EXECUTIVE DIALOGUE

PERFORMANCE EXCELLENCE

Using Advanced Technologies to Personalize the Patient Experience

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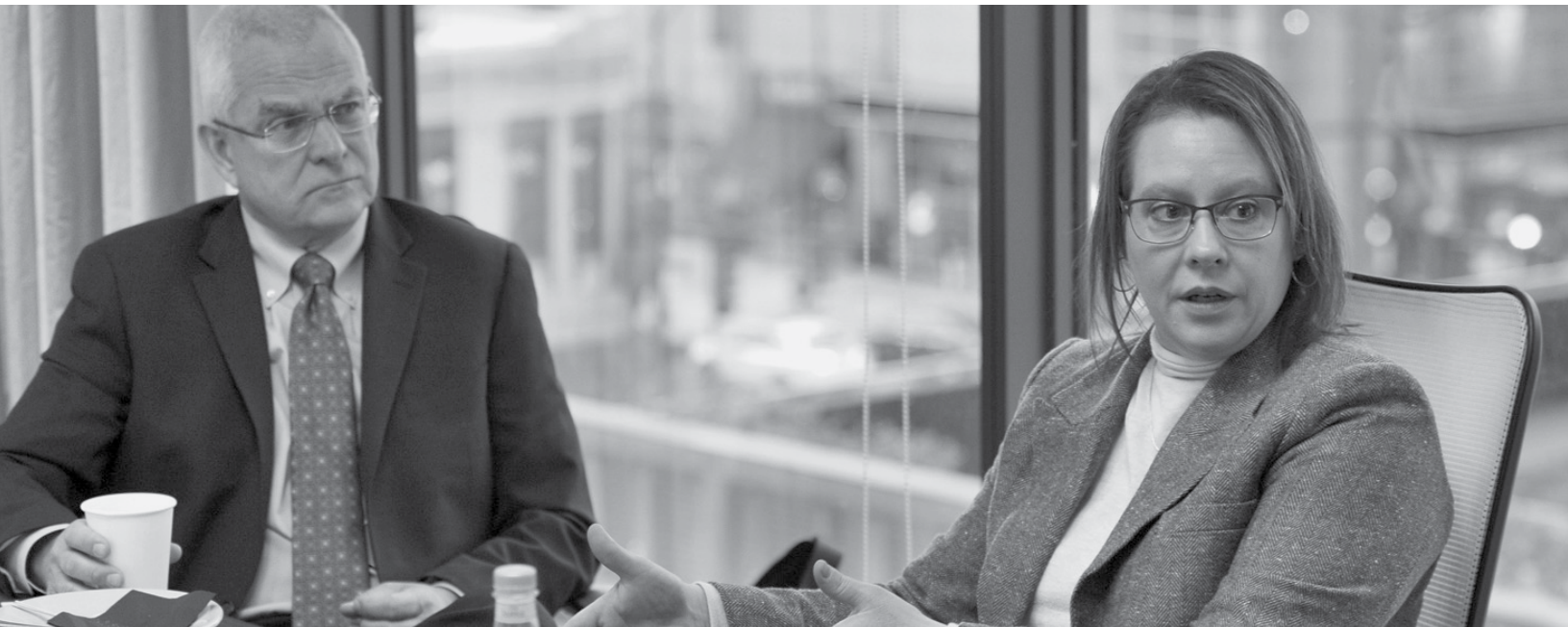
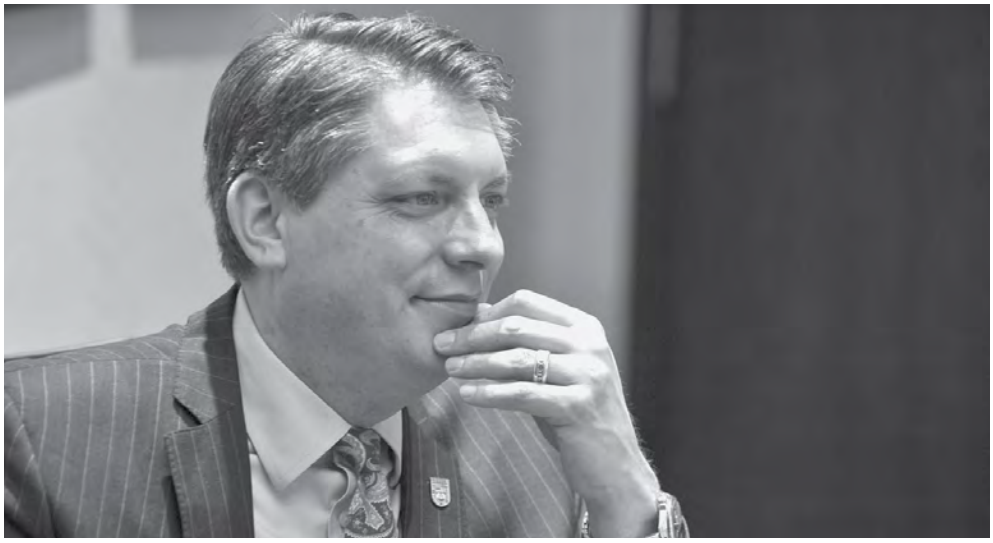


