Cloud computing
Automated check-in
HIE: Patient portals
ACO launches
Fighting infection with RTLS

THOUGHT LEADERS
Naomi Levinthal
MA, MS, CPHIMS, Senior Consultant,
The Advisory Board Company
The case for a shorter Meaningful Use reporting period.
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Creating a new normal

By Jason Free | Features Editor

I

vividly remember the first interview I conducted for Health Management
Technology. It was with Rick Drass, Manager of Information Systems
at Sarasota Memorial Health Care System in Sarasota, FL. I wanted to
learn how he and his staff protected their hospital’s IT infrastructure in
the event of a disaster such as a hurricane. It was a strong interview, but today
I realize that some of Drass’ most important comments never made it to print.

“Technology does no good in healthcare if it does not create a sense of
normalcy for patients. Our job is to pick the best technologies that can help
us to create normalcy quickly and effectively,” Drass said.

Technology is a necessity for our hospitals so that tasks large and small,
such as providing power, communications, patient monitoring and informa-
tion collection, can be performed. I get it. Without these functions working
properly, our 21st century care would be nowhere near as productive, let alone
comfortable or convenient. Simple enough. Actually, I now know my initial
understanding of Drass’ words was far too simple.

Over the past Fourth of July weekend, my mother-in-law was in a serious
car accident where she suffered a broken femur and a fractured pelvis. She has
endured months of complicated surgeries and grueling rehab sessions since
the crash. Throughout her treatment, technology has been a dominate factor
in her moment-to-moment living; a tremendous change from her normal life
before the accident.

At first, all the hospital technology was jarring to her. The noises and lights
scared her, and they were a constant distraction. She was always worried that
“the battery will die.” (There is no battery, Mom. It’s plugged into the wall.) After
a bit of time, however, she became accustomed to most of the equipment. It
was no longer frightening, but some pieces were a nuisance. She felt they “give
the wrong information.” (No, Mom. It’s just telling you things you don’t want to
hear.) Or they forced her to stay in bed. (It’s not the machines keeping you in
bed, Mom. You have a broken pelvis.)

Today, the technology has become normal; her new normal. It’s no longer
difficult for her to operate. (No, Jason. You are pushing the wrong buttons. Give
it to me.) It’s something she now actually enjoys. (I can’t wait for tomorrow. I’m
getting a new gadget!)

Some of the changes in my mother-in-law’s attitudes toward technology are
due to the sheer repetition of its use during her care. However, after witnessing
first-hand her treatment, I am now much more aware of the conscious
“patient-friendly” design elements that were created within some of her equip-
ment and how they helped to facilitate her new and positive perceptions of
her care – which, in turn, improve her rate of recovery.

While I am certain that very, very few of you are as myopic as I was when I
first spoke with Rick Drass, I do want to encourage you all to reconsider how
you define the role of technology in healthcare. Don’t just think about it once
before the accident.

● Viewpoint
Running a large organization?

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“We’re a 600+ bed hospital system and have been running Paragon for a year now. Our experience has been very, very positive. It’s built to handle larger organizations. Some of the other vendors purport it is only for smaller hospitals, but we really have not found that to be the case.”

Steve Stanic
CIO
Mississippi Baptist Health Systems
Jackson, MS

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Smartphones, scanners and how the converged device market is changing health IT

By Jeff Fountaine, Global Healthcare Director, Honeywell Scanning & Mobility

Nurses and medical caregivers historically have been saddled with an array of proprietary communication and IT devices to learn, in addition to managing their medical duties, including pagers, VOIP phones, barcode scanners, voice pendants and other hardware. But the trend today is rapidly moving away from proprietary technology and migrating to a smartphone-based new converged-device approach that can lighten the load for the nursing staff, both literally and figuratively.

What are converged devices? In essence, they are smartphones with added durability and other key features important for enhanced clinical workflows. These new mobile devices, which include a hospital-grade barcode scanner, provide extended battery life — lasting an entire shift on a single charge. They also have to be rugged enough to withstand drops to concrete and tile without shattering the display and be able to handle regular cleaning with caustic, hospital-grade disinfectant cleansers.

There are two approaches to deploying truly converged mobile computing solutions in a hospital today, and the choice depends largely on software, your hardware upgrade/refresh strategy, security requirements, remote management requirements and your choice of mobile device management solution.

For organizations that have deployed or are planning to deploy iPhones to their clinicians, there are protective sleds available that can provide ruggedization, enhanced barcode scanning, improved battery life and other capabilities. Many of the leading electronic medical record (EMR) software vendors have their mobile nursing applications already deployed for the iPhone. While cellular is an option, it is likely most hospitals will deploy Wi-Fi-based iPhones and use apps for VOIP phone calls and secure texting to save cost.

While some hospitals are considering deploying Android phones for their clinical staff, using Android for mobile applications is being hindered by a lack of compatible EMR software. In addition, the options for adding barcode and disinfectant protection to consumer Android smartphones are limited.

Operationally, the converged mobile devices must be able to run a variety of healthcare applications and support multiple messaging platforms so that healthcare organizations can glean the full benefits of mobility. Optimally, users of a converged mobile device in a hospital setting should be able to:

- Receive a phone call from a doctor/clinician;
- Send a secure text message to another clinician;
- Scan a barcode on a patient wristband, blood bag, medication or medical chart;
- Enter patient data directly into the EMR system;
- Look up a drug using a pharmaceutical application such as Epocrates;
- Receive and respond to alarms and alerts from medical equipment and patient rooms; and
- Talk directly to a patient who has pressed the nurse call button.

Combining the functions of the multiple devices that nurses carry now onto one converged smartphone device empowers clinicians to make more informed care decisions when they are on the move or at the patient bedside. In this way, hospitals can improve patient care in the most cost-effective way possible.

Sue Schade named CHIME-HIMSS 2014 CIO of the Year

Sue Schade, FCHIME, FHIMSS, has been selected as the recipient of the 2014 John E. Gall Jr. CIO of the Year Award. Schade is Chief Information Officer at University of Michigan Hospitals and Health Centers in Ann Arbor, one of the largest and most recognized academic health systems in the country.

Sponsored by the College of Healthcare Information Management Executives (CHIME) and the Healthcare Information and Management Systems Society (HIMSS), the award recognizes healthcare IT executives who have made significant contributions to their organization and demonstrated innovative leadership through effective use of technology. The boards of directors for both organizations annually select the recipient of the award, which is named in honor of the late John E. Gall Jr., who pioneered implementation of the first fully integrated medical information system in the world at California’s El Camino Hospital in the 1960s.

Schade’s career in the healthcare IT industry spans 30 years, with 15 spent as a CIO. She joined University of Michigan Health System in November 2012 to oversee the launch of its new EHR system. Prior to joining U-M Health System, Schade spent 12 years as CIO at Brigham and Women’s Hospital, a founding member of Partners HealthCare and a teaching affiliate of Harvard Medical School. Under her leadership, Brigham received national recognition for its Balanced Scorecard initiative — a widely adopted best practice by provider organizations around the country. Schade previously served leadership roles with organizations including Advocate Healthcare in Chicago and Ernst and Young.

Schade will receive the award on April 14, 2015, at the 2015 HIMSS Annual Conference & Exhibition in Chicago.
**Security**

Data breach industry forecast

Forty-two percent of all major data breaches reported in 2014 involved the healthcare industry. To help business executives prevent and manage all that potential data chaos, Experian Data Breach Resolution has released its second annual “Data Breach Industry Forecast,” a white paper outlining key issues and trends to watch in 2015.

Evolving factors such as new threats, regulatory changes and technological advances make the data-breach landscape hard to navigate. Experian predicts these six trends will dominate the security scene this year:

1. The rise and fall of payment breaches;
2. More hackers will target cloud data, so passwords must be safeguarded;
3. Healthcare breaches will persist – and grow;
4. Accountability will shift, putting business leaders under increased scrutiny;
5. Employee mistakes will be the biggest company threats; and
6. The rise in third-party breaches via the Internet of Things.


**Finance**

Accounts payable is No.1 target

According to a new survey report issued by Canon Business Process Services, a majority of senior finance executives say that their top priority for improvement in 2015 is the accounts payable (AP) function. In the study, executives revealed that AP represents their organization’s most time- and labor-intensive finance function, as well as the most manual and paper-intensive process.

The report, “Finance Executive Survey: Priorities, Challenges and Technologies for the Year Ahead,” was designed to help clarify the greatest pressures and highest concerns of CFOs, controllers and other senior finance executives. In one key finding, executives specified that errors are the AP department’s biggest challenge, closely followed by two other major concerns: lack of visibility into invoices and payables, and difficulty handling, managing and finding invoices.

To help solve these challenges, many organizations are planning to increase their investments in accounts payable automation in 2015. Canon advises organizations to:

1. Strategically consider in-house and outsourced support. Finance executives and AP practitioners generally are much more concerned with issues such as accuracy, compliance and supplier relationships than about optical character recognition software, data extraction, workflow and automation. Delegate the latter.
2. Centralize invoice receipt. Implementing a process in which suppliers send invoices directly to the AP department adds a layer of control to the entire AP process – and also provides the ability to save significant time and money.
3. Leverage AP automation to capture and extract data, route invoices for approval, match invoice data and resolve discrepancies. Advancements in workflow automation continuously improve the AP process.

When the concept of “accountable care organizations” (ACOs) emerged as an extension of President Obama’s healthcare reform initiative and at the core of the Affordable Care Act, industry observers offered mixed reviews. On the one hand, some hailed the development as the logical next-generation improvement to “integrated delivery networks” (IDNs) that emerged during President Clinton’s healthcare reform initiative in the 1990s. On the other hand, some also snipped that ACOs were nothing more than a new acronym painted over the old one, with some additional regulatory nuances and rules and maybe a re-emphasis on clinical performance and patient satisfaction to justify the update.

