



Methods Used by Regional Extension Centers (RECs) to Support Accountable Care Organizations (ACOs): Two Case Studies

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By

Mary Crimmins

Bradford Seamon

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Summary

Introduction

“Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program.”¹ Other payers including private insurers and state Medicaid programs are also utilizing ACOs.

ACOs are responsible for patients and their care, but they do not necessarily have full control over the care each patient receives. Patients go to different hospitals, or long term care, or specialists that may not be affiliated with the ACO. Consequently, ACOs need data from other organizations to support patient-centered care. There are currently 34 quality measures that Medicare ACOs report on, and each of those is dependent upon the ACO’s electronic health record’s (EHR) reporting capabilities, the use of registries, or reports from a health information exchange (HIE) or other third party entities.

Regional Extension Centers (RECs) help large and small medical practices: adopt, implement, optimize, and/or replace EHRs; attest to meaningful use and electronic clinical quality measures (eQMs); partner to implement primary care medical home (PCMH) recognition; and develop and/or use high quality reports based on data derived from EHRs. As necessary, RECs assist practices in revising clinical workflows to facilitate effective use of EHRs. In describing ongoing challenges, the *Health Affairs Blog* cites, “creating integrated systems of care is difficult work requiring considerable resource investments (the cost of integration) in increasing EHR functionality, workflow redesign, and developing partnerships with others.”²

The Office of the National Coordinator for Health Information Technology (ONC) contracted with Seamon Corporation to investigate how high-performing RECs work most effectively with ACOs, specifically looking at PCMH certification, optimizing workflows, developing quality reporting from EHRs, and optimizing or replacing existing EHR systems. As a result of the investigation, Seamon put together a research study that identified best practices that other RECs and ACOs might successfully use to accelerate the transformation of health care delivery to a value-based model.

The two RECs that contributed data on working with ACOs are New York City (NYC) REACH and the University of Central Florida REC (UCF REC). The key findings are presented in the first section of the report. The lessons learned and value of the REC to the ACO follows. Appendix A delineates the two use cases, and appendix B provides a full description of the qualitative study.

¹ <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco>

² Shortell S, Sheffler R, Health Affairs Blog June 2, 2015. <http://healthaffairs.org/blog/2015/06/02/accountable-care-organizations-taking-hold-and-improving-health-care-in-california/> Accessed June 9, 2015

Discussion

This study provides rich, qualitative data about two high-performing RECs: NYC REACH and UCF REC. Both of these organizations are housed in well-established, existing organizations, and have unique approaches to working with provider practices. NYC REACH focuses on promoting ACO cross-learning and collaboration. As a city health department program, NYC REACH provides comprehensive population health data and specialized information on how to work effectively with neighborhoods. UCF REC focuses on practice transformation using a fee-for-service consulting model. UCF REC's practice transformation methodology is well developed and recognized by national accrediting bodies.

These RECs seem to have attained a sustainable model by flexing with the changing needs in the market, and by providing unique and affordable services. They help providers incorporate new practices that have helped to achieve goals of each unique practice. Both have highly experienced experts on staff, and the ability to draw on resources in other parts of their organization.

The themes developed in these two case studies suggest that RECs have success building on relationships established with meaningful use funding. RECs successfully promote practice transformation supported by population health reporting, both of the larger community and the practice's patient panel. ACO-REC collaboration is more likely to speed practice transformation as value-based health care predominates. These themes may provide a promising basis for future quantitative research.

Key Findings

NYC REACH and UCF REC staff were interviewed and they provided data on programs and services that they use in their work with ACOs. The following table summarizes those services and notes minor variations across implementations. The primary difference between NYC REACH and UCF REC is based on scale. NYC REACH established an ACO roundtable group with multiple ACO members. UCF worked with specific ACOs and their affiliated practices.

Support	Guidance and Support Services	NYC REACH	UCF REC	Comments
Leadership	Building on meaningful use relationships	✓	✓	RECs had deep relationships with providers from meaningful use programs and built on those for ACOs.
	Facilitating communication	✓	✓	NYC REACH convened ACO roundtables. UCF facilitated communication between providers and the ACO leadership.
	Promoting transparency	✓	✓	NYC REACH roundtables and UCF REC worked with paired practices.
	Engaging ACO leadership	✓	✓	RECs actively engaged ACO leaders.
	Encouraging community collaboration	✓	✓	NYC REACH roundtables and UCF REC outreach.
	Providing community resources	✓	✓	NYC REACH dashboards and public health resources.
Consulting	PCMH certification	✓	✓	RECs and ACOs identified these as important services. RECs charge for these guidance and support services.
	Incentive program requirements	✓	✓	
	Alignment of incentive programs	✓	✓	
	Designing workflows for data capture	✓	✓	
	Data analytics & EHR reporting capabilities	✓	✓	
Infrastructure	IT infrastructure support and integration	✓	✓	ACOs identified these meaningful use guidance and support services as critical to help with basic infrastructure needs.
	Optimizing EHR	✓	✓	
	MU Attestation	✓	✓	
	Vendor selection	✓	✓	
	Readiness to adopting EHRs	✓	✓	

For this study, two affiliated ACOs were interviewed. Montefiore ACO and Primary Partners ACO shared their experiences working with the RECs in their areas.

