Pharmacy e-Health Information Technology Collaborative

January 14, 2013

MacKenzie Robertson
FACA Program Lead
Office of the National Coordinator
   for Health Information Technology (ONC)
Department of Health and Human Services
Patriots Plaza III
355 E Street SW
Washington, DC 20201

      Re: HHS-OS-2012-0007 HIT Policy Committee: Request for Comment
      Regarding Stage 3 Definition of Meaningful Use of Electronic
      Health Records (EHRs)

Dear Ms. Robertson:

On behalf of the membership of the Pharmacy e-Health Information Technology Collaborative (Collaborative), we are pleased to respond to the HIT Policy Committee: Request for Comment Regarding Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs) published in the Federal Register on November 26, 2012.

The Collaborative is supportive of the proposed measures and objectives for the Stage 3 definition. Pharmacists are ineligible for EHR incentives, though they will need to exchange information with EHR systems to connect to and ensure needed bidirectional communication with eligible professionals (EPs). As indicated throughout our comments, that exchange is not at an adequate level today. Pharmacists provide patient-centered care and services, and as part of the integrated health care team, they are directly involved with patients in various practice settings, particularly with a patient's medication action plan. Pharmacists have standards in place to meet Stage 3 requirements.

As implementation of Stage 3 moves forward, it should not create undue financial burdens for pharmacists, pharmacies, and health care organizations. Also as our comments indicate, allowing pharmacists the opportunity to become EPs and receive EHR incentives may lead to adoption of these EHR standards at a level that may be significant.

The following are our comments concerning Stage 3 Definition of Meaningful Use (MU) of Electronic Health Records (EHR):

SGRP 101 – Objective: 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.

Comment: The Pharmacy e-HIT Collaborative fully supports this criterion and support the measure of more than 60%. The Collaborative agrees with our member American Society of Health-System Pharmacists (ASHP's) May 2012 comments "*We support expanding CPOE to 60 percent of medication, laboratory, and radiology orders, and believe that the new denominator is an improvement. The proposal to clarify the definition of CPOE in the proposed rule may be ambiguous as it relates to deciding whether verbal and or protocol orders are considered CPOE and scribes. CMS has very stringent rules around verbal and protocol orders, but the language used in the proposed rule may be subject to interpretation. If the intent is that an eligible professional must enter the order to be considered CPOE, then that should be stated. If one of the expected benefits of CPOE is to deliver clinical decision support at the point of care, then CMS should be specific in specifying that an eligible professional utilize CPOE. The final rule should explicitly state whether or not verbal orders and protocol orders are CPOE.*"

The Pharmacist EHR Functional Profile (HL7 Standard) complies with MU CPOE measures and pharmacists as computerized order entry providers. Pharmacists have access to a high level of drug-drug interaction lists and other medication-related clinical decision support. As health care providers, pharmacists are required by law to review drug-drug interactions, clinically relevant medication orders, cost-effectiveness, and assure medications are appropriately ordered.

SGRP 130: Objective: Use computerized provider order entry 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.

Comment: At points of transition of care, pharmacists practicing in all inpatient and outpatient practice settings play an integral role in assuring orders created by EPs, authorized providers of the eligible hospital, or CAHs inpatient or emergency departments are correct. As awareness and implementation of care transition activities continues to evolve with the utilization of HIT, we encourage ONC to recognize the value of pharmacists' role on the health care team in performing medication reconciliation and transitions of care activities. The pharmacy community is encouraged with the work that the CMS Innovation Center (CMMI) is doing with regards to care transitions and utilization of pharmacists in many of the programs aimed at reducing hospital readmissions.

For additional resource information on the important role that pharmacists in all practice settings play in transitions of care and in helping to reduce hospital readmissions, please see a March 2012 white paper published by Collaborative members APhA and ASHP, *Improving Care Transitions: Optimizing Medication Reconciliation* (available online at http://www.ashp.org/DocLibrary/Policy/PatientSafety/Optimizing-Med-Reconciliation.aspx). The document is helpful for pharmacists working in inpatient settings who may be part of discharge planning and care transition processes, in addition to pharmacists working in outpatient community pharmacy settings who provide care to patients transitioning back to their home or other care setting.   In addition, please see highlights of eight best practices regarding transitions of care identified through survey results and part of ongoing efforts to find successful models improving patient care (available online at: http://www.ashp.org/menu/AboutUs/ForPress/PressReleases/PressRelease.aspx?id=670).

Furthermore, recent studies on medication errors indicate that transitions from one care setting to other settings are a time of high risks for adverse drug events (ADEs) because of prescribing or transcription errors. By having pharmacists review medication orders and report that the orders were reviewed at the time of transition and especially before electronic prescriptions are transmitted would help in reducing medication errors, improve patients' health, and reduce costs. Prior to an electronic prescription being transmitted, we would recommend that the system allow the medication order to be put on hold until the pharmacist logs in to perform the review. If a pharmacist is unavailable to review the medication orders in time, the EHR should have an auto-send feature to ensure patients are able to receive their prescriptions.

In its 2006 *Preventing Medication Errors* study, the Institute of Medicine estimated that there are at least 1.5 million preventable ADEs that occur each year in the United States in various health practice settings (e.g., hospitals, nursing homes, ambulatory care). The Pharmacy e-HIT Collaborative requests the HITPC recommend that certified EHRs be required to report data on the number of patients a provider reviewed for *all* their medications before the patient is discharged from a health practice setting (e.g., hospitals, nursing homes, ambulatory care) and document the credentials of the final reviewer.

SGRP 103 – EP Objective: Generate and transmit permissible prescriptions electronically (eRx).

Comment: Concerning the question on the percentages for transmitting electronic prescription by EPs and EHs, the Pharmacy e-HIT Collaborative supports ONC's established measures and this objective. The EH measure of 30% should be achievable, and moving this from a menu item (MU2) item to a requirement would be beneficial for hospital medication reconciliation programs and possibly improve patient adherence.

With regard to the question asked in this proposed stage, how to include formulary checking into EHR and connection to formulary sources (e.g., PBMs), pharmacists rely on EPs and EHs to provide the formulary check prior to transmitting the electronic prescription. Pharmacists who

are using EHRs in a meaningful way need to have access to the formulary information to assure consistency with the medication order. Additionally, pharmacists should have access to a medication reconciliation process to assure appropriateness before dispensing medications. Pharmacists, in conjunction with payers, should be the last check for formulary alignment before medications are dispensed.

The Pharmacy e-HIT Collaborative supports electronic bidirectional exchange, especially, in areas where formularies are incorrect. Currently, pharmacists have to call the EP prescriber to correct issues. The Collaborative would like to see bidirectional exchange added to Stage 3. Pharmacists need to electronically transmit clarification of prescription information related to formulary with the prescriber using the SCRIPT (prescription change transactions) standard. Bidirectional exchange increases interoperability and would eliminate the need for manual steps to correct formulary errors.

SGRP 104 – Retire prior demographics objective because it is topped out (achieved 80% threshold).

Comment: Pharmacists keep track of demographic information. We agree with retiring the prior demographics objective.

SGRP 105 – **Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate problem list.

