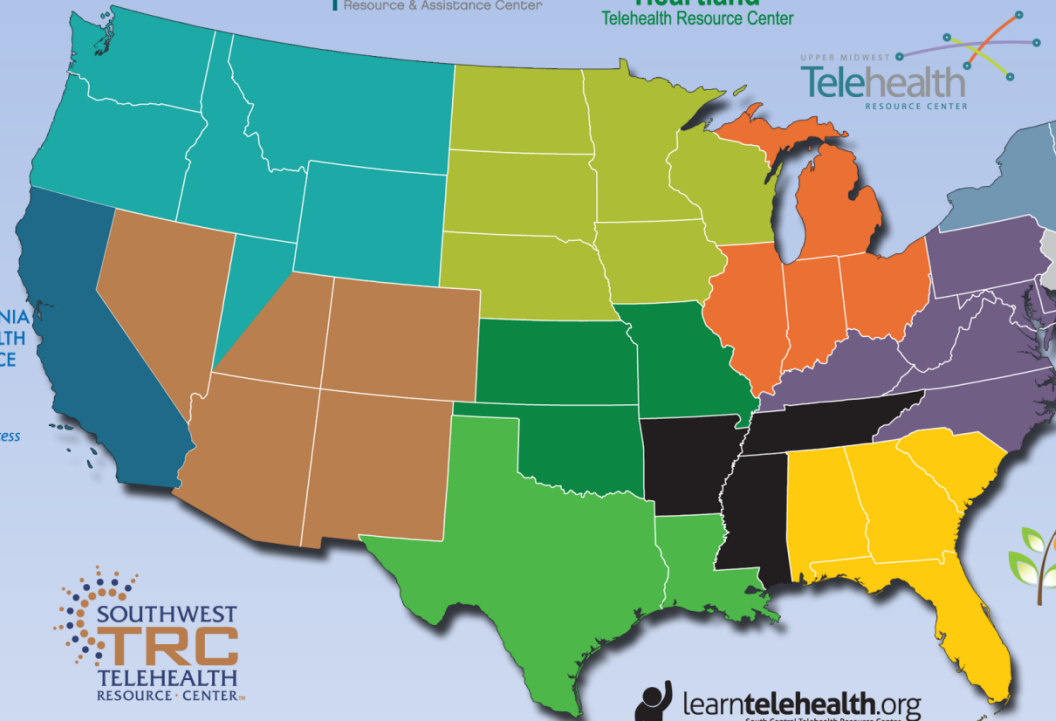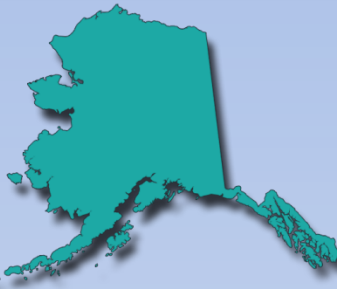# The National Telehealth Webinar Series

Presented by
The National Network of
Telehealth Resource Centers

TelehealthResourceCenters.org

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Telehealth
RESOURCE CENTER

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Great Plains Telehealth
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Telehealth
Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

2 National Resource Centers

12 Regional Resource Centers

Integrating Telemedicine and the EHR

Bruce C. Edmunds, M.Ed., CHTS - IS,IM,PW
Managing Director
West Texas Health Information Technology Regional Extension Center

OCTOBER 17, 2013
(9:00AM HST, 10:00AM AKST, 11:00AM PST, 12:00PM MST, 1:00PM CST, 2:00PM EST)

What will you learn?

❖ Leaders at healthcare organizations across the country are finding innovative ways to use video conferencing devices to meet the specialty care needs of rural patients. However, meaningful use did not specifically address telehealth; so even with this market's growth there will be many frontiers before integration can occur between Telemedicine hardware and EHRs.

❖ Introduction to EHRs and Meaningful Use

❖ Telehealth and EHRs (Regional Extension Center Integration)

❖ Telehealth and EHRs : Where are we now?

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Electronic Health Records: Which one are you??

According to Wikipedia....

An electronic health record (EHR) is an evolving concept defined as a systematic collection of electronic health information about individual patients or populations. It is a record in digital format that is theoretically capable of being shared across different health care settings.

In other words, Are you doing it just to do it!!! Or.....

According to Healthcare Information and Management Systems Society (HIMSS)...

The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

No matter how you look at it....It is inevitable!

