Electronic Health Record Association
Briefing on COVID-19 and Health IT
June 18, 2020

Panelists:

- Janet Campbell, Epic
- Michael Oppenheim, M.D., Northwell Health (NY)
- Kristen McGovern, Alliance for Connected Care
- Hans Buitendijk, Cerner

Role of Health IT

Janet Campbell began her presentation explaining that the role of EHRs and health IT in responding to the pandemic was "absolutely pivotal." Developers not only created new code to support providers caring for an influx of COVID-19 patients, they also helped healthcare organizations to turn on or optimize the tools already built into their EHRs, such as triage logic. Most importantly, EHR developers were well positioned to disseminate news and emerging best practices across their user community.

As the pandemic took shape, developers responded rapidly to organizations using their products, through the creation of new dashboards and planning for increased capacity, sharing regulatory updates, and communicating best practices across organizations. EHRs and national networks such as Carequality and Commonwell were invaluable in supporting emergency surge sites, by enabling physicians to access patient records from tents and convention centers.

When the government quickly moved to allow expanded use of telehealth as part of efforts to flatten the curve, the use of video visits exploded in healthcare, as it did in other industries, and developers helped facilitate clinicians' adaptation to the new platform of patient care. Today, healthcare organizations are beginning outreach to patients to re-establish in-person and virtual visits to care for patients who skipped appointments during stay-at-home orders. However, concerns remain about telehealth waivers attached to the declared public health emergency and how organizations can continue virtual outreach if these waivers are not extended.

Going forward, healthcare organizations will focus on increased testing and contact tracing, as well as mitigating the financial hit caused by the pandemic.

The Provider Experience

Dr. Michael Oppenheim laid out the experience of New York's 23-hospital Northwell Health integrated delivery network. When the pandemic began, their "surgical volume plummeted" as only the most urgent surgeries were scheduled. The ER volume likewise dropped dramatically as patients with non-COVID-19 illness or injury avoided coming in. "We were basically almost all-COVID hospitals."

In its pandemic response, Northwell relied heavily on its EHR, including for situational awareness; preparing for the surge; streamlining provider and hospital administration; staff and patient safety; telehealth engagement with patients anxious about coming in; clinical knowledge dissemination, such as the latest

protocols and recommendations in a fast-changing environment; and research, including making physicians aware of clinical trials that their patients may qualify for.

Data from the EHR was "absolutely critical." Northwell's data was used to create dashboards that answered operational questions, including hospital occupancy rates, patient acuity, and resource needs. Through the dashboards they could identify regions with surge needs and support the creation of full network connectivity for hospitals setting up tents as they ran out of physical space.

To reduce risk to staff and minimize use of personal protective equipment (PPE) supplies, the hospital deployed two-way communications with COVID-19 patients, including continuous monitoring of vital signs through wireless sensors, reducing the number of times staff had to enter the room. Technology also allowed for video chats between patients and family.

Dr. Oppenheim expressed appreciation for government telehealth waivers and other regulatory changes, calling them "critical for success." To prepare for future crises, he recommends addressing:

- Eliminating redundancy in public health reporting
- Quality program delays
- FDA limitations around monitoring devices
- Limitations on data sharing across organizations

During this public health emergency, Northwell received separate data requests from city, county, state and federal agencies. The hospitals report similar data to all of them, but the data are not shared among agencies, nor is the aggregate data shared back to providers to aid in planning efforts.

Telehealth: COVID-19 and Beyond

Kristen McGovern discussed how telehealth has been a key part of the pandemic response. "The COVID-19 pandemic resulted in a massive increase in the use of telehealth" thanks to waived regulations, such as allowing equivalent payment for visits via telehealth and allowing providers to practice across state lines.

Early physician reactions to the transition to telehealth have been overwhelmingly positive, with a majority supporting a permanent shift to telemedicine. "Telehealth has been the biggest and most impactful tool in their toolbox" during the pandemic. Positive reaction from physicians, patients and healthcare organizations sets the stage for increased use of telehealth moving forward, with expectations that it will be the biggest driver of healthcare innovation in the next year. Per Stephen Spielman, SVP of Houston Methodist Physician Organization, "The genie is out of the bottle. Telehealth is our passion now."

To support this shift to telehealth, actions to implement permanent policy changes and expanded access to broadband are needed by states, Congress and federal agencies, including:

- Congress - legislate Medicare reimbursement changes, types of eligible practitioners, health savings account changes, fraud & abuse guardrails
- CMS - maintain new codes and changes to virtual check-ins
- DEA - create permanent ability to prescribe controlled substances via telehealth
- FCC - ongoing support of broadband deployment

COVID-19 and Public Health Data

Hans Buitendijk explained that from the start of the public health emergency, local, state, and federal public health agencies have needed real-time data on COVID-19 testing, COVID-19-positive patients, hospital capacity, and ventilator availability. Yet data requests to hospitals from these multiple agencies have been unclear, unaligned, and often were made with unrealistic turnaround times, especially for data that's not

routinely collected within normal workflows. As noted by Dr. Oppenheimer earlier in the webinar, hospitals were getting requests for similar data from multiple public health agencies.

The pandemic has exposed a critical need for a robust, flexible, extensive public health infrastructure across local, state and federal agencies – with a single clear ownership within HHS. This includes **establishing an upgraded national reporting infrastructure; a surge process infrastructure; and clear privacy and consent requirements.** Encouraging participation in national networks such as Carequality, Commonwell and the eHealth Exchange would be an effective first step.

Congress can help by working with HHS to enable an accurate and unique method to identify patients; a variety of methods and processes are being discussed. Additionally, we urge members of Congress to **support Section 2822 of the HEROES Act**, which would focus on public health preparedness by providing funding to expand and modernize the CDC and other public health data systems.

Questions and Answers

The Provider Experience

1. **Question to Dr. Oppenheim**: You spoke about how you minimized the number of clinicians in the patient's hospital room, using audio and visual conferencing instead. Was that contact considered telehealth or an in-person visit? Were those visits reimbursed?
    a. **Answer**: Most interactions described were around nursing staff, respiratory therapy, aides, and those addressing not only direct medical conditions but patient comfort issues, monitoring issues, etc; thus, the contact was considered a part of the overall hospital stay We did look at our ability to use video for a professional visit by a specialist, which would be considered a reimbursable telehealth contact if the care provider was doing regular assessments, creating a care plan, or making recommendations based on that interaction with the patient.
2. **Question to Dr. Oppenheim**: You spoke about the challenges of having to report EHR data to multiple different public health agencies. What data do you need back *from* public health as you try to stay ahead of clinical needs, possible surges, etc.?
    a. **Answer:** Through the pandemic, we found it necessary to balance patient load across multiple institutions. Neighboring institutions that were competitors became colleagues and collaborators as patients moved back and forth. Getting access to data from these institutions through public health information exchange would be very helpful.
    b. **In addition**, many hospitals and health systems like Northwell do our own hyperlocal community surveillance, tracking metrics like test positivity, syndromic surveillance, etc. Even though that analysis is being done at the macro level on a county and state level, it is important and useful for us to know hot spots (for example, Northwell within our tight NYC geography). That allows us to gear up for what we need to do much more quickly and precisely, rather than relying only on what is available from the public health department. With a hyper-local presence, knowing what is happening not only in our own institution but in areas where patients are present in other institutions, gives us an idea of which resources need to be moved between communities.

