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The Impact of Federal Stimulus Funding on Health Spending in Florida: Accomplishments and Challenges



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Gratitude

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Health care in Florida is benefiting significantly from the American Recovery and Reinvestment Act (ARRA). Of the total amount of ARRA funding, 22 percent, or \$4.36 billion, was devoted to enhanced federal matching payments to the state for Medicaid. Another \$88.6 million in ARRA funding was allocated to assisting community health centers, while some \$54 million was devoted to Health Information Technology. ARRA funding has also supported initiatives to reduce hospital-acquired infections and improve regulatory oversight to enhance patient safety.

A major challenge is to build on this work and achieve sustainable progress. ARRA funding will begin phasing down next year. The promising initiatives highlighted in this report have been seeded by the economic stimulus program, but if they are to blossom fully, the state will need to nurture and support them.

Key Recommendations

After analyzing state and federal data, interviewing stakeholders and culling data from relevant studies, the authors identified seven recommendations the state and private businesses can adopt to benefit health care in Florida:

1 Develop a plan to adjust to the phased reduction in ARRA's enhanced federal support for Medicaid. This should include a strategy to maintain vital services in the Medicaid benefit package and provide payment rates that will support an adequate network of physicians, clinics, hospitals and other providers, which is vital to the long-term viability of the Medicaid program. These measures should be part of the preparation for the enrollment of new populations in 2014.

2 Through enhanced data collection, use this planning period to learn about the complex medical needs of the people who would be newly enrolling in Medicaid, and then determine best practices in chronic care management to serve them.

3 Augment state efforts to redirect patients from emergency rooms for non-emergency care to primary care settings. Increasing the utilization of community health centers is a good place to start. This will improve health and save money.

4 Obtain greater funding for community health centers. The state should try to secure part of the \$11 billion funding under the new national health reform law for the many community health centers and school-based health centers that are struggling to obtain adequate funding as they serve a growing uninsured population and large numbers of Medicaid enrollees. The Low-Income Pool could also continue to provide funding for the centers.

5 Continue the momentum begun with ARRA support for reducing health care-acquired infections.

6 Ensure that the initial vision for moving from a paper-based to an electronic health care system stays on course and is implemented throughout the state. A critical component is to build an interoperable set of electronic medical records for all residents of the state, and to enable physicians and hospitals to pull up patient records and histories in real time as they are treating patients.

7 Sustain initiatives to build up an adequate and qualified health care work force to help assure that the state has enough primary care physicians, nurses, physician assistants, nutritionists and health information technology experts to meet the needs of a growing and aging population. This will be one of the biggest challenges as the state implements health reform.



INTRODUCTION & BACKGROUND

Introduction

The purpose of this report is to assess the impact of the federal government's \$20 billion economic stimulus funding in Florida on the state's health care system. Subsequent reports will focus on other aspects of ARRA funding, including investments in infrastructure and education.

Background

Congress enacted the American Recovery and Reinvestment Act in February 2009, with these stated goals:

- To preserve and create jobs and promote economic recovery.
- To assist those most impacted by the recession.
- To provide investments needed to increase economic efficiency by spurring technological advances in science and health.
- To invest in transportation, environmental protection and other infrastructure that will provide long-term economic benefits.
- To stabilize state and local government budgets, in order to minimize and avoid reductions in essential services and counterproductive state and local tax increases.¹

This federal legislation was passed and signed into law at a time when the U.S. economy was in a downward spiral. The gross domestic product was contracting at an annual rate of more than 6 percent and employment was falling by more than 750,000 jobs per month.²

With the economy contracting sharply and huge corporate layoffs announced almost daily, there was widespread agreement among economists and business experts that a substantial federal government intervention was needed. This took various forms, starting with the Troubled Asset Relief Program and continuing with ARRA. Federal Reserve System interventions aimed at quantitative easing and assuring the flow of credit



to businesses and households were also instituted. Congress enacted laws that were much smaller than ARRA and targeted to particular needs, such as the "Cash for Clunkers" program and extensions of Unemployment Insurance beyond what was called for under ARRA.

With respect to ARRA's overall impacts, a study by the President's Council of Economic Advisors found that ARRA raised the level of Gross Domestic Product (GDP) in the second quarter of 2010, relative to what it would otherwise have been, by between



2.7 percent and 3.2 percent.³ The Congressional Budget Office estimates the positive impact on GDP to be between 1.7 percent and 4.6 percent for the same period. Most stimulus impact estimates from independent economists are within this range. Blinder and Zandi estimated that ARRA boosted GDP growth by 3.4 percent as of the second quarter of 2010. James Glassman of J.P. Morgan Chase found that the stimulus had lifted GDP by 3.7 percent over this period.⁴

The Council of Economic Advisors also estimated that ARRA created or saved 2.5 million to 3.6 million jobs.⁵ Blinder and Zandi calculated that ARRA created or saved 2.7 million jobs.⁶ Estimates from Congressional Budget Office and private forecasters are somewhat lower than the Council of Economic Advisors, but still in the general range.⁷

The above estimates notwithstanding, there are prominent economists that challenge the methodologies used to calculate these estimates and argue that the medium- to long-term impacts on GDP are much lower – perhaps even negative.⁸ Harvard University economist Robert Barro has been critical of the federal stimulus program. Barro bases his pessimism on the likelihood that new government spending under a stimulus package will "crowd out" private investment and eventually require tax increases with adverse effects. Others fear that while new stimulus spending may be intended as temporary, it will not be scaled back when the economy recovers and add to an already large long-term federal deficit.

Large Numbers are Uninsured and Have No Regular Source of Care

According to figures released by the U.S. Census Bureau in September 2010, a little over 4.1 million people in Florida were uninsured in 2009, more than one of five of the 18.4 million residents of the state.⁹ In fact, an estimated 8 million people in Florida, including 800,000 children, lack a regular source of health care.¹⁰ The table below indicates that in 2009, Florida had a much higher rate of uninsured children than the national average. Moreover, Florida is second only to Texas in the proportion of its adult population that is uninsured. Some 3.3 million adults in Florida are uninsured.¹¹

Uninsured Rates in Florida in 2009

State	% of Children Uninsured	% of Adults Uninsured
Florida	17.9	26.6
Texas	16.5	28.5
US	10.0	18.8

Source: http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm.

About 12.8 percent of the state’s residents are enrolled in Medicaid, compared with about 15.7 percent nationwide.¹²

Underlying Causes of the Problem

The large number of uninsured results from a confluence of factors. First, Florida has stringent eligibility standards for Medicaid. For example, an individual must have an income below \$180 a month — \$2,160 a year — to enroll. *This means that an individual in Florida must have an income less than 20 percent of the federal poverty line to get into Medicaid.* Similarly, a family of four must have an income of less than \$364 a month, or \$4,368 a year for Medicaid eligibility (there is also an asset test). This is also equal to about 20 percent of the federal poverty line.¹³

In most cases, a family of four with an income as low as \$5,000 a year cannot qualify for Medicaid in Florida. Families with this level of income are extremely unlikely to be able to afford family health coverage, which in most cases would exceed and probably be twice as much as their total income. Moreover, the job-holders in most families with incomes this low do not work for an employer who offers health coverage. Many employees who work for employers that offer health insurance are not qualified for the coverage because they either work part-time or have not been with the company long enough. Other workers turn down their employer’s offer of coverage because they can’t afford their share of the cost.

