June 26, 2009

Office of the National Coordinator for Health Information Technology
200 Independence Avenue, S.W.
Suite 729D
Washington, D.C. 20201
Attention: HIT Policy Committee Meaningful Use Comments

RE: DEFINITION OF MEANINGFUL USE

Dear Honorable Members of the Health information Technology (HIT) Policy Committee:

The 25 undersigned organizations representing consumers, labor and employers – those who receive and pay for the health care that HIT is intended to improve – appreciate the opportunity to comment on the criteria for the meaningful use of electronic health records (EHR). The definition of meaningful use proposed on June 16 provides a starting point for directing our commitment to HIT into productive applications that result in real value for the American people.

We believe that the national investment in HIT will only be justified if it leads to measurable gains in quality and making care more affordable. The criteria for meaningful use should confirm that an eligible provider has properly implemented EHR technology in ways that achieve quality and efficiency gains. Because the benefits that will result from changing clinical processes may take two years or more to be evident, it is essential that the redesign work begin now and that intermediate yardsticks provide convincing evidence that care is being improved.

We encourage the Committee to create a definition of meaningful use that will help providers better meet patient needs and demonstrate that large public spending is having the desired affect through improvements in four areas that we describe in more detail below:

- Measure collection and use
- Connectivity
- Decision support
- Patient Engagement

Measure Collection and Use

The distinctive contribution of the HIT incentive program to the collection of performance information is to shift the infrastructure for performance measurement toward a fully connected, electronic platform that will enable clinically rich measures. These measures should foster the delivery of care that is integrated, coordinated, and focused on delivering the right, high quality care at the right time. Required measures should support this goal. Many of the measures listed in the draft proposal are too confusing or lack the robustness to propel providers toward this goal and will not necessarily provide useful information to others that should rely on these

measures as the new source for performance reporting. We urge you to consider the following suggestions and concerns:

Ensure all measures are high impact: The draft proposal calls for the collection of a large number of measures. To ensure that this transition is effective without placing undue burden on providers, we urge the committee and CMS to use measures that are "high impact" and enable us to leverage the maximum improvements in quality and efficiency.

We must recognize that this is an opportunity to develop EHRs that allow for collection of data that will ultimately make quality measurement – including measurement of efficiency and outcomes – more feasible and less burdensome to providers. The list of measures in this proposal must reflect that. We urge the committee and CMS to appropriately fine-tune the list of measures in such a way that we will neither fall short in terms of what can be accomplished today, nor are we missing the chance to accomplish improved data collection in the future.

Measuring use, not capacity: Many of the draft measures assess EHR capabilities rather than the extent to which those capabilities are used. In other cases, there are key objectives identified that are not matched to appropriate metrics (e.g., drug safety checks and patient registries). We urge that all measures relate to actual use of system capacities and that each key objective have measureable goals.

Tracking measures over time and early on: Measures must be tracked over time, beginning at the point of the program's inception. The earlier providers have access to their data the sooner they can begin to integrate them into their care processes. We also suggest that measures reflect incremental expectations of quality improvement over time. For example, if we have a 2015 goal of reducing adverse drug events by 50%, we need to begin to <u>count</u> those events in 2011. Or, in the case of drug safety checks, in 2011, installed EHR systems should count how often drug safety checks are run against medication lists and how often alerts identify potential problems. We should continue to collect data on this measure in 2013 but add a measure on how many times an order is changed subsequent to a drug safety alert identifying a problem.

Resource use measures: We commend the Committee for incorporating efficiency metrics into the draft proposal and recognizing HIT's potential to make health care more affordable. While we applaud the inclusion of a 2013 measure on inappropriate use of imaging, we are disappointed that this is the lone resource use measure in the draft proposal. While we understand that there currently are few standard resource use and appropriateness measures, there are promising efficiency measure development efforts underway. Additionally, there are currently available basic resource and appropriateness measures that can and should be included in 2011, such as:

- Generic prescribing rates
- Appropriate use of antibiotics
- Use of imaging studies in the first six weeks following presentation with back pain

It is critical that the Committee indicate that resource use and appropriateness measures are a high priority by including these recommended measures and defining a clear path

for adding additional measures in this area for 2015, as nationally standardized metrics become available.

Verifying measures with rigor: Performance on measures must be verified in a rigorous manner to ensure that incentives are paid out to those providers who actually use EHRs to advance care. We are deeply concerned about the use of attestation as the means for verifying compliance with meaningful use requirements.   Attestation could result in exaggerated reported use levels and weak evidence on which to award federal incentives. Instead, we support the adoption of electronic verification methods that are able to verify meaningful use by accessing provider EHR systems to track functions or actions performed during the routine flow of clinical care. For example, EHRs could maintain standardized transaction logs or cookies to monitor workflow process elements and determine that essential processes are utilized. CMS should be expected to remotely inspect actual use statistics from qualifying EHRs.

Stratifying measures to address and reduce disparities in care: We strongly urge that all data collection and reporting includes information on race, ethnicity, gender and primary language (at a minimum), which can be stratified for analytical purposes. This information is essential to enable providers and other stakeholders to address disparities in care.

