BUILD YOUR DEFENSE!

Proactive data security strategies

Simplifying workflows to improve patient transfers

UDI: Not just for manufacturers

KLAS Midterm Report

Thought Leaders
Michael R. Udwin, M.D., FACOG
Executive Director of Physician Engagement Services, McKesson

Cultivating a great physician champion
I used to be a magician

Brenda, Hospital CEO.

I used to spend my time trying to make the impossible, possible. Now, real-time visibility means I can do what I do best. Lead.
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My ‘big data’ identity crisis

I was sitting in the doctor’s office with my annual ear infection when the interrogator (or “nurse”) entered my room to give me my pre-exam screening. After checking my temperature, weight, height, heart rate, blood pressure, and blood oxygen levels, the real tough questions began – and strangely, not a single one of them had anything to do with my throbbing ear.

After questions related to my recent sexual activity, sleeping habits, past drug use, and night-time glasses of wine, I suddenly felt like I had a lot of problems. I was beaten back.

“Look, can I just get some antibiotics for my ear?” I pleaded. But it didn’t stop there. The next round of questions came at me:

“What’s your smoking history?”

This was an easy one. I rarely smoke tobacco at all, and I despise the smell of cigarettes. “Absolutely not,” I responded.

“Have you ever tried cigarettes?”

“Well, sure, but that doesn’t mean…”

It was too late. She was typing again. And there it was for the world to see: Chad Van Alstin – Smoker. Insomniac. Social deviant. All along I was a rock star, and I didn’t even know it.

All of the answers I gave were honest, and all of this information is kept private between my doctor and me, right? So, what’s the problem? In a world ruled by insurance premiums – where the price of care is used to alter behavior through financial punishment – the truth can be costly. By gathering my answers and recklessly labeling me a nicotine-addicted pariah, the nurse had planted information about me into the everlasting digital realm – and there’s no telling where it may pop up.

Granted, most of the time I add all that incriminating information myself by using a smartphone loaded with apps on a daily basis. And now that providers are encouraging me to use some of these apps – apps that track my posture, caloric intake, activity level, heart rhythm, and just about every move I make – it seems healthy.

But at what point does all of this become a little too much?

All this data being gathered is by no means ineffectual. There are entire companies established to archive, sift through, and organize data related to the lifestyle and choices of individuals. Somewhere on a hard drive right now is a portrait of each and every one of us. This is the ‘big data’ era, one where companies will buy information about their clients to get a better idea of who they are.

Admittedly, most of this data isn’t going to be used for nefarious purposes. But it is too much of a stretch to imagine employers buying profiles of employees to see if they, too, are rockstars – whether it’s true or not? Is it paranoid to think insurance companies may jack premiums, all because some nurse checked a box declaring you a “smoker”? Unfortunately, it’s already happening. And good luck proving you’re innocent… you chimney.

I’d like to believe that HIPAA laws and the collective ethics of the healthcare industry will protect my privacy, but at this point, doing out personal information to anyone is a bit like posting a photo online – you never know where it will end up, and deleting it is just about impossible. We’re slowly building a world where computer algorithms determine our value in a marketplace – and I’m waiting for someone to convince me that such a high cost is worth the touted price cuts and improved services.
JIM’S MEDICAL RECORDS GOT THERE BEFORE HE DID.

When we work as one, care coordination just happens. work as one

athenahealth
Will healthcare get its own Rotten Tomatoes?

By Dr. Anthony Oliva, DO, MMM, FACPE, National Medical Director, Nuance

Rotten Tomatoes has become the trusted online source for film reviews where viewers can rate movies, television shows, and discuss movie trailers. The site is known for its brutally honest feedback, and it's not easy to score high; in fact, for a feature to be considered “Fresh” it has to have a 60 percent or higher approval rating -- everything below is considered to be “Rotten.”

Consumers are taking the time to apply that level of scrutiny to films, how long will it be before we apply that same critical lens and rating system to physicians or a healthcare system? The reality is that it's already happening -- just not how one might expect.

Does sharing really mean caring?

A recent survey shows that more than 70 percent of young millennials (ages 18 to 24) choose their doctors based upon recommendations from family and friends; so for providers, word of mouth is the primary source of new business among this demographic. Millennials are less apt to give feedback to their physicians when they are unhappy with their care; instead, they tell friends, which can pose a big problem for healthcare organizations. What happens when millennials turn to social media and online forums to share negative feedback to the masses unbeknownst to the physician?

With millennials on the verge of surpassing baby boomers as the largest living generation, providers need to solicit input from their younger patients and find new ways to communicate more effectively with them.

Are physician reputations at risk?

Millennials are estimated to spend $200 billion collectively by 2017 and nearly $10 trillion over their lifetime -- and they are savvy shoppers. As digital natives, researching a question or looking up a product review is second nature. We’re fast approaching a new paradigm in healthcare where online patient reviews of clinicians will increasingly drive business.

Just like Rotten Tomatoes, new sites culling physician scorecards and quality metrics are emerging, and patients will take them into account as they select care providers. Having this information available for the first time will impact physicians’ reputations and the referral system. Physicians won’t recommend low-scoring specialists, as it will call their credibility into question. And what provider or payer wants to back the physician with a 20 percent approval rating? This change is a surprise to most doctors who, until now, have not worried about online profiles because they weren’t personal; historically, they’ve always been associated with hospitals or large groups.

Good physicians who are poor at clinical documentation are also put at risk. If the severity of a patient’s condition isn’t accurately reflected in their record, physician ratings or scorecard numbers may be skewed. In comparison to a physician who isn’t treating patients who are critically ill, the first physician may not look good to patients.

While it may seem daunting, this is about transparency between physicians and patients. People want and need to become more involved in their care. Being able to research and choose physicians is the right of every patient. The key to success in this new world of healthcare centers around accuracy -- getting credit for the care physicians provide to their patients, and being appropriately reimbursed for outcomes.

Security

Do you measure up to the ‘Most Wired’ hospitals?

What are the highest priorities for America’s ‘Most Wired’ hospitals? They are health data security, information access for caregivers, and patient engagement, according to results from the 17th annual “HealthCare’s Most Wired Survey” released in July by the American Hospital Association’s Health Forum and the College of Healthcare Information Management Executives (CHIME). Sponsored by VMware, the 2015 survey and benchmarking study aims to be a bellwether for IT use and adoption among hospitals nationwide.

The survey of more than 741 participants, representing more than 2,213 hospitals, examined how organizations are leveraging IT to improve performance for value-based healthcare in the areas of infrastructure, business and administrative management, quality and safety, and clinical integration. It was conducted between Jan. 15 and March 15, 2015.