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How many different EHRs have had at least one recorded Meaningful Use Attestation as of January 2013?
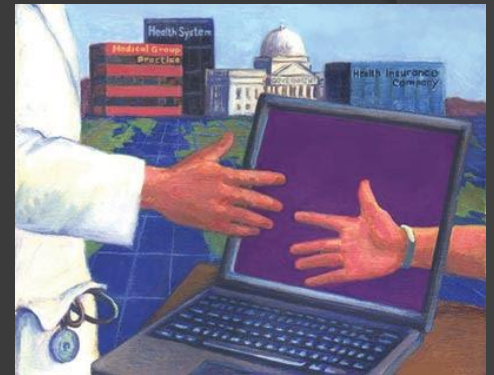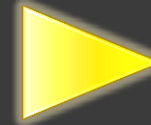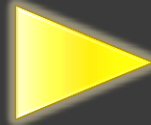
560

Top EHR Vendors Market Share

Based on 176,965 who attested to meaningful use, compared to 350,844 actively registered as of January 2013.
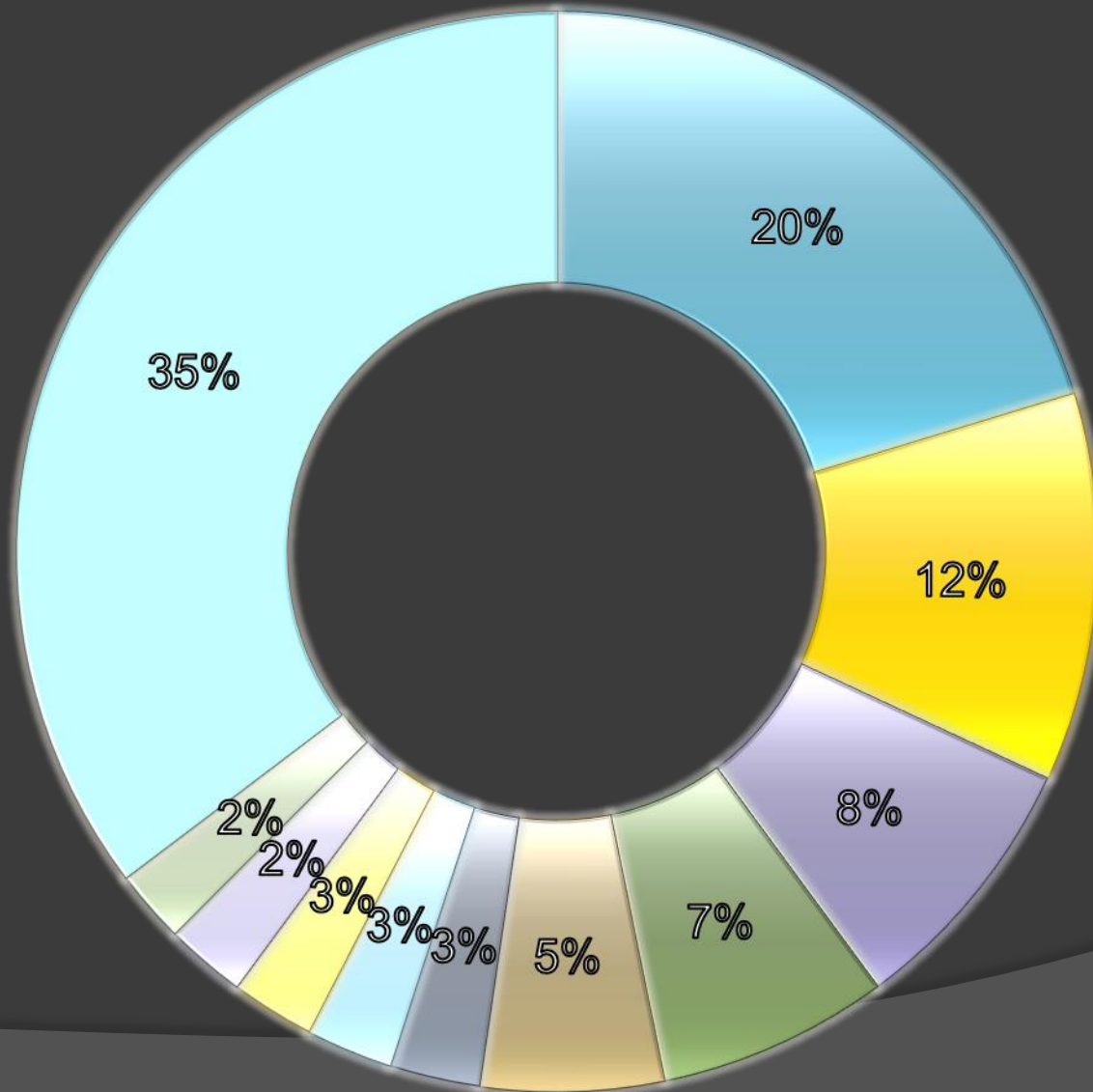
Legend:
- Epic
- Allscripts
- eClinicalWorks LLC
- NextGen Healthcare
- GE Healthcare
- Practice Fusion
- Greenway Medical
- McKesson
- Athenahealth
- Vitera Healthcare
- Other

