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EHR Association Recommendations for ARRA Meaningful User and EHR Certification Criteria for Hospitals

Meaningful User for Hospitals

ARRA incentives are available to health care professionals and hospitals that are "meaningful EHR users." *Meaningful user* has three components: (1) meaningful use of certified EHR technology, (2) information exchange, and (3) reporting on measures using an EHR. This document is the position of the HIMSS EHR Association (EHRA) on how these terms should be defined and implemented by the Secretary of Health and Human Services (HHS).

As an association, EHRA has been focused on advancing standards-based interoperability, standards-based quality measurement, clinical decision support, CPOE, and encouraging effective customer implementation of comprehensive EHRs. Based on this expertise and commitment, we stand ready to work with HHS and others to further develop and refine the definitions and implementation of *meaningful user*.

In implementing this provision, we urge the Secretary to be guided by the following goals:

- Improve the health and health care of Americans
- Improve the health delivery system and support health care reform
- Improve quality and patient safety and reduce costs
- Achieve a critical mass of clinicians and hospitals using interoperable, comprehensive EHRs
- Target high cost/high morbidity chronic disease
- Counter identified barriers to adoption
- Support collection of data to support biosurveillance and public health

Overall Approach

Beyond these broad goals, we urge the Secretary to operate from a few guiding principles, following closely the structure and priorities for *meaningful user* established in ARRA. The key objective of this provision should be to ensure that clinicians in hospital settings are using the EHR to deliver safe, cost-effective, and efficient care.

To maximize adoption and ensure administrative simplicity, the number of criteria should be small in number, while consistent with the statute and overall goals. The criteria should be simple, and ease of reporting should be primary and should reflect the differences between hospital departments. Meaningful use criteria should be viewed as *indicators* of use of a comprehensive EHR; hence, there is no need for specific criteria for all or most EHR functions. Similarly, aspects of automation not directly related to EHR use, such as claims submission, should not be added to these criteria.

The primary initial goal should be to incentivize as much adoption and use as possible of comprehensive EHRs. It is also essential, therefore, to balance the need for accelerated adoption of interoperable, comprehensive EHRs with the need for clinicians and hospitals to implement these in a careful and non-disruptive fashion.

To this end, we urge that the Secretary set meaningful user criteria for the initial years, especially 2011 and 2012, at achievable levels, but with a roadmap for steady uplift over time in expected breadth and depth of use. Such uplift should be on a less than annual cycle, perhaps 24 months, to allow for predictability and effective provider adoption.

Certification criteria and product functionality should, however, anticipate and support projected increased levels of meaningful use. Thus, while we support an initially relatively simple approach to meaningful use, from the beginning providers should be encouraged to adopt EHRs that contain high levels of functionality.

In implementing this provision, we urge HHS to build on applicable current reporting programs in developing meaningful use criteria that can be created well before the end of 2009 and that can be adopted by providers using certified EHRs. At the same time we must learn from the successes and failures of these programs and seek non-intrusive and low cost reporting options, such as reporting measures that are a byproduct of meaningful use of the EHR and/or using surveys and/or attestation in lieu of claim-based reporting for other dimensions of meaningful use.

Meaningful use criteria should support the movement toward standards-based interoperability. Interoperability from the beginning should only be measured using HITSP harmonized standards.

Specific Proposals[1] for Initial Criteria

1. Meaningful Use: *Demonstrate to HHS that the provider is using certified EHR technology in a meaningful manner*:

    a. Clinician view access to hospital clinical data
    b. Use of CPOE (% TBD) for medications, with broader use of CPOE in out-years
    c. Use (% TBD) of electronic medication administration, with bar coding in the out-years
    d. Use of clinical decision support to improve medication safety
    e. Sufficient discrete data capture to support interoperability and quality reporting.

2. Information Exchange: *Certified EHR technology is connected in a manner that provides for electronic exchange of health information, in accordance with law and standards applicable to the exchange of information, to improve quality of health care such as promoting care coordination.*

    The overall requirement would be for connection for exchange of clinical summary data, using HITSP harmonized standards, with other clinicians, hospitals, patients, or other health care settings. We believe that hospitals should be required to satisfy at least one of the following criteria to meet this provision in 2011, with increased requirements in out-years: exchange of patient summary data upon admission and discharge, directly or indirectly, with other health care practices or another hospital; or exchange of patient summary data with a certified HIE upon admission and discharge.

3. Reporting of Measures: *Submit information to HHS on clinical quality measures and other measures (if HHS has capacity to accept electronically, which may be on a pilot basis)*

    Consistent with ARRA, the focus of this criterion should be primarily on a subset of existing NQF-endorsed measures that align with national quality and performance goals.

