From: Robert Record
To: HRSA Paperwork
Subject: [EXTERNAL] Published Document: 2024-27394 (89 FR 92692)
Date: Tuesday, November 26, 2024 9:46:30 AM
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I tend to sit quietly by and not mention anything when new metrics are published. Tend to is not fair, I never comment. I trust our leaders and endeavor to show support by never rocking the boat.
This time, I must ask, who is coming up with these metrics, and do they have any real-world experience in providing primary care medicine? And if they do, do they have any experience in delivery of these services among the underserved? Just a few years ago, we added depression remission as a metric. This is a viable goal, but you chose a tool that is somewhat-valid for depression screening to be the plumbline of depression remission despite it having no validity for such. Now this year, you propose:

- *Tobacco Use Cessation Pharmacotherapies:* A new measure is being added to line 26c2 to identify the number of visits where patients received tobacco cessation pharmacotherapies as an intervention and the number of patients who received this pharmacologic treatment. While the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention electronic-specified clinical quality measures (CMS138v12) (Table 6B, Line 14a) that is currently reported in the UDS assesses for cessation, it lacks the capacity to disaggregate and report a distinct percentage for patients receiving counseling or recommendation to cessation pharmacotherapies. Adding a line for reporting of tobacco use cessation pharmacotherapies will promote greater understanding of the breadth of tobacco cessation interventions provided at health centers, specifically allowing HRSA to see differences in tobacco use cessation approaches.
    - This will only add a reporting requirement. The bulk of tobacco cessation therapies are available to patients OTC. Nicotine replacement therapies are safe for most, and patches, gum, and lozenges are all available OTC. Varenicline is available by prescription only. It is also unsafe for many with depressive disorder. The unintended consequence of this rule is going to push more prescriptions of a less-safe drug because it's easier to track and prove intervention. This is a mistake in every way. Please go back to the drawing board.
- *Medications for Opioid Use Disorder (MOUD):* A new measure for MOUD services will be reported on line 26c3 for the number of visits where MOUD was administered and the number of patients who received this medication-based intervention. This new measure will enhance the existing MOUD related measures that health centers currently report on in Appendix E: Other Data Elements (*e.g.,* number of providers who treat opioid use disorder with MOUD). The inclusion of this measure is critical for supporting public health efforts to address the ongoing opioid epidemic. Greater understanding of the use of MOUD in health centers is necessary both to understand existing services and identify remaining healthcare gaps.
    - I applaud the focus on increasing MOUD prescriptions. There are times that the

right answer is no. The appropriate metric here would be: MOUD prescription considered in patient with opiate addiction. Just knowing a raw number will miss the real question.

- *Alzheimer's Disease and Related Dementias (ADRD) Screening:* A new measure is being added to line 26f to capture the number of visits where patients received ADRD screenings and the number of patients who received the screenings. This measure will encompass assessments representing standardized tools used for the evaluation of cognition and mental status of older adults. The addition of a measure to capture screening of ADRD will be valuable in understanding the level of need and resources required to continue to support the growing aging population served by the Health Center Program and will foster early detection for those at risk for ADRD.
    - Alzheimer's is a devastating diagnosis for which we have no great therapeutic options. We all want to identify it earlier but are not great in altering the course of the disease, even with currently available medications. These screening tools that have proliferated within HRSA's desire for more accountable medicine are extremely time and labor consuming. The unintended consequence of which is the contraction of the number of patients who can be seen. Most good clinicians can diagnose Alzheimer's, depression, opiate use, tobacco readiness to quit, attention deficit, SDOH, and a myriad of other conditions without screening tools. What none of them can do is fulfill their duty to the population while waiting for a litany of screening tools to be completed at every visit. The burden of paperwork is hurting patient access, a key component of the iron cross of quality.
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Table 6B (Quality of Care Measures) Addition

- *Initiation and Engagement of Substance Use Disorder Treatment:* A new measure with two distinct rates is being added to Lines 23a and b to capture the initiation and engagement of substance use disorder treatment, in alignment with electronic-specified clinical quality measure CMS137v13. This measure will report on the percentage of patients 13 years and older with a new substance use disorder episode who received treatment, including (a) those who initiated treatment within 14 days and (b) those who engaged in ongoing treatment within 34 days. By incorporating this measure, HRSA strengthens its alignment with national performance standards and gains greater insight into how effectively health centers are initiating and engaging patients in substance use disorder treatment.
- This is stated as if there is one path or even a very limited number of paths for the treatment of "new" substance use disorders. The better investigatory group would be "Any" person with a substance use disorder. This would allow for regression to the mean of what you are going to be able to measure for intervention. In many of these cases, we are going to refer a patient to Alcoholics Anonymous or other 12-Step program. Please realize that these by definition in their name do not close the referral gap.

I thank you that you are demanding quality out of each of us. I only ask that you consider the number need to harm in your interventions. In each of these cases, you are adding more

burden than improvement. Let's demand and get better quality in patient care. Let's get there by demanding and getting better quality in our quality improvement mandates.

Sincerely,

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