NYC REACH Newsletter

September 2018

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Welcome to the September issue of the NYC REACH newsletter.

In this issue, we provide an overview of confirmed changes to the Meaningful Use program in performance year 2019, and dedicate a full feature to new requirements related to the use of electronic health record systems.

The New York City Department of Health and Mental Hygiene has launched a campaign to address gaps in depression treatment, so we share new care recommendations and resources designed to support primary care providers in addressing depression in their patients.

Finally, we include an interview with Emmanuel Fashakin, MD, who runs Abbydek Family Medical. He discusses the practice's experience with NYC REACH-supported programs and how becoming a patient-centered medical home has improved his practice.

Enjoy the newsletter!

Sincerely,
The NYC REACH Team

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Meaningful Use
Preparing for Performance Year 2019

The Centers for Medicare & Medicaid Services (CMS) has confirmed updates to the Meaningful Use (MU) Program for the 2019 performance year. Requirements and reminders for eligible providers (EPs) participating in Meaningful Use are listed below.

CEHRT Requirements

- EPs must use 2015-edition certified electronic health record technology (CEHRT) during their EHR reporting period for performance year (PY) 2019.
- EPs will no longer be able to meet program requirements using 2014-edition or combination of 2014- and 2015-edition CEHRT.
- Refer to pg. 4 for more information about this requirement.

Stage 3 Participation

- EPs must meet MU Stage 3 objectives and measures in PY 2019 to earn incentive payments. Attesting to Modified Stage 2 is no longer an option.
- MU Stage 3 measures reflect higher thresholds for patient engagement and utilization of EHR technology, but allow for additional flexibility within certain measures.

Reporting Requirements

- The EHR reporting period will be 90 days for all EPs in PY 2019, as in PY 2018.
- The electronic clinical quality measure (eCQM) reporting period will be a full year in PY 2019 for EPs who have previously attested to MU, as in PY 2018.
- The eCQM reporting period for EPs attesting to MU for the first time in PY 2019 will remain 90 days .*
- EPs are required to report on any **6** eCQMs relevant to their scope of practice, as in PY 2018. A full list of eCQMs updated for PY 2019 is available here.

*For example, an EP may have successfully attested and been paid for AIU for PY 2016, but does not plan to attest to MU in PY 2017 or 2018. If this EP attests for MU in PY 2019, they are considered to be attesting to MU for the first time.

Eligibility Requirements

Eligibility requirements will not change.

- Eligible provider types: physician, nurse practitioner, certified nurse-midwife, dentist, physician assistant who furnishes services in a FQHC or Rural Health Clinic led by a PA.

- Medicaid Patient Volume requirements: At least 30% of encounters must be rendered to Medicaid-enrolled individuals (at least 20% for pediatricians) as demonstrated during a 90 day reporting period.

- Only EPs who have successfully attested and been paid for PY 2016 or a prior program year are eligible to attest to PY 2019. EPs who have not successfully attested to a prior program year are not eligible to join the program.

- EPs can participate in the program for a maximum of six years. If PY 2018 is the EPs' sixth year successfully attesting, the EP will have earned the maximum program incentive payments available and will not be able to attest to PY 2019, 2020, or 2021.

EPs who have successfully finished the MU program are encouraged to join more advanced practice transformation programs supported by NYC REACH, such as New York State Patient-Centered Medical Home.

How to Prepare

- EPs who did not attest to MU Stage 3 in PY 2018 should make all necessary preparations for MU Stage 3 by the end of 2018. This includes upgrading to a 2015-edition EHR, adopting workflows for new measures, and beginning to track performance on MU Stage 3 measures.

- NYC REACH will continue to develop educational materials to assist with MU Stage 3 participation. Visit the resource library at www.nycreach.org and browse the Meaningful Use folder for webinars and fact sheets, including the following:

Webinars
Meaningful Use Stage 3: What Eligible Professionals Need to Know in 2018 and Beyond
Meaningful Use Stage 3 Objectives and Measures

Fact Sheets
Meaningful Use Stage 3 Objectives and Measures
Certified Electronic Health Record Technology: Meaningful Use 2018 and 2019 Requirements

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

CEHRT Upgrade Required for Meaningful Use 2019

Eligible Providers (EPs) must use Certified Electronic Health Record Technology (CEHRT) to attest to Meaningful Use (MU). CEHRT refers to EHR systems that meet a set of criteria required for the program. Starting in performance year 2019, EPs must use a 2015-edition CEHRT to attest to MU Stage 3 objectives and measures. EPs will no longer be able to use a 2014-edition CEHRT or a combination of 2014 and 2015 CEHRT.

