Building a Health IT Technical Assistance Capability at the State and Local Level:

Lessons Learned from the Medicare QIO Doctors' Office Quality-IT Initiative ("DOQ-IT")

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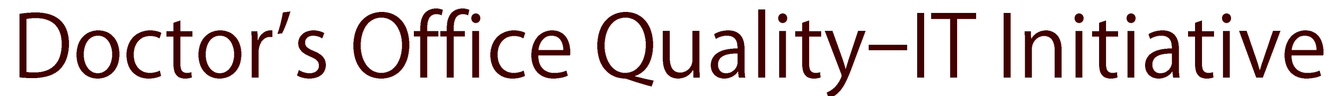
Need for Health IT Technical ssistance

- At least 40% of information technology implementations across industries "are abandoned or fail to meet business requirements".
- Most common causes of failure: inadequate planning and management by the purchaser/user.
- Source: B. Kaplan and K. Harris-Salamone, JAMIA (May-June 2009)

Need for Health IT Technical ssistance

- Add to the underlying difficulty of successfully executing significant IT projects:
  - Many health care providers are unfamiliar with health IT
  - Most office practices and many small hospitals have little internal IT support
  - Many providers have difficulty seeing how their work could and should be changed as a result of implementing health IT
- Result: providers often purchase of health IT without clear objectives, fail to turn on key reporting functions, can't use the capabilities of the technology, and spread word of their frustration.



- Between 2005-2008, CMS hired the national network of private Quality Improvement Organizations (QIOs) to support 3,600 small-to-medium sized adult primary care practices in 3 tasks:
    1. Spur successful adoption of EHR systems
    2. Redesign clinical workflow to use EHR to improve patient care
    3. Use EHR to report clinical quality data to CMS data warehouse

- Without the benefit of payment incentives, QIOs recruited more than the required number of practices–over 3,900–and still had to turn many away.
- DOQ-IT practices exceeded CMS' modest expectations in using EHRs for care management.
- Westat survey of DOQ-IT practices found three quarters of practices were satisfied or very satisfied with their QIO's:
  - knowledge of technology options;
  - ability to assess their technology needs;
  - assistance in improving care quality and efficiency.
- Reporting of quality measures failed nationwide.

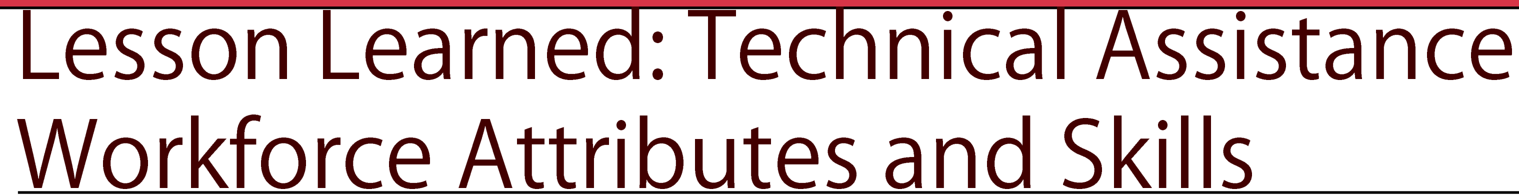
- AHQA contacted QIOs who received "excellent pass" in the CMS DOQ-IT evaluation.
- We asked these QIOs what is needed for successful state/local technical assistance implementation.
- Reporting today on key lessons learned.

- Expectations management—misconceptions undermine planning: “There is not a ‘plug-and-play’ solution but many practices are under the impression that they purchase software and hit the ground running.”
- Encouragement—often as important as “technical” assistance to help practices through rough patches, and keep them from losing heart and giving up.

- Setting clear objectives and planning.
- Anticipating training needs of practice staff.
- Vendor-neutral support during selection of an EHR system.
- Advice during contracting phase with vendor.
- Help on how to generate useful clinical reports from an EHR.
- Clinical workflow redesign and process improvement.
- Support for participating in local community health information exchange.

