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Meaningful Use Objective Comments

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Medication only: More than 30% of unique patients seen during the reporting period with at least one medication in their medication list have at least one medication order entered using CPOE

Stage 2 - Proposed by HITPC

Medications: 60%

Lab: More than 60% have at least one lab order entered

Radiology: At least one radiology test is ordered

Stage 2 NPRM

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.

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

HITPC Comments

The NPRM appears to include all orders in the denominator, including orders written on paper. If this interpretation is correct, and if CMS and ONC decide (e.g., based on public input) that counting paper orders is too difficult, then we recommend as an alternative that the denominator be something that is calculated automatically:

- Medications on the med list
- Resulted lab tests, and
- Resulted radiology tests.

The numerator would be the number of CPOE orders entered by the authorizing provider.

As proposed, orders for medications, laboratory tests, and radiology procedures are aggregated, and the 60% threshold applies to the aggregate percent. In theory, a provider could aggregate the results of medication and laboratory test orders and get a “bye” on radiology procedure orders. Consequently, we recommend applying the 60% threshold to each order type separately.

As a point of clarification, the previously submitted HITPC recommendations did call for lab test orders to be counted. Only radiology procedure orders were recommended to be a yes/no attestation.

The group did not come to a consensus on the issue of scribes, but there was agreement that in order to count in the numerator, licensed professionals must view any relevant CDS interventions prior to signing the order and prior to any action being taken on the order.

There were two options discussed by HITPC for satisfying the above requirement. Some members of the HITPC felt that a licensed professional should enter the order via CPOE, as the NPRM proposed.

Other members felt that anyone could enter the order via CPOE as long as a licensed professional was required to view any relevant CDS intervention and to sign the order before it was carried out. For this second option, certification criteria would have to be updated so that CDS interventions would be presented anytime an order is initially entered and when it is signed, and be able to report the fact that the CDS intervention was presented to the authorizing provider as part of the definition of the numerator.

The requirement for licensed professionals to enter or authorize an order does not apply to entry of progress notes.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Implement drug-drug and drug-allergy interaction checks

Stage 2 - Proposed by HITPC

Employ drug interaction checking (drug-drug, drug-allergy) provider to refine DDI rules

Stage 2 NPRM

Consolidated

HITPC Comments

- (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. Consequently, providers should be able to revise DDI rules to achieve a better predictive value.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

EP only: Generate and transmit more than 40% of all permissible prescriptions electronically

Stage 2 - Proposed by HITPC

EP: Increase threshold to **50%**

EH: Generate and transmit more than 10% of all hospital discharge orders for permissible prescriptions electronically

Stage 2 NPRM

EP Objective: Generate and transmit permissible prescriptions electronically (eRx)

EP Measure: More than 65 % of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.

EH Objective: Generate and transmit permissible discharge prescriptions electronically (eRx)

EH Measure: More than 10% 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

HITPC Comments

Threshold should be 50%; the 65% threshold may be high due to patient preference and pharmacy capabilities in certain geographies.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Record demographics as structured data for more than 50% of all unique patients:

- Preferred language
 - Gender
 - Race
 - Ethnicity
 - Date of birth
 - (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH

Stage 2 - Proposed by HITPC

Record demographics for more than 80% of all unique patients seen during the reporting period with the ability to use the data to produce stratified quality reports

Stage 2 NPRM

Objective: Record the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth

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) have demographics recorded as structured data

- (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH

HITPC Comments

Agree with 80%. Would recommend adoption of CDC demographic standards, which are more granular than (but can be mapped to) 1997 OMB standards.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Maintain an up-to-date problem list of current and active diagnoses for more than 80% of all unique patients: have at least one entry or an indication that no problems are known for patient recorded as structured data

Stage 2 - Proposed by HITPC

No change

Stage 2 NPRM

Consolidated with summary of care

HITPC Comments

We recommend keeping these three 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 recommend more rigorous capabilities in stage 3 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.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Maintain active medication list: more than 80% of all unique patients have at least one entry recorded as structured data (or indication that the patient is on no meds)

Stage 2 - Proposed by HITPC

No change

Stage 2 NPRM

Consolidated with summary of care

HITPC Comments

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 recommend more rigorous capabilities in stage 3 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.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Maintain active medication allergy list: More than 80% of all unique patients seen during the reporting period have at least one entry (or indication that the patient has no known medication allergies) recorded as structured data

Stage 2 - Proposed by HITPC

No change

Stage 2 NPRM

Consolidated with summary of care

HITPC Comments

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 recommend more rigorous capabilities in stage 3 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.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Record and chart changes in vital signs: more than 50% of all unique patients age 2 and over have vital signs recorded as structured data

- Height
- Weight
- Blood pressure
- Calculate and display BMI
- Plot and display growth charts for children 2-20 years, including BMI

Stage 2 - Proposed by HITPC

Record and chart vital signs: more than 80% of all unique patients seen during the reporting period age 2 and over have vital signs recorded as structured data:

- Height
- Weight
- Blood pressure (age 3 and over)
- Calculate and display BMI
- Plot and display growth charts for patients 0-20 years, including BMI

Stage 2 NPRM

Objective: Record and chart changes in vital signs:

- 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

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), blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recoded as structured data

HITPC Comments:

Agree.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Record smoking status for patients 13 years old and older: more than 50% of all unique patients seen during the reporting period 13 years or older have smoking status recorded as structured data

Stage 2 - Proposed by HITPC

Increase threshold to **80%**

Stage 2 NPRM

Objective: Record smoking status for patients .13 years old or older

Measure: More than 80% 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 department (POS 21 or 23) have smoking status recorded as structured data

HITPC Comments

Agree.

