



June 26, 2009

David Blumenthal, M.D., M.P.P.
National Coordinator for Health Information Technology
Washington, D.C.
Attention: Policy Committee Meaningful Use Comments

Dear Dr. Blumenthal:

On behalf of the College of Healthcare Information Management Executives (CHIME), an organization of more than 1,350 healthcare chief information officers across the U.S, we appreciate this opportunity to comment on the HIT Policy Committee's initial draft definition of "Meaningful Use" of certified electronic health record technology. Please note that we endorse comments submitted by our collaborative partner, the American Hospital Association. In addition, we address other points with the intent of refining the definition of meaningful use and achieving the objective of more effective and efficient delivery of care.

Overview. A workgroup of CHIME, which has been engaged in active, moderated discussions since the Stimulus Package was proposed, reviewed the "Meaningful Use Matrix" and other related materials. Universally, members of the workgroup and the members they represent are seeking clarity on the goals. Understanding the intent of proposed incentives will help reviewers of subsequent documentation respond in a more meaningful manner. We would recommend adding rationale to future communications.

It is our understanding that the goal of incentives for meaningful use is to encourage more providers to "get in the game" rather than merely rewarding the early adopters. To this end, the bar should be set accordingly. Further, given the diversity of environments--community hospitals, large multi-hospital systems, teaching institutions, rural and urban facilities, and critical access and specialty hospitals, for example--flexibility in complying with meaningful use is essential to ensure that as many patients as possible reap the benefits of safer, more effective health IT-enabled care. Below, we highlight points needing clarity and factors affecting the implementation of meaningful use.

Sequencing. The Meaningful Use Matrix for 2011 requires "Use of CPOE for all order types including medications." For 2013 under "Improve quality...", the Matrix asks providers to "Record clinical documentation in EHR." Not all providers have followed or will follow this sequence. All participants in healthcare may have different reasons for their sequencing. The goal is to choose a sequence that will improve success for a specific organization, not a class of organizations. To accommodate that variability and yet encourage aggressive action, CHIME recommends identifying a total number of required functions as the final goal

Page 1 of 4

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and permitting flexibility in sequencing these functions for each milestone year. There are approximately 55 elements in the proposed Matrix. We would endorse an approach that enables each organization to pick a defined number of elements for each year where the elements represent any of the 55 total elements. For example,

<u>Year</u>	<u>Elements</u>
2011	20
2012	15 (cumulative 35)
2013	10 (cumulative 45)
2014	10 (cumulative 55)

This flexible sequencing and use of building blocks which are cumulative over the history of the program will reward hospitals for making progress toward the goals of quality/safety/efficiency; engaging patients; improving care coordination; improving population and public health; and ensuring privacy.

CPOE. The 2011 Objective under "Improve quality states, "Use CPOE for all order types including medications." Does this mean "all orders" or one of each "order type"? There is a significant difference in scale of effort to meet this requirement. Additionally, what percentage of orders needs to be entered by a physician or other provider for that matter? On that point, what of orders that are instead entered by nurses and other providers? Are they included? The Matrix does not address this.

CPOE implementation requires major cultural transformation and the resolution of many operational issues required in supporting dual processes. As part of this, sustaining changes in workflow processes over time is important to be sure these changes remain long after the incentive program ceases. "CPOE for all order types" implies an extremely high bar that only a few of the nation's hospitals may be in a position to meet. The technical readiness for CPOE is relatively easy compared to getting both affiliated and owned physicians fully engaged.

Exchange of Clinical Information. The 2011 measure for "exchange [of] key clinical information among providers of care (e.g., problems, medications, allergies, test results) focuses on the "implemented ability to exchange health information with external clinical entities (specifically labs, care summary and medication lists.)" How would this be measured? Does this imply that the actual interchange of data is not required in 2011, but simply the 'ability to exchange'? In the absence of an external HIE, there is concern regarding the ability of a hospital to interface with a potentially wide range of systems selected by independent physician practices. Rural hospitals may have a particularly difficult time because they may be the only "hub" in the community. A clear definition of what is meant by "...exchange health information..." is needed to understand this recommendation.

