

June 26, 2009

David Blumenthal, M.D.
National Coordinator for Health Information Technology
Attention: Health IT Policy Committee, Meaningful Use Workgroup
200 Independence Avenue, S.W., Suite 729D
Washington, DC 20201

Re: Comments on Initial Meaningful Use Definitions for Health IT

Dear Dr. Blumenthal:

On behalf of McKesson Corporation (hereinafter “McKesson”), I am pleased to submit comments to the Office of the National Coordinator for Health Information Technology (ONC) on the initial definitions drafted by the Meaningful Use Workgroup of the Health IT Policy Committee.

For over 175 years, McKesson has led the industry in the delivery of medicines and healthcare products. As the largest health information technology (IT) company in the world, we are actively engaged in the transformation of healthcare from a system burdened by paper to one empowered by interoperable electronic solutions that improve patient safety, reduce the cost and variability of care, and improve healthcare efficiency. Our perspective on these recommendations is based on our extensive experience with health IT and the quality, safety and efficiency improvements that can be realized by the hospitals, health systems, physicians and pharmacies that adopt such technology.

McKesson supports the vision and the conceptual framework for meaningful use proposed by the Workgroup. We agree that the key goals adapted from the National Priorities Partnership provide an effective template for defining the criteria and the progression needed to measure meaningful use over the implementation timeframe for the American Reinvestment and Recovery Act of 2009 (ARRA). We applaud the hard work and thoughtful deliberation demonstrated in developing the framework and would like to offer recommendations to improve its applicability and relevance to both physicians and hospitals.

PREAMBLE

We first recommend that you eliminate the reference to “year” in the progression of requirements for meaningful use. While useful as a guide for any provider who attempts to qualify in the first year of program eligibility, the term fails to recognize that many providers may not be ready for “first year” implementation until 2012 or 2013. We instead recommend that “2011, 2013 and 2015” be replaced with implementation phases of meaningful use which could be labeled simply “Phase 1, 2 and 3.” Alternatively, the implementation phases could be named in relationship to the goal that needs to be achieved, such as data capture, care enhancement and improved outcomes. Therefore, a provider who initially qualifies in 2013 has to only meet the requirements for Phase 1 (data capture) rather than meet the more stringent care enhancement requirements of 2013 as currently proposed.

We believe the stimulus incentives are designed to encourage the broadest deployment of qualified health IT. We are concerned, however, that the initial threshold for provider qualification in Phase 1 is too high to encourage providers to take the first step if they have not yet invested in technology. The stringent Phase 1 requirements may actually increase rather than reduce or eliminate health IT adoption disparities. As proposed, only hospitals with advanced clinical automation or larger physician practices with existing Electronic Health Records (EHRs) would be able to qualify for incentives given the comprehensive Phase 1 criteria. Our specific recommendations to make Phase 1 accessible to more providers are outlined below.

While we also agree that the recommended definition of meaningful use should depend on the healthcare setting in which it is deployed, we recommend that the criteria reference “hospital” or “physician” rather than “IP” or “OP”. Otherwise, hospitals and physicians will require more specific criteria to avoid confusion.

Finally, we have noted that many of the current and proposed EHR-generated quality measures fully apply only to primary care providers. We strongly encourage the Health IT Policy Committee to recognize the critical need to also establish quality benchmarks for medical specialties and to define the EHR certification process to include specialty-specific technology. We recommend the Committee reach out to professional associations that represent specialties such as oncology, rheumatology, urology and ophthalmology for recommendations on measures applicable to their specialty. A useful reference would be specific measures currently utilized in the CMS Physician Quality Reporting Initiative.

PROPOSED TIMELINE OF REQUIREMENTS

Improve Quality, Safety, Efficiency and Reduce Health Disparities

We recommend greater specificity for terms such as “progress note,” “clinical decision support” and “computerized provider order entry (CPOE)” so that providers can be certain as to their compliance with the criteria. This is particularly crucial for providers preparing for Phase 1 qualification.

For the proposed 2011 report on quality measurement, we recommend the following refinements to be consistent with National Quality Forum (NQF) measures and within the control of a physician:

- Change % of diabetics with A1c under control to % checked in prior 6 months
- Change % of hypertensive patients with BP under control to % measured in prior 6 months
- Change % of adult patients with LDL under control to % measured in prior 5 years
- Change % of patients with recorded BMI to % of patients with recorded weight and height in prior year
- Remove % of orders entered directly by physicians through CPOE as this is very difficult to measure
- Remove % of lab results incorporated into EHR in coded format as this depends on source lab compliance with coding standards which is beyond the physician’s control

We also recommend that meaningful use in Phase 1 for hospitals focus on automating at least two of the key integrated steps in an electronic medication use process: medication order to pharmacy, pharmacy order to nursing, bar-code administration from nursing to patient. Used in combination, these automated steps create a closed-loop system that helps prevent medication errors. The importance of a closed-loop medication process in preventing medication errors has been validated by IOM reports and other evidence-based industry data. If bar code medication administration is one of the implemented solutions in Phase 1, we recommend that 80% of medications scanned at the point of administration would be a meaningful measure to enhance patient safety.