Telehealth: COVID-19 and Beyond

1. **Question to Kristen McGovern:** How does telehealth support and acceptance during this period differ between public payers like Medicare and commercial payers?

    a. **Answer**: According to CMS, there have been millions of telehealth visits during the pandemic compared to much smaller Medicare numbers before. Commercial payers are governed by a different set of laws and have made individual decisions about coverage and reimbursement in the geographic areas they cover. So, there hasn't been a universal decision on the part of commercial payers. Commercial payers are also taking some actions to increase telehealth reimbursement, but less consistently.
2. **Question to Kristen McGovern**: Are you seeing commercial payers start to pull back from allowances they were making for the pandemic? Or are they continuing coverage in the same way?
    a. **Answer**: It depends on both the payer and the current state of COVID-19 in their region. This Larry Green Center survey includes anecdotal evidence and comments from primary care providers. Most recently, findings from June 5-8 include anecdotes about how changes in the commercial market are starting to limit providers' ability to offer telehealth.

COVID-19 and Health IT: What's Worked and the Lessons We've Learned for Next Time

Panelist Biographies

Cherie Holmes-Henry, Moderator

Vice President, Government & Industry Affairs
NextGen Healthcare

Cherie Holmes-Henry provides health transformation subject matter expertise and leadership for NextGen Healthcare thought leader involvement and membership in various health information technology (HIT)-related industry organizations and trade associations. She is a vital thought leader resource and speaks frequently representing NextGen Healthcare expertise at industry events, client user groups, and health reform education sessions.

Ms. Holmes-Henry's responsibilities include NextGen Healthcare federal and state government initiatives. She works extensively with key regulatory healthcare decision makers across the country. Ms. Holmes Henry engages with state and regional Health Information Exchanges (HIEs), state primary care associations, and medical associations. She helped launch the NextGen Healthcare Payer Relations Initiative. She serves on the executive committee of the Electronic Health Records Association and serves as the current Chair of the Association. She sits on the Leadership Council and the Policy Steering Committee for the eHealth Initiative, and is an active member of both the Health Information Management Systems Society (HIMSS) and the Texas eHealth Alliance.

Ms. Holmes-Henry has been with NextGen Healthcare since 2009 and previously held several executive level positions throughout her 30-year career in healthcare, managed care and healthcare IT.

Janet Campbell

Vice President of R&D Relations
Epic

Janet Campbell is a software developer and Vice President of R&D Relations at Epic. In her seventeen years at Epic, Janet has led the creation and development of several products in the clinical and patient engagement space. She represents Epic in national conversations on interoperability, usability, meaningful use, and patient engagement.

She serves as Vice Chair of the Electronic Health Record Association's Public Policy Workgroup and has led multiple U.S. government working groups and initiatives.

COVID-19 and Health IT: What's Worked and the Lessons We've Learned for Next Time

Panelist Biographies

Dr. Michael Oppenheim

Vice President & Chief Medical Info Officer
Northwell Health

Michael Oppenheim, MD is Vice President and Chief Medical Information Officer at the Northwell Health in New York. Dr. Oppenheim received his undergraduate degree from Yeshiva College, and his MD degree from the Yale University School of Medicine. Dr. Oppenheim completed residency in Internal Medicine at The New York Hospital – Cornell Medical Center and fellowship in Infectious Diseases at Montefiore Medical Center – Albert Einstein College of Medicine.

Michael is responsible for overseeing the clinical aspects of Information Technology deployment and optimization as well as aligning Health Information Technology efforts with Health System strategic clinical initiatives and priorities, including interoperability, clinical analytics / artificial intelligence / machine learning and technology innovation to support clinical excellence and population health.

Dr. Oppenheim was recently inducted as one of the inaugural Fellows of the American Medical Informatics Association. He continues to practice Infectious Diseases at North Shore University Hospital at Manhasset.

Kristen McGovern

Partner, Sirona Strategies
Alliance for Connected Care

Kristen McGovern has been at the forefront of federal health care policy and politics for more than a decade. As a partner at Sirona Strategies, she supports the Alliance for Connected Care – a coalition dedicated to telehealth advocacy. She also works with senior corporate executives to develop integrated business, advocacy and communications strategies that reflect complex health care policies and regulations on a range of topics including commercial insurance markets, Medicare, accountable care organizations, new payment and delivery models, digital health, behavioral health, transparency initiatives and more.

Prior to launching Sirona Strategies, Kristen served as Chief of Staff to the National Coordinator for Health IT at HHS, and also worked at the Office of Management and Budget in the Executive Office of the President. In both roles, she regularly advised officials at HHS and the White House on key issues such as health IT, appropriations and funding, Medicare payment, quality and program integrity.

Kristen holds a BA from Creighton University in Omaha, NE, and a JD with an emphasis in health law from Saint Louis University School of Law.

Hans Buitendijk, M.Sc., FHL7
Director, Interoperability Strategy
Cerner Corporation

For more than 35 years, Hans Buitendijk has been involved in the development of health IT solutions, client consulting on strategic IT planning, healthcare application development and implementations, large scale business process re-engineering and systems integration, and complex project management, bridging the gap between business process optimization and IT support.

As Director of Interoperability Strategy at Cerner, Buitendijk primarily focuses on establishing and promoting industry standards to enable interoperability across the diverse systems prevalent in health IT. In that role he represents Cerner to a variety of organizations in various leadership roles, including the EHR Association, where he is the Vice Chair and member of the Executive Committee, Chair of the Standards & Interoperability Workgroup, and EHRA's representative on the CARIN Board. He also serves with:

- The Sequoia Project® — Carequality Board Treasurer, Carequality Steering Committee Member, Carequality FHIR Technical Workgroup Co-Chair
- HL7® — Co-Chair Orders & Observations, FHIR® Management Group Member, V2 Tooling Project Lead, V2-to-FHIR Mapping Project Lead
- Da Vinci Initiative — Vice-Chair Steering Committee
- Argonaut Project — Steering Committee Member
- FAST — Steering Committee Member

COVID-19 & HEALTH IT

What's Worked and the Lessons We've Learned For Next Time

EHRA
HIMSS Electronic Health Record Association

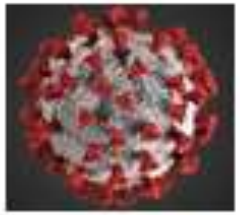
Electronic Health Records Association

The EHR Association's 30 member companies serve the vast majority of hospitals, post-acute, specialty-specific, and ambulatory healthcare providers using EHRs across the United States. Our core objectives focus on collaborative efforts to **accelerate health information and technology adoption**, **advance information exchange between interoperable systems**, and **improve the quality and efficiency of care** through the use of these important technologies.

EHRAblog.org/COVID-19

COVID-19 Resources

This page will be updated frequently.



