

April 20, 2010

OPEN LETTER

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human  
Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

David Blumenthal, MD, MPH  
National Coordinator for Health  
Information Technology  
U.S. Department of Health and Human  
Services  
200 Independence Avenue, SW  
Washington, DC 20201

Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid  
Services  
U.S. Department of Health and Human  
Services  
200 Independence Avenue, SW  
Washington, DC 20201

Tony Trenkle  
Director of the Office of E-Health  
Standards and Services  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human  
Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Secretary Sebelius, Dr. Blumenthal, Ms. Frizzera and Mr. Trenkle:

As you craft the final criteria for meaningful use incentives, the consumer and employer communities wish to convey our strong belief that public funding used to incentivize provider adoption of HIT must result in improvements in the quality and affordability of care, not just the presence of technology in provider settings. The incentive program created by HITECH is a major investment that can help in place the infrastructure necessary not just for better individual health care, but also for system-wide reform.

The undersigned groups strongly support the robust proposed definition of meaningful use, and reiterate the critical importance of maintaining elements of the proposed rule that are most likely to improve health outcomes and reduce costs. A final rule that does not lay a clear path in the first year toward tangible improvements in quality and lay the foundation for the systemic changes necessary for reform could waste taxpayer dollars and not launch us on the needed course for the future.

Other industries have long viewed IT investments simply as a cost of doing business. The health care sector has lagged behind in this evolution, but now has a significant opportunity for unprecedented federal help. As consumers and employers who pay for health care every day, we must see a return on this historic investment.

The meaningful use incentive program is just that – an incentive program. It is not a mandate, and it does not constitute regulation of the health care industry. Providers who want to implement HIT on a different timeline and with their own resources can do so.

While Congress did establish eventual payment penalties, these too represent financial incentives on behalf of taxpayers and patients to assure value in what we pay for. Those who seek and accept taxpayer dollars to more rapidly build-out their capacity must demonstrate that the resources are used wisely to improve health outcomes, better engage patients and families in their care, and reduce health care costs.

We understand that some stakeholders are advocating that CMS slow down the implementation of the first year's requirements. However, we strongly believe that assertions that the criteria are a "one-size-fits-all" policy that ignores upfront cost, time and logistical challenges do not reflect the reality of the thoughtfully balanced proposal. We note that the draft rule already provides flexibility in four key ways:

1. Providers can choose the payment year in which they start.
2. Providers choosing to start in later years will still receive significant payments.
3. In the first payment year, providers will be required to demonstrate meaningful use only for at most a 90 day period, creating extra time for implementation and effective use of HIT systems.
4. The thresholds vary across functional requirements, including lower thresholds for a number of requirements, which appropriately balances both the state of today's HIT product capabilities with the importance of creating a foundation for success in future years.

In addition, we support the HIT Policy Committee's recommendation to provide additional flexibility by allowing providers to defer approximately 20% of some of the functional criteria. We do not, however, believe that this flexibility should include the ability to defer quality measurement, patient and family engagement or privacy and security requirements. Furthermore, this proposal should not be construed as a way to simply ease requirements in future years – any criteria that are deferred must be added to – and not serve in place of – new requirements in the succeeding payment year.

Some of the elements of the proposed rule that we believe are most likely to improve health outcomes and reduce costs – and as such must be reflected in the final rule – include:

- 1) **Collecting, reporting, and improving on measures of health care quality, safety, efficiency and equity.** For consumers and employers, improving quality, safety, and efficiency and reducing disparities is the ultimate expression of the meaningful use of HIT. Beginning the transition to automated data collection and reporting of *clinical* quality measures is critical to improving patient outcomes and reducing costs. In addition, with the implementation of health reform law already beginning, and new payment strategies on the way, we must ensure providers receiving federal tax dollars for HIT are prepared for this new environment.
- 2) **Patient access to information.** New research shows that consumers who have access to their health information electronically know more about their health, ask more questions, and take better care of themselves than when their medical information

was less accessible to them in paper records (CHcF 2010). A number of meaningful use criteria will help us achieve this goal for all patients, including:

- Access to information within 96 hours;
- Summary care records;
- Electronic discharge instructions;
- Electronic copy of medical record within 48 hours;
- Patient education materials so patients can make sense of and use the information in their record to improve their own outcomes; and
- Reminders for patients to receive appropriate care.

