



Webinar Overview

Email us with questions at FPAR2.0@hhs.gov throughout the webinar



OPA's FPAR 2.0 Goals & Strategy
Update on 2.0 Activities & Progress
Review 2.0 tentative timeline

Answer Questions



The importance of EHRs

Answer Questions



The technical infrastructure FPAR 2.0 will leverage

Answer Questions

OPA Needs Your Help!

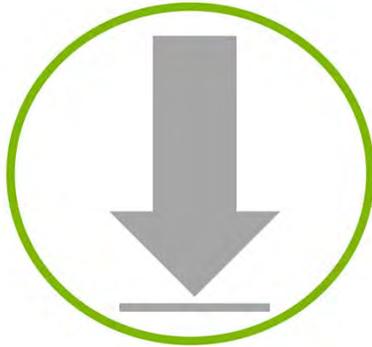
Review Resource Handouts

Hi everyone – This is Christina Lachance – thanks again for joining us to day. I'm excited to update you on all of the ways we're working to bring FPAR 2.0 to fruition and I'm happy to introduce to you two new colleagues who we were fortunate to have join our team 3 months ago. I think you'll see how both of their perspectives and areas of expertise have strengthened our 2.0 bandwidth.

So for today's presentation, I'm going to begin by reminding everyone of OPA's goals and updating you on our 2.0 strategy, activities and timeline. Then we'll take 5 minutes to review and answer your chat or email questions. Then I'll hand it over to Lauren Corboy who will emphasize how important EHRs are for FPAR and beyond, and will take your questions. Johanna Goderre will close us out by describing all of the hard work she has been leading to leverage the current landscape of EHR technology for the purposes of FPAR 2.0. Finally, we will conclude with a specific ask for your help in this arena and take some final questions.

+ Indicates resources available as downloadable handouts

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We have a number of web-based resources that we have compiled for you to consult after the webinar. We have tried to mark all of them with this icon throughout the presentation, so you'll know that you can find them as a downloadable handout. During and after the webinar you can download handouts by going to this collection of papers icon at the top right hand corner of your presentation browser. We'll walk you through these before we sign off today.

The Future of FPAR Presentation
 8/1/13 National Grantee Meeting, Day Three

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Title X Grantee Meeting Presentations

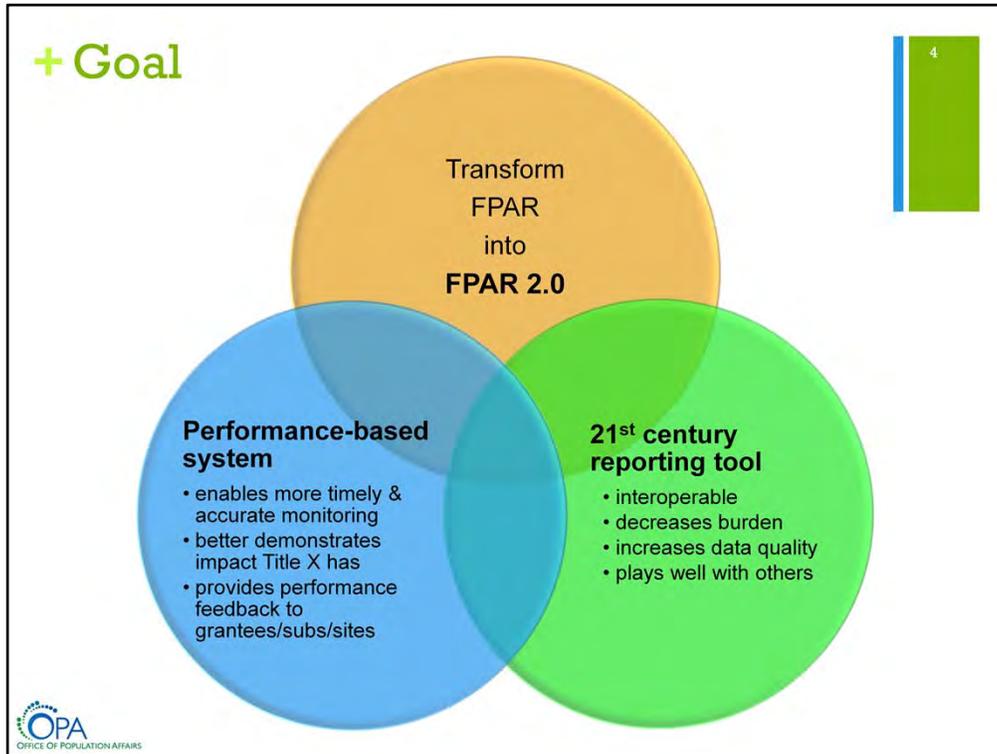
Resource Description:
 The Title X National Grantee Meeting provides an opportunity for Title X grantees to learn about and share current information on a variety of topics relevant to the provision of high quality Title X family planning services.

DAY ONE: Tuesday, July 30, 2013

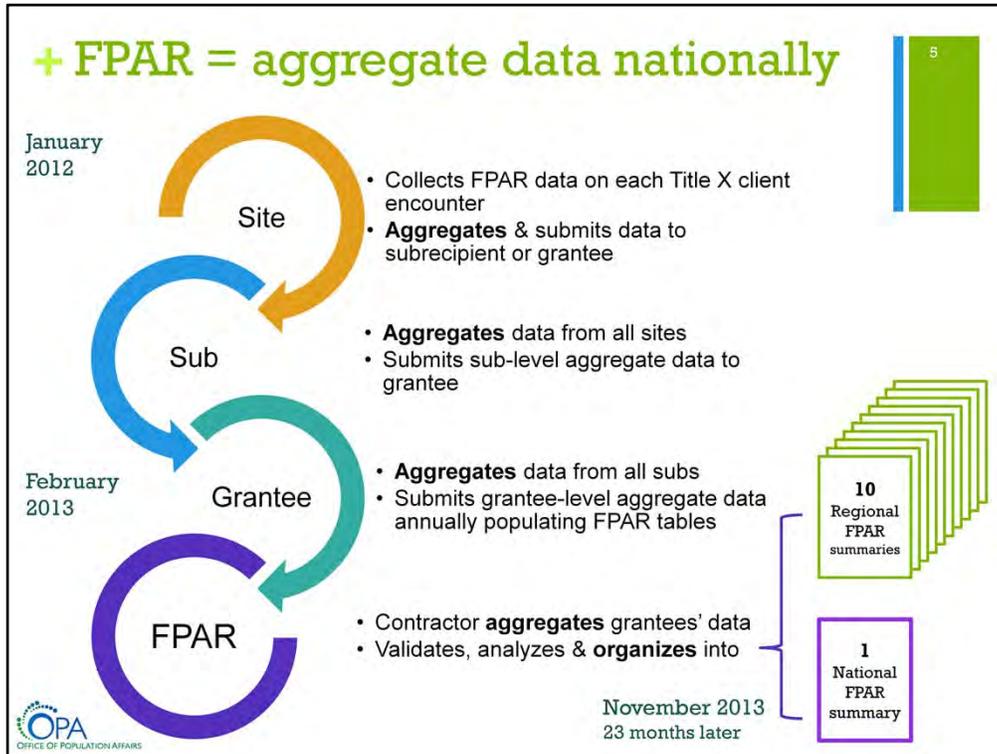
OFFICE OF POPULATION AFFAIRS

The last time I had a chance to update grantees about the FPAR revision was at the National Grantee meeting in August – I’m not going to revisit a lot of the content of that talk due to today’s time constraints, but if you feel like you need more context, the slides and recording are posted at these links on the National Training Center website.

During that talk I spoke about OPA’s vision for the future of FPAR, and the power of encounter-level data collection, but, I left everyone with questions regarding the HOW and the WHEN of this 2.0 revision process. Today, I’m hopeful that you’ll see the effort we’ve put forth to achieve the progress we’ve made in the past 7 months and how our vision has grown and changed.



So OPA’s goal with this FPAR Revision is to transform the current system into a 2.0 version that will have 2 main characteristics the current system lacks: the first is a true performance orientation – meaning that it will enable timely and accurate monitoring, better demonstrate Title X’s impact, and, ideally, provide performance feedback back to the network. The second is that it will be 21st century ready – meaning a smart or interoperable tool that ultimately decreases the burden of data collection and reporting, increases the quality of the data submitted, and interfaces well with other health IT systems, as needed.



As everyone on this call is familiar, our current FPAR relies upon a siloed web-based system of data aggregation and annual reporting that occurs at multiple levels of the network. While the service sites start out collecting encounter, or visit level data, as these data are reported up the chain, there is an aggregation and submission burden that occurs at every rung of the ladder.

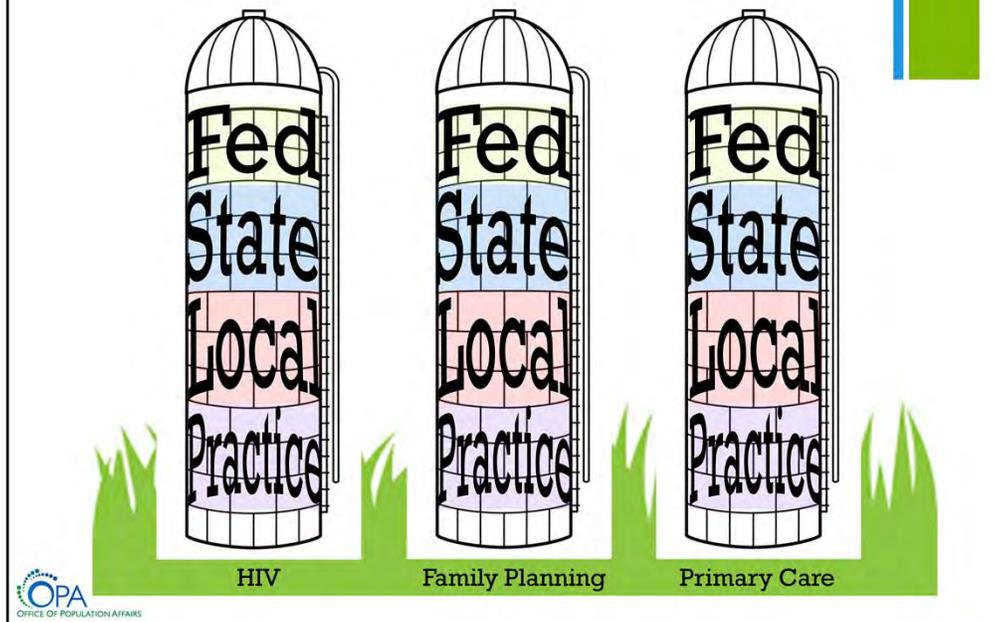
In addition to this aggregation burden, other limitations of the current system are that

- OPA can only analyze FPAR data according to the pre-established FPAR tables that you all populate,
- we only have access to this data once per year at 3 levels: grantee, regional, national
- And that there can be a long lag time from date of original encounter to when that data appear in the national summary – can be up to 23 months

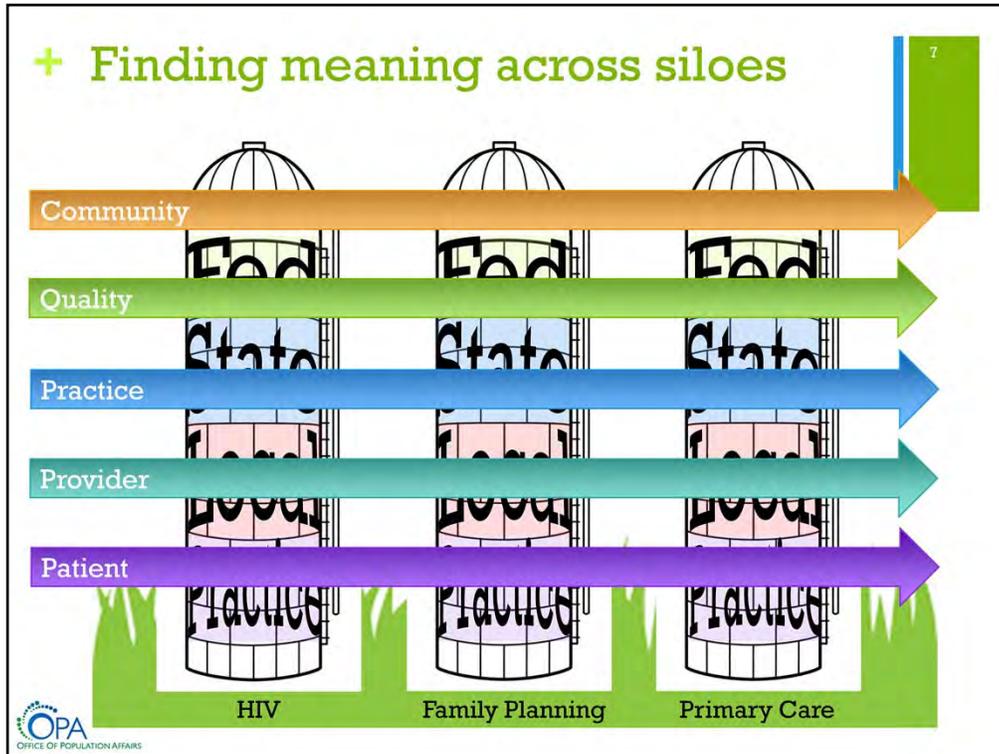
These limitations make the data less optimal for use in monitoring, performance measurement, and QI and which make it difficult for OPA to react nimbly to questions that arise.

