Collaborative Comments on Initial Meaningful Use Definition by HIT Policy Committee

June 16, 2009

Submitted Under Auspices of Markle Foundation, Center for American Progress, and the Engelberg Center for Health Care Reform at Brookings

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These comments are a response to the request for comment on the meaningful use definition released by the United States Department of Health and Human Services (HHS). They are the result of a joint effort by the Markle Foundation, the Center for American Progress, and the Engelberg Center for Health Care Reform at Brookings[1], and are supported to date by the undersigned representatives of a wide range of organizations.

Background

On April 30, 2009, the three organizations participated in a forum to issue a Markle Connecting for Health consensus paper[2] on 'meaningful use' and 'qualified or certified EHR' —pivotal concepts for determining how more than $30 billion in health information technology (IT) incentives should be paid out under the American Recovery and Reinvestment Act of 2009 (ARRA). Representatives from 70 organizations supported the consensus paper.

This collective response is organized according to the five key implications derived from the Markle consensus paper:

1. Set Clear and Achievable Health and Cost Goals
2. Tie Payment Tightly to Results
3. Engage Patients in Achieving Meaningful Use Goals
4. Focus on Information Use, Not Technology Functions or Features
5. Ensure that Standards and Certification Directly Support Meaningful Use and Foster Innovation

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[1] The Markle Foundation's Connecting for Health Initiative brings together leading government, industry, and health care experts to accelerate the development of a health information-sharing environment to improve the quality and cost-effectiveness of health care. The Center for American Progress is a think tank dedicated to improving the lives of Americans through ideas and action. The Engelberg Center's mission is to develop data-driven, practical policy solutions that promote broad access to high-quality, affordable, and innovative care in the United States.

[2] Available online at: http://www.markle.org/downloadable_assets/20090430_meaningful_use.pdf

1. Set Clear and Achievable Health and Cost Goals

The more than $30 billion in health IT investments under ARRA will be evaluated on whether they improve health care quality, reduce growth of costs, help engage patients, and protect privacy.[3] To achieve these goals, HHS must set specific targets, stimulate both technology and care delivery innovation, and foster public confidence through sound policies and steady progress. The targets for these investments must be both ambitious *and* possible through improved use of information and processes of care as well as patient engagement.

ONC's proposed Achievable Vision for 2015 sets the necessary type of clearly stated health and cost improvement aims:

- A million heart attacks and strokes prevented.
- Heart disease no longer the leading cause of death in the US.
- 50% fewer preventable medication errors.
- The racial/ethnic gap in diabetes control halved.
- Preventable hospitalizations and re-admissions cut by 50%.
- All patients have access to their own health information.
- Patient preferences for end of life care are followed more often.
- All health departments have real-time situational awareness of outbreaks.

Built on strong evidence, the Committee's proposed goals send a strong signal to clinicians, health care purchasers and industry, technology companies, and consumers about the purpose of the public investments, and will be most effective if consistently carried out across the Medicare and Medicaid programs. We have supported setting these types of goals because they provide a "north star" to inform use of health IT, technology innovation, and care redesign under ARRA. The draft definition focuses on care coordination, medication management, patient engagement, and privacy, all critical components of meaningful use.

Recommendations:

1. Given the imperative to reduce growth in health care costs, the Achievable Vision would be strengthened by adding a goal to reduce administrative inefficiencies that waste money and create unnecessary cost and human toil for clinicians and consumers alike (e.g., reducing use of paper forms, the need for telephone follow-up for prescriptions or labs, requirements for office-based care and duplicative tests or images). Addressing these day-to-day frustrations through use of health IT would garner support from medical professionals and the public.

2. There will be pressure to add other worthy aims related to myriad medical specialty areas and provider types. While HHS may want to refine the goals based on further input, it should avoid losing focus by adding many new and more specialized goals to address perceived "gaps." Rather, HHS has an opportunity to demonstrate how a diversity of health care actors—including specialists and different provider types—can contribute positively toward achieving the goals already drafted. Nearly all specialty areas can contribute to reducing medication errors and preventable re-admissions

[3] Regarding the privacy goal, we urge HHS to review the privacy section of the Markle meaningful use consensus paper.

through informed prescribing and improved care coordination, or provide patients with access to their own information.

2. Tie Payment Tightly to Results

We also agree with the idea of paying for results—improved health, patient engagement, better care processes—rather than simply paying for technology. This results orientation is reflected in the Committee's proposed definition and in the stipulation of "meaningful use" by Congress. Many of the key results-oriented measures are included in the draft definition, and they should be *emphasized*, such as: percentage of patients with controlled hypertension and lipids; percentage of diabetics with controlled HbA1c; reduced rates of medication errors (drug/drug and drug/allergy interactions); preventable hospitalizations and readmissions after hospital discharge; percentage of patients accessing information electronically; and the other underuse and overuse measures.

