EHR-Enhanced QI: Insights from the NYC DOHMH experience
The Primary Care Information Project

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PCPCC Presentation
July 8th, 2010
AGENDA

• EHR Characteristics that Support QI
  • Brief Overview of the PCIP & Suite of Services
  • Insights from the Quality Improvement Team
  • Lessons Learned – Preliminary Observations
  • PCIP’s next steps
A brief history: NYC DOHMH & primary care interventions

NYC Department of Health & Mental Hygiene (DOHMH)
- Mission: To improve the health of all New Yorkers
- One strategy: Improve the delivery of clinical services

Primary Care in NYC
- 7500+ primary care doctors
- >20 multiple site FQHCs
- 77 primary care residency programs (IM/PEDS/FM)

Two DOHMH programs focused on improving clinical care
- Clinical Systems Improvement
- Primary Care Information Project (PCIP)
Clinical Systems Improvement

- Established 2002
- Mission – To improve clinical management & delivery of preventive services in primary care by sharing the best available scientific knowledge on evidence-based care & introducing methods and tools that support delivery of care which is consistent with best practice standards
- Methods
  - Quality Improvement Collaboratives (40+ practices)
  - Public Health Detailing (>1500 practices)
  - Practice staff training – SM support, CCM, MFI
  - Developing the business case for quality
Primary Care Information Project

• Established 2005
• Mission – To improve the quality of care in medically underserved areas through health information technology (HIT)
• Methods (initial)
  - Develop an electronic health record (EHR) for public health
  - Establish routine, automated, confidential quality indicator reporting
  - Support EHR adoption & EHR use for quality improvement (>1500 providers)
The Opportunity

Apply lessons learned from QI work in primary care to EHR development process to:

- address barriers to implementing best practices
- improve workflows and staff utilization
- support adoption of population management
- enhance patient education and SM support
QI Principles Supported by the EHR

Give the right care at the right time
- Point of care reminders / alerts
- Evidence-based treatment options for measures / order sets

Everyone gets the care they need (population management)
- Detailed “patient panel” reports

Performance feedback is credible and timely
- Primary care giver (responsible party) clearly identified
- Reports based on current clinical data
- Flexible query function for getting more specific data within a measure
- Citywide data available for benchmarking

Care is reliable and efficient
- Standardized workflow
- Clinical practice expectations clear
EHR characteristics that support QI

• Role-based access
• Structured data collection fields
• Clinical decision support tools
• Registry function
• Standardized reporting
• Query tools for ad hoc reporting
Role-Based Access

• Identify “what needs to be done and by whom”

• Facilitate all staff members working to the maximum capacity of their licensure and “frontloading” care

• Support team based care
Tobacco Control (TCNY 2)

Name: test test
Date: 09/21/2007

Are you a:
- current smoker
- former smoker
- never smoker

If "current smoker": How often do you smoke cigarettes?
- every day
- some days, but not every day

If "current smoker": How many cigarettes a day do you smoke?
- 0 or less
- 1-10
- 11-20
- 21-30
- 31 or more

If "current smoker": How soon after you wake up do you smoke your first cigarette?
- within 5 min
- 6-30 min
- 31-60 min
- after 60 min
Structured Data Collection

What
- Entering patient information in a predetermined (not free text) format, i.e. Boolean, pick list, numeric, and date.

Why
- Structured data entry makes it possible to retrieve data and generate reports easily. Information entered in the narrative section only cannot be aggregated for reports.

Example:
- MA takes vitals of patient with hypertension
- MA enters BP of 142/82 in designated BP field
- MD repeats BP reading and enters new BP of 128/78 in comments section of physical exam screen
- When registry report of patients with uncontrolled hypertension (BP not less than 130/80) is run, this pt is listed on the report
- When performance feedback report is run, this patient is not counted as having BP<130/80
Clinical Decision Support System (CDSS)

Clinical Decision Support Systems are active knowledge systems which use patient data (e.g. sex, age, diagnoses) to generate case specific recommendations

Point of Care Reminders (alerts, highlighting, etc.)
- Mammogram coming due
- A1c >9
- Smoking cessation counseling recommended

Interactive forms (“Smart forms”)
- Initial Visit (pictured to the right)
- PHQ 9
- Asthma Severity Assessment
- AUDIT- C

Order Sets
- Smoking cessation (e.g. assessment, educational materials, referral, prescribe cessation med)
- Asthma (e.g. prescribe appropriate med, education, referral for specialty care, spirometry)

Registry reports
- Patients overdue for colonoscopy
- Patients with diabetes who will need a flu shot
Actionable, non-intrusive alert will show on the right-pane.
CDSS Example – Order Set

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Registry

What
▪ A system for collecting and maintaining relevant clinical data for patients to be used to monitor and improve the care of the population

