Welcome to our latest edition of Kohler HealthCare Consulting’s “Pieces for Success”. We hope you find this periodic newsletter to be informative and of assistance. If you know others who may find this information useful, please feel free to share our newsletter with them or with their permission, forward their email address to us for inclusion in our distribution list.

TABLE OF CONTENTS

SPEAKING ENGAGEMENTS, STAFF ANNOUNCEMENTS, AND TIDBITS 2

CMS, OIG AND MEDICARE UPDATES 3

- CMS UPDATE: THE PATIENT ACCESS AND MEDICARE PROTECTION ACT – Janet Ellis.............3
- PET SCAN DENIALS – Deanna Turner .................................................................................................4
- ARE YOU GETTING PAID TOO MUCH FOR YOUR LAB TESTS? CMS THINKS SO. [CLINICAL LABS HAVE NEW REPORTING REQUIREMENTS] – John Ninos........................................................................................................4

FINANCE AND MANAGEMENT 4

- SIGN OF THE TIMES IN REDUCING HEALTH CARE COSTS AND INCREASING PRODUCTIVITY - Charlotte Kohler..................................................................................................................................................4
- PUSHING FOR EXCELLENCE, BUT CREATING FEAR INSTEAD? – Daria Malan ........................................5
- SERVICE LEVEL AGREEMENTS-FOSTERING TEAMWORK AND RESULTS – Chris Fallon ..............5

COMPLIANCE CORNER 6

- DEVELOPING EFFECTIVE COMPLIANCE REPORTING AND MONITORING – Deanna Turner..........6
- HOSPITALS CONTINUE FILING CASES OPPOSING THE ‘TWO MIDNIGHT’ RULE – Susan Walberg6

CODING CORNER 7

- CMS FINALIZES 2016 MEDICARE PAYMENT RULE FOR ADVANCE CARE PLANNING – Tammy Morris ..................................................................................................................................................7

OTHER ARTICLES OF INTEREST 7

- THERE ARE NO CHANGES IN THE PENSION PLAN LIMITS FROM 2015-2016 BECAUSE THERE WAS NO INCREASE IN COST OF LIVING – Charlotte Kohler........................................................................................................7
- ELECTRONIC HEALTH RECORD DOCUMENTATION – Diane Jordan ....................................................8
- TELEHEALTH...TELEMEDICINE...THE FUTURE OF HEALTHCARE (PHYSICIAN/MEDICAL PRACTICE) – Simbo Famure..................................................................................................................................................8

ADDITIONAL INFORMATION 8
SPEAKING ENGAGEMENTS, STAFF ANNOUNCEMENTS, AND TIDBITS

1/19/2016 - Charlotte Kohler is speaking at the AAPC Charm City Chapter-at GBMC, PPE, Rooms A&B on CPT Updates and Changes.

Charlotte Kohler has written an article for the November issue of AAPC’s Healthcare Business Monthly entitled, “Overpayments: Are You Effectively Managing Your Risk?”

2/17/16 – Charlotte Kohler and Janet Ellis are speaking at the AAHAM National Webinar entitled, “Creating a Team – Case Management and PFS from Admission to Discharge.”

Free Kohler Connection Webinars [check our website frequently for any changes]. Contact Noel Asen (nasen@kohlerhc.com) for webinar information. Existing webinars are also available and we can hold one just for your organization! See our website for listings. Again, if interested, please contact us.

Want the most up to date CMS info on 2016 drug-abuse testing codes? First, go to this website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html. Look at the left column, click on Laboratory Public Meetings, then go to the Downloads section and look for the file named “Calendar Year (CY) 2016 Clinical Laboratory Fee Schedule (CLFS) Final Determinations.”

MAC News: CMS is looking to vastly expand audits of Medicare Advantage plans and monitor insurers that may game the system to obtain higher payments. Modern Healthcare reported the RFP: http://www.modernhealthcare.com/assets/pdf/CH1031301228.PDF

RACTrac: 40% of the denials caused by outpatient coding errors. Since most of the outpatient services are driven by the ChargeMaster, it means that either the ChargeMaster needs to be updated, or the departmental staff don’t understand which charge to select. Read more about this at> http://www.aha.org/content/15/15q3tractracresults.pdf. Also remember, KHC are experts in hospital and pro-fee charge masters.