Florida’s population is older than that of the U.S. as a whole, with 16.5 percent of Floridians receiving Medicare, contrasted with 12.4 percent of all U.S. residents.¹⁴

Florida should consider planning carefully for the implementation of national health reform because an estimated 1.6 million uninsured residents will be newly eligible for Medicaid in 2014.¹⁵ The state should use this planning period to learn about the complex medical needs of the people who will be enrolling in Medicaid, and determine best practices for improving their health and saving money.

In addition, Florida has a large number of part-time and seasonal workers (agriculture, tourism, fishing industries), who are in traditionally lower-wage jobs without health coverage. The state relies heavily on the construction and tourism industries, which were hit hard in the recession.

Florida also has a substantial undocumented population that has little access to health care except for emergency services.

The Florida health care system has been characterized by relatively low payment rates to providers, coupled with, and some would say leading to, a large volume of care and/or intensity of care, relative to national averages. For example, hospital care intensity — the amount of resources used in patient care during the hospital stay — in the last two years of life was 14 percent higher in Florida than for the US as a whole.¹⁶ ER use and uncompensated hospital care are high, and only partially offset by the combination of federal Disproportionate Share funds and the Low-Income Pool.

Florida is home to a few promising initiatives and programs to improve health care quality and patient safety. One example is the highly integrated Health First delivery system on Florida’s Space Coast. Another involves the quality initiatives of Memorial Health Care System, where two of the system’s five hospitals in Broward County scored in the top 1 percent of public and private U.S. hospitals on a composite of 23 process-of-care quality measures.¹⁷ AHCA’s Florida Center for Health Information and Policy Analysis is promising. The Central Florida Health Care Coalition, led by Becky Cherney, is a national leader in improving quality.

But there is much more work to be done in Florida to improve quality and patient safety. These examples are rather isolated and are not typical of care delivery or health-care purchasing across the state.

Against this backdrop, there was a real potential for ARRA funding to spur investments in 21st Century health care technology, quality improvement, and patient safety.

PART 2: ARRA'S IMPACT ON HEALTH CARE IN FLORIDA

This section focuses on the impact of ARRA on the health care sector in Florida. It concentrates on four important parts of ARRA investments relating to health care:

- Increase in the Federal Medical Assistance Program (FMAP)
- Expansion and modernization of community health centers
- Interventions to reduce hospital-acquired infections
- Investments in health information technology (HIT)

FMAP increase

ARRA provides for an enhanced federal match under Medicaid. Prior to ARRA, the FMAP in Florida was 55.4 percent. This is the proportion of total Medicaid spending that the federal government agrees to finance. Under ARRA, this proportion rose to 67.64 percent. This higher federal match will phase down over the first six months of 2011, after which the 55.4 percent rate will resume.

The enhanced FMAP in Florida is providing an additional \$4.36 billion in Medicaid funding for the state (total Medicaid spending is about \$19 billion per year in Florida). The \$4.36 billion represents about 22 percent of the total ARRA money flowing into the state and is the biggest single element of ARRA assistance for Florida.

ARRA FMAP required that states adhere to a “maintenance of effort” provision. This requirement translates into refusing to allow states to cut back Medicaid eligibility for the mandatory parts of the program. This means, for example, that states such as Florida that cover parents and children with incomes below certain levels cannot reduce those eligibility standards for these groups. Similarly, for the Aged, Blind, and Disabled populations, another mandatory group for coverage in Florida, eligibility standards must also be maintained.

Two Programs Saved Through FMAP Enhancement

That said, states are permitted to cut back or drop optional coverage under Medicaid even after accepting ARRA funds. Interviews with state officials conducted for this study indicated that the Medically Needy and MEDS-AD programs would have definitely received deep spending cuts or been eliminated without ARRA funding.

Medically Needy Program

The Medically Needy program provides Medicaid coverage to people who start out ineligible for the program, but because of a sudden illness, trauma, or the deterioration of their health as a result of chronic diseases, accumulate such substantial medical bills that they “spend down” into eligibility for the program. In effect, while their gross income would disqualify them for Medicaid, the huge medical bills that pile up during a serious medical crisis pull their real net income — gross income less medical bills —



down to a level that would qualify them for Medicaid. In short, even though they are not “categorically needy,” they become “medically needy.”

There is no income limit for the Medically Needy program (at least in terms of income before medical expenses). The asset limit varies from \$5,000 for an individual to \$8,500 for a family of eight.

In Florida, the budgeted caseload for the Medically Needy program for the state fiscal year 2010/2011 is 39,070. ARRA funding, according to our respondents, saved this program, and could be said to have helped this number of people hold onto their Medicaid coverage.

MEDS-AD Program

The MEDS-AD program provides affordable prescription drugs to two types of low-income people in Florida. The first group is people who are seniors but not participating in Medicare Parts A and B. These may be people who did not have enough quarters of earned income to qualify for Medicare. The second group is comprised of people who are in Medicaid and participate in one of the following types of Medicaid programs: (1) the Institutional Care Program — e.g. nursing home patients; (2) Hospice; (3) people receiving long-term-care services while living in the community through the Home and Community-Based Services waiver program; and (4) people receiving Assistive Care Services.

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Additional requirements assure that these programs are only available to very low-income state residents. For example, entrance into the MEDS-AD program requires that individuals have incomes below \$795 a month (\$9,540 a year) and assets less than \$5,000. Couples must have incomes below \$1,069 a month (\$12,828 a year) and assets less than \$6,000. The budgeted case-load for SFY 2010/2011 for this program is 37,035.

Interviews conducted for this study also found that the MEDS-AD program was scheduled for elimination just prior to ARRA. Thus, ARRA's enhanced FMAP has helped get assistance to lower-income seniors without Medicare and to those in need of long-term care services. The challenge now is to determine how to sustain this program as the economic stimulus money is withdrawn.

In summary, an estimated 76,000 Florida residents are receiving benefits under the Medically Needy and MEDS-AD programs and were helped by ARRA funding that preserved these programs. This funding was well targeted to financial need. Florida should try to retain state funding for these programs after the enhanced FMAP expires in June 2011.

Further, some specific optional health services under Medicaid were also probably preserved as a result of ARRA, according to our respondents. For example, dental services for adults — a perennial candidate for elimination not only in Florida but also in a number of other states — were preserved. This is an important effect because timely oral health services frequently help people maintain their overall physical health by avoiding dangerous infections and serious periodontal disease.

Another optional service that may well have been saved was chiropractic. This service sometimes substitutes for more expensive neurology and orthopedic services. Podiatry services are also optional and continue.

While the maintenance-of-effort requirements under ARRA prohibited states from reducing eligibility, they did not disallow provider rate cuts. Cuts in payments to physicians, hospitals, and other health care providers pose a serious long-term threat to the viability of the Medicaid program, in Florida and across the country.

Interviews conducted for this study indicated that it is very likely that the ARRA-enhanced FMAP spending either averted or at least reduced the size of further provider rate cuts. This would have had a favorable impact on access to care for Medicaid enrollees because continuous rate cuts discourage physicians and other medical providers from accepting Medicaid patients in their practices.

In the post-ARRA environment, Florida should recognize that maintaining adequate payment rates and an adequate provider network are vital to the long-term viability of the Medicaid program. The state should also assess the complex medical needs of the people who would be newly enrolling in Medicaid. This should be part of the preparation for the enrollment of new populations in 2014.