Recommendations:

1. The draft matrix has many measures. HHS should consider whether this risks dilution of purpose or creates unnecessary burdens on clinicians. To focus the nation on "measures that matter," HHS should prioritize those objectives and measures that have **high predictive value for improvements toward the big goals of the Achievable Vision**. Any objective or measure that would not meaningfully contribute to the Achievable Vision goals should not be included. The measures and goals do not need to capture every good outcome. Rather, the right set of measures will have high predictive value for impacting the health goals, and will inherently require meaningful use of health IT.

2. It is necessary to invest in rapidly developing valid measures to fill several gaps (e.g., medication errors, preventable hospitalization and readmission, duplicate testing, unnecessary imaging) and refine measures over time. The evolution of meaningful use measures should result from a built-in evaluative process in the early years of the ARRA incentives. An accountable federal agency with expertise in health improvement should be charged with enlisting the medical community in rapid learning efforts to study the effectiveness of the measures and refine them over time. This should include working with health systems and practices that have already invested in health IT to serve as test beds for rapid evaluation and experimentation to evolve the criteria over time.

3. The mere reporting of measures by clinicians is not enough. Clinical quality will improve when clinicians and patients are clear about the goals and have the systems—both IT and care delivery processes—to support improvement. The definition of "reporting" to support meaningful use should include reporting key quality and cost information *back to* clinicians as well as to consumers. Clinicians should be able to visualize the data they report and compare it with benchmarks. This information should be accessible at the point of care, so that the information can drive process improvements.

4. Validation of meaningful use should occur automatically as a byproduct of using qualified technology, embedding expectations of health IT use. For example, to

generate automated reports of rates of controlled HbA1c, clinicians need an automated list of patients with diabetes and connections to lab test results, and a system for physicians to monitor their patients.

5. It should also be possible for groups of clinicians to report measures and track meaningful use collectively (perhaps termed as “virtual networks” or “accountable care organizations”). This will permit more “systematic” use of resources, avoid duplication of effort, and support collaborative efforts to achieve health improvement.

6. Where possible, existing measurement and reporting efforts should be leveraged if they can be demonstrated to work in alignment towards meaningful use goals. It might be possible, for instance, to use the Centers for Medicare & Medicaid Services’ (CMS) Physician Quality Reporting Initiative (PQRI) or other broadly adopted quality reporting mechanisms to operationalize the validation of meaningful use. This could decrease the burden of reporting, especially for providers in small practices.

3. Engage Patients in Achieving Meaningful Use Goals

It is hard to imagine achieving the dramatic improvements of the Achievable Vision without the transformative participation of American consumers, patients, and their families. It is exciting and appropriate that the draft meaningful use requirements include the provision of electronic personal health information directly to patients (e.g., care summaries and plans, adherence reminders, population of PHRs with EHR data, etc.)

Recommendations:

1. Providing patients with information is only a first step. HHS should consider opportunities to tie patient engagement components of meaningful use directly to the goals of the Achievable Vision. Examples include tools for shared decision-making, and reminders to improve adherence to preventive services and chronic care plans. Specifically, medication management and chronic care are critical opportunities. Improvement requires two-way exchange between patients and providers.

2. HHS should include options for clinicians to use information supplied by patients (e.g., home-monitoring tools or PHRs) to achieve medication management and chronic disease meaningful use criteria. The thresholds for patient engagement should emphasize teamwork with patients for goals such as reducing adverse drug events. HHS should consider whether consumers, based on their information exchange with providers, can contribute data that validate their providers’ meaningful use of technology (e.g., whether provider is sending timely and complete information to consumers).

3. HHS should consider accelerating the expectations that consumers will have convenient access to electronic personal health information.

4. Focus on Information Use, Not Technology Functions or Features

There is substantial consensus that "the definition of 'meaningful use' should hinge on whether information is being used to deliver care and support processes that improve patient health status and outcomes," and that "the definition should focus on the needs of patients and consumers, not on the mere presence or functions of technology."[4] The Committee's draft definition largely avoids technology-specific or functional requirements. It instead appropriately focuses on information use, process improvements and outcomes. However, a few exceptions exist in the proposed grid.

Recommendations:

1. We urge close evaluation of the specific technology requirements (e.g., CPOE for all inpatient orders, or other "recording" functions), based on evidence for how they support and why they are necessary to help patients and clinicians achieve the broad aims of the vision (predictive value must exist). For instance, to reach several of the goals, it may be necessary to enter orders electronically. But that requirement need not be narrowed specifically to CPOE. In the absence of clear evidence, these kinds of requirements have little to offer and can have unintended consequences.

