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¹Berg Insight, mHealth and Health Monitoring, January 2013
³Online First, A Multi-Center Study of ICU Telemedicine Reengineering of Adult Critical Care, December 2013
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Medical Groups and ACOs, HR Priorities, Healthcare Innovations

What are medical group leaders learning through their participation in the Medicare Shared Savings Program and the Pioneer ACO Program? In this month’s cover story beginning on page 8, Editor-in-Chief Mark Hagland interviews ACO leaders about what they have learned, their challenges, failures, and reasons for optimism about this evolving care model.

Although labor ranks among the highest cost items in healthcare, tight budgets and too many other competing initiatives often mean that provider organizations pay scant attention to critical human resource issues. In the story on page 14, Managing Editor John DeGaspari profiles two hospitals that have broken that mold and seen major cost savings as they improve employee retention and patient care quality.

This issue spotlights two stories by Hagland in his coverage of the Health IT Summit, sponsored by the Institute for Health Technology Transformation (IHT2), which was held in Seattle in August. (Since December 2013, IHT2 has been in partnership with Healthcare Informatics through its partnership with Vendome Group LLC.) On page 19 he reports on why Peter Kung, director of strategic technologies at UCLA Health, thinks that the organization’s ambitious initiatives are the genesis of a healthcare innovator powerhouse. In a companion piece on page 21, Hagland describes the transformative journey of the Billings Clinic integrated health system, which CEO Nicholas Wolter, M.D., likens to “astronauts on a critical mission.”

Can clinical documentation be as seamless at having a conversation with your computer? Associate Editor Rajiv Leventhal witnessed a live speech-to-text demonstration at New York Presbyterian Hospital in to see if it’s true. His report appears on page 23.

What are the must-have processes that are essential to a successful IT strategic planning project? On page 25, Fran Turisco, a consulting director of Aspen Advisors, provides valuable advice on planning the work and then working the processes.

At a time when eligible providers and hospitals are lagging on Stage 2 meaningful use attestation, some organizations are moving ahead. Senior Editor Gabriel Perna reports on one critical access hospital that has reached that milestone on page 29.

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I've been completely absorbed of late reading Jared Diamond’s brilliant 2005 book, Collapse: How Societies Choose to Fail or Succeed. I’ve read many an illuminating book on public policy, sociology, culture and the arts, but this one is one of the most intellectually penetrating and magnificently argued I’ve read in a long time.

Diamond looks at a variety of societies with regard to momentous changes—mostly for the worse—in their core economic, cultural, and environmental foundations. Among the most compelling: an examination of Rwanda’s genocide; a look at the collapses in the various Mayan societies; and, most riveting of all, an examination of the complete collapse of Easter Island society prior to the sustained interaction of Easter Islanders with Europeans, a collapse that included the utter destruction of the island’s environment, and a descent into famine and cannibalism.

Of course, not all chapters in the book focus on the apocalyptic: the chapter “Mining Australia” is absolute must-reading for anyone who might wish to understand what long-term economic and environmental “sustainability” means in the world’s only continent-nation, with its vast scenic wonders, but relatively poor core set of natural resources. Diamond offers a particularly trenchant example of poor natural resources policy around timber exportation there. After going through a broad look at why natural resources sustainability is at significant risk Down Under, he talks about the exploitation of Australian timber for export in a way that is counter-productive and unsustainable. He notes that, “Of Australia’s forests standing at the time of European settlement in 1788, 40 percent have already been cleared, 35 percent have been partly logged, and only 25 percent remain intact. Nevertheless, logging of that small area of remaining old-growth forests is continuing.”

He goes into a detailed, but extremely compelling, look at how Australians are chopping down significant portions of their remaining forests to sell wood chips to the Japanese at about $7 per ton, with the Japanese turning around and creating paper from those wood chips, and selling the finished paper for about $1,000 per ton, including to Australia. It is clear that there is a fundamental flaw in that process; as he points out, this is yet another example of how the lack of a conscious, sustainable policy around the economics of dwindling natural resources in a particular society can lead to long-term economic and environmental damage.

Later, in his brilliant chapter “Failure to Perceive,” Diamond widens out to talk about the tendency among all societies to fail to perceive looming threats to their sustainability when those threats come in the form of slow trends concealed by wide fluctuations in activity, as with climate change. One threat that the leaders of the U.S. healthcare system are coming to understand is the core threat of economic unsustainability around healthcare costs. As a result, pioneers are moving forward to develop accountable care organizations, both within the two Medicare shared savings programs, and in concert with private health plans.

What’s particularly interesting is the medical group development aspect of all this. As I note in this issue’s cover story (p. 8), considerable strategic planning and cultural change are required for medical groups to successfully master accountable care. Indeed, developing any sort of ACO requires a massive shift in the entire way in which a patient care organization or collaborative operates.

Yet that is precisely what our society is asking of us in healthcare. The current cost trajectory alone is unsustainable. So we must trudge ahead, as difficult as the path may be. Meanwhile, for negative exemplars of what happens to societies that fail to heed such warnings, one need only to look to the Easter Island model of utter failure.
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AND REVOLUTION

What medical group leaders are learning about the new healthcare through their Medicare Shared Savings Program participation

BY MARK HAGLAND
In the annals of the history of medical group management in U.S. healthcare, some industry observers may well look back on the years 2012 through 2014 as a turning point for medical groups. That’s because it was during that period of time that a number of large medical groups entered into the Medicare Shared Savings Programs for accountable care organizations (ACOs)—either the regular Medicare Shared Savings Program (MSSP) or the Pioneer ACO Program. At the same time, too, many medical groups nationwide entered into ACO contracts with private health insurers; indeed, a large number began participating in both one of the Medicare programs and one or more private-sector programs. (As of May 2014, there were 338 MSSP ACOs and 23 Pioneer ACOs.)

“How hard is it?” is the inevitable question many would like to ask. The answer, of course, depends on whom one asks—and perhaps even on what day one asks the question. Certainly, participating in these kinds of programs is not easy; indeed, in the last week of August 2014, the news went public that Sharp HealthCare had dropped out of the Pioneer ACO program. As reported online in California Healthline, executives from the San Diego-based integrated health system had actually informed the federal Centers for Medicare and Medicaid Services (CMS) of their decision to pull out of the Pioneer program on June 29; but the announcement was not made public until late August.

Alison Fleury, CEO of Sharp’s ACO, attributed the organization’s decision to drop out mostly to the financial model of Pioneer ACOs, telling California Healthline that, “Because the Pioneer financial model is based on national financial trend factors that are not adjusted for specific conditions that an ACO is facing in a particular region (e.g., San Diego), the model was financially detrimental to Sharp’s ACO despite favorable underlying utilization and quality performance.”

What’s more, Sharp HealthCare’s departure follows by one year the departure of nine other original participants, among 32, in the Pioneer program. The other nine had left the program all at the same time, in July 2013, at the same moment that CMS announced publicly that while all original 32 participating organizations had improved the quality of care, only about one-third had lowered costs significantly enough to create shared savings.

The Sharp departure seemed to signal an inflection point for the Pioneer program, and certainly led to industry commentary about the rigors of the Pioneer program, at least. Yet behind the scenes, a more complex landscape was becoming clear, one involving more nuance than at first met the eye.

A CONTINUOUS LEARNING ORGANIZATION IN MASSACHUSETTS

Indeed, for all the challenges facing Pioneer ACO and regular MSSP program participants, some leaders of larger medical groups participating in those programs are feeling confident these days; and most of all, they are using the opportunity to participate in one of the two Medicare programs in order to engage in conscious learning.

A great example in that regard is Atrius Health, a non-profit alliance of six community-based medical groups in Massachusetts. With more than 1,000 physicians and more than 2,100 other staffers, the six medical groups, based in Newton, Mass., are taking care of 35,000 Medicare beneficiaries in the Pioneer program.

In joining along with the other 31 Pioneer organizations in January 2012, “We had very specific goals when we started,” says Emily Brower, executive director of accountable care programs at Atrius. “One goal was to move towards a population-based approach, and a single model of care for the Medicare population, which was population-based, as opposed to thinking about patients being in different service models. What being in the Pioneer ACO did for us was to help us think about the entire Medicare population in the same way clinically—we take an approach that serves that entire population.”

The other goals, Brower says, had to do with aligning all clinicians to work together, Atrius-wide, on care delivery improvement. “We want to think of ourselves as a system of care where we can share best practices, and to replicate, wherever we can find it, across all of Atrius Health, to create systems of care,” Brower says, and working within the Pioneer program is giving her and her colleagues the opportunity to do just that. “That’s been incredibly rewarding. We have a team of about 50 people who are working on our population health strategy, testing [strategies]; we call it our ACO team. It includes our Pioneer population, our Medicare Advantage population, another 30,000 to 40,000, and our dual-eligible population of about 5,000.”

Still, despite that enthusiasm, Brower concedes that there have been challenges along the way, particularly “a couple of challenges around the way the Pioneer model is structured that’s very different, in terms of how accountability is measured,” Brower says. “Just the fact that it’s different from the way things are structured with a regular health plan,” has been challenging, she says. “The way that financial ac-
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countability is set and measured is very different from within the Medicare Advantage program or certain health plans. We’re working within it, but something that is very different is always a bit hard. We’re a very data-driven organization,” she emphasized. “We’re used to tracking things ourselves, but in this situation, we have to rely much more on Medicare.”

TOUGHING IT OUT: A FQHC ALLIANCE JOINS THE MSSP

Interestingly, it’s not only clearly well-positioned medical groups that are participating in one or the other of Medicare’s ACO programs. One of the ACOs participating in the regular Medicare Shared Savings Program is an alliance of three federally qualified health centers (FQHCs) in New York. The story of its participation is fascinating. Family Health ACO was formed by the Institute for Family Health, the Open Door Family Health Center, and Hudson River Community Health. Altogether, the three medical group organizations serve patients in 50 locations in lower New York state, including in New York City, and see 180,000 patients overall, with about 800,000 patient visits a year.

Family Health ACO joined the Medicare Shared Savings Program in January 2014, and, says Neil Calman, M.D., president and CEO of the Institute for Family Health and board chair for Family Health ACO, he and his colleagues pursued Medicare ACO status because “We all realized we needed to do practice in the new world order of reduced cost, outcomes-based, value-driven, and we decided this would be a good idea for the three of us to get together on a clinically driven initiative, to deal with some clinical improvement issues, keeping people out of the emergency room, etc.” Calman says that “We thought this was sort of the best-organized of the programs, and that it would give us an opportunity to look at Medicare claims data; we’re using that data to improve our outcomes and costs, and we believe working with it will help us in our private-sector contracting.”

