**DEPARTMENT of HEALTH and HUMAN SERVICES**

Office of the National Coordinator for Health Information Technology

*Fiscal Year 2012 President's Budget Request to Congressional Appropriations Committees*

**Online Performance Appendix**

*FY 2010 Performance Report*
*FY 2012 Performance Plan*

**Introduction**

The FY 2012 Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2012 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/budget/.

The FY 2012 Congressional Justification and accompanying Online Performance Appendix contain the updated FY 2010 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE SECRETARY**
**NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY**

http://www.healthit.hhs.gov
onc.request@hhs.gov

200 INDEPENDENCE AVE, SW
WASHINGTON, DC 20201

Dear Reader:

The U.S. Department of Health & Human Services (HHS), Office of the National Coordinator for Health Information Technology (ONC) is pleased to present the fiscal year (FY) 2012 Online Performance Appendix to the President's Budget Request to Congressional Appropriations Committees. This performance appendix includes ONC's annual performance report for FY 2010 and the performance plan for FY 2012.

A high performing health system must take full advantage of the information technologies that have transformed every aspect of modern life. To better enable health information to flow more effectively and efficiently throughout the health system, ONC was created in April 2004 by Executive Order 13335, *Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator* and later established in law in 2009 through the American Recovery and Reinvestment Act (Public Law 111-5, "Recovery Act") Health Information Technology for Economic and Clinical Health (HITECH) provisions.

During FY 2010, ONC made important strides in accelerating the development of an interoperable nationwide health information technology infrastructure by conducting and participating in a range of Federal planning and coordination efforts, implementing eight Recovery Act grant programs, and by filling new and important roles required to support recently enacted health care reforms. Among ONC's FY 2010 accomplishments are the following highlights:

- a nationwide network of 62 health information technology regional extension centers (REC) was established to assist health care providers with implementing electronic health record technology in their practice; in the final four months of the fiscal year nearly 12,000 providers signed up;
- the Beacon Community Program was launched in 17 communities across the nation to demonstrate the transformative potential of health IT ; and
- 2,300 students enrolled in health IT workforce training programs at the more than 80 community colleges in the ONC Community College Consortia to Educate Health IT Professionals.

At the time of this writing, there were no known weaknesses in the completeness or reliability of the information in this report.

# FY 2012 ONLINE PERFORMANCE APPENDIX

**U.S. Department of Health and Human Services, Office of the Secretary**
**Office of the National Coordinator for Health Information Technology**

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## Summary of Targets and Results Table

| Fiscal Year | Total Targets | Targets With Results Reported | Percentage of Targets With Results Reported | Total Targets Met | Percentage of Targets Met |
|---|---|---|---|---|---|
| 2007 | 3 | 3 | 100% | 1 | 33% |
| 2008 | 4 | 3 | 75% | 0 | 0% |
| 2009 | 4 | 2 | 50% | 1 | 25% |
| 2010 | 8 | 8 | 100% | 7 | 88% |
| 2011 | 14 | TBD | TBD | TBD | TBD |
| 2012 | 13 | TBD | TBD | TBD | TBD |

## Performance Measures and Accomplishments

The Online Performance Appendix to the President's fiscal year (FY) 2012 budget request describes the status of the Office of the National Coordinator for Health Information Technology's (ONC) implementation efforts that took place during FY 2010 and outlines the strategic goals and performance targets for ONC programs in FY 2012. The discussion of ONC efforts and corresponding performance goals and targets throughout the remainder of this document is structured according to the following five priority areas of the Administration's health information technology (health IT) strategy:

- achieve adoption and information exchange through meaningful use of health IT;
- improve care, improve population health, and reduce health care costs through the use of health IT;
- inspire confidence and trust in health IT;
- empower individuals with health IT to improve their health and the health care system; and
- achieve rapid learning and technological advancement.

In FY 2012, ONC grant programs and policy development efforts will be well underway and will be making significant progress toward meeting the goals of the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2008 (Recovery Act, Public Law 111-5). In so doing, ONC is working toward the goal that all Americans will benefit from secure, interoperable electronic health record technology. ONC's efforts to encourage the development and adoption of health IT are also critical to achieving the Department's overall goals for health care and delivery system reform.

# 1. Achieve Adoption and Information Exchange through Meaningful Use of Health IT

<u>A. Electronic Health Record Adoption</u>

The overall goal of HITECH is to spur the adoption and meaningful use of electronic health records by medical professionals and hospitals. To do so, Recovery Act funding is targeted to accelerating adoption and meaningful use of electronic health records among priority providers including primary care physicians.[1] Accordingly, important measures of the nation's progress in achieving this goal include the rates of electronic health record adoption among professionals, hospitals, and priority groups.

ONC's measures of physician and hospital electronic health record adoption are based on credible, well-defined methods that have been published in peer-reviewed literature and collected consistently over time. These measures of adoption provide the best approach to monitoring progress in the adoption and meaningful use of health IT. In collecting information to calculate these measures, ONC sponsors two health IT-focused supplements to national surveys of physicians and hospitals; one associated with the American Hospital Association Annual Survey of Hospitals and the other with the Centers for Disease Control and Prevention's National Ambulatory Medical Care Survey (NAMCS).

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Percent of office-based physicians who have adopted electronic health records[2] (1.A.1) | 2012 | 40% | TBD |
| | 2011 | 30% | TBD |
| | 2010 | 25% | 25% |
| | 2009 | Baseline | 22% |
| | 2008 | N/A | 17% |
| | 2007 | N/A | 12% |
| Percent of office-based primary care physicians who have adopted electronic health records[3] (1.A.2) | 2012 | 40% | TBD |
| | 2011 | 35% | TBD |
| | 2010 | 23% | 30% |
| | 2009 | Baseline | 21% |
| | 2008 | N/A | 20% |
| | 2007 | N/A | N/A |

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[1] As defined in the Funding Opportunity Announcement for the HITECH program for Health Information Technology Extension Centers, priority primary care providers are physicians (Internal Medicine, Family Practice, OB/GYN, Pediatrics) and other healthcare professionals (PA, NP, Nurse Midwife) with prescribing privileges in the following settings: small group practices (10 or less providers); ambulatory clinics connected with a public or critical access hospital; community health centers and rural health clinics; other ambulatory settings that predominantly serve uninsured, underinsured, and medically underserved populations.

[2] This measure is derived from the NAMCS and reported by the National Center for Health Statistics (NCHS) in the December 2010 publication, "Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians" http://www.cdc.gov/nchs/data/hestat/emr_ehr_09/emr_ehr_09.htm.

[3] "Adoption" of an electronic health record for this measure is defined as "basic, with notes" adoption, as in DesRoches et al. 2008 in the New England Journal of Medicine article *Electronic Health Records in Ambulatory Care – A National Survey of Physicians* http://www.nejm.org/doi/pdf/10.1056/NEJMsa0802005.

