

Open Letter to Dr. David Blumenthal from Community Health Funders

August 12, 2009

Office of the National Coordinator for Health Information Technology
200 Independence Ave, SW Suite 729D
Washington, DC 20201

Dear Dr. Blumenthal,

We welcome your appointment as the National Coordinator for Health Information Technology and congratulate you as you take on the challenges of this position. The adoption of HITECH within the ARRA represents the first significant opportunity to realize the promise of HIT to improve the quality of care throughout the United States. We believe your experience, and in particular, your focus on HIT as a tool to improve quality will serve the country well as we work together towards these shared goals.

As you know, the Community Clinics Initiative (CCI, a joint project of Tides and The California Endowment) has funded and provided technical assistance services to community clinics and health centers in California for the last 10 years with a focus on health information technology, among other areas. <http://www.communityclinics.org>. We are pleased to be joined in this letter by our colleagues at the Kaiser Permanente Community Benefit Program and The Kresge Foundation who are actively supporting the critical work of community clinics and health centers both in California and throughout the country.

We see HITECH as more than an authorization for funding. It represents a framework for HIT and data exchange to support our shared goals of improving the quality of care and reducing costs for all Americans. Particularly now, as both health care reform and payment reform are top priorities for federal policy makers, the opportunity to make significant improvements in our health care system appears stronger than it has in decades. The widespread adoption of EHRs and ensuring their meaningful use are powerful tools for realizing these changes.

We also welcome the invitation in the Office of the National Coordinator's (ONC) Implementation Plan to provide expert comment on the work ahead. Through our work together with you on the 2005 symposium in Washington D.C., *"Realizing the Benefits of Health IT for Community Health Centers: What is Needed and How Does it Get Done"*, we are well aware of your commitment to community clinics and health centers and the groundbreaking work many of them have accomplished in using technology to improve quality.

Both CCI and KP Community Benefit have documented lessons in the area of technology-enabled quality improvement by our nearly 200 grantees over the last 10 years. We have provided significant support to safety net providers to implement and meaningfully use HIT. Moreover, Kaiser Permanente's own experience with the largest civilian implementation of E.H.R.'s has provided a living laboratory for best practices.

HITECH is built on experience and research into best practices for HIT implementation. By focusing its sights on the use of technology as a tool to improve care and reduce disparities, HITECH underscores that it is not the technology itself, but providers' ability to use it effectively that will measure its ultimate success. This is one of the greatest strengths of this legislation.

Although the funding and infrastructure of HITECH provide financial support and wise direction, it will be the decisions made by the Department of Health and Human Services on HITECH's implementation that will ultimately determine whether or not HITECH is a "game changer" in health system transformation.

We realize that the deadlines imposed by HITECH require almost immediate action, yet the decisions you must make are highly complex and their impact far-reaching. We are eager to support your commitment outlined in The Office of the National Coordinator for Health Information Technology's ARRA Implementation Plan, "meeting the long term goals of the Recovery Act will require careful thought and planning while delivering to the American people quick action and effective investment of committed funds."

We find much to be enthusiastic about in HITECH. We applaud the emphasis on best practices in HIT innovation as well as its acknowledgement of the importance of safety net providers and some of the unique HIT needs faced by these providers. But our enthusiasm is tempered by potential pit-falls that require careful attention as agencies at HHS and the states make critical implementation decisions. We appreciate the opportunity to raise our concerns and to identify where, based on our experience and analysis, attention needs to be paid in order for the needs of safety net providers to be attended to within HITECH's implementation process.

Although we have structured our comment and feedback to align with the key programs of HITECH, there are a number of central themes that run through our thinking. Our perspective is different from those technology professionals who develop systems, standards, certification criteria or architecture. Our lessons are drawn from extensive experience with the complex and difficult process of HIT implementation by providers in the trenches working in challenging settings and serving some of our most vulnerable populations.

- **Safety net providers practice medicine in a broad array of settings and organizational structures.**

Both HITECH and the funding available to Federally Qualified Health Centers through HRSA within the ARRA are critical and badly needed sources of support for these effective and critical organizations. We have concerns about how HITECH will or can support other small safety net providers working in underserved communities including free-standing, homeless, migrant clinics, rural health centers, tribal health facilities, and school-based clinics who are not eligible for the HRSA dollars and who, because of their structures and payer mix may not qualify for support under the Medicaid or other provisions of HITECH. If the goal of universal adoption of EHRs and full participation in Health Information Exchange is to be achieved, mechanisms to support these providers must be found. In California alone, these non-FQHC providers serve over 1 million underserved individuals at nearly 250 local sites, providing over 3 million visits a year. A reasonable adaptation would be to include non-profit community and free clinics that meet the same guideline, definition and criteria as FQHCs of serving at least 30% "needy individuals."

