

**Small Provider Organization Written Testimony
Roanoke Chowan Community Health Center
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How will the proposed 2011 and 2013 meaningful-use objectives and measures help smaller practices or hospitals demonstrate that they are improving care?

Roanoke Chowan Community Health Center (RCCHC) is a Federally Qualified Community Health Center located in rural northeastern North Carolina serving citizens in four counties. RCCHC has been utilizing Electronic Health Records (E.H.R.) for twelve years and fully support the ultimate goal of the Meaningful Use of an Electronic Health Record. All of our staff, physicians, clinicians, clerical staff, utilize an E.H.R. and Electronic Billing System. The proposed objectives and measures will enable all Community Health Centers (CHC) to broaden their current objective measurements of improving care. Currently, 86 percent of CHCs maintain at least one disease-specific registry as part of HRSA's Health Disparities Collaboratives. Currently, one-fourth of CHCs have some E.H.R. capacity. Of the CHCs which have E.H.R.s, virtually all have electronic patient's demographics, 85 percent have computerized orders for prescriptions, 83 percent have electronic clinic notes, 71 percent have computerized orders for tests and 71 percent have computerized lab results. CHCs are leaders in this activity; unfortunately only 13 percent of CHCs have the minimum set of functionalities defined by the national HIT Adoption Initiative. We believe by increasing the use of disease registries, improved and updated practice management systems, and increased networking and connectivity that CHCs will be able to further quantify their patient's outcomes.

What are the special considerations when applying meaningful use measures to the small provider organizations I represent?

Research has demonstrated that patient-mix characteristics are the most important factor in understanding E.H.R. adoption rates among CHCs. CHCs with high levels of uninsured/underinsured patients have a lower rate of E.H.R. adoption as compared to CHCs with high levels of Medicare, Medicaid and private insurance. CHCs high proportion of uninsured and poor patients reflects their fragile revenue streams and financial vulnerability as well as the increased complexity of the patients they serve. Special up front financial incentives need to be given to CHCs that have a disproportioned percentage of uninsured/underinsured patient populations to enhance the success of E.H.R. adoption within CHCs.

Nearly two-thirds of CHC patients are racial or ethnic minorities and 30 percent are not fluent in English. The majority of CHC patients live below the Federal Poverty Level and experience both health literacy and health disparity issues. The majority of these patients do not have computers and/or internet access which create significant barriers to engage in their health care, obtain email notifications, electronic appointment scheduling, and obtain proposed care

goals. In addition, most E.H.R. summaries/documents are not created for patients who can not read or have a low reading level. The proposed measures do not take into account the fact that CHCs indigent patients have multiple barriers when accessing care including transportation and money for co-payments, medications, and necessary medical supplies. When these patients do access care, most do not have the financial means to purchase their medications and receive additional chronic disease educational classes. Most patients have to decide whether to pay their electricity bill or buy their medications. Indigent patients will not benefit from the proposed objectives because they can access care or afford the care they need. Special consideration needs to be given to creating objectives and measures that address solutions to these barriers.

Special considerations need to be given to reporting requirements. Currently CHCs report clinical data to HRSA. The reporting standards for CHC required clinical reports needs to be the same as reporting standards and requirements under the HIT initiative.

What other measures would you propose be considered to assess the meaningful use of EHRs by your type of providers and how would they align with the care goals and objectives the Policy Committee has recommended? The committee needs to address the major up-front investment to facilitate initial adoption, as well as ongoing assistance to support IT staffing and ongoing maintenance.

Reaching the ultimate goal of “Meaningful Use of an Electronic Health Record” will be largely based on engaging patients and altering the way health is maintained and care provided on an ongoing basis. The proposed Matrix primarily focuses on the E.H.R. and does not encompass Health Information Technology services that can increase patient access to care, actively engage patients in their care and improve care coordination in a HIPAA compliant environment. The essential missing HIT component is the use of Remote Monitoring and Home Telehealth for the long-term management of patients with chronic disease. Remote Monitoring is the fastest growing area within the Telehealth Industry and excluding this component of HIT would limit the achievement of the desired health outcomes for many of CHCs patients. Chronic diseases are growing rapidly and consuming a large majority of health care expenditures. The majority of all CHCs patient’s live with chronic diseases and can not adequately manage their disease. For the last decade, the Veterans Administration (VA) has utilized telehealth and care coordination to care for over 35,000 Veterans with chronic disease. The VA is rapidly expanding this initiative and the model meets four of the five Health Outcomes Policy Priorities as outlined by the HIT Policy Committee.

