Overview
The meeting of the HIT Policy Committee's Meaningful Use Workgroup on the 13h of March consisted of an expansive discussion of the NPRM Stage 2 measures.

Background
The HITECH Act, part of the American Recovery and Reinvestment Act of 2009, was passed to help promote the adoption of health information technology (HIT) for a better health care system. HITECH established two federal advisory committees to assist the Office of the National Coordinator for Health IT (ONC) in the adoption process, with one of them being the HIT Policy Committee (HITPC). This committee provides recommendations to the ONC on major health IT policy issues for consideration. HITPC consists of many workgroups that cover a variety of topics. One of which is the Meaningful Use Workgroup, who make recommendations to the HITPC on how to define meaningful use in the short- and long-term; the ways in which electronic health records (EHRs) can support meaningful use; and how providers can demonstrate meaningful use.

Summary of Meeting:

Workgroup Discussion

Plan: Compare and contrast MU2 with MU1 and the HITPC MU2 Recommendations. Form recommendations to pass on to the HITPC. The MU Workgroup reviewed Category 1 (Improving quality, safety, efficiency, and reducing health disparities in a previous meeting.

Category 2: Engage patients and families in their health care (Table 1, page 159 of NPRM)

View, Download and Transmit Health Information (EPs): 1) More than 50 percent of all patients are provided timely online access to their health information within 4 days, subject to the EP's discretion to withhold certain information; 2) More than 10 percent of all patients or their authorized representative can view, download, or transmit their information to a third party.
Part 1 Discussion:
- The timeliness should be further defined as getting the information available within 24 hour for a patient encounter and 4 days for test or lab results. Patients need this information as soon as possible because they need to make decisions and the information needs to be available to other providers on the care team.
- Making multiple measures for part 1 is only going to make things more complicated for providers.
- The physician's discretion exemption could give physicians an easy way to avoid meeting the measure.
- There are several ways to define encounter: in-person, online, phone. Perhaps it would be better to list the types of encounters that need to be included with the measure.
Recommendation: To have simplicity and only one measure for part 1, the workgroup recommends that the information must be available online for 50 percent of unique patient encounters within two business days after the EP gains access to the information. This includes information gathered during an encounter and the results of tests. The workgroup will define encounters as office visits and any encounters when an order is generated.

Part 2 Discussion:
- This measure gives more flexibility than our recommendation, which was just to view the information. Adding in the ability to download or transmit information and the ability for an authorized representative to do so creates greater optionality.

- How would patients transmitting information to a third party be counted since it is not easy to measure? A: The NPRM's definition of transmission is very broad and could include the placement of medical information in HealthVault but this is difficult to track.
- Therefore, view and download are better measures because they require patient engagement. Transmit may not necessarily be conducive to patient engagement. If it is something where a patient has to perform an action, such as setting up a mechanism to forward results to their email, it should fulfill the requirement.
- Some practices may not be able to meet this 10 percent threshold because their patient population may not be conducive to accessing information online, such as geriatric patients. This means that some providers will not be able to generate enough interest in online access in their patient population. Perhaps this is only relevant to primary care providers.
- This goal of 10 percent is for three years down the line and providers should be able to incorporate this online patient access into their workflow by then.
- The authorized representative may mitigate this issue, but it is not easy to measure which patients have authorized representatives. EHRs need to have the capability to record this and CMS needs to explore and define the field to a greater extent.

Recommendation: Point out the specialists may not be able to meet this threshold and some areas need to be further defined.

View, Download and Transmit Health Information (EHs): 1) More than 50 percent of all patients discharged are provided timely online access to their discharge information within 36 hours and more than 10 percent of all discharged patients can view, download, or transmit their information to a third party.
Discussion:
- Even though this information is required to be submitted in paper form, 36 hours is not going to be soon enough to transfer the information to the next settings of care. This will make doing this process electronically difficult.

Recommendation: Support measure.

Clinical Summaries: Provided to patients within 24 hours for more than 50 percent of office visits.
Discussion:
- This measure mirrors the HITPC recommendation, but drops the 4 days for lab results.
- This measure should not require the creation of paper clinical summaries. Instead patients should simply be offered online access.

Recommendation: Support measure, with additional clarity about the summaries being provided online.

Patient-specific Education Resources: Provided to more than 10 percent of patients.
Discussion:
- This requirement just refers to having a link to relevant information based on a patient's conditions automatically appear in the EHR without any search efforts from the provider.
- The provider will still need to go over the information presented by the EHR in order to meet the requirement and not simply hand the patient a link to more information.

Recommendation: Support measure.

Secure Messaging: More than 10 percent of patients send a secure electronic message.
Discussion:
- The problem with this issue for providers is that they are relying on the actions of patients in order to meet the requirement.
- 10 percent might be too high for the populations in play since they may not have access to computers.

- The denominator of the measure should be changed to unique patients enrolled in the online portal and place a threshold of 50 percent of these patients for a one year time period.
- Or perhaps the recommendation should be to instead measure the average response time for providers.
- Maybe the measure should be flipped, so that the providers initiate the conversation via the messaging of relevant information (lab results, flu vaccination set-up, dialogs about conditions, etc.). This would open a dialog and allow providers to control their ability to meet the measure. A component that would allow this feature would need to be included in the certified EHR.
- How does this measure work with the view measurement? Is viewing a message about your health information going to fulfill portal view measure? A: This measure is more about communication and not about viewing information.
- There are three things we are trying to achieve through EHRs with patients and providers: 1) View online records 2) Provide relevant reminders 3) Enable more communication. Each of these goals has their own measure. The determination that needs to be made is: how can communication between patients and providers be best measured?