- **Focus on the outcome not on the technology.** Our experience has shown that there are many ways to use technology to successfully improve quality and reduce errors. A fully functional EHR or costly participation in large data exchange organizations may well be beyond the current financial and organizational capacity of small safety net providers (and likely small private practitioners as well). But many of these providers are still able to effectively use technology to improve quality. Community Health Centers, guided by HRSA and AHRQ, have been leaders in demonstrating how relatively simple registry systems can support dramatic improvements in chronic disease management. We are pleased to see the growing acknowledgement by health policy makers that these registries are stronger tools for quality improvement than many of the fully-fledged EHRs on the market today. In California, use of CDMS and other registries have

been shown to support greater gains in quality improvement and faster turnaround of data to 65 to 70 community clinics and health centers than would have been possible with the use of EHR alone.

- **Incremental approaches are not “second best.”** Although fully functioning and utilized EHR systems may still be the holy grail, our experience has made it increasingly apparent that this is often neither the most feasible, nor the most strategic approach for small safety net (and other) providers. Like registry systems, other HIT functions, such as e-prescribing and the automation of orders and results for lab tests, have allowed community clinics and health centers to improve quality, address disparities, gradually redesign their systems, and allow their staffs to become accustomed to the value of technology. Qualification for incentives and rewards should be based on a provider’s ability to carry out the activities in the meaningful use definition, not on specific technology systems or configurations.
- **To achieve the goals of HITECH, strategies need to take into account the widely acknowledged challenges and complexity of HIT innovation.** Despite the hype, HIT implementation is a difficult and disruptive process. By itself, it does not transform health care. The revolutionary potential for HIT is achieved only when it supports dramatic changes in the way medicine is practiced, and adaption and learning by virtually every person the system touches, including patients. Criteria for the use of HITECH dollars should support these readiness and change management activities both in the development and maintenance phases of funding.
- **The promise of HIT as a tool for improving quality, reducing the burden of chronic disease, and improving safety cannot be fully realized without payment system reform.** Payment incentives must be aligned with the practices and activities that lead to these outcomes. Although beyond the scope of HITECH alone, to the extent possible, HITECH’s implementation should support and encourage appropriate payment system reform.
- **Support the upfront implementation activities with money and technical assistance.** The incentives available through Medicaid stand to dramatically benefit many safety net providers if they are able to successfully meet the requirements that CMS and their state Medicaid programs will set forth. But the money comes only when providers are able to successfully demonstrate that they are “meaningful users” of the technology. This back-loading of the funding may be particularly problematic for safety net providers. Obtaining and managing the upfront financing can be insurmountable barriers for providers who have little access to private capital and rarely are able to self fund these large projects.
- **HITECH’s differentiation of timing and funding levels between the Medicare and Medicaid incentives is an important recognition that the financial barriers to HIT implementation in safety net settings may be higher.** The additional time to implement and the absence of sanctions for later adoption or non-implementation are strengths of HITECH. Initial discussions at the Policy Committee suggested that CMS intends to require providers to meet the meaningful use requirements in effect in the year they seek to qualify for incentives. This policy has the potential to undo the benefit of the longer timelines and the incremental approaches to meaningful use we know are critical to long term success in HIT adoption. We are gratified that the Policy Committee in response has recommended that providers be permitted to meet the requirements according to their individual adoption timelines within the program and encourage CMS to adopt this approach in its final definitions of meaningful use.

We recognize that ONC and CMS must act quickly so that those who want to and can meet the first deadlines in 2011 have the guidance they need. But the 2011 deadline is already misunderstood, with many providers moving to accelerate timelines, to the potential detriment of their organizations and patients. We encourage ONC and CMS to as quickly as feasible begin to differentiate their messages so that safety net providers seeking to meet the Medicaid incentive requirements are encouraged to follow a deliberate and thoughtful process towards their HIT planning and implementation.

We are concerned that a focus on the 2011 deadlines may lead providers to shortcut the very readiness activities that have been widely demonstrated to be critical predictors of success for HIT implementation. Readiness assessments recently conducted in 51 Southern California community clinics and health centers (CCHCs) conveyed that only 2% of CCHC's were "highly prepared" for EHR adoption. Regional Extension Centers, loan funds and all aspects of HITECH that reach safety net providers at the beginning of the implementation process should support and require that this critical readiness work be accomplished.

- **Complexity will be a disincentive.** Although the Medicaid incentives likely have the greatest potential to support implementation of HIT in community clinics and health centers, the formulas and requirements of the Medicaid incentives are among the most complex provisions of HITECH. The potential for variation and confusion is increased because state Medicaid programs will finalize their own definitions of meaningful use and have significant discretion on how the funds are distributed. A goal of the implementation of the Medicaid incentives should be simplicity, clarity and consistency so that providers are encouraged to take advantage of the programs.