Our First HCPro Book, Hospital Billing From A to Z, written by KHC staff is a reference guide.
covering Medicare with ease of use for those involved in hospital billing. The book is available thru:


**NOW PUBLISHED:** New HCPro Book written by KHC entitled *Physician Practice Billing From A to Z* is a comprehensive, user-friendly guide to billing requirements, with particular emphasis on Medicare. This resource will help physician practice billers understand the relevant regulations, code sets, compliance issues, and a myriad of other factors that affect the billing process. To learn more about the book or to order go to HCPro: http://hcmarketplace.com/physician-practice-billing-from-a-to-z?code=PPI&utm_source=edit&utm_medium=enl&utm_campaign=ENL_PPI_063015

### Update on PEPPER Report and MAC activities.

The expansion of PEPPER continues to reflect the concerns of the Department of Justice with the addition of reporting on surgery for implantable cardiac defibrillators due to the 70 settlements where the DOJ collected over $250 million in unnecessary procedures. CERT reviews identified a 58.1% error rate for DRG 226 and 227. (See Medicare Fee-for-Service 2014 Improper Payments Report). With this information, hospitals should compare their own volumes with those in the region, MAC area and national. Taking PEPPER reports to your MAC Committee allows for a proactive identification of current and past issues without being identified and investigated by the MACs or RACs. Too often the use of the PEPPER report is limited to Care/Case management. It should be widely distributed (including the CFO and Chief Compliance Officer) to evaluate and minimize compliance issues. It also can identify if your coding is presenting acuity that appears to be too low. On the other hand having a higher utilization rate doesn’t mean there’s a problem, but it does give you the opportunity to be sure.

If you need help in reviewing ICD, PTCA, or other issues identified in your PEPPER report or from CERT reviews, give KHC a call. We have the experience and talent to help identify the appropriate means to resolve these and other issues. **Call to schedule your review: 410-461-5116.**

### CMS, OIG AND MEDICARE UPDATES

#### CMS UPDATE: THE PATIENT ACCESS AND MEDICARE PROTECTION ACT – Janet Ellis

Meaningful use is a Medicare/Medicaid program that assigns incentives for using certified electronic health records to improve patient care. There are three stages in the program. Stage 1 requires electronic securing of clinical patient data and providing the information to patients. Stage 2 reinforces the use of health information technology for quality improvement at the site of care. Stage 3 focuses on improving healthcare outcomes.

President Barack Obama signed the Patient Access and Medicare Protection Act S.2425 into law on December 28, 2015. This bill was initiated due to the short implementation time in the publication of the Stage 2 Meaningful Use Rule, which would not allow providers and hospitals enough time to put the criteria in place to avoid penalties.

This bill will make it uncomplicated for providers and hospitals to obtain hardship exemption from penalties for failing to meet Stage 2 requirements. Providers will have until March 15, 2016 to apply for exemptions. The last date for hospitals to apply is April 1, 2016.

More information pertaining to the medicare/medicaid electronic health record incentive program can be found at www.cms.gov/ehrincentiveprogram.
PET SCAN DENIALS – Deanna Turner

On Dec. 15th, CMS released a memo (CAG-00065R2) indicating that, “[t]he Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to determine that use of a NaF-18 positron emission tomography (PET) scan to identify bone metastasis of cancer is not reasonable and necessary to diagnose or treat an illness or injury or to improve the functioning of a malformed body member and, therefore, is not covered under § 1862(a)(1)(A) of the Social Security Act.”

