Realizing the Benefits of Health IT for Community Health Centers: What is Needed and How Does it Get Done
November 8, 2005
Washington, D.C.

Meeting Summary

Background

This meeting resulted from a collaborative effort on the part of the Center for Primary Care, Prevention and Clinical Partnerships at AHRQ, Community Catalyst, the Massachusetts League for Community Health Centers, the Harvard Interfaculty Program and the Community Clinics Initiative - a partnership between the Tides Family of Organizations and The California Endowment. These organizations were brought together by a shared interest in ensuring that safety net providers, specifically community health centers, have a role in the development of policies and strategies to create and implement a national health information infrastructure. There were two principal goals for the meeting. The first was to explore the requirements for and challenges of widespread adoption of HIT in the community clinic setting, specifically where do community clinics need to be with regard to HIT adoption in order to achieve goals in efficiency, quality and population health. The second was to examine the possible policy pathways for making sure that these requirements are addressed and that community health centers and other safety net organizations are included as national policies for HIT are developed and funding is identified. For example, opportunities to promote HIT adoption as part of initiatives undertaken by the Office of the National Coordinator for Health Information Technology (ONCHIT), as well as opportunities to align new initiatives in the health centers arena and Medicaid reform in support of HIT adoption and implementation. A list of participants by organization is attached to this summary. Support for this meeting was provided by The California Endowment, the Community Clinics Initiative and the Blue Cross Blue Shield Foundation of Massachusetts.

Introduction

David Brailer from the Office of the National Coordinator for Health Information Technology (ONCHIT) provided a brief overview of the continuum of HIT use in CHCs. He observed that, because of great leadership in some organizations, there are exciting examples of CHCs leveraging technologies to provide higher quality care to broader swatches of their communities. On the other hand, he cautioned about the “adoption gap”,...
noting that this rift in the CHC community encompassed more than technology — the have-nots also generally present a lack of financial resources and the talent, skill, and know-how to move complex projects forward. He cautioned that meeting national goals will require devising strategies to close the adoption gap. Finally, he mentioned progress that has been made in developing resources for all CHCs, including the creation of an HIT coordinator position at the Health Resources and Services Administration (HRSA) and movement on creating a standard for ambulatory health records, but cautioned that more work needed to be done to understand specific problems confronting CHCs and HIT adoption, including challenges for rural or urban providers, and differing needs for clinics and provider offices.

Laura Hogan of the California Endowment briefly encouraged CHCs, funders, and researchers to think of HIT as one point-of-entry that can lead to a flourishing of innovation, including changing the role of the medical director, changing processes of care for the community, and providing evidence of the high quality delivery of care by CHCs that had only been assumed before. Ellen Friedman of the Tides Foundation presented the charge to the group, encouraging it to think concretely about how to maximize the intersection of advocacy and information technology and how to get the incentives right to encourage CHCs to invest in information technologies, while bearing in mind the ways that CHCs are and are not exceptional users of HIT.

Panel 1: Community Health Centers: Unique Mission, Unique Needs – Requirements and Challenges in Adopting HIT

This panel consisted of three CHC directors representing a range of communities and experiences with HIT, as well as three researchers and evaluators of large-scale HIT projects in CHCs. Several themes emerged through the course of the panel:

- **One-size fits-all solution not tenable.** Because CHCs are quite heterogeneous, a one-size-fits-all strategy for implementing HIT will not be effective. This heterogeneity applies to many dimensions, from simply plugging in devices to making HIT an institutional priority to setting long-term planning goals based on HIT capabilities to funders creating appropriate funding mechanisms.
  
  - Robert Hoch of Harbor Health Services discussed the challenges in envisioning and paying for a system that would allow data sharing with the rest of the world.
  - Speranza Avram of the Northern Sierra Rural Health Network underscored the difficulties of finding technical support and technical devices in a very rural region.
• There was lengthy discussion about the benefits and challenges of having funders require CHCs to form networks in order to qualify. One the one hand, there are advantages in banding together, including cost efficiencies, greater institutional capital, and an expanded knowledge-base; on the other hand, forcing collaboration based on location or other, non-business imperative, rationale would result in many dysfunctional and failed pairings. There was concern that CHCs could be left out of these networks.
  ▪ Funding could be set aside to help CHCs think through the mechanisms of partnership.

**Substantial costs associated with implementation.** There are a variety of different types of costs associated with implementing HIT.

