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Table of Contents

CRITICAL SUCCESS FACTORS FOR IMPLEMENTING ELECTRONIC MEDICAL RECORDS SYSTEMS IN SMALL CLINICS..... 1
C. Christopher Lee, Lake Superior State University*
Lauren Suppa, Lake Superior State University
Rebecca Fitz, Lake Superior State University
C. Steven Hunt, Morehead State University

REENGINEERING HEALTH CARE DELIVERY TO FOCUS ON HEALTH OUTCOMES 3
Bernard J Healey, King’s College
Marc Marchese, King’s College

ENTITLEMENT AND ETHICS IN COLUMBIA, IRAN, AND THE USA..... 9
Jon Austin Gastrock, University of Texas at Dallas
Brandon K. Miller, University of Texas at Dallas
James “Michael” Shell, University of Texas at Dallas

SOCIAL MEDIA AND HUMAN RESOURCE STAFFING..... 13
Gerald E. Calvasina, Southern Utah University
Richard V. Calvasina, University of West Florida
Eugene J. Calvasina, Southern University

HOW INCORPORATING A SUSTAINABLE BUSINESS MODEL CREATES VALUE..... 15
Sharon Seay, University of West Georgia

CRITICAL SUCCESS FACTORS FOR IMPLEMENTING ELECTRONIC MEDICAL RECORDS SYSTEMS IN SMALL CLINICS

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ABSTRACT

The purpose of this research is to conduct an empirical study on how Electronic Medical Records (EMRs) will impact healthcare in respect to efficiency, workflow, healthcare costs, and quality of patient care on overall success of small clinics. Much research has been done on EMR innovation, but very few studies have investigated the impact of EMR systems on small clinics. This paper fills the gap in the EMR system literature. Surveys of small clinics were conducted across the Eastern Upper Peninsula of Michigan. A multivariate statistical analysis was performed. Results show statistical significances in relation to respondent demographics, efficiency, workflow, healthcare costs, and quality of patient care factors in relation to implementation of an EMR system.

Keywords: Efficiency, Workflow, Healthcare Costs, Quality of Patient Care

REENGINEERING HEALTH CARE DELIVERY TO FOCUS ON HEALTH OUTCOMES

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ABSTRACT

The greatest economic threat to ever face our country is found in our health care delivery system. This country is currently devoting 2.7 trillion dollars to health care representing over 17 percent of Gross Domestic Product (GDP) and that cost is rising at a rate of 6 percent each year. If this cost escalation continues the annual cost of health care in the United States will represent 30 percent of GDP by the year 2030. Unfortunately, our current President and Congress are working on ways to pay for the problem while ignoring any attempt to solve the problem.

Health care services delivery in our country is in need of major change that is designed to improve the health of the population while also reducing the costs of providing these services to all Americans. In order to achieve these outcomes our system of health services delivery needs to be reengineered in order to solve the major problems found in our current system of care. The real secret of success in this process of change involves defining the real challenges facing health care today. These challenges include:

- The recognition of the ramifications of the epidemic of chronic diseases and developing a proactive solution to this problem.
- Restructuring the way that we pay physicians from a system where they are reimbursed on activities rather than positive health outcomes for the patients.
- The health care system has to get very serious about eliminating the epidemic of medical errors and infections that continue to occur in our medical care facilities.

There are many processes in health care delivery that can and should be redesigned in order to improve the quality, safety, convenience and ultimately reduce the costs associated with delivering health care services to consumers. Many of the current processes in the delivery of health care services do not add value to the patient and, therefore, need to be changed. The starting point for this reengineering effort involves redesigning how we deliver health care in order to produce higher quality of care at a lower cost. This paper will attempt to provide solutions to these health care problems through the application of reengineering processes to the delivery of health care services in our country.

INTRODUCTION

The spending on health care has become one of the greatest challenges to ever face our nation and it is definitely a growing problem that needs to be dealt with now. This one category of spending has grown from an insignificant cost issue 50 years ago to almost 18 percent of our

Gross National Product (GDP) on an annual basis. In 1960 this spending represented a total cost of \$26.9 billion dollars representing a per capita cost of \$141. Today this cost has risen to 2.7 trillion dollars and \$8,160 per capita expenditures.

Most economists agree that health care spending has become the greatest economic threat to ever face our country is found in our health care delivery system. This country is currently devoting 2.7 trillion dollars to health care representing over 17 percent of Gross Domestic Product (GDP) and that cost is rising at a rate of 6 percent each year. If this cost escalation continues the annual cost of health care in the United States will represent 30 percent of GDP by the year 2030. Unfortunately, our current President and Congress are working on ways to pay for the problem while ignoring any attempt to solve the problem.

