DEPARTMENT OF HEALTH & HUMAN SERVICES

JUL 1 2 2013

The Honorable Tom Coburn
United States Senate
Washington, DC 20510

Dear Senator Coburn:

Thank you for your letter to Secretary Sebelius requesting information about the Department's progress promoting federal health information technology (IT) adoption and standards. She has asked us to respond on her behalf. We also appreciate the white paper you prepared regarding effective taxpayer investments in health IT.

This letter addresses the Department's plans to achieve interoperability, control billing costs, prevent waste and abuse, protect patient privacy, and promote sustainability. The letter also addresses the questions raised in your April 16 letter.

Interoperability

As noted in your letter, the Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted in part to promote the effective use of electronic health records (EHRs) among hospitals, physicians, and other health care providers. The legislation also established the Office of the National Coordinator for Health Information Technology (ONC) to develop a nationwide health IT infrastructure aimed at improving health care quality and care coordination.

We have two overarching objectives as the nation moves toward improved health and healthcare through the use of information technology. First, we need to achieve the adoption of standardized health IT. Since the law's enactment, we have made progress towards achieving this objective. Overall, approximately 80 percent of all eligible hospitals and critical access hospitals and over half of all eligible professionals in the U.S. have received payment in the Medicare and Medicaid EHR Incentive Programs for successfully adopting, implementing, upgrading, or meaningfully using an EHR.[33] Nearly 90,000 providers eligible for the Medicaid incentive program have received initial payments for adopting, implementing, or upgrading a certified EHR. As of May 2013, more than 220,000 of the nation's eligible professionals and over 3,000 of the nation's eligible hospitals have achieved the requirements for Stage 1 Meaningful Use.[34] We know from the hospitals and clinicians that have achieved Meaningful Use that the payment provided a strong incentive for adoption and Meaningful Use, and it represents an important milestone of achievement.

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[33] *See* HHS News Release (May 22, 2013), http://www.hhs.gov/news/press/2013pres/05/20130522a.html.
[34] *See* CMS presentation to HIT Policy Committee (July 9, 2013), https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HITPC_July2013_Full_Deck.pdf.

Second, we want to ensure that systems that have been put in place are interoperable, which is why creating a path toward interoperability is our top priority. As your report points out, it is a daunting task to improve care coordination through secure and private health information exchange between hundreds of thousands of providers using disparate systems already in place, while accommodating changes in technology. However, we are making steady progress on this path through the use of multiple policy levers and substantial public-private collaboration.

The escalating stages of Meaningful Use and EHR certification criteria and standards are a critical component of our interoperability strategy. Stage 1 supported the systematic conversion of key medical information into structured digital format, while we forged consensus around initial national standards for secure communication between systems. We are working with industry to ensure that EHR technology will be significantly more interoperable when Stage 2 begins in 2014. ONC issued its 2014 Edition Standards and Certification Criteria final rule on September 4, 2012,[35] which defines the common content, format, and structured data that must be used in order for these systems to be certified. These standards support healthcare transactions, including laboratory and pharmacy communications and reporting to public health, cancer, and quality registries.

The standards also enable providers to securely share information as patients make a transition from one care setting to another, which is critically important to support patient care, ensure safety, improve quality, and lower costs. EHR technology developers have been working to incorporate these new standards into their products and test their ability to communicate with each other as part of a new and more rigorous certification program. These certified products will be available both to the hospitals and clinicians who will be using them to exchange information beginning in October 2013 and January 2014, respectively.[36]

Meaningful Use Stage 2 places a strong emphasis on electronic health information exchange with other providers. In Stage 2, both hospitals and eligible professionals will be required to send a summary of the patient's record electronically to the next provider of care following a transition of care to a new provider or care setting. Eligible professionals will also be required to communicate with patients through secure messaging (such as encrypted email) and make patients' health record information available to them electronically. These exchange requirements are important steps forward in advancing interoperability.

