

Stage 2 MU NPRM Comments from the Information Exchange Workgroup

Hospitals Send Laboratory Results to Ambulatory Providers

Comments

The IE WG disagrees with the CMS NPRM decision to exclude this objective and recommends that CMS restore the HITPC-recommended requirement for hospitals to send structured lab results electronically to ambulatory providers using certified electronic health record technology and in accordance with designated standards (references to NPRM):

§ 170.205(k)

HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Standards and Interoperability Framework Lab Results Interface, Release 1 (US Realm)

§ 170.207(g)

LOINC version 2.38

Existing operational interfaces that are delivering structured lab results in accordance with the MU definition should be grandfathered for as long as the existing interfaces are in place.

Discussion

- Hospital labs are an important supplier of lab results to ambulatory providers, representing approximately 40 percent of the ambulatory lab testing market. MU is a powerful and unique lever for getting standardization in an area that has historically been fragmented and difficult to align yet is critically important for the achievement of a wide variety of MU objectives and goals.
- Would constrain some of the optionality that exists in the market today, which is hindering hospital lab results delivery to ambulatory EHRs as each vendor tends to impose different interface requirements.
- Many hospitals would find this objective beneficial because it would create a uniform standard for laboratory exchange transactions--using the LOINC subset and lab results interface requirements developed by the S & I initiative--which would eliminate variation in interfaces, reducing cost and time to deploy.
- Would directly enhance the ability of EPs to meet meaningful use requirements including incorporating laboratory test results into their ambulatory EHRs as structured data, generating lists of patients with particular conditions, and using decision support.
- Would enhance EPs' CQM capabilities by increasing the amount of structured data available for measurement, and by enhancing the quality and integrity of that data, which is critical not only to MU but also to accountable care.
- While it is appropriate to require a hospital laboratory system to be capable of providing LOINC-coded results via HL7 2.5.1, the grandfathering provision would avoid the need to "rip and

replace” existing operational interfaces and give hospitals time to upgrade their systems to HL7 2.5.1, which is already required in the NPRM for hospital ELR reporting to public health.

Perform an HIE Test

Comments

The IE workgroup agrees with the CMS proposal to remove this objective for Stage 1 with no replacement.

Discussion

- According to CMS statistics, this objective has not been widely chosen by EPs or EHs to date. One contributing factor is likely confusion about the intent and requirements of the objective. This was a comment the workgroup made in its Stage 1 recommendations.
- While we understand that removing this objective will eliminate the only Core care coordination measure from Stage 1, this measure is not well enough defined to result in an appropriate escalator towards exchange.
- We do not recommend replacing this objective because relatively few providers will be affected by it as the Stage 1 cohort diminishes over time, the intent of the objective is achieved by Stage 2 interoperability requirements, and we want to minimize the number of changes made to Stage 1 requirements to reduce market confusion.
- Replacing this objective with Option 4 would not be productive because single tests of capabilities end up being little more than “check the box” objectives that do not tend to have a strong or lasting behavioral impact.

Transition of care summaries

Comments - 1

The IE WG supports the requirement to conduct electronic transmission of care summaries, but recommends removing the cross-vendor requirement to meet the 10% electronic exchange threshold.

Discussion

- The workgroup supports the requirement to conduct electronic transitions with non-affiliated organizations, but not with the requirement regarding use of a different vendor.
- There are many markets, both rural and urban, where a single vendor dominates the health care delivery system making this requirement very difficult to achieve.
- The goal of the objective should be to increase standards-based electronic transmission of summaries according to patient flow, regardless of which vendors the provider organizations use. The certification and electronic measurement processes should be made robust enough to ensure that required standards are utilized regardless of which system the recipient provider is using.

- It would be very challenging to develop an automated measurement procedure that could distinguish which vendor system the receiving provider is using.
- An unintended consequence of only recognizing cross-vendor exchange is that it undercuts the incentive for vendors to deeply integrate national standards into their applications. Rather than building their products around national standards, they might instead retain and deeply integrate their own favored proprietary modes for exchange within their system and maintain less integrated workflows for standards-based exchange outside of their system.

