Update on HIT, GME and Delivery System Redesign

Thomas Tsang, MD, MPH, FACP
Healthcare Senior Advisor
Office of the Governor, State of Hawai'i
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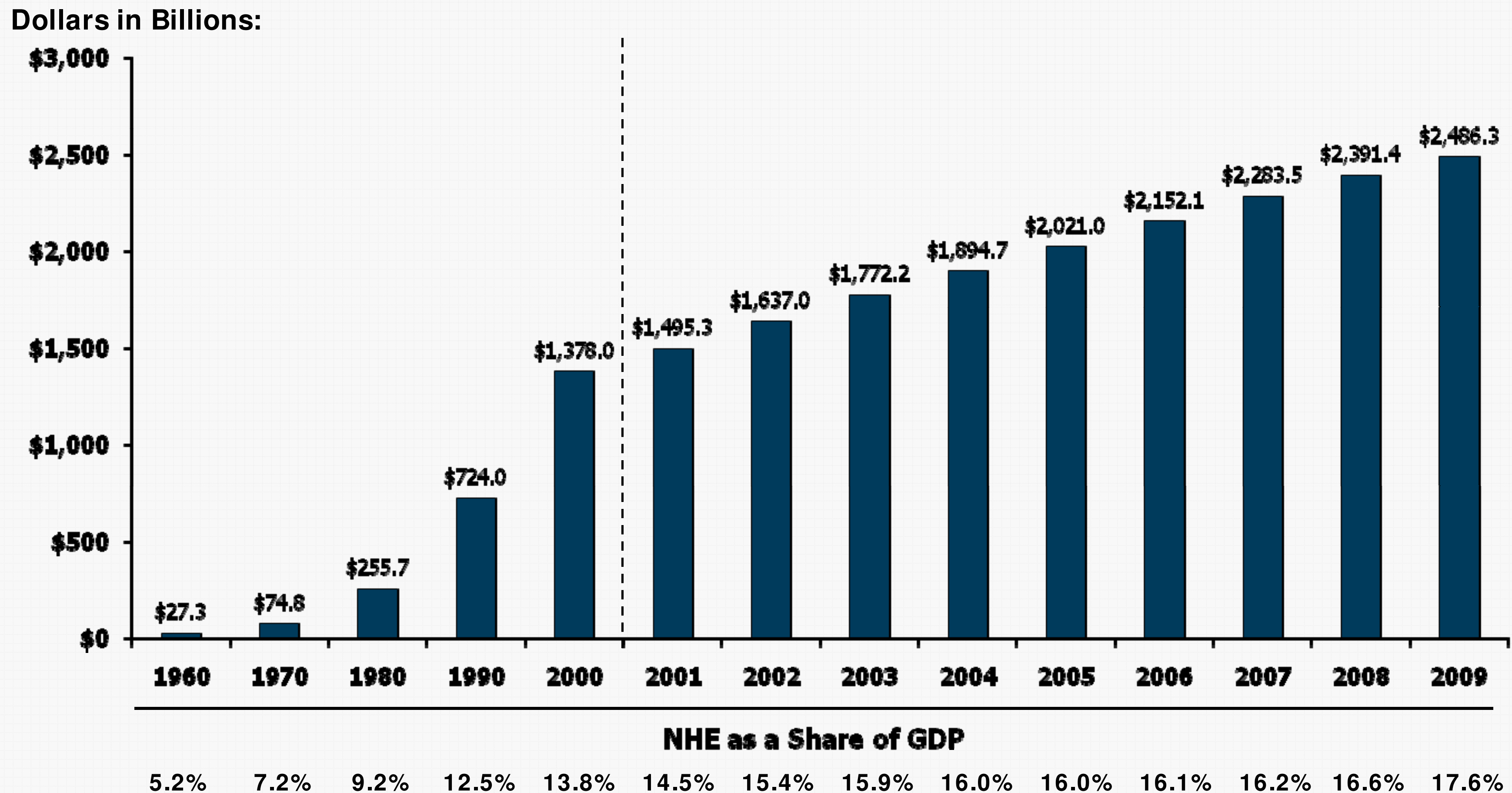
Disclaimer

I have no relevant financial interest in any of the commercial companies that are included in this presentation.

Topics

- National Trends
- ACA
- Innovations
- HIT in training
- Conclusion

National Health Expenditures and Their Share of Gross Domestic Product, 1960-2009



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2009; file nhegdp09.zip).

