Queens Boulevard Extended Care Facility
Queens Boulevard Partners with North Shore-LIJ to Improve Care Continuum for Patients
06 Queens Boulevard Extended Care Facility

Dr. Jonathan Mawere, Administrator and Chief Operating Officer

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Dr. Jonathan Mawere has been with Queens Boulevard Extended Care Facility (QBECF) in Woodside, N.Y., in various capacities since 1999.

Founded in 1995, QBECF is a 280-bed, state-of-the-art nursing facility that specializes in sub-acute rehabilitation. Its services include 24-hour skilled nursing care; physical, occupational, and speech therapy; wound management; and hospice care services.

From the time Mawere arrived at the organization, achieving better care coordination between QBECF and local hospitals in the North Shore-LIJ Health System has been an evolving initiative. The initiative reached its apex in 2009 when QBECF and North Shore-LIJ signed a clinical affiliation agreement that officially made them partners in providing care.

Since its signing, the affiliation has produced outstanding results, but above all else, it has ensured that patients who leave a North Shore-LIJ hospital are guaranteed a smooth transition into QBECF.
We are proud to join in recognizing

Dr. Jonathan Mawere

for his years of dedicated service to the patients at

Queens Boulevard Extended Care Facility.

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Together in order to limit unnecessary readmissions of patients.

“We focused on specific chronic diseases and advanced illnesses that typically would cause patients to end up in the hospital, such as pneumonia, congestive heart failure, diabetes, and COPD, with the goal of improving the way we manage conditions in both the hospital and our skilled nursing care environment.”

Educational opportunities were also opened up for providers both within QBECF and the North Shore-LIJ hospitals. Furthermore, alignment allows medical students and residents to rotate in both care settings, broadening their exposure and experience with the geriatric population.

A PARTNERSHIP OF TRUST AND RESPECT

Mawere said both organizations entered into the affiliation agreement fully knowledgeable of each other’s advantages, with the goal of leveraging their strengths to deliver the best outcomes for the patients.

North Shore-LIJ chose QBECF because of its reputation for excellence. The facility’s four-star rating, which it first received when the rating system was implemented by CMS, has been maintained even after CMS toughened the standards and 1200 facilities lost their rating status.

Additionally, QBECF has been included annually on U.S. News & World Report’s Honor Roll of America’s Best Nursing Homes since the publication began rating facilities.

The affiliation was obvious for QBECF given North Shore-LIJ’s progressive strategic vision and its status as the largest healthcare system in the northeastern United States.

“With our goals and visions being so similar, the affiliation between North Shore and Queens Boulevard Extended Care was an easy choice to make,” Mawere said.

A PARTNERSHIP OF SURVIVAL AND STABILITY

As healthcare organizations transition to the value-based, accountable-care, and bundled-payment models, partnerships and affiliations are paramount to a facility’s success, Mawere said.

“In today’s healthcare arena, the idea that you can survive as an island is antiquated and will not work. You need partnerships. You need affiliations. You need to work with other organizations.”

He believes the only way to achieve the best metrics with bundled payments is by collaborating with partners a leader can trust.

“I would advise every leader in healthcare to find worthy affiliates or partners because no healthcare organization can exist on its own,” Mawere said. “You will not survive any other way. You have to join up with somebody else.”

QBECF’s most recent initiatives have been designed to enhance its value as a collaborative partner. Mawere said the organization is currently integrating an outpatient rehab program into its service line as part of an effort to diversify its portfolio of services. A dialysis unit is in the near future, he added, which will help solve accessibility problems for patients in Queens, Brooklyn, and Manhattan who are seeking dialysis services.

“These services are needed in the community and would improve our ability to work with other organizations,” Mawere said.

QBECF is also working toward unifying its EMR. Right now, the platform is fragmented. The goal is full integration.

“The way things are moving, the future of healthcare is an environment of collaboration among providers, and with that collaboration comes better efficiency and better communication,” Mawere said. “This will lead to better and more effective patient care.”

BY PETE FERNBAUGH
Passionate, committed leadership is at the heart of any transformation project. As models of care change, hospitals need focused leaders who are excited about innovation and willing to lead the charge into new, uncharted territories.

About nine years ago, Kenneth W. Lukhard joined Advocate Christ Medical Center, located in Oak Lawn, Ill., as president and took the organization from a large community hospital with some tertiary services to a tertiary, quaternary medical center.

At Pepper, we don’t just see a building – we see a new way of working, a new partnership, a new opportunity to impact people’s lives. It’s how we’ve always been different, and it’s how we see the future.

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In addition to expanding services, Lukhard wanted the hospital to rank in the top 10 percentile in the nation for measurable outcomes. To achieve this, he built teams of physician leaders and nurses to oversee their service areas.

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To achieve this, he built teams of physician leaders and nurses to oversee their service areas. He created the position of vice president of clinical transformation to develop the playbook for these teams and to engage with them.

Christ Medical Center, which is part of the larger Advocate Health Care system, employed the dyad leadership model, which combines a physician and a nurse to lead the outcomes and quality initiatives for their service line.
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“As an organization, we require a high level of engagement and accountability from physicians on a daily basis,” Lukhard said.

The organization also developed a two-year training program for physicians to assist them in understanding the dyad leadership model and how to put it into practice. Lukhard estimates 90 physicians have been through the training and are now leading clinical teams.

PUTTING THE MODEL INTO PRACTICE

Recently, Christ Medical Center rigorously applied the dyad leadership model to reduce ICU ventilator days.

The hospital has four ICUs with a total of 90 beds and is building a new patient tower that will house another 72 ICU beds. The emergency department handles about 100,000 visits per year, and the ICU sees one of the most severe populations in the country.

In 2012, using a ventilator-day index that divides the number of observed days by the number of expected days, the average was 1.27. Lukhard said his goal was to get that number at or below 1.0, meaning the observed days on a vent would be the same as the expected days. Expected days are determined using the APACHE II scoring system.

By 2013, Lukhard was still not seeing the results he wanted. Facing the reduced clinical outcomes associated with patients spending more time on a ventilator, he called a meeting with the vice president of clinical transformation, the chair of medicine, and the medical director of the ICU.

“We talked about how to change the paradigm and asked the medical director of the ICU to take on a high level of accountability and lead this change,” Lukhard said.

