Engaging Patients Within the Workflow Through Standards-Based Interoperability

(Or how to support patients, get reimbursed, and have it all within the workflow)
The Office of the National Coordinator for Health Information Technology (ONC) defines interoperability as:

“All individuals, their families, and their healthcare providers hav[ing] appropriate access to electronic health information that facilitates informed decision making, supports coordinated health management, allows individuals and care givers to be active partners and participants in their health and care, and improves the overall health of the nation’s population.”

An engaged and activated patient can make the difference between health care success and failure. Informing patients is a key step in unlocking patient engagement, satisfaction, and quality goals.

Using two reimbursement programs by Centers for Medicare and Medicaid Services (CMS), this eBrief will demonstrate how open APIs and standards-based interoperability offer a seamless medium for delivering health education and receiving important information back from the patient, such as a completed health risk assessment (HRA) or the patient’s preferences.

Read more to find out how this all adds up to:
- Better health outcomes.
- Meaningful clinician and patient encounters.
- Increased revenue.
- More support for meeting Meaningful Use patient-education criteria.

Discover how you can have it all within the clinician workflow.
The goals of the Medicare Annual Wellness Visit (AWV) and Chronic Care Management (CCM) services are to help keep patients healthy with evidence-based preventive services and to provide care coordination. Both offer reimbursement opportunities for primary care physicians.
The incentives:

It’s the right thing to do. And it reimburses physicians. Here are “back of the envelope” figures:

<table>
<thead>
<tr>
<th>Average U.S. patient panel size per physician</th>
<th>2,300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit (AWV) physician reimbursement for year one</td>
<td><strong>$172</strong></td>
</tr>
<tr>
<td>Average number of those patients covered by Medicare</td>
<td><strong>27%</strong> (or 621)</td>
</tr>
<tr>
<td>Number of those Medicare patients who have more than one chronic disease</td>
<td><strong>68%</strong> (or 422)</td>
</tr>
<tr>
<td>AWV physician reimbursement in subsequent years</td>
<td><strong>$111</strong></td>
</tr>
<tr>
<td>Chronic Care Management (CCM) services physician reimbursement per year per patient</td>
<td><strong>$511</strong></td>
</tr>
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AWV potential reimbursement can add up to **$106K** for the first year and **$69K** for subsequent years.

CCM services potential reimbursement can add up to **$216K** per year.

The Annual Wellness Visit: Automating Patient Outreach

1. Send an interactive voice response (IVR) to the patient. IVR offers providers an efficient way to interact with patients on the phone. Patients can respond to automatically generated calls using voice or their key pads.

   “Hi. I’m calling from Dr. Smith’s Clinic. I want to let you know that you’re eligible for a no-cost wellness visit. Would you like to schedule your appointment now?
   
   Please press 1 to schedule an appointment.
   
   Press 2 to receive messages from my office.
   Press 3 if you don’t want messages.
   Thank you.”

2. When appointments are scheduled, deliver pre-visit messages through an online patient message center. These messages include:
   - What to expect at your appointment.
   - A questionnaire to capture CCM services’ required patient data, such as medical and family history and a health risk assessment (HRA).
   - Video and information on how to prepare for an office visit.

3. Send an email or text reminder prior to the appointment.

4. During the office visit, enroll patients who have two or more chronic conditions in the CCM services monthly program.

5. Reinforce visit with education and care planning resources delivered through the online patient message center.
The Annual Wellness Visit:
Behind the Scenes

- Access patient education resources with SMART-enabled application
- Deliver education assets and questionnaires electronically with IVR, SMS, or email
- Query the EHR using FHIR and deliver questionnaires
- Use FHIR resources to insert patient responses to questionnaires and educational resources into the record

SMART (Substitutable Medical Apps & Reusable Technology) is a collection of “iPhone-like” apps for the health care industry using standards-based interoperability. It was created to bring HIT up to speed with other industries—like travel, retail, and banking.

FHIR (Fast Healthcare Interoperable Resource) is an open standard from HL7 that:

- Uses web-based technology open API to exchange electronic health records.
- Offers interoperability between health care systems.
- Makes it easier to deliver health information on a wide variety of devices.
- Allows third-party application developers to create medical applications that can integrate into existing systems.

Source: http://en.wikipedia.org/wiki/Fast_Healthcare_Interoperability_Resources
1. Provide 20 minutes or more of chronic care management services per patient per 30 days. Deliver data-driven automated interventions.

2. Provide access to CCM services 24/7. Patient portal features education resources, including self-care videos, symptom checker, drug interaction checker, and after-office-hours contact information.

