Excel Healthcare Group

Identifies 2014 Healthcare

Needs and Trends

By:

Kristie Brown

Matthew Caravana

Marti Catron

Sharon Parks

Noelle Quinn

Brian Sullivan

Pam Watson

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Healthcare Group
Surpassing all others

ACKNOWLEDGEMENTS

All books come to fruition with lots of input and review from many people we come in contact with throughout our lives.

First of all, we want to praise God for the guidance he has given our company since its inception and the amazing growth we have experienced.

We also owe this book to our founder Jimmy Rhoton, our employees, as well as the many healthcare workers we have had the privilege to work alongside the past 5 years.

This is just a short book on some of the hot topics that our consultants see each hospital should be aware of and discussing how they will integrate them with their organization and incorporate into their strategic planning.

ABOUT THE AUTHORS

Kristie Brown

Kristie Brown is the CEO who has over 15 years experience in IT with 10 of those years being in Healthcare. She has an Associate degree in Business Administration Management and a Bachelor degree in Information Networking Telecommunications. Her background in EMR systems includes SMS, PDS, MEDITECH, LSS, as well as several interfaced systems specific to hospital departments. Lately she has been studying social media marketing and promotions. She has a passion for helping people, but especially children. She is a volunteer for Big Brothers Big Sisters (has been for 20 years) and also volunteers a lot of time for Circles of the Heartland helping those in poverty.

Matthew Caravana

Matthew Caravana has been in the Medical Software industry for seven years, the first three spent in the Order Management and Enterprise Medical Record group at Meditech. He has been a Senior Consultant at Excel Healthcare for the past four years, specializing in CPOE implementations, migrations and updates. Matt attended the University of Massachusetts Dartmouth for Business Management and Columbia University for Higher Education Administration.

Marti Catron

Marti Catron has worked in the healthcare field since 1988. Many of those years were spent as an RN in the oncology field. Since joining Excel Healthcare Group, she has served as a Human Resource Generalist and is now Business Development Manager

Sharon Parks

Sharon Parks has over 25 years in healthcare, beginning as a part-time unit secretary in her freshman year of college and progressing to various positions in Admissions, Purchasing, Emergency Department and Surgical Services for a large multi-hospital system. She spent 8 years as Logistics Manager of the Surgery Department for the flagship hospital where she oversaw billing, payroll and supply area. During this time, she worked on the build, installation and maintenance of her first healthcare computer system that integrated all functions for the OR, including payroll, HR, scheduling/preference cards and purchasing/supply and device tracking. Sharon has been an IT consultant for the past 13 years, specializing in Meditech build, installation and go-lives for PHA, OE/OM, ORM and LAB modules including establishing interfaces to McKesson and Pyxis Pharmacy products, for the past 5 years. She believes that one of the greatest challenges faced in the healthcare environment today is making

computers work to improve the life of people rather than have people working to improve the life of computers.

Noelle Quinn

Noelle Quinn has 12 years of healthcare experience with four years working within the hospital environment as both a Radiology Manager Assistant and a Systems Manager Assistant during her college years. Noelle then began implementing and installing Hospital Software with a focus on Therapies, Nursing, Respiratory, Radiology, and Physician Documentation (PDoc) all over North America. Noelle's experience within the hospital and Implementing hospitals brings a broad range of experience to the clients. In the 1970's Noelle's parents migrated to Boston from the West of Ireland. They worked hard so that her and her brother could grow up in America and get a good education which they both did and made their parents proud. Noelle graduated Wentworth Institute of Technology in Boston with a Bachelor of Science. She majored in Computer Engineering Technologies and minored in Electrical Engineering Technology. She has a passion for people and working with groups and teams. She also loves to travel and meet new faces, but said she will never leave her beloved home town of Boston, not even to get away from the snow.

Brian Sullivan

Brian Sullivan has been in the Healthcare arena for 7 years. He attended Roger Williams University in Bristol, RI where he majored in International Business and minored in Communications. He started his healthcare career at Meditech and while he was there he managed Laboratory Implementations for clients throughout the United States and parts of Canada. Today, Brian is a Senior Consultant with Excel Healthcare Group and his responsibilities range from project management, sales, and participating in the information exchange program at Excel. Brian loves the fast pace environment that the Healthcare Marketplace brings and making new relationships with clients though out the country.

