Disconnected
How stalled interoperability hurts patient care

New career directions:
Practice models to consider

Build your strategic plan in five steps

Malpractice coverage after retirement

Streamlining physician credentialing

The last words you should say to patients
An interoperability report from the field: It’s not pretty

Interoperability is a nice dream, but the waking version is still a nightmare.

Many frustrations stem from the lack of standardized programming and data formats. My colleague at Edward Medical Group in Naperville, Illinois, family physician and Epic superuser Ronald Glas, MD, feels that true interoperability may be reached only when hundreds of current electronic health record (EHR) companies fail, leaving only the fittest half dozen.

For successful data exchange, we must know “who, what, where, and how.”

Without a system of national patient ID numbers, algorithms match multiple demographic factors to determine who the right John Smith is. Tedious mapping ensures that what flows from one source to another is correct, e.g., diagnosis, lab result, or immunization. Standardized identifiers (SNO-MED for diagnoses, LOINC codes for lab tests) must be mapped either by the vendor or the end user. eClinicalWorks left some LOINC matching to doctors six years ago, when I exclaimed like Star Trek’s Dr. McCoy, “Damn it, Jim, I’m a doctor, not a LOINC coder!”

Mapping costs, in money and months, explain why most practices only contract with one to two labs. An even greater headache: 50 states with 50 unique immunization registries!

A third problem: Where historical data resides is not standardized across EHR platforms, so a continuity of care document (CCD) flows as a single document instead of populating specific data fields.

Finally, the Health Insurance Portability and Accountability Act (HIPAA) defines how data goes securely from point A to point B. HIPAA defines fax as safer than email, so we use mandated but outdated transmissions.

I love sharing records with the hundreds of local doctors using our version of Epic. The “Care Everywhere” feature enables data exchange among different Epic installations. After getting a patient’s signed paper consent, we can access Epic records in 45 states. However, information from non-Epic EHRs has limited utility. Glas finds that without detailed notes, outside CCDs meet Meaningful Use criteria more than they do clinical usefulness.

Bottom line: Ancient Egyptian papyrus technology and 1970s facsimile technology still thrive alongside 2015 computer programming. Interoperability isn’t quite ready for prime time.”

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Bottom line: Ancient Egyptian papyrus technology and 1970s facsimile technology still thrive alongside 2015 computer programming. Interoperability isn’t quite ready for prime time, but could be as revolutionary as television was. Let’s hope we won’t be waiting until TV’s centennial!

Elizabeth Pector, MD, is a family physician and a member of the Medical Economics Editorial Advisory Board. She practices in Naperville, Illinois.
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I don’t think we’re more interoperable than we were three or four years ago.”
—EDWARD GOLD, MD, INTERNIST

You can’t please all of the patients all of the time. But you can try to thank all of them for coming to see you.”
—JOSEPH SIDARI, MD

16 states have extended Medicare-Medicaid payment parity for physicians

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"I don’t think we’re more interoperable than we were three or four years ago.”
—EDWARD GOLD, MD, INTERNIST

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—JOSEPH SIDARI, MD

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IN-DEPTH COVERAGE

PCMH PLAYBOOK: PLAN FOR A VALUE-BASED FUTURE

Transforming into a patient-centered medical home may become a financial safe harbor for many small practices as payers continue to emphasize value over volume. Practices that undertake the process face challenges, but even if you don’t have a hospital or large-group infrastructure to help you manage the process, you needn’t go through the journey alone. Read more at: bit.ly/pcmh_playbook

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How one physician stayed ahead of the curve by transforming his group into a PCMH.

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Physicians must decide when it makes financial sense to be included in narrow network plans.

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Physicians must decide when it makes financial sense to be included in narrow network plans.
A physician can bill for the incident-to services of another physician as long as all of the criteria is met.”

—Renee Dowling CODING CONSULTANT

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Reporting rarely pays, always gets worse over time, and is designed to cut reimbursement. Instead, make your reporting decisions solely on whether it makes money sense. What makes more sense, ditching a few thousand dollars incentive or paying a hundred thousand for a production-lowering EHR?

Kevin Kelleher, MD, Roanoke, Virginia

‘Fighting Back’ Advice Doesn’t Go Far Enough

“Fighting Back” (August 10 and 25, 2015) is timely in view of the falling number of practices remaining independent, however the advice of your contributors is timid and misdirected. Independent practices should have one maxim: increase income or decrease overhead.

1. “Accept …EHR’s” Wrong! EHRs are expensive, lower provider production, and after a brief recapturing of missed vaccinations or other ancillary charges, lose money, except when artificially up-coding (which is unethical and potentially illegal). Instead, checklist and code accurately and fairly. Stick to paper and narrative charts unless you are a large practice; colleagues appreciate good notes and insurers hate them. Must be a bulls eye!

2. “Look for ways to differentiate” OK, maybe good for a specialty practice, but in primary care it’s the “bread and butter” practices that are going to succeed. Evaluate any procedure on the basis of time and equipment (overhead) and reimbursement and volume (income). If it doesn’t make money sense, refer it out.

3. “Make population management...part of your care.” If you mean analyze your potential clients, that’s market analysis, not epidemiology. I want to know my traffic pattern, the best payers, and the most used procedures. In other words, find out what your patients want and give it to them. Taking an epidemiological approach to “what you think they need” will hang your practice in the same sling academic centers find themselves in...slowly going out of business.

4. “Embrace government reporting mandates.” Reporting rarely pays, always gets worse over time, and is designed to cut reimbursement. Instead, make your reporting decisions solely on whether it makes money sense. What makes more sense, ditching a few thousand dollars incentive or paying a hundred thousand for a production-lowering EHR?

Furthermore, Medicare “incentives” don’t make sense when your Medicare exposure is low. Instead, freeze new Medicare admissions, while catering to the influx of new ACA insured. (I didn’t invent the law, but a savvy businessperson had better react.)

Do the bare minimum to meet reviews and requirements, and don’t make it easy for the reviewers. (Request an on-site visit; why pay for copying and faxing records to a reviewer?) Resist reporting requirements by writing your medical societies and lobbying your representatives.

Bottom line: Your title said “Fighting Back” but you’re prancing around the ring.

Kevin Kelleher, MD
Roanoke, Virginia
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References:

The American Medical Association (AMA) has released an analysis of commercial health insurance markets that says that the proposed mergers of Anthem-Cigna and Aetna-Humana will “exceed federal antitrust guidelines designed to preserve competition” in as many as 97 metropolitan areas in 17 states.

The AMA says that the prospect of reducing the number of the “Big Five” insurers to three would affect health insurance markets already facing a lack of payer competition. This has a direct impact on both patients and physicians, who could see their bargaining power further reduced. AMA President Steven J. Stack, MD, said in a news release that insurer competition must be protected and enhanced.

“Given these factors, AMA is urging federal and state regulators to carefully review the proposed mergers and use enforcement tools to preserve competition,” Stack said.

“Physicians may be pressured to accept unfair terms that undermine their role as patient advocates and their ability to provide high-quality care.”

—Steven J. Stack, MD, AMA president

States that will see diminished payer competition due to payer mergers

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Number of metropolitan areas that would see diminished competition if the two mergers are approved, according to the AMA report.

154
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New regulations target healthcare protections for transgender patients

A large chronic obstructive pulmonary disease (COPD) patient network is in the works to accelerate research and foster innovation in treating the disease.

The COPD Foundation’s COPD360 program will enroll 125,000 patients in databases on an integrated research registry composed of the COPD Patient-Powered Research Network and physician registries.

When fully realized in the next three to five years, COPD360 will combine patient-reported outcomes, clinical data, electronic medical records, and observational research into what the Foundation says will be one of the largest COPD research networks ever assembled. Patients entered into the registry have agreed to share their health information and testimonies on how COPD has impacted their lives.

Part of the COPD360 platform is COPD360social, a social collaborative platform that brings together the patient, caregiver, and provider communities into one location to share information and engage with one another.

IN THE MIDST of changing attitudes regarding gender identity and sexuality, including gender transitioning and same-sex marriages, the Obama administration has proposed new regulations for the Affordable Care Act (ACA) to include gender identity under the umbrella banning sex discrimination in healthcare.

The rules clarify the standards that the Department of Health and Human Services (HHS) would apply in enforcing the protections found in Section 1557, which prohibits discrimination on the ground of race, color, national origin, sex, age, or disability. Under the proposed rules, Section 1557 also applies to the health insurance marketplace and health programs administered by HHS. Section 1557 is the first federal civil rights law to prohibit discrimination on the basis of sex in healthcare.

“The proposed rule applies to every health program or activity that receives HHS funding, every health program or activity administered by HHS, such as the Indian Health Service or the Medicare program, and every health program or activity administered by an entity created by Title I of the ACA,” explains National Center for Lesbian Rights (NCLR) policy director Julie Gonen, JD. “These rules will have a profound effect on the health and very lives of LGBT Americans. We can now see a day in the very near future when transgender people can get coverage for the medically necessary care that they need but for which they are too often denied health insurance coverage.”

“[Health] plans need to ensure that their provider networks include professionals that specialize in working with transgender people to provide the competent care that is consistent with standards of care.”

—JULIE GONEN, JD, POLICY DIRECTOR, NATIONAL CENTER FOR LESBIAN RIGHTS

The proposed rules prohibit insurers from offering plans that contain coverage exclusions for the treatment of gender dysphoria. This includes prescriptions, surgical care, and other healthcare services that are otherwise offered under the plan.

“Similarly, plans need to ensure that their provider networks include professionals that specialize in working with transgender people to provide the competent care that is consistent with standards of care,” Gonen says. “Beyond eliminating coverage exclusions, insurers will need to ensure that transgender people are not denied coverage for routine care due to a mismatch between the gender listed on their insurance records and their anatomy.

Both the federally-facilitated marketplaces and the state-based marketplaces are covered by Section 1557. Thus, if a managed care company or insurer offers plans through Medicare or on the exchanges, all of its plans, including those in the private market, are covered by the Section 1557 regulations.
The program still does not work for many physicians

Doctors have long complained that Medicaid reimbursements don’t adequately compensate them for the costs of treating patients. Despite the Affordable Care Act (ACA) and other changes that have expanded Medicaid coverage, it remains a challenging payer for physicians. What can policymakers do to make the program more workable for practices?

