Meaningful Use Workgroup

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Workgroup Membership

Co-Chairs:

Paul Tang	Palo Alto Medical Foundation
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Members:

• David Bates	Brigham & Women's Hospital
• Michael Barr	American College of Physicians
• Christine Bechtel	National Partnership/Women & Families
• Neil Calman	Institute for Family Health
• Tim Cromwell	Department of Veterans Affairs
• Art Davidson	Denver Public Health
• Marty Fattig	Nemaha County Hospital
• James Figge	NY State Dept. of Health
• Joe Francis	Veterans Administration
• Leslie Kelly Hall	Healthwise
• Yael Harris	HRSA
• David Lansky	Pacific Business Group/Health
• Deven McGraw	Center/Democracy & Technology
• Latanya Sweeney	Carnegie Mellon University
• Greg Pace	Social Security Administration
• Robert Tagalicod	CMS/HHS
• Karen Trudel	CMS
• Charlene Underwood	Siemens
• Amy Zimmerman	Rhode Island Department of Health and Human Services

Agenda

Updates from CDS small group

Continue review of comments from April 4th HITPC meeting

Improve quality safety, efficiency and reducing health disparities

- **Is enough being done to reach domain goals, especially related to efficiencies?**
- **There seems to be little in the rule around disparities.**

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Implement one CDS rule relevant to specialty or priority	Use CDS support - change certification criteria definition	1. Implement 5 CDS interventions related to **five or more** CQMs 2. Drug-drug and drug-allergy interaction checks enabled	**Reinstate the HITPC's original recommendations** **Difference:** **a. Only source/citation of CDS** **b. Not having a special call-out for "linked references" since it is just one type of CDS intervention and our goal was to be flexible and not prescriptive** **Are the 5 attributes covered in the SCC NPRM?**

Agenda

Updates from CDS small group

Continue review of comments from April 4th HITPC meeting

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
>30% patients with at least one **medication** order entered using CPOE	**Medications**: **60%** **Lab:** More than 60% have at least one lab order entered **Radiology:** At least one radiology test is ordered	More than **60%** of medication, **laboratory, and radiology** orders **are recorded using CPOE**	(1) Clarify whether paper orders need to be counted. If counting paper orders is difficult, then we propose that the denominator be 1) medications on the med list, 2) resulted lab tests, and 3) resulted radiology tests. The numerator would be # of CPOE orders entered by the authorizing provider (the goal of CPOE). (2) As proposed, med, lab, & rad orders are lumped so that one could skip an order type completely. Recommend keeping percentage by order type (3) Recommend keeping definition requiring a licensed professional (no scribes, **defined as an intermediary who is not licensed); this is not meant to extend to progress notes.** (4) Clarification- HITPC Proposal: only radiology was suggested as yes/no; laboratory was counted. • **Re denominator, issues of multiple results per panel, putting med on each other's list.** **• Detailed recommendations needed related to the issue of scribes.** **• How does this relate to the need for an objective related to progress notes (i.e., engagement of provider in actual use of EHR)?** **• There doesn't seem to be a way to measure who actually entered the order; instead recommend adding clarifying language to indicate that the person who enters the order needs to be the one to act upon decision support. Decision support needs to be at the point of sign-off.** **• Consider who carries the liability.**

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Implement drug-drug and drug-allergy interaction checks	Employ drug interaction checking (drug-drug, drug-allergy) provider to refine DDI rules	**Consolidated**	(1) We agree with the consolidation, especially because DDI is still separate in the consolidated objective. (2) We believe DDI deserves special attention because current commercial DDI databases are well known to have high false positives, which contribute to alert fatigue. Providers should be able to revise DDI rules. **• Need to understand what it means for providers to be able to revise DDI rules (First Databank supported provider customization in public comment).** **• Is this a temporary provision until the industry can produce DDI with fewer false positives?** **• More research needs to be done – there may be better practices.**
EP only: Generate and transmit electronically > 40% of all prescriptions	**EP:** Increase threshold to **50%** **EH:** Transmit 10% of discharge orders	>**65%** of all EP prescriptions and >10% of all hospital discharge orders for Rx **are compared to at least one drug formulary** and transmitted electronically	65% may be high due to patient preference and pharmacy capabilities in certain geographies; we recommend 50%. ***IE WG comment:*** The IE WG agrees with increasing the eRX requirement, but recommends that the threshold be 50% rather than 65% to account for the persistently wide variation in eRX infrastructure across the country and the non-universal use of eRX among mail-order pharmacies. The IE WG also feels that prescriptions to internal pharmacies should be excluded from the denominator. **• Cautioned that setting the threshold too high can penalize the provider for things outside of control.** **• May be helpful to be consistent with what CMS did for eRx – Terry Cullen.**