ARE YOU GETTING PAID TOO MUCH FOR YOUR LAB TESTS? CMS THINKS SO. [CLINICAL LABS HAVE NEW REPORTING REQUIREMENTS] – John Ninos

Most Medicare payment schedules (APC, MPFS) are adjusted on an annual basis, however, when it comes to the Clinical Laboratory Fee Schedule (CLFS) once payment is determined, payment is not further adjusted. This lack of an established mechanism to adjust payment amounts is unique among the Medicare payment schedules and system. Since there is currently no process to make such adjustments for the CLFS, payment amounts are not changed despite changes in technology which affect the cost of performing the tests. CMS claims this results in inaccurate test payments. CMS states that “the introduction of new tests, advances in equipment and testing techniques, and, the proliferation of advanced information technology have all made testing more efficient and automated.” (MPFS, Final Rule, 2015)

To resolve the situation CMS will conduct a data analysis of codes on the CLFS to determine which codes should be proposed during the rulemaking cycle for a payment adjustment due to technological changes.

This review will involve examining test codes in several different ways, such as examining those that have been on the CLFS the longest, those that are high volume test codes, those that have a high dollar payment, or those that have experienced rapid spending growth, among other considerations.

After finalizing this process, the payment amounts would be re-examined for test codes in CLFS for possible payment revision based on technological changes required by Protecting Access to Medicare Act of 2014 (PAMA). The PAMA requires CMS to implement a new Medicare payment system for clinical diagnostic laboratory tests based on private payer rates. This is the first major change in the clinical laboratory fee-for-service reimbursement methodology since 1994 (the start of CLFS). These included the collection of private sector payment rates. The new rates are expected to take effect on or after January 1, 2017.

Beginning January 1, 2016, and every 3 years thereafter, applicable laboratories will be required to report specific information. Failure to report, misrepresentation or omission in reporting information may result in a civil monetary penalty of up to $10,000 per day for each failure to report or each such misrepresentation or omission. “Applicable laboratory” are defined by CMS as one that receives (1) $50,000 or more in Medicare revenues from laboratory services in a data collection period, and (2) more than 50% of its Medicare revenues for the entire organization from services paid for under the CLFS and the Medicare Physician Fee Schedule. It will be at the Taxpayer Identification Number (TIN) level entity, covering National Provider Identifier (NPI) level components. CMS does not expect hospital laboratories to be considered applicable laboratories, and the agency estimates that more than 50% of independent laboratories and more than 90% of physician offices will be exempt from reporting private payor data under the low expenditure criterion.

The new payment rates will be based on a weighted median. If a new rate results in payment decrease, the adjustment will be implemented over time. Reductions, if applicable, will not exceed 10 percent during 2017-2019 and not to exceed 15 percent during 2020-2022.

CMS expects reductions from this PAMA mandate. CMS estimates that the new policy, which was mandated by the Protecting Access to Medicare Act of 2014 (PAMA), will reduce Medicare CLFS payments by $360 million in FY 2017 and by $5.14 billion over 10 years.

FINANCE AND MANAGEMENT

SIGN OF THE TIMES IN REDUCING HEALTH CARE COSTS AND INCREASING PRODUCTIVITY - Charlotte Kohler

Many (many) years ago it was normal for large industrial companies to have a health clinic inside their plant. Even then, one would not have thought that a hospital would set up their own clinic, but it happened – to keep their own employees out of the hospital and to reduce expenditures. Yes, St. John’s Hospital in Springfield, Illinois is self-funded
like many other hospitals. Controlling costs is still important and St. John has joined with Horace Mann Educators Corp (a for profit insurance company) to create an employer-sponsored health clinic run by the HSHS Medical Group. The overall 4,000 employees and their dependents are required to use the clinic located in the city block between the two employers.

Productivity in radiology practices is being challenged as payments continued to decline from the reimbursement consolidation methodology and value-based pricing. Personally, I have believed that most radiology practices monitor productivity, but training, centralized scheduling, evaluation of locations and hours are pushing radiology to heighten cost/benefit decisions. Bottom line is to book more appointments per day and reduce overhead – the mantra of all organizations.

**PUSHING FOR EXCELLENCE, BUT CREATING FEAR INSTEAD? – Daria Malan**

Some organizations are garnering headlines for offering generous benefits such as longer parental leaves, while employees today often face intense pressure to meet ambitious targets with smaller teams and fewer resources - and expect repercussions if they don't.