Comment: The Pharmacy e-HIT Collaborative believes it is vitally important that pharmacists have access to current problem lists at transitions of care to match medications for patients to use. This is necessary to make sure current problem lists are exchanged between non-eligible professionals, EPs and EHs.

Pharmacists providing patient care services have frequent access to patients and have the ability to capture information regarding problems. Pharmacists support the bidirectional exchange of information about patient problems, particularly, more current updated problem lists, that providers (e.g., EP, EH, CAH) may not have access to. This is particularly important for medication therapy management services pharmacists provide under Medicare Part D. Under Part D, pharmacists providing annual comprehensive medication reviews (CMR) are required to provide active medication lists, including contraindications to medications on the lists. To fully accomplish this, pharmacists must be able to communicate electronically with providers to ensure the medications prescribed have appropriate problem identifications. Pharmacists engaging patients in their care will guarantee appropriate medication use.

SGRP 106 – **Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list.

Comment: Having pharmacists review medication orders in all practice settings including EHs and report that the orders were reviewed at the time of transition and especially before electronic prescriptions are transmitted would help in reducing medication errors, improve patients' health, and reduce costs. The NCPDP SCRIPT standard 10.6 contains transactions for reporting medications filled by a pharmacy (fill status notification), drug utilization review, and cancel notification of discontinued medication.

Pharmacists providing patient care services have the ability to create an active medication list. As mentioned above, pharmacists are required under Part D to keep active medication lists. The Pharmacy e-HIT Collaborative strongly recommends that certification requirements for Stage 3 should include electronic bidirectional exchange of the fill status notification, drug utilization review, and cancel notification of discontinued medication. The Collaborative believes that if EPs use the standards as designed, and if bidirectional exchange is required, this will improve keeping medication lists updated and decrease phone calls to EPs from pharmacists and other manual aspects of keeping these lists current.

SGRP 107 – Certification criteria only: EHR systems should provide functionality to code medication allergies and link to related drug family, and code related reaction.

Comment: The Pharmacy e-HIT Collaborative supports the codification of allergies, pharmacists' access to the information, and pharmacists' ability to update and submit new allergy information to EPs, EHs, and CAHs. Pharmacists providing patient care services have frequent access to patients and have the ability to capture information regarding problems, including food-drug allergies, medication allergies, etc. Our hospital pharmacists and health-systems Collaborative's members are working with data base companies to develop best practices to code medication allergies and link to related drug family, and code related reaction. Pharmacists support the bidirectional exchange of information about patient problems, particularly more current updated problem lists, that providers (e.g., EP, EH, CAH) may not have access to.

Pharmacists need to be able to share this information through consolidated Clinical Document Architecture (cCDA) structured documents. It also is vitally important that pharmacists have access to medication allergies and links related to drug family and code related reactions, especially, at transition of care to match medications for patients to use. This is particularly important for medication therapy services pharmacists provide under Medicare Part D. Under Part D, pharmacists providing annual CMRs are required to provide active medication lists, including indications of the medications on the lists. A cCDA structured document is currently under ballot with HL7 and NCPDP. To fully accomplish this, pharmacists must be able to communicate electronically with providers to ensure the medications prescribed have appropriate problem identifications. Pharmacists engaging patients in their care will improve appropriate medication use.

SGRP 108 – Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018

Comment: The Pharmacy e-HIT Collaborative agrees with retiring this measure.

SGRP 109 – Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028.

Comment: The Pharmacy e-HIT Collaborative agrees agree with retiring this measure. Pharmacists play an important role in smoking cessation and capture patient data regarding smoking behavior.

SGRP 112 – Ensure standards support in CDA by 2016 . **EP MENU/EH Core Objective:** Record whether a patient 65 years old or older has an advance directive.

Comment: The Pharmacy e-HIT Collaborative supports the collection of advance directives by EPs, EHs, and CAHs.

SGRP 113 – **Objective:** Use clinical decision support to improve performance on high priority health conditions.

Comment: The Pharmacy e-HIT Collaborative supports the inclusion of 15 clinical decision support (CDS) interventions. This could be justified by order sets and actual alerts. The Collaborative agrees with our member ASHP's May 2012 comments where ASHP advocates for the development of CDS systems that are proven to improve medication-use outcomes and that include the following capabilities:
"1) alerts, notifications, and summary data views based on
  a. a rich set of patient-specific data,
  b. standardized, evidence-based medication-use best practices, and
  c. identifiable patterns in medication-use data in the electronic health record;
2) audit trails of all CDS alerts, notifications, and follow-up activity;
3) structured clinical documentation functionality linked to individual CDS alerts and notifications; and
4) highly accessible and detailed management reporting capabilities that facilitate assessment of the quality and completeness of CDS responses and the effects of CDS on patient outcomes. We strongly support drug-allergy checking and, furthermore, believe that final rule should reflect that fact that allergy information in most certified electronic health records (EHRs) is incomplete and, therefore, unreliable as an input for drug-allergy checks. For drug-allergy checking to be truly effective, allergens and the past reactions to allergens must be captured as structured information. Currently, an allergy record may only include a drug name without

the corresponding allergic reaction (e.g., rash, wheezing, anaphylaxis). Without stipulating the information needed to properly evaluate an allergy, drug-allergy alerts are less effective.

ASHP also believes that the current definition of an allergy is not sufficient. It is increasingly common to define only immune-mediated reactions to drugs and other substances as allergies, and therefore to segregate, separate and define all other "reactions to substances that are generally not harmful" as intolerances. For drug-allergy checking to be effective and efficient, it is important to distinguish between immune-mediate reactions and other reactions because, for safety reasons, drug selection changes are typically necessary to avoid immune mediated reactions, and not necessary in cases of anticipated, manageable intolerances.

The Society also believes that the final rule should acknowledge how drug-drug interaction checks have been associated with CDS alert fatigue and, therefore, that the requirement to implement drug-drug interaction checks should explicitly acknowledge these problems and permit eligible hospitals and providers to categorize drug-drug interaction alerts by severity and implement alerts accordingly."

Pharmacists currently have access to and use information provided from various repositories with regard to medications. The Pharmacy e-HIT Collaborative strongly recommends the inclusion of bidirectional exchange to share information and data among pharmacists in all practice settings, EPs, CHs, and CAHs, as a required element for this objective. We support the use of NCPDP Structured and Codified SIG within SCRIPT standard 10.6 in a manner that meets the specific needs of the practice setting in question as part of medication related clinical decision support.

SGRP 114 – Objective: Incorporate clinical lab-test results into EHR as structured data.

Comment: Pharmacists providing patient care services provide maintenance laboratory tests (e.g., lipid screening, bone scans). Pharmacists working in all practice settings including inpatient, outpatient and long term post acute care (LTPAC) settings need the ability to exchange laboratory test results and information electronically with EPs, CHs, and CAHs. The Pharmacy e-HIT Collaborative strongly recommends that the electronic bidirectional exchange of information be included as a requirement for this objective.

SGRP 115 – EP Objective: 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. Dashboards are incorporated into the EHR's clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report.

