



Health Directions

Business solutions for healthcare organizations

Benefitting Financially from an Electronic Health Information Exchange

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Agenda

- Environmental Overview
- EHR Stimulus Money and Other Incentives
- Hospitals and Interoperability
- Interoperability and Community Health Information Networks
- Preparing for an Electronic Network
- Case study

Health Directions, LLC

- Health Directions is the premier provider of Consulting Services to Academic Medical Centers, Physician Practices and Hospitals. We support our clients in achieving their optimal financial performance.
- Health Directions delivers its entire suite of Practice Solutions (financial turnaround, revenue cycle management, operations, strategic planning, compensation, EMR implementation and practice transition) through a Seasoned Team of health care professionals
- Health Directions has been assisting hospitals and physician improve their financial performance since 1985

Major Health Directions' Clients

Client	Location	Providers	Locations
Holzer Clinic	Gallipolis, OH	120	9
Summit Medical Group	Summit, NJ	140	25
Practice Plus	Little Rock, AK	250	22
Univ. of Texas-Physicians	Houston, TX	520	17
U. of Florida. Medical Group	Gainesville, FL	700	15
Advocate Medical Group	Des Plaines, IL	220	18

EMR Trends in Health Care

- The U.S. spent over \$2.2 Billion in health care in 2007, yet most of the information exchange is rudimentary
- According to the CDC's National Center for Healthcare Statistics 2008 survey, only 25.9% of medical practices had some form of EMR
- U.S. is adopting EMR technology at a much slower rate than other industrialized nations
- According to a 2008 study conducted by the Institute of Public Health, Physicians who use electronic health records believe "(EMR) systems improve the quality of care and are generally satisfied with the systems".

Government's Role in Promoting EMR Technology

- Promoting incentives for quick implementations of EMR in medical practices
- CMS is paying incentives to physicians for reporting quality data using EMR
- Since early 2005 the Department of Veterans Affairs (VA) Hospitals have been adopting an EMR
- Proposed bills introduced to incorporate EMR technology within all physician offices over the next 3 years
- Obama Administration is promoting EMR technology as means of change reimbursement and slowing the rise in health care spending

Proposed Reimbursement Changes

- Government's position on reducing cost is to tie provider reimbursement to quality data and outcomes
- Medicare (CMS) already began quality based reimbursement with the PQRI program
- Some plans are beginning to follow the government's lead
- Government has created 2 legislative initiatives focus in improve changing healthcare and incorporating more technology

American Recovery and Reinvestment Act of 2009, H.R. 1 (ARRA)

- The American Recovery and Reinvestment Bill signed
 - \$790 billion
 - Approximately \$60 billion within the Bill is allocated towards the improvement of healthcare in some form
 - Health IT
 - Training for more primary care physicians
 - Research on chronic diseases
 - Community Health Centers
 - “Comparative Effectiveness” research
 - Health Information Technology for Economic and Clinical Health Act (HITECH) provides \$19.2 billion in funding for HIT.

Breakdown of \$19 Billion

\$17 billion Physician Incentives
Incentive Bonuses from Medicare/Medicaid

+ \$2 billion HHS Discretionary Funds (For Use By National Coordinator of Health IT)
Standards Development, Grants (AHRQ, HRSA, CMS), HIE Infrastructure, Loans to the States for EHR, Regional HIT Resource Centers, Telemedicine, Efficacy Studies

= \$19 billion

HHS = Health and Human Services

AHRQ = Agency for Healthcare Research and Quality

HRSA = Health Resources and Services Administration

CMS = Centers for Medicare and Medicaid Services

Health Information Technology for Economic and Clinical Health Act (HITECH)

- \$17 billion in incentives require proof of "meaningful" use
 - Use of a certified product as determined appropriate by the Sec. of HHS
 - The EHR technology must be connected
 - Complies with submission of reports on clinical quality measures

