Rheumatology Advisory Board Meeting

Saturday, March 9, 2013 • Orlando, FL
10:00 am – 3:00 pm
Objectives and Introduction

Elisabeth Svensson
Vice-President, Marketing
Cardinal Health Specialty Solutions
- Name, practice name, and number of members in your practice?
- According to you, what are the unmet needs in your practice?
## CHSS & TSI Healthcare Attendees

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Norman Gaylis, MD</td>
<td>Medical Director, Rheumatology</td>
</tr>
<tr>
<td>Roshan Girglani</td>
<td>VP, GM, Rheumatology</td>
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<tr>
<td>Elisabeth Svensson</td>
<td>VP, Marketing</td>
</tr>
<tr>
<td>Chris Wenzke</td>
<td>VP, Business Solution</td>
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<tr>
<td>John Ennion</td>
<td>Director, Healthcare Analytics</td>
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<tr>
<td>Andrew Popp</td>
<td>Director, IT Management- Commercial Solutions</td>
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<tr>
<td>Ron Zesch</td>
<td>Director, Business Solution</td>
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<tr>
<td>Heidi Gidley</td>
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<tr>
<td>Dick Pedersen</td>
<td>Senior VP, Chief Marketing Officer</td>
</tr>
<tr>
<td>Michelle Klaer</td>
<td>Director, Specialty Services Group</td>
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# List of Advisors

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<thead>
<tr>
<th>Name</th>
<th>Practice</th>
<th>State</th>
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Meeting Objectives

- Identify challenges and changes in rheumatology practice today.
- Explore the role of infusion room management software in optimizing the infusion suite.
- Understand the challenges of the infusion suite from a provider and patient perspective.
- Understand the requirements needed to satisfy meaningful use and the role that electronic health records (EHRs) will have in the future of medical practice.
## Meeting Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>10:00 am – 10:15 am</td>
<td>Objectives and Introductions</td>
<td>Elizabeth Svensson</td>
</tr>
<tr>
<td>10:15 am – 11:15 am</td>
<td>Key Changes in Healthcare, Challenges and Unmet Needs in Rheumatology</td>
<td>Norman Gaylis, MD</td>
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<tr>
<td>11:15 am – 11:30</td>
<td>Break</td>
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<tr>
<td>11:30 am – 12:30 pm</td>
<td>TSI: Rheumatology Software and Integration with NextGen</td>
<td>Michelle Klaer</td>
</tr>
<tr>
<td>12:00 pm – 12:30 pm</td>
<td>InfusaTrack – Infusion Room Management Software</td>
<td>Heidi Gidley</td>
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<tr>
<td>12:30 pm – 1:15 pm</td>
<td>Lunch</td>
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<tr>
<td>1:15 pm – 3:00 pm</td>
<td>Q &amp; A and Closing Remarks</td>
<td>Elizabeth Svensson</td>
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</table>
Key Changes in Healthcare, Challenges and Unmet Needs in Rheumatology

Norman Gaylis, MD
Medical Director, Rheumatology
Cardinal Health Specialty Solutions
The rheumatology practice is a business in a rapidly changing environment.

Practice constantly struggle to cope with
  - Declining reimbursement
  - Looming cuts in reimbursement
  - Governmental and regulatory factors creating more complexity in claims management

Increased compliance regulations and implementation of ICD-10-CM by (HIPAA)
  - Impact billing, coding, and claims processing
As per the Patient Protection and Affordable Care Act

- Healthcare coverage will now become available to over 32 million Americans
- The coverage increase the projected shortfall by 31,000 physicians (25%)
- At least one third of practicing physicians are expected to retire.
- The demand for care for the aging population is approximately 36%.
- With the demand for physicians increasing the number of medical graduates is unable to keep pace.