Stage 1 Final Rule

Improve quality safety, efficiency and reducing health disparities

Stage 2 - Proposed by HITPC

MENU: Implement drug-formulary checks with access to at least one drug formulary

Stage 2 NPRM

Implement drug formulary checks according to local needs (e.g., may use internal or external formulary, which may include generic substitution as a “formulary check”)

Policy Priority

Consolidated - included within eRX core objective

HITPC Comments

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 in the EHR, not just those that are electronically prescribed (i.e. those entered into the system, printed, and handed to the patient would still need to be formulary-checked)
- Providers should be required to use the EHR’s automated formulary checking available in CEHRT; MU should not force the provider to perform out of workflow formulary checking
- HITSC/ONC should identify standards to support automated electronic formulary checking by EHRs
- EHR certification should include automated formulary checking applicable to the medication/patient/insurer/product and provide at a minimum formulary status, coverage, and copay

Measure should be that EP has enabled (“turned on”) EHR’s automated formulary checking during the entire reporting period

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Report ambulatory and hospital clinical quality measures to CMS or States

Stage 2 - Proposed by HITPC

No change

Stage 2 NPRM

Removed - Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6

HITPC Comments

Agree.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

EH MENU: Record advanced directives for more than 50% patients 65 years old or older

Stage 2 - Proposed by HITPC

Record an advance directive exists for

EP: Record whether an advance directive exists (with date and timestamp of recording) for at least 25 unique patients seen during the reporting period have recorded and provide access to a copy of the directive itself if it exists

EH: Record whether an advance directive exists (with date and timestamp of recording) for more than 50% of patients 65 years and older and provide access to a copy of the directive itself if it exists

Stage 2 NPRM

EP: N/A

EH Objective: Record whether a patient 65 years old or older has an advance directive

EH Menu Measure: More than 50% 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.

HITPC Comments

EP: We recommend adding a Menu requirement - More than 10% of patients who are 65 or older seen during the reporting period have an indication of an advance directive status recorded as structured data. We strongly recommend moving this proposed menu requirement 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 in stage 2.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

EP: Implement one clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance with that rule

EH: Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule

Stage 2 - Proposed by HITPC

Use CDS to improve performance on high-priority health conditions.

Establish CDS attributes for purposes of certification:

1. Display source/citation of CDS
2. Configurable based on patient context (e.g., inpatient, outpatient, problems, meds, allergies, lab results)
3. Presented at a relevant point in clinical workflow
4. Alerts presented to users who can act on alert (e.g., licensed professionals)
5. Integrated with EHR (i.e., not standalone)

Stage 2 NPRM

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

Measure:

1. Implement five clinical decision support interventions related to five or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period.
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.

HITPC Comments

In addition to DDI, require an additional decision support function addressing efficiency such as reducing overuse of high-cost imaging or use of generic medications.

We recommend use of the original HITPCs recommendation for five CDS attributes. We note that these attributes are incorporated into the certification NPRM, with two exceptions:

- a. We recommend simplifying the citation of the basis of a CDS intervention to include the reference source and any external funding of the development or implementation of the CDS intervention.
- b. We recommend 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

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

MENU: Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests results ordered whose results are either in a positive/negative or numerical format

Stage 2 - Proposed by HITPC

EP/EH: Incorporate lab results as structured data for more than 40% of all clinical lab tests ordered through the EHR for a patient during the reporting period

HITSC: Use LOINC where available

Stage 2 NPRM

Objective: Incorporate clinical lab-test results into EHR as structured data

Measure: More than 55% 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

HITPC Comments

Agree. Okay to count individual tests.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

MENU: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach

Stage 2 - Proposed by HITPC

Generate lists of patients by multiple specific conditions to use for quality improvement, reduction of disparities, research or outreach

Stage 2 NPRM

EP Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach

EP Measure: Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.

HITPC Comments

Agree. We recommend that queries for patient lists be able to accommodate multiple specific conditions (e.g., health condition, disparity variables) to ensure that EHRs were certified to handle more than one variable.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

Improve quality safety, efficiency and reducing health disparities

Stage 2 - Proposed by HITPC

EP MENU: Send preventive or follow-up reminders to more than 20% of all unique patients 65+ years old or 5 years old or younger

EP: More than 10% of all active patients are sent a clinical reminder (reminder for an existing appointment does not count)

Stage 2 NPRM

EP Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care

EP Measure: More than 10% 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

HITPC Comments

EP: 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.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

EH: Medication orders automatically tracked via electronic medication administration record in-use in at least one hospital ward/unit

Stage 2 NPRM

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% 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 are tracked using eMAR.

