NWX-OS-OGC-RKVL

Moderator: Marilyn Keefe
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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. We will conduct a question and answer session during the conference. To request a question please press star then 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time. I will now turn today's meeting over to your host, Marilyn Keefe. You may begin.

Marilyn Keefe: Thank you (Erin). Again, good afternoon; I'm Marilyn Keefe the Deputy Assistant Secretary for Population Affairs. Welcome to our second webinar focusing on Health Information Technology.

I'm here in the central office today with many interested staff members from OPA. Today's webinar features Dr. David Hunt, the Chief Medical Officer in the Office of Health IT Adoption for the National City Offices, the National Coordinator for Health Information Technology here at HHS.

At ONC, Dr. Hunt worked as years as a practicing surgeon and leader in surgical quality and patient safety with hands on experience at all levels of information technology.

He worked for CMS from 2002 through 2007 leading the Medicare Patient Safety Monitoring System as well as the Surgical Care Improvement Partnership, two national programs advancing quality improvement and patient safety.

He's also practiced surgery in both private and academic settings serving as a Clinical Assistant Professor of Surgery at Howard University as well as serving as the Chair Surgical (Peer) Review at various hospitals in the Washington metropolitan area.

We're extremely grateful that Dr. Hunt shares OPA's goals of ensuring that the Family Planning Clinic System is on track to adopt electronic health records and he's here today to share with us some practical tips to help family planning providers move toward meaningful use of health information technology.

We hope everyone is actively engaged in this conversation and prepared to ask questions at the end of Dr. Hunt's presentation, so take it away Dr. Hunt.

Dr. David Hunt: Oh thank you so much Marilyn. I really appreciate this opportunity. And I can't tell you how much we at the Office of the National Coordinator are so excited about the opportunity to work particularly with a group such as Title X Clinics because in so many aspects you represent the core of the providers that we really need and want to reach in terms of this technology.

Now I know that you mentioned this is the second presentation you've had with this. I know that our Director of the Office of Provider Adoption and Support, Mat Kendall and Jessica Kahn from CMS had an opportunity to present and give an overview of our office and the overall program particularly the Regional Extension Center program that I'm going to talk a lot about today because the Regional Extension Centers really do represent the path forward, not to steal my own thunder and tell you the end of the movie just at the title slide here.

But that's really what I'll be focusing on a tremendous amount. But I will recap a little bit about what they had discussed before so this slide actually comes from Mat's previous set of slides.

Just to highlight the fact that the Office of the National Coordinator, we were created in 2004 by executive order. And we've gotten a real breath of new life with the Health Information Technology for Economic and Clinical Health Act. Boy that's a mouthful there. We call it HITECH.

And in that Act it was actually codified. Our office was actually codified into the formal structure of the Department of Health and Human Services. We consider ourselves a resource for the entire United States Health System and we support and coordinate efforts to improve health.

And that really if I have a theme throughout that I'm going to be discussing is that this is all and only about the process of improving the quality and the efficiency of healthcare. And we think that we'll be able to do that in this regard with the adoption of health information technology in the form of an electronic health record as well as the Nationwide Health Information Exchange.

Now when we look at the question, the main, the central question of why should providers actually implement an electronic health record. Again, get backing - getting back to that central theme that this is all and only about value and values.

So to that end, we're have clear and convincing evidence that electronic health records can improve the quality and the efficiency of care that's delivered. We are - have been able to put a wind at our back if you will with the piece of the legislation that actually provides an incentive program for those who adopt and implement and meaningfully use an electronic health record.

That is to say the incentive program through the Medicare and Medicaid Services programs, and I should actually point out that there are a number of other health insurance plans namely Aetna, WellPoint and United Health Care that have already announced, and we're very pleased about that - they've already announced the fact that they will also be aligning them - their pro - some programs for incentives for EHRs around or very similar to if not identical to our meaningful use incentives.

The next thing is when you're looking forward to the horizon; we had a lot of activity. And I'm sure all of you kept up with the discussions around healthcare reform when huge component to healthcare reform discussed accountable care organizations.

If there's any one thing that I would say that is looming big on the horizon and something that everyone is - that's in healthcare in any way should keep an eye on is ACOs, Accountable Care Organizations.

And it's very, very clear that electronic health records will definitely be able to help accountable care organizations leverage efficiencies and provide care much better.

And finally I want to say that our plan is to help walk through a number of options that will help you give some of your maintain or actually manage some of your actual reporting requirements a little bit better through the application of perhaps some macros or some reports that we can work on being able have - to figure out how to generate through the electronic health record.

Now I should say, with all of these wonderful benefits and all of this discussion of how good an electronic health record is, one thing is very, very clear, namely that we have a fair way to go in terms of national adoption.

Here we can see some of the most recent data that we have from 2009 from our study regarding the adoption of ambulatory care EHRs. And you can see that at best for a fully functional system, we have a market share probably on the order of between 6 and 10%.

The reasons for that, they're pretty obviously actually. And they hold true regardless of the provider setting. That is to say some of the biggest cause - concerns with this have to do with the amount of capital needed to actually acquire and implement this, an uncertainly on their investment, one of the return on this investment.