Pose an immediate threat to the future of physician practices, the workforce, and patient access to care.
Largely cognitive services (RVUs)
  - Academic/ intellectual/ unassertive
  - Lack of business expertise
    - No business plan
    - Fear of debt
    - Sparse overhead
    - Inadequate staff
Declining Reimbursement

- Massive mandatory spending cuts, or sequestration effective January 1, 2013
  - A 30% Sustainable Growth Rate (SGR)
  - A 2% sequestration cut to NIH physician reimbursement
  - An 8% sequestration cut to NIH funding
- Additional cost to continue expiring tax policies and to prevent other cut
- The cost of postpone drastic SGR cuts to Medicare physicians reimbursement is $11 billions

We cannot take for granted that the SGR cuts will again be averted at the last moment
The Perfect Storm

- Uncertainties in healthcare industry
- Sweeping policy and payer changes
- Unstable economy
- Fluctuating contract negotiation
- Coding and billing changes

Healthcare Reimbursement
Historical Growth in the Infusion Suite

- Growth from first drug in 1999, leading to a financial model of $25M in 1999 to $4B now
- Multiple drugs now available
- Revenue in infusion portion of practice is equal to or surpasses the rest of the practice revenue
Infusion Center

NOT an Infusion Center
• Does your practice offer infusion services?
  a. Yes
  b. No
• In general, what do you believe to be the challenges in managing infusion centers? *Please select all that apply.*

1. Space
2. Staffing
3. Scheduling
4. Purchasing
5. Billing and reimbursement
6. Inventory management
7. Regulatory compliance
8. Other, please specify: _______________
9. None of the above
Benefits in having an in-office infusion setting

- Provides the ability to deliver this service to your patients in a familiar and supportive setting
- Allows you to direct the administration of treatment
- Prevents referring patients to hospital
- Increases patient adherence with meditation and therapy
- Strengthens doctor-patient relationship
Maximizing Appropriate Use of Infusion Suite

Reduce Attrition after Patient ID

Early Intervention With Biologic Using T2T

Reduce Attrition Post Therapy
• Engage Patients: Track & share target
• Maximize efficacy with dose and interval before switching
• Improve compliance with recommended interval

Increase Referral Base – Become Immunotherapy Center (GI, Derm, Neuro)

Clinical Research Referral Center
Onsite supervision of patients
Managing Infusion Suite

- Establish additional staff (if required)
- Train staff
- Obtain infusion medication through
  - Buy and bill plan
  - Assignment of benefit
- Follow coding and documentation guidelines for infusion
- Be aware of code changes and any new categories for drug administration and infusion
### Areas of Focus

<table>
<thead>
<tr>
<th>Areas of Focus</th>
<th>Specific Indicators</th>
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<tbody>
<tr>
<td><strong>Profitability</strong></td>
<td>✓ Gross income / physician</td>
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<tr>
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<td>✓ Net income / physician</td>
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<tr>
<td></td>
<td>✓ Percentage of gross income for staff costs</td>
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<td><strong>Fiscal Soundness</strong></td>
<td>✓ Days of charges in accounts receivable</td>
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<td>✓ Gross collection ratio</td>
</tr>
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<td>✓ Aged accounts receivable ratio</td>
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<td>✓ Expenses and overhead</td>
</tr>
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<td></td>
<td>✓ Number of new patients / year</td>
</tr>
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<td><strong>Service Capacity</strong></td>
<td>✓ Number of scheduled chair hours / provider</td>
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<td>✓ Earliest available new patient appointments</td>
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<td>✓ Earliest available routine appointments</td>
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<td>✓ Number of examination rooms / provider</td>
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<td>✓ Numbers and types of providers</td>
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<tr>
<td><strong>Inventory Management</strong></td>
<td>✓ Buy and Bill/Specialty Pharmacy</td>
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<tr>
<td><strong>Operational Effectiveness</strong></td>
<td>✓ Ensuring efficiencies of coding</td>
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<td>✓ Maximizing staff time (Infusion nurse, MA, PA)</td>
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</tbody>
</table>
## Sample Coding Chart

