

WIREC Update



Washington & Idaho
Regional Extension Center

www.wirecQH.org

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Objectives

Review WIREC perspective several facets of HIT work required for success

- Programs for distributing the incentive
- Meaningful Use
- The WIREC experience to date
 - Enrollment
 - What we're finding the pain points to be
 - How we are working with practices



Medicare Stimulus Money (6/16)

- First payments to hospitals
 - In the US: 36
 - In Washington: 0
- First payments to eligible providers
 - In the US: 284
 - In Washington: 8
 - Among WIREC participants: 0, although several are preparing to attest.

Medicare Incentives for CAHs



2010	2011	2012	2013	2014	2015	2016	2017
	Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2 Payment	Stage 3	Stage 3	Stage 3
		Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 3 Payment	Stage 3	Stage 3
			Stage 1 Payment	Stage 2 Payment	Stage 3 Payment	Stage 3	Stage 3
				Stage 1 Payment	Stage 3 Payment	Stage 3	Stage 3
					Stage 3 Payment	Stage 3	Stage 3
						Stage 3	Stage 3
Penalties for not achieving stage 3: Reasonable cost reimbursement of 101% would be reduced to:					100.66%	100.33%	100%

Incentive payments calculation based on the Medicare Share of the EHR cost

Washington Medicaid Stimulus

- WA Medicaid on-line registration service will be ready in July 2011
- Attestation for AIU will begin in September
- Assistance in determining the numerator for practices to calculate their percent of Medicaid visits will be ready

MU as moving target - definition

- Precise Definitions are constantly refined
- ePrescribing means turning the feature on and being registered with SureScripts
- Many practices are wrestling with who enters what information. Can an MA or a nurse re-order a chronic medication?
- For Medicaid, what is the data definition for a needy patient



MU as moving target – Stage 2

- Meaningful Use Policy Committee voted to postpone Stage 2 until 2014
 - Implication for strategic planning, incentive to postpone is removed
 - Pressure from providers who haven't implemented EHRs yet
 - Pressure from industry for slower pace of feature development and roll out

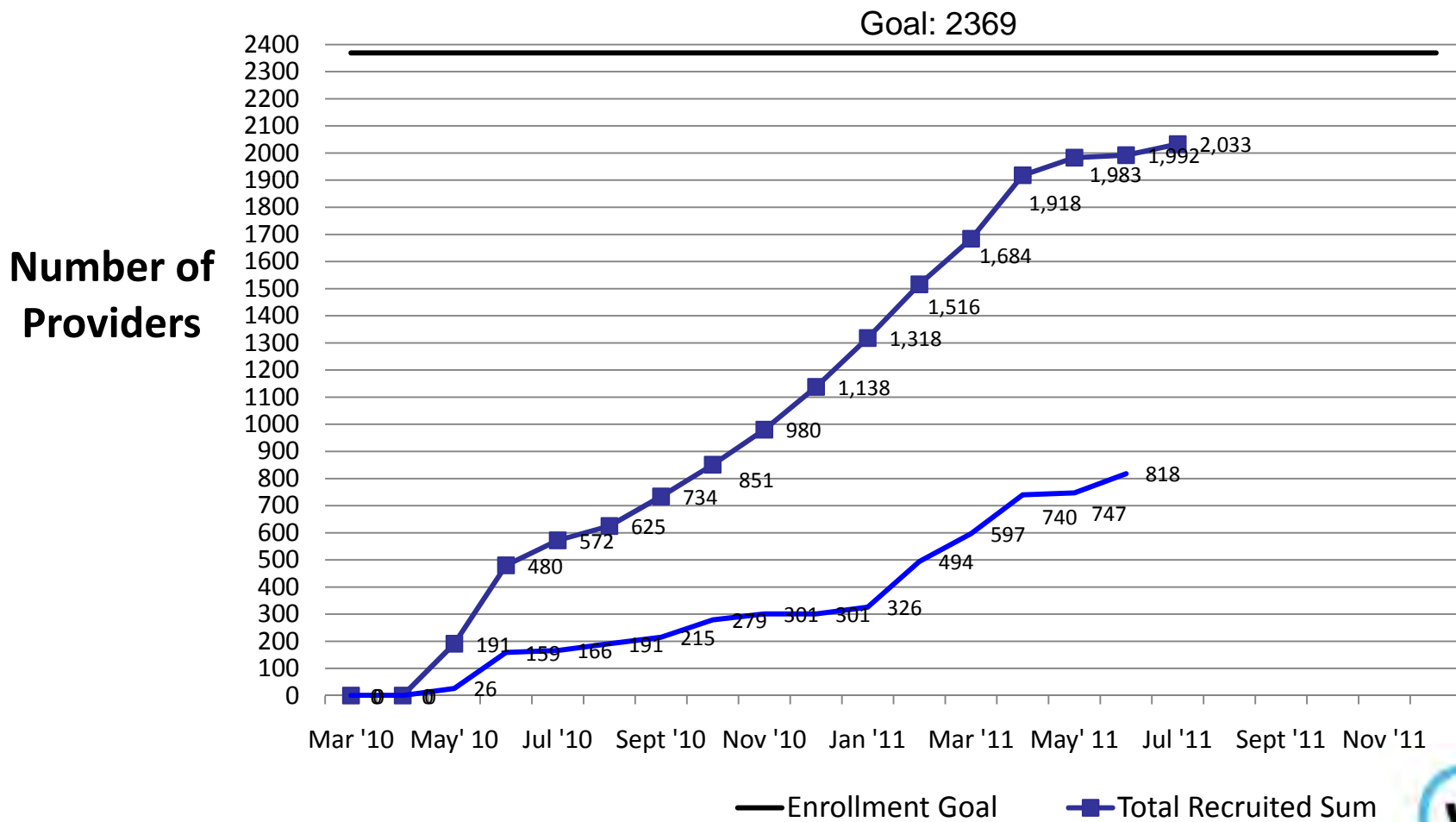
WIREC Structure & Strategy

- Led by Qualis Health with strategic partners including Community Choice
- Goal: 2,369 priority providers in WA & ID
- 8 – 10 consultants across both states
- Strategy:
 - Consulting at no charge to practice
 - Gap analysis to next Milestone: go-live, or MU
 - Workflow redesign workshops offered to all
 - Monthly Webinar series: national content experts
 - Practices near next milestone get intense help

