Health Management Technology
JULY 2015
The Source for Healthcare Information Systems Solutions
www.HealthMgtTech.com

Smother workflows
Achieve the Triple Aim
Safety checks
Evidence-based medicine

DECISION SUPPORT AT WORK

ICD-10 countdown
Digitize your documents
Reducing readmissions
Combat security breaches

Thought Leaders
Jay Sultan, Principal Strategy Advisor Edifecs
Finding the path toward fee-for-value
Allscripts EHR and Revenue Cycle solutions connect people, places and insights by integrating clinical and financial data across all care settings. This delivers a complete view of a patient’s health that follows them through each stage of care. The Power of Healthy, Connected Communities. That’s the Power of Allscripts.
www.allscripts.com/HMT
CONTENTS

::: SECURITY
14 | Protecting health data in a troubling time
   By Ron Ropp, Chief Technology and Security Officer, and Becky Quammen, CEO, Quammen Health Care Consultants

::: EXPERT Q&A: ACOS
12 | The era of accountable care
   By Chad Michael Van Alstin, Features Editor

::: CASE STUDY: DOCUMENT MANAGEMENT
20 | Document imaging helps providers digitize patient records
   By Mike O’Leary, CEO, Ambir Technologies
21 | With patient portals, doctors win too
   By Dr. Jeff Drasnin, M.D., President, ESD Pediatric Group

::: COMPLIANCE: EMRs/EHRs
16 | Ensuring EHR compliance for Meaningful Use
   By Faisal Mushtaq, President, Payer/Life Sciences Business Unit, Allscripts
18 | Where compliance meets opportunity
   By Greg Fulton, Industry & Government Affairs Team Member, Greenway Health

::: THINK TANK
6 | Decision support at work
   By Rick Dana Barlow, Editor-at-large

10 | Coding countdown continues
   By Rick Dana Barlow, Editor-at-large

COLUMNS
2 | Viewpoint
   Cool new tech may yet deliver value-based models
   By Chad Michael Van Alstin, Features Editor

24 | Thought Leaders
   Finding the path toward fee-for-value
   By Jay Sultan, Principal Strategy Advisor, Edifecs

DEPARTMENTS
4 | Industry Watch
   - Coming to an Apple Watch near you
   - CHIME: Stage 3 plans ‘unworkable’
   - Millennials pegged as corporate data security risks
   - Truven names top 15 health systems
   - Is ICD-10 bad for the ER?

22 | Solutions Guide
   Reducing Readmissions With Analytics
Cool new tech may yet deliver value-based models

Every Day at the Health Management Technology office I am subjected to an endless stream of email. As I slog through the merger announcements, glorified product ads, and interview requests, I notice a telling trend with how many of those promoting the healthcare industry view their priorities.

For every email that speaks of lives saved by some new product, there are at least a dozen others that proudly boast cash savings, leaving patient outcomes to seem like some ancillary benefit – you know, just in case any of us “touchy-feeley” people happen to be reading.

Before you think I’m about to ramble on like the late Andy Rooney, I promise my anecdote ends there. All the same, this observation is interesting to consider as we step deeper into the era of the Affordable Care Act, one that seems to promise better measures of patient outcomes and the switch to healthcare models where revenue is generated by getting results, not merely for rendering services.

And that’s exactly what the accountable care model of healthcare services is supposed to do – it puts the burden on providers to actually produce healthier people. If a provider wants to maximize the amount of money they take in, they need to keep patients out of hospital rooms and actually fix whatever is ailing them.

Admittedly, this isn’t working quite as intended – partially due to bureaucratic red tape that measures process more than outcome – but at least it’s a step in the right direction. For an industry that is specifically tasked with keeping a populace healthy, it seems rational to have counter-forces to profits in place to encourage providers to show actual results if they want to make the most money.

Accountable care programs are one way to do this, while the jury is busy deliberating their effectiveness, we could look elsewhere for answers. If the primary goal is to have a world with more healthy people (some depressing numbers are saying we have fewer), and to reduce costs to make them affordable, it’s technology that may hold the answer.

Visionaries are putting power in the hands of the patients themselves – the power to monitor their health, to diagnose, prevent, and even treat a myriad of conditions. Telehealth is opening a door for treatment to happen from your home, to power to monitor their health, to diagnose, prevent, and even treat a myriad of conditions. Telehealth is opening a door for treatment to happen from your home and he can fix my problem, why on earth would I ever need to rack up an expensive hospital bill ever again?

Inevitably, it seems outcome-based care is coming, and just maybe it’s telehealth and mobile health that will lead the way. While accountable care models may not presently make business sense across the board from a bottom line, which is one of those necessary counter-forces that will encourage innovations and mobile apps as serious competition that threatens their revenue is generated by getting results, not merely for rendering services.

Moreso than accountable care programs, healthcare technology is in its infancy. Every year we are seeing new ideas that make last year’s breakthrough seem obsolete. Granted, it’s still idealistic to imagine a world where people keep healthy entirely by tech, but we are moving in that direction. The technology is already to a point where providers should see telehealth innovations and mobile apps as serious competition that threatens their bottom line, which is one of those necessary counter-forces that will encourage better results. If I can see a doctor virtually from my home and he can fix my problem, why on earth would I ever need to rack up an expensive hospital bill ever again?

EXECUTIVE EDITOR/PUBLISHER

Kristine Russell
krussell@healthmgttech.com
(941) 388-7050 ext. 104

EDITORIAL

Features Editor, Chad Michael Van Alstin
(941) 388-7050 ext. 124, cvanalstin@npcomm.com
Associate Editor, Mike Foley
(941) 388-7050 ext. 114, mfoley@npcomm.com
Editor-at-large, Rick Dana Barlow
rdbarlow@npcomm.com

PRODUCTION

Graphic Artists, Guy Vilt & Emily Baatz

ADVERTISING SALES

East Coast: Gregg Willinger
(914) 589-0545, gwillinger@healthmgttech.com
Pacific Coast & AZ: Lora Harrell
(941) 328-2707, lharrell@healthmgttech.com
Midwest: Donna Boatman-Riley
(815) 393-4624, dbotman@healthmgttech.com

SERVICES

Single Back Issues/Subscriptions:
subscriptions@npcomm.com
Reprints: Deborah Beebe
(941) 388-7050 ext. 122, dbeebe@npcomm.com
List Rental/Ad Contracts Manager: Laura Moultou
lmoulton@npcomm.com
AdTraffic Manager: Kathleen Shook
kshook@npcomm.com
eProduct Coordinator: Mary Haberstroh
mhaberstroh@npcomm.com
Managing Director: James Russell

EDITORIAL ADVISORY BOARD

John D. Halakama, M.D., M.S.
- CIO, CareGroup Healthcare System, Harvard Medical School, Chair of HTSP
C. Martin Harris, M.D.
- CIO, Cleveland Clinic
Jonathan Teich, M.D.
- CMIO, Elsevier
Chrisy Yemada
- Senior VP CFO, Evergreen Health
Pamela Shed, RN
- Clinical Systems Manager, Springhill Medical Center
David Miller
- CSO, Covisint
ANY HOSPITAL CAN SEE THROUGH PATIENTS. OURS CAN SEE THROUGH WALLS.

When we work as one, leaders have the insight to achieve their vision. work as one
Secure Communications

Coming to an Apple Watch near you

If you’ve been wondering what exactly you can do with an Apple Watch in healthcare besides tell time (and look cool), the wait is over. The first integrated and secure communications apps are making their debuts – just in time for the device’s broadening availability set for late June.

Coming this summer, the Vocera app for Apple Watch will allow users to manage critical communications by viewing and responding to prioritized calls, alerts, and messages from other care team members, EHRs, and clinical systems, including critical lab values and STAT orders. Users will be able to manage key communication functions by setting their availability to enable proper message routing. Panic calls in “man-down” emergency situations can also be initiated right from the wrist.

The Spok Mobile secure texting app is also getting in on the act. Currently used by numerous hospitals, this app gives smartphone and tablet users quick access to their organization’s directory, allowing staff to communicate securely through encrypted text, image, and video messages. In addition, the app can receive alerts from patient care, nurse call, and other monitoring systems to speed response to critical situations. For now, Apple Watch wearers will be able to receive Spok Mobile message notifications when they have new messages without having to access their iPhone. Additional capabilities are planned to be rolled out in the near future, which should be an exciting development given that Spok currently offers very strong integration with a number of Android wearables that have been on the market, such as Android Wear and Samsung Gear devices.

Meaningful Use

CHIME: Stage 3 plans ‘unworkable’

In official comments dated May 27, 2015, and submitted to the Centers for Medicare & Medicaid Services (CMS), the College of Healthcare Information Management Executives (CHIME) called federal plans for the third stage of Meaningful Use too ambitious and in need of several important changes. However, the professional organization of healthcare CIOs and senior IT executives did voice overwhelming support for a CMS proposal that would shorten Meaningful Use reporting in 2015 from a full year to any continuous 90-day period.

While recognizing the agency’s effort to streamline program participation through a reduced number of objectives and harmonized reporting periods, CHIME deemed the sum total of proposals for Stage 3 of the EHR Incentive Program “unworkable.”

“We were all requirements finalized as proposed, we doubt many providers could participate in 2018 successfully,” CHIME wrote. “And with so few providers having demonstrated Stage 2 capabilities, we question the underlying feasibility of many requirements and question the logic of building on deficient measures.”

CHIME urged CMS to make several changes to the proposed rule for Stage 3, including:

- **A 90-day reporting period for the first year of Stage 3 compliance, at least for payment adjustment purposes;**
- **Modify requirements for, and retain the 90-day reporting period for, providers attesting to Meaningful Use requirements for the first time, whether in a Medicare or Medicaid context;**
- **Eliminate patient action thresholds for the care coordination objective;**
- **Reduce the number of required measures in multi-measure objectives, health information exchange, and care coordination;**
- **Create hardship exceptions for providers switching vendors;**
- **Allow providers to take a 90-day reprieve during any program year for upgrades, planned downtime, bug fixes related to new technology, or optimizing the use of new technology within new workflows; and**
- **Allow, in limited circumstances, paper-based means to achieve measure thresholds.**

Patient action requirements related to care coordination and “unrealistic” thresholds for health information exchange requirements were of particular concern for CHIME. Additionally, the organization said it was troubled over the requirement that all providers must attest to Meaningful Use Stage 3 by 2018, regardless of prior participation and experience with the program.

Read the full text of the CHIME comments at chimcentral.org. Source: CHIME
Analytics

Truven names top 15 health systems

What does it take to be one of America’s 15 Top Health Systems? According to Truven Analytics’ seventh annual study, “winning health systems achieve higher survival rates and fewer errors at a lower overall treatment cost.”

The Truven study analyzed data from 340 health systems and 2,812 member hospitals to identify 15 hospital systems that achieved superior performance based on a composite score of nine measures of care quality, patient perception of care, cost per episode of illness, and operational efficiency. The study relied on public data from the 2012 and 2013 Medicare Provider Analysis and Review (MedPAR) data and the CMS Hospital Compare datasets.