With respect to the emphasis placed on unified standards as part of the EHR certification process, we agree that there is an important federal role in recognizing national healthcare standards, and that the certification program authorized by HITECH is a critical tool in achieving interoperability across disparate, competing products. The EHR Incentive and Certification Programs already require the use of unified standards for recording important clinical information (e.g., problem list, medication list, medication allergy list, race and ethnicity, laboratory test results, etc.) as well as unified standards for the format and transmission of data.

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[35] This final rule is entitled "Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology" and is available at: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-20982.pdf.

[36] For the EHR Incentive Programs, hospitals are on a fiscal year cycle and eligible professionals are on a calendar year cycle.

As noted by the Bipartisan Policy Center Health Information Technology Initiative, the initial standards that clinicians need to support care transitions are, in general, "well supported by Stage 2 requirements." Furthermore, Stage 2 requirements, "…combined with delivery system and payment models, are increasingly creating the 'business case' for clinicians, hospitals, and other providers to begin sharing data electronically across organizational boundaries."[37]

There is significant work yet to be done on accelerating consensus on interoperability standards that enable additional healthcare information to be securely exchanged and used. The ONC Standards and Interoperability (S&I) Framework recognizes this and provides an effective forum for convening industry and experts in identifying unified solutions to high-priority interoperability challenges.

The S&I Framework is a collaborative community of participants from the public and private sectors who are focused on providing the tools, services and guidance to facilitate the functional exchange of health information. The S&I Framework uses a set of integrated functions, processes, and tools that enable execution of specific value-creating initiatives. Each S&I Framework initiative tackles a critical interoperability challenge through a rigorous process that typically includes:

- Development of clinically-oriented user stories and robust use cases;

- Harmonization of interoperability specifications and implementation guidance;

- Provision of real-world experience and implementer support through new initiatives, workgroups and pilot projects;

- Mechanisms for feedback and testing of implementations, often in conjunction with ONC partners such as the National Institute of Standards and Technology (NIST).

In addition to our efforts related to Meaningful Use of EHRs and standards adoption, The Department of Health and Human Services (HHS) has been increasing its emphasis on interoperability by leveraging HHS programs and resources to promote interoperability. For example, we enhanced the effective use of EHRs through programs such as the Blue Button Initiative, which encourages health plans and providers to make health information available to patients electronically. Over a million veterans have downloaded their own medical information through the Blue Button. Medicare beneficiaries can now use the Blue Button to download their Medicare personal health information from MyMedicare.gov and save it onto their computers. These records can be used by computer-based personal health management tools, or shared with other providers of the patient's choosing through technological mechanisms such as smartphones.

Furthermore, in March 2013, we released a Request for Information (RFI) that asked for input from industry, other stakeholders, and the general public to help us accelerate health information

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[37] Accelerating Electronic Information Sharing to Improve Quality and Reduce Costs in Health Care. Bipartisan Policy Center Health Information Technology Initiative, October 2012. http://bipartisanpolicy.org/sites/default/files/BPC%20Accelerating%20Health%20Information%20Excha nge_format.pdf

exchange across settings of care in order to support care coordination and delivery reform.[38] In this RFI, we recognized that some providers and EHR vendors may not yet have a business imperative to share person-level health information across providers and settings of care. To further accelerate and advance interoperability and health information exchange beyond what is currently being done through ONC programs and the Medicare and Medicaid EHR Incentive Programs, HHS is currently considering a number of policy levers that use existing authorities and programs. The overarching goal is to develop and implement a set of policies that would encourage providers to routinely exchange health information through interoperable systems in support of care coordination across health care settings, and the RFI discussed several potential options for this. We have received hundreds of comment letters and are reviewing them to identify the most effective activities we can undertake to further promote interoperability.

Costs and Medical Errors

We are also focused on the use of health IT in the context of controlling costs. As you noted, there have been questions raised about the intersection of clinical use of health IT and coding. While we recognize that there is always the potential for unintended consequences, we continue to believe that health IT has the potential to improve quality of care, patient safety, and reduce healthcare costs through the elimination of redundant tests and procedures and improved care coordination.