Pie chart values: 35%, 20%, 12%, 8%, 7%, 5%, 3%, 3%, 3%, 2%, 2%

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Why Make the Change?

It is a practical First Step

One has to look no further than a practice to find an ideal clinical area in which to take a first practical step to improve care using information technology.

- First of all, Point of Care is an area where there is a great need to improve access to current clinical information. The flawed access that exists today is unacceptable.

- Second, Point of Care is ripe for situations in which patients fall through the cracks, and action is urgently needed to prevent that outcome.

- Third, the logistics and workflow patterns of patient care lend themselves to a focused computerized solution that borrows the best from existing workflow patterns.

- And finally, it makes economic sense to invest in technology that cuts office expenses and that may help prevent or at least deter malpractice claims.

A Strategic First Step Toward EMR Acceptance
Donald W. Miller, Jr., MD, FACOG

The Rationale

- *Access.* There are almost no other clinical areas where a patient will interact with a health system so many times, where information sharing between providers occurs with such predictable regularity, and all within a finite period of time.

- *Consistent care.* The environment in which patient care is often delivered is typified by largely routine, high-volume and brief encounters with both high risk and relatively healthy patients.

- *Workflow.* The workflow for almost every patient visit in the country is amazingly uniform and has changed little in decades.

- *Economics.* From an economic perspective, because of the information needed for the record at the hospital as well as office, maintaining paper patient records is expensive.

A Strategic First Step Toward EMR Acceptance
Donald W. Miller, Jr., MD, FACOG

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In Summary

For many reasons, including clinical, financial, and risk reduction, the delivery of patient care merits review and revision by both clinicians and healthcare information executives.

Because of its unique information access needs, workflow, liability exposure, and requirements for consistency, patient care is the perfect environment to implement information technology solutions.

but how do we get there...

A Strategic First Step Toward EMR Acceptance
Donald W. Miller, Jr., MD, FACOG

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Change Management:
The Change Formula

**(CS x FS x P) > Cost of Change
if Change is to Occur**

**CS = dissatisfaction with Current State;
FS = Acceptance of Future State;**

P = Change Process

**Change Management : Power and Influence
Ned Ellington, PhD
Director – HITRC
ONC/HHS**

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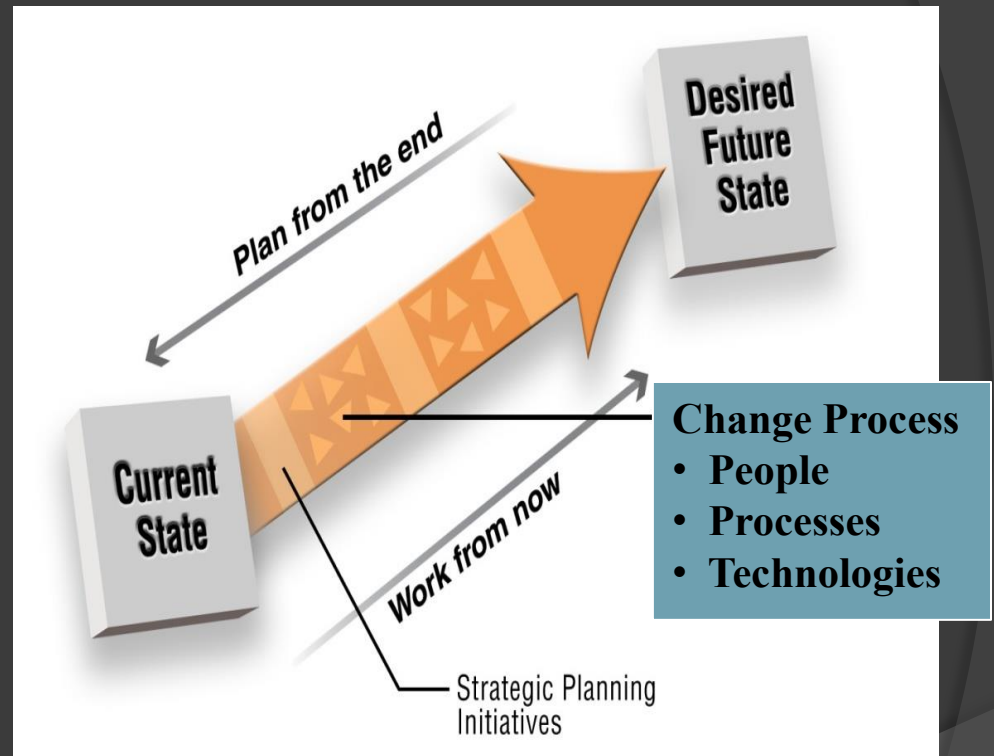
P = Change Process

