Alliance of Specialty Medicine

Sound Policy. Quality Care.

January 14, 2013

Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
US Department of Health and Human Services
200 Independence Avenue, SW
Suite 729-D
Washington, DC 20201

Dear Dr. Mostashari:

The Alliance of Specialty Medicine (Alliance) is a coalition of medical specialty societies representing more than 100,000 physicians and surgeons dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

The undersigned members of the Alliance are writing to share thoughts on the Health Information Technology Policy Committee's (HITPC) preliminary recommendations for Stage 3, and future stages, of meaningful use. Final recommendations for meaningful use by the HITPC will inform future rulemakings associated with the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program. The Alliance recognizes the importance of weighing in during this "pre-rulemaking process" to ensure the concerns of specialty medicine are considered in the development of the final Stage 3 recommendations, and ultimately included in CMS' EHR Incentive Program. We appreciate the opportunity to provide comments in this early stage.

Progressing to Stage 3 and Future Stages of Meaningful Use Poses Concerns

Since the initial set of Stage 1 meaningful use criteria were first recommended by the HITPC, the Alliance has registered concerns that associated objectives and measures are almost exclusively focused on primary care, and not specialty care, which puts specialists at a disadvantage in terms of qualifying under the program. Admittedly, the HITPC, and later CMS, provided some assurances that Stage 2 would offer criteria more relevant to specialists.

Indeed, Stage 2 offered a "menu set" of meaningful use criteria, which included a few new objectives relevant to specialty care physicians, such as a new objective that would give credit for reporting to a specialized clinical data registry. In addition, Stage 2 provided new exclusions for "core set" criteria that aimed to assist specialists with meeting certain objectives and measures that were considered overly challenging, or even unattainable.

Progress on this front is shown in the draft Stage 3 criteria, which offers an expanded portfolio of core and menu set objectives that appear more applicable to specialists, including the addition of new exclusions for objectives not relevant to specialty physicians. The Alliance recognizes and appreciates the hard work of the HITPC in recommending additional criteria that are potentially more attainable for specialty care providers, increasing their odds of earning financial incentives and avoiding future penalties, and their overall willingness to adopt and use EHR systems in a meaningful manner.

Nonetheless, we continue to believe the Stage 3 and future stage recommendations proposed by the HITPC do not go far enough for specialty medicine, nor do they take into consideration some of the unique aspects of providing specialty care. For example, the proposed meaningful use criteria do not offer a broad-enough array of "menu options" that account for the wide variety of different specialty care patient populations and practices and how they may use health information technology to improve patient care. The increased thresholds for several of the objectives also pose a challenge for specialists. We understand the need to progress the program, but for many specialists the current thresholds are difficult to achieve due to specialists practice patterns and lack of vendor recognition of their needs. For example, e-prescribing and clinical decision support.

In addition, we are concerned that recommendations are being made without considering how providers, not to mention specialty providers, have fared with meeting the criteria used in Stages 1 and 2 of the EHR Incentive Program. A recent Alliance survey found specialists faced significant challenges with the Stage 1 criteria and subsequent attestation. These data must be formally collected using validated survey methodologies and thoroughly analyzed before making recommendations for new criteria or increasing thresholds for existing criteria in Stage 3 or future stages of meaningful use.

We are also concerned with the lack of engagement with specialty providers on the part of the HITPC. As the largest coalition of specialty medicine physicians, representing more than 100,000 members, we have a wealth of information on the impact of meaningful use on specialty care providers, unmatched by others. We appreciate our recent dialogue with ONC staff that support the HITPC, and look forward to working closely with the HITPC moving forward.

Finally, we are concerned with the enormous amount of time being spent on developing and modifying meaningful use criteria, when standards to support interoperability are lacking. This, above all else, is what will make the difference between static and robust uses of EHR and successive health information exchange. The HITPC should refocus its efforts on ensuring the development and recognition of interoperability standards so that the true benefit and value of health information technology can be realized.

Specialists Face Real Challenges with Meaningful Use

Specialty physicians believe they are "meaningfully using" health information technologies, such as EHRs, e-prescribing, clinical data registries, practice management systems, and other applications, to improve the quality of care and health outcomes. However, the way specialists are meaningfully using health information technologies does not usually align with the HITPC's and CMS's definition of meaningful use or the way it is measured.

Many specialists generally find e-prescribing applications useful, but do not receive any recognition for their use of e-prescribing applications if their volume of permissible prescriptions is low.

Specialists also use and value applications that allow them to retrieve imaging, lab and diagnostic test results at the point of care, which assist with transitions of care and making more timely and accurate diagnoses. However, these uses are not captured by existing stages of meaningful use, and therefore, providers receive no recognition for this activity.

In addition, and despite the lack of federally recognized interoperability standards, specialists frequently use medical devices that have been engineered to export data into EHR systems, which are also used at the point of care to facilitate timely and accurate medical diagnoses or in developing treatment

protocols or for pre-surgical/pre-procedure planning. Integrating data from medical devices directly into the EHR is a meaningful use of health information technology that deserves recognition.

Finally, specialists find profound value in reporting to and retrieving data from clinical data registries specific to their specialty and/or the diseases and conditions they manage. These clinical data registries have been shown to be particularly useful in improving patient care and outcomes, encouraging clinicians to reflect upon their care and utilization patterns and to better adhere to evidence-based guidelines. Alliance member organizations have developed or are in the process of developing registries, many of which aim to collect robust clinical outcomes data and go well beyond the simple reporting of quality data codes to satisfy federal reporting requirements. Some are even working to incorporate patient-reported outcomes data. The HITPC can also play a greater role in facilitating the use of clinical data registries by encouraging and developing standards for the interoperability between EHRs and registries. Currently, practices are forced to manually enter data into a registry due to no streamlined process existing and the proprietary nature of HIT products. The existing silo adversely affects solo and small practices from participating in a clinical data registry because the manually entry requires a full-time or half-time employee, which is a cost they cannot absorb. Although specialist participation in registries is not recognized today, the Alliance appreciates efforts to do so in Stage 2 and beyond. We encourage HITPC and CMS to continue to look for ways to better recognize those who engage in robust data collection supported by clinical data registries.

Other health information technologies, such as practice management systems, have helped to improve the accuracy and efficiency of both administrative and clinical functions, and should be equally recognized.

Despite attempts to use health information technology in a meaningful way, specialists are challenged and frustrated by the existing meaningful use criteria.

In Fall 2012, the Alliance conducted a survey of more than 1,200 specialty physicians on their use of EHRs. More than 60% (62.8%) of respondents reported using an EHR system. However, of those, only 30.9% reported attesting to "meaningful use" in 2011, with 52.0% indicating they had not attested. Respondents commented with their concerns about meaningful use. Below is a small sample of the comments received:

> *"The data for which we attest really have nothing whatsoever to do with our daily practice of our specialty."*
>
> *"Very time-consuming and challenging to fit the requirements which are very much geared towards primary care. After trying, could not meet the criteria. I use EHR for improved legibility and thoroughness as well as accessibility online, also use Eprescribe which I think is great. Unfortunately, this doesn't meet the govt requirements for EHR incentive so even though I instituted EHR, I will be penalized.."*
>
> *"'Meaningful use' seems to be more compliance with a rule rather than actually improving patient care."*
>
> *"Meaningful use criteria do not apply to my specialty. As a result I either cannot attest or I have to perform screenings that are medicolegally inappropriate for my specialty."*
>
> *"Government regulations mandating we change the way we use the program in order to attest for meaningful use. Some of the changes are the opposite of meaningful."*
>
> *"Meaningful use criteria is impossible to implement and attest to for a surgical*

specialty like neurosurgery. All EHR systems have been designed with the PCPin mind and do not take into account any type of surgical sub-specialty."

"Nearly all of the data used for attestation have nothing to do with our practice of our specialty. Furthermore, we rarely prescribe medications that meet meaningful use criteria."

"The meaningful use criteria are not specific to a surgeon's practice. The criteria were created for a primary care physician/practice."

"Meaningful use" is meaningless in regards to patient care. The subjects chosen have little to no relationship to the specialized care that neurosurgery delivers, yet we are forced to deal with it."