Comment: Pharmacists are trained to capture multiple conditions of patients and are in the position to incorporate clinical workflows and exchange that information with providers who are center point care coordinators.

Many hospitals are implementing dashboards to assist in pharmacist work flow and clinical services provided to the patient. The Pharmacy e-HIT Collaborative member, ASHP is spending considerable resources on a patient acuity and dashboard for prioritizing pharmacist provided care to patients. The use of HIT will enable this. More information about the ASHP request for proposal can be found at http://www.ashpfoundation.org/ComplexityScoreRFP.

SGRP 116 – EP Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.

Comment: The Pharmacy e-HIT Collaborative believes because pharmacists have more frequent access to patients, they are able to remind other health care providers and patients of preventive/follow-up care.

SGRP 117 – EH Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

Comment: EH pharmacists and pharmacists in the LTPAC settings play an important role in assuring that appropriate medications are administered and support use of eMAR, particularly, with regard to patient safety and inventory management.
The Pharmacy e-HIT Collaborative supports our member ASHP's May 2012 comments as follows:

"The definition of 'eMAR as technology that automatically documents the administration of medication into Certified EHR Technology using electronic tracking sensors (for example, radio frequency identification (RFID)) or electronically readable tagging such as bar coding' is problematic because it deviates substantially from the general understanding of the eMAR as a separate technology from barcode medication administration (BMCA).

ASHP suggests changing the proposed definition of eMAR to be the proposed definition of "eMAR with BCMA functionality." We fully support the requirement for eMAR with BCMA functionality.

ASHP disagrees with the statement that, "by its very definition, eMAR occurs at the point of care so we do not propose additional qualifications on when it must be used or who must use it." It is the experience of our members that the eMAR with BCMA, although unintended, is sometimes utilized away from patient. We strongly suggest that qualifications are important to further outline in detail when eMAR with BCMA must be used. The Society suggests that

eMAR with BCMA must be used immediately as medications are administered by eligible hospitals and eligible providers except:
   a) *in response to codes or in situations when urgent life-saving measures are being attempted,*
   b) *within operating rooms before, during and immediately after surgery, and*
   c) *within emergency departments.*

eMAR is unique in the emergency department and creates its own set of challenges. Many hospitals still use automated dispensing technologies. ASHP recommends that CMS clarify if the reporting measure can separate out emergency department eMAR from inpatient eMAR, or if this is intended to be a composite measure where the denominator is the combination of emergency department and inpatient and the numerator is any combination of locations or a specific area of the organization that has implemented eMAR."

SGRP 118 – CORE Objective: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.

Comment: The Pharmacy e-HIT Collaborative supports moving this to the CORE objective.

SGRP 119 – CORE Objective: Record high priority family history data.

Comment: Pharmacists are educated to record family history data that could affect medication use, especially, in pharmacogenetic activity. Pharmacists play an important role in linking medications to gene indications that could drive preventive conditions and target medications based on genetic information. The Pharmacy e-HIT Collaborative supports the recording of high priority family history data as a CORE Objective.

SGRP 120 – Record electronic notes in patient records for more than 30% of office visits within four calendar days.

Comments: Pharmacists currently capture electronically-recorded patient notes related to medication issues and are in a position to bidirectionally exchange these patient notes electronically. All providers should have the ability to exchange these notes electronically. The Pharmacy e-HIT Collaborative strongly recommends that electronic bidirectional exchanges be a required element of Stage 3.

SGRP 121 – EH CORE Objective: Provide structured electronic lab results to eligible professionals.

Comments: Pharmacists providing patient care services provide maintenance laboratory tests (e.g., lipid screening, bone scans). Pharmacists need the ability to exchange laboratory test

results and information electronically with EPs, CHs, and CAHs. The Pharmacy e-HIT Collaborative strongly recommends that the electronic bidirectional exchange of information be included as a requirement for this objective.

SGRP 204A – EPs should make info available within 24 hours if generated during course of visit; 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, and potential to increase both thresholds (% offer and % use) based on experience in Stage 2.

Comments: We support this MU Stage 3 recommendation, as it aligns with the role of pharmacists-provided health care and the services pharmacists provide. Although EPs provide paper summaries as the patient leaves the office, providing clinical summaries electronically within 24 hours, as well as the ability to view online, download, and transmit their health information in four business days, also would help more than just the patient. It is critical that pharmacists either receive these clinical summaries from EPs, as they will have an impact on dispensing or changing of medications, or that pharmacists be able to query this information, as needed, via health information exchanges.   Pharmacists need bidirectional exchange of this information.

It is important to remember that pharmacists are involved in patients' medication action plans, including the provisions of Medicare Part D, in which pharmacists are required to provide CMR structured documents. Pharmacists are in a position to capture medication-related progress notes, as well as results from patient information concerning diabetes, anticoagulation therapy, geriatrics, and share these with providers.

It is also important to note that long-term care and nursing facilities, as well as home infusion settings, have clinical summaries, particularly lab results/values. These settings also involve pharmacists.

Additionally, it appears that after the comment period for MU Stage 2 earlier this year, the timeframe for EPs to provide this information was changed from 24 hours to one business day.

SGRP 204B – MENU: Provide 10% of patients with the ability to submit patient-generated health information 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 questionnaires, and EPs and EHs would choose information that is most relevant for their patients and/or related to high priority health conditions they elect to focus on.

Comments: Some pharmacists provide maintenance services to patients to help them manage certain disease states (e.g., diabetes, hypertension, asthma).   Management of these services

also may include capturing medical device data from the home. The Pharmacy e-HIT Collaborative is involved with the standard development work to prepare pharmacists who receive medical device data from patients to electronically capture patient-generated health information.

SGRP 204D – Objective: Provide patients with the ability to request an amendment to their record online (e.g., offer corrections, additions, or updates to the record) through a patient portal in an obvious manner.

Comments: We support this objective. For years, pharmacists have been in the position to provide patients electronic access to their medication records. The Pharmacy e-HIT Collaborative also is in a position to work with system vendors to develop standards that would meet this objective.

SGRP 205 – The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.

Comments: Pharmacists have identified information that should be included in the CMR, as required by Part D.   The Pharmacy e-HIT Collaborative supports expanding additional summary documents to be included with the CMR, such as the standard cCDA structured document. A cCDA structured document is currently under ballot with HL7 and NCPDP. After the annual CMR, pharmacists provide a medication action plan (MAP) structured document that helps the patient understand what they can do next, as well as call the pharmacist or physician when certain medication-related events arise.

SGRP 206 – Additional language support: 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 or EH's local population, where publically available.

Comments: Pharmacists are in the position to provide educational materials about the medications patients are taking. These materials may not be available in all settings in languages appropriate for patients today; the pharmacy industry is attempting to prepare the materials to be available for Stage 3. The Pharmacy e-HIT Collaborative supports this additional objective.

SGRP 207 – Measure: More than 10% of patients use secure electronic messaging to communicate with EPs.

Comments: In order to meet true interoperability of this measure, there needs to be assurance that pharmacists working in all practice settings including inpatient, outpatient and LTPAC

settings can exchange information electronically with EPs, EHs, etc. The Pharmacy e-HIT Collaborative strongly recommends that the electronic bidirectional exchange of information be included as a requirement for this objective.

