Dr. Niharika Khanna Promotes Patient-Centered Care

Niharika Khanna, MD, associate professor of Family and Community Medicine, Pediatrics and Psychology at UMD, promotes a patient-centered approach to enhance the care of patients. Now program director of the Maryland Health Care Innovations Collaborative (MHCIC), she is pleased to report progress and well-positioned to advance her vision.

After earning her M.D. in Obstetrics and Gynecology at the King George Medical College in Lucknow, India, Dr. Khanna held residencies in Lady Hardinge Medical College, New Delhi; King George Medical College, Lucknow; Cook County Hospital, Chicago; Bronx Lebanon Hospital, New York; and University of Maryland Hospital, Baltimore. Her multiple professional roles include Director of the Home Health Telemedicine initiative for chronic medical diseases in Garrett County; Chair of the Primary Care Committee of the Skin Cancer Coalition of Med Chi and DHMH; and Somatic Director of the Walter P. Carter Center, where she provides medical care to inpatient psychiatric patients. She also serves on review committees for the National Cancer Institute, the Health Resources and Services Administration and the Komen Foundation.

Dr. Khanna's research interests are in cervical cancer prevention and cancer disparities and in drug development for use in chemoprevention and as a vaginal microbicide. A coauthor of the DHMH Cervical Cancer Control Plan, Dr. Khanna serves as Medical Advisor to the Breast and Cervical Cancer Program for the State of Maryland. Her clinical specialties include chronic disease management using telehealth and health disparities research, training and outreach.

Dr. Khanna took a leading role in planning what would become the MHCIC, from her participation in the state multipayer program task force in 2009 to the formation of the Maryland Multi-Payer Patient Centered Medical Home Program (MMPP) established in April 2010 and the launch of the MHCIC in 2011 as a partnership of the UMD School of Medicine, Johns Hopkins and the MHCC. Using resources from the education and research communities, the collaborative launched a three-year pilot program of practice transformation, recruiting 52 practices. According to the announcement from the governor’s office, “This pilot will help Maryland set the stage for a new model of patient treatment focusing on improved patient care, rewarding physicians for the quality of care they provide and controlling costs.”

The selected practices served adult and pediatric populations statewide and included a CRNP-directed practice, solo and small physician-owned practices,
New Guidance Issued on Patient Privacy in Emergencies

In November, in light of the Ebola outbreak, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), issued a bulletin for HIPAA-covered entities and their business associates to clarify how patient health information may be shared under the HIPAA Privacy Rule in an emergency situation, while reminding them that the protections of the Privacy Rule cannot be set aside during an emergency.

Health care providers remain subject to HIPAA’s privacy rule protections in emergency situations. However, the “HIPAA Privacy Rule protects the privacy of patients’ health information (protected health information) but is balanced to ensure that appropriate uses and disclosures of the information still may be made when necessary to treat a patient, to protect the nation’s public health, and for other critical purposes.”

The bulletin restates guidance on the sharing of patient information for purposes of treatment or public health, for informing or notifying family, friends or others involved in the patient’s care, in the case of imminent danger or to provide information to the media or others. It also points to the rule specifying that disclosures must be limited to the “minimum necessary.”

For detailed guidance on privacy rules in case of an emergency, see the full text of the bulletin, at http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/hipaa-privacy-emergency-situations.pdf.

ICD-10 for Small Practices Rated Less Costly; Transition Help Available

Small practices that must meet the requirement that they convert to ICD-10 by October 2015 face concerns over both the process and the cost of implementation. While the first estimates were daunting, better news is arriving from the subsequent experience of larger practices and hospitals making the transition.

New data published in November in the online Journal of AHIMA suggest that the estimated costs, time and resources required by physician offices to convert to ICD-10 are “dramatically lower” than initially estimated. Its facts and figures offer guidance on fitting ICD-10 transition costs into your 2015 budget.

