

U.S. Department of Health and Human Services

**Office of the National Coordinator for
Health Information Technology**



**Summary of Public Comments on
Meaningful Use of Health IT**

**September 14, 2009
FINAL**



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1.0 Introduction

The adoption and meaningful use of health information technology (IT) and electronic health records (EHRs) is integral to the transformation of the health care system and to the improvement of health outcomes. The American Recovery and Reinvestment Act of 2009 (ARRA), signed in February 2009 by President Barack Obama, appropriated approximately \$49 billion to promote the utilization of EHRs and the development of interoperable systems to allow for data sharing across providers. This legislation created financial incentives through the Medicare and Medicaid programs to encourage eligible providers and hospitals to adopt and become “meaningful users” of certified EHRs. Central to the incentive programs was the need to provide an actionable definition of “meaningful use.”

To begin the process of defining “meaningful use,” the National Committee on Vital and Health Statistics (NCVHS) Executive Subcommittee convened a public hearing on “Meaningful Use” of Health Information Technology in April 2009. The NCVHS hearing brought together key healthcare and information technology stakeholder groups for two days of testimony. Transcripts and presentations from this meeting are available at <http://www.ncvhs.hhs.gov/090428ag.htm>

In May 2009, the Department of Health and Human Services (HHS) announced the creation of the two Committees established by Health Information Technology for Economic and Clinical Health (HITECH) Act to advise the National Coordinator on the implementation of health IT. The Health IT Policy Committee, a Federal Advisory Committee (FACA) will make recommendations to the National Coordinator for Health Information Technology on a policy framework for the development and adoption of a nationwide interoperable health information infrastructure, including standards for the secure and private exchange of patient medical information. In addition, appointments were made to the Health IT Standards Committee, also a federal advisory body, which is charged with making recommendations to the National Coordinator on standards, implementation specifications, and certification criteria for the electronic exchange and use of health information. For the purpose of this document, information will be limited to the Health IT Policy Committee since they have been driving efforts to create a draft definition of “meaningful use”.

The first meeting of the Health IT Policy Committee was held on May 11, 2009 in which three working groups were formed with a corresponding broad charge, including:

- Meaningful Use Workgroup: Make recommendations to the Health IT Policy Committee regarding the process for defining and revising meaningful use and



- national goals, proposed new meaningful use definitions and national goals and standards and policy priorities to support meaningful use and national goals.
- Certification and Adoption Workgroup: Make recommendations to the Health IT Policy Committee on issues related to the adoption of certified EHRs, that support meaningful use, including issues related to certification, health information extension centers and workforce training.
 - Information Exchange Workgroup: Make recommendations to the Health IT Policy Committee on policies, guidance governance, sustainability, and architectural, and implementation approaches to enable the exchange of health information and increase capacity for health information exchange over time.

The Health IT Policy Committee held its second meeting on June 16, 2009 to begin this process of defining “meaningful use” of EHRs in which the three Workgroups presented their initial set of recommendations. The draft recommendations presented at that meeting represented extensive work by the Committee’s Meaningful Use Workgroup to review and evaluate diverse ideas and contributions from Workgroup members along with input from other meetings focused on the topic such as the NCVHS meeting. During this meeting, the Policy Committee voted to table the Meaningful Use Workgroup’s recommendations, and asked the Workgroup to bring back a revised set of recommendations for the July 16, 2009 Committee meeting.

Following the June 16, 2009 meeting, the Health IT Policy Committee initiated a public comment period through a Federal Register notice that lasted from June 16, 2009 to June 26, 2009 to allow interested parties to provide comments on the draft recommendations. A total of 792 written responses were received from stakeholders across the healthcare industry. Exhibit 1 summarizes the number of comments received by organization type.