Why
▪ Anticipate (who will need a flu shot)
▪ Prepare (who is coming in for hypertension planned visit and what will they need during the visit)
▪ Recall (who is overdue for mammogram)
▪ Stratify (who is in greatest need of outreach and support)

How
▪ Run standard set of reports on predetermined schedule
▪ Review and formulate recommendations for follow up (e.g. order test, schedule appt.)
▪ Develop systems for follow up (phone outreach, mail merges for batched reminder letters, care management)

Who
▪ Designated panel manager
▪ Functions delegated to different members of the care team with one individual responsible for oversight and coordination of registry functions
Performance Feedback

Performance Feedback reports can be used to:

- Identify systems issues in need of remediation or duplication
- Identify variation: learn from top performers & provide support to providers who may be struggling
- Identify areas for focused QI work
- Identify gaps in knowledge and skills
- Drive and assess ongoing quality improvement work at the provider, practice, and site levels

Effective feedback depends on:

- Clear understanding of what the measures represent
- Accuracy of reports
- Regular and routine dissemination
- Availability of meaningful comparison and benchmark data
- The spirit in which feedback is provided
- The support that is provided for QI work
Quality Measures

Numerator:
Number of patients in denominator having \{total cholesterol <240 and no LDL recorded\} OR \{LDL <160\} on their most recent measurement

Denominator:
Number of male patients at least 35 years of age, and female patients, at least 45 years of age, AND who do not have a diagnosis of IVD or diabetes, AND having a documented visit in the reporting period, and having both HDL and total cholesterol levels recorded anytime in the past 60 months (Numerator of 322)

To generate quality measure for historical dates, run migrate vitals utility for the specific date range. To migrate vitals click on tools menu -> Migrate vital or go to registry band -> vitals tab -> click on Migrate Vitals
### Quality Measures Report

**Measure Name**: Measure 350-CE

**Reporting Interval**: Quarterly

**Reporting Date Range**: 5/29/2006 to 08/29/2007

**Measure Definition**: Patient 18-75 years of age with diabetes who have a poorly controlled lipid panel with LDL > 100.

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Example – Provider performance report

At Least One LDL Test in the Past 12 Months -- Goal: 90%
What Will Make the EHR Work as a Quality Improvement Tool?

A well articulated QI Plan

- Quality Improvement Goals
- List of current QI measures that you want to generate (this may affect data entry requirements post go-live)
- Identification of clinical training needs
- Identification of clinical workflows that need to be revised or designed for conversion from paper to EHR
- Up-to-date policies and procedures, e.g. rules for “inactivating” patients in EHR
- Identified QI champion(s)
What Will Make the EHR Work as a Quality Improvement Tool?

Pre-implementation

• Careful assessment of current practice followed by workflow redesign for key processes- to avoid using a new tool to do everything the old way
• Practice consensus on clinical guidelines and expectations
• Clear assignment of responsibility and a plan for producing and using registry reports
• Clear assignment of responsibility and a plan for producing and using performance feedback reports
What Will Make the EHR Work as a Quality Improvement Tool?

**Post-implementation**

- Consistent use of structured fields for documentation
- Accurate primary care giver/rendering provider assignment
- Running consistent Quality Assurance checks on the integrity of data being entered into the EHR
- Charting during the patient visit
- Responding to point of care alerts
- Using Clinical Decision Support tools (e.g. order sets, right pane)
- Follow-through on registry and performance feedback plans
- Dedicated time for Quality Improvement work
AGENDA

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- Brief Overview of the PCIP & Suite of Services
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- PCIP’s Next Steps
Primary Care Information Project (PCIP) Overview

A bureau of NYC DOHMH, founded in 2005

Mission
- Improve the quality of care in medically underserved areas through health information technology (HIT)

Resources
- Current funding: NYC, NY State, Federal, private

Success
- Over **2500 providers** are using the EHR at
  - 37 CHCs
  - 5 hospital outpatient
  - 433 small practices
Our Vision

**ELECTRONIC HEALTH RECORDS**
oriented to *prevention*

**PAYMENT**
that rewards *disease prevention* & chronic disease management

**CARE MANAGEMENT**
and practice workflows to support *prevention*

Healthcare that maximizes health
Overview of PCIP Services:

**Contemplation**
- Provider outreach & education
- Vendor selection
- Group purchasing discounts
- Readiness assessments
- IT consultation
- Partners for financing & workforce development

**Implementation**
- Contract accountability
- Project management
- Workflow redesign (large practices)
- Social networking
- Communication outreach
- CME credits for training

**Post go live**
- Revenue cycle optimization
- EMR consulting
- QI consulting
- PCMH preparation
- Privacy & security consulting
- Workflow redesign (small practices)
- Patient portal training
- Interfaces (e.g., labs, registries)
- Pilots

