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September 19, 2019

Submitted electronically via HRSA Grants and Electronic Handbooks Contact Center

Jim Macrae
Associate Administrator
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

RE: Proposed Uniform Data System Changes for CY2020

Dear Associate Administrator Macrae,

Bi-State Primary Care Association (Bi-State) appreciates the opportunity to comment on Document Number: 2019-05; Proposed Uniform Data System Changes for CY 2020.

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization promoting access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State's combined Vermont and New Hampshire membership includes 21 Federally Qualified Health Centers, one Look-Alike, one Rural Health Clinic, Planned Parenthood of Northern New England, Vermont Coalition of Clinics for the Uninsured, North Country Health Consortium, Community Health Access Network, and the Area Health Education Centers in both Vermont and New Hampshire. Bi-State additionally operates a Health Center Controlled Network, the Vermont Rural Health Alliance, which is a subgrantee under New Hampshire's Community Health Access Network. Additionally, Bi-State previously supported Community Health Accountable Care, an ACO participating in Medicare, Medicaid, and commercial Shared Savings Programs in Vermont.

The UDS clinical measures are a very useful tool for the health centers, PCAs, and HCCNs, to evaluate the quality of clinical care. The consistency of measures has allowed for trending over time and provided a solid framework for continuous quality improvement. We are grateful for the BPHC's leadership and investment in the UDS, and for the BPHC's efforts each year to keep the UDS aligned with national priorities, while minimizing provider burden.

We appreciate the opportunity to provide input and context for the proposed changes to the UDS for CY2020. Globally, we would offer that counting only the patients who have a visit in the calendar year undercounts the number of patients for whom that health centers care. It excludes patients who do not need to make frequent visits to their health center but receive care at that health center. We would offer that understanding the number of patients who have had a visit in the past 3 years, as Medicare does, in addition to how many patients have visited during the calendar year may give a better indication of how many patients health centers provide services to.

Below, please find our comments on specific measures:

Depression Remission at Twelve Months Measure (CMS159v8). We are not sure that this measure will evaluate all the appropriate care that is being provided to patients at health centers with depression. We have experience collecting this measure from our participation in an Accountable Care Organization in 2014-2017, and we found that health center providers were screening significantly earlier than the one year required in the measure to ensure patient received appropriate and timely follow-up care. These earlier screenings are not reflected in this measure. If patients are diagnosed with depression during the index period and are closely monitored during the first 6 months of care (including receiving a PHQ9), the health center's current practice is likely to include earlier screenings and not a specific 12-month screening. If a health center is required to administer an additional PHQ9 at one year from diagnosis, that would not necessarily provide better care, but would serve to check an administrative box. We would appreciate your consideration of flexibility on the timing of the second screening.

HIV Screening Measure (CMS349v2). Identifying the patients who are living with undiagnosed HIV is clearly an important initiative. We have two concerns with this measure: one is that the numerator may not accurately reflect those patients who are part of the undiagnosed cohort; and the second is that it may be a challenge to obtain older test results.

1. Patients are often not good historians of their care and remembering where and when an HIV test occurred may be difficult. Those patients who have limited risk and just cannot recall the test details may refuse a new test to fulfill this measure. As currently designed, this measure does not account for patient refusal despite a clinician's best education efforts.
2. In addition, our understanding is that the numerator is all patients 15-64 who have ever had a test, which is a large population over a long time period and requires documentation of the test. Our understanding of this measure is that the results must be obtained even if they are 10 or 15 years prior (or earlier) and obtaining these may be burdensome or impossible for health centers given patient migration patterns. It may be more efficient and effective to focus on a smaller, higher risk pool of patients to start and expand over time. Additionally, this measure will take a significant amount of time to reflect the actual screening rate at the health centers due to the sensitive nature of these data. We would appreciate a measure that would focus on the at risk and special populations first to maximize benefit to our patients.

Adding ICD10 Codes to Capture Human Trafficking and Intimate Partner Violence (IPV). We fully support the desire to capture this information about health center patients. We have two concerns regarding these codes: the first is that adding these codes may result in disclosure in the patient portal; and the second addresses implementation concerns.

1. Health centers are working hard to increase patient utilization of their portals; however, EMRs often do not let health centers filter out certain codes, with the result that patients utilizing the portals will see them. Having those codes in the patient portal may be upsetting for some patients.
2. The collection of these elements will also require significant changes to health center operational systems including visit templates and billing systems, creating patient centered workflows with the accompanying clinical champion and time to run plan, do,

study, act cycles, and training providers in the appropriate ways to ask these questions and provide the linkages to the correct services.

Diabetes: Eye Exam (CMS131v8), Diabetes: Foot Exam (CMS123v7), and Diabetes: Medical Attention to Nephropathy (CMS134v8). As we learned with our Accountable Care Organization work, this information is not located in a structured reportable field in most EMRs. Many health centers refer to specialists for this care; most frequently the specialists send a faxed/PDF report, hand-written in some cases, summarizing the referral appointment. These reports are reviewed by health center providers and kept with the record but are not retrievable for reporting purposes in most instances. Changing systems to create and populate structured fields may prove to be administratively burdensome. It could include double data entry, having the actual report in the record reviewed by a provider and also having a staff person read the report and enter the relevant data into the record.

Breast Cancer Screening (CMS125v8). Similar to the Diabetes measures noted above, this measure will also necessitate changes in workflows and administrative processes because these results often arrive at health centers in a fax/PDF format and do not immediately populate a structured field. This may result in some double data entry as well.

We are eager to be of assistance as BPHC considers new measures. In our work supporting health center involvement in Accountable Care Organizations, we have significant experience with several of these proposed measures and the potential unintended consequences with implementation. We appreciate the BPHC's willingness to hear about our experience as it weighs the costs and benefits of the proposed measures. In addition to these written comments and moving forward, we would welcome the opportunity to participate on any kind of working group, etc., to provide feedback on UDS or other quality measures throughout the process. Please contact Georgia Maheras at 802-229-0002 ext. 218 or gmaheras@bistatepca.org with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Tess Kuenning".

Tess Stack Kuenning, CNS, MS, RN
President and Chief Executive Officer