



HEALTH INFORMATION TECHNOLOGY RESOURCES FOR COMMUNITY CLINICS:

Navigating the unprecedented opportunity

Community Clinics Initiative—a joint project of Tides
and The California Endowment

**E.H.R. PATHWAYS TO
SUCCESSFUL ADOPTION**

Issue Brief June 2009

Overview

New funding for health information technology at the federal level offers significant opportunity to advance the efficiency and quality of health care services in California and throughout the nation. There is risk, however, that without coordination of funding, attention to leveraging the multiple resources, and flexible funding for operations, the goals of improved quality through technology adoption will not be fully realized. Risk is acute in the safety net where public funding is the major underwriter of the effort and where tolerance for financial loss is limited by thin margins.

Moreover, the disparity in resources available for clinics that are not Federally Qualified Health Centers (FQHC) threatens to produce a bifurcated system within the safety net—FQHC clinics with financing resources to rapidly implement full health information capability and non-FQHC clinics struggling to finance health information technology systems.

The California HealthCare Foundation (CHCF), with Manatt Health Solutions, developed the issue brief “The Impact of the Stimulus Package on California’s Community Health Centers,” which outlines all American Recovery and Reinvestment Act (ARRA) resources for community health centers.¹ Resources are available from multiple state and federal distribution points with rolling dissemination of deadlines, use requirements, eligibility and implementation timelines that make it difficult for clinic organizations to

analyze the detailed information and map the resources within a timeline that is useful. In addition to the challenge of coordinating federal stimulus resources, clinics—especially non-FQHC organizations—will need to leverage and blend existing technology resources, such as the California Telehealth Network (CTN), to acquire sufficient resources.

This memo offers analysis of 2007 Office of Statewide Health Planning and Development data to provide a landscape of non-FQHCs in California.

Appendix A contains a list of non-FQHC organizations. In addition, this memo, as a companion to the CHCF brief, will focus on how ARRA and non-ARRA funding for technology matches the technology needs of clinics with a focus on non-FQHC organizations. A quick guide to ARRA and non-ARRA health information technology funding and acronyms is listed in Appendix B for reference.

Issues for consideration:

- Non-FQHC community clinics represent substantial primary care capacity available to low income populations; however, analysis of the specific health information technology needs and resources available for this element of the safety net is not well understood.
- Funding challenges for FQHC organizations include timing and coordination while the key challenge for non-FQHCs who cannot access MediCal incentive funds will be insufficient funding.
- Collaborative networks of clinic organizations and support from regional and state associations can improve the successful utilization of resources and the realization of improved quality of care for the entire clinic field.
- Identifying the representative early adopters and offering case studies of their experience offers leap frog advancement for the entire field of community clinics.
- Clinics are uniquely positioned to ensure that broad acceptance, active use of new technology and expanded advocacy efforts by consumers from low income/communities of color are realized.

1. CHCF Issue Brief: The Impact of the Stimulus Package on California’s Community Health Centers, June 2009.

The Landscape of Non-FQHC Clinics in California

There are 97 non-FQHC clinic organizations with 248 sites in California providing more than two million visits annually to approximately one million patients.² Clinics statewide tally 11 million encounters to three million patients through approximately 800 sites. Non-FQHCs include independent community clinic organizations, free clinics, Planned Parenthoods, other reproductive health providers and behavioral health providers offering primary care services. FQHC look-alike clinics are included, as they are not eligible for ARRA funds designated to FQHCs. Clinics operated by school districts, hospitals and county health departments, as well as FQHC organizations, are not included. In addition, there are 153 school-based health centers and 31 tribal health programs in California that include many non-FQHCs, however, reliable data for these organizations are not available through OSHPD or comparable sources.³

Non-FQHC clinics are dispersed throughout California, from Humboldt and Siskiyou Counties in the north to San Diego and Riverside County in the south. Non-FQHC clinics are located in both rural and urban settings. Los Angeles has 29 non-FQHC clinic organizations, Orange County has 12 and San Francisco has seven. The size and scope of services varies tremendously among non-FQHC community clinics with budgets ranging from \$30,000 to \$70 million, however, most represent mid-size clinics with 40 percent of the organizations tallying over 10,000 visits annually. The majority of non-FQHCs are affiliated with a regional consortia or network.

