

Repeal and Replace: It's Complicated

By Barry P. Chaiken, MD, MPH

This past February, the President announced that the delivery of healthcare to America's 300 million residents embraced more complexity than he previously realized. Only a few days before at the annual HIMSS conference in Orlando, former Speaker of the House John Boehner cast doubt on the ability of the President and Congress to repeal the Affordable Care Act (ACA) due to the disruption such a repeal would bring to our healthcare delivery system.

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Unfortunately, few if any of the politicians supporting outright repeal of the ACA attended the recent HIMSS annual conference in Orlando. Had they done so, a short discussion about healthcare with any of its 45,000+ attendees could have dispelled any notion that an ACA repeal would be simple, complete, or non-disruptive.

Just a walk around the conference's exhibit hall with its more than 1,000 vendor booths provides visual evidence of the complexity of healthcare delivery. The basic dollar figures paint the picture as well: An industry that encompasses more than \$3 trillion and 18% of GDP implies, on its face, powerful financial incentives, entrenched political

interests, and enormous complexity of relationships.

The ACA evolved from tough negotiations among all healthcare stakeholders including physicians, provider organizations, life science companies, payers, and technology vendors. Such negotiations led to rules and incentives both intelligent and imperfect. In turn, the stakeholders adjusted their business models to optimize their revenue while working under the provisions of the ACA.

Since its implementation, the ACA facilitated the healthcare coverage of more than 20 million Americans who previously had none. This access to healthcare originated from provisions in the ACA that established insurance exchanges, subsidized premiums for the working poor, and expanded Medicaid coverage to those formerly ineligible. Currently, 32 states (including the District of Columbia) have granted people access to medical care through state participation in Medicaid expansion (Families USA, 2016).

Despite this greatly improved access to services, healthcare costs continue to rise at unsustainable rates. Moreover, the HITECH Act, the ACA's "sister" legislation

that was enacted to speed the adoption of healthcare information technology (IT), has not delivered the quality improvements and cost savings it was initially expected to bring about.

Healthcare IT's triple aim

With the introduction of any new technology, initial visions of impact and benefits almost always fail to materialize exactly as hoped. Instead, unforeseen obstacles, incentives, and consequences intervene to deliver a dose of reality.

The healthcare industry is extremely complex, and medicine itself represents an environment of exponentially increasing knowledge that makes both the diagnosis and treatment of illness unmeasurably complicated. Although the industry has worked to deploy healthcare IT, we are still at the beginning stages of leveraging this technology to significantly impact care.

For the healthcare industry to obtain meaningful value from its investment in healthcare IT while addressing some of the financial shortcomings of the ACA, healthcare IT leadership needs to focus on three areas: 1) clinical workflows, 2) UX/UI, and 3) analytics.

Clinical workflows

Most providers struggle with their electronic medical record (EMR) systems. These systems were developed to optimize billing through enhanced documentation capabilities rather than serving to promote workflows focused on delivering high-quality care. Currently, EMR implementations facilitate documentation targeted at satisfying billing requirements to optimize revenue, and fail to satisfy the needs of clinicians.

To obtain clinical workflows that impact care, we must better leverage the inherent power of healthcare IT. This includes workflow pathways that guide clinicians through their tasks in the most efficient manner while eliminating human activities that the technology can automatically handle. These improved workflows represent clinical best practices or pathways, delivered in a more detailed, exact, coordinated, and consistent manner. They allow all the activities inherent in a best practice for disease treatment to be distributed intelligently across a team of caregivers, eliminating duplicative or unnecessary activities while ensuring patients receive all the care they require.

UX/UI

Smartphones and the way we use them best represents the impact of UX/UI (user experience/user interface) on technology. Unlike early Windows software, today's phone apps require little instruction or training—users intuitively know how to use the software or figure out quickly through trial and error what buttons to press to obtain the utility they desire. This ease of use comes from strong UX/UI: how the user interacts with a technology and what the personal experience is for the user during the interaction.

As technology further integrates with our everyday life experiences, our expectations of how we interact with technology in turn change our expectations of its ease of use and the experience of using it.

Rather than echoing the simplicity of use inherent in most consumer IT products, our current healthcare IT software largely represents the design shortcomings of the pre-Windows era. This failure to optimize the UX/UI for clinical users decreases their ability to effectively utilize the healthcare application. Features and functions that in theory offer significant advantages for clinical care delivery fail to be deployed in effective ways. Clinicians, ever pressed for time due to increasing patient acuity, overloaded schedules, and heightened

demands for documentation set upon them by EMRs, lack the time to learn how to best use healthcare IT and streamline their workflow.

Analytics

Measuring processes and outcomes allows for the proper management of workflows to achieve desired results. Although analytics applications are attractive to provider organizations, little evidence exists that these programs have significantly impacted clinical processes and, in turn, clinical

outcomes. To achieve those results, performing analytics on existing data and producing snappy charts and graphs represents just a small step in using analytics to impact outcomes. As valuable as analytics can be, these untargeted reports can undermine efforts to change processes and workflows. Organizations need to be careful not to focus on the task of generating reports rather than on the end goal of impacting clinical care through by effectively using analytics.

Proper use of analytics requires a sharp focus on organizational goals coupled with a smart approach to the creation and distribution of reports. Every report must be tied to a specific organizational objective with the purpose of monitoring a process and offering insight into any changes that process needs. In addition, reports must be linked to specific managers in the organization that have direct responsibility or control over the process or workflow. This allows managers to focus on analytics that are directly germane to their work while protecting

them from being distracted by tangential information.

Effective analytics requires reports that are role-based and narrowly focused on the work responsibilities of the managers using those reports and tied to the clinical objectives of the organization.

Before our political leaders consider modification or replacement of the ACA, perhaps we need to better understand what care we are providing and how we provide it, so we can educate them on the changes needed. Our IT tools have untapped potential to improve quality

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and access to care while reducing costs. Whether the ACA is repealed and replaced, modified, or left unchanged, we cannot succeed in improving how we deliver care without also bettering our use of healthcare IT. After all, it's complicated. ■

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REFERENCE

Families USA (2016, February). A 50-state look at Medicaid expansion. Retrieved from <http://familiesusa.org/product/50-state-look-medicaid-expansion>