KHSC Newsletter
April 2024

Bridging the Gap: Kiowa County Hospital District and ChartSpan Partner to Elevate Rural Health Care

Kiowa County Hospital District in Eads, CO, faced a challenge common to many rural health centers: providing high-quality, accessible health care to its rural Medicare population. Recognizing the limitations of its in-house Chronic Care Management program, KCHD partnered with ChartSpan to streamline operations, boost revenue and ultimately better serve its patients.

This successful collaboration demonstrates how CCM can optimize health care delivery in rural communities. KCHD's case study offers valuable insights for any health care organization seeking to:

- **Generate consistent, recurring revenue*:** KCHD leveraged ChartSpan's expertise to ensure compliance with the Centers for Medicare & Medicaid Service requirements. This allows them to finally earn reimbursement for its CCM program for every participating patient every month.
- **Prioritize patient accessibility:** ChartSpan's program facilitated monthly communication between patients and care managers, improving care coordination and patient engagement. Patients also gained access to a 24/7 nurse line to have their health questions answered when its providers office closed.
- **Address rural health care needs**: As part of CCM, ChartSpan performed Social Determinant of Health screenings to help KCHD identify patients' transportation, housing and food needs. Care managers connected patients to local resources like car services, food banks, meal delivery services and housing agencies.

In addition to a 24/7 nurse line and SDOH resources, CCM also provided KCHD patients with personalized care plans, monthly check-ins and assistance with appointment setting and medication refills.

By focusing on CCM, KCHD helped its rural patient population engage in preventative care and reduce its risk of hospitalization.

Want to learn more about how your practice can use CCM to offer more accessible health care? Find the full case study here.

*Results may vary by provider.

Hospital Closures and Soaring Transport Costs

The health care landscape is witnessing a concerning trend: the closure of hospitals across the nation, leaving communities vulnerable and increasing reliance on emergency medical transportation. This wave of closures has resulted in longer ride times for patients, leading to rising emergency medical transportation costs. According to the American Hospital Association, there are more than 5,100 community hospitals in the United States, with approximately 65 percent serving urban/suburban areas and 35 percent serving rural communities. Emergency rooms are critical to hospital operations, serving as the hospital's front door and accounting for more than 50 percent of admissions. However, 76 percent of community hospitals are owned by non-profit organizations or state and local governments, relying on external financial support to survive.[1]

During the past four years, more than 100 hospitals have closed, disproportionately impacting rural communities.[2] Factors threatening the sustainability of health care facilities include high fixed costs, availability of skilled labor, reimbursement challenges and limited access to capital. Nearly 600 hospitals, one-third of rural hospitals, are at risk of closure due to these factors, with 50 percent at immediate risk due to financial reserves.[3] Additionally, the availability of obstetric services is in decline, with more than 400 maternity services closing between 2006 and 2020.[4] These types of closures result in longer emergency transportation times, negatively impacting health outcomes, especially for acute cases like heart attacks and trauma.[5]

The weakening financial position of the Medicare Hospital Insurance Trust Fund, the industry's largest payer at 26 percent of revenue, suggests significant Medicare legislation is likely in the next few years.[6] These budget pressures, combined with the increasing Medicare population, strain facilities, staff and budgets, contributing to rising emergency medical transportation costs.[7]

The declining number of hospitals is one of the key factors behind rising emergency medical transportation costs. The very nature of hospital operations (high fixed costs, multiple service lines) favors larger facilities to address the need for larger service areas. Further exacerbating closures are Medicare's declining solvency, the hospital industry's narrow margin for error and significant adverse changes in the operating environment (such as a pandemic, severe economic downturn, etc.). This combination of pressures will likely lead to further hospital closures in the future.

To learn more, read the whitepaper, *Hospital Closures Limit Access to Care*.

Sources:

1: American Hospital Association, “Fast Facts on U.S. Hospitals,” 2024
2: American Hospital Association, “Fast Facts on U.S. Hospitals: Infographic,” 2023
3: Center for Healthcare Quality and Payment Reform, “Rural Hospitals at Risk of Closing,” 2023
4: JAMA Health Forum, “Maternity Care Deserts in the US,” 2023
5: Definitive Healthcare, “A look at hospital operating margins in the United States,” 2022
6: Medicare Hospital Insurance trust fund data: 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds and Congressional Research Service; Medicare: Insolvency Projections.
7: Health Management Associates, “CMS releases national healthcare expenditure and enrollment projections through 2031,” 2023

Unlocking Greater 340 Savings – How to Capture Claims and Savings that Are Often Missed
The 340B program serves as a lifeline for many communities, allowing them to provide critical services to vulnerable, underserved patients. Unfortunately, the industry faces a spectrum of challenges, from mounting drug manufacturer restrictions to incomplete referral claims capture, hindering a covered entity's ability to optimize its 340B program.