Medicaid incentive payments will become available starting in 2011 for providers with electronic health records (EHRs) only if patient volume exceeds 30 percent Medicaid (20 percent Medicaid for pediatricians) or the clinic is an FQHC/rural clinic serving 30 percent “needy individuals.” Only 42 percent of non-FQHC organizations exceed 30 percent MediCal patient volume. It is important to note

that clinics may continue to qualify to begin receiving Medicaid incentive payments up to 2016 and still receive a full five years of payments, therefore, clinics may be able to increase the MediCal volume over the next five years to qualify for payments.

The health information technology capacity of non-FQHCs is outlined through two representative organizations below.

A rural clinic in Northern California with an annual budget under \$2 million belongs to a regional network and operates a practice management system with a disease registry. There is some on-site IT support but the clinic relies on the regional network and individual consultants for assistance with major purchase decisions and support needs. Staff have researched e-Rx and electronic health record systems and identified certified technology that is a fit for the organization. Funding remains a major obstacle as the clinic is unlikely to qualify for incentive payments under ARRA.

An urban clinic in Southern California with two sites and an annual budget near \$5 million utilizes county IT support and receives some IT funding from the county. The clinic uses HealthPro, does not use e-Rx technology but has researched two possible EHR systems as the next technology purchase for the organization. There is no technology plan for the organization and no funding identified for EHR purchase and implementation, however, the organization meets the MediCal volume requirements to receive incentive payments through ARRA if EHR is implemented.

2. CPCA database drawn from Office of Statewide Health Planning 2007 clinic reports. Data reported to OSHPD has improved in recent years, however, this data should be viewed as “best available.”

3. A follow up inquiry that solicits information directly from these programs would be required to assess the level of Medi-Cal participation, as the data is not reported.

Technology Resource and Use Restriction

Non-ARRA Resources	Use	Distribution
CTN/FCC Broadband	Connectivity/Telehealth	CTN funds infrastructure to connect providers/lower rates
Calif. Teleconnect	Discount rates	Direct to nonprofit
Prop 1D	Telehealth	Through local University of Calif. (UC) campus to provider
Calif. Emerging Technology Fund	Connectivity/Telehealth	Grants direct; CTN and state match
Calif Telemedicine e-health Center	Training/TA telehealth	Direct to provider
MHSA	County by county requirements but generally for EHR, E-Rx, HIE	County by county; some may not contract out funding
ARRA Resources	Use	Distribution
BTOP Broadband	Connectivity	Indirect through state/state entity
ONC/HIE grants	Plan/implement	To state entity or state, then to Providers
IHS	Telehealth; RPMS	Direct to tribes then to providers
BTDL	Infrastructure; BTOP and USDA geography may not overlap	TBD but likely to former borrowers; telecom companies in Calif
ONC/EHR loans	HIE, EHR, training	To state/tribe, then to provider
ONC/Regional Extension Centers	TA, best practices	To nonprofit entities: may include clinic associations
MCal Incentive	HIE/EHR	Payment direct; Per provider/if 30 percent Medi-Cal patient volume/20 percent pediatric
HRSA EHR grants	IT system, hardware, EHR, training	FQHC and FQHC controlled networks ONLY

Mapping Resources to Needs

Most available resources are highly restricted and will require careful planning and sequencing by clinic organizations and consortia. The following chart lists health information technology required for comprehensive implementation and maps the resources available.

