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# Medical Staff Briefing

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## In this Issue



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## External peer review: How physicians and organizations can benefit

Leading up to the 21st century, peer review evolved constantly, undergoing rapid change. New regulations and requirements were implemented both by the Centers for Medicare & Medicaid Services (CMS) in the 1960s and by the establishment of the Health Care Quality Improvement Act of 1986. Functions and duties of committees shifted as physicians accommodated their increased responsibilities related to peer review. Even today, many physicians struggle to find the time to fulfill these medical staff activities, while others experience difficulty appropriately defining who should participate in peer review in order to keep it fair and unbiased.

This is where external peer review providers come into play. External peer review occurs when someone outside the organization completes the peer review. For example, a physician on the East Coast may review a case raising concern in a hospital on the West Coast. Even though the two physicians have never met, they still may be considered peers in the sense that they have the same training and perform the same work. External peer review providers help facilitate this process, connecting organizations in need of external peer review with peers who provide that service.

One organization that provides external peer review services is MDReview. According to Sharon Beckwith, the company's CEO, MDReview was founded in 2003 by three hospital physicians holding medical staff leadership positions who were in a situation requiring an external party to conduct peer review. Unconvinced that a resource was available to help them, they created MDReview so no other organizations would experience that same concern.

"We've continued to grow tremendously over the last 17 years. We're in all 50 states, and we work with hospitals of all sizes," states Beckwith, illustrating just how great the need for external peer review is. "When we first started this business, we had this anticipation that it would most likely be smaller, rural facilities that would have a need for external peer review because they oftentimes have a small medical staff, and they just don't have the resources internally. … However, we have found over the years that the size of the hospital isn't necessarily what dictates the need for peer review or external peer review."

Rather, hospitals seeking external peer review services are united in their common goal to improve patient care, even if it means looking beyond their internal resources.

## Why external peer review?

There are a variety of reasons why a hospital might seek external peer review services, which explains why MDReview has worked with all shapes and sizes of hospitals.

"There are conflicts of interest that occur in large medical centers with large medical staffs comprised of hundreds and hundreds of physicians. And there are conflicts of interest that occur in a small organization, even a critical access hospital that maybe only has 10 providers on staff," explains Beckwith.

One of the primary reasons hospitals and other medical organizations may seek an external peer reviewer is because of conflicts of interest that exist within their internal pool of peer reviewers. Since the goal of peer review is to offer objective and unbiased reviews based on facts, any conflict of interest could compromise that.

Beckwith says, "Maybe they've got five positions in the same specialty, and they have a case of concern or a trend that they've noticed is a concern. And they just can't get an objective, unbiased review internally because all of the other providers in the same specialty are either a competitor or a partner."

Ultimately, the purpose of peer review is to improve the quality of care being provided, and external peer review supports this purpose by ensuring that all reviews are objective.

"Most of our requests come from a desire to identify opportunities for improvement within a facility, whether it's a specific medical staff member or an overall department," notes **Don Lefkowits, MD,** medical director at MDReview. "They really do come to us because we're able to provide them with a completely outside set of eyes whose only role is to say, 'You're doing great. Keep up the good work, even though there was an unexpected outcome,' or 'You're doing okay, but here are some ways you can do better,' or 'You have a real problem and you really need to stop and do some soul-searching and intensive rehabilitation of your agency, physician, provider, or team.' "

In many cases, it can be difficult to have this kind of perspective when you work within the facility itself. Therefore, bringing in an outside person with no ties to the organization who can offer his or her view of the situation can be extraordinarily valuable.

"It's oftentimes hard for physicians to be asked to be critical of a peer who they rely on to cover call for them … It can also be difficult to ask a competitor to be really unbiased and objective," Beckwith acknowledges. "So that would be another reason why they would want to go out externally and ask for another physician with the same training and background and experience who's currently performing the same procedure that may be in question, but who doesn't have any sort of knowledge of the physician who is under review."

One of the most important parts of external review is matching the reviewer to the case and/or physician under review to ensure that it is a true peer conducting the review. Making the right match limits bias and alleviates the concern that offering an honest but critical view might negatively impact a relationship with a colleague, allowing for the most accurate possible review of the situation.

Also, just because an organization chooses to engage in external peer review does not mean it is incapable of conducting excellent peer review on its own. Many organizations who seek external peer review do have their own well-developed processes in place and have great respect for those processes.

"Some of our most rewarding client facilities are facilities who already have a pretty robust internal peer review process, so they understand the value. They have physicians who bought in and contribute," Lefkowits states. "But there are plenty of facilities who embrace the opportunity for self-reflection or internal review. They already do it well, but they turn to us when they have a particularly challenging case, or they lack the expertise, and we're able to provide them with a service in addition to what they're already doing well internally."

## The external peer review process

Once the need for an external peer review has been established, the first step is identifying the appropriate peer reviewer, a process that Beckwith says MDReview takes very seriously.

