American Hospital Association

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June 26, 2009

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Attention: HIT Policy Committee Meaningful Use Comments
Submitted via email to: MeaningfulUse@hhs.gov.

Dear Dr. Blumenthal:

On behalf of our 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to comment on the Health Information Technology (HIT) Policy Committee's first draft definition of "meaningful use" of certified electronic health record (EHR) technology. The AHA appreciates the work of the committee and the Office of the National Coordinator (ONC) for Health Information Technology and we recognize the challenging timeline that must be met to implement the HIT provisions of the American Recovery and Reinvestment Act (ARRA).

Hospitals want to adopt EHRs, but the cost of purchasing and maintaining clinical HIT systems is a significant impediment. The definition of "meaningful use" is critical because hospitals need financial assistance to expand HIT use, and want to avoid the Medicare payment penalties that begin in 2015 if they are not "meaningful users." The AHA strongly supports the use of HIT to improve the efficiency and quality of the health care system; however, we have serious concerns about this first draft definition.

FRAMEWORK FOR DEFINING "MEANINGFUL USE"

The ARRA identified three broad requirements for defining meaningful use:

1. Demonstrating to the Secretary of Health and Human Services (HHS) that certified technology is being used "in a meaningful manner;"

2. Demonstrating that the technology is connected in a manner that provides for the electronic exchange of health information; and
3. Using the EHR to submit clinical quality measures selected by the Secretary.

The draft definition uses the National Priorities Partners National Priorities and Goals as a framework. These goals focus national performance improvement efforts on areas with the highest potential for substantial improvements in care – and the AHA fully supports them for this purpose. However, they were not intended as, nor do they provide, an appropriate framework or design for the definition of "meaningful use." The committee creates a future "vision" of a standardized EHR that is laudable, but not achievable in the timeframes proposed.

The AHA recommends that the committee use a practical and operationally oriented approach for defining the major features of an HIT system that supports clinicians and hospitals in the delivery of safe, high quality care. The approach should articulate clear objectives and measures to assess whether these objectives have been met. The objectives should represent critical steps that support the decisions made by clinicians and patients as they seek the best, safest care possible. The approach should stage these objectives in an order that, experience has shown, leads to the effective implementation of EHRs. The staging of these objectives should begin at a level that is achievable for the majority of hospitals.

SETTING A STARTING POINT FOR THE DEFINITION OF "MEANINGFUL USE"

Our members believe that the functional abilities of the EHR that would result from implementation of the draft definition are correct, but that the proposed sequence for adoption is overly aggressive and unrealistic for most. Increasing the requirements for being considered a meaningful user every two years should provide enough time for adoption, but only if the initial requirements are set at an achievable level. The AHA encourages the committee, ONC and the Centers for Medicare & Medicaid Services (CMS) to develop a "meaningful use" adoption timeline that begins with fewer functional requirements and extends the transition to a fully functional EHR beyond 2015.

For 2011, the draft definition requires Computerized Provider Order Entry (CPOE) of all orders, clinical documentation of patient demographics, problem lists, and medication lists, and decision support tools to provide drug allergy and drug-to-drug alerts. CPOE adoption levels in hospitals are very low and CPOE relies on other EHR systems for successful implementation. A recent study published in the *New England Journal of Medicine* shows that just 1.5 percent of hospitals use a comprehensive EHR. Further, the study found that between 8 percent and 12 percent of hospitals, depending on the definition used, have a basic EHR. Even within this group, hospitals know that implementing CPOE and other EHR functions is no small task. Some have spent tens of

millions of dollars to achieve relatively advanced EHR systems, but have not yet implemented CPOE.

Because successful CPOE implementation depends on other EHR components, requires significant cultural changes, and entails significant costs, CPOE should not be required until 2015 or beyond. Most hospitals are not prepared to make such significant advancements under the proposed implementation timeline, so rushing to adopt could compromise patient safety and the success of this effort. Our members, including those with significant previous HIT investments and CPOE, consider a 2011 CPOE requirement to be unrealistic.

We suggest the definition of meaningful use in 2011 should first aim to get the majority of hospitals up and running with the basic components of an EHR system that can be built upon. We agree with the committee that clinical documentation of patient demographics, problem lists and medication lists are appropriate functions for 2011. To start, we propose the electronic functions for 2011 should include:

- Clinical documentation of patient demographics;
- Problem lists;
- Medication lists;
- Discharge summaries; and
- Results viewing for lab reports, radiology reports, and diagnostic tests.

We recommend that decision support tools to provide drug allergy and drug-to-drug alerts, as proposed by the committee for 2011, be functions added in 2013. We recommend adding the following functions for 2013:

- Nursing documentation and assessments;
- Electronic access by pharmacists to formularies;
- Medication bar coding;
- Implementing drug-drug, drug-allergy, and drug-formulary checks;
- Maintaining active medication lists; and
- Maintaining active medication allergy lists.

CPOE and high thresholds of EHR use in the hospital should be transitioned into the definition of meaningful use after these functions are well established, but no sooner than 2015.

Alternatively, the committee could consider a “building block” approach where a hospital could achieve meaningful use by having some overall goals and objectives in place by 2011, increasing the number required every two years, but not dictating the sequence of goals and objectives. With either approach, the keys to an achievable definition are setting an attainable starting point and providing appropriate timeframes.

