Readiness for Meaningful Use of Health Information Technology and Patient Centered Medical Home

Summary of Responses Provided by Homeless Health Care Providers

National Health Care for the Homeless Council
June 2011

NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

The *Readiness for Meaningful Use of Health Information Technology and Patient Centered Medical Home Recognition: Summary of Responses Provided by Homeless Health Care Providers* was developed with support from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

BACKGROUND

At present, there is incomplete information about the status of health centers with respect to Electronic Health Record (EHR) adoption, readiness to meet the standards for Meaningful Use (MU) of Health Information Technology (HIT), and achieving Patient Centered Medical Home (PCMH) recognition. To address this knowledge gap, the Geiger Gibson Program at George Washington University (GWU) developed an online survey to be administered to all 330 public health centers.

This survey was funded by the Geiger Gibson Program in Community Health Policy, Department of Health Policy in the School of Public Health and Health Services at George Washington University (GWU), and developed in partnership with the National Association of Community Health Centers (NACHC), in consultation with leaders of selected Primary Care Associations (PCAs), Health Center Controlled Networks (HCCNs), the National Health Care for the Homeless Council, the National Center for Health in Public Housing, and the National Center for Farmworker Health.

METHODOLOGY

The Readiness for Meaningful Use of HIT and PCMH Recognition survey was administered by Survey Monkey from December 2010-February 2011 (See Appendix for a copy of the survey instrument). Geiger Gibson researchers invited participation of all Section 330 health center grantees, using contact information provided in the Uniform Data System Master List found on the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC) website.

The email invitation requested completion of the survey within 10 days of receipt by an appropriate, knowledgeable person designated by the Executive Director or CEO of the organization. Email invitations included a "Reference Copy Only" pdf version of the survey instrument. Geiger Gibson requested that all organizations complete the survey regardless of whether or not they were currently using an EHR, preparing for Meaningful Use or applying for PCMH recognition for any of their sites. National HCH Council research staff and an Association of Clinicians for the Underserved contractor assisted with follow up of HCH non-respondents identified using monthly state level tracking charts.

The survey included a total of 63 multiple choice and open ended questions. Quantitative data were analyzed using PASW Statistics 18 software. Qualitative data were reviewed and categorized into major themes.

Of all the 330 grantees (1124), 714 participated in the survey. Results from **172** respondents who specified they received health care for the homeless (HCH) funding were shared with National Health Care for the Homeless Council researchers. Of the **172** HCH respondents**, 144** (84%) fully completed the survey and were verified to be HCH (330h) grantees.

At the time of the survey, 207 projects were verified as being HCH grantees; therefore the **144** completed surveys reflect a 70% response rate for HCH grantees. The response rate for all health centers was 64%.

All responses were confidential and organizations that did not want information shared with State/Regional Primary Care Association or National Special Population Organizations with a HRSA Cooperative Agreement were de-identified.

This report reflects the responses from the **144** HCH grantees that completed the survey and does not include subcontractors of the HCH projects. Response rate for all questions was at least 95 percent, unless noted otherwise.

MAJOR FINDINGS

This summary report documents the readiness for Meaningful Use of Health Information Technology and Patient Centered Medical Home recognition of Health Care for the Homeless (HCH) projects.

Respondents of the survey represented 47 states in the United States (Delaware, West Virginia and Vermont were not represented). In addition to 47 states being represented, respondents from the District of Columbia (D.C.) and Puerto Rico also completed the survey. Both rural and urban HCH grantees were invited to participate in the survey. As expected, the majority of the respondents were from urban areas.

Organizational profile questions were included to assess electronic health records (EHRs) adoption, readiness to meet the standards of Meaningful Use (MU) of Health Information Technology (HIT) and to identify Health Information Technology staff and/or Director (s) of IT/MIS who worked onsite at these organizations.

Sixty-six percent of the participating organizations report use of EHR with less than half fully adoptive of EHR. However, of those who have not implemented an EHR, the majority plan to do so within the next 6 to 12 months.

Beyond adopting EHRs, there is a current push for health centers to show "Meaningful Use," the use of the EHR by providers to achieve significant improvements in care. Incentive payments are available through the Medicare and the Medicaid programs for eligible providers who demonstrate that they have achieved Meaningful Use of health information technology, as evidenced by meeting specified criteria as established by the Office of the National Coordinator (ONC). These incentive payments are based on meeting Stage 1 criteria. The criterion have been released and set the baseline for electronic data capture and information sharing. Stage 2 and Stage 3 criteria will be established at a future time.

Requirements for Stage 1 of Meaningful Use include both a core set and a menu set of objectives that are specific to eligible health providers, hospitals and critical access hospitals. For eligible providers, there are a total of 25 Meaningful Use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. There are 15 required core objectives. The remaining 5 objectives may be chosen from a list of 10 menu set objectives.

In response to the questions on Meaningful Use and incentives specifically targeting the ability of organizations to demonstrate that eligible providers have achieved Meaningful Use of Health IT, a substantial majority of HCH respondents (81%) reported either all or some of their providers are eligible. Fifteen percent of the respondents reported they were uncertain if their providers were eligible as they did not fully understand all the criteria or they had not fully reviewed the criteria.

Regarding expectations to apply for Medicaid Meaningful Use (MU) incentives, 70% (n=100) plan to apply for incentives within 12 months, with another 19% planning to apply in 1-2 years. Ten percent (n=15) stated they didn't know when or had no current plans to apply for Medicaid MU incentives.

Participants of the survey were asked to identify challenges and barriers they are facing in complying with MU measures. The qualitative responses were analyzed and grouped into the following common themes:

- compliance and meeting requirements issues

- certification and vendors
- costs, resources and funding
- population serviced
- training providers
- implementation guidance and collaborations and interfacing of systems.

The most common challenges reported under these themes were: cost and limited resources, lack of buy-in from medical leadership, physicians and administration, the challenges of serving a "transient" population, and the inability to provide electronic access to records for those who are unstably housed.

Being aware of health information technology capabilities/ functionalities and the use of an EHR is not only essential to demonstrating Meaningful Use, it is also a key element of the Patient Centered Medical Home (PCMH) model. A patient centered medical home is a "one-stop" source of medical care, which ideally involves patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute, and chronic needs of patients using the best available evidence and appropriate technology.

Some groups prefer to use the term "health home" because it is more inclusive of mental health care services and provides a place for consistent, continual, culturally appropriate care. With the PCMH model, there are now multiple entities developing or offering medical home recognition or accreditation programs. These accreditation and recognition entities include National Committee for Quality Assurance (NCQA), Joint Commission Ambulatory Care Program (JCAHO) and the Accreditation Association for Ambulatory Health Care (AAAHC). There are also some state-funded entities.

In response to questions regarding PCMH recognition, 6% (n=9) of HCH respondents have achieved Level 1 NCQA recognition for one or more sites, 1% (n=2) have achieved Level 3 NCQA recognition, 15% (n=21) have an application pending and 78% (n=112) have never applied for recognition. Of those who have never applied, 44% (n=49) plan to apply within the next 18 months, 56% (n=63) don't know or have no current plans to apply. Of note, 12% (n=17) of respondents reported they are considering receiving PCMH recognition with their respective state programs.

Participants were also asked about challenges in receiving PCMH recognition and the qualitative responses were grouped into themes. One reccurring theme was the need for staff training regarding the PCMH concept. Other challenges and barriers included lack of knowledge regarding the requirements and difficulty of applying or incorporating the PCMH concept into the HCH service delivery model.

Mechanisms have been established to assist health care organizations to become Meaningful Users of EHRs. Such entities include Regional Extension Centers (RECs), which are funded as part of the Health Information Technology Extension Program. RECs offer technical assistance, guidance, and information on best practices to support and accelerate providers' efforts to become Meaningful Users of EHRs.

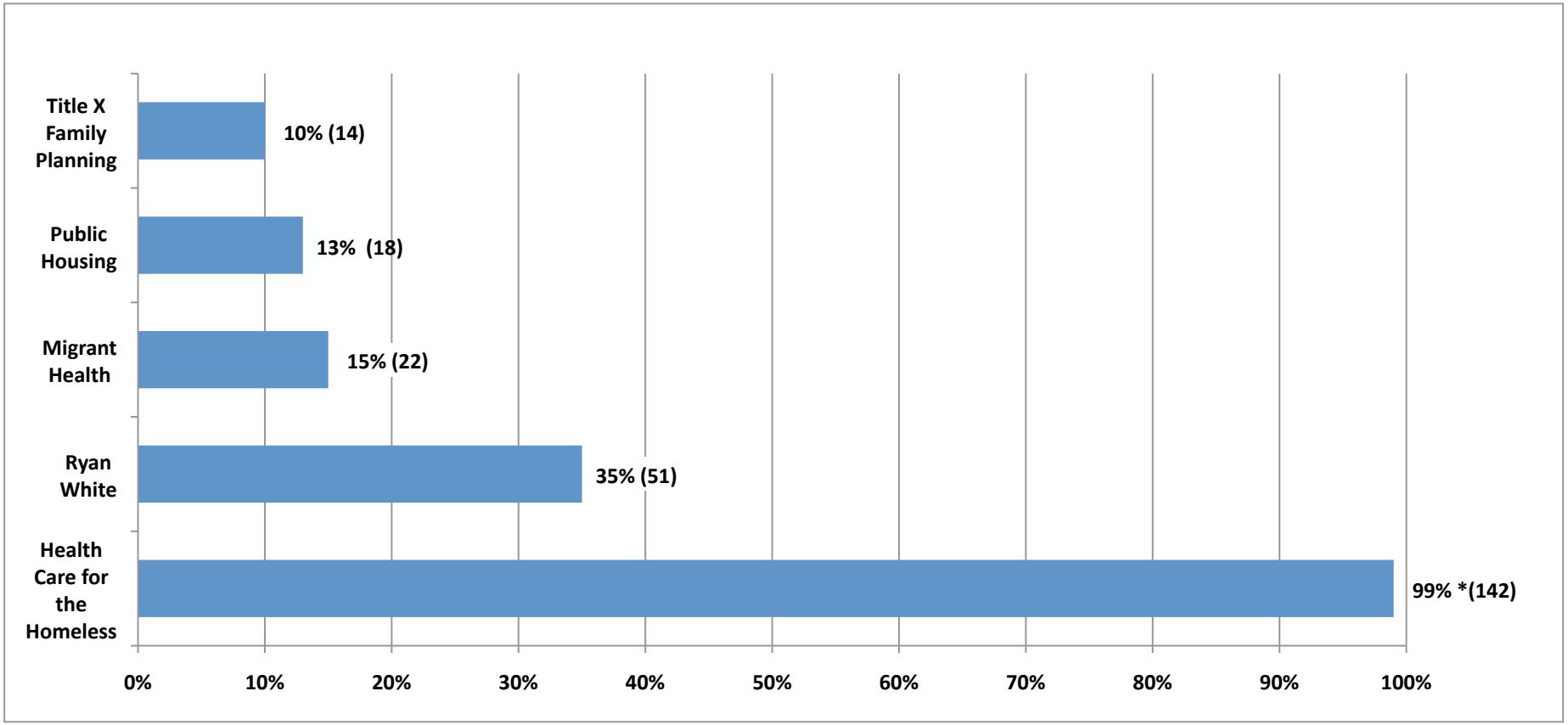
When respondents were asked about their participation or collaboration with an REC or subcontractor, forty-six percent (n=66) of respondents reported that they participate or collaborate with an REC. Of those currently collaborating, 50% (n=33) stated they found the REC collaboration either "Very Helpful" or "Helpful" in advancing efforts to achieve MU status.

As an increasing number of health centers move toward the use of telemedicine and telehealth, just less than half, 49% (n=70), of HCH respondents foresee integrating telemedicine and/or telehealth services into their delivery of health care model in the near future. Many barriers exist in implementing telemedicine and/or telehealth services within the HCH delivery system with equipment costs the number one barrier indicated in this survey.

Responses to all questions are depicted graphically on the following pages.

ORGANIZATION PROFILE

Figure 1. Percentage of Grantees Reporting Receiving Special Populations Funding (Check all that apply); N=144



*Note: In reporting funding source, 142 respondents answered "Health Care for the Homeless." Two respondents failed to indicate HCH funding; however, upon further examination, it was discovered that these participants are HCH recipients. These responses were therefore identified as missing and not discarded.

Figure 2. Location of Organization (Urban Rural, Both); N=144

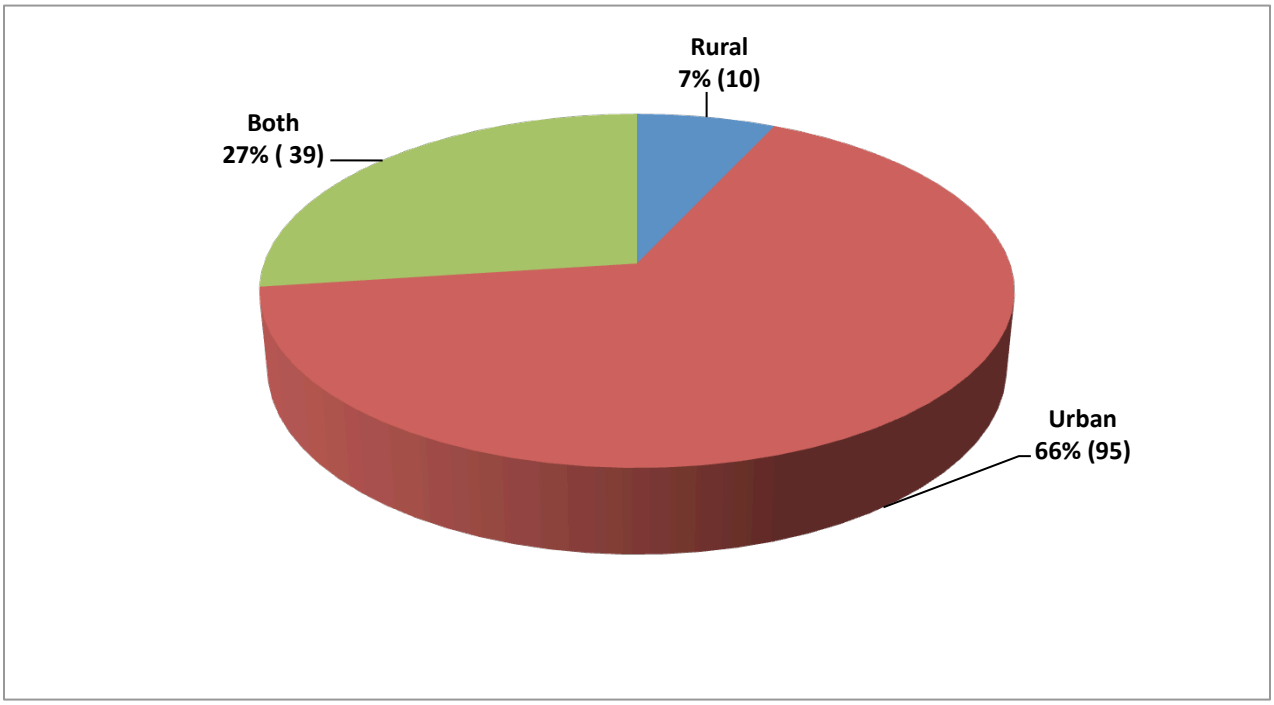


Figure 3. Does organization have onsite health IT staff and /or Director of IT or MIS? (Check all that apply); N=144