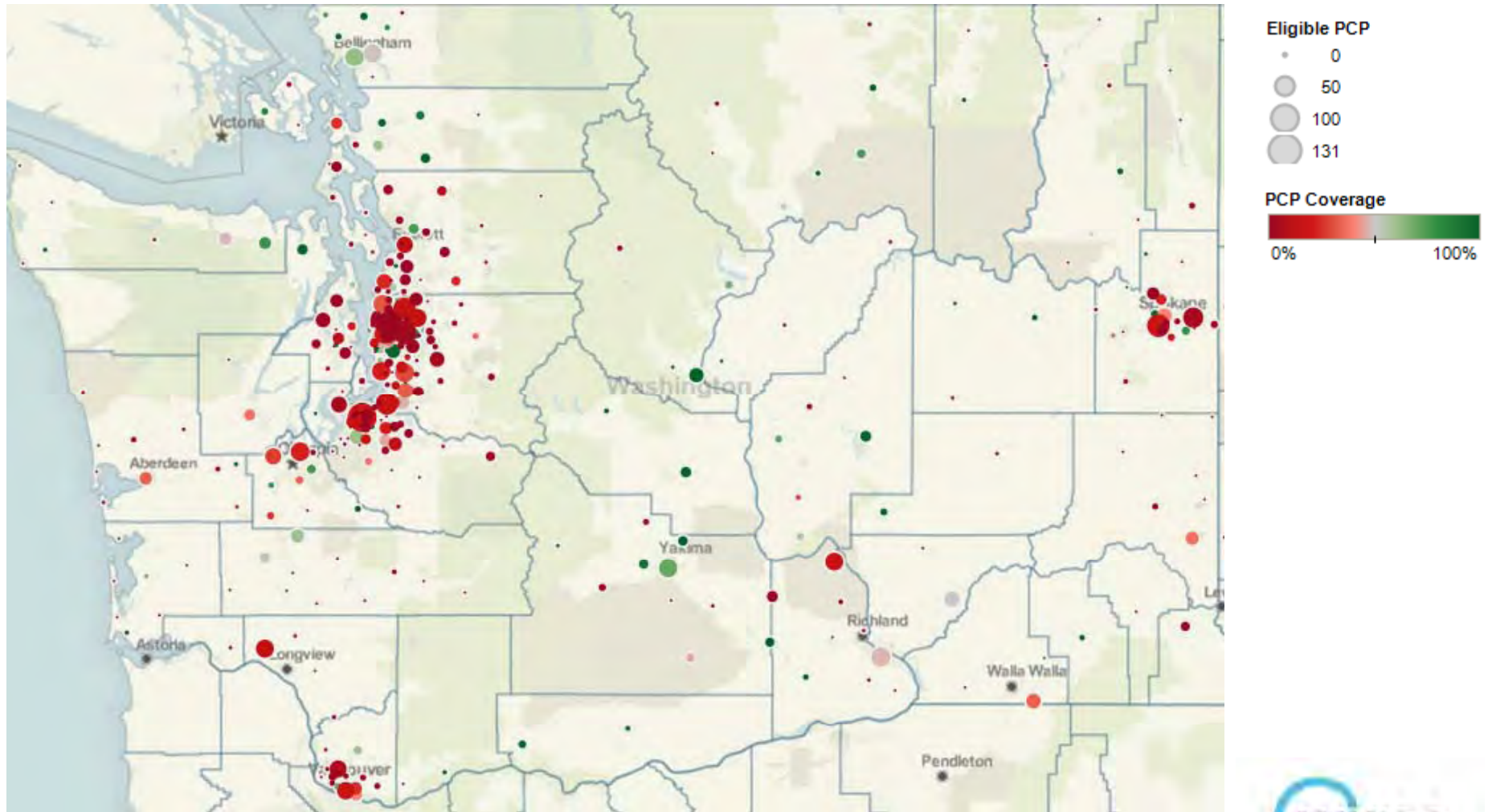


Meeting our enrollment target

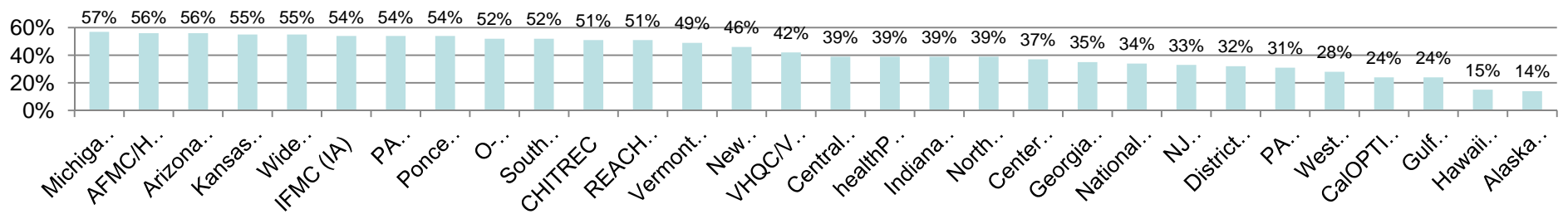
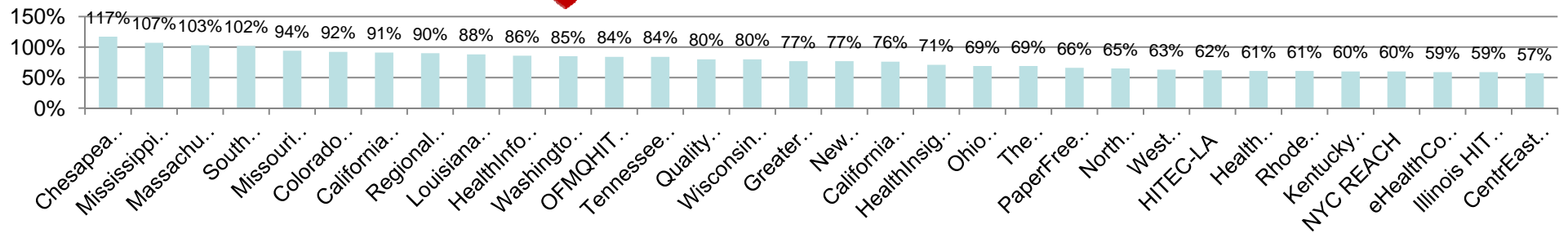
WIREC Recruitment by Month



