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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HITECH: Catalyst for Transformation

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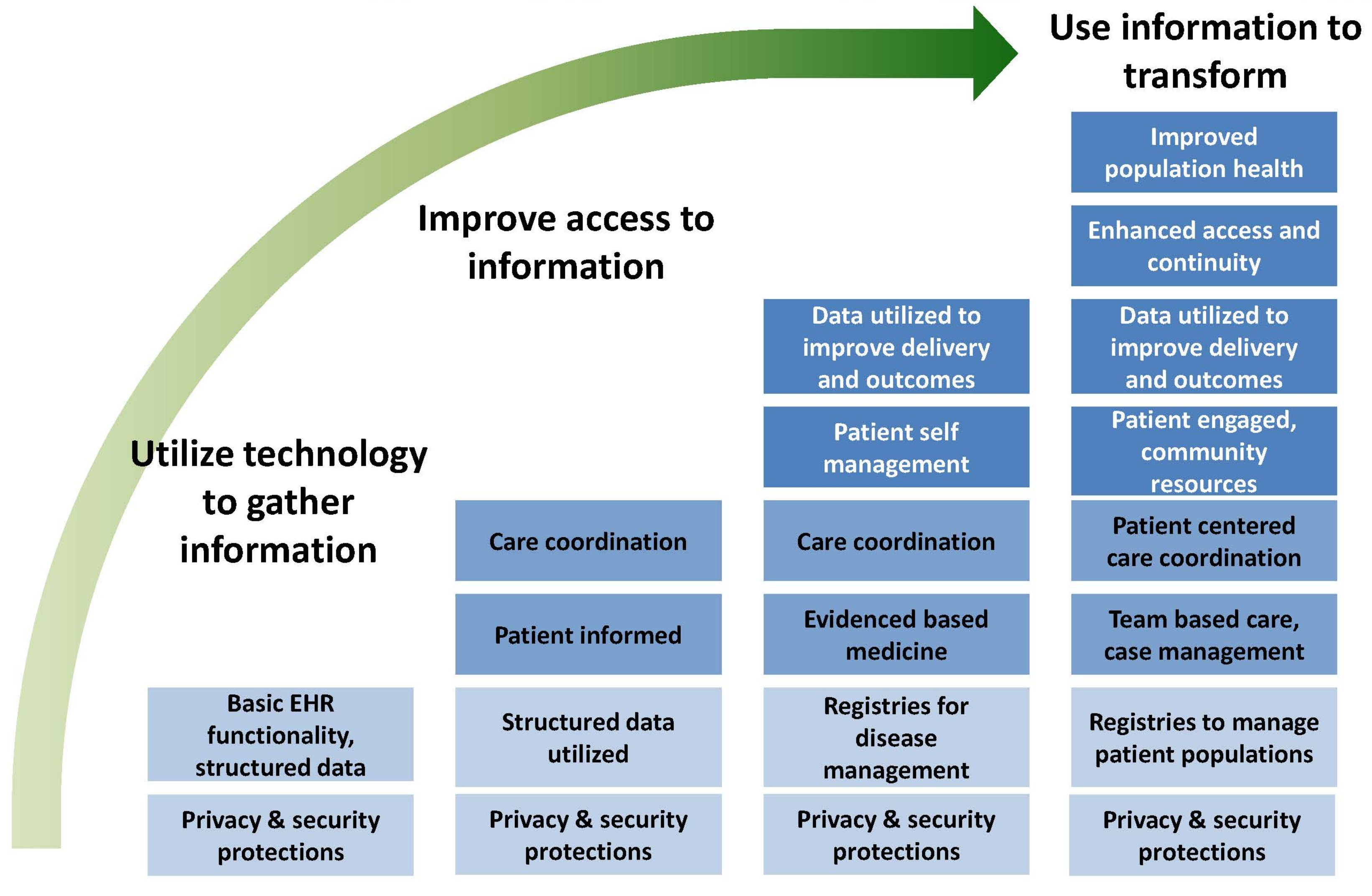
★ Better Healthcare ★ Better Health ★ Reduced Costs

HITECH Act
2009
EHR Incentive Program and 62 Regional Extension Centers

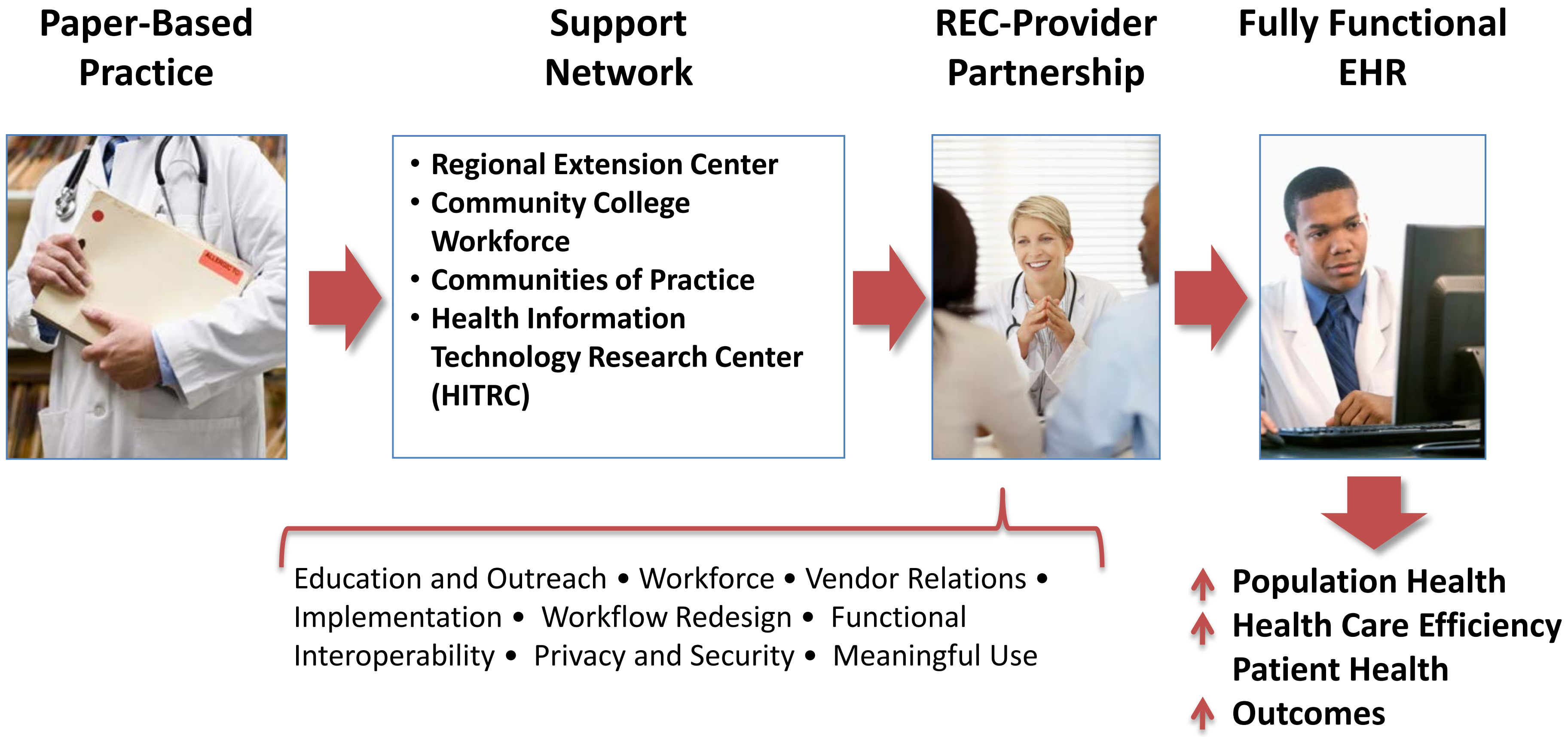
EHRs & HIE
2014
Widespread adoption & meaningful use of EHRs

