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Family Planning Centers and the Adoption of Health Information Technology

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One of the few things that almost everyone seems to be able to agree on when it comes to health care reform is that health care providers need to modernize their practices. Use of new health information technology (HIT)—most prominently, electronic health records (EHRs)—has been touted as a key to meeting two sometimes conflicting goals of reform: improving quality and accessibility of care, and decelerating the growth in health care costs. For that reason, legislators from across the political spectrum have proposed a variety of incentives and policies to encourage the adoption of EHRs and other technologies that many believe can reduce administrative costs, increase staff efficiency, improve care coordination, eliminate unnecessary procedures and medical errors, and otherwise improve the system for patients, providers and public health.

Most of the "health care reform" investments in HIT were actually enacted earlier in 2009 as part of the American Recovery and Reinvestment Act of 2009, the economic stimulus package pushed through by Congress during the initial weeks of the Obama presidency. That law included nearly $50 billion in funding for HIT, to not only create and maintain jobs, but also invest in the country's health infrastructure. Much of that funding takes the form of financial incentives for Medicaid and Medicare providers who adopt and use EHRs. Other funding is dedicated to upgrading the technology and infrastructure specifically at community health centers (CHCs), and to state and regional programs to provide technical assistance and improve connectivity. (The actual health care reform bills moving through Congress seek to maximize the utility of HIT, but they provide little or no additional funding, apart from additional investments in CHCs and states' public health infrastructure.)

Even before the stimulus package was enacted, many health care providers, including some CHCs and specialized family planning centers, had been working to modernize the way they operate their practice. They have been prodded to do so by the practical requirements of working with Medicaid and private insurance plans, and the obvious potential of HIT to improve their practices and their clients' health. Still, family planning providers seeking to adopt new technologies face a host of challenges, ranging from complicated issues of confidentiality to tailoring these technologies to the specific requirements of Title X and other public health programs.

Great Expectations…

The stratospheric expectations for EHRs and other technologies are well-illustrated by the stimulus legislation, which lists 11 distinct goals of developing a nationwide HIT infrastructure. Those goals include improving the quality of care, reducing costs, guiding medical decisions, facilitating research, reducing disparities and identifying public health threats—all while protecting patients' information.

To at least some extent, these expectations have been driven by the established benefits of older technologies, such as electronic practice management and record-keeping systems. Many family planning providers already use electronic inventory and billing systems to help them keep track of their stock of contraceptives and other medical supplies, and to detect changes in client

preferences. These technologies also make it easier to set and maintain a budget and to comply and prove compliance with the rules of government programs. Electronic billing facilitates timely and accurate reimbursement from private insurance companies and Medicaid. All of these systems—as well as more basic applications such as electronic scheduling—can greatly reduce administrative workload, once staff are appropriately trained.

Full-fledged EHRs are a newer technology that enables the collection of information for each client visit, such as medical history, prescriptions and lab results. Having that information on file and easily accessible should mean that clients are asked to fill out fewer repetitive forms, providers order fewer repetitive tests and services, and staff members spend fewer hours on paperwork. EHRs should also allow for easier portability of records, resulting in better care coordination among providers and over time. All of this assumes well-designed software and standards to ensure ease of use and compatibility.

Close analysis of HIT data could help providers to find patterns and trends in the preferences, behavior and health of various groups of clients, including when and where they prefer to schedule appointments, what services and methods they are demanding and what health problems they are experiencing. That, in turn, could help them adjust their hours, restructure the office for better patient flow, identify needed languages and skills among the staff, alter their drug formulary and otherwise adapt to changing needs.

In particular, EHRs and the data analysis that may flow from the technology may help address lingering health disparities. EHRs could be used, for example, to help supply clients with linguistically and culturally appropriate information, or to point clinicians to specific treatments or contraceptive methods that have been demonstrated to work best for specific subpopulations. More broadly, the data captured by EHRs can drive the comparative effectiveness research that identifies such treatments, along with public health research that can identify problems and solutions at the community level.

