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LESSONS LEARNED, INROADS EARNED

EHR adoption rate nearly perfect in New York's poorest neighborhoods thanks to focus on consistent implementation, intensive hands-on support

BY LINDA WILSON

If patients fall behind on their office visits to Dr. Michele Reed's medical practice, they'll hear about it. Literally.

A member of Reed's office staff will call them to schedule an appointment. A staff member queries the electronic health record (EHR) system once or twice a month for a list of patients with certain characteristics. Reed's practice typically focuses on one group of patients each time it pulls a list, such as diabetics with hypertension who haven't been in the office for more than three months.

Then the calling begins. Reed said her staff usually places between 50 and 70 calls per month; more than 60 percent of those patients show up for an appointment.

The reminders help Reed and the four other providers in her practice keep tabs on their patients, hopefully preventing a debilitating chronic disease in healthy patients or a decline in those who already have a medical issue.

The telephone calls appeal to patients as well. "They don't want to feel like they are just another number but that you sincerely care about their health. It is more of a personal touch; it's not like dropping a card in the mail," Reed said.

But that high-touch service would be virtually impossible without the EHR that Reed installed at her New York offices in Garden City and Rosedale (a neighborhood in Queens) in 2008. Reed says her office staff simply doesn't have enough time to cull through paper charts looking for patients who have fallen behind on their office visits. Reed's practice—MS Family Medicine Health Care—logs about 10,000 office visits annually.

MS Family Medicine Health Care is one of 500-plus primary care medical offices, comprising more than 2,400 physicians, in New York City that are using an EHR—thanks to the Primary Care Information Project (PCIP). A five-year-old initiative of the city's Department of Health and Mental Hygiene, PCIP provides subsidized software and related services to primary care providers who serve poor patients, including Medicaid beneficiaries.

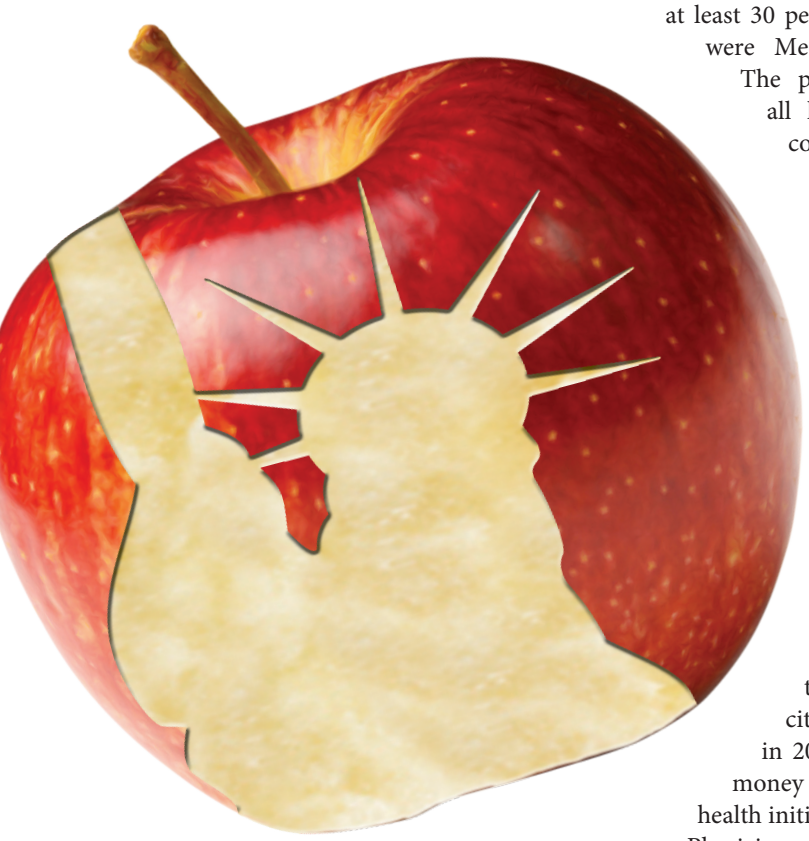
Nearly 40 percent of those providers—967—work at 452 small practices with one or two physicians, while 787 work at 32 community health centers, and 673 work at ambulatory clinics associated with five area hospitals. As of mid-January 2010, another 150 physicians were in the midst of implementing an EHR system, and PCIP had 200 software licenses left to hand out.