Either way, the numbers of ACOs in operation are comparable to the numbers of IDNs before them — excluding those organizations with more creative and looser definitions of IDN. There may be between 5,800 to more than 6,000 hospitals in operation, depending on the data source, but the number of self-defining and professing ACOs and IDNs is nowhere near growing beyond the three-digit range.

If ACOs are as important, if not more important, to healthcare reform, population health and patient satisfaction measures as IDNs were supposed to be, then why aren’t there more of them and why aren’t they dominating the healthcare management landscape in the ongoing quest for effectiveness and efficiency?

Further, what are some of the noteworthy lessons healthcare organizations can learn from those “first-mover” ACOs and those pursuing other opportunities?

Health Management Technology pressed several industry experts for their observations and impressions.
fully invest in programs focused on patient outcomes and patient experience, ranging from implementing care management programs to creating provider transparency around quality to using analytics to uncover cost and quality variations in provider practice patterns. By embracing the ACO concepts, we have seen organizations wring many millions of dollars of waste out of their cost of care, resulting in substantial shared savings for the organization combined with improved quality for their patients.

David Bennett, Vice President of Healthier Populations, Orion Health

Bennett: The transition to accountable care by healthcare organizations has gained traction despite variable results. The biggest gain for these organizations and the populations they serve is the improvement in quality. All participating ACOs have reported improvement on quality measures submitted to the Centers for Medicare and Medicaid Services (CMS) and performed better than their fee-for-service counterparts. The operational focus on structures and processes in support of healthcare quality has produced meaningful results.

Financial gains for the ACOs have been mixed, with only 25 percent savings enough money to share in savings. The root causes of the ACOs’ lack of financial gain have only been speculated to date. Program participants are in varying stages of ACO development, and it could be that many do not have the necessary knowledge or infrastructure to ensure financial success. Those who have had financial success attribute their gains to positioning themselves as the market leader, successfully engaging physicians and ancillary partners, as well as utilizing and enhancing care coordination services.

Greg White, Senior Vice President, General Manager, TouchWorks Business Unit, Allscripts

White: Simply put, improving clinical results has helped improve financial outcomes. One of our Allscripts TouchWorks electronic health record (EHR) clients in an ACO was able, for patients dually enrolled in Medicaid and Medicare, to reduce the average costs by 19 percent or $2,635 per patient in the first year of its ACO contract. The total amount of savings for dual eligible patients was more than $1.2 million. For the diabetic patients who gain control of their blood sugar levels, there are also financial benefits in addition to wellness benefits. Some industry studies show that lower HbA1c levels equate to an annual savings of up to $4,000 per point, per patient. As the industry as a whole moves to value-based payments and continued focus on population health, discrete clinical quality metrics place practices in better positions to receive maximum reimbursements from CMS.

Mellin: We are still in the early phases of ACOs, and there are many aspects of the ACO model that are still undergoing experimentation and refinement. Most would argue that ACOs are not close to their inflated hype and unrealized potential, yet provider organizations continue to make substantial investments and fundamental structural changes in areas such as new leadership, new roles focused on accountable care and new investment in care management, quality and cost-of-care tools instead of brick and mortar. Forward-thinking healthcare leaders know the future of American healthcare is based on providing value to the patient, and whether or not the ACO is the exact right financial and incentive model, the foundational investments they are making now will be required to be successful in any value-based model, not simply to live up to the hype of ACOs in the short term.

Bennett: There are both positive and negative outcomes of ACO development in healthcare. The positive gains include the ability to consistently meet quality objectives for patient care. In addition, the national focus on innovative ways to deliver quality care that is patient centered at lower costs has yielded multiple new models of care delivery that can be leveraged across settings. The attention to the processes of healthcare delivery within the ACO environment has also produced a more collaborative culture where members of the healthcare team have a voice in caring for “their” patients. Unlike partners such as insurers and providers are now working together to promote the triple aim. The paradigm shift from volume to value created by the ACO movement has springboarded IT to the forefront of healthcare needs. The successful ACOs have invested in IT infrastructure, including the promotion of EHRs across settings and integrations to a single platform where patient information can be shared in real time. The benefits of these investments and the enhanced collaboration will take some time to realize to the fullest extent possible, but the interim results appear promising.

White: We’ve seen, first-hand, how our ACO clients have experienced great success over the past year. One Allscripts TouchWorks EHR client has been able to use reporting capabilities to provide comprehensive preventative care for patients and in one year reduced the number of emergency room visits and hospital readmissions by 10 to 15 percent. Improving clinical results has also helped this particular practice reduce unnecessary costs and remain competitive in a rapidly changing regulatory environment. Particularly, from our vantage point, we’ve seen how physicians have leveraged the collective value in capturing the clinical data. Further, we’ve seen very promising results around preventative care and screening. Better preventative care and population health management improves other clinical results.
Population health progress report

By Rick Dana Barlow, Editor-at-large

Through personalized, patient-centered, consumer-directed healthcare, people have been encouraged to take charge and more control over the care they receive. Motivations include more convenient and hopefully easier access to caregivers and data, as well as encouraged or recommended behavioral modifications and personal responsibility for lifestyle choices.

As healthcare organizations, administrators and clinicians offer to share ownership and accountability in the care delivery process with the customers being served, how much of a difference is that making with population health through data and process transparency?

To examine the progress of population health to determine whether healthcare organizations remain on track to produce the prospective outcomes they perceived they could deliver, Health Management Technology asked a group of industry experts to evaluate efforts and achievements to date.

Bennett: The original goals of improving quality of care and patient experience as well as decreasing costs have been met with multiple and varied results. There have been substantial gains in some areas in quality of care and some successes in decreasing costs, but these are not universal. A major gain for this movement has been the awareness of the “triple aim” and collaboration of healthcare professionals in all sectors. We are now seeing competitors on the payer and clinical spectrums working together to combine and structure all the health information available statewide and/or across multiple states to make that information available to the care providers (e.g., Cal INDEX, California Integrated Data Exchange was formed by Blue Shield, CA, and Anthem BCBS, two major payer organizations). The paradigm shift in healthcare will not happen overnight and will require multiple transformations to ensure the ability to care for entire populations.

All of the organizations we work with to improve their IT infrastructure have substantially engaged in organizational change to meet the objectives. If we continue to share outcomes and learn from both the positive and negative results, we will be successful in meeting the aims for population health. This is the greatest challenge at this point. Areas of patient engagement and satisfaction, as well as models of care delivery, are ripe for scientific discovery within this changing environment. We need to continue the national and international focus and move forward.

Khan: There has been some good progress over this past year, but overall the accountable care organization (ACO) market had a mixed year as several organizations either opted out or announced their intentions to do so. On Dec. 1, 2014, the Centers for Medicare and Medicaid Services (CMS) released its long-awaited proposed rule to update the regulation and operation of the Medicare Shared Savings Program (MSSP). This is a good step forward. However, it falls short in two major areas. One area is the MSSP risk adjustment methodology, and another area is the Medicare beneficiary assignment. The proposed rule is open for comment until Feb. 6, 2015, so we will see if these regulations will continue to shift and evolve.

HMT: After a year of population health initiatives and intelligence sharing, how much have healthcare organizations kept on track to achieve the goals they originally sought?
Drozdowicz: As is to be expected in any new arena, initial results are mixed. We have, in general, seen improvement in quality, measures and patient satisfaction scores. We have not seen consistent cost savings, though there are some organizations that have achieved or exceeded desired financial results. We agree with thought leaders who argue that improved quality should result in lower, not higher, costs. Achieving the financial goals may be delayed by the learning curve of new care and reimbursement models, the need to build the operational and IT infrastructure to support those models, and time required for improved quality to translate to reduction in utilization and lower costs. In many cases, the organizations we are working with are just learning to operate under mixed fee-for-service and value-based reimbursement models. These are early times for all – and until organizations make investments in their people, processes and supporting technology in place to manage these types of arrangements, we should expect to see continued variation in results.

Niloff: Results have been mixed. Some organizations have made more progress than others. Technology implementations have been slower than anticipated, often hampered by challenges in data acquisition and interoperability. The most successful organizations have employed a focused approach and achieved improvements in quality metrics and savings from their care management programs. Such success is dependent on focus, resources and aligned incentives.

Hardy: It's important, especially at this early stage, to ask, "What's working? Where are organizations seeing success, and what commonalities can we identify among those seeing the greatest success?"

We have to distinguish between organizations that have successfully implemented effective population health management IT and those that haven’t. The former have the benefit of technology specifically designed to support new...
roles and new responsibilities among clinical staff, which means as an organization they’re not forced to tackle the challenges of population health while simultaneously battling cumbersome workflows and messy, piecemeal reporting.

As more organizations adopt technology that’s truly built for the population health management model, we’ll see an acceleration of progress as well as accelerated evidence-based winnowing of population health management best practices.

White: We’ve seen many of our Allscripts TouchWorks electronic health record (EHR) clients attain industry-leading successes in areas around quality and population health. It’s been a critical initiative for us to continue to partner closely with our clients as they navigate increasing industry pressures, and we are encouraged by their achievements and forward movement, particularly while simultaneously navigating regulatory changes such as Meaningful Use.

Varma: Healthcare organizations are moving in the right direction, but there’s much more that needs to be done. Provider organizations already know that it’s possible to control costs for patients. However, they are still figuring out how to do this effectively; at scale, while keeping their businesses strong. Good population health management leads to reduced costs and lower revenues for providers.