Community Clinic Resources and Needs

Technology	Potential Funding Source and Timing
Complete an organizational readiness assessment Design a technology plan	The use of health information exchange (HIE) funding to states/state entity may result in funds to individual clinic organizations. The Regional Extension Centers are charged with providing technical assistance.
Basic hardware upgrade	HRSA grant. Only FQHC/FQHC controlled network with current grants are eligible. Timing 2009
Connectivity upgrades	Broadband availability and affordability will improve for clinics qualified (early 2009) and approved (decision mid 2009). Additional funding may become available through BTOP to cover all qualified providers.
Telehealth	Prop 1D funds to those partners identified by a local UC campus and approved by UC Office of the President. USDA/DLTB loans, loan guarantee, grants 2009–10 in three rounds but may not overlap with BTOP geography. HRSA grants may be used for telehealth equipment. IHS grants may be used for telehealth. CPUC/Teleconnect Fund: discounts ongoing for training, telemedicine and distance learning.
Practice Management System	HRSA grant. Only FQHC/FQHC controlled network currently receiving operating grants are eligible. Timing: 2009. MHSA may fund PMS. Implemented county by county with largest funding in 2010 and 2011.
HIE capability	ONC/EHR loan fund begins after January 2010 and may be used for HIE if state specifies this use. The use of ONC/HIE implementation funding to states/state entity may result in funds to individual clinic organizations.
E-Rx and lab	HIE planning/implementation grants through states/state entity if state specifies this use. MHSA funds eligible for e-Rx/lab funding but implementation is county by county.
Disease registry	None likely. Possible funds through CDC for IZ registries.
EHR and personal health record (PHR)	MediCal incentive payments begin 2011–2016 and continue for five years if meet requirements. ONC/EHR loan fund begins after January 2010. MHSA may fund EHR but decisions are at county level.
Incorporate a training plan for each technology implementation.	ONC/EHR loan fund begins after January 2010 and may be used for training if state specifies this use. Calif. telemedicine/e-Health Learning Center and UCD/UCSD for telehealth training.
Implement care redesign principles	The Regional Extension Centers are charged with providing technical and change management assistance.

Summary of Gaps

- **Readiness and Planning:** There are no funding requirements that a readiness assessment or technology plan be developed. HRSA grants may be used in a flexible way to support EHR implementation, however only FQHCs are eligible, and given the multiple demands on this grant funding for developing HIE and purchasing EHR, there is little assurance that comprehensive planning will occur. The HIE implementation grants and Regional Extension Centers may develop some elements of readiness and planning under technical assistance activities but these activities will not begin for some time to come.
- **Hardware and Connectivity:** There are multiple telehealth and broadband connectivity resources available through both economic stimulus and other dedicated streams. Coordination of federal, state and private resources, as well as frequent updates to the field, will be the key to ensure that resources result in the desired goals.
- **Applications including practice management systems, HIE capability, e-Rx, lab, EHR and PHR:** EHR and related systems are the primary focus of economic stimulus resources. For some providers, Medi-Cal incentive payments may fund the majority of the cost to implement EHR, however, the clinic must finance the purchase and implementation of quality reporting prior to knowing if they can successfully meet state definitions for meaningful use. Clinics would benefit from a wide range of technical assistance including how to choose a vendor and negotiate the contract; integrating existing technology systems; what training is required; implementation timeline aligned with training/care redesign; quality reporting aligned to state definitions; and privacy and security compliance. An apparent gap exists relative to PHR. At this point, no specific funding priority is set to incentivize PHR adoption under the new funding resources. Given the magnitude of the task associated with health information exchange, electronic health record implementation and quality reporting, PHR adoption could slow down.
- **Use and support including training, care redesign and quality:** The promise of health information technology rests in successfully accomplishing the redesign of business and clinical operations, yet successful change in the core clinical and business elements of organizations is difficult, reduces productivity in the near term and requires sustained effort and measurement. Undoubtedly, the changes required for quality reporting to receive Medi-Cal incentive payments will receive priority but the full potential of system redesign may require additional focus.

Discussion

Clinics will derive maximum benefit by weaving together ARRA and non-ARRA resources, however, the eligibility restrictions and sequence of funding resources are complex for individual organizations to manage.

Successful utilization of available resources will require both organization-level analysis as well as support from technical assistance entities.

The number of simultaneous efforts—telehealth, e-Rx, HIE, EHR, capital improvements—is a risk to the successful implementation of each since it will be difficult to mount multiple technology changes at the same time, yet the funding demands overlapping timelines in many instances. The compressed timelines may lead to hasty purchase decisions of technology that do not serve the long term interest of the organization. Without special focus and attention, individual segments of the marketplace, such as non-FQHC clinics, are at risk of falling behind in technology implementation, especially those clinics that do not qualify for Medi-Cal incentive payments.

