Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

Interoperability and Health Information Exchange Workgroup

Micky Tripathi, chair
Chris Lehmann, co-chair

May 22, 2015

HITPC Comments

1. Request to review recommendation to not allow the inclusion of “selfies”
   - Some HITPC members felt excluding selfies would hurt care coordination.
   - There also appeared to be confusion over what our proposal would exclude.
2. Approved Consumer Workgroup recommendation adds “or data from a non-clinical setting is incorporated in the EHR” to the HIE Objective. How should it be incorporated?
3. Suggestion to develop criteria for determining which specialist should be excluded from measure 3.
4. Can reconciliations that happen prior to the patient visit count for measure 3?
5. How are transfers/referrals counted if the patient doesn’t show up for the appointment?
6. Impact of data segmentation certification criteria on transitions of care approach.

"Selfies" Stage 2 FAQ Language (FAQ9690)

[EHR Incentive Programs] When reporting on the Summary of Care objective in the Electronic Health Records (EHR) Incentive Program, which transitions would count toward the numerator of the measures?

- A transition of care is defined as the movement of a patient from one setting of care (hospital, ambulatory, primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. To count toward the Summary of Care objective, the transition or referral must take place between providers with different billing identities such as a different National Provider Identifier (NPI) or hospital CMS Certification Number (CCN).

- For Measure 1 of the Summary of Care objective, include the transitions of care in which a summary of care document was provided to the recipient of the transition or referral by any means.

- For Measure 2 of the Summary of Care objective, include the transitions of care in which a summary of care document was transmitted electronically using a Certified EHR Technology (CEHRT) to the recipient, or via exchange facilitated by an organization that is an eHealth Exchange participant, or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

- If the receiving provider already has access to the CEHRT of the initiating provider of the transition or referral, simply accessing the patient's health information does not count toward meeting this objective. However, if the initiating provider also sends a summary of care document, this transition can be included in the denominator and the numerator as long as it is counted consistently across the organization and across both measures If:
  - For Measure 1, a summary of care document is also provided by any means.
  - For Measure 2, a summary of care document is provided using the same technical standards used if the receiving provider did not have access to the CEHRT,

- For Measure 3 of the Summary of Care objective, a single summary of care document sent to a provider using a different EHR and EHR Vendor or a test with the CMS and ONC Randomizer test system would meet the measure.

Selfies Stage 3 NPRM Text

"We stated in the Stage 2 proposed rule at 77 FR 13723 that if the receiving provider has access to the medical record maintained by the provider initiating the transition or referral, then the summary of care record would not need to be provided and that patient may be excluded from the denominators of the measures for the objective. We further note that this access may vary from read-only access of a specific record, to full access with authoring capabilities, depending on provider agreements and system implementation among practice settings. In many cases, a clinical care summary for transfers within organizations sharing access to an EHR may not be necessary, such as a hospital sharing their CEHRT with affiliated providers in ambulatory settings who have full access to the patient information. However, public comments received and questions submitted by the public on the Stage 2 Summary of Care Objective reveal that there may be benefits to the provision of a summary of care document following a transition or referral of a patient, even when access to medical records is already available. For example, a summary of care document would notify the receiving provider of relevant information about the latest patient encounter as well as highlight the most up-to-date information. In addition, the "push" of a summary of care document may function as an alert to the recipient provider of the transition that a patient has received care elsewhere and would encourage the provider to review a patient's medical record for follow-up care or reconciliation of clinical information.

Therefore, we are revising this objective for Stage 3 to allow the inclusion of transitions of care and referrals in which the recipient provider may already have access to the medical record maintained in the referring provider's CEHRT, as long as the providers have different billing identities within the EHR Incentive Program. We note that for a transition or referral to be included in the numerator, if the receiving provider already has access to the CEHRT of the initiating provider of the transition or referral, simply accessing the patient's health information does not count toward meeting this objective. However, if the initiating provider also sends a summary of care document, this transition can be included in the denominator and the numerator, as long as this transition is counted consistently across the organization."