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SUMMARY	IMPLICATIONS
Patient-Centered Medical Homes (Section 3502)	
Community-based, interdisciplinary inter-professional teams that support primary care practices	Will drive improved organization of outpatient care
Government to provide grants or enter into contracts with eligible entities	Will fund care coordination and a team-based approach
Accountable Care Organizations (Section 3022)	
Shared-savings program that encompasses primary care, specialist practice, and hospitals	Requires vertical coordination
Care processes to be redesigned for the efficient delivery of high-quality services	Most of the savings are likely to come from acute care sector
Bundled Payments (Section 3025)	
Pilot program	Will provide incentives for care-delivery systems to reduce costs in order to increase margins
Applicable to eight conditions selected by the Secretary of Health	
An ‘episode’ of care defined as the period from 3 days before admission through 30 days after discharge	
Readmissions Reduction Program (Section 3025)	
Reduces payment for readmissions	Will motivate hospitals to engage with care coordinators and organize delivery systems better
Applicable to three conditions selected by the Secretary of HHS; to be expanded in 2014	
Secretary to determine definition of ‘readmissions’	
Hospital-Acquired Conditions (Section 3008)	
Payments for care for hospital-acquired conditions to be reduced, starting in 2015	Will provide hospitals an incentive to standardize protocols and procedures to reduce hospital-acquired conditions
Individual hospitals’ infection data to be made available online	

Medicaid Cost-Containment

- Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020.
- Distribution of DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured
- Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)

Medicaid Payment Reforms

- New Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditionsto designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion. (Effective January 1, 2011)
- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016);
- Make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012);

Kaiser Family Foundation

Primary Care Payment Reforms

- Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013)
- Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. (Effective for five years beginning January 1, 2011)