With 200 employed physicians and 1,000 independent physicians, achieving the desired outcomes required a complete reformation of culture. Where physicians once came in and rounded whenever they wanted, they were now being asked to discuss cases together and to communicate about the patients as a cohesive group.

“Initially, the medical director and I met with intensivists to talk about why this new model is important in terms of quality of care,” Lukhard said. “I personally asked them to commit to me that they would participate.”

The medical director and his dyad partner led the paradigm overhaul among clinical staff and intensivists. The department also had a steering committee working in the background to analyze data to establish leading indicators. Within four months, the ICU saw dramatic changes with ventilator days dropping from 1.27 to 1.0.

Recently, the index has been as low as 0.93.

As a result of this ICU success story, Lukhard has begun to promote the outcomes across the organization, emphasizing the lessons he and his leaders have learned through the dyad leadership model.

“We have told the story dozens of times, showed them the data and the success,” Lukhard said. “It was a hard journey for our leaders, but they are proud of the work they’ve done, and our patients are getting better care.”

EXPANDING THROUGHOUT THE ORGANIZATION

Lukhard believes not only in Christ Medical Center, but also in Advocate as a system and strives to hold the organization to the high standards set by Advocate.

“At Christ we have passionate people, chasing world-class care,” he said. “Advocate is doing it well at the system level, and Jim [Skogsbergh], Lee [Sacks, MD], and their team are pushing us to see how good we can get. We are a 100 Top Hospital according to Truven; the third-best hospital in Chicago according to U.S. News & World Report; and we are meeting our system targets for health outcomes.”

Lukhard credits the organization’s success to the exemplary leadership shown by the dyad teams.

“All our physician leaders and presidents of system hospitals are expected to perform at a high level,” he said. “We have come a long way in embracing these leadership principles, and we have a lot farther to go in our pursuit of excellence.”

BY PATRICIA CHANEY
ENGAGING FRONT-LINE STAFF FOR CHANGE

Advocate Lutheran is a 645-bed non-profit teaching hospital serving the north and northwestern suburbs of Chicago. The hospital has more than 4,500 employees who are referred to as associates. By proactively engaging these associates, Advocate Lutheran’s leadership team has forged a pathway to cost reductions and better care.

“We need to always focus on safety, quality, and service first,” said Chief Operating Officer Barbara Weber. “We needed to involve our front-line associates with the leadership team to be proactive in our cost-management efforts. We never want to be in a position where we have to make drastic decisions because we are not meeting our operating budget.”

Advocate Lutheran has implemented several projects that seek out waste and strive to remove unnecessary delays in each service line. A few years ago, for example, the emergency department developed a process to expedite patient admissions.

“In the emergency department, you have waste when people are waiting or when there are preventable delays in service,” Weber said. “We have reduced the time for getting a patient in a bed once requested from 90 minutes to 20 and lowered our walkout rates.”

To reduce those times, management and front-line associates explored ways to enhance throughput efficiency while sustaining excellent care. The leadership team, Weber said, made a point of engaging with every stakeholder as these changes were being implemented.

“You cannot make assumptions when you’re trying to redesign a process,” she said. “We need to be transparent in how we make decisions and examine who’s impacted and the downstream effects before making a change. This involves executives working with department leaders and those leaders working with their associates.”
Recently, the hospital began holding a daily 8:30 am safety-huddle call. The call is led by the executive team and includes an update from every manager across 60 departments. It lasts only 20 minutes. Managers are provided with an agenda in advance so they know what to report. Most reports are based on safety issues—prevention, close calls, safety events that happened and lessons learned, and any other safety or operational issues.

Weber said the call has raised awareness throughout the hospital, increased the timeliness of response for issues, and improved collaboration. For example, on the morning call, if a bed alarm isn’t working, the manager can address it and maintenance is able to respond that day. If the pharmacy has a medication on backorder, the department can tell every manager the process for limiting distribution.

“We are able to address important concerns during and immediately after this call rather than waiting for someone to read an email,” Weber said. “It allows the chance for everyone to be proactive. Managers can learn from safety events or near misses and implement those lessons on their units.”

The overarching goal of this increased emphasis on collaboration and communication is reducing all serious safety events to zero in 2015. Weber said based on the safety-huddle calls, the hospital maintains a Top 10 Safety Concerns list. The list includes items such as falls or mislabeled specimens. The executive team assigns people to resolve the problem and implement a solution. Once addressed, that problem is taken off the list and the next concern is added.

“Our focus is to provide the safest environment for patients, associates, and physicians,” Weber said. "Our focus is to provide the safest environment for patients, associates, and physicians.”

Advocate Lutheran is a member of the larger Advocate Health system and continues to implement principles of the Advocate Experience. The experience comprises patient, associate, and physician satisfaction. Upcoming initiatives center on efforts to improve population health and transition from fee-for-service to value-based payment models.

“It’s a journey,” she said. “We are always looking at ways to be more efficient. It takes the entire hospital to be involved, with high levels of engagement among leaders, physicians, and associates.”

BY PATRICIA CHANEY
St. Joseph’s Hospital Invests in Community to Improve Care

Understanding the community an organization serves is one of the keys to successfully transitioning to population health. Many hospitals are discovering they need to engage their patient population in ways previously not considered, with transportation challenges, poverty, and literacy comprising some of the intricate issues that prevent patients from adhering to a treatment plan.

St. Joseph’s Hospital Health Center in Syracuse, N.Y., learned this lesson several years ago, and the care it now provides is rooted in serving its community.

Kathryn H. Ruscitto, President

About eight years ago, Kathryn Ruscitto, president of St. Joseph’s, and her leadership team implemented a $250-million investment plan for the 431-bed hospital. Architects mapped out what needed to be done, from patient-room renovations to facilities improvement to parking garages, determining when each element should be completed.

However, before construction began, Ruscitto learned that the hospital’s neighbors were not happy with them, even receiving negative letters about St. Joseph’s place in the community. While sitting in a physician’s office on the edge of campus, she was struck by the poverty surrounding the hospital.

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ST. JOSEPH’S HOSPITAL HEALTH CENTER

CHANGING PLANS AFTER LISTENING TO THE COMMUNITY

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Ruscitto and other leaders began walking the surrounding neighborhoods, holding focus groups, and engaging with local organizations in order to understand the community’s needs. “We really had to stop and listen and not be defensive,” she said. “People said some pretty tough stuff to me in the early days.”

