Financial Incentives for EHR Use and The Washington-Idaho Regional Extension Center Program: WIREC

Jeff Hummel, MD, MPH

UW Bio-Medical Informatics Dept.

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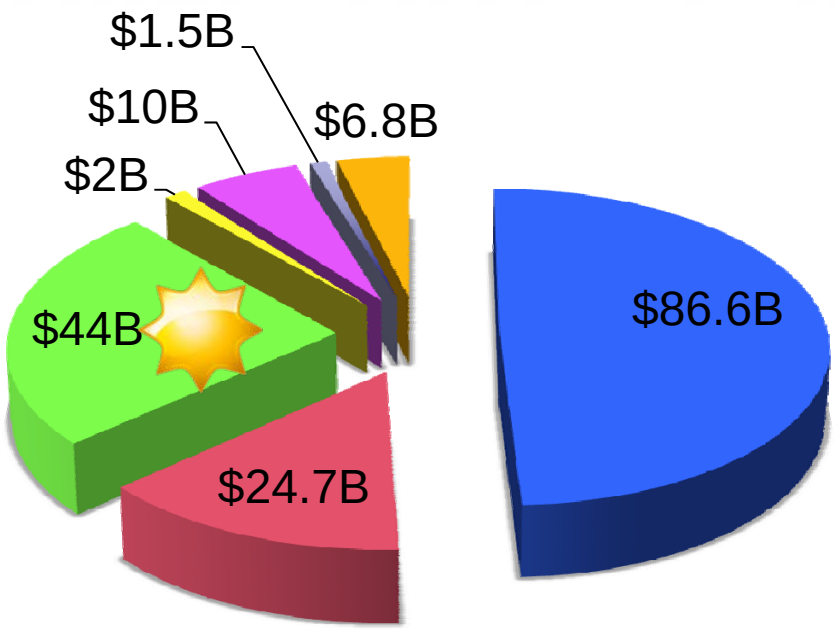
Disclosure: In the past 12 months Jeff Hummel has received compensation, or held equity in the following organizations

- Qualis Health: Medical Director, Washington-Idaho Regional Extension Center, and for Clinical Informatics
- UW Medicine: Clinical Associate Professor and Staff Physician, Belltown Clinic
- Deep Domain, Inc: Co-founder & Chief Medical Officer
- Preferred Professional Insurance Company: Consultant assessing quality of care issues for physicians accused of medical malpractice

Objectives

- High level overview of the HITECH Act Incentives for EHR adoption
- Introduction to the Washington Idaho Regional Extension Center at Qualis Health
  - Services offered: Roadmap and guide service to help providers achieve meaningful use
  - The challenge of integrating technology and clinical workflow

CMS Incentives for HIT Adoption



- Additional Support to States for Medicaid
- COBRA Extension
- CMS for HIT Incentives
- ONC for HITECH
- NIH for Challenge Grants
- HRSA for Community Health Centers
- Broadband & Telehealth

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Incentives for IT Adoption

- Medicare: $23B
  - Acute Care Hospitals
  - MD, DO, DDS, DPM, Optometrists & Chiropractors
- Medicaid: $21B
  - Acute Care Hospitals
  - MD, DO, DDS,
  - Nurse Practitioner and Midwives
  - PA-Cs working in Federally Qualified Health Centers or running Rural Health Centers

Medicare: Short Time-Line

	2011	2012	2013	2014	2015	2016	Total
2011	$18K	$12K	$8K	$4K	$2K		$44K
2012		$18K	$12K	$8K	$4K	$2K	$44K
2013			$15K	$12K	$8K	$4K	$39K
2014				$12K	$8K	$4K	$24K

- Timeline for pre-installation practices will be tight
- > 1 year to choose and install with proper preparation
- Without proper preparation the risk of failure is high
- The gap between implementation and meaningful use is huge