Finding an electronic health record that actually meet a practice's need, that definitely is high up as well as concerns about the capacity to select that after selection to install and implement that.

And the final two of the top six barriers that we've seen to adoption of electronic health records are concerns about system obsolescence and that very, very critical issue of transitional productivity loss.

And again, with many if not all of these barriers, I think that the programs that we have here at ONC, and particular the regional extension center program will help mitigate to a large extent a lot of the concerns associated with these major barriers that we have here.

Now with regard to the top barrier, that is to say the cost of systems, I wish that we could say that we're able to provide funds for the cost of every provider to acquire these systems. That's not completely what we have available through the Medicaid and Medicare programs but we do have some very, very attractive incentives that are available.

In this slide you can see the incentive program that's associated with the Medicaid program. You'll notice first any of you who have been keeping up when - keeping a scorecard, this is significantly higher than the incentive program through the Medicare program which tops off at about $45,000 per provider.

And these dollars - these dollar amounts are per provider I should note, for - per provider within a practice. So if you have two providers, each would be able to have access to the total over five years of about $63,750. These incentives are basically a one-time offer from the Federal government.

And for the Medicaid program the incentive program is actually incredibly generous in that the initial threshold of actually acquiring that first $21,250 per provider. The threshold for that is relatively modest in comparison to the thresholds for say the Medicare program. And we'll talk a little bit about that.

I know Jessica perhaps talked or touched on that at the last session also. Essentially I can give you the big - the key take homes from that right here now. Basically the program indicates that you should either adopt, implement or upgrade. And we call that the adoption implement and upgrade path for the Medicaid and adopt - and you can perhaps have one or two or one of any of those three.

So that's to say if you already have an electronic health record, we want you to upgrade. And for virtually everyone, that's something that's actually taking place over the next year because we were able to establish a new set of criteria for the certification of electronic health records.

And virtually every electronic health record that was on the market, if you already had one, if you have one it'll need to be upgraded to the point where it is a certified health - electronic health record according to the current criteria. So if you have one, simply upgrading it will qualify you for those incentives.

If you have one also or if you've already thought about acquiring one, the big thing in terms of implementation would just be to make sure you begin to put in your patient's information into that system. And that's the implementation that we talk about for electronic health records, simply beginning to use it.

If you don't have one, if you don't have an electronic health record, the threshold for it is to actually acquire one. Just act - just physically acquire an electronic health record and then you would actually qualify. The - each provider that does will actually qualify for that relatively generous benefit - now - benefit.

Now later on we'll talk a little bit about some of the larger requirements toward meeting meaningful use and Medicaid providers along will be in the same basket as Medicare providers toward that as we move a little bit further on after that first year beyond that first threshold.

And here you can see - in this slide you can see just a brief summary of some of the meaningful use requirements. This rule was published relatively recently. There was a lot of discussion of what was going to be in the rule for the longest time as we were developing it. And we were able to actually release the rule in the middle portion of July and with some key caveats from that have changed from those of you who may have taken a look at the proposed rule.

We released the proposed rule earlier in the year and we asked for comments. And one thing that I'll have to say is that it is rare in this business and HHS that I've seen a rule that was released with comments that came back that were so thoughtful and so incredibly well considered.

We got over 2000 comments for the proposed rule. And universally I can say that the concerns that were expressed were genuine concerns. They were very, very well considered. And one thing that we're so grateful for that they were so generous in that rarely did someone just complain about one section that we had proposed. Typically they offered a solution.

To - not to go into the litany of all of the different requirements and go through step by step the entire rule, I will say the big take home is that we heard so many of the concerns that were offered, and the biggest take home from the difference from the proposed rule into the current final rule for Stage 1 is that we have thresholds that are a little bit less than 100% for a lot of the key requirements.

We heard time and time again that the old adage about healthcare is true that you never say never and you never say always. And to provide a set of requirements that basically was an all or nothing process really didn't make sense to the day to day clinical practice or most providers' day to day clinical practice.

So we heard and we've been able to modify. We have different thresholds that - for many of the requirements. Eighty percent - and the requirements for 80% are essentially those that are usually the standard of care and completely under control - the control of the provider.

That is to say it is an expected standard of care that everyone maintain a full and complete medication list, a problem list and an allergy list. And that's very, very standard.

And so to that regard we're asking that you do that for 80% of the patients that you have in your electronic health record. Other things that aren't completely under the control of the provider or aren't necessarily considered the absolute standard of care have a threshold level of about 50%. And those that are a little bit tougher will have a threshold level of about 40%.

Now even with all of that I can say, or especially with all of these requirements that you see, one thing that we heard time and time and time again as we were starting to craft this rule and discuss how we would get a nation to step up and actually begin to adopt and implement electronic health records is that providers need help, that this is a difficult process at best.

And it's not something that a busy provider, small provider will be able to accomplish in very easy form. And that's probably one of the main impetuses that we have to - for creating the regional Extension Center Program.

