Universitas Esa Unggul

ANALISIS MANFAAT RKE

Deskripsi:

Banyak yang percaya bahwa adopsi Rekam Kesehatan Elektronik (RKE) dapat meningkatkan efisiensi dan perbaikan asuhan kesehatan. Pemerintah Pusat USA menginvestasikan dana sebesar US $27 Millyar pada HITECH. Namun sayangnya beberapa artikel penelitian akhir-akhir ini menyatakan hanya sedikit atau tidak pengembalian modal (ROI) dari RKE, dan yang lain mempertanyakan dampak RKE pada kualitas pelayanan, tidak ada bukti perbedaan antara sebelum dan sesudah implementasi RKE (Amatayakul, 2013).

Langkah kritis menunjukkan dan memastikan manfaat RKE seperti dinyatakan pendukungnya, dengan memahami manfaat RKE dan menetapkan tujuan spesifik untuk mencapainya. Chiropractic Journal (Kraus 2008) menyatakan “Anda harus [belajar bagaimana mengembalikan investasi Anda kembali (ROI)]”. Kraus mencatat bahwa dapat menghemat $2.400 per tahun di jam kerja staf *front office* untuk menempatkan dan memindahkan kertas, dan merasa itu adalah salah satu dari keuntungan finansial yang memberi dorongan yang kuat untuk melangkah maju menuju RKE.

A. Jenis Analisis Manfaat RKE

Jenis analisis manfaat RKE yang sering digunakan adalah *Quantifiable vs Anecdotal Benefits*, dan *Cost-Benefits Feasibility vs Benefit Realization Study*.

1. Quantifiable vs Anecdotal Benefits

Quantifiable vs Anecdotal Benefits (manfaat yang dapat diukur dan tidak dapat diukur). Meskipun jelas bahwa penelitian kuantitatif difokuskan dan terbatas pada domain studi tertentu, CEO dan dewan direksi-menginginkan penggunaan RKE semakin meningkat-menginginkan analisis kuantitatif untuk mendukung adopsi RKE. Mengingat definisi penelitian kuantitatif dan kualitatif, semua manfaat RKE bersifat kualitatif. Pendekatan yang lebih baik adalah mengkategorikan manfaat RKE agar dapat diukur (*Quantifiable)*.

Manfaat Terukur (*Quantifiable* Benefits). Manfaat Terukur RKE digambarkan oleh representasi numerik seperti peningkatan persentase, sejumlah pengurangan staf penuh waktu (FTE), atau penghematan biaya karena tidak perlu membeli folder RM kertas. Meskipun para CEO biasanya menginginkan sebuah analisis manfaat yang dijelaskan dalam istilah moneter, lebih banyak mulai menyadari pentingnya memiliki portofolio manfaat yang terdiri penghematan biaya dan peningkatan pendapatan serta keuntungan yang berkaitan dengan kualitas perawatan.

Manfaat Tidak Terukur (*Anecdotal Benefits*) sulit diukur dengan cara apapun, dan dideklarasikan dengan contoh spesifik kejadian yang terjadi atau dihindari saat RKE digunakan. Sebagai contoh, menggambarkan fakta bahwa seorang perawat kunci tidak dapat direkrut karena organisasi tidak memiliki RKE adalah anekdot yang bisa menjadi persuasif. Contoh lain mungkin bahwa RKE memperbaiki perawatan penderita diabetes dengan memantau secara lebih ketat terhadap kepatuhan perawatan rejimen mereka.

Perbedaan Manfaat Terukur dan Manfaat Tidak Terukur RKE dapat dilihat pada tabel 5.2 berikut ini.

Table 5.2. Quantifiable versus anecdotal evidence

Quantifiable/Tangible	Anecdotal/Intangible
Numeric representation (preferably in monetary terms)	Scenario-based case description
Requires establishment of metrics and baseline data for comparison	May reflect quantifiable data from other sources if organization is unwilling or unable to conduct its own study
Provides opportunity for course correction	Requires leadership faith in others' experiences; does not provide direct opportunity for course correction
Example: Today, organization spends Y dollars on transcription. EHR will reduce transcription by X percent, resulting in cost savings of Y – X dollars.	Example: EHR has contributed to attracting qualified nursing staff as evidenced by consistent comments in staff evaluations and applicant interviews.