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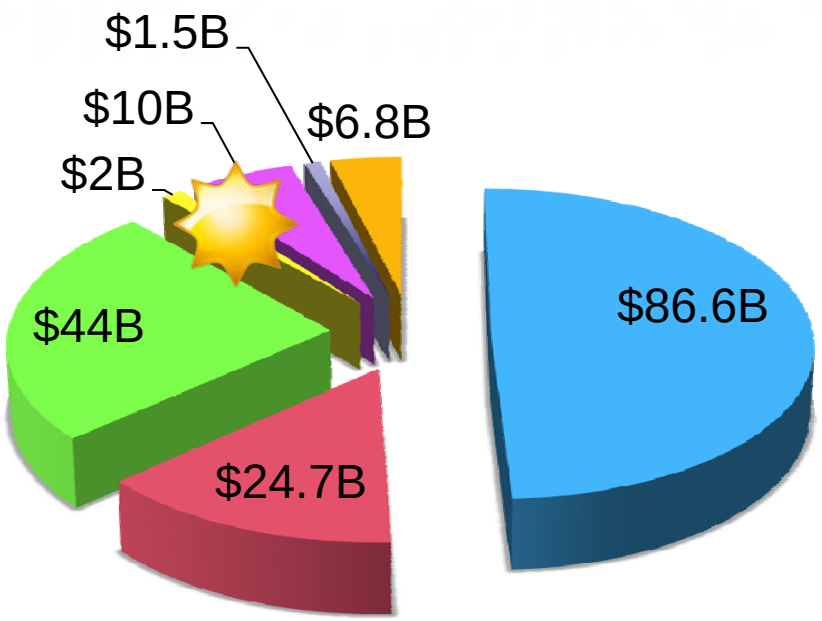
Medicare Penalties

		High Medicare		Low Medicare	
Year	Annual Penalty	Primary Care	Specialty	Primary Care	Specialty
2015	1%	$1,740	$3,000	$725	$1250
2016	2%	$3,480	$6,000	$1,450	$2,500
2017	3%	$5,220	$9,000	$2,175	$3,750
20??	5%	$8,700	$15,000	$3,625	$6,250

Medicaid Incentive

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
2011	21,250	8,500	8,500	8,500	8,500	8,500	0	0	0	0	0	63,750
2012		21,250	8,500	8,500	8,500	8,500	8,500	0	0	0	0	63,750
2013			21,250	8,500	8,500	8,500	8,500	8,500	0	0	0	63,750
2014				21,250	8,500	8,500	8,500	8,500	8,500	0	0	63,750
2015					21,250	8,500	8,500	8,500	8,500	8,500	0	63,750
2016						21,250	8,500	8,500	8,500	8,500	8,500	63,750

ONC National HIT Program



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Overview of ONC Money

- **Regional Extension Center (RECS)**
- State HIE Cooperative Agreement
- Workforce Development
- Strategic Health IT Advanced Research Projects
- Beacon Community Projects
- University Training

The Regional Extension Center Program (REC):

- $644 M distributed to 60 RECs to provide technical assistance
- Qualis Health awarded the Washington and Idaho REC
- Working with 5 Technical Assistance Partners, who will also be delivering WIREC services

Technical Assistance Partners:

- In Washington:
  - Community Choice
  - Inland Northwest Health Services (INHS)
  - PTSO of Washington
- In Idaho:
  - Idaho Health Data Exchange
  - North Idaho Health Network

REC Targeted Populations:

- Solo and small group primary care practices (≤ 10 providers)
- Public and Critical Access Hospitals to the extent that they have affiliated primary care physician practices
- Community Health Centers and Rural Health Clinics
- Other settings: uninsured, underinsured, medically underserved populations

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WIREC Program and Services:

- On-the-ground IT coaches providing direct technical assistance to project managers
- Establishing and maintaining networked IT communities to share learning, including:
  - EHR Group Purchasing
  - Communities of Practice
- Peer-to-Peer Networking

IT Coaches as Local Resources:

- Deployment of local experts to deliver one-on-one technical assistance to participating practices
- Focus depends on stage of HIT adoption
  - EHR selection for practices beginning the process
  - EHR implementation support for practices that have selected an EHR
  - Successful utilization of EHR and achieving “meaningful use” for practices already live

Types of Direct Technical Assistance:

- Vendor-neutral EHR selection and project planning
- Assistance with upgrades and new features
- Workflow redesign consulting
- Project management assistance
- Privacy and Security guidance
- Functional health information exchange
- Tracking of attaining meaningful use milestones

The Value Proposition

- If you think you can turn on your EHR and get to meaningful use without help, think again
- Guiding practices through selection and implementation saves money
  - Reduced revenue loss to provider community
  - Reduced resource expenditure for EHR vendors
- Guiding practices in integrating IT systems into workflow reduces waste
  - Waste of effort that provides no value
  - Waste of diminished information value

