



230 E. Ohio Street, Suite 500
Chicago, IL 60611-3269
Tel 312 664 4467
Fax 312 664 6143

www.himss.org

October 15, 2010

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

Carolyn M. Clancy, MD
Director
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850

Dear Secretary Sebelius and Dr. Clancy:

HIMSS is pleased to submit our comments regarding the proposed National Health Care Quality Strategy and Plan, which was identified in an HHS Press Release requesting public comment on September 9, 2010. HIMSS has leveraged the expertise of our membership to craft answers to the 10 questions identified by the government.

As you know, HIMSS is a cause-based not-for-profit organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. Founded 50 years ago, HIMSS and its related organizations have offices in Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the United States. HIMSS represents more than 30,000 individual members, of which two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 470 corporate members and more than 85 not-for-profit organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through its content expertise, professional development, and research initiatives designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care.

As an organization, we are committed to supporting the best use of information and management systems, across the healthcare continuum, to achieve greater patient safety, improved office efficiency, better quality of care, and improved cost effectiveness of care delivery and access to care. We are pleased that the federal government has decided to move forward on developing a national strategy and plan for quality, and look forward to continuing to provide comments to the government as the National Health Care Quality Strategy and Plan are finalized.

The following comments represent our best understanding of the relevant connection between the National Quality Strategy and health IT.

Question 1: Are the proposed Principles for the National Quality Strategy appropriate? What is missing or how could the principles be better guides for the Framework, Priorities and Goals?

The proposed Principles for the National Quality Strategy are appropriate, however, HIMSS recommends expanding the discussion beyond affordable care to including specific guidance on the need to contain costs through an efficient healthcare system, as well as the specific need for the inclusion of additional care settings as a means to achieving the National Quality Strategy. These specific recommendations from HIMSS are addressed in detail in our answer to Question #4.

Question 2: Is the proposed Framework for the National Quality Strategy sound and easily understood? Does the Framework set the right initial direction for the National Health Care Quality Strategy and Plan? How can it be improved?

HIMSS appreciates the opportunity to comment on the question and would like to offer our observations. First, based on lessons learned from past national plans, HIMSS recommends the government work with constituency groups to develop a clear marketing and communications plan. For example, there is a strong feeling among our members that the anticipated changes following the release of the 1998 Institute of Medicine report, *To Err is Human: Building a Safer Health System* and their subsequent 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, have taken years to materialize because the messages and intended results did not capitalize on the information provided in the report. HIMSS urges the federal government to work with stakeholder groups to truly nationalize the plan to implement the National Health Care Quality Strategy and Plan by creating a structured, well-organized communication plan that takes into account all methods of media and social media to convey the urgency of the need for change.

Second, HIMSS applauds the idea that this is a national or nationwide plan, rather than just a federal plan. The challenge for all levels of government is identifying, tracking, gathering data, and submitting information that is consistent with other federal, state, and local priorities. For example, the number of requirements identified in the HITECH provisions of the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010, and other legislative priorities create an incredible challenge for the federal government. In addition, the ONC Strategic Plan, registry reporting, and state-level quality requirements all need to be taken into account. These varying requirements make metrics for quality measures extremely difficult for hospitals and eligible professionals to meet the quality measures criteria.

Today's healthcare systems and staffs are overtaxed with data management and process requirements for reporting. These requirements along with their corresponding technical formats can vary by state, county, city, as well as financial intermediaries. Efforts to prepare and program multiple report formats take significant time away from the more critical job of improving the actual care delivered to patients. Our members offer several examples of competing metric tracking that may have an impact on reporting for the National Quality Strategy.

- For integrated health systems that span more than one state, differences in reporting requirements unnecessarily complicate data collection, analysis and management. Even minor changes in definitions of terms or population inclusion or exclusion criteria threaten data validity and cause greatly increased manual efforts on the part of quality staffs. At a corporate level, roll up of multiple areas can become too onerous to achieve.
 - a. State Medicaid incentives are continuing to not only grow in the number of measures, but also differ distinctly from CMS requirements and from each other. For example, the Arkansas Medicaid Patient Quality Incentive Program was established in 2006 in collaboration with the state's hospital association and the state's quality improvement organization (QIO) for Medicare. Originally, Arkansas Medicaid offered bonuses for reaching target performance measures on CMS quality measures that hospitals were already reporting. Within the last two years, their incentive program shifted dramatically and now requires submission of measures that are similar, but not actually aligned with other payment programs. Of course, this also means that the Arkansas Medicaid program requirements are no longer aligned with the surrounding states as well.

