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BENCHMARKS: Meaningful use. CMS has big plans for Stage 3 MU (even as the Senate is urging a slowdown), but many providers are still in second gear. PAGE 28

How does your EHR stack up?

Our inaugural EHR Satisfaction Survey rates and ranks electronic health record systems using feedback from those who manage them every day: our readers. PAGE 4

Long distance

Some reality checks for the telehealth applications of Apple’s HealthKit and ResearchKit. PAGE 18

Big deal

After months of anticipation, Cerner’s team edges out rivals to score a landmark EHR contract from the Department of Defense. PAGE 20
Using InterSystems HealthShare®, the Rhode Island Quality Institute’s health information exchange, CurrentCare, is helping everyone get the results they need. Patients are getting the safe quality care they need to feel better. Doctors and nurses are getting the information they need, when, where, and how they need it, to make the best care decisions.

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Blog: Remote access threats are imminent

To reduce opportunities for hackers to succeed, healthcare entities must be proactive about protecting sensitive data across their organization. Security must be an ongoing practice and a top priority.

http://bit.ly/remote-access-blog

VIDEO:

Thomas Mason, MD,
CMO of ONC

Thomas Mason, MD, discusses his role as chief medical officer at the ONC and how his experience as the ambulatory CMIO and practicing physician at Cook County has aligned with the ONC’s work in transforming healthcare delivery.


SLIDESHOW:

‘Most Wired Advanced’ hospitals

This year, only six health systems in the nation earned the designation of HealthCare’s Most Wired “Advanced,” from H&HN, demonstrating leading-edge data security, advanced analytics, patient safety initiatives and overall implementation of IT systems.


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POLICY 8

Delay for Stage 3?
Senate favors Stage 3 slowdown after hearing details about information blocking.

No marvels here
Even a miracle would not boost quality as envisioned by Stage 3, says Brookings.

INSIGHT 14

‘Too many clicks’
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With the flick of a pen, UMass Memorial Health Care CEO begins an Epic EHR journey.

Reducing readmissions
Growing use of mobile technology keeps patients on top of their health – and out of the hospital.

BUSINESS 20

Cerner wins
EHR giant teams up with Leidos, Accenture and Intermountain for the game-changing job.

Finances turned up
We track how one West Virginia hospital took its financial bull by the horns.

DATA 24

Cockpit lessons
Aviation has a grip on ways to avoid errors that healthcare might do well to copy.

HIE’s big moment
Focus on value-based outcomes poised to open doors for data exchange.

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How satisfied are you with your EHR?

Healthcare IT News¹’s EHR Satisfaction Survey asked our readers to rank their EHR vendors across nine different metrics. The results may surprise you.

BY ERIN McCANN, Managing Editor

WANT TO TALK BIG-TICKET PURCHASES? Those behemoth electronic health record systems hospitals and medical practices have rolled out in recent years are easily near the top of that list. According to ONC data, in fact, health organizations could expect to spend up to $70,000 per provider on EHRs.

The 24-hospital Sutter Health in California has paid out more than $1 billion for its EHR. The 38-hospital Kaiser Permanente has handed over a whopping $4 billion.

Hospitals and health systems spend multi-millions – even billions – of dollars to roll out and maintain these massive electronic health record systems, but reviews and ranking data can often be difficult to find.

How interoperable is the EHR with mobile devices? What about with billing systems? On the user end, how would you describe the experience? Is it easy to navigate?

Then there’s the support piece of it all. EHR rollouts not only require serious financial investment, but they also can present huge workflow and training issues, diverting time away from other IT projects. Healthcare organizations need their EHR vendors to be available not only for installation support but also for ongoing platform support.

HIMSS Analytics tracks EMRAM progress, worksite installations and health IT RFPs, but there’s very little data on user satisfaction.

So we took our questions to those in IT management, physicians, and clinician end-users who are actively involved with EHRs in their role. We wanted to hear directly from individuals working in hospital and ambulatory settings, so we eliminated consultants, students and vendors from our list. By using the HIMSS Enterprise Unified Database, which is verified through a variety of opt-in channels – think newsletter signups, print subscriptions, event registrations and target list acquisitions, etc. – we sent this survey to those who could offer the most relevant and valued insight.

The 896 individuals we heard from didn’t hold anything back. We heard their biggest gripes with their EHR platforms, features they’d like to see improve. We also heard what makes them most satisfied about their EHR vendor. We asked our readers to rate their EHR vendor across nine different metrics, from one to 10, in addition to two open-ended responses on vendor limitations and positive features.

The nine metrics ranked in the survey include: EHR/visual appeal; user experience/ease of use; interoperability with medical devices; interoperability with other clinical systems; interoperability with billing systems; quality of installation support; quality of support for ongoing operations; downtime; and overall satisfaction with the product.

For the first time around, we’re focusing specifically on vendors, not individual products or versions.

All EHR vendors with a limited number of user reviews – 12 or fewer – were excluded from our list, which included on this list. Epic currently has just over 20 percent of the hospital EMR market share, according to data from HIMSS Analytics, edging out MEDITECH by fractions of a percent.

Other overall high performers included eClinicalWorks, billed as the largest cloud-based EHR in the U.S., which earned the No. 2 spot. Both Allscripts and Cerner tied for No. 3 overall.

And the lowest rated? That’s not to say there weren’t some Epic users unhappy with the vendor’s interoperability state – would be great to increase sup-

INTEROPERABILITY

This is a big one. And our survey respondents had a lot to say about it.

For all the talk about Epic’s lack of interoperability lately, its user ratings placed the vendor at the top of the list, with an average interoperability rating of 7.2.

Its highest marks under this category were for medical device interoperability at 7.4, followed by interoperability with billing systems at 7.2.

That’s not to say there weren’t some Epic users unhappy with the vendor’s interoperability state – would be great to increase sup-

SEE PAGE 6
Healthcare IT News’ 2015 EHR Satisfaction Survey is based on the ratings, feedback and insight of nearly 400 active EHR users in hospitals and physician practices across the U.S. Users rated their EHR vendors across nine different metrics. We have each vendor’s in-depth scorecard on our website, but check out the overall scores and averages across three macro categories below. The highest possible score is a 10.

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**Support**
- Epic
- MEDITECH
- eClinicalWorks

**Interoperability**
- With medical devices, billing, clinical systems
- Epic
- NextGen
- Cerner

**Features/Design**
- Visual appeal and interface, ease of use
- Epic
- eClinicalWorks
- Allscripts
Speaking out about EHRs

Managers of EHR systems share what they like — and what they’d like to see changed

BY MIKE MILLARD, Editor

We set out to survey Healthcare IT News readers about their electronic health record platforms, we expected they’d have a lot to say. And boy, did they ever.

Our survey was limited to readers who were actively engaged in the management or use of an EHR. After asking them to rate the systems numerically, we posed two open-ended questions: “What do you like best?” and “What would you change?” (EHR vendors with a limited number of user reviews – 12 or fewer – were excluded from our list.)

Most of the nearly 400 people who completed our survey shared their thoughts freely. Many of their replies were detailed, documenting specific problem areas and suggesting lots of ideas for improvement.

Overall, their responses demonstrated a sense of passion about the importance EHRs continue to play in delivering clinical services – and a sincere desire for the systems’ continued improvement. The following offers a flavor of what they had to say about the nine ranking vendors.

**ALLSCRIPTS**

Survey respondents liked the fact that their Allscripts EHR “seems pretty stable” and comes “pre-built with many things that other software requires a separate load to accomplish.” Others were pleased that “the areas that can be customized are very detailed.” In fact, “the customizability of the EHR is outstanding,” said one.

Another said the technology is “intuitive (and patient-oriented),” while another said, simply, “docs love using it.”

But product support drew complaints. “Tech support support improved, but response times are still slow,” wrote one user. “Do not like the support model,” wrote another. “Both implementation and support services could be much better.”

The third, complaining about a support structure that had “narrow silos of product knowledge” and lacked a central support function that could help providers tie the applications together.

**CERNER**

Cerner got high marks for being “very customizable,” with respondents noting the wide variety of solutions available — “like being able to run my own reports out of Cerner,” said one respondent. “Ease of use and interoperability” were appreciated by another. “They have kept up very well with all the new regulations that we have had to comply with,” reported a third.

The support team also drew praise for their “responsiveness” to questions.

“We are a critical access hospital and rural health clinic,” wrote one end-user. “One of the biggest selling points, when we chose Cerner, was OneChart. Our patient records from the clinic environment to the hospital look and act as one chart. Providers can easily see all the information from both environments. Records can be pulled and provided to caregivers at time of transfer from both environments.”

Others, however, complained that the EHR “is not very intuitive,” and tasks in general require “too many clicks.” One suggested “more automation for rote things, especially outbound CCDs for summary of care.” Others wrote that “the software encourages ‘over-customization,’ leading to ‘unnecessary complexity.’”

**ECLINICALWORKS**

Some respondents liked the “speed at which staff can get trained and start using the product,” and there was a general sense of satisfaction with the platform’s ease of use and workflow tools. But eClinicalWorks received a number of complaints about its tech support. One wrote that “we are an enterprise client and we consistently find major bugs in their products that go unresolved for months.” Others agreed, however, with one respondent referring to “good support.”

The wish list from survey respondents included “ancillary functionality such as behavioral health” and “the ability to open multiple screens without having to close a screen while viewing one patient record.” Others would like to see the ability to “customize on the fly... within limits.”

**EPIC**

Epic enjoyed nearly unanimous praise for access to support. The EHR has “lots of capability” and “fairly good” customer service. But one reader wished for a more “modern interface” — in addition to “the ability to have at least minimal interoperability with other applications.”

“The look and feel is outdated compared to many modern applications that are Web-based and responsive,” wrote another.

Data exchange was a common theme. “More interoperability” was a frequent request. “It is ‘reliable,” wrote one respondent, adding that “documentation alerts have gotten better or more sophisticated.” Another liked the “data repository where no information is lost” and “all users have access.” Yet another thought the EHR was “user friendly.”

Suggestions for improvement? “Decrease the amount of flowsheets,” for one. Epic “needs to do a better job” telling “the patient’s story,” wrote another user, pulling “data in from all disciplines.”

Feedback from customers seems not to fall on deaf ears. “They are always making it better,” wrote one. Added another: “There are multiple tweaks that we recommend to Epic, but for the most part I find it more flexible than any other EHR I’ve ever worked with.”

**GE HEALTHCARE**

Survey takers said GE Healthcare’s Centricity Enterprise still had some selling points, particularly with regard to “ease of use” and “interface issues.” The technology is “very customizable,” wrote one end-user. “GE wrote one caps lock enthusiast. “Visually, it is fine for users,” wrote another respondent. But as GE starts phasing out its hospital EHR, some are complaining that vendor support has rapidly withdrawn in the last year.”

Another customer reported that GE “has not been able to keep up” with functionality for meaningful use.” Meanwhile, its CPCE and e-prescribing “are hard to use for all providers” and workflow “doesn’t prioritize efficiencies.” Another user wished for “better support so we don’t need to hire third-party clinical consultants.”

**MCKESSON**

McKesson got positive comments for reliability and ease of use — “basics are not complicated for staff.” Another wrote, “I like the look, the ease of use, the multiple ways to access chart, functionality of the software.”

Some wrote that they liked the integration with financial systems, and one noted “ICD-10 conversion was well planned.” Several noted problems with interoperability: it’s “difficult to integrate with other systems” and “workflows are complex and difficult to manage interdepartmentally.”

**MEDITECH**

The “ability to change things on the fly” was much appreciated by one MEDITECH user. “I can easily change screens and build templates.” The ability to bar code blood products and scan labs,” was another top feature cited by a respondent. Others pointed to good “customer service and training” and the fact that the EHR “was easy to use, intuitive, easy to troubleshoot.”