The proposed criteria to “use CPOE for all order types” is extremely vague. While medication orders may be appropriate for Phase 1, we suggest greater specification in the identification of other order types and the phases in which they must be implemented. These could include laboratory orders, imaging orders, outpatient referrals, inpatient procedures, and other healthcare services, including occupational and physical therapy. While there is ample ambulatory market experience with electronic prescribing and electronic referrals, there is only limited experience with laboratory and imaging orders.

Therefore, McKesson supports a meaningful use requirement for “electronic capture of all orders” and recommends that order types beyond electronic prescribing be phased in as the necessary standards emerge. We recommend harmonizing Phase 1 criteria for electronic orders with the current Medicare Improvements for Patients and Providers Act (MIPPA) incentive program. Additionally, we recommend a phased approach for the percentage of orders that must be supported by clinical decision support, starting with a 50% metric in Phase 2 and increasing to 80% in Phase 3.

The measurement for establishing meaningful use should not be limited only to physician-generated orders. In the ambulatory community, many physicians use and leverage physician extenders for coordinating orders, referrals and other activities. Such use of extenders should be supported by meaningful use language. Similarly, automating interactions between pharmacy and nursing in the hospital environment will provide greater patient safety benefits and continuity of care improvements than an electronic physician order that is manually dispensed and administered.

Under the meaningful use incentives for tracking chronic care patients longitudinally, simply documenting progress notes places a significant workflow change on providers without producing meaningful quality and safety improvements. We recommend moving this requirement to the overall documentation requirements for Phase 2 and/or replacing it in Phase 1 with the requirement for capturing encounter data relevant to longitudinal patient management (e.g., HbA1c).

Patient and Family Engagement

McKesson agrees with the proposed Phase 1 criterion; however, we recommend that Phase 1 also include secure provider-patient messaging, given its crucial role in enabling patient engagement. We recommend that access to a personal health record (PHR) with real-time data from an EHR be moved to Phase 2. Until remote monitoring business models evolve, home medical device connectivity should be moved to Phase 3 with “medical device interoperability.”

Additionally, we recommend deletion of the “clinical summaries” requirement in Phase 1 which duplicates the initial criteria for that phase. A requirement to provide progress notes to the patient as part of a clinical summary places a significant burden on the provider to document appropriately for a lay interpretation.

Improve Care Coordination

McKesson supports the need for medication reconciliation; however, there is confusion as to the intent of the Phase 1 requirement to perform medication reconciliation “at relevant encounters” and the Phase 2 requirement to perform medication reconciliation “at each transition of care from one health care setting to another.” We recommend clarification as to which “transitions of care”, such as an ambulatory care visit, referral or admission, would require medication reconciliation and the specific requirements for each. Based upon evidence from the Joint Commission, careful consideration should be given to medication reconciliation requirements; therefore, we recommend a phased approach that will be achievable for providers.

Improve Population and Public Health

Before requiring the transmission of data to immunization registries, meaningful use criteria should recognize that public health agencies need to have a level of automation and electronic records comparable to hospitals and physician practices. This area needs the same level of standardization currently required of electronic prescribing in EHR solutions. We suggest that ONC spearhead standards development and pilot testing for this criterion with the transmission requirement moved to Phase 2 at the earliest.

Ensure Adequate Privacy and Security Protections for Personal Health Information

McKesson believes that the Phase 1 criteria relative to a Covered Entity (CE) under investigation for HIPAA privacy or security violations is onerous and should not be an accepted criterion for meaningful use. The suspension of incentive participation should be reserved for providers who have been determined to be in violation only following an investigation. This suspension should last only until any violation is effectively remedied.

Security risk assessments and security updates are already occurring under the current HIPAA regulations. We recommend further clarification as to how this would be measured and required as part of the meaningful use qualification process.

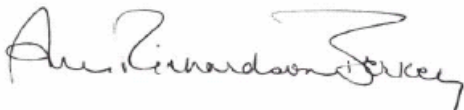
Instead of requiring a separate accounting of disclosures for treatment, payment and operations (TPO), we recommend that a CE expand its privacy policy to include education about the use of health information for TPO and under the circumstances the data is shared. We recommend that sensitive data be defined and that technology be required to enhance access controls rather than using it to segment sensitive data as proposed.

CONCLUSION

McKesson supports many of the initial definitions outlined by the Meaningful Use Workgroup of the Health IT Policy Committee. Our recommendations for modifications and clarifications reflect our real-world experience in working with thousands of hospitals, health systems and physicians across the nation each day. We believe these recommendations will not only make EHRs a reality for every American, but will greatly enhance community health through safer, higher-quality and more efficient care delivery.

We appreciate this opportunity to comment on the proposed definition of meaningful use. Please contact me at ann.berkey@mckesson.com or by phone at 415.983.8494 if we can be of further assistance.

Sincerely,



Ann Richardson Berkey