"Some of the measures pertain to things that we don't routinely do in the normal course of care. Also, some measures call for measuring items that are only done very sporadically"

"Again, there are too many criteria, they cannot be easily achieved, and they mess up my workflow. We are doing things that we don't need to do that don't advance patient care. The time that it takes to do these meaningless things detracts from the time that is available to do the things that I need to do. It's really quite simple. My time is not limitless. It is finite. The more time that I spend entering data that Medicare wants to analyze but that I don't need to deliver care, the less time that I have to capture the data that I do want and that I do need to deliver care. So I spend more time collecting beautiful, meaningless data and this meets meaningful use criteria. And I spend less time collecting the stuff that I actually need and that is actually meaningful to me, and Medicare doesn't care about that since my useful stuff is meaningless to them since it's not discrete data. This will only have negative safety implications in the future."

Making the decision to invest in an EHR system continues to require a considerable amount of time and financial resources for many specialists, particularly for those in smaller, private practices. While specialists are adopting EHR systems, they are struggling with existing meaningful use criteria, unlike primary care providers for whom the program has been geared.

The Alliance contends that specialists have been put at an unfair disadvantage, despite their overwhelming contributions to improving patient care, health outcomes and reducing costs through the use of health information technology. It is incumbent on the HITPC to equalize this inequity and "level the playing field" by recommending criteria that are relevant, achievable, and meaningful to specialty medicine providers. To accomplish this, the HITPC should work with the specialty provider community to develop a broad array of criteria, preferably for inclusion on the "menu set," that are applicable to specialists, and create exclusions for existing meaningful use measures that are, at present, irrelevant and unattainable by specialists. Indeed, the Alliance has already developed a draft set of potential new structural measures for the menu set that is meaningful to specialists. They include

- Collecting patient experience or patient reported outcomes using a well--- recognized, validated data collection instrument (i.e., Surgical CAHPS, functional status questionnaire) through a patient portal or other functionality through CEHRT;
- Reporting Maintenance of Certification (MOC) through CEHRT;
- Sharing information with local health information exchanges (HIE) and/or regional health information organizations (RHIO) through CEHRT;
- Collecting, analyzing and disseminating information from the certified EHR technology to physicians and other non---physician practitioners in the practice to improve care (i.e., inter--- office, inter---practice, inter---clinic registry for purposes of improving care at the practice level);

- Collecting and disseminating information on patient safety and adverse events associated with the certified EHR technology used by the provider in their office or other setting (such as an ASC, hospital, or other healthcare facility);
- Using EHR technology in another practice setting, such as an ASC, where they have ownership or have made a significant financial investment in the adoption of EHR technology; and,
- Facilitating the electronic transmission of data values and information from diagnostic and/or laboratory testing devices to a physician's CEHRT through the use of existing standards.

In addition, the HITPC should place more emphasis on menu set options rather than required core criteria. Flexibility to choose among criteria that are most relevant to a specialist's patient population and practice setting will ensure increased adoption by specialists, more meaningful use of EHRs, higher quality care, and increased buy-in and trust among participants.

Data on the Impact of "Meaningful Use" on Specialty Medicine Providers and Patients Are Needed

We are greatly concerned about the rapid pace with which the HITPC is proposing new meaningful use criteria and increased thresholds for existing criteria for Stage 3 and future stages of meaningful use, particularly given many of the objectives have been insufficiently evaluated and may pose challenges for several specialty physicians, and that performance in earlier stages has not been adequately considered. The Alliance's recent survey of more than 1,200 specialists was enlightening, however, there remains a paucity of solid-evidence regarding the feasibility of Stage 1 and Stage 2 criteria and the effect of those criteria on specialty medicine practices and overall patient care and safety.

It is not clear whether the more than 251,000 eligible professionals that attested to Stage 1 meaningful use and subsequently received an incentive payment as part of the EHR Incentive Program were actually successful in their attempt to be meaningful users of certified EHR technology (CEHRT). As you know, CMS' Office of Financial Management (OFM) recently contracted with Figliozzi & Company to conduct meaningful use audits, which we anticipate will shed significant light on the feasibility of the Stage 1 meaningful use criteria. Whether OFM has directed its contractor to share its findings related to provider challenges with various meaningful use criteria during audits is unclear, however, these data are important and relevant in gauging the impact of the program on physicians. We recommend that HITPC request CMS OFM to direct Figliozzi & Company to include in its contracted reports all findings related to provider challenges with various meaningful use criteria, preferably by specialty, and share those data in time for HITPC to evaluate and consider as it finalizes its recommendations for Stage 3.

In addition, there are still widespread gaps in CEHRT functionality. The ONC's recently released data brief, *Data Brief No. 7, Physician Adoption of Electronic Health Record Technology to Meet Meaningful Use Objectives: 2009-2012,* notes that just half or more of physicians had the capability to meet only 12 Meaningful Use Core objectives, which is less than the required 15. Data from a Centers for Disease Control and Prevention (CDC) Data Brief, *Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001-2012*, also revealed that 27 percent of office-based physicians who planned to apply or already had applied for meaningful use incentives had computerized systems with capabilities to support only 13 of the 15 Stage 1 Core Set objectives for meaningful use.

Recently, the House Committee on Science, Space and Technology, Subcommittee on Technology and Innovation held a hearing to discuss whether the Medicare and Medicaid EHR Incentive Program was delivering "meaningful" results. Marc Probst, Chief Information Officer (CIO) and Vice President of

Information Systems, Intermountain Healthcare, and member of the HIT Policy Committee, made the following statement in his testimony before the subcommittee:

> *"Achieving the requirements of the Meaningful Use program is not easy, and the Meaningful Use program has very real penalties attached to it. Providers and specifically CIOs across the country are increasingly feeling the pressures which Meaningful Use is creating…[t]he stages for Meaningful Use started fast and continue to be rolled out at a very quick pace. The work efforts which Meaningful Use defines in many aspects are cumulative and we do need to be careful that future stages such as Meaningful Use Stage 3 are appropriately timed to allow the majority of our health system to do all that is being asked of it through these transformative times. Because of the difficulty and complexity of the program, I am concerned that the Request for Comment on Stage 3 is expected to be released this month while so many hospitals and physicians are still trying to achieve Stage 1, and the Stage 2 final rule was only officially published in September. I also worry about those providers who have fewer technical resources than Intermountain, and started from a lower level IT adoption – who will be left behind? With respect to the Subcommittee's second question about lessons learned from Stage 1 informing Stage 2 and suggestions for Stage 3, it is structurally impossible to fully benefit from lessons learned in earlier stages when the Meaningful Use timeline is so compressed. Further, everyone could learn from a systematic, independent evaluation of experience to date that looks at the impact on subgroups, such as rural and frontier providers."*

The Alliance agrees with these comments, and supports the suggestion that a systematic, independent evaluation of clinician experience under the EHR Incentive Program be conducted, thoroughly analyzed, and fully considered before new meaningful use criteria are recommended and before thresholds are increased for existing meaningful use criteria in Stage 3 and future stages of meaningful use.

We further recommend that any evaluation of clinician experience include a domain that captures feedback from providers that did not participate in the EHR Incentive Program, or participated but failed to meet meaningful use requirements under the EHR Incentive Programs, to determine which objectives and measures, including associated thresholds, posed the greatest challenge from an administrative and clinical standpoint. The Alliance is eager to assist in developing a specialty domain for such a survey.

Interoperability Standards to Support Robust Health Information Exchange are Essential

The Alliance remains concerned about the lack of interoperability standards to support health information exchange. We are equally, if not more concerned, about the lack of a long-term plan to address this issue. Many of the Alliance organizations are active participants in various domains (Eyecare, Cardiology, Radiology, etc.) of Integrating the Healthcare Enterprise (IHE). Alliance member organizations attempt to address the lack of interoperability standards through the development of IHE profiles that support the sharing of electronic health information using a wide array of standards. In fact, some Alliance members have had great success with the use of IHE profiles integrating medical devices, such as diagnostic and imaging equipment, with their EHR.

Despite successes by the various IHE Domains where Alliance members are engaged, the Alliance contends that a long-term plan for addressing interoperability through the development of and/or federal recognition of existing interoperability standards, is essential.

In his comments before the House Committee on Science, Space and Technology, Subcommittee on Technology and Innovation, Marc Probst stated that:

> *"We need national standards to ensure, as the IOM recommends, 'that the digital infrastructure captures and delivers the core data elements and interoperability needed.' The federal government has made a major investment in electronic medical records, having committed $20 billion from the stimulus bill to it. We must now ensure that, as the capacities of many individual providers grow, they evolve into an efficient and effective national network.*
>
> *…I serve as a member of the Health Information Technology Policy Committee (HITPC)…[t]he first task of the HITPC was to define "Meaningful Use" and the requirements for certification of electronic health records (EHRs)…[t]he majority of these requirements deal with functions that an EHR should be able to perform and requirements for what functions or data should be shared between EHRs. It is time now, however, for the HITPC to focus more on the longer-term plan and activities outside of Meaningful Use that are needed to fulfill our mandate provided in ARRA to 'make recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure.'"*

The development of and/or adoption of interoperability standards that support health information exchange are essential to realizing the value of health information technology in improving quality and health outcomes, as well as reducing healthcare costs. Alliance member organizations are prepared to share their experiences and activities in pursuit of interoperability and health information exchange with the HITPC.

