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Meaningful Use as the Foundation of the Medical Home

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Office of the National Coordinator for Health IT

Use computerized provider order entry (**CPOE**) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines

Record and chart changes in the following **vital signs**: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI

Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities

Generate and transmit permissible prescriptions electronically (**eRx**)

Record the following **demographics**: preferred language, sex, race, ethnicity, date of birth

Record patient **family health history** as structured data

Record **smoking status** for patients 13 years old or older

Use clinically relevant information to identify patients who should receive **reminders** for preventive/follow-up care and send these patients the reminders, per patient preference

Meaningful Use Stage 2

Clinical Quality Indicators

Incorporate clinical **lab-test results** into Certified EHR Technology as structured data

Record **electronic notes** in patient records

Use **clinical decision support** to improve performance on high-priority health conditions

Provide patients the ability to view online, download and transmit (**VDT**) their health information within four business days of the information being available to the EP

The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform **medication reconciliation**

Use clinically relevant information from Certified EHR Technology to identify patient-specific **education resources** and provide those resources to the patient

Generate lists of patients by specific conditions to use for **quality improvement**, reduction of disparities, research, or outreach

Provide **clinical summaries** for patients for each office visit

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a **summary care record** for each transition of care or referral

Capability to submit electronic **syndromic surveillance** data to public health agencies except where prohibited, and in accordance with applicable law and practice

Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT

Capability to identify and report specific cases to a **specialized registry** (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice

Capability to identify and report cancer cases to a public health central **cancer registry**, except where prohibited, and in accordance with applicable law and practice

Meaningful Use Stage 2

Medical Home
(best practices for many)

Medical Home
(required for most)

vital signs

e-prescribe (eRx)

Patient reminders

smoking status

family health history

computerized provider order entry (CPOE)

demographics

lab-tests

Clinical Quality Indicators

electronic notes

clinical decision support

view online, download and transmit (VDT)

medication reconciliation

education resources

quality improvement

summary care record

specialized registry

clinical summaries

syndromic surveillance

cancer registry

Protect electronic health information

Imaging results

Where We Began:
HITECH: Catalyst for Transformation

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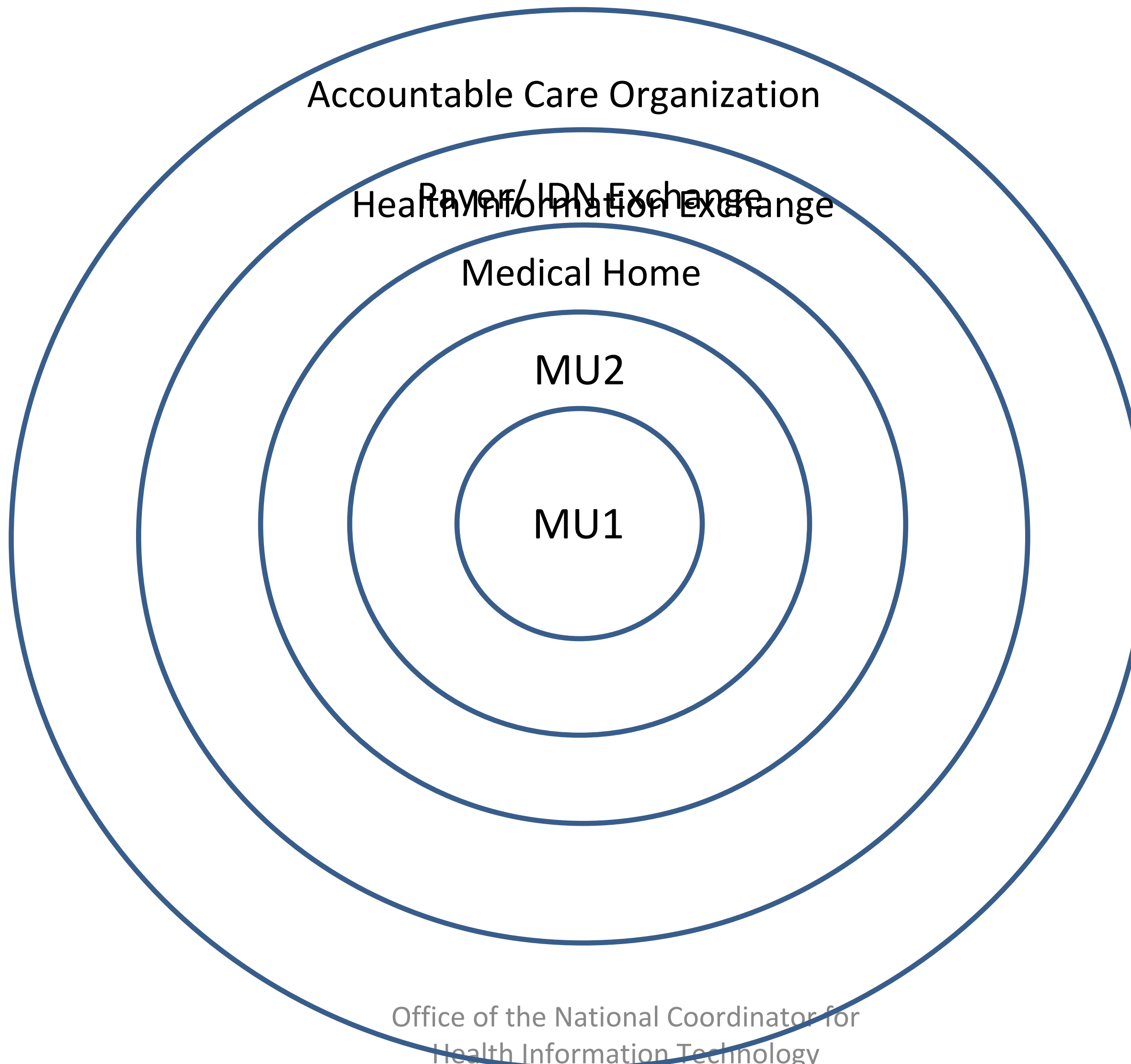
Better Healthcare | Better Health | Reduced Costs

HITECH Act
2009
Gives ONC authority to launch REC, HIE, Beacon & Workforce programs