To help covered entities broaden the reach of their 340B program, SUNRx, a leading 340B technology solutions company, recently acquired AuthorityRx, including the automated Advanced Claims Capture solution. By combining the companies' technology and expertise, SUNRx can provide entities with greater resources to serve patients and communities.

Today, when a patient of a 340B entity visits a referral provider, the entity often loses the potential savings associated with their 340B program. In the past, identifying referral claims and other missed claims with traditional referral capture models has been a complex, often manual process, resulting in missing savings.

By uncovering and resolving fallout claims, ACC offers a user-friendly referral claims capture solution that can help significantly increase 340B savings. In fact, in some cases, it can nearly double capture rates and revenue.

Unique in the Industry

- ACC is a third-party administrator agnostic, so you don't need to change your current 340B TPA. It also can be used by TPAs owned by pharmacy chains.
- Even if you are capturing referral prescriptions today, ACC can help your 340B staff qualify for additional claims.

One Solution Can Have a Big Impact
In an industry subject to ever-evolving, complex regulations and restrictions, compliance remains a constant challenge. Some covered entities even limit themselves by forgoing referral capture, leaving 340B dollars behind because of compliance concerns.

The risk of Health Resources and Services Administration audits is ever-present, validating the importance of the claims capture process. ACC streamlines the audit processes while extending eligibility to outside providers with a proven approach that ensures a high level of visibility and transparency.

Security, Transparency and Control
A claims capture solution should be SOC 2-certified, offer a high level of visibility and transparency and track the progress of claims throughout the process.

Streamlined Data Integration
Many entities want to capture additional savings but do not have the resources to go through a lengthy integration. Combining data and analytics from multiple provider databases and diverse platforms can be complex, but it's critical that systems are compatible and can efficiently share data.

ACC eliminates the need for extensive data integration. They do not need EHR access and can work directly with TPAs to streamline the process. Entities also gain useful drug spending metrics and data that can identify and attract new patients and providers.

How They Can Help
We know 340B savings and community programs go hand in hand. For many covered entities, the 340B program is a lifeline, allowing providers to keep their doors open. ACC was created to help covered entities unlock significant savings and give greater resources to serve patients and their communities.

About SUNRx
As a leading health care technology company, SUNRx assists health care facilities with 340B administration. It's technology helps covered entities optimize their supply chain and pharmacy operations with comprehensive, auditable technology-enabled solutions. To learn more about how SUNRx helps covered entities optimize their 340B program, visit www.sunrx.com.

About Aaron Lott
Aaron Lott, PharmD, is the founder and president of AuthorityRx. He built AuthorityRx and designed the ACC solution with his wife, Kim. AuthorityRx has brought millions of new dollars to health care organizations and their underserved communities across the country with an intense focus on pharmacy marketplace dynamics.

Megaverdicts, Social Inflation and You
During the past decade, 41 states have reported medical malpractice verdicts of $10 million or more. These "nuclear" or "shock" verdicts have become more common in recent years.

Examples of Nuclear Verdicts in the Last Three Years

1. A jury verdict for $111 million against a hospital in Minnesota in a case involving a young man who developed compartment syndrome following a soccer injury. Notably, $110 million of this verdict was for non-economic damages – commonly referred to as "pain and suffering."
2. A $97 million verdict in Iowa City, IA, in which a plaintiff attorney targeted OB-GYN health care providers and their clinic following a severe fetal brain injury, which caused the clinic to file bankruptcy.
3. A verdict of $27 million against an urgent care clinic in Des Moines, IA. The plaintiff attorney attacked health care providers who did not diagnose a case of meningitis in a patient who presented to the clinic with flu-like symptoms. Again, most of the money awarded in this verdict was for non-economic damages.