"We look very specifically when a client hospital contacts us and has a case or set of cases for review,"

she explains. "We drill down to the level of looking at specialty—are we looking at a general surgeon, a neurosurgeon, etc.—but we also drill down to the level of the procedure that is actually under review so that we can ensure our physician reviewer is not only board certified in the same specialty but is also currently privileged in and performing the same procedure that is in question. From a credibility standpoint, that's very important."

Taking the time to get to this level of specificity is important because it ensures that there is a true peer-to-peer match. The more precise the match, the more reliable the results of the review will be.

Additionally, MDReview commits to using only the best physician reviewers and employs a thorough screening process to determine whether a reviewer is a good fit for the program.

"All of the physicians that review for MDReview are actively practicing, board-certified physicians that have been in their area of expertise for a minimum of five years," states Beckwith. "We really like to have reviewers that have some knowledge of the medical staff leadership role and the peer review process. So physicians that have been part of a credentials committee or a peer review committee, someone that has physician leadership background as well, is a good fit. It's also very helpful if they have a good understanding of what peer review is about and what it's meant to achieve."

Requiring such experience allows MDReview to ensure that all their reviewers are capable of carrying out thorough and accurate reviews.

To further ensure that it employs the best physicians to conduct reviews for client hospitals, MDReview only accepts physicians who have come by referral.

"We've worked with our existing network of physicians to consistently grow the number of physicians that we have working for us who are able to conduct reviews," says Beckwith.

This is an example of how quality control is maintained in the external peer review process. Establishing quality control measures is crucial, as organizations want assurance that the external peer review process they are engaging in is thorough, compliant, and trustworthy.

Once the appropriate reviewer has been selected, the physician will begin the review. In most cases, this consists of a thorough examination of all the information that has been presented. Reviewers are trained not just to critique the care, but also to look for other areas that could benefit from improvement.

"Sometimes peer review identifies other opportunities for improvement outside of the care that was provided by a particular physician," notes Beckwith. "Sometimes there are process issues or communication issues that are identified, and I think it's very helpful for the hospitals to hear that and to be given some of these opportunities for improvement."

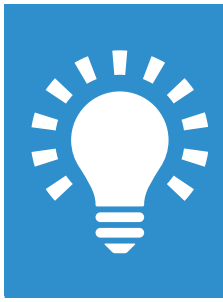
As the reviewer writes up a report, he or she will note any other opportunities for improvement to provide the organization as much feedback possible; doing so allows the organization to improve its processes and overall provision of care beyond that of the care under review.

Once the reviewer completes the report, it is sent on to a medical director.

"Each of those reports is proofread by a medical director before we deem it to be totally complete. So we're getting a proofread from the clinical level to make sure that each report is well supported in its conclusions," says Beckwith.

Just as MDReview takes great care to match the appropriate physician reviewer to the case, it also works to ensure that the medical director is adequately qualified to review the report. MDReview employs medical directors across a wide variety of specialties to ensure that all clinical areas are covered.

"We try to make sure our medical directors are in a position to have the expertise to review, and if there seems to be some internal inconsistency or reference that doesn't support the conclusion—which doesn't happen often—we can go back to the reviewer and try to help them clarify their review because we realize that the facility is counting on the objectiveness, detail, and strength of the review," explains Lefkowits. "They trust that it's based on best demonstrated practice and on current guidelines, and that's our internal way of making sure that's the case 100% of the time."



## Questions Comments & Ideas

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– Karen Kondillis, Managing Editor

Once a report has been proofread by a medical director and deemed satisfactory, it is forwarded to the organization who requested the review. In some cases, that is the end of the external peer review process. However, in others, physician reviewers go a step further in aiding organizations.

"Some of our expert reviewers who have a lot of experience in developing programs and supporting overall programs are willing to take a day or two and do an on-site visit and try to get an assessment of efficiencies and/or calls and processes in addition to doing the specific peer review of the care," says Lefkowits.

This gives an organization the opportunity to both improve the issues unearthed by the specific review as well as other opportunities for improvement the reviewer may have noticed in conducting the review.

### Impact on peer review purpose and culture

Conducting peer review is a difficult task, one that can be taxing for both organizations as a whole as well as the individual physicians who assist in the process.

"Frankly, not all physicians view peer review, whether it's internal or external, in a positive light; they feel like it's more likely to be punitive," explains Lefkowits.

However, instituting external peer review can help to change this perception of peer reviewing by alleviating the burden caused when a physician is expected to be critical of a colleague; it can also help to assuage any fears that one physician in an organization may be biased toward another. Bringing in an external peer reviewer simply adds a level of objectivity that an organization may not be able to achieve internally. Therefore, when done correctly, external peer review can truly be an asset.