EHRs & HIE
2014
Widespread adoption & meaningful use of EHRs

Payment Reform
2014+
Health IT Enabled Reform Models

Meaningful Use Stage 2: Foundational



Meaningful Use as a Building Block

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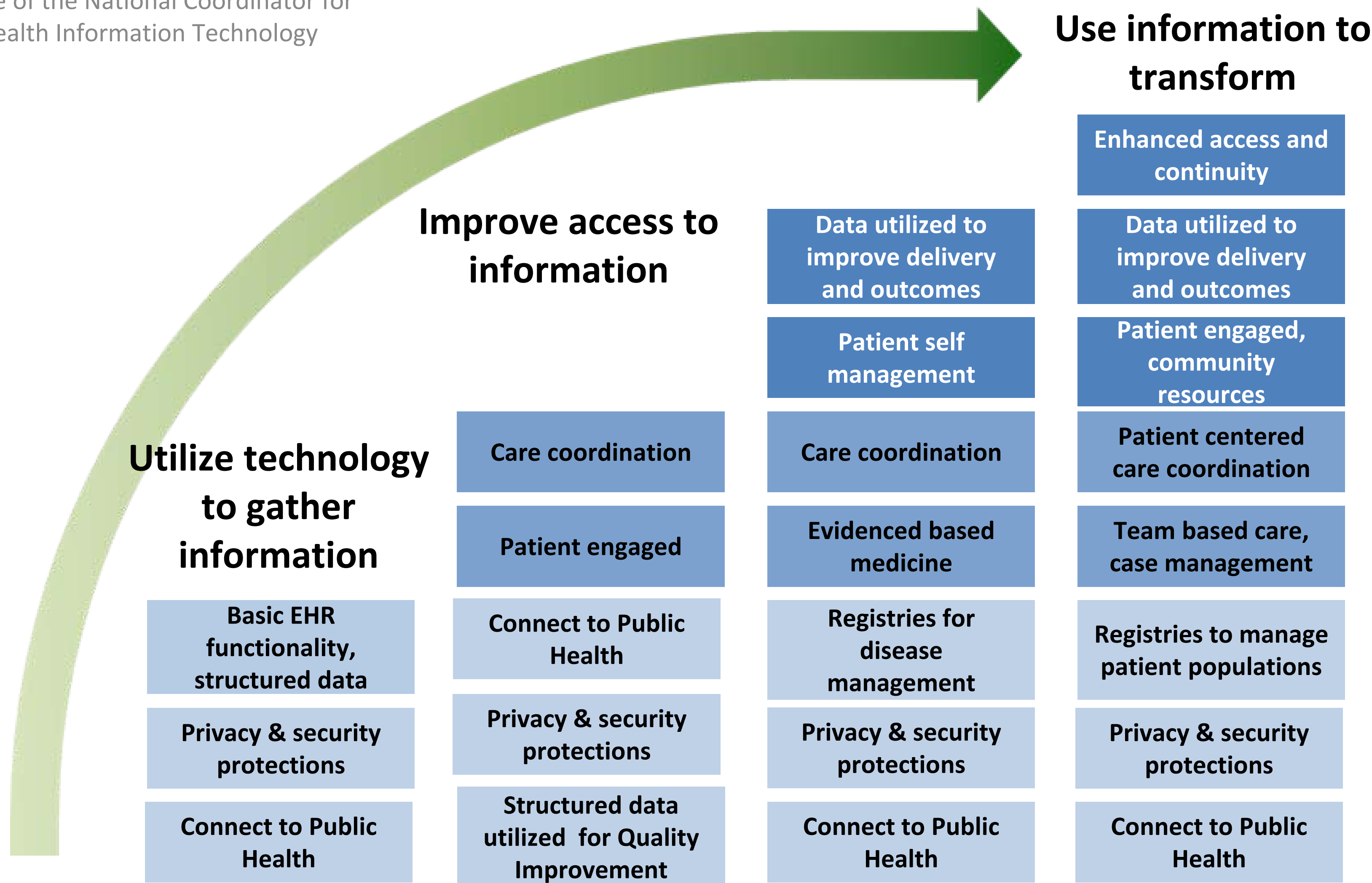

Meaningful Use 2: Return on Investment

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- MU1 & MU2 → Incentive Payments & Avoidance of Penalties
- Medical Home → Payer programs, Health system programs, Medicaid & Medicaid Managed Care programs
- Health Information Exchange → PQRS, Pay for Performance, HEDIS efficiencies, etc.
- Accountable Care Organizations → Payer led ACOs, provider led ACOs, Medicare ACOs, Medicaid ACOs

Meaningful Use: ROI Medical Homes

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Figure 1. Analysis of Seven PCMH Pilot Programs

Pilot	# of Patients	Population	Incentives	Results: Hospitalization reduction (%)	Results: ER visit reduction (%)	Results: Total savings per patient
Colorado Medical Homes for Children	10,781	Medicaid CHP+	Pay for Performance (P4P)	18%	NA	$169–530
Community Care of North Carolina	> 1 million	Medicaid	Per Member Per Month (PMPM) payment	40%	16%	$516
Geisinger (ProvenHealthNavigator)	TBD	Medicare Advantage	P4P; PMPM payment; shared savings	15%	NA	NA
Group Health Cooperative	9,200	All	TBD	11%	29%	$71
Intermountain Health Care (Care Management Plus)	4,700	Chronic disease	P4P	4.8–19.2%	0–7.3%	$640
MeritCare Health System and Blue Cross Blue Shield of North Dakota	192	Diabetes	PMPM payment; shared savings	6%	24%	$530
Vermont BluePrint for Health	60,000	All	PMPM payment	11%	12%	$215

Adapted from Fields D, Leshen E, and Patel K. "Driving quality gains and cost savings through adoption of medical homes," Health Affairs, May 2010; 29(5): 819-826. Appendix Exhibit 1.

Meaningful Use: ROI Medical Homes

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PCMHs lower costs for patients needing chronic care

Publish date: AUG 05, 2013

Print

By: Jeffrey Bendix, MA

Since the idea was first conceived, backers of the Patient-Centered Medical Home (PCMH) have claimed that the model can reduce costs while improving health outcomes for certain patient populations. Now additional evidence has emerged to support that claim.

