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Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Patriots Plaza III
355 E Street, SW
Washington, DC 20201

Attention: Health Information Technology Policy Committee Meaningful Use Stage 3 Request for Comment

Dear Mr. Robertson:

Lantana Consulting Group (Lantana) welcomes the opportunity to comment on the Health Information Technology Policy Committee's request for comment on Meaningful Use Stage 3 objectives, measures, and quality measures. Our comments focus on those areas of particular relevance to our HL7 Clinical Document Architecture (CDA) expertise.

Lantana's work focuses largely around interoperability specifications, although we see interoperability specifications not so much as an end in and of themselves, but as a means to an end; that end being a more data-driven healthcare system. Lantana's mission is to transform healthcare through health information. Lantana principals and employees have served as primary authors for CDA, CCD, Consolidation, QRDA, and eMeasure. Bob Dolin, President and Chief Medical Officer at Lantana, is Past Chair of HL7, and prior co-chair of HITSP Foundations Committee.

Our comments and rationale are outlined below. We are commenting on those areas that will have significant impact on the use, collection, and reporting of health information and where we can lend our knowledge in these areas.

Please contact Liora Alschuler, Lantana CEO, or Bob Dolin, if there are any questions regarding our recommendations.

Sincerely,

Liora Alschuler — Chief Executive Officer

Bob Dolin, MD — President and Chief Medical Officer

Meaningful Use Stage 3 Recommendations

Improving Quality, Safety, and Reducing Health Disparities

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to Proposed MU3 Certification Criteria
§170.314 2014 Edition Electronic Health Record Certification Criteria		
§170.314 (a) Clinical		
§170.314(a)(5) Problem List	ID: SGRP 105 • Certification Criteria: EHR systems should provide functionality to help maintain up-to-date, accurate problem list • Certification Criteria: Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians' maintenance of up-to-date accurate problem lists. Systems provide decision support about additions, edits, and deletions for clinicians' review and action. For example, if diabetes is not on the problem list but hypoglycemic medications are on the medication list: the EHR system might ask the provider whether diabetes should be on the problem list. It would not automatically add anything to the problem list without professional action.	• Review the data elements in the §170.102 Common MU Data Set to identify others that support clinicians' maintenance of accurate, up-to-date problem lists.
§ 170.314(a)(6) Medication List	ID: SGRP 106 • Certification Criteria: EHR systems should provide functionality to help maintain up-to-date, accurate medication list • Certification Criteria: Use of problems and lab test results to support clinicians' maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians' review. For example, an antibiotic (not for acne) has been on the medication list for over say a month, the EHR system might ask the provider whether the medication is a chronic medication. The system will not make any changes without professional approval.	• Include the number of doses ordered, dispensed, and administered. • Include over-the-counter medications.
§170.314(a)(17) Inpatient setting only – advance directives	ID: SGRP 112	• HITPC should note the need for a CDA Advance Directive Implementation Guide so it can be cited in a future stage.

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to Proposed MU3 Certification Criteria
§170.314 2014 Edition Electronic Health Record Certification Criteria		
§170.314 (a) Clinical		
§170.314(a)(8) Clinical Decision Support	ID: SGRP 113 • Certification Criteria: Ability to track CDS triggers and how the provider responded to improve the effectiveness of CDS interventions; Ability to flag preference-sensitive conditions, and provide decision support materials for patients; Capability to check for a maximum dose in addition to a weight based calculation; Use of structured SIG standards; Ability for EHRs to consume CDS interventions from central repositories (e.g., rules for drug-drug interactions, rules for reporting diseases for public health departments, preference-sensitive care lists).	• Establish a criterion that a certified EHR be able to suggest care plans based on problem, medication, allergy, demographics, lab results, or vital signs. • Review the data elements in the §170.102 Common MU Data Set to identify others that suggest available care plans.
§170.314(a)(16) Inpatient setting only – electronic medication administration record	ID: SGRP 117	• Revise to include tracking medication usage over time, including cumulative dose for current episode of care and lifetime dose of medications, even if not currently active, for medications with lifetime dosage limits.

