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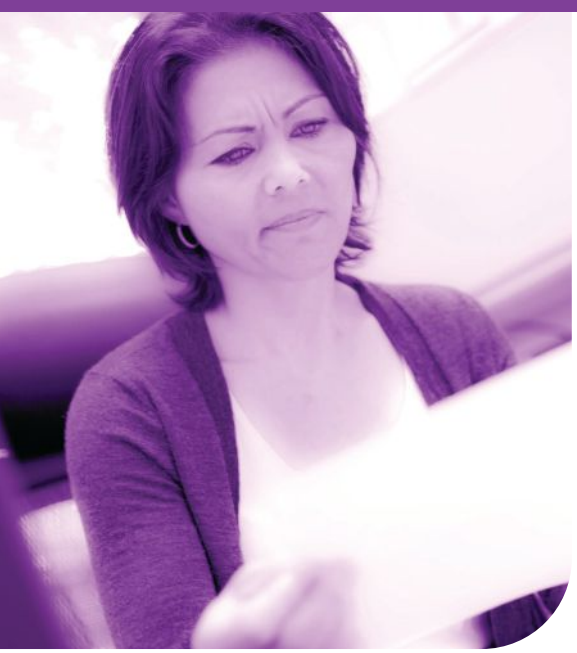

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What Do the Memoirs of an Eighteenth-Century French Noblewoman Have To Do with Readmissions Reduction?

Mark Hagland

I've been reading, and thoroughly enjoying, *Dancing to the Precipice: The Life of Lucie de la Tour du Pin, Eyewitness to an Era*. The 2009 biography by British historian Caroline Moorehead recounts the life of a woman named Lucie-Henriette Dillon, who became Marquise de la Tour du Pin, and was in fact eyewitness to an incredible period of history, from the last, naïve days of the court of Louis XVI at Versailles, to the entirety of the French Revolution, and all the way through the Napoleonic era and up to the Revolution of 1848. Living from 1770 to 1853, Lucie Dillon witnessed, and survived, an astonishing number of revolutions, upheavals, and transformations of society.

As Moorehead notes in the last two pages of her book, "The France into which Lucie was born, in the spring of 1770, was no more. Versailles had become a museum. Steam, the telegraph, trains, gas lighting, the smokestacks of industry had between them transformed the landscape of her childhood into a world she would no longer recognize." What made it worth writing a biography of the Marquise was the fact that she had written long diaries describing her life from her birth in 1770 through to 1814, and, in 1907, 54 years after her death, the Marquise's great-grandson published her memoirs as a book. That book of memoirs, which has rarely been out of print since then, has provided countless readers with a personalized window on those very dramatic times in France and in Europe.

I read the Marquise's memoirs several years ago, and found Moorehead's book even more enlightening. It is fascinating to get her completely unvarnished first-hand perceptions of historical figures like Louis XVI, Marie Antoinette, the Marquis de Lafayette, and Napoleon. Even more fascinating are Lucie's accounts of the waning days of Louis XVI's court at Versailles, a court so decadent and detached from the life of the people of France that its excesses helped to fuel the French Revolution.

What's especially fascinating is how, even after the fall of the Bastille, many French nobles and royals were blind to the emerging Revolution, and tried to carry on as if nothing had happened. Instead, Louis XVI and Marie Antoinette spent the next few years dithering and prevaricating on needed reforms, until their kingdom collapsed, and they lost their heads on the guillotine.

Now, don't worry—I'm not predicting that any U.S. healthcare leaders are going to lose their heads! But as I wrote in a blog in late August, it has been rather astonishing to me how the readmissions reduction program under Medicare has been unfolding of late, with a *Kaiser Health News* analysis published in early August finding that more than half of U.S. hospitals are being penalized for avoidable readmissions, in the fourth successive year of that mandatory program. Is that program a challenging one for hospitals? No doubt. But the reality is that the Affordable Care Act was passed in March 2010, and for a few years before that, there were strong hints that readmissions reduction might become mandatory under Medicare. What's more, private insurers inevitably have gotten into the game, too.

So the rather slow response of so many hospital leaders to the federal mandate around readmissions reduction strikes me as another example of the healthcare industry's generally slow-ish response to rapid changes in the policy and reimbursement landscape. Yes, readmissions work is challenging and difficult. But really, the times are changing rapidly. Take it from a marquise who saw the end of the *Ancien Régime:* once things start changing, change overtakes stasis very quickly indeed.

Mark Hagland, Editor-in-Chief

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[1] Business Strategy: Analytics Leads, Accountable Care Investment Priority, IDC Health Insights, Cynthia Burghard, March 2013
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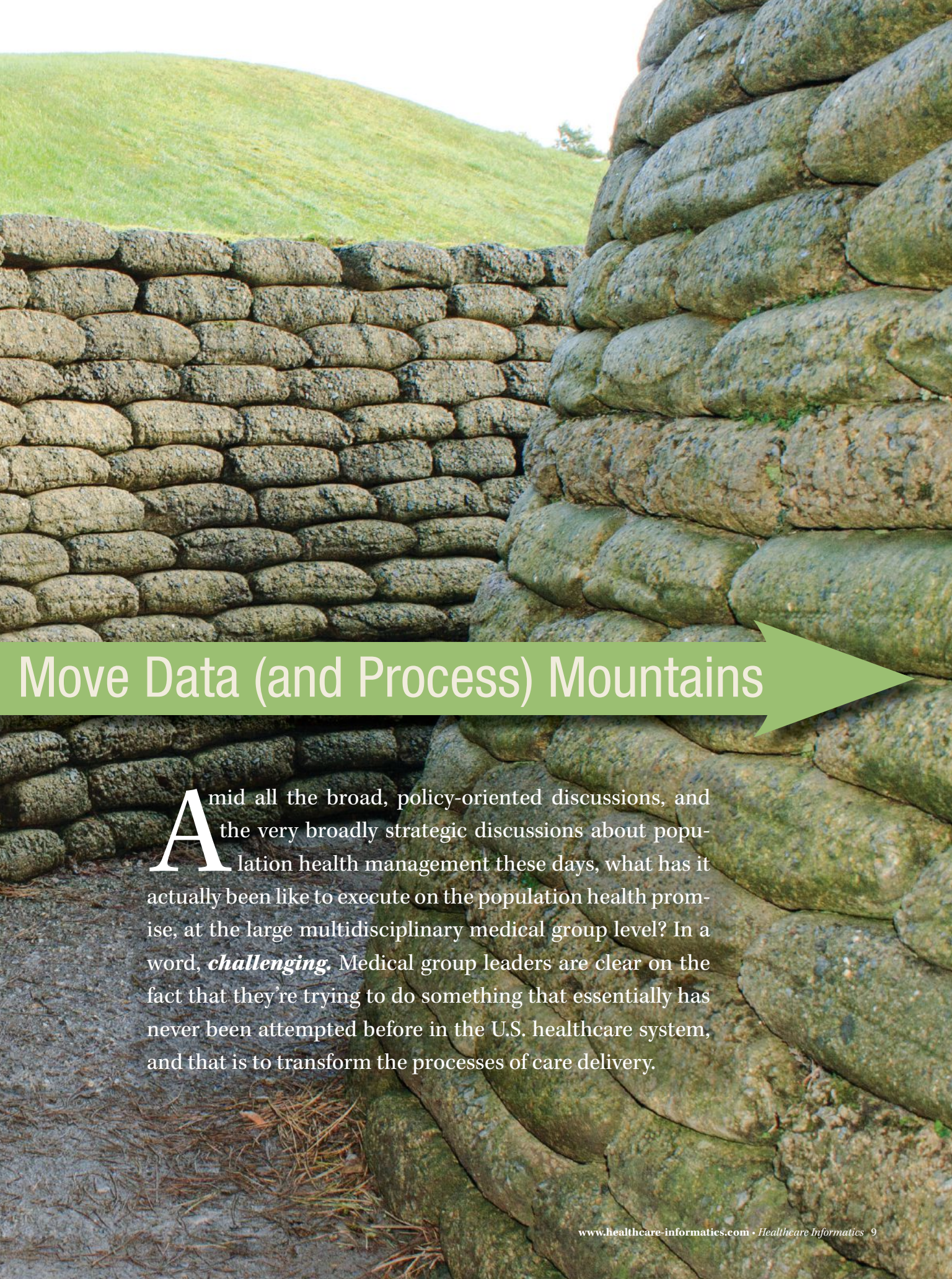
In the Trenches on Population Health:

Medical Group Leaders Move Forward to

By Mark Hagland



Move Data (and Process) Mountains

Amid all the broad, policy-oriented discussions, and the very broadly strategic discussions about population health management these days, what has it actually been like to execute on the population health promise, at the large multidisciplinary medical group level? In a word, ***challenging.*** Medical group leaders are clear on the fact that they're trying to do something that essentially has never been attempted before in the U.S. healthcare system, and that is to transform the processes of care delivery.

What are the common denominators? In interviews with *Healthcare Informatics,* the leaders of pioneering medical groups, while pursuing a wide variety of strategies, are finding common challenges and opportunities in wading into the deep end of the pool in several key, overlapping areas. Among them:

Medical group leaders are beginning to effectively harness clinical information systems (some of them anchored in electronic health records, some of them systems being connected to EHRs) and data analytics to perform health risk stratification across broad populations under defined contracts.

Medical group leaders are also moving ahead to put in place care management systems to support their chronically ill patients and enhance their health status—e.g., optimizing blood sugar control for diabetics, etc.

Closely allied to those first two elements, group leaders are moving forward to participate in what is often referred to as the "blessed cycle" of clinical transformation and performance improvement, meaning a cycle of data collection, data analysis, data reporting, data sharing with clinicians and staff, data-facilitated performance improvement around care delivery processes, and then further cycles of data collection, analysis, reporting, and sharing, to support continuous performance improvement.

Embedded within all of these efforts are specific IT- and data-related efforts, including the creation of chronic disease patient registries, the IT facilitation of care management processes, the building out of data warehouses, the creation of dashboards for physicians and other clinicians, the facilitation of both clinicians and patient engagement via mobility and mobile devices, and the facilitation of data analytics combining claims-based and clinical (via the EHR) data, among other essential capabilities.

Leaders at pioneering medical groups are currently busy addressing the welter of strategic, operational, clinical care process, data analytics, IT-technological and other issues involved, and are laying the foundations for successful initiatives that will be replicable across the U.S. healthcare system.

> **"GETTING THE DATA AS RIGHT AS YOU CAN AT FIRST IS IMPORTANT; GETTING ALL THE STAKEHOLDERS IN EARLY TO PARTICIPATE IN THE OVERALL PROCESS IS REALLY IMPORTANT."**
>
> *–GREGORY SPENCER, CMIO, CRYSTAL RUN HEALTHCARE*

Among the challenges involved is a very fundamental one, says Bob Schwyn, a director at the Chicago-based Chartis Group consulting firm, and a former healthcare CIO. "Our experience across our client base," he says, is that getting clarity on what population health is and what it means is very important to understanding your market and where it's going, and what populations you're focused on, and all the considerations around the value proposition and focus. In many cases, when our clients seek us out for technology assistance, they haven't yet created enough alignment around how the technology will support the business, and often, there's also a lack of clarity around the broader strategic plan for the organization."

