Singing in the Rain..
Into each life some rain must fall;
But

The Electronic Medical Revolution

Provides meaningful use for the consumer, provider and family / caregiver.

By: Susan Rose
RN MSN

This Electronic Revolution is improving healthcare delivery
As the back bone supporting
3 medical trends:

1. The **Medical Home-**
An IT enhanced primary care delivery system.

2 . The Lifetime Electronic health Record,
Open Source – preferable!

3. Imagine - Enjoying our
Aging Futures with
Electronic monitoring and connection devices.

1. What is : The Patient Centered **Medical Home?**

It is- an approach to providing comprehensive Primary Care.
What principles would be necessary your clinic to qualify for this title?

- **Personal Primary Care Provider** with A Team that practices collectively to maximize your health.

- **Holistic-** needs over a lifetime would be addressed, coordinating across specialists, hospitals, home health agencies, and care homes.

- **IT enhanced practice**. Improved access to healthcare via email, electronic monitors, telemedicine – (think Skype with a stethoscope attached). Electronic records, record sharing with other data bases. (Example hospital to primary care office and back.)
E -prescribing to pharmacies.

TransforMED℠

The TransforMED Patient-Centered Model

A Medical Home for All

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication:
  trust, respect, shared decision-making
  - Patient engagement
  - Provider/patient partnership
  - Culturally sensitive care
  - Continuous relationship
  - Whole person care

Access to Care and Information

- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice-Based Services

- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Health Information Technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

Care Management

- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Quality and Safety

- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Care Coordination

- Community-based resources
- Collaborative relationships
  - Emergency Room
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management
- Care Transition

Practice-Based Care Team

- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Find out more at **www.TransforMED.com**

1. Medical Home

•**Coordination of care means**
The pcp or family doctors office knows all the relevant health information about you before you return to their clinic for your next visit.

Approx 70% of first return to primary care visits
Do NOT have records from a recent
Hospital discharge, Urgi- care ER visit,etc.

Ask your doctor before you leave:
I came because _____
What was wrong with me?
How did you decide that?
What did you do to make me better?
What should happen next?

1. Medical Home

- **Quality is** assured by clinical
- decision-support tools, measurement.

Station and Providers: **VISN 21**

Gender: **Female**

FY 10 Performance Measures PCP

February 2010

	Actual	Target	Non-VA Top 3	Patients	Not Met	Unknown
MISSION CRITICAL MEASURES *						
Diabetes Outpt-HBA1C Measured Annually	95.2%	93%	98%	1,204	58	
Diabetes Outpt and HBA1C > 9 (lower is better)	17.8%	25%	27%	1,204	156	58
Diabetes Outpt and LDL<100	55.8%	53%	80%	1,204	455	77
Diabetes and BP < 140/90	74.8%	76%	80%	1,204	279	24
Diabetes Outpt and Retinal Exam in past 2 years	80.8%	70%	88%	1,207	232	
Diabetes Outpt - LDL Measured Annually	93.7%	88%	96%	1,204	76	
IHD - Outpt LDL Measured Annually	87.5%	92%	97%	80	10	
IHD - Patients with LDL < 100	55.0%	69%	85%	80	26	10
Hypertension Outpt and BP < 140/90	73.1%	72%	77%	2,985	779	

1. Properly run **Medical Homes** can bring costs into line.

All Americans must have quality and affordable health care.

$1 spent = $1.50 In savings

Address http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20071011ccnccutscosts.printerview.html

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aafp NEWS NOW

North Carolina Primary Care Program Continues To Save Millions

By James Arvantes
10/11/2007

North Carolina's Medicaid program continues to demonstrate how physician-led primary care networks and patient-centered medical homes can improve health care quality and save costs.

North Carolina Gov. Mike Easley recently released data showing that Community Care of North Carolina, or CCNC, saved the state a combined total of more than $231 million in Medicaid costs for fiscal years 2005 and 2006.

"Community Care is a good example of how we can be smarter in what we do," said Easley in a press release. "The long-term goal is to raise the quality of health care for the patient while at the same time making it cheaper for the state."