A series of 3-year studies of PCMHs in Pennsylvania conducted by Independence Blue Cross (IBC) found "significant reductions in medical costs for patients with chronic conditions treated in primary care practices that have transformed into medical homes," according to an IBC news release.

The results were especially striking among patients with diabetes, which is one of the nation's most prevalent and costly chronic diseases. These patients saw a 44% reduction in hospital costs and a 21% reduction in overall medical costs. Diabetic patients treated in the studied PCMHs also saw a 60% improvement in getting their low-density lipoprotein levels under adequate control. Overall, the number of patients with poorly controlled diabetes declined by 45%, according to IBC.

http://medicaleconomics.modernmedicine.com/medical-economics/news/study-pcmhs-lower-costs-patients-needing-chronic-care

Meaningful Use: ROI Medical Homes

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Case Study #1: Success and Savings at Hill Air Force Base – Improving Quality While Reducing Costs

Beginning in 2009, the U.S. Air Force, Army, and Navy began working together to implement a Tri-Service Patient-Centered Medical Home project to transform care at all primary care practices throughout the Department of Defense (DOD). Among the DOD project sites that demonstrated positive results is Hill Air Force Base in Utah. Since the implementation of PCMH at Hill, the Air Force has saved money and improved the quality of care. By offering team-based care with individualized care plans for patients, encouraging continuity of care, and providing care management and rapid access to care, the project has improved blood sugar control for 77 percent of the diabetic population and stayed at or above 98 percent symptom control for patients with asthma. The Air Force estimates that the project has saved $300,000 per year just by improving their diabetes care.[2] According to Col. Donald Hickman, "Health care costs go up 8 to 15 percent per year nationwide and we have managed to drive down our network care costs about 4.5 percent over the last two fiscal years."[3] Additionally, patients were extremely satisfied with the program, reporting 95 percent satisfaction.

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404563/subassets/rwjf404563_3

Meaningful Use: ROI Medical Homes

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CareFirst PCMH program yields $98M in savings

15

June, 11 2013

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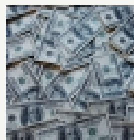
By: Frank Irving



CareFirst BlueCross BlueShield reported on June 6 that the second year (2012) of its patient-centered medical home (PCMH) program yielded cost savings of $98 million for 1 million members covered by the effort.

CareFirst, which covers 3.4 million individuals and groups in Maryland, the District of Columbia and Northern Virginia, said the results represent a savings of 2.7 percent on the total projected 2012 healthcare costs for PCMH-covered members and improve upon the 1.5 percent savings against projected costs registered by the program in 2011.

Approximately 66 percent of participating primary care panels – groups of physicians that join together to participate in the PCMH program – earned increased reimbursements for their 2012 performance in the program, according to CareFirst. Increased reimbursement levels – or Outcome Incentive Awards (OIAs) – are based on a combination of savings achieved by a particular panel against projected 2012 total care costs for CareFirst members and performance on quality measures related to the provision of care to the panel's patients, the not-for-profit company said.

http://www.healthcarepayernews.com/content/carefirst-pcmh-program-yields-98m-savings

Meaningful Use: ROI Medical Homes

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MEDICAL HOMES: A SOLUTION?

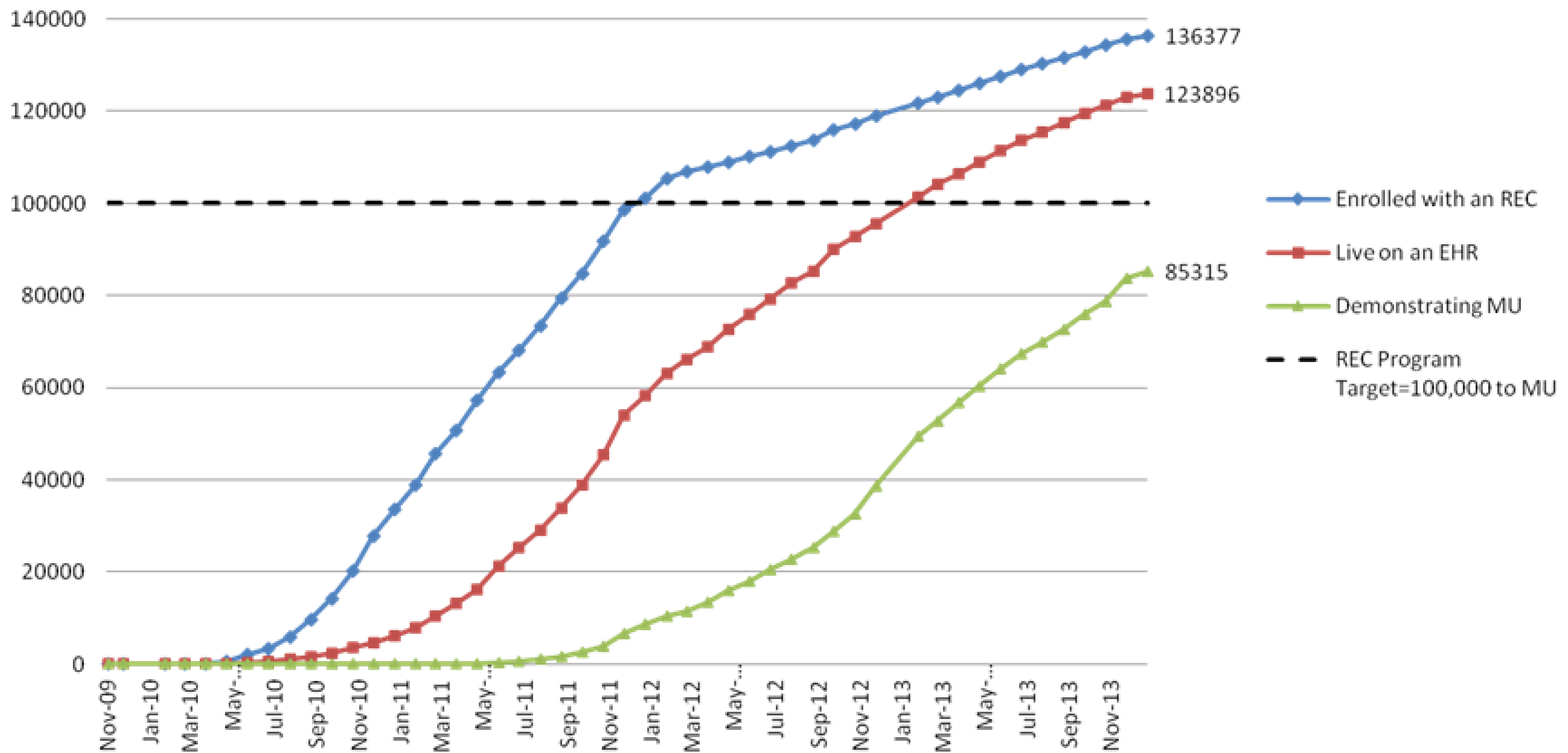
By Robert J. Reid, Katie Coleman, Eric A. Johnson, Paul A. Fishman, Clarissa Hsu, Michael P. Soman, Claire E. Trescott, Michael Erikson, and Eric B. Larson