    For transport of quality measure information, we favor the use of HITSP standards as available or applicable. If some of the needed standards are still under development, with careful review, we could support the use of initial methods that are consistent with anticipated standards. We support allowing the submission of either patient-level data or population-level computed measures so long as the process for such computation is sufficiently specified and validated and the underlying data comes from the EHR. Finally, we support the submission of EHR quality data either directly from an EHR, a data registry or another intermediary.

[1] Each heading paraphrases the ARRA provision

EHR Certification Criteria for Hospitals

The HIMSS EHR Association proposes a progressive and feasible approach to ARRA Certification criteria that will meet the goals of high EHR adoption and use, sophisticated levels of interoperability, enhanced quality of care, and reduction of overall healthcare system costs.

As ARRA certification criteria are finalized, key principles need to be considered. The principles are clarity, relevance to national goals, and sufficient lead time for development. In addition, the certification process must recognize the existence of departmental systems from several different vendors at a single hospital (e.g. pharmacy).

CCHIT 2007 certification criteria include substantial, relevant EHR functionality including CPOE, clinical decision support, and closed loop medication administration and should be the basis of functionality certification.

While much progress has been made on interoperability of EHRs in the last three years through the efforts of HITSP and CCHIT, there do remain significant areas where further progress is needed. Interoperability is recognized as a critical theme for additional Initial Certification criteria. Given the short time frame, to be successful and to take advantage of existing ongoing product development investments, these criteria should be based on the CCHIT roadmap using current HITSP standards. The result will be robust interoperability provided that the HIE to EHR interfaces follow HITSP and IHE standards and are enforced at the HIE implementation level.

To support the quality reporting called for in the ARRA, finalization of standards and additional Certification criteria will be needed.

Clinical Decision Support criteria, which are important to enhancing the quality of care and patient safety, should be added to, building on the existing robust clinical decision support in CCHIT 2007.

ARRA Initial Hospital Certification Proposal

Theme: CCHIT 2007 plus more interoperability, quality reporting and clinical decision support

- CCHIT 2007 Certification criteria
    - These include CPOE, clinical decision support, and closed loop medication administration - all of which support patient safety and evidence based care
- CCHIT 2009 Interoperability criteria as listed:
    - Send ePrescription, refill request, eligibility/formulary and query for med history

    - CCD export with structured meds, problems, and allergies CCD display
    - Document sharing with audit trail and encryption (XDS.b+ATNA+CT)
    - Patient ID mgt (PIX and/or PDQ) [2]

- Additional CCD: clinical reports/results (text with coded section titles)
- Lab document sharing as per HITSP
- Quality Reporting based on widely accepted standards
- Clinical Decision Support criteria: bedside verification of medication administration

ARRA Certification after 2010:

- Extend CCD support by supporting additional sections, more terminology support
- Biosurveillance using modified CCD
- Additional standards-based quality reporting and registry support
- Additional clinical decision support criteria
- Support tracking of order completion
- Patient disclosure services to support the new rules on patient disclosure
- Additional audit and privacy services supported as required

Certification cycles:

We recommend that certification criteria be determined on a 24-month or longer cycle, so as to allow for vendor developmental cycles.

We recommend that ARRA certification be good for at least a two year period (three years is preferable) to allow for customer deployment and update cycles. It may likely be necessary to make further adjustments to the duration of a certificate to accommodate situations where an Enterprise deploys an update late in the certification certificate lifespan.

[2] Based on CCHIT Basic and Advanced Interoperability Criteria released March 30th 2009

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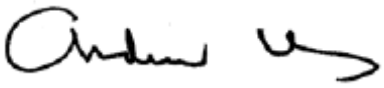

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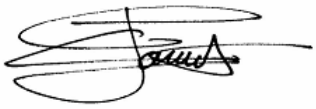

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About HIMSS EHR Association

HIMSS EHR Association is a trade association of Electronic Health Record (EHR) companies that join together to lead the health information technology industry in the accelerated adoption of EHRs in hospital and ambulatory care settings in the US. Representing a substantial portion of the installed EHR systems in the US, the association provides a forum for the EHR community to speak with a unified voice relative to standards development, the EHR certification process, interoperability, performance and quality measures, and other EHR issues as they become subject to increasing government, insurance and provider driven initiatives and requests. Membership is open to HIMSS corporate members with legally formed companies designing, developing and marketing their own commercially available EHRs with installations in the US. The association, comprised of more than 40 member companies, is a partner of the Healthcare Information and Management Systems Society (HIMSS) and operates as an organizational unit within HIMSS. For more information, visit http://www.himssehra.org.