Specific winning health system performance metrics include:

• Lower cost per episode: The winning 15 top health systems spent 7 percent less per care episode than non-winning peer systems.
• Better survival rates: The winning systems experienced 1.2 percent fewer deaths than non-winning peer systems.
• Fewer complications: Patients of the winning health systems had 5 percent fewer complications.
• Better patient safety and core measures adherence: The top health systems had 10.9 percent better patient safety performance and better adherence to core measures of care than their peers.

The study divides the top health systems into three comparison groups based on total operating expense of the member hospitals. The 2015 winners are:

• Large Health Systems (more than $1.5 billion in total operating expense): Allina Health, Minneapolis, MN; Mayo Foundation, Rochester, MN; OhioHealth, Columbus, OH; Spectrum Health, Grand Rapids, MI; and St. Vincent Health, Indianapolis, IN.
• Medium Health Systems ($750 million to $1.5 billion in total operating expense): Alegent Creighton Health, Omaha, NE; Exempla Healthcare, Denver CO; Mercy Health Southwest Ohio Region, Cincinnati, OH; Mission Health, Asheville, NC; and St. Luke’s Health System, Boise, ID.
• Small Health Systems (less than $750 million in total operating expense): Asante, Medford, OR; Maury Regional Healthcare System, Columbia, TN; Roper St. Francis Healthcare, Charleston, SC; Saint Joseph Regional Health System, Mishawaka, IN; and Tanner Health System, Carrollton, GA.

Truven Health introduced new performance measures this year that may be used in future studies, including emergency department (ED) efficiency, 30-day readmission rates for chronic obstructive pulmonary disease (COPD) and stroke, operating margin, and long-term debt-to-capitalization ratio.

Learn more about the study at truvenhealth.com.

Mobile Tech

Millennials pegged as corporate data security risks

They’ve been called “millennials,” “Gen Y,” and even “echo boomers,” but now workers ages 18 to 34 have a new label: highest mobile data security risks.

Results from the new Absolute Software Mobile Device Security Report of connected employees demonstrate clear differences in generational behavior and associated risks related to data security. When it comes to working millennials vs. baby boomers (ages 55+):

• Sixty-four percent of millennials use their employer-owned device for personal use, as opposed to 37 percent of boomers.
• Thirty-five percent of millennials modify their default settings, compared to 8 percent of boomers.
• Twenty-seven percent of millennials access “Not Safe For Work” content, compared with only 5 percent of boomers.
• Twenty-five percent of millennials believe they compromise IT security, compared with only 5 percent of boomers.

Interestingly, amongst the whole sample, 50 percent of respondents say that security is not their responsibility, while 36 percent named IT as being responsible.

The survey, conducted online earlier this year among 762 U.S. adults who use an employer-owned mobile device and work for a company with 50 employees or more, concludes there is more that can be done to modify behavior and educate employees about workplace data security.

Read the full study findings at absolute.com.

Claims & Coding

Is ICD-10 bad for the ER?

Nearly one-quarter of all emergency room (ER) clinical encounters could pose ICD-10 coding difficulties, according to a new study from the University of Illinois at Chicago (UIC). In the study, the UIC researchers looked specifically at the codes used most often by ER physicians to see where problems may arise.

The results, published in the May 2015 issue of American Journal of Emergency Medicine, found that 27 percent of the 1,830 commonly used ER ICD-9 codes had convoluted mappings that could create problems with reporting or reimbursement.

When the researchers looked at more than 24,000 actual clinical encounters in the ER, 23 percent could be assigned incorrect codes if the recommendations from the Centers for Medicare & Medicaid Services (CMS) were followed.

“Despite the wide availability of information and mapping tools, some of the challenges we face are not well understood,” says Dr. Andrew Boyd, Assistant Professor of Biomedical and Health Information Sciences at UIC and principal investigator on the study.

During the past two years, UIC researchers have extensively reviewed how ICD-9 codes map to ICD-10 codes, not only for emergency medicine, but for other problem areas, including pediatrics, patient safety reporting, and long-term research. Some ICD-9 indicator codes translate well, but many have convoluted mappings – and some simply don’t map at all.

Truven Health introduced new performance measures this year that may be used in future studies, including emergency department (ED) efficiency, 30-day readmission rates for chronic obstructive pulmonary disease (COPD) and stroke, operating margin, and long-term debt-to-capitalization ratio.

Learn more about the study at truvenhealth.com.

Source: University of Illinois at Chicago
Decision support at work

Information technology helps to drive workflow improvement.

By Rick Dana Barlow, Editor-at-large

Decision support capabilities operate much like an electronic advisory board or planning committee, minus the circuitous debates and discussions, distracting smartphone use, and other thoughtless interruptions that break concentration.

Theoretically, they occupy less physical space even though they may be more accessible in a smaller footprint, courtesy of, say, cloud computing and wireless benefits.

Still, decision support tools can be nebulously defined or even taken for granted, both at a provider’s own peril.

“Properly implemented decision support drives best practices and clinical workflow across the entire continuum of care, a particular concern for poly-chronic patients with multiple physicians, often working in separate independent systems,” says Larry Schor, Senior Vice President, Medecision. “Decision support ensures timely attention to patient needs in the right clinical setting at the lowest total cost. In other words, it is a key to achieving the goals of the Triple Aim – patients care about safety, quality, and cost. Data-driven decision support and clinical workflow are essential components to performance consistency, medication management, avoiding the cost and risks of unneeded tests or treatments.”

These tools can function like a prototypical app or search engine, according to Sarah Corley, M.D., FACP, Chief Medical Officer, NextGen Healthcare.

“Decision support can help the physicians by making sure they do not miss guideline-based care, order appropriate tests and medications,” she says. “It improves efficiency by allowing other care team members to provide protocol-based services. It provides peace of mind to physicians and enhanced safety to patients by checking drug and allergy interactions rather than depending upon physician memory. It can help the patient by assuring they are getting the latest evidence-based care. It helps reduce costs to patients and callbacks to doctors by showing formulary information at the point of prescribing.”

But Corley issues a word of caution about relying too much on it. “There has to be a balance, however, to limit decision support to the most important areas, so that too many alerts are avoided that might hinder productivity or annoy patients,” she says.

“Failed decision support and interoperability tools have lessened the industry’s enthusiasm for what effective decision support can actually do, which is save lives and money, while making the clinicians job easier,” says Eyal Ephrat, M.D., CEO, medCPU. “But we can’t give up. As a former aviator, I often imagine what it would be like if the pilot settled for only seeing 30 percent of the data from the cockpit. There’s a huge gap between the technological assistance pilots receive and the decision support assistance clinicians receive at the point of care. But the new generation of decision support technology is closing that gap. Proof that it can work is what will ultimately ensure it is given high priority within healthcare organizations.”

Nilo Meharabian, Assistant Vice President, Product Management, McKesson Health Solutions, offers a more holistic perspective on the contributions decision support tools make.

“Automated decision support helps both payers and providers ensure high-quality, appropriate care is delivered, based on the latest medical evidence,” Meharabian says. “It allows clinicians and payers to quickly access the evidence-based medical criteria they need to help determine the appropriate care based on a patient’s presented condition.”

Decision support can impact patient satisfaction, she continues. “Providing appropriate evidence-based care and avoiding unnecessary, and possibly risky, care are what any patient seeks,” she says. “By bringing decision support in at the right time in the care continuum,
which is at the point of decision, we can influence care quality. This is the crucial stage when the physician is determining what care should be provided. Decision management criteria can then be applied throughout a patient’s treatment to measure progress and determine clinically appropriate next steps based on their individual progress.”

Authorization processes can benefit, too. “A patient can know if the authorization was approved before the care is administered,” Mehababian says. “Decision support can also be used for network steerage to help guide the patient to the appropriate physician or facility to get the care or procedure they need.

“In the end, automated decision support can have a substantial value-based impact in several areas,” she adds. “It gives patients transparency into authorization and provider selection – potentially speeding authorizations and start of treatment in the process – and it provides appropriate care guidelines ensuring quality care and reduces unnecessary costs.”

Clinical workflow

Susan Niemeier, R.N., Chief Nursing Officer, CapsuleTech, cites the Centers for Medicare & Medicaid Services’ definition of clinical decision support (CDS) as “a tool to assist care team members in making timely, informed, and high-quality decisions.”

“CDS is not simply an alert or notification,” she says. “CDS provides evidenced-based guidance to the clinician at the right points in workflow to make optimal decisions. Decision support complements and simplifies clinical workflow with the objective of improving patient care delivery that may lead to better outcomes and improved patient satisfaction.”

Certainly, clinical decision support potentially can enhance the interaction between patients and physicians by providing trusted information, according to Thomas Van Gilder, M.D., Chief Medical Officer and Vice President, Informatics and Analytics, Transcend Insights, a wholly owned subsidiary of Humana. “To do this, it’s important that CDS tools provide the kind of information physicians and care team members need to better care for patients and maintain workflow. Poorly executed CDS interrupts workflow, takes the physician’s thoughts and eyes off of patient care, and decreases physician and patient satisfaction,” he says. Transcend Insights was formed in March by the mergers of Certify Data Systems, Anvita Health, and nliven systems.

Mehababian ties decision support to healthcare reform. “By integrating into a provider’s workflow, practitioners achieve a level of efficiency that lends itself to successful value-based care,” she says, “where providing the right care, at the right level, and in the right place is paramount. For example, you don’t want someone being admitted to the hospital or undergoing a procedure when the medical evidence indicates it is not needed. In fact, research has shown that patient care varies from the evidence in over 45 percent of cases, and up to a third of procedures are unnecessary.”

Kathleen Aller, Director of Business Development for HealthShare, InterSystems, warns about separating clinical decision support from clinical workflow. “Well-designed workflow should inherently support good clinical decision making,” she says. “This includes the way information is presented, reference materials, alerts, logic, and the like, all continued on page 9

Have you gotten lost in the healthcare information technology forest? Want to get back on the right path?

With so much emphasis on implementing information technology, you, like many other C-level executives, just might have lost sight of why you started on this journey in the first place — to more strategically operate your healthcare enterprise — bringing about improved clinical care, enhanced patient experiences and reduced costs. And, you just might be encountering some Big Bad Wolf-like dangers as you continue to veer off course. Scary stuff, indeed.

Quammen can help get you on the right path to running your healthcare organization with purpose, while leveraging technologies, such as advanced analytics, to move you forward.

Create your happily-ever-after with Quammen.

407.539.2055 | quammengroup.com
ICD-10, data security distracting from decision support, interoperability?

By Rick Dana Barlow, Editor-at-large

As healthcare organizations concentrate on ICD-10 conversions and data and system security issues, what’s happening with decision support and interoperability concerns? Are they taking a back seat? How do healthcare organizations keep these on the front burners, too? Health Management Technology asks a panel of IT experts for their insights on how to ensure decision support and interoperability maintain a high-priority level.

