DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Strategy To Support Health Information Technology Among HRSA's Safety Net Providers

AGENCY: Health Resources and Services Administration (HRSA), HHS.

ACTION: Response to **Federal Register** notice (71 FR 54829) published on September 19, 2006, regarding strategies to support health information technology (HIT) among Health Resources and Services Administration's (HRSA) safety net providers—Solicitation of Comments.

SUMMARY: The following represents a series of respondents' comments and the Health Resources and Services Administration's (HRSA) responses to the comments regarding the **Federal Register** notice (FRN): September 19, 2006 (71 FR 54829). The FRN proposed strategies to support health information technology (HIT) among safety net providers, and requested comments on HIT topic areas addressing quality improvement, collaboration, general network-related issues, specific health center controlled network (HCCN) related issues, sustainability and building HIT capacity. HRSA received a total of 53 comments from a broad range of stakeholders, including State health departments, non-profit organizations, individual healthcare providers and the health information technology industry. HRSA's responses reflect activities within the Office of Health Information Technology (OHIT) that include, but are not limited to, the development of an HRSA HIT strategic plan, technical assistance resources including the establishment of the HRSA HIT virtual community, the development of HIT online toolboxes tailored to the needs of various HRSA programs, a TA resource center, and the development of funding opportunities. The comments have helped, in part, to shape the direction and activities of OHIT.

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SUPPLEMENTARY INFORMATION: In accordance with Public Health Service Act, Title III, section 330(e) (1) (C), and 330(c)(1)(B) and 330(c)(1)(C).

I. General Comments

The general comments focused on the areas of HIT resources and funding eligibility, sustainability and stability, standardization, population health, and technical assistance.

Comment(s): On the issue of HIT resources, comments indicated a need for competent staff at safety net provider organizations that have a solid knowledge of HIT infrastructure, readiness assessment and maintenance. Several comments also noted that successful applicants need to demonstrate that they will be able to foster partnerships to fully implement electronic health records (EHR) across a network. In addition, comments indicated that other entities, in addition to 330 grantees, should be eligible to apply for the Health Center Controlled Network (HCCN) grants, including Federally Qualified Health Centers (FQHC) Look-Alikes and non-330 funded clinics.

Response: HRSA included the importance of competent staff as well as the strength of the partnerships into its HIT application guidances. In terms of funding eligibility, since the authority for the funding is in accordance with section 330(e)(1)(C) of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended and/or with section 330(c)(1)(C) and 330(c)(1)(B), 42 U.S.C. 254b (as amended), 330 grantees must be the lead organization and maintain 51% control of the network. However, other entities are encouraged to join in any networks that are created.

Comment(s): Several comments noted that health centers cannot replace decreased funding to Networks which have historically supported clinical initiatives, quality initiatives and market based efforts. Comments expressed concerns that there is currently no incentive or directive for FQHCs to ''transfer'' funding from 330 grants to a Network to underwrite services. Comments noted that fiscal improvements and cost efficiencies obtained through collaborative work are plowed back into the HCCN member health centers' bottom lines and not as readily into the HCCN infrastructure, notably because the mission of health centers does not include building for-profit or other non-profit organizations. Comments noted that HCCNs need to develop business plans to prove their value to community stakeholders (including local businesses) in order to structure their requests to large corporations and foundations. As a corollary to the business plan, a comprehensive marketing plan will be needed to attract new members.

Response: HRSA plans to use the HCCN model for HIT adoption because of their business model in terms of cost efficiencies, the ability to attract competent staff, and most of all, their mission and ability to strengthen the health centers' operations in the marketplace. HRSA believes that no one source of funding will be sufficient to pay for EHRs and other HIT initiatives and that sustainability after Federal funding will be expected. The program expectation for HIT funding is for grantees to move to self-sufficiency within the project period. Short-term funding will allow organizations to deal with high initial cost and to implement the HIT while adopting new business models, identifying cost efficiencies and partnerships. This will lead to enhanced care management and health outcomes, while preserving the Network's main health center mission and functions.

Comment(s): Comments noted the need for standardization of performance and health outcome measurements that support interoperability and data sharing. They also noted the need to consider the reliability of such measurements when applied to special populations, and that HRSA should collaborate with health centers to develop such measures. One comment also recommended that HRSA work directly with the Office of the National Coordinator for Health Information Technology (ONC) and its standard-setting activities.

Response: One of HRSA's goals is to assist with the integration of performance outcome and quality improvement measurement with reporting requirements across the agency programs. HRSA is aware of data and statistical challenges of measurement for special populations. In addition, HRSA is working closely with ONC in its efforts to adopt uniform HIT standards. HRSA encourages safety net providers to participate in public comment periods around such standard-setting activities.

Comment(s): Several comments emphasized population management technology as a means to improve health outcomes, and to address special populations in need of quality healthcare and reduce disparities.

Response: HRSA's HIT funding opportunities encourage HIT projects that help grantees and patients manage health care in ways that are quantifiable or produce quantifiable results. In addition, HRSA is working closely with other Federal Agencies to share best practices as they approach HIT from a population health perspective.

Comment(s): The comments also noted a need for technical assistance in

the areas of basic HIT readiness and implementation requirements, HIT strategies on sustainability and stability, support services, HIT integration with other clinical and administrative initiatives, evaluation and performance measurement as well as reporting.

Response: HRSA intends to include these comments for consideration into its HIT strategic planning and HIT technical assistance and related activities. HRSA has conducted several focus groups to date around technical assistance needs. The resulting TA resources, such as online toolboxes, will serve as dynamic resources to meet the changing needs of grantees over time.

II. Quality Improvement

Quality improvement comments focused on quality in general, public health and safety issues that could be addressed with the appropriate use of HIT in the safety net organizations, recommendations to assure improving quality is the ultimate goal of HRSA's HIT strategy, and finally, recommendations on specific performance measures that indicate progress/success of HRSA-funded HIT initiatives.