EHRA Blog Post (3/12/20):
Coronavirus: How EHRs Are Supporting Clinicians

COVID-19 Updates from EHRA Member Companies

Allscripts	Epic	NextGen
athenahealth	Greenway	Nextech
Cerner	Meditech	Office Practicum
CPSI	Modernizing Medicine	STI Computer Services
eClinicalWorks	Netsmart	

COVID-19 Health IT Updates from Federal Agencies

HHS Office of the National Coordinator for Health Information Technology (ONC)

Interoperability Standards Advisory/Interoperability for COVID-19

Interoperability Proving Ground COVID-19 projects

HHS Office for Civil Rights

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019

Centers for Disease Control & Prevention

CDC COVID-19 Patient Impact & Hospital Capacity Module

National Institutes of Health

EHRA Electronic Health Record Association

1 **THE ROLE OF HEALTH IT** Janet Campbell, Epic

2 **THE PROVIDER EXPERIENCE** Dr. Michael Oppenheim, Northwell Health

3 **TELEHEALTH** Kristen McGovern, Alliance for Connected Care

4 **REPORTING & DATA** Hans Buitendijk, Epic

The Role of Health IT

Janet Campbell, Epic

Conclusion:

The EHR is **an essential tool** in supporting the clinical needs of a health system managing the COVID-19 pandemic.

J Jeffery Reeves, Hannah M Hollandsworth, Francesca J Torriani, Randy Taplitz, Shira Abeles, Ming Tai-Seale, Marlene Millen, Brian J Clay, Christopher A Longhurst, **Rapid response to COVID-19: health informatics support for outbreak management in an academic health system**, *Journal of the American Medical Informatics Association*, Volume 27, Issue 6, June 2020, Pages 853–859, https://doi.org/10.1093/jamia/ocaa037

EHRA
European Electronic Health Record Association

An Evolving Role

EHR Functionality

Identifying Patients

CDC travel screens, standardized symptom screening, defining a COVID-19 positive patient, accommodating drive-through testing

Dashboards

Lab results, capacity, ventilator usage, patient volumes, etc

Victories & Opportunities

Easily accessible data

Alert once, show everywhere

Get everyone on the same page

Need for expanded codesets

Lack of standard definitions and counting

Lack of clarity in data requests

Competing requests from multiple sources

An Evolving Role

EHR Functionality

Triage

Online patient-facing tools to self-diagnose, standardized phone triage, predictive models to assess risk

Telehealth

Asynchronous questionnaire-based visits, synchronous video visits, teleurgent care, COVID-19 home care plans

Communication

Patient portals, patient messaging en masse, lab results shared with patients automatically

Victories & Opportunities

- Rapid expansion of video options for providers
- Patients adopted technology quickly
- Driving repeatable decision-making

- Unscalable video technology
- Uncertainty about what comes next

An Evolving Role

EHR Functionality

Effective Resource Use

Remote monitoring at home, PPE conservation (use video in the hospital, virtual patient registration, track inventory), benchmarked capacity metrics

Staff Expansion

Simple workflows, limited security, streamlined training

Surge Planning

Add new areas/beds, extend EHR to non-traditional settings

Victories & Opportunities

Relaxation in mask fittings requirements to preserve PPE

Auditing suspended to reduce surveyors in the field

Lack of clarity/ownership in creating surge sites

PPE shortages

An Evolving Role

EHR Functionality

Reestablishing Care

Rescheduling canceled cases, proactive outreach to high-risk patients

Addressing Social Risk

Social determinant tracking and reporting, PTSD resources for staff

Financial Stability

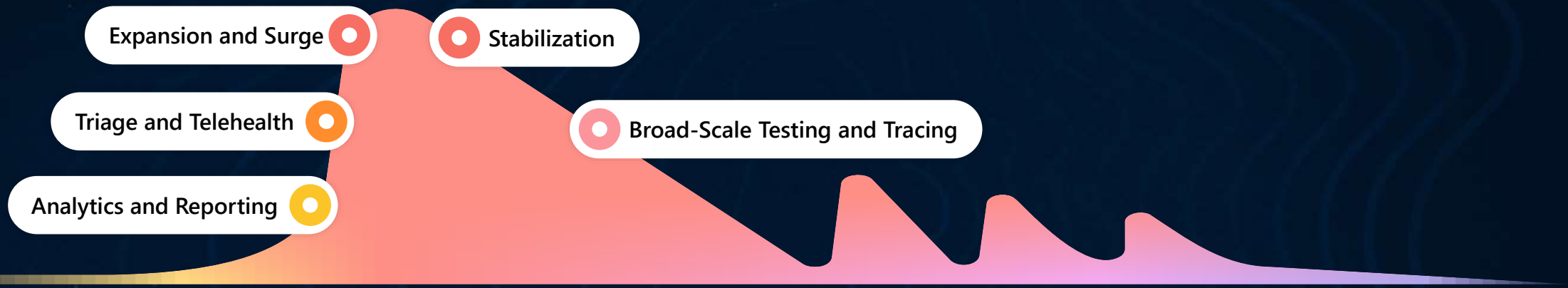
Reports, forecasting, cost-savings measures

Victories & Opportunities

- Repurpose existing population health tools
- Easily identify and stratify cases for rescheduling

- Aid will not fully make up for financial losses
- Unpaid/unreimbursed activities like contact tracing

An Evolving Role



EHR Functionality

Contact Tracing

Identify highest risk individuals, inside the walls, out in the community

Testing

"Advertise" tests to patients, support self-scheduling, provide results online

Vaccinations

Determine areas of community spread for vaccine trials, understand vaccine effectiveness and reinfection potential, spot mutated strains

Victories & Opportunities

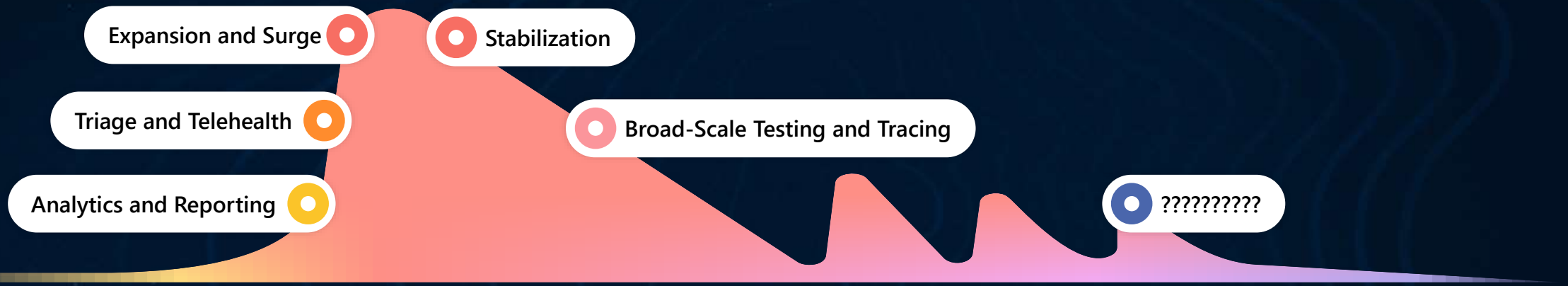
Leverage existing digital engagement platforms

Record once, share often

Unclear if public health is prepared to respond

State-by-state response

An Evolving Role



Where do we go from here?