With legislation as intricate and complex as ARRA, it would have been impossible for timelines and deadlines to be fully aligned. But, to the extent possible, coordination between ONC, CMS, HRSA and other agencies responsible for HIT funding for safety net providers is highly desirable. Already Federally Qualified Health Centers have been faced with the challenge of making decisions on their HIT efforts in order to acquire HRSA funding, decisions that may or may not meet requirements for later funding under the provisions of HITECH.

- **The incentive programs are more likely to succeed if they are closely aligned with the other components of HITECH.** While the most significant funding in HITECH is through the Medicare and Medicaid incentives, the tools for successfully meeting the requirements of the incentives generally are run out of other agencies. In particular, the loan programs and the technical assistance provided by the Regional Extension Centers must directly support providers in meeting the incentive requirements. The Secretary must ensure that there is successful coordination and cooperation between ONC and CMS in order for this to be successful.

Medicare and Medicaid Incentives

The bulk of HITECH funding, flowing through the Medicare and Medicaid programs, will reward providers who successfully implement electronic health records that meet the definition of "meaningful use."

The levels of funding that are available to individual providers are significant, but the schedules and timing are likely to be problematic. The 2014 goal for universal adoption set forth in ARRA has an important role as a symbol, but it flies in the face of experience. ONC's own goals to date underscore the slow rate of adoption. At CCI, after ten years of support, only 28% percent of our clinics have implemented EHRs and an estimated 17% have not even started the process.

The schedules and timelines that flow from the 2014 goal should not interfere with providers or vendors ability to implement HIT according to the best practices HITECH extols. The longer timelines permitted within Medicaid are important, but only if they are well understood by providers seeking to qualify for these incentives.

We have learned along with many of our grantees that the process of HIT implementation is best driven by a careful plan, implemented to meet the realities of that unique provider. Firm external deadlines rarely help; in fact we found that the drive to meet these deadlines sometimes leads to damaging adjustments of these plans. It is important that technical assistance programs, loan funds, and other support mechanisms encourage the type of careful planning and implementation that are hallmarks of success and discourage short term strategic approaches that sacrifice long term success for modest short term gain.

Meaningful Use

The process of defining what constitutes meaningful use has become the most widely discussed aspect of HITECH implementation. From the perspective of safety net providers, a number of issues are of particular importance:

- Several organizations have already called for a clear statement of how meaningful use will be defined over the long term, so that providers, vendors, and those involved in the development of certification criteria and standards have a goal to work towards. We strongly endorse the need for a clear road map for meeting the long term definition as well as an incremental approach to getting there. Few providers have excess resources to support changing courses as the process moves forward; this is particularly true for small safety net providers.
- An incremental approach to meaningful use which begins, as the legislation requires, with steps that will net significant benefit, including e-prescribing and reporting on quality data, will lead to initial successes. These “short term wins” are critical to building support for HIT within health care organizations. ONC and CMS will need to strike a careful balance so that the bar is set at a point where people can be successful, but high enough so that the true improvements in quality, safety, and efficiency will result.
- Meaningful use should also include the ability to collect and analyze data to support the innovative approaches many safety net providers have taken to improving health and decreasing disparities within their communities. Although vendors whose products are in widespread use in safety net settings have begun to respond to the demand for tools to support population based health care improvement, inclusion within the definition of meaningful use will fast track development and improvement in these areas.
- Because a wider range of providers including nurse practitioners and midwives are eligible for Medicaid HITECH incentive payments, the definition will need to be broad enough to encompass the different practice patterns and practice settings in which these professionals often work.

We are also concerned that those providers that have been the vanguard of HIT implementation may not be able to take full advantage of HITECH funding since they will have implemented before the eligibility period. This seems punitive and shortsighted. We urge an interpretation of the language that allows these early adopters to reap the benefit of HITECH; they are the very organizations likely to reinvest this money to lead the way to the next frontiers of technology innovation.

As discussed earlier, as the details of HITECH are better understood, it has become clear that there are categories of small safety net providers working in underserved communities who may “fall through the

cracks” of the various HIT provisions in ARRA. ¹If the goal of universal adoption of EHRs and full participation in Health Information Exchange is to be achieved, mechanisms to support these providers must be found. One approach we recommend for consideration is the extension of the more liberal “needy individuals” standard applied to FQHCs in the Medicaid share requirement to these other categories of safety net providers so they are more likely to meet the threshold to qualify for Medicaid incentives.

