

Instructions

This workbook includes 4 tabs in addition to this instructions tab. Details of what is included in each tab

Stage 2 comparison tab

- This tab prints on **legal size** paper, as there is a great deal of information included
- This tab provides the stage 1 final rule, the HITPC's recommendations for stage 2, both the objective and measure included in the Stage 2 NPRM, MU workgroup comments from last week's
- The variance between stage 1 and the stage 2 NPRM are bolded in the Stage 2 NPRM column
- There were a few measures recommended by the HITPC that were only included as items for comment. These items are included in the appropriate policy priority section, but are noted as **N/A**.
- There are a few objectives in which public comment was explicitly solicited in the NPRM. In these circumstances a notation was made in red (i.e. **Seeking Comment**). The details of the public comment

Seeking Comment

- This tab includes items that public comment was explicitly asked for within the NPRM

Proposed Changes to Stage 1

- This grid was taken directly from the NPRM and details the Stage 1 changes

Proposed payment years

- This grid was taken directly from the NPRM

Health Outcomes Policy Priority	Eligible Professionals	Eligible Hospitals	Eligible Professionals	Eligible Hospitals	Eligible Professionals	Eligible Hospitals	Eligible Professionals	Eligible Hospitals	Stage 2 NPRM page numbers	2014 Edition EHR Certification Criterion
	Stage 1 Final Rule		Stage 2 - Proposed by HITPC		Stage 2 NPRM		Stage 2 NPRM - MU Workgroup Comments			
Improve quality safety, efficiency and reducing health disparities	<p>Medication only: More than 30% of unique patients seen during the reporting period with at least one medication in their medication list have at least one medication order entered using CPOE</p>	<p>Medications : Increase threshold to 60% Lab: More than 60% of unique patients seen during the reporting period with at least one lab test result have at least one lab order entered using CPOE Radiology: At least one radiology test is ordered using CPOE (unless no radiology test is ordered)</p>	<p>Objective: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. Measure: More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE Seeking Comment</p>	<p>(1) The section should be clear whether paper orders need to be counted, or just those in the EHR (be they CPOE or otherwise). Page 50 implies paper. Because these three types of orders go into systems for EHs, the total number is likely countable. For EPs, this may be more difficult. If the NPRM feedback reveals that counting paper orders is onerous, then we suggest considering automated ways of determining numerator and denominators. We propose that the denominator be 1) medications on the med list, 2) resulted lab tests, and 3) resulted radiology tests. The numerator would be # of CPOE orders entered by the authorizing provider (the goal of CPOE). (2) The NPRM appears to lump medication, laboratory, and radiology orders so that one could skip an order type completely if it is less than 60%. (3) We would prefer not to change the definition of who counts for entering orders (a licensed professional). (4) Clarification on the HITPC Stage 2 Proposal: only radiology was suggested as yes/no; laboratory was counted.</p>	pp. 47-53	§170.314(a)(1)	Computerized provider order entry. Enable a user to electronically record, change, and access the following order types, at a minimum: (i) Medications; (ii) Laboratory; and (iii) Radiology/imaging.			
Improve quality safety, efficiency and reducing health disparities	Implement drug-drug and drug-allergy interaction checks	Employ drug interaction checking (drug-drug, drug-allergy) with the ability for the provider to refine DDI rules	Consolidated	<p>(1) We agree with the consolidation, especially because DDI is still separate in the consolidated objective. (2) We believe DDI deserves special attention because current commercial DDI databases are well known to have high false positives, which contribute to alert fatigue. We believe that further work is needed to create nationally endorsed lists of drug-drug interactions. Because commercially available drug-drug interaction rules have limited predictive value, we believe that providers should be able to refine DDI rules in Stage 2. Studies at Partners Healthcare have shown how such refinements can dramatically increase acceptance of DDI alerts and prevention of medication errors.</p>	p. 53					

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Improve quality safety, efficiency and reducing health disparities	Generate and transmit more than 40% of all permissible prescriptions electronically	N/A	Increase threshold to 50%	Generate and transmit more than 10% of all hospital discharge orders for permissible prescriptions electronically	Objective: Generate and transmit permissible prescriptions electronically (eRx) Measure: More than 65 % of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology. Seeking Comment	N/A	(1) We agree with 65%, although there remain challenges choosing a participating pharmacy at the time of writing a prescription. (2) We have some sources reporting that controlled substances should not be included in the denominator. IE workgroup is reviewing as well.	N/A	pp. 53-59	§170.314(b)(3) / §170.314(a)(10) Electronic prescribing. Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with: (i) The standard specified in § 170.205(b)(2); and (ii) At a minimum, the version of the standard specified in § 170.207(h). Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.
Improve quality safety, efficiency and reducing health disparities	Record demographics as structured data for more than 50% of all unique patients: • Preferred language • Gender • Race • Ethnicity • Date of birth	Record demographics as structured data for more than 50% of all unique patients: • Preferred language • Gender • Race • Ethnicity • Date of birth • (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	Record demographics for more than 80% of all unique patients seen during the reporting period with the ability to use the data to produce stratified quality reports	Objective: Record the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data Seeking Comment on age limit	Objective: Record the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data • (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH Seeking Comment on age limit	Agree with 80%. OMB standards are used in the rule, but HHS has published more granular standards.		pp. 60-63	§170.314(a)(3) Demographics. (i) Enable a user to electronically record, change, and access patient demographic data including preferred language, gender, race, ethnicity, and date of birth. (A) Enable race and ethnicity to be recorded in accordance with the standard specified in § 170.207(f) and whether a patient declines to specify race and/or ethnicity. (B) Enable preferred language to be recorded in accordance with the standard specified in § 170.207(j) and whether a patient declines to specify a preferred language. (ii) Inpatient setting only. Enable a user to electronically record, change, and access preliminary cause of death in the event of a mortality in accordance with the standard specified in § 170.207(k).	

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Improve quality safety, efficiency and reducing health disparities	Maintain an up-to-date problem list of current and active diagnoses for more than 80% of all unique patients: have at least one entry or an indication that no problems are known for patient recorded as structured data		<i>No change</i>		Consolidated with objective for providing a summary of care for each transition of care or referral		p. 59	§170.314(a)(5) Problem list. Enable a user to electronically record, change, and access a patient's problem list for longitudinal care in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3).
Improve quality safety, efficiency and reducing health disparities	Maintain active medication list: more than 80% of all unique patients have at least one entry recorded as structured data (or indication that the patient is on no meds)		<i>No change</i>		Consolidated with objective for providing a summary of care for each transition of care or referral		p. 59	§170.314(a)(6) Medication list. Enable a user to electronically record, change, and access a patient's active medication list as well as medication history for longitudinal care.

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Improve quality safety, efficiency and reducing health disparities	Maintain active medication allergy list: More than 80% of all unique patients seen during the reporting period have at least one entry (or indication that the patient has no known medication allergies) recorded as structured data		<i>No change</i>		Consolidated with objective for providing a summary of care for each transition of care or referral		p. 59	§170.314(a)(7) Medication allergy list. Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history for longitudinal care.
						(1) We recommend keeping these 3 lists as separate objectives for the following reasons: 1) they were and still will be important motivators for clinicians to enter and maintain accurate lists of these essential facts about a patient at an easy-to-access summary level; 2) the stage 1 requirement is very minimal; we are planning to add functionality that would provide computerized support to assess and maintain the accuracy and completeness of these lists in future stages; if the objective is dropped, it would have to be put back on in future stages, causing mixed signals; 3) just having these elements in a transition of care document (which may be difficult or impossible for clinicians to access) does not give the information the central visibility it deserves at every step of the clinical workflow; 4) removing the objectives sends a signal that these three items are less important than other items like demographics and vital signs.		

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Improve quality safety, efficiency and reducing health disparities	Record and chart changes in vital signs: more than 50% of all unique patients age 2 and over have vital signs recorded as structured data <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI 	<i>Record and chart vital signs: more than 80% of all unique patients seen during the reporting period age 2 and over have vital signs recorded as structured data:</i> <ul style="list-style-type: none"> • Height • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI 	Objective: Record and chart changes in vital signs: <ul style="list-style-type: none"> • Height/Length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recoded as structured data Seeking Comment					bottom of pp. 63-68	§170.314(a)(4) Vital signs, body mass index, and growth charts. (i) Vital signs. Enable a user to electronically record and change, and access recordings of a patient's vital signs including, at a minimum, height/length, weight, and blood pressure. (ii) Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient's height and weight. (iii) Optional. Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.	
Improve quality safety, efficiency and reducing health disparities	Record smoking status for patients 13 years old and older: more than 50% of all unique patients seen during the reporting period 13 years or older have smoking status recorded as structured data	<i>Increase threshold to 80%</i>	Objective: Record smoking status for patients 13 years old or older Measure: More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data					pp.68-70	§170.314(a)(11) Smoking status. Enable a user to electronically record, change, and access the smoking status of a patient in accordance with the standard specified at § 170.207(i).	

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Improve quality safety, efficiency and reducing health disparities	Implement one clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance with that rule	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Use clinical decision support HITSC: Suggest changing certification criteria definition as indicated on comment summary		Objective: Use clinical decision support to improve performance on highpriority health conditions Measure: 1. Implement five clinical decision support interventions related to five or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.		(1) The certification criteria should include the suggested clinical decision support attributes. (i) Enhance the source/citation criterion as a hyperlink to peer-reviewed literature, or as a name and funding source if it is internally developed. (ii) It should be configurable (see examples). (iii) Presented at relevant point in the clinical workflow, which is mentioned in the NPRM text. (iv) Presented to users who can act on them. (v) can be integrated into EHR (vs. standalone). (2) In addition to DDI, require an additional decision support function addressing efficiency such as reducing overuse of high-cost imaging or use of generic medications.		pp. 71-76	§170.314(a)(8) / §170.314(a)(2) Clinical decision support. (i) Evidence-based decision support interventions. Enable a user to select (or activate) one or more electronic clinical decision support interventions (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in each one or any combination of the following: (A) Problem list; (B) Medication list; (C) Medication allergy list; (D) Demographics; (E) Laboratory tests and values/results; and (F) Vital signs. (ii) Linked referential clinical decision support. (A) Enable a user to retrieve diagnostic or therapeutic reference information in accordance with the standard specified at § 170.204(b)(1). (B) Enable a user to access the reference information specified in paragraph (i)(A) relevant to patient context based on the data elements included in each one or any combination of the following: (1) Problem list; (2) Medication list; (3) Medication allergy list; (4) Demographics; (5) Laboratory tests and values/results; and (6) Vital signs. (iii) Configure clinical decision support. (A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) to be configured by an identified set of users (e.g., system administrator) based on each one of the following: (1) A user's role; (2) Clinical setting; and (3) Identified points in the clinical workflow. (B) Enable interventions to be triggered, based on the data elements specified in paragraph (a)(8)(i), when a summary care record is incorporated pursuant to § 170.314(b)(1). (vi) Automatically and electronically interact. Interventions selected and configured in accordance with paragraphs (a)(8)(i)-(iii) must automatically and electronically occur when a user is interacting with EHR technology. (v) Source attributes. Enable a user to review the attributes for each intervention or reference source for all clinical decision support resources including: (A) Bibliographic citation (clinical research/guideline) including publication; (B) Developer of the intervention (translation from clinical research/guideline); (C) Funding source of the intervention development technical implementation; and (D) Release and, if applicable, revision date of the intervention. Drug-drug, drug-allergy interaction checks (i) Interventions. Before a medication order is placed during computerized provider order entry (CPOE), interventions must automatically and electronically indicate to a user at the point of care of drug-drug and drug-allergy contraindications based on medication list and medication allergy list. (ii) Adjustments. (A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted. (B) Limit the ability to adjust severity levels to an identified set of users or available as a system administrative function.
Improve quality safety, efficiency and reducing health disparities	MENU: Implement drug-formulary checks with access to at least one drug formulary		Implement drug formulary checks according to local needs (e.g., may use internal or external formulary, which may include generic substitution as a "formulary check")		Consolidated - Proposing to include this objective within the core objective for EPs "Generate and transmit permissible prescriptions electronically (eRx)"				p. 85	
Improve quality safety, efficiency and reducing health disparities	Report ambulatory clinical quality measures to CMS or States	Report Hospital Clinical quality measures to CMS or the States	No change	No change	Removed - Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6 - Seeking Public Comment				p. 71	