The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction, And Less Burnout For Providers

ABSTRACT As the patient-centered medical home model emerges as a key vehicle to improve the quality of health care and to control costs, the experience of Seattle-based Group Health Cooperative with its medical home pilot takes on added importance. This paper examines the effects of the medical home prototype on patients' experiences, quality, burnout of clinicians, and total costs at twenty-one to twenty-four months after implementation. The results show improvements in patients' experiences, quality, and clinician burnout through two years. Compared to other Group Health clinics, patients in the medical home experienced 29 percent fewer emergency visits and 6 percent fewer hospitalizations. We estimate total savings of $10.3 per patient per month twenty-one months into the pilot. We offer an operational blueprint and policy recommendations for adoption in other health care settings.

http://www.ncqa.org/portals/0/public%20policy/reid_-_pcmh_success_8.30.12.pdf

Regional Extension Centers:
RECs – How we have grown…



SOURCE: Customer Relationship Management (CRM) Tool, maintained by Health and Human Services, Office of the National Coordinator for Health IT, data as of January 21, 2014..

RECs Engaged in Practice Transformation and Enabling the Three-Part Aim

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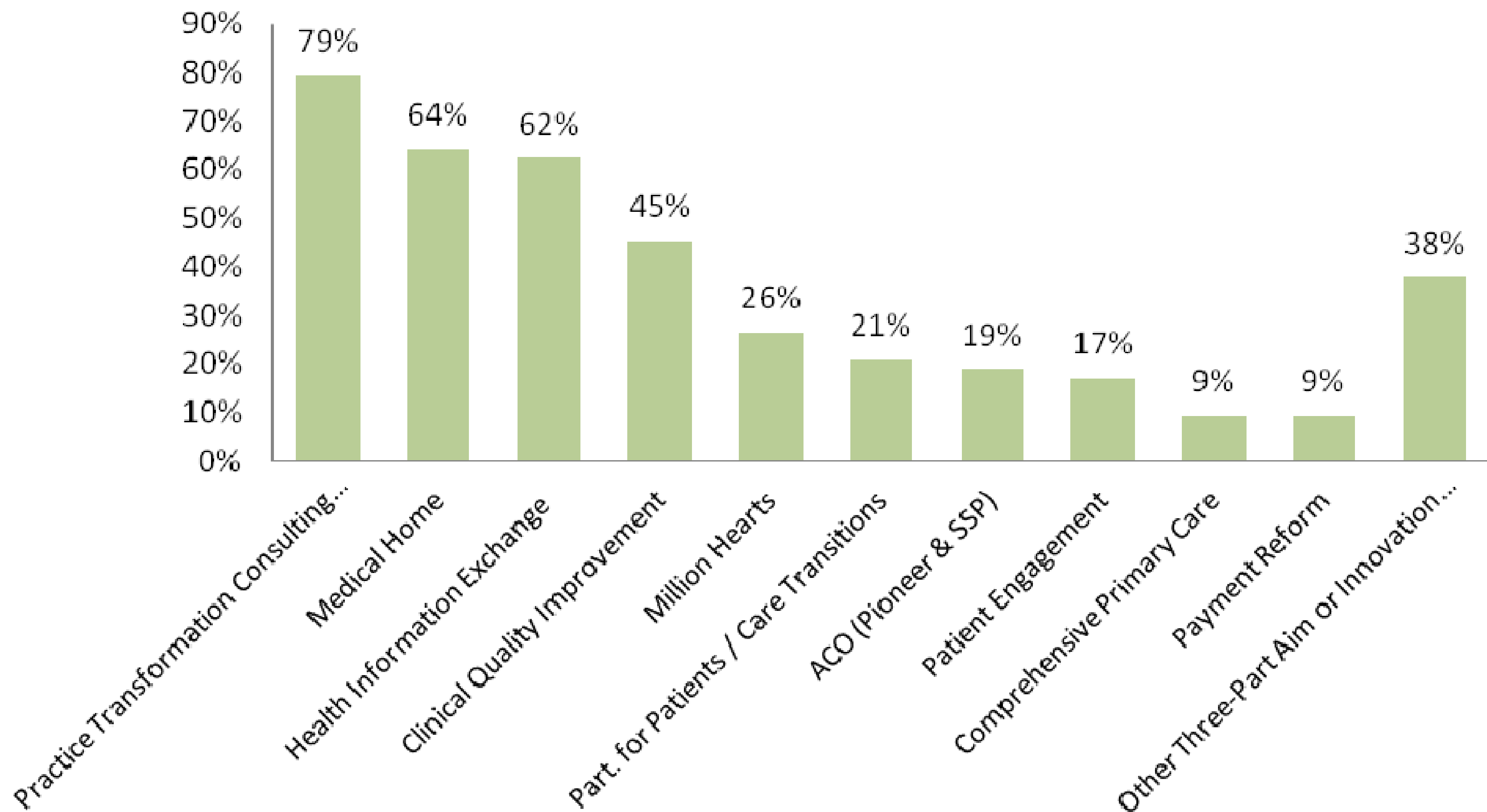
The national network of RECs are currently working on over 300 different programs to help providers transform their practices and demonstrate meet Three-Part Aim goals



