

March 4, 2010

David Blumenthal, MD, MPP
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Blumenthal:

The HIT Standards Committee (HITSC) members were pleased to see that the Notice for Proposed Rule Making (NPRM) included nearly all clinical quality measures recommended by the HIT Policy Committee (HITPC) and reviewed by the HIT Standards Committee (HITSC) for purposes of identifying national standardized performance measures that could be used to operationalize the quality measures and assessing implications for HIT standards. The NPRM did, however, greatly expand the number of clinical quality measures to a total of 43 hospital measures and 90 ambulatory measures. It is our understanding that the HIT Policy Committee will be commenting on the consistency of this expanded set of measures with the high priority areas they identified for assessment of Meaningful Use. The HIT Standards Committee's review has focused on the implications of this expanded set of measures for provider burden and HIT standards requirements.

Burden

The expanded list of measures will provide greater opportunity to assess meaningful use across the diversity of specialists eligible to participate. The NPRM includes 3 core measures applicable to all specialists and measures specific to each of 15 specialty areas. The measures applicable to specific specialty areas range in number from 3 for Ophthalmology and Podiatry to 29 for primary care. Although many of these measures are ones that have been included in CMS's Physician Quality Reporting Initiative (PQRI), not all practitioners have participated in this program. Careful consideration should be given to the appropriate level of reporting requirements. More measures may not translate into more "meaningful use" of HIT and increased burden may deter participation.

Implications of Additional Measures for HIT Standards

To produce the expanded list of measures included in the NPRM, we hope the following concerns can be resolved in the rule for 2011, but those that are not should be considered for 2013 and beyond:

- Medication Allergies. A medication allergy standard will be needed and this should be at the drug level, not the component level. No standard is currently specified for 2011. UNII is listed as a candidate Stage II vocabulary, but UNII describes allergies at the component level and not at the drug level.
- Vital Signs. A vocabulary standard for vital signs (e.g., blood pressure, body mass index and percentile) and clinical findings will be needed. The Clinical Operations Workgroup has suggested that LOINC and SNOMED be used. Recommending two standards for vocabulary can be confusing for implementations. LOINC is preferred.
- Units of Measure. Standard units of measure are required to consistently calculate measures that use laboratory results, medication dosages, vital signs and observations. The HIT Standards Committee recommends using UCUM.
- Content Exchange Standards:
 - o *§170.205(a)(1)(i)* The Clinical Quality Workgroup agrees with the Clinical Operations Workgroup’s recommendation to adopt HL7 Version 3 Clinical Document Architecture (CDA) as the standard for patient summary records. The HL7 Continuity of Care Document (CCD) is one type of CDA with implementation guidance for the CDA standard. The use of CCR supports provider-to-provider communication of patient summaries but does not contain all the data elements needed for quality metrics and can potentially require duplication of efforts for implementations as requirements for reporting are adopted in future years.
 - o *§170.205(e)(1)* CMS Physician Quality Reporting Initiative (PQRI) 2008 Registry XML Specification – The IFR suggests that the PQRI Registry XML will be replaced in the future. Hospital organizations have an established and effective means for reporting now. Requiring hospitals to adopt a new standard in one year and potentially replace it the next year will add confusion and jeopardize adoption of the subsequent standard. The recommendation might be best worded to require reporting consistent with existing CMS requirement at the time of reporting. A minority of the HITSC members suggested that CDA constructs for quality reporting may be too burdensome.

The addition of these HIT standards will help facilitate the reporting of “meaningful use” measure results.

Thank you for the opportunity to provide additional input.

Sincerely,

/Janet Corrigan/

Janet Corrigan

Chair, Clinical Quality Workgroup