



*Health Care Access for All*

January 14, 2013

Farzad Mostashari, MD, ScM  
National Coordinator for Health Information Technology  
Office of the National Coordinator  
United States Department of Health and Human Services  
Patriots Plaza III  
355 E Street, SW  
Washington, D.C. 20201

RE: COMMENTS- Health Information Technology; HIT Policy Committee: Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records

Dear Mr. Mostashari:

On behalf of the California Primary Care Association (CPCA), the 18 regional health center associations and health center controlled networks, the over 900 nonprofit community clinics and health centers (CCHCs), and the 5.1 million patients they serve in California, I thank you for the opportunity to comment on the ONC's Preliminary Stage 3 Recommendations for the EHR Incentive Program. CCHCs from their inception in the 1960s, have worked to engage patients in a culturally and linguistically competent manner, reduce racial disparities, improve patient safety, coordinate care, improve overall efficiency, and ultimately through this work have improved population health. CCHCs have been the medical home for low-income, uninsured, and medically under-served Americans long before the term medical home became popular. The principles used to craft the definition of meaningful use are the same principles that guide healthcare delivery in CCHCs today.

We respectfully submit the following comments. We begin with overarching comments on the Meaningful Use Program, and follow with comments on the Preliminary Stage 3 Proposed Measures and Objectives.

### **General Comments**

#### *Meaningful Use Program*

Before beginning the Meaningful Use Stage 3 conversation with our members, we thought it important to first step back and reflect on the entire Meaningful Use Program. CPCA wanted to know whether the goals and structure of the Program were manageable and beneficial for our membership before delving into new measures and objectives. What we heard was general

support for the Program, with a few grievances. The Meaningful Use Program has confusing eligibility and registration rules and the requirements to achieve the objectives of workflow changes are cumbersome. Despite those challenges, however, our members remain engaged and remain committed to the program. They are keenly aware that Stage 2 will be even more difficult and costly due to the encryption requirements and the patient portal, but they are not dissuaded from participating. While the incentives are the main driving force for their steadfast commitment to the Program, the standardized and structured clinical and operational data that will be generated as a result of participation is also a tremendous benefit.

As an association we remain concerned about our smaller CCHCs; they do not have onsite HIT support or the resources necessary to fully participate in the Program through all stages. We understand that the national program cannot be solely tailored to the needs of the least equipped; however, we do believe that the ONC when designing future stages should take into consideration the very real obstacles that smaller providers face. Our smaller CCHCs are often the only providers in the fragile rural and frontier regions and are an essential part of the national safety net. We request that their challenges be taken into consideration and that we ensure they are not left behind.

CPCA would like to commend the ONC, the HITPC, and CMS for the time and effort that has been dedicated to the Meaningful Use Program and thoughtfulness and consideration with which it has been implemented. Our membership, although challenged by aspects of the Program, will surely emerge stronger and better able to care for our complicated patient population.

#### *Regional Extension Centers*

While the Program, at least to this point, is proving successful, CPCA fears that it may not achieve its ultimate success should the technical assistance provided by the Regional Extension Centers disappear at the end of this year. We acknowledge that the ONC has requested comments to Stage 3, but we are compelled to convey our support for the past and ongoing quality work of the RECs in the earlier stages. In California, the three RECs (CalHIPSOC covering the majority of the state, COREC in Orange County, and HITEC-LA in Los Angeles County) have been essential to the success of our program. The legislature and federal agencies that crafted the Meaningful Use Program clearly anticipated that providers would not be able to install and meaningfully use an EHR without technical assistance. The RECs were an ingenious component to the Program, and are critical to achieving the goals of Meaningful Use going forward. We are very concerned that unless the RECs continue, much of the momentum in achieving the objectives of Meaningful Use could be lost and may threaten the remaining years and goals.

The RECs are an essential element to the Program and should have a dedicated and ongoing funding base from the ONC. The following are just three reasons why keeping them is so important. First, providers need assistance in understanding the program. While CMS and the Medicaid Departments across the country have excellent resources and webinars, they do not meet the needs of providers participating in the Program. The RECs and their partners, like Primary Care Associations, have had to train staff to become experts in the Program in order to

assist their providers in understanding it and then registering. Without the RECs it is likely that many eligible providers will not participate because the Program is so confusing that they will fear doing something incorrectly and then be penalized or inadvertently end up in a legal situation with their Medicaid Department. Organizations, like CPCA, have staff expertise related to the Meaningful Use Program, but we alone cannot provide the necessary one-on-one technical assistance that the RECs have the ability to provide.

