

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: CPOE

Stage 1 Measure:

Use CPOE for 30% of medication orders

Exclusions:

Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure.

Proposed Stage 2:

CPOE (by licensed professional) for at least 1 medication, and 1 lab or radiology order for **60%** of unique patients who have at least 1 such order (order does not have to be transmitted electronically)

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	Yes, with exception	No, but likely exempt based on definition of outpatient prescriptions Most anesthesiologists who provide surgical anesthesia do not write prescriptions so they would be exempt. Those who do, generally are writing controlled substances for the control of post-op pain, which should not be included. Anesthesiologists instead carry out their own orders for medications in the OR which could be captured in AIMS. Orders elsewhere in the hospital could be done through the hospital's EHR. Recommendation: Allow documentation of medications administered in the perioperative setting to count toward both hospital and EP MU. For example, > 30% of patients have medications delivered in the OR documented in an AIMS.		
Cataract and Refractive Surgery Specialty			Yes	Recommend clarification. This order entry must show lab and/or radiology in addition to medication, in 60% of UNIQUE patients. Cataract and refractive surgeons do not do a lot of lab and radiology testing
Chest Physicians	Yes, but potential barriers	Chest physicians often practice in both inpatient (hospital) and outpatient (ambulatory) settings. Denominator could penalize physicians that order/prescribe in an institution that does not have CPOE or eRX even though the parishioners own practice may (and vice versa).	Yes, but potential barriers	Applicability same as Stage 1: Chest physicians often practice in both inpatient (hospital) and outpatient (ambulatory) settings. Denominator could penalize physicians that order/prescribe in an institution that does not have CPOE or eRX even though the parishioners own practice may (and vice versa).
Home Care Physicians	Limited to those who take capable EMR with them		Limited to those who take capable EMR with them	
Neuro Surgery				Maybe. Stage II percentage could be too high. Also, percentage may be hard to obtain if supporting staff cannot assist; need clarification on who can enter the order – does it have to be MD or can it be supporting staff licensed to prescribe for Stage 2?
OB-GYN	N/A	Estimate 12 Medicare prescriptions/mo, so less than 40 over 3 month reporting period.	N/A	
Ophthalmology	Yes	Yes. Most ophthalmologists prescribe medications, and those who don't normally prescribe will utilize the exclusion	Yes	No. Ophthalmologists do not routinely order laboratory or radiology orders for their patients. CPOE in ophthalmology could be better utilized to improve the ordering of diagnostic tests and imaging in the office (e.g., visual field studies, optical coherence tomography, fundus photos, etc.). This is an extremely important part of day-to-day ophthalmology workflow, but it is not covered in the definition of CPOE for Stage 2.

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Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: CPOE

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Otolaryngology			Yes	The threshold for Stage 2 is too high since it expands to labs and x-rays and the physician must order the test. It is not reasonable for physicians to have to collect all the information at the point of care. Medication orders are very different from other non-medication orders. Maintaining this proposal will decrease physician efficiency. Properly trained staff working within established policies and procedures, within a physician offices support structure should be able to build and submit an order in advance of the provider's review and signature. At the current time, there is little if any ability for most physicians to exchange lab and other information with others electronically. While this capability is expected in the future, it does not widely exist today and could take years before most physicians have the ability to engage in this type of data exchange. The Academy recommends either removing the lab and radiology requirements for Stage 2, or decreasing the proposed threshold for medication orders but only requiring that one lab and one radiology order have been entered electronically.
Orthopaedic Surgeons			For some will be very difficult to meet.	The requirement of 60% of patients with medication orders done by CPOE can be challenging in the face of restrictions placed on physicians and EMR companies by the DEA. The majority of prescriptions written by orthopaedic surgeons are for controlled pain medications. There are no EHR/e-prescribing systems presently available in the United States that meet the strict standards of the DEA with regards to electronically prescribing these medications. In fact, AAOS has learned that several large organizations, such as Kaiser Permanente, have had to revert back to paper prescriptions for these medications due to the new DEA requirements. The standard has to reflect intent, and also what is possible, a delicate balance. AAOS recommends the standard read "60% of all patients receiving a prescription that can be done electronically based on present rules and system availability."
Pathologists		No. Written from ordering MD's not receiving MD's perspective.		No. Written from ordering MD's not receiving MD's perspective.
Radiation Oncology		There is ability to write orders such as medication prescriptions and there is ability write lab/diagnostic orders as well but not an efficient system. There is currently no ability to write orders such as referrals.		There is ability to write orders such as medication prescriptions on Varian's ARIA. There is ability write lab/diagnostic orders as well but not an efficient system. There is currently no ability to write orders such as referrals
Radiology	Yes w3ith exemption	No, but most diagnostic radiologists will likely be excluded because of the definition of "prescription." A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded	Yes if exemption included	Not applicable. Radiologists receive orders from referring physicians
Surgeons				Yes. While surgeons support the use of CPOE, we seek clarification on the denominator of this objective. If an EP is using an EHR without this functionality, he/she can not meet this threshold of 60%. Additionally, most EHRs do not integrate CPOE and clinical decision support (CDS) together, which would provide value for electronic orders. Without this integrated functionality, we questions how will safety and efficiency be meaningfully achieved with this requirement.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Drug-drug and drug-allergy checks

Stage 1 Measure:

The EP has enabled this functionality for the entire EHR reporting period;

Exclusions:

None

Proposed Stage 2:

Employ drug-drug interaction checking and drug allergy checking on appropriate evidence-based interactions

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	Applicable, but would require changes to NIST drug-drug testing script. Some systems have drug-allergy checks as well as contaminated/use syringe and expired drug checks. Since clinical anesthesiologists don't usually "order" drugs prior to administration, drug-allergy checks will need to work differently than for most other physicians and clinical situations. More important, however, is the fact that there is currently no drug-drug interaction script available to accommodate drugs administered in the OR. Recommendation: Exempt anesthesiologists and AIMS from drug interaction checks until specific changes, such as the creation of an NIST drug-drug testing script, are made and commercial systems can incorporate these capabilities		
Home Care Physicians	Limited to those with capable EMR		Limited to those with capable EMR and potentially to access in community.	
Ophthalmology			Unsure	Maybe. The workgroup has not yet specified reporting requirements for use of the drug-drug and drug-allergy feature. It is difficult to determine if ophthalmologists can meet the Stage 2 requirement without more clarity on the specific measure. It is unclear if some objectives will be relevant to eye conditions and diseases. If the objectives are defined to include eye conditions and diseases, than ophthalmologists will be able to meet the requirements.
Otolaryngology	Yes		Yes, but potential barriers	
Psychiatry.				Applicable, but "appropriate evidence-based interactions" needs clarification
Radiation Oncology		Yes, but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.		Yes, but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.
Radiology	Maybe, pending situation and technical capabilities	Not fully applicable in the manner described in the regulations. Radiologists generally don't have access to an accurate patient medication list. This is possible with integration with a HIE. Checking for drug-drug interactions for medications not prescribed by the radiologist is outside the scope of practice of radiology. Radiologist should only be responsible for checking for allergies to drugs and contrast they administer and checking the patient history for medications known to interact with contrast or other medications prescribed by the radiologist.	Maybe, pending situation and technical capabilities	Not fully applicable in the manner described in the regulations. Radiologists generally don't have access to an accurate patient medication list. This is possible with integration with a HIE. Checking for drug-drug interactions for medications not prescribed by the radiologist is outside the scope of practice of radiology. Radiologist should only be responsible for checking for allergies to drugs and contrast they administer and checking the patient history for medications known to interact with contrast or other medications prescribed by the radiologist.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: Drug-drug and drug-allergy checks

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Surgeons				Yes. While surgeons support the enabling of automated drug-drug and drug-allergy checks; however, given the large volume of alerts that could result from the many potential drug-drug interactions, we suggest that this measure be clarified to specifically allow EHR adjustment of levels of risk of drug-drug interactions (rather than a simple “on-off” switch as seems to be assumed by the proposed measure for this criterion). Even EHRs that are set at the highest levels could still lead to “alert fatigue,” which could potentially cause physicians to miss some of the most relevant warnings.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: e-Prescribing

Stage 1 Measure:

More than 40 % of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
(Note: only non-controlled substances are permissible)

Exclusions:

Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

50% of orders (outpatient and hospital discharge) transmitted as eRx

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	Not Applicable. Outpatient prescriptions are almost never written by anesthesiologists providing surgical anesthesia in the hospital setting, and those that are written are generally for controlled substances. AIMS alone could not provide this function. Therefore, to meet this requirement, anesthesiologists would have to rely on the hospital providing an eRx function (which they are not required to have) or purchase an eRx system that would never be used just to document that they have one. Recommendation: Ensure that the exemption would not require that anesthesiologists purchase an eRx system.		
Chest Physicians	Yes, but potential barriers	Chest physicians often practice in both inpatient (hospital) and outpatient (ambulatory) settings. Denominator could penalize physicians that order/prescribe in an institution that does not have CPOE or eRX even though the parishioners own practice may (and vice versa).	Yes, but potential barriers	Applicability same as Stage 1: Chest physicians often practice in both inpatient (hospital) and outpatient (ambulatory) settings. Denominator could penalize physicians that order/prescribe in an institution that does not have CPOE or eRX even though the parishioners own practice may (and vice versa).
Home Care Physicians	Depends on the access in community and the ability of pharmacy to receive, etc		N/A	No. Not hospital based.
Neuro Surgery				No. Neurosurgeons don't prescribe very often and when they do, over 75% of their prescriptions are for controlled substances, which are currently prohibited from being eRx in many states. Also concern over the fact that nurses/PAs often prescribe for MD.
OB-GYB	N/A	Estimate 12 Medicare prescriptions/mo., so less than 40 over 3 month reporting period.	N/A	
Ophthalmology:		Applicable: Most ophthalmologists prescribe medications, and those who don't normally prescribe will utilize the exclusion.		Yes. Ophthalmologists who don't normally prescribe medications need clarity that the exclusion will still be available in Stage 2.
Otolaryngology			No	Otolaryngologists are concerned that many physicians will be unable to meet this level of e-prescribing. Surgeons typically prescribe medication in diverse settings, (emergency rooms, surgical centers, hospital inpatient and outpatient, etc) since a universally coordinated computer network does not currently exist, it will pose a greater challenge for physicians to meet this requirement in certain settings. An exemption for e-prescribing of controlled substances is needed because while e-prescribing is now permissible under law, the infrastructure to handle this type of electronic prescriptions still does not exist.
Orthopaedic Surgeons			Could be very difficult to meet.	Upon discharge, from outpatient care or in-hospital care, many orthopaedic patients receive a prescription for a controlled pain medication. Orthopaedic surgeons will find it difficult to meet the 50% threshold for e-prescribing as DEA requirements for prescribing controlled pain medications specify a paper prescription.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: e-Prescribing