HITPC Comments

Agree.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

N/A

Stage 2 NPRM

Objective: Incorporate imaging results and information into Certified EHR Technology

Menu Measure: More than 40% of all scans and tests whose result is an image 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 incorporated into or accessible through Certified EHR Technology

HITPC Comments

- (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 believe that Stage 2 is too soon to expect EPs and EHS to share images with outside providers.

Stage 2 NPRM

Improve quality safety, efficiency and reducing health disparities

Policy Priority

N/A

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

Objective: Record patient family health history as structured data

Menu Measure: More than 20% 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 or an indication that family health history has been reviewed

HITPC Comments

Agree with this measure as a menu item.

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

EP: Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of unique visits during the reporting period (non-searchable, scanned notes do not qualify)

EH: Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of eligible hospital days (non-searchable, scanned notes do not qualify)

Stage 2 NPRM

Objective not included – asked for comment Objective/Measure: Record electronic notes in patient records for more than 30 percent of office visits. While we believe that medical evaluation entries by providers are an important component of patient records that can provide information not otherwise captured within standardized fields, we believe there is evidence to suggest that electronic notes are already widely used by providers of Certified EHR Technology and therefore do not need to be included as a meaningful use objective.

HITPC Comments

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, as originally recommended by HITPC:

EP: Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of unique visits during the reporting period. Notes should be text-searchable (non-searchable, scanned notes do not qualify).

EH: Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of eligible hospital days. Notes should be text-searchable (non-searchable, scanned notes do not qualify).

Policy Priority

Improve quality safety, efficiency and reducing health disparities

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic lab orders received.

* HITSC: Use LOINC where available

Stage 2 NPRM

Objective not included – asked for comment

Hospital Objective: Provide structured electronic lab results to eligible professionals. Hospital Measure: Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 40 percent of electronic lab orders received.

HITPC Comments

We reconfirm our initial recommendation for hospitals to send structured lab results electronically to ambulatory providers using certified electronic health record technology:

Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic lab orders received. LOINC should be used where available.

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

EP: Provide more than 50% of all patients with an electronic copy of their health information upon request

Stage 2 - Proposed by HITPC

Combined with other objectives

Stage 2 NPRM

Replaced

HITPC Comments

Agree.

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

EH: Provide more than 50% of all patients with an electronic copy of their discharge instructions at the time of discharge upon request

Stage 2 - Proposed by HITPC

Combined with other objectives

Stage 2 NPRM

Replaced

HITPC Comments

Agree.

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

Provide more than 10% of all unique patients timely electronic access to their health information subject to the EP's discretion to withhold certain information

Stage 2 - Proposed by HITPC

EP: More than 10% of patients and families view and have the ability to download their longitudinal health information; information is available to all patients within 24 hours of an encounter (or within 4 days after the information is available to EPs)

EH: More than 10% of patients and families view and have the ability to download information about a hospital admission; information is made available within 36 hours of the encounter

Stage 2 NPRM

Replaced

HITPC Comments

Agree.

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

N/A

Stage 2 NPRM

EP Objective: Provide patients the ability to view online, download, and transmit 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 10 % 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

EH Objective: Provide patients the ability to view online and download information about a hospital admission

EH Measure: 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 10 percent of all patients 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**

HITPC Comments

- We appreciate and agree with the intent to keep the timeliness criterion simple (ie, have only 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."
- Denominator: All active patients seen within the last 2 years, less those in the adolescent category (will vary for provider due to individual state laws)
- Numerator: Number of patients or proxies (e.g. parent, child) that have logged in at any time prior to attestation. The threshold would be 10% or greater. Exclusion allowed for low broadband access (according to FCC) and special hardship cases (e.g. Amish). Information of that record is viewed, downloaded, transmitted in a way that is successful to the patient (transmit can include transmission from one provider to patient's personal record or another provider if the patient chooses).

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

EP: Provide clinical summaries for more than 50% of all office visits within 3 business days

Stage 2 - Proposed by HITPC

Provide clinical summaries to patients for more than 50% of all office visits within 24 hours; pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs; (electronically accessible for viewing counts)

Stage 2 NPRM

EP Objective: Provide clinical summaries for patients for each office visit

Measure: Clinical summaries provided to patients within 24 hours for more than 50 % of office visits.

HITPC Comments

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.

To be consistent with the view/download/transmit objective, we recommend that a single timeline of 2 business days be applied to this objective as well

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

MENU: Use certified EHR technology to identify patient-specific educational resources for more than 10% of all unique patients and provide those resources to the patient if appropriate

Stage 2 - Proposed by HITPC

Use certified EHR technology to identify patient-specific educational resources and provide those to the more than 10% of all unique patients

Stage 2 NPRM

EP/EH Objective: Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient

EP Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all office visits by the EP.

