# ESSENTIALS FOR HEALTH REFORM:
## Using Networks to Implement and Improve EHRs and other HIT

**SAMHSA**
Substance Abuse and Mental Health Services Administration
www.samhsa.gov · 1-877-SAMHSA-7 (1-877-726-4727)

**NIATx**

**SAAS**
STATE ASSOCIATIONS OF ADDICTION SERVICES

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FOR COMMUNITY BEHAVIORAL HEALTHCARE

Behavioral Health providers are being challenged to adopt health information technology with very limited resources. There is a need to prepare for increased numbers of patients receiving health insurance benefits, requirements for electronic billing, data exchange among treating providers and an ever increasing need to collect and use health information to improve care.

These intense one day seminars will provide attendees with the necessary information to move forward in adopting, acquiring and implementing electronic health records and other health information technology. Presenters will review the various stages of implementation from initial planning and assessment through advanced topics such as data warehousing. There will be a focus on utilizing networks of care to build on economies of scale. Participants will leave with a thorough understanding of where they are in the process, and a plan for next steps in their health information technology implementation efforts.

These seminars are a collaborative work of NIATx, SAAS and The National Council supported by SAMHSA.

**Topics include:**

➢ **Overview of the CMS Rule on Medicare and Medicaid Incentive Payments**
➢ **Practice Management Systems vs EHRs**
➢ **Benefits & Economies of Scale when working with a Network**
➢ **HIT Planning and Assessment Process**
➢ **HIT Workflow Redesign**
➢ **Due Diligence and Vendor Negotiations**
➢ **EHR Selection and Implementation**
➢ **Disaster Recovery and Business Continuity Planning**
➢ **Data Warehousing**
➢ **Use of Telemedicine**
➢ **Health Information Exchange and Behavioral Health**

# Practice Management Systems

# vs

# EHRs

# Session Description

This presentation will cover the basics of what constitutes a PMS and EHR system, and will provide practical advice on how to identify, evaluate and choose suitable PMS & EHR systems. It will include lessons learned by the presenters, who between them have produced, chosen and successfully implemented such systems in Federally Qualified Health Center (FQHC) and other safety net environments.

# TODAY'S AGENDA

**1.** **Practice Management System Basics**

**2.** **Electronic Health Record System Basics**

**3.** **Implementation Considerations**

**4.** **The Process of Choosing a System**

# Section 1

# Practice Management System Basics

# *WHAT IS A PRACTICE MANAGEMENT SYSTEM (PMS)?*

➢ **PMS is a category of software that deals with the day-to-day operations of a medical practice.**

➢ **Generally, a PMS consists of several functions or modules, integrated into a single system.**

8

# *PMS COMPONENTS*

➢ **Appointment scheduling-a calendaring or scheduling component that allows staff to create and track upcoming patients visits.**

➢ **Patient Demographics-Captures basic patient data, as well as insurance and other information required to process and bill for visits, as well as to produce management reports.**

# *PMS COMPONENTS, CONTINUED*

➢ **Charge, Payment and Adjustment entry-allows tracking and billing of patient visits, as well as keeping account balances correctly.**

➢ **Accounts Receivable Management-Utilizes demographic and billing data to manage patient and 3rd party balances.**

➢ **Electronic Claims Processing-Allows submission of billings without production of paper bills.**

# SOME IMPORTANT ADDITIONAL FEATURES

- ➢ **Sliding Fee Scale calculation**

- ➢ **Insurance eligibility verification**

- ➢ **Credit card transaction processing & posting**

- ➢ **Managed care contract posting and reporting**

- ➢ **Relative Value Unit (RVU) utilization and reporting**

- ➢ **Interface with claims payors**

# *HOW DOES A PMS FIT TOGETHER WITH OTHER HEALTH INFORMATION TECHNOLOGY (HIT) SYSTEMS?*

➢ **Foundational- must have a solid system to ensure smooth front line operations and revenue cycle management to fund operations and expansion into other areas.**

➢ **HL7- should be able to connect or interface to other systems without excessive reprogramming.**

➢ **Consider all systems you might want to use currently or in the future-accounting, eligibility, credit card processing, clearinghouses, Electronic Health Record (EHR) etc.**

# *SHOULD WE CHOOSE A PMS FIRST, AND THEN AN ELECTRONIC HEALTH RECORD (EHR)?*

➢ **If a new start – doing both at the same time, with the right team and support mechanisms, is best.**

➢ **For existing project, how adequate is the current system? What is the business driver for change?**

➢ **Dependent upon funding availability – grant for software? Cash from Operations?**

# Section 2

# Electronic Health Record System Basics

# *Definitions:* EMR vs EHR

- **An EMR (Electronic Medical Record) is defined as:**
  *"An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization."*

- **An EHR (Electronic Health Record) is defined as:**
  *"An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization."*

  *--Office of the National Coordinator for Health Information Technology*

# *Definitions:*

# "EHRs"

*Industry standard abbreviation for: Electronic Health Record system*

# *WHAT IS AN ELECTRONIC HEALTH RECORD SYSTEM (EHRs)?*

A comprehensive and robust system that not only supports the collection of data and documentation of patient care information, but also allows for flexible reporting and aids in decision support for the provider.