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Psychiatry	Yes, with caveats	Yes. Exclusion of controlled substances and general category exclusion address prior APA concerns. The fact that it is cumbersome to manage dual systems for controlled and non-controlled prescriptions is a general concern to psychiatry.	Yes, with caveats	Yes, but the eventual goal of an 80% threshold for this measure could conflict with flexibility towards patient preferences for written prescriptions, either due to practical or privacy considerations. Requests for written prescriptions are more abundant in psychiatry than most other specialties. A lower threshold would maintain flexibility while upholding the purpose of this MU measure.
Radiation Oncology		Yes, but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology		Yes, but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.
Radiology	Yes with exemption	No, but most diagnostic radiologists will likely be exempt because of the definition of "prescription." A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.	Yes, with exemption	No. Exclusion needed.
Surgeons				<p>Yes. Surgeons consider the proposed 50% threshold high, especially in the case of surgical specialists who commonly write prescriptions where electronic transmission is not permissible (that is, for controlled substances). This criterion would require such specialists to simultaneously use dual prescribing systems, electronic and non-electronic, for a large proportion of their patients, creating work flow disruptions and possibly confusing affected patients. Additionally, including hospital discharges in the e-prescribing objective is exceedingly premature for hospital based or predominant practice specialists. Very few hospitals are fully engaged with EHR systems and will not run a side-by-side e-prescribing program during the transition to an EHR. Thus, e-prescribing at the time of hospital discharge may be problematic for some physicians because all hospitals may not be able to provide the necessary e-prescribing infrastructure. It is not reasonable to hold a physician responsible for something outside of his/her control.</p> <p>They also suggest this objective include certain exclusions:</p> <ul style="list-style-type: none"> When a pharmacy is unable to accept the prescriptions electronically; When a patient does not want the prescription to be sent electronically; and When it is not be feasible in areas of the country where relatively few pharmacies are prepared to accept prescriptions electronically. <p>Lastly, the current exclusion of any EP who writes fewer than 100 prescriptions during the EHR reporting period should remain for Stage 2 and Stage 3.</p>

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Record demographics

Stage 1 Measure:

More than **50%** of all unique patients seen by the EP have demographics recorded as structured data

Exclusions:

None

Proposed Stage 2:

80% of patients have demographics recorded and can use them to produce stratified quality reports

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists		Yes. AIMS could meet by drawing on a hospital's EHR or be the primary source if captured in a pre-op interview package. Frequently, pre-op nurses enter much of this data during the pre-op evaluation or the data is available in the system and is transferred from the hospital's EHR where it would have been entered by someone other than an anesthesiologist.		
Cataract and Refractive Surgery				The requirement is only that the practice can use this demographic data but it not required to use it for any specific purpose? What is the exact definition of demographics for "meaningful use" purposes?
Home Care Physicians	Limited to those with EHR.		Unclear as to report purpose and outcomes and ability of EHR.	Depends on purpose, outcomes and ability of EHR.
Pathologists	No	No. Pathologists often don't have access to an EHR.		No. Pathologists often don't have access to an EHR.
Radiology			No	Not applicable with the new language regarding stratified quality reports.
Psychiatry			Yes, with caveats	Yes, but "stratified quality reports" needs clarification to ensure that they will be meaningful to psychiatrists.
Surgeons				Yes. Surgeons continue to question the decision to treat this functionality as an integral part of EHR technology since many physician practices now use their administrative systems to record patient demographics. Furthermore, we have concerns with the proposed requirement of physicians to use the recorded demographics to produce stratified quality reports. We seek clarification on the stratified quality reports and the defined demographics. There needs to be standard data definitions before useful quality reports can be produced. Without support to ensure valid data collection, easy mechanisms to produce reports, and a better understanding of how to interpret and use these reports, such stratified quality reports seem burdensome, costly, and producing little useful quality information.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Report ambulatory quality measures to CMS or the States

Stage 1 Measure:

For 2011, provide aggregate numerator and denominator through attestation. For 2012, electronically submit the measures

Exclusions:

None

Proposed Stage 2:

Continue as per Quality Measures Workgroup and CMS

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	Applicable but need to change NIST script to not require capability to report all CQMs within AIMS. Only 1 of the current core and alternative core CQMs is applicable to anesthesia (recording vital signs). Therefore, anesthesiologists EPs would not be able to meet the CQM requirements. Additional measures for the perioperative setting need to be included or CMS should exempt anesthesiologists from inapplicable measures. Recommendation: Select and apply an alternate set of core CQM from those anesthesiology measures currently used in the Physician Quality Reporting System (PQRS).		
Dermatologists	No, only with exclusions	Currently no quality measures are applicable to Dermatology.	Yes, if exceptions included	Yes, but currently no quality measures applicable to Dermatology.
Gastros				Because of the timeframe to identify valid measures, develop and test measures in EHRs, and implement the required clinical workflows that capture necessary information, gastroenterologists advise no additional quality measures in Stage 2, other than those needed to address material deficiencies for specific physician specialties, and that work on additional quality measures be established for Stage 3 so that measures can be implemented efficiently.
Neurology:			Maybe	No quality measures apply to neurology.
Neuro Surgery		No. Core measures could be reported, but are not necessarily relevant to neurosurgery. A change in work flow most likely required; other staff should be able to enter these.		No. Core measures could be reported, but are not necessarily relevant to neurosurgery. A change in work flow most likely required; other staff should be able to enter these.
OB-GYB		The small number of Medicare patients seen by most ob/gyns makes PQRS reporting a large administrative burden.	Continue as per Quality Measures Workgroup and CMS	The small number of Medicare patients seen by most ob/gyns makes PQRS reporting a large administrative burden.
Ophthalmology:				Yes. There are currently 4 eye care measures listed in the Meaningful Use Final Rule; however, there are an additional 5 PQRS eye care measures which apply for different subspecialties. It would be optimal if all current and future PQRS measures were eligible to meet the meaningful use reporting requirement. Inclusion of future measures is particularly important for ophthalmic sub-specialists (e.g. oculoplastics and cornea sub-specialists) who do not routinely examine the retina. Many existing PQRS measures are not relevant to these physicians.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: Report ambulatory quality measures to CMS or the States

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Otolaryngology		There are no otolaryngology specific measures in the EHR incentive program. The Academy has identified measures that otolaryngologists can report on in order to meet the meaningful use requirements, but some of the measures do not enhance the patient diagnosis. Otolaryngologists may be forced to practice asthma management, which is not within all otolaryngologists' typical scope of practice. The specialty will be reporting just for reporting. The Academy has identified the following measures as possibly applicable: - pneumonia vaccination status for older adults	Unclear	It is difficult for the Academy to provide a "yes" or "no" answer for Stage 2 since the Quality Measure workgroup has not stated what the requirements will be. They have only put forward the measure framework. We hope that ONC and CMS continue to allow exclusions or reporting zeros since there is a lack of otolaryngology specific measures in the program and some of the Core quality measures are not applicable to all otolaryngologists.
Psychiatry		<p>Yes. There are a few challenges psychiatry is facing on the quality measures. We have some measures where psychiatry would be included in the denominator but don't really clinically apply to psychiatry (NQF 0421), and others that do apply but the measure specifications exclude psychiatry (NQF 0027). See below for details. Core measures:</p> <p>NQF 0013 (Hypertension): Not really applicable to psychiatry and encounter code list does not include common psychiatric encounters.</p> <p>NQF 0028 (Tobacco screening): Applies to psychiatry and encounter codes include common psychiatric encounters.</p> <p>NQF 0421 (Weight screening): Does not always apply clinically in psychiatry, but does include psychiatric encounter codes.</p> <p>All core measures: Not really applicable to psychiatry and encounter code list does not include common psychiatric encounters.</p> <p>Additional Measures:</p> <p>NQF 0105 (Anti-depressant meds): Applies to psychiatry and encounter codes include common psychiatric encounters.</p> <p>NQF 0027 (Tobacco use and cessation): Applies to psychiatry but encounter codes do NOT include common psychiatric encounters.</p> <p>NQF 0004 (Alcohol use and treatment): Applies to psychiatry and encounter codes include common psychiatric encounters</p>	Questionable.	Depends on proposed measures.
Radiology		Not applicable with the current set of CQMs for Stage 1. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP reports zero denominators.	Yes, pending availability of radiologist CQMs or zero denominator reporting	Depends on whether or not radiologist CQMs are available for use in Stage 2.
Radiation Oncology		Yes, assuming this includes PQRS.		Yes, assuming this includes PQRS.
Surgeons				Additional measures for perioperative care need to be included

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities **REQUIREMENT:** Maintain an up-to-date problem list of current and active diagnoses

Stage 1 Measure:

More than **80%** of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data

Exclusions:

None

Proposed Stage 2:

Continue Stage 1

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists		Yes. System in ASC or office-based setting wouldn't necessarily be linked in a way that would capture all patient data. In the hospital setting, the pre-op evaluation is often the most thorough and reliable in the patient's record and is transferable to the hospital EHR.		
Home Care Physicians	Limited to those withcapable EHR.		Limited to those withcapable EHR.	
Neuro Surgery		Maybe. System must provide accurate list of diagnoses and have an option to check "diagnosis not listed."		Maybe. System must provide accurate list of diagnoses and have an option to check "diagnosis not listed."
Radiology	Maybe, pending availability of data from others	Not typically applicable. Radiologists do not always have access to information about problems identified by other practitioners. Furthermore, many abnormalities identified on imaging studies often are non-specific findings.	Maybe, pending availability of data from others	Not typically applicable. Radiologists do not always have access to information about problems identified by other practitioners. Furthermore, many abnormalities identified on imaging studies often are non-specific findings.
Radiation Oncology:		This is standard part of patient information that can be entered in Radiation Oncology EHR.		This is standard part of patient information that can be entered in Radiation Oncology
Surgeons				Yes. To make this requirement more feasible, a necessary component of all EHRs would be an ICD-9 "translator" to convert common medical terminology used by clinicians into the appropriate ICD-9 codes.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: **Maintain active medication list**

Stage 1 Measure:

More than **80 %** of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data

Exclusions:

None

Proposed Stage 2:

Continue Stage 1

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists		Applicable. Generally captured as part of a pre-op package		
Home Care Physicians	Limited to those with capable EHR.		Limited to those with capable EHR.	
Radiology	Maybe, depending on technical capabilities	Not fully applicable in the manner required in the regulations. "Active medications" are typically outside the scope of practice of Radiology. This measure is only possible if the radiologist's technology is integrated with an HIE or other providers share this in some other way.	Maybe, depending on technical capabilities	Not fully applicable in the manner required in the regulations. "Active medications" are typically outside the scope of practice of Radiology. This measure is only possible if the radiologist's technology is integrated with an HIE or other providers share this in some other way.
Radiation Oncology:		This is standard part of patient information that can be entered in Radiation Oncology EHR		This is standard part of patient information that can be entered in Radiation Oncology HER
Surgeons				Yes. Maintaining active medication lists for non-primary providers will be a significant challenge unless and until health information exchange abilities are available. We seek clarification on what the term "active" means. Additionally, fully updating a medication list is not something that every clinician does each time they see a patient. And performing such comprehensive visits at each and every encounter with a patient in order to capture information to meet EHR measures is inefficient.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Maintain active medication allergy list

Stage 1 Measure:

Maintain active medication allergy list

Exclusions:

None

Proposed Stage 2:

Continue Stage 1

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists		Yes. Generally captured as part of a pre-op package. The anesthesiologists med/allergy list usually ends up being the most reliable and frequently referenced because a physician edits it to an accurate end point.		
Home Care Physicians	Limited to those with capable EHR.		Limited to those with capable EHR.	
Psychiatry		Recording of vital signs is applicable to psychiatry, but psychiatrists have expressed concerns with regard to the exclusion language for this measure in the final rule promulgated by CMS, which applies to EPs who "believe that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice". This definition is too rigid and should be modified to allow for specialists like psychiatry who may take vital signs when clinically relevant, which will not be with every patient at every encounter. Problems with this requirement will be further reduced when HIE allows for easier clinician access to vital measurements taken in other settings.		
Radiology	Yes for contrast media	Yes for contrast media specifically. Radiologists should not be expected to maintain a medication allergy list for medications they do not prescribe.	Yes for contrast media	Yes for contrast media specifically. Radiologists should not be expected to maintain a medication allergy list for medications they do not prescribe.
Surgeons				Yes. Maintaining active medication allergy lists for non-primary providers will be a significant challenge until health information exchange abilities are available. Additionally, we seek clarification on what the term "active" means.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Record vital signs