While earlier estimates of the cost to small practices, in a 2008 report to the AMA, ranged from $22,560 to $105,506, the authors of the AHIMA article conclude that the cost for a small practice fall in a range of $1,900 to $5,900. Their analysis also indicates that physicians and their office staff, vendors and health plans have made considerable progress on ICD-10 implementation methods that require fewer resources.

The authors examine the costs for training, software upgrades, superbill conversion, end-to-end testing and productivity. They attribute their new, lower estimates to the industry’s increased knowledge and readiness for ICD-10, combined with the availability of low-cost ICD-10 activities and resources.


Concerned that small practices will not be prepared by the October deadline, Medicare has created the “Road to 10: The Small Physician Practice’s Route to ICD-10” website specific to small practices at http://www.roadto10.org/. The site guides you to “Build Your Own Action Plan” and supplies links to common codes, clinical documentation primers, clinical scenarios, and additional resources associated with each specialty.

For area practices, ZaneNet Connect is your local resource in planning for implementation, with our “Certified Coders” who can assist with ICD-10-CM transition areas. For more information or for assistance, you can reach us by phone at 301-830-7799 or by email at kphillips@zanenetconnect.com.
HRSA Announces Behavioral Health Funding for Area Health Centers

In early November, the Health Resources and Services Administration (HRSA) announced new awards of $51.3 million in a second round of Affordable Care Act funding to health centers to support mental health and substance abuse treatment. In the first round of awards, in July, HRSA awarded $54.5 million to 223 other health centers to expand behavioral health services. Health centers use these funds to hire new mental health professionals, to add mental health and substance use disorder health services and to employ integrated models of primary care.

According to HRSA, the purpose of this competitive grant opportunity is to improve and expand the delivery of behavioral health services through the establishment/enhancement of an integrated primary care/behavioral health model at existing health centers. Awardees in Maryland include Family Health Centers of Baltimore; Baltimore Medical System, Inc.; Community Clinic, Inc., of Silver Spring and Western Maryland Health Care Corporation. District of Columbia awardees include Mary’s Center for Maternal and Child Health; Community of Hope, Inc.; the Elaine Ellis Center of Health and La Clinica del Pueblo, Inc.

The new awards will fund 210 health centers in 47 states, the District of Columbia and Puerto Rico to establish or expand behavioral health services for nearly 440,000 people. The Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for approximately 60 million Americans.


Maryland Medicaid Telemedicine Program Expands Billing Services

Effective October 1, 2014, the Maryland Medical Assistance Program (“the Program”) will reimburse approved providers for services rendered to Program participants via telemedicine statewide. The state program will implement this expanded telemedicine service for both providers and participants, regardless of geographic location. Participants may be in the fee-for-service program, a managed care organization (MCO), or a long-term services and supports waiver program. Providers mutually approved by DHMH will engage in agreements both to deliver care and to bill Medicaid for approved telemedicine services, using fee-for-service reimbursement practices.

To participate in the telemedicine program, providers must be enrolled as Medicaid Providers and submit a Telemedicine Provider Addendum outlining their plan for participation.

Additional information about program requirements, billing instructions and resources, including the 2014 Telemedicine Provider Manual and the Telemedicine Provider Addendum, can be viewed and downloaded at https://mmcp.dhmh.maryland.gov/sitepages/Telemedicine%20Provider%20Information.aspx. For questions regarding the telemedicine program, email: dhmh.telemedicineinfo@maryland.gov.

Consent2Share Conference Features Behavioral Health

In November, ZaneNet Connect participated in the two-day “Share with Confidence” Consent2Share conference in Baltimore. ZNC has been working as a subcontractor on a pilot program at the Prince George’s County Health Department (PGCHD) that explores Consent2Share Patient Consent Management in the exchange of sensitive health information across the Electronic Health Network (EHN), an HIE infrastructure. The network enables information to be shared securely between behavioral health electronic medical records (EMRs) and primary care health providers for patients who choose to allow such exchanges.