EH Measure: More than 10% 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

HITPC Comments

Agree.

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

Offer secure online messaging to patients: at least 25 patients

Stage 2 NPRM

Objective: Use secure electronic messaging to communicate with patients on relevant health information

Measure: A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 % of unique patients seen during the EHR reporting period

HITPC Comments

- We are concerned that 10% is 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.
- Exclusion allowed for low broadband access (according to FCC) and special hardship cases (e.g. Amish).

Policy Priority

Engage patients and families in their care health disparities

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

Record patient preferences for communication medium for more than 20% of all unique patients seen during the reporting period

Stage 2 NPRM

Objective not included – asked for comment

EP Objective/Measure: Record patient preferences for communication medium for more than 20 % of all unique patients seen during the EHR reporting period. We believe that this requirement is better incorporated with other objectives that require patient communication and is not necessary as a standalone objective.

HITPC Comments

We recommend inclusion of this objective as a Core measure. 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).

Policy Priority

Improve Care Coordination

Stage 1 Final Rule

Perform at least one test of the capability to exchange key clinical information

Stage 2 - Proposed by HITPC

HIE test eliminated in favor of actual use case objectives

Stage 2 NPRM

Removed for an actual use case

HITPC Comments

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).

Policy Priority

Improve Care Coordination

Stage 1 Final Rule

MENU: Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH

Stage 2 - Proposed by HITPC

Move to core.

Stage 2 NPRM

EP Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

EP Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% 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)

EH Objective: The 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 medication reconciliation

EH Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% 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)

HITPC Comments

Maintain the 50% threshold to eliminate the need to define exclusions. Will need to define certification criteria to allow provider to indicate that a transition is about to occur or has occurred.

Policy Priority

Improve Care Coordination

Stage 1 Final Rule

MENU: Provide a summary of care record for more than 50% of all transitions and referrals of care

Stage 2 - Proposed by HITPC

1. Record and provide (by paper or electronically) a summary of care record for more than 50% of transitions of care for the referring EP or EH
2. Record care plan goals and patient instructions in the care plan for more than 10% of all active patients

Stage 2 NPRM

EP Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

EH Objective: The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

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 65 % 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 electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 % of transitions of care and referrals.

HITPC Comments

- In order to facilitate timely and meaningful referrals, we recommend that the care plan section of the summary of care document include the reason(s) for referral or transition and the results of the referral (recommendations).
- In order to support the measure, the provider needs to capture the fact that a transition is about to occur.
- Part 1 of measure:
 - Lower threshold to 50% of transitions or referrals provided a summary of care record
- Part 2 of measure:
 - Recommend removing the cross-vendor requirement. While it is essential that the exchange of information comply with prescribed standards, 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.
- Query should count in the numerator but the credit needs to go to the provider whose system is being queried, not to the provider who initiated the query. This would only apply to "planned transitions".

Policy Priority

Improve Care Coordination

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

Record health care team members (including at a minimum PCP, if available) for more than 10% of all patients seen during the reporting period; this information can be unstructured

Stage 2 NPRM

Objective not included – asked for comment

Objective/Measure: Record health care team members (including at a minimum PCP, if available) for more than 10 percent of all patients seen during the reporting period; this information can be unstructured. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.

HITPC Comments

Okay to leave as part of the summary of care document.

Policy Priority

Improve Care Coordination

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

EP: Send a care summary (including care plan and care team if available) electronically to the receiving provider for at least 25 patients undergoing a transition of care

EH: Send a care summary (including care plan and care team if available) electronically to the receiving provider or post-acute care facility for more than 10% of all discharges

Stage 2 NPRM

Objective not included – asked for comment

Objective/Measure: Record care plan goals and patient instructions in the care plan for more than 10 percent of patients seen during the reporting period. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.

HITPC Comments

Okay to leave as part of the summary of care document.

Policy Priority

Improve population and public health

Stage 1 Final Rule

MENU: Perform at least one test of the capability to submit electronic data to immunization registries or Immunization Information systems and actual submission in accordance with applicable law and practice

Stage 2 - Proposed by HITPC

Attest to at least one submission of data in accordance with applicable law and practice

Stage 2 NPRM

Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice

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

HITPC Comments

- 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., temptation to pass new laws prohibiting transfer to avoid penalizing local health providers).

Policy Priority

Improve population and public health

Stage 1 Final Rule

Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies and actual submission in accordance with applicable law and practice

Stage 2 - Proposed by HITPC

EH: Attest to submitting to at least one organization in accordance with applicable law and practice

Stage 2 NPRM

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 as authorized, and in accordance with applicable State law and practice.

