



Department of Health & Human Services
Office of the National Coordinator for
Health Information Technology

HIT Policy Committee

Meaningful Use Workgroup

Presentation to HIT Standards

Committee

**Paul Tang, Palo Alto Medical Foundation,
Chair**

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Workgroup Membership

Co-Chairs:

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- David Bates
Brigham & Women's Hospital
- Michael Barr
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- Christine Bechtel
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- Neil Calman
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- Art Davidson
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NY State Dept. of Health
- Joe Francis
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- David Lansky
Pacific Business Group/Health
- Deven McGraw
Center/Democracy & Technology
- Judy Murphy
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- Latanya Sweeney
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- Karen Trudel
CMS
- Charlene Underwood
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Agenda

- MU workgroup timeline for stage 2 recommendations
- Draft recommendations as presented to HITPC for feedback
- Update on timing options
- Next steps

MU Stage 2 Recommendations Work Plan

- Hearings on stage 2 in 2010:
 - Specialists; smaller practices and hospitals
 - State issues
 - Health care disparities
 - Patient and family engagement
 - Population and public health
 - Care coordination
- Dec, 2010 HITPC feedback on initial stage 2 draft criteria
- Jan, 2011 Request for Comment (due Feb 25, 2011)
- Apr 13, 2011: Feedback from HITPC on RFC comments and timing options
- Apr/May: MU WG revises draft recommendations
- **May 11, 2011: Present draft stage 2 MU recommendations to HITPC**
- May 13: Hearing on specialists and early feedback from field
- June 8, 2011: Final stage 2 MU recommendations for HITPC approval

Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities

Stage 1 Final Rule

HITPC Proposed Stage 2

Key: objectives in **blue** indicate new objectives not included in stage 1; **red** indicates proposed change based on comments

Improving Quality, Safety, Efficiency & Reducing Health Disparities

EP: >30% of unique patients with at least one med order have at least one med order entered using CPOE

CPOE for 60% of Rx **and lab**; **radiology CPOE “in use” (≥ 1 order) (unless no radiology orders)**

Implement drug-drug and drug-allergy interaction checks (enabled functionality)

Employ drug interaction (drug-drug, drug-allergy) checking; **Providers have the ability to refine DDI [In stage 3, goal is to have nationally endorsed lists of DDI with higher positive predictive value and ability to record reason for overriding alert]**

EP: Generate and transmit permissible prescriptions electronically for >40% of prescriptions

50% of outpatient medication orders and **20% of hospital discharge** medication orders transmitted as eRx

>50% of all unique patients have demographics recorded as structured data. (preferred language, gender race ethnicity, DOB, data and preliminary COD- EH ONLY).

80% of patients have demographics recorded and can use them to produce stratified quality reports **using more granular demographic categories per IOM report—additions to value sets for existing fields for stage 2; new demographic fields for stage 3 (HITSC needs to work on standards)**

Report CQM as per CMS attestation

Report CQM electronically as per CMS

Maintain an up-to-date problem list for >80% of all unique patients

Maintain problem list **(80%)**

Maintain active med list for >80% of all unique patients

Maintain active med list **(80%)**

Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities, II

Stage 1 Final Rule	HITPC Proposed Stage 2 <i>Key: objectives in blue indicate new objectives not included in stage 1; red indicates proposed change based on comments</i>
Maintain active med allergy list for >80% of all unique patients	Maintain active med-allergy list <u>(80%)</u>
Record and chart vital signs for >50% of all unique patients age 2 and over	80% of patients have vital signs recorded during the reporting year; change age for peds BP from 2 yrs to 3 yrs
Record smoking status for >50% of all unique patients 13 years or older	80% of patients have smoking status recorded [stage 3 add new field in certification for secondhand smoke]
Implement 1 clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance	Use CDS; HITSC: Suggest changing certification criteria definition as indicated on comment summary
Menu: Implement drug-formulary checks with access to at least one drug formulary	Implement drug formulary checks according to local needs (e.g., may use internal or external formularies, which may include generic substitution as a “formulary check”) (move to core)
Menu: Record AD for 50% of all unique patients 65 years and older	For hospitals, 50% of patients >65 who have recorded the result of an advance directive discussion and the directive itself if it exists; for EPs 10% of patients seen during reporting period (need more data on current use to decide on menu vs. core for EPs)
Menu: Incorporate clinical lab-tests results as structured data for more than 40% of all lab tests results ordered	Incorporate lab results as structured data (40%) (move to core); HITSC: Use LOINC where available
New	EHs: Hospital labs send structured electronic lab results to outpatient providers for ≥ 40% of labs sent electronically HITSC: Use LOINC where available

Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities

Stage 1 Final Rule	HITPC Proposed Stage 2 <u>Key:</u> objectives in blue indicate new objectives not included in stage 1; red indicates proposed change based on comments
Menu: Generate at least one report listing patients by specific conditions	Generate patient lists for multiple patient-specific parameters (move to core)
Send an appropriate reminder for preventive/follow up care to more than 20% of all unique patients 65 years or older or 5 years or younger	EPs: 10% of all active patients receive a clinical reminder (appointment reminder not count)
New	30% of EP visits have at least one electronic EP note and 30% of EH patient days have at least one electronic note by a physician, NP, or PA; non-searchable, scanned notes do not qualify [use broad definition of qualifying note types]
New	EH medication orders automatically tracked via electronic medication administration record; (in-use in at least one hospital ward/unit)
New	Consider adding recording of family health history in stage 3 (due to absence of standards for FH)

Draft Stage 2 MU Objectives

Engaging Patients and Families

Stage 1 Final Rule	HITPC Proposed Stage 2 Key: objectives in blue indicate new objectives not included in stage 1; red indicates proposed change based on comments
Provide >50% patients with an electronic copy of health information	DROPPED; to be covered by other objectives and HIPAA
EH: Provide >50% of all discharged patients with an electronic copy of their discharge instructions	Hospitals: ≥ 25 patients receive electronic discharge instructions at time of discharge
New	Hospitals: 10% of patients/families view and download relevant information about a hospital admission; information available for all patients within 36 hours of the encounter
Menu: Provide >10% of all unique patients with timely electronic access to health information (EP)	EPs: 10% of patients/families view & download their longitudinal health information; information available to all patients within 24 hours of an encounter
Provide Clinical Summaries to patients for >50% of all office visits within 3 business days	EPs: patients are provided a clinical summary after 50% of all visits, within 24 hours (pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs)
Menu: User certified EHR technology to identify patient-specific educational resources and provide to patient if appropriate for >10% of all unique patients	Both EPs and hospitals: 10% of patients receive EHR-enabled patient-specific educational resources; make core; take out “if appropriate” instead of raising threshold
New	EPs: patients are offered secure messaging online and > 25 patients have sent secure messages online
New	EPs: Patient preferences for communication medium recorded for 20% of patients
New	Stage 3: Provide mechanism for patient-entered data (supply list); consider “information reconciliation” for stage 3 to correct errors

Draft Stage 2 MU Objectives

Improve Care Coordination

Stage 1 Final Rule	HITPC Proposed Stage 2 Key: objectives in blue indicate new objectives not included in stage 1; red indicates proposed change based on comments
Improve Care Coordination	
Capability to exchange key clinical information – Perform at least one test	ELIMINATED IN FAVOR OF USE CASE OBJECTIVES BELOW
Menu: Perform medication reconciliation for >50% of transitions for receiving provider	Medication reconciliation conducted at 80% of transitions by receiving provider; keep threshold at 50% and move to core
Menu: Provide summary of care record for >50% transitions of care for the referring EP or EH	Summary of care record. EH: 10% of all discharges have summary of care record sent electronically to EP or LTC facility. EP: at least 25 transactions sent electronically (if exclusion for lack of electronic recipients, then must send on paper) [Need HIE preamble.]
New	List of care team members available for 10-20% of patients via electronic exchange; 10% of patients have a list of care team members (including PCP, if available) (unstructured data for stage 2; for stage 3, code by NPI)
New	For longitudinal care plan, merge with summary of care to create “summary and care plan” (old summary plus plan and patient engagement fields)

Draft Stage 2 MU Objectives

Improving Population and Public Health

Stage 1 Final Rule

HITPC Proposed Stage 2

Key: objectives in **blue** indicate new objectives not included in stage 1; **red** indicates proposed change based on comments