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Percentage of non-federal acute care hospitals that have adopted electronic health records[4] (1.A.3) | 2012 | 34% | TBD |
| | 2011 | 24% | TBD |
| | 2010 | 19% | 19% |
| | 2009 | Baseline | 16% |
| | 2008 | N/A | 12% |
| | 2007 | N/A | N/A |

*Preliminary 2010 results and final 2009 results and earlier are presented here.

| Unique Identifier | Measure | Data Source | Data Validation |
|---|---|---|---|
| 1.A.1 | Percent of office-based physicians who have adopted electronic health records | Centers for Disease Control and Prevention, National Ambulatory Medical Care Survey | In 2010 the CDC National Ambulatory Medical Care Survey (NAMCS) surveyed more than 10,000 physicians with a response rate of approximately 68%. The survey allows ONC to examine electronic health record adoption by provider specialty and region in detail. Estimates of performance for FYs 2008-2010 for this measure derive from the mail supplement to the NAMCS. |
| 1.A.2 | Percent of office-based primary care physicians who have adopted electronic health records | Centers for Disease Control and Prevention, National Ambulatory Medical Care Survey | In 2010 the CDC National Ambulatory Medical Care Survey (NAMCS) surveyed more than 10,000 physicians with a response rate of approximately 68%. The survey allows ONC to examine electronic health record adoption by provider specialty and region in detail. Estimates of performance for FYs 2008-2010 for this measure derive from the mail supplement to the NAMCS. |
| 1.A.3 | Percent of hospitals that have adopted electronic health records | American Hospital Association Annual Survey of Hospitals, IT Supplement | The American Hospital Association (AHA) surveys all non-federal acute care hospitals annually. The survey includes a health IT supplement and the response rate is about 63%. |

A "basic" electronic health record system, as defined in peer reviewed literature and used in the performance measures listed above, includes specific functionalities in the following areas of health care and administrative data: patient demographics, patient problem lists, electronic lists of medication taken by patients, clinical notes, orders for prescriptions, laboratory results viewing, and imaging results viewing.

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[4] "Adoption" of an inpatient electronic health record is defined as at least "basic" adoption, without notes, as in Jha et al. 2009 in the New England Journal of Medicine article *Use of Electronic Health Records in U.S. Hospitals* http://www.nejm.org/doi/pdf/10.1056/NEJMsa0900592. This measure excludes federal hospitals, and hospitals located outside of the 50 states and the District of Columbia. It encompasses all non-federal general acute care hospitals in the American Hospital Association annual survey, including critical access hospitals.

**Percentage of Office-Based Physicians using Any Electronic Medical Record/
Electronic Health Record (EMR/EHR) System: United States, 2001-2010[5]**
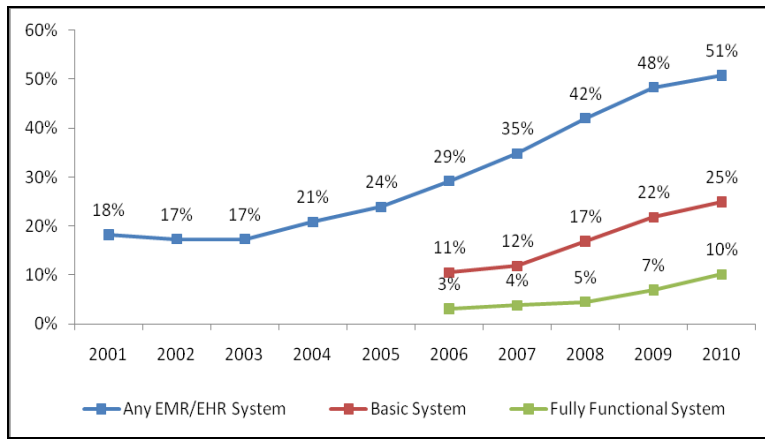


Source: CDC/NCHS, National Ambulatory Medical Care Survey

The category "Any EMR/EHR System" includes all medical or health record systems
that are either all or partially electronic, but excludes systems that are used solely for
billing. The categories of Basic or Fully Functional systems include system
functionalities that health care experts have determined have the capacity to contribute
in a meaningful way to improvements in the quality and cost of health care.

**Percentage of Non-Federal Acute Care Hospitals Reporting Adoption of
at least Basic Electronic Health Record Systems: United States, 2008-2010**
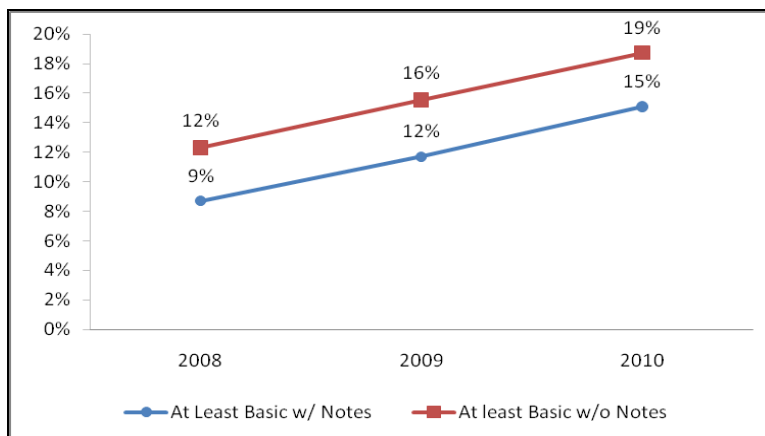


Source: American Hospital Association, Annual Survey of Hospitals, IT Supplement

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[5] The 2010 data are preliminary estimates, based on the mail survey. Estimates through 2009 include
additional physicians surveyed as part of the core in-person NAMCS. Earlier 2009 estimates were
revised to include those physicians. Estimates of basic or fully functional systems prior to 2006 could
not be computed because necessary items were not collected in the survey. Fully functional systems are
a subset of basic systems. Some of the increase in fully functional systems between 2009 and 2010 may
be related to a change in survey instruments and definitions of fully functional systems between 2009
and 2010 (see source article for more details). Includes nonfederal, office-based physicians. Excludes
radiologists, anesthesiologists, and pathologists.

B. Meaningful Use Incentive Payments

The Recovery Act created the Medicare and Medicaid Electronic Health Record Incentive Program to assist health care providers in adopting certified electronic health records and become "meaningful users" of such technology. The incentive program provides payments between 2011 and 2021 to eligible providers that meet established criteria during each of the three stages of the meaningful use. To earn meaningful use incentive payments during Stage 1, providers are required to use the electronic health record technology to:

- improve care coordination,
- improve quality, safety and efficiency of care and reduce healthcare disparities,
- engage patients and their families,
- improve population and public health, and
- ensure adequate privacy and security.