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
>50% of all unique patients seen have demographics recorded	increase to **80%**	More than **80 %** of all patients seen have demographics recorded	Agree with 80%. Would recommend adoption of CDC demographic standards, which are more granular (but can be mapped to) 1997 OMB standards. **How are demographics being used to address disparities?**
Maintain an up-to-date problem list for >80% of all patients	No change	**Consolidated** with summary of care	We recommend keeping these 3 lists as separate objectives for the following reasons: 1) they were and still will be important motivators for clinicians to enter and maintain accurate lists; 2) the stage 1 requirement is very minimal; we were planning to add more rigorous capabilities to facilitate maintaining complete and accurate lists 3) just having these elements in a transition of care document (which may be difficult or impossible for clinicians to access) does not give the information the visibility it deserves; 4) removing the objectives sends a signal that these 3 items are less important than other items like demographics and vital signs. **Is the MU WG suggesting that a quality measure should be proposed for Stage 3? The more we teach to this, there will be positive feedback. Stage 3, ways to facilitate more accurate lists.**
Maintain active medication list >80% of all patients	No change	**Consolidated** with summary of care	
Maintain active medication allergy list for >80% of all patients	No change	**Consolidated** with summary of care	

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
>50% of vital signs recorded: • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI	80% of vital signs recorded: • Height • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	80% of vital signs recorded: • Height/Length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	Agree.
Smoking status for patients 13 & older for >50%	Increase threshold to **80%**	> **80%** of patients 13 and older	Agree.

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
MENU: Implement drug-formulary checks with access to at least one drug formulary	Drug formulary checks according to local needs (internal/external formulary, generic substitution)	**Consolidated -** include within eRX core objective	***IE WG comment:*** The IE WG recommends retaining the formulary objective as a stand-alone measure and making it Core for EPs and hospitals: Formulary-checking should apply to all prescriptions, not just electronic. •Providers should be required to check formularies for at least 50% of prescriptions for which relevant formularies are electronically available through the eRX network. •Patient-relevant formularies are specific to patient, health plan, and health plan product. •Denominator should be prescriptions for which patient-relevant formularies are electronically available through the eRX network; numerator should be number of prescriptions for which provider checked patient-relevant formulary. •HITSC/ONC should identify standards to support automated electronic checking for relevant formularies through EHRs connected to eRX networks.
Report ambulatory and hospital clinical quality measures to CMS or States	No change	**Removed -** Objective is incorporated directly into the definition of a meaningful user	Agree. **Re Group Reporting** **• Team-based care: first answer how group shares patients, then address reporting**

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
EH MENU: Record advanced directives for > 50% patients 65 or older	Record an advance directive exists for **EP:** at least 25 patients and provide access to a copy **EH:** >50% of patients 65 years and older and provide access to a copy	**EH Menu** - >50% of all unique patients 65 or older a have an indication of an advance directive status recorded as structured data.	**EP:** We recommend adding a Menu requirement - More than 10% of patients who are 65 or older. Strongly recommend moving to core for Stage 3. **EH:** This is an important objective and we recommend the original stage 1 objective should be moved to core for hospitals.
MENU: Incorporate clinical lab test results into certified EHR for more than 40% of all clinical lab tests results ordered with a +/- or # format	Incorporate >40% of all clinical lab tests	**EP/EH: >55%** of all clinical lab tests results ordered whose results are in a +/- or # format	Agree. Okay to count individual tests.
MENU: Generate lists of patients by specific conditions	Generate lists of patients by multiple specific conditions	Generate at least one report listing patients of the EP, EH/CAH with a specific condition.	Agree. We had suggested multiple specific conditions, to ensure that EHRs were certified to handle more than one variable. **To ensure adequately achieving priority goals, additional guidance should be provided**