WA Sites & Opportunity by Zipcode



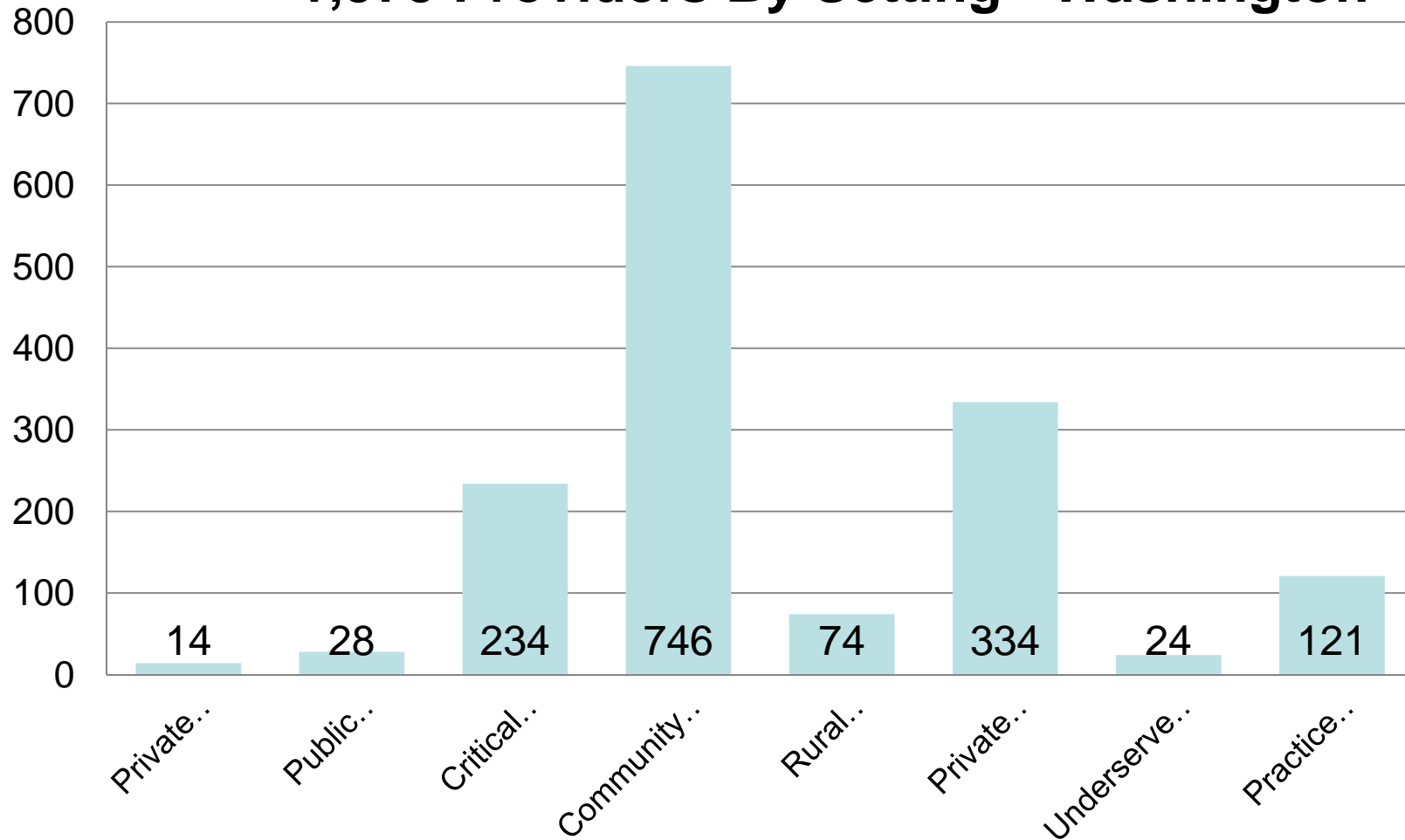
A Respectable Position Nationally



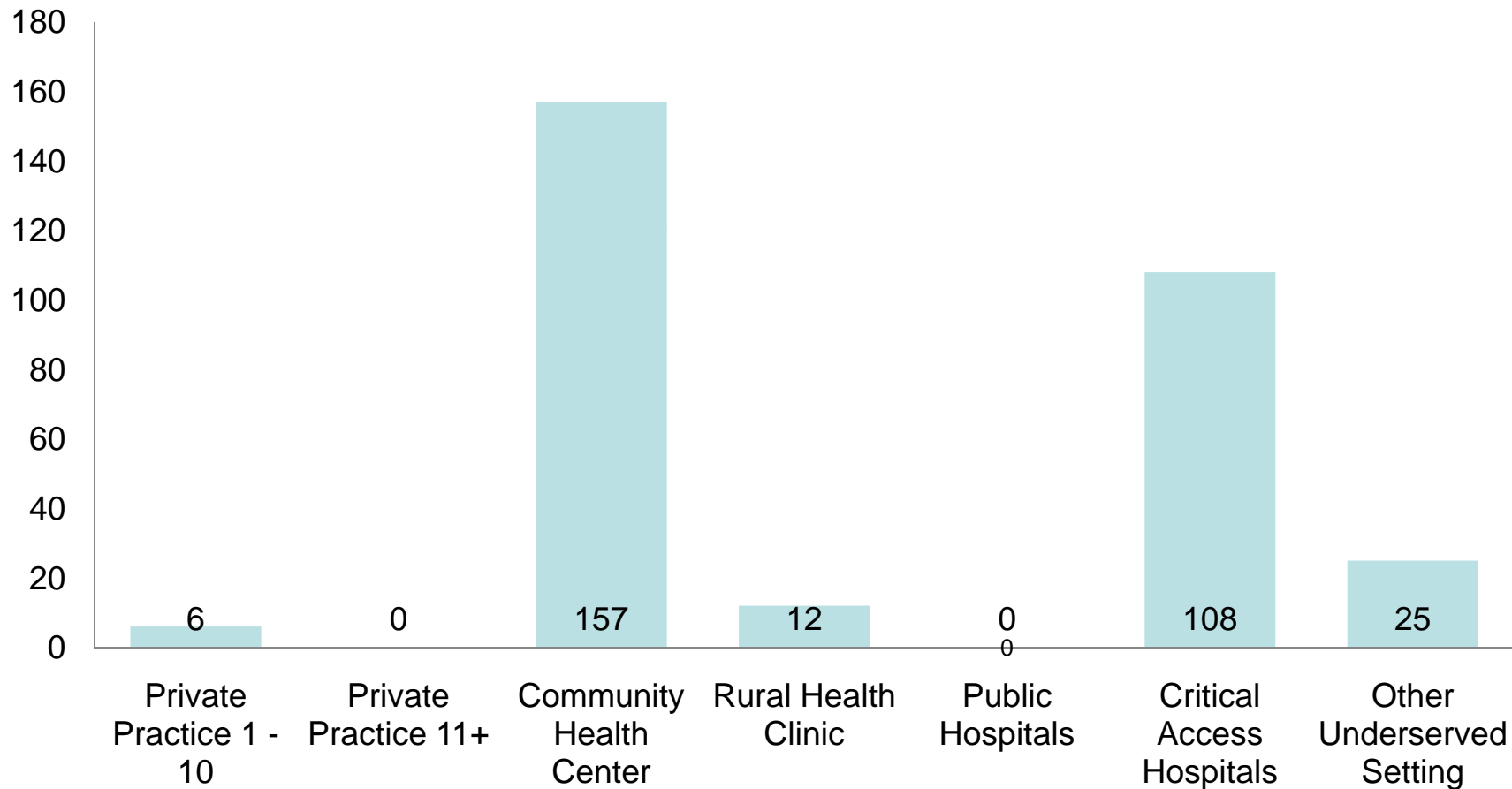
Overview of enrolled practices

- 2,036 individual providers
- 80% in Washington – 20% in Idaho
- 483 practices
- 74% in Washington – 26% in Idaho
- 38% have EHR installed

