



*Health Care Access for All*

February 25, 2011

Department of Health and Human Services  
Office of the National Coordinator for Health Information Technology  
Attention: Joshua Seidman  
Mary Switzer Building  
330 C Street, SW,  
Suite 1200  
Washington, DC 20201.

Re: Meaningful Use Workgroup Request for Comments Regarding Meaningful Use Stage 2

Dear Health Information Technology Policy Committee:

On behalf of the California Primary Care Association (CPCA), the 18 regional health center associations and health center controlled networks, the 870 nonprofit community clinics and health centers (CCHCs), and the nearly five million patients they serve in California, I thank you for the opportunity to comment on the draft Meaningful Use Stage 2 measures and questions.

As you may be aware, CCHCs 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. CCHCs have been the medical home for low-income, uninsured, and medically under-served 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 healthcare delivery in CCHCs.

### **Background**

The community clinics and 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 450 of the 870 CCHCs in California are designated as 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). Additionally, over 30 CCHCs in California are FQHC- Look Alikes. FQHC-LA's operate and provide services similar to FQHCs, however they do

not receive a Section 330 grant. FQHC Look-Alike entities are expected to demonstrate the same commitment as grantees to serve all populations residing in their respective medically underserved communities, and to satisfy the administrative, management, governance and service-related requirements unique to section 330 funded health centers.

Section 1402 in HR 1 specifically refers to FQHCs, which according to Medicaid law includes FQHCs, FQHC-look alike, and specific IHS providers. For our comments, the term FQHCs refers to FQHCs, FQHC-LAs, and those specific IHS providers. Because the delivery model, mission, and payment mechanisms for community clinics and free clinics are nearly identical to FQHCs and FQHC-LA's, our comments will use CCHC to refer to all three types of entities.

We respectfully submit the following comments:

### **Proposed Stage 2: Improving Quality, Efficiency, and Reducing Health Disparities**

#### **1. 50% of orders transmitted as eRx**

It is evident from this proposal and the allowance for fax transmission that the HITPC recognizes the challenges faced by providers serving in underserved areas. Many pharmacies, especially in rural areas, are not equipped to accept electronic transmission of prescriptions. We recommend that these pharmacies be identified and targeted for specific incentive programs to install technology that will allow their systems to receive prescriptions electronically. As long as these pharmacies cannot accept prescriptions electronically we will continue to experience a digital divide in these communities.

#### **2. Record existence of advance directives (make core requirement)**

This is a new criteria and measurement for EPs in Stage 2, and we believe that the 50% criteria is too high. Rather, CPCA recommends a lower threshold for EPs in Stage 2 at 10% and then in Stage 3 50%. We further suggest that the requirement should be that the referring provider discuss the directive with the provider receiving the patient, rather than require an advance directive.

#### **3. Incorporate lab results as structured data (move current measure to core)**

This is an admirable measure, however EPs do not have control over whether or not the lab they are working with can electronically exchange lab results. Meeting this measure would require the purchase of expensive interfaces, which will be exceedingly challenging for small providers in rural areas and safety net providers, and the labs they contract with. Further it would provide an unfair competitive advantage to large labs that can afford the interface and smaller labs that cannot.

CPCA recommends that there be an exclusion option for providers who work with labs where this interface is in not place, or to keep this proposed measure as a menu option rather than move it to the core.

#### **4. Generate lists of patients for specific conditions (make core requirement)**

CPCA appreciates the intent of this proposed measure but would suggest more clarification. What ambulatory care sensitive conditions should be generated? Is it just a list or should these patients be managed? How would this be reported? By an attestation? It would be very beneficial to our providers and their care delivery if there were a structured way to link the generated list to outreach done to patients. Ultimately we agree with the measure, just request more direction and clarification.

#### **5. Send patient reminders (make core requirement)**

The HITPC asked stakeholders how active patient should be defined; we would like to suggest an active patient is one seen in the last year. We also request clarification on the “who” should get the reminder. For patients under 5, does the reminder go to the child or their parent/ caretaker, and the same would apply for a patient over 65. Another thing to consider, is how many things should the EP be reminding the patient of?

As an organization representing the interests of the underserved patients our CCHCs serve, we also ask the HITPC to consider incorporating patient preference for communication be documented in this proposed measure.

And lastly, we agree that the measure should be a core objective, but that the percentage should be increased to 50%. This is a functionality that all EHRs can easily do, and providers can easily do this.

### **Proposed Stage 2: Engage Patients and Families in their Care**

#### **6. Electronic discharge instruction for hospitals are offered to at least 80% of patients**

Our providers are EPs, not EHs, however our providers feel strongly that it is important that the primary care provider of the patient being discharged receive the discharge instructions from the discharging provider. To make this measure more robust we propose to add that the PCP of the patient also receives the discharge instructions.

#### **7. Patients have the ability to view and download relevant information about a clinical encounter 24 hours after the encounter.**

CPCA is supportive of engaged and educated patients, however we believe this measure goes too far. The amount of information in the summary suggested by HITPC is too detailed. We do not believe that collecting and highlighting gender and race information at every visit is necessary. We do agree that collecting language information would be useful, as well as confirming advance directives and providing information about smoking cessation.

