NYC REACH Newsletter

June 2018

Volume 1, Issue 2

Welcome to the second issue of the NYC REACH Newsletter.

In this issue, we highlight events where experts shared Meaningful Use updates, discussed the benefits of using qualified entities, and led discussions with Accountable Care Organizations to address their specific concerns related to qualified entity implementation.

The Meaningful Use program is entering its final stages, so this issue covers some key changes in performance years 2018 – 2021. We will continue to share important program updates in e-mail communications and on our website.

We also include an interview with Teresa Chan, MD, the family practice physician and general practitioner at Lower East Side Family Medicine. She discusses her approach to primary care and how she connects with fellow providers and healthcare organizations.

Enjoy the newsletter!

Sincerely,
The NYC REACH Team

In this issue

NYC REACH Learning Collaboratives
Meaningful Use and Beyond

The Meaningful Use program is entering its final stages, and eligible providers (EPs) will need to learn about new requirements introduced in performance year 2018. NYC REACH hosted two learning collaboratives this spring: one for large practice administrators and a second for practices of all sizes. At both collaboratives, experts shared program updates to Meaningful Use Modified Stage 2 and Stage 3, and resources to guide providers through the final years of the program. For more information on these updates, visit page 6.

Meaningful Use for Large Practices

In April, NYC REACH hosted an event for large practice administrators working to achieve Modified Stage 2 or Stage 3 Meaningful Use. During the interactive event, attendees were able to network and brainstorm strategies to successfully meet program objectives.

NYC REACH experts and representatives from the New York State Department of Health presented strategies for meeting challenging measures such as e-prescribing, health information exchange, public health reporting, and patient engagement. One New York State representative shared a particularly exciting change for attesting to performance years 2017 and 2018: New York State's EHR Incentive Attestation System (also known as MEIPASS) will be fully functional. EPs will no longer need to partially attest with workbooks.

NYC REACH experts also facilitated small group discussions to answer questions about the content and address individual concerns.

NYC REACH expert addresses questions about e-prescribing

Meaningful Use Stage 3

A multi-part collaborative in May also included a Meaningful Use component. Attendees from practices of all sizes learned specifics about Meaningful Use Stage 3 including eligibility, objectives, clinical quality measures, and incentives. Representatives from New York State also shared information about MEIPASS.

One key change discussed was the new health information technology requirements. EPs will need to use a 2015 edition of certified electronic health record technology (CEHRT) to submit data for Stage 3. Using a 2015 CEHRT is required because some of the Stage 3 objectives cannot be met with previous editions.

An NYC REACH expert shared an overview of the Centers for Medicare & Medicaid (CMS) Proposed Rule for the program. This rule establishes incentive rates, quality reporting requirements, and other policies for all participants in CMS Promoting Interoperability (EHR Incentive) Programs. The proposed rule was published in May, CMS accepted comments until the end of June, and the rule will be finalized in Fall 2018. Any changes in this rule will impact program requirements for the 2019 and 2020 performance years.

NYC REACH TIP

Providers must have a plan to upgrade to a 2015 CEHRT by the end of 2018.

A change to the program's name was also explained. CMS is now referring to Medicaid and Medicare EHR Incentive Programs as Promoting Interoperability Programs. The NY Medicaid EHR Incentive Program is a CMS Promoting Interoperability Program, but will continue to operate under the name NY Medicaid EHR Incentive Program. NYC REACH will continue to refer to the program as Meaningful Use.

Read about the other portions of this event on page 4.

NYC REACH experts network with attendees

Support Services for Providers

NYC REACH has created numerous resources for members to support them with program participation. At the event, attendees received educational materials covering Modified Stage 2 and Stage 3 objectives, alignment between other programs, guides to using CEHRT, and more.

These are all available on the NYC REACH resource library. To access these resources, visit www.nycreach.org.

Visit page 6 for more information about program changes. NYC REACH will continue to update providers through member digests, other email communications, and website and resource library posts.

Do you know a provider who could benefit from attending these events? Please invite them to contact pcip@health.nyc.gov to learn about NYC REACH membership.

NYC REACH Learning Collaborative
Qualified Entities & Health Information Exchange

The NYC REACH multi-part collaborative in May reached beyond the scope of Meaningful Use to include discussions about qualified entities (QEs) and health information exchange (HIE). HIE is the process of exchanging health information electronically, and a QE is a system that facilitates HIE. Qualified entities are regionally based and thus often referred to as regional health information organizations (RHIOs).