The incentive program is being managed by the Centers for Medicare & Medicaid Services (CMS) through the Medicare and Medicaid programs, and information about the payment of incentives is maintained by CMS. However, because ONC is focused on the overall success of health IT efforts, three measures of meaningful use are reported here. These measures correspond to the types of health care providers that can receive meaningful use incentive payments: eligible professionals and hospitals. In addition, a measure is established to express the percentage of priority primary care providers receiving incentive payments. On an ongoing basis, ONC and CMS will examine meaningful use attainment by eligible professionals and hospitals to ensure that CMS's incentive programs and ONC's grant programs are achieving their aims.[6]

| Measure[7] | Fiscal Year | Target | Result |
|---|---|---|---|
| Percent of eligible hospitals receiving meaningful use incentive payments (1.B.1) | 2012 | TBD, Increasing | TBD |
| | 2011 | TBD | Baseline |
| | 2010 | N/A | N/A |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |
| Percent of eligible professionals receiving meaningful use incentive payments (1.B.2) | 2012 | TBD, Increasing | TBD |
| | 2011 | TBD | Baseline |
| | 2010 | N/A | N/A |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |

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[6] Note that eligible medical professionals include non-physician providers and providers based outside of office settings so that both the numerator and the denominator of the meaningful use measures will differ from those above. To learn more about eligibility criteria for each of these programs, visit the CMS web site at: http://www.cms.gov/EHRIncentivePrograms/. Regarding the calculation methodology for these measures, ONC will use as the denominator of each measure the estimates of the number of eligible providers developed for the Impact Assessments of the meaningful use rulemaking process.

[7] Baseline and target information for these measures is being developed jointly by between CMS, which implements the Electronic Health Record Incentive Program, and ONC.

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Percent of eligible primary care professionals receiving meaningful use incentive payments (1.B.3) | 2012 | TBD, Increasing | TBD |
| | 2011 | TBD | Baseline |
| | 2010 | N/A | N/A |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |

| Measure | Data Source | Data Validation |
|---|---|---|
| Percent of eligible hospitals receiving meaningful use payments (1.B.1) | CMS Meaningful Use Registration and Attestation System | CMS will make meaningful use payments to eligible providers through the information that providers input into the Medicare & Medicaid EHR Incentive Program Registration and Attestation System. CMS will have measures in place to prevent fraud. |
| Percent of eligible professionals receiving meaningful use payments (1.B.2) | CMS Meaningful Use Registration and Attestation System | CMS will make meaningful use payments to eligible providers through the information that providers input into the Medicare & Medicaid EHR Incentive Program Registration and Attestation System. CMS will have measures in place to prevent fraud. |
| Percent of eligible primary care professionals receiving meaningful use payments (1.B.3) | CMS Meaningful Use Registration and Attestation System | CMS will make meaningful use payments to eligible providers through the information that providers input into the Medicare & Medicaid EHR Incentive Program Registration and Attestation System. CMS will have measures in place to prevent fraud. |

C. Regional Extension Centers

To promote health IT adoption and meaningful use, the Recovery Act also created the Regional Extension Center (REC) Cooperative Agreement Program. The REC program is intended to provide information, guidance, and technical assistance to health care providers to support and accelerate their efforts to become meaningful users of electronic health records. The RECs are located in 62 sites across the country to enable the provision of services to all providers.

The REC program is funded to provide support services to 100,000 priority primary care providers. ONC monitors the performance of the REC program and its grantees by tracking the total number of providers registered to receive services at RECs and the rate of electronic health record adoption among those providers. Based on the rate of progress for transitioning providers to electronic health record systems in similar projects implemented locally, ONC anticipates that a significant number of providers will adopt electronic health records within 10 months of registering with an REC. In addition to these measures, ONC will also monitor the proportion of providers working with RECs who receive meaningful use incentive payments.

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Establish a network of Regional Extension Centers covering 100% of the U.S. population by the end of FY 2010 (1.C.1) | 2012 | Maintain | TBD |
| | 2011 | Maintain | TBD |
| | 2010 | 100% | 100% |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |
| Number of priority primary care providers registered to receive services from Regional Extension Centers (1.C.2) | 2012 | Maintain | TBD |
| | 2011 | 100,000 | TBD |
| | 2010 | 30,000 | 11,875 |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |
| Electronic health record adoption rate among providers registered and working with ONC Regional Extension Centers for at least 10 months (1.C.3) | 2012 | 60% | TBD |
| | 2011 | 40% | TBD |
| | 2010 | N/A | N/A |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |

| Measure | Data Source | Data Validation |
|---|---|---|
| Establish a network of Regional Extension Centers covering 100% of the U.S. population by the end of FY 2010 (1.C.1) | ONC grants management data | ONC Project Officers work in close coordination with grantees and review the information that is submitted. |
| Number of priority primary care providers registered to receive services from a Regional Extension Center (1.C.2) | Regional Extension Center grantee reporting | ONC Project Officers work in close coordination with grantees and review the information that is submitted. |
| Rate of electronic health record adoption among providers who have registered with Regional Extension Centers for at least 10 months (1.C.3) | Regional Extension Center grantee reporting | ONC Project Officers work in close coordination with grantees and review the information that is submitted. |

The data for tracking provider registration and adoption is maintained in a common ONC and REC-grantee client relationship management tool. Data that supports measuring progress towards these goals is reported to ONC regularly by each REC as part of its grantee reporting requirements. Additional information that enables ONC to guide the RECs to target their efforts towards specific segments of the medical provider community is also collected and monitored through the client relationship management tool.

Since beginning registration in February 2010, the rate at which providers enter into signed agreements signaling their intention to receive support services for electronic health record implementation from RECs has increased almost every month. As of the end of FY 2010, RECs had registered 11,875 priority primary care providers, and in the time between the closure of fiscal year and the publication of this report (January 2011), registration has continued to

increase with monthly registration ranging between 5,300 and 9,300. The figure below shows the FY 2010 trend of monthly and cumulative priority provider registration with RECs.

**Priority Primary Care Providers Registered to Receive
Services from Health IT Regional Extension Centers
United States, 2010**
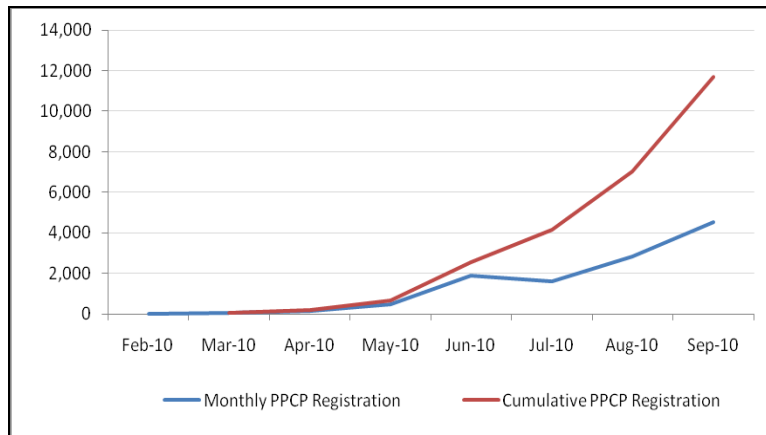


Source: Office of the National Coordinator for Health IT, Office of Provider Adoption Support

### D. Health IT Workforce Development

Ensuring that there is a growing body of trained professionals ready and able to implement new health information technologies is an important facet of health IT-enabled health care reform. To further this important goal, the Recovery Act provided ONC with approximately $118 million to establish activities in four distinct areas of health IT workforce development, including the following:

- Curriculum Development Centers Program,
- Community College Consortia to Educate Health IT Professionals,
- Program of Assistance for University-Based Training, and
- Health IT Competency Examination Program.

