2016 and BEYOND
security
wearables
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data

Women in HIT: Good for our industry
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Mobility solutions
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VIEWPOINT

The time for telemedicine is now!

By Chad Michael Van Alstin, Features Editor

Skyrocketing costs will force patients to find workarounds.

WELCOME TO THE FIRST ISSUE OF HMT FOR 2016! It being the season for resolutions and predictions, I feel obliged to offer my take on the future of healthcare tech, though admittedly my perspective is tainted by my own desires and personal experiences.

As I graduated college, I became unexpectedly ill and was forced to quit a decent job in order to make less money. That may seem absolutely ridiculous, but as an uninsured, single person with an undiagnosed problem (which eventually was revealed to be Lyme disease), qualifying for Medicaid was the only option if I wanted to get the care I needed and avoid a mountain of unpaid medical bills. Quitting my job, going on food stamps, and deferring my interest-bearing loans cost me a fortune and put my life on hold for over a year – but doing so actually minimized the damage. Only in a corrupt, inflationary system would any of this make sense – and sadly, healthcare services in this country are exactly that.

Since my experience, the landscape has changed with the full implementation of the Affordable Care Act, but for me the problem of being uninsured remains. Simply put, health insurance is too costly for a single, indebted millennial like me to justify, and the high-deductible plans I can afford make the insurance I’d pay for utterly worthless. And I’m not alone. The rate of uninsured is dropping due to the mandate, but consumers are being forced to front more and more of the bill for their healthcare. It boggles the mind, and it’s a sign that the system is still every bit as corrupt and inflationary as it was in the past. For single, kid-free members of the middle class like myself, the benefits offered by insurance subsidies may as well be non-existent.

So, either the market will push everyone to have children and take lesser-paying jobs to lower their income, or another solution will present itself. While I remain confident the government will remain in the pocket of the insurance companies, thus continuing on the path of inceptitude when it comes to lowering the cost of care for the middle class, I do believe technology will respond positively to this growing concern – and the response of the health IT industry will be telemedicine.

Going forward, the importance of telemedicine cannot be overstated. While presently the level of adoption and acceptance makes it difficult for the real benefits to be quantified on a mass scale, telemedicine will begin to carve out its own niche in the market by offering consumers cheaper alternatives and more control over their own care as costs continue to soar.

I remain unconvinced that penalties will force holdouts to purchase insurance when they can’t afford it. As such, I believe those who desperately need antibiotics or a swift diagnosis are going to find telemedicine to be far more affordable than the luxury of great insurance coverage. Simply put, health insurance is too costly for a single, indebted millennial like me to afford, and personal experiences.

For resolutions and predictions, I feel obliged to offer my take on the future of healthcare technology, though admittedly my perspective is tainted by my own desires and personal experiences.

As wages remain stagnant, and we continue to see young people saddled with debt, the rising cost of healthcare is going to be difficult to contain – the time for something to give is now. 2016 is the year telemedicine will really find its legs and start to shine. Telemedicine won’t solve the problem of high insurance costs, but for some a prescription and a few diagnostic tests can go a long way toward avoiding a disaster, and there are profits to be had by filling that need.

As always, I welcome your feedback at cvanalstin@npcomm.com.
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2015 Best In KLAS: Medical Equipment

Announced Nov. 12, these vendors earned the title of 2015 Best in KLAS – a highly coveted recognition of their efforts to help healthcare professionals deliver better patient care. Created and updated yearly by KLAS Research, this segmented Best in KLAS designation is reserved for vendor solutions that lead two markets, imaging and pharmacy automation equipment, with the broadest operational and clinical impact on healthcare organizations.

The KLAS performance ratings were gathered over the past 12 months for medical equipment vendors in 15 market segments. Each segment includes a listing of vendor products ranked according to their KLAS performance scores (shown in parentheses below), which have been compiled from the feedback of thousands of healthcare providers at physician offices, clinics, imaging centers, hospitals, and integrated delivery networks throughout the United States and Canada.

**Imaging Equipment**

**Computed Tomography**
- Siemens CT (86.8)

**Mammography**
- Hologic Mammography (91.4)

**Magnetic Resonance**
- Siemens MR (85.8)

**Radiation Therapy**
- Elekta Radiation Therapy (86.5)

**Ultrasound**
- Toshiba Ultrasound (86.7)

**X-ray**
- Shimadzu X-ray (87.0)

**Pharmacy Automation Equipment**

**Automated Medication Dispensing Units**
- Omnicell OmniRx (86.4)

**Smart Pumps**
- CareFusion Alaris (85.2)

Payor Trust Index

Survey uncovers insurers least trusted by doctors

Results from a new poll of more than 600 primary care and specialist physicians across the country indicate that physicians broadly mistrust health insurance companies and say insurers can interfere with their ability to provide high-quality patient care.

The ReviveHealth Payor Trust Index measured trust based on parameters such as physicians’ perspectives on a health plan’s efforts to honor its commitments, to honestly and accurately represent itself and its intentions, and to not routinely take advantage of physicians. The No. 1 factor cited by physicians as influencing their opinions about whether health plans help or hurt the delivery of high-quality care: more coverage and fewer claims denials versus poor coverage and more claims denials.

Physicians said they have the least trust in UnitedHealthcare and Humana. They have the most trust in local Blue Cross Blue Shield Plans (BCBS) and deemed them best at enabling the delivery of high-quality care; United was pegged as the worst.

Unfortunately, physician mistrust of health plans will likely only get worse with the mega-mergers of the nation’s largest health plans now under review by the Department of Justice (DOJ), said ReviveHealth Sounding Board member Nathan S. Kaufman, Managing Director of Kaufman Strategic Advisors and an expert in payor-provider relationships. Those deals include Anthem’s proposed takeover of Cigna and Aetna’s acquisition of Humana.

The Payor Trust Index was established last year by ReviveHealth and research partner Catalyst Healthcare Research as part of the healthcare marketing communication firm’s nine-year annual survey of health system executives’ opinions of what it’s like to do business with the nation’s largest health plans. The agency this year extended the Trust Index to physicians. The Index asks a series of questions examining various issues related to trust and assigns a numeric score from one to 100.

Overall, physician trust in the nation’s largest insurers is bleak; the average of all combined scores was 58.1 out of 100. This is slightly higher than the 51.8 that hospital leadership gave insurers when they took the survey earlier this year.

Key physician perspectives from the latest Payor Trust Index include:

- BCBS plans were identified as the best partner for enabling delivery of high-quality care (46 percent).
- United was most often mentioned as the worst at enabling delivery of high-quality care (26 percent), followed by Humana (16 percent), Aetna (15 percent), and Anthem/Wellpoint (14 percent).
- When considering the justifications for the “best” ratings, five of the top six criteria listed were relationship factors; payment rates were brought up as the sixth most important factor (9 percent).

The survey was administered online among 605 physicians (75 percent medical specialists and 25 percent primary care) representing 45 of the 50 U.S. states and the District of Columbia.

Source: ReviveHealth
**Document Management**

**‘Supertank’ printer wins big-time design distinction**

The creators of the laser-quality Epson WorkForce ET-4550 EcoTank All-in-One color printer solved the problem of dealing with empty ink cartridges in an ingenious way: They got rid of them. Instead, the “Supertank” printer comes loaded and ready with up to two years of ink in its refillable container, so users can print up to 11,000 black/8,500 color pages—equivalent to about 50 ink cartridge sets—without changing anything.

Another big bonus is that the high-capacity tank takes low-cost replacement inks. Genius.

Auto two-sided printing, a 30-page auto-document feeder, fax and scan capabilities, and wireless printing (even without a network) from tablets and smartphones round out the features set.

This under-$500 design is so impressive that it was recently named a CES 2016 Innovation Awards Honoree and was featured in the special Innovation Awards Showcase at the huge International Consumer Electronics Show in Las Vegas this January. Last year’s event catered to a whopping 170,000 attendees from across the globe checking out all the latest next-gen business and personal tech tools.

**Interoperability: Emergency Department**

**Dissatisfaction with EDIS usability widespread**

A new Black Book survey of 738 emergency department (ED) administrative and nursing managers, and 1,104 ED physicians, found that 89 percent of ED leaders believe their hospitals rushed to purchase new EHRs and ED systems between 2010 and 2013 for Meaningful Use dollars, just to see “productivity fall, liability rise, and connectivity stall.”

Respondents say the lack of emergency department information system (EDIS) usability and interoperability with external providers adds to a burgeoning list of ED concerns, creating a swiftly growing replacement market.

Thirty-five percent of hospitals over 150 beds are currently replacing or plan to replace their EDIS in 2016. The majority of replacements (69 percent) are those that are using enterprise EHR emergency modules but are opting for best-of-breed EDIS systems that can integrate with the hospital’s EHR.

A bright spot is that hospital administrators are including ED physicians and nursing staff in the EDIS decision-making process, something that was rarely done just a few years ago when the original systems were chosen.

**Hospitals**

**A room of one’s own cuts HAIs**

Hospital-acquired infections, which affect one in 25 patients according to the CDC, are the most common complication of hospital care in the United States and lead to extended hospital stays that increase costs and risk of mortality.

A new study from researchers at Cornell University finds that the purported high building costs of private hospital rooms can definitely be offset by the financial benefits of keeping patients safer from infection.

“We showed that although single-patient rooms are more costly to build and operate, they can result in substantial savings compared with open-bay rooms—all of this by avoiding costs associated with hospital-acquired infections,” said Hessam Sadatsafavi, Cornell postdoctoral researcher and lead author of a recent paper in the Journal of Critical Care.

The researchers compared costs of constructing single rooms or converting multi-patient rooms to private rooms, including subsequent annual operational costs, and then looked at the “internal rate of return” to assess the financial feasibility of the investment in private rooms. For investors, the internal rate of return must be acceptable—10 percent, for example—to consider the project feasible. The researchers discovered that building new private rooms or private-room conversions made economic sense, as the internal rate of return—over a five-year analysis period—was 56.18 percent, considerably higher than any liberal estimates of rate of return acceptable by healthcare organizations.

Source: Cornell University
Looking forward: HIT in 2016 and beyond

Industry experts forecast future trends – no crystal ball required.

By Chad Michael Van Alstin, Features Editor

The pages of HMT cover a wide variety of topics, from healthcare policy to EMRs, to wearable devices and trendy health gizmos. As such, our look at HIT going into 2016 – and beyond – features a diverse assortment of perspectives from experts across the space. Here we feature voices from providers and vendors alike, each lending insights from their particular area of expertise.

Telemedicine adoption rates will continue to climb

Michael Sherling, M.D., MBA, Co-Founder and Chief Medical Officer, Modernizing Medicine

As a physician practicing in the modern world of medicine, it is abundantly clear to me that technology is a major driving force behind the future direction and success of healthcare. One major trend that has impacted healthcare this past year was the continuing adoption of telemedicine – an industry that, according to Forbes, will become a nearly $2 billion market by 2018. While telehealth has been around since the 1960s, technological advancements of recent years have made remote medicine more viable and valuable than ever before. As we approach 2016 – and as more physicians begin to adopt telemedicine into their practices – we will quickly reach a tipping point of adoption and implementation.