FOR PRIMARY care physician Doug Curran, MD, seeing Medicaid patients comes at a price—literally. The Athens, Texas-based doctor’s only new Medicaid patients are children who leave the emergency room at the hospital he works at occasionally. Currently, his practice includes 15% Medicaid recipients.

“But if I took every Medicaid patient I couldn’t pay my bills,” explains Curran, who is also chair of the Texas Medical Association’s (TMA) board of trustees. “I get paid about $30 by Medicaid to see a child with an earache and that visit costs my practice $45, and those are just the office and administrative costs, it does not include any payment to me.”

He adds that the TMA supports Medicaid expansion but doesn’t want the present system expanded. “Expanding the current Medicaid system would be a nightmare,” says Curran. For example, a level 3 visit is paid at $36 by Medicaid compared with $69.76 from Medicare. (See sidebar “Same service, different pay” below).

In response to complaints about inadequate Medicaid reimbursements, legislators at the state and federal level are working on making the program more palatable for all involved.

HIGHLIGHTS

01 Having survived yet another U.S. Supreme Court challenge to its legitimacy, the ACA seems here to stay. But that hasn’t stopped states from rejecting some of its provisions, most notably the opportunity to expand Medicaid.

02 Primary care physicians view Medicaid expansion with mixed emotions. They want to see the uninsured covered, but low Medicaid payment rates and administrative hassles weigh on them.
provisions, most notably the opportunity to expand Medicaid.

Currently 22 states have not expanded Medicaid eligibility to include adults earning up to 138% of the federal poverty level, as the ACA allows. Whether due to concerns over future funding or fundamental opposition to the Obama administration’s key piece of legislation—or a combination of both—it is not just patients who are left in healthcare limbo.

The ACA requires the Centers for Medicare & Medicaid Services (CMS) to pay 100% of the additional cost of expanded Medicaid coverage through 2016, after which the federal share begins stepping down to 90% by 2020. The federal share in states not expanding Medicaid eligibility can be as low as 50%, and is set on a state-by-state basis by a statutory formula.

Primary care physicians view Medicaid expansion with mixed emotions. They want to see the uninsured covered, but low Medicaid payment rates and administrative hassles weigh on them, and are responsible for nose-diving numbers of primary care doctors who accept new Medicaid patients. In Texas, for example, 67% of all physicians reported accepting new Medicaid patients in 2000, according to the TMA. Today, only 37% do.

Making Medicaid Work

But some states are having success inducing reluctant physicians to give Medicaid a second look. Indiana is a major example. It is the latest and 28th state (plus the District of Columbia) to expand Medicaid coverage. The state negotiated an agreement with CMS to give its Medicaid coverage more of a "private" look than conventional Medicaid. CMS approved the waiver after considerable teeth-gnashing. Governor Mike Pence (R) championed the plan, known as Healthy Indiana Plan (HIP) 2.0. The Indiana State Medical Association also backed the expansion, which launched in February.

Along with expanding Medicaid eligibility, Indiana’s plan reimburses doctors treating Medicaid patients at the same rates as Medicare. Thus it is not surprising that 1,000 physicians, including 367 primary care providers, signed up for HIP 2.0 in the program’s first 100 days. (Medicaid previously paid about 67% of Medicare rates.) “That physician participation is a huge deal for Indiana,” says John Wernert, MD, secretary of the Indiana Family and Social Services Administration.

After 2017 Indiana will pay for its newly-covered Medicaid population using a combination of the federal Medicaid funds, a $1 per-pack cigarette tax, first instituted in 2007, and a new $50 million annual assessment on hospitals.

Some laud the Obama administration’s flexibility in approving the waivers; others, including both Republicans and Democrats, take issue with as-
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pects of those waivers.

Jocelyn Guyer, M.P.A., director of Manatt Health Solutions, the policy division of law firm of Manatt, Phelps & Phillips LLP, says the Obama administration has had an open-door policy for all states to come in and talk about the way states can get to expansion.

“The administration does not need to pressure states into expansion. Any pressure comes from it being a great deal for them and their citizens,” she explains. “The administration has been very open to working with states to get to ‘yes.’”

TOXIC POLITICS

While the Republican bona fides of the Indiana plan would seem to make it a model for other GOP states, that is not the case. Tennessee’s Republican governor Bill Haslam proposed a Healthy Tennessee Plan that was modeled on HIP 2.0 in many respects, only to see it rejected by the state’s GOP-controlled legislature.

Similarly, Republican governors in Wyoming, Idaho, Montana, and Utah, as well as Alaska’s Independent governor, proposed expansions after the 2014 elections, but only Montana is in negotiations with CMS on a Section 1115 waiver for its program.

Other Republican governors have no intention of expanding Medicaid eligibility, and some Republican legislatures have made it clear that any plan sent to them would be dead on arrival. That is the case in Texas, which is frustrating for physicians Curran who would like to see negotiations move forward.

“There is not a lot possible in the current political environment,” Curran complains. “It is almost toxic in the state capitol to talk about the [ACA]. I’m not saying that is right or wrong. But we have to deal with that reality. It is frustrating knowing we could do things better but no one is offering reasonable options.”

Other governors, state legislatures, and some physicians are also worried about the reduction in federal funding starting in 2017. That funding uncertainty is a major reason members of the Alaska legislature give for refusing to accept Governor Bill Walker’s Medicaid expansion proposal. “Whos to say they won’t go down to the current federal share?” says Mike Haugen, JD, MBA, executive director of the Alaska State Medical Association. In Alaska, that is 50%.

“Our members are in favor of making sure all Alaskans have quality access to healthcare, and if that is Medicaid expansion, so be it,” Haugen says “But we have not endorsed the governor’s proposal. The physicians are not quite as excited about it as the hospitals and nursing homes.”

MEDICAID PARITY FOR SOME, NOT ALL

Under the Affordable Care Act, states were required to raise Medicaid primary care payments in both fee-for-service and managed care to the same level as Medicare reimbursements in 2013 and 2014. While bills were introduced in Congress to extend this pay parity, none passed, thus, restoring inequity in 2015.

Currently only 16 states and the District of Columbia have extended Medicare-Medicaid parity:

If I took every Medicaid patient, I couldn’t pay my bills.”

— DOUG CURRAN, MD, ATHENS, TEXAS, CHAIRMAN OF BOARD OF TRUSTEES, TEXAS MEDICAL ASSOCIATION.
REFORM LAW SURVIVES (AGAIN)

With its recent decision in the case of King v. Burwell, the U.S. Supreme Court may have given added momentum to the drive to expand Medicaid eligibility in the states. John Holahan, PhD, a fellow with the Urban Institute’s Health Policy Center, recently told Medical Economics that while Republican-run states could hold out hope for a repeal of the ACA under a Republican president elected next year, such a development is “unlikely.”

“I think more and more states are going to figure out the way to solve it politically, and the economic losses to states are just too great,” he says. “They are particularly great to the big hospitals that serve a lot of low-income people, and the business communities will be increasingly vocal, and more and more states, I think, will adapt the expansion.”

That sentiment was echoed by Shawn Martin, senior vice president, advocacy, practice advancement and policy for the American Academy of Family Physicians, who says that even in Republican-run states, the feeling is that “the [ACA] is here to stay.”

“I think [some states] have a distrust in the political apparatus of Washington, D.C., and they see this is more of a problem on their plate that they need to address or deal with or identify solutions for, including in highly Republican states,” Martin says. “I think you will see a number of governors and states legislators become much more serious about their responsibilities and highly skeptical of Washington’s ability to really do what’s best for their particular state.”

STATES TAKE RESPONSIBILITY?

So while there may not be an rush to expand Medicaid eligibility among these states, the large majority of holdouts appear to be headed in that direction, says Bob Doherty, senior vice president for governmental affairs and public policy for the American College of Physicians.

“Ultimately, I think we are going to see just about every state getting more of the Medicaid expansion, some will be next two years, some may take another five or six or seven years, but I think they are all going to get there,” Doherty says.
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Disconnected
How stalled interoperability hurts patient care

by KEN TERRY Contributing editor

INTERNIST EDWARD GOLD, MD, of Emerson, New Jersey, doesn’t believe that the efforts of the government to promote electronic health data exchange have been successful. “I don’t think we’re more interoperable than we were three or four years ago,” he says. He still can’t exchange secure messages with most other doctors, he notes, and a local health information exchange (HIE) initiative has come to naught so far.

In contrast, Edward Rippel, MD, an internist in Hamden, Connecticut, believes there has been some progress in interoperability over the past year or two. “There has been an increase in electronic communication of clinical information among community-based providers, whether they use disparate EHRs or the same EHR,” he says. “It has grown because of greater provider awareness of its existence and an increased push for the criteria associated with meaningful use.”
Rippel, however, admits that his ability to exchange data with other doctors and his hospital remains very limited. He has not been able to receive any secure messages from physicians who use different EHRs, and the statewide HIE in Connecticut was terminated last year, after spending $4.3 million in federal funds. (A new law requires the state to try again, however.)

Looking at the national picture, Nathan McCarthy, MHA, a senior manager at ECG Management Consultants in St. Louis, Missouri, says that interoperability “has been more promise than action for most of the providers we’re working with.”

Some physicians are easily able to obtain summaries of care, known as continuity of care documents (CCDs) or consolidated clinical document architecture documents (CCDAs), from their colleagues, he notes. But for the most part, the doctors who have this connectivity either work for healthcare systems and are on the same EHR or belong to “a small subset of independent larger practices” in the area, he says.

A host of factors continue to impede interoperability, despite some well-publicized efforts by the government and the private sector. McCarthy says employed physicians have greater access to external data than do their private practice colleagues. But for the majority of physicians, interoperability still seems like a mirage, forever receding into the distance.

MIXED PICTURE
The Office of the National Coordinator for Health IT (ONC), which has given more than $500 million to statewide HIEs, paints a rosy picture of interoperability in a recent report, citing data from an American Hospital Association survey. Among other things, the ONC data brief finds that in 2014, 69% of hospitals exchanged data electronically with other hospitals, and 62% of them exchanged information with ambulatory care providers outside their enterprises.

