Getting to Meaningful Improvement: Meaningful Use & the Maine Regional Extension Center
Maine’s Statewide Regional Extension Center

Quality Counts Provider Lunch & Learn
12N-1PM: Thurs, Sept 2 & Tues, Sept 7, 2010

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Shaun Alfreds – HealthInfoNet & Maine Regional Extension Center
Setting the Stage--Acronyms

- CMS-Centers for Medicare and Medicaid Services
- EHR-Electronic Health Records
- REC-Regional Extension Center
- MERECA-Maine Regional Extension Center
- HIT-Health Information Technology
- PPACA-Patient Protection and Affordable Care Act
- ONC-Office of the National Coordinator for Health Information Technology
- HIN-HealthInfoNet
- HIE-Health Information Exchange
- QC-Quality Counts
- HHS-Health and Human Services
Objectives

• Introduce ARRA/CMS incentives for EHR adoption
• Introduce Maine REC (MERECC) & role of Quality Counts
• Getting to “meaningful use” – what it means to Maine providers
• MERECC core & direct services
  • Services structure
  • Technical assistance & support
• Next steps – input on assistance needed
Federal Stimulus Funding & Health Care Reform: Why?

Currently US healthcare system is...

- Expensive: we spend more on healthcare than any other nation
- Ineffective: many low quality outcomes on standards comparable to other countries
- Fraught with high rates of medical errors
- Not universally available
- Structured in manner unsupportable with impending workforce shortages

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Why Emphasis on HIT?

HIT and EHRs have potential to:

• Improve access
• Redesign work of providers to focus on critical activities
• Reduce costs
• Improve quality of care by identifying areas for improvement
• Save lives
Known Barriers to EHR Adoption

• Cost
• Lack of standards (interoperability)
• Privacy and confidentiality concerns
• Resistance to change
• Workforce issues
• Complexity of the change
ARRA & HITECH

- Feb 17, 2009 – a day that changed everything!
- ARRA - $19B for adoption of health IT
  - $17B in incentives for EMR adoption - starting 2011
  - Penalties for non-EMR use by 2015
- Supported by subsequent federal healthcare reform (PPACA) with increased focus on transparency, payment reform, accountability for outcomes
- (For light-hearted look, see “HITECH: An Interoperetta in Three Acts”: http://www.youtube.com/watch?v=Gv1s8fM3mMk)

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A Busy Year…

ARRA HITECH Act

David Blumenthal Named National Coordinator

ONC Reorganized; Interim Meaningful Use Rule

Healthcare Reform

EHR Certification Rule

Meaningful Use Final Rule


FOA Release for RECs Cycle 1 RECs Awarded Cycle 2: MERECC Awarded

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National Priorities for HIT Use

1. Improve quality, safety, efficiency & reduce health disparities
2. Engage patients and families
3. Improve population and public health
4. Improve care coordination
5. Ensure adequate privacy & security protections for personal health information
Bending the Curve Towards Transformed Health

Achieving Meaningful Use of Health Data

- Data capture and sharing
- Advanced clinical processes
- Improved outcomes

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2009 2011 2013 2015

HealthInfoNet
Incentives for Meaningful Use

Medicare

- $44,000, over 5 years
- Must be a participating Medicare physician
- Tied to 75% of total Medicare allowed charges
- Year 1 incentive payment: $18,000 ($24,000 in allowed charges)
- 2015: penalties for non-EHR use
### ARRA Bonus Payments to Medicare Physicians - EHR Use

<table>
<thead>
<tr>
<th>Year they first file</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>$0</td>
<td>$44,000</td>
</tr>
<tr>
<td>2012</td>
<td>$0</td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>$44,000</td>
</tr>
<tr>
<td>2013</td>
<td>$0</td>
<td>$0</td>
<td>$15,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$39,000</td>
</tr>
<tr>
<td>2014</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$24,000</td>
</tr>
<tr>
<td>2015 or Later</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

**AND,** beginning in 2015, physicians not demonstrating “meaningful use” of EHRs see annual reduction in Medicare fee schedule.

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Incentives for Meaningful Use

**Medicaid**

- $63,750, over 6 years, “85% of net average allowable cost” ($54K for purchase and $20K for maintenance)
- Need 30% (20% for pediatricians) or more Medicaid patient volume, measured over any representative 90-day period in previous year
- Can skip a year, and return (but not for Medicare)
What is “Meaningful Use” of EHR?

- Use of **certified EHR** technology in a “meaningful manner,” (e.g. electronic prescribing) that...
  
  - Demonstrates “**electronic exchange** of health information” to improve the quality of health care, such as promoting care coordination, and can …

- **Report** on clinical quality of care delivered
Meaningful Use: Basic Overview

Stage 1 (2011 and 2012)
- To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
- Eligible Providers have to report on 20 of 25 MU objectives
- Eligible hospitals have to report on 19 of 24 MU objectives
- Reporting Period – 90 days for first year; one year subsequently
Who is a **Medicare Eligible Provider**?

