



RESOURCE AND PATIENT MANAGEMENT SYSTEM

RPMS - EHR End User Training

Agenda

February 25th – March 1st, 2013

Office of Information Technology (OIT)
Albuquerque, New Mexico
and
Southeast Alaska Regional Health Consortium (SEARHC)

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1.0 General Information

1.1 Background

On February 17, 2009, President Barack H. Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA provides incentives to encourage healthcare organizations and office-based physicians to adopt electronic health records (EHRs) and other health information technology (HIT) solutions that reduce costs by improving quality, safety, and efficiency. ARRA contains numerous technology and privacy provisions with aggressive timelines for completion. Many of these ARRA milestones are related to standards and the work of the Healthcare Information Technology Standards Panel.

As part of the ARRA initiative, Tanana Chiefs Conference was awarded \$1.3 million in matching funds to expand the use of Health Information Technology throughout the interior of Alaska. The project includes three sub-regional Section 330 grantees: Tanana Chiefs Conference, Council of Athabascan Tribal Government, and the Edgar Nollner Health Clinic. In addition to the sub-regional clinics, 25 additional village clinics are included in the initiative to improve communication flow, increase access to a higher level of health care, improve the safety of health care, and reduce health care costs by implementing the EHR and integrating the health records of the region.

1.2 Health Information Technology for Economic and Clinical Health Act

The Health Information Technology for Economic and Clinical Health Act (HITECH) is a focal point of ARRA and represents an investment of more than \$19 billion towards healthcare IT related initiatives. The \$19 billion dedicated to HITECH is divided into two portions: (a) \$17 billion toward a Medicare/Medicaid incentive reimbursement program for both healthcare organizations and providers who can demonstrate “meaningful use” of an approved EHR, and (b) \$2 billion available to: providers located in qualifying rural areas; providers serving underserved urban communities; and Indian tribes. “Meaningful use” of an approved EHR will be required in order for providers to qualify for, and continue to receive, benefits from HITECH.

1.3 Incentive Payments

ARRA will provide incentive payments through Medicare and Medicaid reimbursement systems to encourage providers and hospitals to adopt EHRs and HIT. Hospitals that demonstrate meaningful use of certified EHRs and other HIT could be eligible for between \$2 million to \$8 million. Incentive payments are triggered when an eligible provider (EP) or eligible hospital (EH) demonstrates that it has become a “meaningful EHR user.” The highest incentive payments will be granted to EPs and EHs that adopt EHR technology in years 2011, 2012 or 2013. Reduced incentive payments are granted to EPs and EHs that adopt EHR technology in years 2014 or 2015, while no incentive payments are granted to EPs and EHs that adopt EHR technology after 2015. Providers and hospitals that fail to meet this time limit will be subject to penalties in the form of reduced Medicare reimbursement payments beginning in 2017.

1.4 Meaningful Use

“Meaningful use” is a term used by CMS to ensure that providers and hospitals that have adopted certified EHR are using the technology to further the goals of information exchange among health care professionals. EPs and EHs will achieve meaningful use if they: (a) demonstrate use of certified EHR technology in a meaningful manner, (b) demonstrate the certified EHR technology provides for electronic exchange of health information to improve quality of care, and (c) use certified EHR technology to submit information on clinical quality and other measures.

Achieving meaningful use will be accomplished in three stages. Stage 1 will begin in 2011, Stage 2 will begin in 2013, and Stage 3 will begin in 2015. The criteria for achieving meaningful use will increase with each stage and will build upon the prior stage. Medicare and/or Medicaid incentives are available to providers and hospitals who become meaningful users of certified EHR technology, with the maximum incentives being given to EPs and hospitals that become meaningful users in Stage 1. Hospitals may be eligible for both Medicare and Medicaid incentives but EPs must choose between the two incentive programs.