Clinics need ongoing assistance with planning, readiness assessment tools, vendor/product choice, best practice assistance in contracting and legal requirements, and technical assistance surrounding new HIPAA requirements because each organization will move through the stages of technology implementation at different times.

Collaborative networks of clinic organizations can greatly improve the successful utilization of available federal, state and private resources and the realization of improved quality of care.

Once the technology is planned, purchased and installed, clinics must overhaul significant portions of their operations and implement clinical quality reporting that conforms to “meaningful use” definitions not yet final. Early adopters can become key advisers to assist the rest of the clinic field in this endeavor. Identifying the representative early adopters and offering case studies of their experience offers leap frog advancement for the entire field of community clinics.

Finally, clinics and clinic associations will play an important role in the area of consumer confidence and empowerment. Part of the promise of health technology rests in a new level of involvement by consumers in their own health outcomes. The lack of emphasis on PHRs as a specific funding priority is likely to curtail the effort to advance PHR alongside EHR, which may in turn limit one avenue for active consumer involvement in health.

Appendix A

COMMUNITY CLINIC ORGANIZATIONS IN CALIFORNIA

NON-FQHC CLINIC ORGANIZATIONS

Every effort was made to classify clinics appropriately by their FQHC status, however, recent conversions to FQHC status may not yet be reflected here. Please contact CCI of your clinic's change in status at CCI@tides.org.

- | | | | |
|--|---|---|--|
| 1. Alta Family Health Clinic, Inc. | 13. Centro Medico Community Clinic, Incorporated | 24. Delta Health Care And Management Services Corporation | 37. Herald Christian Health Center |
| 2. Anderson Valley Health Center, Inc. | 14. Chico Feminist Womens Health Center | 25. Desert Aids Project | 38. Hollywood Sunset Free Clinic |
| 3. Ashland Free Medical Clinic | 15. Church Of The Valley Retirement Homes, Inc. | 26. East Los Angeles Health Task Force | 39. Institute For Healthcare Advancement |
| 4. Asian Americans For Community Involvement Santa Clara | 16. Coalinga Valley Health Clinics, Inc | 27. Economic Opportunity Commission of San Luis Obispo County, Inc. | 40. Isot, Inc. (Canby) |
| 5. Baart Community Healthcare | 17. Coastside Medical Dental Clinics | 28. El Dorado Community Service Center | 41. Kamila Comprehensive Health Center, Inc. |
| 6. Bay Area Consortium For Quality Health Care, Inc. | 18. Community Action Partnership of Kern | 29. Free Clinic of Simi Valley | 42. Kids Come First Community Clinic |
| 7. Berkeley Women's Health Center | 19. Community Action Partnership of Sonoma County | 30. Fresno County Economic Opporunity Commission | 43. Kids Community Clinic of Burbank |
| 8. Big Sur Health Center | 20. Community Care Health Centers | 31. Garfield Health Center | 44. Knights Of Malta Free Clinic, Inc. |
| 9. Birthing Project Clinic | 21. Community Health Care Clinic | 32. Greater Fresno Health Organization | 45. Koryo Health Foundation |
| 10. Camino Health Center | 22. Compton Central Health Clinic, Inc. | 33. Haight Ashbury Free Clinic, Inc. | 46. Laguna Beach Community Clinic, Inc. |
| 11. Center For Aids Research, Education And Services, Inc. | 23. Conejo Free Clinic | 34. Harbor Free Clinic | 47. Lestonnac Free Clinic |
| 12. Central Rehabilitation Clinic, Inc. | | 35. Health For All, Inc. | 48. Marian Community Clinics |
| | | 36. Health And Life Organization, Inc. | 49. Mayview Community Health Center, Inc. |