- The initial “bump”, or the outlay for the system;
- On-going maintenance costs;
- Costs associated with innovating or pushing the system to its fullest potential;
- And costs associated with generating the population health capabilities of the system (including taking care of the uninsured).

  ▪ Several of the panelists encouraged creative thinking among public and private funders about how to align incentives to encourage CHCs to take on the risks of implementing an HIT system.
  ▪ Kendall Guthrie of Blueprint Research & Design, Inc. noted that requiring CHCs to join consortia in order to receive funding would result in many failures; she emphasized that strong business imperatives should be the root of partnerships because large-scale projects like implementing HIT strategies involve greater risk and require higher levels of trust than other types of projects.
  ▪ Ralph Silber of the Alameda Health Consortium discussed the importance of have a non-discretionary allocation of resources to improving the quality of data, and presented data on the reduction of disparities.
  ▪ Robert Miller of the University of California, San Francisco, noted that work was needed to figure out creative ways to redirect some of the downstream benefits of having HIT back to the CHCs.

**Innovation associated with HIT.**
• Dr. Hoch provided an example of how his group can now truly put the community back in the equation by allowing CHCs to implement population health programs and to push research agendas that meet their needs.

• Mr. Silber found that by offering his staff modules that they identified as valuable, namely connectivity with the county hospital, he achieved greater excitement about and investment in the project.

• **HIT implementation as organizational change.** Designing an HIT system requires large institutional changes, and involves leveraging available sources of support for project management, training, and other core competencies. CHCs may choose to begin their implementation at different points, depending on the specific context, so some start with administrative functions, while others begin with clinical functions.

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**Panel 2: Policy Solutions: The Role of Federal and State Governments in Achieving IT Adoption in Community Health Centers**

This session began with presentations from several representatives of federal agencies that oversee HIT implementation programs. Some important issues that were raised in the presentation portion of the discussion include:

- Concerns of safety net providers need to be represented in HIT discussion about standards, certification, and privacy and security;
- By leveraging HIT, broader collaborations with governmental departments and other partners will be possible around common research interests;
- Various federal agencies can serve as hubs for information sharing about diverse HIT concerns, including disseminating decision models, acting as a clearinghouse for what works, and providing information about opportunities for funding.

Lisa Layman from Senator Stabenow’s office and Heather Mizeur from Senator Kerry’s office noted that their offices supported robust sources of federal investment in improving HIT for safety net providers, and a realignment of investment priorities to ensure this.

Several important themes emerged from the subsequent discussion.

- **It is important to identify payment strategies – part of this process is to leverage political resources in order to open up opportunities.**
  - Since there are two major payers in the CHC world, the key is to re-think payment policies to include HIT costs.
• Developing political support within the large payers for technology-related investment.
• Creatively identify reimbursement methods.
   Pay-for-performance with appropriate case-mix adjustment would better reward the quality care that CHCs are providing, and could more easily be measured with appropriate HIT systems.
• Movement from process to outcome measures – the first step may have to be a leap of faith, namely, putting in the system without proving anything useful; later outcome measures can be phased in.
• Part of this discussion includes how to frame HIT – for example, better administrative data will allow consumers to make better choices about their healthcare; better data will allow CHCs to make better programmatic decisions about population health.
• Funding for HIT must not be discretionary.
   CHCs need to determine the components of an ideal system, as well as what practically will be available.
  • General feeling of nervousness about having HIT standards set without input from CHCs, especially given that CHCs are among the few possible stakeholders with a population health focus. Appropriate standards for HIT at CHCs might differ from that of other practices due to different population needs.
  • The prototype will probably involve some compromise between what the user wants, what payers will pay for, and what technology companies are able to provide.
   As in any other kind of health care innovation, organizational leadership is essential in creating the vision of why HIT is central to the mission of the organization.
  • Developing a road-map that includes guidelines for what leadership skills are needed and what types of organizational changes can be expected.
  • There are templates that provide some answers, like demonstration projects and the Health Disparities Collaboratives, but the lessons from these sources need wider dissemination.
  • Re-inventing CHCs to confront these organizational challenges.
  • New partnerships with consumer groups and others.
• Shift in focus from a deficit model to one that emphasizes and exhibits the richness of resources that CHCs control.

