National Webinar: Milestone 3 Asynchronous Access

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Hello, everyone. I am Krystal Gomez from TMF Health Quality Institute. I'd like to welcome you to our national webinar entitled Milestone 3: Asynchronous Access. First a few announcements.

Today's program is being recorded and will be posted on the collaboration site. The slides for today's presentation are available for download on the collaboration site as of today. We appreciate the presenters' time and effort in preparing for and sharing your valuable knowledge.

Any statements regarding their technology, products, or vendors are expressions and opinions of the person speaking and not an opinion of nor endorsement by the Center for Medicare and Medicaid Innovations, nor TMF Health Quality institute, nor the host of the program. To enrich your listening and participation experience, here are a few tips.

All the lines will remain muted throughout the session. To submit questions, click on the Q&A tab on the right hand side of your screen. I would now like to introduce our speakers for today, Dr. Laura Sessums and a Dr. David Kendrick.

At this point, I'm sure you all know Dr. Laura Sessums. She's a general internist who joined the CMMI CPC team in December as division director of advanced primary care.

Dr. David Kendrick is an associate professor of Internal Medicine and Pediatrics and the Kaiser chair of Community Medicine at the University of Oklahoma's School of Community Medicine. In addition, he serves the university's Health Sciences Center as the assistant provost for strategic planning and the chief of the Division of Community Medical Informatics.

I'd now like to hand things over to Dr. Laura Sessums.

Thank you, Krystal. Today's webinar is focusing on Milestone 3, the requirement for 24/7 access to your practice's EHR for patient care. And the focus today is specifically on the program year 2014 Milestone requirement for implementing at least one method of asynchronous communication. With so many methods of communication available today, this can be a thorny issue for practices.

Of course, patients call the office and leave messages as they always have. Yet, many want to connect with their clinician or care team via email, text, on Facebook, you name it. As a physician, I want to allow my patients to communicate in ways that meet their needs, such as sending in a prescription renewal request in the evening when they notice their statin prescription is about to expire, say. But at the same time, this can get overwhelming and worrisome.

Some years ago, when patients first asked about emailing the office, I gave patients my work email address with verbal instructions on when to email and when to call. Simple communication on email about issues such as home blood pressure monitoring was certainly efficient and effective, and the patients really appreciated the ability to communicate this way. And I certainly found that their typed messages were often clearer than when they left messages by phone.

Yet, then the email volume increased, and I started worrying about missing emails from patients. And since no one but me could see these emails, that this communication method precluded team-based care. Then one of my patients, a man in his 70s with known vascular problems, emailed me from the ski slopes while he was having chest pain. Yikes, this was clearly a real problem, and it was certainly time for me and my practice to consider clear written rules for patients about how and when to use the various methods of communication with our practice.

So to use these non-face-to-face communication methods, you'll need to determine what communication methods your patients can and want to use and decide on which ones your practice has the resources to monitor and support. Importantly, the practice must decide how to communicate these choices to patients along with expectations of how to use them appropriately, unlike what I did back in the day, and when to expect a practice response.

In this webinar, David Kendrick gives a very helpful overview of these various communication methods and lots of practical guidance on what a practice needs to consider before choosing to use one or more of them.

Now, I'm going to turn it over to Dr. Kendrick.

Thank you, Dr. Sessums. So welcome to this webinar. I hope you'll find it helpful. I've tried to really focus in on practical elements. And along the way, please use the Q&A box to ask questions. I'll try to answer as we go if they fit in the time line. Just clicking here.

All right, so the agenda, first to review the requirements. Next, to compare those with the meaningful use requirements, which you're also grappling with at this point, how to choose a solution, and then operationalizing the program, and maybe some important considerations along the way.

So the terms and conditions, as you know, for Milestone 3 read like this. First, attest that the patients continue to have 24-hour/7-day-a-week access to a care team practitioner who has real time access to the electronic medical record. And you did that last year as well. You'll continue to do that this year.

Implement at least one type of opportunity for care provided outside of offices, for example, through patient portals, through email, text messaging, or structured phone visits. And we'll talk about each of these today.

And then, of course, when you implement a capability, you've got to figure out how to message that commitment to the patients that you're taking care of and the families that are caregivers for those patients so that you can be certain to keep track of it, as Dr. Sessums was indicating a moment ago.

So the intent of Milestone 3 is to increase access to care outside of the traditional office visit. And as I've already mentioned, 2013 had that requirement just for EHR. And now in 2014, the level of interactive communication is being raised with this opportunity for care and consultation outside of the office visit. And I think we all know that as providers, we do a fair amount of between visit care, and this is an approach to formalizing that into our practice routines.

So the guidance says communications can be synchronous.