Second, providers cannot achieve the intended outcomes of an EHR or the Meaningful Use Program without hands on technical assistance. This was reiterated just last week in a newly released report in *Health Affairs*, entitled “Small Physician Practices In New York Needed Sustained Help To Realize Gains In Quality From Use Of Electronic Health Records.” The study found that providers who received little to no hands on support showed “no significant improvements in care quality, even after using EHR systems for up to two years.” However those who did receive technical assistance, like what the RECs offer, showed improvements in care quality after nine months. Stage 3 is going to be even more difficult than Stage 2, and providers will need the technical assistance provided by the RECs even more then. Providers will be wary to attempt Stage 3 without technical assistance, especially if they relied on it heavily for Stages 1 and 2.

Third, providers are likely to stop participating in Meaningful Use should the RECs disappear because the total costs of participation and navigating the HIT landscape alone will be higher than the costs of the penalties. The costs of purchasing technical assistance support, buying patient portals, additional encryption, interfaces, and the other software/hardware necessary for Stage 2 and 3 will outweigh the incentive in the Medicare and Meaningful Use Program, and for the providers seeing Medicare patients the 1-5% penalty to Part B payments may be less than the costs of achieving Meaningful Use. RECs are an aggregator of demand and can help their consortium of providers negotiate cheaper rates and packages with vendors, and provide technical assistance. All of this would go away if the RECs went away as well.

CPCA highly encourages that the ONC and CMS consider ways to continue to fund the RECs, for the sake of the success of the entire Program.

### **Stage 3 Comments**

#### *General*

CPCA is supportive of the increased requirements the ONC has put on the EHR vendors. The larger gains of EHRs can only be achieved if the systems are capable of assisting the providers reach those goals. We are concerned, however, that the 2016 timeline for these requirements may be unrealistic. Should the vendor community not be able to meet the timeline with a reliable and robust EHR, we recommend pairing down the certification requirements to something more manageable. We are also concerned that the increased requirements on vendors will end up as increased EHR costs for the providers. If costs increase and the RECs disappear, this would be yet another reason for providers not to participate in the Meaningful Use Program. We recommend that the HITPC work with the vendor community to determine what is feasible for 2016 and the cost implications on providers and refine the certification

requirements accordingly. Providers should not be asked to shoulder the cost burden of advanced EHR systems.

### *Table*

Attachment A (p.7)

### *Additional Questions*

- HITPC Question: Currently, providers have to meet all MU criteria to receive incentives. Is there flexibility in achieving a close percentage of the objectives, but not quite achieving all of them? What is the downside of providing this additional flexibility? How will it impact providers who are achieving all of the MU criteria? If there is additional flexibility of this type, what are the ways this can be constructed so that it is not harmful to the goals of the program and advantageous to others?

CPCA Response: Yes, CPCA believes there should be flexibility in achieving the percentages of the measures. The “all or nothing” aspect of Meaningful Use can be a motivator, but it can also be a deterrent to participation. In Stage 2 and 3 there are measures that are out of the provider’s control, such as the patient engagement measures. It would make participation easier to structure and financially plan for if the provider could be assured that he/she would receive at least some compensation for participating rather than nothing if one of the percentages is not achieved.

The ONC and CMS could instead construct a “sliding-payment” incentive scale, much like the CCHCs “sliding-fee” scale for their uninsured patients. For Meaningful Use it would be for incentive payments, whereas at the clinics it is used for reimbursement. Because the Program is already so nuanced and complicated we recommend tiers of payment based on tiers of accomplishment. Perhaps reconstructing the Program to be like CCHCs- open door providers that don’t turn anyone away based on ability to pay- would be the most judicial manner. Any provider can participate and receive payment, but only those highest achievers receive full incentives.

- HITPC Question: What is the best balance between ease of clinical documentation and the ease of practice management efficiency?

