CHCANYS CLINICAL FORUM AND STATEWIDE CONFERENCE

October 4, 2010

A Practical Approach to Achieving Medical Home and Meaningful Use: The Process of Putting Principles into Practice

Presentation by:

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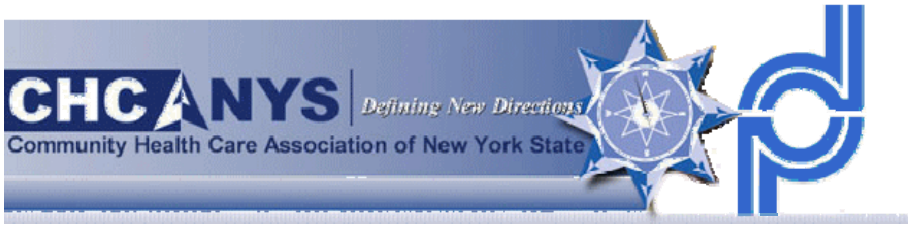
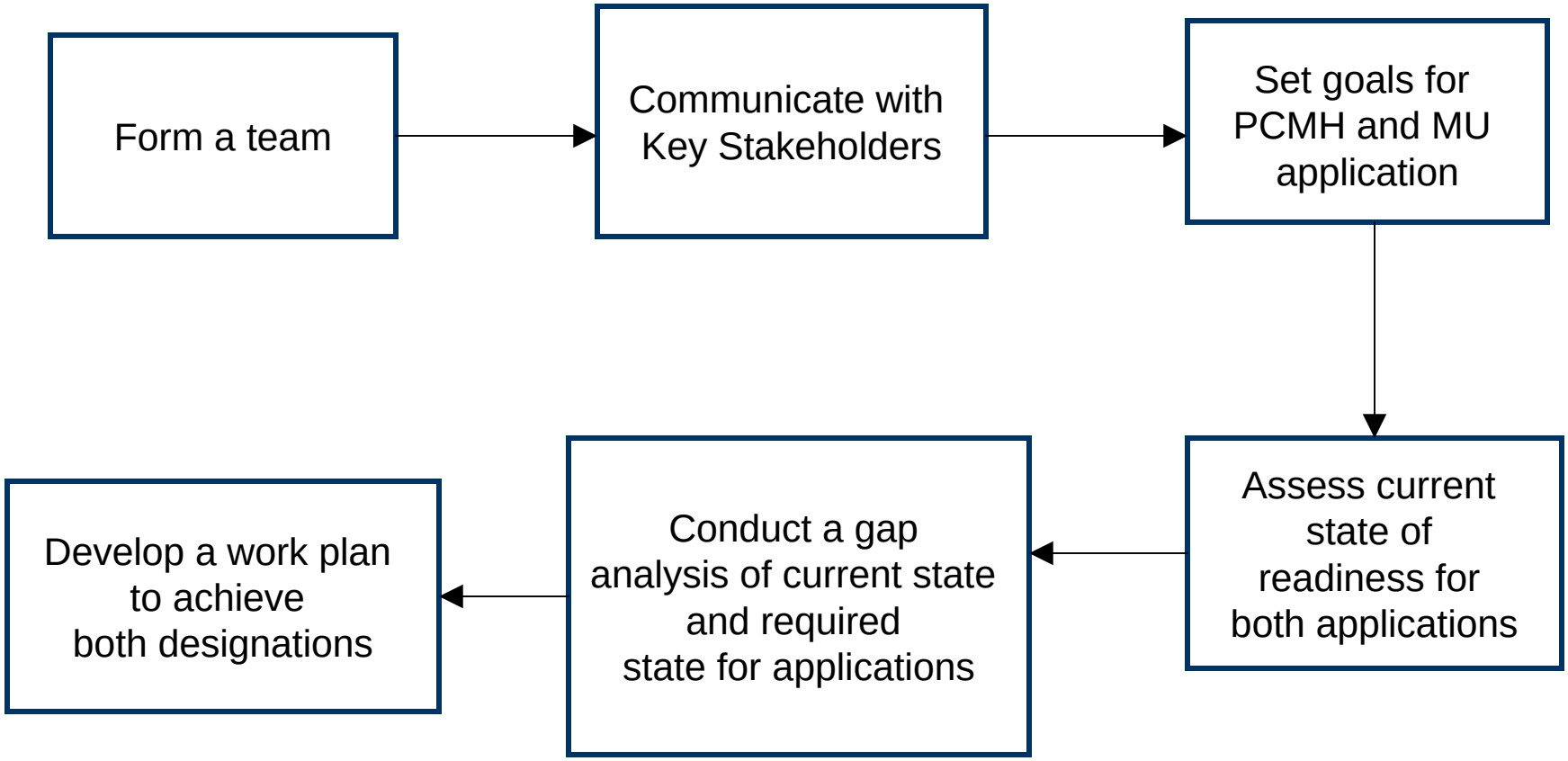


