

April X, 2011

Paul Tang, MD Chair, Meaningful Use Workgroup

George Hripcsak, MD Co-Chair, Meaningful Use Workgroup

Dear Dr. Tang and Dr. Hripcsak:

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, in addition to those sent on April 4th 2011, are helpful in your work.

The Information Exchange Workgroup submits the following comments for consideration by the Meaningful Use Workgroup.

Review of Proposed Objectives:

Patients can view and download information

The Workgroup endorses the goals of this objective but recommends taking a more flexible approach to achieving its aims. We recommend eliminating the reference to web-based portal and make the requirement more generic. For instance the objective could reference various possibilities of delivering this information according to patient preference, including secure email, electronic media (CD, USB), or web-portal capabilities.

Electronic copy of discharge instructions to patients

The Workgroup recommends clarifying that the mechanism to deliver the electronic discharge instructions offered to patients may include various electronic media and methods, such as CD, USB, secure email, and referring patients to a web portal. All of these approaches should be allowed to meet the requirement.

Medication Reconciliation

The Workgroup acknowledges that medication reconciliation is a very complicated process but sees great potential for care improvement by better enabling the flow of medication information. The Workgroup feels this is an area that requires a significant push in terms of standards and functionality for certified EHR technology. Medication information needs to be able to move electronically when a patient moves between providers and care settings.

As first step to enable this functionality the Workgroup recommends facilitating the consumption of medication data from care summary records and fill histories into the EHR in a useful format. Medication data from a care summary record should be able to help populate an EHR medication list and could potentially be used for medication reconciliation.

Perform a test of HIE

The Information Exchange Workgroup anticipates that in Stage 3 many of the Stage 1 measures will require actual electronic exchange of patient information (care summaries, lab results), replacing the need for the “perform a test of HIE” objective for existing objectives. At the same time there are several new Stage 3 requirements that will demand considerable development and testing to assure successful implementation in Stage 3.

In the Workgroup’s letter dated April 4, 2011 we strongly endorsed adding a requirement that a subset of clinical care summaries be exchanged electronically in Stage 2. The Workgroup sees this as an important step in establishing a smooth transition from Stage 2 to Stage 3. At the same time there are several new Stage 3 requirements that will demand considerable development and testing to assure successful implementation in Stage 3.

As an additional step To help smooth the transition path from Stage 2 to Stage 3 the Workgroup recommends establishing a test bed that will assess the capability of implemented EHRs to exchange the data that will be required in Stage 3 for the following objectives:

1. *EHRs have capability to exchange data with PHRs using standards-based health data exchange*
2. *Submit immunization data (test bi-directional functionality)*
3. *Public health button*
4. *List of care team members*
5. *Record a longitudinal care plan*

In addition, if an eligible provider or eligible hospital receives an exception for a Stage 2 objective with an exchange requirement based on the inability of other players in the ecosystem to exchange information, the eligible provider or eligible hospitals should be required to perform a test with the test bed as the method for achieving the objective.

The Workgroup sees the following objective falling under this category.

1. *Submit reportable lab data*
2. *Submit syndromic surveillance data*
- ~~2-3.~~ *Submit immunization data*
- ~~3-4.~~ *Provide summary of care record*
- ~~4-5.~~ *Incorporate lab results as structured data*

The test bed approach would replace the current “perform a test of HIE” objective. The Workgroup stresses the test bed approach should only be used in Stage 2 as a stepping stone to Stage 3. This approach should not be an acceptable method for achieving Meaningful Use objectives in Stage 3.

Reportable labs and Public health button

Adding the submission of reportable lab data to the menu, and then core elements for Eligible Providers caused some concerns in the Workgroup. It should be clarified if reporting specifically addresses laboratory tests performed in the EP practice itself, or those received from commercial or hospital labs (“third party labs”), or both.