Stage 1 Measure:

For more than **50%** of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data

Exclusions:

Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

80% of unique patients have vital signs recorded

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists:	Yes, with exemption.	Yes, but only with exception of growth chart* Growth charts have no relevance to anesthesia and perioperative systems do not have capability to capture or create such charts. Could be information included from hospital EHR but shouldn't be a part of anesthesiologists meaningful use. Recommendation: Exempt anesthesiologists and AIMS from requirement to plot growth chart.		
Cataract and Refractive Surgery			Yes, if exemption included.	Collecting this data is not typically relevant to ophthalmic services. Major issue for ophthalmic practices. This data is generally not relevant for cataract and refractive surgeons so still need exclusion here like stage 1. Adds significant cost to our specialty to set up and monitor vital signs. If the measure is applied, cataract and refractive surgeons should be able to use at their own discretion regarding when vital signs should be recorded. Perhaps the measurement criteria should reflect a much lower standard as one way to handle it.
Dermatologists	No, only with exemption.	No. Many dermatologists do not check each patient's vital signs because it is not relevant to the patient's care.	No, only with exemption.	No. Many dermatologists do not check each patient's vital signs because it is not relevant to the patient's care.
Home Care Physicians	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period qualifies for an exclusion from this objective / measure.	Weight measures are not always feasible in home limited and bed bound.	Weight measures are not always feasible in home limited and bed bound	
Neurology			No	No, not within neurology's scope of practice. Need exemption.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: Record vital signs

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Neuro Surgery	Maybe, with exception.	Maybe, with exception, but still unclear how CMS will interpret reporting of exclusion to indicate that recording of vital signs is not within a neurosurgeon's scope of practice	Maybe, if exemption is included	Only can meet if exclusion is preserved; shouldn't be a core measure- even reporting the exclusion is a burden for those to which this measure does not apply.
Ophthalmology:		No. The taking of height, weight and blood pressure is neither routinely taken nor generally relevant for managing a patient's eye diseases and conditions. In Stage 1, ophthalmologists are excluded because of the lack of relevance to their scope of practice.	Maybe	No. Ophthalmologists support exclusions to objectives with no relevance to an ophthalmologist's scope of practice in future stages of meaningful use, and needs clarity around how applicability of the exclusion criteria will be assessed in the future. Continued exclusions are necessary because as described, height, weight and blood pressure are neither routinely taken nor generally relevant for managing a patient's ocular diseases and conditions. However, there are several objectives where A ophthalmologists see opportunities to substitute more relevant measures, e.g. ocular vital signs and CPOE of diagnostic tests and in-office imaging.
Otolaryngology		We believe that recording all vital signs might be appropriate for primary care physicians but may not be applicable to specialists like otolaryngologist – head and neck surgeons. For example, it would not necessarily be relevant for our members to report growth charts, BMI, etc. when unrelated to the presenting problem, especially as these are functions that are primarily performed by primary care physicians. Therefore, to allow specialists to maintain appropriate work flows and our unique requirements for functionality, we recommend that CMS modify this criterion to state, "Record and chart changes in the appropriate vital signs (based on EP's specialty).	No	Otolaryngologists believe the threshold for this requirement is too high. This requires vital signs being recorded for every visit, regardless of a patient diagnosis of hypertension. We are concerned that this requirement will not allow some specialists like otolaryngologists-head and neck surgeons to maintain appropriate work flows and their unique requirements for functionality. The Stage 1 regulations allowed providers to opt-out by reporting "zero denominator" for areas not relevant to their scope of practice or specialty. The Academy continues to agree with that policy. However, we have heard that this may no longer be permitted in Stages 2. Based on the final requirements and how they must be implemented recording vital signs 80% of the time is problematic because it is not needed for every otolaryngology encounter. To allow specialists to maintain appropriate work flows and our unique requirements for functionality, CMS should modify this criterion to state, "Record and chart changes in the appropriate vital signs (based on EP's specialty). Retaining the language as written is simply too prescriptive and in many cases will have no relevance to a physician's scope of practice or the service that they are providing.
Orthopaedic Surgeons	Yes, but significant barriers remain	Many practices do not have a blood pressure cuff and stethoscope readily available in every patient room.	Yes, but significant barriers remain	This criterion requires additional and unnecessary tests for many orthopaedic patients at each appointment. In a high volume orthopaedic practice the additional time to record vital signs impacts patient access to care. This criterion demonstrates the need for specialty specific MU criteria. We recommend the addition of language making this a requirement "when medically appropriate and necessary at the judgment of the treating physician."
Radiology	Yes, with exemption.	Not typically applicable, but most diagnostic radiologists will likely invoke the exclusion. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.	Yes, if exemption included.	Not typically applicable, but most diagnostic radiologists will likely invoke the exclusion. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.
Psychiatry				Same concerns apply unless addressed by CMS.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Record smoking status for patients

Stage 1 Measure:

More than **50 %** of all unique patients 13 years old or older seen by the EP have “smoking status” recorded

Exclusions:

Any EP who sees no patients 13 years or older during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

80% of unique patients have smoking status recorded

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists		Yes. Generally captured as part of a pre-op package. Some practices even document "smoking cessation discussed." Note that "follow up" to smoking cessation discussion as required by the CQM is not possible given the nature of the PT encounter.		
Cataract and Refractive Surgery				Should be limited to those specialties or physicians where collection of this data is appropriate.
Chest Physicians		EHR vendors should provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.		
Home Care Physicians	Limited to those with capable EHR.		Limited to those with capable EHR.	
Neurologys				Helpful to be asking patients, however, might not have time during every sub-specialty visit. This information is usually out of the scope of practice, but it would be reassuring for neurologists to have official acknowledgement of this.
Radiology	Yes, pending accessibility to this data	No, and the exclusion is not helpful; it should be based on scope, not patient age. If a radiologist needs to hunt this data down (i.e., it was not provided by another party), it will only decrease practice efficiency and add no value to the quality of care.	Yes, pending accessibility to this data	No, and the exclusion is not helpful; it should be based on scope, not patient age. If a radiologist needs to hunt this data down (i.e., it was not provided by another party), it will only decrease practice efficiency and add no value to the quality of care.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Implement clinical decision support

Stage 1 Measure:

Implement one clinical decision support rule

Exclusions:

None

Proposed Stage 2:

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

Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists		Yes. An example would be a reminder for pre-op antibiotic administration. Many others possible with guidance from ASA.		
Cataract and Refractive Surgery			Unclear	Development of appropriate clinical support technology and applications should be delegated to the appropriate specialty societies to design and implement as standard of care once credibility has been established. This is a very vague requirement and probably doesn't apply to specialty care situations like ophthalmology in many cases. Will need significant input from specialty societies before it is made a requirement.
Chest Physicians				Likely will incorporate evidence based protocol from STS and other national society driven database outcomes analyses if they can be embedded into EHR care pathways.
Gastros				CDS should be used to improve performance on high-priority health conditions. The Workgroup should consider encouraging CDS use. Gastros are concerned that the regulations go beyond the ability of the EMR vendors. CDS features with an EHR should allow EPs and hospitals flexibility in designing CDS. By allowing them to customize their CDS alerts and advisories, they can create specific and targeted decision support based on criteria specific to their practice. It would be inefficient for an EHR vendor to hard-code CDS rules into the system. Instead, this is an opportunity to identify a framework that allows EPs and hospitals to create their own clinical decision support rules
Home Care Physicians	Limited to those with capable EHR.		Unsure if capability is within current iterations of EHR.	
Neuro Surgery	Unclear			
Neurology				CDS measures consistent with AAN Clinical Guidelines should be implemented.
Ophthalmology:		Ophthalmologists are able to meet the stage one requirement, however, clinical decision support has not been implemented widely in ophthalmology and is not at a mature stage. More research needs to be done to assess the effectiveness of clinical decision support and the characteristics of good clinical decision support tools. We are also concerned that many vendors lack the expertise to develop relevant tools for specialists, particularly ophthalmology.	No	No. As described earlier, clinical decision support has not been implemented widely in ophthalmology and is not at a mature stage for adoption. The development process for clinical decision support tools is much like that for quality measures, and the tools need to be tied to evidence. Given the state of the industry, it will be difficult to meet the requirement as defined by the Proposed Stage 2 requirements.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: Implement clinical decision support

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Orthopaedic Surgeons				Orthopaedic surgeons believe that clinical decision support rules must be specialty based. Orthopaedic surgeons are in the process of developing those rules for orthopaedics. We do not know what the final result will be. We fully support the idea of the use of CDS tools, but the choice of the measures used must be carefully made in collaboration with the AAOS for orthopaedic surgery
Otolaryngology			No	Clinical decision support is not yet an effective practice tool and Otolaryngologist do not feel it will be there when Stage 2 takes effect. More research needs to be done with respect to documenting the effectiveness of clinical decision support. Rushing a process into practice that is not ready for primetime with the potential to affect the practice of medicine can be detrimental to patient care. They also do not feel comfortable with vendors creating these clinical decision support tools because they lack the expertise to develop relevant tools for specialty physicians. The tools are much like developing quality measures and need to be tied to specialty-specific and relevant evidence. When a tool is not relevant to the treatment of the patient, physicians will not utilize it, or worse – they will comply, adding to their burden and costs, but without real benefit to patients and clinical outcomes. Implementing clinical decision support requires the development of EHR hardware and software and should be a criterion for vendors of EHRs. Once a platform for specialty exists, it is still a formidable task and burdensome to document even with the best systems. Good clinical decision support measures for all specialties are not currently available, and the technology does not currently exist to efficiently record and report clinical decision support and other quality measures.
Pathologists	Unclear.	Unclear. Pathologists work in the LIS and related systems and not the EHR so if the requirement on CDS is for the EHR and not the LIS, they won't be able to meet this.	Unclear.	Unclear. Pathologists work in the LIS and related systems and not the EHR so if the requirement on CDS is for the EHR and not the LIS, they won't be able to meet this.
Psychiatry	Likely, but unknown if EHR products have incorporated CDS rules that are applicable to psychiatry.		Questionable, pending further specificity	The use of CDS to “improve performance” hasn't been proven, and the CDS criteria need clarification.
Radiation Oncology:	No	Unsure of applicability. This seems to apply to hospital based specialties.	No	Unsure of applicability. This seems to apply to hospital based specialties.
Radiology		Yes, but the applicability depends on the availability of software that supports CDS rules relevant to radiology. If CMS get more prescriptive on this, Radiology would not support this.	No	Overly prescriptive.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: Implement clinical decision support

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Surgeons				<p>Yes. Surgeons fully appreciate the intent of this objective, but are concerned about the proposed expansion for Stage 2. Clinical decision support (CDS) is not yet an effective practice tool and more research needs to be done with respect to documenting the effectiveness of clinical decision support. Furthermore, there are many clarifications needed for the expansion of this requirement:</p> <ul style="list-style-type: none"> “High priority” conditions; Use of CDS to “improve performance”; and Good CDS measures for all specialties are not currently available, and the technology does not currently exist to efficiently record and report CDS and other quality measures.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities **REQUIREMENT: Implement drug-formulary checks**

Stage 1 Measure:

The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period

Exclusions:

Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Proposed Stage 2:

Move current measure to core

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	Yes, with exemption.	No. Anesthesiologists determine whether something is on formulary by whether it is available in their OR carts or in their medication dispensing machines. This measure is more relevant to outpatient Rx covered under a PBP. More important, there is currently no NIST script available to cover drugs administered in OR		
Gastros	No	No		Maybe. Gastros believe the current measure should be moved to core, but since formularies are usually payer-specific, in order to reach 80%, a provider might need to have 80-100 formularies, which isn't feasible.
Home Care Physicians	Limited to those with capable EHR and potentially to access in community.		Limited to those with capable EHR and potentially to access in community.	Yes, subject to not including as core measure.
Otolaryngology			No	Otolaryngologists are concerned with making this a core requirement and setting the threshold at 80%. We often hear from members that drug formulary information is not available when they e-prescribe, it is not up-to-date or accurate. For most insurers, in order to view a patient's drug formulary a physician must be a contracted provider. In order to meet the 80% threshold, physicians will be forced to contract with all insurers in order to meet the requirement. Physician's ability to negotiate with insurers will diminish since they will be required to contract with all insurers. Physicians should not be held accountable to meet a requirement that is outside of their control. Physicians should not be the entity measured on this requirement until prescription plans, vendors and pharmacists can implement this properly and accurately and physicians are not forced to contract to obtain the information.
Psychiatry		Yes. We support requiring this as a function of meaningful use. However, it is imperative that the formulary lists and alerts be kept up to date and accurate in order to keep this measure relevant for physicians. The burden for that should extend beyond the EP (e.g. certification requirements).		Applicable to psychiatry but requires external dependencies on availability and quality of formulary data
Radiology	Yes, with exemption	No, but most diagnostic radiologists will likely be exempt because of the definition of "prescription." A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.	Yes, with exemption.	No, but most diagnostic radiologists will likely be exempt because of the definition of "prescription" if included. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.
Radiation Oncology		This is applicable to Radiation Oncology but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.		This is applicable to Radiation Oncology but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Implement drug-formulary checks

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Surgeons				<p>Yes. For most patients, in order to view an insurer’s drug formulary a physician must be a contracted provider. In order to meet the 80% threshold, physicians will be forced to contract with all insurers in order to meet the requirement. A physician’s ability to negotiate with insurers will be diminished since they will be required to contract with all insurers. Physicians should not be held accountable to meet a requirement that is outside of their control. If this proposed requirement is finalized, insurers should voluntarily provide the information so physicians aren’t forced to contract with all payers.</p>

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Record Advance Directive

Stage 1 Measure:

50% (Hospital Requirement only)

Exclusions:

n/a

Proposed Stage 2:

Make core requirement. For EP and EH: **50%** of patients >=65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Cataract and Refractive Surgery				Should only apply to appropriate specialties or perhaps these patients and family members who are present are provided educational materials in the absence of an advance directive. Need a more cogent strategy on how advance directives options are provided to patient and for which specialties is it applicable? It will be disjointed and not well received by patients if every physician is required to have the discussion without the patient being required to make some decisions.
Dermatologists			No, only with exemption.	50% is high for the first year and hope for exemption . The vast majority of dermatologic care is provided in the physician office and the majority of procedures are done under local anesthesia. Due to the mostly non-life threatening nature of dermatologic conditions, the dermatologists are concerned with the appropriateness of advanced directive discussions. They are concerned that these conversations could unnecessarily scare a patient in the context of a dermatologic visit.
Home Care Physicians			Limited to those with capable EHR.	
Ophthalmology			No	No. Ophthalmologists do not routinely discuss with patients their advance directives nor have a need to record the directive itself because it is generally not relevant to the patient's eye disease and condition. Therefore, we are concerned that this requirement would interfere significantly with clinical ophthalmology workflow, decrease the amount of time available for ophthalmology-relevant care, and create potentially awkward situations for patients and physicians.
Otolaryngology				It may be inappropriate for an otolaryngologist to be the primary instigator of a routine discussion on advance directives with their patient since many do not manage the overall care of the patient. If a specialist is performing surgery, managing a potentially lethal condition, or providing long-term care, he/she will discuss this with the patient, but for routine specialty and much acute care an otolaryngologist does not collect this information. We urge the inclusion of an exception for this requirement to be included.
Psychiatry				Maybe. Psychiatrists have concerns that this measure is targeted towards primary care and we urge the inclusion of reasonable exclusionary language for specialties to which the measure is not relevant. Although important, the issue of an advance directive is not always readily raised and often requires an established physician-patient relationship, and considerable time during the visit to discuss all of the elements. If a specialist is seeing a patient for a single outpatient consultation, there would be little need for such a discussion. With expanded HIE, all providers treating a patient should be able to access an advance directive if necessary. In some situations (e.g. patients with paranoia), psychiatrists would feel it clinically inappropriate to ask patients about advance directives.
Radiology			No	Not applicable in any situation.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: Incorporate clinical lab-test results into EHR as structured data

Stage 1 Measure:

More than **40 %** of all clinical lab tests results ordered by the EP 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 — WAS MENU

Exclusions:

An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

Move current measure to core, but only where results are available

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Cataract and Refractive Surgery				Only where results are available.
Home Care Physicians	Limited to those with capable EHR and potentially to access in community.		Limited to those with capable EHR and potentially to access in community.	Yes. Subject to technological ability and would not move to core as a result.
Neurology				Would help to clarify “only where results are available.”
Neuro Surgery	No	Yes. Would result in having to have lab interfaces, which would add to cost/are not necessarily available. Alternatively, would need to have staff manually enter data into EHR system.	No	Yes. Would result in having to have lab interfaces, which would add to cost/are not necessarily available. Alternatively, would need to have staff manually enter data into EHR system.
Ophthalmology:	Yes, with exemption.	No. Most ophthalmologists will be excluded because they normally do not order laboratory tests, and these laboratories do not submit electronically to the ophthalmologists’ office.		No. In order to successfully meet stage two requirements, ophthalmologists will need a continuation of the exclusion for EPs for which this is not relevant to their scope of practice, or for which laboratories do not provide lab tests in an acceptable electronic format. Ophthalmology-specific EHRs often do not interface with laboratory systems because there is little clinical value and labs are disincentivized to provide such interaction due to cost. Therefore, we are concerned that the cost-benefit tradeoffs of this requirement will not be justified for ophthalmologists.
Otolaryngology				The Academy seeks clarification on which lab results the objective is referring to. For example, do the results of allergy skin testing have to be recorded as structured data? What about providers who perform RAST testing, a blood test used to determine what substances a person is allergic in the office? Will they have to modify their equipment to enter results into their records as structured data? What about audiology testing results, and others where the graphic portrayal of clinical data may have to be altered? As long as this requirement allows for the manual input of data into the EHR otolaryngologists will be able to meet the requirement. However, the requirement can pose a significant problem for otolaryngologists and other specialties that order a limited number of lab tests. The Academy is unaware of laboratories providing electronic interface with otolaryngology-only EHR vendors (rather only for large enterprise vendors) because otolaryngologists are typically in small practices (1-3 physicians) and don't order enough lab tests for the laboratories to find it cost-beneficial to create custom interfaces for data exchange. This functionality is assuming that all physicians use their EHR in the same fashion regardless of true utility.
Pathologists	No	No. Written from ordering MD's not receiving MD's perspective.	No	No. Written from ordering MD's not receiving MD's perspective.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

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

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Psychiatry	Yes, with exemption.	Maybe. Lab tests not as prevalent as in other areas of medicine.	Yes, with exemption	Maybe. Lab tests not as prevalent as in other areas of medicine.
Radiology		No, but most diagnostic radiologists will likely be excluded from this measure. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded	Yes, with exemption	No.
Radiation Oncology		Yes, but probably not as relevant as it is to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.		Yes, but probably not as relevant as it is to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.
Surgeons				<p>Lab results are an important part of the EHR, but the requirement poses significant problems for some specialties that order a limited number of lab tests. For example, ophthalmologists order a very small number of lab tests, and surgeons are unaware of laboratories providing electronic interface with eye care-only EHR vendors (rather only for large enterprise vendors) because ophthalmologists don't order enough lab tests for the laboratories to find it cost-beneficial to create custom interfaces for data exchange. Because ophthalmologists rarely order lab tests, this is not a functionality currently built into eye care-only EHRs. This functionality is assuming that all physicians use their EHR in the same fashion regardless of true utility.</p> <p>Furthermore, because there is no requirement for labs to electronically interact with all types of EHRs, the labs have no incentive to invest in the infrastructure or to make themselves compatible with their low volume user. A national EHR vendor charges approximately \$6,000 per lab interface, with ongoing maintenance fees, but laboratories will often subsidize the costs of interfaces for organizations that order a high volume of lab tests. In any case, specialists should not be prevented from meeting meaningful use criteria simply by virtue of their failure to acquire a costly laboratory interface. It is equally important not to require such physicians to enter lab test results manually into their patients' EHRs in order to qualify for EHR incentive payments. Thus, until there is greater uniformity in how laboratories report test results to physician practices using EHR technology, we believe the proposed criterion and its associated measure should be reexamined.</p>

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: **Generate lists of patients by specific conditions**

Stage 1 Measure:

Generate at least one report listing patients of the EP with a specific condition

Exclusions:

None

Proposed Stage 2:

Make core requirement. Generate patient lists for multiple patient-specific parameters

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists		Yes. AIMS provides the capability to sort patients by a specific condition.		
Cataract and Refractive Surgery			Unclear	Not well defined. So we generate the lists, then what? How does this fit with use of patient registries?
Home Care Physicians	Limited to those with capable EHR.		Limited to those with capable EHR.	
Gastros	Difficult			
Neurology				This is challenging and would depend on what they want neurologists to track. For example, how would a subspecialist handle it if they wanted all neurologists to track all patients with stroke?
Otolaryngology			No	Definition of patient lists and what data elements are required needs clarification. It is unclear for which issues a specialist is responsible for completeness. For example, kidney stones are very important for a urologists, number of C-sections to OB/GYN, but for a Medicare beneficiary in an otolaryngology setting this has dubious value.
Pathologists		Yes. In some instances, if demographic data is available in LIS		Yes. In some instances, if demographic data is available in LIS
Psychiatry:				Yes. Expanding beyond diagnosis to other categories such as specific medications would make it even more useful to psychiatrists.
Radiology		Applicability depends entirely on subspecialty. For example, a breast imaging subspecialist would see more value in this functionality than a general radiologist.	Maybe, pending on how it would be implemented.	This should not be more prescriptive than Stage 1.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: **Send reminders to patients**

Stage 1 Measure:

More than **20** % of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period

Exclusions:

An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology qualifies for an exclusion from this objective/measure

Proposed Stage 2:

Make core requirement.]