Questions

- **Do "selfies" enhance care coordination by acting as an alerting function between providers who are using the same EHR?**

- **Does allowing this encourage vendors/providers toward a sub-optimal technical approach (i.e., sending an email to yourself rather than alerting within the EHR application)?**

- **Does allowing this have positive spillover effects for exchange with other trading partners (i.e., by generally encouraging use of Direct and establishing consistent workflows for internal and external recipients)?**

Recommendation

The Workgroup's consensus is that "selfies" do not support the intent of Objective 7 which is enhancing transitions of care with clinical information otherwise unavailable to the receiving provider. While selfies may be useful as "alerting" mechanisms within large health care organizations, that is not the intent or goal of Objective 7. Therefore we affirm our previous recommendation to not allow "selfies".

Background on incorporating non-clinical settings

NPRM Objective 6 (Patient Engagement) Measure 3

- "Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15 percent of all unique patients seen by the EP or discharged by the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period."

Consumer WG has recommended:

- Patient-generated health data for 10% of all unique patients
- Moving "non-clinical setting" requirement to Objective 7 (HIE)

Comparison of Patient Engagement Measure and HIE Measure

Category	Patient Engagement Measure	Current IOWG HIE Measure 2 Recommendation
Applicability	All unique patients seen in the reporting period	Encounters from transitions/referrals or new patients for which an electronic summary of care record is available
Threshold	NPRM: data from patient or non-clinical setting for 15% of patients seen in the reporting period CWG recommendation: patient-generated data for 10% of patients seen in the reporting period	25% of qualifying encounters
Payload requirement	Any type of data or document	Electronic summary of care record: CCDA with clinically relevant structured CCDS data elements
Transport requirement	None specified	Any electronic means
Source providers	Any provider who is not an EP, EH, or CAH as defined by MU program	Provider making transition or referral, or identified by new patient
Key exclusions	None	Can exclude transitions/referrals from providers who cannot send CCDAs (i.e., those without CEHRT)

Emerging consensus

Reconciling these measures is not straightforward because they apply to different types of information from different types of providers for different groups of patients

While we did not have time to get consensus on a specific recommendation that merges the measures, we do recommend that CMS use the following principles in doing so:

1. Merge with Measure 2 as recommended
2. Do not set separate targets for "non-clinical providers" (e.g., separate measure or X% for all providers, Y% for "non-clinical providers")
3. Set a two-tier objective, with a higher threshold with greater content/format flexibility and a lower threshold based on CCDAs (e.g., incorporate any type and format of clinically relevant information for 25% of TOCs/referrals, incorporate CCDAs for 15% of TOCs/referrals)
4. Retain TOCs/referrals + never before encountered + electronically queried as denominator
5. Require electronic means of transmission
6. Allow exclusion for "electronic means not available"
7. Allow incorporation of electronically queried information outside of specific episodes of care
8. Clearly define the meaning of "incorporate" for CCDA and non-CCDA information

Additional Comments and Responses

- **HITPC Comment: Can we provide any more guidance on which specialties should be allowed exclusions from information reconciliation requirements?**
  - Workgroup response: We were not able to determine any additional criteria in the time allotted

- **HITPC Comment: Can reconciliations that happen prior to the patient visit count for measure 3?**
  - Workgroup response: The measure does not address the timing of when a reconciliation can occur and count in the numerator. We request CMS provide clarity that reconciliations occurring prior to the patient visit can count towards the numerator.

- **HITPC Comment: How are transfers/referrals counted if the patient doesn't show up for the appointment?**
  - Workgroup response: The denominator for Measure 2 only includes patient encounters so instances where the patient doesn't show up would not be included in the measure.

- **HITPC Comment: Impact of data segmentation certification criteria on transitions of care approach.**
  - Workgroup response: The Workgroup does not see specific impacts from the addition of data segmentation to certification on the recommended approach to the HIE Objective.