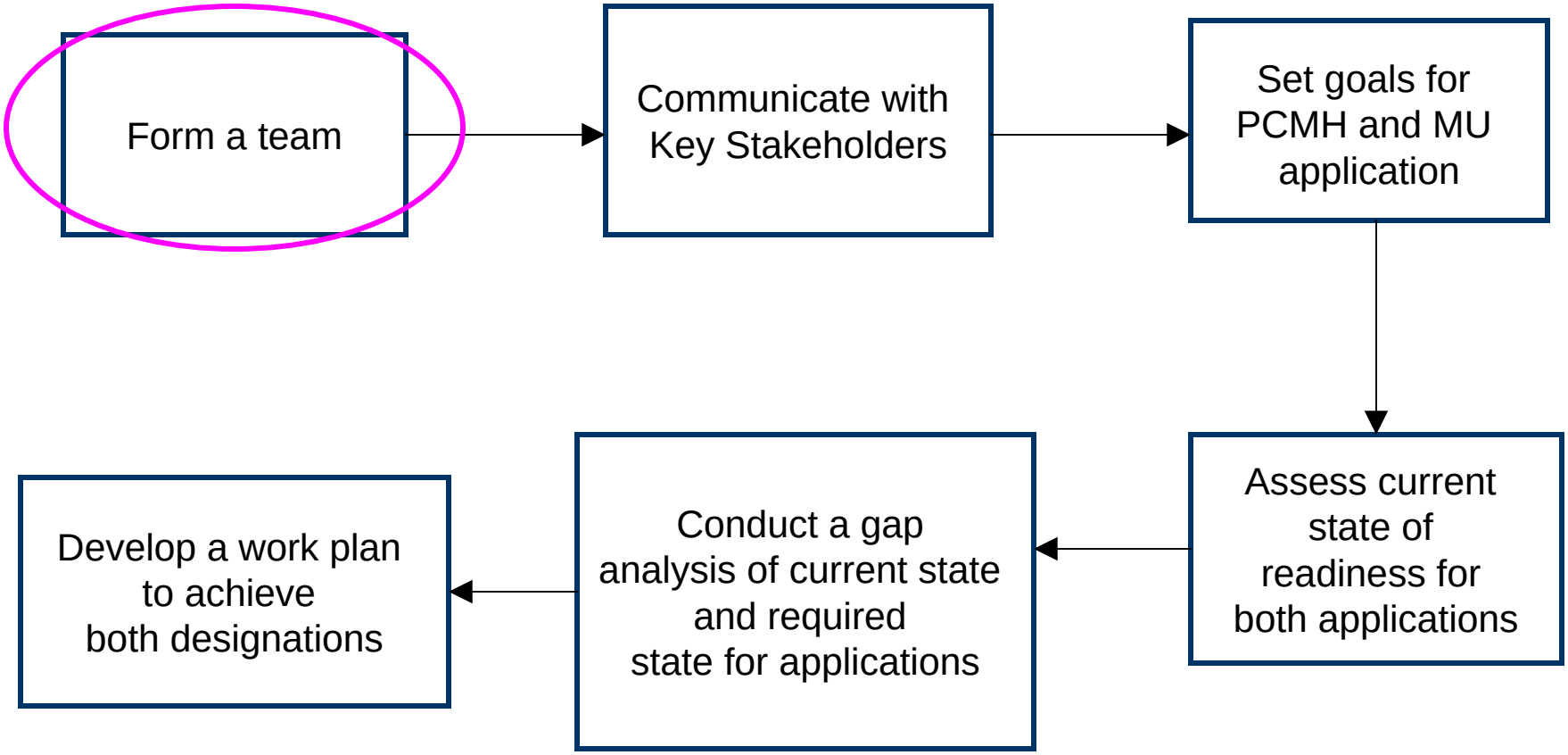
PRIMARY CARE DEVELOPMENT CORPORATION

Objectives of this session

- To provide a practical, achievable roadmap for the "how" and "when"
- To present helpful educational tools and methods for engaging your Board, staff and patients and to assess your center's needs and priorities
- To provide guidance on developing a customized work plan and to also begin the work
- To learn how to "Measure Twice, Cut Once" – to leverage efforts to achieve both designations

The Process:


Form a team
Communicate with Key Stakeholders
Set goals for PCMH and MU application
Assess current state of readiness for both applications
Conduct a gap analysis of current state and required state for applications
Develop a work plan to achieve both designations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Why do you need a team?

- Too much for one person – scope and skill range
- Time frame is long term – 3 stages/levels; 2-6 years
- Requires multiple perspectives - multidisciplinary
- Work requires massive coordination

Identifying a team

A team is a:

"small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable"

Katzenbach & Smith,
"The Wisdom of Teams"

Team Composition

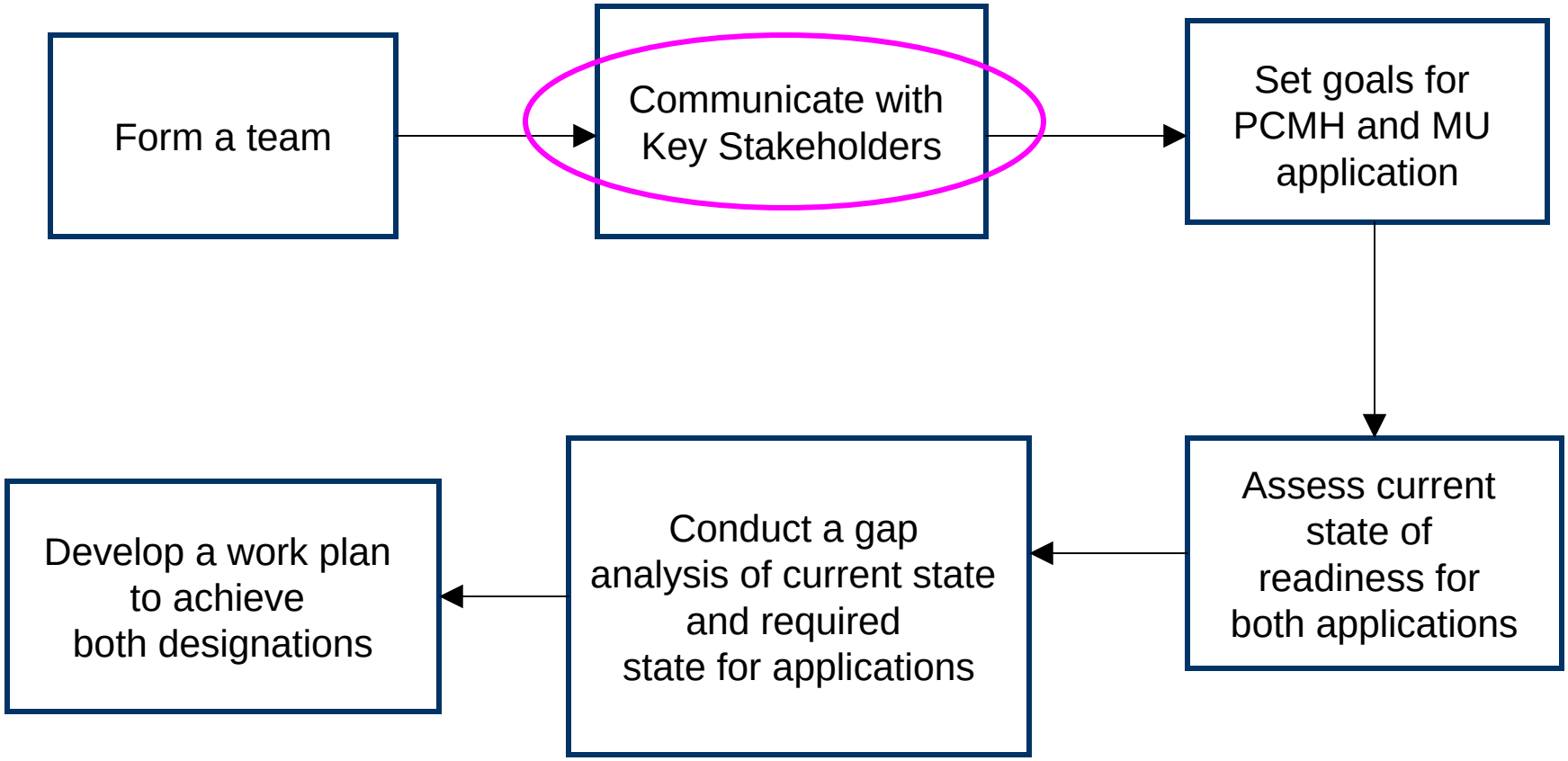
- Organizational factors to consider:
  - Size
  - Number of sites
  - Culture
  - Management style
  - Project goals