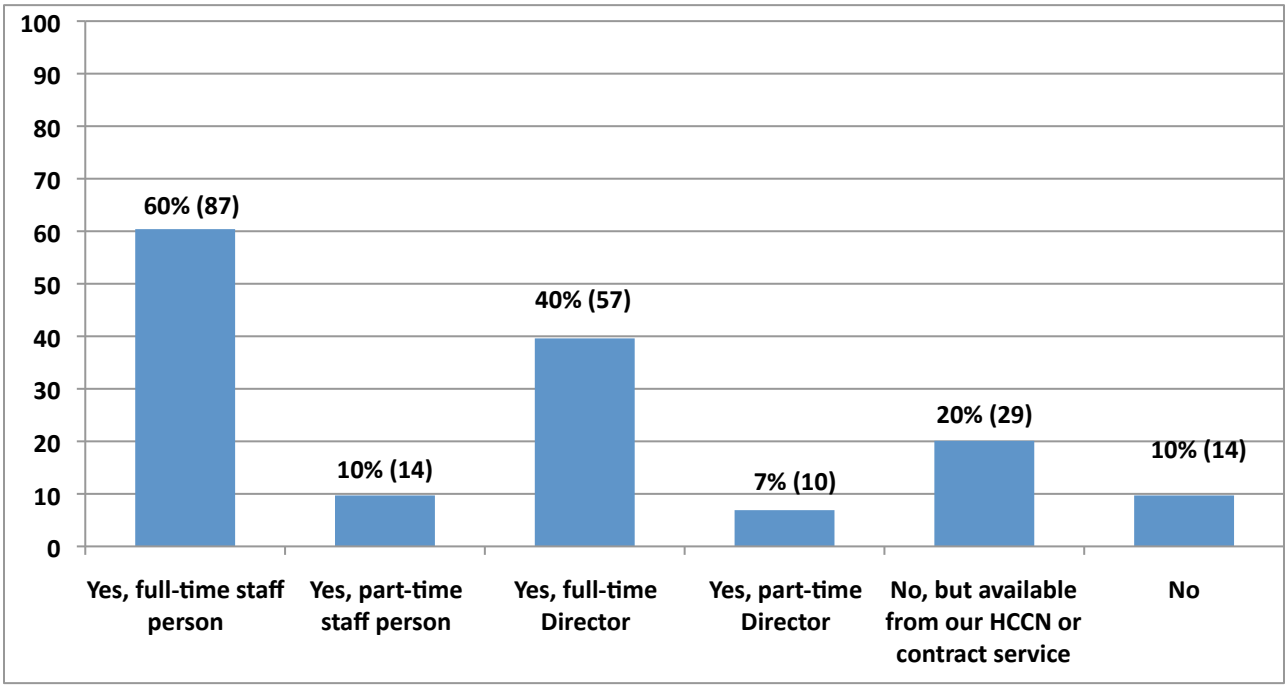


Figure 4. Does organization use an electronic health record (EHR)? (Check only one); N=144

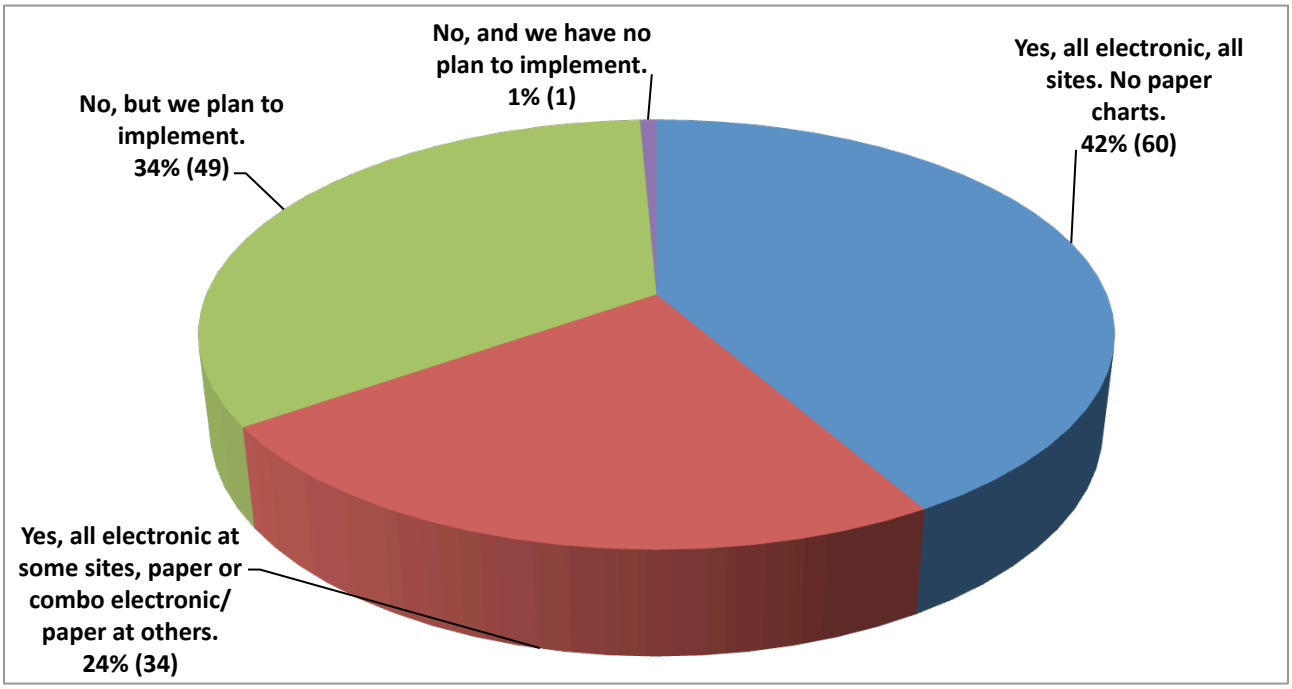


Figure 5. Which EHR product is organization using? (Check one); n=94

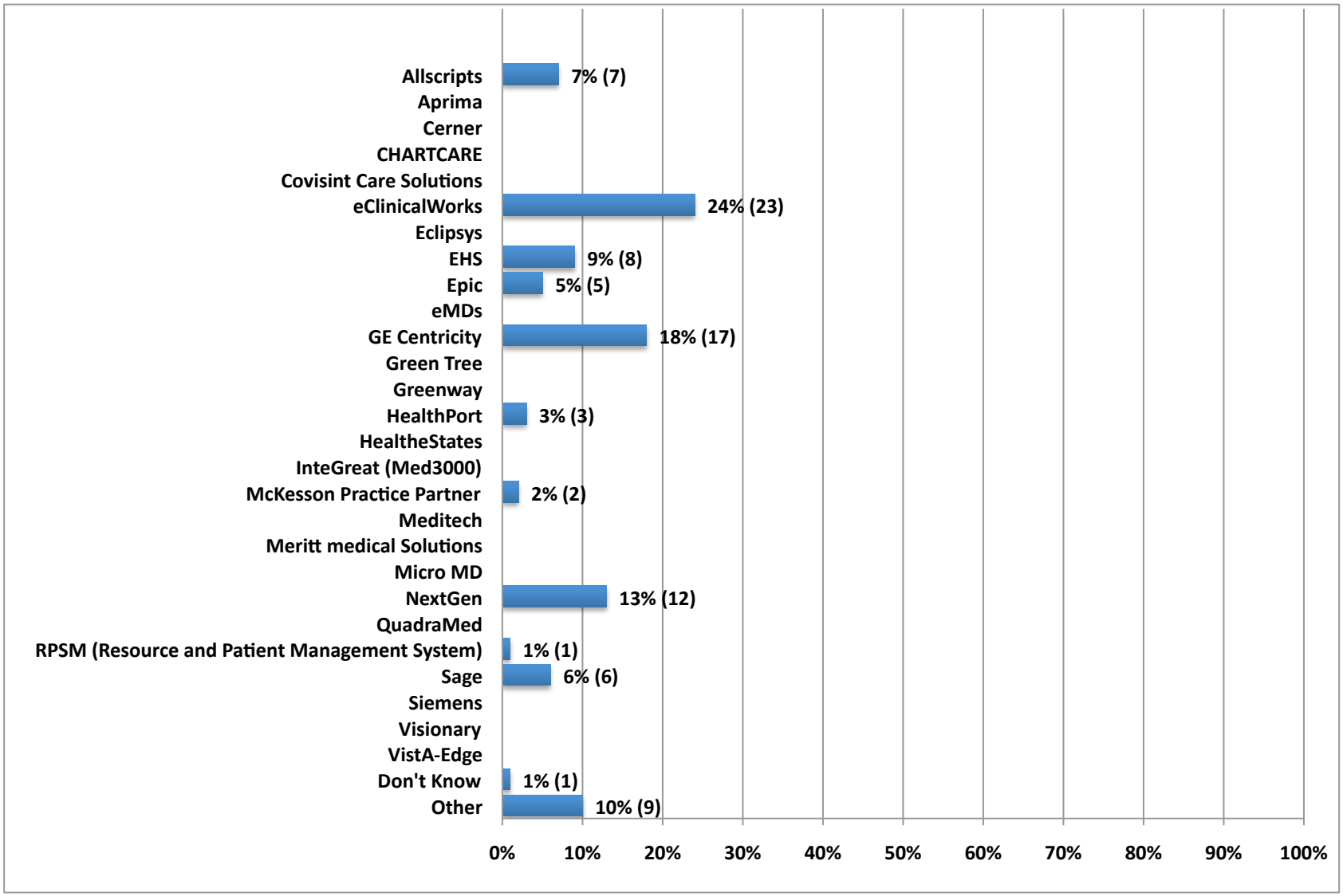


Figure 6. How long ago did organization go live with the EHR? (Check one); n=94

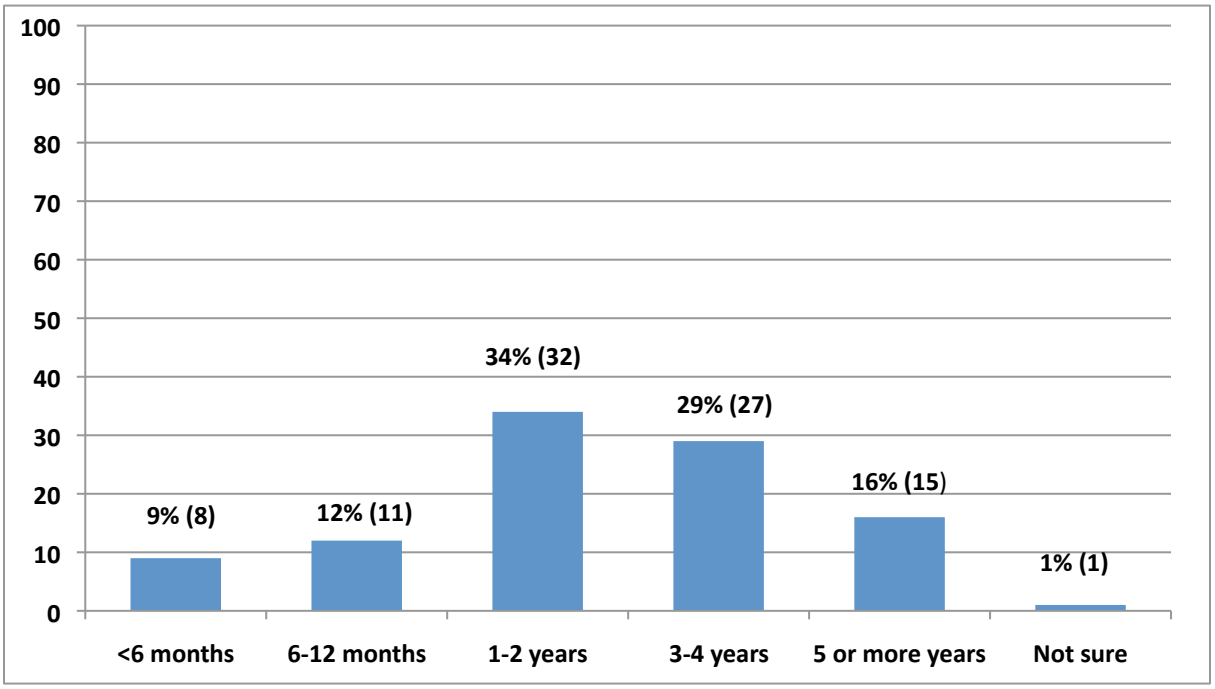


Figure 7. How does organization host the EHR? (Check one); n=94

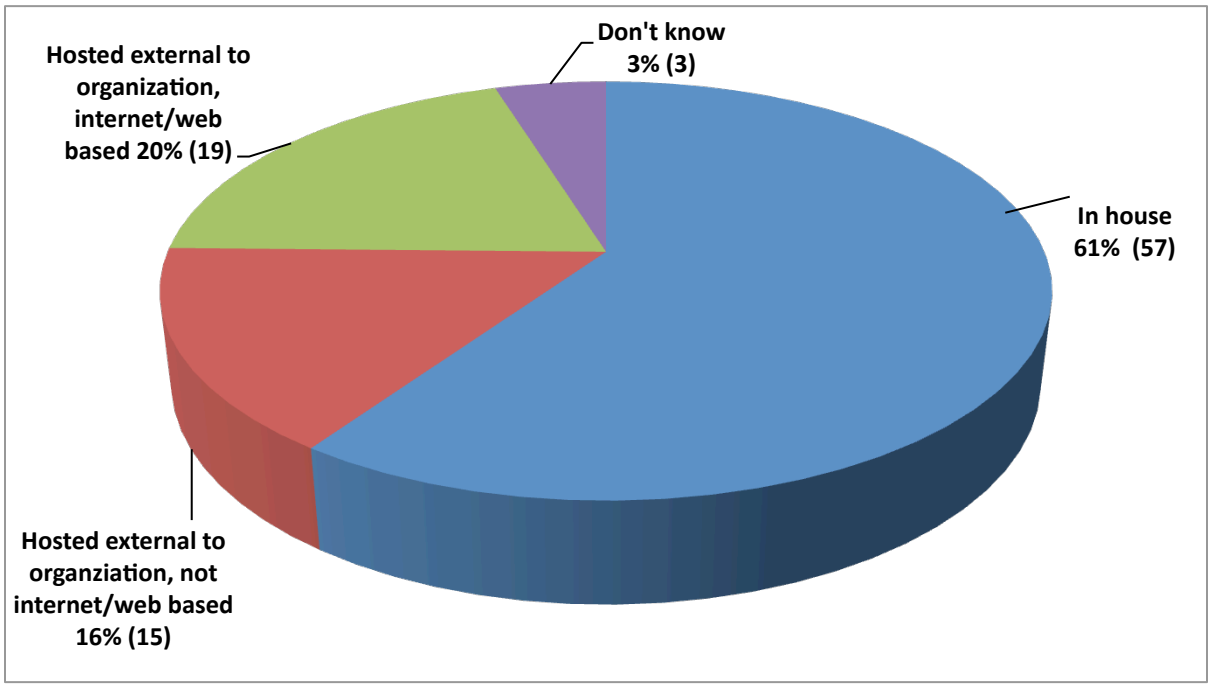
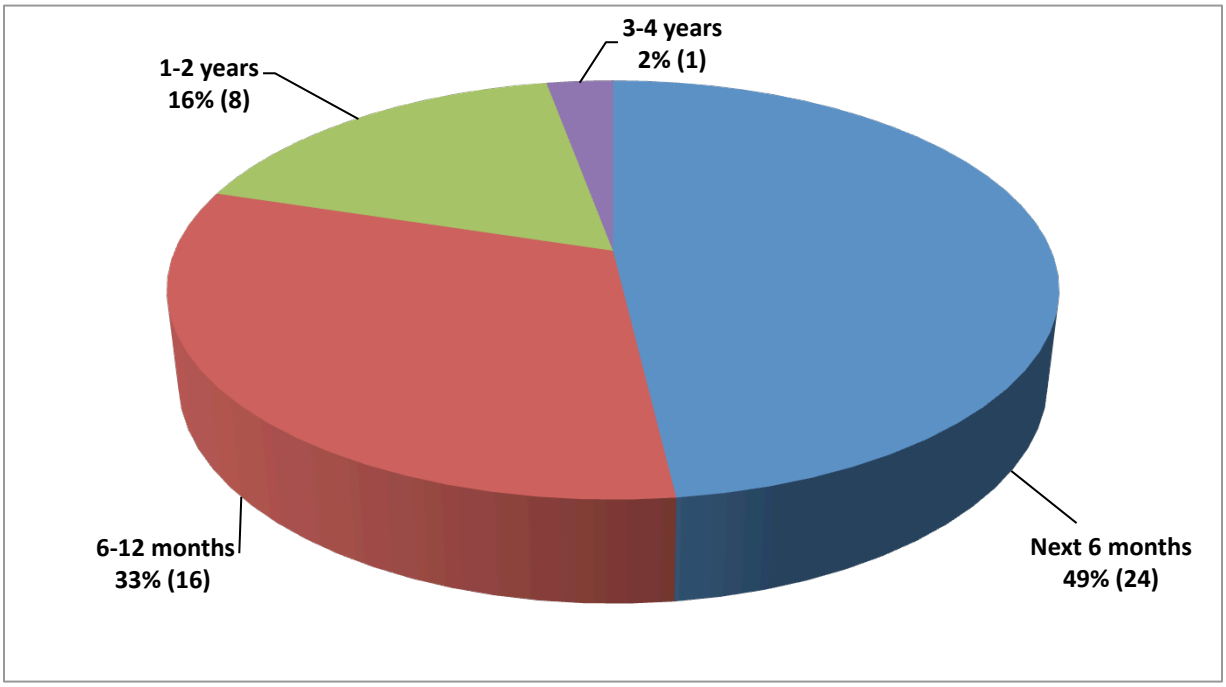