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Improve quality safety, efficiency and reducing health disparities	N/A	MENU: Record advanced directives for more than 50% patients 65 years old or older	<i>Record whether an advance directive exists (with date and timestamp of recording) for at least 25 unique patients seen during the reporting period have recorded and provide access to a copy of the directive itself if it exists</i>	<i>Record whether an advance directive exists (with date and timestamp of recording) for more than 50% of patients 65 years and older and provide access to a copy of the directive itself if it exists</i>	N/A	Objective: Record whether a patient 65 years old or older has an advance directive Measure: Menu - More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	<i>We suggest moving to a Menu requirement - More than 10% of patients who are 65 or older. Strongly recommend moving to core for Stage 3.</i>	<i>Revert to original objective. This is an important objective and should be core for hospitals.</i> <i>ONC will research for more information about states. Challenge grants? Begin to identify experts for a panel discussion related to Stage 3.</i>	pp. 149 - 152	§170.314(a)(18) Inpatient setting only. Advance directives. Enable a user to electronically record whether a patient has an advance directive.
Improve quality safety, efficiency and reducing health disparities	MENU: Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests results ordered whose results are either in a positive/negative or numerical format	<i>Incorporate lab results as structured data for more than 40% of all clinical lab tests ordered through the EHR for a patient during the reporting period HITSC: Use LOINC where available</i>	<i>Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic orders received</i>	Objective: Incorporate clinical lab-test results into EHR as structured data Measure: More than 55% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data Seeking Comment	NEW Objective: Generate and transmit permissible discharge prescriptions electronically (eRx) Measure: More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology	<i>Agree. Okay to count individual tests.</i>	<i>To be discussed further.</i>	EP - pp. 85 - 88 EH - pp. 141 -144	§170.314(b)(5) Incorporate laboratory tests and values/results. (i) Receive results. (A) Ambulatory setting only. (1) Electronically receive clinical laboratory tests and values/results formatted in accordance with the standard (and implementation specifications) specified at § 170.205(k) and, at a minimum, the version of the standard specified in § 170.207(g). (2) Electronically display the tests and values/results received in human readable format. (B) Inpatient setting only. Electronically receive clinical laboratory tests and values/results in a structured format and electronically display such tests and values/results in human readable format. (ii) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (iii) Incorporate tests and values/results. Electronically incorporate a laboratory test and value/result with a laboratory order or patient record. §170.314(b)(3) /§170.314(a)(10) Electronic prescribing. Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with: (i) The standard specified in § 170.205(b)(2); and (ii) At a minimum, the version of the standard specified in § 170.207(h). Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.	
Improve quality safety, efficiency and reducing health disparities	MENU: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	<i>Generate lists of patients by multiple specific conditions to use for quality improvement, reduction of disparities, research or outreach</i>		Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach Measure: Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.		<i>Agree. We had suggested multiple specific conditions, to ensure that EHRs were certified to handle more than one variable.</i>		pp. 88-89	§170.314(a)(14) Patient lists. Enable a user to electronically select, sort, access, and create lists of patients according to, at a minimum, the data elements included in: (i) Problem list; (ii) Medication list; (iii) Demographics; and (iv) Laboratory tests and values/results.	

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Improve quality safety, efficiency and reducing health disparities	MENU: Send preventive or follow-up reminders to more than 20% of all unique patients 65+ years old or 5 years old or younger	N/A	More than 10% of all active patients are sent a clinical reminder (reminder for an existing appointment does not count)		Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care Measure: More than 10% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference	N/A	Agree. It may require exclusions for some specialists, such as surgeons who do not require follow up after the initial post-op visit or manage preventive services.	N/A	pp. 89 - 91	§170.314(a)(15) Ambulatory setting only. Patient reminders. Enable a user to electronically create a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data elements included in: (i) Problem list; (ii) Medication list; (iii) Medication allergy list; (iv) Demographics; and (v) Laboratory tests and values/results.
Improve quality safety, efficiency and reducing health disparities	N/A	N/A	N/A	Medication orders automatically tracked via electronic medication administration record in-use in at least one hospital ward/unit (“automatically” implies “5 rights” recorded without manual transcription)	N/A	Objective:Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) Measure: More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR.	N/A	Agree.	pp. 138 - 141	§170.314(a)(17) Inpatient setting only. Electronic medication administration record. (i) In combination with an assistive technology that provides automated information on the “rights” specified in paragraphs (i)(A) through (i)(D), enable a user to electronically verify the following before administering medication(s): (A) Right patient. The patient to whom the medication is to be administered matches the medication to be administered. (B) Right medication. The medication to be administered matches the medication ordered for the patient. (C) Right dose. The dose of the medication to be administered matches the dose of the medication ordered for the patient. (D) Right route. The route of medication delivery matches the route specified in the medication order. (i) Right time. Electronically record the time and date in accordance with the standard specified at § 170.210(g), and user identification when a medication is administered.
Improve quality safety, efficiency and reducing health disparities	N/A	N/A	N/A		Objective: Incorporate imaging results and information into Certified EHR Technology Measure: NEW MENU - More than 40% of all scans and tests whose result is an image ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are incorporated into or accessible through Certified EHR Technology		(1) We agree with the first objective, including the 40% EH threshold, but we wonder about the 40% threshold for EPs. We would prefer a 10% threshold for EPs with an exclusion if they have no access to electronic images (e.g., local imaging centers do not offer electronic access). (2) We agree with the spirit of the second objective, and agree with the need to encourage sharing, but believe that Stage 2 may be too soon to expect EPs and EHs to share 10% of their images with outside providers.	pp. 127 - 130	§170.314(a)(12) Imaging. Electronically indicate to a user the availability of a patient's images and/or narrative interpretations (relating to the radiographic or other diagnostic test(s)) and enable immediate electronic access to such images and narrative interpretations.	
Improve quality safety, efficiency and reducing health disparities	N/A	N/A	N/A	N/A	Objective: Record patient family health history as structured data NEW Measure: MENU - More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been reviewed		Although we support the spirit of this objective, we are not aware of adopted standards in this area and there are some concerns about the cost/benefit of the information as currently captured.	pp. 130 - 132	§170.314(a)(13) Family health history. Enable a user to electronically record, change, and access a patient's family health history.	

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Improve quality safety, efficiency and reducing health disparities	N/A	N/A	Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of unique visits during the reporting period (non-searchable, scanned notes do not qualify)	Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of eligible hospital days (non-searchable, scanned notes do not qualify)	N/A Seeking Public Comment Objective/Measure: Record electronic notes in patient records for more than 30 percent of office visits. While we believe that medical evaluation entries by providers are an important component of patient records that can provide information not otherwise captured within standardized fields, we believe there is evidence to suggest that electronic notes are already widely used by providers of Certified EHR Technology and therefore do not need to be included as a meaningful use objective.	N/A	Agree with adding text-searchable notes to certification. Because some certified EHRs do not have clinical documentation, and we believe that having a complete record, including progress notes, is required to deliver high quality, efficient care, we recommend that provision for recording progress notes should be a meaningful use objective.	p. 155	§170.314(a)(9) Electronic notes. Enable a user to electronically record, change, access, and search electronic notes.	
Improve quality safety, efficiency and reducing health disparities	N/A	N/A	N/A	Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic lab orders received. ** HITSC: Use LOINC where available	N/A Seeking Comment - Hospital Objective: Provide structured electronic lab results to eligible professionals. Hospital Measure: Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 40 percent of electronic lab orders received.	N/A	The providers depend upon hospital labs which are about 40% of the market. Coordinate with IE workgroup.	pp. 152 - 153	§170.314(b)(6) Inpatient setting only. Transmission of electronic laboratory tests and values/results to ambulatory providers. Enable a user to electronically create laboratory tests and values/results for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(k); and (ii) At a minimum, the version of the standard specified in § 170.207(g).	
Engage patients and families in their care	Provide more than 50% of all patients with an electronic copy of their health information upon	N/A	Combined with other objectives	N/A	Replaced	N/A		p. 146		
Engage patients and families in their care	N/A	Provide more than 50% of all patients with an electronic copy of their discharge	N/A	Combined with other objectives	N/A	Replaced		p. 146		