So far, only one of the PCIP providers gave up and unplugged the EHR system, giving PCIP a success rate of more than 99 percent.

Success under adverse conditions

As the 62 federally designated regional extension centers nationwide gear up to help paper-based medical practices transition to digital health records, PCIP is one model for how to succeed.

Indeed, the staff of the Office of the National Coordinator (ONC) for Health Information Technology includes two former PCIP employees, Dr. Farzad Mostashari, formerly the assistant New York City health commissioner in charge of PCIP and currently deputy national coordinator for programs and policy at ONC, and Mat Kendall, formerly director of operations for PCIP and currently director of the office of provider adoption support within ONC.



The idea for PCIP was launched during Mayor Michael Bloomberg's 2005 re-election bid, when he promised to commit $30 million to subsidize the cost of EHR adoption among physicians serving the poorest patients, Kendall recalled. The idea: use digitized records as a springboard from which to improve the health of poor and minority New Yorkers.

PCIP started small. "It began just with the providers in the three district public health office areas, which were the poorest, most medically underserved parts of New York. Those are the South Bronx, Harlem and Central Brooklyn. We wanted to get every provider in there," Kendall said. The program has since expanded to serve providers serving Medicaid patients in neighborhoods throughout the city.

To qualify for the program initially, physicians needed a caseload in which at least 30 percent of the patients were Medicaid beneficiaries. The physicians also paid all hardware costs and contributed $4,000 to the Fund for Public Health in New York to defray the cost of ongoing technical support from PCIP's experts.

PCIP has since modified its requirements: Physicians currently need a caseload that is at least 10 percent Medicaid, and they pay $5,200 to the fund, which city officials launched in 2004 to solicit private money to support public health initiatives.

Physicians also make a significant in-kind contribution because they scale back their office visits during go-live.

PCIP's EHR-enabled primary-care physicians are in the minority nationally. Less than half of all primary-care physicians, or 46 percent, use them, according to a 2009 survey funded by the Commonwealth Fund and published in *Health Affairs*. The adoption rate among providers serving the poor is much lower. The rate among community health centers, for example, was 13 percent in 2006, based on meeting federal requirements of minimal functionality, according to a 2007 paper in *Health Affairs*.

But the PCIP program goes beyond installing EHRs. PCIP staffers also manage numerous quality improvement programs, such as telephoning patients to schedule office visits as is done in Reed's practice. The project is funded with a $1.5 million grant from the Pfizer Foundation.

Lessons learned

PCIP already has applied the lessons its staff has learned to NYC REACH (Regional Electronic Adoption Center for Health), which is the federally designated regional extension center that PCIP manages.

The primary lesson: It is hard work. The staff at PCIP makes an average of 22 contacts with each physician's office before a contract is signed. "It is the kind of thing where every single touch makes a difference," said Dr. Amanda Parsons, the assistant health commissioner who now directs both PCIP and NYC REACH.

Implementation isn't any easier, she added. PCIP-subsidized physicians typically spend about 24 weeks to fully transition to an EHR, and even longer—anywhere from six months to 18 months—to feel completely comfortable using the system.

Why does it take so long? Many of the PCIP physicians work in practices with only one or two providers. They often not only treat and counsel patients but also answer phones, schedule appointments, file paperwork and send out bills, Parsons said. So when they transition to an EHR, they have to learn all of the automated functions necessary to run a medical practice, not just those that apply directly to physicians, such as how to order a lab test.

A minority—between 10 percent and 15 percent—begin their EHR journey with very little computing experience. "We have had providers who don't know how to upload a document or use a mouse," Parsons said. "We have had to meet them where they are, and

sometimes that has been at the very early stages. We have had to provide them with computer classes or early computer training," Parsons said.

That's another lesson PCIP staffers have learned: The process of helping physicians become savvy EHR users is very time-intensive. Vendors' on-site training during go-live is but a small portion of the support physicians need.