“It’s easy to get lost in ‘initiatives de jour,’ or projects of the day, month, or year. However, we must place the lives of patients as the reason why decision support and interoperability take precedent. The first step is to set explicit goals and engage with healthcare organizations, partners, and experts to build an infrastructure of evidence-based steps – perhaps even focusing on preventing harms and avoidable deaths. Don Berwick, M.D., said it nicely when he challenged U.S. hospitals to reaching the bold goal in the Institute for Healthcare Improvement’s 100 Million Healthier Lives campaign: ‘Some is not a number; soon is not a time.’ Dr. Berwick’s message relates today as we consider ways to raise the priority level of decision support and interoperability efforts.”

– Susan Niemeier, R.N., BSN, MHA, Chief Nursing Officer, CapsuleTech

“Hospital IT departments face great challenges in the next few years, and we are at risk of stagnating on the interoperability issue. I think the greatest push for connecting data and developing decision support systems will come from the economic, quality, and efficiency gains required in the coming years. There is no question value-based reimbursement and the care delivery models such as medical homes will be dependent on data stored in various health databases.

“We are reaching limits for innovating on staffing and supplies costs. The only realistic area to push innovation is on the technology front. Most healthcare systems and practices will be unable to change EHR vendors due to the expense and disruption that result from such a decision. Even for those who are currently considering or have undergone a merger, most will realize the problems remain. Looking for an innovative way to address these needs and working to design systems that are able to expand to the unforeseen needs of the future will provide the competitive advantage and most importantly, address the needs of our patients in a cost-effective and acceptable manner.”

– Donald Volta, M.D., Department of Anesthesiology and Medical Director of the Main Operating Room at Aultman Hospital in Canton, OH

“It’s critical to focus on care and patient experience in order to bring decision support and interoperability issues to a higher level. Without interoperability or decision support that enhances the patient experience, the promises of health IT will not be realized. Interoperability and decision support are so important that to worry about downstream issues is putting the cart before the horse. Showing the impact that these tools have on patient outcomes would be the best way to raise these issues to a higher level. Until clinicians and patients are involved in the design process, the care transformation process will not be complete.”

– Thomas Van Gilder, M.D., Chief Medical Officer and Vice President, Informatics and Analytics, Transcend Insights

“All these things contribute to the clinical mission of care providers, but they also fit neatly into two major buckets: remaining financially viable and avoiding legal exposure. We need to make sure people understand them all that way. Navigating through the ICD-10 conversion is about making sure you can send a claim/bill and keep cash flowing. Likewise, interoperability-enabled information sharing and collaboration between partners is a critical success factor for shared-risk payment arrangements and for delivering better, safer – and less litigious – care. Similarly, data breaches are costly and lead to lawsuits. Decision support contributes to more timely interventions and to better outcomes for patients covered by shared-risk payment arrangements; both are important for financial health and avoiding legal exposure from patient safety issues.”

– Kathleen Aller, Director of Business Development for Health-Share, InterSystems

“ICD-10 is a great example of the criticality of strong decision support. Deferring on decision support will be a mistake, as the impact of the event is unpredictable, and will demand fast reactions to unfolding events regarding clinician, administration, and payer performance. We’re planning to broadly share real-time industry data during ICD-10 conversion to help drive decision support and increased transparency.”

– Jason Williams, Vice President, Business Analytics, Financial Solutions, McKesson RelayHealth Financial

“Regulatory mandates, such as ICD-10 or Meaningful Use, and risk management issues, such as data security, are priorities because failure to perform will result in significant financial repercussions. Decision support and interoperability become relevant priorities when investments in these functions can be clearly linked to the enterprise’s financial performance. As alternative payment models become a larger share of total revenue over the next few years, systems will prioritize consistency, quality performance, outcomes measure, and a commitment to the lowest total cost of care — requirements that HIE and decision support enable.

System leadership that can ‘see over the wall’ and recognize the strategic imperative of investing early, before fee-for-service margins get even lower, in technologies that will prepare the enterprise for value-based compensation will thrive.”

– Larry Schar, Senior Vice President, Medecision

“Vendor products have been ready for ICD-10 for several years now, and most providers have had ample opportunity to retrain their staff or move to a revenue cycle management service. So the main concern about the ICD-10 transition will be whether there are any delays in payment on the part of insurance companies not being ready to handle the codes. As we move into new payment models where physicians and hospitals are being paid for outcomes, we will see that the business case for decision support and interoperability is going to drive interest and resources to focus on more use of decision support and broader sharing of data. The market will support the business needs of clients, and payment reform will change the business case from counting coding points to supporting accountable care-based reimbursement.”

– Sarah Conley, M.D., FACP, Chief Medical Officer, NextGen Healthcare

“The best method is to leverage an existing infrastructure to achieve interoperability and open it with applications in support of decision support, independently from the infrastructure. Without this approach, healthcare would go back to do over and over the infrastructures to popular practices like ‘rip and replace.’ Rip and replace [approach] resets the health IT organization to ground zero, making it fall behind more in terms of providing clinical decision support to providers and not concentrating on other issues, such as ICD-10 and security.”

– Thanh Tran, CEO, Zoeticx
Reflective of the user’s scope of responsibility and all delivering information for timely intervention at the point of decision. In general, clinical decision support should contribute to positive outcomes, better opportunities for shared decision-making, and hence higher patient satisfaction, but there will rarely be an unambiguous cause-and-effect relationship between the two.”

Chris Hobson, M.D., Chief Medical Officer, Orion Health, concurs.

“Rather than affecting clinical workflow, decision support should fit with the clinician’s workflow,” Hobson says. “Clinical decision support should be designed to provide the right information, to the right person, in the right format, through the right channel, at the right time, such as when the information is needed most.”

Orion Health promotes clinical pathways and care management, terms that many commonly refer to as clinical workflow. “In this setting, we put a lot of effort into appropriate decision support for clinicians as they manage their patients across the care continuum according to structured care plans, alerts and notifications, intelligent task management, etc.,” he says.

“Patient satisfaction is improved to the extent that patients have safer and improved care at a lower cost, as well as avoidance of adverse drug events and other related issues,” he adds. “It is also possible to provide appropriate clinical decision support to patients directly, exposed through the patient portal or mobile device. As a company, we are investing in this area. We have a clear strategy and have already made concrete progress in delivering this type of capability to our customers.”

Decision support tools can improve the meaningful use of electronic health record systems, too, according to Donald Voltz, M.D., Department of Anesthesiology and Medical Director of the Main Operating Room at Aultman Hospital in Canton, OH.

“One of the problems with all of the current EHRs is a lack of decision support to do even low-level tasks, such as alerting to the completion of a lab result or the addition of a consultant’s opinion in the care of a patient,” Voltz says. “Using decision support to monitor the data coming into a patient’s digital health record and alerting the care team members of this status change would go far to enhance EHR functionality.

“If this is then coupled with an ability to view the newly added data and capture a physician’s interpretation of the data along with an intervention, we would begin to realize gains in efficiency. Without even this low-level decision support, physicians and other members of the care team are forced to search for new information.”

Voltz agrees that decision support can be useful as a patient engagement tool, “provided we give them the opportunity,” he says. Voltz is board certified in Informatics and is an Assistant Professor of Anesthesiology at Case Western Reserve University and Northeast Ohio Medical University.

“More efficient clinical workflow equates to fewer failures, which means better quality of care and improved patient satisfaction,” Ephrat says. “It’s worth noting that clinician satisfaction with decision support is also critical. They should be getting meaningful, accurate alerts in real time, at the point of care, without disrupting their workflow and, as we move into the next generation of decision support technology, clinicians will become more satisfied as well, as long as the technologies they are using meet these criteria.”

Have you gotten lost in the healthcare information technology forest? Want to get back on the right path?

In the real world, save-the-day heroes like the Woodman don’t always appear at the right place and at the right time.

You can, however, reach out to Quammen Health Care Consultants to get your healthcare organization out of the woods. With our focus on all things strategic, we can get you back on the path toward delivering improved clinical care and enhanced patient experiences — all while reducing costs. Contact Quammen today and see how we can work together to make sure your information systems are not just successfully implemented but strategically optimized to bring you real-world results.

Create your happily-ever-after with Quammen.
Coding countdown continues

ICD-10 strategies, tactics must ramp up for October launch.

By Rick Dana Barlow, Editor-at-large

The year-long delay for implementing the ICD-10 coding system placed the eager-and-willing organizations between the proverbial rock and a hard place, while enabling the wary (and those in denial) to procrastinate toward a last-minute, mad-dash scramble.

For those chomping at the bits and bytes to make the switch, the delay offered a mixed blessing in that they would have additional time to make process improvements, even as they trained their staff to learn the new codes while continuing with the current ones.

For those pining for the status quo and another delay, what occurs this October will represent a costly and disruptive wake-up call if another delay miraculously fails to happen.

Michael O’Rourke, Senior Vice President and CIO, Catholic Health Initiatives (CHI), Englewood, CO, encourages healthcare organizations to use the time effectively, even as the new deadline approaches.

“The additional time allows us to really put more focus, more quality, and more investment into the ICD-10 effort in preparation for clinical documentation and training physicians, clinicians, and coders so we are sure we have a good, quality outcome,” O’Rourke says. “Time is always a wonderful gift. For us, outside of the cost involved, it allows us to have a better outcome for ICD-10, and we will be better prepared. Will compensation be improved? That remains to be seen. ICD-10 allows us to be far more discrete about DRGs, processes, and procedures – and that is better for our patients and should be better for CHI.”

Barbara Waxenfelter, R.N., Senior Manager, Ernst & Young, agrees, noting that most organizations are looking at this as a chance to get it right.

“This delay has provided a perfect opportunity to analyze the output of dual coding and dual processing; to test more rigorously between payers, providers, and clearinghouses; and smooth out all of the kinks before the cutover,” she says. “Having been in the weeds with CMS’ general equivalence mappings, I have a healthy respect for the complexity of the new code set. Much of it lacks straightforward bi-directional mapping and presents huge challenges for reimbursement on both sides of the aisle. Payers, providers, and clearinghouses must commit to rigorous and enhanced end-to-end testing to facilitate a smooth transition and promote revenue neutrality.”

Much depends on how providers are using their time leading up to the October deadline, according to Ana Croxton, Vice President, Electronic Data Interchange (EDI) Products and Services, NextGen Healthcare.

“It can make a huge difference if the time is spent on how to properly code, or it can make little difference if they just kick the can down the road,” she says. “I think the industry is attempting to use the time for additional testing and education, and is encouraging providers to do the same thing.”

Healthcare providers can reap an “enormous opportunity” if they are using the time “wisely by dual coding and advanced medical record training with the coders, along with the deployment of a feedback loop with the physicians and administration,” says Angela Hickman, Senior Consultant, Culbert Healthcare Solutions. “Time and practice will make experts out of coders. What we put into it is directly proportional to what we will get out of it. There is much that will reveal itself in the wake of the extra time that will also allow for better mitigation and resolution prior to the implementation date.”

Working a plan

But providers must approach this transition in the right way to achieve the desired results, particularly when it comes to improvements in revenue cycle management, according to Karen England, Revenue Cycle Consultant, Ingenious Med.

