

NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health

March 15, 2010

Ms. Charlene Frizzera, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Ms. Frizzera:

On behalf of the National Association of County and City Health Officials (NACCHO), I appreciate the opportunity to provide input into the proposed rule for the electronic health record (EHR) incentive program.

As a leader, partner, catalyst, and voice for the nation's 2700 local health departments (LHDs), NACCHO seeks to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives. NACCHO does this by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

Structure of Comments

NACCHO makes its comments from both an eligible professional (EP) and a population health point of view. Approximately one-third of LHDs provide comprehensive primary care services as safety net providers, and they often serve a large Medicaid population. These LHDs, and their eligible professionals, could potentially become meaningful users and qualify for Medicaid bonus payments. All comments made from a provider perspective relate to eligible professionals and not hospitals.

All LHDs, regardless of their clinical service provision, have an interest in improving population health outcomes. NACCHO is therefore submitting comments on the proposed rule with a view to facilitating this mission. The two perspectives being offered run parallel throughout this document under different headings.



General comments

- NACCHO is strongly supportive of the population health objectives and measures included in the proposed rule. NACCHO believes that the areas chosen, and measures used, generally strike the correct balance between advancing the use of data for population health improvement and recognizing the limitations that exist with the current technology. More specific comments are included in the relevant section below.
- NACCHO is working with its members to promote the adoption of health information technology (HIT) that will assist LHDs in achieving meaningful use. In addition, NACCHO and LHDs are beginning to identify best practices for making use of the information that will become available to public health agencies. NACCHO looks forward to continuing to work with the Centers for Medicare and Medicaid Services (CMS), the Office of the National Coordinator for Health Information Technology (ONC), and other federal partners, such as the Centers for Disease Control and Prevention (CDC), to advance LHDs' use of HIT.
- It is important to recognize that almost all LHDs provide some level of individual care, such as maternal and child health services, tuberculosis case management, immunizations, refugee health, and sexually transmitted disease clinics. These services, while not comprehensive primary care, all generate large amounts of data that form an important part of a patient's record. As it currently stands, there are no financial incentives for LHDs to develop systems that will feed into the network of EHRs and health information exchanges (HIEs) being promoted through the Health Information Technology for Economic and Clinical Health (HITECH) Act. Without an expanded interpretation of "meaningful use," or a separate system of financial incentives, this information will remain disconnected from other patient data and an opportunity to improve the quality of care will be missed.
- As the proposed rule notes, the infrastructure necessary to support the electronic exchange of information has yet to be developed in many parts of the country. This is particularly true for LHDs, which have varying capacity to send and receive data electronically. In a recent NACCHO survey of LHDs, only 42 percent of LHDs regularly send or receive data electronically with hospitals, and 27 percent do so with other health providers. This situation is likely to be slow to change given the dire economic situation in which LHDs find themselves. There is a risk that one of the five key goals identified by ONC and CMS for the use of EHRs, improving population and public health, will not be achieved without additional investment. NACCHO recognizes that rectifying this situation is outside the purview of this proposed rule but would like to point out that meaningful use will not be fully achieved simply by widespread adoption of EHRs.

Specific Comments

Section II: Provisions of the Proposed Regulations

A. Definitions across the Medicare FFS, Medicare Advantage, and Medicaid Program

1. e. EHR Reporting Period

Provider Perspective

- **NACCHO agrees with the 90 days reporting period for the first year and full year in subsequent years.** NACCHO believes this is beneficial for Medicaid providers, especially LHDs, by allowing them more time to implement meaningful use of EHRs.

2. b. Common Definition of Meaningful Use under Medicare and Medicaid

Population Health Perspective

- **NACCHO supports the ability of state Medicaid agencies to apply additional criteria as is currently outlined in the rules.** This provides sufficient flexibility to create additional definitions of meaningful use for Medicaid EHR incentive programs, such as requiring additional transfer of population health information among public health agencies and providers. **NACCHO recommends that the Secretary of Health and Human Services consider the extent to which LHDs have been consulted when evaluating proposed alternatives.**

2. c. Considerations in Defining Meaningful Use

Provider Perspective

- **NACCHO supports the proposed phasing of meaningful use.** It is a good compromise between advancing meaningful use and allowing providers to adjust to the use of EHRs. Technology will mature allowing later adopters to move to Stage 3 in a shorter time period.

Population Health Perspective

- **NACCHO strongly advises moving “improving population health” from Stage 3 to Stage 2.** This will allow public health agencies to gain a sense of, and comment on, what will be expected of providers in terms of population health. The vision of bidirectional transfer of health information among providers and public health agencies relies on both parties implementing systems capable of electronic exchange. Currently, few LHDs have the capacity to interact in this way. NACCHO’s recent informatics needs assessment found that just 22 percent of LHDs were involved with an HIE in their area. If public health agencies are going to expend scarce resources in pursuit of bidirectional information exchange, they are more likely to do so when all the functional requirements are able to be anticipated. This reduces the likelihood that continuous change and investment will be required to keep up with meaningful use requirements.