Health Information Technology for Economic and Clinical Health Act (HITECH) (Con't)

- “Early Adopters”, those that adopt first will benefit the most (declining incentives)
 - Physicians can earn between \$44,000 to \$64,000 over five years from Medicare / Medicaid if they are utilizing an EHR in 2011
 - Late adopters will receive significantly less
 - Providers may receive incentives under only one of the programs
 - 2015: reductions in Medicare/Medicaid fees for non-EHR users
- Hospitals can earn up to \$2,000,000 plus discharge bonuses (total payout to them could be \$10 million +)

Medicare Incentive Payments

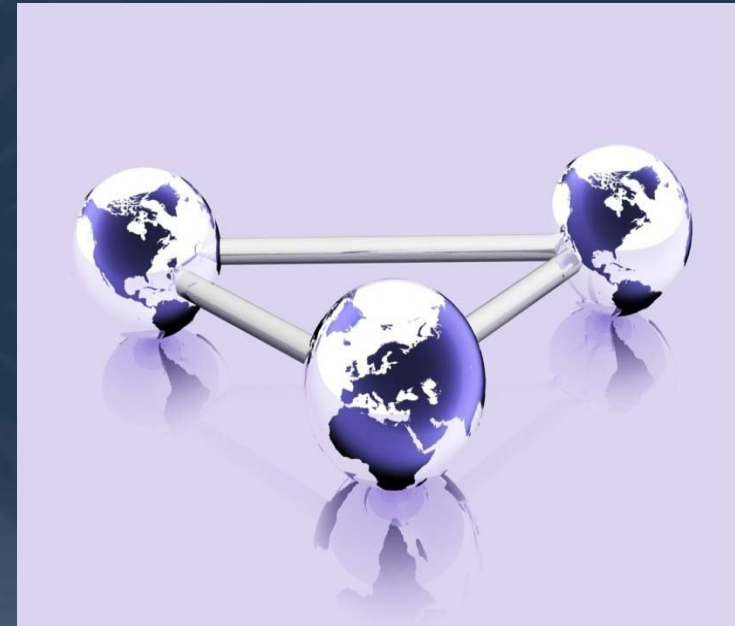
- Medicare incentive payments will be available to “eligible professionals and hospitals” for the first five years 2011-2015.
 - If eligible professionals and hospitals do not demonstrate meaningful use by 2015, Medicare payments will be reduced.
- First Payment Year
 - \$18,000 if the first payment year is 2011 or 2012
 - \$15,000 if the first payment year is 2013
 - \$12,000 if the first payment year is 2014
- Second Payment Year: \$12,000
- Third Payment Year: \$8,000
- Fourth Payment Year: \$4,000
- Fifth Payment Year: \$2,000

HITECH Act: Overview

- The Bill Aims to Accomplish Four Major Goals:
 - Health information technology infrastructure for interoperability in place
 - Standards expanded by 2010
 - Saving the government \$18 billion
 - Strengthening Federal privacy and security law through standards maturation
- Expected Results
 - The Congressional Budget Office estimates that 90% of doctors and 70% of hospitals will be using comprehensive EHR by 2020

The Direction EHR Technology

- Promote electronic health technology within physician practices
- Electronic health networks and interoperability platforms are the future of technology
- Allow for efficient and safe transfer of health information



What is Interoperability in Healthcare?