“Look at the most frequently used diagnosis codes from ICD-9. Pull patient charts, and code to ICD-10. Focus on anything that results in an unspecified code. Is laterality missing? Is the type of diabetes documented? What about use of insulin? Is the patient’s condition acute or chronic? Addressing and emphasizing the need for this type of specificity will allow for speedier and more appropriate processing of claims and reimbursement,” England says. “In addition to working toward physician compensation, it is important to focus on timely reimbursement and compensation. Fewer denied claims result in lower AR days and increased efficiencies for coding and billing staff.”

Amy Amick, President, Revenue Cycle Management, MedAssets, concurs with a
strategy that concentrates on improving revenue cycle operations.

“At the time of the original deadline, 46 percent of healthcare leaders anticipated revenue loss from ICD-10 implementation,” she says. “That would be on top of already significantly shrinking operating margins.”

“We encourage providers to dedicate additional time to improving their overall revenue cycle processes – driving both sustainable impact today, and for the future under ICD-10. For example, taking advantage of the ICD-10 delay to deploy a clinical documentation improvement [CDI] program today yields more efficient billing and steady cash flow now. CDI has become a stalwart strategy for hospital finance departments to support their revenue cycle, but its importance is further amplified with ICD-10. You can expect payers to demand much more supporting documentation in cases of denial underpayments or audits. An effective CDI program requires both technology and people training – which, again, take time to achieve.”

Ray Desrochers, Executive Vice President, HealthEdge, says he foresees the additional specificity from ICD-10 coding as making a “tremendous difference as payers and providers ramp up care collaboration and risk-sharing.”

**Testing, testing**

Louis Hyman, Chief Technology Officer, SigmaCare, emphasizes the basics in stressing that “the additional time will make a meaningful difference in generating improved accuracy and efficiency in coding and billing.

“The ICD-10 code set is much more complex than ICD-9, and providers need to ensure they are knowledgeable on the new coding rules,” he says. “The extension also allows vendors to ensure their IT providers are also compliant with ICD-10 and coding information and be seamlessly exchanged with third parties.”

“What often gets overlooked is the need to improve documentation practices,” Hyman continues. “With the size and complexity of the codes, which include laterality and new manifestations, the need to capture accurate clinical data to facilitate accurate coding will be key to ensure seamless billing processes and avoid callback to providers for additional details.”

That’s why testing among integrated systems is paramount, according to Hyman. “Physicians must be able to document appropriately, but can the claims make it from the practice management system to the claims clearinghouse to the payer? Testing should not focus solely on getting a claim out the door,” she says. “ICD-10 encompasses a completely different format than ICD-9. Characters are different, alphanumeric formats are different, and the placeholders within ICD-10 are a new concept. Systems need to be able to differentiate between I and 1, 0 and O. The other primary thing to keep in mind is to catalog all systems needing testing. You don’t want to be reminded of that homegrown OR system on Oct. 2, 2015.”

Amick agrees that providers should be looking beyond the code changes and necessary education. “They should be pursuing revenue modeling and potential technology investments now,” she says. “These investments will only serve to prevent obstacles to staff productivity and cash flow down the road.”

Heather Haugen, CEO and Managing Director, The Breakaway Group, a Xerox company, says that based on client reports, the additional time isn’t necessarily helping facilities generate more efficiency, but prepare for more changes in the future.

“Our hope is that the delay will allow those organizations that haven’t been able to prepare for ICD-10 in the past due to lack of resources, to now concentrate on educating their staff and making system and operational changes as needed,” she says. “The real value in ICD-10 is, at its core, its ability to ensure better patient reporting across the organization, from check-in, physician visit, lab requests, discharge, etc. It’s also enabling healthcare organizations to get prepared for ICD-11.”

Regardless, the financial impact will be significant, according to Ben Quirk, CEO, Quirk Healthcare.

“Provider billing will be more expensive because of the level of specificity required,” he says. “I expect payers and Medicare to use the new data for further payment and quality tiering. And, of course, there will be glitches which will greatly increase AR days, so everyone needs to keep extra cash reserves on hand.”

“Ultimately, the providers who are on the ball with their preparation efforts will be the most successful, and those that didn’t start preparing yet will probably struggle more,” Laura Pazera, ICD-10 Program Manager, TriZetto Provider Solutions, says.

**So many moving parts**

Hickman emphasizes that ICD-10 implementation extends way beyond IT as a department and function and is more about “developing relationships with the whole spectrum of healthcare professionals” such that “the IT professionals will need to stretch outside of their comfort zone to get actively engaged with the users.”

Haugen agrees that integration is essential.

“ICD-10 is everyone’s responsibility,” she says. “It’s not just for the IT team. We always remind our clients how important it is to bring together leadership from all over the organization to become ICD-10 compliant. The IT team should understand this and support the effort to bring everyone to the table, including those physician champions who can build support for the changes needed.”

Don’t ignore business and clinical processes, Pazera says.

“We need to make sure that our IT teams are not working in a vacuum,” she says. “Since ICD codes are used for clinical documentation as well as billing, the transition also will impact business processes. One way providers can gauge the impact of ICD-10 is by performing testing to confirm that all their internal systems can accommodate the ICD-10 codes. They also should aim to conduct external testing with payers to confirm that they can accept and return the claims, and to identify any shifts in reimbursement that may occur due to the new expanded ICD-10 code set.”

**HMT**
The era of accountable care

Industry experts weigh-in on the status of ACOs.

By Chad Michael Van Alstin

The guiding principle behind accountable care organizations (ACOs) is a simple one: Coordinate health services to maximize efficiency and facilitate better patient outcomes. Providers would be paid for the results they produce, not simply for the care they provide.

Over the years, these coordinating groups of practices have gone by many names, but it wasn’t until the reforms of the Affordable Care Act that ACOs began to take their present form, focusing on meeting new patient satisfaction benchmarks and reducing the financial burden caused by patients receiving unnecessary services. While the hype for ACOs promised better care quality and increased revenue, the reality of ACO launches has seen mixed results. Health Management Technology asks two industry experts for their views on the present and future of the accountable care model, now that ACOs have become a reality.

Keegan Bailey, Vice President, Collaborative Care Strategy, Mirth

Q: The goal of any ACO is to lower costs while improving the quality of care. Most still seem to use the fee-for-service pay model, but the hope is that by better coordinating a patient’s care and avoiding unnecessary treatment, revenues would inevitably increase. In your opinion, why then are many providers seeing a reduction in profits after they adopt an accountable care model?

I think you answered the question. The reality is that this thing we call “value-based health,” or healthcare, is the end, and there is a transition where “value” is the measurement of outcomes that matter over true costs. If you sum all commercial and public payer reimbursement for a healthcare organization, there is a significant portion that is still fee-for-service. Granted, the rate at which value-like contracts are entering the business of healthcare is increasing – in particular in the last six to 12 months. As two examples, the federal government announced earlier this year the goal of tying 30 percent of Medicare payments to quality and value by 2016, and 50 percent of payments by 2018. The private sector followed with a similar commitment. Therefore, many organizations are faced with operating both value-based and fee-for-service contracts, and will be for some time.

The reimbursement models are also at odds with each other. Fee-for-service requires a focus on efficiency and volume, where value-based models require a significant investment in time and resources. However, the difference between an organization succeeding and failing at balancing the two models is proficiency in data and resource allocation [and] reallocation. It is not sufficient to focus just on outcomes or just on system efficiency – success is achieved through a commitment to both.

Q: For ACOs that are struggling, is there evidence that patients are, on average, at least receiving better care? Are patients more satisfied, and is that aspect of the Meaningful Use requirements being better demonstrated?

The jury is still out, and here is why: The definition of satisfaction and what “better care” means is evolving in the market. Traditionally, there are organizations like AHRQ (Agency for Healthcare Research and Quality) and NCQA (National Committee for Quality Assurance) that have created institutions around surveying patients and reporting the results to healthcare organizations. The same organizations promulgate quality measures that are intended to measure whether “better care” is delivered. Both the surveys and quality measures are present in both commercial and public ACO contracts and requirements, but they do not measure what they intend to measure.

By focusing on process components of the care, or derivative elements of satisfaction – i.e. whether an HbA1c test was performed and whether a provider shared the results with the patient – what actually matters to the patient is missed completely. A true outcome, like improved daily function and lifestyle if you are diabetic, is often overlooked. Whether patients are receiving bet-
ter care or not will be a difficult question to answer until true outcomes become a focus of most or all value-driven organizations in healthcare.

Q: We have seen mixed reports regarding the adoption of technology by ACO groups. Does having an organization made up of coordinating providers make it easier or more difficult for them to all be on the same page when it comes to adopting the latest tech?

An ACO is any value-driven organization that has cared enough to take a look inward and assess their business, rather than simply responding to external requirements and stimulus that have traditionally come from payers. These are advanced health systems – loosely defined – that could be hospital-centric, provider-centric, or another combination of stakeholders. Whichever organization is leading value-initiatives should spearhead the investment and adoption of significant infrastructure to connect their provider community.

Our experience is that technology implemented with the appropriate leadership, governance, and expertise – technology such as a centralized data repository, enterprise data warehouse, and care and chronic disease management tools – will succeed at enhancing care continuity and coordination within the health system and with its trading partners.

Q: In what ways can ACO regulations be improved to promote better care while also assuring practices aren’t bogged down in extra layers of bureaucracy?

Anecdotally, they have already, but there is a lot more work to be done. In December 2014, CMS published a Notice of Proposed Rulemaking governing CMS ACOs. Many industry comments that were received were an accumulation of experiences in the program over the last four-plus years, and urged CMS to enhance the program to promote better care and reduce red tape.

[Recently], CMS demonstrated their attentiveness to some of those comments by announcing the publishing of an ACO Final Rule in the Federal Register on Tuesday, June 9. Some provisions include: making the program more attractive to new contractors, a new Track 3 with higher rates of shared savings, and the opportunity to use new care-coordination tools, making it easier to access claims data. ... CMS estimates that the impact of these changes would provide an additional $240 million in program savings, bringing the total to $780 million.

---

Tom Merrill, Senior Analyst, Leavitt Partners

Q: For those ACOs that are seeing improvements on both the revenue side and patient care, is there a common trend in terms of the approach they’re taking?

Amongst ACO types, there may be shared approaches that are working, but probably not across the board. For example, hospitals are benefiting patients by helping them avoid unnecessary readmissions, but it’s hurting their revenue. When physician-only ACOs help patients avoid readmissions, they get to share in revenue that wouldn’t have been theirs prior to the ACO contract.

The approach that is leading to improvements on both sides are the groups that are able to take on full risk and benefit from lower-volume/lower-cost structure. ... Irrespective of revenue issues, most ACOs are building care-coordination teams usually comprised of nurses, PAs, and/or other lower-cost providers. Most are purchasing some sort of analytics solution that allows them to stratify their populations into the most needy and focus their efforts.