Some were not happy with the user interface: “Nurses document in one area, physicians in another,” wrote one. “There is not a way in the current system to print the ‘complete’ medical record,” wrote another. “We have to go into the modules to print all sections.”

A third complained that there’s “no physician logic available in document,” citing “product-based order entry,” and the fact that one “can only send and receive CCD in CDA format (no other document types).”

**NEXTGEN**

Customers like NextGen’s “flexibility,” and the way it enables users to “build their own templates and workflows.” Its ambulatory is “very intuitive,” wrote one, and support staff is “very knowledgeable.” One noted the freedom to go into the modules to print all sections.”

A third complained that there’s “no physician logic available in document,” citing “product-based order entry,” and the fact that one “can only send and receive CCD in CDA format (no other document types).”

**SIEMENS**

A year after its acquisition by Cerner, Siemens systems are still in use. Positive comments were related to the cost, which one provider thought was reasonable. Another said, “financials are the best aspect.” But many survey respondents expressed frustrations in day-to-day use. “Our facility currently struggles to hire outside consultants to try to get the systems to work,” one reported. Another wrote: “Its modules make optimizing all the functionality difficult because organsiations don’t prioritize efficiencies” such as “automated upload of bedside data pumps” and vitals tracking. “The costs associated with these modules are perceived as nice to have rather than prioritizing efficiency.”

**EHR CONTINUED FROM PAGE 4**

For this category, we asked survey participants to rate interface/visual appeal and user experience of use. This one’s important, too. It’s not just how visually appealing the EHR interface looks, it’s how well clinicians and other users are able to navigate it, access it. For instance, one survey respondent said their EHR needed to be more “user friendly for clinicians in the field. Too many clicks are required to get anything accomplished.” Another user said their EHR interface was “too chaotic.”

In this category, again, Epic snagged the No. 1 spot, earning an overall score of 7.5 across the two categories. Epic users rated the interface/visual appeal a bit higher (7.7) than the user experience of use (7.4).

eClinicalWorks took the No. 2 spot in this category, with its users giving it a 7.1 overall.

And the underperformers on the list? Again Siemens earned the lowest score, at 5.0 in the category, followed by MEDITECH and McKesson who both saw scores of 5.5. In the open-ended response section of our survey, many customers of MEDITECH and McKesson said they wanted to see big improvements with ease-of-use and interface.

**SUPPORT**

No surprise: Epic took the No. 1 spot in this category too. But what made it more of an outlier is that this is the category where Epic essentially shattered the competition. They were rated nearly 20 percent better than all the other vendors here. MEDITECH and eClinicalWorks also fared well, earning the No. 2 and No. 3 spots, receiving scores of 6.4 and 6.3, respectively.

Low performers in the support category were NextGen at 5.3, McKesson at 4.6 and Siemens, at 4.1.

Want to get a more detailed breakdown of vendors’ strengths? To see more of the Healthcare IT News EHR Satisfaction Survey, including nine vendor report cards that include rankings in each category, visit HealthcareITNews.com.
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Senate suggests Stage 3 MU delay
Recommendation follows testimony about information blocking by vendors and providers

BY MIKE MILIARD, Editor

AFTER A DAY spent hearing from health IT experts about information blocking practices, Republican Sen. Lamar Alexander, chair of the Senate Health, Education, Labor & Pensions Committee, said July 23 that he’s asked HHS to consider a delay of Stage 3 meaningful use.

Before that hearing on Capitol Hill, Alexander noted he’d heard from many providers that Stage 1 MU had helped spur adoption, that Stage 2 had been a “mixed blessing” — but that Stage 3 was a “whole nother kettle of fish.”

As such, his “instinct,” was to tell HHS Secretary Sylvia Burwell, “Let’s not go backwards on electronic healthcare records, but let’s not impose on physicians and hospitals a system that doesn’t work, and which they spend most of their time dreading,” said Alexander.

“My usual hospital refuses to share my information,” he said. “The electronic systems at both hospitals don’t talk to each other. My usual hospital says it will charge Vanderbilt a huge fee to send my electronic medical record to them. That’s an example of something physicians buy into, rather than something they dread.”

That morning, Alexander mentioned he was curious to hear from industry stakeholders about their thoughts on putting the brakes on the rush toward Stage 3 — “not with the idea of backing up on it,” he said, “but with the idea of, ‘Let’s get this right.’”

The HELP Committee heard testimony from Allscripts CEO Paul Black, DirectTrust CEO David C. Kibbe, MD, and others on one of healthcare’s persistent challenges — and a huge impediment to the industry’s efforts to move toward more seamless interoperability: information blocking on the part of vendors and providers alike.

There are several scenarios through which such data blocking could occur, said Alexander. “My usual hospital refuses to share my information,” he said. “The electronic systems at both hospitals don’t talk to each other. My usual hospital says it will charge Vanderbilt a huge fee to send my electronic medical record to them. That’s an example of something physicians buy into, rather than something they dread.”

“Even if this miracle happens, we will not achieve much in terms of quality or efficiency in the healthcare system.”

JACK McCARTHY, Contributing Writer

“Ignoring the differences among medical providers, and simply requiring all of them to attest to the same measures is not a smart policy,” writes Niam Yaraghi.

The Bipartisan Policy Center to electronic health records is essential in modernizing healthcare — yet, in practice, meaningful use has made it painful and progress thus far has been intermittent.

Indeed, the proposed rules for the third stage of meaningful use, particularly the requirements for greater participation of doctors and hospitals, is now coming under even more fire than the program has seen in the past.

“Given the distance between the proposed rules of the meaningful use program and the reality of the healthcare market, the program’s success should be considered a miracle,” wrote Niam Yaraghi, a fellow in the Brookings Institution’s Center for Technology Innovation, in a post on the think tank’s site. “Even if this miracle happens, we will not achieve much in terms of quality or efficiency in the healthcare system.”

As important as it is to have a successful EHR system, the one currently proposed is failing to live up to its promise and, what’s more, the meaningful use program does not anticipate that medical providers vary in natural practices, Republican Sen. Lamar Alexander, chair of the Senate Health, Education, Labor & Pensions Committee, said July 23 that he’s asked HHS to consider a delay of Stage 3 meaningful use.

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ONC unveils patient safety roadmap

‘We need to ensure health IT enables safe, high quality care’

BY MIKE MILIARD, Editor

A n ongoing battle against medical errors and adverse events, the Office of the National Coordinator has released its Health IT Safety Center Roadmap, putting forth a plan for making IT a better protector of, rather than a risk to, patient safety.

So ONC has drawn up plans for a national Health IT Safety Center that will home in on two big, interrelated goals: “using health IT to make care safer, and continuously improving the safety of health IT.”

“The sluggish progress we’re discussing today most closely stems from one critical deficit: the lack of a strong business case or a true market driver for interoperability.”

Paul Black

organizations and others who are not following available standards in their work, should be required to do so,” he added.

The measures include the percentages of eligible UnitedHealthcare Medicare Advantage members who received a breast cancer screening or colorectal cancer screening.

One thing the government can do, however, is to help work with “trade groups, standards and policies organization, and others to set expectations for interoperability of EHRs and other applications certified as interoperable, especially those that have been federally subsidized within the meaningful use programs,” said Kibbe.

“Ultimately, however, ‘the sluggish progress we’re discussing today most closely stems from one critical deficit,’ said Black. ‘The lack of a strong business case or a true market driver for interoperability.’

From his perspective, Direct Trust’s Kibbe told the HELP Committee that “information blocking by healthcare provider organizations and their EHRs, whether intentional or not, is still a problem for some providers wishing to use Direct exchange, as well as for these providers’ clinical partners who want to be able to exchange Direct messages and attachments with them, and sometimes fail.”

Still, he said, the fault for poor data sharing practices – and the onus to improve them – lies mostly with the private sector, not with feds.

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**Patient matching plan to be tested**

WEDI, HIMSS, MGMA launch Virtual Clipboard

BY BERNIE MONEGAIN, Editor-At-Large

**PATIENT MATCHING** and patient registration could get a boost. Organizations working on the Virtual Clipboard Initiative on July 17 released the design and specifications for its new pilot program.

The Sullivan Institute for Healthcare Innovation is leading the effort. It is collaborating with the Workgroup for Electronic Data Interchange, HIMSS and MGMA. The specifications released July 17 include defined user functionality, pilot scope and functionality. It also documents future strategic design considerations.

“We expect the Virtual Clipboard Initiative to significantly improve the burdensome patient intake process - a critical and overlooked component of the healthcare delivery system,” Devin Jopp, president and CEO of WEDI, said in a news release announcing progress on the initiative. “In an unprecedented collaborative effort, key stakeholders from across the healthcare continuum have come together to define initial standards for mobile healthcare applications,” Jopp added. “Leveraging the technology that many patients already use, the pilot seeks to demonstrate dramatic improvements to the healthcare registration process.”

The initial phase of the Virtual Clipboard Initiative pilot will be to facilitate the automated collection of critical patient health summaries, however the provider who was supposed to receive them will fail to meet the second and third requirements.

About a quarter of physicians have attested to the second stage of the program and are already sharing a large portion of their patients with other providers who were not able to meet the second stage of meaningful use and, thus, are likely unable to generate meaningful use summary care records. “This leads to a situation in which even tech-savvy providers will not be able to fulfill the requirements of the third stage of the meaningful use program, regardless of their intentions and efforts,” Yaraghi wrote.

Rather than force providers to exchange health information under federal regulations, they should be encouraged to invest in EHRs with an eye on the benefits of information exchange for patients, payers and providers.

“Ignoring the differences among medical providers,” Yaraghi wrote, “and simply requiring all of them to attest to the same measures is not a smart policy.”

**Post-acute care’s turn to go digital?**

New CMS rules could provide opening for EHR uptake

BY BERNIE MONEGAIN, Editor-At-Large

WASHINGTON – Proposed new rules for long-term care released by the Centers for Medicare & Medicaid Services on July 16 could spur an uptake of EHRs by nursing homes across the country.

If that uptake occurs, it could be the missing link to making the health system digitally whole. The long-term care sector was left out of the government’s meaningful use program, which, through the HITECH Act, dangled billions of dollars in incentives for EHR uptake in front of medical practices, hospitals and health systems – along with the prospect of penalties further down the road.

More than 15,000 long-term, post-acute care facilities – large and small, nonaffili-ated and networked – provide care for about 1.5 million Medicare and Medicaid patients across the country.

The proposed CMS rules, detailed in 403 pages, go broad and deep, focusing on improving the quality of care for these beneficiaries. They also call for better oversight. There is no mandate for using EHRs, no incentives for adopting EHRs and no penalty for sticking to manual ways of doing business.

However, the proposed rule would require nursing home and long-term care facilities to send patient care summaries to the nursing facility receiving the patient in the event of a transfer. It would not require the summary to be in digital form.

While the new rules would not require EHRs, the language does urge their adoption and use.

“We encourage facilities to explore how the use of certified health IT can support their efforts to electronically develop and share standardized discharge summaries,” CMS writes in its proposed rule.

Some post-acute care insiders view the new requirement as an opening to ask for help on the digital front.

Majd Alwan, senior vice president of technology at LeadingAge and executive director of its Center for Aging Services Technologies, recognizes that electronic transmission and the adoption of an electronic medical record system is not a mandate under the CMS proposed rule.

“But, it is generally going to drive more and more reliance on these tools and will significantly improve administrative efficiency – while at that same time bring together a powerful alliance of patient advocates, providers, health plans and vendors, the Sullivan Institute, along with WEDI, are forging a clear pathway forward to better patient care.”

