AIRA MONTHLY UPDATE

DECEMBER, 2012

MEANINGFUL USE STAGE 3 COMMENTS

One of the greatest opportunities AIRA has to help shape the direction of Meaningful Use is to provide thoughtful comments on the proposed The Standards and Interoperability Steering Committee has been hard at work drafting a response for HITPC Meaningful Use Stage 3 Recommendations. The comments are located at the end of this document.

There will be an AIRA Membership Meeting on **Thursday, January 3rd from 3:30 – 4:30 pm ET (12:30 – 1:30 pm PT)** to review AIRA's draft Meaningful Use Stage 3 comments. Click here for call and webex information, and see below for the draft comments.

MEMBERSHIP DUES

Don't forget AIRA Membership dues are due! For more information about membership, visit our website. Thank you to those of you who have paid your dues. Everyone else, please submit your dues payment as soon as possible.

HIGHLIGHTS – WHAT'S COMING UP IN 2013

AIRA began a new three year Cooperative Agreement (CA) with the CDC on October 1, 2012. AIRA's Steering Committees will undertake interesting new efforts for the first year of the CA. The Assessment Steering Committee has begun working on data quality assessment and coverage assessment initiatives and the MIROW Steering Committee will be conducting an assessment of the MIROW chapters, while continuing work on the mini-guide for inventory management and the updated data quality chapter; the Standards and Interoperability Steering Committee will continue to provide oversight for AIRA responses to Meaningful Use Stage 3 proposed rules, and the Education Steering Committee will continue to publish SnapShots, develop and offer topical educational webinars for our members, and will begin planning for a 2014 national meeting.

To ensure AIRA's course and direction over the next three

JANUARY AT AIRA

- January 2nd 2:00-3:00 p.m. ET: **AIRA Online Training Workgroup Meeting**
- January 3rd 3:30-4:30 p.m. ET: **AIRA Membership Meeting to Discuss MU Stage 3 Comments**
- January 7th 2:00-3:30 p.m. ET: **AIRA Board Meeting**
- January 9th 1:00-2:00 p.m. ET: **AIRA Standards & Interoperability Steering Committee**
- January 14th 3:00-4:00 p.m. ET: **AIRA Web Services & Real Time Data Exchange Workgroup**
- January 16th 2:00-3:00 p.m. ET: **Education Steering Committee**
- January 17th 4:00-5:00 p.m. ET: **MIROW Steering Committee**
- January 28th 2:00-3:30 p.m. ET: **AIRA Partners and Board meeting**

years, the AIRA Board of Directors will have an in-person strategic planning meeting in March. Key topics will include sustainability, bylaws review, association products, and association goals. A strategic plan will be developed as a result of this process and shared with the membership.

DECEMBER RECAP

Assessment Steering Committee

- The ASC did not meet in December.

Standards and Interoperability Steering Committee

- The SISC met on December 12th, 2012. AIRA's comments on Meaningful Use Stage 3 recommendations were discussed and developed. There was also a discussion of the NDC coding system, which is the system used in bar codes, and is proposed as an eventual replacement for CVX/MVX codes. The FDA has agreed to allow the CDC to create and maintain NDC codes for not otherwise specified vaccine doses. While NDC codes won't be proposed as a standard in 2013, it was suggested that by working on NDC codes now the IIS community can be prepared for possible changes in the future.

Education Steering Committee

- The ESC met on December 19th, 2012. The MIROW Inventory Management Webinar sponsored by the ESC has been rescheduled for January 15th at 3:00 pm EST (http://www.immregistries.org/events/2013/01/15/aira-webinar-mirow-inventory-management). The committee members continued planning for the pre-conference workshop that will be offered at the 2013 National Immunization Conference; discussed the next issue of SnapShots, which will be released in late January; and began discussions on a workplan and charter update to reflect activities in the new 3 year cooperative agreement.

MIROW Steering Committee

- The MIROW Steering Committee met on December 5th & 20th 2012. The committee has been hard at work identifying the scope for an evaluation of the MIROW documents and drafting language for an RFP. Committee members also discussed progress on the current topic, Data Quality Assurance; and discussed progress on the mini-guide for the inventory management topic.