Unfortunately, some challenges dogged the Family Health ACO from the beginning. “FQHCs have very few Medicare patients,” Calman notes, “so we’re struggling to get to 5,000 members, the minimum required for participation. You’d think we’d have about 7,000-8,000 members,” he adds; “but we’re struggling with the attribution number now. We’re struggling to find people who should be attributed to us but who are not,” he says. Unfortunately, he reports, “There’s no mechanism to go back to Medicare and find out about ‘lost’ people; you only get the claims data on people who are attributed.”

Participating in the MSSP has turned out to be far more difficult than expected, Calman says. But the benefit for the three medical groups under the Family Health ACO umbrella is clearly this: the opportunity to work with clinical and claims data to try to improve clinical outcomes and cost-effectiveness—even as those FQHCs are already treating patients as cost-effectively as humanly possible.

OPTIMISM AND A STEEP LEARNING CURVE IN ARIZONA

A couple of thousand miles to the southwest, the operational landscape is totally different than at Family Health ACO; and yet the medical group development intentions are remarkably similar, at Banner Medical Group, a Phoenix-based, 1,100-doctor group, and at Banner Health Network, which is one of the Pioneer ACOs. (Banner Health Network encompasses Banner Medical Group, which employs its physicians; as well as two independent practice association-type networks, Banner Physician Hospital Organization and Arizona Integrated Physicians.)

Banner Health Network, which is providing care for 300,000 attributed covered lives, encompasses 3,000 providers, and was accepted into the Pioneer MSSP program in November 2011 and began operating as a Pioneer ACO in January 2012. Banner Health Network and Banner Medical Group are in turn affiliated with the vast Banner Health, which operates more than 25 hospitals in seven states.

Clearly, Banner Health Network is better resourced than is Family Health ACO. Yet some of the same intentions are present among the Banner physicians and physician leaders, in terms of using the MSSP experience as a learning lab kind of process.

Robert Groves, M.D., vice president of health management at Banner Health, and Anton Decker, M.D., chief medical officer of Banner Medical Group, both have thoughts about the physi-
cian leadership learnings currently taking place at Banner. “The way that Banner Health is structured, I am not the lead of the medical group—that’s Dr. Decker,” says Groves. “But my vice president of health management title is essentially director of population health. One of the key learnings we’ve had around population health,” he says, “is data. Physicians and hospitals and medical groups are historically not used to seeing data that was the privy of insurance companies. Now that we’re seeing that data, it’s creating a beautiful opportunity and a lot of engagement.” Fortunately, he notes, physicians in practice are far more open to data-driven care delivery improvement.

What have been the biggest collective learnings around accountable care, Decker says that “it’s a steep learning curve, and absolutely fascinating, and a lot of fun. The first thing that comes to mind for me,” he says, “is data. Physicians and hospitals and medical groups are historically not used to seeing data that was the privy of insurance companies. Now that we’re seeing that data, it’s creating a beautiful opportunity and a lot of engagement.” Fortunately, he notes, physicians in practice are far more open to data-driven care delivery improvement.

With regard to collective physician learning around accountable care, Decker says that “it’s a steep learning curve, and absolutely fascinating, and a lot of fun. The first thing that comes to mind for me,” he says, “is data. Physicians and hospitals and medical groups are historically not used to seeing data that was the privy of insurance companies. Now that we’re seeing that data, it’s creating a beautiful opportunity and a lot of engagement.” Fortunately, he notes, physicians in practice are far more open to data-driven care delivery improvement.

Among the most difficult elements, Penso says, is “developing the point-of-care tools with the right information available. From an IT perspective,” he says, “that can mean recreating structured fields within EHRs, and training everyone to use them. Getting those gap reports or care alert-type reports, into the EHR, and you have to get the physicians and others engaged, and to do that, you have to create workflow that fits with where they are and doesn’t screw up their lives.” He adds, “There is also a fundamental cultural shift that has to take place within medical groups in order to make all this work, he emphasizes.

Penso has an interesting take on the Sharp HealthCare departure from the Pioneer program, by the way. Indeed, he was a senior executive at Sharp when the organization applied to become a Pioneer ACO, and helped write that application himself. His perspective on the departure this summer? “I don’t think that anyone expected all the Pioneer organizations to succeed; I think people realize they would learn over time. The challenges in restructuring care management, in delivering the utilization improvement, in restructuring EHRs, those are challenges, yes,” he adds. “But the [more intense] challenge they’re finding is in the benchmarking for performance. Depending on the market you’re in and the benchmarking system involved—even if you’re hitting all the benchmarks involved—that can be tricky.”

In the end, says Atrius’ Brower, “One of the things that the Pioneer ACO, or really, any PPO population, because Medicare really is our country’s largest PPO, can teach you, is that it really brings you face to face with the fragmentation of care. This is a population with high needs, and using a lot of services, and these patients are getting them from a very broad network of providers, hospitals, specialists, etc.; so when we started to look at the data, we really stepped back and said, wow; if there ever was a population that needed coordinated care, this was it; and for those patients, it’s really all about providing a great experience.” She adds quickly, “If you think about Medicare patients with multiple chronic conditions and who are on multiple medications—well, if we can do this with one EHR and one medication list, we can make the experience a safer one for patients.”
Although labor ranks among the highest-cost items in the budgets of most healthcare organizations, tight budgets and the lack of time and resources from tackling too many initiatives have posed significant challenges to healthcare provider organizations when it comes to human resources and staffing issues. That’s among the conclusions of two recently released industry reports that look at issues of hiring, staffing and employee retention in the healthcare sector.

Yet employee productivity and skill sets are especially relevant to healthcare providers that are intent on improving the quality of care. Joe Van De Graaf, senior research director and author of a report from the Orem, Utah-based KLAS on human capital management released in August, points out that while human capital management—the set of practices and processes around managing people in an organization—may not be the absolute number-one priority from a strictly IT perspective, it is an important initiative and shared goal at the senior executive level at many provider organizations that are seeking to manage and train the employees they have.

He also thinks that human capital management is likely to become even more crucial going forward than it has been in the past, given the ramifications of the Affordable Care Act. He observes that transparency around physician performance, for example, is one of the competitive differentiators of providing care in an integrated value-based environment.

Many provider organizations have higher expectations when it comes to human capital management solutions. Broadly speaking, providers are beginning to require solutions that will support their efforts around accountable care, Van De Graaf says. "Healthcare organizations are looking for more than just efficiencies," he says. One example of how HR and payroll systems might address provider needs: a searchable database that will allow provider organizations to compensate employees based on performance. "The idea around accountable care is that we are going to provide healthcare in a way that not only gives better care and is patient centered, but we are going to be compensated for the way we perform," he says.

With human capital management, Van De Graaf sees significant activity in terms of demand and vendor offerings in the area of staffing to predicatively manage employee time, and avoid unnecessary overtime expense. One particular area of interest is clinically advanced staffing, which goes beyond basic nurse staffing to mobile scheduling, and allows communication among the nursing staff without reliance of an IT administrator, he says.

While talent management systems have been used in the past to automate hiring and track performance goals, he is seeing early adoption of talent management for compensation and suc-
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cession management as well. Although he acknowledges that human capital management and clinical systems are not a natural connection, he notes that that the employee is indeed at the center of the organization’s operation. “That’s what human capital management is about,” he says. “Not only can we have the right employees, but how we can help to train them, look at their employment record, and use these systems to optimize the training, the retention and the skills that are needed.”

Meanwhile, healthcare HR initiatives are moving forward on a number of fronts, according to a survey on healthcare initiatives sponsored by the American Society for Healthcare Human Resources Administration (ASHHRA) and HealthcareSource. The survey is based on the responses of HR professionals in 500 healthcare organizations in the U.S.

Among the survey’s findings are: streamlining HR processes ranked number one in efforts to reduce costs, cited by 74 percent of respondents. It was followed by efforts to improve retention rates, cited by 69 percent of respondents. Interestingly, while the percentage of respondents concerned about healthcare reform was significant at 44 percent, that percentage was 20 percentage points lower than it was in last year’s survey.

Improving employee satisfaction (cited by 79 percent of respondents) and fostering a culture of employee accountability (68 percent) were top priorities for improving patient satisfaction. Other highly ranked initiatives for improving patient satisfaction include creating a service-oriented culture and providing employee education.

As for current HR initiatives to improve patient safety, 69 percent of respondents identified a focus on employee education and development, followed by improvement of employee satisfaction (59 percent) and hiring for cultural fit (54 percent).

Challenges to putting their initiatives into place are significant, according to respondents. The top challenges were too many initiatives (cited by 67 percent of respondents), followed by no budget to implement the programs (49 percent) and insufficient systems and inadequate technology (43 percent).

**ALAMEDA HEALTH SYSTEM: A FOCUS ON LABOR UTILIZATION**

Labor optimization is a major component of a comprehensive effort to control costs and improve revenues at the Alameda Health System in Alameda County, Calif. The Alameda System consists of three hospitals: John George Psychiatric Hospital (JGPH), a 475-bed acute psychiatric care facility; Highland Hospital, which includes a medical-surgical trauma center; and Fairmont Hospital, which is a skilled nursing and acute rehabilitation facility. Alameda also includes several federally qualified health centers throughout the county. Three years ago Alameda set out on a comprehensive initiative to cut costs and improve its revenue streams. (The hospital system has partnered with MedAssets, Alpharetta, Ga., to help identify and implement cost-saving strategies.)

Guy Qvistgaard, hospital administrator for JGPH, says the initiative was put in place at all three hospitals in an approach that he describes as transformational and system-wide. Qvistgaard notes that JGPH is a safety net hospital system, and needed to restructure its costs as the healthcare industry moves toward supporting the accountable care model. “We also, as a public hospital, needed to strengthen our revenue streams and internal processes,” he says. Those needs served as the impetus for embarking on the cost-cutting initiative, which was undertaken by all three hospitals in the Alameda system.
Alameda set an initial goal of saving $19.5 million during the first 18 months; $12 million of that figure was labor costs, which was the largest component. Longer term, the health system set a goal of saving $165 million by 2022. Working with MedAssets, Alameda identified focus areas of the initiative, set up a governance structure, established signoff and formal reporting processes, established timelines, and measured results.

Qvistgaard says that one of the biggest challenges of the labor component of the project was standardizing on labor processes. Among the steps it took were establishing a centralized staffing office, agreeing on labor utilization practices, and standardizing around the use on online scheduling tools, he says. It agreed on data to measure the labor processes and make sure that the data had integrity. “Those were relatively new processes for us, and the rigor around them was very new,” he says.

From the beginning, Alameda included all stakeholders in the project, which Qvistgaard says was key to the success of the initiative. “We were changing the mix of our staffing and the schedules of our staffing,” he says. “We had to have the unions, employees and management all on board.”

Labor utilization data was brought up and benchmarked against other provider organizations providing like services in similar communities and similar organizations, to analyze where labor was being over-utilized or under-utilized, and staffing levels could be adjusted so that quality was being provided without overspending, Qvistgaard says.