“The Virtual Clipboard Initiative pilot is an important step forward as we progress in the multi-phased approach of re-engineering the flow of healthcare information between health plans, patients and providers,” Lisa Gallager, vice president of technology solutions for HIMSS, added. “HIMSS is eager to bring the work we’ve undertaken with the other aligned organizations to fruition in this pilot phase of the Virtual Clipboard Initiative.”

CHIME, which represents more than 1,400 CIOs and other health IT professionals, has also taken on patient matching as a critical patient safety issue to solve. Earlier this year, the organization announced a million-dollar challenge to anyone who could come up with a solution. CHIME CEO Russell P. Branzell called it an “ethical duty” for health IT professionals.

AHIMA, too, has called for technology that addresses the patient-matching conundrum.

“One of the largest unresolved issues in the safe and secure electronic exchange of health information is a nationwide patient data matching strategy that would ensure the accurate, timely and efficient matching of patients with their healthcare data across different systems and settings of care,” AHIMA wrote in the online research journal Perspectives in Health Information Management.

While other providers do not send electronic summaries, however, the provider who was supposed to receive them will fail to meet the second and third requirements.

About a quarter of physicians have attested to the second stage of the program and are already sharing a large portion of their

**STAGE 3**

CONTINUED FROM PAGE 9

ure and each operates in a unique environment.

Here’s the rub: Stage 3 of meaningful use for EHR implementation requires providers to send electronic summaries for 50 percent of patients they refer to others, receive summaries for 40 percent of patients who are referred to them and reconcile past patient data with current reports for 80 percent of such patients. If other providers do not send electronic summaries, however, the provider who was supposed to receive them will fail to meet the second and third requirements.

Based on a number of state surveys he’s seen, his educated guess is that 80 to 93 percent of nursing homes use an EHR today. And, a LeadingAge survey of 150 of the organization’s largest member providers, shows the number of long-term care facilities employing an EHR is at 75-76 percent.

He also cautions against increasing the gap between the rural, smaller, non-affiliated providers versus the larger, networked providers that already have implemented these technologies.

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EHR vendors assessed, by customers large and small

I F THE Department of Defense had access to the firsthand opinions in Healthcare IT News’ first-ever EHR Satisfaction Survey, would it have made the same choice it did this summer? When it finally made its pick for that massive and much-anticipated EHR modernization project, the DoD said “market share was not a consideration” in tapping Cerner over rivals Epic and Allscripts.

Instead, as DoD officials told Healthcare IT News (see page 20) it was looking for a vendor that could offer “minimum modifications to the software,” the ability to work with modular capabilities from other vendors, robust training and support offerings and a commitment to interoperability as “a vital piece of care coordination.”

Those were many of the same criteria that cropped up over and over again in the comments submitted by 196 users and managers of nine different EHR systems, who weighed the pros and cons—often with decidedly colorful language—of the tech-

A variation of the phrase “too many clicks” appeared more than a dozen times in our EHR Satisfaction Survey.

ology in which their organizations have invested so much time and money.

As it happens, Cerner was a fairly high scorer on our inaugural survey—as was Epic (which came out on top across every metric) and Allscripts, for that matter.

Our readers variously applauded “custom-izability,” vendor support teams “responsive-

The future of patient-generated data

Components are evolving that will fundamentally change the way we deliver care

BY JOHN HALAMKA, MD, BIDMC

I HAVE OFTEN WRITTEN about the IT strate-
gies of accountable care organiza-
tions and the need for a care management medical record, which incorporates EHR data, patient generated data, customer relationship management features, protocols/guidelines and a workflow engine.

Although I have yet to see mature products in the marketplace, components are evolving that will fundamentally change the way we deliver care.

People know that I have been very tran-

sparent about my own medical history. Here’s how I’m using patient-generated healthcare data in my own care management activities.

For the past 15 years, I’ve had a supraventricular tachycardia, an AV nodal reentry syndrome. My resting heart rate is 45-50 beats per minute. On hot days, after I’ve eaten, my heart rate leaps to 170 beats per minute if I exercise vigorously then suddenly stop. I perform a Valsalva Maneuver and within a few minutes, my heart rate returns to normal.

I’ve never had any lasting consequences from this SVT. I could take beta blockers, have an ablation of the ectopic pacemaker in my heart, or just accept that a few times per year I’ll have an arrhythmia. I’ve chosen the later.

We’ve attempted to capture an ECG of my arrhythmia, but have never been successful. We’ve tried to stress test, a Holter monitor, and other wearable approaches. It occurs too infrequently to capture.

We now have a solution. I have attached an AliveCor ECG monitor to my iPhone 6. The next time I have symptoms, I’ll just hold my phone and capture a perfect Lead I ECG.

From my phone, I can send it after capture to my PCP and the BIDMC electrophysiol-
ICD-10: Pick your own adventure

Charting a proper course might lead to a veritable treasure trove of data. Or providers could lose their way and smash into sunken productivity and minimum compliance. Which direction will you navigate?

BY TOM SULLIVAN, Editor-in-Chief

VEN THOUGH it has felt, perhaps, as if the opposite was true for several years, hospitals and medical practices are captains of their own ICD-10 ships – a fact that is more apparent now, literally days from shore, than ever before.

A caveat: If Congress has somehow sunk the ICD-10 boat with a piece of last-minute legislation between the time I scribbled this and that moment you're gazing upon it, well, then either bookmark it for future reference or tear this page out and pet it to your office wall.

But for now, as masters at the wheel, it's imperative to navigate past the cliffs of productivity, avoid flouting in iron otherwise known as minimum compliance, and chase that chest – the one containing riches in the form of more granular patient data.

Ready to hoist anchor and begin the journey?

Hospital leaders already educating staff and training coders might as well look beyond the cliffs and skip to minimum compliance.

Data-savvy CIOs and their IT shops, meanwhile – the ones that have remodeled systems, mapped out analytics tactics and plotted ways to put ICD-10 data to work – can bypass both chapters and head straight to the pot of population health gold.

CHAPTER 1: ABOUT THOSE CLIFFS

Much the way explorers once believed the world to be flat – that if one sailed far enough into the horizon boat and crew would ultimately fall off the world's edge and meet their makers – the productivity of medical coders is widely expected to tumble over a cliff come Oct. 1, 2015. ICD-10-CM and its approximately 69,000 diagnosis codes (ICD-9 has about 14,000), the dissenting argument goes, will require more effort to locate codes – the idea being that clinicians previously selecting from a handful of options to find a patient's condition will now have to pinpoint the best one among a greater number.

The ultimate upside to that granularity may one day be discovered among presently buried treasure, but in the near-term it's more likely to complicate matters.

A prominent example of this: When Canada set sail to ICD-10, it experienced a dip in coder productivity that estimates project was somewhere between 25 percent and 50 percent and still hasn't fully come around. I'd imagine it's safe to say that varied from one coder to the next but, obviously, their experience shows that the new classification system will hurt at first. Whether or not proficiency ever returns to ICD-9 levels here in America is anyone's guess. The harsh reality is that to maintain current productivity rates, in addition to educating and training existing staff, you'll grapple with the need to hire more coders.

There goes some of that found treasure. Provider and IT leaders interested in understanding degrees of compliance, keep reading. Those who already know they're gurning for more can skip ahead to this column's final chapter.

CHAPTER 2: COMPLIANCE

Whereas it’s far too early to define any notion of maximum compliance, the phrase “minimum compliance” has been bandied about for years now, and the Centers for Medicare & Medicaid Services’ surprising recent treaty with the American Medical Association inevitably wrinkled the sails of what, exactly, it will mean to meet the ICD-10 mandate.

So-called minimum compliance could look an awful lot like this: Providers will repurpose clinical software, EHR, revenue cycle and any other systems that ICD-10 touches – and essentially spend the year learning ICD-10 one necessary code at a time, falling back on “unspecified” when apropos, knowing that CMS will reimburse those claims so long as they're submitted in ICD-10 and not ICD-9.

One potential pitfall within this approach is that among small and even some mid-sized providers, the temptation to defer to “unspecified” is fierce, which will only inhibit the nation's trek to a land with more detailed information for the greater good. The way things stand today, however, that will only last for one year, after which healthcare organizations of all sizes must use ICD-10 with accuracy to collect payments from CMS.

You've made it this far. Now it's time to hunt for that treasure chest.

CHAPTER 3: POPULATION HEALTH POT O' GOLD

Congratulations, you've arrived at the unknown. Treasure maps tease of accurate and dense data sets that everyone from academicians, clinicians, informaticists, researchers and scientists, in some cases patients themselves, can tap into and discover a deeper understanding of chronic conditions, disease states – even genomics, to a certain extent – to tailor precise and personal treatments that bolster outcomes for individuals and populations. Indeed, population health and, beyond that, precision medicine, represent a new world of sorts. Like all uncharted territory, the only way to know whether it is really full of fertile soil, or arid and craggy, is to actually go there.

ICD-10 is a key spot on those geographies not just for its greater specificity but also because, at this point, ICD-9, an antiquated 30-year-old classification system, is dried up and not expandable to include new codes that keep pace with so many exciting revelations emerging out of the medical community. Here’s the rub, though. No precedent exists for harnessing big iron and impactful analytics software to dig out information from buried treasure within this new data chest? There's inevitably plenty of bounty to be had for providers who can manage the latter.

Time to write your own ending. •

“It’s clear to me that patient wellness (rather than treating sickness) will require more objective and subjective data than we gather today.”

As part of my initial assessment, I’m using a Withings Wireless blood pressure monitor with my iPhone 6.

I’m taking readings when I first wake up, before/after the Massachusetts Turnpike commute, at the end of the business day, and before bed.

Thus far, I'm seeing normal blood pressures on weekends after a day of farm work. I'm seeing 140-150s after the commute. In case you’re not familiar with driving in Boston, it looks like this.

After a 12 hour day of meetings, I've seen a few spikes to 160, then a return to 130s by bedtime.

All of my measurements are uploaded automatically to the BDIMC electronic health record from my phone within one second.

The cost of this level of monitoring is $120.

I also use a Withings Pulse to monitor my steps/elevation/distance/calories burned/ pulse/pulse oximeter and a Withings Smart Body Analyzer to track my weight/body mass index.

All of this data is displayed with a variance analysis on my phone.

I’m not endorsing these products and have no financial relationship with either AliveCor or Withings. I’m simply describing my experience that an iPhone 6 can become a middleware hub for healthcare information, enabling me to be the steward of my own data and share it with a healthcare system/provider at minimal cost.

The devices are easy to use and there is end-to-end data integrity from point of origin (the measurement) to point of use (the doctor).

It’s clear to me that patient wellness (rather than treating sickness) will require more objective and subjective (pain score, mobility, mood) data than we gather today. EHRs are not yet optimized for incorporating the new technologies in the care management medical record used for team-based coordination of lifetime care, must leverage the power of new healthcare enabled mobile devices. •

Insight

Innovation Pulse

Tom Sullivan

Data

CONTINUED FROM PAGE 14

ogy expert for review. It will be reassuring to know that I do not have episodic atrial fibrillation or an untreatable ventricular tachycardia.

The cost of this technology is $70 dollars. Although my body mass index has been constant at 22 for the past 15 years and my caffeine free, low sodium, vegan diet has kept me healthy, my genome is finally catching up to me and I'm starting to experience the essential hypertension (systolic of 140-150) that has been present in generations of both sides of my family.

Diet, exercise, blood pressure monitoring, vitamin D (may be helpful), and salt restriction are reasonable first approaches. If they fail, then thiazide diuretics, calcium channel blockers or ace inhibitors are the next step, presuming there is no underlying root cause to treat.