In addition, the system includes:

1. Complete patient visit documentation: nurse triage, histories, review of systems, progress notes, orders, printed or electronic prescriptions
2. Real-time drug/allergy interaction
3. The capture and reporting of discrete patient data
4. Ability to interface labs, hospitals, other community providers
5. Tools/triggers to aid in decision support and adherence to evidence based medicine
6. Ability to scan paper documents and "file" into the chart

# WHAT TRENDS ARE PUSHING THE ADOPTION OF ELECTRONIC HEALTH RECORDS?

1. In the not so distant past, practice management systems were the center of the universe. Today, EHRs are the center of the universe

2. The market is clamoring for clinical data and it is survival of the fittest for systems to deliver the data.

3. Pay for performance, HRSA, CMS all putting pressure on providers and health systems to focus on health outcomes.

- CMS EHR Adoption Incentive Program - "Meaningful Use" objectives and clinical quality measures

- Patient Centered Medical Home initiatives

- Enhanced reimbursement for demonstrated improvement in outcomes *(Pay for Performance)*

# OTHER DRIVERS FOR ELECTRONIC HEALTH RECORDS

1. **Reduction of medical errors:**
   - Real-time drug/allergy interactions
   - "In-your-face" evidence based medicine triggers/reminders

2. **Records more legible:**
   - Reduces medical risks
   - Improves staff efficiency in trying to read notes

3. **Medical records staff efficiency:**
   - No more lost records!
   - No pulling a chart when the pharmacy or a patient calls
   - No more sticky notes
   - Routing charts between multiple locations eliminated

## 4. Security and Privacy:

- Security prevents unauthorized access
- Audit trails provide details on who accessed what and when
- Ability to back up data – prevents loss of records
- Time and data stamping to prevent accidental or deliberate misdating

## 5. Reduce lab and radiology order time/tracking:

- Easily see labs ordered and results
- No more lost results (with a functional interface)

## 6. Other Efficiencies:

- Provider chart review readily accommodated
- QA staff time for chart pulls reduced, over time, as electronic reports produce metrics from discrete data
- Long term savings in record retention costs

# *Definitions:* ROI

- **ROI = "Return on Investment"**

- **If there is no value, why do it?**

- **Tangible costs vs. intangible costs**

  1. Factoring in acquisition and implementation costs

  2. Personnel savings and resource shifts

  3. Defining recurring costs

  4. Quality improvement and market readiness – intangibles to factor in

  5. Data allows organization to measure productivity / outcomes and realign resources to meet strategic goals

# Tangible Information Management Needs in a Practice

**In one internal medicine practice's experience, a wide variety of tasks all have information needs**

## Typical Physician Day

- 18.1 office visits
- 12.1 prescriptions to be refilled
- 31.5 lab/imaging reports to review
- 23.7 phone calls to be processed

## Typical Information Needs

- 18.1 office visits/day with patient in room with chart
- **67.3 additional tasks per day where information is necessary for patient care outside office visits**

Baron RJ. Meaningful use of health information technology is managing information. JAMA. 2010; 304(1):89-90.

# *SAMPLE EHR RETURN ON INVESTMENT: INFORMATION MANAGEMENT IN PAPER WORLD*

- **Estimated staff hourly rate (with benefits) = $24**

- **Staff per Provider = 3**

- **Hours saved per staff per day = 1***

- **Number of compensation days = 260**

- **Total Annual Savings Possible = $18,720**

   *\*Conservative estimate – savings derived from staff not having to pull charts for visits or re-file, look for lost charts, inter-office patient-related communications, quality review efforts, and more. Savings only achieved if staff hours re-allocated to other tasks.*

# *JUST A FEW OTHER RETURN ON INVESTMENT METRICS TO EVALUATE:*

- **Tangible (Personnel):**

  - Chart pulls: Visits, QA, Billing
  - Calls to / from pharmacies
  - Tracking / case management logs
  - Chart Routing (multiple locations)
  - Referrals to other providers / specialists
  - Filing

- **Intangible:**

  - Improved Patient Safety
  - Legibility
  - Improved Information
  - Compliance
  - Provider Recruitment

- **Non-Personnel Costs:**

  - Paper
  - Chart Space
  - Transcription
  - Chart Supplies

# Thomas E. Langley Medical Center found:

- Time to locate, pull, and route a chart in their "paper" environment is 2.5 minutes

- Given the center's average number of charts pulled per day (365), 15.25 staff hours are spent per day in the paper chart environment in this task alone

- When charts are misfiled, the time study record jumped to 45 minutes (.75 hour) on average

- Workflow benefits under electronic records for chart pulls alone should recoup the cost of staff resources equaling two full time equivalents (FTE) over the course of a year