**DEVELOPING A NEW LABOR MANAGEMENT METRIC**

Qvistgaard says that JGPH, working with MedAssets, has come up with a new set of labor metrics in its ED that takes length of stay into consideration, rather than basing it only on the volume of visits. The problem with the volume approach, which he says is typical, is that the lengths of visits vary widely, making it difficult to staff effectively. The hospital’s new approach, which includes length of stay as a workload driver “made more financial sense to us, rather than just linking it to patient arrivals for a visit,” he says.

JGPH started putting the new metric into effect in 2012; Qvistgaard links it to the hospital’s ability to significantly reduce overtime and the need to use registry nurses to fill labor gaps. Last year, for example, JGPH was budgeted for 18.9 registry full-time nurses, against about 270 employees. Its current year-to-date utilization is 5.9 registry nurses. “We credit that to having very accurate utilization data throughout all of our units, and especially our psychiatric ED,” Qvistgaard says. In addition, JGPH came in under-budget by 10 full-time regular employees, he adds.

Qvistgaard says the labor reductions have had no negative effect on quality at JGPH. In fact, he says patient satisfaction scores have increased at JGPH significantly, from the bottom decile to the top quartile nationally. Employee satisfaction scores have also increased significantly throughout the Alameda Health System, he says. In his view, using more regular staff lends itself to better continuity of care and better relationships between the patients and the nursing staff.

One of the goals of the labor initiative is to eliminate variability in the labor allocation process as much as possible. One example is the use of “sitters” for one-on-one care of patients with special needs. Previously, according to Qvistgaard, the process of determining who needed one-on-one care was not consistent at JGPH; often the charge nurse made the call with no checks or balances to the decision, and was not necessarily tied to good clinical outcomes, he says. JGPH has now implemented a formal workflow for one-on-one staff approval, auditing and checking, which is tied to the central staffing office, to help ensure that the care is both provided and pulled back in a timely manner, he says. He adds that while the formal process has added some time to the process, it was not untenable to good patient care. Since implementing the process, instances
of one-on-one care has dropped significantly, he says.

PENN STATE HERSHEY: MEDICAL GROUP TRANSPARENCY

Penn State Hershey Medical Group, which is associated with Penn State Milton S. Hershey Medical Center in Hershey, Pa., consists of 50 practice sites, including 165 subspecialties, located across the state as far as 90 miles away. Labor represents 80 percent of the medical group’s operational expense, according to Sherri Luchs, chief administrative officer for the medical group, yet there was a lack of transparency in how the staff was allocated. Last year the medical group implemented scheduling and labor analytics software that it says has saved more than $800,000 from lower overtime costs and more efficient staff allocation.

Interestingly, the initiative centralized the staffing allocation tasks, which Luchs says is an unusual approach for medical groups where individual practices often delegate their labor allocations autonomously. Luchs says the medical group required a better understanding of whether the practices had sufficient clinical and non-clinical staff allocated during the day. One of its early tasks was to analyze the time spent during the entire patient encounter, both face-to-face and over the phone or through patient portals, she says.

In June of 2013 it deployed scheduling software (Smart Square, supplied by Avantas, Omaha, Neb.), which has allowed visibility into the staffing needs of each practice. Luchs explains that each medical practice has a core staff of full-time and part-time employees. A contingency labor pool is managed centrally, so that when there are fluctuations in the number or frequency of visits, contingency staff can be added to the core staff to meet those needs. “We can now see centrally the visits and staffing on a daily basis, morning and afternoon, and at regular intervals,” she says.

The medical group uses analytics to measure the peaks and valleys of its visits and better match its full-time and part-time staff to meet the needs of the individual practices, Luchs says. The analytics also provides insight into the scope of practice, to make sure that the employees with the right skills are provided in the right place at the right time.

Six months prior to deploying the scheduling software, it began laying the groundwork by educating its physicians and managers. Prior to rollout it did staffing analysis and developed a staffing matrix based on industry benchmarks and internal benchmarks including front office staff, medical office associates and phone volume. That information is fed into the scheduling software, which provides live feeds of the number of visits, staff that is being deployed, and the number of float employees that need to be deployed.

In addition to staff scheduling, the medical group has begun work on a predictive model for the number of visits and required staff at each practice site. This model will refresh data as the visit date approaches, allowing the staff to be more accurately deployed.

“We are still fine-tuning that model,” Luchs says, especially for walk-in clinics and family community medicine sites, where there is more variability than traditional physician offices.

Within the first year of deployment, Penn State Hershey Medical Group saw a combined savings of $828,000 because staff was allocated more efficiently to meet the volume of visits. In addition, the medical group has been able to lower the use of agency nurses from 3 percent to 1 percent and has lowered its overtime as well.

“It’s changing how we allocate our staff, based on looking at our processes and procedures for the way we work, and making full-time and part-time employees available through the contingency pool,” she says. ◆
UCLA Health’s Goal: An Incubator of Healthcare Innovation

At a time of constrained resources, UCLA Health is actively collaborating with IT vendors and others to develop new approaches to supporting compassionate, coordinated care

BY MARK HAGLAND

What does it mean to actually link strategy, innovation, and execution? The folks at UCLA Health—the four-hospital, 150-clinic integrated health system based around facilities at the University of California Los Angeles—believe it means bringing together patient care innovation, medical research, and technology and information technology development, in a combined effort with a vision of the future.

That’s what Peter Kung, director, strategic technologies at UCLA Health, told his audience on Aug. 19, in a keynote presentation entitled “Linking Strategy, Innovation, and Execution.” Kung spoke as part of the Health IT Summit in Seattle, sponsored by the Institute for Health Technology Transformation, or iHT2. (Since December 2013, Healthcare Informatics has been in partnership with iHT2 through HCI’s parent company, the Vendome Group, LLC.)

With four hospitals, more than 150 clinics, 7,800 employees, 3,000 physicians, and a strong market position in Southern California, the leaders at UCLA Health could be content to rest on their laurels and simply continue to provide high-quality care to their patients. Indeed, by most measures, they are currently highly successful, with overall occupancy rates that were at 90 percent in 2012, and are over 100 percent now, with some days actually reaching 110 percent inpatient capacity; but that’s not what UCLA Health is all about, Kung told his audience.

WE’RE TRYING TO FIND HIGH-VALUE INNOVATIONS THAT RADICALLY REDUCE COST AND IMPROVE CARE OUTCOMES. WE’RE TRYING TO DE-RISK THE PROCESS OF TRYING TO FIND INNOVATIONS.

—PETER KUNG

Instead, referencing his organization’s mission and vision statements, Kung shared a very proactive overall strategy at UCLA Health, one that involves a variety of strategic initiatives and impulses. “Our mission is to deliver leading-edge patient care, research, and education,” he noted. “Our vision is to heal humankind, one patient at a time, by improving health, alleviating suffering and delivering acts of kindness; and, he said, “our values ensure integrity and compassion.”

PURSUING INNOVATION WITH AN EYE ON COSTS

Put those together along with a commitment to forge new paths in medical research, technology, and other areas, Kung said, and what one gets is a vision of the future in which UCLA Health is actively collaborating with IT vendors and others to develop new approaches to supporting compassionate, coordinated care, in a time of constrained resources and growing policy and regulatory demands on providers.

Or, as Kung put it succinctly, “You can't raise questions about improving value without having a discussion of cost, any longer, in healthcare. What innovation does in this space, and Michael Porter [Michael E. Porter, Ph.D, Bishop Lawrence University Professor at Harvard Business School] would agree with this,” he added, “is that there are a lot of
high-value, lower-cost innovations to look for. It’s really finding a set of activities that will nurture those innovations that we’re looking to facilitate. At UCLA, we identify, pilot and deploy high-value innovations that deliver better health and greater value to more people.” In short, he said, “We want to be a value accelerator, and at UCLA, we don’t really mind where innovation comes from; we want to share. We believe that all boats are lifted whenever anyone shares.”

Kung further clarified for his audience that, in his view and that of his colleagues, “Innovation to us is not just an innovation or a product; it is about reaching a new business model or service. We also have to take account of cost now.” As a result, he said, “We opened our arms and asked, where are the high-impact innovations? Importantly,” he said, “an innovation doesn’t have to be new to the world. We can take a lot of things from other industries; I think about banking and ATMs. Innovation is a new way of doing business. We believe that successful innovation requires a disciplined process.”

**WE OPENED OUR ARMS AND ASKED, WHERE ARE THE HIGH-IMPACT INNOVATIONS? —PETER KUNG**

As a result, Kung and his colleagues have developed what they call an “innovation life cycle.” There are three broad stages to that life cycle, with elements within those stages. The stages are: identify/scan, pilot/design, and deploy/scale.

The inclusion criteria involved for determining which innovations can be pursued are as follows. First, innovations must provide for utilization-based savings within three years of implementation. Second, they must have been implemented by at least two healthcare organizations or health plans. Third, the utilization-based savings must be documented. Innovations explicitly excluded are those associated with declines in patient access or patient outcomes.

Kung assured his audience that things are seriously ramping up for expanded facilitation of innovation over the next few years at UCLA Health. And most importantly, he emphasized, “We want to be an incubator for innovation,” across the spectrum of organizations operating within the U.S. healthcare system. Strategic, focused, and pragmatic—those are words that describe what the UCLA Health folks hope to achieve. Only time will tell what results emerge out of all this activity, but Kung emphasized that senior leaders at UCLA Health are determined to leverage their intellectual and other assets to positively impact healthcare innovation in the coming months and years, to the benefit of patients and communities nationwide.

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DEFINING A LIFE CYCLE OF INNOVATION

As a result, Kung and his colleagues have developed what they call an “innovation life cycle.” There are three broad stages to that life cycle, with elements within those stages. The stages are: identify/scan, pilot/design, and deploy/scale.

With regard to identifying and scanning, Kung said, “We’re trying to find high-value innovations that radically reduce cost and improve care outcomes. We’re trying to de-risk the process of trying to find innovations. The UCLA Health Global Lab scans domestic and international markets for high-value innovations,” he added.

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In a keynote address on Aug. 19 at the Marriott Seattle Waterfront Hotel, Nicholas Wolter, M.D., CEO of the Billings Clinic, an integrated health system based in Billings, Montana, told his audience at the Health IT Summit in Seattle that culture, vision, and mission are at the core of clinical and organizational transformation and successful IT implementation. Wolter’s keynote on Wednesday was delivered based on the theme, “Culture, Safety, and Quality: Strategies to Enable IT.” The Health IT Summit in Seattle is sponsored by the Institute for Health Technology Transformation, or iHT2 (since December 2013, Healthcare Informatics has been in partnership with iHT2 through HCI’s parent company, the Vendome Group, LLC).

One of the truly pioneering patient care organizations in the United States, the Billings Clinic encompasses a 290-physician multispecialty medical group (founded in 1917), a 285-bed community hospital, a psychiatric hospital, a long-term care facility, 11 critical-access hospitals, five rural clinics, and other resources caring for patients across a 43-county service area that spans much of central Montana and northwestern Wyoming, and is as wide in geographic area as the distance between Washington, D.C. and Chicago. The organization’s annual net revenues amount to about $550 million. As Dr. Wolter noted, “We’ve become quite large by Montana standards.”