HITPC Comments

- 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., temptation to pass new laws prohibiting transfer to avoid penalizing local health providers).
- Need to define "successful ongoing submission"

Policy Priority

Improve population and public health

Stage 1 Final Rule

Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice

Stage 2 - Proposed by HITPC

Attest to at least one submission in accordance with applicable law and practice

Stage 2 NPRM

Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice

EP Menu Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period

Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice

EH CORE Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period

HITPC Comments

- 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., temptation to pass new laws prohibiting transfer to avoid penalizing local health providers).
- Need to define "successful ongoing submission"

Policy Priority

Improve population and public health

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

N/A

Stage 2 NPRM

EP Objective: Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.

EP Menu Measure: Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period

HITPC Comments

- Recommend consolidating two registry objectives (cancer and specialty registry) into **one menu objective**.
- Examples **from CDC/NCI funded registries:**
 - 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.

Policy Priority

Improve population and public health

Stage 1 Final Rule

N/A

Stage 2 - Proposed by HITPC

N/A

Stage 2 NPRM

EP 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 Menu Measure: Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period

HITPC Comments

Recommend consolidating two registry objectives (cancer and specialty registry) into **one menu objective**.

Policy Priority

Privacy and security protections for personal

Stage 1 Final Rule

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

Stage 2 - Proposed by HITPC

1. Perform, or update, security risk assessment and address deficiencies
2. Address encryption of data at rest

Stage 2 NPRM

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

HITPC Comments

The adoption of this Policy Committee recommendation provides some of the policies, technical capabilities and controls necessary for ensuring the privacy and security of patient health information, and **we urge both CMS and ONC to retain them in the final rule**

Clinical Quality Measure Comments

Quality Measures

Continue to develop outcome measures that represent Quality Measure WG supported concepts

After comparing the 2011 QMWG recommendations to the 2012 NPRM EP and EH measure sets, the workgroup reports the following:

- All 5 original domains have at least one concept that is fully represented (an NPRM measure closely extends the intention of the recommended concept) in a Stage 2 NPRM measure.
- All domains also have both a fully represented and at least one partially represented concept in a Stage 2 NPRM measure.
- The NPRM reflects efforts to drive innovation in e-measurement. For three domains, Population/Public Health, Care Coordination, Patient Safety, the Stage 2 NPRM includes measures that the WG suggested for Stage 3 MU (such as Longitudinal Improvement in Blood Pressure).
- The Clinical Appropriateness and Population and Public Health domains have the complete coverage and also contain a plurality of the NPRM measures that represent 2011 WG concepts.
- **Care Coordination is the domain at greatest risk. Of the 5 Care Coordination measure concepts that the WG recommended, only one is fully represented and one is partially represented. The sub-domain Effective Care Planning has no measure representation in Stage 2 NPRM.**

Falls risk screening - encourage broad measurement of falls risk that captures risk across care settings

- **There is no proposed inpatient eCQM that addresses fall risk, but hospitalized patients and recently discharged patients are at especially high risk for falls.**
- Consider an inpatient measure for fall risk in future versions of the incentive program.
- The WG appreciates such a measure may be out of scope for planned validity/feasibility testing in time for MU2 FR.

Medication Reconciliation - wider age band , NQF 0097

- **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 reconsolidation is such an important issue, for quality of care and patient safety, that the practice should be measured across settings and age bands.**

ADE Prevention & Monitoring – clarify the type of medication and monitoring tracked by this measure

- The QMWG recommends warfarin as the measured drug and INR as the monitored test.
- The QMWG recommends an outcome measure to monitor ADEs.
- The measure description is currently vague in its description of what drug will be the measure target and which tests results should be monitored.

Potent ART for HIV/AIDS, NQF 407 - Minimize the influence of "check box" compliance

- This measure accepts the presence of HAART on a provider attestation that a patient on HAART or has a plan or care.

The eCQM set should emphasize patient experience

- The QMWG reaffirms its recommendation that MU eCQMs quantify patient experience and recommend CMS consider CAHPS measures or a similar measure set that broadly captures and describes patient experience and satisfaction.
- The QMWG supports CMS efforts to use The MU CQMs to drive development of valid, EHR-enabled patient reported measures.

Continue to align CQMs across quality improvement programs

- To encourage provider adoption, reduce administrative burden and support focused improvement, CMS should continue to align measures across its suite of measurement and payment programs. MU 1 was challenging for small practices. CMS should appreciate the extent to which increasing requirements can be barriers for MU2.

Incentivize MU eligible providers to exchange information with non-MU eligible providers, such as SNFs, HHAs and behavioral health

- The QMWG recommends that CMS select quality measures with existing or potential future relevance to providers and facilities across a wide range of care and settings, even those that are outside of scope for the EHR Incentive Payment Program. (for example falls measure, medication reconciliation measures, and other care coordination and patient engagement measures)
- This would encourage EHR Incentive Program participation among behavioral health providers and long term facilities that report to other CMS quality improvement programs.

