

Meaningful Use Workgroup Recommendations for Response to Stage 2 Notice of Proposed Rule Making on EHR Incentive Program

**Paul Tang, Palo Alto Medical Foundation, Chair
George Hripcsak, Columbia University, Co-Chair**

April 4, 2012

Workgroup Membership

Co-Chairs:

Paul Tang
George Hripcsak

Palo Alto Medical Foundation
Columbia University

Members:

- David Bates
 - Michael Barr
 - Christine Bechtel
 - Neil Calman
 - Tim Cromwell
 - Art Davidson
 - Marty Fattig
 - James Figge
 - Joe Francis
 - Leslie Kelly Hall
 - Yael Harris
 - David Lansky
 - Deven McGraw
 - Latanya Sweeney
 - Greg Pace
 - Robert Tagalicod
 - Karen Trudel
 - Charlene Underwood
 - Amy Zimmerman
- Brigham & Women's Hospital
American College of Physicians
National Partnership/Women & Families
Institute for Family Health
Department of Veterans Affairs
Denver Public Health
Nemaha County Hospital
NY State Dept. of Health
Veterans Administration
Healthwise
HRSA
Pacific Business Group/Health
Center/Democracy & Technology
Carnegie Mellon University
Social Security Administration
CMS/HHS
CMS
Siemens
Rhode Island Department of Health and Human Services

Agenda

- Initial MU WG response to stage 2 NPRM
- Initial MU WG response to selected other questions in NPRM
- Q&A and Discussion

Response Timeline

- Meaningful Use Work Group deliberation on response to stage 2 NPRM
- Selected objectives and quality measures assigned to other work groups
- April 4: Present initial recommendations for HITPC feedback
- April: MU WG revise recommendations
- May 2: Revised recommendations for HITPC approval
- By May 7: Submit HITPC response to NPRM

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
>30% patients with at least one medication order entered using CPOE	Medications: 60% Lab: More than 60% have at least one lab order entered Radiology: At least one radiology test is ordered	More than 60% of medication, laboratory, and radiology orders are recorded using CPOE	(1) Clarify whether paper orders need to be counted. If counting paper orders is difficult, then we propose that the denominator be 1) medications on the med list, 2) resulted lab tests, and 3) resulted radiology tests. The numerator would be # of CPOE orders entered by the authorizing provider (the goal of CPOE). (2) As proposed, med, lab, & rad orders are lumped so that one could skip an order type completely. Recommend keeping percentage by order type (3) Recommend keeping definition requiring a licensed professional (no scribes). (4) Clarification- HITPC Proposal: only radiology was suggested as yes/no; laboratory was counted.
Implement drug-drug and drug-allergy interaction checks	Employ drug interaction checking (drug-drug, drug-allergy) provider to refine DDI rules	Consolidated	(1) We agree with the consolidation, especially because DDI is still separate in the consolidated objective. (2) We believe DDI deserves special attention because current commercial DDI databases are well known to have high false positives , which contribute to alert fatigue. Providers should be able to revise DDI rules.
EP only: Generate and transmit electronically > 40% of all prescriptions	EP: Increase threshold to 50% EH: Transmit 10% of discharge orders	> 65% of all EP prescriptions and >10% of all hospital discharge orders for Rx are compared to at least one drug formulary and transmitted electronically	65% may be high due to patient preference and pharmacy capabilities in certain geographies. Will defer to IE WG for final recommendation. We agree with the EH recommendation.

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
>50% of all unique patients seen have demographics recorded	increase to 80%	More than 80 % of all patients seen have demographics recorded	Agree with 80%. Would recommend adoption of CDC demographic standards, which are more granular (but can be mapped to) 1997 OMB standards.
Maintain an up-to-date problem list for >80% of all patients	No change	Consolidated with summary of care	We recommend keeping these 3 lists as separate objectives for the following reasons: 1) they were and still will be important motivators for clinicians to enter and maintain accurate lists; 2) the stage 1 requirement is very minimal; we were planning to add more rigorous capabilities to facilitate maintaining complete and accurate lists 3) just having these elements in a transition of care document (which may be difficult or impossible for clinicians to access) does not give the information the visibility it deserves; 4) removing the objectives sends a signal that these 3 items are less important than other items like demographics and vital signs.
Maintain active medication list >80% of all patients	No change	Consolidated with summary of care	
Maintain active medication allergy list for >80% of all patients	No change	Consolidated with summary of care	
Record and chart changes in vital signs for >50%: Ht,Wt, BP, BMI, growth charts 2-20 yrs	Record and chart vital signs for >80% : Ht,Wt, BP (3 and >), growth charts for patients 0-20 yrs	> 80% of all patients record blood pressure (3 and >) and ht/ lgt and wt (for all ages) recorded	Agree.