REVITALIZING HOUSING IN THE COMMUNITY

To start, St. Joseph’s worked with two housing development not-for-profits, Housing Visions and Home Headquarters, to acquire the three blocks adjacent to the hospital. Through state tax credits and public funds, the hospital built a stretch of green townhomes.

The people who were displaced during building were provided temporary housing and were offered the first opportunity to live in the new homes. Ruscitto said many entry-level hospital employees realized the first opportunity to live in the new homes. And they were provided temporary housing and were of-fered the first opportunity to live in the new homes.

Walking tours and focus groups uncovered such concerns as the lack of local job opportunities and frustration with patients parking in front of homes and blocking driveways. Hospital leaders were then prompted to rework the initial construction schedule, prioritizing projects that would most benefit the community. For example, the parking garage was built first rather than toward the end as originally planned.

BEING A GOOD NEIGHBOR

Ruscitto said the hospital paid more attention to the impact of construction on its neighbors as well, taking into account inconveniences and environmental concerns. “We let locals know when noise was coming or when power outages were expected,” she said. “We created a power outage around dinnertime one evening, so we sent pizza to everyone affected.”

The hospital also wanted its appearance to be more inviting to the community and removed high-walled buildings from the construction plans, step-ping down to street level in order to present greater accessibility.

Additionally, St. Joseph’s incorporated a greener environment into the plans. The United States Green Building Council recently awarded the hospital its LEED Gold Certification for the new Emergency Services Building.

The newly constructed Nappi Surgical Tower received an American Institute of Architects award for excellence in design. The 104,000 square-foot tower, which opened in September 2014, features 110 private rooms, new intensive care units, and a waiting room with seating for approximately 135. The entire tower has vast swaths of daylight streaming in from tall windows, and it extends St. Joseph’s green footprint beyond the Emergency Services Building.

The building materials and finishes include recycled content, with low- or no-volatile organic compounds in the paints, carpets, and finishes. A storm-water retention system is also in place, and the entire building will be powered by green energy.

STIMULATING THE LOCAL ECONOMY WITH JOB TRAINING

Creating new housing around the campus still didn’t solve the poverty issues confronting the local community, which is why the hospital helped to create a Northside Urban Partnership that developed Health Train, a 12-week class on job readiness. Those who completed the training were given an automatic interview at St. Joseph’s.

“We needed to figure out how to get people into the jobs we have,” Ruscitto said. “The hospital has greatly benefitted from this program. Usually, we have about a 40 percent turnover rate for these positions, but the Health Train graduates stick. We’ve had 100 percent retention.”

Seeing how the hospital, community, and Urban Partnership could work together to improve housing, employment, the environment, and health was a profound learning experience for St. Joseph’s leadership, Ruscitto said.

“If we had not first engaged in the community, our interpretation of what we needed to do was not what the community needed us to do. We did have some self-interest on the front end, but then we realized the power of what we were doing, and we have become a much more strategic, externally focused organization.”

In comparison with the hospital’s budget, the community work did not require a large cash investment. Ruscitto said it was time-intensive, and the success was largely because they found the right partners. She estimated the hospital invested up to $55 million into the neighborhood.

The success of this investment attracted other developers and businesses into the community as a result. In fact, after the first transformation, 10 other investors began revitalization projects in neighborhoods around the hospital. These efforts have all laid the groundwork for St. Joseph’s to transition into population health management.

“We get it now,” Ruscitto said. “We know how to work with the community. We’ve developed wellness programs that meet people where they are. It’s different work than we’ve done as healthcare institutions, but we cannot afford to continue running healthcare the way it has been.”

BY PATRICIA CHANEY
Prior to becoming chief operating officer of Emanuel Medical Center in Swainsboro, Ga., Damien Scott, PT, MS, OCS, had a lengthy career as a physical therapist. But he eventually tired of the overwhelming negativity toward change that trickled down from his administrators and decided to transition into healthcare leadership, hoping he could have a positive impact.

Scott previously served as chief executive officer at Candler County Hospital in Metter, Ga., but when CCH was acquired by the recently established ER Hospitals LLC, he was moved to its sister hospital, Emanuel. Although it might seem as if transitioning from a standalone, autonomous organization like CCH to a management situation at Emanuel would be a challenge, Scott actually saw it as a relief.

“Emanuel Medical Counters Rural Challenges by Embracing Progress

To be a standalone rural community hospital that’s struggling is a challenge,” he said. “You don’t have the resources that a larger company can bring to the table in terms of leadership. You don’t have the expertise, and there’s no way that a single person can be an expert in all areas of the hospital.”

The state of Georgia still has many standalone, independent community hospitals that are structured according to the traditional inpatient model. Scott said this model simply won’t exist in the future, and standalones lack the resources, expertise, and progressive outlook needed to speed up their transition from inpatient to outpatient care.

MODELING THREE SOLUTIONS FOR RURAL GEORGIA HEALTHCARE

As a physical therapist, Scott prioritizes and identifies the problems first before establishing goals. Taking stock of the hospitals around Emanuel, he said many have closed, some are near closure, and the rest are fighting for survival. He delineated three solutions to this dilemma, all of which are embedded in the work of ER Hospitals.

The second solution is examining which niche service lines a particular organization, such as Emanuel, can offer. The third solution is expanding telemedicine in collaboration with regional hospitals, so that outlying residents can have access to specialty services.

For Emanuel, the first two solutions are indelibly connected. Scott has determined that Emanuel is about relationships, both with its customers and other community hospitals and tertiary centers in the area. Competition is out, he said. Communication and collaboration are in.

Forming these relationships enables Emanuel to focus on niche services, per ER Hospitals’ second solution. The reality is, Scott said, his hospital simply cannot offer every medical service, but there are a few services it can perform just as well as anybody else in the United States.

One of these services is inpatient geropsychiatric, which is much-needed throughout the hospital’s patient population.

After examining the data, Emanuel’s leadership realized there are 28 nursing-home facilities within 40 miles of the hospital, comprising 2,260 beds. In addition, 10 percent of the population is over 65, which is well above the state average. And the paucity of psychiatric programs in the region doesn’t come close to meeting the needs presented by the data.
On July 1, Emanuel will open a brand-new geriatric-site program after receiving a certificate of need and completing a $1.5-million renovation. On the telemedicine side, the governor has chosen Emanuel as one of four hospitals to participate in a pilot project for expanding telemedicine within communities by collaborating with schools, EMS facilities, and tertiary centers. “Just putting the telemedicine equipment in isn’t going to be enough,” Scott said. “We’re going to have to have those relationships to make sure we can actually get this off the ground and work.” He said the plan is to name a point person to facilitate communication across these partnerships.