- b. Note "[Profiles of Progress3](#)", a compendium of State Health IT initiatives provides insight into the multiple efforts, such as health information exchange, that are in progress as a result of ARRA funding. This snapshot in time of health IT initiatives led by State CIOs emphasizes the need for both coordination among States and between States and the Federal government to ensure a National Quality Strategy.

Question 3: Using the legislative criteria for establishing national priorities, what national priorities do you think should be addressed in the initial National Health Care Quality Strategy and Plan in each of the following areas? Better Care: Person-centered care that works for patients and providers. Better care should expressly address the quality, safety, access, and reliability of how care is delivered and how patients rate their experience in receiving such care; Affordable Care: Care that reins in unsustainable costs for families, government, and the private sector to make it more affordable; and Healthy People/Healthy Communities: The promotion of health and wellness at all levels.

As referenced in our response to HHS Question #1, expanding the discussion beyond affordable care to including specific guidance on the need to contain costs through an efficient healthcare system, and the specific need for the inclusion of additional care settings as a means to achieving the National Quality Strategy, is recommended by HIMSS.

According to the [National Health Expenditure Accounts](#) (NHEA), which captures the official estimates of total health care spending in the U.S., health care spending growth decelerated in 2008, increasing 4.4 percent compared to 6.0 percent in 2007. Total health expenditures reached \$2.3 trillion, which translates to \$7,681 per person or 16.2 percent of the nation's Gross Domestic Product. The health spending share of GDP reached 16.2 percent, up from 15.9 percent in 2007.

Achieving improvements in healthcare efficiencies must be accomplished. Value is often defined as quality divided by cost, with improved quality outcomes, leading to greater efficiencies and the decrease in overall costs to the system. Electronic data capture in concert with real-time decision support will facilitate this value equation. The industry does have substantial examples from HIMSS [Nicholas E. Davies Award winning organizations](#) of leveraging health IT to achieve efficiencies. A small sample of these award winning organizations include the following:

- Maimonides Medical Center: As a result of the alerts and reminders of its clinical decision support system, 164,250 alerts were identified resulting in 82,125 prescription changes. Its problem medication orders dropped 58% and medication discrepancies were reduced by 55%.
- NorthShore University HealthSystem: NorthShore has the ability to introduce new order sets in hours to meet the needs of new medication recommendations. As an example, in one instance, it changed 32 order sets and 22 preference lists in 3 hours. As another example, its omitted administration of medications decreased 22% from a total of 18 to 14 a month.
- Sentara Health System: Sentara has achieved a reduction in average length of stay for patients (reduced severity adjusted length of stay 16,000 patient days with \$6.9M savings; health plan realized \$2.8M due to reduction in severity-adjusted length of stay); a reduction in hospital readmission rates (readmission ratios reduced by 5% to 18%); shortened length of time from admission to bed assignments (the time from bed assignment to admit an ED patient has decreased 90 minutes); decreased times from medication orders to administration (reduced from approximately 90 minutes to 30 minutes or less); and prevented more than 100,000 potential medication errors due to bar-coding scanning alerts across its hospitals through its system-wide EHR.

The ability to abstract and report data directly from the EHR, eliminating the inefficiencies of manual paper abstraction as well as claims based data which is retrospective, is a key step towards increasing healthcare efficiencies. Electronic data abstraction will allow for improvements in continuity of care, decreases in duplicative testing, and increases in preventive care, all leading to improved efficiencies, decreased costs, and potentially improved outcomes. Although this is a requirement of meaningful use, it is still a work in progress within the healthcare industry

Information alignment is needed among key stakeholders as a priority to enable not only better care, and affordable care, but measurable care. Real-time or nearly real-time data is needed for providers to have information at the point of care to support their decision making process, and allowing for measurable care. Traditional claims data allows for only retrospective information which is not timely or inclusive enough information for clinicians to effectively use for clinical decision making purposes in the patient care process. Real-time data will enable greater communication between the provider and patient and among the multiple providers for a patient and patient populations. Real-time data is critical for effective patient care treatment and clinical decision making resulting in measurable care, which will optimize the health care system.