In light of concerns about the clinical use of health IT and coding practices, Secretary Sebelius asked the HIT Policy Committee – a federal advisory committee that advises ONC -- to study EHR documentation. As a result, the HIT Policy Committee conducted two days of hearings on a range of topics such as the role of clinical documentation from a clinician's perspective and the role of clinical documentation in care coordination. The HIT Policy Committee meetings were open to the public and transparent. We expect that the participating workgroups will draft recommendations for the HIT Policy Committee to consider. In addition, CMS and ONC held a public listening session on May 3, 2013, with a wide variety of stakeholders that represent physicians and other providers, hospitals, coding and billing specialists, and developers in the healthcare IT industry. Invited speakers focused on a number of issues pertaining to billing and coding for electronic health records, including the impact of EHRs on clinical documentation and the need to balance billing concerns with consideration of the usability and usefulness of the EHRs to providers. Additional information on this session is available on the CMS website.[39]

As the adoption and use of EHRs continues to grow, HHS will continue to monitor for any unintended consequences across the health system. The *Health IT Patient Safety Action and Surveillance Plan* ("Safety Plan" or "Plan") addresses the role of health IT within HHS's commitment to patient safety and builds upon the recommendations made in the 2011 Institute of Medicine (IOM) Report *Health IT and Patient Safety: Building Safer Systems for Better Care*. The Plan has two related objectives:

5. Use health IT to make care safer; and

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[38] https://www.federalregister.gov/articles/2013/03/07/2013-05266/advancing-interoperability-and-health-information-exchange.

[39] *See* http://www.cms.gov/ehealth/codingsession_may3.html.

6. Continuously improve the safety of health IT.

Consistent with the premise that all stakeholders share the responsibility to ensure that health IT is used to make care safer, the Plan leverages existing authorities to strengthen patient safety efforts across government programs and the private sector—including patients, health care providers, technology companies, and health care safety oversight bodies. It also lays out concrete steps to increase knowledge about the impact of health IT on patient safety and maximize the safety of health IT-assisted care.

ONC released the Health IT Safety Plan for public comment on December 21, 2012. The final version of the Plan was published on July 2, 2013. ONC is coordinating the implementation of the Plan through the ONC Health IT Safety Program.[40]

Oversight

We remain committed to preventing fraud, waste and abuse as we continue to oversee our health IT initiatives. CMS has used the Office of Inspector General's recommendations to inform its administration of the EHR Incentive Programs. CMS is currently engaged in several audit and review efforts to monitor physician self-attestation for EHR Incentive Programs Meaningful Use requirements. Beginning with attestations submitted during January 2013, CMS instituted pre-payment audits for Medicare providers. These pre-payment audits include random audits, as well as audits that target suspicious or anomalous data. For those providers selected for pre-payment audits, CMS will request supporting documentation to validate submitted attestation data before releasing payment. CMS will also continue to conduct post-payment audits during the course of the EHR Incentive Programs. Providers selected for post-payment audits will also be required to submit supporting documentation to validate their submitted attestation data.

If a provider is found not to be eligible for an EHR incentive payment based on an audit, the payment will not be issued (pre-payment audits) or will be recouped (post-payment audits). CMS may also pursue additional measures against providers who are found not to be eligible to receive an EHR incentive payment.

Your report also discussed whether some EHR vendors may be using improper business practices to effectively block the sharing of data, or make it difficult for customers seeking to transfer patient data to a new EHR system. We agree that such business practices are corrosive to a well-functioning market. To assist providers, ONC included a new provision under the ONC HIT Certification Program that requires EHR technology developers to notify providers about additional types of costs that they may need to pay to implement certified EHR technology in order to attempt to achieve Meaningful Use. We will continue to monitor these issues closely and consider both regulatory and non-regulatory approaches to address them.