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	No. Anesthesiologists typically do not maintain offices and patients do not see them for preventive or follow-up care. This is generally a function of the surgeon. Anesthesiologists should not be required to purchase or document usage of a system with this requirement. Recommendation: Anesthesiologists should be exempt from requirements.		
Cataract and Refractive Surgery				A more appropriate measure might be to monitor follow up for patients with chronic conditions.
Home Care Physicians	Limited to those with capable EHR and subject to method of reminder as many patients lack electronic access for reminder.		Limited to those with capable EHR and subject to method of reminder as many patients lack electronic access for reminder.	
Neurology			No	Neurologists don't track immunizations. Clarification is needed on whether a "reminder" is for patient appointments or whether it is just a reminder about a preventative health measure?
Ophthalmology:				Yes
Pathologists		Yes. Depends on state law; some pathologists could remind patients of tests they need, but do PCPs want pathologists to do it?		Yes. Depends on state law; some pathologists could remind patients of tests they need, but do PCPs want pathologists to do it?
Psychiatry:		Maybe. Psychiatrists may have few preventative and follow-up appointment reminders, and MU measure exclusion does not account for that or patient preferences regarding privacy of EP communication.		Maybe. Psychiatrists feel that this measure should remain menu set and needs a robust exclusion for EPs who do not generally send patient reminders in the first place, or for scenarios in which a very small percentage of patients express preference to receive electronic reminders. Specialties such as psychiatry may have few preventative reminders, and follow-up appointment reminders may or may not be necessary for patients. Furthermore, many patients who seek treatment for mental health conditions have privacy concerns and we would expect that many would opt not to receive reminders from their clinician or would limit reminders to only one type (e.g. only emails, but not phone calls or mailed cards). We recommend that this measure's requirements be modified to allow physicians to attest that they send patient reminders when appropriate and by following patient preferences when possible.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities

REQUIREMENT: Send reminders to patients

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Radiology	No for most.	Not usually applicable. With the exception of mammography, diagnostic radiology is not a routine preventive service. This is actually one of the most difficult measures for radiologists to comply with in Stage 1 because of the numerator and denominator.	No for most.	Not applicable. With the exception of mammography, advanced diagnostic radiology is not a routine preventive service. This is actually one of the most difficult measures for radiologists to comply with in Stage 1 because of the problematic numerator and denominator. The denominator should be changed from "unique patients" to "patient encounters requiring follow-up." The exclusion should be changed to be scope-based, not age-based.
Surgeons				This is another criterion that may not be appropriate for all specialists. For example, it would make sense for a primary care physician to send reminders to his or her patients with one or more chronic condition, but not for a surgeon who treated a patient for some acute, time-limited condition, such as appendicitis, acute otitis, or a traumatic injury such as a fracture. Thus, sending patient reminders should not be a core requirement. In addition, because physicians use many forms of communication in issuing patient reminders, the reminders should be flexible enough to allow for reminders to be provided via multiple methods such as telephone calls, voice mail messages, emails, or printed reminder notices provided after the initial visit.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improving quality, safety, efficiency and reducing health disparities REQUIREMENT: **NEW (for EP) Electronic Note**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

30% of visits have at least one electronic EP note

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Home Care Physicians			Limited to those with capable EHR.	
Otolaryngology			Unclear	Not enough information has been provided by ONC to say "yes: or "no". Clarification is needed in regards to this new objective and whether a written note scanned into the system as a PDF file will constitute an electronic note. We would also like the HIT Policy committee to verify whether a private physician who admits patients to a hospital has to be provided access to its EMR system and learn the EMR system for each hospital where he admits patients. If your EMRs don't line up, then you have to scan your EMR note into the hospital system. It is very cumbersome to reenter all the data in another EMR format. Once MEDCIN and SNOMED coding lines up it will make the objective a little easier to meet.
Neuro Surgery				Maybe. Need clarification on "electronic note."
Radiology				Depends on implementation and definition.
Radiation Oncology			Unclear	Unclear

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide patients with an electronic copy of their health information

Stage 1 Measure:

More than **50%** of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days

Exclusions:

Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

Continue Stage 1

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	No. Patients rarely, if ever, request their health record from the individual anesthesiologist. Instead, requests generally go through the hospital. Anesthesiologists should be exempt from requirements.		
Chest Physicians	Yes, but potential barriers exist	Time frame aggressive. 7 business days currently accepted. Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. In addition, the ACCP recommends the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.	Yes, but potential barriers exist	
Cataract and Refractive Surgery			No	This measure might not be appropriate for specialties with a more senior population. Providing the patient with a summary of their visit might be a better measure. Also cost and security concerns for providing electronic copies at this time. Security/HIPAA concerns with most electronic forms, extra expense for providers to comply both with HIPAA and this requirement. Additionally how does the EHR show that the request was for an "ELECTRONIC COPY" and how do you guarantee protection of the record once "put out there electronically."
Home Care Physicians	Limited to those with capable EHR		Limited to those with capable EHR.	
Neurology				How is it recorded that patients request their records?
Neuro Surgery		Maybe. Cost involved with providing electronic copy either via CD, etc or patient portal.		Maybe. Cost involved with providing electronic copy either via CD, etc or patient portal.
OB-GYN		Format or technique should be decided by medical practice based on their capabilities.		
Ophthalmology				Yes. Stage 2 requires many new "add-on" features that will bring significant new and ongoing costs to physicians. Incentives will provide little relief from the added costs. Very few ophthalmologists currently offer PHRs to their patients, and many ophthalmology EHRs do not even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable to the practice.
Pathologists		Yes, but depends on state laws		Yes. Depends on state laws.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide patients with an electronic copy of their health information

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Psychiatry		Maybe, but the allowance for the EP to withhold information from the patient if it could lead to potential harm will apply in certain situations in psychiatry. Thus a 3 business day turnaround may be too aggressive to make this determination and to withhold the information from the electronic record. (HIPPA Privacy Rule, 45 CFR 164.524: "A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person"). Additionally, three business days may be insufficient for the clinician to make the shared information comprehensible to the patient.		See Stage 1 comment.
Radiology		Applicable if only the information captured by the EP is acceptable.		Applicable if only the information captured by the EP's technology is acceptable.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

[Engage Patients and Families in Their Care](#)

REQUIREMENT: Discharge Instructions (Hospitals only)

Stage 1 Measure:

Provide electronic copy of discharge instructions (EH) at discharge (50%)

Exclusions:

n/a

Proposed Stage 2:

Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 80% of patients (patients may elect to receive only a printed copy of the instructions)

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians	Yes, but potential barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time.	Yes, but potential barriers exist	
Home Care Physician:	N/A	Receipt by specialist when treating patient post transition would be good	N/A	Receipt by specialist when treating patient post transition would be good
Ophthalmology:	N/A		N/A	
Radiology			N/A	N/A.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide patient-specific education resources

Stage 1 Measure:

More than 10 % of all unique patients seen by the EP are provided patient specific education resources

Exclusions:

None

Proposed Stage 2:

Continue Stage 1

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	Yes. Anesthesiologists will currently need to rely on the hospital EHR to meet this requirement. AIMS should be exempt until modifications to currently available commercial products can be made.		
Cataract and Refractive Surgery				Added cost for capturing preferences and filtering communications appropriately
Neurology				Reviewer 1: Yes, especially for medications. However, it's unclear how it is decided who needs educational material? Can the EHR just provide links, or does a file must be printed directly from inside the EHR?
Pathologists		Yes. Do other physicians want pathologists directly contacting their patients? Pathologists have these resources, but may not have contact info for the patient in all instances.		Yes. Do other physicians want pathologists directly contacting their patients? Pathologists have these resources, but may not have contact info for the patient in all instances.
Psychiatry		Yes, but questionable applicability without clarification of what is meant by "education resources".		See Stage 1 comment.
Radiology		Yes, but this is one of the more ambiguous Stage 1 requirements. Is providing a link to a patient-oriented educational website like RadiologyInfo.org enough, for example?		Yes, but this is one of the more ambiguous Stage 1 requirements. Is providing a link to a patient-oriented educational website like RadiologyInfo.org enough, for example?
Surgeons				While surgeons support the need to provide patients with educational resources regarding their health care, this can be costly, especially for smaller practices. Additionally, surgeons are seeking clarification on the following: <ul style="list-style-type: none"> • Whether the percent is of patients in a practice or seen; • How will EHR vendors provide these resources; and • What are "the common primary languages"?

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide clinical summaries for patients

Stage 1 Measure:

Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days. An office visit is defined as any billable visit that includes: 1) Concurrent care or transfer of care visits, 2) Consultant visits and 3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider

Exclusions:

Any EP who has no office visits during the HER reporting period.

Proposed Stage 2:

Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in human-readable and structured forms (HITSC to define)

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	Yes, with exemption	No. With the exception of pain specialists, clinical anesthesiologists do not maintain offices or conduct traditional "office visits." Therefore, in theory, they should be exempt. The question is, what constitutes an "office visit?" Anesthesiologists often provide anesthesia services in an office-based setting and submit the claim using POS code 11 but they are providing the service for the physician conducting the procedure in his/her office. Are anesthesia services provided in an office-based setting considered office visits? If yes, they shouldn't be. If no, then anesthesiologists should not have to attest to or install a certification requirement that is never used. Recommendation: Anesthesiologists should be exempt from requirements.		
Cataract and Refractive Surgery			No	A printed summary might be more appropriate and easier to manage until cost and security concerns are addressed. Data are available in human-readable and structured forms (HITSC to define).
Chest Physicians	Yes, but potential barriers exist	Seven business days is the currently accepted timeframe. HIE's are in their infancy. CCD's are not yet widely in use. EHR vendors should provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.	Yes, but potential barriers exist	As long as patient portal technology implemented in EH.
Dermatologists				Yes, but, the 24 hour requirement, if kept in place, would make this impossible for dermatologists due to the volume of patients seen. The ability to comply with this measure is highly dependent on a substantial increase in the timeline.
Home Care Physicians	Limited to those with capable EHR.		Limited to those with capable EHR and question EHR capacity of patient viewing function. And see concerns under "Applicability."	Yes, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide clinical summaries for patients

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Neurology				This would require a functioning patient portal offered through a physician's EHR. Patient access to this information is going to create a large increase in work burden to practices as patients who do not have the sophistication to interpret data will be making a number of speculations as to the meaning of results. They will then call the office for detailed explanations – resulting in unreimbursed expenses of staff or physician time. The requirement to file subsequent lab results in a particular visit is excessive and burdensome as well.
Ophthalmology:				Yes. Ophthalmologists support the proposed objectives to provide patients with an electronic copy of their health information, however the "24-hour" and "4 day" time limits are arbitrary, fail to recognize that physician practices are not typically open 24-7, and fail to appreciate that some information should only be provided to patients during a face-to-face encounter. If CMS must adopt time limits, they should be specified in terms of business days rather than hours to account for weekends and holidays. It should be noted that even four business days is significantly under the 30 days allowed under HIPAA for providing an electronic copy of health information, and would be an inappropriately short period of time for "new" test results and information that has not already been discussed with the patient. Complete records might not even be available in ophthalmology offices within 24 hours, as many MDs will dictate or scan notes because ophthalmology documentation involves many hand-drawn sketches. Turnaround times to incorporate this information into the EHR may be longer.
Otolaryngology			No	Otolaryngologists support the proposed objective to provide patients with an electronic copy of their health information; however, they are opposed to the proposed measure that would require physicians to provide clinical summaries within 24 hours and provides patients the ability to view their health information within 4 days of the information being available to the practice. The "24-hour" and "4 day" time limits are arbitrary, fail to recognize that physician practices are not typically open 24-7, and fails to appreciate that some information should only be provided to patients during a face-to-face encounter. If the proposed criteria and measures are retained, physicians should have the option of disclosing only appropriate information and upon request. Physicians and patients are in the best position to determine what records are needed and when they are needed.
Orthopaedic Surgeons	Significant barriers exist	Orthopaedic surgeons provide care in hospitals, in clinics (office), and in other settings. While in the hospital an orthopaedic surgeon may not necessarily have access to the office EHR system to update patient files. Orthopaedic surgeons may not be able to complete surgical case documentation within 24 hours due to a variety of reasons ranging from overall case load to handling orthopaedic trauma. For many orthopaedic surgeons the typical week of practice is divided between hospital and clinic. Requiring documentation ready for review and downloading within 24 hours of a patient encounter is a substantial added burden for physicians given workload.		
Psychiatry		Yes, but determining and withholding potentially harmful information is a concern in Psychiatry and may take more than 3 business days (see "Provide patients with an electronic copy of their health information" above). See also previous comments on time requirements for providing an understandable and useful clinical summary.		Yes, but in order to meet an unnecessarily expedited timeframe of 24 or 36 hours, resulting information may be inaccurate, incomplete, and of limited use to the patient. While it may be straightforward to make raw data available to the patient, information that is synthesized to be understandable and useful to the patient may take more time. Furthermore, psychiatric record releases often require the approval of the treating psychiatrist, and patient access to records during an inpatient hospitalization is limited. These special considerations, and variations in state law on records disclosure, justify more flexible timetables.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide clinical summaries for patients