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
<th>Medications</th>
<th>HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>96360</td>
<td>Intravenous infusion, hydration; initial, 31 minutes to one hour</td>
<td>Normal saline</td>
<td>J7050</td>
</tr>
<tr>
<td>96361</td>
<td>Each additional hour (list separately in addition to code for primary procedure)</td>
<td>Normal saline</td>
<td>J7050</td>
</tr>
<tr>
<td>96365</td>
<td>Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour</td>
<td>IVIG, Zoledronic acid</td>
<td>J1561/J1566, J3488</td>
</tr>
<tr>
<td>96366</td>
<td>Each additional hour (list separately in addition to code for primary procedure)</td>
<td>IVIG, Zoledronic acid</td>
<td>J1561/J1566, J3488</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic, prophylactic, or diagnostic injection (list separately in addition to code for primary procedure)</td>
<td>Gold, Denosumab</td>
<td>J1600, J0897</td>
</tr>
<tr>
<td>96374</td>
<td>Intravenous push, single or initial substance/drug</td>
<td>Methylprednisolone sodium succinate, Ibandronate</td>
<td>J2920, J1740</td>
</tr>
<tr>
<td>96375</td>
<td>Each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure)</td>
<td>Methylprednisolone sodium succinate, Ibandronate</td>
<td>J2920, J1740</td>
</tr>
<tr>
<td>96401</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; nonhormonal antineoplastic</td>
<td>Methotrexate</td>
<td>J2920</td>
</tr>
<tr>
<td>96413</td>
<td>Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug</td>
<td>Infliximab, Cyclophosphamide, Abatacept, Rituximab, Tocilizumab</td>
<td>J1745, J9093, J0129, J9310, J3262</td>
</tr>
<tr>
<td>96415</td>
<td>Each additional hour (list separately in addition to code for primary procedure)</td>
<td>Infliximab, Cyclophosphamide, Abatacept, Rituximab, Tocilizumab</td>
<td>J1745, J9093, J0129, J9310, J3262</td>
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## Infusion Services
### 2007 Compared to 2011

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2007 Payment</th>
<th>2011 Payment</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>96413</td>
<td>First Hour of Infusion</td>
<td>$178.18</td>
<td>$158.23</td>
<td>-11%</td>
</tr>
<tr>
<td>96415</td>
<td>Subsequent Hours of Infusion</td>
<td>$39.28</td>
<td>$33.49</td>
<td>-15%</td>
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</table>
Infusibles Forecasted to Lose Share Without Interventions to Support Practices

Note: Sales figures are based on EvaluatePharma projections. Changes in formulations are based on Datamonitor research.

Source: EvaluatePharma, IMS, Datamonitor, Company data
Growing Challenges to Infusion Suite

- Increasing A/R Due to Increase # Infused Drugs
- Coordination of Patient Assistance
- Higher Patient OOP Cost
- Reduced/ Delays in Payment
- Inventory Management BB/SP
- Payer Preference SQ
• Does your practice use any software system to manage infusion services?
  a. Yes
  b. No
  c. Unsure
• Is your practice able to manage infusion medication inventory with any software system?
  a. Yes
  b. No
  c. Unsure
Pre-meeting Survey Result

• Is your practice utilizing buy and bill or specialty pharmacy drug replacement for infusion medications?
  a. Yes
  b. No
  c. Unsure
• How satisfied are you with your practice’s current methods of managing infusion services?
  a. Extremely dissatisfied
  b. Somewhat dissatisfied
  c. Neutral
  d. Somewhat satisfied
  e. Extremely satisfied
InfusaTrack™ is a web-based infusion room management tool that makes it easier for community rheumatology practices to offer in-office infusion therapy services to patients:

- Alleviate administrative burden
- Chair scheduler
- Enables patient profiling
- Enables patient alerts
- Generates billing changes
- Optimize business functions
- Drug inventory control
• Does your practice use an electronic health record (EHR) system?
  a. Yes
  b. We are currently installing/implementing an EHR system
  c. No, but we plan to buy or begin using one within 1-2 years
  d. No, and we don’t plan to buy or begin using one within the next 1-2 years
  e. Unsure
In January 2011, the Centers for Medicare and Medicaid Services (CMS) kicked off an electronic health record (EHR) meaningful use incentive program.

Universal adoption of an EHR system and also using it meaningfully in 5 years (by 2015) is the mandate of the current president.

The goal is to collect structured data on patients and to use that data to support and coordinate patient care.

It’s not just about installing a system but adopting and using it effectively.
- EHR are often considered as pain and purely a documentation tool.
- It is as much of a medical instrument as a stethoscope.

**Written about the Stethoscope in 1834**

“That it will ever come into general use, notwithstanding its value, is extremely doubtful; because its beneficial application requires much time and gives a good bit of trouble both to the patient and practitioner; because its hue and character are foreign and opposed to all our habits and associations.”

– *London Times*
By implementing EHR system and subsequently achieving meaningful use:

- Eligible Medicare providers get incentives up to $44,000 over 5 years and,
- Eligible Medicaid providers get incentives up to $63,750 over 5 years.