CPCA Response: The CCHCs are not only participating in the Meaningful Use Program, but also the transformation to Patient Centered Medical Home as well as numerous other efforts often related to grants. They are constantly engaged in change management. Most realize that the large upfront costs have long term gains, but they still must manage how to afford the upfront costs in terms of time and finances. One possible solution is for the ONC and CMS to refine the timeline of reporting on the objectives and measures. Because the majority of the work with the objectives and measures is the programming and creation and implementation of the new workflow, more than it is increasing the percentage of patients captured, we recommend allowing

providers to report for 90 days the first year in each stage, and that a provider could use more than one 90 day period for reporting. For example, a provider could take the first three core requirements in Stage 2 and report on them for February-April, then the next four and report on those for April-June. Just as long as all of the objectives and measures were captured, met, and reported, the provider would be considered a meaningful user. Under this refinement, a provider or CCHC would be able to determine how best and when to implement each objective rather than having to do all of them at once.

- HITPC Question: As we propose to expand the features of the eQIM measure set, how can it be done in ways to minimize health care costs and reduce burden on health care providers?

CPCA Response: CPCA recommends that the ONC and CMS partner with the agencies and departments within HHS that collect clinical measures to align and standardize all measures being collected from providers. Streamlining measures at the federal level will save thousands of hours and resources in the field. Additionally, it would be tremendously valuable if there were a single HHS portal where all measures could be reported, and from that portal the agencies, departments and federal programs could collect their requisite measures.

- HITPC Question: Meaningful Use program has used menu objectives and menu CQMs to provide flexibility for providers. Should there be core CQMs for high priority health conditions, such as controlling hypertension?

CPCA Response: We appreciate the ONC and CMS's desire to have national high priority goals, but we recommend against setting core CQMs. There are already so many requirements on providers and types of providers participating in the Program that having clinical priorities/ requirements, would be too burdensome and confusing for providers. Dentists, for example, want to participate in Meaningful Use but are constantly confused by the clinical nature of the program. Adding core CQMs would only add to the confusion and difficulty experienced by dentists and specialists.

- HITPC Question: Which, if any, high priority CQM domains should receive prioritized attention in Stage 3?

CPCA Response: As we commented above, we do not recommend prioritizing any CQMs because we believe there should be flexibility to account for the numerous requirements already imposed by the Meaningful Use Program, and the array of providers participating.

However, we do believe that a greater emphasis should be placed on oral health and that there need to be additional oral health measures. More work is necessary in this field; however, the ADA has published pediatric oral health measures that can be added

to the Meaningful Use Program. The ADA Dental Quality Alliance (DQA) has published an E-Measure document titled: *Pediatric Oral Healthcare, Exploring the Feasibility for E-Measures*. This document explores the feasibility of adapting the DQA's Starter Set of administrative (using claims/eligibility data) measures for pediatric oral health into e-Measures. CPCA recommends that the HITPC incorporate the proposed measures to the Meaningful Use Clinical Quality Measure Data Set.

Thank you for allowing CPCA to share our recommendations. Should you have any questions about these comments, please do not hesitate to contact our Deputy Director of Regulatory Affairs, Andie Patterson, at (916) 440-8170 or [apatterson@cpc.org](mailto:apatterson@cpc.org). Thank you for your attention and consideration.

Sincerely,

Deborah Ortiz  
Vice President of Government Affairs  
California Primary Care Association