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Helping Community Health Centers Meet People's Needs

Another important set of ARRA-funded initiatives comprises support for community health centers (CHCs). Florida has 44 federally qualified community health centers (FQHCs) operating in nearly 300 locations. Centers in Florida received a total of \$88.6 million in ARRA funding, including grants of \$6.2 million to Project Health in Sumterville, \$4.8 million to Tampa Family HC, and \$3.7 million to Community Health of South Florida in Miami.

A medical homes model, as practiced in FQHC settings, is vitally needed in Florida. A recent study conducted by the National Association of Community Health Centers found that Florida experienced more than \$1 billion in avoidable health expenditures associated with avoidable emergency room visits in 2006 alone. At least one-third of all ER visits are 'avoidable' — that is, they are not for urgent care and treatable in primary care settings. Nationally, the use of community health centers could save Medicaid \$4 billion a year by reducing inappropriate use of hospital ERs.¹⁸

A strong body of evidence makes a compelling case that timely primary care improves health outcomes, reduces health care disparities, and substantially reduces total health expenditures.¹⁹

Florida should augment state efforts to redirect patients from the emergency room for non-emergency care to primary care. Increasing the utilization of community health centers is a good place to start. This will improve health and save money.

Florida's health centers serve an estimated one of nine state residents. Yet they struggle to keep up with rising demand, making them an appropriate target for ARRA assistance. Between 1996 and 2006, when the number of uninsured Floridians rose by 32 percent, the number of uninsured patients served by FQHCs rose by 51 percent.²⁰

By targeting ARRA funding on FQHCs, Florida is directly assisting many of the neediest and most vulnerable residents of the state.

ARRA funding is being used to establish three new health centers as well as to expand others. According to Andrew Behrman, President/CEO of the Florida Association of Community Health Centers, ARRA funds are being used to help centers bring on additional providers (e.g. one more physician, a dentist); expand facilities; add new services such as mental health and substance abuse treatment; expand hours of operation and work with hospitals on ER diversion programs (getting patients who use ERs for non-emergency care directed to a primary care site that can serve as their medical home).

CHCs have also received financial assistance from Florida's Low-Income Pool, which primarily funds uncompensated hospital care. About \$18 million in Low-Income Pool funding is directed to FQHCs this year. This money, plus ARRA funding, has helped the centers meet the large increase in demand for their services associated with the economic downturn and the rising number of uninsured.

Florida Community Health Centers, Inc.

An example of ARRA funding helping a community health center can be found in central Florida (West Orange and Lake counties). Community Health Centers, Inc. operates a network of 10 clinics serving 46,000 patients a year who make some 161,000 visits. This network provides medical, dental, pharmacy, pediatric and obstetric services.



Using \$1.9 million in ARRA funds, this organization is:

- Building a new dental clinic and adding pediatric dental services.
- Building six new exam rooms
- Updating and modernizing facilities
- Installing a new telephone system and upgrading all of the telecommunications systems to form a centralized call system for all of the clinics. With an average of 6,000 calls a week, this new system allows them to identify "peak-load" times and adjust their staff deployment accordingly.

For information, contact: Tanya Stewart, Community Health Centers, Inc. tstewart@chcfl.com.

The new national health reform law provides \$11 billion for community health centers and school-based health centers. Florida should work to obtain funding under this law for the many CHCs in the state that are struggling to obtain adequate funding as they serve a growing uninsured population and large numbers of Medicaid enrollees.



It is clear that ARRA investments have helped a number of community health centers expand and modernize their facilities and add vital services. *A key challenge going forward will be to help the CHCs maintain and operate at the expanded levels. ARRA funds, for example, helped CHCs with some important capital costs — for a new wing, new dental chairs, or needed repairs. But the clinics will have to cover the operating costs of these investments after ARRA funding winds down. This may require support from other sources.*

For example, as noted earlier, the new funding for CHCs in health reform could help maintain the progress to date and extend these promising models to other communities in Florida. The Low-Income Pool fund in Florida has recently provided some funding for CHCs even though the primary focus of this pool of money is on assisting hospitals. This could be a platform for further support in a post-ARRA environment.

Sun Coast Community Health Centers

Sun Coast Community Health Center is a network of FQHCs in Hillsborough County, encompassing the Tampa/St. Petersburg metropolitan area. Sun Coast operates three full-service community health centers in the Tampa region — Ruskin, Dover, and Plant City. These centers provide comprehensive health services, including pediatrics, family medicine, women's health, radiology, pharmacy, and general dentistry.

Sun Coast has benefited from Hillsborough County's designated revenue source for funding indigent health care. The county has a half-cent sales tax that provides funds for uncompensated care to two hospitals, Tampa General and St. Josephs, and to the FQHCs. But like most CHCs, the Tampa area's centers serve primarily uninsured and Medicaid patients, with the former bringing no payment source and the latter paying well below commercial payment rates.

ARRA-funded projects

ARRA funding is making the following projects possible:

- At the Plant City pediatric facility, ARRA funding is establishing five new exam rooms. It is also covering the cost of expanding to evening and Saturday hours.
- At the Plant City adult care facility, as many as five additional dental chairs are being put in.
- At the Ruskin facility, a complete renovation is about to start that will add 700 square feet of space. ARRA funding will also make possible the conversion from well water to city water and sewer services, yielding savings to the center. In addition to the expansion, the new facility is being renovated. It will now be more accessible to people with disabilities, and it will have a new sprinkler system, and more energy efficiency. As part of this renovation, the center will also continue the work it has already begun toward converting to electronic medical records.
- Twelve new exam rooms are being added at the Ruskin facility.

Sun Coast is also finding ways to bring health care directly to community residents. Using state funding, the organization has acquired a portable dental van. This van has three dental chairs and is going door-to-door in under-served communities to provide children with varnishes, dental sealants, and cleanings. If the exam detects a need for restorative work, referrals are made to community health centers.

The next step for Sun Coast is to apply for funding to purchase a truck that would bring dental care, including major restorative work, to these communities. The Plant City health center is also conducting "dental care fairs" on Saturdays, providing dental screenings for kids and instructing parents on how to work with the children on oral health.

For further information, contact: Brad Herremans and/or Bob Rodriguez; Sun Coast Health Centers. 813-349-7568.



Reducing Health Care-Associated Infections

ARRA stimulus funding has launched an important new statewide initiative to bring down the rate of several kinds of health care-associated infections. HAIs, as they are known, are estimated to occur in 5 percent of all acute-care hospitalizations. The incidence of HAIs is more than 2 million cases per year.²¹ Such infections are highly dangerous and very expensive.²²

The Agency for Health Care Research and Quality has demonstrated that implementing Centers for Disease Control and Prevention's HAI prevention recommendations can reduce these types of infections by 70 percent, and virtually eliminate some types of infections. In addition to reducing patient suffering, avoiding these infections holds the real potential to reduce health care spending.

The Florida Department of Health is taking the lead in forming collaboratives across the state to reduce HAIs. The department received ARRA funds via a grant from the Centers for Disease Control and Prevention (CDC) to address the monitoring and prevention of HAIs. The CDC funding runs through December 2011. The main components of this initiative are:

- Program management, in concert with a multi-disciplinary statewide advisory board
- Surveillance of HAI and promotion of the National Health Care Safety Network
- Establishment of Regional Prevention Collaboratives
- Certification of professionals in infection control.