+ Finding meaning across siloes

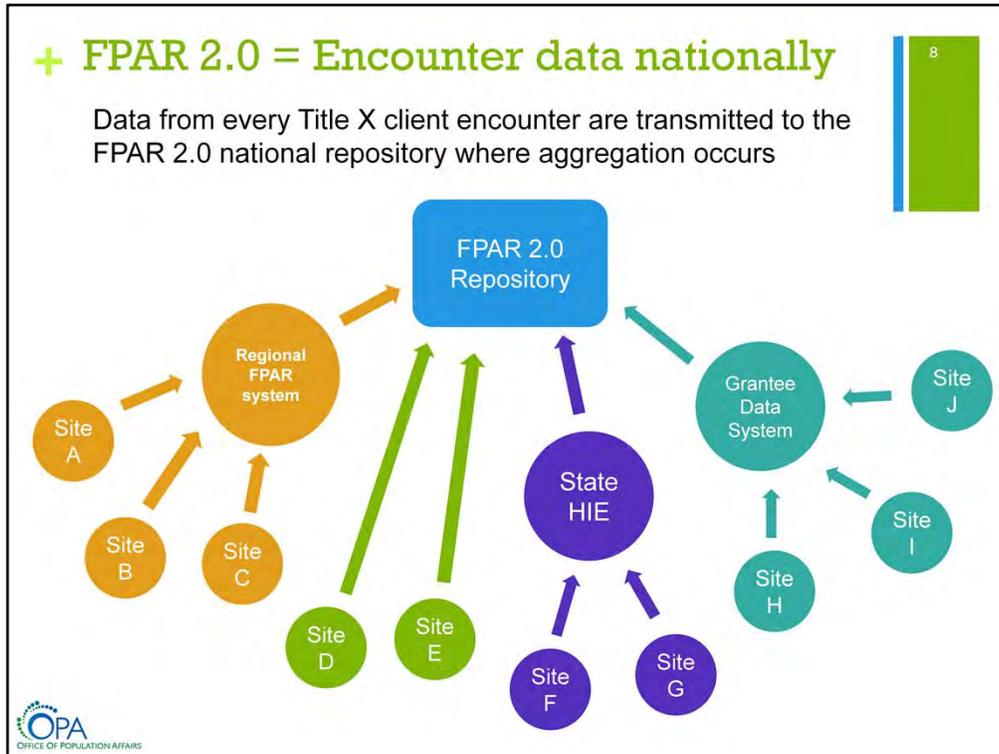
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The fact that we have relied upon a “silo” system is actually a familiar problem not unique to family planning or really even public health. As you are all well aware, various federally and state-funded programs require similar kinds of reporting with only slight variations through different siloed system across healthcare. This model makes it difficult to achieve efficiencies in workflow and reductions in burden on the part of those reporting and also hard for funding agencies to extract data in a way that can facilitate understanding held at different levels of community and practice.

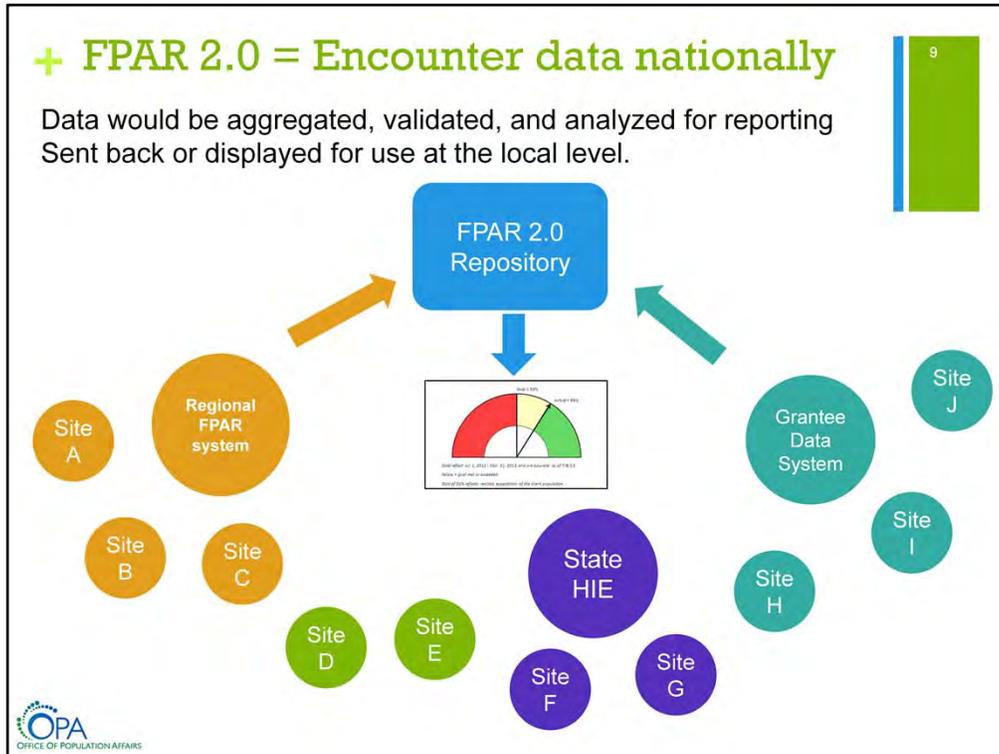


One way to address these issues is to move out of a silo model into an interoperable model that takes the same data elements from the same place and reuses it for different reporting and quality metric purposes.



So what we mean when we say we'd like to move to an interoperable encounter-level system at the national level is a system that relies upon the infrastructure already or about to be in place, thanks to the adoption of electronic health records, where data about a Title X client's encounter are transmitted directly from a site's EHR into an FPAR 2.0 data repository.

This model assumes that these systems all speak the same standards-based languages, so data could be transmitted through a number of routes to the 2.0 Repository. It could be sent through an existing Regional FPAR system, a grantee's data system, if sites were connected to a state health information exchange – could be submitted that way - or sites could submit directly to the 2.0 repository themselves. This model eliminates the intermediary aggregation and submission burden for sites, subs and grantees – ideally, there would be triggers put into place to passively transmit data.



Once the data reaches the repository, the repository would then take on that aggregation burden and summate the encounter-level data into national level analyses for reporting purposes. Because OPA would have access to data at the encounter-level, we could then flexibly crosstabulate many different variables, examine them at all levels of the network, perform analyses more frequently than once a year and use the results to provide more immediate performance feedback and technical assistance to assist with quality improvement efforts. We also think there is power and great utility to giving data back to providers/sites/states for use at the local level to see how they compare with peers.

The greatest advantage of this model is that the data are not constrained to one funding agency's silo – they are instead entered into a single system, the EHR, and re-used efficiently so that multiple funding entities could extract the same or similar data elements from this single source without creating an onerous reporting burden for sites and providers.

How we got here

	Action	Outcome
2012	Mar Data Work Group convenes	Added variables of interest to current FPAR tables
	Aug Stakeholder Expert Work Group members invited	RPCs nominated 1 rep/Region; other stakeholders invited by OPA central office
	Nov 1 st EWG Meeting held	EWG saw & reacted to proposed 2.0 elements & modified draft FPAR tables for first time
	Dec - Meeting 1 input incorporated - EWG gathers feedback from field	Field commented on proposed 2.0 elements & modified 2 nd draft of tables
2013	Jan DWG synthesizes comments from field	Modified proposed elements & table additions to ↓ burden & ↑ acceptability
	Mar 2 nd EWG Meeting held	- EWG reacted to 3 rd draft of tables - New 2.0 PMs introduced - EWG provided support for <ul style="list-style-type: none"> • Revised 2.0 elements • Transition to encounter-level data collection
	May 2.0 Prep contract work began	Contract awarded to JSI in September
	Aug National Grantee Meeting	Communicated vision to the grantees
	Sep Engaged with IHE	Expanded 2.0 efforts into EHR realm

I think it's important to remind everyone that it has taken 2 years for us to arrive at this specific encounter-level model. Throughout the years we have tried to make this process transparent and inclusive by convening our FPAR data and expert workgroups for their input at key stages. OPA decided to move to encounter level data collection after the FPAR Expert Work Group provided support for the move in March of last year. And only we made the decision to take the interoperability route this past Fall.

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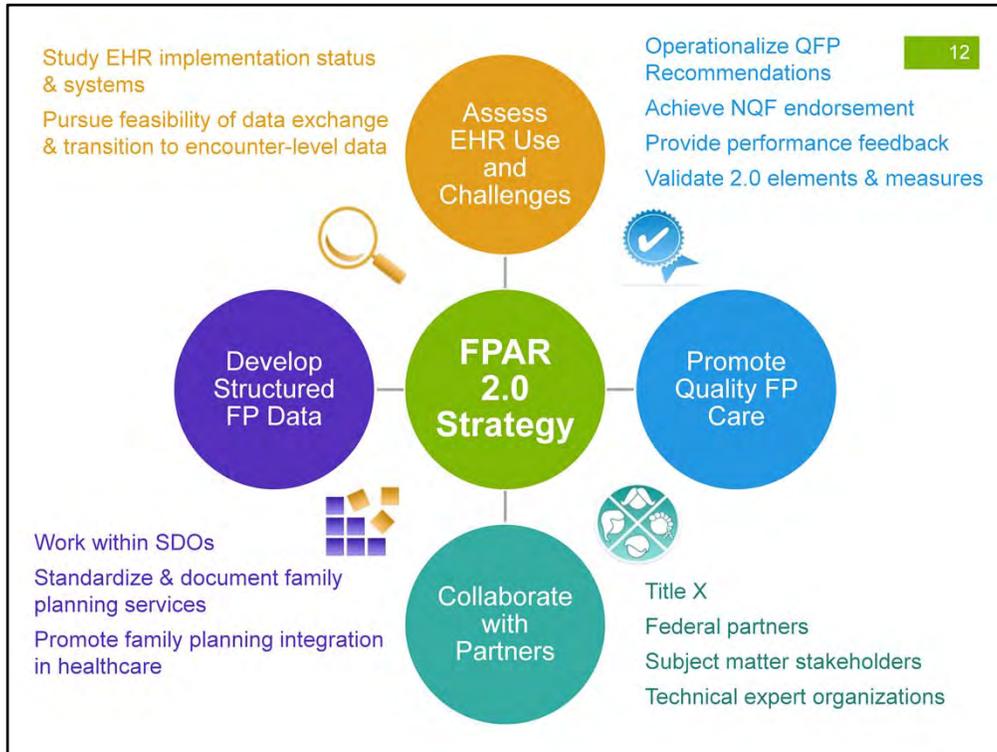
+ “To do” after decision to move to encounter-level data collection

1. Engage with the larger Title X community
2. a) Further develop & test
b) Formally adopt
FPAR 2.0 data elements and performance measures
3. Assess the state of HIT within the Title X network
4. a) Engage additional partners within & outside HHS
b) Align with larger federal efforts in re common public health data elements, exchange and reporting harmonization
5. Design, test, pilot, and build the FPAR 2.0 system



As of last Spring, immediately after that March EWG meeting, there were a number of next steps that became apparent – which I called my FPAR 2.0 “to do” list.

It became clear that, first, we needed to engage with the larger Title X community to get a sense of what a move like this would mean on the ground, second we needed to further develop and test the proposed 2.0 data elements and performance measures and ultimately navigate the federal process to formally adopt them, third we needed to get a better handle on the status of EHR implementation within the network, And needed to engage new partners within and outside of HHS to educate ourselves further on how to align with the larger harmonization efforts already ongoing, and finally we needed to find a way to fund and intelligently design, test, pilot and build the 2.0 repository.



Today, I'm happy to report that that to do list has evolved into our FPAR 2.0 strategy that we will all be addressing during this presentation.

In the following slides, I'm going to focus on the two blue circles to discuss the quality framework that will be established by the forthcoming guidelines – abbreviated here as QFP for quality family planning recommendations – our current performance measure efforts and the feasibility validation work we're funding. I'll also discuss the many collaborations we're engaging in - how we're interfacing with numerous partners in order to harmonize efforts.