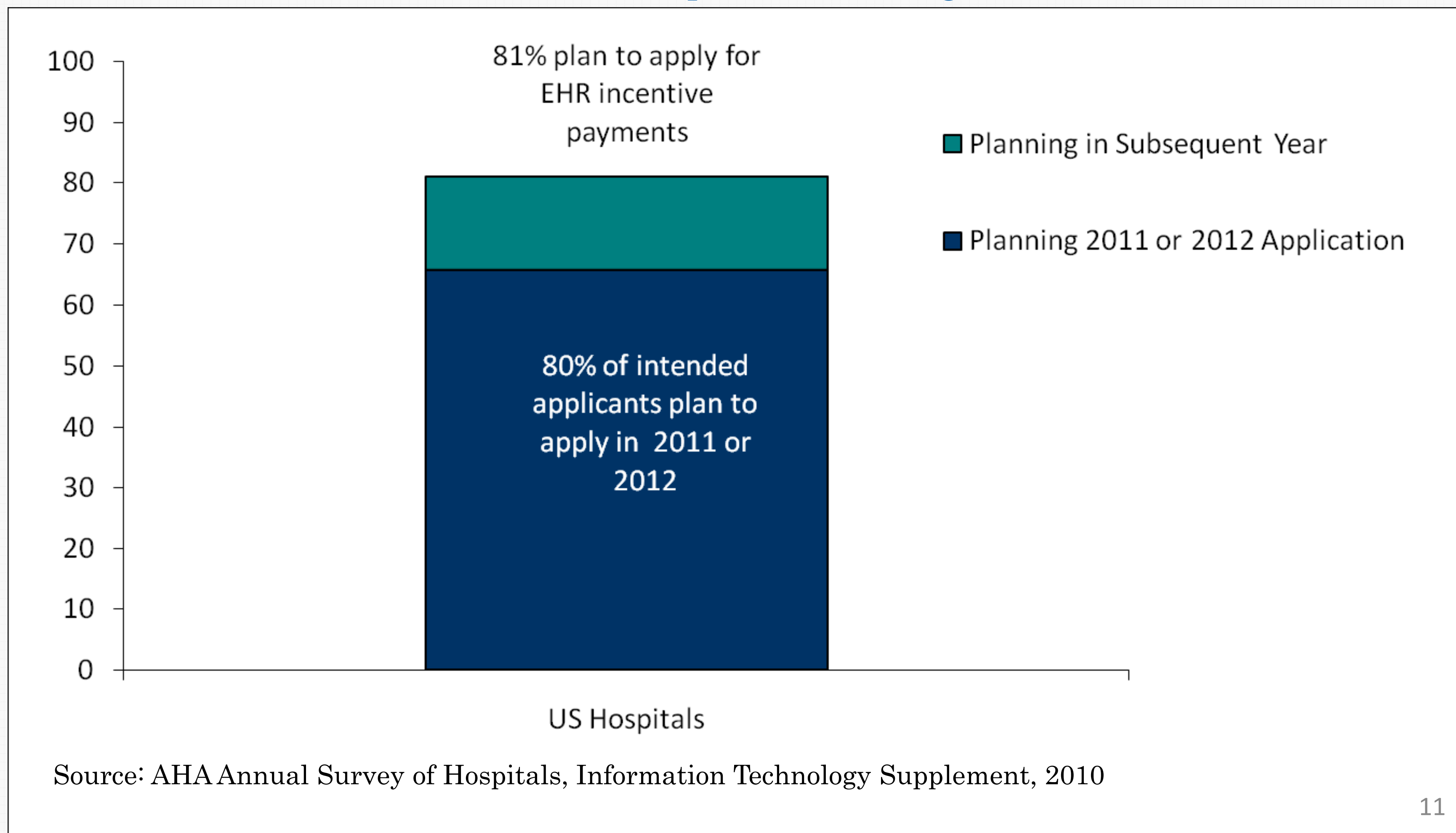
Workforce Provisions

- Increase workforce supply and support training of health professionals through scholarships and loans;
- Support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas;
- Establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health;
- Promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary)

HIT Landscape

81% of Hospitals Plan to Apply for MU

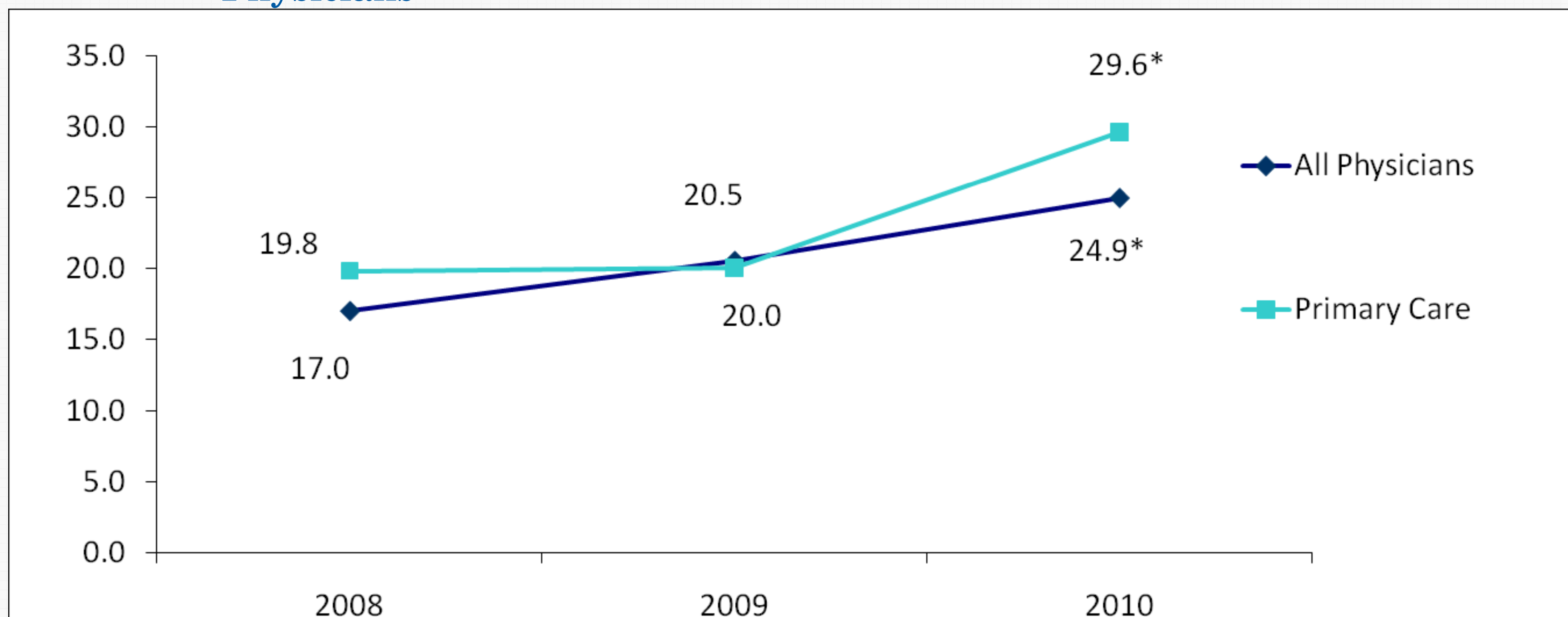
Figure 1.2: Intent to Apply for Medicare/Medicaid EHR Incentive Program Among Non-Federal Acute Care Hospitals (Meaningful Use intent)