Exhibit 1. Number of responses received by organization type.

| Organization Type | Categories of Organizations Included | Number of Responses |
|-----------------------|--|---------------------|
| ▪ Academic | ▪ Colleges, Universities, Academic-affiliated associations | ▪ 26 |
| ▪ Governmental | ▪ Federal agencies ▪ State and local agencies, registries | ▪ 9 ▪ 23 |
| ▪ Hospital | ▪ Hospitals, health systems, medical centers, hospital-affiliated associations | ▪ 207 |
| ▪ Government Hospital | ▪ Government-run hospitals | ▪ 2 |
| ▪ Industry | ▪ Cross spectrum of industry to include pharmaceutical companies, IT service organizations, healthcare delivery organizations, and industry-related associations/consortiums | ▪ 165 |



| Organization Type | Categories of Organizations Included | Number of Responses |
|------------------------------------|---|---------------------|
| ▪ IT Groups | ▪ IT-focused coalitions, associations, foundations, and commissions | ▪ 20 |
| ▪ Medical Transcriptionists | ▪ Transcription-related organizations and individuals | ▪ 66 |
| ▪ Non-Profit | ▪ Wide-spectrum of associations and other non-profit entities (excludes IT, hospital, other provider and academic-based associations) | ▪ 40 |
| | ▪ Consumer Centric Organizations | ▪ 19 |
| ▪ Payers/Health Plans | ▪ Insurance companies, affiliated associations, pharmacy benefit managers, and health plans | ▪ 6 |
| ▪ Providers (non-hospital) | ▪ Non-hospital provider associations, societies, individual providers and provider groups | ▪ 106 |
| ▪ Self/Individual | ▪ Individual comments | ▪ 75 |
| ▪ Blank | ▪ Organization Type not identified | ▪ 8 |
| ▪ Health Information Organizations | ▪ State-based Health Information Organizations, Regional Health Information Organizations, and the eHealth Initiative | ▪ 14 |
| Total Comments | | 792 |

This document presents a summary of the major themes and inputs received on the draft recommendations on the definition of meaningful use during the public comment period only. Where appropriate, comments have been stratified by organization type.

These comments were taken into account by the Meaningful Use workgroup of the Health Information Technology Policy Committee as they were developing a revised version of a matrix to help frame the definition of meaningful use. The revised matrix incorporating feedback received was endorsed by the Policy Committee on July 16, 2008. These recommendations were then submitted to the National Coordinator for Health Information Technology to help inform the Federal process for developing a Proposed Rule on meaningful use. A second public comment period will solicit comments on the Notice of Proposed Rule Making including the definition of “Meaningful Use” as proposed by the Department as well as specifics on how the incentive payments will be implemented.

2.0 Scope of the Meaningful Use Definition

The comments received regarding scope of the meaningful use definition varied extensively. The majority of respondents concurred that the focus of meaningful use must be on improving health outcomes, not simply to promote the adoption of technology. Stakeholders generally applauded the emphasis on quality, and in fact some sought additional measures to ensure meaningful use and the tie backs to quality



and performance. More than a third of the stakeholders expressed pleasure with the initial guidance overall.

At the same time, the majority of the respondents suggested some change, ranging from overall reductions in scope to specific changes to individual requirements, usually building upon the Meaningful Use Preamble and the Meaningful Use Matrix foundation.

2.1 Recurring Themes

Several key topics were identified by stakeholders where further clarification or consideration is needed. Specific topics that received consistent feedback included: computerized physician order entry (CPOE), health information exchange (HIE), and patient access to data/personal health records (PHRs).

CPOE was mentioned by more than 10% of total respondents. Feedback regarding CPOE was mixed. Some stakeholders expressed support for the 2011 requirements, as they consider it a critical functionality for early implementation. However a majority of respondents indicated concern, citing the need to change provider culture before requiring CPOE, the need to allow other practitioners to enter orders, the risk of providers implementing incomplete order entry systems, and the delay that could be caused by the required implementation of CPOE.

The role of the exchange of health information in meaningful use was mentioned by slightly less than 10% of total respondents. While respondents generally supported the exchange of health information in concept, there was disagreement on the timeframe for requiring the exchange of health information and the scope of exchange (e.g., types of information exchanged, number of linked entities) necessary to meet requirements. Most who cited the exchange of health information as a concern, specifically hospitals, stated that health information exchange capability and an interoperability framework must be established first. As such, these stakeholders support incentives for promoting the exchange of health information, and advocate for training and support to help facilitate adoption. Conversely, some stakeholders were concerned about the complexity of the exchange of health information, the challenges of linking multiple entities, and suggested that participation in Health Information Organizations (HIOs) should not be required. Certification of HIOs and Regional Health Information Organizations (RHIO) was also referenced in the comments, and this feedback is discussed below in the "Certification" section.

