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Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Centers for Medicare & Medicaid Services
42 CFR Parts 412, 413, 422, and 495
CMS-0033-P
RIN 0938-AP78

On behalf of Trust for America's Health (TFAH) and Partnership for Prevention (PfP), we are pleased to submit these comments on the proposed rule for implementation of the Electronic Health Record Incentive Program authorized by the American Recovery and Reinvestment Act of 2009 (ARRA). Trust for America's Health is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. Partnership for Prevention is a non-profit, non-partisan member organization of leaders in business, health care, and government who are working to make evidence-based prevention an increased national priority.

TFAH's and PfP's interest in the implementation of health information technology (HIT) and electronic health records (EHRs) stems from the potential these innovations hold for prevention and population-based health. A successful, integrated, and usable EHR system could allow for advances in health and syndromic surveillance, community-based prevention, and outbreak response. These comments are submitted with an acknowledgement that the public health system needs further investment in HIT training and infrastructure before it can fully tap into the resources of a widespread EHR system. However, it is imperative that the Centers for Medicare & Medicaid Services (CMS) consider the public health implications of the regulations as they are developed, rather than as an afterthought. We applaud the Department of Health and Human Services (HHS) for including public health among its goals for the Stage 1 and Stage 3 phases¹ of implementation.

¹ Federal Register, Vol. 75, No. 8, Jan. 13 2010. P. 1852.

Overall, we believe that development of EHRs must include bidirectional exchange of ideas and information.² Public health can be as useful to providers as providers can be to public health. Providers can be informed by public health departments regarding what tests and screening are necessary for each patient, tailored by information entered into an EHR system. Conversely, what appear to be isolated events (e.g., small rises in the numbers of patients with high fevers seen by different individual providers) can be identified as a pattern when viewed through a public health lens and can result in earlier identification and containment of an outbreak. We urge you to ensure that the reporting capabilities measured in Stage 1, including reporting immunization data, lab results, and syndromic surveillance data to public health agencies, are made more robust and widespread in future stages of implementation.³

A discussion of our recommendations regarding specific provisions in the proposed rule is below.

Stage 1 Criteria for Meaningful Use **(2) Health IT Functionality Measures**

There are several functionality measures in the proposed rule that could be leveraged to further the objective of improving prevention and population health.

We applaud the rule's commitment to collection of patient health data. In addition to reporting to CMS, however, we should strive for the capability to report data to public health departments and to follow up with appropriate preventive care. We urge that the following three measures be reported to public health departments in aggregate, where the health department capacity exists, so that health departments can recognize health trends and target population-based interventions as appropriate:

- **Record and chart changes in vital signs.**⁴ Including BMI for all patients and growth tracking for children among recording requirements should lead to an increased recognition of health warning signs for providers and subsequently to more appropriate preventive care and treatment.
- **Record smoking status for patients 13 years old or older.**⁵ Similarly, recording smoking status may lead to an increase in the number of patients who receive smoking cessation treatment. The age threshold is important as counseling for adolescent smokers has been shown to be effective, approximately doubling long-term abstinence rates in the multiple studies. We agree with the choice to include this status as recommended by the 2008 Update to the Public

² ASTHO, Statement of William D. Hacker, MD, before the National Committee on Vital and Health Statistics Executive Subcommittee Hearing on Meaningful Use, April 29, 2009.

<http://www.ncvhs.hhs.gov/090429p07b.pdf>

³ FR, p. 1869.

⁴ FR, p. 1861.

⁵ FR, p. 1862.

Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence.⁶

- **Generate list of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.**⁷ In addition to being useful for hospitals and eligible providers (EPs) to track patient data, we recommend you include “population health” as an appropriate use of patient lists (in such cases, data should be aggregated and patient privacy maintained).

We strongly urge you to add the following measures to this section to improve infectious disease prevention and treatment:

- **Recording the sexual activity status of patients age 13 years and older.** Recording sexual activity status would be an effective way to trigger recommended screening for sexually transmitted diseases, such as chlamydia, or related health services.
- **Screening for pregnant women.** In addition to screening for HIV as suggested in the guidance, related infectious disease screenings for Chlamydia, syphilis, gonorrhea, and hepatitis should also be included both to protect the mother and reduce risk of perinatal transmission.
- **Screening for infectious disease risk factors including country of birth, number of sex partners, and substance use (including alcohol).** These factors are strongly associated with higher risk of HIV, STDs, TB, and viral hepatitis. Screening for these risk factors can help a health provider identify appropriate follow-up screenings and preventive services. These factors should be recorded for patients 13 years old or older, similar to the language for smoking status.
- **Geographic data for each patient contact.** Public health surveillance is largely place-focused, so gathering information about the location of a patient can help health departments and facilities tailor public health interventions.