Comment(s): Several comments asserted that quality and safety could be improved with effective HIT use in the areas of increased patient access, decreased adverse drug events and increased communication among providers which can ultimately lead to a decrease in medical errors. The appropriate use of HIT was indicated to increase the quality and safety of health care by aiding in health prevention, tracking immunization, diagnostic tests and procedures reminders, provider prompts, proper patient identification based on Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, integrated patient registries, continuity and coordination of care and patient treatment compliance. In addition, it was noted that HIT can prevent duplication of laboratory and radiology services, reduce waiting time, improve patient education, track population health trends and accelerate response to a disease outbreak. Several comments affirmed that electronic prescriptions will help with the appropriate identification and referral of drug seeking patients and help track compliance patterns. Comments stressed that clinical decision-trees based on best practices can enhance the quality of health care. Furthermore, HIT can aid in reducing health care disparities by tracking regional, local, State, and national outcome measurements for specific interventions. In turn, this can assist in the establishment of evidenced-based best practices that meet the often complex needs of underserved populations. The comments also noted the advantage of forming various partnerships within the Federal and private sectors in developing standards that will address the timeliness and quality of data captured. As a result, any outcome areas that need improvement will be properly identified and HRSA will be able to mentor grantees in the areas where they need assistance. The addition of data warehouse capability was suggested, combined with highly capable analysis and reporting tools to provide the information needed to assist quality assurance and quality improvement programs on both the network and health center level, as well as providing surveillance and assistance in state and national reporting. It was also suggested that data be made available for epidemiological studies at the network or national level.

Response: HRSA concurs that HIT is a tool that can be used to improve quality and safety; HRSA delineates the significance of aligning quality measures and having grantees report on such measures in the funding opportunities. HRSA has included specific measures in its funding opportunities to address the areas of effectiveness, efficiency and safety to measure the impact of HIT on quality. Moreover, HRSA is working internally across its Bureaus, Programs and Offices, and externally with other Federal agencies, existing grantees, associations, Networks and other partners to develop new reporting requirements for clinical outcomes and other program data. The agency's goal is to simplify and integrate performance measurement information reporting.

Comment(s): One comment stressed that the adoption of electronic health records does not automatically lead to quantum improvements in the quality of health care. In its estimation, quality could be improved if Federally Qualified Health Centers have action plans to achieve stability, an effective management team, and the development of at least one Quality Improvement leader. In one observer's view, it is not the use of EHRs and data management that improves quality and reduces disparities, but instead it is the use of population management software. In its view, EHR systems improve the legibility of documentation and ease of access of data of an individual patient but do not do the same for populations of patients. Population management software systems are much less complex and less expensive than EHRs which allow health center staff more time to manage their patients instead of managing the EHR system. In this observer's view, HRSA should consider promoting adoption of population management systems as a step towards building capacity for quality improvement of population health. In turn, this would help ensure that future EHR vendor selections would look critically at the population management issue, and the workflows developed with EHR implementation would not unintentionally hurt quality.

Response: HRSA views HIT as a tool that can be used to improve the quality of care. While published research recognizes that many quality improvements can come from registries, others may not be achievable with this tool such as medication error prevention and live clinical decision support; for example, EHRs that integrate population management tools represent an ideal future model.

HRSA recognizes that effective implementation of HIT system improvements in care delivery settings requires organizational leadership commitment, clear definition of goals, and effective planning. HRSA grantees occupy a spectrum of organizational readiness to implement EHRs, and HRSA intends to assure its HIT strategy is flexible enough to support the appropriate range of individualized HIT needs and capabilities.

Comment(s): In terms of assuring linking quality of care and improvement of patient outcomes to HRSA HIT strategy, comments included a range of recommendations on the development and implementation of performance measures. Comments focused on HRSA's clinical collaboratives to help link quality of care to improvement of patient outcomes using HIT strategies. One comment stated that rather than opening up opportunities for criticism of performance, the goal of performance measures should be the sharing of the results and demonstration of a system that will result in clinical quality improvement.

Response: HRSA is committed to demonstrating the impact of its programs on the underserved populations served by the agency. As such, HRSA acknowledges the significance of having grantees report on a core set of measures and incorporates this into funding opportunities. HRSA also acknowledges that the measures should be appropriate to the various stages of HIT adoption and integration among our grantees. One of HRSA's goals is to coordinate, simplify, and improve its systems of reporting. This has begun with the Electronic Handbook

(EHB) as well as the alignment of performance measurement across HRSA programs. HRSA's OHIT and Center for Quality (CQ) are working very closely together to align the efforts in HIT adoption and quality improvement.

Comment(s): One comment stated that ensuring access to a comprehensive panel of services is paramount to quality of care outcomes. It was illustrated that providing comprehensive primary care without an integrated service system linking safety-net providers to secondary and tertiary care providers has created an increasing health disparity based on socio-economic status and ethnicity. Networks providing clinical integration for access to specialty and hospital-based services for patients served by member sites helps bridge the quality chasm for the poor and racially at risk. Using HIT to ensure accurate and timely exchange of information between the provider groups is an appropriate step in reducing overall costs of a currently redundant system of care.

Response: HRSA concurs with this comment and has included health information exchange within its funding opportunity announcements to promote innovative practices. HRSA recommends grantees choose HIT systems that are flexible enough to incorporate new and changing measures.