But other studies have gotten very different results. A 2014 study published in Health Affairs found that health information exchange was still quite low, despite the rapid increase in the percentages of providers who had adopted EHRs. Only 14% of physicians, for example, shared information with providers outside their organizations in 2014.

Similarly, a 2013 study showed that only Providers want to obtain data across the care continuum, but they’re able to get only some of that data, or they’re getting it in a non-consumable format.”

—NATHAN MCCARTHY, SENIOR MANAGER, ECG MANAGEMENT CONSULTANTS, ST. LOUIS, MISSOURI

According to the Healthcare Information and Management Systems Society (HIMSS), interoperability is defined as the extent to which systems and devices can exchange data, and interpret that shared data. For two systems to be interoperable, they must be able to exchange data and subsequently present that data such that it can be understood by a user.

HIMSS’ definition of interoperability includes three levels: foundational, structural and semantic.

1 FOUNDATIONAL
Interoperability that allows data exchange from one information technology system to be received by another and does not require the ability for the receiving information technology system to interpret the data.

2 STRUCTURAL
An intermediate level of interoperability that defines the structure or format of data exchange where there is uniform movement of healthcare data from one system to another such that the clinical or operational purpose and meaning of the data is preserved and unaltered.

3 SEMANTIC
Interoperability at the highest level, which is the ability of two or more systems or elements to exchange information and to use the information that has been exchanged. This level of interoperability supports the electronic exchange of patient summary information among caregivers and other authorized parties via potentially disparate electronic health record (EHR) systems and other systems to improve quality, safety, efficiency, and efficacy of healthcare delivery.

Source: HIMSS
There has been a lot of discussion about “information blocking,” in Congress and elsewhere, since ONC released its report about it last spring. ONC said it had anecdotal evidence that some vendors were engaging in this practice, which included such tactics as charging high fees for interfaces with other EHRs and high data transmission fees. Soon after the report came out, Epic Systems, the largest ambulatory care vendor, said it would no longer charge fees for sending or receiving clinical messages.

The ONC report also cited evidence showing that some providers were erecting barriers to the free flow of information. In some cases, healthcare systems were said to be making it difficult to exchange data with other organizations in order to protect referrals of patients to their own hospitals.

A Senate committee recently held hearings about information blocking, and witnesses testified that the practice continues to be a problem. A provision in the 21st Century Cures Act, which recently passed in the House of Representatives, aims to make that more difficult. But University of Michigan School of Public Health assistant professor Julia Adler-Milstein, Ph.D., says that information blocking is likely to continue because “it’s legal, and it’s profitable.”

For example, she says, “EHR vendors can make a lot of money building complex interfaces. Even though their systems could enable exchange in a lower cost way, that option is not described to customers as something that’s available. They’re told that paying for an interface is their only choice.”

Large healthcare organizations may also engage in information blocking by telling their staff physicians that the best way for them to exchange information with the hospital is by switching to the same EHR that the hospital uses. Internist Edward Rippel, MD, has encountered that with his own hospital. While the facility offers to provide some connectivity to independent practices for a fee, it has strongly urged the private practice doctors to adopt its EHR.

Rippel, a solo practitioner, can’t see why he should, since he likes his current EHR. “Why would I switch to a system that’s cumbersome, not modifiable, and doesn’t reside on my premises, and I don’t control it? I have a lot of issues with that.”

On the other hand, he doesn’t think the government-mandated approach of meaningful use is the key to improving interoperability. “Something needs to be done about interoperability,” he says. “But it needs to be done in a way that’s a minimal interruption for practices and providers, because what’s happening now is getting us no place.”

In addition, the survey didn’t ask how many providers the hospitals had exchanged information with or whether they used different EHRs. To meet the meaningful use Stage 2 requirements, a hospital must transmit electronic care summaries in 10% of transitions of care, but it must send just one of those from its EHR to an EHR from a different vendor. Even if a hospital transmitted only enough CCDs to satisfy these criteria, it could have claimed it was interoperable in the survey data used by ONC.

**DIRECT MESSAGING**
Direct messaging is ONC’s great hope for leveraging the EHR
interoperability. Certified EHRs must include Direct capability, although Direct is not the only acceptable way for eligible providers to exchange information.

Two-thirds of “health information organizations” have deployed Direct messaging, according to a recent study by the Health Information Management and Systems Society (HIMSS). The fairly small sample in this survey included physician practices, hospitals, healthcare systems, accountable care organizations, HIEs, and health information service providers (HISPs).

Among the respondents using Direct, the top benefits included faster information access, reduced paper handling, and more accurate and complete patient information. Major challenges included high cost, changing workflows, and other providers not willing to communicate via Direct.

The most common uses of Direct were exchanging care summaries at transitions of care, notification of admissions, discharges, and transfers (ADTs), patient communication, and secure email for communication only. Slightly below that were physician referrals and other kinds of peer-to-peer collaboration.

There is evidence that the use of Direct messaging is growing. The leading HISPs—which convey Direct messages among providers—are seeing a strong increase in the number of providers using their services, says David Kibbe, MD, CEO of DirectTrust, a trade association for HISPs.

The 34 HISPs belonging to DirectTrust also have begun sharing their directories of Direct addresses, he notes. This makes it easier for physicians who use different HISPs to locate one another on the Direct network.

Federal agencies are increasingly using Direct in their healthcare operations, Kibbe adds. For example, the Centers for Medicare and Medicaid Services (CMS) plans to use Direct in its Electronic Submission of Medical Documentation (ESMD) program. ESMD enables providers to send documentation electronically in response to requests from Medicare auditors.

**DIRECT CHALLENGES**

While some EHR vendors have embraced Direct, other developers “have not put in the features and functions that make their Direct capabilities usable by providers,” Kibbe says. For example, there may be no Direct inbox or no easy way to compose a Direct message in the EHR.

That is not a problem in Gold’s EHR, but he has trouble finding the Direct addresses of the specialists to whom he refers patients. In many cases, they don’t have Direct addresses, perhaps because they don’t want to pay the fees for HISP service, he says. Many other doctors use different HISPs than his, so he can’t locate their addresses. Despite what Kibbe says about HISPs sharing directories, the only one Gold can access is that of Surescripts, he says.

Surescripts says it’s in the process of sharing directory information with other HISPs. It plans to share its Direct addresses with every other HISP with which it has a trust relationship through DirectTrust, a spokeswoman says.

Gold finds the whole process of exchanging care summaries via Direct messaging “clunky.” There should be an easier way than creating messages, searching for addresses, uploading and downloading CCDs, and reviewing their contents for the desired information, he says. He would like to have the data go into his EHR fields, instead of coming in as a PDF document.

Rippel’s EHR vendor, eClinicalWorks, provides “peer-to-peer” secure messaging for free, he says. If a colleague is on the eClinicalWorks network, whether or not he
or she has the same EHR, Rippel can send the person a referral message, attaching a care summary and other documents. Then the other doctor can import the CCD or print and scan it, depending on the system.

Rippel has received secure messages from other physicians who use eClinicalWorks, but not from practices that have different EHRs. eClinicalWorks has told him that to get Direct messaging, which provides a higher level of interoperability, he’d have to pay the vendor an additional monthly fee.

An eClinicalWorks spokeswoman confirms that customers must pay an additional fee for Direct messaging. But she says that practices should be able to exchange messages with disparate EHRs through the vendor’s proprietary system.

McCarthy has seen other problems with Direct messaging. “Providers want to obtain data across the care continuum, but they’re able to get only some of that data, or they’re getting it in a non-consumable format. It’s a CCD document that’s not discretely digestible by their EHR.”

He adds, however, that most of the challenges doctors encounter are related to the process, not to the technology. For example, if a physician has to go to a portal to get Direct messages, instead of receiving them in his or her EHR, the physician may become frustrated when visiting the portal and doesn’t find the information he or she is seeking. And with so many doctors not using Direct, a physician who does may not receive referral data electronically and may have to request that information be sent via fax.

Nevertheless, McCarthy stresses, “The physicians we work with see Direct as a much bigger value over fax. It saves their staff a lot of time and there’s a recordable record that it was sent over in a much more reliable fashion than a fax machine.”

HEALTH INFORMATION EXCHANGES

As noted earlier, a small minority of physicians use statewide or regional health information exchanges (HIEs). While there are vigorous, successful HIEs in some states, such as New York, Indiana, Michigan, and California, these organizations are not widespread, and efforts to start more of them have met with significant challenges.

In northern New Jersey, for instance, Edward Gold’s practice has been waiting for the formation of an HIE that promised to provide interoperability with the local hospitals and an ACO in which Gold is the medical director. Unfortunately, he says, “The HIE hasn’t come to fruition, and I doubt they will. They talk a good game, but they haven’t produced.”

Summarizing her team’s national research on HIEs, Adler-Milstein says, “We’re not seeing a massive dying off of HIEs. But we’re not seeing a large number of new efforts or a big increase in the number of engaged providers. It doesn’t seem there’s rap-

Interoperability barriers remain

Several barriers continue to inhibit nationwide interoperability and must be overcome rapidly. These barriers include:

1. Electronic health information is not sufficiently structured or standardized and as a result is not fully computable when it is accessed or received. That is, a receiver’s system cannot entirely process, parse and/or present data for the user in meaningful and usable ways. It is also difficult for users to know the origin (provenance) of electronic health information received from external sources. Workflow difficulties also exist in automating the presentation of externally derived electronic health information in meaningful and appropriately non-disruptive ways.

2. Even when technology allows electronic health information to be shared across geographic, organizational and health IT developer boundaries, a lack of financial motives, misinterpretation of existing laws governing health information sharing and differences in relevant statutes, regulations and organizational policies often inhibit electronic health information sharing.

3. While existing electronic health information sharing arrangements and networks often enable interoperability across a select set of participants, there is no reliable and systematic method to establish and scale trust across disparate networks nationwide according to individual preferences.

Source: ONC
There has been an increase in electronic communication of clinical information among community based providers ... It has grown because of greater provider awareness of its existence and an increased push for the criteria associated with meaningful use.”

—EDWARD RIPPEL, MD, INTERNIST, HAMDEN, CONNECTICUT

id growth, and that HIEs have reached a tipping point and that they’re robust and widespread. The challenges remain the same, but the exchanges continue to exist, so they’re filling some need.”