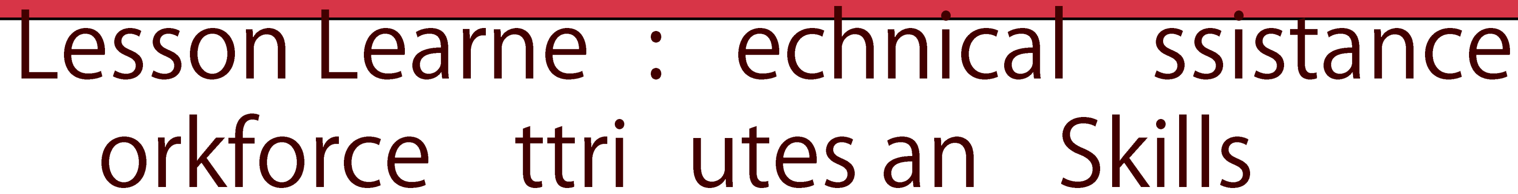
Lesson Learned: Technical ssistance ust Include Clinical Process Redesign

- Process redesign is critical to improvements in quality outcomes, patient safety, and prevention—otherwise practices will simply automate current paper processes.
- Changes are needed at every stage of care.
- Few practices fully appreciate the changes required to effectively use HIT and most are unprepared to successfully navigate the change process without assistance.



Lesson Learned: Technical Assistance Workforce Attributes and Skills

- Knowledge of provider circumstances.
- Trust of partners in professional and vendor community.
- Orientation to quality.
- Knowledge of clinic process redesign.
- Technical knowledge of HIT products.
- Vendor neutrality.



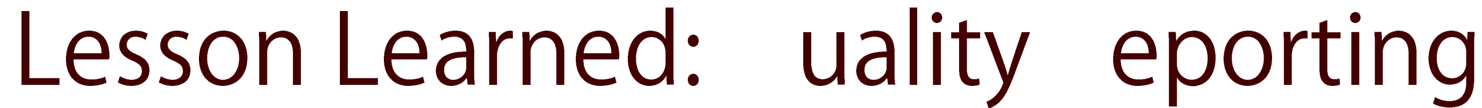
Lesson Learne : echnical ssistance orkforce ttri utes an Skills

- Ability to configure a variety of HIT products so they produce necessary reports.
- Detailed knowledge of structure of specifications for quality measures, how measures map to EHR architecture, and how to extract them so they can be reported.
- Knowledge of HL7 standards, HITSP interoperability standards, CCHIT criteria, clinical terminology, and technical interfaces with local health information exchange.

Lesson Learned: Caseload for Technical ssistance Workforce

- Estimates range from 1 technical assistance consultant for every 5 practices to 1 for every 30 practices.
- QIOs reported an average of 1 technical assistance consultant for every 18 practices (median 19).
- QIO ratios include a part time staff person back at the office to track practices and answer practice questions.
- Ratios were influenced by size of state, travel time (e.g., 1 consultant to 5 practices in a very rural state).
- Having centralized support (e.g., privacy policies, contract language, templates, vendor liaison process) would reduce the number of consultants required.
- Hospital providers require much more assistance because of the complexity of the organization.

- Support before, during, after system “go live.”
- At least monthly onsite contact.
- Onsite readiness assessment with entire practice (QIOs commonly invested a day).
- Coaching through 2-3 vendor demos.
- Schedule, accompany practice leaders on site visits to view finalist EHRs in use.
- Support contracting phase (e.g., suggest upgrade clause)—not in lieu of legal advice.
- Onsite guidance through the implementation customization phase (commonly 2 days).



Lesson Learned: uality eporting

- 3rd DOQ-IT task was to have practices report to a CMS data warehouse.
- Only a handful of practices were successful in reporting quality measures to CMS.
- Relatively few practices sought to report.
- Practices trying to report found many barriers to reporting were beyond their control.
- Understanding reporting barriers in DOQ-IT is useful in establishing “meaningful use” criteria.

Lesson Learned:
Barriers to uality easure Reporting

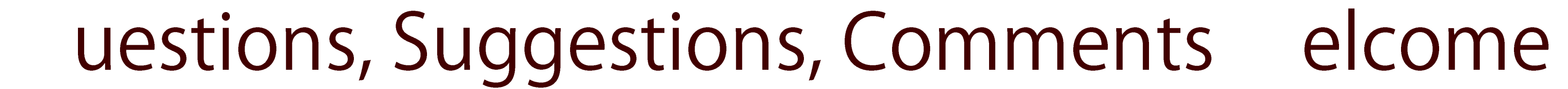
Relatively few practices sought to report:

- Practices took longer to implement EHR than they anticipated, so had no data.
- Physicians and vendors often focused on reporting through competing public and private reporting initiatives (e.g., PQRI) offering financial rewards and with no requirement to report through an EHR.

Lesson Learned:
Barriers to uality easure Reporting

Few practices could report, despite trying.

- EHRs could not export quality reports and were not easily reconfigured.
- Government data warehouse must be able to receive provider reports immediately.
- Government must provide certainty and lead time for reporting: vendors reluctant to invest resources in retroactively and frequently modifying their products to export data.
- Warehouse “help” desk must be available *when practices need it*.



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