QEs provide a comprehensive view of patient care. These systems streamline communication between independent providers, patients, hospitals, pharmacies, and other organizations involved in a patient's care. Connecting to a QE is also an important step towards success in practice transformation programs such as Meaningful Use, the New York State Patient-Centered Medical Home, and the Quality Payment Program.

At the event, NYC REACH experts explained the benefits of using a QE, how to connect to one, and the HIE landscape in New York City. Representatives from the New York City QEs - Bronx RHIO, Healthix, and NY Care Information Gateway (NYCIG, formerly known as Interboro) - gave live product demonstrations and described their networks and services for participant organizations. Providers who have connected to these QEs discussed their experiences with the networks.

An additional conversation about QEs took place during an Accountable Care Organization (ACO) Roundtable, which focused on how ACOs can use QEs to achieve population health goals.

Provider Perspective

Providers shared their own reasons for using a QE during a panel moderated by **Sachin Jain, MD**, Executive Director, Informatics and Evaluation, Primary Care Information Project. Chief among these reasons is the real-time alert function. QEs send alerts to providers on a range of patient activities, including when a patient visits the emergency room (ER) or is hospitalized, is incarcerated, or enters a homeless shelter.

From left to right: Sachin Jain, MD, Sarah C. Nosal, MD, FAAFP, Kenneth Boockvar, MD, and Sue-Ann Vilano.

Sarah C. Nosal, MD, FAAFP, Chief Medical Information Officer at the Institute for Family Health and Medical Director at the Urban Horizons Family Health Center, notes that these alerts are particularly helpful for treating complex patients.

"I'll get an alert that a patient is at the ER instead of an appointment, and we can intervene," said Nosal. "We can prevent them from unnecessarily using the system and connect them with the right care."

Kenneth Boockvar, MD, Internal/Geriatrics Specialist at Bronx Veterans Hospital and Associate Director for Research at the James J Peters VA Geriatric Research, Education, and Clinical Center, pointed out the value in having a patient's full medical history in one place. "I once had a new patient that couldn't remember why they were taking a certain medication," recalls Boockvar, "and I found through the RHIO that they were being treated for a rare condition that I otherwise would not have known about."

ACO Roundtable

The Primary Care Information Project's ACO Roundtable Series gives ACOs opportunities to network, share best practices and common concerns, and work together to develop innovative solutions for communities across New York City and State. PCIP hosts roundtables focused on various topics including value-based payment arrangements, quality-based programs, closing referrals loops, and more.

At the ACO Roundtable, QE representatives presented the key ways that ACOs can use QEs to achieve their population health goals. PCIP invited HHC ACO, Inc. from NYC Health + Hospitals to share a case study of how they use data insights from NYCIG to drive quality improvement strategies. HHC ACO finds the care transition data particularly useful. Care transition data includes medication, diagnoses, reasons for referral, and other health information providers need to ensure successful transitions.

HHC ACO also engages primary care clinical leadership to learn about data needs and deliver actionable data at the clinical level regularly. They monitor key metrics to understand treatment impact, and celebrate success in clinical leadership meetings.

Since connecting to NYCIG, HHC ACO has seen decreases in hospital discharges, emergency department utilization, and ambulatory care sensitive condition discharges. They have also made significant improvement in their overall quality score.

Bronx RHIO, Healthix, and NYCIG all offer similar features. NYC REACH offers free technical assistance with connecting to a QE. Contact NYC REACH at (347) 396-4888 or pcip@health.nyc.gov to learn more.

Meaningful Use Through 2021: FAQs for Providers

Meaningful Use, also known as the NY Medicaid EHR Incentive Program, is still active and will continue through 2021. This gives eligible providers (EPs) more time to participate and earn additional incentive dollars.