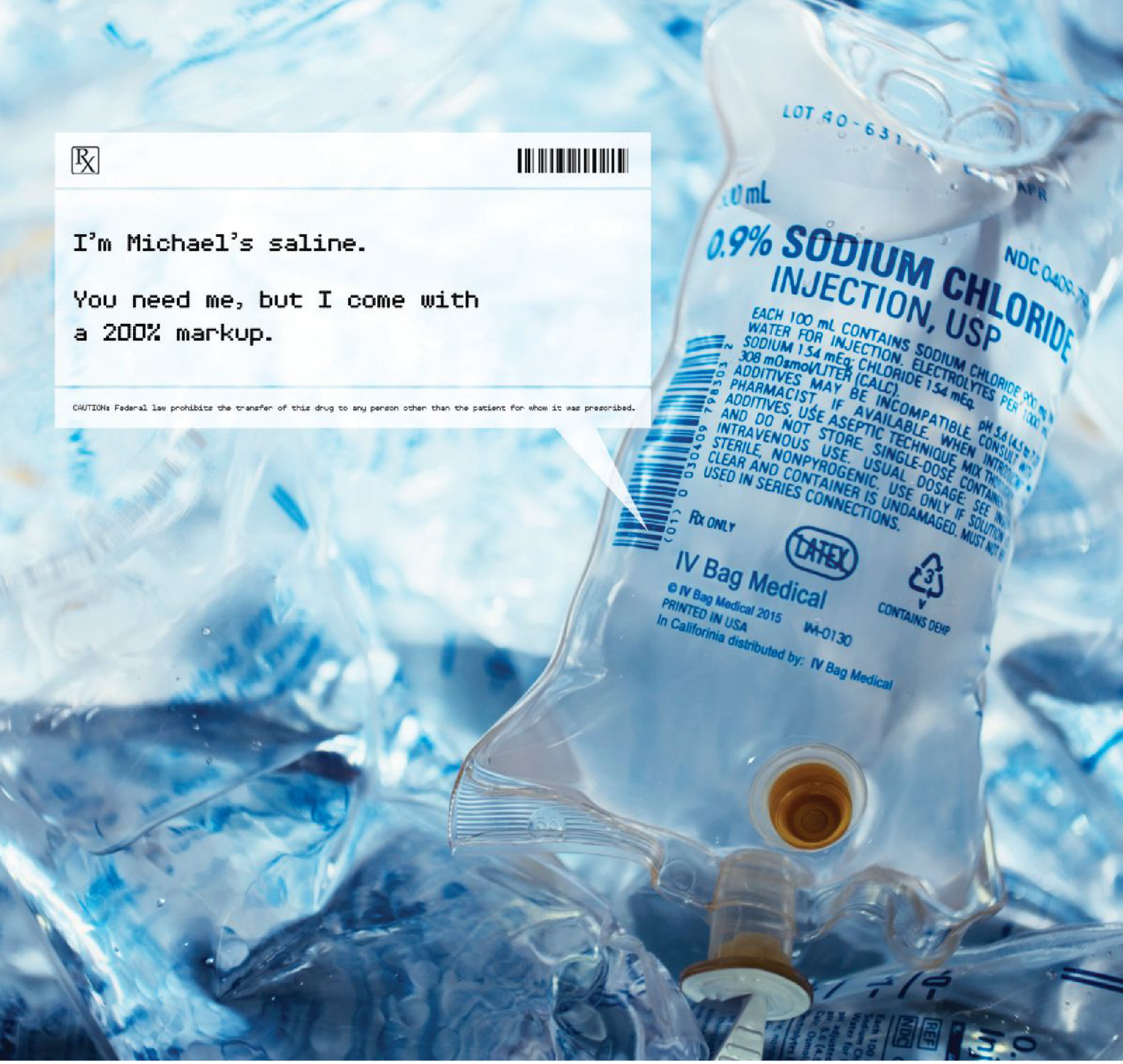
Schwyn's colleague at Chartis, Mark Werner, M.D., the firm's director and national leader for clinical consulting, adds that "One of the things we're learning is that it's a phrase with a lot of meanings," speaking of population health. "Part of what I think is happening in the trenches is that people are gradually realizing that it's not just an IT initiative or a primary care medical home initiative, or an isolated-contract initiative, but rather that it really does require an enterprise-level effort to link to your strategic plan. Part of the problem is that there remains confusion about population health at the public health or community health level, since we're trying to achieve some public or community health goals via what is still an acute-care-based health system. So you have to begin to stratify populations and realize you're already taking care of multiple populations."

Below are three case studies that illustrate the challenges and opportunities involved, and the diverse approaches that physician group leaders are taking as they move forward to fully leverage IT and data analytics to facilitate population health management. Each illustrates different facets of the landscape.

A FULL-COURT PRESS IN NEW YORK STATE

At the Middletown, N.Y.-based Crystal Run Healthcare, a multispecialty group practice with 35 locations and 375 providers (300 of whom are physicians), all of the senior leaders are absolutely committed to a population health strategy as their organization's core organizing strategy going forward.

Prefacing his comments modestly, Gregory Spencer, M.D., Crystal Run's CMIO, says, "I don't know that any of our learnings have been terribly profound." Instead, he says, the basics are fairly clear: "Getting the data as right as you can at first is important; getting all the stakeholders in early to participate in the overall process is really important. And having an iterative workflow so that people can see that there's an



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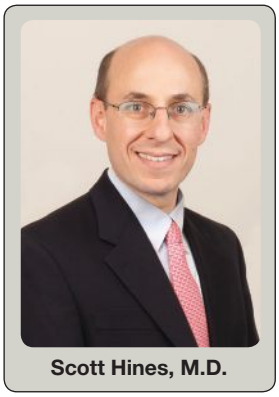
Scott Hines, M.D.

In fact, notes Scott Hines, M.D., Crystal Run's chief quality officer, "When we first really started leveraging data to improve outcomes, our first steps were looking at creating registries to identify patients who had gaps in care, and then distributing those registries to every doctor and their nurse, to try to close those gaps in care. But we realized over time that primary care doctors in particular were becoming overwhelmed by tasks, and that approach wasn't the best use of their time. So we took a step back and what we could take off their plates."

Three important initiatives have come out of that rethink, Hines reports. First, he and the other senior leaders in the medical group created a Care Optimization Team, led by a nurse and staffed by four non-clinician staffers. Each member of that team is assigned to one or more patient-centered medical homes, and it is those individuals who reach out to patients who it is discovered have gaps in their care for process measures such as immunizations, breast cancer screenings, colon cancer screenings, necessary labs, and so on. "We leverage data from the EHR and reports from payers, to help us to identify those patients and reach out to them as soon as possible," he says.


Jonathan Nasser, M.D.

The second initiative coming out of the rethinking process is Crystal Run's Payer Quality Scorecard, developed in 2014. "That mechanism allows us to track internally what we're doing in terms of quality performance for measures for each payer we have a risk-based contract with. Prior to that, we had been using registries, but relying on the primary doctors and their staffs to reach out and close gaps in care, but since then, we've built this team so doctors can concentrate on performance measures like blood pressure control, that kind of thing. So that's one way we're using technology to improve the quality of care."

And the third initiative has been the group's Variation Reduction Program, which has led to reducing variation in medical practice across specialists working in the same specialty. For example, the Crystal Run physicians have examined their endocrinologists' annual total charges around cancer care, including professional, lab, imaging, and procedure charges. As he and his colleagues, including Jonathan Nasser, M.D., Crystal Run's chief clinical transformation officer, have found, variations in spending have zero correlation to clinical quality outcomes. Hines notes, "Jon and I meet quarterly with each division to perform on a guidelines adherence exercise. And ahead of time, we ask the division which diagnosis they want to tackle, and then we assign one or two physicians in that division to research what guidelines or evidence exist in the literature, and so they come to that meeting armed."

Specifically in the case of physician orders around cancer care, Hines says, "We'll ask a question such as, how often do you do ultrasounds or tumor markers for patients with thyroid cancer? And we'll always have a lot of variation in the frequency of what the physicians do. But it turns out that the American Thyroid Association has recommendations in that area. So in that case, we were able to incorporate their guideline into a guideline we've since developed here through consensus." Based on that work, the Crystal Run physicians have reduced the number of visits per patient, based on appropriate adherence to consensus- and evidence-based guidelines, which then ends up allowing more patients to be seen, and helps balance out care delivery, with costs appropriately rising slightly among doctors who had been underutilizing and falling among those who had been overutilizing, but costs overall going down.

One of the challenges inherent in population health management work at the medical group level, Nasser notes, is that "A lot of utilization takes place outside our setting, of course, such as through inpatient hospitalizations and ER visits, and care in nursing homes. We try to accomplish as much as possible for the patients who are in front of us. And we arm physicians and teams with data, and ask for suggestions for improvement and we try things out through PDCA cycles or meetings; and then when patients aren't in front of us, we're also involved in their care through care optimization, and we also utilize care managers who help to facilitate care for our sickest patients, and looking at telephonic outreach etc." Events that take place outside the practice will continue to pose a challenge, Nasser says, "But leveraging data through scorecard reporting, team analysis and individual reports helps us here internally, and we come together to determine things we need to improve and how we go about doing them. But that's the structure of how we take a look at the population health work.

In fact, the very first Variation Re-

duction Program effort, Hines notes, was around diabetes. Through a process of researching the literature, analyzing data, and convening meetings with the primary care physicians in the group, Crystal Run leaders were able to see clearly that there was a "three-to-four-fold variation in terms of cost," among PCPs caring for diabetics. "And really, cost is just a surrogate for utilization," Hines notes. In the event, it turned out that some PCPs were seeing their well-controlled diabetics every three months, some every four months, and some once a year, while they discovered that the American Diabetes Association had recommended an interval of every six months. Through data analysis, sharing, and discussion, a consensus was reached among the group's primary care physicians to settle on a protocol of seeing their well-controlled diabetics once every six months. As a result, they realized a 9-percent reduction in charges per patient per year within six months after developing that initiative, compared to the level of charges per patient per year in the six months prior.

"Sometimes," Hines notes, "you just get locked into your pattern of practice and you ask people why they do things a certain way, and it's just how they were taught to do it, or how they did it. So this process forces you to look at the evidence and update what's going on."

> **"A LOT OF THE CHALLENGE FOR US HAS BEEN A DATA CHALLENGE. THE GOAL HERE IS TO AGGREGATE CLAIMS AND LABEL DATA FROM DISPARATE SOURCES AND PUT THAT INTO AN ANALYTICAL TOOL AND DERIVE APPROPRIATE RISK."**
>
> *–DOUGLAS GOHN, M.D., PHYSICIAN EXECUTIVE FOR POPULATION HEALTH, LANCASTER GENERAL HEALTH*

PENNSYLVANIANS FOCUS ON PCMH-BUILDING

For leaders at Lancaster General Health in Lancaster, Pa., which in August became part of the Philadelphia-based Penn Medicine system, two main areas of focus have been Lancaster General Health's participation as an accountable care organization (ACO) in the Medicare Shared Savings Program (MSSP) for ACOs, and its universalization of the patient-centered medical home (PCMH) model across all of its medical clinic sites. Among those helping to lead the charge in Lancaster are Douglas Gohn, M.D., physician executive for population health at Lancaster General Health, and Michael Ripchinski, M.D., Lancaster General's chief quality and medical information officer. With regard to ACO development, LGH is managing the care of 18,000 in the MSSP program and 70,000 in some sort of risk-based contract. LGH is also participating in the Bundled Payment Pilot Initiative out of the Centers for Medicare & Medicaid Services (CMS), doing cardiac stents, bypass surgery, pacemakers, hip and knee joint replacements, and some spine procedures as well, Gohn reports.

Douglas Gohn, M.D.

Michael Ripchinski, M.D.

Overall, Gohn notes, "The starting block" for population health-based work has been "the patient-centered medical home. All 28 of our primary care practices are Level 3 PCMHs. We're trying to upgrade to the 2014 standards for PCMHs. There are some changes, not real substantive ones, but that require tweaks. So the PCMH and team-based care are in my mind the foundation for population health. Then you need to connect the physician IT infrastructure to all of that. A lot of the challenge for us," he adds, "has been a data challenge. The goal here is to aggregate claims and label data from disparate sources and put that into an analytical tool and derive appropriate risk. Claims, EHR, and some form of social determinant, all need to be added to that, and now we're also beginning to look on patient-provided data, such as from wearables and implanted devices, though we haven't even done that yet." Importantly, he adds, "You need a care management platform that that sits on."

As their colleagues at virtually every other medical organization are finding, Ripchinski reports that "It's very difficult to manage both claims data and clinical data. There are companies trying to merge clinical and claims data to create a path forward, but we're early on" in that journey, he notes. "And as part

of setting up the MSSP in January 2014, we started to get claims data and began to do typical payer analysis—what's the pharmacy spend, who are the high ED users, who are the chronic condition patients?"

