State of the Regional Extension Center Investment
Meaningful Use Coaching as a Vehicle for Health IT Adoption, Optimization and Care Transformation

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Widespread adoption & meaningful use of EHRs

Better Healthcare  Better Health  Reduced Costs

HITECH Act 2009
EHR Incentive Program and 62 Regional Extension Centers

EHRs & HIE 2014
Widespread adoption & meaningful use of EHRs

Payment Reform 2014+
Health IT Enabled Reform Models
Meaningful Use as a Building Block

Utilize technology to gather information

- Basic EHR functionality, structured data
- Privacy & security protections
- Patient informed
- Structured data utilized
- Privacy & security protections
- Care coordination
- Evidenced based medicine
- Registries for disease management
- Privacy & security protections

Use information to transform

- Improved population health
- Enhanced access and continuity
- Data utilized to improve delivery and outcomes
- Patient self management
- Patient engaged, community resources
- Patient centered care coordination
- Team based care, case management
- Registries to manage patient populations
- Privacy & security protections

Stage 1 MU
Stage 2 MU
PCMHs 3-Part Aim
ACOs Stage 3 MU
Network of Support for Every Provider

- Regional Extension Center
- Community College Workforce
- Communities of Practice
- Health Information Technology Research Center (HITRC)

Support Network

Education and Outreach • Workforce • Vendor Relations • Implementation • Workflow Redesign • Functional Interoperability • Privacy and Security • Meaningful Use

REC-Provider Partnership

Fully Functional EHR

- Population Health
- Health Care Efficiency
- Patient Health
- Outcomes
Comprehensive Support Beyond EHR Implementation

**Primary goal:**
Give providers as much support as possible

**Plan:**
- Conduct readiness assessment
- Identify tools needed for change (i.e. EHR system, workflow changes, etc)

**Implement:**
- Provide technical assistance
- Partner with local stakeholders, HIEs

**Transition:**
- Redesign practice workflow
- Perform HIT education & training

**Operate & Maintain:**
- Continuous quality improvement
- MU Stages 1, 2, 3

**Improve Care Quality:**
- Assess ACO, PCMH models
- Prepare for future pay for performance
- Empower patients in their own health care
Initial Program Goal:
100,000 priority primary care providers achieve meaningful use (MU) by 2014

Every REC:
• Has a defined service area and specific number of providers
• Provides unbiased, practical support throughout process
• Serves as two-way pipeline to federal and local resources

Approach differs by REC:
• Independent operations
• Affiliation with QIOs and universities
• Partnership with other HHS grantees (HCIA, Beacon, ACO, CPC, HCCNs, QIOs, HIE)
• Variety of hospital and payer partnerships
While RECs are encouraged to work with all providers, they focus on “Priority Settings”:

- Individual/small group primary care practices (<10 PCPs)
- Public Hospitals and CAHs
- Community Health Centers and Rural Health Clinics
- Other settings that serve medically underserved populations

Many RECs are also working with specialists and LTPAC, BH providers
Cumulative Number and Proportion of REC Primary Care Providers Enrolled, Live on an EHR, and Demonstrating Meaningful Use (MU) Over Time

SOURCE: Customer Relationship Management (CRM) Tool, maintained by Health and Human Services, Office of the National Coordinator for Health IT, data as of January 21, 2014.
Proportion of REC-enrolled PCPs Live on an EHR

- 1 state has less than 70% of REC-enrolled PCPs Live on an EHR: Hawaii
- 1 state have 70 to 79% of REC-enrolled PCPs Live on an EHR: Maryland
- 12 states have 80 to 89% of REC-enrolled PCPs Live on an EHR: Georgia, Idaho, Iowa, Kansas, Kentucky, Michigan, Nevada, New Jersey, New Mexico, New York, North Dakota, South Carolina
- 38 states have 90 to 100% of REC-enrolled PCPs Live on an EHR: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming

SOURCE: Customer Relationship Management (CRM) Tool, maintained by Health and Human Services, Office of the National or Health IT, data as of December 31, 2013.
An October 2013 GAO report found that Medicare providers working with RECs were over 1.9 times more likely to receive an EHR incentive payment than those who were not partnered with an REC.

