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Family Planning Centers Confront Roadblocks On the Information Superhighway

By Adam Sonfield

Three years ago, Congress made a multibillion dollar investment in the nation's health information technology (HIT) infrastructure, as part of the economic stimulus package known as the American Recovery and Reinvestment Act of 2009. Most of that investment took the form of financial incentives to hospitals and clinicians participating in Medicaid and Medicare who adopt one advanced type of HIT: electronic health records (EHRs).

Even without these financial incentives, providers have strong reasons to modernize their health centers and practices. Health insurance plans are increasingly demanding that providers make use of electronic billing and records. In addition, the Patient Protection and Affordable Care Act—the health reform legislation enacted in 2010—has added to the pressure: After health reform is fully implemented in 2014, the number of Americans with private insurance or enrolled in Medicaid managed care plans is expected to grow rapidly.[1] The Affordable Care Act has also accelerated a trend of consolidation and coordination in the health care world, and HIT is considered key to making that work.

According to new research from the Guttmacher Institute, however, many publicly funded family planning centers have made only halting progress toward adopting electronic records and other types of HIT. These providers face numerous financial, technical and logistical challenges, and many will need help to adopt these technologies and survive in the 21st century.

A National Movement

Policymakers, providers and other experts have widely promoted the use of electronic records and other HIT to improve the quality, accessibility, safety and cost-effectiveness of care. If designed and adopted appropriately, these technologies are considered to have the potential to reduce administrative costs, increase staff efficiency, improve care coordination, eliminate medical errors, facilitate better research, identify public health threats and otherwise improve the U.S. health care system.

Historically, the earliest types of HIT focused on managing a health center or practice: managing inventory, scheduling appointments, billing insurers, ordering and receiving lab tests, and generating a variety of internal and external reports. EHR systems are a more recent development that enable the entry, storage and transmission of clinical notes, medical histories, prescriptions, lab results and other information about clients and client visits. In addition, they may be used to prescribe medication, provide clinical decision support (such as alerting providers to contraindications or new medical protocols) and facilitate referrals to or from outside providers or within an agency with multiple sites. Many of the current HIT products also offer modules promoting various modes of communication with patients.

To help encourage the nationwide adoption of electronic records and other types of HIT, the stimulus package established Medicaid and Medicare EHR incentive programs. These programs are designed to help pay for the purchase

and implementation of a new or upgraded EHR system, as well as staff training, maintenance and ongoing use. For Medicaid clinicians—including physicians, nurse practitioners, certified nurse-midwives and some physician assistants—the incentives could total as much as $63,750 over six years, with about one-third of that available in the first year to help with upfront costs.[2] The incentives are awarded to individual providers, so health centers with multiple eligible providers could access many times this amount.

By the end of December 2011, more than 175,000 health care providers had registered for an incentive payment.[3] Most of the $2.5 billion distributed initially went to hospitals, but payments to Medicaid clinicians have increased rapidly. Clinicians now have hundreds of EHR products to choose from that have received federal certification.[4]

Qualifying for Incentives

The Medicaid incentives provide a major potential pathway for publicly funded family planning centers to modernize their information infrastructures. Yet, even qualifying for incentive payments is far from automatic. One important criterion is that at least 30% of a clinician's clients (calculated at either the individual clinician or health center level) must be Medicaid enrollees. In states with restrictive Medicaid eligibility criteria and low enrollment, this threshold may be very difficult for most clinicians to reach. In states that have successfully implemented a Medicaid family planning expansion or that cover large populations under their broader Medicaid program, however, it may be an easier task. Moreover, the Affordable Care Act, starting in 2014, will standardize and greatly expand Medicaid eligibility and enrollment, which should make it easier for clinicians across the country to qualify for the incentives—if they can afford to wait that long.