A culture of fear has permeated many workplaces since the recent recession and is taking a long-term toll on employee morale and efficiency, experts say. The Society of Human Resources has stepped out to suggest the notion that maybe we are creating a “Psychology of Fear” vs. a “Culture of Engagement.”

Many organizations have become obsessed with managing workers through measuring, monitoring, goal-setting and dictating processes to reach those goals. When people are frightened, they don't perform well, are less engaged, less productive and have higher absentee rates.

How do you know if a culture of fear exists at your organization? Telltale signs: employees quiet during meetings, speak up after leaders leave the room, keep a low profile, work to the requirement (but nothing more), and vent within an active rumor mill.

How can executives reverse the fear factor? Leaders can start being straightforward, admitting mistakes, keeping promises, showing vulnerability and letting go of grievances. Most importantly, listen - don’t judge. Acknowledge employee's worth and help them succeed. Studies show that happy, engaged employees are more productive and feel an intrinsic reward from working. A culture of fear is a conundrum, but the way out isn’t terribly complicated.

**SERVICE LEVEL AGREEMENTS-FOSTERING TEAMWORK AND RESULTS – Chris Fallon**

Efficient and high quality healthcare delivery is highly dependent on different disciplines working together for patient safety and patient care. Poor business or clinical processes or even personnel clashes can harm working relationships. To deal with this, sometimes Management levels above the clashing participants are brought in to sort out the issues and demand improvements. Those improvements can quickly fall back to the prior poor levels and behaviors if the underlying issues, measured by data are not considered.

An approach to deal with this type of situation is to establish interdepartmental Service Level Agreements (SLA). An SLA is not a complaint stifling mechanism or a quick fix. It is a contract-like agreement that defines and outlines the support or business process parameters that departments provide to one another within an organization. Important, the agreement outlines the specific metrics to which each party agrees and the acceptable measures for performance (i.e. “95% accuracy”) and commits the parties to process improvement steps to further enhance performance. The SLA value is not just cooperation, the process itself of establishing an SLA helps to open up communications and the degree of commitment that the parties have towards improvement.

Industry benchmarks can be very useful in establishing the delta between current performance and targeted performance. The benchmark targets should be widely accepted, practical and achievable industry standards. The parties must use the same criteria to evaluate service quality or data integrity and thus, there will be a shared understanding of needs and priorities.

Once agreed to, there must be a commitment to live up to the letter and spirit of the agreement and there must be consequences for failure. To reduce the likelihood of failure, there must be a Management component to oversee the tracking of service effectiveness, resolution of disagreements and future revisions of the SLA. This oversight, depending on the underlying issue to the organization, should be more frequent and intensive in the early stages and periodically thereafter to be sure the initiative stays “on the rails”. There must be Management discipline and rigor for the SLA initiative to be successful. A satisfaction rating system may be useful to the end users as feedback on performance.

With improved cooperation, as enforced by metrics and agreement, previously troubled parties often find less contention and much improved communication. It can be that one party has unrealistic expectations that can frustrate the other party or parties. There are many benefits from an operational SLA including organizational harmony,
improved job satisfaction and greater organizational efficiency.

**COMPLIANCE CORNER**

**DEVELOPING EFFECTIVE COMPLIANCE REPORTING AND MONITORING – Deanna Turner**

Hospital institutions are governed by Boards of Directors and, whether elected or appointed, Boards are often composed of members of a community who may know very little about quality health care delivery or what constitutes compliance with the many regulations regarding the healthcare industry. Nonetheless, the Boards have a fiduciary duty to their institutions as a whole, and Medicare places the responsibility for quality in hospitals squarely on the shoulders of the boards. (See, 42 CFR § 482.21(e), CMS’s Conditions of Participation for Hospitals, the governing body of the hospital is responsible for quality of care.)