The surviving HIEs are moving to support new care delivery models, including ACOs, Adler-Milstein says. Among those that responded to her team’s survey, 80% said they’re building capabilities for quality reporting and population health management.

Little data exists on the number and prevalence of privately-funded HIEs. But McCarthy has observed that private HIEs are continuing to grow faster than public HIEs, which are still somewhat dependent on the willingness of individual states to fund them. (ONC recently made some HIE grants available, but most of the federal money available for that purpose has already been spent.)

Larger healthcare organizations and ACOs have formed most of the private HIEs. In many cases, these are open only to providers who are affiliated with these enterprises. For example, McCarthy cites a group of providers in Montana who have formed an HIE specifically to connect the members of their ACO.

Overall, Adler-Milstein predicts ACOs will promote public HIE formation going forward. But she admits that that might depend on whether an ACO can motivate patients to seek care within the ACO’s network. “If you think you can, then the right solution is to get real connectivity with your ACO partners,” she says. “If you think you can’t, you need to know when your patients are being treated elsewhere, and some level of connectivity [with external providers] is needed for that.”

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COMING SOON
Interoperability: The future of healthcare or a pipe dream?
Experts discuss the issues surrounding interoperability in our exclusive roundtable conversation
Coming in the October 25, 2015 issue of Medical Economics

ON THE WEB
ONC’s plan to solve the interoperability puzzle http://bit.ly/1Kf8Wtm

The interoperability problem: Why ACOs can’t share data http://bit.ly/1F8w7Zp
DISCONNECTED, PART 2:
New interoperability approaches offer promise and challenges

by KEN TERRY Contributing editor

Although the interoperability of electronic health records (EHRs) currently is very limited (see “Disconnected, part 1” on page 30), several moves are afoot to improve it. Some of these initiatives are well underway, while another one is in an early, experimental phase. They range from new combinations of existing techniques to a novel approach that applies widely used Internet standards to healthcare.

Most physicians are unlikely to see the fruits of these labors for some time, however. But CommonWell plans to expand to 5,000 sites by the end of 2015, and major developments in all of these projects can be expected in the next few years. Here’s a brief rundown on each of them, including how they might help you in the future.

COMMONWELL HEALTH ALLIANCE
CommonWell Health Alliance is a collaboration of EHR vendors that represent about 70% of the hospital market and 24% of the ambulatory care market. It is implementing an interoperability network that includes a common patient matching method, a nationwide record locator, and privacy and security safeguards. Launched early in 2013, CommonWell started testing at a few sites later that year.

Today, CommonWell includes the biggest EHR vendors in the acute-care market except for Epic, which is also the largest ambulatory care EHR vendor. As a result of Epic’s refusal to join CommonWell, the alliance represents less than a quarter of the ambulatory care EHR market.

CommonWell now has 29 members and expects to have 40 by year’s end, according to Jitin Asnaani, MBA, the alliance’s executive director. So far, only 73 provider sites have gone live on CommonWell, but rollouts by some big EHR vendors to their customer bases are expected to begin this fall. The 5,000-site goal includes practices and hospitals that will have the ability to connect with CommonWell but will choose not to initially, Asnaani admits.

Three vendors—Cerner, McKesson, and athenahealth—have said they’ll make CommonWell available to their clients for free. A Cerner spokesman said the company would offer the service gratis for five years after a customer signs up for it “with the exception of a one-time setup fee.”

It’s unclear whether the CommonWell vendors will charge usage or subscription fees later if the service catches on, Asnaani says. But for now,
they’re paying fees to support the organization, and they’re bearing the cost of interfaces to RelayHealth, the McKesson subsidiary that provides the backbone for CommonWell. Cloud-based EHR vendors need write only one interface to RelayHealth; some suppliers of premise-based EHRs are connecting all their customers to a cloud-based solution that they link to RelayHealth through a single interface, Asnaani pointed out.

RelayHealth supplies peer-to-peer connectivity among participating sites, regardless of which CommonWell member’s EHR they use. CommonWell acts as a hub for patient matching, record location and retrieval, patient access, privacy, consent management, and trusted data access.

Asnaani estimates that the accuracy of CommonWell’s patient matching across sites is in the 80%-90% range, compared with the national average of 50%-60% for external data exchange. Besides using the customary demographic information, he says, CommonWell’s algorithm incorporates driver’s license numbers and answers to questions that patients are asked at provider sites.

According to Asnaani, CommonWell is in a “solid position” to provide interoperability in the long term. But he cautions, “For interoperability to work, you need to get technology in front of the user and build a great user experience so they want to use the technology.”

The user experience has not been so great to date at Palmetto Health in Columbia, South Carolina, says Tripp Jennings, MD, system vice president and medical informatics officer for Palmetto. In the first year of testing and using the system, he says, “We haven’t seen the use of CommonWell on the outpatient side like we would have hoped.”

The CommonWell service is being used mainly by physician practices outside of Palmetto Health, many of which lack access to the organization’s private HIE, he explains. For Palmetto physicians, he notes, part of the challenge is that they have separate icons in their EHR for CommonWell, the HIE, and a U.S. Drug Enforcement Admin-

Guiding Principles for Nationwide Interoperability

1. **Build upon the existing health IT infrastructure**
   Significant investments have been made in health IT across the care delivery system and in other relevant sectors that need to exchange electronic health information with individuals and care providers. To the extent possible, we will encourage stakeholders to build from existing health IT infrastructure, increasing interoperability and functionality as needed.

2. **One size does not fit all**
   Interoperability requires technical and policy conformance among networks, technical systems and their components. It also requires behavior and culture change on the part of users. We will strive for baseline interoperability across health IT infrastructure, while allowing innovators and technologists to vary the usability in order to best meet the user’s needs based on the scenario at hand, technology available, workflow design, personal preferences and other factors.

3. **Empower individuals**
   Members of the public are rapidly adopting technology, particularly mobile technology, to manage numerous aspects of their lives, including health and wellness. However, many of these innovative apps and online tools do not yet integrate electronic health information from the care delivery system. Electronic health information from the care delivery system should be easily accessible to individuals and empower them to become more active partners and participants in their health and care.

4. **Leverage the market**
   Demand for interoperability from health IT users is a powerful driver to advance our vision. As delivery system reform increasingly depends on the seamless flow of electronic clinical health information, we will work with and support these efforts. The market should encourage innovation to meet evolving demands for interoperability.

Source: ONC, “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap”
Interoperability

5. **Simplify**
Where possible, simpler solutions should be implemented first, with allowance for more complex methods in the future.

6. **Maintain modularity**
Because medicine and technology will change over time, we must preserve systems’ abilities to evolve and take advantage of the best of technology and health care delivery. Modularity creates flexibility that allows innovation and adoption of new, more efficient approaches over time without overhauling entire systems.

7. **Consider the current environment and support multiple levels of advancement**
Not every individual or clinical practice will incorporate health IT into their work in the next three to 10 years and not every practice will adopt health IT at the same level of sophistication. We must therefore account for a range of capabilities among information sources and information users, including EHR and non-EHR users, as we advance interoperability.

8. **Focus on value**
We will strive to make sure our interoperability efforts yield the greatest value to individuals and care providers; improved health, health care and lower costs should be measurable over time and at a minimum, offset resource investment.

9. **Protect privacy and security in all aspects of interoperability**
It is essential to maintain public trust that health information is safe and secure. To better establish and maintain that trust, we will strive to ensure that appropriate, strong, and effective safeguards for electronic health information are in place as interoperability increases across the industry. We will also support greater transparency for individuals regarding the business practices of entities that use their data, particularly those that are not covered by the HIPAA Privacy and Security Rule, while considering the preferences of individuals.

10. **Scalability and universal access**
Standards and methods for achieving interoperability must be accessible nationwide and capable of handling significant and growing volumes of electronic health information, even if implemented incrementally, to ensure no one is left on the wrong side of the digital divide.
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Eventually, the Healthcare Management and Systems Society (HIMSS), which represents health IT professionals and EHR vendors, took over the eHealth Exchange/IWG project. HIMSS recently started an offshoot called ConCert by HIMSS that has taken on IWG’s testing and certification.

Meanwhile, the eHealth Exchange has continued to add provider organizations and networks that show the ability to exchange information using the exchange’s standards and meet other requirements. Mariann Yeager, MBA, executive director of the Sequoia Project, says that the leading EHRs comply much better than they did two years ago with underlying standards such as HL7’s Consolidated Data Architecture, which forms the basis for standardized care summaries that must be exchanged to meet a meaningful use requirement. Some of these products can be quickly tested for interoperability and have very consistent performance, she says.

“Any eHealth Exchange member can query and get authorization to access records from any other participant in the country,” she notes. A major drawback, however, is that the eHealth Exchange doesn’t have a record locator service. As a result, physicians have to query specific organizations where the patient for whom they’re seeking records has received care previously.

In addition, Yeager notes, software interfaces that connect disparate systems are still required. “It’s not plug and play yet. That’s a vision. That comes when we have more specific constraints and more mature health IT systems. We’re starting to see examples of close to plug and play, but there’s no testing program in our industry that can do that out of the box.”

An Intel case study of an eHealth Exchange implementation in Oregon was more critical of the exchange’s capabilities. Intel’s researchers looked at the exchange of patient data between two different versions of Epic EHRs at Kaiser Permanente and at Providence Health & Services, and a Greenway EHR used by Promine Health, a worksite clinic.

While the participants were able to pull and push records from and to one another, partly through Direct messaging, the Intel team found that the standards lacked specificity and varied greatly in their implementation. The customization of EHRs by healthcare organizations created a unique experience in setting up each data exchange, they note. Significant resources were required to resolve these differences, fill gaps in interoperability, and “incorporate the exchanged data into coordinated care workflows.”

**CONCERT BY HIMSS**

This relatively new organization tests and certifies EHRs, health information exchange (HIE) software, and HISP s. Its certification requirements are far more rigorous than those of the Office of National Coordinator for Health IT (ONC), but pertain only to interoperability.

ConCert tests and certifies the interoperability of EHR and HIE software and health information service providers (HISPs), which enable Direct messaging between healthcare providers. In this context, “interoperability” means the adherence of these products to specifications developed by IWG, Integrating the Healthcare Enterprise (IHE), and HIMSS.