1,575 Providers By Setting - Washington



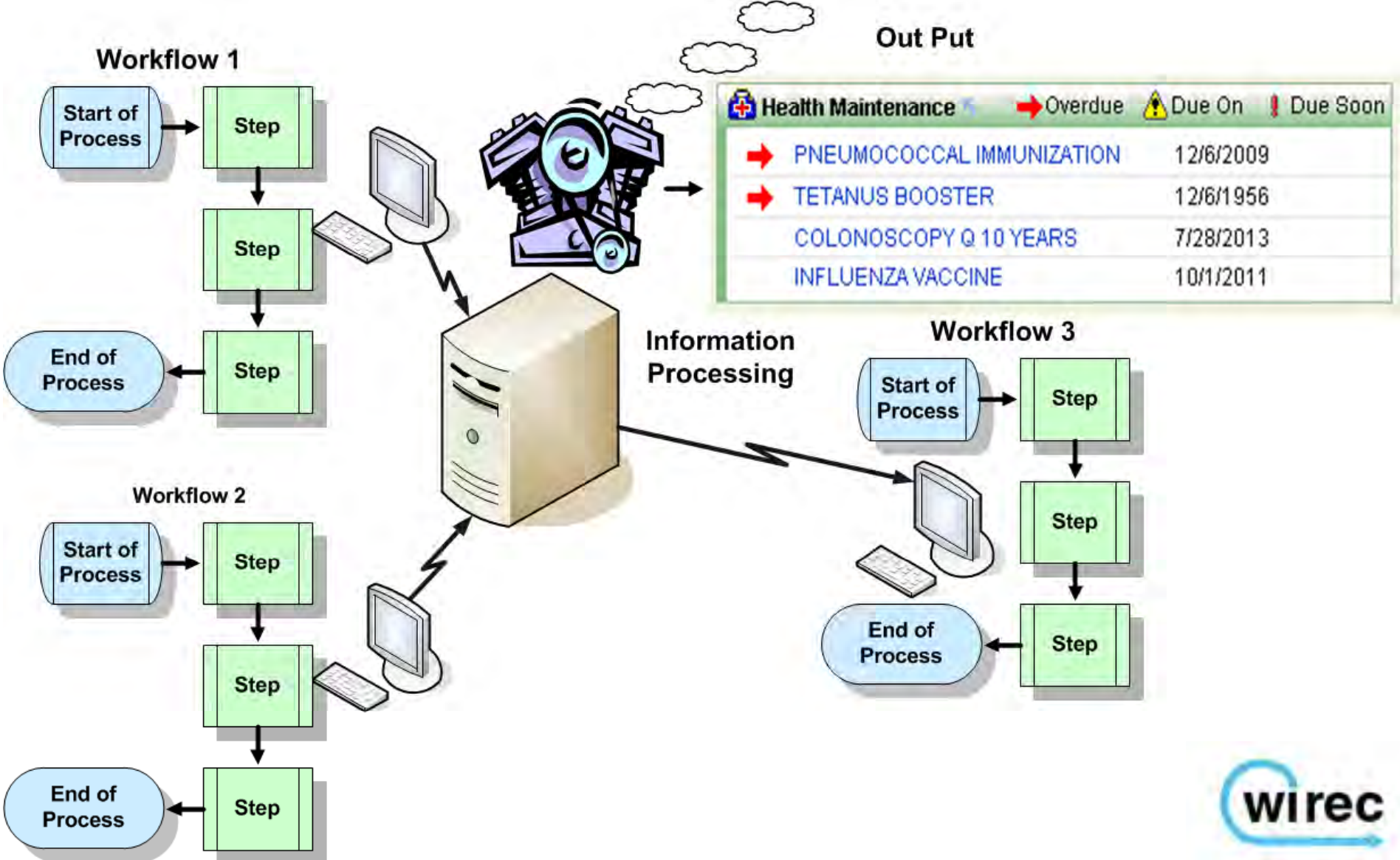
Community Choice - Enrolled Providers By Setting



Challenges on the Front Lines

MU Type	MU element	Workflow	Feature set-up	Receiving capacity	Data definition	Report Writing
Data Gathering	Demographics VS, Smoking Meds & Allergies	✓				✓
Clinical Decisions	CPOE, Problem List	✓				✓
Decision support	Med-Med/Allergy alerts, CDS, Patient Lists, AVS, Clinical Reminders	✓	✓			✓
Data sharing	Reports to Public Health, Immunization registry, Quality Reporting, Pt copy of record, eRx, Transmit key data set, CCR, Med reconciliation	✓	✓	✓	✓	✓