Release communication to signal MU Stage 3 intentions

- CMS should consider an interim publication, following the FR of Stage 2 MU and preceding the Stage 3 MU NPRM. CMS should also consider advancing the release date for Stage 3 MU NPRM to allow vendors more time to develop the appropriate functionality and allow providers time to adjust applicable clinical workflows.
- To the extent that such a timetable switch is infeasible, the WG encourages CMS to send clear, strong signals through the Stage 2 MU FR this fall. Although the committee recognizes that CMS cannot make Stage 3 final decisions without experience from implementation of Stage 2, a clear signal of intentions would be very helpful to make vendor and provider implementation more feasible. Furthermore, the availability of measures to satisfy reporting domains remains weak and will need substantial attention for Stage 3. Data elements and data types needed for Stage 3 should be captured by Stage 2 certification.

Advance the timetable for the release of future MU NPRMs

- An earlier release of future NPRMs or future informational letters will allow additional software design and development time for vendors and workflow planning time for providers.

Continue to use MU to advance innovation in EHR based quality measurement

- Accelerate the design, development and testing of eCQMs that take advantage of functional capabilities of EHR captured data that were previously unavailable or unfeasible via abstracted and claims-based quality measurement.

Use MU to test novel measures

- The QMWG supports the release of "pilot" eCQMs to allow testing of EHR-enabled measurement on a national scale in a broad range of vendor platforms.

Use MU as a forum to demonstrate local, operational, practice-level EHR-based eCQMs.

- The QMWG recognizes that IDNs, ACOs, and other provider networks have developed, tested and deployed unique eCQMs that measure and enhance quality care for diverse patient populations across the nation.
- The QMWG also recognized that these practice-level eCQMs are often not vetted by national quality endorers.
- The QMWG encourages CMS to use MU as a forum to focus national attention on practice-level innovation in eCQM deployment.

Comments Solicited in NPRM

General Comment Topic

Group Reporting

Stage 2 NPRM Language

We seek public comment on a group reporting option that allows groups an additional reporting option in which groups report for their EPs a whole rather than broken out by individual EP. What should the definition of a group be for the exercise of group reporting? For example, under the PQRS Group Reporting Option, a group is defined as a physician group practice, as defined by a single Tax Payer Identification Number, with 25 or more individual eligible professionals who have reassigned their billing rights to the TIN. We could adopt this definition or an alternative definition. FR 13766

Comments

- In 2011 the HITPC recommended that a group reporting option allow provider groups to report for their EPs as a whole rather than being partitioned by individual EP. Group reporting meets CMS's goal of reducing both the administrative burden of reporting and encouraging high quality, team-based care.
- Whereas multi-fold variations in care quality and utilization persist in American medicine, the QMWG supports finding more efficient batch reporting options that do not obscure variability within the group.
- The QMWG has concerns that the group reporting option, as described in the NPRM, may allow "groups" of doctors that only share a tax ID to report together without having coherent practice with care coordination. The WG suggests making the financial incentive align for "natural" groups like ACOs, but make the financial incentives stronger for "artificial" groups (e.g., multi-specialty group sharing a tax ID, but not exchanging data or providing care coordination) to report individually rather than as a group.

Comment Topic

EP Reporting Options

Stage 2 NPRM Language

We are proposing two reporting options that would begin in CY 2014 for Medicare and Medicaid EPs, as described below:

Options 1 and 2. For Options 1, we are proposing the following two alternatives, but intend to finalize only a single method:

- Option 1a: EPs would report 12 clinical quality measures from those listed in Table 8, including at least 1 measure from each of the 6 domains.
- Option 1b: EPs would report 11 "core" clinical quality measures listed in Table 6 plus 1 "menu" clinical quality measure from Table 8. FR 13745

Comments

- Select 1a as the process for individual EP reporting
- Allow individual EPs to report 6 measures via option 1a instead of requiring 12.
 - The QMWG recognizes that many providers will confront a significant challenge when choosing a dozen measures that are relevant to their field of practice from the 6 domains.
 - The QMWG also appreciates that the number of measures in the final rule may be reduced from the 125 proposed.
 - We are confident that internists, family medicine physicians and geriatricians will find a variety of relevant measures to their practice but many other specialists/subspecialists will have a greater challenge
- Proposed alternative

Health IT Policy Committee (HITPC) Comments on Stage 2 CMS EHR Incentive Program NPRM