Now I know that Mat was able to give you a big broad outline of what the Extension Center Program is and how they're essentially to work. To capsulize what he said basically is the REC program was established because it was a recognition that the work that we're asking providers to do isn't easy. They don't have the skill set or the resources. Particularly they don't have the time, that key resource that so many providers tell us that they need to actually be able to do this.

Regional Extension Centers or RECs can actually, having to work with a number of providers in their local area, are able to generate some economies of scale in terms of the technical assistance that they can provide as well as some of the support that they can generate from vendors actually recognizing that the REC when they speak to a particular vendor may be speaking for dozens, hundreds of actual providers.

It gets a little bit better attention and the service level is a little bit better. And not only that but part - or the RECs are going to be partnering with a variety of providers in your area such that they have a great sense of the local medical community -- what the challenges are as well as what some of the solutions are for your local medical community. And that can't be overstated because again we've seen time and time again that these are not cookie cutter approaches that can be used.

Now having said that there are some relatively standardized things that in the generic form that the Regional Extension Centers will be able to provide. They'll provide help in terms of the identifying the best vendor or best

electronic health record vendor for a particular practice as well as implement the support for it.

They'll help with the overall, the large big picture of how you take this provider or practice from the very beginning all the way through a completely successful implementation. And a key part of that is the actual redesign of the workflow.

One thing that I often say is that I've been -- our practice in surgery has had electronic health records since the late 1990s. And the one thing that we realized with our practice was that an electronic health record changes absolutely everything that you do as far as a practice is concerned.

If you use it well and leverage it well, it can definitely augment so many features in terms of the flow that your patients have through your offices, your ability to make sure that things don't fall through the cracks and very, very importantly the ability to have everyone work as what we say at the top of their license.

That is to say everyone with access to a relevant portion of the electronic record means that they can all have an opportunity to work at the full set of skills that they've been trained in. And that can be either from medical assistance, the receptionist, the clinicians all throughout the entire practice.

And part of the reason in so many clinics and so many practices, everyone isn't working at the top of their licenses because with each individual patient there's one record. And if the doctor has the patient record the medical assistant can't make their notes or do what's necessary to help with the prescriptions or any number of things with one physical paper record.

With an electronic health record meaning that multiple clinicians can have access or multiple members of the staff can have access to that same record in a flow, at a work timing that actually suits their work schedule best means that everyone will have a chance to do everything that they've been trained to do and make their entries within the electronic health record.

So it definitely is able to make the office a lot more efficient and primarily again through the change and the optimization of workflows. Now the REC program is helping to provide this technical assistance through a number of different mechanisms, one of which are communities of practice where we'll have actual vendors, providers, technical assistant staff work together to solve some of the major problems and major challenges or to promote some of the best practices that are associated with some individual electronic health records.

Effectively we want the Regional Extension Centers to be the total resource that a provider or that a practice within their local area can rely on the help desk to call the geek squad if you will, the entire package of technical support that's necessary to actually begin to implement and again meaningfully use this.

With that in mind, I'd like to talk - I'm going to talk a little bit about some of the steps that the REC will actually take to bring a practice up to speed with regard to electronic health records. And it's a very, very stepwise approach. Part of the biggest - one of the biggest and most important things is that the Regional Extension Center's going to help you understand the way your practice actually operates.

In many clinics throughout the country is essentially an ad hoc set of processes that may not be necessarily completely documented. That is to say

the path that a new patient will take or an existing patient will take as they navigate through your setting to receive services.

It may be poorly documented. I may be ad hoc. There may be multiple paths that are taken. And it may not have been what we call optimized. I love to refer to this quote from William Edwards Deming who basically said that if you can't describe what you do as a process, then you don't really know what you're doing.

I'm not saying that this is the situation of many of my colleagues and the practice in the paper world but it's not far from that actually. They can't necessarily describe all that goes on in their practice as a set of very reproducible optimized steps.

How do you always know that the patient gets their prescription and that they've actually gotten and received all the services that they'll need to do -- need to receive at their individual visit? It's often an ad hoc system paper based that is many cases catch is as catch can.

And one of the first things, in fact I would say among the first steps that a Regional Extension Center or anyone who's going to help you learn how to adopt an electronic health record will do - will be to walk you through a discussion of what exactly goes on in your practice, in your clinic and then start to talk about what are the most efficient ways to do that.

And that's absence any discussion of which is the best electronic health record for you. That actually is a process that needs to be done because we can't simply take the processes or the steps that you're currently using and throw those into an electronic health record.

We won't gain the efficiencies. What a friend of mine over at CMS, Debbie Hattery, says affectionately - essentially what you'll be doing is you'll be electrocuting your practice. That is to say you'll be taking everything that you do right now in the current state with a bunch of paper forms and putting it on a computer.

You won't really get the major benefit that we expect to see in the efficiencies out of electronic health records. And so the Regional Extension Center will actually go through a stepwise plan to figure out exactly what goes on in your practice and then talk to you about some of the things, some of the steps that need to be changed in terms of being able to begin to think about adopting an electronic health record.