To learn more about any of the information contained in the Monthly Update, please contact Rebecca Coyle at Coyler@immregistries.org

AIRA DRAFT COMMENTS TO THE HITPC MEANINGFUL USE STAGE 3 RECOMMENDATIONS

SGRP 113

Objective: Use clinical decision support to improve performance on high priority health conditions

Measure:

1. Implement 15 clinical decision support interventions or guidance related to five or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 CDS interventions should include one or more interventions in each of the following areas, as applicable to the EP's specialty:
   - Preventative care (including immunizations)
   - Chronic disease management, including hypertension* (e.g., diabetes, coronary artery disease)
   - Appropriateness of lab and radiology orders
   - Advanced medication-related decision support** (e.g., renal drug dosing)
2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

AIRA response:

AIRA supports this measure, and would like to emphasize that IIS have a long history of creating, maintaining and updating vaccine recommendations and forecasting, including other information critical to vaccine recommendations such as contraindications, history of disease, and substance refusal reasons into their systems. A great amount of time is spent on immunization clinical decision support; there is a unique expertise that is required as there are technical aspects and nuances of each vaccine that need to be understood, including the fluid nature of the recommendations themselves which require on-going maintenance. The CDC has recently published guidelines for IIS clinical decision support, so there is now one, comprehensive and authoritative venue for ensuring that IIS forecasting is correctly coded based upon the ACIP recommendations. Please see the following link for these guidelines: http://www.cdc.gov/vaccines/programs/iis/interop-proj/cds.html.

Some states allow for flexibility or local variations in the schedule, and this functionality is already supported by IIS.

Any CDS engine that is used should be able to produce accurate forecasting based upon the ACIP recommendations and available data. It is not necessary for the CDS to be built into the EHR but an external CDS could be utilized, and consuming the forecast provided by an IIS may be a better way to produce the forecast. We encourage EHR vendors to utilize the local IIS CDS or a public health CDS web service that is supported by the state/city/county immunization program in the jurisdiction that the provider office resides. We do not believe it is feasible to mandate a *single* CDS solution for immunization; we believe the

proposed recommendation recognizes this reality. We further believe that the CDC CDS guidelines for IIS clinical decision support should be referenced as the authority for ensuring the IIS forecasting is correctly coded based upon the ACIP recommendations, and in accordance with applicable law and practice.

SGRP 401A

EP/ EH Objective: Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice.

Measure:
Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period.

Exclusion:
EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories.

Certification criteria:
EHR is able to receive and present a standard set of structured, externally-generated, immunization history and capture the act and date of review within the EP/EH practice.

AIRA's response:
If we understand the use case correctly, this measure is referring to the ability of the EHR to be able to query an IIS with demographic data and receive back a consolidated, de-duplicated immunization history for a patient. AIRA supports this measure for a number of reasons. First, this functionality is already in production in a number of jurisdictions around the country. Second, the query and response most commonly supported by IIS include not just the immunization history but also the vaccine forecasting/evaluation. On that note, we would recommend that this be added to the measure, such as "Capability to receive a patient's immunization history and vaccine recommendations/forecast…" Since the EHR already has to get the history, getting the recommendations/forecast would be the easy and obvious thing to do. Finally, national standards currently exist for these transactions and are in use in some states.

Thus, AIRA feels that 401A is in alignment with current usage and future adoption and should be included in the final rule.

Proposed for Future Stage under 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.

AIRA's Response:

AIRA fully supports this measure and would be supportive of including it in Stage 3, as most IIS need these critical components now. Many EHR's are already submitting vaccine contraindications, history of disease and substance refusal reasons to IIS, so we believe this should be an easy addition to Stage 3.

AIRA assumes that past approved measures in previous stages are expected to continue in future stages. For instance, the Stage 2 measure of ongoing submission to PHA's is expected to continue in all future stages.

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.

Measure:

Implement an immunization recommendation system that: 1) establishes baseline recommendations (e.g., Advisory Committee on Immunization Practices), and 2) allows for local/state variations. For 20% of patients receiving an immunization, the EP/EH practice receives the recommendation before giving an immunization.

Exclusion:

EPs and EHs that administer no immunizations.

Certification criteria:

EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.