Monitoring the performance of these activities is essential to ensuring that there is a sufficient cadre of professionals equipped to assist providers in implementing health IT-enabled care delivery improvements.

*Curriculum Development Centers*

During FY 2010 ONC made significant strides in furthering the development of a common curriculum for health IT workforce training by releasing a Funding Opportunity Announcement and issuing grants to five institutions of higher education. The Curriculum Development Centers grant program provides $10 million to each grantee for their collaborative engagement in the development of curricular and instructional materials to enhance workforce training programs in community colleges. ONC awarded grants for this purpose to the following entities:

- Oregon Health & Science University,
- University of Alabama at Birmingham,
- Johns Hopkins University,
- Columbia University, and
- Duke University.

During FY 2010, ONC and the Curriculum Development Center grant recipients completed the development of a significant portion of the community college curriculum that was implemented in the fall enrollment period of 2010. The remaining elements of the curriculum are being completed during FY 2011.

For more information or to view the current status of health IT curriculum components being developed from this effort, visit the ONC web site at http://www.healthit.hhs.gov/curriculumdevelopment.

*Community College Consortia Program*

To further promote the formation of a health IT-enabled health care workforce, ONC is implementing a Recovery Act-funded, $70 million, two-year grant program to develop the nation's capacity to train 10,500 students per year at community colleges. In March FY 2010, ONC issued grants to five community college consortia groups comprised of more than 80 member community colleges to implement these training programs. In these programs, students are receiving training and experience in six months or less to become adept in one of six roles in the health IT field: practice workflow and information management redesign specialists, clinician/practitioner consultants, implementation support specialists, implementation managers, technical/software support staff, and trainers. Community colleges are implementing a variety of learning modalities from traditional on-campus instruction to distance-learning and combinations thereof. The programs are designed to train professionals with an IT or healthcare background and to provide them with the skills needed to facilitate implementation of an electronic health care system. The first students complete the training program in the spring of 2011.

For a complete list of community college consortia or the participating Community Colleges access the ONC web site at http://www.healthit.hhs.gov/communitycollege.

ONC's performance monitoring of the Community College Consortia to Educate Health IT Professionals program includes rates of student enrollment and completion of the established training programs. In addition to tracking these key performance metrics, ONC is also committed to evaluating the extent to which students completing these trainings are employed in the health IT-related jobs for which they trained. However, such information will not be available with sufficient frequency during the short time span of this program's administration to be a viable annual performance measure.

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Number of students enrolled in health IT training programs at Community College Consortia participants (1.D.1) | 2012 | 6,500* | TBD |
| | 2011 | 6,500 | TBD |
| | 2010 | 300 | 2,287 |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |
| Cumulative number of students completing health IT training programs at Community College Consortia participants (1.D.2) | 2012 | 12,250* | TBD |
| | 2011 | 7,000 | TBD |
| | 2010 | N/A | N/A |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |

| Measure | Data Source | Data Validation |
|---|---|---|
| Number of students enrolled in health IT training programs at Community College Consortia participants (1.D.1) | Community College Consortia Grantee Reporting | ONC Project Officers work in close coordination with grantees and review the information that is submitted. |
| Cumulative number of students completing health IT training programs at Community Colleges consortia participants (1.D.2) | Community College Consortia Grantee Reporting | ONC Project Officers work in close coordination with grantees and review the information that is submitted. |

* The period of performance for the Community College Consortia to Educate Health IT professionals ends April 2, 2012. Accordingly, performance targets reported here are pro-rated for the portion of FY 2012 that includes the grant program's period of performance. At the full 2012 performance level, which includes a portion of FY 2012 which is outside the program's period of performance, ONC expects the community colleges associated with the Consortia to have the capacity to train 10,500 students per year.

The methodology for estimating the target number of students enrolled with the community college consortia members assumes that some enrolled students will not complete their training. For this reason, there are higher targets for student enrollment than correspond with the target numbers of students completing their training. As community college consortia members continue to enroll and report their completion rates to ONC, the assumptions about the impact of attrition may be changed and targets may be revised.

*University-Based Training*

The Recovery Act also authorized ONC to implement an approximately $32 million grant under the Program of Assistance for University-Based Training to rapidly and sustainably increase the number of individuals qualified to serve in specific health IT professional roles requiring university-level training.  Grantee educational institutions are charged with promptly establishing new and/or expanded training programs as rapidly as possible while assuring their graduates are well prepared to fulfill their chosen health IT professional roles. The six roles targeted by this program are clinician/public health leader, health information management and exchange specialist, health information privacy and security specialist, research and development scientist, programmer and software engineers, and health IT sub-specialist. Many of these programs can be completed by a trainee in one year or less and all of the programs are expected to remain in operation once established or expanded with the support of this grant. In April 2010, the following colleges and universities were awarded grants as part of this program:

- Columbia University,
- University of Colorado Denver College of Nursing,
- Duke University,
- George Washington University,
- Indiana University,
- Johns Hopkins University,
- University of Minnesota,
- Oregon Health & Science University, and
- Texas State University.

E. Information Exchange

The Recovery Act provides $548 million to ONC for the creation of the State Health Information Exchange Cooperative Agreement Grant Program, which provides funding to all 56 states and territories to help them develop and advance resources that facilitate the exchange of health information among the health care providers and hospitals within their jurisdiction. The ultimate goal of the program is to encourage and support information exchange across states, and in so doing, the program seeks to promote innovative approaches to the secure exchange of health information within and across states and to ensure that health care providers and hospitals can meet national standards and meaningful use requirements.

The electronic exchange of information is integral to achieving the benefits of health IT adoption, and will be the main focus of Stage 2 of the Electronic Health Record Incentive Program and the meaningful use of health IT. One of the most important points of leverage in the health care system, given their ability to quickly contribute to cost and quality of care improvements as a result of introducing electronic health information exchange, are community pharmacies. Accordingly, ONC promotes and monitors the effects of state efforts to increase electronic prescribing.