Engagement of patients and families, patient access to records and use of PHRs was mentioned by approximately 5% of total respondents. Some stakeholders, including PHR vendors, were pleased with the engagement of patients early in the process, as their active involvement can improve care. Some individuals and non profit



organizations suggested advancing access to patient data in 2011, while other providers suggested keeping patient access in 2013. There seemed to be a difference in perception around the scope of the challenge. For example, a few hospitals and providers expressed concerns regarding patient access to health information via PHRs, indicating that focusing on a patient-centric portal may be more desirable in the short-term.

2.2 Increased Emphasis on Specialty Care

The Meaningful Use Matrix developed by the Meaningful Use subcommittee of the Health Information Technology Policy Committee provides objectives and measures most specific to hospitals and certain ambulatory providers, with an acknowledged emphasis on primary care. The Meaningful Use Preamble states that other measures under development by the National Quality Forum (NQF) and other recognized organizations will address the work of specialists in the future. Despite this, approximately 130 of the 800 total comments received, recommended increasing the scope of the draft definition on meaningful use to include additional populations for inclusion in the initial meaningful use criteria, or requested they be given special consideration with regard to meaningful use criteria.

Of these 130 comments, more than half requested specific criteria or consideration for various medical specialties (e.g., pediatrics, behavioral health, dental, radiology, ophthalmology) and for allied health professionals (e.g., home health professionals, physical therapists, physician assistants, optometrists medical transcriptionists). These comments were consistent with the specialty, profession, or facility type the respondent represented.

2.3 Other Considerations for Defining Scope

Various issues were raised by a handful of respondents (defined as less than 10). Though not all of these comments are discussed in this summary, a sample of comments is provided to illustrate some of the points raised and the range of opinion expressed.

- Specific considerations for those who deal with more vulnerable populations, such as children and the uninsured
- The use of data registries and its role in meaningful use
- The role of unique patient identifiers
- The burden on smaller or rural hospitals and physicians to select and procure health IT solutions
- The need for educational and technical support to assist health providers in the selection and adoption of health IT



- The impact of health IT adoption on human factors, workflow and productivity
- Impact of health IT adoption on public health agencies
- The alignment of Medicare and Medicaid metrics with meaningful use goals, objectives, and metrics
- The interaction between meaningful use and Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance
- The need for information systems and clinical practice workflows to accommodate multiple languages, literacy levels, and cultural and ethnic sensitivities.

3.0 Meaningful Use Timeline

Nearly sixty percent of all respondents provided input and commentary on the Meaningful Use Matrix and timeline. Respondents' comments focused primarily on the aggressiveness of the timeline, as well as which year specific objectives should be met. While approximately 25% of those respondents who commented on the timeline overall categorized the timeline as too aggressive, other respondents either suggested moving specific requirements into the 2011 timeframe, or did not provide commentary on the timeline at all. These findings suggest that respondents vary in their opinions as to which care goals should be advanced first, but they want trade-offs to ensure the set of care goals for 2011 are realistic. Generalized feedback on the timeline stratified by organization type is summarized herein.

3.1 Academic Organizations

Four of seventeen academic organizations that provided feedback on the timeline specifically noted that the meaningful use timeline is too aggressive. The others voiced concern on specific issues, but did not specifically suggest changes to the timeline. For example, at least one academic organization suggested that the proposed measures will slow providers down and prolong the time it takes for the healthcare industry to adopt health information technology. This may result in resistance from providers which may ultimately delay meeting the goals and objectives in the timeline. Furthermore, two organizations indicated that the health IT vendors are not prepared to implement modifications to meet the goals and objectives which will result in additional delays.

3.2 Government Organizations

Five of the 25 government organizations that provided input on timeline indicated that the meaningful use timeline is too aggressive. All of these respondents were state agencies. Two other government organization respondents highlighted the need to modify timeline requirements specifically for CPOE (to move it to 2011) and clinical decision support (to push this back from 2011). A few government organizations indicated that there are too many objectives to address. Two organizations commented



that measures should take into account potential reductions in productivity during the initial adoption phases. Another organization noted that adoption of health IT among small and medium sized practices will be dependent on the receipt of loans and technical assistance programs. As such, delays in distributing funding and providing support will impact ability to achieve the goals established in the timeline. One entity suggested that requirements to enable connectivity with HIOs/RHIOs, where applicable, should be added to the timeline.