Innovative healthcare professionals are turning to telemedicine as an added way to serve patients more effectively and expediently. The convenience offered by this technology allows physicians to provide treatment, diagnosis, and professional advice for patients when a virtual visit is appropriate. Often, patients are not able to come into a doctor’s physical office for a variety of reasons, including a lack of mobility, geographic separation from the doctor’s office, or work or family obligations. Telemedicine creates a more timely and convenient way to treat and assist patients that might not require an in-person appointment.

Beyond time savings and improved access to care, telemedicine also opens up a new revenue stream for physicians, allowing them to bill for virtual appointments, without increasing physical traffic in their office. Finally, the ability to manage common care issues remotely allows physicians to spend more time and focus on complex cases or patients with atypical symptoms.

While physicians have to carefully research and understand new technologies like telemedicine before adopting and implementing them in their practices, there are clear and significant advantages.

Telemedicine provides a unique opportunity for physicians to increase patient care access through technology, and I expect that we will continue to see advancements and subsequent adoption rates in 2016 and beyond.

Wearables will show their true colors

Ron Razmi, M.D., CEO, Acupera

The current wearables landscape, overall, is not unlike Gartner’s Hype Cycle. Consumers are out buying wearables and are either sitting at the edge of the Peak of Inflated Expectations, pumped that their new wristbands will be helpful in some way, or have already fallen into the Trough of Disillusionment, recognizing that they only collect finite information that really doesn’t help them plan or behave differently, as it relates to overall health and wellness.

Today’s wearables market has created a confusing data deluge that will actually slow progress. This can only be changed if devices are architected in ways that permit them to absorb, analyze, and create workflows in real time, based on the user’s information. The lack of definition regarding how wearables should actually help consumers and providers – and compounding the issue, the lack of integration with overall care management platforms and processes – has relegated the devices, for now, to mere novelties.

Where there’s opportunity for wearables to actually be effective is with those in need of chronic care management, and for these devices to capture data that aligns with the workflows of their care management strategies. Only when health systems and providers determine what information will be useful – and how it fits into overall care management strategies – will the wearables landscape start pulling up toward the Slope of Enlightenment, moving closer to a true Plateau of Productivity. This transition will only begin once care managers and health systems really understand which data sets are needed from these devices to strengthen population health management and make consumer collaboration central to care.

In a perfect world, wearables would be developed in ways that capture and share truly useful data, transforming it into workflows for consumers and providers. Today, the data is just a nuisance – and consumers are being scammed.
Mobile advancements will push personalized medicine

I believe that 2016 will be the year of personalization in healthcare. Consumers are tired of counting calories and looking at large quantities of data to help them improve their health. History has proven this method is not sustainable, and people are finally beginning to realize that. Consumers are also sick of being stuck in the one-size-fits-all approach of the healthcare system, and they have started to demand the same level of customiza-
tion from healthcare that they receive from other industries. This is the year we will begin to see consumers get what they want.

Technology, and more specifically health applications, will drive this level of personalization. Although there are over 165,000 health apps right now, few focus on people as individuals. In order to help create meaningful behavior change, we have to provide consumers with personalized feedback that adds context around their data and actions. A high level of personalization can be created by providing people with specific information based on their lifestyle and background, as well as understanding what motivates them and what sets them back when guiding them to their best overall health.

As a physician, I find that it is absolutely critical for me to treat each of my patients as individuals. I understand the importance of knowing my patients on a personal level and treating them based on this. The same is true with a health application. In order for people to find success with this platform, they must be able to trust that it is providing them with the best solution for them as an individual.

Now is the time to shift to value-based care

Every eight seconds a boomer enters Medicare. In 2016, this trend will continue as the more than 76 million members of the baby boomer generation continue to leave the workforce and move into retirement. At 65 or older, and often presenting one or more chronic diseases, this population requires increased medical care and is directed to Medicare as their primary health insurance coverage.

With more than one-third of the U.S. population having left, or on its way to leaving, the private insurance network, the increased move to Medicare is tightening margins for payers across the board. As much as 45 percent of this population is noncompliant with their healthy lifestyle recommendations and live with unmanaged chronic diseases, such as diabetes, obesity, and cardiovascular disease, which also leads to higher out-of-pocket costs for patients as well as a decrease in payer revenue.

To compensate for these shifts, 2016 will be a tipping point in the move from a fee-for-service model to preventive medicine with compensation based on outcomes. The transition to value-based care is not easy considering less than half of providers are aware of value-based programs related to chronic care management (CCM) and transitions of care management (TCM). Additionally, it will require more advanced analytical, care-coordination and patient-engagement tools and services. Putting actionable insights into providers’ hands, these tools enable practices to reconcile patient data, stratify risk, streamline revenue, track quality compliance, drive patient engagement, and facilitate personalized remote care. Essentially, the right tools can make value-based care not only possible, but profitable.

Practices and providers should take advantage of the opportunity to opt in and get ahead of the curve. Beyond deeper engagement with patients, value-based programs offer financial benefits and can be particularly attractive to primary and ambulatory care providers that deal with preventable chronic diseases on a daily basis. With the right tools in place, 2016 is the year to embrace value-based medicine – making an impact on the cost of health care, improving patient outcomes, and strengthening your bottom line.

LTPAC will finally embrace e-prescribing

While use of EHR and e-prescribing technologies is commonplace within many hospitals and health systems, the long-term and post-acute care (LTPAC) market is just beginning to dip its toes in the information technology pool – and 2016 promises to be a good year for swimming.

As it relates to use of these technologies within our organization – for example, if a member of the medical staff gets a call and needs to write an order – he or she has access to the patient’s entire medical record at a glance via our automated e-prescribing program provided by SigmaCare. Physicians can remotely access our e-prescribing system on their phones, tablets, and computers and directly communicate with the pharmacy. Not only does this expedite the prescribing process, it prevents transcription errors, dosing issues, and other safety lapses and cultivates a more symbiotic and collaborative relationship between clinicians and pharmacists at our facilities.

In terms of the future for the industry as a whole in the coming year, LTPAC organizations face many challenges that technology-enabled solutions can address. To remain competitive in this increasingly crowded market, organizations will need to find ways to enhance value and outcomes for patients – something that electronic systems are designed to do. At the same time, tightening reimbursements will mean these organizations will be called on to do more with less, pushing them to improve efficiency and prioritize cost-saving initiatives. Reporting requirements are also skyrocketing, and organizations that don’t adopt an integrated EHR and financial system may quickly get overwhelmed.

With the advent of a new year, LTPAC organizations stand on the edge of opportunity. The coming year will certainly see some changes as providers begin to join their hospital and health system peers in embracing technology and initiating exploration and adoption of specific processes, like e-prescribing.

Smooth sailing for the ICD-10 transition

Overall, the ICD-10 transition went exceptionally well. Providers were more prepared than initially anticipated, which is evident from the low number of diagnosis-related denials from payers since Oct. 1. Payers were also prepared, with few syntax errors, indicating their systems were ready to at least receive the
Hopefully, healthcare IT executives will industry is beginning to think of security. As we move into 2016, the healthcare approach to security. A paradigm shift is coming in the changes rolling out in the New Year, ensuring regulatory requirements are continued educating their staff on ICD-10 documentation as well as the new specificity in ICD-10 codes will make it easier for payers to reimburse providers and patients. However, biomedical devices are a special case – and healthcare IT executives need to stop worrying so much about the traditional IT devices – PCs, laptops, smartphones – and start protecting the most important things: patient data and identities. With this mindset, the healthcare IT industry can begin investing in long-term strategies rather than thinking of security as a short-term necessary cost, and begin to see that security must be part of a holistic, comprehensive digital strategy, not a series of unconnected point solutions.

Finally, implementing information governance will also shift the focus from technology to the people and policies that generate, use, and manage the data and information required for care and related processes. And, as with all technology, we’ll recognize that fancy, expensive tools will not fix security. This isn’t about tools; it is about educating employees and encouraging a workplace culture focused on enhancing security. To do this, security leaders and their teams will stop trying to do security manually. Instead, executives and staff will automate security to the greatest degree possible in their organization or use services to enhance it. And, to top it all off, they will learn to better communicate with management to help them understand what is happening and the risks involved, so they can be actively engaged in security decisions.

As we move into 2016, the healthcare industry is beginning to think of security as more than just checking boxes. Hopefully, healthcare IT executives will realize that security is not only a compliance issue but also an assurance issue, and non-IT executives will begin to understand that security is a people issue, not a technology issue. Computers don’t click links, steal critical data, or social engineer – people do. And it’s people who can stop breaches from occurring.

We must also recognize that biomedical devices represent a huge security gap to providers and patients. However, biomedical devices are a special case – and healthcare IT executives need to stop worrying so much about the traditional IT devices – PCs, laptops, smartphones – and start protecting the most important things: patient data and identities. With this mindset, the healthcare IT industry can begin investing in long-term strategies rather than thinking of security as a short-term necessary cost, and begin to see that security must be part of a holistic, comprehensive digital strategy, not a series of unconnected point solutions.

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A paradigm shift is coming in the approach to security

David Finn, Health IT Officer, Symantec

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I’ve been in private practice as a primary care provider for over 20 years. I’ve been watching the news over the years suggesting that more and more physicians are seeking employment with larger health systems and hospitals. For several years the trend seemed to be growing at a steady pace. But recently it appears to have slowed. Today, the number of doctors who are employed by a hospital is a little over 30 percent, according to the American Medical Association, while just over 50 percent say they are owners in their own practice.

As I talk to my colleagues now, I hear many saying that they’d prefer to stay independent – or go back to private practice – and they are seeking ways to do that and be successful. They ask me how I’ve done it. Honestly, the first thing I say is that I have tried to be open to trying new things, and I have chosen technology that can support me no matter what path I take.

I believe that physicians and patients are more satisfied when doctors control their own destiny without too much interference. There are more solutions and support for the independent provider today, and it is possible to thrive despite the challenges. I predict that the independent doctor will be something we will see more of – not less – in the coming years.

Epic will continue to dominate, Optum will regain market share

Michael Creef, M.D., Family Practice Physician in Chesapeake, VA

Epic will continue its dominance of the EMR market in large hospital systems. Epic signed up over 100 new clients in 2015. Continued merger and acquisition activity coupled with strong sales will lead to more and more hospitals using Epic. Love them or hate them, Epic is universally recognized as the best-in-class vendor for large hospitals. “Best of breed” doesn’t work with enterprise-wide systems. Ask anyone who came from the ERP (enterprise resource planning) space. Hospitals need technology to seamlessly integrate so the people in IT aren’t doing data entry all day. The easiest way to integrate is to use the same vendor for as many areas as possible, even if that vendor isn’t best of breed in every area. Epic does not let implementation fail and is the best and most integrated EMR system. The war is over, and Epic has won.

