Comments on Meaningful Use Stage 3

ID#	Comment
SGRP113	The Immunization Information System (IIS) community already has maturing products in place to provide decision support services related to immunization several ways: 1. Via web services, an IIS or companion system can provide CDS when provided with a patient's immunization history, age, gender, and disease occurrence (*e.g.,* had chicken pox). 2. In response to a standard HL7 v2 message querying for immunization history, many IIS return the CDS information as well. The transaction may or may not be transported via web services. HLN is developing an open source immunization CDS service called ICE (http://www.hln.com/ice) based on a general-purpose open source product called OpenCDS (http://www.opencds.org). At least one major ambulatory EHR vendor has also incorporated ICE into the next release. HLN strongly supports the continuing inclusion of CDS in MU recommendations, and we think the IIS community can serve as a strong early adopter of independently-available services-based products that provide this functionality within the immunization domain. This functionality is *in production* between IIS and EHR systems today. HLN supports an implementation of this service at some scale in New York City in conjunction with the Department of Health and Mental Hygiene.
SGRP401A	HLN supports the Stage 3 recommendations as proposed. Note that as described in our response above this functionality is already in production in a number of jurisdictions around the country. National standards exist for these transactions, and additional work is being done in 2013 to reduce the variability in implementation of these standards across the country to make interface development easier for EHR vendors and EP/EHs.
SGRP401B	As described in our response to SGRP113 above, IIS already are moving to provide CDS services to EHR systems and EP/EHs. While there is general uniformity in CDS rules – almost always based on ACIP recommendations – there is still some variability due to regional differences, ambiguities in the ACIP recommendations themselves, and slightly differing medical practice. We do not believe it is feasible to mandate a *single* CDS standard for immunization; we believe the proposed recommendation recognizes this reality. HLN strongly supports the recommendation as proposed.

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SGRP408	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.
IEWG101	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 object seem to assume and require not only clinical documents (as opposed to other types of messages) and 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. With respect to the behavior of the EHR receiving an *inbound* query, we do not believe that consent management standards or implementation have evolved (or will likely evolve in the time threshold of Stage 3) to the point where the behavior described will be feasible. In addition, state-level consent laws vary greatly. Some jurisdictions do now allow for an electronic attestation of a patient consent signature but require the actual signature to be conveyed to the record-holding organization. This requirement should be incorporated into the language of the criterion. Finally, we do not agree that an EHR should be *required* to query an outside entity for the authorization language. Standards are not widely implemented for this. So long as an EP/EH needs to obtain a signature on a form the acquisition of the proper form should optionally be an out-of-band activity. 4. 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. The HIMSS Patient Identity Integrity Working Group is another source of this best practice information.

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IEWG102	You ask whether standards exist for external provider directory query. We believe standards are emerging. But the key question is whether there will be sufficient *implementation* in time for Stage 3 and of that we are less sure.