That is telephone call or video conference. And by synchronous I mean both parties live on the interaction at the same time. Or asynchronously, such as text messaging, instant messaging, email, eVisits, and any number of other things that have been developed in the last 5 to 10 years.

So the quarterly attestation at this point is to attest quarterly that you have 24/7 availability of medical record to the provider caring for your patient, and now that between visit care communications are happening. And so what you'll need to attest is that you first identify the approach that you're using and then estimate the amount of time that provider and staff will spend. And presumably then you could true that out, adding subsequent quarterly, meaning that is — report actual time spent.

And then some indication of how that option is being communicated to the patients. Is it a brochure? Is it verbal communication at the end of a visit, et cetera?

So when I approach this question, first I wanted to know what are the — what's my rubric for evaluating the different options that are out there? And so I thought first I would identify the options that met the requirements.

Second, look at those options for efficacy. Do they actually have any evidence in the literature that they've improved care, access to care, outcomes, or reduced costs? And then estimate the cost of those options, because these are not free things to do in our practices. At a minimum, they take staff time, but some of them also require technology purchases, and implementations, and so on.

And then of course, we've also got to talk about risk in the setting of new kinds of communication. We've got to make sure that risk is covered as well.

And then finally, because we've got lots of other things going on in our practice at the same time, of the lea least of which is meaningful use, but other things that we're doing in terms of quality and performance, we want to make sure that this investment aligns with the other directions that your practice is going.

So the options identified include from the most simple to the most complex, phone, protocol, secure email, texting, direct messaging emails. That is the new ONC protocol for secure email, is called direct messaging. A patient portal, that also includes direct messaging, or a patient portal with more advanced structured electronic visits with patients, which I'll talk more about in a moment. Or a patient portal with structured visits and even perhaps live video consoles or live video streaming.

And so when I think about considerations for that range, I also want to make sure that we've got stage two meaningful use in the mix as well. And I know everybody's trying to work out exactly how they're going to adhere these things, but let's just review quickly what the requirements are.

Typically, this is referred to as the VDT requirement, which stands for view, download and transmit. And in stage two of meaningful use, patients must be able to view a summary of their record in a web based format. They must be able to download a copy of their record and transmit it or share it to someone else, share it with someone else on their care team, or perhaps even a family member. And then finally, they have to be able to review an activity log on their VDT activity, so they can basically audit how their information is being shared and where.

And then, of course, the performance requirement, which is the thing that really makes most providers swallow hard, is that first of all, 50% of our patients have to be provided with electronic access to their record. But more importantly, 5% of those patients must actually access that online record. And so generally, I believe most practices and certainly large health systems are rolling out individual patient portals, which we'll talk about more in a moment for those health systems or practices.

And so, here's the potential solution spectrum that I was referring to earlier with the telephone protocols on one end. And when I say less and more complex here in this arrow, I mean technologically speaking. But certainly a telephone protocol can be every bit as challenging to manage from a staff perspective as an electronic protocol.

Secure email or texting, secure direct email, that's the ONC standard for secure emails. Online patient portal with unstructured eVisits capabilities, and typically that could be direct email or other kinds of emails. And then an online patient portal with structured eVisits, and when I say structured eVisits, I mean the use of templates to gather specific data from the patient and then answer specific questions. And then finally, the online patient portal, the structured eVisits and some synchronous video capabilities, which is probably on the higher end of the complexity spectrum.

And then, of course, I wanted to highlight here which of these qualify for stage two of meaningful use from a technology perspective. Of course, any technology you choose to meet meaningful use with has to have the ONC certification stamp on it, so be aware of that. But from a capabilities perspective, everything in this outlined box should meet meaningful use as long as the technology itself is certified.

So some considerations for making a decision about which end of that spectrum to work on or where you are in this. And so the first question about what kind of investment to make I think comes down to a supply versus demand question. And that is, do you have an oversupply of visits or an under supply of visits for your patient population?

Or do you generally find yourself with your next available appointments being very far out, and therefore you really need some mechanism of increasing capacity in your practice? Or do you find that you have plenty of capacity left in your practice, and you want to leverage the technology to try and get your patients who need to be seen off the couch and into your clinics?

So third next available appointment is something you may or may not be familiar with, but that's a standard way that is used in health services research to decide what capacity in the health care system is. So you look at your schedule, and you determine not the next available appointment or the second next available appointment, but the third next available appointment and how soon is that. Generally relates to the businesses of your practice and your schedule.

And then, of course, you want to get ahead of these all important post hospital, post ER, and post-operative visits and get those in your practice in a timely fashion, especially now with reimbursement tied to these things and certainly shared savings will have — these elements have a big impact on shared savings.

And so once you decide where more demand exists, if you decide you need more available visits, then you can use these eVisits to expand your availability, that is to handle questions from patients that don't necessarily merit a full office visit to take up a slot, but they can instead redirect the patient with some education, maybe a prescription, to manage their condition at home.