Hunt: St. Vincent’s Health Partners (SVHP) has achieved operational success in its foundational goal of defining a narrow network of physicians representing primary care and more than 40 specialties in addition to St. Vincent’s Medical Center (our flagship medical center), four skilled nursing facilities, four home health agencies and an advanced practice registered nurse (APRN) group allowing extension into all post-acute care environments. SVHP is the first organization to be nationally recognized by the Utilization Review Accreditation Commission (URAC) as clinically integrated and aligns with the Federal Trade Commission’s and Department of Justice’s healthcare guidelines. The focus of the narrow network initially has been on transitions of care and the need to support patient care.

SVHP has also established functional and operational differences between medical management (population health management) and medical services (services directly provided to the patient). The Care Coordination and Integration Division works collaboratively with payers and employers to utilize population health and is recognized for the improvements in utilization. The SVHP’s Playbook sets an organizational standard that each member is expected to meet with regard to evidence-based quality care.

SVHP has helped its membership participate with commercial ACO-like reimbursement models, transform to initiate CMS’ Bundled Payment Care Initiative, and prepare the organization for the move from fee-for-service to quality reimbursement. The current contracts reflect these initiatives and the potential for shared savings. SVHP is preparing to accept full-risk contracts in the near future by investigating the total cost of care.

Being able to measure, capture, and manage the total cost of care depends on the meaningful use of prospective data (practice management, EMR and procedure) and retrospective data (claims) to be able to adjudicate and manage populations aggressively. The significant challenge is to have timely information that is impactful and useful to provide high-quality cost-effective care. SVHP continues to use data aggressively from as many sources as possible. The aggregation of the data remains manual with improving automaticity. Barriers being successfully overcome in pursuit of this goal include reluctance of physician practices to share data and the lack of portability with various technologies. Although still in its infancy, population health management is providing a compelling contribution towards achieving the “triple aim.”

van Terheyden: We are still in its early days. While everyone can see the benefit and the necessity given the looming need to manage healthcare costs and ACOs, the integration of data and the lack of significant commercial drivers have hindered progress. Currently, everyone is focused on Meaningful Use and to a lesser degree, ICD-10, so there are fewer resources available to focus on data integration.

For the larger systems who have integrated data and systems, it is easier to share this data. For most others, the data is distributed and hard to access. Sharing data does not always work in favor of competitive interests. Until this changes, healthcare organizations will not have reliable and complete access to the required data sets to manage their population.

Khan: Several pieces have to fall into place before we will see the real impact on outcomes. In the past, due to misalignment of interests between key stakeholders in the industry such as the payers, providers and the consumers, it was very difficult to come to an agreement on what the goals are. At this moment, we finally have some alignment of interests and are beginning to see a will to work together, however there are significant cultural barriers that need to be addressed before we share a common vision and work full steam ahead to achieve that.

Bennett: From our perspective, none of our clients are “off track.” They have all reached a certain level of health information exchange (HIE) development, adoption and sustainability. They are implementing further enhancements in clinical and analytical investments.
capabilities. Population health is a complex undertaking. Still, our clients and partners are implementing incrementally according to their schedules.

It is early yet to see prospective outcomes. For instance, most healthcare organizations are only just beginning to report on their 2014 results. Cost benefits are already being achieved at the same time some clinical quality improvements are happening. We know that attaining actual improved clinical outcomes will take time. In order to achieve the desired improved care outcomes, healthcare professionals will need to understand how to engage patients to be active participants in their care, and patients need to be more proactive in taking personal responsibility for their health. This will happen once science meets operations and we understand what motivates or detracts from one’s ability to manage his/her own health.

Drozdowicz: We have seen targeted programs – specific to given patient populations – achieve positive outcomes. Broader-based programs have produced mixed results thus far, with some organizations announcing success and others looking to restructure their organization and processes to increase the likelihood of success. Where we are largely focused on providing technology to make these organizations successful, the key ingredients in our successful customers include having strong clinical and IT champions to lead change in their respective organizations.

Niloff: Many organizations are still primarily working on program development, IT implementation and provider engagement – all fundamental elements for successful population health programs. Few new programs are fully implemented, so it is too soon for them to realize significant improvements in outcomes. That said, we are seeing early successes including improved quality metrics, reduced costs among patients in care management programs, reductions in ambulatory drug costs, reduced rates of admissions and readmissions, and reduced emergency room encounters.

White: There’s been opportunity to identify and, subsequently, learn in these first few years of accountable care:
1. To understand where the gaps in service are for their networks and how engaging patients will keep them in network (i.e. engage and assess the market and business model and embrace an organization’s capacities).
2. To build the organization correspondingly and reach out to partners that have the capacity to reach specific goals.
3. To identify and empower physician champions to execute the strategies.
Compliance

Taking ICD-10 from burden to strategic opportunity

By Becky Quammen

In March 2014, Congress extended the deadline for the transition from ICD-9 to ICD-10 from October 2014 to October 2015. Even though the healthcare industry made use of the additional time allotted to prepare for the changeover to the new coding system, many organizations still have a long way to go, according to a recent study from the Workgroup for Electronic Data Interchange (WEDI).

“Based on the survey results, all industry segments appear to have made some progress since October 2013, but the lack of progress by providers, in particular smaller ones, remains a cause for concern as we move toward the compliance deadline,” said Jim Daley, WEDI Chairman and ICD-10 Workgroup Co-Chair.

According to the survey results, only about 50 percent of the providers indicated they have completed their ICD-10 impact assessments – essentially the same number as in the October 2013 survey. About 35 percent of providers have begun external testing, while in the October 2013 survey about 60 percent had expected to begin by the middle of 2014. The apparent lack of progress has prompted officials at the Centers for Medicare and Medicaid Services (CMS) to call for healthcare organizations to address the pending transition more purposefully.

“Many of you may think, ‘Well, I have another year to go,’” said Denesecia Green of CMS’ Administrative Simplification Group during a November 5, 2014, Medicare Learning Network webinar. But time is of the essence, according to Green, and “pre-work is the important piece in getting your organization ready for ICD-10.”

Instead of concentrating on the ICD-10 deadline, leaders should focus more keenly on the overall value ICD-10 can bring to their healthcare organizations. In essence, the conversation needs to move from a tactical one to a strategic one. The state of readiness has once again, however, prompted a number of industry groups to form back with a request for even more time. Most recently, the National Physicians’ Council for Healthcare Policy, the Medical Society of the State of New York, the Texas Medical Association and other state medical groups sought to delay the ICD-10 implementation deadline – this time until October 2017. The medical groups sent a letter to Congress, calling for a delay to be included in a bill.

The continued tussling over the ICD-10 deadline is understandable, considering that the change definitely won’t be easy. But the conversation needs to shift. Instead of concentrating on the ICD-10 deadline, leaders should focus more keenly on the overall value ICD-10 can bring to their healthcare organizations. In essence, the conversation needs to move from a tactical one to a strategic one.

The good news is that a recent survey from the American Health Information Management Association (AHIMA) and the eHealth Initiative concluded that as healthcare executives become more familiar with ICD-10, they are beginning to recognize the long-term benefits of the updated code set and plan to use it for quality improvement and performance measurement.

The expanded coding system is, in essence, designed to help support value-based care models. With its greater complexity and granularity, ICD-10 can support a system that closely ties reimbursement to clinical care – and, thereby, can help to create a clinically driven revenue cycle. Indeed, ICD-10 can apply codes to their clinical actions more precisely, making it possible to link payment to care more accurately. And with advanced electronic health records (EHRs) in place, organizations will be able to integrate the new and improved coding into the care process so that it becomes a by-product of patient care – and not another burden.

With this more strategic understanding of ICD-10’s potential, organizational leaders can finally stop worrying exclusively about the pending ICD-10 deadline and instead focus on how the move to the new coding system can bring added value to their organizations. As such, the deadline, wherever it may ultimately land, will seem less like an administrative hassle and more like a strategic opportunity. With this mindset, leaders will understand the ultimate value in the work involved – and will be more likely to enthusiastically jump into a change initiative that gets their organizations ready for ICD-10 by:

• Developing a plan that addresses all aspects of the transition, from clinical documentation improvement to information technology changes to education to communications.
• Formulating a budget that anticipates the financial impact associated with training, IT upgrades and potential lost revenue due to the transition.
• Launching a comprehensive testing program that covers all applications and interfaces.
• Conducting clinical documentation training that ensures that front-line clinicians understand the potential impact on care documentation.
• Revising processes and forms to include diagnosis and procedure information that is used in the new codes.
• Bulletproofing the revenue cycle against any negative impact that might emanate during the transition.
• Preparing to temporarily code in both ICD-9 and ICD-10 in an effort to smooth the transition to the new system.
• Upgrading all software, interfaces and reports to meet the new requirements.

The state of readiness has once again, however, prompted a number of industry groups to form back with a request for even more time. Most recently, the National Physicians’ Council for Healthcare Policy, the Medical Society of the State of New York, the Texas Medical Association and other state medical groups sought to delay the ICD-10 implementation deadline – this time until October 2017. The medical groups sent a letter to Congress, calling for a delay to be included in a bill.

The continued tussling over the ICD-10 deadline is understandable, considering that the change definitely won’t be easy. But the conversation needs to shift. Instead of concentrating on the ICD-10 deadline, leaders should focus more keenly on the overall value ICD-10 can bring to their healthcare organizations. In essence, the conversation needs to move from a tactical one to a strategic one.

