

February 25, 2010

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: Request for Comments on Draft Definition of Meaningful Use Stage 2

Dear Honorable Members of the Health Information Technology (HIT) Policy Committee,

The 27 undersigned consumer, purchaser, and labor organizations appreciate the opportunity to submit comments on draft Stage 2 functional measures for the Meaningful Use Incentive Program. As representatives of those who receive and pay for health care, we support the Office of the National Coordinator (ONC) strengthening the requirements that eligible providers (EPs) and hospitals will need to meet in order to receive an incentive payment through the Meaningful Use program. We believe that the draft definition presented by the ONC HIT Policy Committee (HITPC) for Stage 2 of the program builds upon Stage 1 criteria in a progressive, rational, and feasible way, presenting a comprehensive set of requirements. Further, we believe that any downgrading of the proposed requirements will simply delay the critical need for transformation of our currently fragmented and inefficient system into one that delivers patient-centered, affordable, high-quality, high-value care.

Thus, we support and applaud the HITPC's efforts to draft a Stage 2 definition that will result in improved health outcomes for patients, improved individual experiences of care, and reduced costs to the system. Moving forward, we urge adoption of a Meaningful Use definition that remains focused on requirements that advance patient engagement, care coordination, and safety by:

- Addressing the critical need for systems that enable patients to have longitudinal health records;
- Developing Meaningful Use functional and quality measures that apply to specialty care;
- Giving patients portable and accessible health information to use in managing their health;
- Driving the use of data systems and measurement tools that support the capture of patient-reported data on outcomes, functional status, and patient experience of care, while providing timely results to patients and providers; and
- Facilitating the use of clinical decision support (CDS) tools by providers in a way that significantly increases the percentage of care that is evidence based.

While we make a number of suggestions for how the Stage 2 draft definition could be further strengthened, overall, we believe that as drafted, the definition strikes the appropriate balance between setting the bar high enough to achieve meaningful use, while at the same time establishing requirements that providers can reasonably meet in order to encourage participation in the program. Many of the alterations to former Stage 1 criteria, as well as newly established Stage 2 criteria, address the points made above. We also urge the HITPC and ONC, when developing the final set of recommendations for Stage 2 for CMS, to consider how to align Meaningful Use with other quality measurement and payment programs to ensure that HIT is implemented in a way that will support the growth of new models of delivery and payment for care, such as Accountable Care Organizations and Patient-Centered Medical Homes.

Our specific comments fall into the following three areas:

- Commendation of specific elements of Stage 2 requirements;
- Suggestions on ways the Stage 2 definition can be further improved to allow for more consumers and purchasers to reap the benefits of effectively-used HIT; and
- Responses to selected specific questions posed in the Request for Comments (RFC).

We hope our comments contribute to the development of Meaningful Use Stage 2 requirements that result in a noticeable difference in how patients and their caregivers experience the health care system. Rather than having them bear much of the responsibility and cost for keeping track of multiple providers, specialists, lab results and medications, an HIT-based system will better enable patients to partner with their providers in their care management and coordination. And providers who participate in the program will be more equipped to provide quality care to their patients by using HIT to get the information at the point of care.

SUPPORT FOR STAGE 2 ELEMENTS

We are very encouraged by the draft definition that the HITPC has developed for evolving the Meaningful Use program from Stage 1 to Stage 2. *We fully support the migration of all the Stage 1 "menu" functional criteria to being "core" criteria in Stage 2.* Creating a robust set of core requirements is essential to ensuring that EPs and hospitals demonstrate significant functional capabilities to receive their MU bonus payment. While we agree with the importance of all of the functional criteria outlined in the RFC, we want to highlight the criteria that must be incorporated into the final definition of Stage 2 if the program is to have the necessary impact:

In the domain *Improving Quality, Safety, Efficiency and Reducing Health Disparities* we support:

- The increase in the percentage of the patient population for whom the usage rate of computerized physician order entry (CPOE) and E-prescribing must be recorded.
- The addition of "appropriate evidence-based interactions" to the drug-drug and drug-allergy interaction checks, which reflects the need to reduce the false positive interaction rules and "alert fatigue."
- Changing the clinical decision-support (CDS) objective to focus CDS on improving performance, particularly for patients with high-priority health conditions. We cannot overemphasize the importance of CDS to the overall goal of improving patient care and outcomes. The Meaningful Use program should use its incentive structure to the greatest extent possible to leverage increased use of CDS. We also believe that Meaningful Use criteria can be designed to increase engagement of specialists. Later in our comments we offer suggestions on how to add CDS requirements that address specialists' concerns about the program.
- The addition of new objectives: 1) 30% of EP visits having at least one electronic note; 2) 30% of hospital patient days have at least one electronic note; and 3) 30% of medication orders are automatically tracked by electronic medication administration recording.