Privacy

Your letter discussed the need to protect sensitive patient information in a cost-effective manner. We believe that patient trust in the privacy and security of their health information is

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[40] The Health IT Safety Plan is available at http://www.healthit.gov/policy-researchers-implementers/health-it-and-patient-safety.

fundamental for a successful transition to electronic health IT and electronic exchange of information. In order to provide and pay for health care and improve its quality, patient information is generated and exchanged with a variety of organizations according to federal and state privacy and security laws. Everyone who is involved in the health care sector (including the government, the developers, the plans, the providers, and the patients) shares the responsibility for protecting patient information. We address this complex issue from a number of different perspectives, three of which are detailed below.

First, HHS has issued rules that address the privacy and security of electronic individually identifiable health information. The Privacy Rule issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the use and disclosure of identifiable health information held by most health care providers. The HIPAA Security Rule requires covered health care providers to have administrative, technical, and physical safeguards for electronic individually identifiable health information. These protections are intended to ensure that health information remains confidential, that it is not inappropriately changed or deleted, and that it remains available. Performing a security risk analysis is a foundational requirement of the Security Rule. HHS requires providers to attest that they have conducted or reviewed such a security risk analysis as part of Meaningful Use under the EHR Incentive Programs.[41] To keep pace with the evolving e-health landscape, HHS recently has issued regulations under HITECH that expand the categories of organizations and people who are required to protect individually identifiable health information under the HIPAA Privacy and Security Rules. These regulations effectively extend the use and disclosure requirements of the Privacy Rule, as well as most provisions of the Security Rule, to the contractors of HIPAA-covered health care providers and health plans ("business associates"), including health information organizations, e-prescribing gateways, and others that facilitate data transmission, as well as their subcontractors.

Second, HHS has stepped up enforcement of the HIPAA Privacy and Security Rules. In calendar year 2012, the Department's Office for Civil Rights (OCR) investigated over 4,340 complaints alleging a violation of the Privacy and/or Security Rules, of which more than 3,360 were resolved through corrective action by the covered entity. OCR has levied more than $15 million in penalties and settlement amounts resulting from investigations of violations of the HIPAA Privacy and Security Rules since 2008. In addition, OCR piloted an audit program performing 115 audits of covered entities to assess compliance with the HIPAA Privacy and Security Rules.[42]

Third, HHS has taken steps to encourage developers to build security into their products. This will make it easier for health care providers to secure their health information in a cost-effective manner. In particular, in response to the HHS Office of Inspector General's Report referenced in your letter, ONC has included a number of examples of security-related capabilities that EHR

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[41] Additional information about the security risk analysis required under the EHR Incentive Programs can be found at http://www.healthit.gov/providers-professionals/ehr-privacy-security.

[42] For more information on the HIPAA Privacy, Security and Breach Notification Audit Program, see http://www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/index.html.

technology must have in order to be certified to the 2014 Edition Standards and Certification Criteria. To be certified (see 45 CFR 170.314), EHR technology must be able to:

- By default, encrypt the electronic health information stored on end user devices such as desktops, laptops, and smart phones;
- Authenticate users of the EHR technology system;
- Limit access to the EHR technology system;
- Record, by default, auditable events such as accessing data; and
- Produce an audit report.

In addition, HHS endorsed the OIG's recommendation that it use its leadership role to provide guidance to the health care industry on security best practices by developing and publishing a number of privacy and security technical assistance materials in a variety of easy-to-use formats, including short videos and training games. This material is available at www.healthit.gov.

Program Sustainability

The white paper discussed the sustainability of maintaining health IT systems after the initial HITECH grant money and incentive payments run out. As noted, the marketplace has seen increased rates of adoption and use of EHRs in hospitals and by health professionals. To foster additional market advancement and encourage widespread health IT adoption and integration into clinical practice, HHS has developed programs to assist providers and consumers with establishing the health information infrastructure necessary for the health care community to attain improved health care, improved population health, and reduced health care costs.