EHRs as basis for quality & cost control

- EHRs do not control costs or improve outcomes
- EHRs make lower costs and better quality possible
  - Medicine is an information-rich profession
  - Computers are tools for managing a lot of information
  - Goal: Integrate EHR into workflow
  - Strategy: get the right information to the right person at the right time to make the right clinical decision
  - Without careful planning computers result in:
    - Providers awash in a sea of poorly organized information
    - Spending much of their time on data entry

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Computers Work Differently Than Humans

- Technology is a great tool (when it works right)
- Technology is a terrible master, no matter how well it works
- Technology processes information completely differently than the human mind – when information is configured for one, it makes no sense to the other
- Let technology do what it does best
- Let people do what they do best

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What technology does best

- Keep track of large amounts of data
- Keep track of data over long periods of time
- Organize data so known patterns are visible
- Remember complex rules and protocols
- Maintain check-lists for completeness
- Prompt humans with decision support
- Function with constant reliable performance

What do people do best?

- Make decisions and be accountable for them
- Recognition of non-programmed patterns
- Judge the relative importance of information
- Put information into the context of the patient
- Use intuition and experience to give advice
- Assess emotional valence of information
- Assess the value of quality of life
- Establish and maintain relationships with patients

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Format the Information to Fit the User

- Make sure the data inputs are formatted properly for the EHRs to use in those tasks we rely on technology to do
- Make the EHR outputs easy for the the human brain to use for those tasks humans do best
- For information that is already processed by the mind far better than a machine could do, preserve the quality of that information

The Latest List for Meaningful Use

- Computerized Order Entry
- Drug-Drug; Drug-Allergy; Drug-Formulary checks
- ePrescribing
- Active Medication List
- Med reconciliation
- Active Med Allergy List
- Problem List: ICD-9 or SNOMED
- Record Demographics
- Record Vital Signs
- Record Smoking Status
- Clinical Laboratory Results
- Lists of Pts by condition
- Check insurance eligibility
- Submit data to immunization registry
- Protect Health Information Privacy
- Clinical decision support tools
- Submit claims electronically
- Pt copy of health info
- Pt access to health info
- Pt clinical visit summaries
- **Transition of care summary**
- **Report quality to CMS**
- **Send reminders to Pts**
- **Submit data for syndromic surveillance**
- **Exchange key data set**

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This Won't be Easy for Anyone

- EHR Features in Development
  - Some proposed MU features aren't available
  - IT pipeline is measured in years
  - Penalty for early adopters applies to upgrades
- Big systems using EHRs "pretty competently" have had big IT shops and years to get there
- Small practices without resources must repeat that feat in 2 years
- The biggest challenge is tolerance for change