Lessons Learned

NYC REACH Lessons Learned

The two primary types of ACOs that NYC REACH worked with were provider led and hospital led.

- Provider-led ACOs generally needed help with infrastructure, upfront capital, and to understand how they would benefit from operating as an ACO.

The provider-led organizations, (including Independent Practice Associations [IPAs]) generally had less infrastructure and upfront capital. Often, they had issues with cash on hand and needed to plan carefully to meet the near-term infrastructure challenges. ACOs and providers weighed their existing infrastructure against the cost of improvements and the anticipated monetary incentives.

- Hospital-led ACOs predominantly needed to train employed practices how to work in an ACO.

Hospital-led ACOs had IT infrastructure and their network providers were mostly employed, so the providers focused on learning to comply with ACO initiatives; these hospital-led ACOs sought assistance with a train-the-trainer approach.

- ACOs needed to teach providers how to use EHRs for appropriate documentation to strengthen alignment with multiple incentive programs.

Much of the ACO's coordination work required a strong infrastructure. NYC REACH is an expert in teaching providers how to use their EHRs to document and more accurately demonstrate their performance, so they can be reimbursed appropriately. That data collection then supported providers who wanted to participate in other potential incentive programs.

- ACOs need to help providers with EHR reports, workflow redesign, and templates to document performance.

Providers may intuitively know which of their patients smoke, but they were not documenting that they had screened smokers. NYC REACH worked with them to pull the appropriate EHR reports, documented performance, trained them on fitting documentation into their workflow, and instructed them in setting up templates to facilitate documentation.

- Follow up and evaluation of progress against peers spurred further performance improvement.

The Montefiore Pioneer ACO in New York City had data showing that providers who had an EHR were performing at higher levels than paper-based providers. Sharing this information with other providers helped NYC REACH be more effective in their outreach efforts. NYC REACH followed up several months later to pull the reports and determined if there had been improvement in the measures. NYC REACH let the practice know how they compared with other providers in the area. NYC REACH observed that a competitive spirit drove change in practices. NYC REACH provided citywide benchmarks for comparison.

- NYC REACH provided awareness to providers about multiple funding opportunities.

NYC REACH educated ACOs and providers on multiple grant opportunities, such as the CMS State Innovations Model and Transforming Clinical Practices Initiative. NYC REACH studied program requirements, worked with existing partners, and distilled the requirements for each program.

- The ability to crosswalk multiple programs helped ACOs establish a population health roadmap so they could progress stepwise and build from their baselines.

NYC REACH helped ACOs strategically plan population health roadmaps. Without the REC's help and access to other state, federal, and local initiatives, ACOs would need to improvise on working with these separate programs. NYC REACH helped them plan how to incrementally build a sustained quality improvement system that drove revenue and improved health outcomes.

- Working with public and private payers, NYC REACH demonstrated that their EHR services are associated with improved quality on selected measures.

NYC REACH worked with two payers to establish pilot programs to evaluate whether working with the REC would result in changes of selected quality measures. The results provided a proof of concept that NYC REACH's expertise in EHRs could improve quality measures and support quality improvement initiatives that were being developed across multiple private and public health plans. The pilot programs demonstrated that providers need a streamlined approach to participating in these programs.

- Payers learned that EHR data quickly and accurately shows performance.
- ACOs learned the importance of evaluating the accuracy of claims data.

The pilots helped the payers learn that EHR data provided more accurate and timely ways to evaluate performance. Payers use historic claims data to evaluate performance, so it was critical to work with ACOs and providers to ensure that clinical, coding, and billing data were recorded consistently.

- NYC REACH had unique access to de-identified data from one large EHR vendor that allowed them to develop dashboards.

NYC REACH developed a unique ability to manipulate de-identified data from one EHR vendor that covers 700 practices, or over 3,200 providers. This allowed them to develop reports and supported development of a dashboard for either an area in the city or for individual provider practices.

- Dashboards provided immediate feedback and stimulated improved performance.

These dashboards were implemented during the first pilot. With the dashboard, practices could immediately see how successful they were in changing their workflow. The dashboard made change actionable. Feedback was immediate and the providers really engaged in implementing changes.

- Smaller organizations responded more quickly to implement changes indicated in dashboard reports.

The pilot project's results varied by practice size. NYC REACH trained practices in the use of the dashboards. In large practices with multiple administrative layers, adoption and change occurred slowly. The small practices were able to make decisions and communicate directly so providers could implement the changes right away. The pilot was six months long and results were generally better with small, one- or two-doctor practices.

- Process measures showed improvements in the six months of the pilot; clinical outcome measures will require longer study duration.

Both pilot programs were six months in duration and focused on a small selection of process and outcome measures that overlapped across multiple programs, including ACO and meaningful use. Analysis of clinical EHR data showed that process measures could be impacted positively within six months in smaller practices, where the training was given directly to providers. The change in outcome measures (blood pressure control and LDL control) did not appear to be impacted as positively, but the length of the study may not have been adequate to detect changes.