Hospitals will continue to struggle with ICD-10. While some of the largest hospital systems adequately prepared and trained their people, many hospitals were expecting ICD-10 to be delayed indefinitely and did not prepare nearly enough. ICD-10 is significantly more complex than ICD-9, and most coders cannot yet code effectively. Productiv-
It is down across the board, consulting rates are through the roof, and there is a massive talent shortage. Outpatient coders are having a harder time adjusting than inpatient coders. The scores on our ICD-10 coding tests are bad for inpatient and absolutely horrible for outpatient. I believe this is because outpatient coders need a much deeper knowledge of the human anatomy to code correctly in ICD-10. It is going to be years before things stabilize.

I also think Optum 360 gains back market share from 3M in the coming year. Optum 360 is significantly easier to use, and clients are seeing a much smaller drop in productivity than 3M clients. Sorry 3M, but Optum has a better product.

Clinical documentation improvement is going to be huge as hospitals attempt to retrain every doctor on how to write their charts to maximize reimbursements. HIM departments have been so focused on making sure they code correctly that they have not had time to train the doctors. This changes in 2016.

2016: The year of open EHR platforms

Jonathan Bush, Co-Founder, CEO, and President, athenahealth

2016 will be the year of open platforms. Most hospitals and health systems run legacy technology that was never designed for the Internet age or to let information flow beyond a health system’s walls. Counter-intuitively, our institutions are fighting to hold onto their old, conveniently outdated platforms. But market forces are pushing healthcare to open up, expose its APIs, and let innovators in. Closed health information systems will have a harder time surviving as the hospital moves farther away from the epicenter of care. Patients are becoming the healthcare consumers they were born to be, seeking care from retail clinics, telemedicine, and urgent-care chains.

These patterns, coupled with the emergence of value-based reimbursement, are placing more pressure on hospitals to share information and coordinate care. It’s now crucial for institutions using different health IT platforms to share clinical data and deliver seamless care in order to achieve — and get paid for — high-quality outcomes. This paradigm shift is going to open the interoperability floodgates. Fortunately, there is a new class of cloud-based technology that allows health information to flow.

No institution can be all things to all patients. Most hospitals can’t offer the convenience of a retail brand. Retail clinics will never do brain surgery as well as an academic medical center. To remain viable, institutions need to become “focus factories” and specialize in the slice of the healthcare market where they can have the best outcomes, lowest costs, and offer the most convenient services. Under this model, information sharing, not information hoarding, will be a health systems’ greatest asset and comparative advantage.

References

AMA, CHIME focus on interoperability

American Medical Association (AMA)

We must improve the interoperability of health information systems, and 2016 is shaping up to be an inflection point for the seamless exchange of data throughout the healthcare system. A redesigned Stage 3 is needed in the coming year to shift the conversation away from the prescriptive mandates of Meaningful Use and toward a flexible approach with a focus on achieving better clinical outcomes. That means we must see an end to the fixation on electronic health records as the only digital health tool at our disposal. EHRs don’t change patient behavior or improve engagement.

To enhance the patient-physician relationship, we need policies in 2016 that encourage a choice from the broad pallet of digital health tools. Telemedicine, mobile apps, and other digital health tools can play a greater supportive role in team-based care, preventive services, and individual wellness. Prerequisites for this patient-centered approach are interoperability and usability.

- Steven J. Stack, M.D., President, AMA

College of Healthcare Information Management Executives (CHIME)

Since enactment of the HITECH Act in 2009, the nation’s healthcare providers have made significant strides in implementing electronic health records. The adoption of robust health IT systems will better enable providers to achieve the Triple Aim of better care, an improved patient experience, and reduced costs. However, we still face some significant challenges – not the least of which is being able to exchange patient information across the care continuum. What’s needed now is a laser-like focus on interoperability. Providers, vendors, and government officials must make interoperability a priority in 2016.

Ensuring that providers can exchange patient information is key as we continue to see the development of accountable care organizations and population health management. Because patients are more mobile than ever before, we need to make sure that their medical records are accessible wherever and whenever they seek care. We believe that a national patient identification system is an essential building block to achieving interoperability.

We’ll also see a greater emphasis on cybersecurity in 2016. Healthcare CIOs are tasked with the daunting job of protecting patient information in a highly digital environment. Threats are evolving, and there’s no respite on the horizon. Working across the industry and with other stakeholders, including the federal government, we must continue monitoring for cyber threats and establish best practices for minimizing the risk of a cyberattack.

- Russell Branzell, FCHIME, CHCIO, President and CEO, CHIME
Correcting critical misperceptions about patient engagement

Clinicians objectively measure. We implement improvement processes. Then we measure again. We do all this with the aim of increasing value: improving clinical outcomes, reducing costs, and increasing patient satisfaction.

But not when it comes to “patient engagement.”

To many healthcare leaders, integrated delivery network (IDN) administrators, even to doctors and nurses, patient engagement is at best a fuzzy concept. Today’s continually evolving potential threats (reimbursement penalties) and rewards (shared savings) demand strategies founded in “evidence-based” content and clear, specific, measurable clinical and financial outcomes. In this world of objective tools and strategies, “patient engagement” is simply too ambiguous. After all, if we can’t objectively measure it, if we don’t clearly understand its clinical and financial impact, and if we are unable to improve it, there are simply too few resources and not enough time to waste on patient engagement.

But here’s the shocking truth: We can measure patient engagement. And we can understand the (significant) impact of engagement on value. And we can drive improvement. But first, our society must undergo a paradigm shift in who we view as a healthcare “provider.”

Doctors, hospital CEOs, senators, plumbers, electricians, chefs, teachers, your mom, my dad … we must all appreciate that if our society (including our loved ones and our wallets) is to realize the full potential of healthcare reform, we must dramatically expand our perception of who is responsible for our health and healthcare. We must not only accept but embrace the patient as provider. Because the reality is that we will only experience a limited bump in clinical and financial improvement if we continue to define “provider” so rigidly, legislating reform on the backs of traditional providers. Even those suffering from chronic conditions spend only hours annually under the care of a doctor, nurse, or other clinician. Thus, it will only be when a significant percentage of us truly accepts ownership of our health – the way that we own our finances, child-rearing responsibilities, and virtually everything else in our lives – that our society will achieve dramatic and sustainable improvement in the quality and cost efficiency of our healthcare.

The comparison I frequently use is that we legislate seat belt usage, but only when drivers and passengers buckle up do we see a reduction in the physical, emotional, and financial damage that results from auto accidents.

The common perception is that there is no valid way to measure it objectively and repeatedly. This could not be further from the truth. Likely the most frequently utilized instrument to objectify patient engagement is the Patient Activation Measure (PAM). This 13-question survey-style tool was developed through a rigorous process at the University of Oregon by a team led by Judith Hibbard.

Now commercially available, the PAM has been repeatedly evaluated in more than 20 countries and languages, with study results published in peer-reviewed articles. The PAM is simple for patients to understand and requires only minutes to complete. Thus, the first critical piece of the puzzle is in place: We can objectively and repeatedly measure patient engagement.

Based on such credible measurement instruments, a nation, state, city, accountable care organization (ACO), or IDN, or even single hospital or ambulatory center, can stratify its patient population into sub-populations based on demonstrated levels of engagement. For instance, the PAM segregates survey users into four high levels of patient healthcare ownership and involvement: Disengaged and Overwhelmed; Becoming Aware but Still Struggling; Taking Action; and Maintaining Behaviors and Pushing Further. Dividing a population into valid engagement-level cohorts is enormously powerful, allowing resource managers to allocate staff, money, and time more effectively and efficiently.

Patients on the lower end of the ownership spectrum may be targeted for more frequent and deeper outreach (including personal outreach by nurses or others), whereas populations demonstrating greater engagement may require less frequent and simpler interactions (such as emails or auto-calls).

But the use of the PAM or other patient engagement measurement tools is only useful for resource allocation if there is a clear relationship between engagement and desired outcomes.

And there is.

The evidence demonstrates that engaged patients have better clinical outcomes and lower costs of care. In terms of the PAM specifically, pa-
tients with higher scores are more likely to demonstrate a number of higher value behaviors, such as: autonomously seeking out medical knowledge and using medical resources; eating a healthy diet, exercising regularly, and maintaining a healthy weight; controlling blood pressure, cholesterol, and HbA1c; adhering to prescribed medical regimens; better managing chronic conditions; completing prescribed post-operative physical therapy; and participating in preventative care activities. And the correlation between PAM score and patient outcomes holds true on the opposite end of the spectrum: Patients with lower scores are more likely to be admitted to the hospital, utilize the emergency department, and be readmitted soon after hospital discharge (almost twice as likely). And here’s the kicker: Improvement in PAM score has been shown to correlate with meaningful improvement in healthcare value. For example, even small PAM score increases correlate with reduced hospitalizations and increased prescribed medication compliance. Thus, the second piece of the puzzle is in place: There are clear, objective correlations between both static and dynamic patient engagement measurements and value.

That we can measure patient engagement, that patient engagement correlates with desired clinical and financial outcomes, and that improvement in patient engagement translates to improved value is the framework on which sound, impactful patient engagement strategy can be created and implemented. Fortunately, the third and final piece of the puzzle is already both available and continuously improving: HIT solutions that (when combined with appropriate human-to-human interaction) can truly engage, educate, and ultimately empower patients.

A limited number of vendors provide creative solutions to address the first challenge, which is true engagement. These impressive, interactive, social media-like products incorporate gaming, captivating iconography, and even humor to rapidly draw their target audience in. Next, the engaged patients and their loved ones have access to evidence-based information to guide them in preventative and health maintenance activities specific to them. Leading patient engagement vendors offer this critical educational material in text and video formats, in the hospital or at home, in multiple languages and in varying educational levels. Finally, more and more interactive products are empowering engaged, educated patients in seeking credible, specific information and appropriately communicating with their providers. Don’t get me wrong, there is little doubt that HIT solutions that support care delivery by doctors, nurses, pharmacists, and other clinical personnel can reduce preventable deaths and harm. But ask yourself, “How many hours did I spend under the direct care of a traditional provider this last year?” Statistically, people spend their entire lives away from doctors, hospitals, and clinics. We don’t depend on our insurance agent for our driving. Thus, depending even moderately (let alone heavily) on the small population of traditional providers to alter the behavior and activities of the entire population is (to put it kindly) naive. Traditional providers are the seat belts in our healthcare system. Only when the population of patients and future patients (that is to say, all of us) chooses to buckle up will we harness the true potential of healthcare reform.
BY MOLLY MALOOF, M.D., Medical Advisor, Kareo

The key to creating a healthcare environment that patients want to keep coming back to is found in two words: patient engagement.

Patient engagement is probably one of the most misunderstood and controversial recent buzzwords in healthcare. Depending on who you are, patient engagement is either the second coming of healthcare or another pesky hurdle for providers to overcome. Furthermore, it can have a different meaning depending on who you ask.