Patients increasingly are making decisions about who delivers their care and how they engage digitally in the delivery of that care. Challenged by new market entrants and other disruptors that seek to attract new health care consumers and encroach on existing patient-provider relationships, hospitals and health systems are looking to provide a digital health care experience that is ubiquitous and seamless, more affordable and integrated into patients' lives.



KEY FINDINGS

1. Hospitals and health systems are looking to artificial intelligence to address clinician burnout. AI has the potential to alleviate many of the administrative tasks that prevent clinicians from spending time on direct patient care.

2. Patient portals are being used in the inpatient setting to enhance patient engagement and satisfaction.

3. As organizations continue to encourage digital exchange between clinicians and patients, they are challenged with setting appropriate parameters around length of exchange and when to request that the patient come in for a face-to-face visit.

MODERATOR *(Suzanna Hoppszallern, American Hospital Association)*: **How are you using intelligent process automation? What feedback are you receiving from clinicians regarding its impact on their workload?**

AMY HUVELDT *(Baptist Health)*: We're a five-hospital health system in northeast Florida with over fifty primary care and specialty practices. Many physician offices that were acquired had either no electronic health record (EHR) or a variety of different systems from practice to practice. We are on a journey to a single EHR. Our clinician response has been mixed. Those who have worked with paper charts their entire career have had a more challenging transition, but there are definite benefits to shared information and ease of access. We do have a patient portal that is working well and has been received positively by patients.

On the inpatient side, our clinicians have been using EHRs for many years. Standard order sets have been created to streamline processes for physicians, and we are working on predictive analytics to help expedite diagnosis and treatment. Although technology makes some processes more efficient, on a patient-interaction level, clinicians often feel that technology can be a burden that creates a barrier to making a more personal connection with patients.

VANI PRASAD *(CareTech Solutions)*: We are helping hospitals with the front-end changes that can ease some of the clinician burden stemming from the EHR. It's true that people feel more burdened with technology. And it should be the opposite, right?

TAD GOMEZ *(Loyola University Medical Center)*: Our biggest challenge is trying to get all of our physicians to switch their scheduling processes to all patient self-scheduling. We've had some early adopters, and it's been great. It's improved our patient access. One of our biggest patient dissatisfiers is that it's hard to get into our system. Once they get into our system, they love our physicians and nurses, but we have a problem with access. We're trying to leverage our patient portal and self-scheduling to improve that.

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– Tad Gomez
Loyola University
Medical Center

MODERATOR: That's an undertaking.

GOMEZ: It is, but it's necessary. The Chicago area market is tight, so patients won't wait around a long time for appointments. This is something we need to do.

JIM PRISTER *(RML Specialty Hospital)*: All of our patients are complex; about 95% come right out of the intensive care unit (ICU). Our needs are different, because we have no outpatient services nor the physician office piece. What we do have are long patient stays. Your average length of stay is more than 35 days. If we were to print a patient record, it would be a few thousand pages long. The ability to manage patients over a long period is challenging because there are many small, incremental changes for these patients. We have to make sure that we partner with our referral sources which include academic medical centers and trauma programs.