Lauren will focus on the orange circle and the importance of EHRs. Finally, Johanna will focus on the purple circle and discuss how we're developing structured family planning data capture within one standards development organization.

+ FPAR 2.0 & Quality

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Promote Quality FP Care

Operationalize QFP Recommendations
Achieve NQF endorsement
Provide performance feedback
Validate 2.0 elements & measures



FPAR 2.0 will seek to operationalize a culture of quality within Title X that we believe will be established by the forthcoming recommendations. 2.0 will do this by not just counting numbers and services, but by attempting to better measure what truly counts about those numbers and services

+ Draft Performance Measures

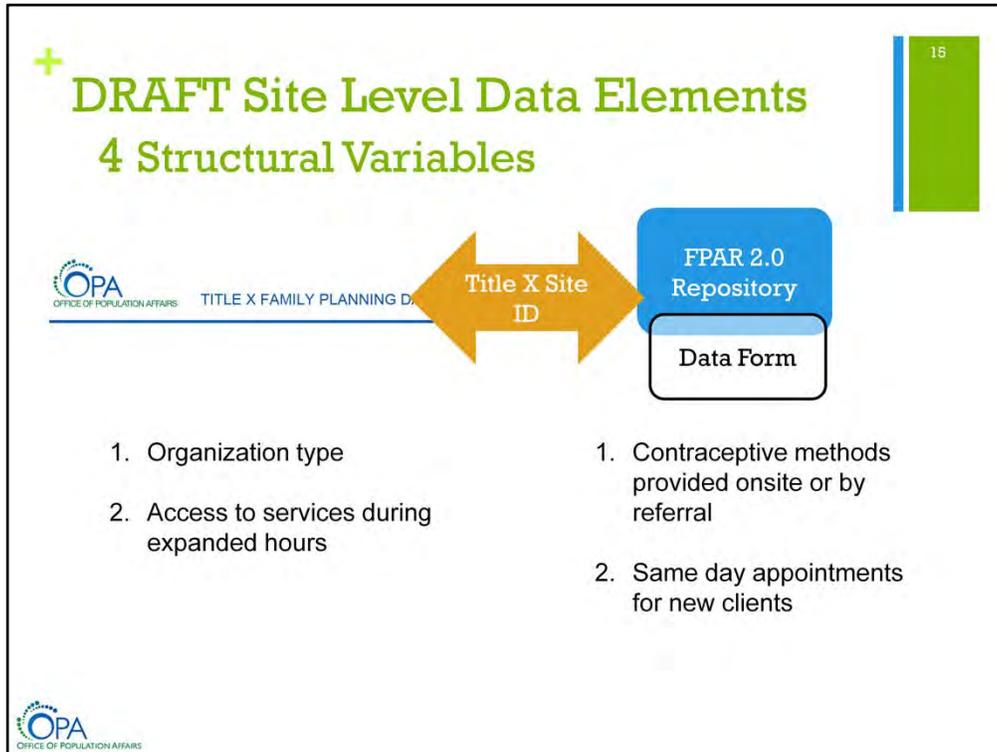


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Measure	Source	Aligns with
Proportion of sites that dispense or provide on-site a full range of contraceptive methods	AGI clinic survey, PIMS	Clinic survey, HP2020
Proportion of female users at risk of unintended pregnancy who adopt or continue use of the most effective or moderately effective FDA-approved method of contraception .	PIMS	NQF proposal, HP2020
Proportion of female users ≤ 24 years who were identified as sexually active and who had at least one test for Chlamydia during the measurement year	PART, PIMS	HEDIS, HP2020
Proportion of users ≥ 18 years of age who had their BMI documented during the measurement year.	QFP	HEDIS, HP2020
Proportion of users who were screened for hypertension during the measurement year.	QFP	HP2020
Proportion of users who were screened for tobacco use during the measurement year.	QFP	HP2020, Meaningful use
Proportion of users who stated clear childbearing intentions .	IOM, PIMS	*TBD*



Having a quality framework necessitates common measures and indicators to assess one's performance against – we have to know what we're reaching for in order to make it happen. So this is a reminder of the draft performance measures we are looking to start out with for the FPAR 2.0 system – they either come from or align with vetted sources or professional recommendations so we think they're a reasonable start upon which future efforts can be expanded. The indicators that make up these measures will come from a couple of different sources.

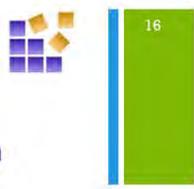


First we are proposing to measure 4 structural variables at the service site level. Two of them, type of organization (site, sub, grantee/FQ vs. a planned parenthood) and whether the service site offers access to Title X services during expanded hours, are things we already collect through the OPA clinic database. So the plan is to continue to collect them through the clinic database because we don't want to ask you to enter the same information in multiple places.

The second set of structural access variables will be collected using a data form within the 2.0 repository that sites will complete at least once a year. The first variable will populate the performance measure regarding on-site provision of the full range of contraceptive methods and the second measures same day access to contraceptive appointments.

All of these variables will be tied together by a single Title X site ID that OPA will generate for each service site. We believe that these two systems can nicely complement each other, but that it will be CRITICAL for the OPA clinic database to be kept better up to date than it is currently in order for this plan to work.

+ DRAFT Encounter-level Elements



- Client ID
- Provider ID
- Visit date
- Date of birth
- Sex
- Ethnicity
- Race
- Limited English Proficiency status
- Family size
- Income
- Principal health insurance coverage
- Pregnancy intention
- Pregnancy history
- Contraceptive method at entry & exit or Reason for no method
- Date of last pap and/or HPV test
- Screening tests for Chlamydia, Gonorrhea, and HIV
- HIV positive test result
- Linkage to HIV medical care
- Systolic and Diastolic BP
- Height and Weight
- Smoking status




This slide lists the variables that OPA is considering collecting at the encounter or visit level. This has not changed much since August except we recently added pregnancy history to the list for further consideration. The elements in black font are things that we anticipate you are already collecting for current FPAR reporting, while those in purple indicate a new variable to FPAR – though a couple of them are standard vital signs that you also should already be collecting for meaningful use.

At this point in time, we're thinking of defining Pregnancy intention with a 12 month timeframe as in - Would you like to become pregnant in the next year?
 Pregnancy history - number of times a female client has been pregnant in her lifetime
 Linkage to HIV medical care - **If HIV-positive, date client attended first HIV medical appointment – Secretary's goal: within 90 days of diagnosis**

We are proposing that all of these elements come directly from the EHR – or in some cases the practice management system – but, in both cases, a robust electronic system. In order to ensure Title X clients' privacy protections we are looking at protocols that will ensure the data are deidentified and secure.

+ Tentative Timeline

FPAR 2.0
Repository

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Spring – Fall 2014	Market research 2.0 design/build specs
Spring – Fall 2015	Fund 2.0 build (assuming sufficient OPA budget)
2016 – 2017	Build system
Early 2017	Test and pilot system
Mid 2017	Go live with an initial cohort of grantees' sites
By end of 2018	Have data from all grantees' sites for analysis



The build and launch of 2.0 will depend on a number of factors, but as of today this is our planned timeline. We plan to continue our current market research activities and follow this timeline so that by the end of 2018, we will be able to have data from all grantees' sites ready for analysis.



+
Activities to Address
FPAR 2.0 Strategy

So now that you've been reminded of where we're heading, I'm going to talk about what we are doing to get us there. And I want to emphasize that this is definitely a marathon we're running, not a sprint

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+ JSI Data System Prep Contract

Task	Delivery	
1 2.0 data dictionary and implementation manual	Jan-Feb '15	 
2 Conduct pilot feasibility case studies	Aug '14	 
3 Perform analysis of common EHR/EPM systems	Sep '15	 
4 Assist with OMB burden estimate and supporting statement	Sep'15	

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One of the first activities we pulled together to address multiple parts of the 2.0 strategy was funding a data system preparation contract that I couldn't discuss at the time of the grantee meeting due to federal procurement policy. This contract evolved out of that to do list I showed you earlier and is one of the main ways OPA is studying what 2.0 will mean for the network. In Sept, OPA awarded a contract to John Snow Inc. to conduct the following FPAR 2.0 System Prep tasks over two years.

The contract funds 4 main deliverables:

1. A refined 2.0 data dictionary that will enumerate the structure and definitions of all of the data elements I just showed you. Along with an implementation manual that will provide technical guidance and best practices to assist the network with transitioning to encounter level reporting.
2. Pilot feasibility case study engagements with 9 grantee networks to assess the on-the-ground feasibility and anticipated burden of collecting the 2.0 data elements
3. An analysis of up to 8 commonly used EHR or other FPAR data collection systems to document existing capabilities and needed changes to implement the 2.0 elements
4. Finally, JSI will use all of the information collected to inform a preliminary burden estimate that OPA will use to begin discussions with OMB about approval of the 2.0 system

This contract represents a significant amount of time and energy OPA is investing to doing this right and we are grateful to those grantees who have already expressed willingness to serve as feasibility case study subjects.

+ Proposed NQF Performance Measures for Contraceptive Services

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Proportion of female clients aged 15-44 years who received contraceptive services in the past 12 months, that adopt or continue use of FDA-approved methods of contraception that are:

- | | |
|--|---|
| 1. Most effective | <ul style="list-style-type: none">• male or female sterilization• implants• intrauterine devices (IUDs) |
| OR | |
| moderately effective | <ul style="list-style-type: none">• injectables• oral pills, patch, ring• diaphragm |
| 2. Long-acting reversible methods of contraception (LARC) | <ul style="list-style-type: none">• implants• intrauterine devices (IUDs) |



On the performance measure front, our colleague, Lorrie Gavin, along with other CDC staff, has been leading efforts for the past 18 months to have two measures of contraceptive services endorsed by the National Quality Forum. Currently, there are no family planning measures endorsed by NCQA or NQF, so this work will fill a very important quality metrics gap. The measures are listed here and measure 1 is also one of the proposed 2.0 performance measures.

Lorrie and her team have been collaborating with the Iowa State Family Planning and state Medicaid programs to conduct an inter-rater reliability work and perform preliminary analyses that demonstrate how these 2 programs might use encounter level data to monitor performance. They are in the process of writing up their findings and preparing to officially submit the measures for NQF's official consideration by the end of this year.



Also, on the performance measure front, in September, OPA funded our existing research grantee, ChildTrends, to conduct a mixed-method study to inform a measure of clients' future pregnancy intentions for FPAR 2.0

The researchers conducted 100 Key Informant Interviews with Title X providers regarding the info they collect, record and use about *clients' pregnancy intentions*. They are also performing a literature Scan of Existing Measures of Intention. And will perform Cognitive Interviews in the coming weeks to test the measures they're recommending with women at risk for unintended pregnancy.

The results of this work should be available by this fall and will help us finalize whether we want to adopt the One Key Question frame for the 2.0 pregnancy intention performance measure or pursue a different question entirely.

+ Progress on Quality-focused Initiatives

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Underway	Just Begun	On Deck
2.0 Data Dictionary refinement	2.0 Feasibility case studies	Pilot testing 2.0 performance measures
Pursuit of NQF endorsement of contraceptive measures	Defining full range of contraceptive methods – site level	Collaborating on NQF endorsement of additional FP/RH measures
Defining pregnancy intention variable	Promoting FP measures w/in larger federal CQM efforts	Formally adopting 2.0 performance measures



This slide summarizes where we are with the various quality initiatives – the previous slides are captured in the first two columns. The “on deck” column lays out the work we have yet to embark on. This includes both formally, and informally, pilot testing the 2.0 performance measures to establish targets. We plan to implement this through our QAQIE national training center in the coming year, but we also welcome grantees who want to pilot on their own to reach out to us. The grantee in the state of NH has already committed to doing this and we look forward to learning from their efforts.

In the near future – once we’re through this first NQF process, we plan to work with partners to pursue endorsement of additional FP quality metrics

And once we have a reporting system that is closer to being up and running, we will formally adopt the performance measures within HHS.