The Provider Experience

Dr. Michael Oppenheim, Northwell Health

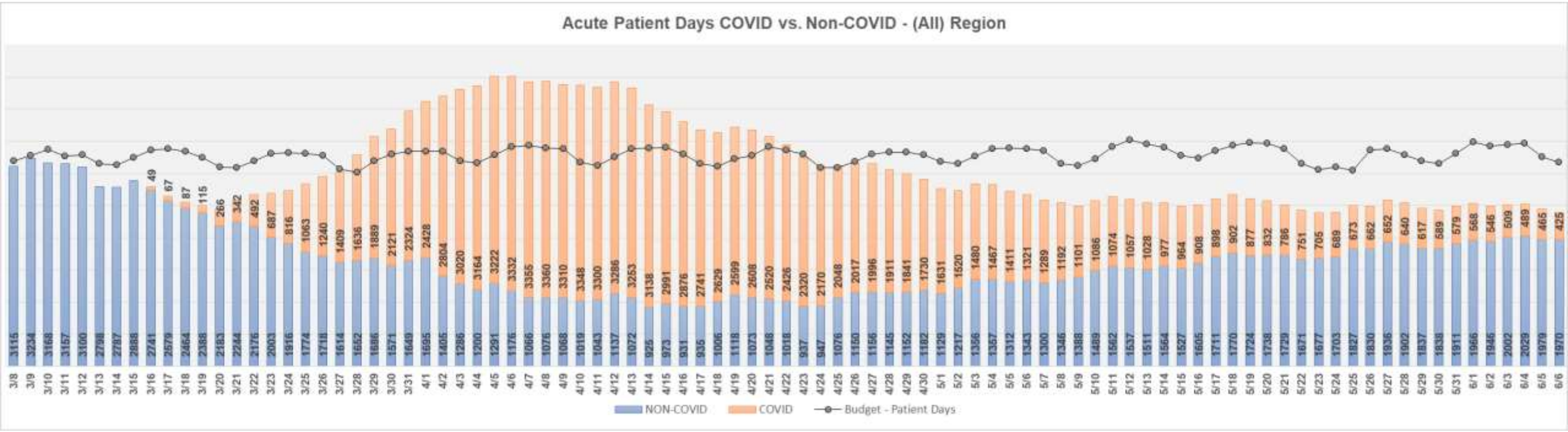
COVID-19 and HIT:
Perspectives from a New York Metro Area Health System

