

Draft Description of the Program for Establishing Regional Centers to Assist Providers Seeking to Adopt and Become Meaningful Users of Health Information Technology¹

June 11, 2009

Charles Friedman
Office of the National Coordinator for Health Information Technology
United States Department of Health and Human Services
200 Independence Ave, SW., Suite 729D
Washington, DC 20201

Attention: Health IT Extension Program

Dear Mr. Friedman:

The Markle Foundation's Connecting for Health Initiative has since 2002 brought together leading government, industry, and health care experts to accelerate the development of a health information-sharing environment to improve the quality and cost-effectiveness of health care. Together with the Center for Democracy and Technology, the Center for Medical Consumers, Childbirth Connection, Microsoft Health Solutions Group, National Partnership for Women & Families, Mark Frisse, Vanderbilt Center for Better Health and J. Marc Overhage, Regenstrief Institute, we submit these comments in response to HHS' draft description of a program for establishing regional centers (Centers) to assist providers seeking to adopt and become meaningful users of health information technology.²

Our comments recommend clarifying and further developing the program description to better meet this goal:

1. Clearly define the scope of Center activities to support meaningful use and American Recovery and Reinvestment Act of 2009 (ARRA) goals before grants are made.
2. Centers should help providers use health IT to engage consumers and support their active health management.

¹ Federal Register/Vol. 74, No. 101/May 28, 2009.

² The following additional people were consulted during development of this draft. Their input was important to drafting these comments but their participation does not imply endorsement: Neil Calman, President & Chief Executive Officer, Institute for Family Health, Gerry Hinkley, Partner, Davis Wright Tremaine LLP, David Kibbe, Senior Advisor, American Academy of Family Physicians, David Lansky, President and Chief Executive Officer, Pacific Business Group on Health, Micky Tripathi, President & Chief Executive Officer, Massachusetts eHealth Collaborative, Steven Waldren, Director, Center for Health Information Technology, American Academy of Family Physicians.

3. Broaden the definition of health IT to include health IT services and tools that support providers in achieving meaningful use.
4. Tie funding to program goals, not minimum and maximum amounts per geographic area.
5. Use flexible and outcome-oriented criteria to select organizations most likely to have a long-term impact.

1. Clearly define the scope of Center activities to support meaningful use and ARRA goals before grants are made.

The Centers should help providers achieve meaningful use of health IT to improve health care quality and reduce cost growth. These goals are achieved through effective use of information and improved care processes, not just by installing software or hardware. The Markle Connecting for Health definition of Meaningful Use is stated in our recent consensus document, [*Achieving the Health IT Objectives of the American Recovery and Reinvestment Act: A Framework for "Meaningful Use" and "Certified or Qualified" EHR.*](#)³

Effective use of information is what enables a consumer to play an active role in maintaining health and getting the best care, prevents a patient from suffering a medical error, helps a clinician prescribe the right treatment at the right time, allows a care team to coordinate care in the most effective and affordable way, and benefits efforts to improve quality, accelerate research, and advance public health. **The definition of "meaningful use" should hinge on whether information is being used to deliver care and support processes that improve patient health status and outcomes. The definition should focus on the needs of patients and consumers, not on the mere presence or functions of technology.**

The scope and phasing of Center activities to reach these meaningful use goals and the objectives outlined in ARRA (increase care coordination, improve medication management through e-prescribing and focus on quality and quality reporting) should be clearly defined to include:

- a. **Identify priority health improvement goals and the information, health IT capabilities, and care processes needed to achieve them.** For example, if a key goal is decreasing medication errors, prescribing physicians and pharmacists will need reconciled medication history information, laboratory information, information about patients' medication allergies and health IT tools and care processes to identify and avoid potential drug-drug interactions and other medication errors.
- b. **Evaluate vendor products against requirements.** This rigorous evaluation is critical. For example, if meaningful use requirements or desired health goals include

³ Markle Connecting for Health. 2009. Achieving the Health IT Objectives of the American Recovery and Reinvestment Act: A Framework for "Meaningful Use" and "Certified or Qualified" EHR. http://www.markle.org/downloadable_assets/20090430_meaningful_use.pdf.