Choose your fate: Will you comply minimally, just enough to get paid? Or implement robust technologies to uncover buried treasure within this new data chest?

ICD-10 data. Yes, it’s true that several other developed nations made the switch to ICD-10 years ago, that much we know. We just don't have an “X” marking the spot so the U.S. or anyone else can see where ICD-10 triggered substantive improvements in patient care and illustrating exactly how to land there.

But does that mean it's impossible, you ask? Of course not.

I’d argue the opposite – no health-care entity, for that matter – has yet been in a position to make use of ICD-10 data for population health or precision medicine. The technology simply wasn't there at the onset.

When our neighbors to the north transitioned to ICD-10 between 2001 and 2004, for instance, the armada of advanced analytics tools for healthcare was smallish, big data and cloud computing were not household buzzwords and, since that pre-dated the HITEX Act, neither were electronic health records.

Today’s providers, rather, have reason access to those products as well as ICD-10-centric tools including clinical documenta tion improvement and computer-assisted coding software, natural language processing, a burgeoning cadre of apps, and many online gadgets, like free code conversion sites.

None of those, however, are guarantees of success. There's simply no way to tell yet whether ICD-10 will yield untold riches or merely be a bucket of fool's gold.

And this is where I surrender the captain's wheel to you, dear reader, to steer toward your own fate: Will you comply minimally, just enough to get paid? Or implement robust technologies to uncover buried treasure within this new data chest? There's inevitably plenty of bounty to be had for providers who can manage the latter.
CLINICAL

UMass Memorial picks Epic for EHR
Also unveils plans to offer virtual physician visits for common health issues

By Bernie Monegain, Editor-at-Large

UMASS MEMORIAL Health Care will be rolling out an Epic EHR system to replace its Soarian EHR from Siemens. Siemens is now part of Cerner. There was no formal announcement.

― Epic is coming,‖ UMass Memorial President and CEO Eric Dickson, MD, wrote in a blog.

―Today I signed one of the most important contracts I have signed since becoming CEO ten and a-half years ago,‖ Dickson wrote. ―I signed the contract to install Epic as our enterprise-wide electronic health record and billing system! Why Epic? It basically came down to one thing: Hundreds of our caregivers tested the options available to us, and they resoundingly selected Epic as the best system.‖

UMass Memorial is the largest not-for-profit healthcare system in Central Massachusetts with more than 12,900 employees and 1,670 physicians.

CIO Tim Tarnowski and his team worked closely with a task force headed by Bill Corbett, MD, and Matthias Waltz, MD, during the evaluation of potential software solutions, Dickson wrote. The task force ranked Epic highest on important evaluation criteria.

On the same day Dickson announced the Epic move, UMass Memorial also introduced virtual physician visits for diagnosis and treatment of common health concerns.

The hospital has partnered with Zipnosis, a Minneapolis-based company, to provide an online diagnosis and treatment service that will connect patients to UMass Memorial clinicians online to receive care for common medical conditions, such as sinus infections, colds and flu, female bladder infections and pink eye.

Starting this coming October any of UMass Memorial Health Care’s 12,900 employees who have a UMass Memorial provider will be able to use the new service.

The healthcare system plans to extend the service to the public in early 2016 for a flat fee that may be covered by insurance. The service is available 24-hour a day, with provider diagnosis and treatment available from 7 a.m. to 10 p.m. daily. Requests that come after hours will be prioritized for response in the morning.

UMass Memorial is working with Zipnosis, a software company that helps healthcare providers offer virtual care services to diagnose, treat or triage more than 90 minor medical conditions.

―Through our partnership with Zipnosis, we are excited to give more patients access to fast, affordable mainstream medicine in minutes,‖ said Dickson in a statement. The platform, as he explained, ―will allow us to make high-quality care from our own clinicians available to patients where and when they want to receive it, at an affordable price.‖ He added that virtual visits were conceived as a critical component of UMass Memorial’s commitment to growing our virtual medical capabilities.

―We’ve long offered cutting-edge virtual care for the most serious conditions – for instance we remotely monitor patients in more than 14 intensive care units across the state through our eICU program, and our uTelesurgery program which covers eight hospitals, representing 887 inpatient beds,‖ Dickson noted.

New app monitors signs of depression
Researchers at Northwestern University’s department of preventive medicine have developed a novel mobile health application that aims to take on a disorder affecting 16 million adult Americans each year, one that costs the $210.5 billion. The app they’re calling Purple Robot, requires “no effort on the part of the user,” David Mohr, director of Northwestern’s Center for Behavioral Intervention Technologies, says. “The significance of this is we can detect if a person has depressive symptoms and the severity of those symptoms without asking them any questions.” Purple Robot monitors phone use — data suggests the more you’re using the phone, the higher the chances you’re depressed.

NYU Langone launches brain injury effort

NYU Langone Medical Center will launch the first mental health consortium of its kind in New York City dedicated to improving the diagnosis and treatment of post-traumatic stress and traumatic brain injury, thanks to a $1.5 million gift from the Home Depot Foundation. The funding will make it possible for the Steven and Alexandra Cohen Veterans Center at NYU Langone to spearhead the establishment of the Greater New York City Military Family Clinic Consortium Coordinating Center. The center’s principal mission is to create an integrated mental healthcare network of academic medical centers that provide mental health services to veterans and their families.

CDS helps reduce false-positive diagnoses

Children’s Hospital of Pittsburgh of UPMC’s electronic surveillance framework for hospitalized kids is poised to significantly reduce false-positive identification of serious health conditions. This according to new peer-reviewed research published today in the journal Pediatric Critical Care Medicine. The retrospective study of 16,239 Children’s Hospital pediatric admissions between January 2006 and December 2013 compared the use of vital signs, a common indicator of patient condition, to that of Perlman’s Pediatric Rothman Index, or PRI. The research, conducted by Children’s Hospital clinicians, found that use of vital signs alone led to false-positive identification of serious events 46 percent of the time. The PRI had a false-positive rate of just 1 percent.

Hospitals turn to apps to help curb readmissions

Goal is to engage patients in maintaining their health

By Sherree Geyer, Contributing Writer

NYU Langone, MD, chief quality officer at Cleveland Clinic, sees burgeoning use of mobile technology at the health system. While emphasizing that, of course, “some readmissions are clinically appropriate and necessary,” Deyling says Cleveland Clinic, like so many other hospitals and health systems these days, is putting a focus on “reducing preventable readmissions through improved patient education, follow up, communication and care coordination.”

Smartphones are playing a big part in helping them get there.

―We have apps in development that will support access by allowing patients to quickly identify local Cleveland Clinic resources, including on-demand scheduling,‖ she says. ―Other tools, including apps that promote patient wellness and chronic disease management, are also in use.‖

A 2014 study from the Mayo Clinic showed that patients who used smartphone apps to record weight and blood pressure — and participated in cardiac rehab — lowered cardiovascular risk factors and 90-day readmissions. According to the study, 20 percent of the app-user patients experienced readmission compared to 60 percent of patients who completed rehab only.

Another mobile technology survey from HIMSS this year suggests, “healthcare organizations are widely beginning to deploy mobile technologies with the aim of engaging patients.” Use of mobile technology continues to interest providers as a way to meet requirements for meaningful use and Medicare reimbursement requirements, the study shows.

Andrey Ostrovsky, MD, CEO of Bos-
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Apple’s HealthKit in the real world
Platforms like HealthKit and Qualcomm Life’s 2net bring plenty of promise but also raise a few eyebrows about data quality

BY ERIC WICKLUND, Contributing Editor

The introduction of HealthKit and ResearchKit appears to be a watershed moment for both medicine and telehealth tools. These innovative platforms are seen as the missing link that tied consumers to providers in real time and remotely. Now anyone with an iPhone can gather, track and send health data to a doctor or researcher who, in turn, would have access to a large segment of the population.

“This is an inflection point for medical research,” said Corey Bridges, CEO of LifeMap Solutions, which helped develop the Asthma Help app – one of five unveiled for ResearchKit at its launch – and is engaging in a study with Mount Sinai Health’s Icahn School of Medicine. “This will lead to larger and much more interesting studies.”

Apple may get most of the attention in this space, but it’s not alone. Qualcomm Life, for instance, offers the 2net hub that draws data directly from the device, be it a mobile monitor or home-based unit, without any human intervention. The data is pulled into the cloud, where it’s analyzed and used by researchers and providers.

When HealthKit hit the stage in mid-2014, it was immediately embraced by healthcare providers who wanted a reliable means of connecting with consumers outside the hospital setting. By this spring some of the nation’s largest health systems had launched HealthKit pilots – among them Stanford University and Duke Medicine.

Stanford Health Care’s CEO Amir Dan Rubin described that engagement as ‘highly effective.’

“It’s nice to have direct access to your patients, but that only 36 percent described that engagement as ‘highly effective.’”

The biggest challenge and opportunity is to fully optimize and leverage the wide capabilities that mobile technologies and platforms offer, according to the report. Another wrinkle is that 2 percent of current apps achieve the HIPAA Triple Aim of improving the patient experience and population health and reducing per-capita costs – with only 23 percent having any peer-reviewed research evidence for their claims,” says Oresky.

He offers the following guidelines to help direct effective technology selections. Technology should:

• Be evidence-based;  Validate quality improvement claims within six months of deployment; Support National Quality Forum Committee measurements;
• Produce positive outcomes for reimbursement;
• Identify risk factors for patients;  Improve workforce quality and satisfaction;
• Be platform agnostic;
• Adhere to interoperability standards;
• Sustain long-term supports and services;
• Provide technical assistance for baseline capacity.

Mobile apps represent “a natural home for telemedicine” and patient appointments according to “The ROI of Patient Engagement: Readmissions Reduction” from Axial Exchange, a Raleigh, N.C., developer of hospital mobile technology.
New tech in the works to avert falls

It’s a small piece of White House’s sweeping agenda for the country’s aging population

BY BERNIE MONEGAIN, Editor-at-Large
WASHINGTON – Healthcare IT giant Epic is working on a clinical decision tool aimed at helping healthcare providers reduce the risk of falls in unsteady patients. The technology is expected to be ready and available to Epic’s EHR clients by year’s end.

Longtime Epic customer Kaiser Permanente will roll out the tool at its facilities across the country and will also make its evidence-based falls prevention program widely available to other health systems and health plans.

The technology is called STEADI, an acronym for Stopping Elderly Accidents, Deaths & Injuries. The tool is being designed based on CDC’s guidelines for falls assessment. The goal is to make it easier for healthcare providers to screen for falls, intervene to reduce risk and provide follow-up care.

The announcement came at the end of a White House Fact Sheet released July 13 regarding The White House Conference on Aging, which President Barack Obama hosted that day.

The conference agenda focused on issues facing Americans as they plan for retirement. Many of the measures proposed build on the Affordable Care Act and on efforts to improve Medicare and Medicaid.

“In a year that marks the 50th anniversary of Medicare, Medicaid and the Older Americans Act, as well as the 80th anniversary of Social Security, the White House Conference on Aging is an opportunity to recognize the importance of these programs, highlight new actions to support Americans as we age and focus on the powerful role that technology can play in the lives of older Americans in the decade ahead,” the White House announced.

The preventive fall technology that is in development is called STEADI, an acronym for Stopping Elderly Accidents, Deaths & Injuries.

FEDERAL DATA TO BE RELEASED
The Administration announced that by September 2015, federal data sets relevant to aging and to elderly Americans would be made easily available on Data.gov, the repository for the U.S. government’s open data. This resource will continuously be updated with datasets on aging, much like it is for other important Administration priorities such as climate, public safety and education.