3.3 Hospitals

Approximately 40 percent of the hospital (70 of 165) organizations that responded to the timeline indicated that the meaningful use timeline is too aggressive, with several citing the current economic climate as a major barrier. Sixty-four organizations suggested that requirements related to CPOE and medication reconciliation should occur in later years rather than in 2011. Other feedback received on the timeline suggested that the implementation of quality measure reporting should also be pushed back. There were several specific reasons given for a need to delay the timeline, including concern that requirements for interoperability with ambulatory EHRs and PHR systems will add time to the deployment phase, concern that vendors are not prepared to support the goals as referenced in the timeline and the time needed to create effective change within organizations. A few noted that change management, even in large organizations with significant resources, is complicated and can delay implementation timelines. Two hospital organizations suggested the need to distinguish between what providers have responsibility for and what hospitals are responsible for with regard to achieving meaningful use objectives. One organization suggested that meaningful use should be decoupled from patients' adoption of PHRs, suggesting that hospitals cannot be responsible for how patients adopt technology outside of the care setting. Several organizations stressed the need to ensure ARRA funding is allocated to the institutions that need funding the most, specifically among small hospitals and provider practices that have not yet adopted health IT.

3.4 Health Information Organizations

Feedback from HIOs and RHIOs regarding the meaningful use timeline was mixed across the 11 respondents who submitted comments on the timeline. One HIO indicated that the timeline is too aggressive, while another organization, a RHIO, was positive about the matrix and timeline. One HIO noted that some requirements can be met in areas where EHRs are in place and exchange is occurring. One HIO expressed concern about the ability for rural hospitals to meet requirements as specified in the timeline.



3.5 Industry

Feedback from industry organizations regarding the meaningful use timeline was also diverse. Eight of the 110 industry organizations that responded to the timeline indicated that the meaningful use timeline is too aggressive, with nine organizations specifically noting that the timeline associated with CPOE adoption is unrealistic. Several entities indicated that the implementation of CPOE is challenging and time consuming given the many workflows, interactions and processes that need to be reconfigured. A few industry organizations cited the current economic climate as a compounding issue related to health IT adoption and as a barrier to achieving progress toward the meaningful use measures and objectives. Several industry organizations cited that vendors are not prepared to meet the requirements of meaningful use. As such, industry organizations suggested changes such as the allowance for incentive payments for partial meaningful use, and the extension of incentives beyond 2015 with a corresponding delay in penalties. A few industry organizations suggested that all the requirements specified in the timeline cannot be achieved at once, and as such, priority areas need to be determined. One organization suggested that meaningful use should also include practical use measures, since initial adoption will reduce productivity.

3.6 Information Technology Organizations

Three of the 16 IT organizations that responded to the timeline indicated that the meaningful use timeline is too aggressive, while four IT organizations suggested that the timeline associated with CPOE adoption is unrealistic. Other commentary suggested that the timeline to achieve quality reporting standards and patient access objectives are too aggressive.

3.7 Non-Profit Organizations

Approximately 20% of the 43 non-profit organizations that provided input to the timeline indicated that the meaningful use timeline is too aggressive. Two non-profit organizations commented that the timeline for CPOE is unrealistic and too aggressive and recommended that the timeline be adjusted accordingly. Other respondents suggested that the meaningful use timeline could have the impact of marginalizing small and rural providers from the overall benefits of health IT. Consumer centric organizations provided specific feedback on the meaningful use timeline, but no trends could be inferred from the commentary.

3.8 Payors/Health Plans

Two of four payor organizations commenting on the timeline suggested that the timeline requirements to achieve meaningful use as proposed should stand, and not be delayed, while one organization suggested that the timeline is too aggressive. One payor organizations suggested allowing for optionally in adoption of certain functionality as opposed to an all or nothing approach.