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Smoking status for patients 13 & older for >50%	Increase threshold to 80%	> 80% of patients 13 and older	Agree.
Implement one CDS rule relevant to specialty or priority	Use CDS support - change certification criteria definition	1. Implement 5 CDS interventions related to five or more CQMs 2. Drug-drug and drug-allergy interaction checks enabled	(1) The certification criteria should include the suggested clinical decision support attributes. (i) Enhance the source/citation criterion as a hyperlink to peer-reviewed literature, or as a name and funding source if it is internally developed. (ii) It should be configurable (see examples). (iii) Presented at relevant point in the clinical workflow, which is mentioned in the NPRM text. (iv) Presented to users who can act on them. (v) can be integrated into EHR (vs. standalone). (2) In addition to DDI, require an additional decision support function addressing efficiency such as reducing overuse of high-cost imaging or use of generic medications.
MENU: Implement drug-formulary checks with access to at least one drug formulary	Drug formulary checks according to local needs (internal/external formulary, generic substitution)	Consolidated - include within eRX core objective	Agree.
Report ambulatory and hospital clinical quality measures to CMS or States	No change	Removed - Objective is incorporated directly into the definition of a meaningful user	Agree.

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
EH MENU: Record advanced directives for > 50% patients 65 or older	Record an advance directive exists for EP: at least 25 patients and provide access to a copy EH: >50% of patients 65 years and older and provide access to a copy	EH Menu - >50% of all unique patients 65 or older a have an indication of an advance directive status recorded as structured data.	EP: We recommend adding a Menu requirement - More than 10% of patients who are 65 or older. Strongly recommend moving to core for Stage 3. EH: This is an important objective and we recommend the original stage 1 objective should be moved to core for hospitals.
MENU: Incorporate clinical lab test results into certified EHR for more than 40% of all clinical lab tests results ordered with a +/- or # format	Incorporate >40% of all clinical lab tests	EP/EH: >55% of all clinical lab tests results ordered whose results are in a +/- or # format	Agree. Okay to count individual tests.
MENU: Generate lists of patients by specific conditions	Generate lists of patients by multiple specific conditions	Generate at least one report listing patients of the EP, EH/CAH with a specific condition.	Agree. We had suggested multiple specific conditions, to ensure that EHRs were certified to handle more than one variable.

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
EP MENU: Send reminders to >20% of all patients 65+ or 5 or younger	>10% of all active patients are sent a clinical reminder (existing appointment does not count)	>10% of all patients w/in 24 months prior to the EHR reporting period were sent a reminder, per patient preference	Agree. It may require exclusions for some specialists, such as surgeons who do not require follow up after the initial post-op visit or manage preventive services.
N/A	EH: Medication orders automatically tracked via electronic medication administration record in-use in at least one hospital ward/unit	EH: > 10% of medication orders created by authorized providers are tracked using eMAR.	Agree.
N/A	N/A	NEW MENU - >40% of all scans and tests whose result is an image ordered are incorporated into or accessible in EHR	(1) We agree with the proposed objective, but would recommend a 10% threshold with an exclusion if they have no access to electronic images (e.g., local imaging centers do not offer electronic access). (2) Re: question about a <i>potential</i> measure requiring exchanging images for 10%. While we agree with the spirit of the potential measure, we but believe that Stage 2 may be too soon to expect EPs and EHs to share images with outside providers.
N/A	N/A	NEW MENU: >20 % have a structured entry for one or more first-degree relatives or an indication that family health Hx has been reviewed	Although we support the spirit of this objective, we are not aware of adopted standards in this area, and we have concerns about the cost/benefit of the information as currently captured (e.g., FH is dependent on the clinical condition).