CCNC provides care to more than 750,000 Medicaid recipients in North Carolina, relying heavily on patient-centered medical homes, population health management, case management services and community-based networks to deliver care. Since its inception in 1999, the program has saved North Carolina nearly a half a billion dollars, becoming a driver of quality initiatives in the state in the process.

"We make sure every Medicaid recipient has a medical home," said Allen Dobson, M.D., of Concord, a family physician and former assistant secretary for health policy and medical assistance at the North Carolina Department of Health and Human Services. "We give (Medicaid recipients) a case manager who becomes their coach to make sure they understand what the doctor has ordered, so they can get to their appointments on time."

Since 1999, CCNC has grown to encompass 15 networks, 3,500 primary care physicians and 1,000 medical homes. Under the program, the state pays physicians 95 percent of Medicare plus a $3 per-member, per-month case-management fee. The state also pays networks a $3 per-member, per-month fee for care and disease management.

Patient Centered Primary Care Teamlet

Administrative Support

Customer Service
- Initial point of contact
- Patient Advocate
- Address customer service concerns & coordinating solutions.
- Hand-off communication

Assists providers
- Prepare paperwork requested by the Veteran and/or PCP
- Specialty consult completion tracking
- Coordinate information exchange for the co-managed patient
- Manage telephone demand (receiving and documenting)
- Manage appointment scheduling including EWL & recall.
- Pre-visit patient reminder calls

Face to Face Visits
- Appointment check in
- Assists w/My HealtheVet registration
- Performs In-Person Authentication
- Assists with updating and verifying demographics and insurance information

Team Work
- Daily huddle
- Team Meeting

Clinic support
- Identify & prepare required forms, documents/records prior to clinic session
- Faxing, copying, mail mgt
- Manage clinic grids
- Manage office supplies & setup

Provider (Physician, NP, PA)

Direct Patient Care
- Scheduled Clinic Visits
- Walk in or Urgent Visits
- Group Visits
- Telephone Visits
- Incoming telephone demand
- Pertinent Clinical Reminders

Secure Messaging
- Triaged messages from patients
- E-mail with consultants

Care Management
- Virtual review of patients including inpatients
- Identify high risk for hospitalization.
- Appropriate for CCHT, OEF/OIF, HBPC
- Preventive care needs
- Non VA records
- View alerts
- Diagnostic result
- Discuss care with/refer to specialty consultants
- Traveling veterans
- Medication Reconciliation
- Refer to other team members as appropriate

Team Work
- Daily huddle
- Team Meeting
- Midlevel Collaboration

Education
- New patient orientation
- Provider CME , Grand Rounds
- Teaching trainees

Veteran

Schedule appointments
As needed or requested by primary care team

Appointment check in (including correct ID)
- Utilizes kiosk to check in when available (performs In-Person Authentication)
- Updates insurance & demographic info

Face to Face Visits
- Arrive on time
- Bring medications
- Required Paperwork
- Health risk assessment completion (with RN)
- Lab work completion

Prepare for Primary Care Visit
- Discuss concerns and plan of care
- Utilize My HealtheVet
- Contact PC "teamlet" with any problems/concerns that arise during/after face to face encounter.

Participate
- Attend committees, patient advisory groups, and task forces

RN Care Manager

Direct Patient Care
- Scheduled Clinic Visits
- Walk in or Urgent Visits
- Group Visits
- Telephone Visits
- Incoming telephone demand
- Triage/place orders by protocol
- Pertinent Clinical Reminders

Secure Messaging
- Triaged messages from patients
- E-mail with consultants

Care Management
- Virtual/F2F in-depth and ongoing review of patients including inpatients
- Identify high risk for hospitalization.
- Initiate appropriate consultations for CCHT, CM, OEF/OIF, HBPC, hospice/palliative care
- Discuss care with specialty consultants
- Preventive/chronic disease care needs
- Triage to other team members as appropriate
- Non VA records
- View alerts
- Follow-up calls

Team Work
- Daily huddle
- Team Meeting

Education
- New patient orientation
- Mentor/precept nurse trainees
- Patient health education/coaching

Clinical Support

Direct Patient Care
- Assist with triage
- Assist providers with exams/procedures
- Perform treatments (EKGs, V/S, blood sugar, etc)
- Administer meds, wound care
- Pertinent Clinical Reminders

Secure Messaging
- Triage messages from patients

Care Management
- Track/administer required immunizations
- Triage phone calls for appointments
- Coordinate group visits
- Identify additional services needed by Veteran/Family

Team Work
- Daily huddle
- Team meetings

Education
- New patient orientation
- Assist with patient education

Clinic Support
- Daily equipment/supply checks
- Keep exam rooms stocked

1. Medical Home, Where?? Home is where the heart is.

Secure email and availability of electronic medical records encourage patients to communicate electronically with their healthcare providers rather than by phone or direct visits.