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Engage patients and families in their care	Provide more than 10% of all unique patients timely electronic access to their health information subject to the EP's discretion to withhold certain information	N/A	More than 10% of patients and families view and have the ability to download their longitudinal health information; information is available to all patients within 24 hours of an encounter (or within 4 days after the information is available to EPs)	More than 10% of patients and families view and have the ability to download information about a hospital admission; information is made available within 36 hours of the encounter	Replaced	Replaced			p. 76	
Engage patients and families in their care	N/A	N/A	N/A	N/A	Objective: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP. NEW Measure: 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information 2. More than 10 % of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download , or transmit to a third party their health information	N/A	We appreciate and agree with the intent to keep the timeliness criterion simple (1 timeline). However, we believe there is value in providing the patient with prompt access to the summary of an encounter (which we define as an office visit or other contact in which an order is generated). We propose that a single timeliness criterion be applied, and that it be shortened to "within two business days of information becoming available to the EP." To what extent is the provider accountable for patient engagement?	pp. 94 - 100 pp. 144 - 149	\$170.314(e) (1) View, download, and transmit to 3rd party. (i) Enable a user to provide patients (and their authorized representatives) with online access to do all of the following: (A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data elements: (1) Patient name; gender; date of birth; race; ethnicity; preferred language; smoking status; problem list; medication list; medication allergy list; procedures; vital signs; laboratory tests and values/results; provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; and care plan, including goals and instructions. (2) Inpatient setting only. Admission and discharge dates and locations; reason(s) for hospitalization; names of providers of care during hospitalization; laboratory tests and values/results (available at time of discharge); and discharge instructions for patient. (B) Download. Electronically download: (1) A file in human readable format that includes, at a minimum: (i) Ambulatory setting only. All of the data elements specified in paragraph (e)(1)(i)(A)(1), (ii) Inpatient setting only. All of the data elements specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2). (2) A summary care record formatted according to the standards adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): (i) Patient name; gender; date of birth; medication allergies; vital signs; the provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; (ii) Race and ethnicity. The standard specified in § 170.207(f); (iii) Preferred language. The standard specified in § 170.207(i); (iv) Smoking status. The standard specified in § 170.207(j); (v) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (vi) Encounter diagnoses. The standard specified in § 170.207(m); (vii) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); (viii) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); (ix) Laboratory values/results(s). The value(s)/result(s) of the laboratory test(s) performed; (x) Medications. At a minimum, the version of the standard specified in § 170.207(h); and (xi) Inpatient setting only. The data elements specified in paragraph (e)(1)(i)(A)(2). (3) Images formatted according to the standard adopted at § 170.205(i). (C) Transmit to third party. Electronically transmit the summary care record created in paragraph (e)(1)(i)(B)(2) or images available to download in paragraph (e)(1)(i)(B)(3) in accordance with: (1) The standard specified in § 170.202(a)(1), and (2) The standard specified in § 170.202(a)(2). (ii) Patient accessible log. (A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A)-(C), the following information must be recorded and made accessible to the patient: (1) The electronic health information affected by the action(s); (2) The date and time each action occurs in accordance with the standard specified at § 170.210(g); (3) The action(s) that occurred; and (4) User identification. (B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(i)(A) if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(i)(A) is accessible by the patient.	

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Engage patients and families in their care	N/A	N/A	N/A	N/A	N/A	<p>Objective: Provide patients the ability to view online and download information about a hospital admission</p> <p>NEW Measure: 1. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge 2. More than 10 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period</p>		<p>Discharge instructions were available at discharge in stage 1, and in NPRM that goes to 36 hrs</p>	pp. 94 - 100	§170.314(e)(1) View, download, and transmit to 3rd party. (i) Enable a user to provide patients (and their authorized representatives) with online access to do all of the following: (A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data elements: (1) Patient name; gender; date of birth; race; ethnicity; preferred language; smoking status; problem list; medication list; medication allergy list; procedures; vital signs; laboratory tests and values/results; provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; and care plan, including goals and instructions. (2) Inpatient setting only. Admission and discharge dates and locations; reason(s) for hospitalization; names of providers of care during hospitalization; laboratory tests and values/results (available at time of discharge); and discharge instructions for patient. (B) Download. Electronically download: (1) A file in human readable format that includes, at a minimum: (i) Ambulatory setting only. All of the data elements specified in paragraph (e)(1)(i)(A)(1). (ii) Inpatient setting only. All of the data elements specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2). (2) A summary care record formatted according to the standards adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): (i) Patient name; gender; date of birth; medication allergies; vital signs; the provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; (ii) Race and ethnicity. The standard specified in § 170.207(f); (iii) Preferred language. The standard specified in § 170.207(j); (iv) Smoking status. The standard specified in § 170.207(i); (v) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (vi) Encounter diagnoses. The standard specified in § 170.207(m); (vii) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); (viii) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); (ix) Laboratory value(s)/result(s). The value(s)/result(s) of the laboratory test(s) performed; (x) Medications. At a minimum, the version of the standard specified in § 170.207(h); and (xi) Inpatient setting only. The data elements specified in paragraph (e)(1)(i)(A)(2). (3) Images formatted according to the standard adopted at § 170.205(j). (C) Transmit to third party. Electronically transmit the summary care record created in paragraph (e)(1)(i)(B)(2) or images available to download in paragraph (e)(1)(i)(B)(3) in accordance with: (1) The standard specified in § 170.202(a)(1); and (2) The standard specified in § 170.202(a)(2). (ii) Patient accessible log. (A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A)-(C), the following information must be recorded and made accessible to the patient: (1) The electronic health information affected by the action(s); (2) The date and time each action occurs in accordance with the standard specified at § 170.210(g); (3) The action(s) that occurred; and (4) User identification. (B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.
Engage patients and families in their care	Provide clinical summaries for more than 50% of all office visits within 3 business days	N/A	Provide clinical summaries to patients for more than 50% of all office visits within 24 hours; pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs; (electronically accessible for viewing counts)	N/A	<p>Objective: Provide clinical summaries for patients for each office visit</p> <p>Measure: Clinical summaries provided to patients within 24 hours for more than 50 % of office visits.</p>	N/A	<p>The NPRM says that HITPC recommended that for clinical summaries information be made available within 24 hrs OR within 4 business days of info becoming available. The HITPC actually recommended that for clinical summaries information be made available within 24 hrs or within 4 (calendar) days of becoming available. We should note that in our response, and that is consistent with our new recommendation to use 2 business days overall.</p>		pp. 76 - 82	§170.314(e)(2) Ambulatory setting only. Clinical summaries. Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, the following data elements: provider's name and office contact information; date and location of visit; reason for visit; patient's name; gender; race; ethnicity; date of birth; preferred language; smoking status; vital signs and any updates; problem list and any updates; medication list and any updates; medication allergy list and any updates; immunizations and/or medications administered during the visit; procedures performed during the visit; laboratory tests and values/results, including any tests and values/results pending; clinical instructions; care plan, including goals and instructions; recommended patient decision aids (if applicable to the visit); future scheduled tests; future appointments; and referrals to other providers. If the clinical summary is provided electronically, it must be: (i) Provided in human readable format; and (ii) Provided in a summary care record formatted according to the standard adopted at § 170.205(a)(3) with the following data elements expressed, where applicable, according to the specified standard(s): (A) Race and ethnicity. The standard specified in § 170.207(f); (B) Preferred language. The standard specified in § 170.207(j); (C) Smoking status. The standard specified in § 170.207(i); (D) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (E) Encounter diagnoses. The standard specified in § 170.207(m); (F) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); (G) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); (H) Laboratory value(s)/result(s). The value(s)/result(s) of the laboratory test(s) performed; and (i) Medications. At a minimum, the version of the standard specified in § 170.207(h).

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Engage patients and families in their care	MENU: Use certified EHR technology to identify patient-specific educational resources for more than 10% of all unique patients and provide those resources to the patient if appropriate		Use certified EHR technology to identify patient-specific educational resources and provide those to the more than 10% of all unique patients		Objective: Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all office visits by the EP.		Objective: Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient Measure: More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology		pp. 100 - 103	§170.314(a)(16) Patient-specific education resources. Enable a user to electronically identify and provide patient-specific education resources according to: (i) At a minimum, each one of the data elements included in the patient's: problem list; medication list; and laboratory tests and values/results; and (ii) The standard specified at § 170.204(b)(1).
Engage patients and families in their care	N/A	N/A	Offer secure online messaging to patients: at least 25 patients have sent secure messages online	N/A	Objective: Use secure electronic messaging to communicate with patients on relevant health information Measure: A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 % of unique patients seen during the EHR reporting period	N/A		We are concerned about 10% being too high to achieve by Stage 2. We recommend lowering the threshold to 5% (which is 10% of the necessary 50% with portal access) for patient-initiated messages. The patient-initiated message could be a response to a provider message. IE workgroup	pp. 135-138	§170.314(e)(3) Ambulatory setting only. Secure messaging. Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures: (i) Both the patient and EHR technology are authenticated; and (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f).
Engage patients and families in their care	N/A	N/A	Record patient preferences for communication medium for more than 20% of all unique patients seen during the reporting period	N/A	N/A Seeking Public Comment EP Objective/Measure: Record patient preferences for communication medium for more than 20 % of all unique patients seen during the EHR reporting period. We believe that this requirement is better incorporated with other objectives that require patient communication and is not necessary as a standalone objective.	N/A		HITPC's intent was to capture a patient's preferred communication method in order for the system to use that media for future non-urgent communication. This respects the patient's wishes and is more efficient for the provider. We recommend that the preferred communication field support multiple message types (e.g., non-urgent clinical, administrative) and preferred media (e.g., electronic, phone, SMS message).	p. 153	EHRs should also collect patient preferences.
Improve Care Coordination	Perform at least one test of the capability to exchange key clinical information among providers of care and patient authorized entities electronically		HIE test eliminated in favor of use objectives		N/A - Removed for an actual use case			We agree with eliminating the test. For Stage 1, we prefer option 4 (actual electronic transmission of a summary of care document).		We agree with eliminating the test. For Stage 1, we prefer option 4 (actual electronic transmission of a summary of care document).

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Improve Care Coordination	MENU: Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH		<i>Move to core.</i>	Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	Objective: The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)		<i>The certification criteria should support the reconciliation process (e.g., comparing multiple medication lists and resolving differences). In order to support the measure, the provider needs to capture the fact that a transition has occurred. Because detection of the occurrence of a transition must be captured manually, we recommend that the threshold remain at 50%. Coordinate with IE workgroup</i>		pp. 104 - 106	§170.314(b)(4) Clinical information reconciliation. Enable a user to electronically reconcile the data elements that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically display the data elements from two or more sources in a manner that allows a user to view the data elements and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to merge and remove individual data elements. (iii) Enable a user to review and validate the accuracy of a final set of data elements and, upon a user's confirmation, automatically update the list.
Improve Care Coordination	MENU: Provide a summary of care record for more than 50% of all transitions and referrals of care		<i>1. Record and provide (by paper or electronically) a summary of care record for more than 50% of transitions of care for the referring EP or EH 2. Record care plan goals and patient instructions in the care plan for more than 10% of all active patients</i>	Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral. Measure: 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 % of transitions of care and referrals. 2. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 % of transitions of care and referrals.	Objective: The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral. Measure: 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 % of transitions of care and referrals. 2. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 % of transitions of care and referrals. Seeking Comment		<i>In order to facilitate timely and meaningful referrals, we recommend that the care plan section of the summary of care document include the reason(s) for referral or transition and the results of the referral (recommendations). In order to support the measure, the provider needs to capture the fact that a transition is about to occur. We agree with the requirement for measure 2 that the transmitted summary of care document should cross organizational barriers. However, we believe that while it is essential that the exchange of information comply with prescribed standards, we believe that requiring that the transmission occur between different vendor systems may cause unintended consequences in some regions geographic regions where a few vendors may have a dominant market share. The group was divided on whether to support a countable number of electronic transmissions or a percent of all transitions. Coordinate with IE workgroup.</i>		pp. 106 - 118	170.314(b)(1) §170.314(b)(2) Transitions of care - incorporate summary care record. Upon receipt of a summary care record formatted according to the standard adopted at § 170.205(a)(3), electronically incorporate, at a minimum, the following data elements: Patient name; gender; race; ethnicity; preferred language; date of birth; smoking status; vital signs; medications; medication allergies; problems; procedures; laboratory tests and values/results; the referring or transitioning provider's name and contact information; hospital admission and discharge dates and locations; discharge instructions; reason(s) for hospitalization; care plan, including goals and instructions; names of providers of care during hospitalization; and names and contact information of any additional known care team members beyond the referring or transitioning provider and the receiving provider. Transitions of care - create and transmit summary care record (i) Enable a user to electronically create a summary care record formatted according to the standard adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): (A) Patient name; gender; date of birth; medication allergies; vital signs; laboratory tests and values/results; the referring or transitioning provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; (B) Race and ethnicity. The standard specified in § 170.207(f); (C) Preferred language. The standard specified in § 170.207(j); (D) Smoking status. The standard specified in § 170.207(1); (E) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (F) Encounter diagnoses. The standard specified in § 170.207(m); (G) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); (H) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); (I) Laboratory value(s)/result(s). The value(s)/result(s) of the laboratory test(s) performed. (J) Medications. At a minimum, the version of the standard specified in § 170.207(h); and (ii) Inpatient setting only. Hospital admission and discharge dates and location; names of providers of care during hospitalization; discharge instructions; reason(s) for hospitalization; and indication of whether an advance directive exists. (iii) Transmit. Enable a user to electronically transmit the summary care record created in paragraph (i) in accordance with: (A) The standards specified in § 170.202(a)(1) and (2). Optional. The standard specified in § 170.202(a)(3).