Michael I. Oppenheim, MD, FAMIA
VP & Chief Medical Information Officer

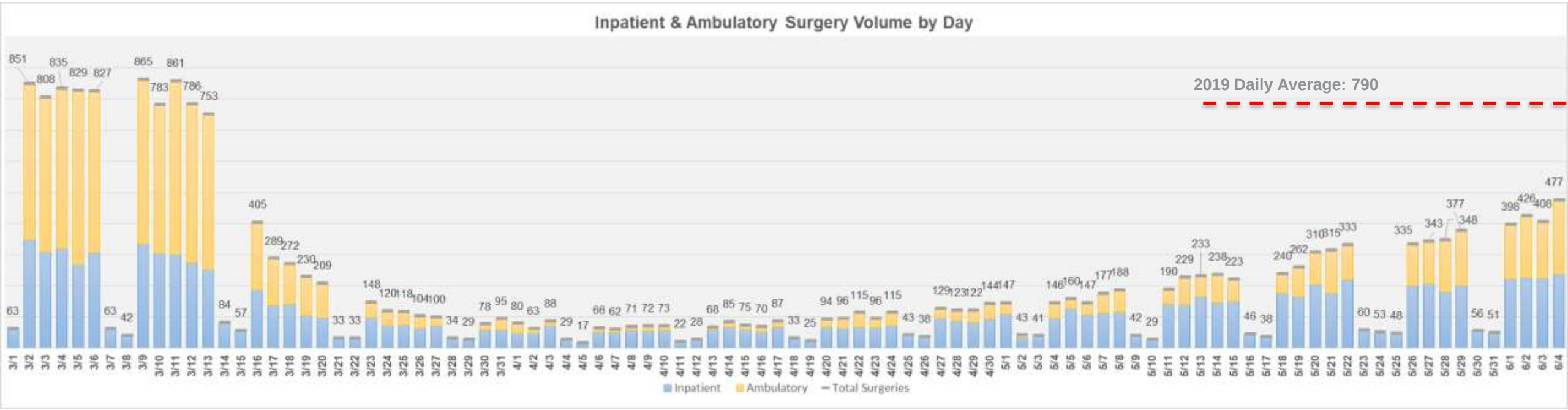
June 18, 2020

Northwell Health®

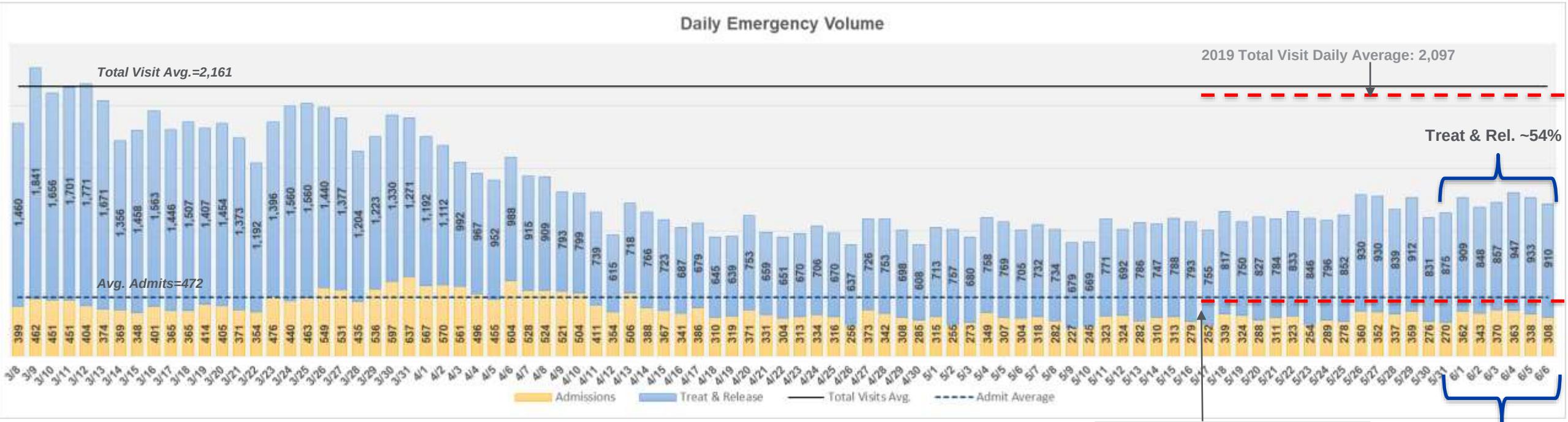
Acute Patient Days COVID vs. Non-COVID



Daily Inpatient & Ambulatory Surgery Volume

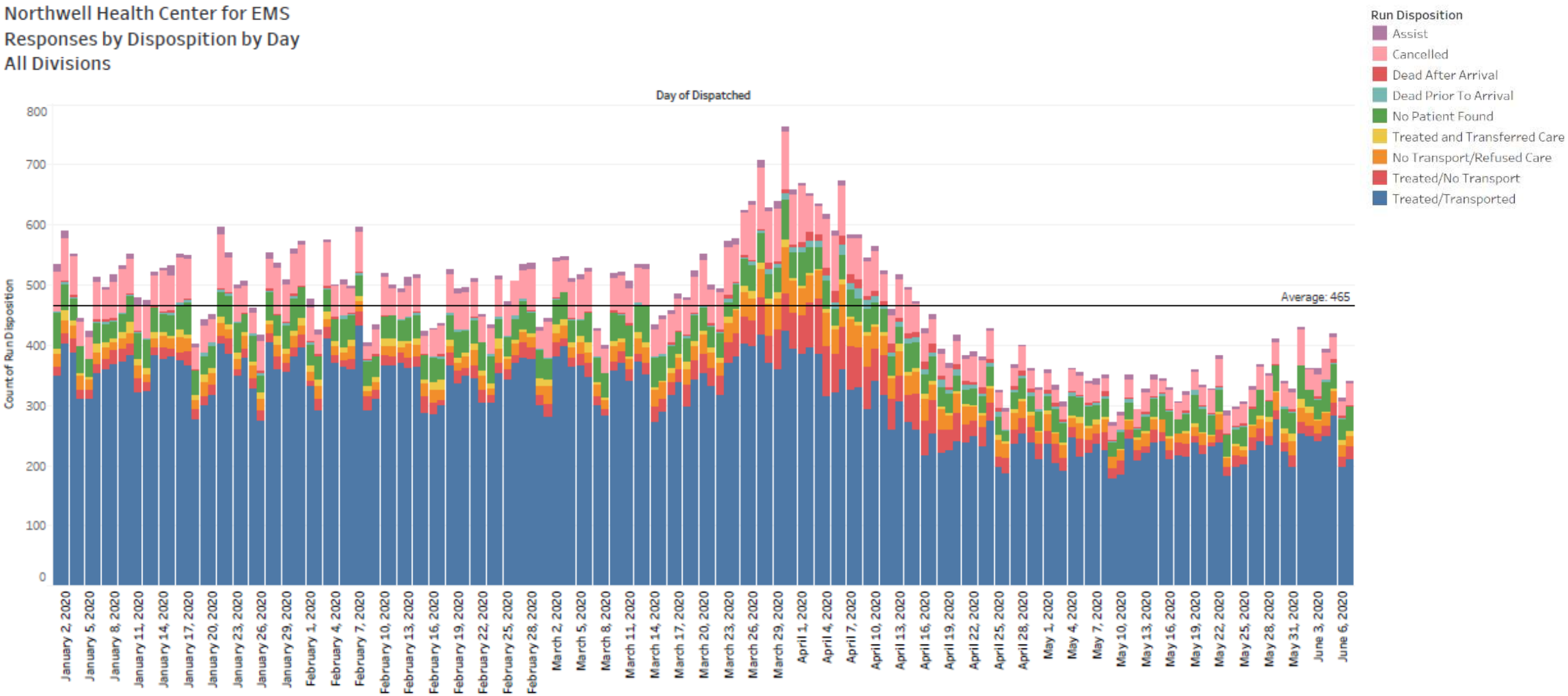


Emergency Visits by Day

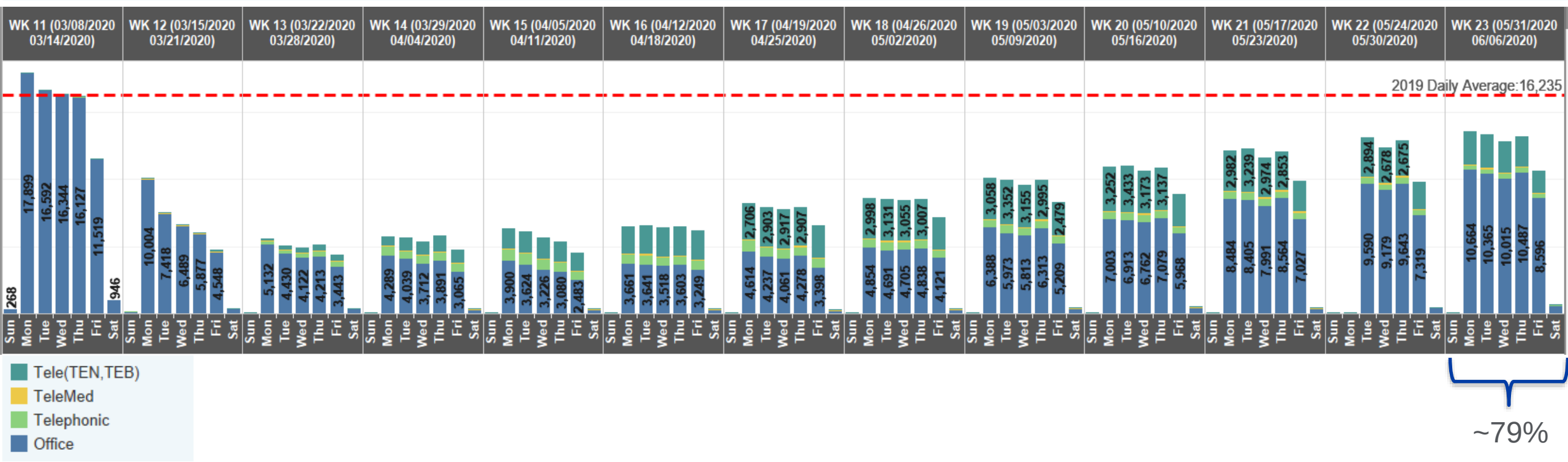


Excludes PHELP, NWEST, Mather & Peconic

CEMS – Responses by Disposition by Day



Daily Physician Appointments



~79%

Northwell Pandemic Response

Situational Awareness

- Enable Emergency Operations at both facility and central levels to understand supply/demand for facilities, equipment and services

Physical Capacity Expansion ("Surge")

- Rapid buildout of non-clinical space and popup-locations to create general and intensive care beds necessitated by patient volumes

Care Efficiency & Throughput

- Streamline provider and hospital administrative processes to focus on patient care and optimizing beds/resources

Staff and Patient Safety

- Minimize staff exposure to infectious patients without compromising patient monitoring and safety

Patient Engagement

- Maintain interactions with patients despite increasing scale of calls for information and services

Clinical Knowledge Dissemination

- Assure rapid delivery of latest treatment protocols and recommendations to clinicians

Research / New Knowledge Discovery

- Participate in clinical trials
- Leverage accumulated clinical data to enable better patient monitoring and treatment

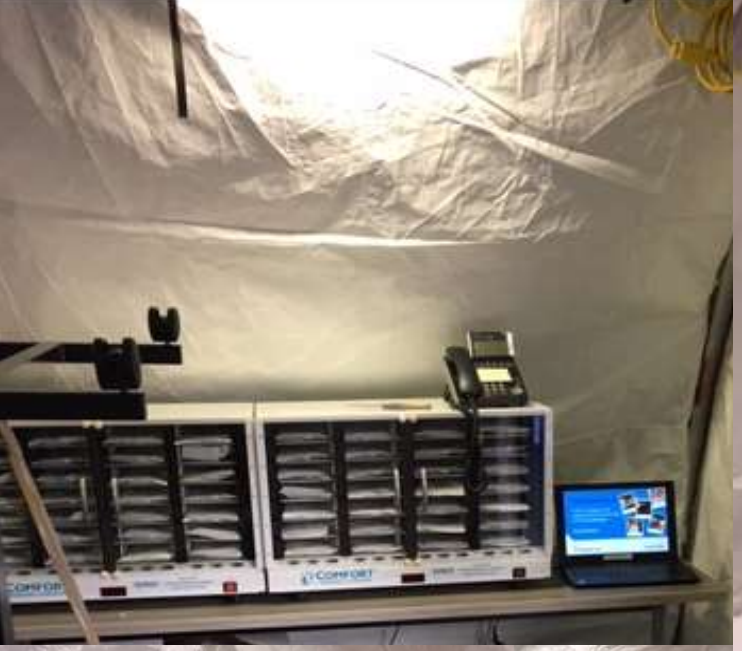
Situational Awareness

- Built COVID-19 specific Data Mart to enable data analytics throughout organization.
- Developed Enterprise and facility-level dashboards to understand hospital-occupancy, patient acuity and determine resource needs.
- Developed and monitored leading indicators to identify regions with surge need and overall bed and ventilator requirements.