+ Collaborations



- Title X
- Federal partners
- Subject matter stakeholders
- Technical expert organizations

+ Title X

- Visits to grantees and service sites
- FPAR Expert Work Group
- Presentations
 - 2013 Grantee meeting
 - 2013 APHA meeting
 - Today's webinar
 - 2014 NFPRHA Annual Meeting
- Dedicated FPAR inbox: FPAR2.0@hhs.gov
- Listserv announcements & RPC updates
- JSI feasibility study & data dictionary feedback



Within the Title X family, we have made visits to 3 local grantees' service sites to look at their EHR systems and performance metrics and learn from those closest to the ground

We have ongoing engagement with our FPAR EWG members who recently gathered together in February to vet an early draft of the 2.0 data dictionary

At that meeting, we were encouraged to share our updated 2.0 strategy more widely, so we are presenting in a few different forums to get the word out

We established the FPAR2.0@hhs.gov mailbox for grantee feedback in August – as a place that any of you can send us questions

We are doing our best to provide listserv updates and brief the RPCs when we reach critical junctures

And, as I described, our contractor, JSI will be engaging directly with grantees around the feasibility issues in the coming months

We also plan to solicit feedback on the data dictionary from the wider network towards the end of this year

+ Federal Partners

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CDC	Divisions of Reproductive Health & STD Prevention	
CMS	Centers for Medicare & Medicaid Services	★
HRSA	Health Resources and Services Administration <ul style="list-style-type: none"> • Bureau of Primary Health Care - UDS • Office of Quality & Data, HIT Branch • HIV/AIDS Bureau – Ryan White 	★
OMB	Office of Management and Budget	
ONC	Office of the National Coordinator for Health IT <ul style="list-style-type: none"> • Convenes NLM, AHRQ, FDA, CDC, HRSA • S&I Initiative's Structured Data Capture Initiative, Clinical Quality Framework 	★
USAID	U.S. Agency for International Development <ul style="list-style-type: none"> • Global Health, Office of Population & Reproductive Health 	



= Importance of



TITLE X FAMILY PLANNING DATABASE



We have both ongoing and new federal partners who we are engaging with around our 2.0 efforts. In 2014, we have been fortunate to make inroads with the blue font partners as our 2.0 work has led us deeper into the technical realm. A key new partner for us has been the Office of the National Coordinator for Health IT because they are charged with coordinating all the national efforts to implement and improve electronic exchange of health information. We ended up first working outside the government to get their attention, Johanna will explain more about that in a bit, but they are key players because they are a central convener of ALL the feds and also have strong links to the private sector vendors. So we're doing our best to orient them to what is important to family planning and to be at the table where important health IT decisions are being made. I also wanted to point out that we are in conversations with new international partners so that we can make sure the groundwork we're laying for 2.0 could also have relevance to international settings.

Again, I have to reiterate how important having an up to date clinic database is for these efforts. When we come to the table knowing which of our sites overlaps with another federal agencies' in terms of funding, it enables us to have a much deeper conversation and obtain their buy-in to work together to coordinate at the federal level.

+ Subject matter stakeholders

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Current national partners:

National
Family Planning
& Reproductive Health Association

Planned Parenthood
Care. No matter what.

ACOG
THE AMERICAN CONGRESS OF
OBSTETRICIANS AND GYNECOLOGISTS

ARHP

New national & international partners we're reaching out to:

NACCHO
National Association of County & City Health Officials

**NATIONAL ASSOCIATION OF
Community Health Centers**



astho

**World Health
Organization**



= Importance of

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TITLE X FAMILY PLANNING DATABASE



Outside the federal structure, we are engaged with a number of family planning subject matter experts through ongoing collaborations around performance and clinical quality measure development with NFPRHA, PPFA, ACOG and ARHP. We are fortunate that so many important organizations are actively convening clinicians, funders, and other experts to better measure quality using health IT – the challenge is to coordinate and harmonize these important efforts.

We are also actively working to engage even more partners outside the usual domestic family planning circles – and, again, our clinic database is playing a key role in bringing some of these folks to the table.

+ Technical expert organizations & implementers

National Quality Forum	2013 – present	
Standards Development Organization Integrating the Healthcare Enterprise (IHE)	Sep 2013 – present	
State Health Information Exchanges (HIEs)	Jan 2014 – present	
EHR Vendors	Apr 2014	

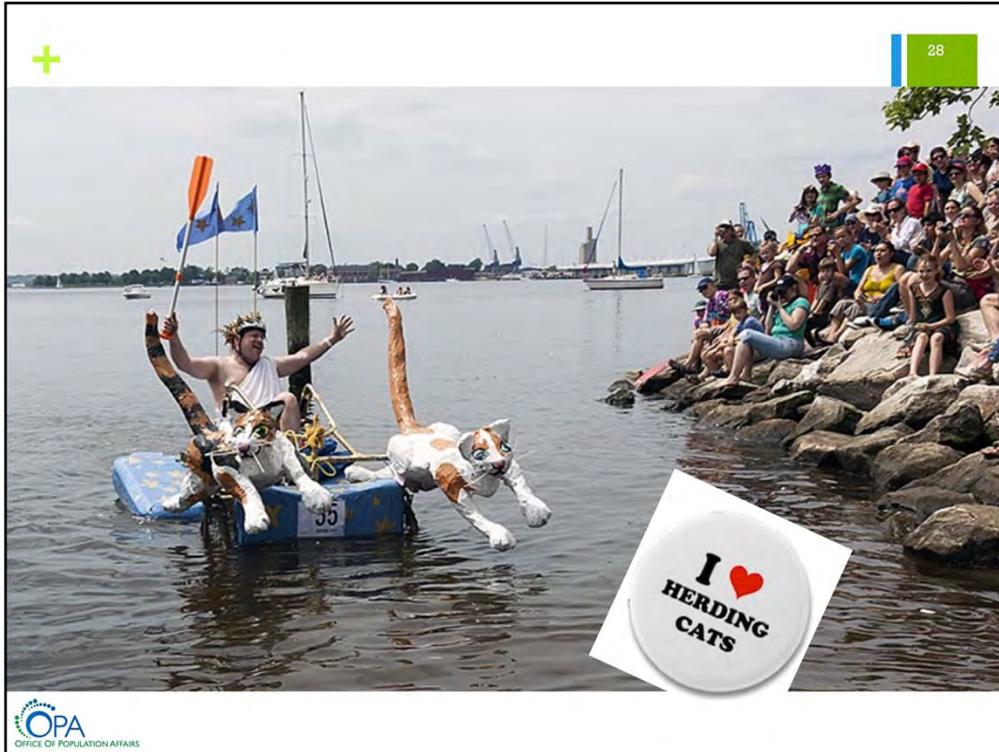
  

Finally, we are also entering new territory by engaging with technical expert organizations, both on the quality side as well as on the technical development and certification side.

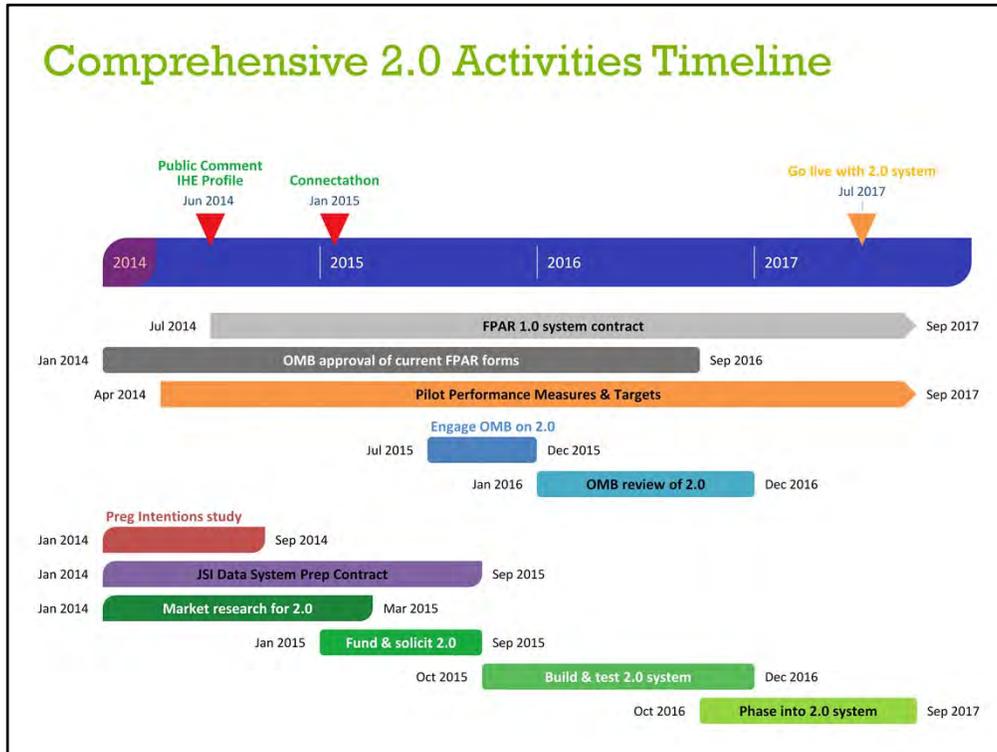
I've already talked about NQF. In terms of these others, we are engaging with one Standards Development Organization, IHE, which Johanna will describe further.

We are also pursuing relationships with a number of state-based health information exchanges or HIEs, which are networks that allow health care providers and patients to access and securely share a patient's medical information electronically to improve the speed, quality, safety and cost of care. If you are already connected to a local HIE, please let us know how it's going!

The final group that we have just started actively engaging are the systems vendors – and we'll explain more about why they're important and make a specific request for your help in Johanna's portion of the talk.



All this to say that we are doing everything within our limited capacity to herd the various cats and again be transparent and strategic with our engagements. We really want to use this work as an opportunity to take family planning out of the silo and integrate it into the larger healthcare system and to spotlight our priorities in the right circles.



I'm ending with this timeline that presents the bigger picture view of the many key activities that will get us to the realization of FPAR 2.0 – this is mostly for your information, to give you a sense of the many simultaneous moving and interrelated parts that make up the main pieces of this transition. I hope that I've demonstrated how we are working to plan this thoughtfully, collaboratively, and how we're willing and expecting to make mid-course corrections to refine our approach in the coming years. So while all of the small details that makes up each of these colored bars are not fully clear at this early stage, I wanted to reassure that we do have a plan.

+ Thank You!

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Questions?

Chat now

Contact us later at: FPAR2.0@hhs.gov



EHR Vendor Selection & Other Tips: A “Best Practices” Refresher



Lauren Corboy, MPH
ORISE Fellow



Lauren Corboy – joined OPA in January 2014 after working at a regional extension center working with providers and vendors on EHR implementation.

+ Strategies around EHRs

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Study EHR implementation
status & systems

Pursue feasibility of data
exchange & transition to
encounter-level data

Assess EHR
Use and
Challenges



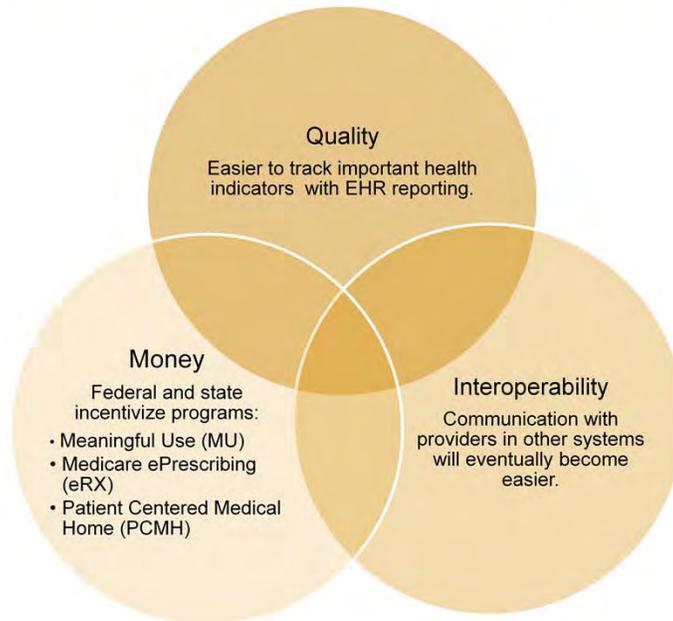
+ Roadmap

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+ Why Should I Use an EHR, anyway?