PCIP's managers addressed this problem through the structure of their program. First, they contracted with only one EHR vendor—eClinicalWorks in Westborough, Mass.—making it feasible for PCIP's employees to become certified experts in the system.

The single-vendor approach also provided PCIP with enough leverage to convince eClinicalWorks to customize its standard software for PCIP physicians with functionality that fosters clinical quality improvement.

For example, the system tracks data on public health issues—such as hypertension and cigarette smoking as well as vaccinations and cancer screening tests—and then includes alerts in individual patient records to remind physicians about the issues they need to address during a given patient's office visit.

A patient portal also is available. In the past, physicians paid extra for the portal but now it is included with the standard eClinicalWorks package. So far, "less than 5 percent of providers have turned it on," Parsons said, but she expects the percentage to increase to "80 percent in the next year [because] it is one way to satisfy several meaningful use criteria."

Boots on the ground

PCIP also has put together a panel of reasonably priced and competent outside information-systems consultants because PCIP requires physicians to retain the services of an IT consultant.

"We didn't initially require that they had an IT consultant. It wasn't until a year later that we realized what a mistake that was," Parsons said. The providers "don't have the ability to protect person-

The Primary Care Information Project

The Primary Care Information Project (PCIP) isn't about technology but about public health.

Through PCIP, New York City subsidizes the cost of EHR adoption for primary care physicians serving the poor because of the role digitized health records can play in helping physicians improve both preventive care and the management of chronic medical issues, such as hypertension or diabetes. Through better medical care for needy patients, city officials hope to address the problem of health disparities—the tendency of the poor to be sicker and die younger than their more affluent peers.

PCIP staffers solicit grant funds to pay for clinical quality improvement.

One example of PCIP's quality improvement efforts is Health eHearts.

PCIP launched Health eHearts in 2009 with a $6 million grant from the Robin Hood Foundation, a New York City-based philanthropy. Health eHearts operates like a clinical trial. Physicians in one group earn payments based on their performance on cardiovascular best practices, while physicians in the second group do not receive the payments. PCIP sends all doctors reports summarizing their performance on each of three metrics:

- Patients with either hypertension or high cholesterol whose disease is well controlled.
- Patients with diabetes or coronary artery disease who are on an aspirin regimen.
- Smokers who receive smoking-cessation treatments or counseling to help them quit.

Incentive payments are not only tied to performance but also are based on whether a patient has other health conditions or is a Medicaid beneficiary or uninsured. "You are not incentivized to drop patients; you spend more time on the patients who need it the most," said Dr. Amanda Parsons, the assistant New York City health commissioner in charge of PCIP.

Surprisingly, there was no significant difference in the performance between the two groups of physicians during the first year of the study, which ran from April 1, 2009 to March 31, 2010. Both groups performed well. As a result, PCIP increased the size of the performance bonuses in the second year and also plans to pay bonuses quarterly instead of annually to see if the changes "tease out" a difference between the two groups, Parsons said.

Dr. Michele Reed, a family practice physician with two offices, participates in the program and is in the incentive group. While she won't disclose the size of her performance bonus for the first year of the study, she says money wasn't the primary reason she was driven to improve her patients' health.

"For me, prevention is the key, but if you already have the disease, my job is to prevent it from getting even worse," said Reed.

al health information or set up firewalls. They don't know how to protect wireless access nodes," Parsons said. "We have had people who have kept servers under their front desk and then the front-desk staff knocked over coffee and destroyed the whole server."

PCIP also has a 90-person staff of hands-on experts divided into teams. The teams augment eClinicalWorks' training services.

For example, a PCIP implementation team helps physicians prepare for an EHR implementation. Team members coach physicians on how to reorganize their work processes to accommodate the EHR. The team also follows up with physicians immediately after the vendor's trainer leaves to help with unanswered questions and ensure that physicians and office staff are entering information into the EHR correctly.

"We could be on site for hours," said Anastasia Perchem, implementation manager for small practices.

Another team of experts is certified in eClinicalWorks, providing ongoing help for up to two years after physicians go live. Other teams focus on clinical quality improvement and billing issues, while an outreach team recruits physicians for the program.