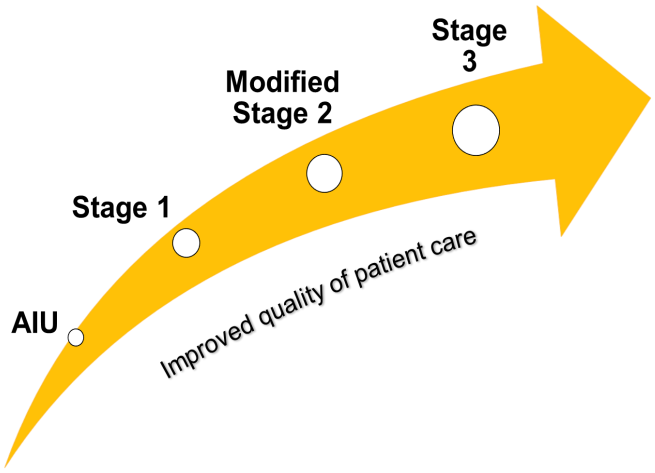
Providers may have heard about recent changes to the program, including new objectives and eligibility requirements. To address the changes, we have included answers to frequently asked questions below. We also list resources available on the NYC REACH resource library - including webinars, fact sheets, and detailed guides - that can provide EPs with more information on all aspects of the program. NYC REACH will continue to provide resources and updates to ensure successful participation.

Has the name of the program changed?

The Centers for Medicare & Medicaid Services (CMS) is now referring to Medicaid and Medicare EHR Incentive Programs as Promoting Interoperability Programs. The NY Medicaid EHR Incentive Program is a CMS Promoting Interoperability Program, but will continue to operate under the name NY Medicaid EHR Incentive Program. NYC REACH will continue to refer to the program as Meaningful Use.

What are the eligibility requirements?

- Eligibility requirements related to Medicaid patient volume and eligible provider type have not changed from previous years.
  - Eligible provider types: Physician (MD or DO), Nurse Practitioner, Certified Nurse-Midwife, Dentist, Physician Assistant (PA) who furnishes services in a FQHC or Rural Health Clinic led by a PA
  - 30% of encounters are Medicaid patients (20% for pediatricians)
  - Medicaid patient volume reporting period is 90 days



- EPs who have **not** attested prior to 2016 cannot attest moving forward.
- To attest to performance years 2017 through 2021, EPs must have received and **kept** at least one incentive payment for performance year 2016 or earlier. Incentive payments that were returned due to a failed audit cannot be counted.
- EPs can only participate for six years. EPs who successfully attested to six years already are unable to attest moving forward.

For more information
Watch NYC REACH's recorded webinar, Meaningful Use Stage 3: What Eligible Professionals Need to Know in 2018 and Beyond

What is the difference between Modified Stage 2 and Stage 3?

EPs may attest to Modified Stage 2 or Stage 3 in 2018. All EPs are required to attest to Stage 3 starting in performance year 2019. The measures in Stage 3 reflect higher thresholds of patient engagement and utilization of electronic health record (EHR) technology, but allow for additional flexibility within certain measures.

GOALS

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency & efficiency
- Empowered individuals
- More robust research data on health system

If an EP attests to Modified Stage 2 in 2018, the EP should make all necessary preparations for Stage 3 by the end of 2018. This includes upgrading software and tracking performance on the Stage 3 measures.

Key differences between Modified Stage 2 and Stage 3 and performance years 2018 and 2019 include:

- Performance year 2018: Modified Stage 2 includes 10 objectives
- Performance year 2018
  - Modified Stage 2 or Stage 3: EPs attest to a continuous 90-day period
  - Modified Stage 2: EPs can use 2014 CEHRT, 2015 CEHRT, or a combination of 2014 and 2015 CEHRT
  - Stage 3: EPs can use 2015 CEHRT or a combination of 2014 and 2015 CEHRT
- Performance years 2018 and 2019: Stage 3 includes 8 objectives with mostly higher thresholds
- Performance years 2018 and 2019: Stage 3 reduces reporting burden by aligning with other federal and state programs, specifically the Merit-based Incentive Payment System (MIPS) track of the Quality Payment Program (QPP)
- Performance year 2019
  - Stage 3 (required): EPs attest to a full calendar year; CMS recently proposed a rule that would change the reporting period to 90 days, but this rule has not yet been finalized
  - Stage 3 (required): EPs must use 2015 CEHRT

For more information

Refer to NYC REACH's Meaningful Use Modified Stage 2 and Stage 3 Objectives fact sheet. This compares requirements for Meaningful Use Modified Stage 2 and Stage 3. Read the Meaningful Use Stage 3 Objectives and Measures guide. This contains the full list of requirements for Stage 3.

Can I still receive program incentives?

Yes. EPs who participate in the program for six years can receive the maximum incentive funds of $63,750. Participation does not have to be consecutive, but the last year providers can attest and receive a payment for is performance year 2021. After the first year of the program, providers can earn $8,500 for each year that they successfully achieve Meaningful Use.

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Can participation help my practice with other programs?