improving diabetes outcomes, providers will need health IT products that enable them to manage a panel of patients with diabetes and access critical information including medications, data collected by patients such as home glucometer readings and recent laboratory results. The role Centers can play is to identify what is needed (what information and health IT capabilities to serve what health goals and processes), lay these out as clear procurement requirements and give vendors feedback about their products.

c. **Work with participating providers on practice and process redesign.**

Providers will be best able to achieve the goals of meaningful use if the health goals are clearly established and they are able to use health IT to support their practice and care delivery process redesign. Centers should help providers use health IT to coordinate care with other providers, streamline administrative processes, communicate and share information with consumers, and redesign workflow and care processes to use information and reach health improvement goals. Analysis of workflow and practice redesign should precede implementation so that IT is deployed in a way that supports care delivery changes and quality improvement. If not, health IT will just automate inefficiencies and poorly designed care processes.

These required activities and services should be clearly defined and shared with program applicants before they draft grant proposals, ideally by releasing a revised description before the request for proposal is released. Laying out clear expectations will greatly increase the potential for success.

The suggested role for the Centers is consistent with the lessons learned by other major health IT initiatives⁴ that:

- Clinical and administrative goals must be defined before software, hardware or services are procured. Otherwise systems may not provide needed information and functionality.
- A narrow focus on IT procurement and installation without assistance to redesign workflow and care processes will not produce desired outcomes.
- Arms-length support alone (sharing informational materials, providing remote technical assistance) is not a highly effective way to support health IT adoption and meaningful use, especially for those who are not early adopters.
- A broad skill set is needed to support meaningful use of health IT by providers including expertise in care redesign, privacy, patient engagement and quality improvement, as outlined in the draft description.⁵ The skill set of people engaged by the Centers will need to go beyond technical expertise in procurement and installation and extend to these areas, or the program will fall short of its goals.

⁴ Including efforts by New York City's Primary Care Information Project (PCIP), the American Academy of Family Physicians, the Massachusetts eHealth Collaborative (MAeHC) and the Doctors Office Quality - Information Technology (DOQ-IT) program.

⁵ For instance, MAeHC staff are practice implementation specialists, project managers, technical managers, interface/network managers, system architects, communication specialists, evaluation specialists, attorneys, budget analysts and business analysts.

- The roles and responsibilities of providers, extension centers, vendors and consultants should be clearly defined in advance. The balance of each contribution will vary across settings, but clearly defining each participant’s contributions and expectations is critical.

Centers should be designed to provide the “above and beyond” services that will help providers achieve meaningful use of health IT, without taking on vendors’ basic implementation responsibilities for installation, configuration and training on their products. At the same time, Centers will have a key role in holding vendors (and practices) accountable to their implementation responsibilities. Centers may develop ongoing relationships and partnerships with vendors that are responsive and have affordable and effective products, but Centers cannot become agents for vendors’ interests or lock providers into a single technology solution.

Centers will not be the only source of support and guidance for providers. Some with ample resources will rely primarily on guidance from consultants, funded through operational budgets. Other practices, and especially priority providers⁶, may lack needed staffing and experience for effective implementation or the financial resources to hire consultants and will be much more reliant on Centers. It will make sense for Centers to concentrate on providing hands-on support to these priority providers—including those in rural areas, small practices and federally qualified health centers. A clear focus and specific priorities will be necessary to be effective.

At the same time, a more general dissemination and education role is needed, and this should be the responsibility of the Health Information Technology Research Center. The national center should develop broadly applicable materials and resources that take advantage of new media and dissemination tactics to educate and help providers succeed in improving health and outcomes for patients. These materials and strategies can be developed by distilling the lessons learned of the Centers in an ongoing and active manner by requiring Centers to report on a regular basis against a set of metrics and milestones.

It should also be recognized that adoption will be incremental, and different providers will progress at different rates. Centers should support providers “where they are”, providing meaningful support to both leaders and slower adopters.