Beyond size and scope, the Billings Clinic organization has for years now been recognized as an outstanding pioneer among U.S. patient care organizations for its care delivery and quality innovations. For example, the organization became nationally known when it joined the Medicare Physician Group Practice Demonstration Project, participating from April 2005 through 2010, along with nine other medical groups. As an important July 2011 report on the demonstration project noted, all 10 of the medical groups involved made considerable progress in increasing the efficiency, effectiveness, and care quality of their management of patients with diabetes, congestive heart failure, and coronary artery disease, and in their preventive care efforts.

Dr. Wolter reviewed the history of Billings Clinic for his audience, and then articulated how it is that the development of vision, mission, and a culture of safety and innovation has been foundational both for the organization’s ongoing clinical transformation work and for its IT development.

TRIED AND TESTED

Things haven’t been all rainbows and unicorns along the way, of course. In 1997, four years after the merger of the medi-
IN 2005, WE PUT ON THE TABLE THAT WE’D LIKE TO BE BEST IN THE NATION ON SAFETY, QUALITY, AND SERVICE. THEN IN 2010, WE DECIDED WE WANTED TO BE BEST IN THE NATION IN TERMS OF SAFETY, QUALITY, SERVICE, AND VALUE.

—NICHOLAS WOLTER, M.D.

cal group and hospital entities, the integrated health system faced significant financial losses, and was forced to do a reduction in force and hire turnaround consultants in order to move forward financially. “We’ve achieved tremendous financial stability,” Dr. Wolter told his audience, and, not coincidentally, “we’ve spent a tremendous amount of time on mission and vision, as well as physician recruitment.” Key to the organization’s current development was the creation of an explicit mission that not only aimed very big, but also was forged through consensus, particularly among its physicians; the organization considers itself to be a physician-led organization, and “the decision-making process really does emphasize physicians,” Wolter noted.

“In 2005, we put on the table that we’d like to be best in the nation on safety, quality, and service,” Wolter noted. “Then in 2010, we decided we wanted to be best in the nation in terms of safety, quality, service, and value.” Were those mission statements ambitious? No doubt about it. But they also reflected where Wolter and his colleagues felt Billings Clinic needed to go. Since then, the integrated health system has received a number of national recognitions, including from HealthGrades, the chief impact of which has been a strong “boost in morale,” Wolter noted.

Among the key areas that Dr. Wolter and his colleagues in Billings’ leadership have focused on include: regularly surveying all staff members to find out where they see patient safety gaps, with the results from those surveys informing senior management and the board as to where to intervene to improve patient safety; focusing on continuous clinical performance improvement and on building a culture of safety and eliminating preventable harm; and actively engaging physician leaders and rank-and-file physicians and nurses in helping to lead change management around patient safety, care quality, and cost-effectiveness.

I.T. AS A KEY FACILITATOR FOR CLINICAL TRANSFORMATION

When it comes to IT strategy, that strategy is completely integrated with the overall strategic direction of the organization, Wolter told his audience. It is focused on facilitating change, not on technology for technology’s sake. “We have a single EHR [electronic health record] for the clinic, hospital, and all our regional sites, from Cerner,” he said. “We were very early attesters for meaningful use. We’re launching a new revenue cycle management solution from Cerner. We’re using [the Seattle-based] Caradigm for analytics. When it comes to vendors, he added, he and his colleagues have been “pushing Cerner hard” to help them customize and optimize clinical decision support and other functionalities for the Clinic.

Importantly, he noted, when it comes to clinical informatics work to support clinical transformation, Billings Clinic employs three different practicing physicians—a primary care physician, a medical specialist and a surgeon, each working one-third time—as a triad of CMIOs, to help lead their colleagues in moving forward on clinical transformation.

Looking ahead, Dr. Wolter told his audience that what is clear, as Billings Clinic continues to move forward, is that the world of care delivery is rapidly changing, and that information technology and data will be needed to help facilitate clinical transformation going forward. That technology, and that information, will need to be used strategically by teams, no longer by individual physicians working in a care continuum vacuum. “We’re no longer fighter pilots,” Wolter said metaphorically. “We’re astronauts on a mission, needing a whole host of support. This [clinical transformation work] is very challenging, and the electronic health record, while pushing change, is also making many tasks harder.” Vendors need to improve core functionalities and interoperability to support the coordinated care of the future, he emphasized.

He ended by referencing a quote from Charles H. May, M.D., one of the founders of the Mayo Clinic, who in 1913 had predicted “50 years of advancements in improvements in the organization and team work of how healthcare is delivered.” Wolter noted that Dr. May “Might be very disappointed in the pace of change until now,” but he added quickly that “I am very hopeful for the future” when it comes to the potential for fundamental systemic change in healthcare going forward. ◆
When it comes to medical data, most people probably think about numbers and text rather than voice. But in recent years, speech recognition has proven the ability to enhance clinical documentation in various ways, which is more important now than ever as the demand for accurate documentation with every patient care encounter is growing.

At the Manhattan-based New York Presbyterian Hospital (NYPH), Brian Levine, M.D., has been using speech recognition software for years, since his days in medical school. Currently, Levine—a clinical fellow in reproductive endocrinology and infertility—sees up to 50 patients a day in addition to operating two to three days a week. Needing to maximize his time with patients, Levine knows that saving a few minutes here and there each day could prove extremely valuable.

As such, reproductive endocrinologist Levine has adopted Dragon Medical software from the Burlington Mass.-based vendor Nuance. After only 90 minutes of training, Levine says he became comfortable enough with the technology to begin using it in his daily workflow. “Since I started using it, it has saved me minutes per day, hours per month, days per year,” Levine says. “That is found time, and in this profession, found time is really valuable.”

When it comes to speech recognition software, a big concern is the accuracy of the transcription. Nuance says that Dragon Medical is up to 99-percent accurate out-of-the-box, and includes medical vocabularies covering nearly 80 medical specialties and subspecialties. Levine backs this claim, and adds that when he first started to use it, the program asked him what his specialty was to tailor its vocabulary to his needs, and even asked where he was from just in case it needed to pick up a particular accent.

HANDS-FREE EDITING, OBSERVED FIRST-HAND
Levine was actually able to show me first-hand how accurate it was during a recent visit to NYPH. Using the program, Levine is able to dictate in real time into its electronic health record (EHR) in his own words, letting him instantly review, sign, and make his notes available for other clinicians. Levine even speaks into the program’s microphone—which is plugged into his personal laptop—to tell the program to open.

—BRIAN LEVINE, M.D.
He literally has no need for a keyboard, giving the program commands from “select all” to “new paragraph” to “cut and paste” to “scratch that” when he wants something deleted. There is no need to speak like a robot, as speaking at your normal pace works just fine, Levine says. “Anywhere you can click, you can type. And anywhere you can type, you can talk,” he says. Levine was able to dictate the note in well under a minute, with no errors in accuracy.

“I can dictate a note before most people think about writing one,” Levine says. If there was a mistake, Levine simply would tell the program where the mistake was and how to fix it. Levine also uses the software to enter a patient’s order into the EHR’s computerized physician order entry (CPOE) system with a simple command. If there ever a need to look up something on the web about pelvic pain, for example, or search for an ICD-9 code, Levine uses the program’s microphone for those things as well.

Levine has also found other ways to leverage the technology. During a physical exam, for instance, he can dictate the patient’s note while the patient is right there in the office. Without a program such as this, he says, physicians will enter the note non-verbally, and that a) takes more time and b) doesn’t prove as effective in getting the patient more engaged and informed. “The patient becomes engaged when you document by speaking with him or her right in front of you,” he says. “They hear key things.”

Previously, with operative notes, Levine says that he and his colleagues would speak into the phone and have the note get transcribed by someone—likely in another country—only to have it sent back to be edited. This cumbersome process can take as much as 72 hours, Levine says. “Operative notes can be very sloppy for this very reason; and of course, there are transcription costs involved with third-party companies. With this program, physicians can pay per license or institutions can subscribe to a site-wide license.”

**HIGHER SPEED, LOWER COSTS**

Undoubtedly, voice recognition software has provided the means to lower transcription costs, speeding efficiency and populating data for achieving meaningful use; now Levine can open a note and transfer the accurate text right into the EHR. To that end, Levine says that physicians often cut and paste their notes from previous ones, which can be dangerous because the note becomes much harder to defend. In fact, earlier this year, the Chicago-based American Health Information Management Association (AHIMA) released a statement saying that the use of the “copy and paste” functionality in EHRs should only be permitted in the presence of strong technical and administrative controls. “Now, I can justify everything that I have done,” Levine says, noting that when it comes to being audited, comprehensive and accurate notes are important.

When asked about criticism regarding speech recognition software, Levine says the negativity boggles his mind. “Doctors in smaller practices are worried about their practices staying open, but this type of software could save the doctors that need to type with [one finger at time],” he says. “In fact, I think EHR vendors should be telling these doctors how helpful this program could be to them.”

He adds that there is a consensus fear among many clinicians about adopting any kind of technology, as they think it will change their workflow too much. “The learning curve scares them. They think it’s too steep and too long. But with programs such as this one, there are no bells and whistles. It’s really the difference between something being cumbersome and efficient. With this software, tell me who can be more efficient than me in the EHR?” Levine asks. “I’ll argue that until I’m blue in the face.”

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**THEY THINK [THE LEARNING CURVE] IS TOO STEEP AND TOO LONG. BUT WITH PROGRAMS SUCH AS THIS, THERE ARE NO BELLS AND WHISTLES. IT’S THE DIFFERENCE BETWEEN SOMETHING BEING CUMBERSOME AND EFFICIENT.**

—BRIAN LEVINE, M.D.
Plan the Work, Then Work the Process

‘Operationalizing processes’ are an essential part of an IT strategic planning project  BY FRAN TURISCO

Today, an IT plan without the rigor of the associated processes to implement the recommendations leaves organizations holding the thick book of projects and a high-level roadmap, asking, “Now what do we do?”

While an approach without established processes worked fine years ago when we were eagerly moving from paper to electronic transactions, the approval of the IT plan is no longer the endpoint for the planning effort, due to the complexities of technologies, dependencies and external data sharing and communications.

There has never been a more pressing time when an organization needs to have clear, consistently followed processes, effective checkpoints, and leadership support to manage the IT plan and monitor its progress and value. The volume of IT requests has skyrocketed in recent years, yet resources are scarce and options and dependencies are many, which requires numerous shifts and project trade-offs. New requests come into Information Services (IS) almost instantaneously with the approval of the IT plan. Without clearly defined processes and standards for requests and changes, it is natural to fall back on a “business as usual” mindset which in many cases means a LIFO (Last In First Out) method for new requests.