But if you're on the other of the spectrum and have excess visit availability, then you want to think about how to use these technologies and tools to use your excess or idle time that you might have in your practice, or your staff might have to focus in on your higher risk patients and deliver services to them. Because as you know with shared savings approaching, it's not necessarily the patients who choose to come to see us that are the ones that need the most touches and the most guidance in managing their care. So this is an opportunity with these eVisits to perhaps to do more engagement with those higher risk patients.

So, of course, another consideration is cost, and you're going to want to factor in what those costs are. So you're going to have the technology costs, which will be both usually an initial set up and some ongoing fees, staff costs, time. And if you're going to work to build a telephone protocol from scratch, that's going to take some staff time, but so is managing an online environment, a portal, and handling structured eVisit capabilities.

Provider costs, of course, it's your time as well. It's very important to manage here. And if you choose a system that is in Dr. Sessums' example at the beginning — emails you directly and has you on the hook for answering these things — that often is considered a bit risky, because when you get busy or you go on vacation, that inbox really needs to be monitored by someone else. But even important in this situation is that if you have sole responsibility for that inbox, it could take you away from clinical time, and you need the ability really to delegate the access. And so more sophisticated technologies provide those delegation capabilities.

And then revenues, there are a couple of things to think about on the revenue side, of course. First of all, I see you have a question about this, and so I'll answer it now. And that is some payers do reimburse for eVisits. There is a body of literature out there that demonstrates the possible improvements and outcomes but also reduce costs from having eVisits. And so a number of payers will actually reimburse for these, but it varies significantly from region to region and from payer to payer.

So it's important to do some research on that. And of course, once you do that, you're going to have to figure out what the documentation burden is for those eVisits. You're going to make sure you adhere to those completely.

An unfortunate challenge, of course, at this moment is that not all payers do it the same way or using the same codes, and so you'll have to nail that down. And certainly that would be, in my mind, a topic for the larger CPC community to centralize the knowledge on once you guys begin gathering that information. It'd be a tremendous resource, I think.

And then, of course, the real reason or, the most important reason, we want to increase availability and access for our patients is to make sure that we're helping those patients make the most efficient use of the health care system and getting access to the input they need when they need it, not just when they haven't had a visit scheduled. So if we can avoid ER visits and urgent care visits by using these technologies, then the potential to earn shared savings from that will also increase.

So the most basic of these from a technology perspective, not necessarily from a clinical perspective, of course, is the phone visit. It requires no new technology. You can put protocols in place for common conditions, UTIs, URIs, allergies, and so on. But it does require a good documentation process, and then there is risk in not documenting phone notes and the use of phone visits. So you're going to want to make sure that you have a protocol in your practice for getting these kinds of things documented.

And another thought here is that phone visits should be scheduled so that you can — especially if you're in the second group where you want to make use of idle time for staff to get phone visits done, or even yourself. Try and get those on the schedule. So blood pressure follow ups and checks, post visits for certain kinds of acute visits, they're all pretty amenable to phone visit protocols.

And there are a couple of excellent resources I came across as I was researching this that you want to consider using to guide your creation of a phone visit protocol if that's the route you choose. The first one there is a nursing continuing education site, but it's all about doing phone triage, and the different gotchas, and the kinds of patient categories that you probably shouldn't handle on the phone, and others that you could handle on the phone, red flag alerts.

Things like a child with confusion is never something you want to deal with on the phone. That's something you need to get into care immediately. Those kinds of things are all available on that site, and it's freely available, though you can pay and get the credits if you happen to be a nurse.

And then the second category you probably know well, and that's the national guideline clearinghouse. And that's a good place to start in writing your protocols.

The next category is eVisits via email. And email has lots of connotations these days, but generally enables patients to communicate with a provider asynchronously. And there are 3 types that I think about.

One is unsecured email. That's the general inbox that you and I have today that we use with friends and family. It's unsecured, Gmail, or Hotmail, or whatever your preferred flavor is.

And then there's the security email, and that is usually what folks have today who have patient portals, and that requires you to email someone a link. So when the patient clicks on the link, they create a user account, and then they're looking at the email. And it's very much a closed system.

And the challenge with those, of course, is that when patients have multiple doctors or get seen in a couple different health systems, they've probably been required to access several different secure email systems, which creates basically an adoption problem. Why would the patient keep track of 5 or 10 different email addresses and passwords for their bank? They certainly wouldn't do that. They don't particularly, I find, want to do that for their clinical environment either.

Now the unsecured email, I should point out, if you're using unsecured email, you make sure that you've got a documented patient consent for that or that most people say that if a patient has initiated the emails, rather than they've consented to communication in that environment.

