Department of Health & Human Services
Office of the National Coordinator for
Health Information Technology

HITECH in Action

Key ONC Programs and Opportunities for Partnership with the PCPCC Membership

Office of the National Coordinator for Health Information Technology

September 7, 2010

Overview

- What is HITECH?
- Regional Extension Centers
- State Health Information Exchange
- Beacon Community Program

HITECH Vision

- A major transformation in American health care
- Each patient receives optimal care through nationwide health information exchange
- Programs and regulations to help you overcome obstacles to adoption and Meaningful Use of electronic health records (EHRs)

Federal Government Responds: HITECH Act

- Part of American Recovery and Reinvestment Act of 2009 (ARRA)
- Goal: Every American to have an EHR by 2014
- Systematically addresses major barriers to adoption and Meaningful Use:
  - Money/market reform
  - Technical assistance, support, and better information
  - Health information exchange
  - Privacy and security

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How HITECH Addresses Barriers to Adoption

Obstacle	Intervention	Funds Allocated
Market Failure, Need for Financial Resources	• Medicare and Medicaid EHR Incentive Programs for "Meaningful Use"	• $27.3 B*
Addressing Adoption Difficulties	• Regional Extension Centers • Health IT Research/Resource Center	• $643 M • $50 M
Workforce Training	• Workforce Training Programs	• $84 M
Addressing Technology Challenges and Providing Breakthrough Examples	• Strategic Health Information Technology Advanced Research Projects • Beacon Communities Programs	• $60 M • $250 M
Privacy and Security	• Policy Framework • New Privacy and Security Policies	Addressed across all Programs
Need for Platform for Health Information Exchange	• NHIN, Standards and Certification • State Cooperative Agreement Program	• $64.3 M • $548 M

*$27.3 B is high scenario

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Regional Extension Centers (RECs)

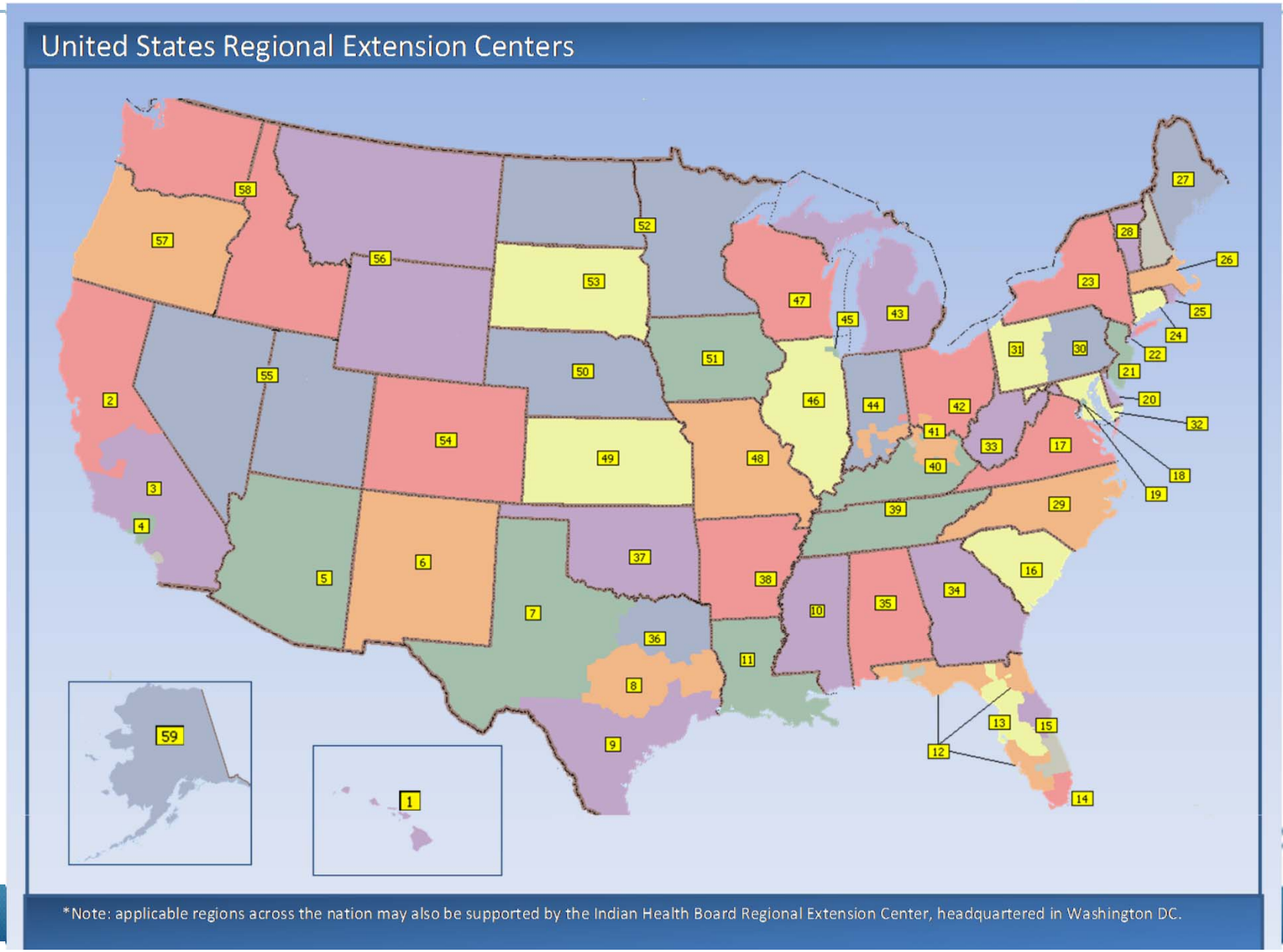
- **Goal:** Assist at least 100,000 providers in achieving Meaningful Use by 2012
- Establish RECs nationwide to support providers in adopting and becoming Meaningful Users of HIT through comprehensive, “on-the-ground” services:
  - Outreach and education
  - EHR vendor selection support
  - Project management assistance
  - Workflow redesign support
  - Help with achieving Meaningful Use