Objectives not included - Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Enter at least one electronic note for > 30% of visits (non-searchable, scanned notes do not qualify)	N/A Record electronic notes in patient records for >30 % of office visits.	Agree with adding text-searchable notes to certification. Because some certified EHRs do not have clinical documentation, and we believe that having a complete record, including progress notes, is required to deliver high quality, efficient care, we recommend that provision for recording progress notes should be a meaningful use objective.
N/A	Hospital labs send (directly or indirectly) structured results to outpatient providers for >40% of electronic lab orders received.	N/A Hospital labs send structured electronic results to outpatient providers for >40% of electronic lab orders received.	The providers depend upon hospital labs which are about 40% of the market. Coordinate with IE workgroup.

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Provide >50% with an electronic copy of their health information	Combined with other objectives	Replaced	Agree.
Provide >50% with discharge instructions	Combined with other objectives	Replaced	Agree.
>10% of unique patients timely electronic access to their health information	>10% view and have the ability to download EP : available w/in 24 hrs (or 4 days after available) EH : available w/in 36 hrs	Replaced	Agree, with improved timeliness to 2 business days for EPs.
N/A	N/A	NEW Measure 1. > 50% provided online access EP 4 business days EH w/in 36 hrs 2. >10 % of patients view, download, or transmit to a 3rd party	<p>We appreciate and agree with the intent to keep the timeliness criterion simple (1 timeline). However, we believe there is value in providing the patient with prompt access to the summary of an encounter (which we define as an office visit or other contact in which an order is generated). We propose that a single timeliness criterion be applied, and that it be shortened to "within two business days of information becoming available to the EP."</p> <p>The MU WG is divided about the threshold for patients seen who have actually viewed, downloaded, or transmitted during the reporting period.</p> <p>NB: Discharge instructions were available at discharge in stage 1, and in NPRM that goes to 36 hrs</p>

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Clinical summaries for >50% of all office visits within 3 business days	Provide clinical summaries to >50% within 24 hours; available within 4 days	EP: Clinical summaries provided to patients within 24 hrs for >50 % of office visits.	The NPRM says that HITPC recommended that for clinical summaries information be made available within 24 hrs or within 4 <i>business</i> days of info becoming available. The HITPC actually recommended that for clinical summaries information be made available within 24 hrs or within 4 (calendar) days of becoming available. That is consistent with our new recommendation to use 2 business days overall to achieve a single timeline for all data.
MENU: Use certified EHR to identify patient-specific educational resources for >10% of all patients	Identify educational resources and provide to >10%	Patient-specific education resources are provided to patients for >10% of all office visits	Agree.
N/A	Offer secure online messaging to patients: at least 25 patients	A secure message was sent using the electronic messaging function for > 10 % of patients	We are concerned about 10% being too high to achieve by Stage 2. We recommend lowering the threshold to 5% (which is 10% of the necessary 50% with portal access) for patient-initiated messages. The patient-initiated message could be a response to a provider message.

Objective not included - Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Record preferences for communication for >20%	<p>N/A</p> <p>EP: Record preferences for communication for >20%</p>	<p>HITPC's intent was to capture a patient's preferred communication method in order for the system to use that media for future non-urgent communication. This respects the patient's wishes and is more efficient for the provider. We recommend that the preferred communication field support multiple message types (e.g., non-urgent clinical, administrative) and preferred media (e.g., electronic, phone, SMS message).</p>