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Percentage of community pharmacies in the US that are capable of exchanging health information electronically[8] (1.E.1) | 2012 | 97% | TBD |
| | 2011 | 89% | TBD |
| | 2010 | 85% | 85% |
| | 2009 | 76% | 76% |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |

| Measure | Data Source | Data Validation |
|---|---|---|
| Percentage of community pharmacies in the US that are capable of exchanging health information electronically (1.E.1) | National Progress Report on E-Prescribing, Surescripts | ONC obtains this information from a publicly available annual report by an industry leader that handles the largest fraction of electronic prescribing. |

### F. Certification of Electronic Health Records

ONC's success in advancing electronic health record adoption and health information exchange is dependent on health IT products that are secure, interoperable, and will allow eligible providers to meet the criteria of the Electronic Health Record Incentive Program. To this end, a final rule on an initial set of standards, implementation specifications, and certification criteria for adoption by the HHS Secretary was issued on July 13, 2010. This final rule represents the first step in an incremental approach to adopting common standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of health IT and to support its meaningful use. The certification criteria adopted in this initial set establish the required capabilities and related standards and implementation specifications that certified electronic health record technology will need to include in order to, at a minimum, support the achievement of meaningful use Stage 1 (beginning in 2011) by eligible professionals and eligible hospitals under the incentive programs. During FY 2010, ONC approved three Authorized Testing and Certification Bodies (ATCB) to certify electronic health record systems against the criteria established in the final rule. Three additional ATCBs were approved by ONC in the first quarter of FY 2011, and there are currently over 290 certified electronic health record products approved for use in ambulatory and/or inpatient health care settings.[9]

ONC's performance measure for certification and standards development focuses on the number of organizations using established information exchange components to demonstrate live health information exchange through the National Health Information Network Exchange. Included among these important health information exchange partnerships are projects that are facilitating the Social Security Administration's disability determination process, allowing the creation of the Virtual Lifetime Electronic Record to improve health care and services for veterans transitioning between the Defense and Veterans Affairs Department's health systems, and

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[8] Read the Surescripts "National Progress Report on E-Prescribing"
http://www.surescripts.com/media/515306/2009_national-progress-report.pdf
[9] For more information about the certified health IT product list, go to http://www.onc-chpl.force.com/ehrcert

advancing health care sciences through the aggregation and evaluation of de-identified clinical and administration information for health care quality assessment.

For more information, visit http://www.healthit.hhs.gov/NHIN.

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Number of organizations using at least one complete NHIN information component to exchange information[10] (1.F.1) | 2012 | Discontinue | N/A |
| | 2011 | 15 | TBD |
| | 2010 | 10 | 10 |
| | 2009 | 0 | 2 |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |

| Measure | Data Source | Data Validation |
|---|---|---|
| Number of organizations using at least one complete NHIN information component to exchange information (1.F.1) | Office of Standards and Interoperability | The number of certified ambulatory electronic health records products will be known to ONC. |

ONC proposes to discontinue this measure beginning in FY 2012 because the measure does not provide sufficient context related to the level of health information exchange occurring or the proportion of or benefit to organizations using common standards compared to other organizations exchanging health information. During FY 2011, ONC will develop a more robust measure set for electronic health records certification and standards and interoperability that addresses the above-stated weaknesses and also aligns with the specific processes being formulated and implemented during FY 2011.

## 2. Improve Care, Improve Population Health, and Reduce Health Care Costs through the Use of Health IT

ONC has continued to play a critical role in advancing the national strategy for health system delivery and payment reform through targeted activities that improve the health care and public health infrastructures' capacities to address such priority issues as disease prevention, early detection, and chronic condition. To this end, ONC and its partners continue to seek out, demonstrate, and proliferate IT-infused health care reforms with transformative potential. Notable accomplishments during FY 2010 include improved coordination among local, state, and federal public health entities and the continuation of important research and demonstration projects related to health IT.

The Beacon Community Cooperative Agreement Program is ONC's flagship health IT program that promotes real-life implementations of health IT in communities across the nation. The Beacon Community Program is a Recovery Act-authorized grant program that provides

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[10] The National Health Information Network (NHIN) is a set of conventions that provide the foundation for the secure exchange of health information that supports meaningful use. The foundation includes technical, policy, data use and service level agreements and other requirements that enable data exchange, whether between two different organizations across the street or across the country.

$250 million over 36 months to 17 communities so that they may further innovate and demonstrate the ways in which health IT can create a high performing health care system. The Beacon Community Program grant recipients were selected based on their prior accomplishments and their potential for developing and demonstrating further innovations. Each recipient is expected to develop and strengthen the existing infrastructure of interoperable health IT and standards-based information exchange within its service area. Recipients are also expected to advance specific clinical and non-clinical interventions and programs that make use of their health IT resources.

During FY 2010, ONC awarded cooperative agreements to 17 Beacon Communities across the nation. Since their grant award, the Beacon Communities have identified focus areas and significantly advanced their efforts to select community-specific health IT interventions and performance measures that suit their community's needs. The goals that each Beacon Community has identified as its overarching priority are listed below.

| Beacon Community | Goal |
|---|---|
| Bangor Beacon Community, Brewer, ME | Improve the health of patients with diabetes, lung disease, heart disease, and asthma by enhancing care management; improving access to, and use of, adult immunization data; preventing unnecessary ED visits and re-admissions to hospitals; and facilitating access to patient records using health information technology. |
| Beacon Community of the Inland Northwest, Spokane, WA | Increase care coordination for patients with diabetes in rural areas and expand the existing health information exchange to provide a higher level of connectivity throughout the region. |
| Central Indiana Beacon Community, Indianapolis, IN | Expand the country's largest Health Information Exchange to new community providers in order to improve cholesterol and blood sugar control for diabetic patients and reduce preventable re-admissions through telemonitoring of high risk chronic disease patients after hospital discharge. |
| Colorado Beacon Community, Grand Junction, CO | Demonstrate how costs can be reduced and patient care improved, through the collection, analysis, and sharing of clinical data, and the redesign of primary care practices and clinics. |
| Crescent City Beacon Community, New Orleans, LA | Reduce racial health disparities and improve control of diabetes and smoking cessation rates by linking technically isolated health systems, providers, and hospitals; and empower patients by increasing their access to Personal Health Records. |
| Delta BLUES Beacon Community, Stoneville, MS | Improve access to care for diabetic patients through the meaningful use of electronic health records and health information exchange by primary care providers in the Mississippi Delta, and increase the efficiency of health care in the area by reducing excess health care costs for patients with diabetes through the use of electronic health record. |