Even though we're owned by two large systems in Chicago, if we receive a patient from another academic medical center (AMC), it is expected that we return the patient as quickly as possible.

– Jim Prister
RML Specialty Hospital

MODERATOR: What happens once patients are released? Do you use any digital health technologies with the patients as a follow-up and to avoid unnecessary readmission?

PRISTER: It is expected that patients seek follow-up with their referring providers. Even though we're owned by two large systems in Chicago, if we receive a patient from another academic medical center (AMC), it is expected that we return the patient as quickly as possible. That's part of the model that we put in place. However, it creates a challenge in terms of data and information exchange. We provide, of course, all of the information at discharge. We also have a remote Citrix dial-in for clinician follow-up. But it's really fascinating: If a patient is in post-transplant, clinicians will look more in-depth at our record. But if a patient is on a ventilator, weaning off the vent and has a long stay, the expectation is to get the patient off the vent and then look at the clinical condition of the patient at that time. Patients who come to us have long recovery processes, so the ability to get information to them and their clinicians is important.

CARYN ESTEN *(Froedtert Health)*: We have done a lot over the last several years in terms of pursuing a digital strategy. About five years ago, we created Inception Health, a joint-venture innovation company between Froedtert and the Medical College of Wisconsin. We've siphoned off investment dollars and given the venture more agility than the rest of the system would have to move things forward. Inception actually houses the operations of our e-ICU, so it has some direct operational responsibilities, but it also manages an investment strategy to look at startups and areas where we feel that there may be a good opportunity to be part of the creation of those companies. Inception Health also works to identify and select digital platforms that we can scale to improve the functionality of our patients before, during and after the healing process. It's been good in identifying digital strategies. Inevitably, when the agile organization decides we're ready to scale, they come over and see a gigantic brick wall that says, 'corporate bureaucracy, corporate IT, cybersecurity, no, no, no.' We're still working that

out. By setting it up as a separate organization, they get some additional support because the IT plate is full, and Inception has the capacity for the project.

Since its launch, we haven't been as good at failing fast, but we're failing at a faster speed than we have in the past. Sometimes we will make an investment or test something early and find out it's not scalable or it doesn't work well with our EHR. We actually have started things and stopped things, which has been historically uncharacteristic of our organization. That's really critical to our success going forward. We are starting to track digital engagement and have created a monthly scorecard, which identifies about eight key metrics that look at both digital transactions people are engaged in, and also digital engagement. Did they sign up for MyChart account? Are they interested in digital transactions? For engagement, we look at whether our patients interact with clinicians via MyChart. In 2020, we will have three digital engagement metrics built into our leadership incentive plans to start encouraging staff to move patients to MyChart or enlist them to use some of our health engagement. We are trying to make it part of everyone's responsibility. There's always resistance, but when we talk to clinicians, most of them are supportive. They are a bit more skeptical about how the digital tools will enhance their relationships with patients, though.

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– Caryn Esten
Froedtert Health

It's important that we continue to pursue digital solutions to make clinician workflow more efficient. Physicians are spending too much time during their normal workday on tasks unrelated to direct patient care. It potentially impedes their ability to deliver care in the exam room or at the bedside. I spent a week shadowing one of our oncologists and was alarmed by the amount of time she spent at home setting up her EHR records for the day after her children went to bed, just so she could see patients for five or six hours. And then they go back and do it again. This really contributes to a loss of joy in the practice of medicine.

MODERATOR: As several of you have brought up, some of the technologies hospitals and health systems have adopted have actually added more burden to clinicians. **What are some of the top things that you're doing now to relieve some of that burden?**

HUVELDT: When we talk to clinicians on both the inpatient and outpatient sides, we hear that medication reconciliation remains a huge burden. We are working hard on that. Like most of you, we're in the early stages of the artificial intelligence (AI) journey. We're making some progress and we're excited for the future.

PRISTER: What's everyone doing from a staffing efficiency standpoint? As we've adopted the EHR and more advanced technologies, we've placed greater responsibilities on our caregivers. It is a burden. I remind them of what we have gained since EHR adoption. What would it be like to go back to paper? I'm being facetious, of course. At times, though, I wonder whether clinicians are more worried about documentation than providing time for hands on patient care. Has anyone here conducted an internal review of time documentation vs. patient care?

