

Instructions

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

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 meeting, the page numbers from the NPRM, and the 2014 Certification Criterion
- 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 explicated solicited in the NPRM. In these circumstances a notation was made in red (i.e. **Seeking Comment**). The details of the public comment being solicited can be found on the Seeking Comment tab.

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 Stage 1 Final Rule	Eligible Hospitals Stage 1 Final Rule	Eligible Professionals Stage 2 Proposed by HITSC	Eligible Hospitals Stage 2 Proposed by HITSC	Eligible Professionals Stage 2 NPFM	Eligible Hospitals Stage 2 NPFM	Overarching Theme	Eligible Professionals Stage 2 NPFM - Patient Engagement Power Team Comments	Eligible Hospitals Stage 2 NPFM - Patient Engagement Power Team Comments	Stage 2 NPFM page	2024 Edition EHR Certification Criterion	COMMENTS
Improve quality safety, efficiency and reducing health disparities (Task 1)							Note System or Patient Theme (N) In EHR column - example: Patient Theme, I am a Contributing member of the Care Team	Note all specific themes that apply in this column, if unique to EP or EH, split column. example: Patient generated data is relevant to care - In care real-time - Historically - Prospectively	Note all specific themes that apply in this column, if unique to EP or EH, split column. example: Patient generated data is relevant to care - In care real-time - Historically - Prospectively	p. 53	Note specific recommendations to standards in this column in red. If there is no change recommended note SUPPORT. Note stage 3 after stage 2, and indicate they are for consideration for stage 3. example: Stage 2: Support data standards and encourage adding fields and accelerating these additions where patient generated data is likely. Stage 3: Modify standard to include patient generated data to include, patient results observations and self care plans.	
Improve quality safety, efficiency and reducing health disparities (Task 1)	MENI: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	MENI: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate lists of patients by multiple specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate lists of patients by multiple specific conditions to use for quality improvement, reduction of disparities, research or outreach	PATIENT INFLUENCING ITEM 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.	PATIENT INFLUENCING ITEM 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.	How does my care compare to clinical quality measures?	Use of system to proactively identify that I am getting the services that I should, when I should, compared to industry standards and/or people like me (new)	Use of system to proactively identify that I am getting the services that I should, when I should, compared to industry standards and/or people like me (new)	pp. 86-80	§170.314(a)(54) 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; SUPPORT (ii) Medication list; SUPPORT (iii) Demographics; and SUPPORT that with clarification - see below (iv) Laboratory tests and values/results; SUPPORT Question: When formulating patient lists - Do we use <u>Default list and/or Diagnosis</u> when making patient lists. Should there be a distinction between diagnosis and problem lists? <u>Comments:</u> what must be included in the standards: age, sex, race/ethnicity, religion, street address, place of birth? From Federal register demographic data includes language, gender, race, ethnicity, and date of birth/ do we agree with this as the most important demographic data needed Stage 2 Memo/Stage 3 EOP: List capability should be able to be dynamically created using any combination of patient-related elements that are being tracked - similar to widely available standard report writer capabilities. List output should be able to be used in patient communication/out-reach and population health related system features.	
Improve quality safety, efficiency and reducing health disparities (Task 1)	MENI: Send preventive or follow-up reminders to more than 20% of all unique patients 65+ years old or younger	N/A	More than 20% of all active patients are sent clinical reminder (reminder for an existing appointment does not count)	More than 20% of all active patients are sent clinical reminder (reminder for an existing appointment does not count)	PATIENT DIRECT INVOLVEMENT Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care Measure: More than 20% of all unique patients who have had an appointment within the 12 months prior to the beginning of the EHR reporting period received a reminder, per patient preference	N/A	How does my care compare to clinical quality measures?	Use of system to proactively identify that I am getting the services that I should, when I should, compared to industry standards and/or people like me (new)	Use of system to proactively identify that I am getting the services that I should, when I should, compared to industry standards and/or people like me (new)	pp. 89 - 91	§170.314(a)(51) Appointment 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; SUPPORT (ii) Medication list; SUPPORT (iii) Medication allergy list; SUPPORT (iv) Demographics; and SUPPORT but not rate below (v) Laboratory tests and values/results; SUPPORT Clarification #1 - needed on what the basic demographics will include. Also, what other data elements do we do we minimally want to include? Do we want adding family history being here. Example: family hx of breast cancer, prostate cancer. Family hx will definitely dictate need for preventive or follow up care Clarification #2 - Need to be specific regarding patient preferences in terms of channel/format/process to be received (secure message, text/link to portal, phone, etc.) Stage 2 Memo/Stage 3 EOP: Reminders should be driven by a variety of system processes including the List capability above, evidence-based medicine driven rules engines, care plan (jointly created and agreed to by patient and/or proxy), etc.	