3.9 Providers

Twelve of the 59 provider organizations commenting on the timeline and entities that responded indicated that the meaningful use timeline is too aggressive. Eight provider organizations specifically suggested that the timeline associated with CPOE adoption is too aggressive. Two organizations noted that the timeline is too ambitious for clinicians and small practices that are just beginning to consider the purchase and integration of EHRs into their clinical setting.

3.10 Feedback on the Meaningful Use Matrix

Exhibit 2 stratifies feedback on the timelines associated with the care goals in the Meaningful Use Matrix. Only those care goals and objectives that received feedback are included in the exhibit.



Exhibit 2. Summary of feedback received on the Meaningful Use Matrix stratified by organization type.

| Proposed Year | Care Goal | Total Number of Comments | Academia | Government (State Agencies) | Hospitals | HIOs | Industry | IT | Non-Profits | Non-Profit Consumer Groups | Payors | Providers |
|---|--|--------------------------|----------|-----------------------------|-------------------|------|----------|-----|-------------|----------------------------|--------|-----------|
| 2011 | Use of CPOE | 92 | 1-C | 2-C | 64-C | 1-C | 9-C | 5-C | 2-C | | | 8-C |
| | Use of e-Prescribing | 7 | | 1-A | | | 2-A | 2-C | | | | 2-A |
| | Provide patients with electronic copy of- or electronic access to-clinical information (including lab results, problem list, medication lists, allergies) per patient preference (e.g., through PHR) | 9 | | 1-C | 5 ⁺ -B | | | | 1-C | | | 2-B |
| | Report quality measures | 2 | | | 1-C | | | 1-C | | | | |
| | Send reminders to patients per patient preference for preventive /follow up care | 2 | | | | | 1-C | | | | | 1-C |
| | Record primary language, insurance type, gender, race, ethnicity | 2 | | | 1-C | | 1-C | | | | | |
| | Implement drug-drug, drug-allergy, drug-formulary checks | 2 | | | 2-C | | | | | | | |
| | Incorporate lab-test results into EHR | 1 | | | 1-C | | | | | | | |
| | Provide clinical summaries for patients for each encounter | 2 | | | | | | | | | | 2-C |
| | Exchange key clinical information among providers of care (e.g., problems, medications, allergies, test results) | 1 | | | 1-C | | | | | | | |
| | Maintain active medication list | 1 | | | | | | | | | | 1-A |
| 2013 | Record patient preferences (e.g., preferred communication media, advance directive, health care proxies, treatment options) | 1 | | | | | 1-A | | | | | |
| | Conduct medication administration using bar coding | 3 | | | 1-A | | 1-A | | | | | 1-A |
| | CDS at point of care | 11 | | 1-A | | | 8-A | 1-A | | | | 1-C |
| | Record clinical documentation in EHR | 8 | | | 2-A | | 4-A * | | | | | 2-B |
| | Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge) | 1 | | | | | 1-A | | | | | |
| | Use of evidence based order sets | 4 | | 1-A | 1-C | | 1-A | | | | | 1-C |
| Retrieve and act on electronic prescription fill data | 1 | | | | | 1-A | | | | | | |



| Proposed Year | Care Goal | Total Number of Comments | Academia | Government (State Agencies) | Hospitals | HIOs | Industry | IT | Non-Profits | Non-Profit Consumer Groups | Payors | Providers |
|---------------|--|--------------------------|----------|-----------------------------|-----------|------|----------|----|-------------|----------------------------|--------|-----------|
| | Report to external disease (e.g., cancer) or device registries | 1 | | | | | 1-A | | | | | |
| 2013 | Documentation of family medical history | 3 | | | | | 1-A | | | | | 2-A |
| | Upload data from home monitoring devices | 3 | | | | | 3-A | | | | | |
| | Manage chronic conditions using patient lists and decision support | 5 | | 1-A | | | 3-A | | 1-C | | | |
| | Perform medication reconciliation at each transition of care from one health care setting to another | 1 | | | | | 1-A | | | | | |
| | Provide access to patient-specific educational resources in common primary languages | 2 | | | | | | | 1-A | 1-A | | |
| | Offer secure patient-provider messaging capability | 6 | | | | | 4-A | | | 2-A | | |
| | Receive health alerts from public health agencies | 1 | | | | | | | | | 1-A | |
| 2015 | Multimedia support | 3 | | 1-C | | | 2-A | | | | | |
| | Electronic reporting on experience of care | 1 | | | | | 1-A | | | | | |
| | Provide patients, on request, with an accounting of treatment, payment, and health care operations disclosures | 1 | | | | | 1-A | | | | | |
| | Access for all patients to PHR populated in real time with data from EHR | 8 | | | 5-C | | | | | | 1-A | 2-B |
| | CDS for high priority conditions | 1 | | 1-A | | | | | | | | |
| | Medical device interoperability | 5 | | | 2-C | | 2-A | | | 1-A | | |