According to the survey, hospitals are taking more aggressive privacy and security measures to safeguard patient data. Top growth areas among this year’s Most Wired organizations include privacy audit systems, provisioning systems, data loss prevention, single sign-on, and identity management. The survey also found that 96 percent of Most Wired organizations use intrusion detection systems compared to 85 percent of all respondents. Privacy audit systems (94 percent) and security incident event management (93 percent) are also widely used. Seventy-nine percent of Most Wired organizations conduct incident response exercises or tabletop tests annually, a high-level estimate of the potential for success of a cybersecurity incident response plan, compared to 37 percent of all responding hospitals.

As hospitals and health systems begin to transition away from volume-based care to more integrated, value-based care delivery, they are utilizing IT to facilitate better information exchange across care settings and between hospitals and physicians. According to the survey, the physician portal is a key factor in strengthening physician-hospital alignment. In 84 percent of Most Wired organizations, physicians can view and exchange other facilities’ results in the portal compared with 63 percent of hospitals surveyed, and 76 percent use the portal and electronic health record (EHR) to exchange results with other EHRs and health information exchanges compared to 56 percent of those surveyed.

Driven beyond the requirements of Meaningful Use Stage 2, this year’s Most Wired hospitals are utilizing the benefits of a patient portal to get patients actively involved in their health and healthcare. For instance, 89 percent of Most Wired organizations offer access to the patient portal through a mobile application.
Even if patients are limited to a managed care option, data to understand care access, utilization, and outcomes are necessary to determine the impact of managed care and assess the quality of care provided to patients.

Q: Retail companies have all sorts of indirect methods to gather customer data – loyalty cards, surveys with rewards, etc. Beyond what’s put into an EMR, what can health care organizations do to gather information directly from their members more effectively?

Healthcare organizations can capture patient-generated health data for use through emerging approaches that leverage both existing investments and new technologies.

Many health systems engage with patients and collect additional information with existing investments in patient portal technology. Patient portals now integrate with medical devices, such as glucometers and consumer fitness trackers, to provide access to near real-time health data. They can also monitor post-acute care patients as they recover at home. Hospitals can reduce readmissions and improve post-acute care surveillance and coordination with questionnaires designed to identify unexpected complications in the recovery process, securely distributed to patients through a portal’s notification system.

Many well-funded startups in the rapidly growing digital health space offer new opportunities to capture patient-generated health data. They are piloting platforms designed to improve remote patient-monitoring capabilities, such as mobile apps that engage with chronically ill patients between visits through app notifications and text-message alerts that provide medication and appointment reminders, as well as daily disease-monitoring questionnaires.

Q: For those organizations moving away from paper, is there a reasonable strategy for compiling all of those filing cabinets into consumable digital information?

When organizations transition from paper to an electronic record with the goal of optimizing consumable data, they should first examine and analyze the processes and existing paper forms used to capture documentation. An optimized strategy will then recreate as many of these forms as possible as electronic versions that use standardized data fields. This will provide the facility with consumable data to be used in conjunction with a data repository or warehouse solution.

For existing paper records, organizations can best accomplish the migration of historical patient data via a scanning and archiving solution that allows batch scanning of the paper forms used to capture documentation. An optimized strategy will then recreate as many of these forms as possible as electronic versions that use standardized data fields. This will provide the facility with consumable data to be used in conjunction with a data repository or warehouse solution.

Q: Are analytics software solutions limiting in terms of what type of actionable data they can produce?

Analytic software solutions are only as good as the data entered into the product; as such, these solutions are not the limiting factor. It is up to providers, analysts, and administration to ensure consistency of processes and methods for collecting the data, and ultimately to take that data and make decisions about what actions should be taken. The data can help prioritize projects, but there must be an interpretation as to the actions to take. The people and processes take precedence in actionable data over analytics software solutions.

Q: After the data is analyzed and a conclusion is made, who turns it into actionable change? Is it the providers? The administrators? In a hospital, there often isn’t a traditional hierarchy when it comes to clinicians that work by contract.

All of the above and more! The adage “It takes a village” applies. Actionable, sustainable change requires the full support of administration. Providers also must lead these changes, especially if they are clinically related. Others, such as nursing, pharmacy, information technology, finance, and other clinical ancillary services, will be part of the team implementing the changes. It is up to each organization to design processes that account for this team effort and involve all departments in delivering systemwide changes to the benefit of the patient, organization, and individual teams involved.

Q: What about patient separation?

There are several ways to identify patient populations and, ultimately, trends within them. A basic segmentation can be by payer, such as Medicare, Medicaid, or “dual eligibles.” Patients can be viewed as segments, such as pediatric or geriatric patients, or even by disease state. Ultimately, with consistent data, hospitals may segment patient populations with high utilization rates, readmissions, emergency department visits, and observation visits. The idea is to have complete, accurate data across segments, not allowing an artificially designed segment to dictate how data is gathered or used.

PATIENT DATA ANALYTICS  EXPERT Q&A  

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E X P E R T  Q & A  ::::::::::  
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Making data personal

Healthcare leaders sound off on how big data can be used to help providers see patients as people.

Q: For an individual with special circumstances or needs that may be overlooked, can data analytics help them – or is this all more about identifying group trends?

Lee Rivas, CEO, Public Sector and Healthcare, LexisNexis Risk Solutions

Clinical analytics provide us with a lens through which we can understand health risks, motivation, and specific care-planning needs at an individual level. The ability to drill down to the individual level is critical to understanding what resources to deploy, when to deploy them, and how to deploy them. Analytics that take into account unique population characteristics are superior to those that simply group populations together based on broad categories like age, condition, etc. This is why tapping into non-traditional sources of data is necessary to move the needle in healthcare.

Imagine one of many single parents who has just gone through a divorce and had to move to a new neighborhood that has high crime rates. Up until then, they were healthy – and from a clinical perspective, there is nothing to indicate otherwise – but living in a less safe place than they did before, needing to find a job after caring for a child at home, and dealing with emotional effects of divorce all make them susceptible to serious stress that can set off a series of adverse health challenges. It is this socio-determinant data that affords a unique view into an individual’s clinical risks and can allow either the plan or provider to be proactive in getting the patient and her child the care they need.

This type of insight is equally critical for diagnosing and treating low or nonusers of the healthcare system. In this case, a plan or provider has scarce clinical information and cannot adequately predict the individual’s health risks and would need to rely on a picture presented by the socioeconomic data.

