

June 26, 2009

Office of the National Coordinator for Health Information Technology  
U.S. Department of Health and Human Services  
200 Independence Ave., SW  
Suite 729D  
Washington, D.C. 20201  
Attention: HIT Policy Committee Meaningful Use Comments

**Re: Meaningful Use**

To Whom It May Concern:

The Children's Partnership is a 15-year old nonprofit policy and strategy center, with offices in Washington, DC and California, working to improve the health of children and to improve their educational achievement, economic opportunities, and health outcomes through effective use of the Internet and other technology tools. A key focus of our research and policy development is the potential for health information technology (HIT), if properly deployed, to support the transformation of our health care system into one that is more patient-centered and that promotes higher quality, coordinated, cost-effective care that is designed to produce better health outcomes for all, including America's 74 million children.

The American Recovery and Reinvestment Act (ARRA) HIT incentives offer a tremendous opportunity to drive such system improvements. We applaud the considerable work that has already been done to articulate the means by which the meaningful use of HIT can help achieve the goal of enabling significant and measurable improvements in population health through a transformed health care delivery system. We appreciate the emphases on patient and family engagement and population and public health, as well as the recognition of the importance of privacy and security. Yet there are a number of opportunities to strengthen the framework, particularly regarding children's health.

The ARRA specifically directs ONC and States to address children and other populations with unique needs in HIT efforts, including regarding meaningful use. Specific attention to children is essential if we are to realize the stated goal of these HIT efforts, not only because such efforts will improve children's health, but also because many prevalent and costly adult-onset conditions have their origins in childhood. We offer the following recommendations in furtherance of the ARRA requirement to address the unique needs of children and to ensure that the desired transformation is achieved for all, including all children.

Recommendations

1. **Establish special working groups for pediatrics under ONC's advisory committees.** Children should not be an afterthought in developing our national HIT priorities. Their needs, and measures to ensure that their needs are addressed, need to be integrated into the policy framework and HIT infrastructure. A working group that is specifically tasked with considering children's needs across the full range of federal HIT efforts, including the definition of meaningful use, would help to ensure this result.
  - a. **Establish a special working group for pediatrics under the HIT Policy Committee.**
  - b. **Establish a special working group for pediatrics under the HIT Standards Committee.**
  - c. **Include representation of child and family advocates as well as pediatric providers on all of the working groups.**

2. **Explicitly include children in the priorities framework.** The overall framing of the vision for meaningful use implicitly focuses heavily on issues and measures of primary relevance to the Medicare population and Medicare providers (e.g., reference to diabetes-related amputations, heart disease, end of life preferences, and declining level of Medicare incentives in future years). To ensure that children's needs are met, we recommend the following changes to the framing of the meaningful use definition:
  - a. **Amend the preamble description of the “ultimate vision” to include affording improved access and elimination of health care disparities “over the life course.”**
  - b. **Include in the preamble framework a specific discussion of the ways in which the effective use of HIT will meet the unique needs of children.** Such discussion should highlight the specific impacts for children of care goals and objectives included in the definition. Objectives and measures should be updated to ensure these impacts are realized.
  - c. **Include pediatric examples in illustrative lists in the preamble wherever possible.** For example, childhood obesity, childhood diabetes, and asthma should be listed among the illustrative examples of chronic conditions to be addressed through HIT-enabled interventions.
  
3. **Explicitly include Medicaid and CHIP in the priorities framework.** Medicaid faces similar challenges as Medicare in terms of appropriately balancing the competing goals of encouraging provider participation while promoting progress towards reform. In addition, there is a lack of clarity regarding the extent to which the meaningful use definition, and measures for demonstrating meaningful use, might vary between Medicare and Medicaid. Moreover, States have made considerable advances in HIT through their Medicaid and CHIP programs in recent years that should provide a foundation for meaningful use of HIT by Medicaid providers.<sup>1</sup>
  - a. **Include in the preamble framework a specific discussion of the meaningful use definition in Medicaid versus Medicare and invite comment on the extent to which program requirements should vary.** There is sufficient lack of clarity on these issues to warrant specific solicitation of comment in the next draft proposal for meaningful use.
  - b. **Invite comment on establishing a federal “floor” for the meaningful use definition that allows States the flexibility to devise Medicaid EHR incentive programs that recognize the realities of the HIT environment in the State and drive improvements that have the highest potential impact for the underserved populations in the State.** For example, some States may have sufficiently advanced immunization information systems to allow for bi-directional sharing of childhood immunization information at a faster pace than is possible in other parts of the nation. In such cases, States should have the flexibility to require such information sharing as a meaningful use of HIT.
  - c. **In assessing the proper balance between setting aggressive timetables for progress toward goals and ensuring provider participation, explicitly consider Medicaid providers and err on the side of aggressive timetables.** In doing so, however, we also urge you to prioritize Medicaid providers (such as pediatric providers, particularly those in small and/or rural practices) who may have difficulty achieving these timetables when making available funding, training, technical assistance, and other forms of support available through the HIT Extension Program and other HIT provisions of the ARRA.
  - d. **Include exchange of eligibility data as a meaningful use of HIT.** Many health care providers assist patients in applying for and enrolling in programs such as Medicaid and CHIP. Medicaid and CHIP eligibility data can also have a clinical impact and be helpful in accomplishing health education and outreach. Incorporating such data exchange in the meaningful use definition would help to reduce the number of uninsured, including the estimated 6 million uninsured children who are currently eligible but not enrolled in Medicaid or CHIP.

