February 17, 2010

David Blumenthal, MD, MPP
National Coordinator for Health Information Technology

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Blumenthal:

The HIT Policy Committee (HITPC) members have developed several recommendations to communicate to the Centers for Medicare & Medicaid Services (CMS) in response to its Notice of Proposed Rule Making (NPRM) regarding CMS's incentive program for the meaningful use (MU) of electronic health records (EHRs). In the discussion below, we outline these recommendations and explain why we believe that these changes to the NPRM will result in more effective achievement of CMS's objectives with this incentive program for eligible professionals (EPs) and hospitals.

## HIT POLICY COMMITTEE RECOMMENDATIONS:

### RECOMMENDATION 1: REINSTATE HITPC RECOMMENDATION TO INCLUDE PROGRESS NOTE DOCUMENTATION FOR STAGE 1 MU DEFINITION FOR EPs.

The committee strongly believes that electronic progress notes are a core element of EHR functionality. The committee respectfully disagrees with the statements in the NPRM that electronic documentation of progress notes will naturally occur and is "not directly related to advanced processes of care or improvements in quality, safety, or efficiency." Electronic access to progress notes is key to delivering high quality care and for coordination of care for several reasons, including the following:

- Handwritten medical records not only take more time to decipher, their illegibility often obscures important information
- Information that is not entered electronically at the point of care is lost forever, thus rendering the record less complete.
- Hybrid systems (part electronic, part paper) cause fragmentation of the record and inefficient workflow
- Maintaining progress notes on paper impedes patients' access to this information because there is no structured way to provide patients with context to those data.
- Sharing electronic progress notes is fundamental to successful care coordination.
- Textual progress notes provide significant information about the patient that is not captured in the structured format elsewhere. Providers use these to know the patient as a human being, and patient focus groups suggest the best way to improve quality of care is for personal clinicians to "really know me."

Furthermore, the NPRM states that "documentation of progress notes is a medical-legal requirement and a component of basic EHR functionality," implying that eligible professionals are likely to enter electronic progress notes even without the objective and measure. Without an explicit requirement for including progress notes as part of the EHR, we are concerned that a significant portion of eligible professionals may choose to continue to document patient encounters on paper, which would significantly impede the goals of improving quality of care and care coordination. Furthermore, eliminating this requirement would obviate the need for vendor products to be certified to accommodate inclusion of progress notes.

***Recommendation 1.0: Include "Document a progress note for each encounter" for Stage 1 EP MU definition.***

***Recommendation 1.1: Signal clinical documentation as a required MU criterion in Stage 2 for hospitals.***
Although the committee believes that progress notes are equally valuable for inpatient care, it recognizes that the state of inpatient systems lags ambulatory systems in this regard.

**RECOMMENDATION 2: REMOVE CORE MEASURES FROM STAGE 1.**

***Recommendation 2.0: Remove core measures from Stage 1 criteria***

The concept of a set of core measures that should apply to all providers was originally proposed by the Policy committee, but they were different from the ones proposed in the NPRM. The workgroup used the following criteria to assess candidates for core measures:

- Based on the Institute of Medicine's Six Aims (safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness) and priorities identified by the National Priorities Partnership
- Have an evidence-based link to improvement in outcomes
- Can be measured using coded clinical data in an EHR (to minimize burden)
- Is captured as a byproduct of the care process (fits clinician workflow)
- Applies to virtually all eligible providers
- Measures outcome, to the extent possible

When reviewing the proposed core measures, the workgroup found that none of the proposed core measures adequately met the above criteria for inclusion. For example, NQF measures 0028 and 0013 are process measures, and the group felt that the outcomes-improvement goal of the overall HIT incentive program should be reflected in any measure to the greatest extent possible. Measure 0022 suffers from a lack of consensus on definitions of "drugs to be avoided in the elderly" at this time, so the group felt it would be challenging to define this measure with enough precision that it could serve as a core measure. Consequently, the work group recommends removing the three proposed measures (NQF 0013, 0022, 0028) as "core measures" per se. The health

priorities motivating the proposed core measures could be incorporated in relevant specialty measures in stage I, preferably using outcome-oriented measures.

The workgroup recognizes and supports the concept of having key national health priorities motivate selection of quality measures for the HIT incentive program. We will work with ONC to recommend strategies to identify key health priorities for which effective use of HIT has special applicability, and will re-explore the concept of "core measures" or "shared health priorities" for later stages.

**RECOMMENDATION 3: REINSTATE HITPC RECOMMENDATION TO STRATIFY QUALITY REPORTS BY DISPARITY VARIABLES.**

> ***Recommendation 3.0**: **Providers should produce quality reports stratified by race, ethnicity, gender, primary language, and insurance type.***
>
> CMS has stated that an explicit health outcome policy priority is to "reduce health disparities." No assessment of disparity reduction can be made without stratifying data reports by these variables. The EPs and hospitals should attest that they make use of these stratified reports to assess the effectiveness of their efforts to reduce healthcare disparities.