Pam Watson

Pam Watson is a Registered Nurse with a diverse background specialty in Clinical Informatics and Project Management. Pam has been engaged in many facets of healthcare and healthcare systems including; home healthcare, hospitals; inpatient, outpatient, clinics as well as being a Nurse Manager. This combined knowledge and experience allows Pam to strive to understand her client's requirements on any task. Her skill set is primarily focused around, but not limited to strategic planning, building and implementation in MEDITECH Advanced Clinicals; Patient Care Systems (PCS), PDoc (PCM) and OM- with CPOE being her specialty. Most recently she was involved with assisting a hospital reach stage 6 HIMSS EMR adoption model and prepare for stage 7. Pam possesses many qualities including experience with project management, business analytics, and has led teams of 100+ employees through various positions. She is able to identify organizational needs relative to quality measures, best practices, adherence to regulations, and optimized reimbursement. She specializes in the assessment, build, and

implementation of meaningful use, Dragon Implementation, Zynx Evidenced Based Order Sets and Care Plans, and custom report analysis.

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INTRODUCTION

Healthcare is an ever changing industry that is making great strides in technology, but it also is slow in the areas of adopting technology. We want to highlight some things our employees feel will be the hot topics of interest in 2014 for any hospital. Some of the information is old or the technology has been around awhile, but we wanted to provide a history into how we got to where the industry is today. Skip the sections that are not relevant to your organization, as some organizations have already implemented a lot of these ideas while others do not even know what some of these topics encompass. This book is written alphabetically by topic, so there is not a specific reading order.

We have been able to work along with some amazing organizations and other excellent consulting firms, and we wanted to take time to give you a free reference and give back to anyone who doesn't have the time to research and go to seminars to find out about this information. Some of the information is stuff you have mastered, but it is amazing how we come across organizations that struggle with some of these items that other organizations seem to implement and master with ease. Certain topics are very broad and so websites have been listed that will give more information and detail about that topic.

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ACCOUNTABLE CARE ORGANIZATIONS (ACO)

Doctors, hospitals, and other health care providers who work together voluntarily to provide high quality care to Medicare patients, are being referred to as Accountable Care Organizations (ACO). These providers will be paid in untraditional ways – it is a fee for service. That means they get paid a set amount (a higher amount than they used to) and the provider accepts responsibility that for the patients they provide care, those patients will get high quality care and preventative services with the goal of decreasing acute care services for those patients. With Obamacare, a law came into effect that states the ACO providers must handle the healthcare needs for a minimum of 5,000 Medicare Beneficiaries for at least three years.

Certain diseases have criteria defined that these providers will track. For example, a lot of patients who are overweight can lower their health issues just by losing weight. Therefore, ACO's strive to meet this criterion for their patients:

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.

Normal Parameters: Age 65 years and older BMI greater than or equal to 23 and less than 30. Age 18 – 64 years BMI greater than or equal to 18.5 and less than 25.

In their EMR system, ACO track these patients as well as the criterion for five domains which are listed as patient/caregiver experience, care coordination, patient safety, preventative health, and at-risk population/frail elderly health.

How does an organization become an ACO? They must apply and if accepted they are signing up for a minimum of 3 years participation in the program. This program is monitored by CMS and they offer a couple sessions each year for new organizations that are interested in applying. They also do webinars and forums. Check out their website at http://innovation.cms.gov/Webinars-and-Forums/index.html for more information.

Another website that focuses on ACO is http://www.accountablecarefacts.org/ with tons of information on ACO and Health Care Reform as well as Case Studies. You can also search by zip code to see current ACO's in your region if you want to speak with someone locally who has received the recognition.

You have several options (or had) when applying for ACO.

- **Shared Savings Program**
  The Shared Savings Program facilitates coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.

- **Advanced Payment Model (They are currently not accepting new applicants)**
  The Advance Payment Model is designed for physician-based and rural providers who have come together to give coordinated high quality care to the Medicare patients they serve.