The good news is that a recent survey from the American Health Information Management Association (AHIMA) and the eHealth Initiative concluded that as healthcare executives become more familiar with ICD-10, they are beginning to recognize the long-term benefits of the updated code set and plan to use it for quality improvement and performance measurement.

The expanded coding system is, in essence, designed to help support value-based care models. With its greater complexity and granularity, ICD-10 can support a system that closely ties reimbursement to clinical care – and, thereby, can help to create a clinically driven revenue cycle. Indeed, ICD-10 can apply codes to their clinical actions more precisely, making it possible to link payment to care more accurately. And with advanced electronic health records (EHRs) in place, organizations will be able to integrate the new and improved coding into the care process so that it becomes a by-product of patient care – and not another burden.

With this more strategic understanding of ICD-10’s potential, organizational leaders can finally stop worrying exclusively about the pending ICD-10 deadline and instead focus on how the move to the new coding system can bring added value to their organizations. As such, the deadline, wherever it may ultimately land, will seem less like an administrative hassle and more like a strategic opportunity. With this mindset, leaders will understand the ultimate value in the work involved – and will be more likely to enthusiastically jump into a change initiative that gets their organizations ready for ICD-10 by:

• Developing a plan that addresses all aspects of the transition, from clinical documentation improvement to information technology changes to education to communications.
• Formulating a budget that anticipates the financial impact associated with training, IT upgrades and potential lost revenue due to the transition.
• Launching a comprehensive testing program that covers all applications and interfaces.
• Conducting clinical documentation training that ensures that front-line clinicians understand the potential impact on care documentation.
• Revising processes and forms to include diagnosis and procedure information that is used in the new codes.
• Bulletproofing the revenue cycle against any negative impact that might emanate during the transition.
• Preparing to temporarily code in both ICD-9 and ICD-10 in an effort to smooth the transition to the new system.
• Upgrading all software, interfaces and reports to meet the new requirements.
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Handling the demands of a population boom

Using RTLS to improve patient care and workflows

By Dan Hamilton

Just about all healthcare organizations want to see as many patients as possible— as efficiently as possible. Doing so makes sense, as a quick in-and-out operation typically results in happy providers, staff and, most importantly, patients.

Recently, however, seeing more patients in a timely manner turned from a “nice-to-have” to a non-negotiable “must-have” here at Nor-Lea Hospital District. Our not-for-profit, community-based healthcare organization owns and operates Nor-Lea General Hospital and several clinics serving New Mexico’s Lea County, where the population has been growing rapidly due to a boom in oil-gas exploration.

In the fall of 2013, for example, the population already had increased 16 percent from the last census, and it was expected to jump up another 16 to 20 percent in 2014, as the oil and gas economy here continued to prosper.

With all these people migrating to the area, handling increased demand quickly became a common challenge for all businesses in this “boom town.” Real estate developers were building apartment complexes to handle the demand for housing. Hotels were experiencing huge nightly upticks in reservations. Even fast food restaurants were trying to eliminate hour-long waits for burgers. In short, our entire region was pushed beyond capacity, including Nor-Lea’s Emergency Department.

So, to start, leaders set out to reduce wait times while also improving patient flow and staff utilization. We did so by implementing a workflow solution from Versus Technology utilizing a real-time locating system (RTLS) in two existing outpatient clinics (our Evening Clinic and our Lovington Clinic) as well as in the hospital’s Emergency Department.

Here’s how it works: When patients come into central registration, they are registered and then provided with a small, lightweight VersusBadge that emits low-powered infrared and radio-frequency identification (RFID) signals. Through these signals, the system automatically tracks patient location and monitors interactions with staff. Using a sophisticated rules-based workflow engine and integrations to Nor-Lea’s electronic health record (EHR), lab and scheduling systems, clinicians and other staff members always have a real-time handle on:

• Where patients are and how long they’ve been waiting;
• Which ancillary services have been ordered and which are ready;
• Which patients are ready to see a provider; and
• Which rooms are available, assigned or in need of cleaning.

With this real-time information available to all clinicians and staff members, it’s easy to speed up the patient flow. Instead of continually checking the waiting room and constantly communicating with each other about the status of various patient care tasks, physicians and other staff members can simply consult the RTLS system and immediately know what actions to take to keep patients moving throughout the facility.

Data for continual process improvement

In addition to checking the information in real time, we also routinely leverage the historical, analytical data that has been collected through the RTLS reporting module. In fact, sharing these analytics with staff makes it possible to pinpoint both areas for improvement and best practices—ultimately helping to fine tune the patient flow and workflow processes.

As a result, patient wait times in the outpatient clinics have been cut in half, from an average of 30 minutes to just 15 minutes. The improved patient flow enabled the Evening Clinic to serve 475 patients per provider per month in June 2014, up from 319 in June 2013, an increase of 49 percent per provider.

At the Lovington Clinic, more efficient patient flow made it possible to not only see more patients, but also to use our exam spaces more efficiently, increasing the number of providers working in the facility. As a result, the Lovington facility is now serving 45 percent more patients, from 3,300 per month in June 2014 to 4,788 patients per month in December 2014.

In addition, we have put together cross-functional teams to examine the analytical reports and come up with strategies to improve overall patient flow and workflow throughout the clinics. Such evaluation is helping us proactively develop patient flow and workflow strategies.

Empowered with both real-time and longitudinal data from the RTLS, the performance improvement team has identified the following strategies that we recently implemented:

• Elimination of the registration desk.

Under the former patient flow scenario,
all patients filled out forms at the registration desk before receiving their RFID badge. As such, there was no way to measure how long the actual registration process was taking. Now, however, all patients are pre-registered on the phone. Instead, they immediately receive their badges when entering the clinic – and their total door-to-door time in the facility is documented via the RTLS.

- Assigning more staff to each physician. Previously, physicians would spend considerable amounts of time each day looking for staff members between patient appointments. Frequently, the medical assistants would be helping another doctor or attending to a patient – and the physician would have to wait before working with the next patient. As a result, we are now assigning two dedicated medical assistants to each provider. This team of three is then able to work in unison – making it possible to streamline the patient flow process. Under this scenario, one medical assistant stays with the patient from start to finish, while the other medical assistant is preparing the next patient for the doctor.

With these interventions in place, there is no longer a need to book one-hour appointments that enable the physicians to "catch up." We are now booking patients for 15-minute and 30-minute slots. One doctor, as a matter of fact, is exclusively booking 15-minute appointments. The providers are working in only two exam rooms each instead of three, making better use of our resources and further streamlining workflow.

Perhaps most important, though: patients are happy with the service they are receiving. Since implementing the system, the number of complaints about wait times and the ability to schedule an appointment has been reduced to practically zero.

Yet we are still striving to leverage the system to make our customer care even better. More specifically, we are working toward implementing a complete self-rooming process. Under such a scenario, patients will receive the Versus badges upon arrival and will immediately follow directions to an open exam room, eliminating the waiting room and staff escort.

An enthusiastic embrace
While the RTLS technology enables healthcare organizations to add capacity by improving patient flow and staff work processes in the moment, Nor-Lea has gotten the most from the system by leveraging both its real-time and analytical capabilities. In essence, instead of merely implementing the RTLS and using the real-time data, we have proactively invited all physicians and staff members to use historical analytics to drive various improvement strategies. In this way, the system has become a critical component of our strategic performance improvement program.

In the final analysis, this system allows us to quickly identify and implement workflow improvement strategies, making it possible to handle the growing demand for healthcare in what has become a real boom town. That is a big plus for clinicians, staff and, of course, the many patients who walk through our doors looking for quality care and exceptional service.
Case Study: RFID/RTLS

Fighting infection with RTLS

By Jon Poshywak, Vice President and General Manager, TeleTracking Technologies

The most common reason hospitals purchase location-tracking technology is to track assets, and the most common motive is to save $1 million or more in medical devices that are stolen, hidden or lost every year. But if that’s your only reason, you are missing the potential of many millions more in cost reduction and revenue generation.

Real-time location systems (RTLS) now enable the automation of many workflows as well as tracking patients, staff, physicians and procedures. RTLS fights the spread of infection, monitors the temperature of medicine and blood products, helps optimize procedure areas and automates discharge. It’s the key technology behind operational platforms that are increasing productivity in nearly every segment of care delivery.

Until recently, infection was considered an inevitable risk of healthcare delivery. Now that perception has changed as reimbursement guidelines penalize readmission and infection-related length of stay. A record 2,610 hospitals are under the Centers for Medicare and Medicaid Services (CMS) penalties for readmissions currently. Last year, nearly 18 percent of Medicare patients were readmitted within 30 days at a cost of $17 billion.

RTLS fights infection in several ways. It can track the contacts an infected patient has throughout the hospital as well as equipment that may have been exposed to disease. A recent British hospital study illustrated the importance of this capability when it was determined that a hospital-acquired infection (HAI) patient came in contact with 216 different people in one day!

When time is of the essence, such as the Texas outbreak of Ebola, your institution must have the means to identify in minutes the hospital personnel who came in contact with a contagious patient.

Yet even the best infection-control precautions fail when employees are not alerted about potential exposure to infection. Right now, housekeepers, transport personnel and other staff can walk into an isolation room without knowing its status because in many hospitals infection-control nurses still manually prepare lists of isolation rooms. Those lists can be outdated before the nurses leave their office to post the warnings.

RTLS combined with automated patient flow technology helps alert those personnel to isolation status so they can better protect themselves from contagion.

Between 70,000 to 100,000 lives are lost to infection in America annually, with an attendant cost of $45 billion. A 500-bed hospital, at the current infection rate, could average 194 unnecessary deaths and $28 million in unnecessary costs per year.