And then the last is this direct email that I alluded to earlier. And the direct protocol is a new federal standard that's required in stage two of meaningful use, so it should be built into your electronic health record systems, in your upgraded systems, your 2014 version of those systems. Or you may have subscribed to direct messaging through a health information exchange or another system.

But the idea behind direct email is that you can securely email anyone in the direct ecosystem, that is someone that uses a direct protocol who may be completely across the country and using another health information service provider. You should be able to reach them through the direct protocols. Now, this is early in its development, and the protocols are pretty well set. There's an organization called directtrust.org that certifies, but there are other certifying bodies for these.

And so it's like the early days of the internet — or even really I should say the early days of email — when we had various communities would have what was called a bulletin board, and geeks at home — I guess like myself — would dial into those bulletin boards and would tee up a message. And that message would get sent from one bulletin board to the next bulletin board to the next bulletin board as they dialed to one another.

And direct email works somewhat analogous to that, in that my HISP, or health information service provider, that I get my direct account from has to have a connection to the other HISPs around the country in order to move my message. But once they do, then we can be confident of a secure end to end messaging standard being in place. And since it's now a requirement and should be available to you in your EHRs, I think that provides a pretty good option for secure email.

Now, what comes up next is I have four slides on some best practices for eVisits. I discovered these online, and I've used them for a number of years. They're put together by Dr. Scherger, who was — and they're posted on the TransforMED site. You see the link there at the bottom of the page to get back to them. But I find these to be very helpful in thinking through my communications with patients.

First of all, offer email visits only to existing patients whose medical history you are familiar with, rather than the patients you've never treated. It's bad to meet somebody the first time over email.

Second is keep complete records of your email exchanges or direct messaging exchanges. One of the benefits, of course, is that it documents the full exchange completely to do an email. You're going to want to develop some terms of service, and phone consent, and any other legal documents with your professional legal counsel. And I didn't actually do a deep search, but there are probably samples of this that you can find online.

And be upfront with your patient about any fees, if you're going to charge them a copay or something on that. And then, of course, give them the ground rules. And ideally you give them those ground rules in writing. And you should probably include in those ground rules the kinds of transactions and email that will get them, not fired from your practice but certainly eliminated, or remove their email privileges from you, because you're going to want to have that option, unfortunately.

And then you're going to want to establish an expectation for the turnaround time for messages. Are you going to be doing these in 24 hours or 48 hours? And this, of course, highlights the real importance of creating this account as one that not only are you, the provider, able to see and read, but that your staff are monitoring and staying on top of, just like the voicemail inbox in the clinic.

And some additional best practices here. Use a disclaimer. Make sure that your signature line in your email or your signature block says at least these words in it and anything else that you think is important or relevant. You want to clearly differentiate between online consultation for an existing condition and online diagnosis and treatment of a new condition, and try and be clear which of those you're doing, and implement a policy for each of those types of interactions. And then if you find yourself emailing back and forth with the patient several times on a topic or an issue, it might just be best to recommend that the patient schedule an appointment so that they can get their issue dealt with definitively and in person.

Always clearly communicate the follow up plan and the next step to the patient. You're going to want to make sure you have a method for tracking the follow up on that, but it's almost like we learned in grammar school, the essential components of a short essay, the essential components of communication with a patient, or to make sure that you restate what they've said they have, or is there a concern, and that you indicate what you think might be going on, and that you indicate what the follow plan might be. And generally, I find it helpful as well to always include a statement at the end saying please call me if any of this doesn't meet your understanding or your expectations so that we can further explore it in detail.

If you provide links to other materials online in the email, make sure that you've vetted those and that they're credible and authoritative. There are several National Library of Medicine sites, NIH for patients, and so on that are helpful, and you can Google those, of course. But I find that those sources are kept accurate and up to date.

As always, communicate professionally and politely. Never say something in an email that you wouldn't say straight to the person. And I would say even better, never say anything in an email that you wouldn't say to the person with other witnesses present. Make sure you stay professional there. Don't use sarcasm, irony, or jokes, no matter how well you know the patient, because these health care communications are part of the legal record.

And then finally, don't use abbreviations with patients. Limit the use of them. Check spelling. Evaluate your grammar. Make sure that you've stated things clearly, no misplaced modifier, and so on, because at worst, they can harm the patient, and at best, they really don't reflect on us well as professionals.

And then append that standard signature block, as I alluded to earlier, with all of your full name and the contact information for the clinic and of course, that information I showed you earlier about the security of the email exchanges. And then make sure that inappropriate — to call out inappropriate uses of secure messaging with the patients, and make sure that's in any information you give them about it. And of course, you're not going to want to email patients bad news obviously.