Q: Presumably, data warehouses have a lot more information about patients than just their medical history. At what point in time does data collection on patients become a violation of privacy – or a HIPAA violation?

Regulation exists – such as HIPAA, CMS guidelines, parts of the Accountable Care Act – so that data collection doesn’t violate privacy. HIPAA mandates aggregation and de-identification of data and prohibits re-linking data that would lead to identification of an individual, especially in reference to analytics. Even clinical analytics models themselves can and should be HIPAA certified.

Whether through a member portal or EHR, once a payer or provider has access to analyzed information they are well positioned to help their patients and society improve clinical outcomes, such as addressing why 20 percent of the population do not come back for follow-up visits nor fill their prescriptions; enhancing participation in wellness management programs; reducing avoidable costs by identifying actions or care plans that can lower the chance of complications or the continuation of adverse outcomes; and minimizing fraud and abuse – for example, by identifying an orthopedic surgeon overprescribing Xanax or another controlled substance.

Q: When segmenting data in order to identify trends in populations, how does one best choose how to separate their demographics?

Saeed Aminzadeh, CEO, Decision Point Healthcare Solutions

Segmentation is part science and part art. The science part has to do with ensuring that there are enough patients in the segment for the segment to be meaningful, and to segment patients based on logical categories, such as age and type of insurance. The more nuanced segmentation is in trying to segment members based on their “barriers to engagement” in order for the healthcare organization to be able to be more focused and personalized in communicating with the patient. For example, segmenting by health literacy enables the healthcare organization to divert healthcare educational resources to patients who need it the most.

Q: How do you ensure the conclusion an organization comes to after data is analyzed is able to be fine-tuned on demand and continuously updated as new needs arise and new information is gathered?

Effective data analytics is a continuous learning experience, enabling healthcare organizations to get smarter and more targeted over time. At a macro level, it is important to understand whether the organization was effective in achieving its clinical and business goals, and in what areas and across which populations it was most effective. This type of understanding is a key part of any analytics platform. This way the organization can continue to deploy the most effective strategies, while modifying the less effective strategies in order to promote continuous improvement. At a micro level, it is also important to understand the relative changes in the population in order to ensure that the services offered are in line with the population’s needs.
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Crafting a continuous engagement program

How mobile apps are changing the face of maternity care.

The marketplace is saturated with mobile health apps, but few operate on an enterprise-grade level and can unite payers, providers, and patients in a friendly, seamless way. Even more elusive is a platform that fits this bill and is HIPAA compliant, guidelines based, and developed in conjunction with clinician thought leaders.

The challenges that face this endeavor include IT integration across stakeholder systems, meeting high user expectations, developing effective marketing channels, and navigating enterprise security requirements. All this, and it has to be engaging to consumers too.

Wildflower Health, a San Francisco-based technology company, is meeting these challenges and changing the engagement conversation. Since 2012, their smartphone-based maternity program, called Due Date Plus, has been helping women have healthier pregnancies by tracking their milestones, looking up symptoms and issues, and connecting to healthcare providers and services driven by health plans and Medicaid.

Mobile health (mHealth) programs are especially important in the Medicaid community, which makes up nearly half of all U.S. pregnancies. Smartphone penetration has increased over the last four years by 96.7 percent overall. Within low-income communities (households with income less than $30,000), smartphone use has skyrocketed from 22 percent in 2011 to 50 percent in 2015. In addition, nearly 50 percent of physicians use mHealth apps on a daily basis. The mobile platform has become the common denominator.

Partnering for maternal health

Since 2014, Wildflower has partnered with Xerox to bring Due Date Plus to Medicaid populations nationwide, starting with the state of Wyoming. With an eye to providing a Medicaid-based healthcare resource that can help ensure healthier pregnancies and increase patient engagement, Wyoming agreed to implement Wildflower’s Due Date Plus with Xerox because it is the only pregnancy app that links patients and their clinical information with community resources. The app collects data that can be shared with care managers and nurses, employs tap-to-call for nurse support, and enables access to other statewide Wyoming health resources and programs, such as the Public Health Nurse program and Wyoming’s tobacco quit line. The platform is integrated with Wyoming’s eligibility system to provide Medicaid benefits status.

The WYhealth Due Date Plus program was purpose-built to connect to the healthcare system and specifically support the physicians, nurses, and care managers that work with health plan members during pregnancy. Connecting users through Due Date Plus to their health plan programs and services provides additional maternity support and access to healthcare professionals who can help assess and address risks to the pregnancy. Up to 70 percent of Due Date Plus users access information and services like these within the application.

How does it work? Pregnant women use Due Date Plus to project and map their pregnancy health milestones – from upcoming tests, to fetal development milestones, to feeling the baby’s first kicks. They can track their own weight gain, which is an important issue in pregnancy, look up symptoms and issues, and connect to a 24/7 nurse hotline to get specialized help.

Combining access and analytics to manage risk

Behind the tools and content, Due Date Plus’ pregnancy health algorithm stratifies the pregnant population based on over 50 risk factors specific to pregnancy and refers high-risk women to the WYhealth Case Management program administered by Xerox. The goal is to refer the right women to the program at the right time so that the WYhealth team can better target women who need their services most.

From an engagement standpoint, the system relies on user-driven actions. While many programs employ health risk assessments that consist of one-time interactions and long lists of questions, the Due Date Plus platform allows for continuous engagement. This captures high-risk issues as they happen and provides a more user-friendly interface.

From an analytics standpoint, rolling up data that Wildflower captures in the application with outcomes data generated through medical claims that are analyzed by Xerox allows development of
a rich story of actions that can be used to drive improved healthcare outcomes. The fruits of this analysis will become apparent as more and more users engage and have their babies, and reported outcomes data becomes available.

In order to facilitate this analysis, Wildflower has built a HIPAA-compliant data warehouse and analytics platform. This enables several types of reporting, from risk identification and notification services, to periodic reporting on performance and engagement, to deeper studies to look at particular areas, such as referrals to smoking cessation programs.

**Case managers are a tap away**

WYhealth’s Xerox case managers are an important part of the services that Wyoming provides to their Medicaid population. Their mission is to work with women who need extra support during health events such as pregnancy, especially for those with high-risk health conditions and with behaviors such as smoking and drug use that are dangerous during pregnancy. The mobile application supports these women between contacts with their case manager, giving them a resource to stay connected and involved with their pregnancy.

Due Date Plus is also integrated with the State of Wyoming network of public health nurses to promote the many health services they provide. The application contains a location-based lookup so that users can find the nearest nurse to them and reach out via phone, email, or in person. The connection goes both ways; nurses are important referrers to the program as well.