The Heavy Burden of the Plaintiff Litigation Industry
The overall cost of malpractice tort litigation to the health care system is hard to quantify but is estimated to be between $50 and $150 billion annually. Health care providers and their liability insurers bear the initial brunt of these costs, but ultimately, patients bear these costs—in the form of higher health care costs, less access to quality health care and the potential for poorer health care outcomes due to defensive medicine.

The Role of Social Inflation

The shock verdict trend may be a symptom of a broader phenomenon called "social inflation." Insurers use the term "social inflation" to describe the rising costs of claims due to the interplay of complex societal factors, including those discussed below.

Advertising and Public Persuasion Campaigns by the Plaintiff Litigation Industry

Plaintiff attorneys promote tort litigation and frame their marketing efforts in the language of social justice – though they usually leave out that a large portion of the "justice" ends up in their own pockets. Plaintiff attorney advertising has been increasing across the country. For example, between 2017 and 2021, attorney advertising in Kansas increased approximately 64 percent and exceeded $24 million.

Public Desensitization to the Value of Money and Persistent Economic Inflation

In recent years, the public has been inundated with news skewing its perception of money: Elite athletes and corporate figures make nine—and ten-figure salaries. Billions of dollars in "free" money are provided to businesses and individuals through public programs to address COVID disruptions. Fast food restaurants charge $18 for Big Mac meals. It's not surprising some juries may now feel more comfortable awarding multimillion-dollar verdicts to someone who has suffered a serious injury or an unexpected catastrophic health care outcome.

Diminished Person-to-Person Connections Between Patients and Providers

These diminished connections can be caused by changes in how patients utilize health care, changes in health care delivery models and increased administrative burdens on providers tending to reduce face-to-face time with patients. It's much easier to blame and shame someone viewed as an anonymous service provider than someone viewed as a personally trusted professional.

Plaintiff Attorneys and a Toxic Incentive Structure

Plaintiff attorneys profit from contingency fee agreements, which require the injured client to pay their lawyer a large portion of any settlement or verdict—often 40-50 percent. Because the attorney's cut is taken after all litigation expenses are deducted, it's not uncommon for the injured patient to receive only around 25 percent of the settlement or verdict.

Even though juries find most claims litigated by medical malpractice plaintiff attorneys to lack merit if the claim goes to trial, these contingency fee agreements create incentives for plaintiff attorneys to artificially extend litigation and drive up settlement demands. The rise of third-party litigation funding (a process by which hedge funds and other financiers invest in lawsuits in exchange for a percentage of any settlement or judgment) has further exacerbated this toxic incentive structure.

Good News for Kansas Providers

No Nuclear Verdicts in Kansas

Kansas juries generally continue to be reasonable in assessing malpractice claims against health care providers. This is despite the best efforts of the plaintiffs' litigation industry to drive up jury verdicts and settlement values, including their partially successful attempts to undermine the Kansas statutes designed to promote health care availability, such as statutory caps on excessive jury verdicts.

KAMMCO Stands up for Health Care Providers and Wins
KAMMCO is not afraid to challenge the plaintiff litigation industry by taking cases to trial rather than settling. KAMMCO-insured health care providers have won approximately 90 percent of the medical malpractice cases that have gone to trial during the past decade. The last ten jury trials of claims against KAMMCO-insured providers have resulted in a complete defense verdict in favor of the health care provider.

The KAMMCO Approach to Claims
Some of the strategies and methods recently identified nationally as effective ways to deal with the new, more challenging malpractice claims environment are the same things that have been the hallmark of KAMMCO's approach to claims for nearly 35 years.

KAMMCO remains vigilant in monitoring the national trend of excessively high monetary awards in medical malpractice claims. They continue to do their part by steadfastly defending accused health care providers and pushing back on the plaintiff litigation industry's attempts to bully health care providers into feeding the litigation machine by paying settlements for non-meritorious claims.

The Negative Impact of Medical Credit Cards and Patient Interest Charges
The Consumer Financial Protection Bureau, U.S. Department of Health and Human Services and U.S. Department of Treasury launched an inquiry into high-cost specialty financial products, such as medical credit cards and installment loans, that encourage patients to pay for routine medical care and drive up health care costs and medical debt. The request for information builds on CFPB research on medical payment products and medical billing and collections, in addition to other actions by the CFPB and federal agencies to relieve the burden of medical debt and collections practices.