RECs

Focus on supporting primary care providers that are least likely to achieve Meaningful Use on their own:

- Small practices with less than 10 providers
- Public and critical access hospitals
- Community health centers and rural health clinics

Current RECs



State Health Information Exchange

- **Goal**: Give every provider options for meeting health information exchange (HIE) Meaningful Use requirements
- 4-year program to support state programs to ensure the development of HIE within and across their jurisdictions
- 56 states and territories awarded funding for HIE planning and implementation
- States need an ONC-approved State Plan before federal funding can be used for implementation
- Exchange must meet national standards

The Beacon Community Program

- **Goal**: Share best practices that help communities achieve cost savings and health improvement
- 15 demonstration communities* that will:
  - Build and strengthen their HIT infrastructure and exchange capabilities and showcase the Meaningful Use of EHRs
  - Provide valuable lessons to guide other communities to achieve measurable improvement in the quality and efficiency of health services or public health outcomes

*Two additional communities to be funded in Summer 2010

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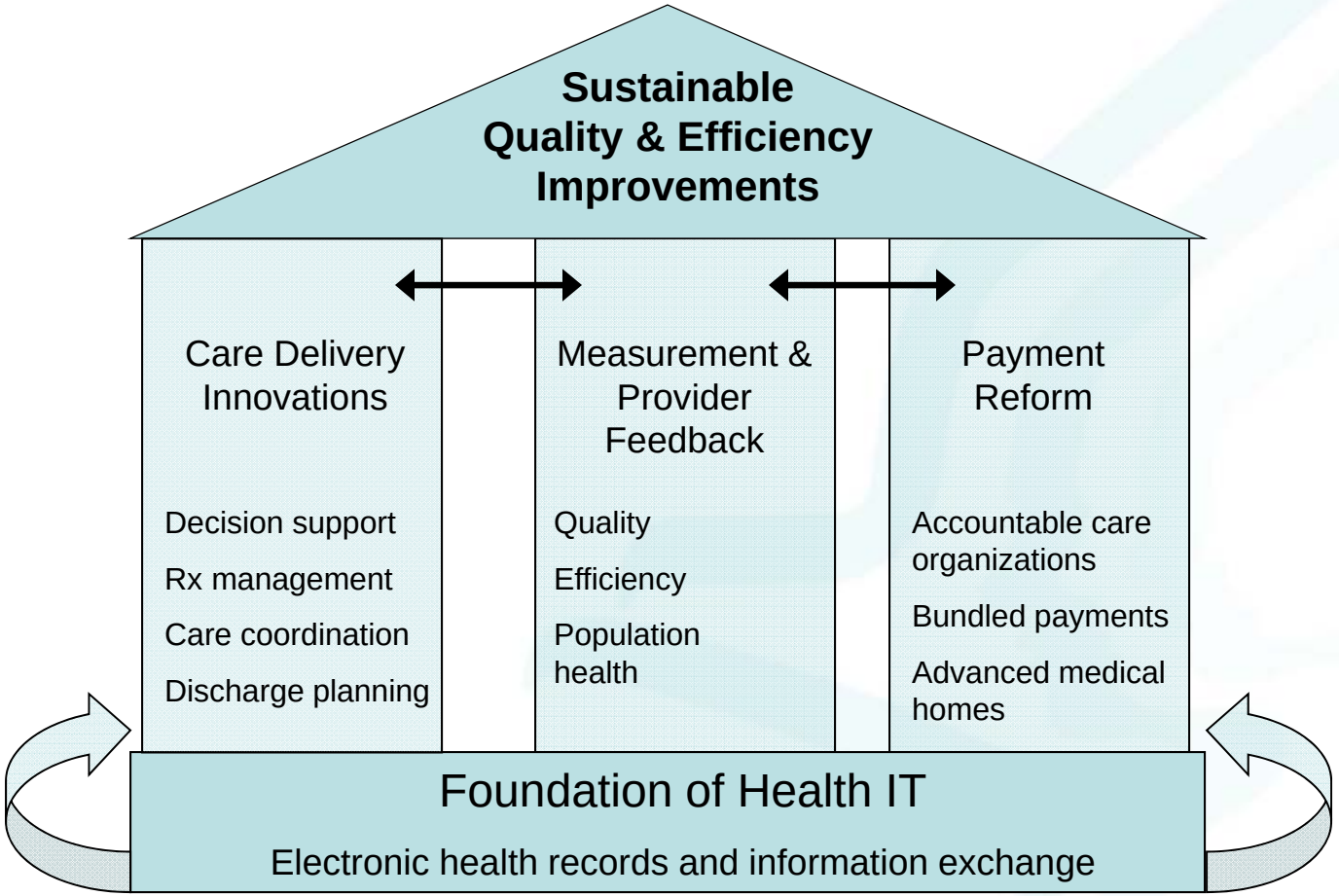
Beacon Community Program: Conceptual Model