Revised Full Recommendation Deck

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Introduction

- IOWG was asked to look at:
  - Objective 7: Health Information Exchange
  - Specific questions from NPRM, including questions on HIE governance

Objective 7: Overview

Objective 7 (Health Information Exchange) comprises 3 measures, and providers have to meet only two out of three (but must report on all three):

- Measure 1: Send electronic summary of care record for 50% of outgoing transitions or referrals
- Measure 2: Receive and incorporate electronic summary of care record for 40% of incoming transitions or referrals
- Measure 3: Reconcile clinical information for 80% of transitions or referrals

We note that these measures are inter-related

- The ability to receive is related to the volume of sending
- The availability of clinical information to reconcile is related to the volume of information sent, and received
- The ability to streamline and automate information reconciliation is related to the quality of the information received

Agreement on the importance of the objectives and on increasing thresholds

In general, the IOWG agrees with the direction and goals of the Objective 7 measures

- Important for quality and safety
- HIE functions are gaining traction in the market, and these objectives are good impetus to keep progressing

However, we are concerned about setting thresholds that are unrealistically high

- We agree with setting higher thresholds
- However, we don't want to have to backtrack on the threshold, as has happened with VDT
- Want to motivate providers to "own the problem", but not penalize them for factors that are genuinely out of their control

Can balance thresholds with judicious allowance for exclusions

- May want to consider trade-offs between thresholds and exclusions
- Keep threshold high if also allowing exclusions, or conversely, lower threshold if not allowing exclusions

What is current experience with Stage 2?

Among those who have attested to Stage 2, rates are generally below proposed rates for Measure 1, and well above proposed rates for Measure 3 (med rec only)

- Measure 1: EP = 40% and EH = 36% versus proposed threshold of 50%
- Measure 3: EP = 93% and EH = 87% versus proposed threshold of 80%
  - Note: Stage 2 required only medication reconciliation – Stage 3 proposal adds med allergies and problems, and raises the threshold to 80% for all three

However, there is likely strong selection bias in the current Stage 2 attestation results

- High percent of providers (76% of qualifying EPs and 35% of qualifying EHs) either taking hardship exemptions, leveraging the flex rule, or have not yet attested in 2014
- Furthermore, very high percent (86%) of EPs have taken exclusion from the "send" measure for <100 transitions/referrals in a reporting period
  - Consequence of a reduction in the reporting period during 2014 from 1 year to 90 days *without* corresponding adjustment to the exclusion threshold
- Thus, only about 8,000 EPs have attested to Stage 2 for 2014 so far, who are likely better positioned for successful achievement of the measures than the average provider

Stage 2 experience suggests that the Stage 3 thresholds are higher compared with performance to dates, and perhaps significantly higher given the small sample results to date.

Measure 1 Description

Stage 3 NPRM Measure	Description
Measure 1: <u>Send</u> electronic summary of care record for 50% of outgoing transitions or referrals	1. Increase from Stage 2 threshold (10%)
	2. Requires electronic transport but does not specify use of a standard or participation in any particular HIE arrangement (i.e., no longer requires Direct transport or under a governance mechanism created by ONC)
	3. Allows inclusion of patient self-referrals
	4. Allows inclusion of transitions/referrals to providers on the same EHR ("selfies")
	5. Summary of care must include CCDS data elements
	6. Allows exclusion if zero transitions/referrals in reporting period
	7. Allows exclusion for providers in counties with low broadband penetration

Measure 1 Recommendations

IOWG recommends the following on Measure 1:

1. Lower threshold to 40% (from 50%)	Disagree with NPRM
2. Allow any electronic transport	Agree with NPRM
3. Allow patient self-referrals	Agree with NPRM
4. Do not allow “selfies”	Disagree with NPRM
5. Allow flexibility in CCDS payload	Disagree with NPRM
6. Allow exclusion for <100 transitions/referrals	Disagree with NPRM
7. Do not allow exclusion for low broadband penetration	Disagree with NPRM

Measure 1 Recommendations Discussion (1 of 3)

1. **Lower threshold to 40% (disagree with NPRM)**
   - Stage 2 data suggests that average provider will be well below 50%
   - 2014 exclusion allowance (by which 86% of EPs avoided the TOC requirement) has slowed market adoption of TOC functions
   - However, want to keep rate high to motivate forward progress

2. **Allow any electronic transport (agree with NPRM)**
   - Industry challenges with Direct could be barrier to achievement in many markets (also, see recommendation on HIE governance)
   - Gives credit to those who have other types of HIE capabilities

3. **Allow patient self-referrals (agree with NPRM)**
   - IOWG is concerned that the measure adds workflow burden which, without automated HIE functions, offers little benefit to patient care
   - However, inclusion encourages use of automated HIE functions such as automated response to utilization alerts or electronic query