A recent study conducted by Kaiser-Permanente demonstrated that online communication brought down the likelihood of a primary care visit by 7-10% and phone communication by 14%.

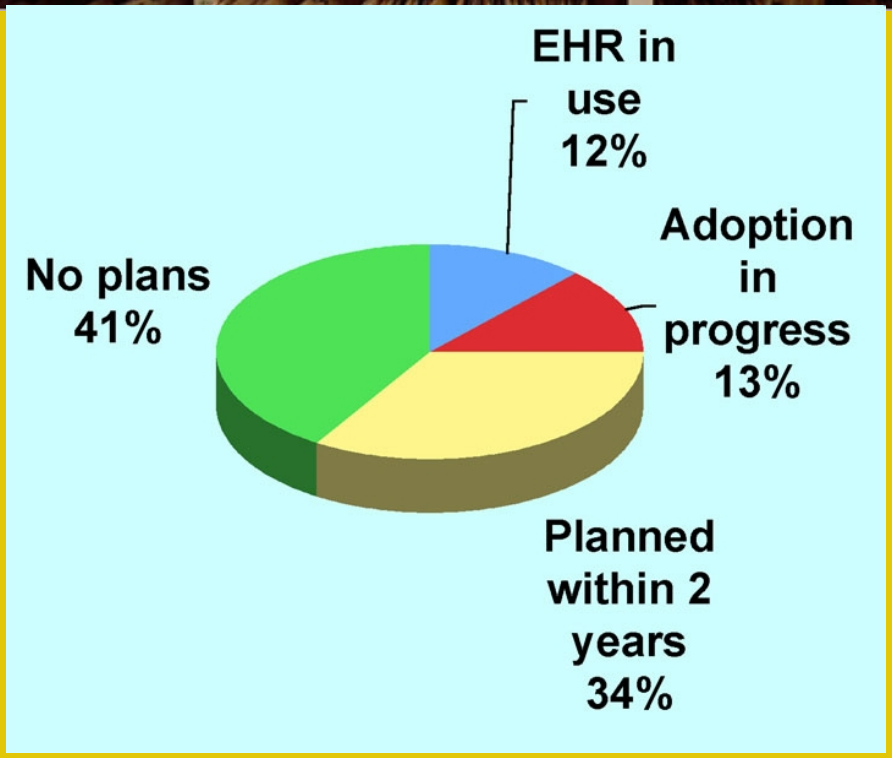
July 19, 2007
http://www.healthnewsdirect.com/?p=61

2. Medical Homes getting excited about a "killer application."

Goal: 100%
Lifetime electronic medical record.
Examples- Army to VA records.

2005 data for pie chart:

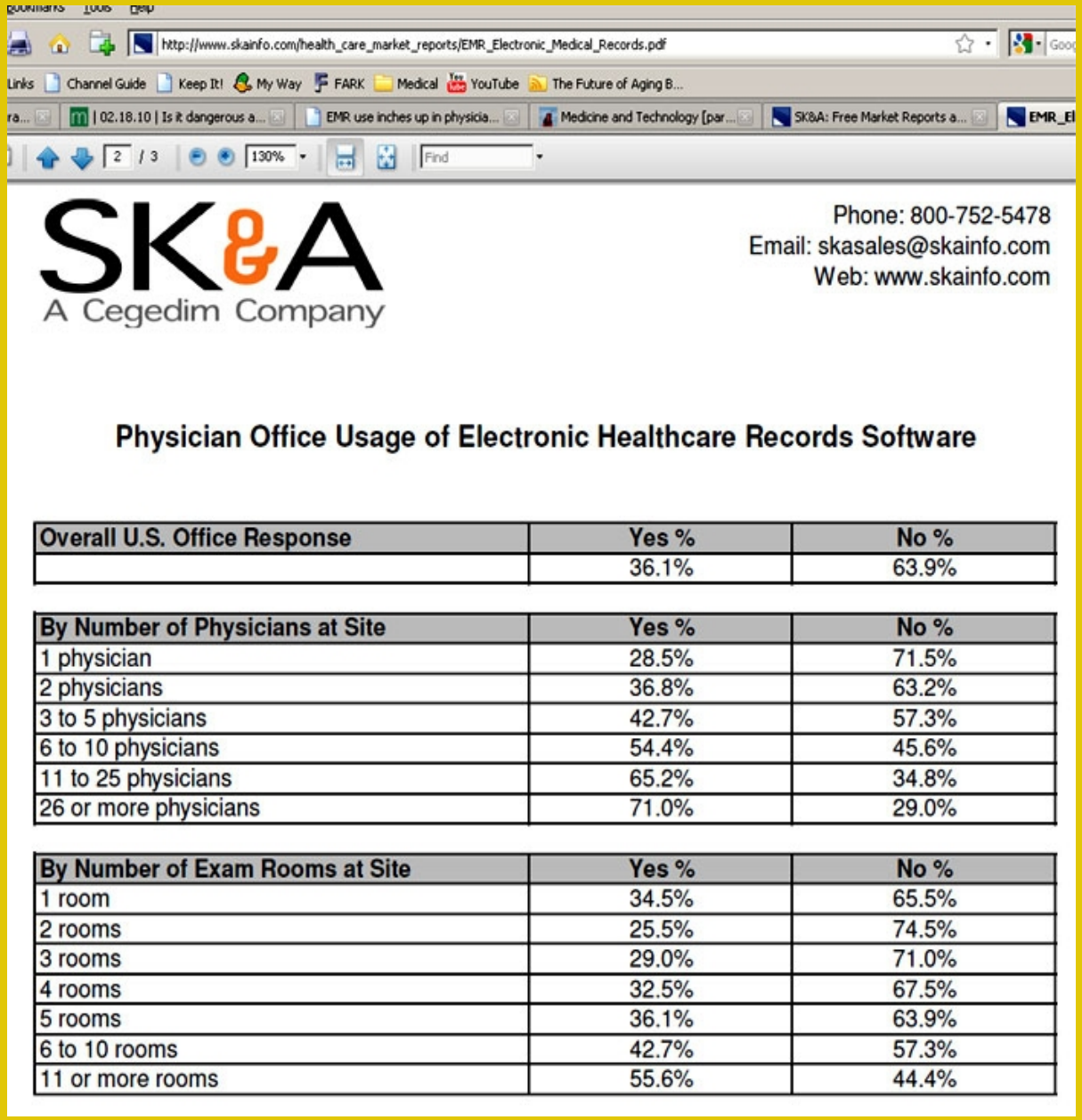
2010:
Recent survey: 48% of public now report their doctors using a computer in the exam room.



2. Medical IT Continues to Grow!

January 6, 2010
Based on telephone survey of 179,768 U.S. medical sites

Percent surveyed, using the electronic Medical record:
2005 12%
2009 28%
1 36.1%



http://www.skainfo.com/health_care_market_reports/EMR_Electronic_Medical_Records.pdf

