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
## How HITECH Addresses Barriers to Adoption

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

*$27.3 B is high scenario
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

*Note: Applicable regions across the nation may also be supported by the Indian Health Board Regional Extension Center, headquartered in Washington DC.*
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
Beacon Community Program: Conceptual Model

Sustainable Quality & Efficiency Improvements

Care Delivery Innovations
- Decision support
- Rx management
- Care coordination
- Discharge planning

Measurement & Provider Feedback
- Quality
- Efficiency
- Population health

Payment Reform
- Accountable care organizations
- Bundled payments
- Advanced medical homes

Foundation of Health IT
Electronic health records and information exchange
Round 1 Beacon Communities
Beacon Communities

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

Program Goals

15 Days

Beacon “Community Objectives” encompassing cost, quality, and population health

Well-defined measurable improvement goals

Defining risks and barriers and establishing plans to prevent or mitigate them

60 Days

Operational and process results of core activities

Tasks/interventions leading to outputs

Resources needed to support activities and meet stated outcome goals

90 Days

Sustainability plan outlining provider reimbursement, program revenue, and other strategies

Narrative 30 Days

Community Objectives

Measured Outcomes

Outputs

Activities

Resources
# Indiana Health Information Exchange

<table>
<thead>
<tr>
<th>Service area</th>
<th>Central Indiana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>1,154,294 people in target population 2,700,000 people in geographic service area</td>
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</tbody>
</table>

## Summary of Action Plan
- HIE-based measurement and provider feedback
- P4P, accountable care organizations and payer engagement
- Remote telemonitoring

## Selected Performance Improvement Goals

<table>
<thead>
<tr>
<th>Quality</th>
<th>Population Health</th>
<th>Cost/Efficiency</th>
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</thead>
<tbody>
<tr>
<td>Increase by 10% the proportion of diabetic patients with controlled blood sugar levels (HbA1c&lt;9.0%)</td>
<td>Increase by 5% the proportion of patients screened for colorectal and cervical cancer</td>
<td>Reduce by 3% the number of ambulatory care sensitive (ACS) hospital admissions</td>
</tr>
<tr>
<td>Increase by 10% the proportion of diabetic patients whose cholesterol is controlled</td>
<td>Increase by 5% the rate of adult immunizations, with an initial emphasis on the flu</td>
<td>Reduce by 3% the number of ACS emergency visits</td>
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<td></td>
<td>Reduce by 10% the number of ACS readmissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce by 10% the number of redundant radiologic studies</td>
</tr>
<tr>
<td>Service area</td>
<td>Grand Junction Area, CO</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
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<td></td>
</tr>
<tr>
<td>Population</td>
<td>298,028 target population/people in geographic service area</td>
<td></td>
</tr>
</tbody>
</table>
| 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**

<table>
<thead>
<tr>
<th>Quality</th>
<th>Population Health</th>
<th>Cost/Efficiency</th>
</tr>
</thead>
</table>
| 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 |
For More Information

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