ACO Accelerated Development Learning Session

Baltimore, MD
November 17–18, 2011

Module 3A: Connecting Providers and Health Information Technology

November 18, 2011
10:00 a.m.–12:00 p.m.

A. John Blair, III, MD, CEO
MedAllies

Susan Stuard, MBA, Executive Director
THINC, Inc.

DISCLAIMER. The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
Goals

• Learn about our experience connecting providers using health information technology (HIT)
• Understand foundational competencies of an ACO related to using HIT
• Provide suggested action steps and timelines
• Share with each other current capabilities, key considerations, and future decision points for your organization
Key Questions

Seek to address two key questions:
• How do you effectively connect providers?
• What are key priorities for achieving connections between and among providers?
Module Agenda:
Address These Questions in Five Domain Areas

1. **Electronic Health Records**—optimizing usage, managing care transitions, basic EHR connectivity

2. **Connectivity**—primary models for connectivity; what data and source of data, sharing the care plan

3. **Transformation**—to support optimal deployment of EHR and connectivity. What needs to transform at the practice and at the community level?

4. **Measurement and Remediation**—what are you measuring to make sure transitions are happening?

5. **Appropriate Use of Claims Data**—interacting with commercial payers and securing claims-based information
Guiding Principles

• **HIT is a tool.** EHRs and health information exchange must be in service of a larger set of goals (i.e., care transitions and care management). Workflow eats HIT for lunch.

• **Connectivity to EHR is critical.** Many methods to achieve connectivity between EHRs. Leverage what is available to support care transitions. Keep providers in their EHR workflow.

• **Avoid information overload.** More can definitely be worse than some or no information. Focus on providing only the key clinical data.

• **Remediate with current users.** Much of what is currently available via connectivity/HIE is inadequate. Work with the “converted” users (aka your current users) to improve system for them.

• **Then turn to the non-users.** Once system is working better do the hard work to get non-users to share the appropriate data.
Group Discussion

• Discuss within your team where you stand with respect to:
  – Electronic health records
  – Connectivity
  – Transformation
  – Measurement and remediation
  – Appropriate use of claims data

• Think about baseline status, additional interventions needed, and key issues/decision points to achieve strong functioning in the five areas

• Will then discuss baseline status and next steps/key priorities across all session participants
## Sample Grid for Notes

<table>
<thead>
<tr>
<th>Domain</th>
<th>Baseline status</th>
<th>Additional interventions</th>
<th>Key issues for strong functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Health Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connectivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transformation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement and Remediation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Use of Claims Data</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hudson Valley Experience With EHRs
THINC’s MISSION

To advance health care quality and coordination of care among health care organizations in the Hudson Valley

THINC ACTIVELY

• Sponsors health care transformation initiatives
• Promotes health information technology adoption and secure health information exchange (HIE)
• Sponsors activities that enable population health and quality improvement
• Supports and sponsors rigorous independent evaluation
Hudson Valley of New York State

- THINC covers a discrete geographic area
- Westchester, Putnam, Dutchess, Rockland, Orange, Ulster, and Sullivan Counties
- Have seen strong collaboration in this community—particularly the Hudson Valley Initiative
Hudson Valley Building Blocks

• THINC and its vendor, MedAllies, with a HEAL 1 grant from the New York State Department of Health, have supported the implementation of more than 800 EHRs in the last 3 years, a significant factor in the area’s high rate of EHR adoption.
Hudson Valley Building Blocks

- The Hudson Valley’s first HIE has been operational since 2001 and has helped providers achieve demonstrable gains in quality of care.
- An enhanced HIE going live this winter to enable exchange of structured data between EHRs to support coordination of care and interoperability statewide.