…And the Promise of an Influx of Funds

Among publicly funded family planning providers, only CHCs appear to have been able to make considerable investments in EHRs: A July 2009 analysis by researchers at the George Washington University School of Public Health and Health Services found that 43% of physicians based at CHCs were fully or partially using EHRs in 2006, more than any other group of physicians studied. Specialized family planning centers are making an effort to catch up. In 2007, the four Pennsylvania-based Title X grantees contracted for a new HIT system, including EHR, patient management and billing functions, according to Roberta Herceg-Baron, managing director of programs at the Philadelphia-based Family Planning Council. The council expects that it will improve, at a minimum, its ability to manage first- and third-party billing and receivables for its delegate agencies, to collect and report data for its Title X grant and to conduct quality assurance reviews.

The affiliates of Planned Parenthood Federation of America (PPFA), meanwhile, agreed in 2007 to adopt one of two selected practice management and EHR systems over the next few years, in an attempt to standardize the technology in use across the PPFA system. The results from two early adopters, Mt. Baker Planned Parenthood in Washington state and Planned Parenthood Association of Utah, appear promising. The HIT systems reportedly have sped up and otherwise improved a number of routine tasks, such as notifying patients about abnormal Pap and STI test results, sending in prescriptions to retail pharmacies, reporting STIs to county health departments, completing annual Title X data reporting and auditing patient records for quality assurance and improvement. The new technology has also improved coordination of care among health centers, allowing clients, for example, to pick up supplies anywhere in the affiliate's network.

Still, modernizing a health center's infrastructure is an expense that many family planning providers simply cannot afford. In theory at least, the 2009 economic stimulus package has provided a rare opportunity to change this dynamic. Within that massive, $787 billion legislation were

a series of new provisions intended to spur and coordinate investment in HIT, particularly EHRs. Those provisions included a program to establish regional centers that offer technical assistance in adopting EHRs, another to support states in promoting connectivity among HIT systems and data, and a third to help states develop loan programs for facilities to adopt HIT. The stimulus provisions also established numerous federal initiatives, led by the Office of the National Coordinator for Health Information Technology, to set national standards, test and certify technology, coordinate and enforce HIT privacy policies, conduct comparative effectiveness research and otherwise support the adoption of HIT and maximize its effectiveness.

The largest of the stimulus HIT programs will provide substantial financial incentives to individual Medicaid and Medicare providers who adopt and demonstrate meaningful use of EHRs. For Medicaid providers—who may include physicians, nurse practitioners and some physician assistants—the incentives could surpass $60,000 over six years, a third of that in the first year; a health center with multiple eligible providers could receive many times this amount. The incentives will help pay for the purchase and implementation of a new or upgraded system, as well as staff training, maintenance and ongoing use.

One major caveat is that providers are only eligible if at least 30% of their clients are Medicaid enrollees. That standard, if applied today, might exclude providers in many family planning centers, particularly in states that have very restrictive eligibility criteria for general Medicaid and that have not established a Medicaid expansion program specifically for family planning. Assuming the enactment of health care reform legislation, that standard should become more forgiving, because reform will almost certainly include major expansions in Medicaid eligibility—likely to all individuals with family incomes below 133% or 150% of the federal poverty level—and would also make it easier for states to expand Medicaid further for family planning services. (Those Medicaid expansions, under the current bills, would take place by 2013 or 2014; providers can begin claiming the six-year Medicaid EHR incentives as late as 2016.) Having a greater proportion of their clientele with public or private insurance coverage would also free up other funding sources, such as Title X, to improve infrastructure.

The one group of publicly funded family planning providers that will almost universally be able to take advantage of the stimulus incentives are CHCs. That is because the law includes a broader standard for CHC-based provider eligibility: At least 30% of their clients must be "needy individuals," defined as those covered by Medicaid or the Children's Health Insurance Program, and those receiving uncompensated care or care on a sliding-scale basis. On top of that, the stimulus act provides $2 billion earmarked for CHCs to establish new centers, renovate existing facilities and invest in HIT, and health care reform would pour further billions into the CHC network, to ensure that newly insured low-income Americans have places to access care.