Workflows and Information



Specific Pain Points

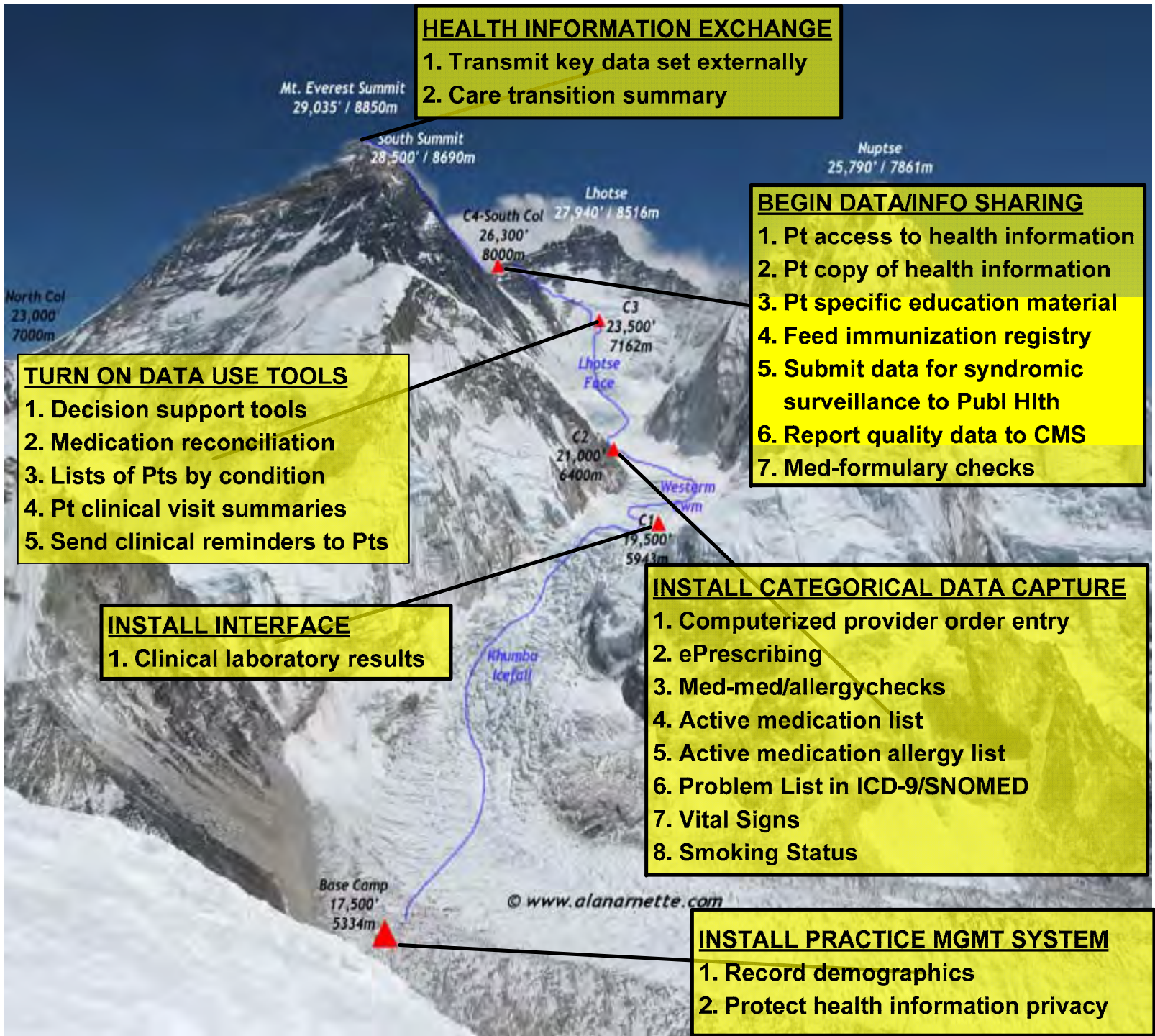
- Smoking Status:
 - workflow change
 - Plan for intervention for smoking & BMI
- Medications
 - Pt & MA knowledge
 - Delegation & oversight
- Providers entering structured data
 - eRx, CPOE & Problem Lis
 - Other data on ad hoc basis – teaching others
- Clinical Summaries & After Visit Summaries

More Specific Pain Points

- HIE
 - lack of clarity about what meets the measure
 - lack of infrastructure,
 - misinformation from vendors
- Immunization Registry –
 - some vendors have more difficulty than others
 - state registry priorities (childhood vs adult)
 - Additional costs charged by vendors to clinics to set up interface versus ability to use State HIE
 - VARS lacking interfacing capability capacities,

More Specific Pain Points

- Lab interfaces
- Barriers to upgrading to certified EHR products
 - certified EHRs requiring add'l hardware for upgrades
 - Rip & Replace decisions
- Organizational priorities
 - CAHs prioritizing inpatient MU work primary care
 - Multispecialty groups decide to delay features
- Reporting
 - Calculate patient volumes for Medicaid incentive
 - Non-transparent data definitions



HEALTH INFORMATION EXCHANGE

1. Transmit key data set externally
2. Care transition summary

BEGIN DATA/INFO SHARING

1. Pt access to health information
2. Pt copy of health information
3. Pt specific education material
4. Feed immunization registry
5. Submit data for syndromic surveillance to Publ Hlth
6. Report quality data to CMS
7. Med-formulary checks

TURN ON DATA USE TOOLS

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

INSTALL INTERFACE

1. Clinical laboratory results

INSTALL CATEGORICAL DATA CAPTURE

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

INSTALL PRACTICE MGMT SYSTEM

1. Record demographics
2. Protect health information privacy

WIREC Expedition Guide Service:
Provisioning route-finding and crevasse rescue

“We’ll make sure you have every thing you need, but you do have to climb the mountain yourself.”

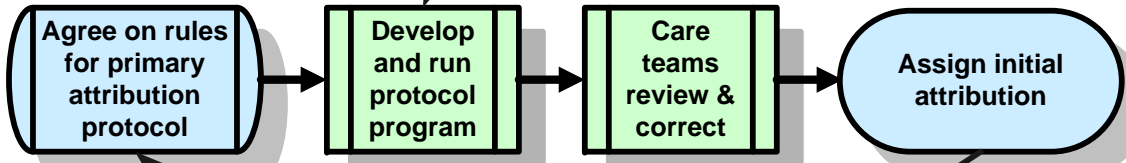


Conceptual Framework

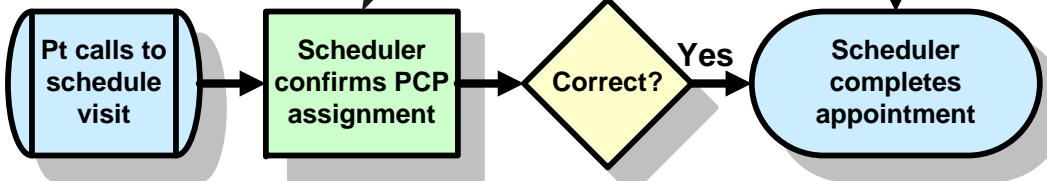
- The PCMH is our best vision for a resilient and sustainable model to deliver high-value healthcare at an affordable cost
- An EHR, used correctly (meaningful use) is the information management infra-structure for *powering the workflows* in a PCMH
- “Meaningful use” is simply an operational definition of the information management requirements for supporting a PCMH