In the domain *Engaging Patients and Families in their Care* we support:

- Raising from 50 to 80 percent the population of patients who will be offered an electronic copy of discharge instructions from hospitals. We are particularly supportive of the change in this criterion for hospitals to proactively offer this function.
- Refinements to the objectives related to providing: 1) electronic copies of discharge instructions and 2) the ability to view and download clinical summaries for each office visit.
- The new objectives: 1) requiring that 80% of patients be offered the ability to view and download, via a web-based portal, longitudinal information about their hospital stays and ambulatory care; 2) providing online secure messaging to patients; and 3) recording patient preferences for communication medium.

In the domain *Improving Care Coordination* we support:

- Expansion of the requirement to exchange information with three external providers or a health information exchange. However, in our next section of comments, we offer rationale for why we believe the bar for this requirement should be set higher.
- Performance of medication reconciliation by a receiving provider at 80% of patient care transitions.
- The addition of new objectives related to: 1) creating the list of care team members and 2) recording a longitudinal care plan.

MAKING MEANINGFUL USE MORE PATIENT-CENTERED

Supporting Patients In Playing a Significant Role In Their Care

Effective use of HIT plays a key role in supporting a health care delivery system that meets the Institute of Medicine aims of being safe, timely, efficient, effective, equitable, and patient-centered. Implemented correctly, interoperable HIT infrastructure will support consumers and patients in taking an active role in their care. We applaud the Stage 2 criteria that require providers to allow patients to view and download their health information, but we also suggest making the following alterations to the draft definition to further strengthen the HIT-enabled role that patients can and should play in their care:

- Require that at least 25 percent of patients receive patient-specific education resources, versus the 10 percent of patients in the current definition.
- Measure not simply whether CPOE and CDS are implemented, but require sustained monitoring of these systems to ensure they are, and remain, safe and effective for patients. Ongoing monitoring of HIT is critical for patient safety and should be part of meaningful use criteria.
- Increase the population of patients for whom clinical office visit summaries, as well as timely electronic access will be provided, to 30 percent. This requirement, which records how many patients actively use a web-based portal, truly focuses on the communication between providers and patients, and will require significant provider leadership and potential culture change to succeed in its goal of getting more patients activated in their own care. We applaud the HITPC for including this objective in a way that brings providers appropriately into the equation.
- Remove any reference to a “test” of exchange, and tie existing criteria strategically to the exchange of health information. For example, ONC should consider tying the requirements of providing a summary of care record and medication reconciliation specifically to the requirement to exchange information electronically. There is evidence in the field that a higher volume of data exchange is feasible, and should be required, for Stage 2. Pilot projects operating in seven states – overseen by The Direct Project – on myriad elements of health information exchange across different settings, demonstrate that there is capacity and capability now for providers to exchange robust and sophisticated data on a greater volume than is indicated by the Stage 2 HIE objective. We encourage the HITPC to consider raising the bar further in this area, and we would be happy to provide more information on this issue to your committee.

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 in Stage 2, all measures relate to actual use of system capacities and that each key objective have measureable goals, tied as closely as possible to outcomes, such as mortality, morbidity, healthcare-acquired conditions, readmissions, patient-reported functional status, patient experience of care, care coordination, care transitions, and efficiency. For example, physicians should actually be using HIT to address overuse of lab and radiology tests, which result in unnecessary and wasteful spending, and in the case of radiological tests can also put patients at risk by exposing them to unnecessary radiation.

Creating a Pathway for Greater Specialist Participation

As noted above, we do have concerns regarding ensuring specialists are appropriately engaged in the program, both in terms of the functional criteria and the quality measures. We strongly suggest that thought be given to how to operationalize greater use of clinical decision support, and in particular, focus on how CDS requirements in Meaningful Use can be directed at the way specialty care is provided. For example, a requirement that each specialty identify specific CDS rules for implementation on a menu basis, e.g. implement at least three specialty-specific rules by 2013, then 10 rules by 2015. While our focus is often on primary care and the needs of the primary care provider community, patients – particularly those with multiple chronic conditions who count multiple specialists among their care team – will be ill served by a program that does not reflect the needs of, and include a significant proportion of, specialty providers.