34



- It's important to realize that all of these benefits of EHR use intersect and relate to each other

+ EHRs & Title X Sites

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June 2013 NTC Training Needs Assessment Results

- 454 Subrecipients, 1101 Service Sites
 - 33% Using EHRs
 - 32% Planning or implementing EHRs
 - **35% No EHR implementation plans**
- Variation in certification level, vendor, and functionality

OPA
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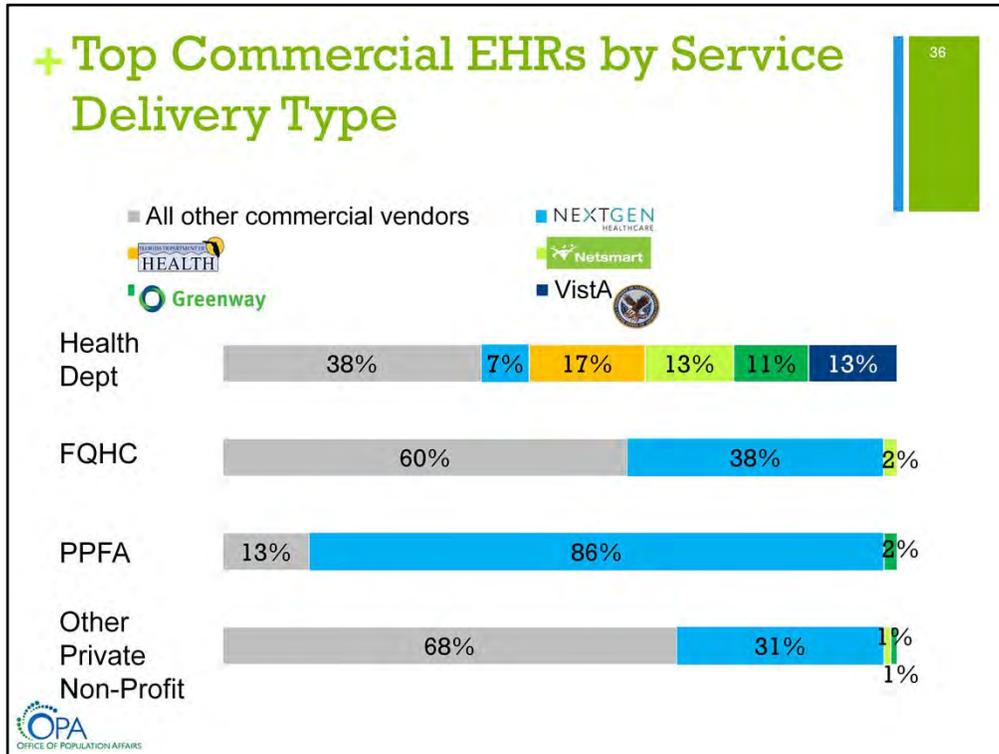
In June of last year the training centers did a Training Needs Assessment, and discovered some valuable information. Of the 454 Sub-recipients and 1101 we heard from, only 33% were using EHRs. An additional 32% said they were planning on or were already in the process of implementing an EHR. But the really interesting information is that 35% of respondents said they had zero plans to implement an EHR.

Now, of those using or planning to use an EHR, there was a lot of variability.

Many EHRs and EPMs in use already. eCW, Greenway, Allscripts, home-grown

Certified and non-certified systems

Used at different levels. From mostly working on charts and also e-prescribing to sites that have developed their own standard fields recording during the clinical encounter and then entered into an EHR for later summarization and submission to FPAR.

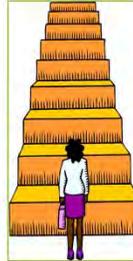


Variation was particularly noticeable when we broke it down by both vendor and grantee type. This graphic shows you which types of grantees using which EHRs. As you can see, there are a multitude of systems being used by different types of service sites, especially when you realize that the gray portions represent “all other commercial vendors”, not just one vendor.

+ Challenges of Adoption and Implementation:

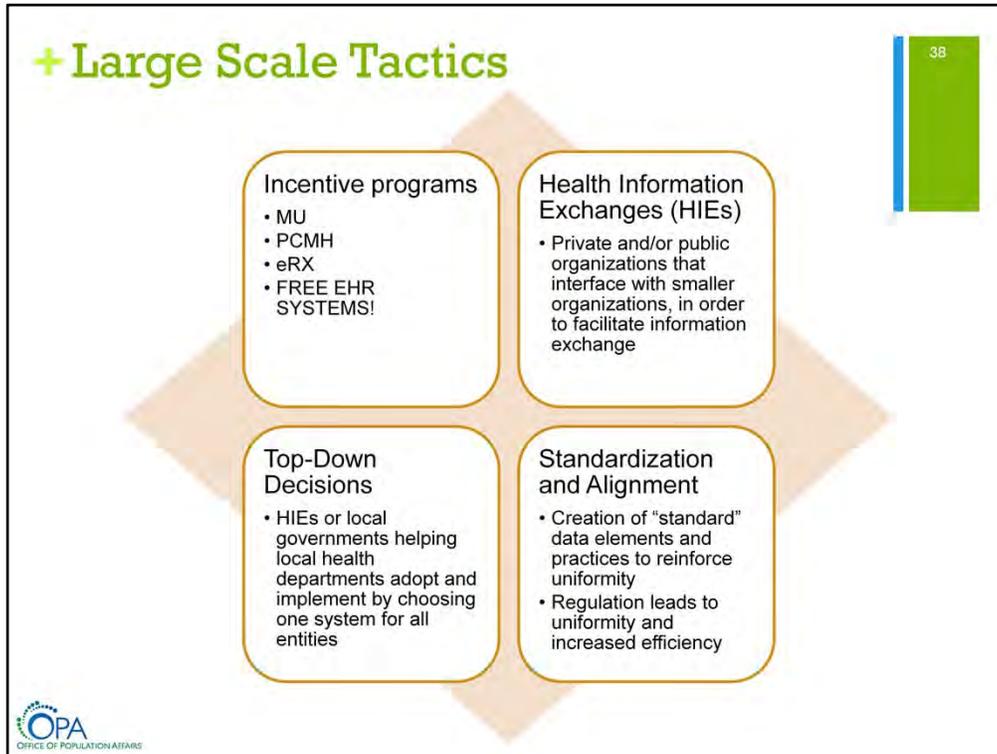
37

- Financial burden
- Time constraints
- Small staff (or big staff!)
- Workflow (i.e. habit) redesign
- Lack of technical expertise
- Influx of systems on the market
- Forced migration onto a new system due to vendor consolidation
- Studies show EHRs take *at least* 1-2 years to start making good on their ROI promises
- Not “plug and play,” but a complicated, active, “team-sport” that requires a lot of planning, effort, and monitoring



- 2,000 certified systems

- We expect a lot of consolidation and merging of EHR companies, and we've already started to see it happening, so hopefully that won't remain the case for too long
- HOWEVER, that can lead to a new challenge of forced migration if your vendor is bought out or merges with another company



- These are some of the larger-scale tactics we've seen to overcome the challenges we just discussed

+ General Tips for Adoption



39

- Define your needs and goals before you start the selection process
 - “Before evaluating vendors, you must evaluate your practice”
 - What do you want the technology to achieve for you?
 - “Don’t buy a Ferrari if you only need a Toyota”
- Three main things a practice needs, to be successful:
 - Time
 - Stamina
 - Leadership
- Patience is important:
 - The average implementation time for a solo practitioner is 12-18 months (longer for bigger practices)



- What do you want the tech to achieve for you? → More efficient work-flow? Save time? Make reporting easier? Quality improvement?

+ DEAL-BREAKERS!

40



TWO ABSOLUTE DEAL-BREAKERS:

1. **An uncertified system**
 - Your EHR system must be certified by the Centers for Medicare and Medicaid Services (CMS) in order to participate in Meaningful Use, and to avoid penalties in the future.
2. **A company that is unwilling and/or unable to interface with other systems (EHRs, EPMs, HIEs, etc.)**
 - Your EHR system must have the capability to interact with other systems.
 - This is now a requirement of Meaningful Use, as well as other incentive programs.
 - Ask your vendor about this, and be sure they answer you with concrete plans to establish this capability or, ideally, processes that are already in place.

+ “Certified Systems”

41

- What do you mean by a “certified system”?
 - To be “certified” means that the system is a fully-integrated EHR, and meets certain standards laid out by CMS. A certified EHR is capable of documenting certain information, pulling varying types of reports, and other functionalities.
- How do I know if a system is certified?
 - A vendor will be able to tell you which version of their software (if any) is certified. *However, you should double-check on your own, as well.*



+ What is NOT a Certified System?

42

EPM ≠ EHR!

- An Electronic Practice Management System (EPM) is not the same as an Electronic Health Record (EHR)!
- EPMs typically only deal with workflow issues like scheduling and billing. EHRs actually contain clinical information, can pull reports, etc.

+ Upgrading to a Certified System

43

I am already using an uncertified EHR. What should I do?

- Ask your vendor if they have a certified version or system already available.
 - If yes:
 - How much will it cost to upgrade?
 - What does the upgrading process involve? (Timeline, new training, extra fees, etc.)
 - If no:
 - Do they have plans to create a certified version?
 - When would that version be ready?
 - Be sure to ask all questions above, as well!

NOTE: Be extremely cautious if you are told a certified version is “in the works” or will be coming soon. A concrete solution already in existence is ALWAYS your safest bet!

+ What if I *JUST* signed a contract for an uncertified system?

- Read your contract
 - Is there any indication you might be able to break the contract, if necessary?
- Have a lawyer read your contract
 - Best to double-check, regardless of what you find in the contract.
- Talk to your vendor
 - Do they have plans to become certified by 2015?
 - If not, then when?
 - How much would it cost for me to upgrade?
 - What does that process look like?

+ Who to Talk To



45

- Your Colleagues!**
 - They have invaluable insights from an *impartial*, clinical perspective, which vendors and RECs won't be able to give you. Ask all the tough questions!
- Vendors**
 - Find out about as many systems as possible. Do demos!
 - Don't forget, you're talking to salespeople.
- Regional Extension Centers (RECs)**
 - ONC-funded to help providers adopt and implement EHRs, and achieve Meaningful Use.
 - Federal funding is ending soon, but there is still time. Call today to find out how they can help!



- RECs – reach out again, even if you already have (they may have different services now, different staff, etc)
- If you have reached out to the REC and had trouble, please email us at the FPAR inbox (FPAR2.0@hhs.gov).

+ Thank You!

46

Questions?

Chat now

Contact us later at: FPAR2.0@hhs.gov

Infrastructure Needed For FPAR 2.0

HRSA HIV/AIDS Programs
SPNS - Special Projects of National Significance (Part F)

Johanna Goderre, MPH
Senior Health Informatics Advisor, OPA

Johanna Goderre, working with OPA since Sept 2013 as a technical consultant

+ Infrastructure Development

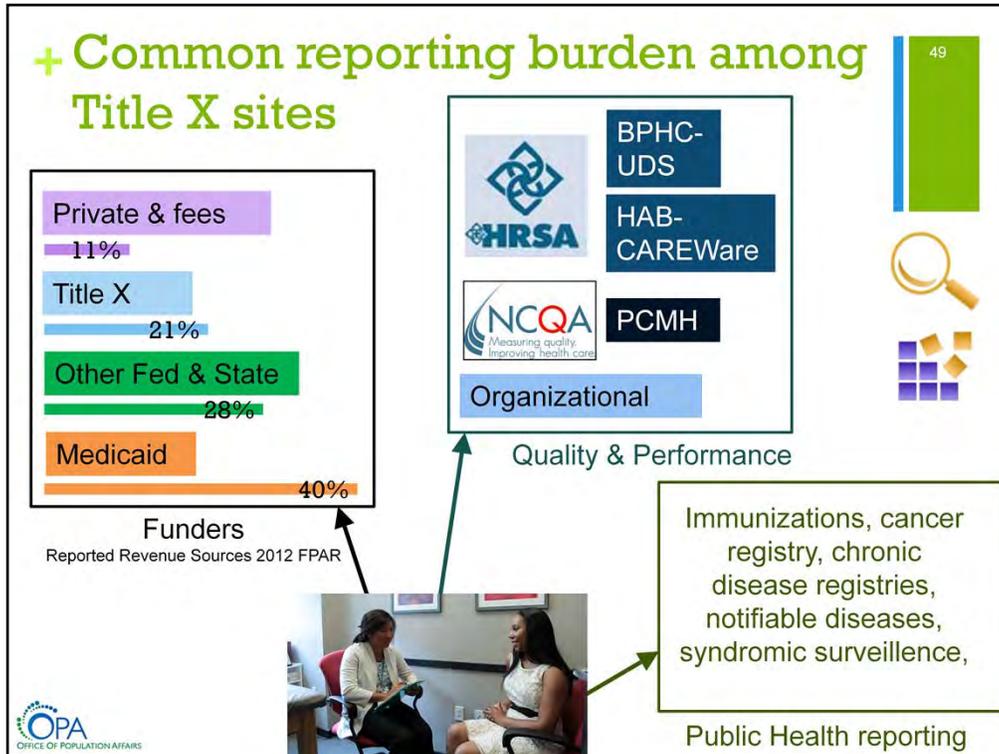
- Work within SDOs
- Standardize & document family planning services
- Promote family planning integration in healthcare

Develop Structured FP Data

48



- Christina has filled you in on our vision for FPAR 2.0 and the critical role of EHR systems.
- Lauren talked about how certified EHR systems help with your long-term sustainability
- I am going to give you an idea of what we have been doing specifically to make the benefits of certified EHR systems pay off for FPAR 2.0.
- We are relying on the work being done nationally, aligning with common data elements and reporting requirements experienced by Title X services sites, and leveraging those commonalities for FPAR 2.0.