2. d. Stage 1 Criteria for Meaningful Use

Improving Quality, Safety, Efficiency, and Reducing Health Disparities

Provider Perspective

- Use computer physician order entry (CPOE): **NACCHO suggests lowering the CPOE requirement from 80 percent to 50 percent.** The current threshold may be unrealistic for smaller LHDs and those that are transitioning to EHRs.
- Implement drug-drug, drug-allergy, and drug-formulary checks: **NACCHO recommends adding drug-age-weight checks to this list of requirements.** It is very relevant to pediatricians and many vendors already provide this functionality.

Population Health Perspective

- Record the following demographics: preferred language, insurance type, gender, race and ethnicity, and date of birth: **NACCHO supports the inclusion of all of these demographics because they are important components for identifying disparities and high-risk populations** (e.g., this would have been useful for the response to the H1N1 pandemic). It is also crucial to be able to link demographic, disease and risk factor information with a patient's address to examine spatial differences. Where a person lives and works plays an important role in their behaviors and health outcomes. **NACCHO recommends adding patient's address to the list of required data elements, or creating another mechanism to ensure that it can be linked (for example from billing information).**
- Record and chart the changes in the following vital signs: height, weight and blood pressure..., including BMI: **NACCHO supports the inclusion of these vital signs.** Obesity is a leading cause of death and disease in this country and recording this information in a systematic way will allow both providers and public health agencies to better respond to the needs of a community.
- Record smoking status for patients 13 years and older: **NACCHO supports including this objective, but recommends lowering the age limit for recording this information to 12 years** for two reasons: 1) though the proportion is small, smoking initiation does take place among 12-year-olds, and 2) this would be in line with other statistics relating to tobacco use (e.g., those collected by the Substance Abuse and Mental Health Services Administration and the National Cancer Institute).^{1,2} **NACCHO also suggests that CMS clarifies whether only tobacco smoke is to be recorded or if this measure includes other products.**
- **NACCHO recommends adding an additional objective or modifying the previous objective to record exposure to tobacco smoke in the home among children aged 18 years and younger.** Children are more heavily exposed to secondhand smoke than adults, and the health risks from this exposure are numerous.³ Collecting this information will not only help practitioners provide better care for their patients, but will also allow LHDs to better understand and respond to the needs of their communities.
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach: access to this information will greatly improve the ability of public health agencies, particularly local health departments, to conduct public health syndromic surveillance and respond to the needs of their community. For example, the data could be used for a community needs assessment

or quality improvement for hospital-acquired infections. **NACCHO recommends changing this objective to allow local public health agencies to request and receive not only lists of patients by specific conditions (syndromes), but also relevant demographic and spatial data.** The corresponding measure will also need to be adjusted to reflect the change. **NACCHO suggests that EPs and hospitals be required to generate both a report for their own purposes and one for LHDs.**

- Send reminders to patients per patient preference for preventive/follow-up care: NACCHO disagrees with CMS's assertion that patients over the age of 50 are more likely to require additional preventive or follow up care. For example, many children require preventive and follow up visits, particularly for immunizations (in this case the reminder would go to the child's parent or guardian). **NACCHO advocates that providers be able to choose where to focus their follow up efforts based on the needs of their patient base, and recommends that the measure be changed to this effect. NACCHO supports maintaining a 50 percent threshold for patients for Stage 1, but suggests increasing it in later stages.**
- Check insurance eligibility electronically from public and private payers: **NACCHO supports the inclusion of this objective.** It allows for more people to be referred to safety net providers (including LHDs) where they otherwise may not receive care. It also allows for decision makers to gain a greater understanding of the burden that exists in a community due to people lacking adequate insurance.

Engage Patients and Families in their Health Care

Provider Perspective

- Provide access to patient-specific resources upon request—**NACCHO disagrees with CMS's decision to not include this measure.** There are an increasing number of vendors who are demonstrating this ability in their EHR products, including information in other languages. Including this objective, even with measures that allow for patients to opt in (in a manner to the measure for reminders), will strengthen the objective of engaging patients and families in their health care.

Population Health Perspective

- Provide patients with timely electronic access to their health information (including lab results, problem lists, medication lists, allergies) within 96 hours of the information being available to the EP: **NACCHO urges that consideration be given to how health information will be reconciled if different storage mediums are used by providers and patients (e.g. in a personal health record and an EHR).**

Improve care coordination

Provider Perspective

- Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically: **NACCHO strongly supports this objective.** Many LHDs provide primary health care services to incarcerated individuals in local jails and having the capability to exchange information is vital for providing quality care and discharge planning.