Because all of this happens on their smartphone, help is always at hand. This is especially important for moms having their second or third child, as they are less likely to be sitting at a computer when an issue arises. Access to a nurse or case manager is just a phone call away.

**Meet the awareness challenge**

Consumer outreach and education has been one of the toughest areas payers face, because of a historic challenge with member engagement. This is all changing with the rise of healthcare consumerism driven by the Affordable Care Act. The Wyoming pilot also has an added advantage as the app is available for use by anyone in the state, not just Medicaid patients. As such, OB/GYNs across Wyoming are engaged and, in turn, offering the program to their patients.

Xerox and Wildflower have developed a two-way engagement model whereby the application can refer users to WYhealth case managers, and conversely case managers refer users to the application.

**Connected customers are happier**

WYhealth Due Date Plus is a very cost-effective way to support maternal health. Women prefer to use their mobile devices to access health information, and this program is a convenient way for them to get connected to Wyoming Medicaid’s resources during pregnancy.

And mobile applications that connect health plans with their members create higher user satisfaction. Members who contacted their health plan via a mobile app at least once in the past year rated their plan satisfaction 108 points higher (on a 1,000-point scale) than those that hadn’t. In the end, it seems the numbers show that engaging patients with useful mobile applications yields better results for providers and patients alike.

---

**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.

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The advantages of self-service screenings

Patient-centric technology improves data collections.

Conducting clinical screenings through conventional practice is time consuming for patients and staff, the methods for collecting the information are rarely consistent, and the quality of the information collected is not always accurate. However, technology offers an opportunity to make clinical screenings a consistent part of patient registration. Patient self-service, delivered on tablets or onsite kiosks, is an effective tool for overcoming these challenges in emergency departments, clinics, and private practice settings. Not only does this solution help providers meet the clinical quality measures (CQMs) put forth by Meaningful Use Stage 2, but allowing the patient to answer clinical screening questionnaires through an electronic device can improve patient satisfaction, accuracy of the data, cost savings, and outcomes.

In a 2012 study at Johns Hopkins Medicine, Associate Professor of Emergency Medicine Dr. Yu-Hsiang Hsieh and his team used patient self-service kiosks to screen patients for HIV in the emergency department (ED). According to the study, 70 percent of patients preferred interacting with a kiosk over in-person bedside interviews with clinical staff. A compelling 60 percent also said they would be interested in using the kiosk to self-test in the future. By using an electronic survey, patients felt less judgment than if they were interviewed by a clinician and therefore responded more willingly and more honestly to sensitive lifestyle questions. Thus, the kiosk-based screening resulted in testing significantly greater portions of patients with high-risk sexual behavior and IV-drug users, and yielded higher rates of newly identified HIV-positive patients. Johns Hopkins presented a compelling use of innovative technology for meeting CQMs goals.

Similarly, Dr. Edwin Boudreaux, Professor of Emergency Medicine, Psychiatry and Quantitative Health Sciences, University of Massachusetts Memorial Medical Center, conducted a study to maximize patient acceptability and data completeness of collecting patient-reported outcomes in the ED. This study replaced the conventional method of collecting patient-reported outcomes, including pain ratings, past medical history, and a battery of behavioral health screeners recommended by the National Institutes of Health, with an electronic system delivered through tablet PCs at the bedside. The system allowed for efficient collection and documentation of patient-reported outcomes with no clinician effort.

The application was optimized to improve acceptability and data completion by patients, leading to more than 95 percent of ED patients who initiated the survey completing all of the items. Key features to maximize completeness included: presenting a single question per screen, using multiple-choice response options rather than responses that require alphanumeric keying, and allowing patients to pause and return to the assessment if they were interrupted by medical testing or interventions. Satisfaction assessments revealed that 90 percent of patients found the survey length, which took an average of nine minutes, to be acceptable during their ED visit. This study shows that patients are satisfied with patient-centric technology, even in the busy, demanding setting of an ED.

Self-service technology can also be used for gathering answers to intake questionnaires. In one example, a private practice of 30 orthopedic physicians uses configurable questionnaires to gather information pertaining to the onset and mechanism of the patient’s injury, as well as family history, past medical history, social history, and key demographic information. Twenty percent of their patients currently complete the preregistration questionnaire prior to their appointment, and another 55 percent complete this information in the waiting room. The use of this innovative technology has reduced errors in patient data. As an added benefit to this change in workflow, this physician group has been able to pre-populate the history of present illness (HPI) for the physician, reducing dictation transcription costs in 2013 by $351,562, or 93.24 percent over the previous year.

One clinic in California that is part of a national health system effectively used patient-directed questionnaires as a tool for preventative care and achieved tangible financial results as an added benefit. By using questionnaires to screen for inappropriate use of antibiotics through kiosks and a decision support algorithm, the clinic reduced inappropriate prescription of antibiotics for its patients and subsequently avoided the cost of acute care for patients who develop pneumonia as a result of resistance to antibiotics. Acute respiratory infections (ARIs) make up 10 percent of outpatient visits at this organization’s clinics, and 20 percent of that patient population are overprescribed antibiotics. Patients with pneumonia are typically treated at the hospital for an average of two weeks, and the cost of treating patients with antimicrobial-resistant organisms versus those without can range from $6,000 to $30,000. Using the lower estimate of $6,000 in hospitalization costs, early intervention to reduce overprescription of antibiotics through the kiosks has the potential to save a clinic of 10,000 patients $1.2 million a year.

The search is on for the holy grail of best practices in preventative care. However, addressing preventative care doesn’t have to be a formidable effort — there are simple ways to produce significant return and better outcomes. Conducting simple patient-directed self-guided clinical screenings through technology is a viable way to start achieving this objective. Very small implementations have proven successful in collecting information for CQMs with a positive patient response and significant return on investment.

REFERENCES
IBM announces the IBM Watson Care Manager as part of a larger move into the cloud

IBM Watson Care Manager brings together Phytel’s patient engagement tools, Apple HealthKit, and Apple ResearchKit, and integrates all of the above into the Watson platform, enabling care providers and patients to work together to support individual health.

The new offering is designed to integrate disparate types of clinical and individual data and apply cognitive analysis to draw out insights for nurses, physicians assistants, and other care managers so they can closely monitor and counsel individuals with complex, costly conditions.

For example, a patient with chronic heart failure may receive a personalized care plan that includes tracking weight daily and monitoring physical activity. Currently, how patients report such data and how care managers evaluate and act on that data has largely been a manual process.