"We recognize that we need to be fair, balanced, consistent, and accurate not only in assessment of care but in our determination about variation from standard of care and identification of opportunities for improvement so that the physician or group of physicians who are being reviewed can be receptive to it," says Lefkowits. By holding its reviewers to high standards, MDReview is able to ensure that the honorable goals of peer review are fulfilled.

"It's a good reminder of what the purpose of peer review is: It's the improvement of quality care, the improvement of patient outcomes, and it really is intended to be a nonpunitive and an educational process," says Beckwith.

Furthering the success of peer review doesn't start and end with physicians, though. MSPs also have an important role to play in upholding the provision of high-quality patient care.

"The MSP has a pretty large job in ensuring that all of the physicians within a given hospital are currently competent," Beckwith explains. "There is this huge responsibility to live up to that expectation and ensure that when a patient comes to the hospital, there are currently competent physicians there that can provide high-quality care. Peer review is just a part of that whole process." ■

## The due process manual, Part 1: Introduction

*by William K. Cors, MD, MMM, FAAPL, chief medical officer, Lehigh Valley Health Network, Lehigh Valley Hospital–Pocono, East Stroudsburg, Pennsylvania*

It is useful to recall that there is no prescribed format for creating medical staff bylaws and associated documents. Laws, regulations, and accreditation standards require medical staffs to address some issues in the bylaws, but how these issues are organized and addressed is up to each medical staff. In previous articles, we identified that a best practice is to organize medical staff responsibilities and functions into a series of manuals. Each manual deals in depth with a particular area in an organized fashion. The manuals are designed to clearly capture how the medical staff handles required or delegated functions. Here is how the series of manuals might look:

1. **Governance manual.** This manual was explored in depth in a recent series published in *Medical Staff Briefing* and constitutes a core set of bylaws that rarely change. It includes medical staff membership, medical staff rights and responsibilities, medical staff categories, medical staff officers, voting rights, conflict resolution, adoption and amendment of bylaws, investigations and corrective action, due process and fair hearing, credentialing process, departments/sections/service lines, committees, meeting attendance, and quorum.
2. **Due process manual**. This manual will be the focus of the current series. The Health Care Quality Improvement Act of 1986 (HCQIA), which established federal protections for peer review, is

the foundation for this manual; in order to receive the protections afforded by HCQIA, the medical staff needs to have a due process manual that incorporates HCQIA's requirements. Additionally, each state may have its own set of peer review protections. That said, there are still multiple best practices concerning how to carry out the requirements for this manual, and these will be explored later in this work.

3. **Credentialing and privileging procedures manual.** The basis of this manual is the myriad requirements for credentialing and privileging established in the CMS *Conditions of Participation* and the additional requirements of the accreditation body your hospital uses. This manual gathers together and clearly coordinates anything that touches on practitioner competency and will be the subject of a future series.
4. **Organization and functions manual.** This manual is a tactic to ensure that all medical staff functions required by regulatory or accreditation bodies are listed. More importantly, it then addresses how these functions will be organized and carried out. Key areas will be addressed in more detail in a future series.
5. **Rules and regulations manual.** The medical staff can use the rules and regulations manual to expand and clarify standards of care including admission, discharge, medical records, and standards of practice (coverage, call, critical care, consultation, death, autopsy, surgical care, professional conduct, and so forth). How the rules and regulations can augment the other manuals will be explored at a later date.
6. **Policies and procedures manual.** The purpose of this manual is to clarify how a process or action will actually be carried out. For example, there are expectations of professional conduct for any medical staff member or practitioner holding privileges that are listed in the bylaws proper. But what happens if there is a complaint about the professional conduct of a practitioner? A specific policy and procedure will address the definition of professional conduct, the expectations for professional interactions, and how a complaint is to be investigated, validated, and handled with the practitioner involved.

## Introduction: The due process manual

One of the most important purposes of the bylaws is to state the rights and due process to be accorded members of the medical staff and practitioners with privileges. These rights and protections can sometimes be invoked under contentious circumstances that could lead to litigation; therefore, it is imperative that they are described in the bylaws clearly and meticulously. It is also important that these parts of the bylaws comply carefully with federal and state statutes and regulations.

The most important of these is HCQIA, which provides federal immunity from monetary damages for medical staff professional peer review actions. This statute also created the National Practitioner Data Bank (NPDB) and its reporting requirements. HCQIA lists many details of due process that must be available to physicians undergoing corrective action by the medical staff. These details will be examined in much greater depth in the next installment of this series. Suffice it to say, at this juncture the due process manual must carefully and clearly incorporate the requirements set forth by HCQIA in order for the medical staff to be afforded its broad protections.

In addition to HCQIA, every state has its own laws that affect the corrective action section of the medical staff bylaws. These include state peer review statutes and any additional reporting regulations issued by state health departments or other government entities. When composing a due process manual, it is always prudent to work with an attorney well versed in both state law and HCQIA.