LEVERAGING THE DEDICATION OF THE MEDICAL STAFF

Although rural healthcare is beset with challenges, Scott said Emanuel has one major factor working in its favor: a committed medical staff. “They have a servant’s heart,” he said. “They love caring for patients. Even the hospitals that are really struggling love caring for patients. It’s why they do what they do. What’s different about Emanuel, there’s also a certain level of excitement because we’re building something. We’re doing something new and that’s not been happening in the rural hospitals. There’s been more shrinking and cutting and slashing.”

It’s not that Emanuel is special, he hastened to point out. It’s the temperament of the leadership. Too many rural administrators spend their time complaining instead of leading. “Don’t complain about the state of healthcare today,” he said. “The staff doesn’t want to hear that. The staff wants to see a leader that’s going to take them through healthcare today, and healthcare today is not what we offered even 10 years ago. It’s got to be something different.”

BLESSED ARE THE FLEXIBLE

While the basics of healthcare remain, they have to be adapted to the new paradigm, Scott observed. Healthcare workers will follow an executive who embraces change and leads in spite of the challenges posed by it. “What they’re not going to follow is somebody that’s saying, ‘I wish we had it like it was. I hate how this system is.’ Blessed are the flexible. We’ve got to be flexible. We’ve got to be willing to adjust to what our patients’ needs and desires are.”

He believes Apple serves as an example of how a niche company was willing to think beyond its standard box and adapt to the marketplace through such groundbreaking innovations as the iPod and iPhone, becoming an industry leader in the process. “In order to survive we’ve got to shift, and the thing that has been so exciting to me is to see how we can share those services now that we’re not a competitor with a hospital 25 or 30 miles away. I’m learning so much from these other folks that we’re able to bring into our facilities.”

BY PETE FERNBAUGH

HALIBURTON HIGHLANDS HEALTH SERVICES

HHHS Joins with Other Community Organizations to Provide Continuous Care

Creating hospital and community partnerships is key to delivering quality, seamless healthcare for future generations. This holds true in Canada as well as the United States, where the country is focused on improving outcomes, reducing chronic disease, and responding to the increasing numbers of Baby Boomers who need healthcare services.

In Haliburton County, Ontario, Haliburton Highlands Health Services (HHHS) has joined forces with community services to develop a continuum of care under the hospital umbrella.
BRINGING EVERYONE TO THE TABLE

In the fall of last year, three organizations that provided community care services, hospice services, and adult day programs and foot care transferred their programs to HHHS. This transfer took about a year and a half of planning, and HHHS is still adapting to the structural changes the transfer brought about within the organization.

“Allof the groups moving under the HHHS umbrella, this transition was a difficult and personal decision. For example, Community Care Haliburton County transferred all of its programs and services to HHHS and is winding down as a corporation. The decision of Community Care Haliburton County was significant on the part of that board,” Eskedjian said. “We support that decision and feel no jobs were lost.

The three organizations—Community Care Haliburton County, Supportive Initiatives for Residents of the County of Haliburton, and the Victorian Order of Nurses—Ontario Branch—were primarily volunteer-based service providers, and 95 percent of the volunteers stayed on after the transfer. This greatly aided in providing uninterrupted care to clients. Employees and providers making the transition did have to adapt to a new culture and changing workloads, Eskedjian said. Some staff and providers chose to retire based on changes from the transfer.

“The organizational change has created additional work in some areas, and we had some people choose to retire based on the additional workload,” Eskedjian said. “We support that decision and feel that we have retained a staff that is able to lead the organization in this new direction.”

To keep everyone engaged, Eskedjian said it was important that he and the other leaders were champions throughout the process and maintained open lines of communication with all stakeholders.

The hospital leadership is now organized into three divisions: community support services, hospital services, and long-term care. Eskedjian said everyone is working to come together and develop a common culture.

“Compared to our partners, we are a large company, but we are still a relatively small organization with a small management team, so planning and details have been a challenge and required a lot of work from myself and the leadership group,” he said. “Having the support of the board throughout this time has been critical to our success.”

Looking ahead, HHHS is planning to coordinate all of the services in order to develop a program supportive of population health. He said HHHS is looking to grow community support programs to improve community health and lessen the burden on the hospital emergency departments and inpatient unit.

“The integrated organizational structure is the vehicle whereby we are looking to enhance the quality and the range of services devoted to the healthcare needs of the county,” Eskedjian said. “We are now able to facilitate patients’ access to services and create orderly transitions between providers.”

BY PATRICIA CHANEY

REAL Issues : REAL Solutions

Restructuring the Organization to Improve Care

Bringing these services and programs under HHHS created the need for an expanded organizational structure. Previously, the system included a 14-bed inpatient unit, two emergency departments, 30-bed and 62-bed long-term care facilities, and satellite offices for other programs.

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BY PATRICIA CHANEY
When Thomas Keller began his tenure as president and chief executive officer of Ozarks Medical Center in West Plains, Mo., on Feb. 17, 2014, he brought with him one simply worded question that would serve as the foundation of his first year: How does the patient define quality care?

“Rounding visits are done not only by nurse managers, but by directors and vice presidents,” Keller said. “It’s a way to engage patients in a conversation about what they want.”

These conversations include keeping patients informed as to why certain processes, such as drawing blood at four in the morning, are being done. The conversations are also designed to give patients a sense of control, realizing how helpless some feel in a hospital.

“We use words and language in hospitals that most people aren’t used to,” Keller said. “So we want the staff to slow down and listen to the patients, then ask the patient if they understand what’s being done and how long it will take, so the patients feel they have some control every step of the way.”

In 2013, fall-outs from core quality measures happened an average of 21 times each month. When Keller arrived, he felt this was one weakness that needed to be addressed.

“Just because we fall out doesn’t mean the patient received bad care,” he said. “So we want the staff to slow down and listen to the patients, then ask the patient if they understand what’s being done and how long it will take, so the patients feel they have some control every step of the way.”

Keller decided to approach this issue from a perspective of purpose.