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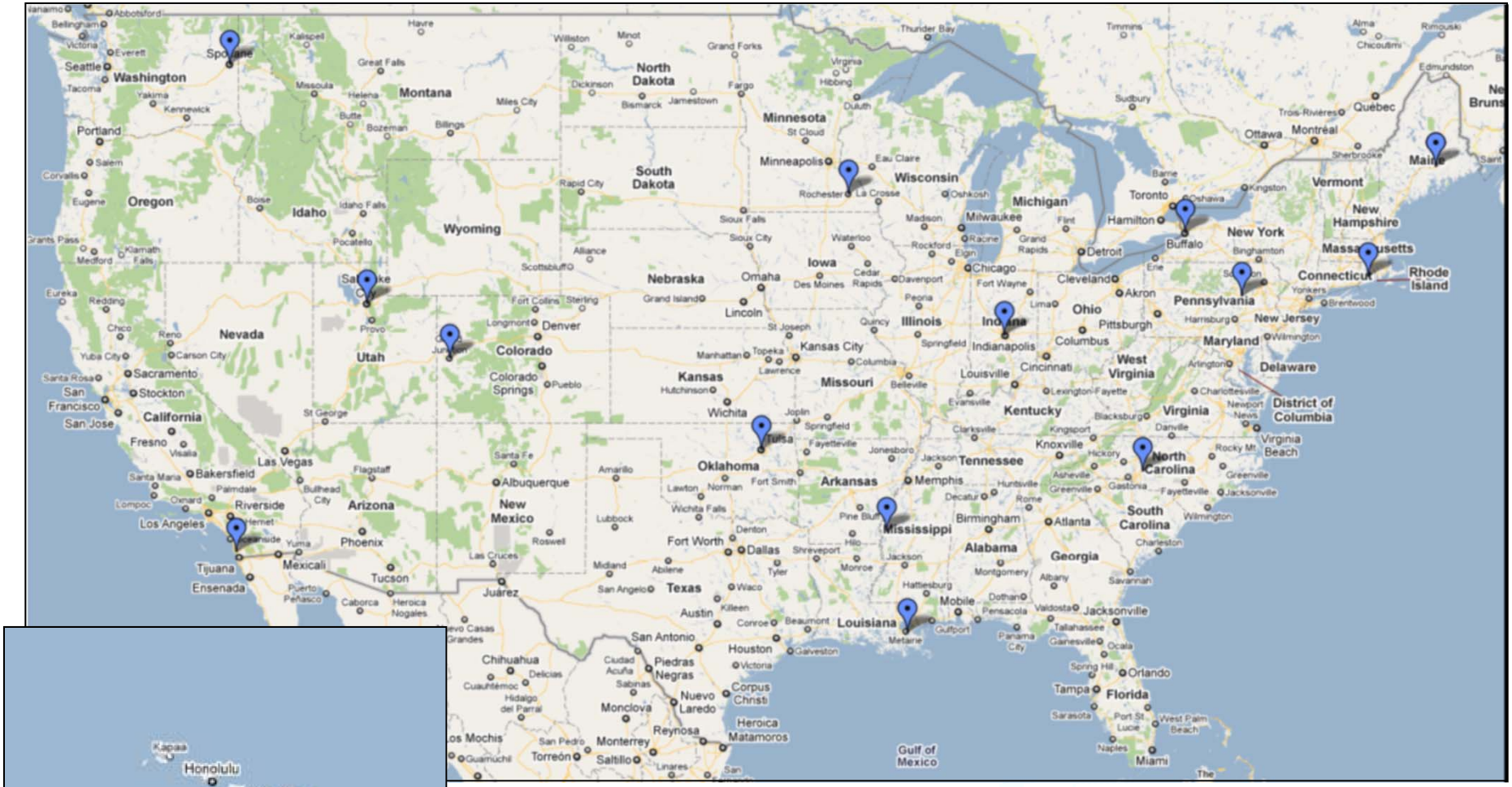