2. Cost-Benefits Feasibility vs Benefit Realization Study

Cost-Benefits Feasibility vs Benefit Realization Study (Studi kelayakan manfaat biaya vs Studi Manfaat Realisasi). Isu lain sehubungan dengan bukti manfaat terukur versus anekdot adalah apakah bukti tersebut akan digunakan dalam studi analisis manfaat biaya atau studi manfaat realisasi. Secara umum, kedua bentuk studi manfaat ini ada kesamaan, yang terpenting keduanya bergantung pada visi yang jelas,

dukungan manajemen eksekutif, dan harapan yang realistis akan manfaatnya tetapi ada juga perbedaan utama, dan tingkat detailnya. Tabel 5.3 menunjukkan perbedaan kedua studi manfaat RKE.

Table 5.3. Cost–benefit feasibility study versus benefits realization study

Characteristic	Cost–Benefit Feasibility	Benefits Realization
When performed	Before decision is made to undertake EHR initiative	Before decision is made to undertake EHR initiative *and* after EHR implementation
Purpose	To determine if an EHR initiative is appropriate for the organization at this time	To determine if anticipated benefits are realized
Additional value	May highlight "broken" processes to be fixed	• May highlight "broken" processes to be fixed • May contribute to system build • Will identify areas not meeting benefits for corrective action
What is measured	• All costs associated with acquisition of hardware and software, installation, implementation, and ongoing maintenance • Expected ROI from quantifiable benefits and anecdotal evidence (See further in chapter 11.)	Quantifiable changes associated with differences in processes, such as units of work, percent of improvement, etc. (See further in this chapter.)
Level of detail	• May be estimated and not detailed OR • Based on process assessment and detailed	Based on process assessment and detailed
Critical success factors	• Clear vision of EHR • Senior management support • Realistic expectations	• Clear vision of EHR • Senior management support • Realistic expectations • Valid metrics • Process assessment skills (See further in chapter 6.)

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B. Jenis Manfaat RKE

Secara umum ada dua jenis manfaat RKE yaitu manfaat ekonomi dan manfaat klinis.

1. Manfaat Ekonomi RKE (Economic Benefits from EHR)

Sebuah organisasi mulai menetapkan tujuan dan harapannya, pertama-tama dapat berguna untuk berpikir secara luas tentang apa yang dilakukan RKE untuk orgganisasi dan kemudian menyempurnakan konsep-konsep ini ke dalam pernyataan tujuan SMART. Umumnya manfaat RKE dikategorikan sebagai manfaat ekonomi dan manfaat klinis atau kualitas perawatan. Manfaat ekonomi secara langsung dapat

menyumbangkan uang ke organisasi. Tidak semua organisasi organisasi dapat mencapai manfaat ekonomi, namun beberapa contoh yang layak termasuk yang teridenfikasi pada gambar 5.6 berikut ini..

Figure 5.6. Types of economic benefits from EHR

Cost Savings
- Elimination of paper chart supply costs
- Reduction in transcription
- Reduction in copy services
- Reduction in courier costs
- Reduction in clerical staff costs (for large organizations)
- Reduction in storage costs
- Reduction in malpractice insurance premiums or increases in premiums

Cost Avoidance
- Not having to expand the file area
- Not having to acquire warehousing space
- Avoiding staff recruitment costs because EHR improves staff retention
- Avoiding the cost of a specialty care referral
- Avoiding the cost of repeat diagnostics studies
- Avoiding the cost of readmissions
- Not having to hire more staff when patient volume increases
- Avoiding more expensive medications

Revenue Increases
- Attract more business
- Retain patients due to better follow-up, shorter wait time, greater satisfaction
- Ensure appropriate reimbursement for level of service provided
- Earn incentives
- Reduce lost charges
- Reduce bad debt

Contributions to Profit
- Reduce length of staff visits or repeat visits (in a managed care environment)
- Improve cash flow
- Enable or expand e-visits

