Responses to
HITPC Request for Comment

HITSC Workgroups Assigned

- Clinical Quality Workgroup
- Privacy & Security Workgroup
- Clinical Operations Workgroup
- NwHIN Power Team
- Implementation WG

Clinical Quality WG

1. Retire attestation as satisfying measures—and report use (not collection) of data. *(SGRP 108 & 109)*
2. Care Plan: Standard content & terminologies needed. For MU-3: diagnoses, patient goals, advance directives, core care-team. *(SGRP 304)*
3. Focus on CQMs that support efficient, evidence-based care processes. *(QMWG 01)*
4. Focus on CQMs that support interdisciplinary, cross-venue care. *(QMWG 01)*
5. Standardize the CQM data model and CQM-authoring tools. *(QMWG 03)*

Clinical Quality WG

6. Core measures? Pros and cons. Perhaps, e.g., shared decision making, pain management. *(QMG 04)*
7. Wider Input: Use states, learned societies, focused interviews, and crowd-sourcing methods. *(QMG 05)*
8. Patient input needs standards development. Start with symptoms, including adverse effects. *(QMG 07)*
9. Patient input occurs now thru validated instruments, e.g., for depression. *(QMG 08)*
10. Focus on suites of process and outcome measures. *(QMG 9 & 10)*

Clinical Quality WG

11. Align CQMs with MU objectives. *(CQMG 14)*
12. Transitions of care are high priority. *(CQMG 16)*
13. "Local" CQMs would require management and be hard to include in EHR certification. *(CQMG 18-24)*
14. Population-Management platforms are not standard; they are ready for sharing best practices. *(CQMG 28-30)*

Privacy and Security Workgroup

- IEWG102 asking for directory standard ➔ inappropriate to externalize directory services by creating a separate certification criterion (NwHIN PT agrees)
- MU03 re need for IT safety risk assessment ➔ agree on need, especially since HIPAA security risk assessment addresses only risks to PHI; start with general measure, let standards and certification criteria evolve
- MU04 re patient consent for sharing categories of information with special legal protections ➔ need access control solutions for labeling and protecting special categories, and for coding, managing, and sharing patient consents across organizations (via push or pull); capitalize on security engineering approaches to MAC and DAC, foundational work of VHA; ultimate solution must enforce access rules based on both clinical labels and individual consents, must support logical and intuitive workflows, must engender trust for both providers and consumers, and must be scalable at a national level (NwHIN PT agrees)
- PSTT01 re reconciling EHR certification with NSTIC approach of using 3rd-party credentials ➔ the two are complimentary – start with multi-factor authentication for Stage 3, then accept NSTIC certificates when available; allow consumers' and providers' use of NSTIC certificates to develop independently
- PSTT04 and 06 re making specific HIPAA requirements meaningful use measures ➔ no single HIPAA Security Rule standard or implementation specification should be called out as a MU measure

Clinical Operations Workgroup

Clinical Operations WG comments can be categorized as follows (with examples):

- WG agrees with proposed direction or proposed revision to existing objective
  - Higher threshold for incorporation of lab results can be achieved using existing standards
  - Formulary transmission can use existing NCPDP standards for formulary and benefits
- WG recommends pursuing the proposal with modifications or clarifications
  - Define “pertinent information” for an office visit, define “high priority conditions” etc.
  - Define radiation dose in radiology report template instead of putting every thing in one summary
- WG disagrees with proposed direction or change
  - Demographic data collection requirements should not be dropped
- Standards or processes are immature requiring a multiyear work plan beyond MU3
  - Reconciliation of problem list and allergies from disparate data sources has multiple challenges
  - Requiring use of CDS rules from central CDS repository is not realistic at this time
- Defer/reconsider or account for additional dependencies/alternatives
  - Complex filtering for clinical trials is applicable to very few patients , may just link to clinicaltrials.gov
  - Device data integration should be coordinated FDA UDI final rule implementation, not at odds with it

NwHIN Power Team

- SGRP113 re query of central repository for CDS rules ➔ unclear business model for CDS repository, but EHR vendors likely to welcome availability of repositories from which standard CDS data could be retrieved; standards for CDS data (e.g., order sets) more mature than standards for business logic; recommend further definition of a practical business model for CDS repositories, and standards for CDS data (defer standards for business logic)
- SGRP209 re query for clinical trials ➔ Stage 2 HL7 "Infobutton" standard and certification criterion should support; recommend ONC (perhaps with CDISC) review criterion and test scripts to assure sufficient and appropriate data elements are included to enable query for relevant clinical trials
- IEWG101 re ability to query outside entity for patient information; asks for recommendation re patient identity ➔ Lack of reliable patient identifier is significant challenge to care quality; proposed measure is overly prescriptive, should let current efforts around "directed query" evolve; ONC should support development of new models for using voluntary or other high-quality identifiers and authentication methods (P&S WG agrees)
- IEWG103 re switching EHRs ➔ create new standard CCDA template for data export; start with Transitions of Care and add necessary elements; Canada Infoway and NHS work re transfer of records may be helpful (P&S WG agrees)

Implementation Workgroup

COMMENTS FOR RESPONSE

- Ensure a plan that recognizes a realistic timeline for new or modified measure: entry into the federal register → vendor software modified and certified →implementation into the provider care environment → data collected /submitted for attestation
- Balance between ambition for change and ability of the industry to execute
- Proposed expansions or additions of measures should align with physician/clinician workflow to allow for the most efficient use of physician's resources and EHR product functionality.
- Encourage/Allow Innovation by recognizing when standards and state of the industry is good enough to get started…and provide support for incremental innovation and iteration.
- Summary reports are often used to reference important clinical information, the requirement that original data/image be always accessible could be burdensome.
- Keep current provider workflow in mind when increasing existing thresholds, proposals should direct towards a goal and not discourage due to unrealistic expectations.
- At this point in the evolution of Stage 3 requirements, it is valuable to consider incremental steps up in compliance level. Maintain vigilance Stage 2 compliance and then make the final decision.