A single clinical encounter generates information that can be reduced to clearly defined data elements. Those data elements become important to many entities involved with a given Title X service site and those data elements serve a variety of billing, reporting, and quality needs. We don't want to re-invent the wheel if our needs align well with national efforts. More importantly, if national efforts to standardize data representations have forgotten family planning services then we want to submit the necessary proposals to improve the quality of those efforts so that they **will** suit family planning.

+ Vital signs stored as structured, numeric data MU Stage 2

50

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*

§170.314(a)(4) Record and chart vital signs

- (i) Vital signs. Enable a user to electronically record, change, and access, at a minimum, a patient's height/length, weight, and blood pressure. Height/length, weight, and blood pressure must be recorded in numerical values only.
- (ii) Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient's height and weight.
- (iii) Optional—Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.

*Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.

Record Vital Signs

Objective

Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.

Measure

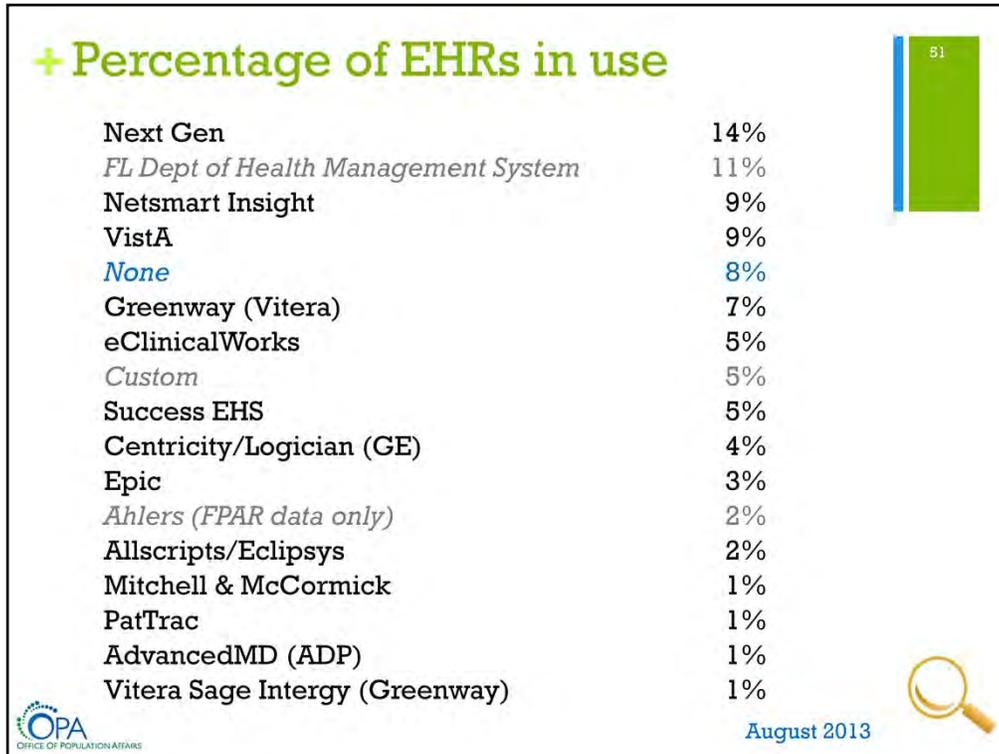
More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.



Certified EHR systems, for example, are required to demonstrate that they can record vital signs as structured data. So blood pressure, height, and weight should be recorded as **numeric** values | **not** as open text with any number of possible formats in any number of locations in the EHR.

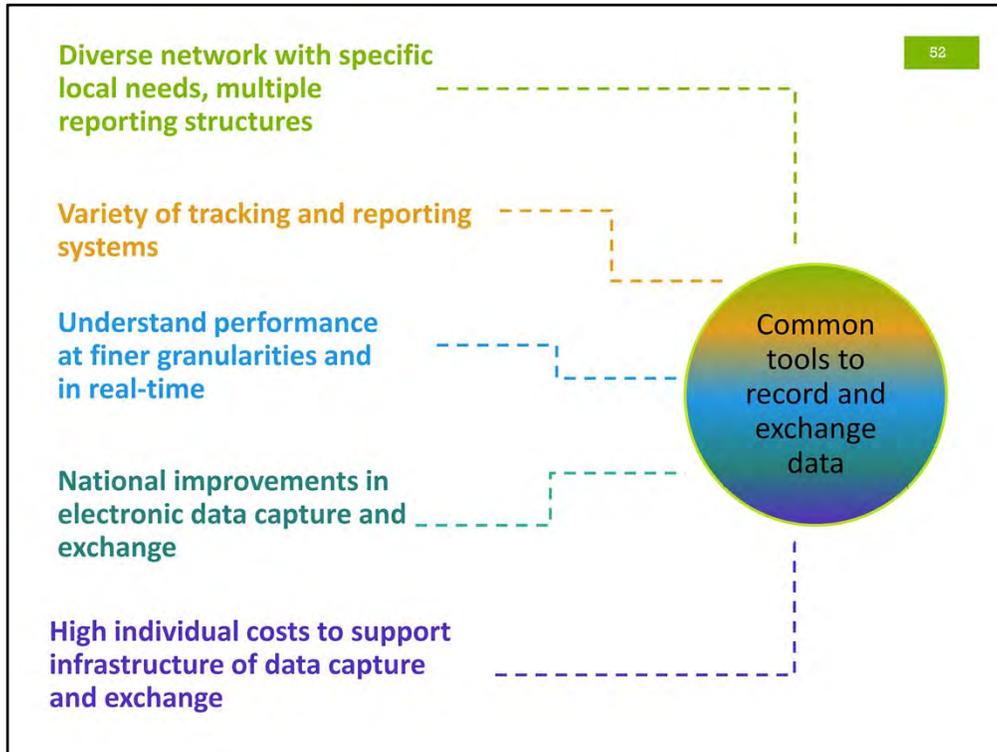
There is also an associated metric for certification of a given criterion.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_4_RecordVitalSigns.pdf



In one of last year's surveys, grantees reported EHRs in use at their service sites. Among the top 90% of EHR systems in use there is **no clear winner**. There are many different solutions being used.

There was also some confusion about what an EHR is as compared to a general data management system.



We are faced with a variety of concerns...

We have a diverse network with specific local needs and multiple reporting structures

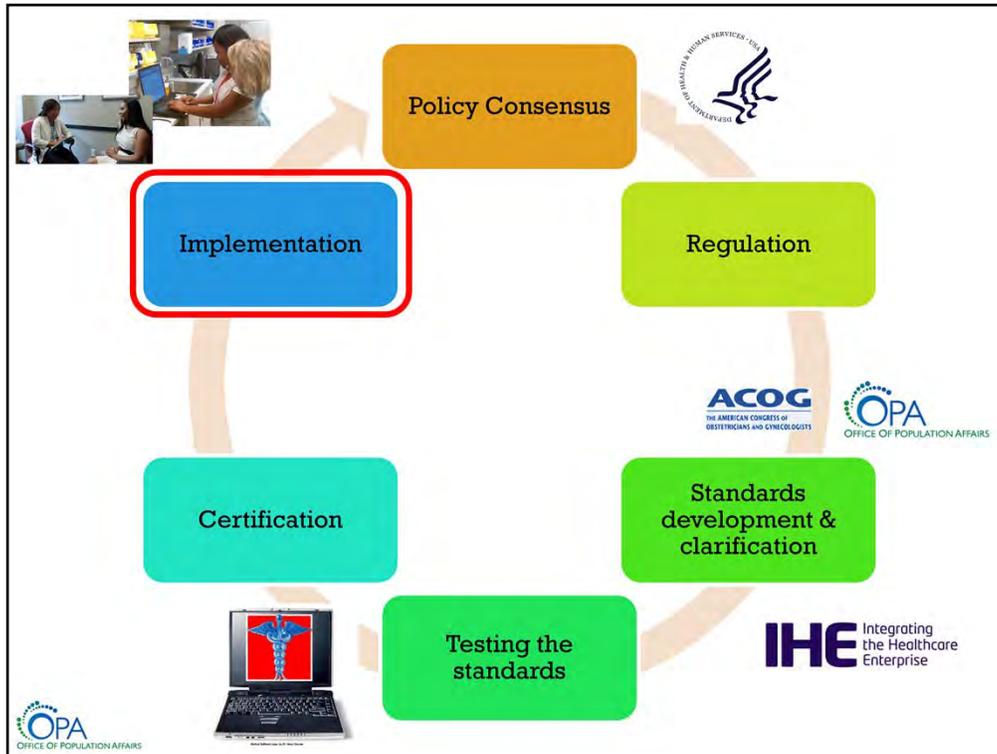
Those sites use a variety of tracking and reporting systems

We also want to understand performance at finer granularities in the context of quality efforts and in real-time

There are a lot of national improvements in electronic data capture and exchange

But there can be high individual cost to support that infrastructure

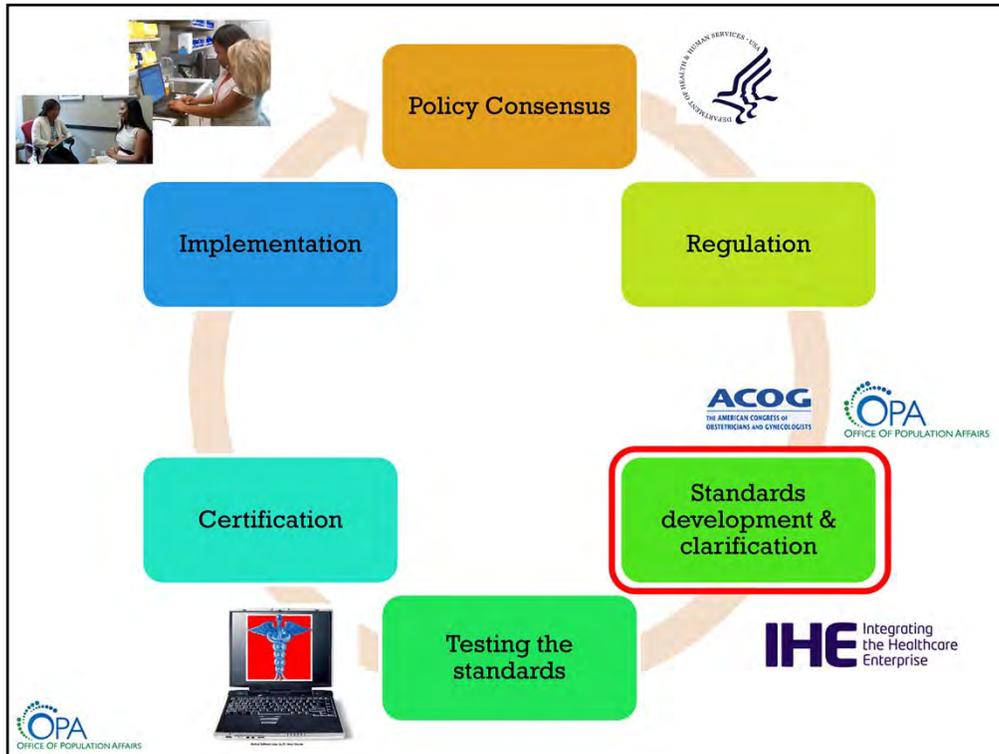
In response to this mix of issues, we look to common tools to record and exchange data.



