HIT Policy Committee
Meaningful Use Workgroup
Summary of the Meeting - September 22, 2010

KEY TOPICS

1. Opening
Judith Sparrow, Office of the National Coordinator (ONC), called the roll and announced that the meeting was public.

2. Introduction and Plan for the Day

Process – Use Tool:

1. **Review Final MU Rule**
2. **Review Placeholders from July 2009 Matrix, Stage 2 and 3**
3. **Review Summary & Recommendations from Public Hearings**
4. **Draft Initial Recommendations for Stage 2 (Parking Lot for Stage 3)**
5. **CQM Concepts**

Paul Tang, MD, Chair, reminded members of the purpose and limitations of the Workgroup's scope. He reviewed the history of Workgroup efforts, saying that the meaningful use criteria for stage 1 were formulated in a very brief time period. More time has been allocated for making recommendations for stage 2 and 3 criteria. Hearings were held to get input from various stakeholder categories and continuous input has been received from the public. NQF convened a group of experts to consider the availability of quality measures. (See the Gretzky Group Report.) Quality measures are being identified by the Quality Work Group. The Workgroup's recommendations will be presented to the HIT Policy Committee October 20. ONC will issue an RFI at the end of the year, and review the comments early 2011. The earliest date to apply for stage 1 incentives is April 2011. The work group will review the experience of early submitters before finalizing its recommendations for stage 2 and 3

Chairperson Tang said that the group could proceed in one of two ways: begin with and build on the stage 1 criteria or start with stage 3 and consider how to get there. Most of the members appeared to prefer the latter approach. Dr. Tang reminded them of the previously agreed upon general criteria for selecting objectives—parsimony, evidence of a link between HIT and the outcome measure, use of coded data to reduce response burden, capture of data during work flow, and broadly applicable to providers. ONC staff had prepared a template to guide the discussion. The Chair and Co-Chair had added their comments. As the Chairperson led the discussion, Co-Chair George Hripcsak, MD, recorded notes on the template, which was shared with members via the Web conference. (Immediately after adjournment, these notes were distributed to the members.)

3. Quality, Safety, Efficiency, Disparities Category
Dr. Tang directed the members' attention to the grid that listed for each objective the stage 1 final rule, CMS signal for stage 2, HITPC preliminary directions for stage 2 and stage 3, recommendations from public hearings, related CQM, and suggestions for stage 3 measures

provided by the Chair and Co-Chair. Members discussed a range of topics for each objective including purpose, definitional and measure concerns, and setting percentage targets. They acknowledged that the percentages were assigned arbitrarily.

Under the CPOE objective, which they noted is one of the essential EHR functions, they considered that the purpose is to improve ordering. One member asked if "all orders" includes referrals. The Chairperson noted that who (which category of health care professional) can enter orders is dependent on state law. It was agreed that the objective should apply to orders across the board since any differentiation of type of orders would likely interfere with work flow. They set 60% as the suggested stage 2 target and 90% for the stage 3 target.

The drug-drug and drug-allergy interaction checks objective discussion raised the possibility of using the leap frog process and identifying a subset of potential interactions to be checked with a stage 3 objective being the percent of interactions detected. A lengthy discussion ensured. A member said that it would be necessary to have the medical history prior to running an interaction check. It was noted that this is an exchange and care coordination issue as well as a quality test. Since the goal is to reduce drug interactions, the e-prescribing industry representatives may be able to suggest more appropriate measures. A member pointed out that when reporting is required, incidence increases. The Workgroup does not want to create an incentive for not reporting. Someone asked why the measure was separated from CPOE, which is key to medication reconciliation and prevention of adverse reactions. The measurement must be captured from the coded data. Then the discussion veered off into the need for a system of adverse drug event reporting or a patient safety reporting system. The members were reminded about a previous recommendation for the establishment of an organization on patient safety. They agreed to coordinate recommendations on this measure with the Quality Measures Workgroup, which is considering the best way to measure adverse events. AHRQ may be working on measures of quality. Members suggested concentrating on drug-drug interactions in stage 2 and expanding to other kinds of interactions for stage 3.

The 40% of prescriptions done electronically for stage 1 excludes controlled substances. Some members thought that the final rule on controlled substances had been issued. Other members thought not. They agreed to increase the 40% to 60% and 80% in stages 1 and 2 respectively.

They said that the objective for reporting demographics should be increased to 90% in stage 3 and include the use of IOM-recommended codes. State laws may affect the capture of demographic data. A member said that the software currently exists to facilitate use of IOM categories. Collection of demographic data will enable the stratification of health outcome data and quality measures.

Reporting of CQM electronically is a certification criterion. CMS needs to research the legal requirements. The ability to report was required for stage 1. 90% should be required for stage 3. Members wondered if the Standards Committee was working on this measure. Reporting through intermediaries is permissible. The intent is to capture and store the data in standardized formats.