- The ability for EMRs to electronically share data and communicate with one another
- The systemic exchange of patient health information
- The exchange of patient health information between entities, providers, patients, health plans, pharmaceuticals and laboratories
- Regional health information organizations as a means of centralizing patient data exchange for communities

Interoperability Goals for Hospitals

- To exchange data accurately, timely, consistently, and to receive value from the information exchanged
- Technical components of interoperability are critical:
 - Enterprise Master Patient Index (EMPI) – single patient identifier in each system
 - Enterprise Continuity of Care Record (ECCR) – what data will be shared
 - Interconnectivity Standards – defined set of data standards
 - Information Security Standards – developing a secure and reliable environment
- Interoperability provide hospitals with a distinct advantage in the competitive and increasingly consumer-driven healthcare market

Community Health Integration Strategy

- Electronically connecting hospitals, IPAs, physicians, patients, payers, labs, pharmacies, into a secured digital networks
- Many stakeholders, but hospital and physicians will take the lead
- Allow for a secured efficient transfer of medical information between entities
- Provide patients with new “healthcare conveniences” through the use of technology
 - Web portals
 - E-mails
 - Text Messaging

*Hospitals will be looked to as the **driving force**
of electronic health connectivity for
physicians, patients and the community*

Hospitals as the Driving Forces

- Improved software capabilities
 - EHR software integration
 - Connectivity with 3rd parties
 - Clinical (evidence-based) outcome tracking
- Industry and governmental momentum
 - Publicity surrounding medical errors
 - HITECH Act and stimulus funds
 - Physicians beginning to realize it's "When" do they implement and EHR not "IF"
- Exceptions granted to "Stark" laws
 - Changes allow for substantial subsidy (up to 85%) from hospitals to physicians to financially enable EMR adoption

Value to the Hospital

- Use technology as means of building a strategic relationship
 - As physicians are incorporated into the network, they begin to appreciate the convenience of technology
- Negotiate quality performance outcomes within payer contracts
 - Example: Advocate Health Care and United Healthcare recent contract negotiations*
 - Negotiated mandatory pay-for-performance standards
 - Identified a number of programs to promote quality care
 - Promote adoption of health information technology
 - Payment incentives negotiated into agreement for optimal performance outcomes

Value to the Hospital (Con't)

- Patient begin to understand and rely on technology and equate to higher quality of care
 - Patient portals, reminder calls/text messages, automated secured results
 - Strong relationship builder with patients
- Reduction in redundant tests
- Improved patient access and accuracy of information
 - Efficient revenue cycle processes
 - Higher collections through capturing of patient information
 - Streamlined registration processes across entities

Hospital-Physician Relationship and Electronic Health Technology

- Electronic Medical Records, interoperability and clinical performance outcomes can drive revenue
- Clinical outcomes are becoming a bigger part of reimbursement and physician compensation for employed physicians
- Electronic health technology improves patient care through documentation, coding and reduction of errors
- Pay for performance and evidence based reimbursement will drive future managed care contracting strategies

Investment in Electronic Community

- A viable community health integration strategy begins with choosing the right ambulatory EHR and data sharing model
- Identify Total Cost of Ownership (TCO)
 - Software license (non-recurring purchase)
 - Software maintenance (monthly fee)
 - Network connectivity (monthly data line fees)
 - Servers/server hosting (ASP Model)
 - Implementation services and end-user training
 - Interface/interoperability costs
 - Physician office hardware/cabling
- Estimate TCO by provider and practice to amortize cost over time

Data Sharing Components

- Created around the clinical integration of community stakeholders with access to central data repositories or Regional Health Information Organizations (RHIOs)
- 3 Primary Components of data sharing
 - Enterprise Data Sharing – created around a unique patient identifier or MPI #
 - Centralized Data Repository Model – physicians have the ability to access information through a secured web portal
 - Distributed Model - creation of a single, unified view of the patient record based on data from different systems without the necessity of having a central data repository

Electronic Health Technology and Patient Care

EMR has an impact on clinical outcomes, utilization and workflow processes

- Streamline, structure order process
- Ensure completeness, correctness
- Charge capture and display
- Supply patient data
- Drug authorization, formulary approval and interaction
- Redundant test reminders
- Reduced transcription costs
- Reduced chart pulls
- Improved clinical messaging and workflow
- Improved charge capture and accounts receivable
- Improved referral coordination

