

**Comments to CMS Notice of Proposed Rulemaking (NPRM)
Issued December 30, 2009
Regarding Implementation of Meaningful Use Under
ARRA HITECH**

**Submitted by Picis, Inc.
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Introduction

Picis, as a leading US healthcare information technology provider, has focused its efforts for the past 13 years entirely on the high-acuity areas of hospitals: the emergency department (ED), the operating room (OR) and the intensive care unit (ICU). Like many in the healthcare sector, we eagerly anticipated the publication of proposed rules implementing ARRA HITECH, as we believe that the Act will help drive and accelerate adoption of healthcare IT, and thereby propel the country toward the ultimate goals of improved healthcare for US citizens and its more cost-effective provision.

We find the vast majority of the proposed rules issued by CMS on December 30, 2009 laudable, and a faithful interpretation of the spirit of the Act and the intent of the Office of the National Coordinator (ONC) within the Department of Health and Human Services (DHHS). In fact, in some areas, the rules expand on the earlier proposals for meaningful use issued by ONC in August, 2009, for the better. For example, making several additional quality reports mandatory should further both the collection and reporting of critical data and the provision of better care. Likewise, the inclusion of discharge summaries as part of the meaningful use definition should improve patient transitions and continuity of care.

However, we must comment on what we consider a serious flaw in the proposed rules – the exclusion of the emergency department (ED) from the definition of, and thus the elimination of the ED as a source of, demonstration of meaningful use, and therefore access to the incentive payments.

The Proposed Rule

As we read the proposed rule, CMS has chosen to define “inpatient” for the purpose of hospital incentive funding based on Place of Service Codes. Under this proposed definition, an “inpatient facility/department” includes only those with place of service code 21, and specifically excludes the emergency department, which bears a place of service code of 23.

Our fear is that if not changed, this rule will take the focus off the automation of the ED for hospitals, which would work against the spirit of ARRA HITECH. Further, it would run counter to the earlier meaningful use definitions, as proposed by the HIT Policy Committee.

Our Comments

As outlined in the *Federal Register*, these are the priorities set forth by CMS in the development of the rules:

The first health outcomes policy priority specified by the HIT Policy Committee is improving quality, safety, efficiency and reducing health disparities.

The HIT Policy Committee identified the following care goals to address this priority:

- Provide access to comprehensive patient health data for patient's healthcare team.
- Use evidence-based order sets and computerized provider order entry (CPOE).
- Apply clinical decision support at the point of care.
- Generate lists of patients who need care and use them to reach out to those patients.
- Report information for quality improvement and public reporting.

The second health outcomes policy priority identified by the HIT Policy Committee is to engage patients and families in their healthcare.

The third health outcomes policy priority identified by the HIT Policy Committee is to improve care coordination.

In virtually every one of these areas, exclusion of the emergency department works against the policy goals as stated:

- Lack of ED-generated and -captured data will rob the patients' healthcare teams of vital clinical information, essentially ruling out "comprehensive patient data" for millions of Americans each year. Hospitals on average receive 50% of their admissions through the ED, and in some cases (busy urban trauma centers, for example), that figure can approach 80%. The gap in information from the ED in the care record would at best result in a lack of completeness, and at worst create a patient safety hazard.
- It certainly works against the complementary goals of improved care coordination and the desire to engage patients and families in healthcare. Data from the ED is crucial to patients' primary care physicians (PCPs), who ultimately need that information, regardless of whether the patient is discharged from, or admitted through, the ED. The focus on health information exchanges (HIEs) in ARRA HITECH is commendable in drawing PCPs, patients and their families closer together for key medical decisions. Not requiring ED data to "feed" the records in the HIE, or to not have access to information about patients' conditions and previous treatment episodes, we believe, would be inexcusable.
- The ED is a care area that generates a large proportion of orders in a hospital. Not including the ED in the regulations will result in an incomplete picture of the ordering profile in any given hospital, hindering the gathering and dissemination of evidence useful to the development of evidence-based order sets.
- From a practical standpoint, not allowing the ED to count toward the 10% CPOE criterion for FY2011 will cause many hospitals to fall short of meaningful use, delaying the dissemination of the funds intended to bolster and sustain the recovery just beginning to take hold. We believe the ED is crucial to the overall goal of creating and/or saving jobs the Administration and Congress intended in the development and passage of ARRA.
- If any area of the hospital can benefit from clinical decision support, it is the emergency department. The pace here is hectic, the opportunities for error abound. Clinical decision support and risk management tools can have a profound effect on patient outcomes and safety. They can also reduce the incidence of medical errors, holding out the potential of fewer lawsuits, and thus the possibility of reducing the tort burden which currently drives up costs across the entire healthcare spectrum.
- Excluding the ED works against the goal of reducing disparities. Health insurance reform, should it pass, holds out the hope of more universal access to health resources. In the meantime, we need to acknowledge that many currently without coverage use the ED as their primary point of care, knowing that they cannot be turned away. This applies disproportionately to those on the lower rungs of the socioeconomic ladder, as well as such populations as the chronically unemployed and those for whom COBRA benefits have expired or are too expensive to continue paying. Including the ED in the rules will improve the quality and efficacy of care for these populations and help reduce disparities.



Conclusion

For all the reasons outlined above, we encourage CMS to reconsider its exclusion of the emergency department (ED) place of service as the rules for meaningful use are finalized after the comment period. We hope that it was an oversight in the NPRM. Whether intentional or unintentional, we believe that excluding the ED works against many of the goals outlined by the HIT Policy Committee in its recommendations.