The processes can no longer be conveyed in PowerPoint diagrams. Rather, workflows, procedures, new tools, and education are requirements to make sure the most critical, highest priority needs are addressed first, and approved projects are continually tracked and successfully implemented. The following are some of the exemplary practices that innovative organizations have used to manage the transition from planning to doing while keeping the momentum going.

INVOLVE THE PMO EARLY IN THE PLANNING PROCESS

The Project Management Office (PMO) is an integral part of executing the IT plan, so get them involved early on to make sure the tools, data, and processes are in place once the plan is approved. Some important work done by the PMO during the planning engagement includes:

- Building/refining the IT request form, standard status report format, issue log, and project monitoring dashboards;
- Building workflows and associated procedures from the high-level IT request process diagram in the plan; and
- Setting standards for what defines a project, the level of detail for costs, and value realization analysis for an IT request.

MARRY THE I.T. REQUEST PROCESS WITH THE CAPITAL BUDGETING PROCESS

While not part of the IT planning initiative, processing new requests is an important aspect of managing and adjusting the plan to fit the needs of the organization. When the planning project is underway, it is also the time to build the process for streamlining the IT and capital budgeting process, and here is why. It is not uncommon for organizations to have the capital request process separate from the IT request process. In this instance, the requestor needs to enter much of the same information, such as scope, benefits, costs, resources, and total cost of ownership (TCO) into two different systems. This approach is very confusing to the requestor if, for example, the capital budget request is approved, but the IT request is denied.

Organizations need to combine the two processes with the understanding that any capital request that uses technology and needs IS resources must go through the IT request approval process first. Once approved, then it should be sent onto the capital budgeting committee. Luckily, the IT request approval committee and the finance committee have many of the same members, so if a project gets through the IT process, the capital will most likely be made available.

Marrying the two also improves the adoption to the new IT request and process as users are familiar with capital budgeting process and won’t need to do double duty for requesting the technology too.
MAKE BUSINESS SPONSORS ACCOUNTABLE

IT projects identify a business or executive sponsor to show approval for the project and its value to the organization. However, beyond the signature, the business sponsor is often not held responsible for the outcome or involved in the project to address issues and barriers. Important characteristics for a sponsor include:

- Holding the position of senior vice president or executive;
- Ensuring the project generates the intended business benefit and return on investment (ROI) and working with the steering committee and its respective advisory group to establish clear metrics for determining the initiative’s success; and
- Acting as a change agent and driving the redesign or deployment of new processes for both organizational change and process and performance improvement.
- Being responsible for securing funding and presenting the project to the appropriate steering committee and IT oversight committee;
- Asserting an overall accountability for system/process implementation;
- Assigning and directing a project director who partners with the IT business associate to execute the project;
- Having the authority to assign resources and time to “own” the project;
- Resolving issues that “bubble up”; and
- Being accountable for outcomes and reporting regularly to the IT steering committee.

ENLIST FINANCE AS A RESOURCE AND A GATEKEEPER

Similar to combining the IT request and capital budgeting process, the finance department is a valuable resource and gatekeeper for IT planning and new requests. Two important areas where they can expedite and improve the quality of the information are:

- Assisting in the development of costs, benefits, and TCOs for large projects; and
- Making sure that all capital requests that include IT and IS have been through the IT request process and have been approved.

THE PROJECT MANAGEMENT OFFICE IS AN INTEGRAL PART OF EXECUTING THE I.T. PLAN, SO GET THEM INVOLVED EARLY ON TO MAKE SURE THE TOOLS, DATA, AND PROCESSES ARE IN PLACE ONCE THE PLAN IS APPROVED. —FRAN TURISCO

I.T. IS THE RESPONSIBILITY OF THE EXECUTIVE I.T. GOVERNANCE COMMITTEE TO START THE COMMUNICATIONS FLOWING AND THEN THE MEMBERS OF THE COMMITTEE TO EDUCATE THEIR STAFF WITH THE DETAILS. —FRAN TURISCO

This partnership aligns the allocation of money to the availability of resources and eliminates surprises for IS when projects are approved without their input.

COMMUNICATE AND EDUCATE CHANGES (AND THEN HOLD THE LINE)

The planning project involves interviews and intensive work by the team and finally, approval by the executive committee. However, most of the end users are not aware of the plan details, nor the changes in governance and processes. It is the responsibility of the executive IT governance committee to start the communications flowing and then the members of the committee to educate their staff with the details.

The hard part is not the communication of the changes; it is adhering to them. It is so easy to “squeeze” in one more request without going through the process, but in the long run it is easier if you don’t. Once the process is baked in (and combining it with the capital budgeting process helps), it becomes second nature, and the right projects for the organization are the ones that are approved and implemented.

LOCK AND LOAD

After the IT plan is approved by the executive IT governance committee, then it is time to get started. Load the projects into the IS PMO application. Start with the mandatory and high priority projects for the upcoming year—setting agreed upon start dates, confirming IS and end user staffing commitments, creating work plans, making sure the capital is secured, and acquiring external resources. The sooner you treat the IT plan as part of business as usual, the sooner it will be.

Bottom Line: What was the end of an IT planning effort is no longer. IT plans have matured from laundry lists of new applications and infrastructure implementations to complex project roadmaps with dependencies, special skill requirements, and significant end user resource commitments, in addition to external connectivity and data sharing. To be successful, organizations need to plan the work and then work the IT plan processes.

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Can the adoption and implementation of electronic health records (EHRs) be tied to hospital performance and lowered mortality rates? While we might be a bit of time away from being able to make that precise claim, new research does suggest a measurable beneficial relationship.

The findings were revealed by HIMSS Analytics, the research arm of the Healthcare Information and Management Systems Society (HIMSS), and Healthgrades, an online resource for comprehensive information about physicians and hospitals. The value of EHRs has long been discussed, but until now evaluations have lacked comprehensive clinical data, according to HIMSS officials.

Using HIMSS Analytics’ Electronic Medical Record Adoption Model (EMRAM) and mortality rate measures collected by Healthgrades across 19 unique procedure and condition based clinical cohorts, the analysis found that hospitals with advanced EHR capabilities (as reflected in high EMRAM scores) demonstrated significantly improved actual mortality rates, most notably for heart attack, respiratory failure, and small intestine surgery.

Most cohorts experienced improvement in predicted mortality rates when compared to hospitals with lower EMRAM scores. The predicted mortality rate is an indicator of the level of documentation and capture of patient risk factors that are correlated to increased risk of mortality. In total, 4,583 facility records were selected from the HIMSS Analytics database, representing the total number of facilities with complete data from 2010 through 2012.

COLLECTING THE DATA
One such facility that participated in the study was the Charlottesville-based University of Virginia Health System, which includes a 604-bed hospital, Level I trauma center, cancer and heart centers, and primary and specialty clinics throughout central Virginia. According to UVA Health System’s CIO, Richard Skinner, who is also a board member for HIMSS Analytics, while the EMRAM model has enabled healthcare systems to see where they rank as far as EHR maturity, any kind of data that describes the impact of implementing an EHR on clinical performance has been missing until now. “The reason for this study was to describe potential benefits from the EHR, and preliminary results say there are benefits,” Skinner says.

For years, HIMSS Analytics has collected a very detailed data set from each hospital in the U.S. with the exception of some very small ones; the model has very specific criteria for which capabilities a facility needs to have for each stage (0–7) on the scale. “Every year, [HIMSS] will call someone from each hospital and ask them to renew that data set. They ask questions such as, ‘Do you have an electronic medical administration record and do you do CPOE [computerized physician order entry],’ for example. With all of that data in hand, HIMSS can then say Hospital A is at Stage 4,” says Skinner. Then, Healthgrades takes Centers for Medicare & Medicaid Services (CMS) data and looks at people who have died in a specific facility, and CMS’ grading of those people in the aggregate who were expected to have died given their diagnoses and so forth, Skinner says.


**EARLY IMPLICATIONS**

According to Skinner, to date, the study has shown that those facilities that are higher on the EMRAM (in Stages 6-7) have a better ratio of actual mortality to expected mortality than do hospitals that are lower down on the scale; but Skinner does say that a deeper dive of the data is coming, and that the analysis is very preliminary. “We don’t know why that is yet, but to date that’s what the data has showed us. And you might ask about other factors—‘Are the ones higher on the EMRAM better funded, bigger, and in urban areas?’ There are a host of factors that can come into play; but again, the preliminary data shows a correlation between mortality rate and implementation of EHRs,” says Skinner.

As of today, the study hasn’t gotten down to institutional level to see what happened at a given organization, Skinner says. “It might not, because the power of the study is the size of the sample, and it’s the size that enables being able to discover the correlation. If you did it at one hospital, there would be so many other variables that statistically, you couldn’t make that association,” he says.

At UVA Health System, Skinner says he has looked at the organization’s clinical performance indicators over time and whether they are improving or not. “For some of those indicators, it’s clear there is at least an association with having better data and having that data in front of clinical decision makers. For others, it’s hard to tell, he says. “Things like urinary tract infection (UTI rates) are getting markedly better, but is that all because of EHRs? No, but you can credit the EHR with at least being able to expose the data and communicate it effectively.”

**THE REASON FOR THIS STUDY WAS TO DESCRIBE POTENTIAL BENEFITS FROM THE EHR, AND PRELIMINARY RESULTS SAY THERE ARE BENEFITS.**

Skinner says that the reason why such evaluations have lacked comprehensive clinical data is two-fold. First of all, the EHR is a relatively new phenomenon, as most organizations have only implemented a comprehensive EHR in the last few years, and getting it to operate effectively takes some time, he says. The second factor is that the contributing factors to an improvement in clinical performance are, even in the simplest cases, “numerous and interrelated.” So analytically, Skinner says, “It’s difficult to figure out what the most causative variable happens to be in improvement in expected mortality, or whatever it is that you’re trying to measure. I think the message to the industry is that for hospitals with EHRs, there exists great potential to get further benefits from these tools as we mature in figuring out how to use them,” he says.

Skinner adds that he feels confident in saying there is a “statistical” correlation between advanced EHR capabilities and improved mortality rates. “But again, what part of that correlation is causative awaits further analysis of the data and is not in the preliminary report. All we can say at this point is that there is a correlation. Now, intuitively, it stands to reason that further analysis will filter out those other variables to get to the real contribution to having an EHR.”

What’s more, Skinner does say that the results so far are exactly in line with what he expected. “Of course I am a biased CIO who has a stake in this business,” he says. “But organizations that have spent billions in the aggregate to implement EHRs obviously have the same expectations. While meaningful dollars play a role in that, the entire industry has the expectation that having better information better organized in front of clinical decision makers will lead better results. This study indicates that we’re starting to see that.”

Skinner says he feels that it’s important for the industry to demonstrate this not only because of the magnitude of the investment that’s already been made, but also because there is a huge amount of work left to make truly optimal use of these tools to improve performance. “That’s the hill we are climbing as an industry,” he says.