Why 2015 CEHRT

Most criteria categories for the 2014 and 2015 editions are the same. However, 2015-edition CEHRT **expands on the capabilities of 2014 editions** to improve patient care, patient engagement, and health information exchange. These advanced capabilities can improve a provider's ability to meet Meaningful Use objectives. EPs will not be able to attest to MU Stage 3 without 2015-edition CEHRT.

A key difference is that Application Programming Interfaces (APIs) are incorporated into 2015-edition CEHRT. APIs allow providers to view patient data found on commonly used health applications on smartphones. These health applications **automatically capture and summarize information** related to various aspects of a person's health (such as sleep quality and exercise). Patients can use this information to play a greater role in their own care and share progress with providers.

When to Upgrade

Upgrading to a new edition is a multi-step process, so EPs should begin the process as soon as possible. EPs will need time to communicate with their EHR vendor, familiarize staff with the new system, transfer necessary practice information, and perform other related tasks before fully implementing the new system. The entire process may take several months to complete. As a first step, providers should contact their EHR vendor to discuss 2015 CEHRT availability.

NYC REACH Support

Visit the Meaningful Use Pre-Attestation folder on the NYC REACH Resource Library to access the document entitled **Certified Electronic Health Record Technology: Meaningful Use 2018 and 2019 Requirements**. This includes best practices for upgrading, a guide to discussing the upgrade with a vendor representative, and checklists providers can use to keep track of important pre- and post-upgrade tasks. Pre-upgrade tasks are listed below.

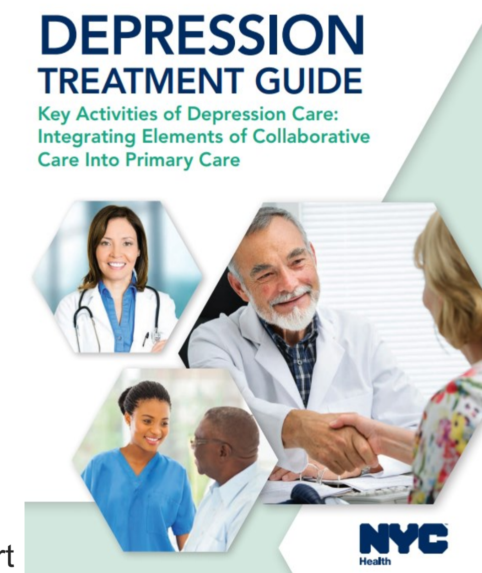
Pre-Upgrade Tasks

Practices should perform the following tasks before implementing the new system to ensure a smooth transition process.

- [ ] Confirm the amount of time required to upgrade the CEHRT
- [ ] Determine any costs involved with the upgrade
- [ ] Understand which features will be included in the new system
- [ ] Plan for CEHRT upgrade-related down-time; reduce patient scheduling to allow time for staff training and confirming that all necessary functionality is available
- [ ] Save important documents and reports on a computer, external hard drive, or in paper files
- [ ] Designate super users at the practice - a group of staff familiar with the practice's processes, workflows, and CEHRT: super users can help with workflow adjustments, staff training and post-upgrade issues
- [ ] Train staff to use the new system and update roles and responsibilities

To request support with upgrading an EHR system, contact NYC REACH at (347) 396-4888 or pcip@health.nyc.gov

New Depression Treatment Resources



The New York City Department of Health and Mental Hygiene (NYC DOHMH) has undertaken a number of initiatives to expand access to mental health services, including the treatment of depression. According to recent estimates, more than half a million adults in the City have depression, and nearly 60 percent of those individuals are not being treated.[+]

One of the most effective ways to reduce gaps in behavioral health treatment is to identify and treat depression within primary care. NYC DOHMH's Public Health Detailing Program, a provider education and engagement program, has launched a campaign to support primary care providers and staff, and equip them with the necessary tools to address depression in their patients. Through this campaign, NYC DOHMH has provided evidence-based recommendations and supporting materials related to the screening, management, and treatment of depression.

Care Recommendations

The treatment of depression within primary care presents an opportunity to improve overall patient health. Depression can contribute to and worsen chronic disease, and is associated with poor medication adherence among patients with chronic disease. Adults with chronic disease and low-income individuals are more likely to report being depressed. NYC DOHMH recommends a number of ways to integrate depression treatment into practice workflows. Evidence-based recommendations include:

1. Use the PHQ-9 to screen all patients for depression at least annually and monitor treatment response.
2. Educate patients on the connection between physical health and mental health when counseling them on diet, exercise, other lifestyle modifications, and self-care.
3. Develop and implement a treatment plan using the key principles of collaborative care, and engage patients in the care planning process.
4. Consider social factors that influence health, such as employment and housing, and connect patients to community resources that can address their social needs.