The contaminated hands of healthcare workers are recognized as the primary source of healthcare-associated pathogens. Decontamination using gel or soap is the simplest, most effective way to prevent the spread of infection between patients. England’s Broomfield Hospital totally eradicated methicillin-resistant Staphylococcus aureus (MRSA) in one year with meticulous hand washing, frequent garment changes for physicians, removing jewelry from caregivers, rigorous cleaning and restriction of wheelchair movement.

The most common methods for monitoring compliance are:

1. Self-audits using the World Health Organization (WHO) “5 Moments for Hand Hygiene” checklists, measuring purchasing changes for soap and gel, and
2. Making manual compliance observations, which are labor intensive, random, subjective and cause only temporary behavior changes by staff.

A remote hand-hygiene monitoring capability can increase compliance significantly by continually recording the handwashing practices of anyone who comes in contact with patients. RTLS-based technology helped New Cross Hospital increase hand-washing monitoring by 2,000 percent in a single month.

The New Cross effort was prompted by the federally sponsored Safe Hands program, designed to determine how RTLS can positively impact hand-washing compliance. All soaps and gels in bay areas, side rooms and on beds were fitted with memory modules to capture hand hygiene at the point of care. The integration of automated capacity management software and RTLS allows infection-prevention nurses to remotely observe and analyze hand-hygiene behaviors of ward staff. The system also matches server timing to workflow in order to give staff maximum credit for hand-hygiene events.

Time after “go live,” the hand-hygiene indicator (HHI) was switched on, giving real-time feedback, refreshed every 30 minutes, which informed the wards how they were doing. Hand-hygiene observations went from 600 manual observations per month to over 2 million remote observations.

Color coding was given to this score to show what was good, average and bad to drive changes in behavior. Notably, staff did not like being in the red or yellow (bad/average) zones, and they challenged one another to get into the green.

HMT
Tagging assets in 2020

What do four RTLS executives foresee about their tagging technology’s reach and utility five years from now?

Barry Cobbey, Director of Sales Engineering, Versus Technology
We are already seeing a continued increase in not only the number of healthcare organizations implementing RTLS, but also in the use of the technology in more meaningful ways. There’s an increasing level of education in the marketplace about what RTLS can do—a realization that it’s more than about basic locating; it’s about workflow management and process improvement. Hospitals are now, and will continue, moving beyond asset tracking and use RTLS to monitor and manage complex workflows. Also, the technology is expanding into different areas of healthcare. Not only hospitals, but outpatient clinics, primary care and eye care practices, just to name a few, are implementing RTLS to help with process improvement. RTLS is helping improve patient flow, giving these practices the ability to increase patient volume and provide more access to care. With millions of new patients entering the front doors of physician offices and emergency departments as a result of the Affordable Care Act, healthcare must turn to efficiency tools like RTLS. As we approach 2020, this type of RTLS use will move from the bleeding edge to the mainstream.

Joel Cook, Senior Director of Healthcare Solutions, Stanley Healthcare
The most exciting part about the future of RTLS really goes beyond the technology—it’s about how extensively empowered healthcare professionals are going to become. The business intelligence and predictive analytics capabilities associated with RTLS will open entirely new windows of visibility within healthcare organizations, providing them a level of knowledge and insight that’s never been accessible before. Productivity and efficiency is just the starting point. By having both real-time and historical information about the movement, status and conditions that are occurring 24/7 throughout the facility, we’re going to see significant advancements in the quality of care by enabling healthcare professionals to predict conditions before they ever occur—thereby permitting them to focus on patient care, better clinical and financial outcomes, and enhanced patient experience and staff satisfaction.

Adam Peck, Director of Marketing, CenTrak
As RTLS matures from addressing simple asset tracking use cases to a clinical visibility infrastructure, new applications utilizing location awareness will be woven into operations. In the future, RTLS will support the orchestration of care throughout the clinical enterprise. It will streamline processes, make more efficient use of scarce resources, both human and capital, will improve clinical quality while reducing preventable errors, and will integrate with existing information systems to share data across a wider range of users.

Matt Perkins, Chief Technical Officer, Awarepoint
Today, the industry is so focused on debating the merits of various technology approaches that it’s largely missing the point. The key consideration should be evaluating RTLS platforms that can grow as different technologies are invented or realized. The healthcare community really hasn’t embraced RTLS beyond basic locating and tracking, but a few organizations are impacting a wide range of operational efficiency and customer satisfaction goals. The power of this technology in the future has great potential to positively impact many components of patient and family satisfaction with its ability to create a seamless patient experience.

It is absolutely critical to choose a platform that can grow with new technology developments and new requirements, especially when considering integration with other health systems. You will need to incorporate lots of different technologies, whether they be ZigBee, Bluetooth low energy or traditional RFID—passive or active—because there is no one-size-fits-all solution. In the next five years, the RTLS platforms that cannot accommodate various inputs are not going to meet the needs of the end users and will ultimately filter themselves out of the market. I envision a future where intelligent RTLS technology converges to address a wide range of commercial, clinical, personal and family needs through location-driven context awareness.
Expert Q&A: Cloud Computing

Our expert trio takes on the cloud

To cloud or not to cloud?

By Bob Rossi, Vice President, CDW Healthcare

Earlier this year, we surveyed 150 healthcare decision makers familiar with their organization’s cloud implementations and gained a deeper understanding of key cloud trends in the healthcare marketplace.

Healthcare decision makers report that 35 percent of their organizations’ IT services are either totally or partially delivered via the cloud, highlighting the industry’s growing enthusiasm for the platform. (This finding aligns with other industry yardsticks, such as Improvista’s 2013 Desktop Virtualization Trends in Healthcare report, which found that 30 percent of healthcare IT decision makers were using cloud apps and services.) Of the cloud services recorded in our survey, organizations migrated 53 percent into the cloud from traditional delivery models, while 47 percent originated in the cloud.

Looking ahead, healthcare organizations report considering delivery of 33 percent of future IT services totally or partially via the cloud; however, developments in healthcare IT such as telehealth and health information exchanges provide additional incentive for healthcare organizations to continue making strides toward greater cloud adoption.

Where’s the money?

Cost savings continue to be one of the most advertised benefits of cloud services, with Frost & Sullivan reporting that cloud storage can cost 10 times less than regular storage systems. The impact of the cloud multiplies when you consider the “soft cost benefits,” including improved efficiency, productivity and more. However, 58 percent of our healthcare survey respondents stated that cloud is expensive to buy, but expensive and/or difficult to implement and integrate with other resources – highlighting an often-overlooked aspect of cloud costs that can be difficult to quantify.

Regardless of savings potential, there is no consensus on a preferred model for predicting costs and benefits of cloud services. According to our survey, vendor-provided financial models are the most popular among healthcare organizations (35 percent), followed by models from IT analyst firms and third-party consultants (both tied at 25 percent). Despite financial forecasting attempts, almost half (48 percent) of healthcare organizations say their models proved to be off by more than 10 percent. The cloud savings are real enough, but an organization should measure savings within the context of its own financial figures, not the entire cloud industry. By carefully considering the savings variables used in financial models, organizations can take the first steps to ensuring accurate models.

What are some of the benefits healthcare organizations are seeing through the adoption of cloud computing?

By Jonas Hellgren, President, Chief Executive Officer, Vaultive

First and foremost are the cost savings; the partnership with a cloud computing provider eliminates the need for organizations to invest in hardware infrastructure and maintenance. Secondly, the cloud also enables improved collaboration – when specific information is needed in multiple places, by different service providers at the same time, this information can be synchronized and shared in real time. Third, access and flexibility have emerged as benefits of the cloud as well. With the emergence of bring-your-own-device (BYOD) policies, health practitioners are able to utilize their personal laptops, smartphones and tablets with the cloud, making it possible to be more productive and access patient data anywhere, anytime.

Are concerns around security and the confidentiality of patient information unwarranted?

These are valid concerns, which is why healthcare organizations need to do their due diligence when selecting a cloud service provider (CSP) to partner with. Cyber attackers are focusing more and more on accessing patient and healthcare data. At the same time, regulations such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health (HITECH) Act mandate the protection of personal healthcare information. The Office of Civil Rights has intensified HIPAA-HITECH breach penalties to create consequential incentives for securing healthcare data. Healthcare organizations need to do their homework when it comes to confirming that their CSP is HIPAA ready. To ensure compliance with regulations and minimize risk, healthcare organizations should adhere to these best practices:

• Have a business associate agreement (BAA) with your CSP that is in line with the new requirements of HIPAA through the Omnibus Rule.
• Make sure your CSP offers daily operational procedures that log and monitor the data in the cloud 24/7 in order to look for any suspicious activity and adhere to notification requirements as defined by HIPAA.
• All healthcare data stored on CSP hard drives, including emails and attachments, must be encrypted throughout the data lifecycle – spanning encryption in transit, at rest and in use.
• The encryption keys must be separated from the data, ensuring segregation of duties between the provider hosting your data and the encryption keys.
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athenahealth provides cloud-based services for EHR, practice management and care coordination, helping caregivers do well doing the right thing.
How did the HIPAA Omnibus Rule change things for the cloud?

On January 25, 2013, the U.S. Department of Health and Human Services (HHS) released the Omnibus Rule that modified the 1996 legislation of HIPAA. Any credible CSP should be happy to sign a BAA, but it’s important to remember that it’s only a starting point. A BAA acknowledges the hosting provider’s legal responsibilities and liabilities to the healthcare organization. But even more than that, it establishes a culture of a partnership geared toward compliance. Any agreement should include provisions for the following:

• User tools. Before contracting a CSP, healthcare organizations must fully understand the provider’s built-in tools, enterprise-wide privacy and security protections, as well as any configurable tools to establish additional privacy and security protections. The availability of these tools and how they will allow the user to increase the level of privacy and security should be included in the BAA.

