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June 11, 2009

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

Dear David:

The Network for Regional Healthcare Improvement (NRHI) would like to offer comments and recommendations on the draft description of the Health Information Technology Regional Extension Program, as requested in the May 28 Federal Register Notice (Vol. 74, No. 101, pp. 25550-2552).

We recommend that you make the following additions and modifications to the proposed criteria for determining qualified applicants:

- **Require technical assistance for HIT through Regional Extension Centers to be explicitly connected to regional quality improvement and quality measurement efforts.**
- **Give preference to Regional Health Improvement Collaboratives and Chartered Value Exchanges for designation as Regional Extension Centers.**
- **Enable funding for quality improvement programs and in-kind services to count as matching funds.**
- **Allow awards of more than $10 million in appropriate circumstances, and make three-year commitments of funds (contingent on performance), rather than two-year awards.**

In addition, we recommend that you expand the goals of the program beyond technical assistance related to electronic health records, and allow funding to be use for assistance in the implementation and use of other forms of "health information technology" (such as patient registries) to improve the quality and reduce the costs of health care.

More detail on each of these recommendations is provided below.

Focus on Quality Improvement and Cost Reduction

As you know, the real promise of HIT is not just turning paper records into electronic form, but enabling fundamentally new approaches to

monitoring and coordinating patient care, using evidence-based medicine, preventing errors, and measuring quality and efficiency.

For example, although current quality measurement programs are a major advance, their ability to improve care is constrained by the inherently *post hoc* and time-lagged nature of today's measurement systems. Rather than merely telling physicians, hospitals, and other providers how they performed after the fact, the goal should be to help them identify what should be done *before* the opportunity is missed. Moreover, rather than waiting for data to be processed and reported back to them through periodic comparative quality reports, they should have the capability of continuously analyzing their own performance so that they can make immediate improvements in performance. Realizing this vision will require the use of information technology, such as electronic health records, but unfortunately, many EHR systems do not have capabilities such as patient registries which enable identification of patients who have not received appropriate care and which enable analyses of performance on quality measures to be easily generated.

We believe that in selecting Regional Extension Centers, it is essential to be explicit regarding the central importance of connecting HIT to quality improvement efforts. **To emphasize this, we recommend modifying the final criterion in your proposed list of Required Criteria to read:**

- ***Propose an efficient and feasible strategy to furnish deep specialized expertise (in such areas as organizational development, legal issues, privacy and security, economic and financing issues, ~~and~~ evaluation, quality improvement, quality measurement, and process improvement) broadly to all providers served and intensive, individualized, "local" presence from an interdisciplinary extension agent to smaller groups of providers assigned to individual agents. The strategy should demonstrate how the assistance given to providers will help to improve the quality and/or improve the efficiency of healthcare delivery in the region.***

Build on Existing Regional Health Improvement Collaboratives

We commend you for developing a focused, yet flexible list of criteria for selection. The size, structure and capacity of healthcare providers differ dramatically from region to region across the country, and there is similar variance in the level of adoption and use of HIT by those providers. Consequently, the nature and structure of technical assistance will also need to vary, and having flexible criteria will facilitate that.

However, it is also important that this important new technical assistance program not be implemented in a way that fragments, confuses, or conflicts with efforts that are already underway in many communities to improve the quality and value of healthcare, including the effective use of HIT. In particular, there are over 50 Regional Health Improvement Collaboratives in the U.S., all working to improve the quality of healthcare services while controlling skyrocketing costs. These Collaboratives have already brought together the types of major stakeholders you

Regional Health Improvement Collaboratives in the U.S.

identify in your draft program description: employers, clinicians, hospitals, patients and families, and health plans. With the participation and support of these stakeholders, Regional Health Improvement Collaboratives have designed and implemented programs ranging from public reports on the quality and cost of physicians, hospitals, health plans, and other healthcare providers, to projects that reduce hospital readmissions and improve the health of people with chronic diseases. Two dozen of these Collaboratives have been designated as Chartered Value Exchanges by HHS. Two Collaboratives (the Louisiana Health Care Quality Forum and the Pittsburgh Regional Health Initiative) are working with HHS/CMS to implement the Medicare EHR Demonstration project, and are already carrying out many of the same roles expected of Regional Extension Centers.

We believe that in regions where Regional Health Improvement Collaboratives exist, it is important that the Regional Extension Centers build on the work of those Collaboratives, rather than duplicate or compete with them. Regional Health Improvement Collaboratives already meet several of the proposed criteria you have defined: they are *non-profit organizations* that work to improve healthcare quality and value in a *specific geographic region* of the country through a *collaborative effort of multiple healthcare stakeholders* (providers, payers, purchasers, and consumers). Although not all Regional Health Improvement Collaboratives will want to serve as Regional Extension Centers, those that have the willingness and ability to do so should receive preference in the designation process, since that will ensure maximum coordination and synergy between the Regional Extension Center services and other quality improvement initiatives.