E.H.R. PATHWAYS TO SUCCESSFUL ADOPTION

- | | | | |
|---|---|---|---|
| 50. M.E.N.D. | 63. Sac Health Systems, Inc | 76. St. James Infirmary | 88. Vietnamese Community of Orange County, Inc. |
| 51. Mount Shasta Medical Clinic, Inc. | 64. Samaritan House | 77. St. Vincent De Paul Village, Inc. | 89. Planned Parenthood Golden Gate |
| 52. Nhan Hoa Comprehensive Health Clinic | 65. Samuel Dixon Family Health Centers | 78. Taiwan Buddhist Tzu Chi Medical Foundation, USA | 90. Planned Parenthood Shasta Diablo |
| 53. Operation Samahan, Inc. | 66. San Francisco Free Clinic | 79. Tarzana Treatment Centers, Inc. | 91. Planned Parenthood Los Angeles |
| 54. Orange County Rescue Mission Health Care Services, Inc. | 67. San Gabriel Valley Foundation | 80. Tavarua Medical Rehabilitation | 92. Planned Parenthood Mar Monte, Inc. |
| 55. Pacific Family Health | 68. San Joaquin Family Healthcare Association Inc. | 81. The Gary Center | 93. Planned Parenthood Pasadena and San Gabriel Valley, Inc. |
| 56. Pathways to Life | 69. Santa Barbara Neighborhood Clinics | 82. The Salvation Army A California Corp | 94. Six Rivers Planned Parenthood |
| 57. Potter Valley Community Health Center | 70. SDVP Management, Inc. | 83. Tides Center, Women's Community Clinic | 95. Planned Parenthood of OCSB |
| 58. Presbyterian Health Physicians | 71. Share Our Selves Free Medical Clinic | 84. Tulare Community Health Clinic | 96. Planned Parenthood of San Diego & Riverside Counties |
| 59. Reproductive Health Care Center, Inc. | 72. Sierra Family Medical Clinic, Inc. | 85. United Health Organizations, Inc | 97. Planned Parenthood of Santa Barbara, Ventura and San Luis Obispo Counties |
| 60. Rector Wardens and Vestry of the Church of Our Saviours | 73. Siskiyou Family Healthcare | 86. Universal Health Foundation | |
| 61. Ritter Center | 74. South Bay Childrens Health Center Association, Inc. | 87. URDC Human Services Corporation | |
| 62. Sac Norton | 75. St. Anthony Foundation | | |

Appendix B

AVAILABLE RESOURCES FOR HEALTH INFORMATION TECHNOLOGY

American Recovery and Reinvestment Act of 2009 (ARRA)

Medi-Cal Incentive payments: CMS through California DHS. Payments begin in 2011 in varying annual amounts up to \$64,000 total per provider (M.D., D.D.S., CNM, NP, PA) based on meeting specific requirements including: use of EHR certified by the federal Certification Commission for Healthcare Information Technology (CCHIT) to perform electronic exchange of health information/electronic prescribing, submit data on clinical quality and meets other requirements for “meaningful use.” A federal definition will be available in spring 2009, however the definition may be refined by the State of California and may not be final until late 2009. Providers must have operational EHR that complies with the meaningful use definition by October 2011 to receive maximum incentive payments.

FQHC/FQHC controlled network grants: Direct from Health Resources and Services Administration. Competitive grants totaling \$1.5 billion may be used for construction, renovation, equipment and purchase of health information technology. Some portion, probably \$120 million, will be restricted to health information technology only. Non-FQHCs are not eligible for these resources. Funding will begin in 2009.

<http://www.bphc.hrsa.gov>

Health Information Exchange (HIE) planning and implementation grants: Office of the National Coordinator (ONC) through state designated entity or the State of California to health care providers: State entity or State may apply for planning or implementation grants to support adoption of health information exchange. It is likely California will receive the larger implementation grant. Funds will begin to flow from ONC during 2009.

<http://www.healthit.hhs.gov>

EHR Loan Program: Office of the National Coordinator (ONC) through the State of California and Indian Tribes:

State of California may apply for competitive grants to set up loan funds for the purchase, upgrading of technology, training and health information exchange. Grants to the state/tribes will be made after January 2010. The loan fund may be combined with private loan resources.