Comment(s): In terms of recommendations on specific performance measures (process and/or outcome) to indicate progress/success of HRSA-funded HIT initiatives, several comments noted that performance measures may be defined based on the HIT project being undertaken. They also suggested that HRSA develop a short list of performance measures to be used by grant applicants. Some suggestions included clinical operational and outcome measures, financial measures, productivity sustained, population health measures, patient satisfaction, and patient safety issues. Measures should complement not only Bureau of Primary Health Care (BPHC) required data, but also Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). In addition, suggestions were made to incorporate measures recommended by the Centers for Medicaid and Medicare Services (CMS) and National Committee for Quality Assurance (NCQA) in the development of HRSA requirements. The comments also affirmed that quality of life measures should be monitored for improvements in known areas of health disparities measured by race, income, citizenship and other barriers to health. Several complex and simple measures were proposed. Complex ones included decreased inpatient admits, total inpatient cost, outpatient visits, total outpatient cost, total emergency department visits, total emergency department cost, and total lab cost. Several simple performance measures were also suggested including reduction in medication errors, increased clinical documentation and accuracy in diagnosis and treatment. As for HIT integration, several measures were proposed in assessing a successful integration including the number of clinics which adopt and operationalize integrated practice management/HIT disease management, the number of clinics which utilize reports from HIT as part of a quality management program and to inform clinical decisionmaking and the increased number of interoperability points. Other suggested HIT integration measures included: Reaching identified participation levels in terms of the number of centers and/or providers utilizing the EHR system; and achieving quality/patient outcome measures (on a network-wide basis), provided that such measures are carefully scaled to avoid penalizing health centers that have already made strides in improving patient outcomes. It was also stated that performance measures should include a cost per encounter to provide categories of service (i.e. HIT, financial management, clinical leadership support, central billing) and that specific clinical measures be identified (i.e. HbA1C). The comments also indicated that performance measures should be as flexible as possible until a coordinated pay for performance strategy is determined at HRSA. One health center suggested reviewing the original process/outcome measures by the HCCN Work Group and to revive the Work Group and task it with developing performance measures.

Response: HRSA is committed to measuring the impact of its programs on the underserved populations served by the agency. Thus, HRSA acknowledges the significance of aligning quality measures with nationally recognized organizations and of having grantees report on such measures in the funding opportunities. HRSA intends to provide flexibility to grantees to achieve these measures and is positioning itself to provide and share information on the quality improvement process. HRSA intends to pilot any standard measures among grantees across HRSA programs with various technology capabilities.

Comment(s): Some comments noted that HRSA should include lessons learned from the Health Communities Access Program (HCAP) grants, formerly supported by HRSA. HCAP provided funding for Management Information Systems (MIS) that interface with other systems to support community based collaborative care. This program asked grant applicants to describe the goals and functionality of the MIS project and how the changes/enhancements would improve the effectiveness, efficiency, and coordination of services for uninsured and underinsured individuals in the communities served, thus providing quality health care at a lower cost.

Response: HRSA used lessons learned from HCAP and other health systems oriented programs, such as the Health Disparities Collaborative, the Telehealth Network Program, and the HCCNs, in developing the new HIT funding opportunities.

III. Collaboration

Comment(s): Comments regarding collaboration focused on the role of Telehealth in the overall HIT strategy, collaboration between State Primary Care Associations (PCA) and HCCNs, recommendations for approaches to include State Medicaid agencies, public health departments, other HRSA grantees, and other providers and stakeholders in HIT adoption as well as approaches to a coordinated approach in a State or community for health information technology/exchange, use and support.

Many comments discussed the central role that Telehealth plays in assuring access to quality health care, especially for rural and transient populations, and its critical role in the overall HIT strategy, specifically to health centers. The ability to successfully integrate Telehealth and HIT at the health center level is necessary. Additionally, there must be capacity to build or change the technology as it continues to develop. With Telehealth enabled by EHRs, specialists can provide services from a remote location to patients in a safety net clinic. While many comments focused on Telehealth's effect on rural access, some comments addressed the benefits in urban settings, illustrating that it is a common myth that persons living in urban communities have access to all the medical services they need. These comments noted that providing access to specialty care consults in urban settings, as well as rural ones, would increase HIT adoption and quality of care to underserved populations.

Response: HRSA concurs that Telehealth plays a key role in the access to quality health care and is a critical component in HRSA's HIT Strategy. The

Office for the Advancement of Telehealth (OAT), within HRSA's Office of Health Information Technology, promotes the effective use of Telehealth as a tool to assure access to quality health care, regardless of location. Although initially focused on rural communities, HRSA has placed greater emphasis on both urban and rural applications of Telehealth technologies. As of December 2006, 16 programs funded under the Telehealth Network Grant Program have included FQHCs. These programs have provided services, such as cardiology, mental health, dermatology, radiology, and pharmacy in over 77 FQHC sites. Over the coming year, HRSA's OHIT will collaborate with BPHC to provide TA to health centers through OHIT's Telehealth Resource Centers and BPHC's State and National Technical Assistance Cooperative Agreements. This collaboration will address challenges and opportunities of health centers in deploying Telehealth services in underserved urban as well as rural communities. In addition OHIT is developing a Telehealth Technical Assistance toolbox that will be made available over the Web to assist health centers in deploying Telehealth services in their communities.

Comment(s): Another comment pointed out that EHRs alone will not create access to specialty and diagnostic services for isolated populations and small, rural health centers; that ongoing investment in Telehealth connectivity infrastructure and other technology is equally critical; and that, ideally, EHR systems supported by HRSA should be able to engage in Telehealth services. Another comment noted Telehealth can be used to support home and community based services through network access and that personal health records can be used to help engage home based patients in their own medical care.

Response: HRSA/OAT recently awarded 3 three-year grants to organizations to support Telehealth based home services. This was the first funding opportunity to support such an endeavor, and HRSA will be working closely with the grantee community to develop best practices in this area. HRSA concurs that the need for specialized support services in health centers represents an excellent opportunity for Telehealth services. Moreover, the emphasis on EHR development in health centers provides an outstanding opportunity for creating synergy between the adoption of interoperable EHRs and the cost-effective deployment of Telehealth services that can build on that HIT infrastructure. Increasingly the Telehealth Networks have emphasized the integration of EHRs into their services. However, one barrier to doing so has been the lack of interoperability among the various health information systems. With the implementation of interoperable EHRs, the application of Telehealth technologies becomes a much more feasible and cost-effective option for health centers.