Improve quality safety, efficiency and reducing health disparities (Task 1)	N/A	N/A	N/A	Medication orders automatically tracked via electronic medication administration record in use at or least one hospital/ambulatory ("automatically" implies "right" recorded without manual transcription)	N/A	Objective: Automatically track medication from order to administration using assistive technology in conjunction with an electronic medication administration record (eMAR) Measure: More than 20% 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.	How does my care compare to clinical quality measures?	Ensuring it enforces principle that patient safety is a system property (new)	Ensuring it enforces principle that patient safety is a system property (new)	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 (1)(A) through (1)(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. (E) Right time. The time and date of administration matches the standard specified in § 170.210(g), and user identification when a medication is administered. SUPPORT ALL ABOVE	
Improve quality safety, efficiency and reducing health disparities (Task 2)	N/A	N/A	N/A		PATIENT INDIRECT INVOLVEMENT Objective: Incorporate imaging results and information into Certified EHR Technology Measure: NEW MENI - More than 40% of all exams 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	PATIENT INDIRECT INVOLVEMENT Objective: Incorporate imaging results and information into Certified EHR Technology Measure: NEW MENI - More than 40% of all exams 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	Many EHR actions have a corresponding or correlating patient system reaction	Create once use often in both EHR and patient facing systems	Create once use often in both EHR and patient facing systems	pp. 127 - 130	§170.314(a)(22) 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. Clarification: "define 'narrative'" electronic access? - Any reasonable exceptions and if so what is the defined exception (e.g., no more than 24 hours) to the patient for them? Team discussion point: Should providers be able to review results before seen by patient? a point made in Policy Committee this week said that this should be a preference set by the patient - see	
Improve quality safety, efficiency and reducing health disparities (Task 2)	N/A	N/A	Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, directly authored 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, directly authored for more than 30 percent of unique 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	N/A	Many EHR actions have a corresponding or correlating patient system reaction	Create once use often in both EHR and patient facing systems	Create once use often in both EHR and patient facing systems	p. 155	§170.314(a)(9) Electronic notes. Enable a user to electronically record, charge, access, and search electronic notes. <u>Relevant comment/rationale:</u> From a patient's perspective, it is widely used than that is great and a "tam down" requirement for providers to meet - by including it in MU it sends a clear message that for the few that don't enter notes when they should, not just to enter notes to check a box, it's important to do so, especially when sent along with the clinical summaries to other providers who don't have to waste time contacting the first provider for more background. This will also provide value directly to the PCP if they are a third party to the referral, and to the patient (or their designated caregiver) depending on their health literacy. <u>Relevant comment/rationale:</u> Should author of documentation be the only one who can make changes to that documentation? If errors noted in documentation made by other health care team members, should there be a standard as to how correction is noted.	
Improve quality safety, efficiency and reducing health disparities (Task 2)	N/A	N/A	N/A	Hospital labs send (directly or indirectly) structured electronic clinical lab results to equipment providers for more than 40% of electronic lab orders received. ** HITSC: Use LOINC where available	PATIENT INDIRECT INVOLVEMENT Objective: Provide structured electronic lab results to eligible equipment providers. 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	Many EHR actions have a corresponding or correlating patient system reaction	Create once use often in both EHR and patient facing systems	Create once use often in both EHR and patient facing systems	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(a); and (ii) At a minimum, the version of the standard specified in § 170.207(a). <u>Comments:</u> Standard should include name of test and code number of test. <u>Comments:</u> Agree with HITSC recommendation that it be LOINC so that the data can be computed in a standardized way both within the provider systems and within consumer/patient tracking and assessment tools.	