Wrap-Up Discussion

David Blumenthal from the Harvard Interfaculty Program for Health Systems Improvement challenged the group to identify several short-term and longer-term priorities. There were calls to the representatives of federal agencies to provide leadership in helping CHCs become more innovative by organizing funders, helping CHCs join together to strategize about HIT implementation, and in helping CHCs take advantage of programs like Regional Health Information Organizations (RHIOs). In addition, these departments could help by acting as repositories of information, including organizational tools, standardized consumer reports about vendors and products, establishing a menu of options or common definitions, and coordinating the development of best practices. There were different thoughts about what the priorities at the CHC level should be that might guide this work. For example, some argued that priority should be given to processes at the work level of the clinic, like clinical decision support systems or integrated clinical and billing systems; others pushed for a patient-centered information model, such as an electronic health record that would belong to the patient. There was discussion about how to leverage the unique relationships between CHCs and the communities they serve, including using their “patient power” to help them identify and secure needed resources. Farzad Mostashari from the New York City Department of Health and Mental Hygiene encouraged CHCs to utilize the natural partnerships between state and local public health departments in terms of gathering data, surveillance, and disease management. Finally, there was a general discussion about how to make the specific IT components less expensive, including using disruptive technologies and utilizing collective activities like repurchasing to bring down costs.

Expected Outcomes and Next Steps

The November 8th meeting was designed to make progress on the following goals and targeted outcomes:

- Greater cooperation and collaboration across the diverse group of stakeholders, policy makers, federal managers and organizations working to promote the adoption of health IT in community health centers.
- More regular and systematic involvement of this recognized group of experts and stakeholders in national and state policy discussions to promote and facilitate health IT across all providers.
- A set of policy proposals and supporting materials based on strategies and solutions identified as a result of the meeting to be used with key policy makers and agency leaders to pursue the group’s suggestions and recommendations.
- A strategy for disseminating and shepherding policy proposals at the federal level through advocacy groups and key legislative leaders including preparation of issue briefs as needed.
- Greater involvement on the part of community health centers, and their state and national leadership in policy discussions aimed at promoting the adoption of health IT at the state and national level.

The original planning group – Ellen Friedman, Lisa Dolan-Branton, Jeremy Nobel and Karla Pollick - has continued to meet and is currently working on identifying a set of follow up actions based on input and suggestions from the meeting participants, consistent with these desired outcomes. Cheryl Austein-Casnoff, in her new role as Director of the Office of Health Information Technology at the Health Resources and Services Administration, has joined the group to work on framing and implementing possible next steps.
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Meeting Participants

Access Community Health Network
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Alliance of Chicago Community Health Services, LLC
Fred Rachman, M.D., Medical Director and CEO

Blueprint Research & Design, Inc.
Kendall Guthrie, Ph.D., Vice President for Strategy

California HealthCare Foundation
Margaret Laws, M.P.P., Director, Public Financing and Policy

Community Catalyst
Robert Restuccia, M.P.H., Executive Director

Connecting for Health
David Lansky, Ph.D., Chair, Personal Health Working Group

Department of Health and Human Services
Agency for Healthcare Research and Quality
Helen Burstin, M.D., Director of the Center for Primary Care, Prevention and Clinical Partnerships
Lisa Dolan-Branton, R.N., Senior Advisor for Community-Based Health Information Technology
David M. Stevens, M.D., Center for Quality Improvement & Patient Safety

Centers for Medicare and Medicaid Services
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National Association of Community Health Centers
Daniel Hawkins, Vice President for Federal, State and Public Affairs

National Committee for Quality Assurance
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National Health Policy Forum
Eileen Salinsky, Principal Research Associate

National Opinion Research Center
Daniel Gaylin, M.P.A., Senior Vice President and Department Director
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Northern Sierra Rural Health Network
Speranza Avram, M.P.A., Director

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Primary Care Development Corporation of New York
Ronda Kotelchuck, Executive Director

RealBenefits
Enrique Balaguer, Executive Director

The California Endowment
Laura Hogan, Program Director

The Commonwealth Fund
Anne-Marie Audet, M.D., M.Sc., Vice President, Quality Improvement

Tides Foundation and Tides Center/Community Clinics Initiative
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United States Senate
Heather Mizeur, Director of Domestic Policy, Office of Senator John Kerry
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Additional Attendees:
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Joanne Howes, DDB Issues and Advocacy
Karla Pollick, Harvard Interfaculty Program for Health Systems Improvement
John Ruiz, National Association of Community Health Centers
Emily Shortridge, Health Policy Ph.D. Program, Harvard University
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