Comment(s): One comment described Telehealth as one technical capability that is best addressed in a network environment. Trained personnel and technical resources required to provide the service and equipment infrastructure needed to provide Telehealth services would be facilitated in a network environment. Given the technical staff and infrastructure limitations of individual FQHCs, Telehealth may be best deployed in an HCCN environment. Another comment illustrated that if the HCCN has a large number of members, it can create a market that might be attractive to specialists and providers of devices and services to fill identified needs not conveniently or cost-effectively available to remote centers or disproportionate providers with limited budgets. It was suggested that HCCNs can provide information technology (IT) data and consultation conducive to Telehealth and can arrange for and/or provide the appropriate connectivity.

Response: HRSA is pleased that both the HCCN program and the TNG program are in the same office, due to the similarities in the network model, both in terms of advantages (cost efficiencies and expertise) as well as challenges (diverse needs of network members). HRSA's OHIT will continue to foster collaboration among the Telehealth network grantees and HCCN grantees. One example is the consideration of planning grants for HCCNs to adopt Telehealth Technology to bridge the gap of needed services.

Comment(s): Finally, one comment noted HRSA should include Telehealth in the overall HIT strategy and consider working with the appropriate Federal agencies to expand Medicaid and Medicare reimbursement for these services. Medicaid and Medicare currently limit reimbursement for Telehealth services. For example, Medicare requires that a patient be located at a site such as an FQHC clinic or hospital that is in a rural area for provider reimbursement. A comment stated that urban areas experience similar shortages in linking uninsured patients with specialty care, and therefore should also be eligible for reimbursement. In addition, although some Medicaid programs reimburse for Telehealth services in urban areas, there is great variation in which types of Telehealth services are reimbursed. For example, in some States, Medicaid will reimburse for group Telehealth visits for nutrition counseling, but not for Telehealth group therapy or smoking cessation sessions, despite the fact that both types of group visits have proven to be very successful with patients.

Response: OAT has funded 6 technical assistance resource centers to assist HRSA grantees, in addition to other health care organizations in the implementation of cost-effective Telehealth programs to serve rural and medically underserved areas and populations. The five regional Telehealth Resource Centers serve as a focal point for advancing effective use of Telehealth technologies in their respective communities and regions of the Nation, and the national Telehealth Resource Center provides a mechanism for sharing experiences across the Nation in addressing legal and regulatory barriers to the effective implementation of Telehealth technologies. A listing of the resource centers can be found at *http://www.hrsa.gov/healthit.*

Comment(s): In terms of collaboration between State Primary Care Associations (PCA) and HCCNs, most comments noted that collaboration between the two entities is important to ensure that FQHCs have access to all available resources and that those resources are effectively used. Coordination and collaboration between HCCNs and PCAs on HIT should be a requirement for seeking grants, especially with the onset of statewide health information exchanges (HIE). Other comments noted that collaboration between PCAs and HCCNs should be allowed, but not required, as some PCAs view HCCNs as competitive and not collaborative. Comments noted that PCAs can facilitate communication about issues related to HIT, be a resource for technical assistance, and assist with the expansion of the infrastructure to promote HIT throughout the State in health centers. Comments noted that a network model is more appropriate to take on a business venture of actual implementation. It was suggested that PCAs and Networks convene around meeting their common member obligations with HIT systems and work on similar priorities for synergy.

Response: HRSA will continue to encourage collaboration among community partners, including PCAs and HCCNs, to best serve the needs of the health centers. HRSA sees both

PCAs and HCCNs as valuable resources for health centers. HRSA recognizes that there are additional local partnerships which continue to be developed and improved that can serve as effective models in leveraging supportive resources.

Comment(s): There were several recommended approaches to include State Medicaid agencies, public health departments, other HRSA grantees, and other providers and stakeholders in HIT adoption as well as approaches to a coordinated approach in a State or community for health information technology/exchange use and support. The comments noted that applicants should be required to address how other agencies will be included in discussions of HIT adoption for health centers including the requirement to identify existing capacity in stakeholders and what collaboration efforts have been attempted. It was suggested that members of reform committees, executives of the State Medicaid and Medicare programs, members of the local hospital Networks, and clinicians should coordinate for HIT exchange and support. The comments indicated that HRSA should support links to statewide or regional health information exchange (HIE) initiatives and encourage HCCNs to use this initiative as leverage for support. In addition, a few comments noted that HRSA should take the lead and work closely with relevant agencies to ensure that health centers' needs are addressed and that safety-net organizations are able to overcome the barriers to technology adoption.

If the HIT infrastructure is to be successful within a State, it was emphasized that Medicaid, public health and other HRSA grantees should have linked systems. On an FQHC level, it was cited that HRSA's support could be critical in: (a) Getting HIT acquisition and maintenance costs to be effectively included in determining Medicare/Medicaid FQHC reimbursement levels; and in (b) providing clear direction to state Medicaid agencies to incorporate HIT costs in determining state Prospective Payment System (PPS) rates. The comments indicated that HRSA should work in tandem with entities like the National Association of Community Health Centers, the Center for Medicaid and Medicare Services (CMS), and others to advocate for a pay-for-performance demonstration at health centers with HIT adoption as a component of the part of the demonstration. The use of pay-for-performance incentives from state Medicaid agencies could serve to support clinic quality improvement efforts while offsetting HIT operating costs.

As systems are developed for care coordination, interoperability was strongly illustrated to be the key to an effective and coordinated information exchange. This is especially critical for statewide syndromic surveillance systems and information sharing related to public health alerts and disaster preparedness. Ensuring safety net representation in HIT advisory committees, such as the American Health Information Community (AHIC), was noted as critical to ensure that safety net providers' concerns are addressed in any interoperable health care communications system.

Response: HRSA will continue to work closely with the Office of the National Coordinator (ONC) and with CMS in these areas. It should be noted that AHIC's bioserveillance committee has been renamed the Populations Health Committee, with HRSA's safety net sister agency, the Indian Health Service (IHS), as a Federal representative. In addition, HRSA encourages its safety net providers to participate in public comment periods around such activities.

