Interoperability/ Telemedicine Update

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Agenda

- Overview of NPO/NPO-HIE.
- Discuss the HIE system in Michigan.
- Interoperability Challenges.
- Some solutions being worked on in Michigan.
- Telemedicine overview and NPO's role.

NPO?

- A physicians organization primarily located in Northwest Lower Michigan.
- Over 500 members.
- We manage two Medicare Accountable Care Organizations (ACOs).
- Physician owned and led.
- We are a qualified Health Information Exchange in Michigan.

We're dedicated to assisting providers in maintaining their independence (if they desire to) and to manage the transition to value-based care.

Why is NPO an HIE?

- To ensure that physicians helped to decide what sort of integrations would occur (and their priority).
  - Physicians are too often excluded from Health Information Technology discussions.
- To maximize our member-owners' investment in Information Technology resources.
- To provide physicians with an ambulatory focused HIE platform to better meet the needs of ambulatory providers.

HIE System in Michigan

- MiHIN is the main data exchange hub in Michigan.
  - Think of them as the large mail sorting center, and the HIEs as your local village/city Post Office.
  - HIE's handle to and from the final destination.
  - When something needs to go further, it goes through MiHIN.
- This is called a hub/spoke or network of networks model.
- HIEs can focus on meeting user needs, not replicating existing data sharing infrastructures.
  - This is accomplished through a legal infrastructure created by MiHIN and well-designed payer incentives (mostly from BCBSM).

HIE System in Michigan

- This structure is good for HIEs in Michigan because it
  - Enables competition
    - Data hording cannot be used to harm competition.
  - Encourages innovation
  - Allows for HIEs to specialize for certain users.
  - Gives providers and other users choice in what to use.

Despite some concern, it has not led to more confusion; rather, it has enabled the growth of data sharing in Michigan.

Interoperability Challenges

- Not a surprise to anyone here – we haven't met the promise of interoperability yet.
- There are many specific challenges (especially vendor specific challenges and political/system specific challenges).
- Most vendor challenges, however, fall into these categories:
  - Cost
  - Functionality
  - Workflow

Note about Political/System Challenges

- Some organizations are cautious or antagonistic to sharing data.
  - Competing priorities could exist.
  - Concerns about competitors using the data for non-patient care purposes.
- Blue Cross, the primary funder of HIE incentives has done a lot of work to mitigate these challenges to ensure a functioning state-wide information sharing infrastructure.
  - BCBSM incentives require that data flows through MiHIN.
  - They are HIE agnostic.

Cost

- EMR billing looks like the hospital bills patient's complain about.
- Providers feel – not unjustly – that they are being nickeled and dimed by their vendors.
  - At the HIE/Physician Organization level, we've encountered this as well.
- In some cases, per provider/per patient billing models render useful integrations unaffordable for physician practices.

It is encouraging that the ONC is now starting to research and strategize how to assist providers in overcoming cost barriers.

Functionality

- There is a gap between advertised interoperability capabilities and actual capabilities.
  - This is an industry wide phenomena.
- There is an emphasis by vendors on simply meeting regulatory requirements rather than improving the workflow of their customers.
- Even where capabilities exist, there is still a lot of manual work involved and poor design limits its usefulness.

Workflow

- The growth in interoperability will require examinations in practice/provider workflows.
  - Just adding additional steps doesn't help anyone.
- In some cases, current processes will need to be augmented or unlearned entirely.
- Additional computer/EMR training for staff and providers may be required
  - This helps to ensure efficient EMR usage and to maximize the gains from available integrations.

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Work in Michigan to Overcome Challenges

- There are three large projects underway to help the provider community overcome interoperability challenges.
  - BCBSM's DirectTrust initiative.
  - The all payer supplemental clinical quality reporting project.
  - BCBSM's 2018 HIE incentive

What is DirectTrust?

- A secure, HIPAA compliant e-mail system that allows for documents to be shared between practices/providers.
  - It is a relatively cheap way to promote interoperability.
  - It is built into most (if not all) MU certified EMRs.
  - It can be used for referrals.
  - Its use helps a practice with their ACI for MACRA/MIPS.

BCBSM's DirectTrust Initiative

- For PGIP practices, BCBSM is incentivizing the acquisition of DirectTrust addresses.
- They are working with other stakeholders (vendors, POs, practices, MDC) to develop documentation for every major EMR.
- The goal is to eventually develop a state-wide directory of DirectTrust addresses to promote its use.