ROI around Electronic Community Health Networks

- Hospitals needs to look at TCO versus short term and long term revenue opportunities
- Revenue associated with improved contracting
- Focus ROI down to physician level
 - The providers use technology, great the value
- Expenses due begin to decrease over time
- Grant funding through states and federal government

Sources of Through Grant Funding

- Available through HHS
 - Agency for Healthcare Research and Quality AHRQ
 - National Institutes of Health NIH
 - Office of the National Coordinator ONC
- Outside HHS
 - National Institute of Standards and Technology NIST
 - Department of Agriculture
 - Department of Commerce
- Health Information Exchange Regional Grants
 - \$300,000,000 for regional efforts toward health information exchange
 - Regional Health Information Organizations
 - Health Information Exchanges
 - Regional approach

Key success of any community health initiative is ensuring the physicians use the technology....it begins with EMR

Reasons Why Physicians Have Not Implemented an EMR

- Costs are too high
- Electronic health technology will interfere with my office workflow
- An EMR will slow me down, I'll see less patients
- I'm going to wait to see the "technology direction" of the hospital
- A huge undertaking and may not practice much longer



Revenue Opportunities for Providers with an EMR

- Improved accuracy of documentation most of the time leads to better coding, more revenue
- Increase in charge capture of services and improvement accuracy of claims
- Negotiate quality performance outcomes within payer contracts
- Assist providers in understanding stimulus money, e-prescribing and PQRI incentives

Anticipated Savings with EMR

- Areas of real savings:
 - Transcription cost
 - Chart creation
 - Physical storage space
 - Medical records FTE
 - Encounter forms
- Time spent looking for lost charts, transferring charts and coding tickets
- Efficiencies and lower costs associated with Rx refill
- Printing of patient education materials

EMR Return On Investment

- Time and motion studies
 - Cost of charts pull, phone triage, messaging
 - Test results processing
 - Form completion
 - Immunizations forms, etc.
 - Prescription re-issue
 - Chart creation
- Average of cost of staff
 - Patient phone calls
 - Rx refills and pharmacy calls
 - Referring physicians requests
 - Insurance information and referral/pre-cert processing

Successful Components of an EMR

Best Practices

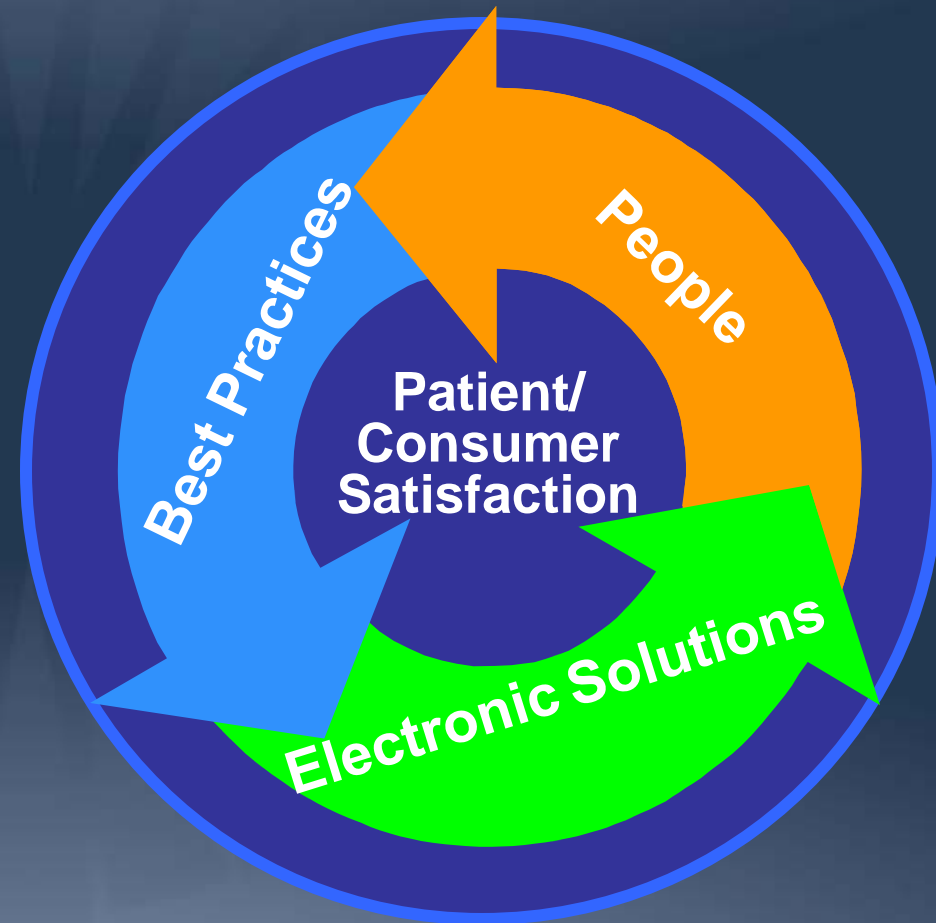
- Clinical workflows
- Revenue cycle processes
- Standardized policies, procedures and work flows