For the 2011 Medicare incentives, EPs must report on three core measures and a set of specialty measures which vary depending on the EP’s specialty. Eligible hospitals must report on a set of 35 measures that includes emergency department, stroke and VTE, among other measures. Reporting of clinical quality measures in 2011 will be accomplished by attestation. Beginning in 2012 for both Medicare and Medicaid incentives, EPs and hospitals must submit information electronically on both the health IT functionality and clinical quality measures.

1.5 Objectives

The first health outcomes policy priority specified by the HIT Policy Committee is improving quality, safety, efficiency and reducing health disparities. The HIT Policy Committee has identified objectives and measures for providers to address this priority:

Provide access to comprehensive patient health data for patient's healthcare team.

Use evidence-based order sets and computerized provider order entry (CPOE).

Apply clinical decision support at the point of care.

Generate lists of patients who need care and use them to reach out to those Patients

Report information for quality improvement and public reporting.

Use CPOE – 10%

Implement drug-drug, drug-allergy, drug-formulary checks.

Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 CM or SNOMED CT® - 80% of all patients have at least one problem recorded

Generate and transmit permissible prescriptions electronically (eRx) – 75% of all prescriptions

Maintain active medication list – 80% of all patients

Maintain active medication allergy list – 80% of all patients have allergy or no allergy recorded.

Record the following demographics: preferred language, insurance type, gender, race, and ethnicity, and date of birth. – 80% of all patients

Record and chart changes in the following vital signs: height, weight and blood pressure and calculate and display body mass index (BMI) for ages 2 and over; plot and display growth charts for children 2 - 20 years, including BMI – 80% of all patients.

Record smoking status for patients 13 years old or older – 80% of all patients.

Incorporate clinical lab-test results into EHR as structured data – 50% of all clinical lab results ordered by provider.

Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach – Generate at least one list

Report hospital quality measures to CMS.

Send reminders to patients per patient preference for preventive/follow-up care to at least 50% of patients with unique conditions.

Implement five clinical decision support tools.

Check insurance eligibility electronically from public and private payers – 80% of all patients.

Submit claims electronically to public and private payers – 80% of all patients.

1.6 Instructors and Facilitators

Disclosure Statements: All of the faculty for this course have completed the disclosure process and have indicated that they have no significant financial relationships or affiliations with any product or commercial manufacturer that might constitute a conflict of interest. Additionally, they have agreed to use generic or multiple trade names when referring to medications and will identify an off-label or experimental uses of medication.

- David Taylor, MHS, RPh, PA-C, RN, EHR Training and Deployment Manager, Office of Information Technology
- Philip Taylor, RN, Contractor (Medsphere – Remote)

2.0 Detailed Agenda

	Time	Old Eye Office (3 PCs)	Blue Room (6 PCs)	Other
Day 1 Mon	8:00 - 8:30 am	Setup	Setup	
	8:30 - 10:00 am		Clinic orientation for David, Phil, others	
	10:00 - Noon	EHR: Women's Health, Diabetes, Healing Touch	EHR: Overview for PARs, Rx Tech, others	
	Lunch	Lunch	Lunch	
	1:00 - 3:00 pm	CAC Office Hours: Women's Health, Diabetes, Healing Touch	LAB: Treatment Room Staff	
	3:00 - 4:30 pm			
	4:30 - 5:00 pm	See Blue Room ==>	EHR: Check-in call - PM	
	After Hours, time TBD		EHR: Workflow Analysis	

	Time	Old Eye Office (3 PCs)	Blue Room (6 PCs)	Other
Day 2 Tues	8:00 - 8:30 am	See Blue Room ==>	EHR: Check-in call - AM	
	8:30-10:00 am	EHR: Tobacco	LAB: Clinical Assistants	
	10:00-Noon	Open		
	Lunch	Lunch	Lunch	
	1:00 - 3:00 pm	CAC office hours: Tobacco, EHR Lab	Lab: RNs	
	3:00 - 4:30 pm			
	4:30 - 5:00 pm	See Blue Room ==>	EHR: Check-in call - PM	
	After Hours, time TBD		EHR: Workflow Analysis	