Sandra Vance, MHA, senior director of interoperability initiatives for HIMSS North America, says that the initiatives of ConCert by HIMSS and eHealth Exchange are “complementary.” However, the two organizations are still working out how to use their testing programs together, she notes.

Unlike the eHealth Exchange and CommonWell, Vance says, HIMSS simply certifies that products meet interoperability standards; it’s not providing a network for information exchange. It’s also not guaranteeing that EHRs or HIEs can connect without interfaces, she says, although compliance with the specs will make it easier for vendors to write those interfaces.

In addition, she says, “much less” work will be required to exchange Consolidated Clinical Document Architectures (CCDAs) between HIMSS-certified products.

The ConCert certification for EHRs goes far beyond what’s required for Meaningful Use stage 2. Besides Direct messaging capability, EHRs must be able to query other EHRs for records. In addition, the certification is supposed to include support for a provider directory. But Vance says IWG is still working on the latter feature.

To date, Cerner, Greenway, and NextGen have all joined the ConCert initiative, and “another great big” vendor will be announced soon, Vance says. Ten companies

**Most patients don’t want to be the drivers [of data exchange]. Most patients are healthy, and they don’t want to be the ones responsible for it unless there are very easy solutions to do it.”**

—MICKY TRIPATHI, PH.D., PRESIDENT, THE MASSACHUSETTS EHEALTH COLLABORATIVE
are going through pilot testing, she adds.

**FAST HEALTHCARE INTEROPERABILITY RESOURCES (FHIR)**

As long as EHR vendors have to write interfaces to other systems and HIEs for each implementation, or “instance,” of their products, interoperability will continue to be limited. Moreover, interoperability currently focuses on sending and receiving care summaries, rather than individual records. This form of information exchange is not very useful to physicians who need specific data about a patient quickly and don’t have time to search for it in a CCDA.

Even in advanced interoperability models like CommonWell, the record locator can only determine where records on a patient are stored, not what’s in those records, notes Micky Tripathi, Ph.D., president of the Massachusetts eHealth Collaborative. That doesn’t help providers who are looking for a particular piece of information.

Fast Healthcare Interoperability Resources (FHIR), a proposed standards framework from HL7, the leading healthcare standards organization, promises to solve all of these problems. By using snippets of data known as resources to represent clinical entities within EHRs, FHIR will enable developers to write plug-ins that can connect to any FHIR-enabled EHR through a standard application programming interface (API). Not only will this eliminate the need to write customized interfaces, but it will allow providers to query databases for individual records, FHIR proponents say.

The Argonaut Project, a collaborative of 68 software developers, EHR vendors, healthcare organizations, and consulting firms, is testing the first iteration of FHIR with the 16 data elements that are found in CCDAs, plus the OAuth Internet authorization standard. Tripathi, who is also the Argonaut Project manager, said he expects some EHRs to be FHIR-enabled within the next 12 to 18 months. Among the EHR vendors in the collaborative are athenahealth, Cerner, Epic, GE, McKesson, Meditech, NextGen, and Practice Fusion.

It is likely that FHIR will be used initially for purposes other than health information exchange. For example, it might expand the capabilities of EHRs by allowing outside developers to plug third-party applications into them. Consumers might also be able to use FHIR-enabled mobile health apps with their providers’ EHRs.

The mechanism for FHIR-enabled EHRs to exchange health information is unclear, partly because of privacy and control issues. Patients might download their records, store them in some kind of online repository, and send them to the providers they choose. Or providers in a region might form a cloud-based network that can share data through apps plugged into their EHRs.

Tripathi believes that both of these kinds of FHIR-enabled information exchange will be used, depending on the circumstances. Provider-to-provider exchanges won’t disappear, he says, “because most patients don’t want to be the drivers [of data exchange]. Most patients are healthy, and they don’t want to be the ones responsible for it unless there are very easy solutions to do it.”

However, he predicts that as health data becomes available in standardized forms, consumers might store their health records online in health information “banks.” These services might be provided by pharmacies or perhaps an entity such as Microsoft HealthVault, he suggests. Then, if a patient were visiting a physician that didn’t have his or her records from other sources, the patient could authorize the provider to download them from the health information bank.

**CONCLUSION**

Interoperability is far from a reality today. While it’s slowly becoming easier to interface different EHRs through networks that allow query-based as well as Direct exchanges, the implementation of these exchanges is still laborious and expensive, and manual work often is required to ensure that providers get the information they’re looking for. On top of that, patient matching is still relatively poor within and between most organizations—an issue that networks like CommonWell are just starting to address.

Despite the potential of FHIR, which is exciting to many in the industry, it is still in a very early stage, notes Sandra Vance of HIMSS. She expects that the incremental approach to improving interoperability will prevail for the foreseeable future. But it’s unclear that it will produce the kind of instant access to specific patient information that providers are craving. Until that arrives, physicians will have to make do with what they already have.
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Tech Talk

How patient portals can help you build a PCMH

by SUSANNE MADDEN, MBA, Contributing author

If you are thinking about implementing a patient portal, or already have one in place, you may not realize that this is a great tool to help you meet certain criteria necessary for achieving Patient-Centered Medical Home (PCMH) recognition.

MANY PORTALS offer the components required to meet part of the National Committee for Quality Assurance’s (NCQA) PCMH Standard for patient-centered electronic access. The purpose of doing so is to allow the practice to offer information and services to patients and their families via a secure electronic system whereby patients can view their medical record, access services, and communicate with the healthcare team electronically.

Providing electronic access to this information also enables practices to meet meaningful use requirements, so you get a double return on your portal investment if you are attempting to meet requirements for both the NCQA PCMH and meaningful use programs.

So what exactly does your portal need to provide to meet the criteria?

**Online access to records**

Patients need to have online access to their health information (within a defined period of time). That information typically includes pertinent details such as diagnoses, medication lists, and recent test results.

**Clinical summaries**

This is an after-visit summary that provides a patient with relevant and actionable information and instructions. It contains the patient name, provider’s office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for the visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, and a summary of topics covered during visit. Some summaries may also include the time and location of the patient’s next appointment and any testing, if scheduled or recommended.

**Secure communication**

There must be secure two-way communication between your patients and your practice. Some practices worry that they will be inundated with patient messages through the portal, but the reality is that these communications are often handled much more quickly than via phone calls, thus freeing up provider time significantly.

**Request services**

Patients must be able to request appointments, prescription refills, referrals, and test results. Moving those requests online decreases call volume significantly, and enables staff and physicians to respond outside of peak visit hours, which not only reduces the time your staff spends handling calls but also helps to streamline workflow over the course of the day.

Susanne Madden, MBA, is founder and chief executive officer of The Verden Group, a consulting firm located in Nyack, New York. This article first appeared in our partner publication, Physicians Practice. Send your technology questions to medec@advanstar.com.
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New Career Directions

Financial factors and practice models to consider

by JANET KIDD STEWART  Contributing author

Driven by technology, a wave of practice consolidations and changes in the regulatory environment, some physicians are steering their skills into new ventures, practice models, or job roles that they hope will deliver a more promising financial future. 

Kennealy worked in a California primary care practice for nine years earlier in her career, but increasingly felt less authority to dictate patient care as managed care gained popularity in her state. She added a part-time role as a hospital administrator, but quickly realized she couldn’t do both jobs well.

She decided to concentrate exclusively on the administrative side, eventually becoming a hospital chief executive officer.
Career transitions

and, more recently, a career coach for doctors. Her take-home pay her first year in her own business? An $11,000 loss. She was fortunate to have a working spouse, however, and the couple worked as a team to keep personal expenses in check, she says.

“Physicians are feeling a great deal of stress right now, particularly mid-career physicians. They trained with one practice model and that’s changed significantly. There are increased clinical pressures, administrative tasks, and patient metrics,” says Cathy Lanteri, MD, FAPA, a psychiatrist in private practice who also coaches other physicians. “It’s not just getting an accurate diagnosis today.”

KEYS TO SUCCESS

A few additional points to keep in mind when thinking about a career change

1. It might be less costly than you think
   Afraid you can’t afford to take a pay cut? Do the math. Late-career physicians in the highest tax bracket who are also contributing a sizeable amount of salary to retirement plans often are actually living on far less than those gross salary amounts. Assess your basic living expenses and your must-have discretionary items, then compare that figure to the potential lower salary to see how much you’d have to supplement your new income from retirement accounts. Financial planner Jonathan Guyton believes you can take an initial 5% from savings for income in the first year provided you’re willing to take a modest pay cut if markets perform badly in later years. (See more at: http://bit.ly/safe-withdrawal-rates).

2. Monetizing You, Inc
   Are there aspects of your expertise you could make into a curriculum for delivery over the Internet? High-level wellness content could be a good fit for primary care physicians with a passion for nutrition and fitness, for example, says David Gruder, an organizational psychologist with CEO Space, which offers training to aspiring entrepreneurs.

3. You might be heading back to class
   Be aware that you may be expected to get another degree, says Robin Singleton, managing partner with Healthcare Services & Solutions for executive search firm DHR International. That could mean an MBA, master of medical management (MMM), or advanced training in healthcare data analytics, she says.

4. Don’t forget the bean counter
   If you decide to sell your practice to a hospital or group, hiring the right tax adviser is crucial. “If a doctor can just sell stock in the practice, that can sometimes be done as capital gains, instead of ordinary income,” says Saul Rudo, director of the tax-planning practice at Katten Muchin Rosenman LLP. Particularly with the new Medicare surtax now in place, receiving income at lower capital gains rates not subject to payroll taxes will put more money in your pocket.

5. If you just don’t know
   Want to make a change but have no idea where to begin? Personality assessments are a common starting point, but executive coach Michael Melcher of Next Step Partners has clients contemplate some blue-sky career moves, even if there’s little chance they’ll pursue them. “Do they really want to keep the same type of practice but do it in a different part of the country? Move into global health? Open a bed and breakfast in Vermont? Write a paragraph about what their lives would be like. Most great career leaps start as small ideas.”