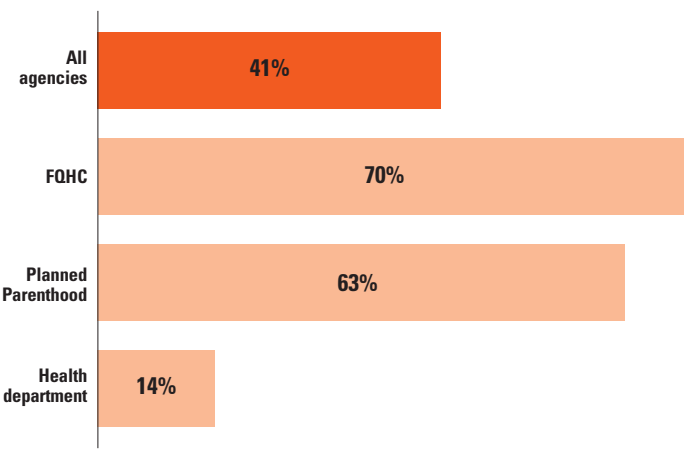
Findings from a new Guttmacher Institute study, *Health Information Technology and Publicly Funded Family Planning Agencies: Readiness, Use and Challenges*, indicate that the Medicaid incentive program does hold considerable promise for family planning centers.[5] Three-quarters of the agencies responding to the survey reported that some or all of their service sites billed at least 30% of their total client encounters to Medicaid. About four in 10 had already assessed whether any of their clinicians would be eligible for the incentives, and nearly all found that at least some clinicians would be.

Nevertheless, several potential trouble spots stand out. Health departments—which account for 35% of family planning agencies, and 58% of those subsidized by Title X—were far less likely than other types of providers to have assessed their clinicians' eligibility for the incentives (see chart). Moreover, only one-quarter of agencies—and only 5% of health departments—said they planned to apply for the incentives as soon as possible. More than half, including eight in 10 health departments, said they were uncertain whether they would apply or that they would not apply.

By contrast, federally qualified health centers (FQHCs)—community health centers and others funded under the federal Section 330 program—seem poised to almost universally take advantage of the incentives. One reason is that the law makes it far easer for clinicians working at

ASSESSING ELIGIBILITY

Health departments are far less likely than federally qualified health centers (FQHCs) or Planned Parenthood agencies to have assessed their clinicians' potential eligibility for Medicaid's electronic health records (EHR) incentive program.



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FQHCs to qualify: Rather than having at least 30% of their clients enrolled in Medicaid, they instead must have at least 30% of their clients be "needy individuals," defined as including not only those covered by Medicaid, but also those covered by the Children's Health Insurance Program and those receiving uncompensated care or care on a sliding-scale basis.

Also, FQHCs were more likely than other agencies to report having already received some type of financial assistance for HIT at the time the survey was fielded in late 2010 and early 2011—49%, compared with 26% of Planned Parenthood affiliates and 9% of health departments. That comes as no surprise, because the 2009 stimulus legislation earmarked $2 billion in grants to expand and improve the FQHC network, including its adoption of HIT, and the Affordable Care Act included another $11 billion for those health centers.