Specialized family planning providers have fewer opportunities, but could benefit from smaller-scale federal grants from the Office of Population Affairs (which runs the Title X program) or other federal or state agencies. The Family Planning Council in Philadelphia, for example, has had to completely self-finance its HIT system, except for a small grant awarded through its Title X regional office.

Implementation Challenges

How all of these various stimulus bill provisions are implemented will have a major impact on whether moving to EHRs is made easier or more difficult for providers. One of the first key decisions to be made is how to determine what constitutes "meaningful use" of EHRs. The Office of the National Coordinator, aided by a pair of advisory councils, is in the process of defining this term in the context of the incentives for Medicare providers. State Medicaid programs will be able to write their own definitions, but are expected to use the federal one as their model. Federal and state regulators will also have to establish the maximum value for incentive payments, the timeframe for implementation, the

process for determining eligibility and many other important details.

These decisions will matter for the nuts and bolts of setting up and running an EHR system. The Medicaid incentives might be able to help providers overcome the hurdle of start-up costs, especially if they are allowed to claim the incentives before the first bills come due. The speed with which state Medicaid programs act and how they set rules for gauging the eligibility standard will also impact that challenge. The quality and availability of technical assistance will affect whether family planning centers are able to identify which HIT system best fits their needs and to learn how to set up the system appropriately, train their staff in its use, and maintain and upgrade it over time. Federal standards for certifying HIT and defining meaningful use will impact the degree to which a provider's system can communicate effectively with those used by other providers, vendors, pharmacists, labs and government agencies, and how the system can facilitate communication with and education of clients with low English proficiency or facing mental health, substance abuse or other difficult issues.

Federal and state decisions will also affect how well these new programs mesh with existing ones that family planning and other safety-net providers have long relied upon. One area of potential difficulty is the set of indicators that providers will have to report on to meet the meaningful use standard. It is as yet unclear whether these indicators will be adaptable enough to reflect the standards of care under programs like Title X or set by medical provider associations or will be synchronized with other reporting requirements under Title X, the Sec. 330 program that funds CHCs or states' STI surveillance laws. The Family Planning Council's Herceg-Baron, for example, asserts that it continues to be challenging to extract from an EHR system the specific (and in some cases, unusual) data elements required by Title X (e.g., language spoken during the visit or contraceptive method in use at the time of a visit if the method was not dispensed at the visit). If designed appropriately, these federal standards could ensure that EHR vendors design their products to better aid providers in meeting all of their program requirements—or they could hinder that goal further.

Implementation of the stimulus provisions will, finally, have a substantial impact on the issue of confidentiality. All health care providers must worry about confidentiality, of course, and the stimulus provisions merely build upon earlier federal laws by including stepped-up enforcement measures, new privacy standards related to security breaches and authorization of a chief privacy officer at the Office of the National Coordinator to coordinate privacy standards at the federal level and with states, localities and foreign governments. Ensuring the privacy of health data will be a core priority addressed as federal and state regulators define meaningful use and set certification standards. In doing so, it is crucial that regulators take into account the reality of sensitive medical care, including reproductive health care (related article, page 12). PPFA, for one, has made public comments calling on regulators to help alleviate its clients' and providers' fears, by limiting information transfers to the minimum set of data needed; keeping control of personal data in the hands of the original health care provider and the patient herself; and preventing, detecting and punishing the misuse of data—not only for inappropriate or illegal economic ends, but also for political ends, such as threatening, harassing or sabotaging providers and their patients. The government must also help educate the public about the benefits and drawbacks of HIT, and about their rights in accessing and protecting their personal information.

Going forward, it is clear that investments in HIT are not only economically and programmatically wise, but probably necessary. Family planning providers are moving fitfully in that direction, but they face myriad challenges. Their ability to access dedicated HIT funding is paramount, of course, but implementation challenges also abound. Along with the advocates and policymakers supporting them, they will need to tread carefully as they navigate these stormy waters in the years to come. **www.guttmacher.org**