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Recorder: Jeremy Arnette	Date: 4/26/17 – 3:30p

Session Title: Solutions to Modernize IHS Health Information Technology

Panelists: Carolyn Crowder – Crowne Consulting & CAPT Mark Rives IHS OIT

Summary of Issues and Items Discussed:

Rives:

1. IHS OIT Service Catalog: Service catalog is a curated collection of healthcare IT services available to tribes, and is nearing completion. Catalog is in final review period now, and will be published following a few remaining webinars and a comment period. Draft is available now on IHS.gov

2. Strategy for Healthcare IT systems, specifically EHR/RPMS: Immediate updates are required for RPMS, regardless of future choices for EHR software, and are in progress now. These include two-factor authentication for EPCS electronic RX writing, third-party billing updates, infrastructure updates and operations/maintenance patches. Completion of all items expected in 2017.

VA moving to a new system from VISTA will have an impact on RPMS userbase, although VA has an obligation to keep IHS informed. IHS will actively engage with VA on timetables for VISTA; any changeover by VA expected to take 5+ years, giving OIT time to make necessary accommodations before VISTA service is terminated. During the changeover period VA will still provide support for VISTA and RPMS as a derivative of VISTA.

3. Changes being explored for RPMS:

The primary change under consideration is the operation of RPMS in a private cloud, which could be packaged as a service and marketed to smaller facilities that do not currently use RPMS. This would lower costs for OIT and increase the discretionary budget through service income, and would lower the administrative burden for the client. Also a major area of focus is interoperability with other EHR systems, which will allow other EHR software to "read" the data stored in RPMS. An ISAC workgroup will be responsible for guiding the future development of RPMS.

Crowder:

Quality Payment Program (QPP) will base compensation to providers on:

- Patient health outcomes
- Activities that improve their clinical practices
- Efficient use of medical resources
- **The meaningful use of certified Electronic Health Records (EHRs)**

2017 is Transition Year for Medicare, will affect payments in 2019
CMS leading way, commercial systems to follow
QPP offers 2 pathways:

- Merit-based Incentive Payment Systems (MIPS)
    - Eligible professionals will be measured on quality, resource use, clinical practice improvement, and the ability to capture and share health information.
- Advanced Alternative Payment Models (APMs)

These are Value-based payment programs authorized by the ACA to pay for care given to Medicare beneficiaries. They include accountable care organizations (ACOs) that involve two-sided risk models offering not only the potential for increased payment for improving quality and containing costs, but also potential downside penalties for failing to achieve financial and quality targets.

The new standard of care is challenging for I/T/U, as quality care requires a significant increase in connectivity. Less than 10% of homes in Indian country have broadband access and only 70% have basic telephone access.

Network bandwidth is a key requirement to successfully provide health care services. Many IHS sites are experiencing challenges to fund the cost of the necessary bandwidth upgrades to make telehealth services successful. Approximately 75% of IHS sites are located in areas defined as 'rural' by the Federal Communications Commission (FCC). These rural sites pay a higher percentage of their operating budget than urban locations on monthly circuit costs. When bandwidth upgrades are required, rural IHS sites are frequently asked to fund the capital costs of these upgrades. These projects can range from tens of thousands to over a million dollars in cost, and can take years to complete. In some cases, telecommunication providers are not able to offer any upgrade options for IHS locations.

While each year IHS replaces some obsolete network equipment based on funding availability, there continues to be a large amount of network equipment which has reached end-of-support status from the vendor. Industrial averages for IT equipment refresh are normally within 5 years from the date of purchase. A recent analysis of the network equipment on the IHS network revealed that approximately 49 percent of the IHS network equipment is more than 5 years old, with 19 percent ten or more years old.

During 2016, IHS upgraded network bandwidth at over 50 locations. IHS is moving away from slow speed networks such as T1 lines (1.5Mbits) to Ethernet networks which offer bandwidth in the 10 to 100Mbits range. To help fund the monthly recurring network costs associated with these upgrades, IHS is increasingly leveraging the financial support provided by the Healthcare Connect Fund (HCF). The HCF is an FCC program to provide rural healthcare providers with financial support for bandwidth charges. Approximately 50% of IHS still rely on network connections of 3mbits or less, resulting in a constantly saturated network.

Capabilities such as telehealth, patient access to records, staff and patient education, clinical decision support, and transmission of medical data and images are severely hampered by bandwidth insufficiency. Upgrading bandwidth can be extremely costly and often must be paid from the facility's health care operations budget. In some cases, local telecommunications providers are simply unable to provide the upgrades needed for the health care facilities.

RPMS has outgrown the agency's ability to support and enhance it due to flat IT funding and the withdrawal of tribal IT shares by large tribes opting for commercial solutions to meet their own requirements. Any "rip and replace" strategy for RPMS would cost an estimated $1-3.5B. A more realistic HIT budget increase of at least $75 million per year for application development would allow IHS to modernize RPMS and enable advanced mobile health technologies. Additional increases to support local workforce development, training and support must also be considered.

There are three major categories of HIT EHR systems that should be considered for the future. 1. IHS RPMS system, which has strong clinical data capture and reporting abilities but is weak on third-party billing and can be entangled in bureaucracy, 2. A commercial off-the-shelf system, which has stronger third-party billing support but will have less support/input because the commercial providers will have non-IHS clients, and 3. Cloud Based Systems such as CareCloud and Azure, which have low hardware requirements and require no scheduled backups, while constantly growing and expanding in size and level of service offered.

Four immediate actions should take place to move IHS and tribes towards an EHR solution:
1. Create an HIT task force by 5/1/17
2. Evaluate RPMS as an IT solution
3. Evaluate other IT solutions and new technologies
4. Return results for tribal consultation by 9/30/17

Questions from the Audience:

Rives:

Q1: RPMS is going through some upgrades, one of which is cloud based service, what is the timeline for those upgrades?
A1: There is no true project timeline at this time.
Q2: How much money is available for R & D?
A2: We have scraped some funds together, I'll get back to you with the exact amount.
Q3: Do you have a calculated shortfall for what is needed to improve the system?
A3: We have a priority list by severity and level of effort required, I do not have a dollar amount attached to that list at this time. What is most helpful is not a one time infusion in funding, but rather a dedicated line item.
Q4: What steps are you taking to improve the processes in the RPMS system?
A4: No Answer
Q5: Have you taken any steps towards interoperability?
A5: Interoperability is a priority, and will be more of a reality once RPMS is cloud-functional.
Q6: Behavioral health programs are our bread and butter, is there a plan to integrate BH with the existing EHR?
A6: Yes
Q7: We have baby cacs (Clinic Applications Coordinator), we are in need of additional training
A7: We are developing a formal CAC training program
Q8: Will you develop some core competencies for CAC?
A8: No Answer
Q9: Are you moving forward to Windows 10?
A9: Yes, we are planning for that.
Q10: Some data needs should be centralized, such as pharmacy databases.
Q11: How many IHS sites still use RPMS?
A11: About 250.
Q12: Do you have anything written on your presentation today?
A12: No, but I will create and provide some accompanying slides
Q13:We're concerned about meaningful use stage 3, having a certified EHR, can you elaborate?
A13: We're looking at modular purchased capabilities to speed up the process to meet deadlines. We would typically build in house but in the interest of time, looking for a modular solution.
Q14: Can IHS support the costs of maintaining the system in the cloud?
A14: No Answer

Follow Materials, Documents, Websites for Reference:

https://www.ihs.gov/isac/ - IHS Information Systems Advisory Committee
https://www.ihs.gov/ehr/clinicalapplicationcoordinator/ - IHS Clinical Applications Coordinator