- Quarterly check-ins with providers after the pilot's end was important for sustaining changes.
- Recognition of the unique goals of each practice had to be incorporated into providing service to that medical practice.

NYC REACH staff reported that a primary lesson learned was the importance of recognizing the uniqueness of each practice, i.e. "if you have seen one practice, you have seen one practice." NYC REACH met the provider with that recognition and helped to identify their overall goals. Once goals were clear, NYC REACH helped the provider understand opportunities for change that align with those goals. In some instances, providers really wanted to understand the minimal coding that they need to do, and in others, providers really got engaged and wanted to make changes and be proactive. It was best to start with small steps to ensure success.

UCF REC Lessons Learned

The UCF REC's biggest lesson for PCMH was how important it was to have engaged leadership for practice transformation. Engaged leadership involved more than the owner's commitment to practice transformation. Commitment involved devoting the necessary staff and resources to the project.

- ACO leadership had to demonstrate laser focus every day on proactive population health management.

The leadership team helped facilitate the culture change and make it a focus of every day. When the culture change stabilized, the practice was no longer providing reactive care to patients. Instead, the work with patients was proactive and involved taking the appropriate time to manage patient population health.

- ACOs had to be prepared to provide resources to help small practices achieve PCMH certification.

Smaller practices were often challenged to transform due to lack of time and resources. In one instance, an ACO was able to help a small physician practice with resources that were needed to achieve PCMH recognition. Small practices often struggled to implement care coordination processes, enhanced access, and patient care management.

- EHRs had to be capable of reporting standardized structured data to manage care processes.

The technology that the organization used had to capture standard structured data and report on it. Maintaining an effective medical home was very challenging if the data was not consistently available to manage processes and performance against the standard.

- Medical practices had to attend daily to the changes PCMH had driven, or they would regress to the mean.

One of the biggest challenges to PCMH transformation was the ability to sustain change over the long term. If practices did not incorporate and implement adopted changes on a daily basis, they regressed to the mean. UCF REC was committed to following up, working closely with practices to implement and sustain change. The UCF REC learned to work very closely with providers to implement changes and helped by periodically monitoring them to ensure that they were still meeting the standards.

- Documentation is critical to develop an individualized care plan.

The UCF REC worked with provider organizations to develop templates for structured data to assist providers in creating care plans and managing practice population.

- Comprehensive goal driven data was necessary to maintain a culture of quality.

Data was necessary to support a culture of quality. PCMH activities were not limited to flipping through paper charts, filling out super bills, and writing progress notes. PCMH required a complete narrative backed by data to help patients help themselves. The narrative then provided a stronger baseline of information to use going forward.

Value of the REC to the ACO

NYC REACH Value to the Montefiore ACO

Montefiore ACO was interviewed to assess the value of REC service, and identified these strengths.

- NYC REACH provided reports on affiliated Montefiore practices and overall ACO performance.

NYC REACH reported to Montefiore on affiliated providers for the key status components of EHR adoption, PCMH certification, MU status, EHR vendor, and other infrastructure components. NYC REACH provided citywide data on performance from their de-identified EHR data. Montefiore did not have any other way to get the benchmarking data that NYC REACH provided. With this data, Montefiore was able to track how it was progressing with its ACO milestones.

- Montefiore valued the meaningful use work that NYC REACH did with their affiliates to develop quality improvement strategies that were EHR specific.

NYC REACH had sustained ongoing relationships with many of these providers by helping them with MU and practice transformation. Montefiore required its voluntary affiliated providers to register with NYC REACH to leverage REC services. NYC REACH worked collaboratively with vendors and practices to develop a quality improvement strategy for that specific EHR system.

- NYC REACH helped by providing guidance in the selection of EHR vendors that the REC had found were responsive to REC questions.

These questions included EHR vendor functionality, availability of onsite training for REC staff, openness to REC suggestions on new features, and availability of training materials. These vendors were familiar with the unique needs of small/independent practices in NYC and offered low-cost options, which facilitated EHR adoption.

- NYC REACH brokered the Montefiore ACO roundtables to encourage collaboration.

NYC REACH promoted ACO collaboration through roundtables; these drove better communication and there was always a healthy exchange between the ACOs that would not have occurred naturally if NYC REACH did not broker the discussions.

- NYC REACH provided resources in the public health domain and promoted collaboration on these topics.
- NYC REACH kept the Montefiore ACO up to date on the health care context.

NYC REACH promoted discussion with health information exchanges and taught voluntary providers how health information exchange could integrate with PCMH. NYC REACH continued to be a strong partner for Montefiore in building functional PCMH clinical practices.

- NYC REACH's support for ongoing ACO progress.

Montefiore sees NYC REACH as a supporting partner that has helped practices after they go live and reported on progress with EHR implementations at affiliated practices, particularly voluntary ones.

UCF REC Value to the Primary Partners ACO

The Primary Partners ACO was interviewed to assess the value of REC service, and identified the following strengths.

- UCF REC's readiness assessment provided strategic value in Primary Partners ACO provider practice selection.

For the Primary Partners ACO the UCF REC performed a readiness assessment on 14 primary care practices interested in becoming PCMH accredited and 12 were deemed prepared at that time. Of those, 11 practices achieved PCMH recognition.