People

- Staff training and education
- Measure outcomes and tracking
- “Patient-focused” approach

Electronic Solutions

- Access Management
- Electronic Medical Record
- Business Intelligence



Key Components in Implementing an EMR

- Review implementation for plan of Vendor
- Identify a physician champion and super user
- Document current clinical workflow processes
- Maximize physician input in EMR development and design
- Develop thorough understanding of new EMR system
- Ensure proper training



Success Criteria Of EMR Implementation

- Design EMR technology to allow physicians to incorporate “easy-to-retain” functionality as well as clinically intuitive pathways
- Redesign clinical workflows that promote automation and efficiencies
- Don’t forget your revenue cycle
- Adopt an incremental deployment strategy in order to increase comfort level and build confidence in EMR
- System should be built to ensure physicians use the technology
 - If not, nothing else matters

Design and Implementation Strategy

- Look at current processes and determine what will change in the move from a paper based environment to an electronic one
 - Handling of paper forms
 - Transcription and the incorporation into the EMR
 - e-Prescription
 - Charge Capture
 - Claim scrubbing
- Don't try to fit current processes in a new environment
 - Go through a total workflow redesign that addresses every aspect of the Revenue Cycle
- How will information flow from the PM system to the EMR?
 - What functions will be maintained in the Practice Management System?

Design and Implementation Strategy

(Con't)

- With the added technology what processes will be needed to manage each function?
 - Charge Capture Edits
- What additional hardware/software is needed to support an electronic environment in the Clinic?
 - Scanners
 - Many organizations purchase scanners that are too narrow in functionality i.e. card scanners vs. multi-function
 - Organizations can be too focused on “room at the front desk” and not seeing the bigger picture of a paperless environment

Physician Involvement

- Common mistakes to avoid
 - Moving too fast with the implementation without consideration of the network's growth strategy
 - Overestimating Physician confidence with electronic solutions
 - Under involvement of physicians in the EMR selection and the consensus building process
 - Limiting the Physician involvement in the design and implementation phases
- Design the electronic process around technical process without enough focus on operational flow
- Templates and tasks need to support the physician's specialty and not a generic electronic note

Consequences to Physician Involvement

- Keeping Physicians in the dark, leads to reluctance to trust the “system”, hence limiting your success factors
- Physicians will be reluctant to adopt many features of the EMR that would greatly benefit their clinical workflow
- In addition, their reluctance will cause the implementation team to make decisions based on pacification vs. successful implementation.

Document Conversion

- Need to create a plan for conversion of records and incoming information
- Are their archived transcription files?
- Consider how far back in time to begin the patient record conversion
 - 3 year history
 - Appoints for the next 6 months
- Scanning of current and new patients
 - How much of the chart and how far back?