Key:

| | |
|--|--|
| The numbers in each cell represent the number of comments received by organization type. | |
| A | Majority of respondents suggest pushing the timeline up |
| B | Responses were split (no clear majority) between pushing the timeline up or back |
| C | Majority of respondents suggest pushing the timeline back |
| + 3 respondents proposed to move this measure back | |
| * 1 respondent proposed to move this measure back | |



4.0 Measures

Slightly more than one quarter of all respondents provided input on the measures proposed by the Meaningful Use Workgroup. Respondents' comments focused primarily on the ability of the measures to represent the spectrum of health care practice, the types of measures, and the clarity of measures.

About half of those who provided comments on measures suggested additional measures. Quality and safety measures were the most frequently mentioned across a range of stakeholders: academic institutions, government entities, providers, not-for-profit organizations, industry, and individuals. Another area offered for inclusion was measures for specific clinical specialties (for example, pediatrics, dental health, oncology). A few respondents also mentioned including measures that demonstrate actual health information exchange across entities; measures that reflect the use of EHRs to capture and store clinical information; public health/population measures; cost and efficiency measures; and measures of patient and family engagement.

Approximately 20% of respondents who provided comments on measures advocated that measures of meaningful use should not be created *de novo* but should borrow from already developed measure sets which have been endorsed and approved by national organizations. For instance, several hospitals and academic institutions that commented on meaningful use metrics recommended adoption of measures endorsed by NQF. Several hospitals and hospital associations also suggested that measures adopted by the Hospital Quality Alliance be used to measure meaningful use, and several governmental agencies and departments of public health suggested using measures from Healthy People 2020. Some hospitals, providers, and several other stakeholders also asked that reporting burden be minimized by utilizing measures from measure sets already used for reporting, such as the Joint Commission Core Measures and the CMS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) measures for hospitals, and the CMS Physician Quality Reporting Initiative (PQRI) measures, National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) measures for physicians.

Respondents from virtually all stakeholder groups requested that there be "more clarity" in the definitions of the measures. Requests included the need for thresholds or defined percentages that indicated achievement of meaningful use, and the need to better define terms such as "coded format," "permissible prescriptions," "fair data sharing" and "under control." Another representative example that demonstrates the need for specific definitions includes the classification of smoking status which includes multiple categories (old vs. new smoker, intermittent, vs. social, recovered, etc).



5.0 Privacy and Security

Eighty-three respondents from virtually every stakeholder group submitted comments about the proposed privacy and security objectives and measures.

The most common concern, found primarily among hospitals but also shared by respondents within the provider, government, industry, and information technology groups, was the proposed inability to achieve meaningful user status for organizations under investigation for a HIPAA violation. Three respondents pointed out that at any given time, many large provider organizations are under investigation for an alleged violation, but these cases either result in corrective action or a finding of no violation. They noted that not only will this proposal unfairly penalize some organizations, but it might also lead to unintended consequences.

Six respondents across multiple stakeholder groups also questioned why meaningful use needed to include privacy and security objectives and measures, stating that this was creating redundancy to HIPAA and was unnecessary, since it does not directly affect patient care. Others agreed that privacy and security should be included as part of a meaningful use definition, but wanted to ensure that the definition, including the specific objectives and measures, aligns with HIPAA.

A few organizations noted that language in the objectives and measures section on privacy and security needed to be clarified. Terms that respondents felt need more definition included: "compliance" (with HIPAA and fair data sharing practices), "fair data sharing practices," and "sensitive health information" or "sensitive data."