	Time	Old Eye Office (3 PCs)	Blue Room (6 PCs)	Other
Day 3 Wed	8:00 - 8:30 am	See Blue Room ==>	EHR: Check-in call - AM	
	8:30-10:30 am*	Open	EHR: Clinical Assistants*	LAB: Lab Staff
	10:30-Noon*		EHR: RNs*	
	Lunch	Lunch	Lunch	
	1:00 - 3:00 pm	EHR: Physical Therapy	LAB: Providers	

3:00 - 4:30 pm	LAB: Diabetes, WH, Dental	CAC Office Hours: RN, Clinical Assistants	EHR: Dental Medications
4:30 - 5:00 pm	See Blue Room ==>	EHR: Check-in call - PM	
After Hours, time TBD		EHR: Workflow Analysis	

*Note schedule change for Wednesday only

	Time	Old Eye Office (3 PCs)	Blue Room (6 PCs)	Other
Day 4 Thu	8:00 - 8:30 am	See Blue Room ==>	EHR: Check-in call - AM	
	8:30-10:00 am	Open	CAC Office Hours: RN, Clinical Assistants	
	10:00-Noon		EHR: Providers	
	Lunch	Lunch	Lunch	
	1:00 - 3:00 pm	Open	EHR: Providers + Treatment Room + FESC	
	3:00 - 4:30 pm			
	4:30 - 5:00 pm	See Blue Room ==>	EHR: Check-in call - PM	

	Time	Old Eye Office (3 PCs)	Blue Room (6 PCs)	Other
Day 5 Fri	8:00 - 8:30 am	See Blue Room ==>	EHR: Check-in call - AM	
	8:30-10:00 am	CAC Office Hours: Providers	EHR: Clinical Assistants	
	10:00-Noon		EHR: RNs + Treatment Room + FESC	
	Lunch	Lunch	Lunch	
	1:00 - 3:00 pm	Open	CAC office hours: Open topics	
	3:00 - 4:30 pm			
	4:30 - 5:00 pm	See Blue Room ==>	EHR: Check-in call - PM	

3.0 Biographical Sketches

CAPT (ret) David R. Taylor, MHS, RPh, PA-C, RN, NCPS
EHR Training and Deployment Manager
IHS Office of Information Technology

CAPT (ret) David Taylor is a retired Commissioned Officer in the United States Public Health Service and is a certified physician assistant, registered pharmacist, and registered nurse. Captain (ret) Taylor holds more than 33 years of public health, clinical, and clinic-administrative experience in the Indian Health Service (IHS). During his commission, he has served as a pharmacist, physician assistant, quality manager, risk manager, and compliance officer for the Pine Ridge, South Dakota and Cherokee, North Carolina Indian Hospitals. He has also served as an HIV/AIDS/STD consultant, performance improvement consultant, pharmacy consultant, and diabetes clinical consultant for the Nashville Area Indian Health Service. At this time, he is the EHR Deployment Manager for the IHS Office of Information Technology and has been charged with both training and deployment of the Electronic Health Record throughout the entire Indian Health Care system. David Taylor has been awarded the PHS Meritorious Service Medal (MSM) in recognition for his accomplishments in the EHR arena.

Philip Taylor, RN
Contractor (Medsphere)

Phil is a Clinical Consultant for Medsphere Systems Corporation. Phil has been a Registered Nurse for over 30 years. He holds a degree in Nursing from Vincennes University and a B.A. in Classical Studies from Indiana University. Phil provided clinical application support to VA Medical center staff using the VistA electronic medical record system for over 12 years prior to joining Medsphere. Phil's clinical history was primarily in Psychiatric Nursing. Currently Phil's primary responsibilities are providing training support (such as Basic CAC School and EHR for Inpatient) and configuration/setup support to OpenVista/EHR installations.