



Response to the HIT Policy Committee's Recommendations for Meaningful Use
Approved by the HIMSS Board of Directors
Friday, June 26, 2009

HIMSS appreciates the opportunity to review the HIT Policy Committee's draft recommendations on Objectives and Measures for Meaningful Use of EHR and HIT solutions. Across our more than 23,000 members (73% of which work in the end-user setting), HIMSS covers the spectrum of healthcare IT and management systems. Many of our communities and committees, listed as follows, undertook a systematic, comprehensive, and careful look at the Committee's recommendations.

Ambulatory Information Systems
Clinical Engineering
Financial Information Systems
Management Engineering &
Process Improvement
Personal Health Record
Physicians
Senior IT Executive

Advocacy & Public Policy
Enterprise Information Systems
Health Information Exchange
Nursing Informatics
Patient Safety & Quality Outcomes
Pharmacy Informatics
Privacy & Security

Summary Comments

Overarching all of HIMSS's comments, we express our strong concern that the Committee does not distinguish clearly enough between hospitals and physician practices. We urge separate objectives & measures for each setting. Our Board of Directors approved a [member-created definition of meaningful use](#) which includes a progression of measures for each setting – hospitals and physician practices. We urge the Committee to refer to our definitions for specific information.

In responding to the proposed recommendations posted by the HIT Policy Committee, HIMSS members' comments coalesced around three categories: Implementation Timeline & Structure, Adoption Sequence, and Workforce.

1. Implementation Timeline & Structure

HIMSS recommends a clear progression for all stakeholders be identified; a "ramp-up" approach – rather than "big-bang" implementation – is preferable. Provider members consistently indicated deep concern regarding the healthcare community's ability to meet the meaningful use timeline; including requesting a strategy for those who begin implementation later in the incentive period. If a provider or community hospital has not yet chosen a health IT solution, they will find it almost impossible to meet 2011 criteria. For example, based upon the more than 12 years of experience in recognizing excellence in the meaningful use of EHRs, the Nicholas E. Davies Organizational Award recipients cite 12-18 months as being the necessary window of time for appropriate planning, preparation, and infrastructure development prior to implementation, while Ambulatory Award recipients indicate a 6-12 month window.

In addition, considering the amount of diversity within the defined quality metrics, HIMSS members are concerned that the implementation timeline will be difficult to achieve. Many of the stated metrics

are not currently installed, and stakeholders will not be able to incorporate them within stated timelines. Further, smaller/outpatient/ambulatory facilities will not be financially able to comply with the Committee's recommended quality reporting metrics. HIMSS recommends that qualification for incentive payment be dependent on meeting the measures, not attestations to meeting the specific objectives.

Finally, HIMSS urges the Committee to reconcile its objectives with existing health IT goals and initiatives, including Joint Commission Patient Safety Goals, CMS requirements, and conversion to ICD-10. If these initiatives continue asynchronously, metrics/initiatives can become barriers. In general, HIMSS notes that quality reporting objectives can be enhanced by a focus on the use of quality metrics for patient management, as well as strict adherence to HITSP harmonized standards-based exchange.

2. Adoption Sequence

HIMSS urges the Committee to be mindful of the cultural and political differences between how practices and hospitals determine best implementation approaches. In practical terms, providers can currently choose one of several implementation sequences. Health IT is a series of important components (i.e PACS, imaging etc.). Providers can employ implementation timelines resulting in a prioritization of "core" components. As a general measure, we recommend the Committee consider revising the items – once setting-specific measures have been established – so that they can be achieved over a series of years. We urge the Committee to recognize that demographic information should be patient-reported and voluntary; capturing such data ought not be a required responsibility of the provider.

Overwhelmingly, HIMSS' provider-centric groups recommend that the Committee shift CPOE use to 2013. Providers resoundingly support patient safety initiatives and suggest starting in 2011 with ensuring discrete clinical observations are electronically entered and available to clinicians throughout the organization, and consistent across systems. And, we urge the Committee to carefully distinguish between goals, objectives, and measures. We presume the Goals and Objectives are designed to set context, while the Measures will form the basis for establishing specific criteria which will measure attainment of meaningful use.

HIMSS members are concerned about potential debates over 2013 & 2015 timelines for objectives and measures in such areas as medication reconciliation, pay for value, quality reporting, and inclusion of personal health records. Finally, HIMSS members are deeply concerned about the lack of definition for the 2015 metrics. Physicians and hospitals need the metrics now so that they can get started on the long process of implementation with its significant out-of-pocket costs and inefficiencies that result in the early stages of adoption.

3. Workforce

HIMSS members are also very concerned about the timeline's impact on our nation's ability to educate healthcare professionals and clinicians about IT planning, implementation, and utilization. Currently, there are not enough qualified professionals to do the "heavy lifting" necessary to meet the Committee's recommendations. We look forward to public & private collaborations to address the projected shortfalls in identifying and training these future-qualified professionals.

Comments regarding 2011 Recommendations:

Health Outcomes Policy Priority I: Improve quality, safety, efficiency, and reduce health disparities

HIMSS recommends that “Use CPOE for all order types. . .” be moved to 2013. Regarding “Send reminders to patients...” and “Generate lists of patients who need care and reach out to patients”, HIMSS urges the Committee to differentiate these items so they are setting-appropriate. With regard to “Reporting of quality measures”, scale the measures between 2011 and 2013.

Health Outcomes Policy Priority II: Engaging patients and families

HIMSS calls upon the Committee to recognize the wide disparity in computer access, literacy and ability across various populations. In addition, we recommend the Committee move “Provide patients with electronic copy...” to Year 2013, as there should be a standard methodology defined, rather than specifying “per patient preference.”

