February 25, 2011

Office of the National Coordinator for Health Information Technology

c/o Joshua Seidman
Mary Switzer Building
330 C Street, SW, Suite 1200
Washington, DC  20201

Dear Mr. Seidman:

On behalf of the American Heart Association (AHA), its American Stroke Association (ASA) division, and our more than 22 million volunteers and supporters, we applaud the significant efforts of the HIT Policy Committee (HITPC) on defining meaningful use Stage 2. We are particularly pleased with the Committee’s decision to provide several points for public input and AHA appreciates the transparency of the Committee’s approach to subsequent meaningful use stages.

The AHA is dedicated to building healthier lives, reducing death and disability from cardiovascular diseases and stroke, and addressing issues of access, quality, and cost from the patient’s perspective. Although the United States has been successful in reducing death rates for coronary heart disease and stroke, much work remains to address these leading causes of death and disability. Among other issues, the fragmentation of services and the lack of coordination of care for people with chronic conditions are a major cause for concern. While health IT is not a panacea, it can, when used effectively, be a powerful tool to improve the quality and efficiency of care through the use of decision-support tools and by supporting better coordination of care. Providing health information and educational tools directly to patients can also improve personal involvement in self management of health problems, which is central to addressing chronic conditions such as cardiovascular disease.

AHA’s comments on the Policy Committee’s Request for Comment document follow. We provide specific comments on the table in Section C, followed by our answers to select questions in Sections D and E.

Section C

• Implement One (1) Clinical Decision Support Rule

In the Meaningful Use Stage 1 proposed rule, the HITPC proposed that because clinical decision support (CDS) can be used to improve performance on high priority health conditions, a CDS rule should be included. For Stage 2, the committee goes on...
to state that it will be important to establish attributes for purposes of certification: (1) authenticated (sources cited); (2) credible evidence-based; (3) patient context sensitive; (4) invokes relevant knowledge; (5) timely; (6) efficient workflow.

The AHA fully supports the creation of a rule that seeks to define attributes of CDS for purposes of certification. The AHA portfolio of quality improvement programs, known as “Get With The Guidelines - Heart Failure,” “Get With The Guidelines - Stroke,” and “Get With The Guidelines – Resuscitation” were developed with the intent to improve the quality of care for patients through application of CDS tools. To this end, the AHA has worked to include CDS components into these quality improvement programs, including but not limited to real time logic checks, links to robust coding instructions, and links to guidelines and scientific statements, out of recognition of the value of these tools for health professionals charged with the care of cardiovascular patients.

The AHA believes the inclusion of clinical decision support, therefore, is critical to furthering the quality of care received by all patients. We strongly urge, however, that stakeholders be consulted throughout the rule development process and prior to public comment. These stakeholders would include but not be limited to, professional societies, healthcare organizations, disease groups, and patient advocates. It is critical for HITPC to gain input from entities that have previously developed clinical decision support tools in order to assess issues that may arise during development, implementation, and maintenance of the tool. For example, one concern with clinical decision support is ensuring that the most up-to-date guidelines are integrated into the tool. Consulting with the guidelines/statement developers up front may help to identify the best means by which to ensure that certified vendors are integrating the most recent guidelines/statements into tools and in a timely manner. Evidence based guidelines/statement developers, particularly those who develop guidelines/statements for high priority health conditions, should also be consulted in identifying what type of CDS is most valuable.

AHA would also recommend that the HITPC provide examples of readily available CDS tools that contain the minimum criteria and consider mandating integration of these particular systems as part of the Stage 2 objectives. For cardiovascular and stroke patients, AHA’s Get With The Guidelines (GWTG) tools with CDS have demonstrated quality improvements, which are reflected in the scientific literature.\textsuperscript{1,2,3} The HITPC should take this opportunity to leverage and promote the use of existing tools with demonstrated positive impacts, in order to most effectively bring about the quality improvement that the Electronic Health Record Incentive Program was intended to bring, and do so in a timely manner.

- Provide electronic copy of discharge instructions at discharge
For Stage 2, one of the proposed measures would require hospitals to offer electronic discharge instructions to at least 80% of the patients. Furthermore, the patient would be able to elect if they wanted to receive only a printed copy of the instructions. HITPC also delineates information that should be included in the discharge letter including: patient’s condition, discharge medications, activities and diet, follow-up, appointments, pending tests that require follow-up, referrals, and scheduled tests.