Source: AHA Annual Survey of Hospitals, Information Technology Supplement, 2010

Steady Growth in EHR Adoption Overall; Jump for Primary Care Physicians

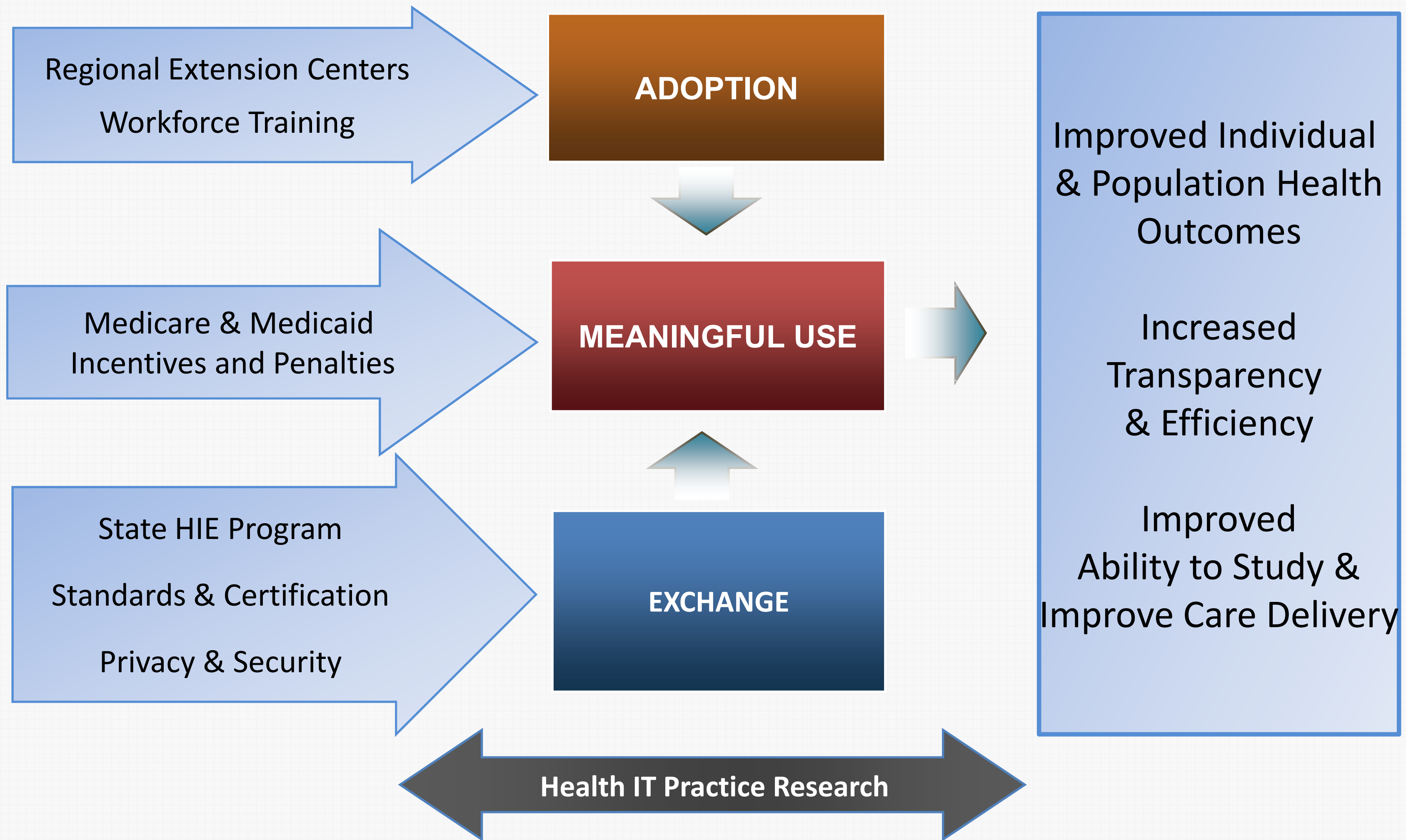
Figure 1.3 : Percent Adoption of Electronic Health Records Among Office-based Physicians*



*Adoption of "Basic" electronic health records as defined in Hsiao CJ, et al. Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians: United States, 2009 and Preliminary 2010 State Estimates Health E Stats. National Center for Health Statistics, Centers for Disease Control. Source: Physician