6. Don’t go it alone
   Former pediatric oncologist and medical school dean Philip Pizzo, MD, is founding dean of the Stanford Distinguished Careers Institute, a new, year-long fellowship program that gathers leaders from a variety of fields and puts them through individualized curricula aimed at helping them re-tool and network to extend their working lives. “When I was a pediatric intern many decades ago I witnessed physicians in their late 60s and early 70s who didn’t see the signs of transition and needed to be moved away from practices. Potentially, this type of program can forecast a better life journey.”
Career transitions

In a survey of 2,005 physicians released in April by Cejka Search and VITAL WorkLife, 15% of respondents said stress caused them to leave their practice. Of those, however, just 52% reported that the change alleviated the stress, with the remainder saying it helped only somewhat or not at all.

“It’s a common fantasy for unhappy physicians to want to bail out when things get stressful,” says Francine Gaillor, MD, MBA, executive director of the Physician Coaching Institute. “I try to get them thinking about career expansion instead, not abandoning the white coat,” but widening the scope of their careers, she says.

CAREER LONGEVITY

For family practitioner Jeffrey Gold, MD, of Marblehead, Massachusetts, extending his career meant switching to a direct care model, seeing patients on a retainer basis without involving an insurer, after a decade in an employed situation.

“To be blunt, I had no other choice but to leave the current system because it doesn’t work for the two people who matter most, the doctor and patient,” Gold says. “To me, as scary as change has been, it was scarier to continue in a model in which I was doing nothing more than spinning a hamster wheel and assembly-line medicine.”

Even though he worked for a large employer that handled most back-office functions for him, onerous coding and billing issues interfered with patient care, he says. Then, about two years ago he read a Twitter post by a physician in a direct care practice boasting that his cost for migraine injections was about $8, compared with $216 in the emergency department. From there, he started researching the direct care model.

After pitching the idea to his employer (the employer passed), Gold obtained a bank loan to start his own business, but a little networking led him down a different financing path.

“One of my patients used to work in the insurance industry and uses a concierge doctor in Florida when he’s there,” says Gold. “He handed me some stuff to read before he went down there and said let’s talk when I get back.”

Instead of using the higher-interest bank loan, Gold borrowed startup cash from the patient, who charged a lower interest rate in exchange for 75% of the practice profits until he repaid the loan.

In Gold’s new practice, patients pay an annual retainer that covers most primary care services and neither he nor the patients bill a third party. Patients also carry high-deductible plans for other services. He hopes to add a partner to the business to share call responsibilities, but says he’s already much happier using the new model, even though he’s the only doctor available for the occasional evening suture.

MAKING IT WORK

How’s he managing financially? He says he built a salary that is “close to” his former pay into his loan agreement with his financier, and rolled his 401(k) retirement plan from his previous employer into a SEP-IRA, which is an individual retirement account for small businesses or the self-employed that offers tax advantages with fewer reporting requirements and employee protections than a group 401(k) plan.

Going forward, he can sock away the lesser of 25% of his compensation or $53,000 (the limit for 2015) in the SEP, which stands for Simplified Employee Pension plan. Remember that if you have employees, they must be included in the plan if they meet certain eligibility requirements.

Of course, now it’s up to him to pick the right investments and make up for not having employer matching funds, key factors that often get overlooked in the rush to change practice models, some experts say.

When helping physician groups negotiate mergers, comparing the two entities’ retirement savings plans is always on the list of discussion items, says Lee Ferber, CPA, a partner at Gettry Marcus CPA who counsels hospitals and practice groups. “We typically discuss the pension plans, and usually it’s the one area that is not acted on” because merging them can be a lengthy process, he says.

MIND THE DETAILS

Compensation is typically negotiated in detail, he says, but even so, key points are sometimes left out of contracts.

“Sometimes there is a straight RVU [relative value unit] formula, other times it’s eat-what-you-kill, less overhead,” Ferber says. “It’s important to get in writing what’s included in overhead, particularly for prac-
tices like cardiology when the physician is retaining office equipment,” he says.

Also keep in mind that there will be a price to pay for retaining control in a practice rather than becoming an employee. “You have to be willing to invest in technology and infrastructure to share in the possible upside of the new value-based payment models,” Ferber says. “You want to be in a position to say to a payer, ‘I cover quite a large number of lives and we can collaborate to provide better care at lower cost.’ That’s the future of medicine that doctors at first said was never going to happen, but it’s happening.”

Also remember there are startup costs associated with any new venture. Family practitioner Angela Kerchner, MD, recently earned a certification in integrative medicine and is working as a hospitalist while she prepares to launch a direct care practice that combines family practice, integrative and holistic medicine.

She hired an attorney and a business strategist, and attended a week-long business course to learn about branding, messaging, and details on protecting her corporation. “I’ve spent the last several months brushing up on business skills and taking care of the legal and compliance issues that needed to be addressed, and now hope to find a venture capital team to help launch the practice,” she says.

JUST A TWEAK

Some physicians aren’t looking for a change at all, but have it thrust upon them. That’s the position cardiovascular surgeon Brian Wilcox, MD, found himself in about two years ago when the partners in his 62-physician cardiology/CV surgery practice partners tapped him to be the practice’s lead physician executive, a new position for the group.

He still maintains about 75% of his former surgery load, while also working as a .75 FTE administrator. “Some of the stressors are larger than I anticipated,” he says, mostly due to juggling between unpredictable patient care and administrative meetings. He finally had to stop scheduling patients on administrative days.

The payoff: A different kind of career satisfaction. “Clinically, you perform an operation and a few hours later the patient’s life is a lot better. With administration, you have three- or five-year objectives, so it’s a very different paradigm. Quick fixes are rare, but you get to pull people together and see long-term results,” he says.

A traditional career path often includes a clinician taking on a medical director role, and then becoming energized by something in the role, says Joel Sauer, MBA, vice president, consulting, for MedAxiom Inc. and a former practice manager for a 23-physician cardiology practice.

“I do see some physicians quitting their practices for administration, but usually they don’t quit entirely because then they’ll be seen as a ‘suit,” says Sauer. “It seems to be best if you can maintain some semblance of a practice.”

What trips up many clinicians, however, is relying on the kind of crisis-management thinking that medical school teaches. “Physician training is anathema to human resource management. It’s all about life and death and acting on information very quickly, which can get you in big trouble on the management side,” Sauer says. “Also, the data they work with are more fluffy, which drives physicians bonkers. And they don’t like legal, accounting, and HR departments, which are all necessary evils to keep you out of trouble.”

Another pitfall to avoid, says Gaillor, is believing that the grass really is greener in every other career. “There just aren’t many careers that pay as well as being a physician,” she says. “Medicine is still one of the most stable career paths you’ll have. So if you do leave medicine for an administrative job be aware they often last three to four years and then you need to be looking in other markets for the next thing. I had one client in a medical leadership role and the whole leadership team was replaced. It was very unsettling for him and he went back to clinical practice.”

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We relentlessly defend, protect, and reward the practice of good medicine.
INCIDENT-TO BILLING CLARIFICATION: A PHYSICIAN AS AN EXTENDER

Q: Will Medicare allow a physician to render a service incident-to another physician?

A: We received a number of questions about our Coding Insights column published in our August 10, 2015, issue, particularly about this sentence: “Health and Human Services has recently clarified that a physician can function as an extender under the direct supervision of another physician. As a result, it would be permissible to report services performed by a non-credentialed physician under the name of a credentialed physician when all the incident-to requirements have been met.”

The Centers for Medicare & Medicaid Services (CMS) has verified that a physician can bill for incident-to services rendered by another physician as long as all incident-to criteria is met. Medicare’s incident-to requirements are primarily contained in the Code of Federal Regulations (CFR) 410.26 and in CMS Medicare Benefit Policy Manual, Chapter 15, Section 60.

Since this information was quite different than how we’d been taught, we followed up with our local Medicare carrier and received clarification that this was being done in part because the Medicare enrollment was behind and they didn’t want to preclude physicians from working while they wait for their enrollment to be finalized.

However, I want to reiterate that I don’t believe this is the best practice—and that this only applies to Medicare, not any other payer.

Q: What constitutes a new problem for a patient when billing incident-to? Is it any new problem requiring a change to the original MD treatment plan?

A: According to Medicare’s MLN Matters Number SE0441, “To qualify as ‘incident-to’, services must be part of your patient’s normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment.” That means that a physician has to have personally evaluated the patient and determined the plan of care, which would then be followed by the nurse practitioner (NP) during subsequent visits. Therefore, to answer your additional questions, any change in the treatment plan would need to be determined by the physician in order to be followed by the NP. Wisconsin Physician Services, our regional Medicare carrier, has clarified that a new plan of treatment change would need to be determined again by the physician in order for subsequent visits to be billed incident-to. In other words, the specific plan of care for a situation would need to be instituted by the physician in order for an NP to follow.

Q: Are we supposed to bill external cause codes in ICD-10? Are we allowed to bill unspecified codes?

A: MLN Matters® Number SE1518 specifies the use of external cause and unspecified codes in ICD-10-CM.

Here are some points to consider:

External cause code reporting

MLN Matters® Number SE1518 states that there is no national requirement for mandatory ICD-10-CM external cause code reporting. This is similar to ICD-9-CM coding.

The only exceptions to this are if you are subject to a state-based mandate for external cause reporting or a particular payer requires these codes to be billed. Outside a state or payer...
requirement, you are not required to report ICD-10-CM codes found in Chapter 20, External Causes of Morbidity, of the ICD-10-CM codebook. However, you are encouraged to voluntarily report external cause codes, because they provide valuable data for injury research and evaluation of injury prevention strategies. Also, submitting this information could cut down on questions from your payers, who are trying to determine whether or not a workers’ compensation payer would be liable for the cost of the services rendered.

**Unspecified code reporting**

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s). When sufficient clinical information is not known for a particular health condition to be able to assign a more specific code, it is acceptable to report the appropriate unspecified code (i.e., a diagnosis of pneumonia has been determined but the specific type has not been determined).

In fact, you should report unspecified codes when they most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

All the Medicare claims audit programs will use the same approach under ICD-10 as are used under ICD-9. All providers are expected to code correctly and document to support the code(s) selected. For example, if a physician is treating a patient for diabetes, there should be an ICD-10 code on the claim for diabetes. The level of specificity of the diabetes code selected will not change the coverage and payment of services in most cases.