• Encryption. HIPAA regulations specify that encryption should protect patient data throughout its lifecycle – in transit, at rest and in use. The BAA should address this, as well as who will hold the encryption keys.

• Return of data. HIPAA regulations require that BAAs address the return or destruction of patient data at the termination of a business associate relationship.

• Contingency planning and disaster recovery. Cloud providers can often provide better protection in the event of outages or disasters; however, the BAA should address the specific requirements to be met by the provider in this type of event.

• Service level agreements (SLAs). SLAs outline the metrics by which a CSP’s performance will be measured and establish the penalties they must pay if performance falls short.

What are the new notification requirements as defined by HIPAA, and how can healthcare organizations make sure they’re meeting them?

The Omnibus Rule made a number of changes to the Breach Notification Rule. Most notably, it clarified the term “breach” to basically mean guilty until proven innocent. It added language to the definition of breach to clarify that an impermissible use or disclosure of protected health information is presumed to be a breach unless the healthcare organization, or its business associate, is able to prove there is a low probability that the protected health information has been compromised. If an organization is not able to prove this, they are required to notify all affected parties following the breach notification guidelines.

For these reasons, encryption really is an organization’s best option when it comes to this redefinition of what constitutes a breach and what’s required in its wake. For those organizations that encrypt their patient data, they can be sure that even if unauthorized access has occurred, all that’s being viewed by anyone not holding the encryption keys is gibberish – making it easy for them to prove the low probability of compromise.

Why do you think there’s still resistance within the healthcare community when it comes to encryption?

Much of this resistance is based on fear of change – a fear of what encryption could inadvertently do to sensitive integrated healthcare systems. The issue in healthcare is that data needs to be shared across a large number of organizations, including doctor’s offices, medical clinics, hospitals, various outpatient providers, health insurance providers, pharmacies and much more. It is no surprise that healthcare organizations are resistant to encryption, since access to this data is required by so many.

Many healthcare leaders believe that encrypting data increases the time to retrieve and review information, which ultimately decreases efficiency. However, this is no longer the case with today’s encryption technologies. The need for encryption is not just theoretical – it’s seen in the real world every day. Just two years ago, a Massachusetts-based healthcare provider was ordered to pay $1.5 million as a result of stolen patient data on an unencrypted laptop. A more thorough encryption strategy could not only have saved this organization $1.5 million as a result of stolen patient data on an unencrypted laptop. A more thorough encryption strategy could not only have saved this organization $1.5 million but also saved them from damage to an invaluable asset – brand trust.

Healthcare organizations need to be very specific about the type of encryption they deploy, however. HIPAA calls for patient data to be encrypted throughout its lifecycle – in transit, at rest and in use. Securing data in all three states ensures patient data is never exposed to anyone, except the organization holding the encryption keys.
How has protecting patient information in the cloud evolved?

By Jake Hughes, Citrix Healthcare Evangelist

As the amount of patient data continues to grow at an unprecedented rate, more and more hospitals and healthcare organizations are looking for ways to integrate cloud computing into their existing IT systems. And with the potential benefits and cost savings enabled by the cloud, IT and business decision makers face the formidable task of evaluating and comparing cloud computing offerings from different providers.

Adding complexity to these considerations is that ensuring HIPAA compliance requires hospitals and providers to keep electronic patient health information (ePHI) secure while still making it readily accessible to clinicians when and where they need it.

The challenges associated with these requirements continue to evolve. Traditionally, electronic medical record (EMR) or picture archiving communication systems (PACS) contained ePHI. However, with the complexity and scale associated with deploying IT infrastructure in healthcare, controlled data is now everywhere. No longer limited to just those systems, ePHI appears throughout the entire IT infrastructure.

To accommodate this proliferation of sensitive information, hybrid and public cloud providers as well as internal healthcare IT teams have developed strategies to make sense of how this data is controlled, ensure it doesn’t get into the wrong hands, and take necessary precautionary measures to make sure it’s not usable by third-party entities or organizations.

Utilizing traditional IT systems and strategies meant that ePHI and other controlled data was constantly moving out to locations that were less and less secure, primarily distributed workstations out in the field as well as through virtual private networks (VPN), and unsecured machines like home computers and even public kiosk machines. This situation – in which the agendas of data availability and security are seemingly at odds with each other – drives a constant struggle: Can we create a usable, enhanced clinician environment from an IT standpoint that is also secure?

These competing agendas also result in a fight for control over the user experience. When environment security is viewed as the top priority, it typically impacts overall clinician satisfaction with the IT experience in a negative way. Conversely, when techniques are used to improve user/clinician satisfaction, an environment’s security decreases. Modern healthcare organizations have to find a way to deliver a favorable user experience while still ensuring data security.

To take advantage of the cloud and all it has to offer, hospitals and healthcare organizations have started to embrace the idea of moving away from physical servers, virtualizing assets within the data center and adopting a private cloud environment where services, applications and infrastructure are pooled together. Doing so is an attempt to provide a more effective, efficient environment – and the beginning of offering private cloud and on-demand resources.

However, the private cloud mentality views the infrastructure and orchestration leveraged by IT as highly complex. Rather than improving internal IT’s ability to deliver resources and applications that enhance the user experience, the private cloud grew more and more, the amount of competition increased and the complexities of the data center surged. Similar to trends in other industries, this led the IT shops themselves to look for a way to improve operations efficiency, reduce capital and operational costs, and achieve an infrastructure-as-a-service (IaaS) model rather than manage the basic plumbing and infrastructure component.

In recent years, cloud service giants like Amazon and Microsoft have matured to a point where moving significant portions of infrastructure to a public cloud is now a viable alternative. However, making this shift in a regulated industry such as healthcare presents an issue. The draw to reduce operational overhead, increase efficiency, reduce capital cost and move to cloud services competes with the need to maintain control of knowledge, auditing and overall security. Additionally, security is also viewed as a challenge because the burden of securing critical data is now someone else’s responsibility.

In an effort to address these concerns, the HIPAA Omnibus Rule with Business Associate Agreements put much more responsibility on cloud service providers in September 2013, extending the liability of breaches to the entity serving the data. Holding these third parties accountable for data breaches has made cloud computing a more viable – and for some even preferable – option for storing and using ePHI.

The hybrid cloud, in which some information and infrastructure is stored on-premise and some is located at an off-site data center managed by a cloud provider, is typically used within healthcare systems for non-controlled data and applications that do not contain ePHI. Two factors still prevent many healthcare organizations from storing controlled data in the public cloud: The organization’s perceived loss of control as well as the liability burden to the cloud provider.

Today, we’re moving more and more controlled data into true cloud services. It’s a necessary shift, as organizations are now requiring entire IT environments “as a service” so that healthcare cloud...
What are the key considerations that healthcare organizations should make relative to the use of public clouds?

Some of the specific challenges that healthcare organizations encounter when moving controlled assets into the public cloud are very basic, such as ensuring visibility and auditing capabilities of the shared infrastructure, as well as regulatory HIPAA requirements. From a cloud provider standpoint, there’s much room for improvement in these areas. When using a private cloud, visibility into what the servers are doing, who’s accessing them, breach attempts and more is all readily available to a healthcare IT group.

From a compliance standpoint, the same level of detail needs to be available from public cloud providers. However, this can be relatively difficult to achieve because the provider’s basic responsibility is to contain security information logs and other relevant information within its private environment. The maturation and blending of this visibility and auditing is a deficit that is slowly but surely improving within the public cloud environment.

Another struggle that early adopters, innovators and disrupters in the healthcare environment encounter involves fallback procedures. A breach, compromise or security issue only requires a basic operational change control that is generally non-disruptive to end users. In a 24/7 environment like healthcare, however, cohesive control and auditing is crucial, with full process continuity if a disruption occurs. This includes communicating the issue back to hospitals to trigger fallbacks – a technical requirement for HIPAA – for clinical staff (for example, to revert from electronic records to paper).

These processes typically owned and evolved by healthcare organizations now have one, two or three third-party entities that need to understand the complications of determining whether or not an outage causes clinical impact. In an industry as unique as healthcare, it is crucial to explain to third-party entities how minor disruptions can be detrimental as they can cause patient safety issues, breaches and possibly expose the healthcare environment to much higher risk.

This isn’t to say that the public or hybrid cloud can’t achieve the same levels of security or compliance that a private cloud can; in fact, because cloud providers can invest much more in infrastructure, security and control, it can actually improve an organization’s security posture when moving to the cloud. However, it must be done carefully and diligently to ensure the proper processes and procedures are in place.

How does the industry overcome its fear of change?

The bottom line is that wholesale cloud adoption within healthcare has little to do with convincing healthcare and IT leaders of technical capability – and much more to do with basic perception and peace of mind. Healthcare industry leaders who are professionally and personally liable for their organization’s data protection need to feel in control. And because the cloud isn’t physically present within the organization’s data center, there’s still a perception that the cloud isn’t safe.

This perception continues to challenge the industry, preventing organizations from moving out of a private to a hybrid cloud, or out of a hybrid cloud or into a fully public cloud. This trend will likely continue throughout the next five to 10 years. The industry needs innovators who are willing to take risks and act as pioneers when it comes to cloud implementation. Seattle Children’s Hospital (SCH), for example, was one of the first organizations to take this step. They invested in virtualization, networking and private cloud solutions that helped doctors and nurses spend more time with patients – and less time interacting with technology. SCH professionals can now use technology resources more easily and efficiently no matter where they go while reducing the costs of providing exceptional patient care.