## REC Enrollment

<table>
<thead>
<tr>
<th>Providers</th>
<th># of Providers Enrolled with an REC</th>
<th>Total Number of Providers Nationwide</th>
<th>Proportion of Providers Enrolled with an REC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Primary Care Providers</td>
<td>24,691</td>
<td>47,000</td>
<td>53%</td>
</tr>
<tr>
<td>Total Primary Care Providers</td>
<td>135,123</td>
<td>302,726</td>
<td>45%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organizations</th>
<th># of Organizations Enrolled with an REC</th>
<th>Total Number of Organizations Nationwide</th>
<th>Proportion of Organizations Enrolled with an REC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federally Qualified Health Center and FQHC Look-Alike Grantees</td>
<td>954</td>
<td>1,147</td>
<td>83%</td>
</tr>
<tr>
<td>Critical Access Hospitals</td>
<td>1,050</td>
<td>1,327</td>
<td>79%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sites</th>
<th># of Sites Enrolled with an REC</th>
<th>Total Number of Sites Nationwide</th>
<th>Proportion of Sites Enrolled with an REC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Primary Care Initiative Sites</td>
<td>265</td>
<td>503</td>
<td>53%</td>
</tr>
<tr>
<td>Advanced Primary Care Initiative Sites</td>
<td>409</td>
<td>500</td>
<td>82%</td>
</tr>
</tbody>
</table>

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3. Rural areas defined using the Core Based Statistical Area Micropolitan and Small Rural designations in US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. Area Resource File, 2011-2012. Rockville, MD. Primary Care Provider count includes Physicians, NPs and PAs. Community Health Aide Practitioners and Nurse Midwives were excluded from the numerator because these counts are not available in the SK&A database.
4. Primary Care Provider count includes Physicians, NPs and PAs.
5. Federally Qualified Health Center (FQHC) universe and matching of FQHC grantees against REC-enrolled practices defined using the US Department of Health and Human Services, Health Resources and Services Administration. Data Warehouse. Rockville, MD.
6. Critical Access Hospital (CAH) denominator and matching of CAHs against REC-enrolled practices defined using the US Department of Health and Human Services, Centers for Medicare and Medicaid Services. CMS Certified Hospital List. Baltimore, MD.
7. Comprehensive Primary Care Initiative (CPC) denominator and matching of CPC sites against REC-enrolled practices defined using the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. List of Comprehensive Primary Care Initiative sites, August 2011. Baltimore, MD.
8. Advanced Primary Care Initiative (APC) denominator and matching of APC sites against REC-enrolled practices defined using the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. List of FQHC Advanced Primary Care Practice Demonstration sites, November, 2011. Baltimore, MD.
## REC Providers by Area Type, Practice Setting and Provider Type