** As reported by 56 out of 62 RECs. Many REC are working on several initiatives within each category.*

REC Enrolled By Certification Type

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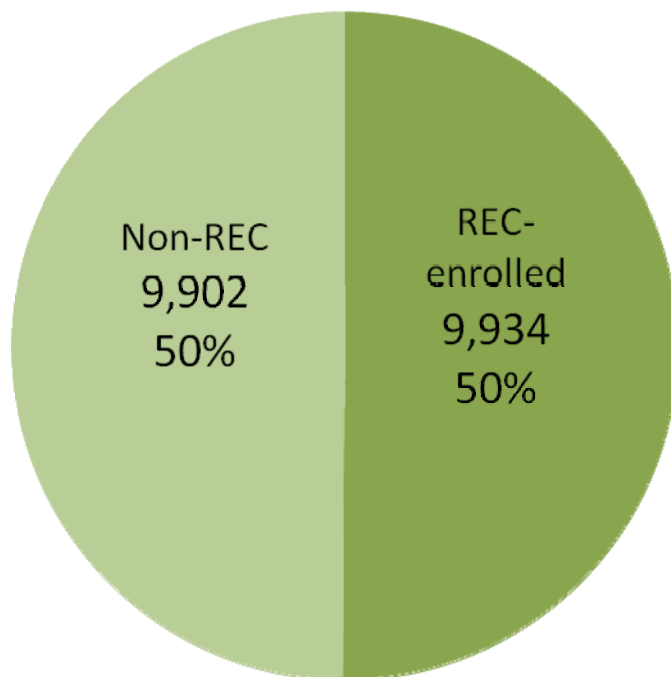
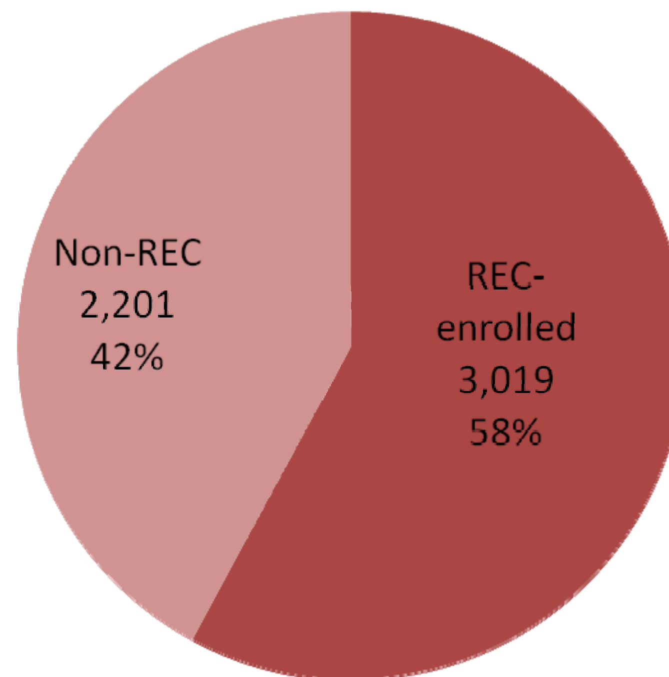
2008 Certified PCMH Providers

n=19,836



2011 Certified PCMH Providers

n=5,220



Based on ONC CRM data as of March 19, 2013, merged by provider NPI to NCQA PCMH data as of February 28, 2013.

Proportion of Certified REC Providers by Practice Setting

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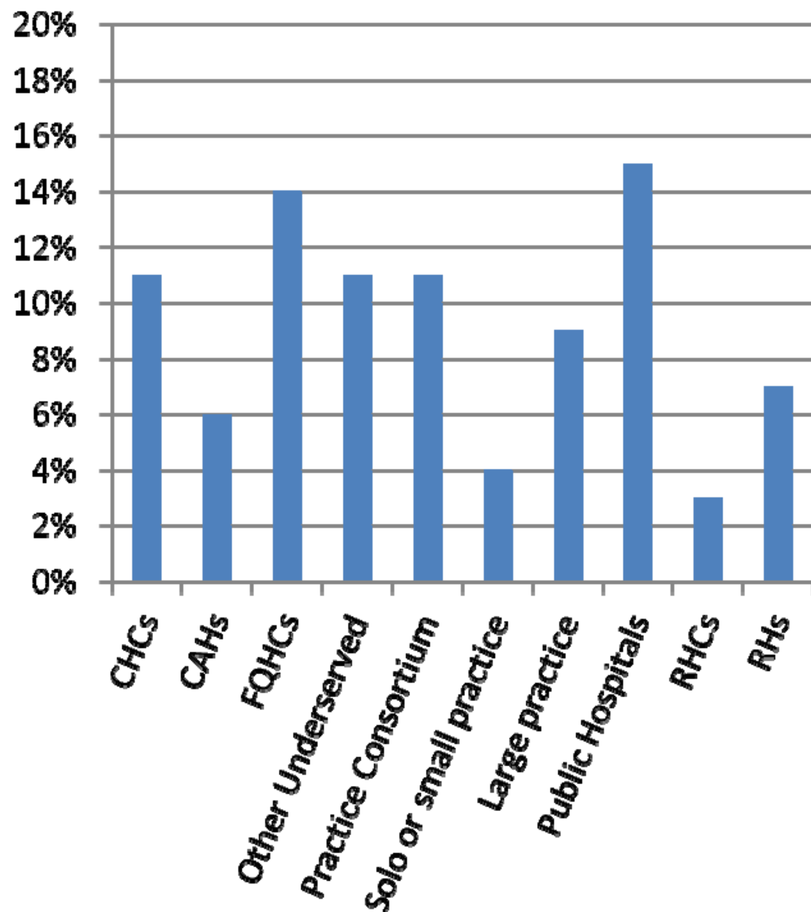
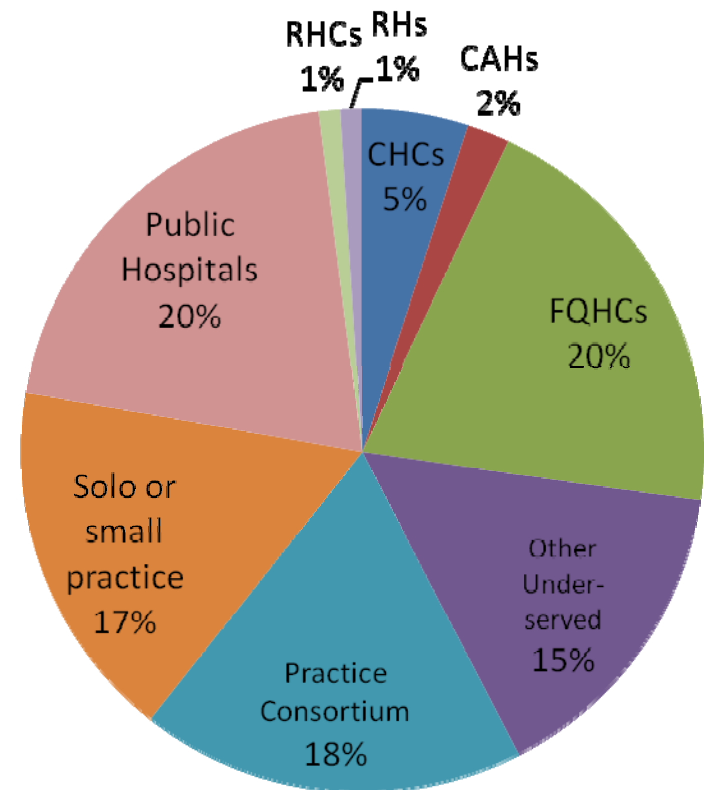
Within Setting, Proportion of PCMH Certified Providers