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Radiology		No. Providing the radiologist report to the referring physician, which is the most appropriate clinical summary of the encounter, should suffice. Then, the referring physician can decide to share or summarize the report with his/her patient.		Depends on regulatory implementation.
Surgeons				Yes. While surgeons support the proposed objectives to provide patients with an electronic copy of their health information, they oppose the proposed measure that requires physicians to provide clinical summaries within 24 hours and to patients to view their health information within 4 days of the information being available to the practice. The "24-hour" and "4 day" time limits are arbitrary, fail to recognize that physician practices are not typically open 24-7, and fail to appreciate that some information should only be provided to patients during a face-to-face encounter. Thus, if CMS must adopt time limits, they should be specified in terms of business days rather than hours to account for weekends and holidays. However, even four business days is significantly under the 30 days allowed under HIPAA for providing an electronic copy of health information, and would be an inappropriately short period of time for "new" test results and information that has not already been discussed with the patient. Additionally, the 24 hour requirement fails to take into account situations when some information should only be provided to patients during face-to-face encounters. Receiving a bad test result electronically and without context could be very stressful for a patient and contrary to good medical practice. At the very least, if the proposed criteria and measures are retained, physicians should have the option of disclosing only appropriate information. Physicians and patients are in the best position to determine what records are needed and when they provide copies under HIPAA have been recognized in the proposed rule. Finally, we are needed. Also, it is unclear whether circumstances that allow providers to refuse to question the requirement to automatically provide clinical summaries of most office visits, whether or not desired by the patient. This appears to be an overly burdensome requirement. In addition, we are concerned about potential liability if such clinical summaries are provided automatically (that is, without obtaining the patient's authorization), yet contain sensitive information.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide patients with electronic access to their health information

Stage 1 Measure:

More than 10 % of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information

Exclusions:

Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) (e.g., lab test results, problem list, medication list, medication allergy list, immunizations, and procedures) during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in human-readable and structured forms (HITSC to define).

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	No, and it will require changes to NIST testing script. Patient requests for records generally go to hospital and not the individual anesthesiologist. Therefore, anesthesiologists should be exempt from having to install or attest to having a system with this functionality, as this is a function more relevant to hospitals. If this is not possible, changes to the NIST scripts will be required so that the information provided is relevant to the perioperative setting. Anesthesiologists should be exempt from requirements.		
Cataract and Refractive Surgery			No	Again, cost and security concerns at this time until technology advances to catch up with requirements
Chest Physicians	Yes, but significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE’s are in their infancy. CCD’s are not yet widely in use. The ACCP recommends that the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.	Yes, but significant barriers exist	As long as Patient Portal technology implemented in EHR
Dermatologists		Depends on the vendor.		Depends on the vendor.
Home Care Physicians	Limited to those with capable EHR		Limited to those with capable EHR	Yes, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use
Neurology				Yes, however, patient access to this information is going to create a large increase in work burden to practices as patients who do not have the sophistication to interpret data will be making a number of speculations as to the meaning of results. They will then call the office for detailed explanations – resulting in unreimbursed expenses of staff or physician time.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: Provide patients with electronic access to their health information

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Orthopaedic Surgeons	Significant barriers exist	Orthopaedic surgeons provide care in hospital, in clinic (office), and in other settings. While in the hospital an orthopaedic surgeon may not necessarily have access to the office EHR system to update patient files. Orthopaedic surgeons may not be able to complete surgical case documentation within 24 hours due to a variety of reasons ranging from overall case load to handling orthopaedic trauma. For many orthopaedic surgeons the typical week of practice is divided between hospital and clinic. Requiring documentation ready for review and downloading within 24 hours of a patient encounter is a substantial added burden for physicians given workload.		
Ophthalmology:			Yes, with exemption.	No. Very few ophthalmologists currently offer personal health records (PHRs) to their patients, and many ophthalmology EHRs do not currently even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable. Some large ophthalmology practices have received estimates of nearly \$20,000 for initial implementation of patient portals and then ongoing annual maintenance fees thereafter. Without already having implemented a PHR, it may be very difficult to meet these Stage 2 guidelines. Providing electronic access will also require practices to educate the patients on what they are viewing so they can understand the information.
Otolaryngology			No	The Academy is supportive of patient portals and the ability for patients to be able to review and update their medical information. However, we have been told by vendors that incorporating patient portal capabilities into an EHR is an additional significant cost- both one time and recurring for each provider in the practice. It will require practices to educate the patients on what they are viewing so they can understand the information. As ONC looks to incorporate more modular type functions into meeting meaningful use they must take into consideration the cost of implementation and functionality. In addition, there are concerns for a physician's liability for patients' use of a personal health record and whether they use this type of functionality to manage their care.
Radiology		Yes if the information is specific to the service.		Applicable if the information is specific to the service.
Psychiatry		Yes. 10% threshold should allow for exclusion of patients for whom access to this information may take more than 4 business days if the EP determines that it could harm the patient if not withheld.		Maybe. See above regarding timeline and below regarding proposed MU measure.
Surgeons				Yes. Surgeons are supportive of patient portals and the ability for patients to be able to review and update their medical information. However, incorporating patient portal capabilities into an EHR is yet an additional cost for providers. Additionally, it will require practices to educate the patients on what they are viewing so they can understand the information without causing confusion. As ONC looks to incorporate more modular type functions into meeting meaningful use, surgeons urge consideration of the cost of implementation and functionality.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: This objective sets the measures for “Provide timely electronic access (EP)” and for “Provide clinical summaries for each office visit (EP)”

Proposed Stage 2:

EPs: **20%** of patients use a web-based portal to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Cataract and Refractive Surgery			No	Physicians are not in control of which patients may choose to use a web-based portal to access their information. Particularly specialties with high populations of elderly patients which may have no internet access or skills. Agree, it is out of the EP's hands whether a patient chooses to access their record via the web. Should not be a requirement.
Chest Physicians			Yes, but significant barriers exist	As long as Patient Portal technology implemented in EHR.
Dermatologists				No. The physician does not have control over a patient's choice to use a web-based portal
Home Care Physicians			Limited to those with capable EHR. And see concerns under “Applicability.”	Yes, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use. Exclusion is important and should be applied to measures with similar patient access and understanding considerations
Neurology:				Patient access to this information is going to create a large increase in work burden to practices as patients who do not have the sophistication to interpret data will be making a number of speculations as to the meaning of results. They will then call the office for detailed explanations – resulting in unreimbursed expenses of staff or physician time.
Ophthalmology:			No	No. We have concerns with the structure of this measure, because it is designed to measure patient behavior rather than provider behavior. The ophthalmologist could implement a portal (which is an add-on feature for most EHRs and an additional, unreimbursed cost to the physician) and then be penalized because patients are not interested in using it. This concern is augmented for practices that see a high volume of Medicare patients. Stage 2 requires many new “add-on” features that will bring significant new and ongoing costs to physicians. Incentives will provide little relief from the added costs. Very few ophthalmologists currently offer PHRs to their patients, and many ophthalmology EHRs do not even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable to the practice.
Otolaryngology			No	See above (provide patient with electronic access) for comment.
Psychiatry				APA has concerns that the burden for meeting this measure is dependent upon the EP's patient population and their interest, access, and technological wherewithal to use the web portal proposed here. APA has recommended that this measure be modified to make the information under consideration available to access if the patient wants, and through other electronic methods than specifically an EP-side web portal.
Radiology			No	No. This suggests monitoring a patient's internet behavior.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: **Secure online messaging – NEW**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

EPs: online secure patient messaging is in use

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Cataract and Refractive Surgery			No	No. There are cost/ and security issues for implementation. Who will assure security?
Chest Physicians			Yes, but significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use.
Home Care Physicians			Limited to those with capable EHR	Yes, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use. Exclusion would be important and should be applied to measures with similar patient access and understanding considerations.
Neurology				Patient access to this information is going to create a large increase in work burden to practices as patients who do not have the sophistication to interpret data will be making a number of speculations as to the meaning of results. They will then call the office for detailed explanations – resulting in unreimbursed expenses of staff or physician time.
Neuro Surgery			Unclear	Maybe. Need more clarification. Seems burdensome and should not be a core requirement.
Ophthalmology:			No	No. Online messaging is an added expense, "add-on" by the electronic health record vendors, which must be paid for by the physician and is not well defined. Further, even if the information is "secure" from the physician's end there is no way to verify or guarantee that it is secure on the patient side.
Otolaryngology			No	If this objective is adopted, it will be another unfunded mandate for physicians. Medicare does not reimburse for online consults. Under no circumstances should this be mandated while Medicare's policies do not provide payment for time spent in responding to patients' online communications. In lieu of the proposed requirement, that it be replaced with one that permits reimbursed e-visits. Aside from our above objections, it is not clear what constitutes "secure patient messaging."
Pathologists				Maybe. Don't have ability thru EHR.
Psychiatry			Questionable	Yes, but it is not well established whether secure online messaging saves time or not versus phone calls. Measure will need flexibility to account for patient preference towards potentially sensitive communication.
Radiology			No.	Probably not applicable. This could be applicable for certain imaging subspecialists, but this infringes upon the role and duties of the primary care provider and could be overly burdensome in a specialty with a much larger volume of patients than PCPs.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: **Patient Communication Preference NEW**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

Patient preferences for communication medium recorded for **20%** of patients

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians			Yes, but significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use. The ACCP recommends that the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented. As long as EHR software certified for stage 2 MU with Patient Portal, will be able to meet stage 2 MU measure.
Home Care Physicians			Limited to those with capable EHR.	
Neurology				Yes, however, this will create administrative burden. There needs to be a way to transmit all of this information seamlessly into the EMR externally without requiring office staff to input all the data.
OB-GYN			Unclear	Meeting this measure for Medicare-only population for ob/gyns would be very difficult. Over-65 y.o. patients will rarely need regular communication from ob/gyns.
Otolaryngology			No	While otolaryngologists support flexibility for patient communication purposes, if this objective is adopted, it will be another unfunded mandate for physicians and so we strongly object to its inclusion. The EHR incentive requirements should focus on EHR adoption and it is premature to focus on PHR related requirements. While they understand the patient convenience issues, there are a number of important factors that have not been adequately considered such as security, liability, cost, and physician time. For example, if a patient prefers unsecure texting should that be permitted? Who is responsible for the cost of the texting? Will CMS reimburse physicians for this time? What other communication preferences would need to be offered? Would there be a minimum standard set of acceptable communication media, with standard data entry fields, abbreviations, or definitions? If not, how would the patient's preference be recorded and monitored? If so, who will create these standards? How many currently available EHRs offer any such a data field, or any tools for responding to patient communication preferences? Most importantly, have there been any studies to suggest this is an important feature to patients, or that it is safe and effective to implement a system of multi-modal communications according to patient preferences? Until issues associated with reimbursement, data collection and management, and patient safety are resolved, this requirement remains simply unworkable.
Radiology			No, this relies on referring physicians to provide this information.	No