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
EP MENU: Send reminders to >20% of all patients 65+ or 5 or younger	>10% of all active patients are sent a clinical reminder (existing appointment does not count)	>10% of all patients w/in 24 months prior to the EHR reporting period were sent a reminder, per patient preference	Agree. It may require exclusions for some specialists, such as surgeons who do not require follow up after the initial post-op visit or manage preventive services.
N/A	**EH:** Medication orders automatically tracked via electronic medication administration record in-use in at least one hospital ward/unit	**EH:** >**10%** of medication orders created by authorized providers are tracked using eMAR.	Agree.
N/A	N/A	**NEW MENU -** >40% of all scans and tests whose result is an image ordered are incorporated into or accessible in EHR	(1) We agree with the proposed objective, but would recommend a 10% threshold with an exclusion if they have no access to electronic images (e.g., local imaging centers do not offer electronic access). (2) Re: question about a *potential* measure requiring exchanging images for 10%. While we agree with the spirit of the potential measure, we but believe that Stage 2 may be too soon to expect EPs and EHs to share images with outside providers.
N/A	N/A	**NEW MENU:** >20 % have a structured entry for one or more first-degree relatives or an indication that family health Hx has been reviewed	Although we support the spirit of this objective, we are not aware of adopted standards in this area, and we have concerns about the cost/benefit of the information as currently captured (e.g., FH is dependent on the clinical condition).

Objectives not included - Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Enter at least one electronic note for > 30% of visits (non-searchable, scanned notes do not qualify)	**N/A** Record electronic notes in patient records for >30 % of office visits.	Agree with adding text-searchable notes to certification. Because some certified EHRs do not have clinical documentation, and we believe that having a complete record, including progress notes, is required to deliver high quality, efficient care, we recommend that provision for recording progress notes should be a meaningful use objective.
N/A	Hospital labs send (directly or indirectly) structured results to outpatient providers for >40% of electronic lab orders received.	**N/A** Hospital labs send structured electronic results to outpatient providers for >40% of electronic lab orders received.	We continue to support this objective and believe it should be included. ***IE WG comment:*** The IE WG disagrees with the CMS NPRM decision to exclude this objective and recommends that CMS restore the HITPC-recommended requirement for hospitals to send structured lab results electronically to ambulatory providers using certified electronic health record technology and in accordance with designated standards

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Provide >50% with an electronic copy of their health information	Combined with other objectives	**Replaced**	Agree.
Provide >50% with discharge instructions	Combined with other objectives	**Replaced**	Agree.
>10% of unique patients timely electronic access to their health information	>10% view and have the ability to download **EP:** available w/in 24 hrs (or 4 days after available) **EH:** available w/in 36 hrs	**Replaced**	Agree, with improved timeliness to 2 business days for EPs.

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	N/A	**NEW Measure** 1. > 50% provided online access **EP** 4 business days **EH** w/in 36 hrs 2. >10 % of patients view, download, or transmit to a 3rd party	We appreciate and agree with the intent to keep the timeliness criterion simple (1 timeline). However, we believe there is value in providing the patient with prompt access to the summary of an encounter (which we define as an office visit or other contact in which an order is generated). We propose that a single timeliness criterion be applied, and that it be shortened to "within two business days of information becoming available to the EP." The MU WG is divided about the threshold for patients seen who have actually viewed, downloaded, or transmitted during the reporting period. NB: Discharge instructions were available at discharge in stage 1, and in NPRM that goes to 36 hrs **We believe that 10% of active patients (or care givers) need to have logged on (agreed to terms, authenticated, etc.; view, download, and transmit all count) at any time in the past (not just this reporting period). We believe it is reasonable to reuse previous log-on events in future years.** **Important that what is given to the patient speaks to both the provider and patient.** **• Concerned about specifying %, as this is beyond the control of the provider.** **• May need to revisit work done to identify exclusions (Christine)** **• Suggestion to adjust denominator (e.g., could use patient preferences)** **• Some commented 10% too high (GH), others 2 days too long (LW)** ***IE WG comment:*** IE WG supports the intent of the patient engagement objectives but recommends the following changes: Recommends changing the measure so that what counts towards the numerator are usersregistered for a patient portal or method to transmit to a patient-controlled application (eg, PHR). Threshold should gradually increase over the Stage 2 period, beginning at 10% in year 1 and increasing 5 percentage points per year to a maximum of 25%. Numerator should count two options for transmit: 1) patient entering a portal and pushing information or 2) provider sending information automatically to an end point designated by the patient (for instance, to their Direct address).

Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Clinical summaries for >50% of all office visits within 3 business days	Provide clinical summaries to >50% within 24 hours; available within 4 days	EP: Clinical summaries provided to patients **within 24 hrs** for >50 % of office visits.	The NPRM says that HITPC recommended that for clinical summaries information be made available within 24 hrs or within 4 *business* days of info becoming available. The HITPC actually recommended that for clinical summaries information be made available within 24 hrs or within 4 (calendar) days of becoming available. That is consistent with our new recommendation to use 2 business days overall to achieve a single timeline for all data.
MENU: Use certified EHR to identify patient-specific educational resources for >10% of all patients	Identify educational resources and provide to >10%	Patient-specific education resources are provided to patients for >10% of **all office visits**	Agree.
N/A	Offer secure online messaging to patients: at least 25 patients	A **secure message** was sent using the electronic messaging function for >**10 %** of patients	We are concerned about 10% being too high to achieve by Stage 2. We recommend lowering the threshold to 5% (which is 10% of the necessary 50% with portal access) for patient-initiated messages. The patient-initiated message could be a response to a provider message. **We support patient-initiated messages, as provider-initiated reminders and educational materials are already covered in other objectives.** **Asked to consider a two part requirement 1) provider sends the message 2) add a timeliness requirement for responses to any messages that the provider receives back from patients. Must respond to message received within 2 business days. This would make it more useful for patients** ***IE WG comment:*** IE WG agrees with the intent to encourage greater electronic communication between patients and providers, however, we recommend modifying this measure to also count in the numerator physician-initiated messages that are specifically relevant to the patient's clinical situation.

Objective not included - Engage patients and families in their care

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Record preferences for communication for >20%	**N/A** **EP:** Record preferences for communication for >20%	HITPC's intent was to capture a patient's preferred communication method in order for the system to use that media for future non-urgent communication. This respects the patient's wishes and is more efficient for the provider. We recommend that the preferred communication field support multiple message types (e.g., non-urgent clinical, administrative) and preferred media (e.g., electronic, phone, SMS message).

Improve Care Coordination

- **This is the most important domain and is the weakest link when thinking about how to incorporate different vendor records, certification standards will be crucial.**

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Perform at least one test of the capability to exchange key clinical information	HIE test eliminated in favor of use objectives	**Removed** for an actual use case	We agree with eliminating the test **for Stage 2**. For Stage 1, we suggested option 4 (actual electronic transmission of a summary of care document). ***IE WG comments:*** The IE workgroup agrees with the CMS proposal to remove this objective for Stage 1 with no replacement. **Need to verify that it is okay to defer to the IE WG for final recommendation. Need appropriate onramp and escalator. [Stage 1 continues indefinitely for new EPs; e.g., consider option 4 for 2014. (CB)]**
MENU: Perform medication reconciliation for >50% of transitions	Move to core.	Performs medication reconciliation for >**65%** of transitions	The certification criteria should support the reconciliation process (e.g., comparing multiple medication lists and resolving differences). In order to support the measure, the provider needs to capture the fact that a transition has occurred. Because detection of the occurrence of a transition must be captured manually, we recommend that the threshold remain at 50%. ***IE WG comment:*** The IE WG agrees with the medication reconciliation objective and measures, but recommends that the exclusion criteria account for specialties and/or clinical situations where medication reconciliation would not be warranted or necessary. ***Quality Measure workgroup*:** The measure proposed in the NPRM tracks medication reconciliation for patients older than age 65. Medication reconciliation should be encouraged in all patients, regardless of age. Medication reconciliation is such an important issue, for quality of care and patient safety, that the practice should be measured across settings and age bands.