**Meaningful use**
- Quality measures
- Interoperability
- Patient engagement
- Biosurveillance
- Pay-for-Quality program
Timeline for Suite of Services

- eCW project management ... eCW account management

- Pre Go-live
  - Implementation prep (12-16 weeks)

- Initial “ramp up” phase
  - ~1-2 months

- Steady state phase
  - ~3-6 months post go-live

- PCIP Outreach

- PCIP implementation management ... PCIP integration management

- PCIP Billing consulting

- PCIP EMR consulting

- PCIP QI consulting

- PCIP Pay for Quality

- Panel Management
PCIP BILLING CONSULTANT OVERVIEW – WHAT DO WE DO?

– Provide up to **5 on-site visits** from our Billing Consultants, including an Initial Practice Assessment

– Provide **technical assistance** to help practices improve their billing processes working with front desk staff, billers, physicians, and other medical staff as needed

– Provide **training to physicians on E/M coding guidelines**

– **Identify universal issues** and bring them to the attention of PCIP and eCW

– Conduct free **group trainings** to reach as many physicians as possible
  – Billing Improvement Classes held at multiple sites and times
PCIP SUPER-USER CONSULTANT OVERVIEW– WHAT DO WE DO?

– Provide **technical assistance** to physicians to help them configure the record as needed to improve documentation, minimize “slowness”, improve reimbursement and overall, decrease frustrations

– Identify areas where physicians are struggling and **strategically configure record** to preserve functionality while improving user experience

– Identify “bugs” and raise them to the appropriate development teams

– Provide **support during lab interface set up** for practices

– Help **create training materials** to provide additional support to practices

– Provide **feedback to the teams at PCIP** on what we observe during site visits (Development, IS, Billing, QI)
PCIP QUALITY IMPROVEMENT OVERVIEW – WHAT DO WE DO?

– Provide **technical assistance** to physicians to help them improve the health outcomes of patients,
  – Focus on 4 priority TCNY areas (ABCS)
  – Help providers get to **meaningful use**
  – **Provide CME/CNE credits** for participating with QI

– Provide **support for office redesign** (e.g., workflows, documentation, standard processes) to improve office efficiency
  – if desired, prepare for **NCQA Patient Centered Medical Home (PCMH)**

– Provide **additional coaching on preventive-health features** & how to use them for QI

– Provide a **forum for discussing performance feedback** and sharing best practices for QI efforts

– Provide **feedback to the teams at PCIP** on what we observe during site visits (Development, IS, Billing, EMR)
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Patient Centered Medical Home (PCMH)

Technical Support
A QI Specialist will:
▪ Help practices understand the PCMH standards
▪ Assess practices and suggest ways to implement PCMH techniques (proactive, preventive and follow up care)
▪ Develop an individualized project plan and timeline
▪ Provide guidance on submitting the application and supporting materials to NCQA

Multisite survey
PCIP has arranged for eligible practices to receive 36.75 points towards the PCMH survey for Quality Improvement work:
▪ Decrease administrative burden of application

Application fee
PCIP practices pay half of the sponsored rate – a significant discount
Identifying Practices for PCMH

- Practices need to be proficient on the basic system functions before thinking about advanced concepts such as PCMH
- Establish workflows, apply customizations, configure billing and fix system bugs before deploying QI
- Teach practices QI techniques to apply after on-site visits end

Practices are assessed during a Quality Improvement site visit -- the QI Specialist performs a gap analysis using the NCQA PCMH standards. If eligible, a project plan is established and the application process begins.
PCMH: Success of PCIP Practices

There are 42 PCMH in NYC and PCIP accounts for 62%.

Small Practice vs. Large Practice

Size of Practice

PCMH Status as of 2010

- Recognized
- Pending Evaluation
- In Progress
- Interested
Overview of MEANINGFUL USE

- The American Recovery and Reinvestment Act (ARRA) authorizes the Centers for Medicare & Medicaid Services (CMS) to offer a financial incentive to physician and hospital providers who demonstrate the “meaningful use” of an electronic health record (EHR).