When creating text for medical staff corrective actions, it is wise to keep these four goals in mind:

1. The process must make patient safety and well-being the foremost consideration. The corrective action process should not be so onerous or convoluted that this fundamental goal is not readily achieved.
2. The process must also protect individual members of the medical staff from abuse by colleagues or hospital officials. Doing so requires an approach that is fair in all regards.
3. The process should facilitate appropriate participation by members of the medical staff and protect them from retaliation by angry colleagues. With regard to this latter point, many medical staffs will enumerate the ways in which the hospital will indemnify medical staff leaders who might be sued or dragged into litigation by a colleague.

4. The bylaws should also clearly indicate that the medical staff peer review process and corrective actions recommended or taken by the medical staff and the board are intended to have the full protection of state and federal laws.

### Next time

In Part 2 of this series, we will delve into HCQIA, which forms the framework upon which the due process manual will be built. Until then, be the best you can be. ■

## Gearing up for risk: The role of infrastructure, staffing, and culture

*by Sanjay Seth, MB, BS, executive vice president at HealthEC in Edison, New Jersey; and Cliff Frank, interim executive director at Shore Quality Partners in Somers Point, New Jersey*

Healthcare providers are taking on increased risk under accountable care models like the Centers for Medicare & Medicaid Services (CMS) Pathways to Success plan to overhaul the Medicare Shared Savings Program (MSSP). To ensure the success of value-based initiatives, leadership teams have important decisions to make. New regulations limit how long providers can stay in Shared Savings before moving toward a risk arrangement. Healthcare organizations, including accountable care organizations (ACO), must now determine the right path forward and strategically realign people, processes, and technology to guard against downside risk.

For example, navigating risk-based contracts requires increased reliance on data and analytics as organizations seek to better assess patient populations and provider performance. Technology that identifies high-risk, high-cost patients and easily monitors key performance metrics will be vital to driving evidence-based decision-making for ACOs. Leaders will also need to cultivate a provider engagement culture that supports infrastructure changes—including provisions for potential risk funding—in order to succeed.

There are many factors to consider when selecting an accountable care performance track, including the following:

- Track options
- Risk level
- Entry point
- Experienced vs. inexperienced provider group
- Low- or high-revenue organization
- Benchmark changes
- Assignment changes
- Attribution methodology changes
- Agreement length

To make proper performance track determinations, it is important to understand critical differences between new and existing regulations.

### Infrastructure requirements in the era of downside risk

Organizations that elect to move forward with a downside risk model will need to conduct an infrastructure and operations assessment. For example, leaders should evaluate staffing to determine where more capabilities may be needed to support new efforts. In some cases, new partnerships with local behavioral health organizations may be warranted to address social determinants of health. It may also make sense for ACOs to partner with a home health agency to initiate additional programs focused on hospice and home healthcare.

From a technology perspective, as organizations take on more risk, use of a data management platform at the central office supports provider network efficiency improvements. ACOs can provide practices with targeted lists of at-risk patients that can include, for example, chronic condition patients, patients missing flu shots or wellness exams, high-risk patients who have not been seen in six months, or patients with high emergency service utilization. Efforts should support rather than disrupt existing workflows.

Most importantly, ACOs should engage physician and administrative leadership in more active discussions. Data transparency will be central to this. Insight into top and bottom performers for each quality and cost metric motivates clinicians to improve performance. Accelerating the data ethos into a more public process drives physician involvement and accountability in performance improvement.

### The role of physician culture in achieving success

Physician culture—including the ability or willingness of physicians to drive change when taking on financial risk—plays a tremendous role in achieving success. Hard conversations typically avoided due to fear of provider project abandonment will be necessary. An effective physician engagement strategy should address these five areas:

1. Drive down patient leakage from the network
2. Focus referrals to high-performing specialists
3. Consistently meet the basics of patient wellness, prevention, immunizations, annual visits, follow-ups, transitions of care visits, and medication reconciliation
4. Keep patient engagement at a fundamental level, including working with Medicare patients to keep small issues small
5. Take direct, limited financial risk

The first area mentioned above, patient leakage, is a growing issue in healthcare as patients expand their care choices and provider options. Patients' ability to see the care providers of their choice makes leakage an especially significant problem in ACOs as many patient services are provided outside the framework of the ACO network.

Getting primary care physicians (PCP) to be aware of and attentive to making patient referrals to providers in the downstream network is essential. Changing referral relationships can be difficult, and leakage will never be zero. However, moving the leakage rate back by addressing this issue has a significant and favorable impact on provider activity.

Support for admission and readmission reduction is another important physician culture imperative. Transition of care patients who must be seen after discharge necessitate improved communication between hospitalists or treating specialists and PCPs. Likewise, skilled nursing facility network management becomes paramount to ensuring patients receive reliable, high-quality care.

Providers must remain mindful of patient satisfaction. If patients are unhappy, they may be motivated to move out of the ACO, the foundation of the ACO begins to disintegrate, and success under risk-based models becomes harder to achieve.