- 3) **CPOE.** Computerized physician order entry is essential for knowing what is happening in the patient's care. It is also a function upon which other capabilities will build – including clinical decision support and collecting measures of quality and efficiency. Implementing five decision support rules is a reasonable first step.
- 4) **Progress Notes.** Electronic progress notes are key to patient-safety. They help eliminate errors due to illegible handwriting. Illegible notes, both in outpatient and inpatient settings, also impede appropriate communication between providers as notes are often illegible in whole or in part. In addition, progress notes are part of the medical record and as such, they must be captured electronically to be made available electronically to patients.
- 5) **Privacy and Security.** Patient trust in HIT is essential if it is to deliver on the promise of better health outcomes and better patient engagement, at a lower cost. We support the recommendations of the HIT Policy Committee that would add requirements in the area of privacy and security. These elements should be requirements of all providers, and they should not be able to be deferred.

We are aware that some have raised concerns about safety issues related to the technical functioning of electronic products on the market. We certainly believe that any problems in the functioning of electronic systems should be reported so they can be addressed. We also believe that this issue is most effectively viewed in the broader context of patient safety. As you know, conservative estimates rank medical errors, many of which occur due to lack of information when and where providers need it, as the eighth leading cause of death in the US, higher than motor vehicle accidents, breast cancer, and AIDS. We absolutely should investigate problems with these systems and ensure that they perform properly, but the harm we are avoiding by implementing these systems must also be taken into account. These potential technical issues are not a reason to slow progress toward adoption, implementation, and meaningful use of HIT to improve the care and safety of all patients. Rather, we must concurrently ensure that methods are in place to rapidly report and address any technical issues.

As you know, many of the requirements of the recently passed health reform act depend on the meaningful use of electronic medical records and other forms of health IT. Delaying the foundational elements included in the robust proposed definition of meaningful use for 2011 will not only squander the golden opportunity provided by

HITECH, but will also jeopardize the success of this Administration's bold work to reform our health care system. We urge you to maintain the clear path toward using HIT to improve outcomes that is reflected in the proposed rule.

Sincerely,

AARP

Alzheimer's Association

American Benefits Council

American Federation of State, County & Municipal Employees (AFSCME)

American Hospice Foundation

Bridges to Excellence

Business Health Care Group

CalPERS

Center for Advancing Health

Center for Democracy and Technology

Center for Medical Consumers

Center for Medicare Advocacy

CHADD – Children and Adults with Attention-Deficit/Hyperactivity Disorder

Childbirth Connection

Community Catalyst

Consumers Advancing Patient Safety (CAPS)

Consumers Union

Employers' Health Coalition

Fairhill Partners

Families USA

HealthCare 21 Business Coalition

Healthwise

Health Policy Corporation of Iowa

HEREIU (Hotel Employees and Restaurant Employees International Union) Welfare Fund

Iowa Health Buyers Alliance

Medical Advocacy Mural Project

Medicare Rights Center

Mental Health America

National Association of County Behavioral Health and Developmental Disability Directors

National Business Coalition on Health

National Center on Caregiving, Family Caregiver Alliance

National Coalition for Cancer Survivorship

National Consumers League

National Council of Jewish Women

National Family Caregivers Association

National Health Law Program

National Indian Council on Aging, Inc.

National Partnership for Women & Families

National Retail Federation  
NCCNHR: The National Consumer Voice for Quality Long-Term Care  
New York Business Group on Health  
OWL - The Voice of Midlife and Older Women  
Pacific Business Group on Health  
Prometheus Payment  
Puget Sound Health Alliance  
PULSE of America  
SEIU  
Society for Participatory Medicine  
The Alliance  
The Arc of the United States  
The Children's Partnership  
The Leadership Conference on Civil and Human Rights  
The Leapfrog Group  
UHCAN Ohio  
United Cerebral Palsy  
Walmart  
Well Spouse™ Association

Signatory Logos:





CENTER FOR MEDICAL CONSUMERS



Medical Advocacy Mural Project



Let's change the "face" of healthcare.

**MEDICARE RIGHTS CENTER**

Getting Medicare right

**MIIA**  
Mental Health America

**NBCH**  
National Business Coalition on Health

**FOA**  
FAMILY CAREGIVER ALLIANCE®  
National Center on Caregiving

**NCCS**  
NATIONAL COALITION FOR CANCER SURVIVORSHIP

**NCL**  
NATIONAL CONSUMERS LEAGUE

**NCJW**®

National Council of Jewish Women

**NFCA**  
National Family Caregivers Association

**NHeLP**  
NATIONAL HEALTH LAW PROGRAM



national partnership  
for women & families

**National Retail Federation**®  
*The Voice of Retail Worldwide*

**NCCNHR**  
The National Consumer Voice For Quality Long-Term Care



**PBGH**  
Pacific Business  
Group on Health