"Meaningful Use" Should Align with Related Quality Improvement Programs

The Alliance has long requested that specialists be able to use a single set of criteria that simultaneously satisfies the reporting requirements of multiple CMS quality improvement programs. Although CMS is working with ONC to better align the EHR Incentive Program with other programs, such as the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM) and Accountable Care Organizations (ACOs) programs, these programs continue to have overlapping and often conflicting reporting requirements. We cannot stress enough the importance of aligning government-sponsored quality improvement programs, where appropriate, to assist specialists with compliance. This is particularly important given many of these overlapping programs will become punitive in future years, based on data collected in the current year. We encourage the HITPC, ONC, and CMS to continue collaborating on efforts to accomplish this goal.

Patient Safety is a Top Priority for Specialty Physicians

As part of the aforementioned survey, the Alliance queried its members on ongoing challenges with patient safety and adverse events related to the use of their EHR. Approximately 250 comments were received. The overwhelming majority expressed concern about the volume of data they must wade through to get to the information they needed to assess the patient, which was believed to put patients at risk for delayed or missed diagnosis. Other concerns raised by respondents are below.

> *"The nurses do not read or follow our orders. There have been issues with adverse outcomes related to the EMR. The hospital is just not being transparent with the physicians…"*
>
> *"Frequently the nurses will put in orders for medications that I have already put into PM the system because they do not know how to take the order off. This has led to the nurse placing the wrong dose for one patient"*
>
> *"Quantities have calculated incorrectly when sending them erx to pharmacy"*
>
> *"Recently, an issue was identified where a lab technician entered the test result in the wrong patient's chart on EMR. There was no way to completely erase the result from*

the EMR so that it actually was acted upon unfortunately by a care team that saw the result and did not realize it was an invalid result."

"The [hospital name omitted] faced real disasters when it implemented an electronic record and ordering system. Transfers from the ICU were attended by and increased morbidity and mortality just related to the difficulty in communication. This was documented by a publication after the hospital administration tried to prevent its submission for review. Electronic ordering through pharmacy resulted in critical drugs needed for treating patients in full arrest taking up to 15 minutes to come from the pharmacy. In the new "system" the drugs were no longer available on the resuscitation carts in the ICU. The system got ultimate control at the expense of patient care."

"typed orders currently look too similar in type set to the order prompt and orders have been missed. It is easy to choose the wrong dose for meds in the prescription software."

"Default function for entering allergies is to list reaction to the allergen as critical which sets many patients up to not get medication classes they may need"

"Drug lists too specific and interactions could be missed for similar drugs

"[Vendor name omitted] has the following wonderful patient safety issues. When the Allergy icon lights up, it means that the Allergy section has been completed (including entering NKDA), NOT that the patient has an important Allergy. There is NO way to highlight critical Allergies for our specialties, such as Penicillin, Erythromycin/Clarithromycin, Iodine Contrast, etc. For the drug interaction module, it does not simply list the potential drug interactions of the new medication that is being prescribed with the patient's existing medications, but it lists ALL potential interactions between all the patient's existing medications also. That means that for a patient who is already on more than half a dozen medications, this drug interaction screen will almost always pop up with bright red colored interaction warnings, most of which does not apply to me.."

"EHR does not prioritize information the way a conventional record did. Accordingly there is always the danger of missing an important piece of information buried in all the required data which has little to do with patient care."

"An obvious one is that charts are now so full of boiler plate info and MU data that the crux of a particular pts care is buried and must be unearthed."

Recent efforts of the ONC to address ongoing concerns by providers about the impact of HIT on patient safety and adverse events are encouraging. While ONC's draft plan offers a number of ideas to address these and other challenges, we are disappointed that ONC did not reach out to the specialty provider community, whose input may have been valuable in developing the initial plan. We strongly encourage the HITPC and ONC to work with the Alliance to address specific specialty medicine concerns associated with patient safety and adverse events related to the use of EHRs as it moves forward with developing a national action plan.

Other Notable Concerns

While not directly in the purview of the HITPC, nor included in its request for comment, we feel compelled to share our concern with the impact of the EHR Incentive Program on "hospital-based" physicians; that is, physicians who furnish 90% or more of their services in a hospital setting.

We understand that if a provider is eligible for the incentive, they are also subject to the penalty. As you know, some hospital-based physicians may "teeter" on the 90% threshold. One year, they may be

considered an eligible professional, and the next year they are not. While this may be problematic for those providers during the "incentive" years, it will be detrimental during the "penalty" years. We are asking the HITPC for assistance in preventing providers whose eligibility fluctuates from year-to-year from facing the EHR Incentive Program penalties. Specifically, we ask the HITPC to make a broad recommendation to the ONC, and to CMS, to make accommodations to those providers whose eligibility may frequently change. This may be accomplished by permanently exempting those providers who are, for any year, deemed "hospital-based" or by exempting, for X period of time, those providers who were once deemed "hospital-based" and later become eligible.

Further, we ask the HITPC to recommend that ONC and CMS be vigilant in efforts to identify providers that may fall into this category, by providing them frequent updates about their program eligibility. These updates could be monthly or quarterly.

Attached to this letter is a table that includes Alliance comments on the specific objectives and measures recommended by the HITPC for Stage 3 and beyond, as well answers to some of the specific questions posed by the committee.

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We appreciate the opportunity to comment on this important issue and for the committee's consideration of our feedback. Notwithstanding our concerns, we are encouraged by efforts of the HITPC to incorporate criteria more relevant to specialists in its draft Stage 3 recommendations. We look forward to engaging in a more robust and frequent dialogue with the HITPC moving forward, and we encourage the HITPC to seriously consider the recommendations we have made herein. For questions, please contact the Alliance's outside consultant, Emily L. Graham, RHIA, Vice President, Regulatory Affairs, Hart Health Strategies, at 202-729-9979 x. 103, or egraham@hhs.com.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society

Alliance of Specialty Medicine

Sound Policy. Quality Care.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		Improving quality, safety, and reducing health disparities			
SGRP 101	**Eligible Provider (EP)** **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 **Eligible Hospital (EH)** **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 **EP/EH Measure:** More than 60 percent of medication, We see percent of laboratory, and 30 percent of radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's	**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. CPOE for medications includes drug-drug interaction (DDI) checking for "never" combinations as determined by an externally vetted list. **Measure:** More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE **Certification Criteria:** EHR must be able to consume an externally supplied list of "never" DDIs, using RxNorm and NDF-RT	Seeking externally maintained list of DDIs with higher predictive value		-We are concerned about increasing the threshold since many EPs still find CPOE use challenging -Exemptions needed for EPs who work in regions where HIT adoption by labs, pharmacies and radiology facilities is low. -While the objective recognizes "professionals who can enter orders into the medical record per State, local and professional guidelines," we request that the measure itself more specifically recognize "permissible" prescriptions in its definition of medication orders since e-prescribing could be considered a CPOE function, which could pose a problem for those unable to e-prescribe controlled substances due to state/local laws. -Ensure that EPs can satisfy threshold using CPOE for any combination of events (e.g., medication, lab OR radiology).