Pathways to Success requires intentionality to address these topics with physicians and drive organizational improvements. Determining whether physician financial risk can be quantified and included in a flow-of-funds calculation represents the next step in the physician culture engagement strategy.

## Six funding options for what-if scenarios

When taking on downside risk, a pivotal factor is preparing for the eventuality or potential that the organization has to write a check back to Medicare.

## Pathways to Success: Risk performance track considerations

Significant changes have been made in several areas for ACOs preparing to enter Pathways to Success tracks.

- **Attribution methodology.** Member ACO assignment traditionally has been determined through a retrospective look at primary care services, revealed in CMS year-end calculations. Going forward, ACOs can continue with that methodology or move to a prospective member attribution model. The difference is, if those members move to a new state, they remain members of the ACO for the rest of the year. However, advanced knowledge of ACO membership can help care management organizations focus efforts on patients who will definitely be part of the risk profile.

- **Level of risk.** Performance tracks C, D, and E now introduce downside risk. In Track C, ACOs are at risk 1% in year one, 2% in year two, and 4% in years three, four, and five (CMS 2018). While there is more upside (10% each year) than downside risk, entering into any downside risk raises a number of fundamental financial and organizational issues, as most ACOs lack reserves needed to cover any potential downside risk payment.

- **Telehealth.** Telehealth has been added as a covered service. Although payments are not significant enough to prompt many ACOs to pursue addition of the service, coverage expansion will benefit those already offering telehealth.

- **Member notification.** Members now have to be notified that they are in an ACO. This requirement could slow down primary care offices. ACOs may consider managing notifications on behalf of providers.

- **Beneficiary incentives.** New regulations introduce a beneficiary incentive program with a monetary value of up to $20 per member. These funds offer ACOs a new avenue to help reinforce patient engagement programs (such as congestive heart failure patient notification of weight changes to primary care physicians, for example).

- **Benchmarks.** Key performance benchmarks have transitioned from a 70% regional and 30% historical blend to 50% regional and 50% historical.

- **Funding.** ACOs can no longer rely solely on a reinsurance contract to meet financial obligations for financial security and solvency. ACOs now have to have cash or a surety bond guarantee tied to the ACO via a parent hospital or insurance company owner, for example. Freestanding, physician-owned ACOs will need a letter of credit guaranteed by some cash source.

Although Pathways to Success tracks A and B are no-risk, ACOs only receive 25% of savings and can only stay there for one or two years (CMS, 2018). Track C is the entry point for risk, and its five-year risk corridor means an ACO managing 10,000 lives could have to write a $1 million–$1.5 million check back to Medicare should they fail to meet cost and quality metrics. Several funding options can help organizations meet funding needs when participating in downside risk models:

1. **PCP membership fees.** One option for funding the risk corridor is for ACOs to appeal for contributions from participating physicians. If there is no loss, money rolls over to the next year. Physician willingness to participate can help promote hospital interest in also sponsoring the financial requirement.
2. **Net collections from reinsurance.** Another possibility is collection from a reinsurance product. ACOs can buy an aggregate reinsurance policy that will kick in at 102%–103% of expected claims. An ACO may pay more in premiums than they would in collections, and Medicare may or may not recognize the policy as an adequate funding mechanism, but this option may appeal to ACOs with limited alternative options.
3. **Medicare Advantage (MA) star bonus program.** Bonus money an ACO receives for helping physicians raise MA star ratings and Hierarchical Condition Category scores, for example, can be used as a potential funding source.
4. **Previous year bonus carryover.** Dedication of a portion of any bonus payouts made to ACO physician members or hospital sponsors can serve as a funding source.
5. **Bonus deductions.** In ACOs with a bonus distribution methodology whereby providers incur a financial penalty for missing cost, quality, or network utilization thresholds, penalties can be put aside to support any potential payment the ACO may face.
6. **Hospital/investor line of credit.** Hospital sponsors may be willing to guarantee a surety bond knowing there is a funding strategy and deficit carryforward provision in place. If the ACO is still short on any payment penalty, that amount would come off the top of the bonus the following year.

It is worth noting that Pathways Track C incurs a five-year contract commitment, and ACOs must hit 100% of quality metrics and meet the minimum savings rate of 3% to qualify for savings.

### Put your best foot forward in the world of risk

Understanding performance track options and requirements, ensuring physician buy-in, establishing funding, and mitigating risk through data-driven operations are all crucial to provider success in the brave new world of risk. The right technology solutions also play a key role. Look for solutions that support each of the ACO's value-based contracts in a unified system. Tools should integrate analytics with care management and care coordination activities without disrupting existing workflows.