For example, a 2012 Government Accountability Office (GAO) report[43] found that Medicare providers working with Regional Extension Centers (RECs) were over 2.3 times more likely to achieve Meaningful Use than those who were not, demonstrating that RECs are valuable change agents in health care transformation. ONC believes that the RECs are uniquely equipped to support better quality care and lower costs by helping providers to identify, understand, and implement best practices, and through quality improvement initiatives, using health IT. RECs are supporting providers through education and technical assistance. This includes testing new payment programs; implementing patient portals, online scheduling and other systems that are designed to empower consumers; improving the privacy/security of their practices; and implementing other quality improvement and health IT optimization programs. For example: 64 percent of RECs are supporting providers to receive patient-centered medical home (PCMH) designations, 62 percent are providing support with interoperability and information exchange, 45 percent are supporting clinical quality improvement projects, and 17 percent are assisting providers to develop consumer engagement programs. Collectively, the RECs are working with over 85 percent of the nation's Federally Qualified Health Centers, over 50 percent of practices that are participating in the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care (CPC) initiative, and 58 percent of all PCMH providers certified by the National Committee on Quality Assurance.

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[43] GAO, *Electronic Health Records: Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011*, GAO-12-778R (Washington, D.C.: July 26, 2012).

Additionally, with the strong uptake of Meaningful Use of EHRs by providers in 2012, RECs are well positioned to continue to assist providers with the full implementation of Meaningful Use and further develop and implement other core competencies such as privacy and security assessments, health information exchange, and education. Supporting providers' efforts in the use of health IT to transform their delivery of care is a natural extension of their work to get providers to meaningfully use EHRs.

HHS is also committed to a multi-year and incremental, yet comprehensive approach to accelerating different types of health information exchange (HIE) in support of care coordination, quality improvement and value-based payment. Incremental steps to accelerate HIE will stem from Affordable Care Act delivery reform programs, physician fee-for-service payment, prospective payment to hospitals, long-term care providers, Medicare Advantage plans, and Medicaid reimbursement policy. The program-specific changes to accelerate information exchange will result in expanded patient access to their electronic health information, routine sharing of health information between hospitals and physicians, primary care physicians and specialists, nursing homes and hospitals, and community-based providers.

The Beacon Community Program also offers an important example of HITECH's investment to help communities generate a robust body of knowledge that can be shared broadly to improve care at the local level and ultimately inform national policy. Each Beacon Community represents a portfolio of activities with health IT as the foundation to support improvement and innovation across a single, yet diverse, community. Through the Beacon Community Program, lead grantee organizations were encouraged to come together with stakeholders from across their community and deliver a customized plan based on local priorities and unique local context. The foundation of the Beacon Community Program begins with patients and families and builds to include providers, hospitals, integrated delivery networks, and ultimately the full community. Thus far, the Beacon Community Program has impacted over 8.2 million patients' lives and involved almost 8,800 providers across 17 unique communities.

All 17 communities have been increasing Meaningful Use of EHRs and provider access to patient records through investments in exchange of health information. The insights of Beacon Community Program providers and hospitals are proving to be valuable in helping others understand how EHRs and exchange of health information can support better health and care coordination. For example:

- Several Beacon Communities (Rhode Island, Maine, and Colorado) are using data from EHRs to help physicians understand their own quality performance, and use the information to help target areas for improvement. Their experiences serve a critical role in providing evidence of what works in health care by understanding how EHRs can simplify quality reporting through better data collection, clinical measure calculation, and measure development;

- Several communities have focused on sharing information between hospitals and primary care practices at the time of transitions between care settings. As a result of their pioneering work in the realm of exchange of health information, Beacon Communities have been able to inform policy making on ways to support more robust exchange; and

- The ONC is supporting the Beacon Nation Project, an initiative funded by the Hawaii Beacon Community. Launched in February 2013, this project will draw on insight and experience from existing Beacon Communities to distill actionable information about specific technology-enabled solutions and provide implementation guidance. This information will be developed into *Learning Guides*, a common set of materials describing a promising IT-enabled intervention that can be deployed in a community to accelerate change and innovation.