Information scorecards and dashboards have emerged as a vital tool for hospital Boards committed to promoting compliance within their organizations. A well-designed dashboard can raise awareness of areas in which the organization is meeting targets and which is underperforming. The scorecard presents critical data in summary form. The information concisely presented enables the Board to determine what is being done as well as what needs to be done to improve compliance.

There should be a balanced approach to dashboard metrics. The Board must understand that there is a key relationship between payment and compliance. A balance of dashboard metrics can help to establish a link between compliance and finances. Dashboards that emphasize this link can help senior leaders realign priorities to meet quality goals and achieve desired financial returns.

There are many questions about the creation and use of the scorecard and dashboard. For example, how do hospitals determine the measures to be used? Should the Board’s compliance committee be involved with the creation of the measures? Who, in addition to the Board, should be given the scorecard/dashboard? How frequently should the scorecard/dashboard be updated? What actions should the Board take in response to the information presented in the scorecard/dashboard? How can the dashboard be linked to the organization’s strategic plans or objectives?

The contents of the scorecard should answer seven fundamental questions for every key area of compliance.

What happened (during the last quarter)?

- How does what happened compare to what was supposed to happen?
- Why was there a difference between what happened and what was supposed to happen?
- How does what happened compare to what happened the last time (same quarter last year)?
- Why was there a difference between what happened the last time and what happened this time?
- How does what happened compare to what is going to happen in the future?
- What are you doing today to make sure things are different tomorrow?

Scorecards/dashboards enable all data to be consolidated into one central location instead of multiple reports that present only a fragmented view of the organization’s compliance program. The scorecard/dashboard should highlight what the Board needs to know because the hospital’s compliance strategy is dictated by information given.

**HOSPITALS CONTINUE FILING CASES OPPOSING THE ‘TWO MIDNIGHT’ RULE – Susan Walberg**

As recently reported in Modern Healthcare (January 11, 2016), 50 more hospitals have joined the fray in the fight against HHS’ controversial Two-Midnight rule. According to the article, there have been multiple lawsuits filed by hospitals due to the payment reductions that result from the rule. All in all, nearly 200 hospitals have filed, a total of four cases, objecting to the Two Midnight regulations. Despite the controversy, CMS has not backed down on the rule, although it did provide some greater latitude for physician discretion in the 2016 Outpatient Prospective Payment System regulations. This issue is far from resolved, however, as a federal judge ruled last September that HHS needs to provide better justification for the cuts and must open that portion of the regulation to public comments. We will provide additional updates as the situation continues to evolve.
CMS FINALIZES 2016 MEDICARE PAYMENT RULE FOR ADVANCE CARE PLANNING – Tammy Morris

Two new Advance Care Planning (ACP) codes were added to CPT in 2015. CPT codes 99497 and 99498 are time-based codes used to report the face-to-face service between a physician or other qualified healthcare professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. CPT defines an advance directive as a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Advance care planning is not just about old age. It is about ensuring appropriate medical care, at any age, when a patient is sick or in a medical crisis and not capable of making those decisions. Because the purpose of the visit is the discussion, no active management of the patient’s problem(s) is performed at the time of the visit.

CMS issued a final rule detailing how the services will be provided to Medicare beneficiaries. It supports patient and family-centered care for seniors and other Medicare beneficiaries by providing payment for advance care planning with their provider. The rule was finalized in October 2015.

These services may be billed on the same day or on a different day from billing of other Evaluation and Management (E/M) services, but not on the same date of service as critical care services. Per the CPT descriptor, these codes are for services furnished by physicians or other qualified professionals, but not by social workers, chaplains and others. The services may be billed incident to the services of the billing practitioner under the “incident to” rules with a minimum of direct supervision.

