

## Newsbytes, 1/18

**Raymond D. Aller, MD, and Hal Weiner**

### **Why pathologists shouldn't 'pass the baton' with IT**

It may be tempting to stay in your comfort zone and leave the technology decisions to the information technology experts. But pathologists who abdicate oversight of IT projects within their departments are setting up those projects for failure, says John H. Sinard, MD, PhD, professor of pathology and medical director of pathology informatics at Yale University School of Medicine.

A pathologist may think, "these are technical issues that are beyond me, so I'm just going to pass the baton. We'll let the IT people figure it out," says Dr. Sinard. "But you don't need to be an IT expert; you're a pathology expert, and technology solutions deployed in the absence of an understanding of the workflow in pathology are not likely to solve the problem."

Avoiding technology decisions is just one of the common management mistakes Dr. Sinard highlighted as the leader of a roundtable discussion titled "Managing the people who manage your information system," at CAP17 last fall. Another is assuming that installing new technology, such as a whole slide imaging system, can fix all departmental problems. "You'll hear people say, 'If we just scanned all of our slides, we'd be more efficient, or we would be able to find everything,'" Dr. Sinard says. "But that doesn't take into account who's going to do the scanning, when in the course of slide preparation the scanning will be done, how many scanners you need to get the work done in a timely fashion, what you are going to do with the failed scans, who's going to manage and back up the storage. Those are all elements of the solution."

Understanding how new technology will impact the department's workflow is critical, Dr. Sinard maintains, but pathologists must also consider whether a new system can handle exceptions to the standard workflow rules. A histology tracking solution, for example, would usually follow blocks through a standard progression: ordered, received, processed, embedded, cut, filed. Many tracking systems will support that progression only, Dr. Sinard says. "But what do you do if you go to cut a block and you realize it's not properly fixed? Then it has to be reprocessed and go back from a status of 'embedded' to a status of 'on the processor.' That doesn't happen often, but if your system doesn't support that, then you'll have to circumvent the system. Pathologists need to think of exceptions like this when they're looking at a system's capabilities."

Other issues can arise when pathologists neglect to get buy-in from their lab staff who will use the new technology, Dr. Sinard continues. The technology may not meet their needs, or they may resist it simply because they were not consulted about the change. One approach to involving staff is to test-drive the new technology in select segments of the workflow, he says. "If you're trying out a new stainer, maybe you put a subset of slides on it. If you're implementing new software, is there a test environment that people can play with it on? Or do you just do a subset of specimens as a trial run?"

When the pathology department at Yale implemented barcodes on the blocks and slides in the histology lab, "we let the histotechs designate three individuals to represent them," Dr. Sinard explains. "In this case, we were developing our own software. Over the course of several meetings, we showed them our plans, got their feedback on what they thought would and wouldn't work, and asked them where on the screen they wanted certain information and what changes they would like to see. Then their job was to keep their team updated on the developments."

The key, Dr. Sinard says, is to become involved in a project early, before major or irreversible decisions have been made by others outside the pathology department. Before a project begins, a pathologist should approve the end-point solution, in detail, as well as the phasing and timeline of the deployment. "Think about whether the workflow can be segmented or if it has to be an all-or-nothing deployment," says Dr. Sinard. "Can you do it in phases? If a

phase doesn't work, what's the roll-back plan?" Clinical care can be compromised if pathologists don't approve the timeline, he adds. "If a vendor decides to install a bunch of new processors, and they move out the old processors before the new ones are installed, what are you supposed to do with the work that day? Pathology needs to know what the implications to the workflow are; you've got to be operational throughout the entire deployment."

When the inevitable IT-related issues do arise, pathologists should describe the problem to the IT department in detail, with examples, rather than lobbing general complaints, Dr. Sinard says. "Giving an idea of the scope of the problem, if you know that, will affect the priority that the problem is given," he says. "So you can say, 'This issue is affecting not only our new cases but all of our old cases as well,' or, 'This is going to affect 50 patients a day.' Keep in mind that you have to recruit [IT] resources to the problem, and you're competing with other people for those resources." —*Jan Bowers*

## **HHS offers tips to deter data breaches by past employees**

The Department of Health and Human Services has released a newsletter featuring recommendations to curb the potential for data breaches by former employees of health care organizations, as well as links to related information.

Identity- and access-management policies and controls "can include many processes, but most commonly would include the processes by which appropriate access to data is granted, and eventually terminated, by creating and managing user accounts," according to the document.

The cybersecurity newsletter can be accessed at [www.bit.ly/data-breach-tips](http://www.bit.ly/data-breach-tips).

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## **Xifin releases RCM offering**

Xifin has introduced its next-generation revenue cycle management solution, Xifin RPM 9.

This latest version of RPM offers several new features, including:

- integrated insurance discovery, which allows the system to automatically search for a patient's insurance provider and update the system with this information.
- automated document management, which allows documentation to be uploaded and attached to claims and appeals or faxed to payers.
- enhanced business intelligence capabilities, including new monthly and quarterly metrics and benchmarks and collection waterfall charts.
- new patient portal functionality that includes the ability to deliver test results and take prepayments on orders.

RPM 9 extends Xifin's outsource service model to hospital outreach laboratories and other types of diagnostic service providers.

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## Regenstrief Institute updates LOINC database and RELMA

The Regenstrief Institute introduced, last month, LOINC version 2.63 and RELMA version 6.22.

Among other improvements, the latest Logical Observation Identifier Names and Codes release has added 1,660 terms, including 736 specific to the laboratory, bringing the total number of terms to 86,528. LOINC is a standard coding system for identifying laboratory test results.

The most recent enhancements to the Regenstrief LOINC Mapping Assistant include the ability to filter search results by user-defined subsets. "Many countries support a curated, nationally-approved list of LOINC codes for use in their jurisdiction," according to a press release from the Regenstrief Institute. "Rather than search the whole 80,000+ LOINC database, with this new feature, their searches within RELMA are limited to only what they need."

Additional details about the latest releases of LOINC and RELMA are available at [www.bit.ly/LOINC\\_RELMA\\_updates](http://www.bit.ly/LOINC_RELMA_updates).

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