**RECOMMENDATION 4: PROVIDERS SHOULD MAINTAIN UP-TO-DATE LISTS OF PROBLEMS, MEDICATIONS, AND ALLERGIES**

> ***Recommendation 4.0**: **EPs and hospitals should report the percentage of patients with up-to-date problem lists, medication lists, and medication allergy lists***
>
> In order to support quality of care and care coordination, key patient summary information (e.g., active problem lists, active medication lists, medication allergy lists) must be maintained in the electronic health record. The work group believes that one-time reporting on non-blank lists is a process measure that does not demonstrate meaningful use of EHRs. The work group proposes that the measure be an attestation that the problem lists, medication lists, and medication allergy lists are up-to-date. There are several approaches to assist providers in maintaining accurate lists, including comparative reports of encounter diagnoses, prescribed medications, and test results with diagnoses on the problem lists. The specific approach used by a provider organization would be left to the discretion of the provider. CMS audit could be conducted by chart review of a set of randomly selected charts.

**RECOMMENDATION 5: REINSTATE HITPC RECOMMENDATION TO INCLUDE RECORDING OF ADVANCE DIRECTIVES FOR STAGE 1 MU DEFINITION FOR EPs AND HOSPITALS.**

***Recommendation 5.0: EPs and hospitals should record whether the patient has an advance directive as part of the Stage 1 MU criteria.***

The committee believes that, particularly for Medicare providers, recording of advance directives should apply to virtually all patients. In order to limit the application of the measure to an appropriate population, the measure could specify the percentage of all patients 65 and older who have an advance directive recorded

**RECOMMENDATION 6: REINSTATE BUT AMEND HITPC RECOMMENDATION TO INCLUDE PATIENT-SPECIFIC EDUCATION RESOURCES FOR STAGE 1 MU DEFINITION FOR EPs AND HOSPITALS.**

***Recommendation 6.1: EPs and hospitals should report on the percentage of patients for whom they use the EHR to suggest patient-specific education resources.***

Making available relevant educational resources is critical to the CMS stated health outcome priority to "engage patients and families" so that they can better understand their health condition and the meaning and importance of newly accessible data. In addition, providing patients and families with electronic access to their health information without guiding them to educational content to place that data into some context could overwhelm providers with questions about the meaning of that personal health information. The committee members with experience of providing educational resources indicate that provider vetting of consumer educational content represents a substantial improvement in the content consumed by patients and families compared to unguided searching of the Internet. Several EHR vendors and health education content providers (including the National Library of Medicine's MedlinePlus) have developed partnerships that facilitate EHR-enabled connections to patient-specific content.

**RECOMMENDATION 7: REINSTATE HITPC RECOMMENDATION TO INCLUDE MEASURES OF EFFICIENCY FOR STAGE 1 MU DEFINITION FOR EPs AND HOSPITALS.**

The committee had recommended two high impact efficiency measures dealing with use of generic medications and coding of indications for high-cost imaging services. We note that neither of these measures was included, but no explanation was given. We note that the CBO discussion of benefits of using EHRs includes use of cost-effective generic medications. We recommend inclusion of measures that assess the meaningful use of EHRs to make cost-effective clinical decisions.

***Recommendation 7.0: All EPs should report to CMS the percentage of all medication, entered into the EHR as a generic formulation, when generic options exist in the relevant drug class.***

On page 1987 of the NPRM, CMS cites "prompt providers to prescribe cost-effective generic medications" as one of the key "Benefits to Society" in its impact analysis. In order for CMS to promote this benefit to society, the work group recommends reporting on this performance measure. We do not recommend setting a threshold in Stage 1.

***Recommendation 7.1: CMS should explicitly require that at least one of the five clinical decision support rules address efficient diagnostic test ordering.***

The NPRM states that EPs and hospitals need to: "implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering." In order to highlight an important area of health care system efficiency, the committee recommends that the wording should be amended to: "implement five clinical decision support rules relevant to specialty or high clinical priority, at least one of which should be aimed at improving the efficiency of diagnostic testing or the ordering of appropriate treatment."

## RECOMMENDATION 8: CMS SHOULD CREATE A GLIDEPATH FOR STAGE 2 AND STAGE 3 MU EXPECTATIONS

***Recommendation 8.0: CMS should advance its timetable for the release of future MU NPRMs in order to allow adequate ramp-up time for vendors and providers.***

To the extent possible, CMS should consider publishing the Stage 2 MU NPRM well before its anticipated December 2011 timeframe because vendors need more time to develop the appropriate functionality and providers need more time to integrate it into the clinical workflow. To the extent that such a timetable switch is infeasible, the committee urges CMS to send strong directional signals through the Stage 1 MU final rule it issues this spring. Although the committee recognizes that CMS cannot make Stage 2 and Stage 3 final recommendations without experience from the field on implementation of Stage 1 criteria, a strong signal of intentions would be very helpful to make the realization of future expectations more feasible.

## RECOMMENDATION 9: CPOE SHOULD BE DONE BY THE AUTHORIZING PROVIDER.

In the description for calculating the numerator for the CPOE measure (p 1859 in NPRM), it states that the numerator is "orders issued by the EP entered using the CPOE functionality of certified EHR technology…" The committee wishes to clarify the definition of the numerator to ensure that CPOE requires that the authorizing provider for an order directly enters the order into the EHR. The reason for the direct-entry requirement is because it is through this interaction with the EHR that the authorizing provider may get important feedback related to the patient or that order.