We also have a few questions about the proposal. Would the clinical care summary include only new data or just be a summary of care? If it is a summary of care, how far back does it go?

#### **8. 20% of patients use a web-based portal to access their information at least once.**

CPCA fully supports this proposed objective, but suggests that the concept of a web based portal account for cell phone applications as well. Many of our mobile, transient, and lowest

income populations do not readily have access to or use computers, but many do have cell phones. Rather than just focus on web portals, the ONC and CMS should be encouraging the vendors to make web based portals easily translatable onto a cell phone platform so that patients can access their health information in the format they are most interested and comfortable using.

#### **9. Online secure patient messaging is in use**

We appreciate this new measure, but have concerns around privacy and security. We do not want our providers using any communication format that is not safe and secure for our patients. We recognize the HITPC's inclusion of the word "secure" but we want to reinforce that we remain apprehensive of text messaging even though we believe this is likely one of the best ways to communicate with our patients. We suggest that standards be put into place to allow for such secure messaging.

#### **10. Stage 3: Patients offered capability to report experience of care**

HITPC is looking for steps in Stage 2 to achieve this objective by Stage 3. We recommend a basic survey once a year during Stage 2 and then during every encounter in Stage 3. We suggest, however, that the questions be limited to less than five and that CMS coordinate with the patient centered medical home surveys at the federal level to maximize the goal of improving patient care and experience.

#### **Stage 2: Improve Care Coordination**

##### **11. Connect to at least three external providers in primary referral network or establish an ongoing bidirectional connection to at least one HIE.**

We have a number of concerns and questions about this proposed objective. While we too share the ONC's and CMS' goal of health information exchange, we are keenly aware of the realities and barriers to creating HIE and it is from this vantage that we provide comment on this proposed objective.

First, we suggest that the HITPC define all the terms used; what is a primary referral network? What is a provider? What is connect? Can the three providers be in the same location, like a hospital or clinic? All of these clarifications will influence how to accomplish this objective.

We know that the HITPC is familiar with the realities of the health care delivery system and how difficult it is to get just one health information exchange relationship in place. In California HIE is far from ubiquitous. It takes years sometimes just to get business associate agreements in place with external providers, let alone having the trust framework and financial resources in place to create an HIE. We want to continue elevating the standards for meaningful use while also being aware of the challenges providers face. As such, CPCA recommends that this proposed objective be expanded by allowing evidence of effort. For example, a provider could attest to and prove that an MOU or agreement was in place between a external referral network and that progress was underway to creating the connection. Or CPCA recommends that the HITPC create an exclusion to this objective in the case that the provider does not have

the resources for the interface or their referral networks do not have the resources to build a connection.

#### **12. Provide summary of care record (move to core)**

CPCA supports this proposed objective and suggests that the discharge instructions required for EHs in Stage 2 measures be included in the summary of care record. Further, CPCA suggests that the PCP be listed as a provider required to receive the summary of care, not just specialists. Lastly, CPCA suggests that the HITPC better define what the numerator for this objective would be.

#### **13. List of care team members available for 10% of patients in HER**

CPCA fully supports this measure, however we have a number of clarifying questions: What does “available” mean? Is this list for the patients or for the care team? How does HITPC define team? Does stage 2 not have to be available electronically as it does in stage 3? Where does this information go?

#### **14. Record longitudinal care plan for 20% of patients with high priority health conditions**

We appreciate how this measure relates to the goals of patient centered medical home, and support its inclusion in the meaningful use objectives. There remain some elements, however, that need further clarification. CPCA suggests that the HITPC better define longitudinal with concrete timelines so that there is no confusion. Also, further define high priority health conditions. For ambulatory care they could include diabetes, CHF, asthma, COPD, and HIV(PC). Also, we would recommend include self-management goals to the requirement.

### **HITPC Open Ended Questions**

#### **2. For Patient/Family access to personal health information, what standards should exist regarding accessibility for people with disabilities?**

We suggest that EHR vendors be required to meet the Americans with Disabilities Act standards for electronic and written communication. As for clinics and health centers, we are not sure factors related to disability access would affect our communication or care delivery within the clinic. We ask that if requirements be put into place it be very clear what is required of vendors and what is required of providers when they use a certified EHR to care for their patients.

#### **3. What strategies should be used to ensure that barriers to patient access are appropriately addressed?**

Clinics and health centers pride themselves on delivering culturally competent and linguistically appropriate care. This ability however can be hampered by the technology, as the vendors do not necessarily include appropriate health material for patients within the EHRs. It is then the responsibility of the provider and the health center staff to translate and create material for the patients that is not only at the appropriate literacy level, but also in a language the patient can read, and written in a manner sensitive to his/her culture. From our clinics experience, EHRs will often provide visit summaries that are a list of codes. It then falls on the providers to translate the code into intelligible information for the patient. This type of activity takes unnecessary time away from directly caring for the patient, and vendors should be held more

accountable to providing appropriate information via their EHRs. One manner to address this on the provider end, would be to require EHRs have a place to capture the literacy level of the patient, so that providers can determine the most appropriate manner in which to communicate with the patient.

