



Main Office
7501 Wisconsin Ave.
Suite 1100W
Bethesda, MD 20814
301.347.0400 Tel
301.347.0459 Fax

Division of Public Policy &
Research
1400 Eye Street, NW
Suite 910
Washington, DC 20005
202.296.3800 Tel
202.296.3526 FAX

January 28, 2019

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via healthit.gov

RE: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs

Dear Secretary Azar:

On behalf of the National Association of Community Health Centers (NACHC), we would like to take this opportunity to provide comments in response to the draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*.

NACHC is the national membership organization for federally qualified health centers (referred to as “FQHCs” or “health centers”). With over 1,400 organizations and more than 11,000 sites nationwide, health centers are non-profit, community-directed providers that serve as the primary health home for over 28 million patients, including 1 in 6 Medicaid beneficiaries. Health centers are the largest primary care network in the country providing comprehensive services in all 50 states and U.S. Territories. For more detail on health centers, please see Attachment A.

NACHC and its members appreciate the Department’s effort to reduce the burden associated with Health IT and EHRs and are overall supportive of the draft strategy. In its comments, NACHC will focus primarily on opportunities to help FQHC providers minimize the associated burden of Health IT and EHRs and allow them to maximize their time spent on direct patient care. We welcome the opportunity to work with the U.S. Department of Health and Human Services on opportunities for the implementation of the final strategy.

Better Align EHR System Design with Real-World Clinical Workflows

Health centers have been leaders in the adoption of EHR systems – in 2016, over 95% of health centers had operational EHR systems installed in all of their sites and for all providers.¹ NACHC believes improving the usability of health IT systems is a key step in reducing provider burden. As part of Strategy 1 of Health IT Usability and the User Experience (page 51), we would encourage HHS to consider standards for how developers execute the initial implementation and deployment processes. This is the first area where the ease of use is based on the user’s knowledge and the developer’s interpretations of the end users’ needs.

¹ 2016 HRSA Uniform Data System Report

Partner with clinical stakeholders to promote clinical documentation best practices.

Best practices vary depending on the care setting. The tools and resources that are made available by ONC need to include best practices for health centers and keep in mind the additional steps they must take to fulfill FQHC requirements and data capturing in their workflows. Furthermore, best practices on documentation need to cater to the variety of sizes of health centers. For example, larger health center best practices cannot be applied to a smaller health center with limited resources.

Standardize Results Display Conventions within Health IT

NACHC supports the recommendation in Strategy 3 of Health IT Usability and the User Experience (page 55) to standardize order entry and results display. However, there are vendors who are not yet compatible with certain health IT developers. NACHC would encourage HHS to consider standards and enforcements for all entities that perform lab tests to ensure compatibility with EHR systems as a way to reduce the burdens associated with both sending laboratory tests and receiving results electronically.

Leverage Health IT Functionality to Reduce Administrative and Financial Burdens Associated with Quality and EHR Reporting Programs

As recommended in Strategy 2 related to EHR Reporting, NACHC supports the development of standards for promoting interoperability and patient access to health information. Standards for access, extraction, integration, and analysis of data has the potential to help health centers better coordinate care and bend total cost of care trends while improving population health. We would welcome the opportunity to help inform those standards and recommend providers be given ample time and opportunity to learn and be trained on such standards.

Continue to promote nationwide strategies that further the exchange of electronic health information to improve interoperability, usability, and reduce burden.

The success of ONC's proposed Trusted Exchange Framework and goal to create interoperability is reliant on the use of Application Programming Interfaces (API) by HIT vendors. HIT vendors should be enforced, not recommended, as an industry standard to use API interfaces in order to save healthcare organizations from the "financial burdens" and difficulty that come with building costly interfaces to exchange data between the multiple HIT systems necessary to fully function as a healthcare organization. Furthermore, there should be a requirement that prohibits EHR vendors from attaching costly fees to extract data from their EHR systems. The data belongs to the healthcare organization, not the EHR vendor. An EHR vendor's revenue stream and fee structure should never be attached to their customers request to access their data and we believe that ONC should prohibit this practice and provide the appropriate oversight to ensure that this practice is prohibited.

Inventory Reporting Requirements for Federal Health Care and Public Health Programs that Rely on EHR Data to Reduce Collection and Reporting Burden on Clinicians. Focus on Harmonizing Requirements across Federally Funded Programs that Affect a Critical Mass of Health Care Providers.

The Health Resources and Services Administration (HRSA) manages a standardized reporting system on performance measures that health centers are required to report annually. This system, known as the Uniform Data System (UDS), encompasses data on patient population demographics, staffing, services provided, clinical indicators, outcome measures, costs, and revenues. The UDS assists in identifying trends over time, improving health center performance, and comparing health center populations with the U.S. population. In addition to reporting data to HRSA, health centers also collect and share data to inform care delivery and meet reporting requirements for health plans, Medicaid agencies, and other partners.

NACHC supports the recommendation in Strategy 2 of Public Health Reporting (page 66-67) to look at opportunities to inventory, harmonize, and provide additional guidance on reporting across federally funded programs, in a timely manner. Previously, health centers have experienced unnecessary burden due to delays in releasing UDS data, which leads to changes in EHR vendor modules. We believe that better and timely coordination amongst partners can reduce the burden on all participants.

We thank the Department for recognizing community health centers as a key stakeholder in this effort and welcome the chance to partner with HHS to not only reduce burden but support targeted and coordinated approaches to care delivery across the health care system.

Thank you for the opportunity to comment on the Draft Strategy. NACHC and its member organizations are willing to provide clarification or answer any follow up information on our comments, please contact Kersten Burns Lausch at klausch@nachc.org.

Sincerely,



Steve Carey

Chief Strategy Officer

National Association of Community Health Centers

Attachment A: OVERVIEW OF FEDERALLY QUALIFIED HEALTH CENTERS

For over 50 years, health centers have provided access to quality and affordable primary and preventive healthcare services to millions of uninsured and medically underserved people nationwide, regardless of their ability to pay. At present there are almost 1,400 health centers with more than 11,000 sites. Together, they serve **over 28 million patients**, including 8.4 million children and more than 1 in 6 Medicaid beneficiaries. **Health centers provide care to all individuals, regardless of their ability to pay.** All health centers provide a full range of primary and preventive services, as well as services that enable patients to access health care appropriately (e.g., translation, health education, transportation). A growing number of health centers also provide dental, behavioral health, pharmacy, and other important supplemental services.

To be approved by the Federal government as a health center, an organization must meet requirements outlined in Section 330 of the Public Health Service Act. These requirements include, but are not limited to:

- Serve a federally-designated medically underserved area or a medically underserved population. Some Health centers serve an entire community, while other target specific populations, such as persons experiencing homelessness or migrant farmworkers.
- Offer services to all persons, regardless of the person's ability to pay.
- Charge no more than a nominal fee to patients whose incomes are at or below the Federal Poverty Level (FPL).
- Charge persons whose incomes are between 101% and 200% FPL based on a sliding fee scale.
- Be governed by a board of directors, of whom a majority of members must be patients of the health center.

Most Section 330 health centers receive Federal grants from the Bureau of Primary Health Care (BPHC) within HRSA. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing care to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients who are not indigent or who have insurance, whether public or private, are expected to pay for the services rendered. In 2017, on average, the insurance status of health center patients is as follows:

- 49% are Medicaid recipients
- 23% are uninsured
- 18% are privately insured
- 9% are Medicare recipients

No two health centers are identical, but they all share one common purpose: to provide primary health care services that are coordinated, culturally and linguistically competent, and community-directed, to uninsured and medically underserved people.