HUVELDT: We have, as part of a review of staffing and demand analysis. We brought in nursing consultants to conduct extensive time studies. One of the things they highlighted was our medication administration process, specifically how long it takes between when a physician orders a new prescription and when it is administered to a patient. It was a lot longer than it should be, so we conducted a deep dive into why. What are we doing? What can we take off our clinicians' plates to streamline workflow? That's a big area of concern for us.

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– Amy Huveldt
Baptist Health

ESTEN: We're just starting to look at this. It's complex, of course, across our various hospitals. Our AMC is at 100% capacity, while our community hospitals' census average 50-60%. We've looked at various platforms and just launched our systemwide capacity platform. We're trying to alleviate some of the strain on the nursing units in dealing with where the patient goes, so nurses can spend more time providing care rather than negotiating who gets to go to what floor at what point in time. We're optimistic and we're moving toward a central staffing model. We're not there yet, but that's something we're exploring.

GOMEZ: We're in a similar space. Looking at our most recent acquisition, bringing another community hospital on board created some big workflow challenges. We're still working through it. We have too many nurses and physicians practicing well below their licenses, which is a problem. And the job market is of no help. It's hard to find primacy care technicians and other clinicians that support the caregiver so they can be more efficient. We're running close to 20% turnover rate and it's a metric that we track every week because we have so many vacancies.

WAYNE DESCHAMBEAU (*Wayne HealthCare*): Wayne HealthCare is located in Greenville, Ohio, northwest of Dayton. We are a medically underserved area, so we have a Federally Qualified Health Center (FQHC) that represents probably 90% of our primary care doctors, and we employ the rest.

MODERATOR: Do you have any issues with clinician burnout? Are you experiencing that in the rural setting?

DESCHAMBEAU: We had a couple older physicians who retired about five years ago and we were fortunate to have replaced them with younger physicians. About 80% of our doctors are younger than 45, so they haven't reached the point of burnout yet. But, they're working on it.

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– Wayne Deschambeau
Wayne HealthCare

MODERATOR: Shelton, are you using intelligence process automation or digital health with your patients and with your clinicians?

SHELTON MONGER (*Wayne HealthCare*): Not at this time. We have limited resources and can't afford a lot of that. We do have an EHR, but we have many disparate systems to mesh together to get a coherent record. This makes it difficult to deploy any kind of AI. We are looking at different products to make caring for patients a bit easier. For example, we're looking at a product that will help with patients who are going on insulin and need to have their blood sugar levels in check quickly. We are only able to take on small chunks.

We are trying to reduce the burden before clinicians burn out. I don't know any physician who is not irritated by having to enter so much data into the EHR to document the patient encounter. It's a challenge. We task our most expensive people with data entry, but the truth is, they're the ones who need to do it. They are the tip of the spear and anything downstream greatly relies on the accurate reporting of conditions and treatment protocols. I don't know anybody else who can do it as effectively.

MODERATOR: We've talked about the use of patient portals. Some of you are engaging your clinicians in communicating more with their patients via a portal. **Is it helping with patient-physician engagement?**

ESTEN: It's something that we measure. We've found that 98% of the messages sent by a patient through MyChart are being read and responded to by a care team member. And 97% of responses are subsequently being opened by our patients. That is relatively high engagement. Patients find MyChart to be a useful way to access information and communicate with their clinicians. One of the challenges is, of course, how to moderate the communications. For specialty care, the discussions can be lengthy. We need to find the best way to determine at what point we should encourage the patient to make an appointment. Physicians don't feel comfortable telling patients to stop emailing. And, of course, it's hard for the physicians because they can't bill for this time. If they spend 45 minutes exchanging emails back and forth with a patient, it equals a visit. But we can't create a billable encoun-

ter for that. We're trying to determine how we can help them navigate what's appropriate for that method of communication and when we should redirect people to an in-person visit. It's useful, but it also creates some of these conceptual challenges, and physicians, in particular, want to understand where the boundaries are in using that tool? We're working to expand the use of MyChart within the inpatient stay. We've talked to other system officials who've seen significant bumps in patient engagement, and patient and family experience as a result of it, because it's putting tools into the hands of the inpatient.