¹ These include free-standing, homeless, migrant clinics, rural health centers, tribal health facilities, and school-based clinics that are not eligible for the HRSA dollars and who, because of their structures and payer mix, may not qualify for support under the Medicaid or other provisions of HITECH.

Loan Funds

Because it presents opportunities for upfront funding support, the loan fund program, one of the least discussed aspects of HITECH, is a critical component for the program’s ultimate success. It is unlikely that the funds directly available through HITECH will be enough on their own to meet existing need. State matches can help, but private sources of funding will also be needed. The availability of funding at the back end of this process should make these loan funds much more attractive to private lenders than they have been to date. We encourage ONC to strategically allocate the federal loan funds so that they will leverage greater levels of state and private dollars and the development of creative funding strategies and to include criteria that will encourage the allocation of significant portions of these funds to safety net providers.

Regional extension centers

There is great merit in the concept of regional extension centers to provide technical assistance and disseminate best practices in HIT innovation. The requirement that safety net providers be given priority access to their services is an asset in the plan.

The assistance and training these providers receive needs to reflect best practices in HIT implementation within safety net settings. The Community Clinics Initiative and others have documented these best practices and developed readiness assessments and a range of technical assistance tools that can appropriately support IT implementation in safety net settings.

Differences in mission, patient and payer mix, reporting requirements and focus on prevention and community health lead to unique HIT needs among community clinics and health centers. Extension centers, particularly if they are to be run by large organizations, should be required to demonstrate that they are addressing these distinctions both in the services they provide and the management and leadership of their programs.

We are also in support of the need for the programs of these centers to be closely aligned with the requirements for meaningful use. The goal of the regional extension centers should be to use the best of what has been learned in HIT implementation to successfully position providers to satisfy the meaningful use requirements on a timeline that allows for them to proceed carefully and thoughtfully. If providers cannot meet the initial deadlines and will be more successful if they follow a slower and more methodical process, extension centers should encourage and support these decisions. Measuring success of these centers only by how many providers meet the initial 2011 deadlines would represent short sighted policy.

Health Information Exchange

The lines between Health Information Technology and Health Information Exchange are quickly blurring. In the not distant future, a medical record available through an EHR at a provider's office will be viewed as incomplete if it does not reflect the patient's activity with other providers. Although HITECH recognizes the importance of HIE within the definition of meaningful use and in the transformation of the health care system, the \$300 million allocated to state and regional HIE grants is clearly insufficient and we expect and support the allocation of significant amounts of additional funding to this purpose from the 1.6 Billion dollars in unspecified funding available to ONC.

But in allocating this funding, ONC needs to take steps to ensure the deliberate inclusion of safety net providers in the planning and implementation of local, regional, and statewide information exchange efforts. Many, perhaps most, statewide efforts to establish information exchange began without participation from the safety net. Safety net providers have frequently commented on their difficulty in getting a seat at the table. If their ability to successfully meet the criteria for Medicaid incentives is dependent upon their capacity to participate and exchange data, then the unique HIE needs of these providers, and their heightened concerns about confidentiality for their patients need to be addressed as HIE systems are developed. This means they must be included in the planning and implementation of these projects. The requirement for participation by a broad network of constituencies in order to obtain ONC funding for HIE projects is a good step, however the grant criteria can be more specific to require appropriate participation in HIE decision making and governance bodies by safety net providers.

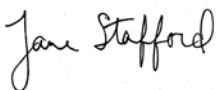
Others have proposed that ONC and CMS consider waiving HIE requirements for meaningful use in the initial stages of incentive payments when the appropriate HIE mechanisms are not in place in a particular geographic area. We support the consideration of this approach.

Concerns have also been raised about safety net participation in the various committees and operating organizations functioning under the ONC umbrella in the past. There has been a tendency to equate safety net providers and consumers under the same rubric. While many safety net providers play a role in representing the needs of their communities, they need to also be represented in their role as providers. We recognize that there is representation of these providers on the new ONC policy committee and are pleased that our colleague, Dr. Neil Calman, has the opportunity to bring the safety net provider perspective to these discussions. We encourage similar nominations as new structures are developed.

Overall, HITECH represents a thoughtful and informed approach to a federal plan for HIT innovation. If implementation strategies address the issues described above, it will give safety net providers the tools they need to improve the high quality of care they provide to our nation's most vulnerable populations.

We look forward to working closely with you in the years ahead.

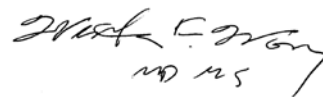
Sincerely,



Jane Stafford
Managing Director
Community Clinics Initiative



David D. Fukuzawa
Program Director
The Kresge Foundation



Winston F. Wong, M.D., M.S
Medical Director, Community Benefit
Kaiser Permanente, National Program
Office