Comments - 2

The IE WG recommends adjusting the electronic transmission measure denominator in two ways:

- Exclude from the denominator referrals to providers that have the ability to view or query patient clinical data, either directly from the referring provider's EHR or from a repository or HIE populated with patient data by the referring provider.
- Exclude the provider from the objective if the resultant denominator is fewer than 50 referrals per year.

Discussion

- The IE WG supports objectives that move HIE from "push" to "query-retrieve" functionality. In consideration of the fact that some organizations, such as those participating in NwHIN Exchange, have advanced to query functionality, the WG discussed possibilities for recognizing this capacity by allowing such transactions to qualify for the 10% electronic transitions of care requirement. The group concluded, however, that such transactions are functionally equivalent to providing access to an EHR (which the NPRM excludes from this measure) and should thus be treated similarly by excluding such transactions from the measure denominator.
- We note that HIE models that allow "subscriptions" to information that is automatically "pushed" during transitions of care should count toward measure fulfillment (i.e., allowed in the numerator) so long as it meets all other requirements (content, timeliness, use of CEHRT).

Medication reconciliation

Comment

The IE WG agrees with the medication reconciliation objective and measures, but recommends that the exclusion criteria account for specialties and/or clinical situations where medication reconciliation would not be warranted or necessary.

Discussion

- Some situations do not require medication reconciliation and the requirement could impose workflow burdens with no corresponding clinical benefit (for example, orthopedist treating sprained wrist of an elderly person who is on multiple medications – med rec could be time-consuming but may not be relevant to the diagnosis or treatment).

- This expansion of allowed exclusions is especially important because this requirement is being moved from Menu to Core.

Electronic prescribing

Comment

The IE WG agrees with increasing the eRX requirement, but recommends that the threshold be 50% rather than 65% to account for the persistently wide variation in eRX infrastructure across the country and the non-universal use of eRX among mail-order pharmacies. The IE WG also feels that prescriptions to internal pharmacies should be excluded from the denominator.

Discussion

- IE WG remains concerned about the difficulty of achieving this objective in many parts of the country.
- According to Surescripts, only 60% of the mail-order prescription volume is electronically enabled through the SureScripts network.
- Regarding internal pharmacies, we note that the HIT Standards Committee recognized the same problem (much internal eprescribing happens today via HL7 messages) but recommended a different approach; to add HL7 as an approved standard for eRx transactions. Rather than diluting the policy toward eRX standards by adding another approved standard, the IE WG recommends excluding internal pharmacy transactions from the measure denominator.

Drug Formulary

Comment

The IE WG recommends retaining the formulary objective as a stand-alone measure and making it Core for EPs and hospitals:

- Formulary-checking should apply to all prescriptions, not just electronic.
- Providers should be required to use the EHR's automated formulary checking available in CEHRT; MU should not force the provider to perform out of workflow formulary checking
- HITSC/ONC should identify standards to support automated electronic formulary checking by EHRs
- EHR certification should include automated formulary checking applicable to the medication/patient/insurer/product and provide at a minimum formulary status, coverage, and copay
Measure should be that EP has enabled ("turned on") EHR's automated formulary checking during the entire reporting period

Discussion

- Formularies should not be intrinsically linked to electronic RX transactions. Some types of prescription transactions will inevitably be paper-based during the Stage 2 period (for example, due to patient preference and/or lack of pharmacy eRX infrastructure) and policy should encourage formulary use for ALL prescriptions, not just those that are electronically transacted.
- Formularies are specific to the health insurer and health insurance product of each individual patient. Relevant formularies are thus not often available to the provider, either because the health plan does not participate in national eRX networks or the health plan has not made an electronic formulary version readily available for a particular her.
- If EHRs are certified for automated electronic formulary checking, and this capability is enabled by the EP, no other measure should be required beyond electronic confirmation of continuous enablement

Public health (general)

Comment

The IE WG concurs with the inclusion of NPRM objectives that increase the volume and value of public health reporting and, in particular, with requiring public health submissions “except where prohibited” in Stage 1.

IE WG recommends more specific definitions for the key parameters of the public health requirements to assure rapid momentum in electronic reporting to public health.