Yes. Continued participation in Meaningful Use will prepare providers to be successful in new programs that are shifting towards value-based payment arrangements, such as QPP and New York State Patient-Centered Medical Home (NYS PCMH).

Stage 3 requirements related to the use of health information technology (HIE) and care coordination can be used towards NYS PCMH. Other Meaningful Use activities can be counted toward QPP scoring. Eligible clinicians who successfully participate in QPP can avoid negative payment adjustments and may be eligible for positive payment adjustments.

For more information
Refer to the Meaningful Use Clinical Quality Measures crosswalk. This is a full list of eCQMS that count towards Meaningful Use, NYS PCMH, QPP, and other programs.

How do I attest?

MEIPASS is the New York State Department of Health portal used for attestation. EPs should continue to monitor emails from NYC REACH for more information on attestation deadlines, processes, and resources.

For more information
Use NYC REACH's Meaningful Use Pre-Attestation Checklist as a guide throughout the process.
Watch NYC REACH's recorded webinar, Medicaid Meaningful Use Pre-Attestation Administrative Processes.

Where can I find additional support?

NYC REACH staff will continue to work directly with members to ensure successful participation in the program. NYC REACH will alert members to any program updates via member digests, other e-mail communications, and website updates. Additional materials in the resource library can guide clinicians through the program. These include webinars and fact sheets on pre-attestation, the public health reporting objective, audit preparation guides, CEHRT requirements, and more. Visit www.nycreach.org to access the resource library.

To request support with Meaningful Use, contact NYC REACH at (347) 396-4888 or pcip@health.nyc.gov.

Q&A with Teresa Chan, MD

Teresa Chan, MD, is a member of NYC REACH and the Primary Care Information Project Physician Advisory Council (PCIP PAC). Dr. Chan runs a solo private practice, Lower East Side Family Medicine, within one of the Seward Park Cooperative Towers. Her sister, Serena, is the RN and office manager. Luis Espinoza is the medical assistant. The practice opened in 2013, but Dr. Chan has been serving the Lower East Side community in various non-profit settings since 2000.

From left to right: Luis Espinoza, Teresa Chan, MD, Serena Chan

This small practice sees about 20 patients a day. They treat teenage, adult, and geriatric patients (the oldest patient is 98 years old). The patients come from diverse backgrounds and many speak only Spanish or Cantonese - which Dr. Chan speaks as well. Holding to Dr. Chan's belief in the importance of access to good medical care, the practice accepts all kinds of insurance. Patients come from all five boroughs and nearby states including Connecticut and New Jersey. Even patients who spend most of the year in Florida continue to visit Dr. Chan.

We spoke with Dr. Chan about her approach to primary care and her experience with the PAC.

What are solutions to challenges facing NYC providers?

One of the early challenges was that not everyone was on board with using an EHR. And while there have been significant increases in electronic health records adoption over the past decade, there are still outliers and skepticism abounds. There's a wide perspective on the utility and role of EHRs in healthcare - what it should be doing is augmenting our ability to help our patients. Interoperability is also a big deal. If more electronic data can be shared between providers, that will improve the way we practice and what we can do for our patients. Care needs to be as comprehensive and holistic as possible, and increased interoperability will be one thing that can help get us there. There are so many different EHRs, so getting these systems to talk to each other will be a big deal. I absolutely do believe in health information exchanges, we just need to get it to work seamlessly for both big organizations/hospitals and community physicians.

How do you work with other organizations to improve patient care?

Over the years, NYC REACH has definitely helped us with practice transformation efforts. My practice just attested to Meaningful Use for the fourth year. Our practice facilitator has been really instrumental in navigating that whole process.

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I did the HealthyHearts program and Join the BEAT as well. It's definitely paid off for us. We also are part of Healthix, a qualified entity of the State Health Information Network of New York (SHIN-NY).

Joining CAIPA (the Chinese American Independent Practice Association) has also been greatly beneficial to my practice. They are very proactive about supporting their members and helping us with quality assurance projects, providing us tech/EHR support as well as helping us maximize reimbursement via better contracts with certain insurers.

How important is self-care for providers?

The emotional, spiritual well-being of PCPs is so important. You absolutely have to regenerate and detoxify every day...it's like the oxygen mask when the plane's going down. Like I tell my patients, you have to find a way to manage stress. I do carve out time for myself and my staff to take breaks and holidays. We have kids. When we close for Christmas break, we close. We're not going to sacrifice that family time. I don't ask my staff to hold down the fort while I'm gone; if I'm on vacation, we're all on vacation. There needs to be that time for family and friends.

