# AHIMA Comments on Stage 2 Meaningful Use Measures

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By Chris Dimick

Increased quality measurement, better patient access to health information, and greater volume of information exchange is in store for providers and hospitals participating in the federal stage 2 meaningful use incentive program.

On March 7 the Centers for Medicare and Medicaid Services (CMS) published the Electronic Health Record Incentive Program Stage 2 "meaningful use" proposed rule in the *Federal Register*. Interested parties had 60 days to submit comments to CMS, which the organization said they will use to craft the stage 2 final rule-expected later this summer.

The following is a selection of AHIMA's comments and recommendations to CMS on the stage 2 proposed rule. To view AHIMA's full comments on the proposed rule, visit www.ahima.org/advocacy.

## Quality Measures Aligned

Stage 2 better aligns the meaningful use quality reporting requirements with those of other federal quality programs, such as the Physician Quality Reporting Systems and the Medicare Shared Savings Program. AHIMA "applauds" this move, as well as CMS' intent to leverage the six quality domains indentified by the National Quality Strategy, according to AHIMA's comments.

"We trust this will result in fewer reporting burdens for EPs (eligible providers) as well as greater comparability of quality data within the medical practices as well as across federal programs," AHIMA commented. But mixed with this praise was criticism. AHIMA expressed concern regarding the increased burden that the proposed stage 2 Clinical Quality Measures (CQMs) will place on eligible hospitals-specifically, critical access hospitals and pediatric hospitals and clinics. A majority of the proposed CQMs are not applicable to critical access hospitals and the pediatric practice setting, which may discourage these entities from participating, AHIMA said.

For example, quality measures addressing obstetrical departments or neonatal intensive care units would not be applicable to a number of critical access hospitals that don't offer these types of care. An issue specific to pediatric facilities is that many of the quality measures do not apply to individuals under the age of 18, partly due to the federal government's overall lack of measure development for minors.

"At present, the low number of National Quality Forum-endorsed hospital measures that are applicable to individuals less than age 18 and included in the list of 49 candidate inpatient measures in the proposed rule will continue to present challenges to CMS and children's hospitals as they seek to implement EHRs that support meaningful quality measurement," AHIMA's comments said.

Although the number of measures applicable to minors is greater for providers, the measures are largely focused on primary care and some specialties. This limits the ability to capture measures across multiple care domains and in specialty care facilities.

"We restate our recommendation that pediatric hospitals and providers be exempted from measures that apply only to patients greater than or equal to age 18 and that case thresholds are applied to all members," the comments said.

## Better Access to Information

Stage 1 meaningful use asked providers to make health information electronically available to patients through a variety of methods-USB flash drives, CDs, and downloads among them. But stage 2 steps up this requirement by calling on providers to give patients the ability to view online, download, and transmit their health information within four business days of the information being available to the provider.

Specifically, the measure states that more than 50 percent of all unique patients seen by a provider during the EHR reporting period must be provided timely online access to their health information.

For hospitals, more than half of their inpatient and emergency department patients must have online access to information about their admission within 36 hours of discharge.

Also, more than 10 percent of patients must view, download, or transmit their health information to a third party. The objective replaces three stage 1 requirements related to providing patients electronic copies of their information.

AHIMA supports the objective of allowing patients increased access to their health information. However, the association felt that the measure requiring 10 percent of patients to view, download, or transmit their information was misguided.

The patient population's use of a provider service, like a health information portal, is outside of the provider's control. Providers should not be punished if patients refuse or are unable to use the technology.

An alternative proposed by AHIMA suggested that CMS could instead measure a provider's or hospital's communication to patients informing them of their capability to view, download, or transmit health information. This would be a measure that providers and hospitals could personally control, AHIMA commented.

AHIMA also presented some logistical concerns when it comes to hospitals providing online access to certain health information within 36 hours of discharge.

While the development of a patient portal would make this timeline feasible for some records, it doesn't solve all issues. A system would need to be put in place for providers to notify the HIM department when pending lab tests are available for inclusion in the record.

The 36 hour deadline also does not allow the HIM department enough time for "assembly and analysis" when processing weekend discharges, which includes ensuring that the information is accurate and complete, signatures have been collected, and the "correct results on the correct patient" have been confirmed, AHIMA wrote.

The strictest current regulations, set by the Healthcare Facilities Accreditation Program, requires the discharge summary to be completed within seven days. The HFAP surveys hospitals for compliance with the Medicare Conditions of Participation and Coverage.

"Without alignment with this regulation, HIM departments will be required to change physician practice and HIM roles to accommodate having the problem list completed and available within 36 hours," AHIMA wrote.

## Exchange of Information Heightened

Many pieces of the stage 2 proposed rule calls on providers and hospitals to increase their exchange of key clinical information. Several measures increase public health reporting, including the requirement that providers submit electronic data to immunization registries.

Other measures increase the exchange of information between providers and hospitals when transferring patients, such as the measure requiring hospitals to provide a summary care record for 65 percent of patients that they transition to another setting of care.

While AHIMA had some specific concerns regarding these measures, in its general comments the association supported "CMS' belief that meaningful use of electronic health records (EHRs) must involve ongoing exchange of health information for care coordination."

"We do not support the option to remove exchanging key clinical information as this would be detrimental to those eligible providers and hospitals that have actively been engaged in working towards that objective," AHIMA commented. "We realize there are challenges associated with implementing such functions; however it is critical to maintain momentum and drive the industry forward with health information exchange."

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