

Implementation Workgroup Testimony

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**Respectfully Submitted: Lisa Levine, MPH, Vice President for Operations
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I would like to thank you for the opportunity to address the questions posed by the Panel on implementation support and the Regional Extension Centers. I am here today representing the experience of The Family Health Center, of Worcester, Inc., a Federally Qualified Health Center located in Worcester, Massachusetts.

Family Health was founded in 1970 and currently serves 33,000 patients a year, providing comprehensive primary care, dental, behavioral health, nutrition, lab, pharmacy and radiology services. We are a family practice model of care which means that we see all of our patients in the context of their family and community. We care for patients of every age, including pregnant women, infants, toddlers, children, youth, teens, college students, adults, and seniors. Our patients are multicultural and multilingual. We currently provide care in over 30 languages. Of our patient population, 50% receive Medicaid, 10% receive Medicare, 24% are uninsured and 16% have insurance, either private or through the Massachusetts Connector. We employ 34 providers that meet the definition for an eligible professional (EP) under the Meaningful Use criteria. Each of these providers is already enrolled in the Massachusetts Regional Extension Center (MeHI).

There is much to commend in the HITECH Act; it is hard to argue with policy goals that focus on improving quality, safety, efficiency and coordination of care for patients and populations. But, as with all major change, the translation of policy to practice must be managed by those who are mandated to implement that change.

In many respects, we are fortunate to reside in a state that recognizes the importance of health information technology, demonstrated by the passage of Chapter 305 in 2008 which promotes cost containment, transparency and efficiency in the delivery of care and includes a goal to implement electronic health records in all provider settings by 2014. It is fitting that the Primary Care Association in Massachusetts, the Massachusetts League of Community Health Centers, had the vision to recognize the

enormity of the changes to come and supported its members in the adoption of electronic health records, providing technical and infrastructure support and participating at the State level in the development of policy and programs. Yet, despite all this, the adoption of an EHR and meaningful use is one of the most daunting challenges facing our health center, and I would suggest, other centers throughout the country.

Because Massachusetts was an early adopter of the utility of electronic records, there was a good deal of information and product available to providers, hospitals and health centers. That utilization, although seemingly complex then, is simple compared to the demands and complexity of compliance and reporting required by the HITECH Act. Where the pace of adoption was more deliberate allowing for a methodical and self paced adjustment to the concomitant changes in practice management and delivery, there is now urgency and the challenges it presents can appear overwhelming especially to an organization that operates on the financial margin because it provides care to traditionally underserved, low-income and culturally diverse patients.

1. Identify your challenges, barriers, and successes when providing services (for RECs) or using the implementation support (for REC users) from a Regional Extension Center.

The Regional Extension Center in Massachusetts has made a concerted effort to reach out to community health centers regarding meaningful use, and for good reason. First, Massachusetts community health centers have made significant headway in planning for, obtaining and implementing EHRs. Forty-one of the state's 48 community health centers have completed EHR implementations, four of them in early roll out. Seven centers do not have an EHR and four others need to replace their EHRs to meet current expectations. The centers are more attuned to the regulatory deadlines outlined by the HITECH Act and Chapter 305 and are therefore more inclined to appreciate the role of the REC. Second, as a whole, CHCs employ a large number of eligible providers and enrollment of these providers by health centers would do a good deal to move the REC toward its enrollment goal.

However, the REC model does not fully accommodate the uniqueness of community health centers. It is built for a system of individual and small private practice providers, not for employed providers, i.e. CHC providers or the non-profit organizations that employ them. As an example, the

Massachusetts REC charges a \$600 enrollment fee for primary care providers and \$800 for specialists, which must be paid in order to receive services from one of the REC-approved IOOs (Implementation and Optimization Organizations). My health center employs 36 eligible providers and the cost to enroll was therefore \$21,600. While this may not appear to be that significant, it is an unbudgeted cash expense. Certainly this enrollment was a necessary step in order to receive assistance in achieving meaningful use, but I would have hoped that the REC would have found an enrollment strategy that more fairly reflected the unique role of health centers in providing the bulk of primary care for the Massachusetts Medicaid population. Because each REC is allowed to determine its enrollment structure, there is inconsistency across states in the fees that are charged.

There is also inconsistency in the criteria used to certify IOOs and EHRs, which is also troubling. The HITECH Act has spawned the growth of software companies, consulting groups and numerous entrepreneurial ventures that want to take advantage of the opportunities presented by the thousands of providers and health care organizations scrambling to meet the standards required by the HITEC Act. By dint of their responsibility to vet each of these EHRs and IOOs, the REC, in effect, serves as somewhat of a consumer protection agency. However, if the standards are not consistently rigorous, health centers could end up investing scarce resources in poorly performing goods and services. Clearly this inconsistency would also be difficult for vendors trying for certification in multiple states.

The fact that each REC has different standards will also impact on the quality and quantity of the services provided by IOOs. While I am pleased that the Massachusetts League of Community Health Centers, our state HRSA recognized primary care association, is a certified IOO and will perform REC implementation and adoption services for Family Health, it is also helpful to know that the REC serves as an arbiter in the relationship between the center and its Primary Care Association as an IOO.

Because of the emphasis on individual providers, the REC model risks not recognizing or fully engaging the CHC or provider group in the implementation strategy. While our REC and IOO recognize the importance of engaging CHC leadership and organizational strategy the payment models and enrollment process tends to diminish the importance of the organization.

2. Outline the implementation support and methodologies you used that worked and didn't work. Include any real-world user stories, illustrations, or examples.

Family Health Center is now looking to its IOO and REC to help us move toward meaningful use. But moving toward meaningful use is much more than simply implementing an electronic health record. It requires a major transformation in the delivery and practice of clinical services in order to achieve the underlying vision of both the HITECH Act and Chapter 305 of measurable improvements in quality, efficiency, safety and cost of care.