In addition to helping to shape future stages of Meaningful Use and health IT policy, Beacon Communities are expected to continue to advance and adopt innovative, standards-based technology beyond the funding period that will continue to demonstrate how technology can support better health at lower costs.

More fundamentally, however, the long-term sustainability of provider investments in health IT will come as a result of the movement towards value-based purchasing by Medicare, Medicaid, and commercial health plans. Managing information for individuals and populations is essential for transforming care delivery and managing total cost. Managing populations over time requires Meaningful Use of EHRs, registries, quality reporting and feedback, information exchange across treating providers, data analysis and actionable information at the point of care. The market demands tools that manage the total cost of care and longitudinal health outcomes to achieve these goals. In addition, by adopting and utilizing health IT systems, hospitals and health professionals are investing in infrastructure that will yield long-term benefits that promote patient safety and address cost. We believe that while HITECH has accelerated and shaped the development of the necessary infrastructure to enable providers to meet this transformed delivery system, the business case for providing better care at lower cost will support and sustain these investments over time.

HITECH Contracts

Of the nearly $2.0 billion obligated under the HITECH Act, $267.2 million was obligated through contracts at the HHS organizations identified in Section 3011 of the HITECH Act (the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Indian Health Service). This amount is specific to contract obligations and excludes statutory transfers and EHR Incentive payments. The table below summarizes major HITECH contracting activity:

Spend Plan	Projects	Amount ($M)
Privacy and Security	- Enforcing updated HIPAA provisions - Strengthening privacy protections and security safeguards	$24.3
HIT Extension Program	- Providing technical assistance to RECs - Development and/or identification of best practices with the Health Information Technology Resource	$53.1

	Center	
Beacon Communities	• Providing technical assistance to Beacons • Conducting comprehensive evaluations	$15.5
Omnibus	• Development and harmonization of standards and tools • Evaluating and monitoring adoption and implementation • Supporting innovation and clinical decision support	$143.8
Health IT and Public Health	• Supported CDC efforts to create interoperability between public health agencies and providers	$30.6
Total		$267.2

Program Evaluation

Information about specific program evaluations related to HITECH is provided below.

Global HITECH Evaluation

The purpose of the Global Evaluation is to assess the overall progress towards the goals of the HITECH Act. This evaluation will examine the interactions of the programs in supporting EHR adoption and Meaningful Use as well as the resulting changes in health care quality and cost. Qualitative data collection efforts exploring the barriers and facilitators to EHR adoption and Meaningful Use include key informant interviews and case studies of how HITECH is unfolding in local markets. Quantitative analysis of data from the Medicare and Medicaid EHR Incentive Programs and Medicare claims will examine the growth in EHR adoption and Meaningful Use. The evaluation is being conducted by Mathematica Policy Research and the Urban Institute.

The Global Evaluation process is continuous, and evaluators produce quarterly monitoring reports that synthesize select statistics and activities relating to the implementation of HITECH. These reports are posted online.[44] Reports are available for the last nine quarters, beginning in January 2011.

Further information on the Global Evaluation can be found in the attached peer-reviewed paper: Marsha R. Gold, Catherine G. McLaughlin, Kelly J. Devers, Robert A. Berenson, Randall R. Bovbjerg. "Obtaining Providers' Buy-In and Establishing Effective Means of Information Exchange Will Be Critical to HITECH's Success." *Health Affairs*, March 2012.

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[44] Quarterly reports are available at http://www.healthit.gov/policy-researchers-implementers/reports.