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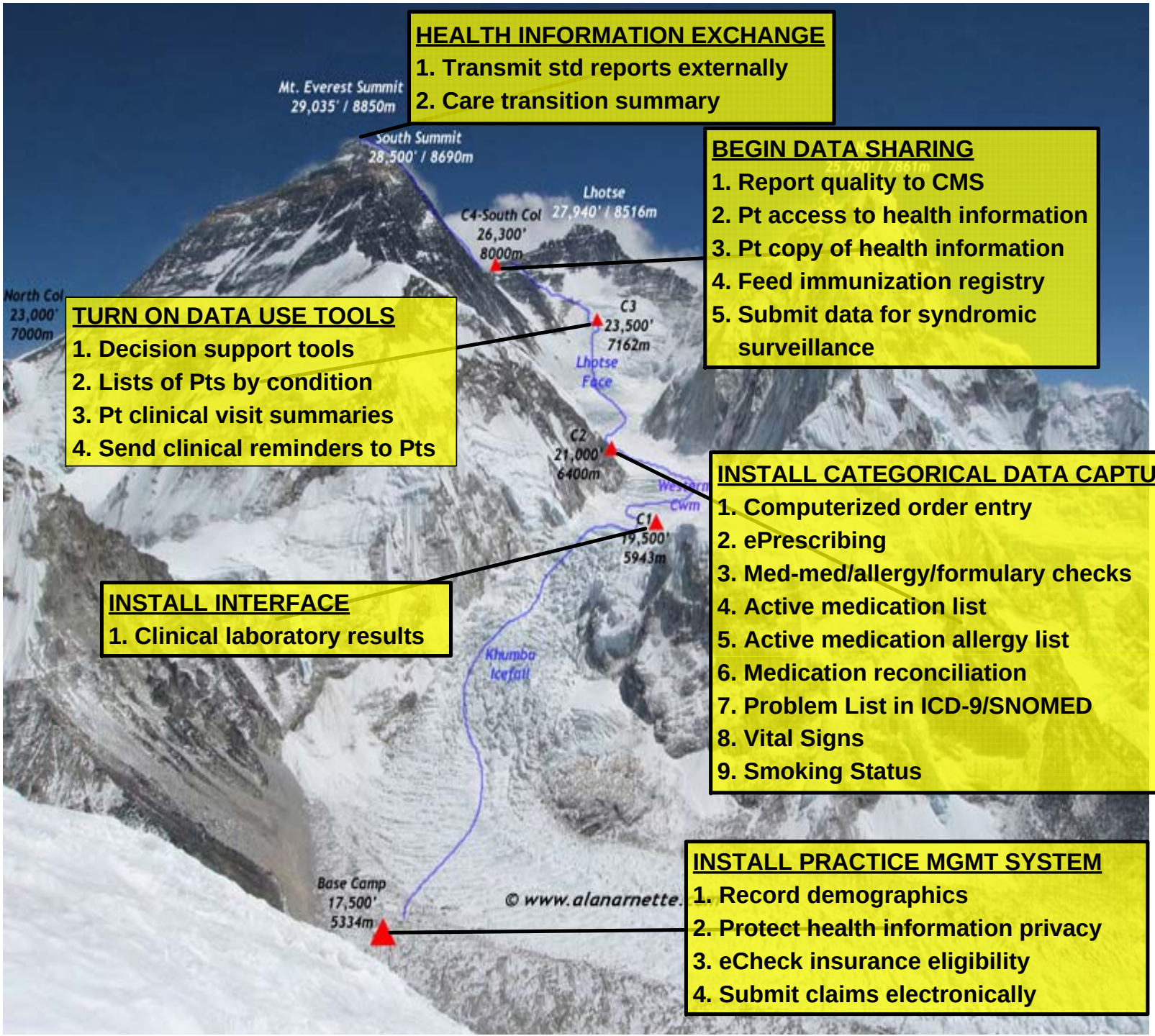
Meaningful EHR Use is a Huge Step

- Actually it is a bunch of smaller steps
- Each step involves multiple elements of “meaningful use” grouped by common characteristic
- Climbs involving stairs, ladders and mountains work best when the steps are taken in logical sequence



HEALTH INFORMATION EXCHANGE

1. Transmit std reports externally
2. Care transition summary

BEGIN DATA SHARING

1. Report quality to CMS
2. Pt access to health information
3. Pt copy of health information
4. Feed immunization registry
5. Submit data for syndromic surveillance

TURN ON DATA USE TOOLS

1. Decision support tools
2. Lists of Pts by condition
3. Pt clinical visit summaries
4. Send clinical reminders to Pts

INSTALL CATEGORICAL DATA CAPTURE

1. Computerized order entry
2. ePrescribing
3. Med-med/allergy/formulary checks
4. Active medication list
5. Active medication allergy list
6. Medication reconciliation
7. Problem List in ICD-9/SNOMED
8. Vital Signs
9. Smoking Status