2. There should be a broadened emphasis on connections to information networks and use of available electronic information for better care (e.g., using recent medication history data from pharmacy networks or clearinghouses for drug-drug interactions checking, or retrieving recent laboratory results from local or national networks.) The right requirements and measures (improvements in medication safety, reductions in duplicate testing) will increase use and usefulness of these networks. The definition of "exchanging data with external clinical entities" should include use of these networks to access critical patient health information. Similarly, the use of networks to fulfill reporting requirements for groups of participating physicians should be allowed to demonstrate "sufficient statistics."

5. Ensure That Standards and Certification Directly Support Meaningful Use and Foster Innovation

While unaddressed in the initial draft definition, a factor that is critical to implementation success will be the eventual requirements for standards and certification. Even with all of the right goals and measures, the technology criteria for payment can make or break the success of the health IT investments. There is no way around it: We must innovate our way out of health care crisis. We must ensure that the standards and certification regimens encourage, not discourage, innovations in technology and care delivery.

[4] See Markle consensus paper: http://www.markle.org/downloadable_assets/20090430_meaningful_use.pdf

Recommendations:

1. Calibrating the technology requirements to remain in line with Congress' intentions will require close coordination by ONC and its HIT Policy and Standards Committees, and National Institute of Standards and Technology (NIST).

2. We urge a minimalist approach to data standards, focusing only on those needed to achieve meaningful use and (initially at least) those currently in use. Responsibility for identifying data standards under ARRA rests with the HHS Secretary. The Secretary will create "market certainty" by specifying sets of standards on a timeline that can be responsive to the implementation milestones. Standards will be necessary to support meaningful use, but should not become a singular focus of or barrier to its achievement. Clear and rapid adoption of a minimal set of workable and necessary standards by HHS is desirable.

3. Medical practices and hospitals ready to install, support, and manage more complex EHR systems should do so and receive ARRA incentives for it. However, ARRA must also be an opportunity for smaller practices—which still account for the bulk of outpatient doctor visits in the United States—to benefit from market innovation, Web-enabled tools, and lighter-weight approaches that can be demonstrated to improve health and health care outcomes. HHS must focus on information use to achieve goals rather than on specific technology requirements, which would risk "locking in" current tools. Rather than assuming that only a fully evolved EHR can achieve meaningful use, the technology requirements should not preclude internet-based services and modular applications that can work together to provide more functionality over time.

4. The measures for privacy in the draft grid do not yet fully account for the timing or the content of new privacy rules and guidance that HHS is charged with developing under ARRA. For instance, the accounting for disclosure requirements should be shown in 2011 to reflect regulatory requirements for new purchasers.

5. As these rules are promulgated, they must undergird the specifications for technical standards and the requirements for "qualified or certified" technology. As pointed out in the April 30 Markle consensus paper, however, certification cannot be the only means for enforcing the privacy provisions. In addition, the Nationwide Privacy and Security Framework should be further strengthened to outline a complete set of meaningful information sharing practices and policies consistent with the Markle Connecting for Health Common Framework.

6. In addition to a pluralistic approach to the types of applications that may be used to achieve meaningful use, HHS should leave the door open to a pluralistic approach to certification in order to meet the tight timelines. Certification against a commonly defined set of criteria must be market-ready, low-cost, and nimble so that certification itself does not become a vehicle, intentionally or unintentionally, for unduly slowing innovation. This is particularly important given the diversity of sizes, types and technology needs of medical practices. It's plausible that a plurality of certifiers can be more rapidly responsive to the needs of a diverse marketplace of

medical specialties, as long as they all certify against a core of basic requirements set by HHS.

Looking ahead

The draft definition of meaningful use is a very constructive start. For the vision to be achieved, at least two factors must converge:

1. Top public and private sector leadership must firmly and publicly embrace the goals and support them through communications to their own organizations and the American public. Ultimately, it is critical that the public has confidence in and sees value in the ARRA investments and use of health IT in terms of the quality of care they receive, interactions with the health care system, ability to support their own health improvement and trust that their information will be protected.

2. The specific objectives and measures incorporated into the definition for meaningful use of health IT must be disciplined (i.e., focused tightly on the vision) and appropriately sequenced (i.e., they must optimize the timelines for financial incentives with timelines for adoption of necessary technology and process improvements). This will necessitate some requirements to be accelerated to coincide with the front-loading of the financial incentives under the Recovery Act.

It is concerning that the timeline for the Achievable Vision goals culminate as ARRA's health IT incentives will be phasing out. Even if ARRA is dramatically successful, it calls into question the sustainability of the desired improvements. For this reason, broader health care reforms must pick up where ARRA leaves off, by rewarding better outcomes, slowing growth of health care costs, and protecting privacy. It will be important for policy makers to bear in mind the challenge recognized in the final bullet of the slide presentation on June 16th, 2009 by Glaser, Mostashari and Tang: *"Meaningful use of HIT is a precursor to effective health reform, and contingent upon health care financing reform."*

These comments are jointly submitted by the Markle Foundation, Center for American Progress, the Engelberg Center for Health Care Reform at Brookings, and the following additional supporters:

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