This problem has become so serious that many health policy experts fear that escalating health care costs can threaten our future economic survival. The unfortunate fact is that the vast majority of Americans are not even aware of the very serious nature of this challenge. Americans and their representatives fail to understand the long term consequences of a health care system in desperate need of immediate repair before the system of health care delivery in our country is destroyed by its own size.

Health care services delivery in our country is in need of major change that is designed to improve the health of the population while also reducing the costs of providing these services to all Americans. In order to achieve these outcomes our system of health services delivery needs to be reengineered in a way that improves the health of the population while reducing the costs of health care delivery to those who really require the services.

Arnold (2012) argues that leaders make during the decision making process is assuming that the problem under consideration has been defined correctly. I believe that this is what happened to politicians during the spirited debate a few years ago when passing the Accountable Care Act. They never did correctly define the real issue in the health care crisis. Unfortunately, our politicians believe that the problem in health services delivery is a funding issue that can be solved by legislation. The problem is much larger than funding and will require a complete change in how health care services are delivered to Americans. This reengineering of health care services is going to require a much better definition of the challenges that face our health care system.

The real secret of success in this process of change involves defining the real challenges facing health care today. These challenges include:

- The recognition of the ramifications of the epidemic of chronic diseases and developing a proactive solution to this problem.
- Restructuring the way that we pay physicians from a system where they are reimbursed on activities rather than positive health outcomes for the patients.
- The health care system has to get very serious about eliminating the epidemic of medical errors and infections that continue to occur in our medical care facilities.

Although the future of cost effective health care delivery is uncertain there are tremendous opportunities being presented on a daily basis for the reduction of costs and the improvement of the quality of the health care experience. These opportunities are being found in both the private and public sector as everyone is finally realizing that health care delivery has become the greatest problem facing all Americans.

According to Champy & Greenspun (2010) the delivery of health care services in our

country costs too much and achieves too little because it is inefficient in its work process. This process of delivering vital services needs to be changed or reengineered in order to focus on better health outcomes for those who consume the services, the patients. The major problems that include: chronic diseases, reimbursement of providers and the epidemic of medical errors all require major change in the organization and focus of our current health care delivery system. These changes will require time and major changes in the way resources are currently used in health care but it can be done.

THE CHRONIC DISEASE EPIDEMIC

The country is now faced with a new epidemic that involves chronic diseases that do not lend themselves to cure or counseling and testing. These diseases are different in their etiology, incubation period, prevalence and burden to society. The chronic diseases have become epidemic in the U.S. and show no signs of leveling off in the near future. These are extremely expensive diseases in terms of morbidity, mortality and costs of care. They must be dealt with through educational programs designed to prevent the development of poor health behaviors like tobacco use, poor diet, physical inactivity and alcohol abuse.

This new epidemic of chronic diseases and their complications is the real cause of over seventy percent of our annual health care expenditures. In order to deal with these very expensive chronic diseases resources have to be shifted from curing diseases to preventing diseases. This change will require health providers to spend a great deal of their valuable time on educating their patients how to prevent the development of these diseases in the first place. This educational process will have to be supplemented by schools, workplaces and government.

THE EPIDEMIC OF MEDICAL ERRORS

The Institute of Medicine (IOM) (1999) released a study revealing that as many as 98,000 of the 33 million individuals hospitalized each year die and many more receive secondary infections because of poor quality health care while hospitalized. According to Black and Miller (2008) the percentage of hospital admissions experiencing injury or death is 2.9 percent on the low side and 3.7 percent on the high side. Medical errors and hospital acquired infections have become epidemic in this country and the problem seems to be getting worse. It is frightening to think that many medical errors are actually reimbursed for by the patient's insurance company.

The IOM (1999) defines medical errors as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." These medical errors typically occur in operating rooms, emergency departments and intensive care units. There is mounting evidence that entering the medical care system at any location increases the risk of adverse drug events, errors in care delivery and hospital acquired infections. These errors are increasing the cost of health care delivery, requiring longer hospital stays, and causing disability, death and the loss of trust in medical care. In fact, medical errors are now estimated to be the eighth leading cause of death in the United States.

The major causes of medical errors are miscommunication among health care professionals. This represents one of the greatest challenges faced by health care managers. How can the manager get all of the providers of health care services for the patient connected in order to achieve the best outcome for each individual patient? This team communication is the ultimate management responsibility found in the delivery of cost effective, efficient quality care.

The solution to this problem will require the development of a culture of safety in health service delivery. There is currently no real incentive to improve safety and the quality of care. This must change through the adoption of a zero tolerance policy by all providers of health care services in this country.

