

October 20, 2009

David Blumenthal, MD, MPP
Office of the National Coordinator for Health Information Technology
200 Independence Avenue, SW
Suite 729D
Washington, DC 20201

RE: Comments to the HIT Policy Committee on the Effects of “Meaningful Use “ Criteria

Dear HIT Policy Committee Members:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the request to present to the HIT Policy Committee on the “meaningful use” criteria and its affect on underserved populations. NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as “health centers” or “FQHCs”) throughout the country, and is a 501(c) (3) tax exempt non-profit organization.

BACKGROUND

There are, at present, approximately 1200 FQHCs in over 7,500 sites nationwide serving close to 20 million patients. Most of these FQHCs receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS).

Under this authority, health centers fall into four general categories (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center’s board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one’s ability to pay.

Their mission is:

Improve the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services

BPHC’s grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to uninsured and underinsured indigent patients, as well as to maintain the health center’s infrastructure. Patients from eligible communities, who are not indigent and able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately **35 percent are Medicaid recipients**, approximately 7.5 percent are Medicare beneficiaries, and **approximately 40 percent are uninsured**. Some important information about health centers and the population they serve from 2008 Uniform Data Set (UDS) data provided to HRSA/BPHC include:

MAIN OFFICE
7200 Wisconsin Ave, Suite 210
Bethesda, MD 20814
301-347-0400
301-347-0459 fax

FEDERAL AND STATE AFFAIRS OFFICE
1400 Eye Street, NW, Suite 330
Washington, DC 20005
202-296-3800
202-296-3526 (fax)

17.1 Million Patients (1 in 18 of the U.S. population) (this number is now estimated at 20 million)

- 92% Below 200% poverty (1 in 6)
- 70% Below 100% poverty (1 in 3)
- 38% Uninsured (1 in 7)
- 934,000 Homeless Individuals
- 834,000 Migrant/Seasonal Farmworkers
- 157,000 Residents of Public Housing

67 Million Patient Visits

- 1,087 Grantees – half are in rural areas
- 7,500+ Service Sites

Over 113,000 Staff are employed in health centers

- 8,400 Physicians
- 5,100 NPs, PA, & CNMs

Health centers **provide primary care services** to this large population and serve as their medical home. We expect that health centers will continue to expand to meet the needs of the underserved and uninsured and serve 30 million people by 2014.

COMMENTS ON THE EFFECT OF “MEANINGFUL USE” ON UNDESERVED POPULATIONS

NACHC appreciates the opportunity to respond to your questions on how the “meaningful use” criteria may affect underserved populations.

1. *How will the proposed 2011 and 2013 meaningful-use objectives and measures help your specific area (pediatrics, psychiatrist, nurse practitioner dentists, etc.) demonstrate that they are improving care?*

Improving quality, safety, efficiency, and reducing health disparities

The “meaningful use” criteria will assist FQHCs to further their mission of improving healthcare outcomes, eliminating disparities and improving the overall health of the patients that FQHCs serve. Many EHRs on the market today do not provide the full functionality that health centers require. Health centers are leaders in preventive care, population management and eliminating disparities and have for many years been involved in providing comprehensive primary care. They have utilized disease registries for population management activities which have proven useful and have had a positive effect in improving care. The most recent data from HRSA/Bureau of Primary Care shows that health centers across the country are managing chronic illnesses and focusing on treatment interventions that improve overall population health. FQHCs are required to report on these activities yearly to HRSA/BPHC. The most recent data from 2008 for over 17 million patients served that year show:

- 73% Diabetes Under Control
- 62% Blood Pressure Under Control
- 65% First Trimester Prenatal Care
- 7.6% Low Birth Weight
- 70% Childhood Immunization
- 57% Pap Tests for Women
- \$588 Cost Per Patient; \$129 Per Visit

Requiring that all EHRs provide this functionality as part of the EHR will greatly expand the EHR offerings available to FQHCs and make the selection process easier. Currently there are only a few vendors out of the 80 or so that are CCHIT certified for ambulatory care that actually have the functionality that health centers require.