- Specifically define “successful ongoing submission” to be 10% of all qualifying transactions increasing 10 percentage points per year over Stage 2 to a maximum of 50%
- The goal is to accommodate: 1) possible delay between the time an EH or EP offers to begin ongoing submission and the time that data/message/transport testing (“on-boarding”) is complete. This delay may occur both due to PH on-boarding capacity and the quality-testing and refinement often needed; and 2) the disruptions to ongoing transmission that might be due to either sender, receiver, or intermediaries. Specify transport requirements for public health transactions, aligned with transport requirements specified for electronic transmission care summaries for transitions. Grandfather existing transport approaches and apply new transport requirements only on new or replacement interfaces.
- Support policy of a single standard for public health transactions (uniformly use HL7 2.5.1 rather than permitting the 2.3.1/2.5.1 choice offered in Stage 1), however, recommend grandfathering those EPs and EHs who: 1) implemented 2.3.1 to achieve Stage 1 objective; 2) went beyond the single test and maintained submission to public health during the Stage 1 period; 3) are reporting to a public health department that is accepting 2.3.1 messages, and 4) are utilizing the same EHR technology that was used for their Stage 1 attestation.
- The Workgroup recognizes that local variation in the application of a national Implementation Guide is often needed (due to local law or practice) but should not increase the risk to EPs and EHs of failing to be able to comply with MU. Further consideration of how local variation may

be defined, limited and communicated in with ample advance notice to all impacted EPs and EHs is advised.

- Additional specificity is needed around the criteria by which providers can apply for exclusions; this should include cases where the public health agency/registry does not support ONC recognized transport, ONC recognized standards, implementation guides and vocabulary standards, or goes materially beyond the requirements of the implementation guide
- We note that the CDC has begun a process to guide development of local implementation guides that are flexible to local needs but still conform to HL7 2.5.1 and CDC implementation guides. An example for immunization transactions can be found here: <http://www.cdc.gov/vaccines/programs/iis/stds/downloads/hl7-IG-Template.docx> .

Discussion

- Recognize that public health is very decentralized, and that MU did not provide funding or authority over CDC or public health departments.
- Nevertheless, allowing so much discretion for public health reporting will be a significant barrier to success.
- Combined with “except where prohibited” requirement, imposes unreasonable burden on vendors to meet multiple, highly varied, state-specific requirements on use and transport standards.
- Regarding policy on HL7 standards, the IE WG believes it is important to not penalize those providers who in good faith met the Stage 1 public health objectives according to the requirements defined at that time. In particular, many EHR vendors could charge providers for interface upgrades which would impose a burden on such providers.

Public health (Syndromic surveillance)

Comment

The IE WG supports CMS’ proposal to make Syndromic Surveillance a Core requirement for EH/CAHs and a Menu requirement for EPs.

Discussion

- This was the IE WG recommendation last year.
- Public health infrastructure is not yet prepared to receive syndromic surveillance data from ambulatory care settings.
- The necessary standards are under development but do not yet exist so the WG is unable to assess the reasonableness of the requirement.
- We also note that for EPs this would be a new public health requirement that did not even exist in the paper world, so will be a whole new workflow and adoption challenge for ambulatory practices.

Public health (immunizations)

Comment

IE WG recommends that CMS broaden exclusion criteria to include circumstances where the immunization registry has designated a “health information exchange” to receive the information so long as this alternative is a reasonable alternative in terms of price and integration requirements.

IE WG recommends that CMS define more specifically which immunizations are required to be reported by providers.

Discussion

- NPRM allows exclusion where a public health entity is not capable of receiving immunization information, but exclusion does not apply where public health entity has designated a “health information exchange” or other entity to receive such information on its behalf.
- To the extent that such organizations may charge a fee or have high integration or other requirements, the exclusion should specify that the requirements for submission through the designated entity should be “reasonable”.

Public health (cancer and specialty registries)

Comment

IE WG recommends that CMS specifically designate which registries in each state or territory would qualify for this objective. These registries should also adhere to any standards being required through EHR certification.