Measure 1 Recommendations Discussion (2 of 3)

4. **Do not allow "selfies" (disagree with NPRM)**
   - Disproportionately favors integrated delivery networks
   - "Selfies" do not add to patient care – information already available in EHR and in most cases is accessed that way

5. **Allow flexibility in CCDS payload (disagree with NPRM)**
   - In many transition or referral use cases, it is not clinically beneficial to provide the entire CCDS
   - Contributes to "CCDA bloat", which many providers note makes CCDAs unusable
   - Allow provider discretion, as is proposed for labs and clinical notes, rather than requiring that all CCDS elements be populated if available

Measure 1 Recommendations Discussion (3 of 3)

6. **Allow exclusion for <100 transitions/referrals (disagree with NPRM)**
   - Cost of implementing electronic capabilities for <100 transitions/referrals per year outweighs clinical and efficiency benefits to patients
   - Any future adjustments to reporting periods should adjust inclusion/exclusion thresholds as well

7. **Do not allow exclusion for low broadband penetration (disagree with NPRM)**
   - This exclusion appropriate for patient engagement measures but not for measures of provider-provider exchange
   - There may be circumstances where electronic exchange is not dense enough to allow a provider to meet measure threshold
   - IOWG did consider recommending an "ecosystem" exclusion to address such cases, however, we were not able to come up with an approach that didn't add more complexity than it solved
   - We do recommend that CMS monitor this issue carefully and consider such an exclusion in the future if the problem appears significant and beyond the control of EPs and EHs in certain markets (e.g., exclusion if large fraction of transitions/referrals go to settings that are not EPs or EHs)

Measure 2 Description

Stage 3 NPRM Measure	Description
Measure 2: Receive and incorporate electronic summary of care record for 40% of incoming transitions or referrals of new patients	1. New measure – 40% threshold
	2. Need to "incorporate" summary of care record
	3. Allows for "active" or "passive" receipt; allows any type of query
	4. Allows patients "never before encountered" for whom "electronic summary of care is available"
	5. Restricts applicability to transition/referrals episodes
	6. Allows exclusion for encounters where information "unavailable" – requested manually and not fulfilled, and either tried through an HIE and not fulfilled OR provider has no access to HIE with query capability
	7. Allows exclusion for providers in counties with low broadband penetration
	8. Allow utilization alerts?

Background: IOWG Measure 2 Recommendations

IOWG recommends the following on Measure 2:

1. Change threshold to: incorporate any type of information for XX% of TOCs/referrals or never before encountered patients, and CCDAs for YY% of TOCs/referrals or never before encountered patients
2. Allow for provider discretion in what to incorporate
3. Allow for "active" or "passive" receipt; allow any type of query (i.e., phone, fax, etc)
4. Allow "never before encountered" in measure denominator
5. Allow for queries outside of specific transition/referral episodes
6. Allow exclusion for "information unavailable" or "electronic means unavailable"
7. Merge "non-clinical settings" into Measure 2
8. Do not allow "utilization alerts"
9. Do not allow exclusion for low broadband penetration

Measure 2 Recommendations Discussion (1 of 5)

1. **Lower threshold to 25% (from 40%) (disagree with NPRM)**
   - This is a new measure for which we have no experience
   - By allowing some flexibility in how it is done, we are still comfortable setting a high bar for a new measure
   - Needs to be somewhat aligned with Measure 1 – ability to receive and "incorporate" tied to quantity and quality of what is sent

2. **Allow for provider discretion in what to incorporate (disagree with NPRM)**
   - Draft rule requires "incorporate" if available
   - Addresses concern about "CCDA bloat" – complements discretion allowed in Measure 1
   - Also recommend that CMS clearly define "incorporate" vs "reconcile"

3. **Allow for "active" or "passive" receipt; allow any type of query (agree with NPRM)**
   - Good first step to enabling fully electronic query capability
   - With no widely available, mature standards for query, and no ecosystem to support such exchange, flexibility is required
   - Gives credit to those who are in data sharing arrangements with electronic query or record location services

Measure 2 Recommendations Discussion (2 of 5)