# Section 3
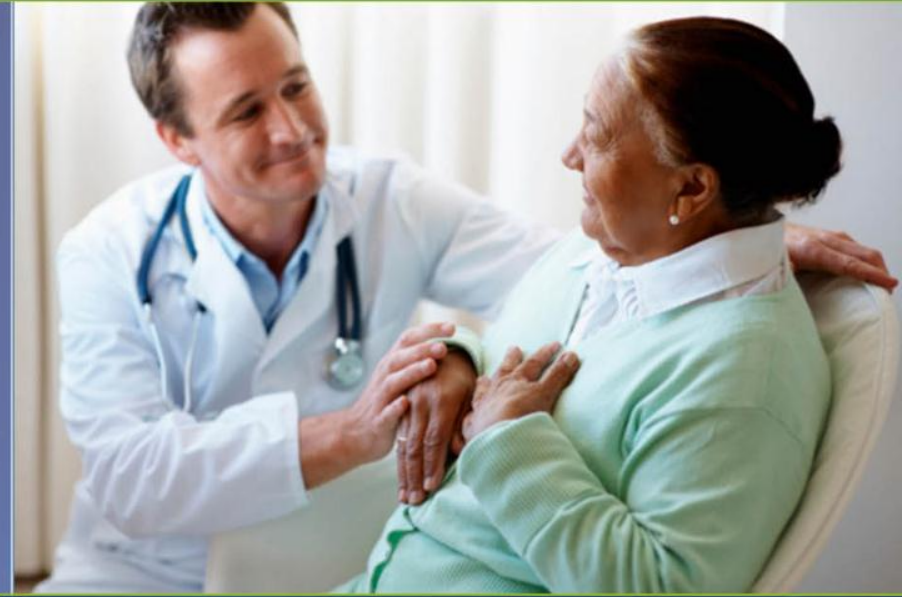
# Implementation Considerations

# SHOULD WE IMPLEMENT MULTIPLE SYSTEMS AT ONCE, OR DO THEM ONE AT A TIME?

➢ **Easier done at a new project where patient volumes are low.**

➢ **Depends on how much organization can afford to spend.**

➢ **If organization is already operational with large volumes, we don't recommend implementing  both at the same time as the impact on the organization will be enormous.**

# *MUST WE GET ALL OF OUR SYSTEMS FROM THE SAME VENDOR?*

## ➢ **Potential Pros:**

- ➢ Single point of contact
- ➢ Cross over accountability
- ➢ Systems should "play nicely" together
- ➢ Funding sources should be considered

## ➢ **Potential Cons:**

- ➢ May be weaknesses in one functional area
- ➢ If vendor has problems, both sides of the house can be adversely affected

# *MARRYING BEST OF BREED – 2 VENDORS*

➢ **Potential Pros:**

    ➢ Quality products for both areas

    ➢ Quality support

➢ **Potential Cons:**

    ➢ Interface issues in making systems work together

    ➢ "Finger pointing" between vendors

    ➢ Additional costs in developing and testing interfaces between products

# SHOULD WE DO IT ALONE, OR PARTNER WITH A NETWORK?

➢ **Pros of doing it alone:**

- ➢ Your organization is the sole decision-maker

- ➢ Needs of the individual organization / practice always come first

➢ **Cons of doing it alone:**

- ➢ All infrastructure costs (production server, redundancy, data lines) borne alone

- ➢ Required depth of staffing and diversity of skillsets borne alone

- ➢ No benefit of other expertise and collaboration

- ➢ Costs of implementation (project management, training, go-live support) borne alone

# *PROS OF THE NETWORK MODEL*

- ➢ **Pooled financial resources enable the hiring of high quality staff**

- ➢ **Working together enables the hiring of "depth"**

- ➢ **Two heads are better than one – typically, setup and implementation higher quality and more successful**

- ➢ **Cost sharing will allow for server redundancy, disaster recovery and other more robust solutions**

# *CONS OF THE NETWORK MODEL*

- ➢ **Collaboration takes time and effort**

- ➢ **Lots of communication is needed between partners**

- ➢ **Working together requires compromises be made between partners**

# APPROACHES TO EHR DEPLOYMENT

- **"Baby Step" Approach:**

    – **By Module(s)**

    – **By Locations**

    – **By Departments**

    – **By Provider**

- **"Big Bang" Approach**

# "BABY STEP" VERSUS "BIG BANG"

## Baby Step Pros:

- Return on Investment comes more quickly

- Growing champions is easier

- Implementation and support can be built slowly

- Productivity levels return more quickly

## Baby Step Cons:

- Patience required as all functionality not available initially

# "BABY STEP" VERSUS "BIG BANG"

## Big Bang Pros:

- A more complete, comprehensive system is deployed to providers

- More time available for configuration and testing

- Comprehensive change management strategy employed

- Less "Change Fatigue" – painful, but gets over quickly *(likened to "ripping the band-aid off all at once")*

## Big Bang Cons:

- More functionality at Go-Live may impact productivity levels for a longer period of time

- Large staffing infrastructure needed to support on day one

- Larger investment required up-front

- Potentially longer time frame to recoup investment dollars

**Section 4**

# The Process of Choosing a System

# WHAT PLAYERS SHOULD BE INVOLVED IN THE PROCESS OF CHOOSING A PMS?

- **Who should manage the project?**
  - Experienced project management – poor project management can increase costs
  - Business leaders – financial and operations management
- **Who else should be involved and in what roles?**
  - Finance – must, in advance, determine reporting needs and evaluate product
  - Operations – must, in advance, determine current and future operational, appointment, and patient flow management needs to evaluate product
  - Billing – experienced billing personnel familiar with state Medicaid and other practice-specific billing needs
- **Role of the IT department:**
  - Support for business departments and functions
  - Infrastructure, communications, desktops

# WHAT ADDITIONAL PLAYERS / MODIFICATIONS ARE NEEDED IN THE PROCESS WHEN CHOOSING AN EHRs?

- **For an EHR system selection and implementation to be successful, clinical leaders are required – must be clinician driven to be successful!  Key:**
  - Provider Champion(s)
  - Nursing Champion(s)
  - *"Super Users"*

- **EHR can not be viewed as an "IT project" – it's a clinical project that uses technology**

- **Role of the IT department:**
  - Support for clinical departments and functions
  - Infrastructure, communications, desktops

# WHAT ADDITIONAL PLAYERS / MODIFICATIONS ARE NEEDED IN THE PROCESS WHEN CHOOSING AN EHRs?

- **Executive Leadership:**

  - Cannot just say "go forth and do."