SGRP 208 – EP and EH Measure: Record communication preferences for 20% of patients, 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).

Comments: The Pharmacy e-HIT Collaborative supports this measure. Pharmacists are in a position to provide patients with their records, refill reminder notices, and information to assure patients adhere to medications prescribed in their communications preferences. Pharmacists need to be given the capability to be a part of this EP/EH process.

SGRP 209 – Certification Rule Only: Capability for EHR to query research enrollment systems to identify available clinical trials. No use requirements until future stages.

Comments: The Pharmacy e-HIT Collaborative supports the capability for EHR to query research enrollment systems to identify available clinical trials. The capability for such queries by providers, including pharmacists, would provide greater interoperability among integrated health care teams in providing patient care.

SGRP 302 – Reconciliation of contraindications (any medical reason for not performing a particular therapy; any condition, clinical symptom, or circumstance indicating that the use of an otherwise advisable intervention in some particular line of treatment is improper, undesirable, or inappropriate).

Comments: We support the reconciliation of contraindications for medications, medication allergies, and medication problems. The Pharmacy e-HIT Collaborative agrees with the 50% measure. Having pharmacists review medication orders in all practice settings including EHs and report that the orders were reviewed at the time of transition and especially before electronic prescriptions are transmitted would help in reducing medication errors, improve patients' health, and reduce costs.

Although pharmacists are capturing this information, they need electronic bidirectional exchange with EPs, EHs, CAHs, and other providers to share and receive problems related to patients' medications, particularly at the transition of care level, which is not included in this objective.   Transition of care involves more than EPs and eligible hospitals. Pharmacists in inpatient, outpatient/community and LTPAC practice settings will be involved in the transition of care and medication reconciliation. Pharmacists are able to collect social history as it relates to the patient's medical history (e.g., alcohol). Please see comments in SGRP 125 below for

further discussion.

SGRP 303 – EP/ EH / CAH Objective: EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care. Provide a summary of care record for each site transition or referral when transition or referral occurs with available information.

Comments: The Pharmacy e-HIT Collaborative supports the summary of care records for 65% of transitions of care and referrals at 30%. Pharmacists currently provide a summary of care record through CMR using cCDA. A cCDA structured document is currently under ballot with HL7 and NCPDP. Pharmacists support the bidirectional exchange as the focal point of transition of care in all practice settings, especially with regard to problem lists, particularly more current updated problem lists, that providers (e.g., EP, EH, CAH) may not have access to. It is vitally important that pharmacists have access to current problem lists at transition of care, particularly with regard to long-term care, to match medications for patients to use. This is particularly important for medication therapy management (MTM) services pharmacists provide under Medicare Part D. Bidirectional exchange of summary of care documents will help meet this MU Stage 3 objective.

SGRP 304 – EP/ EH / CAH Objective: EP/ EH/CAH who transitions their patient to another site of care or refers their patient to another provider of care.

Comments: The Pharmacy e-HIT Collaborative supports this objective. With frequent access to medications and patients, pharmacists are in a position to make this exchange. Pharmacists support the bidirectional exchange as the focal point of transition of care in all practice settings, especially with regard to problem lists (particularly more current updated problem lists) that providers (e.g., EP, EH, CAH) may not have access to. It is vitally important that pharmacists have access to current problem lists at transition of care to match medications for patients to use. This is particularly important for MTM services pharmacists provide under Medicare Part D. Under Part D, pharmacists providing annual CMR are required to provide active medication lists, including contraindications of the medications on the lists. To fully accomplish this, pharmacists must be able to communicate electronically with providers to ensure the medications prescribed have appropriate problem identifications. Pharmacists engaging patients in their care will guarantee appropriate medication use.

SGRP 305 – EP / EH / CAH Objective: EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby beginning to close the loop.

Comments: We support this objective. From a standards perspective, pharmacy systems are accustomed to order receipt and tracking. The Pharmacy e-HIT Collaborative supports

standards for referral requests, authorizations, etc., and certification criteria. The use of NCPDP SCRIPT standards for electronic prior authorization for medications is being developed and supported by the Pharmacy e-HIT Collaborative. Pharmacists are in a position to help close the loop. Electronic bidirectional exchange of cCDA documents supports MU Stage 3. A cCDA structured document is currently under ballot with HL7 and NCPDP.

SGRP 127 – Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care.

Comments: With frequent access to medications and patients, pharmacists are in a position to make this exchange of problem lists. Pharmacists support the bidirectional exchange of problem lists (particularly more current updated problem lists) that providers (e.g., EP, EH, CAH) may not have access to. It is vitally important that pharmacists have access to current problem lists at transition of care to match medications for patients to use. This is particularly important for MTM services pharmacists provide under Medicare Part D. Under Part D, pharmacists providing annual CMR are required to provide active medication lists, including contraindications of the medications on the lists. To fully accomplish this, pharmacists must be able to communicate electronically with providers to ensure the medications prescribed have appropriate problem identifications. The Pharmacy e-HIT Collaborative works with the standards development organizations and supports backward compatible versioning of standards.

SGRP 125 – Medication reconciliation: create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring).

Comments: The Pharmacy e-HIT Collaborative supports medication reconciliation performed by pharmacists but not necessarily from claim-based data only. Pharmacists have access to nonprescription drug medication and cash payment data. Pharmacists would not develop an active medication lists based on claims data only.

We noted that for Stage 2 the electronic exchange of information is not a requirement for medication reconciliation. We believe that it should be a requirement.   As noted previously, in the pharmacy industry's *Improving Care Transitions: Optimizing Medication Reconciliation* (a 2012 white paper published by Collaborative members APhA and ASHP and available online at: http://www.ashp.org/DocLibrary/Policy/PatientSafety/Optimizing-Med-Reconciliation.aspx), the comprehensive goals of medication reconciliation are "to obtain and maintain accurate and complete medication information for a patient and use this information within and across the continuum of care to ensure safe and effective medication use," to electronically communicate accurate patient medication information, and then take appropriate actions to resolve any discrepancies. This bidirectional electronic communication concerning the movement of a patient is needed by pharmacists working in health-systems as part of discharge planning/care transitions and in community settings receiving such transitions of care data to work with

patients as they return home or to other outpatient setting. Including pharmacists as key stakeholders in the expanding and evolving utilization of transitions of care and medication reconciliation processes should help address and help alleviate a variety of medication-related problems that may lead to hospital readmission.

SGRP 308 – EH Objective: The EH/CAH will send electronic notification of a significant healthcare event in a timely manner to key members of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required.

Comments: Pharmacists are key members of the patient care team and must be included in bidirectional exchange of information for the coordination of care when patient consent is authorized. The Pharmacy e-HIT Collaborative supports this objective.

SGRP 401A – EP/EH Objective: Add submission of vaccine contraindication(s) and reason(s) for substance refusal to the current objective of successful ongoing immunization data submission to registry or immunization information systems.