Improve Care Coordination

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
MENU: Provide a summary of care record for >50% of all transitions and referrals of car	1.Record and provide (by paper or electronically) a summary of care record for >50% of transitions of care for the referring EP or EH 2. Record care plan goals and patient instructions in the care plan for >10% of all active patients	Summary of care record provided for >65% of transitions of care and referrals. Electronicall y for >10% of transitions (outside organization and other EHR vendor).	Care plan section of the summary of care document should include the reason(s) for referral or transition and the results of the referral (recommendations). To support the measure, the provider needs to capture the fact that a transition is about to occur. We agree with the requirement for measure 2 that the transmitted summary of care document should cross organizational barriers. However, we believe that while it is essential that the exchange of information comply with prescribed standards, we believe that requiring that the transmission occur between different vendor systems may cause unintended consequences in some geographic regions where a few vendors may have a dominant market share. The group was divided on countable number vs. percent. ***IE WG comment:*** 1. Raise the exclusion threshold for the 65% measure requirement from 0 to 10 transitions per year. 2. The IE WG supports the requirement to conduct electronic transmission of care summaries, but recommends removing the cross-vendor requirement to meet the 10% electronic exchange threshold. 3. The IE WG recommends adjusting the electronic transmission measure denominator in two ways: 1. Exclude from the denominator referrals to providers that have the ability to view or query patient clinical data, either directly from the referring provider's EHR or from a repository or HIE populated with patient data by the referring provider. 2. Exclude the provider from the objective if the resultant denominator is fewer than 50 referrals per year. **• Critical to think about the technical capability to merge fields into a different EHR.** **• Need to facilitate communication among all relevant providers. Seem to be imposing artificial constraints on what it means to supply the info. Direct should count. The rule talks about certified EHR technology, consider broadening.** **• Need to do more than just receive a document, unhappy with the slow adoption of smart receipt.** **• Need to be able to send to non-MU EP and have the transmission count.**

Objectives not included - Improve Care Coordination

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	Record health care team members for >10% of all patients; this information can be unstructured	**N/A** Record health care team members for >10% of all patients.	Okay to leave as part of the summary of care document.
N/A	Send care summary (with care plan and care team) electronically to the receiving provider **EP:** at least 25 pts. with transition of care. **EH:** for >10% of discharges	**N/A** Record care plan goals and patient instructions in the care plan for >10% of patients seen during the reporting period.	Okay to leave as part of the summary of care document.

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
MENU: Perform at least one test of the capability to submit electronic data to immunization registries	Attest to at least one submission of data in accordance with applicable law and practice	Successful ongoing submission of electronic immunization data to an immunization registry or **except where prohibited**, and in accordance with applicable law and practice	We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. **Need clarification on "except where prohibited." Participation should be encouraged beyond transfers required by law, but we are concerned about unintended consequences (e.g., need to pass new laws prohibiting transfer to avoid penalizing local health providers).** **Need one standard to communicate with registries, maybe we can get there by stage 3.** ***IE WG comments:*** IE WG recommends that CMS broaden exclusion criteria to include circumstances where the immunization registry has designated a "health information exchange" to receive the information so long as this alternative is a reasonable alternative in terms of price and integration requirements. IE WG recommends that CMS define more specifically which immunizations are required to be reported by providers.

IE General Public Health comments:

The IE WG concurs with the inclusion of NPRM objectives that increase the volume and value of public health reporting and, in particular, with requiring public health submissions "except where prohibited" in Stage 1.

IE WG recommends more specific definitions for the key parameters of the public health requirements to assure rapid momentum in electronic reporting to public health.

Specifically define "successful ongoing submission" to be 10% of all qualifying transactions increasing 10 percentage points per year over Stage 2 to a maximum of 50%

The goal is to accommodate: 1) possible delay between the time an EH or EP offers to begin ongoing submission and the time that data/message/transport testing ("on-boarding") is complete. This delay may occur both due to PH on-boarding capacity and the quality-testing and refinement often needed; and 2) the disruptions to ongoing transmission that might be due to either sender, receiver or intermediaries. Specify transport requirements for public health transactions, aligned with transport requirements specified for electronic transmission care summaries for transitions. Grandfather existing transport approaches and apply new transport requirements only on new or replacement interfaces.