  - Must be part of the on-going reinforcement to ensure that the return on investment occurs.

  - Should give encouragement throughout the process as staff meet implementation milestones.

## *SHOULD WE BOTHER GOING THROUGH A FORMAL REQUEST FOR PROPOSALS (RFP) PROCESS WHEN SELECTING A VENDOR?*

*Yes:*

- **"Dog n' Pony" shows do not ensure quality – just good vendor sales pitches**

- **RFP response can become part of a contract**

- **Ensures a more apples-to-apples comparative**

- **Protects CEO and Board – demonstrates due diligence**

# *HOW DO WE DEVELOP THE VENDOR RFP?*

- **Requires experience and keen understanding of environment**

- **Legal input is recommended**

- **Evaluate the vendor and reputation in addition to the product**

- **Use HRSA document as a resource for functional requirements baseline**

- **Review CCHIT BH Guidelines**

| Specifications | | PRI | MU | RESP | Yes, Included | Yes, Additional Cost | No | Comments / Clarifications |
|---|---|---|---|---|---|---|---|---|
| 1 | Meaningful Use (as defined in CMS' Final Rule for the Medicare & Medicaid EHR Incentive Program) | | | | | | | |
| 1.1 | The system supports the entire Meaningful Use Final Rule. Each of the specification target dates is met with ample time to allow for template modifications, data entry and report production | H | X | | | | | |
| 2 | General | | | | | | | |
| 2.1 | The system supports both a total paperless function and a hybrid function (part paper, part electronic) where the contents of the electronic record can be printed for inclusion in the paper chart. | H | | | | | | |
| 2.2 | The system interfaces with a variety of digital and analog dictation systems (state devices). | H | | | | | | |
| 2.3 | The system date and time stamps all entries. | H | | | | | | |
| 2.4 | The system includes automatic translation of codes to data. For example: | | | | | | | |
| 2.4.1 | ICD-9-CM | H | | | | | | |
| 2.4.2 | DSM-IV | D | | | | | | |
| 2.4.3 | CDT | D | | | | | | |
| 2.4.4 | CPT (4 and 5) | H | | | | | | |
| 2.4.5 | ICD-10 (As of 1/15/10, current CMS deadline for implementation of ICD-10 is 10/1/13 | H | | | | | | |

# http://hrsa.gov/healthit/ehrguidelines.html

**http://www.cchit.org/workgroups/behavioral-health**

## HOW SHOULD WE EVALUATE THE VENDOR RESPONSES TO THE RFP?

- **Create a scoring tool – which of the functional requirements are "required" vs. "optional"?**

- **Use of a scoring tool – weighting the required items**

- **Document, document, document – questions and answer exchange**

## *THE VENDOR WANTS TO COME DO A DEMO-WHAT SHOULD WE DO?*

- **Allow free form demos first**

- **Follow up with controlled demos**

- **Don't be afraid to make them demo again and again**

- **Understand that demos can have value, but they are designed solely to make the product look good and weaknesses will not be addressed**

# *ONCE WE CHOOSE THE PRODUCT WE WANT, HOW DO WE NEGOTIATE WITH THE VENDOR?*

- **Understand their various licensing models available**

- **Understand your needs and how they match the licensing model**

- **Pay the money as deliverables are met, not all up front**

- **It pays to contract with a competent resource to assist in this process**

# *HOW DO WE DEVELOP AN IRONCLAD CONTRACT WITH THE VENDOR TO PROTECT OUR ORGANIZATION?*

- **Read the contract thoroughly, understand the various licensing options**

- **Use a competent attorney experienced in software contracts**

- **Use a competent resource to advocate for your needs and help with the review process**

- **Don't scrimp on expertise here or it will cost you in the long run**

# WHICH SYSTEMS SHOULD WE LOOK AT?

## Can any ambulatory Electronic Health Record system work in our environment?

### No:

- **Most ambulatory primary care systems do not include robust / comprehensive documentation for Behavioral Health**

- **Many products are strong in only one niche or another**

- **Product must be able to support your service offerings**

- **Systems must be customizable:**

  - **For patient / client visit documentation**

  - **Custom reporting**

  - **Case management**

## BEYOND THE BASICS OF AN EHR, WHAT PRODUCT / VENDOR CONSIDERATIONS ARE IMPORTANT?

1. **Flexibility in form customization**

2. **Ability to meet and continually comply with grant / other federal requirements**

3. **Ability to allocate patients to certain programs, grants, or studies**

4. **Interface capabilities / vendor willingness to work with competition**

5. **Vendor's client list – you don't want to be the lowest priority *(Also may be risky to be the only priority)***

6. **Reporting, reporting, reporting – data is useless if it can't be turned into meaningful information**

# *ALTERNATIVE TO VENDOR APPROACH: WORK WITH AN EXISTING NETWORK*

1. **Health Center Controlled Networks create solutions partnerships with their members, not just contracts for specific products**

2. **Unlike vendors, the partnership with a network is long-term and relies on evolving needs of its membership, not just market conditions or sales opportunities**

3. **Many different models under the HCCN umbrella: from menu-based to turnkey offerings**