The definition and any future staging of additional requirements for meaningful use should recognize that hospitals will be constrained by the number of new systems they

can bring online at the same time. Hospitals often roll out HIT systems by department and the staging process should ensure that hospitals are given adequate time to implement EHR functions across a hospital over multiple years. Additionally, most hospitals have voluntary medical staffs in which the majority of physicians practice independently. It is often difficult to get physicians to use hospital EHR systems, and rushing to implement new EHRs may make that even more challenging. Requirements regarding the level of clinician and physician EHR use should start at modest adoption levels (e.g. 20 percent of all notes entered electronically) and grow over time.

Staging the requirements and use levels in the definition also should recognize other HIT initiatives already underway and the likely vendor and workforce constraints hospitals may face. Hospitals are required to move to the new X12 Version of 5010 HIPAA standards in 2010 and ICD-10 in 2013. The AHA also is concerned that vendors will not be able to improve, test, implement and support HIT systems in hospitals nationwide due to the increased and simultaneous demand for HIT services and products. Vendor and hospital IT workforce capacity constraints should be considered as well.

DEMONSTRATING ELECTRONIC EXCHANGE OF HEALTH INFORMATION

The draft definition's 2011 requirement to "exchange key clinical information among providers" needs clarity. The AHA recommends that any data-sharing requirements start in 2011 with internal sharing between a hospital and its medical staff. Data exchange requirements should gradually increase to external sharing as interoperability standards are identified and implemented and as the infrastructure for health information exchange is developed. While the definition for meaningful use will be determined by the end of the year, the standards setting process likely will continue for many more. Connectivity in any form should not be required unless standards to support it are in place.

USING THE EHR TO SUBMIT CLINICAL QUALITY MEASURES

The ARRA requires that EHRs be able to submit clinical quality measures in order to meet the definition of meaningful use. The ARRA also stipulates that quality reporting through an EHR cannot be required unless CMS can receive the information; however, there are no standards or systems that allow CMS to do this. The AHA urges the committee to omit this requirement for 2011. It should be part of the definition of meaningful use, but, as with most major changes to federal policy, this requires a transition.

The AHA strongly believes that all quality measures must be endorsed by the National Quality Forum (NQF) and adopted by the Hospital Quality Alliance (HQA). These two organizations are the primary consensus groups for hospital quality reporting. Through the NQF, health care stakeholders agree to endorse measures that are useful for quality improvement and public reporting. Through the HQA, public and private partners come

together to identify, from among the NQF-endorsed measures, the most important for assessing and improving quality in hospital care.

The draft definition includes many measures that do not exist, and other measures that are not NQF-endorsed or HQA-adopted. It would be extremely challenging for these measures to be developed, specified, tested, and endorsed by the NQF and HQA in time for implementation beginning in 2011. The process of re-specifying existing measures so that they may be collected electronically is also likely to take longer than the timelines allow.

OTHER CONCERNS

The AHA also is concerned that the abbreviations for "inpatient" and "outpatient" as listed on the matrix do not clearly delineate requirements for hospitals versus physician offices. Many settings would qualify as outpatient settings, including hospital emergency departments, hospital outpatient surgery centers, and hospital outpatient clinics, in addition to physician offices. While hospitals provide outpatient services, many of the measures in the matrix are not appropriate for hospitals. We urge the committee to state explicitly which objectives and measures are required of hospitals and/or physicians.

On privacy and security, the 2011 objective refers to "fair data sharing practices" in the Nationwide Privacy and Security Framework. This is unclear, because that document does not use that terminology. The definition also calls for security risk assessments, which are already required under the HIPAA security rule; we urge you to avoid this redundancy. In the 2013 objectives and requirements, the phrase "summarized or de-identified data" is introduced. The definition must clarify whether this is a new term or if it refers to phrases already in common use such as the limited data set or "minimum necessary." Finally, the meaning of the phrase "utilize technology to segment sensitive data" is unclear.

AHA also has significant concerns about the privacy measure that would prevent a hospital from being considered a meaningful user if it is under investigation by the Office of Civil Rights (OCR) or CMS for a privacy or security violation. Hospitals can be under OCR privacy investigations on a regular basis, because many investigations take more than a year to close and often end with a finding of no violation.

CAPACITY AND RESOURCE CONSTRAINTS

The push to expand EHR use comes as hospitals are facing declining financial performance and an uncertain financial outlook. Many have limited access to capital to make the investment and fund the ongoing operational costs of adding new EHR systems. This is particularly true for Critical Access, other small and rural, and inner-city safety net hospitals.

Additionally, the expected release of a final definition will be past the 2010 budget cycle for most hospitals – making the definition proposed for 2011 unmanageable. A rush to implement the draft definition, combined with the lack of capital and personnel, could result in many hospitals choosing not to, or being unable to, participate in the incentive program. For those that do, this aggressive schedule could threaten patient safety and quality of care as hospitals are forced to shift to a mere technical implementation of technology rather than the more methodical process of implementing HIT system changes along with care process and cultural changes needed for a successful HIT adoption and use.

For more information or questions about this document, contact Rod Piechowski, Senior Associate Director, Policy at 202.626.2319 or rpiechowski@aha.org; or Beth Feldpush at 202.626.2963 or bfeldpush@aha.org.

Sincerely,
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Executive Vice President