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
	inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	standards along with a TBD DDI reactions value set. **Certification Criteria for EPs** EHR must have the ability to transmit lab orders using the lab order and results Interface guidelines produced by the S&I Framework Initiative.			
SGRP 130	**New**	**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. **Measure:** More than 20% of referrals/transition of care orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded.			Would orders simply have to be recorded or actually transmitted? If the latter, these capabilities may not be available by Stage 3. Health information exchange remains a significant challenge and measures requiring transmission of information should be deferred or offered only as a menu item until these capabilities are established, well tested, and widely incorporated into EHR systems.
SGRP 103	**EP/EH Objective:** Generate and transmit permissible prescriptions electronically (eRx) **Measure:** More than 50% of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT.	**EP Objective:** Generate and transmit permissible prescriptions electronically (eRx) **EP Measure:** More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary **(reviewed for generic substitutions)** transmitted electronically using Certified EHR Technology. **EH Objective:** Generate and	Advanced medication reconciliation to check for formulary compliance. Medication formulary checking: • If Rx is formulary-compliant, transmit to pharmacy. • If Rx is not formulary compliant, prescriber presented with	How to include formulary checking into EHR and connection to formulary sources (e.g., PBMs)?	-We support maintaining the 50% threshold since formulary information is not always available, up-to-date or reliable. -Measure should define "permissible prescriptions" and ensure that controlled substances, or any other drug that cannot be e-prescribed due to local, state, or federal laws, is not included in this definition. -Similarly, this measure should recognize that those who qualify for any of the exemptions under the e-Prescribing Program would be automatically exempt from this measure. -To ensure feasibility, it is critical that vendor

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
	EH MENU Objective: Generate and transmit permissible discharge prescriptions electronically (eRx) **EH MENU Measure:** More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology	transmit permissible discharge prescriptions electronically (eRx) **EH Measure:** More than **30%** of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology	alternatives (if available through formulary database) or provided a structured prior-authorization form to complete before Rx transmitted. Capability for automatic approval of prior-auth should be available.		certification criteria include a mechanism by which EPs can access formularies before this feature is made a requirement of the Stage 3 measure.
SGRP 104	**EP Objective: Record the following demographics** • Preferred language • Sex • Race • Ethnicity • Date of birth **EH Objective: Record the following demographics** • Preferred language • Sex • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to	Retire prior demographics objective because it is topped out (achieved 80% threshold). **Certification criteria:** • Occupation and industry codes • Sexual orientation, gender identity (optional fields) • Disability status • Differentiate between patient reported & medically determined Need to continue standards work		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.	-Support retiring for Stage 3.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
	the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.				
SGRP 105	**Consolidated in summary of care objective** Maintain an up-to-date problem list of current and active diagnoses	**Certification criteria:** EHR systems should provide functionality to help maintain up-to-date, accurate problem list **Certification criteria:** Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians' maintenance of up-to-date accurate problem lists. Systems provide decision support about additions, edits, and deletions for clinicians' review and action. For example, if diabetes is not on the problem list but hypoglycemic medications are on the medication list, the EHR system might ask the provider whether diabetes should be on the problem list. It would not automatically add anything to the problem list without professional action.	Patient input to reconciliation of problems	The implementation of these criteria will assist in achieving the CDC's goal of using EHR technology features to identify patients meeting criteria for hypertension who are not yet diagnosed and managed for the disorder. How to incorporate into certification criteria for pilot testing? The intent is that EHR vendors would provide functionality to help maintain functionality for active problem lists, not that they supply the actual knowledge for the rules.	-Support new certification criteria/functionality for Stage 3. -If patient input is added as a functionality in future years, it should be used to supplement the medical record and better inform clinical decision making. It should NOT be used as the basis of determining physician accountability since EPs do not have direct control over patient actions.

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SGRP 106	**Consolidated with summary of care -** Maintain active medication list	**Certification criteria:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list **Certification criteria:** Use of problems and lab test results to support clinicians' maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians' review. For example, an antibiotic (not for acne) has been on the medication list for over say a month, the EHR system might ask the provider whether the medication is a chronic medication. The system will not make any changes without professional approval.	**Certification criteria:** Use other EHR data such as medications filled or dispensed, or free text searching for medications to support maintenance of up-to-date and accurate medication lists.	How to incorporate into certification criteria for pilot testing? The intent is that EHR vendors would provide functionality to help maintain functionality for active medication lists, not that they supply the actual knowledge for the rules.	-Support this functionality and recommend that it be incorporated into certification criteria as soon as possible. -Certification criteria should eventually also include the ability for an EHR system to access pharmacy systems and other databases so that EPs can see a complete list of Rxs filled by the patient/prescribed by other clinicians. We recognize this may be challenging given interoperability and patient privacy issues, but we encourage the HITPC to work toward the goal of helping EPs access a complete picture of a patient's care.
SGRP 107	**Consolidated with summary of care -** Maintain active medication allergy list	**Certification criteria:** EHR systems should provide functionality to code medication allergies including its related drug family to code related reactions.	Contraindications that could include adverse reactions and procedural intolerance.	The intent is that EHR vendors would provide functionality to help maintain functionality for active medication allergy lists, not that they supply the actual knowledge for the rules.	-We support this functionality and encourage the HITPC to make this a requirement for certification as soon as possible.
SGRP 108	**Objective: Record and chart changes in vital signs:** • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would	-Support retiring for Stage 3.

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	• Plot and display growth charts for patients 0-20 years, including BMI **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data			mean an additional number of objectives that providers will need to attest to.	
SGRP 109	**EP/EH Objective:** Record smoking status for patients 13 years old or older **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.	-Support retiring for Stage 3.
SGRP 112	**EH MENU Objective:** Record whether a patient 65 years old or older has an advance directive **EH MENU Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible	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 **EP MENU/EH Core Measure:**			-Support for maintaining this important measure.

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	hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.			
SGRP 113	**EP/EH Objective:** Use clinical decision support to improve performance on high-priority health conditions **Measure:** 1. Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested	**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	**Certification criteria:** Explore greater specificity for food-drug interactions *Procedure/Surgery/lab/radiology/test prior authorization v.A*: for those procedures/surgeries/lab/radiology/test with clear and objective prior authorization requirements and a structured data prior authorization form is available, clinician fill out the prior authorization form using structured data fields and prior authorization can be granted electronically and in real-time by the payor. *Procedure/Surgery/lab/radiol*	Ability for EHRs to consume CDS interventions from central repositories. The EHR would query (via web services) available databases to identify "trigger event" conditions (e.g., case reporting criteria, drug-drug interactions, potentially relevant trials) based on the patient's health condition, diagnoses, location, and other basic facts.	-We support the value of CDS, but have serious concerns about the burden of increasing the threshold three-fold (from 5 in Stage 2 to 15 in Stage 3). -We encourage evaluation of implementation/effectiveness of this measure in earlier stages before increasing reporting threshold in Stage 3. -We have serious concerns with specialists being able to meet the measure due to the lack of available CDS for specialists. Most EHRs, for example, do not have a neurosurgery template or module so there is no way to determine the interventions to be presented through EHR technology. Similarly, using the EHR to generate preventative care prompts is usually irrelevant to specialty care and mostly geared towards primary care. Physicians should not be forced to implement low level CDS that is not meaningful to their practice to meet the objective.

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	that one of the five clinical decision support interventions be related to improving healthcare efficiency. 2. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	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. **Certification criteria:** 1. Ability to track CDS triggers and how the provider responded to improve the effectiveness of CDS interventions 2. Ability to flag preference-sensitive conditions, and provide decision support materials for patients. 3. Capability to check for a maximum dose in addition to a weight based calculation. 4. Use of structured SIG standards 5. Ability for EHRs to consume CDS interventions from central repositories (e.g., rules for drug-drug interactions, rules for reporting diseases for public health departments, preference-sensitive care lists) * This will assist in achieving the CDC's goal of improvements in hypertension control. **Kuperman, GJ. (2007)Medication-related clinical	*ogy /test prior authorization v.B*: for those procedures/surgeries/lab/radiology/test, for which prior authorization is non-standardized and is highly individualized, a standardized form is created that collects from the clinician text fields answering an agreed upon set of medical necessity questions, standardized form is sent electronically to insurer for review, insurer responds with Approval/Denial (with rationale if denied) using a standardized format text document back to clinician with either approval and/or denial with rationale.	The HITPC is interested in experience from payors that may contribute to CDS.	N/C

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		decision support in computerized provider order entry systems a review. *Journal of the American Medical Informatics Association*: JAMIA, 14(1):29-40.			
SGRP 114	**EP/EH Objective:** Incorporate clinical lab-test results into Certified EHR Technology as structured data **Measure:** More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data	**Objective:** Incorporate clinical lab-test results into EHR as structured data **Measure:** More than 80 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data			-We oppose increasing this threshold since standards to facilitate incorporation of this data have not yet been established and data regarding provider experiences using this measure have not yet been considered. -Certification criteria should also require that EHR systems provide access to other lab systems/databases so that EPs can access a complete picture of other lab tests/results ordered by other clinicians. We recognize the challenges associated with accessing such information, but still encourage the HITPC to work toward this goal.
SGRP 115	**EP CORE Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of	**EP Objective:** Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting)			-It is unclear how many "lists" would be required under this modified objective. -We recommend that lists be held to a minimum and that EPs have flexibility to select type of lists

