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Via Electronic Delivery

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Office of the National Coordinator for Health Information Technology
200 Independence Ave., S.W., Suite 729-D
Washington, DC 20201
Attn: HIT Policy Committee Meaningful Use Comments

Dear HIT Policy Committee:

The Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 131 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members which include clinical teaching physicians, 75,000 medical students, and 106,000 resident physicians. The AAMC is pleased to respond to the Committee's request for comments announced at its June 16, 2009, meeting and published in the Federal Register on June 18, 2009 (74 Fed. Reg. 28937). We hope our insights will be helpful to the Committee in crafting this important definition.

Teaching hospitals and faculty practices (the organizations through which clinical teaching faculty provide patient care) will play an essential role in the process of achieving widespread use of electronic health records (EHRs). These are the places where the next generation of physicians will learn how to practice medicine and to become successful users of EHRs. EHRs will not transform the health care system over night, and a few studies have suggested that they have the potential for generating new types of errors. Therefore, it is crucial that in the venues where medical students, residents, and other health professionals are taught—the teaching hospitals and faculty practices—EHRs are widely available.

Incorporating the use of EHRs into the educational process will allow students to become practitioners who play a key role in transforming the health care system into one that resembles the vision suggested by the Meaningful Use Workgroup. It is also important to understand that teaching institutions may use EHRs in unique ways to support their teaching mission. For example, they need to track how students and residents enter, review, or modify medical notes

within EHRs, and may be able to use data in the EHRs to ensure that students receive required educational experiences. Many teaching hospitals and faculty practices have already made substantial investments—or are in the process of doing so—in the development of their own EHR systems, or the purchase of systems. It is vital that they be able to receive EHR incentive payments, just as others in the community must, so that the ideal of a broad, interoperable health care system can be achieved at some point in the future.

The American Recovery and Reinvestment Act (ARRA) establishes three categories of meaningful use—certified EHR technology; information exchange to improve the quality of health care; and reporting on measures using an EHR—each of which must be met to qualify for incentives. In developing the matrix for reporting on measures, the Meaningful Use Workgroup was guided by a vision: to enable significant and measurable improvements in population health through a transformed health care delivery system. The AAMC agrees that this vision should be a goal for the future, but does not believe it is the optimal guide for achieving meaningful use in the short timeframe imposed by the statute. The AAMC supports the establishment of initial reporting measures that are achievable by large numbers of hospitals and physicians by 2011 or 2012; increasing the requirements incrementally over time; and ensuring that all measures are consistent with quality reporting programs already established by CMS. Further, it is essential that requirements related to the use of EHRs not create any impediments to comparative effectiveness and other research that is so essential to quality health care and improvements in population health.

If the HIT Policy Committee decides to proceed with its current priorities and matrix model, the AAMC believes that numerous changes must be made to the current draft. The AAMC’s general comments on the proposed matrix are as follows:

1. The measures in the matrix focus on primary care and preventive care services. We agree that is a good first step, but the Committee should recognize that these measures will not apply to all specialties and physician practices. Because transforming the health care system will require all providers—regardless of specialty—to use EHRs, the Committee must consider ways in which all eligible professionals may qualify as “meaningful users” during the period of earlier adoption and in the years thereafter.
2. Where applicable, quality measures must be endorsed by the National Quality Forum (NQF) and approved by the Hospital Quality Alliance (HQA) for inpatient and hospital outpatient measures. To achieve meaningful use, it is important that the requirements employ quality reporting measures that are consistent with those already in place through established programs including Medicare’s Physician Quality Reporting Initiative (PQRI) and those of other organizations such as the Joint Commission.
3. Where measures indicate that a certain percentage is required for compliance, it is not clear what constitutes the total population against which the measure must be evaluated. For example: is the total population meant to be all Medicare beneficiaries; all Medicaid beneficiaries; or all inpatients? To accurately and meaningfully report measures, there

must be clarity about what is included in both the numerator and denominator, as is true for Medicare's hospital and physician quality reporting programs.

4. The measures in the draft matrix do not appear to account for the fact that population-level data initially may not be available. Providers are not able to capture and enter certain population data retroactively, making reporting impossible for certain measures in the initial years.
5. The matrix is ambiguous about implications for the requirements in even-numbered years. For instance, are providers who become "meaningful users" in 2012 (rather than 2011) disadvantaged in any way?
6. Vendors are integral to a provider's ability to become a "meaningful user." The Committee must take into consideration vendors' willingness and ability to make systems available that will accomplish each of the measures listed in the matrix.