<table>
<thead>
<tr>
<th>Eligible Providers in Medicare FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Professionals (EPs)</td>
</tr>
<tr>
<td>Doctor of Medicine or Osteopathy</td>
</tr>
<tr>
<td>Doctor of Dental Surgery or Dental Medicine</td>
</tr>
<tr>
<td>Doctor of Podiatric Medicine</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
</tr>
<tr>
<td>Chiropractor</td>
</tr>
<tr>
<td>Eligible Hospitals</td>
</tr>
<tr>
<td>Acute Care Hospitals*</td>
</tr>
<tr>
<td>Critical Access Hospitals (CAHs)</td>
</tr>
</tbody>
</table>

*Subsection (d) hospitals that are paid under the PPS and are located in the 50 States or Washington, DC (including Maryland)
Who is a Medicaid Eligible Provider?

<table>
<thead>
<tr>
<th>Eligible Providers in Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Professionals (EPs)</strong></td>
</tr>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>Nurse Practitioners (NPs)</td>
</tr>
<tr>
<td>Certified Nurse Midwives (CNMs)</td>
</tr>
<tr>
<td>Dentists</td>
</tr>
<tr>
<td>Physician Assistants (PAs) working in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is so led by a PA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospitals (now including CAHs)</td>
</tr>
<tr>
<td>Children’s Hospitals</td>
</tr>
</tbody>
</table>
## Stage 1 Meaningful Use Criteria

### Core (all 15)

1. Patient demographics
2. Vital signs
3. Problem list
4. Medication list
5. Allergy list
6. Smoking status
7. Clinical summaries
8. E-copy of health information
9. E-RX
10. CPOE
11. Drug-drug-allergy check
12. E-information exchange
13. Clinical decision support rule
14. Protection of Privacy
15. Clinical Quality Measures

### Menu (select any 5)

1. Drug formulary checks
2. Incorporate structured lab data
3. Generate patient lists for QI etc.
4. Identify pt specific education material
5. Medication reconciliation
6. Summary of care in transitions
7. E-submission of immunizations
8. E-submission of surveillance data
9. Patient reminders
10. Electronic patient portal

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Stage 1 Meaningful Use: Reporting Clinical Quality Measures

- **Required “Core” clinical quality criteria:**
  1. Hypertension: Blood Pressure Management
  2. Tobacco Use Assessment and Cessation Intervention
  3. Adult Weight Screening and Follow-up

- **Alternate “Core” criteria:**
  1. Influenza Immunization for Patients ≥50 y/o
  2. Weight Assessment and Counseling for Children and Adolescents
  3. Childhood Immunization Status

- **PLUS: 3 additional measures from list of 38**

*Quality Counts!*
RECs: National Strategy for Promoting EHR Adoption

*Note: applicable regions across the nation may also be supported by the Indian Health Board Regional Extension Center, headquartered in Washington DC.
Framework for The Regional Extension Center (REC)

- Based on Agricultural Extension Service Model
- Organized out of the Office of National Coordinator (ONC) - HIN was awarded to service the State of Maine
  - Total grant award = $4.7 Million over 2010-2011
  - $1 Million committed to “core service” requirements
  - $3.7 Million paid to EHR vendors/suppliers for “direct services” for 1002 “Priority Primary Care Providers”
- Focused on optimizing EHR adoption and utilization by PCPs
- REC gets 90/10 federal match Yrs 1 & 2; 10/90 federal match in Yrs 3 & 4
Framework for The Regional Extension Center (REC) Cont.

• REC supports to be delivered to “Priority Primary Care Providers” that include:
  • Licensed doctors of medicine or osteopathy in:
    • Family practice,
    • Obstetrics and gynecology,
    • General internal or pediatric medicine,
  • PAs, NPs in these specialties.

• To qualify, practitioners must also treat patients in:
  • Individual and small group practices that are predominantly focused on primary care
  • Outpatient clinics associated with public and non-profit CAHs
  • Community Health Centers and Rural Health Clinics
  • Other settings that primarily serve uninsured, underinsured, and medically underserved populations
The Maine Regional Extension Center

**Mission:** Over the next 2 years HealthInfoNet, the Maine REC will manage a process of group purchasing, service contracting and support services targeted at implementing and optimizing the use of EMRs in Maine. The objectives are to:

- Drive down the cost of investment in interoperable EMR
- Help providers successfully implement and optimize the use of EMRs in conjunction with “meaningful use” criteria
- Deliver interoperability between individual EMR implementations and the Health Information Exchange to
  - Better coordinate care,
  - Improve patient safety,
  - Improve quality outcomes, and
  - Manage reductions in duplicate testing and other areas of cost.
Maine Regional Extension Center (MERECC) Service Area

Service Area Statistics

- All Counties within Maine
- ME Congressional Districts 1 & 2
- Total Population: 1.3 M
- 3,500 Providers
- 1,634 Primary Care Providers
- 1,002 Priority Primary Care Providers
- Total Patients Served by HIE: 724,813
How Does The Money Flow?