Q: Some have suggested that having one organization manage all the care of a patient is detrimental to the patients’ individual freedom by limiting choice. How do we avoid a situation where the adoption of ACOs doesn’t cause a serious market convergence?

I think you make it so the consumer is making an informed choice. No patient in their right mind would demand an all-inclusive network if it meant that the premium was unaffordable. If the payer/provider can demonstrate what a consumer will get under an affordable product, the market will respond.

Q: A lot of organizations that use the “accountable care” label are resisting the adoption of the more “official” MSSP (Medicare Shared Savings Program) model. Why do you think that is? After all, most ACOs have goals in-line with government requirements.

A few reasons. The government programs are very prescriptive and can represent a lot of work just to apply to a program like the MSSP, Pioneer, or Next Generation ACO program. Depending on the market, providers can demand a lot of flexibility in their contracts from their commercial payers. That’s not the case with Medicare. With the MSSP [and the rest of the government ACO programs], it’s either take it or leave it. The other reason is that commercial contracts are much more likely to have risk be optional, whereas CMS has the incentive to move ACOs to downside risk as soon as possible – although they just capitulated on that with the Final Rule.

Q: Is the future for ACOs a bright one?

I believe the future is bright for the ACO concept and those providers bold enough to jump in and push the market toward a more accountable system. Terms will fade or change, models will be modified, but the idea of paying providers for outcomes will not go away. Results so far have been modest, mostly because the restructuring has been modest. Greater distribution of risk will lead to larger restructuring in the way we provide care. That is when we will truly see results.
Protecting health data in a troubling time

Understand who and what you’re up against.

By Ron Ropp and Becky Quammen

“The methods that will most effectively minimize the ability of intruders to compromise information security are comprehensive user training and education. Enacting policies and procedures simply won’t suffice. Even with oversight, the policies and procedures may not be effective: My access to Motorola, Nokia, ATT, Sun depended upon the willingness of people to bypass policies and procedures that were in place for years before I compromised them successfully.”

— Kevin Mitnick, infamous convicted computer hacker, in a statement delivered to the Senate Committee on Homeland Security and Government Affairs in 2000, just six weeks after his release from prison.

His observation from Kevin Mitnick, a hacker who, according to his own testimony, has “gained access to some of the largest corporations on the planet, and … successfully penetrated some of the most resilient computer systems ever developed,” is one that healthcare leaders need to take to heart in quick order. Why? It looks as if healthcare organizations are losing the war on data protection to the bad guys, and therefore need to quickly find a way to turn things around.

Indeed, large-scale healthcare data breaches are becoming alarmingly commonplace, according to a research letter published in the April 14, 2015, issue of the Journal of the American Medical Association. In fact, from 2010 to 2013, nearly 1,000 large breaches affected more than 29 million individual health records, and more than half resulted from theft or loss of laptops, thumb drives, and paper records, according to the report, which is based on researchers’ evaluations of government data. The yearly number of breaches rose from 214 in 2010 to 236 in 2011, 234 in 2012, and 265 in 2013.

What’s even more disconcerting is the fact that hacking incidents more than doubled during those years, according to the U.S. Department of Health and Human Services database of breaches of unencrypted health information, which includes information reported by Health Insurance Portability and Accountability Act (HIPAA) covered entities.

“We found that as many as 30 million records were compromised in a four-year span,” said lead author Dr. Vincent Liu of the Kaiser Permanente Division of Research. “If each of these represented records from a unique patient, it could suggest that as many as one of every 11 American’s healthcare data has been compromised.”

So far, in 2015, large-scale data breaches have continued to plague the industry. Perhaps most notably, a breach at Anthem Health affected about 80 million people and is being described as the largest healthcare data breach ever. According to a news release from the healthcare payer, hackers “gained unauthorized access to Anthem’s IT system” and obtained personal information from current and former members, such as their names, birthdays, medical IDs/social security numbers, street addresses, email addresses, and employment information, including income data.

As a result, business leaders cannot assume that they are immune from cyberattacks and data breaches, and must start to think – and act – more strategically to protect their healthcare organizations’ data.

Reading their minds

To start, as a healthcare leader, you need to understand how the bad guys think and use that understanding to protect your organization. The “check the box” mentality of performing security assessments is no longer enough and can simply mask problems. Instead of just thinking of what security measures you can take, you need to form a proactive defense that takes into account the fact that these bad guys are likely to do the following:

• Walk through a parking lot and randomly check for unlocked car doors;
• Circle around a building and check dumpsters in an effort to find discarded paperwork;
• Walk in a delivery entrance and see how far they can get before being stopped;
• Peruse your websites and social media pages and download all the documents and videos for tidbits of information;
• Collate the names of your employees and providers so they can gather their schedules (and announced vacations on social media);
• Compile the names of all newborns born at your facility;
• Call and act like a provider or employee to have their password reset;
• Volunteer at your healthcare facility to gain access;
• Act (and dress) like a delivery service or vendor to gain access to your facility;
• Infect/sniff or capture wireless network traffic while sitting in the lobby or parking lot; and/or
• Hack the Facebook, Twitter, or other online accounts of your employees.

In essence, the enemies in these scenarios will look for the easy ways to gain access to data. More often than not, they won’t take the difficult road – breaking through your firewall or kicking in the front door. Instead, they will find the unlocked door, the un-configured Web application, the recently terminated employee account, the unprotected Web community outreach portal, the unintended information shared on social media, or data stored on commercial devices.
services—or, they will simply steal your laptop from the back seat of your car while you are grabbing lunch.

Unfortunately, healthcare organizations across the country figuratively leave the back window open on computer systems while barring the front door more often than most will admit. Remember, a misconfigured or incomplete system or application that is put into production without testing, or an unfinished project, or lack of change control on day-to-day operations are apt to leave your organization exposed.

Hackers are not going to announce their arrival and try to scale the walls on your systems. They are going to find the “hidden” employee entrance and let themselves in, get what they want, prop a few other windows and doors open, then let themselves back out without you ever knowing. Many times these exploits sit unnoticed. Having systems, processes, and software that are proactive rather than reactive is good, but everyone in your organization also needs to change their mindset by getting into the minds of the enemy—and thinking like a bad guy when protecting systems, software, and people.

It is especially imperative for you, as a healthcare leader, to have a mindset that considers things you might think as outlandish to protect your organization. You cannot stop every threat, but you can make sure you are not leaving yourself open to easy access. Thinking like the bad guy is a great way to start a data-protection initiative.

In parts two and three of this ongoing series, we will look at how you can build upon this philosophy and further protect data at your organization by understanding your own vulnerabilities and then creating a comprehensive strategic plan that will help to safeguard patient information. HMT
Ensuring EHR compliance for Meaningful Use

Electronic health record (EHR) systems are revolutionizing the collection and standardization of patient medical information. Healthcare practitioners now have patient information readily available, enabling more efficient and accurate care. However, there are still varying views on whether providers feel they are realizing the true value from EHR technology.

Organizations originally put EHRs in place to collect data, but the market has grown more sophisticated, and healthcare reform has shifted the way providers need to operate in a more value-based environment. This requires more than just data collection and is best served by an open, connected community solution – a solution that connects both clinical and financial insights across the entire care community. This type of construction connects all systems, regardless of location or vendor, and delivers a single view of the patient record.

While the market for EHRs is now mature, there is still movement. Some vendors have announced sunset plans due to the challenges of meeting Meaningful Use requirements, which has led to a relatively active replacement market. In addition to this, the healthcare industry is reviewing recent significant regulatory developments from the U.S. Department of Health & Human Services.

**Meaningful Use**

Meaningful Use sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs. Meaningful Use requirements intend to:

- Improve quality, safety, and efficiency;
- Reduce health disparities;
- Engage patients and family;
- Improve care coordination; and
- Maintain privacy and security of patient health information.

Elements within the U.S. Department of Health & Human Services proposals are still subject to change, but there are some considerable ideas to process in each of them. Here is a summary of the big three proposed rules from CMS and the Office of the National Coordinator for Health Information Technology (ONC):
CMS: Definitions of Meaningful Use – Changes to Stage 3

It is anticipated CMS will finalize this rule in August or September this year. Focusing heavily on interoperability, it provides the foundation to focus on quality and outcomes-based payment models. It proposes an option in 2017 of moving to Stage 2 or 3, with all participants moving to Stage 3 in 2018. Effectively, CMS would abolish stages at that point. All reporting periods also would become one calendar year.

ONC: Definitions of certifications – Facilitate interoperability

This proposed rule’s main purpose is to improve accessibility and exchange of data with a single certification program that serves several types of programs. Software certification would no longer be exclusively tied to Meaningful Use under the proposals. This means that certified systems would need to be able to provide functionality that is not only about what Meaningful Use participants are measured on but also that which is helpful to other advanced payment models, such as accountable care organization (ACO) models.

CMS: Meaningful Use modification rules for 2015-17

This rule affects the year 2015, as CMS is suggesting it will finalize the rule in July for the reporting periods. 2015 becomes a 90-day reporting period – no matter what stage or year you are in. Eligible hospitals would also move to a calendar year, which would give them three extra months this year.

Tips for regulatory success

In processing these three proposed rules, it’s important to understand what steps providers can take even while the government reviews and finalizes the rules. Smart providers know that preparation is the key to success when it comes to regulatory compliance. A few specific action items include:

1. Respond to the public comment. This goes for all proposed rulings and regulations, and it is in the best interest of providers to do so. This can be simply done at cms.gov; sending comments to the specified address set up under that respective project title. Public comments are highly valuable to the government, and it has been said that this type of comment is the most important they receive.

2. 2015 should be treated as a full year. It is important to not stop demonstrating successes even if the reporting period may only be 90 days. If you do stop trying to achieve these goals, only to return to them later, it’s like jumping off a moving bus and trying to jump back on. The reality is the modification rule is only proposed, so take it as if it is not changing until it’s finished.

3. Get started and never let up on the effort. Be vigilant with patient engagement; it takes time and dedicated effort to build success here.

4. Watch out for workflows involving paper. It’s a good idea for organizations to wean completely off paper-based processes. Remember that giving paper to patients and documenting electronically after the fact will not count.

5. Operate openly. Ensuring you work in an open and connected way with all of your peers will ultimately help you achieve a smoother working system.

6. Fully integrate processes and resources to ensure measurable accountability. To be successful with accountable care delivery models, providers must increasingly align with the health plans that serve their populations. Those who have highly integrated EHRs and practice management systems that allow for open collaboration with their health plans will benefit.

The benefits of achieving Meaningful Use

The proposed rule would reduce required reporting, enabling providers to focus on objectives that support advanced use of EHR technology and quality improvement, including health information exchange. By simplifying the reporting requirements, the proposed rule would enable providers to focus on objectives that support advanced use of EHR technology, including quality measurement and quality improvement.

EHR vendors need to be strategic partners to their clients to maximize the value they are getting from their EHR investments. As platforms, EHRs need to be a care companion to providers, delivering insights and key information in real time to help manage patient care while helping to reduce the cost of care.