Payment Reform
2014+
Health IT Enabled Reform Models

Meaningful Use as a Building Block



Network of Support for Every Provider



Comprehensive Support Beyond EHR Implementation

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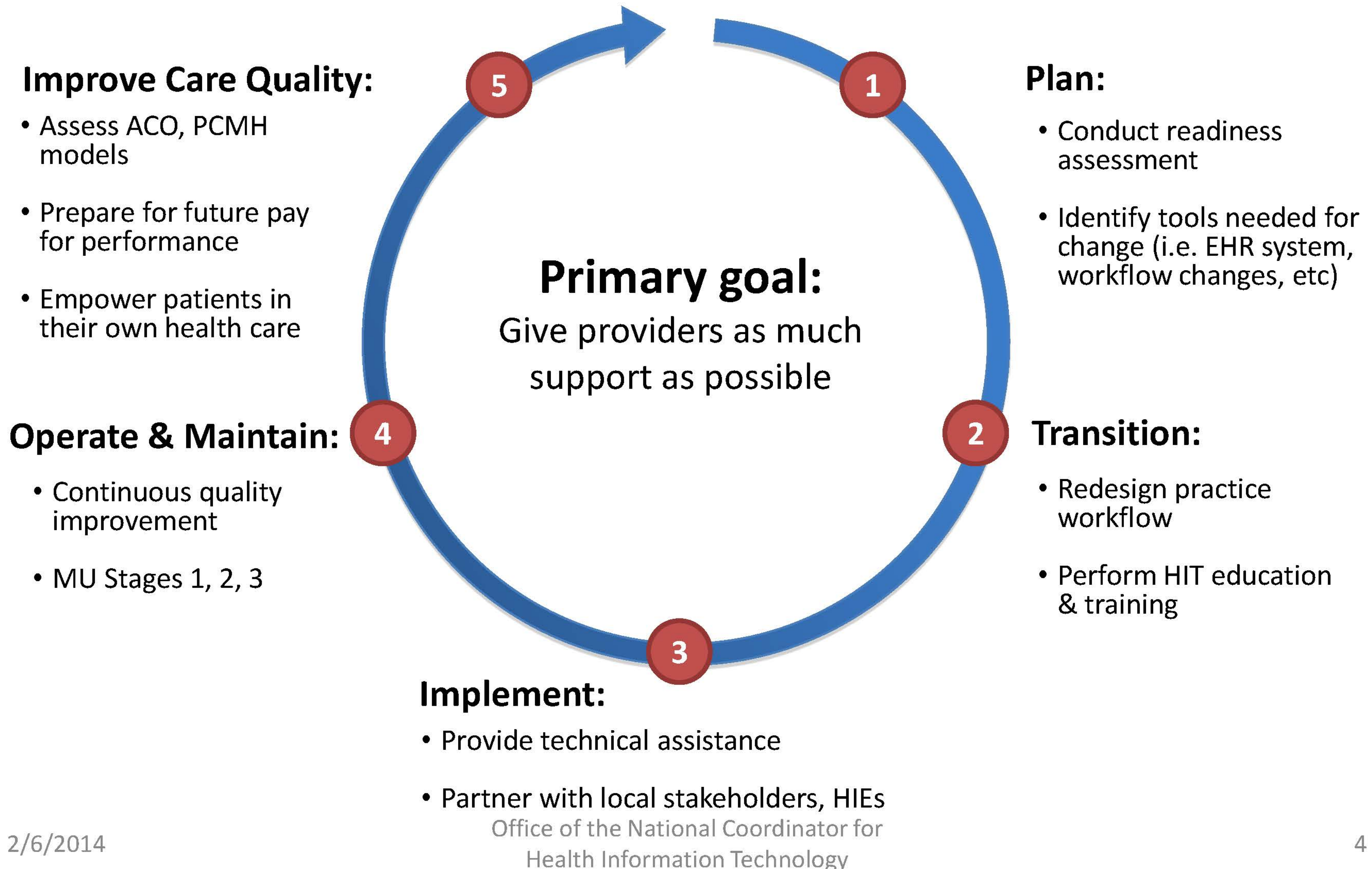

62 Regional Extension Centers (RECs) Cover 100% of the USA

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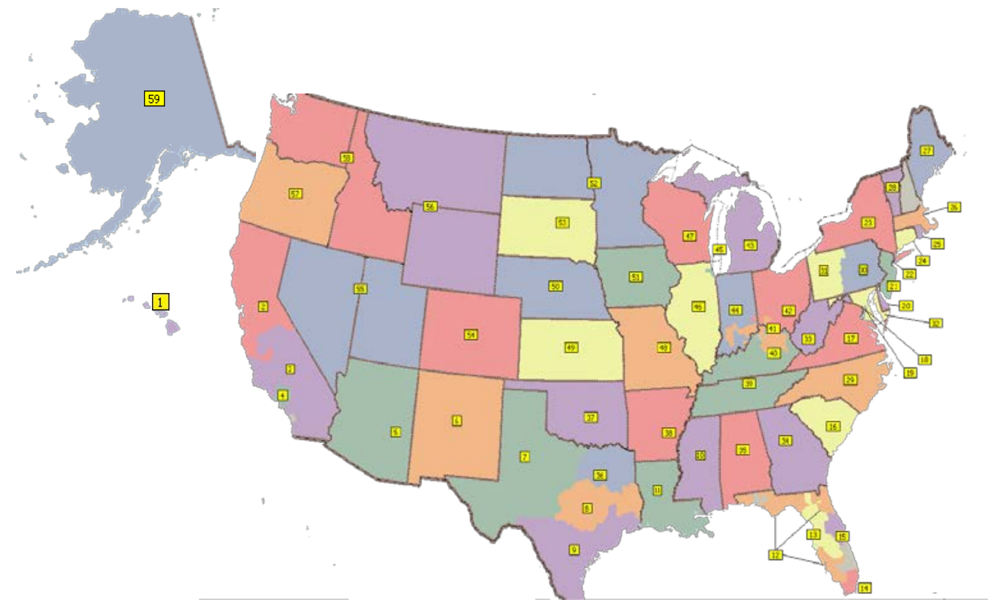
Initial Program Goal:

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

REC Focus: Priority Primary Care Providers

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

REC Performance as of December 2013

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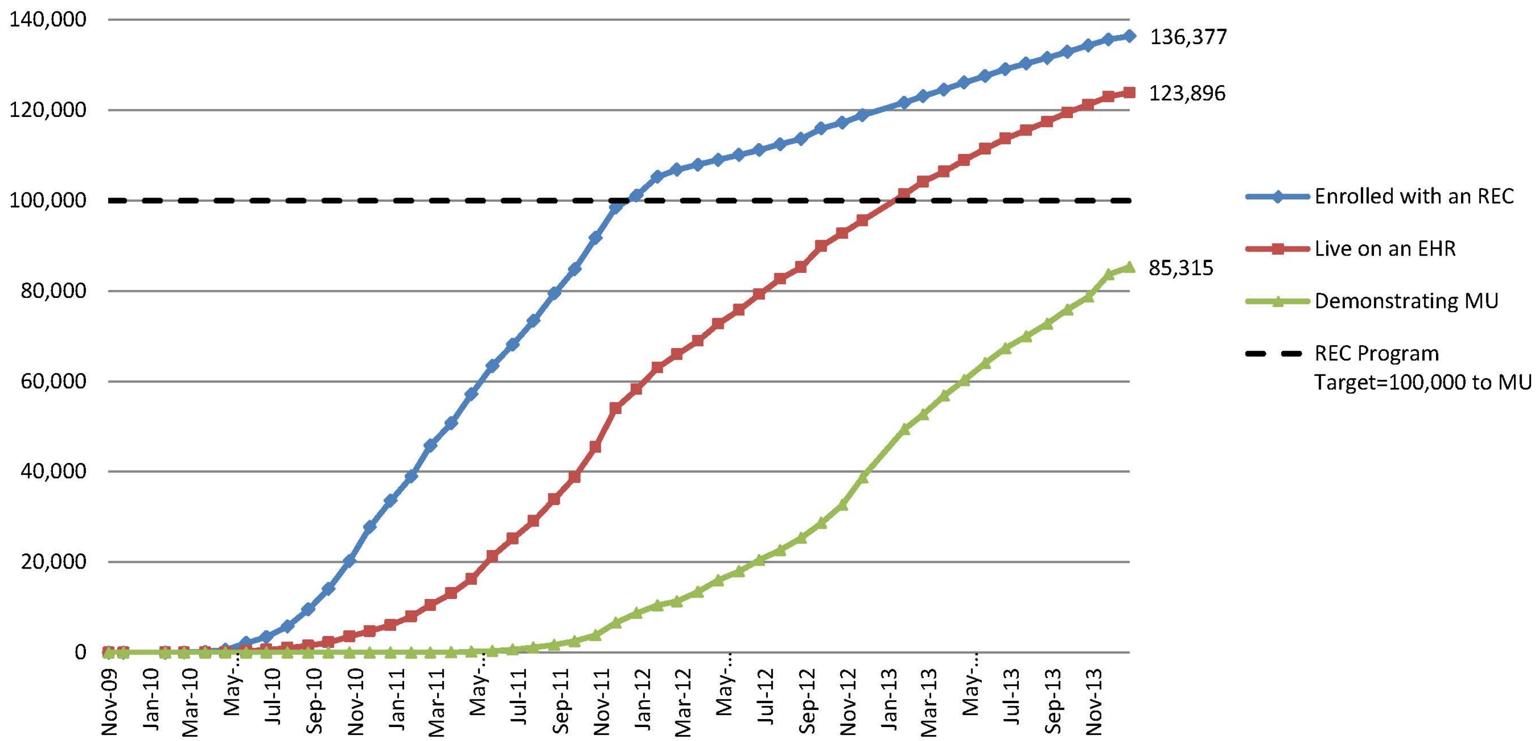
Cumulative Number and Proportion of REC Primary Care Providers Enrolled, Live on an EHR, and Demonstrating Meaningful Use (MU) Over Time



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

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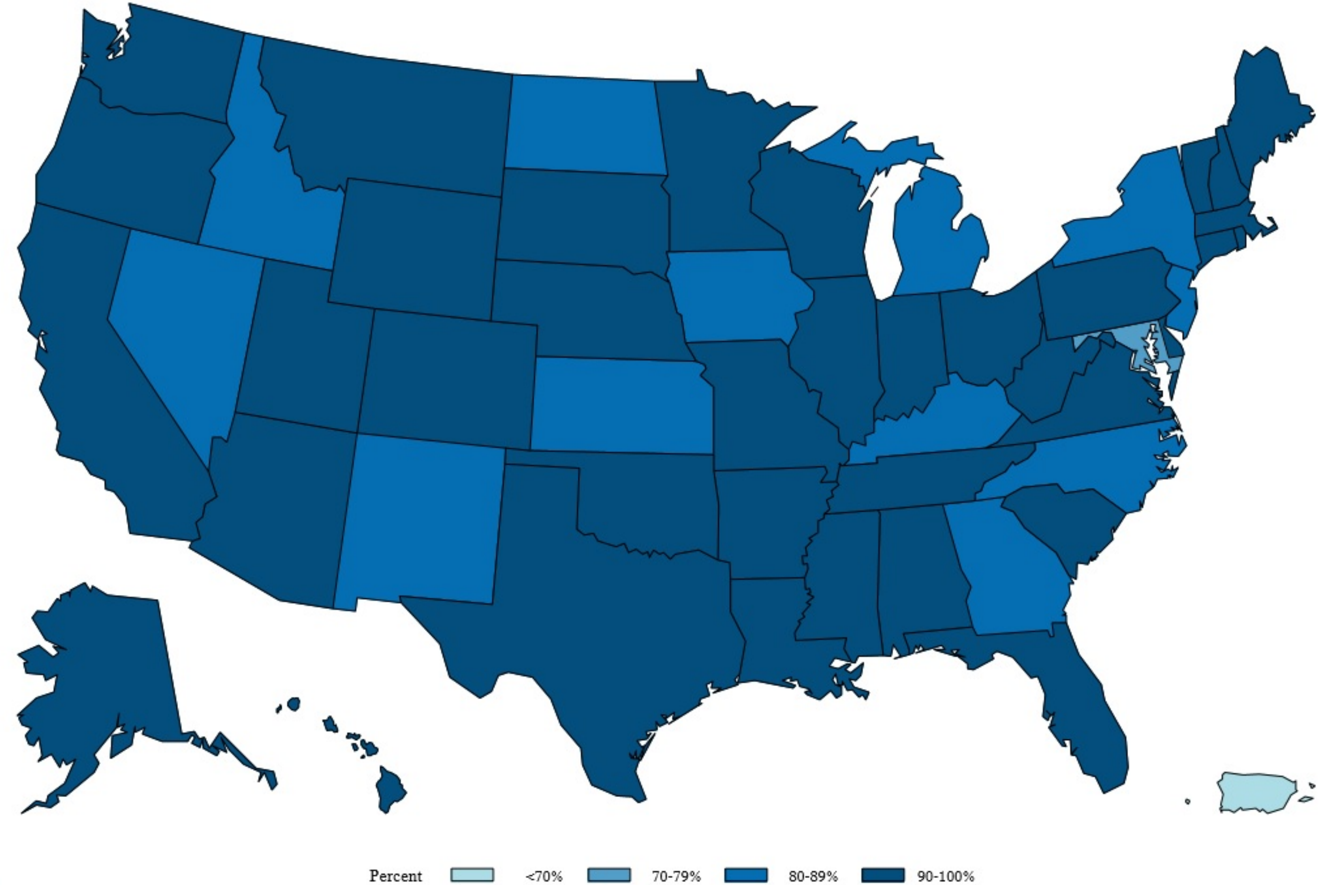

- 1 state has less than 70% of REC-enrolled PCPs Live on an EHR: Hawaii
- 1 state have 70 to 79 % of REC-enrolled PCPs Live on an EHR: Maryland
- 12 states have 80 to 89 % of REC-enrolled PCPs Live on an EHR: Georgia, Idaho, Iowa, Kansas, Kentucky, Michigan, Nevada, New Jersey, New Mexico, New York, 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.