Continuity of care requires collaborative interactions among multiple clinicians from a broad array of specialties, often in different locations. As such, the National Quality Strategy should strive for nothing less than an integrated healthcare community, including the healthcare consumer, where enabling technologies promote usable, efficient and seamless information flow. Including information-rich, patient-centered documentation as part of the National Quality Strategy can facilitate continuity of care, enabling improved safety, quality, and processes of care delivery. The National Quality Strategy should encompass communication among acute, ambulatory, rural, long-term, rehabilitation, community-based, home care, behavioral health, pharmacies and public health based settings, whereby data and information necessary for managing the health of these populations is shared.

The National Priorities Partnership (NPP), a multi-stakeholder group convened by the National Quality Forum emphasizes this need to coordinate care to drive efficiencies. NPP's eight goal areas focus on the need to eliminate harm, waste, and disparities in the healthcare system:

1. Patient and Family Engagement
2. Safety
3. Care Coordination
4. Palliative and End-of-Life Care
5. Equitable Access
6. Elimination of Overuse
7. Population Health
8. Infrastructure Supports:

HIMSS recently became a Partner of NPP and has already begun to contribute to the goals and recommendations of the NPP, as NPP outlines its own recommendations to inform the National Quality Strategy.



Question 4: What aspirational goals should be set for the next 5 years, and to what extent should achievable goals be identified for a shorter timeframe?

As an achievable goal, HIMSS strongly encourages the government to continue to leverage the NPP's identified goal areas for improving healthcare delivery. As referenced in Question #3, the eight goal areas are intended to eliminate harm, waste, and disparities in the healthcare system.

As an achievable goal, HIMSS strongly encourages the federal government to identify near real time measurable goals for the implementation and execution of the National Quality Strategy to assist the government in demonstrating improvements in the quality of care delivered through the healthcare system.

As aspirational goals, HIMSS recommends an evaluation of existing health IT infrastructure as part of the National Quality Strategy to be conducted in order to assess gaps in the healthcare industry, and inclusion of a robust health IT infrastructure to support the National Quality Strategy. The advent of meaningful use is certainly a catalyst for change, which will positively affect the level of adoption of electronic health records in hospital and private practice settings. In addition, meaningful use and the State Health Information Exchange Cooperative Agreement Program are anticipated to greatly facilitate health information exchange initiatives between healthcare providers across the patient care continuum. Health information organizations (HIOs) and health information exchange (HIE) initiatives are anticipated to play a critical role with providers in meeting the future anticipated Meaningful Use criteria. HIO and HIE initiatives provide the technical platform for communication, data sharing and reporting across all providers along the care continuum leveraging their deployed software applications such as the electronic health record. Interoperability of these software applications is critical in achieving successful data exchange. The results of successful data exchange activities not only include data sharing and communication but can result in improved patient care processes and efficiencies, decreased costs and reduced duplication of patient treatment services. The goals of data exchange across the patient care continuum are improved care coordination among health care providers; reporting of notifiable conditions, immunizations, and syndromic surveillance to public health; and reporting of quality measures to CMS and Medicaid.

HIMSS recommends the proposed National Quality Strategy and Plan leverage the work of the Quality, Research and Public Health domain of Integrating the Healthcare Enterprise (IHE) to address the infrastructure necessary to share information relevant to quality improvement in electronic patient care and health care records.

HIMSS recommends the aspirational goal that healthcare organizations become less reliant on paper over the next five years, and encourages implementation of digital health records with discrete structured data in a standardized format to increase interoperability, and for the EHRs to be the primary source of provider documentation, ordering, and result retrieval.

HIMSS recommends the aspiration goal of implementing electronic business processes in healthcare that drive efficiency and support higher quality decision making.