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Improve Care Coordination	N/A	N/A	Record health care team members (including at a minimum PCP, if available) for more than 10% of all patients seen during the reporting period; this information can be unstructured		N/A Seeking Public Comment Objective/Measure: Record health care team members (including at a minimum PCP, if available) for more than 10 percent of all patients seen during the reporting period; this information can be unstructured. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.		N/A <i>Okay to leave as part of the summary of care document.</i>		p. 154	
Improve Care Coordination	N/A	N/A	Send a care summary (including care plan and care team if available) electronically to the receiving provider for at least 25 patients undergoing a transition of care	Send a care summary (including care plan and care team if available) electronically to the receiving provider or post-acute care facility for more than 10% of all discharges	N/A Seeking Comment Objective/Measure: Record care plan goals and patient instructions in the care plan for more than 10 percent of patients seen during the reporting period. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.		N/A <i>Okay to leave as part of the summary of care document.</i>		p. 154	
Improve population and public health	MENU: Perform at least one test of the capability to submit electronic data to immunization registries or Immunization Information systems and actual submission in accordance with applicable law and practice		Attest to at least one submission of data in accordance with applicable law and practice		Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited , and in accordance with applicable law and practice Measure: Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited , and in accordance with applicable law and practice Measure: Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority.		pp. 121-123	§170.314(f)(1) / §170.314(f)(2) Immunization information. Enable a user to electronically record, change, and access immunization information. Transmission to immunization registries. Enable a user to electronically create immunization information for electronic transmission in accordance with: (i) The standard and applicable implementation specifications specified in § 170.205(e)(3); and (ii) At a minimum, the version of the standard specified in § 170.207(i).

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Improve population and public health	N/A	Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies and actual submission in accordance with applicable law and practice	N/A	Attest to submitting to at least one organization in accordance with applicable law and practice	N/A	Objective: Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited , and in accordance with applicable law and practice NEW Measure: Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.		<i>We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority.</i>	pp. 123 - 124	170.314(f)(5) / §170.314(f)(6) Inpatient setting only. Reportable laboratory tests and values/results. Enable a user to electronically record, change, and access reportable clinical laboratory tests and values/results. Inpatient setting only. Transmission of reportable laboratory tests and values/results. Enable a user to electronically create reportable laboratory tests and values/results for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(g); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g).
Improve population and public health	Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice		Attest to at least one submission in accordance with applicable law and practice		Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice Measure: MENU - Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period	Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice Measure CORE - Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period		<i>We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited".</i>	pp. 124 - 127	§170.314(f)(3) / §170.314(f)(4) Public health surveillance. Enable a user to electronically record, change, and access syndrome-based public health surveillance information. Transmission to public health agencies. Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with: (i) Ambulatory setting only. (A) The standard specified in § 170.205(d)(2). (B) Optional. The standard (and applicable implementation specifications) specified in §170.205(d)(3). (ii) Inpatient setting only. The standard (and applicable implementation specifications) specified in §170.205(d)(3).
Improve population and public health	N/A	N/A			Objective: Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice. NEW Measure: MENU - Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period	N/A		<i>Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited". Further clarification is needed regarding what is an acceptable registry.</i>	pp. 132 - 134	§170.314(f)(7) / §170.314(f)(8) Ambulatory setting only. Cancer case information. Enable a user to electronically record, change, and access cancer case information. Ambulatory setting only. Transmission to cancer registries. Enable a user to electronically create cancer case information for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(i); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g).

Health Outcomes Policy Priority	Eligible Professionals	Eligible Hospitals	Eligible Professionals	Eligible Hospitals	Eligible Professionals	Eligible Hospitals	Eligible Professionals	Eligible Hospitals	Stage 2 NPRM page numbers	2014 Edition EHR Certification Criterion
	Stage 1 Final Rule		Stage 2 - Proposed by HITPC		Stage 2 NPRM		Stage 2 NPRM - MU Workgroup Comments			
Improve population and public health	N/A	N/A	N/A	Objective: Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. New Measure: MENU - Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period	N/A		We are in agreement with the objective. Need to consider whether sufficient standards are available to support the interfaces between EHRs and commercial registries. Panelists at our hearing also expressed concern about the proprietary nature of some registries, which affects the costs to participate, and in some cases places contractual restrictions on use of data and ability to participate in other registries. <i>Need clarification on "in accordance with applicable law" and further explanation on "except where prohibited". Further clarification is needed regarding what is an acceptable registry.</i>		pp. 134 - 135	General usage of Certified EHR Technology (No specific certification criteria).
Ensure adequate privacy and security protections for personal health information	Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of the its risk management process		1. Perform, or update, security risk assessment and address deficiencies 2. Address encryption of data at rest	Objective: Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3). and implement security updates as necessary and correct identified security deficiencies as part of its risk management process			Privacy and Security Tiger Team		pp. 82 - 84	§170.314(d)(1) Authentication, access control, and authorization. (i) Verify against a unique identifier(s) (e.g., username or number) that a person seeking access to electronic health information is the one claimed; and (ii) Establish the type of access to electronic health information a user is permitted based on the unique identifier(s) provided in (d)(1)(i), and the actions the user is permitted to perform with the EHR technology. §170.314(d)(2) Auditable events and tamper-resistance. (i) Enabled by default. The capability specified in paragraph (d)(2)(ii) must be enabled by default (i.e., turned on) and must only be permitted to be disabled (and re-enabled) by a limited set of identified users. (ii) Record actions. Record actions related to electronic health information, audit log status and, as applicable, encryption of end-user devices in accordance with the standard specified in § 170.210(e). (iii) Audit log protection. Actions recorded in accordance with paragraph (d)(2)(ii) must not be capable of being changed, overwritten, or deleted. (iv) Detection. Detect the alteration of audit logs. §170.314(d)(3) Audit report(s). Enable a user to create an audit report for a specific time period and to sort entries in the audit log according to each of the elements specified in the standard at § 170.210(e). §170.314(d)(4) Amendments. (i) Enable a user to electronically amend a patient's health record to: (A) Replace existing information in a way that preserves the original information; and (B) Append patient supplied information, in free text or scanned, directly to a patient's health record or by embedding an electronic link to the location of the content of the amendment. (ii) Enable a user to electronically append a response to patient supplied information in a patient's health record. §170.314(d)(5) Automatic log-off. Terminate an electronic session after a predetermined time of inactivity. §170.314(d)(6) Emergency access. Permit an identified set of users to access electronic health information during an emergency. §170.314(d)(7) Encryption of data at rest. Paragraph (d)(7)(i) or (d)(7)(ii) must be met to satisfy this certification criterion. (i) If EHR technology manages electronic health information on an end-user device and the electronic health information remains stored on the device after use of the EHR technology on that device has stopped, the electronic health information must be encrypted in accordance with the standard specified in § 170.210(a)(1). This capability must be enabled by default (i.e., turned on) and must only be permitted to be disabled (and re-enabled) by a limited set of identified users. (ii) Electronic health information managed by EHR technology never remains stored on end-user devices after use of the EHR technology on those devices has stopped. §170.314(d)(8) Integrity. (i) Create a message digest in accordance with the standard specified in 170.210(c). (ii) Verify in accordance with the standard specified in 170.210(c) upon receipt of electronically exchanged health information that such information has not been altered. §170.314(d)(9) Optional. Accounting of disclosures. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in §170.210(d).