We would also like to suggest, as we've mentioned earlier in our comments, that the ONC consider requiring a certified EHR be capable of sending patient reminders or health information to a patient's cell phone.

**5. For future stages of meaningful use assessment, should CMS provide an alternative way to achieve meaningful use based on demonstration of high performance on clinical quality measures?**

We have concerns about CMS allowing for this alternative because process measures are important methods to understand your care delivery. For example, having low adverse drug events is good, but the more you improve your capacity and ability to collect the information the higher that percentage increases. In this case, improved process allows a provider to see where their care delivery is flawed, but allowing a provider to skip the process could ultimately result in masking fatal problems.

**6. Should Stage 2 allow for a group reporting option to allow group practice to demonstrate meaningful use at the group level for all EPs in that group?**

We suggest that groups be provided the choice of either reporting by individual providers in the group or as a group as a whole. Health centers report measures by organization, such as the Uniform Data System to the Health Resources and Services Administration. It would be administratively time consuming and difficult to report UDS data by individual provider. Further, group reporting is supportive of the movement towards a care team model and health home. For clinics, health centers and groups moving in this direction, they should be afforded the option of doing so. However, we understand that there are accountability issues with reporting by provider, and that is a very powerful tool for our clinics and health centers to use in improving quality. As such we believe this too should be an option.

**General comments**

**CPCA recommends that HITPC encourage the ONC to make functionalities required to meet any of the core and menu objectives be core components of certified EHRs.**

The incentive payments are definitely a motivating factor to participate but if the costs of participating begin to overrun the incentive payments providers will stop working to achieve meaningful use, ultimately undermining the goal of the program.

**CMS should consider allowing for a rolling submission of the meaningful use reporting once the full calendar year reporting begins for payment year 3.**

As the rule is currently written, meaningful use reporting for Payment Year 3 Stage 2 requires a full calendar year of reporting, as do all the following Payment Years. CPCA recommends that CMS allow for a full 12-months of reporting rather than requiring the reporting to be done in the calendar year cycle which would mean beginning January 1 and ending December 31. As

incentive payments are reliant on the reporting to be verified, it would seem that having all EPs submit data at one time would create an enormous backlog and delay in payments. Rather it seems appropriate to allow for a rolling submission as long as the reporting is done over a consecutive 12 month period.

**CMS should consider extending the timelines for providers to achieve later stages of meaningful use.**

CPCA is keenly aware of the variety of programs within the HITECH Act, especially the meaningful use incentives as it relates to the providers at our CCHCs, and the regional extension center (REC) program, as we helped to form one. CPCA with the California Medical Association and the California Association of Public Hospitals formed CalHIPSO, the largest REC in the country. As such we follow the policy and regulation guiding each program and are aware when there are incongruous elements.

For example, the Office of the National Coordinator (ONC) recently extended the timelines for the RECs, making what was essentially a two-year program into a four-year program. It would seem appropriate for the Centers for Medicare and Medicaid Services (CMS) to make a corresponding change, by delaying implementation of Stage 2 for all providers until 2014. This change would greatly benefit the RECs and the providers who are relying on them. As it now stands, the criteria and objectives of meaningful use will be changing roughly halfway through the REC program, REC staff will have to quickly learn the new rules and assist providers achieve the Stage 2 requirements, and almost just as quickly shut down operations as is expected of most REC programs once federal funding ceases. Ensuring RECs can get all providers who are eligible to Stage 1 would be a tremendous success for our country.

Lengthening the time between stages is also a benefit to providers. Providers will feel less overwhelmed and will have more time to adjust their practice workflows to the new electronic environment, especially those that are reliant on connecting to other practices and providers.

**The federal government should consider ways to provide resources and support to public health agencies to assist with their transition to digital data sharing.**

Two of the menu set requirements from Stage 1, which are made mandatory for Stage 2, involve reporting to immunization registries and public health agencies. Most of our public health departments in California currently do not have this capability and it will require substantial resources to make this possible. CPCA agrees that public health should be a priority for meaningful use, however, this likely is not possible without additional federal resources. CPCA recommends that the federal government provide additional resources to public health entities to allow for this reporting.

Thank you again for the opportunity to comment on the draft Meaningful Use Stage 2 measures and questions. If you have any questions about these recommendations, please do not hesitate

to contact our Assistant Director of Policy, Andie Martinez Patterson, at (916) 440-8170 or [amartinez@cpc.org](mailto:amartinez@cpc.org). Thank you for your attention and consideration.

Sincerely,

A handwritten signature in black ink that reads "Carmela Castellano Garcia". The signature is written in a cursive, flowing style.

Carmela Castellano-Garcia, Esq.  
President and CEO  
California Primary Care Association