



Health Care Access for All

June 25, 2009

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RE: Preliminary Definition for EHR Meaningful Use

Dr. Blumenthal:

On behalf of the California Primary Care Association (CPCA), the 18 regional health center associations and health center controlled networks, the 800 nonprofit community health centers, and the four million patients they serve in California, I thank you for the opportunity to comment on the preliminary definition for EHR meaningful use. We appreciate the Policy Committee's integration of the National Quality Forum's priority areas in crafting the definition of meaningful use. Community health centers (CHCs), from their inception in the 1960s, have worked to engage patients in a culturally and linguistically competent manner, reduce racial disparities, improve patient safety, coordinate care, improve overall efficiency, and ultimately through this work have improved population health. CHCs have been the medical home for low-income, uninsured, and medically-underserved Americans long before the term medical home became popular. The principles used to craft the definition of meaningful use are the same principles that guide health care delivery in CHCs.

Background

The community health centers CPCA represents are nonprofit, tax-exempt clinics that are licensed as community or free clinics, as defined under Section 1204 of the California Health and Safety Code, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients. Over 400 of the 800 CHCs in California are designated

Federally Qualified Health Centers (FQHCs); 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). For the purposes of our comments, “CHCs” refers to both FQHCs and non-FQHCs, and “clinics” refers to non-FQHCs.

Comments

We are generally supportive of the matrix of measures and the staggered timeline the Policy Committee has presented. The ultimate goal, made possible through the collection of data and data exchange, has far reaching implications for improved patient health. CHCs are willing and excited to participate in this ambitious goal. That being said, we believe there are some fundamental elements missing from the preliminary definition of meaningful use.

We respectfully submit the following comments:

1. The Medicaid incentive funding is not sufficient for the acquisition and meaningful use of an EHR for many free-standing non-FQHCs that serve large Medicaid and uninsured populations.

The financial resources and the preliminary definition of meaningful use have narrowed the playing field for which providers will take advantage of the Medicaid incentive funding for the acquisition of EHRs. Free-standing, non-FQHCs rarely have the financial or personnel infrastructure to integrate an EHR. For those non-FQHCs it is questionable as to whether the Medicaid incentives will be sufficient to cover the capital, maintenance, infrastructure, and on-site technical expertise costs required for EHR implementation success. Many of these clinics regularly struggle with fiscal and personnel resources and typically are not structured to manage onerous data reporting requirements. CPCA realizes that the HITECH Act provides funding for Regional Extension Centers and EHR Loan funds, however, there may not be sufficient resources to provide HIT support for these smaller and vulnerable clinics that are often the only access point to primary and preventive care for underserved populations in their regions.

Our main concern is that the reporting and HIE provisions for these dollars will not sufficiently take into account issues such as the lack of high speed internet capacity in very rural regions. It may be unrealistic to assume that with the very limited resources of rural-frontier providers such as rural hospitals, private physicians' offices and clinics that they will be able to have a fully functional HIE within the published draft timelines. If the standard is such that this is what is demanded in order to see any of the incentive funds, rural providers will be deeply disadvantaged.

In short, these expectations, particularly in the first 3-5 years of the roll-out, may not be realistic for rural-frontier health care providers, including clinics. Moreover these expectations may undermine clinics who will have invested in EHRs with the expectation of receiving these support dollars only to find out, that through no fault of their own, they cannot meet the full definition of meaningful use, particularly with respect to HIE and data reporting requirements. At the very least, rural-frontier providers need to have an appeal process to allow them to make their case when such environmental circumstances (e.g. no high speed internet available) complicates their ability to meet the full measure of these new standards.

2. The Medicaid incentive funding should reward early adopters by allowing them to access the initial \$25,000 for purchase and implementation of an EHR.

Currently as the regulations are drafted, the EHR Medicaid Incentive funding is directed at new EHR adopters and does not acknowledge those that have already implemented or implement before 2011. It is essential that early adopters who have not met the meaningful use definition prior to 2011 be eligible for the initial \$25,000 per provider. There are numerous health centers in California that spent years researching products and vendors, negotiating with vendors, implementing products, working with vendors to ensure the product met the health centers needs, and are now teaching and mentoring other health centers on the process. These lessons are invaluable to the health care field and without these health centers there would be no input on meaningful use and the possibilities for the advancement of HIT. The ONC should reward the courage and resourcefulness of EHR early adopters, especially those in the safety-net where the ROI is negligible or non-existent.