Topic	HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments	Quality Measure WG
Group reporting	<p>We seek public comment on a group reporting option that allows groups an additional reporting option in which groups report for their EPs a whole rather than broken out by individual EP. What should the definition of a group be for the exercise of group reporting? For example, under the PQRS Group Reporting Option, a group is defined as a physician group practice, as defined by a single Tax Payer Identification Number, with 25 or more individual eligible professionals who have reassigned their billing rights to the TIN. We could adopt this definition or an alternative definition.</p> <ul style="list-style-type: none"> Should there be a self nomination process for groups as in PQRS or an alternative process for identifying groups? Regarding the availability of Certified EHR Technology across the group, should the group be required to utilize the same Certified EHR Technology? Should a group be eligible if Certified EHR Technology (same or different) is not available to all associated EPs at all locations? Should a group be eligible if they use multiple Certified EHR Technologies that cannot share data easily? With respect to EPs who practice in multiple groups or in a group and practice individually, how should meaningful use activities be calculated? <p>As the HITECH Act requires all meaningful users to be paid 75 percent of all covered services, how should the covered services performed by EPs in another practice be assigned to the group TIN?</p> <ul style="list-style-type: none"> How will meaningful use activities performed at other groups be included? Should these services be included in the attesting group, or should CMS just ignore this information or account for it in other ways? How should the government address an EPs failure to meet a measure individually? If an EP chooses not to participate in a particular objective should they be a meaningful EHR user under the group if their non-participation still allows group compliance with a percentage threshold? How should yes/no objectives be handled in this situation? <p>Some EPs in a group participate in Medicaid while others participate in Medicare; what covered services should the meaningful use calculation capture?</p> <ul style="list-style-type: none"> Incentive payment assignment. Should the incentive payment be reassigned to the group automatically or does the EP still need to assign it to the group at registration? Should the same policy exist if the EP has covered services billed to other TINs? How should covered services for EPs who leave a group during an active EHR reporting period be handled? How should payment adjustments for Group reporting be handled? What alternative options should be considered for reporting meaningful use, while capturing necessary data? <p>For options presented, please share how each would be effectively implemented while meeting the objectives of the statute. For example, should EPs continue to report individually, use the batch file process proposed in this proposed rule or be included in a report of all EP data combined under one TIN?</p>	p. 241-242	<p><i>We maintain the benefit side of acting as a group, but need to do further work to come up with recommendations for how to actually do this. We are reluctant to move forward with group reporting at the CQM level because we recognize that there this is complexity and there are a number of unanswered questions. If not moving forward with this in stage 2, we will conduct hearings to discuss future benefits.</i></p>	<p><i>Supports finding more efficient batch reporting options that don't hide variability in the group. However the WG has concerns that the group reporting option as described in the NPRMN may allow "groups" of doctors that only share a tax ID to report together without them having coherent practice with care coordination. The WG suggested making the financial incentive align for "natural" groups like ACOs, but make the financial incentives stronger for "artificial" groups (e.g. multi-speciality group sharing a tax ID, but not exchanging data or doing care coordination) to report individually rather than as a group.</i></p>
Exchanging key clinical information	<p>We have found the objective of "capability to exchange key clinical information" to be surprisingly difficult for providers to understand, which has made the objective considerably more difficult to achieve than we envisioned in the Stage 1 final rule. As the measure for this objective is simply a test with no associated requirement for follow-up submission, we are concerned the value of this objective is not sufficient to justify the burden of compliance. However, we also strongly believe that meaningful use of EHRs must ultimately involve real and ongoing electronic health information exchange to support care coordination, as the Stage 2 objectives on this subject (described below) make clear. We considered four options for this objective, and welcome comment on all four, that variously reduce or eliminate the burden of the objective or increase the value of the objective. The first option we considered is removal of this objective. This acknowledges our experience with Stage 1 and the limited benefit of just a test. The second option is to require that the test be successful. This would increase the value of the objective and eliminate a common question we receive on what happens if the test is unsuccessful. The third option is to eliminate the objective, but require that providers select either the Stage 1 medication reconciliation objective or the Stage 1 summary of care at transitions of care and referrals from the menu set. This would eliminate the burden and complexity of the test, but preserve the domain of care coordination for Stage 1. The fourth option is to move from a test to one case of actual electronic transmission of a summary of care document for a real patient either to another provider of care at a transition or referral or to a patient authorized entity. This would increase the benefit of the objective and reduce the complexity of the defining the parameters of the test, but potentially increases the real burden of compliance significantly beyond what is currently included in Stage 1. We are proposing the first option to remove this objective and measure from the Stage 1 core set beginning in 2013 (CY for EPs, FY for eligible hospitals/CAHs). In Stage 2, we propose to move to actual use cases of electronic exchange of health information as discussed later in this proposed rule, which would require significant testing in the years of Stage 1. We encourage comments on all four options and will evaluate them again in light of the public comment received. Starting in 2014, Certified EHR Technology will no longer be certified to the Stage 1 EP and hospital core objectives of providing patients with electronic copies of their health information and discharge instructions upon request, nor will it support the Stage 1 EP menu objective of providing patients with timely electronic access to their health information. Therefore starting in 2014, for Stage 1, we propose to replace these objectives with the new "view online, download and transmit" objectives.</p>	p. 32	<p>Information Exchange Workgroup</p>	
CQMs - not supported MAP measures	<p>We also considered the recommendations of the Measure Applications Partnership (MAP) for inclusion of clinical quality measures. The MAP is a public-private partnership convened by the National Quality Forum (NQF) for the primary purpose of providing input to HHS on selecting performance measures for public reporting. The MAP published draft recommendations in their Pre-Rulemaking Report on January 11, 2012 (http://www.qualityforum.org/map/), which includes a list of, and rationales for, all the clinical quality measures that the MAP did not support. The MAP did not review the clinical quality measures for 2011 and 2012 that were previously adopted for the EHR Incentive Program in the Stage 1 final rule. We have included some of the clinical quality measures not supported by the MAP in Tables 8 (EPs) and 9 (eligible hospitals and CAHs) to ensure alignment with other CMS quality reporting programs, address recommendations by other Federal advisory committees such as the HITPC, and support other quality goals such as the Million Hearts Campaign. We also included some measures to address specialty areas that may not have had applicable measures in the Stage 1 final rule. We anticipate that only a subset of these measures will be finalized. When considering which measures to finalize, we will take into account public comment on the measures themselves and the priorities listed previously. We intend to prioritize measures that align with and support the measurement needs of CMS program activities related to quality of care, delivery system reform, and payment reform, especially:</p> <ul style="list-style-type: none"> Encouraging the use of outcome measures, which provide foundational data needed to assess the impact of these programs on population health. Measuring progress in preventing and treating priority conditions, including those affecting a large number of CMS beneficiaries or contributing to a large proportion of program costs. Improving patient safety and reducing medical harm. Capturing the full range of populations served by CMS programs. 	pp. 172-173	<p>Quality Measures WG</p>	<p><i>The work group supports reporting option 1a- allowing eligible providers to pick from a menu of measures across the 6 domains. For this to be viable, the committee encourages a robust number of measures to be included so that providers have a variety of options in each domain. At the time of the MAP endorsement, the new measures were only measure concepts, not specific measures, therefore the MAP could not evaluate these.</i></p>
EHR Safety	EHR safety (in certification rule - Quality management process, user centered design, common-format reporting)	pp. 38-43 of standards nprm		
Clinical summary - care plan definition	<p>We propose to describe a care plan as the structure used to define the management actions for the various conditions, problems, or issues. For purposes of meaningful use measurement, we propose that a care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome). We encourage EPs to develop the most robust care plan that is warranted by the situation. We also welcome comments on both our description of a care plan and whether a description is necessary for purpose of meaningful use.</p>	p. 80		

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Summary of Care Record - definition of lists	We solicit comment on whether the problem list should be extended to include, "when applicable, functional and cognitive limitations" or whether a separate list should be included for functional and cognitive limitations. We define an up-to-date problem list as a list populated with the most recent diagnoses known by the EP or hospital. We define active medication list as a list of medications that a given patient is currently taking. We define active medication allergy list as a list of medications to which a given patient has known allergies.	p. 110	<i>This is like any other health indication for the patient - it would appear when applicable.</i>	
Stage 2 Core and Menu Objectives	In the Stage 1 final rule we outlined Stage 1 criteria, we finalized a separate set of core objectives and menu objectives for both EPs and eligible hospitals and CAHs. EPs and hospitals must meet or qualify for an exclusion to all of the core objectives and 5 out of the 10 menu measures in order to qualify for an EHR incentive payment. In this proposed rule, we propose to maintain the same core-menu structure for the program for Stage 2. We propose that EPs must meet or qualify for an exclusion to 17 core objectives and 3 of 5 menu objectives. We propose that eligible hospitals and CAHs must meet or qualify for an exclusion to 16 core objectives and 2 of 4 menu objectives. Nearly all of the Stage 1 core and menu objectives would be retained for Stage 2. The "exchange of key clinical information" core objective from Stage 1 would be re-evaluated in favor of a more robust "transitions of care" core objective in Stage 2, and the "Provide patients with an electronic copy of their health information" objective would be removed because it would be replaced by an "electronic/online access" core objective. There are also multiple Stage 1 objectives that would be combined into more unified Stage 2 objectives, with a subsequent rise in the measure threshold that providers must achieve for each objective that has been retained from Stage 1.	pp. 16-17		
CPOE - licensed healthcare professionals	With this new proposal, we invite public comment on whether the stipulation that the CPOE function be used only by licensed healthcare professionals remains necessary or if CPOE can be expanded to include non licensed healthcare professionals such as scribes.	p. 49	<i>The essential feature is that the EP or EH professional be able to act on the automated decision support and be accountable for the order.</i>	
CPOE - denominator	We encourage comments on whether a denominator other than number of medication, laboratory, and radiology orders created by the EP or in the hospital would be needed for EPs and/or hospitals. For example, the HIT Policy Committee recommended a denominator of "patients with at least one type of order." We are proposing, however, a different denominator for this measure, which we believe would be possible to collect given our experience in Stage 1 of meaningful use and a much more accurate measure of actual CPOE usage. The denominator of "patients with at least one type of order" is a proxy measure for the number of orders issued by the EP, eligible hospital or CAH. We encourage comments on whether the barriers to collecting information for our proposed denominator would be greater in a hospital or ambulatory setting. As we noted previously, the denominator used in Stage 1 (as well as the denominator recommended by the HIT Policy Committee) is much more representative of CPOE use in a hospital setting than an ambulatory setting, so these settings could require different denominators or measures. We request comment on different denominators or measures and encourage any commenter proposing an alternative denominator to discuss whether the proposed threshold or an alternative threshold should be used for this measure and to include any exclusions they believe are necessary based on their alternative denominator.	p. 50		
CPOE - lab/rad	We welcome comment on whether laboratory and radiology orders are sufficiently different in the use of CPOE that they would require a different threshold and whether such a threshold should be a lower percentage or a yes/no attestation.	p. 52		
eRx - controlled substances	Although the Drug Enforcement Administration's (DEA) interim final rule on electronic prescriptions for controlled substances (75 FR 16236) removed the Federal prohibition to electronic prescribing of controlled substances, some challenges remain including more restrictive State law and widespread availability of products both for providers and pharmacies that include the functionalities required by the DEA's regulations. However, as Stage 2 of meaningful use would not go into effect until 2014, it is possible that significant progress in the availability of products enabling the electronic prescribing of controlled substances may occur. We encourage comments addressing the current and expected availability of these products and whether the availability would be sufficient to include controlled substances in the Stage 2 measure for e-Rx or to warrant an additional measure for EPs to choose that would include controlled substance electronic prescriptions in the denominator.	p. 54		
eRx - OTC meds	We do not believe that OTC medicines will be routinely electronically prescribed and propose to continue to exclude them from the definition of a prescription. However, we encourage public comment on this assumption	p. 55		
eRx - exclusion criteria	We also have considered instances where an EP may prescribe medications in a facility (such as a nursing home or ambulatory surgery center) where they are compelled to use the facility's ordering system, which may not be Certified EHR Technology. While we are not proposing exclusionary criteria related to this circumstance, we encourage comments on whether one is necessary or if the proposed 50 percent threshold is low enough to account for this situation.	p. 58		
Demographics - cause of death	The recording of the cause of death raised many questions from providers in Stage 1 of meaningful use. Some cases are referred to medical examiners to determine the official cause of death while others are not. Individual hospital policies and local/State laws and regulations vary. For purposes of meaningful use, we refer to the preliminary cause of death recorded by the hospital. This preliminary cause is not required to be amended due to additional information, but the hospital may amend the information if they want to maintain the most accurate information. The recording of the preliminary cause of death also does not have to occur within a specified timeframe from the death. We believe these clarifications will enable hospitals to meet this measure, but we encourage comments on our description of recording the cause of death.	p. 61		
Demographics - disability status	We encourage public comment on the burden and ability of including disability status for patients as part of the data collection for this objective. We believe that the recording of disability status for certain patients can improve care coordination, and so we are considering making the recording of disability status an option for providers. We seek comment on the burden incorporating such an option would impose on EHR vendors, as well as the burden that collection of this data might impose on EPs, eligible hospitals, and CAHs. In addition, we request public comment on --(1) how to define the concept "disability status" in this context; and (2) whether the option to collect disability status for patients should be captured under the objective to record demographics, or if another objective would be more appropriate. We also seek comment on whether, we should also include the recording of gender identity and/or sexual orientation. We encourage commenters to identify the benefits of inclusion and the applicability across providers.	p. 62		
Vitals - age limitations	Encourage public comment on the age limitations of vital signs.	p. 65		
Vitals - exclusions	We believe there are situations where height/length and weight may be relevant, but blood pressure is not. We are less certain that there would be cases where blood pressure is relevant, but height/length and weight are not. We propose for Stage 2 to split the exclusion so that an EP can choose to record height/length and weight only and exclude blood pressure or record blood pressure only and exclude height/length and weight. We encourage comments on this split and whether it should or should not go both ways.	p. 67		
Smoking status - age limit	We have not observed any significant consensus around when it is appropriate to collect smoking status, regardless of the presence or absence of other risk factors. If commenters disagree with our age limitation, we encourage them to include their reasons for disagreement and any evidence that may be available as to improved consensus among healthcare providers on what age limit is appropriate.	p. 68		