Categories of teams based on Content need

- **HIT-** Technologies (Network, HIE, etc.), Applications (EMR, PMS etc.), Data, Reporting, Meaningful use criteria, HIT standards, Security and Privacy
- **Clinical** – Care Management, Care Coordination, Clinical decision making, Patient experience, PCMH, Medication Management, Longitudinal Patient Information
- **Organizational/Administrative** – Workflow, Gap Analysis, Redesign, Senior Leadership and Support, Communications, Team charter, ROI vs. Cost effectiveness, Strategy
- **Project Management** – Change Management, Planning, Milestones, Tasks, Monitoring, Work Quality

Categories of teams based on Personnel Traits and Skills

- **HIT**- Analytical, Standards Translation, Systems troubleshooting, Technical Policy and Procedure, Technology Life Cycle (Readiness, Implementation, Effective Use etc.), Vendor Relations
- **Clinical** – Medical, Patient Interaction, Clinical documentation, Results Interpretation, Application Adoption
- **Organizational/Administrative** – Decision making, Enthusiastic, Communicative, Team Coordination, Goal Congruence, Resource Allocation, Policy and Procedure
- **Project Management** – Coordination, Driver, Monitor/Evaluator, Task Coordination, Resource Management, Vendor Relations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MESSAGE #1: What is Health IT? AND Why should we go to all this trouble?

Who is the audience?

- Patients
- Board of Directors
- Executive Leadership
- Clinicians
- Staff

MESSAGE #1: Educational Materials

- For Patients
  - Brochure in 14 languages
  - Video by Emmi Solutions to explain the PCMH concept for patients is available at: http://www.emmisolutions.com/medicalhome/transformed/

- For Providers
  - Educational brochure

Three part series of presentations on PCMH can be viewed and downloaded at: http://www.acponline.org/running_practice/pcmh/

See the right hand column: "What is the PCMH?" and "Common Questions About the PCMH."

  - Provider PowerPoint, above brochures and more available at: http://www.ehealth4ny.org/resources.html
  - FAQs on Meaningful Use available at http://www.nyecrec.org/index.php/education-a-resources

MESSAGE #1 : Educational Materials

- For Staff:
  - Free EHR 101 training by the Institute for Family Health, funded by a grant from New York State
  - Contact: Susan Weiman, SWeiman@institute2000.org
  - Additional resources at: http://www.nyecrec.org/index.php/education-a-resources

MESSAGE #2: Communicating the Benefits & Costs of PCMH & MU

- Who is your Audience?
  - Board of Directors
  - Executive Leadership
  - Clinicians
  - Staff

MESSAGE #2: Communicating the Non-Financial Benefits

- Greater efficiencies (Pre-visit planning; improved internal communications)
- Greater effectiveness = care quality (clinician alerts and decision support; tools to reduce medication & testing errors and improve care management & care coordination)
- Patient satisfaction (improved access to care and health information; patient engagement in care; patient education)
- Center reputation (Are you on the cutting edge of health technology, keeping up with your competitors)
- Clinician & staff recruitment & retention
- Other

Communicating the Financial Benefits: What is ROI?

- The calculation of Return on Investment (ROI), is a comparison of the benefit (return) of an investment to its cost; the result is expressed as a percentage or a ratio.

- A ratio > 1 indicates that the benefits of a project exceed its costs. If you are comparing 2 or more projects, the one with the highest ROI yields the greatest benefit per dollars spent.

$$ROI = \frac{(\text{Gain from Investment} - \text{Cost of Investment})}{\text{Cost of Investment}}$$

ROI – Tool: Calculating the Incentive Payments

I. Meaningful Use: Complete A OR B										
A. Eligible Professionals (EP's) - Medicaid Incentive	Number of EP's (1)	Year 1 $21,250	Year 2 $8,500	Year 3 $8,500	Year 4 $8,500	Year 5 $8,500	Year 6 $8,500	TOTAL
Physicians		$0	$0	$0	$0	$0	$0	$0
Dentists		$0	$0	$0	$0	$0	$0	$0
Nurse Practitioners		$0	$0	$0	$0	$0	$0	$0
Nurse Midwives		$0	$0	$0	$0	$0	$0	$0
Physicians' Assistants (2)		$0	$0	$0	$0	$0	$0	$0
TOTAL		$0	$0	$0	$0	$0	$0	$0

II. Medical Home: Complete A AND B									
A. Fee-For-Service		Number of Claims with E&M or Preventive Codes	2011	2012	2013	2014	2015	2016	TOTAL
Level 1	$5.50		$0	$0					$0
Level 2	$11.25		$0	$0	$0	$0	$0	$0	$0
Level 3	$16.75		$0	$0	$0	$0	$0	$0	$0
			$0	$0	$0	$0	$0	$0	$0

III. GRAND TOTAL MEANINGFUL USE & MEDICAL HOME INCENTIVE REVENUE [(I.A. or I.B.)+ II.C.]	
A. If Meaningful Use Incentive is Medicaid	$0
B. If Meaningful Use Incentive is Medicare, non HPSA	$0
C. If Meaningful Use Incentive is Medicare, HPSA	$0