| Beacon Community | Goal |
|---|---|
| Greater Cincinnati Beacon Community, Cincinnati, OH | Develop new quality improvement and care coordination initiatives focusing on patients with pediatric asthma, adult diabetes, and encouraging smoking cessation, and provide better clinical information and IT "decision support" tools to physicians, health systems, federally qualified health centers, and critical access hospitals. |
| Greater Tulsa Health Access Network Beacon Community, Tulsa, OK | Leverage broad community partnerships with hospitals, providers, payers, and government agencies to expand a community-wide care coordination system, which will increase appropriate referrals for cancer screenings, decrease unnecessary specialist visits and (with telemedicine) increase access to care for patients with diabetes. |
| Hawaii County Beacon Community, Hilo, HI | Improve the health of the Hawaii Island residents through implementation of a series of healthcare system improvements and interventions across independent hospitals, physicians and physician groups. Engaging patients in their own healthcare is also a primary focus. |
| Keystone Beacon Community, Danville, PA | Establish community-wide care coordination through the expanded availability and use of health information technology for both clinicians and patients in a five-county area to enhance care for patients with pulmonary disease and congestive heart failure. |
| Rhode Island Beacon Community, Providence, RI | Improve the management of care through several health information technology initiatives to support Rhode Island's transition to the Patient Centered Medical Home model, which create systems to measure and report processes and outcomes that drive improved quality, reduce health care costs, and improve health outcomes. |
| San Diego Beacon Community, San Diego, CA | Expand electronic health information exchange to enable providers to improve medical care decisions and overall care quality, to empower patients to engage in their own health management, and to reduce unnecessary and redundant testing. |
| Southeast Michigan Beacon Community, Detroit, MI | Make long-term, sustainable improvements in the quality and efficiency of diabetes care through leveraging existing and new technologies across health care settings, and providing practical support to help clinicians, nurses, and other health professionals make the best use of electronic health data. |
| Southeastern Minnesota Beacon Community, Rochester, MN | Enhance patient care management, reduce costs associated with hospitalization and emergency services for patients with diabetes and childhood asthma, and reduce health disparities for underserved populations and rural communities. |
| Southern Piedmont Beacon Community, Concord, NC | Increase use health information technology, including health information exchange among providers and increased patient access to health records to improve coordination of care, encourage patient involvement in their own medical care, and improve health outcomes while controlling cost. |
| Utah Beacon Community, Salt Lake City, UT | Improve the management and coordination of care for patients with diabetes and other life-threatening conditions, decrease unnecessary costs in the health care system, and improve public health. |
| Western New York Beacon Community, Buffalo, NY | Expand the Western New York network, close gaps in service, and improve health outcomes for patients with diabetes. |

Across these 17 communities, a wide range of IT-enabled clinical and administrative interventions are being implemented and their impact on improving clinical quality and administrative costs is being tracked. Interventions range from innovative IT-enabled care management strategies to computerized clinical decision support tools to assist providers in routine decision making to personal health records and medication therapy management services that empower consumers.

Two measures are used to monitor the extent to which the Beacon Communities are successfully leading the nation in demonstrating the quality and cost improvement impacts possible when health information technologies are integrated into health care communities of practice. The first, the number of physicians participating in Beacon Community interventions, is used to monitor and challenge the ability of the Beacon communities to engage physicians in their service area. The second measure, the proportion of eligible providers in Beacon Communities that receive meaningful use incentive payments, tracks the success of the Beacon Communities at demonstrating that their communities are in fact the vanguard in IT-enabled health care reform.

| Measure | Fiscal Year | Target | Result |
|---|---|---|---|
| Number of physicians participating in Beacon Community interventions (2.A.1) | 2012 | TBD, Increasing | TBD |
| | 2011 | Baseline | TBD |
| | 2010 | N/A | N/A |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |
| Proportion of eligible providers in Beacon Communities that receive meaningful use incentive payments (2.A.2) | 2012 | 60% | TBD |
| | 2011 | 30% | TBD |
| | 2010 | N/A | N/A |
| | 2009 | N/A | N/A |
| | 2008 | N/A | N/A |
| | 2007 | N/A | N/A |

| Measure | Data Source | Data Validation |
|---|---|---|
| Number of physicians participating in Beacon Community interventions (5.A.1) | ONC Office of State and Community Programs | ONC Project Officers work in close coordination with grantees and review the information that is submitted closely. |
| Proportion of eligible providers in Beacon Communities that receive meaningful use incentive payments (5.A.2) | ONC Office of State and Community Programs | ONC Project Officers work in close coordination with grantees and closely review the information that is submitted. |

## 3. Inspire Confidence and Trust in Health IT

Confidence in the privacy and security protections embedded in health information technologies is critical to advancing adoption and realizing the benefits of electronic health record meaningful use.  During FY 2010, ONC's Office of the Chief Privacy Officer undertook a variety of initiatives designed to promote and ensure that privacy standards and policies related to the storage and transmittal of electronic health information are strong, credible, trusted, and broadly implemented. Additionally, ONC developed a comprehensive security and cyber security program that addresses both short-term objectives in supporting early gains in health IT adoption, as well as long-term objectives in creating a secure and protected health IT infrastructure for health information exchange. Working in close collaboration with nearly 70 different stakeholders representing critical segments of IT infrastructure, ONC also advocated that ongoing government-wide efforts address the privacy and security priorities of health information exchange when developiong the National Strategy for Secure Online Transactions.

Looking forward, a survey fielded by ONC during FY 2010 pertaining to consumer attitudes about the privacy and security of electronic health records and health information exchange will create a new source of data during FY 2011 from which key insights can be garnered, priorities can be benchmarked, and performance measures can be constructed. The data gathered from this ONC survey as well as other related data collection efforts will enable ONC to better assess the factors affecting consumer confidence in health IT and then to further develop and implement targeted outreach and communications strategies during FYs 2011 and 2012.

## 4.  Empower Individuals with Health IT to Improve their Health and the Health Care System

Health IT is a critical tool in empowering individuals and shifting care to be more patient-centered. Existing and emerging health information technologies allow data to flow directly to and from the individual, not confined by the walls of the clinical setting. Personal health records (PHR) allow patients to capture their health information from providers and record their own health observations. Other tools allow individuals to track their health and wellness, maintain their treatment regimen, and communicate with their health care providers. Patients managing illnesses or other ailments can keep better track of their health care, receive health care solutions remotely, and participate in their care coordination.

ONC is using the certification regulations and the Electronic Health Record Incentive Program meaningful use criteria to enumerate the capabilities and requirements for health care providers to make data more readily available to individuals. To receive incentive payments, providers must increasingly share and exchange data with their patients.

To this end, ONC is working with several of its grantees to identify the nature and characteristics of e-health tools being used, particularly PHRs, assess consumer and provider experiences using these tools, identify effective outreach and education strategies for deploying consumer e-health tools, and evaluate consumer needs and preferences regarding tool functionality. The findings

from this study will be made widely available to support future consumer engagement and consumer e-health initiatives, including through the Electronic Health Record Incentive Program.

## 5.  Achieve Rapid Learning and Technological Advancement

Health IT investments such as the State Health Information Exchange Cooperative Agreement Program; privacy and security initiatives; and standards, interoperability and certification activities are focused on promoting and enabling the development of a diffused and interoperable nationwide health IT infrastructure with the capacity for efficient, effective, and secure health information exchange, yet other important investments, including meaningful use incentive payments, health IT extension centers, and the expansion of health IT workforce trainings are designed to address some of the key financial and implementation barriers encountered by health care providers who are implementing health information technologies.

Because the future of IT-enabled health care and the success of certain aspects of health care reform depend on the continuous identification of barriers to reform and the proposition and development of targeted solutions that address those barriers and achieve breakthrough advances, ONC is also implementing the Recovery Act-authorized Strategic Health IT Advanced Research Projects (SHARP) Program, which provides $60 million over four years for focused research.