GAO reports on EHRs and Medicare Payments

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

Source: GAO, *Electronic Health Records: Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011-2012, GAO-14-21R (Washington, D.C.: October 24, 2013)*

REC Enrollment

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Providers	# of Providers Enrolled with an REC	Total Number of Providers Nationwide	Proportion of Providers Enrolled with an REC
Rural Primary Care Providers	24,691	47,000	53%
Total Primary Care Providers	135,123	302,726	45%
Organizations	**# of Organizations Enrolled with an REC1**	**Total Number of Organizations Nationwide**	**Proportion of Organizations Enrolled with an REC**
Federally Qualified Health Center and FQHC Look-Alike Grantees	954	1,147	83%
Critical Access Hospitals	1,050	1,327	79%
Sites	**# of Sites Enrolled with an REC1**	**Total Number of Sites Nationwide**	**Proportion of Sites Enrolled with an REC**
Comprehensive Primary Care Initiative Sites	265	503	53%
Advanced Primary Care Initiative Sites	409	500	82%

[1] US Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. Customer Relationship Management database. September 05, 2013
[2] SK&A Office-based Providers Database, SK&A Information Services, Irvine, CA. 2011.
[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

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Area Type	Number of Primary Care Providers Enrolled	Proportion Live on an EHR	Proportion Demonstrating MU
Urban	109,109	86%	48%
Rural	24,522	87%	47%
Primary Care Health Professional Shortage Area (HPSA)	3,202	82%	39%
Practice Setting	**Number of Primary Care Providers Enrolled**	**Proportion Live on an EHR**	**Proportion Demonstrating MU**
Small Primary Care Practice	51,562	84%	54%
Public Hospital Outpatient Dept. or Other Underserved	36,128	87%	49%
Practice Consortium	22.027	91%	62%
Federally Qualified Health Center	18,650	93%	41%
Small Rural Hospital, Rural Health Clinic, or Critical Access Hospital	10,848	84%	41%
TOTAL	139,215	87%	47%
Provider Type	**Number of Primary Care Providers Enrolled**	**Proportion Live on an EHR**	**Proportion Demonstrating MU**
Physician	102,568	88%	56%
Nurse Practitioner	20,874	87%	40%
Physician Assistant	9,699	90%	41%
Certified Nurse Midwife	1,982	87%	39%
Community Health Aide Practitioner (Indian Health Service)	392	96%	1%
TOTAL	135,515	88%	52%

[1] Data Source: US Department of Health and Human Services, Office of the National Coordinator for Health Information Technology. Customer Relationship Management database. September 5, 2013
[2] Area types defined using the US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. Area Resource File, 2011-2012. Rockville, MD.
[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.
[5] Rural Hospitals matched against REC-enrolled practices defined using the US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. Small Rural Hospital Improvement Program list, 2012. Rockville, MD. Formerly available at: http://www.hrsa.gov/ruralhealth/about/hospitalstate/index.html

REC Program: Foundational Strategies

- 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**

Business Intelligence & Knowledge Management Tools

- 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

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- 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

Step 1: Assess Your Practice Readiness
Step 2: Plan Your Approach
Step 3: Select or Upgrade to a Certified EHR
Step 4: Conduct Training & Implement an EHR System
Step 5: Achieve Meaningful Use
Step 6: Continue Quality Improvement
EHR Implementation Lessons from the Field
Get Implementation Support

Clinical Summaries

Objective:

Provide clinical summari

Measure:

Clinical summaries provi
within 3 business days.

Clinical Importance

The Clinical Summary—
provided, such as medic
better communication ar
shared with both patients
occurred during office vis

CMS Resources

The following resources a
meaningful use core mea

- EHR Meaningful Use
Summaries [PDF - 1

Related CMS EHR Incen

National Learning Consortium Resources

Resource Name	Description	Source
Providing Patients in Ambulatory Care Settings a Clinical Summary of the Office Visit Download › [DOCX - 3.9 MB]	Fact sheet outlining details and implementation considerations for a clinical summary.	Health Information Technology Resource Center (HITRC)
Clinical Summary FAQs Download › [DOCX - 1.1 MB]	Frequently Asked Questions (FAQs) and tips related to Core Measure 10: Clinical Summaries	Health Information Technology Resource Center (HITRC)
Tips for Engaging Safety Net Patients Using Health IT View ›	Webinar that provides tips on how safety net providers and staff can use Health IT to increase patient engagement.	Health Resources and Services Administration (HRSA)
Providing Clinical Summaries to Patients after Each Office Visit: A Technical Guide	Guide to help eligible professionals (EPs) and their organizations gain a better grasp of how to successfully meet the criteria of giving clinical summaries to patients after each office visit.	Qualis Health

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."

nator, Regional Extension Assistance Center for
REACH)

entified the importance of workflow when compiling an
nts. The goal is for everyone who works with the
their particular license permits. The physician can
t front desk or nursing staff enters into the EHR,
to focus on the patient. This takes a clinical team
tion from each of the job roles. Once a workflow is
s encouraged so that the clinic can work out any
he process before going live across all patients and

rs providers to finish their initial assessment during
nation needed to print a clinical summary ensures that
imely manner and is given to patients after each

ld Medical Care Systems, Vermont Information

hat has worked in the field is when providers do all
ent and plan prior to the patient leaving the exam
ire a cognitive discussion for a particular problem; but
abs and referrals that are made. The remaining details
included for the clinical summary to be printed and

of the most difficult core measures to accomplish
n times, they are not completed prior to the patient

on and Optimization Specialist, Polaris Danforth in

Partnering with Providers to Achieve their HIT Goals

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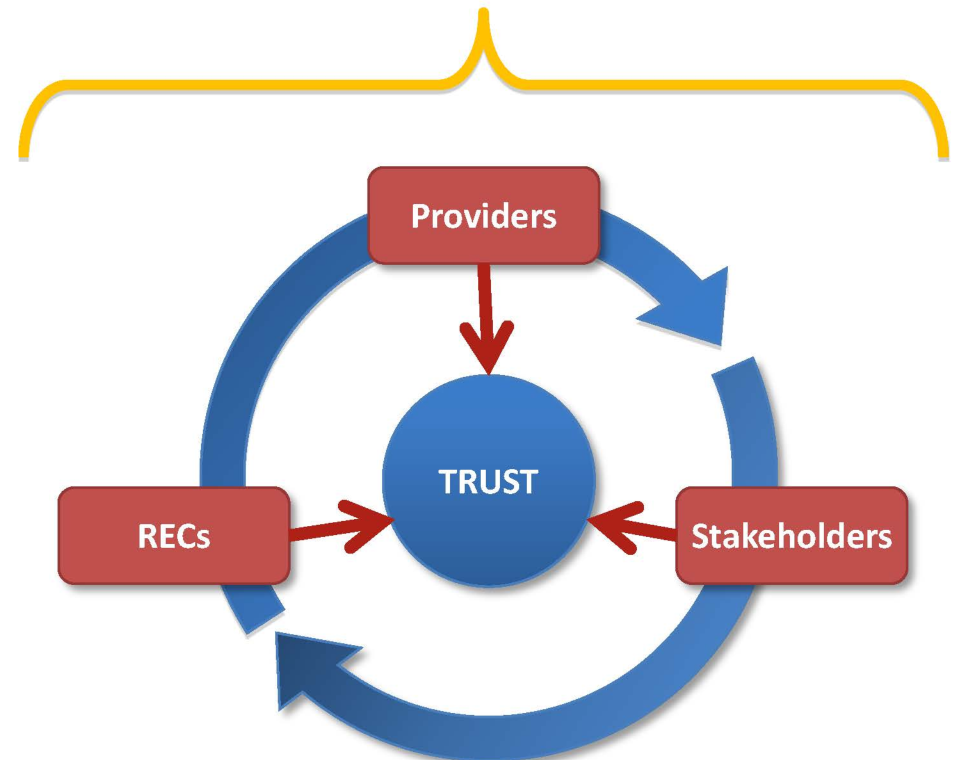
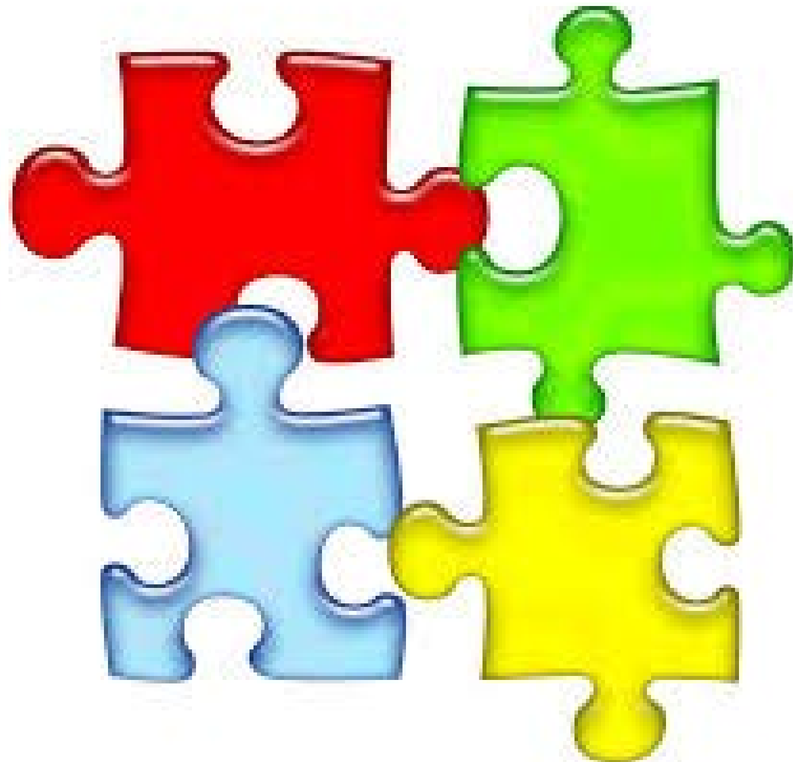
- Meet providers where they are
- Offer unbiased support
- Provide broad, practical expertise
- Act as pipeline to resources
- Offer relevant MU expertise