Source: National Center for Health Statistics, Centers for Disease Control, NAMC (National Ambulatory Medical Care) Survey (mail-only respondents), 2008-2010

HITECH Framework: Meaningful Use at its Core



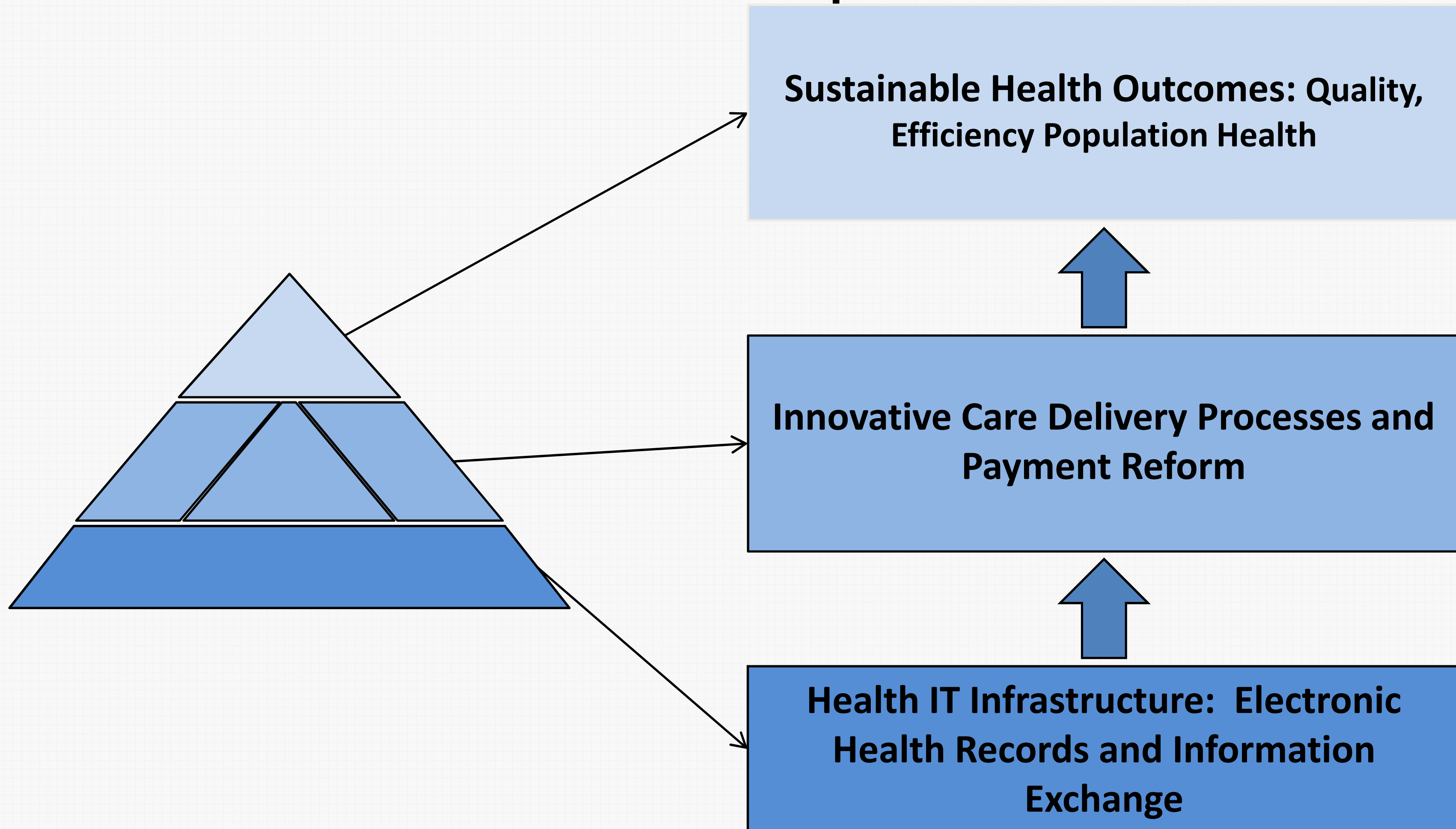
ONC’s five year strategic plan

1. Achieve adoption and information exchange through meaningful use of health IT.
2. Improve care, improve population health, and reduce health care costs through the use of health IT.
3. Inspire confidence and trust in health IT. This is the focus on privacy and security to build trust with providers and consumers.
4. Empower individuals with health IT to improve their health and the health care system. This is using HIT to engage consumers through better access and tools.
5. Achieve rapid learning and technological advancement. This is using HIT to enable innovation and generate knowledge about care across populations

E-prescribing adoption

- Surescripts announced that over half of US-based physicians are now using e-prescribing. This includes over 350K prescribers.
- Adherence and ROI. Electronic prescribing is having a positive impact on primary adherence. Surescripts study showing a 7% increase in patient pick-up of first-fill prescriptions when they are electronic.
- CVS Caremark also released research showing a strong ROI for medication adherence on downstream medical costs.