Policy leaders define it as “lowering costs by increasing operational efficiencies and quality of care.” Entrepreneurs define it as “finding inefficiencies and bringing value through products or services.” Providers define it as “beneficial to overall patient outcomes and care, but with a negative return on investment (ROI),” because they see it as more unreimbursed for taking the time to digitally communicate with patients – not to mention how to obtain ROI from investing in these technologies.

However, there are some clear returns when practices invest time and money into a patient engagement and practice-marketing platform. The most significant is the reduction of no-shows by sending text and email reminders. A secondary benefit is that visit surveys, which can be syndicated on a variety of online review sites, can also be sent after the appointment. This cycle of electronic communications not only brings convenience to the patient and reduces lost revenue, but it also has a positive impact on the practice’s online reputation. As a result, the practice is better positioned to increase new patients who are searching online for a provider.

According to Google, over 75 percent of patients search online before making an appointment with a medical provider. Doctors, practice administrators, and CIOs should be looking at digital marketing to attract new patients, retain existing ones, and grow their practice. Smaller practices can gain as much as 20 percent of their new patients from online sources.

A new wave of cloud-based technologies is offering independent practices ways to engage with patients effectively online and on their mobile devices as well as to market their practices better on the Internet and social media. Effective, profitable patient engagement through digital marketing at any size practice really boils down to the “3 Rs”: reminders, reviews, and recare.

Plenty of research and real-life experience has taught the industry what patients want: to be able to go online and email their doctor, book an office visit, see physician reviews, get appointment reminders, and view their medical records. But it isn’t clear for many how a small practice physician can get reimbursed for taking the time to digitally communicate with patients – not to mention how to obtain ROI from investing in these technologies.

Patients want doctors who offer email and automated text and email appointment reminders. For example, Westgate Skin and Cancer, a solo practitioner dermatology office in Austin, TX, has a very effective mix of sending email reminders two days before a patient appointment followed by a text message reminder two hours before the actual appointment. This has resulted in an impressive 70 percent reduction in patient no-show rates.

Reviews are a very important consideration when looking toward online patient engagement and marketing. Professor Michael Luca at Harvard Business School published a study about this called “Reviews, Reputation, and Revenue: The Case of Yelp.com.” An interesting statistic he found shows that where Yelp reviews penetrated a local market, the business of chain restaurants declined because consumers began trying more independent businesses as they gained confidence about their quality. This is an exciting statistic, as it points to a strong opportunity for independent practices to compete effectively against larger health systems by embracing an aggressive and effective positive reviews strategy. The survey also found that an increase in star rating can be tied to an increase in revenue – a one-star increase equated to a 9 percent increase in revenue.

The final “R” of effective engagement is recare. At its heart, recare is a method to engage patients by reminding them to come in for office visits or routine checkups. Recare messages should be done through emails – not text – as they lack the immediacy of an appointment reminder. Take great care in testing how your recare messages appear to patients on iPhones and Android phones, since many people now read most email on their smartphone.

Make sure the subject line is straightforward and to the point. It should tell the reader what is inside the email, not sell the reader the content. Subject lines can make a significant difference in the open rate of recare emails. Most people will assume a subject line that reads like an advertisement will be spam. You want your patient to know the message is from your clinic and not just random junk mail.

There are two types of recare messages – those that are generic and those that are...
condition specific. Many reminder systems allow your office to send mass emails such as newsletters, or send patients an annual, bi-annual, or more frequent series of reminders to book an appointment for an office visit. There are more sophisticated types of recare systems that will read the chart or billing data in an EHR or practice management system and send your patients unique, condition-specific recare messages. For example, a Type 2 diabetes patient could receive a series of diet or medication reminders. While independent practices can use the first type of generic recare messaging well, condition-specific recare messages for smaller practices are still in their relative infancy as an industry or feature set.

There is a question of whether or not condition-specific recare messages may create more workload for practices. Condition-specific messages may prompt patients to ask continued questions to the provider, and in manners that are not compensated or reimbursable for the practice. Because this feature is still a relatively new field, the data emerging is not yet conclusive. Even if condition-specific recare software isn’t available for small practices, some doctors send out seasonal messaging to fit the needs of their clientele, while others send out messages to patients on their birthdays. Seasonal recare messages are great for reminding patients about flu season and safe summer fun. Practices can also use birthday recare messages to remind patients of health checks that happen around their milestone birthdays, such as a prostate exam email for men on their 50th birthday.

Ideally, the 3 Rs work together to keep your patients connected to your practice, improve their satisfaction, and potentially improve wellness and outcomes. In addition, by encouraging those patients to re-review your practice, new patients are more likely to choose your practice over one that isn’t offering options to meet changing patient needs and expectations.

Patient engagement is incredibly important for medical practices to consider in today’s healthcare landscape and for other reasons as well. The potential ROI will only grow as value-based reimbursement continues to expand and practices look to take advantage of programs like chronic care management. It will also play an important role in increasing patient loyalty as practices strive to remain independent and stand out from competing retail clinics and hospital-owned practices. HMT

REFERENCE

HIMSS Value Score is next-gen health IT analytics tool

If you are looking for ways to qualify and quantify your health IT efforts and spend across departments, divisions, and the whole enterprise, the Healthcare Information and Management Systems Society (HIMSS) is on your wavelength.

The HIMSS Value Score, the latest generation of several HIMSS-developed standards and resources, is billed as “healthcare’s first international quality measurement for the value of health IT” and aims to “give providers a way to look at their entire organization and capture a 360-degree view of how they achieve value beyond the electronic health record.” It’s a natural development for C-suite leaders who have turned to HIMSS throughout the years for insights and guidance on how to use IT optimally to tackle today’s challenges and prepare for those to come. In the long term, it should help users optimize and use IT to improve clinical and financial outcomes, and drive efficiencies in care.

But how can it help in the real world? Pat Wise, R.N., Vice President of HIMSS, gives the following example: Two organizations could be Stage 7. However, their Value Score could be significantly different based on how they are utilizing HIT to drive clinical, financial, and operational outcomes. In another scenario, a Board of Directors could use the Value Score to understand the extent to which executive management is optimizing outcomes. The converse is also true: The C-suite could use the Value Score to demonstrate to the Board of Directors how investment in HIT is being realized.

The Value Score is the next generation of several HIMSS-developed standards and resources that have served as the leading health IT adoption models for providers over the last decade. For example, HIMSS Analytics’ EMRAM has helped hospitals and clinical practices track and benchmark their EMR adoption and utilization goals since 2005. The HIMSS Health IT Value Suite and Value STEPS, released in 2013, have provided both a framework and vocabulary for providers to articulate their value strategy. They offer thousands of entries and more than 900 detailed case studies that can provide strategies, tactics, and measures used to document value.

HIMSS developed the guidelines for the Value Score and is currently refining the scoring algorithm across provider organizations in the United States and abroad, including HIMSS’ Davies Award winners and small critical access hospitals. The results for this initial pilot group will include actionable data sets and scores.

Upon entering the next phase of technology and innovation, healthcare will need a new, truly universal standard and model for value. HIMSS says that its Value Score will “fill that void.”
Is Meaningful Use the most effective way to build an interoperable health system?

The United States Congress, with the passage of the HITECH Act in 2009, forever changed the face of medical information delivery. Despite the ubiquitous adoption of billing systems in the 1990s, and some early adopters of electronic health records (EHRs), healthcare remained sorely behind other industries in use of modern technologies for one reason: There was little business case to do so.

Then came the EHR Incentive Program, also known as Meaningful Use, which aimed to incite broad adoption and lay the groundwork for larger delivery system reforms. The legislation created a business case to adopt and use EHRs that applied to most (but not all) healthcare providers. The response across stakeholder groups was broadly positive, and the process to bring the idea to fruition began.

Now, five years into the program for Eligible Professionals (EPs) and Eligible Hospitals (EHs), healthcare has changed. Most hospitals and physician practices use an EHR today, and these adoption levels represent a huge success within the EHR Incentive Program. Essentially, we’ve constructed the information highway and are now focused on putting as many cars on it as possible.

However, we haven’t reached other initial goals of the program, and in some cases the regulatory fingerprint has had unintended consequences. Which begs the question: Is Meaningful Use still the most effective way to drive behaviors we want from healthcare institutions, clinicians, and patients?

The Centers for Medicare & Medicaid Services (CMS) has said that continuing Meaningful Use is necessary to transition the industry away from fee-for-service to fee-for-value. Some providers are still moving to an EHR or switching to a system that offers more advanced features, and some may still be motivated by the remaining Medicaid incentive dollars. CMS also makes a valid point when they say some providers haven’t yet embraced practices that will deliver great benefit to patients, such as a liberated exchange of information among providers, regardless of financial affiliation.

That said, now is the time to evaluate if the program’s current structure, execution, and statutory authority can satisfy the next goals: information exchange and outcomes improvement. Or would other policy levers be more effective in prompting consistent clinical information exchange and, ultimately, achieving a digitized, connected community of health?

At the advent of the program, focusing on functional and process measures made sense. It was a training program, in some ways, for most EPs and EHs going live on their first EHR or dramatically ramping up from basic EHR use. It ended up pushing EPs and EHs to incorporate clinical decision support into their workflow, for example, and provided valuable benefits from the medications-allergies cross-check functionality within EHRs. All of that was good progress.

However, CMS now expects program participants to do much more than Stage 1 requirements. The challenges with Stage 2 (and likely Stage 3) have caused many providers to resist continuing further. The EHR Incentive Program does not address the fundamental gap between what is best for patients (ensuring the availability of all necessary information) and the reality of what CMS actually pays healthcare professionals to do.

Until we address the complexity of interconnected factors of payments and delivery system mechanics, we limit our collective ability to advance interoperability and data exchange.

So what to do?

The Department of Health and Human Services (HHS) is taking its first step with the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) and is also evaluating the best paths forward for additional delivery system reform programs. It is also a perfect time to evaluate how the EHR Incentive Program will fit into this future.

Generally, there is a clear tie between payment policy and the choices professionals make. When fee schedules from government and commercial payers started to reward care coordination and information exchange, such behavior started to increase. After dabbling in payment and delivery reforms like accountable care organizations (ACOs) and patient-centered medical homes, we now have data to help evaluate what has worked, jettison what has not, and protect those who have done well from future penalties.

In fact, Secretary of Health and Human Services Sylvia Burwell has the authority to expand the successful payment models without Congress. There’s no need to navigate legislative gridlock or the yearly budgeting and appropriations process – instead, the CMS Innovation Center can expand what works at its own discretion.

The MACRA offers additional levers to drive...
change. CMS has a significant amount of discretion in how it formulates the program, and it can implement approaches that the market has been requesting. For example, when writing the detailed rules for the Merit-based Incentive Payment System (MIPS), the agency has an opportunity to re-vamp the EHR Incentive Program. CMS can tie incentives to outcomes-based measures and correct some of the most challenging elements of past regulations, such as the all-or-nothing approach to satisfying Meaningful Use requirements.