+New York City Department of Health and Mental Hygiene. NYC Health and Nutrition Examination Survey, 2013-2014.

Resources for Providers

The cornerstone of this campaign is the Depression Action Kit, which contains clinical tools, provider resources and patient education materials. Designed to be used across the entire practice, the Action Kit supports the integration of depression and other behavioral healthcare into a practice's workflow using the evidence-based Collaborative Care Model. Tools and resources to support this include:

Clinical Tools

- Patient health questionnaire-9 (PHQ-9) screening tool
- Informational flip chart for patients to learn more about depression
- Depression self-management goal sheet for patients

Provider Resources

Materials provide guidance on:

- Communication strategies for speaking with patients about depression
- Strategies for identifying depression and improving care
- Addressing patients' social needs for better mental health
- Identifying and treating depression in primary care
- Mental health services billing

Patient Education Materials

Patient education materials in the Action Kit are designed to empower patients and de-stigmatize depression. This helps patients and their family and friends to understand their condition. These materials - which include health bulletins, brochures, and posters - are targeted to all literacy levels and available in multiple languages. They cover:

- Types of therapy and self-care
- How to get help 24/7
- How to communicate with healthcare providers

How to Order Materials

To download this kit, visit nyc.gov/health and search "Depression Action Kit."

To download action kits designed for the management of chronic diseases - including diabetes and hypertension - visit www.nyc.gov/health and search "Public Health Action Kits."

To order select materials from the Action Kits, call 866-692-3641. Additional resources include medication lists for patients, a medication adherence fact sheet, and a patient guide to speaking with providers about medication.

To learn more about how your practice can incorporate behavioral health treatment, contact NYC REACH at (347) 396-4888 or pcip@health.nyc.gov.

Q&A with Emmanuel Fashakin, MD

Dr. Emmanuel Fashakin runs a family medicine practice called Abbydek Family Medical. The 22-year old practice has offices in Queens (Flushing and Richmond Hill), Nassau County (Elmont), and Brooklyn (East New York). Each location sees about 20 patients a day. They treat patients of all ages and accept all types of insurance. Their patients, who come mostly from underserved areas, have every type of chronic condition, but most commonly hypertension, diabetes, high cholesterol, and asthma. Most patients speak English or Spanish but many speak Yoruba, Dr. Fashakin's native language, or Pashto, which Dr. Fashakin has learned over the years from an Afghan staff member and his many Afghan patients.

Dr. Fashakin with his wife, Abby Fashakin, a Nurse Practitioner at the practice

Dr. Fashakin has participated in a number of NYC REACH-supported programs including HealthyHearts NYC, Meaningful Use, and Patient-Centered Medical Home (PCMH). The practice is also connected to the Healthix Qualified Entity (QE).

We asked Dr. Fashakin how participating in these programs and connecting to a QE has transformed his practice.

Why did your practice become a PCMH?

The main thing, to be honest, is that the PCMH approach helps with patient care. The money is secondary. PCMH enabled us to practice medicine the way we want to practice it. The model's approach is to do the types of things we already like to do – like calling patients for their labs, booking their appointments and referrals, tracking and getting results. Those are great things to enhance patient care. That's why I love it and my patients notice the difference. They tell me other doctors don't do these things and they really appreciate it.

How has operating as a PCMH improved patient care?

In the older days, so many people would fall through the cracks. You'd say "Ok, A1C is high," and you try to get it under control, but then you don't see them for another year, and when they come back it's even worse. But now, we have workflows to track all our patients and they each have "care coordinators." Anyone with a chronic

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condition has someone monitoring them: calling them every week, every month, to check on their medicines and referrals and labs and getting them in for appointments. It motivates the patients too and helps to keep their treatment plans on track. If they did a blood test and the results are good, we call and say "Whatever you're doing is working; keep it up!"

How has operating as a PCMH improved your relationships with patients?

PCMH concepts improve the dialogue with patients. One big advantage is it's helping us keep track of all of the patients better. Sometimes it's a nightmare to reach a patient. Twice in the past we had to tell the police we couldn't reach them because the patient had terrible glucose and we wanted the police to go to their house and make sure they were not in a diabetic coma. So it's very, very important to have accurate information.

Now we can contact them easier – we can e-mail them through the patient portal, and our care coordinators make sure we have the right phone numbers and demographics…and if the patient can't get through to the office, they have their care coordinators' phone numbers, and the coordinators can help.

Has operating as a PCMH improved your relationship with specialists?