I practice the way I feel is in the best manner for my patients and for my team. I'm big on preventive care and on continuity. I love talking to my patients and letting them talk to me! I can spend up to an hour on a new patient physical, for example. It's probably not the best business decision to do that, but if I couldn't do it this way, I probably would have quit medicine years ago. At the end of the day, I need to be able to find time for me and my family, have a flexible schedule, and decide how many patients I can or need to see in a day to make it all work. Without that flexibility, I can't provide the kind of care that I believe my patients deserve. The key is to practice medicine the way that works best for you.

About the PAC

The Primary Care Information Project (PCIP) aims to create services and programs that address common challenges facing NYC primary care providers. In order to understand those challenges and provide solutions, PCIP solicits input from a Physicians Advisory Council (PAC), a diverse group of providers from across the City.

The PAC provides a clinician's perspective on range of issues in primary care – from managing high blood pressure, to operating under value-based payment arrangements, to adopting electronic health record technology. This valuable insight guides PCIP's broader efforts to change care management and workflows, strengthen the healthcare system through advocacy and technology, and mitigate the burden of chronic disease.

How did you get involved with the PAC?

When I was a physician at the Henry Street Settlement, I helped to launch their first EHR system. I reached out to NYC REACH for assistance with that project. I got involved with PCIP back in 2010, when PCIP's main goal was to get providers set up with EHRs. We talked about helping providers with health information exchange and vendor selection as well as barriers to Meaningful Use and provider outreach.

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We were a sort of "focus group" for PCIP. I felt from a provider standpoint that it was a great opportunity to be a part of that conversation.

How does connecting with other providers help your practice?

I find our quarterly PAC meetings very helpful, very inspiring - hearing other people's stories and managing solutions. It's the amount of help that is offered from the council itself, and the friendships we've developed outside of the council. We can ask each other questions about our practices and things like, "What's your answering service? How are you using the EHR? What templates have you created?" I even completed a course through Small Business Services with other council members that gave us insight into how practices could be run better like any other business.

How important is involving providers in healthcare policy?

Providers want to know where these decisions come from; who's deciding what we need to do and how we do it to determine if we are good doctors. And that's part of the problem – [policymakers] can forget about the provider in the process. Of course, as good physicians, we want to have everyone quit tobacco, we want to get our hands around the opioid crisis, and we want to help patients who are depressed. But at the end of the day, this is not always possible to do without help. It's important to canvass the people on the front lines to see what's preventing them from doing the right thing by their patients. You want to *help* them be better doctors. It's nice to hear our city understanding that and wanting to help.

Sometimes it feels like our needs aren't really understood or taken into consideration. We lack resources and have a lot of red tape with insurers. There are many things I wish I could have at my fingertips for my patients… things related to insurance issues, reimbursement issues, mental health access and social work resources. We can share those "wish lists" with PCIP.

How does the PAC play a role in that?

The PAC gives PCIP a perspective from the trenches that they otherwise wouldn't have. And it allows primary care providers like me to see what's on the horizon. For example, if the City is rolling out a tobacco cessation program they may show us the plans ahead of time and get our perspective. They get our opinion on whether we think it will work, what should change, what's going to be helpful. That's always part of the problem when you make policy: if you don't know how things really work in a real practice setting, you can't know if it's going to be successfully adopted or welcomed by the providers you are trying to help or target. Having this diverse group on the PAC means that everyone brings a really unique perspective to the table and can increase the chances of a successful endeavor.

PCIP will soon begin the selection process for the 2019 PAC. If you are interested in joining the PAC, e-mail pcip@health.nyc.gov to learn about the application process and membership commitments.

ABOUT NYC REACH

New York City Regional Electronic Adoption Center for Health (NYC REACH) is New York City's Regional Extension Center, a designation of the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology.

NYC REACH supports and enhances the healthcare delivery system to improve population health by assisting New York City-based independently-owned private practices, community health centers, and hospital-based ambulatory sites with adopting and implementing health information systems, quality improvement, and practice transformation initiatives. To accomplish these goals, NYC REACH provides technical expertise and guides healthcare practices to utilize delivery models that emphasize care coordination, patient engagement, and community resource linkages.

NYC REACH is operated by the Primary Care Information Project (PCIP), a bureau in the Division of Prevention and Primary Care at the New York City Department of Health and Mental Hygiene.

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