Further, the second option under MACRA – the Alternative Payment Models (APMs) – will open the door to creative policy-making that will present new opportunities to physicians and other caregivers. CMS will expand models that already exist, such as ACOs, and we can expect testing and formulation of new approaches in the next several years before and as the APM reporting period officially starts. For example, given the impact of cancer care and costs on the national landscape, it would be wise to fast-track payment reform for cancer. We should also scale up multi-payer state programs, which harmonize quality measurement efforts and prioritize electronic care coordination within a geography (addressing one of today’s main complaints from physicians and hospitals).

Most importantly, an intensified focus on payment and delivery-system reform enables actual market-focused use cases to drive interoperability efforts. Letting physicians and other caregivers prioritize efforts to exchange information where it will deliver the greatest value would have an immediate impact on interoperability success. Instead of executing what they must to satisfy regulatory requirements, providers would want to exchange information because it would be financially beneficial and clinically relevant to their patients. It would also help develop end-goal programs – such as establishing and expanding precision medicine, for example – enabling them to take root more quickly and effectively.

To realize success, the policy-making process must begin now. Some recommendations for consideration:

• View information exchange infrastructure as a public infrastructure. Address the questionable policies of the Office of the National Coordinator for Health Information Technology (ONC) of five years ago, which allowed states to set up data-exchange approaches without any requirement to adopt common standards. Fixing this issue will afford opportunities for all providers – regardless of geography.

• Significantly shift ONC’s focus to reviewing and promulgating standards and expanding privacy and security requirements. The ONC needs to move away from the overly prescriptive feature-function regulations of recent years, allowing software developers to make up ground by expanding the benefits of user-centered design.

• Similarly, it is time to recognize that certification of EHR products should not take the place of other more effective policy approaches. For example, CMS indicated in the Request for Information on the MACRA implementation that it is considering additional certification programs, which would likely expand the government’s influence on product development. Additionally, it is evaluating how EHRs could perform a variety of tasks that do not fall within the data-capture structure of the systems, such as patient-satisfaction survey results. Innovative healthcare technology should be limited as little as possible by government-dictated constructs, as this approach will negatively impact user workflows and ultimately program success.

• CMS must recognize the unique challenges of independent small practices that are barely skimming the surface of their technology in many instances, within MACRA regulations. It would be prudent to escalate requirements gradually, reflecting the need for an orderly transition to the new payment environment while also responsibly raising the bar on information exchange.

• The shift to a quality-based payment schema means two important things. First, the industry will need to work collectively to rapidly develop, test, incorporate, and train on a significant number of quality measures in the coming years so physicians and others feel confident that the measurement determining their Medicare payments is valid and clinically legitimate. Additionally, the measurement and reporting requirements will only continue to grow. While disruptive, they will provide an opportunity to address data-capture technologies and workflows creatively. While Meaningful Use is required within the MACRA legislative language to be part of the MIPS program, it should not be part of the APM rules in coming years. It is sensible to require providers to use certified EHRs and continue to demonstrate a commitment to interoperability and privacy protections, but a prescriptive approach to Meaningful Use simply won’t make sense as APMs take hold at the end of this decade. Instead, it is more sensible to allow market forces – under new payment models within the APMs – to naturally drive information technology use where it delivers real value.

HMT
Look beyond EHRs for MU compliance

Since its creation as a part of the American Recovery and Reinvestment Act of 2009, Meaningful Use has grabbed healthcare IT headlines every few months. Physician sentiment toward electronic health records (EHRs), attestation statistics, and politicians seeking to amend or freeze the program have all resulted in media-worthy controversy. Just last October, rulemaking changes were announced that simplified the reporting burden for Stage 2 and extended the deadline for providers and states to comply with the new requirements and prepare for the next set of system improvements.

To refresh your memory, the American Recovery and Reinvestment Act of 2009 specified the three main components of Meaningful Use: 1. The use of a certified EHR in a meaningful way; 2. The electronic exchange of health information to improve the quality of care; and 3. The use of certified EHR technology to submit information about clinical, quality, and other measures.

There are three successive phases, each more rigorous than the one that came before. Simply put, “meaningful use” means providers and hospitals need to show they are using certified EHR technology in ways that can be measured to improve healthcare quality, and when they do, they receive incentive payments.

My extensive work with EHRs and those using them has led me to conclude the use of an EHR alone is insufficient to meet the goals articulated by the creators of the Meaningful Use program. Very often, providers using EHRs do not know what happens once a patient leaves their facility. Hospitals and physician practices need a complementary platform that catches all of a patient’s interactions with the healthcare system – a platform that integrates and aggregates the information from all sources to create a full, 360-degree view of the patient and his or her risks and ideally automatically populates pertinent, prioritized actionable patient-specific information into the existing clinician workflow.

The creators of the Meaningful Use program had five core goals, and today’s innovative analytics and insights platforms offer providers and hospitals robust tools that go beyond the EHR to meet these goals cost effectively.

Goal #1: Improve the quality, safety, and efficiency of care while reducing disparities

There are a number of features within cutting-edge analytics and data solutions that help providers achieve this goal. A common data fabric brings disparate sources of data together, including clinical, claims, EHRs, medications, lab results, family medical history, and patient-generated information from clinical and fitness wearables, and integrates all of this information into a single, holistic patient record. This 360-degree view of the patient improves the visibility of information to all members of the care team and, subsequently, reduces silos of care and improves care coordination. Leading analytics platforms seamlessly provide prioritized actions to the clinician, integrate the information into a patient summary, and identify open care opportunities, such as mammograms and colonoscopies, and open quality opportunities to improve a patient’s health based on clinical guidelines.

Similarly, there are a number of provider-specific features, including:
• Provider performance information and dashboards that illustrate efficiency and trends, and demonstrate how providers are managing quality and efficiency as compared to peer groups and/or benchmarks;
• Quality performance dashboards with high-level statistical information for attributed patients currently enrolled in disease or case management programs that illustrate how providers are performing with respect to standard measures, such as healthcare effectiveness data and a physician quality reporting system;
• Opportunities and gaps related to coding, quality, and care, and the ability to submit metrics to the Centers for Medicare & Medicaid Services (CMS) and health plans; and
• Cost and utilization reporting that enables administrators to understand how consumers – whether they are called employees, members, or patients – can be guided to use healthcare services more efficiently.

Goal #2: Engage patients and families in their care

The single holistic patient record referenced above also supports patient and family engagement by including all members of the patient care team: primary care physicians, specialists, facilities, nursing, and support staff, as well as involved family members. Referrals can be made easily to other care team members and care management nurses. Information is seamlessly shared among the complete care team.

Mobile engagement apps can be integrated into the patient record to improve engagement and health. Similarly, some mobile apps and patient portals engage patients and members in important ways to understand cost and price transparency, interact with clinicians, and educate them on diseases and health conditions.
Meaningful Use

Goal #3: Promote public and population health
The common data fabric that integrates multiple and varied sources of data into a holistic record for each patient enables all venues of care to achieve the Triple Aim and Meaningful Use goals, thereby supporting public and population health. Measurement of providers by cost, utilization, and specialty enables benchmarking and lends support for the best practices to achieve population health.

The most robust analytics platforms not only identify coding, quality, and care gaps, but also push these opportunities into the provider and payer workflows to facilitate closing these gaps. Rules and algorithms that continuously sniff the data and dynamically create new insights that improve individual and population health are equally important features in these platforms. Understanding and stratifying patient risk and using that information in day-to-day healthcare operations is key to achieving the “meaningful use” of EHRs. This requires organizations and systems to interoperate and, rather than just automate, use the technology to redefine their processes.

Goal #4: Improve care coordination
The holistic patient record built from the common data fabric improves care coordination where members of the patient care team, including primary care physicians, specialists, facilities, nursing, and support staff, as well as involved family members, can easily share information with each other and communicate. The EHR in a hospital or a physician’s office typically does not have the ability to show everything that a patient experiences as they move through the healthcare system to get care.

In addition, a population health platform with the 360-degree view of the patient includes care gaps with the ability to close them at the point of care. It should also include tasks and workflows that allow the care team to view and manage every encounter a patient has – regardless of whether those encounters are inside or outside their facility. The result is better management of patient care, improved patient experience, and fewer touch points. A true longitudinal view of the patient record uses advanced predictive algorithms at an individualized patient level, such as the ability to predict their propensity to engage in health programs like oncology or disease management.

Goal #5: Promote the privacy and security of patient information
Above all, today’s data and analytics platforms must protect the privacy and security of patient information. Our ability to create a holistic, 360-degree view of each patient and use this information to improve their health is predicated upon the consumer’s belief that we have deployed the best minds and cutting-edge technology to protect their data – and will continue to do so.

It seems likely that physicians and hospitals will continue to be challenged by the expanding Meaningful Use requirements that must be met to receive incentive payments, and that increasingly they will look beyond the EHR to innovative analytics and insights platforms to help them meet these requirements while simultaneously improving the health of their patients.

CHIME calls for ‘laser-like focus’ on interoperability and a new timeline to implement Stage 3
The College of Healthcare Information Management Executives (CHIME) urged the federal government on Dec. 14, 2015, to give healthcare providers more time to adjust to recent changes to the Meaningful Use program before mandating new Stage 3 requirements. CHIME said extending the timeframe for Stage 3 no sooner than 2019 would allow all stakeholders – policymakers, providers, and vendors – to fully implement modifications made in October to Stage 2, and to focus energies on the critical issue of interoperability.

“CHIME members are committed to the goals of the Meaningful Use program,” said CHIME Board of Trustees Chair Charles E. Christian, CHCIO, LCHIME, FCHIME. “We have made significant progress in implementing information technology systems to improve patient care and reduce costs. However, we do not believe that the course laid out by the Centers for Medicare & Medicaid Services for Stage 3 will help us achieve some important goals, including better alignment of quality improvement efforts and widespread health information exchange. We need to let providers and vendors continue down the adoption curve and perfect systems that many are still putting in place.”

What’s needed now, Christian added, is a laser-like focus on interoperability. Central to that is finding a safe, secure, and accurate methodology for patient identification. Also, Christian said, there needs to be a concerted effort to protect patients’ health information from cyber threats and data breaches. Christian also noted concerns among CIOs and IT vendors that the Stage 3 timeline is unrealistic for ensuring that certified products are available in the marketplace.

In written comments to CMS on Stage 3 regulations that were published in October, CHIME called for:
1. Starting Stage 3 no earlier than 2019 and only after 75 percent of all eligible providers have met Stage 2;
2. Removing the 2017 transitional year for meeting Meaningful Use Stage 3 and requiring 2015 Edition CEHRT no earlier than 2018;
3. Creating a 90-day reporting period for every year of the program, including the first year at Stage 3, to allow providers adequate time for upgrades, planned downtime, fixes related to technology, or optimizing the use of new technology within workflows;
4. Creating parity for both eligible providers (EPs) and eligible hospitals (EHs) by removing the existing pass/fail approach for Meaningful Use; and
5. Reducing the burden for providers by streamlining reporting redundancies and refraining from requiring data collection and submission on measures that do not advance patient care.