IV. Specific HCCN-Related Comments

Comment(s): Specific HCCN-related comments included challenges and opportunities in restructuring the HCCN grant program, other approaches to consider in promoting quality of care and improvements in patient outcomes through HIT adoption for minority and underserved populations, key considerations that should be taken into account when designing the new funding opportunities, and if and/or how HRSA should consider retaining the HCCN administrative, financial and clinical core services in the proposed funding opportunities as they relate to promoting HIT adoption.

Overall, financial and organizational concerns were two of the main topics for consideration in restructuring the HCCN grant program. As one comment noted, safety net providers will be challenged to have the necessary hardware equipment, consistent power and connectivity to take advantage of EHRs. Comments described financial concerns such as start up costs to purchase application software, hardware and networking equipment, training and implementation services, and ongoing costs to maintain systems for support and maintenance and operational funds.

Comments also provided mixed viewpoints on how teamwork and collaboration should fit into a restructured HCCN program; however, many acknowledged the need for teamwork and for collaboration in and of itself. One comment explained that the shared collaborative approach provides great opportunities but that it needs significant ongoing support and funding to ensure the mobilization of stakeholders, the development of governance guidelines and the participation in the HCCN. The most significant challenge facing the restructuring of the HCCN grant program is to design a grant that rewards and enhances the teamwork skills that are required of FQHCs while supporting the needs of the HCCN to successfully develop a network environment. Another comment felt that an additional challenge is how to best attract and engage the appropriate additional members to the existing network environment.

Comments indicated that HRSA should collaborate with the Agency for Health Care Research and Quality (AHRQ), the Substance Abuse and Mental Health Agency (SAMHSA), IHS, the Federal Communications Commission, ONC, CMS and State Medicaid agencies to develop incentives for EHR adoption. For example, it was suggested that the CMS Medicaid Transformation grants could have encouraged State Medicaid agencies to work with Networks and with the community health centers that would have helped both the Medicaid and the uninsured populations. In addition, it was suggested that HRSA explore adapting the IHS's EHR.

Response: HRSA has given priority to partnering with other Federal agencies and national organizations including the National Governors Association, The National Conference of State Legislatures, the Association of State and Territorial Health Officers and the National Association of County Health Officials, among others. HRSA has also developed an internal HRSA HIT Policy Council to enhance communication and collaboration across all of its offices and bureaus. HRSA is also working actively with its Federal Government partners including IHS, AHRQ, CDC, ONC, CMS, SAMHSA, and the FCC to encourage support for HRSA's HIT activities.

Comment(s): Many comments also indicated that without Federal funding and support, it is unlikely that the utilization of HIT to transform health care delivery systems will take place. For example, one comment described how the HRSA investment in HCCNs has allowed the recruitment of highly skilled staff that health centers would not have been able to afford on their own. Another indicated that financial support should come from a dedicated

funding stream separate from the financial support health centers receive to provide care to uninsured and underinsured patients. It was also suggested that HRSA should seek special funding from Congress and resources from other agencies to assist centers and Networks in upgrading and adopting the technology needed to communicate with other providers.

The comments also recommended several avenues in HIT support and technical assistance such as centers for excellence and disease management modules in order to support each community health center's technological evolution in a manner that reflects the clinic's comfort, its user sophistication, budgetary restrictions, operational strengths and challenges.

Response: HRSA concurs with the comments that funding for HIT will come from a variety of funding streams. HRSA is committed to building partnerships with other Federal agencies, foundations, and State and Federal organizations to help support the safety net. In addition, HRSA encourages it grantees to reach out to these types of public and private organizations to emphasize the contributions that safety net providers can make to the adoption and effective use of HIT to improve access and quality of care for all populations.

Comment(s): In terms of key considerations that should be taken into account when designing the new HCCN funding opportunities to increase EHR adoption and to improve quality and health outcomes, comments provided a range of considerations. One comment stated that HRSA should structure the program so that it provides a predictable source of funding that can be used to build and maintain network information system infrastructure, technical assistance, appropriate IT systems and quality improvement, and medical informatics staff to implement and manage an EHR program. One comment indicated that funding should go beyond technology to address the process and workflow redesign needed to enhance EHR adoption as well as to address the infrastructure improvement requirements. Comments also noted that funding should be provided for various activities including: needs assessments, training and building a team of experienced personnel, evaluation of various business models, further development of technology enhancements and system interfaces, and the support of quality management including quality assurance and quality improvement. One comment stated that HRSA should address three components in EHR adoption: Outlay expenses for the system, an experienced team to oversee implementation, and ongoing support post implementation. Comments noted that costs were considerable and that start-up and on-going sustainability expenses of new HIT systems must be recognized. Several comments stated that funds should be provided only when collaboration and linkages to the community could be delineated. Overall, many comments expressed agreement with requiring collaboration and linkages to the community as conditions for funding. Some comments also suggested that HRSA should commit to long-term funding of HCCNs that have integrated progressive HIT systems.

Response: HRSA reflected many of these comments as part of its funding opportunities, including the need to recognize the continuum of readiness for HIT adoption. However, HRSA believes funding for HIT adoption and sustainability must come from a variety of funding sources, and that grantees must develop HIT models that are sustainable over time.

Comment(s): In terms of if and/or how HRSA should consider retaining the HCCN administrative, financial and clinical core services in the proposed funding opportunities as they relate to promoting HIT adoption, the majority of the comments responding to this question indicated that the administrative, financial, and clinical core services of the HCCNs are necessary. Retaining established core HCCN services was indicated to be critical because these provide the basis for participation in HIE and will play an important part in a RHIO or in a broader safety net specific HIE network. It was recommended that HRSA support these core functions within an HCCN network when the function is clearly integrated into the overall HIT and quality improvement goals of the network. In addition, it was emphasized that HCCNs provide cost effective administrative, financial and clinical core services that are thoroughly intertwined with HIT services. The combined integrated services allow more effective adoption of HIT and increased sustainability for existing centers, new starts and new access points while enhancing their ability to reach underserved communities.