Improve Population and Public Health

Capability to submit electronic data to immunization registries or immunization IS – Perform a test

EH and EP: Submit immunization data (attest to at least one) in accordance with applicable law and practice; move to core for both EH and EP [In Stage 3, view cumulative immunization record and recommendations]

EH: Capability to submit electronic lab data on reportable lab results to public health agencies – Perform a test

EH: Submit reportable lab results (attest to submitting to at least one organization) in accordance with applicable law and practice; move to core

Capability to submit electronic syndromic surveillance data to public health agencies - Perform a test

EH: Submit syndromic surveillance data (attest to at least one) in accordance with applicable law and practice; move to core
EP: [CMS to consider]

New

EP: [CMS to consider] Submit reportable cancer conditions (attest to at least one) in accordance with applicable law and practice (to HITSC: possible use of IHE cancer reporting implementation guide)

New

For Stage 3: Patient-generated data submitted to public health agencies

Draft Stage 2 MU Objectives

Ensure Privacy and Security Protections

Stage 1 Final Rule

HITPC Proposed Stage 2

Key: objectives in **blue** indicate new objectives not included in stage 1; **red** indicates proposed change based on comments

Ensure adequate privacy and security protections for personal health information

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

Perform, or update, security risk assessment and address deficiencies.
Address encryption for data at rest and attest to policy (not required for all but need policy).

FOR HITSC CERTIFICATION:
Authentication of providers: certification of EHR needs two-factor authentication for controlled substances and providers to have digital certificates at entity level.
Single factor authentication (user and password) for patient online account.
Audit trails for access to patient online account.
Provisions for data provenance.
Portal should have secure download ability (e.g., to transfer to PHR).
Instructions to standards committee about demographic fields, etc.

Signal Stage 3 plans about NWHIN governance.

Update on Stage 2 Timing Options

Timing of EHR Certification and MU Stage Objectives

TABLE 1—STAGE OF MEANINGFUL USE CRITERIA BY PAYMENT YEAR

First Payment Year	Payment Year			
	2011	2012	2013	2014
2011	Stage 1	Stage 1	Stage 2	Stage 2.
2012 .....	.....	Stage 1	Stage 1	Stage 2.
2013 .....	.....	.....	Stage 1	Stage 1.
2014 .....	.....	.....	.....	Stage 1.
	Complete EHRs and EHR Modules certified by ONC-ATCBs or ONC-ACBs ² to all of the applicable certification criteria adopted for the 2011 & 2012 payment years meet the definition of Certified EHR Technology.		Complete EHRs and EHR Modules certified by ONC-ACBs to all of the applicable certification criteria adopted for the 2013 & 2014 payment years meet the definition of Certified EHR Technology.	

Draft Timing Options

Relative Impact on Program Attributes

1. Maintain current timeline and one-year EHR reporting period; or
2. Maintain current timeline and permit 90-day EHR reporting period; or
3. Delay transition from stage 1 to stage 2 by one year (affects only providers who begin MU program in 2011)

Impact of Timing Option on:	Option 1	Option 2	Option 3
Establishment of infrastructure for delivery system reform	++	+	0
Vendor development timeline (new functionality)	--	-	++
Provider implementation timeline	--	0	++
ICD-10 synergy	-	-	+
CMS & states' program operational complexity	0	-	0
CQM measurement & reporting	0	-	0
Probability of recommendations standing in Final Rule	-	+	++
Maintaining MU pace up the escalator	-	0	++

++ = implementing this option strongly supports this attribute; + = implementing this option supports this attribute
 0 = implementing this option has relatively no impact on this attribute; - = implementing this option negatively impacts this attribute; -- = implementing this option has a significant negative impact on this attribute

Next Steps

- May 13 hearing on specialists and experience from the field
- Incorporate HITPC feedback and hearing findings into final MU WG recommendations for stage 2
- June 8: Present final draft recommendations to HITPC for approval
- June, 2011: Submit final HITPC stage 2 Meaningful Use recommendations to ONC and CMS
- End-2011: anticipate HHS MU NPRM
- Mid-2012: anticipate HHS MU Final Rule