Importantly, Ripchinski notes, "Aligned with our claims analysis work, we've also done risk stratification of patient populations using the clinical data in the EHR. And we've timed these so one method of analytics can use the other." For example, he notes, "In the EHR, we will find out a particular patient is in seven different disease registries, they've had claims for eight different conditions, they've been in the EHR five times." So one of the key strategies involved, he reports, is marrying EHR-based and claims-based data "to look at managed lives by how many patients have had multiple hospitalizations, or high ED visits, in a two-year period."

Shawn Parsley, D.O.

Barbara Adams

TEXANS CONFRONT THE DATA CHALLENGES

At Texas Health Physicians Group (THPG), the physician organization integrated into the Arlington, Texas-based, 21-hospital Texas Health Resources, are Shawn Parsley, D.O., president of THPG, and Barbara Adams, vice president, innovative technology solutions, for THPG, and Texas Health Resources. THPG is participating both in the MSSP program, in concert with the UT-Southwestern Medical School in Dallas, and in several commercial ACOs.

"Clearly," says Parsley, "having analytics makes up a major portion of your ability to actively do anything with these contracts. There's a period of time where we're standing with a proverbial foot in the boat and foot in the dock, in terms of the fee-for-service world and the fee-for-value world." What Parsley, Adams and their colleagues have tackled first is "a quality incentive program for the docs that was really payer-agnostic, and designed to represent the entire panel a physician had, with incentives. And we really want our physicians to think about how they take care of all their patients. So the first step was to develop a quality analytics dashboard that would have the capacity to look into the EMR data, without regard to which EMR is involved, and extract the information and compile it in a centralized database." At least 50 percent of THPG physicians are actively and robustly using the dashboards that THPG is providing them, to improve their management of ACO patients with chronic illnesses, Parsley notes.

Asked what some of the main data analytics challenges have been, Adams says, "Guess how many places a doctor can document tobacco cessation? About five different places; but there is only one place in the EMR where it will give them credit, because [documenting patient tobacco cessation in that place] is mapped to the dashboard. And it's not the doctors' fault. You get into a groove with your EMR. And we can't map five different places. But variation in EMR documentation leads to a complicated mapping process," she notes. Other challenges include the need to customize EMRs on a variety of different servers, and data validation, she adds.

MAKING IT WORK FOR THE PHYSICIANS

It is very important in all this work, everyone agrees, to recognize how profoundly this important, innovative work affects physician workflow, productivity, and practice. Dean Field, M.D., vice president for informatics and operations at the nine-hospital, Tacoma, Wash.-based CHI Franciscan Health, says, "Among the biggest issues at the medical group level, in tackling population health, is around the added responsibility. There is a shrinking population, or at least stagnant, of primary care physicians, and yet population health management requires us to manage more in terms of what the patient came in with. So we're asking primary care physicians to do more; so that's one challenge. The second challenge is how we begin to capture the information critical for population health management, in a structured format. Most EHRs were implemented with adoption in mind, but allowing people to do free text." But it will take considerable application of natural language processing in order to extract key data elements needed for pop health, from electronic health records, he notes.

In the end, all those interviewed agree, making serious advances in population health at the medical group management level will inevitably involve years of foundational work in the coming many months. But these case studies demonstrate that the leaders of pioneering medical groups are indeed laying the foundations for successful pop health practices U.S. healthcare-system wide. ◆

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Urban Legends of Radiology Study Storage: The Importance of a Viable Data Retention Policy

by Kayt Sukel

Digital storage has become—and will remain—one of healthcare's biggest information technology challenges. According to the Wall Street Journal, nearly 600 million imaging procedures, including CT scans, X-rays, ultrasounds, mammograms, and MRIs, are performed each year in the United States alone. And as imaging technology makes new gains, allowing for higher resolution, three-dimensional, and live-action views, those image files are expanding. So much so, AT&T Inc.'s ForHealth Group estimates that image archives are growing by approximately 40 percent each year.

So what can a healthcare organization do beyond investing in more server space? To start, take a hard look at their corporate data retention policies.

What do I keep? And for how long?

Shelly Susong, a senior application analyst in Radiology Information Systems at Covenant Health in East Tennessee, says the storage costs for the health system were growing exponentially. This hospital system, with nine acute care hospitals, multiple outpatient and specialty facilities, and other affiliated member organizations and physician clinics, serves thousands of patients annually.

"We produce about 650,000 studies each year. And these images keep getting bigger and bigger. As the technology gets better, the same number of images is requiring even more storage," she says. "The culture, for us, was to keep everything. And it was becoming too much. The administration was getting tired of us coming to them and asking them to buy more and more storage."

Storage that could cost hundreds of thousands of dollars. Data retention across the enterprise was quickly becoming a difficult balancing act. How could Covenant Health continue to offer state-of-the-art imaging, part and parcel of high quality patient care, and yet rein in expanding storage needs? To answer that question, they needed to revisit the organization's internal data retention policy—and define what, where, and for how long each study needed to be kept.

The Importance of Buy-In

Of course, solidifying a data retention policy is easier said than done. Susong says that there are a lot of urban myths surrounding image retention in the healthcare space. And those myths have, historically, driven procedure.

"Most technologists will tell you that mammograms have to be kept forever. And so films were kept and shuffled around to support that," says Susong. "Pediatric images were kept until the patient reached the age of majority at 21. And some sites thought that you needed to keep nuclear management studies for 10 years. But the truth is, we weren't completely sure what we were really required to do."

But the team was determined to find out. Susong and colleagues started digging in, looking for documentation to separate the image retention myth from fact. And they found that many of the

Covenant HEALTH

assumptions they were operating under were not supported by law or hospital regulations.

"We dug and dug. We looked at documentation from the American College of Radiology, at The Joint Commission, at the state of Tennessee, at everything we could get our hands on," she says. "We soon learned that we were only required to keep images for four years and mammograms for 10. Nuclear management studies did not have to be kept for 10 years, just the radiation dosing records. We soon learned we were keeping a lot more than we had to."

If Covenant Health changed the existing retention parameters based on that research, they could free up a significant amount of storage space—a move that would not only allow them to store future studies but also permit clinicians to pull up those studies on the organization's various information technology systems more quickly. With their updated research in hand, Covenant Health's radiology, legal, risk management, integrity compliance, privacy, health information management (HIM) and administrative departments convened to fine-tune and then finalize their data retention policies based on fact and mandate, not healthcare urban legends.

"We've now documented our retention policy for everything. The state of Tennessee says we need to keep images for four years. We decided to err on the side of caution and retain images for five years—including the pediatric images. Because we want to do the right thing for our clinicians and our patients," she says. "With the backing of the executive leadership, we were able to get past a lot of confusion, work together, get buy-in from all parties, and come up with the right policy for us."

Putting Policy into Action

With the new policy in place, Covenant Health then had to go through the arduous task of deleting outdated files—more than 15 years worth of studies. The healthcare system procured Conserus™ Image Repository Retention Management application, an add-on for Conserus™ Image Repository, to help them safely remove those files in both accordance with HIPAA regulations and their new retention policy. Susong and colleagues started slowly, first deleting studies stored prior to the year 2000 across the enterprise.

"The application allowed us to set rules by site, by number of years, and other parameters we had set," she says. "We started with small chunks at a time—making sure that everything was working the right way with those very oldest of images. And we were pleased to see it was doing what it was supposed to be doing."

Working methodically, the team has moved from those older files to more recent ones. Again, the application allowed the team to delete legacy images from the PACS and other systems, leaving behind a simple message that the image has been deleted due to Covenant Health's data retention policy. She credits the application for helping the team quickly put their new policies into action. "We wouldn't have been able to do it without the application, there's no question," she says. "It is not a task we could have ever managed without it."

Susong says that implementing the application was very straightforward—and the team was quickly trained on its use with a training webinar. "It's a fairly intuitive system," she says. "And a very easy implementation."

And not only does it allow for automatic deletion per the system's retention policy rules, technologies can also put a hold on deletions for legal or other reasons, ensuring the deletions don't get in the way of physician workflow, patient care, or administrative needs.

Keeping Storage Costs in Check

Since implementing the new data retention policy, Susong says that Covenant Health has saved a significant amount of storage and related fees. "As we are getting near to being caught up, we can think about other possibilities," she says. "We are now looking to carve out different areas of storage to maximize speed of image retrieval. And we're planning to add more."

Susong says the Conserus™ Image Repository Retention Management application has been an excellent tool to help her team follow the Covenant's image retention policy rules. "In the past, we weren't following our own rules. We weren't always sure what the rules were. This tool helps make sure we do what we are supposed to do," she says. "And with image retention requirements growing by leaps and bounds each year, keeping up with these rules will help us save money on storage and make room for new larger data sets. Ultimately, it's something that is going to be a great benefit for our clinicians and our patients."

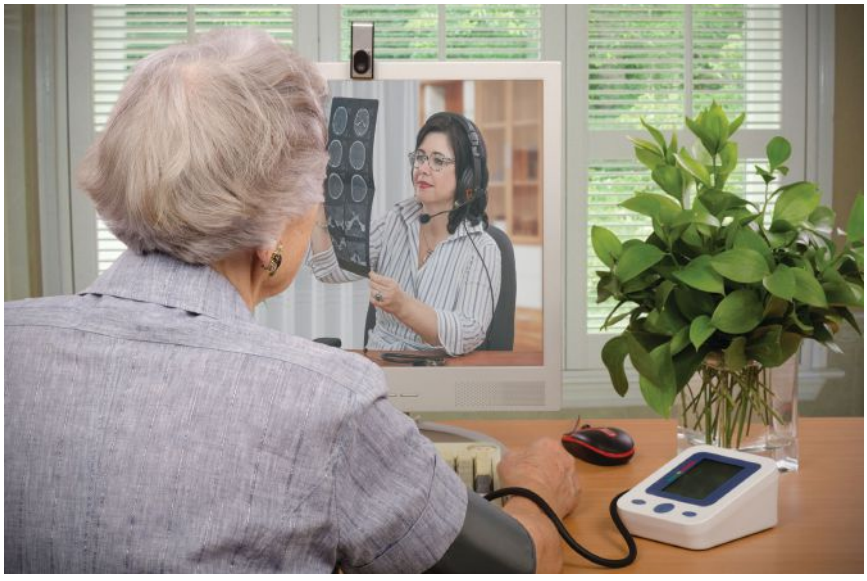
Telehealth Policy Picture Improving — But Slowly

States fail to take comprehensive approach, advocates say

BY DAVID RATHS

Families in Delaware struggling with Parkinson's disease often have to travel to Baltimore or Philadelphia for care because there are no Parkinson's specialists in the state. Many of those patients have worked with Ray Dorsey, M.D., of Johns Hopkins University in Baltimore, whose research focuses on the use of telemedicine for neurological conditions.

But those families also got involved with the nonprofit Delaware Telehealth Coalition and this year successfully petitioned the state legislature to pass a bill to require commercial insurers to cover telehealth visits. "There may have been policies that covered telemedicine services in private insurance, but we couldn't find them," says Carolyn Morris, a member of the coalition and director of telehealth planning and development in the Delaware Department of Health and Social Services. "This is going to benefit many people who have not been able to access certain services using telehealth in the past because there were no provisions in Delaware for insurance coverage for services using technology."



STATE POLICIES NOT COMPREHENSIVE

For almost 20 years, telehealth advocates have faced the Sisyphean task of trying to get the U.S. Congress to expand Medicare coverage for telehealth beyond traditional rural settings. Meanwhile, they continue to hammer away at the uneven and confusing landscape of state laws and regulations. For instance, the rules regarding Medicaid coverage of telehealth are different in each state.

"One of the biggest frustrations for healthcare providers, administrators and CIOs is that the technology is so far ahead of the policy," says Danielle Louder, program manager for the Northeast Telemedicine Resource Center, which is funded by the Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth to provide technical assistance, education and other resources. Although Louder wouldn't describe the policy pace at the state level as rapid, there has been an uptick recently. "We had 80 bills introduced about telehealth just in our eight-state region this year," she says.

Nate Lacktman, a healthcare attorney and partner with Foley & Lardner LLP, says state telehealth coalitions such as the one in Delaware are having an impact as more states grapple with issues of commercial payer statutes. "It is important to fund telehealth through the private sector," he says. "Relying solely on Medicaid and Medicare changes is not the way to go. The private market will help drive adoption. The provider community is beginning to have a more focused voice on this issue. People are seeing the value and embracing it."