Empanelment

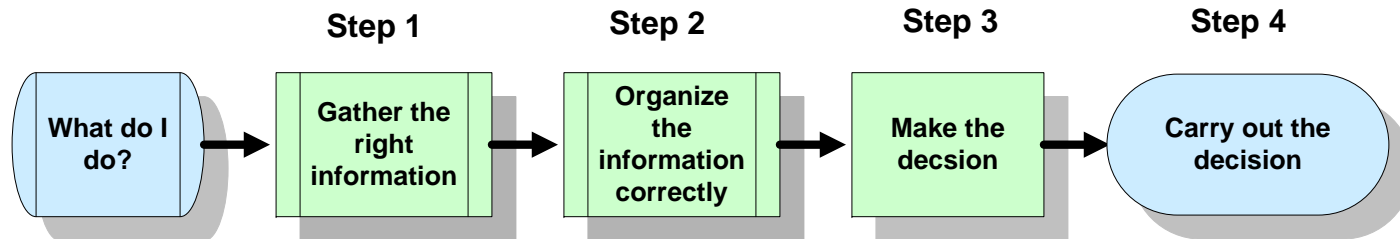
Initial Empanelment Process



PCP Verification Process



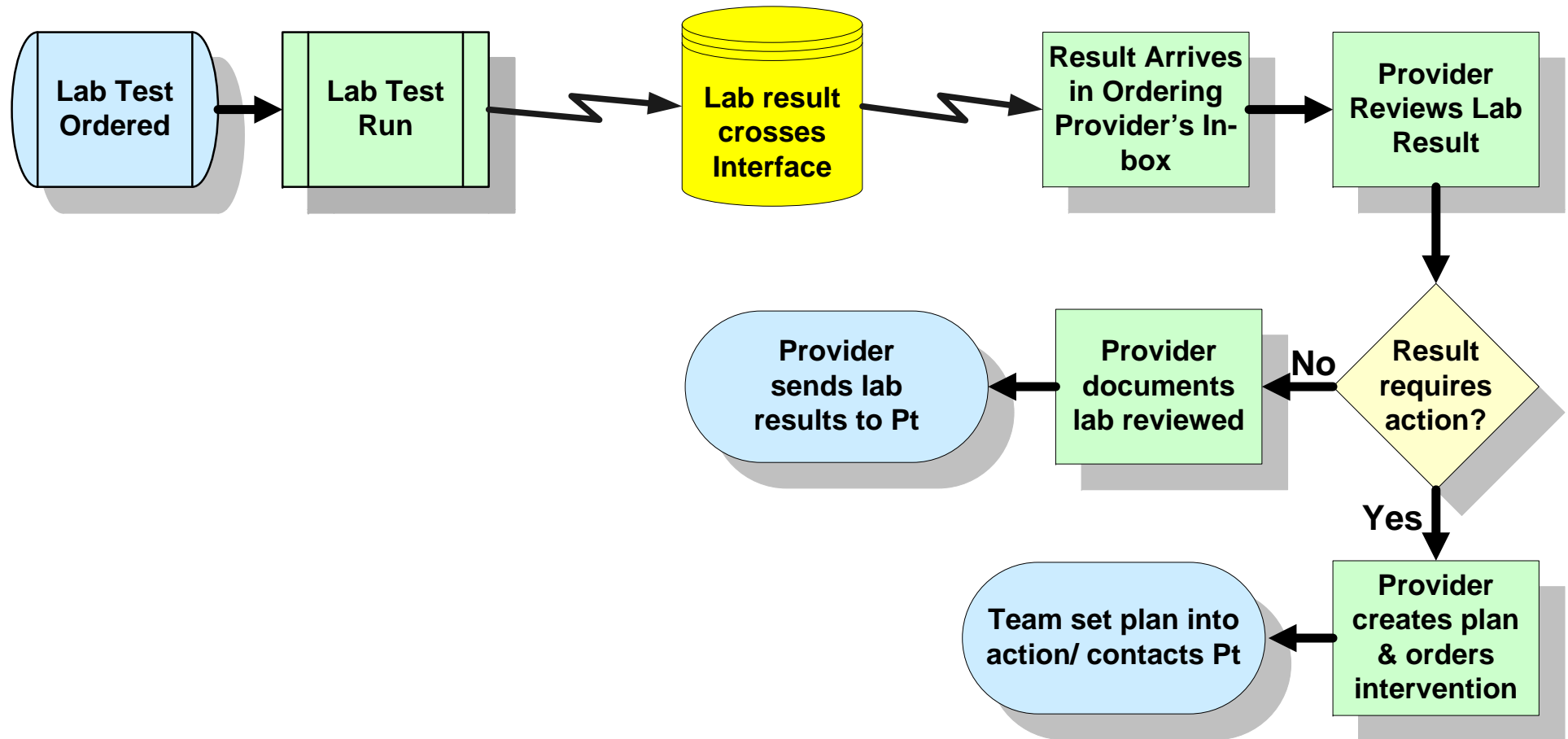
Team-based Care & role definition



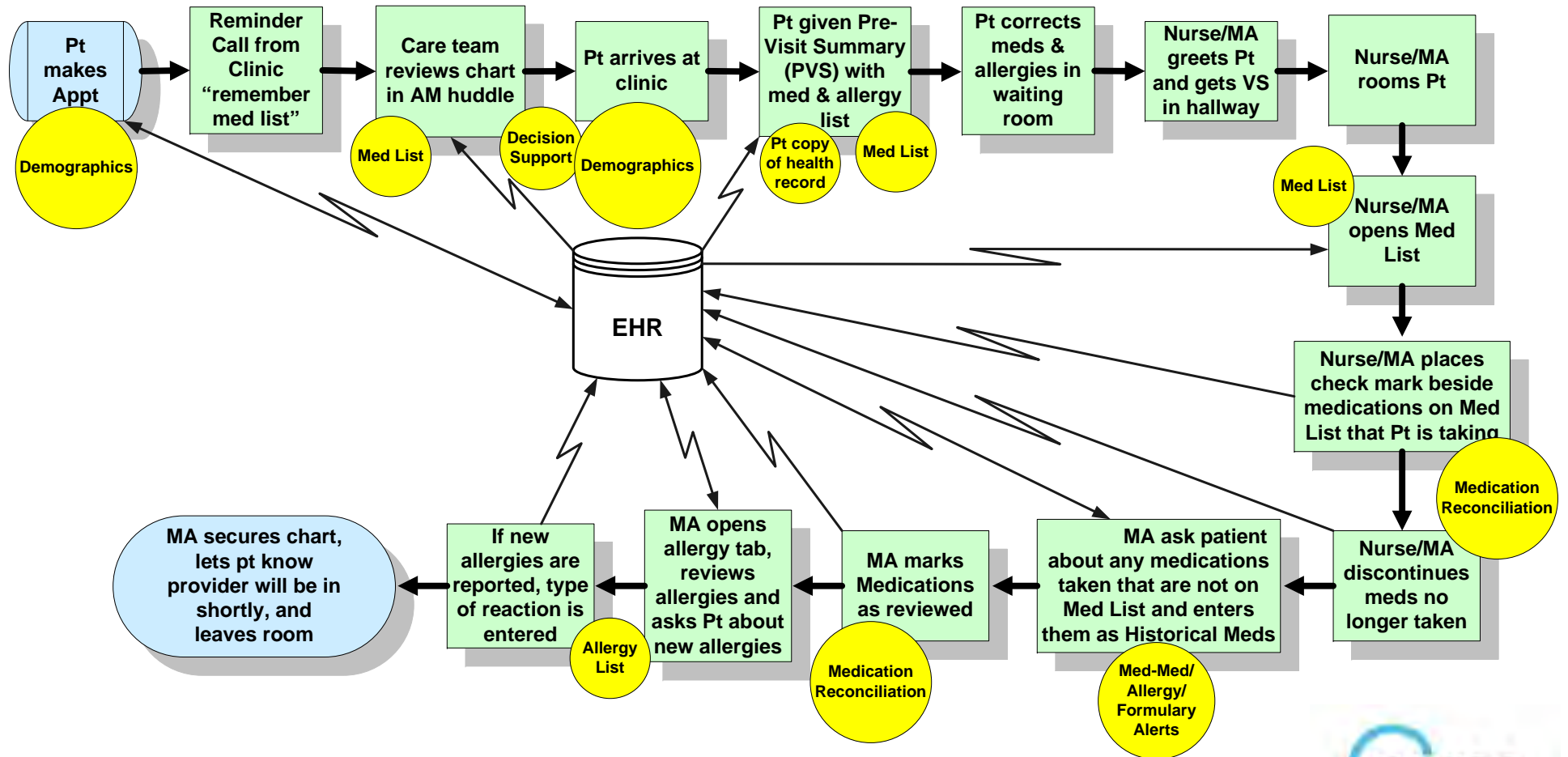
Teams are defined by how they handle this sequence