“With the flexible workflow tools and automated patient engagement functionality, we’re able to build evidence-based programs that support our care management team in delivering care to our patients,” says Juie LaPrade, Vice President of Quality, inHealth – a consortium that has curated technology-driven solutions in support of optimal patient outcomes. “This is proving to be enormously valuable in our work in accountable care and population health.”

With IBM Watson Care Manager, a patient can opt-in to have data collected from wireless-enabled scales, wearable devices, other types of sensors, and from assessments delivered to the patient’s device, such as an Apple Watch. Care managers receive insights derived from cognitive analysis of a patient’s integrated data streams, toward the goal of enhancing engagement with the patient so potential health problems are spotted and addressed early. The data related to that individual’s case is then fed back into the IBM Watson Health Cloud, which analyzes over time which interventions correlate with positive results and applies that knowledge to future care management options.

The move comes as part of an expansion to improve the capabilities of the Watson Health Cloud platform, including a program that will help biomedical companies with compliance for new technology.

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 Woodsman 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.

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IBM Watson Health

Quammen
UDI: Not just for manufacturers anymore

Have you heard of UDI? It stands for unique device identifiers; more specifically, it refers to the U.S. Food and Drug Administration’s Unique Device Identification Rule. If you are a busy healthcare executive, it is not surprising if you haven’t, but you should – for multiple reasons.

UDI will likely become part of the growing regulatory lexicon for providers, and it can also play an important role in helping achieve the objectives of healthcare reform.

Why UDI?
We all remember the “To Err is Human” report. The landmark 1999 Institute of Medicine study found that as many as 98,000 people die in U.S. hospitals each year as the result of preventable errors. Many studies indicate that number may have more than doubled in the years since. Many of those errors were medication related – wrong medicine, wrong dosage, wrong patient – leading the FDA Center for Drug Evaluation and Research to work toward creation of a rule requiring prescription drugs and over-the-counter medicine dispensed in hospitals to carry a barcode containing the drug’s National Drug Code (NDC) number. At the same time, the side of the FDA that regulates medical devices, the Center for Devices and Radiological Health (CDRH), wanted to do the same thing, only to find there was not a code analogous to the NDC in wide use for most medical devices. That set the wheels in motion for the UDI rule.

In 2007, the FDA Amendment Act called for creation of “a unique device identification system for medical devices, requiring the label of devices to bear a unique identifier … [to] adequately identify the device through distribution and use, and may include information on the lot or serial number.” It took the FDA another five years to publish the final rule, in large part because the agency wanted to make sure the use of UDI would have faster uptake in hospitals than its pharmaceutical counterpart. In other words, if hospitals and healthcare providers do not use the UIDs, all the rule will have done is add cost and regulatory burden to healthcare manufacturers, which eventually everyone pays for – if not in cost, then certainly in patient safety.

UDI and patient safety
During the time the FDA was working on the UDI rule, there were a number of notable recalls of medical devices due to problems the agency believes it could have identified sooner if UDI had been in place. The UDI is central to the FDA’s plan for “Strengthening our National System for Post-Market Surveillance,” which envisions capturing UDIs for implantable devices in a patient’s electronic healthcare record (EHR) and eventually in product registries. Other regions of the world, including Canada, the European Union, South Africa, and China, are also seeking their own UDI regulations for similar purposes. Thanks to efforts of the International Medical Device Regulatory Forum, those regulations could be globally harmonized, which would mean data captured about usage of a medical device in a registry in one part of the world would be relatable to data about the same product on the other side of the globe. If this vision can be realized, clinical researchers and providers will have access to much more robust data on the real-world performance of medical devices.

UDI regulatory requirements
The UDI Rule as it currently stands primarily impacts medical device manufacturers that sell their products in the United States, although there is one current requirement for healthcare providers and others on the horizon. Briefly, the rule requires medical device manufacturers to assign a UDI-compliant code to each of its covered products, to label those products with the code in both human and machine-readable (e.g., barcode, RFID) formats, and to publish additional data on those devices to the FDA’s Global UDI Database. The deadline for Class III devices to be in compliance was last September, with the second batch of products (those deemed implantable, life saving, and life sustaining) required to comply by September and with the database component by Oct. 24. That means all implantable devices, regardless of class, should bear UDIs this year. The compliance deadline for the balance of Class II devices is Sept. 24, 2016, and two years later for all non-exempt Class I devices.

When the FDA published the final rule, the agency also announced it was going to make amendments to some existing regulations to conform with the new rule in order to create a more holistic approach to integrating medical device information throughout the entire healthcare system. In other words, UDI will be fundamental to everything CDRH does around medical devices going forward. That includes how it receives information about adverse events. One of the conforming amendments changed Part 803.32 in the Electronic Code of Federal Regulations, requiring hospitals and other sites the FDA deems user facilities to include the UDI when reporting adverse events involving serious injury or death.
Earlier this year, the Centers for Medicare and Medicaid Services (CMS) issued a proposal that would require providers to exchange UDIs for implantable devices as part of the proposed Common Clinical Data Set (CCDS) in EHRs to meet Meaningful Use Stage 3 (MU3), while the Office of the National Coordinator for Health IT (ONC) would expand the criteria that EHR technology must meet to be certified for MU3, including the ability to:

- Create a list of a patient’s implantable devices in the EHR;
- Parse the device identifier and production data, (e.g., lot, serial number, expiry date) from the UDI;
- Link to the Global UDI Database (GUDID) to retrieve additional device information; and
- Add the UDI to the CCDS to enable the list of implanted devices to be exchanged as part of a patient’s core medical history. CMS and ONC are expected to issue their final rule based on comments received on the proposals by the end of the year. While support among hospitals is mixed, supporters believe UDIs in EHRs can help answer critical questions such as:
  - Is an implanted device compatible with MRIs?
  - Which patients must be notified in the event of a recall?
  - How well is the device performing?
  - Does the surgeon know, prior to revision surgery, which device needs to be explanted?

As you might imagine, many of the EHR vendors (with the notable exception of athenahealth), commented that they thought the proposals were premature, with some suggesting that, if anything, UDI capture should be handled as free text. Surprisingly, given that the UDI rule specifically requires manufacturers label devices in a manner that the UDIs can be captured using auto-identification and capture (AIDC) technology, there was no mention of AIDC requirements in the 2015 proposal. Prior proposals and the FDA post-market surveillance plan both highlight the importance of deploying such technology, which can avoid manual entry errors when capturing UDIs and other information.