So that concludes emails. The next step up in technology is to use a portal with direct email, and my presumption would be that you would be using a portal of some sort since that's a meaningful use requirement now, not a Comprehensive Primary Care initial requirement, of course. That is purely a requirement of meaningful use.

And so a portal, of course, is an online environment where the patient can log in and access their information. And it's used primarily in the meaningful use sense for that view, download, and transmit that I was describing earlier. And some of those provide secure messaging as well, and a few even provide direct messaging.

The advantage to a portal is that clinical data in the portal can be exchanged with providers and that the direct messaging in some portals allows patients to interact with all their providers. So that for example, rather than coming to my practice and picking up my business card out front with a phone number and a fax number only from my clinic on it and maybe a generic public email address, instead I can present our secure email addresses as well, our direct email for those patients who have access to direct messaging.

And so, an online patient portal with eVisits, as I said earlier, most EHR vendors are offering such a patient portal. It usually integrates patient data from those EHRs into the portal. And as I said, direct messaging seems to be a coming format in those platforms.

Other vendors of patient portals, not necessarily your EHR vendors, have additional or separate features. Maybe they support care management, more capability. Maybe they keep caregivers in the loop and allow more interaction with caregivers. And so, one in particular that I want to talk about today

— and of course it's a commercial system, but it is free to patients, and it has some advantages that I'll talk about. But there are others out there like this. I'm just using this as an example.

And in our community we realize that every patient, every practice, and every hospital system was standing up their own patient portal system in part to meet to meet the meaningful use requirements. But also in part, frankly to help brand and market the practice or the health system to patients to help bring patients in and further engage them in their providers. And so that's very helpful, except that what we're seeing evolve, I think, is that patients who see more than one provider — which is almost every patient — are being asked to log into different patient portals. And then that effect of that we think is decreased utilization of any given patient portal.

And so HealthVault was attractive, because it was freely available and could be connected to by any other patient portal. It also includes direct messaging for patient use. It also has home device interoperability — which I'll show you more about in a moment — and it is now certified for stage two of meaningful use, which is helpful for providers.

So this is HealthVault. This is my account, my personal account. It's not very fancy. I haven't put a skin on it or even a photo in it. But you can see that it has all the major components of a medical history on the page there. And I can log in and manage each of these myself, and I can even manage permissions on them as well.

You can see here a sampling from blood pressure management, and I have a blood pressure cuff that anyone can buy at Walgreen's for $40, or Walmart, or any of the big box — or even independent — pharmacies have these devices. And they have it come with a USB plug or even a Wi-Fi built into them.

And through that connection, the patient can upload their blood pressure readings. Or there are glucometers now. I think there's a glucometer that's only $18 that will upload its data to these HealthVault portals. And so that's a really helpful capability to have built in here, because then the patient has the capacity to send me that.

I also have a set of scales, Wi-Fi scales. They're about $100, maybe $110. And every time I step on the scales, my body weight, BMI, and body fat estimate are all transmitted into the system so that they're uploaded here. If we're managing patients with congestive heart failure, renal failure, or even just obesity management, this is a great option to have in the patient's home. In fact, I've often thought that hospitals discharging patients with CHF would be wise to send them home with one of these sets of scales so that the primary care provider could do more monitoring.

So in this environment, what you see is the ability to have pretty rich interaction, not just with the patients having to enter their own data, which I think is the downfall of most patient portals. Because patients generally speaking don't want to spend more time thinking about their health than they think about other things in their lives. And for them to sit down and type in all their data, they're going to have to have a block of time.

In the case of this system, you can actually push their data out for them to their HealthVault account by sending a direct email to their HealthVault account, and then their data from say a CCD — a Continuity of Care Document or CDA, which is a new format for patient chart summaries — could be uploaded and attached to their HealthVault account. So they'd have a starter set of their information.

And then, of course, other kinds of devices, you may notice the explosion of consumer health devices out there now, everything from EKGs on your iPhone to now Fitbits and activity monitors. And these activity monitors are very interesting from my perspective as a primary care provider, because now I've got not just what's your activity level, but here's some objective measures of the patient's activity, calorie burned, and even diet in some cases when they enter that information. This happens to be a Fitbit, but there are lots of other tools out there from Nike and others.

And one of the things I find interesting about these tools that I'm excited to start using in my practice is the sleep patterned tracking. Some of these tools actually track patients' sleep patterns, which can be very helpful.

So those are some of the capabilities of a patient portal, and I really appreciate and enjoy the ability to have device interoperability. But now HealthVault also has direct messaging built into the system. And one of the things that you may know — and I've actually got a question here about it — with direct messaging is that in order to be a participant in directtrust.org, which is a certification level, the organizations, the protocol requires that the recipient of a direct address be identity proofed or that their identity be verified at the time of receiving that address. And that's how we know that people aren't just creating these direct accounts and spoofing or impersonating someone.