I'll say one of the first things that we came to realize in my own practice when we went electronic, and I've seen this occur and replicated hundreds if not thousands of times is that the biggest change that electronic health records will bring about is an organizational or a cultural change.

That is to say it changes a lot of aspects about the practice that have nothing to do with the absolute provision of healthcare services. It's a different way of having your practice or your clinic actually take care of patients. And we've seen it time and time again. It's a more efficient way. It's a more effective way.

One thing that we stand by and one of the reasons that we're so excited about having the entire country begin to adopt and implement this is that we've seen that there are very, very few occasions when you would have someone who adopts and electronic health record who goes back to the paper system.

Even in situations where you may have heard they may have said oh it was difficult, it was very, very tough. But once they've actually been able to cross that threshold very, very rarely does anyone actually go back.

And a lot of that is because they've seen that they can actually improve the delivery of healthcare but also that we're able to set up a system in which their organization can actually get - work more efficiently.

So some of the steps, and this is just an example of some of the things that our Regional Extension Center may do not necessarily in this exact order but they'll talk to practices about what they're actually doing, begin to talk about the steps that patients actually take as they navigate their way through your clinic.

They'll talk about some of the organizational things that will need to be changed; cultural changes if you would that have to occur within your practice to be able to actually effectively implement this. And then after they've gone through those steps they'll start to talk about what would be some of the best electronic health records that are available for you to use.

And they'll begin to narrow down the numbers and help you begin to select probably one of the optimal EHRs for you. And they'll also help map out a new change organization that will be able to effectively use this electronic health record.

And then after that is the implementation phase. Now you'll notice that there's a lot of work that goes on before you actually have that shiny new software installed in your clinic or in your practice, a tremendous amount of work. That work cannot be overstated. It cannot be something that you lend a little credibility or a little time and resources to.

That is the work that will determine whether or not you have a successful and the most -- the easiest implementation or whether or not you'll have difficulty down the road. And once implemented, then you begin to talk about how you can make it better and then you're actually taking care of patients.

But again the big thing that I would stress with this entire process of adopting is that it is something that changes the tone, the tenor and the culture of your organization. One of the key aspects to this entire process is that the leadership has to take an active role in this process and that they must have a very, very clear vision for what they expect to see in terms of -- particularly in terms of the quality of care that they expect to see out of the healthcare services that are delivered and by extension with the help of the electronic health record. That is so incredibly important.

There are a number of tools out there that will help the REC to begin to do this and many of the RECs are using some of the tools from a number of programs. One of - this is one example of such a tool that basically is an organizational readiness assessment tool. And it goes through a few steps to figure out whether or not you're not yet prepared moderately prepared or optimally ready to actually begin to adopt that -- an electronic health record.

And they go through a number of steps asking questions about the organization's readiness to actually look at an electronic health record. The involvement of specific clinicians, the involvement of specific staff, also some involvement many times in terms of patients because again this adoption, this implementation will change everything that you do about the care of those who have come to seek your services.

So it's incredibly important that at some step that you make sure you make provision for the wishes and needs of your patients. This next slide is actually just a further example of the steps that are needed. It starts with the practice workflow.

Basically the biggest and most important thing is that the practices and the clinics actually learn what it is that they do when they care for patients. What exactly do - happens when someone comes in for a typical visit, for an extended visit? What services are provided and what's the actual flow?

Universally everyone finds efficiencies in this step of the process. And even absent a decision to actually go and implement an electronic health record, everyone's practice and clinic are the better for looking at these steps and actually beginning to think through this with the full participation, the full participation of the entire staff.

I can't overemphasize that. This is not a top down process where we just get with the clinicians and ask them well what happens because so many times the clinicians are actually clueless as far as so many of the steps that are involved.

A great example of that you'll see is just when you ask any of the clinicians on the front lines exactly what happens when a lab result comes into your practice. What are the steps that are actually taken to make sure that that lab is identified, is evaluated, the assessment is made and the information and the necessary information is received by the patient?

These are two examples of lab flows -- work flow of lab results in a paper based system and one through -- in which an electronic health record is used. You'll notice obviously that the EHR system is many fewer steps. It's a lot more efficient and it is much, much simpler in so many ways.

Not only that, it is auditable. That's one excellent feature of EHRs. And many practices have been able to find that they're able to simply manage their practice much better because every aspect of it, all of the individual steps are auditable.

You can actually see what is going on and you can actually prepare and make pathways within the electronic health record of taking patients through a specific pathway implementing sets of orders that you always want to have occur or set to things that you always want to make sure you do so you have a strong quality control.

It's just some of the big things that an electronic -- that a Regional Extension Center will help you with in terms of being able to get your practice up and optimized.

Again, I wish I could go through everything that our office is doing. I don't want to begin to suggest that this is a time to discuss all of the features of the programs that we have. I just include this slide right here as a brief overview of some of the high points of the things that we're doing, recognizing that for this entire nationwide program to take off and to be effective it is more than just adoption of electronic health records with the assistance of Regional Extension Centers.