The Ultimate Goal of Improved Health



Value Based Payments

- Clinical Quality Metrics need to be reported or improved
- Clinical Quality Measures are reported via claims or EHR data
- Measure will play a new critical role in shaping provider behavior
- Providers and Hospitals will receive penalties on payments or incentives based on quality improvement or attainment

Outcome based Payment System Using Quality Measures

- Measures are transitioning from claims-based to electronic-measures
- Electronic measures will be used to evaluate provider performance for payment purposes (VBP, ACOs, PQRS, MU, Patient Centered Medical Homes, HEDIS)
- Measures will be calculated based on clinical information in EHR using standardized codesets (PQRS and MU are using already)

Hospital Payment Interactions

- Hospital Acquired Infections
  - HACs reported through claims do not qualify DRG payment for severity adjustment-potentially – potentially .02% reduction
- Meaningful Use
  - reduction to annual market basket update by ¼, ½, and ¾ in 2015, 2016, and 2017, respectively for hospitals that have not qualified as meaningful users.
- Hospital Inpatient Quality Reporting
  - 2% reduction in annual market basket update for non-reporting of clinical quality measures

New Health IT sector growth

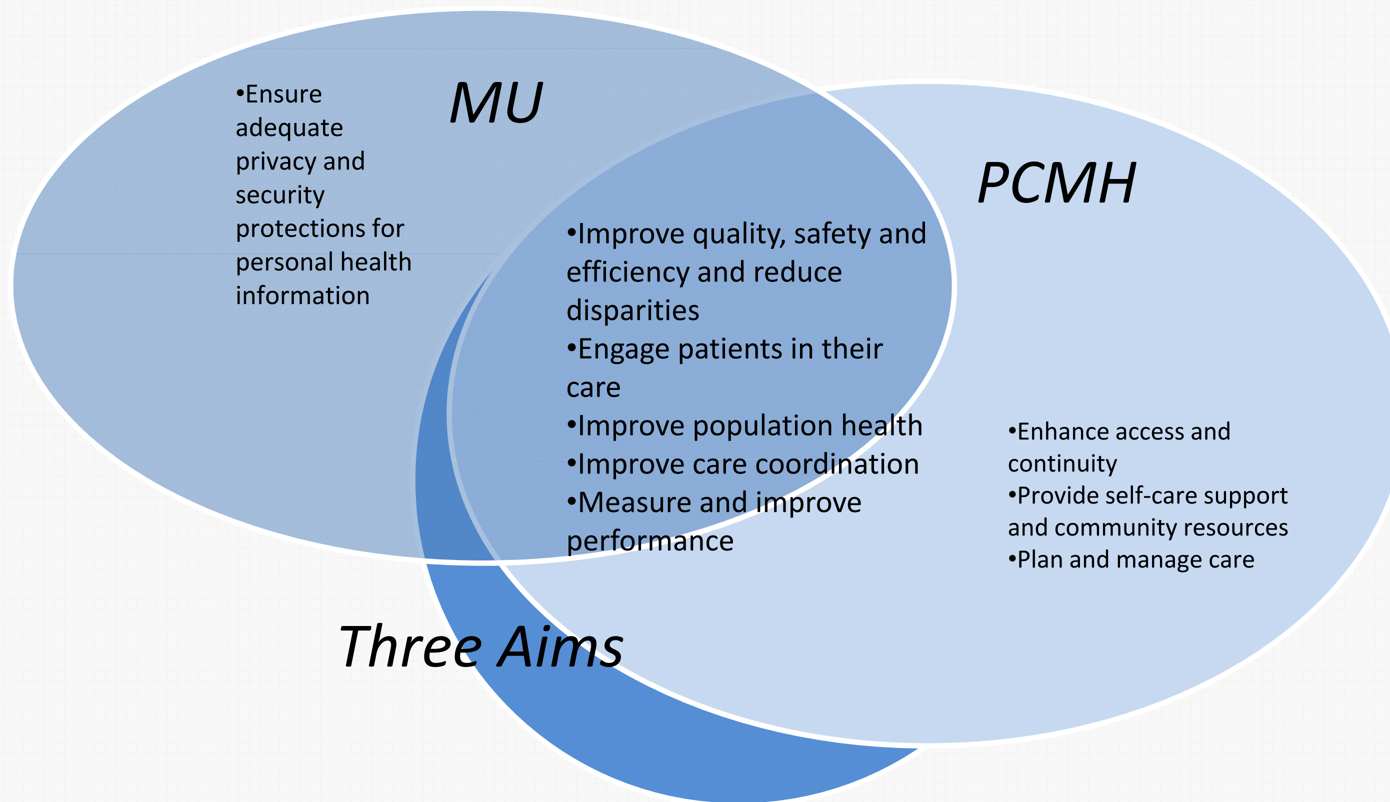
- Over 1100 products certified
- New emerging field of analytics and risk prediction (Humana/Medco, Archimedes/Kaiser)
- Payers in HIT exchange (Aetna buying Medicity, United buying Axolotyl)
- Health IT Challenges and VC funding for new start-ups (games, analytics, population management tools)