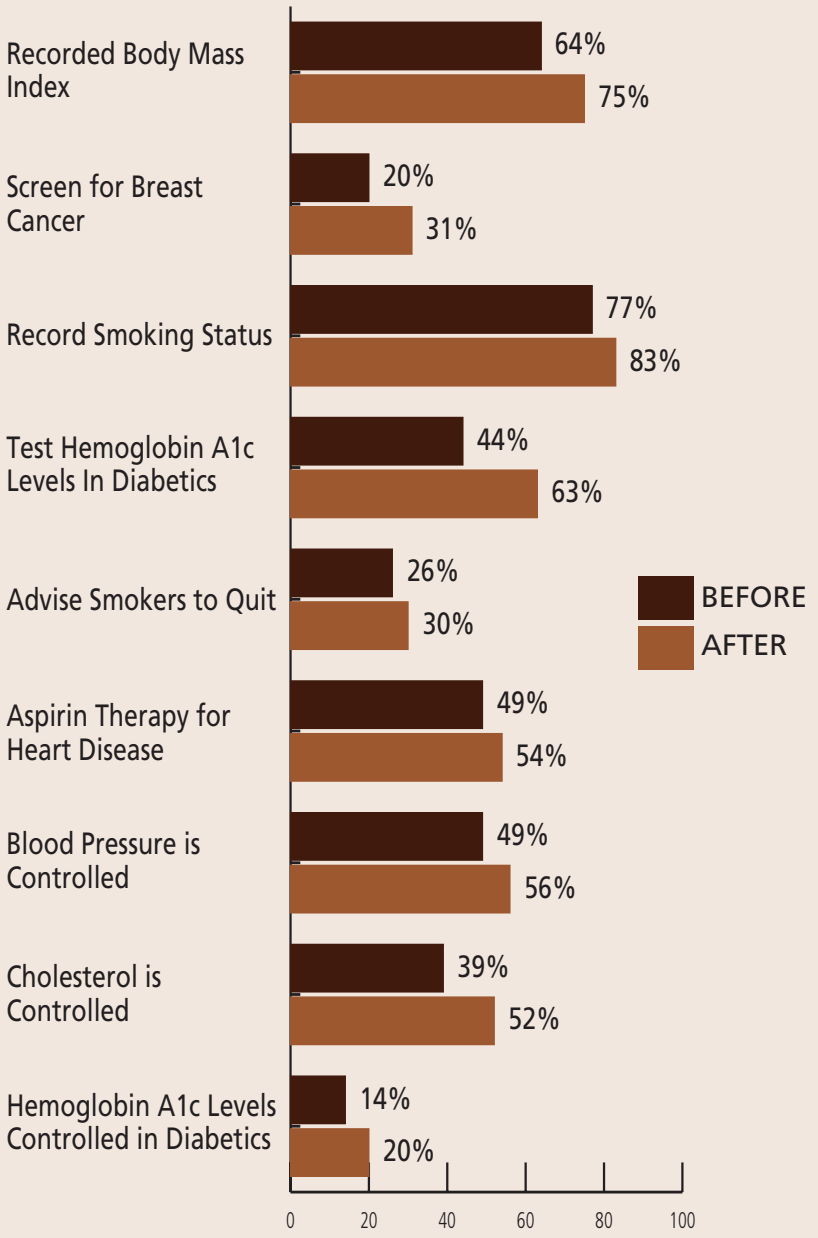
"They have made a big difference. Their people come to my practice all the time. This software is really quite elaborate and has so many features that a solo guy like me could never sort through," said Dr. Jack Resnick, whose medical practice is located on Roosevelt Island.

The EHR "has changed how I practice medicine," said Resnick. First, he now carries a tablet computer rather than a briefcase full of paper files on house calls to patients who are poor, disabled and elderly—comprising about one-third of his business.

Second, he said, "The data is there. You can find it. It doesn't get lost. The system almost forces you to organize the medications; to make sure they are all right, and to look at the labs." ■

Electronic Health Records = Healthier New Yorkers

The Primary Care Information Project (PCIP) measured the performance of providers on seven clinical measures, comparing two time periods: After they went live on an EHR, and after they activated the system's decision support features and received extensive training on how to use an EHR.



Source: Primary Care Information Project : Based on data from 51 practices, sample of more than 6,000 patients.