***Recommendation 9.0: The numerator for the CPOE measure should define a qualifying CPOE order as one that is directly entered by the authorizing provider for the order***

**RECOMMENDATION 10: AMEND PREVENTIVE/FOLLOW-UP REMINDERS CRITERION TO APPLY TO A BROADER POPULATION AND ALLOW FOR PROVIDER DISCRETION FOR WHERE TO FOCUS REMINDER EFFORT.**

The intent of the original HITPC recommendation to provide reminders to patients was for the reminders to be patient-specific and to apply to all patients. The NPRM measure restricts the patient population to those over the age of 50 and does not look for patient specific reminders. The committee recommends reinstating the patient specific reminders, and offers the following measure.

> ***Recommendation 10.0: Change the measure to read, "For a chosen preventive health service or follow up (the EP chooses a relevant preventive or follow up service for their specialty), report on the percent of patients who were eligible for that service who were reminded."***
>
> The denominator would be: All patients who were potentially eligible (e.g., meet demographic criteria) and who had not already received the service. The numerator would be: All eligible patients who were reminded according to their preference (e.g., paper or electronic).

**RECOMMENDATION 11: CLARIFY "TRANSITIONS OF CARE" and "RELEVANT ENCOUNTER"**

Under the "Improve Care Coordination" category, the phrases "transition of care" and "relevant encounter" are not precisely defined. The committee recommends deleting "relevant encounter" and using the following definitional approach to "transition of care" for the purpose of the meaningful use criteria: a "transition of care" occurs when a patient moves from one setting of care to another. For the purpose of the meaningful use criteria, a setting of care includes the following: hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility.

***Recommendation 11.0: Delete "relevant encounter" from the medication reconciliation measure***

***Recommendation 11.1: Define "transition of care" to be the movement of a patient from one setting of care (*****hospital, ambulatory primary care practice, ambualtory specialty care practice, long-term care, home health, rehabilitation facility) to another.**

**RECOMMENDATION 12: ALLOW SOME FLEXIBILITY IN MEETING MEANINGFUL USE CRITERIA**

We believe it is important to exhibit some flexibility in the "all-or-nothing" approach to earning meaningful use incentives, while preserving a floor of important mandatory functional use requirements. We wish to move the nation forward quickly towards meaningful use by applying the front-loaded meaningful use incentives, yet we recognize that providers and vendors must have sufficient time to achieve an extensive array of objectives and measures. Unfortunately is it difficult to predict which objectives and measures will be most difficult to achieve for a given provider in the local environment. Therefore, we believe that the incentive program should contain some inherent flexibility, and that it should recognize providers who make good progress toward Stage 1 meaningful use.

We recommend consideration of the following approach that gives eligible professionals and hospitals some flexibility in achieving the meaningful use objectives and measures. We propose that a provider (EP or hospital) organization be permitted to defer fulfillment of a small number of meaningful use criteria and still qualify for incentive payment. The deferment would last until Stage 2 criteria apply. To avoid allowing providers to skip an entire priority area (e.g., skip all of patient engagement), however, we suggest the following "3-1-1-1-0" proposal, which allows EPs & hospitals to qualify for Stage 1 MU incentives if they defer no more than the specified ("3-1-1-1-0") number of objectives in each category, as indicated in the table:

***Recommendation 12.0: Eligible professionals and hospitals should be given the flexibility to defer up to 6 meaningful-use criteria as described in the table below, but must meet all mandatory objectives.***

| **Priority area** | **# objectives that may be deferred by EP or hospital (all EPs and hospitals must fulfill "mandatory" objectives)** | **Mandatory objectives (all EPs and hospitals must meet these)** |
|---|---|---|
| Improving quality, safety, efficiency, and reducing health disparities | 3 | • Have demographics recorded as structured data<br>• Report ambulatory/hospital quality measures to CMS or the States<br>• Use CPOE/Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)<br>• Generate and transmit permissible prescriptions electronically (eRx) |
| Engage patients and families in their health care | 1 | • Patients discharged are provided electronic copy of their instructions and procedures |

| Priority area | # objectives that may be deferred by EP or hospital (all EPs and hospitals must fulfill "mandatory" objectives) | Mandatory objectives (all EPs and hospitals must meet these) |
|---|---|---|
| Improve care coordination | 1 | • Test EHR capacity to electronically exchange key clinical information |
| Improve population and public health | 1 | |
| Ensure adequate privacy and security protections for personal health information | 0 | • Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities |

The HIT Policy committee sincerely appreciates the thoughtfulness that went into developing the NPRM on meaningful use. We find it generally consistent with the overall framework proposed by the Meaningful Use Work Group and approved by the HIT Policy committee in July, 2009. The committee respectfully submits the recommendations contained in this letter, which we believe would strengthen the criteria and respond to many of the issues and concerns which were made known to the committee.

We remain available and willing to assist the Office and the Department in any way we can.

Sincerely,

Paul Tang, Chair George Hripcsak, Co-Chair