The benefits EHRs need to deliver to providers include:

- Providing clinically relevant data at the point of care.
- Improving patient adherence to improve outcomes.
- Giving access to data and insights to drive improvement.
- Driving action at the point of care by providing information that can change patient behavior.

Effective compliance can lead to higher-quality data, which can enable physicians to provide better care for their patients. Patients become more satisfied and involved with their own care, and independent healthcare organizations can remain independent by being more efficient and at the forefront of new emerging payment models.

Conclusion

The Medicare and Medicaid EHR Incentive Programs include three stages with increasing requirements for participation. CMS recently published a set of proposed rules that include the proposed rule for Stage 3 of Meaningful Use, which focuses on the advanced use of EHR technology to promote health information exchange and improved outcomes for patients.

With this in mind, it has highlighted the need and importance to maintain a secure EHR system and realize the true value of the technology and the benefits resulting from effective compliance. This will result in effectively providing patients with a secure electronic record of their health and discharge information while enabling this information to be passed on to all relevant parties to ensure a consistent standard of care.

Effective compliance can lead to higher-quality data, which can enable physicians to provide better care for their patients. Patients become more satisfied and involved with their own care, and independent healthcare organizations can remain independent by being more efficient and at the forefront of new emerging payment models.

REFERENCES


Where compliance meets opportunity

Streamlining quality reporting programs lightens reporting demands when technology solutions keep up.

Implementing and meeting quality reporting program demands can feel like assembling a 1,000-piece puzzle – the pieces of which have been scattered and mixed into the mismatched pieces of dozens of other puzzles along the way. Even worse, the puzzle keeps expanding.

Currently, you may be juggling requirements for the Physician Quality Reporting System (PQRS), patient-centered medical home (PCMH), and accountable care organization (ACO) while preparing your practice for the transition to ICD-10, but there are additional pieces on the horizon – such as the White House precision medicine initiative, Meaningful Use (MU) Stage 3, changes to Medicare patient volume, and yet-to-be-decided interoperability demands.

Altogether, you have a jigsaw nightmare. Fortunately, recent healthcare legislation and alignment across quality reporting and payment requirements have made it easier to sort out the many jumbled pieces. Slowly, the final picture is coming into view and, with it, hope of relief for practices.

Good news within Meaningful Use

While Meaningful Use can be a complicated brainteaser on its own, there’s simplification ahead. The Centers for Medicare & Medicaid Services (CMS) recently released a proposal shortening the 2015 MU reporting period to 90 days, and still to come this year is a 50 percent cut in overall MU objectives and a reduction in the threshold measures within them.

The anticipated changes would apply to eligible professionals (EPs) and eligible hospitals (EHs) through 2017 and then merge with the mandatory advent of Stage 3 in 2018 (2017 is an optional year to begin Stage 3).

For EPs in Stage 2, the 17 core objectives and six menu options will be reduced to nine objectives, including one public health reporting objective with two measure options.

For EHs in Stage 2, the proposal reduces 16 objectives to eight, including the public health objective with three measure options.

CMS has not yet passed the final rule; however, it’s expected to pass without many changes in late summer and would allow the reporting data to come from any continuous 90-day span from within the 2015 calendar year for EPs, and even earlier for EHs.

Medicare Access and CHIP Reauthorization Act

More commonly known as the permanent “doc fix” or sustainable growth rate (SGR) reform, this new law establishes a 0.5 percent annual increase in Medicare fee-for-service reimbursements beginning this year, which will be replaced by a 100-point scoring system that determines reimbursement in 2019.

Meaningful Use represents 25 percent of that scoring, with remaining factors including PQRS and the Value-Based Modifier, patient engagement, and other still-to-be-identified quality reporting measures.

But there is a way out: Providers who are already in or join an “alternative payment model” (APM) and receive certain percentages of income from them can be excluded from the scoring system.

Alignment to the rescue: A true story

Increasing alignment of payment and quality measures across programs is already simplifying the puzzle for some providers. Nancy Brown, administrator at the 18-provider multispecialty practice The Veranda in Albany, GA, reports that electronic health record (EHR) functionality and adaptable workflows enable them to meet the requirements of multiple quality reporting programs and their internal care delivery standards.

“We know how providers can get very frustrated with regulation,” she says. She notes that nurturing the provider mindset remains key. “If you can really look at the model and the proactive management of the patient, you can find what works on all levels,” she says.

For The Veranda, taking advantage of the alignment of Meaningful Use objectives and PCMH standards has contributed to success. The practice has achieved Level III recognition from the National Committee for Quality Assurance’s (NCQA) PCMH program and works with private payers on monthly per-patient and annual-bonus incentive structures.

For Meaningful Use, the practice has successfully attested since 2011 and even survived a post-payment audit. (A tip from Brown: Archive printouts of your MU reporting to avoid having to pull it from your system.)

The practice administrator is well aware of how Stage 1 and PCMH 2011 – and sub-
EMRs/EHRs

Alignment 2.0

Other areas of alignment are also expected to expand within SGR payment reform. Federal agencies know they’re adding to the complexities of patient care as they carry out the mandates of the HITECH Act and the Affordable Care Act. And since CMS has a hand in so many incentive programs, and private payers have taken quality program cues from the agency, expect an increase of quality reporting alignment opportunities among the various programs. Seeking out the opportunities that fit your organization is a major strategy for streamlining your data capture and liquidity. If you’re a member of or are considering joining a CMS ACO (also known as a Medicare Shared Savings Program, or MSSP), the seven patient experience measures are expected to align with what will become patient engagement measures within the SGR reform scoring system. Patient surveys affix one or two possible points for each measure, with a high score of 14 points. Those measures are:

1. Timely care, appointments, and information;
2. Provider communication skills;
3. Patient overall rating of provider;
4. Access to specialists;
5. Health promotion and education;
6. Shared decision-making; and

Still to be seen is whether membership within a CMS ACO will count as an alternative payment model within the SGR reform payment structure options from 2019 onward.

Alignment also exists within the CMS Comprehensive Primary Care Initiative (CPCI). This is another quality reporting program that should be an AFM option in SGR reform, and it’s noteworthy because, like many PCMH programs, it’s supported by commercial payers.

Four hundred sites in seven states are participating in the CPCI pilot, which will close at the end of 2015. Results to date have been favorable enough that the program is expected to expand. The alignment point is that within the scoring domains – patient engagement (again), care management, access and continuity, chronic/preventive care, and care coordination – the specific quality measures within patient engagement mirror those of CMS ACOs.

Further contributing to alignment momentum, in early May 2015, CMS released the list of clinical quality measures for 2016 reporting and made a point to note that the number of CQMs in Meaningful Use is not increasing. This is another signal that CMS is seeking as much programmatic stability as it can within congressional legislation.

Pick your spots, and lean on your vendor

Whether it’s the complex chronic care incentive within the 2015 CMS Physician Fee Schedule, Meaningful Use, PCMH, or ACO programs, continue to seek out where quality reporting and payment alignment match your patient population, volumes, and the level of care-plan adherence your patients are achieving.

Following alignment trends, savvy vendors will build documentation and reporting tools into their systems to simplify your tasks. Be wary of vendors who didn’t keep up with regulatory changes in the past, such as those who struggled to supply a 2014 edition ONC-certified solution in time for a successful MU attestation.

The 2015 certification so far proposes 63 criteria to meet Meaningful Use and other program requirements as early as 2017. Certification is no longer just an EHR functionality test for MU requirements, but is currently expanding to ensure that EHRs can comply with new programs on the horizon.

An unprecedented spotlight on HIT

There’s been an unprecedented congressional spotlight on EHRs and health information technology this year, brought by the billions of dollars paid out for MU incentives and a general unhappiness with the state of interoperability. For example, in Congress this session the 21st Century Cures bill may finalize several years of debate on the role of EHRs in patient safety, whether providers will be asked to report any incidents tied to health IT, and whether the Food & Drug Administration should have regulatory oversight of EHRs.

Given all of this, your relationship with your IT solutions partner is paramount. As the quality program puzzle aligns and futures are increasingly tied to compliance, access to tools and solutions designed with current and emerging needs in mind will be your solution for success.
Document imaging helps providers digitize patient records

Scanning makes meeting Meaningful Use objectives easier.

By Mike O’Leary

Since 2009, the American Recovery and Reinvestment Act (ARRA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) have set the stage for physicians, hospitals, and other healthcare providers to implement electronic health records systems (EHRs). While fast-forwarding American healthcare into the digital age is an important aim of both laws, the ultimate goal is to establish Meaningful Use requirements for digitizing information to improve patient care and outcomes, and portability of patient information.

Eligible providers meeting EHR and Meaningful Use requirements (established in three stages) can receive $44,000 in Medicare incentive payments over five years or $65,000 over six years under Medicaid. The incentive program began in 2011 and will end in 2016 and 2017 respectively.

For those healthcare providers who haven’t yet adopted certified EHR systems and cannot demonstrate meeting Meaningful Use requirements, they will see reductions in their Medicare Part B reimbursements by 1 percent this year and will see further 1 percent reductions each subsequent year of delay up to a maximum of 5 percent.

In addition to Medicare penalties, there could be penalties associated with individual state mandates. Furthermore, healthcare providers who do not meet requirements run the risk of engendering inefficiencies in delivering patient care when interfacing with other providers who have adopted EHRs, payment delays in dealing with healthcare insurers, undermining portability of medical information, difficulties in assembling family medical histories, complications in establishing legal health records, and hampering patient access to their information.

There are more than enough reasons to go digital. The challenge is what to do with patient healthcare records and other information residing on paper?

While some older records can remain on paper, those with relevance need to be in digital form. There are two ways to digitize paper-based records: Create new ones digitally by inputting information, or convert paper records to digital files through document imaging scanners. In either case, most healthcare provider offices do not have the bandwidth to do either.

Enter Colorado Hi-Tech Solutions of Colorado Springs. Colorado Hi-Tech Solutions is a document imaging reseller that has established a service application to digitally scan paper-based health records into digital files that can be uploaded to EHRs, accelerating healthcare provider offices’ abilities to meet Meaningful Use requirements.

“We provide scanning services to a number of local physician and other healthcare providers, digitally converting up to 20 years of patient medical records,” says Brent Watson, President of Colorado Hi-Tech Solutions.

Colorado Hi-Tech Solutions has several employees working at physician, healthcare provider, and hospital sites performing the scanning services. The company works via a monthly charge to scan and upload the files into cloud-based and premise-based EHRs and EMRs.

“We literally scan boxes of healthcare records at a time using Ambir ImageScan Pro DS 960 AS desktop document scanners,” Watson says. “We are talking about making a huge number of scans. For example, we have one account where we have performed more than a quarter of a million scans with a desktop scanner, requiring the client to provide us only a desk from which to work and to keep those pallets of boxes coming. Even after 250,000-plus scans, we are only halfway through the paper records.”

Colorado Hi-Tech Solutions integrates each scanner to the EHR each provider uses. As the Ambir document scanners use industry-standard TWAIN drivers for operation, integration is fairly straightforward.