4. **Typically, members are heavily involved in governance, ensuring that your organization has a voice in the strategic plan of the network**

# Questions?

# **Original Content Developed for SAMHSA by**

www.hcnetwork.org

www.southfloridarec.org

# Our Footprint

- HCCN - Member Center CEOs serve as Board of Directors
- 41 member centers in 10 states (FL, HI, KS, MD, MO, NM, RI, TX, UT, WV)
- Approximately 800,000 patients

- Covering Priority Primary Care Providers (PPCP) in Miami-Dade, Broward, Monroe, Martin, Palm Beach, Indian River, Okeechobee, and St. Lucie Counties
- Provider Goal = 2,500



UTAH 18,000 patients
RHODE ISLAND 35,000 patients
KANSAS 10,000 patients
WEST VIRGINIA 65,000 patients
MARYLAND 27,000 patients
NEW MEXICO 109,000 patients
TEXAS 9,000 patients
MISSOURI 20,000 patients
FLORIDA 475,000 patients
HAWAII 7,000 patients
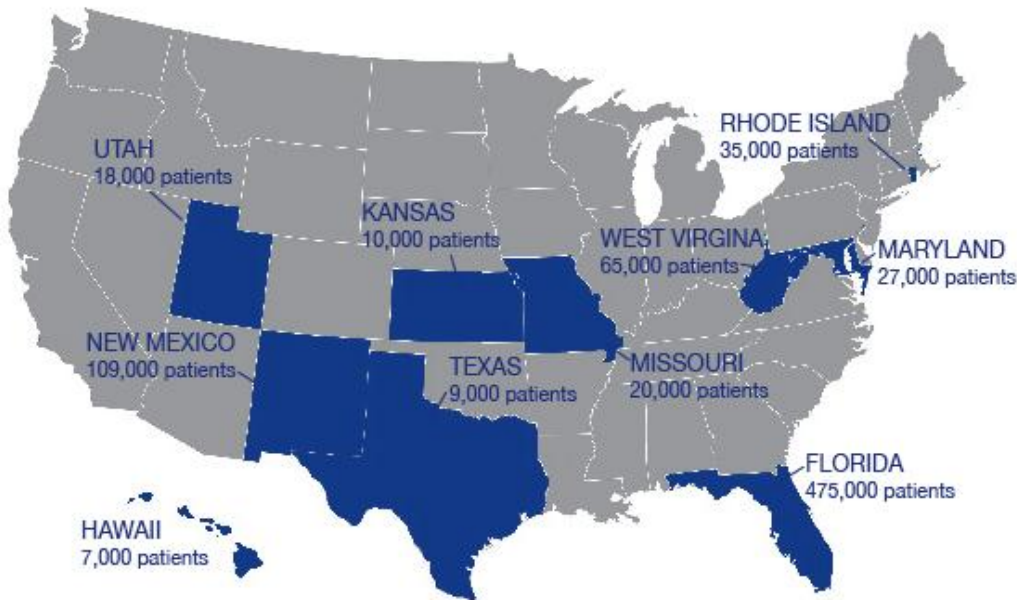
# HCN Health Information Technology Services

- **Electronic Health Record**
  - Medical / Dental / Behavioral
  - Custom Provider Templates
  - School Based Dental
  - School Based Medical
  - Document Imagining
  - Voice Recognition
  - CCD

- **Network Administration**
  - Hosting Services
  - Back office / Email Support
  - Disaster Preparedness
  - Infrastructure Design (LAN/WAN)
  - Web Design/Mgmt

- **Implementations and Training**
  - Project/Change Management
  - Training and Staff Development
  - Best Practices Matrix
  - Reimbursement Coordination

- **Support Services**
  - 24hr Service Desk (Hardware/Software)
  - Project Management
  - Vendor Escalation
  - BETA Testing

- **Business Intelligence**
  - Meaningful Use Reporting
  - Clinical Reporting
  - Fiscal Reports (Black Book)
  - Web based Reporting Tools
  - Practice Management Support

HCNetwork.org®
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INNOVATIVE HEALTH TECHNOLOGY SOLUTIONS

*Headquartered in Portland, Oregon, OCHIN is a national non-profit collaborative, currently comprised of 42 organizations across seven states representing over 400 clinics and over 2,000 providers.  With the ultimate goal of transforming health care in the United States, OCHIN provides integrated HIT software products and a wide variety of services, training and education to community health clinics, mental health services and small practices serving the medically underserved.*

[www.ochin.org](http://www.ochin.org)

# Who We Are

- 501c(3) Collaborative Health Center Controlled Network

- 51% of Board Members are Community Health Center Executives

- 42 member organizations, over 400 individual clinics & 2000 providers

- 1M patients, 2.140M Practice Management & 1.712M Electronic Health Record annual visits