## Attachment A

| I. Improving quality, safety, and reducing health disparities   |  |  |
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| Stage 2 Final Rule  | Stage 3 Recommendations  | CPCA COMMENTS  |
| <p><b>Objective:</b> Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</p> <p><b>Measure:</b> More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.</p> | <p><b>Objective:</b> Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. CPOE for medications includes Drug-Drug Interaction checking for “never” combinations as determined by an externally vetted list.</p> <p><b>Measure:</b> More than 60% of medication, laboratory, and radiology orders created by the EP during the EHR reporting period are recorded using CPOE</p> | <p>CPCA is supportive of the increase in percentage for laboratory and radiology orders, but recommends that the percentage not be increased beyond 60% for future stages due to EMRs not being able to “think” intelligently. Research indicates that CPOE can lead to alert fatigue or that through automation and default selections nonstandard care procedures can be overlooked.</p> |
| <p><b>New</b></p>   | <p><b>Objective:</b> Use CPOE for referrals/transition of care orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.</p> <p><b>Measure:</b> More than 20% of referrals/transition of care orders created by the EP during the EHR reporting period are recorded</p>   | <p>CPCA is supportive of this proposal.</p>  |
| <p><b>Objective:</b> Generate and transmit permissible prescriptions electronically (eRx)</p> <p><b>Measure:</b> More than 50% of all permissible prescriptions or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT.</p>   | <p><b>Objective:</b> Generate and transmit permissible prescriptions electronically (eRx)</p> <p><b>Measure:</b> More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary (reviewed for generic substitutions) transmitted electronically using Certified EHR Technology.</p>  | <p>CPCA is supportive of this proposal.</p>  |
| <p><b>Objective: Record the following demographics</b></p> <ul style="list-style-type: none"> <li>• _Preferred language</li> <li>• _Sex</li> <li>• _Race</li> <li>• _Ethnicity</li> <li>• _Date of birth</li> </ul> <p><b>Measure:</b> More than 80 percent of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data.</p>  | <p>Retire prior demographics objective because it is topped out (achieved 80% threshold).</p>  | <p>CPCA is supportive of retiring the objective and not requiring providers to capture the measure any longer.</p> <p>Further, we support for the proposal to retain “Industry” and “Occupation” as demographic information in the final electronic health record (EHR) software certification criteria.<sup>1</sup></p>   |
| <p><b>Objective: Record and chart changes in vital signs:</b></p> <ul style="list-style-type: none"> <li>• Height/length</li> <li>• Weight</li> <li>• Blood pressure (age 3 and over)</li> <li>• Calculate and display BMI</li> <li>• Plot and display growth charts</li> </ul> <p>California Primary Care Association, Preliminary Stage 3 Proposed Rule Comments</p>  | <p>Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via COM NQF 0018</p> <p>CPCA supports the Migrant Clinicians Network’s recommendations:1)The sys</p>   | <p>CPCA is supportive of retiring the objective and not requiring providers to capture the measure any longer.</p>   |

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| <p><b>Measure:</b> More than 80 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data</p>  |  |  |
| <p><b>Objective:</b> Record smoking status for patients 13 years old or older<br/><b>Measure:</b> More than 80 percent of all unique patients 13 years old or older seen by the EP during the EHR reporting period have smoking status recorded as structured data</p>  | <p>Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028</p>   | <p>CPCA is supportive of retiring the objective and not requiring providers to capture the measure any longer.</p>   |
|   | <p><b>MENU Objective:</b> Record whether a patient 65 years old or older has an advance directive<br/><b>MENU Measure:</b> More than 50 percent of all unique patients 65 years old or older admitted during the EHR reporting period have an indication of an advance directive status recorded as structured data.</p>   | <p>CPCA is supportive of this proposal. Some of CPCA's Federally Qualified Health Center (FQHC) members are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and in order to meet those requirements the FQHC must be able to meet the HITPC's proposed new measure. Other FQHCs have already incorporated this practice into their workflows because it is considered standard operating procedure for quality care.</p> |
| <p><b>Objective:</b> Use clinical decision support to improve performance on high-priority health conditions<br/><b>Measure:</b> 1. <u>Implement five clinical decision support</u> interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency.<br/>2. The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p> | <p><b>Objective:</b> Use clinical decision support to improve performance on high priority health conditions<br/><b>Measure:</b> 1. <u>Implement 15 clinical decision support interventions</u> or guidance related to five or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 CDS interventions should include one or more interventions in each of the following areas, as applicable to the EP's specialty:<br/> <ul style="list-style-type: none"> <li>• <u>Preventative care</u> (including immunizations)</li> <li>• <u>Chronic disease management</u>, including hypertension* (e.g., diabetes, coronary artery disease)</li> <li>• <u>Appropriateness of lab and radiology orders</u></li> <li>• <u>Advanced medication-related decision support**</u> (e.g., renal drug dosing)</li> </ul> 2. The EP has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p> | <p>CPCA is <u>not</u> supportive of adding an additional 10 clinical decision support interventions for Stage 3. The move from Stage 1 to Stage 2, an increase of 5, is already anticipated to be a heavy lift from an operations perspective. There is significant programming necessary for each intervention as well as workflow changes. CPCA recommends implementing no more than 10 interventions for Stage 3.</p>   |
| <p><b>Objective:</b> Incorporate clinical lab-test results into Certified EHR Technology as <u>structured data</u><br/><b>Measure:</b> <u>More than 55 percent of all clinical lab tests results</u> ordered by the EP during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated</p>   | <p><b>Objective:</b> Incorporate clinical lab-test results into EHR as structured data<br/><b>Measure:</b> <u>More than 80% of all clinical lab tests</u> results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data</p>  | <p>CPCA is supportive of this proposal. We would note, however, that this measure is much easier to achieve for organizations that work with solely one lab vendor. For organizations that work with multiple lab vendors this will be more difficult to achieve.</p>  |