“Always in healthcare you have to remind people why they choose a career in healthcare, talking to people about great care for every patient every time and making it a very human thing with them,” he said. “But I also would say accountability is a huge part of it and that starts with the board of directors and me saying, ‘Every patient every time.’ It’s me saying, ‘We can.’ It’s me making sure that people understand that it’s a priority that we focus on this culture of safety and having a safe place for patients. It’s all of us talking about it whenever we get a chance to talk about it in staff meetings, between the nurse leader and the individual nurse, talking about the importance of it and why we do it.”

Keller implemented an operational huddle every morning at 8:30. Between 20 and 25 leaders attend daily to discuss various issues that are confronting the hospital that day. They discuss core measures and identify patients who may need extra care or may pose a fall risk.

Showing this kind of attention to detail is especially important for a community hospital like Ozarks Medical Center, he said, because the town is very involved in its daily operations. After all, the
Sensiotec Reconfigures Data Collection with Cross-Platform Sensor Solution

Atlanta, Ga., has evolved into a hub of innovation for medical-device start-ups, thanks in part to the Georgia Institute of Technology’s Advanced Technology Development Center (ATDC) and its flagship program, ATDC Select, which serves as one of the top incubators for high-potential startups in the United States.

In 2013, ATDC Select recruited Sensiotec, a leading innovator in biosensor and digital-health technology, for the program. Founded by Robert Arkin, chief executive officer, Sensiotec received the Start-Up Company of the Year Award at the 2014 Health IT Summit and the 2015 SSA Impact Award for Emerging Mega Trends from TAG/Southeastern Software Association.

“Sensiotec is reinventing patient monitoring with a medical-grade, mHealth monitoring solution that is focused primarily on post-care clinical care,” Arkin said. “We are the first company that’s developed a viable patient-monitoring solution for nursing homes and assisted living facilities that has received FDA 510(K) Class II medical device clearance.”

Robert Arkin, Founder and Chief Executive Officer

LEADING THE CHARGE AND SETTING GOALS

Along with its many accomplishments last year, OMC’s financial outlook also improved.

“It’s possible to have great quality, great patient satisfaction, and to have improved financial results as well,” Keller said. “In 2013 we had a less than zero percent operating margin. Now we have an over four percent operating margin.”

However, such changes can only be achieved through fearless leadership from leaders who are willing to put themselves at the forefront, he said. They have to be the ones who are saying, “We can do it.” Above all, leaders must be the ones who are asking questions and exploring new ways of achieving goals.

“It’s never been an ‘I’ thing in healthcare,” Keller said. “I’ve never done anything that didn’t involve a whole bunch of people. It’s a ‘we’ thing, but the leader has to be out there in front saying, ‘We’re going to change this drastically.’ And I think most people, if they’re connected to purpose and why they got into healthcare can immediately wrap their arms around it and believe and be engaged 100 percent.”

BY PETE FERNBAUGH

PIONEERING THE NON-CONTACT SENSOR PANEL SOLUTION

Sensiotec’s solution consists of a non-contact sensor panel that is placed unobtrusively under a patient’s bed or chair at the point of care, enabling a completely passive patient-monitoring experience. The panel transmits and receives ultra-low-powered radio signals that reflect off the patient’s internal organs, torso, and limbs. These signals are processed onboard the sensor panel at the edge of the network.

The signals are then converted into biometric data, encrypted, and relayed continuously to a HIPAA-compliant web server, which catches the large data sets being generated over long periods of time.
In addition, the web service hosts Sensiotec-developed proprietary web applications that utilize this data to monitor patient presence, patient agitation, patient positioning, heart rate, and respiration rate. Arkin explained that this information is available in real time from any smart mobile device. “The web app identifies variations from the patient’s baseline,” he said. “We present the data in real time from anywhere via one’s iPhone, iPad, or iPod touch. Sensiotec is busy applying the IoT concept to medical devices, Arkin said. The sensor panel functions as an IoT appliance, delivering data to the cloud. That data is then available to people who need it for patient monitoring.

“Only in our case, instead of monitoring temperature, we’re monitoring what’s going on inside the body by measuring the micromovement of the internal organs, as well as torso and limb movement,” he said.

It’s easy to assume that Sensiotec is actively applying this technology within hospital ICUs, but Arkin said the patient-to-caregiver ratio in ICUs is usually one caregiver for every two patients. Sensiotec is focused on the areas of the care continuum where the ratio is wider, such as on the general floor where you have one caregiver for every five to seven patients, or in post-acute settings like a skilled-nursing facility or an assisted-living facility where one caregiver is providing for every 10 to 15 patients. In the future, Sensiotec plans on expanding to home-care monitoring, where a caregiver is only present a few times each week.

“The relationship between the ICU and our technology solution is inverse. The further away the patient gets from the ICU, the bigger the benefit to the patient,” Arkin said. “We believe our value proposition for nursing homes and assisted living facilities is particularly strong. With our solution, we believe these facilities can improve the quality of the care they deliver. We also believe we can help them increase lengths of stay, reduce readmissions to hospitals, and increase overall occupancy rates. This, of course, has a direct bearing on revenue and profitability.”

**PROVIDING PATIENT MONITORING FROM ANYWHERE**

Tech developers envision a time when all software, sensors, and electronics—the Internet of Things (IoT)—will have the ability to interact seamlessly with each other while retaining their unique identification.

For example, Apple’s Nest Learning Thermostat is still a traditional household thermostat designed to regulate temperature and environment. However, it breaks with tradition in that it can be controlled from anywhere via one’s iPhone, iPad, or iPod touch.

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**PRODUCING A CONTINUOUS DATA STREAM**

Sensiotec’s non-contact sensor-panel solution also gives the provider a continuous stream of manageable data.

“In the med/surg unit of a hospital, a patient may have his or her vitals measured every four to six hours. This might represent 30 biometric data points per day,” Arkin said. “In our case, the data stream is continuous. As long as the patient is in the bed or in a chair, our system is going to be generating 400,000 biometric data points per hour.”

The future of healthcare is in prevention, and Sensiotec is creating granular databases that will support the development of algorithms for generating predictive healthcare analytics on chronically ill and acute patients.

“We’re actually acquiring data every few nanoseconds, compiling that medical information derived from the data neatly in a data packet, and then sending it to the server every second or two,” Arkin said.

Remarkably, the footprint produced by this data collection is light, only generating about 3.5 bytes of data per second.

Currently, Sensiotec has formed a strategic partnership with three high-profile players, including WellStar Health System in Georgia, and is open to exploring other partnerships.