Consider New Ways to Manage the Revenue Cycle

- Evaluate how you managed your Revenue Cycle before an EMR implementation
 - Was/Is it effective?
- Were you effectively using your Practice Management System and/or Business Intelligence tools to manage?
- What tools does your EMR offer to manage the functions you implemented?

Managing through Metrics

- Key Areas to Monitor System Utilization
 - Scheduling
 - Registration
 - Scanning
 - Transcription
 - Coding/Charge Capture
- Practice Management System & EMR
- Missing charges and coding/claim edits

Managing through Metrics (Con't)

- Develop daily, weekly and monthly reports to help you manage the electronic environment
- Sample EMR Metrics
 - # of Active Users
 - # of Documents Scanned
 - # of Charges Billed
 - # of Dictations Created
 - # of Orders Authorized



Case Study

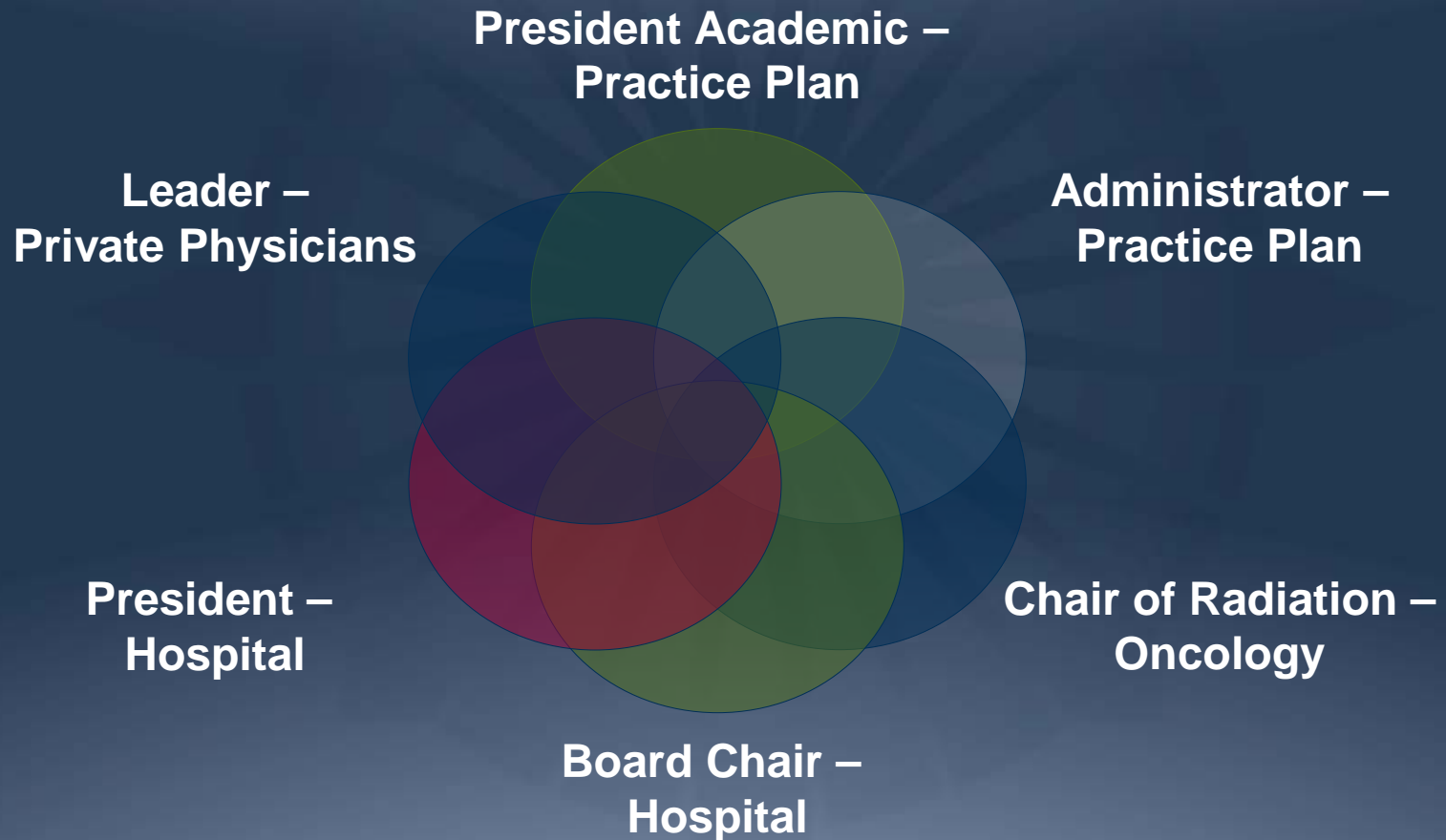
Background

- 2 Hospital system with 50 employed physicians
- Many providers in community do not have an EMR and a less than optimal practice management system
- Few reports were used to manage revenue cycle functions
- Minimal connectivity to hospital systems (Lab, Pacs, etc)
- Multiple problems with patient registration through multiple systems

Hospital Strategy

- Create an electronic network for employed physicians and community providers
- Allow patient, providers and third parties to access electronic network
- Create a coordinated network of care
- Build an MSO to manage IT structure and relationship
- Use technology to build relationship with providers and patients

Steering Committee Established



Implementation Strategy

- Selected a well respected vendor with a powerful enterprise solution
- Phased in implementation approach
- Implementation & Design Committees were physician driven
 - Many members had little working knowledge of EMR but new clinical process
 - Education was required to balance technology with outcomes and expectations
- Most physicians were interested in adopting EMR, but did not know where to begin

MSOs were the Strategic Asset for Driving Electronic Network

- MSO was formed to manage the complex relationships between physicians and hospitals
- MSO leadership guided the transformation of healthcare services from hospitals to physician offices
- MSO provided the catalyst for the transformation of electronic health technology into physician practices
- The Hospital promoted connectivity to patient and the community