According to the CMS, a provider uses an EHR “meaningfully” when he or she:

1) Improves quality, safety, efficiency, and reduces health disparities
2) Engages patients and families
3) Improves care coordination
4) Improves population and public health
5) Ensures adequate privacy and security protections for personal health information
A Basic Comparison

**Meaningful Use**
- Improve quality, efficiency and reduce health disparities
- Engage patients and families
- Improve care coordination
- Improve population and public health
- Ensure privacy and security

**PCMH**
- Access and communication
- Patient tracking and registry
- Care management
- Patient self-management
- E-prescribing
- Test tracking
- Referral tracking
- Performance reporting & improvement
- Advanced electronic communications

Primary Care Information Project
## What to Focus on: Stage 1 Meaningful Use Measures (2011-12)

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<thead>
<tr>
<th>Improve Quality</th>
<th>Coordinate Care</th>
<th>Public Health</th>
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<tbody>
<tr>
<td>• Computer Physician Order Entry</td>
<td>• Establish exchange of clinical information</td>
<td>• Transmit data to immunization registries</td>
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<tr>
<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
<td>• Perform medication reconciliation for relevant encounters and transitions of care</td>
<td>• Transmit syndromic surveillance data to public health agencies</td>
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<td>• Maintain an up-to-date problem list and active diagnoses</td>
<td>• Generate lists of patients by specific condition for outreach</td>
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<td>• Generate and transmit permissible prescriptions electronically (eRx)</td>
<td>• Report selected quality measures to CMS</td>
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<tr>
<td>• Maintain active medication and allergy list</td>
<td>• Send patients reminders for routine care</td>
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<td>• Record key demographics for 80% of patients</td>
<td>• Implement five clinical decision rules relevant to clinical quality measures</td>
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<td>• Record and chart changes in vital signs for 80% of patients</td>
<td>• Incorporate structured lab-test results into EHR</td>
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<td>• Check insurance eligibility electronically</td>
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### Engage Patients
- Provide patients with electronic access to their health information within 96 hours upon request
- Provide clinical summaries for office visits

### Privacy and Security
- Conduct routine security risk analyses of procedures for privacy and security
AGENDA

- EHR Characteristics that Support QI
- Brief Overview of PCIP & Suite of Services
- Insights from the Quality Improvement Team
  - Lessons Learned – Preliminary Observations
- PCIP’s Next Steps
PCMH CHALLENGES

▪ Good guide for office transformation, but practices have to buy into the concept first

▪ Sometimes, the transformation is the easiest part. Proving it is the challenge
  ▪ Care coordination efforts are rarely documented
  ▪ EMRs not yet ready to facilitate capture of that information
  ▪ Hard to get aggregate look (many fields are not queriable)
  ▪ How do you prove something was given or printed?

▪ Some things are not yet feasible, e.g.,
  ▪ Notification if patient is in the ER or hospitalized
  ▪ Referral system that alerts you if preauthorization is necessary
  ▪ Patient education materials available in all languages

▪ Small Practices differ greatly, making it hard to standardize and generalize
  ▪ Need to find what physicians and staff will engage on
    ▪ Attempt to make standard curriculum based on disease failed and evolved to workflow and PCMH
  ▪ Staff varies: size, skill, training, and will – need to adjust QI approach to meet staff

▪ Health Plans have been slow to follow suit
  ▪ Many are in the pre-contemplative stage (aka pilots)
  ▪ Concerns that we are missing out on an unprecedented time in history
LESSONS LEARNED

• Recognize the **limited resources** (time and money) small-practice physicians have to do QI work

• Define and clearly communicate the scope of the QI activities and how they all fit together in **an organizing framework**

• Focus early on **making sure the quality data can be trusted**

• Leverage **best-practices** from people who have done this before

• **Respect provider preferences** while still being able to focus on the areas we think matter the most

• **Pace the interventions** as providers can only absorb a set amount of information in one sitting

• Find ways to deliver **concrete value to the provider**

• **Help providers get paid** for the work they do
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• PCIP’s Next Steps
NYC REACH: A New Project of PCIP

• The federally designated Regional Extension Center for New York City

  ▪ Covers EHR selection through Meaningful Use
  ▪ Focuses training explicitly on MU criteria
  ▪ Reaches more providers (no Medicaid requirement)
  ▪ Works directly with other Extension Centers and federal HHS to solve problems
  ▪ Funnels providers to other programs (P4P, PCMH, etc) – access to these programs is a benefit of REACH membership
NYC REACH SERVICES: How we will help providers

**Education**
- On-site staff training
- Billing
- Lab Interfaces
- Community classes

**Vendor Selection and Group Purchasing**
- Assessing practice IT needs
- Negotiating vendor contracts
- Holding vendors accountable
- Support a “choice of offerings”

**Project Management**
- On-site staff training
- Billing
- Lab Interfaces
- Community classes

**Health Information Exchange**
Help practices connect to HIE infrastructures:
- Administrative transactions
- Lab orders and results
- Medication prescriptions
- Quality and public health reports
- Patient summaries

**Practice and Workflow Redesign**
- Mapping work processes to quality improvement initiatives
- Updating roles and responsibilities
- Supporting workflow to meet federal Meaningful Use criteria

**Privacy and Security**
- Physical security
- Access controls
- Back up and Recovery
- HIPAA compliance
- Best practices training
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