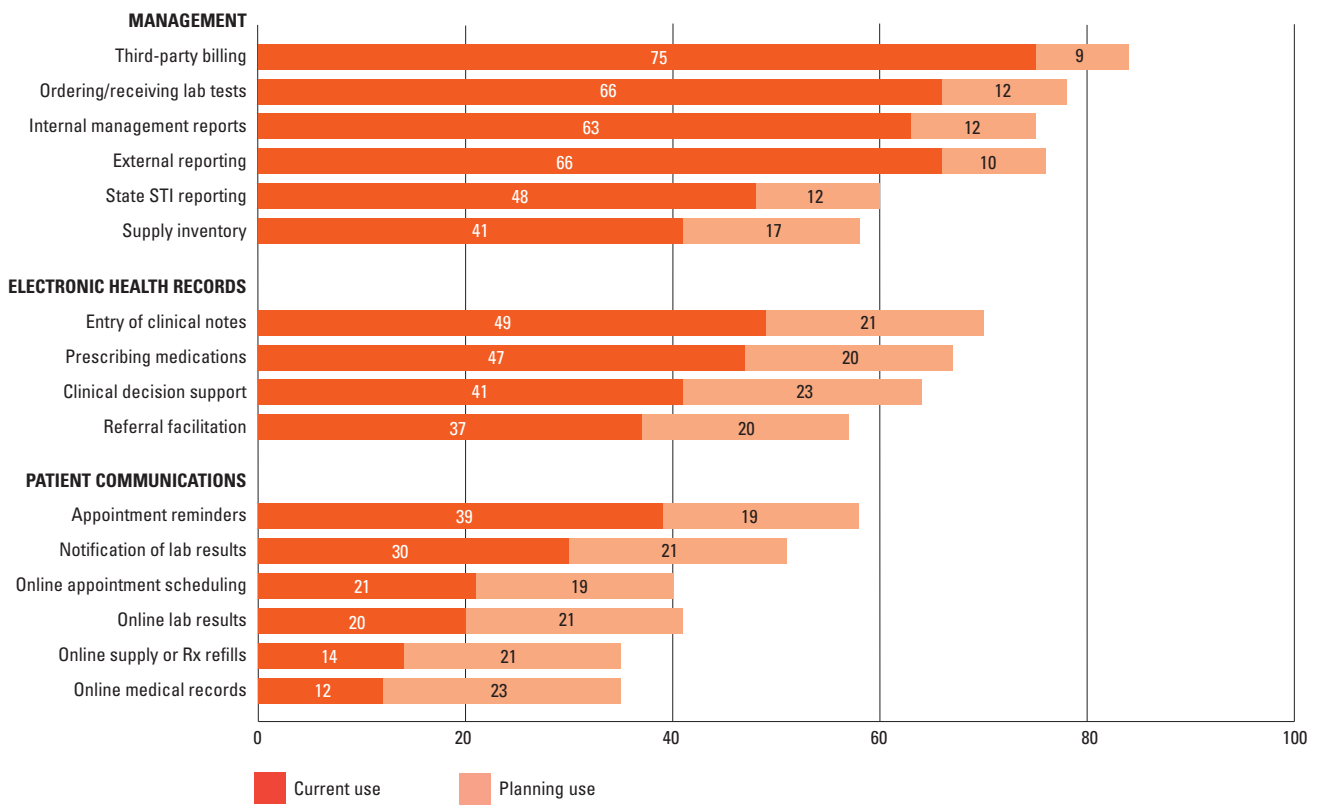
Defining and Achieving 'Meaningful Use'

Beyond meeting the basic eligibility standards for the Medicaid incentives, clinicians must also be able to demonstrate by the second year of incentive payments that they are making "meaningful use" of their EHR systems. The meaningful use standard is designed to be an evolving target that helps to rapidly expand how U.S. health care providers make use of information technology. To maintain their certification under national standards developed by the U.S. Department of Health and Human Services, the manufacturers of EHR systems will have to expand the capabilities of their products to keep pace.

Currently, clinicians are required to meet stage 1 meaningful use standards, which consist of a package of 15 required core objectives (e.g., sending electronic prescriptions; maintaining lists of clients' prescriptions and allergies; imple-

MEANINGFUL USE

Publicly funded family planning agencies report higher levels of health information technology (HIT) use for most practice management functions, such as third-party billing, than for activities involving eletronic health records and patient communications.



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menting at least one clinical decision support rule, such as contraindication alerts; and reporting a series of clinical quality measures to the state Medicaid agency) and at least five out of a menu of 10 additional objectives (e.g., sending reminders to clients about preventive or follow-up care; providing clients with online access to lab results and other information; and providing records to other providers on referral).[6] Proposed stage 2 standards—originally slated for 2013, but now delayed until 2014—would raise the statistical thresholds for meeting many of the stage 1 objectives, make several of the menu options mandatory and add new objectives, such as giving patients the option of secure online messaging.[7]

According to the Guttmacher study, family planning providers vary considerably in their current use of HIT to perform many of these functions. Family planning centers are most likely to be using such technologies for traditional practice management functions, with three-quarters using them to assist with billing and receivables, and about two-thirds using them for ordering lab tests and generating internal and external reports (see chart).[5] In follow-up interviews, several agencies reported having implemented some of these functions as far back as the 1980s.

By contrast, only about half of the agencies surveyed had implemented the core EHR activities of electronic entry of clinical notes and electronic prescribing of medications. Use of HIT for patient communications was typically even less common: Four in 10 agencies reported using electronic appointment reminders, but far fewer had implemented online patient portals that allow clients to schedule appointments, view their lab results, request prescription refills or even view their medical records. About two in 10 agencies said they had plans to implement all of the core EHR and patient communication functions in the next two years, with several noting that they were waiting for manufacturers to update their systems to meet the evolving federal standards.

These findings point to important gaps in family planning centers' use of HIT. Even for the most commonly used function—billing insurance plans—one out of every four family planning agencies nationwide are technologically behind the times, placing them in real danger of being left out of Medicaid and private health plan networks.