- UCF REC facilitated meetings which identified needed resources and barriers from the providers' perspective.

The UCF REC facilitated weekly meetings with the ACO leadership and provided weekly status reports of the affiliated practices that wanted to receive PCMH recognition. The UCF REC identified issues or barriers and then the ACO intervened to provide support.

- UCF REC worked with interns and paired practices to improve ACO performance.

Primary Partners ACO affiliated practices were paired in a buddy system and worked together to collaborate and share best practices. Half of the ACO practices were further supported by the use of graduate and undergraduate interns from UCF who were students in health administration. These interns helped practices by writing administrative policies and other documentation that was required for PCMH. The students dedicated four hours to each practice weekly, for a total of 120 hours for undergraduate students and 240 hours for graduate students. The UCF REC led weekly meetings with the interns to discuss lessons learned and best practices, and helped each other with suggestions. The interns could also get assistance from the REC, as the REC worked closely with the practices in PCMH recognition by providing transformation services.

- UCF REC acted as a partner in delivering on ACO expectations.

For the Primary Partners ACO affiliated practices and the interns, the ACO's leadership clearly set expectations and followed up intensely on any issues. The REC worked with ACO leadership to support this effort and to help the interns understand what their role was in each project.

Appendix A: REC Descriptions and Use Cases

New York City NYC REACH

Background

NYC REACH is administered through the New York City Department of Health in the Primary Care Information Project (PCIP) bureau. Over the past six years, NYC REACH has assisted over 4,200 small provider practices in the New York City region with meaningful use and has connected providers to over \$250 million in meaningful use incentive funds. The NYC REACH REC service delivery model is built on having staff in-house, including a field team that conducts remote and onsite support, and subject matter experts in health policy, privacy and security, billing and coding, and clinical quality improvement. NYC REACH staff work with hospital ambulatory clinics, independent and community based primary care practices, and community health centers to adopt EHRs, optimize workflow, extract reports, meet meaningful use requirements, and attest for the incentive payments.

NYC REACH has engaged 18,000 providers and provided technical assistance to the preferred primary care providers funded by the REC program and Medicaid-eligible specialists funded by New York State (NYS) Medicaid. In addition, NYC REACH has worked with other stakeholders, such as health plans, ACOs, IPAs, and hospitals. In addition to providing REC meaningful use services, NYC REACH began supporting practices to achieve PCMH recognition in 2010. The PCMH work built on the foundation of meaningful use and had a greater emphasis on quality improvement practice transformation and consulting services. In 2013, NYC REACH began working with ACOs, primarily to get their practices to adopt EHRs, achieve meaningful use, and obtain PCMH recognition. This stepping-stone approach helped ACO providers transition to new value-based payment models. NYC REACH also offered support for coding and billing to complete their suite of consulting services. This component was important to providers who expressed concern about losing revenue during EHR implementation.

ACO Affiliate

Montefiore is a pioneer ACO, operating primarily in the Bronx, Westchester, and recently in the Hudson Valley. The ACO is a very diverse, complex, hybrid network with multiple hospitals, Montefiore providers, and voluntary provider practices. In the spring of 2015, there were 3,452 Montefiore-employed and voluntary providers, and five hospital affiliates that served ACO patients. Since 2014, the number of patients grew from 28,000 to 60,000, as Montefiore continued to add affiliated hospitals and practices.

NYC REACH Use Case

Purpose

NYC REACH used a variety of strategies to promote practice transformation for ACOs and affiliated practices.

ACO Roundtable

NYC REACH held an ACO roundtable to increase awareness among ACO leadership of meaningful use incentives, overlap of meaningful use and ACO initiatives, and the EHR consulting services available for ACO-affiliated providers through the REC program.

Building on Meaningful Use Relationships

Some of the ACO leaders had an existing relationship with NYC REACH because they led hospitals and IPAs that NYC REACH had already been working with to engage affiliated providers with using their REC services.

Learning Community Model

After the initial roundtable meetings, the ACOs were very interested in sharing their experiences and challenges with each other and asked for quarterly meetings. The quarterly roundtables were structured so that one or two ACOs gave a presentation and NYC REACH provided information on opportunities to collaborate on grant programs aligned with ACO initiatives.

Meetings with ACO Leadership

After each roundtable, NYC REACH followed up with the ACOs that seemed highly engaged to discuss individual collaboration, such as joint communication about REC services, REC presentations at ACO provider meetings, and trainings for ACO providers. Several of these ACOs engaged NYC REACH to provide PCMH training for their providers, either through sponsored group trainings or onsite support.

Prominence of Medicaid

As of January 2014, there were 13 ACOs that practiced in the New York City region; of these, eight were provider led, three were led by hospitals (including one pioneer ACO), and two were multispecialty group practices. Several of these ACOs had practices outside of the New York City area, and some were in Long Island but acquiring practices in New York City. After analyzing provider self-reported data collected for the REC grant, NYC REACH found that most New York City ACO providers served a larger proportion of Medicaid patients than Medicare patients.