AIRA response:

As included in our comments to SGRP 401A and SGRP 113, AIRA would like to reiterate that IIS have a long history of creating, maintaining and updating vaccine recommendations and forecasting, including other information critical to vaccine recommendations such as contraindications, history of disease, and substance refusal reasons into their systems. A great amount of time is spent on

immunization clinical decision support (CDS); there is a unique expertise that is required as there are technical aspects and nuances of each vaccine that need to be understood, including the fluid nature of the recommendations themselves which require on-going maintenance. The CDC has recently published guidelines for IIS clinical decision support, so there is now one, comprehensive and authoritative venue for ensuring that IIS forecasting is correctly coded based upon the ACIP recommendations. Please see the following link for these guidelines:

http://www.cdc.gov/vaccines/programs/iis/interop-proj/cds.html.

Some states allow for flexibility or local variations in the schedule, and this functionality is already supported by IIS.

Any CDS engine that is used should be able to produce accurate forecasting based upon the ACIP recommendations and available data. It is not necessary for the CDS to be built into the EHR but an external CDS could be utilized, and consuming the forecast provided by an IIS may be a better way to produce the forecast. We encourage EHR vendors to utilize the local IIS CDS or a public health CDS web service that is supported by the state/city/county immunization program in the jurisdiction that the provider office resides. We do not believe it is feasible to mandate a *single* CDS solution for immunization; we believe the proposed recommendation recognizes this reality. We further believe that the CDC CDS guidelines for IIS clinical decision support should be referenced as the authority for ensuring the IIS forecasting is correctly coded based upon the ACIP recommendations, and in accordance with applicable law and practice.

Therefore, AIRA supports this measure.

New: 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.

Measure:

Attestation of successful electronic transmission of standardized adverse event reports to the FDA/CDC from the Certified EHR Technology. Total numeric count (null is acceptable) of adverse event reports from the EH/EP submitted electronically during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.

Certification criteria:

EHR is able to build and send a standardized adverse event report message to FDA/CDC and maintain an audit of those reports sent to track number of reports sent (Common Format).

AIRA response:

Though vaccine adverse event reporting is mentioned in this measure, to our knowledge CDC is unable to accept an electronic submission of a VAERS report (see http://vaers.hhs.gov/esub/index). Provision for electronic submission is at best in the "R&D" stage at CDC, so any future adoption of this functionality would be predicated on the development of this capability. Of course, these events are few and far between, and it is questionable whether EHR systems need to have the capability to do this reporting when they will rarely if ever make use of it.

IEWG 101:

MENU objective: For patients transitioned without a care summary, an individual in the practice should query an outside entity. The intent of this objective is to recognize providers who are proactively querying.

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:

a) Patient query based on demographics and other available identifiers, as well as the requestor and purpose of request.
b) Query for a document list based for an identified patient
c) Request a specific set of documents from the returned document list

When receiving inbound patient query, the EHR must be able to:

a) Tell the querying system whether patient authorization is required to retrieve the patient's records and where to obtain the authorization language*. (E.g. if authorization is already on file at the record-holding institution it may not be required).
b) At the direction of the record-holding institution, respond with a list of the patient's releasable documents based on patient's authorization
c) At the direction of the record-holding institution, release specific documents with patient's authorization

The EHR initiating the query must be able to query an outside entity* for the authorization language to be presented to and signed by the patient or her proxy in order to retrieve the patient's records. Upon the patient signing the form, the EHR must be able to send, based on the preference of the record-holding institution, either:

1. a copy of the signed form to the entity requesting it
2. an electronic notification attesting to the collection of the patient's signature

Note: The authorization text may come from the record-holding EHR system, or, at the direction of the patient or the record-holding EHR, could be located in a directory separate from the record-holding EHR system, and so a query for authorization language would need to be directable to the correct endpoint.

AIRA Response:

We have several comments about this proposed objective:

1. Public health registries are potential targets for these queries – in fact, IIS already respond to standard queries for immunization history and CDS. We recommend adding them as another example in the first paragraph of the certification criteria.
2. The details of this measure seem to assume and require not only clinical documents (as opposed to other types of messages) but also an IHE XDS-like workflow. We do not believe the query/response mechanism should be restricted to this format and transaction standard as other types of queries (especially via web services but not based on IHE profiles) are dominant now and for the foreseeable future.
3. Patient identity is still a critical problem when querying between systems in the absence of a national patient identifier. HIEs can be very helpful in providing Master Patient Index (MPI) services that allow participating systems to "register" their patients and that relate patient data together from disparate sources. In addition, public health registries have been struggling with patient identity issues for years when working to build consolidated records from multiple sources (like a consolidated immunization history in an IIS). This experience should be leveraged in developing best practice guidelines for patient identification.