Beyond that, the study also found clear if unsurprising patterns of disparity across most of the HIT tasks studied: FQHCs were more likely to use HIT than health departments, with Planned Parenthood affiliates and other agencies somewhere in between; larger agencies were more likely than smaller ones, and urban agencies more likely than rural ones. Moreover, because the Title X network is dominated by health departments, Title X–supported agencies tend to be behind the curve compared with other family planning agencies.

There are certainly exceptions to these patterns, in some cases where legal requirements or collective effort have had an impact. For example, health departments head the pack in electronically reporting STIs to their state. Nevertheless, the patterns reflect the fact that some types of agencies face particularly strong challenges to adopting HIT.

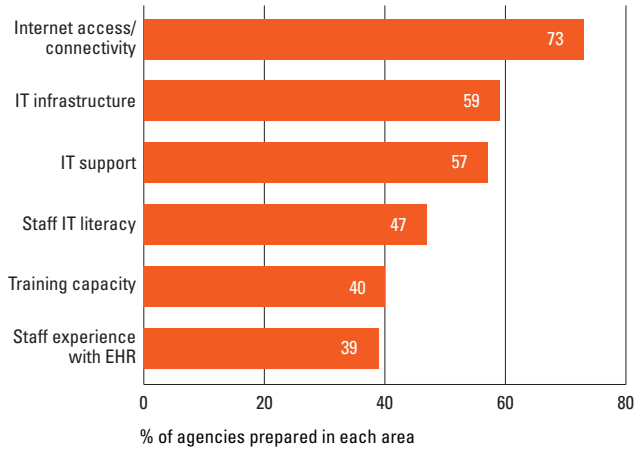
Readiness and Challenges

Indeed, these same disparities—by agency type, size and location—were identified across a wide range of questions asking agencies to assess their preparation for and challenges in implementing HIT. Almost nine in 10 FQHCs had conducted their own readiness assessment, compared with about half of Planned Parenthood affiliates and only one-quarter of health departments. And when asked about specific areas of readiness—from Internet connectivity to technological infrastructure and support to staff training and experience—FQHCs, larger agencies and urban agencies outpaced their counterparts.

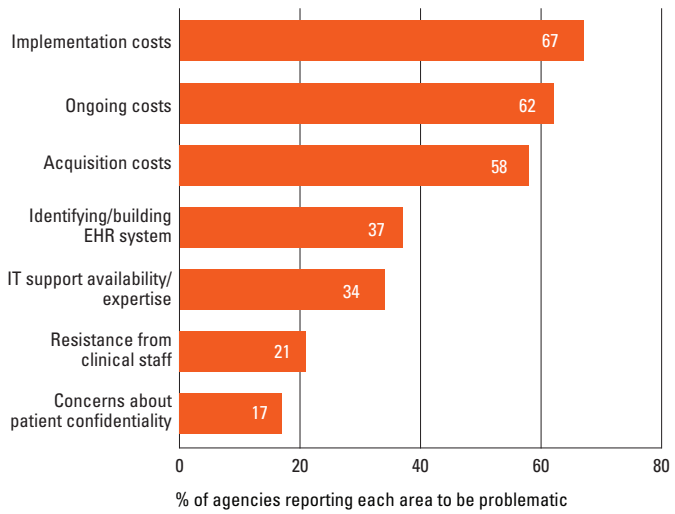
Across the board, agencies were considerably less likely to say they were prepared on the staffing-related issues than on the infrastructure issues (see chart, page 6). Several agencies emphasized that they had needed to identify and train some clinicians and staff members to serve as HIT point persons, capable of providing training and assistance to their peers, and of helping to design and implement aspects of the HIT

READY AND NOT

Family planning agencies report being less prepared for implementing and using HIT in terms of staffing than infrastructure…



…and when asked which areas are most problematic for HIT use, agencies report being most concerned about initial and ongoing costs.



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system to match the agency's procedures and protocols.

When asked to assess the seriousness of various challenges to adopting and using HIT, providers of all types focused on issues of cost. Problematic areas included the initial acquisition costs of researching options, and of purchasing and installing equipment and software; implementation costs related to training staff and converting procedures and paper records; and ongoing costs related to maintenance and upgrades. Follow-up interviews made clear that agencies' costs vary widely according to such factors as the number of their clinicians and sites, the quality of their current infrastructure and the range of HIT functions they were seeking to implement. But initial costs can be a six- or seven-figure investment—without even counting temporary cutbacks in clients served during the transition—with additional annual costs in five figures.