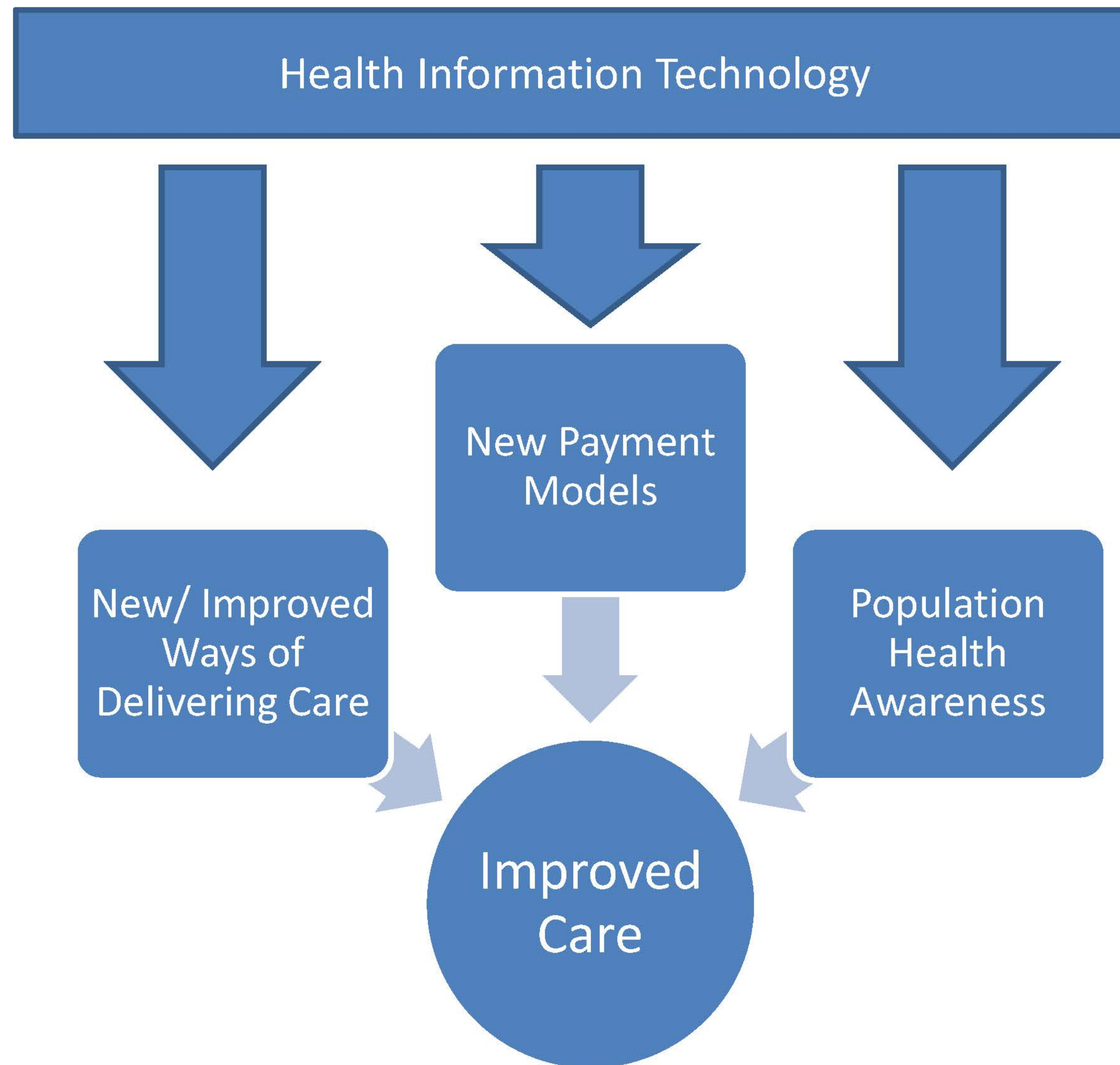


2014 and MU Stage 2



- 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



Public-Private Alignment for Care Delivery Transformation

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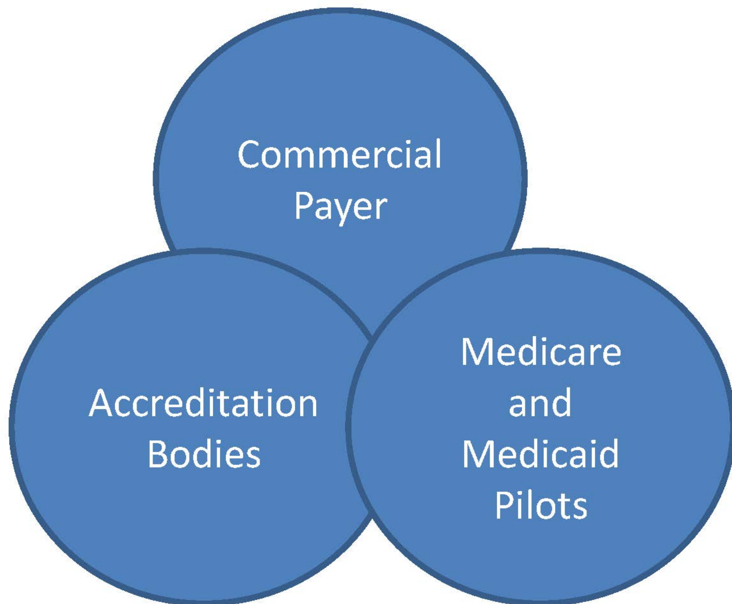
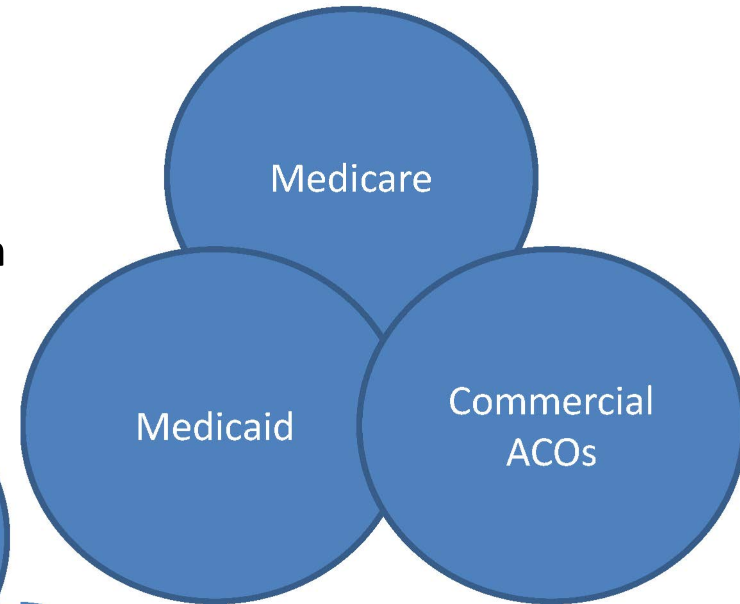