It does help. We're doing PCMH together with MU – so the two programs sort of enhance each other and help with the electronic transmission.

Now specialists are reporting back me, thanking me for references. They're sending electronic messages to me, I'm sending messages to them, and our practice is getting a lot more referrals. I tell them, "Because we're trying to do MU and PCMH I need a reply back within seven days of your referral – and if you don't reply back to me I'm not going to send you patients again." That works! And then my staff is calling them to say "My doctor is very upset!" if the specialist is late in sending back reports.

How has operating as a PCMH and participating in MU impacted your staff?

Now as a PCMH and MU and everything, our medical assistants spend 10-15 minutes with patients in triage. They ask about colonoscopies, do screenings for smoking, STDs, drug use, a lot of things. Making all of this part of triage; that was a breakthrough. They are the bedrock of success: the MAs that cover gaps in care. Also, our care coordinators get a score card every month to

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track how they are performing on different measures with their patients and they can see how the other coordinators are doing too. They are each assigned a list of patients and we pick a measure for the month, such as how many adolescents were seen or colonoscopy results are received.

Every month the care coordinators with the top three scores get bonuses. This month we are measuring mammograms. The care coordinator who has the highest percentage of patients who got mammograms gets $200, the second highest gets $80, and the third highest gets $40. It's a way to incentivize them.

"PCMH enabled us to practice medicine the way we want to practice...my patients notice the difference."

At the end of the year, if we meet our payer incentives for a measure, the staff get $1000. If we meet our target for 10 measures, staff get another $1000 bonus. Sometimes the coordinators have already reached their end-of-year goals by July. This is even possible on hard measures like adolescent well visits because our staff starts in January and calls our patients until they come, sometimes 9 times! We take our incentive payments from these programs and give it back to our staff. Wages for our staff have gone up and we don't have a high staff turnover. People stay. The sky is the limit for them now.

A lot of your patients are using the patient portal. How did you make that happen?

Number one: It is automatic signup. It is mandatory for every patient that walks through our door to be web-enabled; that we have an e-mail address for every patient. I check personally to make sure the patient's email is there. Sometimes we print their username and password right at the onset. I tell them "I'm going to send you an email. Go to the site." Number two: I tell them what the portal is all about. You have to be proactive. I say "Look, it's not free, I pay good money to set up the portal for you, so make good use of it! You can see your records, results, you can make appointments, request refills - you don't even have to call the office."

How did participating in HealthyHearts NYC improve patient care?

Getting return appointments and blood pressure control were the two main things we derived from it. NYC REACH helped us a lot. When they started with us, [hypertension control] was like 10 or 15 percent [of hypertensive patients]. Now it's more like 80

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or 90 percent. Believe it or not, many of the things we implemented in our practice then are still with us. We don't accept bad blood pressure. My providers know you can't just go through the motions. If somebody's not controlled, you must tell me what you have done, what intervention, to give us a better outcome. The difference is glaring.

How do you make sure patients show up for return appointments?

After HealthyHearts NYC, we got up to about 60% for return appointments, and we were still trying to improve it. Took me two years to figure it out, and I finally nailed it down! If a patient has high blood pressure or diabetes, the MA gets them to make a three month return appointment in the office *before* they see me – that's the key. So they already have the return appointment date when they see me. *That day* they get a message in the portal, and the day before a text, phone call, email. It's so strict now. Even in the absence of hypertension diagnosis, if the MA sees that their blood pressure is elevated when they are in triage, they make a return appointment.

Has connecting to Healthix been useful for your practice?

It is helpful in a lot of ways. Now and then patients go to the hospital, so we need that information, and we download information on new patients. It's most useful for new patients. Some patients just walk in to our office with nothing. We have a good system now to check on all their medicine, download all their drug history and everything.

One patient told me "Never in my life have I had blood pressure." But when I went to check Healthix, everything lit up like Christmas! I could see he had been taking medication for hypertension. We tell patients that consenting to join the QE is an advantage to them and it's in their best interest. We say "if you're in the hospital in the middle of the night, you have everything available. We get a call and can advise the doctor at the hospital. We can also make sure you come in to see us afterwards." That education and rapport with patients is very important to us.

Is achieving PCMH Recognition worth the effort?

It's worth it. Absolutely. My only regret is that we hadn't done it years ago. It looks like an onerous thing to gather all this data, you know. We are busy clinicians! But later I realized many of the things they are asking us to do we are doing anyway, so it's just going to enhance that. The extra payment is good because now we've got more staff. We have five people working permanently just as care coordinators.

To learn more about becoming a PCMH, contact pcmh@health.nyc.gov.

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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