Twenty-eight states now have laws that require insurance parity for services delivered via live video, several of which were passed in their most recent legislative session. "State legislatures are recognizing that parity laws

are the easiest policy issue to deal with from their vantage point to recognize that telehealth is just a way to deliver care and to ensure that there are no discriminatory barriers that prevent telemedicine providers from getting reimbursed for services that are already covered under healthcare plans," says Latoya Thomas, director of the State Policy Resource Center at the American Telemedicine Association (ATA).


Mario Gutierrez

Yet Mario Gutierrez, executive director of the HRSA-funded Center for Connected Health Policy (CCHP), which tracks telehealth policy nationwide, says that with the exception of California, which passed comprehensive legislation in 2011, efforts to reform telehealth policies have been piecemeal in every state. "States are taking a cautious approach," he says. "When we meet with legislators, we are are often surprised by how little information they have about telehealth."

Although many states are starting to address how private payers treat telehealth, the devil is in the details of the language in each state, he adds. Gutierrez also questions whether it makes sense to require equal payment for telehealth services that are designed to create efficiencies and reduce costs.


Gary Capistrant

"To create a requirement that the insurer pay the same for remote monitoring, where you are creating efficiencies, is counterproductive to the intent of the benefits of telehealth," he says. "I don't think the people who are developing those policies have really thought it through. It makes sense that a live videoconference should be paid the same. But where remote patient monitoring could save money, if you require they pay the same, what's the point?"

State Medicaid programs have been much better at identifying telemedicine as a worthwhile tool for providers to use to help underserved communities access healthcare services, says Gary Capistrant, the ATA's chief policy officer, "but what we have seen is disparities in the way that Medicaid covers services. States implement arbitrary barriers like a distance requirement or not allowing statewide coverage or limiting the types of technology that can be used."

"TO CREATE A REQUIREMENT THAT THE INSURER PAY THE SAME FOR REMOTE MONITORING, WHERE YOU ARE CREATING EFFICIENCIES, IS COUNTERPRODUCTIVE TO THE INTENT OF THE BENEFITS OF TELEHEALTH"

–MARIO GUTIERREZ, EXECUTIVE DIRECTOR, CCHP

California, Gutierrez says, now has a framework for both public and private systems to use telehealth in a much broader way. It is still lagging in terms of reimbursement for remote patient monitoring, but with the entire Medicaid program now under managed care contracts and a greater push toward value-based care, telehealth is becoming more attractive, he says. "In a fee-for-service world, it is always going to be seen as a cost, not as a cost saver."

CROSSING STATE LINES

One contentious issue has been licensing providers across state lines. Clinicians who want to treat patients in another state have had to apply for and pay for licenses in those states, a costly and time-consuming process. Some state boards have sought to prevent or limit the expansion of telehealth, citing patient safety concerns.

Every medical board has several interests, Lacktman says. One is protecting the safety and welfare of patients; another is responding to the needs of its constituency: licensed doctors in the state. In a vast majority of the boards, you see a real drive to enact new policies that will allow for innovations and new developments in technology, he says. "They are trying to get their policies flexible enough because they know they cannot keep changing policy as fast as the technology and delivery changes."

(The Texas Medical Board is locked in a legal battle with telehealth provider Teladoc. The board claims it is protecting patient safety, while the company says it is violating federal antitrust laws.)

ATA's Capistrant gives another example of the type of tension that exists. In Tennessee last year, the legislature passed a bill requiring telehealth parity for private insurance, Medicaid and state employee benefits, he reports. A month later, the medical board came out with regulations that would have put several barriers on telehealth, basically squelching what the legislature had done. "This year the legislature passed a bill that said the medical board could not hold telehealth to a higher standard than other care, and the Tennessee Medical Board has done a 180 since then," he adds.

Telehealth Legislation Trends from the The Center for Connected Health Policy

Medicaid Reimbursement

- An increase in states offering reimbursement for live video through their Medicaid program (47 & D.C., up from 44), and a lessening of geographical restrictions. However, it is still common to restrict originating sites to a limited list of facilities.
- Much slower uptake for "store and forward" reimbursement (from 7 to 9 states), and limited to specific specialties. One state (South Dakota) actually eliminated S&F from Medicaid reimbursement during this period.
- The largest increase (from 10 to 16) in state policy activity has been for establishing reimbursement for remote patient monitoring. However, most states still tie this reimbursement to specific chronic conditions delivered by home health agencies.

Private Payer Reimbursement

- Most laws now require the same coverage for services delivered via telehealth as in-person (28 states and D.C., up from 16).
- This requirement most commonly applies only to services delivered via live video, but may also include store and forward/asynchronous telehealth in some instances. Currently, very few states require private payers to reimburse for remote patient monitoring.
- Except in a few instances, these laws also prohibit the insurer from requiring an in- person examination as a condition for reimbursement.
- Only a small subset of these laws require unconditional parity in payment for telehealth-delivered services as in-person.

Consent, Licensure & Prescribing

- Consent requirements (verbal and/or written) for telehealth have become increasingly popular as a requirement in Medicaid, statute, and professional board regulation.
- Professional licensing and certification boards are starting to establish rules related to online prescribing, and explicitly addressing whether or not an initial in- person exam is needed to issue a prescription.
- State professional boards are increasingly passing telehealth standards of practice regulations and/or guidelines.

Source: Center for Connected Health Policy

To try to deal with the license portability issue, the Federation of State Medical Boards (FSMB) has created the Interstate Medical Licensure Compact, an option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all states participating in the compact. So far, 11 states have enacted legislation to participate.

Although it is too early to say whether it will have a positive impact, some observers believe the compact idea does not go far enough. For instance, CCHP's Gutierrez sees the compact as a way to mollify the pressure that has been building around state medical boards to appear like they are doing something, "but I don't think it is going to have much effect," he says, adding that he would like the federal government to create nationwide telehealth licenses for clinicians working for federally funded programs such as federally qualified health centers or VA hospitals. "Why not have such a license when we have such a shortage of specialists and such a poor distribution of services?"

Joel White, executive director of the Health IT Now Coalition, called the interstate licensure compact a misguided progress. "The compact says you can get a duplicate license faster, but it doesn't change the fact that you still need a duplicate license. Instead of eliminating this barrier, it just says you can do it quicker. The cost issue still remains. You still have to get them, not for safety reasons, but just because state medical boards want to line their pockets and retain control. Every doctor has to take nationwide competency exams. This is about protecting a guild system started in the 1600s and 1700s."

WORKING TOWARD CHANGE AT THE FEDERAL LEVEL

If progress at the state level is uneven at best, the federal landscape isn't much better. The fact that Medicare coverage for telehealth only applies to rural patients is still a huge barrier, says the Northeast Telemedicine Resource Center's Louder. "We talk to people in urban areas who really want to use telehealth to increase access," she says, "because we know that socioeconomic status

and transportation can be daunting in urban areas. But because the policy has been set around rural areas, it is a real problem. We don't have a big research base about its use in urban areas, and that is what drives practice."

The Center for Medicare & Medicaid Services (CMS) had been considering eliminating a number of barriers to telehealth in its Medicare Shared Savings Program, but when the final rule was announced this year, none of the proposed changes made it into the final rule.

CMS' Next Generation ACO Model waives Medicare's originating site and geographic requirements for participating ACOs, but CCHP's Gutierrez notes that there will be only 20 Next Generation models funded around the country for a two-year period, "so it is going to be slow on the uptake," he says. "If we are talking about value-based care, we should be moving quickly into allowing these ACOs to utilize technology to its fullest."

The ATA is trying to ensure that payment innovations such as ACOs are able to fully use telehealth as well as supporting stand-alone legislation regarding more narrow approaches. "There's a bill to cover remote stroke diagnosis," Capistrant says. "The American Heart Association figures it could save over a billion dollars, but we can't get Congress to ask the CBO [Congressional Budget Office] to score it. And so it just doesn't happen. But we continue to develop congressional support, and the experience of states is helpful to move it forward."

Health IT Now's Joel White says advocates are still trying to break the code to get Medicare to cover more telemedicine services and reimburse for it, and the biggest holdup has been the CBO. "They have always said if you expand the number of covered services, and reimburse at the same rate, total costs will go up."

Each congressional session, legislation is introduced to expand Medicare's coverage of telehealth. This year, the TELE-MED Act (H.R. 3018 and S. 1778) was introduced with bi-partisan support in the U.S. House of Representatives by Reps. Devin Nunes (R-CA-22) and Frank Pallone (D-NJ-6) with 16 other co-sponsors and in the U.S. Senate by Sens. Mazie K. Hirono (D-HI) and Joni Ernst (R-IA).

Many research studies show that telehealth can be a powerful tool to reduce overall costs, especially over time as it decreases the likelihood that patients will have untreated chronic conditions, Lacktman says. "But those are long-term savings. So if there is an initial uptick in the Medicare budget, that is an important fiscal consideration for Congress to think about." He says the "doc-fix" bill passed this year requires the Government Accountability Office to prepare two reports by 2017 on telehealth cost savings and cost projections in Medicare. "Those will be important studies Congress can use for financial cost projections before implementing policy changes," he adds.

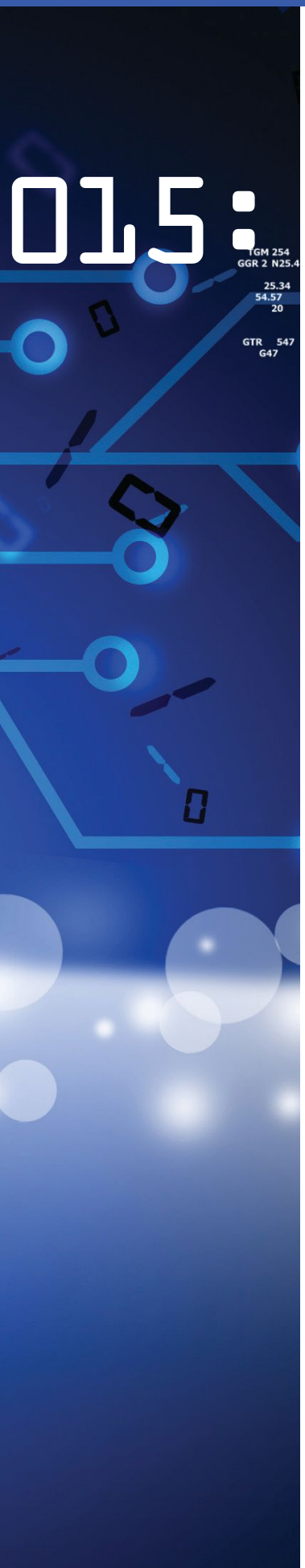
White says advocates have been working for a long time to get the CBO to change its view on telemedicine. "I think a lot of people have been upset that CBO hasn't more quickly changed its view of telemedicine. I am not surprised. We have to change the system based on the rules of the road. CBO has outlined a tough set of rules of the road. But they are manageable and we are working within those rules to expand telehealth to more Medicare beneficiaries, but it is just going to be a process, and we have to keep plodding along."

"THE AMERICAN HEART ASSOCIATION FIGURES IT COULD SAVE OVER A BILLION DOLLARS, BUT WE CAN'T GET CONGRESS TO ASK THE CBO [CONGRESSIONAL BUDGET OFFICE] TO SCORE IT. AND SO IT JUST DOESN'T HAPPEN. BUT WE CONTINUE TO DEVELOP CONGRESSIONAL SUPPORT, AND THE EXPERIENCE OF STATES IS HELPFUL TO MOVE IT FORWARD."