## The OCHIN Collaborative
CALIFORNIA • OREGON • WASHINGTON • OHIO • ALASKA • NORTH CAROLINA • WISCONSIN
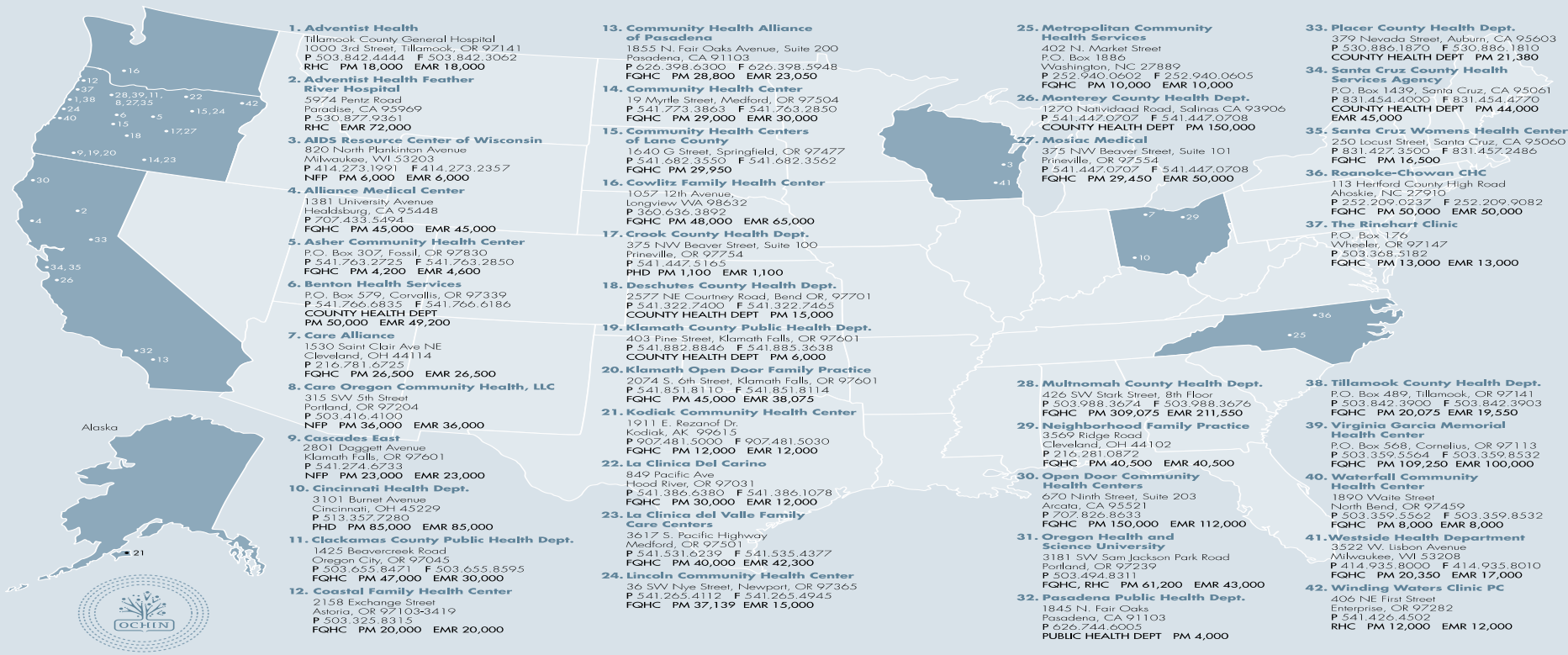
**1. Adventist Health**
Tillamook County General Hospital
1000 3rd Street, Tillamook, OR 97141
P 503.842.4444  F 503.842.3062
RHC  PM 18,000  EMR 18,000

**2. Adventist Health Feather River Hospital**
5974 Pentz Road
Paradise, CA 95969
P 530.877.9361
RHC  EMR 72,000

**3. AIDS Resource Center of Wisconsin**
820 North Plankinton Avenue
Milwaukee, WI 53203
P 414.273.1991  F 414.273.2357
NFP  PM 6,000  EMR 6,000

**4. Alliance Medical Center**
1381 University Avenue
Healdsburg, CA 95448
P 707.433.5494
FQHC  PM 45,000  EMR 45,000

**5. Asher Community Health Center**
P.O. Box 307, Fossil, OR 97830
P 541.763.2725  F 541.763.2850
FQHC  PM 4,200  EMR 4,600

**6. Benton Health Services**
P.O. Box 579, Corvallis, OR 97339
P 541.766.6835  F 541.766.6186
COUNTY HEALTH DEPT
PM 50,000  EMR 49,200

**7. Care Alliance**
1530 Saint Clair Ave NE
Cleveland, OH 44114
P 216.781.6725
FQHC  PM 26,500  EMR 26,500

**8. Care Oregon Community Health, LLC**
315 SW 5th Street
Portland, OR 97204
P 503.416.4100
NFP  PM 36,000  EMR 36,000

**9. Cascades East**
2801 Daggett Avenue
Klamath Falls, OR 97601
P 541.274.6733
NFP  PM 23,000  EMR 23,000

**10. Cincinnati Health Dept.**
3101 Burnet Avenue
Cincinnati, OH 45229
P 513.357.7280
PHD  PM 85,000  EMR 85,000

**11. Clackamas County Public Health Dept.**
1425 Beavercreek Road
Oregon City, OR 97045
P 503.655.8471  F 503.655.8595
FQHC  PM 47,000  EMR 30,000

**12. Coastal Family Health Center**
2158 Exchange Street
Astoria, OR 97103-3419
P 503.325.8315
FQHC  PM 20,000  EMR 20,000

**13. Community Health Alliance of Pasadena**
1855 N. Fair Oaks Avenue, Suite 200
Pasadena, CA 91103
P 626.398.6300  F 626.398.5948
FQHC  PM 28,800  EMR 23,050