We actually do not believe that the 2011 and 2013 criteria go far enough in requiring disease registry functionality in EHRs and an expansion of this functionality will better assist health centers in performing their activities and improving population health. Until this functionality is fully incorporated into EHRs FQHCs will still be required to integrate two different systems in order to be able to track and report on the above indicators which are required reporting activities under their HRSA/BPHC grants. Health centers will also need to be careful in selecting an EHR that may identify itself as meeting the “meaningful use” criteria. It may still not have the functionality that FQHCs require.

Engaging Patients and Families

We believe that requiring the functionality outlined for 2011 and 2013 will provide the tools for health centers to better engage with patients and families. It may be a challenge, however, for health centers with EHRs to meet all of the “preferred language” needs required to communicate with patients that FQHCs serve. We treat patients with many different language preferences.

Improving Care Coordination

Requiring EHRs to exchange key clinical information among providers of care (e.g., problems, medications, allergies, test results) will greatly assist health centers to further their mission and better coordinate care with other providers. This communication and care coordination can lead to better management of patients, decreased emergency room utilization and decreased duplication of services.

Improving Population and Public Health

Health centers fully support the focus on improving population and public health. Health centers treat the most vulnerable segment of the population and have a great deal of knowledge and experience in this area and are leaders in improving population and public health outcomes. Requiring this functionality in EHRs will greatly assist in this activity.

Ensuring adequate privacy and security protections for personal health information

Health centers are concerned with ensuring adequate privacy and security protections for personal health information and requiring EHRs to have this functionality embedded in them will be very helpful and assist to engender trust in the population served by FQHCs and their use of EHRs.

- 2. What are the special considerations when applying meaningful use measures to your specific area or to underserved populations?*

Improving quality, safety, efficiency, and reduce health disparities

The current “meaningful use criteria” reporting measures differ from what health centers are required to report. FQHCs are currently required to report on HRSA/BPHC Clinical Quality Measures and many report on Health Effectiveness Data and Information Set (HEDIS) measures. We strongly recommend that the “meaningful use” measures should be uniform and harmonized for all primary care providers. In their current form FQHCs would be required to report on certain measures for HRSA/BPHC and other measures for “meaningful use”.

We would like to point out, however, that it is not the reporting that is the problem. The intensive care coordination that is required to manage these patients may be problematic. Pulling the data is relatively easy. FQHCs actually manage patients according to the measures that were identified above. This includes having systems in place to input data into disease registries, having staff in place to provide the enabling services and care coordination that is so important in chronic disease and population management activities to obtain positive outcomes etc. This is why health centers do a better job of disease and chronic care management than most non FQHC primary care providers. It may be difficult for an FQHC to manage one set of patients on a measure for HRSA/BPHC and then add an additional cohort for “meaningful use” at the same time that they are adopting and implementing an EHR.

We recommend that measures should be uniform across all federal agencies and parallel the “meaningful use” criteria and recommend that the HIT Policy Committee make this recommendation to ONC to coordinate this across all federal agencies and **harmonize the clinical measures** across the board. This will also assist in evaluation of programs and services as we will then be able to compare apples to apples.

Until this harmonization takes place we recommend that FQHCs that already report on a number of clinical measures **be allowed to continue to report on the HRSA/BPHC measures and that this reporting be accepted as meeting “meaningful use” criteria**. These clinical measures are audited and attested to on a yearly basis when they are reported to HRSA/BPHC.

Engaging Patients and Families

Due to the nature of the patient population that FQHCs serve health centers may not be able to meet some of the patient engagement criteria. This would include the language preferences of patients. **We believe that many EHR vendors will not be able to meet the requirement of providing patients with medication lists, problem lists, treatment summaries and access to clinical information in the language of their choice.**

Improving Care Coordination

Although EHRs will be required to have the capability to exchange key clinical information there is another consideration that may affect FQHCs. The financial model for HIE has not been clearly established. It should be noted that FQHCs work on very small financial margins (less than 1%). **If there is a financial cost associated with the exchange of information many health centers may not be able to absorb that cost.** They may have the capability to exchange the data but the cost of the HIE in their particular area may be prohibitive. Mechanism will need to be in place to ensure that the cost of HIE is funded.

