National Association of
Community Health Centers, Inc.

4/29/09

**National Committee on Vital and Health Statistics**
**Comment on "Meaningful Use" of EHRs**
**National Association of Community Health Centers**

Thank you for allowing me to provide comment to the National Committee on Vital and Health Statistics from the National Association of Community Health Centers.

Founded in 1971, the National Association of Community Health Centers (NACHC) is a non-profit organization whose mission is to enhance and expand access to quality, community-responsive health care for America's medically underserved and uninsured. NACHC represents the nation's network of over 1,200 Federally Qualified Health Centers (FQHCs), which serve more than 18 million people through 7,000 delivery sites in all 50 states, the District of Columbia, Puerto Rico, the US Virgin Islands, and Guam.

NACHC would ask the Committee to consider the effects of any "meaningful use" definition on the large population of underserved individuals that NACHC serves 53% of whom are in rural areas. The issue of requiring the sharing of information among providers is our goal, however, please be aware of the many areas that lack the infrastructure to actually share data as the neither the broadband nor the HIE capabilities may be in place.

Clarification regarding who health centers will need to share data with is also important. Many health centers approx 40% or more already share data with laboratories and approximately 20% share some data with hospitals in their area. Will these be enough or will they need to connect to other local providers or with other health centers?

We would also caution against using administrative mechanisms such as claims payment mechanisms to identify "meaningful use". Approximately 38% and in some instances 50% of patients seen in health centers are uninsured and no administrative data are available for these patients on which to base the incentive.

We also believe that some consideration should be given to second year payments under the Medicaid incentives. Installing EHRs is a process that may take 12 – 18 months in many cases. We would encourage the Committee to allow a health center to be moving along the continuum of "meaningful use" in year two as the health center may not have been able to fully implement the EHR in year one and be fully implemented to meet all of the "meaningful use" criteria until late in year two or early in year three.

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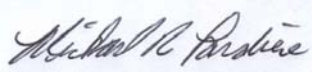
We were also encouraged by the suggestion by Dr. Clancy to implement Quality Improvement Networks. Federally Qualified Health Centers currently have an infrastructure to meet these requirements in the organizational structure that has been advanced and supported by HRSA known as Health Center Controlled Networks. These are groups of health centers that have agreed to come together to share a core function, usually around quality improvement and EHR implementation. We would, however, suggest that these networks need not be all using the same system. What is necessary is there be a mechanism to aggregate the data from disparate systems and feed back the data regarding quality initiatives to the health centers in a locality or a region of the country. We believe that this focus will speed up interoperability of systems and feedback loops to providers to improve quality care. Requiring QI Networks to all be on the same system would actually impede the movement towards interoperability.

The National Association of Community Health Centers hopes to work cooperatively with the Committee and I will be available to answer any questions or assist the Committee to better understand the needs of Federally Qualified Health Centers and the patients they serve.

Thank you for this opportunity to comment.



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