Improve Care Coordination

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Perform at least one test of the capability to exchange key clinical information	HIE test eliminated in favor of use objectives	Removed for an actual use case	We agree with eliminating the test. For Stage 1, we suggested option 4 (actual electronic transmission of a summary of care document), but will defer to the IE WG for final recommendation.
MENU: Perform medication reconciliation for >50% of transitions	Move to core.	Performs medication reconciliation for > 65% of transitions	The certification criteria should support the reconciliation process (e.g., comparing multiple medication lists and resolving differences). In order to support the measure, the provider needs to capture the fact that a transition has occurred. Because detection of the occurrence of a transition must be captured manually, we recommend that the threshold remain at 50%.
MENU: Provide a summary of care record for >50% of all transitions and referrals of car	1.Record and provide (by paper or electronically) a summary of care record for >50% of transitions of care for the referring EP or EH 2. Record care plan goals and patient instructions in the care plan for >10% of all active patients	Summary of care record provided for >65% of transitions of care and referrals. Electronically for >10% of transitions (outside organization and other EHR vendor).	Care plan section of the summary of care document should include the reason(s) for referral or transition and the results of the referral (recommendations). To support the measure, the provider needs to capture the fact that a transition is about to occur. We agree with the requirement for measure 2 that the transmitted summary of care document should cross organizational barriers. However, we believe that while it is essential that the exchange of information comply with prescribed standards, we believe that requiring that the transmission occur between different vendor systems may cause unintended consequences in some geographic regions where a few vendors may have a dominant market share. The group was divided on countable number vs. percent. Coordinate with IE workgroup.

Objectives not included - Improve Care Coordination

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Record health care team members for >10% of all patients; this information can be unstructured	N/A Record health care team members for >10% of all patients.	Okay to leave as part of the summary of care document.
N/A	Send care summary (with care plan and care team) electronically to the receiving provider EP : at least 25 pts. with transition of care. EH : for >10% of discharges	N/A Record care plan goals and patient instructions in the care plan for >10% of patients seen during the reporting period.	Okay to leave as part of the summary of care document.

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
<p>MENU: Perform at least one test of the capability to submit electronic data to immunization registries</p>	<p>Attest to at least one submission of data in accordance with applicable law and practice</p>	<p>Successful ongoing submission of electronic immunization data to an immunization registry or except where prohibited, and in accordance with applicable law and practice</p>	<p>We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited".</p>
<p>Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies</p>	<p>Attest to submitting to at least one organization in accordance with applicable law and practice</p>	<p>NEW Measure: Successful ongoing submission of electronic laboratory results in accordance with applicable State law and practice, except where prohibited</p>	<p>As above.</p>
<p>Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies</p>	<p>Attest to at least one submission in accordance with applicable law and practice</p>	<p>EP MENU/EH Core - Successful ongoing submission of electronic syndromic surveillance data to a public health agency except where prohibited and in accordance with applicable law and practice</p>	<p>As above.</p>

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	N/A	NEW MENU - Successful ongoing submission of cancer case information except where prohibited, and in accordance with applicable law and practice.	Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited". Further clarification is needed regarding what is an acceptable registry.
N/A	N/A	New MENU - Successful ongoing submission of specific case information to specialty registries except where prohibited, and in accordance with applicable law and practice.	We are in agreement with the objective. Need to consider whether sufficient standards are available to support the interfaces between EHRs and registries. Panelists at our hearing also expressed concern about the proprietary nature of some registries, which affects the costs to participate, and in some cases places contractual restrictions on use of data and ability to participate in other registries. Concern about requiring all EHRs to interface all data with all registries. Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited". Further clarification is needed regarding what is an acceptable registry.

Privacy and security protections for personal

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
<p>Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of the its risk management process</p>	<p>1. Perform, or update, security risk assessment and address deficiencies 2. Address encryption of data at rest</p>	<p>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3),and implement security updates as necessary and correct identified security deficiencies as part of its risk management process</p>	<p>Privacy and Security Tiger Team</p>

Comments Solicited in NPRM (I)

Topic	Comments Solicited in NPRM	MU WG Comments
Group reporting	<p>We seek public comment on a group reporting option that allows groups an additional reporting option in which groups report for their EPs a whole rather than broken out by individual EP. What should the definition of a group be for the exercise of group reporting? For example, under the PQRS Group Reporting Option, a group is defined as a physician group practice, as defined by a single Tax Payer Identification Number, with 25 or more individual eligible professionals who have reassigned their billing rights to the TIN. We could adopt this definition or an alternative definition.</p>	<p>The MU WG believes that the functional objectives should be met individually and supports the Quality Measurement WG language for quality measures: [The QM WG] supports finding more efficient batch reporting options that don't hide variability in the group. However the WG has concerns that the group reporting option as described in the NPRM may allow "groups" of doctors that only share a tax ID to report together without them having coherent practice with care coordination. The WG suggested making the financial incentive align for "natural" groups like ACOs, but make the financial incentives stronger for "artificial" groups (e.g., multi-specialty group sharing a tax ID, but not exchanging data or doing care coordination) to report individually rather than as a group.</p>
EHR Safety	<p>EHR safety (in certification rule - Quality management process, user centered design, common-format reporting)</p>	<p>Consider asking HITPC to provide comments on the IOM recommendations to ONC. If so, then HITPC can designate a Tiger Team to accomplish this.</p>

