

June 25, 2009

[If by electronic means]
MeaningfulUse@hhs.gov

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

RE: Preliminary Definition for EHR Meaningful Use

Dear Dr. Blumenthal:

The National Association of Community Health Centers, Inc. (NACHC) is pleased to respond to the above-cited solicitation from the Department of Health and Human Services (HHS) on the preliminary definition of “meaningful use.” 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) non-profit organization.

BACKGROUND

There are, at present, approximately 1200 FQHCs nationwide serving close to 18 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.

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 of who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35 percent are

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Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured.

COMMENTS ON THE DEFINITION

NACHC appreciates the opportunity to share the following comments and questions to the “meaningful use” definition and matrix.

Proposed Timeline

The Matrix identifies 2011 as the first year of Medicare payment. However, as health centers are eligible for the Medicaid incentives, it is our understanding that states will determine their “first year” of Medicaid incentives, which may or may not be 2011. It is also our understanding that Medicaid Incentives the first year will be paid for “adoption” of EHRs; however, there is no indication of what constitutes “adoption.” We ask NCHIT to clearly define “adoption.” We also have some concerns regarding the lack of clarity of the required measures (for all years) and need more specifics on required measures before we can meaningfully comment.

Certification of Electronic Health Records (EHRs)

NACHC has some concerns with the assumption that currently certified EHRs can in fact provide the functionality that is being requested to meet the “meaningful use” guidelines and measures. We believe that most EHRs that have been certified in fact collect the proper data; however, it is unclear if all EHRs that have been certified to date have been tested to ensure that the EHR can provide the reporting functionality to produce the measures within the EHR itself. An EHR vendor simply identifying that the EHR stores data “in the system” without providing the functionality within the system, thus requiring a provider to seek yet another software package to extract the data, is insufficient. Providers must have the knowledge and security that purchasing a “certified system” actually means that the system can produce the reports on the measures that “meaningful use” requires. NACHC requests that all of the certification criteria be included in the definition of meaningful use, ensuring that certified EHR systems meet all of the requirements.

We also recommend that the “meaningful use” measures parallel current data measures already in place and outlined by other federal agencies and bureaus. Health centers currently report on the HRSA’s Uniform Data Set (UDS) clinical measures as well as Health Effectiveness Data and Information Set (HEDIS) measures. Data reporting requirements should be aligned with these sectors.

Health Outcomes Policy Priorities

Improve quality, safety, efficiency, and reduce health disparities

Implementation of an EHR product is a large project for any provider. These implementations usually take 12 – 18 months or more and functionality is phased-in over time. We believe that all orders should be entered electronically in year one, however, we have concerns if this requirement includes the full definition of CPOE, meaning that the orders are not only entered electronically but sent and received by another party electronically. This may not be possible due to limitations on the receiving party side. Health centers and other providers should not be

penalized due to the lack of electronic capabilities from health care professionals that they do business with in their community. In many instances especially in rural areas there may not be a choice of provider partners.

We applaud ONC and the Policy Committee for including “generate lists of patients by specific condition to use for quality improvement, **reduction of disparities**, and outreach” in the matrix as well as “we would encourage and fully support the capturing of race, ethnicity, language preferences as these are important components of identifying disparities.” We would recommend, however, that a standard dataset for the collection of disparity information be established as currently there are different datasets used by different regulatory bodies. Health centers currently capture and report this data according to HRSA requirements.

This is a major focus of health centers and this objective will assist us and other providers to move towards the elimination of health disparities in our population.

Engage Patients and Families

NACHC also believes that requiring this objective in year one is setting the bar too high for this activity. As discussed above, implementations take 12 – 18 months or more. This functionality is not part of all EHRs and to establish the functionality to provide the patient with an electronic copy in year one may make many providers ineligible to meet the meaningful use criteria. We recommend that providing the patient with a paper copy be the requirement in the first year after adoption and providing electronic copies not be required until the end of the second year or beginning of the third year of implementation.

There are also issues of health literacy and computer access for underserved populations that may prevent health centers and other safety net providers from meeting this standard. The meaningful use requirement in 2013 that the provider have implemented the ability to incorporate data uploaded from home monitoring devices again may depend on the EHR vendor being able to do so. This requires the EHR when certified to prove that it has this functionality.

Improve Care Coordination

The requirement to “exchanging key clinical information among providers of care (e.g., problems, medications, allergies, test results)” requires further clarification. It is unclear which providers will be involved with the exchange. Will it include all providers in the community or just certain providers? Are there specific providers that will be required to establish exchange mechanisms? Which specific data will be required? We would recommend that the specific data be identified and providers be allowed to phase in full implementation over time.

Improve 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. In order to meet this goal it will be imperative that public health entities have

the capabilities to accept the data electronically from EHRs and that “certified” EHRs have the capability to send the data to public health entities electronically.

Ensure adequate privacy and security protections for personal health information

NACHC requests clarification on the measure “an entity under investigation for a HIPAA privacy or security violation cannot achieve meaningful use until the entity is cleared by the investigating authority.” Specifically, we believe the level of “investigation” should be taken into consideration. Would a minor infraction that is under investigation and that is being appropriately addressed internally by the organization be a limiting factor and not allow that health center or other provider to meet the meaningful use criteria? Being in full compliance with HIPAA and Conducting or updating a security risk assessment and implementing security updates as necessary should be enough to meet the standard. Just because the health center or other provider had a breach and are under investigation is not a reason in and of itself to identify that they are not a meaningful user of their EHR.

We appreciate the opportunity to comment on this notice and would welcome the opportunity to further discuss these concerns. If you have questions, please contact Michael Lardiere, Director of Health Information Technology at 301.347.0400.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is fluid and cursive, with the first name "Roger" and last name "Schwartz" clearly distinguishable.

Roger Schwartz, Esq.
Associate Vice President, Executive Branch Liaison
Legislative Counsel