- The explanatory text for this objective specifies that “patient authorized entities” may include a personal health record (PHR) vendor. The term “exchange” implies both the capacity to send and receive information. Therefore, it is conceivable that a PHR could act as a conduit for information between providers (for example, a provider could send a medication list to a patient’s PHR, and then with the patient’s approval a different provider could access the list from the PHR, rather than directly exchanging the information between providers). **NACCHO would like clarification from CMS as to whether or not testing such a mechanism would meet the measure for the stage one objective.**

Population Health Perspective

- Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically: **NACCHO strongly supports this objective.** As noted above, most LHDs provide direct, individual care for people within their community. Having this information available to public health nurses and other public health professionals will greatly improve the quality of care delivered.
- It is equally important that providers be able to receive clinical information from LHDs (where they have been able to implement the appropriate HIT). For example, LHDs that provide Women, Infants and Children (WIC) services measure height, weight, and hemoglobin information. Providing this information electronically would avoid duplicative testing.

Improve Population and Public Health

Population Health Perspective

GENERAL COMMENTS

- **NACCHO strongly supports the inclusion of population health objectives in the proposed rule.** Their presence will greatly increase the ability of local health departments to respond to public health issues in their community, and to communicate with providers and the public about these issues.
- **NACCHO is supportive of the three subject areas chosen to be covered by the objectives—**immunizations, laboratory reports, and syndromic surveillance—because these areas are the most developed in terms of the electronic collection, storage, and transfer of information. Starting with these topics will allow both providers and public health agencies to experience early gains during the widespread adoption of EHRs, and sets a solid platform from which to build in Stage 2.
- **NACCHO also wishes to comment on the complementary nature of the three subject areas and supports the rule’s requirement that EPs and hospitals be able to submit data in all areas (two in the case of EPs).** The H1N1 pandemic showed that public health agencies require timely and accurate access to information across all three topics. Syndromic surveillance played a crucial role in detecting outbreaks of influenza, laboratory tests helped to confirm diagnoses, and immunization registries assisted some public health agencies to target individuals at greatest risk from H1N1 and track H1N1 vaccinations.
- As the proposed rule notes, the infrastructure that is necessary to support the electronic exchange of information has yet to be developed in many parts of the country. This is particularly true for LHDs, which have varying capacity to send and receive data electronically. This situation is likely to be slow to change given the adverse economic situation in which LHDs find themselves. NACCHO’s informatics

survey found that insufficient funding was overwhelmingly seen as the biggest barrier to implementing an information system. There is a risk that one of the five key goals identified by ONC and CMS for the use of EHRs, improving population and public health, will not be achieved without additional investment. NACCHO recognizes that rectifying this situation is outside the purview of this proposed rule, but would like to point out that meaningful use will not be fully achieved simply by widespread adoption of EHRs.

- For all three objectives relating to this goal, the measure consists of at least one test of a certified EHR's capacity to submit data. For the transfer of laboratory and syndromic surveillance data, this is required only when the public health agency has the capacity to receive the information electronically. This exemption does not seem to apply for immunization information. NACCHO is working with its members and partner organizations to build the capacity to receive information electronically (notwithstanding the resource constraints mentioned in the bullet point above). These efforts will be made significantly more difficult if LHDs do not perceive that EPs and hospitals will be able to provide them with data. For EPs and hospitals, there will be diminished incentive to implement and test the capacity to exchange population health data if they perceive that LHDs or other public health agencies will not be able to receive the information (and that this will not impact their bonus payments). **NACCHO therefore recommends removing the clause that excuses EPs or hospitals from not performing a test of their exchange capacity.**
- There does not appear to be an explicit date on which the EP or hospital must perform the test, as long as it is completed by the end of the reporting period (§II.A.4.b), so conceivably a test could be performed early in the reporting period. **NACCHO recommends adjusting the measure to require an additional test should the public health agency or agencies develop the means to electronically receive information during the financial or calendar year (whichever is appropriate).**
- Although NACCHO considers the objectives and measures a good starting point, the capacity to transmit information does not ensure that the data received will be complete or correct. **NACCHO recommends that CMS or ONC develop a quality standard that ensures accurate information is transmitted.**

CAPABILITY TO SUBMIT ELECTRONIC DATA TO IMMUNIZATION REGISTRIES AND ACTUAL SUBMISSION WHERE REQUIRED AND ACCEPTED

- **NACCHO recommends that EPs and hospitals also be required to have the capability to electronically receive immunization data (where provided by the immunization information system).** This will contribute to the goal of improved care coordination (by avoiding duplicative immunizations) and also assist providers to provide a comprehensive record of immunizations for their patients (for example, at the beginning of the school year).
- The preferred term for immunization registries is now immunization information systems.