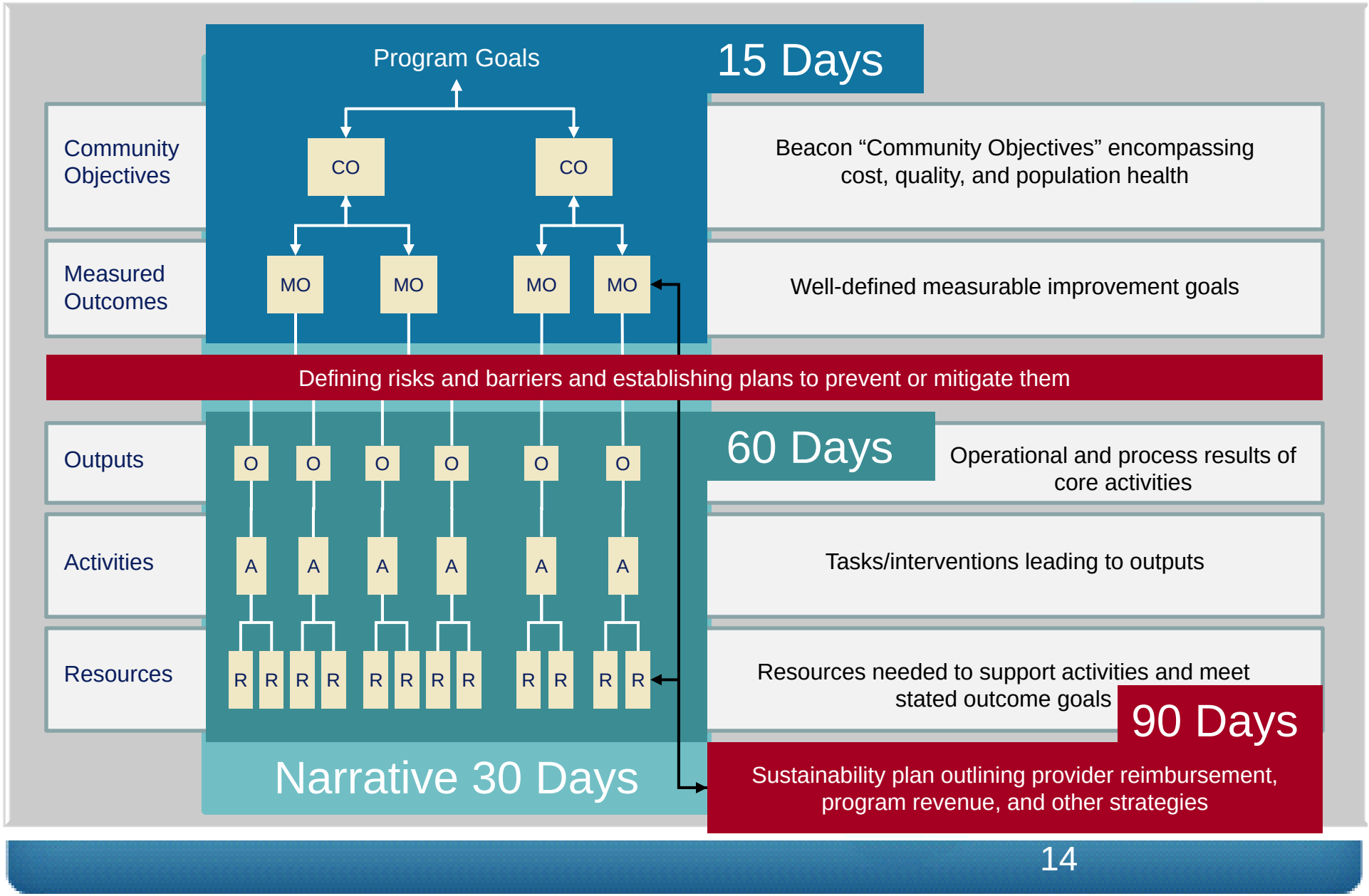
Round 1 Beacon Communities



