

## **Information Exchange Workgroup Letter on Meaningful Use Stage 2 Exchange Related Objectives**

Dear Dr. Tang and Dr. Hripsak:

The Information Exchange Workgroup appreciates the opportunity to provide input to the Meaningful Use Workgroup as it establishes its recommendation for Stage 2 Meaningful Use. We hope the following comments and recommendations are helpful in your work.

### **Background**

Over the month of March the Information Exchange Workgroup held a series of meetings to review the information exchange requirements included in Meaningful Use Stage 2 objectives. The Workgroup identified the proposed Stage 2 Meaningful Use objectives that require information exchange and for each objective walked through the following questions:

- What exchange infrastructure is required to support the objective?
- Does the required infrastructure currently exist or will it be available for Stage 2? (is the ecosystem ready)
- Is this the right objective?
- Is it the right level of stringency? (too challenging or not rigorous enough)

The Workgroup also considered what if any objectives were missing from Stage 2 that could be supported by the current health information exchange infrastructure in the health care ecosystem.

The Information Exchange Workgroup submits the following comments for consideration by the Meaningful Use Workgroup. The comments are broken into three sections; a review of proposed objectives, recommended objectives to add and other considerations:

### **Review of Proposed Objectives:**

#### *Incorporate Lab Results as Structured Data*

The Workgroup concurs with the proposed Stage 2 objective.

#### *Summary of Care Record*

The Workgroup concurs with the proposal to move the objective to Core. In an effort to increase the level of exchange in Stage 2 the Workgroup recommends the following addition to the objective:

Provide summary of care record for more than 50% of transitions or referrals. For 30% of these transitions or referrals the summary of care record must be transmitted electronically.

This approach will remove the ability to use paper or fax for a subset set of the summary of care records provided and will enable a glide path to the proposed Stage 3 objective that moves the measure to 80% and requires electronic transmission only.

### *Electronic Prescribing*

The Workgroup feels the health care ecosystem is most prepared to rapidly push forward on electronic prescribing, in particular on the ambulatory side. The Workgroup recommends splitting the measures for eligible provides and eligible hospitals and CAHs. This will allow a rapid ramp up of the requirement for eligible professionals while enabling a more phased implementation of this new objective for eligible hospitals and CAHs.

	Stage 2 Measure	Stage 3 Measure
Eligible professionals	70%	90%
Eligible hospitals and CAHs	40%	70%

The Workgroup recommends keeping the exemption for controlled substances in Stage 2 but thinks the ecosystem could be ready in Stage 3 for ending this exemption. The Workgroup recommends considering the inclusion of two-factor authentication as a certification criteria for Stage 2 to lay the foundation for removing the controlled substance exemption in Stage 3.

### *Perform Test of HIE*

The Workgroup had a long and deep discussion of this objective. Some members don't see a need for this objective especially if Stage 2 Meaningful Use includes specific electronic exchange requirements (hospitals send electronic lab results, providers share care summaries electronically). Other members see this objective as a vital tie to push forward the development of robust capacity for query-based exchange in the country. There was agreement that the purpose of the requirement and what is needed to meet it are not clear. The Workgroup recommends the Meaningful Use Workgroup address the following questions:

- Clarify the purpose of this objective, and consider deleting it if the main objective is to motivate electronic exchange of lab results, care summaries, etc.
- Clarify and define:
  - “bidirectional connection”?
  - “health information exchange”?
  - Who is a qualified external provider and who isn't (needs more specificity)?
  - Whether the policy infrastructure to support robust exchange currently exists?

- Will the technical infrastructure be ready in Stage 2? If so, will enough providers have implemented this infrastructure?
- Are the necessary standards in place for this objective?

#### *Submit immunization data*

Electronic immunization reporting is often allowed or authorized by states but is not required. To reflect this and to better align with the language used in the Stage 1 final rule the Workgroup recommends revising the proposed Stage 2 objective to:

EH/CAH and EP: Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), in accordance with applicable law and practice.

The Workgroup has concerns about the capability of existing infrastructure to handle bi-directional exchange in Stage 3. Without funding to upgrade their systems state and local public health agencies may not be ready for bi-directional exchange in Stage 3.

#### *Syndromic Surveillance*

The Workgroup is supportive of moving the eligible hospital/CAH objective to Core in Stage 2. The Workgroup expressed caution about moving the eligible professional requirement into Core for Stage 2. It is unclear the public health infrastructure is ready to receive syndromic surveillance data from ambulatory care settings or that the necessary standards exist to exchange this data.

#### *Submit reportable lab data*

Workgroup is concerned about including eligible professionals in Stage 2. It is unclear that significant additional benefit is gained from requiring eligible professionals to submit reportable labs as in most states labs are already sending these results to public health departments on behalf of eligible providers. The Workgroup also recommends removing the requirement for reportable conditions from this objective.

### **Recommendation Objective(s) to Add in Stage 2:**

#### *Hospital Labs send results as Structured Data*

The Workgroup recommends adding an objective to:

##### MU Requirement

Require hospital labs to electronically send labs results in a structured format to providers **for more than 40 percent of labs sent.**

##### Certification requirements/Standards

Adopt and test LOINC for most common subset of labs.

Requiring hospital labs to send lab results electronically and in a structured format will significantly improve data liquidity in the ecosystem and greatly increase providers'

ability to improve the quality and effectiveness of care using EHRs. Having structured electronic lab results in EHRs is critical for improved clinical decision-making—it is estimated that 70 percent of clinical decisions rely on lab results—including maintaining accurate diagnoses and problem lists, avoiding unnecessary repeat testing, effective medication management, proactive care for patients with chronic conditions and quality reporting. Currently X% of lab tests ordered by providers are conducted by hospital-based labs.

The Workgroup sees great value in requiring use of LOINC for this reporting, and specifying a value set of the most common lab results. Targeting this set of labs will allow for a significant advancement in standardization across the health care sector and substantially reduce complexity of incorporating these results into EHRs for providers receiving the information. The S&I Framework is currently working on a project that could produce recommendations in this area.

### **Other considerations:**

#### *Qualified Entities*

The objective for “perform a test of HIE” proposes participation in a health information exchange organization as one way to meet the objectives. This proposed framework of allowing participation in a qualified entity (that enables robust exchange) as one potential manner to meet specific objectives in Meaningful Use is a new approach under the program. The Workgroup had a long conversation about the implications of such an approach and how it could be operationalized.

Workgroup members were not in agreement on whether or how such an approach should be included in Meaningful Use. Some felt strongly this is vital element, as it will provide the option for regions with the needed infrastructure in place to leverage Meaningful Use and will help drive toward robust exchange in the long term. Others were concerned this approach would be exclusionary and used to establish a business model for a specific set of existing exchange entities. Still others in the Workgroup felt it was a reasonable approach as long as the requirements to be a qualified entity were focused on functionality and not the type of entity (i.e. EHR vendors, IDNs, and HIOs could all become qualified entities).

As discussed above, the Workgroup was in agreement that the HIE test requirement is not well defined, and either needs to be clarified or removed.

#### *Quality Measures*

The Workgroup feels this is an area requires rapid progress. The infrastructure for quality measurement is essential to facilitate health care reform and the current health care infrastructure (both technology and policy) is not ready for robust quality measurement that requires data from more than one source or more than one point in time. A number of key policy and technical questions need to be answered rapidly to push forward on this vital issue.

We appreciate the opportunity to provide these recommendations on Stage 2 Meaningful Use, and look forward to discussing next steps.

Sincerely yours,

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David Lansky  
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cc: Josh Siedman,  
Judy Sparrow  
Claudia Williams