CAPABILITY TO PROVIDE ELECTRONIC SYNDROMIC SURVEILLANCE DATA TO PUBLIC HEALTH AGENCIES AND ACTUAL TRANSMISSION ACCORDING TO APPLICABLE LAW AND PRACTICE

- There appears to be a typographical error in the commentary for this objective and measure, with the text referring to immunization registries.
- **NACCHO strongly recommends that CMS include a definition of the term syndromic surveillance and specify what this means in terms of data fields.** As noted earlier, LHDs require a wide range of

information to develop public health intelligence and respond to their community's needs. **NACCHO suggests that any definition of syndromic surveillance recognizes the need for LHDs to be able to specify the information it requires.**

2. e. Request for Public Comment on Potential Health IT Functionality Measures for Eligible Professionals and Eligible Hospitals in 2013 Payment Year and Subsequent Years

- **NACCHO supports CMS's intent to raise the threshold for the objectives in Stage 2, in particular the requirement to actually transmit population health data (if this is not already required by the Medicaid agencies). NACCHO also suggests including the ability to receive certain pieces of information (e.g., health alerts) from public health agencies.** NACCHO will be working to support this goal by assisting LHDs to develop the capability to send and receive information electronically.

3. Sections 4101(a) and 4102(a)(1) of HITECH Act: Reporting on Clinical Quality Measures Using EHR by EPs and all Eligible Hospitals

Population Health Perspective

- **NACCHO is supportive of including quality measures that can have a positive impact on population health, for example those that deal with disease screening and chronic disease management.**

D. Medicaid Incentives

3. Identification of Qualifying Medicaid EPs and Eligible Hospitals

- **NACCHO considers the list of eligible professionals in the proposed rule (and therefore the Social Security Act) to be inadequate for promoting widespread adoption of EHRs.** This individualistic approach seems focused on individual or group practices made up of self-employed practitioners, and appears to overlook the value of entities such as LHDs that provide safety net care with salaried healthcare professionals. Although the legislation determines to some extent the parameters for this proposed rule, NACCHO urges CMS to broaden the scope of who is eligible for Medicaid incentives.
- The rationale for such a broadening is that it is the LHD, not each practitioner, that will take on the task, and cost, of implementing an EHR. It therefore makes sense for incentive payments to be allowed at an organizational level in some cases. In these situations, factors such as the 30 percent patient volume threshold should also be applied at the organizational level.
- **In the absence of a change to the eligibility of LHDs to receive payments, NACCHO recommends that the 30 percent "needy individual" test be available to Medicaid EPs practicing in an LHD.** As safety net providers, much like federally qualified health centers and rural health clinics, a large proportion of an LHD's patient base is made up of patients who fit into one or more of the three criteria that identify needy individuals. There is a real possibility that some EPs practicing in LHDs will not meet the 30 percent Medicaid patient threshold, even though a large proportion of their patients are uninsured.
- NACCHO would like clarification from CMS as to whether or not LHDs that implement an EHR for use by its practitioners would be considered to be "enabling and oversight of the business, operational and legal issues involved in the adoption and implementation of EHR".

7. Activities Required to Receive Incentive Payments

- **NACCHO is supportive of the ability of Medicaid EPs to receive incentive payments for adopting, implementing, or upgrading a certified EHR.** Given the financial situation of many Medicaid providers, including LHDs, this flexibility is more likely to lead to the goal of EHR adoption.

Conclusion

Thank you again for the opportunity to provide comments on the proposed rule. The meaningful use of EHRs will play an important role in improving population health and has large implications for the interaction between providers and LHDs. NACCHO hopes that the comments provided in this letter will better enable CMS and others to achieve the goals set out by the ONC Policy Committee.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert M. Pestronk".

Robert M. Pestronk
Executive Director
NACCHO

Bibliography

1. Substance Abuse and Mental Health Services Administration. *Results from the 2007 National Survey on Drug Use and Health: National Findings*. September 4, 2008.
<http://oas.samhsa.gov/nsduh/2k7nsduh/2k7results.cfm#Ch4> (accessed January 20, 2010).
2. National Cancer Institute. *Cancer Trends Progress Report - Age at Smoking Initiation*. January 8, 2008.
http://progressreport.cancer.gov/doc_detail.asp?pid=1&did=2007&chid=71&coid=703&mid (accessed January 20, 2010).
3. Department of Health and Human Services. *Children and Secondhand Smoke Exposure. Excerpts from The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2007.