**Q: How are home health claims going to be paid when the stay spanned before and after October 1?**

**A:** Medicare recently reported that ICD-10-CM codes are required on Home Health claims with a THROUGH date on or after October 1, 2015.

Since Home Health claims are submitted for a 60-day payment episode, there may be cases where an episode spans October 1. In these cases, the Requests for Anticipated Payment (RAPs) for an episode will be submitted using ICD-9 codes and the corresponding claim will be submitted using ICD-10 codes. Medicare does not require ICD-10 coding of these episodes in advance of the ICD-10 implementation date. Home Health Agencies should determine whether identifying the ICD-10 codes in advance will benefit them.

Answers to readers’ questions were provided by Renee Dowling, a billing and coding consultant with VEI Consulting in Indianapolis, Indiana. Send your billing and coding questions to medec@advanstar.com.

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Implementing a strategic plan in five steps

by NICK HERNANDEZ, MBA, FACHE Contributing author

Physicians often devise strategic plans, only to see nothing come of them. To ensure that your strategies are successfully implemented, you must build the execution into and across the planning process. Here are the five steps to successful strategy implementation.

**Align your initiatives**
A new strategy means new priorities and new activities across the practice. Every activity (other than the most functional) must be reviewed against its relevance to the new strategy. A good way of doing this is to create a strategic value measurement tool for existing and new initiatives. Initiatives should be analyzed against their strategic value and the impact on the practice. Measuring your initiatives will help highlight the priorities and ensure the right initiatives are adopted for delivery.

**Align budgets and performance**
Ideally, your budgets are structured in such a manner as to protect strategic expenditure from being re-allocated to short-term requirements of operating expenditures while subjecting strategic initiatives to a rigorous review (e.g. forecasted revenue growth and productivity) similar to a capital expense. The practice's business performance should be closely aligned to strategy. Performance measures should be tied to goals for each physician and staff member. All staff members will have job functions that will impact strategy. Ensure that employees are aware of their role.

**Structure follows strategy**
A transformational strategy may require a transformation to structure. Does the structure of your practice allow strategy to cascade across and down the organization in a way that meaningfully and efficiently delivers the strategy? Practices that try and force a new strategy into an outdated structure will find their strategy implementation eventually reaches a deadlock.

**Monitor and adapt**
A strategy must be a living, breathing document. Strategies must be adaptable and flexible so they can respond to changes in both our internal and external environments. Strategy meetings should be held regularly throughout the year, where initiatives and direction are assessed for performance and strategic relevance. At least once a year we should put our strategy under full review to check it against changes in the market as well as your internal environments.

**Engaging staff**
Bring influential employees into the planning process. They will contribute meaningfully to strategy, and also ensure the practice engages with the strategy. Confirm that every staff member understands the vision, and what their role will be in delivering on it. And enrich the communication experience. Communicate the strategy through a combination of presentations, meetings, emails, and updates. Continue strategy and performance updates throughout the year.

Nick Hernandez, MBA, FACHE, is chief executive officer of ABISA, a consultancy specializing in solo and small practices, located in Tampa, Florida. This article first appeared in our partner publication, Physicians Practice. Send your practice management questions to medec@advanstar.com.
Why malpractice coverage is still needed when practicing ends

by JEFFREY D. BRUNKEN, RPLU, CPCU Contributing author

Even if a physician stops practicing medicine, malpractice coverage needs to continue. Here’s how to ensure you are covered.

THE AMERICAN populace is aging, and that includes physicians. A report earlier this year from the American Medical Association showed that about 25% of all doctors in the United States are aged 65 and older, although not all are seeing patients.

Clearly, many of these doctors are continuing to work past age 65, and like many of us, they are likely thinking about retirement. But unlike most other workers who retire, physicians need to be concerned about the possibility of a malpractice suit long after they see their last patient. Why? A patient could discover years later that a doctor missed a diagnosis, for example.

The problem is that ensuring adequate coverage can be difficult, because most doctors will stop paying malpractice premiums when they retire, close a practice, relocate, change insurers, become disabled, or otherwise leave the practice of medicine.

In any of these events, a physician’s options will depend on the state laws where the practice is located and other factors that are best discussed with an insurance broker. For this discussion, we’ll consider two common options: one is to buy a modified claims-made policy and the other is to get tail coverage, which may be a less costly option.

To ensure malpractice coverage is in place, consider taking these three steps in the months before discontinuing practice:

Step 1
Understand how your state’s statute of limitations applies to malpractice cases. Clearly, some lawsuits will come years after a patient is treated, and so statutes of limitations will apply. Most states have a two-year limit on medical malpractice filings, meaning physicians will need coverage for only two years after the last day they treat patients.

However, some states also allow patients to bring a medical malpractice claim if a doctor erred in a way that caused the patient harm. Under what’s called the “discovery rule exception,” where a doctor might miss a tumor when viewing a patient’s X-rays, for example, a patient diagnosed with cancer years later could ask that the X-rays be reviewed again. If the tumor can be seen on the earlier film, then the doctor could face a medical malpractice claim.

Step 2
Ask your insurance adviser about tail coverage. Tail coverage is useful for claims filed after the end of the policy to cover events like the one described above that can come years later.

The advantage of tail coverage is that most malpractice insurers will provide it at no cost if the physician was insured with them for five years or more before retirement. Some insurance companies require only one year of malpractice coverage for a retiring physician to receive a no-cost tail coverage policy. Be sure you know your carrier’s policy.

Step 3
Select tail coverage from an insurer that will be in business for many years. This point is vitally important because if your insurer goes out of business, your tail coverage would be worthless. Therefore, insurance brokers should advise physicians to do whatever they can to ensure they’re covered by a financially secure and reputable insurance company with a high rating, such as A+ by AM Best.

Jeffrey D. Brunken is president and chairman of the board of The MGIS Companies, Inc., which specializes in physician protection. This article first appeared in our partner publication, Physicians Practice. Send your legal questions to medec@advanstar.com.
The last words you should say to any patient

Could I borrow a few bucks from you? You see, I lost a lot of money at the racetrack and I need to pay my bookie."

"Gee you’re cute. Are you seeing anyone these days? How about we go for drinks after this?"

"Sorry I’m running a little late today. How about we skip the physical exam so I can get back on track with my next patient?"

Just to make it clear; you should never, EVER talk with a patient like this. Not to the family member who accompanies the patient, nor the home health aide. Not even the Portuguese interpreter translating for you. Never cross this line. Otherwise, you will bring the doctor-patient relationship to a very bad place.

However, if you are looking to stir things up a little, and change the character of your interaction with your patients, you may want to try what I did. And it starts with just two little words—that is, the last words you must say to each and every patient. Let me explain.

It all started two years ago. I was (and still am) part of a large multispecialty group practice. Our group prided itself on being forward thinking and ahead of the curve. We routinely emailed our patients. We had a division dedicated to population health and recently, one for telemedicine. We are now even trialing apps to improve patient access and care.

The one area where we have been frustratingly mediocre has been with our patient satisfaction scores. We do have certain providers who are “rock gods” in the pantheon of patient satisfaction, but most in our group hover around the 50th percentile. Since we strive to be the best in all we do, it was time to set our sights on improving this metric.

We have tried a whole host of methods to improve patient satisfaction scores. Financial incentives and dis-incentives. Laud ing the top performers on our intranet, and embarrassing the bottom feeders. Nothing worked. Well, nothing until we retained a consulting firm who taught us about AIDET.

Now, the acronym AIDET is not a secret. I encourage all of you to Google it and read more. But the quick-and-dirty description of AIDET is that it stands for the action words that comprise the patient visit from start to finish: Acknowledge (the patient and associated family in the room); Introduce (yourself and tell your role and credentials); Describe (what you are going to); Explain (what you did, and what will happen next); and lastly Thank (say thank you). Pretty simple, right?
Of course the consultant reviewed more than just AIDET, but the amount of pages I'd need to describe the entire process would have a greater BMI than Harrison's Principles of Internal Medicine. For the purpose of this essay, I'll focus on AIDET.

I thought most of it sounded like common sense, stuff I was already doing. But our group had paid good money for a consultant to teach us all the mystical ways of AIDET, so I tried to drink the Kool-Aid with the rest of my colleagues. While everyone else began to incorporate this new dogma into our practice, I continued in my old ways. And then a funny thing happened.

After years of mediocrity, our scores for The Patient Experience (as we now called it) began to inch upwards. We started at the 50th percentile. Six months later we shot up to the 60th percentile, and a year later, the 70th percentile. Two years into AIDET, our average patient satisfaction scores topped the 82nd percentile.

It was a modern rags-to-riches story. My colleagues were always good, caring men and women, dedicated to the health of their patients. But now the patients seemed to be uniformly thrilled with us. Every doc saw his or her score increase. Well, almost every one. My score remained frustratingly flat during this time.

Now, my scores were always good. I was solidly in the top quartile of docs. But now that the majority of my colleagues were at eighty-two, seventy-five started to smell like last week’s laundry. I had to be missing something. But I had convinced myself I was already doing it all. I was polite and friendly, caring and thorough. I never rushed. I remembered details about my patients’ jobs, hobbies and families. I was doing everything I was supposed to in this new world of AIDET. Or almost everything.

Do I really have to thank the patient? I was helping them. Weren’t they supposed to thank me for the pill, or inhaler, or test, or procedure that I prescribed? Well I supposed I could give it a try.

As I tied up the loose ends during a new consult, I tossed in this comment as I stood to shake the patient’s hand. “Thanks for coming in to see me on this problem. I will do my best for you.” The patient did a double take, and then replied, “You’re welcome, doctor. And thank you, too.” I saw him smiling as he left my exam room and walked down the hall. He seemed touched that I would thank him. I decided to try it again.

“Thanks for taking your medicine; I knew it would help you to feel better.”

“Thanks for coming in to see me for your check-up.” I said to a little child. “See you again in six months.” “Thanks for continuing to work with me on this tough problem; we’ll get to the bottom of things soon.”

And so on and so on. And you know what? It worked. My patients seemed happier. I believed they knew I cared about them, but now they also knew that I appreciated them. Patients have so many options in healthcare; we physicians need to be aware of that. When they choose to come to see us, we should be grateful for it.