We support the following measures and recommend widespread implementation, as amended below:

- **Send reminders to patients per patient preference for preventive/follow-up care.**⁸ We urge HHS to consider expanding the patient population for this measure beyond the over-50 age group. As we see growing rates of childhood obesity, leveling off of adult smoking, and staggering chronic disease rates, it is important to remind practitioners that preventive care must be provided to patients regardless of age. Limiting the patient population by age may reinforce the mistaken belief that prevention need only be targeted to the elderly population. Because the costs of a chronic disease over a patient’s lifetime are exorbitant when the disease begins in childhood or young adulthood, prevention must begin

⁶ Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. April 2009.

⁷ FR, p. 1862.

⁸ FR, p. 1863.

at an early age.

Furthermore, we encourage you to explicitly link this objective with the previous two objectives – recording vital statistics and smoking status – so that health professionals can provide appropriate preventive care based on risk factors. Many providers think prevention is merely a matter of early screening or disease management (i.e. secondary and tertiary prevention). In fact, the most cost-effective form of disease prevention is primary prevention, that is, helping a patient avoid a condition before it is diagnosed.

Additionally, one specific component of an EHR system, provider reminder systems, are recommended by CDC's Task Force on Community Preventive Services for tobacco cessation, and targeted and universally recommended vaccines, as discussed below.

Vaccines - We also recommend that you explicitly include reminders for scheduled vaccines for children and adults in this objective, as well as within the objective to provide patients with electronic access to their health information.⁹ 40,000-50,000 adults die every year from vaccine-preventable death, due in large part to gaps in the adult vaccine delivery system.¹⁰ Both providers and patients are failing on a wide scale to stay abreast of appropriate vaccines for adults, and automated reminders to both parties should be commonplace by the time Phase 3 is complete. All providers, not just primary care, should be aware of a patient's vaccine history, given his/her risk factors. For example, the H1N1 influenza disproportionately impacted individuals with chronic diseases. An endocrinologist could receive a reminder through EHRs that a diabetic patient is due for a flu vaccine, and then provide that shot during the next visit. This mechanism is especially useful given that many adults do not have regular access to the primary care system. An effective EHR system would remind both patients and providers of the schedule of vaccines. Vaccines, just as other medication use, need to be a standard part of all forms, not in a separate form only accessible to primary care providers. A truly interoperable system would allow any provider to be reminded of a patient's vaccine schedule, even in the absence of a medical home.

- **Check insurance eligibility electronically from public and private payers.** If successfully implemented, this objective could help alleviate uncompensated care issues during a disaster.¹¹ In a public health emergency, many victims, especially evacuees, lack proper insurance information. Electronic verification could help ensure appropriate care and that health systems remain fiscally solvent following an emergency by reducing the number of patients treated without complete insurance data.

⁹ FR, p. 1864.

¹⁰ Trust for America's Health, *Adult Immunizations: Shots to Save Lives*, Feb. 2010. <http://healthyamericans.org/assets/files/TFAH2010AdultImmnzBrief13.pdf>.

¹¹ FR, p. 1863.

- **Capability to submit electronic data to immunization registries and actual submission where required and accepted.**¹² We encourage you to include adverse reactions to this objective.
- **Capability to provide electronic submission of reportable lab results to public health agencies and actual submission where it can be received.**¹³ The regulations should use a broad definition of lab, ensuring that public health is able to receive reports from clinical, anatomic pathology and molecular labs.
- **Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.**¹⁴ These previous three objectives should be strengthened so that actual reporting begins in 2011, not just the capability to report. We recognize that some providers and public health departments may not have the same level of capacity to submit and receive such information electronically during the first stage of EHR implementation. However, delaying reporting requirements until phase two will further hinder modernization of our biosurveillance system. Providers should be able to prove both capability and actual reporting in phase 1, and in cases where health departments are not prepared to receive, meaningful users can opt out of the objective.

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

a. General.

We urge you to expand the definition of “clinical quality measures” on p. 1871 to include “appropriate clinical prevention.”¹⁵

d. Proposed Clinical Quality Measures for Electronic Submission Using Certified EHR Technology by EPs.

We are encouraged that the clinical quality measures have a focus on preventive care, specifically those clinical preventive services that provide the highest value as recommended by the National Commission on Prevention Priorities (NCPPI). These include influenza immunization rates, smoking cessation counseling, BMI screening and follow-up, cervical cancer and chlamydia screening, and aspirin therapy.¹⁶ We suggest that any preventive care and screening measures that have a related US Preventive Services Task Force (USPSTF)¹⁷ recommendation should follow the USPSTF guideline, and the regulations should allow for preventive and screening measures to be updated as the evidence base changes. We also ask you to make the following changes to this

¹² FR, p. 1866.

¹³ FR, p. 1866.

¹⁴ FR, p. 1866.

¹⁵ FR, p. 1871.