Beyond these partnerships, however, Arkin said Sensiotec would like to break down the silos that exist between tech companies, emphasizing communication over competition.

“Part of the effort is to open up the established companies to what’s going on with the emerging companies in the area and to be able to create a more cohesive ecosystem in which the companies are supporting each other.”

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**REAL ISSUES : REAL SOLUTIONS**

“On one hand, we have spot data and trend data, which provides great detail about the condition of a patient at a single point in time and over a longer period of time, but we also include very simple, visual graphics that use red/yellow/green-type traffic-light icons to indicate degrees of severity.”

BY PETE FERNBAUGH
PIONEERING NEW TECHNIQUES

Ziering Medical Grows Reputation in Hair Restoration with Technology and Innovation

Previously regarded as an industry filled with gimmicks and overly priced potions that rarely delivered, hair restoration procedures have made huge advances in science and technology to become reputable, trusted options that offer quality results.

Ziering Medical, based in Beverly Hills, Calif., but with offices throughout the United States, is a leader in hair-loss treatments and surgical hair restoration.

Initially, Ziering said, the robotic device was used to harvest follicular units or hair grafts, one at a time, from the donor area back of the head. The grafts are then divided and carefully placed into the recipient sites, according to the surgeon’s design and judgment on what will achieve the most natural-looking results.

The next innovation in the works is to use a tablet to develop a 3D model of the patient’s head and map out the procedure, including hairline, hair pattern, follicles to transplant, and recipient sites. The model will then be transferred to the robot to line up markings on the head, and recipient sites can be made on the scalp.

“We are getting better and quicker with the robot, with the goal of combining the robot’s precision and repetition with the surgeon’s artistry and aesthetic skill,” Ziering said.

Ziering is never content with the status quo and is constantly pushing the technology to see what can be accomplished. The robotic procedure has opened up more options for patients as well. Previously, women had been told they were not good candidates for the robotic procedure. Ignoring conventional wisdom, Ziering became the first hair transplant surgeon to perform a robotic FUE procedure for a female patient.

In continuing to promote the science of hair restoration, Ziering Medical is participating in clinical trials using stem cell therapy to stimulate hair growth. For this procedure, fat is extracted and then injected back into the scalp to stimulate hair growth and thickening. Ziering said the initial results hold promise for early intervention in hair loss for patients with a strong family history.

WORKING CLOSELY WITH PATIENTS FOR A NATURAL LOOK

The key to Ziering’s success is not found in his adoption of technology alone, but also in his dedication to patients.

“In everything we do, we ask ourselves, ‘Will this be good for our patients? Does it offer them an alternative solution to their hair loss? Does it help them achieve their aesthetic goals? Will it have a positive impact on their lives and their hair-restoration journey?’” he said.

Ziering works closely with patients to understand these aesthetic goals, to educate them on the procedures, and to set realistic expectations.

“It is important to have a dialogue with patients and to listen to them,” he said. “It is the surgeon’s responsibility to consider what goes into the procedure—skill set, technology, limitations such as weak hair all over or too much loss as it relates to available donor hair—and use that to inform a discussion with the patient about expectations. We look to what we can do with small amounts of hair to create the impression of having a lot more.”

Ziering developed a hair-pattern classification system and surgical-restoration technique for identifying growth patterns on the back of the head called the Ziering Whorl.

Together, the system and technique help restore bald spots in a measured, scientific manner by reintroducing the patient’s natural hair pattern, giving patients natural-looking results with the fewest grafts possible. For patients with limited donor hair, this is great news.

MAKING THE PROCESS WORK FOR PATIENTS AND STAFF

Adapting to technology and pushing the envelope is challenging, particularly in a medical field where people tend to be creatures of habit and repetition. Ziering has developed a staff that is open to change and innovation. In turn, Ziering Medical has invested heavily in educating them.

“We have a strong educational component for our nurses, surgeons, patient advisors, and receptionists,” he said. “We need to make sure everyone is speaking the same language and giving the same information.”

Ziering also strives to educate patients through the organization’s website, advertising, educational materials, and testimonials. Going forward, he’s focused on discovering new ways of enhancing the patient experience by participating in research and exploring groundbreaking opportunities for hair restoration.

“I get a lot of satisfaction when a patient comes in and says they have been following our ads for years and are ready for a consultation,” he said. “We have many patients who are conscientious, gather their information in advance, and look to us as a credible source for answers.”

BY PATRICIA CHANEY
Tuba City Regional Explores Ways to Expand Access within Navajo Nation

With unique challenges to funding and its patient population, Tuba City Regional Health Care is committed to serving the residents of the Navajo and Hopi reservations in and around Tuba City, Ariz.

Tuba City Regional Health Care is a 638 self-determination organization, which means it receives some funding from the Indian Health Services, but it can operate independently and seek out other funding sources. The organization recently named Lynette Bonar as chief executive officer, after she served in an interim capacity. She succeeded the retiring Joseph Engelken, with whom HCE Exchange spoke back in 2011.

Bonar has been instrumental in expanding upon Engelken’s mission for the organization and has brought many new services to the community.

Lynette Bonar,
Chief Executive Officer

Approximately 30 to 40 percent of Tuba City Regional’s patients have diabetic issues, including heart and vascular conditions, wound healing issues, and other comorbidities, Bonar estimates.

A few years ago the organization built a three-story, 34,000-square-foot outpatient clinic to provide better service to patients. The clinic is equipped with primary care, an outpatient pharmacy, and a healthy living center.

The healthy living center promotes positive lifestyle habits, particularly for those living with diabetes. Tuba City Regional received federal grants for health promotion and diabetes prevention in order to fund these programs.

“We are able to take more time with patients that are diabetic to give them medication counseling and nutrition information,” Bonar said. “We have a foot program, eye program, and dietician available to help patients manage their disease.”

She said the podiatry program has become a major factor in improving the quality of life for many diabetes patients. Patients are now able to receive wound care and treatment rather than having their symptoms worsen and risk amputation.

The next step for the center is to expand its interventional radiology program. Bonar credited this program with enhancing Tuba City Regional’s ability to address the vascular issues afflicting its diabetic patients.

With more than 8,000 residents, the center does its best to service all of Tuba City. The outpatient building stays busy with specialty care, family medicine, and women’s and children’s services.

“Since the outpatient center opened, our appointments have almost doubled,” Bonar said. “Everybody wants to come here.”