Beacon Communities

Lead Organization	Location
Community Services Council of Tulsa	Tulsa, Oklahoma
Delta Health Alliance	Stoneville, Mississippi
Eastern Maine Healthcare System	Brewer, Maine
Geisinger Clinic	Danville, Pennsylvania
HealthInsight	Salt Lake City, Utah
Indiana Health Information Exchange	Indianapolis, Indiana
Inland Northwest Health Services	Spokane, Washington
Louisiana Public Health Institute	New Orleans, Louisiana
Mayo Clinic College of Medicine	Rochester, Minnesota
The Regents of the University of California, San Diego	San Diego, California
Rhode Island Quality Institute	Providence, Rhode Island
Rocky Mountain Health Maintenance Organization	Grand Junction, Colorado
Southern Piedmont Community Care Plan, Inc.	Concord, North Carolina
University of Hawaii at Hilo	Hilo, Hawaii
Western New York Clinical Information Exchange	Buffalo, New York
HealthBridge	Cincinnati, Ohio
Southeastern Michigan Health Association	Detroit, Michigan

Beacon Community Workplan



Indiana Health Information Exchange

Service area	**Central Indiana**
Population	**1,154,294 people in target population** **2,700,000 people in geographic service area**
Summary of Action Plan	**HIE-based measurement and provider feedback** **P4P, accountable care organizations and payer engagement** **Remote telemonitoring**

Selected Performance Improvement Goals

Quality	Population Health	Cost/Efficiency
Increase by 10% the proportion of diabetic patients with controlled blood sugar levels (HbA1c<9.0%) Increase by 10% the proportion of diabetic patients whose cholesterol is controlled	Increase by 5% the proportion of patients screened for colorectal and cervical cancer Increase by 5% the rate of adult immunizations, with an initial emphasis on the flu	Reduce by 3% the number of ambulatory care sensitive (ACS) hospital admissions Reduce by 3% the number of ACS emergency visits Reduce by 10% the number of ACS readmissions Reduce by 10% the number of redundant radiologic studies

Rocky Mountain Health Maintenance Organization

Service area	**Grand Junction Area, CO**
Population	**298,028 target population/people in geographic service area**
Summary of Action Plan	**HIE-based performance measurement and feedback** **HIE-based care coordination in conjunction with PCMH payment reform** **Technology-enabled patient activation**