6.0 Patients and Family

Thirty-two respondents across all stakeholder groups provided comments that addressed issues related to engaging patients and families as part of meaningful use. The comments focused on the types of functionality that should be made available to patients and families, the importance of patient preference, and access to educational materials.

Half of the comments received on issues related to patients and families spoke to specific technical functionality that should be available (or not available) to patients and families, and in what timeframe they should be offered. The Meaningful Use Matrix includes an objective for 2011 that indicates that patients should have an electronic copy of or electronic access to lab results, problem lists, medication lists, and allergies. A cross section of respondents, including one hospital, one government hospital, and two industry organizations suggested it was not realistic or desirable to allow patients access to personal health information via a PHR until at 2013 or beyond, with some of these respondents indicating that EHR implementation and secure provider-patient



messaging should occur first. Some respondents also questioned what modality besides a PHR would be considered acceptable as a vehicle to meet this 2011 requirement for meaningful use. Most believed that secure messaging, health education, and documentation of patient preference might be more feasible areas than PHRs to begin patient engagement and could be candidates for 2011 objectives.

Five respondents expressed concern over patients having full access to their record (due to legal risk, provider burden, and others), and recommended instead that some type of summary or subset of data be offered to patients and other authorized caregivers.

Five respondents commented on the use of the term “patient preference” within the Meaningful Use Matrix. While all felt consideration of patient preference was vital, a few believed the definition too open-ended or broad, and requested further clarification and/or more specificity. One respondent identified the need to better educate patients prior to recording patient preferences for the areas described in the Matrix. Another respondent, because of the importance of the topic, believed that the patient preference objective aligned to 2013 should be a higher priority than the patient access objectives scheduled for 2011.

Respondents who commented on educational materials agreed that patients need access to these materials; several specifically mentioned patient decision support and self-care management tools. However, opinions varied on how to deliver education (via computer or via nursing staff) and in what timeframe.

7.0 Consumer Perspectives

Eighteen organizations representing consumers provided comments on the definition of meaningful use. Six of these organizations represented a consortium of multiple consumer groups or business leaders interested in consumer issues. Comments were provided on timeline, privacy and security, scope, measures, and specific populations that should be addressed in the definition for meaningful use of EHRs.

Six consumer organizations commented on the timeline for demonstrating meaningful use. Comments focused on advancing specific care objectives to an earlier year than proposed. Two organizations indicated that secure messaging should be moved up from 2015, with one of these organizations suggesting that it should be moved to 2011. One organization suggested that care coordination and care transition measures should be moved to 2011, two organizations indicated that research objectives should be included in 2011, and another organization indicated that functional status objectives should be included in 2011. Another organization indicated that by 2013, they would like to see patients able to access all of their data, not just lab results and problem lists.



Three consumer organizations provided input on privacy and security. One organization indicated that the ability for patients to control the use and disclosure of all protected health information was critical for demonstrating meaningful use of EHR data. The other two organizations articulated the need for a nationwide privacy and security framework and the need for patient consent for registry reporting, though neither of these comments was tied back directly to meaningful use.

A few consumer organizations provided input on topic areas they would like to see included and/or emphasized in the definition of meaningful use. Examples include the ability to correct errors/fraud in EHRs; management of chronic conditions; effectiveness and efficiency of healthcare services; adverse event reporting; transitions across care settings; linkages to public health screening programs, immunization registries, and non-medical specialists such as schools.

A few consumer organizations suggested areas where measures were needed, though they were not always explicitly linked back to demonstration of meaningful use. Examples of suggested areas for measures include newborn screening, child health (specifically measures endorsed for use in Medicaid and CHIP), measures that help identify deficiencies in treatment (e.g., appropriate use of antibiotics, imaging, diagnostics, and labs) and medical errors, cardiovascular risk factors, childhood immunizations, imaging, emergency room use by asthmatics, alcohol and tobacco use, and re-hospitalization. Two respondents also referenced the need for more outcome measures, with one emphasizing outcome measures for patient engagement, care coordination, and population health.

Finally, two consumer organizations provided input that the meaningful use definition should address the need of populations with special needs such as children and the underserved, as well as Native Americans.