Under 2011 Care Coordination Objectives regarding "Exchange....of test results," further clarification is needed. For example, the criteria do not indicate a preference for standardized coded data or delivery of results through a messaging system.

Inpatient vs. Outpatient. The Matrix does not clearly distinguish between criteria for hospitals and physician offices. "OP" and "IP" abbreviations do not effectively address our concerns. Many hospital departments are clearly accessed on an outpatient basis such as the emergency department, day-surgery or medication clinics such as that for Coumadin. Objectives and Measures required for each venue should be clarified.

Page 2 of 4

Privacy. As stated in the 2011 Measures, an entity under investigation for a HIPAA violation will be deemed as not achieving meaningful use until its record or case is cleared. We believe HIPAA regulations should not be part of the criteria. The current laws already require adherence to standards and have associated penalties for those parties who do not comply. Further punishment will not help promote the overall goals of HITECH. If it is not feasible to remove this requirement, some accommodation should be made as to the nature of complaints. The regulations should differentiate allegation from proven abuse. Complaints are easy to file and a well-meaning, but uninformed person who files a complaint could have a major impact on an organization.

PHRs. Currently, PHR development is a relatively easy technical challenge, but an especially difficult community problem. Mature use of the PHR requires that communities address a wide range of issues, particularly those associated with privacy, security, and confidentiality. Their use and acceptance varies considerably across the country. Moreover, hospitals are not in a position to mandate or force use of a PHR. For these reasons, we recommend that PHR Measures be deferred to a later time.

Vendors. Meaningful use depends on the ability of a vendor and often multiple vendors' ability to respond to their customers' needs. Some concerns include:

- Adequate staffing to implement and support a much higher customer demand;
- System design to meet reporting requirements without rework;
- Capability of products to exchange CCD; and
- Development workload essential to make products compatible with associated stimulus requirements and ICD-10 adoption.

Other Issues

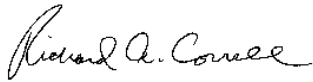
- New ICD-10 code sets to report health care diagnoses and procedures take effect on Oct. 1, 2013 and the updated X12 standard, Version 5010, for certain electronic health care transactions and an updated version of the National Council for Prescription Drug Programs (NCPDP) standard, Version D.0, for electronic pharmacy-related transactions are scheduled for 2012. These regulatory actions will have a major effect on the hospital environment.
- Sharing information between providers without a universal health ID number will be a challenge, particularly for purposes of a nationwide HIE at some future point.
- Capital is in short supply as the AHA comments stated, a point we wish to underscore. Many healthcare providers have experienced cutbacks in HIT staffing and projects this year. The same is true for building projects, clinical equipment and other clinical program investments. Addressing the expected meaningful use investment will mean additional staffing and new projects which will be very challenging for some, if not many.

Conclusion. The task of encouraging adoption of health IT in the hospital setting is a daunting one. According to the 2007 AHA Annual Survey on Information Technology, 1.5 percent of U.S. hospitals had a comprehensive electronic-records system implemented across all major clinical units and an additional 7.6 percent had a basic system that included functionalities for physicians' notes and nursing assessments in at least one clinical unit. In addition, the adoption of electronic medical records in the ambulatory care setting is very low with 4 percent of physicians having an extensive, fully functional EHR and another 13 percent reporting use of a basic EHR (*New England Journal of Medicine*, June 18, 2008).

Given this, we urge caution and attention to the concerns noted above. To address these issues, CHIME is committed to working with ONC, surveying our members regarding up-to-date progress in adoption and fostering a dialog on identified issues and problem-solving toward developing HITECH implementation solutions.

For more information or questions on this response, contact CHIME's Senior Director of Advocacy Sharon Canner, (703) 562-8834 (scanner@cio-chime.org).

Sincerely,



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