“Our services are quite cost effective as we operate at the client’s site using desktop document scanners doing the job usually requiring commercial production scanners typically found in document imaging service bureaus, eliminating expenses to clients for transporting records to service bureaus and of course, storing paper records at either a certified document storage facility or, far more riskier, a private storage locker, which believe it or not, some do,” Watson says.

In recent months, Colorado Hi-Tech Solutions has seen significant upticks in demand for the services from healthcare providers. Watson attributes it to clients striving to meet Meaningful Use Stage 2 proposed regulations, which include providing for patients to have access to their healthcare records via patient portals.

“The regulations for healthcare providers to adopt certified EHR systems and those specific to Meaningful Use have brought digitization and information management governance to the healthcare space for bettering patient care and outcomes. The need to digitize paper-based patient medical records and information is great, as we all benefit,” Watson says. HMT
With patient portals, doctors win too

By Jeff Drasnin, M.D.

Dr. Jeffrey Singer, a surgeon in Arizona, recently wrote in the Wall Street Journal that he blames EHRs for damaging connection with patients. It’s an awful feeling for any physician. We all wish for longer appointments, fewer charts, and more time spent looking patients squarely in the eyes, rather than into our keyboards. In more than a cursory measure, I rue the end of the era in which my father, also a pediatrician, was lucky to practice: one where care was personal, immediate, and — sometimes, even — delivered in the home. I’m not an HIT apologist. But for all of HIT’s warranted criticisms, there is still so much to admire. Dr. Singer should know that despite his particular system’s shortcomings, good technology is synonymous with connection. I suggest he try a patient portal on for size.

Admittedly, patient portals are the unloved stepchild of many HIT adopters. The market has been slow to adopt portals; as a result, their functionality is less developed than EHRs and practice management services. Aside from a cursory measure in Meaningful Use Stage 2, patient portals aren’t intrinsic to practices’ workflows in the way that submitting claims, documenting visits, charting, and ordering labs are with other applications. It’s no surprise, then, that portals’ reach and popularity are lacking.

But to dismiss all manner of patient engagement is to lose a shot at what all providers want: connection. We are so brutalized by administrative burden, so squeezed trying to navigate the narrow corners of healthcare, that a tool that has the power to connect the dots with patients cannot be overlooked.

Patients demand a digital connection in their lives, and healthcare is no exception. Their engagement with my practice’s portal is staggering: 80 percent use it semi-regularly to send email and secure electronic messages, receive test results, pay bills, and complete medical histories. I receive feedback all the time that they appreciate the immediate gratification and the surprising sense of productivity that they’re unaccustomed to in healthcare. The portal streamlines my practice’s eligibility and check-in processes and lets my front-office staff move my patients through the office more efficiently. This allows me more time during the heart of the encounter. I routinely hear from patients (and the parents of patients) that they feel they’re receiving the full benefit of our time together. Patient volume has climbed steadily by 25 percent, and satisfaction is at an all-time high.

I connect with my patients better electronically than I would through a nurse’s note left on my desk. I can connect more quickly, and more accurately, than if I wait for a follow-up visit days or weeks later. Conversations that occur within the portal are captured in my patient’s chart, making it an exact reflection of our interaction.

The portal also allows me to scratch the surface of population health management — a precipice over which healthcare is currently peering with trepidation. With the portal, I can target campaigns to specific populations, encouraging them to schedule their well visit, get their flu shot, and generally receive the care they’re entitled to. This little nudge to human behavior not only drives schedule density but undoubtedly keeps patients healthier. It also helps me retain an upper hand in my negotiations with payers. As a physician-hospital organization (PHO), I get competitive reimbursement rates based on the quality of care my practice administers. Because my practice’s portal is cloud-based, we can easily report how and when we meet our targets.

If this sounds like value-based reimbursement, it’s not — at least, not quite. There is no CPT code for time spent responding to patient queries, no compensation for resolving otherwise income-bearing health episodes electronically. The biggest reason why portals aren’t widely adopted, of course, is because providers aren’t remunerated for their use. But at-risk contracting is already here. In the not-too-distant future, it will be foreseeable to make money not by packing my schedule, but by keeping patients healthy and out of office. That makes sense to me; we get rewarded for fixing problems and keeping people healthy. It’s what we all went into medicine to do, after all. When that day comes, my cloud-based patient portal will be able to run more reports, not just on how much care I’ve administered but on what outcomes that care has achieved.

On that day, my patient engagement strategies will have come full circle; financial results, patient satisfaction, and outcomes will all be connected in an inextricable circle. So I would tell Dr. Singer, ‘Of course, you’re right.’ Connection isn’t important to healthcare; it is healthcare. But you can’t get it without technology. Start with an underutilized tool like a patient portal, and you may be amazed by the results. HMT
Population Health

Customizing care

By Alan Bugos, Head of Technology and Innovation, Philips Home Monitoring

Analytics has the power to help solve the readmission challenge by providing a deeper level of insight into the patient’s health journey. As key to population health management, analytics can provide critical insights into entire patient populations, going as micro as identifying individual patients who are at risk for adverse medical events and as macro as identifying gaps in care for whole populations.

One of the key benefits of analytics is its power to provide health systems and clinicians with the ability to identify who is at risk and preemptively intervene before an adverse medical or life-critical event occurs, helping provide better quality care for patients and reducing unnecessary hospital admissions and readmissions. By utilizing analytic-driven population health management solutions, clinicians get the knowledge they need to customize care delivery, creating a clearer path in today’s complex healthcare environment and yielding a more significant impact on patient health.

For patient care to be impactful, it needs to be connected across the health continuum. This extends past the traditional 30-day window considered for readmissions and requires looking at the larger story of a patient’s health. Most healthcare systems agree that reducing readmissions is a win-win scenario for improving care and reducing costs, but regulations have caused many to focus only on the 30-day post-discharge period.

One patient population this is especially important for is seniors. Seniors are the largest consumers of healthcare, but poor transitions in care are a key cause for readmissions, emergency department visits, and unnecessary hospitalizations. By looking at the full picture across the full health continuum and using data and analytics to monitor seniors’ health while they are at home, healthcare systems can identify the patients most likely to have health issues, allowing clinicians to intervene before problems occur – and helping seniors stay healthier and out of the hospital.

In a world of mobility, it becomes easier to collect data, and the variety of data we can gather expands broadly as healthcare technology evolves. Going hand in hand with evolving analytic capabilities, wearables, health apps, and telehealth programs are using advanced technology to take steps toward better physician/patient connectedness, opening the door for real-time insights that are actionable. By creating more data touchpoints to analyze, clinicians not only get a more comprehensive patient profile, but they can better customize patient care and identify potential solutions.

Telehealth solutions extend patient care from the hospital and into their homes, ultimately improving care, cutting costs, and reducing hospitalizations. They provide innovative clinical programs that allow health systems to improve health and lower the cost of select patient groups in all care settings, both inside and outside the hospital. A health system supported by a mix of advanced telehealth technologies and analytics-driven population health management solutions has the power to truly impact not only readmissions, but also patients’ overall health.

SOLVED GUIDE

REVERSING READMISSIONS WITH ALIANICS

Population Health

Customizing care

By Alan Bugos, Head of Technology and Innovation, Philips Home Monitoring

Analytics has the power to help solve the readmission challenge by providing a deeper level of insight into the patient’s health journey. As key to population health management, analytics can provide critical insights into entire patient populations, going as micro as identifying individual patients who are at risk for adverse medical events and as macro as identifying gaps in care for whole populations.

One of the key benefits of analytics is its power to provide health systems and clinicians with the ability to identify who is at risk and preemptively intervene before an adverse medical or life-critical event occurs, helping provide better quality care for patients and reducing unnecessary hospital admissions and readmissions. By utilizing analytic-driven population health management solutions, clinicians get the knowledge they need to customize care delivery, creating a clearer path in today’s complex healthcare environment and yielding a more significant impact on patient health.

For patient care to be impactful, it needs to be connected across the health continuum. This extends past the traditional 30-day window considered for readmissions and requires looking at the larger story of a patient’s health. Most healthcare systems agree that reducing readmissions is a win-win scenario for improving care and reducing costs, but regulations have caused many to focus only on the 30-day post-discharge period.

One patient population this is especially important for is seniors. Seniors are the largest consumers of healthcare, but poor transitions in care are a key cause for readmissions, emergency department visits, and unnecessary hospitalizations. By looking at the full picture across the full health continuum and using data and analytics to monitor seniors’ health while they are at home, healthcare systems can identify the patients most likely to have health issues, allowing clinicians to intervene before problems occur – and helping seniors stay healthier and out of the hospital.

In a world of mobility, it becomes easier to collect data, and the variety of data we can gather expands broadly as healthcare technology evolves. Going hand in hand with evolving analytic capabilities, wearables, health apps, and telehealth programs are using advanced technology to take steps toward better physician/patient connectedness, opening the door for real-time insights that are actionable. By creating more data touchpoints to analyze, clinicians not only get a more comprehensive patient profile, but they can better customize patient care and identify potential solutions.

Telehealth solutions extend patient care from the hospital and into their homes, ultimately improving care, cutting costs, and reducing hospitalizations. They provide innovative clinical programs that allow health systems to improve health and lower the cost of select patient groups in all care settings, both inside and outside the hospital. A health system supported by a mix of advanced telehealth technologies and analytics-driven population health management solutions has the power to truly impact not only readmissions, but also patients’ overall health.

Research and Studies

Twice as likely to readmit

A recent study of Clostridium difficile (C. diff) infections published in the April 2015 issue of the American Journal of Infection Control revealed that patients diagnosed with the deadly diarrheal infection (whether in the community or acquired during a hospital stay) are twice as likely to be readmitted to the hospital within 30 days.

Researchers from the Detroit Medical Center (DMC), a seven-hospital system in southeastern Michigan, conducted the large study to understand the epidemiology of CDI readmissions, analyzing 51,353 all-cause discharges between Jan. 1 and Dec. 31, 2012. There were 615 patients (1 percent) who were discharged with a CDI diagnosis, including 318 where CDI was present on admission, and 297 who were diagnosed during their hospital stay. The study indicated that 30.1 percent of CDI patients were readmitted after 30 days versus 14.4 percent of all-cause discharges.

“We found that CDI readmissions for any reason had almost a one-week longer average length of stay than all-cause readmissions,” said Teena Chopra, M.D., MPH, a leading CDI expert from DMC’s Division of Infectious Diseases who led the study.

According to the CDC, C. diff has become the most common microbial cause of healthcare-associated infections in U.S. hospitals, costing up to $4.8 billion each year in excess healthcare costs for acute care facilities alone. Patients who take antibiotics are most at risk for developing C. diff. Learn more about this study in the article, “Burden of Clostridium difficile infection on hospital readmissions and its potential impact under the Hospital Readmission Reduction Program” at aicjournal.org.

Source: Association for Professionals in Infection Control and Epidemiology (APIC)

Books and Literature

Pop health’s good read

If you need help navigating the uncharted waters of value-based care and how population health outreach can contribute to provider reimbursements for healthy outcomes, you are not alone. Luckily, a new book aims to set physicians and health administrators on course.