<table>
<thead>
<tr>
<th>Area Type</th>
<th>Number of Primary Care Providers Enrolled</th>
<th>Proportion Live on an EHR</th>
<th>Proportion Demonstrating MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>109,109</td>
<td>86%</td>
<td>48%</td>
</tr>
<tr>
<td>Rural</td>
<td>24,522</td>
<td>87%</td>
<td>47%</td>
</tr>
<tr>
<td>Primary Care Health Professional Shortage Area (HPSA)</td>
<td>3,202</td>
<td>82%</td>
<td>39%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>Number of Primary Care Providers Enrolled</th>
<th>Proportion Live on an EHR</th>
<th>Proportion Demonstrating MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Primary Care Practice</td>
<td>51,562</td>
<td>84%</td>
<td>54%</td>
</tr>
<tr>
<td>Public Hospital Outpatient Dept. or Other Underserved</td>
<td>36,128</td>
<td>87%</td>
<td>49%</td>
</tr>
<tr>
<td>Practice Consortium</td>
<td>22,027</td>
<td>91%</td>
<td>62%</td>
</tr>
<tr>
<td>Federally Qualified Health Center</td>
<td>18,650</td>
<td>93%</td>
<td>41%</td>
</tr>
<tr>
<td>Small Rural Hospital, Rural Health Clinic, or Critical Access Hospital</td>
<td>10,848</td>
<td>84%</td>
<td>41%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>139,215</td>
<td>87%</td>
<td>47%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Number of Primary Care Providers Enrolled</th>
<th>Proportion Live on an EHR</th>
<th>Proportion Demonstrating MU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>102,568</td>
<td>88%</td>
<td>56%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>20,874</td>
<td>87%</td>
<td>40%</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>9,699</td>
<td>90%</td>
<td>41%</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>1,982</td>
<td>87%</td>
<td>39%</td>
</tr>
<tr>
<td>Community Health Aide Practitioner (Indian Health Service)</td>
<td>392</td>
<td>96%</td>
<td>1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>135,515</td>
<td>88%</td>
<td>52%</td>
</tr>
</tbody>
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3. Federally Qualified Health Center grantees matched against REC-enrolled practices using the US Department of Health and Human Services, Health Resources and Services Administration. Data Warehouse. Rockville, MD.
4. Critical Access Hospitals matched against REC-enrolled practices defined using the US Department of Health and Human Services, Centers for Medicare and Medicaid Services. CMS Certified Hospital List. Baltimore, MD.
• Responsiveness to the marketplace using adaptive business intelligence
• Developing infrastructure for rapid cycle improvement and diffusion of innovative practices and lessons from early adopters
• Partnerships and collaboration
• Health Information Technology Research Center (HITRC): online knowledge management portal
• Learning Management System: online training
• National Learning Consortium: facilitates communities of practice and disseminates leading practices
• Customer Relationship Management (CRM): tracks provider demographics and progress on programmatic milestones
BI to Understand, Respond and Meet Outcomes

• BI tools converge to provide real-time performance monitoring and multimodal situational awareness of local markets and national trends
  – Informs program, ONC and HHS priorities for technical assistance, policy needs and opportunities to improve operations

• And create a systematic way to track and respond to challenges faced by these diverse providers
  – Example: providers reported challenges to MU included incorporating the Clinical Summary into practice workflow, impacting providers across all practice settings
Diffusion of Innovation

• Communities of Practice utilize common processes and can develop customized CRM reports to bring on-the-ground experience from individual RECs to share success areas, identify barriers and develop solutions
  – Resources and tools were tested, revised, and disseminated among all RECs, then made publically available on HealthIT.gov
  – These efforts then inform individual interactions in provider offices and can increase the adaptive reserves of individual practices and REC staff supporting their efforts
Challenges in Adoption

Step 5: Achieve Meaningful Use

Clinical Summaries

Objective:
Provide clinical summaries

Measure:
Clinical summaries provided within 3 business days.

Clinical Importance:
The Clinical Summary—provided, such as medical history, better communication and coordination among providers, and shared with both patients and providers, can result in a faster and more coordinated care process.

Clinical Summaries FAQs

Tips for Engaging Safety Net Patients Using Health IT

CMS Resources

Related CMS EHR Incentive Program Information

Lessons from the Field

“Developing an after visit summary takes a multidisciplinary team. Bringing multiple team members together to input information at different times during a patient appointment ensures all information is recorded and the patient can pick up a copy at the end of the visit.”

Vermont Information

Providing Clinical Summaries to Patients after Each Office Visit: A Technical Guide

Putting the I in Health IT

www.HealthIT.gov
Partnering with Providers to Achieve their HIT Goals

- Meet providers where they are
- Offer unbiased support
- Provide broad, practical expertise
- Act as pipeline to resources
- Offer relevant MU expertise

⭐ Better Healthcare
⭐ Better Health
⭐ Reduced Costs
2014 and MU Stage 2

- Functionality is new
- Providers have lots of questions/needs
- Providers want tools/resources/support to help them implement the new functionality
- Functionality needs to be linked to provider priorities
Ways that Health IT can be Meaningfully Optimized to Improve Patient Health

Health Information Technology

New Payment Models

New/ Improved Ways of Delivering Care

Population Health Awareness

Improved Care
Public-Private Alignment for Care Delivery Transformation

Care Delivery Improvement through Medical Home
- Commercial Payer
- Accreditation Bodies
- Medicare and Medicaid Pilots