Figure 8. When does organization plan to implement an EHR? (Check one); n=49



BEHAVIORAL HEALTH

Figure 9. Does organization provide onsite behavioral health services?; N=144

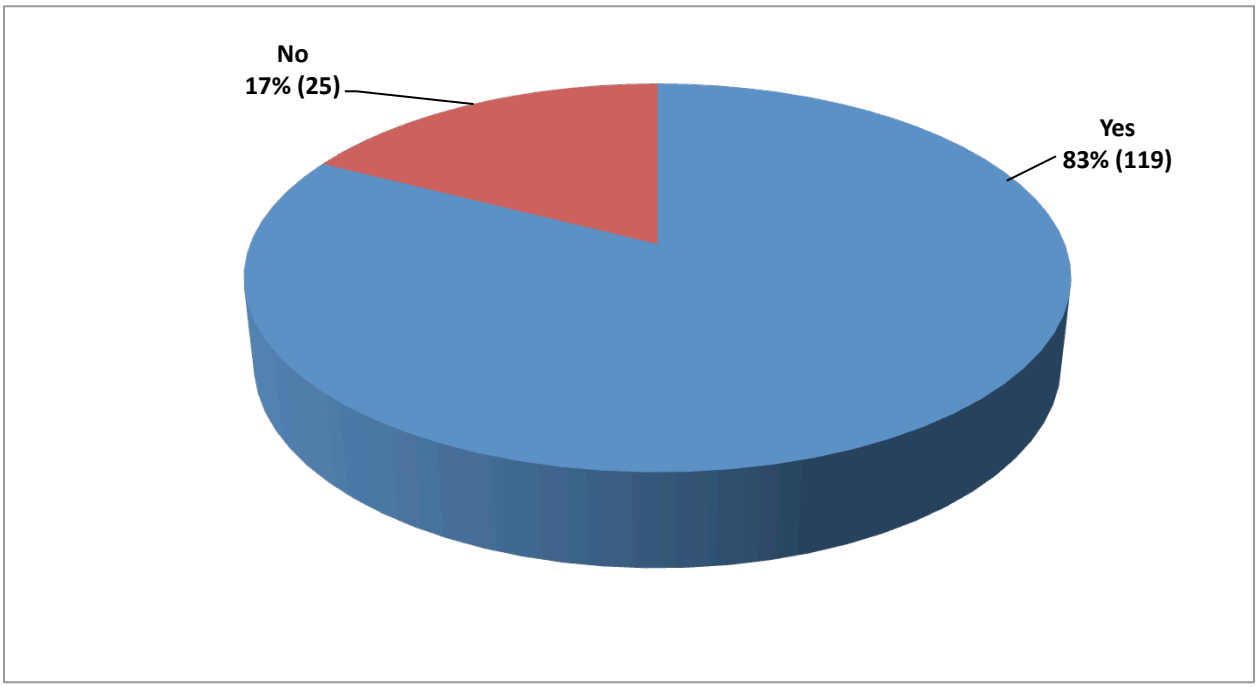


Figure 10. In what format are the behavioral health records?; n=119

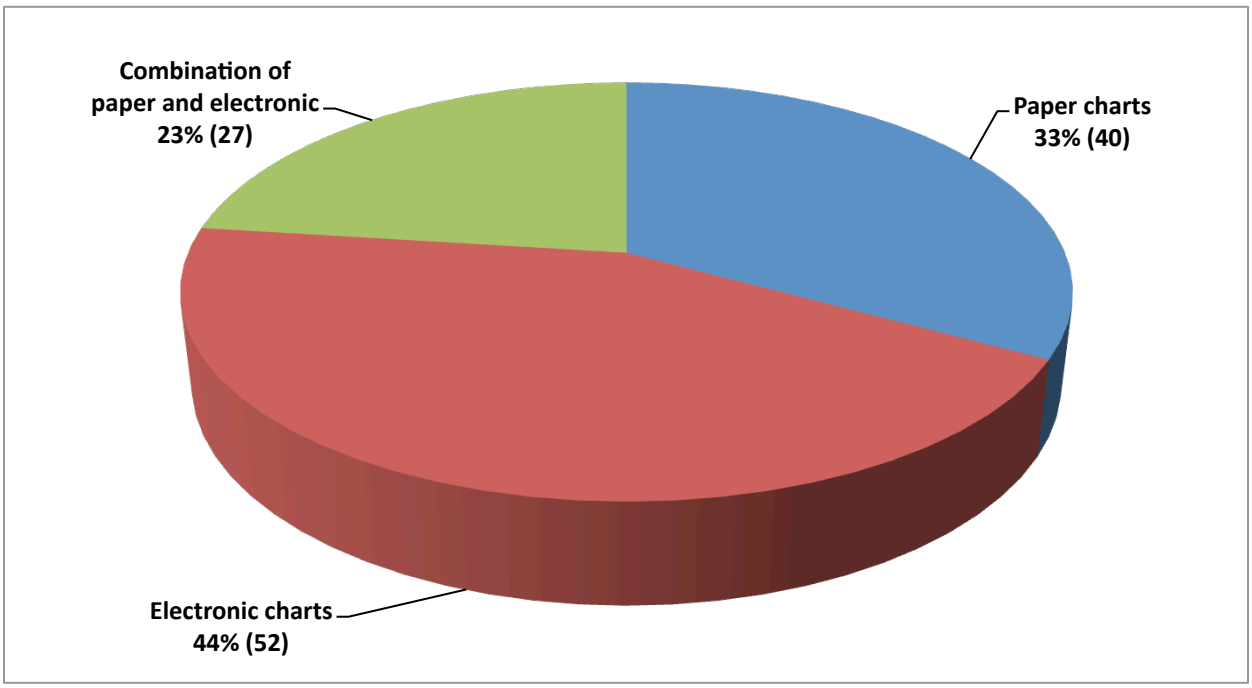


Figure 11. Are the medical and behavioral health records integrated (either paper or electronic)?; n=119

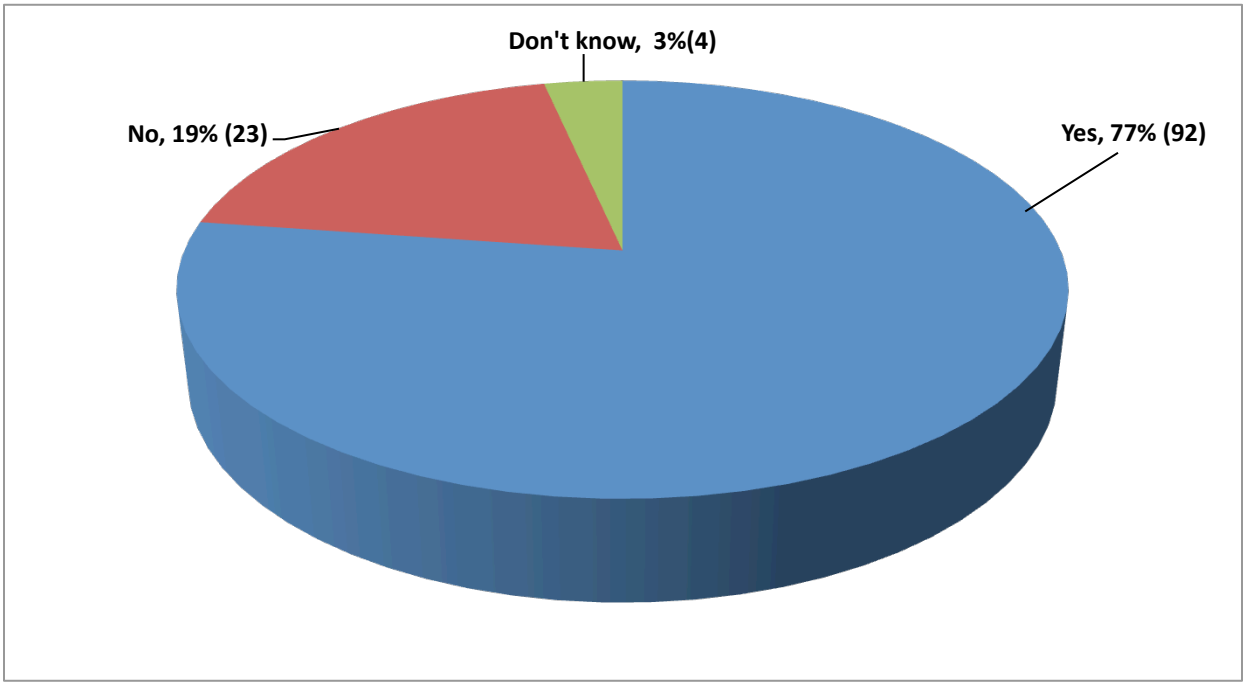
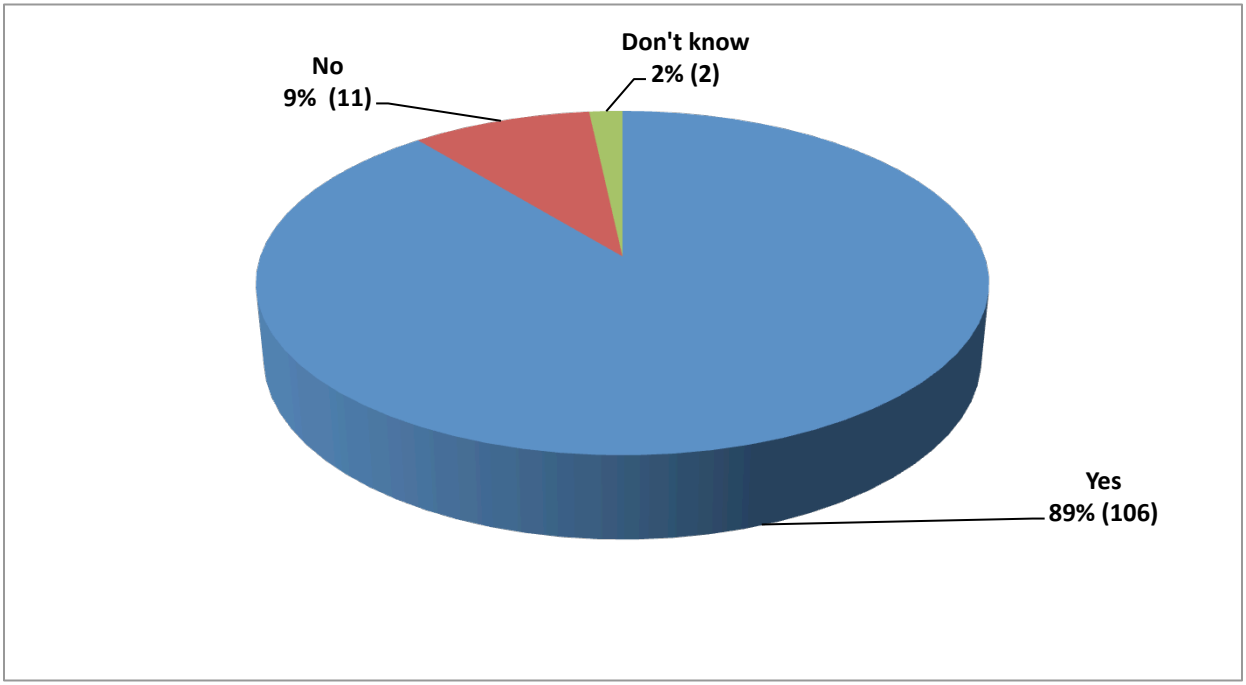


Figure 12. Do medical staff and behavioral health staff have access to a shared problem list and medication list (paper or electronic)?; n=119



ELECTRONIC DENTAL RECORD (EDR) ADOPTION

Figure 13. Does organization provide onsite dental services?; N=144

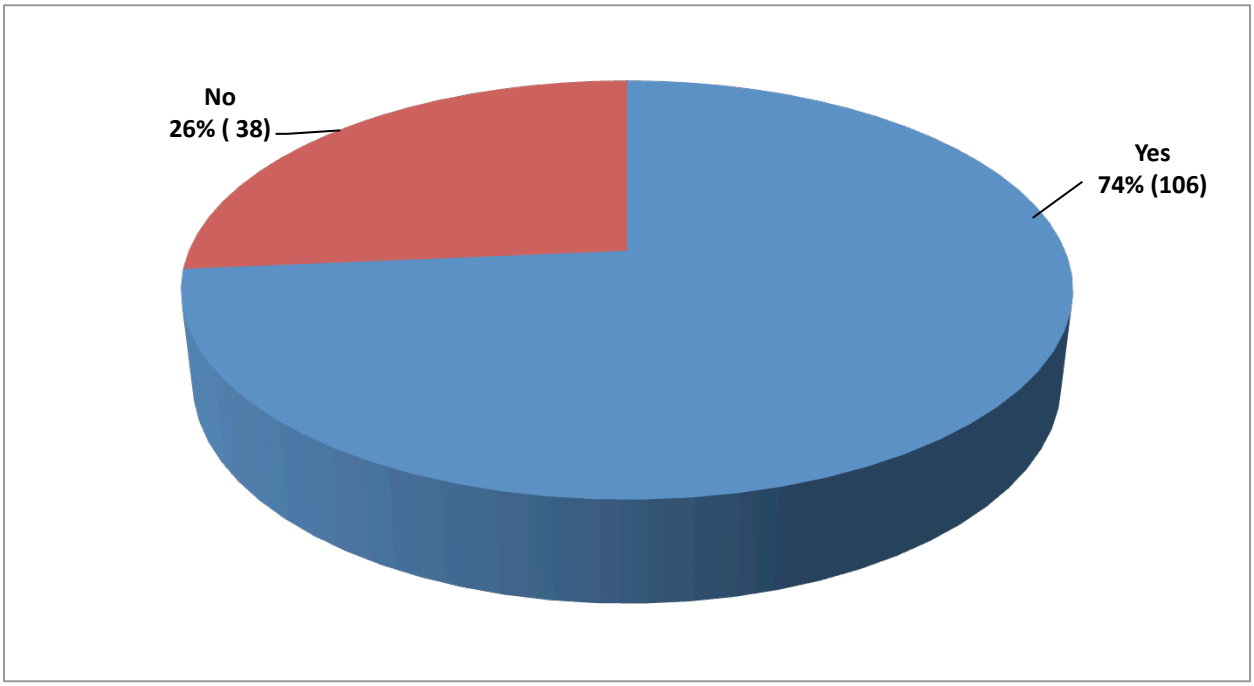


Figure 14. Is organization currently using an electronic dental record (EDR)? (Check one); n=106