A key role for Centers is providing guidance, training, policy advice and technical assistance on privacy and security of health IT systems and information-sharing policies. Providers will need assistance implementing a comprehensive framework of privacy and security protections for electronic health data. This issue must be addressed from the outset, as it is often difficult or impossible to remedy problems or restore public trust after a breach or other problem occurs. For additional discussion of these issues, please see comments submitted to HHS on the draft description by the Center for Democracy and Technology (available at www.cdt.org/healthprivacy).

⁶ Public, not-for-profit or critical access hospitals; federally qualified health centers; providers serving rural and underserved groups; and individual or small group practices.

2. Centers should help providers use health IT to engage consumers and support their active health management.

The Markle Connecting for Health consensus definition of Meaningful Use⁷ clearly makes the case that patients' access to information must be included in the definition of meaningful and effective use of health IT. If we are to achieve the goals of improved outcomes and more efficient care delivery, the use of health IT must include a role for the patient. The ARRA legislation states that providers must provide patients access to an electronic copy of their record if such record exists in electronic format – yet many providers may struggle with a means to do this that supports provider workflow and true patient engagement. Centers could play a valuable role in helping providers meet these requirements by sharing information directly with patients and populating consumer-controlled PHRs or other tools patients choose and using health IT to engage consumers and support their active health management (including through electronic communication tools, remote monitoring, eVisits, and mechanisms for shared decision-making). Like other aspects of meaningful use, the elements of patient engagement may build to more robust requirements over time.⁸

3. Broaden the definition of health information technology to include health IT services and tools that support providers in achieving meaningful use.

The program technology definition should be forward-looking, enabling innovation and alternative pathways for achieving meaningful use of health IT. This means the health IT that a provider uses need not be exclusively bound to the full array of features and functions that currently define EHRs. This approach will leave room for rapid evolution of health IT solutions that increasingly achieve the meaningful use objectives over time. Centers will have a critical role in helping providers take advantage of innovative new solutions offered by the market created as a result of these public investments to help providers achieve meaningful use.

4. Tie funding to program goals, not minimum and maximum amounts per geographic area.

The funding levels (\$1 to \$2 million per center) and cap (\$10 million) are reportedly lower than the levels spent by current successful programs.⁹

⁷ Markle Connecting for Health. 2009. Achieving the Health IT Objectives of the American Recovery and Reinvestment Act: A Framework for "Meaningful Use" and "Certified or Qualified" EHR. http://www.markle.org/downloadable_assets/20090430_meaningful_use.pdf.

⁸ That is, providers may first focus on giving patients electronic access to information, then on improved electronic communication approaches, and next on supporting out-of-office care delivery models.

⁹ MAeHC estimates costs of approximately \$10K per physician. Assuming a similar scope of activities, per-provider costs would likely be higher for Centers serving priority provider groups.

It is also important not to place artificial geographic constraints on Centers. The requirements should leave open the possibility for additional models that can achieve the outcome-oriented objectives, including the possibility that a single entity might adeptly serve more than one geographic area.

Funding should be tied to anticipated and actual provider participation levels, amount of hands-on support needed and achievement of program goals. There are several possible approaches for incentive-based grant funding, but one would be to link initial funding to the number of providers supported by a Center, and ongoing funding to achievement of meaningful use by participating providers.

5. Use flexible and outcome-oriented criteria to select organizations most likely to have a long-term impact

Eligible Centers should be identified and selected based on their impact on priority providers, potential for sustainability and their expertise, leadership, and capacity to perform the scope of defined activities. The eligibility criteria should anticipate a variety of entities and approaches for meeting the needs of different groups of providers, communities and settings, without artificial geographic constraints. Some Centers might have a geographic basis; others may be based on some other affinity, such as an association of a priority provider group that is already working with members on health IT adoption and quality improvement. This means re-assessing the “one center per area” and “serving a defined geographic area” specification to leave room for other models to emerge that will achieve the program’s goals. All Centers will need to be able to engage and reach out to providers and effectively provide the defined scope of services including on-site implementation and care redesign support. Tying ongoing funding to proven success, while remaining open to different organizational models, will allow experimentation and innovation to identify what works.

Please let us know if you have any questions or need further information.

Sincerely,

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Childbirth Connection
Microsoft Health Solutions Group
National Partnership for Women & Families
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