Failing to achieve meaningful use will incur 1% reimbursement penalties starting in 2015. Penalties rise up to 5% by 2019.

Entice providers to adopt EHR/meaningful use and not mandate it …

In Simple words, DANGLE A CARROT IN FRONT OF THEM
Pre-meeting Survey Result

• Do you believe that your practice uses its EHR system successfully and meaningfully?
  a. Yes
  b. No
Do you think that your practice’s EHR provides the opportunity to meet the objectives of meaningful use in order to receive incentives?

a. Yes
b. No
c. Unsure
Is your practice in compliance with the meaningful use guidelines as required by CME?

a. Yes
b. No
c. Unsure
• In the year end of 2012, did your practice receive meaningful use incentive payment for achieving compliance?

a. Yes
b. No
c. Unsure
Has your practice been advised by Medicare that you will be subject to penalties of 1.7% for future payments for not being in compliance with their timeframe for e-prescribing?

a. Yes
b. No
c. Unsure
# The Medicare Carrot

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<tr>
<td>2011</td>
<td>$18,000</td>
<td>$24,000</td>
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<tr>
<td>2012</td>
<td>$12,000</td>
<td>$16,000</td>
<td>$18,000</td>
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<tr>
<td>2013</td>
<td>$8,000</td>
<td>$10,666</td>
<td>$12,000</td>
<td>$15,000</td>
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<tr>
<td>2014</td>
<td>$4,000</td>
<td>$5,333</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$12,000</td>
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<tr>
<td>2015</td>
<td>$2,000</td>
<td>$2,666</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>-</td>
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<td>2016</td>
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<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
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<tr>
<td>2017</td>
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<td>-</td>
<td>$0</td>
<td>$0</td>
<td>-</td>
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<tr>
<td>Total</td>
<td>$44,000</td>
<td>$58,665</td>
<td>$44,000</td>
<td>$39,000</td>
<td>$24,000</td>
<td>$0</td>
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| Health Shortage Area | +10% | +10% | +10% | +10% |

- Forfeit incentive for skipped year(s)
- Actual Payment based on 75% of allowable charges for each year to maximum
The Stick

*If for 2018 and subsequent years, the proportion of eligible providers who are meaningful users is less than 75%, the secretary of Health and Human Services may cut payment up to, but no more than 5%.

Significant hardship exceptions, granted on a case-by-case basis, may exempt an eligible provider who is not a meaningful EHR user from payment adjustment for the year. Exemption is subject to annual renewal and will not be granted for more than 5 years.

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR system for electronic exchange of health information to improve quality of healthcare.
3. The use of certified EHR technology to submit clinical quality and other measures.
Five Goals Fueling Meaningful Use

- Improve quality, safety, efficiency, and reduce health disparities
- Ensure privacy and Security protections for personal health information
- Improve coordination of care
- Engagement of patients and families
- Improve population and public health

Policy Priorities
What does meaningful EHR use look like in practice

Collect Structured Data

Use the Data to Support Practice

Use the Data for Care Coordination and Public Health

Privacy and Security

> medications
> problems
> allergies
> vital signs (blood pressure, height, weight)
> smoking status
> demographics (preferred language, date of birth, gender, race)
> lab results

> drug-drug checks
> drug-allergy checks
> clinical decision support
> patient profiling
> drug formulary
> clinical quality measures

> patient reminders
> patient education
> encounter summary
> chart export

> capability for data exchange among care team
> medication reconciliation
> summary of care for transitions of care and referrals
> data submission to public health registries
Pre-meeting Survey Result

• How has implementing an EHR system affected your practice? Please select all that apply.

a. Decreased productivity
b. Increased productivity
c. More efficiency
d. Increased practice revenue
e. Increased medical errors
f. Lower costs
g. Other, please specify: _____________________
h. It has not affected my practice
## Medicare and Medicaid EHR Incentive Program