- If the team is defined as “people standing around waiting to do what I tell them” ...
 - This process doesn’t start until the doctor walks into the exam room
 - Only the 4th step is delegated
- In a PCMH care team:
 - Many “What do I do?” questions can be decided in the team huddle
 - Gathering the right information is delegated to other team
 - The provider-lead educates and supports team members in what information to gather and how to gather it
 - Organizing the information can be greatly enhanced with HIT

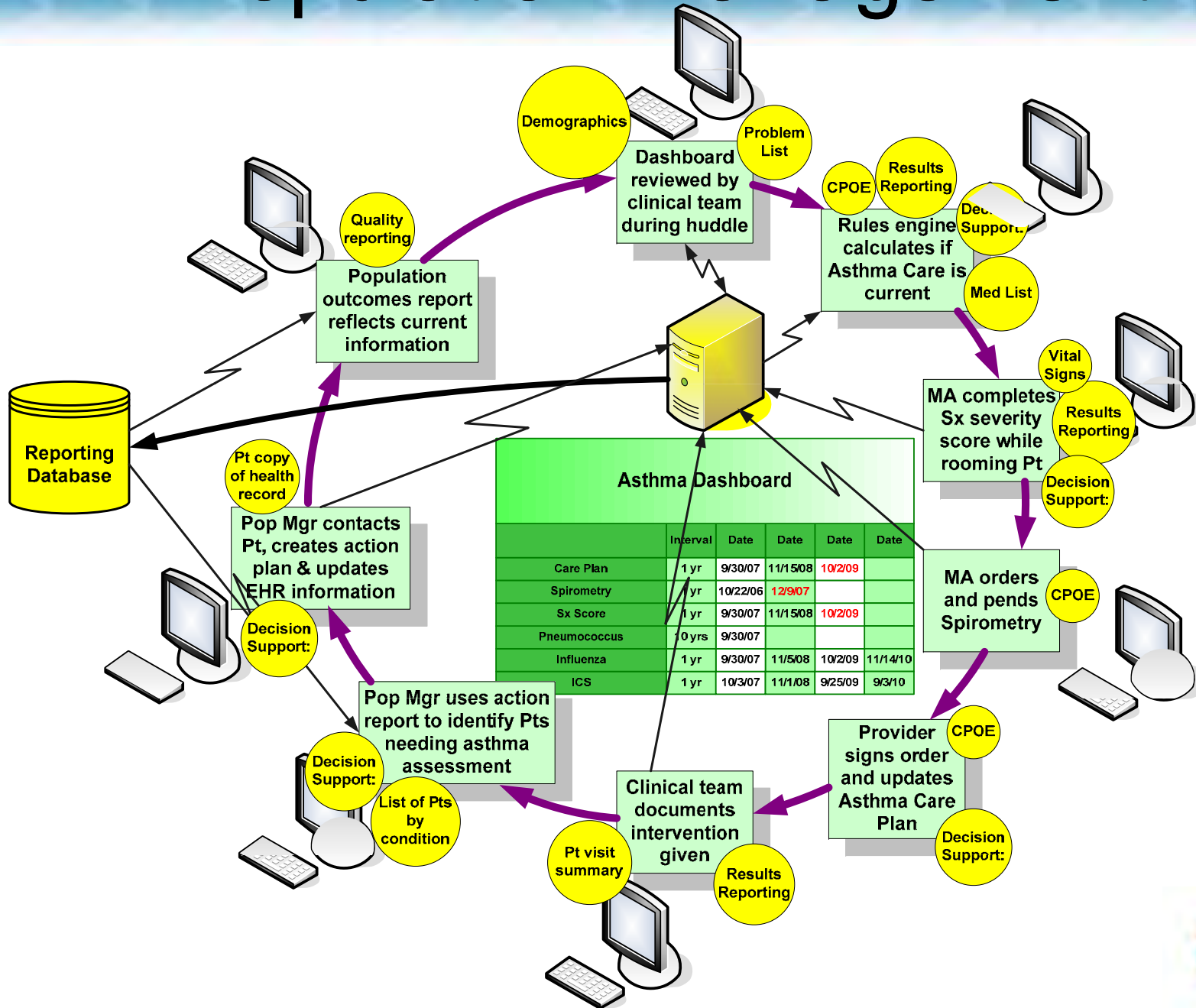
Getting lab results to patients



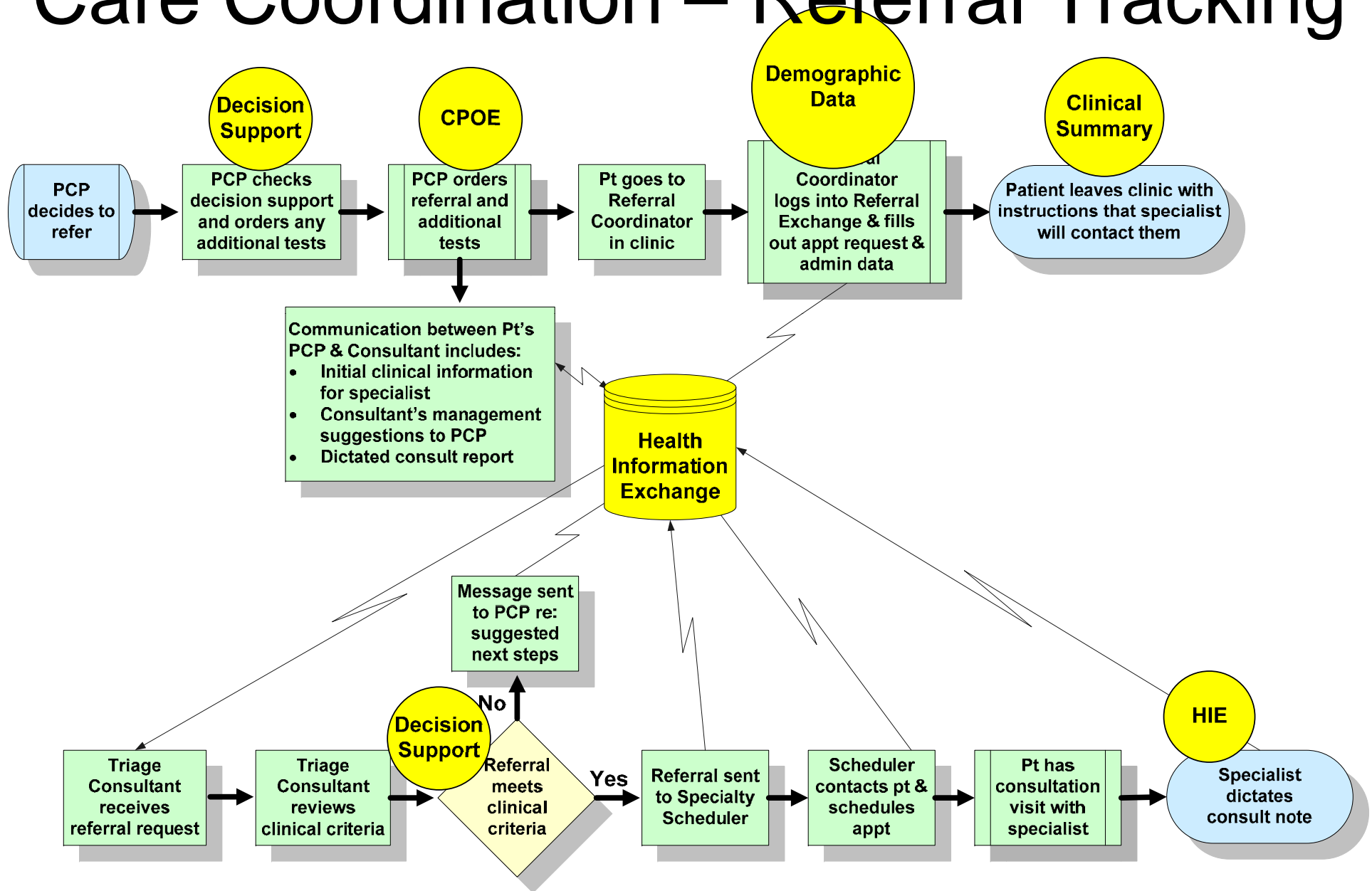
Med List Mgmt in Ambulatory Practice