Question 5: Are there existing, well-established, and widely used measures that can be used or adapted to assess progress towards these goals? What measures would best guide public and private sector action, as well as support assessing the nation’s progress to meeting the goals in the National Quality Strategy?

As referenced in the answer to Question #4, HIMSS recognizes the work of the National Priorities Partnership (NPP), which represents a broad based public-private multi-stakeholder membership. NPP’s report for recommendations to inform the National Quality Strategy include the three pillars of 1) Better health, 2) Affordable care, and 3) Healthy people and communities. Additionally, it contains the four core principles of 1) Patient-centeredness and family engagement, 2) Care for patients of all ages, populations, service locations, and sources of coverage, 3) Elimination of disparities, and 4) Alignment of public and private sectors.

Originally, NPP had six Priorities (listed in our response to Question #3) presented in detail in the National Priorities Partnership’s report National Priorities and Goals: Aligning Our Efforts to Transform America’s Healthcare, Washington, DC: National Quality Forum; 2008. Two additional priorities, introduced in 2010, are noted by the Partnership as cutting across each of its six Priorities —equitable access and infrastructure supports. Health information technology is one facet included within this new eighth priority of infrastructure supports. As discussed in our response to Question #4, HIMSS recommends the aspirational goal of evaluating existing health IT infrastructure as part of the National Quality Strategy to be conducted in order to assess gaps in the healthcare industry, and inclusion of a robust health IT infrastructure to support the National Quality Strategy, and is alignment with the NPP goal of infrastructure supports.

Additionally, the NPP recommendations are aligned with existing initiatives of the Affordable Care Act, the Office of the National Coordinator’s (ONC’s) Health Policy Committee and meaningful use framework, the Institute of Medicine’s (IOM’s) report and recommendations on the National Health Care Quality Report (NHCQR) and the National Health Care Disparities Report (NHCDR), the IOM report on Leadership by Example, and the IOM report Health Professionals Education, a Bridge to Quality.

For these reasons, HIMSS views the work by the National Priorities Partnership as a comprehensive framework, and endorses its premise. Additionally, HIMSS is a newly accepted partner of NPP, and will be directly contributing to this and other NPP efforts.

Finally, measurement of electronic business process transformation has been undertaken by the US Healthcare Efficiency Index® and, with some adjustments to incorporate broader participation; this could be used to measure this important area.

Question 6: The success of the National Health Care Quality Strategy and Plan is, in large part, dependent on the ability of diverse stakeholders across both the public and private sectors to work together. Do you have recommendations on how key entities, sectors, or stakeholders can best be engaged to drive progress based on the National Health Care Quality Strategy and Plan?

As noted in HIMSS response to HHS questions #3, #4 and #5, HIMSS endorses the work of the National Priorities Partnership, and is an active participant. HIMSS recommends the Department engage with the NPP as it does represent a multi-stakeholder view of both the public and private sectors.

In addition, the business of healthcare has its own set of stakeholders and more recently, banking and financial institutions have begun to make investments in healthcare information technology related to healthcare financial management. HIMSS Medical Banking Project has facilitated a multi-stakeholder group that is specialized around this area in order to isolate, promote and speed adoption of best practices for electronic business transformation in healthcare. We anticipate continued updates, and will be sharing these with the government and the NPP.



Question 7: Given the role that States can play in organizing health care delivery for vulnerable populations, do the Principles and Framework address the needs and issues of these populations?

HIMSS appreciates the opportunity to respond to the question. As indicated in earlier comments, HIMSS is very interested in ensuring that all populations have equal access to quality healthcare delivery. As such, we strongly encourage the federal government to work together with the state-level organizations, and outside individuals to ensure there are common goals for the entire health care community. With specific reference to vulnerable populations, HIMSS emphasizes that we have several years experience working with the HIT Collaborative for the Underserved populations to educate consumers, providers, and other entities on the importance of the program, on aligning the National Quality Strategy with the ONC Strategic Plan, other federal plans, and the state-level plans (registry reporting, meaningful use Strategic Plans at State Levels, HIE activities, Healthy People 2020, and aligning with the Prevention Strategic Plan that is coming in Spring 2011).