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	disparities, research, or outreach **EP CORE Measure:** Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.	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.			most relevant to their practice. -We request exclusions for those subspecialties that treat only a few conditions. -Certification criteria needs to first incorporate the functionality to quickly generate these lists and dashboards. -We caution against proceeding with this functionality until ICD-10 has been fully implemented. Generating these lists in the midst of the ICD-10 transition would be very complicated.
SGRP 116	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder per patient preference. **Measure:** More than 10% of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care **EP Measure:** More than 20% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference **Exclusion:** Specialists may be excluded for prevention reminders (could be more condition specific).			-Exclusions should be provided for not only preventive care reminders, but also follow-up reminders since these are not necessarily applicable to specialists and procedure-concentrated specialists-who treat acute conditions. Exclusions should also account for patients that do not provide a preference.
SGRP 117	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** More than 10	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** 1) More than 30% of medication orders created by authorized			N/C

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	percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.	providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR. 2) Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked for use in quality improvement.			
SGRP 118	**MENU Objective: I**maging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **MENU Measure:** More than 10 percent of all tests whose result is one or more images ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology.	**CORE Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **CORE Measure:** More than 10 percent of all tests whose result is an image (including ECGs) ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology		What barriers could be encountered in moving this to core?	-We support the value of including this functionality, but recommend that this measure remain in the menu set since vendors continue to face challenges with this functionality and it was new for Stage 2 so evaluation needs to be made. ONC should instead focus efforts on developing standards to facilitate the exchange of radiology information prior to recommending the migration of this measure to the core set. - We understand the intent of the measure, but the threshold is too high. The pure volume of data that will be required to be stored for radiology orders requires tripling practices storage servers to hold all the data images. -We also do not support the proposal that 10 percent of all scans and tests whose result is one or more images ordered by the EP during the EHR reporting period and accessible through Certified EHR Technology be exchanged with another provider of care. The images that are created may not be accessible due to the system of the EP or other health care provider who creates the images. It would be burdensome for the ordering EP to figure out which other providers have the ability to receive the images electronically since secure health information exchanges and interfaces do not readily exist. Furthermore, in some specialties, such as neurosurgery, often there is not another physician involved in the care so the necessity to exchange is not there.

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SGRP 119	**MENU Objective:** Record patient family health history as structured data **MENU Measure:** More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives	**CORE Objective:** Record high priority family history data **CORE Measure:** Record high priority family history in 40 percent of patients seen during reporting period **Certification criteria:** Make sure that every appropriate CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach).			-We support the importance of this data, but make an overall request that thresholds not be increased and that measures not be moved to the core set until CMS first evaluates provider experiences with measures during earlier stages.
SGRP 120	**EP/EH MENU Objective:** Record electronic notes in patient records **EP MENU Measure:** Enter at least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of unique patient office visits. Notes must be text-searchable. Non-searchable scanned notes do not qualify but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure. **EP MENU Measure:** Enter at least one electronic progress note created, edited, and signed by an authorized provider of the eligible hospital's or CAH's inpatient	Record electronic notes in patient records for more than 30 percent of office visits within four calendar days.			-We support maintaining this measure as part of the menu set.

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	or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable, scanned notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure.				
SGRP 121	**EH MENU Objective:** Provide structured electronic lab results to ambulatory providers **EH MENU Measure:** Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of electronic lab orders received	**EH CORE Objective:** Provide structured electronic lab results to eligible professionals. **EH CORE Measure:** Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 80% of electronic lab orders received.			N/C
SGRP 122	**NEW**	**Objective:** The EHR is able to assist with follow-up on test results **Measure:** 10% of test results, including those which were not completed, are acknowledged within 3 days **Certification Criteria:**			-Overall, we support this measure, but pending the development of appropriate certification criteria to ensure this functionality. -Since this is a new measure, we recommend that it be added to the menu set (not the core set). -We request clarification on how HITPC would define "acknowledged."

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		• EHRs must have the ability to identify abnormal test results and to notify the ordering providers when results are available or not completed by a certain time. • EHRs must record date/time test results are reviewed and by whom			
Engage patients and families in care					
SGRP 204A	**EP Objective:** Provide patients the ability to view online, download, and transmit (VDT) their health information within 4 business days of the information being available to the EP. **EP Measure:** 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. 2. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.	• 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 pts within four business days of info becoming available to EPs • Potential to increase both thresholds (% offer and % use) based on experience in Stage 2 **Note:** Depending on experience in Stage 2, CMS may want to give credit to some providers (e.g. specialists) for view/download/transmit where the patient has requested that they prefer info to be sent to a location they specify (such as another provider portal or PHR), rather than only making available	Building on Automated Transmit: 1a. Create the ability for providers to review patient-transmitted information and accept updates into EHR. 1b. Related certification criteria: Standards needed for provider directories in order to facilitate more automated transmissions per patients' designations.	Explore the readiness of vendors and the pros and cons of including certification for the following in this objective: • Images (actual images, not just reports) • Radiation dosing information from tests involving radiation exposure in a structured field so that patients can view the amount of radiation they have been	-CMS has released data showing that patients are not accessing their health information to the extent desired by federal agencies. Furthermore, EPs continue to have concerns about being held accountable for actions outside their direct control. While it is reasonable to hold EPs accountable for making information available to patients, it is unreasonable to hold EPs accountable for actions taken voluntarily by the patient. -HITPC needs to evaluate the reasonableness and burdensome nature of the 24-hour turnaround time required by this measure~~,~~ prior to moving from 4-business days to 24-hours. Physicians already follow standards for communicating medical information to patients and know best how the patient will accept and react to the information, etc. Therefore, physicians should have the ability to make these decisions based on the physician-patient relationship. The volume of patient information that has to be made available within 24-hours for the entire calendar year would be extraordinary for most practices and their staff to manage. This rigid measure does not take into account the realities of running a practice. Technological glitches, staffing shortages due to vacations, holidays, and other unforeseen circumstances that occur throughout the calendar

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	EH Objective: Provide patients the ability to view online, download, and transmit information about a hospital admission 1. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge 2. More than 5 percent of all patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period.	information on the provider's portal. **MENU item:** Automated Transmit*: (builds on Automated Blue Button Initiative (ABBI)): Provide 50% of patients the ability to designate to whom and when (i.e. pre-set automated & on-demand) a summary of care document is sent to patient-designated recipient** (for example, a one-time request to send information from specialist to primary care, or a standing request to always send an updated care summary when certain events arise, such as a change in medication or the completion of new tests or procedures). *Subject to the same conditions as view, download, transmit **Before issuing final recommendations in May 2013, HITPC will also review the result of Automated Blue Button pilots, in addition to considering public comments received.		exposed to Add a MENU item to enable patients to view provider progress notes (re: Open Notes: Doctors and Patients Signing On. *Ann Intern Med*. 20 July 2010;153(2):121-125) What is the best way to ensure that individuals who access their health information through the view/download/transmit capability are	year and could cause a delay in providing the patient information within the required time frame. -We feel the 24 hour timeline is completely unreasonable. The 4 day turnaround is still an issue from Stage 2. -While patients deserve full access to their medical record, the HITPC must balance the need for informed decision-making with the risk of overloading patients with too much information or information that is too technical and will simply confuse the patient. -We seek clarification regarding this suggested menu item. Was this functionality not included as part of the original measure? What functionalities were included in earlier stages to ensure that patients could view/download/transmit this information? -We recommend a "pop-up" disclaimer, as has been recommended In the past for patients trying to access data on CMS' Physician Compare web site.

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				provided with transparency and education about the benefits and potential risks of downloading health information, consistent with the HIT Policy Committee's recommendations of August 16, 2011? Is certification an appropriate vehicle for ensuring such transparency is part of CEHRT? If so, what would the certification requirement look like? If not, what are other mechanisms for ensuring transparency to consumers using the view/download/transmit capabilities?	