The next quarter I was surprised—no, shocked—to see my patient satisfaction score creep up 10 points. And the next quarter, I reached the Holy Grail of the Patient Experience: the 90th percentile.

Now, I was not some grade-grubbing pre-med who needed an “A” in every class to feel good about myself. I was happy because I knew I had made a deeper connection to more of my patients. I knew this in my heart months ago; as I noted the smile each patient bore on his or her face when leaving my exam room. But it was nice to see the score as an objective measurement of that fact.

To paraphrase Abraham Lincoln, you can please all of the patients some of the time, and some of them all of the time. But you can’t please all of the patients all of the time. But you can try to thank all of them, all of the time, for coming to see you.

One last thing: Thanks for reading my essay. Hopefully it will allow you to connect with your patients on a deeper level and vault your practice to the top of the patient satisfaction food chain. 

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“
You can’t please all of the patients all of the time. But you can try to thank all of them, all of the time, for coming to see you.”
To ensure your medical practice does not leave money on the table, proper physician credentialing is a must.
Credentialing a partner with medical practice consulting firm Global Health Management Services, noting that inefficiency can also contribute to higher administrative costs. "Many practices underestimate the importance of proper credentialing, but it can have a major impact on your revenue cycle."

1/ Monitor and track
The initial submission of credentialing applications for a new physician is a labor-intensive process that can take between 90 days and 180 days to complete.

But that’s merely the first step. Most payers, hospitals, and surgical facilities also require periodic recredentialing of specific documents. "Recredentialing tends to be staggered, so the smart practice will literally use an Excel spreadsheet to develop a database of every provider in their practice, with information on their licensure, their Drug Enforcement Administration numbers, their Medicaid and Medicare numbers, anything that will need to be resubmitted, and when the renewal dates are," says Hertz.

Larger groups and those with deeper pockets often invest in credentialing software or Web-based programs that can help to automate workflow and integrate practitioner quality data. Others outsource the credentialing process entirely.

But smaller practices typically handle such submissions manually, making it all the more important to designate a point person to manage and maintain the provider database on an ongoing basis. Your “credentialing czar” should be detail-oriented, says Hertz, and able to submit on-time and accurate forms as minor mistakes can delay the process or cause applications to be rejected. He should also be skilled at cultivating a professional relationship with the points of contact at payers, hospitals, and healthcare agencies.

“Make friends with these people because these are the people you are going to need,” says Hertz. “We all know very well that if you’ve got a good relationship with somebody it’s remarkable how things get done that were otherwise impossible.”

The best internal systems use an electronic tickler file, giving your practice a warning when renewal deadlines draw near. Don’t wait for the payers to notify you. “You might get a calendar pop-up 90 days before the deadline that tells you Dr. Smith’s Medicare number or state licensure needs to be renewed,” says Hertz. “You can’t leave it to chance. It’s your duty as the administrator to make sure that happens properly or to hold the person whose job it is accountable.”

2/ Coordinate and communicate
Physician credentialing is a less burdensome task for small practices, notes Hertz, as there are fewer providers to manage.

“Larger practices sometimes get into the position of hiring a physician and the only way the billing department finds out there’s a new doctor is they start getting charges from them, but they haven’t been credentialed,” says Hertz. Thus, larger medical practices need to emphasize coordination and communication among human resources, upper management, and the practice manager. “All of these pieces are connected,” he says.

When new providers are hired practices should begin the credentialing process right away to allow for processing time and to ensure they can begin billing for the physician’s services on day one, says Patrick Boyle, vice president and director of managed care for Catalyst Consulting. “You want to make sure you get a head start as soon as possible,” he says. To encourage the timely submission of key signatures and copies of diplomas by
Credentialing

the physician, practices might also consider tying the receipt of those documents to the physician's start date.

Boyle notes that Medicare does not allow practices to submit a credentialing application any sooner than 60 days prior to a new physician's start date, but it is also one of the few payers that will credential physicians retroactively, meaning your practice can retro-bill for Medicare patients seen before the doctor was officially credentialed. Many commercial payers will not. As you bring new physicians into your fold, then, it may make sense to allow them to phase in their schedule as payer credentialing comes through.

To ensure your practice does not leave money on the table, proper credentialing is a must. The most effective managers put timelines in place, create physician databases, and assign a point person to keep well ahead of the deadlines. "It's not brain surgery, but it does need to be thoughtfully addressed in an organization and standardized in a concrete fashion," says Hertz.

3/ Streamline with technology

The nonprofit Council for Affordable Quality Healthcare (CAQH) has a standardized electronic application form, CAQH ProView (formerly known as the Universal Provider Datasource,) that can reduce the time and resources needed for credentialing. It can also minimize the opportunity for manual error, reduce duplicative paperwork, and reduce administrative costs.

The free database enables providers to enter a range of demographic and professional information into a secure datacenter, creating a profile that can be shared electronically. The provider can then submit it to multiple authorized healthcare organizations in every state.

"That makes the process a little easier and it also shortens the time as you won't need to fill out as much paperwork," says Global Health Management's Malloy. The form was developed with health plans, health systems, and providers.

Boyle suggests having new hires submit their information and upload supporting documentation to the CAQH database immediately upon starting so that they can obtain a profile number. The office manager, or person in charge of credentialing, then can submit that number to each health plan with which the practice contracts.

"That's the trick," says Boyle. "Each plan has their own process, but the majority of the major plans use CAQH so it makes it more streamlined."

Editor's note: This article was first published in our partner publication, Physicians Practice.
Practical Matters

The guide for physicians to remain independent

by ERICKA L. ADLER, JD Contributing author

Physicians in private practice frequently contact me asking whether I know of a hospital or other entity that may be interested in acquiring their practice. Sometimes the physician is nearing retirement, but more often he or she simply has determined that remaining in private practice is a hopeless endeavor. But that’s not always the case.

ALTHOUGH independent physicians often opine that the independent practice is no longer sustainable, recent data from the American Medical Association shows that more than 60% of physicians continue to work in practices with 10 physicians or fewer and their practice size did not really change all that much between 2012 and 2014.

In the study, evidence seems to show that although more physicians are becoming employed by hospitals and health systems, they may not be doing so at the rate or speed previously thought. Certainly the trend towards increased physician employment and decreased physician practice ownership is clear, but it’s hardly the wave of change that was predicted. Could it be a trend that is showing signs of slowing? Is it a movement that physicians can halt?

There is no doubt that independent and small practices are still an important part of the healthcare delivery system. Many are continuing to thrive despite the ongoing changes in healthcare taking place in this country.

How can physicians continuing in private medical practice of medicine hold on to traditional healthcare? The practices I’ve spoken with that seem most successful are engaged in some of the following strategies:

- expansion into multispecialty groups and new areas of ancillary healthcare;
- involvement in clinical integration, accountable care organizations, and other strategies that focus on reducing unnecessary utilization and costs for which practices are not compensated in traditional fee-for-service contracts;
- supergroup models in which independent practices share in the expense of compliance and technology, share resources, and gain the benefit of group market power; and
- strategic models that use high numbers of mid-levels and lower overhead and other costs of traditional medical practices. These groups are often expanding into home visitation and other untapped areas of physician services.

Other practices also look to concierge models to limit patient volume and defray costs by charging patients for extras the physicians are willing to provide. However, the uncertainty with concierge models that still rely primarily on insurance is whether there will continue to be non-covered services for which such physicians will be able to bill.

While remaining independent may be a challenge for many, independent practices are among the most clever and entrepreneurial clients that I work with. I am hopeful they will continue to flourish and explore all viable models for their future.

Ericka L. Adler, JD, is a partner in the firm of Roetzel & Andress specializing in healthcare law in Chicago, Illinois. This article first appeared in our partner publication, Physicians Practice. Send your legal questions to medec@advanstar.com.
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The right interoperability must become reality

Solving the problem of electronic health record (EHR) interoperability is just a small step toward integrating the exploding healthcare information technology system. Hospitals and physicians have made progress toward secure data-sharing. Patient portals allow limited communication with clinicians. Pharmacy drug-drug interactions and disease-focused case management are done electronically. But how do these interfaces address the proliferation of personal healthcare technology?

Almost a decade ago, Newt Gingrich declared in a speech to the AAFP Scientific Assembly that developing a unified platform for medical data would be a top government priority. So why hasn’t that happened? At that time, the “Internet of Things” was just beginning and the ability to store and access data remotely in the “cloud” did not exist. EHR development was focused on converting physician notes and labs into searchable archives.

Since then, advances in mobile technology have empowered patients to analyze and manage their own data. It is too late to retrofit all EHRs, but we still have the opportunity to shift the focus of healthcare IT development to include all the places that patients access care and generate health data. Instead of continuing to build on the complex EHR framework, new development should focus on cloud-based, HIPAA-secure data interchanges.

Patient portals are required for meaningful use, but each portal is customized for a healthcare entity. Three hospital systems in my area use the same EHR vendor, but access to each patient portal is slightly different. In addition to having to remember three separate logins, many of my patients navigate online access to their healthcare data at their health insurance provider, employer health website, veterans administration, specialty clinics—and none of this information directly integrates with my primary care clinic’s EHR.

Maybe it is time to let go of the vision of standard platform data interchange and start creatively designing a system that can organize the many places which store and collect patient healthcare data. How about a hypothetical “Personal Health Dashboard (PHD)” application which would be chosen and managed by the patient? The Cloud-based PHD might function like this: After a consult note arrives in a patient’s chart, my EHR would automatically generate a notification to the patient’s PHD. Similarly, imaging results from an urgent care clinic or sleep data generated by a mobile app would link to the PHD, which patients would view on the device of their choice. Patients would no longer be responsible for multiple portal logins and separate interfaces.

With these apps, patients could allow family and doctors to access and exchange data with agencies of the patient’s choice. This would enable development of new tools for analyzing the data across multiple platforms because access would be controlled at the dashboard level, while HIPAA-covered entities and vendors would continue to manage the security of data storage, effectively solving interoperability.

Interoperability is an issue of safety and patient-centered care. It is no longer a question of whether EHR interoperability is going to happen. The question is, can we do it right?

Melissa Lucarelli, MD, is a full-time independent family physician who practices in rural Wisconsin. She is a member of the Medical Economics editorial board.