

Meaningful Use Workgroup Hearing

May 13, 2011

Panel 4: Experience from the Field
Presented by Angela Duncan Diop, ND
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Washington, DC

Good Afternoon. My name is Angela Duncan Diop, I am a Naturopathic Physician and the Director of Information Systems at Unity Health Care, Inc. in Washington DC. I would like to thank the Workgroup for the opportunity to speak this afternoon.

About Unity Health Care

Unity Health Care, Inc.(Unity) is a Federally Qualified Health Center serving the residents of the District of Columbia (District). Our patients are primarily the under/unserved and under/uninsured residents of the District, including hard-to-reach populations such as the homeless, substance abusers and ex-offenders. The individuals that we serve are predominately African American and Latino women and men who often face barriers and disparities in care. In 2010, we provided 81,915 patients with 503,457 visits throughout 28 locations. For many of our patients English is not their first language and many have different cultural perspectives on health care. Forty nine percent of our patients relied on Medicaid and twenty six percent were uninsured in 2010. High rates of poverty and unemployment across the District contribute to the health disparities seen in their communities. Over 75% of our patient population lives below the Federal Poverty Limit (FPL).

Unity uses an electronic health record (EHR) and practice management system that was implemented throughout our sites in 2009. The system supports 900 users, 200 of these users are providers. We estimate that 90 of these providers will qualify for Meaningful Use.

Since the implementation of the EHR, we are thrilled to now have the opportunity to deliver to our patients quality health care with the help of state of the art technology through our EHR. In the short period of time since the implementation of our EHR, we have already seen significant improvements in business efficiencies, leading to increased access for our patients, as well as standardization of our work flows resulting, in improvements in the quality of care. We feel that the Meaningful Use requirements and incentives will further enhance our ability to bring quality care to a patient population that is often last to get the state of the art care.

Unity's Plan to Qualify for Meaningful Use

Unity plans to apply for reimbursements for Meaningful Use of HIT through the Medicaid option. We will exercise the option to adopt, implement or upgrade in year one in order to qualify for incentives. To prepare to meet this phase of qualifying, we implemented e-prescribing throughout our health centers in February of 2011. We are in the process of upgrading our existing EHR to the Meaningful Use certified version released by our EHR software vendor early in 2011.

We plan to begin our Stage 1 Meaningful Use reporting period, reporting on measures, in

January of 2012. We will spend the third and fourth quarter of 2011 preparing for the reporting period by addressing gaps found in our Meaningful Use gap analysis that we conducted last fall, getting an early look at how well providers are meeting the requirements and lastly providing feedback and training to providers who may be challenged with meeting specific requirements.

We estimate that our project costs to implement meaningful use over a three year period of time to be \$1,350,000. This estimate is for a three year period because we are assuming that the majority of the project costs will occur in the early years. Two thirds of that costs are for resource people to implement the project and the remainder is for equipment and the cost we must pay for increased functionality of our EHR.

Challenges in Meeting the Objectives

We have found the core and the menu set requirements and their thresholds individually to be reasonable. Because we are an FQHC many of the requirements, such as recording demographics, vital signs and clinical measures are information that we are already required to collect to satisfy our funders. We will be able to meet many of the measures by simply being on a fully functioning certified EHR.

The most challenging core set measure has been meeting the objective of exchanging key clinical information among providers of care and patient authorized entities electronically. To meet this requirement, we will be joining the Regional Health Information Organization (RHIO) that was incubated by our the District of Columbia Primary Care Association (DCPCA) and has now been adopted as the District's Health information Exchange platform. The challenges are that this is a large collaborative project that is pushing the envelope of our vendor's technological capabilities, we are shifting the paradigm of how we do business and it has taken considerable resources to implement.

We also feel the quality measures are reasonable. We are pleased that there are a large set to select from. As an FQHC we are already required to report many measures to our funders such as our 330 Health Center or Ryan White grants. We see opportunities to select quality measures that are aligned with some of our these grant measures. And over the last several years we have seen a trend to align these measures.

Our greatest challenges with respect to meeting Meaningful Use are more oblique and beyond the measures themselves. They include:

The granularity of the reporting. In the past we have reported our data in the aggregate for the health center. With meaningful use, we will be reporting and qualifying on a provider by provider basis. Frankly, at this point, we do not know what that data will look like.

Also, although we will be qualify through our providers, many the objectives will be met by other people in our health center. For example, a patient's race and ethnicity is recorded by patient registration clerks and vital signs are reported by nurses and medical assistants. This means that the training regarding meaningful use can not be limited to providers, but must be conducted throughout our organization. We have now had to broaden our efforts to educate staff about about the measures, which means education will require more resources than we initially thought.

The administration of the program. Unlike hospitals, community health centers will not receive the incentives directly. Over the last five years we have spent millions of dollars planning, implementing, stabilizing, optimizing and upgrading an EHR for our providers and now we are in the position of trying to determine how best to work with provider to administer this incentive program since qualifying providers will be expected to assign their payments over to us.

Competing priorities. In order to meet Meaningful Use we have to implement multiple large projects in a short period of time. To meet the requirements, we have to upgrade our EHR, build and interface to connect to a RHIO, implement e-prescribing, implement a dental module, implement an electronic patient reminder system, implement a patient portal, develop a system to administer and monitor this program, as well as insure that providers are trained and are meeting the requirements. Add to the mix other large changes in the industry – such as ICD10 conversion – we are finding our staff is stretched thin.

External Challenges

Our external challenges stem from the District and our vendor. We have had limited communication from the District about the program. This was an election year and there was turnover in key positions in the District. The best case scenario is that the District will be distributing funds very late this year, however currently we are not clear whether or not the District will be distributing Meaningful Use incentives this year. We have moved forward in good faith to do major planning and have made significant investments with the assumption that the District will disburse funds this year. Not being able to receive incentive payments this year would be a hardship.

We have had challenges with our vendor. Meaningful use rides on the premise that our vendor will be able to provide us with the technology to meet these measures. One of our biggest challenges has been the limited reporting function of our EHR. This has been a problem before Meaningful Use and continues to be an ongoing challenge with our vendor. The vendor is releasing a special Meaningful Use module, that we hope will be better. But the vendor frequently promises more than it delivers.

Conclusion

There is no doubt that meeting Meaningful Use requirements will require considerable time and resources. We are committed to do it because we know it is the right thing to do and will ultimately bring better care to our patients. We are on the cusp of a evolution in health care and we are determined to make sure that our patients get the benefit that was intended for them.

Thank you.