More specifically, with regard to the 2011 Measures, the AAMC's comments are as follows:

1. Quality and Safety:

- a. In general, the AAMC believes that the names given to the measure specifications should be sufficiently descriptive to allow them to be easily and consistently understood.
- b. Each measure appears to be given equal importance. The AAMC would like to emphasize that the mere ability to collect information does not make that information of high value. Selection of measures should include consideration of the ability to collect the data, but more importantly, the ability to improve the quality and safety of care provided to patients.
- c. Not all measures are relevant to all physician practices. For example, the PQRI reporting program allows physicians to identify the appropriate measures from an approved list of 153 individual measures and 7 measure groups. The Committee should consider how physicians can report meaningful measures without the burden of reporting less-relevant measures.
- d. Stratifying reports by insurance type, race, and ethnicity may be difficult to implement by 2011. Few providers record primary language and there may be state law or other restrictions about collecting information on race and ethnicity.
- e. The proposed measure entitled "% of orders entered directly by physicians" should be reconsidered and/or clarified. For example, the Committee should consider workflow issues and when it may be acceptable for nurses, students and residents to enter orders instead of a physician.

- f. We have several concerns regarding the proposed measure entitled “send reminders to patients per patient preference for preventive/follow up care.” Electronic reminders raise significant privacy concerns, and paper reminders have proved extremely costly. The measure’s contribution to a provider’s ability to demonstrate “meaningful use” is not clear.
- g. The Committee should reconsider the measure entitled “% of lab results incorporated into EHR in coded format.” It is not clear how the denominator would be calculated (i.e., how do you calculate the number of labs results **not** in the EHR?).

2. Privacy and security:

- a. The AAMC is extremely concerned about the measure entitled “an entity under investigation for a HIPAA privacy or security violation cannot achieve meaningful use until the entity is cleared by the investigating authority.” This measure presumes the guilt of the entity under investigation (an investigation designed to determine whether the entity has violated HIPAA) and raises serious due process concerns. If an entity ultimately is found to have committed a **material** violation of HIPAA privacy and security rules, perhaps then it may be required to forfeit some portion of its “meaningful use” incentive payments. An enforcement authority should have the opportunity to consider whether sanctions above and beyond those already imposed by HIPAA would be appropriate, however, *before* such an extreme sanction is imposed.
- b. Quite aside from considerations about “meaningful use,” covered entities and business associates are required to comply with all HIPAA privacy and security requirements. It is not clear, therefore, why these criteria should be incorporated into the definition of meaningful use. The Committee may consider adopting an attestation that all HIPAA requirements have been met, but there is no certification body for HIPAA compliance, and this is not information likely to be found in an EHR.

3. Engage patients and families:

- a. It is not clear what is meant by the measure entitled “% of all patients with access to patient-specific educational resources.”

4. Population and public health:

- a. Regarding the measure entitled “report up-to-date status for childhood immunizations,” it is not clear whether this measure applies only to pediatricians or to a broader spectrum of providers.

- b. The measure entitled “% reportable lab results submitted electronically” may be difficult to report, assuming that all labs are not in the electronic record.

5. Care coordination:

- a. In general, the AAMC notes that many vendors’ systems currently do not have standards that allow for the easy exchange of clinical information.
- b. Regarding the measure entitled “reporting 30-day re-admission rate,” the Committee must take into account the fact that a hospital is only able to report its own readmissions; a hospital is not able to account for patients who are readmitted to another hospital. Additionally, hospitals may not have the required clinical data to be able to perform an adequate risk adjustment of this data accounting for all of the patient’s co-morbidities.
- c. In the measure entitled “implemented ability to exchange health information with external clinical entity,” it is not clear how either “clinical” or “external” are defined.

The AAMC looks forward to continuing collaboration with the Policy Committee as it moves forward in making recommendations to the National Coordinator. Please do not hesitate to contact either Ivy Baer or Lori Mihalich-Levin of my staff, both of whom may be reached at 202-828-0490, with any questions or comments you may have.

Sincerely,



Joanne M. Conroy, M.D.
Chief Health Care Officer