We -- I -- just on the adoption piece, we want to make sure that we have an adequately trained workforce. And our office has been very, very proactive in terms of setting up a set of training programs throughout the country based on our community college programs, a nationwide community college consortium to actually begin to train the staff that is going to be using these electronic health records.

I touched briefly on the incentive programs from CMS. The penalties are primarily on the - in the form of the Medicare program. There are no penalties associated with the incentive program through the Medicaid program.

And the big optimal goal that we're trying to have is really that exchange of healthcare information. And we have a huge set of programs that are just worth looking at the actual exchange of information. And again, time precludes me actually going through many of the details.

But some of the high points include state grants for health information exchange. Every state will have an exchange -- a health information exchange program and we - one division of our office is actually working actively to help sustain all of those state programs.

There's a tremendous amount of work that's already been going on and will continue in the area of standards and certification. And then the biggest, probably the biggest thing associated with the exchange of information, the foundation if you would to all of this is a broad and deep program that discusses the privacy and security of these.

Privacy is a fundamental tenet of everything that we do. It's the basis for the trust that patients place in us. And we must make sure that as we cross this threshold into the electronic health record that we don't diminish that. And there are many ways that we can actually augment the security and the privacy of electronic health records.

That might seem a bit counterintuitive but we've seen it time and time again that efficiently and effectively implemented electronic health record system

means that you can actually improve the quality of privacy and security within your clinic.

But at the end of the day, and oh I should also point out, and I always give this a very brief discussion, but I do want to also point out that we have a whole program devoted to improving the quality of the information technology, the quality of the software that's used.

And we have an entire research on that actually represents the resources for it actually represents the entire budget of ONC just a couple of years ago. But we have over $60 million that are devoted to the discussion or to the answering the questions of how can we improve the actual quality of this technology.

But at the end of the day - at the end of the day it really all comes back to making a healthcare system that has greater quality and actually meets the six aims of healthcare quality that the IOM set apart so many years ago.

It should be safe. It should be effective. Patient centered, timely, equitable and efficient. The one thing that we learned though is we begin to implement the systems as we begin to feed the deficiencies that are currently in our paper base system that you can't be any more efficient than you are safe.

We've realized that effective treatment actually is actually synonymous with timely treatment. And in so many situations I don't see any way that you can provide equitable care without being fully patient centered. And we've seen that with the implementation of an electronic health record that you can more effectively and a bit easier -- it would be a bit easier to actually meet these goals.

But I really don't want to gloss over the fact that this is hard work. Not only is this hard work but this is work that on a scale that has never been tried before. Very, very few systems with the complexity of the United States have actually ever embarked on this endeavor. It's a larger enterprise than has gone on in any of the European countries; any of the countries that we have typically associated that are a little bit more advanced in terms of information technology than the United States.

And I use this lie just to bring me home and to tell me -- and to make sure that we are grounded in the reality that we are about to do something that has never ever been tried before. And we're going to learn things that have never been known before simply through the implementation and the meaningful use of electronic health records.

And the - we'll need your help. We'll need all of your help. And it is incredibly important that all sectors of our healthcare system actually join in with us and work with us in figuring out what is the best way learning things that can be learned in no other way. What is the best way to actually implement electronic health records?

And it's incredibly important that a sector such as yours that care for those that have needs for the services that are so critical. The Title X clinics is what I'm referencing that is so important that you as in many cases the safety net for our nation's healthcare in so many aspects of the care that you deliver that you're fully engaged with this and that we actually provide as much technical assistance and support as we possibly can.

That's really why I'm here to convince you that we are here to help and that we will be able to provide the full range of services to Title X clinics that we're providing to providers that were given to providers nationwide.

And I'm hoping that with this we'll be able to convince every one of you to begin to work with our Regional Extension Centers to help be able to figure out what is the best way.

Now given that you're a large group of similarly focused clinics, we've taken to begin to work at a central level to figure out what are some of the requirements that a generic, that an overall general Title X clinic may have such that we can make even the process of you working with the Regional Extension Center a little bit more efficient, take away some of those early steps that may be a little bit more time consuming and identify perhaps a small set of electronic health records that will be useful to the large majority of Title X clinics and then go through and discuss what are some of the reports that are typically generated through services generated at your clinics and perhaps streamline some of that also.

What I'm basically saying is that I think that working with your leadership that we'll be able to even make the process of working with the Regional Extension Centers even that much more efficient such that we'll be able to get nationwide every one of the Title X clinics up and running on electronic health record in relatively short order.

Well I see that I've been talking for an awfully long time and I wanted to make sure that we have enough time for any questions that you may have with regard to this and any suggestions that you have in terms of where you see the path forward.

So I'll stop right here and I'll ask Marilyn and the others to join in. And if (Erin) can open up the lines perhaps we'll have a few questions.

Marilyn Keefe: Thank you so much David. That was wonderful. And we particularly liked your final words. So does anyone have any questions for David? I know there were a couple that looked like they were posted that we're trying to get into but is there anyone who wants to ask a question?