ROI Tool: Calculating the Costs

Expense Category	Hours/week	$/Hour	# of Weeks	Year 1 @100%	Year 2 @ 50%	Year 3 @ 50%	Year 4 @ 50%	Year 5 @ 50%	Year 6 @ 50%	Total
PERSONNEL										
Team Member Time				$0	$0	$0	$0	$0	$0	$0
Replacement Staff Time				0	0	0	0	0	0	0
Executive Time				0	0	0	0	0	0	0
Training Time:										
Trainers				0	0	0	0	0	0	0
Trainees				0	0	0	0	0	0	0
Other Staff Time				0	0	0	0	0	0	0
ELECTRONIC SYSTEMS										
Hardware				0						0
Software										0
Maintenance										0
Support										0
CONSULTANTS				0						0
COLLABORATIVE FEE				0						0
NCQA PCMH SURVEY FEE										0
										0
	Visits/week	$/Visit	# of weeks							
LOSS OF PATIENT CARE REVENUE				0	0	0	0	0	0	0
OTHER:										
Total				$0	$0	$0	$0	$0	$0	$0

MESSAGE #3: Communicating with your Providers re: Assigning the MU Payment

- Who is your audience?
- Providers, for the Medicaid Incentives:
  - Physicians
  - Dentists
  - Nurse Practitioners
  - Nurse Midwives
  - PAs

MESSAGE #3: Communicating with your Providers re: Assigning the MU Payment

What is the message?

- Checks will be made payable to the eligible provider
- There will be a process to allow assignment of the checks to the employer
- Clinicians will have to authorize assignment
- What are the discussion points?
- What options can you offer to incentivize your clinicians?

Discussion Points

- Incentives are to help the center cover its costs
- NACHC is lobbying to have the legislation changed so that incentives may be paid directly to the center
- Incentives are paid directly to hospitals
- The center will handle all necessary registration

MESSAGE #3: Communicating with your Providers re: Assigning the MU Payment

- Who is the team?
  - Clinician champion
  - HR/Personnel – re: policy & procedure
  - Legal Advisor – re: implications for employment contract
  - Tax Advisor – re: tax implications for providers
  - Credentialing Staff (or other) – re: provider registration

Creative Options

- Assignment as donation to health center, so tax-deductible
- Consider sharing some of the incentive funds with the clinicians via an internal P4P (pay for performance) program

  Examples: Addabbo, Urban Health Plan

MESSAGE #4: Engaging Your EHR Vendor

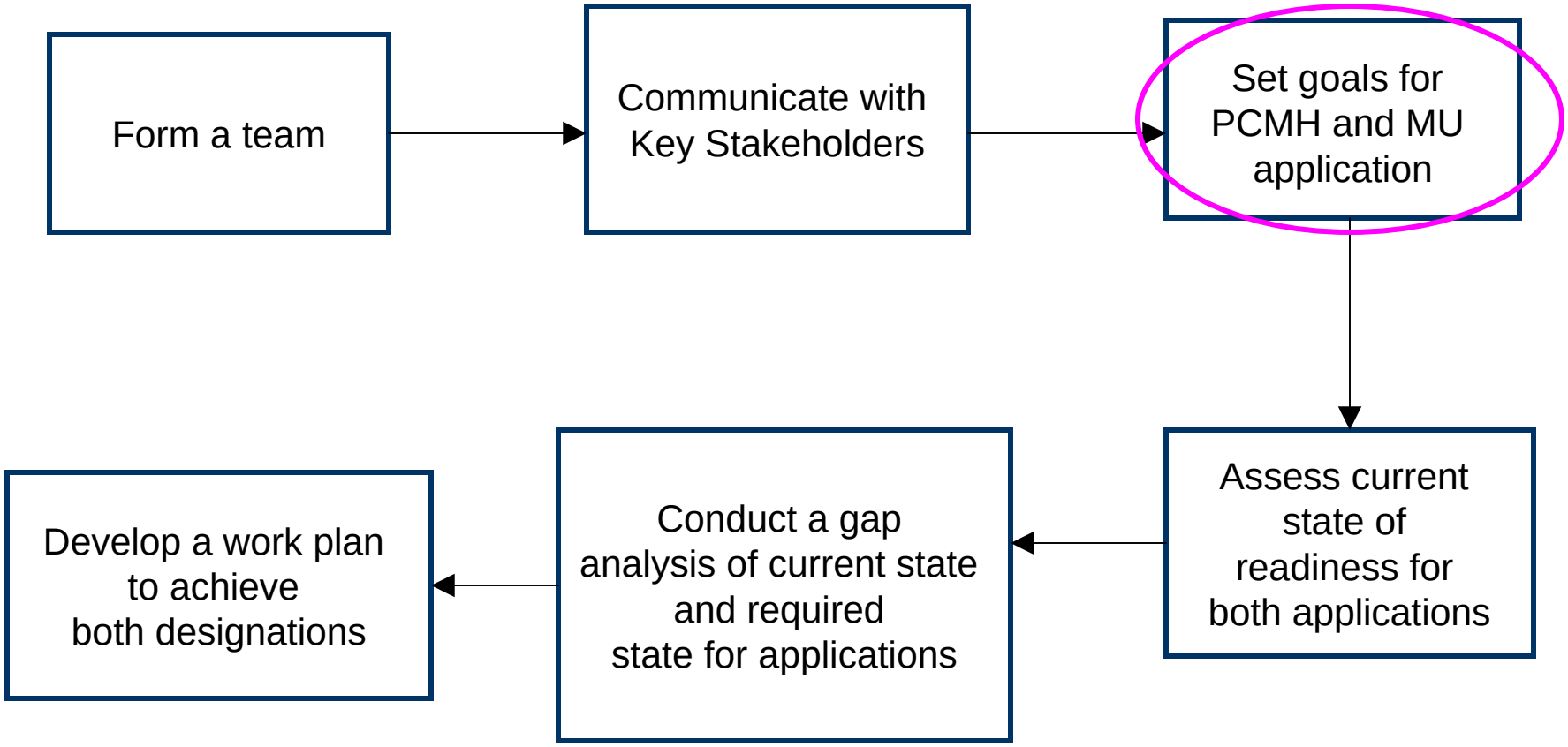
Questions to ask:

- Ask what training, materials, and technical assistance is available to achieve PCMH & MU
- Ask for a demo of the version to be certified for MU and when it is expected to be available in General Release
- Ask for contract provisions re: PCMH & MU
- Ask for a contact in Product Management who can answer more in-depth questions about functionality than Sales can

MESSAGE #4: Engaging Your EHR Vendor

Things to do:

- Attend all free educational sessions, webinars
- Make sure you are on the vendor's schedule for upgrade
- Establish a close relationship with the highest level person you can reach at the vendor
- Join a user group – local, statewide, regional, national: volunteer to work for the group; get your issues on the agenda
- See our Vendor Resources tool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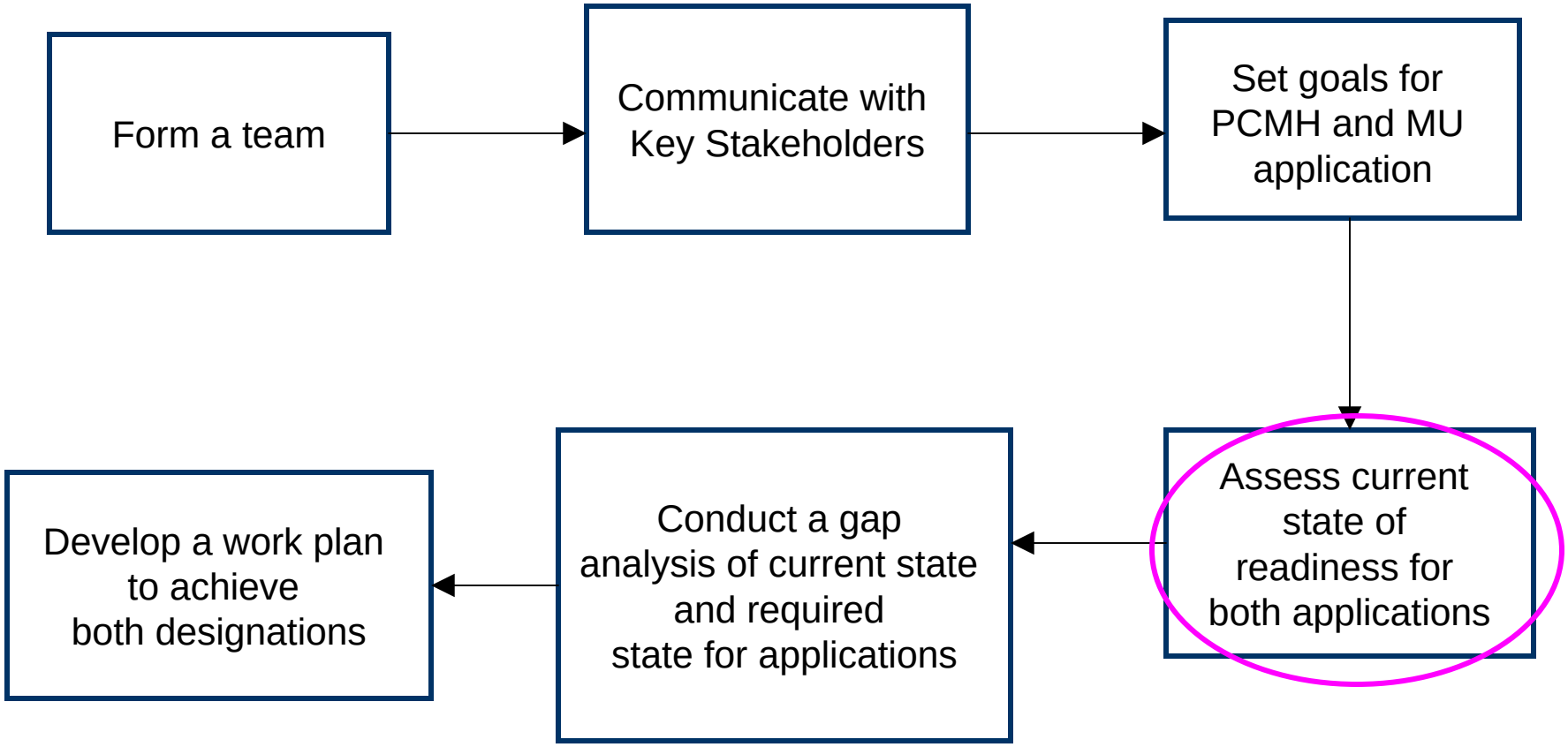
When setting goals:

Answer the following questions:

- Why is our organization seeking PCMH and MU recognition?
- What level of NCQA PPC-PCMH recognition do we want to obtain (and why)?
- When do we want to obtain recognition by (and why)?
- When do we want to attest that we have achieved "Adopt, Implement or Upgrade"? When do we want to attest that we have achieved Stage 1 Meaningful Use?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Objective of Conducting Assessments

- Opportunity to evaluate your current performance against PCMH & MU requirements

- First critical step in developing effective workplans for achieving overall goals around PCMH and MU

Detailed PCMH Assessment

Navigating the Detailed PCMH Assessment Tool

- Contains 12 tabs
  - One for instructions
  - Two for summary statistics (overall and must pass)
  - One for each of the 9 NCQA PPC-PCMH standards (color-coded)

- Summary statistics automatically calculated
  - Total points
  - # of “must-pass” elements pass at the 50% level
  - Level of recognition (1, 2 or 3)

Factor	Score Rating A	B	C	D	Existing Documentation	Documentation Next Steps *(completed for "A"/"B" rated items)*	Implementation/Improvement Steps *(completed for "C"/"D" rated items)*
ELEMENT A: ACCESS & COMMUNICATION PROCESSES (MUST PASS) *The practice establishes in writing standards for the following processes to support patient access:*							
1. Scheduling each patient with a personal clinician for continuity of care							
2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip							
7. Providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time							
8. Providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week							
9. Providing secure e-mail consultations with physician or other clinician on clinical issues, answering within a specified time							
10. Providing an interactive practice Web site							
11. Making language services available for patients with limited English proficiency							
12. Identifying health insurance resources for patients/families without insurance.							
Total Possible Points for PPC 1: Element A:	4	4	4	4	**Additional Notes for 1A:**		
Total # of Factors with "Yes" for PPC 1: Element A:	0	0	0	0			
% Points Received for PPC 1: Element A:	0%	0%	0%	0%			
Total # of Points Received for PPC 1: Element A:	0	0	0	0			
Must Pass Element - Passed at 50% Level?	NO	NO	NO	NO			

4-tiered rating system

(Columns C – F)

Existing Documentation

(Column G)

Documentation and Implementation Next Steps

(Columns H & I)