HEALTH IT EFFORTS
Like Epic’s, several of the planned projects surrounding the aging initiative have healthcare IT underpinnings. These are put forward by the private sector:

As part of its annual HackFest, LeadingAge, an association of 6,000 not-for-profit organizations and businesses representing a broad field of aging services, will partner with Hewlett-Packard using HP’s 3D immersive computing platform and federal open data to challenge innovators to create technology-driven tools to improve the lives of older adults and their families.

The employer coalition ReACT (Respect a Caregiver’s Time), Care.com and the Massachusetts Institute of Technology are joining forces to generate the tools employers need to effectively support employees who are caregivers. MIT and Care.com will jointly conduct a case study based on MIT’s approach to employer-supported elder care.

Uber is announcing pilot programs in Florida, Texas, Ohio, Arizona and California that will partner with senior community centers and other advocates to provide free technology tutorials and free or discounted rides to older Americans to increase access to transportation options and support mobility and independence.

Airbnb has conducted research to support and understand the experience of older Americans in their travels and in their use of technology and is partnering with communities to enhance accessibility and the user experience for older populations.

Walgreens has made advancements in its digital technologies to connect individuals with their telehealth services provider, which offers 24/7 access to U.S. board-certified doctors. Seniors also can track their health behavior with personal wellness smartphone technologies from Walgreens and WebMD.

Peapod has adopted “best in class” Web accessibility standards to ensure that all individuals, including those with disabilities and those who are unable to shop at traditional stores, can use its website and mobile applications.

Honor, a tech-enabled company that matches seniors with care professionals, will offer $1 million in free home care across 10 cities in the country and work with established care providing organizations in those communities to ensure this care goes to helping older Americans.

The University of Washington’s School of Nursing and the HEALTH-E (Home-based Environmental Assisted Living Technologies for Healthy Elders) initiative are introducing an Aging and Technology Laboratory, which includes hardware and software tools to support participatory design of technology for older adults.

The laboratory will allow scientists, engineers and others to engage older adults and their families to accelerate the generation of new solutions to support aging.

The Stanford Center on Longevity will develop a State of Longevity Index to be released in early 2016 that will measure how well the U.S. is doing to improve the prospects for long-term well being in financial security, physical health, social connectedness, educational attainment and age-friendly communities.

IDEO is announcing the launch of “The Powerful Now,” a project to build a cross-sector collaboration around positive aging for all.

Among the planned government initiatives:

Facilitating state efforts to provide workplace-based retirement saving opportunities: About a third of the workforce lacks access to a workplace retirement plan, the White House notes. That’s why, in every budget since taking office, the President has put forth proposals to provide access for 30 million Americans to workplace-based retirement savings by requiring employers not currently offering a retirement plan to automatically enroll their workers in an IRA.

But in the absence of Congressional action, the states are leading the charge.

Launching Aging.gov – today: The intent is to provide older Americans, their families, friends and other caregivers, a one-stop resource for government-wide information on helping older adults live independent and fulfilling lives.

Modernizing federal rules that affect long-term care, healthy aging and elder justice: Steps announced in July include: a new Centers for Medicare and Medicaid Services proposed rule to update, for the first time in nearly 25 years, the quality and safety requirements for more than 15,000 nursing homes and skilled nursing facilities to improve quality of life, enhance person-centered care and services for residents in nursing homes, improve resident safety, and bring these regulatory requirements into closer alignment with current professional standards.

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Cerner scores landmark EHR contract

By Tom Sullivan, Editor-in-Chief

The U.S. Department of Defense handed down the largest and most-anticipated electronic health record system contract in history on July 29. The team of Cerner, Leidos and Accen- ture was picked for a contract whose ini- tial piece, valued at $4.3 billion, calls for the team to provide “an electronic health record off-the-shelf solution, integra- tion activities and deployment across the Military Health System,” a DoD spokes- person told Healthcare IT News.

DoD’s choice, in the end, came down to three teams: the Cerner group; Epic Systems and IBM; and Allscripts aligned with Computer Sciences Corp. and Hewlett-Packard. “Market share was not a consideration,” said DoD Under Secretary for Acquisition, Technology and Logistics Frank Kendall. “We wanted minimum modifications.”

“Market share was not a consideration,” said DoD Under Secretary for Acquisition, Technology and Logistics Frank Kendall. “We wanted minimum modifications.”

“We believe that, like in so many other transactions, we have an opportunity to take advantage of private sector innovation,” said Assistant Secretary of Defense for Health Affairs Jonathan Woodson, MD. He added that during the process of choosing a vendor, DoD officials visited with many health systems to learn how they transition from proprietary to commercial EHR systems.

Part of DoD’s requirement, in fact, was that the EHR interoperate with pri-

Cerner headquarters in Kansas City, Mo. urged DoD to choose an open-source EHR system that would be “extensible, flexible and easy to safely modify and upgrade as technology improves and interoperability demands evolve.”

“DoD is about to procure another major electronic (health records) system that may not be able to stay current with – or even lead – the state-of-the-art, or work well with parallel systems in the public or private sec- tor,” the authors wrote. “We are concerned that a process that chooses a single commercial ‘winner’, closed and proprietary, will inevitably lead to vendor lock and health data isolation.”

The authors of the report urged DoD to show some leadership. “We believe that, like in so many other

Is Cerner deal good for DoD?

Some have big doubts

By Bernie Monnegain, Editor-at-Large

SOME OBSERVERS WEIGHING IN on the $4.3B EHR modernization contract the Department of Defense signed with Cerner on July 29 think the government could have missed a better play.

Indeed, the announcement comes at the same time that Congress and the Administration are heavily invested in finding the answer to the question: How is it that most of the systems in use today still don’t talk to each other after $30 billion being invested?

“At the front end, it strikes me as unfortunate and puzzling that we’re about to put another $10B – conservatively – into one of the very systems responsible for the supposedly unacceptable status quo,” Dan Haley, vice president, government and regulatory affairs at cloud-based health IT company athenahealth, told Healthcare IT News in July, hours before DoD announced its selection.

To Haley, that reaction was not particu- lar to Cerner, Epic or Allscripts, the three contenders left in the running for the 10-year government contract. Regardless of the ven- dor, he said, it calls to mind the old insanity saw about repeatedly doing the same thing and expecting different results.

“The finalists are all very good, very credible purveyors of data software sys- tems that aren’t very good at exchanging information outside of their platforms,” he added. “Not because they don’t want to be, but because they’re not built for that. They’re pre-Internet platforms. They were literally created to share information within the confines of a closed network. And now they’re jerry-rigged to share information outside themselves.”

That, he says, is an expensive proposition, and Haley has some influential company to bolster his position.

Back in February the Center for New American Security released a report that

Athenahealth offers free texting for providers

Athenahealth has launched athenaText, a secure text messaging service integrated with athenahealth’s cloud-based EHR platform. It is available free not only to the more than 1 million healthcare professionals on the athenahealth network, but also to every healthcare professional across the country. The service is accessible through the standalone athenaText and also via Epic’s and mobile apps. Any healthcare professional can join the athenahealth network by accessing athenaText at no cost via mobile. This new service makes it possible for physicians to more easily coordinate care, according to athenahealth executives.

Limelight Health lands $3M in funding

Limelight Health, a provider of mobile enterprise technology for the health insurance industry, has received $3 million in Series A funding from MassMutual Ventures, the corporate venture capital arm of Massachu- setts Mutual Life Insurance Com- pany and AXA Strategic Ventures. Also investing in the round is the series seed lead investor LaunchPad Digital Health. Limelight will use the funds to help grow its sales and engineering teams, to enhance its cloud-based SaaS technology platform and to expand distribution nationally. QuotePad, Limelight’s first commercial product, provides a mobile, data-driven quoting and modeling platform that enables health insurance professionals to simply and quickly quote and compare employee health insurance benefits information.

NantHealth completes Harris acquisition

NantHealth announced on July 16 it had completed the acquisition of Harris Corp.’s commercial health-care solutions business. Harris, a clinical integration system com- pany, has retained its government healthcare services business. By combining NantHealth’s existing platforms with Harris’ FusionFX suite, NantHealth executives aim to bring molecular medicine insights directly to the point-of-care. The terms of the deal were not disclosed. It comes on the heels of NantHealth’s strategic alliance with Allscripts and its dbMotion semantics engine. The two companies announced back in March they would collaborate on the development and delivery of precision medicine at the point of care.
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How one hospital turned its finances right side up

On track for $18M boost by year’s end

BY ERIN McCANN, Managing Editor

The Camden Clark Medical Center in Parkersburg, W.V., had a serious financial problem. It had been cited for regularly having “poor operating performance” and was posting operating losses of more than $6 million and $35 million in 2012 and 2013, respectively.

But after bringing in a consulting firm that helped change its care management processes and optimize its IT systems, the hospital is now on track for an $18 million improvement by year’s end.

It wasn’t just one issue that set the stage for CCMC’s poor financial performance. There were health system-hospital integration factors (CCMC recently joined West Virginia United Health System). There were factors related to bad payer mix. There were location factors, making it difficult to find qualified employees in the area. And some of the hospital’s processes needed serious reworking.

Enter Accenture, which the hospital retained starting in October 2014, to help with care management shortcomings and to overhaul its employee physician group and IT optimization.

“This project was a lot of process work, and some people and some IT,” Doug Pedersen, managing director of healthcare providers at Accenture Strategy, told Healthcare IT News. “But you have to touch all of them. It’s always better to (be) comprehensive across the system.”

If you go in and just focus on one area, he pointed out, sometimes you fix that one area, but it negatively impacts another.

One of the biggest deficiencies the Accenture team identified was around care management processes that impacted length of patient stays. The hospital’s average LOS was higher than the national average by 4.8 days. So Accenture started implementing daily unit huddles, said Pedersen.

These huddles brought together case managers, the Accenture team, nurses, physicians on call in that part of the hospital so all of them could look at what was happening with certain patients, “so that everyone was clear what needed to happen,” he said.

Then they started what Pedersen described as an “outlier management meeting” -- that is, looking at the patients who had been in the hospital for more than five days and figuring out what they needed to do to discharge them.

A common problem with patient discharges, Pedersen said, is that the hospital isn’t ready to discharge them -- it’s that the patient doesn’t have a ride, or beds aren’t available at a nursing facility.

Part of improving this involved working with and better optimizing the hospital’s bed management system, he said.

The hospital started to organize it so patients who were going to be discharged first were at the bottom of the list on a board at the nursing station. If a clinician’s name was on the top of the list, it meant they’re the one whose patient is being discharged latest in the day.

Thus, the sentiment would be, “Oh, wow, I don’t want to be at the top of the list, so what can I do to get this done? Do I just need to go track down the missing lab, figure out what’s going on with radiology?” said Pedersen.

“The choreography of getting the patient to leave the hospital is tricky,” he added. “Unless you are really structured in your processes and in your IT systems so you can keep track of those things, it’s really easy for a couple patients to just get lost in the shuffle, and all of a sudden they’re there another day.”

The so-called Navigator Program developed at CCMC focused on transitioning these patients out of the hospitals. “Making sure they had rides available, making sure their family members knew,” improving the overall care coordination process, said Pedersen.

In addition to the pre-discharge process tweaks, the initiative also implemented a post-discharge follow-up process that had staff helping to schedule follow-up appointments with primary care physicians.

Another piece of it all, as Pedersen explained, was around centralizing the hospital’s scheduling. This involved more effectively utilizing CCMC’s Allscripts system to have one group of people schedule across all physicians.

This IT optimization and care management work combined with some serious initiatives around revenue cycle management has the hospital poised for an $18 million improvement by the end of 2015, he said.