This new project enables Florida to consolidate and coordinate several program initiatives that had been operating more or less in isolation. Best practices from other states, such as Michigan's program to reduce urinary tract infections, conducted in cooperation with Johns Hopkins University, can be brought to Florida. Dr. Peter Pronovost of Johns Hopkins University has helped save countless lives by developing and promoting the simplest of management tools: a checklist for preventing hospital-acquired infections. Michigan hospitals began implementing his checklist in Intensive Care Units in 2003. Within three months, hospital-acquired infections in a typical ICU in the state fell from 2.7 per 1,000 patients to zero — and sustained spectacular results for years.²³ Various sets of best practices can be combined, including linkages between health information technology initiatives (described below) and infection control. Electronic records, for example, can help reduce infections.

The infection control programs also represent a good working partnership between the Department of Health and the Florida Hospital Association.

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Florida is working closely with and relying upon the National Health Care Safety Network as a key source of guidance and support for the ARRA-funded projects. The network is a voluntary, secure, internet-based surveillance system that integrates patient care and health care personnel safety surveillance systems managed by the Division of Health Care Quality Promotion at CDC. The network has the capacity for health care facilities to share data in a timely manner either within a hospital system, for example, or across systems. CDC collaborates with federal and national partners to create standards that will prevent duplication of efforts at facilities, reduce reporting burdens, and harmonize performance measures.²⁴

This National Health Care Safety Network program forms the backbone of Florida's initiative to provide every hospital in the state with access to best clinical practices with regard to avoiding serious health care-associated infections. Florida can discover what is working in other parts of the country and, with appropriate adaptations for local circumstances, bring the lessons learned into the local delivery systems.

Florida's advisory board of partnering organizations and technical experts is providing guidance to the state Department of Health on the implementation of the infection prevention programs. The long-term vision is to have a state without health care-associated infections. This will require a culture of patient safety and training of personnel in best practices, as well as coordinating care across a continuum as patients move from one setting to another.

The U.S. Department of Health and Human Services has developed five-year prevention targets for HAI. From this set of targets the Florida Department of Health has selected three for this ARRA-funded initiative:

- Central line-associated blood stream infections
- Catheter-associated urinary tract infections
- Clostridium difficile

Collaboratives set up for each of the infection control programs will require participants to provide senior-level support and leadership through letters of commitment and the establishment of teams to implement prevention strategies. One such collaborative was established to reduce urinary tract infections (UTIs) in Florida's hospitals. Ten hospitals and 10 skilled nursing facilities will be selected to participate in this collaborative. The goal is to achieve a 25 percent reduction in UTIs, and to eliminate these infections in the emergency departments, by the end of 2012. Another goal is to achieve a 50 percent reduction in urinary catheter days per patient over the same time frame in one or more units of hospitals participating in the collaborative. The hospitals will use evidence-based prevention strategies and serve as a pilot group for the National Health Care Safety Network program. As part of the ARRA support, these Florida hospitals using new approaches to reduce UTI will provide mentoring to other Florida hospitals newly using these strategies.²⁵

This translates into many residents of Florida avoiding the suffering and long-term threats to their health that are frequently associated with these infections. It also has the potential to translate into real cost savings across the state.



Florida should continue the momentum begun with ARRA support for reducing health care-acquired infections.

Enhanced Regulation and Oversight of Health Care Facilities

Another use of ARRA funds in the health care field involves augmented regulation of health care facilities. The Agency for Health Care Administration (AHCA) obtained ARRA funding from the Centers for Disease Control and Prevention (CDC) to step up its surveillance of ambulatory surgical centers.

This grant resulted from concern at the Centers for Medicare and Medicaid Services (CMS) about threats to patient safety in these surgical centers. The source of those concerns was a serious medical error in Nevada two years ago. This involved re-using single-use vials for injections at surgical centers in that state. Not only were some patients getting vials re-used from an earlier injection that they had received, but far more dangerously, patients were getting injections from vials re-used from other patients. This raised serious alarms about contamination and the spread of infectious diseases.

Based on this concern, CDC developed a new survey of the states and CMS launched an infection control pilot project covering Arizona, Maryland and New York and aimed at ambulatory surgery centers. The pilot project found other problems and concerns related to infection control, including those related to sterilization of surgical supplies. In fact, 40 percent of the FY 2009 survey sites reported deficiencies or complaints related to patient safety.

In this context, ARRA funding was instrumental. CDC asked for states that might be willing to try out the new survey process and provided a modest amount of funding to cover the cost. Florida was eager to volunteer but needed financial support to participate. AHCA received about \$16,000 in ARRA funding to cover the cost of conducting three surveys, beginning in federal fiscal year 2009. AHCA agreed to use the federal (CDC) format. ARRA support was also used for state-conducted provider training and training of workers regarding fielding a web-based survey.

Stepping Up State Oversight

Based on the findings of the survey, and ARRA funding, AHCA was able to hire additional workers and roughly triple its oversight of safety precautions at ambulatory surgical centers. Instead of sending one inspector to visit the surgical centers on site for one day, AHCA was able to step the effort up to send three people out for three days, per site visit. This extra amount of time and personnel enabled the state employees to evaluate the safety procedures and policies with greater depth.

Furthermore, the state doubled the number of site visits. Thus, while they had previously visited 16.5 percent of the surgical center sites, they were now able to conduct site visits/inspections at about one-third of all sites (33 percent).

The bottom line: ARRA funding enabled the state regulatory oversight to become both more extensive (two to one on the number of sites) and more intensive (three to one level of effort per site).



The more intensive nature of the site visits led to a better understanding of the overall process of assuring safety at each stage of patients' experience with the ambulatory surgical centers. This involves, for example, check-in, preparation for surgery, the surgery itself, and the recovery. Inspectors could make a "check list" of safety procedures.

The added oversight illustrated the notion that the more you look, and the more closely you look, the more you are likely to find. Thus, while the 2009 survey found a 40 percent rate of deficiencies, as noted above, this figure jumped to 69 percent in the recently completed 2010 survey. Moreover, 42 percent of those deficiencies were serious enough to put the sites in jeopardy of losing Medicare and Medicaid participation if not fixed within 90 days, compared with only 8 percent of the deficiencies found in 2009. Further, a sizeable number of the deficiencies found in 2010 were so serious that the facilities were given only 23 days to correct them or be dropped from participation in Medicare and Medicaid.

Examples of the prevalence of various types of deficiencies:

Frequency of Various Types of Citations for Deficiencies in Florida Ambulatory Surgical Centers

Description of Deficiency	Number of Times Cited
Administration of Drugs	54
Infection Control Program Direction	42
Admission Assessment	36
Infection Control	35
Form and Content of Record	34
Sanitary Environment	34
Pre-Surgical Assessment	33
Governing Body and Management	32
Discharge Order	31

Source: Florida Department of Health, 2010.

The direct impact on jobs emerging from this effort was that five new positions in state government were filled. ACHA is hopeful that these will turn into permanent positions.

Florida Health Information Technology Exchange and the Stimulus

The Health Information Technology for Economic and Clinical Health Act was enacted January 6, 2009, as part of the American Recovery and Reinvestment Act (ARRA) effort to improve the nation's health system by investing in health information technology (HIT).²⁶ The Office of the National Coordinator for Health Information Technology in the Department of Health and Human Services was charged with overseeing the implementation of a nationwide HIT infrastructure that will allow for the electronic use and exchange of health information. The national coordinator wants to build a secure and interoperable system that improves quality; reduces medical errors; supports provider decision-making in real time; ensures meaningful public input; promotes prevention, early detection, and management of chronic diseases; and reduces total spending.²⁷

Under federal regulations released in July 2010, physicians and hospitals will have five years to demonstrate "meaningful use" of HIT. To achieve meaningful use, these providers will need to demonstrate that they have mastered the use of electronic medical records and are using them in their practices. These electronic records would enable the providers to see a patient's full medical history as they examine that patient, including care received in other settings. They would also enable providers to schedule appointments; send patient reminders; receive lab and other test results; and share notes with other physicians, nurses, etc., to integrate their care for each patient.