Recommendation: The key of this measure is to create patient response through messaging. Allowing providers to initiate the conversation by sending out lab results and giving patients the ability to respond to the results is probably the best method. The threshold for this measure should be 5 percent of all patients seen during a reporting period.

New Requirement: Patient Communication Preference (outlined in the discussion portion of the NPRM): Have the ability for EHRs to record the patient preference for communication for at least 20% of patients for both providers and hospitals.
- Vendors support this issue because it is fairly easy to do.
- Providers support this issue because it allows them to be more efficient in communicating with their patients.
- This communication preference needs to be further developed as some people may want lab results via an online portal, billing sent via mail and their appointments set-up on the phone. This is a complex issue with the potential for several fields to populate.

Recommendation: The workgroup reaffirms their recommendation to include this measure in Stage 2 and specifically include multiple ways to note preference and for a variety of situations. This requirement should be expanded to include hospitals because they are part of the care team.

Category 3: Improve Care Coordination

HIE Testing: NPRM eliminates measure in 2013.
- This measure was eliminated because it was found to be difficult to test and determine if it existed.
- There were four proposed options to alter this measure: eliminate it, require the test to be successful, require providers to select either the Stage 1 medication reconciliation objective or transitions of care objective, or require a case of actual electronic transmission of a summary of care document.

Recommendation: Eliminate the test and recommend option four (summary of care documents) for Stage 1.

Medical Reconciliation: Is performed for more than 65 percent of transitions of care.
Discussion:
- More clarity is needed around the definition of transitions of care, how specialists send information back to PCPs, and when a transition of care occurs so that medical reconciliation is triggered at the appropriate time in the workflow.

Recommendation: Support the measure, but lower the threshold to 50 percent and insure that the EHR certification criteria include the ability for EHRs to perform medical reconciliation by checking for transitions of care and then asking other questions based on the response.

Summary of Care Record: Within an organization 65 percent of transitions or references have a summary of care record and 10 percent for entities with no affiliation with the original organization.
Discussion:
- There should be the following spaces in the EHR's care plan section: 1) Reason for referral or transition 2) Care goals 3) Instructions and 4) The results of the referral or transition.
- The referring provider in the first measure is able to find and input the information.
- However, for the second measure the denominator is difficult to determine because providers cannot control or count whom patients pass their information to. This is a particular problem for entities that are not eligible for meaningful use or do not use certified EHR systems such as long-term care providers. It is nearly impossible to determine who these providers are and include them in the denominator of the second measure.
- Could we just count parties that are using the national standards for interoperability? This would pull non-meaningful use providers into the fold.
- There are four options that we can propose for Part 2: 1) Use 10 percent of all transitions of care for the reporting period (as currently written) 2) a countable number of certifiable transmissions (25) 3) change the denominator and threshold to transitions involving meaningful users or 4) all users.

Action: Further comment, debate and help are needed on this issue.

Category 4: Improve Population and Public Health

Immunization Data: Successful ongoing electronic submission to an immunization registry or system.
Discussion:
- Are there actually states or countries where the submission of immunization registries is illegal? A: Yes, some sovereign American Indian nations are not required to report the information to the state they are located in.
- States are building the infrastructure to accept this data, but it may take some time to build a critical mass.
- This Workgroup should focus on what is feasible from the providers standpoint and not the public health agencies or registries.

Recommendation: Support this measure and emphasize that it is the most important public health measure.

Laboratory Results: Successful ongoing electronic submission to public health agencies.
Discussion:
Recommendation: Support this measure and note that this is the second most important measure to report.

Syndromic Surveillance: Successful ongoing electronic submission to a public health agency.
Discussion:
Recommendation: Support this measure and rank it as the third most important measure.

Cancer Information (Menu): Successful ongoing electronic submission of cancer case information to a cancer registry.
Recommendation: Support measure but several questions were raised:
- Are there existing registries?
- Can the vendors build the necessary EHR interfaces?

Specific Case Information (Menu): Successful ongoing electronic submission of specific case information to a specialized registry.
Recommendation: Support measure, but several questions were raised:
- Are the standards ready for the existing registries?
- What is the proprietary nature and costs of these registries and measures?
- Are vendors ready to build the necessary interfaces into EHRs?

The Workgroup will next go through the questions posed in the NPRM and create answers.

Category 1: Questions posed in the NPRM
Can other non-licensed professionals enter data or report data back to the ordering physician? This would include scribes, medical assistants and nurses.
Discussion:
- In some environments unlicensed professionals will need access to the data especially the results.
- This determination could be left to state licensing boards.
- Are the non-licensed professionals going to be held accountable for the information they enter or is it going to be the provider?

Recommendation: The EP and EH should be able to act on, and be held accountable for, all orders. However, there are other requirements for this already in existence stemming from CMS billing requirements.

Action: There will be two more MU Workgroup meeting before the HITPC meeting in the beginning of April. In these meetings the Workgroup will clean up their comments and answer the remaining questions posed in the NPRM.