Plan from the end

Desired Future State

Current State

Work from now

Change Process
- People
- Processes
- Technologies

Strategic Planning Initiatives

Change Management : Power and Influence
Ned Ellington, PhD
Director – HITRC
ONC/HHS

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Four Steps for Individual Change

Awareness
Recognize you need change

Interest
In getting to future state

Trial
Find what works: Workflow Design

Adoption
Implementation phase

Change Management : Power and Influence
Ned Ellington, PhD
Director – HITRC
ONC/HHS

Once you decide on Change:

The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Eligible Provider EP :Medicaid Basics

- Must be one of 5 types of EPs
  - Physicians (primarily doctors of medicine and doctors of osteopathy)
  - Nurse practitioner
  - Certified nurse-midwife
  - Dentist
  - Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.

  Must either:

  - Have ≥ 30% Medicaid patient volume (≥ 20% for pediatricians only); or
  - Practice predominantly in an FQHC or RHC with ≥30% needy individual patient volume
- Licensed, credentialed
- No OIG exclusions (http://exclusions.oig.hhs.gov/),
- Must not be hospital-based

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Hospital Eligibility: Medicaid Basics

- What is an Eligible Hospital under the Medicaid EHR Incentive Program?

  - Acute care hospitals (including CAHs and cancer hospitals) with at least 10% Medicaid patient volume
  - Children's hospitals (no Medicaid patient volume requirements)

- Acute care hospital with ≥ 10% Medicaid patient volume

  - General, short-term stay
  - Cancer
  - Critical Access Hospitals
- Children's hospitals

EP Eligibility: Medicare Basics

- Eligible professionals under the Medicare EHR Incentive Program include:

  - Doctor of medicine or osteopathy
  - Doctor of dental surgery or dental medicine
  - Doctor of podiatry
  - Doctor of optometry
  - Chiropractor

- Must have Part B Medicare allowed charges

- Must not be hospital-based

- Must be enrolled in PECOS

Hospital Eligibility: Medicare Basics

- What is an Eligible Hospital under the Medicare EHR Incentive Program?

  - "Subsection (d) hospitals" in the 50 states or DC that are paid under the Inpatient Prospective Payment System (IPPS)
  - Critical Access Hospitals (CAHs)
  - Medicare Advantage (MA-Affiliated) Hospitals

- Title XVIII subsection(d) qualified
  - Must be in 50 United States or D.C.

- Critical Access Hospitals

- Children's Hospitals

In order to get first year Medicare payment

- ◉ <u>Medicare EPs and hospitals</u>

  - Meet meaningful use measures using certified EHR technology
    - ○ 15 Core
    - ○ 4 of 10 Menu MU requirements + immunizations or syndromic surveillance
    - ○ 3 Core Clinical Quality Measures or
    - ○ 3 Alternate Core Clinical Quality Measures (Required ONLY if Core CQM has a denominator of 0)
    - ○ 3 Additional Clinical Quality Measures
  - Conduct or revisit Security and Risk Self Assessment
  - Attest to all program requirements,
  - Get EHR certification number from CHPL
  - Assign Payment accordingly (This is done when registering with CMS, but is verified during the attestation process

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In order to get First Year Medicaid payment

- ⦿ <u>Medicaid EPs and hospitals</u>
  - Adopt, implement, upgrade, or meaningfully use certified EHR technology
    - ○ Purchase Order
    - ○ Contract Signature Page
    - ○ Subscription for a Certified EHR
    - ○ User Agreement
    - ○ Support Agreement
  - Supporting Documentation for Patient Volumes including:
    - ○ Medicaid Client Number
    - ○ Date of Service
    - ○ Claim Status
    - ○ Provider Number
  - Supporting documentation for multiple providers
  - Attest to meeting all program requirements

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Meaningful Use Core Measures (15)

- (1) Use CPOE for medication orders directly entered by any licensed healthcare professional.