Clearly a proponent of EHRs, Skinner says that those who criticize the technology for not providing clinicians enough value might not be accurately measuring what the “value” really is. “It may be that a specific clinician hasn’t found much value to him or her, but that doesn’t mean his or her use of the EHR hasn’t proved value to the patient, to the institution as a whole, or to other parts of the institution,” he says.

Skinner notes that the case is easier to make at the organizational level than it is than it is at the individual physician level. “Providers do have a point in that they are being asked to do more and put their hands on a tool they never had to worry about. So there’s no question they have acquired added burdens. But the real question is, ‘Has the institution and its patients gotten sufficient benefit to justify that extra burden?’”

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**IT MAY BE THAT A SPECIFIC CLINICIAN HASN’T FOUND MUCH VALUE TO HIM OR HER, BUT THAT DOESN’T MEAN HIS OR HER USE OF THE EHR HASN’T PROVED VALUE TO THE PATIENT, TO THE INSTITUTION AS A WHOLE, OR TO OTHER PARTS OF THE INSTITUTION.**

—RICHARD SKINNER
Stage 2 ‘Can Be Done’: First Critical Access Hospital Attests

Clinical leaders at one small rural hospital describe the challenges encountered during the hospital’s successful Stage 2 meaningful use attestation

BY GABRIEL PENA

While the number of eligible providers (EPs) and eligible hospitals (EHs) that have attested to Stage 2 of meaningful use continues to lag behind, one rural hospital found a way to get it done.

Odessa Memorial Healthcare Center is a 25-bed critical access hospital (CAH) in Odessa, Wash., a tiny hamlet located approximately 70 miles to the west of Spokane with a population of less than 1,000. According to Megan Shepard, R.N., clinical services director at Odessa Memorial, the hospital’s volume is so low that most of the managers oversee multiple departments and projects.

In fact, Shepard says the hospital doesn’t even have an IT department. She was part of the electronic health record (EHR) team that helped the hospital attest to meaningful use Stages 1 and 2. It also used outside assistance. “INHS (Inland Northwest Health Services) was our IT department. They were the ones who have been doing our IT support for meaningful use and information gathering to reach the goals,” Shepard says.

INHS is a Spokane-based nonprofit corporation made up of member hospitals in the region that collaborate on services such as IT guidance. INHS has a division, Engage, which acts as a health IT software vendor to organizations like Odessa, providing EHR and meaningful use guidance. Engage has a partnership with the Westwood, Mass.-based Meditech, and administers the company’s clinical and finance software for end-users, especially at rural hospitals like Odessa.

THE HARDEST THING FOR US WAS GETTING PATIENTS INTERESTED IN USING THE PORTAL. THE POPULATION WE SERVE IS ELDERLY, MANY DIDN’T GROW UP USING A COMPUTER, AND MANY DON’T EVEN HAVE EMAIL.

—MEGAN SHEPARD, R.N.

ENGAGING PATIENTS WAS A CHALLENGE

Despite using this kind of assistance, Odessa had its struggles. It still had to get patients to use its portal. This, Shepard confirms, was the hardest part of Stage 2, which requires EPs and EHs to have five percent of their patients view, download, and transmit their health information electronically.

Indeed, this seems to be what’s holding up most providers. A recent study by researchers, led by Julia Adler-Milstein, Ph.D., University of Michigan School of Public Health assistant professor of information, looked at adoption of EHR systems in hospitals since the enactment of the Health Information Technology for Economic and Clinical Health (HITECH). They found that a measly 10 percent of hospitals surveyed met the threshold for having patients view, download, and transmit their health information electronically. That criterion had the lowest percent of adoption among every single Stage 2 measure by hospitals, just ahead of the transitions of care measure.

“The hardest thing for us was getting patients interested in using the portal,” Shepard says. “The population we serve is elderly, many didn’t grow up using a computer, and many don’t even have email.”

(Continued on page 31)
As they move from their initial phase of getting established toward a sustainable future, most statewide health information exchanges (HIEs) are incrementally ramping up their service offerings, and thereby enhancing the value proposition of participating. The 800-member Kansas Health Information Network, based in Topeka, is a good example. I recently spoke with KHIN Executive Director Laura McCrary about several recent developments there.

In one big change, KHIN has started including behavioral healthcare data, resulting in a more complete medical record for patients. How did KHIN work around regulatory rules limiting the sharing of substance abuse information without patient consent each time the data is accessed?

“We worked through those issues and got a sign-off from the Association of Community Mental Health Centers and SAMHSA (Substance Abuse and Mental Health Services Administration) on the procedures we put in place,” McCrary says.

KHIN’s technology vendor, ICA, does a global opt-out of the patient information if the patient does not provide consent to participate in the health information exchange. The data is still in the exchange but it is locked. “We allow the security to be overridden, or the more common term is ‘break the glass’ in two instances: If the patient gives consent at the point of care, or in the event of a medical emergency,” she says.

Pertaining to substance abuse treatment, KHIN opted out every single patient that had received substance abuse treatment services. That allows the patient to provide consent at the point of care to a provider in that one instance. “It is a fairly simple solution to a very complex problem,” McCrary says, “but it works quite well. Prior to any facility beginning to integrate their data with KHIN, if it provides substance abuse treatment services, we opt out all their substance abuse patients, but it just blocks the data until the patient provides consent.”

**ONE OF OUR KEY REASONS FOR JOINING THE eHEALTH EXCHANGE WAS TO SHARE MEDICAL RECORDS WITH THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF DEFENSE. KANSAS IS THE HOME OF THREE LARGE MILITARY BASES AND OVER 200,000 VETERANS.**

Laura McCrary

KHIN also is making progress in its efforts to offer Kansans personal health records independent of health systems’ portals. The MyHealth eRecords PHR is now officially launched, after being in a “soft launch” since October 2013.

The early implementation was a little clunky, McCrary admits. “Initially populating the patient’s personal health record was a manual process. The provider had to send a Direct message to the patient’s PHR account and Direct email account with the C-CDA [consolidated-clinical document architecture] attached,” she says. “For a small hospital of physician practice, it isn’t all that challenging, but when you start looking at larger organi-
zations, they don’t have the resources to do that.” In phase 2 the PHR will be automatically fed from the HIE. “So anytime a C-CDA is launched to the exchange, it will also be launched to the PHR across all providers,” she says. The PHR solution, working with vendor NoMoreClipboard, is currently in a pilot phase with 16 small and mid-sized healthcare organizations.

Another milestone for KHIN is joining the national health information network, the eHealth Exchange. “One of our key reasons for joining the eHealth Exchange was to share medical records with the Veterans Administration and the Department of Defense,” she says. “Kansas is the home of three large military bases and over 200,000 veterans.”

**REPORTING TOOLS FOR PROVIDERS UNDER DEVELOPMENT**

KHIN also is in the early stages of developing reporting templates for providers. It noted that before 2014 there was not enough information in KHIN to make reports feasible or worthwhile. However, KHIN now has real-time clinical information on over one million patients and access to information on over five million patients.

The first report offering involves sending alerts to physicians or care coordinators if a significant event occurs with their patient, such as a hospital admit or discharge. Another involves information for physicians who want to determine gaps in preventative care for their patients.

“We also are looking at working with health plan members to start alerting them that a patient has had a medication prescribed by a doctor but it hasn’t been filled,” McCrary says. “This really is a new idea for us. Health plans have the filled prescription data, which we do not have. We only have what’s been ordered, which the health plans don’t have; so when you bring those two pieces together, you can begin to identify patients who have not gotten an important prescription filled, and that could be critical to health outcomes.”

A secondary data committee is working to determine under what conditions data can be made available for research, population health and emergencies.

She says KHIN hasn’t yet worked out business models for these reports. “We know the health plans will pay for things they receive. In terms of the providers, we are a provider-led organization, created by the Kansas Hospital Association and the Kansas Medical Society. Our goal is to help providers, so if we can provide these reports at low or no cost, that will be what we do.”

Sustainability is an issue for every HIE and each one is looking for ways to provide value to their constituent base and to cover what is pretty expensive technology infrastructure, McCrary says. “I think that as an HIE you have to have a wide variety of revenue sources. Provider revenue is only one piece of that pie. If you rely entirely on that piece, in my opinion, you are likely to fail. There are just not enough resources to cover the costs.”

**MEANINGFUL USE (Continued from page 29)**

This forced Odessa to recruit family members and directly engage with someone younger, especially if they had experience in using a computer. Because of the small staff, Shepard says it was easy to recruit providers and get them on board with this mission and the overall meaningful use project. In fact, she notes that a radiology technician calls ER patients every week and tries to see if they are interested in using the patient portal.

Despite this effort, it wasn’t easy to get past that five percent view, download, transmit threshold. Other meaningful use measures, Shepard says, were easier because it was simply building on top of Stage 1. Even the transitions of care measures weren’t as hard. “If you did [the other measures] well in Stage 1, it’s just a matter of the numbers increasing and the percentages increasing,” she notes.

Of course, for many hospitals, Stage 2 attestation is more complex. In its most recent data release, the Centers for Medicare and Medicaid Services (CMS) indicated that 78 out of approximately 3,000 eligible hospitals have attested to Stage 2. Marcy Cheadle, R.N., the director of meaningful use and advanced clinicals for Engage, says that there is a lot up in the air with regard to Stage 2.

**MAKING THE CASE FOR CLINICIANS AND PATIENTS**

“From a pure canvas, check it off the list standpoint, Stage 2 is doable. However, from a ‘can we make the information and usability case for clinicians and our patients meaningful,’ that’s yet to be determined,” says Cheadle. “We have a lot of work to do in analyzing information from Stage 2, particularly related to quality measures. We have a tremendous amount of work in understanding the transitions of care summary, the continuity-of-care document exchange, and quality data going to the federal government.”

Cheadle says Stage 2 attestations will continue to lag behind Stage 1 and predicts a number of sites are going to forgo the incentive dollars in 2014. In terms of the Stage 2 flexibility announced in May that was recently finalized, she adds that “it came very late in the game,” especially for hospitals who run on a fiscal quarter. She also says it was a bit confusing in its wording and the lack of clarity may even cause some hospitals to step back completely.

Naturally, this kind of uncertainty doesn’t apply to the tiny hospital in the tiny town of Odessa, Wash. They will march on and continue to take the meaningful use program one step at a time, says Shepard, who believes Stage 2 can be done.

“I don’t see why [the deadlines and requirements around Stage 2] are not fair,” Shepard says. “But it is a huge change and getting everyone used to the changes that are the requirements for meaningful use. Like I said, we’re a small hospital and can easily communicate with our clinicians. In these bigger health systems, I can see where it would be a problem.”
Four of the scariest letters in the English language for health IT executives are B-Y-O-D. This, of course, is short for “bring your own device.”