- CMS and ONC could require EPs and EHs to submit 5 measures, one for each measurement domain identified by the QM workgroup last year and included in the proposed rule. If there are existing measures that are relevant and useful to providers, they may submit them. If not, EPs and EHs, may work with their professional societies and trade associations, other measure developers, EHR vendors, community measurement projects or some combination of the above, to develop and test measures in each of the 5 areas, using the federally funded NQF Quality Data Model and Measure Authoring Tool.¹ Measures developed would need to meet criteria outlined below, which were established by the QM workgroup and accepted by the HITPC.
- NQF, through a special 'preliminary review' committee (which could potentially be the new fast-track measure development feedback process they are instituting), could provide provisional approval for MU that would include methodological monitoring and feedback that guides the testing entity down a path toward eventual endorsement. The standardization and parsimony necessary for meaningful, sustainable reporting will be achieved through the current endorsement process, which evaluates and prioritizes competing measures.
- This approach provides an opportunity for a more rapid, iterative measure development process without sacrificing the robustness necessary for reliable and valid quality metrics for use in reporting and payment programs. In addition, it provides a tremendous opportunity for achieving greater buy-in for and relevance of quality metrics to a wide array of providers – primary care and specialist; large, teaching hospital and CAH, and even for disciplines other than physicians, such as nursing, physical therapy, and nutrition. CMS and ONC should leverage this opportunity to engage all members of the quality measurement enterprise in the measure development process to advance the use of critical technical capabilities that are not incentivized by the proposed measure sets.

General Comment Topic

Core and Menu

Stage 2 NPRM Language

We are proposing a total of 17 core objectives and 5 menu objectives for EPs. We propose that an EP must meet the criteria or an exclusion for all of the core objectives and the criteria for 3 of the 5 menu objectives. This is a change from our current Stage 1 policy where an EP could reduce by the number of exclusions applicable to the EP the number of menu set objectives that the EP would otherwise need to meet. We received feedback on Stage 1 that we have received from providers and health care associations leads us to believe that most EPs had difficulty understanding the concept of deferral of a menu objective in Stage 1, so we are proposing this change for Stage 2, as well as for Stage 1 beginning in 2014, to make the selection of menu objectives easier for EPs. We are proposing this change because we are concerned that under the current Stage 1 requirements EPs could select and exclude menu objectives when there are other menu objectives they can legitimately meet, thereby making it easier for them to demonstrate meaningful use than EPs who attempt to legitimately meet the full complement of menu objectives.

Comments

Strong support for this new approach.

General Comment Topic

Stage 2 Core and Menu Objectives

Stage 2 NPRM Language

In the Stage 1 final rule we outlined Stage 1 criteria, we finalized a separate set of core objectives and menu objectives for both EPs and eligible hospitals and CAHs. EPs and hospitals must meet or qualify for an exclusion to all of the core objectives and 5 out of the 10 menu measures in order to qualify for an EHR incentive payment. In this proposed rule, we propose to maintain the same core-menu structure for the program for Stage 2. We propose that EPs must meet or qualify for an exclusion to 17 core objectives and 3 of 5 menu objectives. We propose that eligible hospitals and CAHs must meet or qualify for an exclusion to 16 core objectives and 2 of 4 menu objectives. FR 13700

Comments

We agree with use of the menu approach to provide:

1. Flexibility
2. Strong signals with lead time to develop/implement new functionality
3. Accommodation for all-or-nothing qualification rule

General Comment Topic

CPOE - licensed healthcare professionals

Stage 2 NPRM Language

With this new proposal, we invite public comment on whether the stipulation that the CPOE function be used only by licensed healthcare professionals remains necessary or if CPOE can be expanded to include non licensed healthcare professionals such as scribes. FR13709

Comments

The essential feature is that the EP or EH professional be able to view and act upon the automated decision support and be accountable for the order. See comments under CPOE.

General Comment Topic

eRx - OTC meds

Stage 2 NPRM Language

We do not believe that OTC medicines will be routinely electronically prescribed and propose to continue to exclude them from the definition of a prescription. However, we encourage public comment on this assumption FR 13710

Comments

We believe it is important for EHRs to be able to capture OTC medicines (without transmitting to pharmacy) and to ensure that these medicines can be used to detect drug-drug interactions. We agree, however, that for measurement purposes, OTCs can continue to be excluded from the denominator

General Comment Topic

Demographics - disability status

Stage 2 NPRM Language

We encourage public comment on the burden and ability of including disability status for patients as part of the data collection for this objective. We believe that the recording of disability status for certain patients can improve care coordination, and so we are considering making the recording of disability status an option for providers. We seek comment on the burden incorporating such an option would impose on EHR vendors, as well as the burden that collection of this data might impose on EPs, eligible hospitals, and CAHs. FR 13712

Comments

Important signal to send for Stage 3, but data standards do not exist yet. The ACS questions on disability status from the National Health Interview Survey (NHIS) is a logical starting point for collecting demographic information about people with disabilities, since these questions have been widely tested and are in use in multiple government surveys. The ACS questions were also adopted as the data standard for disability status in the HHS/OMH survey standards.

General Comment Topic

Summary of Care Record - Care Plan

Stage 2 NPRM Language

For purposes of meaningful use measurement we propose that a care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome). We encourage EPs to develop the most robust care plan that is warranted by the situation. We also welcome comments on both our description of a care plan and whether a description is necessary for purpose of meaningful use. FR 13716

Comments

Although the information content in the summary of care document (intended for providers) may overlap with the content in clinical summaries (intended for patients), the way the information is expressed in the patient-facing document should be understandable to patients. We note that “relevant past diagnoses” requires a precise definition and would require human intervention to implement.