SK&A
A Cegedim Company

Phone: 800-752-5478
Email: skasales@skainfo.com
Web: www.skainfo.com

Physician Office Usage of Electronic Healthcare Records Software

Overall U.S. Office Response	Yes %	No %
	36.1%	63.9%

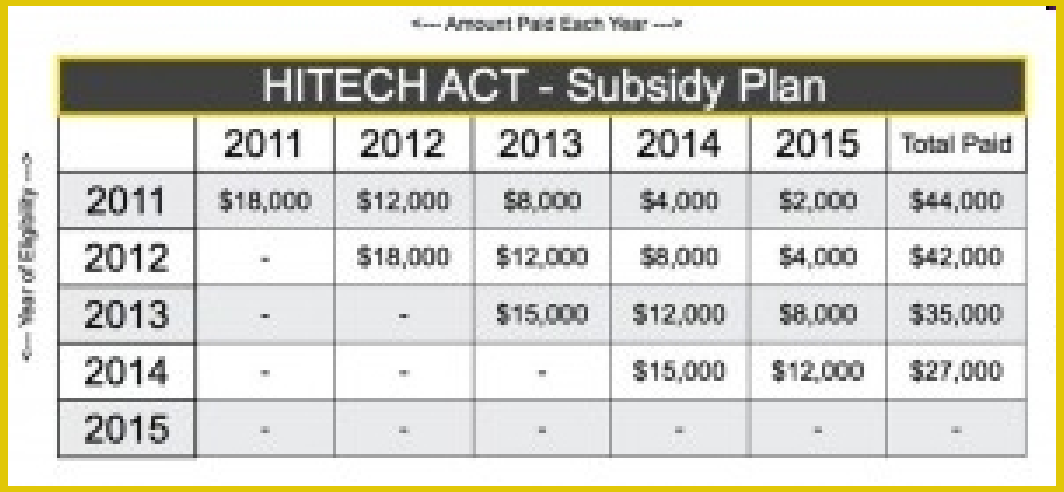
By Number of Physicians at Site	Yes %	No %
1 physician	28.5%	71.5%
2 physicians	36.8%	63.2%
3 to 5 physicians	42.7%	57.3%
6 to 10 physicians	54.4%	45.6%
11 to 25 physicians	65.2%	34.8%
26 or more physicians	71.0%	29.0%

By Number of Exam Rooms at Site	Yes %	No %
1 room	34.5%	65.5%
2 rooms	25.5%	74.5%
3 rooms	29.0%	71.0%
4 rooms	32.5%	67.5%
5 rooms	36.1%	63.9%
6 to 10 rooms	42.7%	57.3%
11 or more rooms	55.6%	44.4%

2. Follow the Money!

Up to
***A* 44,000 dollar subsidy.**

Medical Homes need electronic updating!



<— Amount Paid Each Year —>

<— Year of Eligibility —>

HITECH ACT - Subsidy Plan						
	2011	2012	2013	2014	2015	Total Paid
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
2012	-	$18,000	$12,000	$8,000	$4,000	$42,000
2013	-	-	$15,000	$12,000	$8,000	$35,000
2014	-	-	-	$15,000	$12,000	$27,000
2015	-	-	-	-	-	-

(HHS) Meaningful Use

1) Improve quality, safety, efficiency, and reduce health disparities
2) Engage patients and families
3) Improve care coordination
4) Improve population and public health
5) Ensure adequate privacy and security protections.

2. The Gold Rush - Everyone is getting in the act

Health Blog

WSJ's blog on health and the business of health.

« Obama Budget Director Criticized as Vague on Health Reform

MARCH 11, 2009, 8:39 AM ET

Wal-Mart to Sell Electronic Medical Records to Doctors

Article | Comments (24)

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By Sarah Rubenstein

Wal-Mart is jumping into the health-IT fray with plans to sell systems for handling electronic health-care records in small medical practices, the New York Times reports.

Convincing small practices to invest in the costly technology has been one of the biggest conundrums in the push to digitize the nation's medical records. One doc told the WSJ's Andy Jordan it cost about $300,000 to make the switch. Wal-Mart thinks it can solve the problem by doing what is has done with so many other products.

"We're a high-volume, low-cost company," Marcus Osborne, who works in health-care business development for the company, told NYT. "And I would argue that mentality is sorely lacking in the health-care industry."

The retailer's Sam's Club division, working with Dell for the computers and eClinicalWorks for software, plans this spring to make electronic medical records available for under $25,000 for the first physician in a practice and some $10,000 for each additional doctor, NYT says. Continuing maintenance and support will run another $4,000 to $6,500 a year.

That's still certainly an investment, but the federal economic stimulus package also may grease the wheels for small practices: It offers financial incentives for docs to adopt electronic records.

Wal-Mart has been getting more deeply involved in health care in recent years, drawing a lot of attention for its $4 generic-drug program. It has improved its image in health after drawing criticism for offering stingy health benefits.

Photo: Bloomberg News

Advantages:

Reduce healthcare costs

Improve quality of care

Promote evidence-based Medicine