Coordinator: Thank you. We'll now begin the question and answer session. If you would like to ask a question, please press star 1. You'll be prompted to record your name. Please unmute your - oh - if you have your phone on mute please unmute it to record your name clearly. One moment while we look for the first questions.

Man: (Okey doke).

Coordinator: As a reminder, if you would press - ask a question please press star 1.

Marilyn Keefe: There are some questions that have been sent in that I'll read. And I guess the first question for you David is can you talk about an example of how a Regional Extension Center has assisted in Title X family planning programs or another program with similar issues to Title X such as Behavioral Health to establish an ERH or a (depth), a larger hospital's ERH to include this project?

Dr. David Hunt: Absolutely. Across the country we have a number of examples of where Regional Extension Centers have been able to actually begin already to partner with providers that are very similar if not many that some of the Title X clinics.

I would say that behavioral health is a touch model because the incentive plans actually exclude benefits in many cases to behavioral health. And unfortunately that's something that I would love to see corrected. But that would have to be done at a statutory level.

But you'll all know that through a series of - working through a - with a number of different providers from small family practitioners to family planning clinics through Federally qualified health centers that the Regional Extension Centers have already begun to sign up individuals.

And in New York is probably our greatest example and that's the model that we use currently to get out to providers and actually get them up and on board with an electronic health record typically taking their entire staff through the process of figuring out what is the best electronic health record, selecting it and helping them to implement it.

In many cases the processes that were involved, the first steps of which as I mentioned earlier had nothing really to do with the nuts and bolts of getting an electronic system as much as actually figuring out what your clinic or practice actually provides in terms of services and to figure out how to best streamline that.

So I could say that all across the country you - we could pick any state at all and I'll be able to pull up examples of where the REC has already begun to sign up and work with providers of various abilities. We were lucky. We've been able to cross the threshold of about 20,000 providers that have already signed up for assistance with the Regional Extension Center program.

Marilyn Keefe: Thanks David. We have another question. Is the incentive money available to local health departments since they bill Medicaid for family planning services?

Dr. David Hunt: Well the incentives are actually to license providers. So inasmuch as a provider has a license, they're able - they're eligible for the incentive. So it

wouldn't go to - it depends on - my hesitation is it depends on the structure of the health department clinic. But for the most part I would say yes. If they provide healthcare services to Medicaid patients, they would be eligible -- the providers within that clinic.

Now it may be 10 or 12 providers within a clinic or more or less. And each of them would be - would have ability to gain or to apply for the incentive. I will say there is some institutional barriers. The biggest one has to do with hospitals. And that's why I hesitate in forming my answer.

Those individuals who are employees of hospitals, providers who are employees of hospitals aren't eligible for these incentive programs. But for the most part, if you're in a clinic, you're taking care of Medicaid or Medicare patients, the provider that is, the clinicians, each individual that is a license clinician would be eligible for the incentives.

Marilyn Keefe: Thank you. (Erin) can you open up the line for questions from (Robin)? I see a little...

Coordinator: I can take questions from the queue. (Robin) has not queued up yet but I do have several in queue if you would like to answer some of those.

Marilyn Keefe: Sure.

Coordinator: Okay. Our first question comes from (Vicky Lynn). Your line is now open.

(Vicky Lynn): Hi. Thank you David for your presentation. I appreciated your last comments as well about looking for economies of scale and working with the central leadership. I have another question. I posted that one on the Internet and I'm also wondering what you could share with us when two different electronic

health record systems are built, what you see about those becoming interoperable later?

So for instance, if a Title X project has built one that's completely different maybe from a hospital based site they want to work with. What do you see in the future about those being able to work together?

Dr. David Hunt: Oh that’s a great question. Actually the ability for electronic health records to work together is the Holy Grail. And it really is the end gain that we're all looking for. The technical term of Art for this is interoperability which means that I can take information from my electronic health record and share it with you in the hospital or you in another clinic or you in another physician's office.

And the information would be seamlessly incorporated within the electronic health record of the recipient. They would be able to use it just as they would as if it were natively generated. That's interoperability and that is really the Holy Grail that we're going for.

And I see a world that we definitely will have fully interoperable electronic health records. How do we start off right now? What is the level of the state of interoperability at this first stage of meaningful use? It's relatively simplistic and definitely not as sophisticated as we would like to see in the end, but we will be able to share medication lists, allergy lists, problem lists as well as a clinical summary of the - of patient's care.

So that's the base level that we're starting off with right now. So if you have a certified electronic health record, you should be able to share that level of information with virtually anyone else who has a certified electronic health record.

Now I thought one question you were going to ask and it frequently comes up, one thing that is a misunderstanding to many people in the public is that they go into a physician's office, they almost always see a CRT or a monitor screen and they know that they're computers in the office.

So the question is well are these computers used for electronic health records? Typically they're used for billing and that's the - for predominantly what computers are used in a practices offices are. And it is incredibly important. I think it is fundamentally important that whatever electronic health record you use that it work seamlessly with your practice management or your billing system.