Connectivity

The ability of EHRs to connect with other electronic networks enables providers to have a more comprehensive picture of the care that patients are receiving from multiple providers. It also provides access to data in near real-time. Congress required clinical data exchange in the ARRA legislation, and the related meaningful use criteria should be strengthened to reflect this. The Committee should augment its current electronic prescribing requirements to include the electronic download of patient medication lists from pharmacies; if a patient has multiple physicians, this becomes a critical component of effectively coordinating care and decision support. This requirement is already present in the CMS Electronic Prescribing Incentive program and should be aligned with and reinforced in the HIT incentive program. We note, however, that e-prescribing reporting requirements must go well beyond those delineated in the CMS program, for which providers only report on whether prescriptions were generated via a qualified e-prescribing system.

We also propose clarification of the 2011 measure that reads "implemented ability to exchange health information with external clinical entity." The measure should be clarified to ensure that providers share clinical patient information with appropriate entities.

Decision Support

EHRs can offer providers an array of clinical decision support systems (CDSS). CDSS can help providers make more evidence-based and efficient decisions at the point of care. Unfortunately, the draft proposal over-emphasizes clinical documentation without effectively implementing the CDSS tools that can add value and improve outcomes. While clinical decision support is a stated goal for 2013, we believe it is not enough to have only one instance – drug safety checks in e-prescribing – in which the use of clinical decision support is required. Even in the area of e-

prescribing, EHRs have a tremendous ability to contribute to the decision making process. Other e-prescribing decision supports include the ability to download medication list and information on lower cost therapeutically appropriate alternatives. The current proposal should enhance the CDSS requirements to include other types of clinical decision support beyond the narrow safety check in e-prescribing, and require certified EHR systems to monitor use of CDSS functions.

Promoting Patient Engagement

Patients must be full partners in their health and their health care. To be effective participants in their care, they need ongoing access to information about their health status and the treatments and medications they have received. The HIT incentive program must ensure that patients can have access to, and use of, their own information. We appreciate the draft proposal's inclusion of these functions but believe they should be strengthened in the following ways:

> ***Strengthening the personal health record***: It is critical that health care providers with EHRs give their patients electronic and timely access to personal health information through a portal or personal health record (PHR). This will enable patients to obtain real-time information (e.g., lab results, prescription lists) and participate more effectively in their care. However, in its current form, the scope of patient access objectives and measures is narrowly defined and focuses too much on the existence of a PHR or portal rather than patient use of them. Instead, the 2011 measure on "the percent of all patients with access to personal health information electronically" should be replaced with measures that capture how many patients have registered to access their portal or PHR, visited the portal or PHR, and made use of the portal or PHR. We suggest adding a 2013 objective related to the need for patients to receive timely access to all data, not just lab results and problem lists. We also encourage the addition of a measure by 2013 that captures the extent to which patient-generated data (such as blood sugar levels, blood pressure, weight, etc.) are entered into the PHR.
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> To facilitate patient use of PHRs, we propose that the criteria for meaningful use recognize that patients may access their PHRs through venues other than their individual clinician. We recommend the development of an objective that reflects the capacity to upload PHR information to other platforms. Additionally, there must be consideration given to the accuracy of PHR uploaded data. PHRs are sometimes populated with billing records, which can reflect imprecise information because they are based on clunky diagnostic coding language that sometimes fails to clearly articulate the story of a person's health care history. The inaccurate information from billing data could subsequently lead to improper treatment. We recommend including requirements for PHRs that will address potential patient confusion in these cases, such as clearly indicating the source of data for each diagnosis and educating patients about these challenges. Finally, we believe that meaningful use should include the capture of data that is in existing paper medical records, and making sure that data is entered into the newly installed EHR/PHR to insure continuity of care when making the transition from paper to electronic data. Without this provision, exceedingly valuable historical patient information may get lost, potentially leading to medical errors based on incomplete knowledge of prior treatments, allergies, tests, immunizations, etc.

***Respecting patient preferences*:** The 2013 objective of providing patients with access to patient-specific educational resources should be moved up to 2011 as educational resources (e.g., shared-decision making tools) are already available. The objective should also be made more detailed to help patients receive the information they need to make better decisions about their care. We recommend that the objective's text say that "patients eligible for preference sensitive care receive information and counseling to support their decision-making." The accompanying measure would be the percent of preference-sensitive interventions for which information was provided prior to care.

Finally, patient preferences should be respected in end-of-life care. Advance directives can help make patients' wishes clear to their families and health care providers. We recommend a separate 2011 measure be added to address this key issue: the percent of patients with an advance directive recorded in the EHR. The current draft combines the capture of advance directives with several other categories of patient preferences, failing to individually address and report on this significant subject.

Again, we thank you for the opportunity to comment on the definition of meaningful use. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Peter V. Lee, Executive Director of National Health Policy for the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,

American Benefits Council
American Hospice Foundation
Asian and Pacific Islander American Health Forum
Bridges to Excellence
Buyers' Health Care Action Group
Center for Health Improvement
Childbirth Connection
Consumers Union
Employers Health Coalition
Group Insurance Commission of Massachusetts
Healthcare 21 Business Coalition
Health Policy Corporation of Iowa
HR Policy Association
Iowa Health Buyers Alliance
National Business Coalition on Health
National Partnership for Women & Families
National Retail Federation
New Jersey Health Care Quality Institute
New York Business Group on Health
Pacific Business Group on Health
St. Louis Area Business Health Coalition
Service Employees International Union
The Alliance
The Leapfrog Group
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