Using the PCMH Assessment Tool

Effort Level	Description
A: Minimal (Column C)	**Factor is present and practice is likely to receive points with documentation as-is** (e.g., policy already documented and implemented)
B: Low (Column D)	**Factor is present, but the practice must improve documentation to receive points** (e.g., process in place but needs to be documented, data currently captured but report needs to be generated)
C: Moderate (Column E)	**Factor and/or documentation requires moderate redesign to receive points** (e.g., have parts of process in place but not fully implemented across practice, report is more time-consuming to design and generate)
D: Significant (Column F)	**Factor not present and practice must conduct significant redesign to receive points** (e.g., requires new or substantial modification of existing electronic systems such as the EMR, requires new protocol, requires discussion and agreement with staff)

Using the PCMH Assessment Tool

Column	Description
Column G	• Indicate existing documentation available to show evidence that a given factor is in place at your organization
Column H	• Indicate next steps to compile/develop documentation (not currently available) to meet NCQA's requirements
Column I	• Indicate implementation next steps to meet NCQA's requirements; this column will typically be filled out for factors rated with an effort level of C or D

Example 1

- Factor 1A1: Practice establishes in writing standards for scheduling each patient with a personal clinician for continuity of care
  - Informally, patients are scheduled with their assigned PCP and all patients are assigned a PCP but this is not documented anywhere
    - Rating?
    - Next Steps?

Example 2

- Factor 3C1: Non-physician staff remind patients of appointments and collect information prior to appointments
  - Once in awhile, the MA will do reminder calls if s/he has time but it is not being done consistently across the practice
    - Rating?
    - Next Steps?

Example 3

- Element 5B6: Drug allergy alerts specific to the patients
  - This capability is built into your EMR and is currently being used
    - Rating?
    - Next Steps?

Example 4

- Factor 6A1: Tracks all laboratory tests ordered or done within the practice, until results are available to the clinician, flagging overdue results
  - While this capability is available in your EMR, it is not being used since you do not have a bi-directional lab interface with the top lab vendors
    - Rating?
    - Next Steps?

Detailed MU Assessment

Navigating the Detailed MU Self-Assessment Tool

- **Four columns that describe the MU Objectives**
  1. Is the measure Core or from the Discretionary Menu set (C or D/M)?
  2. The description of the measures, grouped by Policy Goals
  3. The measure or requirement associated with each objective
  4. The functionality your EHR must have to be certified
- **Two columns to score and explain your readiness**
  1. Your readiness score for each objective
  2. Your explanation for the readiness score you gave yourself on each objective

Obj	Core (C) Discretionary / Menu (D/M)	2011 Meaningful Use Objectives	Stage 1 2011 MU Measures	Required EHR Functionality	Readiness	Explanation of your Readiness Score
			§170.302(n) Automated measure calculation. For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.	Note: Includes CFR § references	0 = Not present or Ready 1 = Present and Ready 2 = In Use 3= In Use & Able to Measure Degree of Compliance with Threshhold 4 = In Use & In Compliance with Threshhold	As briefly as possible please explain why you selected this readiness score. In the case of readiness specify what condition, system feature, process, or other factor contributed to the logic in your scoring. For example, if you scored a "1" for CPOE you might say that physicians are resistant or untrained, or they order labs but do not order medications, or that the EMR cannot calculate number of unique patients, etc.
Obj. A		Improve quality, safety, efficiency, and reduce health disparities				
1	C	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state,local and professional guidelines Definition *Computerized Physician Order Entry (CPOE): Provider"s use of computer assistance to directly enter medical orders (for example, medications).*	More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE	§170.304(a) Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types: (1) Medications; (2) Laboratory; and (3) Radiology/imaging.		
2	C	Implement drug-drug and drug-allergy interaction checks	Functionality is enabled for these checks for the entire reporting period	§170.302(a) (1) Notifications. Automatically and electronically generate and indicate in real-time, **notifications at the point of care** for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE).		
				(2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.		

MU Readiness Scoring for each Objective

0 = Not present or ready

1 = Present and ready

2 = In use

3 = In use and able to measure degree of compliance with threshold

4 = In use and in compliance with threshold

Score automatically sums & calculates a Percentage MU Readiness

Example 1

Objective: Maintain up-to-date problem list of current and active diagnoses

Measure: More than 80% of patients have at least one entry or an indication that no problems are known for the patient recorded as structured data

Readiness Score: 2 = In use

Explanation of Readiness Score: You maintain the required problem list but your EHR does not currently give you the option to show "No Problems" & you do not know how to measure your percent compliance with the threshold