–GARY CAPISTRANT, CHIEF POLICY OFFICER, ATA

Of course, all of these policy and reimbursement uncertainties and disparities make it difficult for telehealth programs to integrate themselves more fully into health system operations. During a July Health IT Summit panel session in Denver, Samantha Lippolis, telehealth manager for Centura Health, said that a traditional challenge for those working in telehealth has been that it has evolved slowly with pilot projects based on grant money. "And so it's very difficult for leadership to understand that this is just one more tool to deliver healthcare. So just as organizations have developed strategies around ambulatory care and so on, we need to integrate this into everything we do, so that a physician's normal daily practice is, patient #1 is in room 5; patient #2 is on my video screen; and patient #3 is in room 6," she says. "And if you provide a half-day a month endocrinology clinic, how is that really improving access? You need to think about how you provide telehealth as part of a [normalized] full range of healthcare services." ◆

DATA SECURITY IN 2



2015: A NEED TO BE PROACTIVE

It's been a trying year already for healthcare organizations and data security. Can anything be done to stop the bleeding?

BY RAJIV LEVENTHAL

As the healthcare industry continues its push forward for more accessible data, greater interoperability, and an increased lean on mobile devices, one of the biggest questions that need to be answered is, Can patient care organizations across the U.S. properly secure the influx of data both within and outside of their walls?

Indeed, data security is as hot an issue in healthcare as it ever has been. In recent months, it has felt as if the industry has been in "reactive" rather than "proactive" mode, constantly on its heels, simply waiting for the next big Health Insurance Portability and Accountability Act (HIPAA) breach to be announced. It's not difficult to see why. In July, the Los Angeles-based UCLA Health System was hacked, with a massive data breach affecting 4.5 million people. A few months before that, in March, Premera Blue Cross, a Mountlake Terrace, Wash.-based health insurer, acknowledged that it was victim of a cyber attack that affected some 11 million of its customers. And in February, Anthem, a large Indianapolis-based payer, suffered a massive hack of its IT systems that exposed the personal data of approximately 80 million customers.

Which organization will be next? Certainly, the issue of data breaches is high on healthcare leaders' minds. A recent cyber security survey conducted by the Chicago-based Healthcare Information and Management Systems Society (HIMSS), found that 87 percent of respondents reported that data security/cyber security has become a higher priority in their organizations, while two-thirds noted that they had experienced a significant data security incident recently.

Mac McMillan, CEO of the Austin, Texas-based CynergisTek consulting firm, and nationally-recognized data security expert, noted the HIMSS survey in a recent keynote address at the CHIME Lead Forum-Seattle, cosponsored by the Ann Arbor, Mich.-based College of Healthcare Information Management Executives (CHIME) and the Institute for Health Technology Transformation (iHT2—a sister organization to *Healthcare Informatics* under the joint umbrella of the Vendome Group, LLC). According to *HCI* Editor-in-Chief Mark Hagland, who covered the event, "McMillan spoke extensively about the need for the healthcare IT leaders at patient care organizations to begin to focus on proactive, automation-facilitated monitoring of the behaviors of individuals in patient care organizations, and the need to let go of the illusion that simply fulfilling federal compliance mandates will do the job."

McMillan said in his keynote, per Hagland, "What's really interesting to me is that this industry has absolutely embraced technology in the way that it supports care—in terms of medical and surgical procedures. We have all kinds of technology that assists us in terms of doing procedures, and yet we still don't think

of IT as a strategic asset. If we thought of it as a strategic asset, we would probably think we need to protect it better. And yet we spend less than half of what other industries spend on security."

WORTH THE COST?

Data breaches are unquestionably of high cost to provider organizations—in the past two years, healthcare organizations spent an average of more than $2 million to resolve the consequences of a data breach involving an average of almost more than 2,700 lost or stolen records, according to the Ponemon Institute's fifth annual survey about privacy and security issues facing healthcare organizations. That being said, it isn't easy to implement the necessary controls, says Alexander Grijalva, head of information security risk management at the New York City-based NYU Langone Medical Center. "The bigger you are, the more expensive it gets to implement controls," Grijalva notes.

The fortunate part of Langone is that it is an internationally renowned institution, known for providing excellent care, Grijalva adds. "We draw patients from all over the world who want the best care; and we also have generous benefactors who care deeply about the medical center. But most hospitals in the U.S. are losing money," he notes. "They look at their health IT budgets and when it comes down to it, there might not be much left for security. I have a dollar, and I have to put it somewhere, so some folks say they will deal with security later. Sometimes there just isn't the focus that there needs to be," he says.

Grijalva says that now, phishing campaigns have become much more proficient and effective. "We have moved away from the poor English grammar [attacks] to much more sophisticated campaigns, and the moment you have those credentials you can do a lot of damage with that," he says. "In the hospital space, even with education, with the volume of emails that you get and all of the activity that you have to do in terms of responding to everything, people aren't spending time to really see how legitimate something is." Grijalva recalls a phishing campaign he heard about from another organization that referenced an information security project that the institution was working on and that employees were educated on. The attack used the logo of the medical center as well, he says. "No one thought anything of it at first. Nothing seemed unusual. Phishing has become very difficult to protect against. No one has really understood how to address that."

What's more, says Grijalva, is that healthcare is in a precarious position compared with other industries, with the recent trend being towards opening technology systems and giving more people more, unprecedented access to information. "What you see going on in healthcare overall makes security very challenging," he says. "With healthcare, mandates are steered towards making information more accessible. So you're not trying to limit or shield off information, but you're aggregating more and making it more available across all aspects of workflow from hospitals to insurance carriers to health information exchanges (HIEs). In a way, it's a reverse direction from other industries, and that makes it more difficult since the risk level is increased." Grijalva notes that clinicians now have access to every patient record in the organization,

as you cannot segregate what he or she can see in case of an emergency. "That physician needs immediate access to the information," he says. "But it's hard to catch when someone is looking at records he or she shouldn't be looking at. That also makes the job of security much more difficult compared with securing the perimeter or trying to secure against malware," he says.

Moving forward, Grijalva believes that the key to getting organizations at the level of preparedness they need to be is collaborating with one another. "Hospitals need to come together and say, 'These are the issues we have, and how are you dealing with that?' Folks can share information that way," he says. Grijalva notes that he is a former co-chair of the Association of American Medical Colleges (AAMC) security work group for hospitals and academic medical centers, and there, they talk amongst themselves about what they are seeing and where the biggest challenges lie. "You need clinicians to buy in too," he adds. "They are scientists and are not used to limiting access to, or restricting distribution, of scientific information. Information security can sometimes be contrary to the culture and needs of their profession. And you have to accommodate that. These are all things we have to factor in." ◆

> "We have all kinds of technology that assists us in terms of doing procedures, and yet we still don't think of IT as a strategic asset. If we thought of it as a strategic asset, we would probably think we need to protect it better."
>
> —*Mac McMillan, CEO CynergisTek*

ENABLING THE ALWAYS-ON BUSINESS FOR HEALTHCARE

Data management continues to be a high priority for healthcare businesses today, but tight budgets are a fact of life.It is primarily the rising costs of patient care and of new treatments—not the direct investments in IT—that have caused an increase in healthcare spending. Yet, healthcare businesses face exponential data growth each year, and healthcare professionals are demanding access to data 24/7 from any device—with no tolerance for downtime. Add to this another layer of complexity with the Health Insurance Portability and Accountability Act (HIPAA) and other compliance mandates which require in some cases a minimum of data retention periods of as long as 100 years — a difficult proposition considering the sheer amount of healthcare data generated by an aging population. The stakes are high in this industry, with the cost of any gap in healthcare data being measured not only in the loss of time and money, but also in human lives. Access to patient data, including clinical records and all related information must be available 24/7, despite any IT disasters. In other words, any modern healthcare business today must function as an Always-On Business™.

On the technical side, all of these challenges for healthcare can be summarized as follows:

- Privacy of patient data must be maintained: Encryption features, data access security features, and delegation features are key points.
- Long-term retention of patient data is almost always required: This can be from 50 to100 years, depending on the local regulations. Consequently, tape or deduplication devices are crucial for long-term retention.
- Availability for all systems must be guaranteed: No downtime can be permitted on healthcare systems.

Veeam® understands the challenges the modern data center faces and the high level of availability that healthcare companies require. Veeam Availability Suite™ addresses healthcare challenges with solutions that provide:

- Encryption and restore delegation features that fully safeguard the privacy of patient and employee data at medical institutions.
- Integrated tape and deduplication appliances that minimize backup file space and ensure the longer retention policies required in the healthcare industry.
- Fast backup, Instant VM Recovery™ and storage integration features that guarantee the shortest RPO and RTO and meet requirements to implement an automated offsite data backup solution with on-demand recovery.

Veeam enables the Always-On Business™ by providing solutions that deliver Availability for the Modern Data Center™, which provides recovery time and point objectives (RTPO™) of < 15 minutes for all applications and data. Historically, this level of availability has been unachievable: 96% of Veeam recoveries are within RTO SLAs, compared to 78% for other solutions. Veeam has a large portfolio of satisfied customers who have installed Veeam Availability Suite.

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Enabling the Always-On Business for Healthcare

Q&A: DATA SECURITY


Terry Edwards, PerfectServe CEO

A patient record can sell for more than $50 – much more than a credit card, or even Social Security number. This is creating a treacherous environment for healthcare providers, who have faced a record number of cyber-attacks in recent years.[1] We spoke with Terry Edwards, CEO of PerfectServe, to discuss how healthcare organizations can secure their data to ensure patient privacy.

1. **Where are the challenges to protecting the privacy and security of patient information?**
   As providers move toward population health, care delivery isn't nearly as contained as it used to be. Patients receive care across so many different care settings, and care teams are growing in size and scope. In addition, patients and providers are relying on technology to share data. Each device offers another entry point for cyber criminals to infiltrate. To top it off, tight IT budgets are making it harder for organizations to keep up with hackers, who are getting more advanced and nimble.

2. **Are providers taking this threat seriously?**
   Yes, I believe they are. According to a recent survey of 955 healthcare professionals[2], conducted online by Harris Poll and commissioned by PerfectServe, more than 8 in 10 respondents (83%) said secure communication is a top priority at their organization. But despite these efforts, there's still a lot of work needed, particularly around clinical communications. The survey revealed that 21 percent of respondents have received unsecure texts or voice messages from their personal smart phone containing patient health information, and 13 percent have personally sent unsecure text messages.

3. **What steps do providers need to take to protect the privacy and security of patient health information?**
   First, providers need to perform a full risk analysis to identify any potential vulnerabilities – like third party call centers, or unsecure texting platforms – and create a strategic plan to address those vulnerabilities. Next, organizations need to educate and train staff members. Organizations need to provide frequent reminders for employees to speak up about suspicious emails, change passwords regularly and encrypt communication with protected health information. Finally, organizations need to stay vigilant. Are employees following best practices and HIPAA compliance policies? As technology changes, are your policies evolving with them? The IT department plays a big role, but they can't do it without the support of the rest of the team.

4. **What types of IT solutions can help providers address security issues?**
   Healthcare organizations have used a piecemeal approach to try to secure communications by using a collection of tools. According to the survey results, nearly 7 in 10 healthcare professionals surveyed (69%) say their organization uses a mix of different applications and technologies for secure communications. I see this creating a fragmented system that makes it hard for clinicians to consistently use secure communication channels.

   Unified communications platforms, such as PerfectServe Synchrony, offer a solution that makes it easy for clinicians to communicate securely in the method that works best for them, whether that is via a phone call, page, voice mail, or a secure text message. By consolidating all electronic protected health information on a single, interoperable and secure platform, all types of communication can be accommodated – securely.

1. http://www.medscape.com/viewarticle/824192
2. "Healthcare professionals" includes hospitalists, primary care physicians in large offices, specialists in both hospital and office settings, nurses in hospitals, case managers, hospital administrators, and office managers.
   Visit perfectserve.com/survey to download the full report.

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HEALTHCARE ORGANIZATIONS NEED TO RUN (not just step) UP TO THE DATA PROTECTION PLATE

BY RON ROPP & BECKY QUAMMEN

Data breaches are hitting healthcare organizations at a rapid rate. Simply scan recent headlines and you'll discover that the media has been reporting on various incidents frequently, with headline after headline calling attention to this troubling problem.

Indeed, large-scale health data breaches have become common, according to a research letter published in the April 14, 2015 issue of the *Journal of the American Medical Association*. From 2010 to 2013, nearly 1,000 large breaches affected more than 29 million individual health records, and more than half resulted from theft or loss of laptops, thumb drives and paper records, according to the report. The yearly number of breaches rose from 214 in 2010 to 236 in 2011, 234 in 2012 and 265 in 2013.

