June 26, 2009

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National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
200 Independence Ave, SW
Suite 729D
Washington, DC 20201

Re: HIT Policy Committee Meaningful Use Response

Dear Dr. Blumenthal:

On behalf of the Association of Medical Directors of Information Systems (AMDIS), thank you for the opportunity to respond to the ONC Meaningful Use definition proposal. AMDIS was founded in 1997 as the premier professional organization of physicians responsible for healthcare information technology. Our members are physician leaders dedicated and experienced in the integration of information technology in large, medium and small healthcare settings throughout the United States. Two thousand members strong, AMDIS physicians are the "front line" of applied clinical informatics, experienced in the transformation and enhancement of healthcare via the application of health information technology (HIT). We have been waiting and hoping for the advent of Meaningful Use for a long time. Furthermore we applaud the vision and goals of ONC in defining Meaningful Use.

AMDIS believes it is essential to *achieve momentum* in the introduction of HIT in America and that the benefits of transformation will enable a new era of healthcare quality, safety and cost-effectiveness.

Therefore, our focus in this response will be on the bigger picture and broad themes rather than detailed item-by-item feedback on each objective and measure. Our recommendations are based on ONC's specific interest in receiving feedback on the aggressiveness of proposed requirement timelines and how best to frame these measures.

RECOMMENDATION 1: Meaningful use "as seen through the patient's eyes" should specifically inform objectives and measures.

We suggest that the best way to frame the measures is "through the patient's eyes" – that is from what we see to be the patient's perspective on meaningful use of health IT, and that the measures should reflect evidence of each of these perspectives. To that end, we believe that patients and families expect that during the time period between 2011 and 2015, their healthcare professionals will:

- Use only EHR systems that are considered "safe and effective" by a trusted authority.
- Appropriately record, retain, organize, use, safeguard and share relevant health information about them with other authorized members of the care team.
- "Keep me informed and answer my questions" – Make their important health information

(results, actions, advice) available to them in a timely and convenient manner, in a format that fits their preferences, including electronic means.

"Talk to each other" – Providers should communicate important information about the patient in a timely manner and use it to make coordinated, patient-centered decisions.

"Handle my medications and prescriptions" – Use technologies and processes such as electronic prescribing and medication reconciliation to protect patients against medication errors, preventable adverse events, inconvenience and unnecessary expense.

"Make sure I get everything I need" – Implement and use clinical decision support tools such as alerts, reminders, protocols and other patient-specific electronic strategies to help providers ensure their patients get the right care at the right time.

"Get help when I need it" – use electronic knowledge resources as needed to resolve unanswered clinical questions, get the latest information, and support clinical decisions.

RECOMMENDATION 2: Please clarify the requirements for payment under ARRA for meaningful use. It is currently unclear whether payment will require meeting some or all of the objectives, measures or both.

It is difficult to provide well-informed feedback regarding whether the timeline of requirements is too aggressive or not challenging enough without greater clarification with regard to which objectives and measures must be met, how they will be operationally defined and at what level of achievement each must be met.

RECOMMENDATION 3: Keep early (2011) objectives and measures of meaningful use sharply focused on demonstrated evidence of appropriate EHR data capture and sharing.

Our experience as physicians and clinical informatics leaders reinforces our sense that the first step in meaningful physician EHR use is "regular and appropriate use" for data capture and sharing, within and beyond the organization. While AMDIS members also seek accelerated physician EHR adoption and meaningful use, we are mindful that this process typically follows a` "crawl-walk-jog-run" progression, requiring cycles of training, practice and continuous improvement. These cycles cannot be skipped or condensed into short time intervals without risking failure to "go the distance" in the marathon that is HIT-powered healthcare transformation. In our local healthcare organizations, we routinely calibrate our expectations for physician EHR use to the expected level of capability of the user and system at the time, setting measurable stretch goals that users can be expected to achieve without introducing new errors or becoming discouraged and giving up.