At the point of care, we are racing to meet that vision but feel as though we are turning the Titanic. All of the systems within the Center are changed by this level of use of health technology. Appointments, billing, follow-up, prescribing, the patient visit itself, all require new structures. Practice flow, documentation, protocols and priorities change to accommodate the electronic template.

At the individual level, it also initially changes the style of patient/provider interaction, as providers figure out how to type on a computer and still make the patient feel that they have the provider's attention. It's important to note that a large percentage of our providers were trained before electronic records. Their style of communication developed utilizing a paper chart which more easily supported face to face communication. For many of our providers, the EHR is an obstacle to that communication, especially for those that can't type. So teaching a provider to use the EHR is not just a matter of instructing them on the mechanics of the system. It is also helping them adjust to an entirely new approach to the patient visit and to the time it takes to document that visit.

This accommodation takes time and takes a toll on productivity and therefore revenue. At Family Health our provider productivity decreased by 75% during the first week of implementation and then we were able to build back up the number of visits per provider in each subsequent week of implementation. The loss in patient access and in revenue during this initial period is significant.

However, what is more concerning is the infrastructure that must be developed within the health center to support health information technology and meaningful use. The implementation of an EHR is just a small step forward. Certainly through our IOO we will have consultant support to advise and support us through the transitions to come. We can turn to the REC and the IOO to help us develop

interoperability with other health care institutions in our area. As a participant in the MA League's Community Health Information Association we are part of a central data repository that will help us to enhance our reporting capacity, clinical benchmarking and the quality and effectiveness of patient care management as a Patient-Centered Medical Home. But to sustain what we must build, we have to have our own staff and infrastructure to support it. Frankly, at the organization level, it would have been better if the funds passing from the REC to the IOO could have gone directly to the organization that, in turn, could use those funds to build a sustainable infrastructure. Our center's lack of staff and infrastructure presents its own concerns. Health Centers have had a great deal of experience trying to compete for a workforce that was not large enough to meet a national demand. Since their inception, health centers have struggled through recurring shortages of primary care physicians, competing with institutions and practices that could offer significantly more money. To even that playing field, health centers have benefited from Federal and State Loan repayment programs and the National Health Service Corps. Now we must build our own internal resource professionals who can sustain and support the health IT environment. However, there is a national shortage of this workforce and once again, health centers are at a recruiting disadvantage. The REC and the IOO are not designed for workforce development but they could be instrumental in assisting in the design and implementation of workforce initiatives.

3. Discuss your outcomes/results. Include any surprises or unexpected outcomes and how you addressed them?

We took a phased approach to implementation and staggered the EHR implementation from team to team. This approach was thought to be less disruptive although I believe that there is no approach that will mitigate the turmoil inherent in this type of major change. Although we knew that the phased approach would lengthen the overall implementation period, we did not anticipate the loss of key leadership – the Vice Presidents of Medical Services and the Vice President of Operations. This extended the period of time it took the Health Center to implement its EHR. It also may have helped us had we included in our plan a fulltime on-site dedicated project manager and a faster implementation strategy. In balance, we were able to move at a pace that we could manage and lead.

We were fortunate to have grant funding from the Neighborhood Health Plan, a CHC-based MCO. The Massachusetts League of Community Health Centers distributed that funding and also provided the Health Center with implementation and project management support which kept the rollout moving despite obstacles. The support was invaluable to moving Family Health from paper to electronic systems that are now Center-wide. All of our providers are e-prescribing and we expect to go live with our lab interface on January 24, 2011. We initially implemented the practice management side (PM) of the EHR. This is a critical element in an integrated EHR and to support effective reporting. Now that both applications are being used we are in the process of constructing our reporting needs and disease registries.

It is important to note how critical it is for CHCs to implement their PM properly. This is a complicated phase of the implementation because of the mix of services and payers at CHCs. The time and the resources needed for this are not fully recognized in the REC plans, timeline and strategy.

The REC will provide additional funding to the League as the Family Health Center's IOO, which will allow it to continue from implementation and to Meaningful Use. The need to continue to have support after our providers go live is critical to success and proper use of the EHR. The services will not only help in achieving MU but help the Health Center gain PCMH accreditation.

Because there are other CHC's that have implanted NextGen's EHR it would appear there would be an opportunity for great collaboration. The Mass League has tried to provide that type of forum, but again, given limited time and resources to devote to this type of activity, it is hard to take advantage of that knowledge. Perhaps there is some opportunity for RECs to play this type of role for CHCs. We anticipate and are hopeful that the Mass League's role as an IOO will evolve into establishing an infrastructure for continued support of CHCs as an "information association" strengthening use of EHRs and addressing areas such as HIE.

4. Describe your experience using the ONC and CMS communications regarding the meaningful use criteria, standards specifications and measurement.

The Regional Extension Center in Massachusetts has done an admirable job in disseminating information about HIT, meaningful use and its own services. Informational sessions have been held throughout the state to many different stakeholder groups. The Mass League has also played a critical role in distributing information electronically and providing training and leadership sessions. Prior to the meetings held throughout the state by the REC, and those of the MA League, Family Health had limited knowledge of the HITECH act or the Meaningful Use incentive program. Further, the sense of information overload is overwhelming. Between keeping the health center operational, and responding to a number of the other HITECH grants available to CHC's, there was little time or resources to devote to other aspects of the Federal legislation. Without these resources keeping us updated and translating often confusing regulations, we would be at risk of missing critical steps.

It is easy to visualize the benefits and outcomes inherent in meeting all the stages in meaningful use. As we move forward I would hope that the ONC will continue to understand the significant need for resources and support required at the point of care in order to make this vision a reality.