Comments: The Pharmacy e-HIT Collaborative supports Immunization Information System (IIS) in place to provide decision support services related to immunization. Pharmacists are leading providers of immunizations throughout the United States. As such, pharmacists document vaccine contraindications and the reasons for vaccine refusals. The Pharmacy e-HIT Collaborative is working with the pharmacy industry to ensure immunization information is exchanged with immunization registries. Additionally, the Pharmacy e-HIT Collaborative is working with structured documents, using cCDA to electronically exchange immunization information with EHRs, which includes contraindications and substance refusals. A cCDA structured document is currently under ballot with HL7 and NCPDP.

The Pharmacy e-HIT Collaborative supports electronic data submission to immunizations registries and believes they can be effective tools to promote patient and population health; however, because such registries are maintained at the state and local levels through public health agencies, there needs to be a uniform standard for reporting. We would encourage the support and harmonization of standards, such as the HL7 and NCPDP (SCRIPT and Telecom) standards for this area. This would not only encourage EPs, hospitals, and CAHs to submit electronically and uniformly, but it would also afford uniform reporting opportunities for non-EPs, especially pharmacists, who are administering immunizations. The American Pharmacists Association reports that there are 175,000 pharmacists, including student pharmacists, trained to administer immunizations.

SGRP 401B – EP/EH Objective: Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events

from immunization registries or immunization information systems) as applicable by local or state policy.

Comments: With the adoption of EHR, pharmacists will have the capability to capture, receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy. As qualified immunizers, pharmacists follow national, state, and local rule sets, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review. The Pharmacy e-HIT Collaborative supports this objective.

SGRP 402A – EH Objective (unchanged): No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system.

Comment: The Pharmacy e-HIT Collaborative supports electronic data submission of laboratory information to public health agencies and registries and believe they can be effective tools to promote patient and population health; however, because such registries are maintained at the state and local levels by public health agencies, there needs to be a uniform standard for reporting. We would encourage the support and harmonization of standards, such as the HL7 and NCPDP (SCRIPT and Telecom) standards for this area.

SGRP 402B – EP Objective: Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice.

Comments: Pharmacists provide patient care services and external information for case management in transition of care. Pharmacists are an integral part of the health care team and submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice. Pharmacists have frequent access to patients and are in a position to observe and report pandemic situations to the appropriate authority. Pharmacists should have access to external data and be in an operative position to exchange data using standardized (e.g., cCDA) case reports and submit these to the state/local jurisdiction. A cCDA structured document is currently under ballot with HL7 and NCPDP. The Pharmacy e-HIT Collaborative supports this objective.

SGRP 403 – EP MENU Objective: Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.

Comments: Because of their frequent access to patients, pharmacists are in a position to submit electronic syndromic surveillance data to public health agencies. As noted previously, the Pharmacy e-HIT Collaborative supports electronic data submission to public health agencies and registries and believe they can be effective tools to promote patient and population health; however, because such registries are maintained at the state and local levels by public health agencies, there needs to be a uniform standard for reporting. We would encourage the support and harmonization of standards, such as the HL7 and NCPDP (SCRIPT and Telecom) standards for this area.

SGRP 404 – EH/EP Objective: Capability to electronically participate and send standardized (i.e. data elements and transport mechanisms), commonly formatted reports to a mandated jurisdictional registry (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.

Comments: The Pharmacy e-HIT Collaborative supports reporting to cancer and specialized registries and believe they can be effective tools to promote patient and population health. Pharmacists need access to such reports, as well as the ability to report. Because such registries are maintained at the state and local levels through public health agencies, there needs to be a uniform standard for reporting. We would encourage and support the harmonization of HL7 and NCPDP (SCRIPT and Telecom) standards for this area. This would encourage EPs, hospitals, and CAHs to submit electronically and uniformly.

SGRP 405 – EP Objective: Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements (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.

Comments: Because of their frequent access to patients, pharmacists are in the position to capture immunization, cancer, hypertension, and diabetes information and submit to public health agencies and other registries in accordance with applicable laws. The Pharmacy e-HIT Collaborative is working on methods/solutions with the pharmacy industry for adoption.

We support reporting to specialized registries and believe they can be effective tools to promote patient and population health. Pharmacists need access to such reports, as well as the ability to report. There needs to be a uniform standard for reporting, however. We would encourage and support the harmonization of HL7 and NCPDP (SCRIPT and Telecom) standards for this area. This would encourage EPs, hospitals, and CAHs to submit electronically and

uniformly.

SGRP 407 – EH Objective: Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice.

Comments: The Pharmacy e-HIT Collaborative supports this objective. This supports work on antimicrobial resistance that CDC/NHSN is already developing. The use of administered antimicrobials (eMAR data) would be helpful in the CDC goals with this program. More about the program can be found at http://www.cdc.gov/nhsn/psc_ma.html. The CDC has been working with EHR vendors to support this CDA based data exchange.

Because of their frequent access to patients and medications, particularly, their knowledge of antibiotics and symptom-based products for infections (prescription and nonprescription), pharmacists would be in a position to electronically send standardized HAI reports to the NHSN using a common format from certified EHR. Additionally, with their knowledge of nonprescription medications, pharmacists would be apt to know of potential infections to report to EPs and public health. The Pharmacy e-HIT Collaborative supports this objective.

SGRP 408 – EH/EP Objective: Capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR, except where prohibited, and in accordance with applicable law and practice.

Comments: The Pharmacy e-HIT Collaborative supports this objective. Incorporating FDA Medwatch reports into EHRs would be beneficial in this area. The incorporation of MAUDE http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfmaude/search.cfm for medical devices should also be considered.

Because of their frequent access to patients and medications (prescription and nonprescription), pharmacists are in a position to send reports on adverse events to the FDA and the CDC in accordance with applicable laws, as well as exchange that information with EPs, EHs, and CAHs. The Pharmacy e-HIT Collaborative is working with pharmacists who can send EHR documents. A cCDA structured document is currently under ballot with HL7 and NCPDP. The Pharmacy e-HIT Collaborative supports this objective.

IEWG 101 – Certification criteria: The EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a health information exchange, or an entity on the NwHIN Exchange, for example. This query may consist of three transactions:

Comments: The Pharmacy e-HIT Collaborative is working with system vendors so that pharmacy EHR is able to query outside records and respond. Pharmacy management systems are the standards that drive query and response activity from outside records (e.g., connection to e-prescribing networks). The Pharmacy e-HIT Collaborative supports these certification criteria.

IEWG 102 – Certification criteria: The EHR must be able to query a Provider Directory external to the EHR to obtain entity-level addressing information (e.g. push or pull addresses).

Comments: The Pharmacy e-HIT Collaborative is working with system vendors so that pharmacy EHR is able to query an external provider directory. Pharmacy management systems are the standards that drive query activity with external provider directories. For example, when receiving an electronic prescription, the pharmacist must verify the prescriber through an external directory. The Pharmacy e-HIT Collaborative supports these certification criteria.

IEWG 103 – Certification criteria: Enable a user to electronically create a set of export summaries for all patients in EHR technology formatted according to the standard adopted at § 170.205(a)(3) that represents the most current clinical information about each patient and includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s).