During FY 2010, ONC awarded the cooperative agreements to the institutions listed below. Each recipient is implementing a research program that addresses a specific focus area needed to advance the SHARP program's two-part mission of implementing a collaborative, interdisciplinary program of research addressing short- and long-term challenges in their respective focus area, and developing and implementing a cooperative program between health IT stakeholders – researchers, industry, health care providers, and others – to transition the research findings into practice.

| Research Focus Areas (Recipient) | Description |
|---|---|
| Security of Health Information Technology (University of Illinois at Urbana-Champaign) | This research area addresses the challenges of developing security and risk mitigation policies and the technologies necessary to build and preserve the public trust as health IT systems become ubiquitous. |
| Patient-Centered Cognitive Support (The University of Texas Health Science Center at Houston) | This research area addresses the challenge of harnessing the power of health IT to integrate with, enhance, and support clinicians' reasoning and decision-making, rather than forcing them into a mode of thinking that is natural to machines but not to people. |
| Healthcare Application and Network Platform Architectures (Harvard University) | This research area focuses on the development of new and improved architectures that are necessary to achieve electronic exchange and use of health information in a secure, private, and accurate manner. |
| Secondary Use of EHR Data (Mayo Clinic College of Medicine) | This research area focuses on strategies to make use of data that will be stored in EHRs for improving the overall quality of health care, while maintaining privacy and security of the data. |

During FYs 2011 and 2012, the SHARP program cooperative agreement awardees will develop technology solutions in their selected area of research and make information solutions available to the health IT market, in addition to making research results available through publications.

## Agency Support for HHS Strategic Plan

ONC is the principal Federal organization charged with coordination of national efforts related to the implementation and use of electronic health information exchange. Although computer technology has changed the way that Americans communicate and share information, for the most part health care data are still available to health care providers and patients only through paper and film records.  Leading the public and private sector efforts to improve the quality of health care through information technology is a key ONC role.

ONC published a *Federal Health IT Strategic Plan for 2008 - 2012* in June 2008. In light of section 3001(C)3 of the Recovery Act, the plan must be updated and will be published in the spring of 2011. The following table crosswalks the goals in ONC's existing strategic plan with the HHS Strategic Plan for 2010 - 2015.

| | ONC Goal 1: | ONC Goal 2: | ONC Goal 3: | ONC Goal 4: |
| | Encourage Adoption and Meaningful Use of Health IT | Engage Consumers in Health Care Through Health IT | Inspire Confidence and Trust in Health IT | Enable Rapid Learning, Knowledge Creation and Health Reform |
|---|---|---|---|---|
| **1      Transform Health Care** | | | | |
| 1.A:   Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured | | | | |
| 1.B:   Improve health care quality and patient safety | | | | |
| 1.C:   Emphasize primary and preventive care linked with community prevention services | | | | |
| 1.D:   Reduce the growth of health care costs while promoting high-value, effective care | | | | |
| 1:F:   Promote the adoption of health information technology | X | X | X | X |
| **2      Advance Scientific Knowledge and Innovation** | | | | |
| 2.A:   Accelerate the process of scientific discovery to improve patient care | | | | |
| 2.B:   Foster innovation at HHS to create shared solutions | | | | |
| 2.C:   Invest in the regulatory sciences to improve food and medical product safety | | | | |
| 2.D:   Increase our understanding of what works in public health and human service practice | | | | |

| | | ONC Goal 1: Encourage Adoption and Meaningful Use of Health IT | ONC Goal 2: Engage Consumers in Health Care Through Health IT | ONC Goal 3: Inspire Confidence and Trust in Health IT | ONC Goal 4: Enable Rapid Learning, Knowledge Creation and Health Reform |
|---|---|---|---|---|---|
| **3** | **Advance the Health, Safety and Well-Being of Our People** | | | | |
| 3.A: | Ensure the safety, well-being, and healthy development of children and youth | | | | |
| 3.B: | Promote economic and social well-being for individuals, families, and communities | | | | |
| 3.C: | Improve the accessibility and quality of supportive services for people with disabilities and older adults | | | | |
| 3.D: | Promote prevention and wellness | | | | |
| 3.E: | Reduce the occurrence of infectious diseases | | | | |
| 3.F: | Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies | | | | |
| **4** | **Increase Efficiency, Transparency and Accountability of HHS Programs** | | | | |
| 4.A: | Ensure program integrity and responsible stewardship of resources | | | | |
| 4.B: | Fight fraud and work to eliminate improper payments | | | | |
| 4.C: | Use HHS data to improve the health and well-being of the American people | | | | |
| 4.D: | Improve HHS environmental, energy, and economic performance to promote sustainability | | | | |

# Full Cost Table[11]

(Dollars in Millions)

| | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|
| **1    Transform Health Care** | | | |
| 1.A:  Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured | | | |
| 1.B:  Improve health care quality and patient safety | | | |
| 1.C:  Emphasize primary and preventive care linked with community prevention services | | | |
| 1.D:  Reduce the growth of health care costs while promoting high-value, effective care | | | |
| 1.E:  Ensure access to quality, culturally competent care for vulnerable populations | | | |
| 1:F:  Promote the adoption of health information technology | 1,880.59 | 220.72 | 78.41 |
| **2    Advance Scientific Knowledge and Innovation** | | | |
| 2.A:  Accelerate the process of scientific discovery to improve patient care | | | |
| 2.B:  Foster innovation at HHS to create shared solutions | | | |
| 2.C:  Invest in the regulatory sciences to improve food and medical product safety | | | |
| 2.D:  Increase our understanding of what works in public health and human service practice | | | |
| **3    Advance the Health, Safety and Well-Being of Our People** | | | |
| 3.A:  Ensure the safety, well-being, and healthy development of children and youth | | | |
| 3.B:  Promote economic and social well-being for individuals, families, and communities | | | |
| 3.C:  Improve the accessibility and quality of supportive services for people with disabilities and older adults | | | |
| 3.D:  Promote prevention and wellness | | | |
| 3.E:  Reduce the occurrence of infectious diseases | | | |
| 3.F:  Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies | | | |
| **4    Increase Efficiency, Transparency and Accountability of HHS Programs** | | | |
| 4.A:  Ensure program integrity and responsible stewardship of resources | | | |
| 4.B:  Fight fraud and work to eliminate improper payments | | | |
| 4.C:  Use HHS data to improve the health and well-being of the American people | | | |
| 4.D:  Improve HHS environmental, energy, and economic performance to promote sustainability | | | |
| **5    Strengthen the Nation's Health and Human Services Infrastructure and Workforce** | | | |
| 5.A:  Invest in the HHS Workforce to help meet America's health and human service needs today and tomorrow | | | |
| 5.B:  Ensure that the Nation's health care workforce can meet increased demands | | | |
| 5.C:  Enhance the ability of the public health workforce to improve public health at home and abroad | | | |
| 5.D:  Strengthen the Nation's human services workforce | | | |
| 5.E:  Improve national, state, and local, and tribal surveillance and epidemiology capacity | | | |
| **Total** | 1,880.59 | 220.72 | 78.41 |

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[11] This table includes actual and estimated obligations from Recovery Act and annual discretionary appropriations.

