Time and technical assistance required to improve quality in medically underserved areas

Arizona Health-e Connection (AzHeC) operates the Arizona Regional Extension Center (REC), one of 62 RECs nationally that were created by a part of the American Recovery and Reinvestment Act of 2009 to advance the use of electronic health records (EHRs) and health IT. The Act established RECs to provide assistance and education to all providers in a region and directed them to prioritize assistance to individual or small group primary care practices, critical access hospitals, federally qualified health centers (FQHCs) and other entities that are located in medically underserved areas,[1] areas defined as not only having a shortage of health professionals but also as having population issues such as high infant mortality, high poverty and/or a high elderly population.

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The REC now assists more than 2,400 providers across Arizona, including community health centers (CHCs), critical access hospitals (CAHs), public hospitals, small primary care practices and health care organizations that provide care to underserved populations. Since opening its doors in October 2010, the REC achieved its grant goal of recruiting 1,958 primary care providers to the program by February 2012. To date, 77% of these members have successfully implemented a certified EHR and 19% have successfully attested to Stage 1 Meaningful Use.[2]

Like most RECs, we have put a lot of time, effort and resources into assisting and transforming provider practices through the adoption of EHRs. A good and legitimate question, however, is whether RECs can make a real difference in medically underserved areas, that is, whether measurable improvements in health care quality can be achieved through the assistance of an REC.

This question was addressed in a recently published study in the January 2013 issue of *Health Affairs*.[3] The study evaluated the early effects on quality of the Primary Care Information Project which provides subsidized EHRs and technical assistance to primary care practices in underserved neighborhoods in New York City, using the REC model. The project started in 2005 and became an REC in 2011. This project is an ideal subject for a study since, with more than 3,300 physicians in more than 300 practices enrolled in the program, it is the largest community-based EHR implementation and extension program in the United States and one of the models used in developing the REC program nationally. The study tested whether physicians in the project improved their outpatient quality measures more than a set of matched comparison physicians in New York who did not participate in the program.

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The study looked at improvements in quality measures, including "EHR-sensitive" measures that can be monitored through

an EHR such as breast cancer screening for women, urine testing for patients with diabetes, chlamydia screening for woman, and colorectal screening. The study also looked at any improvements in quality of care at six, twelve, eighteen and twenty-month intervals; and any improvements associated with the number of technical assistance visits received by a practice, from zero to eight or more technical assistance visits.

The results of the study supported three main conclusions:

- Participation in the project did not show improvement in quality of care across all quality measures, only in "EHR-sensitive" measures;
- EHR implementation alone was not sufficient to improve quality of care. Only those physicians who received high levels of technical assistance, i.e. eight visits or more, associated with EHR implementation saw improvement. Even physicians exposed to EHRs for up to two years were not associated with quality improvement without high levels of technical assistance;
- Even with high levels of technical assistance, about a year of exposure to the project was required before the positive effects on quality of care were observed.

While these conclusions are not surprising, they are well worth noting. The REC model works, but it doesn't work without a considerable investment in time, effort and technical assistance. It can be a valuable tool in assisting with improvements in EHR-sensitive quality measures and other measures that help transform a provider practice. That is why the REC recently opened its doors to all Arizona providers, hospitals and clinics, including original REC members who want to continue their practice transformation after they have attested to Meaningful Use Stage 1. To learn more about membership in the new REC, call us at 602-688-7200 or email us at ehr@azhec.org.

AzHeC is also providing education and assistance to providers on health information exchange (HIE) and e-prescribing, two areas that are critical in continuing to meet Meaningful Use in 2013 and beyond. For more information on HIE or e-prescribing, please visit www.azhec.org and click on the Programs tab. **AM**

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1 *HITECH Act, Section 13301, PHSA Section 3012 (c)(4)*

2 *www.cms.gov/EHRIncentivePrograms*

3 *Health Affairs 32, No.1 (2013): 53-62*

Best Care at Lower Cost

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information that can be used to improve outcomes. This is a paradigm shift from the traditional medical model, in which we assume we know the right thing to do, and the only question is: "How well did we do it?"

What Have We Got To Lose?

According to the *Best Care at Lower Cost* report, "If the care in every state were of the quality delivered by the highest-performing state, an estimated 75,000 fewer deaths would have occurred across the country in 2005. Current waste diverts resources from productive use, resulting in an estimated $750 billion in 2009."

In Arizona, we have some way to go before we reach that "highest-performing" level. However, through the ACA and other initiatives, we each have opportunities to bring a new focus to our own practice or organization—a focus of continuously learning by performing real-time cycles of improvement that speed the generation of practical evidence and translate into improved patient care. But we need to move quickly: the influx of new patients and the increased complexity of care, coupled with the explosion of biomedical and clinical knowledge, could soon overwhelm us if we do not find a way to evolve in tandem with all the changes taking place in American health care. Learning never stops. **AM**

1 *Institute of Medicine. 2012. Best Care at lower cost: The path to continuously learning health care in America. Washington, DC: The National Academies Press. Available at http://www.nap.edu/catalog.php?record_id=13444.*

2 *Gruber, Jonathan. July 9, 2012. Will the Affordable Care Act Kill Jobs? The New Republic. Available at http://www.newrepublic.com/blog/plank/104791/gruber-care-act-job-killing.*

3 *U.S. Department of Health and Human Services. February 11, 2013. News Release: Departments of Justice and Health and Human Services announce record-breaking recoveries resulting from joint efforts to combat health care fraud. Available at http://www.hhs.gov/news/press/2013pres/02/20130211a.html.*

4 *Office of the Attorney General of Massachusetts. 2011. Examination of health care cost trends and cost drivers pursuant to G. L. c. 118g, § 6½ (b). Available at http://www.mass.gov/ago/docs/health care/2011-hcctd-full.pdf*

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