Others requested more information, such as how to define an implantable device or document implantable devices in the consolidated clinical document architecture (CCDA) guidelines. These types of questions raise some of the technology challenges that need to be overcome to achieve the full potential of UDI. One of the comments questioned the necessity of UDI in the first place, noting that it will require significant investment from a software perspective with little return. These comments mirror some of the original concerns stated by manufacturers who questioned, if they go to the expense of implementing UDI – which can easily be in the tens of millions of dollars, even for a mid-size supplier – will their customers use the data?

### Technology implications

There are a few pioneering provider organizations that have started on the journey to UDI adoption and implementation, even without government regulation. One of the first was St. Louis-based Mercy, which conducted a UDI demonstration project in the cath lab under the FDA’s Medical Device Epidemiology Network (MDEpNet). The primary purpose was to create a database that would match patient information from clinical records with UDI-associate data attributes for coronary stents implanted in those patients, although a secondary objective was to identify obstacles in the process. One of the technology lessons learned was that the hemodynamic software deployed in the cath lab could not receive barcode product information from the point-of-use system, requiring double scanning by clinical staff until a functioning interface could be developed.

Figure 1 depicts where Mercy uncovered integration challenges in capturing and sharing UDI-like data. Initial discussions with the technology vendors uncovered a perception that developing closed architecture systems is a competitive advantage. That relatively prevalent opinion among many vendors is starting to change, especially in light of heightened Congressional interest in the interoperability of EHRs. Other issues included the inability of some software to hold the full UDI, which includes both the device identifier and production data, such as serial number and expiration date, and the need to crosswalk between various product identifier formats, as well as standards used for facilities and locations.

While there were challenges, there were also recognized benefits in a variety of areas, including:
- More accurate and automated charge capture,
- Improved inventory management,
- Reduced supply chain inefficiencies,
- Reduced days payable outstanding,
- Visibility to real-time product usage and automated replenishment, and
- More effective adverse event reporting and comparative effectiveness research.

Mercy has quantified the value of many of these improvements. For example, one of the cath labs discovered it had $1.9 million in physical inventory, compared to an estimated $800,000 listed on the books. Within just six months, it had already cut that number by nearly 20 percent. In another case, the effort uncovered $300,000 in expired inventory for a single vendor, prompting negotiations to create a shared savings program around reducing product wastage.

On the other hand, other benefits are hard to quantify. By being able to link specific implant data with patients, Mercy can not only save time responding to recalls but it can also reassure patients like one who commented, “I feel exposed and anxious that if there is a recall I won’t know if I have that cardiac device.” As the MasterCard commercials say, some things you can quantify, while others are “priceless.”

### REFERENCES


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![Figure 1](https://example.com/figure1.png)
Simplifying workflows to improve patient transfers
Software allows Hershey Medical Center to streamline referrals.

By Chad Michael Van Alstin, Features Editor

There was a time when Penn State Milton S. Hershey Medical Center, located in Hershey, PA, had difficulty accepting new patients, especially those coming from referrals. When Director of Patient Logistics at Hershey, Heather Boyle, recalls the issue, she is frank and to the point.

“The referring hospitals were unhappy with how difficult it was to get patients into Penn State Hershey,” she says. “The process was very decentralized, and even though calls were coming in to one number, the person taking those calls had to coordinate the acceptance of a patient through many places.”

During our conversation, Boyle went on to detail the old process, which sound ed arduous and time consuming. In short, a nurse had to make several calls before being able to give a simple ‘yes’ to another organization about Hershey’s ability to accept a patient. And worse yet, because so many individuals were involved in the process, the inability to get the correct person on the phone sometimes resulted in the patient being turned down, even though a bed was open and available.

After calling in consultants to examine their workflow, data revealed what clinicians at referring organizations already knew - the Hershey Medical Center admissions process could use some improvements to meet the high standards of the teaching hospital. Beds were too often left empty, and patients were stuck waiting unnecessarily. Hershey was simply not operating at maximum capacity, and consultants believed a simple workflow change could solve the problem and improve efficiency.

Armed with numbers and specific recommendations from the consulting firm, funding came through to establish a Patient Logistics Department and a new Transfer Center to handle referral admissions.

Bringing in the right software
Powering this new center is the appropriately named TransferCenter software from TeleTracking, which Boyle says was selected in part because of Hershey’s relationship with the company, which dates back to pre-2008. Further, the workflow changes promised by the software met the recommendations of the consulting firm by allowing for a streamlined, simpler admission process, thanks to patient flow monitoring capabilities.

Whereas the original process was decentralized and involved the person on the phone contacting several others to complete a successful admission, the new TransferCenter system is cleaner, in part simply because the R.N. who actually receives the transfer request is able to coordinate everything from their computer screen through the TeleTracking system. Without even leaving the line, the nurse can bring an attending physician into a call for some basic questions, assign a bed, and coordinate all necessary transportation.

“It’s all done through one central person, and they can do everything really quickly,” says Boyle, detailing features of the TransferCenter software that allow the user to view a patient’s admission order and track details such as what time it came through, which bed is for which patient, and how each bed has moved through the health system as they’ve received care.

Despite a necessary period to habituate staff and familiarize clinicians with the new workflow, Boyle, who says her job is to monitor the hospital’s capacity and workflow procedures, says the Transfer Center and the Patient Logistics Department met their goal of increasing referral rates “very, very quickly.” After only a few months, the hospital was able to improve its number of transfers from an average of 11 per day to almost 13.

“We were able to increase the number of transfers from outside the hospital per day within the first six months,” she says. “Just by nature of having the centralization and the software to visualize what we’re doing, we increased the number of transfers right away.”

Still moving forward
Sitting now just shy of three years after the initial launch of the Patient Logistics Department and the adoption of the TransferCenter solution, Boyle says Hershey has sustained all of its initial growth and operates at full capacity. While she admits they haven’t grown their number of transfers further, that’s only because “there’s simply not a lot of room to increase further. We’ve sustained our improved referral rates without adding any beds.”

Future business studies are currently being drafted to implement TeleTracking’s Orchestrate application to improve operating room workflow, and RTLS technology to better monitor equipment and the movement of patients. Boyle says she hopes to implement these solutions to allow more patients to receive timely care. HMT
USER RATINGS IDENTIFY BIGGEST IMPROVERS

Everyone likes to see improvement, and KLAS Research’s “2015 Midterm Performance Report: Software & Services” report lets healthcare organizations in on who the power performers are when it comes to rated technologies. Thousands of healthcare providers at physician offices, clinics, hospitals, and integrated delivery networks (IDNs) in North America gave their opinions on the healthcare software they’ve been using, and scores have been tracked over time. The report, released July 30, provides feedback on healthcare technology software vendors in 93 market segments and features the software products that have demonstrated the greatest improvement in score since the “2014 Best in KLAS: Software and Services” report published in January of this year. HMT takes a look at what makes these five highest scorers exceptional.