Physical Capacity Expansion (“Surge”)

Northwell “Network in a Bag” (“Flight Pack”)

- Created and deployed a fully self-contained kit delivering a “Northwell network anywhere” capability. Kit provides secure way of connecting to the network via wired/wirelessly methods.
- Operational dashboard for load balancing amongst various sites.



Inside the Northwell BluMed Tents

Care Efficiency & Throughput

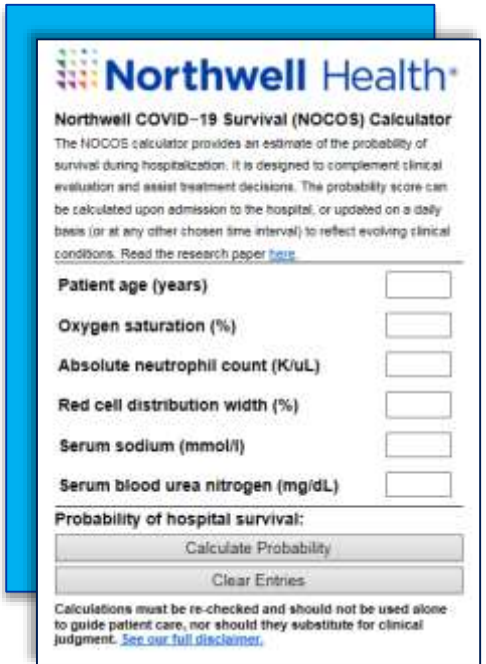
- Rapid buildout/modifications to **inpatient** Electronic Health Records to enable clinicians to focus on high volumes of complex patients.
- Developed special documentation and tools for severity-based longitudinal monitoring and tracking of COVID+ **outpatients**.
- Deployed “readiness for discharge” machine-learning-based predictive model to identify both non-COVID and COVID-19 patients appropriate for discharge to support bed use optimization.
- Developed machine-learning based predictive model to identify patients with highest risk of mortality for goal-of-care discussions and resource allocation.
    - Northwell COVID-19 Survival (NOCOS) Calculator made publically available on the web for all institutions:

https://cbmi.northwell.edu/nocos/ or http://feinstein.northwell.edu/nocos

Development and Validation of a Survival Calculator for Hospitalized Patients with COVID-19

Todd J. Levy, Safiya Richardson, Kevin Coppa, Douglas P. Barnaby, Thomas McGinn, Lance B. Becker, Karina W. Davidson, Stuart L. Cohen, Jamie S. Hirsch, Theodoros Zanos, Northwell & Maimonides COVID-19 Research Consortium

doi: https://doi.org/10.1101/2020.04.22.20075416



Staff and Patient Safety

- Deployed consumer-grade two-way audio-video communication systems in patient rooms to minimize entry by staff, thus reducing PPE utilization and lowering exposure risk.
- Instances where enhanced safety monitoring was required, continuous video-surveillance with night-vision capabilities were deployed in lieu of an in-room Patient Sitter to assure patient safety.
- Continuous monitoring of patient vital signs status through wireless sensors with automated alerting to nursing, providing closer monitoring of patients without requiring frequent staff entry into rooms and decreasing PPE use (limited pilots completed).

Patient Engagement

- Implemented text-based Chatbot for follow-up program for ED treat & release patients via their smart phones.
- Created chat bots for COVID test results to maintain call center efficiency and minimize wait times.
- Provided in-room devices with software to give patients the option for video chats with family, as no visitors were allowed.
- Rapid deployment of telehealth to maintain contact and provide ongoing medical care to outpatients (for both COVID and non-COVID).

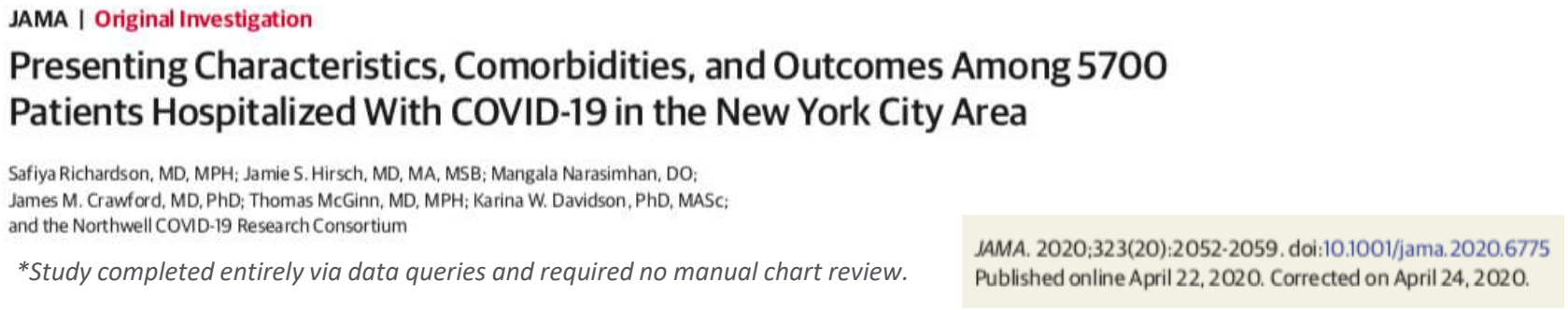
Clinical Knowledge Dissemination

- Deployment of prebuilt order sets with **automated dosing recommendations** in the EHR to standardize COVID treatment and support research protocols.
- Automated tools for insertion of COVID results, treatment plans, vitals, and other clinical data into documentation/provider progress notes.

Research / New Knowledge Discovery

Use of Data Mart for Research, Clinical Trial Notifications in EMR; Clinical Trial Order Sets

- Deployed tools to support identification and enrollment of appropriate patients for COVID clinical trials.
- Rapid-cycle database-based research to identify best-practices for treating COVID-19 patients.



JAMA | Original Investigation

Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the New York City Area

Safiya Richardson, MD, MPH; Jamie S. Hirsch, MD, MA, MSB; Mangala Narasimhan, DO; James M. Crawford, MD, PhD; Thomas McGinn, MD, MPH; Karina W. Davidson, PhD, MASc; and the Northwell COVID-19 Research Consortium

**Study completed entirely via data queries and required no manual chart review.*

JAMA. 2020;323(20):2052-2059. doi:10.1001/jama.2020.6775
Published online April 22, 2020. Corrected on April 24, 2020.