Medicaid Enhanced Reimbursement

New York Medicaid provided enhanced reimbursement to PCMH-recognized practices. PCMH, with its enhanced payment structure, was attractive to small providers that operated with severe financial constraints. The enhanced payments provided predictable income and supported practice transformation. Some providers were not able to meet the required benchmarks and quality measures for ACO reimbursement and therefore had invested in the transformation, but did not receive any payment for it.

Impact on the Revenue Cycle

NYC REACH found that providers were concerned about lost revenue due to implementation of an EHR. With MU incentives and PCMH's enhanced reimbursement, practices received additional income to support the transformation. Additionally, PCMH provided a standardized framework to conduct ACO care coordination activities.

Aligning Incentive Programs

NYC REACH helped providers understand the alignment and requirements for many other incentive programs. Working with NYC REACH, providers learned to incorporate workflows into their practice that met those requirements and capitalized on incentives. Starting with PCMH certification, these providers learned to use CPT II quality codes to more accurately demonstrate improved patient care.

Advising on Vendor Performance and Reporting Capabilities

NYC REACH advised the ACO on how to engage providers by rolling out a centralized EHR that was low cost and customized to support reporting for multiple programs. ACOs benefited from the REC's experience with how responsive vendors had been over the years, and what types of reporting functionalities were critical to support health care transformation. The ACO then worked directly with the vendor to customize reporting and negotiate rates. This made it easier for providers to adopt or replace an existing system. Another benefit was that it provided required ACO quality reporting mechanisms. Even the highly-functioning ACOs benefited from NYC REACH's expert consulting advice.

Value

NYC REACH recognized three primary assets:

- (1) Excellent relationships with providers from giving them technical support on clinical and billing/coding documentation and connecting them to incentives
- (2) Understanding of the full health care context due work with state and federal partners
- (3) Staff expertise in clinical quality improvement, billing & coding, practice transformation, and EHR optimization

Relationships with Providers

Without the support of NYC REACH, small providers would have had a harder time participating in the incentive programs. NYC REACH provided a suite of services, including billing and coding, to optimize revenue -- from adopting EHRs, connecting EHRs to incentives by explaining how to navigate complicated attestation processes within deadlines, communicating what needed to be done for each incentive program so they could focus on practicing medicine, including them in grant-funded initiatives for quality improvement, and providing PCMH practice transformation services at their request.

Understanding the health care context

NYC REACH is housed in the NYC Department of Health, which gives it a unique advantage. As an REC, they are connected at the federal level and are able to contextualize changes in the health care system. Understanding the synergies between meaningful use and payment reform added value for providers. The REC added expertise in summarizing complex rules and regulations, and provided advice on how, what, when and why small and independent community-based practices could take action.

In addition to engaging at the federal and state level, NYC REACH collaborated with public and private payers. NYC REACH developed a solid relationship with payers, and was therefore able to articulate the needs of providers to the payers, and conversely, from the payers to the providers. NYC REACH leveraged this relationship to secure contracts from two payers to sponsor a pilot where NYC REACH provided technical assistance for EHR optimization and billing and coding for practices in both NYC REACH's and the payer's networks.

Staff expertise

NYC REACH employed staff with expertise in quality improvement, practice transformation, EHRs, and coding optimization. Quality improvement expertise helped providers build processes and adopt systems to improve population health. Practice transformation expertise helped with EHR adoption and workflow redesign. EHR optimization helped to create efficiencies that, combined with coding documentation, optimized revenue for providers. NYC REACH built a billing staff so providers could

minimize the reduction in revenue that is typically associated with EHR adoption. This also helped practices obtain enhanced reimbursement from payers by training practices on the appropriate documentation necessary for reimbursement. Once a provider was coding properly, NYC REACH helped educate practices on leveraging this to renegotiate contracted rates with payers. The combined expertise in billing, quality improvement, and practice transformation showed the true value RECs bring to providers.

Methods Used to Support ACOs

Montefiore ACO

NYC REACH provided assistance in seven major areas for the Montefiore ACO:

1. Reports on key status components of affiliated providers
2. Meaningful use support and attestation assistance
3. EHR implementation for voluntary practices
4. ACO roundtables
5. Public health domain
6. PCMH training
7. Other benefits

Reports

NYC REACH reported on Montefiore-affiliated providers for the key status components of EHR adoption, PCMH certification, meaningful use status, EHR vendor, and other infrastructure components. This helped Montefiore design a quality assurance plan that worked best for each practice. Montefiore could not access the data that NYC REACH provided in any other way, and this helped Montefiore track how it was progressing with its ACO milestones.

Meaningful Use

For meaningful use support, NYC REACH worked with providers on Medicare and Medicaid, facilitating attestation and advising practices on quality measures. NYC REACH sustained ongoing relationships with many of these providers, helping them with practice transformation. Montefiore required its voluntary affiliated providers to register with NYC REACH to leverage REC services.

EHR Implementation

NYC REACH used an eight-step process after practices had gone live that has been very helpful. They facilitated work with the voluntary practices for the ACO and worked collaboratively with vendors and the practices to develop a quality improvement strategy for that specific EHR system. There were 9 or 10 resources that NYC REACH provided that helped Montefiore provide better support to the EHR sites.