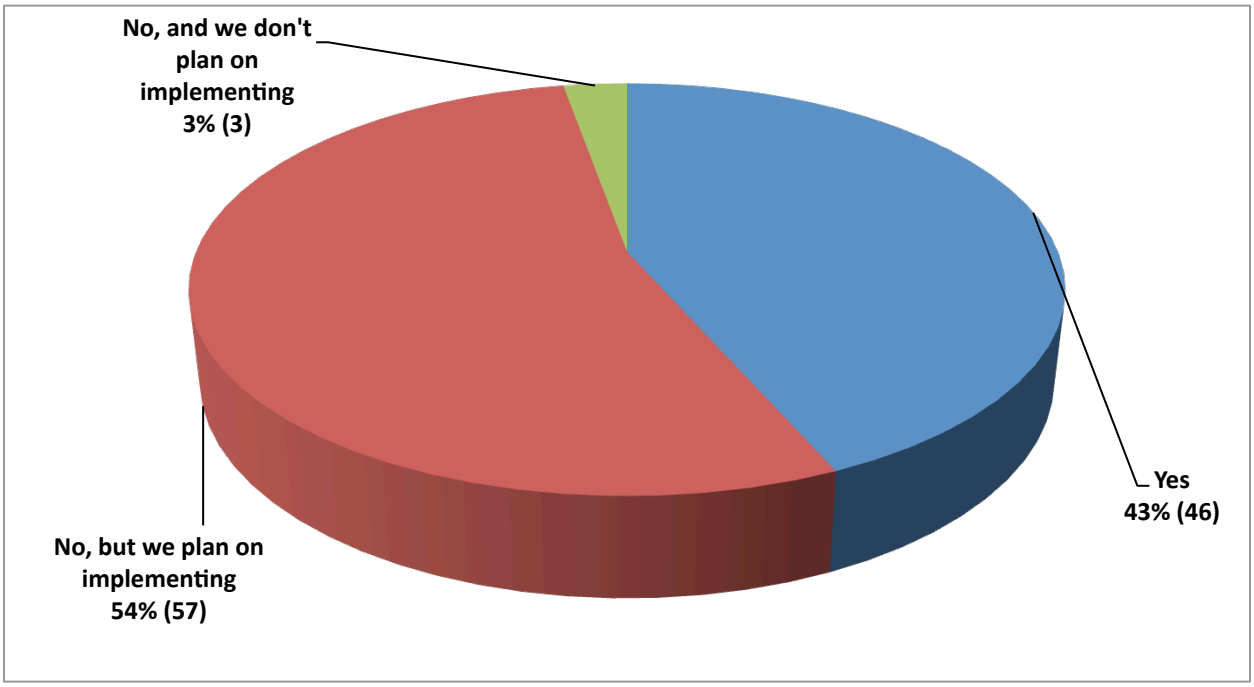


Figure 15. Which of the following EDR products is organization currently using?; n=46

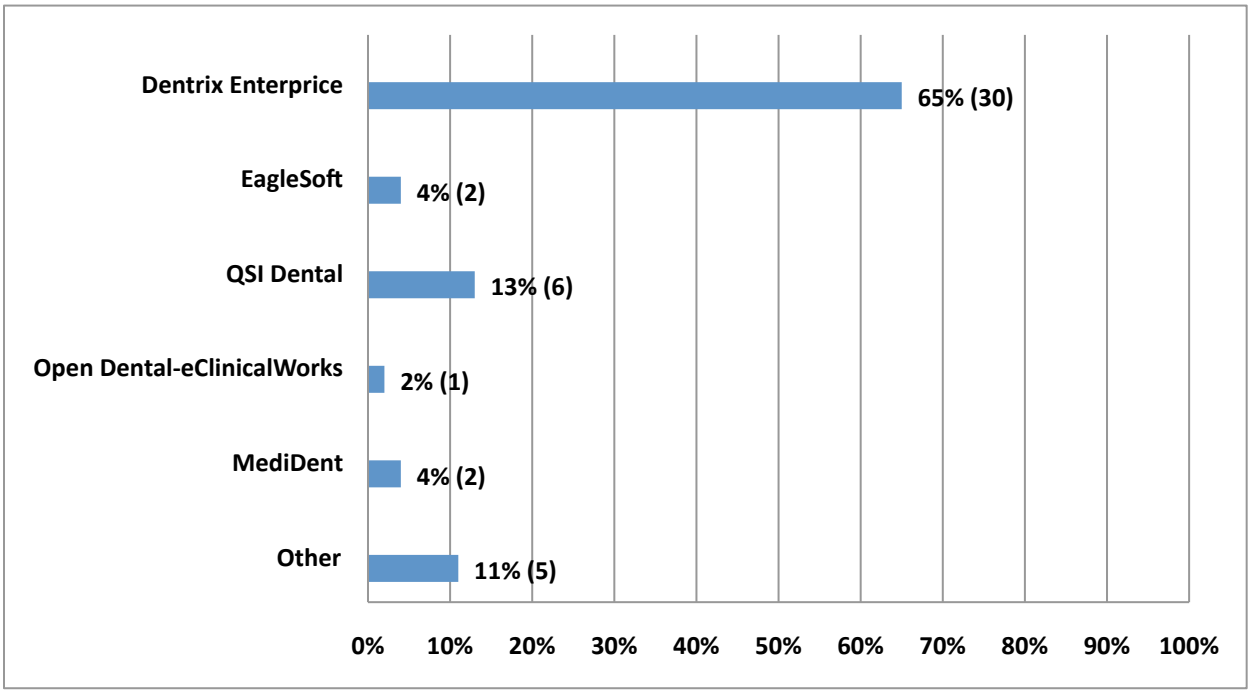


Figure 16. How long ago did organization go live with the EDR?; n=46

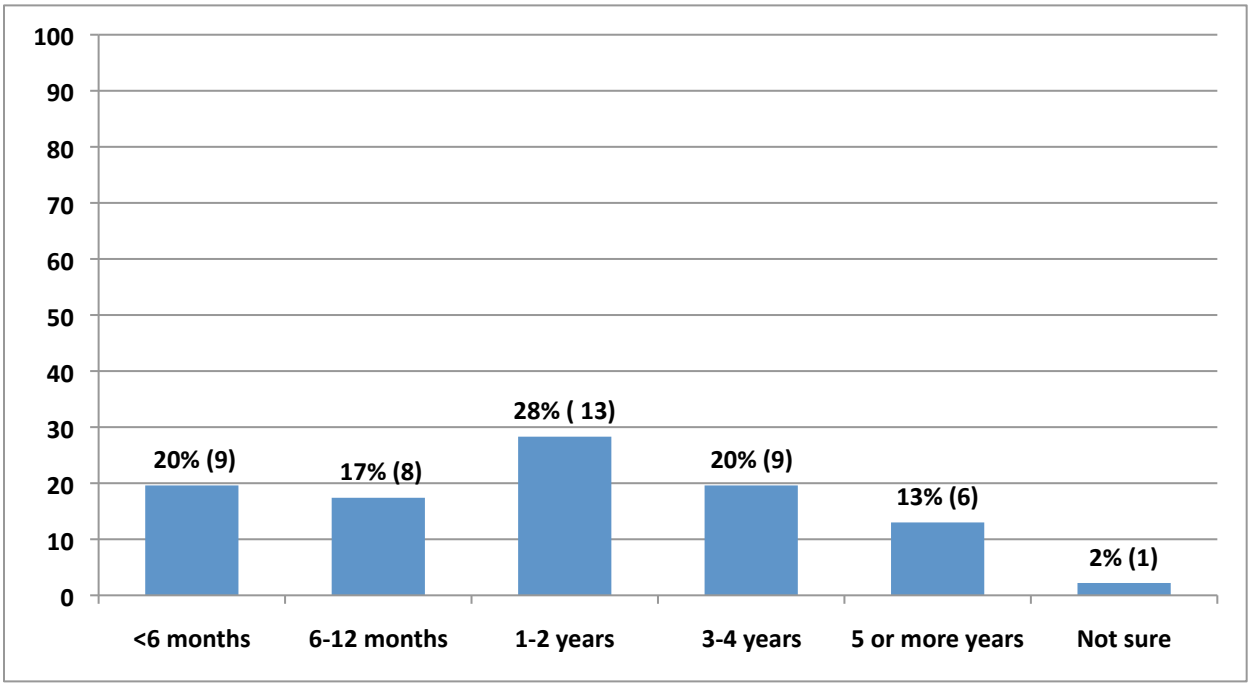


Figure 17. How does organization host the EDR?; n=46

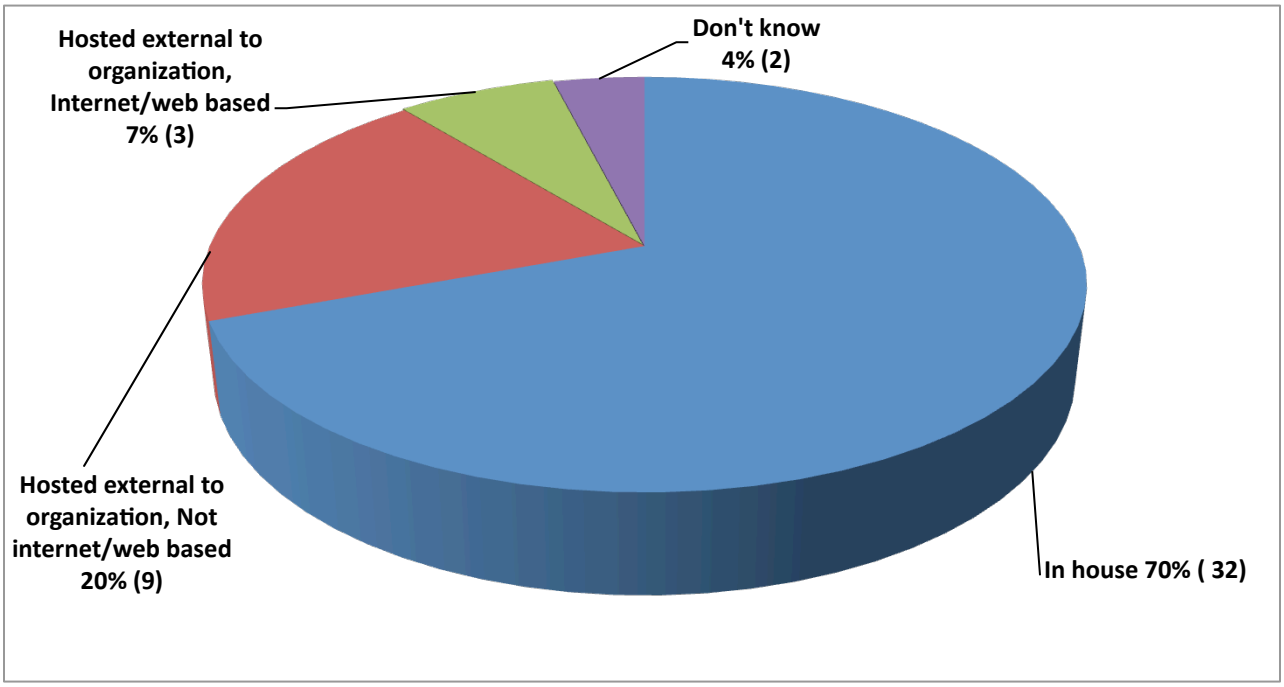
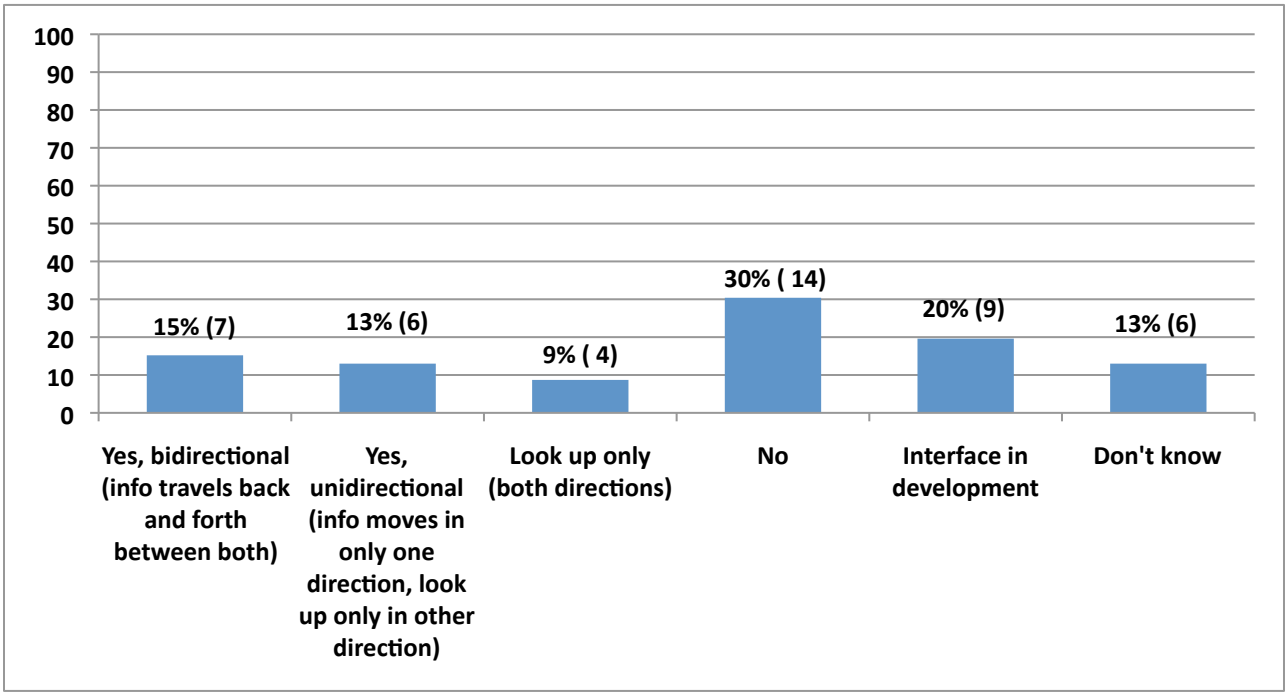
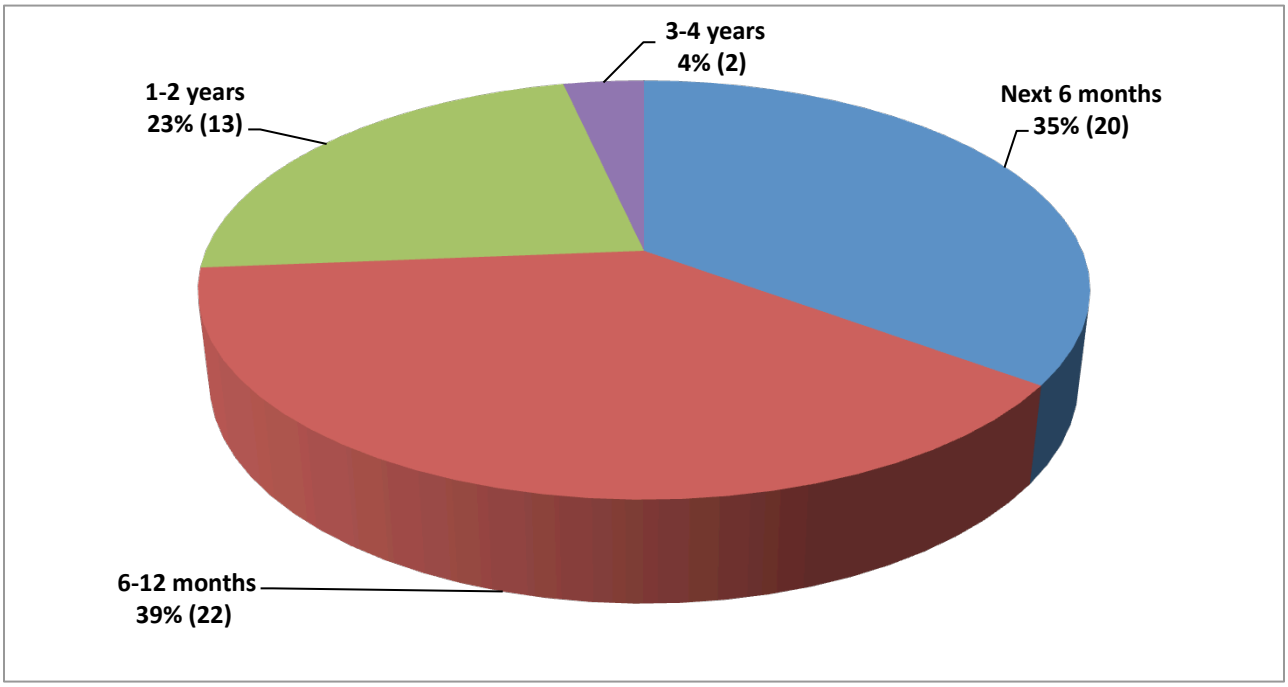


Figure 18. Is there communication between the EHR and the EDR?; n= 46



*Note: Participants who responded that there was communication between the EHR and EDR were asked what type of information was accessible between the two systems. Five responded and all reported that problem lists were accessible between the two.

