a dinner for our physicians one evening. We did demos, provided training, and asked the physicians for their input.”

*Ms. Engle:*

“We have a small IT department, just myself and one other person, so we’re not always immediately available. We hired a person, Jay Stewart, whose entire work day is devoted to answering clinician questions and providing assistance with order entry. Jay has a good rapport with our providers — they trust him 100%. And he has a real can-do attitude.”
Dr. Westberg:

“Physicians generally don’t like to ask questions in a group. The key to improving utilization is having somebody who understands the program well and is available whenever a question comes up. Jay serves our physicians on the physicians’ terms.”

Mr. Wells:

“We have a fulltime clinical IT specialist, a person with a nursing background who also has a computer background. She’s available whenever physicians and other providers have questions. It’s often difficult for the IT department to communicate at the clinical level, for example, understanding how they implement nursing forms and assessments. Our clinical IT specialist speaks their language and has earned their trust.

“We also have super users in each department. Being a super user is part of their annual performance evaluation; this helps us retain these product experts.”

Mr. Stewart:

“I try to present information in a way that’s not belittling to our physicians. I work with a lot of different personalities. Some are easygoing and open to new things. Others are more stuck in their ways. I find different ways of interacting with all of them.”

Tactic #8: Be flexible in your deployment

Dr. Westberg:

“Establish expectations, but give your providers a flexible set of criteria to meet those expectations. For example, they may have the option of placing orders through direct data entry or voice recognition software. Let them fumble their way through it and get it done in whatever way they choose.”

Ms. Engle:

“We met one on one with our providers to determine each one’s specific workflows — you can’t take a cookie-cutter approach — and then figure out how to mesh his or her practice with the system. By showing providers how the system benefits their individual practices, they’re much more willing to accept it.”
Tactic #9: Make sure everyone is on the same page

Mr. Wells:

“Get all of your providers on the same page. They need to see the same things and share the same viewpoints about what the system will do. Develop a standard format so that they all have the same information and are using the same capabilities.”

Mr. Magee:

“Don’t short-change the importance of nurses, both administrative and floor nurses. Their work and attitude affect how the physicians work and their attitudes. We would not have done what we did without our nurses.”

Tactic #10: Hold your physicians accountable

Dr. Westberg:

“Jay Stewart, our Clinical Support Specialist, doesn’t just teach physicians how to use the system. He’s monitoring how they use the system. They need to be held accountable to ensure that everyone is using the system appropriately. On a monthly basis, Jay does audits of our providers. If the audit reveals an issue, Jay works with the physician one on one to work out the bugs.”

Mr. Wells:

“Provider training needs to happen on an ongoing basis. We’re good about doing it with support staff, but not as much with physicians. This is very important, especially as the vendor upgrades its product and offers new capabilities.”
For rural hospitals, EHR technology offers numerous benefits, including improved patient safety, streamlined access to patient charts, more complete views of patient information, increased operational efficiencies, and the opportunity to receive Medicare and Medicaid EHR Incentive payments. But without the acceptance and adoption of physicians who serve the hospital, none of this can happen.

One of Dr. Westberg’s comments from above bears repeating: “You can give the speech 100 times about all the benefits of EHR. But until you get out there and starting using EHR and experiencing all the benefits at the personal level, it’s just talk.”

So, how do you get beyond the talk and into actual EHR experience? There is no blueprint for all hospitals. However, from the physicians and others who provided input for this white paper, we can identify several tactics that have proved effective in rural hospitals across the country:

1. **Involve physicians early in the process** — including the selection of an EHR solution, if possible.
2. **Start with small wins**, and celebrate those wins.
3. **Don’t make unrealistic promises** — be honest about the system’s deliverables.
4. **Establish a positive tone at the top**, set goals for the system, and make those goals part of the strategic plan.
5. **Identify and engage a “physician champion,”** someone who will lead by example.
6. **Identify and engage your most resistant physician** — this person’s acceptance will inspire others to get on board.
7. **Provide training on the physician’s terms** — when it fits into their schedule, and provide ongoing support from someone who speaks their language.
8. **Be flexible in your deployment** — enable physicians to get tasks done in the way that suits them.
9. **Make sure everyone is on the same page** as far as what everyone sees and what the system does.
10. **Hold your physicians accountable** — monitor how they’re using the system, and provide ongoing training as upgrades and new features are deployed.
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