By using Consent2Share, patients with behavioral health conditions benefit from the advantages of an integrated health record that also protects the confidentiality of sensitive health data. The conference brought together open-source tool developers, clinicians, policy makers and federal agencies focused on how to enable patients to “share with confidence” their Continuity of Care Documents (CCD).
hospital-owned practices, faculty-based practices and Federally-Qualified Health Centers. Maryland Medicaid, commercial insurers and large employers were among supporters of the pilot. A primary goal was to prepare each practice to participate in the Maryland Multi-Payer Patient-Centered Medical Home (PCMH) Program. To this end, the program assisted participants to expedite the NCQA review process.

In an interview, Dr. Khanna described some of the diverse resources the pilot program drew on to achieve these results. She sees teamwork as primary; essential internal and external communication procedures were developed as needed and expert advising instituted, in particular, by working with practice transformation coaches and adding care managers to the providers’ teams. An academic, Dr. Khanna also helped establish curricula that engaged learners; the techniques of huddles and discussions supported and encouraged teamwork.

Supported throughout by MHCC and by CRISP, the program ensured that all participants had implemented electronic medical records systems. All the pilot practices were linked to CRISP’s Encounter Notification Service (ENS), with 80% actively using ENS by the time of the final evaluation. The Maryland Hospital Association participated in the crucial step of providing care transition, linking hospitals to the practices’ care managers, all of whom were trained for embedded care management.

By the end of the program, all participants had reached PCMH status and achieved recognition from NCQA. Dr. Khanna points out that the evaluation of 21 quality metrics for 3 years for the 52 pilot practices shows significant improvement in chronic and prevention metrics; the vast majority of practices qualified for shared savings. Further, findings from a survey evaluation suggest that the practices’ participation had enhanced access to care, influenced patient outcomes, improved care coordination and increased use of health information technology.

Anticipating a similar mix of support for the future—and echoing the pilot program’s processes and techniques, MHCC describes how it means to continue this model of practice transformation: “by using a Learning Collaborative and within practice coaching of existing staff by expert Practice Transformation Coaches, and introducing an additional Care Manager to implement this model with rigorous outcomes evaluation of process, systems of care, [and] physician/clinician, patient-related and disease outcomes measures.”

Despite an agenda that might seem daunting to many, Dr. Khanna’s own vision for the future encourages a focus on new areas: for instance, building on partnerships such as that she enjoys with the Maryland Million Hearts program, educating PCMH practices about resources available to help patients achieve better cardiovascular disease outcomes. She envisions a focus on high utilizers and "creating a workaround with CRISP“ to identify high users and tell practices about them so that high utilizers are signaled with notifications. Further, she would like to see population health growth in practices that enables practices to look at their patient panels and identify gaps in care that they can try to meet.

Dr. Khanna report with satisfaction that some gains have been made in the ability of practices to meet behavioral health needs, an area where “we had significant enhancements [and] can get some information.” She would like to see motivational training, to train practices in what would then become a process to include depression and anxiety screenings and guidelines and a pediatrics “hotline” at UMD and Johns Hopkins to call for difficult patients.

Progress in two areas in which issues of privacy still remain to be resolved is nevertheless on Dr. Khanna’s wish list. She hopes to see funding for the development of sharable Continuity of Care Documents (CCD) records that would be available on the CRISP website. And now that funding has been achieved for linking records to smoking cessation help, ZaneNet has been contracted to work under Dr. Khanna’s program to provide workflow optimization support and other technical support to explore the feasibility and effectiveness of a secure electronic system that can link primary care patients with telephone tobacco Quitline services in a fully electronic, HIPAA-compliant way. The pilot will demonstrate how exchange of data between health providers to referral programs via a health information exchange can improve health outcomes by increasing the number of tobacco users referred to Quitline treatment.