And so in our situation, when we use HealthVault's direct messaging, when we connect to a HealthVault account from our environment, we basically do so with the patient in the clinic where we can identify the patient and get their address. And that's something you might want to consider doing for yourself.

Now, the directtrust.org still leaves the option up to HISPs or the direct email providers as to whether they're going to insist on only communicating with systems that are in directtrusr.org. But many are for reasons of having direct email of patients are not restricting themselves to that environment. But it is a good idea to know when you're receiving direct emails to have confirmed the identity of the patient and their address before you do that.

So what you see here is my direct messaging account in HealthVault, and it looks like any other online or web mail tool. And when I open to send a new message, you can see that the from account is me in my HealthVault account, and then I'm sending it to myself on our health information exchange.

And I'm just crafting a message here about blood pressure control, asking Dr. Kendrick, letting him know my home blood pressure readings have been getting higher and I'm wondering about a medication change. And you'll see these other two buttons here, Attach Health Info From HealthVault or Attach A File.

If I choose Attach Health Info From HealthVault, you see that I get a picker here where I can actually choose the different kinds of data that I want to attach to this email and send across. And I can choose all dates or a specific date range.

And then when I attach those, this is the information. It allows me to preview what will be attached. You can see my blood pressure's here in a tabular form to this message that now will be sent in to the provider. And then once sent, I get a receipt back from the receiving end that this message went across.

And so now I'm the physician looking in my direct inbox, and I can see here this message from patient David Kendrick, and see the message there. And you also see the HealthVault recorded data as a CCD attached there. It's an XML file. And if I click on that open it, now I'm looking at this patient's chart within from just that email.

And so if I scroll down through this, I get down to the bottom here of the day that it came off of the home blood pressure monitor, and I can see the trend in home blood pressure readings there. And so then I can just generate a response, and say here's what I'm going to do with your medications or you need to come see me, whatever the response is. And I have a log of everything that went on in that transaction.

So that's a pretty nice closed loop, and it's entirely free to have that kind of interaction with your patients, using a tool like HealthVault, or perhaps others as well. Now, the other thing that I've found helpful about this particular tool and is a good feature you should look for in these tools is the ability to have proxies.

And so you can see here I'm in my personal as a patient account for HealthVault, and in here I have proxy capabilities on, say, my elderly parents or my kids. And so my son happens to have pretty bad asthma, and so I can drop into his account and see his peak flow meter readings that have also been uploaded from his digital peak flow meter. And I can send a similar email to, say, his pediatrician about what his control has been for the last day or two or week on his asthma. And it allows then me as a parent or a caregiver to coordinate care for a number of folks in my life just by using these free tools.

All right, so that concludes the basic portal, a free portal with direct messaging. Then you get into the more advanced kinds of messages, which are structured eVisits. And as I say, they're more advanced. And typically there are condition specific templates that you would use, like choose which of the 10 things your messaging is about.

Is it a rash? Is it a fever? Is it a cough? And each of those chief complaints would lead the patient down some logic tree that gets the appropriate history gathered from the patient so that I can use that in responding to the question, or my staff can use it. And typically structured eVisits employ some workflow to them.

So you notice in the previous example, really it comes down to patient using a blank sheet email, provider using a blank sheet email, and maybe the provider has some protocol where I would have my staff monitor that inbox and maybe even answer certain questions.

Well, eVisits form, the good ones, as far as I'm concerned, allow you to do some workflow so that maybe you have a triaging person in your practice who can triage these cases and route only those that are most important over to the provider. Now, you could accomplish this in direct email as well, but it might not have all the same bells and whistles to it. And of course, the eVisits in a structured form usually have more robust reporting as well.

Now, the last category on the far right into the spectrum we talked about are these video visits, which are synchronous. I consider these to be telemedicine, and of course telemedicine is reimbursable in some situations and coming from certain groups — I mean, coming from certain locations. So Medicare rarely, as far as I know, reimburses for telemedicine to the primary care office. Although it might do so in certain states and in certain rural areas.

But other places like critical access hospitals and others are places where telemedicine can be reimbursed. But it does require the patient to have equipment, which is every patient has Skype now, even in the palm of their hand on their phone. So it's not quite the heavy lift it used to be.

And as I mentioned, Skype or something like Skype, the Apple equivalent, could technically be used, but you're going to want to make sure that encryption levels are appropriate or that you get patient approval to use that technology. And of course, you're going to need to document the video visit in your chart. So it's just like a face to face visit, except that you would be doing it over video, so you really should have a documentation of that in your chart. I'm not aware of anybody who actually records all of these visits and saves the video, but I suppose that could be done as well.