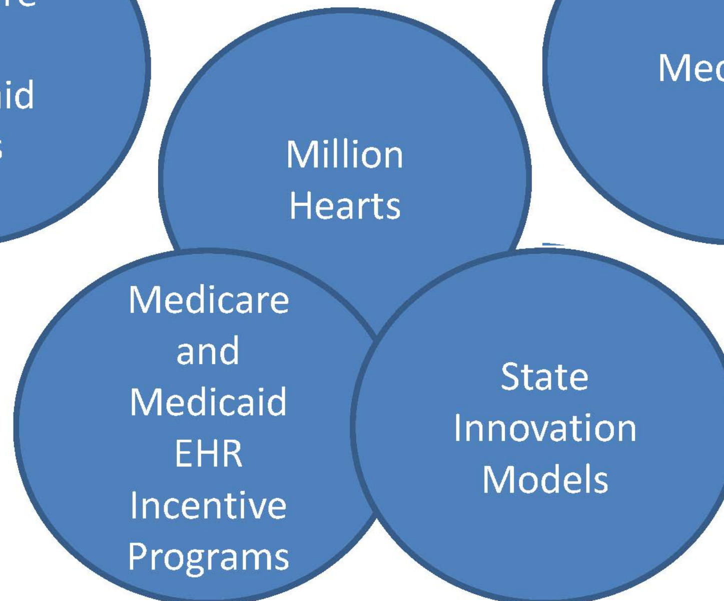
Care Delivery Improvement through Medical Home



New Payment Model through Accountable Care



Population Health Awareness



Skill Demands to Support Care Delivery Transformation

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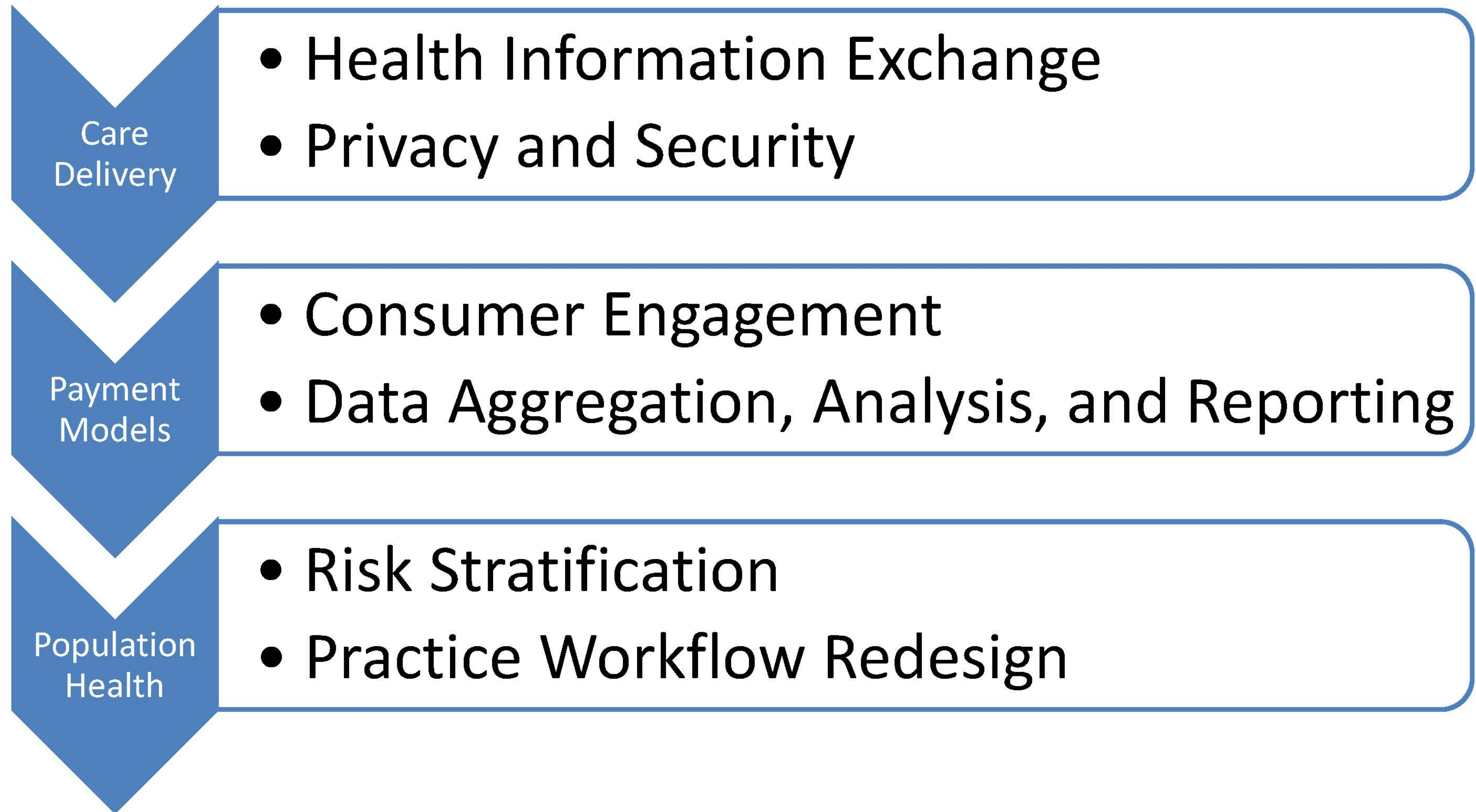