• Funds awarded to Maine REC - paid to suppliers/vendors delivering EHR installation, implementation and optimization services

• Payments spread over three milestones:
  – Contract executed between provider organization & REC
  – Provider organization achieves use of certified EMR including use of e-Prescribing & quality reporting
  – Provider achieves “Meaningful Use” criteria and is exchanging information with the statewide HIE

• REC reports achievement of milestones to ONC quarterly to release funds
Maine REC Services Structure

HealthInfoNet (Prime Contractor)

HealthInfoNet Contract Office (REC Direct Service Brokerage)

REC Contracts

Core Services (HIN and Partners)
- Vendor Selection and Group Purchase
- Education and Outreach
- National Learning Consortium
- Functional Interoperability HIE
- Privacy and Security Best Practices
- Quality & Reporting
- Local Workforce Development through Partnership with OSC

Brokerage for REC Direct Services
- Request for Proposal (RFP) Process for all Direct REC Services
- Vendor Neutral Contracting
- Implementation Optimization Organizations (IOOs)
- EMR
- Vendors
- Wholesale Providers

Direct Services
- Practice Workflow Redesign
- EMR Implementation Support
- Meaningful Use Compliance
- Quality Improvement Services

Wholesale (Affiliated Practices)
- Eastern Maine
- MaineGeneral
- Central Maine
- Maine Health
- Maine PCA
- Nova Health
- Franklin Memorial
- Maine Coast
- Martin’s Point
- Mercy
- St. Joseph’s
- Western ME PHO

Retail (Unaffiliated Practices)
- Private Practices
- Small-Med Groups
- Independent Clinics / Hospitals
Maine REC Technical Assistance Program

Wholesale Primary Care Marketplace

Core Services:
- Provider Education and Outreach
- Workforce Integration
- National Learning Consortium
- Functional Interoperability
- Privacy and Security
- Group purchasing

Procurement Contracting

Implementation Guidelines / Training

Meaningful Use Reporting

Core Services: Quality Improvement
- Data Use and Capture
- Quality Measurement and Benchmarking
- Chronic Disease Management
- Medical Home
- Practice Quality Optimization

Meaningful Quality Improvement

Procurement Support
- Readiness Assessment
- Workflow Redesign
- Selection Support
- Procurement Services
- Business/Financial Planning

Implementation Technical Assistance
- Deployment and Management Services
- Best Practices
- Workflow Redesign

Meaningful Use
- Data Collection and Reporting
- EHR Optimization
- Bi-directional interface and HIE supports
- Continuous Improvement

Retail Primary Care Marketplace
Role of REC “Wholesale” Partners

• Support owned/affiliated practices
  • EMR implementation and optimization
  • Meaningful use

• Drive meaningful quality improvement across organizations through the use of HIT
  • Optimize practice workflow and evidenced based practice
  • Drive quality by having the “right” information at the “right” time leveraging HIE

• Meet meaningful use criteria to enable CMS incentives funding to flow
• Meet statewide quality improvement guidelines
Maine REC Support – “Retail” Market

- Support EMR implementation for unaffiliated practices:
- Provide access to supported, low-cost EMR product(s)
- Vendor support for practice workflow redesign
  - EMR vendors and Implementation Optimization Organization(s) (IOO)
- Direct assistance for EMR implementation
  - Vendor and IOO
- Quality reporting
- Education – through core supports
“Wholesale” + “Retail” practices - i.e. all REC Supported practices:

- Educational tools, resources, & information
- Educational sessions
- Collaborative learning opportunities for practice transformation & using data for improvement
  - Bi-annual “Learning Sessions” in 4 regions
- 1:1 Practice Quality Improvement Coaching
  - Encouraged for Wholesalers, provided to Retail practices
  - Build on existing provider/PHO QI staff
Patient Centered Medical Home (PCMH)

- PCMH – i.e. culture change!
- Ensure access and continuity
- Identify and manage patient populations
- Plan and manage care
- Support patient self-management
- Track and coordinate care
- Measure performance and use data to improve quality
HHS/ARRA Meaningful Use

• Data capture & sharing through EMR
• Advanced clinical processes
• Improved outcomes
Meaningful…

PCMH + HHS/ARRA Meaningful Use = Meaningful Improvement!

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THANK YOU! For More Information:

- **HealthInfoNet:**
  - Todd Rogow, REC Director ([trogow@hinfonet.org](mailto:trogow@hinfonet.org))
  - Shaun T. Alfreds, COO ([salfreds@hinfonet.org](mailto:salfreds@hinfonet.org))
  - Web resources:
    - [http://www.hinfonet.org](http://www.hinfonet.org)
    - [http://www.youtube.com/user/HealthInfoNet](http://www.youtube.com/user/HealthInfoNet)

- **Quality Counts:**
  - Lisa Letourneau MD, Exec Dir ([letourneau.lisa@gmail.com](mailto:letourneau.lisa@gmail.com))
  - Sue Butts-Dion ([sbutts@maine.rr.com](mailto:sbutts@maine.rr.com))
  - [www.mainequalitycounts.org](http://www.mainequalitycounts.org)

- **CMS:** [http://www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)