So how do we operationalize these eVisits? We talked about quite a spectrum of capabilities and technologies. The first is, how do we communicate it to the patient? What message are we going to give to our patients about the eVisits? Are they going to get brochures, handouts, or emails?

That's something you want to be very concrete about doing. You want to add your practice direct messaging address to your appointment cards, I would suggest. And one thing I tend to counsel physicians I work with on is it's probably a good idea to have a direct account for appointments, maybe a direct account for refills, and so on so that you can break out the workflow. And then of course, your individual staff can monitor those.

And then enrollment, where will the patient account be created and given to the patient? And this comes back to that definitive identification requirement. You're going to want to make sure that the patient gives you their account in person, so you know that that's somebody that you can accept messaging from and that you know their identity.

And then what training will the patient receive? Again, they're going to want to make sure they understand everything in the literature you give them about this, but you're also likely to want to have somebody in your practice at least go through what's appropriate and what's not for these kinds of messaging.

Then support, how will the patient account be serviced? If you're doing it internally, say, on proprietary email or in a proprietary portal, you're going to have to manage the patients' password changes, give them tech support, and so on. If you use a free portal like with HealthVault, patients can manage their own password changes.

And then, of course, what is the escalation path for concerning messages? You're going to want to have what I always call concentric rings of notification. You're going to want to have after a certain period of time additional people looped into messages that might be concerning.

And then monitoring, who's going to monitor the communications and ensure timely responses? And how do we deal with inappropriate use of the system? And I alluded earlier to the fact that in your literature, you're probably going to want to have the right, the option always to refuse to do eVisits with certain patients or for certain conditions.

And then finally, risk and liability, this is one that everybody appropriately wants to discuss and understand. And the issues with risk and liability are numerous. First of all, you're going to want to make sure that you have critical policies and procedures documented and in effect before you do these kinds of activities. You're going to want to ensure that the patient consent documents clearly call out the fact that you have a patient portal and not give them access to the patient portal, or that you would use eVisits with these patients.

And if you're entertaining doing eVisits, emails, or video conferencing with a patient, you're going to want to consider adding a telemedicine writer to your med-mal insurance. In my experience, that's as simple as checking an extra box with your provider, but you're definitely going to want to have the backup from your med-mal provider that you do engage potentially in telemedicine activities.

There has never been shown any additional risks, and telemedicine visits have generally been seen to be as safe as face to face for what they're used for. That is there's not a big case law indicating that telemedicine is risky or anything. And therefore, most med-mal insurers — in fact every one that I'm aware of — doesn't even charge any extra for it. But it's just important to make sure they're aware that you might be using these new modalities. And then, of course, you're going to want to make sure your consent documents have these new modalities in them.

So I've got a couple of questions here that I want to answer. One is, what do we do if our patient population is elderly? I mean, how do we get, for example, 5% of them to use the patient portal. And I agree, that's a challenge we struggle with.

One of the things that I've done in the past when we want to get something, say, a risk assessment tool or a piece of communication that happens to be digital out to patients is really to focus on their caregiver, if they happen to have a caregiver that comes with them to the clinical environment. And grandkids are also a great way to get the elderly connected to technology.

In fact, sometimes I think — I showed you the proxy tool where I was able to drop into my son's chart. You can imagine if you were taking care of your elderly mom or dad, it would be really helpful to have all

their medications and records in one place. And so it may be that the caregiver, not the patient, is the target of focus for getting this kind of capability launched.

David, this is Bruce Fink. I might also say, just taking a line from your previous slide for that particular practice, this might be a reason to look at a less technologically intense form of access.

Absolutely.

And you might like phone visits.

Yeah, absolutely. Yeah, I tend to talk only about the technology piece, but the phone is just as valid a mechanism for engaging patients in between visits. Thanks, Bruce for bringing that up. Any other questions?

Dr. Kendrick, it looks like there's a question from Dr. Holly Miller.

OK.

For a directtrust.org providers, do they need to be level 3 ID proofed?

So that's what I was alluding to when I was talking about the difference between directtrust.org certified HISPs, or health information service providers, and others is Direct Trust does have a requirement for identity proofing, but it doesn't necessarily prevent you from connecting to systems that don't have that level of identity proofing.

But my strong recommendation is that you should know who's on the other end of that account you're communicating with, which is the equivalent of level 3 ID proofing. And so in our practice, patients who we are willing to do electronic mail with have either been given the account by us directly, which is what happens with a proprietary patient portal, or they share with us their direct account when they come to the clinic so that we can know that a message coming from them is indeed them. So I agree that's a really important element to have in this brave new world.

David, there's one question —

[INTERPOSING VOICES]

Go ahead.

Did you have another question that you were going to ask, Krystal?

No, I don't see anything else in the question and answer tab.