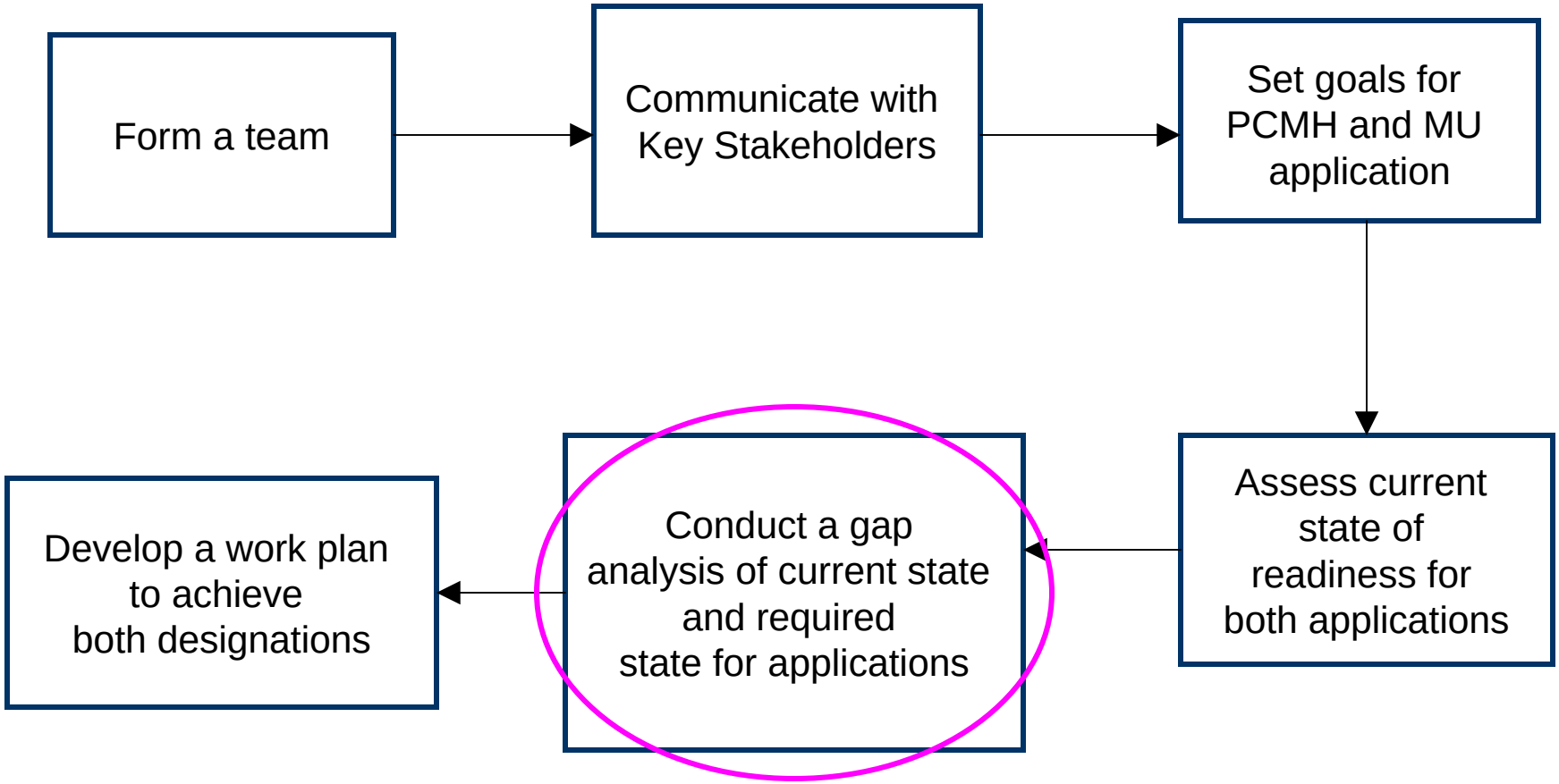
Example 2

Objective: Provide clinical summaries for patients for each encounter/office visit

Measure: Clinical summaries provided to patients for more than 50% of all office visits within 3 business days

Readiness Score: 1

Explanation of Readiness Score: Your EHR is capable of printing a patient summary, but you do not provide them regularly to patients and do not know how to measure compliance with the threshold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Conducting a Gap Analysis

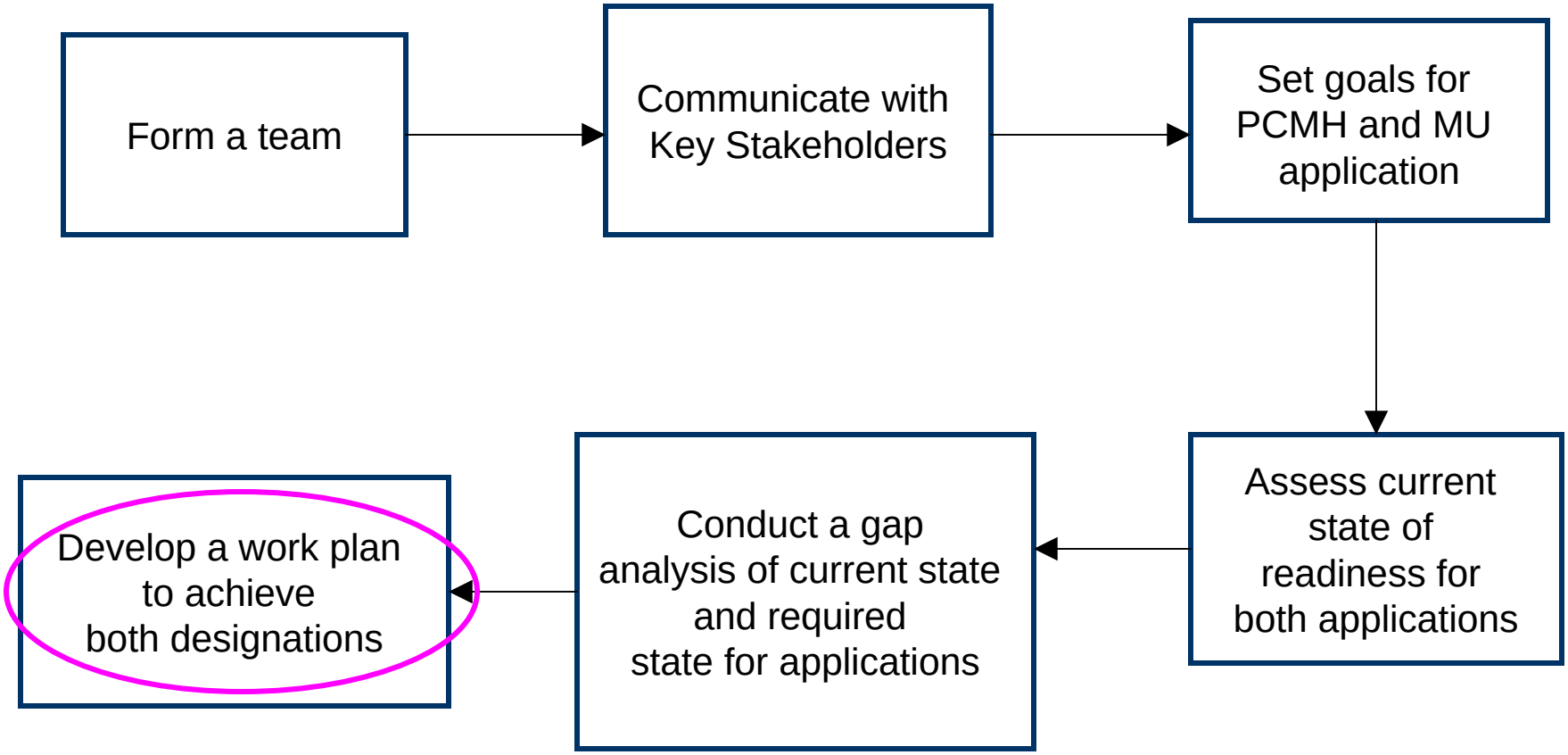
- Assess your internal resources
  - Entire project team reviews application and baseline assessment scores for both designations
  - Conduct technology gap analysis: compare what HIT you have in place against what is required to complete the elements
  - Based on your baseline and HIT capabilities, confirm or reconsider your organizational goals for seeking recognition and modify accordingly