Regulatory Changes Critical for Success:

Telehealth-Related Waivers

- Allowed initial visits via telehealth.
- Removed limitations on provider location at time of telehealth visit.
- Allowed use of non-HIPAA compliant technologies if needed.

Payer Parity for Tele-visits for Medicare Beneficiaries (Commercial Payers followed) including Telephonic

Relaxation of Hospital Care Documentation Requirements

- Enabled clinicians to spend more time on clinical care with less administrative/documentation burden.

Quality Program Delays

- Numerous Federal reporting programs delayed because focus on COVID-19 prevented implementation of systems to address programs and reporting requirements.

COVID19: Unaddressed Opportunities for Regulators

Redundancy in Public-Health Reporting

- Limited sharing of data across public health organizations added significant work burden on Northwell personnel.
  - Similar data requested by Center for Disease Control / National Healthcare Safety Network (NHSN), city, county and state Departments of Health.
- No sharing of public health data back to provider organizations to support our planning efforts.

Quality Program Delays

- Clinical Decision Support / Appropriate Use Criteria (Protecting Access to Medicare Act - PAMA) requirement NOT delayed; significant burdens on hospitals to meet requirements given halting of implementation of systems needed to meet requirements.

FDA Limitations Around Monitoring Devices

- Use of cutting-edge biosensors for patient monitoring limited because of pending FDA approvals for some components of those devices.
- No regulatory relief from FDA for use of devices if deemed safe and validated by organization (as was done by FDA for laboratory assays).

Limitations on Data Sharing Across Organizations

- Public Health Informational Exchange in NY requires actively asserted patient consent (“opt-in”), which limits clinical data sharing across organizations in same region cooperating on load balancing and resource optimization.
- Universal access to immunization data across regions/states will be needed once COVID immunization is being performed.

Telehealth

Kristen McGovern, Alliance for Connected Care

ALLIANCE for CONNECTED CARE

Telehealth Policy Developments
COVID-19 and Beyond

June 18, 2020

ALLIANCE FOR CONNECTED CARE

Members

ALLIANCE ADVISORY BOARD

- Alliance for Aging Research
- Alzheimer's Foundation of America
- American Academy of Family Physicians
- American Academy of Nurse Practitioners
- American Nurses Association
- American Academy of Physician Assistants
- American Heart Association
- American Language-Speech-Hearing Association
- American Osteopathic Association
- American Urological Association
- Association for Behavioral Health and Wellness
- Children's Mercy Hospitals and Clinics
- Digestive Disease National Coalition
- Infectious Diseases Society of America
- HealthCare Chaplaincy Network
- Indiana University Health
- Mental Health America
- National Alliance on Mental Illness
- National Association of ACOs
- National Association of Chain Drug Stores
- National Association of Homecare & Hospice
- National Council for Behavioral Health
- National Council of State Boards of Nursing
- National Health IT Collaborative for the Underserved
- National Multiple Sclerosis Society
- National Organization for Rare Disorders
- Parkinson's Action Network
- Population Health Alliance
- The ALS Association
- United Spinal Association
- Visiting Nurse Associations of America
- The Evangelical Lutheran Good Samaritan Society

OVERVIEW, FEDERAL TELEHEATLH POLICY CHANGES

- Medicare will pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's home.
- Wide array of health care providers getting paid for telemedicine, including **NPs, MDs, PAs, PTs, OTs, SPs.**
- Interactive audio-visual telecommunications system that *permits* real-time communication.
- Adds some payment codes for prolonged audio-only evaluation and management services.
- 80 new Part B codes added to telehealth list.
- Risk adjustment by telehealth for MA temporarily allowed.
- Physician supervision provided virtually, using real-time audio/video technology.
- Waiver of enforcement of HIPAA for provision of services in good faith via FaceTime and Skype.
- The HHS Office of Inspector General grants flexibility to providers on waiver of co-pays.
- Removal of established relationship requirement for "virtual check-ins."
- FQHC and Rural Health Clinic payment
- DEA prescribing regs are waived

EARLY PROVIDER REACTION: Physicians

In an April poll of 1,300 physicians:

85% now seeing patients via video or telephone

90% have colleagues using telemedicine

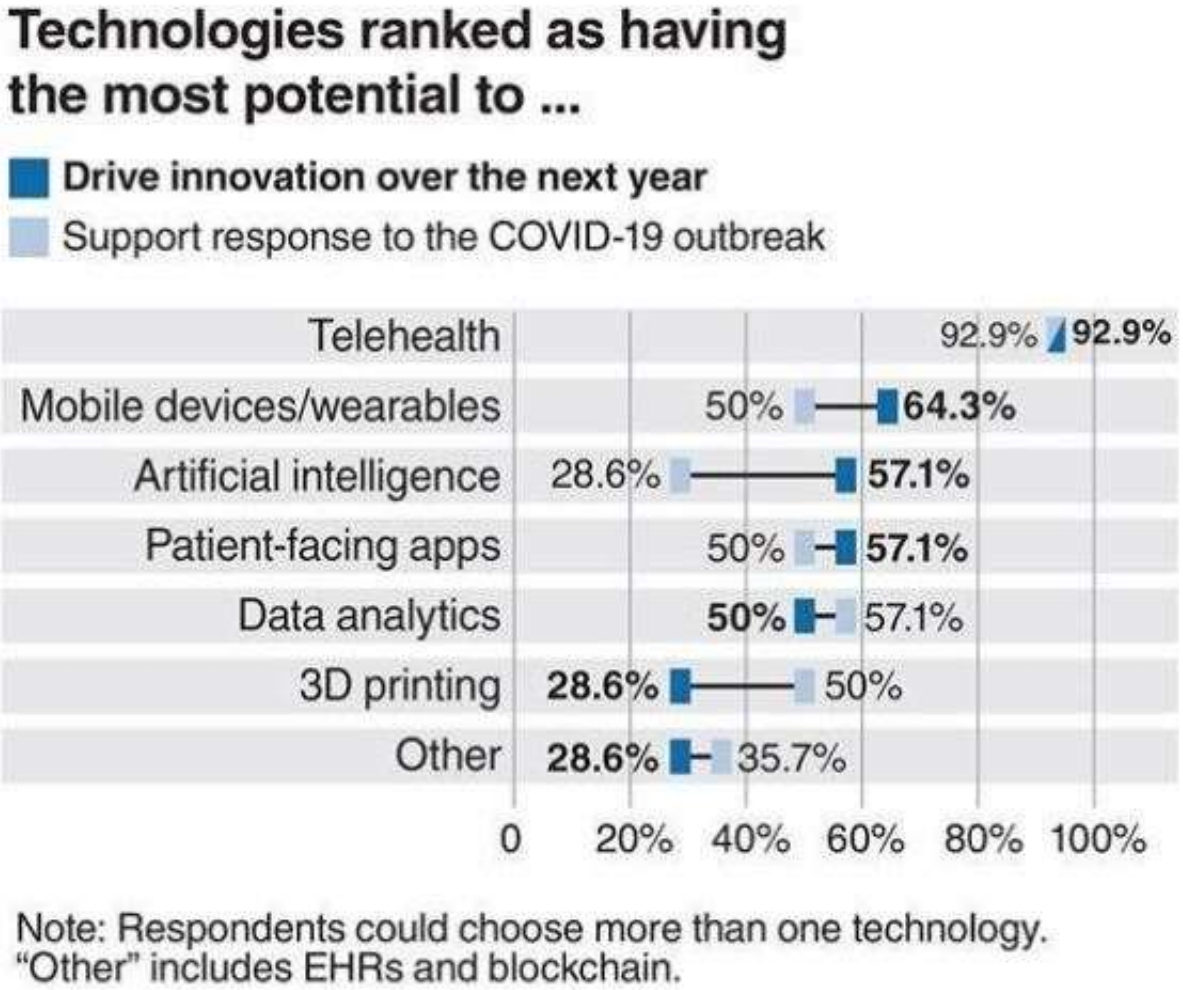
68% believe it will have a lasting impact on how doctors see patients—