Engage Patients and Families in Their Care

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to MU3 Certification Criteria
§170.314 (e) Patient engagement		
NEW	ID: SGRP 204A ID: SGRP 204B	• Establish a new criterion requiring the ability to receive and display a CDA Patient Authored Note.

Improve Care Coordination

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to MU3 Certification Criteria
§170.314 (b) Care coordination		
§170.314(b)(1) Transitions of care – receive, display, and incorporate transition of care/referral summaries	n/a	• Update the criterion to reference the latest version of Consolidated CDA (which may include a Transfer Summary, Referral Note, Care Plan, etc.).

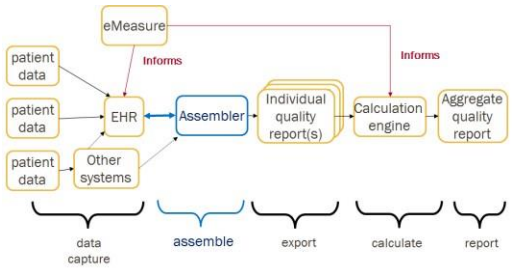
MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to MU3 Certification Criteria
§170.314 (b) Care coordination		
§170.314(b)(4) Clinical information reconciliation	ID: SGRP 302 • Certification Criteria: Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e. severity). • Proposed Certification Criteria for Future (Beyond Stage 3) Stage: Standards work needs to be done to support the valuing and coding of contraindications.	• Review the criterion against requirements for a shared care plan (e.g. a CDA Care Plan Implementation Guide). In many cases, the ability to share a plan will require that data elements be "incorporated into the recipient provider's EHR. One way to achieve incorporation is via data reconciliation.
§170.314(b)(2) Transitions of care – create and transmit transition of care/referral summaries	ID: SGRP 303 • Certification Criteria: EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral. • Certification Criteria: Ability to automatically populate a referral form for specific purposes, including a referral to a smoking quit line. • Certification Criteria: Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which are expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Consultation Request (Referral to a consultant or the ED); Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency) ID: IEWG 103 • No Stage 3 Certification Criteria outlined but question from HITPC is: "What criteria should be added to the next phase of EHR Certification to further facilitate healthcare providers' ability to switch from using one EHR to another vendor's EHR?"	• Compare data elements in the §170.102 Common MU Set with data elements implied by certification criteria to minimize discrepancies as part of the MU3 criteria validation. For example, §170.314(b)(4) Clinical Information Reconciliation requires certain provenance data elements (e.g. source of information) that should also be required under §170.102 Common MU Set. • Review data elements in the §170.102 Common MU Set to identify others (e.g. immunizations) that should be included in a Consolidated CDA. • Add immunizations to the data elements communicated in a CDA transition of care/referral summary. • Add data element level provenance metadata (e.g. source of information) to the data elements communicated in a CDA transition of care/referral summary. • "Raise the bar" on Functional Status, Cognitive Status, Mood, and Skin Integrity data elements, to use Meaningful Use CDA templates and vocabulary. • Update the criterion to reference the latest version of Consolidated CDA (which may include a Transfer Summary, Referral Note, Care Plan, etc.).

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to MU3 Certification Criteria
NEW	ID: SGRP 127 • Proposed Certification Criteria for Future Stage (beyond Stage 3): Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care. ID: SGRP 304 • Proposed Certification Criteria for Future Stage (beyond Stage 3): Develop standards for a shared care plan, as being defined by S&I Longitudinal Coordination of Care WG. Some of the data elements in the shared care plan overlap content represented in the CDA. Adopt standards for the structured recording of other data elements, such as patient goals and related interventions.	• Establish a criterion that creates, transmits, receives, displays, and incorporates a CDA Care Plan document containing a structured representation of the care plan components (health concerns, goals, interventions, outcomes), similar to that being developed through the HL7 Patient Care Work Group. • Establish a criterion that links a health concern in a Care Plan to a problem on the Problem List (as defined in §170.314(a)(5) Problem List) • We support HITPC's recommendation requiring an up-to-date interdisciplinary problem list inclusive of versioning in the support of collaborative care, and we recommend that it be promoted as an MU3 criterion. We request that HITPC clarify the distinction, if any, between an "interdisciplinary problem list" and the list of "health concerns" on a care plan.
NEW	ID: SGRP 305 • Certification Criteria: Include data set defined by S&I Longitudinal Coordination of Care WG and expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Shared Care Encounter Summary (Consultation Summary, Return from the ED to the referring facility, Office Visit) • Certification Criteria: Include standards for referral requests that require authorizations (or pre- certifications) for procedure, surgery, lab, radiology, test orders	• Establish a criterion that creates, transmits, receives, displays, and incorporates a CDA Referral document.