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| in Certified EHR Technology as structured data  |   |  |
| <p><b>Objective:</b> Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach</p> <p><b>Measure:</b> Generate at least one report listing patients of the EP with a specific condition.</p>  | <p><b>Objective:</b> <u>Generate lists of patients for multiple specific conditions and present near real-time (vs. Retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports.</u> Dashboards are incorporated into the EHR's clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report.</p>   | <p>CPCA is supportive of this proposal as a menu objective. While dashboards are a best practice, they are difficult to implement and as such the measure should be a choice.</p>  |
| <p><b>Objective:</b> Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder per patient preference.</p> <p><b>Measure:</b> <u>More than 10% of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available</u></p>   | <p><b>EP Objective:</b> Use clinically relevant information to identify patients who should receive <u>reminders for preventive/follow-up care</u></p> <p><b>Measure:</b> <u>More than 20% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference</u></p> <p><b>Exclusion:</b> Specialists may be excluded for prevention reminders (could be more condition specific).</p> | <p>CPCA is supportive of this proposal.</p>  |
| <p><b>MENU Objective:</b> Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.</p> <p><b>MENU Measure:</b> <u>More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through Certified EHR Technology.</u></p>  | <p><b>CORE Objective:</b> Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.</p> <p><b>CORE Measure:</b> <u>More than 10 percent of all tests whose result is an image (including ECGs) ordered by the EP during the EHR reporting period are accessible through Certified EHR Technology</u></p>  | <p>CPCA is supportive of this proposal as long as there is an option for how the image is stored. For our smaller clinics and health center members, they would prefer to store a scanned image in their systems. Our larger members, however, would prefer to interface to an outside entity so that the images are stored in a cloud solution or external servers.</p> |
| <p><b>MENU Objective:</b> <u>Record patient family health history as structured data</u></p> <p><b>MENU Measure:</b> <u>More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives</u></p>   | <p><b>CORE Objective:</b> <u>Record high priority family history data</u></p> <p><b>CORE Measure:</b> <u>Record high priority family history in 40% of patients seen during reporting period</u></p>  | <p>CPCA is supportive of this proposal.</p>  |
| <p><b>MENU Objective:</b> Record electronic notes in patient records</p> <p><b>MENU Measure:</b> <u>Enter at least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of unique patient office visits. Notes must be text-searchable. Non-searchable scanned notes do not qualify but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure.</u></p> | <p><u>Record electronic notes in patient records for more than 30% of office visits within four calendar days.</u></p>  | <p>CPCA is supportive of this proposal with amendments. We recommend that the measure be changed to seven calendar days or five business days. The longer time period is more reasonable for our clinics and health centers that have residents and part-time providers who practice one day a week at the clinic or health center.</p>                                  |
| <p><b>NEW</b></p>   | <p><b>Objective:</b> <u>The EHR is able to assist with follow-up on</u></p>   | <p>CPCA is supportive of this proposal with</p>  |