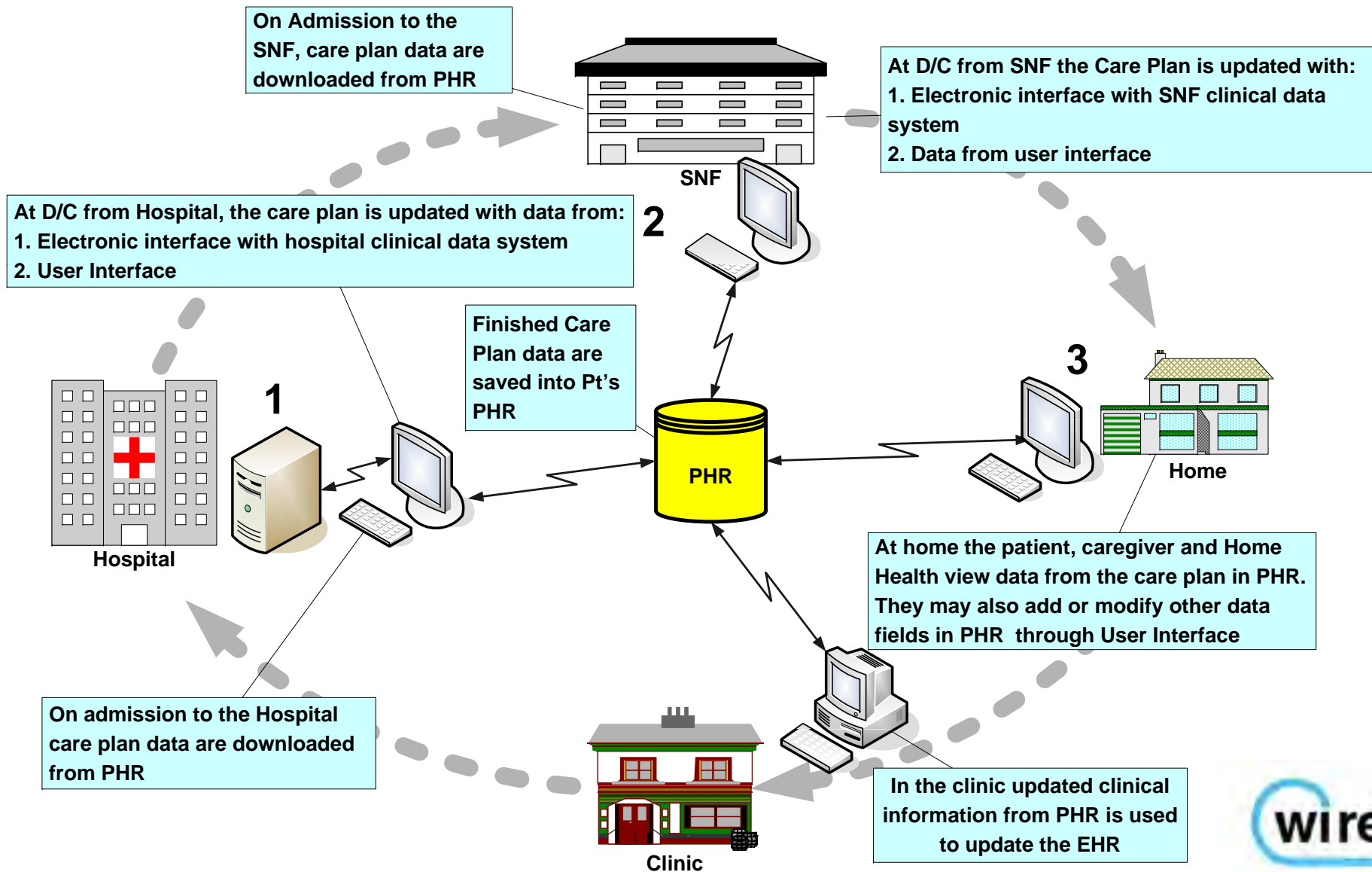
Population Management



Care Coordination – Referral Tracking



Health Information Exchange



Conclusion

- HIT is necessary, but insufficient for a PCMH
- Without HIT, the burden of work-arounds to get the right information to the right person at the right time become the limiting factor
- Without a vision for practice transformation, HIT becomes just one more expensive not-so-magic bullet that won't fix our broken healthcare system
- The optimal planned HIT implementation strategy is ideally suited for staged conversion to a PCMH



Questions

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