“CHIME appreciates the increased flexibility CMS created in Stage 2 and the agency’s willingness to receive comments on Stage 3 regulations,” Christian said. “We are all striving to create a more efficient delivery system; one that improves patient care and lowers costs.”
Visualization improves workflow, referral numbers

St. John Health System sees big improvements after implementing patient flow software.

By Chad Michael Van Alstin, Features Editor

When someone would call out “code purple” over the loudspeaker at St. John Medical Center in Tulsa, OK, the staff would mobilize. They would meet in an empty room and develop a plan of action, discussing priorities and patient-flow strategies based on the information they had with them. The problem was, by the time they walked out of the room, the plan had already changed.

In a hospital environment, days are constantly in flux, and a successful one is measured by how quickly staff can react to new challenges. “We thought we were pretty innovative with our ‘code purple’ calls,” says Shelisa Scott-Combs, R.N., BSN, Nursing Director of Patient Logistics Center, St. John Health System. “But really, we were giving ourselves a headache. First, because we were calling nurses away from their floors, and secondly because we were already planning based on old data. What you thought was going to happen isn’t always what happened, because there may be an emergency call, staff illness, issues with a patient, unexpected arrivals, or some other thing. We were just having to be very reactive at every moment – you couldn’t plan anything, you couldn’t anticipate anything. So, it was just rather interesting because we stayed at a code purple state constantly.”

“Code purple” goes off the air

In December 2013, the code-purple calls went silent when St. John adopted TeleTracking’s Capacity Management Suite system for their 550-bed facility. Compared to the old workflow of printed charts and guesstimations, Scott-Combs says the pinpoint-specific data provided by the TeleTracking system allowed St. John to spot inefficiencies and respond to changes before they happened. “We thought we were pretty innovative with our ‘code purple’ calls,” says Shelisa Scott-Combs, R.N., BSN, Nursing Director of Patient Logistics Center, St. John Health System. “But really, we were giving ourselves a headache. First, because we were calling nurses away from their floors, and secondly because we were already planning based on old data. What you thought was going to happen isn’t always what happened, because there may be an emergency call, staff illness, issues with a patient, unexpected arrivals, or some other thing. We were just having to be very reactive at every moment – you couldn’t plan anything, you couldn’t anticipate anything. So, it was just rather interesting because we stayed at a code purple state constantly.”

“Code purple” didn’t seem leading-edge any longer.

“It’s interesting how you think you know what’s going on, but until you can truly see the data attached to it – and it’s not data that’s subjective – you really are missing a lot of pieces,” Scott-Combs says.
The decision to adopt the full TeleTracking Capacity Management Suite came after success with other TeleTracking products, including BedTracking and TransportTracking – two solutions that track bed turnover and patient transport. With measurable progress in timestamps and operational capacity continuing to reach benchmarks, St. John decided to upgrade for a more complete picture.

But simply adopting new software wasn’t enough. With a change of this magnitude, workflow adjustments and training are unavoidable. Scott-Combs says that the staff was initially hesitant, but with time the “code-purple” era became little more than an unwelcome legend of the past.

“I think it was just a change in how we did business that concerned the staff – that was the biggest thing. The technology itself is pretty intuitive, and so we did have some training classes and things like that. We also had a lot of support from TeleTracking – they were here all the time during the initial adoption,” she says. “But again, most of the stress was a result of workflow changes. The technology itself is easy to use; once you kind of get in there and look at it – play around a little bit – it becomes very self-evident how this thing works.”

**“Skittles” bring colorful progress**

In the Patient Logistics Center, there hangs what Scott-Combs affectionately calls the “Skittles board,” a detailed, color-coded display screen that gives her team a comprehensive view of every bed at St. John. The Skittles analogy becomes clear upon seeing TeleTracking’s electronic bedboard – a display of colorful markings, each representing a patient or location. It’s in the Patient Logistics Center that staff has converged, allowing team leaders who were once spread out all over the facility to see changes in real-time.

On the floors, staff and unit managers have their own downscaled electronic board with detailed information on the status of rooms, including the name and schedule of each patient. In the past, communication between departments came through phone calls and running down the hall looking for somebody with answers. Now, wherever pertinent information arises, it can be added to the TeleTracking system, and display screens throughout St. John will instantly refresh.

“Every couple of minutes, the screens update,” Scott-Combs says. “And so, we’re never operating off old information – when I say we can view everything in real time, I mean it.”

It’s the real-time information that has allowed St. John to see further growth, especially in their outside referral numbers. Now, when a patient is coming to the ER or needs a bed, an answer is as simple as looking at a monitor. And because workflow kinks are being ironed out, more patients can find space at St. John, which Scott-Combs says presently operates at 98 percent capacity on a regular basis.

“Our transfer numbers have just significantly grown – oh gosh – I’d say our external transfers have grown around 16 percent,” she says. “And each year it just keeps getting better. I may not have known what TeleTracking was before we worked with them, but I can speak to the results – and they speak for themselves.”

**Results: St. John Health System incoming transfers from external referral sources**

![TeleTracking's electronic bedboard](image_url)
Making a breakthrough in healthcare interoperability

Good Samaritan anticipates substantial revenue increase while containing integration costs.

The long-awaited road to true healthcare IT system interoperability is being implemented at Good Samaritan in Indiana, enabling the 232-bed community healthcare facility to better deliver on its commitment to providing exceptional patient care. The system will also enable the hospital to substantially increase its revenue while containing healthcare system integration costs.

“We strive to be the first choice for healthcare in the communities that we serve and to be the regional center of excellence for health and wellness,” says Rob McLin, President and CEO, Good Samaritan. “We are proud to be the first hospital in the country to implement this great integrated health record system that will allow us to provide a much higher level of continuity of care for our patients, as they are our top priority.”

The integration is made possible with Zoeticx’s Patient-Clarity interoperability platform, which will integrate WellTrackONE’s Annual Wellness Visit (AWV) patient reports with Indiana’s health information exchange (HIE) and the hospital’s Allscripts EHR. Indiana is the largest HIE in the country, serving 30,000 physicians in 90 hospitals – or six million patients in 17 states.

WellTrackONE and Zoeticx will enable patients’ AWV data to flow from the application to the Allscripts EHR and the Indiana HIE system. With Zoeticx’s Patient-Clarity platform and WellTrackONE’s software, the healthcare IT integration passes on increased revenue from the Centers for Medicare & Medicaid Services (CMS) and decreased IT costs for medical facilities.

Medicare pays medical facilities $164.84 for each initial patient visit under the AWV program and $116.16 for each additional yearly visit. With the AWV integration in place, the hospital is now able to meet CMS’ stringent requirements for patient reimbursements.

It is estimated that the Good Samaritan will be able to generate $500 to $1,200 per AWV patient from follow-up appointments for additional testing and referrals for approximately 80 percent of the Medicare patients that are flagged by the AWV for testing, imaging, and specialty referrals within the hospital.

This subscriber number is expected to trend upward into 2050 and will create billions in new revenue in the United States as the population ages. The hospital is not charged any costs for the system until it is reimbursed by CMS.

Overcoming healthcare system limitations

The hospital began offering Medicare’s AWVs a few years ago, but had to develop its own tracking protocols, which impacted their budget and staff resources. The system they created also operated poorly, allowing them to only view about 10 to 15 percent of their patient data.

Good Samaritan medical teams were also constrained by interoperability, spending valuable patient face time trying to find specific patient data buried in the EHR system. They also had all of the data contained in WellTrackONE and the Allscripts system, but no way to integrate the two, let alone achieve that integration with the Indiana HIE.

“Our systems were working fine, independently of each other,” says Traci French, Director of Business Development and Revenue Integrity, Good Samaritan. “But we could not achieve true interoperability between the two systems. The best we could do was basically reshuffling PDF documents. The next challenge was to integrate that data with the exchange. We needed to get data to providers where they needed it, when they needed it.”

“This technology breakthrough enables providers to electronically invoice Medicare and Medicaid with a new billing code number, creating a new medical facility profit center and substantially impacting caregiver revenue for the approximate 15 million patients who have two chronic diseases and qualify for CCM care.”

By Thanh Tran, CEO, Zoeticx
Searching for a solution
The facility turned to Robert Storch, Founder, National Medical Reps, who identified three goals when asked to find an interoperability solution for the hospital’s AWV integration. “We wanted to have the ability to seamlessly integrate with any EMR product, but we also saw another specific need that no one in the market had addressed – the inclusion of integration with health information exchanges. It was the best way we could help keep costs down for our customers and allow them to share that information across the HIE’s multiple providers and facilities to provide a better continuity of care for AWV participants,” says Storch.

“First, I set out to find the best companies we could to integrate the AWV, provide interoperability across all EMRs, and include seamless integration into the chronic care management side of the equation,” says Storch. “WellTrackONE was already implemented, but finding Zoeticx was a bit more complicated. Everyone complains about lack of interoperability, but Zoeticx appears to be one of the few companies doing anything about it.”

Storch discovered that not only did Zoeticx solve interoperability, but it had identified the steps needed to connect the dots of the long-elusive CMS stringent requirements for its Chronic Care Management (CCM) patients. “It appears that Zoeticx is the first medical facility EHR integrator to access this multibillion-dollar aging population market. This technology breakthrough enables providers to electronically invoice Medicare and Medicaid with a new billing code number, creating a new medical facility profit center and substantially impacting caregiver revenue for the approximate 15 million patients who have two chronic diseases and qualify for CCM care,” says Storch.

Connecting data points
WellTrackONE gathers and processes 280 patient data points, identifying potential catastrophic and chronic medical conditions. Once the assessment is complete, those conditions are outlined for review by a medical provider, flagging potential for current risks and chronic conditions in multiple categories, such as functional capacity, safety, cognitive, mental, vision, and other areas.

Current and potential catastrophic and chronic conditions that meet CMS’ AWV guidelines are outlined by category, subcategory, and severity and include suggestions for clinical testing and referrals to specialists. The clinical triggers provide medically necessary information for follow-up visits, lab, and other testing as well as referrals of the patient to specialists to ensure the patient is obtaining the best possible care to minimize the risk of hugely expensive catastrophic events.

Addressing all challenges associated with the lack of interoperability
To begin addressing the integration of these data-laden reports and overcoming their previous interoperability challenges, Zoeticx’s Patient-Clarity server used its powerful data switch to “push” WellTrackONE’s reports into both of the hospital’s Allscripts EHRs and the Indiana HIE system. This was done using Zoeticx’s middleware-driven application program interface (API) to translate the data.