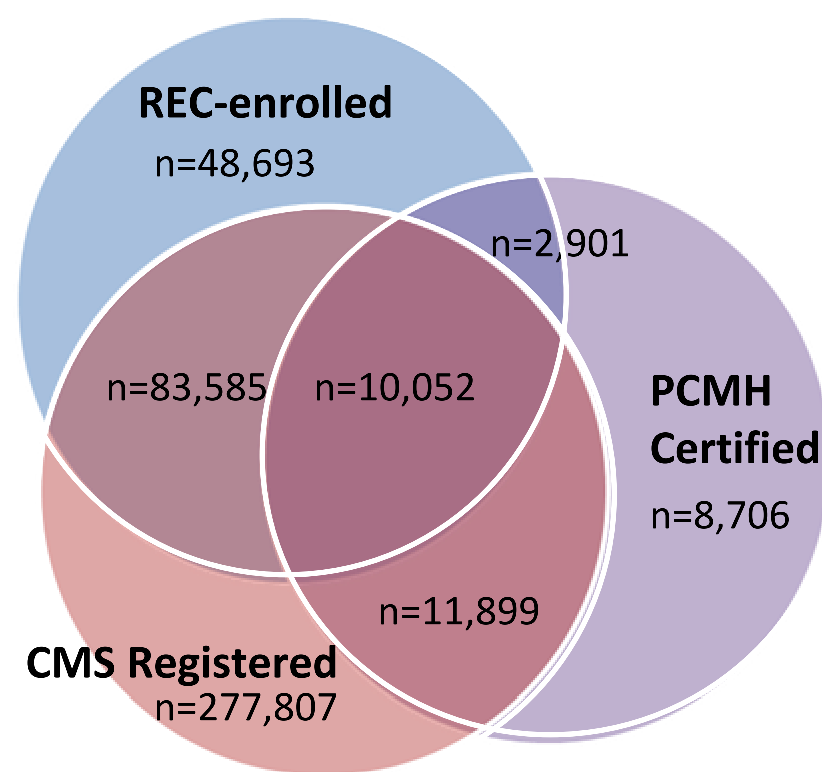


Across Settings, Prevalence of Providers



Based on ONC CRM data as of March 19, 2013, merged by provider NPI to NCQA PCMH data as of February 28, 2013.

PCMH Certification, REC-Enrollment, and CMS Registration



	Percent Registered
PCMH providers	75%
2011 certified providers	80%
2008 certified providers	74%
PCMH REC-enrolled providers	**78%**
2011 certified registered with Medicaid	49%
2008 certified registered with Medicaid	36%

Based on ONC CRM data as of March 19, 2013, merged by provider NPI to NCQA PCMH data as of February 28, 2013 and CMS EHR Incentive data through January 31, 2013.