NPO has been part of this initiative since its inception (early 2017), and we have nearly 100 practices with DirectTrust addresses.

All Payer Reporting

- A project started by MiHIN and MSMS to:
  - Ease the burden on providers for reporting HEDIS metrics.
  - Covers the 27 most common measures.
- The State of Michigan also uses it for SIMs quality reporting.
- There are around 10 payers involved and live data is currently being sent to some payers.
  - This data is being evaluated so that payers can build it into their existing HEDIS data processes.
  - Payers are currently working on creating standardized gaps in care reports to share back with the provider community.

BCBSM's 2018 HIE Incentive

- After encountering many of the same interoperability issues described previously, BCBSM, in 2018, decided to (for PGIP practices):
  - Incentivize the EMRs to meet specific, basic functional requirements.
  - Require that POs, practices, and MiHIN sign off on functionality before a vendor receives final payment.
  - Require the vendor to agree to a specific timeline to accomplish the tasks.
- They have also engaged with other payers to expand the scope of this project.
- It has also been endorsed by MDHHS.

BCBSM's 2018 HIE Incentive

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Category	Core Capability	Timeline
REPORTING	Patient Demographics (ACRS 2.0 and CAHPS--NRC and Press Ganey formats)	Phase I
REPORTING	Practice-generated All-Payer Supplemental files for PPQC	Phase I
REPORTING	Automated Send of QRDA via Direc Secure Messaging or Web Services - Cat III	Phase I
REPORTING	Automated Send of QRDA via Direc Secure Messaging or Web Services - Cat I	Phase II
CCDA	Automated CCDA send to MiHIN via Direct Secure Messaging or Web Services	Phase I
CCDA	CCDA import via Direct Secure Messaging or Web Services and Import Functionality - Allergies	Phase I
CCDA	CCDA import via Direct Secure Messaging or Web Services and Import Functionality - Medications	Phase I
CCDA	CCDA import via Direct Secure Messaging or Web Services and Import Functionality - Problem List	Phase I
CCDA	CCDA import via Direct Secure Messaging or Web Services and Import Functionality - Labs	Phase II
DIRECTORY	Import and Export Direct Secure Messaging addresses to EHR Directory	Phase II
COMMON KEY	Import Common Key and send as part of CCDA, ACRS, PPQC files	Phase II

Telemedicine

- There are three main types of telemedicine being used/promoted:
  - **Telemonitoring** – remote monitoring of patients, usually elderly and/or frail with significant chronic conditions.
  - **Televisits** – audiovisual real-time encounters between a provider and a patient; Either can be remote for it to be a televisit.
  - **Store-and-forward Telemedicine** (also called asynchronous telemedicine) – this is not in real-time and involves a provider sending information to another and receiving feedback electronically (at a later date) on a treatment plan recommendation or if a referral request if warranted.

Telemonitoring

- NPO is in discussions with McLaren to pilot telemonitoring for CHF patients in the Petoskey area that meet certain criteria.
  - If efficacious, it will be expanding to other conditions and to the Gaylord area.

- It will involve care managers remotely monitoring enrolled patients and if certain clinical indicators are met, a cardiologist from McLaren will be brought into the discussion
  - To recommend changes in treatment.
  - To see the patient via a televisit.

We will provide more information about this as we receive it.

Televisits

- NPO is providing support to member practices that want to begin seeing patients via Televisits.
  - Many commercial plans already reimburse for encounters where the patient is not in the practice.
  - There are strict site of service requirements for Medicare/Medicaid currently.
    - Legislation has been introduced to remove such requirements.
- NPO has worked with some EMR vendors that offer solutions and with third party vendors to assist practices in affordably introducing televisits into their practice.
- We are encouraging this as we have seen external entities promoting telemedicine solutions with remote providers, and we want to ensure that the patient-provider reltionship is strengthened, not fragmented by televisits.

Store-and-Forward

- NPO piloted this in 2016-2017 with a company called CybrCare.
  - It proved beneficial – many unnecessary specialist visits were avoided.
  - We could not introduce it further into the region as there were no reimbursement mechanisms available yet.

- In early 2018, BCBSMs payment committee will consider whether or not to being paying low intensity E&M codes for store-and-forward visits where a picture was used.

We will keep members posted on this; if the payment change is approved, we will promptly reintroduce CybrCare into the community.

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