The codes are payable in both facility and non-facility settings without limitations to any specific physician specialty. If voluntary advance care planning, upon agreement with the patient, is performed as part of an Annual Wellness Visit (AWV), CPT code 99497 would be reported and, if applicable, add-on code 99498 for each additional 30 minutes in addition to AWV codes G0438 or G0439. When advance care planning is billed with an AWV, the deductible and coinsurance for advance care planning can be waived by appending modifier 33 to the advance care planning code(s). Advance care planning cannot be billed with a Welcome to Medicare visit because end-of-life planning is a required part of that service. Documentation requirements must be met and may include the following with the first three being required:

- A person designated to make decisions for the patient if the patient cannot speak for him or herself
- The types of medical care preferred
- The comfort level that is preferred
- How the patient prefers to be treated by others
- What the patient wishes others to know

OTHER ARTICLES OF INTEREST

THERE ARE NO CHANGES IN THE PENSION PLAN LIMITS FROM 2015-2016 BECAUSE THERE WAS NO INCREASE IN COST OF LIVING – Charlotte Kohler

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<th>Limit on Elective Deferrals</th>
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ELECTRONIC HEALTH RECORD DOCUMENTATION – Diane Jordan

The electronic health record is a computerized record of health information and associated systems designed to provide users with access to complete and accurate data. Currently, there are several terms used when referring to health records: electronic medical record (EMR), computerized patient record (CPR), and electronic patient record (EPR), are the most common. The preferred term currently is electronic health record (EHR).

The health record is the repository for clinical documentation relevant to the care and treatment of one specific patient. The main functions are related to specific healthcare encounters between providers and patients. The primary goals of the health records system are to facilitate the sharing of clinical information and to ensure the quality and safety of patient care. Processes must be in place to ensure the documentation for the health information used in care, research, and health management is valid, accurate, complete, and trustworthy. The EHR should meet these goals and also help care providers document effectively and comprehensively.

You should develop, implement, and enforce policies and procedures to ensure the quality of clinical care and the safety of patients. Policies are general written guidelines that dictate behavior or direct decision making within the organization. Procedures provide detail written instructions on how functions and processes are implemented. Procedures should fulfill the stipulations of general policies. Both of these are often overlooked.

Organizations usually model their internal policies and procedures after applicable state and federal regulations, legal guidelines, accreditation standards, clinical practice standards, and voluntary industry standards. Internal policies must also reflect the facility’s own service goals and standards of care.

The standardization of the format, terms, and functionality of the EHR template promotes quality care and completeness of clinical documentation of the patient’s treatment. Documented guidelines for the development of templates which will also provide templates which are compliant and supports the integrity of the electronic health record content.

If you need an example of a policy for the development of templates for the electronic health record, please contact me at djordan@kohlerhc.com or 443-756-0202. The policy is not all inclusive and you can add, delete, and/or revise the content to meet the needs of your specific facility or organization.

TELEHEALTH…TELEMEDICINE…THE FUTURE OF HEALTHCARE (PHYSICIAN/MEDICAL PRACTICE) – Simbo Famure

Over the last few years there has been a lot of advancement in healthcare information technology. Several new models for equipment and communications have been created to not only make medical care available in remote locations where a medical provider is not physically present, but to also improve the quality and safety of patient care.

There are currently 200 teledmedicine networks in the USA. There are 3500 service sites and 300,000 VA remote consultations were conducted in 2011. In 2014, there was an estimated 75 million telehealth visits. It is also predicted that the revenue generated from telemedicine will increase from approximately $240 million 2014 in to $1.9 billion by 2018. That basically means that in about 5 years, 50% of healthcare would be provided remotely.

Statewide programs currently exist in Georgia, Arizona and California. Currently, most of these telehealth programs involve tele-radiology (remote monitoring), diagnostic and image reviews. Other programs that used in telemedicine involve distance or hub sites where a physician or licensed practitioner delivers a service (evaluation or consultation) via a telecommunication system to a patient at another site. This is often used for psychiatry consults.

As more research is being performed regarding efficient methods for providing healthcare, the results so far are positively impressive.

ADDITIONAL INFORMATION

Thank you for your interest in Kohler HealthCare Consulting, Inc. If you wish more information about KHC and the services we offer, please visit our website http://www.kohlerhealthcare.com or call 410.461.5116. If you prefer not to receive future issues of our publication, please hit ‘reply’ and let us know and we will immediately remove you from our distribution. Thank you.