Both a visionary and a frontline worker, Dr. Niharika Khanna is truly a leader in improving health care through collaboration and the thoughtful use of health information technology.
Bread for the City’s Abramson Cites ENS Benefits

Since 1991, Dr. Randi Abramson, M.D., has provided direction and management for the medical program offered by Bread for the City, a nonprofit agency serving people in need in the District of Columbia. The agency seeks “to provide vulnerable residents of Washington, DC, with comprehensive services, including food, clothing, medical care, and legal and social services, in an atmosphere of dignity and respect.”

With the medical program, the agency hopes to create a model of how care should be delivered — as an integral part of the larger organization. Its extensive array of medical clinic services includes examinations, pediatric care, gynecological care, dental care and, recently, behavioral health services for patients with mental health concerns. Patients receive referrals for specialty care, including mammograms and radiology.

Abramson’s work ranges from managing recruitment of medical volunteers, cultivating relationships with medical schools to establish residency programs, and overseeing and coordinating the development and operation of medical clinics to conducting patient examinations and referrals. She also serves as Assistant Clinical Professor at George Washington University Medical Center; she holds an M.D. degree from Rush Medical College in Chicago, Illinois.

Keeping records updated, error-free and easy to use presents a particular challenge to this large and diverse enterprise. Detailed and timely information must be available on an active patient list of some 2600 unique individuals, consisting of uninsured and underinsured women, children and men who have made 10,495 free medical visits in this last year. And it must be sharable by the staff, consisting of two full-time physicians, a staff dentist and a dental assistant, a physician assistant, a family nurse practitioner and more than 40 volunteer physicians, nurses, nurse practitioners, residents, students and others.

Consequently, Abramson welcomed the advent of CRISP’s Encounter Notification Service (ENS), a recent addition to the clinic’s electronic health records system that delivers secure real-time notification of patients’ transitions of care. Through ENS, a spreadsheet arrives every morning by email spotlighting the hospital admission and discharge records of clinic patients, including any emergency room visits. Without this information, the clinic may never have heard of their patients’ hospital experience. The patients’ chief complaint and contact information may also be supplied. After printing the spreadsheet, a clinic nurse places calls to the patients to discuss their transitions, possibly to schedule a check-in for an admitted

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Lee Emeni Returns to ZaneNet Connect

ZaneNet Connect is pleased to welcome returning Health IT project manager Leliveld (Lee) Emeni and expects to utilize his new certifications and experience fully in our latest projects. Our members are familiar with Lee’s earlier efforts helping primary care and specialist providers across Maryland transition to electronic health records and achieve Meaningful Use. With the Prince George’s County Health Department, he worked to design and implement a Local Health Network to exchange data across multiple clinics.

As a Certified Professional in Health Information Management Systems (CPHIMS), Lee has recently used his knowledge and experience in managing and implementing complex information systems. As a certified Patient-Centered Medical Home Content Expert (PCMH CEC), Lee also worked with larger health systems to implement the Patient-Centered Medical System of Care. With the New England Quality of Care Alliance in Massachusetts, he assisted practices first to draft and then to implement policies and procedures based on the NCQA 2011 PCMH standards, successfully submitting both single-site and multi-site applications to NCQA for recognition.

ZaneNet Connect Website Displays New Face

We are proud to introduce the redesigned ZaneNet Connect website, which went live in December. Its new graphics and updated text will better assist health care providers— including primary care providers, specialists, long term care facilities, clinics and hospitals (with an emphasis on medically underserved areas)— to take advantage of ZaneNet’s technical assistance to transform their practice.

Please visit us online to enjoy our new appearance and expanded services. Explore our practice transformation services that introduce practices to new systems of care and alternative payment models. Look into our telehealth services and software, designed to improve care coordination and on-going care management.