“Provider-Led Population Health Management” by Richard Hodach, M.D., and Phytel’s Chief Medical Officer and Vice President of Clinical Product Strategy, aims to explain how providers can lead population health management (PHM) initiatives using automation to fit the effort within care teams.

“This book connects the dots for physicians embracing population health,” says David B. Nash, M.D., MBA, founding Dean of the Jefferson School of Population Health at Thomas Jefferson University in Philadelphia, the nation’s only school of population health. “It takes components of population health management, such as ACOs, PCMHs, and shared savings contracts, and clearly articulates expert definitions.”

Included in the primer is information on how organizations can use health IT to automate care management and patient engagement in order to scale and prioritize care delivery to the level required to achieve PHM. The 266-page paperback is available on Amazon. Source: Phytel
Solutions

Master coordinated care transitions

With its fully integrated EHR, MEDITECH supports coordinated care transitions that help healthcare organizations eliminate unnecessary readmissions and maintain their bottom lines. Several key system features give providers the tools they need to see a complete clinical picture of their patients – inside the hospital as well as outside of it – and provide a multidisciplinary approach to care management and discharge planning. These include: customizable surveillance status/quality boards, comprehensive medication reconciliation, integrated home care solution (including a telehealth option), and a Web-based patient and consumer health portal for better patient engagement. MEDITECH www.rsleads.com/507ht-181

Home monitoring data connected to EHR

Cerner, through a partnership with Qualcomm, is extending its medical device connectivity capabilities beyond the hospital and into the home. Cerner will leverage Qualcomm Life’s FDA-listed 2net Platform and Hub to capture data from medical devices and sensors (such as weight scales, blood pressure monitors, and pulse oximeters) within a patient’s residence and transmit it to Cerner healthcare clients through Cerner’s CareAware device connectivity platform. Using this solution, care providers can remotely monitor chronically ill patients in near real time to enable proactive engagement and potentially reduce the risk of an acute care episode. Data values will transmit via CareAware to the Cerner Millennium EHR and be viewable to the patient in HealthLife, Cerner’s patient engagement solution. Cerner www.rsleads.com/507ht-182

Data + devices = better analytics for care

CareSage combines actionable insights with wearable medical alert devices to help reduce hospitalizations of elderly patients, keeping them at home and independent. This predictive analytics engine provides analysis of real-time and historical data from health care providers and Philips LifeLine to proactively identify patients most likely to have health issues so clinicians can intervene before problems occur, helping patients stay healthier and reduce avoidable hospitalizations. CareSage is the latest innovation being built on the Philips HealthSuite Digital Platform, an open cloud-based platform that supports the secure collection and analysis of health and lifestyle data from multiple sources and devices. Royal Philips www.rsleads.com/507ht-183

Research and Studies

What an extra day can bring

Ever wondered if staying in the hospital an extra day can really do any good? Researchers at the Columbia Business School have, and they say that keeping patients in the hospital just 24 hours longer can significantly cut readmissions, save patient lives, and reduce costs. Their study, “Should Hospitals Keep Their Patients Longer? The Role of Inpatient and Outpatient Care in Reducing Readmissions,” compares the impact of an extended length of stay in the hospital to the effects of outpatient care for Medicare patients. In it, the researchers found that one additional day in the hospital can:

• Reduce mortality risk by 22 percent for patients treated for pneumonia;
• Reduce mortality risk by 7 percent for heart-attack patients;
• Result in five to six times more lives being saved when compared with outpatient care; and
• Decrease readmission rates by 7 percent for severe heart-failure patients.

Additionally, the study showed that one extra day in the hospital would, in many cases, cost less overall than the associated outpatient care required with early discharge. Currently, about one in every five Medicare patients is readmitted to the hospital within 30 days of discharge, costing U.S. taxpayers at least $17 billion annually.

The study analyzed the Centers for Medicare & Medicaid medical records of more than 6.6 million Medicare patients ages 65 or older with in-hospital visits between 2008 and 2011. It compared the potential benefits of a one-day extended hospital stay to those of outpatient care in terms of reduced readmissions, death rates, and costs. Study results were released in October 2014. Read more about this study at www.nber.org/papers/w20499.

Reach out and learn about someone

The new Caradigm Patient Outreach solution leverages Eliza’s expertise in crafting highly effective, multi-channel patient interactions to enable providers and ACOs to reach outside the care setting and engage patients in health-related behavior change. Interactions are targeted based on patients’ clinical and life circumstances, making the messaging more relevant and compelling, and leading to improved patient involvement. The system also gains insights about patients based on each interaction, resulting in improvements in both the effectiveness of interactions and patient perceptions of their provider organizations. This solution specifically targets boarding, health risk assessment, transitions of care, and gaps in care. Caradigm www.rsleads.com/507ht-184

Index of Advertisers

<table>
<thead>
<tr>
<th>Advertiser</th>
<th>Web</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allscripts Healthcare Solutions</td>
<td><a href="http://www.allscripts.com/HMT">www.allscripts.com/HMT</a></td>
<td>IFC</td>
</tr>
<tr>
<td>athenahealth</td>
<td><a href="http://www.athenahealth.com">www.athenahealth.com</a></td>
<td>3</td>
</tr>
<tr>
<td>McKesson Paragon HIS</td>
<td><a href="http://www.mckesson.com">www.mckesson.com</a></td>
<td>BC</td>
</tr>
<tr>
<td>Quammen Healthcare Consultants</td>
<td><a href="http://www.quammengroup.com">www.quammengroup.com</a></td>
<td>7</td>
</tr>
<tr>
<td>Quammen Healthcare Consultants</td>
<td><a href="http://www.quammengroup.com">www.quammengroup.com</a></td>
<td>9</td>
</tr>
</tbody>
</table>

This index is provided as a service. The publisher does not assume liability for errors or omissions.
Finding the path toward fee-for-value

The path toward fee-for-value drives a new connection between the clinical and financial world. Going forward, the financial value of a service will be based more discreetly on the clinical value of the service, and the decision about the delivery of services will be made based on the new metric of volume plus value, instead of just volume. This may seem self-evident, but many organizations have not yet come to terms with the impact of this simple idea.

The problem is organizational in nature. Both payer and provider organizations have people who focus on specialized areas (departments) as driven by business needs. However, business needs are undergoing a radical shift.

Consider the provider world

Today, a chief of staff at a hospital knows the head of managed care, but they do not talk each time a new care pathway is approved. There is no data flow that adequately addresses and drives information about incentives, risk, and quality into the care delivery driven by an EMR, CPOE, or by the chief of staff at a hospital.

But the problem is worse. Almost all value-based contracts require providers to work with other providers outside their organization. These affiliated provider relationships are often the most critical when creating the correct coordination and alignment to deliver care effectively in the new world.

Providers need to balance value into everything they do. EMR systems could help with this, but few providers have implemented their EMRs in a manner to meet these needs. While driving toward Meaningful Use, they failed to make the use of their software meaningful.

Bottom line: Financial and clinical departments in a provider network need to talk, share data, and make better decisions based on what each knows and does. Then, they can solve that problem across multiple independent providers, and solve it multiple times for different value-based contracts with different terms.

Imagine a doctor employed by a hospital. Of the 20 patients they will see today that need imaging, one patient is in an ACO with a commercial payer. In this ACO, the hospital will earn 50 percent of all savings. The patient needs an MRI and can either be sent to the doctor's hospital or an independent imaging center across the street.

Using the hospital’s MRI, the hospital will be paid $2,000 for the procedure, but the cost of doing the MRI is $1,500 – a $500 profit. At the independent imaging center, the cost is $800. This creates $1,200 of savings, which translates to $600 of profit. But what system anywhere in the U.S. is able to place that choice (decision driver) into the hands of a provider in an informed manner? I imagine 10 percent of hospitals today focus on volume in this example and keep the business internal.

The problem is just as bad for a payer

The head of network contracting just signed a great deal with an orthopedic surgeon to do episodes of care. He knows the surgeon has a great plan to reduce costs and improve outcomes by increasing the use of outpatient physical therapy.

But the medical director has just finished working with claim operations to change the clinical edits in their core system, ensuring no member gets more than a few physical therapy visits, as he knows how much these are abused.

After a bunch of denied claims and patients being turned away by the physician therapist, the head of network contracting figures out what happened with a frustrated surgeon. Even if he can convince the medical director that care under this contract is different, how can the core system be told to make this edit conditional? I am only aware of a single vendor offering technology that can do this, and it is very limited in its market adoption.

Bottom line: The decisions made in contracting and claims operations have to be driven by what the clinical side of the organization understands and vice versa. The financial and clinical data within a plan has to flow much better and in far better context.

Bring in the business intelligence team

Since the clinical side of payer operations is focused on different tasks, a surrogate is often used: the business intelligence team. The head of provider contracting has to rely on SAS programmers to write custom reports that attempt to explain what clinical performance is happening in the value portion of the contract they want to write.

But there is an ever-larger need, driven by the nature of the new fee-for-value partnerships in healthcare: Payers and providers must have data, workflows, and efficiencies flow between each other.

In a larger context, the provider is the clinical element, and the payer has financial ownership in ways the provider cannot match. Sharing the data between payer and provider is needed in order to establish trust. Each payer and provider has data the other needs to be successful in the relationship. This data, once shared, can also be used to hurt each other. But I cannot envision how new value-based partnerships can work without sharing this kind of data – even before contracting.

There is also the need for shared workflows between payers and providers. Streamlined ways of processing authorizations are the type of activity that adds value in a partnership, reducing pain and cost for both payer and provider.

It was recognized years ago that the trend toward value would cause payers to start acting more like providers and providers to start acting more like payers. The combination of payer and provider functionality through partnership, or through actual integration in the case of health systems owning health plans, is not only necessary, but organizations doing it well will have a significant competitive advantage over those who do not.
What does the future hold?

AUGUST
Interoperability
Population Health
Patient Care Connectivity
Disaster Recovery
Document Management
HIPAA

SEPTEMBER
Claims & Coding
Secure Messaging
Cloud Computing
ePrescribing
BYOD Wireless Devices
ICD-10

SUBSCRIBE OR RENEW NOW:
www.HealthMgtTech.com/subscribe
Who would have thought 13 could be your lucky number?

Paragon® Release 13.0 featuring the Paragon Clinician Hub has arrived!

Designed to help increase productivity, effectiveness and ready-access to critical information, the latest version of Paragon features:

• Paragon Clinician Hub—an innovative, visual and intuitive presentation of data with minimal clicks offering secure, web-based accessibility from anywhere enabling more timely care decisions
• Enhanced support for multi-facility organizations
• Improved Paragon Lab functionality
• Additional real time alert features in the Paragon Rules Engine, a clinical decision support tool for caregivers

Contact your McKesson representative or visit www.mckesson.com for more information.

Copyright © 2015 McKesson Corporation and/or one of its subsidiaries. All rights reserved. Paragon and Paragon Clinician Hub are trademarks of McKesson Corporation and/or one of its subsidiaries.