4. **Allow "never before encountered" (agree with NPRM)**
   - IOWG is concerned that the measure adds workflow burden which, without automated HIE functions, offers little benefit to patient care
   - However, inclusion encourages use of automated HIE functions such as automated response to utilization alerts or electronic query
   - Recommend that CMS define "never before encountered" to mean "no record in EHR" – covers cases where patient sees new EP in same clinical organization

5. **Allow exclusion for "information unavailable" (agree with NPRM)**
   - Ecosystem maturity will take time so need to accommodate such exceptions if we keep a high 25% threshold on a new measure
   - Should define HIE availability as: "Query capability has been in production and functionally available through the entire reporting period, as attested to by provider"

Measure 2 Recommendations Discussion (3 of 5)

6. **Allow for queries outside of specific transition/referral episodes (disagree with NPRM)**
   - Population health management is increasing demand for information outside of discrete episodes of care
   - Including information received from queries outside of specific transitions/referrals encourages use of advanced HIE functions and promotes cognitive activities such as care planning and care coordination
   - Including such queries does require adjustment of measure definition – how to determine the denominator for discretionary queries?
   - For measure, allow EP/EH discretion on which queries are clinically appropriate and include in numerator and denominator
   - Within an EP practice, give MU credit to any EP who has seen patient (preferred), or to PCP, or to last EP to have seen patient

Measure 2 Recommendations Discussion (4 of 5)

7. Merge "non-clinical settings" into Objective 7

Reconciling these measures is not straightforward because they apply to different types of information from different types of providers for different groups of patients. While we did not have time to get consensus on a specific recommendation that merges the measures, we do recommend that CMS use the following principles in doing so:

1. Merge with Measure 2 as recommended
2. Do not set separate targets for "non-clinical providers" (e.g., separate measure or X% for all providers, Y% for "non-clinical providers")
3. Set a two-tier objective, with a higher threshold with greater content/format flexibility and a lower threshold based on CCDAs (e.g., incorporate any type and format of clinically relevant information for 25% of TOCs/referrals, incorporate CCDAs for 15% of TOCs/referrals)
4. Retain TOCs/referrals + never before encountered + electronically queried as denominator
5. Require electronic means of transmission
6. Allow exclusion for "electronic means not available"
7. Allow incorporation of electronically queried information outside of specific episodes of care
8. Clearly define the meaning of "incorporate" for CCDA and non-CCDA information

Measure 2 Recommendations Discussion (5 of 5)

8. **Do not allow "utilization alerts" (agree with NPRM)**
   - Too complex to determine "qualifying alert"
     - Not all alerts are related to transitions/referrals for a particular EP/EH
     - Multiple alerts often generated in a single episode of care
   - Utilization alerts typically contain very little, if any, clinical information

9. **Do not allow exclusion for low broadband penetration (disagree with NPRM)**
   - This exclusion appropriate for patient engagement measures but not for measures of provider-provider exchange

Measure 3 Description

Stage 3 NPRM Measure	Description
Measure 3: Reconcile clinical information for 80% of transitions or referrals of new patients	• Increase threshold from 50% to 80%
	• Increase scope to include med allergies and problems as well as medications
	• Required for transitions/referrals and any encounter with new patients
	• Automated versus manual?
	• Allow credentialed MAs to perform med rec?
	• Applicability to specialists?

Measure 3 Recommendations

IOWG recommends the following on Measure 3:

1. Set threshold at 80% for medications and medication allergies	Agree with NPRM
2. Lower threshold for problems to 10%, or make problems optional	Disagree with NPRM
3. Remove "never before encountered" patients from denominator	Disagree with NPRM
4. Allow either automated or manual reconciliation	Agree with NPRM
5. Allow credentialed MAs to perform reconciliation	Disagree with NPRM
6. Allow exclusions for some specialists	Disagree with NPRM

Measure 3 Recommendations Discussion (1 of 4)

1. **Set threshold at 80% for medications and medication allergies (agree with NPRM)**
   - The IOWG believes that information reconciliation should be done 100% of the time, however, need to account for practical reasons where it may not be possible or clinically appropriate
   - The IOWG is concerned with setting such a high threshold for reconciliation while the thresholds for sending (Measure 1) are much lower
   - However, we agree with CMS that reconciliation is critically important
   - We believe that meds and meds allergies are sufficiently well-defined, and there is enough flexibility in how reconciliation can be performed to meet the requirement, that it is appropriate to set a high goal in these areas