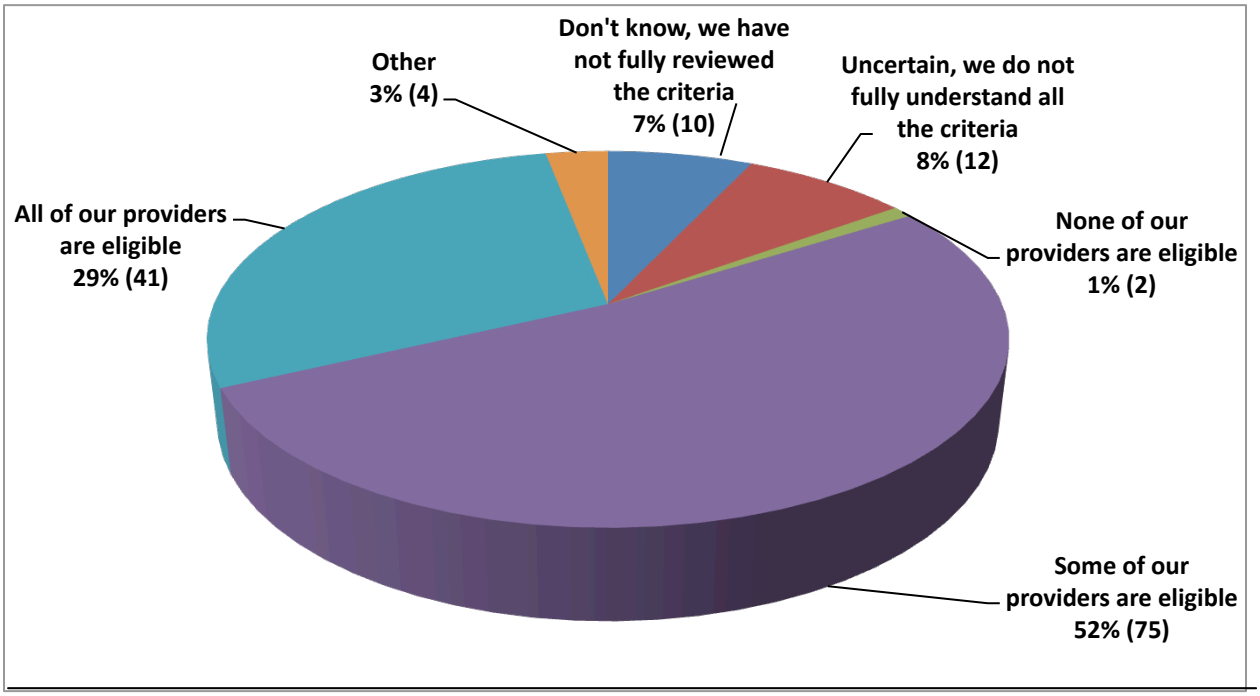
Figure 19. When does organization plan to go live with an EDR?; n=57



MEANINGFUL USE

Beginning in 2011, the Centers for Medicare and Medicaid Services will offer incentives through the Medicaid program to practices that demonstrate that eligible providers have achieved "Meaningful Use of Health IT."

Figure 20. After reviewing provider eligibility criteria, organization has determined (Check one); N=144



*Note: Other responses – "Oregon FQHCs not eligible for MU"; "Only our PAs will NOT be eligible"

Determination of Readiness to Comply with Stage 1 Meaningful Use Measures
The following chart displays the 25 Stage 1 MU measures percentages given per response for each measure.

Table 1. Core Functional Measures (Eligible Providers MUST DO ALL 15); N=144

Core Functional Measures	Yes, Now	Yes, By 2012	No, Not By 2012	Unsure
1. Uses CPOE for medication orders	49% (70)	29% (42)	4% (6)	18% (26)
2. Implements drug to drug and drug allergy interaction checks	59% (85)	31% (44)	4% (5)	7% (10)
3. Generates and transmits permissible prescriptions electronically (eRX)	48% (69)	44% (63)	4% (6)	4% (6)
4. Records patient demographics	76% (110)	19% (27)	1% (2)	4% (5)
5. Maintains an up-to-date problem list of current and active diagnoses	69% (100)	22% (32)	4% (5)	5% (7)
6. Maintains active medication list	72% (103)	21% (30)	4% (5)	4% (6)
7. Maintains active medication allergy list	70% (101)	22% (31)	4% (5)	5%(7)
8. Records and charts changes in vital signs	73% (105)	22% (31)	2% (3)	4% (5)
9. Records smoking status for patients 13 years old or older	63% (90)	27% (39)	3% (4)	8% (11)
10 Implements one clinical decision support rule	45% (65)	38% (55)	3% (4)	14% (20)
11. Reports ambulatory clinical quality measures	51% (74)	35% (51)	4% (6)	9% (13)
12. Provides patients with electronic copy of their information	24% (34)	53% (76)	6% (9)	17% (25)
13. Provides clinical summaries for patients for each office visit	35% (51)	50% (72)	5% (7)	10% (14)
14. Exchanges key clinical information among providers of care	42% (60)	40% (58)	4% (6)	14% (20)
15. Protects electronic health information	74% (107)	20% (29)	2% (3)	4% (5)

Table 2. Menu Set Measures

(Eligible Providers MUST DO Either #1 or #2 AND any 4 of the remaining #3-#10); N=144

Menu Set Measures	Yes, Now	Yes, By 2012	No, Not By 2012	Unsure
1. Submits electronic data to immunization registries (Population Health measure)	39% (56)	40% (57)	6% (8)	16% (23)
2. Submits syndromic surveillance data to public health agencies (Population Health measure)	18% (26)	36% (52)	10% (15)	35% (51)
3. Implements drug formulary checks	41% (59)	42% (60)	4% (6)	13% (19)
4. Incorporates clinical lab test results as structured data	56% (81)	33% (48)	3% (4)	8% (11)
5. Generates lists of patients by specific conditions for QI outreach	61% (88)	29% (42)	2% (3)	8% (11)
6. Sends reminders to patients for preventive/follow up care	34% (49)	40% (58)	8% (12)	17% (25)
7. Provides patients with timely electronic access to their health information	16% (23)	48% (69)	12% (17)	24% (35)
8. Identifies and provides patient-specific education resources if appropriate	51% (73)	32% (46)	3% (4)	15% (21)
9. Performs medication reconciliation at relevant transfers of care	38% (54)	33% (47)	5% (7)	25% (36)
10. Provides summary of care record for each transition of care or referral	41% (59)	30% (43)	4% (6)	25% (36)

Figure 21. When does organization expect to apply for Medicaid MU incentives?; N=144

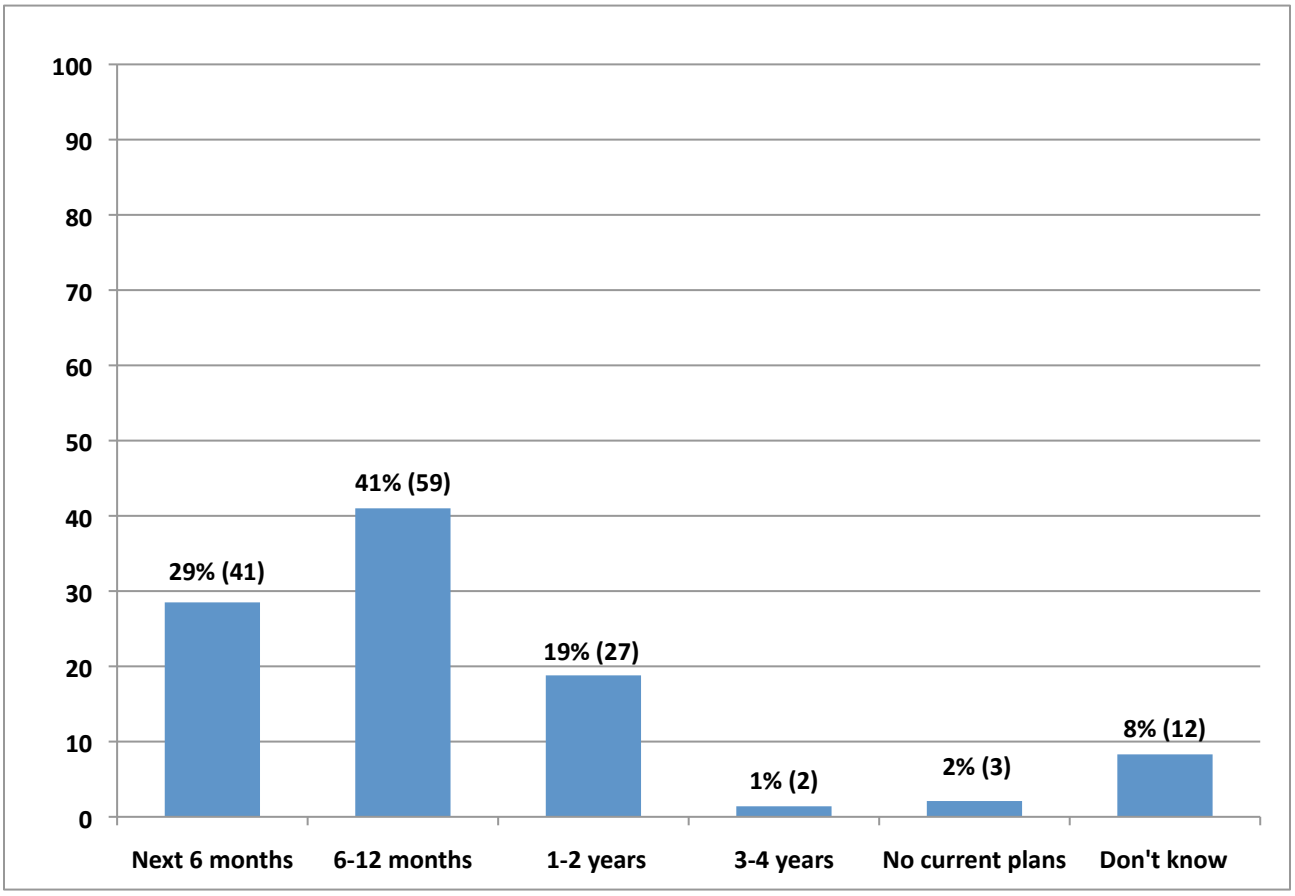


Table 3. Challenges and Barriers in Complying with the MU Measures

Challenges and Barriers as Stated by Respondents (Common Themes)
Compliance and Meeting Requirements Issues • "ePrescribing, making sure we are enrolled properly, complying with security requirements" • "Getting the final set of rules and the process from our State Medicaid Agency" • "Meeting the more sophisticated requirements after Year One" • "Strategies to demonstrate compliance. Staying within timelines for compliance to maximize incentive" • "Understanding the requirements, timelines, and vendor capacity to implement necessary changes to meet the requirements"
Certification and Vendors • "Our current vendor is not yet certified. We are looking to change vendors." • "Vendor uncertainties - upgrade to new certified version of eCW will determine Meaningful Use compliance" • "EHR certification" • "Current software has not received certification; platforms for data exchange between hospital and other providers have not yet been built; State of NH has limited electronic capacity; staff learning curve of MU measures and entering in appropriate field of EMR for data extraction; challenges of patient portal given HCH target population" • "Timely updates and upgrades from software company to install certified Meaningful Use version. Full understanding of what qualifies for the incentives" • "Current software has not received certification; platforms for data exchange between hospital and other providers have not yet been built; State of NH has limited electronic capacity; staff learning curve of MU measures and entering in appropriate field of EMR for data extraction; challenges of patient portal given HCH target population"
Costs, Resources and Funding • "Cost of EHR implementation fractured medical services environment" • "Costs, resources needed to effectively implement EHR across the organization" • "Funding, Integration of data from various systems, no inpatient EHR yet" • "Staffing (i.e., recruiting PCPs) financial pressures, lost productivity associated with implementation IT expertise" • "Cost of Patient Portal" • "Resources to implement patient portal for electronic access; many patients uninsured, low income, their use of internet varies" • "Up front Capital investment. Loss in productivity. Ability of Vendor to Implement all Meaningful Use requirements. Appropriate time for training, establishment and participation in HIE" • "Support and funding to adapt EHR for Behavioral Health especially around state funded programs. Standardization of data for reporting and billing needs. Our state does not have a standard as of this writing." • "Cost of ongoing training; exchanging information between this health center and other providers; staff resistance to change in workflow patterns; lack of secure mechanism for transferring information, e.g. emailing medical records securely" • "What are allowable costs from previous years? Can we count ARRA funded software licenses? How will registry work? Getting providers to sign amendment to contract for assignment of incentive funds. Specific examples of how we prove a few of the alternative measures"

• "Lack of onsite technical staff; lack of equipment; lack of funds to purchase electronic health record software and other necessary technical applications"
Population Served • "Homeless population is transient and often do not report for medical assistance/follow-up in timely manner " • "People experiencing homelessness have attenuated access to electronic technologies." • "We serve homeless population = barrier to providing electronic access to records; expense of necessary security systems for electronic patient access"
Training Providers and Incentives • "Training and monitoring of providers at 13 separate care sites. Ensuring compliance with Per Diem providers" • "Staff training time roll-out of EHR" • "Need also to learn more about MU measures and how we can best implement within the parameters of service and EHR which is due to be implemented within next 6 months" • "Provider incentive payment pass-thru to health center, size and geographical locations, staff behavior and work flow/process changes. Impact to organizations financial solvency" • "Assignment of MU financial incentives" • "Pulling data out for QI is more difficult than expected" • "Medical Leadership" • "Ensuring the eligible provider meets criteria in an FQHC setting"
Instructions and Implementation Guidance • "Clear instructions on registering EPs" • "Changing guidelines; determining which optional measures to select"
Collaborations and Interfacing of Systems • "Lack of interface with state vaccine registry and state health department at this time. Homeless patient population limits mailings, provision of e-copy of record" • "Patients seen in homeless setting hard to comply with electronic requirements. The state is yet to have a way for us to send other than in an excel sheet a copy of dtat, We have tried for a long time with our school based program but still have to print out enter into multiple systems as theirs is not interfaced with ours. "

