February 3, 2014

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Marilyn Tavenner, RN
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Karen DeSalvo, MD
National Coordinator for Health Information Technology
Department of Health and Human Services
Room 729-D, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: ACP Concerns Regarding Efforts to Increase Meaningful Electronic Health Record
Implementation

Secretary Sebelius, Ms. Tavenner, and Dr. DeSalvo:

The undersigned members of the American College of Physician's (ACP) Council of
Subspecialty Societies (CSS) are writing to share our views on issues related to the federal
government's efforts to promote the clinical use of electronic health record (EHR) systems, the
development of necessary communication standards to support such use, and the way the
Meaningful Use (MU) program is being used to achieve the goal of widespread EHR
implementation.

Our comments complement recommendations previously provided to each of your agencies by
ACP in a letter dated September 12, 2013 available at
http://www.acponline.org/acp_policy/letters/acp_letter_meaningful_use_concerns_2013.pdf .
We, the undersigned, agree with these recommendations, which supported:

- the timetable for 2014 certified technology.
- providing more time for providers to begin their reporting on Stage 2 measures.
- additionally extending Stage 2 by at least one year.
- ongoing efforts to make clinical quality measures (CQM) better and aligned not just to
  measuring activity, but improving quality.

- de-coupling certification requirements from Eligible Professional (EP) implementation and reporting requirements.
- switching to a more flexible scoring system that recognizes the differences in practices and the differences between incentives and penalties:
- a less prescriptive approach to workflow requirements that allows practices to address the unique characteristics of their practice, specialty, and patient population.
- Stage 3 rulemaking that is guided by the intent of Meaningful Use and further informed by where most providers should be at that point in their Meaningful Use journey; which is the ability to successfully attest solely by their participation in an appropriate variety of deeming activities, such as participation in Million Hearts®, national registries, or other specified Maintenance of Certification (MOC) programs.

Members belonging to the undersigned organizations of ACP's CSS provide a significant portion of specialty and subspecialty care to Medicare beneficiaries, and we are concerned that current efforts to expand EHR implementation are unintentionally serving as a barrier to our ability to provide effective and efficient coordinated care to our patients throughout the medical neighborhood. We offer the following comments and recommendation to help address these concerns:

Meaningful Use Objectives and Clinical Quality Measures (CQM)s --- Measures currently available and required under MU Stage 2 are not relevant to many specialties/subspecialties --- requiring them to measure various aspects of care that do not contribute to their diagnostic and treatment efforts. The emphasis of these measures is on primary care workflow and expectations, not specialty care. Some examples of these inappropriate measures include recording height and weight; reminders for preventive/follow-up care; and capability to submit electronic data to an immunization registry. This results in unnecessary burden and cost to practices, and competes with the need to efficiently use the limited time available to provide direct clinical care. It also promotes a "check the box" approach, rather than true meaningful use that advances patient care. In order to address this problem, the undersigned recommend increased physician flexibility in choice of required measurement, better exclusion criteria to eliminate the need to report inappropriate, and at times duplicative measures, and more specialty input to develop meaningful measures for their specialty area.

HL7 Clinical Document Architecture (CDA) ---The standards included in the new version of the Consolidated CDA (C-CDA) currently going through the balloting process have received minimal input from clinical specialty societies, are not aligned with the needs of our members, and are too wedded to current practices, as opposed to the innovations being encouraged and developed based on the implementation of value-based payment systems. More specifically;

- None of the undersigned groups were formally involved in the development process or requested to review the developed standards. ACP's CSS has been formally working on the area of improved care coordination since 2007 and these efforts have resulted in a 2010 policy paper "The Patient-Centered Medical Home Neighbor: The

Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices" available at
http://www.acponline.org/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf
and more recently the initiation of a High Value Care Coordination (HVCC) project with the goal of developing a set of recommendations and tools to facilitate more effective and efficient patient-centered referral and referral response interactions between primary care and specialty/subspecialty practices. Yet this expertise and knowledge has not been tapped to help inform the development of this new C-CDA.

- There are increased needs and opportunities for care coordination among providers within the medical neighborhood, which would be facilitated by standards that;
    o allow bi-directional dialogue among practices;
    o provide a framework allowing e-consultations; and
    o require communication of acknowledgements regarding clinical information provided, appointments being kept and referrals being completed. These "closing the loop" requirements would mitigate a number of safety and liability concerns.

Increased Usefulness and Efficiency in Clinical Data Transmission --- There is increased need to indicate in provided clinical information the data that are **truly important**; rather than the current trend to send large amounts of data from one provider to another (data-dumps) without any rapid means of directly assessing the relevant information connected to the specific use case. Approaches that facilitate the delivery of a synopsis of findings or referral information are needed.

Increased Standardization in Interoperability Approaches --- There is a need for increased standardization in approaches towards interoperability to facilitate efficient communication among providers. Current activity that encourages (or at least permits) multiple networking standards and approaches, makes efficient electronic communication difficult and quite costly --- particularly to the small practice. There is a need for a more uniform approach or set of approaches**.**

Increased Need to Prioritize EHR Usability within the Certification Process ---The EHR as a clinical tool has great potential to assure that the physician has the appropriate information available for patient care and to assist in the coordination of patient care across different physicians and even different systems. The American Medical Association (AMA) recently commissioned a study of physician satisfaction performed by the RAND Corporation (http://www.rand.org/pubs/research_reports/RR439.html#key-findings). One of the findings is that physicians are highly dissatisfied with the **usability** of EHR systems. The lack of usability and the resulting disruption of the workflow in the office is a major source of physician dissatisfaction. The lack of usability is a major barrier to physicians effectively using the EHRs and as a result is a major barrier to the clinical benefits of the EHR. We strongly encourage the ONC to prioritize expanded usability requirements within the EHR system certification process.

Meaningful Use Timeline --- The undersigned commend ONC and CMS for their December 6, 2013 decision to extend Stage 2 Meaningful Use through 2016 and delay the beginning of Stage 3 requirements until 2017. We agree that this change will facilitate the successful implementation of the enhanced patient engagement; interoperability and health information exchange functionalities required under Stage 2 and allow some increased time to utilize data from Stage 2 participants to inform the development of Stage 3 requirements. **Nonetheless, we remain concerned that many of the physicians represented by our societies, particularly those in small practices, will continue to have significant difficulties meeting Stage 1 and/or Stage 2 requirements in time to avoid the 2015 payment adjustment. This difficulty is a result of limited personnel and financial resources as well as the low priority these practices received from vendors to implement necessary health information technology and related updates. Thus, we are formally requesting that the 2015 penalty also be postponed for at least one (1) year.**

We, the undersigned societies, recognize the many benefits that can be provided through the meaningful use of interoperable EHR systems. Current efforts, while laudable, can be improved through increased input from the physician community and other healthcare professionals directly engaged in the day-to-day delivery of care. We are committed to assist efforts both within the federal government and private sector towards effecting this improvement. Please contact Neil Kirschner, Ph.D. at (202) 261-4535 or nkirschner@acponline.org if you would like to discuss our concerns and recommendations in greater detail.

Sincerely,

American Academy of Allergy Asthma and Immunology	American Medical Society for Sports Medicine
American Academy of Neurology	American Society of Clinical Oncology
American Association for the Study of Liver Diseases	American Society for Gastrointestinal Endoscopy
American College of Allergy, Asthma and Immunology	American Society of Hematology
	American Society of Nephrology
American College of Chest Physicians	American Thoracic Society
American College of Physicians	Endocrine Society
American College of Rheumatology	Renal Physicians Association
American Geriatrics Society	Society of Critical Care Medicine
	Society of General Internal Medicine