Selected Performance Improvement Goals

Quality	Population Health	Cost/Efficiency
Ensure that all identified hypertension patients are in the 90th percentile based on national data Ensure that all identified diabetic patients are in the 90th percentile based on national data	Increase the number of children immunized within the 90th percentile Increase by 5% the number of uninsured children who are immunized at equivalent rates to other populations Increase the number of all patients immunized greater than 5% above the 90th percentile	Reduce unnecessary emergency department utilization among children ▪ 5% Medicaid and uninsured, 1% privately uninsured Reduce unnecessary hospital readmissions within 90 Days of Discharge in Children ▪ 2% Medicaid and uninsured, 0.5 % privately uninsured

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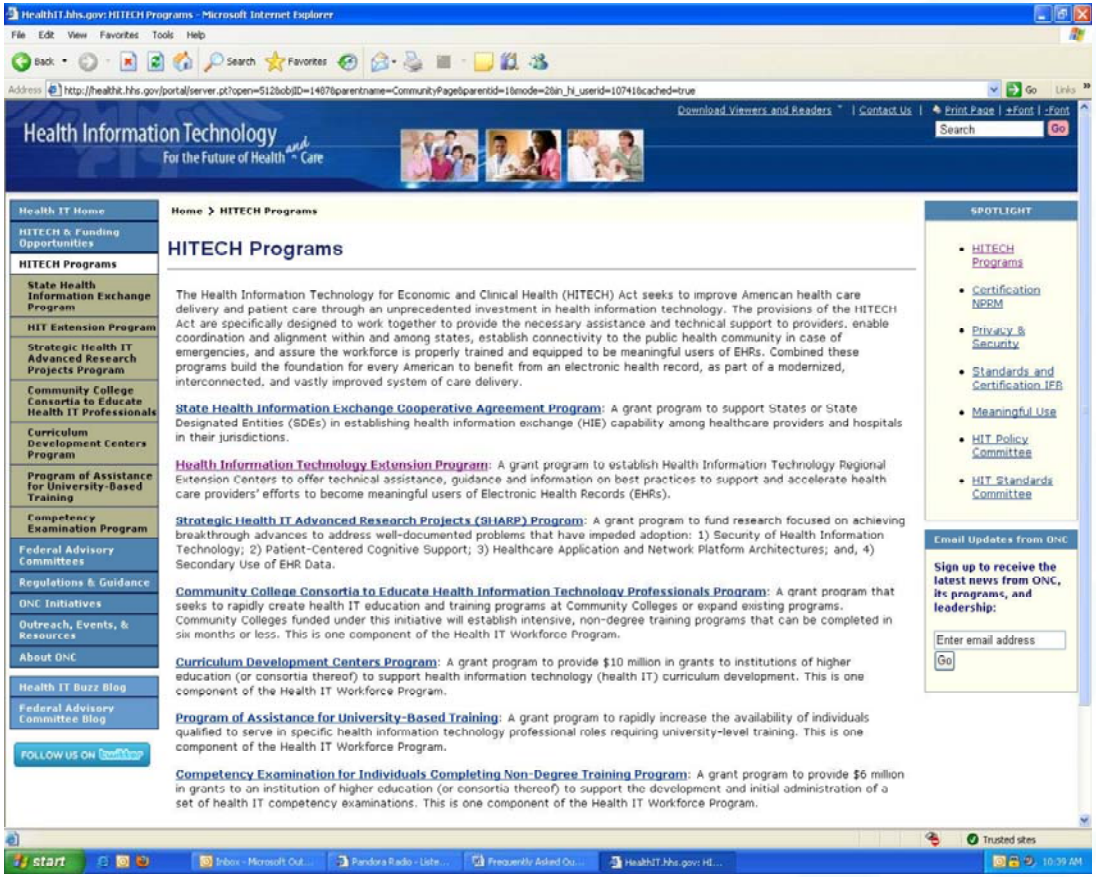
For More Information

Visit the ONC Web site: **healthit.hhs.gov**



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Conclusion and Discussion Questions

- How do the ONC programs and PCPCC partners best align to support regional improvement?
- What is the optimal way to ensure coordination at both the local and national levels?
- How do we ensure that the lessons learned from communities participating in various regional programs are shared in a broader learning network?