



June 26, 2009

David Blumenthal, M.D., M.P.P.
National Coordinator
Office of the National Coordinator for Health Information Technology
200 Independence Ave, SW
Suite 729D
Washington, DC 20201
Attention: HIT Policy Committee Meaningful Use Comments

Submitted via email to: MeaningfulUse@hhs.gov

Dear Dr. Blumenthal:

On behalf of our 32 member hospitals, the New Hampshire Hospital Association (NHHA) 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. Our comments presented in this letter are similar to those presented by the American Hospital Association (AHA) along with a couple of additions listed under "Other Comments". The NHHA appreciates the work of the HIT Policy 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). We are committed to working with you as this process unfolds.

Hospitals want to adopt EHRs to improve patient care, quality, and efficiency, but the high costs of purchasing and maintaining clinical HIT systems is a significant impediment. The definition of "meaningful use" is critical because hospitals need the financial assistance to expand and want to avoid the Medicare payment penalties that will begin in 2015 if they are not "meaningful users" of certified technology. The NHHA strongly supports the use of HIT to improve the efficiency and quality of the health care system, and the spirit of the incentives provided through ARRA; 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 addresses these requirements using the National Priorities Partners National Priorities and Goals as a framework. These goals were designed to help focus national performance improvement efforts on high-leverage areas – those with the most potential to result in substantial improvements in health and health care – and the NHHA fully supports them for this purpose. However, they were not intended and we do not believe 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 that are proposed in the draft definition of meaningful use.

NHHA 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 on a day in and day out basis. The approach should articulate clear objectives that must be met and measures that assess whether these steps have been accomplished. The objectives selected should represent steps that are critical for supporting the decisions made by clinicians and patients to achieve the best care possible and prevent harm to the patients. The approach should stage these objectives in an order in which experience has shown effective EHRs can and should be implemented. 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 meaningful use definition are correct, but that the proposed sequence for adoption is overly aggressive and unrealistic for most hospitals. 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 NHHA 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, 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. For example, electronic nursing documentation, medication bar coding, and formulary availability in the pharmacy are considered building blocks of CPOE and must be in place prior to its implementation. Because successful CPOE implementation depends on other EHR components, enacts significant cultural changes, and entails significant costs, CPOE should be viewed as a long-term goal, and should not be required until 2015 or beyond. The majority of hospitals are not prepared to make such significant advancements under the proposed implementation timeline. Rushing to adopt will have a serious negative impact on 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 which, once in place and operating, can be built upon in a deliberate and achievable manner. 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.

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. The HIT Policy Committee should consider the way many hospitals roll-out HIT systems by department and ensure that hospitals are given adequate time in the meaningful use definition to implement EHR functions across a hospital over multiple years. 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 of meaningful user should also recognize the likely vendor and workforce constraints. NHHA is concerned that vendors will not be able to improve, test, implement and support HIT systems in hospitals across the country due to the increased and simultaneous demand for HIT services and products. Vendor capacity constraints should be considered as the Committee determines an appropriate meaningful use definition and staging timeline.

Electronic Exchange of Health Information

The draft definition's 2011 requirement to "Exchange key clinical information among providers" needs clarity. NHHA recommends that any data sharing requirements start in 2011 with internal sharing between a hospital and the physicians of its medical staff. Data exchange requirements should gradually increase to external sharing as standards are identified and implemented. 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 has an ability to receive the information. To date there are no standards or systems that allow CMS to receive this information. NHHA urges the Committee not to include this requirement in 2011. It should be part of the definition of meaningful use, but as with most major changes to federal policy, this requires a transition and should be part of a later stage in the definition of meaningful use.

NHHA strongly believes that all quality measures must be endorsed by the National Quality Forum (NQF) and adopted by the Hospital Quality Alliance (HQA). Through the NQF, interested health care stakeholders come together to endorse measures that are useful for quality improvement and public reporting. Through the HQA, public and private partners have come together to identify from among the NQF endorsed measures, those that are most important for assessing and improving quality in hospital care. These two organizations are the primary consensus groups for hospital quality reporting.

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

NHHA also is concerned about the terminology for the measures, which implies that providers would be required to meet certain performance thresholds for each quality measure. For the purposes of the financial incentives for HIT implementation, providers should not be evaluated against any performance standards on these measures but should be counted for meeting the definition of meaningful use if certified HIT systems are used to report quality related data.

Other Concerns

NHHA also is concerned that the draft definition does not clearly delineate requirements for hospitals versus physician offices. The abbreviations for "inpatient" and "outpatient" as listed on the matrix do not provide that clarification. There are many different settings

that 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 listed with the outpatient objectives in the matrix are not appropriate for hospitals. For example, the measure assessing the percentage of patients over age 50 with an annual colorectal cancer screening is not relevant to hospitals. We urge the HIT Policy Committee to explicitly state which objectives and measures are required of hospitals and/or physicians.

Regarding the privacy and security elements of this proposed definition, the 2011 objective refers to “fair data sharing practices” in the Nationwide Privacy and Security Framework. It is unclear as to what this refers, as that document does not use that terminology. The definition also calls for security risk assessments, which are already required under the HIPAA security rule; clarity is required regarding this possibly redundant requirement. 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.

NHHA also has a concern regarding the “improve population and public health,” where the matrix implies hospitals must provide all kinds of public submissions for public health. In New Hampshire, many of the public health reporting systems do not exist, or if they do, do not accept electronic submissions. We would suggest that the individual measures would be waived if a state public health department does not have the capability to accept an electronic data submission.

We would also like to point out that under the proposed definition, funding will be withheld so long as an organization is under investigation for a HIPAA privacy or security violation. While we can view this as a laudable goal from a public policy perspective, it seems like an awful large penalty to impose for an investigation, not a finding, that could be triggered from as little as one individual not following policy. There are already penalties established under HIPAA, and this seems like a double hit (or greater).

Capacity and Resource Constraints

The negative impact of a rush to implement the draft definition of meaningful use, 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 the hospitals that attempt to meet this draft definition, 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.

A recent study published in the *New England Journal of Medicine* shows that just 1.5% of hospitals use what its authors call a comprehensive electronic health record (EHR). Further, the study found that between 8% and 12% of hospitals, depending on the

definition used, have a basic EHR. This level of adoption has taken many years to achieve and has come through significant financial investment by the few hospitals that have had the resources to pursue HIT. Even within this group, hospitals know through experience that implementing CPOE and other EHR functions is no small task. In fact, some member hospitals that have spent tens of millions of dollars to achieve relatively advanced EHR systems have not yet implemented CPOE.

Given the current economic situation, hospitals are facing increasing financial difficulties. Many hospitals have little financial capacity and 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 Hospitals, other small and rural, and inner-city safety net hospitals. A recent study showed that many hospitals in New Hampshire had to suspend or cancel planned HIT and HIE projects because of ongoing economic situation in our state and country.

For more information or questions about this document, contact Kathy A. Bizarro, Executive Vice President / Federal Relations at kbizarro@nhha.org or (603) 225-0900.

Sincerely,

A handwritten signature in cursive script that reads "Steve Ahnen".

Steve Ahnen
President