Be sure to check in with the individuals who make up our team and the history and mission of our company. Finally, take a look at our newsletter, the ZaneNet Connect e-News, and feel free to get in touch with us directly with any responses or queries. We’d love to hear from you.
PQRS in 2015: Meeting New Rules and Avoiding Penalties

Since 2007, the Physician Quality Reporting System (PQRS) has been a voluntary federal program, offering Medicare incentive payments to those who report quality measure data to CMS. However, the Affordable Care Act requires that CMS phase out incentive payments and instead apply penalties by 2015 to physicians who fail to satisfy PQRS reporting requirements. As a result, physicians who do not satisfy the program’s requirements in 2015 will be subject to a 2.0% penalty in 2017.

In January, CMS described the Physician Quality Reporting System (PQRS) as a “voluntary quality reporting program that applies a negative payment adjustment to promote the reporting of quality information” by eligible professionals (EPs) identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN), or group practices participating via the group practice reporting option (GPRO), referred to as PQRS group practices. Providers should check the CMS website to determine their eligibility to participate.

After February 28, when the window closes on reporting 2014 PQRS practice data, what do eligible professionals and group practices need to know to report successfully in 2015?

Reporting requirements differ depending on the reporting method selected, and certain requirements have changed for 2015. According to CMS, those reporting data for 2014 could choose among the following methods, some of which are provided on a fee-for-service basis.

- Utilizing an EHR Direct Product that is Certified Electronic Health Record Technology (CEHRT)
- Utilizing an EHR data submission vendor that is CEHRT
- Utilizing a qualified PQRS registry
- Participating through a Qualified Clinical Data Registry (QCDR)
- Submitting Medicare Part B claims to CMS

The extent of changes to this list is not yet clear. Further information will be forthcoming from CMS about the 2015 methods. It is known, for example, that an eligible professional reporting individual measures via claims or a qualified registry must submit data on nine PQRS measures from three different domains, one of which is from a list of “cross-cutting” measures, for at least 50% of applicable Medicare Part B patients. EPs who see one Medicare patient in a face-to-face encounter must report on one cross-cutting measure.

Further information on claims-based reporting can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/PQRS/Downloads/2015PQRS_Claims_Made_Simple.pdf, including verifying eligibility, understanding the claims reporting options and measures and establishing an office workflow to ensure that each measure’s denominator-eligible patient is accurately identified on the Medicare Part B claim.

2015 Data and the Value-Based Payment Modifier

In addition, the Affordable Care Act establishes performance-based programs that adjust payments to physicians based on the reported data from a set of quality and cost measures in PQRS. This data will be used to calculate a separate performance-based payment adjustment known as the Value-Based Payment Modifier. Starting with the 2017 payment year, the value-based payment modifier will apply to all physicians, and payments will be based on 2015 PQRS reporting. To avoid negative adjustments in 2017, it is imperative that providers report on quality measures into PQRS in 2015.

For both individual and group practices, the ZaneNet Connect team offers ready assistance with PQRS reporting, including informative webinars and individualized help from experienced professionals.
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patient or a consultation on the reason for an emergency room visit, and to schedule follow-up visits as necessary.

Understandably, patients can be confused about just what occurred during their emergency room or hospitalization experience, which may have brought medication alterations or new diagnoses. Abramson would like to see a next iteration of the system to include discharge summaries and other information about the experience, especially noting any changes in treatment. Ultimately, she would hope to get specialty reports directly; currently, obtaining this information often takes time.

Abramson has used the daily ENS reports to update her patient list, catching up with patients with whom the clinic had lost touch, to ensure that they will again come in for primary care, or learning that some former patients are covered because they have gone elsewhere for that care.

Looking at how Bread for the City patients have already benefited from ENS services, and pondering possible future changes, Abramson pronounces the ENS “a great system with lots of potential.”

ZaneNet will be presenting with Dimensions Health Care at the upcoming MHCC event

Symposium:
Advancing Telehealth through Innovative Transitions of Care Projects

February 25, 2015 | 4:00PM – 7:00PM
House Office Building, Room 180
6 Bladen Street, Annapolis, MD 21401