- **Pioneer Model (They are currently not accepting new applicants)**
  This is for those organizations who joined the ACO as a pioneer and have years of experience as an ACO.

Some people think ACO's will harm the healthcare reform while others think it is the way to fix the rising costs of healthcare. Whatever you think, you must understand what has happened to those organizations who have been pioneers of this concept. Estimates say more than 50% of all hospitals in the US will be trying to become an ACO by 2015, which is not too far away. They just announced that 123 new organizations have been accepted into the ACO program which will help more than 1.5 million people. There has been a report in the decline of cancer patients and the costs of the healthcare provided to them in an ACO. Other studies say the administrative burdens will become too much for providers even if they believe in the concept and want to participate in becoming an ACO. Even if you do not want to be certified as an ACO, you can incorporate some of their criteria into your treatment plans for your patients and make their diseases and lives easier to manage.

ASSESSMENTS

With the need today to have the latest technology, medical services, and patient care, comes the need to periodically assess where you currently stand and how you would like to grow as a healthcare organization. With financial costs increasing today, assessments can sometimes be minimized. However, it is with utmost importance to conduct a proper assessment to ensure your organization exceeds today's healthcare standards and thrives as an organization. Doing so will not just benefit your patients, but your employees and community as well.

The term Assessment is very general but can be categorized into many different process functions. When looking up the definition of Assessment you find "the evaluation or estimation of the nature, quality, or ability of someone or something." In healthcare organizations we commonly see assessments conducted for patient services, employee performance/satisfaction, and information systems.

Some areas to focus on while doing a pre-assessment:

Define What Exists Today:

- Without clearly understanding what is in place today, how can you define the future? Proper documentation such as procedure manuals, hardware manuals, performance evaluations, etc should be consistently updated and archived for reference at any time. Doing so will greatly save on costs and will save hours of time when the documentation is needed for review.
- Conduct management meetings to review the documentation to ensure all parties have a full understanding of what currently exists today.

Define Future:

- Conduct management meetings to define short term goals, long term goals, needed improvements, and strategies in how to achieve these goals and improvements.
- Go over the pros and cons of each decision to anticipate what the final result will be. Once a decision is made, it is very difficult many times to go back to the drawing board.

Employee Involvement:

- Way too often decisions are made by the management team only. While the management team has years of experience and should make the final decision, it is important to involve those front line employees where the organization change will affect the workflow the most. This will ensure stronger employee involvement and produce a greater outcome at the end of the project. Plus, they may have ideas that will be better for them and the patients.

- Frontline employees are the first ones to speak to the public and are usually willing to share their honest opinion of the new processes that they are about to put into place .Therefore, making sure employees are heard is an essential part of an assessment.

Define A Realistic Timeline:

- If you haven't completed a project similar to the one you are starting, it can be hard to assess a realistic timeline. For example, if you are implementing a new information system, how do you know how much time is needed to build, test, and train? For this example you would ask your vendors to provide you with an implementation plan which would have a detailed timeline defined. The implementation plan provided should be a plan that has been used by many organizations and should reflect an accurate timeline. Also be sure to ask if the timeline is relevant to an organization your size because it can take different amounts of time and effort depending on the size of organizations. Ask specifically about the size of the IT staff since that is another department where the type and number of employees varies greatly.
- With all the healthcare reform changes today, organizations are receiving compensation for completing projects by a certain deadline. This can be very beneficial as the costs of the projects keep increasing. Organizations should plan ahead to make sure they are able to meet the needed timeline and guidelines. It is usually recommended to forecast an extra 2-3 months to allow room for delays. The last thing you want is to not receive all the compensation owed to your organization.

Define the Right Amount Of Resources Needed:

- Does your organization have experienced staff that is capable of handling the proposed project? Will they be handling this new project and their current job? It is very important to make sure you have the right staff on the project and that they have the time to complete the project and their current job duties. Typically it is rare to find a healthcare organization that has staff underutilized.
- If the needed experience does not exist in your organization, you may need to hire experienced vendors/consultants who can lead and ensure the project is completed on time and successfully. While this can often look to be a costly option, it can end up saving your organization money because these experienced resources have the knowledge to manage the project ensuring it will be done on time and done the right way the first time.