PATIENT CENTERED MEDICAL HOME (PCMH)

Figure 22. Has organization received PCMH recognition from NCQA for one of more sites? (Check one); N=144

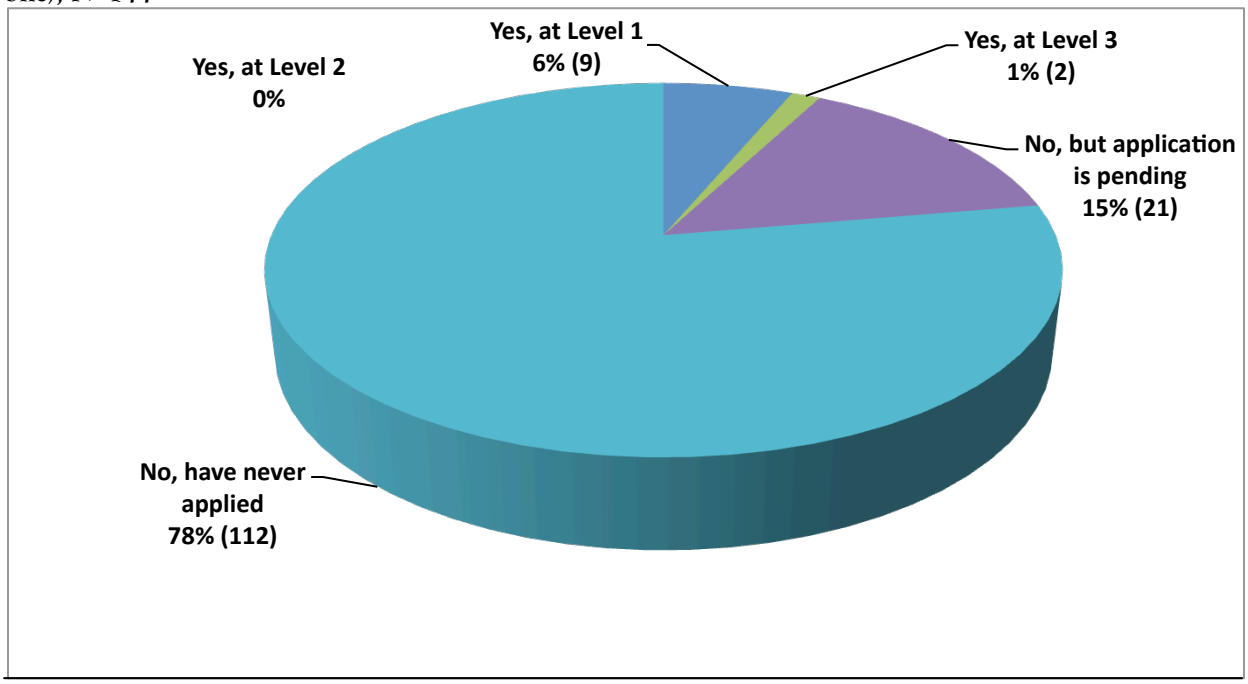


Figure 23. What year was initial PCMH recognition received from NCQA for any level at any site?; N=144

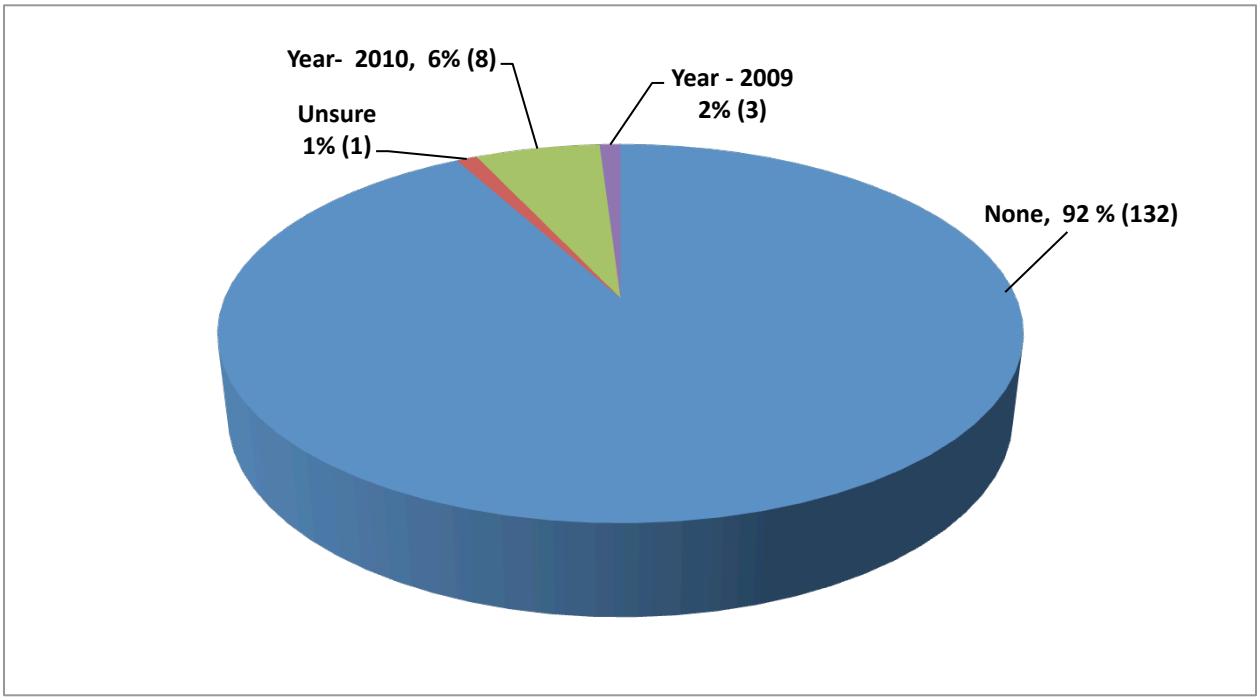


Figure 24. When is organization planning to apply to NCQA? (Check one); n=112

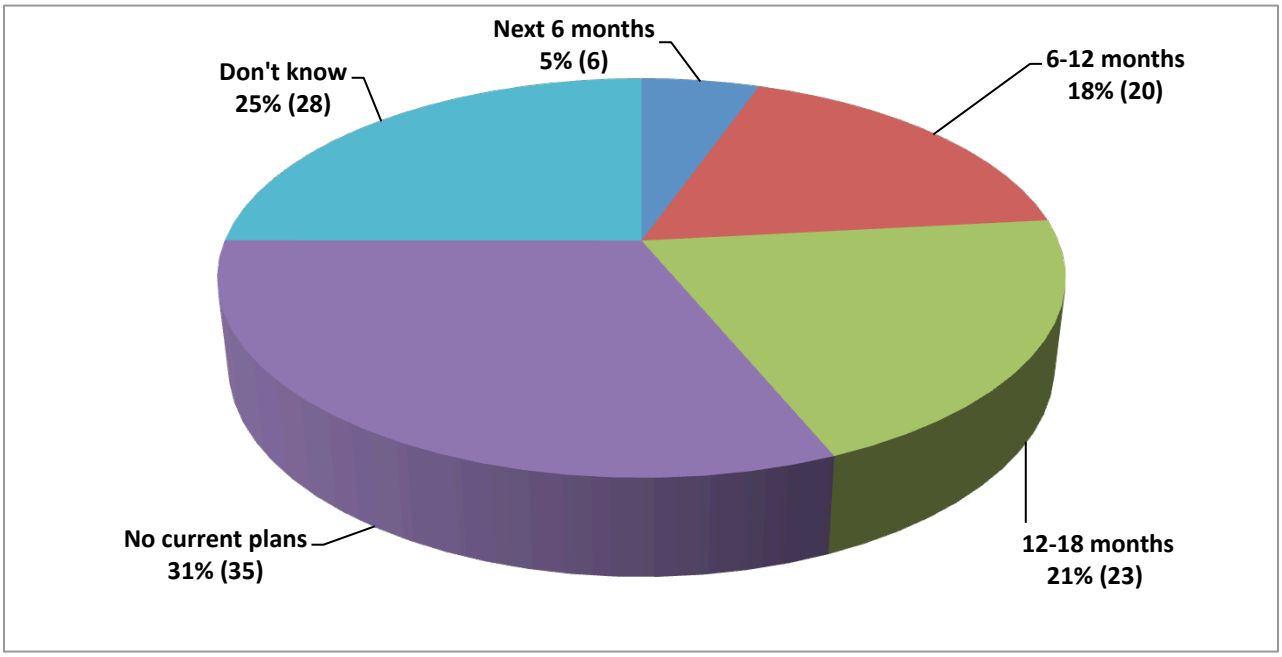
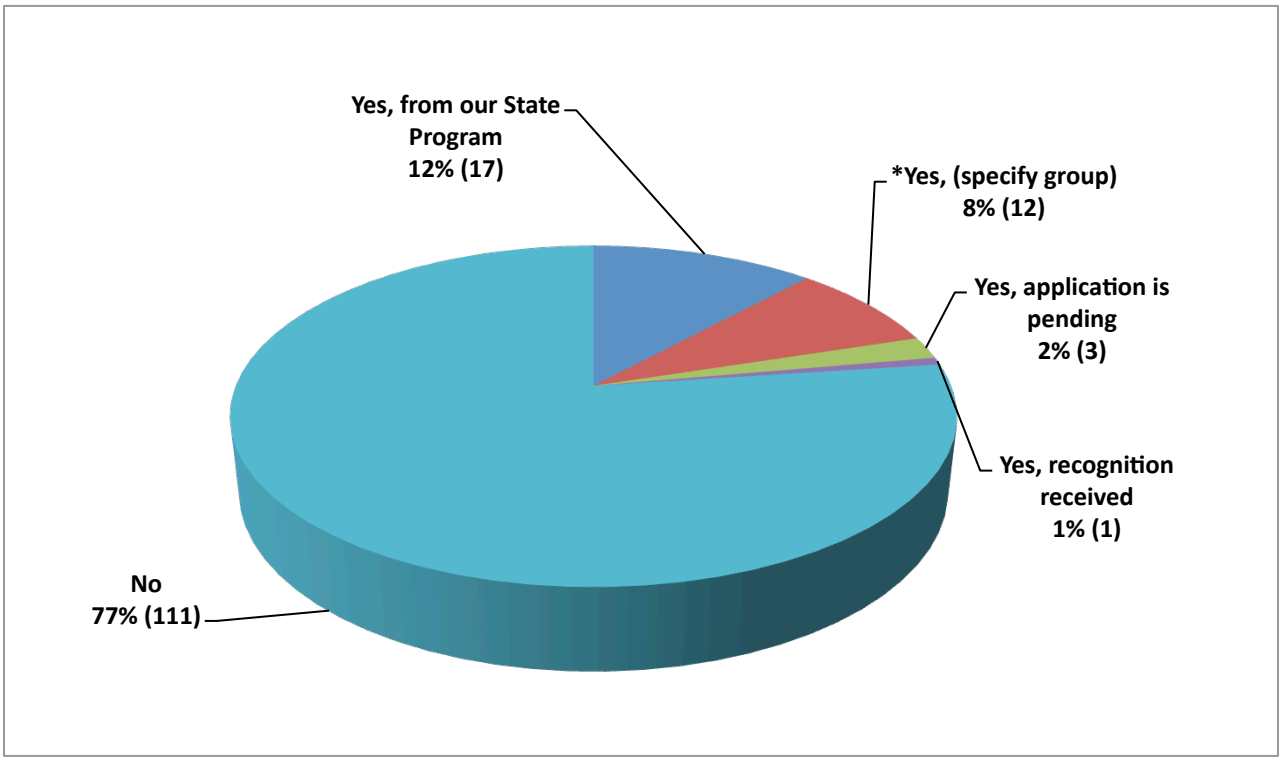


Figure 25. Is organization considering PCMH recognition from a group other than NCQA?; n=144



*Note: Groups specified: Joint Commission (7), AAAHC (4), PCIP BC/BS (1). One respondent stated they had received Joint Commission recognition in 2010.

Table 4. Challenges and Barriers in Preparing for or Maintaining PCMH Designation

Challenges and Barriers as Stated by Respondents (Common Themes)
Completing MU First • "We would like to complete the implementation of our EHR before applying for PCMH certification." • "Current work to implement EHR and other initiatives is consuming most of staff's time." • "Consultants have advised against seeking recognition while in the middle of EHR implementation."
Population Served • "Transient patient population and health IT issues" • "Homeless population will be difficult to track to maintain standards of PCMH."
Training • "Staff training and access to providers" • "HRSA has not been clear about which PCMH programs it will recognize. They seem to favor NCQA but they also endorse AAAHC accreditation. They also seem to say they will support JCAHO but they don't even have standards yet while AAAHC does. This needs to be made clear." • "Lack of knowledge of requirements and timeline, and expense" • "Providers need education re: Meaningful Use … incentive eligibility … and incentive assignment; also to tease out their respective private practice from the time spent at the HCH clinic"
Costs, Resources, Staffing • "Manpower to pull together all of the documentation. Waiting on eCW version upgrade for patient portal and e-messenger features which will help meet PCMH requirements" • "Cost, loss of productivity" • "There's a need for staff whose services would be unpaid for, lack of many consultants available to accept patients here so difficulty improving outcomes other than offering better access to our care. Cost for a certificate and ongoing costs" • "Staffing needs to meet requirements, complete definitions of standards, non-billable positions to meet requirements which create sustainability issues" • "Lack of manpower for the transition of client flow, policy and procedure revision, and client education" • "Cost of ongoing training; exchanging information between this health center and other providers; staff resistance to change in workflow patterns; lack of secure mechanism for transferring information, e.g. emailing medical records securely"
Time Limitations • "All of the quality data reporting and tracking" • "It's a lot of work." • "Time to implement - staff awareness"
Questions regarding PCMH Model • "Not clear what is the role of health care for the homeless in providing medical home" • "Little evidence that chosen indicators have any connection to outcomes" • "NCQA guidelines are not particularly special population focus friendly" • "Future criteria to maintain PCMH designation is not defined. Unable to respond regarding barriers until criteria maintaining PCMH designation is available" • "Current payment system based on face to face visits. Need new incentives that recognize other work & doesn't penalize the safety net" • "Payment methods do not incentivize outcomes based health care."

- "We are already 4 years into implementation of PCMH model but do not believe NCQA adequately captures true essence of the model. We would consider state recognition but does not yet exist in Oregon."