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: **Self-management Tools – NEW**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

n/a

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians			Yes, but significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use. The ACCP recommends that the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.
Dermatologists			No	
Home Care Physicians			Limited to those with capable EHR.	Applicable, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use. Exclusion would be important and should be applied to measures with similar patient access and understanding considerations.
Gastros			Difficult	
Neurology			Unclear	
Ophthalmology:			No	Very few ophthalmologists currently offer personal health records (PHRs) to their patients, and many ophthalmology EHRs do not currently even offer PHRs as an option. Without already having implemented a PHR, it may be very difficult to meet these Stage 2 guidelines. When available, electronic self-management tools are an added expense, "add-on" by the electronic health record vendors, which must be paid by the physician and is not well defined. Stage 2 requires many new "add-on" features that will bring significant new and ongoing costs to physicians. Incentives will provide little relief from the added costs. Very few ophthalmologists currently offer PHRs to their patients, and many ophthalmology EHRs do not even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable to the practice.
Neurology				Unclear.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: **PHR data exchange – NEW**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

n/a

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians			Yes, but significant barriers exist.	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use. The ACCP recommends that the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.
Dermatologists			No	
Gastros			No	Waiting on State level activity.
Home Care Physicians			Limited to those with capable EHR.	Applicable, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use. Exclusion would be important and should be applied to measures with similar patient access and understanding considerations.
Neurology			Unclear	This will depend on vendor development of this capability.
Ophthalmology			No	No. Very few ophthalmologists currently offer personal health records (PHRs) to their patients, and many ophthalmology EHRs do not currently even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable. Some large ophthalmology practices have received estimates of nearly \$20,000 for initial implementation of patient portals and then ongoing annual maintenance fees thereafter. Without already having implemented a PHR, it may be very difficult to meet these Stage 2 guidelines. Stage 2 requires many new "add-on" features that will bring significant new and ongoing costs to physicians. Incentives will provide little relief from the added costs. Very few ophthalmologists currently offer PHRs to their patients, and many ophthalmology EHRs do not even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable to the practice.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: **Patient Care Experience Reporting – NEW**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

n/a

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians			Yes, but significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use.
Dermatologists			No	
Home Care Physicians			Limited to those with capable EHR.	Applicable, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use. Exclusion would be important and should be applied to measures with similar patient access and understanding considerations
Ophthalmology:			No	Yes. This functionality is an expensive "add-on" by the electronic health record vendors, which must be paid by the physician and is not well defined. Stage 2 requires many new "add-on" features that will bring significant new and ongoing costs to physicians. Incentives will provide little relief from the added costs. Very few ophthalmologists currently offer PHRs to their patients, and many ophthalmology EHRs do not even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable to the practice.
Neurology			No	It should be Government's role to collect this information, not the individual providers.
Radiology			No	No. With some exceptions, patients typically experience the technical component of imaging studies and the personnel (such as radiologic technologists) who work the imaging equipment, not the professional component of the service where the physician comes into play.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Engage Patients and Families in Their Care

REQUIREMENT: **Patient Capability to upload data into EHRs – NEW**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

n/a

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians			Yes, but significant barriers exist.	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use. The ACCP recommends that the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.
Dermatologists			No	
Home Care Physicians			Limited to those with capable EHR.	Applicable, however, patient population lacks computer access, connectivity and often impacted by dementia, etc. beyond ability to make use. Exclusion would be important and should be applied to measures with similar patient access and understanding considerations.
Ophthalmology			No	Very few ophthalmologists currently offer personal health records (PHRs) to their patients, and many ophthalmology EHRs do not currently even offer PHRs as an option. In cases where the feature is available, it is an added expense which is not reimbursable. Some large ophthalmology practices have received estimates of nearly \$20,000 for initial implementation of patient portals and then ongoing annual maintenance fees thereafter. Without already having implemented a PHR, it may be very difficult to meet these Stage 2 guidelines.
Neurology			No	This is vendor controlled. It would be important to know what data is anticipated to come from the patients.
Radiology			No.	No.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: Exchange key clinical information

Stage 1 Measure:

Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information

Exclusions:

None

Proposed Stage 2:

Connect to at least three external providers in “primary referral network” (but outside delivery system that uses the same EHR) or establish an ongoing bidirectional connection to at least one health information exchange

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	Yes. Interoperable exchange with the hospital's EHR system is currently limited in ability to exchange structured data in commercially available systems.		
Cataract and Refractive Surgery			No	Interoperability and available software tools to provide this functionality are limited at this time. Should not be a requirement until standardized systems exists and are proven valuable and functional. Also, multispecialty care may all occur in one practice (ex: retina, cataract docs all in one practice with no outside of practice referral germane to eye care).
Chest Physicians:	No, significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use. The ACCP recommends that the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.	No, significant barriers exist.	
Gastros	Difficult			
Home Care Physicians			Limited to those with capable EHR and potentially to access and interoperability across community	Yes, however, subject to concerns under “Ability” and should be subject to exclusion based on community based interoperability.
Neurology			Unsure	This is vendor control. HIEs must be operable before care coordination and exchange of key clinical information can be prioritized into stage II. This may be very difficult for a rural, small practice.
OB-GYN			Unclear	Ob/gyns probably don't have a primary referral network.
Ophthalmology			No	Yes. The standards for health information exchange are not universally adopted, making connection to other outside providers difficult and potentially expensive. In addition, there are no existing standards for exchange of ophthalmology-specific health information. We are currently working to develop these standards, but are concerned that this cannot be created and tested to meet the Stage 2 timeline.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: Exchange key clinical information

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Otolaryngology			No	The Academy feels this objective is premature. At the current time there is no agreement on the use of MEDCIN vs. SNOMED or both, and translational coding to connect the two.
Pathologists				Maybe. Depends on interfaces.
Psychiatry			Serious concerns	Applicable to psychiatry but APA has concerns that interoperable health information exchange (HIE) must be functioning and available in the EP's geographical area to meet this measure. Though progress is currently underway, regional information exchange networks are generally still in their infancy. How mental health information is handled by HIE networks is still a topic of active discussion, and psychiatrists will have trouble meeting this requirement if mental health information is withheld from HIE in certain areas. APA recommends that moving further with additional requirements for HIE be based on the realistic capabilities of exchange infrastructure available to the EP.
Radiology				Depends on regulatory implementation.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: Medication reconciliation

Stage 1 Measure:

The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. “Relevant encounter” is an encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP, judges it to be so. “Transition of care” is the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. When conducting medication reconciliation during a transfer of care, the EP, that receives the patient into their care that should conduct the medication reconciliation

Exclusions:

An EP who was not the recipient of any transitions of care during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

Medication reconciliation conducted at **80%** of care transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	Yes. In the hospital setting, full medication reconciliation is generally a pharmacy or nursing function, either in the pre-op or inpatient setting. However, in the OR setting, transitions between anesthesiologists providers occur regularly. AIMS could capture reconciliation of medications administered in OR they could upload full reconciliation information included in the hospital EHR. Recommendation: (1) Clarify the intent and definition of medication reconciliation and (2) exempt intraoperative transitions of care from requirements of performance of medication reconciliation		
Cataract and Refractive Surgery				How is this MU requirement appropriately measured? If a patient is sent in for an eye exam by a referring doctor, are we required to do a medication reconciliation?
Home Care Physicians:	Limited to those with capable EHR.		Limited to those with capable EHR.	
Neurology				Yes (as best as the non-primary care physician can reconcile the meds)
Neuro Surgery	Yes, with exemption	No. Only likely applicable with exclusion; presents workflow issues (MD or nurse?)	Yes, if exemption included	No. Stage II threshold too high, especially considering low applicability.
Ophthalmology		No	No.	No. Ophthalmologists are generally responsible for medications prescribed for a specific eye condition or group of conditions. An ophthalmologist is not a primary care provider, but tries to maintain the most accurate information on a patient as possible, but often it is not obtainable because the patient does not know their medical history or the ophthalmologist doesn't have access to the information. Once a truly interoperable network is put in place, this objective could be more easily achieved and the information will be readily available for all physicians to view.
Otolaryngology			No	The threshold for this requirement is too high to be universally and routinely applied to specialists. How does a specialist interface with this requirement when they are not the ordering physician for 99% of the medications ordered? As specialty providers, otolaryngologists make every attempt to maintain the most accurate information on a patient as possible, but often such information is not obtainable because the patient does not know the medication they are taking or the otolaryngologist doesn't always have access to the information.
Psychiatry			Yes, with caveats.	Yes, but burdensome for solo and small practice psychiatrists to perform manual medication reconciliation without interoperable health exchange.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: Medication reconciliation

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Radiology	No	No. The exclusion is also ambiguous. The exclusion should be scope-based.	No	No.
Radiation Oncology		Yes, but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.		Yes, but probably not as relevant to other specialties whose primary focus is prescribing medicines such as internal medicine or medical oncology.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: Provide summary care record for each transition of care and referral

Stage 1 Measure:

The EP who transitions or refers their patient to another setting of care or provider of care should provide summary of care record for more than 50 percent of transitions of care and referrals

Exclusions:

An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period qualifies for an exclusion from this objective/measure

Proposed Stage 2:

Move to Core

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	No	Yes. Anesthesiologist rarely discharge patients from a facility. However, they do transition patients to other settings within the same facility (e.g. from OR to PACU). The NIST script will need to be changed to incorporate OR-specific content. While the anesthesia record is an integral part of any copy of records that go to an outside facility, it is generally the responsibility of the hospital, not the anesthesiologist to transfer the records. Recommendation: (1) Modify requirements with respect to NIST testing script to incorporate anesthesia-related transitions and (2) exempt intraoperative transitions of care from MU requirements.		
Home Care Physicians:	Limited to those with capable EHR.		Limited to those with capable EHR.	
Neurology				Yes, especially when patients are admitted from clinic
Ophthalmology:				Yes. An exclusion for providers who do not transfer or refer patients during the reporting period is needed.
Radiology		No. Radiology reports and images should suffice		No. Radiology reports and images should suffice.
Radiation Oncology	No, not yet		No, not yet	

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: Provide summary care record for each transition of care and referral

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Surgeons				<p>While surgeons support the proposed objectives to provide patients with an electronic copy of their health information, we oppose the proposed measure that requires physicians to provide clinical summaries within 24 hours and to patients to view their health information within 4 days of the information being available to the practice. The “24-hour” and “4 day” time limits are arbitrary, fail to recognize that physician practices are not typically open 24-7, and fail to appreciate that some information should only be provided to patients during a face-to-face encounter. Thus, if CMS must adopt time limits, they should be specified in terms of business days rather than hours to account for weekends and holidays. However, even four business days is significantly under the 30 days allowed under HIPAA for providing an electronic copy of health information, and would be an inappropriately short period of time for “new” test results and information that has not already been discussed with the patient. Additionally, the 24 hour requirement fails to take into account situations when some information should only be provided to patients during face-to-face encounters. Receiving a bad test result electronically and without context could be very stressful for a patient and contrary to good medical practice. At the very least, if the proposed criteria and measures are retained, physicians should have the option of disclosing only appropriate information. Physicians and patients are in the best position to determine what records are needed and when they are needed. Also, it is unclear whether circumstances that allow providers to refuse to provide copies under HIPAA have been recognized in the proposed rule. Finally, we question the requirement to automatically provide clinical summaries of most office visits, whether or not desired by the patient. This appears to be an overly burdensome requirement. In addition, we are concerned about potential liability if such clinical summaries are provided automatically (that is, without obtaining the patient’s authorization), yet contain sensitive information.</p>