Like Seattle Children’s Hospital, other healthcare organization pioneers can help demonstrate that the cloud is safe and also exemplify how they’ve mitigated the risks and concerns associated with cloud implementation. As misperceptions related to the cloud are replaced with knowledge and understanding of security capabilities, we’ll see improving rates of adoption within the healthcare industry.
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The innovative system integrates the advanced technologies from four industry-leading companies. The result is a secure, streamlined, cloud based solution that delivers unbeatable service and ROI.
Any of the struggles within healthcare today are not created by outside factors such as government regulations or changing care models, but rather by a simple lack of vision. There are far too many work-related inefficiencies that have been institutionalized within the industry that could be remedied if more open-minded approaches were taken. One such pain point for many healthcare organizations is the patient check-in process.

In the first update to this Living Case Study series, I made the claim that healthcare is currently in a “sweet spot” where available technology, organizational needs and consumer tastes have converged in such a way that the use of ATM-like technology at the point of patient check-in could reap enormous benefits for a facility. But to say that this opportunity is solely based upon good timing would be a shortsighted. A tremendous amount of vision and collaboration was required as well – two ingredients that are often lacking during project planning and implementation in our industry.

As we learned in the previous installments of this Living Case Study Series, the self-service kiosks at Baptist Health are the result of a consortium of companies pulling together their expertise and resources. This convergence was not done in a casual fashion. A single vision was shared and agreed upon by each company. This vision required disciplined preparation and thorough planning by all parties. There was no hierarchy created where one company possessed a higher status than the rest. Each company respected that the others had spent years working to achieve the highest level of success within their given fields and that their pursuit of excellence continues with every new project in which they participate. Even today, each constituent constantly builds upon its skill sets and remains focused on expanding the reach of its solutions.

In a former life, I worked in the music industry and I was always impressed with how well jazz musicians worked with one another. At first, I attributed their inclination for cooperation with the improvisational, seemingly haphazard, nature of the music they create. However, as I spent more time observing professional players, I learned that pushing forward music that was created just a few instances ago by a fellow musician requires a high degree of collaboration and support. As I spent more time observing professional players, I began to understand that jazz is not, and cannot be, a free-for-all. Each player must recognize his or her strengths and limitations as well as the strengths and limitations of their band partners. Mistakes are seen as opportunities to move in new directions. Successes are never attributed to a single person. The only thing that truly matters is their common goal of producing a fulfilling and pleasurable experience for their audience. As I examine how the consortium’s members came together to create their self-service kiosk, I am reminded of this collaborative spirit.

When I initially interviewed Brian Stone, Chief Financial Officer, Clearwave, he said, “We are a kiosk-software company. We don’t manufacture hardware. To achieve our vision of an effective kiosk patient-registration solution, we needed to piece together partners like Posiflex, Image Manufacturing Group and Acuant. Without their talents, we would have never accomplished what we have.”

One of the first partners the Clearwave leadership sought was Posiflex, a maker of point-of-service (POS) and industrial touch terminals and hardware. “Our initial kiosk hard-
facturing Group (IMG), a design and manufacturing company wanted to enable our kiosk to extract information as well.” Th is said Stone. “We not only wanted to read the ID, but we also meant, we saw the need to read government-issued identification,” the best solutions in the market. “Within the healthcare environ-

image-processing and OCR software company, Acuant has one of Card Scanning Solutions] as a partner,” said Stone. As a leading search, it was clear that we ought to approach Acuant [formerly fi eld of optical character recognition (OCR). At the end of our

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to integrate the Posifl ex unit along with the Acuant scanner in a very attractive and eff ective fashion.”

The members of the consortium wanted to fi nd ways to have patients know just by looking at the kiosk what they are supposed to do, and they wanted something more aesthetically pleasing than a black box. With IMG’s expertise, their kiosks draw immediate attention and provide higher levels of functional ease. Practices can insert their logos and their facility’s color schemes so that the kiosks are seen as natural extensions of their environment.

“We sought out and evaluated the most reliable vendors in the fi eld of optical character recognition (OCR). At the end of our search, it was clear that we ought to approach Acuant [formerly Card Scanning Solutions] as a partner,” said Stone. As a leading image-processing and OCR software company, Acuant has one of the best solutions in the market. “Within the healthcare environ-

mental ease. Practices can insert their logos and their facility’s color schemes so that the kiosks are seen as natural extensions of their environment.

self-check-in kiosks have also helped our staff   to reduce their involvement with large and time-consuming activities, such as dealing with duplicate records,” said Jeri Pack, Director, Revenue Solutions, Baptist Health. “At our center, we have a high volume of duplicate medical records and duplicate corporate numbers. That’s a big deal for any facility like ours because a master patient index (MPI) cleanup can cost in excess of $1 million. Our kiosks require nowhere near that level of expense, and they do a wonderful job with these tasks.”

like seasoned jazz musicians, the consortium members brought together their individual talents and years of experience with a common mission in mind. They created opportunities for one another to display their talents to their audience, and they always understood that their whole team was greater than the sum of their parts. If these collaborative mindsets became more common practice in healthcare, I firmly believe we would experience many, many more success stories of innovative solutions to industry-wide problems. HMT

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that produces interior and exterior signage, kiosks and customer engagement solutions within a wide array of fi elds such as sports, academics, retail and government. Stone said, “When people are ill, or with their loved ones who are ill, they don’t want to be left wandering around a hospital lobby looking for help. We needed to make sure patients were drawn to the kiosk.”

Common sense tells us that in a hospital setting, patients will not automatically feel at ease approaching what may look like a black-box computer and a piece of scanning technology sitting on a table. Many would ask themselves, “Okay, am I supposed to go to that? What am I supposed to do?”

“We saw the level of customization and functionality that IMG offered to their clients; clients such as United Airlines and Delta,” said Stone. “We felt confi dent that they would be able to integrate the Posifl ex unit along with the Acuant scanner in a very attractive and eff ective fashion.”

The need for another company to join the consortium sprang forth when Clearwave began to ask the question: Is there tech-

technology available that would enable our kiosk to scan a patient’s driver’s license?

“We sought out and evaluated the most reliable vendors in the fi eld of optical character recognition (OCR). At the end of our search, it was clear that we ought to approach Acuant [formerly Card Scanning Solutions] as a partner,” said Stone. As a leading image-processing and OCR software company, Acuant has one of the best solutions in the market. “Within the healthcare environ-

mental ease. Practices can insert their logos and their facility’s color schemes so that the kiosks are seen as natural extensions of their environment.

In addition to the high ease of use for our patients, the self-check-in kiosks have also helped our staff   to reduce their involvement with large and time-consuming activities, such as dealing with duplicate records,” said Jeri Pack, Director, Revenue Solutions, Baptist Health. “At our center, we have a high volume of duplicate medical records and duplicate corporate numbers. That’s a big deal for any facility like ours because a master patient index (MPI) cleanup can cost in excess of $1 million. Our kiosks require nowhere near that level of expense, and they do a wonderful job with these tasks.”

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Building trust is key to HIE success

By Lee Barrett, Executive Director, Electronic Healthcare Network Accreditation Commission (EHNAC)

An August 2014 report1 by the Office of the National Coordinator for Health IT (ONC) found that in 2013, less than 40 percent of all physicians in the United States participated in some type of health information exchange (HIE). These numbers represent a significant jump in data exchange activity since 2008, thanks mostly to the Meaningful Use incentive program.

While HIEs have focused their efforts on helping providers meet the Meaningful Use objectives, there are still 74 percent, according to a Robert Wood Johnson Foundation (RWJF) survey2, who are struggling to develop a sustainable business model. The survey conducted by RWJF resulted in similar findings to the ONC report and was released in August 2013.

The struggles many HIEs are facing can be attributed to one overarching problem: They have failed to gain the trust of their would-be partners—and their patients. That trust includes an assurance that there is a business case for advanced data exchange beyond what is required for Meaningful Use and stakeholder confidence that HIEs are able to ensure data integrity, privacy and security, an issue that is often overlooked until there is an incident or a breach.

According to the ONC report, less than 14 percent of healthcare organizations exchange any type of data outside their own organizations. As a result, individuals reported gaps in their health information, including having to provide medical history to another provider because their records were not transferred and duplicating tests because the results were lost.

Because there’s no revenue generation in security and privacy, it’s often treated as an afterthought. To build solid data exchange infrastructures, organizations need to understand all that goes into assuring data security. It’s a fundamental component of the foundation that is paramount to building trust and gaining “buy-in” from both partnering providers and patients.

Creating value

Most healthcare organizations would agree transparency is important, but their business practices suggest otherwise, often unintentionally. For high-functioning HIEs, there are many “moving parts” and myriad federal guidelines and laws governing how they must operate. Add to that the criterion organizations must meet to qualify for federal incentive programs, and it all becomes too much for any one organization or technology vendor to fully stay on top of. A goal of EHNAC, the federally recognized, non-profit standards development organization, is to change the face of healthcare from one that is opaque to one that is transparent and accountable.

There’s also the issue of profitability. When HIEs, many of which are struggling to stay financially viable, are forced to prioritize, their focus has understandably been on profit-generating activities. Right now, that means maintaining a laser focus on Meaningful Use measures.