Comment: The Pharmacy e-HIT Collaborative is working with the pharmacy industry standards organization (HL7 and NCPDP) to provide the functionality within the pharmacist EHR to exchange cCDA structural documents. These structural documents would contain the Common MU Data Set. Adoption of cCDA is occurring with Medicare Part D regulatory requirements to provide an electronic version a patient summary after a pharmacist-provided annual CMR. A cCDA structured document is currently under ballot with HL7 and NCPDP. The Pharmacy e-HIT Collaborative supports these certification criteria.

<center>**HITPC Stage 3 Request for Comment**</center>

MU01-05 – In an attempt to focus on outcomes and performance improvement, would it be possible to focus on a specific health issue? Meaningful Use could be used to improve performance on cardiovascular disease which is the leading cause of premature death, and leads health care spending.

Comment: The Pharmacy e-HIT Collaborative supports the inclusion of MU01-05 into Stage 3. Pharmacists provide patient-centered care, which includes services directed toward improving cardiovascular health (e.g., blood pressure checks, cholesterol screenings, and smoking

cessation). Pharmacists also have the ability to capture medication issues across the patient care spectrum. In their role of providing patient-centered care, pharmacists can meet these MU objectives and bring together those EPs specializing in specific disease states in a patient care coordinated way.

The Collaborative is working with the pharmacy industry to assure capturing MU01-05 in documenting and exchanging information concerning each of these measures. Pharmacists have electronic capabilities to assist with care coordination, especially during points of transition of care.

MU03 – To improve the safety of EHRs, should there be a MU requirement for providers to conduct a health IT safety risk assessment? Are there models or standards that we should look to for guidance?

Comment: The Pharmacy e-HIT Collaborative supports the following guidelines and research mostly surrounding CPOE safety: Institute for Safe Medication Practices (ISMP) http://www.ismp.org/newsletters/acutecare/articles/20021201.asp, ASHP http://www.ashp.org/DocLibrary/BestPractices/AutoITGdlCPOE.aspx , and published in the Journal of the American Medical Informatics Association (JAMIA) "*The impact of the electronic medical record on structure, process, and outcomes within primary care: a systematic review of the evidence*" http://www.ncbi.nlm.nih.gov/pubmed/21659445.

MU06 – 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?

Comment: The Pharmacy e-HIT Collaborative understands the need for flexibility by provider specialists in meeting the MU objectives; however, there may be a downside to this. The downside of providing flexibility could inhibit effective patient-centered care coordination. Pharmacists who are MU users of EHR have the capability of improving care coordination where flexibility of specialized providers occurs. This would be especially critical for medically complex patients who use multiple medications.

Patient Centeredness
QMWG01: How can the HITPC and QMWG capture input from a wide variety of providers, patients, organizations and societies?

Comments: Pharmacists provide patient-centered services as part of a health care team. The HIT Policy Committee and Quality Measures workgroup should solicit input from pharmacists through the Pharmacy e-HIT Collaborative.

QMWG02: What additional channels for input should we consider?

Comments: The Pharmacy e-HIT Collaborative represents pharmacists of all practice settings, which has the ability to network with pharmacists and pharmacies throughout the country. For input, contact the Pharmacy e-HIT Collaborative.

QMWG03: Please comment with guidance on how consumer-reported data can be incorporated into CQMs. What examples are there of EHR-enabled quality measures that use data directly entered by patients?

Comments: Pharmacists are trained to communicate with patients on medication information. Pharmacy management systems have the capability to capture patient outcomes, and in some instances, can capture these outcomes electronically through medical devices (e.g., diabetes monitors, blood pressure equipment, and inhalers).

Pharmacists are in a unique position to not only capture but also exchange this information with other providers who may not have access to these types of consumer reported data. The Pharmacy e-HIT Collaborative can provide guidance on how consumer-reported data can be incorporated into clinical quality measures.

QMWG04: Please provide examples of how patient-directed data is informing shared decision-making. How does the public view the integration of EHR derived data with patient generated data for quality measurement? How important is it to keep this data separate? Should it be separate?

Comments: Part of the Medicare Part D, effective January 1, 2013, requirements is to provide patients with an annual medication review by pharmacists. Patients will use the information provided as a means to ensure that their medications are used appropriately and to follow up with their pharmacists and providers regarding these medications. Having them available by using cCDA, patients will have the ability to not only print the information provided in a human readable form but also integrate the structured data into their personal electronic health record. A cCDA structured document is currently under ballot with HL7 and NCPDP.

The Pharmacy e-HIT Collaborative is working with standards development organizations to identify between patient-generated data and provider-generated data. The Collaborative believes it is important to keep the data separate.

QMWG05: Please provide comment on how the HITPC should proceed with our focus on clinical outcomes. Should the HITPC focus its efforts on building point-of-care process measures

or value-centered outcome measures?

Comments: The Pharmacy e-HIT Collaborative supports the focus on patient medication outcomes. The Collaborative also recommends the HITPC to focus its efforts on value-centered outcomes rather than on building point-of-care process measures.

QMWG06: Is this a false or unnecessary dichotomy? Should we instead consider a third approach, to promote process-outcome measure "suites", combinations of end outcome measures that are potentially associated with process measures? For example, Stage 2 eCQM set will include three HIV measures. The outcome of viral load suppression is accompanied by two related process measures for an HIV medical visit and for Pneumocystis Pneumonia prophylaxis.

Comments: The Pharmacy e-HIT Collaborative believes HITPC should be considering and measuring value-centered outcomes and not a third approach.

QMWG07: Please comment on challenges and ambiguities in retooling legacy paper abstracted and claims based eCQMs.

Comments: The Pharmacy e-HIT Collaborative understands the challenges of retooling paper and e-based measures, but we do not support e-based quality measures, rather, we support outcomes quality-based measures.

QMWG08: Is this a shift away from retooling legacy paper-based CQMs in exchange for designing CQMs de novo a reasonable course of action?

Comments: The Pharmacy e-HIT Collaborative agrees with shifting designing away from legacy paper-based quality measures and is in favor of outcome quality-based measures.

QMWG09: Please comment on the provider/payer/patient experience with using retooled measures as opposed to experience with de novo measures designed and intended for EHR-based measurement.

Comments: The Pharmacist e-HIT Collaborative believes all claims-based measures should be moved to EHR-based measures.

QMWG10: Please comment on aligning CQMs with MU Objectives. Would eCQM-MU Objective alignment be clinically valuable to providers or might this be a redundant exercise in shifting resources?

Comments: The Pharmacy e-HIT Collaborative agrees believes this is a redundant exercise in shifting resources.

QMWG11: Which measures and objectives, in particular, have the greatest potential to maximize meaningful alignment? Please recommend eCQM/Objective alignment opportunities.

Comments: The Pharmacy e-HIT Collaborative believes medication-related objectives are the important ones that will have the greatest potential to maximize meaningful alignment.

QMWG12: Which, if any, high priority domains should receive prioritized attention in Stage 3? What measure concepts, addressing these domains, should be considered for development? What EHR capabilities should be leveraged to realize these concepts?