Support policy of a single standard for public health transactions (uniformly use HL7 2.5.1 rather than permitting the 2.3.1/2.5.1 choice offered in Stage 1), however, recommend grandfathering those EPs and EHs who: 1) implemented 2.3.1 to achieve Stage 1 objective; 2) went beyond the single test and maintained submission to public health during the Stage 1 period; 3) are reporting to a public health department that is accepting 2.3.1 messages, and 4) are utilizing the same EHR technology that was used for their Stage 1 attestation.

Additional specificity is needed around the criteria by which providers can apply for exclusions; this should include cases where the public health agency/registry does not support ONC recognized transport, ONC recognized standards, implementation guides and vocabulary standards, or goes materially beyond the requirements of the implementation guide

The Workgroup recognizes that local variation in the application of a national Implementation Guide is often needed (due to local law or practice) but should not increase the risk to EPs and EHs of failing to be able to comply with MU. Further consideration of how local variation may be defined, limited and communicated in with ample advance notice to all impacted EPs and EHs is advised.

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies	Attest to submitting to at least one organization in accordance with applicable law and practice	**NEW Measure:** Successful ongoing submission of electronic laboratory results in accordance with applicable State law and practice, except where prohibited	As above.

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies	Attest to at least one submission in accordance with applicable law and practice	**EP MENU/EH Core -** Successful ongoing submission of electronic syndromic surveillance data to a public health agency except where prohibited and in accordance with applicable law and practice	As above. ***IE WG comments: See IE General Public Health comments above.*** The IE WG supports CMS' proposal to make Syndromic Surveillance a Core requirement for EH/CAHs and a Menu requirement for EPs.
N/A	N/A	**NEW MENU -** Successful ongoing submission of cancer case information except where prohibited, and in accordance with applicable law and practice.	Need clarification "except where prohibited." Further clarification is needed regarding what is an acceptable registry. ***IE WG comments: See IE General Public Health comments above.*** IE WG recommends that CMS specifically designate which registries in each state or territory would qualify for this objective. These registries should also adhere to any standards being required through EHR certification. For Cancer Registries, recommend changing "state cancer registry" to "Public Health Central Cancer Registries" or just "Central Cancer Registries", which would include all of the registries funded by CDC's Division of Cancer Prevention and Control and by NCI's SEER program. These include cancer registries maintained by states, territories, and regions. (SEER also includes some Indian nations.) The word "central" is typically used to distinguish these from hospital cancer registries. **• Need to take a step back to figure out what makes sense in the long term. What is the basis for selecting cancer registry?**

Improve population and public health

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
N/A	N/A	**New MENU** - Successful ongoing submission of specific case information to specialty registries except where prohibited, and in accordance with applicable law and practice.	We are in agreement with the objective. Need to consider whether sufficient standards are available to support the interfaces between EHRs and registries. Panelists at our hearing also expressed concern about the proprietary nature of some registries, which affects the costs to participate, and in some cases places contractual restrictions on use of data and ability to participate in other registries. Concern about requiring all EHRs to interface all data with all registries. Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited". Further clarification is needed regarding what is an acceptable registry. ***IE WG preliminary:*** ***See IE General Public Health comments above.*** More specificity is needed on the definition of what would be qualifying registries. **• May not be paying enough attention to gov't registries.** **• There is no standard to describe data elements of registries. If turn to certification would have to require EHRs to work with all registries.** **• Advanced Directive registry in Maryland was provided as an example.** **• Need to take a step back to figure out what makes sense in the long term longer, selecting cancer registry is a disservice.** **• Other countries looking at US for standards. This will set the example for other countries to follow.** **• More feedback is needed.**

Privacy and security protections for personal

Stage 1 Final Rule	Stage 2 - Proposed by HITPC	Stage 2 NPRM	Stage 2 NPRM - MU Workgroup Comments
Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of the its risk management process	1. Perform, or update, security risk assessment and address deficiencies 2. Address encryption of data at rest	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), **including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3)**,and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	**Privacy and Security Tiger Team comments:** Addressing security of data at rest requires assessments of at least three situations: (a) data on portable devices or media; (b) data on devices in public areas or locales with poor physical security and data on servers in locales that are physically and electronically protected well. Addressing encryption of data at rest may result in different solutions in these locales. In particular, the requirement to attest to addressing the issue of encryption of data at rest is critical in protecting against data breaches involving portable media.