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Smoking status - expand to tobacco use	In Stage 1 of meaningful use, we considered whether to expand the collection of information from smoking status to other forms of tobacco use. We continue to believe that there are insufficient electronic standards for collecting information on other types of tobacco use and that situations where a patient might use multiple types of tobacco would damage the standardized collection of smoking data, but we request comment on whether this is the case.	p. 69		
Smoking status - second hand smoking	We encourage commenters to submit information to us that demonstrates consensus and/or standards around the collection of second hand smoking data that would provide the basis on which to create an additional tobacco-related measure that is applicable to all EPs and hospitals.	p. 69		
Clinical summary - timing	We note that the vast majority of information required in the clinical summary should be immediately available upon completion of the office visit. Although we provided 3 business days to send the clinical summary in Stage 1, we now believe that a faster exchange of information with patient is not only possible but also encourages better quality of care. However, we welcome comments on this timeframe. As in Stage 1, if a paper summary is mailed to the patient, the timeframe relates to when the summary is mailed and not when it is received by the patient.	p. 77-78	Information Exchange Workgroup	
Labs - count panels or groups	The measure in Stage 1 and Stage 2 counts lab tests individually, not as panels or groups in both the numerator and the denominator for the very complications illustrated by the inquiries that occur when this is not done. However, we solicit comment on whether such individual accounting is infeasible. We note that this in no way precludes the use of grouping and panels when ordering labs. While we are not proposing to move beyond numeric and yes/no tests, we request comments on whether standards and other capabilities would allow us to expand the measure to all quantitative results (all results that can be compared on as a ratio or on a difference scale).	p. 88	Information Exchange Workgroup	
Labs - expand to all quantitative results	While we are not proposing to move beyond numeric and yes/no tests, we request comments on whether standards and other capabilities would allow us to expand the measure to all quantitative results (all results that can be compared on as a ratio or on a difference scale).		Information Exchange Workgroup	
Patient education - literacy levels	We are specifically inviting comments and seeking input on whether EPs and hospitals believe that patient-specific education resources at appropriate literacy levels and with appropriate cultural competencies could be successfully identified at this time through the use of Certified EHR Technology.	p. 101		
Summary of Care Record - Care Plan	For purposes of meaningful use measurement we propose that a care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome). We encourage EPs to develop the most robust care plan that is warranted by the situation. We also welcome comments on both our description of a care plan and whether a description is necessary for purpose of meaningful use. All summary of care documents used to meet this objective must include the following: <ul style="list-style-type: none"> • Patient name. • Referring or transitioning provider's name and office contact information (EP only). • Procedures. • Relevant past diagnoses. • Laboratory test results. • Vital signs (height, weight, blood pressure, BMI, growth charts). • Smoking status. • Demographic information (preferred language, gender, race, ethnicity, date of birth). • Care plan field, including goals and instructions, and • Any additional known care team members beyond the referring or transitioning provider and the receiving provider. In addition, eligible hospitals and CAHs would be required to include discharge instructions. In circumstances where there is no information available to populate one or more of the fields listed previously, either because the EP, eligible hospital or CAH can be excluded from recording such information (for example, vital signs) or because there is no information to record (for example, laboratory tests), the EP, eligible hospital or CAH may leave the field(s) blank and still meet the objective and its associated measure. In addition, all summary of care documents used to meet this objective must include the following: <ul style="list-style-type: none"> • An up-to-date problem list of current and active diagnoses. • An active medication list, and • An active medication allergy list. We encourage all summary of care documents to contain the most recent and up-to-date information on all elements. In order for the summary of care document to count in the numerator of this objective, the EP or hospital must verify these three fields for problem list, medication list, and medication allergy list are not blank and include the most recent information known by the EP or hospital as of the time of generating the summary of care document.	pp. 108 - 109		QMVG discussed which fields or elements are required for stage 2 clinical quality measures, therefore should be included in the quality data model and in the final rule for certification. Some suggestions from the group were priority topics- including patient experience with process or outcomes of care, patient reported outcomes
Summary of Care Record - transport standards	ONC requests comments on whether equivalent alternative transport standards exist to the ones ONC proposes to exclusively permit for certification. Comments on transports standards should be made to the ONC proposed rule published elsewhere in this issue of the Federal register, while comments on the appropriateness of limiting this measure to only those standards finalized by ONC should be made to this rule. Note, the use of USB, CD-ROM, or other physical media or electronic fax would not satisfy the measures for electronic transmittal of a summary of care record. The required elements and standards of the summary of care document will be discussed in the ONC standards and certification proposed rule published elsewhere in this issue of the Federal Register. We are considering, in lieu of requiring solely the transmission capability and transport standard(s) included in a provider's Certified EHR Technology to be used to meet this measure, also permitting a provider to count electronic transmissions in the numerator if the provider electronically transmits summary of care records to support patient transitions using an organization that follows Nationwide Health Information Network (NwHIN) specifications (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_nhin_resources/1194). This could include those organizations that are part of the NwHIN Exchange as well as any organization that is identified through a governance mechanism ONC would establish through regulation. We request public comment on whether this additional flexibility should be added to our proposed numerator limitations.	p. 114	Information Exchange Workgroup	
Summary of Care Record - Transport standards	Another potential concern could be that another transport standard emerges after CMS' and ONC's rules are finalized that is not adopted in a final rule by ONC as part of certification, but nonetheless accomplishes the objective in the same way. To mitigate this concern, ONC has indicated in its proposed rule that it would pursue an off-cycle rulemaking to add as an option for certification transport standards that emerge at any time after these proposed rules are finalized in order to keep pace with innovation and thereby allow other transport standards to be used and counted as part of this measure's numerator. We solicit comments on how these standards will further the goal of true health information exchange. Additionally, in order to foster standards based-exchange across organizational and vendor boundaries, we propose to further limit the numerator by only permitting electronic transmissions to count towards the numerator if they are made to recipients that are -- (1) not within the organization of the transmitting provider; and (2) do not have Certified EHR Technology from the same EHR vendor...	pp. 111 - 118	Information Exchange Workgroup	
Public Health - Transport standards	We expect that CMS, CDC and public health agencies (PHA) will establish a process where PHAs will be able to provide letters affirming that the EP, eligible hospital or CAH was able to submit the relevant public health data to the PHA. This affirmation letter could then be used by the EP, eligible hospital or CAH for the Medicare and Medicaid meaningful use attestation systems, as well as in the event of any audit. We request comments on challenges to implementing this strategy.	p. 120	Information Exchange Workgroup	

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Public Health - Transport standards	In addition, whether moved to the core or left in the menu, States may also specify the means of transmission of the data or otherwise change the public health measure, as long as it does not require EHR functionality above and beyond that which is included in the ONC EHR certification criteria as finalized for Stage 2 of meaningful use. We solicit comment on extending State flexibility as described for Stage 2 of meaningful use and whether this remains a useful tool for State Medicaid agencies.	pp. 35-36		
Public Health - Syndromic Surveillance Menu item	We specifically invite comment on the proposal to leave syndromic surveillance in the menu set for EPs, while requiring it in the core set for eligible hospitals and CAHs.	p. 125	<i>We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority.</i>	
Imaging - Definition of accessible and direct link	For Stage 2, we do not propose the image or accompanying information (for example, radiation dose) be required to be structured data. Images and imaging results that are scanned into the Certified EHR Technology may be counted in the numerator of this measure. We define accessible as either incorporation of the image and accompanying information into Certified EHR Technology or an indication in Certified EHR Technology that the image and accompanying information are available for a given patient in another technology and a link to that image and accompanying information. Incorporation of the image means that the image and accompanying information is stored by the Certified EHR Technology. Meaningful use does not impose any additional retention requirements on the image. A link to the image and accompanying information means that a link to where the image and accompanying information is stored is available in Certified EHR Technology. This link must conform to the certification requirements associated with this objective in the ONC rule. We encourage comments on the necessary level of specification and what those specifications should be to define accessible and what constitutes a direct link. We also solicit comments on a potential second measure for this objective that would encourage the exchange of imaging and results between providers. We are considering a threshold of 10 percent of all scans and tests whose result is one or more images ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period and accessible through Certified EHR Technology also be exchanged with another provider of care.	p. 128-129	Information Exchange Workgroup	
Imaging - Definition of accessible and direct link	We also solicit comments on a potential second measure for this objective that would encourage the exchange of imaging and results between providers. We are considering a threshold of 10 percent of all scans and tests whose result is one or more images ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period and accessible through Certified EHR Technology also be exchanged with another provider of care.	pp.129-130	Information Exchange Workgroup	
Family Hx - Definition of first degree relative	First degree relatives include parents, offspring, and siblings. We considered other definitions, including those that address both affinity and consanguinity relationships and encourage comments on this definition. We note that this is a minimum and not a limitation on the health history that can be recorded. We invite comment on the utility of expanding this definition to capture risks associated with social and other environmental determinants.	p. 131		
Secure messaging - threshold	A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 percent of unique patients seen by the EP during the EHR reporting period. We invite comment on this new measure and whether EPs believe that the 10 percent threshold is too high or too low given the patient's role in achieving it.	p. 139		
Hospital discharge meds - limit to new or changed Rx	The HIT Policy Committee recommended that this measure be limited to new or changed prescriptions that were ordered during the course of treatment of the patient while in the hospital. The limitation is necessary because prescriptions that originate prior to the hospital stay, and that remain unchanged, would be within the purview of the original prescriber, and not hospital staff or attending physicians. We propose to include this limitation as we agree with the HIT Policy Committee that the hospital would not issue refills for medications they did not authorize or alter during their treatment of the patient. We ask that commenters consider whether a hospital issues refills to patients being discharged for medications the patient was taking when they arrived at the hospital and, if so, whether distinguishing those prescriptions from new or altered prescriptions is unnecessarily burdensome for the hospital.	p. 142	<i>We are concerned about 10% being too high to achieve by Stage 2. We recommend lowering the threshold to 5% (which is 10% of the necessary 50% with portal access) for patient-initiated messages. The patient-initiated message could be a response to a provider message.</i>	
View, download from hospital admission -	We propose this as a core objective for hospitals in Stage 2 with the following information that must be available as part of the objective: <ul style="list-style-type: none"> • Admit and discharge date and location. • Reason for hospitalization. • Providers of care during hospitalization. • Problem list maintained by the hospital on the patient. • Relevant past diagnoses known by the hospital. • Medication list maintained by the hospital on the patient (both current admission and historical). • Medication allergy list maintained by the hospital on the patient (both current admission and historical). • Vital signs at discharge. • Laboratory test results (available at time of discharge). • Care transition summary and plan for next provider of care (for transitions other than home). • Discharge instructions for patient, and • Demographics maintained by hospital (gender, race, ethnicity, date of birth, preferred language, smoking status). This is not intended to limit the information made available by the hospital. A hospital can make available additional information and still align with the objective. A hospital has any number of ways to make this information available online. The hospital can host a patient portal, contract with a vendor to host a patient portal, connect with an online PHR or other means. As long as the patient can view and download the information using a standard web browser and internet connection, the means is at the discretion of the hospital.	pp.146 - 147		
View, download from hospital admission -	This objective replaces two Stage 1 objectives for providing patients electronic copies of their health information upon request and providing electronic copies of discharge instructions. In Stage 1 of meaningful use, there was a measure of 50 percent of patients requesting electronic copies (within 3 business days) and discharge instructions (at time of discharge) were provided to them. The creation of this Stage 2 combined objective creates different time constraints. The HIT Policy Committee recommended 36 hours from discharge as an appropriate time period to meet this measure. We see no compelling reason to alter this recommendation; however, we encourage comment on whether this is an appropriate time frame for this new measure.		Information Exchange Workgroup	