Improve Population Health

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to MU3 Certification Criteria
§170.314 (f) Public health		
§170.314(f)(1) Immunization Information	ID: SGRP 401A • Certification Criteria: EHR is able to receive and present a standard set of structured, externally- generated, immunization history and capture the act and date of review within the EP/EH practice.	• Add immunizations to the data elements communicated in a CDA transition of care/referral summary.
NEW	ID: SGRP 401B • Certification Criteria: EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.	• Add immunizations to the data elements communicated in a CDA transition of care/referral summary.

Patient Centeredness

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to MU3 Certification Criteria
§170.314 (c) Clinical quality measures		
§170.314(c)(1) Clinical Quality Measures – capture and export	ID: QMWG 05 through QMWG 08	• Establish an "assemble" criterion. Patient-centered care and the emergence of Accountable Care Organizations (ACO) will change the way quality reporting and source(s) of quality data are viewed when a patient is receiving care at multiple sites. The "assemble" criterion recognizes these new models in care, and requires the ability to gather together all data necessary to measure quality of care, regardless of source of capture. Whereas MU2 criterion *§170.314(c)(1) Clinical Quality Measures – Capture and Export* implies that data capture and export of all quality data will come from a single EHR, new models of care will require the assemblage of data from several EHRs and/or other systems, resulting in changes to the MU quality reporting model. This new "assemble" criterion is illustrated in the following figure. The double-headed blue arrow in the figure represents the two-way communication required by the EHR to provide decision support capabilities to the point-of-care provider, giving that provider a complete picture of the patient. Not all data in the Assembler is relevant to the point-of-care provider nor must it be incorporated into the provider's EHR. For example, patient satisfaction surveys used as a measure of quality do not necessarily affect provider decision making in real time the way that a lab result might. Likewise, some ratio-based quality measures may require population statistics (e.g. number of patients having a central line over the preceding month) that are not contained within an EHR. Thus, our proposed model for MU3 quality reporting changes criterion *§170.314(c)(1) Clinical Quality Measures – Capture and Export* to soften the requirement that an EHR capture all data and to introduce a new "assemble" capability.  • Revise §170.314(c)(1), softening the requirement that all data be captured via a single EHR and noting that exported data comes from the assembler.

Additional Comments

MU2 Final Rule Certification Criteria	HITPC MU3 Proposed Recommendations on Certification Criteria	Lantana Recommended Enhancements to MU3 Certification Criteria
§170.102 Definitions – Common MU Data Set		
NEW	n/a	• Compare data elements in the §170.102 Common MU Set with those implied by certification criteria to minimize discrepancies as part of the MU3 criteria validation. For example, §170.314(b)(4) Clinical Information Reconciliation requires certain provenance data elements (e.g. source of information) that should also be required.
§170.102(14) Care plan field(s), including goals and instructions	n/a	• Implement Care Plan data elements to align with the CDA Care Plan Implementation Guide.
NEW	n/a	• Add Immunizations aligned with Consolidated CDA.
NEW	n/a	• Add Functional Status, Cognitive Status, Mood, Skin Integrity data elements, aligned with Consolidated CDA for quality reporting.
NEW	n/a	• Add provenance metadata (e.g. source of information), including §170.314(b)(4) Clinical Information Reconciliation requirements.