With up-front assessments, alignment of operational and financial resources, and physician and technical support, healthcare organizations can thrive under risk-based payment models. ■

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## Avoiding clinical staff burnout during a rigorous EHR transition

*by Alex Tate, health IT writer and blogger. Tate provides perceptive, engaging, and informative consultancy on industrywide topics including EMR systems, practice management, billing solutions, and MACRA/MIPS. He may be reached at alextate07@gmail.com.*

At some point in your practice's lifecycle, you may find the need to replace your current electronic health record (EHR) system. Your system could be outdated or ill suited for your practice, or you may be working with an unresponsive or unhelpful vendor. In any case, transitioning from one EHR to another is likely to be stressful, costly, and highly disruptive, and lead to physician and staff burnout during and after the process.

### When to switch an EHR

You may consider switching to a new vendor due to a number of scenarios, including:

- Undeveloped functionality by your current vendor to comply with newer regulations and quality reporting
- High operational costs or undisclosed additional costs

- Lack of customizations needed for your specific patient services
- Dissatisfactory system functionality and services
- Security failures or threats with serious consequences for your organization and patients
- Discontinued support for your specific specialty
- Significantly increased prices with a renewed contract
- Failure to fulfill an EHR's purpose, e.g., to reduce physician workload
- New practice services that the current EHR does not support yet

## EHR-related stress in clinicians

Research has established a link between EHR-related stress and burnout, and there is no denying that transitioning to a new system is stressful. A study of registered nurses considered the following independent variables: time spent on the EHR at home, daily frustration related to the EHR software, and time for documentation. The data revealed that 20% of participants experienced at least one symptom of burnout, while 50% strongly agreed that their EHR contributed to their daily frustration.

Additionally, a survey found that 70% of physicians in Rhode Island reported experiencing stress related to health information technology, while 25% specifically reported symptoms of burnout.

## EHR transition and clinician burnout

When transitioning medical records, whether it's replacing an old EHR or part of a move from paper or hybrid records, there are several factors that contribute to stress:

- The process is costly because the transition requires purchasing the software, training employees, hiring external resources, and converting the system
- Clinical risks can occur from the disruption of access to patient data and business records
- Data migration may be incomplete between vendors
- It takes time for staff and physicians to learn the new system
- Staff and/or stakeholders may find change difficult and be resistant
- Productivity, workflow efficiency, and number of patients seen may be negatively impacted
- There may be incomplete implementation or lack of adoption of the new system by users

## Tips to ensure a smooth EHR transition

In order to make the transition easy, effective, and stress free, and to ensure that the clinical staff doesn't experience burnout, physicians must assume leadership roles in the process. The following are some ways physicians can be involved in the transition.

**Create an engagement and training plan**

It is recommended that physicians involve their clinical staff in EHR software selection, as this will make them feel like they are a part of the process and not merely being forced to adopt a new system. Inform them of the decision to replace the EHR as early as possible, discuss options, and invite feedback about what the previous system lacks and what is needed in a new EHR.

Other physicians working in the practice should also be actively involved in the decision-making process, especially with regard to clinical workflows, interface, quality improvement, customization options, etc.

**Find an EHR that meets your specific needs and growth plan**

Research has shown that independent practices are now likely to switch their EHR if it fails to provide a quick return on investment. Therefore, you need to look for a system that offers both functionality and efficiency by meeting your physicians' needs and your practice's growth plans.

Shortlist the most suitable EHRs, consider whether you want a cloud-based or on-premises system, evaluate the prices and features, set up demos, and connect with current clients before deciding. Remember that choosing the right system—one that requires the least amount of screen time—will best reduce the burden on the staff.

**Make data migration a priority**

Perhaps the most stressful part of an EHR transition is ensuring that all patient data is successfully transferred to the new system or otherwise stored if full migration is not possible. To avoid challenges in the process, consider the following:

Connect with the old and the new EHR vendors to discuss data transition and mapping costs

- Anticipate data mapping needs
- Thoroughly plan the transfer of information into the structured fields in the new EHR
- Use continuity of care documentation (CCD) to accurately read the transferred data

**Create a transition timeline**

With a timeline in place, the clinical staff will know what to expect, which reduces the chance of burnout resulting from unexpected burden and stress.

A good EHR system should take only weeks to implement, but could take a few months depending on data migration and other individual practice requirements. Ideally, you should accomplish tasks in the following order leading up to the launch of the new EHR:

- Communicate with staff, create a vendor list, and attend product demos
- Evaluate staff readiness through meetings and surveys
- Set a timeline for implementation as well as staff and physician training
- Appoint an internal EHR transition team, define roles, and plan data mapping and new workflows
- Work with the old vendor to secure your patient data and other medical archives
- Test the new interface and workflows, and transfer patient records
- Customize new templates according to your practice and recheck workflows
- Get regular staff feedback on the process before the final launch
- A few weeks after the transition, follow up with staff regarding any concerns, and contact the new vendor for any needed improvements or customizations

While replacing your EHR is not an easy task and can overwhelm clinical staff and physicians, implementing the right system and process will ensure that the benefits it provides will compensate for the time and money spent to acquire it. ■

# The role of care coordinators and technology in addressing the opioid crisis

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As physician practices transition to value-based care and incorporate population health management (PHM) solutions into their day-to-day workflows, there are opportunities to close the communication gaps that can lead to opioid abuse. By aggregating and analyzing data across the care continuum, healthcare organizations can proactively recognize patients with conditions that put them at risk for abuse (e.g., cancer, COPD, and muscular skeletal disorders), flag specialists that are overprescribing, and note which pharmacies are dispensing the most opioid prescriptions.