Topic	HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments	Quality Measure WG
View, download from hospital admission - Threshold/broadband issues	The second measure represents a new concept for meaningful use criteria, because it measures the hospital based upon the actions of the patient. The HIT Policy Committee noted that providers would want flexibility with respect to the type of guidance provided to patients. In turn, the HIT Policy Committee recommended best practice guidance for providers, vendors, and software developments. We believe the hospital can sponsor education and awareness activities that result in patients viewing their information. Also, the low threshold of 10 percent recognizes that this kind of measure is in its earlier stages. A patient who views their information online, downloads it from the internet or uses the internet to transmit it to a third party would count for purposes of the numerator. However, we recognize, that in areas of the country where a significant section of the patient population does not have access to broadband internet, this measure may be significantly harder or impossible to achieve. For example, for a hospital in an area with 100 percent broadband availability, only 10 percent of the patient population must view the information. However, a hospital in an area with 30 percent broadband availability must essentially have a third of their patient population view the information. In addition, areas with high broadband penetration tend to correlate with more prolific users making it more likely that patients will view information online. There are 2 possible solutions to this disparity. The first is to exclude hospitals that operate in areas with below a certain threshold of broadband penetration. The second would be to change the measure to 10 percent of the broadband penetration. According to the FCC, 370 counties in the United States have broadband penetration of less than 50 percent (www.broadband.gov). Hospitals in areas of low broadband availability tend to service large areas that may extend beyond the county in which the hospital is located. Under the first option we considered if the county in which the hospital is located has less than 50 percent of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period, the hospital may exclude the second measure. Under the second option, the hospital would have to meet 10 percent of the broadband availability according to the FCC in the county in which they are located at the beginning of the EHR reporting period. For example, if the reported availability in a county on October 1 2014, for a hospital was 23 percent, the hospital's threshold for the second measure would be 2.3 percent. There are counties currently with zero percent availability. If there is a hospital in a county with zero percent availability, those hospitals would not have to meet the second measure. We propose to adopt the first method as we believe the second method is too complex to be a practical requirement. However, we welcome comments on both options as well as the correct threshold for the first option.	pp. 146 - 148	<i>Information Exchange Workgroup</i>	
Advanced directives - Did not follow HITPC recommendations	We have continuing concerns that there are potential conflicts between storing advance directives and existing State laws. Also, we believe that because of State law restrictions, an advance directive stored in an EHR may not be actionable. Finally, we believe that eligible hospitals and CAHs may have other methods of satisfying the intent of this objective at this time, although we recognize that these workflows may change as EHR technology develops and becomes more widely adopted. Therefore, we do not propose to adopt the HIT Policy Committee's recommendations to require this objective as a core measure, to store an electronic copy of the advance directive in the Certified EHR Technology, or to link to an electronic copy of the advance directive.	p. 150		
Advanced directives - EP	The HIT Policy Committee has also recommended the inclusion of this objective for EPs in Stage 2. In our Stage 1 final rule (75 FR 44345), we indicated our belief that many EPs would not record this information under current standards of practice and would only require information about a patient's advance directive in rare circumstances. We continue to believe this is the case and that creating a list of specialties or types of EPs that would be excluded from the objective would be too cumbersome and still might not be comprehensive. Therefore, we are not proposing the recording of the existence of advance directives as an objective for EPs in Stage 2. However, we invite public comment on this decision and encourage commenters to address specific concerns regarding scope of practice and ease of compliance for EPs.	p. 151	<i>Reference: Stage 2 Comparison!E19</i>	
CQMs - Time period	We are not proposing any changes to the time periods for reporting clinical quality measures. The EHR reporting period for clinical quality measures under the EHR Incentive Program is the period during which data collection or measurement for clinical quality measures occurs. The reporting period is consistent with our Stage 1 final rule (75 FR 44314) and will continue to track with the EHR reporting periods for the meaningful use criteria: <ul style="list-style-type: none"> • Eligible Professionals (EPs): January 1 through December 31 (calendar year). • Eligible Hospitals and Critical Access Hospitals (CAHs): October 1 through September 30 (Federal fiscal year). • EPs, eligible hospitals, and CAHs in their first year of meaningful use for Stage 1, the EHR reporting period would be any continuous 90-day period within the calendar year (CY) or Federal fiscal year (FY), respectively. 	pp.164 - 165	<i>Quality Measures WG</i>	<i>We have not yet discussed this item</i>
CQMs - reporting methods	The Office of the National Coordinator (ONC) sets the certification criteria for EHR technology, which for clinical quality measures are described in 45 CFR 170.314(c) in ONC's proposed rule published elsewhere in this issue of the Federal Register. Certified EHR Technology will be required for the reporting methods finalized from this proposed rule. This may include attestation, reporting under the PQRS EHR reporting option, the group reporting options for EPs, the aggregate portal-based reporting methods, and the finalized reporting method for eligible hospitals and CAHs. Readers should refer to ONC's proposed rule for an explanation of the definition of Certified EHR Technology that would apply beginning with 2014.	pp.167 - 168	<i>Quality Measures WG and Information Exchange Workgroup</i>	<i>Supports finding more efficient batch reporting options that don't hide variability in the group. However the WG has concerns that the group reporting option as described in the NPRMN may allow "groups" of doctors that only share a tax ID to report together without them having coherent practice with care coordination. The WG suggested making the financial incentive align for "natural" groups like ACOs, but make the financial incentives stronger for "artificial" groups (e.g. multi-specialty group sharing a tax ID, but not exchanging data or doing care coordination) to report individually rather than as a group.</i>
CQMs - wide range of measures	Criteria for Selecting Clinical Quality Measures - We are soliciting comment on a wide ranging list of 125 potential measures for EPs and 49 potential measures for eligible hospitals and CAHs. We expect to finalize only a subset of these proposed measures.	p. 168	<i>Quality Measures WG</i>	