Comments: The Pharmacy e-HIT Collaborative agrees believes the following domains are the important ones:
1) Improving Quality, Safety, and Reducing Health Disparities
2) Improving Care Coordination
3) Engaging Patients and Families
4) Improving population and public health

Medication-related issues should be considered for development.

In order to reach care coordination, EHR should have the capability to receive and exchange interoperable data from external providers (e.g., pharmacists).

QMWG13: Are there EHR based exemplar measures that exist, or that are being conceptualized or developed, that address these domains and theses concepts? What scientific evidence, if any, supports these concepts and exemplars?

Comments: The Pharmacy e-HIT Collaborative supports the focus of medication-related concepts. There is a large number of scientific evidence that shows appropriate medication use can improve patient outcomes.

These citations are noted in the Pharmacy e-HIT Collaborative Roadmap: http://www.pharmacyhit.org/pdfs/11-392_RoadMapFinal_singlepages.pdf.

QMWG14: Please comment on the desirability and feasibility of such an innovation track as a voluntary, optional component of the MU CQM requirement.

Comments: The Pharmacy e-HIT Collaborative and its members have a desire to track medication-related MU clinical quality measures.

QMWG15: The QMWG has considered two approaches to institution-initiated eCQMs. A conservative approach might allow "Certified CQM Development Organizations", such as professional societies and IDNs to design, develop, release and report proprietary CQMs for MU. An alternate approach might open the process to any EP/EH but constrain allowable eCQMs with certain design standards. There are advantages and disadvantages to both. Please submit comments on either, both or unique approaches.

Comments: The Pharmacy e-HIT Collaborative supports professional societies to design, develop, release, and report proprietary CQMs for MU.

QMWG16: What information should be submitted with a locally developed CQM to help CMS and other healthcare providers assess the innovative measure? For example, should the submission form include a brief description of: 1) importance/rationale of the measure domain; 2) evidence basis for the specific measure; 3) feasibility, and 4) usefulness of the measure?

Comments: The Pharmacy e-HIT Collaborative does not support use of locally developed CQMs for attestation. The Collaborative supports the use of local CQMs to facilitate innovation as long as the local CQMs are nationally validated through research.

QMWG17: What constraints should be in place? Should individual providers have an option to choose and/or design their own measures outside of the established CQM EHR Incentive Program set? Should these "practice-level" measures be required to conform to the Quality Data Model data elements and/or entered into the Measure Authoring Tool or conform to a simplified HQMF XML?
Comments: The Pharmacy e-HIT Collaborative supports optional CQMs for specific practice settings and providers and the Measuring Authoring Tool (MAT). We do not believe individual providers should chose their own measures designed outside of the established CQM EHR Incentive Program set.

QMWG18: What precautions might be necessary to mitigate fraud, waste and abuse and to avoid submission of trivial new measures that are unlikely to advance the field?

Comments: The Pharmacy e-HIT Collaborative supports use of metadata tagging, using nationally adopted standardized vocabulary to capture CQMs as a way to mitigate fraud, waste, and abuse.

QMWG19: For the existing and/or in the proposed expanded institution-initiated CQMs, how can federal agencies better support consistent implementation of measures for vendors and local practices (e.g., test case patients, template workflow diagrams, defined intent of measure

and value set)?

Comments: The Pharmacy e-HIT Collaborative does not support individually designed CQMs. We support optional CQMs for specific practice settings and providers.

QMWG20: Stage 3 may increase the number of measures EPs and EHs calculate and report. Considering provider burden, is there a limit to the number of measures that a provider should be expected to calculate? Is there evidence to support a limit?

Comments: The Pharmacy e-HIT Collaborative supports the capture of CQMs by using metadata tagging and national standard vocabulary. This will eliminate many of the manual processes needed to manually calculate measures.

QMWG21: Please comment on the value and feasibility of the eCQM and EHR features listed.

Comments: The Pharmacy e-HIT Collaborative value and feasibility comments are:

Ability to accept downloaded specifications for new measures with little tailoring or new coding
- High value; medium feasibility

Minimal manual data collection or manipulation
- High value if using metadata tagging/standardized vocabulary

Ability to aggregate measure data to varying business units (practice, episode, ACO, medical home, MA plan, etc)
- High value if using metadata tagging/standardized vocabulary

Ability to build measures that incorporate cross-setting records for episodes, medical homes, outcomes (e.g., readmissions)
- High value if using metadata tagging/standardized vocabulary

Ability to build multi-source data records, including claims, patient reported data
- High value; medium feasibility

Ability to implement machine-readable HQMF that minimizes manual vendor coding
- High value; medium feasibility

Ability to drill-down on reported measures for QI analyses
- Medium value/high feasibility if using metadata tagging/standardized vocabulary

QMWG23: What is the role of multi-source data exchange in achieving these features?

Comments: The Pharmacy e-HIT Collaborative is in favor of multi-source data exchange as long as pharmacists in all practice settings are part of that exchange.

QMWG24: Please comment on the value and feasibility of the CQM Population Management Platforms. Is there an evidence basis for clinical population management platform use? Is there a business case? Is this an area that could benefit from HITPC policy guidance or will the market mature and evolve without input?

Comments: The Pharmacy e-HIT Collaborative supports clinical population management platform use. Pharmacists capture and document population-based information and are in a position to share this information with other providers and government agencies, such as FDA, NIH, and Public Health Service.

QMWG25: What information or features might be present in a basic clinical CQM population management view (population score, denominator members, patient-level data element drill down, provider comparison, risk adjustment, ad-hoc queries, etc)?

Comments: The Pharmacy e-HIT Collaborative and its members are leaders in collecting and managing genetic information at the patient level. At a minimum, CQM population management could begin to capture clinical genetic data. The Collaborative supports information or features such as capturing immunization compliance, disease management (e.g., diabetes, hyperlipidemia, hypertension and behavioral features (e.g., smoking cessation, diet, nutrition, and exercise)).

QMWG26: What are the technological challenges to widespread release and adoption? Can the HITPC encourage technology in this area without being prohibitively prescriptive? Should the HITPC and HHS pursue avenues outside of regulation to support this technology: e.g. design open source prototypes, challenge grants, demonstration projects, guidance document, etc?

Comments: The Pharmacy e-HIT Collaborative supports HITPC to encourage technology designs to meet clinical QM population management platforms. The Collaborative supports medication-related technology solutions for HITPC and HHS to pursue following the regulatory process.

Privacy and Security

PSTT01: How can the HITPC's recommendation be reconciled with the National Strategy for Trusted Identities in Cyberspace (NSTIC) approach to identification, which strongly encourages

the re-use of third party credentials?

Comments: The Pharmacy e-HIT Collaborative supports a national strategy approach to identification.

PSTT03: Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third party authentication service provider?

Comments: The Pharmacy e-HIT Collaborative supports certification with third party authentication service providers.

PSTT04: What, if any, security risk issues (or Health Insurance Portability and Accountability Act (HIPAA) Security Rule provisions) should be subject to Meaningful Use attestation in Stage 3? For example, the requirement to make staff/workforce aware of the HIPAA Security Rule and to train them on Security Rule provisions is one of the top 5 areas of Security Rule noncompliance identified by the HHS Office for Civil Rights over the past 5 years. In addition, entities covered by the Security Rule must also send periodic security reminders to staff. The HITPC is considering requiring EPs/EHs/CAHs to attest to implementing HIPAA Security Rule provisions regarding workforce/staff outreach & training and sending periodic security reminders; we seek feedback on this proposal.