8.0 Certification

Sixty-seven unique comments were received regarding the certification of EHRs as it relates to meaningful use. Respondents' comments focused on a variety of topics, including perspectives on the link between certification and meaningful use, the need for certification, the role of a certification entity, the certification process itself, and the readiness of vendors and the health IT community to comply with standards and deliver certified EHR products. Feedback on these topics varied across all stakeholders, with no common perspectives shared within or across stakeholder groups.

Respondents who commented on the linkage of meaningful use to certification asserted that certification standards should support the goals and definition of "meaningful use."



Two individuals specified that they supported establishment of meaningful use criteria based on the Certification Commission for Health Information Technology's (CCHIT) 2007 required inpatient functionality (computerized physician order entry, clinical decision support, and closed-loop medication administration). One of these respondents further expressed the perspective that the use of criteria where standards already existed would facilitate the ability of providers to more easily meet 2011 objectives. One respondent encouraged the government to consider certification of meaningful use in the context of health IT solutions that incorporate multiple technologies that work together to achieve meaningful use goals and standards.

About a third of the respondents who commented on certification provided input on the functionality, domains, or technical areas that certification should encompass, though not all respondents tied this feedback directly to meaningful use. Referenced areas included:

- The ability to add new features
- Interoperability standards
- Specific functions for EHR such as dictation-transcription, and uniformly formatted and coded narrative reports

One respondent mentioned the need to prioritize certification processes for EHRs supporting high revenue departments such as surgery, critical care, cardiology, radiology, obstetrics and gynecology, and oncology. A few respondents referenced other specialties where they would like to have EHR certified products, including pediatrics, dentistry, and ophthalmology. One respondent referenced the need for HIO and RHIO certification. Another respondent indicated that they did not feel there was a need for certification at all.

Some respondents provided input on the need for a certification entity and the process this entity should use to certify products. Of these respondents, a few indicated that they did not feel CCHIT should continue to maintain this role, with one respondent citing CCHIT's close relationship with vendors as a potential conflict of interest. Another respondent indicated that the certification of standards should be left to the government. However, other respondents were supportive of CCHIT efforts. Suggestions regarding certification processes included a recommendation that a scoring system be used in lieu of certification. In addition, several respondents suggested that a focus on maximizing existing standards (ex: SNOMED, CHI, HL7, xHR) could help to conserve costs and indicated that mandating new standards may cause delays in the creation of new and innovative technologies.

Some respondents also voiced doubt as to the readiness of EHRs and the health IT community (including vendors) to comply with certification requirements. Several were



specifically concerned that current EHRs do not have the functionality to comply with the standards needed to demonstrate meaningful use.

9.0 Other Key Themes

There were several recurring themes in the received comments that did not fit into any of the previously discussed categories. These comments included general concerns, as well as the topics of partial incentives and medical transcription.

Regardless of timeline, there were some respondents who expressed general concerns around the effectiveness of EHRs, specifically when compared to the cost of the product and the perceived negative impact on care delivery. Several respondents who expressed concern indicated that these systems did not work as intended, had not met their needs, or were too cumbersome, and questioned the true value of the system. A few respondents stated that the cost of the system was too much and some, mainly those in smaller physician practices, mentioned that incentives were not enough to spur adoption because the money would be received too late. Some hospitals expressed resistance because of perceived physician resistance.

To make the incentive process more manageable, 40 unique respondents, from hospitals, providers, and industry, recommended partial incentives. Most that mentioned this idea suggested interim incentives to provide funding for partial functionality as they proceed to full implementation. Respondents suggested a phased approach, to receive funding for accomplished modules or meeting interim goals sooner; for example, providing a reward for meeting a past year's objectives. Several respondents recommended two tracks for incentives, one for early adopters (to make improvements and provide retrofits to prepare for interoperability) and one for new adopters. Some recommended there be different criteria for different categories of providers, such as rural and critical access hospitals who may be more challenged by broadband access, or various types of providers who may be more constrained in their ability to fund office EHRs. Separate tracks were also recommended for behavioral health and homecare providers.

There were a significant number of responses from the medical transcriptionist community. Most of the comments from this stakeholder group advocated the value of medical transcriptionists citing the "crucial role the medical transcription sector plays in clinical documentation by ensuring the accuracy and completeness of patient health records."