REC Enrolled By Certification Type

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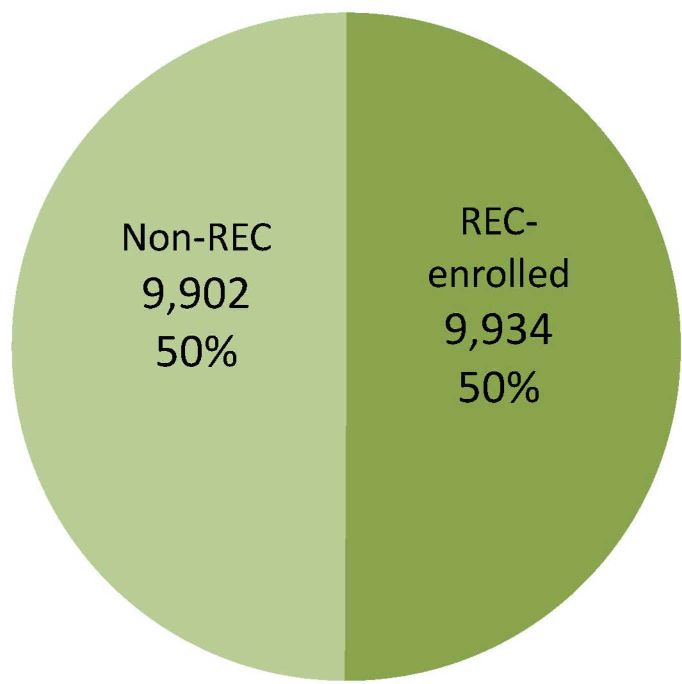
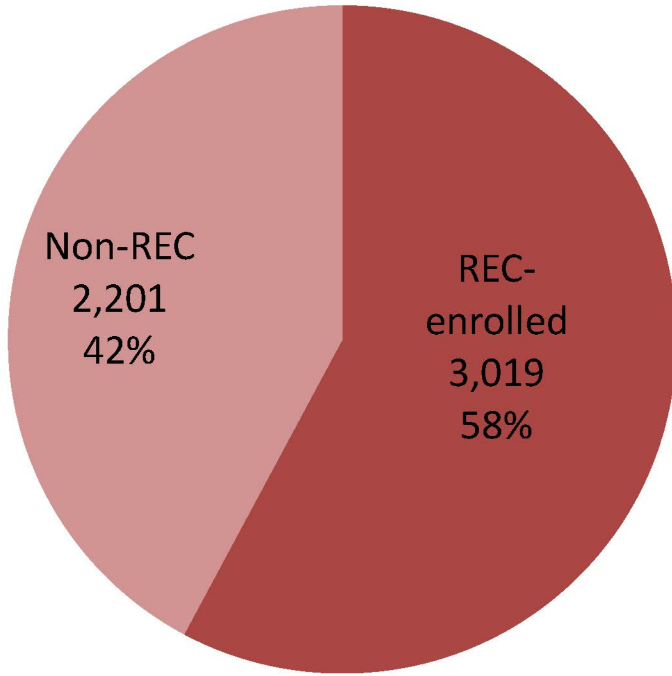
2008 Certified PCMH Providers

n=19,836



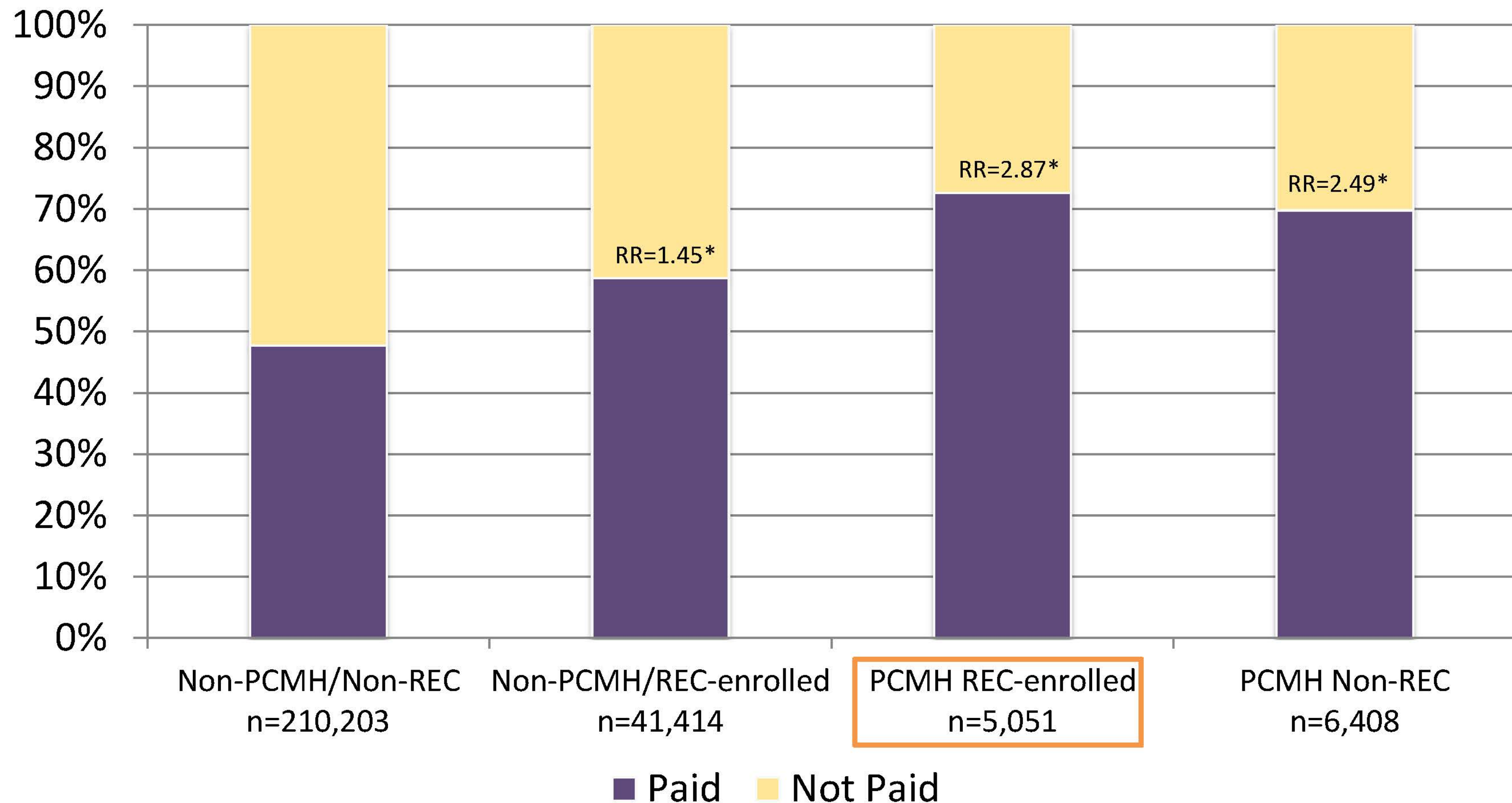
2011 Certified PCMH Providers

n=5,220



Based on ONC CRM data as of March 19, 2013, merged by provider NPI to NCQA PCMH data as of February 28, 2013.