PATIENT REGISTRIES/CLINICAL DATA WAREHOUSES

Figure 26. Patient registry products currently in use in organization? (Check all that apply); n=132

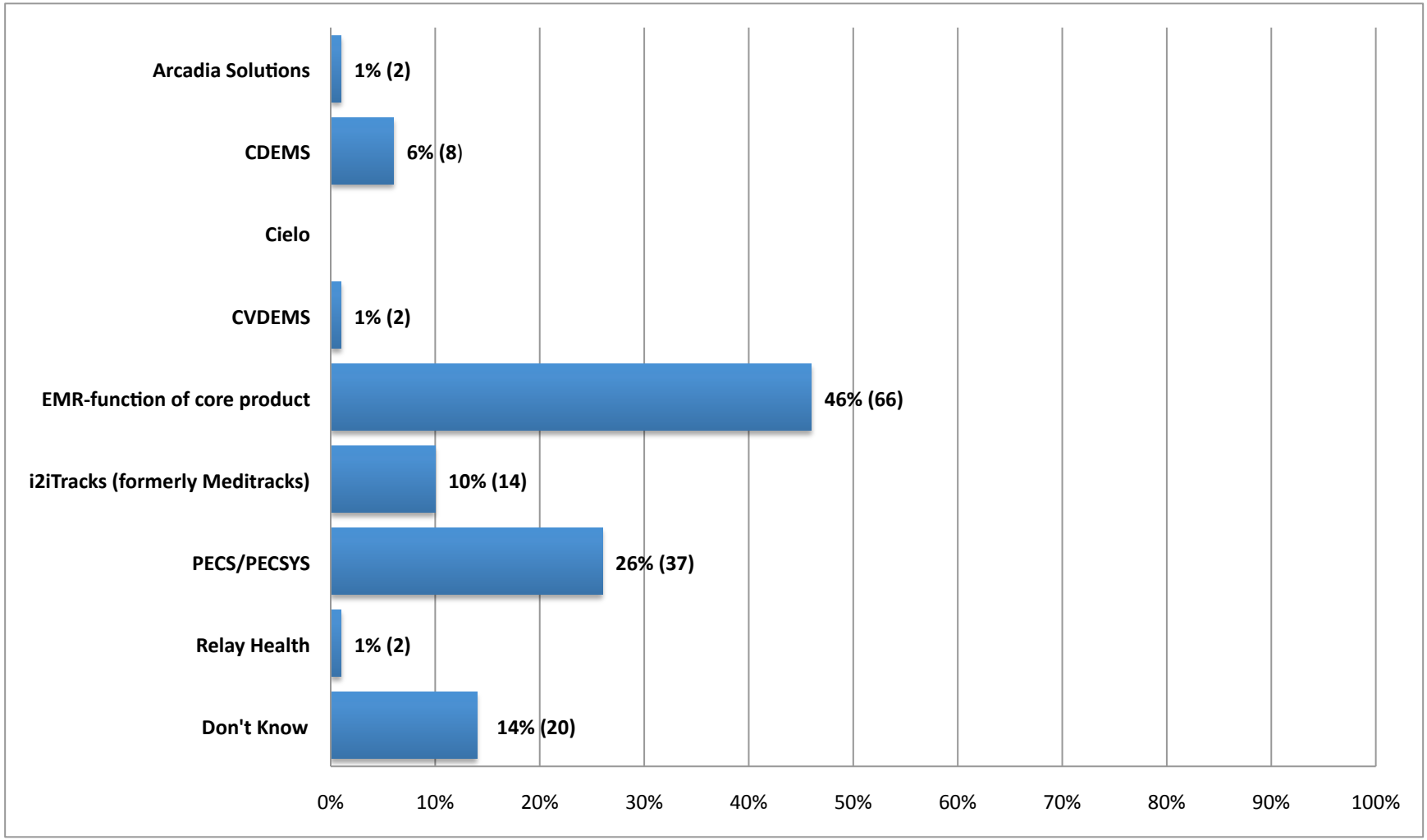


Figure 27. Is organization currently involved with any local or regional clinical data warehouse project that will or is currently providing information regarding clinical performance on selected measures within and among participating practices?; N=144

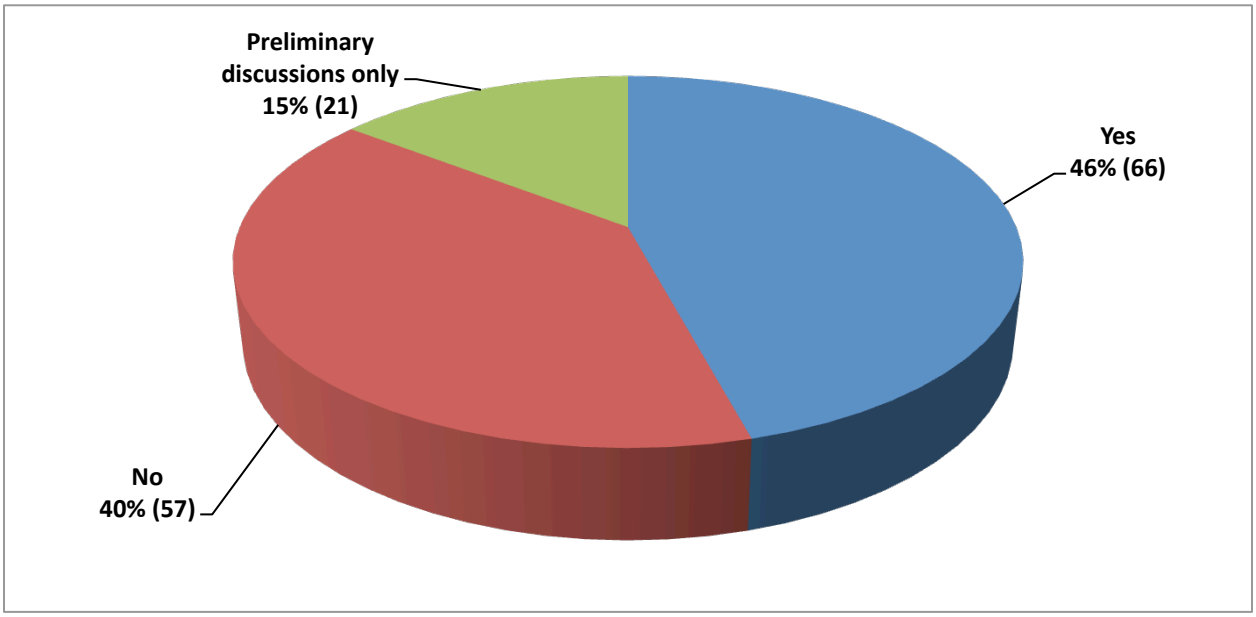


Table 5. *Type of Involvement with Local or Regional Clinical Data Warehouse Project

Type of Involvement
• "Mountain Pacific Quality Health - four Medicare clinical measures" • "Well logic" • "Involved with Mass League of CHCs – CHIA-DRVS project" • "Clinical data from member Heath Choice Network (HCN) centers is collected and reports are made available by HCN as to how member centers compare to each other on key indicators. Via SQL Server reporting services, QUICK reports. Other service vendors pending." • "Better Health Cleveland: initiative to track services and outcome in Cleveland" • "We are involved with the NYCDOH and PCIP project. They are assisting us in gaining Meaningful Use and with Medical home designation. Clinical measures are directly obtained by DOH/PCIP from the EMR and feedback is given to us." • "Currently, Delta Health Alliance hosts our Electronic Medical Records. Delta Health Alliance is at the forefront of developing and implementing Health Information Technology (HIT) in the state of Mississippi. The primary goal of this project is to implement Electronic Health Records in provider clinics across the Delta. Currently there are 16 Provider groups, representing 34 physical locations active on the DHA Electronic Health Records (EHR) system." • "Charles Drew Health Center belongs to a local network (Heartland Network) that allows us to make better use of our resources to implement and maintain the EMR. This also includes data collection." • "MLCHC CHIA DRVS project" • "Working with a regional health consortium" • "Agreement with CareSpark" • "MediQ home project through BCBS" • "UDS measures" • "Wisconsin Primary Care Association" • "Central Coast Santa Clara Valley Health and Hosp. Systems (pending)" • "Local Data Repository and Data Warehouse" • "Diabetes Collaborative and PECS" • "Member of Community Health Access Network (CHAN), 330-funded integrated network" • "Part of the CHIP consortium"

***Note: Only some of the responses are represented. The above are a sampling of the total responses.**

ROLE OF REGIONAL EXTENSION CENTER (REC)

Figure 28. Does organization participate or collaborate with a Regional Extension Center (REC) or subcontractor?; N=144

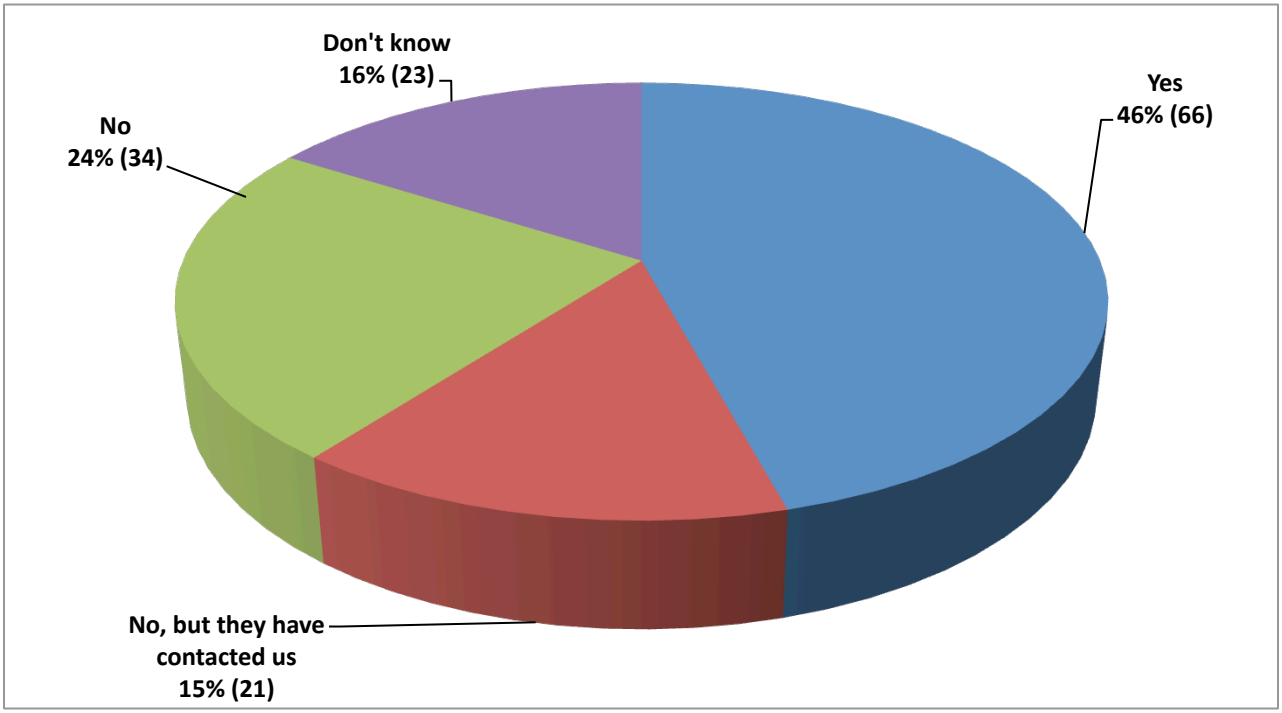
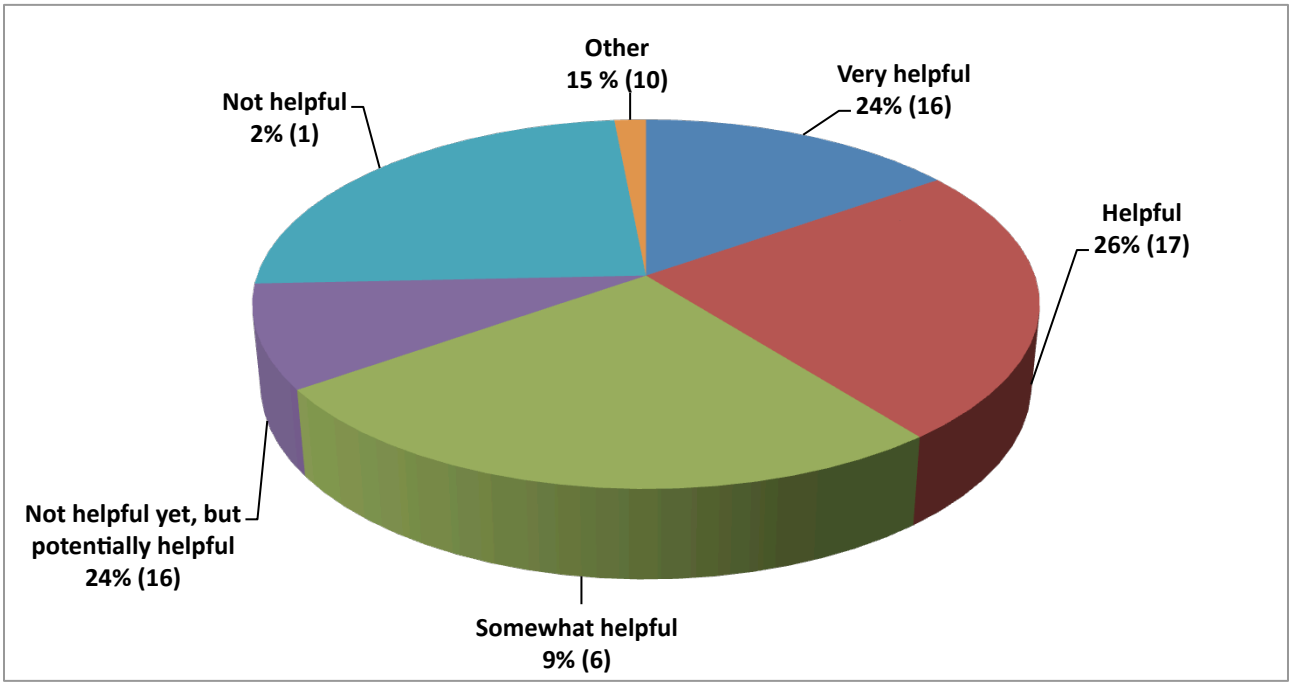


Figure 29. How helpful is this REC collaboration in advancing efforts to achieve MU status?; n=66



TELEMEDICINE/TELEHEALTH

Telemedicine is the exchange of clinical information from one location to another through electronic audiovisual media to improve patients' health status. The exchange may either be between providers or between provider and patient. This exchange may be rendered by using audio-visual technology such as webinars or video-conferencing that is interactive in real time (synchronous) or by transmission of clinical information using technology such as email with document and image transfer that is not interactive in real-time (asynchronous); i.e. send a message or question and wait for a response.