New Payment Model through Accountable Care
- Medicare
- Medicaid
- Commercial ACOs

Population Health Awareness
- Million Hearts
- Medicare and Medicaid EHR Incentive Programs
- State Innovation Models

Health Information Technology
Skill Demands to Support Care Delivery Transformation

- Health Information Exchange
- Privacy and Security

- Consumer Engagement
- Data Aggregation, Analysis, and Reporting

- Risk Stratification
- Practice Workflow Redesign
Based on ONC CRM data as of March 19, 2013, merged by provider NPI to NCQA PCMH data as of February 28, 2013.
Relative Risk (RR) compares the likelihood of being paid for MU when compared to the non-PCMH/non-REC enrolled providers.

Among REC-enrolled providers, those that are PCMH-certified are 8% (p=0.0008) more likely to be paid for MU than those not certified. **Among PCMH-certified providers, those enrolled with an REC are 76%* more likely to be paid for MU than those not enrolled with an REC.** PCMH-certified providers not enrolled with an REC are more likely to be paid by Medicare for MU when compared to REC providers not certified for PCMH (RR=1.54*).  *p-value <0.0001

Based on ONC CRM data as of March 19, 2013, merged by provider NPI to NCQA PCMH data as of February 28, 2013 and CMS EHR Incentive data through January 31, 2013.
The national network of RECs are currently working on over 300 different programs to help providers transform their practices and demonstrate meet Three-Part Aim goals.

* As reported by 56 out of 62 RECs. Many REC are working on several initiatives within each category.
The Iowa REC program is helping CAHs and rural health clinics leverage MU to support patient engagement and Patient Centered Medical Home (PCMH) through intensive, hands-on practice transformation work. They also are supporting statewide health information exchange, especially in rural areas.

Incentives weren't the driving force behind the decision to upgrade Cass County's EHR. It was the benefit to the patient.
Accountable Care Organizations

NJ-HITEC is offering consulting services in collaboration with our NJ Accountable Care Organizations (ACOs) to assist in data mining, registry submission, and data analytics focusing on capturing structured data and reporting to CMS. In addition, we assist ACO members with vendor selection, workflow redesign, and Meaningful Use with the goal of supporting our members and their staff in meeting the required milestones to participate in an ACO.

For more information, contact Ron Manke at 973-642-4484.

ACO Development in New Jersey: One CMO’s Learnings from First-Stage Efforts

What NJ-HITEC Members are Saying

"We have found NJ-HITEC to be extremely knowledgeable about ACO measures. They have shown us how to achieve the measures and what needs to be done the EHR in order to coordinate care. We would not have been able to do this ourselves."
The Minnesota and North Dakota REC garnered an award to support strategies that achieve practice transformation and health care delivery through state-led initiatives and multi-payer payment reform model development and testing.

NATIONAL RURAL ACCOUNTABLE CARE ORGANIZATION PROJECT

Rural providers are struggling to participate in health care reform initiatives. The National Rural Accountable Care Organization (NRACO) offers a program that minimizes up-front investment and risk, provides turn-key solutions, and allows rural physician/hospital organizations to carefully implement and evaluate new delivery models to understand their impact on the health, quality, and financial viability of their rural community and health care delivery system.

The majority of rural hospitals and their affiliated physicians are struggling to transform their delivery system from cost-based reimbursement and fee-for-service (pay for volume) to the new model of chronic disease management, population health, and patient-centered care (pay for value). Rural community physician/hospital alliances are well poised to improve care and lower costs but lack the incentive programs, capital, and infrastructure to move from the current model of care to the patient-centered care delivery model. Most are not able to participate in the Center for Medicare and Medicaid Innovation (CMMI) and Center for Medicare and Medicaid Services (CMS) incentive programs due to beneficiary enrollment issues, insufficient volumes, lack of tertiary and specialty care, and exclusions based on cost-based reimbursement. They lack strong cash reserves to survive the shift from fee-for-service to fee-for-value and they lack the information technology infrastructure to provide 21st century data-driven healthcare.
In Arkansas, the REC has partnered with TransforMed to deliver clinical support for CPC milestone 5, using data to guide care improvement at the provider / care team level in CPC practices.
Questions?

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