Productivity Improvements
- Providers see more patients in a day
- Use nurse time savings to perform improved patient instruction and patient care follow-up and thereby reduce readmissions or repeat visits for complications
- Use front-office staff time savings to perform patient appointment follow-up, to verify eligibility for benefits and thereby reduce denial of coverage
- Use back-office staff time savings to negotiate improved contracts and more aggressively perform collections
- Use patients or their caregivers to perform tasks that can be automated (e.g., appointment scheduling, bill paying, retrieval of diagnostic study results)

2. Manfaat Klinis RKE (Clinical Benefits from EHR)

Manfaat klinis jelas, banyak manfaat ekonomi juga berkontribusi pada peningkatan kualitas asuhan atau apa yang dapat disesuaikan sebagai manfaat klinis. Banyak manfaat klinis dapat denggan mudah dikuantifikasi, namun lebih sulit untuk

menetapkan nilai moneter pada mereka. Faktor-faktor yang berkontribusi terhadap manfaat klinis, yaitu:

- Access to clinical information
- Patient follow-up/recalls
- Reduced errors/patient safety
- More tailored patient education
- Enhanced documentation
- Physician–patient communication/more time to spend with patients
- Clinical decision making with guidelines and protocols
- Coordination of care
- Support for quality measurement, reporting, and improvement

Table 5.4. Examples of medication errors reduced through CPOE

Intervention	Description	Means of Benefit	Potential #/Year	Effect	Savings $/Year
Ondansetron guidance	Changed default frequency for IV administration	Guided toward effective, but less expensive dose	3,000 displays per year	92% switch to new dose	$500,000 in charges
Vancomycin guidance	Prompt to guide initial use of drug and to consider stopping after 3 days	Reduce overutilization; decrease spread of vancomycin-resistant *Enterococcus*	5,000 orders per year	Under study	Under study
Nephros/ Gerios	Changes recommended dosing based on patient's renal function and age	Prevent adverse events due to failure to reduce drug dosing	106 adverse events per year	Not measured yet	$640,000 in costs*

Source: Teich et al. 1996.

*Estimated hospital cost savings based on prior analysis that shows that each adverse event costs $6,000 to the hospital. These costs are primarily due to extended length of stay and to additional testing and therapeutic measures needed because of the adverse event. This figure excludes cost and detrimental effect to the patient, as well as any liability the hospital may incur.

Figure 5.8. Care coordination concepts

Concept	Definition
Care coordination	Deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.[1]
Care management	Program that supplies systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost-effective, nonduplicative services.[2]
Utilization management	*Also called medical management*, the evaluation of the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, facilities under the provisions of the applicable health benefits plan.[3]
Case management	*Also called discharge planning*, a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a consumer's health needs through communication and available resources to promote high-quality, cost-effective outcomes. Case managers may work for health insurers, providers, and employers.[4]
Disease management	*Also called population health or integrated care*, a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.[5] Because "disease management" carried a negative connotation, alternative terms and new definitions[6] have caused the Disease Management Association of America to change its name to the Care Continuum Alliance.[7]
Health call center	An independent organization within an insurance company or hospital system providing triage and health information services to the public.[8]
Independent review	A process, typically performed after all appeal mechanisms within the health benefits plan have been exhausted, wherein a party independent of all affected parties, such as a quality improvement organization (QIO), determines whether a healthcare service is medically necessary and appropriate or experimental/investigational.[9]
Patient-centered medical home	An approach to providing comprehensive primary care where the healthcare setting facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. Care is coordinated and/or integrated across all elements of the complex healthcare system, and is facilitated by registries, health information technology, health information exchange, and other means to assure patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.[10] PCMHs may be recognized by the NCQA.[11]
Accountable care organization	As described in the Affordable Care Act of 2010, an organization of healthcare providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.[12]

[1]Agency for Healthcare Research and Quality 2007.
[2]Center for Health Care Strategies 2007.
[3]URAC 2005.
[4]Case Management Society of America n.d.
[5]URAC 2005.
[6]Peytremann-Bridevaux and Burnand 2009.
[7]Care Continuum Alliance 2011.
[8]URAC 2005.
[9]URAC 2005.
[10]Patient Centered Primary Care Collaborative n.d.
[11]NCQA 2011.
[12]Centers for Medicare and Medicaid Services 2011