Regarding maintenance of problem lists, active medication lists, and medication allergy lists, members referred to difficulties of operationalization. "Up to date" and "current" do not have

agreed-upon definitions. Current may mean the most recent visit. Although they did not agree on definitions, they agreed that updated information was essential in exchange. They put the definitions on the parking lot.

The CMS representative reported that CMS is working with ONC to expand the FAQs and to clarify inconsistencies that have been identified in the regulations. CMS is issuing quality guidance.

The objective for both stage 2 and 3 is to have 80% of patients with vitals reported during the reporting year. There is no requirement for reporting vitals at each visit. Some vitals are age based. The growth chart cannot be recorded as structured data, according to one member.

Reporting on smoking status should increase to 80% and 90% in stages 2 and 3. Someone suggested adding reporting of exposure to second hand smoke for pediatric patients. It was suggested that an inquiry be made to the Standards Committee as well as to the Quality Measures Workgroup. The Chair reminded the members that the Workgroup is not a comprehensive certification body and is not expected to cover the entire spectrum of health issues.

Members said that to be certified EHRs must include CDS. They discussed how "use CDS" is to be defined in using CDS to address for stage 2. Perhaps this objective is linked to a quality measurement function. Local priorities should be recognized. Someone reported that the HHS secretary is expected to declare national quality conditions; these are potentially CDS conditions. Several members emphasized the need to leave the conditions open to take into account local issues and specialty concerns. Others stressed the importance of including public health issues, such as immunization. One member noted that since this is where the government's capital investment is expected to pay off, the recommendation should be prescriptive.

Members said that the infrastructure for implement drug formulary checks was not yet available. There are many formularies in use in the ambulatory environment. They said that this objective should therefore be deleted. The current measure can be moved to a core measure. In stage 1 a provider can defer reporting on up to five measures. The provider is then required to pick up reporting at stage 2.

The CMS representative reported that the objective of recording advance directives had generated interest from many groups. He said it would be helpful if the Workgroup examined the objective more closely, including soliciting testimony. Members raised issues of appropriate age requirements, applicability to ambulatory and specialty providers, and effect of state laws. They said that the objective should focus on having and recording a discussion about advanced directives not that a patient is required to have one. Members agreed to seek counsel on this objective prior to making a recommendation and to call out questions of appropriate age and applicability to the ambulatory and specialty environments in the RFI.

Regarding storing of lab results as structured data, members raised the objective to 90% in stage 3. They considered issues such as bidirectional reconciliation and difficulties encountered by ambulatory providers who are forced by MCO contracts to use more that one lab. They agreed to check with the Information Exchange Workgroup on standards.

Members discussed the relevancy of generating patient registry lists. Testimony at the hearings indicated that registries were considered not to be of great importance. Registry lists are only narrowly applicable to specialties. However, the creating and use of lists is very useful in CQI. They agreed to delete "registry".

Members agreed to continue the objective of 20% patient reminders to stage 3 and eliminated the age-based requirement, saying that clinical appropriateness was more important than age. They acknowledged that "clinical appropriateness" would be difficult to calculate. Several members noted that existing guidelines do not necessary require annual visits for the entire population. Other members argued that keeping the percentage low and including all patients would encourage clinicians not to neglect the age 18 to 50 population. In considering the denominator, they again acknowledged the ambiguity of "active patient". Someone said that one definition is a patient seen within a 2-year period. Another member suggested keeping the definition broad in order to capture underutilizers. They discussed the application of the objective to both preventative and follow up visits. Physician members noted that reminders would typically not be send until a visit was missed, a factor that should be taken into account in defining the denominator. Also, some patients may prefer not to receive a reminder. There was agreement that patients' preferences for mode of reminders should be respected. One member emphasized that most patients would appreciate these reminders; this is a visible benefit for patients and can be used to demonstrate the benefits of funding. They agreed to obtain input from providers who serve different populations prior to setting a target.

They moved on to progress notes. The Policy Committee recommended the inclusion of progress notes but CMS did not accept the recommendation for inclusion in the final rule. Reportedly, one reason for exclusion was the difficulty of defining progress notes. Members said that the inclusion of progress notes in the EHR is essential for continuity and coordination of care. Ideally, there should be at least one note per visit. One member pointed out that dictation and EHRs are not mutually exclusive; there are many work flows available that incorporate progress notes. The importance of including nursing notes in the hospital EHR was recognized. The possibility of a menu was discussed. They preliminarily agreed that targets of 30% and 90% were appropriate for stages 2 and 3 respectively, pending comments from the RFI.