What's troubling, however, is that even with the spotlight unrelentingly shining on data security, many health systems are still leaving themselves vulnerable. In fact, even in the wake of all this media attention, many organizations still are not implementing essential security and data protection programs. In fact, some have not even taken the basic step of encrypting sensitive patient data.

TAKING ACTION

The time is now for healthcare leaders to protect patient data. To do so, leaders should take the following steps:

Think like the "bad guys." You need to understand how the enemy — or "bad guys" — think and use that understanding to protect your organization. For example, assume that these attackers will look for the easy ways to gain access to data. More often than not, hackers won't take the difficult road — breaking through your firewall or kicking in the front door. Instead, they will find the unlocked door, un-configured web application, unprotected community outreach portal or unintended information shared on social media. Or, they will simply steal your laptop from the back seat of your car. As such, always consider things that you might think of as outlandish to protect your organization.

Create a strategic security plan that gets the executive-level sponsorship needed to succeed. To get this buy-in, it's important to realize that information security strategic planning needs to be in sync with greater organizational plans. In addition, the security plan needs to be recognized as something that adds value to your organization and customers, not simply as a cost or risk management item.

Spell out the mission. Your plan should specifically spell out how your organization will achieve its goals and exactly how you will progress toward these objectives. In addition, it's important to make sure that the plan is continually evolving through ongoing reviews and revisions.

Incorporate a variety of components in your plan. While there is no one template for a security plan, you should consider addressing the following: governance, compliance with regulations, data loss prevention, access protection, training, risk assessment, contingency steps, situational awareness, incident response and organizational standards and procedures.

Ron Ropp is the Chief Technology and Security Officer and Becky Quammen is the CEO at Quammen Health Care Consultants, a full-service health care information system and business consultancy that offers planning, assessment and implementation services as well as a variety of strategic alternative sourcing solutions. For more information, go to www.quammengroup.com or call 407.539.2015.

Quammen
HEALTH CARE CONSULTANTS

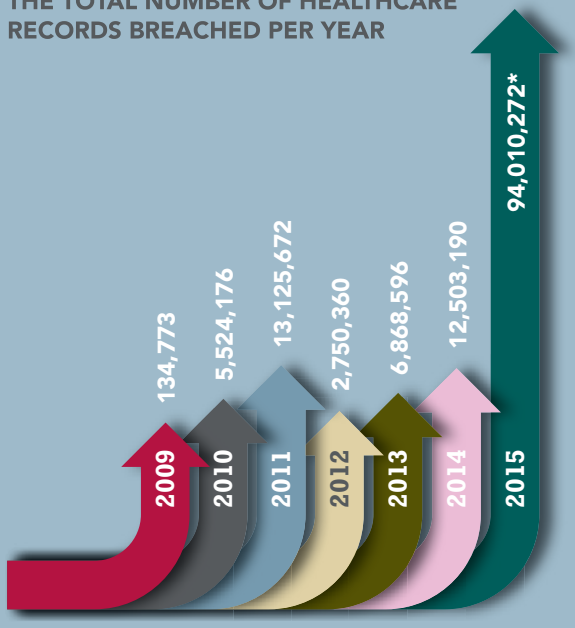
DATA BREACHES IN HEALTHCARE:
TACKLING A BIG PROBLEM

THE FIVE BIGGEST HEALTH DATA BREACHES [SO FAR]

1. **Anthem Health Breach:** Affected ~ 80 million people [Hacking/IT incident]
2. **Premera Blue Cross:** Affected ~ 11 million people [Hacking/IT Incident]
3. **Science Applications International Corp:** Affected ~ 4.9 million people [Loss]
4. **Community Health Systems:** Affected ~ 4.5 million people [Theft]
5. **University of California, L.A.:** Affected ~ 4.5 million people [Hacking/IT incident]

Source: U.S. Department of Health and Human Services, Office for Civil Rights. https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

THE TOTAL NUMBER OF HEALTHCARE RECORDS BREACHED PER YEAR



**2015 data through June 26, 2015*
Source: U.S. Department of Health and Human Services, Office for Civil Rights. https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf

DATA PROTECTION: AN EMERGING PRIORITY FOR HEALTHCARE ORGANIZATIONS

87% OF HEALTHCARE PROFESSIONALS INDICATED THAT INFORMATION SECURITY HAD BECOME A CRITICAL BUSINESS PRIORITY

81% BELIEVE MORE INNOVATIVE AND ADVANCED TOOLS ARE NEEDED

63% OF ORGANIZATIONS ARE PLANNING TO INCREASE SPENDING TO OFFSET DATA THREATS

Source: HIMSS 2015 Cybersecurity Survey, which included responses from 297 healthcare professionals with level of responsibility for data security.
Source: Harris Poll survey of 920 IT decision makers conducted on behalf of Vormetric. http://www.eweek.com/small-business/data-breaches-common-in-health-care-industry.html

DATA PROTECTION AND SECURITY: READY – OR NOT?

73% OF ORGANIZATIONS HAVE IMPLEMENTED A DATA BREACH RESPONSE PLAN

BUT

- **67%** DON'T HAVE SOLID UNDERSTANDING OF WHAT NEEDS TO BE DONE TO MINIMIZE DAMAGES AND RETAIN CONSUMER TRUST IF A BREACH OCCURRED
- **41%** HAD NO SET TIME FOR REVIEWING AND UPDATING PLANS
- **37%** HAD NOT REVIEWED THEIR PLAN SINCE IT WAS CREATED

SMALL HOSPITALS: READY, WILLING — BUT NOT ABLE?

- **91%** OF SMALL HEALTHCARE PROVIDERS (LESS THAN 250 EMPLOYEES) HAVE SUFFERED A DATA BREACH
- **23%** HAVE HAD A MEDICAL IDENTITY THEFT INCIDENT
- **100%** OF THESE ORGANIZATIONS ARE TAKING STEPS TO PROTECT DATA

BUT only **30%** HAVE RESOURCES NEEDED TO ENSURE PRIVACY/SECURITY REQUIREMENTS ARE MET

Source: Ponemon Institute, Is Your Company Ready for a Big Data Breach? The Second Annual Study on Data Breach Preparedness. The study included responses from executives from several business sectors including healthcare.
Source: Ponemon Institute, Data Security in Small Healthcare Organizations.

SAFEGUARDING AGAINST A DATA BREACH: DON'T MISS THESE 8 BASIC STEPS

1. Conduct a HIPAA security risk analysis
2. Perform vulnerability assessments and penetration testing
3. Implement SIEM [Security Information & Event Management]
4. Know who can legitimately access your systems from the outside
5. Get rid of generic passwords
6. Develop and implement a strategic data security plan
7. Train employees in data security and privacy issues
8. Encrypt all patient data

Premier's Damore: With the Right Help, ACOs Are Moving in the Right Direction

As new Medicare Pioneer ACO and MSSP program results are released, Premier, Inc.'s Joe Damore shares insights on Premier ACO Collaborative members' progress

BY MARK HAGLAND

Shortly after the federal Centers for Medicare & Medicaid Services (CMS) announced the latest results coming out of the two main accountable care organization (ACO) programs operating under the aegis of the Medicare program, the Medicare Shared Savings Program for accountable care (MSSP) and the Pioneer ACO Program, leaders at the Charlotte-based Premier, Inc. were able to trumpet positive results coming out of Premier's population health initiative.

As the statement attributed to Joe Damore, vice president, population health management, at Premier, noted, "Members of the Premier healthcare alliance commend all 353 participating care providers on the successes of the Medicare Shared Savings Program (MSSP) and the Pioneer Accountable Care Organization (ACO) Program for their notable quality improvements and $411 million in total savings. We believe ACOs hold great promise and are particularly pleased that more than 45 percent of the MSSP and Pioneer ACOs participating in Premier's population health management collaborative, one of the largest ACO collaboratives in the country, qualified for shared savings payments," Damore's statement said. "Critical to their success, collaborative members focus on 10 key strategies to operate a highly-successful population health management entity, including benchmarking performance with peers, population health data management, leveraging a gap assessment tool and sharing best practices."

Futhermore, the statement stated that "All participants deserve credit for taking accountability for the quality and cost of care for a defined population. This is difficult work that requires new capabilities and investments. Moreover, the Centers for Medicare & Medicaid Services (CMS) model is evolving and we believe additional steps need to be taken, which we outlined in our recommendations to CMS."

In fact, Damore reported to *HCI* Editor-in-Chief Mark Hagland, the details of Premier's ACO collaborative's progress are particularly positive. Here's how the numbers stack up: in 2014, 181 of the 333 MSSP ACOs generated some level of savings, while 152 ACOs in that program generated no savings; and 15 of the 20 ACOs in the Pioneer ACO Program generated some level of savings, while five generated none. Expressed in terms of percentages, 55 percent of MSSP ACOs generated some level of savings, while 45 percent generated none; meanwhile, 75 percent of Pioneer ACOs generated some level of savings, while 25 percent generated none.

Meanwhile, among ACOs involved in Premier, Inc.'s ACO collaborative, the 2014 results were as follows, Damore noted: 50 percent of the Pioneer ACOs in Premier's collaborative achieved some level of savings, while that same percentage, 50 percent, also received shared savings payments from CMS. Meanwhile, 63 percent of MSSP ACOs in Premier's collaborative achieved some level of savings, and 47 percent received shared savings payments from CMS.

In other words, among the MSSP ACOs participating in Premier's collaborative, 63 percent achieved some level of savings, compared with 55 of MSSP ACOs overall.

On August 27, Damore spoke with Hagland about the results, and shared his perspectives on what is working in moving accountable care/population health initiatives forward. Below are excerpts from their interview.

What have been your and your colleagues' key learnings so far in the ACO venture?

The key question is, where do you invest your time in improving quality and lowering costs? That's what we're good at. We've worked with 65 ACOs that are MSSPs and Pioneers so far. And we're really excited about it, because we think we're doing some things that are really helping organizations. And if you talked to them, they'd tell you that. We provide a benchmarking tool for them, and a service we provide is that we'll come in and do a gap assessment for them so they can focus on their efforts. We've done about a dozen of those, and the reaction, among a mix of Pioneer and MSSP ACOs, has been very positive. We identify the gaps.

What are the biggest gaps you're finding?

In general, what we're finding is that the organizations not making money have not made care management changes. We're talking about managing high-risk patients, setting up a care management program for the 2 to 3 percent who make up

40 percent of the total expenses. And we use a hybrid model that includes clinical people and non-clinical people, so nurses, and also laypeople, who would be addressing issues like transportation, support systems for people, and there's a high return on investment in using the care management. It's very cost-effective.

There are six main chronic diseases that are the cause of the bulk of healthcare costs in this country: asthma, diabetes, congestive heart failure, COPD [chronic obstructive pulmonary disease], hypertension, and chronic depression. Those are the chronic diseases to focus on. If you look at a pyramid of healthcare utilization, the sickest 2 to 3 percent are the folks we have to focus on. Among the Americans in that top 2-3 percent, there are five main subgroups. The first subgroup includes people with multiple chronic diseases; typically, they're obese with diabetes, high blood pressure, etc. Another subgroup is anybody over 85 years of age. The third subgroup would be people with renal disease, a very expensive group. The fourth group has both a chronic disease plus a behavioral health issue. And the fifth subgroup is facing end-stage, life-threatening diseases. Those are the most common groups of people in those subgroups of the 2-3 percent. Historically, no one really paid attention to those groups of people.

So the first large group that any ACO needs to look to take care of are those individuals I've just described, including those five subgroups. Below that top 2-3 percent of high utilizers in your patient population, the next group to look at is the 10 to 15 percent of people with at least one chronic disease. There are all kinds of studies showing that caring for them is very cost-effective.

So you start by looking at those populations. That is the first area to get involved in. The next area is integrating a patient-centered medical home model into a team-based primary care model.