These analytics-driven technologies and the evolving role of care coordinators have an important part to play in addressing the opioid epidemic. When used together, these resources enable healthcare providers to quickly identify and proactively care for patients at risk of opioid abuse. This article illustrates how holistic solutions that account for social determinants of health and rely on technology, personal intervention, and education can be adopted to help healthcare organizations stem the tide of opioid addiction.

## The origins of opioid abuse

Many patients develop opioid dependence after taking pain medications for an extended period of time. A simple patient case example demonstrates how easy it is for patients to end up with multiple pain prescriptions that they may become dependent on or addicted to later:

A patient is seen by an orthopedic surgeon after a motor vehicle accident. The patient is prescribed a 30-day supply of Percocet®, MRIs are performed, and the patient is referred to a neurologist for pain management. The neurologist administers three steroid injections and prescribes a 30-day supply of Vicodin® with one refill. The patient then sees their primary care physician, where more Percocet is prescribed.

In this scenario, communication gaps in care management contributed to the threat of opioid abuse. Without proper care coordination protocol in place, multiple physicians assumed responsibility for the patient, resulting in three separate pain medication prescriptions filled at three different pharmacies. Many patients find themselves with pain medication addictions due to simple scenarios like this one.

In response to the recent spike in overdoses, many physicians have pulled back on prescribing opioids. Without referrals in place for managing pain as prescriptions are scaled back, many patients experience adverse effects related to withdrawal and end up in the emergency department (ED). Some patients end up bypassing healthcare to get pain medications on the street. This trend highlights physician challenges in pain management and underscores the importance of slowly tapering patients off opioids to reduce the potential for long-term dependency.

## Overcoming challenges in the opioid epidemic

New regulations and guidelines are emerging to help providers better address opioid issues. Prescription drug monitoring programs (PDMP) are being used to aggregate patient data portals and monitor drug use. This enables providers to see all controlled substance prescriptions across neighboring states. The Centers for Disease Control and Prevention require providers to check PDMPs every three months and before every opioid prescription. The New York State Department of Health now requires that drug treatment plans include patient goals, tapering plans, treatment alternatives, and a risk factor evaluation that must be reviewed annually with patients.

The objective is to streamline processes and reduce drug utilization and the associated costs of abuse. Overarching goals for physicians and clinical teams addressing the opioid epidemic include:

- Identification of patients at risk
- Closing gaps in communication across primary care, specialists, pharmacy, and others
- Shifting to alternative first lines of addiction treatment
- Establishing goals for pain and function
- Discussing the benefits, risks, and availability of alternative addiction treatments

New medication-assisted treatment options, addiction treatment mentor programs, and increased drug risk evaluation training for medical professionals represent some of the strategies that healthcare organizations are employing to address the opioid crisis. Technology and care coordinators have emerged to play a pivotal role as well.

## Role of technology

Consensus is building on the importance of understanding the patient profile for opioid addiction risk. Several factors influence the profile for opioid abuse risk, including:

- Family history of substance abuse (alcohol, illegal drugs, and/or prescriptions)
- Personal history of substance abuse (alcohol, illegal drugs, and/or prescriptions)
- Age
- History of preadolescent sexual abuse
- Psychological disease (ADD, OCD, bipolar disorder, schizophrenia, and/or depression)

Technology attacks the opioid epidemic head on by applying complex algorithms to aggregated data sets to help providers identify patients who are at high risk. This may include looking for patients with multiple providers, high ED visit tallies, and the presence of comorbidities that might warrant high prescription volumes. Veterans, for example, often have higher addiction rates where dual physicians are seen (typically at Veterans Affairs and Medicaid facilities) due to lack of care coordination between providers.

Technology solutions like PDMPs and PHM platforms are helping healthcare organizations remove data barriers so providers have a more comprehensive view into patient health records. Many electronic medical record systems are customizable, allowing providers to implement an alert system to notify providers of at-risk alcohol and drug abuse patients. Once a detection system is in place to flag instances of potential drug abuse, care coordinators can then step in to help these at-risk patients with appropriate next steps in their care journey.