As such, we recommend that the most important 2011 stretch goal for most physicians and hospitals will that physicians and staff become regular and appropriate users of those core EHR functionalities that are relatively easy to implement and use in EHR systems certified under the 2008 CCHIT criteria. Specifically, we recommend that the 2011 requirements focus on measuring the quality and extent to which physicians and staff appropriately capture electronically or directly enter problems, medications, allergies, histories, prescriptions and vital signs. We also support the expectation that by 2011 providers and staff routinely enter office progress notes and patient-related messages electronically (patient-provider and provider-

provider). Further, to ensure that data recorded in one health information system can be shared and meaningfully used in another system, we also recommend a requirement that the captured data be encoded in a manner that facilitates automated health information exchange.

The structured data capture requirement will set the stage for the next phase of meaningful use (EHR/HIT-supported advanced clinical processes), and ultimately for improved outcomes. Improved performance against these meaningful adoption measures will also drive the availability of more uniform datasets for the reporting of outcome measures and subsequent comparative effectiveness research.

RECOMMENDATION 4: Required reporting of quality measures should be deferred until 2013, by which time appropriate data capture and sharing should be widely diffused and deeply infused in physician practices and hospitals that have qualified for payments in 2011.

We see placing the reporting of quality measures in advance of reporting measures of meaningful EHR adoption as akin to putting "the cart before the horse" – the fields that form the basis for automated quality reporting must first be populated on a regular basis through appropriate data entry and capture, and then presented to physicians for validation. This is a critical step in EHR use optimization and for the changes in behavior that will remediate care deficiencies. If the goal of quality measure reporting is to generate more light than heat and to prompt improvements in performance, physicians must first become competent producers and consumers of EHR system data, trust that the data are reliable, know how to repair deficiencies in documentation or care, and gain practice in doing so. Distracting physicians with inaccurate or incomplete quality data risks derailing physician engagement in a shared quality agenda. Once the healthcare environment is more acclimated to reporting quality data, it will be important that it be distinguishable from reporting methods that are currently in place, which can be done today by healthcare delivery organizations with limited or no EHR capabilities, such as through manual chart abstraction or charge-based reporting. Quality reports should be accompanied by evidence that the data were largely derived through automated reporting that is a natural byproduct of how the EHR is routinely used, not from chart abstractors manually extracting data from free text entries or scanned paper documents.

RECOMMENDATION 5: Defer the requirement to "Use CPOE for all order types including medications" to 2013 or beyond.

Implementing full CPOE is an important but complicated undertaking fraught with potential unintended negative consequences if done too quickly or incorrectly. Even in the hands of our most experienced members working in organizations with EHR systems that are already up and running, successfully implementing robust CPOE functionality is generally a challenging, multi-year undertaking that requires careful planning and execution. As such, and despite our own desire to see CPOE move forward as quickly as practicable, we recommend that a requirement to use CPOE for all order types be deferred to a later phase because it requires more advanced planning, building, testing, training, experience, data capture, data sharing and decision support than many practices and hospitals can successfully achieve in the next 2-3 years. Ambulatory e-prescribing is a notable CPOE exception that we are comfortable recommending for 2011 because it is a mature enough technology to be reasonably considered "ready for prime time"

and will have a sufficiently impactful effect on quality and cost to be worth striving for.

RECOMMENDATION 6: Support meaningful use through EHR/HIT certification criteria and expectations for sending and receiving entities.

Meaningful use depends not only on appropriate physician and staff use of qualifying EHR systems but also that such systems "talk to" outside systems and entities to complete a communication or reporting transaction. We recommend that meaningful use payments be processed for any practice or hospital that satisfactorily demonstrates it has fulfilled those aspects of data transmission under its control, whether or not the other party is able to send/receive the data, and that technology vendors be held to qualifying criteria that ensure such data transmissions can be completed successfully.

SUMMARY AND CONCLUSIONS

For AMDIS, the validation of decades of work in striving to better leverage the power of information technology to improve the safety and quality of healthcare delivery is, as per the slogan, *priceless.* We are dedicated to the success of the stimulation of HIT introduction and meaningful use across our country and know that it is both necessary and essential to achieving the balance between quality, safety and cost of what, when it is at its best, is still the finest healthcare in the world. Neither placing the "bar" of achieving Meaningful Use too high nor too low will accomplish these goals. Yet the unwavering commitment to achieving that goal is our organization's reason to be. We again thank you for your office's work in promoting and refining this effort and look forward to next steps.

Sincerely,

AMDIS

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