The AHA supports the efforts by HITPC to increase the use of discharge instructions with this information. However, we would note that depending on the disease state of the patient, there may be other specific information that may be helpful to include in the discharge letter. For example, for a stroke patient, it is beneficial to provide information on whether the NIH stroke scale was provided and what specific types of patient education materials were given to the patient. For example, the AHA “Get With The Guidelines- Stroke” program requests that information on the following types of counseling be provided to the patient:

- Personal modifiable risk factors for stroke
- Stroke warning signs and symptoms
- How to activate EMS for stroke
- Need for follow-up after discharge

For heart failure, our “Get With The Guidelines-Heart Failure” program includes data reporting on the following types of counseling:

- Daily weight
- Salt restriction
- Warning signs or worsened heart failure and what to do
- Need to adhere to medical regimen

These serve as two examples of where discharge information valuable to patient care may be disease specific, even though it can be generally classified as patient education. We believe that including disease specific information on the discharge instructions is important to improving patient care. Therefore, HITPC should consult with organizations that deal with chronic diseases, like the AHA, to assess whether there are specific types of information that would be particularly valuable in the discharge instructions and to further continuity of care.

- **EHR Enabled Patient Specific Educational Resources**

While AHA recognizes that the HITPC asked for comments specific to Stage 2 and only provided Stage 3 objectives to be illustrative, we believe our comments will be helpful to the HITPC given it is approaching Stage 2 objectives as bridges to these Stage 3 concepts.

For Stage 3, HITPC suggested that it would require that 20% of online patient-specific educational resources be offered in common primary languages. HITPC references a definition developed by the Office of Civil Rights, which defines primary
language as “any language spoken by 5% of the total population eligible to be served or 1,000 persons in that population, whichever is less.” In general, the AHA is supportive of HITPC’s efforts to promote greater EHR enabled patient-specific educational resources. Patient education is critical in the management of a patient’s disease and especially for those with chronic or co-morbid conditions. We would, however, make the following observations with regards to what is laid out for Stage 3.

First, while the AHA supports the HITPC’s goal to further patients’ access to educational materials in their primary languages, using the definition referenced above, we think that it may be more feasible to first start by identifying a set of commonly spoken languages in the country and focusing on making resources in these “core” languages. While we agree that the goal would be to have educational materials in all languages, it might be more feasible to start with a defined set of primary languages and focus initial efforts on making materials in these languages as clear and useful to patients, as possible. Translating materials in a readily understandable, actionable way for patients and caregivers is a resource intensive process, and could potentially require consumer research. In this way, the AHA believes that an incremental approach to achieving this objective is more appropriate.

Furthermore, we would also like to ask that the HITPC consider expanding this goal to also note the importance of consumer research on what type of patient education materials patients and their caregivers find most useful. Increasing online access to patient education materials is beneficial, but its value is greatly increased by the ability of the patients and caregivers to understand the content and be able to act on the recommendations provided in the materials. Similarly, the AHA believes that minimum standards to ensure the quality of the patient education tools, themselves, is appropriate, should also be included when the HITPC provides more specific information on the Stage 3 objectives. AHA has experience in developing patient education tools and would be happy to serve as a resource to the Committee as it pursues this objective further.

- **Electronic Self Management Tools**

The HITPC notes that for Stage 3 it would like to further the goal of having EHRs offer electronic self management tools to patients with high priority health conditions and asks for public comment on what would be needed in Stage 2 to achieve the proposed Stage 3 objective.

The AHA fully supports all efforts to encourage the adoption and use of online tools that can help both in primary, secondary, and tertiary prevention. We believe that for Stage 2 it may be important to identify what currently existing self management tools are available and could be offered to the patient. Identifying existing tools and focusing on increasing awareness of them in Stage 2 could be an appropriate foundation for offer and use rates in subsequent stages.
As examples, we have provided descriptions of two tools developed by the American Heart Association that can help patients with cardiovascular disease and stroke better manage their health.

The American Heart Association’s Heart 360 can help to improve a patient’s engagement in their own health. Heart 360 is a secure, online cardiovascular wellness center that empowers patients to track and manage their health information and share it directly with their health care team (available at https://www.heart360.org). With Heart360, patients can track their blood pressure, blood glucose, cholesterol, weight, physical activity and medications and they can access heart healthy tips, tools, and resources as they take the steps they need to get heart healthy. This tool enhances the patient-provider relationship by allowing the provider to remotely monitor their patients and electronically communicate directly with them anytime, anywhere. Heart360’s many patient management tools allow providers to access patient data at any time, set filters, alerts, and notifications, and generate both patient and practice-based reporting. Moreover, patients can sign up to receive reminders delivered via text directly to their mobile phone. With this feature, they can also conveniently input their data by responding directly to the reminder.