You can learn more about the inquiry below:

AblePay – KHSC Endorsed Business Partner
We are excited that the Kansas Health Service Corportation-endorsed business partner (AblePay) is the "antithesis" of the concerns highlighted above. AblePay (based out of Allentown, PA) is addressing the affordability gap by helping patients with savings on out-of-pocket expenses (up to 13 percent), savings over time, or extended terms with 0 percent interest, while also providing advocacy services if a patient has a question on a bill. Their solution is rapidly expanding across the country by helping both providers and their patients. AblePay is significantly changing the financial landscape for providers and their patients.

Ephraim McDowell Health Case Study: Improving Revenues and Patient Relationships with AblePay
Ephraim McDowell Health serves patients in six counties in Central Kentucky through three hospitals (two critical access) and 48 outpatient centers. It has more than 1,700 employees and $282 million in annual net revenue.

With revenues declining and the cost of collecting patient out-of-pocket responsibility steadily rising, Ephraim McDowell Health was in search of a way to improve its patient post-insurance collections.

Ephraim McDowell selected AblePay's unique process to increase revenue and decrease the cost of collections while also enhancing the experience for their patients. By assuming all payment risks, AblePay not only eliminated the unpredictability of patient payments, but all the associated costs. This positively impacted the health system while patients benefited from the savings, flexible payment options, a convenient payment portal and billing advocacy provided by AblePay.

The results of the Ephraim case study with AblePay included:

- 106 percent increase in collection rate compared to their historical collection rate.
- 48 percent increase in revenue per patient.
- 46.2 percent of patients who enrolled in AblePay paid zero on prior bills.
- Days to collect decreased from 107 days to 14 days for AblePay members.

Philips Respironics Represents the Latest Class Action Settlement
Kansas Health Service Corporation has partnered with Class Action Capital, a market leader in managing class action settlement claims. Class Action Capital works with many hospitals, health care facilities and state hospital associations across the country to help them recover meaningful refunds from class action settlements.

Many health care companies do not have the time, resources or relevant data available to file a settlement claim. CAC will work with you to submit a fully comprehensive claim recovery while minimizing the use of your time, internal resources and the risk of error if you were to take on claims management on your own.

CAC is currently working on the Philips CPAP, BIPAP and Ventilator Economic Loss Settlement. Plaintiffs in this settlement assert Economic Loss Claims relating to the approximately 10.8 million CPAPs, BIPAPs, ventilators and other devices sold or otherwise distributed in the U.S. that were subsequently recalled by Philips RS North America LLC ("Philips Respironics"). Plaintiffs allege the noise-reducing foam used in the recalled devices was defective.

Philips Respironics announced the recall on June 14, 2021, and began the Recall Programs in September 2021 to replace certain recalled devices with remanufactured CPAPs, BIPAPs and ventilators.

The total settlement fund is a minimum of $479,000,000 to be split between two groups:

- User Class: Those who purchased, leased, rented, paid for (in whole or in part), or were prescribed a recalled device. This fund is at least $445,000,000.
- Payer Class: Those who reimbursed (in whole or in part) a payment to purchase, lease, rent or otherwise pay for a recalled device, including insurers, self-funded employers and third-party payers (i.e., machines that employees on a hospital's health plan were prescribed). This fund is at least $34 million.

The filing deadline for this settlement is Aug. 9, 2024.
For more information about this settlement or Class Action Capital, please contact Joshua Kerstein at Josh@classactioncapital.com.

Felonious Assault Coverage for Health Care Workers

The threat of workplace violence is an unfortunate fact of life for workers in all industries and settings. This is especially true for those in health care—which is sadly ironic given their dedication to helping others. Nevertheless, the U.S. Bureau of Labor Statistics' latest data on workplace violence in health care[1] reveals health care and social services workers are five times more likely to suffer from a workplace violence injury than workers overall.

Workplace violence in health care takes many forms and impacts all types of workers. According to a June 2023 joint survey by health care improvement company Premier and the Agency for Healthcare Research and Quality,[2] 40 percent of health care workers—including those in clinical care and administrative roles, as well as security personnel—experienced an incident of workplace violence in the last two years. Incidents ranged from emotional and verbal assaults to physical and sexual abuse. Contributing factors listed by survey respondents included mental illness, drugs/alcohol and other patient-related factors.

The ongoing issue of workplace violence in health care has not gone unnoticed by state governments. The American Nurses Association lists a total of 38 states that have created specific penalties for assaults against nurses,[3] with some also updating existing laws to include additional penalties for violence committed against first responders and other health care workers and volunteers.