3. Ensure that the patient has continuity of care with a designated practitioner or member of the care team and is able to get successive appointments. Send appointment and care reminders via email or text messages.

4. Provide care management of chronic conditions that includes:
   - Systematic assessment of the patient’s medical, functional, and psychosocial needs. Deliver questionnaire that uses behavior change science, such as motivational interviewing, and provide interactive tools that help patients self-assess.
   - System-based approaches to ensure timely receipt of all recommended preventive care services. Send appointment and care reminders via email or text messages based on patient panel segmentation.
   - Medication reconciliation with review of adherence and potential interactions. Deliver decision aid on drug adherence and a video on medication adherence.

5. Create a patient-centered care plan document to ensure that care is provided in a way that is compatible with patient choices and values, and provide a written or electronic copy of the care plan to the patient. Deliver education resources matched with the care plan, including automated education interventions.

6. Manage care transitions between and among health care providers and settings.

7. Coordinate with home- and community-based clinical service providers as appropriate.

8. Offer enhanced opportunities for care team to communicate with the patient and any relevant caregiver. Use online patient message center as a centralized communication platform.
Did you know?

Many of the CMS-required steps also support Meaningful Use 1 and 2 patient education criteria:

- Use certified EHR technology for patient-specific education resources.
- Integrate decision-focused, meaningful patient education with patient downloads and clinical summaries to help patients understand what they find in their medical records.
- Enhance the effectiveness of patient reminders for follow-up care with patient-friendly information about tests and procedures.
- Complement provider-to-patient messages with robust patient health education and interactive tools.
Chronic Care Management Services:
Behind the Scenes

What’s an open API?
Open APIs use sets of technologies that enable websites to interact with each other.

- Access patient education resources with SMART-enabled application.
- Use FHIR to query the EHR to recommend educational assets tailored to patient-specific chronic condition and the care plan.
- Use open APIs to build a secure message center that can be deployed as a standalone or integrated into existing patient portals.
- Deliver education assets and capture patient response electronically with IVR, SMS, or email.
- Document goals, activity, and patient response in the Care Plan using FHIR resources.
Do more with your EHR or care coordination platform

Standards-based open APIs can help optimize efficiency of workflow and minimize added costs associated with the new AWV and CCM reimbursements.

**Patient education and engagement**
- Delivers, automates, and collects patient participation agreements through IVR.
- Sends patient-specific education using data available in the EHR and accessible via FHIR.
- Automates outreach to electronically prescribe education.
- Creates a robust collection of SMART-enabled educational resources, including an online health message center, self-care videos, symptom checkers, drug interaction checker, and decision aids.

**Standards-based interoperability**
- SMART-enabled EHR with the necessary FHIR resources.
- Secures access for clinician and patients using open APIs.
- Seamless integration creates a system of patient and provider communication.

**Segmenting populations**
- Query EHR’s FHIR server to create education resource lists for Patient, Condition, and Encounter resources.

**Care plans and continuity of care**
- Map educational assets to goals in the care plan and track patient activity.
- Automate care and visit reminders with pre-visit education delivered by IVR, SMS, secure messaging, or a patient portal.

**Billing and reporting**
- Identify and track the patient encounters that are eligible for physician-reimbursement programs.
Summary

Aligning your CMS reimbursement program goals with your patient engagement goals leads to better health outcomes, increased satisfaction, and meaningful clinician and patient encounters. Here’s what you need:

- Built-in, workflow-efficient solution that uses text messaging and IVR to automate reminders, link to schedule appointments, and deliver supporting education.
- A standards-based health education solution that integrates seamlessly across HIT systems and platforms.
- Flexible fulfillment options, including a secure online message center to deliver patient-specific tools and education.
- Patient activity recorded in the medical record so physicians and the care team can offer informed, personalized clinical encounters.
Connect with and engage people when they need support the most. Automated health-education interventions delivered by email, IVR, or text messaging are a low-cost way to reach more people. Choose from pre-defined campaigns with proven results, or create custom campaigns to meet your population health goals. Or build your own unique set of health education resources.

Send a one-time outreach, or deliver time-based, ongoing health education interventions to support an individual’s specific needs for:

- Diagnoses. Provide an online self-management program for people newly diagnosed with diabetes or other high-priority health issues.
- Upcoming procedures. Give visit-preparation instructions to people scheduled for surgeries or other procedures.
- Preventive screenings. For example, deliver a reminder about scheduling a colonoscopy for colon cancer to people on their 50th birthday.