Hospitals Used Technology to Create Value

- Ala Carte model of information technology
 - Leveraging the hospital's technology to offer cost effective electronic health technology to physicians
 - IT support services to reduce overhead
 - MSO practice management support to training, educate and assist with practice growth
- Interoperability with hospitals and physicians
 - Lab, x-ray and ancillary results
 - Patient registration information
- Electronic health technology as patient referral mechanism
- Patient portals through the web

Hospital's Electronic Community Health Design

- The organization focused their information systems around the end user
 - What will make the systems “user-friendly”?
- Selected a vendor that supported community e-connect and enterprise functionality
- Value was driven from patient referrals and addition revenue from more efficient process
- Hospital invested over \$3MM in technology with idea of amortizing costs to providers over time

Value to Providers

- Hospital offered technology to community physicians and a discounted (but fair market value) rate
- Providers received a state of the art system at a fraction of the cost
- Interoperability access was incorporated into the cost with opportunities for additional subscription services
- Physician were positioned well for additional revenue and stimulus dollars

Current State

- Completed a technical redesign of the entire patient electronic health record
- Automated many of the manual processes through a phased in go-live process
- Physicians went through a reeducation process of clinical workflow and EMR benefits to change attitudes and behaviors
- Once physician understood the functional use of interoperability, they became reliant on technology to deliver care
- On going education with patients in community on how to access information

Where do You go from here?

- Talk with colleagues and networks to assist with decision making
- Your decision will come based more about “when” to implement and not “if”
- The stimulus money and other government incentives are important components of the EHR return on investment
- Begin thinking about your organization’s strategic goals, IT objectives and implementation initiatives
- When it finally comes down to moving forward, it’s really not about the technology, it’s about the clinical processes and workflows that drive success

Questions

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