They reviewed the family history inclusion recommendation, another recommendation not accepted by CMS. They considered its potential for a quality measure. They noted its importance is calculating risk factors and risk adjustments but said that the capture of structured family history data is difficult. Although most EHRs include family history, the data may not be captured in a useful way. They agreed not to recommend it for stage 2.

They discussed closed-loop medication management, which they said was becoming standard. They suggested the possibility of using it as an outcome measure and debated which kinds of errors to capture. They considered efficiency measures, saying what CDS measures could be recommended to increase efficiency. They agreed to stage a hearing on efficiency. It was noted that the percent of claims submitted electronically and percent of visits with insurance status verified were not included in the final rule. CMS may need to reconsider including these administrative efficiency measures for stages 2 and 3. The Chair said that the eligibility group may have recommendations for meaningful use. In accordance with the principle of parsimony,

he said that the objectives should be reviewed taking into account all applicable rules in addition to meaningful use.

4. Patient and Family Engagement Category

Members discussed the importance of having timely access to data including the capability to upload data from multiple providers into one place designated by the patient. EHRs have the capability to exchange data with PHRs using standards-based health data exchange. Several members emphasized the importance of having access to a "blue button" download from a portal, similar to that offered by the VA. They said that downloadable information in a human readable format should be available. They noted that "access to" and "copy of" are not the same and both should be available. They discussed the delays required for clinicians to review test results. The overall goal is for patients to have portable records. In stage 3, 90% of patients are to have access to portable records, including connectively to mobile devices. It was suggested that interested members work off-line on a more precise definition of the objective.

Regarding provision of discharge instructions and clinical summaries, they discussed patients' needs to have information in their preferred languages. Information must be understandable to specific populations. They noted that the technology was available to take coded information and recode it into another language. In stage 2, 50% of patients are to be offered electronic discharge instructions.

Some members said that patients do not necessarily want copies of clinical summaries. Others said it was important to provide it regardless. They debated the terms "delivered", "provided", and "offered". They agreed that patients should have choices as to format (paper, web portal, electronic).

EHR-enabled patient-specific educational resources are to be provided for the most "highly prevalent conditions". Perhaps, the resources can be embedded in the clinical summary. An objective of 30% offered secure patient messaging online in stage 2 will be increased to 90% for stage 3. They discussed the application of this objective to inpatients and qualified e-visits.

They considered the objective pertaining to recording patient preferences for communication, saying that additional research and discussion were needed. Regarding patient-contributed information, it was reported that the Quality Measures Workgroup is working on standards for biometric monitoring.

5. Population and Public Health Category

Tabled for October 5

6. Care Coordination Category

The Chairperson said that stage 1 is a test of peer-to-peer exchange. As HIT matures to stage 3, the goal is to exchange data that meet interoperability standards with all members of the care team. NHIN Direct is in pilot testing.

In stage 3, the summary care record is to be provided electronically for 80% of transitions and referrals. They discussed what should be included in the summary. The longitudinal care plan

should be exchanged, not only made "available", to all members of the care team. Members of the care team should be identified. They considered whether requirements for accountable care organizations and medical homes could be accommodated in these objectives. Currently available EHRs may not have all necessary elements in place.

7. Summary and Next Steps
The Workgroup is scheduled to meet October 5.

8. Public Comment
Robin Raiford, a home care nurse, informed the members that a care plan cannot be designed without knowing the patient's social history. She advised the members to become more informed about home health services.

Mark Segal spoke about18-month timing requirements. Providers need lead time to plan for IT and certification. The Workgroup should allow time in stage 2 for clarification of requirements. Providers need greater clarify on what they are expected to respond to. The focus should be on building use of functionalities. The objectives should accommodate a range of providers.

FNAME Hardy noted that stage 1 requirements are patient friendly. There is opportunity for changing the mind sets of both providers and patients. He advised against age-based requirements for advanced directives.

Shelly Spiro, representing an HIT pharmacy collaborative, once again described her organization. Pharmacists want to become eligible professionals. They can help with the selection of measures for medication management. The bidirectionality of e-prescribing should be acknowledged.

FNAME LNAME, AHA, agreed with the Workgroup's broad principles. She suggested greater coordination with ONC to review what is known about capacity and the market and barriers to adoption. Medicare does not reimburse for e-visits. She offered to make educational resources available.

Mike Kapell recommended reconsidering the meaningful use recommendations for hospitals and other providers. He said that the discussion indicated that most members lack experience in both environments. He suggested a reconsideration of the closed loop recommendations, which involve serious safety issues. Medical administration is important to consider.

SUMMARY OF DECISIONS AND ACTION ITEMS:
None

Meeting materials:
Agenda
Aug 2009 Matrix MU WG
Final MU Rule
Public Hearings Summary

Development Tool/Spreadsheet
MU WG Letter Commenting on NPRM
Gretzky Group Report
Criteria from earlier face-to-face meeting