Third-party accreditation programs like the one developed by EHNAC support the needs of HIEs by helping them stay abreast of federal legislative mandates in healthcare, respond to developing trends, increase stakeholder trust and reduce risk of a breach or incident. Remaining profitable in this industry requires the acute awareness of best practices shaping the HIE landscape, a knowledge that can only be gained by the collaboration of many partners and industry experts—an asset many struggling HIEs don’t as yet have.

References

Interoperability Standards

HL7 launches Argonaut Project to advance FHIR interoperability standard

Health Level Seven International (HL7) has joined with major industry players to launch the Argonaut Project to accelerate the development and adoption of HL7’s Fast Healthcare Interoperability Resources (FHIR).

FHIR is a next-gen standards framework that leverages the latest Web standards and applies a tight focus on implementation. FHIR is a RESTful (representational state transfer) application programming interface (API), an approach based on modern Internet conventions and widely used in other industries. FHIR represents a significant advance in accessing and delivering data while offering enormous flexibility. For patients and providers, its versatility can be applied to mobile devices, Web-based applications, cloud communications and electronic health record (EHR) data sharing using modular components.

The purpose of the Argonaut Project is to rapidly develop a first-generation FHIR-based API and Core Data Services specification to enable expanded information sharing for EHRs and other health information technology based on Internet standards and architectural patterns and styles. Spring 2015 is the target date for the first FHIR profiles and implementation guides to be provided to the industry by the group.

Project members include: athenahealth, Beth Israel Deaconess Medical Center, Cerner, Epic, Intermountain Healthcare, Mayo Clinic, MEDITECH, McKesson, Partners HealthCare System, SMART at the Boston Children’s Hospital Informatics Program and The Advisory Board Co. The Massachusetts eHealth Collaborative will serve as project manager.

“FHIR is our best opportunity to accelerate interoperability,” says HIT Standards Committee Co-Chair and CIO of Beth Israel Deaconess Medical Center John Halamka, M.D. “We have an unprecedented opportunity to apply additional resources and focus, producing a simple, consensus-based implementation guide for query/response transactions in healthcare using the same type of technologies that Facebook, Google and Amazon have already implemented at scale.”

HL7 is a non-profit, ANSI-accredited standards development organization with affiliates established in more than 30 countries. Source: HL7

February 2015
Access patient records longitudinally

Capella Healthcare of Franklin, TN, is on its way to creating easy-to-access longitudinal patient records. The organization, which includes 13 acute care and specialty hospital facilities across six states, is leveraging Clinical Connectivity solutions from RelayHealth to consolidate clinical information from a wide array of disparate EHR systems, enabling data exchange across the healthcare enterprise. With RelayHealth, Capella Healthcare is now working to acquire and aggregate information from a variety of information systems into one view, making it possible for clinicians to access comprehensive patient information in a single place. RelayHealth

www.rsleads.com/502ht-181

Get seamless provider-to-patient portal exchange

Kodak alaris

For healthcare providers, making patient information available via a portal within four days of treatment is an important part of Meaningful Use 2 (MU2) compliance. Kodak Alaris has partnered with Access My Records (AMR) and Inofile to create a comprehensive HIE solution between physicians, care providers and patients. The solution solves workflow challenges and enables secure, standards-based patient information exchange, contributing to HIPAA compliance. It also provides a method to replace faxing with the addition of document scanners from Kodak Alaris and Kno2 software from Inofile. Doctors can easily Direct Message unstructured and structured patient information as a Continuity of Care Document (CCD) or Clinical Document Architecture (CDA) to the AMR Patient Portal, whether they are using an EHR system, a paper-based system or a hybrid system. Data from multiple facilities or practices is automatically organized into the AMR Patient Portal. This gives patients a complete view of their detailed health information from participating physicians, service care providers and other sources within an organized, search-friendly platform. Kodak Alaris

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Interoperability for the lab and beyond

Consolidation of providers and diffusion of testing create networks of care providers that must be able to share information to effectively coordinate patient care. Sunquest partners with other vendors to find connectivity and interoperability solutions that meet the needs of the Affordable Care Act and participate actively in building the infrastructure to support health information exchanges (HIEs) and regional health information organizations (RHIOs) and comply with Meaningful Use criteria. Sunquest aims to deliver a seamless, reliable method for data exchange among all entities within healthcare organizations. Sunquest

www.rsleads.com/502ht-183

Homeland Security implements eClinicalWorks

The U.S. Department of Homeland Security has gone live using eClinicalWorks’ Cloud-based EHR system for up to 1,000 of its medical professionals to help manage care at all 23 U.S. Immigration and Customs Enforcement (ICE) detention facilities. Using eClinicalWorks allows the department to create a complete, longitudinal record and share data between facilities. Integration with its current systems, including laboratory, radiology and pharmacy, will extend the benefits of this solution. The ClinicalWorks system is a key part of Harris Corporation’s solution to deliver integrated medical records, patient tracking and shared information throughout the ICE Health Service Corps. ClinicalWorks

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Patient Information Access

Portals need provider promotion for success

Americans may be more open to getting their health information online than you think—with a little extra help from their doctors.

The results from the 5th annual Xerox survey on usage of electronic health records found that many Americans are open to getting medical records online if they are given instruction on how to obtain access by their medical providers.

This information may prove especially valuable to providers, who can earn Meaningful Use (MU) Stage 2 federal incentives if they demonstrate that 5 percent of patients are using secure portals to view, download and transmit their health information.

The Harris Poll survey, conducted in September 2014 among 2,017 U.S. adults, found that a majority of Americans (64 percent) do not currently use online patient portals, but more than half of those who don’t use them (57 percent) say they would be much more interested and proactive in their personal healthcare if they had online access to their medical records.

Interestingly, while security remains a concern, the survey found that many people are simply unaware of patient portals. Among those who do not use patient portals, 35 percent did not know a portal was available, and 31 percent said their physician had never spoken to them about portals. Among Americans who do use online patient portals, 59 percent say they have been much more interested and proactive in their personal healthcare since they received access.

Survey results suggest that healthcare providers could make strides toward meeting MU Stage 2 requirements and improving care by focusing specifically on the portal needs of millennials (ages 18 to 34 in this survey) and baby boomers (ages 55+ in this survey). Millennials report the highest preference in accessing patient portals on the go, while baby boomers, with their rising need for care, are ripe for provider engagement. Boomers accounted for the highest percentage (83 percent) of Americans who say they already do or would communicate with healthcare providers via a patient portal.
Stage 2 was no failure

The case for a shorter Meaningful Use reporting period.

By Naomi Levinthal

The electronic health record (EHR) incentive program’s (i.e., Meaningful Use [MU]) headlines of late are mostly negative. One could conclude from these stories that Stage 2 is a total failure, but based on data from current attestations, past trends and College of Healthcare Information Management Executives (CHIME) survey data, we project that 95 percent of eligible hospitals (EHs) may eventually attest to Stage 2. Industry groups should use this data to encourage the Centers for Medicare & Medicaid Services (CMS) to offer shortened reporting periods in 2015.

65 percent of eligible hospitals already attested with several weeks to go

Some analyses of attestation data conclude that only a third of EHs demonstrated MU in 2014, but the number is much higher when we account for the fact that MU requires a step-wise journey through each stage. A total of 2,563 EHs were slated to attest to Stage 2, and in early December the CMS data shows that 1,681 did so (or 65.6 percent) – with several weeks still remaining in the reporting window. Eligible professionals (EPs) have until February 28, 2015, to attest, thus it is premature to draw conclusive insights. In fact, it is difficult to draw conclusions about MU trends until the final months of any reporting year because most providers wait until the final days to attest. The 2014 EH Stage 2 trends support this, as the cumulative month-by-month attestation count was: 10 in July, 143 in August, 840 in November, and 1,681 in early December (the reporting window closed December 31).

Furthermore, 2014 was not a year to test the true viability of Stage 2 because CMS changed the reporting options available. In September, CMS acknowledged how difficult it had been for providers to obtain the required upgrades needed in 2014. They finalized a policy that allowed those who experienced these delayed upgrades or were unable to fully implement the upgrade a way to essentially “roll back the clocks” and report on different sets of measures and objectives. For example, an EH scheduled to meet Stage 2 in 2014 could report Stage 1 measures alternatively. A CHIME survey estimated that about one-third of EHs scheduled to meet Stage 2 would use the alternate reporting options this year. If that estimate holds true, together with current attestation volume more than 95 percent of EHs would have demonstrated MU in a year when it appeared near impossible to do so.

Shortened reporting periods supported by data

CHIME and others call for a shortened MU reporting period in 2015. Our experience guiding Advisory Board members with their attestations shows that providers do best when they are able to choose from more than one reporting period. We find that the shorter 2014 reporting period allowed providers to shift their plans as necessary. For example, many of our members at the outset of federal fiscal year (FFY) 2014 planned to monitor performance for the second or third reporting quarter. Most, if not all, of our members had to move those plans back to either the third or last quarter. A longer than three-month reporting quarter in 2014 would have most likely derailed their entire MU effort.

Detailed attestation data from The Office of the National Coordinator for Health Information Technology (ONC) provide another data source that complements the need for shorter reporting periods in 2015. This data shows that providers are only just meeting the required thresholds. CMS could choose to shorten reporting periods on this fact alone. Those that have met the demands of Stage 2 make it with much smaller volumes of patients included in these measures’ denominators (which are based on numbers of patients seen or admitted/discharged during a set period of time).

A close examination of the information shows that when the final attestations are in for Stage 2, it will not likely be a failure. However, the facts also show that this success is, to a large degree, due to a shorter reporting period. Those supporting the Flex-IT Act can use these details to make the case that a shorter reporting period is required to make the future stages of MU successful as well.
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