Clearly, health care workers who deal directly with the public face risks while performing daily business activities, even with security presence on the premises. Employers can offer valuable insurance protection for workers by providing them with coverage—such as that offered by Chubb's Felonious Assault solution—against serious injuries that may occur on the job in the event of felonious assault. Felonious assault involves the unlawful use of force against workers in conjunction with crimes such as robbery, theft, hostage-taking, and more.

You may already be familiar with Chubb who, together with Conrade, is KHSC's preferred partner for Kansas hospital property insurance. Chubb realizes accidents due to felonious assault may cause more than just physical damages. In the case of an assault, workers' compensation may not be enough to meet all the financial needs or additional expenses that result. Chubb's felonious assault solution provides a cash benefit due to hospitalization for a covered incident, along with a meaningful, lump-sum benefit to beneficiaries in the event of a death. It also includes psychological therapy benefits that may become critical to a worker's recovery. This is a significant benefit, as a report issued by National Nurses United[4] has shown the effects of experiencing an act of workplace violence can lead to burnout, along with moral distress and injury.

For example, if a health care worker was accidentally injured during a violent altercation in the emergency room, Chubb's felonious assault policy would pay a lump sum benefit to that worker. This benefit would pay above workers' compensation, allowing the employer to help the worker transition from this event. If required, the psychological therapy benefit would reimburse expenses for the worker's therapy as required by a physician, up to 5 percent of the principal sum for expenses incurred for treatment. The benefit is payable on an excess basis for treatment occurring within two years of the covered accident, subject to a total benefit maximum of $10,000. In the end, purchasing a felonious assault policy would allow the employer to provide valuable insurance benefits for workers while potentially going above statutory requirements and building goodwill.

Click here for more information about Chubb's felonious assault coverage. To discuss how you can offer this coverage to your valued workers, contact Chris Conrade, president and risk consultant for Conrade Insurance Group, Inc., at (316) 999-8014 or cconrade@conradeinsurance.com.

The claim scenario described is hypothetical and offered solely to illustrate the types of situations that may result in claims. This is not based on actual claims and should not be compared to an actual claim. The precise coverage afforded is subject to the terms and conditions of the policy as issued. Chubb is the marketing name used to refer to subsidiaries of Chubb Limited providing insurance and related services. For a list of these subsidiaries, please visit www.chubb.com. Insurance is provided by the Federal Insurance Company. All products may not be available in all states. This communication contains product summaries only. Coverage is subject to the language of the policies as actually issued. Chubb, 202 Hall's Mill Road, Whitehouse Station, NJ 08889-1600. 03/2024

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[1]U.S. Bureau of Labor Statistics. (n.d.). Workplace violence in healthcare, 2018. U.S. Bureau of Labor Statistics. https://www.bls.gov/iif/factsheets/workplace-violence-healthcare-2018.htm
[2]Premier survey reveals key insights on workplace violence incidents... Premier. (n.d.). https://premierinc.com/newsroom/blog/premier-survey-reveals-key-insights-on-workplace-violence-incidents-in-healthcare
[3]Workplace violence. ANA. (2017, October 26). https://www.nursingworld.org/practice-policy/advocacy/state/workplace-violence2
[4]Deadly shame. (n.d.). https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf

Clear Communication Is Essential for Effective and Equitable Health Care
The partnership between Voyce and Maimonides Medical Center in Brooklyn, NY, showcases the vital role of industry-leading remote medical interpretation services for patients who do not speak English.

A Dynamic Partnership
A network of three hospitals and more than 2,000 physician partners, MMC is building on 110 years of innovative service to the richly diverse communities making up Brooklyn.

- Maimonides sees more than 780,000+ patients annually across three locations
- Maimonides Medical Center, Maimonides Midwood Community Hospital and Maimonides Children's Hospital
- The Brooklyn borough is one of New York's most diverse, where ~30 percent of residents have limited English proficiency
- Voyce introduced 240+ on-demand languages, delivered by physician-trained interpreters

Kevin Cottingham, assistant vice president of operations management shares, "I appreciate the partner that Voyce has become here at the medical center. [Language interpretation] is a major challenge for us, and it's quite costly here to continue language services for our diverse population. And to have a partner like Voyce is fantastic."