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<sup>1</sup> Beth Morrow, *Emerging Health Information Technology for Children in Medicaid and CHIP Programs* (Washington, D.C.: Kaiser Family Foundation, November 2008). Available at <http://www.childrenspartnership.org/ehealthsnapshotHIT>.

4. **Include child-specific quality measures for prevention and health promotion.** To ensure optimal prevention and health promotion efforts for children, we recommend the measures for these objectives be expanded as follows:
  - a. **Review existing child-specific quality measures and assess which should be included in 2011 versus 2013.** Numerous recommendations and measures regarding prevention and wellness care for children can serve as a resource, such as EPSDT standards, the Bright Futures guidelines, and the quality measures currently being developed pursuant to the Children's Health Insurance Program Reauthorization Act.
  - b. **Add measures for 2011 regarding receipt and follow-up on newborn screening lab results.** We applaud the 2011 objective to incorporate lab-test results into the EHR. We believe the associated measure of the percentage of lab results incorporated into the EHR is appropriate but not sufficient. More direct measures of quality improvement, such as an additional measure on the percent of infants for whom newborn screening results are incorporated and the percent of positive results for which follow-up is recorded, would accelerate progress toward the care goals.
  - c. **Stratify reports by gender, insurance type, primary language, race, and ethnicity.** We strongly support the inclusion of this stratification in the measures for 2011. We recommend this stratification apply to child-specific measures and all other measures of meaningful use.
  
5. **Strengthen objectives and measures for engaging patients and families.** We applaud the inclusion of patient and family engagement as a national priority. To accelerate progress on this priority, we recommend the following:
  - a. **Move the objective and measures for secure patient-provider messaging to 2011.**
  - b. **Include incorporation of patient-generated data as an objective for 2013.**
  - c. **Amend the 2011 objective regarding patients' electronic access to clinical information to specify that such access must be provided on a timely basis, including access in real-time where available (e.g., for lab results).**
  - d. **Clarify the 2011 objective regarding patient-specific educational resources to include self-management and shared decision-making tools.**
  
6. **Expand the care coordination vision to include exchange of information among the array of programs and professionals that serve children.** Coordination of care for children requires more than just coordination among medical providers. Information sharing across settings and programs that serve children, such as schools, behavioral health, developmental health, social services, child welfare services, public health, juvenile justice, and Medicaid and CHIP, can promote better health outcomes for children generally and particularly for vulnerable children, such as children in foster care and children with special health care needs. To ensure that this whole-child approach to care is realized, we recommend the following:
  - a. **Include this expanded vision of care coordination in the preamble framework for the meaningful use definition and highlight it as a specific means of addressing the unique needs of children, as proposed above.**
  - b. **Clarify that the care goal regarding exchange of meaningful clinical information is bi-directional and not limited to exchange among medical providers, when consistent with patient privacy protections and preferences.**
  - c. **Acknowledge the need for further infrastructure development and investments to enable the full care team to participate in HIT-enabled care coordination.** Because the ARRA EHR incentives are fairly narrowly targeted to hospitals, physicians, and a limited number of other health care professionals, other members of the care team may not have the capacity to engage in electronic information exchange. Nevertheless, the vision should be articulated to encourage such connections in the future. For example, we strongly support the objectives and measures relating to bi-directional exchange of information with public health agencies, but would urge the preamble to acknowledge that public health departments may not have the capability of engaging in these kinds of exchanges in a fully electronic, seamless manner. Therefore, additional resources may be required to realize the full health benefits of this meaningful use.

- 7. Clarify privacy protections for children's health information.** Uncertainty, real or perceived, regarding privacy protections can be a barrier to adoption and use of HIT for both providers and consumers. Areas of uncertainty in federal and state privacy protections of particular concern to children and families, and providers of services to them, include: standards for information about adolescents' health; standards in situations of complex parental rights or guardianship, such as joint custody or foster care; and standards for sharing information across settings and programs that serve children, such as schools, social services, child welfare services, public health, juvenile justice, and Medicaid and CHIP.
- a. **Develop guidance that fosters common understanding and standards for protecting children's health information while supporting the communication that can lead to more effective, better coordinated care.**
  - b. **Ensure that meaningful use objectives and measures that rely on patient preference (e.g., electronic access to clinical information; reminders for preventive or follow-up care) appropriately and separately account for preferences of patients and their parents, guardians, or other authorized representatives.**

Thank you for the opportunity to comment on this preliminary definition of meaningful use. We look forward to working with you to maximize the impacts of the ARRA HIT provisions for children and all Americans. Please contact Terri Shaw, Deputy Director, at 510-967-3165 or [tshaw@childrenspartnership.org](mailto:tshaw@childrenspartnership.org) if you have any questions about these recommendations or the work of The Children's Partnership.

Sincerely,

Wendy Lazarus  
Founder & Co-President