Consequently, we recommend that two additional criteria be added to the preference criteria you have proposed, namely:

- ***"Give preference to organizations which have an ongoing program for healthcare quality measurement and/or healthcare quality improvement, and which present a plan for coordinating their activities under those programs with the technical assistance that would be delivered as a regional extension center."***
- ***"Give preference to organizations that have been designated as Chartered Value Exchanges (CVEs) by the U.S. Department of Health and Human Services in regions where CVEs have been designated, and in regions where a CVE has not been designated, give preference to non-profit, multi-stakeholder organizations that are already working to improve healthcare quality and value in their state or region."***

Flexibility Regarding Definition of Regions, and Adequacy of Financial Support

We commend you for providing flexibility for organizations to define their own geographic regions, rather than having ONC pre-define regions, and to allow both state and substate regions (e.g., metropolitan areas), rather than requiring multi-state regions. We encourage you to retain that flexibility in the final version of the priorities.

We also recommend two modifications to the proposed amounts and duration of financial assistance to Regional Centers:

- **Remain open to granting more than $10 million to some Centers, particularly those providing technical assistance on a statewide basis in states with limited resources and many small providers.**

- **Committing three years of assistance to Centers, rather than two.** It is unlikely that truly successful realization of the full potential of HIT can occur within even two years. Centers will be better able to focus their time on technical assistance and to commit themselves to multi-year support for providers if they know they will have the resources to support that. The third year of funding can be made contingent on adequate performance.

Allow Funding for Quality Improvement Programs and In-Kind Services to Count as Match

We recommend that "matching funds" not be construed narrowly to only include non-federal dollars used for the exact same *services* for which the HITECH Act funds are used, but also to count funds that are used for complementary quality improvement activities with the same *providers* which receive HITECH Act-funded services. Consistent with the points made earlier, the maximum impact on healthcare quality and costs will come from a coordinated strategy to (a) help providers successfully implement and use health information technology for quality improvement efforts, and (b) help those same providers implement quality improvement efforts that utilize health information technology.

In addition, many Regional Health Improvement Collaboratives rely on voluntary contributions of time and expertise by their participating stakeholders, and we would urge that these contributions also be considered as matching resources.

To implement these recommendations, **we recommend modifying the language in the final Preference Criterion to read:**

- **…give preference to applicants identifying viable sources of matching funds. Funding will be counted as "matching funds" if the funding supports (a) the same services for which the HITECH Act funds are used, or (b) quality improvement services (e.g., practice coaching, training in quality improvement methods, etc.) which are delivered to the same providers receiving services supported by the HITECH Act funds and which enable those providers to improve the quality or efficiency of the care they deliver. Viable sources could include grants from states and non-profit foundations, charitable contributions from private entities, and payment for services from providers able to make such payment. In addition, the value of in-kind contributions of time and expertise may be considered as matching funds. For example…**

Define HIT More Broadly Than EHRs

Finally, although the HITECH Act defines the role of Regional Extension Centers more broadly than just electronic health records, the Preamble to the draft program description states that "the major focus of the Centers' work with most of the providers that they serve will be to help to select and successfully implement certified electronic health records (EHRs)." In addition, it proposes that the goals of the regional extension center program be focused on adoption and use of EHRs.

It is important to recognize that many EHRs do not have HIT capabilities, such as patient registries, which are critical to quality improvement efforts. In some cases, particularly for small providers, HIT systems other than EHRs may actually deliver a higher return on investment at this

stage of the development of EHRs. For example, a recent article in the *Annals of Family Medicine* evaluating the experience of physician practices in implementing medical homes states:

> "For example, it is possible and sometimes preferable to implement e-prescribing, local hospital system connections, evidence at the point of care, disease registries, and interactive patient Web portals without an EMR."
> ("Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home," *Annals of Family Medicine*, Volume 7, Number 3, May/June 2009.)

Consequently, we recommend that the Extension Program be given the flexibility to provide technical assistance with respect to any and all forms of HIT that will help to improve quality. **Specifically, we recommend the following changes to the goals you have proposed:**

…the goals of the regional center program should be to:

- **Encourage adoption of electronic health records, patient registries, and other health information technology that will promote quality and efficiency by clinicians and hospitals;**
- **Assist clinicians and hospitals to become meaningful users of electronic health records, patient registries, and other health information technology that will promote quality and efficiency; and**
- **Increase the probability that adopters of electronic health record systems will become meaningful users of the technology.**

Thank you for the opportunity to comment. NRHI would be pleased to provide any additional information or assistance that you would find helpful in finalizing and implementing the requirements for this important program.

Sincerely,

Harold D. Miller
President and CEO

cc: Charles P. Friedman, Ph.D., Deputy National Coordinator