

December 23, 2010

David Lansky
Chair, Quality Measures Work Group
Office of the National Coordinator for Health IT
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Suite 729-D
Washington, D.C. 20201

**RE: Request for Comments on Clinical Quality Measures for Stage 2 and Stage 3
Meaningful Use of Health IT**

Dear Dr. Lansky:

On behalf of the undersigned organizations, we are pleased to present the Quality Measures Workgroup with our comments on the new clinical quality measures for Stage 2 and Stage 3 Meaningful Use of health information technology (HIT). We believe that HIT presents the opportunity to improve individual wellbeing as well as strengthen the health of the nation. Our comments reflect these goals.

HIT Policy Measure Concepts

We are pleased with the inclusion of patient health outcomes, community resources coordination, healthy lifestyle behaviors, effective preventive services, and health equity in the measure concepts established by the policy committee. It is important to note the health IT is not just a tool to improve healthcare quality and reduce errors, but to improve the health outcomes for individuals and the population. These concepts reflect an understanding that a person's health, as well as the reach of HIT, extend beyond the clinic walls to the places where people live, work, and play. As a result of proper use of HIT, we could see improved disease surveillance, outbreak response, population-based measures of health, and implementation of effective preventive services such as recommended vaccinations, screening and counseling services.

We applaud the inclusion of healthy lifestyle behaviors in the measure concepts and the focus on smoking, BMI, and alcohol use. We believe these health behaviors should be included in the healthy lifestyle behaviors measures concepts for the promotion of health and wellness at all levels. Each of these health factors affect a variety of health outcomes, including obesity, heart disease, infectious disease transmission, and violence.

In 2010, the Robert Wood Johnson Foundation and University of Wisconsin Public Health Institute developed the County Health Rankings project, a model which shows how various

health factors influence health outcomes.¹ Within the model, the study measures four key health behaviors that dramatically affect population health:

- Alcohol use;
- Tobacco use;
- Diet and exercise; and
- Unsafe sex.

We therefore urge you to add sexual behaviors and expand the BMI measure to include diet and exercise to better reflect the impact on population health. We will discuss several of these measures in more detail in the next section.

Examples of Quality Measures

The Workgroup has asked for examples of specific measures that would effectively achieve the goals outlined in the measure concepts. We encourage you to modify or include the following measures to the Healthy Lifestyle Behaviors and/or Effective Preventative Services sections to improve disease prevention and treatment:

- **Record and chart changes in vital signs.** Including BMI as well as diet and exercise tracking 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. Tracking exercise in addition to BMI is important because physical activity alone can ameliorate the health hazards of obesity² and also has health benefits beyond chronic disease, such as improving academic achievement,³ decreasing the risk for dementia,⁴ and helping reduce falls and injury among seniors.⁵
- **Record smoking status for patients 13 years old or older.** 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 Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence.⁶

¹ Robert Wood Johnson Foundation and University of Wisconsin Public Health Institute, *County Health Rankings: About this Project*. Available from: <http://www.countyhealthrankings.org/about-project> (Accessed October 2010).

² See Lee, DC, Sui, X and Blair SN, Does physical activity ameliorate the health hazards of obesity, *Br J Sports Medicine* 2009 43: 49-51; and Sui X, LaMonte MJ, et al., Cardiorespiratory Fitness and Adiposity as Mortality Predictors in Older Adults, *JAMA* December 5, 2007

³ Grissom JB. "Physical Fitness And Academic Achievement." *JEPonline* 2005;8 (1):11-25. Available from: <http://www.asep.org/files/Grissom.pdf> (Accessed December 2010).

⁴ Larsen EB, et al. "Exercise Associated with Reduced Risk for Incident Dementia among Persons 65 Years of Age and Older." *Ann Intern Med* January 17, 2006 144:73-8. Available from: <http://www.annals.org/content/144/2/73.full> (Accessed December 2010).

⁵ Centers for Disease Control and Prevention, "Falls Among Older Adults: An Overview," Sept 2010. Available from: <http://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html> (Accessed December 2010).

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.

- **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.
- **Vaccine tracking.** We also recommend that the measures 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. 40,000-50,000 adults die every year from vaccine-preventable death, due in large part to gaps in the adult vaccine delivery system.⁷ 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. 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.

Any measures put forth by the Workgroup should 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.⁸ We suggest that any preventive care and screening measures that have a related US Preventive Services Task Force (USPSTF)⁹ recommendation should follow the USPSTF guideline, and the regulations should allow for preventive and screening measures to be updated as the evidence base changes.

Department of Health and Human Services. Public Health Service. April 2009.

⁷ Trust for America's Health, *Adult Immunizations: Shots to Save Lives*, Feb. 2010.

<http://healthyamericans.org/assets/files/TFAH2010AdultImmnzBrief13.pdf>.

⁸ 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>

⁹ <http://www.ahrq.gov/clinic/uspstfix.htm>

Within the January, 2009 proposed rule for implementation of the Electronic Health Record Incentive Program, there were several proposed HIT clinical quality measures.¹⁰ We propose the Workgroup consider the following expansion of measures first proposed in previous ONC regulations:

- In addition to measuring immunizations for infants,¹¹ as was proposed in the January 2009 proposed rule, 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,¹² 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 measures¹³ 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.¹⁴
- Expand aspirin therapy beyond those who already have cardiovascular disease.¹⁵ 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.¹⁶ 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.¹⁷
- 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.¹⁸ This recommendation is poorly implemented,¹⁹ so including it as a quality measure can help spur action.
- In addition to measuring blood pressure management in adults 18 and over,²⁰ the clinical quality measures should also include monitoring control of hypertension, as recommended by the Joint National Committee on the Prevention, Detection, Evaluation,

¹⁰ Federal Register, Vol. 75, No. 8, Jan. 13 2010.

¹¹ FR, p. 1886.

¹² FR, p. 1884.

¹³ FR, p. 1893.

¹⁴ 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>

¹⁵ FR, p. 1891.

¹⁶ US Preventive Services Task Force. *Aspirin for the Prevention of Cardiovascular Disease*. March 2009. <http://www.ahrq.gov/clinic/USpstf/uspsami.htm>

¹⁷ Maciosek MV, et al. "Aspirin chemoprophylaxis: Technical report prepared for the National Commission on Prevention Priorities." <http://www.prevent.org/content/view/44/114/>

¹⁸ Centers for Disease Control and Prevention, "Hepatitis B Information for Health Professionals: Perinatal Transmission." June, 2008. <http://www.cdc.gov/hepatitis/HBV/PerinatalXmtn.htm#section1>

¹⁹ 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>

²⁰ FR, p. 1885.

and Treatment of High Blood Pressure,²¹ and abnormal lipids, as recommended by the National Cholesterol Education Program's Adult Treatment Panel.²²

- 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.²³

Thank you for the opportunity to offer our comments as the Clinical Quality Measures Workgroup develops measures and recommendations regarding meaningful use. We look forward to continuing to work with you as the Workgroup and Office of the National Coordinator implement these measures. Should you have any questions, please contact Trust for America's Health's Director of Government Relations, Annie Toro, at (202) 223-9870 ext. 25 or atoro@tfah.org.

Sincerely,

American Academy of HIV Medicine
Association of Asian Pacific Community Health Organizations
HIV Medicine Association
National Alliance of State & Territorial AIDS Directors
Partnership for Prevention
Trust for America's Health

cc: David Blumenthal, ONC

Farzad Mostashari, ONC

Seth Foldy, CDC

Laura Conn, CDC

²¹ 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/>

²² 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>

²³ FR, pp. 1892-93.