Define A Realistic Budget:

- Define a project budget and then add to it. It is too common today that there are surprise costs, delays, or just added functionality that organizations seek to add on later. The last thing you want is to be in the middle of the project and not know how it will be financed.

Reach Out To Organizations:

- Sometimes reinventing the wheel will just cause it to keep spinning and cause delays. With today's social technology it is easy to reach out to other organizations that have already spent the energy and time inventing new processes. Many organizations are more than willing to share their success stories. In addition, there are typically online forums that you can search discussions for projects. This is one of the best resources to tap on because you are getting an honest answer.

After your new project/change has been implemented for a month, it is a great idea to conduct a post assessment to ensure your goals that were set originally are met and that the project was a success.

Some areas to focus on while doing a post-assessment:

Lessons Learned:

- It is probably safe to assume that there were some hiccups throughout the project. Create a log of these lessons learned so that similar future projects are implemented without the same risks/issues.
- How were your vendors during the project? Would you use or hire them again?

Employee Feedback:

- Many times in projects there can be some hesitation because not everyone likes change. However, if you involved your employees from the beginning, you should expect to hear more positive feedback as they helped in the decision making process.

Patient Feedback:

- If the implemented changes affect patients, survey them to see how they feel towards these new changes.

BRING YOUR OWN DEVICE (BYOD)

One of the newest, rapidly increasing trends in Healthcare Information Technology is called BYOD (Bring Your Own Device). Healthcare employers are now allowing their employees to use their own personal mobile devices for work. Today, mobile devices allow employees to work longer and more efficiently, while being accessible on the road and at home, if needed. Users can access the EMR remotely to review a patient's Vital Signs, Lab Results or CT findings. CPOE providers can place orders from their tablet, or enter a Progress Note or review test results and medications. In fact, some hospitals are now hosting "Open Houses," where physicians can have their mobile devices set up for CPOE access, prior to going live with a new software release. This allows the physician time to become comfortable with accessing the EMR from their personal device, and makes the transition much more seamless once the new system is live.

User satisfaction should increase in most cases because employees are using mobile devices that they have independently purchased, as opposed to devices that have been company mandated. Moreover, it also eliminates the need to carry a personal and a work device. Along with user satisfaction will be better productivity because users will be more comfortable using their own device that they are experienced with and understand all the functionality that it offers. There will also be a smaller learning curve for users; however, there will always be the need for further education as devices, software and apps progress.

Allowing employees to use their own personal mobile devices will also offer cost savings because the user typically picks up the cost on the device that they own. Sometimes users will get compensated for expenses they occur for business such as phone use and data plans. Ideally, employers will not have to focus so much attention on making sure their hardware is up to date as users typically update their personal mobile devices on their own. However, there will always be outliers who do not update their devices as frequently, and it will still be role of the IT department to make sure personal mobile devices are functioning properly and monitor for important updates that need to be installed on the devices. The use of mobile devices whether solely for business or for business and personal use, brings an innate amount of security risks. Many personal mobile devices do not require passwords to access them, as opposed to company issued devices, which typically do. However, even companies who issue their own mobile devices, have problems with their employees using the devices for more than business. There will always be greater security risks with mobile devices than stationary devices. Just as dealing with any PHI, the onus and trust fall upon the user.

New technology called Container Technology allows the IT department the ability to segment an area out of your Smartphone, tablet, or other mobile device to securely store and transmit data for work purposes only. Containers are said not to overlap or interfere with personal space on personal mobile devices. In addition IT professionals also have the ability to wipe out these containers entirely if the employee leaves the company or if the device is stolen or lost. Container protection is simply software that is downloaded on to the device. Overall, the future indicates that mobile devices will continue to be

used in the healthcare industry as mobile technology continues at the forefront of our everyday lives.

CLINICAL QUALITY MEASURES (CQM)

CMS (Centers for Medicare and Medicaid Services) has created clinical quality measures (or CQMs) that are used to measure and track the quality of healthcare services you receive as a patient. According to CMS.gov CQMs "measure many aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagements, population and public health, and clinical guidelines. Continuously measuring and reporting these CQMs helps to ensure that our health care system can deliver effective, safe, efficient, patient-centered, equitable, and timely care."