Ten years’ experience with health information exchange (HIE)
Hudson Valley Building Blocks

• 305 primary care providers achieved NCQA Level 3 PCMH recognition in THINC’s pay-for-performance and medical home project, run in collaboration with Taconic IPA.
• This gives the Hudson Valley community an unusually high concentration of NCQA PCMH Level 3 providers.
Hudson Valley Building Blocks

• Six commercial health plans partnered with THINC in pay-for-performance/medical home project.
• Paid an estimated $1.5 million in incentives in 2010.
• Populating a multiyear claims data set to enable quality and cost outcome analysis.
• Working on embedded care manager pilot with Geisinger.
Current Participants (Across Projects)

- 90 physician practices
  (at ~190 sites representing 1,600+ MDs)
- 19 hospitals
- 3 community health centers
  (at 29 sites representing 200+ providers)
- 6 health plans
- 1 employer
- 7 local health departments
- 8 commercial labs
- 3 consumer reps on Board and Privacy Committee
EHR Survey

• Who did we contact?
  – Practice administrators at 1,300 practices
    • Westchester, Dutchess, Ulster, Sullivan, Greene, Orange, Rockland, Columbia, and Putnam Counties

• Survey response rate
  – Physician-level response rate
    • 64%
  – Practice-level response rate
    • 63%
EHR Survey: Response Rate Breakdown

Does your practice use an electronic health record (EHR), not including billing records or appointment scheduling?

- a: yes, we only use an EHR (67%)
- b: no, but we plan to adopt in the next 12 months (18%)
- c: no, we have no plans to adopt in the next 12 months (13%)
- no response (2%)
- other (0%)

N = 3138
EHR Survey: Results

<table>
<thead>
<tr>
<th>Category</th>
<th>Certified EHR</th>
<th>Imminent adopters</th>
</tr>
</thead>
<tbody>
<tr>
<td>solo (N=532)</td>
<td>25%</td>
<td>27%</td>
</tr>
<tr>
<td>2 (N=99)</td>
<td>27%</td>
<td>41%</td>
</tr>
<tr>
<td>3-5 (N=104)</td>
<td>42%</td>
<td>35%</td>
</tr>
<tr>
<td>6-10 (N=36)</td>
<td>61%</td>
<td>36%</td>
</tr>
<tr>
<td>11-25 (N=17)</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>26-100 (N=13)</td>
<td>92%</td>
<td>8%</td>
</tr>
<tr>
<td>&gt;100 (N=4)</td>
<td>100%</td>
<td>-</td>
</tr>
</tbody>
</table>

**DISCLAIMER.** The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
Health IT and the Medical Home

Access
- Expand hours, stratify patients, top of license

Team
- All contribute, physician-led

Physician/patient collaboration
- Communication, education, shared decisions

Care coordination
- PCP coordinates among settings (specialists, hospitals, SNF); information critical

Population health
- Choosing patient populations, understanding individual patient status

High-risk patients
- Expertise, tools

DISCLAIMER. The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
**Health IT and the Medical Home**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Software/Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand hours, stratify patients, top of license</td>
<td>Scheduling software</td>
</tr>
<tr>
<td>All contribute, physician-led</td>
<td>All have access to patient record always</td>
</tr>
<tr>
<td>Communication, education, shared decisions</td>
<td>Educational software, patient/provider connectivity</td>
</tr>
<tr>
<td>PCP coordinates among settings (specialists, hospitals, SNF); information critical</td>
<td>Interoperability, managing information</td>
</tr>
<tr>
<td>Choosing patient populations, understanding individual patient status</td>
<td>Registries</td>
</tr>
<tr>
<td>Expertise, tools</td>
<td>Templates, care management software, analytics</td>
</tr>
</tbody>
</table>

*DISCLAIMER.* The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
Health IT and the Medical Home

- Scheduling software: PMS, EHR
- All have access to patient record always: EHR
- Educational software, patient/provider connectivity: EHR, PHR
- Interoperability, managing information: EHR, HIE
- Registries: EHR
- Templates, care mgmt. software, analytics: EHR, third-party software

DISCLAIMER. The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
Health IT and the Medical Home

- **Access**: PMS, EHR
- **Team**: EHR
- **Physician/patient collaboration**: EHR, PHR
- **Care coordination**: EHR, HIE
- **Population health**: EHR
- **High-risk patients**: EHR, third-party software

**DISCLAIMER.** The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
DISCLAIMER. The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
EHR

- Configuration
- Workflow
- Monitoring
Configuration

• Meaningful use
• Transitions of care (ToC)
Workflow

• Actors
• Roles and responsibilities
• Training
• Tracking
• Compliance
Monitoring