Response: HRSA has reflected many of these comments as part of its funding opportunities.

V. General Network-Related Comments

General network-related comments focused on the benefits of funding Networks to provide HIT support to health centers and other safety net providers, types of incentives, if any, to encourage health centers, and other HRSA grantees to join Networks, and the capacity needed for a Network to promote HIT among a group of health centers and other HRSA grantees, such as number of health centers and/or number of patients.

Comments provided specific descriptions of the benefits of HIT in Networks and also recommendations of incentives to expand Networks. Description of benefits included: The ability to recruit and retain quality staff, reductions in operating costs, greater purchasing power, ability to compare data, ability to evaluate patient outcomes, and the creation of data for research and quality improvement. The comments cited additional benefits to funding HIT in Networks such as: economies of scale, interoperability systems, improved data access, increased rate of HIT adoption among safety net providers, minimized waste and duplication of efforts, standardized interfaces and data exchange agreements to ancillary providers, alignment with national directives to build HIT infrastructures and data exchange standards and functionalities, public health surveillance, improved medication management, ability to eliminate fragmentation, redundancy, and incomplete information for existing personal records, clinical decision tree capability and collaborations allowing for a greater level of shared resources and expertise among the network based HIT entities.

Specific recommendations for creating incentives to expand the Networks included increasing the grant award amount available to Networks with numerous health centers, and building financial incentives to compensate Networks for increasing the number of participating health centers. Comments indicated HRSA should offer financial incentives to centers to encourage their membership in the Networks for integrated functions. One comment explained that HRSA could provide concrete incentives such as preference points on grant applications for FQHCs that participate in an HCCN network and another stated that HRSA should fund assistance for HCCNs and health centers to participate in RHIOs and state HIEs. One comment indicated that applicants choosing to remain outside of a Network model for its HIT project should have to demonstrate the economic, competitive, and functional advantage of their decision.

Response: HRSA has supported expert panels and studies around the use of HIT to improve the quality, safety,

efficiency and effectiveness of health care in the health centers as well as models for successful systems implementation. One notable study was funded by the U.S. Department of Health and Human Service's Office of the Assistant Secretary on Planning and Evaluation entitled, ''Community Health Center Information Systems Assessment: Issues and Opportunities.'' Key among the themes from the expert panels and studies is that the HCCN model is an efficient and effective way to promote HIT among health centers. HRSA will continue to stress the importance of health centers coming together as a network to implement HIT in order to maximize scarce resources and minimize risk, waste and duplication of effort, as comments noted.

Comment(s): In terms of capacity needed for a Network to promote HIT among a group of health centers and other HRSA grantees, such as number of health centers and/or number of patients, comments varied greatly from supporting a large to a small network. Additional comments were provided related to capacity but not directly to size and often these comments provided specific details to delineate the level of complexity involved in addressing this topic. Several comments indicated that size should not matter. One comment explained small numbers can have greater impact than large numbers because the focus can be more targeted. Another comment stated that the capacity of a network should be limited only by the ability to adequately address the potential of stakeholders' shared requirements and that it is important for the network to be inclusive, whereas other comments proposed specific metrics for the capacity size. A comment stated that size does matter and indicated that a larger network is better. This comment explained that with initial IT investments being as large as they are, scaling the implementation is critical. The comment further explains that when too many organizations are involved, the necessity to define a single approach can be crippling. Implementation of HIT in existing, large health centers should be a priority in order to gain the highest impact with the lowest complications. Another comment indicated a preference for a larger size because it is critical to have a network that connects all primary care providers, specialists, as well as facilities in order to assure timely transmission of information and data to any provider involved in a patient's care. Another comment noted that regional Networks that include participation by local hospitals, county services, laboratories, and pharmacies would be beneficial to clinics regardless of the number of patients served. The comment further explains that Networks that are solely clinic based could potentially support data collection and regional trending, but may not optimize the interoperability necessary to support delivery of a comprehensive continuum of care. Another comment also expressed support for a larger size indicating that HIT focused Networks should be required to demonstrate a solid integrated network with an ability to reach significant geographic regions, a sound business plan and governance, and economies of scale to enable future sustainability on an established timetable. Finally, one comment suggested the combination of smaller, more business like boards, combined with a large membership that has operational and programmatic advantages in order to deliver sophisticated HIT capabilities and services quickly.

Response: While HRSA will continue to foster HCCNs that consist of at least three organizations in order to promote both horizontal and vertical integration, HRSA also recognizes the contributions of large multi-site health centers and if funding permits, will take this additional approach into consideration. Geographic consideration will be taken into account in the funding opportunities to assure a mix of both urban and rural Networks. HRSA will require applicants to specify a number of metrics (such as number of patients, centers, sites, encounters, and software licenses) so HRSA can continue to better assess the relationship between capacity and resources.

VI. Sustainability

Sustainability comments focused on expectations for Networks around sustainability, including long-term sources of funding. The key themes in the response to this topic include HCCN's assuring their own sustainability, HRSA investing long term in HIT infrastructure, and HRSA working with payers, who benefit from the cost saving of HIT implementation and improved quality of care.

Some comments stressed that application guidance should include a section requiring the applicant to address how they intend to develop a feasible and reasonable plan for sustainability. Comments noted that project-only funding for infrastructure development is a failed strategy because infrastructure itself (buildings, furniture, utilities) does not create benefit; people create benefit. Project-only funding for a well defined project with defined start and end times can be a successful strategy. Not every project requires ongoing support after completion. HCCNs should be expected to provide a sound business and governance plan that demonstrates the ability to take advantage of economies of scale. This is a key factor in assuring sustainability. Business plans should include agreements up front for reinvestment of some of the savings from economies of scale in maintenance of the network infrastructure needed to stay in business. It is critical that HCCNs develop business plans to prove their value to community stakeholders (including local businesses) in order to structure their requests to large corporations and to foundations. As a corollary to the business plan, a comprehensive marketing plan will be needed to attract new members. HRSA should also promote and assist HCCNs in obtaining and or facilitating HIT dedicated funds from other federal agencies and private sector partners.