Comments Solicited in NPRM (II)

Topic	Comments Solicited in NPRM	MU WG Comments
Stage 2 Core and Menu Objectives	<p>In the Stage 1 final rule we outlined Stage 1 criteria, we finalized a separate set of core objectives and menu objectives for both EPs and eligible hospitals and CAHs. EPs and hospitals must meet or qualify for an exclusion to all of the core objectives and 5 out of the 10 menu measures in order to qualify for an EHR incentive payment. In this proposed rule, we propose to maintain the same core-menu structure for the program for Stage 2. We propose that EPs must meet or qualify for an exclusion to 17 core objectives and 3 of 5 menu objectives. We propose that eligible hospitals and CAHs must meet or qualify for an exclusion to 16 core objectives and 2 of 4 menu objectives.</p>	<p>We agree with use of the menu approach to provide:</p> <ol style="list-style-type: none"> 1. Flexibility 2. Strong signals with lead time to develop/implement new functionality 3. Accommodation for all-or-nothing qualification rule
CPOE - licensed healthcare professionals	<p>With this new proposal, we invite public comment on whether the stipulation that the CPOE function be used only by licensed healthcare professionals remains necessary or if CPOE can be expanded to include non licensed healthcare professionals such as scribes.</p>	<p>The essential feature is that the EP or EH professional be able to act on the automated decision support and be accountable for the order.</p>
eRx - OTC meds	<p>We do not believe that OTC medicines will be routinely electronically prescribed and propose to continue to exclude them from the definition of a prescription. However, we encourage public comment on this assumption</p>	<p>We believe it is important for EHRs to be able to capture OTC medicines (without transmitting to pharmacy) and to ensure that these medicines can be used to detect drug-drug interactions. We agree, however, that for measurement purposes, OTCs can continue to be excluded from the denominator.</p>

Comments Solicited in NPRM (III)

Topic	Comments Solicited in NPRM	MU WG Comments
Demographics - disability status	We encourage public comment on the burden and ability of including disability status for patients as part of the data collection for this objective. We believe that the recording of disability status for certain patients can improve care coordination, and so we are considering making the recording of disability status an option for providers. We seek comment on the burden incorporating such an option would impose on EHR vendors, as well as the burden that collection of this data might impose on EPs, eligible hospitals, and CAHs.	Important signal to send for Stage 3, but data standards do not exist yet.
Summary of Care Record - Care Plan	For purposes of meaningful use measurement we propose that a care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome). We encourage EPs to develop the most robust care plan that is warranted by the situation. We also welcome comments on both our description of a care plan and whether a description is necessary for purpose of meaningful use...	Although the information content in the summary of care document (intended for providers) may overlap with the content in clinical summaries (intended for patients), the way the information is expressed in the patient-facing document should be understandable to patients. We note that “relevant past diagnoses” requires a precise definition and would require human intervention to implement.
Summary of Care Record - Definition of lists	We solicit comment on whether the problem list should be extended to include, "when applicable, functional and cognitive limitations" or whether a separate list should be included for functional and cognitive limitations. We define an up-to-date problem list as a list populated with the most recent diagnoses known by the EP or hospital.	The conditions listed are similar to any other health condition, and consequently should appear on the problem list when applicable.

Comments Solicited in NPRM (IV)

Topic	Comments Solicited in NPRM	MU WG Comments
Public Health - Syndromic Surveillance Menu item	We specifically invite comment on the proposal to leave syndromic surveillance in the menu set for EPs, while requiring it in the core set for eligible hospitals and CAHs.	We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014 . If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority .

QUESTIONS AND DISCUSSION