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- Some committee members felt the complexity and cost of reporting laboratory results from ambulatory EHRs might exceed the benefit.
- There was a difference of opinion about the phrase: “either directly or through their performing labs.” Some members felt it was inappropriate for EPs to be asked to attest to the behavior of other entities (third-party laboratory providers). Others believed that precedent existed, in that eligible hospitals with outsourced laboratory services were likely to attest for reporting from ~~their~~ outsourced labs using the lab’s EHR-certified laboratory information systems.
- For these reasons the committee failed to reach a consensus about EP electronic reporting of laboratory results to public health.

The request for comment contained the language “reportable lab results and conditions are submitted.” The committee believes it remains a critical element of public health protection for eligible providers and hospitals to supply clinical case reports to public health. This activity not only supports outbreak detection, better care for patients and protection for their contacts, it also triggers infection control that protects healthcare facilities as well. Today’s manual (paper) processes for such reporting impede the workflow of all involved. The Workgroup is supportive of including a requirement around reportable conditions but would recommend establishing it as a separate objective from reportable labs.

Although several implementations of such electronic reporting of non-laboratory data from EHRs currently exist, there is no single clear national standard for this activity. Therefore the committee recommends that this be forecast as a Stage 3 objective, pending development of a national standard, rather than including it in Stage 2.

The concept of a “Public Health Button” appears to cover reportable conditions as well. The button concept implied to some Workgroup members that this objective was proposing a manual process. Again the Workgroup suggests that it is appropriate to endorse the objective of reporting, but not a particular technology, at this time.

Record a longitudinal care plan

The Workgroup is supportive of the goal of this objective but has some questions about the intent and believes a number of key questions will have to be answered to move forward on this objective.

- For Stage 2 a clear definition of a care plan will need to be established.
- For Stage 3 is the Meaningful Use Workgroup envisioning a longitudinal care plan that cuts across unaffiliated providers and is jointly maintained? Or is the Workgroup envisioning one facility exchanging a care plan with another facility?
 - For Stage 3 if the approach is a longitudinal care plan jointly maintained across unaffiliated entities more work would be needed to describe the options for operationalizing this. For instance how will the care plan be

- accessed, maintained and updated? How will the source of information be documented?
- For Stage 3 if the intent is for unaffiliated providers to electronically share a care plan (rather than jointly maintain a care plan) then content standards would need to be developed.

List of care team members

The Workgroup is supportive of the goal of this objective but has some questions about the intent and believes a number of key questions will have to be answered to move forward on this objective.

- A clear definition of what is included in a list of care team members should be established.
 - At what level will care team members be captured? For instance would every provider by name be listed or would the provider be indicated by organization, e.g., Kaiser?
 - Standardized representation of different provider types will be required.
- How will the list of care team members be maintained and updated?

The Workgroup found it difficult to express the information exchange capabilities required to exchange a care team list without having a better understanding of how this will be operationalized in an EHR.

Both the longitudinal care plan and the care team requirements point to evolving care processes and advanced use of HIT capacity to coordinate patient care across unaffiliated organizations and episodes of care. It would be extremely helpful to identify and fully explore the potential models and approaches for doing this—describing both the care processes and the HIT use or needs—so that the Meaningful Use requirements can be fully informed by emerging innovations in this area. The Workgroup recommends this as an important topic for upcoming hearings.

Stage 2 Stepping Stones for Stage 3 Recommendations

EHRs have capability to exchange data with PHRs and Patients can upload and incorporate patient-generated data

The Workgroup is in agreement with the goals of these objectives. To ensure the ecosystem is ready in time to address these objectives in Stage 3 work will need to be completed in the next few years around the following items:

- What additional content or transport standards will be needed to facilitate sharing patient-generated data?
- How will the source of information be documented (e.g., home monitoring device, patient entered etc)?
- What policies will need to be established on what would trigger such data exchange between EHRs and PHRs? Is it a manual process or automatic?

- What is the mechanism for uploading patient-generated information (i.e. PHR, portal, remote monitoring devices, secure messaging)?
- What will be the requirements for identity resolution and authentication for consumers?

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

Sincerely yours,

Micky Tripathi
Chair, Information Exchange Workgroup

David Lansky
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cc: Josh Siedman,
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