The hospital’s employee physician group is currently losing about $12 million, but officials expect that number will decrease to $6 million or $7 million. There’s still work that needs to be done, said Pedersen, specifically around revenue cycle and selling off one of the hospitals. But an $18 million improvement is a darn good start.
EHR market expected to grow until 2020

Annual growth rate pegged at 6.4 percent

BY BERNIE MONEGAIN, Editor-At-Large

Paper-based records are being phased out at a rapid pace in healthcare, and digitization and virtualization are creating a whole market within the global healthcare industry, according to Transparency Market Research, or TMR. Researchers say the trend will continue until 2020.

The ball has been set rolling with more than 54 percent of physicians in the U.S. having adopted electronic health record systems by 2011, researchers point out the estimates reported by the U.S. Centers for Disease Control. In the same year, 50 percent of physicians who were not already using an EHR system said they planned to invest in one within the next 12 months.

A similar change is taking place in the U.K., where the National Health Service is slated to go entirely paperless by 2018.

The global electronic health records market is projected to show a CAGR of 6.4 percent between 2014 and 2020. This marks an imminent phase of moderate growth that will largely be seen in traditional markets, according to TMR.

The global EHR market can be segmented based on the way the EHR systems are installed as Web-based or client server-based. Client server-based accounted for the better part of the market share in 2013, when considered from the revenue perspective. But, the CAGR of Web-based EHR systems is expected to be higher through 2020 largely because the systems have only a nominal upfront cost, and do not call for the installation of hardware systems and components.

The market for EHRs can also be classified based on the end-users who purchase such systems. Hospitals were the dominant segment by revenue in 2013, as 90 percent of all hospitals in the U.S. had a certified EHR system in 2013, according to the Annual Health IT Survey conducted by the American Hospital Association.

Most of the hospitals opted for a client server-based EHR because it facilitates faster data transmission between multiple facilities when compared with cloud-based electronic health record systems, according to TMR findings. However, the future growth prospects of the ambulatory centers end-user type are expected to be most promising for cloud-based vendors. With minimal or no upfront costs to ambulatory centers, cloud-based EHR systems offer an appealing solution, researchers say.

About 42 percent of the total global EHR market was held by North America in 2013. The second largest market was Europe, followed by Asia Pacific. Until 2020, these rankings are unlikely to change, as North America will continue to hold a lead over other regional markets supported by solid government funding, according to TMR.

The EHR market is gathering steam in Australia and New Zealand as well as Asian countries such as China, Japan and India. The three Asian economies will exhibit the fastest growth, and will grow consistently to contribute to a major chunk of the market revenues by 2020, according to the report.

The leaders in the electronic health records market have a grip on more than 50 percent of all revenues. The leading players include: Cerner, Epic, Allscripts, GE Healthcare and Epic Systems, according to TMR.
What clinical decision support can learn from a helicopter cockpit

Both pilots and physicians need sound technology for ‘mission-critical activities’

By Mike Miliard, Editor

Before he co-founded clinical decision support developer medCPU, Eyal Ephrat, MD, was a practicing physician. Before that, he was a helicopter pilot. Want to guess which workplace had the more reliable information system?

This past May, Metairie, La.-based East Jefferson General Hospital partnered with medCPU for a new clinical decision support system to help its clinicians make the most accurate decisions at the point of care.

As it worked to prevent adverse patient events such as deep venous thromboembolism, sepsis and stroke, EJGH deployed medCPU technology to help alert physicians and nurses better adhere to clinical protocols and its own treatment guidelines.

“Sitting in a cockpit ... you are completely, 100 percent dependent on the accuracy of the computer system in order to have a safe flight and accomplish your mission,” says Eyal Ephrat, MD.

Toward efforts to offer broader capabilities for population health.

IDC sees a “major shift” in HIE vendor focus – beyond just enabling interoperability, and toward efforts to offer broader capabilities for pop health. Its two new studies take stock of an HIE market far-removed from the grant-funded initiatives of early aughts. The first, which focuses on packaged tools, examines seven companies: Cerner (MobileMD), eClinicalWorks, Informatics Corporation of America, Medicity, Optum, RelayHealth and Transcend Insights.

“Packaged solutions are designed to meet a very specific set of requirements and reduce the risk of uncertainty related to project scope, timelines and costs,” said Lynne A. Dunbrack, research vice president, IDC Health Insights, in a press statement. “Speed to value will be an important consideration for healthcare organizations.”

BY MIKE MILIARD, Editor

HE PUSH TOWARD value-based outcomes means health information exchange technology has new opportunities for value-add, according to reports published in July by IDC Health Insights.

With the expansion of accountable care and patient-centered medical home models, opportunities now exist for HIEs that didn’t fit into a fee-for-service environment, according to IDC.

Now that incentives to exchange data are much more closely aligned than they were under older reimbursement models, platforms have the chance to prove their worth as the need for analytics and ability to aggregate and centralize health information come to the fore.

BY MIKE MILIARD, Editor

New value propositions’ coming for HIE

Exchanges have ‘undergone a significant metamorphosis over the past two years’

Packaged solutions are designed to meet a very specific set of requirements and reduce the risk of uncertainty related to project scope, timelines and costs,” said Lynne A. Dunbrack, research vice president, IDC Health Insights, in a press statement. “Speed to value will be an important consideration for healthcare organizations.”

PCORI invests $142M to expand research

The Patient-Centered Outcomes Research Institute Board of Governors has approved nearly $142.5 million to support the continuing development and expansion of PCORnet, the National Patient-Centered Clinical Research Network. PCORI is an independent, nonprofit authorized by Congress in 2010 to fund patient-centered research. The new funds enable the addition of seven health data networks to PCORnet, which is designed to link researchers, patient communities, clinicians and health systems in research partnerships that leverage the power of large volumes of health data maintained by the partner networks. PCORI is developing PCORnet to conduct effective research less expensively, and with the greatest impact possible.

NextGen connects to Mass Hlway

Healthcare IT company NextGen Healthcare Information Systems has connected to the Mass Hlway, marking the opening of a new secure electronic communication channel for healthcare providers in Massachusetts. This has created thousands of connections across hospitals and eligible professionals across the country. The connection makes it possible for clients who use NextGen Share to exchange patient information with more than 350 organizations connected to the Mass Hlway, the statewide health information exchange. Cloud-based health IT company Athenahealth also recently announced it would connect to Mass Hlway.

ONC awards $38M to boost data exchange

The Office of the National Coordinator for Health IT is disbursing about $38 million in grants to 20 organizations, working to drive better information exchange for care coordination and population health. The grants build on programs funded by the 2009 HITECH Act, and aim to help health data be more widely exchanged among providers, vendors and consumers. “As we move beyond adoption to a learning health system where information is available when and where it matters most, it is important to ensure greater care coordination at the community level,” said ONC chief Karen DeSalvo, MD, in announcing the awards.
When it comes to big data and analytics, the healthcare industry is flooded with fancy tools and models, but at the end of the day, it’s really about how your organization is using analytics to mine data, improve clinical care and, as a direct result, reducing healthcare costs. Join us for two results-driven days of conversation, case studies, and expert insight on how to make the transition to value-based care.

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ICD-10: 3 tips for keeping coders productive

Expecting coder output to crash?
These tactics can help

BY TOM SULLIVAN, Editor-in-Chief

Among the concerns that the mandated transition to ICD-10 brings is a widespread expectation that medical coders will essentially drop off a cliff, productivity-wise, once the compliance deadline arrives.

ICD-10’s greater specificity and more numerous codes, the thinking goes, will make it trickier and more time consuming for physicians and clinicians to find exactly what they need.

To that end, the American Health Information Management Association, in a Journal of AHIMA article, offered three tactics for maintaining productive coding after Oct. 1, 2015, and while these may seem obvious they are nonetheless worth considering if you’ve not already.

1. Training. “This is not just a one-day or week intensive education session,” AHIMA explained. Instead, healthcare entities should provide coders continuous opportunities to practice ICD-10; dual-coding is one option. “It may not be practice to dual-code every chart but even just a couple charts per day is better than nothing at all.”

2. Hire more coders. No one said ICD-10 was going to be easy — or inexpensive. Maintaining the same level of coding productivity you had with ICD-9 might demand more manpower. AHIMA recommends two places to look for new hires: contract coding companies and communite health education programs accredited by the Commission on Accreditation for Health Informatics and Information Management Education.

3. Top available technologies. Existing tools include computer-assisted coding, clinical documentation improvement — even a burgeoning crop of free or inexpensive apps geared to help coders transition to and ultimately use ICD-10. “Coding productivity is predictable to take a dip during the transition to ICD-10,” AHIMA explained. “That dip will be a minor speed bump or a gigantic crater, depending on many factors — which can be mitigated in these last few months leading up to implementation.”

Think about the fact that both pilots and physicians are dealing with people’s lives, with mission-critical activities, seeing how different it is from the experience perspective of the pilot getting very reliable assistance, compared to what I as a physician get from the computer systems, you see how frightening the difference is.”

Eyal Ephrat, MD

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7 pain points of big data

Many datacenters are finding it hard to keep pace with the demands growing information sets are putting on them.

Hospital datacenters are being overwhelmed by the ongoing data explosion. Pushed to acquire, analyze, secure and deliver actionable intelligence to business managers, clinicians or customers, many datacenters are struggling to keep pace. A recent report by the BPI Network, “Accelerate How You Innovate: Data Center Evolution in the Era of the Cloud,” examines how organizations are adapting to a new model of business-responsive datacenters and networks. And as they do healthcare IT leaders are starting down seven critical pain points.

1. Moving datacenters into the cloud. The worldwide market for in-house datacenter equipment and solutions skyrocketed to $122 billion in 2014, according to the report. Yet despite this growth, many hospitals are not keeping up with business needs. What they need is the ability to manage data, including the flexibility to add compute power and storage capacity quickly when needed. Many executives said that due to the choices that companies face trusted advisors will play a key role helping them design the hybrid solution that works best for them as they bring their datacenters into the cloud era, the report said.

2. Mastering compliance and security. Today, cyberattacks spring from foreign governments seeking economic advantage, highly organized criminal gangs who re-sell personal data on the black market, and even competitors gunning for trade secrets. And the more data collected in one place, the report said, the more valuable a target it becomes for hackers. On the compliance side, regulations can be their own nightmare. Each situation needs to be addressed in the context of other regional considerations such as the practices at local telecommunication services, political realities, state regulations, or anything that involves moving data from one point to another, the report said.

3. Job requirements for the new IT. The necessity for better performance is creating demand for technology workers with skill sets that are better-suited to a more agile environment. The report said IT managers, asked what skills they’d be hiring for in the coming year, listed application development (41 percent); help desk/IT support (36 percent); business intelligence and analytics (25 percent); and security (24 percent). The skills and processes associated with running a datacenter have changed dramatically. “The new skills that are needed today are on the application level, not the transmission and physical level or the security level,” says Martin Zuckerman, CEO of Tsysware Technologies, a data center engineering consultancy firm.

4. Regional variations inspire challenge and change. Planning a global enterprise now includes a world divided by borders, privacy laws, energy shortages, temperature ranges, workforce availability and varying costs for reliable telecommunication service, according to the report. While this complex situation may tempt a concerned IT professional to keep his datacenter in place, healthcare organizations that navigate those challenges can expect to find enhanced performance.

5. Enterprise apps. Massive organizational applications, such as enterprise resource planning or customer relationship management packages, traditionally have been driven by on-premise installations but the emergence of cloud-based applications is driving the need for what some call “hybrid ERP” or “postmodern ERP.” The future environment would be a more flexible suite of tools that blends on-premises applications with Software-as-a-Service custom-built applications in the cloud.