ACO Roundtables

NYC REACH promoted ACO collaboration through roundtables. These roundtables drove better communication, and there was always a healthy exchange between the ACOs that would not have occurred if NYC REACH had not brokered the discussions.

Public Health Domain

NYC REACH taught Montefiore ACO about the needs of New York City and the boroughs. Both organizations had a number of closely-aligned initiatives, such as cardiovascular conditions, high blood pressure, colorectal screening and smoking cessation. NYC REACH provided resources in those areas and promoted collaboration on those topics.

PCMH Training

NYC REACH trained Montefiore ACO providers to help them reach PCMH 2014 level three certification. NYC REACH promoted discussion with health information exchanges and taught voluntary providers how health information exchange integrated with PCMH. For advanced PCMH recognition, the key was building the process of care plans. Many of these practices had scarce resources to support care plans, even though many were PCMH certified. There was a vast difference between being certified and actually working as a PCMH clinical practice. NYC REACH was a strong partner for Montefiore in building functional PCMH clinical practices.

Other Benefits

NYC REACH provided intangible benefit by sharing resources the organization had developed, and by putting Montefiore in situations where collaboration could easily occur. Montefiore saw NYC REACH as a supporting partner that provided assistance to practices after they went live, and an excellent partner in advising on progress with EHR implementations at affiliated practices, particularly voluntary ones.

University of Central Florida REC

Background

The University of Central Florida Regional Extension Center is a division of the College of Medicine, and offers a variety of professional services including meaningful use consulting, PCMH transformation and recognition services, revenue cycle services and training that includes ICD-10, evaluation and management (E/M) coding, and billing audits. In the Spring of 2015, they began work to deploy an analytics platform to provide near real-time analytics to ambulatory providers, and to support population health management. Staff expects the analytics platform will enhance the services that they provide to ACOs. Their plan is to focus on PCMH as the next logical step following MU for practices to achieve full transformation and prepare their community providers for pay for value. The UCF REC sees the analytics platform as a means to address issues with data capture, reporting and sharing. To effectively deliver ACO services, providers need access to patient-centered information from multiple organizations. The state HIE for Florida currently offers hospital admit, discharge and transfer (ADT) data via Direct secure messaging through their event notification service (ENS).

The National Committee for Quality Assurance (NCQA) selected the UCF REC as a partner in quality (PIQ) and invited them to present on PCMH transformation work done with a local free clinic. The presentation was given at the first NCQA national conference on PCMH in October 2015, in San Francisco.

The UCF College of Medicine provides a reputational advantage to the REC. Established in 2006, the College of Medicine prides itself on being a forward-looking medical school with a culture based on partnerships and collaboration. To draw the brightest students, the college raised funds from local sources and provided full scholarships to the first class of medical students. Community support for the school was well developed and the College of Medicine played a strong role in the vision and plan for the UCF REC.

ACO Affiliate

Primary Partners ACO is located in Clermont, Florida, and has 45 practices and 63 providers, 70% of which are solo practitioners. Primary Partners LLC and Primary Partners ACIP LLC were participants in the Medicare Shared Savings Program as an ACO, sponsored by the Centers for Medicare & Medicaid Services (CMS). Their goal was to provide Medicare fee-for-service beneficiaries in Florida with a positive patient experience and improved health outcomes, while reducing growth in Medicare expenditures for the same patient population.

UCF REC Use Case

Purpose

The UCF REC began working with ACOs on PCMH transformation in early-2013. In working with the ACOs, the UCF REC and the ACOs agreed that providers would become recognized as PCMH practices. UCF REC staff researched processes that were being used, and distilled best practices to develop a robust practice transformation service line that begins with an assessment for practices considering PCMH. This strict assessment process began by ensuring that the practice had a certified EHR and achieved MU. The assessment included the organization's willingness to transform and the capacity of the organization to embrace the changes necessary to become a PCMH. This assessment was critical in advance of the practices undertaking PCMH transformation, which was a lengthy and resource-intensive process that required sustained dedication to address the numerous challenges in becoming a functioning medical home.

Value

The community recognized that the UCF REC as a neutral third-party affiliated with an academic institution.

Practice Transformation Services

The UCF REC is working with the Florida Department of Health, providing PCMH transformation services under a state wide grant program to community health centers, FQHCs, and other Medicaid practices across the state. In addition, the UCF REC provided PCMH transformation services to a number of independent primary care organizations throughout the Central Florida Region. The UCF REC provided additional support to community providers through educational webinars and live events on the PCMH process and the benefits of PCMH transformation.

Patient Centered Medical Home (PCMH) Recognition

To promote return on investment, the UCF REC recommended practices that join ACOs undertake PCMH practice transformation and recognition as an investment in their future. As practices with a majority of Medicare patients shift from fee for service to pay for value, becoming a PCMH in an ACO-affiliated practice will be critical to long-term sustainability. PCMH recognition ensures improvements in quality, efficiency, and population health. Practices that monitor their performance and report on how they compare with the community will have the necessary data to better negotiate contracts and rates with payers.

Assistance understanding other payer programs

Florida did not have expanded Medicaid services. Florida shifted all Medicaid to managed care organizations. Some Medicaid managed care organizations and other commercial payers offered

incentives for PCMH practices and the UCF REC helped make practices aware of those programs, although this was not a significant source of reimbursement.