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|  | <p>test results</p> <p><b>Measure:</b> 10% of test results, including those which were not completed are acknowledged within 3 days</p>  | <p>amendments. While we agree that the measure aims to institute an important clinical care standard, it will be difficult for our community clinic and health center members to achieve the target within the proposed 3 days. We recommend the days to complete be lengthened to at least 7 calendar days. The longer time period is more reasonable for our clinics and health centers that have residents and part-time providers who practice one day a week at the clinic or health center.</p> <p>We also recommend that the HITPC better define this objective and measure. Can orders be open for 90 days? Should the patient not complete the test within those 90 days would the provider be notified by the EHR on day 91 that the patient had failed to comply with the follow up test? We request additional clarification on this measure for the next iteration of the Stage 3 proposal.</p>   |
| <b>Engage Patients and Families in their Care</b>  |  |  |
| <p><b>Objective:</b> Provide patients the ability to view online, download, and transmit (VDT) their health information within 4 business days of the information being available to the EP.</p> <p><b>Measure:</b> 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.</p> <p>2. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.</p> | <ul style="list-style-type: none"> <li>• <u>EPs should make info available within 24 hours if generated during course of visit</u></li> <li>• <u>For labs or other types of info not generated within course of visit, it is made available to patients within four business days of info becoming available to EPs</u></li> <li>• <u>Potential to increase both thresholds (% offer and % use) based on experience in Stage 2</u></li> </ul> <p><b>Note:</b> Depending on experience in Stage 2, CMS may want to give credit to some providers (e.g. specialists) for view/download /transmit where the patient has requested that they prefer info to be sent to a location they specify (such as another provider portal or PHR), rather than only making available information on the provider's portal.</p> <p><b>MENU item:</b> Automated Transmit*: (builds on Automated Blue Button Initiative (ABBI)): <u>Provide 50% of patients the ability to designate to whom and when (i.e. pre-set automated &amp; on-demand) a summary of care document is sent to patient-designated recipient**</u> (for example, a one-time request to send information from specialist to primary care or a standing request to always send an updated care summary when certain events arise, such as a change in medication or the completion of new tests or procedures). *Subject to the same conditions as view, download, transmit</p> <p>**Before issuing final recommendations in May 2013, HITPC will also review the result of Automated Blue Button pilots, in addition to considering public comments received.</p> | <p>CPCA is supportive of this proposal with amendments. We recommend that because the timeline is being reduced that the percentage be left the same. We agree that reducing the timeline for when a patient receives their information is a good standard of care.</p> <p>Just as we commented during the Stage 2 process we remain very concerned about any measure where patients must electronically engage in order for that measure to be achieved by the EP. Even with our health centers that have had EHRs for years and have provided their patients with the ability to communicate electronically, it has been very difficult to get the patients to engage. The elderly population is not as interested in this medium of connection, while our younger patients are more apt to engage electronically, but due to income limitations may not have a home computer or adequate internet connection and speed to prioritize communicating with their provider electronically. We strongly suggest removing the requirement where patients are required to engage in order for the measure to be achieved, however we agree that it should be a priority and as such the measure should be a menu option.</p> |
| <p><b>New</b></p>  | <p><b>MENU:</b> <u>Provide 10% of patients with the ability to submit patient-generated health information</u> to improve performance on high priority health conditions, and/or to improve patient engagement in care (e.g. patient experience, pre-visit information, patient created health goals, shared decision making, advance directives, etc.). This could be accomplished through semi-structured</p>  | <p>CPCA is supportive of this proposal with amendments. We request additional language stipulating what type of health information this measure would capture. We suggest that the health information be listed in large categories of information, such as medical device input.</p>  |