The third area is re-visioning post-acute care. Under the old healthcare model, no one was paid to pay attention to the quality and cost of post-acute care. There were no studies on the most effective sites, providers, etc. So people were referred to skilled nursing facilities without any analysis. So there are a lot of people in skilled nursing facilities for two or three weeks until their co-pay kicks in, and under Medicare, it kicks in at 21 days, so we see a lot of SNF stays of 20 days, and we're finding that the model is really primarily economically driven, not clinical.

And how is that model being impacted by ACO participation?

Well, we're seeing a shift over to home-based care. One of the ACOs we're working with has seen a 30-percent reduction in their average daily census at skilled nursing facilities. That is the result of a shorter average length of stay, and a decrease in skilled nursing facility admissions, and an increase in the use of home care. And they've built a much more advanced home care-based model, one that includes telemetry in the home; they also provide a small camera connected to their flat screen TVs, so the nurse can do virtual visits through their TV. And the nurse will ask them their blood pressure, heart rate, blood sugar, etc. and then we figure out how to advise the patient across that telemedicine connection. This is an early adopter of that technology; we're going to see that spread across the U.S.

And we're seeing an actual improvement in patient satisfaction and in quality scores, not a decline. So we're really doing what's right and focusing more on the patient, so that works.

A fourth area of activity is around end-of-life care, and how we're really supporting people. Can we do a better job by providing palliative care and hospice care? We're seeing a growth in much more support to families and patients.

So those are some of these areas working across all these sites. And we have an agreement with CMS under which we're getting the claims data for these sites, and then we prepare comparative reports for them, to see how they're stacking up with other ACOs in areas like ER visits per 1,000 patients. And we know there's overuse of ERs, and if we can increase access to primary care, we can reduce ER utilization and improve care outcomes. We also look at post-acute care costs per member per month.

That's a full menu of efforts and activities.

Yes, it is. And the measures I've mentioned are just a few of the total number that we're looking at with the members of our ACO collaborative. But it really works. It's just so impressive to see what some of these organizations are doing across the country. Among the pioneers in this are Banner Health and Mosaic Life in St. Joseph, Missouri, a smaller town, doing really well. Another one is Summa Health in Akron, Ohio—just a few organizations that really have embraced this transformation of care, and they're focusing on value-based care. We're really blessed to work with these organizations. And we're trying to learn from them and help others, and that's the whole point of our benchmarking program.

And this may be the first time these organizations have ever had full access to claims data; because you can't possibly manage a population without having access to all that data. So when we help our member organizations to prepare for contract negotiations with private payers, we tell them, you've got to have all that.

So it's exciting; I think the country's moving in the right direction. And we're seeing savings. And we're just at the beginning of transformation, and this is hard stuff. A lot of this requires change management, which is difficult. And we're all trying to help organizations integrate care across the entire organization. I go to a provider that is a patient-centered medical home, and my family does. And I think this is what needs to be done across the U.S. healthcare system. ◆

The Thorniest Barriers to Robust Data Analytics? Panelists Uncover a Tangle of Them

Panelists at iHT2-Seattle take on some of the thorniest barriers bedeviling attempts at robust data analytics BY MARK HAGLAND

How can data really be made useful to efforts to improve patient care outcomes and engage in population health initiatives? Panelists participating in a discussion around data analytics plunged into some very thorny issues in healthcare during an afternoon panel discussion on Aug. 18 at the Health IT Summit in Seattle being held at the Seattle Marriott Waterfront, and sponsored by the Institute for Health Technology Transformation (iHT2, a sister organization to *Healthcare Informatics,* under the corporate umbrella of parent organization Vendome Group, LLC).

The panel, entitled "Analytics: Integration, Standards, and Workflow," ended up tackling some of the most vexing issues facing healthcare leaders who are attempting to fully leverage data analytics for clinical performance improvement, cost reduction, population health management, and other purposes.

"EARLY ON WE WERE REALLY WORKING ON THE EHR, AND WE WEREN'T NECESSARILY CAPTURING DATA DISCRETELY; INSTEAD, WE WERE FOCUSING ON GETTING PEOPLE ON BOARD."

–STEVE WEISS, R.N., CNIO, PROVIDENCE HEALTH & SERVICES

Zachery Jiwa, former innovation fellow at the U.S. Department of Health and Human Services, led the discussion. The other panelists were David Chou, M.D., chief technology officer at UW Medicine (Seattle); Dean Field, M.D., vice president for informatics and operations at the Tacoma-based CHI Franciscan Health; Steve Weiss, R.N., CNIO for the Seattle-based Swedish Region of Providence Health & Services; Sean Kelly, M.D., vice president and chief medical officer at the Lexington, Mass.-based Imprivata and a practicing emergency physician at Beth Israel Deaconess Hospital in Boston; and Erik Giesa, senior vice president for informatics and operations at the Seattle-based ExtraHop Networks.

Among the problems inherent in the current struggle to leverage data for analytics purposes, Weiss noted, is the fact

that such efforts have been relatively recent overall, and have followed a number of years focused on electronic health record implementation and on the creation of some informatics foundations, including the creation of data warehouses. "Early on," Weiss said, "we were really working on the EHR, and we weren't necessarily capturing data discretely; instead, we were focusing on getting people on board. And as we progressed, we focused on moving onto enterprise data warehouses and registries, and beginning to work on data definitions. That's

about where we are now," he said. "It would be great to move into data definitions in communities," he added. "We want to continue to work on population health. The problem is that definitions in medicine are difficult."

"We've been live on our current EHR for two years now," Field reported. "And while we're still in our infancy on our implementations, now suddenly, we're realizing we need to be able to pull data out of it. And now that we're in this adolescent phase, we're still very much reactive, reacting to CMS [policy mandates from the federal Centers for Medicare & Medicaid Services], reacting to other external pressures, and not necessarily following our own vision."

"Two things are necessary" to begin to leverage data analytics robustly, Chou asserted: "a useful vocabulary, and understanding data context. I don't think either of them are at a satisfactory level yet," he said. "And the consistent practice of medicine isn't there yet, either." In fact, Chou said, one fact that should sober any leaders attempting to move forward to robustly leverage data analytics is this one: "There are something like 690 definitions of glucose" in EHRs and other clinical information systems, he noted. "And that's a disaster. And that's assuming that they all mean the same thing, which they don't. So you have to decide what you're going to map to. And every time I go through an interface, I lose information. And with regard to, for example, blood pressure, I don't even know what the information is around the blood pressure, I don't have the context. So," he said, looking at an analytics landscape that encompasses clinical, technological, policy, and practice challenges, "you have to understand the practice of medicine, and you have to have the context. And eventually, without that, you're going to drive the clinician crazy."

EHRS NEVER DESIGNED FOR ANALYTICS WORK

A very simple reality is also very important to keep in mind, Giesa said. "When you look back at the design, from as much as 30 years ago, of the EHR, and you look at how we're now trying to apply it to analytics, it's like trying to turn a square into a wheel now. And when I hear terms like data mapping, I want to note that the practice of medicine isn't standardized or structured," he emphasized. "When they built these applications, they did not anticipate using them for analytics or informatics. So there's a new paradigm emerging now around structuring data in unstructured data stores, giving you the flexibility to not necessarily have to do data mapping."

It might seem like a stretch to apply such informatics concepts to patient care, Giesa said but he noted that "That's something that applications like LinkedIn and Facebook do: the same principles apply. You have one user who might be doing five, 20 different things, interacting with all sorts of different applications, but at the end of the day, that user wants to see what they want to see. All of that relies on structured data being put into unstructured contexts for end user use. I don't believe that the structures around EHRs were designed to do what we're trying to accomplish."

Kelly agreed. "I think you're absolutely right," he told Giesa. "The reality is, you need to try, and fail, and try, and fail," as leaders in patient care organizations beginning to move forward to harness analytics. "And it's an iterative process." In fact, he said, "you probably got traction to begin with because someone caring for patients or doing the billing and coding, cared about what you were doing. Some stakeholder in the hospital cared about that data. And all you can do is try a first cut of it and reiterate that over and over again."

"WHEN THEY BUILT THESE APPLICATIONS, THEY DID NOT ANTICIPATE USING THEM FOR ANALYTICS OR INFORMATICS. SO THERE'S A NEW PARADIGM EMERGING NOW AROUND STRUCTURING DATA IN UNSTRUCTURED DATA STORES, GIVING YOU THE FLEXIBILITY TO NOT NECESSARILY HAVE TO DO DATA MAPPING."

–ERIK GIESA, SVP FOR INFORMATICS AND OPS, EXTRAHOP NETWORKS

Indeed, Kelly said, "The places that are beginning to succeed fail and fail over and over again, but have multidisciplinary teams working on this. So I ask them, what are you doing to get the right stakeholders together at the same table, and asking the right questions? And some of the most interesting stuff we're finding" in terms of revelations coming out of analytics, "is actually unexpected, right? It's not necessarily what we were looking for."

ACHIEVING EARLY GAINS—AND SEEING THE LIGHT AT THE END OF THE TUNNEL

When Jiwa asked his fellow panelists how far they'd gotten so far in beginning to share data with their communities, and about the interoperability standards that needed to be addressed, Field said, "I don't know that I would describe our journey as completely successful yet. We're on a journey," he stressed. "For us, part of the challenge was creating a unified platform between inpatient and outpatient. We decided to choose a single vendor to create a platform for that. It also requires creating an organizational vision, and lens, for where you want to go. For any organization, you can look at IT infrastructure as an expense. And when you manage that expense, you want to manage the cost of it. But it's much more important to focus the lens on the commu-

nity," he emphasized, "and to have that to support the community, rather than focusing solely on the expense."

In fact, Chou said, "I can tell you from the personal side, that for me as a clinician and as an informaticist, I can say that there's a huge gap in terms of discharge of patients into the community. We have no good mechanism" for fully documenting and sharing clinical data around discharges of patients into the community, he said. "Nursing homes don't have EHRs of any kind, some of them. And they seem to have very little incentive" to implement EHRs, "given low reimbursement, and so on. And the whole discharge at UW—we don't have a smooth transition to nursing homes."

Kelly shared his view that "There's good news and bad news. The bad news is that it's a mess—the whole area of [documenting] transitions of care [and sharing data around them]. Despite that," he said, "we're doing a good job. We've created home-grown systems built on our EHR, to manage the transitions. There are electronic things going back and forth, CCDs"—continuity of care documents. Still, he noted that the infamous problem of "note bloat" in physician documentation is only getting worse. "On the CMIO listserv last month," he reported, "someone sent out an example of a 337-page CCD, something like that."

"WHEN WE DO RISK STRATIFICATION AND LOOK AT POPULATIONS AND WHY THEY'RE COMING BACK, WE CAN LOOK AT ISSUES AROUND CONTINUITY OF CARE. BUT WE HAVEN'T YET FIGURED OUT HOW TO SHARE IMPORTANT INFORMATION ACROSS THE ORGANIZATION."

–STEVE WEISS, R.N., CNIO, PROVIDENCE HEALTH & SERVICES

Continuing on now to speak as a practicing emergency physician, Kelly said, "So, let's say that I'm in the ER and a patient comes in unconscious, and somewhere in that 337 pages is something important that I don't have time to look at or find, but you can be sure that a malpractice lawyer will find it sometime. So are we helping ourselves and each other, or harming?" he asked, in reference to the over-abundance of data and text points in clinical documentation. "But the good news is that there are a lot of people who care about the patients, and vendors are building things, and there are a lot of things happening out there in smaller places that are very exciting."

All of this speaks at a fundamental level to how EHRs were originally conceived, of course. "To be honest," Field said, "EHRs were built for billing and coding, not necessarily for patient care."

Things are in early stages of maturity around analytics work, as a result of all the factors cited by the other panelists, Weiss said. "When we do risk stratification and look at populations and why they're coming back, we can look at issues around continuity of care. But we haven't yet figured out how to share important information across the organization."

"The data's actually there, right?" Kelly said. "But what do we do with it? The critical questions are, who needs it, and how do you get it to them? And it takes people with clinical, operational, and technical knowledge to sort through all of it."