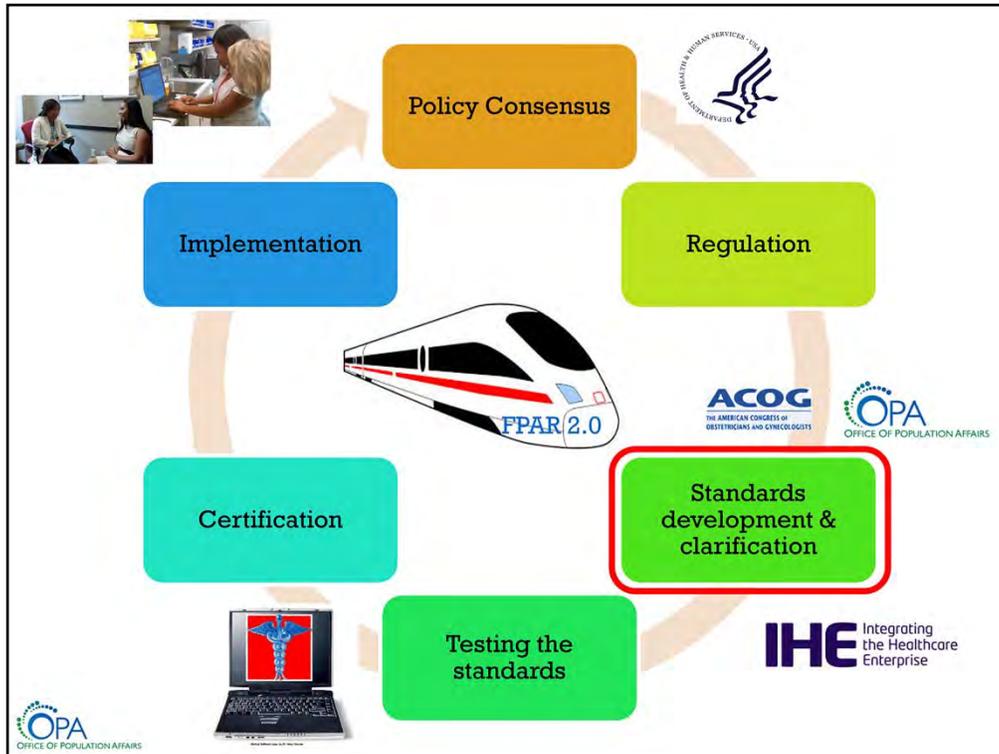
Arriving at those common tools is still quite a process. In general, many communities contribute expertise to create policy consensus, Then we see regulation of data elements and protocols based on that consensus, Standards are developed in accordance with regulation, Vendors test and deploy systems in accordance with standards, Certification gets even more into the weeds by specifying structure, value, and formats, Implementations and pilots point out failures that inform the start of the cycle all over again.

If standards are under-developed when released then it will be taken back up a bit in the cycle and to be re-worked.

Red Implementation. Typically custom reports and encoding happens between a client and their vendors – this happens more at the end of the cycle and individuals are faced with cost and resource burdens.



Red Standards FPAR 2.0 is trying to get in on this cycle at an **earlier** stage where we help define common formats as much as possible.



This hopefully will reduce individual requests for functionality needed by **all** service sites and the friction that can happen without clarity in standards



There are a range of stakeholders that, through consensus process, help define standards of data formats, security, and transmission. The goal of standards is generally to help a heterogeneous network send, receive, and digest content in clear and expected ways. It helps keep local needs and network needs in a dynamic balance using the same language or translation standards.

ACOG recommended that we work with IHE, Integrating the Healthcare Enterprise, based on their success developing standards for ante- and post-partum care protocols with EHR systems.



At IHE we sit on the Quality, Reporting, and Public Health committee and are advised by representatives from vendors, American College of Physicians, ACOG, a few different arms of the CDC, the Clinical Data Interchange Standards Consortium (C-DISC), and others who have longstanding experience in this area. We are also working with the chair of the Patient Care Committee on the details of the modeling in our profile.

In the profile we first describe issues in family planning, the interoperability problems that we face, issues specific to Title X, and make a business case for the relevance of this problem to commercial vendors.

We describe the kinds of systems that we expect will be interacting. In our case, it will eventually be a data repository, the EHR systems in our provider network, and range of other stakeholders that help exchange data.

+ Publish the IHE Family Planning profile June 2014

58

Clinical Data Element	Optionality	CDA pseudo XPath
Weight	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation – Weight Code
Systolic Blood Pressure	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation – Systolic Blood Pressure Code
Diastolic Blood Pressure	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation – Diastolic Blood Pressure Code

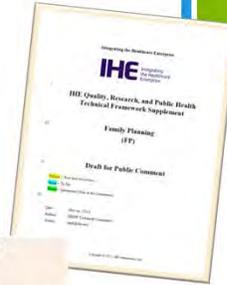


We reference standards related to security and confidentiality concerns and provide specific instructions about how to best represent our data elements according to common structures, behaviors, and architecture of clinical documents. Much of the heavy lifting for this work in software engineering has already been done by standards groups to model healthcare delivery concepts summarized as clinical documents – we are tasked with making it clear how someone pulls this all together in **one recipe** to create a family planning form in an EHR system. We tell vendors how our data elements align to that existing architecture ...
 where it is commonly placed

+ Publish the IHE Family Planning profile June 2014

59

Clinical Data Element	Optionality	CDA pseudo XPath
Weight	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation - Weight Code
Systolic Blood Pressure	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation - Systolic Blood Pressure Code
Diastolic Blood Pressure	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation - Diastolic Blood Pressure Code



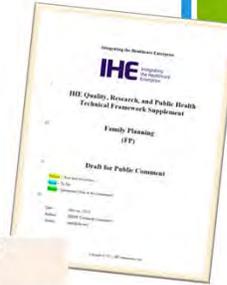
Template Type	Template Title	Opt and Card	templated
Entry	Vital Sign - Weight	[1..1]	1.3.6.1.4.1.19376.1.5.3.1.4.1 3.2
Entry	Vital Sign - Systolic Blood Pressure	[1..1]	1.3.6.1.4.1.19376.1.5.3.1.4.1 3.2
Entry	Vital Sign - Diastolic Blood Pressure	[1..1]	1.3.6.1.4.1.19376.1.5.3.1.4.1 3.2

... relationships of data elements, and

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60

Clinical Data Element	Optionality	CDA pseudo XPath
Weight	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation - Weight Code
Systolic Blood Pressure	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation - Systolic Blood Pressure Code
Diastolic Blood Pressure	R	VitalSigns.vitalSignsOrganizer.vitalSignsObservation - Diastolic Blood Pressure Code



Template Type	Template Title	Opt and Card	templated
Entry	Vital Sign - Weight	[1..1]	1.3.6.1.4.1.19376.1.5.3.1.4.1.3.2
Entry	Vital Sign - Systolic Blood Pressure	[1..1]	1.3.6.1.4.1.19376.1.5.3.1.4.1.3.2
Entry	Vital Sign - Diastolic Blood Pressure	[1..1]	1.3.6.1.4.1.19376.1.5.3.1.4.1.3.2

codeSystem	codeSystemName	Description
2.16.840.1.113883.6.1	LOINC	Logical Observation Identifier Names and Codes
2.16.840.1.113883.6.96	SNOMED-CT	Systematized Nomenclature Of Medicine Clinical Terms
2.16.840.1.113883.6.8	UCUM	Unified Code for Units of Measure



and
 how to encode the values related to clinical findings.

+ Publish the IHE Family Planning profile June 2014

61

Clinical Data Element	Optionality	CDA pseudo XPath
Weight	R	VitalSigns.vitalSignsOrganizer.vitalSignsOb
Systolic Blood Pressure		
Diastolic Blood Pressure		

Template Type	Terminology
Entry	Vital Sign - S
Entry	Vital Sign - S
Entry	Vital Sign - S

```

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<templateId root='/'>
<id root=' ' extension='/'>
  <code code=' ' displayName=' '
  codeSystem=' '
  codeSystemName='/'>
<statusCode code='completed'/>
<effectiveTime value='/'>
<!-- For HL7 Version 3 Messages
<author classCode='AUT'>
  <assignedEntity1 typeCode='ASSIGNED'>
    :
  </assignedEntity1>
</author>
-->
<!-- One or more components -->
<component typeCode='COMP'>
  <!-- Or a pregnancy status observation -->
  <observation classCode='OBS' moodCode='EVN'>
    <templateId root='/'>
      :
    </observation>
  </component>
</organizer>

```



IHE Quality, Research, and Public Health Technical Framework Supplement
Family Planning (FP)
Draft for Public Comment

tion
ifier Names and
ure Of Medicine
Measure



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This recipe book also provides examples of how to structure, describe, and format the data.

The public comment period is critical for realistic implementation and reducing the **total** amount of time a standard must be tested. Vendors or IT staff at Title X service sites may disagree or have implementation concerns and it is best to have a wide review this May-June. It is also critical to have review by family planning subject matter experts to read the profile and ensure that the data elements we propose and the way the values are encoded will help us get to the performance metrics for FPAR 2.0.

+ Vendors test their implementation of the Family Planning Profile at Jan 2015 IHE Connectathon

IHE Quality, Research, and Public Health Technical Framework Supplement
Family Planning (FP)
Draft for Public Comment

Legend:
New text for review
To Do
Questions (Add to the comments)

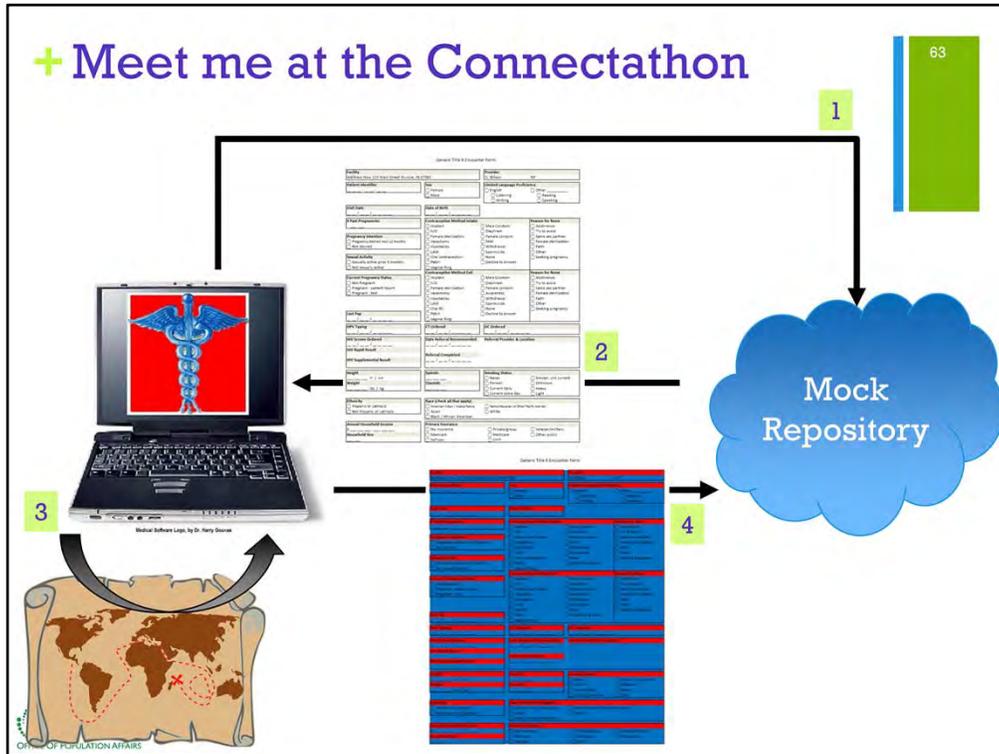
Date: Mar 18, 2014
Author: 00000000000000000000

IHE Connectathon: A Unique Testing Opportunity
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So hopefully the standard will be reviewed thoroughly and accepted. Starting the fall, a contractor will build the testing platform to help vendors demonstrate that they can implement our profile.

We will also be working with the contractor to recruit vendors and help them successfully onboard and develop in the weeks leading up to the Connectathon.

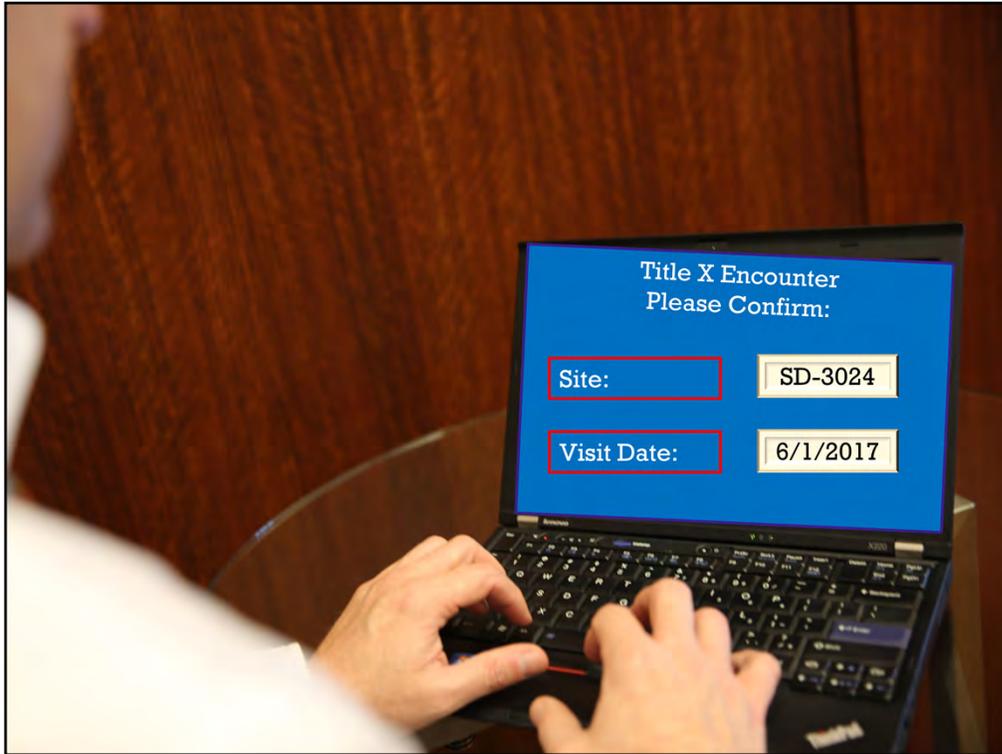
Then in January we will help up to 3 vendors attend the week-long Connectathon and be tested on how well their product demonstrates that they understood the profile and can incorporate it into their systems correctly.