There are also tools that can help encourage patients to assess where they could improve their health. For example, My Life Check (http://mylifecheck.heart.org/) was designed to improve overall health by educating the public on how best to live. The seven areas addressed by My Life Check are: the need for physical activity, better eating habits, benefit of losing weight, controlling cholesterol, managing blood pressure, reducing blood sugar, and stop smoking. This program has now been integrated into Heart 360, as well, to facilitate patient use in monitoring their health on an ongoing basis.

By highlighting these two tools we hope that HITPC will consider reaching out to stakeholders to identify existing tools that may help to manage patient conditions and facilitate the adoption of such tools in Stage 3, if not sooner. We would be happy to work with HITPC to identify what other tools exist for cardiovascular disease and stroke care, in addition to those we have highlighted above.

HITPC also seeks comment on the goal of furthering the capability to upload and incorporate patient-generated data into EHRs and clinician workflow. We believe that having the ability to integrate patient level reported data is important to managing a patient’s care. However, we would encourage that efforts be taken to ensure that the patient can only upload information and not be allowed to alter data fields that have been included in the record by their physician. Any correction or adjustment to physician-entered data should be handled through a separate process by which that patient may notify the provider of a needed change if that patient believes any data element is incorrect.
Section D: Additional Questions

• **Question #5: High performance on clinical quality measures as substitute for demonstration of Meaningful Use (MU)**

The AHA supports the use of high performance on quality measures as a substitute for the demonstration of meaningful use requirements. Given that meaningful use is intended to further the quality of patient care, we believe that hospitals and practitioners who are successful in demonstrating high performance on clinical quality measures and improvements in quality of care should be considered as meeting the MU requirements. We look forward to more information from HITPC as to how, and for which specific measures, high performance could serve as demonstration of meaningful use.

Additionally, there are several existing functionalities in currently available health IT tools which could be used to identify those practitioners who have achieved “high performance.” For example, AHA’s Get With The Guidelines suite of quality improvement programs, discussed in more detail above, provides quarterly feedback reports to participating physicians with information on how they compare to care delivery benchmarks. Designation of achievement by public recognition programs for quality improvement could also be used to identify the recipient as a meaningful user.

• **Question #7: Advance directives as a required objective**

The AHA supports changing the advance directive objective from an optional objective to a requirement. Consistent with the overall patient and family engagement goal, a high quality health system is one that respects the values, beliefs, and wishes of the patient. Similarly, the meaningful use objectives are not only intended to spur the adoption of health IT, but also the use of that technology in a way that facilitates the delivery of high quality health care. An advance directive allows the patient to indicate his or her preferences about the care he or she receives at the end of life and serves as a surrogate for relaying that information when the individual is no longer able to communicate those preferences.

Randomized control trials have demonstrated the ability of advance directives to improve patient experience, by showing that their presence increases the likelihood that a patient’s end of life preferences are known and respected and improves patient satisfaction and quality of life. Consistent with the latter portion of the meaningful use goal, studies have also demonstrated that advance directives reduce the emotional trauma of the patient’s family through reductions in post traumatic stress, anxiety, and depression during the end-of-life and after the family member’s death.  

---

Measurements of the percentage of patients with an advance directive vary, but research into patient preferences related to end-of-life care show that patients expect clinicians to initiate discussions around advance directives. Connecting a meaningful use measure to the existence of a directive could prompt the clinician to initiate this discussion if it has not already occurred and better serve the preferences and needs of patients.

**Section E: Evidence Base/Rationale for Proposed New Objectives**

With respect to the new objectives proposed by the HITPC, the AHA asks that where a measure is referenced in the table, that the measure number assigned by the National Quality Forum and its short title, are also included. This would help those who are less familiar with the existing measures included in the core and menu sets to more readily follow this valuable table.

In closing, AHA appreciates the ongoing efforts of the HITPC and is happy to work with the Committee’s members to further address these issues. If you have questions or need additional information, please do not hesitate to contact Madeleine Konig in our DC Advocacy office at 202.785.7930 or Madeleine.konig@heart.org or Penelope Solis in our Quality Improvement office at 202.423.3124 or Penelope.solis@heart.org.

Sincerely,

Ralph Sacco, MD, FAHA
President
American Heart Association