Response: HRSA has included many of these comments as part of its funding opportunities.

Comment(s): Other comments noted that HRSA should not assume that a model of financial sustainability will appear in the future. Sustainability may be possible in only a few cases without ongoing external support. OHIT should encourage HRSA to sustain a long-term commitment to the development and sustainability of funding HIT solutions. The HCCN movement over the past decade has repeatedly demonstrated that fiscal improvements and cost efficiencies obtained through collaborative work are reinvested back into the HCCN member health centers' bottom lines and not as readily into the HCCN infrastructure. This occurs, in part because the mission of health centers does not include building for-profit or other non-profit organizations. A fundamental shift is necessary at both the Federal level and HCCN level that supports some continued ongoing funding for those HCCNs that demonstrate continued efficient use of Federal funds. Comments noted that Networks are an important infrastructure of the 330 grantees and the long-term survival of these Networks should mimic those of the 330 grantees. The Networks must demonstrate cost savings in their support efforts, but the funding challenges faced by such Networks are the same as that found by the 330 grantees. Any other approach to funding the Networks places the burden of network sustainability on the 330 grantees that use the service. The realities about what it costs to provide

an agreed upon cadre of core required services needs to be agreed upon. Then long term planning with realistic funding sources (including HRSA) needs to be done in relation to cost realities. With the implementation of HIT, costs expand and CHC's are expected to absorb these increased costs while the benefits accrue to the data recipients (i.e. payers). By supporting network infrastructure, HRSA will help ensure that the CHC's HIT systems are affordable and available.

Response: HRSA believes funding for HIT adoption and sustainability must come from a variety of funding sources.

Comment(s): Since EHR systems have proven to be effective tools for reducing medical costs through improved quality, HHS should consider ways to get payers, such as Medicaid, Medicare, and Blue Cross, to include an additional incentive component in their reimbursement for health centers and other safety net providers which adopt HIT systems. Such broad-ranging strategies may prove to be critical in determining the overall sustainability of the President's HIT initiative.

Response: HRSA is working closely with other Federal agencies, and with public and private sector organizations to promote the goals of HIT adoption among safety net providers. In addition, HRSA provides information on funding opportunities to current grantees and other interested applicants as they become available. HRSA has also created a special portal for health centers as part of the AHRQ HIT Resource Center to share information on best practices, literature and funding opportunities.

VII. Building HIT Capacity

Comments on this topic focused on types of HIT investments, other than EHRs, that HRSA should consider investing in, to improve quality of care and health outcomes, as well as Model practices in other parts of the safety net or private industry to build key HIT capacities in under-resourced environments.

The comments provided various HIT investments that HRSA should consider to improve the quality of care and health outcomes. Comments focused on HIT areas such as collaboration in advancing HIT adoption, health information exchange, quality improvement, Telehealth, and technical assistance. Some comments also indicated unique and specific HIT investments that may or may not require an operational EHR system such as practice management systems, clinical and fiscal reporting systems, templates (computer notes), e-mail, instant messaging and chat sessions in clinical settings, e-lab (ordering, tracking and reporting), e-radiology (tracking and reporting), e-pharmacy (formulary/interaction checks), telemedicine/teleradiology/video consultation to extend specialist access in shortage areas, electronic filing cabinets/scanning, clinical guideline software, chronic condition and disease management software, voice dictation, web portals, linkages/interfaces to community providers such as (SNO) and Regional Health Information Organizations (RHIO), e-prescribing, disease registries, clinical data capture technology, personal and community health record. These areas were primarily suggested to be potential HIT funding projects in addition to EHRs.

Health Information Exchange (HIE) systems were mentioned as potential HIT investments for HRSA. Comments indicated that HCCNs should have the capability to operate or interface as a federated HIE infrastructure with government funded program systems such as Medicaid Management Information Systems and SAMHSA reporting systems. It would also provide an excellent opportunity to invest in an approach that leads to improved quality of care and coordination of services. Funding opportunities in alignment with the critical components of the ONC strategic framework such as health information Networks and personal health records were also mentioned. Electronic Data Exchange, data backup for redundancy, as well as preparing for an emergency or disaster were noted as having a key role in the buildup of data warehousing.

Quality improvement initiatives were also a main theme. The comments requested that HRSA consider investing in the development of structured quality improvement programs within Networks where there is a commitment to openly share data among FQHCs within the Network and/or through community coalitions/collaborations.

Telehealth initiatives were also mentioned as potential investments in improving quality of care and health outcomes, particularly in frontier communities where access is an issue. It was also suggested as one of the key tools in ensuring cultural competency.

Investment in technical assistance and support is also one of the main themes of the comments. The comments requested technical assistance in the areas of planning and evaluation projects to assess utilization models, governance issues, development of infrastructures to support shared services collaborations, assistance to PCAs to conduct HIT strategic planning with members' organizations, HIT infrastructure development, funding, training and basic HIT start-up. These elements were generally indicated to be critical in establishing and maintaining a successful HIT initiative.

Response: Many of the themes mentioned such as Telehealth, quality improvement, technical assistance and collaboration will form the basis of HRSA's HIT strategy. In addition, HRSA recognizes the continuum of HIT that can be used in efforts to improve health outcomes; therefore, HRSA has included many of the ideas mentioned in its HIT Innovation funding opportunity.

Comment(s): In terms of model practices in other parts of the safety net or private industry to build key HIT capacities in under-resourced environments, several comments noted that the existing Operational HCCN grantees are the models that can be used to build key HIT capacities in under-resourced environments due to their aggregate knowledge and experience. The IT support provided by a Network to several sites results in economies of scale and can promulgate best practices in HIT implementation and support. Existing models to promote HIT often require providers to produce matching funds in order to receive grants. This model is difficult for community health centers and other safety net providers due to limited matching funds. In addition, one comment noted that it is critical that HIT models are geared towards the community health center industry, that they provide full life cycle care, and emphasize chronic disease and maternal-and-child management.