HOW TO REIMBURSE HEALTH CARE PROVIDERS

It is critical that our system of reimbursement for health care services offers real incentives for excellent health outcomes. There are many ways to pay health care providers especially the physician who has the ultimate responsibility for the health of his or her patient. Physicians are currently paid on a fee for service basis under which the doctor is paid for each procedure or service that is provided to a patient. This payment mechanism encourages the physician to offer many services which may not be cost effective and can even be very dangerous for the patient.

The current system of reimbursement along with the practice of defensive medicine to avoid lawsuits has become the real driver of cost escalation and a contributor to many medical errors. Our current health insurance system has the unique ability to refuse care to many needy patients while offering too much care to those without need.

Halvorson (2009) argues that this fee for service system represents a very large number of independent, unlinked, unconnected, economically self-focused providers needs to be changed. Their incentives have to change from producing a large number of questionable activities to a focus on improved health outcomes for every patient.

There have been a few well documented approaches by large health care organizations to move away from this traditional fee for service compensation system. One of these examples is described in detail in a relatively recent article entitled “Redesigning physician compensation and improving ED performance” by Finkelstein, Lifton and Capone (2011). A brief synopsis of this article is provided here. This article focuses on the Hospital of Central Connecticut (HCC). HCC originally compensated physicians in the emergency department (ED) comparably to other hospitals. Physicians would receive a base salary and incentive compensation based on productivity (fee for services model). Base salaries were a function of tenure and subjective performance ratings by superiors. Changes in leadership at HCC lead to a change in compensation goals for the ED. The compensation system now had three goals: improve quality of health services, productivity, and patient satisfaction. To help build ownership and commitment to these goals, ED staff physicians were involved in establishing these goals.

The first step to implement these goals was to equalize base salary for all ED physicians. HCC came to the conclusion that seniority does not directly relate to quality, productivity or patient satisfaction. Seniority is rewarded through HCC’s retirement plan and thus not completely discounted. The new compensation model was broken down into two areas: productivity (75%) and patient satisfaction (25%). The productivity component was determined by “revenue generated in relative value units above baseline volume” (p. 116). In addition, the productivity component required physicians to meet or exceed predetermined quality standards. HCC developed ten quality indicators for the ED department. Some of these quality standards originated from external agencies (e.g., The National Quality Forum), whereas others were developed in-house. A couple examples of these quality indicators were: “heart attack patients given aspirin at arrival 95% of the time” and “blood culture performed on pneumonia patients prior to administering antibiotics 90% of the time.” ED physicians were required to meet eight of

the ten quality standards to be eligible for a pay increase. Failure to meet eight of the ten quality standards two consecutive quarters was grounds for termination. To receive incentive compensation based upon patient satisfaction, HCC required the entire ED physician group to be at or above the 70th percentile for the quarter.

As a result of this new compensation system numerous positive outcomes were reported. Patient satisfaction with the ED was at an all-time high. Wait times for patients in ED decreased significantly. ED physician satisfaction and productivity increased, whereas turnover in the ED decreased. Lastly, physicians outside ED were more satisfied with the ED. Overall; this innovative compensation approach appeared to benefit all relevant parties: the hospital, the ED physicians, other physicians and the ED patients.

Another recent example of an innovative compensation approach comes from the Geisinger Health System of Pennsylvania (Lee, Bothe, & Steele, 2012). According to this article, this revised compensation approach pertains to approximately 900 of their staff physicians. This compensation system had 20% of these physicians' pay as variable and 80% as fixed. The physicians were eligible for incentive pay twice a year.

The base salary for these physicians was comparable to the base salary described for HCC. Geisinger assessed the work relative value units for each physician. A physician's base salary was increased (or decreased) if the work relative value units were consistently above or below expectations. Geisinger's goal for physicians was that their fee-for-service productivity meets or exceeds the 60th percentile for the physician's specialty area.

The movement away from a strict fee-for-service pay system was present in the variable pay component of their compensation. The goal of increasing quality and efficiency was reflected in the incentive system which impacted 20% of the physician's pay. The incentives varied based upon whether the physician was a specialist or in primary care. For specialty physicians, quality metrics comprised 40% of the variable pay measurement. The other 60% of the incentive was based on factors such as: innovation, growth, legacy and financial metrics. An example of a quality incentive for endocrinologist was to "reduce hemoglobin A1c levels to less than 7% for 29% of diabetes patients" by a specified date. An example of a quality goal for ED physicians was "to reduce the proportion of patients who leave without being seen to less than 1.5%." An example of an innovation goal was "to develop an inpatient wound service." An example of a legacy goal was "to complete 100% of resident evaluations within 30 days." Lastly, an example of a growth goal was "to develop Spanish podcasts for a women's health website." For primary care physicians the incentive pay was based on quality metrics, citizenship (defined as collaboration and teamwork with colleagues) and financial performance. An example of a quality goal for primary care physicians was "to increase the proportion of patients who use the patient portal to Geisinger's electronic health records."