"I agree with you," Chou said. "Two years ago, we wouldn't even have been talking about transitions of care. But we're at the point where we are transmitting, which really is a big, big improvement over where we were." In other words, panelists agreed, things remain in early stages around successfully and robustly leveraging analytics for clinical transformation, population health management, and other important purposes in U.S. healthcare. And yet they are also further along than they have been—and moving forward in a landscape of accelerating effort and activity. ◆

A Mission to Become Paperless: How a Single Doc Dermatology Office is Making it Happen

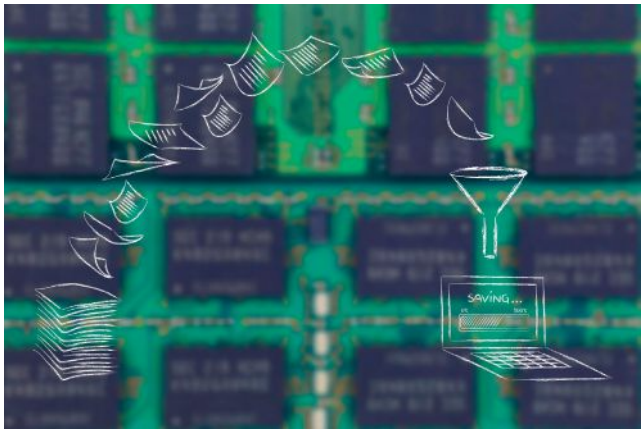
Most small practices don't have the mindset to become paperless from the get-go. In Austin, Texas however, a jack-of-all-trades practice manager has made that ambition become a reality for a dermatology office. BY RAJIV LEVENTHAL

When Daniel Soteldo's wife graduated from medical school and wanted to start her own dermatology private practice, he knew he was going to help her run the business, but in what specific capacity that would happen he was unsure about. Soteldo, after all, has a background filled with technological and business proficiency, but not one in medicine or even practice management; his last job involved managing a team of sales engineers for enterprise software. While Soteldo has experience working with Fortune 500 companies who had medical institutions as customers, running his wife's practice was a whole different story. Soteldo says that one of the first things he realized was that a lot of smaller practices don't use much technology, and that's something he wanted to change right off the bat. "From the get-go, I wanted this to be a paperless office," he says.

Blakely Richardson, D.O., is the solo practitioner at the Austin, Texas-based Westgate Skin & Cancer, a facility where her husband, Soteldo, practice manager, bears all of the financial and administrative responsibilities. "I really do everything here but clinical," he says. "I'm not grabbing an iPad and running into the room with a patient, but I am responsible for understanding the notice that was created with the encounter, and what it means for billing and payers. I manage all HR and financials, and all the technology. So I really have a view into everything."

"FROM THE GET-GO, I WANTED THIS TO BE A PAPERLESS OFFICE. THERE ARE INITIAL COSTS YOU WOULDN'T HAVE IF YOU WERE ON PAPER. BUT TIME, AUTOMATION, EASE OF USE, AND PATIENT EXPERIENCE ARE WHAT IT COMES DOWN TO." *–DANIEL SOTELDO*

As such, in the time that Westgate has been open, one of



Soteldo's main priorities has been making the practice as tech-heavy as possible, something that is often a difficult endeavor for small medical offices. "It's tough, but I liken it to making an investment. There are initial costs you wouldn't have if you were on paper. But time, automation, ease of use, and patient experience are what it comes down to," he says. The practice has tapped software-as-a-service technology company Kareo (Irvine, Calif.) as the core system that everything else integrates with. "It's the glue that holds our practice together," Soteldo says. When Kareo recently acquired DoctorBase, a practice marketing and patient communications solution, Soteldo immediately jumped on board.

Westgate uses DoctorBase for automated emails and texts to patients, eliminating the need for an employee to do those tasks. With the new software, between emails and re-directing people to the online patient portal, the patient appointment no-show rate has gone down about 80 percent, says Soteldo. "The no-show rate was pretty high before, at about 20 percent, and now it's something like one out of 20, so it is way lower. We also have an idea of who will no-show us because they didn't confirm with an email or don't pick up the phone if we have time to call and follow up. So we can be proactive by double booking those spots we predict will be no-shows. [Relieving] my staff by dropping no-show rates has been the biggest improvement thus far," he says. Since dermatology is

a high-volume specialty where Dr. Richardson hopes to see 35 to 40 patients a day eventually, there is a huge benefit to having these types of things being automated and done online, Soteldo notes. "If your practice is rural, people don't want you texting them. But in Austin there is a higher expectation of service. It's an energetic town, so when you text and email them, it's a breath of fresh air. They love it—they hit 'confirm' and DoctorBase marks it as confirmed. It's such a great thing for our staff, as they know what's going on right away," Soteldo says.

Soteldo adds that DoctorBase has made Westgate ROI-positive in its first month, and even more than that, its success has been evident based on patient reviews. "We immediately see family and friends of patients coming in, and when we ask them how they heard of us, it's often due to reviews and word of mouth. We are growing rapidly because of that," he says. He adds, "We are really investing in our future. What we are building is hard, but it will pay off because we are busy building the foundation for a modern practice. Now is the only time to do it too, because once you start seeing more patients and get completely booked up, it becomes twice as hard to [implement the technology]. At that point, the car is moving at 60 MPH already, rather than 5 or 10 like it is now," he says.


Daniel Soteldo

A GUTSY CALL

The mindset of integrating expensive technology now, rather than down the road, certainly is a courageous one that many small practices might not be willing to risk. Soteldo says that it's the same mindset of a startup mentality, of which he has worked at plenty of in the past. "In the beginning you work like crazy to build it, you have your projections and you do your homework, but you still won't get it all right," he says. "The first year here was very difficult due to having no experience in this industry. I taught most of it to myself, reading online and looking at blogs on healthcare technology. I'm always looking at press announcements from different technology companies. Certainly, my background has helped me, and now it's starting to pay off as we're getting busy," he says.

Soteldo admits that federal mandates such as meaningful use have presented their own challenges. "We have been waiting for the Centers for Medicare & Medicaid Services (CMS) to release its rules on the program, and waiting for that has been frustrating. In many ways, for us, meaningful use has just been a distraction," he says. "Some practices might need it, but we have a high level of focus on using the right tools, automation and accuracy, so meaningful use is a distraction since we're already doing a lot of these things. If I could get every patient to fill out a portal before they come in, I already would, so I don't need this program to tell me to do that. Many other small practices don't run this way, though," he admits.

Specifically for meaningful use, Soteldo says he ran and wrote the security report with just a consultant's help. He also clearly defined the practice's workflows and processes with little things such as taping instructions to the back of the iPad case that reminds staff to ask Medicare patients certain questions. He additionally made it part of the front desk process to automatically activate everyone's portal and incentivize patients by telling them they will save time in the office if they fill out these forms in advance. And it works, Soteldo says, because no one wants to be in the office for 15 to 20 extra minutes. He notes that Westgate has attested to Stage 1 of meaningful use after filing a hardship exemption due to timing. "We were one of the last people to get that incentive check," he says.

Soteldo says another benefit of the technology is helping with care coordination and data exchange. "We are a solo practice and we put a high level of effort in making sure we get notes and results back to the primary care provider who referred that patient. It's part of our intake process," he says. "Thankfully with our systems, the workflow is easy," Soteldo says, referring to another piece of Kareo technology, Modernizing Medicine's Electronic Medical Assistant. "For example, if that referring physician is in the system, it prompts the doctor when the summary of care is ready and automatically sends it back to them. Coordination of care is huge," he continues. "EMR companies are all competing so maybe they're not as incentivized to share data. We work around it the best we can though. We have found that because we're new, we get patients in fast for next-day appointments, we close the loop, get notes back, and let physicians know if their patients have been appropriately cared for. It makes for a better doctor and patient experience." ◆

"WE ARE REALLY INVESTING IN OUR FUTURE. WHAT WE ARE BUILDING IS HARD, BUT IT WILL PAY OFF BECAUSE WE ARE BUSY BUILDING THE FOUNDATION FOR A MODERN PRACTICE. NOW IS THE ONLY TIME TO DO IT TOO, BECAUSE ONCE YOU START SEEING MORE PATIENTS AND GET COMPLETELY BOOKED UP, IT BECOMES TWICE AS HARD TO [IMPLEMENT THE TECHNOLOGY]."

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Back Channel References Can Be Risky

When making a new hire, be sure to do your due diligence without hurting others

BY TIM TOLAN

Tim Tolan

There are no six degrees of separation in our industry. I've always touted that there are probably three degrees in most cases and usually less for us HCIT veterans. We all know many people in the healthcare technology ecosystem—which is a good thing. It can also be a very bad thing if we use our connections the wrong way by conducting a back channel reference and unknowingly sabotage a candidate's career. This long-used approach to validate a candidate's value through people we know and trust, while unintentional, can lead to some very challenging conversations with the candidate's current employer and even result in termination if the back channel call is done at the wrong time or without providing some notification to the search consultant or the candidate. It can be a slippery slope to say the least.

The practice of calling people we know and trust to get the real "skinny" on a candidate has been around for years but is now more simplified by using tools like LinkedIn to help you connect the dots on who knows who. I always encourage my clients to be a part of the reference check process so they feel like they can talk openly to peer executives to get information on a potential new hire. But let's face it—if this is done in a clandestine manner and secretly without having consent or giving notice to others involved in the process—the risks of the current employer finding out about it increases exponentially.

Unless the candidate has signed off for you to contact somebody from their current place of employment, you run a huge risk of forewarning their boss that they are actively looking for a new gig. Do you really want to be responsible for that sort of damage you could create? It's best to navigate around those who may tip off their current manager. For top executives (even in healthcare) finding another job can take a while depending on lots of factors. I tell candidates to count on a 3-6 month window to find a new job, but it could take longer. This timeline becomes even more challenging when the candidate loses their job because their current employer finds out through a back door channel reference and decides to start searching for their replacement. And what happens if they don't get an offer? Now they are exposed and at risk for not. It happens a lot more than you might think. It just happened last week to a candidate I know and the consequences of the whistle blower could be grave and even create legal issues.

"UNLESS THE CANDIDATE HAS SIGNED OFF FOR YOU TO CONTACT SOMEBODY FROM THEIR CURRENT PLACE OF EMPLOYMENT, YOU RUN A HUGE RISK OF FOREWARNING THEIR BOSS THAT THEY ARE ACTIVELY LOOKING FOR A NEW GIG. DO YOU REALLY WANT TO BE RESPONSIBLE FOR THAT SORT OF DAMAGE YOU COULD CREATE?"

—TIM TOLAN

To conduct a reference summary on behalf of a candidate, backdoor or otherwise, you must have written consent signed by the candidate. It's a common practice for our firm and we have a standard release form that the candidate must sign to start their reference check. If the candidate refuses to sign the release, then big red flags begin to appear. Unless they specifically state that they do not want you to use any other sources to confirm their suitability except for those referees they have provided, you are within your rights to look for references on candidates through any method you want to, provided they have confirmed you are allowed to check their references. If you decide to do a back door reference you definitely need to make sure there is a signed release form in place or you could be putting the candidate, their livelihood and their family at risk.

It's perfectly fine to do your due diligence when making an important hire. Just make sure you are following the rules of the road so you avoid putting others in a bad situation. Do onto others… well you get the point. ◆

Tim Tolan is senior partner at Sanford Rose Associates-Healthcare IT Practice. He can be reached at tjtolan@sanfordrose.com or (904) 875-4787. His blog can be found at www.healthcare-informatics.com/tim_tolan.

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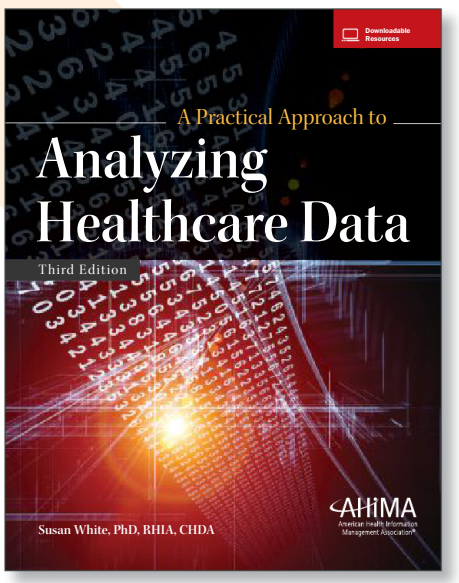

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