Response: HRSA has included many of these comments as part of its funding opportunities.

VIII. Other Comments

In general, the comments stated that adoption of an EHR does not automatically lead to health improvement. Factors that contribute to success include clinic stability, strong and effective management team and a focus on quality improvement. Comments recommended that HRSA solicit these items in the grantee's work plan and the focus on quality improvement should be strengthened at the clinic level.

Population Management was frequently cited to improve quality and reduce disparities. Comments recommended that HRSA promote the adoption of population management systems as a step towards building HIT capacity for quality improvement. The comments also pointed out that although EMR adoption is a critical component of HIT, advancing the EHR

adoption should not necessarily preclude the other components such as population management systems.

Comments also raised the issue that HIT is far from reality for most of the safety net providers. Because of lack of resources, HIT is not a priority. Many safety net providers are struggling with outdated practice management systems that need constant repair and with scarce resources available to maintain them. It was suggested that HRSA provide access to resources or approaches that can support sustainability of some level for Safety-Net Provider Networks.

Response: HRSA appreciates that there are other HIT solutions in addition to EHRs and included many of these comments as part of its funding opportunities. In addition, HRSA believes funding for HIT adoption and sustainability must come from a variety of funding sources.

IX. Paperwork Reduction Act

Should any of the HIT initiatives involve the collection of information applicable to requirements of the Paperwork Reduction Act of 1995, the agency will request OMB review and approval.

Dated: January 16, 2008.

Elizabeth M. Duke,

Administrator.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Loan Repayment Program for Repayment of Health Professions Educational Loans

Announcement Type: Initial.

CFDA Number: 93.164.

Key Dates: January 18, 2008 first award cycle deadline date, September 30, 2008 entry on duty deadline date.

I. Funding Opportunity Description

The Indian Health Service (IHS) estimated budget request for Fiscal Year (FY) 2008 includes $11,581,766 for the Indian Health Service (IHS) Loan Repayment Program (LRP) for health professional educational loans (undergraduate and graduate) in return for full-time clinical service in Indian health programs.

This program announcement is subject to the appropriation of funds. This notice is being published early to coincide with the recruitment activity of the IHS, which competes with other Government and private health management organizations to employ qualified health professionals.

This program is authorized by Section 108 of the Indian Health Care Improvement Act (IHCIA) as amended, 25 U.S.C. 1601 *et seq.* The IHS invites potential applicants to request an application for participation in the LRP.

II. Award Information

The estimated funds available is approximately $11,581,766 to support approximately 258 competing awards averaging $44,740 per award for a two year contract. One year contract continuations will receive priority consideration in any award cycle. Applicants selected for participation in the FY 2008 program cycle will be expected to begin their service period no later than September 30, 2008.

III. Eligibility Information

1. Eligible Applicants

Pursuant to Section 108(b), to be eligible to participate in the LRP, an individual must:

(1) (A) Be enrolled—

(i) In a course of study or program in an accredited institution, as determined by the Secretary, within any State and be scheduled to complete such course of study in the same year such individual applies to participate in such program; or

(ii) In an approved graduate training program in a health profession; or

(B) Have a degree in a health profession and a license to practice in a state; and

(2) (A) Be eligible for, or hold an appointment as a Commissioned Officer in the Regular or Reserve Corps of the Public Health Service (PHS); or

(B) Be eligible for selection for service in the Regular or Reserve Corps of the (PHS); or

(C) Meet the professional standards for civil service employment in the IHS; or

(D) Be employed in an Indian health program without service obligation; and

(E) Submit to the Secretary an application for a contract to the LRP. The Secretary must approve the contract before the disbursement of loan repayments can be made to the participant. Participants will be required to fulfill their contract service agreements through fulltime clinical practice at an Indian health program site determined by the Secretary. Loan repayment sites are characterized by physical, cultural, and professional isolation, and have histories of frequent staff turnover. All Indian health program sites are annually prioritized within the Agency by discipline, based on need or vacancy.

Section 108 of the IHCIA, as amended by Public Laws 100–713 and 102–573, authorizes the IHS LRP and provides in pertinent part as follows:

(a)(1) The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (hereinafter referred to as the ''Loan Repayment Program'') in order to assure an adequate supply of trained health professionals necessary to maintain accreditation of, and provide health care services to Indians through, Indian health programs.

Section 4(n) of the IHCIA, as amended by the Indian Health Care Improvement Technical Corrections Act of 1996, Public Law 104–313, provides that:

''Health Profession'' means *allopathic medicine,* family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, and allied health profession, *or any other health profession.*

For the purposes of this program, the term ''Indian health program'' is defined in Section 108(a)(2)(A), as follows:

(A) The term ''Indian health program'' means any health program or facility funded, in whole or in part, by the Service for the benefit of Indians and administered—

(i) Directly by the Service;

(ii) By any Indian Tribe or Tribal or Indian organization pursuant to a contract under—

(I) The Indian Self-Determination Act, or

(II) Section 23 of the Act of April 30, 1908, (25 U.S.C. 47), popularly known as the Buy Indian Act; or

(iii) By an urban Indian organization to Title V of this act.'' Section 108 of the IHCIA, as amended by Public Laws 100–713 and 102–573, authorizes the IHS to determine specific health professions for which Indian Health LRP contracts will be awarded. The list of priority health professions that follows is based upon the needs of the IHS as well as upon the needs of American Indians and Alaska Natives.

(a) Medicine: Allopathic and Osteopathic.

(b) Nurse: Associate and B.S. Degree.

(c) Clinical Psychology: Ph.D. only.

(d) Social Work: Masters level only.

(e) Chemical Dependency Counseling: Baccalaureate and Masters level.

(f) Dentistry.

(g) Dental Hygiene.

(h) Pharmacy: B.S., Pharm.D.