¹⁶ Maciosek, M., et al. “Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis.” *American Journal of Preventive Medicine*, 2006; 31(1).
<http://www.prevent.org/images/stories/clinicalprevention/article%201669p.pdf>

¹⁷ <http://www.ahrq.gov/clinic/uspstfix.htm>

section:

- In addition to measuring immunizations for infants,¹⁸ the clinical quality measures should include an immunization package for adolescents, which includes such recommended vaccines as TDaP, HPV, and meningococcal.
- In addition to prenatal screening for HIV,¹⁹ the screening of pregnant women for infectious diseases should be expanded to include hepatitis, syphilis, and Chlamydia.
- HIV positive individuals should be screened for a range of other infectious diseases, including hepatitis, Chlamydia, syphilis, and gonorrhea.
- Influenza immunization measures²⁰ should be expanded to patients of all ages, given the recent determination by the CDC's Advisory Committee on Immunization Practices (ACIP) that the seasonal influenza vaccine should be administered to everyone age 6 months or older.²¹
- Expand aspirin therapy beyond those who already have cardiovascular disease.²² USPSTF recommends aspirin therapy for men age 45 to 79 years and women age 55-79 when the benefits of reducing heart attacks and strokes, respectively, outweigh the harms for potential GI bleeding.²³ Aspirin therapy for primary prevention of heart disease and stroke is considered a high value preventive service, and expanding its use could save an estimated 45,000 lives annually.²⁴
- Add a measure to provide Hepatitis B vaccine/immune globulin to newborns born to mothers who have chronic hepatitis B infection as recommended by the CDC.²⁵ This recommendation is poorly implemented,²⁶ so including it as a quality measure can help spur action.
- In addition to measuring blood pressure management in adults 18 and over,²⁷ the clinical quality measures should also include monitoring control of hypertension, as recommended by the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure,²⁸ and abnormal lipids, as

¹⁸ FR, p. 1886.

¹⁹ FR, p. 1884.

²⁰ FR, p. 1893.

²¹ Centers for Disease Control and Prevention, "CDC's Advisory Committee on Immunization Practices (ACIP) Recommends Universal Annual Influenza Vaccination." February 24, 2010.

<http://www.cdc.gov/media/pressrel/2010/r100224.htm>

²² FR, p. 1891.

²³ US Preventive Services Task Force. *Aspirin for the Prevention of Cardiovascular Disease*. March 2009.

<http://www.ahrq.gov/clinic/USpstf/uspsasmi.htm>

²⁴ Maciosek MV, et al. "Aspirin chemoprophylaxis: Technical report prepared for the National Commission on Prevention Priorities." <http://www.prevent.org/content/view/full/44/114/>

²⁵ Centers for Disease Control and Prevention, "Hepatitis B Information for Health Professionals: Perinatal Transmission." June, 2008. <http://www.cdc.gov/hepatitis/HBV/PerinatalXmntn.htm#section1>

²⁶ Goodwin, J. "1 in 5 At-Risk U.S. Babies Doesn't Get Hepatitis B Vaccine," *Healthday*, March 8, 2010.

<http://www.healthday.com/Article.asp?AID=636751>

²⁷ FR, p. 1885.

²⁸ National Institutes of Health, The Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, August 2004.

<http://www.nhlbi.nih.gov/guidelines/hypertension/>

recommended by the National Cholesterol Education Program's Adult Treatment Panel.²⁹

- Percentage of patients 18 years and older with a diagnosis of abnormal lipids who had most recent lipid levels in control (<100 mg/dl for LDL-C, <200 mg/dl for total cholesterol, >= 60 mg/dl for HDL-C);
 - Percentage of patients 18 years and older who had a lipid profile screen at least once within the last five years; and
 - Percentage of patients 18 years and older with a diagnosis of hypertension who had most recent blood pressure measure in control (less than 140/90 mmHg).
- Add chlamydia screening to quality measures for primary care and pediatrics as is included to the quality measures for obstetricians and gynecologists.³⁰

e. Clinical Quality Measures for EPs

Within the tables of medical specialties, we believe this chart should include a Measure Group for infectious disease specialists. By adding this specialty, the clinical quality measures could be expanded to include measures specific to infectious diseases such as HIV and TB.

Conclusion:

We are at an exciting moment in the American healthcare system – a time when paper-based treatment, disease surveillance, and recordkeeping give way to real-time health communication. If implemented appropriately, EHRs could revolutionize not just the way we treat patients within the clinic, but also the interaction between the healthcare system and the public health system. Two-way communication between these entities should not be dependent on individual providers taking the initiative to report and public health workers sifting through paper records. The communication in both directions should be seamless. EHRs should enable public health to work with the clinical care system to mitigate the effects of a disease outbreak, investigate cases, and tailor prevention to at-risk communities with the goal of increasing utilization of clinical preventive services and improving implementation of evidenced-based community prevention.

We thank you for the opportunity to comment on the proposed rules and look forward to an EHR system that assures optimal outcomes in quality, prevention, and population health.

²⁹ National Institutes of Health, *Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report*. 2002. <http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3full.pdf>

³⁰ FR, pp. 1892-93.