Tuba City Regional is able to maintain more than 100 physicians, all of them employed, across many specialties. The center is planning to contract with physicians from nearby medical centers to provide care a few days a week in specialties such as neurology and rheumatology.

CONNECTING WITH THE COMMUNITY

In addition to the main campus, Tuba City Regional owns satellite clinics that are spread throughout the surrounding area. The reservation is expansive, and many patients have to travel 20 or 30 miles to receive care, with some being located as far as 70 miles away.

To help with access issues, Tuba City Regional is expanding its telemedicine and mobile care programs. The organization has three vans that travel to seven communities and provide dental care and medical care.

Tuba City Regional has also strengthened its mail-order pharmacy program to improve access with physicians from nearby medical centers to provide care a few days a week in specialties such as neurology and rheumatology.
CHEYENNE REGIONAL MEDICAL CENTER

Cheyenne Regional Leads State with Wyoming Institute of Population Health

Cheyenne Regional Medical Center is the largest hospital in the state of Wyoming. With 222 beds, it was honored by CMS with the Health Care Innovation Award that includes a three-year, $14.2-million grant to develop a trademarked division of the organization known as the Wyoming Institute of Population Health (Institute).

Given the large percentage of rural populations in Wyoming, the need for population-health management is great. CMS chose Cheyenne Regional to represent Wyoming in developing strategic platforms that would enable healthcare organizations across the state to take a more proactive approach to population health.

Real Issues : Real Solutions

CHEYENNE REGIONAL MEDICAL CENTER

Dr. Phyllis Sherard, Chief Strategy Officer and Vice President of Population Health

to medications and assist patients in sticking with their care plans.

The medical center’s connection to the community is vital, Bonar said. There’s a huge diversity among the staff and patients with some coming from different tribes and others from outside the reservation. Bonar said the outpatient clinic has helped forge a stronger bond with the community.

“We have patients that were born here and receive end-of-life care here,” she said. “We can see their full medical history. We need to know what’s important to our community.”

In addition to providing for patients, inadequate housing has been a problem with recruiting staff and physicians. Tuba City Regional owns 300 housing units and is building three more apartment buildings with 36 units each just for staff.

“We need professionals out here, and we have to provide them a place to live,” Bonar said.

FUNDING THE FUTURE

Funding is always a problem for smaller medical centers, and Tuba City Regional faces unique challenges. It can take years to obtain approval and money from the Indian Health Service. By being a self-determination organization, Tuba City Regional has more freedom and is able to use reimbursements from Medicare, Medicaid, and third-party payers. The organization recently procured a loan for the outpatient building and makes full use of all grants it receives.

In an effort to advance telemedicine and provide access to care across its 6,000-square-mile service area, Tuba City Regional is looking for investors to help improve the Internet services. An adequate broadband system is needed for future telemedicine vans and for general communication across facilities.

Tuba City Regional has also implemented electronic medical records in its inpatient hospital, but is looking to change vendors in the coming years.

For now, the organization is continuing to improve quality of care and access to care, as well as managing the sustainability of its programs in order to ensure that it is able to continue serving the Native American population far into the future.

BY PATRICIA CHANEY
"It was unique in that we have an organization that is willing to look at the statewide needs, not just our own system’s needs," Greg O’Barr, director, business development and analysis at Cheyenne Regional, said. It created this interesting dynamic where those that we see as competitors every day are now also our collaborators and our partners.

As the grant nears the end of its three years, Wyoming healthcare has undergone a makeover in which organizations are less siloed and more collaborative under the Institute’s leadership.

HELPING PRACTICES ACHIEVE PCMH CERTIFICATION
Wyoming is classified as a Frontier State. Only two cities are considered urban areas, and even that’s a stretch, O’Barr said. For example, the system’s hometown, Cheyenne, has a population of over 60,000.

Because of the state’s classification, the Institute was primarily concerned with using the grant to bolster primary care throughout Wyoming. It created multiple programs that were focused on assisting primary-care practices in achieving PCMH certification through NQF.

The Institute also established the Wyoming Rural Care Transition Program® with the goal of expanding care beyond the traditional four walls of standard healthcare entities.

For participation in this program, inpatients who were 65 years or older with one of 10 diagnoses were signed up. These patients were then followed post-discharge for 90 days by an RN, who made home visits, conducted medical reconciliation within the home, and followed up to ensure doctor appointments were made.

The results were so positive in reducing readmissions, O’Barr said the program now includes two additional locations with pilots for patients 18 years or older and features a behavioral-health component as an additional diagnosis.

Furthermore, the grant has enabled the Institute to oversee the largest investment in telehealth infrastructure in Wyoming. The Institute has also partnered with the state on medical donations, working with a pharmacist to acquire unused, unwrapped pharmaceuticals from hospitals and giving them to the uninsured and underinsured.

MEASURING OUTCOMES AGAINST FIVE STRATEGIES
Dr. Judit Olah, director of analytics within the Institute, said they are tracking outcomes from these programs according to the standards of the Triple Aim. The quality of the services are further measured against five strategies.

“We are basically looking at the breadth and depth of the programs, the number of connections that are available, the number of PCMHs, and the number of access points that are available,” she said.

Olah said they have consulted with physicians, practice managers, patients, payers, and other stakeholders to develop a subset of nine NQF measures, including preventive and high-risk standards. After being vetted by the advisory group, the measures were then pushed out to participating facilities for monitoring outcomes.

Payers have since intensified communication with the Institute and the program participants, Olah said. In fact, five major payers in Wyoming have partnered with Cheyenne Regional to ensure the reporting of these nine measures.

“We were able to sidestep the reporting burden that you read about across the nation by bringing everybody to the table, presenting regularly, giving feedback on movement, and having that buy-in,” Olah said.

“IT’s quite amazing how willing people are to report on the data when the payer comes back and says there’s an incentive with an enhanced reimbursement because you are reporting,” O’Barr added. “When payers see that they are measuring, they are willing to pay to keep that patient well. And that’s why we think we’ve had good luck with the program.”

LEARNING AND GROWING THROUGH PARTNERSHIPS
Dr. Phyllis Sherard, chief strategy officer and vice president of population health at Cheyenne Regional, believes the success her team has experienced with the Wyoming Institute of Population Health should encourage other rural executives to partner within their care communities.

“IT’s the only way you’re going to attract investment capital in the form of grants that will allow you to make the investments in shifting from the acute-care hospital to population health,” she said.