The middleware design approach addresses multiple challenges relating to the lack of EHR interoperability. First, WellTrackONE’s solution becomes agnostic to any EHR infrastructure, opening up to more opportunities to address care provider needs for AWV. Second, healthcare IT addresses the challenges of integration where patient medical information flow is now integrated between EHRs and the Indiana HIE. The reports are available to all Indiana HIE patients and participating facilities to provide a much higher level of continuity of care for the patient.

Fast implementation was also required from Zoeticx as the hospital was preparing to place an additional Allscripts EHR online. It needed interoperability for the hospital’s two Allscripts EHR systems, one for the clinical side and one for the rest of the hospital, but also its connected facilities. In addition to speed and seamless integration, the hospital required customization for its billing capability. It had to be able to invoice the AWV under specific physicians while reports from patient assessments were custom routed to the attending physicians via Zoeticx’s platform.

Additional customization was also needed to ensure that the hospital’s laboratories and on-site specialists were included in the referral process by integrating the labs and specialists to the referral links within WellTrackONE. This would enable ease of use and ensure the referrals were going to the right lab, testing facility, or specialist.

“The whole integration took no time, and we were up and running with a newly integrated system. Our expectations were perfectly met, and we now have more efficient providers who can better treat patients, their primary care, says French. “We also had no out-of-pocket costs and were able to generate substantial revenue for the hospital and its providers, and achieve healthcare IT integration between EHR and Indiana HIE at the same time.”

Proactively looking ahead
The next step for Good Samaritan is to add its seamless Chronic Care Management program to the equation. It will provide the hospital with a complete, end-to-end solution that will give providers the latest up-to-date information to manage their patients’ chronic and catastrophic illnesses and provide them with the best care possible. The challenge will be supporting the chronic care documents available to care providers within and outside the healthcare network.

Looking to the future, Good Samaritan is also aware of the trend in which hospitals in particular have been purchasing physician and specialty clinics. Physician offices and specialty clinics often have their own EHR systems, and they are never upgraded under a single EHR vendor, which results in disparity of EHRs. Similar interoperability problems occur when a hospital system makes a wholesale purchase, but the complexities are even more pronounced. Different areas within the hospital usually operate a version of the EHR system used by the whole facility.

“Whether we need to integrate additional EHRs for our healthcare IT system or through acquisition, with Zoeticx’s interoperability, we are well positioned for any possible future expansion,” French says.

Ron McLIN, President and CEO, Good Samaritan

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Increasing mobility to improve patient experience
Better design leads to improved workflow.

Improving patient experience and engagement are the top priorities for every hospital, health system, and doctor’s office in the country. In order to maximize opportunities for funding and reimbursement, every step in the patient process continuum, from admittance to discharge, is being heavily evaluated for areas of improvement.

One area under increased scrutiny is the physical workflow process as it pertains to patient-facing staff, particularly nurses and nurse practitioners. Nurses on the front lines of patient care, more often than not, have a direct impact on whether the patient views their care in a positive or negative light – a point emphasized in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Of note, the first three questions of the survey are centered on nurse interaction:

DURING THIS HOSPITAL STAY, HOW OFTEN DID NURSES TREAT YOU WITH COURTESY AND RESPECT?
DURING THIS HOSPITAL STAY, HOW OFTEN DID NURSES LISTEN CAREFULLY TO YOU?
DURING THIS HOSPITAL STAY, HOW OFTEN DID NURSES EXPLAIN THINGS IN A WAY YOU COULD UNDERSTAND?

Clearly, there is a great deal of emphasis being placed on the ability of nurses to provide not only the highest level of care, but also emotional comfort to patients and their families. However, what else can healthcare facilities do to improve clinician workflow processes and ensure that nurses are being best positioned for success?

Nursing is an extremely demanding and taxing profession that often leads to issues that directly and indirectly affect the patient care experience. While progress has been made in this area in recent years, research suggests that there are still workflow and safety issues that must be addressed in order to improve frontline performance of today’s healthcare professionals – especially in the realm of a nurse’s own health. According to research commissioned by Ergotron, nursing has the third highest reported injury rate of any profession. In addition:

- Forty-eight percent of nurses are likely to have wrist, back, and ankle sprains or strains;
- Nurses typically walk upwards of five miles per 10-hour shift;
- Fifty-three percent of reported injuries were due to overexertion;
- Sixty percent of nurses believe their job is negatively impacting their overall health;
- Twelve percent have been injured on the job during the past year.

While these statistics relate directly to the physical health hazards of the nursing profession, their impact on the overall quality of the patient experience cannot be discounted. While common injuries encountered by nurses have been well documented, what has not received the right level of attention is how these injuries and varying levels of discomfort affect patient care. In the same Ergotron research, a direct link between physical discomfort and negative interactions with patients was established:

- Twenty-two percent admit to being less friendly or engaging with patients;
- Twenty-two percent modify or limit their activity on the job;
- Seventeen percent admit to being distracted;
- Fourteen percent often require additional assistance from other staff;
- Forty-nine percent report feeling some level of discomfort while inputting chart data.

Based on this data, understanding the underlying reasons behind the physical discomfort, fatigue, and the challenges to physical clinician workflow will not only lead to a healthier and happier nursing staff, but will also impact overall patient care and satisfaction.

Mobile, tablets, handheld devices, and wall-
mounted solutions have all been introduced to the modern healthcare facility, and there is no turning back. In a recent survey from HIMSS Analytics, 71 percent of nurses reported they would not consider going back to paper-based medical records. In addition, nurses tend to agree that EHR benefits are good for patient safety; 72 percent believe EHRs improve patient safety and avoid medications errors, and 73 percent admit they enable collaboration with other healthcare professionals.

Despite the many positives that come through the implementation of technology, there are improvements to be made and many of them focus on improving poor workflow process designs. It is important to remember that, while technology can solve many of the problems facing healthcare facilities, technology cannot solve the problem by itself. To date, the use of technology in medical facilities has been emphasized heavily, but more thought or planning needs to be given to the actual implementation and daily use of these solutions. What do the technology and EHR workflow mean to clinicians?

The reality is that today’s exam and treatment rooms present challenges for integrating EHRs into the point of patient care—the triangle of care—and too often EHRs are awkwardly brought into a room where they do not promote a personal clinician-patient interaction, which can delay the caregiver interaction with the EHR.

For the most part, the design of exam or patient rooms reveals a lack of fundamental awareness of what is in the best interest of the healthcare worker in terms of safety and how much improper ergonomics can contribute to nurse fatigue. For example, even though charting at a patient’s bedside has been proven to reduce errors and improves the patient’s perceived quality of care, Ergotron’s study found that only 21 percent of nurses do the bulk of charting in the patient’s room. The main barriers to this activity included:

- Forty-two percent cited lack of space to maneuver technology;
- Thirty-nine percent mentioned the placement of fixed computer equipment;
- Twenty-four percent indicated a lack of available power and long-lasting power options.

All of this is made more relevant when you consider how nurses spend roughly 35 percent of their typical 10-hour shift doing documentation. Ergotron’s study also highlighted the fact that when technology does not have the proper infrastructure to support its use, it can actually cause more harm and interruption to the patient care process. As it relates to EHR reform, responses indicated that:

- Sixty-one percent of nurses and healthcare workers are concerned about the placement of technology within the rooms;
- Fifty percent responded that they have experienced an increase in work-related stress;
- Forty-two percent said there has been no increase in patient care time;
- Thirty-six percent said there has been no improved patient interaction and engagement.

Technology will continue to evolve in healthcare practices, but so too must the mobility and flexibility of the solutions that are being deployed. Moving from paper to electronic record keeping can improve accuracy and efficiency, but what are commonly missed are the physical workflow implications for clinicians. Nurses are being required to learn emerging technologies on top of existing workloads, while still maintaining patient care requirements. As currently constituted, facilities are still only seeing a limited return on their investment. They are improving the collection and accuracy of data, but they are not adding value to the patient experience, as nurses are often being distracted by technology rather than using it to their advantage.

To combat this, a greater focus on design, ergonomics, and practical usage is in order. Having workstations in every room that are easily accessible and adjustable for all users is just the beginning. As new technologies are introduced into the practice, what worked five years ago—or even last year—may be ergonomically obsolete by today’s standards.

At the end of the day, patients are going to assess their experience not only by the care they received, but by their interactions with the nurses and front-line staff at the medical facility they visit. When nurses feel that they’ve done a good job, it improves their quality of care. Conversely, injuries and physical discomfort directly affect patient interaction. Having the proper ergonomically adjustable workstations is a win-win for nurse comfort and EHR implementation success. Whether it is HCAHPS or other initiatives that continue to drive reform in healthcare, the goal should be the same: to arm healthcare workers with the appropriate solutions and training they need in a supporting infrastructure that creates greater efficiencies and comfort for all and improves the patient-caregiver exchange.

Increased mobility and better workflow design alone will not cure all the problems of the healthcare industry or ensure that every patient experience meets the highest expectations. However, it will go a long way in improving the working conditions for those on the front lines of the patient/healthcare worker interaction. By improving the processes and conditions for these groups, we will ensure they are at their best and able to provide the highest levels of patient care possible. That is how we improve the patient experience. HMT

REFERENCES

MOBILITY SOLUTIONS

Exercise your power options
The Elora Modular Battery System is designed to dramatically transform battery management for any portable point-of-care technology, including mobile workstations, vital signs monitors, and EKG monitors. The system includes the Elora 240 high-capacity, 240 Watt-hour (Wh) lithium-ion battery with four-hour charge time, the wall-mounted Elora “Smart” Charger with built-in infection-control UV LED technology, the Elora Battery Interface for easy device integration, and the on-cart fuel gauge called the Elora Battery Pain Scale. Together, it’s a whole new way to think about battery systems. Anton/Bauer

Light and easy on nurses and IT
Designed specifically to carry a wide array of laptops and tablets, the SV10 series of StyleView Medical Carts is the line’s lightest cart yet. Weighing just over 30 pounds, this cart has a patented lift engine that offers caregivers 15 inches of vertical travel for both seated and standing use. Its integrated handbrake secures the platform height to provide an ultra-stable work surface that is smooth and easy to clean. The 1-slot channel interface on the cart’s column allows for integration of accessories to customize a solution that’s right for a variety of applications for both nurses and technicians. Add-on power systems can be used to help power a tablet or laptop throughout a shift. One cart, the StyleView S-Tablet Cart SV10, was developed exclusively for Microsoft Surface and is compatible with all Surface devices. Ergotron

Act on mobile operational intelligence
MobileView Analytics, the visual business intelligence platform for the AeroScout Real-Time Location System (RTLS) solutions, is in use at hospitals across the United States, supporting measurable improvements in key areas that include HCAHPS scores, room utilization, asset management, staff efficiency, and regulatory compliance. New, out-of-the-box dashboards and additional supported solutions for this tool, which is powered by Tableau, include: Clinic Patient Experience and Room Utilization Analytics, Asset Management Visibility Center, Asset Management Workflow Optimization, Environmental Monitoring Visibility Center, and Hand Hygiene Compliance Monitoring Analytics. STANLEY Healthcare