Providers achieving meaningful use must demonstrate that they can use electronic health record technology in a way that improves quality, patient safety, and the efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination and public health; and ensures adequate privacy and security protections for personal health information.²⁸

Why Is HIT Important?



There is widespread agreement that the United States relies on a paper-based medical records system. This system has been known to lead to medical errors, missed opportunities to improve patient care, unnecessary costs and threats to patients' health (i.e. prescribing medication that may interact dangerously with another medication that a patient is taking). One study conducted by Health Grades, an independent health-care ratings company, found that from 2006-2008 nearly 1 million patient safety incidents occurred among 39.5 million inpatient hospitalizations. The cost of these

incidents was estimated to be \$8.9 billion. Patients at hospitals in the top 5 percent on quality experienced 43 percent fewer patient safety incidents, on average, compared to poorly performing hospitals. If all hospitals performed at the level of those in the top 5 percent, 218,572 patient safety incidents and 22,590 deaths could potentially have been avoided, saving \$2 billion from 2006-2008.²⁹ Health Grades is a national organization that provides ratings of hospitals, physicians, and nursing homes to consumers, corporations, health plans, and hospitals.

While the use of health information technology has certainly increased over the past few years, hospitals are still far from adopting a universal system. In a 2006 survey conducted by the American Hospital Association, only 11 percent of hospitals reported having fully implemented electronic medical records, while 57 percent had "partially" implemented systems and 32 percent had not yet started. Moreover, physicians in only 10 percent of hospitals routinely ordered medications electronically at least half the time.³⁰

One study estimated that the widespread adoption of HIT could lead to potential savings for both inpatient and outpatient settings that would average \$77 billion per year.³¹

Florida should ensure that the initial vision for moving from a paper-based to an electronic health care system stays on course and is implemented throughout the state. A critical component is to build an interoperable set of electronic medical records for all residents of the state, and to enable physicians and hospitals to pull up patient records and histories in real time as they are treating patients.

Through electronic bar coding of hospital-delivered medications, HIT can avoid giving a patient the wrong drug, or the correct drug in the wrong dosage. By allowing physicians to see the latest information about best practices in treating the disease a patient is presenting, HIT can improve the physician's ability to correctly diagnose and treat that patient. By allowing members of a provider team to share notes on a patient in a secure electronic environment, HIT can foster team-based care. HIT can also show a physician that a test being considered has already been done (and display the results). These are just some of the many ways that HIT can improve health and lower long-term spending.

The Importance of Health Information Exchanges

The formation of Health Information Exchanges (HIEs) is intended to mobilize health-care information electronically across organizations within a region, community, or hospital system. The goal is to facilitate access to clinical data and the ability to quickly retrieve it in a secure, timely way. An effective HIE should reduce paperwork, duplicate tests, faxing of documents, telephone calls, and missing patient information.

HIEs are being organized both by government agencies and by independent organizations. Florida is organizing a statewide HIE, which will be discussed below. The government also sponsors regional versions of HIE, frequently called Regional Health Information Organizations, or RHIOs. These RHIOs are geographically organized entities that develop standards for HIEs, prepare for the electronic exchange of information, and establish contractual arrangements among the participating parties.

These regional initiatives can promote better health outcomes and lower spending by establishing a central repository of information on patients' health, sharing information among physicians, nurses, and hospitals, to avoid duplication of services, establish team-based and individualized care plans, and reduce medical errors. All of these outcomes, if they can be achieved, will lead to better health for the residents of Florida, and lower total health spending in the state.

The Florida HIE Initiative

To work toward the national goal established under the Health Information Technology for Economic and Clinical Health Act, ARRA provided \$2 billion in grant funding for states to develop HIEs and facilitate the adoption of electronic medical records in an interoperable system across various communities or regions. ARRA also mandated the adoption of national standards and policies.³² Under ARRA, the Secretary of Health and Human Services is directed to spend \$300 million of the \$2 billion fund to establish more HIE initiatives in regions and cities as well as helping existing HIEs in connecting providers.³³

On March 15, 2010, the Florida Agency for Health Care Administration received \$20.7 million in ARRA federal funding to be used over a four-year period for the purpose of supporting a statewide HIE initiative.³⁴

The purpose of this HIE project is to develop a Florida statewide health information technology plan. Florida chose to work through the Medicaid program, but the system applies to the records of people insured by Medicaid, Medicare, and commercial payers, as well as patients who buy coverage on their own or who are uninsured. Medicaid is the source of the incentive payments for providers, discussed below, and AHCA is the lead agency for developing the statewide HIE.



Planning objectives for the statewide health information technology (HIT) include the development of an 'As-Is' landscape for HIT activities (e.g., where do it stand now?); the development of a vision or 'To-Be' for HIT activities through 2014; the identification of specific actions necessary to implement the incentive program; and the creation of a road map of steps to move from the 'As-Is' to the 'To-Be' HIT landscape.³⁵

Under ARRA, Florida has established a number of projects and initiatives to move toward a statewide HIE. The specific projects that will be discussed in the following section are:

- **Establishing Regional Extension Centers:** these centers enable the coordination and training of health care providers to become "meaningful users" of HIT.
- **Expanding broadband:** this is required in order for HIE to be possible in rural and hard-to-reach areas.
- **Creating financial incentives for providers to adopt EHRs:** Medicare and Medicaid incentive payments will help physicians and hospitals move to an electronic system.
- **Developing HIT Workforce Initiatives:** an effective HIT system must have a workforce trained to use it.

An important challenge is to sustain the initial progress that will be described below:

1. Establishing Regional Health Centers³⁶

Section 3012 of ARRA provides funding for support to Health and Human Services to support regional extension centers. RECs, as they are known, will provide technical assistance across a region to accelerate the adoption of electronic health records in a way that is interoperable. The funding for the RECs is expected to assist health care providers adopt, implement, and effectively use certified electronic health record technology. In August 2009, the Office of the National Coordinator announced a grant opportunity in the form of cooperative agreements with not-for-profit entities. Thirty-two RECs have been awarded funds nationwide as part of the ARRA investment in advancing the use of HIT.³⁷

In February 2010, Health and Human Services Secretary Kathleen Sebelius awarded ARRA grants totaling \$33 million to four Florida institutions to develop and implement RECs throughout the state in order to further the statewide HIE initiative.

Health Choice Network (HCN) was awarded \$8.5 million of ARRA money to establish a South Florida Health Information Technology Regional Extension Center (SFREC). HCN was the first REC to be funded in Florida. HCN is a nonprofit organization that serves as the umbrella for a network of community health centers in South Florida. HCN coordinates shared risk agreements with partner Health Maintenance Organizations to manage the continuum of care for patients. HCN maintains a centralized information technology environment serving all of its health centers with links to pharmacies, laboratories, hospitals and the Medicaid eligibility system.³⁸ The key goals of HCN's ARRA grant include:

- 1) Identifying and recruiting physicians who need help with implementing electronic health records (EHRs) and meeting the requirements of Meaningful Use
- 2) Implementing EHRs
- 3) Achieving "Meaningful Use" criteria

HCN formed a collaborative including major safety net hospitals, community health centers, and county health departments. In its first year, HCN signed up some 1,500 health care practices. This includes primary care physicians, internists, pediatricians, and obstetricians/gynecologists in individual and small practices. The 1,500 physician organizations became charter members of the REC, receiving technical assistance at no charge, a readiness review, and positioning for Medicare and Medicaid financial incentives related to achieving meaningful use.