There was one question that was asked that's more I think directed to CMS privately in the chat, but I think others may be interested in. So I'll — this is Bruce Fink. I'll recap the question and then answer it if that's OK.

You had pointed out, David, that meaningful use requires a certain threshold percentage of patients who use the portal for meaningful use requirements. And the question was asked, does CPC have similar kinds of thresholds or numbers that we require for this Milestone. And the answer is no.

For those of you who looked through the web app reporting summary for the quarterly reporting, we ask that you tell us what you're doing and tell us how you're communicating that and communicating expectations around it with your patients. So we can get a sense of what you're doing there. And that you count — that you have a sense of how many folks are using it and also how much of your staff time it's requiring. I mean, this is all — these are all things you'll want to know — as I think Dr. Kendrick pointed out really well. You need to have an understanding internally of what resources this is taking.

And then you are in the position to assess whether to expand it, and how quickly to expand it, and how much to use it. We recognize that this is moving into new territory for many of you, and I think the idea of testing small and then gradually increasing as you gain confidence in the technology and comfort with it is a proven way to go. So we don't set — again, CPC doesn't set any thresholds. We just ask that you monitor how it's being used and how much of your own staff time you're allocating to this resource.

Yeah, this is David again. I would agree that I this is a situation where everybody's going to need to figure out their own way through the requirement. And in that vein, I think some vignettes or some messaging back about how you find it helpful or not would be helpful too to get over time, even more than just the time spent. But some specific cases if they become of interest.

And you pointed out, David, that there's some areas for sharing here about what a purchase people are taking. And of course, that's been a place the collaboration site has really helped us. Many of you have shared experience or approaches that you're taking on the collaboration site, and we get some good conversation going back and forth on that. So that's a great way to begin to take advantage of the large community of innovation that we have here, both nationally. And of course, also there'll be opportunities within your own regional learning communities.

Great. I see another question has popped up. It says can you clarify whether patients can sign up independently for a direct email address, or do they have to be assigned one through the use of a portal or HISP. The latter is my experience. And I would agree that's typically the way this is done, but I would — the example I showed you in HealthVault, every patient whom has a HealthVault account has a direct account as well, at least the way it's configured.

And that's why I wouldn't limit my communications via direct with patients to — I mean, I would make sure that I'm aware or that you're aware when you are doing direct messaging with a patient, if you didn't actually give them the account through the portal or HISP, they may have received it themselves by logging in and creating their own account. And in that situation, that's the one where we find it most critical to make sure the patient themselves gives us a copy of their address so that we know who it is when it comes in. And actually in our workflow, we have the ability to assign or link the patients' HealthVault account with their account in the health information exchange, and that's very helpful for making sure the patient's identity is what they say they are.

Dr. Kendrick, it looks like we have one more question, and while you're answering that, if you could pass me the ball, I'll cover the last couple of slides.

Okie doke. What is that question? I don't see it.

It says if an insurance company doesn't cover eVisits, can you charge the patient for an eVisit?

I think we're free to charge patients for anything we want. And in fact, I'm aware of systems that state very clearly up front, run your credit card first, and then you can ask your question. So it is possible for you to charge for your services just like anyone else does.

Now, whether that conflicts with a contract you might have with that insurance company, I don't know. You're going to want to make sure that your contract with that particular payer doesn't forbid you from charging other fees or whatever; but generally speaking, I think we're professionals and allowed to establish our fee schedules.

And, David, I would point out from a CMS standpoint, of course, that — or from a CPC standpoint simply — the aim of this Milestone, it's not primarily a revenue enhancement Milestone. It's great if you have avenues for charging services to increase access. That's terrific, but the idea here is to, again, use the enhanced payment resources as a framework for building more comprehensive primary care.

So I would say to meet the Milestone requirements for CPC then would be to figure out how you can do that in a sustainable way that doesn't involve necessarily charging patients for these services, and certainly not Medicare patients for whom I think by law you've agreed not to charge additional beyond Medicare for these services.

Thank you for that. I suspected each payer might have their own opinion on that, so that's good to know. I don't see any other questions there, Krystal. Do you see anymore that I'm missing?

Great. I do not. So I'm just going to quickly point out that on March 11 at 1 PM, come prepared with questions and copies of your survey results for a very informative webinar called Put a Feather in Your CAHPS, reviewing your CAHPS results.

We also have two deep dives coming up, one on the behavioral health integration and also on self-management support on the 18th and the 25th. There's a CPC attributions refresher and a national open mic event coming up soon as well.

So, this concludes our webinar, and I want to thank you so much for attending. We hope that you found this presentation very informative. You can exit this session by clicking on the File menu option at the top left of our screen. Select the option to leave this session. You will be taken to a post-webinar survey that needs to be completed in order to receive credit for attending this presentation. Thank you so much.