Medicaid Registered Providers and AIU Payment

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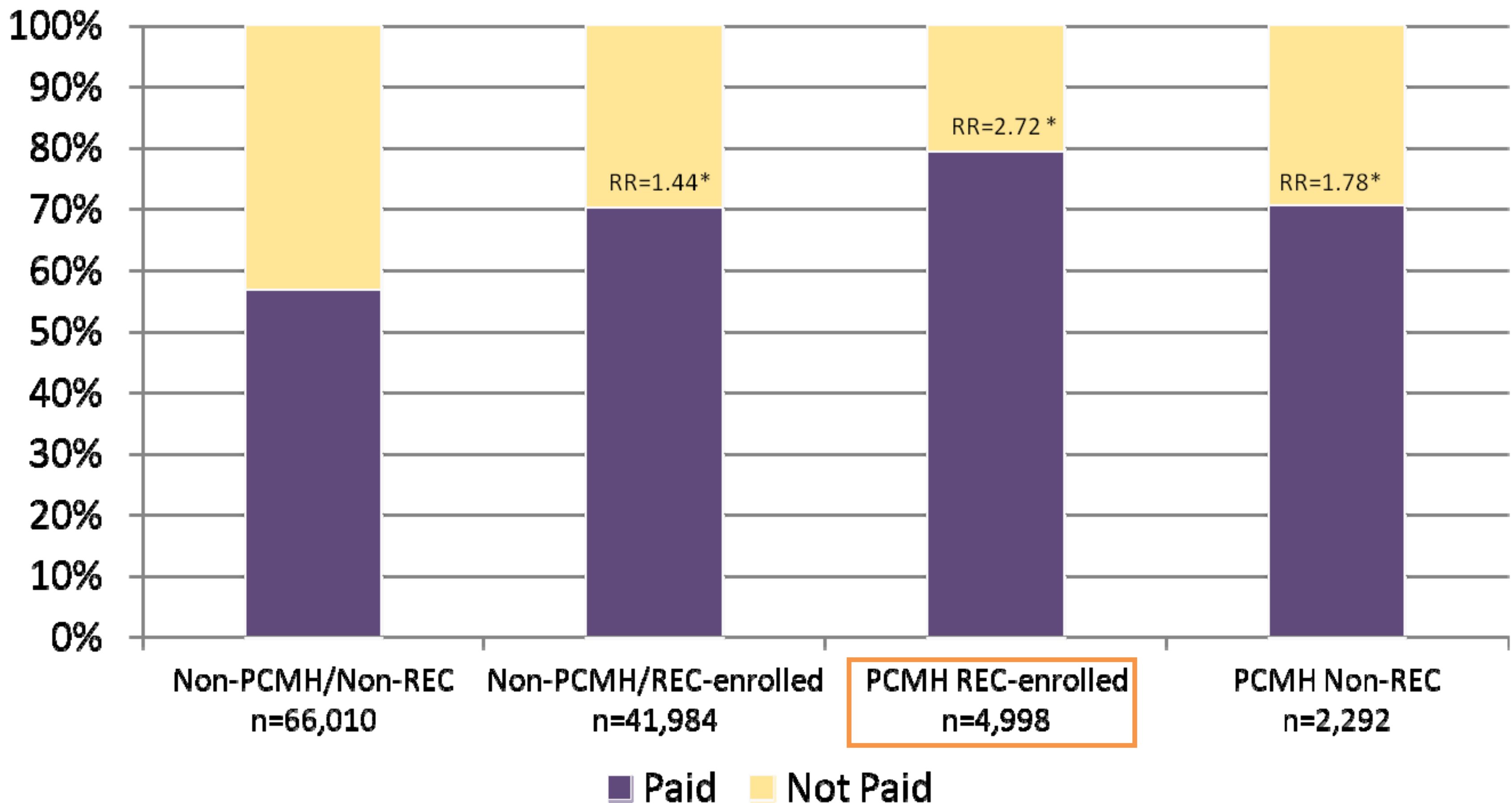
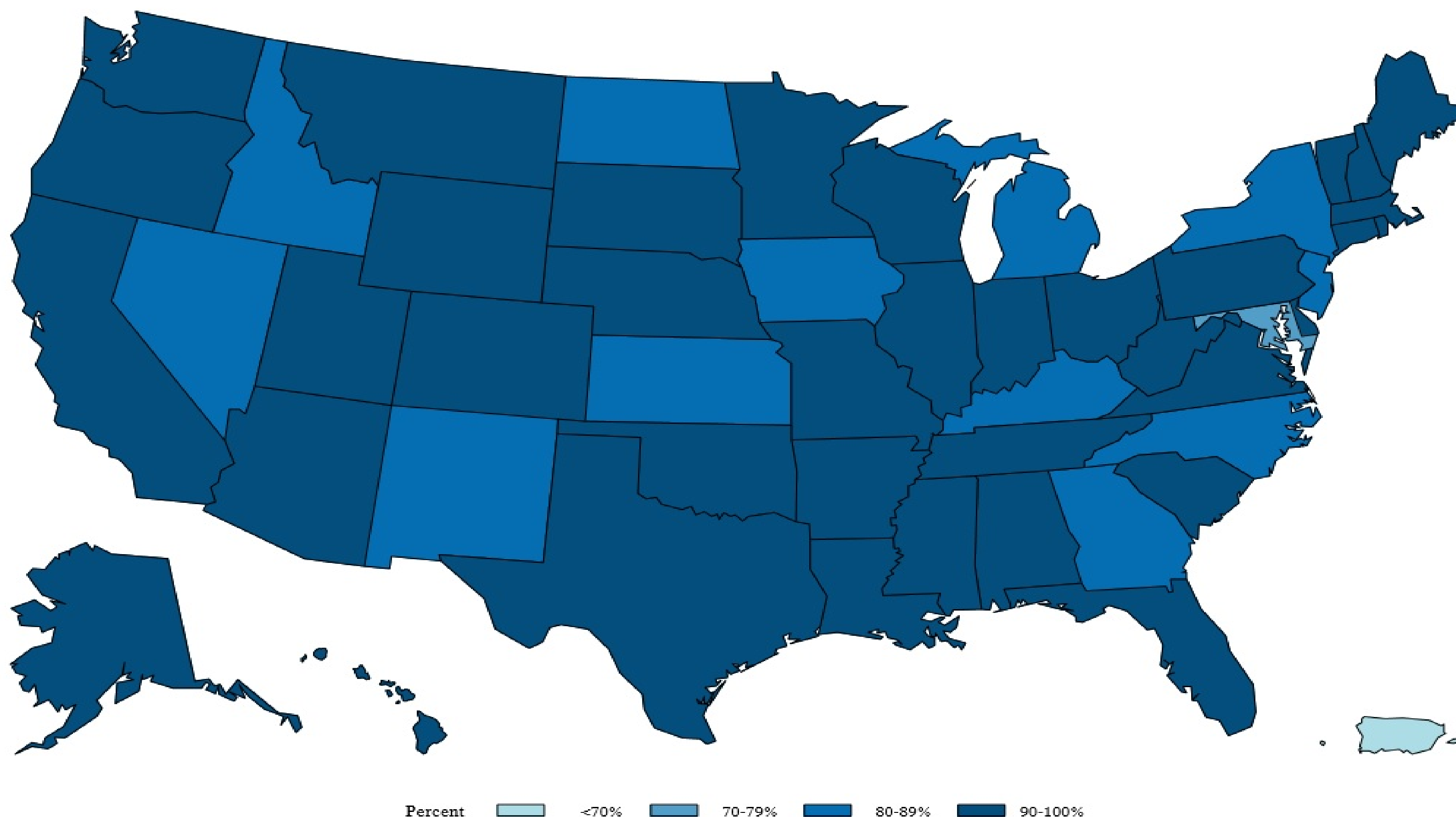


Relative Risk (RR) compares the likelihood of being paid for AIU when compared to the non-PCMH/non-REC enrolled providers. **Among REC-enrolled providers, those that are PCMH-certified are 55%* more likely to be paid for AIU than those not certified.** Among PCMH-certified providers, those enrolled with an REC are 17%* more likely to be paid for AIU than those not enrolled with an REC. There is no significant difference in the likelihood of AIU payment between PCMH-certified providers not in an REC and REC providers not certified for PCMH. *p-value <0.0001

Based on ONC CRM data as of March 19, 2013, merged by provider NPI to NCQA PCMH data as of February 28, 2013 and CMS EHR Incentive data through January 31, 2013.