Practice Transformation Services to Medicaid Managed Care Practices

The health plans in Florida worked on PCMH and found that organizations slipped back if PCMH was not fully integrated into everyday ongoing work. The payers were concerned and saw working with the UCF REC program as a potential solution. The UCF REC is working with several state Medicaid payers to assist their provider organizations with the adoption of sustainable PCMH activities. The Medicaid managed care organizations have certain performance measures in their state contracts, including practices that are meaningful users and PCMH recognized. Health plans aimed to have higher functioning practices, as it improved their per member per month (PMPM) costs.

EHR Consulting, Population Health Management and Reports

The ACOs had great intentions when they first started. Many struggled with the technology and being able to manage their populations effectively, due to data and reporting challenges. Assisting with the technology foundation, measures reports for population health, and PCMH transformation were key services for the UCF REC. These services created value for ACOs and PCMH practices when the care they provided were measured based on quality and cost.

Primary Partners ACO

Building on Meaningful Use

The UCF REC recognized early on the value of building on the services they were already providing to the community and taking advantage of the knowledge of their existing team. They selected PCMH transformation recognition services as the natural next step in their evolution and chose a core team to get NCQA content expert certification for PCMH. The UCF REC provided a lot of value because they had existing relationships with some of the ACO practices, were familiar with meaningful use policies and regulations, and understood how EHRs were used as an effective tool in the PCMH model.

Affordable Local Expertise

The Primary Partners ACO distributed an RFP seeking PCMH training and consultative services. Several large organizations submitted bids for transformation services that were very expensive. The ACO was skeptical that someone who did not know the local community would be able to provide appropriate services for small practices without costly onsite visits to learn the market and meet the providers. They feared that travel to practices would incur significant costs and place heavy time burdens on the practices. From an economic standpoint, the REC provided a more affordable option, had the relevant expertise and knew the market better so they were selected as the successful bidder.

Methods Used to Support ACOs:

The UCF REC assisted Primary Partners ACO by:

1. Focusing on small practices
2. Providing active and engaged project management
3. Providing consistent hands on help
4. Providing practice transformation best practices
5. Building a sustainable quality improvement structure
6. Recognizing each medical practice's uniqueness

7. Conducting readiness assessments
8. Regular reporting to ACO leadership
9. Supporting ACO's use of pairing medical practices to share
10. Supporting ACO's use of college interns in practices
11. Actively partnering with ACO leadership

Focus on Small Medical Practices

The UCF REC was engaged by Primary Partners, a local ACO with 20 primary care organizations, to work with a set of high-performing practices to become NCQA PCMH recognized. Those primary care organizations ranged in size from one provider to more than 10, and their capabilities and technology all varied.

Active and Engaged Project Management

The UCF REC took a very hands-on approach to working with the practices, providers, and the ACO. The UCF REC led weekly meetings throughout the project with the ACO to discuss the status of each organization, and collaborated with the ACO to mitigate any barriers. If the UCF REC identified a practice that was falling behind, the ACO could provide them with additional resources and tools to get past that challenge.

Consistent Hands-on Help

Working in the practices involved hands-on facilitation and transformation support. Every other week, the UCF REC staff worked alongside the practice to develop policies and processes, map workflows, train staff, report capabilities, and generate templates and reports.

Sustainable Quality Improvement Infrastructure

The UCF REC staff spent a considerable amount of the time working with each organization to develop a sustainable quality improvement infrastructure. The UCF REC's PCMH program emphasizes transformation over recognition; meaning that achieving PCMH recognition was important, but truly transforming, taking the steps to change the organization's culture, and operating as a medical home were much more important. Their goal was to ensure that organizations were able to sustain these processes long term and avoid regression to the mean. The project supported the ACO's 20 primary care practices in achieving NCQA recognition over a total timeline of about 18 months.

Recognizing Each Medical Practice's Uniqueness

The UCF REC staff worked with one provider practice that had an EHR, but had not achieved meaningful use because the EHR was not certified. The staff of this practice were completely engaged in this project from the get-go and understood there would be challenges in getting recognized. The entire staff, including the lead physician, embraced the necessary team-based culture required for success. In the end, although they faced tremendous challenges, they were able to achieve Level II NCQA recognition.

Readiness Assessment

For the Primary Partners ACO, the UCF REC performed a readiness assessment on 14 primary care practices interested in becoming PCMH accredited and 12 were deemed prepared at that time. Of those, 11 practices completed PCMH transformation and recognition.

Reporting to the ACO Leadership

The UCF REC facilitated biweekly meetings with the ACO-affiliated practices that wanted to become PCMH certified, and facilitated weekly meetings with ACO leadership. The ACO leadership then easily identified issues or barriers and intervened to remove barriers or added needed resources.

Pairing Medical Practices to Share

ACO-affiliated practices were paired in a buddy system and worked together to collaborate and share best practices. This was further supported by the use of interns from UCF who were graduate and undergraduate students in health administration.