PCMH 2011's alignment with meaningful use:

- Electronic prescribing
- Drug formulary, drug-drug, drug allergy checks
- Maintaining an up-to-date problem list of current and active diagnoses and medications
- Recording demographics on preferred language gender, race, ethnicity and date of birth
- Recording and charting changes in vital signs
- Recording smoking status
- Reporting ambulatory quality measures
- Implementing clinical decision support rules

Source: NCQA

PCMH & MU Crosswalk



Six HIT domains cross-walked with ACO

HIT Segments	Health IT Tools
1. Clinical information and point-of-care automation	Integrated ambulatory and inpatient records and a central clinical data repository
2. Enterprise data management and integration	Population management repository; master person and provider indexes
3. Health information exchange	Data exchange via push and pull from heterogeneous systems
4. Patient engagement	Patient portals and secure messaging E-visits, tele-visits, telemedicine, telemonitoring Patient maintained personal health record Social media and mobile health apps
5. Care management and coordination	Provider-to-provider communication including referral and request tracking Close-loop order processing and medication reconciliation Case and disease management applications including discharge planning and management
6. Performance management	Provider level quality and efficiency data collection Integrated business and clinical intelligence and analytics Real-time reporting and alerts including enterprise performance

HIT Enabling ACO Functionalities

ACO HIT "Domains"	HIT Tools
Clinical information at point of care	IntegratedEHRs from "virtual network" with access from "exchange"
Health Information Exchange	Ability to "push" and "pull" from clinical repository accessible to network
Patient Engagement	Patient portals, patient reported outcomes and risk assessment
Care coordination and care management	Transitions of care- medication reconciliation; closing the referral loop; longitudinal care records; "Direct" secure messaging
Provider Feedback/Quality Improvement	Quality measure analytics;

NQS Priorities Supported by

National Quality Strategy Priorities	HITPC-Proposed Stage 2 MU Requirement
Making care safer by reducing harm caused in the delivery of care	Electronic medication administration record (eMAR) Safety-related clinical quality measures (CQMs)
Ensuring that each person and family are engaged as partners in their care	View & download (similar to Blue Button) Secure messaging New patient-reported CQMs Recording patient preferences
Promoting effective communication and coordination of care	More robustHIE expectations Shared care plan List of care team members
Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease	Higher thresholds

GME and HIT

MedPAC recommendations

- Medicare invests close $10B in GME 2010
- MedPAC concluded that the the GME system must join others in transforming the US healthcare system; ACGME has taken efforts to re-orient the system– but process has been "slow" (Glenn Hackbarth NEJM 2/14/11)
- $3.5 B (IME portion) should be carved out for "incentive based" performance metrics placed on residency programs
- Joint Select Committee on Deficit Reduction considered reducing CMS support of GME

MedPACrecommendations

- MedPAC recommended that Congress give the HHS the authority to modify the current system of funding for GME in order to "support medical education that supports skills needed in a delivery system that reduces cost growth while maintaining or improving quality.”