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				In its recent final rule, and in response to comments, ONC adopted Level A conformance as the standard for the accessibility web content in accordance with the Web Content Accessibility Guidelines (WCAG). ONC indicated per commenter's suggestions that WCAG Level AA conformance would be considered for the next edition of certification criteria. Given that all EHR technologies certified to the view, download, transmit to a 3rd party certification criterion will have met Level A, how difficult would it be for EHR technology to have to meet Level AA conformance?	N/C

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SGRP 204B	**New**	**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. Based upon feedback from HITSC this should be a MENU item in order to create the essential functionality in certified EHRs.		Readiness of standards to include medical device data from the home? 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? How can the HITECH incentive program support allowing	-We appreciate this measure, but caution that current standards to facilitate such data capture are not yet available/have not yet been adequately tested. -We are concerned about challenges of collecting patient generated notes in a standardized manner. -We also are concerned about the availability of validated tools for capturing this type of patient-generated health information in an electronic environment. Survey instruments that have been validated to capture information through other media (paper, mail, phone, in-person survey) may not be validated for use in the electronic environment. -If this measure is adopted, it should include appropriate exclusions to account for situations when such data collection is not relevant to a practice or when they are already collecting such information through a separate practice website or patient portal that is not able to synch with the EHR. It should also be part of the menu set and should only assess whether the patient was provided with the ability to submit such data and not whether the patient actually took action since that is beyond the control of the EP.

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				doctors and patients to mutually agree on patient-generated data flows that meet their needs, and should the functionality to collect those data be part of EHR certification? Please provide published evidence or organizational experience to support suggestions.	
SGRP 204D	**New**	**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 VDT in an obvious manner.			-We request additional clarification on this objective, particularly the definition of "an obvious manner."
SGRP 205	**EP Objective:** Provide clinical summaries for patients for each office visit **EP Measure:** Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits.	The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.		What specific information should be included in the after visit summary to facilitate the goal of patients having concise and clear access to information about their most recent health and care, and understand what they can do next, as well as	-We request clarification on to what extent the summary needs to be "pertinent to office visit." -We also seek clarification on whether the 1 business day is maintained. If so, it is still problematic. We are supportive of physicians providing patients with clinical summaries, but the 24 hour timeline is not realistic. Turn-around time for dictations may require greater than 24 hours of time and will be difficult to reach, unless the summary is not reconciled and will likely be useless summation complied solely from the EHR. Care plans and complete dictation in a surgical practice usually happen after the patient leaves and the chart note is completed.

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				when to call the doctor if certain symptoms/events arise?	
SGRP 206	**EP/EH Objective:** Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient **EP CORE Measure:** Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period **EH CORE Measure:** More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology	**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.			-We are concerned about the financial burden of requiring that this information be translated into 5 non-English languages. Will the functionality to accomplish this be included in the certification requirements for the EHR? If not, who is responsible for funding the translation? - Educating the patient on the treatment or disease for the encounter is important, but it should be at the discretion of the EP to determine which resources are best suited for the patient and if they are needed. The EHR should not be dictating the resources the physician chooses to provide to the patient. The addition of this feature will be an additional cost to the provider as educational resources associated with the EHR are typically add-on features.
SGRP 207	**EP Objective:** Use secure electronic messaging to communicate with patients on relevant health information **EP Measure:** A secure message was sent using the electronic messaging function	**Measure:** More than 10 percent* of patients use secure electronic messaging to communicate with EPs	Create capacity for electronic episodes of care (telemetry devices, etc.) and to do e-referrals and e-consults	*What would be an appropriate increase in threshold based upon evidence and experience?	-We have serious concerns over the proposal to increase this measure and to maintain it as a core measure. -Again, EPs should not be held accountable for actions beyond their control. EPs are already deferring patient engagement objectives due to related challenges. -We request clarification on the meaning and intent of the recommendation to create capacity for e-

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	of Certified EHR Technology by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period				episodes of care, e-referrals and e-consults. How would this differ from the functionalities currently being built into CPOE systems? HITPC should also take into consideration the fact that consults are no longer payable under Medicare, nor are e-visits reimbursed.
SGRP 208	**Not included separately (in reminder objective)**	**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).			-In satisfying the requirements of this measure, EPs should be able to indicate that a patient did not express a particular preference despite outreach.
SGRP 209	**New**	**Certification Criteria:** Capability for EHR to query research enrollment systems to identify available clinical trials. No use requirements until future Stages.		The goal of this objective is to facilitate identification of patients who might be eligible for a clinical trial, if they are interested. The EHR would query available clinical trial registries and identify potentially relevant trials based on patient's health condition, location, and other basic facts. Ultimately, the EHR would not be able to determine final eligibility for the trial; it would only be able to identify	-We support this functionality by Stage 3, as well as the recommendation that use requirements not be considered until future stages.

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				possibly relevant trial opportunities.	
			Improve Care Coordination		
SGRP 302	**EP/EH CORE Objective:** The EP/EH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. **EP/EH CORE Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	**EP / EH / CAH Objective:** The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform reconciliation for: - medications - medication allergies - problems **EP / EH / CAH Measure:** The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than 10% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23). **Certification Criteria:** Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e. severity).	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) **Certification Criteria:** Standards work needs to be done to support the valuing and coding of contraindications.	Feasibility to add additional fields for reconciliation e.g. social history? Is anyone currently doing reconciliation outside of meds, med allergies, and problems and what has the experience been?	-We oppose any changes to this objective until data on provider experiences from prior stages of meaningful use are available, analyzed, and demonstrate that providers are ready for such changes.
SGRP 303	**EP/EH CORE Objective:** The EP/EH/CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care	**EP/ EH / CAH Objective:** EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another		*What would be an appropriate increase in the electronic threshold based upon evidence and	-We oppose increasing this threshold until standards to support health information exchange are available and until more provider experience data is collected and evaluated.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
	provides summary care record for each transition of care or referral. **CORE Measure:** 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. 2. The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. 3. An EP, eligible hospital or CAH must satisfy one of the two following criteria: (A) conducts one or more successful electronic exchanges of a summary of	provider of care Provide a summary of care record for each site transition or referral when transition or referral occurs with available information Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant): 1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral) 2. Setting-specific goals 3. Instructions for care during transition and for 48 hours afterwards 4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF (**D**irect care provision, **E**motional support, **C**are coordination, **A**dvocacy, and **F**inancial)) **Measure:** 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		experience?	

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
	care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii) (B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was developed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or (B) conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.	30%* electronically). **Certification Criteria:** EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral. **Certification criteria:** Ability to automatically populate a referral form for specific purposes, including a referral to a smoking quit line. **Certification Criteria:** Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which and are expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: 1) Consultation Request (Referral to a consultant or the ED) 2) Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency)			

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
SGRP 304	**New**		**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 For each transition of site of care, provide the care plan information, including the following elements <u>as applicable:</u> •Medical diagnoses and Stages •Functional status, including ADLs •Relevant social and financial information (free text) •Relevant environmental factors impacting patient's health (free text) •Most likely course of illness or condition, in broad terms (free text) •Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver •The patient's long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals •Specific advance care plan (Physician Orders for Life-	How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care, and includes the patient and their non-professional caregivers? Interested in experience to date and the lessons learned. Think through these priority use cases: 1. Patient going home from an acute care hospital admission 2. Patient in nursing home going to ED for emergency assessment and returning to nursing home 3. Patient seeing multiple ambulatory specialists needing care	-We support electronic shared care planning and collaboration tools as a longer-term goal so long as exclusions are included and appropriately account for circumstances beyond a physician's control

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
			Sustaining Treatment (POLST)) and the care setting in which it was executed. For each referral, provide a care plan if one exists **Measure:** The EP, eligible hospital, or CAH that transitions or refers their patient to another site of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver. **Certification Criteria:** Develop standards for a shared care plan, as being defined by S&I Longitudinal Coordination of Care WG. Some of the data elements in the shared care plan overlap content represented in the CDA. Adopt standards for the structured recording of other data elements, such as patient goals and related interventions.	coordination with primary care 4. Patient going home from either hospital and / or nursing some and receiving home health services What are the most essential data elements to ensuring safe, effective care transitions and ongoing care management? How might sharing key data elements actually improve the communication? Consider health concerns, patient goals, expected outcomes, interventions, including advance orders, and care team members. What data strategy and terminology are required such that the data populated by venue specific EHRs can be exchanged. How	N/C