6. Automation’s emerging role. The datacenter and software-defined networks will be the next significant step for automation, according to the report. Automation saves money by ensuring a more efficient use of resources. And more importantly it enhances an organization’s ability to scale by reducing complexity, facilitating product development and supporting global expansion.

7. High availability and disaster recovery. A key role for healthcare IT shops is to maintain high availability of service even if the datacenter is destroyed by some natural event. Moving all or parts of a datacenter to the cloud, across multiple locations, can help — presuming, of course, healthcare IT departments can work through this list of challenges.

Vendor’s position interoperability as an enabling technology for population health management and analytics.

Lynne Dunbrack

One interesting takeaway is that there are different buyers for HIE technology, as opposed to more population health-focused tools.

“The focus was on connectivity, the buyer tended to be the CIO who was interested in cutting off fax machines and aggregating the data,” according to IDC. “As HIE evolves into care management and population health management, the new buyers are CFOs and chief medical information officers who are trying to get a handle on risk-based contracts.”
MEANINGFUL USE

Stage 2 still ongoing for many

As Washington looks toward Stage 3 meaningful use, many are still stuck in second gear – but making progress

BY MICHELLE RONAN NOTEBOOM, Contributing Writer

SINCE Stage 2 meaningful use was finalized in 2012, critics have decried the strenuous requirements, especially those tied to patient engagement and transitions of care. Despite objections and relatively low attestation rates in 2014, many eligible hospitals and providers now appear to be on target to attest by the end of 2015.

“Like most people we will wait until the last minute to attest,” said Lyle Berkowitz, MD, associate chief medical officer of innovation at Northwestern Memorial HealthCare, a 1,200-physician multi-specialty group in Chicago. “Meaningful use is not a big problem for us and we are committed to doing it with 100 percent success.”

Similarly, Baylor Scott & White Health’s Central Texas division plans to attest to Stage 2 by the end of the year. “We are tracking our potential success for Stage 2, and it is looking really good,” says one CMIO.

Thomas Thrower, chief information officer for The Austin Diagnostic Clinic, reports that his organization is in the final stages of preparing for attestation after spending significant time updating software and modifying workflows. “We put in our Stage 2 certified code last November and applied a significant number of patches since then to address deficiencies around areas like immunizations and the transition of care.”

Austin Diagnostic Clinic also invested considerable resources to achieve the patient-specific education resource core measure. “Our providers historically have been very good about giving educational information to patients,” explained Thrower. “But our whole workflow had to change in order to have it counted in the EMR.”

“We had to do a lot of work into customizing the basic functionality that was delivered in our software in an effort to accommodate the physician workflow,” said Thrower. “Personally I think this was one of those measures that, while well-intended, actually creates a bit of a disconnect for providers.”

San Diego-based Sharp Healthcare attested to Stage 2 for its hospitals in 2014, though its physicians will attest later this year. Senior Vice President and COO Ken Lawonn said that the two biggest Stage 2 challenges for his organization were preparing for the transition of care requirement and encouraging patients to access the acute care patient portal.

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“One challenge is around the data capture and reporting required for attestation. While the vendors have been certified to do this reporting, it is hard for us as the attestor to know how they are coming up with the numbers. We have to do a lot of analysis to really understand and trust it all.”

Thomas Thrower
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Patient safety: It’s a work in progress

Culture of safety has to come from the top

BY JOHN ANDREWS, Contributing Editor

The key to patient safety is transparency, and while more hospitals are showing a commitment to being more transparent, they are also struggling to provide consistently safe, high-quality care, says one of the leading patient safety advocates in the healthcare industry.

Leah Binder, president and CEO of The Leapfrog Group and identified by Healthcare IT News as one of the industry's most influential figures in patient safety, says a new report from the watchdog group and Castlight Health shines a light on the progress made and challenges that remain for healthcare providers.

The Leapfrog-Castlight report is based on a survey of more than 1,300 hospitals about their performance on hospital-acquired conditions, intensive care unit staffing, safe practices and “never” events.

“We're excited to see a growing culture of safety,” Binder said. “But there is much work to be done.”

Binder says there is a strong need for hospital executives to make it a priority.

“In order for there to be more acceleration, executives must have a safety provision in their contracts,” she said. “We are seeing more of that, which is great progress. But more leaders need to recognize that safety should be at the top of their agenda.”

“GALVANIZING” EFFECT

Binder says there is a strong connection between transparency and change.

“The more transparent a hospital is, the faster change happens,” she said. “It has a galvanizing effect on staff and the public, creating more engagement, highlights strengths, exposes problems and gets people moving.”

To generate more incentives for patient safety, it must be tied to the new value-based purchasing business model, Binder said, and CMS should be doing more on this front.

“I’m happy with what we have so far, but we also need more from payers – a recognition that safety should be included in value,” she said.

Broaching the patient safety issue with providers can be a delicate task because they are under enormous pressure to deliver perfect results every time, Binder said. Even so, she insists the financial aspect of patient safety requires providers’ attention.

“The highest and lowest performers have been paid the same rate and that has to change,” she said.

BATTLING ALARM FATIGUE

When clinicians ignore an urgent patient status alert due because they get too many “nuisance” alarms over the course of a shift, it can jeopardize patient safety and should be seen as a critical issue, says Janet Dillione, CEO of Milford, Conn.-based Bernoulli.

Both the Joint Commission and ECRI Institute identify alarm fatigue as a major hazard and that it should be a top priority for healthcare organizations to correct.

“There are millions of alarms per month – the numbers are staggering,” Dillione said. “Customers are paying attention to it and it has impact on HCAP scores.”

Alarm fatigue has grown as devices have spread beyond the ICU into telemetry, post-op and the medical-surgical units “with no ombudsman to regulate workflow and consisting of multiple vendors, multiple devices, multiple product lines, each with a different heritage and no alarm protocol,” she said. “If you automate a mess, you get a bigger mess.”

In essence, the technology must get smarter, allowing for more discretion, intuition and nuance, Dillione said.

“It’s not enough to broadcast alarms – there needs to be more intelligence applied so that only the most important alerts get to the clinician,” she said. “The notification device can’t just be beeping constantly.”

Because a majority of secondary alerts are technical (a probe or lead fell off the patient) rather than physiological (dramatic escalation in blood pressure), prioritizing the type of alarms can help clinicians discern which alerts deserve immediate attention and which ones can wait, Dillione said.

Forming an interdisciplinary alarm committee that focuses on reducing the number of “nuisance” alarms can also help an organization assuage alarm fatigue without compromising patient safety, she said.

“In order for there to be more acceleration, executives must have a safety provision in their contracts.”

Leah Binder

“The more transparent a hospital is, the faster change happens.”

Janet Dillione

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NEW PRODUCTS

**Agfa introduces new mobile DR system**

**MORTSEL, BELGIUM** - Agfa HealthCare unveiled its new mobile DR system with FreeView telescopic column. Agfa’s FreeView technology creates better maneuverability and ease of use by offering a telescoping column for an unobstructed view while driving the mobile DR system. Agfa executives say. The highly maneuverable, wireless DX-D 100 direct radiography unit combines full mobility with Agfa HealthCare’s gold-standard MUSICA image processing, enabling high-quality radiology exams to be efficiently performed in mobile environments, including intensive care units, operating rooms and at the patient bedside. With the new FreeView technology, the telescopic column of the DX-D 100 can be collapsed when moving and positioning the system.

**ECRI aims to boost decision-making with TruVu**

**PLYMOUTH MEETING, PA** - ECRI Institute introduced TruVu, an interactive decision support tool that is an addition to its SELECTplus suite of decision-making products. TruVu is designed for supply chain and healthcare leaders. The technology accelerates and improves complex decision-making, especially for the purchase of high-priced capital technologies, by engaging all stakeholders in an unbiased, transparent value-based process, according to ECRI executives. TruVu combines the collective intelligence of ECRI Institute’s technology and research experts with an intuitive, interactive, visual software platform that helps hospital value analysis teams, decision-support staff, physicians and C-level executives make objective, value-based decisions faster.

**HealthStream app automates compensation workflow**

**NAVIDALE, TN** - HealthStream, which develops workforce, patient experience and provider technology for the healthcare industry, has launched HealthStream Compensation Planner, which company officials describe as a full-featured, SaaS-based application for compensation management in healthcare organizations. With the Compensation Planner, healthcare organizations can automate time-consuming workflows, eliminate spreadsheets, make the best possible recommendations for salary increases and incentive awards, and simplify budget definition and approval processes all through an application with the highest levels of accuracy and security, according to HealthStream executives.

**Vida, AstraZeneca launch heart app**

Vida Health and AstraZeneca have teamed up to launch a new app for recovering heart attack patients aimed at helping them recover faster and better cope with the trauma associated with such life-threatening experiences. Heart disease is the leading cause of death for both men and women in the U.S. The HIPAA-compliant smartphone app is launching through a trial program at Duke University. It walks patients step-by-step through the recovery process using live digital coaches and educational materials, like videos, articles and food journals, to help patients implement lifestyle changes and adhere to their new drug regimen.

**Micron, Intel chalk one up for storage**

**BOISE, ID** - Micron Technology and Intel announced the availability of their 3D NAND technology, billed as the world’s highest-density flash memory. Flash is the storage technology used inside the lightest laptops, fastest data centers and nearly every mobile device, Micron executives note. The technology stacks layers of data storage cells vertically with “extraordinary precision,” execs say, and create storage devices with three times higher capacity than competing NAND technologies. This enables more storage in a smaller space, bringing significant cost savings, low power usage and high performance to a range of mobile consumer devices and enterprise deployments.

**GE’s new cloud expected to make for ‘better, faster healthcare’**

**FAIRFIELD, CT** - GE will enter the cloud services market with Predix Cloud, which it bills as the world’s first and only cloud solution designed specifically for industrial data and analytics. The platform-as-a-service, or PaaS, will capture and analyze the unique volume, velocity and variety of machine data within a highly secure, industrial-strength cloud environment, GE executives say. GE is banking on its assertion that the number of devices connected to the Internet will continue to swell, generating an unprecedented collection of data and analytics in several industries, including healthcare. “A more digital hospital means better, faster healthcare,” said Jeffrey Immelt, CEO of GE, in a statement. “A more digital manufacturing plant means more products are made faster.”

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Healthcare’s next wave: data virtualization

Integration can occur without data having to move

BY PAMELA BARTZ, Contributor

There have been unprecedented growth and adoption of business intelligence tools, as well as the rise of Accountable Care Organizations (ACOs) and value-based reimbursement models. In addition, mergers and acquisitions of large health systems have resulted in duplicate systems of records that rely on proprietary code. Exacerbating the situation, recent mergers and acquisitions have triggered a wave of data virtualization solutions.

DATA VIRTUALIZATION IN HEALTHCARE: BIG DATA, EHRI AND BEYOND

Business intelligence and analytics are playing a major role in the push to achieve unified data access and improve patient interactions. With better insight, healthcare institutions can provide more accurate one-on-one care, allowing for improved data integration, shared data, and patient portals without changing or moving the original source code.

DATA VIRTUALIZATION VS. DATA WAREHOUSE

The enterprise “Data Mart” concept is not new, yet the advanced technologies that can make it successful are. Newly released data virtualization solutions take it further by enabling the data to be easily accessed by more end users with unprecedented speed and simplicity, making the creation of a true enterprise-data-as-a-service model a reality.

REAL-TIME ACCESS

While pulling data together in a data warehouse integrates data across disparate platforms, it brings several limitations. First, the unified data must conform to a predefined schema for all consumers of the data, requiring customization for each report. Second, data warehousing relies on scheduled ETL (extract, transform, load) processes, making real-time analysis difficult. These and other limitations slow data interaction, to the frustration of IT and business users alike. However, the most significant difference is that data virtualization allows eSaaS to deliver vital information in real time.