According to this article, Geisinger's new compensation system led to numerous positive outcomes. For example in specialty areas like cardiac surgery, Geisinger has seen a substantial reduction in complications and readmissions. In terms of diabetes, Geisinger has seen a significant reduction for myocardial infarction, retinopathy and amputations. Overall Geisinger has attributed a 10% increase in its clinical services revenue to this new pay system. Finally, the turnover rate of physicians has also decreased since this program has been implemented.

In conclusion, these two articles represent promising developments in reimbursing health care providers away from a basic fee-for-services model. In both of these organizations clear goals were established (with input from physicians) that can be easily measured and evaluated. These goals include both traditional financial metrics and quality indices. As these compensation

approaches become more commonplace the emphasis on quality and efficiency will increase, whereas rewarding unnecessary medical exams and the use of defensive medicine will decrease. This is a critical step to reengineering health care.

DISCUSSION

These three areas offer a great opportunity for our country to improve the health of our population while improving the quality of health services and substantially reducing the costs associated with the delivery of these services. All three areas of concern offer tremendous challenges, require time for solution but the potential results will be well worth the time and resources required to meet these challenges.

The entire health care industry must become engaged in a massive reengineering effort that is designed to reduce costs while at the same time attempting to improve the quality of the services delivered. This unbelievable task is going to demand the best from everyone working in health care service delivery. This effort will not succeed with the same old strategies and ways of doing business that have failed in the past. There is a need for creativity and innovation to be unleashed by those who work in this industry. This effort will also require a new type of health care manager who is dedicated to changing the way health care is delivered in our country.

There needs to be incentives available to develop national health promotion programs designed to stop the escalation of chronic diseases and their complications. This would include strong efforts to reduce obesity, poor dietary habits, increase physical activity among children and adults and continued reduction in the use of tobacco products.

Reimbursement by all health insurance providers including the government must change the way that they pay providers of health services from a fee for service mechanism to a financial system that reimburses for positive health outcomes. As a nation we cannot continue to reward providers for wasting a large portion of scarce health resources providing tests and medical procedures of very low if any value. When physicians agree to accept an individual as a patient their goal must be to keep them healthy throughout their life not wait for them to become ill and then subject them to sometimes dangerous medical procedures.

Finally, our health care system has to get very serious about allowing medical errors and infections to occur while they are under the physicians care or hospitalized. Medical errors and hospital acquired infections can be reduced and ultimately, eliminated if health professionals start working as a team refusing to allow these dangerous and deadly mistakes to occur.

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ENTITLEMENT AND ETHICS IN COLUMBIA, IRAN, AND THE USA

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ABSTRACT

In the current paper we examine the constructs of entitlement and ethics within Columbia, Iran, and the USA. We find differences in terms of whether assessments are done in rural or urban areas – with larger variations within the countries than between the countries. We do however find that as one’s sense of entitlement increases that the behaviors which would generally be deemed unethical tend to increase. There are also large differences in the responses to unethical behaviors in Iran as opposed to the USA and Columbia. Data from the World Bank is also used in order to examine the environmental impact of ethical differences. Suggestions for future research are provided.

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SOCIAL MEDIA AND HUMAN RESOURCE STAFFING

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ABSTRACT

The use of social media by employers to find and select the right individuals to employ has increased dramatically in recent years. Bullhorn, an international recruitment software company, reported that 98% of respondents to its survey of recruiting agency professionals used social media for recruiting in 2012 (Bullhorn, 2013). With increased use of social media, employers are also discovering additional legal risk. The purpose of this paper is to examine how employers are utilizing social media to find and select the right individuals, the potential legal risk associated with the use of social media and human resource staffing, and the steps employers can take to reduce their exposure to litigation.

HOW INCORPORATING A SUSTAINABLE BUSINESS MODEL CREATES VALUE

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ABSTRACT

Sustainable business and sustainability reporting allow companies to capture the influence they have on their stakeholders and on their physical, social, and economic environments---and vice versa. Strong investors understand that the fate of the companies they own is tied to the nature of the relationships these companies have with other stakeholders. As the business case for sustainability practices becomes increasingly clear, reporting offers real value to those whose business is to assess the current financial health of companies and anticipate future performance. Much of the sustainability reporting data captured in nonfinancial terms or as qualitative policy descriptions can be readily translated into financial terms. Clearly, sustainability initiatives will have little or no credibility with shareholders, the Board of Directors, or members of the senior management team whose bonuses are dependent on performance if the link between sustainable business and performance is not demonstrated. Therefore, it is imperative for the firm to develop a framework for assessing how sustainability initiatives directly or indirectly impact performance. This study provides input toward such a framework and demonstrates how the integration of sustainability into business processes and products creates value for all of a company's stakeholders.