Many EHRs have their own billing packages that will allow you to subsume all of that work within it. Others - in other situations you may want to actually toggle between those two. So information would have to be fed from the EHR into the practice management system.

The thing I can't overemphasize though is that the systems have to be compatible. And that's one of the key points that a good technical - a - the - some good technical assistance will help you navigate to and will help you avoid the possibility of getting systems that are not compatible.

If you want to keep your practice management or billing system you should definitely make sure that you get an EHR that works seamlessly through it - with it because otherwise you're going to have two different workflows and that's really not sustainable.

But to get back to your original question, I see a world where there's completely interoperability. That's actually the end gain that we're looking

toward. And I wouldn't be surprised at all as we move up to Stage 2 and Stage 3 of meaningful use that you see more and more emphasis on that interoperability component of our EHRs.

Coordinator: As a reminder if you would like to ask question please press star 1. Our next question it comes from (Jody). You have an open line.

Man: (Unintelligible).

(Jody): Thank you. Thank you Dr. Hunt. I - my question's about the RECs. And we have been already in our state speaking with them.

Dr. David Hunt: Wonderful.

(Jody): One question I have is in Title X you may or may not know we have an annual report that needs to be filed that pulls a lot of data from our systems. And will the - is it your expectation that we could expect the RECs to help our providers set up their data systems or their practice management systems so that that information - the information for the specific Title X reports can be pulled easily?

I know that when our clinics have set up, you know, got practice management systems, that's always been an issue of how to, you know, because these are your reports that aren't usual for the management system.

So my question is that can we expect that type of assistance from our RECs when we contract with them?

Dr. David Hunt: Absolutely. And one thing that we're going to be doing is working centrally because I have been able to begin to talk with the office of - here at HHS with

Marilyn Keefe and her staff as far as what data it is exactly that the Title X clinics are providing to HHS.

And one thing that I hope to be able to do is identify one, the key data elements, two, some data elements that may be needed in the future if she has some insight or the group has insight into things that may be coming down the road to be able to identify where those elements are within the standard sets of electronic health records.

And then we can work out ways to develop standardized or canned reports or help the RECs identify canned reports that can then help you provide this information. We - it's a fair - a fairly extensive process and we'll have to make sure we go through and identify each and every element that you're expected to provide.

The one thing that I can say is that for the most part, I would expect that a good - that the combination of what you're already providing in terms of information that's coming from your practice management or your billing system as well with any information that you're pulling out of the charts, I think that we'll be able to actually (malgomy) some reports in a standardized fashion that the Title X clinics could use.

And that information we would love to share with all of the Regional Extension Centers such as they'll all know exactly what's the best way to set up their Title X clinics.

So I think that working centrally, being able to identify what the needs are centrally and then to be able to push that out to help the REC serve you better, we definitely see that.

(Jody): Thank you.

Marilyn Keefe: Hi. Is April still on the call? April Pace? She had two questions.

Dr. David Hunt: Oh I'm sorry.

Coordinator: Oh I do have actually have her in queue right now. Would you like me to place her with an open line?

Marilyn Keefe: Yes please.

Coordinator: One moment please. April your line is open.

April Pace: Great thank you. Hi David.

Dr. David Hunt: Hi.

April Pace: This is April Pace. I'm the Director at the Center for Health Training in Seattle at Region 10.

I have two questions. One is can you share your organizational readiness tools? That's something that a lot of the RTCs use and it would be helpful to have this?

Dr. David Hunt: Yes.

April Pace: Okay. And then I wanted to know was there any data on efficiency gained by clinics that have shifted over? I've - we've heard from several clinics that they were disappointed in how clinics slowed when it came to processing clients

and they didn't see the level of increased efficiency that they had hoped for even a year after implementation.

Dr. David Hunt: Yes. That's tough. And we have precious little data one way or the other in terms of the overall efficiency. But your experience, what you've just described is not uncommon to say that in terms of overall productivity and efficiency many providers will say that it wasn't what they expected which is really why many of them need some basic technical assistance in those first few steps in how to set up and actually train their staff and get up on board in terms of an electronic health record.

We expect to see and hear, as the Regional Extension Center program really gets up and running, we are hoping that we'll be able to have more exemplars of grade efficiencies that were obtained by providers who went through and helped to - or got assistance through this very, very good technical assistance that the RECs are able to provide.

But what you've said is the concern that so many people have expressed. And I'll be honest with my own practice that was the experience that I had, that we had in our own practice that we were definitely slower for some time. I'm ashamed to tell you how long that process took, but it was well over a year.

Having said that, now that we've been able to optimize and have some experience under our belt, we could definitely have gotten there. If I were going to do it again, we could definitely get to the point where we're much faster and much more efficient probably in less than six months or so.

The big thing that I wanted everybody to understand on this call is that this is as simple as I try to make it sound. And as tremendous as the assistance from

the Regional Extension Center is, this is a change. This is something that is going to affect deeply everything about your practice.

And the first experiences is that things are going to go slower. So it is going to be tough. Any time you change anything fundamental about any major process or in any business at all is painful at first. And I can't - I don't want to scare you away, but I don't want to also paint too rosy a picture to indicate oh well you'll be just clicking patients through with twice the speed that you had before. It's going to be very, very tough.