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|  | questionnaires, and EPs would choose information that is most relevant for their patients and/or related to high priority health conditions they elect to focus on. Based upon feedback from HITSC this should be a MENU item in order to create the essential functionality in certified EHRs.   | We also suggest the measure be an on/off or yes/no measure rather than a measure with a low target percentage. This measure would require that a program be created and turned on at the health center, and it would be offered to all the patients rather than a subset.   |
| <b>New</b>   | <b>Objective:</b> <u>Provide patients with the ability to request an amendment to their record online (e.g., offer corrections, additions, or updates to the record) through VDT in an obvious manner.</u>  | CPCA is supportive of this proposal.  |
| <b>Objective:</b> Provide <u>clinical summaries</u> for patients for each office visit<br><b>Measure:</b> Clinical summaries provided to patients or patient-authorized representatives <u>within 1 business day for more than 50 percent of office visits.</u>  | <b>The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.</b>  | CPCA is supportive of this proposal and suggests that the pertinent information include anything that was discussed or addressed during the office visit.   |
| <b>Objective:</b> Use Certified EHR Technology to <u>identify patient-specific education resources</u> and provide those resources to the patient<br><b>CORE Measure:</b> Patient specific education resources identified by CEHRT are provided to patients for <u>more than 10 percent of all unique patients with office visits</u> seen by the EP during the EHR reporting period | <b>Additional language support:</b> For the top 5 non-English languages spoken nationally, provide 80% of patient-specific education materials in at least one of those languages based on EP's local population where publically available   | CPCA is supportive of this proposal, but recommend that there be certification requirements on the vendors to ensure the provider is able to achieve the measure. Vendors do not have non-English functionality built into EHRs, but as our patient population is 42% non-English speaking, CCHCs with the resources have had to build this functionality themselves.   |
| <b>Objective:</b> Use secure <u>electronic messaging to communicate with patients</u> on relevant health information<br><br><b>Measure:</b> A secure <u>message was sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients</u> (or their authorized representatives) seen by the EP during the EHR reporting period      | <b>Measure:</b> <u>More than 10%* of patients use secure electronic messaging to communicate with EPs</u>   | CPCA is supportive of the concept of the proposal, but recommend the measure be left at 5%. Any measure that is reliant on patient engagement electronically is nearly impossible for the provider to control. One health centers that has had an EHR for years and a patient portal continues to struggle to get messaging about 1% use. The CCHC patient population is low-income, may not have a home computer or fast internet connection. This measure is too much too fast for the 2014 timeline. |
| <b>Not included separately (in reminder objective)</b>   | <b>Measure:</b> <u>Record communication preferences for 20% of patients</u> , based on how (e.g., the medium) patients would like to receive information for certain purposes (including appointment reminders, reminders for follow up and preventive care, referrals, after visit summaries and test results).  | CPCA is supportive of this proposal as most of our CCHCs are already doing this. Many of our clients require private visits and this functionality and practice is important in that care delivery.   |
| <b>Improve Care Coordination</b>   |   |   |
| <b>Objective:</b> The EP/EH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform <u>medication reconciliation.</u><br><b>Measure:</b> The EP performs medication reconciliation for <u>more than 50% of transitions</u> of care in which the patient is transitioned into the care of the EP                  | <b>Objective:</b> The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should <u>perform reconciliation for: - medications - medication allergies - problems</u><br><b>Measure:</b> The EP performs reconciliation for medications <u>for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than 10% of transitions of care in which the patient is transitioned into the care of the EP.</u> | CPCA is supportive of this proposal.  |
| <b>Objective:</b> The EP who   | <b>Objective:</b> EP who transitions their patient to another   | CPCA is supportive of this proposal.  |

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| <p>transitions their patient to another setting of care or provider of care or refers their patient to another provider of care <u>provides summary care record for each transition of care or referral.</u></p> <p><b>Measure:</b> 1. The EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than <u>50 percent of transitions of care</u> and referrals.</p> <p>2. The EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.</p> <p>3. An EP must satisfy one of the two following criteria: (A) conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in “measure 2”<br/>§495.6(j)(14)(ii)</p> | <p>setting of care or refers their patient to another provider of care</p> <p><u>Provide a summary of care record for each site transition or referral when transition or referral occurs with available information</u></p> <p>Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant):</p> <ol style="list-style-type: none"> <li>1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral)</li> <li>2. Setting-specific goals</li> <li>3. Instructions for care during transition and for 48 hours afterwards</li> <li>4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF (<b>D</b>irect care provision, <b>E</b>motional support, <b>C</b>are coordination, <b>A</b>dvocacy, and <b>F</b>inancial))</li> </ol> <p><b>Measure:</b> The EP that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for <u>65% of transitions of care and referrals (and at least 30%* electronically).</u></p> |   |
| <p><b>New</b></p>   | <p><b>Objective:</b> EP to whom a patient is referred <u>acknowledges receipt of external information and provides referral results to the requesting provider, thereby beginning to close the loop.</u></p> <p><b>Measure:</b> For patients referred during an EHR reporting period, <u>referral results generated from the EHR, 50% are returned to the requestor and 10% of those are returned electronically*</u></p>   | <p>CPCA is supportive of this proposal. We suggest that there be exclusions for providers with limited internet capability.</p>   |
| <p><b>Improve Population and Public Health</b></p>  |   |   |
| <p><b>Objective:</b> Capability to <u>submit electronic data to immunization registries</u> or immunization information systems except where prohibited, and in accordance with applicable law and practice</p> <p><b>Measure:</b> <u>Successful ongoing submission of</u> electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period</p>  | <p><b>Objective:</b> Capability <u>to receive a patient’s immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow,</u> except where prohibited, and in accordance with applicable law and practice.</p> <p><b>Measure:</b> Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system <u>for 30% of patients who received immunizations</u> from the EP/EH during the entire EHR reporting period.</p> <p><b>Exclusion:</b> EPs that administer no immunizations or jurisdictions where immunization</p>   | <p>CPCA is supportive of this proposal. However in California our providers will struggle with achieving this measure because we are limited by what the immunization registries can do. Currently, most registries can only accept information but do not have the capability to send information. Further, EHRs don’t often capture location field, so creating a longitudinal record is very difficult and spotty. The holes must then be filled through abstraction which is very time consuming.</p> |