McKesson Practice Partner

This fully integrated EHR and practice management (PM) software helps practices of all sizes do more for patients with less effort. The Practice Partner system includes three powerful applications that are available individually or together: Patient Records, Medical Billing, and Appointment Scheduler.

What makes it a standout: The flexible documentation tools adapt to each provider’s preference, be it templates, speech recognition, digital pen, dictation, and/or Web-based patient data entry. The coding wizard checks claims as they are posted for compliance with insurance rules. Support for wave scheduling, double booking, and customized daily calendars improves scheduling flexibility.

CureMD EMR

CureMD is a leading provider of innovative healthcare solutions and services, namely EHR, practice management, patient portal, population health management, and medical billing services that transform the administrative and clinical operations of healthcare organizations. With 109,000 satisfied users across 44 states and 34 specialties, this EHR software has proved to be extremely adaptable with the availability of all modules in a single system, offering anytime/anywhere information availability.

What makes it a standout: Constant focus on research and development has helped CureMD raise the bar for usability. The solution is packed with enterprise-grade functionality minus the complexity that has become characteristic of many similar EHR vendors.

Designed by physicians, CureMD provides specialty-rich content and decision support for delivering better care at a fraction of the cost charged by other vendors. Its focus on both software and services has ensured quality delivery throughout, enabling CureMD providers to meet all regulatory, ICD-10, PQRS, and Meaningful Use requirements without compromising patient care. With a focus on individualized service, CureMD support has one of the lowest issue-resolution times in the industry.

Recondo Technology Patient Access

Hundreds of U.S. hospitals rely on the Recondo suite of Patient Access solutions to deliver complete and current answers on patient coverage, liability, and demographics, plus real-time authorization requirements and status.

What makes it a standout: Like the rest of Recondo’s revenue cycle solutions, the EmpoweredPatientAccess suite leverages the company’s patented Reconbot technology, which takes the revenue cycle to the next level by automatically querying payer websites and then retrieving, normalizing, and presenting critical information about eligibility, authorization, and claim status. This solution was also given high marks in KLAS’s “KLAS 2016 Midterm Report” with a +15% increase in score.

OnShift (Long-Term Care Only)

OnShift delivers cloud-based staff scheduling and labor management software and proactive services to solve everyday workforce challenges in healthcare. Post-acute and senior-living organizations rely on OnShift to control labor costs, improve performance, and drive quality care by empowering providers to staff more efficiently. OnShift predicts and prevents overtime and understaffing while dramatically reducing time spent on scheduling and managing open shifts.

What makes it a standout: Intuitive design, predictive analytics, and customer success management are why thousands of post-acute care and senior-living organizations depend on OnShift. Only OnShift provides easy-to-use, predictive tools to help providers schedule employees, predict overtime to lower costs, and fill openings to staff properly—each and every shift.

Allscripts Sunrise Emergency Care

Sunrise Emergency Care is a complete emergency department information system designed by ED clinicians to support this fast-paced environment. It is powered by the Allscripts Sunrise EHR platform—an integrated suite of solutions for acute, post-acute, ambulatory, surgery, revenue cycle, and emergency healthcare providers.

What makes it a standout: The interactive Tracking Board provides real-time, rules-based patient tracking, including icons with real-time badges that show orders, status, and results with patent-pending hover technology. A workflow manager tool monitors patient-centric tasks that need to be completed for compliance or best clinical practices that enhance patient outcomes and increase throughput.

STATDOCs templates streamline discharge documentation for high-frequency, low-acuity complaints—about 60 percent of all discharges. ED Provider Notes and ED Procedures use complaint-driven templates to speed the documentation of common procedures and high-acuity complaints. Advanced visual documentation through an interactive 3D human avatar provides drag-and-drop functionality of clinical objects that enter discrete values into the patient record, which significantly decreases the time needed to document.
Information Exchange
What APIs bring to EMR/EHR interoperability

By David Boerner, Senior Solution Consultant, Orion Health

Much has been made of embracing an open application program interfaces (API) strategy to achieve interoperability, but what does this actually entail? Think of APIs as programmatic gateways to allow access to information in a controlled manner. The Centers for Medicare & Medicaid Services (CMS) has proposed the use of APIs for EMRs, which would allow providers to enable new functionalities to support data access and patient exchange. So what is an open API strategy’s role in helping achieve interoperability? Let’s delve a little deeper.

What do open APIs solve?
- Connectivity: APIs can solve connectivity between systems by clearly defining transmission and security rules.
- Expansion: APIs can grow the healthcare ecosystem by allowing applications to share data with any other system.

What don’t open APIs solve?
- Integration: End systems still require clearly defined message standards dictated by their clinical systems. Just because you’ve sent data to a system doesn’t mean the system is capable of interpreting it.
- Workflow: Arguably the most complex interoperability challenge, APIs can only connect the dots, not determine which dots to connect.
- Services: An open API strategy will expose connections, but they are meaningless without the services behind them to actually do something. These will need to be developed.

Why should you look at an open API strategy? Cost is one major factor. The financial savings could be impressive. If the API strategy is implemented soundly, there could be major implications for reimbursement, speed, and ease of deployment of new interoperable services. Safety is the other major factor. Security of patients’ protected health information (PHI) could be increased due to more effective and secure interoperability standards.

As far as deployment goes, open API strategies are starting to be used in the healthcare ecosystem, especially in the healthcare startup world, where they are following widely successful use in the social media (Facebook, Twitter) and e-commerce (Amazon, eBay) industries. Federal organizations such as the Office of the National Coordinator for Health Information Technology (ONC) have taken note and included an open API strategy as a path toward meeting thresholds for the eight measures in Meaningful Use Stage 3 (MUS3). Meanwhile, healthcare providers and payers are seeking new paradigms to increase the adoption and speed of interoperability amongst the players in the healthcare ecosystem.

But when could we realize any tangible benefits? If two parties have already fully implemented an open API strategy, then yesterday. The reality is that most have not, and it will require time to design, implement, document, expose, and connect the systems together.

How do I embark on an open API strategy?
- Evaluate: Look at your current strategy. Is your organization struggling with interoperability and integration? If it isn’t broken, don’t fix it.
- Investigate: Explore the ecosystem of products your organization interacts with. Do they have plans to expose APIs? Open API is only effective when everyone works together.