State Health Information Exchange Program Evaluation

The State Health Information Exchange (HIE) Cooperative Agreement Program facilitates and expands the secure, electronic movement and use of health information among organizations according to nationally recognized standards. This program's evaluation will assess the implementation and impact of the State HIE Program through four main activities: qualitative research, quantitative research, a survey of laboratories, and evaluation technical assistance. The array of qualitative activities includes interviews with program leadership from 27 states, case studies, and provider focus group discussions in 5 states. Quantitative evaluation activities will leverage secondary data sources to assess changes in HIE measures at the state level. A national survey of clinical laboratories is being fielded to hospital and independent laboratories to assess the proportion of labs capable of sending structured test results and the total volume of test results sent electronically. In addition, each state's evaluation plan was reviewed as part of the national program evaluation, a resource document for state evaluators was developed, and a technical assistance webinar was hosted to support the state program evaluation activities. The State HIE evaluation is being conducted by NORC at the University of Chicago.[45]

Beacon Community Program Evaluation

Throughout the course of the Beacon Community Program, the ONC Beacon Program Office has been working with each individual community to monitor progress against community-level milestones. The Beacon Community Program defines success along three key dimensions: 1) success of each individual Community in achieving their program objectives, 2) evaluation of the full portfolio through an external contract, and 3) national dissemination of bright spots, critical challenges, and policy implications from the Beacon Communities.

ONC funds NORC at the University of Chicago to conduct a four-year national program evaluation. The evaluation continues through 2014 and uses qualitative, quantitative, and mixed-method approaches to characterize the Beacon Communities and assess the impact of their efforts to transform clinical care and care delivery. At least 14 of the 17 Beacon Communities are also undertaking at least one site evaluation. These evaluations are tailored towards each Beacon Community's intervention types and involve quantitative and qualitative measures.

Regional Extension Center Evaluation

The implementation and impact of the Regional Extension Center (REC) program is being analyzed using qualitative and quantitative methods. Qualitative data collection consists of case studies and focus groups of REC staff. In addition, a survey of small physician practices will be fielded. The survey instrument is currently being finalized. The survey will capture information on practices' experiences achieving Meaningful Use, including the technical assistance utilized by practices to overcome barriers to Meaningful Use and perceived impacts of Meaningful Use. In addition to the data from the survey, administrative program data will be used to assess program effectiveness. The evaluation is being conducted by the American Institutes for Research.

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[45] For further information on the HIE program, including individual case studies, please see www.healthit.gov/sites.
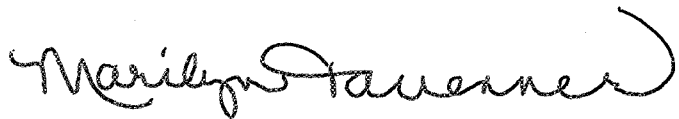
Disparities Report

On May 9, 2013, NORC at the University of Chicago, under contract to ONC, produced a report, entitled "Understanding the Impact of Health IT in Underserved Communities and Those With Health Disparities."[46] A copy of the report is attached to this letter. This report contributes to the understanding of how providers in medically underserved communities and communities with disparities can effectively implement health IT. It provides an overview of underserved communities and key functionalities of health IT and examines the potential impact of health IT in communities with health disparities. It also examines how health IT is being used to reduce and better manage chronic disease in these communities. The report also presents in-depth information about policies and programs used to increase adoption of health IT in communities with disparities, including strategies that underlie the programs and efforts to address barriers to health IT implementation. The report synthesizes nine case studies[47] and a briefing paper.[48] These materials are attached.

We appreciate your interest in these important matters, and we look forward to continued dialogue. This letter has also been sent to your co-signers.

Sincerely,

Farzad Mostashari MD, ScM
National Coordinator for
Health Information Technology

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services

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[46] The report is online at http://www.healthit.gov/sites/default/files/hit_disparities_report_050713.pdf.
[47] Case studies are available at http://www.healthit.gov/policy-researchers-implementers/health-it-and-disparities.
[48] The briefing paper is available at http://www.healthit.gov/policy-researchers-implementers/health-it-and-disparities.