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|  | registries/immunization information systems cannot provide electronic immunization histories.   |    |
| <b>New</b>   | <p><b>Objective:</b> <u>Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations</u> (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy.</p> <p><b>Measure:</b> <u>Implement an immunization recommendation system that: 1) establishes baseline recommendations</u> (e.g., Advisory Committee on Immunization Practices), and <u>2) allows for local/state variations. For 20% of patients receiving an immunization, the EP practice receives the recommendation before giving an immunization.</u></p> <p><b>Exclusion:</b> EPs that administer no immunizations.</p>   | NA |
| <p><b>MENU Objective:</b> Capability to submit electronic <u>syndromic surveillance</u> data to public health agencies, except where prohibited, and in accordance with applicable law and practice</p> <p><b>Measure:</b> <u>Successful ongoing submission of electronic syndromic surveillance data</u> from Certified EHR Technology to a public health agency for the entire EHR reporting period</p>              | No change from current requirements.  | NA |
| <p><b>MENU Objective:</b> Capability to <u>identify and report cancer cases to a public health central cancer registry</u>, except where prohibited, and in accordance with applicable law and practice.</p> <p><b>MENU Measure:</b> <u>Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period</u></p>                     | <p><b>Objective:</b> <u>Capability to electronically participate and send standardized (i.e. data elements and transport mechanisms), commonly formatted reports to a mandated jurisdictional registry</u> (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to either local/state health departments, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to prior requirements for submission to an immunization registry.</p> <p><b>Measure:</b> Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. <u>Attestation of submission for at least 10% of all patients who meet registry inclusion criteria</u> during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.</p>                     | NA |
| <p><b>MENU Objective:</b> <u>Capability to identify and report specific cases to a specialized registry</u> (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.</p> <p><b>MENU Measure:</b> <u>Successful ongoing submission of specific case information</u> from Certified EHR Technology to a specialized registry for the entire EHR reporting period</p> | <p><b>EP Objective:</b> <u>Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements</u> (e.g., immunizations, cancer, early hearing detection and intervention, and/or children with special needs). Registry examples include hypertension, diabetes, body mass index, devices, and/or other diagnoses/conditions) from the Certified EHR to a jurisdictional, professional or other aggregating resources (e.g., HIE, ACO), except where prohibited, and in accordance with applicable law and practice.</p> <p><b>Measure:</b> Documentation of successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. <u>Attestation of submission for at least 10% of all patients who meet registry inclusion criteria</u> during the entire EHR reporting period as</p> |    |

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|                             | authorized, and in accordance with applicable state/local law and practice.  |   |
| <b>Information Exchange</b> |  |   |
| New                         | <b>MENU</b> objective: <u>For patients transitioned without a care summary, an individual in the practice should query an outside entity.</u> The intent of this objective is to recognize providers who are proactively querying. | CPCA is supportive of this measure. We recommend that the HITPC consider and make exceptions for those providers that are in communities that are dominated by one EHR. In these communities querying outside of system is difficult. |