Topic	HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments	Quality Measure WG
CQMs - domains	<p>We welcome comments on these domains, and whether they will adequately align with and support the breadth of CMS and HHS activities to improve quality of care and health outcomes.</p> <ul style="list-style-type: none"> • Patient and Family Engagement. These are measures that reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient-reported data and the ability to impact care at the individual patient level as well as the population level through greater involvement of patients and families in decision making, self care, activation, and understanding of their health condition and its effective management. • Patient Safety. These are measures that reflect the safe delivery of clinical services in both hospital and ambulatory settings and include processes that would reduce harm to patients and reduce burden of illness. These measures should enable longitudinal assessment of condition-specific, patient-focused episodes of care. • Care Coordination. These are measures that demonstrate appropriate and timely sharing of information and coordination of clinical and preventive services among health professionals in the care team and with patients, caregivers, and families in order to improve appropriate and timely patient and care team communication. • Population and Public Health. These are measures that reflect the use of clinical and preventive services and achieve improvements in the health of the population served and are especially focused on the leading causes of mortality. These are outcome-focused and have the ability to achieve longitudinal measurement that will demonstrate improvement or lack of improvement in the health of the US population. • Efficient Use of Healthcare Resources. These are measures that reflect efforts to significantly improve outcomes and reduce errors. These measures also impact and benefit a large number of patients and emphasize the use of evidence to best manage high priority conditions and determine appropriate use of healthcare resources. • Clinical Processes/Effectiveness. These are measures that reflect clinical care processes closely linked to outcomes based on evidence and practice guidelines. 	pp. 170 - 171	<i>Quality Measures WG</i>	<i>QMWG endorsed the 6 domains once again- see separate analysis of the Tiger Team comparison to the CQMs outlined in the NPRM</i>
CQM - Reporting	<p>We are proposing two reporting options that would begin in CY 2014 for Medicare and Medicaid EPs, as described below: Options 1 and 2. For Options 1, we are proposing the following two alternatives, but intend to finalize only a single method:</p> <ul style="list-style-type: none"> • Option 1a: EPs would report 12 clinical quality measures from those listed in Table 8, including at least 1 measure from each of the 6 domains. • Option 1b: EPs would report 11 "core" clinical quality measures listed in Table 6 plus 1 "menu" clinical quality measure from Table 8. <p>We welcome comment regarding the advantages and disadvantages of Options 1a and 1b, including EP preference, the appropriateness of the domains, the number of clinical quality measures required, and the appropriate split between "core" and "menu" clinical quality measures. It is our intent to finalize the most operationally viable and appropriate option or combination of options in our final rule. As an alternative to Options 1a or 1b, Medicare EPs who participate in both the Physician Quality Reporting System and the EHR Incentive Program may choose Option 2, as described below (the Physician Quality Reporting System EHR Reporting Option).</p>	pp. 178- 179	<i>Quality Measures WG</i>	<i>The work group supports reporting option 1a- allowing eligible providers to pick from a menu of measures across the 6 domains. The committee discussed this giving appropriate flexibility to multiple practice settings and specialties for eligible providers to choose measures that are clinically relevant at the local level.</i>
CQMs	<p>Therefore, we refer to clinical quality measures that apply "beginning with" or "beginning in" CY 2014.</p> <ul style="list-style-type: none"> • Option 1a: Select and submit 12 clinical quality measures from Table 8, including at least 1 measure from each of the 6 domains. <p>We are proposing that EPs must report 12 clinical quality measures from those listed in Table 8, which must include at least one measure from each of the following 6 domains, which are described in section II.B.3. of this proposed rule:</p> <ul style="list-style-type: none"> • Patient and Family Engagement. • Patient Safety. • Care Coordination. • Population and Public Health. • Efficient Use of Healthcare Resources. • Clinical Process/Effectiveness. <p>EPs would select the clinical quality measures that best apply to their scope of practice and/or unique patient population. If an EP's Certified EHR Technology does not contain patient data for at least 12 clinical quality measures, then the EP must report the clinical quality measures for which there is patient data and report the remaining required clinical quality measures as "zero denominators" as displayed by the EPs Certified EHR Technology. If there are no clinical quality measures applicable to the EP's scope of practice or unique patient populations, EPs must still report 12 clinical quality measures even if zero is the result in either the numerator and/or the denominator of the measure. If all applicable clinical quality measures have a value of zero from their Certified EHR Technology, then EPs must report any 12 of the clinical quality measures. For this option, the clinical quality measures data would be submitted in an XML-based format on an aggregate basis reflective of all patients without regard to payer. One advantage of this approach is that EPs can choose measures that best fit their practice and patient populations. However, because of the large number of measures to choose from, this approach would result in fewer EPs reporting on any given measure, and likely only a small sample of patient data represented in each measure.</p> <ul style="list-style-type: none"> • Option 1b: Submit 12 clinical quality measures composed of all 11 of the core clinical quality measures in Table 6 plus 1 menu clinical quality measure from Table 8. 	pp.180 - 181	<i>Quality Measures WG</i>	<i>The work group supports reporting option 1a- allowing eligible providers to pick from a menu of measures across the 6 domains. The committee discussed this giving appropriate flexibility to multiple practice settings and specialties for eligible providers to choose measures that are clinically relevant at the local level.</i>
CQMs - Core/Menu	<p>We request public comment on the core and menu set reporting schema described as well as the number and appropriateness of the core set listed in Table 6. We are considering that all identified core clinical quality measures must be reported by all EPs in addition to a menu set clinical quality measure. The policy on reporting "zeros" discussed previously under Option 1a would also apply for this core and menu option. In this option, an EP who does not report all of the identified core clinical quality measures, plus a menu set clinical quality measure, would have not met the requirements for submitting the clinical quality measures.</p>	p. 184	<i>Quality Measures WG</i>	<i>WG did not explicitly discuss</i>
EH CQMs - 2013	<p>For the EHR reporting periods in FY 2013, we propose that the eligible hospitals and CAHs would be required to submit information on each of the 15 clinical quality measures that were finalized for FYs 2011 and 2012 in the Stage 1 final rule (75 FR 44418 through 44420, Table 10). We refer readers to the discussion in the Stage 1 final rule for further explanation of the requirements for reporting those clinical quality measures (75 FR 44411 through 44422).</p>	p. 218	<i>Quality Measures WG</i>	<i>WG did not explicitly discuss</i>
EH CQMs - 2014	<p>Clinical Quality Measures Proposed for Eligible Hospitals and CAHs Beginning with FY 2014 We are proposing to change the reporting requirement beginning with FY 2014 to require eligible hospitals and CAHs to report 24 clinical quality measures from a menu of 49 clinical quality measures, including at least 1 clinical quality measure from each of the 6 domains. The 49 clinical quality measures would include the current set of 15 clinical quality measures that were finalized for FYs 2011 and 2012 in the Stage 1 final rule as well as additional pediatric measures, an obstetric measure, and cardiac measures.</p>	p. 219	<i>Quality Measures WG</i>	<i>wg did not explicitly discuss</i>
CQM - case threshold	<p>We are also soliciting comment on limiting the case threshold exemption to only children's, cancer hospitals, and a subset of hospitals in the Indian health system as they have a much more narrow patient base than acute care and critical access hospitals. Comments are solicited for application of the thresholds to Stage 1 of meaningful use in 2013, as the issue would be mitigated for Stages 1 and 2 by a beginning in 2014 proposed menu set of hospital clinical quality measures.</p>	p. 220	<i>Quality Measures WG</i>	<i>WG did not explicitly discuss</i>

Topic	HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments	Quality Measure WG
CQM - Reporting 2014	<p>(b) Reporting Methods Beginning with FY 2014 Under section 1886(n)(3)(A)(iii) of the Act, eligible hospitals and CAHs must submit information on the clinical quality measures selected by the Secretary "in a form and manner specified by the Secretary" as part of demonstrating meaningful use of Certified EHR Technology. Medicare eligible hospitals and CAHs that are in their first year of Stage 1 of meaningful use may report the 24 clinical quality measures from Table 9 through attestation for a continuous 90-day EHR reporting period as described in section II.B.1. of this proposed rule. Readers should refer to the discussion in the Stage 1 final rule for more information about reporting clinical quality measures through attestation (75 FR 44430 through 44431). Medicare eligible hospitals and CAHs would select one of the following two options for submitting clinical quality measures electronically.</p> <ul style="list-style-type: none"> • Option 1: Submit the selected 24 clinical quality measures through a CMS-designated portal. For this option, the clinical quality measures data would be submitted in an XML-based format on an aggregate basis reflective of all patients without regard to payer. This method would require the eligible hospitals and CAHs to log into a CMS-designated portal. Once the eligible hospitals and CAHs have logged into the portal, they would be required to submit through an upload process, data that is based on specified structures produced as output from their Certified EHR Technology. • Option 2: Submit the selected 24 clinical quality measures in a manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs using Certified EHR Technology. 	pp. 233-234	<p><i>Quality Measures WG Information Exchange Workgroup</i></p>	<p><i>QMWG supports the hospital reporting structure- reporting 24/49 measures. The group did not discuss option 1 vs option 2.</i></p>
CQM - Patient population	<p>We are considering the following 4 options of patient population – payer data submission characteristics:</p> <ul style="list-style-type: none"> • All patients – Medicare only. • All patients – all payer. • Sampling – Medicare only, or • Sampling – all payer. <p>Currently, the Hospital IQR program uses the "sampling – all payer" data submission characteristic. We request public comment on each of these 4 sets of characteristics and the impact they may have to vendors and hospitals, including but not limited to potential issues with the respective size of data files for each characteristic. We intend to select 1 of the 4 sets as the data submission characteristic for the electronic reporting method for eligible hospitals and CAHs beginning in FY 2014.</p>	p. 234	<p><i>Quality Measures WG</i></p>	<p><i>QMWG discussed but did not elicit a consensus opinion about which payers to include in the incentive program reporting</i></p>
EP that will attest	<p>We invite public comments on the estimated percentages and numbers of (registered) EPs that will attest to the aforementioned criteria because such information would help use more accurately determine the burden on the EPs.</p>	p. 337		

Stage 1 Objective	Proposed Changes	Effective Year (CY/FY)	MU WG Comments
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines	Change: Replacing the measure More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE	2014 – Onward (Required)	
Record and chart changes in vital signs	Change: Addition of alternative age limitations More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data	2013 – Only (Optional)	
Record and chart changes in vital signs	Change: Addition of alternative exclusions Any EP who (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	2013 – Only (Optional)	
Record and chart changes in vital signs	Change: Age Limitations on Growth Charts and Blood Pressure More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data	2014 – Onward (Required)	

Stage 1 Objective	Proposed Changes	Effective Year (CY/FY)	MU WG Comments
Record and chart changes in vital signs	Change: Changing the age and splitting the EP exclusion Any EP who (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	2014 – Onward (Required)	
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically	Change: Objective is no longer required	2013 – Onward (Required)	
Report ambulatory (hospital) clinical quality measures to CMS or the States	Change: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6	2013 – Onward (Required)	
EP Objective: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request. Hospital Objective: Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request. EP Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4business days of the information being available to the EP.	Change: Replace these three objectives with the Stage 2 objective and one of the two Stage 2 measures. EP Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP EP Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. Hospital Objective: Provide patients the ability to view online, download and transmit information about a hospital admission. Hospital Measure: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.	2014 – Onward (Required)	
Public Health Objectives:	Change: Addition of "except where prohibited" to the objective regulation text for the public health objectives under 42 CFR 495.6	2013 – Onward (Required)	

WORK PRODUCT: This document is a work product for the Health IT Policy Committee’s Meaningful Use Workgroup to support its ongoing discussions and does not represent HHS policy or opinion

First Payment Year	Stage of MU										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017								1	2	2	3

Questions	Location
1. Group reporting functional measures	HITPC_Comments Solicited - C6
2. Exchange data requirement a. Across orgs b. Across vendors	Discussed as part of summary of care objective, but have asked the IE workgroup to review further
3. Imaging - what is right intent	Note added to objective comments
4. Hospital lab reqt	The IE workgroup has been asked to review
5. Specialty registry if no standards exist	Note added to objective comments
6. Removing exchange requirement for st 1	HITPC_Comments Solicited - C7, the IE workgroup has also been asked to review
7. Use of new (?non-NQF endorsed) measures that address measure concepts HITPC had recommended (but may not be fully tested to meet NQF endorsement requirements)	HITPC_Comments Solicited - C8
8. EHR safety (in certification rule - Quality management process, user centered design, common-format reporting)	HITPC_Comments Solicited - C9
9. Provider accountability for patient engagement	Note added to objective comments
10. Bidirectional registries?	Note added to objective comments
11. Could you add the question of whether EP 3/5 and EH 2/4 menu objectives is the right number?	HITPC_Comments Solicited - C12
12. on p 108: "welcome comments on both our description of a care pan and whether a description is necessary for purpose of meaningful use." We need to discuss this.	HITPC_Comments Solicited - C10
13. We also need to comment on the definitions of active problems, meds, allergies on p 110	HITPC_Comments Solicited - C11
14. I'm re-reviewing the matrix, and I have some questions. Instead of listing this (Hospital eRx 10%) as a separate objective, would you mind including it with eRx for EPs (since that's where we also put the HITPC recommendation)?	Fixed
15. We overlooked the fact that the NPRM did not recommend Advance Directive for EP. We need to include that in our discussion on our next call.	Note added to objective and HITPC_Comments Solicited - C44 and C45

Questions	Location
16. We also didn't close on the fact that discharge instructions were available at discharge in stage 1, and in NPRM that goes to 36 hrs?	Note added to objective comments
17. Is there a typo for EP view and download? The objective says 24 hr and the measure says 4d.	Fixed