The vendor's system will

1. request the Title X form. Our testing system will
2. send that form to the vendor. The vendor's system uses **their** implementation of **our** profile to
3. map the test cases in their system, confirm the data, and
4. send it back – but the data are represented in a way that is faithful to our profile.

The data that they send is checked and, if successful, the vendor can be certified at the end of the week.



I want to reiterate that vendors tailor our specifications to their systems, (RED ON BLUE FIELDS) but the core data, how it is represented and transmitted, (BROWN) is consistent across vendors. This helps to create a national infrastructure for Title X that is vendor neutral.

+ IHE FP profile alignment with FPAR 2.0 data elements

Facility	HIV Screen Ordered
Provider	HIV Rapid Screen Result
Visit Date	HIV Supplemental Result
Patient Identifier	Date of HIV Supplemental Result
Date of Birth	HIV Referral Needed
Sex	HIV Referred Provider Information
Limited Language Proficiency	Data HIV Referral Completed
Lifetime Number of Pregnancies	Systolic blood pressure
Pregnancy Intention	Diastolic blood pressure
Sexual Activity	Height
Current Pregnancy Status	Weight
Contraceptive method at Intake	Smoking status
Contraceptive method at Exit	Ethnicity
Reason for no contraceptive method	Race
Date of last Pap test	Household Annual Income
HPV typing	Household size
CT Screen Ordered	Primary Visit Payer
GC Screen Ordered	



The variables that we are currently proposing in the IHE profile align with the QFP, FPAR 2.0, and expert opinion from leaders in Title X. We are setting up this profile to serve us for a longer time span to be tested and adopted but ready for FPAR 2.0 metrics in a few years.

+ Success Stories

HRSA BPHC Health Center Controlled Network (HCCN)
 East Providence, RI
 NCQA PCMH L3, HCCN, & Title X
 EHR system: NextGen



NFPRHA Case Study of group EHR purchasing
 Indiana Family Health Council
 EHR system: iSalus



HHS ONC Case Study of EHR implementation
 Portland, OR
 FQHC & Title X
 EHR system: Epic





66

Again, when we meet with stakeholders the clinic directory is proving extremely valuable to show how Title X sites and our reporting vision overlap with their systems.

We've highlighted a few success stories in the Title X network of service sites that have implemented new EHR systems and are using them to improve the quality of their clinical services.

These three entities purchased and implemented as part of groups and capitalized on a variety of incentive programs. You can read more in the resources download.

I also would like to repeat the emphasis on the OPA clinic directory. The database must be kept up to date with regards to services provided and contact information. More importantly, the records must be complete. For example, if a grantee or sub recipient also delivers services then they **MUST** have a second entry in the directory as a service site.

www.NACHC.com/EhrVendors.cfm

https://www.nachc.com/ehrvendors.cfm

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NATIONAL ASSOCIATION OF
Community Health Centers

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Clinical Issues

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Conferences
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Publications & Resources
Job Board



Stay updated on
Community

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In this Section

- HR Clearinghouse
- Financial/Operations Management
- Capital Development
- Governance
- Health Center Growth/Development
- Risk Management
- Emergency Management
- Health Information Technologies (HIT)
- Outreach and Enrollment

EHR Vendors Text Size: [A](#) [A](#) [A](#)

Electronic Health Record (EHR) Vendor Site Visits and Reviews

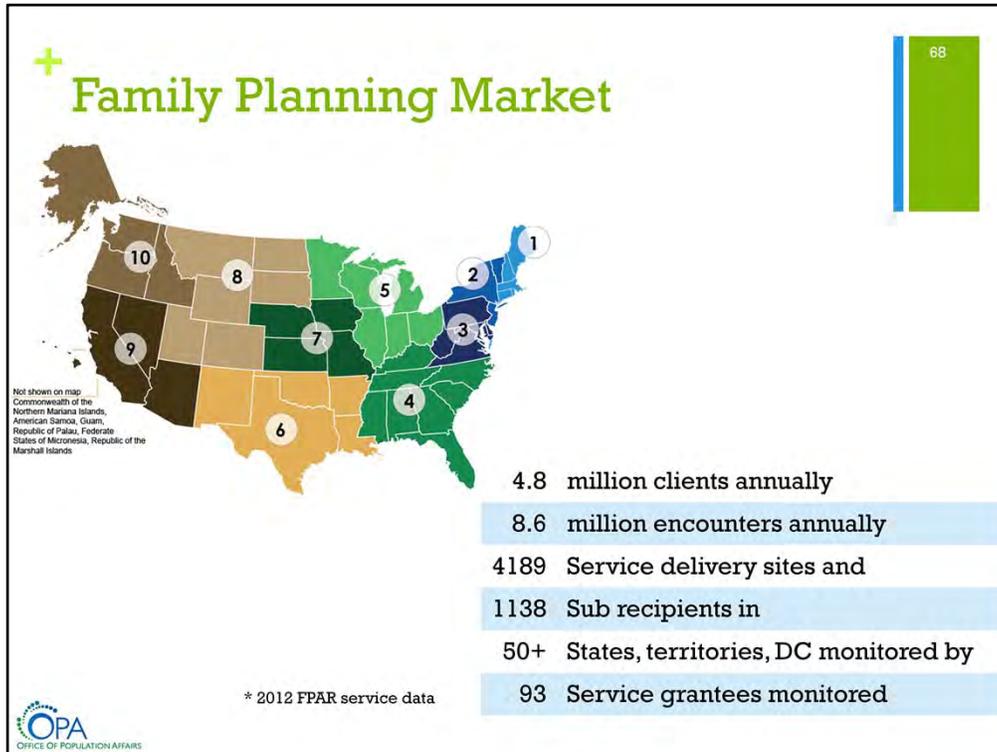
Over 100 health centers in over 40 states using more than 20 different EHRs are available to assist you in your EHR implementation efforts.

In this area you can:

- Locate health centers that have implemented specific EHRs
 - Identify individuals who can provide the low-down on their experience with a specific EHR vendor;
 - Discuss arranging a site visit to see an EHR live
- If you would like to provide a review of an EHR product please send an e-mail to Shane Hickey, Director of IT Assistance, at shickey@nachc.com



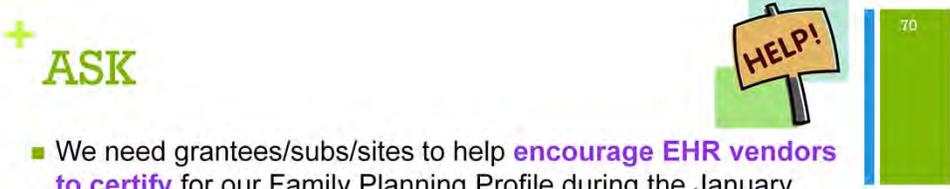
Lastly, the National Association of Community Health Centers has provided a list of health centers that have implemented a variety of systems and are willing to provide assistance to others. I cross-referenced this list with our clinic directory and found ample overlap by clinic name as well as by zip code and city-state. This means there are a number of peer resources through NACHC that are also Title X sites. This is also available as a resource today.



The Connectathon setting is the foundation for later, higher levels of certifications with live systems. Vendors have to **believe**, though, that there is a market for this product. We need **you** to demonstrate that Title X sites **want** this for their systems and that the content of this work has merit beyond Title X to improve the quality of delivering family planning services.

We presented a lot of information so far today and we could spend hours going into more detail. We mostly want to assure you that we are aligning with bigger efforts and taking advantage of that synergy and experience. Christina is going to focus on specifically what you can do next.





+ ASK

- We need grantees/subs/sites to help **encourage EHR vendors to certify** for our Family Planning Profile during the January 2015 IHE Connectathon
- All vendors welcome, but we are specifically interested in recruiting:
 - AllScripts
 - eClinicalWorks
 - Greenway
 - NextGen
 - NetSmart
 - SuccessEHS
- OPA has already begun vendor outreach & discussions
- Vendors listen to their customers (and potential customers)!



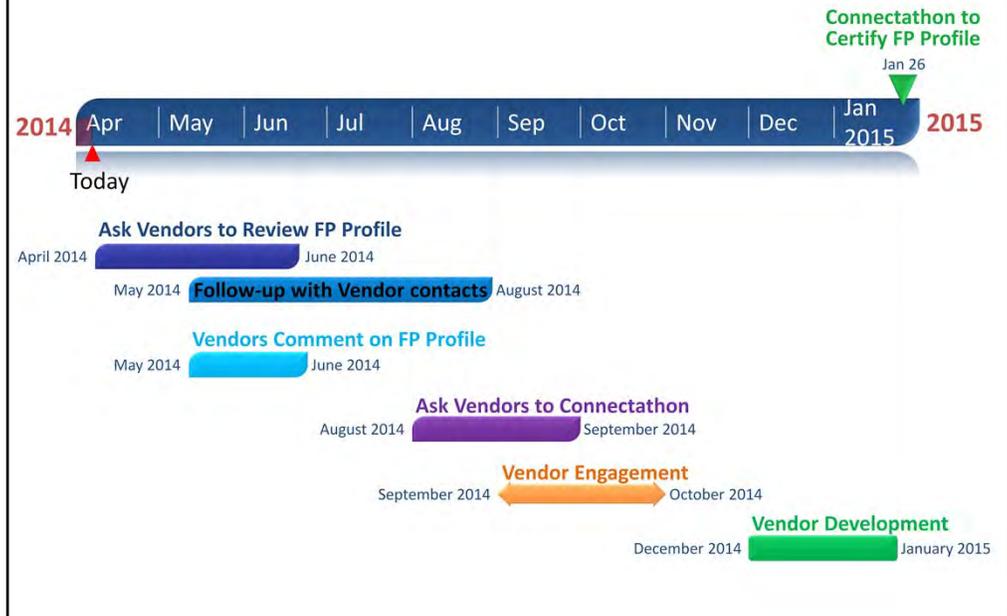
OPA needs help from Title X grantees/subs/sites to encourage EHR vendors to certify for our Family Planning Profile during the January 2015 IHE Connectathon

Our vision and plan to achieve interoperability will only work if we can demonstrate that there are customers who are demanding the FP profile. We need to make a value proposition to the vendors that they should feel compelled, amidst ICD-10 and meaningful use and everything else going on right now, to attend this testing event and sign up to certify with our profile

Send it between now and Sept 1 – need to percolate up – CUSTOMER REQUEST – start development and participate Nov-Jan

Begun discussions with Allscripts and eCW.

Timeline for IHE Connectathon Ask



+ ACTION ITEM

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- Download the attached handout: Vendor Outreach
- Tailor the language as needed
- Email or call your EHR vendor to request their review & participation
 - Feel free to cc us at FPAR2.0@hhs.gov
 - Follow up with your vendor and let FPAR2.0@hhs.gov know if your vendor is serious about participating
- If vendors have questions, they can also reach out to us at FPAR2.0@hhs.gov



Campaign to get our family planning profile on EHR vendors' radars
OPA will be happy to answer all technical questions and details – we need
grantees/subs/sites to drive vendors to us

+ Thank You!

73

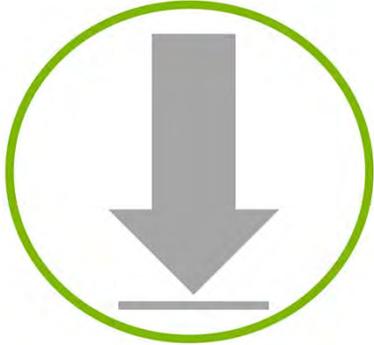
Final Questions

Chat now

Contact us later at: FPA2.0@hhs.gov

+ Resources

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6 resources from today's session:

- Vendor Outreach script – word doc
- List of additional resources – word doc
- Longer EHR adoption toolkit – PDF
- List of NACHC sites that will mentor others on EHR adoption – Excel file
- PDFs of both FPAR presentations