GOMEZ: How do you expect inpatients to engage in their own care? What do they do?

ESTEN: This communication vehicle gives patients more control when they are in the hospital. It enables communication with caregivers if questions arise after rounding, etc. It gives inpatients more control and makes their stay more manageable. We're not live with this yet, but we have pilots in place and we're very excited. The leaders of the organizations that have this in place all say the success of the implementation depends heavily on the engagement of the nursing staff. They need to understand it and they need to know how it impacts their workflows as well as the overall expectations.

GOMEZ: Who instructs the patient on how to use it? I realize that things are supposed to be intuitive, but they're not always.

ESTEN: There is some integrated education through our EHR so that patients can self-educate. We'll be working through who iwill be the primary communicator, because you don't want your bedside nurses to be spending tons of time doing tech training. Fortunately, many patients already have MyChart and are fairly comfortable with it. In our pilots, we are going to give patients an iPad as part of their check-in process and they and their family members will be able to use that during their stay. The MyChart bedside application does allow individuals to install it on their own phones. I believe that most people would probably prefer to do that.

DESCHAMBEAU: Our FQHC uses iPads and, unfortunately, the older population doesn't care much for them. They take them and go up to the counter and say, 'I'm ready now.' One of the challenges we've seen with the patient portal is that physicians and patients receive test results at the same time. It's challenging because patients will call physicians before they've had time to review the results. It is particularly difficult when the results come back with a negative prognosis and the news should be delivered in person. That's a challenge we're having.

ESTEN: We're able to stagger our results notifications, so that helps. It's dependent upon the type of tests.

DESCHAMBEAU: That's what our physicians would like. They would like to get test results now, and then 12 hours later, give patients access to them. Then physicians can be prepared.

HUVELDT: There is so much going on right now, and there's a tsunami of change coming. One thing we need to prepare for and understand is remote monitoring and what to do with all of the data that will be brought to us. Are we going to have a service desk to support physicians with all of the alerts? And to Caryn's point, how do we determine the perameters of saying two emails are enough of an exchange between physician and patient?

GOMEZ: We've had a similar experience to that of Caryn with our outpatients regarding patients' ability to send and receive messages with our primary care and specialty providers. It's use is growing and we've seen a corresponding increase in our patient experience, particularly in our physician clinics. We don't have the answer yet as to how to limit these messages. We thought that we'd receive more pushback from our physicians, but we haven't. We get some but, by and large, we've had good engagement from our physicians. And we have excellent engagement from our patients. We have a plan to expand our outpatient services and we're looking at our digital health platform and e-visits. How do we capture these patients for future inpatient services? Building satisfaction and engagement on the outpatient side is important.

HUVELDT: One thing that I forgot to mention earlier is that we developed sepsis alerts to help physicians more quickly identify patients who are in decline. That's been helpful and our mortality rates have improved.

MONGER: Do you use AI for that?

HUVELDT: Yes, we developed internal predictive tools.

... it's important that we continue to look at IT solutions that can simplify workflows and allow clinicians to spend more time with patients.

– Vani Prasad
CareTech Solutions

PRASAD: Technology can seem overwhelming for many organizations. And, it's easy to be overwhelmed with all of the IT projects that most organizations have. But it's important that we continue to look at IT solutions that can simplify workflows and allow clinicians to spend more time with patients. And the more we have connected data, the easier things will flow. All of you have talked about processes, activities and portals. As far as technology goes, AI isn't too difficult to adopt, and it has great potential, if we start by embedding AI into tasks. There is plenty of opportunity to expand, and, thanks to what's evolving in the market, we're at a point where when patients come in, we will be able to predict their satisfaction levels. We can already predict their risk scores well. A lot of mundane tasks can be done using the technology, reducing data entries or for double checking and so on. And if you do it right, then efficiencies will come. I think we all want to move toward a point at which, the automation is better trained and we are able to trust the technology better.

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