Using College Interns to Support ACO Practices

The ACO had the interns help practices by writing administrative policies and other documentation that was required for PCMH. The students dedicated four hours to each practice weekly, for a total of 120 hours for undergraduate students and 240 hours for graduate students. The interns met weekly as a group to discuss lessons learned and best practices, and helped each other with suggestions. The interns received assistance from the REC, as the REC worked closely with the practices on EHR implementation, meaningful use and PCMH transformation.

Partnering with ACO Leadership

For both the affiliated practices and the interns, the ACO's leadership set clear expectations and followed up intensely on any issues. The REC worked with ACO leadership to support this effort and helped the interns to understand what their role was in each project.

Appendix B: Qualitative Study Description

Introduction

“Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will **share in the savings** it achieves for the Medicare program.”³ Other payers including private insurers and state Medicaid programs are also utilizing ACOs.

ACOs are responsible for patients and their care, but they do not often have full control over the care each patient receives. Patients go to different hospitals, or long term care, or specialists that may not be affiliated with the ACO. Consequently, ACOs need data from other organizations to support patient-centered care. There are currently 33 quality measures that ACOs report on, and each of those is dependent upon the ACO’s EHR’s reporting capabilities, or the use of registries, or reports from an HIE.

RECs have helped large and small provider practices adopt and implement EHRs and attest to meaningful use and eQMs. They have experience designing complex workflows and in pulling data from EHRs; both of these skills are important to ACOs. In describing ongoing challenges, the Health Affairs Blog cites, “creating integrated systems of care is difficult work requiring considerable resource investments (the cost of integration) in increasing EHR functionality, workflow redesign, and developing partnerships with others.”⁴

Research Design

Seamon Corporation evaluated systems in New York City and Central Florida to understand how these RECs worked successfully with ACOs. Each of these RECs has a different history and business model. The RECs were chosen to illustrate differing types of methods used to work with ACOs.

This report describes how the Seamon Corporation evaluated methods used by RECs working with ACOs to support health care transformation. This report includes methods used to support ACOs and specific use cases to demonstrate and support practice transformation.

Data collection

Data for this study was collected using an open-ended, semi-structured interview guide. Respondents included members of the REC’s team. In addition, a second semi-structured interview guide was used with ACO leaders to gather information on the value of the REC, lessons learned, and recommendations. These providers included the manager of health system’s pioneer ACO and the CEO of a provider-led ACO.

³ <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco>

⁴ Shortell S, Sheffler R, *Health Affairs Blog* June 2, 2015. <http://healthaffairs.org/blog/2015/06/02/accountable-care-organizations-taking-hold-and-improving-health-care-in-california/> Accessed June 9, 2015

Research Questions

Research topic one: Understanding the needs of ACOs

RECs need to understand the needs of ACOs in their designated areas in order to assist ACOs with adoption of EHRs, redesigning workflow, and obtaining reports from EHRs or registries. Researchers needed to understand the context for REC-to-ACO services, including the history of the REC; the nature of its previous engagement with providers, practices, and hospitals; the methods the REC used to understand the service needs of the ACO; other service offerings; and the availability of HIE.

Research topic two: Population Health

Reports on patient panels must be available to ACO management to monitor population health for each and all affiliated providers. To evaluate this, researchers considered the methods that were used to assess individual provider performance and ACO performance, and how population health reporting was done, as well as what quality improvement strategies were used.

Research topic three: Value of REC services

REC services must be perceived as valuable, scalable, and flexible to meet ACO needs and sustain REC services. To test this hypothesis, researchers considered the perceived value of REC services to the ACO, the degree of formality evidenced in the relationship between RECs and ACOs, the business model the REC had developed for sustainability, the scalability and flexibility of REC services, and the importance placed upon strategic planning for future services.

Research topic four: Relationship with Payers

RECs have developed relationships that will help promote accountable care with Medicaid and private insurance payers. To investigate this hypothesis, researchers considered what payers the REC had been working with, its outreach to other payers, and future plans for working with other payers.

Analysis

Interviews with REC staff and ACOs were summarized. The themes developed for each research question were reviewed, and are presented here.

Research topic one: Understanding the needs of ACOs

NYC REACH and the UCF REC are historically high-performing organizations. Each has a different business structure, with NYC REACH being located in the city health department and the UCF REC uniquely positioned as part of a school of medicine.

Each REC has enjoyed deep and lasting business relationships with their customers through engagement to help in selecting EHR vendors, redesigning workflows, attesting to and achieving MU.

NYC REACH works with ACOs in a learning collaborative, where ACO leaders share challenges and lessons learned. The UCF REC uses a highly-structured method for relationship development and management.

New York reported having some regional HIE activity, although it was not ubiquitous. UCF reported limited HIE activity.

Research topic two: Population Health

As a health department organization, NYC REACH has unique assets in public health data to support ACOs. NYC REACH and the UCF REC had developed expertise in pulling reports from EHR data to help providers assess performance. Both RECs focus on helping practices develop EHR-supported quality improvement strategies.

Research topic three: Value of REC services

The ACOs reported achieving value and improved performance with the REC services they received.

Research topic four: Relationship with Payers

NYC REACH ran several pilots with other payers that provided a proof of concept for developing relationships and providing supportive services for other value-based payer efforts.