Unfortunately I don't have firm and hard numbers from - in terms of the efficiencies obtained through the Regional Extension Center primarily because many of them are - have just literally been stood up over the next - over the last few months. And we expect to see - they're still in the final phase and we expect to see the efficiencies from their technical assistance come down the road.

I should have said actually, I feel so silly, I'm sorry that it's taken me this long to actually get to one of the major points. I told you that each of you should work with your Regional Extension Center. I'm hoping that each and every one of you on this call will today call up your Regional Extension Center and actually sign up to work up - to work with them.

That is critically important in so many ways that I - it's tough to be able to say. But at very least, take that very first step of going - you can go to the URL that you see on this very last slide, helpit.hhs.gov, find the Regional Extension Center in your zip code, call them up and say I want to work with - I want to sign up to be a provider that gets technical assistance from you and then take it from there.

Marilyn Keefe: And just to emphasize Dr. Hunt's message again for those of you who are grantees, please get that message out to delegate agencies and clinics and all levels in the family planning system that they should be contacting their RECs.

I think there are a couple of quick questions that Dr. Hunt can answer. One is what's the cost to individual clinics for using the services of the REC?

Dr. David Hunt: And that varies. Some Regional Extension Centers are actually at no charge. Others will charge a fee per provider and it varies some is on the order of $500 to $1000. And it definitely - call up your center and find out what's the fee structure.

Regardless of - well not regardless, but I can say that all of the fees associated with it will be recouped because as you can see the incentives even for that first year far outstrip any of the fees that the RECs are charging.

And the main thing that you're getting from the REC is the ability to become a meaningful user, that you will be able to meet those goals. That's the whole reason that they're there. They're not there to help you just map out your processes. They're not there to help you just pick a vendor.

They're there to help you become a meaningful user which means that you will qualify for those incentives that are being provided through CMS. That's when they're successful. And that's the measure that we're using here at ONC to measure their success.

So having said that, even those that are charging a fee, you can easily see where it will be a very, very good investment to be able to engage the

Regional Extension Center to make it a - to have a good shot, a great shot of becoming a meaningful user and getting those incentives.

Marilyn Keefe: We had another caller asking if this presentation will be archived on any Web site and it will be on the OPA Web site. It'll probably take about a week for it to be posted.

The next question is is there any REC assigned to the Pacific jurisdictions, specifically Hawaii?

Dr. David Hunt: Yes. You have a great REC in Hawaii. And I wish I could come up with the name right off the top of my head but yes. Every population center in the United States has a Regional Extension Center. And yes, you have a great one in Hawaii.

Actually I think the one in Hawaii is associated also with the Health Information Exchange so you get a lot of economies in terms of working with them. You'll be able to - they'll be able to also help you get on the exchange program even faster than other RECs may be able to.

Marilyn Keefe: Thank you. And I think we're back to the queue.

Coordinator: Our next question comes from (Cindy). Your line is open.

(Cindy): Thank you. I was curious about the communities of practice Dr. Hunt. And is there guidance going out to the RECs about who they are because it would certainly seem that Title X could potentially be one of those and grantees and individual states could maybe go ahead and work with them about setting them up. So you didn't spend a lot of time on that and I was just curious about how that will look.

Dr. David Hunt: Yes. Actually we're - we've already started to stand up a number of communities of practice. And they've been - the few that have been going for a while we've had tremendous success with. One thing that we want to see is that we have a critical mass, a sufficient number of providers or a sufficient number of individuals that are interested at - before we set up that community.

I say that to say if we have a ground swell, particularly of Title X clinics that are signing up, it will be a no-brainer for us to easily say well let us set up that community of practice immediately working with the Title X clinics. And that would just speed things right along.

So I say that the ability to get this technical assistance even at a higher level by having also a community of practice dedicated to some of your needs can be augmented by the speed with which your community's able to sign up to the RECs.

The community of practices meet specific needs and obviously the greatest needs are trying to - we try to meet those first. So sign up and we'll have that community of practice up lickety split.

Marilyn Keefe: Are there more questions in the queue?

Coordinator: There are no more questions in the queue.

Marilyn Keefe: In that case thank you very much Dr. Hunt. This has been a wonderful presentation. And thank you all for participating. And again just to reminder that this should be posted on the OPA Web site within about a week.

Dr. David Hunt: Thank you so much. I really appreciate this opportunity. And I hope my email actually shows well or transmits well. Everyone can feel free to use that or if you want to go through Marilyn to ask questions and she can consolidate them, but I'm definitely looking forward to hearing from every one of you that may have an additional question.

If you didn't get a chance to ask it right now or if you thought of it on the way home, send me a note and tell me what you think or are - have a question or ask a question of what the REC program can do and I'll be more than happy to get back to you.

Marilyn Keefe: Thank you very much. All right. Have a great afternoon everyone. Thanks for participating.

Dr. David Hunt: Take care.

Marilyn Keefe: Thank you.

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