**14. Community Health Center**
19 Myrtle Street, Medford, OR 97504
P 541.773.3863  F 541.763.2850
FQHC  PM 29,000  EMR 30,000

**15. Community Health Centers of Lane County**
1640 G Street, Springfield, OR 97477
P 541.682.3550  F 541.682.3562
FQHC  PM 29,950

**16. Cowlitz Family Health Center**
1057 12th Avenue,
Longview WA 98632
P 360.636.3892
FQHC  PM 48,000  EMR 65,000

**17. Crook County Health Dept.**
375 NW Beaver Street, Suite 100
Prineville, OR 97754
P 541.447.5165
PHD  PM 1,100  EMR 1,100

**18. Deschutes County Health Dept.**
2577 NE Courtney Road, Bend OR, 97701
P 541.322.7400  F 541.322.7465
COUNTY HEALTH DEPT  PM 15,000

**19. Klamath County Public Health Dept.**
403 Pine Street, Klamath Falls, OR 97601
P 541.882.8846  F 541.885.3638
COUNTY HEALTH DEPT  PM 6,000

**20. Klamath Open Door Family Practice**
2074 S. 6th Street, Klamath Falls, OR 97601
P 541.851.8110  F 541.851.8114
FQHC  PM 45,000  EMR 38,075

**21. Kodiak Community Health Center**
1911 E. Rezanof Dr.
Kodiak, AK 99615
P 907.481.5000  F 907.481.5030
FQHC  PM 12,000  EMR 12,000

**22. La Clinica Del Carino**
849 Pacific Ave
Hood River, OR 97031
P 541.386.6380  F 541.386.1078
FQHC  PM 30,000  EMR 12,000

**23. La Clinica del Valle Family Care Centers**
3617 S. Pacific Highway
Medford, OR 97501
P 541.531.6239  F 541.535.4377
FQHC  PM 42,300

**24. Lincoln Community Health Center**
36 SW Nye Street, Newport, OR, 97365
P 541.265.4112  F 541.265.4945
FQHC  PM 37,139  EMR 15,000

**25. Metropolitan Community Health Services**
402 N. Market Street
P.O. Box 1886
Washington, NC 27889
P 252.940.0602  F 252.940.0605
FQHC  PM 10,000  EMR 10,000

**26. Monterey County Health Dept.**
1270 Natividaad Road, Salinas CA 93906
P 541.447.0707  F 541.447.0708
COUNTY HEALTH DEPT  PM 150,000

**27. Mosiac Medical**
375 NW Beaver Street, Suite 101
Prineville, OR 97554
P 541.447.0707  F 541.447.0708
FQHC  PM 29,450  EMR 50,000

**28. Multnomah County Health Dept.**
426 SW Stark Street, 8th Floor
P 503.988.3674  F 503.988.3676
FQHC  PM 309,075  EMR 211,550

**29. Neighborhood Family Practice**
3569 Ridge Road
Cleveland, OH 44102
P 216.281.0872
FQHC  PM 40,500  EMR 40,500

**30. Open Door Community Health Centers**
670 Ninth Street, Suite 203
Arcata, CA 95521
P 707.826.8633
FQHC  PM 150,000  EMR 112,000

**31. Oregon Health and Science University**
3181 SW Sam Jackson Park Road
Portland, OR 97239
P 503.494.8311
FQHC, RHC  PM 61,200  EMR 43,000

**32. Pasadena Public Health Dept.**
1845 N. Fair Oaks
Pasadena, CA 91103
P 626.744.6005
PUBLIC HEALTH DEPT  PM 4,000

**33. Placer County Health Dept.**
379 Nevada Street, Auburn, CA 95603
P 530.886.1870  F 530.886.1810
COUNTY HEALTH DEPT  PM 21,380

**34. Santa Cruz County Health Services Agency**
P.O. Box 1439, Santa Cruz, CA 95061
P 831.454.4000  F 831.454.4770
COUNTY HEALTH DEPT  PM 44,000
EMR 45,000

**35. Santa Cruz Womens Health Center**
250 Locust Street, Santa Cruz, CA 95060
P 831.427.3500  F 831.457.2486
FQHC  PM 16,500

**36. Roanoke-Chowan CHC**
113 Herford County High Road
Ahoskie, NC 27910
P 252.209.0237  F 252.209.9082
FQHC  PM 50,000  EMR 50,000

**37. The Rinehart Clinic**
P.O. Box 176
Wheeler, OR 97147
P 503.368.5182
FQHC  PM 13,000  EMR 13,000

**38. Tillamook County Health Dept.**
P.O. Box 489, Tillamook, OR 97141
P 503.842.3900  F 503.842.3903
FQHC  PM 20,075  EMR 19,550

**39. Virginia Garcia Memorial Health Center**
P.O. Box 568, Cornelius, OR 97113
P 503.359.5564  F 503.359.8532
FQHC  PM 109,250  EMR 100,000

**40. Waterfall Community Health Center**
1890 Waite Street
North Bend, OR 97459
P 503.359.5562  F 503.359.8532
FQHC  PM 8,000  EMR 8,000

**41. Westside Health Department**
3522 W. Lisbon Avenue
Milwaukee, WI 53208
P 414.935.8000  F 414.935.8010
FQHC  PM 20,350  EMR 17,000