HCN requested proposals for EHR incentives and received 40 responses. HCN is now putting together a "preferred vendors list." This list will allow HCN to choose vendors that will help support the community in implementing EHRs and help promote job creation. For example, HCN will hire 20 full-time-equivalent Extension personnel to help support the functions of the RECs.

The goal for South Florida, as defined by the national coordinator, is to recruit 15,000 physicians to become members of the South Florida REC by the deadline of the first Tollgate, which is February 2011. Tollgates involve different "doors" that physicians can pass through, reflecting successful training on the adoption and use of electronic medical records and other key elements of health information technology. The regional health center must help all 15,000 physicians achieve meaningful use of EHRs. The role of the regional center is to provide leadership to community health providers in both clinics and office-based practices and help them feel comfortable in achieving EHRs and choosing and working with vendors.

The goal is to update the skills of EHR users, make them comfortable in sharing data, and certify that the EHRs meet top-level standards. The achievement of these goals will help HCN work with providers to meet quality metrics and goals, in such areas as reducing avoidable hospital readmission rates, meeting best-practice targets for treating heart attack victims, reducing hospital-acquired infections, and getting lab results back on time.

The initiative in South Florida to bring a large number of physicians into meaningful use of EHRs and the formation of an interoperable system where information can be securely exchanged among providers and used in their real-time medical practices, yields the potential to improve patient outcomes and reduce total health care spending. For this to occur, however, the various participants in this important "HIT laboratory" will need to find the funding to make this effort sustainable over many years.

For further information, contact: Lisa Rawlins, Executive Director, South Florida Regional Extension Center; Kevin Kearns, President and CEO, Health Choice Network, 305-599-1015.





Other RECs in Florida

The Community Health Centers Alliance was awarded \$10.9 million of ARRA money to lead the efforts to develop and implement the Center for the Advancement of Health IT REC, also known as the Rural and North REC. Community Health Centers Alliance is collaborating with other nonprofits and primary care providers to help physicians, nurses, and other health professionals achieve meaningful use of HIT by 2014.

One of the partners participating in this REC is the Big Bend RHIO, operating throughout the Florida Panhandle and down the peninsula to Gainesville. Tallahassee Memorial Hospital and Capitol Regional Medical Center in Tallahassee are participating, along with various community health centers and physician group practices.

The Big Bend RHIO has an estimated 500 participating credentialed providers (about half physicians and half physician “extenders,” i.e. nurse practitioners and physician assistants), serving about 500,000 patients. This secure, credentialed “community-wide portal” receives about 15,000 queries a month and provides electronic referrals and clinical data. *The most important outcome of this work is that the architecture of the central repository provides physicians and hospitals with longitudinal records of patient-specific information in real time as they are diagnosing and treating patients.* A physician seeing a patient, for example, could at a glance know that this patient was hospitalized last year, and for what reason, and that the patient had a certain type of lab work done recently (and see the results), and also had a CT scan (with the following results). All of this information forms a quick and easily accessible medical history that can be brought to the office as the patient is being seen, as opposed to the physician thumbing through endless paperwork

from his or her own charts, and of course, not knowing the results of treatment outside of this particular office.

Another REC in Florida was organized by the University of Central Florida, College of Medicine, which received \$7.6 million of ARRA money to help central Florida doctors develop and effectively use EHRs. The University of South Florida

also received \$6 million to develop and implement another REC, which is called PaperFree Florida.

Key Challenges

One of the challenges in running a REC is getting the data shared among providers. Some providers fear that sharing health information data may be used against them and may threaten the viability of their practices. The key question is getting the critical mass of physicians to accept the meaningful use of EHRs. Doctors should feel that they are losing out if they are not part of the EHR system, and they should also understand the positive benefits.

Many physicians are frustrated by what they see as continuous cuts in reimbursements, particularly from the public payers, and wonder why they are being asked to invest in HIT even as their reimbursements are held down or reduced.

Sustainability is also an issue. After two years the ARRA funding for the RECs will diminish significantly. The key question of sustainability is how the RECs will continue to create value so that providers keep supporting them after the ARRA funding ends. The ARRA money is meant to “jump start” the RECs and get them to a viable position with a critical mass, but not to provide long-term financial support.

RECs play a critical role in the adoption of EHRs. Electronic health records will help reduce the duplication of care and avoid medical errors. The leaders of the RECs and RHIOs in Florida hope that the meaningful use of EHRs will save Medicaid and Medicare, as well as employers and individuals, a significant amount of money.

PART 2: ARRA'S IMPACT ON HEALTH CARE IN FLORIDA

2. The Broadband Initiative

Using ARRA funding for smart investments in technology can be seen in Florida's efforts to expand internet bandwidth in underserved areas. Many rural communities, for example, do not have enough bandwidth to enable the exchange of large amounts of information. Without adequate broadband capacity, HIT development could be impeded from reaching its full potential.

Congress decided to include funding in ARRA to implement an initiative to expand broadband to rural and underserved areas. The National Telecommunications and Information Administration, which is an agency of the U.S. Department of Commerce, was given \$4.7 billion in ARRA appropriations to establish a Broadband Technology Opportunities Program to award grants to develop and expand broadband services in rural and underserved areas.³⁹

In parts of rural Florida, the broadband capacity is well below the level needed for HIE to be effective.⁴⁰

One of the new initiatives is led by AHCA, which along with the State Libraries and Archives of Florida and the Florida Learning Alliance, received an ARRA grant of \$3.8 million to form the Broadband Telecommunications Opportunity Program and the Broadband Sustainable Adoption Grant program. These programs bring broadband services awareness, education, and training programs to 32 rural counties, and are expected to reach 2 million Florida residents.⁴¹ The programs emphasize improving awareness among the public through statewide public service announcements, television programming, web-based and written material distributed in schools and libraries, website links through hospitals, clinics, and state agencies, health IT Regional Extension Centers, and presentations to key stakeholders in schools, libraries, health care facilities, and venues.⁴²

AHCA's role is to oversee the curriculum and educational components involving implementing EHR systems and the adoption of HIT for telemedicine, telehealth and HIE.⁴³ This outreach will provide needs assessment data on public knowledge about broadband, the services it facilitates, subscribership, and their major areas of interest about broadband.⁴⁴

A second initiative pre-dates ARRA. In November 2007 the Federal Communication Commission (FCC) awarded \$9.6 million (as an 85 percent contribution requiring a 15 percent match of \$1.7 million) to the Big Bend RHIO to build a broadband network connecting rural hospitals and clinics in the Florida Panhandle.⁴⁵ The aim is to connect 10 rural hospitals and four urban hospitals in a broadband, optical fiber network, and then connect nonprofit clinics using wireless broadband technologies.