While use of personal smartphones and tablets has increased in healthcare settings, unease from CIOs and IT leaders has not gone away. According to the Ponemon Institute’s Fourth Annual Benchmark Study on Patient Privacy and Data Security, 88 percent of organizations allow employees and medical staff to connect personal devices to their organization’s networks. However, the same survey also revealed more than half of organizations are not confident that the personally owned mobile devices are secure.

Studies have shown that when BYOD works, it can increase efficiency and productivity, improve physician morale, and decrease costs for infrastructure. However, many CIOs worry that the privacy implications and risks are too high to justify.

Can providers and IT leaders find themselves in a win-win situation? Yes, says Melissa Markey, a healthcare technology lawyer at the Indianapolis-based Hall, Render, Killian, Heath, & Lyman. Markey advises providers on how technology can be a benefit while presenting risks to the patient, and how

**NOT EVERYONE SHOULD BE ABLE TO ACCESS COMPANY DATA ON THEIR PERSONAL DEVICE. YOU SHOULD NEED A REASON TO NEED ACCESS TO COMPANY DATA WHEN YOU’RE NOT SITTING AT A STATIC LOCATION.**

—MELISSA MARKEY

to protect the patient from those risks. She recently spoke with Healthcare Informatics Senior Editor, Gabriel Perna on the risks and benefits of BYOD as well as implementing an effective BYOD protocol that will leave providers happy and IT executives at ease. Below are excerpts from the interview.

**PROVIDER CONCERNS ON BYOD**

Healthcare Informatics: As a healthcare technology lawyer, when did you start getting inquiries on BYOD policy?

Melissa Markey: A long time ago, doctors had pagers on their hips. Then it became two pagers. It eventually became inconvenient to keep track of multiple devices, and as phones became smarter and tablets became more capable, and applications became richer in functionality, [providers] started saying, ‘Why do I have to have multiple devices? Why can’t I just use one device for everything I need and make my life simpler?’ The CIOs recognized that it was necessary to address that desire for two reasons. First, you don’t want rogue devices on your network. Number two, the reason we exist is to care for patients. If we can take an innovation and use it in a way that makes it more efficient for healthcare providers to take care of patients, that’s a win-win situation. That’s what we’re
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When your phone won’t work and your Outlook calendar won’t of apps are going to mess with your phone and functionality, I can tell them no,’ but it’s just not the right thing to do. It’s understandable to say, ‘Tell IT department’s job harder. It’s understandable to say, ‘Tell there are big operational considerations and it does make the is coming through,’ your poor help desk has to figure it out. There are 492 different weird systems, and on top of everything else, 492 different weird someone training on this phone,’ you need to train the help of saying, ‘We’re going to use this mobile phone and I’ve got is patient-care focused. Because instead of saying, ‘We’re going to use this mobile phone and I’ve got someone training on this phone,’ you need to train the help desk to deal with 12 models of phone, four different operating systems, and on top of everything else. 492 different weird applications that people have, because it’s their phone. A lot of apps are going to mess with your phone and functionality, when your phone won’t work and your Outlook calendar won’t sync, and they call the help desk and say, ‘None of my calendar is coming through,’ your poor help desk has to figure it out. There are big operational considerations and it does make the IT department’s job harder. It’s understandable to say, ‘Tell me I can tell them no,’ but it’s just not the right thing to do.

WHAT CAN BE EFFECTIVE IS COMING UP WITH REASONABLE, RATIONAL POLICIES, EDUCATING PEOPLE ABOUT WHY YOU NEED TO HAVE THOSE POLICIES AND WHY THEY’RE NOT RANDOM POLICIES, AND HELPING THEM RECOGNIZE THE REASON IS PATIENT-CARE FOCUSED. —MELISSA MARKEY

WHAT ARE THE SECURITY RISKS?

HCI: In terms of security risks, what can those lead to if not properly monitored?

Markey: To be perfectly honest, there are several components of a security risk. The biggest security risk is that these devices get lost. People take them out of their pockets and put them on the table at lunch, and they walk away and leave them. They leave them at the bathroom. They leave them in taxis. They leave them all over the place. They get lost. We then have a phone wandering around with protected health information (PHI) on it and we can’t say for certainty that there’s no breach. That’s a big problem.

Another problem is that while you may have information encrypted, it’s not always encrypted. For example, text messages are freely visible a lot of times on the telephone. It’s easy for anyone to eavesdrop. Those apps that everyone loves are literal information gathering devices. They take so much information and nobody knows it because no one bothers to read to the privacy note. You don’t know what’s happening on the back end and some of them are bad apps, they sometimes provide a route into the hospital network. That type of security concern is out there.

The other concern is you have data stored on your personal device that is personal data, and now you have corporate data on that device. It leads to the mixing of personal and business, which can lead to other concerns. You end up blurring those lines and there are a host of legal considerations that go along with that. For example, if you’re an hourly worker and have a BYOD program, and work shift ends and you go home, and you start reading emails at home, are you logging in for overtime? Do you need to be paid overtime? That can raise labor standards issues. If you have data on your phone that becomes the issue of litigation in the future, and you have to put litigation hold on that data, it may mean we need to take custody of that phone for a little bit. There are whole host of legal issues. You need to be thorough when putting together a BYOD policy.

THE BASIS FOR A SOUND BYOD POLICY

HCI: What is involved in an effective BYOD protocol?

Markey: I put it into a very generally ‘who, what, when, where, why, and how’ format.

Who needs to use a BYOD device? Not everyone should be able to access company data on their personal device. You should need a reason to need access to company data when you’re not sitting at a static location. Also, you need to identify who has the authority to approve a BYOD request and in the policy, identify who owns the data.

What kind of data can go on that device? What kinds of applications can on the device? Are you going to set up an approved app store that shows you’ve vetted certain apps? Or are you going to let folks download any app they want
and deal with the problems later? What controls are needed on device? Are you going to require mobile device management software? How complex are you going to require passwords to be? How long before the screen lock comes on? All of those types of technological/security control questions need to be addressed.

You have to answer what devices are going to be ok. Even though you are going with a BYOD policy, there may be decisions that you are only going to approve devices you are familiar with. There may be limits on brand specifications, operating systems. Whatever the technology guys decide is reasonable. Then you have to think about what your service policy is going to be. Is your IT help desk going to fix phones when they are not working? If they’re not going to fix phones, this means the phones are going to the carrier, and what are the implications if you’ve got confidential data on the phone?

Why is documenting why users will be given access to data on that device. Why access can be terminated and the details behind the reasoning allowing the use of the BYOD.

When talks about when is data access is granted, when it’s removed. When is also when was the device lost and when do you have to report the device is lost?

Where is where the devices can be used and where they can’t be used? And are there care areas where special rules have to be followed? For example, there are a couple of cool apps for tablets that the orthopedic surgeons and oncology surgeons like to use that overlay the imaging modalities over each other. If you are taking your iPad into the operating room (OR), it’s probably not very clean by OR standards. There needs to be special rules for taking BYOD into a special care area, so you’re not contaminating it.

How is how do you get permission to use the device? How is mobile device management applied to the device? How is the device wipe administered? How do you get the message from HR that someone is being terminated so we can decommision them out of the BYOD program? How is the mechanics of how this actually works.

**One thing we need to be really careful about is our photographs. Sometimes we have caregivers who take photographs of wounds, injuries, bruises, those kinds of things. Then they forget that they have them on their phone. Then you’ll have a family members pick it up and see the patient photos. Obviously, that’s a bad thing. Maybe you should think about using a special camera for photographs, so it doesn’t accidentally get uploaded to iCloud.**

**Markey:** My preferred approach is to have the data not residing on the device. I’d rather the data be on a server and transmitted on the device. You can view it on the device and save it on a server. We lose these devices all of the time. If it’s viewed on the device and saved on the server, I have fewer concerns. They are not completely gone but fewer. One thing we need to be really careful about is our photographs. Sometimes we have caregivers who take photographs of wounds, injuries, bruises, those kinds of things. Then they forget that they have them on their phone. Then you’ll have a family members pick it up and see the patient photos. Obviously, that’s a bad thing. Maybe you should think about using a special camera for photographs, so it doesn’t accidentally get uploaded to iCloud.

**HCi:** Overall, do the security risks outweigh the benefits of mobile devices or vice versa?

**Markey:** If you’ve got a good mobile device policy, I think patient care can be improved by mobile devices. I think we have to use them smartly. If we don’t think about what we’re doing and we’re not smart about the way we use mobile devices, it could cause harm. You have to be on guard against that.

For example, I know healthcare providers like to text information back and forth. There may be times where that is an effective way to communicate, although Joint Commission rules say you cannot text orders. But if you ever want a divot picture of the risks of that kind of communication, just Google autocorrect and you will see how often autocorrect distorts what you are trying to text. So if you are going to do it, you have to double check what you just typed and make sure when you read something, it makes sense. Make sure you’re in the moment and paying attention. You can’t use mobile devices when your attention is divided in healthcare. It’s easy to have errors. If you’ve got PHI on your phone, you have to be extremely vigilant that you know where your phone is at all times.

**HCi:** Do you have anything else to add on BYOD?

**Markey:** Just that to have a strong BYOD policy and program, it’s really important to involve a lot of different people.
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Clearing the Air on the ICD-10 Transition

AHIMA’s Sue Bowman shares her perspectives on the current moment in the journey towards the ICD-10 transition

BY MARK HAGLAND

When, this March, the U.S. Congress inserted a yearlong delay in the mandate for the transition from the ICD-9 coding system to the ICD-10 coding system from Oct. 1, 2014, to at least Oct. 1, 2015, as part of a broader bill creating a temporary “SGR fix” (a delay in Medicare physician payment cuts under the program’s sustainable growth formula), it threw ICD-10 planning into disarray across the U.S. healthcare system.

At the Chicago-based American Health Information Management Association (AHIMA), the national association of health information management (HIM) professionals, the reaction to Congress’s March 31 action was one of shock and dismay. After the U.S. Senate passed the SGR-fix bill on March 31, and just before President Obama signed it into law on April 1 (the provision on ICD-10 had been slipped quietly into the SGR-fix bill by lobbyists representing medical specialty societies), AHIMA issued a press release saying that “The American Health Information Management Association (AHIMA) expressed deep disappointment that the U.S. Senate voted today to approve H.R. 4302, Protecting Access to Medicare Act of 2014, which included language delaying implementation of the ICD-10 code set until at least Oct. 1, 2015.”

The press release included a formal statement from AHIMA CEO Lynne Thomas Gordon stating that, “On behalf of our more than 72,000 members who have prepared for ICD-10 in good faith, AHIMA will seek immediate clarification on a number of technical issues such as the exact length of the delay.” It went on to say that “It has been estimated that another one-year delay of ICD-10 would likely cost the industry an additional $1 billion to $6.6 billion on top of the already incurred costs from the previous one-year delay. This does not include the lost opportunity costs of failing to move to a more effective code set.” It added that “The United States remains one of the only developed countries that has not made the transition to ICD-10 or a clinical modification, a more modern, robust and precise coding system that is essential to fully realize the benefits of the investments in electronic health records and maximize health information exchange.”