Another concern is the ability of other providers to share data with health centers. 2013 criteria focus more on sharing data and although health centers may have an EHR that can share data local hospitals especially in rural areas and other safety net hospitals may not be able to do so.

Although health centers are provided for in ARRA and designated to receive funds for the adoption and “meaningful use” of EHRs, other providers that we share patients with were not included. This would include free clinics that do not meet the provider eligibility requirements and also community mental health centers. It is imperative that these service providers have the capability to exchange patient information with FQHCs in order for their care to be coordinated and for them to receive the best quality care.

This is especially important for behavioral health patients specifically those with chronic mental illness. These patients are dying twenty-five (25) years earlier than the rest of the population and they are dying from chronic medical diseases not mental illness. If we do not coordinate their care and manage their chronic illnesses we will be ignoring a significant portion of the population, not eliminating disparities and continuing to discriminate against those with behavioral health disorders. We would encourage the HIT Policy Committee to make recommendations to ensure that the providers for these populations have the tools necessary to coordinate care with FQHCs.

Improving Population and Public Health

FQHCs may only be restricted in this activity due to the ability of local and state authorities’ ability to accept the data electronically.

3. *What other measures would you propose be considered to assess the meaningful use of EHRs by your specialty, and how would they align with the care goals and objectives the Policy Committee has recommended?*

We believe that the HRSA/BPHC Clinical Measures are a very good starting point, however, other clinical measures that would be important include:

- Screening for Depression
- Screening for Substance Abuse and providing Brief Interventions (where necessary (SBIRT)
- 1st Trimester Enrollment in Treatment
- Pre Term Deliveries
- Cancer Screening for those conditions where there are evidenced based screening protocols

Most important these measures should be harmonized, uniform and aligned across the board.

5. *What are other EHR adoption barriers unrelated to the definition of meaningful use, that affect providers like you? What solutions would you recommend to address those issues? What would your role as a provider be in this solution?*

Start Up Capital to Purchase Systems

Barriers that are unrelated to “meaningful use” include the ability of FQHCs to obtain the start-up capital to pay for the EHR system in order to meet “meaningful use” criteria. As we understand the process at this time the states will provide reimbursement to FQHCs for the adoption of EHRs in the first year and for meeting “meaningful use” in years two through six. These funds will be coming after the FQHC shows adoption or “meaningful use”. Where will the

FQHC obtain the funds for the initial implementation which will include the cost of software licenses, hardware (desktop computers, servers, routers etc), consultant costs, and loss of revenue during implementation etc? There is no clear indication as to where these funds will come from. As noted earlier health centers work on less than a 1% margin and the cost of software licenses alone at only \$5,000 per provider (which is on the low end) would be \$100,000 to a health center with only 20 eligible providers. Health centers may not be able to access any reserve capital they may have as HRSA/BPHC requires a certain amount of capital be in reserve for regular ongoing operations.

We would recommend that “meaningful use” funds be provided to FQHCs in the first year as soon as an FQHC informs the state of its intent to sign an agreement with an EHR vendor and the funds be available to the FQHC within 30 days of the notice to the state. This would allow the FQHC to move forward with adoption and be on their way to “meaningful use”. Unless these funds are available the adoption of EHRs may be stalled. NACHC could assist with this process through our work with the various State Primary Care Associations which could act as a coordinating vehicle for the states to assist with the coordination and administration of this activity to FQHCs.

Engaging Patients and Families

Although not directly related to “meaningful use” there were no funds specifically identified in ARRA for education to consumers about the benefits of using an EHR. We believe that it would be important to have an educational campaign directed at consumers around the benefits of using EHRs and to raise their expectation that the use of EHRs can lead to good quality care.

It should also be recognized that due to the nature of the population that health centers serve they may not be able to demonstrate a high percentage of patients actually receiving their data electronically due to health literacy issues and lack of access to computers.

We would encourage the HIT Policy Committee to require that the translation of educational materials be a required component of the EHR.