PRIMARY CARE DEVELOPMENT CORPORATION

Patient Centered Medical Home (PCMH) & Meaningful Use (MU) COLLABORATIVE

PCMH & MU Gap Analysis Tool

A. MH Principle	B. MU Policy Priority	C. Content Area	D. Related PCMH elements / factors	E. Related MU Objectives	Identification of Gaps				
					F. HIT	H. Workflow / Procedure	I. Training & Use	J. Reporting	Other
Patient-centered, whole-person orientation	Engage patients and families	1. Patient Engagement							
		a. Patient Preferences	4A, 4B1	A13					
		b. Self Management / Educational Resources	3C3 4B2 - 6 9C2	B4					
		c Access to Personal Health Info	1A9, 10 9A	B1, B2, B3					
Coordinated care	Improve care coordination	2. Care Management - Provider-to-Patient	3C1 3D 3E4, 7, 10 4B7 6A4, 6	A13					
		3. Care Management / Coordination - Provider-to-Provider							
		a. HIE	3E2, 3	C1					
		b. Summaries of Health Information for Transitions	3E9	C3					
		c Medications Reconciliation		C2					
		d. Communication	3C4 3E1, 6, 8 9C1						
		e. Referral Tracking	7A						
		f. Test Tracking	6A1, 2, 5						
Continuous access to care	Not specified	4. Patient Experience Measures							
		a. Collection	1B 8B						
		b. Reporting	8C						
		c Corrective Action	8D						
		5. Access & Communication	1A1-8, 11, 12						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Objective of a Work Plan

- Roadmap to guide the team throughout the project and hold team members accountable
- Identify key deliverables and completion dates
- Identify resources and assign tasks/activities to specific individuals

Elements of the Workplan

- **Content area** – lists the general categories of topics to focus on
- **Activities/Tasks** – derived from Gap Analysis
- **Status/Notes** – keep track of progress of completion
- **Person Responsible-** person responsible for task completion
- **Timeline**: consider competing priorities, external needs (vendor assistance) etc

Content Area	Activity/Task	Status	Person(s) Resp.	Gap Type	Timeline																	
					Sep		Oct				Nov					Dec				Jan		
					20	27	4	11	18	25	1	8	15	22	29	6	13	20	27	3	10	
1. Patient Engagement																						
a. Patient Preferences	1.a.1.																					
	1.a.2.																					
	1.a.3.																					
b. Self Management / Educational Resources	1.b.1																					
	1.b.2																					
	1.b.3																					
c Access to Personal Health Info	1.c1.																					
	1.c2.																					
	1.c3.																					
2. Care Management - Provider-to-Patient	2.1																					
	2.2.																					
	2.3.																					
3. Care Management / Coordination - Provider-to-Provider																						
a. HIE	3.a.1.																					
	3.a.2																					
	3.a.3																					
b. Summaries of Health Information for Transitions	3.b.1																					
	3.b.2																					
	3.b.3.																					
c Medications Reconciliation	3.c1.																					
	3.c2.																					
	3.c3.																					

PCMH Application Checklist

- Obtain free copy of NCQA PPC-PCMH Standards & Guidelines available at http://www.ncqa.org/tabid/629/Default.aspx#pcmh
- Purchase $80 NCQA PPC-PCMH Survey Tool available at http://www.ncqa.org/tabid/629/Default.aspx#pcmh
- Determine survey approach if part of multi-site network (multi-site or standard survey)

PCMH Application Checklist

- Complete NCQA PPC-PCMH Application Documents (must be completed and returned to NCQA prior to uploading documentation and completing submission; should be completed at least 2-4 weeks prior to anticipated submission date to avoid delays to timeline)
  - Agreement (includes Attestation, Data Release, NCQA Agreement and HIPAA Business Associate Agreement)
  - Practice Background Information Worksheet
  - Application, including submission date
  - Multi-Site Group Survey Assessment Questionnaire (if interested in using multi-site survey option)
  - Determine fee (refer to NCQA PPC-PCMH Fee Schedule available at http://www.ncqa.org/tabid/631/Default.aspx); NCQA accepts checks and credit cards

PCMH Application Checklist

- Compile PPC-PCMH submission
  - Identify three clinically important conditions
  - Develop system for labeling and organizing documentation required for submission (nomenclature should clearly identify relevant factor(s); if using multi-site option, should clearly indicate relevant site(s))
  - Compile documentation required for submission
  - Identify 36 patients to include in chart review and conduct chart review for relevant elements (2C, 2D, 3D, 4B) (refer to NCQA's Record Review Workbook for information regarding the methodology for selecting your sample and tool to use to conduct chart review)
  - Upload documentation and complete on-line survey (including notes to reviewer)

MU Checklist: 2010 & 2011

- Prepare for upgrade to certified version of your EHR
  - Contact vendor to learn upgrade process and requirements (may include upgrade of related software and/or hardware)
  - Schedule your upgrade
  - Prepare for upgrade
- Conduct communications campaign with Board, patients & staff
- Discuss assignment of MU incentives with your providers
- Register your providers for 2011 MU incentives & assignment
  - Stay tuned for further instructions from NY State Medicaid
- Attest for each provider that you have satisfied requirements of "Adopt, Implement, or Upgrade"

MU Checklist: Now - 2012

- Conduct detailed self-assessment & gap analysis for Stage 1 MU
- Develop work plan
- Begin system configuration, workflow revision, training, report development & other activity required to achieve each MU objective
- Compile documentation of compliance with each MU Objective for 90-days in 2012
- Attest for each provider

NYeC | Regional Extension Center

NEW YORK eHEALTH COLLABORATIVE

- Regional Extension Centers (RECs) have been funded to provide technical assistance in achieving MU
- CHCANYS is an extension agent of the NYeC REC, serving all FQHCs in New York State except those in New York City
- New York City FQHCs are served by REACH, the NYC DOHMH REC
- Please contact us if you are interested in more information:

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Sustaining the Effort

- Become a learning organization
- Develop leadership and communication skills
- Monitor “change fatigue”
- Be practical
- Recognize staff and resource limitations
- Keep the organization’s entire staff in the loop
- Work with your peer organizations
- Take a step back

CHCANYS CLINICAL FORUM AND STATEWIDE CONFERENCE

CHCANYS Community Health Care Association of New York State

PRIMARY CARE DEVELOPMENT CORPORATION

October 4, 2010