What’s more, the leaders at AHIMA have been very active in the Coalition for ICD-10, a group advocating for a speedy and comprehensive transition to ICD-10. That group includes a broad array of industry groups, including America’s Health Insurance Plans (AHIP), the BlueCross BlueShield Association, the Medical Device Manufacturers Association (MDMA), the American Hospital Association (AHA), and American Medical Informatics Association (AMIA).

AHIMA strongly applauded the announcement on July 31 by the federal Centers for Medicare and Medicaid Services
ICD-10 UPDATE

(CMS) that the new transition date would be Oct. 1, 2015 (the earliest day allowed by the congressional legislation), with the association saying in a statement on July 31 that “Now, everyone in the healthcare community has the necessary certainty to move forward with their implementation processes, including testing and training.”

AHIMA’s leaders say they continue to do everything possible to help healthcare organizations prepare for the transition, while making it clear that they will oppose any further delays, and speaking out against what they see as myths propagated by the opponents of the ICD-10 coding system.

In that context, Sue Bowman, senior director, coding, policy, and compliance, at AHIMA, spoke recently with HCI Editor-in-Chief Mark Hagland regarding the current moment in the ICD-10 transition saga, and her perspectives on it. Below are excerpts from that interview.

LESS NEGATIVITY SURROUNDING THE ISSUE

**Healthcare Informatics:** In interviews I’ve done recently, I’ve heard some pushback about the usefulness of the ICD-10 system. Are you hearing any pushback right now?

*Sue Bowman:* Well, nothing new, really. In fact, as people become more familiar with ICD-10, their negative view is changing. People are still saying there was no clinical input in the development of the coding system; but from the beginning, all of the content of it really came from the clinical community. There’s actually something called the Coordination and Maintenance Committee, co-chaired by the National Center for Health Statistics, and CMS. They’re responsible for the maintenance of ICD-10 code sets in the U.S. NCHS maintains ICD-10-CM, which is a diagnosis system; and CMS maintains ICD-10-PCS, the new procedure coding system, for hospitals; so they’ve been guiding the development process.

It’s a public process, where people can submit proposals for new and expanded codes. And so even from the development to how it’s being maintained now. On the one hand, you hear people complaining about the detail and specificity of it; but it’s physician organizations that want more codes—which is kind of funny.

**HCI:** Is it correct that ICD-10 in this country will be different from the ICD-10 systems in other countries, with 10 times the codes of other ICD-10 systems? That’s what a few people have told me.

*Bowman:* No, that’s not entirely correct. The first few digits have to be kept standardized internationally; but beyond the first few digits, codes can be expanded for your specific country’s needs. Within the constructs of the code sets of the international system, you have to maintain stability in the first few characters. A lot of the specificity we’ve added is not new diseases; it’s specific details about anatomy; but a significant percentage is around laterality—left or right side. If you can code broken left arm or broken right arm, that doubles the number of codes right there; but it doesn’t add to the complexity of the system; indeed, it provides clinical clarity that speaks to patient safety. Of course, hopefully, laterality is already being documented in the medical record.

**HCI:** Are those expressing dissatisfaction just a few isolated grumblers?

*Bowman:* It’s like with anything else; the negative people tend to be louder; but the vast majority of people, including physicians, is in support of the ICD-10 transition, and realizes we need to replace ICD-9 after 35 years of use. You’d think, of any country, that we’d have more motivation than anyone else to change systems, for all the reasons we use healthcare data. If you think of how things were in the 1970s—it’s just a different environment today inpatient care.

MORE PHYSICIANS ARE READY TO MOVE AHEAD

**HCi:** Do you think everyone’s pretty much ready at this point?

*Bowman:* Yes, and interestingly, I’ve heard from a number of physicians in practice who weren’t happy with the delay, including my own personal physician. My physician said, ‘I’m the kind of guy who follows directions, and turns in his homework on time. Now I’m going to have to keep my staff trained and systems up; and so the delay is going to cost more money for everyone except for those who did nothing—why are we rewarding them?’ I think we’ve gotten so lost in arguments that some people have lost sight of why we’re doing this. We’re doing this to get better data, not just for the U.S., but to share globally around things like global health threats. Healthcare today is global, just like everything is global.
**HCI:** Should people be doing dual coding now?

**Bowman:** Yes, a lot of organizations are doing dual coding to keep their coders in ICD-10 practice, because a lot of people have already been trained; otherwise, they’ll forget it. Also, people are using that dual-coding data to assess reimbursement effects and payment mix. Instead of hypothesizing how ICD-10 might affect them, they can see it in real data.

**HCI:** What percentage of hospitals and medical groups are doing dual coding?

**Bowman:** I’m not sure of the exact percentage. Probably not the smaller practices; it does take additional time to dual-code. I would imagine it would be hospitals and larger practices.

**HCI:** Has anyone shared with you what they’ve done with this?

**Bowman:** Yes, we had something on that in a white paper that we produced after an ICD-10 summit. Obviously, this is giving people more practice in ICD-10, which means that on the transition date, hopefully, the impact will be considerably less, because they will have been coding in ICD-10 for some time at least in some records; the other thing is that the training for ICD-10 has actually improved coding for ICD-9. It’s also pointed out that the ICD-9 coding isn’t all that great.

When you talk about the impact of ICD-10 on coding accuracy, then you discover that actually, ICD-9 coding wasn’t optimal to begin with, so the training is helping to strengthen core coding principles and practices. Some people going through ICD-10 coding training may never have had formal ICD-9 coding training. A lot of people coming to ICD-10 training just sort of picked up ICD-9 on the job.

**HCI:** What should CIOs know about all this?

**Bowman:** They should know that this isn’t simply an “HIM thing.” Now, certainly, CIOs should know that this is an enterprise-wide transition. Codes, underneath the surface, are driving different initiatives. When people begin doing their assessments, they have a lot of surprises about places where codes are used, not just in claims. I can send your our preparation checklist; but some things are disease management programs, where they use ICD-9 codes to identify patients; registration for medical necessity—when the patient registers, a lot of times, a code is put into the system to match data against any review policies, to make sure it will be a covered service by a payer, so, eligibility. I’ve even heard of things like OR scheduling systems, where the codes are used to identify patients.

**REASON FOR OPTIMISM**

**HCI:** Overall, how do you feel about what’s going on right now?

**Bowman:** I feel pretty good. I know that with the delay, some momentum was lost. There’s some skepticism—some people think it could still be delayed again—but I’ve seen a lot of evidence that people are moving forward. I’m glad to see CMS come out with testing information, because that’s the stage people need to get to next. There are a lot of strong messages out there around what needs to be done. A year seems like a long time, but it really isn’t. Don’t wait until the last minute.

**HCI:** And physicians shouldn’t be afraid?

**Bowman:** No, they really shouldn’t. There’s been so much fear-mongering out there, but once physicians experience it, they say, oh, this isn’t so bad. It turns out that many of the codes have been created by their own medical specialty societies, and they’re still only going to be using a small subset of codes that they typically use in their area. You can still use a super-bill; you’ve still got your list of common conditions. All you have to do is translate the codes you use already into ICD-10 codes.

**HCI:** There will be more codes, but it won’t be overwhelming for individual physicians?

**Bowman:** Right. In a lot of cases, they might find the terminology of the codes closer to how they document to begin with. An example I use is asthma. In ICD-9, it’s broken down into terms like “extrinsic” and “intrinsic,” terms that no physicians have used for years in documenting; instead, asthma under ICD-10—the vocabulary has been updated to terms physicians use today. And the physician community had a lot to do with modernizing that terminology.
Dancing with Retirement

Are you planning for retirement? Take a page from the playbook of someone who has done it right BY TIM TOLAN

Last month my wife went to the St Augustine Amphitheatre to see Crosby, Stills and Nash on a warm summer night here in northern Florida. It’s great to see them still playing gigs—and like a fine wine they keep getting better. The concert was awesome and also surreal in so many other ways.

The first thing I observed as we walked into the venue was the crowd. Multiple generations were present, but I couldn’t help notice that the largest demographic were those soon to be or already retired. I wanted to put myself into the younger demographic, but have to admit that, like everyone, I am definitely getting older. I don’t run from it. While I consider myself in the prime of my career, I have definitely reached an age where I contemplate retirement now more than ever. Many candidates I talk to also bring up the subject and I always stop to listen, occasionally giving my own advice if I’m asked.

Like many of you, I’ve spent my entire career in healthcare and healthcare technology, and my network of colleagues and business contacts are the people that I converse with on a daily basis. It’s the space that I know well. Many of us know lots of people who we see at conferences year after year, read about in press releases or work with on a regular basis. That all changes the minute you retire, or at least it changes for most of us.

I have lots of friends who have retired and I always enjoy talking with them to learn how they are doing and how they are keeping themselves busy. I realize there are lots of ways that we can choose to retire and I don’t pontificate that one path is any better that another. What I do recognize is that you need to think about how to keep yourself busy, active and healthy once you retire. Your daily routine will be much different than the way you spend your time today.

Chris, a dear friend of mine, and I were talking a few months back about retirement. He retired a few years ago but still remains very active today. He’s built his retirement around his life and the things he likes to do. For him its

spending time with his lovely wife Marsha, sailing on their boat to the Caribbean during the cold winter months, playing golf, serving on the Architectural Committee of his neighborhood, enjoying his kids and grandkids, spending time with his aging mother, traveling around the world, working with start-ups and doing some consulting with me! He always keeps his hands in multiple projects that are interesting to him. He continues to learn new things that interest him and he gets to choose what he wants to do and when he wants to do it. He’s figured it out.

He told me about a party he and Marsha attended a few years ago. During happy hour he found himself talking to a few people he’d just met. Pretty soon the conversation turned to “So, what do you do for a living?” The minute he mentioned he was retired the conversation was redirected to others in the group who still had a work-related identity. Little did they know that Chris was a very successful investment banker who bought and sold over a hundreds companies in the healthcare revenue cycle market. His firm was the leader in that space for decades.

We tend to create our own identity with the rest of the world based on what we do every day. Once we retire we lose that identity unless we reinvent ourselves and find other ways to keep learning and growing. That’s the reason I have elected to keep doing the things that I enjoy as long as I am having fun. True retirement would allow me to take a page from the playbook of my friend Chris. I too, want to do the things I enjoy whenever I choose to do so. It’s that simple.

Retirement is what you make it, but requires a lot of thought and consideration to make sure you are happy and content with whatever you do.

RETIREMENT IS WHAT YOU MAKE IT, BUT REQUIRES A LOT OF THOUGHT AND CONSIDERATION TO MAKE SURE YOU ARE HAPPY AND CONTENT WITH WHATEVER YOU DO. —TIM TOLAN

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