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
				might existing terminologies be reconciled?	
				What are the requirements (legal, workflow, other considerations) for patients and their identified team to participate in a shared care plan? Is it useful to consider role-based access as a technical method of implementing who will have access to and be able to contribute to the care plan? How will such access be managed?	N/C
SGRP 305	**New**	**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. **Measure:** For patients referred	Continue working to close the loop with an acknowledgement of order receipt and tracking for completion.	The HITPC would appreciate comments on the return of test results to the referring provider.	-While "closing the referral loop" is important, this would be more appropriate for future stages of MU when interoperability standards and certification criteria have been tested and are in place.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		during an EHR reporting period, referral results generated from the EHR, 50% are returned to the requestor and 10% of those are returned electronically* **Certification Criteria:** Include data set defined by S&I Longitudinal Coordination of Care WG and expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Shared Care Encounter Summary (Consultation Summary, Return from the ED to the referring facility, Office Visit) **Certification Criteria**: Include standards for referral requests that require authorizations (or pre-certifications) for procedure, surgery, lab, radiology, test orders *This builds upon the clinical quality measure (CQM) in Stage 2 for closing the referral loop,CMS50v1 (NQF TBD)			
SGRP 127	**New**	**New**	Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care		-The Alliance supports
SGRP 125	**New**	**New**	Medication reconciliation: create ability to accept data feed from PBM (Retrieve external medication fill history for medication		-We support, as noted earlier, and encourage the same for laboratory and imaging systems/databases, as well.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
			adherence monitoring) Vendors need an approach for identifying important signals such as: identify data that patient is not taking a drug, patient is taking two kinds of the same drug (including detection of abuse) or multiple drugs that overlap. **Certification criteria:** EHR technology supports streamlined access to prescription drug monitoring programs (PDMP) data. For example: ▪ Via a hyperlink or single sign-on for accessing the PDMP data ▪ Via automated integration into the patient's medication history Leveraging things like single sign on or functionality that could enable the linkage between PDMPs and prescribers and EDs?		
SGRP 308	**New**	**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			-It is unclear which EPs would be held accountable under this measure. It seems it would disproportionately affect some types of providers over others.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		consent if required. **EH Measure:** For 10% of patients with a significant healthcare event (arrival at an Emergency Department (ED), admission to a hospital, discharge from an ED or hospital, or death), EH/CAH will send an electronic notification to at least one key member of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required, within 2 hours of when the event occurs.			
Improve population and public health					
SGRP 401A	**EP/EH Objective:** Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	**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	**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.		-Since the proposed Stage 3 objective transitions from capability to *submit* immunization data to capability to *receive* such data, it is critical that certification criteria first ensure this modified function before holding EPs accountable. -Also critical that exclusions be maintained.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
SGRP 401B	**New**	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. **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			-Would it be the responsibility of the EP or the EHR vendor? It would be reasonable to expect the EP to access and consider recommendations before giving an immunization, but actually implementing such a system seems like a large responsibility for the EP.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		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.			
SGRP 402A	**EH Objective:** Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice **Measure:** Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period.	**EH Objective (unchanged):** No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system			N/C
SGRP 402B	**New**	**New**	**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.		-We support as a menu set option for future stages of MU so long as it includes exclusions to protect EPs for which this is not relevant.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
			Measure: Attestation of submission of standardized initial case reports to public health agencies on 10% of all reportable disease or conditions during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit. Could similar standards be used as those for clinical trials (SGRP209)?		
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 **EH Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except	No change from current requirements.			-We support maintaining this menu objective so long as there is accompanying certification criteria to ensure this functionality, as well as appropriate exclusions for those who lack the capability to exchange this information and for those to which this measure is simply not relevant.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
	where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period				
SGRP 404	**EP only MENU Objective:** Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period	**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. **Measure:** Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as			-We support maintaining this in the menu set, but seek additional guidance on how EPs can implement this objective. We also recommend that this measure include appropriate exclusions that not only account for lack of capability to exchange this information, but also for physician practices to which this measure is simply not relevant.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated registry, maintain an audit of those reports, and track total number of reports sent. **Exclusion:** where local or state health departments have no mandated registries or are incapable of receiving these standardized reports			
SGRP 405	**EP only MENU Objective:** Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period	**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. **Measure:** Documentation of			-We strongly support this objective/measure so long as this functionality is built into EHRs by Stage 3 and so long as the measure includes appropriate exclusions that not only account for lack of capability to exchange this information, but also for physician practices to which this measure is not relevant. -We cannot overemphasize the need for interoperability standards to facilitate exchange of data between EHRs and registries, Currently, physicians must manually enter data from EHRs into registries due to the lack of a streamlined/standardized process and the proprietary nature of HIT systems. Standards need to be in place and required as part of federal certification criteria before this measure can be implemented -We request clarification of the terms "jurisdictional, professional or other aggregating resource." Is HITPC referring to actual clinical data registries here (e.g., a specialty society sponsored registry) or ACOs and

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** EHR is able to build and send a standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent.			HIEs? These are considerably different.
SGRP 407	**New**	**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. **Measure:** Documentation of successful electronic transmission of standardized healthcare acquired infection reports to the NHSN from the Certified EHR			-We support as a menu set option so long as functionalities are available and appropriate exclusions included.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		Technology. Total numeric count of HAI in the hospital and attestation of Certified EHR electronic submission of at least 10% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria**: EHR is able to send a standard HAI message to NHSN, maintain an audit and track total number of reports sent.			
SGRP 408	**New**	**New**	**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		-We support as a menu set measure in future years when this functionality has been developed and tested and so long as appropriate exclusions are included -We also question the readiness of FDA to collect this data from EHRs directly, given the fact that the Unique Device Identification (UDI) system has yet to be finalized.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
			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).		
Information Exchange					
IEWG 101	**New**	**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		Should the measure for this MENU objective be for a number of patients (e.g.25 patients were queried) or a percentage (10% of patients are queried)?	-We support this concept, but given the complex systematic requirements regarding patient authorizations, etc., we recommend that this be delayed until after Stage 3. -When it is implemented, it would seem more logical to base it on percentages of transitioned patients without a care summary that were queried rather than a set number of such patients since this number will vary from practice to practice.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		demographics and other available identifiers, as well as the requestor and purpose of request. b) Query for a document list based on 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		What is the best way to identify patients when querying for their information?	N/C

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
		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.			
IEWG 102	**New**	**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).		Are there sufficiently mature standards in place to support these criteria? What implementation of these standards is in place and what has the experience	While an admirable goal, it's unclear what HITPC envisions in terms of future objectives/measures.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/Comments	Alliance Comments
				been?	
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): (i) *Encounter diagnoses.* The standard specified in § 170.207(i) or, at a minimum, the version of the standard at § 170.207(a)(3); (ii) *Immunizations.* The standard specified in § 170.207(e)(2); (iii) Cognitive status; (iv) Functional status; and (v) *Ambulatory setting only.* The reason for referral; and referring or transitioning provider's name and office contact information. (vi) *Inpatient setting only.* Discharge instructions.			What criteria should be added to the next phase of EHR Certification to further facilitate healthcare providers' ability to switch from using one EHR to another vendor's EHR?	-We recommend that ONC work to ensure there are interoperability standards and that they are incorporated into the certification criteria.

Additional Questions from the HITPC

ID#	Questions	Alliance Comments
MU01	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?	-We recommend that menu options exceed core requirements, which would allow practices to choose which functionality are most meaningful and actionable to improving quality and efficiency in their patient population and practice.
MU02	What is the best balance between ease of clinical documentation and the ease of practice management efficiency?	N/C
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?	-The Alliance recognizes the work/progress of private sector groups and the ONC.
MU04	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. • How can EHRs and HIEs manage information that requires patient consent to disclose so that populations receiving care covered by these laws are not excluded from health information exchange? • How can MU help improve the capacity of EHR infrastructure to record consent, limit the disclosure of this information to those providers and organizations specified on a consent form, manage consent expiration and consent revocation, and communicate the limitations on use and restrictions on re-disclosure to receiving providers? • Are there existing standards, such as those identified by the Data Segmentation for Privacy Initiative Implementation Guide, that are mature enough to facilitate the exchange of this type of consent information in today's EHRs and HIEs?	N/C
MU05	The HITECH ACT has given a lot of emphasis to EHRs as the central distribution channel for health information, but there may be limits on how much we can add on to EHR technologies. As additional program demands are added onto EHRs, what can be done to foster innovation to share information and receive intelligence from other, non-EHR applications and services that could be built on top of that data architecture? For example, Is it possible to create an application programming interface (API) to make available the information defined in a CCDA so that systems can communicate it with each other? Is the information defined in the CCDA the appropriate content for other uses of clinical information? Are the standards used to communicate between EHR systems (e.g. Direct, Exchange) adequate for communication between EHRs and other kinds of systems? What other technologies, standards or approaches could be implemented or defined to facilitate the sharing of clinical knowledge between EHRs and other systems?	N/C
MU06	What can be included in EHR technology to give providers evidence that a capability was in use	-We recommend that ONC certification require all EHRs to have clearly formatted

ID#	Questions	Alliance Comments
	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?	dashboards and reminders to make it easier for users to monitor their compliance with meaningful use. Reports should be easy to run and review.