Recommended Standards

- **Quality measurement and improvement, evidence-based medicine, multidisciplinary teamwork, care coordination across settings, and health information technology**
- Additional concepts to focus on: practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, including integration of community-based care and hospital care

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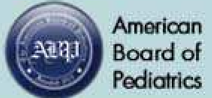

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Activity Profile

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Sponsor(s)	American Board of Pediatrics
Title	2011 Electronic Health Records: Improving Care
Description	The Electronic Health Records: Improving Care Self-assessment contains approximately 60 items that address a broad range of topics related to knowledge that physicians should know to use electronic health records to improve care. Each item is a single-best-answer with five options. A full text reference list is provided for your use to prepare in advance for this self-assessment and as you are answering each item. A narrative description of the correct answer is provided after a candidate commits their response. Note: Self-assessment exercises remain on the menu for three years. Candidates are required to complete the assessment before the end of their Maintenance of Certification cycle.
Completion Criteria	Approximately 10 to 15 hours will be required to read the reference citations and answer the questions presented in this assessment. Once you begin the assessment, you have until the end of your MOC cycle to complete it, but are not required to complete it in one sitting. You must answer all items in the self-assessment and answer 80% of them correctly in order to receive credit for this exercise.
Credit Approval Period Begin Date	09/26/2011
Credit Approval Period End Date	12/31/2013
MOC Part	Part 2
MOC Point Value	20
CME Available	No
Specialty	General Pediatrics
Eligibility	Open
Diplomate Direct Cost	Included with MOC enrollment fee
Participation	Individual
	Launch Activity

Using Your ABP Portfolio
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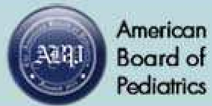

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Online Module:
2011 Electronic Health Records: Improving Care

Welcome to the ABMS Knowledge Self-assessment for physicians entitled "Electronic Health Records: Improving Care." The ABMS, working with the American Board of Pediatrics (ABP), the American Board of Family Medicine (ABFM), and the American Board of Internal Medicine (ABIM), under a contract to the ABMS-Research and Education Foundation from the Office of the National Coordinator (ONC), has developed a self-assessment exercise consisting of 50 single-best-answer questions, with full text references, to help physicians understand the use of EHRs to improve care, protect patient privacy, and meet requirements of Meaningful Use to receive financial assistance in implementing EHRs. This module is intended for use by all physicians across specialties and was developed by a team of six experts in medical informatics from multiple disciplines. The American Medical Informatics Association (AMIA) provided the literature review. One to three hours will be required to complete this self-assessment, depending upon prior knowledge of EHR use. A passing score of 80% is required but there are no limits on the number of times the assessment can be taken. Completing this module will qualify you for MOC Part 2 credit.

Content Experts

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MOC KNOWLEDGE SELF-ASSESSMENTS PLATFORM

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Welcome to the Knowledge Self-assessments (KSA) Platform

What Can I Do Here?

- Select a KSA to the right to:
  - Earn MOC credit (May not apply to all Boards)
  - Access KSA reference material
  - Access topic-related simulations to earn additional MOC credit
- Track your Progress in the **My KSAs** section of this website.
- Keep your profile up to date in the **My Profile** section of this website.
- Visit the **Support** pages if you need help.

Latest KSAs

Electronic Health Records: Improving Care

Date Added: 03/11/2011

Assess your knowledge of health information technology and how it can be used to improve patient care and safety.

Go to Overview »

MOC *Sponsored by: The Office of National Coordinator for Health Information Technology*

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MOC KNOWLEDGE SELF-ASSESSMENTS PLATFORM

KSA: *Electronic Health Records: Improving Care*

Release Date: 03/11/2011

Overview

Assess your knowledge of how to use electronic health records to improve patient care.

Passing Score

To earn a passing grade and MOC credit for this KSA a score of 80% or higher is required. **You may take the KSA as many times as necessary to earn a passing grade.**

Instructions for Use

When answering questions there are three actions you can take:

1. Choose an answer and **Commit** your answer. You will not be able to change the answer after it is committed.
2. Choose an answer and **Hold** your answer. You will be able to change the answer until it is committed.
3. Skip the question by selecting **Next**. You can come back to skipped questions later.

If you choose an answer, but do not select either Commit or Hold the system will not remember your answer.

You can navigate between questions using the Next and Previous buttons. You can also navigate to questions using the Jump to Question drop-down menu. Click on the Progress tab for an overview and a status for each question.

Reference List

Read reference articles recommended by experts to improve your knowledge about using electronic health records to improve patient care. These articles were used to develop the self-assessment.
Download Reference PDF

KSA Module

Assess your knowledge of health information technology and how it can be used to improve patient care and safety.

Start Module Now

Issues to consider

- How can we train residents in the areas of team-based care?
- How can we incorporate innovations and HIT/MU areas within GME?
- How can we move from acute “sick” care to population health/preventive care models?
- How do we teach “value”/efficiency?

Mahalo