General Comment Topic

Public Health - Syndromic Surveillance Menu item

Stage 2 NPRM Language

We specifically invite comment on the proposal to leave syndromic surveillance in the menu set for EPs, while requiring it in the core set for eligible hospitals and CAHs. FR 13726

Comments

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.

General/Other Comments

We are pleased that the NPRMs address many of the Committee's previous privacy and security recommendations

- With respect to the proposed Stage 2 meaningful use objectives, CMS proposes to require providers to perform a security risk assessment (the same criterion currently included for Stage 1). CMS also proposes to require providers to specifically attest to addressing encryption of data at rest in Stage 2.
- With respect to new proposed certification criteria, ONC proposes that Certified EHR Technology have the capability to make amendments to a patient's health data and be able to append information from the patient and any rebuttal from the entity regarding the data. These criteria will help support providers' compliance with the HIPAA Privacy Rule.
- ONC also proposes that Certified EHR Technology include a patient accessible log to track the use of the view, download, and transmit capabilities for Stage 2 MU Certified EHR Technology certification.
- **The adoption of these Policy Committee recommendations provides some of the policies, technical capabilities and controls necessary for ensuring the privacy and security of patient health information, and we urge both CMS and ONC to retain them in the final rule**

Patient Portals (View, Download, Transmit)

- The HITPC previously recommended that providers should require at least single factor authentication for patients using view, download, and transmit functionalities. We recognize that the HIPAA Security Rule already addresses technical safeguards requiring person or entity authentication, and requires covered entities to verify that a person or organizations seeking access to PHI is the one claimed. However, we noted that there is some inconsistency in how authentication is described in ONC's NPRM, which may be misleading to providers. For example, the proposed rule states that Certified EHR Technology must authenticate users for secure messaging; however, there is no comparable authentication requirement for patient access to view, download, and transmit.
 - **To ensure that providers understand the need to authenticate patients, we recommend that ONC clarify in the NPRM preamble that the term "user" includes patients using the view, download, and transmit capabilities.**
- The HITPC also recommended that EHRs be certified to ensure information can be securely downloaded from patient portals, either to the patient or to a third party at the patient's request. This recommendation was not adopted in ONC's NPRM.
- Because the HIPAA Security Rule does require physical, technical and administrative safeguards for portals, it is important for providers to understand how these providers can meet these legal obligations with respect to the portals.

- **We recommend that the HHS Office for Civil Rights, which oversees and enforces the HIPAA Security Rule, provide guidance to providers on application of the Security Rule to the portal. We also recommend that ONC provide technical guidance to providers who will be purchasing Certified EHR Technology that will include this functionality.**
- The HITPC also recommended that certification of portal functionalities include requirements for data provenance. We note that the NPRM states that the adoption of the Consolidated CDA addresses the need for data provenance, which is accessible to the user, as recommended by the Committee. However, we are concerned that the rule might not be sufficiently clear that data provenance information is to be visible to the patient. Thus, **we agree with this approach, provided that ONC include in the final rule clarification that the data provenance information must be visible to the patient in human-readable form.**
- While briefly mentioned in CMS’s NPRM for Stage 2 MU, we also want to underscore the Committee’s previous recommendations with respect to providing guidance (as opposed to certification criterion) for providers, vendors, and software developments on being transparent with patients about the potential risks associated with patient portals when using the view, download and transmit capabilities. **We encourage ONC to more formally endorse these best practices and to provide clear guidance to providers.** As patient portals are expected to be in more robust use by 2014, we strongly encourage ONC to develop and implement a dissemination strategy for this guidance, such as through the Regional Extension Centers.

ⁱThe Quality Data Model (QDM)

The QDM is an “information model” that clearly defines concepts used in quality measures and clinical care, and is intended to enable automation of structured data capture in EHRs, PHRs, and other clinical applications. It provides a way to describe clinical concepts in a standardized format so individuals (i.e., providers, researchers, measure developers) monitoring clinical performance and outcomes can clearly and concisely communicate necessary information. The QDM describes information so that EHR and other clinical electronic system vendors can uniformly express, consistently interpret, and easily locate the data required.

The QDM provides the potential for more precisely defined, universally adopted electronic quality measures to automate measurement and compare and improve quality using electronic health information. Use of the QDM will enable more standardized, less burdensome quality measurement and reporting and more consistent use and communication of EHRs for direct patient care. In addition to enabling comparisons across performance measures, the QDM can promote delivery of more appropriate, consistent, and evidence-based care through clinical decision support applications.

Measure Authoring Tool (MAT)

The MAT is a standardized tool that allows measure developers to more easily create eMeasures. Built upon the language created with the QDM, the MAT acts as a usable graphic interface, allowing measure developers to more efficiently and consistently create standardized eMeasures that are compatible with or readable by EHR systems and other clinical IT systems. The MAT should significantly reduce the time required to create new quality eMeasures and convert existing paper based measures to EHR-readable format.