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>MEDICAID</th>
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<tbody>
<tr>
<td>Implement in either 2011 or 2012 for max incentive</td>
<td>Implement as late as 2016 to qualify</td>
</tr>
<tr>
<td>Must begin by 2014 to receive incentive payments</td>
<td>Incentives available through 2021</td>
</tr>
<tr>
<td>Last payment year is 2016</td>
<td>1st Year: adopt, implement or upgrade to a certified EHR</td>
</tr>
<tr>
<td>Maximum payment = $44,000 over 5 years</td>
<td>Maximum payment = $63,750 over 6 years</td>
</tr>
<tr>
<td>1st Year: demonstrate meaningful use of a certified EHR for continuous 90-day period</td>
<td>Must demonstrate meaningful use in each subsequent year to qualify for payment</td>
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<tr>
<td>Medicare</td>
<td>Medicaid</td>
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<td>----------------------------------------------</td>
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<tr>
<td>Doctor of medicine or osteopathy</td>
<td>Physicians (primarily doctors of medicine and doctors of osteopathy)</td>
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<tr>
<td>Doctor of dental surgery or dental medicine</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>Doctor of podiatry</td>
<td>Certified nurse e-midwife</td>
</tr>
<tr>
<td>Doctor of optometry</td>
<td>Dentist</td>
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<tr>
<td>Chiropractor</td>
<td>Physician assistant who furnishes services in a federally qualified health center of rural clinic that is led by a physician assistant</td>
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### Stages of Meaningful Use

<table>
<thead>
<tr>
<th>First Payment Year</th>
<th>Payment Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>2011</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>2012</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2013</td>
<td>1</td>
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<td>2014</td>
<td>1</td>
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<td>2015</td>
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Stages of Meaningful Use

1. Capture health information in a coded format
   - Track key clinical conditions
   - Communicate key clinical condition information for care coordination purposes (structured format whenever feasible)
   - Implement clinical decision support tools to facilitate disease and medication management
   - Report clinical quality measures and public health information

2. Stage 1 criteria plus the following:
   - Use of health IT for continuous quality improvement at the point of care
   - Exchange information in the most structured format possible, electronically, including:
     - Orders entered using CPOE
     - Diagnostic test results

3. Stage 1 and Stage 2 criteria plus the following:
   - Promote improvements in quality, safety and efficiency
   - Focus on decision support for national high priority conditions
   - Provide patient access to self management tools
   - Provide access to comprehensive patient data
   - Improve population health
Installing EHRs could go far beyond the monetary incentives

- Some private insures have already declared that EHR utilization will play a role in contracting decisions.
- In future, EHR utilization could also play a role in board certification.
- And with the government planning to disclose lists of meaningful users market pressure is expected to become relatively extreme.
- As of March 2012, 76,612 healthcare professionals and hospitals are enrolled in the federal government's (EHR) incentive program and have received a total of $4,484,340,767 in incentive payment.
  - California (20,630)
  - Texas (16,671)
  - Pennsylvania (12,960)
  - Florida (12,952)
  - New York (12,294)
  - Ohio (10,141)
  - Illinois (9,935)
Why are EHR so important?

- The use of standardized electronic health records and the secure exchange of health information will improve health care quality and safety, and reduce healthcare costs by:
  - Making health information available to authorized health care providers wherever and whenever a patient gets care, improving the coordination and continuity of care and promoting informed decision-making;
  - Giving consumers more complete and accurate information to inform decision-making about their own health care;
  - Reducing preventable medical errors and avoiding duplication of treatments and procedures;
  - Lowering administrative costs and reducing clerical errors;
  - Enhancing research by facilitating the collection of standardized data to evaluate promising medical techniques, devices and drugs; and
  - Reducing the time it takes to bring safe, effective products and practices to the marketplace.
Shortcomings of today’s EHR system

- Quality measures appropriate for rheumatology have not been integrated into the system.
- Records supplied are “unworkable.”
- Templates “impossible.”
- Records received from others practices are “unreadable.”
• How satisfied are you with your EHR system?
  a. Extremely dissatisfied
  b. Somewhat dissatisfied
  c. Neutral
  d. Somewhat satisfied
  e. Extremely satisfied

Pre-meeting Survey Result
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- Are you satisfied with your EHR interconnectivity?
  a. Yes
  b. No
• In general, how likely would you be to switch an EHR system that you disliked?
  a. Extremely unlikely
  b. Somewhat unlikely
  c. Neutral
  d. Somewhat likely
  e. Extremely likely
TSI Healthcare’s Solution to deem “Meaningful Use”
Q & A

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Thank you