



June 26, 2009

Office of the National Coordinator for Health Information Technology  
200 Independence Avenue, SW  
Suite 729D  
Washington, DC 20201

Attn: HIT Policy Committee - Meaningful Use Comments

Thank you for the opportunity to comment on the draft recommendations for defining “meaningful use” of health IT. The American Medical Group Association (AMGA) commends ONC and the Committee for developing this thorough and thoughtful framework, particularly under such an aggressive timeline.

AMGA represents multi-specialty medical groups and other organized systems of care, most of which have been early adopters of HIT to coordinate care for their patients, provide clinical decision support, and enable a population-based approach to continuous improvement of quality and efficiency.

**Population Health and Quality Improvement.** The draft matrix focuses on use of HIT at the point of care, but there is little emphasis on (a) tools like registries to facilitate pro-active care and care coordination, and (b) retrospective analysis to identify and prioritize opportunities to improve population health.

Among our member medical groups are integrated delivery systems known for innovation in patient care. In most cases, HIT at the point of care is central to these innovations, but registries and population-based analytics are essential counterparts. We strongly recommend an explicit emphasis on these critical tools and processes.

In particular, the Population Health section of the matrix includes only one bullet on care goals. We recommend additional bullets encouraging individual care providers and provider organizations to think in terms of population health, with specific measures related to the use of registry functionality and establishing priorities from a population perspective.

We support the emphasis on reducing disparities, which will indirectly encourage a population-based view, and we agree with the care goals related to registry functionality (outreach) in the section on Quality, Safety, Efficiency, and Disparities. We would suggest emphasizing retrospective analysis and priority setting in the section on Population Health.

**Care Coordination.** We are delighted to see the separate heading for Care Coordination in the matrix. The collective experience of our member medical groups in improving quality, safety, and efficiency strongly supports this level of focus and attention on the issue of care coordination.

We also support the theme of the objectives and measures in this section, and we would encourage setting aggressive goals as a way to stimulate HIT vendors to accelerate development and delivery of more robust functionality, including comprehensive support of the Continuity of Care Document (CCD) standard, based on structured data. At the same time, the level of achievement required to earn the stimulus incentive shouldn't get too far out in front of currently available functionality. Performance thresholds should recognize the time required to implement and redesign clinical workflow to take full advantage of these evolving capabilities.

**Interoperability.** We agree with the emphasis on interoperability, including semantic interoperability in later years. This is essential for effective care coordination and is a hallmark of patient-centered care.

However, as the preamble points out, we must balance the long-term vision with current realities, in considering the most effective way to structure these incentives. Today, regional and local health information exchanges (HIEs) are relatively rare. Moreover, replicable, sustainable business models for these entities have yet to be established. If earning the incentive depends on access to a broad HIE, the establishment of which is beyond the control of any individual practice, we may be wasting an opportunity to drive change.

While HIEs are maturing, initial incentives should emphasize (a) adoption of HIT at the point of care, (b) capture of data in structured form using standard terminologies, and (c) population-based analytics to support enhanced quality, safety, and efficiency. Many rural practices are providing a broad scope of services, out of necessity, and they are coordinating care internally, thus achieving the core objective. They should not be deprived of "interoperability" incentives because they aren't, technically, exchanging data with a separate organization.

Interoperability should be measured in terms of functional benefit to patient populations, not arbitrary organizational boundaries. Many multi-specialty medical groups and integrated delivery networks were formed precisely to enable effective care coordination to be achieved within the organization. Measures of interoperability should reward the effective data interchange among providers of different specialties or among hospitals, ambulatory practices, and other settings of care, whether they're within the same organization or separate organizations.

**Structure of Incentives and Measures.** We agree with the concept of incenting favorable outcomes, rather than prescribing specific solutions, but as the preamble points out, our current quality measures are relatively primitive. We applaud the clear statement of a coherent vision and the concept of progressively more sophisticated measures, encouraging long-term investment in a robust HIT and workflow optimization, rather than short-term Band-Aid solutions aimed at individual "quality measures."

Interoperability measures may reward simple exchange of transactions in the early years, but it should be clear that these expectations will dovetail with expectations for structured documentation using standard terminologies, to achieve semantic interoperability, as a clear future expectation. This will give sound guidance as provider organizations consider strategic investments in IT and performance improvement.

Incentives should reward early adopters, even if they achieve the initial performance goals relatively easily. These organizations will continue to provide leadership for next-generation capabilities. Some AMGA members are on their second or third ambulatory EHR, paying greater attention to the unique documentation and decision support needs of certain specialties, steadily increasing the proportion of data and documentation that are captured in structured form, refining clinical workflow, and advancing e-prescribing capabilities. They are working on such issues as customized goals for individual patients, based on shared decision-making with their providers. It will be a while before broad “quality measures” will accommodate this kind of nuance, but, as a matter of policy, we should encourage and reward the organizations that are paving the way.

**Cost, Efficiency, and Value.** We agree that the incentives—and the measures on which they are based—should focus on the overall cost of care. It is a key issue that we as a nation must face, and AMGA endorses accountability for efficiency, as well as quality and safety. We recommend, however using the concept of *value*, rather than simply cost or efficiency. It is possible to provide unnecessary care with great technical efficiency, but it produces no value. The term “value” shifts the focus to providing the right care at the right time, with respect for the patient’s informed preferences.

**Setting of Care.** We are concerned that some individual measures seem to be ascribed to the inpatient setting, when in fact they reflect aspects of care provided across the continuum. For example, 30-day readmissions and emergency department visits and hospitalization for ambulatory-sensitive conditions are identified as “IP” measures, but achieving these goals in practice requires collaboration among hospitals, ambulatory practices, home health organizations, and other providers. We recommend that such goals be framed broadly, specifically to *encourage* constructive collaboration, whether within individual organizations or across multiple organizations within a community. Similarly, some of the most effective examples of syndrome surveillance are in the ambulatory setting, so we recommend that these measures, too, be framed more broadly.

Thank you for your serious consideration of our comments and concerns. Should you have questions, please contact Karen Ferguson, of my staff, at [kferguson@amga.org](mailto:kferguson@amga.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher".

Donald W. Fisher, Ph.D.  
President and CEO