I. Quality Measures

ID #	Questions	Alliance Comments
QMWG 01	As we propose to expand the features of the eCQM measure set, how can it be done in ways to minimize health care costs and reduces burden on health care providers?	N/C
QMW G02	Furthermore, when considering the finite resources available to technology developers, what measures, types of measures or attributes of measures should be a high priority?	N/C
QMW G03	Are there innovations or technological capabilities for measure development or specification that the HITPC could support that would reduce the burden on technology developers?	N/C
QMW G04	Meaningful Use program has used menu objectives and menu CQMs to provide flexibility for providers. Should there be core CQMs for high priority health conditions, such as controlling hypertension?	-We recommend that if this were to proceed, core CQMS should be established for high priority health conditions by specialty, rather than across the board, since more specialized specialties and subspecialties do not have control over what some may view as national high priority health conditions. HITPC should also ensure there are appropriate exclusions for conditions that may not apply to a provider's practice.

A. Patient Centeredness: Broaden Stakeholder Input

ID #	Questions	Alliance Comments
QMWG05	How can the HITPC and QMWG capture input from a wide variety of providers, patients, organizations and societies?	-We recommend proactive outreach to specialty societies and coalitions of specialty societies; convening of focus groups; and ensuring that each specialty is represented.
QMWG06	What additional channels for input should we consider?	-We recommend convening focus groups and ensuring that each specialty is represented.

B. Patient Centeredness: Patient-Reported and Patient-Directed Data

ID #	Questions	Alliance Comments
QMWG07	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?	-We recommend that consumer-reported data be used to inform the development of new CQMs. We suggest that the entire suite of CAHPS surveys be validated for patient experience data collection via patient portals or other electronic means that could be captured by practices for improved patient experience and satisfaction, which would likely improve overall cost and quality.
QMWG08	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?	N/C

C. CQM Pipeline: Process and Outcome Measures

ID #	Questions	Alliance Comments
QMWG09	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?	-We suggest a combination of both. While outcome measures are ideal, there will always be a need for a mix of measures that accommodate different patient populations and practice settings. While we should continue to work to develop better outcome measures, it is also critical that process measures support positive outcomes. Measure groups that support overall outcomes, but include some process measures, are also valuable.
QMWG10	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.	-See above.

D. CQM Pipeline: Measure Development Lifecycle

ID #	Questions	Alliance Comments
QMWG11	Please comment on challenges and ambiguities in retooling legacy paper abstracted and claims based eCQMs.	N/C
QMWG12	Is this a shift away from retooling legacy paper-based CQMs in exchange for designing CQMs de novo a reasonable course of action?	N/C
QMWG13	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.	N/C

E. CQM Pipeline: MU Alignment with Functional Objectives

ID #	Questions	Alliance Comments
QMWG14	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?	-We support continued efforts to align eCQMs and MU Objectives in order to minimize reporting burden, duplication of effort, and confusion. Given the increasingly diverse number of available quality measures and the increasing frequency with which they are being e-specified, there seems to be an opportunity to incorporate relevant CQMs into the reporting requirements of certain objectives (i.e., going forward, CQMs do not necessarily need to remain a separate and unique reporting requirement, but can instead be matched up with and listed as part of specific MU objectives).
QMWG15	Which measures and objectives, in particular, have the greatest potential to maximize meaningful alignment? Please recommend eCQM/Objective alignment opportunities.	N/C

F. CQM Pipeline: Domains and Exemplars

ID #	Questions	Alliance Comments
QMWG16	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?	-We suggest improving quality and safety and improving population health as priorities.
QMWG17	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?	N/C

G. CQM Pipeline: MU and Innovation

ID #	Questions	Alliance Comments
QMWG18	Please comment on the desirability and feasibility of such an innovation track as a voluntary, optional component of the MU CQM requirement.	-We support the ability of EPs to submit a locally or professional society- developed CQM as a menu item in partial fulfillment of MU requirements. This would promote more flexible approaches that better recognize local needs and the needs of specific patient populations and settings. It would also allow CMS to learn more about CQMs developed by EHR users in the field, which may stimulate new and more appropriate measure development.
QMWG19	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.	-Pros of the conservative approach: encourages adoption and use of EHRs by ensuring more relevant and feasible CQMs while also ensuring a minimum level of quality and consistency among members of the same specialty so that the data could be analyzed over time for trends and patterns related to performance and adherence. -Pros of allowing any EP to develop a measure: promotes more flexibility and innovative forms of measurement that more precisely meet the needs of local populations, but requires minimum standards (e.g. minimum sample sizes or use by a minimum number of practices). -While the Alliance supports flexibility in QI strategies and the alternative approach of allowing individual EP selection of CQMs would allow for the most flexibility, it

ID #	Questions	Alliance Comments
		may be difficult to evaluate the effectiveness and feasibility of measures when so many different measures are being used by so few practices.
QMWG20	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?	-While we support a *brief* description of the listed elements to help ensure a minimum quality standard, we do not necessarily recommend applying the rigorous testing requirements of the National Quality Forum (NQF) process, which requires heavy investments of time and resources. We encourage the ONC to develop guidelines or minimum standards for entities to initially follow when they are developing these alternative measures.
QMWG21	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?	-We support the proposal to allow providers to submit a locally or professional-society developed CQM as a menu item in partial fulfillment of MU requirements. This would promote more flexibility, while also allowing CMS to learn more about CQMs developed by EHR users in the field, which may stimulate new and more appropriate measure development.
QMWG22	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?	N/C
QMWG23	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)?	-We support the strategies listed as examples, as well as other guidelines or recognized standards, such as those developed by the American National Standards Institute (ANSI), if available.
QMWG24	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?	-We request better alignment between EHR program and other federal reporting programs, such as PQRS, so that one measure set can be reported across programs. -Increasing the number of measures to report does not necessarily necessitate quality improvement if the measures have little to no relevance to the practice or improve outcomes. HITPC should recommend more flexibility in reporting, as opposed to forcing providers to report in specific domains. -Providers should be able to meet CQM reporting if they participate in a clinical data registry. It provides more meaningful information to the provider and a provider is not just reporting on de-facto measures that may not have much relevance to their practice.

H. Quality Improvement Support: Architecture and Standards

ID #	Questions	Alliance Comments
QMWG25	Please comment on the value and feasibility of the eCQM and EHR features listed below: - Ability to accept downloaded specifications for new measures with little tailoring or new coding - Minimal manual data collection or manipulation	-There is tremendous value in each of these items, but we remain concerned over the ability of vendors to manage this and the lack of standards to help support this activity.

ID #	Questions	Alliance Comments
	- Ability to aggregate measure data to varying business units (practice, episode, ACO, medical home, MA plan, etc) - Ability to build measures that incorporate cross-setting records for episodes, medical homes, outcomes (e.g., readmissions) - Ability to build multi-source data records, including claims, patient reported data - Ability to implement machine-readable HQMF that minimizes manual vendor coding - Ability to drill-down on reported measures for QI analyses	
QMWG26	What other features, if any, should be considered? Please make suggestions.	-We recommend the ability to query this information in real-time.
QMWG27	What is the role of muliti-source data exchange in achieving these features?	N/C

I. Quality Improvement Support: CQM Population Management Platform

ID #	Questions	Alliance Comments
QMWG28	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?	N/C
QMWG29	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)?	N/C
QMWG30	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?	-We support less prescriptive options that allow for testing and evaluation, such as challenge grants and demonstrations.

II. Privacy and Security

ID #	Questions	Alliance Comments
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?	N/C
PSTT02	How would ONC test the HITPC's recommendation in certification criteria?	N/C
PSTT03	Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third party authentication service provider?	N/C

Feedback on security requirement next steps

ID #	Questions	Alliance Comments
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.	-We recommend preservation of the requirement that meaningful users meet HIPAA Security Rule requirements. -To ensure compliance, HITPC should develop tools, such as webinars, PowerPoint presentations and YouTube videos to assist with understanding the HIPAA Security Rules.

Feedback on standards for accounting for disclosures

ID #	Questions	Alliance Comments
PSTT05	Is it feasible to certify the compliance of EHRs based on the prescribed standard?	N/C
PSTT06	Is it appropriate to require attestation by meaningful users that such logs are created and maintained for a specific period of time?	-This question is confusing. The EHR system should include functionality to query this data. If this functionality were in place, wouldn't the provider be able to provide this information at any time, so long as they continue to use the same EHR system?
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?	N/C
PSTT08	Are there any specifications for audit log file formats that are currently in widespread use to support such applications?	N/C