3. The certification requirements for EHRs should be more stringent and most importantly require a robust population management functionality.

EHR vendors notoriously make claims about the capabilities of their product that in practice are not accurate. If meaningful use is to be met by providers, meaningful use capabilities must first be in place within the products. For example, population management is touted as a functionality in many EHR products, however, in our experience with EHR implementation population management is often the weakest and least developed capability in an EHR. CHCs are adept at population management, and have been doing so for many years. The EHR products, however, limit our expertise and the data from going electronic and being exchanged. If CHCs are expected to perform this function, the product must first be capable of it and this capability must be demonstrated by the products before any sales or certifications are made.

In addition to the population management functionality, EHRs need to improve their report writing capabilities. If one of the ultimate goals is reducing health disparities, an EHR needs to be able to stratify reports by gender, insurance type, primary language, race and ethnicity, as the Policy Committee outlines in the preliminary definition. However, this capability is not robust in most EHRs.

There are numerous other lacking capabilities and functionalities in EHRs, even among the few that have risen to the top in the CHC environment. To rectify this glaring problem, that ultimately impedes the goal of the ONC to improve the overall health of Americans, CPCA proposes that before any EHR product is deemed certified it be validated by industry leaders. One of the industry leader groups needs to be CHCs. Both FQHC and non-FQHC representatives should participate in this group. This is especially important for CHCs because they do not comprise the bulk of the market share demanding EHR products. Of the hundreds in existence, health centers use primarily eight EHR vendors, most of which serve a broad healthcare provider audience. Without this detail to CHC specific needs the market may not respond quickly enough, thus leaving CHCs unable to meet the definition of meaningful use. This would further result in a lack of critical data about the uninsured and medically-underserved populations.

4. The health outcome policy priority objectives and measures should be staggered by product and technology capability.

The preliminary meaningful use definition expects that EHR products can produce the outlined measures, health information can be exchanged, and patients can access their health records in parallel fashion, and as soon as 2011. From health center EHR implementation experience in California, we know that the parallel timelines for all three expectations are not realistic. First and foremost, the majority of EHR products do not have the capability of producing the measures requested in 2011. This lack of capability renders the health information exchange expectations suspect. Further, expecting products and providers to tailor currently non-compliant EHR products to patient specific needs by 2011 is too high of an expectation.

We propose that the 2011 timeline be for EHR product capabilities, the 2013 timeline for health information exchange, and the 2015 timeline for patient access to personal health information.

5. The meaningful use data measures should parallel current data measures already outlined by federal government agencies and bureaus.

Federally Qualified Health Centers are expected to report Uniform Data System (UDS) and Health Effectiveness Data and Information Set (HEDIS) measures, and for efficiency, cost

effectiveness, and statistical tracking purposes the meaningful use data reporting requirements should mirror these data reports or be the same. FQHCs comply with some of the most onerous reporting requirements in the health care environment. Data reporting requirements for meaningful use should build upon or utilize what FQHCs are already required to do.

6. The consent to electronically transmit patient health information should be received at the point of eligibility from the insurer, and should not be a requirement placed on individual providers.

CHCs should not be required to ask for specific consent to transmit HIPPA compliant electronic information on their patients as it is too onerous of a requirement. This can easily and efficiently be done during the eligibility process of the various payors, including Medicaid agencies.

7. No provider should be penalized if his/her CHC or patient population does not have high speed connectivity.

As noted above, while broadband connectivity is proliferating throughout the country, and in California with the soon-to-be built California Telehealth Network, many rural communities lack and will lack access to high speed internet for many years. The meaningful use definition must be inclusive of rural providers and their patients and provide additional resources for overcoming these barriers, or provide for an appeal process to allow for payments for EHR systems that cannot meet some of these expectations through no fault of their own.

8. The meaningful use definition should prioritize capturing socio-economic data.

Every health outcome policy priority should include as a baseline measure: "stratify reports by gender, insurance type, primary language, race, and ethnicity." This measure is listed in the first health outcomes policy priority, and should additionally be added to each of the subsequent health outcomes policy priorities. Adding this measure will reinforce the ultimate goal of reducing health disparities.

If you have any questions about these recommendations, please do not hesitate to contact our Associate Director, Andie Martinez, at (916) 440-8170 or amartinez@cpca.org. Thank you for your attention and consideration.

Sincerely,

Robert E. Beaudry
Chief Operating Officer
California Primary Care Association