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: Care Team Members – NEW

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

List of care team members available for 10% of patients in EHR

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Cataract and Refractive Surgery				Not well defined as to how to manage this information as it changes Agree, define "the care team"
Chest Physicians			No, significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use.
Dermatologists				No. Beyond the provider's direct referral network, the provider cannot accurately generate this list without the patient's cooperation and input. Also, having the patient's list of their full care team may not always be relevant to the quality of care provided to that patient.
Home Care Physicians			Limited to those with capable EHR	
OB-GYN			No	This assumes that there is a care team that includes the ob/gin physician, which is unlikely for Medicare population.
Neurology			No	
Otolaryngology			Unclear	
Psychiatry			Questionable	The definition of "care team members" varies widely across settings and specialties, and includes participants that the patient may never come in direct contact with nor need to interact with in the future. For inpatients in particular, there could be hundreds of people on one's "care team". A definition of care team is not provided here and will need further clarification. Meeting a measure like this could foreseeable require external dependencies, including information that would have to be drawn from either the patient directly or from integrated HIE that would be capable of compiling or supplementing the list for the EH or EP
Radiology			No	Not applicable. PCP or disease management specialist only.
Radiation Oncology			No	

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Care Coordination

REQUIREMENT: **Longitudinal Care Plan – NEW**

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

Record a longitudinal care plan for 20% of patients with high-priority health conditions

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Cataract and Refractive Surgery			No	Again, “high priority” conditions likely do not apply to ophthalmic care in many cases
Chest Physicians			No, significant barriers exist.	Not likely to assume longitudinal care plan for chronic conditions.
Dermatologists			Yes, but only with exemption.	No. Beyond the provider’s direct referral network, the provider cannot accurately generate this list without the patient’s cooperation and input. Also, having the patient’s list of their full care team may not always be relevant to the quality of care provided to that patient
Home Care Physicians			Limited to those with capable EHR.	
Neurology				Not sure, high-priority needs to be defined
OB-GYN			No	Ob/gyn will not develop a care plan for Medicare patients.
Ophthalmology:			Yes	Yes, but a high-priority health condition is not defined. However, if it is defined to include eye diseases and conditions, ophthalmologists will likely be able to meet the requirement. It is unclear if this objective will be relevant to eye conditions and diseases.
Otolaryngology			Unclear	Not enough information is provided to say “yes” or “no”. The Academy requests clarification on which conditions qualify as high priority health conditions and how they will be updated and checked? What happens when a specialist makes a modification to a primary care plan? Or what happens when there are multiple plans for the same condition? The objective needs to be moved to a later stage. The intent is good in regards to care coordination, but the ability to communicate easily among providers is not available. Translation exchange is needed for this to occur.
Psychiatry				Requirement needs more specificity.
Radiology:			No	No. PCP or disease management specialist only
Radiation Oncology			No	
Surgeons				While we believe that developing a longitudinal care plan is appropriate for certain providers, we have concerns about this objecting for specialists. Currently, this objective is focused heavily on primary care and we seek clarification on how specialists who may only provide services limited to a surgery and post-operative global period will meet this requirement. We feel it is unnecessary for a surgeon to develop a surgery specific longitudinal care plan.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Population and Public Health

REQUIREMENT: Submit electronic data to immunization registries

Stage 1 Measure:

Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)

Exclusions:

An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure

Proposed Stage 2:

EH and EP: Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), if accepted and as required by law

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	Yes, with exemption	No. Not within the scope of practice for anesthesiologists and not supported by AIMS. This would be an inappropriate measure to include in AIMS. Anesthesiologists should not be required to purchase or document usage of a system with this requirement. Anesthesiologists should be exempt from requirements.		
Cataract & Refractive Surgeons:				Exclusion criteria should continue
Chest Physicians:	No, significant barriers exist	Patient portals are separately subscribed add feature to most EHR. The added expense may prove prohibitive to practices in environment of decreasing reimbursement. These are not widely used by private practices OR hospitals at this time. HIE's are in their infancy. CCD's are not yet widely in use.	No	Not applicable. Do not routinely administer immunizations
Dermatologists	Yes, with exemption	No. Vast majority do not give immunizations.	Yes, if exemption included.	No. Vast majority do not give immunizations.
Home Care Physicians	Limited to those with capable EHR.		Limited to those with capable EHR.	
Neurology				No.
Neuro Surgery	Yes, with exemption	No. Not applicable to neurosurgery; exclusions critical	Yes, with Exemption	No. Not applicable to neurosurgery; exclusions critical
OB-GYN	N/A		N/A	
Ophthalmology:		No	Yes, if exemption is included.	No. Immunizations are not relevant to the management of patients with eye diseases and conditions, so an exclusion is needed.
Otolaryngology			No	Otolaryngologists do not perform immunizations so having to perform a mandatory test for a function they will not utilize is overly burdensome. The exclusion for Stage 1 needs to be obtained since otolaryngologists do not perform immunizations.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Population and Public Health

REQUIREMENT: Submit electronic data to immunization registries

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Radiology	Yes, with exemption.	No, but most diagnostic radiologists will likely be excluded. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.	No	No. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.
Radiation Oncology	Yes, with exemption.	No	Yes, with exemption.	No.
Psychiatry		Not applicable to psychiatry, but robust exclusion included.	Yes, with exemption	Assuming exclusion.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Population and Public Health

REQUIREMENT: Submit reportable lab data – (For Stage 1 was for hospitals only)

Stage 1 Measure:

(EH Only) Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)

Exclusions:

An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure

Proposed Stage 2:

EH: move Stage 1 to core EP: lab reporting menu. For EPs, ensure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law).

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians	N/A		No, significant barriers exist	HIE's are in their infancy. CCD's are not yet widely in use
Dermatologists	Yes, with exemption	No.	Yes, if exemption included	Not Applicable to all dermatologists.
Home Care Physicians	N/A		Limited to those with capable EHR.	
Neurology				Maybe with diseases such as CJD, HIV.
Ophthalmology:	Yes, with exemption	No.	Yes, with exception.	No. Reportable syndromic results are not generally relevant to the management of patients with eye diseases and conditions, so an exclusion is needed.
Otolaryngology			Unclear	Unclear because otolaryngologists do not know the requirements for each public health agency and if an additional modular will need to be purchased from the EHR vendor for this objective to be met.
Radiology	Yes, with exemption.	No	Yes, with exemption.	No
Radiation Oncology:	Yes, with exception	No.	Yes, with exemption	This is not applicable to Radiation Oncology
Psychiatry	Yes, with exception.	No	Yes, with exception.	Assuming exclusion

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Population and Public Health

REQUIREMENT:

Provide electronic syndromic surveillance data to public health agencies

Stage 1 Measure:

Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)

Exclusions:

An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure

Proposed Stage 2:

Move to core.

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Anesthesiologists	Yes, with exception	No. This would be a function of a hospital's EHR. The only reportable data related to anesthesiology practice would be reporting malignant hypothermia episodes or difficult airway to a registry but these are not public health repositories. Anesthesiologists should not be required to purchase or document usage of a system with this requirement. Anesthesiologists should be exempt from requirements.		
Chest Physicians	No, significant barriers exist	CCD's are not yet widely in use	No, significant barriers exist	Applicability same as Stage 1: HIE's are in their infancy. CCD's are not yet widely in use
Dermatologists	Yes, with exemption	No.	Yes, if exception included	No.
Home Care Physicians	Limited to those with capable EHR and subject to Exclusion		Limited to those with capable EHR, community connectivity and Exclusion should remain. Accordingly, do not move to core.	
Ophthalmology:	Yes, with exception	No	Yes, with exception	No. Syndromic surveillance data are not relevant to the management of patients with eye diseases and conditions, so an exclusion is needed in future stages
Otolaryngology	Yes, with exception.		Yes, with exception.	The exclusion must stay for otolaryngologist's to continue to be able to meet the objective.
Radiology	Yes, with exception	No, but most diagnostic radiologists will likely be excluded. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded	Yes, if exception included	No, but most diagnostic radiologists should continue to be excluded. A combination of certified EHR Modules should not be required to include a product certified for the associated certification criterion if the EP is excluded.
Radiation Oncology:	Yes, with exception	No.	No	This is not applicable to Radiation Oncology
Psychiatry		No.	Yes, with exclusion	No

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Population and Public Health

REQUIREMENT:

Submit notifiable conditions using a reportable public-health submission button – NEW

Stage 1 Measure:

n/a

Exclusions:

n/a

Proposed Stage 2:

n/a

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Cataract and Refractive Surgery			N/A	Need further clarification on its applicability to our specialty. Define notifiable conditions.
Chest Physicians			No, significant barriers exist	CCD's are not yet widely in use. HIE's are in their infancy. CCD's are not yet widely in use
Dermatologists:			No	Not Applicable to all dermatologists.
Home Care Physicians			Limited to those with capable EHR, community connectivity and exclusion should be developed.	
OB-GYN			N/A	
Ophthalmology:			No	A notifiable condition is not defined; there is uncertainty whether this pertains to patients with eye diseases and conditions.
Radiology			Yes or no, pending practice setting	Not really applicable.
Radiation Oncology			No	No

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Improve Population and Public Health

REQUIREMENT:

Submit patient-generated data to public health agencies – NEW

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians:			No, significant barriers exist	HIE's are in their infancy. CCD's are not yet widely in use. The ACCP recommends that the Centers for Medicare and Medicaid Services mandate EHR vendors to provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.
Dermatologists			No	Not Applicable to all dermatologists.
Home Care Physicians			Limited to those with capable EHR, community connectivity and exclusion should be developed.	
Ophthalmology:			No	No. Patient-generated data for public health agencies is not defined; there is uncertainty whether this pertains to patients with eye diseases and conditions.
Radiology			No	No.
Radiation Oncology			No	No.

ABILITY TO MEET AND APPLICABILITY OF STAGE 1 AND PROPOSED STAGE 2 REQUIREMENTS

Health Outcome Policy Priority:

Ensure Adequate Privacy and Security Protections for Personal Health Information

REQUIREMENT: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

Stage 1 Measure:

Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Exclusions:

None

Proposed Stage 2:

Specialty	Ability to Meet MU Stage 1 (Y/N)?	Applicability to Specialty	Ability to Meet MU Proposed Stage 2 (Y/N)?	Applicability to Specialty
Chest Physicians	Yes, but potential barriers exist	Compliance protocols education to be provided. EHR vendors should provide functionality for maintenance of confidentiality for adolescents. Sensitive medical information, including use of tobacco in children aged 13 or older, should be protected from view and/or reporting requirements to their parents. Furthermore a waiver should be created regarding providing patients, aged 13-18 years, with an electronic copy of their health information until the necessary software solutions can be implemented.		
Neurology				Yes, but small practices will struggle to meet this requirement. They will need help in securing the appropriate support for this. The government- in form of the RECS should provide this function.

DISCLAIMER: The intention of this document is to share initial feedback from many but not all medical specialty organizations surveyed on the Stage 1 and proposed Stage 2 meaningful use measures. This feedback is intended to represent each specialists readiness per measure and is not intended to represent an individual specialist's ability to meet MU in its entirety. The criteria in total have additional challenges such as change capacity and aggressive timelines. Also it is important to realize that physicians and practices within a specialty have different resources and are in different stages of health IT adoption, which may make achieving a MU criterion easier or harder than outline in this document. Physicians have just started to participate in the Stage 1 of the meaningful use incentive program so additional surveying is needed to fully assess physicians' abilities to meet the Stage 1 program requirements. We urge HHS to survey physicians who elected to participate and those who elected not to participate during Stage 1 of the incentive program and identify barriers to and solutions for physician participation prior to moving to Stage 2.