## Role of care coordination

Care coordinators are a vital asset in healthcare organizations' efforts to address opioid addiction. These caregivers are often able to identify patterns of abuse that may inform patient risk factor algorithms. Common red flags for opioid abuse reported by care coordinators include:

- Frequently lost or stolen prescriptions
- Frequently canceled appointments
- Use of other drugs and/or alcohol
- Seeking drugs from multiple providers
- Using prescriptions for euphoria and anxiety relief
- History of prescription forgery
- Selling or sharing prescription drugs
- Repeated increase of prescription dosage
- History of drug or prescription overdose
- Aggressive demands to increase prescription dose
- Altering the route of administration
- Arrest for DUI or other drug-related activities

When identifying at-risk patients for targeted care follow-up, care coordinators can leverage data analytics platforms to ensure that key steps are taken to help the healthcare organization better manage opioid-dependent patients. Analytics resources enable care coordinators to:

- Stratify patient data using multiple data sources
- Apply risk scores
- Focus on the top 5% of patients to make the greatest impact
- Decrease the amount of high ED users
- Increase annual wellness and preventive care appointments
- Monitor and track chronic disease patients
- Coordinate care to close communication gaps between providers
- Improve discharge planning
- Ensure primary care physician follow-up within five to seven business days

Care coordinators act as the liaison between patients and disparate providers and care settings, bridging gaps where common communication failures typically occur. This may include verifying claims data with real-time prescription information, calling the patient to discuss or arrange drug treatment options, or documenting data for case escalation with a medical director.

As the opioid crisis continues, the healthcare industry must address the problem directly. And while there is no simple solution, data analytics and new care coordination protocols can be significant agents of change. ■

## Five strategies to improve opioid use disorder care in hospitals

A recent report provides five system-level strategies with specific initiative examples for hospitals to improve prevention, identification, and treatment of opioid use disorder.

Hospitals are on the front line of the opioid epidemic. In 2016, the rate of opioid-related inpatient stays in hospitals increased to about 300 per 100,000 population—nearly double the 2008 rate, according to the federal Agency for Healthcare Research and Quality. From 2008 to 2017, opioid-related emergency department (ED) visits more than doubled, according to AHRQ's Healthcare Cost and Utilization Project.

The new report was released by two Boston-based healthcare organizations, the Institute for Healthcare Improvement and the Grayken Center for Addiction at Boston Medical Center, and states that hospitals can play a key role in addressing the opioid epidemic.

"In response to the growing volume of inpatient admissions and outpatient visits for individuals with a substance use disorder, hospitals are the primary point of care for many patients in need of comprehensive substance use care. Fortunately, hospitals also have the opportunity to make a major impact in reducing morbidity and mortality related to opioid use, from prevention, to screening, to treatment, to engaging with communities to reduce harms," the report's coauthors wrote.

The five strategies described in the report are focused mainly on organizational best practices rather than specific forms of clinical care.

### Identify and treat opioid use disorder patients in key clinical settings

- Identify patients with opioid use disorder in the emergency room and provide urgent treatment and referrals. For example, ED clinicians should be trained to treat acute withdrawal.
- Identify and treat inpatients with opioid use disorder. For example, provide peer services and case management.
- Integrate addiction treatment into primary care and other appropriate care settings. For example, nurse care managers can conduct consistent follow-up.
- Boost specialty addiction treatment offerings. For example, build links to specialty addiction treatment programs for targeted groups such as adolescents and young adults.
- Improve clinician training and competency to offer evidence-based comprehensive treatment such as medications in combination with behavioral therapy. For example, educate clinicians about substance use disorder treatment throughout their training from medical school to continuing medical education courses.

## Minimize harm and maximize benefit in opioid prescribing

- Improve prescribing practices for acute and chronic pain patients. For example, opioids are not first-line medications for many acute pain conditions and alternatives should be tried first.
- Improve opioid dispensing. For example, require clinicians to check your state's prescription drug monitoring program before dispensing opioids and to make treatment referrals when appropriate.
- Prevent diversion of opioids from patients to other people to use illicitly. For example, create secure drug disposal sites at community facilities such as pharmacies and police stations.
- Increase access to multimodal pain management strategies. For example, improve clinician pain management training.

## Train stakeholders about opioid use disorder risks and prejudice

- Educate healthcare professionals, patients, and the public about opioid risks. For example, provide clear information on addiction risk to patients.
- Decrease prejudice about substance use disorders. For example, speak clinically rather than judgmentally with patients.

## Identify and screen high-risk patients

- Screen high-risk patients for developing opioid use disorder and educate them about addiction risks. For example, screen patients with a co-occurring substance use disorder or a history of substance use.

## Reduce substance use disorder harms

- Improve access to supportive social services and connections to ongoing, comprehensive treatment. For example, increase access to social services that support recovery such as affordable housing agencies and childcare.
- Develop and promote harm reduction services that boost the safety of patients with addictions. For example, provide syringe exchanges and safe use instructions.

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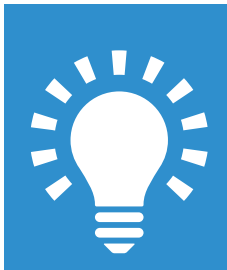

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