Health Outcomes Policy Priority III: Improve care coordination

HIMSS seeks clarification on the care goal for “Exchanging meaningful clinical information among professional healthcare team”. And, we believe providers should be affiliated with different entities (not within same Covered Entity).

Health Outcomes Policy Priority IV: Improve Population and Public Health

HIMSS recommends the creation of separate objectives for public health, quality reporting, and research. For example, public health and real-time quality monitoring have a timeliness aspect, whereas research and quality reporting do not. HIMSS suggests the Committee engage with the HIT Collaborative for the Underserved. This initiative, which has been funded by the HHS Office of Minority Health, is in its second year of addressing population health and health disparities issues.

Health Outcomes Policy Priority V: Ensure Adequate Privacy and Security Protections

HIMSS believes that Care Goals should not be limited to “confidential” information or the notion of confidentiality. The Committee should consider including security goals, as well as data integrity and availability objectives and measures. We urge the Committee to recognize that security is not just a privacy protection – it is also a quality and safety protection.

HIMSS notes that HIPAA requirements, penalties and enforcement were strengthened by separate ARRA provisions. Adding them to the “meaningful use” definition presents the risk of conflicting interpretation and enforcement and is, therefore, unnecessary. And, we question the objectives that calls for “Compliance with. . .the Nationwide P&S Framework”. As this document has yet to be updated, compliance by 2011 seems improbable.

If HIPAA is ultimately included as a meaningful use requirement, it should be phrased as requiring “substantial compliance” with federal and state privacy and security requirements so that a slight deviation from “full compliance” does not disqualify a provider or cause a forfeiture of incentives. This is important given the rapidly evolving and escalating obligations under HIPAA and well-documented ambiguities in some state laws. We recommend the Committee delete the disqualification of an entity “under investigation” for a HIPAA violation until it is “cleared” as it is inconsistent with the presumption of innocence until guilt is proven. Rather, disqualify providers convicted of a HIPAA violation or who were subject to an enforcement action (after appeal periods had expired).

Comments regarding 2013 Recommendations:

Health Outcomes Policy Priority I: Improve quality, safety, efficiency, and reduce health disparities

Assuming the Committee meant “non-physician” when it uses the word “clinical” in the following phrase, HIMSS encourages the Committee to move its 2013 objective “Record clinical documentation in EHR” to 2011. Further, HIMSS recommends the Committee expand this item to include the electronic medication administration record.

Health Outcomes Policy Priority II: Engaging patients and families

HIMSS notes that electronic access requirements should not expand requirements of current law regarding information availability in different languages. Translation services are effectively used for detailed information on an as needed basis because making all clinical information available in all languages would be very expensive. (Some urban hospitals currently serve populations that speak 40 different languages.)

Health Outcomes Policy Priority V: Ensure Adequate Privacy and Security Protections

HIPAA requirements are different; public health information need not be de-identified – rather “anonymized”. As HIPAA already requires minimum necessary, we do not understand the value-add in this circumstance. In general, we note the lack of a clear progression/implementation path of privacy and security objectives/measures from year-to-year. Thus, their value as a whole to either the organization itself and/or its efforts to demonstrate meaningful use is unclear.

Comments regarding 2015 Recommendations:

Health Outcomes Policy Priorities II and IV: Engaging Patients & Improve Population and Public Health:

HIMSS urges the Committee to more clearly define “PHR”. In regards to the measure of “% of patients with full access to PHR populated in real time with EHR data” – and again for “automated real-time surveillance” under population & public health – HIMSS recommends eliminating references to “real time”, as it is difficult to achieve. We suggest replacing this phrase with either “near real-time” or “within x hours”.

Health Outcomes Policy Priority V: Ensure Adequate Privacy and Security Protections

In the phrase “Incorporate and utilize technology to segment sensitive data”, HIMSS urges the Committee to define the term “segment” and specify the technical requirements of “segmentation”. Is the Committee interested in implementing “multi-level security” or another form of security requirements? In general, we suggest adding progressive implementation objectives such as, “the electronic capture, enforcement, and exchange of individual privacy authorizations and informed consents (for research)” for 2015.

General Comments Not Tied to a Specific Year

HIMSS members urge the Committee to take into account specialty care and the associated variations in reporting. Many of the Committee’s objectives and measures seem to be associated with primary care without accounting for specialty care’s workload norms. In addition, we notice that medical imaging has been overlooked, and suggest that imaging should be on the same level as lab tests. Finally, our members believe that the timing of the proposed rules, combined with the limited capital available, will create an added obstacle for adoption by physicians and organizations that have not already started implementing health IT solutions.

HIMSS continues to see the value of patient identification management as a critical component toward developing an NHIN. Historically, Labor, HHS, and Education Appropriations has limited HHS’ ability to address patient identification management. We urge the government to find a way for HHS to engage in identifying a feasible solution.

Based on a June 16th Committee presentation, HIMSS notes that consolidation of HIE formats and standards will not be realized until late in 2009. We encourage the Committee to coordinate the HIE efforts with the meaningful use recommendations, so as to decrease the difficulty which the healthcare community will have consolidating and defining the metrics.

Finally, HIMSS anticipates the healthcare community will be interested in clarifying policy requirements and definitions for several items, and suggests the government consider a series of clarifications including “clarifying Medicaid populations”, as well as definitions for “discrete data exchange”; “electronic exchange”; and “encounter (as referenced in % encounters)”.

In summary, HIMSS thanks the HIT Policy Committee for its hard work and sincere efforts. Our members deeply value the opportunity to inform the development of the recommendations. We applaud the work accomplished to-date and look forward to ongoing constructive engagement to make healthcare better for all Americans through the best use of IT and management systems. If ONC or HIT Policy Committee have questions, please feel free to contact [Mr. Thomas M. Leary](#), HIMSS Sr. Director for Federal Affairs at 703.562.8814.