**42. Winding Waters Clinic PC**
406 NE First Street
Enterprise, OR 97282
P 541.426.4502
RHC  PM 12,000  EMR 12,000

Alaska

# OCHIN PRODUCTS AND SERVICES

- **Practice Management**
  - ✓ Scanning solutions
  - ✓ FQHC customizations
  - ✓ Special and community Library Reports
  - ✓ Flexible build and configuration
  - ✓ Automated patient notifications
  - ✓ Revenue cycle management

- **Electronic Health Record**
  - ✓ Integrated community health record- medical, dental, behavioral health, school-based clinics
  - ✓ E-prescribing
  - ✓ Decision support tools
  - ✓ Case/care management tools
  - ✓ Integrated lab interfaces
  - ✓ Advanced role based security
  - ✓ Voice recognition
  - ✓ Reporting and benchmarking tools
  - ✓ Document management
  - ✓ Continuity of Care Record (CCD)
  - ✓ Patient Personal Health Record (PHR)

- **Implementation, Training and Products**
  - ✓ Project management
  - ✓ Information systems implementation
  - ✓ Network design
  - ✓ HIT integration & interoperability
  - ✓ Billing and revenue cycle management
  - ✓ Staff PM/EHR training
  - ✓ Web-based training modules

- **Support**
  - ✓ Project Management
  - ✓ 24/7 service desk
  - ✓ Advisory and consulting services
  - ✓ Meaningful Use reporting tools
  - ✓ Clinical reporting tools
  - ✓ Specialty build for grant
  - ✓ Vendor escalation

- **Practice Based Research Network**
  - ✓ Safety Net clinical research & clinical collaboration opportunities

**www.CHCAlliance.org**

**Health Center Controlled Network**

**Est. 1999**

**www.AdvanceHealthIT.org**

**Regional Extension Center**

**Est. 2010**

![Community Health Centers ALLIANCE]

# *"Meaningful" Users of EHR Since 2005*

## Core Health Information Technology Offerings

▸ **Practice Management System**
*(including Practice Analytics)*

▸ **Electronic Health Records**

*(240,000+ Patient Records)*

 ▸ **ePrescribe**

 ▸ **Lab Orders / Results**

 ▸ **Specialty Provider Referrals**

 ▸ **Quality Reporting**

▸ **Electronic Oral Health Records**

 *(including Digital Imaging)*

## Professional Services

▸ **Project Management / Implementation Support**
  - ▸ Leadership and task level monitoring
  - ▸ End to end project / system design
  - ▸ Workflow / Process Consideration
  - ▸ On-site Go-Live Choreography

▸ **Training**
  - ▸ Modalities matched to provider / end user needs, including classroom, coaching, and web-based tools
  - ▸ Competency exams

▸ **Report Writing / Administration**
  - ▸ Custom QA/QI, Peer Review, and Operations reporting
  - ▸ Meaningful Use – Workflows, Provider-level detail, and gap analysis

▸ **EHR Development / Enhancement**
  - ▸ Clinical Committee directed
  - ▸ Interface management to support HIE and other functionality to the provider desktop

▸ **Technical Assistance & Support**
  - ▸ Help Desk processes more than 7,000 requests annually; fewer than 5% escalated to vendors
  - ▸ 24x7 System Availability

▸ **Tier 1 Data Center Partner**
  - ▸ Server Redundancy
  - ▸ Privacy / Security Monitoring & Management
  - ▸ 24x7 Server Monitoring / Network Administration
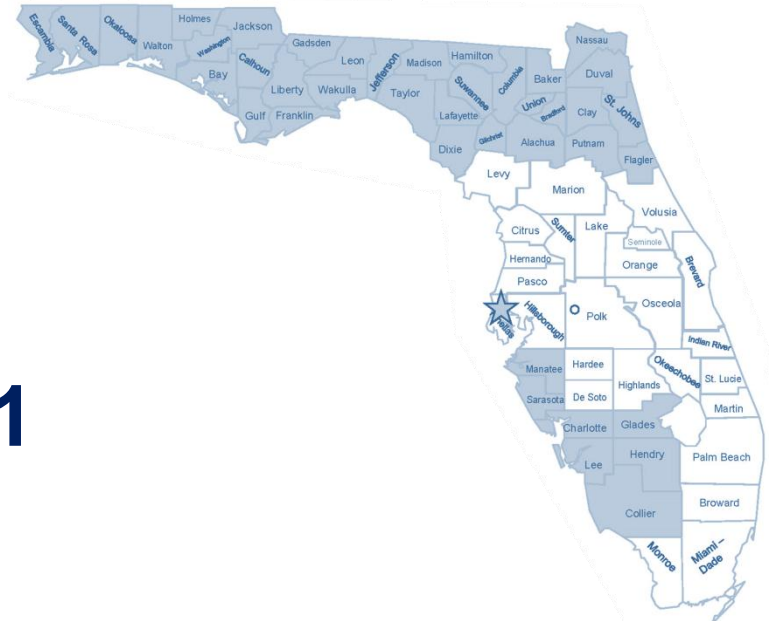
# Service Area Counties: 41
# Provider Goal: 2,026

- Education and Trusted Resource for Latest Information
- Best Practices Dissemination
- System selection assistance
- System implementation support
- Technical assistance
- Privacy and security best practices
- Workflow redesign

- Clinical outcomes reporting / data integrity
- Federal regulations navigation
- "Meaningful Use" education, application, and attainment
- Education and assistance in achieving eligibility for CMS EHR Adoption Incentive Program funding *(Designed to help overcome the financial barrier to EHR adoption)*