# Summary of Findings and Recommendations from Completed Program Evaluations

There were no program evaluations focused on ONC that were completed by the HHS Office of Inspector General or Government Accountability Office during FY 2010.

# HHS High Priority Goal: Health Information Technology

### Obligations Related to Priority Goal Attainment (Recovery Act)
(Dollars in Millions)

|  | FY2010 Actual | FY 2011 Planned | FY 2012 Planned |
|---|---|---|---|
| Regional Extension Center Program | 676.637 | 44.363 | 0.000 |
| **Total** | **676.637** | **44.363** | **0.000** |

Introduction

The HHS high priority goal for health IT is focused on the Health Information Technology Extension Program, Regional Extension Center Cooperative Agreement program, which was established in section 3012(a) of the Recovery Act.

The Health Information Technology Extension Program is a $774 million effort assisting priority primary care providers and rural and critical access hospitals in becoming meaningful users of electronic health records and health information technology. The Health IT Extension Program consists of a nation-wide network of 62 Regional Extension Centers (REC) and a Health Information Technology Research Center (HITRC). While the RECs offer direct technical assistance and information to support and accelerate health care providers' efforts to become meaningful users of electronic health records, the HITRC gathers information on effective practices from across the REC community and helps the RECs collaborate with one another and relevant stakeholders efficiently and effectively.

Goal Statements

By the end of FY 2011, ONC will establish the infrastructure necessary to encourage the adoption and meaningful use of health IT by:

- Establishing a network of Regional Extension Centers covering 100% of the United States population by the end of FY 2010.
- Registering 30,000 providers to receive services from Regional Extension Centers by the end of FY 2010.
- Registering 100,000 providers to receive services from Regional Extension Centers by the end of FY 2011.

- Achieving 40% adoption of electronic health records among providers who have been registered with a Regional Extension Center for at least 10 months by the end of FY 2011.

Performance towards Priority Goal Attainment

HHS priority goals and performance measures for the Health IT Extension Program track the establishment of the nationwide network of RECs, registration of priority providers, and the electronic health record adoption rate of providers registered and receiving services from RECs for 10 months or longer.

During FY 2010, ONC issued the Funding Opportunity Announcement for the Regional Extension Center Program.  In three phases, 62 cooperative agreements were established implementing the Health IT Research Center and REC programs. Since the time of award, RECs have been staffed, ONC has provided a combination of targeted technical assistance and nation-wide coordination and collaboration opportunities, and RECs have begun registering priority primary care providers.

*Establishment of a Nation-wide Network of Regional Extension Centers*

|  | FY 2009 Result | FY 2010 Result | FY 2011 Target | FY 2012 Target |
|---|---|---|---|---|
| Establish a network of Regional Extension Centers covering 100% of the U.S. population by the end of FY 2010 | N/A | 100% | Maintain | Maintain |
| Number of priority primary care providers registered to receive services from a Regional Extension Center | N/A | 11,875 | 100,000 | Maintain |
| Rate of electronic health record adoption among providers who have registered with Regional Extension Centers for at least 10 months | N/A | N/A | 40% | 60% |

Progress to date includes laying the REC program groundwork through the provider adoption of certified electronic health records and the awarding of the cooperative agreements, completing the Stage 1 meaningful use rule, and establishing an electronic health record certification program. All of these activities occurred during FY 2010, with the rule making and selection of certifying bodies being finalized during the 4th quarter. As a result of this timing, RECs began registering providers to receive services in the 4th quarter of FY 2010.
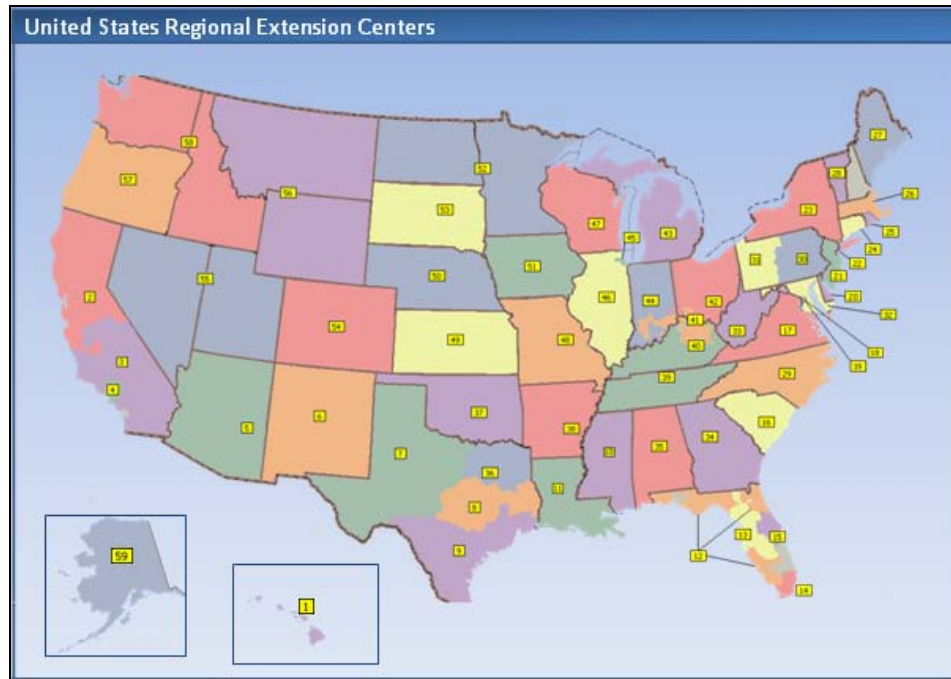
*Note: Applicable regions across the nation may also be supported by the Indian Health Board Regional Extension Center, headquartered in Washington, DC.*

## Deviations between Targets and Actual Results

Regional Extension Centers –Priority Primary Care Providers Registered:

There were 11,875 priority primary care providers registered with RECs during FY 2010, which is below the target of 30,000.  Attainment of the annual target was inhibited due to the time required to execute the processes of establishing the nation-wide network of RECs (which included 3 rounds of Funding Opportunity Announcements and awarding 62 cooperative agreements), establishing the Stage I meaningful use rule, and creating the temporary and final certification program for electronic health record systems. ONC expects that the rate at which priority primary care providers are registered to receive services from RECs during FY 2011 and 2012 will continue to increase. However performance at the goal level will remain ambitious and a challenge for grantees to accomplish.

## Discontinued Performance Measures

Discontinued measures are referenced in the related subsections of ONC Health IT Performance Measures and Reporting section of this document.

ONC proposes to discontinue one measure in FY 2012 related to the number of organizations using at least one complete NHIN information component to exchange information. For additional information, see page 13.

## Disclosure of Assistance by Non-Federal Parties

There was no assistance provided to ONC by non-Federal parties in preparing this performance plan and report.