Comments: The Pharmacy e-HIT Collaborative supports current HIPAA security rule provisions.

PSTT05: Is it feasible to certify the compliance of EHRs based on the prescribed standard?

Comments: The Pharmacy e-HIT Collaborative believes it is feasible to certify compliance of EHRs on the prescribed standard. Pharmacists currently do this as a requirement for dispensing controlled substances.

PSTT06: Is it appropriate to require attestation by meaningful users that such logs are created and maintained for a specific period of time?

Comments: The Pharmacy e-HIT Collaborative believes it is appropriate to require attestation by meaningful users. Pharmacists currently maintain such logs as required by state and federal laws.

PSTT07: Is there a requirement for a standard format for the log files of EHRs to support analysis of access to health information access multiple EHRs or other clinical systems in a healthcare enterprise?

Comments: There currently is not a requirement for a standard format for log files. The Pharmacist e-HIT Collaborative does see a need for standard format for log files for EHRs.

PSTT08: Are there any specifications for audit log file formats that are currently in widespread use to support such applications?

Comments: The Pharmacy e-HIT Collaborative believes specifications that are currently for audit log file formats exist only within specific health systems for organizations.

ONC Addendum

ONC02: What could facilitate identify matching -- query (e.g., maintain external patient id, standards for matching attributes)?

Comments: The Pharmacy e-HIT Collaborative supports the HIMSS initiative for HHS to establish some standard format for patient identification.

ONC03: For the objective identified as SGRP303 - The EP, eligible hospital, or CAH 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 65% of transitions of care and referrals (and at least 30% electronically). Could the electronic threshold be raised to 50% for this measure?

Comments: The Pharmacy e-HIT Collaborative supports raising the threshold measure for transitions. Pharmacists play an important role in care at transitions and can support a higher threshold measure.

ONC04: For the objective identified as SGRP204B - Provide 10% of patients with the ability to submit patient-generated health information to improve performance on high priority health conditions, and/or to improve patient engagement in care….

What information would providers consider most valuable to receive electronically from patients? What information do patients think is most important to share electronically with providers? What data would be most valuable as an initial minimum set for patients to send to providers electronically outside the clinical visit? What other data could be added in the future?

Comments: The Pharmacy e-HIT Collaborative considers an active medications list reconciled by a pharmacist to be the most valuable data received electronically from a patient. This value is not only shared with patients but is expressed by numerous patient advocacy groups asking providers to accept a list of medications that the patient is actually using.

Information about prescription and nonprescription drugs can be obtained from multiple sources, including input from the patient. Obtaining information from prescription claims-based medication history *only* should not be used to meet the requirements of an active medication list. Obtaining patient input, especially about nonprescription medications and herbal alternatives in a medication list, is critical and must be shared with all providers.

Pharmacists are highly trained in communication with patients to obtain active medication lists and reconciling those lists to improve patient safety.

ONC05: What is the best balance between ease of clinical documentation and the ease of practice management efficiency?

Comments: The Pharmacy e-HIT Collaborative and its members are defining pharmacists' specific processes to document patient care services. The Collaborative supports the use of cCDA-structured documents when receiving and exchanging pharmacist provided clinical information. A cCDA structured document is currently under ballot with HL7 and NCPDP. This process will assure the best balance between clinical documentation and the ease of practice management efficiency.

ONC08: Some federal and state health information privacy and confidentiality laws, including but not limited to 42 CFR Part 2 (for substance abuse), establish detailed requirements for obtaining patient consent for sharing certain sensitive health information, including restricting the recipient's further disclosure of such information.

Comments: The Pharmacy e-HIT Collaborative supports the data segmentation for privacy that are mature enough to facilitate the exchange of this type of consent information in today's EHRs and HIEs.

OCN09: There are many cases where EHR systems supply clinical information to other systems e.g. registries, accountable care organizations. Is it possible to create an application programming interface (API) to represent the information defined in a CCDA so that systems can communicate with each other? Is the information defined in the CCDA the appropriate content for other uses of clinical information?

Comments: The Pharmacy e-HIT Collaborative supports cCDA structured documents for the exchange of clinical information. A cCDA structured document is currently under ballot with HL7 and NCPDP.

ONC10: For the objective identified as SGRP113 - Use clinical decision support to improve

performance on high priority health conditions…. Could certification criteria be added for EHR access to prescription drug monitoring programs (PDMP)?

Comments: The Pharmacy e-HIT Collaborative supports certification criteria to be added for EHR access to PDMP.   Using CDS with appropriate alerting to prompt providers in discharge prescribing of controlled substances to patients could be beneficial to prevent abuse. Querying the PDMP at the time of dispensing and/or discharge planning could be helpful. The Collaborative wants to assure that pharmacists providing patient care services who might not be part of the pharmacy have access to PDMP while providing patient care.

ONC11: What can be included in EHR technology to give providers evidence that a capability was in use during the EHR reporting period for measures that are not percentage based. This capability will need to support measures that occur in all stages of MU (e.g. there are yes/no measures in stage 1 that still need to be supported). Are there objectives and measures that should be prioritized to assist providers in showing that the capability was enabled during the reporting period?

Comments: The Pharmacy e-HIT Collaborative supports the bidirectional exchange of cCDA structured documents using a query and response process accredited by standard development organizations. A cCDA structured document is currently under ballot with HL7 and NCPDP. Embedding national standardized vocabulary and using metadata tagging for reporting quality measures should be a priority.

ONC12: For the objective identified as SGRP305 **-** EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby beginning to close the loop.
Add receipt of test results?

Comments: The Pharmacy e-HIT Collaborative supports the use of real time query and response processes accredited by standard development organizations. This should include a receipt for test results, similar to the receipt received for transmitting an electronic prescription.

Formed in the fall of 2010, the Collaborative's focus is to assure the meaningful use (MU) of standardized EHR that supports safe, efficient, and effective medication use, continuity of care, and provides access to the patient-care services of pharmacists with other members of the inter-professional patient care team.

The Collaborative seeks to ensure pharmacist-provided patient care services are integrated into the National HIT interoperable framework. The Collaborative's founding organizations represent pharmacists in all patient care settings and other facets of pharmacy, including pharmacy education and pharmacy education accreditation. The Collaborative's Associate Members represent e-prescribing networks, a standards development organization, transaction processing networks, pharmacy companies, system vendors and other organizations that support pharmacists' services. The Collaborative was founded by nine pharmacy professional associations representing over 250,000 members and includes six associate members from other pharmacy related organizations. For additional information, visit www.pharmacyhit.org

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On behalf of the Pharmacy e-HIT Collaborative, thank you again for the opportunity to comment on the Definition of Meaningful Use of Stage 3 Electronic Health Records proposal. For more information, contact Shelly Spiro, Executive Director, Pharmacy e-HIT Collaborative at shelly@pharmacyhit.org.

Respectfully submitted,

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