What Staff at Maimonides Say:

- "Voyce came in as a pilot project, and it was lights out. They did such a great job that shortly thereafter, we moved into contract with them." - Kevin Cottingham, assistant vice president of operations
- "Voyce did a wonderful job hiring additional interpreters in different languages because we are so diverse here. They matched what our need was; and since they've come on, it's been nothing but a pleasure to deal with them." - Kevin Cottingham, assistant vice president of operations
- "It makes me proud to know that we provide professional interpreters who have a complete understanding of the medical terminology being spoken to them, and we aren't putting [family members in a] nerve-wracking position." - Diya Sarsour, supervisor of patient relations

Discover More

This case study is just one instance of how Voyce is revolutionizing health care communication across North America, guaranteeing every patient receives the care they need. Explore its website to see more success stories.

Join Its Mission

By joining forces, we can eliminate language barriers in health care, ensuring every patient is understood, every need is addressed and every voice is heard. Together, we can foster a health care environment prioritizing understanding and inclusivity, improving outcomes for all.

Cybersecurity Best Practices for Nonprofit Healthcare Boards

Cybersecurity continues to be a focal point for nonprofit health care boards, underscored by the stark reality that cyberattacks on health care organizations are both rising in frequency and complexity. The task of safeguarding sensitive patient information, thwarting cyberthreats and protecting organizational data is becoming more challenging, highlighting the need for boards to prioritize cybersecurity.

According to Insider Intelligence, in 2022 alone, there was an alarming 86 percent increase in cyberattacks on health care entities, with 1,463 attacks recorded weekly. This escalation not only disrupts operations but also jeopardizes patient safety and erodes trust among stakeholders and donors, which are crucial for the survival of nonprofit health care organizations.

The IBM Cost of a Data Breach Report 2023 starkly reminds us of the financial implications of cyber vulnerabilities. It reveals the health care sector suffers the most financially from data breaches, with the average cost of a breach soaring to $10.93 million. Since 2020, the cost of health care data breaches has surged by more than 53 percent, making it abundantly clear why cybersecurity is not just a technical issue but a critical strategic concern for your board.

Given this backdrop, it's essential for nonprofit health care boards to integrate robust cybersecurity practices into their operational blueprint. A dedicated purpose-built board management solution is a solid foundation as it helps protect sensitive board information, unlike email, commercial file or document-sharing applications. Encrypted communication tools, clear cybersecurity protocols, comprehensive training for all board members through programs such as Diligent Institute's Cyber Risk & Strategy Certification and routine security assessments are things you can implement today in your organization to make it more proactive and resilient against cyber threats.

Regular updates to these security measures are also vital to ensure the organization stays ahead of cyber threats, as cybercriminals continuously refine their strategies to exploit vulnerabilities.

As guardians of the organization's mission, board directors play a crucial role in cybersecurity, and it is imperative every member of the board actively engage in stringent measures.

Embracing and championing cybersecurity best practices is no longer optional, but necessary to ensure the continuity of quality care and protection of sensitive data. Continue reading to learn more and discover ten best practices for cybersecurity for health care boards.

Clearview Provides Solutions During EMR Change
Trinisys is a leading provider of enterprise data migration, integration, workflow automation and legacy data archival in health care. Proven in some of the largest health care settings, Trinisys has more than 20 years of experience perfecting rapid and reliable software solutions reducing organization costs, improve data quality and ensure security and compliance.

ClearView revolutionizes the way health care organizations traditionally aggregate, process and access clinical, financial and operational data from disparate legacy systems. The intuitive point-and-click solution serves as a single source of truth for providers and return on investment teams and enables users to start using the platform in minutes.

A few advantageous features include:

- Consolidation of non-strategic and disparate legacy systems into a single repository
- Role-base views and controls with detailed auditing functionality that can be exported to monitoring services
- Granular access to practice and document types based on Active Directory Groups to enhance system compliance
- Robust search capabilities allow users to quickly retrieve data, as well as view details at the facility, encounter or document level
- Reliable infrastructure with on-premise or cloud offerings

Trinisys has deep experience with 200+ EHR, PM, and ERP solutions, making us confident in our approach of identifying data migration, conversion, storage, and access requirements and implementing the best solution to fit organizational needs.

For more information about Trinisys ClearView, please visit www.trinisys.com, or contact Pat Regan at pregan@trinisys.com or (629) 800-5852.