- (2) Implement drug-drug and drug-allergy interaction checks.

- (3) Maintain an up-to-date problem list of current and active diagnoses.

- (4) Generate and transmit permissible prescriptions electronically (eRx).

- (5) Maintain active medication list.

- (6) Maintain active medication allergy list.

- (7) Record all of the following demographics:
  - Preferred language, Gender, Race, Ethnicity, Date of birth

- (8) Record and chart changes in the following vital signs:
  - Height, Weight, Blood pressure, Calculate BMI, Plot and display growth charts for children 2–20 years, including BMI.

- (9) Record smoking status for patients 13 years old or older.

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Meaningful Use Core Measures (15)

- (10) Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.

- (11) Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

- (12) Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.

- (13) Provide clinical summaries for patients for each office visit.

- (14) Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.

- (15) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. Security and Risk Self Assessment.

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Meaningful Use Menu Set Measures (5)

- (1) Implement drug formulary checks.

- (2) Incorporate clinical lab-test results into EHR as structured data.

- (3) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

- (4) Send patient reminders per patient preference for preventive/follow-up care.

- (5) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.

- (6) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

- (7) The EP who receives a patient from another setting of care or provider of care should perform medication reconciliation.

- (8) The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

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Meaningful Use Public Health Measures

- (9) Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

OR

- (10) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

Telemedicine and Meaningful Use: Can it be done?

Ryan Spaulding, Director of telemedicine and telehealth at the University of Kansas Medical Center held a talk on May 9, 2013 in Austin ,Texas specifically to answer this question…

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Key Points from the talk....

⦿ He posed the question, and answered, "Of course it can be done. I think the question might have been. "*How* can it be done?"

⦿ Spaulding pointed out that there is no formal authority at the national level like there is for meaningful use of electronic medical records. Nor is there a roadmap or strategic plan.

⦿ "Sometimes people forget there was a lot of work done in 2004 and 2005 before meaningful use came along," Spaulding said.

⦿ Spaulding suggested Telehealth/Telemedicine also might benefit from something similar to the Regional Extension Centers that the government established in all the states across the country to provide doctors with help selecting an EHR system, implementing it and then using it in a meaningful way, all of which leads to CMS incentive payments that turn into penalties in 2015.

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So what are possible next steps?

Telemedicine is being used by more physicians and patients every day, but there are no standards regulating reimbursement and how telemedicine is being integrated with electronic health records.

Do you?

- Add Telehealth/Telemedicine to the Meaningful Use Program

- Create a separate Meaningful Use Program for Telehealth/Telemedicine.

- Set up 12 regional Telehealth/Telemedicine resource centers, which would be similar to the regional extension centers (RECs) designed to help doctors meet meaningful use requirements.

- *Integration of Telemedicine in School Systems

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What we do know?

- It is NOT about the Technology

- It IS about enabling changes is a Clinical Practice. Used well it can help deliver:

  - Workforce Flexibility

  - Improved Patient Services

  - Improved Interventions

  - Services convenient to clinicians and patients, at a lower cost

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Let's Compare (We can only learn from the past)

- The Educational System faced a similar dilemma in the late 90's when trying to fully incorporate technology into the classroom with similar barriers:

  - Teachers preferring to retire than implement any type of technology in their classroom

  - Technology learning curves (Training)

  - The cost of the technology

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So where is Education Today?

- The wedding of technology and education is so commonplace today that it would be difficult to conceive of a school being constructed in 2013 and hereafter without some decided emphasis on the incorporation of computer technology.

- According to an article by US News published in January 2013, 62.4 % of Colleges and Universities offered fully online programs in 2012, as compared to 34.5% in 2002.

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So what is my point?

We can find many similarities between the incorporation of technology into the classroom and that of Technology in to a Clinical Setting.

Just like Education today can you imagine if:

- Clinical care was available anytime and anywhere

- Clinicians could obtain consultations with Medical Centers of Excellence anytime and Anywhere

- Home bound patients could be monitored remotely anytime and anywhere

- Medical Education programs were available anytime and anywhere

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So What's Next?
Open Discussion and Questions

Bruce C. Edmunds
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