INSTALL INTERFACE

1. Clinical laboratory results

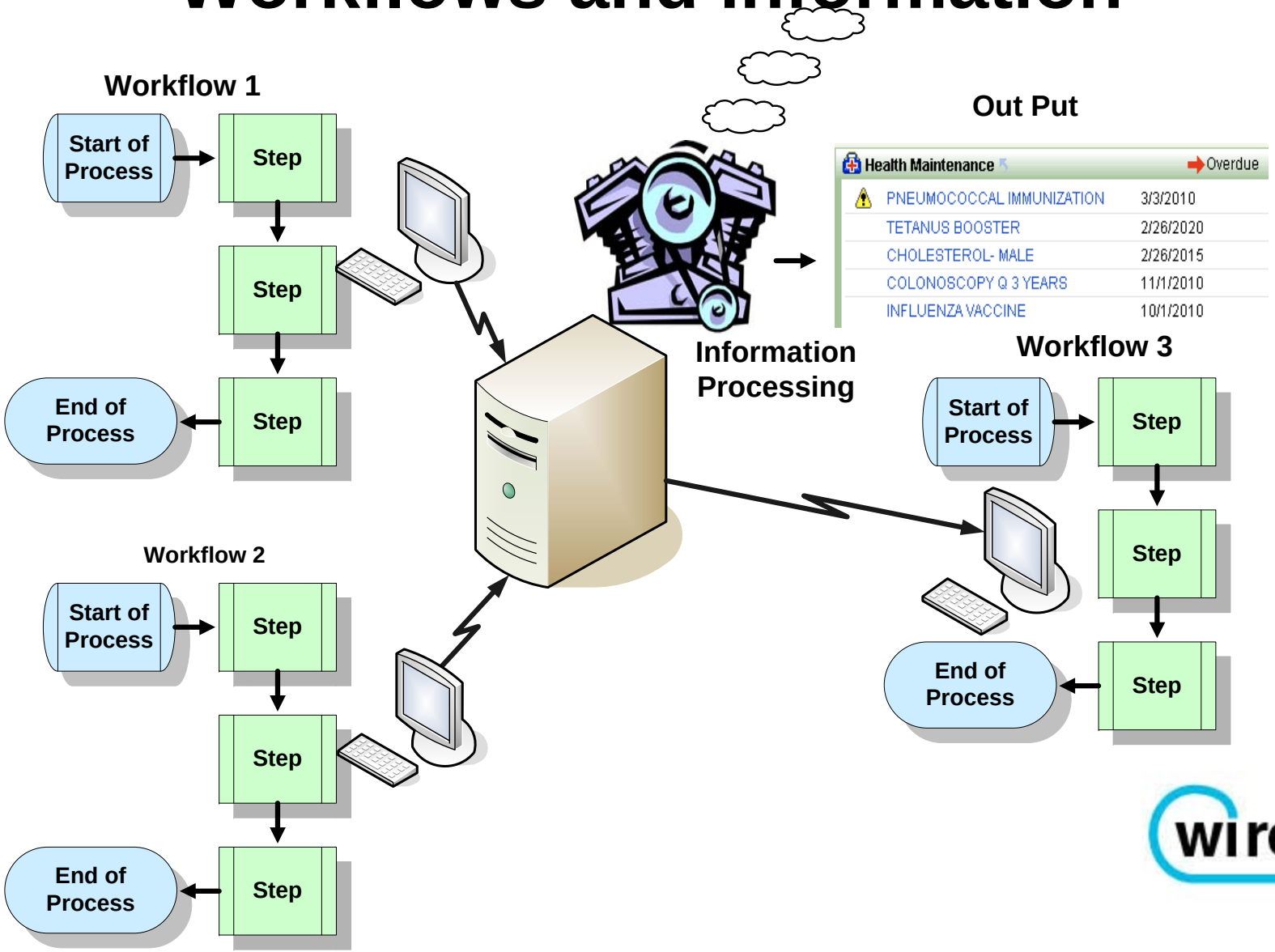
INSTALL PRACTICE MGMT SYSTEM

1. Record demographics
2. Protect health information privacy
3. eCheck insurance eligibility
4. Submit claims electronically

Use CPOE. Measure: CPOE is used for at least 80 percent of all orders

- Train providers to place orders in the exam room and associate all orders with an encounter diagnosis
- Set up order preference lists & panels for common orders
- Set up process for responding to provider requests for preference lists and panels for orders
- Set up CPOE outputs for each order type so every order goes directly to the person responsible for carrying out subsequent steps in the order processing workflow
- Set up workflows for each order carried out internally: meds & immunizations given on site, EKGs, nebulizer Tx, etc
- Set up workflow for MAs to order & pend orders based on clinical decisions made in daily huddle

Workflows and information



Provide clinical summaries to patients for each office visit. 80 Percent of Pts leave with After-visit Summary

- Determine print-groups to be included in the after-visit summary (AVS), and layout, e.g. current medication list, tests and treatments ordered and associated diagnoses, preventive care status, current printed instructions for consults or imaging and follow-up
- Test the AVS with patients and modify where possible to improve value to patients
- Develop, pilot and spread a workflow to assure the AVS is given to each patient before leaving the clinic

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Questions?

jeffh@qualishealth.org