Costs are not the only challenges facing family planning providers. About one-third of agencies—including half of health departments and smaller agencies—said they had problems identifying and building an EHR system that fits their needs. Several agencies described how different configurations of hardware and software (e.g., bolted-down hardware versus rolling carts versus laptops or tablets) could have major implications for how efficiently and effectively clinicians and staff go about their work. And among agencies that reported having already implemented an electronic record or practice management system, six in 10 said that substantial customization was done to support sliding fee scales and related billing issues, and nearly half reported customization to ensure patient confidentiality. Among those in the Title X system, three-quarters reported substantial customization to meet the program's annual reporting requirements, the Family Planning Annual Report; several noted that unless EHR systems are customized, they are not designed to track a client's continued use of a contraceptive method, an element necessary to meet the requirements.

Clearing the Roadblocks

Considering the range of concerns agencies report in regard to HIT implementation, it is no surprise that a majority of them believe technical assistance would be helpful on multiple fronts. Most commonly, agencies cited a need for training—more than six in 10 agencies of every type did so—but also assistance with conversion from paper to electronic records, implementation and project management, readiness assessment and project planning, and customization to ensure patient confidentiality.

The 2009 stimulus legislation devoted substantial resources to technical assistance, most prominently through the Health Information Tech-

nology Extension Program, which includes a national research center and dozens of regional extension centers—local organizations that provide training, information, support and technical assistance. It is unclear, however, whether these extension centers have the capacity to fully meet the demand for their services, or whether specialized family planning centers will be a top priority as regional extension centers triage requests for assistance.

Certain groups of providers can draw on assistance from local and national associations or government agencies. Some FQHCs, for example, have received information and other tangible assistance from the National Association of Community Health Centers and from the Health Resources and Services Administration, the federal agency that runs the FQHC grant program. Several Planned Parenthood agencies rely on Voxent, a nonprofit organization set up to provide technical assistance and other services to affiliates using HIT products sold by one manufacturer, NextGen Healthcare.

Nevertheless, family planning providers are clamoring for information, assistance and funding. Given the ever-evolving nature of the technology and the increasing pressure to adapt placed on providers by governments, insurance companies, clients and others, it seems reasonable to assume that these needs will continue unabated for years to come.

One obvious source of assistance—at least for providers supported by the Title X program—is the Office of Population Affairs (OPA), the agency that runs Title X. OPA could help providers meet the challenges posed by HIT in several ways: For example, in making funding allocations, it could scale back its historic priority on the number of clients seen by providers, to allow them to devote resources toward investments in information infrastructure and other areas needed to adapt to the post–health reform marketplace. Client numbers have long been used to demonstrate Title X's effectiveness to appropriators. However, in the context of conservatives' recent stepped-up attacks on Title X and the family planning provider network, these numbers can do little to appease this purely ideological opposition. Ironically, that may make this a politically reasonable time for OPA to make a shift in how it allocates funding.

OPA could also shift some of its own technical assistance resources, including its network of regional training centers, toward HIT issues and other changes to the health care marketplace. It could help providers identify ways to customize existing HIT products to fit the special needs of Title X–supported family planning programs, such as Title X's sometimes unique reporting requirements. Going further, it could work with the appropriate federal agencies to ensure that the national HIT certification standards account for Title X's annual reporting and other requirements. OPA might also help providers assess opportunities for outsourcing some specialized tasks, such as identifying and adapting appropriate EHR packages, providing ongoing network support or processing third-party billing.

More aggressively, OPA could help its network of providers explore potential areas of formal collaboration to take advantage of economies of scale; some Planned Parenthood affiliates and the four Pennsylvania family planning councils have already taken this route. The agency could also forge alliances with other groups of specialized health care providers—such as STI clinics and substance abuse treatment centers—that are facing the same series of challenges. In doing so, these safety-net systems could share information and solutions, and take advantage of even greater economies of scale.

These types of steps could be instrumental in ensuring that all of the family planning network can navigate its way down the information superhighway. Absent such help, too many family planning providers are in danger of having the future pass them by.

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