With the assistance of AHCA, the project was awarded the funding to cover the state's required match for the FCC-sponsored project in the form of a Rural Infrastructure Grant from the Governor's Office of Tourism, Trade and Economic Development, allowing construction to begin.⁴⁶ Big Bend's efforts will aid in establishing and improving an electronic records system (i.e. clinical health records, laboratory reports, medication history, and digital reporting); creating a master patient index, a master provider index, record locator services, and clinical record exchange); e-prescribing, and allowing for paper records to be scanned and retrieved from a record repository.⁴⁷



3. Medicare and Medicaid Electronic Health Record Incentives Program

ARRA provides state grant funding and monetary incentives to physicians, hospitals, and other health care providers for the adoption of EHRs.⁴⁸ Eligible providers⁴⁹ must become “meaningful users” of EHRs over a specified period and may choose to receive incentive payments from either Medicare or Medicaid, but not from both. Achieving meaningful use is a prerequisite for health care providers to receive incentive payments.⁵⁰

The standard full amount of Medicaid incentive payments that an eligible provider could receive is larger than the standard full amount for the Medicare eligible provider incentive payments: about \$65,000 versus \$44,000 for Medicare.⁵¹ Hospitals meeting Medicare meaningful use requirements are deemed eligible for Medicaid incentive payments and can receive payments for both Medicare and Medicaid.⁵²

Medicare will provide \$18,000 in incentive payments to eligible providers in the first year for physicians that demonstrate meaningful use of EHR in 2011 or 2012. Incentive payments of \$15,000 for the first year will be available to physicians that begin using EHRs by 2013 or 2014. The payments continue to decrease over time with the exception that those incentive payments will be increased by 10 percent if the provider predominantly serves patients in areas designated as a “health professional shortage area.” There will be no payment incentives after 2016 and ARRA will not provide incentive payments for providers adopting EHRs in 2015 or later.

Eligible professionals qualified for Medicaid incentive payments are non-hospital-based physicians, dentists, nurse practitioners, and certified nurse midwives. Physician assistants practicing predominantly in a Federally Qualified Health Center or Rural Health Clinics directed by a physician assistant are also eligible. Eligible professionals who practice in hospital-owned outpatient clinics also qualify for the incentive program. To be qualified for incentive payments, they must meet a requirement that at least 30 percent of their patient volume comprises Medicaid patients over a 90-day period, with the exception of pediatricians, who must meet a 20 percent minimum Medicaid volume threshold over 90 days. The maximum amount eligible providers can collect through Medicaid incentive payments is \$63,750 — \$21,250 for the first year and \$8,500 per year for years two through six.⁵³

Eligible hospitals will receive incentive payments over a four-year period — a base amount of \$2 million and a discharge payment. They will receive \$200 for each discharge paid under the inpatient prospective payment system, starting with its 1,150th discharge and continuing through its 23,000th discharge. The incentive payments will decrease to 75 percent of the full amount for the second year; 50 percent for the third year; and 25 percent for the final year.

Hospitals will not receive incentive payments if their EHR system is not operational by FY 2015. Beginning in FY 2015 ARRA provides for penalties, implemented over a three-year period, for hospitals that do not submit required quality data and for those that do not adopt EHRs. Failure to submit data will result in a 2 percent decrease in the hospital’s annual Medicare payment update. Hospitals that are not meaningful users of EHRs will face further penalties. The Congressional Budget Office estimates that these provisions of ARRA will result in about 90 percent of doctors and 70 percent of hospitals adopting certified EHRs within the next decade.⁵⁴

So why are all these financial incentives required? As noted at the outset of this section on HIT, *most health care providers today do not use electronic health records. Respondents interviewed for this study asserted that about 90 percent of Florida’s health care system is still paper-based. The idea behind these requirements and incentives is to move the health care delivery system into 21st Century technology at a much faster pace than it would on its own. This will save lives and reduce outlays.*





3. To increase the number of health care professionals trained in HIT resulting in certificates and degrees earned as well as to provide skills at different levels of training in the HIT field specifically for health care professionals.⁵⁷

The Consortium's career path model intends to cover pre-college career academies to create interest in health care as a career path. Training will be offered on multiple levels: entry level, advanced level, and post-graduation work.⁵⁸ The training will lead to a certificate or degree with the measurable technical and/or occupational skills needed to gain employment.⁵⁹ Florida State College and St. Johns River Community College will provide technical training and associates degrees in the HIT field as part of this initiative.

The Consortium stresses that it is important to facilitate the adoption of EHR by the health professions staff in order to meet the increasing demand for HIT. Thus, a successful Health IT strategy requires an adequately trained work force, and vice versa.

4. HIT Workforce Development Initiatives

Section 3016 of ARRA mandates that the Health and Human Services Secretary, in consultation with the National Science Foundation, provide assistance to higher education institutions to expand medical health informatics education programs, including certification, undergraduate, and master's degree programs for both information technology and students in various health care professions. Some of the activities eligible for support are recruiting and retaining students, developing and revising curricula, acquiring instructional equipment, and enhancing bridge programs between community colleges and universities.⁵⁵

Florida is in the process of making several efforts to enhance the HIT Workforce Development Initiatives in the state. The Growth and Access in Nursing and Information Technology Regional Consortium of Northeast Florida is also making efforts to boost workforce developments in the state.⁵⁶ The Consortium proposes to share best practice models, fill in gaps to skills and employment, and develop agreements to meet emerging industry sector needs in nursing and HIT. The Consortium's three objectives are:

1. To support a regional career path model to increase the number of trained nursing assistants, licensed practical nurses, registered nurses, baccalaureate degree nurses, and master's level nurses.
2. To provide pre-entry educational assessments and ongoing program activities that include participant scholarships, supportive services, retention activities, and job placement for unemployed workers, incumbent workers, and low-wage workers.

Florida should sustain initiatives to build up an adequate and qualified health care work force to help assure that the state has enough primary care physicians, nurses, physician assistants, nutritionists, and health information technology experts to meet the needs of a growing and aging population. This will be one of the biggest challenges as the state implements health reform.

ARRA financial support has enabled some real progress to date on bringing parties together within regions of the state, and also supporting the medical community with the costs of acquiring HIT and the training to use it.

Yet, a number of these new HIT projects are still in the planning stage or the initial phase of development. The goals are impressive but it remains to be seen how much progress can be made and over what time period. If the state and the federal government, through a long-term commitment of resources including financial incentives for adopting electronic medical records and through technical assistance, are successful, the results could be a safer, higher-quality, and less costly health care system. Along the way, many new jobs would be created.

IN CONCLUSION

Florida has already achieved some health care goals with ARRA funding. ARRA has supported important new initiatives in areas including assisting community health centers, reducing hospital-acquired infections, improving regulatory oversight, and establishing a path to a health information system keyed to electronic medical records.

The challenge for Florida now is to accelerate the implementation of these initiatives. The share of funding awarded that is spent should be increased as rapidly as possible so that new projects can be launched and those in progress can be moved along. It would be a major mistake to abandon the economic stimulus program now, or allow it to sputter.

Much of the overall ARRA funding spent to date has been on the tax benefits and the entitlement programs. Going forward, the contracts and grants under ARRA will be the more dominant part of the program. As this report shows, many of the most promising programs that will help Florida adopt 21st century technology and make real progress on improving health outcomes, enhancing patient safety, and reducing long-term health spending are just getting under way or are in early stages of development. There is ample remaining ARRA funding to carry out these programs. Florida can use this money in 2011, 2012, and beyond, and should do so.

Florida should continue to implement the goals of the stimulus program. The money can and should be spent, and the state will benefit from it.