Regional Extension Centers: Office of the National Coordinator (ONC) to nonprofit organizations: partial funding (up to 50 percent for four years) is available to support technical assistance and dissemination of best practices to providers to accelerate implementation and utilization of health information exchange technology beginning in 2009. It is likely that multiple organizations in California will apply and be funded.

Broadband Technology Opportunities Program (BTOP): U.S. Department of Commerce National Telecommunications and Information Administration to State of California or nonprofit or broadband service provider: competitive grants awarded in three rounds by October 2010 for broadband connections, training, equipment and public awareness—at least one grant per state.

www.ntia.doc.gov/broadbandgrants

Distance Learning, Telemedicine and Broadband Program: U.S. Department of Agriculture (USDA/DLTB) Rural Utility Service: grants, loans and loan guarantees will be provided in three rounds of funding to expand broadband and telehealth in rural geographies that do not overlap with the Department of Commerce grants detailed above. The eligible applicants are not defined but telecommunication borrowers under title II receive priority and include three California-based telephone companies.

www.ntia.doc.gov/broadbandgrants

Indian Health Service (IHS): Federal allocation of \$85 million to be used to contract for enhancements to the Resource and Patient Management System used by IHS providers, for equipment and to expand telehealth in Indian clinics. Funds will be allocated by the end of 2010 (60 percent in 2009 and 40 percent in 2010).

www.ihs.gov

California HIT Resources non-ARRA

Federal Communication Commission (FCC): The California Telehealth Network⁴ was awarded \$22 million from the FCC to connect at least 300 providers to broadband for telehealth. Providers applied in early 2009 and almost 1,000 were certified eligible to participate in the program. Applications from telecommunications companies are being reviewed currently and it is expected that connectivity may begin in summer/fall 2009. No funding is available for equipment, training or internet fees for providers. There is not sufficient funding to connect all 1,000 eligible providers, however, the ARRA BTOP listed above may be used to expand the number of providers who benefit.

www.caltelehealth.org

www.ConnectedHealthCA.org

Proposition 1D: State bond measure to the University of California (UC) for infrastructure, including telemedicine. At least \$10 million is set aside from the total \$200 million bond for community partners. Each UC campus receives an allocation of funding and will designate its community partners for funding of telemedicine equipment. Much of the money is currently frozen due to state cash flow, therefore timing is uncertain.

www.ConnectedHealthCA.org

California Teleconnect Fund: California Public Utility Commission. Nonprofit entities may apply to receive discounts on telecommunication rates in support of training, telemedicine and distance learning.

www.cpuc.ca.gov/PUC/Telco/Public+Programs/CTF

UnitedHealth/PacifiCare California Investment Program: A \$200 million loan program established in the merger of United Healthcare and PacifiCare to provide capital

and information technology loans to underserved communities in California. A companion grant program has ended. No health information technology loans have been made due to the difficulty of establishing a financing package that meets the program specifications and serves providers. Staff is interested in exploring concepts to leverage ARRA grants, loans or incentive payments or private foundation funding that may open the loan program to information technology investments.

California Emerging Technology Fund (CETF): A \$60 million spend-down foundation established under conditions set by the California Public Utilities Commission during the merger approval of SBC/AT&T and Verizon/MCI to minimize the digital divide. CETF has provided \$20 million over two years to nonprofit organizations including funding for the state match of the FCC grant.

www.cetf.org

Mental Health Services Act (MHSA): Proposition 63 funds through the California Department of Mental Health to counties. Information technology funding totaling \$450 million is allocated county by county for behavioral health information technology including EHR.

http://www.dmh.ca.gov/Prop_63/MHSA/Technology/default.asp

California Telemedicine and eHealth Center (CTEC): Training centers at UC Davis and UC San Diego offer training for telehealth.

<http://www.cteonline.org>

4. CTN is a coalition of the University of California, California Emerging Technology Fund, government agencies, providers administered by UC.

PREPARED FOR CCI BY LAURA HOGAN.

Questions/comments may be directed to laurahogan100@gmail.com.

E.H.R. PATHWAYS TO SUCCESSFUL ADOPTION