ADDITIONAL SPECIFIC QUESTIONS FOR PUBLIC COMMENT

1. *For patient/family access to personal health information, what standards should exist regarding accessibility for people with disabilities?*

There are a number of existing standards and practices which should be used to ensure accessibility and usability by people with disabilities. For example:

- Websites should be designed using the Web Content Accessibility Guidelines (WCAG 2.0) developed by the World Wide Web Consortium;
- Information technology should reflect the federal requirements in Section 508 of the Rehabilitation Act for accessible Electronic and Information Technology (EIT) for accessible equipment;
- Any telephone assistance hotlines – for instance, Interactive Voice Response (IVR) systems -- should comport with the requirements for accessibility and usability found in the Communications Act (Sections 255 and 251); and
- Telephone call center services representatives, including via click through from web sites, should be trained in receiving calls from people with hearing disabilities and from people with speech disabilities who use the various forms of relay service.

2. *What strategies should be used to ensure that barriers to patient access – whether secondary to limited internet access, low health literacy and/or disability – are appropriately addressed?*

We believe one of the most useful tools for finding out what the barriers are to patient access to information and how to address them is talking directly to patients. Thus, we suggest that ONC and CMS work together to conduct focus groups with consumers, patients, family caregivers, and others who play a role in helping consumers and patients access and interpret information. Following this, ONC and CMS should share information with consumer and patient advocacy and support organizations (e.g., HIT Regional Extension Centers), EHR vendors, providers and other identified stakeholders to determine how best to implement solutions.

3. *For future stages of meaningful use assessment, should CMS provide an alternative way to achieve meaningful use based on demonstration of high performance on clinical quality measures?*

We began to address this question above in the area of “Measuring Use, Not Capacity.” We believe the scenario posed in this question reflects our ultimate goal, and that ONC and CMS must take a leadership role in supporting and actively pursuing the development of quality measures that will provide the kinds of patient-reported information on outcomes and care coordination that we need in order to determine whether HIT is being used in a meaningful way. In order to base demonstration of meaningful use on high performance on clinical measures, we must have in place an appropriate dashboard of measures available for this purpose. To help achieve this goal, we urge ONC to include among the functional criteria, requirements that will support better quality measures for Stage 2 and beyond. These functions include ability to capture, select, and transmit email addresses for use in patient-reported data capture, ability to interface to claims/administrative data using common

identifiers (e.g. plan member ID) to permit construction of longitudinal measures that will capture information on readmissions, and finally, tools for capturing patient-reported data from an external source, such as a health risk assessment or the Patient Reported Outcomes Measurement Information System (PROMIS) tool.

4. *In stage 1, as an optional menu objective, the presence of an advance directive should be recorded for over 50% of patients 65 years of age or older. We propose making this objective required and to include the results of the advance directive discussion, if available.*

We strongly support making both objectives – recording the presence of the advance directive, and recording the results of the advance directive – mandatory core objectives for both EPs and hospitals. This approach greatly increases the impact of this criterion, which is a key opportunity for engaging patients and their families in decision-making about their care. The benefit – both to patients and their care teams – of creating opportunities to have these important discussions and providing information that is pivotal to following a patient's preferences for his or her care, cannot be overstated.

5. *What reasonable elements should make up a care plan, clinical summary and discharge summary?*

The elements proposed in the RFC for clinical summaries and discharge summaries are on target. We believe the required elements for a care plan must include the following:

- List of active diagnoses
- Goals for treatment/care and timeline(s)
- Care team member names* and contact information
- Advance directive status and content*
- Need for and capabilities of caregivers at home
- Assessment of living situation and available resources, relative to need
- Patient preferences for language and communication*
- Necessary actions, responsible party, timeline, and status
- Anticipated transitions and approximate timeline
- Evidence of patient and family participation in developing the plan

Several of these critical elements (indicated by the *) are already included in other Meaningful Use criteria. Requiring collection of the additional elements in Stage 2 Meaningful Use would both advance the concept of a longitudinal, shared care plan in a very concrete way and create tremendous value for patients, their families, and their care teams.

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments on the Meaningful Use program. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Debra L. Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health.

Sincerely,

AFL-CIO
American Benefits Council
American Hospice Foundation
Business Healthcare Group of Southeast Wisconsin
Buyers Health Care Action Group
Childbirth Connection
Consumers' CHECKBOOK
Consumers Union

Employers' Coalition on Health
Employers Health Coalition of Ohio, Inc.
Florida Health Care Coalition
Health Action Council Ohio
Health Care Incentives Improvement Institute
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
HR Policy Association
Iowa Health Buyers Alliance
The Leapfrog Group
Mid-Atlantic Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Pacific Business Group on Health
Puget Sound Health Alliance
South Carolina Business Coalition on Health
St. Louis Area Business Health Coalition