- For Cancer Registries, recommend changing “state cancer registry” to “Public Health Central Cancer Registries” or just “Central Cancer Registries”, which would include all of the registries funded by CDC’s Division of Cancer Prevention and Control and by NCI’s SEER program. These include cancer registries maintained by states, territories, and regions. (SEER also includes some Indian nations.) The word “central” is typically used to distinguish these from hospital cancer registries.

Discussion

- As certification requirements are still unclear, this is appropriate as a Menu set requirement. If this becomes a Core measure at some point, it could create an implementation burden across the industry. Many specialty registries may charge fees or impose integration requirements that present an unreasonable burden on provider and EHR technology vendors.

View, download, transmit

Comment

IE WG supports the intent of the patient engagement objectives but recommends the following changes:

- Recommends changing the measure so that what counts towards the numerator are users registered for a patient portal or method to transmit to a patient-controlled application (e.g., PHR).
- Threshold should gradually increase over the Stage 2 period, beginning at 10% in year 1 and increasing 5 percentage points per year to a maximum of 25%.
- Numerator should count two options for transmit: 1) patient entering a portal and pushing information or 2) provider sending information automatically to an end point designated by the patient (for instance, to their Direct address).

Discussion

- There is wide variation in market success with patient adoption of patient-facing applications; the vast majority of EPs and EHs do not even have such technology in place, and of those who do, some larger, more experienced organizations have reached relatively high (50%+) active patient usage, but many providers have likely not been able to achieve comparable adoption.
- Agree that providers play an important role in patient adoption and thus agree with the intent of the objective to motivate EPs and EHs to take actions that encourage the use of such technologies. Our primary concern with the NPRM on this issue is that it goes too far given the state of the industry. It expects providers to motivate relatively sophisticated use of nascent technologies by a significant fraction of patients, when the reality is that providers have real but limited influence to affect patient adoption, especially as these nascent technologies are very new both to providers and to patients.
- “View/download/transmit” requires that a patient not only create a patient access account, but that they use it an ongoing manner. IE WG believes that providers reasonably have (or will have) the ability to affect one-time account creations, but not on-going use.
- IE WG thus proposes to incent and measure providers’ ability to get patients to “register” for such technologies, where “register” would mean the one-time step of having patients sign-up for an account, have security credentials (username/password) issued, and initiate or activate the account (perhaps by an initiation log-on to the account or responding to an activation email).
- In order to encourage forward progress during Stage 2, the IE workgroup also recommends that the performance threshold be gradually increased over the Stage 2 time period to motivate providers to continue to sign-up new patients. This could be increased during consideration of the Stage 3 NPRM if market uptake at that time would appear to allow it.

Secure messaging

Comment

IE WG agrees with the intent to encourage greater electronic communication between patients and providers, however, we recommend modifying this measure to also count in the numerator physician-initiated messages that are specifically relevant to the patient's clinical situation.

Discussion

- There is wide variation in market success with patient adoption of patient-facing applications; the vast majority of EPs do not even have such technology in place, and of those who do, some larger, more experienced organizations have reached relatively high (50%+) active patient usage, but most providers have likely not been able to get adoption at such high levels
- Agree that providers play an important role in patient adoption and thus agree with the intent of the objective to motivate EPs to take actions that encourage the use of such technologies. Our primary concern with the NPRM on this issue is that it goes too far given the state of the industry. It expects providers to motivate relatively sophisticated use of nascent technologies by a significant fraction of patients, when the reality is that providers have real but limited influence to affect patient adoption, especially as these nascent technologies are very new both to providers and to patients.
- In addition to the barriers cited above in the discussion of the view, download or transmit measure, a further barrier is that most health insurers do not currently pay for electronic communications with patients. While the limited evidence from market experience suggests that such communications do not, on net, generate more workload for providers once fully in place, uncertainty about this point and the upfront investment in time and effort required to put it in place make the lack of compensation for the model a significant barrier to widespread acceptance by providers.
- Anecdotal evidence from the field suggests that the biggest motivator of patient use of secure messaging is provider use of such messaging.
- Even though we are suggesting expansion of the numerator to include provider-initiated messages, we recommend maintaining the measure at 10% of all patients because providers would only be able to initiate clinically relevant messages to a fraction of those patients who have registered for secure messaging access.