These measures were created and became a requirement of Meaningful Use (MU) and for more information on the specifics of MU see the MU section of this book. With regards to ARRA (American Recovery and Reinvestment Act), everyone is required to report on core clinical quality measures and clinical quality measures selected from a list. If you don't collect the information on one or more of the core measures (or it reports zero), you replace them with other items from the list. These are not calculations but reports that are created from your EMR and the data reported as it appears on the report. There is not a minimum value to achieve - it just needs to be reported (for the requirements as of today).

Core Quality Measures required for MU:

NQF0013 Hypertension: Blood Pressure Measurement

NQF0028 Preventative Care and Screening Measurement Pair:

1) Tobacco use assessment
2) Tobacco Cessation Intervention

NQF0421/PQRI128 Adult Weight Screening and Follow-up

Additional List of Clinical Quality Measures:

1) Diabetes: Hemoglobin A1c Poor Control
2) Diabetes: Low Density Lipoprotein (LDL) Management and Control
3) Diabetes: Blood Pressure Management
4) Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

5) Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD patients with prior Myocardial Infarction (MI)

6) Pneumonia Vaccination status for older adults

7) Breast cancer screening

8) Colorectal cancer screening

9) Coronary Artery Disease (CAD): Oral antiplatelet therapy prescribed for patients with CAD

10) Heart Failure (HF): Beta-blocker therapy for Left Ventricular Systolic Dysfunction (LVSD)

11) Anti-depressant medication management:

    a) Effective acute phase treatment

    b) Effective continuation phase treatment

12) Primary Open Angle Glaucoma (POAG): Optic nerve evaluation

13) Diabetic Retinopathy: Documentation of presence or absence of macular edema and level of security of retinopathy

14) Diabetic Retinopathy: Communication with the physician managing ongoing diabetes care

15) Asthma Pharmacologic Therapy

16) Asthma Assessment

17) Appropriate testing for children with pharyngitis

18) Oncology Breast Cancer: Hormonal therapy for Stage IC-IIIC estrogen receptor/progesterone receptor (ER/PR) positive breast cancer

19) Oncology Breast Cancer: Hormonal therapy for Stage III Colon cancer patients

20) Prostate cancer: Avoidance of overuse of bone scan for staging low risk prostate cancer patients

21) Smoking and Tobacco Use Cessation, Medical assistance:

    a) advising smoker and tobacco users to quit

    b) discussing smoking and tobacco use cessation medications

    c) discussing smoking and tobacco use cessation strategies

22) Diabetes: Eye exam

23) Diabetes: Urine screening

24) Diabetes: Foot exam

25) Coronary Artery Disease (CAD): Drug therapy for lowering LDL-Cholesterol

26) Heart Failure (HF): Warfarin therapy patients with atrial fibrillation

27) Ischemic Vascular Disease (IVD): Blood pressure management

28) Ischemic Vascular Disease (IVD): Use of aspirin or another antithrombotic

29) Initiation and engagement of alcohol and other drug dependence treatment

    a) initiation

    b) engagement

30) Prenatal care: Screening for Human Immunodeficiency Virus (HIV)

31) Prenatal Care: Anti-D Immune Globulin

32) Controlling High Blood Pressure

33) Cervical Cancer screening

34) Chlamydia screening for women

35) Use of appropriate medications for asthma

36) Low back pain: Use of imaging studies

37) Ischemic Vascular Disease (IVD): Complete lipid panel and LDL control

38) Diabetes: Hemoglobin A1c Control (<8.0%)

These items may be modified in the future as each stage of Meaningful Use requires more of these CQM's to be met in order to get ARRA funding. However, some of these measures could fail and not make it possible for providers to meet the qualifications. Some patients may have a contraindication to a treatment, and they do not account for those contraindications in these measures. Some patients may not react appropriately to certain treatment approaches and may need a different approach, but those are not accounted for in these measures either. We anticipate exclusions or exceptions for these measures. We expect some changes to the Clinical Quality Measures to come in the next few years as more clinical quality data is gathered and evaluated.

http://www.qualitymeasures.ahrq.gov is another good resource for more information on CQMs.