APPENDIX

LIST OF INTERVIEWEES

- Andrew Behrman**, President/CEO, Florida Association of Community Health Centers
- A.C. Burke**, Florida Department of Health
- Allen Byington**, President/CEO, Big Bend Regional Health Care Information Organization
- Louis Galtiero**, President, SunCoast RHIO, Inc. and Health Information Exchange
- Tracy Gordon**, Professor, School of Public Policy, University of Maryland
- Brad Herremans**, Chief Administrative Officer, Suncoast Community Health Centers
- Kathy Holzer**, Vice President of Health Policy, Florida Hospital Association
- Kevin Kearns**, President and CEO, Health Choice Network (HCN)
- Lisa Rawlins**, Director, South Florida Regional Extension Center
- Robert Rodriguez**, Chief Financial Officer, Suncoast Community Health Care Centers
- Tanya Stewart**, CEO, Community Health Centers, Inc.
- Kim Streit**, Vice President of Health Care Research and Information Services, Florida Hospital Association
- Tom Wallace**, Budget and Fiscal Planning Supervisor, AHCA
- Polly Weaver**, Chief, Bureau of Field Operations, AHCA
- Phil Williams**, Assistant Deputy Secretary for Medicaid Finance, AHCA
- Don Winstead**, Florida Economic Stimulus Special Advisor
- Karen Zeiler**, Deputy Secretary, Florida Agency for Health Care Administration (AHCA)



- ¹ http://flarecovery.com/_resources/documents/pl1115.pdf. (H.R. 1)
- ² Executive Office of the President, Council of Economic Advisers. "The Economic Impact of the American Recovery and Reinvestment Act of 2009. Fourth Quarterly Report." July 14, 2010. p. 1.
- ³ These two estimates emerge from two different methodologies used by CEA to project the impact of ARRA. The 2.7 percent estimate emerges from an economic model that estimates the effects of fiscal policy employing mainstream estimates of "multiplier effects." The 3.2 percent figure relies on a statistical baseline forecast of what would have happened in the absence of stimulus and compares that to the actual path of GDP with the impact of the stimulus incorporated. Both estimates run through the end of the second quarter of 2010.
- ⁴ CEA Report, *supra*, p. 16.
- ⁵ In this case, the Statistical Projection approach again yields the higher figure.
- ⁶ Alan S. Blinder and Mark Zandi. "How the Great Recession Was Brought to an End." July 27, 2010. Blinder and Zandi also estimated that in the absence of the total of all of the government's interventions to pull the economy out of recession, including the actions of the Federal Reserve, GDP in 2010 would be about 11.5 percent lower and employment would be less by 8.5 million jobs.
- ⁷ CBO estimates of job impact, for example, range from 1.4 to 3.4 million and Moody's Economy.com is 2.2 million.
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- ¹⁴ www.statehealthfacts.org
- ¹⁵ <http://www.statehealthfacts.org/comparecat.jsp?cat=3&rgn=11&rgn=1>.
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- ²³ <http://www.leighbureau.com/speaker.asp?id=472>
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- ²⁵ Florida Department of Health
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- ²⁷ ARRA, Section 3001, p. 116.
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- ³³ http://www.nefrho.org/NEFRHO_Response.htm.
- ³⁴ <http://www.fhin.net/FHIN/StateHealthInformationExchange.shtml>.
- ³⁵ <http://www.fhin.net/FHIN/workgroups/MeetingMaterials/Dec1009/MedicaidHITPAPDraftHIECC.pdf>. For further information please visit the Florida Health Information Network (FHIN) website noted below or contact Christopher Sullivan, Ph.D or Carolyn Turner of FHIN (<http://www.fhin.net/>)
- ³⁶ http://www.fhin.net/FHIN/ARRA/FLARRA_funds.shtml.
- ³⁷ <http://www.fhin.net/FHIN/RegExtCenters.shtml>.
- ³⁸ <http://www.hcnetwork.htm>
- ³⁹ Florida Health Information Network. (2009) Broadband Program Initiatives. <http://www.fhin.net/FHIN/BroadbandProgramsandInitiatives.shtml>.
- ⁴⁰ Interview with Kathy Holzer of the Florida Hospital Association. June 11, 2010.
- ⁴¹ State Electronic Prescribing Advisory Panel Meeting. (2010) Florida Center Health Information Exchange and Adoption Initiative. Florida: AHCA. January 28, 2010.
- ⁴² Florida Health Information Network: Broadband Programs and Initiatives. (2009) The Florida Rural Broadband Education Campaign: Florida Learning Alliance. <http://www.fhin.net/FHIN/BroadbandProgramsandInitiativespercent20Files/Executivepercent20Summarypercent20Broadbandpercent20Educationpercent20Campaign.pdf>.
- ⁴³ State Electronic Prescribing Advisory Panel Meeting. (2010) Florida Center Health Information Exchange and Adoption Initiative. Florida: AHCA. January 28, 2010.
- ⁴⁴ FHIN Florida Learning Alliance, 2009.
- ⁴⁵ Florida Health Information Network. (2009) Health Information Technology Initiatives. <http://www.fhin.net/FHIN/HITInitiatives/RHCPP.shtml>.
- ⁴⁶ State Electronic Prescribing Advisory Panel Meeting. (2010) Florida Center Health Information Exchange and Adoption Initiative. Florida: AHCA. January 28, 2010.
- ⁴⁷ Florida League of Cities; Florida Association of Counties. (2009) The American Recovery and Reinvestment Act of 2009: Broadband Connectivity Health Information Technology and Florida's Broadband Strategy. The Economic Stimulus Summit. May 15, 2009.
- ⁴⁸ ARRA. Section 3013.
- ⁴⁹ In Health IT/E circles Eligible Providers are generally called EPs.
- ⁵⁰ <http://www.hhs.gov/news/press/2009pres/12/20091230a.html>.
- ⁵¹ <http://edocket.access.gpo.gov/2010/E9-31217.htm>.
- ⁵² <http://www.fhin.net/FHIN/MedicaidElectronicHealthRecordIncentiveProgram-Files/EligibleHospitalEHRIncentiveProgram1paper.pdf>.
- ⁵³ <http://www.fhin.net/FHIN/MedicaidElectronicHealthRecordIncentiveProgram-Files/EligibleProfessionalsEHRIncentiveProgram1Pager.pdf>.
- ⁵⁴ <http://edocket.access.gpo.gov/2010/E9-31217.htm>.
- ⁵⁵ Florida Health Information Network. (2009) "HIT Workforce Development Initiatives, Florida Health Information Network. <http://www.fhin.net/FHIN/HIT-WorkforceDevelopmentInitiatives.shtml>. (accessed June 25, 2010).
- ⁵⁶ The members are Florida State College at Jacksonville*; Jacksonville University; University of North Florida; St. Johns River Community College; Lake City Community College; First Coast Technical College; and the Region 8 Workforce Development Board, WorkSource. Public and private employers along with community partners are also vital members of the GAIN-IT Consortium (GAIN-IT, 2009).
- ⁵⁷ GAIN-IT Regional Consortium of Northeast Florida. (2009) Department of Labor ETA CFDA 17.275: Health Care Sector and Other High Growth and Emerging Industries. Florida Health Information Network. <http://www.fhin.net/FHIN/HITWorkforceDevelopmentInitiativespercent20Files/GAINITconsortiumOfNE-FLwkforceProposal.pdf>.
- ⁵⁸ For participants completing training, grant funds have been budgeted to help provide childcare and transportation stipends for participants as a way to remove barriers to opportunities (GAIN-IT, 2009).
- ⁵⁹ Nursing training programs will include: Certified Nursing Assistant (CNA); Licensed Practical Nurse (LPN); LPN to Registered Nurse (RN); Bachelor's of Science in nursing (BSN); a Master's of Science in Nursing (MSN); and a post-graduate certificate as a Family Nurse Practitioner (FNP) (GAIN-IT, 2009).



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