It is important to realize that, although an open API strategy serves a role within the interoperability puzzle, it isn’t the solution. If implemented soundly, an open API strategy could enhance the interoperability landscape, all while growing your pool of integrated applications and services. The challenge lies in understanding that APIs aren’t a panacea for all interoperability challenges and will require significant development behind the scenes to create and expose useful Web services.

REFERENCES

Interoperability
Alliance’s info swap keeps growing

Five Cerner clients in the Pacific Northwest have agreed to use CommonWell Health Alliance services to securely exchange patient data with a growing number of provider sites across the United States. CommonWell Health Alliance is a not-for-profit association of health IT companies working together to create universal access to healthcare data. Cerner clients Virginia Mason Medical Center, Seattle Cancer Care Alliance, EvergreenHealth, Tuality Healthcare, and Mason General Hospital & Family of Clinics will share records with regional physician practices that use Greenway Health and athenahealth EHRs, as well as with the acute and ambulatory healthcare provider organizations nationwide who already use CommonWell. The alliance expects to have more than 5,000 provider sites enrolled in CommonWell services by the end of the year. Cerner is a founding alliance member.

CommonWell services address four key challenges in healthcare interoperability:
1. Patient identification and linking: Assist healthcare IT suppliers to identify patients more quickly and accurately as they transition through care facilities.
2. Patient access, privacy, and consent management: Potential future capabilities include a patient-authorized means to simplify management of data-sharing consents and authorizations.
3. Record locator and retrieval: Help providers locate and access their patient records, regardless of where the encounter occurred, by providing a “virtual table of contents” that documents available data from each encounter location.
4. Trusted data access: Provide authentication and auditing services that facilitate secure data sharing among member systems.

The CommonWell approach to patient record accessibility is unique. Services are built directly into the CommonWell Health Alliance’s info swap network, keeping growing.
Get integrated secure text messaging

athenaText, a secure text messaging service that is fully integrated with athenahealth’s cloud-based EHR platform and accessible through the standalone athenaText and Epocrates mobile apps, is now available, at no cost, to all 1 million-plus healthcare professionals on the athenahealth network. This includes every athenaClinicals EHR and Epocrates user. Whether using athenaText via Web-based athenaClinicals, a mobile phone, or Apple Watch, providers can leverage the power of the new text messaging service to communicate with teams in dynamic environments, create care networks for curbside consult or patient referrals, and access clinical intelligence through Epocrates. Later this year, physicians will be able to exchange patient charts securely across care settings via athenaText. athenahealth www.rsleads.com/510ht-183

Built to handle the U.S. Coast Guard

The U.S. Coast Guard is using the InterSystems HealthShare health informatics platform to enable strategic interoperability for its Integrated Health Information System (IHiS), making it possible, for the first time, to view a comprehensive EHR across the Coast Guard’s disparate systems. As the Coast Guard transitions from legacy systems to a commercial EHR solution, HealthShare provides standards-based interoperability to unify health information from civilian and Coast Guard care providers. Clinicians can now view longitudinal health records for Coast Guard and U.S. Department of State beneficiaries. The IHiS encompasses ambulatory care, urgent care, dental, physical therapy, optometry, behavioral health, occupational health, immunizations, audiology, radiology, pharmacy, and laboratory records. InterSystems www.rsleads.com/510ht-182

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Cultivating a great physician champion

As the healthcare industry transitions to value-based models, hospitals, healthcare systems, and physician groups have come to recognize the value that physician champions can bring. In fact, in a recent survey of healthcare executives, The Advisory Board Company found that nearly 90 percent were interested in engaging physicians in cost and quality enhancements— which had been ranked third in importance in 2014. Physician engagement has emerged as a top strategic priority among healthcare organizations because institutions have discovered that buy-in from clinicians is imperative to value-based care, and this in turn has made the role of the physician champion more important than ever before.

Along with improving engagement, a strong physician leader can also influence those clinicians who are concerned about how the transition to value-based care will impact their ability to provide high-quality care to patients. A 2015 survey of primary care providers conducted by The Commonwealth Fund/Kaiser Family Foundation revealed that many providers have mixed views about medical homes and accountable care organizations, and have negative opinions about the increased use of metrics to assess performance. Additionally, nearly half said they are considering early retirement because of recent health trends, which underscores the need for leadership.

Part nature, part nurture: Finding the right physician champion

The process of finding the right physician leader within an organization is just as crucial as the need for the role itself, and it can be very challenging. Many healthcare organizations do not have a formal selection process in place. While physicians are some of the most highly educated professionals in our society, their formal education does not typically prepare them to address the challenges that come with leading the operation of a healthcare facility. This can make identifying the right candidate internally—one who possesses the leadership and skills to improve hospital outcomes, meet evolving industry needs, influence clinicians about value-based care, and ensure that patients receive the best possible care—a daunting exercise.

Here are some guidelines that provider organizations should consider when searching for the physician champion who best suits their needs:

1. Establish clear objectives and metrics. Before reaching out to candidates, take a step back to set expectations and make sure that there’s a consensus on what success should look like and the path to get there. For example, is there a need to address whether or not physicians at the organization are concerned about penalties for things they can’t control in the new value-based care model? What’s most important to tackle first: reducing the number of unnecessary lab orders or improving patient satisfaction? To achieve success, first define key values, strengths, needs, and priorities, then seek out candidates who are already meeting or exceeding those standards and expectations.

2. Acknowledge needs and current workflow. No single person can do everything by themselves, and no two physicians are the same. It’s important to understand the unique challenges that your champion may already be facing. Also, be sure to prioritize workflow goals as this will help physician leaders avoid burnout or dissatisfaction—which could easily spread throughout the wider physician community.

3. Set leaders up for success with an evidence-based approach. Provide data and leverage analytics to help the leader determine those drivers and circumstances within the organization that are affecting performance. Objective data can empower physician leaders when coaching other physicians.

4. Establish realistic short-term goals for quick rewards. By setting short-term, realistic goals, physician champions can achieve early success and serve as a role model or advocate for other physicians, patients, and executives. For example, a provider could be tasked with improving diabetic hemoglobin A1C levels among his or her cohort by 10 percent over the course of six months. By implementing tailored blood-glucose monitoring, nutrition counseling, and exercise, a physician could achieve this within the established time frame to showcase not only how a process improvement can be successful, but also significantly improve patient health and satisfaction. Starting small creates early successes and lays the groundwork for future, larger scale projects.

While these guidelines are a great start, the actual process of identifying and cultivating a physician champion will vary greatly between organizations. The most successful healthcare organizations will be those that are strategic about selecting and investing in the best physician champion for their needs.

References

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