However, in making this shift, she advises that executives take their wins where they can get them, implementing strategies only when their organization is ready, not because an urban-community timeline dictates they should.

“Find the things that work for your community, work for your size hospital, work for your hospital’s culture, and then start to recognize that in creating a medical neighborhood,” she said. “It is mostly about the relationships you form in that medical neighborhood.”

O’Barr agrees with Sherard. He said it can seem like a dictatorship when one hospital is overseeing a program similar to the type the Institute facilitates. Therefore, “success equals personal relationships.”

Additionally, regular feedback from participating practices is important, Olah said. However, this feedback needs to be shared with all participants, so they are aware of more than just the progress of their facility.

Sherard said the mid-sized and smaller hospitals in the program had to adjust the roles they played within their communities as they partnered with each other and as they reached out to other nonhospital-based programs in their service area.

She likened it to a learning laboratory in which all participants educated and sharpened each other.

“Be committed to drawing a perimeter of health around your service area,” she advised, “but don’t neglect the nontraditional partners that are out there in the community.”

BY PETE FERNBAUGH
Liaison Brings Integrated Security to Healthcare IT Platforms

In a world of healthcare start-ups, Liaison Technologies stands out from the crowd, especially in 2014 when the company was lauded with numerous honors and recognitions.

In November 2014, for example, the company was included on Deloitte’s Technology Fast 500, placing it among the fastest-growing North America technology companies. Gartner also named Liaison a leader in the 2014 Magic Quadrant for Integration Brokerage, and Liaison’s team of entrepreneurs and innovators were honored with 10 medals at the Golden Bridge Awards.

Nine Live Media included the company on its MSPmentor 501 Global Edition, ranking it rather highly at No. 7. Network Products Guide included Liaison as a finalist in its 2014 Hot Companies and Best Product Awards, and it was part of the Georgia Fast 40 list of companies. Finally, Talkin’ Cloud 100 named Liaison among the top 25 cloud service providers in the United States.

Bob Renner, chief executive officer, said these honors reflect the company’s mission to provide secure, cloud-based data management and integration services and solutions around the world.

Currently, he said, Liaison is focused on capturing a healthcare marketplace that is desperate to have its platforms interact with each other.

SECURING AND ENCRYPTING DATA AT THE SOURCE

There are three features of data protection that Liaison integrates: encryption, tokenization, and key management.

Liaison has developed “the first data security solution that integrates strong encryption, centralized key management, and a new variation on tokenization,” known as Format Preserving Tokenization, Renner said. His team has achieved all of this with one solution, Liaison Protect.

Liaison Protect encrypts all of an organization’s stored data across the system’s infrastructure. No matter where you send that data, it is encrypted. However, there’s an “additional layer of protection to encryption,” Renner said, with tokenization. Liaison has pioneered Tokenization as a Service (TaaS).

Tokens, also known as surrogates, replace the original data, while the encrypted data is stored in a data vault, as opposed to sending it back to its originating source or database.

Format Preserving Tokenization, which replaces the original data, is a reference to that data without presenting a mathematical relationship that would link the two. For this reason, the token can be used in any file, application, database, or backup medium.

If a cybercriminal would happen to access one of these tokens, it is of no value. A video on the Liaison website compares the token “to a poker chip outside of a casino.” Furthermore, Liaison has pioneered tokenization-as-a-service (TaaS).

Liaison’s centralized key manager generates, distributes, rotates, revokes, and deletes all keys. This means, Renner said, that only authorized users can access the data.

He further pointed out that Liaison Protect not only reflects best practices for data protection, but it also frees the data to be used across databases, in applications, and on devices.

UNDERSTANDING THE IMPORTANCE OF DATA PROTECTION

It’s vital that executives realize just how vulnerable the majority of their data is, Renner said, whether they’re looking at patient records, payment information, or EMR security. The consequences of this information being hacked and breached are far-reaching and destructive.

Most hackers and cybercriminals have learned to get around firewalls and access controls, which is why Liaison believes information must be protected at its source.

Liaison Protect covers all data types, no matter what the platform, and it reduces the scope of regulatory audits and minimizes the cost of compliance, Renner said.

He also believes Liaison’s experience with providing security in other industries makes it uniquely qualified to handle healthcare IT.

“Our experience with data management and security within the financial industry informs our solutions for healthcare,” he said.

OFFERING SOLUTIONS THAT FAVOR INTEGRATION

According to Renner, all of Liaison’s solutions are “rooted in cloud-based interoperability.” Its other solutions beyond Liaison Protect include EMR-Link, which eliminates re-entry of data into a lab-ordering system and enables automatic validation of medical necessity and secure sharing of lab reports.

Liaison Direct Messaging provides a portal that protects messaging among providers within the organization. Its Alloy Health Platform™ creates a Virtual Health Record (VHR) that supports data aggregation, harmonization, and curation in order to enhance clinical trials. It is also compatible with disparate EHRs, Renner said.

As the company’s website, www.liaison.com, explains, the Liaison Alloy Health Platform™ provides “complete, real-time visibility…achieved through the data-visualization layer, LENS,” and features “an architecture based on big-data infrastructure” that adds “value in relationship discovery and taking actions on top insights.”

It is also compatible with disparate EHRs, Renner said.

Whether it’s managed services, such as integrating systems, data, and processes; cloud services that will increase the flexibility of data within your system; consulting services that offer the benefit of an outsider’s perspective on business-process integration (BPI), application integration, business-process management (BPM), master-data management (MDM), and various vendor platforms, including TIBCO, IBM, Pegasystems, Software AG, among others; or professional services that go beyond technology and into tactics, processes, and staff, Renner made it clear that Liaison is interested in making your organization as efficient and cost-effective as possible.

“Our solutions are tailored as every environment and situation is different,” Renner said.

“We’ve made our business about being flexible and open to our customers, and the core competency we’ve built up and concentrated in Alloy proves this. It is a little bit difficult to find professionals who have spent the last 10 years doing exactly what we’re doing with integration and data management.”

BY PETE FERNBAUGH

Chief Executive Officer

LIAISON TECHNOLOGIES

Bob Renner

Gartner also named Liaison a leader in the 2014 Magic Quadrant for Integration Brokerage, and Liaison’s team of entrepreneurs and innovators were honored with 10 medals at the Golden Bridge Awards.
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