HIMSS is aware that as we move forward with healthcare transformation, institutions are going to be asked to inform changes in healthcare delivery. Associated questions include whether facilities that are addressing the needs of vulnerable populations will be able to remain fiscally viable. Additionally, as more individuals embrace social media technologies, how will these technologies improve or hinder patient involvement in health information gathering and dissemination?

In addition, HIMSS notes the underserved and the “unbanked”, an area of concern in the banking industry in order to raise the economic status of underserved people groups, have overlapping demographics. A poignant example of this is the use of cell phones in underserved parts of the world to pay for healthcare using mobile banking technology. While 1.5 billion people have access to the Internet, over 5 billion have cell phones, thus the use of this platform for healthcare and banking has come under scrutiny by UN Foundation and the World Bank. An aspirational goal of the “medical banking” movement, where banks are engaging healthcare, is to provide new tools that target vulnerable populations with healthcare and financial programs. We believe, again, that efficient use of available funds goes hand in hand with better healthcare in the community. Banking and financial systems in healthcare are teaming to support “advanced community care platforms” that seek to provide better access to healthcare services to the underserved population.

Finally, HIMSS suggests that the government clarify the definition of vulnerable populations, so the healthcare community can understand the baseline for future comments and interactions with the government.

Question 8: Are there priorities and goals that should be considered to specifically address State needs?

As referenced in our response to HHS Question #2, HIMSS reiterates the importance of coordinating federal, state, and local healthcare quality initiatives.

Question 9: What measures or measure sets should be considered to reflect States’ activities, priorities, and concerns?

HIMSS recommends alignment with the efforts of the National Quality Forum (NQF) to harmonize measures and take steps to harmonize clinical practice guideline development and clinical decision support (CDS) content. As part of the Department’s efforts to respond to the requirements in the Medicare Improvements for Patients and Providers Act of 2008, we understand the Department is working with NQF to help establish a portfolio of quality and efficiency measures that will allow the federal government to more clearly see how and whether healthcare spending is achieving the best results for patients and taxpayers.



Of particular note is the NQF work being managed by the HHS Assistant Secretary for Planning and Evaluation that addresses measurement alignment in the following areas:

- Formulation of a National Strategy and Priorities for Healthcare Performance Measurement
- Implementation of a Consensus Process for Endorsement of Healthcare Quality Measures
- Maintenance of Consensus Endorsed Measures
- Focused Measurement Development, Harmonization, and Endorsement Efforts to Fill Critical Gaps in Performance Measurements

Question 10: What are some key recommendations on how to engage with States and ensure continued alignment with the National Quality Strategy?

HIMSS recommends alignment across federal agencies and national initiatives to include a conference among entities including, but not limited to, the Office of the Secretary of Health and Human Services, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the National Quality Forum, the National Governors Association, the National Conference of State Legislatures, and other interested parties. The conference should spend considerable time focusing on potential avenues to achieve agreement on federally identified measures.

Other items:

In order to improve quality strategies in the U.S., HIMSS suggests the federal government engage in a dialogue with the healthcare community regarding potential improvements to the National Provider Identifier. Such improvements are likely to improve care coordination and control of quality reporting providing greater accuracy in tracking quality performance by providers.

In addition, HIMSS strongly encourages the federal government to establish an informed patient identity solution, to include the lifting of the ban on the Department of Health and Human Services expenditures toward a patient identifier; and the HHS conducting a study of the cost/benefit and practicality of implementing Unique Identifier solutions.

In summary, we commend the Department for the collective effort to improve the national coordination on the many quality improvement activities that are underway. We look forward to continued dialogue with the government on these important matters. If you have any additional questions please contact [David A. Collins](#), Director, Healthcare Information Systems, 703.562.8848 or [Thomas M. Leary](#), Senior Director, Federal Affairs, 703.562.8814. Thank you for consideration of these comments which represent the input from our membership.

Sincerely,

C. Martin Harris, MD, MBA, FHIMSS
Chief Information Officer and
Chairman, Information Technology Division
Cleveland Clinic
Executive Director, e-Cleveland Clinic
HIMSS Chair

H. Stephen Lieber, CAE
President/CEO
HIMSS