USE DATA AS NEEDED

Data virtualization masks data’s source location, structure, and format from the user. And, because some of the newest data virtualization solutions employ RESTful Web services (Representational State Transfer) the data is quickly and easily connected, more intuitive to view and analyze, and shared in user-friendly formats. In the end, modern data virtualization provides the passageway that makes unified data available to all end users and allows them to use data in a format they need, not how the data source dictates.

EASILY GRANT ENTITLEMENTS

With data virtualization, not only is information more easily attainable, it is also more easily managed. Some of the newest solutions offer multi-level data entitlement features that enable an administrator to grant or deny access to data from a complete data source, down to opening just a specific field within a data file. In addition,
with these new solutions data access management can be adjusted instantaneous-ly, via any mobile device.

REAPING LONG-TERM BENEFITS FROM DATA VIRTUALIZATION

Data virtualization gives healthcare enterprises the ability to take applications and extend them by including data from other sources. Leveraging data virtualization makes possible the integration of data from any location, be it a physician practice, pharmacy, lab, patient portal, hospital, insurance carrier or remote monitoring device.

In addition, data virtualization provides for greater data accountability and agility and provides the ability to foster further internal collaboration among physicians, clinicians, staff, and patients. On the back end, it benefits IT staff by making possible the creation of one centralized platform to control, monitor and respond to requests for data. This means real-time, up-to-date, remote data access regardless of whether you have a data warehouse. And a more stable, consistent development environment makes it possible to maximize IT talent and resources, freeing them up to deal with more pressing IT matters within the healthcare organization.

Finally, having multiple ways to access the data and deploy the finished application means much more flexibility in the way future applications are developed and deployed, such as mobile apps, patient portals and other highly in-demand applications. This, in turn, helps healthcare entities attract patients in these highly competitive times.

6 CONSIDERATIONS WHEN SELECTING A DATA VIRTUALIZATION SOLUTION

For organizations looking to invest in a data virtualization solution, it’s important to keep an eye out for several key capabilities that have only recently come to market in newer data virtualization packages:

- IT and stakeholder ease of use: A data virtualization platform should be simple and intuitive for both IT staff and data end users. Look for a solution that requires no coding to set up, deploy or use. One that employs features such as drag-and-drop data mapping and mobile access is ideal.
- Legacy and open systems connectivity: Look for a solution that not only connects a variety of modern data sources and locations, including relational, NoSQL, on-premises and cloud, but also insist on one that integrates all legacy data to hold off expensive migrations.
- Read/write data interaction: Look for a data virtualization solution with bi-directional interaction. If you are only able to access information and not subsequently send back updates to the source(s), you are only getting half of the benefit of a true data virtualization platform. Many of the data virtualization solutions today only allow access to data.
- Multi-level enablement: A comprehensive virtualization platform will allow multi-level, flexible access control. Look for a solution that allows an administrator to grant or deny access to data at many levels, such as by groups, roles or individuals.
- Mobile access: Data access requests don’t always happen Monday through Friday, 9 to 5, especially in healthcare. Make sure your data virtualization solution is accessible remotely via any browser so that access to data can be established and granted when it is needed, without requiring a trip into the office.
- No Coding, eDaaS Enablement: Enterprise IT staff have enough on their plates – look for a data virtualization solution that helps IT save time and effort by enabling an internal eDaaS platform.

MEET IMMEDIATE COMMITMENTS, SOLVE MANAGEMENT ISSUES

According to Forrester Research, growing investments in new data management capabilities highlight the importance of solving tough information management problems. Enterprise architects must seek solutions with long-term, enterprise benefits that also help project teams deliver on immediate commitments. Use unmet data integration requirements to evaluate data virtualization and introduce it into your enterprise. Develop an information integration architecture that employs a canonical business model at the center and then work with internal stakeholders to identify opportunities for enterprise-wide deployments.

Data virtualization can provide single point, real-time access to multiple, diverse data sources, including third-party, mainframe, relational, NoSQL, cloud, etc. Unlike data warehousing or competing data virtualization solutions, data flows bi-directionally, meaning it can call data for integrating into various applications or analysis tools, as well as send updates back to the original source when needed. What’s more all interaction is real time so the data called is always relevant and accurate without synchronization issues.

- For IT and data governance administrators, it makes providing data access easier for the end user and more manageable for IT while supporting data governance policies.
- Virtualization enables connecting to legacy data in minutes, even the notoriously “hard-to-access” mainframe data. As enterprises are no longer forced to migrate off older technologies, they can let data remain on the original platform and still achieve seamless, intuitive access, for the long haul, or choose to migrate data on their terms. In the end, organizations immediately realize the benefits of migration without the risk or investment of time, capital and energy to migrate.

Pamela Bartz is chief marketing officer for GT Software, Envue.

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ON THE MOVE

CHOP names its first female CEO

Children’s Hospital of Philadelphia named Madeline Bell CEO – the first female to lead the hospital. Bell has served as president and chief operating officer of CHOP for the past five years. She began her career at CHOP in 1983 as a nurse. She left the organization temporarily to work in hospital administration and returned to CHOP in 1995 as the head of home care and case management. She was promoted several times before being named president and COO in 2010. Bell succeeds Steven M. Altschuler, MD, who retired after 15 years as CEO. Mortimer J. Buckley, chairman of CHOP’s board of trustees, said that Bell’s 20-year career at CHOP would ensure a seamless transition of leadership at the nation’s first pediatric hospital.

Former CMS administrator Marilyn Tavenner joined America’s Health Insurance Plans as CEO. Tavenner was a nurse and hospital executive before taking the helm as CMS Administrator. She succeeds Karen Ignagni, who left AHIP after 22 years to step into the CEO role at EmblemHealth in New York. Tavenner began her healthcare career in 1981 as a nurse at Johnston-Willis Hospital in Richmond, Va. In 1993, she took over as CEO of Johnston-Willis and then in 2001 was named president of parent company Hospital Corporation of America’s central Atlantic operations and later group president of outpatient services. She left HCA in 2005 to serve as Virginia’s Health and Human Resources and in 2011 accepted the Acting Administrator’s at CMS. In May 2013, she was elevated to Administrator.

Former ONC deputy coordinator joins Uniphy Health board

Uniphy Health named Jacob Reider, MD, to its national board of advisors. Reider is former Deputy National Coordinator and Chief Medical Officer of the Office of the National Coordinator for Health Information Technology. He is a physician and an expert in health information technology policy, innovation and strategy. Prior to his role at ONC, Reider was CMIO of Allscripts, medical director of clinical systems at CapitalCare Medical Group and associate dean of biomedical informatics at Albany Medical College. He is CEO of Kyron, a health analytics startup in Palo Alto, Calif. Throughout his career he has been an advocate for enhanced usability and safety of clinical tools and systems, and the use of technology in improving the quality, efficiency and cost of healthcare.
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Q&A: Geisinger CIO Frank Richards

‘For a long time I was the sole clinical computing person...’

BY SKIP SNOW, Contributing Writer

RANK RICHARDS HAS HELMED Geisinger Health System’s technology operations for 15 years – and has been an employee of the care delivery pioneer for nearly four decades.

While Geisinger’s $4 billion doesn’t make it a revenue giant among healthcare systems in the U.S., this vertically integrated healthcare organization is increasingly thought of as a go-to model. A thriving regional system, fast-growing Geisinger combines operational excellence with innovation.

Healthcare IT News recently spoke with Richards to learn how the long-tenured CIO sees the current and future state of healthcare technology. Here are six things to know about him and his work.

1. Thirty-eight years at Geisinger give him deep institutional knowledge. “I came to Geisinger in 1977 out of a graduate program at Ohio State with a degree in chemistry for an internship. At the end of that internship, they offered me a job. I worked then in the laboratory in the toxicology department. In 1981, they wanted somebody who had a computer background, which I had from college. That’s how I made the switch to IT. For a long time I was the sole clinical computing person, with a small operations staff. I did all the computer work for pharmacy, laboratory, pathology and the other clinical departments. I took over as CIO in 2000.”

2. He’s helped make Geisinger a technology pioneer. “The original Geisinger medical center was patterned after the Mayo Clinic, a multidisciplinary teams of specialists with a single-unit medical record. As we expanded in the ’80s and into the ’90s, the model of single-unit record could not work with paper. You can’t operate within the continuum in a paper world. Through the 1980s to the early 1990s, we were still using paper-based medical records. We tried many different kinds of things: faxing and document repositories and all kinds of things. We signed with Epic in 1995. We learned a lot of things the first two to three years, and the software got better. Now, I can’t imagine operating without it. The next iteration of electronic health records needs to be smarter, culling through information, presenting providers information they need to act upon. I see the evolution from where nobody could find anything because it was on paper to our situation where we have so much information and need smarter systems presenting the users with actionable data.”

3. The health system is heading toward real-time analytics. “We have had a sophisticated data warehouse for 10 years. This warehouse now services about 2,000 users. We look for patients who may not be receiv- ing the care that they should be based on lab studies or other things that fall through the cracks across our multiple venues of care. We provide real-time alerting dashboards for inpatient critical care areas based on constant monitoring of information. We continue to expand our ability to analyze real-time data. We started with the emergency ICU. Now we go far beyond the ICU to some of our regular high-acuity beds. We’re going to need systems that can more effectively monitor all our clinical data in real time, getting information to the correct provider to take action. You need massive amounts of computer power to collect data and do something with it. That’s been one of our hurdles. A lot these systems generate tons of data from patients, but it has to go somewhere and be analyzed. There’s big promise in big data analytics, and we are just getting out there with Hadoop and other tools.”

4. Integrating newly-merged business entities can take work. “To date, we’ve been able to convert all acquisitions to our entire suite of products, not just Epic, but lab, radiology, pathology and so on. We’ve been able to convert every one of our acquisi- tions to the Geisinger medical record scheme. This takes a certain amount of effort because we have to do a conversion of their exist- ing medical records to our scheme. In some organizations, they haven’t standardized their medical records as much as we have; they live with that challenge even within their own systems.”

5. Patient identity challenges continue to be an issue – but national ID isn’t the answer. “There’s no national identifier and not even any set national parameters of data elements to identify someone. It continues to be a challenge for our health information exchange, which services 3,800 organizations in western Pennsylvania. As much as I would like it, a single national identifier would not make everybody’s life easier. I don’t even think it’s workable. My concern about having a standard national identifier is that it would get watered down and abused. What’s more interesting to me is creating standards for the common data elements we all agree on. These identifiers could create a positive enough ID so that I can at least return a list of possible people you might be looking for. Today, if I make a query to another health system and I don’t have enough information about the patient for them to return one and only one possible person that matches, the standard says don’t send any. That’s just not workable without some kind of positive ID.”

6. Leadership means delegating. “The key is to hire people that you trust who can operate independently. You can’t be involved in everything. You can’t know everything that’s going on. The health plan’s got operations in several differ- ent states, and we’re talking of acquiring a system in New Jersey. So I really need to rely on the team and they need to rely on people on the front lines to know what the job is and to deliver. We have a lot of frustrated people in IT who have been doing the EHRI implementations. We have about 20 years of expertise here. People have to feel comfortable coming to you and telling you that there’s this problem or they’re run- ning into problems and not wait until the last minute when things blow up. My staff is very good at giving me early warnings. Sometimes they turn out not to be anything, but that’s OK.”

“The next iteration of electronic health records needs to be smarter, culling through information, presenting providers information they need to act upon. I see the evolution from where nobody could find anything because it was on paper to our situation where we have so much information and need smarter systems presenting the users with actionable data.”

Frank Richards

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