No. 1 entry-level workstation updated
The HP Z240 Tower and Z240 SFF Workstation (pictured) feature next-generation Intel processors and HP Z Turbo Drive options, raising the bar for entry-level workstations. The Z240 is the latest update to the world’s No. 1-ranked entry-level workstation, the HP Z230. As HP’s most affordable workstation, the Z240 is particularly good for customers in the image-viewing industries. The HP Z240 offers more performance, greater storage capacity, more IO, and greater flexibility. At 57 percent smaller than the tower, the HP Z240 SFF conserves space and maintains workstation performance. New innovations include: an integrated M.2 slot, optional dust filters, integrated front and rear handle ledges, integrated ambient temperature sensors, more efficient airflow, enhanced acoustics, and a cleaner layout of internal cables. HP

Get keyless access and auto-relock
The Non-Powered VX10 Workstation is a lightweight, versatile, and highly maneuverable computing workstation with a fully configurable storage area featuring keyless access and auto-relocking for optimal security. Choose from a wide selection of accessories to further streamline clinical workflow and health IT efficiency at the point of care. This solution is perfect for laptops, all-in-ones, and other computing hardware with integrated power systems. Simple ergonomic adjustment of the monitor, work surface, and keyboard permits comfortable use for clinicians in standing or sitting positions. This cart also features storage flexibility and can be configured with drawers, including 3- and 6-inch depths for supplies, treatments, and instruments. Capsa Solutions

Keep your info agile and accessible
OneContent delivers enterprise-wide data in a single, centralized system designed for efficient hospital workflow, regardless of the EHR system or document management products in place. Built with open API integration and HTML5 functionality, OneContent enables information agility across the enterprise. For current McKesson customers, OneContent consolidates McKesson Patient Folder and Enterprise Content Manager to achieve a consistent, stable, cost-effective content strategy. For document management, this solution streamlines the process of content storage, transmittal, and integration for smoother access and improved ROI, driving value across the enterprise. McKesson
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CMS provides first-look numbers

After nearly a full month of ICD-10 transition experience, the Centers for Medicare & Medicaid Services (CMS) released report metrics for claims processing using the new coding scheme on Nov. 29, 2015. The report provided first-look details on Medicare Fee-for-Service claims from Oct. 1-27. The initial results show little variance from historical baseline results using ICD-9 – a promising sign so early in the game.

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<th>METRICS</th>
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<tr>
<td>Total claims denied</td>
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NOTE: Metrics for total ICD-9 and ICD-10 claims rejections were estimated based on end-to-end testing conducted in 2015 since CMS has not historically collected this data. Other metrics are based on historical claims submissions.

It took three years and a posse . . .

At private-practice cloud technology solutions provider AdvancedMD, the trail to ICD-10 transition success was a long one. A cross-functional team of experts called the “ICD-10 Posse” waged a significant three-year campaign to provide tools and continuous education on the coding update process. As a result, 100 percent of AdvancedMD clients were ICD-10 compatible on Oct. 1, and the first ICD-10 payment was received only seven days after the transition.

Several weeks after the transition, clearing house rejections and carrier-level rejections have decreased from ICD-9 levels, and successful claims were at the highest level ever, signifying a positive financial impact for clients. Today, the pre-adjudication carrier rejection average for practices on AdvancedMD stands at 1.5 percent, far lower than the rate of 2.3 percent under ICD-9.

AdvancedMD credits its “full court press” on awareness and education for its clients’ success, and also its early and keen recognition that smaller physician practices, particularly those lacking extra staff, faced unique challenges with the ICD-10 conversion. Some clients initially slowed their claims billing on Oct. 1 in order to ensure a smooth transition. Claim submissions have since accelerated and recently broke the single-day claims record for AdvancedMD clients.

$25B and counting

Joshua Berman, RelayHealth Financial

A mere two-and-a-half weeks after the changeover to ICD-10, RelayHealth Financial reported that it had successfully processed more than $25 billion in claims using ICD-10 codes. The dollar volume represented more than 13 million institutional and physician claims processed using RelayHealth Financial’s revenue cycle management solutions, including RelayClearance Plus, RelayAssurance Plus, ConnectCenter, and EDI Services.

The revenue-cycle-management company says that it had its entire portfolio ready a full two years before the ICD-10 deadline:

“Claims are flowing successfully, and now the industry must be ready to tackle the next set of challenges: timely and correct reimbursement,” says Joshua Berman, ICD-10 Lead for RelayHealth Financial.

In order to help that process along, providers can monitor critical industry key performance indicators (KPIs) affected by ICD-10 on RelayHealth Financial’s real-time analytics dashboard at ICD10Central.com. Among these metrics, “days to final bill” is important to keep an eye on, says Berman, because it indicates whether providers are generating claims using ICD-10 as efficiently as they did using ICD-9. This number could drop, but should rebound once providers gain proficiency in using ICD-10. Berman says if the number dips and does not rebound, that means that urgent attention is required.

It’s great to be independent

David Mitzenmacher, Kareo

Kareo, a provider of cloud-based solutions for independent medical practices, announced six weeks after the ICD-10 transition date that 99 percent of claims submitted in the first month of the ICD-10 coding transition were successful. Additionally, 87 percent of Kareo customers had already been paid for at least one submitted claim.

“In October, we saw close to 6.6 million electronic claims representing more than $735 million submitted through Kareo using the ICD-10 coding scheme,” says David Mitzenmacher, Vice President of Customer Success at Kareo. “Compared to results released by the Centers for Medicare and Medicaid Services (CMS) for October, practices using Kareo appear to have outperformed the larger healthcare industry in terms of the ICD-10 transition.”

Kareo also surveyed its customer base directly to gauge its experience with the transition. Based
One in 10 call it ‘failure’

Todd Ellis, KPMG

Seventy-nine percent of the 298 attendees of a Nov. 9 KPMG ICD-10 webcast described their transition experience as successful. On the flip side, about 11 percent designated the transition a “failure.”

“While the transition to ICD-10 can be considered a thing of the past for some organizations, there is a subset of entities who considered their ICD-10 efforts as less than optimal,” says Todd Ellis, Managing Director, KPMG, an audit, tax, and advisory firm. Ellis gives the following reasons:

- Lack of physician readiness/training, as some providers thought the date would get pushed out again.
- Lack of proper system testing (how codes were actually mapped from ICD-9 to ICD-10);
- Relying on vendors for ICD-10 readiness and not addressing internal operational impacts (thinking a vendor platform would address all of the ICD-10 requirements);
- Impact of coders who were not prepared for the ICD-10 transition (lack of proper training); and
- Inability to hire HIM resources due to market demand.

Luckily, says Ellis, “There is still time for these entities to self-correct.”

ICD-10 Solutions

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ICD-10 Success for the Long Run

The Health division of Wolters Kluwer has released additional ICD-10 remediation capabilities that enable payers and providers to build a solid foundation for long-term clinical, financial, and operational success in a post-ICD-10 environment. The enhancements are in the latest version of LEAP I-10, part of the Health Language family of services and solutions, and include the ability to import ICD-10 claims and analyze ICD-10 to ICD-9 DRG shifts, helping pinpoint areas of reimbursement risk. Users can also analyze new ICD-10 claims to identify payment variances and review detailed results by service line, specialty, facility, provider, and DRG; generate detailed reports to view the frequency of unspecified ICD-10 codes; convert ICD-9 codes within legacy reports with custom maps from ICD-10 to ICD-9 and vice versa; and stratify potential DRG shifts by financial impact to identify root causes. Wolters Kluwer

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Powered by ICD Sherpa, VitalWare’s patent-pending, proprietary Physician Documentation Engine, iDocuMint, bridges the gaps frequently found in clinical documentation today, guiding physicians to perform accurate documentation faster. Embedding ICD Sherpa into the physician workflow via PC or any mobile device effectively alleviates productivity concerns brought on by the new clinical documentation requirements. The company’s updated website includes a 90-second intro video showing physicians how simple and precise clinical documentation can be when using iDocuMint. Vitalware

Improve clinical documentation on the fly

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Some say follow your passion. I agree, but at the same time, I wouldn’t have found my passion had I not first followed the opportunity. I’ve often been either the only woman, or one of very few, sitting down to a meeting with my colleagues. No surprise, given the statistics about how few women are in science, technology, engineering, and math (STEM) careers. Although women fill close to half of all jobs in the U.S. economy, they hold less than 25 percent of STEM jobs, according to a U.S. Department of Commerce report. This despite the fact that STEM jobs pay more than non-STEM jobs and that, according to the report, the gender wage gap is smaller in STEM jobs than in non-STEM jobs. Women in STEM careers make 33 percent more financially than women in non-STEM occupations.

There are a number of theories about why fewer women go into the STEM workforce. Among the possible contributing factors are a lack of female role models and gender stereotyping. I always knew I loved technology, but working in a field where I had a better chance of achieving financial stability was important to me. And that pursuit ultimately led me to my true passion of working in health IT, where every day I get to see the impact technology can have in patients’ lives. Selling technology isn’t always easy, and there’s a lot to learn and demonstrate. I have the most amazing memories of working with incredibly smart, highly competent, fun, and very funny women and men that have given me opportunities that I’d never have found.

A natural progression

It’s important that more women go into the technology industry not just for their own sake, but also for the sake of our industry. The U.S. Department of Labor Statistics predicts that by 2018 there will be 1.4 million technology jobs open in the United States. According to a Microsoft Research white paper, at the rate that students are now graduating with computer science degrees, only 61 percent of those openings will be filled — and just 29 percent of applicants will be women.

So, where are the women? We are working in healthcare! According to the Centers for Disease Control and Prevention, healthcare is the fastest-growing sector of the U.S. economy, employing over 18 million workers — and women represent nearly 80 percent of the healthcare workforce. A natural progression for women is to move from direct patient care as a clinician or nurse into IT. And being comfortable with technology is a requirement for any position in healthcare — even hospital beds include computerized monitors. In addition, there are healthcare positions that have a hand in both patient care and IT, such as the “chief nursing information officer” and the burgeoning profession of nursing informatics.

What’s more, we need more women in STEM careers so they can help shape the future. Tackling many of the world’s toughest challenges in health care, for example, will rely on the help of technology. According to the National Center for Women and Information Technology, research shows that groups with greater diversity solve complex problems better and faster than do homogenous groups. It also shows that teams with 50-50 gender membership are more experimental and efficient.

The fact is, to meet the diverse and changing needs of health professionals and the populations they serve, we need the teams working to meet those needs to be just as diverse. That means we need teams made up of both men and women from all walks of life and cultures who can offer a wide range of perspectives and insights based on their varying experiences. It means embracing equality and diversity, with both women and men.

I know many of you reading this are leaders in the health or technology industry, so please help me encourage more girls and women to join us. I’d also love to hear your story. Why did you get into the technology industry? How have you seen diversity contribute to innovation? Where do you think we need to grow for our industry? Email me at sarahmu@microsoft.com. I’d love to hear from you.

References

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