Measure 3 Recommendations Discussion (2 of 4)

2. **Lower threshold for problems to 10%, or make problems optional (disagree with NPRM)**
   - The IOWG is concerned with expanding the scope to problems at such a high threshold
   - Problem reconciliation is operationally very difficult and different in nature from meds and meds allergies reconciliation
     - Patients can report meds and med allergies in most cases, however, they are less able to reliably report on diagnoses
     - There is ambiguity in coding conventions – multiple ICD codes can cover single experience of illness
     - Providers vary widely in their approach to problem lists – "lumpers versus splitters", active versus inactive, etc
   - Agree that it should be done over time and thus IOWG recommends including it at low level to give CMS opportunity to increase it over time

Measure 3 Recommendations Discussion (3 of 4)

3. **Remove "never before encountered" from denominator (disagree with NPRM)**
   - With new patients there is nothing to reconcile against
   - Recommend that CMS define "never before encountered" to mean "no record in EHR" – covers cases where patient sees new EP in same clinical organization

4. **Allow either automated or manual reconciliation (agree with NPRM)**
   - There is still too much variation in quality of structured data to require automated reconciliation

Measure 3 Recommendations Discussion (4 of 4)

5. **IOWG did not reach consensus on if credentialed MAs should be allowed to perform reconciliation (disagree with NPRM)**
   - IOWG believes that providers should have flexibility to delegate work as clinically appropriate and as allowed by State law
   - However, some members of the IOWG remain concerned that MAs may not be qualified to perform some reconciliation such as problems
   - The IOWG recommends that CMS emphasize that providers are responsible for ensuring that staff are fully qualified and diligently supervised if they are allowed to perform reconciliation functions

6. **Allow exclusions for some specialists (disagree with NPRM)**
   - High levels of reconciliation is not appropriate for some specialties with narrow scopes of practice (e.g., low prescribers, orthopedists for whom problem list reconciliation is not clinically relevant, information not available due to narrow scope of practice, etc)
   - There are no "low volume" exclusions allowed for Measure 3
   - The IOWG recommends that CMS include exclusions for specialties where it may not be clinically relevant or practically possible to achieve high rates of formal reconciliation.

7. **CMS should clarify that reconciliations occurring prior to the patient visit count towards the numerator.**

Governance Question

NPRM allows any electronic means for transport for Measures 1 and 2

CMS questions in NPRM

- Should providers be allowed to use any electronic means, OR only "in a manner consistent with governance mechanism ONC establishes for nationwide health information network"
- How should governance mechanism established by ONC at later date be incorporated into EHR incentive program?

IOWG agrees with allowing any electronic means and NOT tying EHR incentives to governance mechanisms that may be established by ONC (agree with NPRM)

HIE Governance Recommendation Discussion (1 of 2)

For Measure 1 and Measure 2, providers should have flexibility in which electronic means they use to meet objectives

- Future objectives that require HIE capabilities should focus on the "what" (HIE outcomes), not on the "how" (HIE processes)
- It is the providers' responsibility to assure that the means used for electronic exchange satisfy Federal and State privacy and security laws (among other regulatory requirements), their patients' clinical needs, and their business needs
- It would be very risky for the Federal government to pick "winners and losers" among data sharing arrangements – the market is highly fragmented, heterogeneous, and very dynamic
- Tying incentives to HIE governance would not be practical until or unless ONC established a governance mechanism that applied to all HIE, which would be operationally complex and take considerable effort and time to establish

HIE Governance Recommendation Discussion (2 of 2)

Nevertheless, a more assertive Federal Government role may be required at some future date if HIE does not progress sufficiently, safely, and equitably according to objective and meaningful metrics

- CMS should establish meaningful benchmarks and associated metrics to assure that health information exchange is progressing safely and equitably across the health care continuum
- Market-based governance mechanisms are already getting traction and should be encouraged through value-based purchasing, alignment of Federal agency purchasing and provider activities, and guidance on privacy/security/safety
- The JASON Task Force recommended a series of specific non-regulatory steps that the Federal Government should take to promote nationwide interoperability