COLLABORATIVE VENTURES NETWORK

Informatics and the 2019 Program Assistance Letter from HRSA

Even though it's important to ensure that reporting on 2018 care is as complete as possible in 2019, it is also worth noting that there will be modifications to how we measure our efforts beginning January 1st, 2019. As many of you are aware, HRSA distributed its Program Assistance Letter, or PAL, in June of 2018, describing the changes they have proposed for the upcoming calendar year. While this may not be what most think of as "Informatics", in actuality, identifying where the most critical needs for patient care, whether it be mapping data or a staff resource, is something very much in the wheelhouse of those involved with Community Health Informatics.

It's customary that changes to the clinical measures with regard to e-CQMs in Tables 6B & 7 usually take center stage (please see updates clinical measures here) in the upcoming year's PAL, however it's important to note that those changes encompass 13% of the changes listed. Of the remainder, 75% (6 of 8 proposed changes) are focused on staffing. Changes such as identifying mental health & substance use disorder providers; quantifying telemedicine/virtual visits in staffing tables; and retiring tenure for health center staff are some of the items that were highlighted. Even the proposed change on closing the referral loop is essentially about staffing. Primary care is the predominant "specialty" among FQHCs yet when some diagnoses as well as treatments require other types of providers for assistance, health center patients are referred elsewhere. HRSA recognizes that there isn't a very good system currently in place to answer questions about the scope and nature of referrals currently being done at FQHCs such as what type of specialty has the highest volume of referrals and which specialty is the most difficult to schedule due to the feedback loop between FQHCs and specialists being unstructured.

The focus of proposed changes alludes to a broader adjustment, as stated in one of the final changes cited- Appendix F: Workforce, that recognizes a need for a full and robust accounting of staffing for community health centers. Without solid enumeration of what kinds of providers are available at FQHCs and where there is a gap between community need and provider staffing, it is difficult to have an appropriate strategy surrounding the quadruple aim both directly (provider satisfaction) and indirectly (patient satisfaction, improved outcomes, and lower cost of care). In order to achieve the goals set forth by CMS or CDC, HRSA is aware that knowing what is truly "on hand" with regard to the provider aspect of FQHCs is critical. Or as HRSA stated it," Questions around provider and staff satisfaction will be included…given the implications on retention and quality of care".