REC Medicare Providers, PCMH and MU Payment

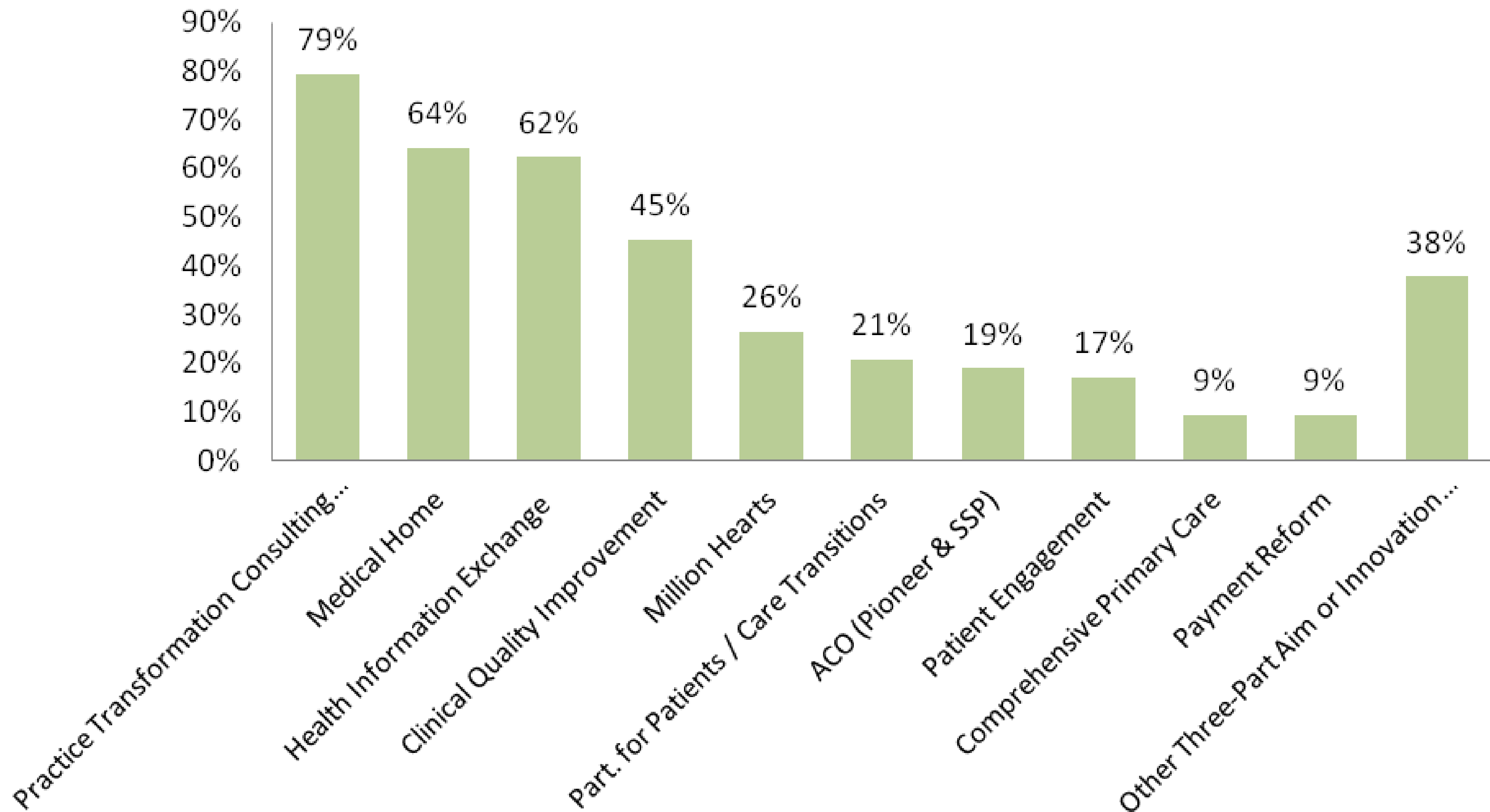


Relative Risk (RR) compares the likelihood of being paid for MU when compared to the non-PCMH/non-REC enrolled providers.
Among REC-enrolled providers, those that are PCMH-certified are 8% (p=0.0008) more likely to be paid for MU than those not certified.
Among PCMH-certified providers, those enrolled 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.

RECs Engaged in Practice Transformation and Enabling the Three-Part Aim

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.*

RECs Supporting Information Exchange & Consumer Engagement

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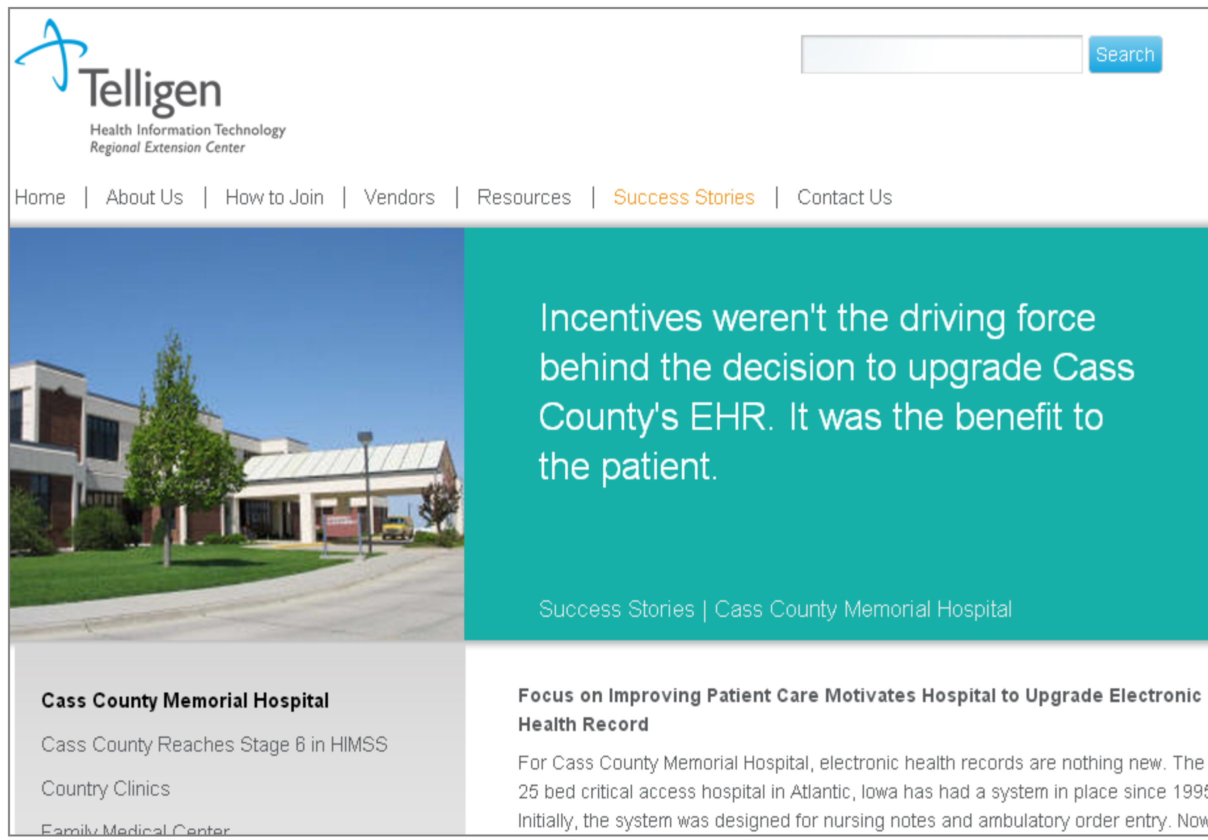
The Iowa REC program is helping CAHs and rural health clinics leverage MU to support patient engagement and Patient Centered Medical Home (PCMH) through intensive, hands-on practice transformation work. They also are supporting statewide health information exchange, especially in rural areas.



RECs and Accountable Care Organizations (ACOs)

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- NJ-HITEC Member Portal
- Medicaid Specialist Program
- Accountable Care Organizations
- Comprehensive Primary Care Initiative
- Health Information Exchange
- ICD-10
- Patient-Centered Medical Home (PCMH) Consulting
- PQRS Data Registry

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."

RECs and the State Innovation Models (SIM) Initiative

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.

Approximately 30% of Minnesotans live in rural areas, and 40 percent of them are medically underserved.

Home > Expertise & Services > Rural Health

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 assignment 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.

RECs and the Comprehensive Primary Care (CPC) Initiative

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.

	Domain	NQF #	Measure Title / Description
1	Population / Public Health	0041	Title: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 years old *Description: Percentage of patients age 50 years and older who received an influenza immunization during the flu season (September through February)*
2	Population / Public Health	0028	Title: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention *Description: a. Percentage of patients age 18 years and older who have been seen for at least two office visits who were queried about tobacco use one or more times within 24 months b. Percentage of patients age 18 years and older identified as tobacco users within the past 24 months and have been seen for at least two office visits, who received cessation intervention*
3	Clinical Process / Effectiveness	0034	Title: Colorectal Cancer Screening *Description: Percentage of patients age 50 to 75 years of age who had appropriate screening for colorectal cancer*

Thank You

Questions?

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