• Meaningful use
• Additional measures
  – NCQA
  – NQF
  – Proprietary
HIE

- Basic connectivity
  - Bidirectional labs
- Community record (traditional)
- Direct (point to point)
  - Care transitions
    - Ambulatory
    - Inpatient to ambulatory
  - Care plan
Connecting Providers/Data

- Data volume
- Data content
- Data origin
- Data consumption
DISCLAIMER. The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
Commercial Payers

• Commercial health plans are already busy evaluating provider ACO partners

• Among many hurdles, they are evaluating HIT:
  – Ability of ACO providers to use and deploy information at the point of care—more than just having an EHR
  – Do you give providers information about individual and group performance?
  – Can you sharing information electronically across settings?
  – Are you running registries?

• In short, do you have a data and feedback culture that will make health plan reports on quality and utilization worthwhile and actionable?
Commercial Payer Reports

- Within Hudson Valley, only a minority of the health plans are ready to offer a full suite of reports to share with providers.

- Key reports:
  - **Daily Census and Inpatient and Outpatient Authorizations.** Attributed patients in the hospital and approved authorizations for service.
  - **Predictive Modeling Reports.** Of the practices attributed patients, which trigger predictive models as high-cost patients ($5–10k minimum). Of use in targeting care manager resources.
  - **Cost and Utilization Reports.** Trend, year-to-year comparisons, or comparison to network average for total utilization, inpatient (by type of admission), outpatient surgery, lab and radiology, etc. Monthly or quarterly.
  - **Quarterly Expense vs. Benchmark.** Report summarizing costs attributed to group as compared to savings benchmark established for ACO.
More Key Commercial Payer Reports

• **Ambulatory and Inpatient Quality Measures.** Annual report covering any quality measures specified in the ACO contract and performance on quality “gates” or thresholds. Comparison to network average or other agreed-upon comparison group.

• **Registry report.** For targeted quality measures, a report noting members who according to claims data are overdue for a screening/test relevant to the quality measure.

• **Practice Pattern Variation Reports.**
  - Episode Treatment Groups (ETGs). Condition-specific reports to identify practice variation within like clinical episodes of illness. Individual provider data benchmarked against network.
  - Emergency Department Use. Variation in the use of ED for certain conditions. Individual provider data benchmarked against network.
Implementation Steps (Strategy)

1. EHR/ Meaningful Use
2. Connectivity/ Interoperability
3. Practice Transformation
4. Community Transformation
5. Monitoring and Compliance

DISCLAIMER: The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
## Sample One-Year Timeline

<table>
<thead>
<tr>
<th>Suggested Next Steps</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper-based practices—deploy certified EHR</td>
<td>12 months</td>
</tr>
<tr>
<td>EHR-based practices—NCQA Level 3 PCMH</td>
<td>12 months</td>
</tr>
<tr>
<td>Communities with HIE—Participating provider rollout</td>
<td>12 months</td>
</tr>
<tr>
<td>Communities without HIE—Connectivity using direct</td>
<td>12 months</td>
</tr>
</tbody>
</table>
## Initiative Tracking

<table>
<thead>
<tr>
<th>HIT/Connecting Providers</th>
<th>Impact</th>
<th>Resource Commitment</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical</td>
<td>Financial</td>
<td>FTEs</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DISCLAIMER.** The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.
Tools and Resources

• Dartmouth Institute for Health Policy and Clinical Practice: Better to Best: Value Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations

• Care Continuum Alliance: “Achieving Accountable Care: Essential Population Health Management Tools for ACOs”
  – Section IIC, Infrastructure and HIT:

• Profile of the Marshfield Clinic’s approach to HIT:
  – AHRQ Health Care Innovations Exchange: “Electronic Medical Record-Facilitated Care Process Redesign Enhances Access to Care, Reduces Hospitalizations and Costs for Patients with Chronic Illnesses”:
    http://www.innovations.ahrq.gov/content.aspx?id=1725

• One vendor analysis of HIT needs for ACOs:
Module 3A: Connecting Providers and Health Information Technology

A. John Blair, III, MD, CEO
MedAllies
jblair@medallies.com

Susan Stuard, MBA, Executive Director
THINC, Inc.
sstuard@thinc.org

DISCLAIMER. The views expressed in this presentation are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.