Figure 30. Does organization provide or participate in any of the following clinical telemedicine services? (Check all that apply); n=82

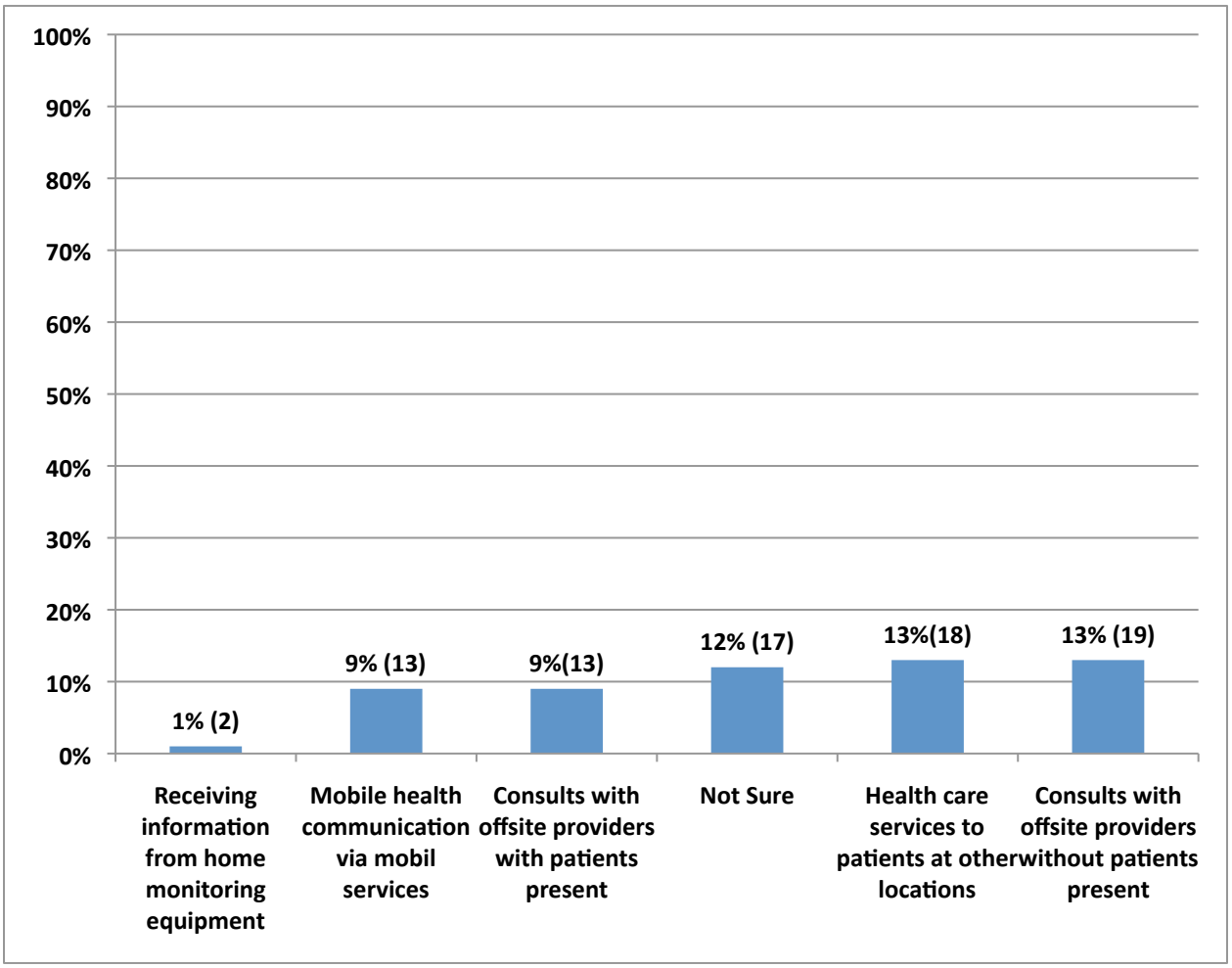


Table 6. For which type of clinical consultation service(s) does organization use telemedicine, either internally within network or externally with other health providers? (Check all that apply)

Clinical Service	***Frequency**
Behavioral health (mental health or substance abuse)	16
Diabetic retinopathy	9
Dermatology	6
HIV and AIDS related	5
Dental	5
Endocrinology	2
High risk obstetrics	2
Neurology	1
Primary care backup to Homeless Clinic(s)	9
Primary care backup to School-based Health Clinic(s)	4
Primary care backup to Free Clinic(s)	2
Primary care backup up HIV/AIDS Clinic(s)	1
Primary care backup to remote or rural health clinic	1
Primary care backup to Family Planning Clinic(s)	1
Primary care backup to Home Health Care program(s)	1
Psychiatry	9
Radiology	3
Not sure	15
No Response	
Trauma/Emergency services	
Primary care backup to Public Housing Clinic(s)	
Other Responses	
Bioterrorism, Chronic Disease Education	
Diabetes pilot project	
Geriatric	
Hep C consult (Project Echo) with U of Washington	
Ophthalmology	
Pediatric developmentalist for autistic children	
TelePharmacy	

***Frequency of responses per pre-identified clinical consultation service**

Telehealth is the delivery of health-related services and information via telecommunications technologies; it is often used to encompass a broader range of health care beyond direct clinical services. As with telemedicine, this information exchange may use either synchronous interactive, real time technology or use asynchronous technology that is not real time.

Figure 31. Does organization provide or participate in any of the following telehealth services, either internally within network or externally with other organizations or groups? (Check all that apply); N=144

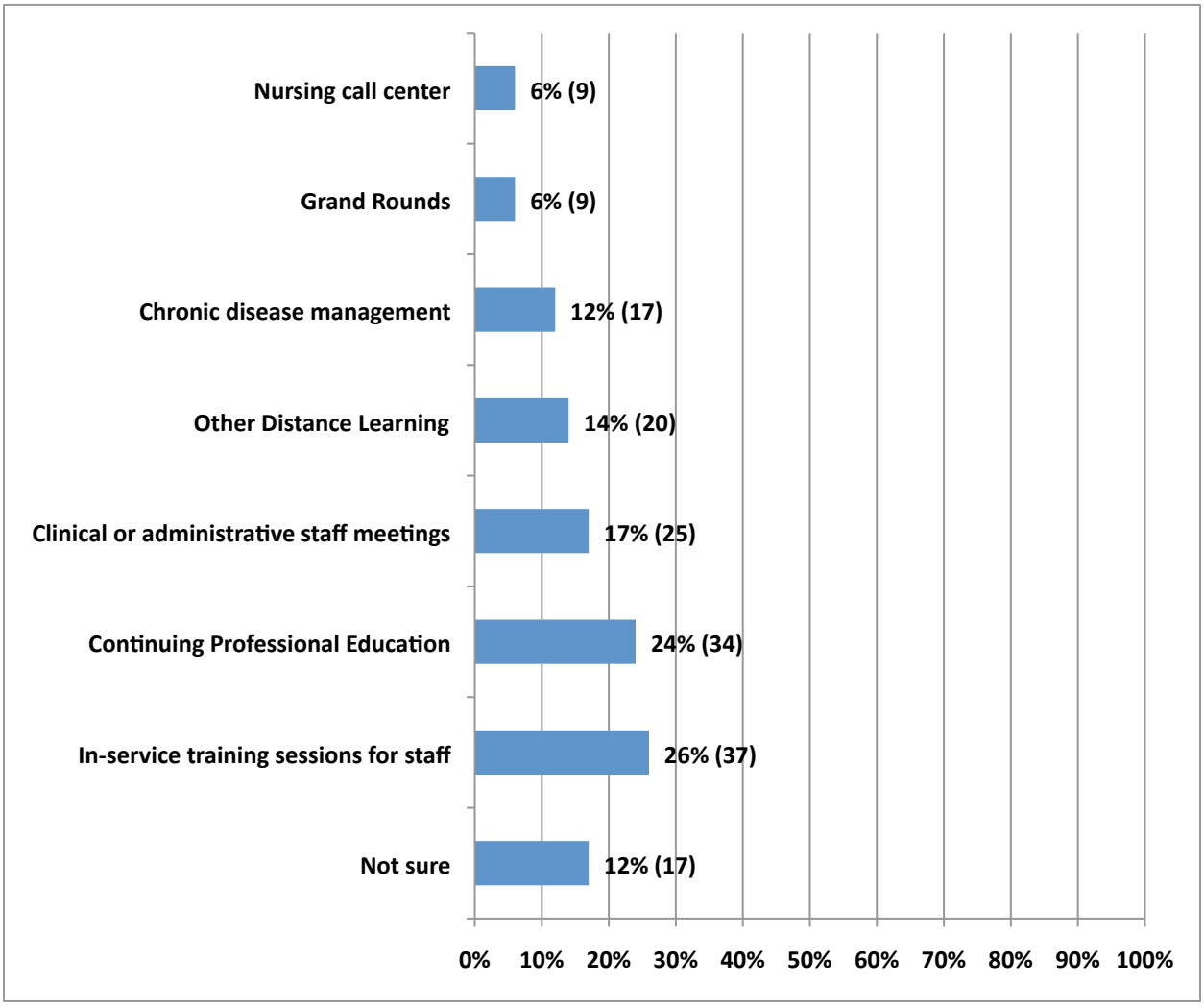


Figure 32. Does organization foresee integrating telemedicine and/or telehealth services into care delivery model in the near future (1-2 years)?; N=144

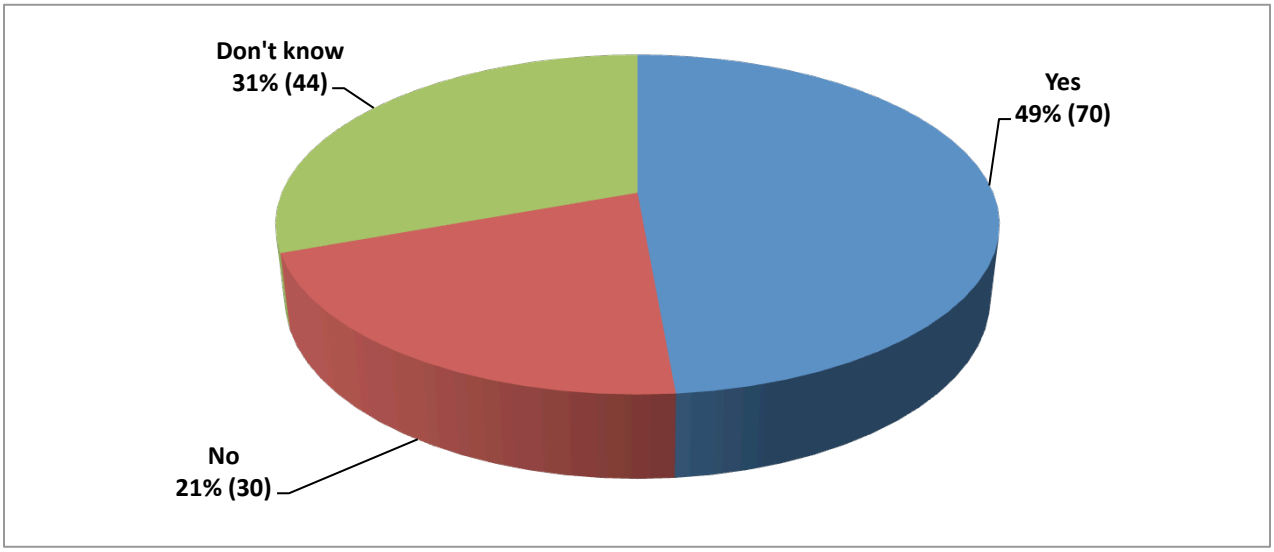


Table 7. What does your organization see as barriers to implementing telemedicine and/or telehealth services? (Check all that apply)

Barriers	*Frequency
Equipment costs	63
Reimbursement of specialist	47
Training of our staff	42
Connectivity/bandwidth costs	42
Connectivity/bandwidth availability	37
Availability of certified specialists	34
Low demand or utilization	25
Not sure	21
Other	
Funding	3
Reimbursement to clinic	2

***Frequency of responses per identified barrier.**

TECHNICAL ASSISTANCE (TA) AND TRAINING

Table 8. In which areas is organization interested in receiving TA or training? (Check all that apply) N=144

Areas of Interest	* Frequency	Percentage
Preparation for applying for PCMH recognition	71	49%
Workflow redesign and practice transformation	69	48%
Preparation for compliance with MU measures	65	45%
Using HIT to improve clinical care	64	44%
Medicaid EHR incentives	63	44%
Registries and clinical data warehouses	56	39%
Assessment/gap analysis of readiness for MU	52	36%
Regulatory analysis	38	26%
Selecting an EHR and /or EDR vendor	13	9%
Other		
Administrative leadership	1	1%
Forms Building/Training on new EHR	1	1%
NCQA	1	1%
Patient Portal	1	1%
Payment issues if payment goes directly to providers working in a CHC	1	1%
Privacy/Security, Internal policy guidance, vendor contract, review/negotiation,	1	1%
Financial model, tools for sustaining support of EHR/EDR	1	1%
Targeted training for providers "The benefits of converting to EHR" Limited understanding/sense of urgency.	1	1%

*** Frequency of responses per area of interest in receiving TA or training**

Table 9. From which group(s) is organization currently receiving TA or training in any of the areas mentioned above? (Check all that apply); N=144

TA/Training Group	*Frequency	Percentage
Primary Care Association (PCA)	75	52%
EHR vendor	66	46%
Regional Extension Center (REC) or Sub-contractor	48	33%
Health Center Controlled Network (HCCN)	23	16%
Other area Health Centers	14	10%
Private-Public Partnership (PPP)	5	3%
Other	11	8%

*** Frequency of responses per group currently providing TA or training**

Table 10. How satisfied are you on a scale of 1 (low) to 5 (high) with the TA you are now receiving from the applicable groups?; N=144

Group	1 (Low)	2	3	4	5 (High)	N/A	Skipped Question
EHR Vendor	4% (5)	10% (15)	24% (35)	19% (27)	11% (16)	10% (14)	22% (32)
PCA	4% (5)	4% (5)	13% (19)	19% (27)	17% (24)	14% (20)	31% (44)
HCCN	4% (5)	1% (2)	3% (4)	8% (11)	5% (7)	34% (49)	46% (66)
Other area Health Centers	1% (2)	4% (5)	6% (8)	6% (9)	4% (5)	30% (43)	50% (72)
REC or Sub-contractor	4%(6)	4% (5)	7% (10)	10% (15)	9% (13)	30% (43)	36% (52)
PPP	1% (1)	-	-	1% (1)	1% (1)	42% (60)	57% (81)
Other (per above)	1% (1)	1% (1)	-	4% (6)	1% (2)	35% (50)	58% (84)

CONCLUSION AND RECOMMENDATIONS

The results of this survey indicate that HCH grantees are moving toward the implementation of EHRs, with 76% either having EHRs or having plans to implement EHRs. However, not all HCH grantees are moving toward NCQA recognition, with 56% of HCH respondents indicating that they don't know or have no current plans to apply for PCMH recognition from NCQA. In a rapidly evolving health reform environment, it is critical that all Health Center grantees become Meaningful Users of EHRs and recognized Patient Centered Medical Homes.

HCH grantees' perception that obtaining PCMH recognition is particularly difficult for this special population community is a significant challenge to progress. Although challenges exist, with training, technical assistance and a dedicated staff these challenges are surmountable, as has been demonstrated by the 6% HCH grantees obtaining Level 1 PCMH recognition from NCQA, 1% obtaining Level 3 recognition and 15% with applications pending. The National HCH Council is committed to providing intensified, targeted training and technical assistance (T/TA) to HCH grantees, particularly those that have not yet made progress on these issues, to assist in overcoming some of the challenges identified in this survey. Currently, we are developing case studies on several HCH grantees as they progress in achieving Meaningful Use and PCMH recognition.

As Regional Extension Centers, State and Regional Primary Care Associations, Health Center Controlled Networks and National Cooperative Agreements provide additional T/TA, the National HCH Council is eager to help them understand the special circumstances of Special Populations grantees and the populations they serve, and to help coordinate efforts among TA providers.

Survey results reveal a need for T/TA in at least the following areas:

- workflow redesign and practice transformation
- compliance with MU measures
- selection of software vendors
- application of HIT to improve clinical care, track outcomes and provide measures that improve quality and performance
- Medicaid EHR incentives

Importantly, respondents very frequently cited the costs of software, hardware, connectivity, and personnel as the most significant barrier to achieving Meaningful Use or PCMH recognition. HRSA and other funders of these grantees should assure that the grantees are financially capable of meeting any expectations that are placed upon the grantees.

LIMITATIONS

There are a few limitations to these findings. All the data collected is self-reported and is subject to the knowledge and interpretation of the individual(s) who completed the survey. The survey included questions

that asked respondents to check all that apply. Therefore, since items are not mutually exclusive, responses to these questions make it difficult to make inferences and prioritize areas of importance or greatest need.

Qualitative data were reviewed and grouped into common themes identified by the researcher; therefore, generalizations and statistical inferences cannot be made regarding this data.

The National HCH Council will utilize the results of this survey to guide our provision of technical assistance and training. The findings listed will be addressed in webinars, regional trainings and the National HCH Conference, helping to meet the needs HCH grantees in the areas of Meaningful Use and obtaining PCMH NCQA recognition.