Since 2006, RCCHC has provided remote monitoring and chronic care management for patients with Cardiovascular Disease, Diabetes Mellitus, and/or Hypertension who were experiencing health disparities. This conceptual model of care is based on the VA’s successful program. Inclusion of remote monitoring

and telehealth will strengthen and expand HIT goals beyond just E.H.R implementation.

We propose that by including objectives and measures for remote monitoring and home telehealth 4 of the 5 five Health Outcomes Policy Priorities will be strengthened.

Priority 1 Improve quality, safety, efficiency, and reduce health disparities

Remote Monitoring

- Provides the patient daily access to their health care data
- Uses evidence based standards for CVD, DM and HTN disease
- Collects data to report to patient registries
- Increases access to daily monitoring and care management
- Decreases health disparities by eliminating barriers to care (transportation, visit co-payments)

Priority 2 Engage patients and families

Remote Monitoring

- Patients actively collect daily objective (blood pressure, pulse, weight, blood sugar, oxygen saturation level) and subjective (signs and symptoms, compliance to medication and nutritional regimen) data
- Patients actively participate in daily health assessment and education
- Patients learn behavioral “cause and effect” resulting in an increased compliance to their medical and nutritional regimen
- Patients do not experience social isolation and become knowledgeable and skillful to manage their own disease

Priority 3 Improve care coordination

Remote Monitoring

- Patients, family members, and all approved health care providers can exchange meaningful clinical information (blood pressure, pulse, blood sugar, weight, oxygen saturation, signs and symptoms and medication and nutrition compliance) through a secure web portal
- Communication among PCPs and specialist increases

Priority 5 Ensure adequate privacy and security protections for PHI.

Remote Monitoring

- Meets all HIPAA regulations

What are E.H.R. adoption barriers for small provider organizations and what solutions would you recommend? What role should small provider organizations play in improving that adoption?

Lack of capital

According to research published in HEALTH AFFAIRS in 2007, 91 percent of CHCs without an E.H.R. system cite lack of capital as the most important barrier to adoption. Lack of capital includes capital for EHR software, servers/access/wiring, upgraded computer terminals, laptops, notebooks. Most small practices have few to no computers with enough memory/power to run E.H.R systems - some have no or only 1 computer with internet access. Three-quarters of CHC patients are uninsured or covered by Medicaid with a current average operating margin of less than 1 percent, leaving CHCs poor

equipped to make substantial capital investments. CHCs will not be able to shift adoption costs to private payers, nor can they be expected to have the level of access to private lending capital enjoyed by providers with robust privately sponsored operations.

Solution – Funding or incentives measure must be put in place for CHCs to upfront the dollars to cover the cost of an E.H.R with features to meet meaningful use criteria - eg. registry function, inquiry/reporting functions, e-Rx etc

Loss of Productivity/Income

The second major barrier to EHR adoption for CHCs is loss of productivity and income during the transition. Currently CHCs serve more than sixteen million patients, including one in four people with family incomes at or below the federal poverty level, one in seven who are uninsured, one in nine Medicaid beneficiaries, one in ten minorities, and one in nine rural residents. According to cited research, CHCs serving a greater proportion of uninsured patients had only 47 percent the odds of having a functional E.H.R. compared to centers whose uninsured patient distribution was below the federal poverty level median. Many CHCs are experiencing physician shortages and can not financially afford to provide provider training and a long E.H.R. implementation learning curve. In addition, providers have limited or no time to learn to use systems while still trying to care for the rapidly growing uninsured patient populations. In addition, the average time for full E.H.R. implementation is 1.5 years which

Solution

Implement an incentive plan for CHCs during the training and implementation learning timeframe. This would allow CHCs another financial resource to overcome this significant barrier.

Poor or limited E.H.R. function on existing systems on the market

Most systems currently on the market have poor or limited function and many do not perform as expected. Many systems have no registry function, inquiry/reporting function, ability to interface with outside software systems, data base, decision support systems (for management of chronic diseases)

Solution

Require all E.H.R. systems to have all necessary functionality before they can be sold. Create a standardized Request for Proposals for E.H.R. purchases. Require actively practicing clinicians to assist in the design of efficient templates and documenting tools.