28% of the physicians polled believe that seeing patients in person is far too important

77% in right circumstances, support permanent shift toward telemedicine

Source: https://www.sermo.com/telemedicine-explodes-in-these-uncertain-times/

EARLY PROVIDER REACTION: Health System CEOs

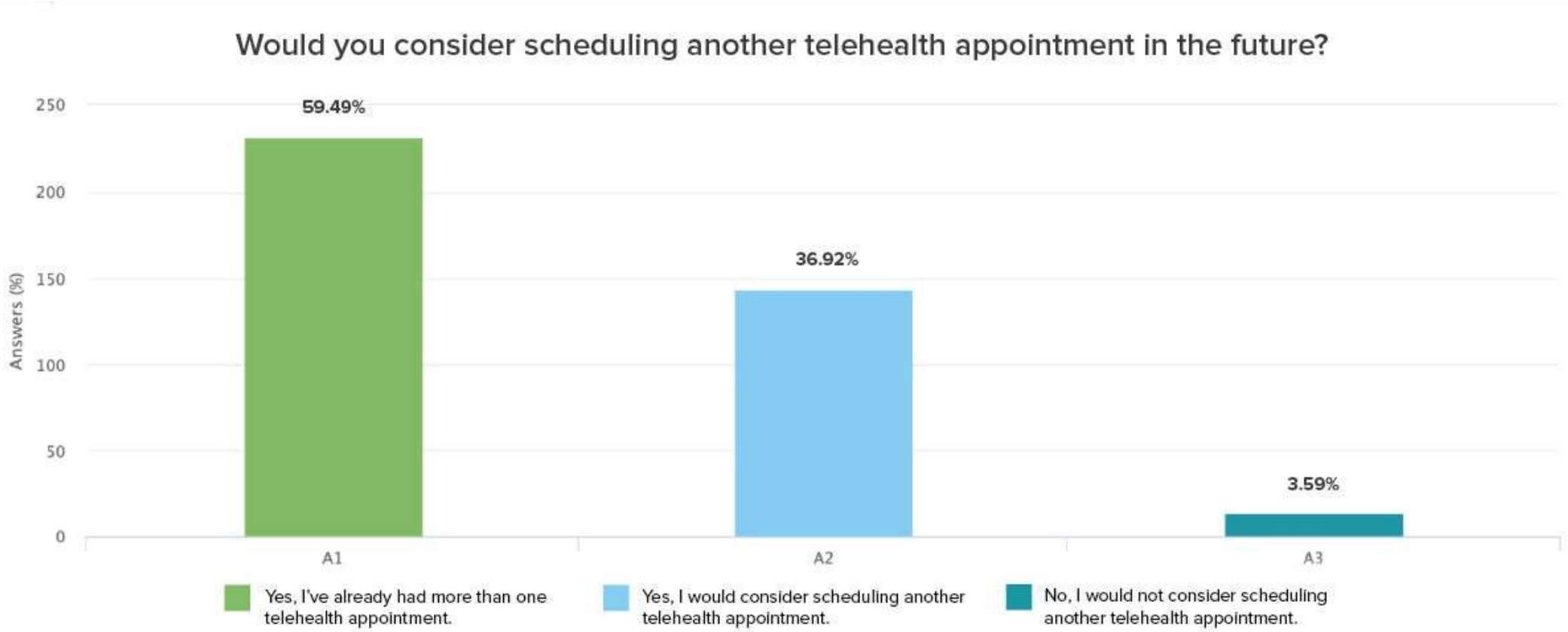


Note: Respondents could choose more than one technology.
"Other" includes EHRs and blockchain.

Source: Modern Healthcare CEO Survey, May 2020

EARLY PATIENT REACTION

Sykes survey of 2,000 U.S. Adults March 18-19 2020



PERMANENT POLICY CHANGE IS NEEDED

Congressional Action

- Medicare reimbursement changes
- Types of Practitioners
- Technology Definitions
- Health Savings Account Changes
- Fraud & Abuse Guard Rails

HHS Action

- CMS maintain new codes
- CMS maintain changes to virtual check-ins
- Ongoing implementation of new authority from Congress
- Office of Civil Rights unlikely to extend HIPAA exceptions
- Office of Inspector General unlikely to extend Anti-kickback exceptions but could create through value-based care rules

PERMANENT POLICY CHANGE IS NEEDED

DEA Action

- Create permanent ability for prescribing controlled substances via telehealth

Federal Communications Commission

- Ongoing support of broadband deployment

State Action

- Types of Practitioners
- Established Relationships
- Cross-state Licensure
- Technology Definitions

WHAT WILL IT TAKE?

Reporting & Data

Hans Buitendijk, Cerner

A Complex, sometimes Contradictory, Landscape

DATA REQUESTS

- Admissions
- Hospital capacity
- Bed availability
- Testing (positive, negative, pending)
- Ventilator utilization
- Demographics
- Co-morbidities
- Vital signs
- Case reports
- All patient data

CHALLENGES

- Aligning measures across requesters
  - Duplicate reporting
  - Need standard definitions
- Short-turnaround requests for large volumes of historical data
  - Ensuring consistent & complete reporting
  - Minimum necessary

Critical Need

A robust, flexible, extensible public health IT infrastructure across local, state, and national jurisdictions.

Our Ask of Congress:
Establish single, clear ownership in HHS to…

Upgrade the National Reporting Infrastructure

Core dataset

Report once, share widely

Standards

Incentives and funding

Education and training

Establish a Surge Process and Infrastructure

Emergency capacity

Additional data definitions

Ongoing preparedness evaluation

Clarify Privacy and Consent Requirements

For patients

For healthcare delivery organizations

Data retention and protection policies

Research

EHRA Electronic Health Record Association

Our Ask of Congress:

Encourage Participation in National Networks

Carequality, CommonWell, eHealth Exchange, etc

Patient info at the point of care

Additional data beyond core dataset

Support Accurate, Unique Patient Identification

If not a national unique identifier, then something else

Support section 2822 in the HEROES Act

Funding to expand and modernize CDC and public health data systems

Focus on public health preparedness

EHRA Electronic Health Record Association

COVID-19 & HEALTH IT

What's Worked and the Lessons We've Learned For Next Time

EHRA
HIMSS Electronic Health Record Association