New Development on the Ability of Regional Extension Centers to assist in meeting the “Meaningful Use” Criteria

Over the last several days it has come to our attention that the Regional Extension Centers will be capped at being reimbursed for only ten (10) providers under a single Tax ID#. While this may make sense for small practices (as that is in keeping with the spirit of ARRA) it does not make sense for an FQHC. As already noted, FQHCs are multi-site organizations with over 7,500 sites of which more than half (53%) are in rural areas.

There are also concerns that this limitation was never identified in the guidance and therefore no one had any opportunity to comment during the comment period. We would certainly have done so had this been identified. It also was not identified in the first presentation that was provided on the RECs back in late August or early September.

Limiting group practices of individual providers to 10 per Tax ID# seems to be in keeping with the spirit of ARRA i.e. to focus on small provider practices.

FQHCs, however, were identified as a separate category specifically in ARRA and specifically called out as the number two priority in the REC guidance. There was no limitation on the number of providers in an FQHC practice. It is well known that FQHCs have multiple sites and provide services in wide and disperse geographic areas. An FQHC with 5 or 6 sites under one Tax ID# may have 20 providers. They currently serve over 20 million of the most underserved population and all FQHCs are in medically underserved and medical provider shortage areas.

Many Health Center Controlled Networks (HCCNs) decided after the initial presentation on RECs to begin to partner with other organizations to apply for and become an REC. HCCNs already have the infrastructure and provide many of the services that are required under an REC. They make excellent partners for an REC and will be shouldering much of the direct hands on contact and assistance that providers require.

As an example:

In a west coast state the HCCN is partnering with the applying organization to provide these services and they are expecting to bring 500 “eligible providers” up to meaningful use. These providers work in 5 community Health Centers (i.e. 5 unique Tax ID#s) but span over 35 clinics and care delivery sites throughout the state. The HCCN had an agreement with the lead organization to receive a certain amount of funds to provide these hands on services and activities to these 500 providers. Let’s assume they agreed to \$100 per head for the 500 providers and that would meet their costs. With the limitation of 10 providers set to FQHCs the HCCN would now only receive funds to cover the cost of implementing 50 or so providers (i.e. there are only five community health centers and 5 Tax ID#s. Any provider over 10 on a tax ID# would not be eligible for the REC to receive funds for these activities). So instead of receiving \$50,000 to bring up 500 providers they are now only able to receive \$5,000 to bring up the same 500 providers.

This limitation does not allow the HCCN to capitalize on its resources and to put in place the additional resources required to bring up the maximum number of eligible providers in a smooth, fast, and quality manner. They are now left with the decision to either pull out of the consortium or to decrease the numbers of implementations to whatever number capping 10 providers under each Tax ID requires.

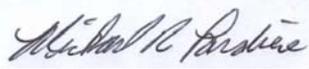
Also, this limitation does not help further the goal of getting all eligible providers in FQHCs to adopt and to use EHRs in a meaningful way. We know from experience in this area that providing the hands on training and services needed to implement EHRs and move to meaningful use requires more resources depending on the number of providers you are working with. You cannot bring up 20 providers with the same resources required to bring up 10. This is especially true when your providers are spread out over large geographic areas.

There is a great amount of work to do in the FQHC world to have providers adopt and use EHRs in a meaningful way. Placing this seemingly arbitrary barrier in the way will not help us to meet our goals.

We encourage the HIT Policy Committee to reconsider the significant impact of this barrier in relation to FQHCs and allow the RECs to receive funds for each and every eligible FQHC provider that they bring to adoption and meaningful use of EHRs.

We appreciate the opportunity to comment on this notice and would welcome the opportunity to further present on October 28, 2009. If the Committee would have questions, please contact me at 301.347.0400 or via email at mlardiere@nachc.com

Respectfully Submitted,

A handwritten signature in black ink, reading "Michael R. Lardiere", is displayed on a light blue rectangular background.

Michael R. Lardiere,
Director HIT; Sr. Advisor Behavioral Health
National Association of Community Health Centers