Regional Extension Centers:
REC-enrolled PCPs Live on an EHR



SOURCE: Customer Relationship Management (CRM) Tool, maintained by Health and Human Services, Office of the National Coordinator for Health IT, data as of December 31, 2013.

Regional Extension Centers:
Where Medical Home assistance is…

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46 RECs currently offer Medical Home Coaching and Facilitation assistance in 42 DC/States/Territories.

21 Federal / State / Payor

State / Medicaid: CO, CT, IA, LA, NY, MI, MN, OH, OR,
Payor: NH, NV, PR, SC, WI,
Customized: AR, AZ, IN, KY, MO, MT, NC, NE, NV, OH, SD, TX, WA, WI,

22 Recognition and Accreditation Programs

NCQA: AHIT/Central/South FL, GA, IA, KS, LA, MN, NJ, NYC REACH, PA, RI, Central/Gulf Coast Texas,
All: AK, DE, IN, FL, ME, MN, OH, TN, VA,

6 Innovating around new models of patient-centered care

Behavioral Health: NY,
Comprehensive Primary Care : CO, OH, NJ,
State Innovation Models: ME, MN,

9 Specialist PCMH Rural PCMH HCCN PCMH

Rural & Critical Access Hospitals: DE, CO, OH, WY,
HCCN: CA, MT, TX,
Specialist: Central FL, MI,

RED RECs did not include known PCMH work in Q15.
Six to Verify: Arkansas, FL AHIT, Missouri, NC, NYCe, Oregon,
These states are included in 46 RECs and 42 #s above.

Regional Extension Centers:
FY 14: ~4,000 Provider touch-points

Medical Home Providers to be reached by REC practice coaching and facilitation

Regional Extension Center	Providers
CA / HITEC-LA	370
PA REACH EAST	250
PA REACH WEST	250
Kentucky Regional Extension Center	300
Louisiana Health Care Quality Forum	180
Texas / North Texas REC	150
Nevada-Utah / HealthInsight	200
Michigan Center for Effective IT Adoption (M-CEITA)	600
Ohio / Greater Cincinnati Health Bridge Inc.	120
South Dakota/healthPOINT	200
Virginia HITREC/VHQC	60
Iowa / IFMC	700
South Carolina Regional Extension Center	250
Wisconsin Health Information Technology Extension...	16
DE / Quality Insights of Delaware, Inc.	40
NJ Healthcare Information Technology Extension Center	13
Kansas Foundation for Medical Care	13
Indiana Health Information Technology Extension...	50
FL / South Florida Regional Extension Center	100
CT / eHealthConnecticut Regional Extension Center	100

Regional Extension Centers:
FY 14: ~1,600 Practice touch-points

Practices to be reached by REC Medical Home services

REC	Practices
CA / HITEC-LA	27
PA REACH EAST	100
PA REACH WEST	100
Kentucky Regional Extension Center	50
Louisiana Health Care Quality Forum	90
Texas / North Texas REC	50
Nevada-Utah / HealthInsight	50
Michigan Center for Effective IT Adoption (M-CEITA)	500
Ohio / Greater Cincinnati Health Bridge Inc.	40
South Dakota/healthPOINT	70
Virginia HITREC/VHQC	10
Iowa / IFMC	300
South Carolina Regional Extension Center	100
Wisconsin Health Information Technology Extension…	6
DE / Quality Insights of Delaware, Inc.	20
NJ Healthcare Information Technology Extension Center	4
Kansas Foundation for Medical Care	6
Indiana Health Information Technology Extension…	4
FL / South Florida Regional Extension Center	50
CT / eHealthConnecticut Regional Extension Center	20

Y-axis: -, 50, 100, 150, 200, 250, 300, 350, 400, 450, 500

Regional Extension Centers:
FY 14: ~4.86M Patients impacted

Estimated Patients to be reached by REC Medical Home partnerships

REC	Estimated Patients
CT / eHealthConnecticut Regional Extension Center	2,500
FL / South Florida Regional Extension Center	5,000
Indiana Health Information Technology Extension Center (I-HITEC)	15,000
Kansas Foundation for Medical Care	18,759
NJ Healthcare Information Technology Extension Center	20,000
DE / Quality Insights of Delaware, Inc.	24,000
Wisconsin Health Information Technology Extension Center...	32,000
South Carolina Regional Extension Center	50,000
Iowa / IFMC	50,000
Virginia HITREC/VHQC	120,000
South Dakota/healthPOINT	200,000
Ohio / Greater Cincinnati Health Bridge Inc.	300,000
Michigan Center for Effective IT Adoption (M-CEITA)	312,000
Nevada-Utah / HealthInsight	360,000
Texas / North Texas REC	450,000
Louisiana Health Care Quality Forum	450,000
Kentucky Regional Extension Center	500,000
PA REACH WEST	625,000
PA REACH EAST	625,000
CA / HITEC-LA	700,000

Axis: - 100,000 200,000 300,000 400,000 500,000 600,000 700,000 800,000

Tell Me More!

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Meaningful Use Stage 2

vital signs

e-prescribe (eRx)

Patient reminders

smoking status

family health history

computerized provider order entry (CPOE)

demographics

lab-tests

QUESTIONS?

Clinical Quality Indicato

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