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

Health Outcomes Policy Priority	Eligible Professionals Stage 1 Final Rule	Eligible Hospitals Stage 1 Final Rule	Eligible Professionals Stage 2 Proposed by HITEC	Eligible Hospitals Stage 2 Proposed by HITEC	Eligible Professionals Stage 2 NPFM	Eligible Hospitals Stage 2 NPFM	Overarching Theme	Eligible Professionals Stage 2 NPFM - Patient Engagement Power Team Comments	Eligible Hospitals Stage 2 NPFM - Patient Engagement Power Team Comments	Stage 2 NPFM page	2014 Edition EHR Certification Criterion	COMMENTS
Engage patients and families in their care TEAM 2 Jim/Heidi	N/A	N/A	N/A	N/A	PATIENT DIRECT INVOLVEMENT Objective: Provide patients the ability to view, review, download, and transmit their health information within a business day of the information being available to the provider. NEW Measure: 1. More than 50 percent of all unique patients seen by the EHR during the EHR reporting period are provided timely (within a business day after the information is available to the EHR) online access to their health information related to the EHR encounter to which the information is available to all unique patients seen by the EHR during the EHR reporting period for their authorized representative(s) view, download, or transmit to a third party their health information.	N/A	I am a contributing care team member Nothing about me, without me Patient-facing systems are not limited by legacy transactional systems	Patient generated data is relevant to care I can contribute to CDM success: <i>effective self-management, counseling, education, and adherence</i> Data should be viewable, downloadable and transmittable in a computable, transferable, easily moveable way to be trended, and at the data element level and human readable level of the patient's preference.	Patient generated data is relevant to care I can contribute to CDM success: <i>effective self-management, counseling, education, and adherence</i> Data should be viewable, downloadable and transmittable in a computable, transferable, easily moveable way to be trended, and at the data element level and human readable level of the patient's preference.	pp. 144 - 149	§170.314(a)(3) ** See COMMENTS to call to the right ** View, download, and transmit to 3rd party. (1) 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: (i) Patient name; gender; date of birth; race; ethnicity; preferred language; smoking status; Do include discharge/disposed; 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; reasons for hospitalization (what is the patient's problem list, diagnosis, and/or symptoms)? Do we need to define all providers of care/would this include all specialists (do include psychiatric and perhaps occupational and physical therapists, nutritionists, case managers etc.), names of provider of care during hospitalization; (3) Inpatient setting only. All of the data elements specified in paragraph (a)(1)(i)(A)-(I); (4) Download. Electronically download; (5) A file in a human readable format that includes, at a minimum: Define human readable format: is a PDF document? (6) Ambulatory setting only. All of the data elements specified in paragraph (a)(1)(i)(A)-(I); (7) Inpatient setting only. All of the data elements specified in paragraphs (a)(1)(i)(A)-(I) and (a)(1)(i)(II)(A)-(C); (8) A summary care record formatted according to the standards adopted at § 170.205(a)(5) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standards:(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; (9) Race and ethnicity. The 1997 revised standards will have five minimum categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There will be an category for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino." The standard specified in § 170.207(a)(1); (10) How about race AND/OR ethnicity. Example: RACE: Caucasian. Is my ethnicity usable if grandparents born in Russia? (11) Preferred language. The standard specified in § 170.207(a); (12) Smoking status. The standard specified in § 170.207(a); (13) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (14) Encounter diagnoses. The standard specified in § 170.207(a)(1); (15) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(5); (16) Laboratory tests. At a minimum, the version of the standard specified in § 170.207(a); (17) Laboratory values/results. The values/results of the laboratory tests performed; (18) Medications. At a minimum, the version of the standard specified in § 170.207(b); and (19) Inpatient setting only. The data elements specified in paragraph (a)(1)(i)(A)-(I); (20) Images formatted according to the standard adopted at § 170.205(a); (21) Transmit to third party. Electronically transmit the summary care record created in paragraph (a)(1)(i)(B)(2) or images available to download in paragraph (a)(1)(i)(B)(3) in accordance with: (1) The standard specified in § 170.205(a)(1), and (2) The standard specified in § 170.202(a)(1); and (3) Patient accessible log. (Word clarification here) (A) When electronic health information is viewed, downloaded, or transmitted to a third party using the capabilities included in paragraphs (a)(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(a); (example: must date/time of medication changes, therapy changes, etc. be noted for every change in care management of patient); (3) The action(s) that occurred; and (4) User identification. (Define it as the user transmitting the information?) (B) EHR technology presented for certification may demonstrate compliance with paragraph (a)(1)(i)(A) if it is also certified to the certification criterion adopted at § 170.314(a)(2) and the information required to be recorded in paragraph (a)(1)(i)(A) is accessible by the patient.	Content: General Comments from first full team, team #1 call and Policy Cms mtg related to view, download & transmit: * Link document are associated with the use case of a person collecting existing records from their provider(s) portal to print or aggregate them in a PDF or other tool (PULL). The consumer paradigm that this follows is on-line banking where the user selects date ranges, date types, etc. as well as output formats for both readable (PDF, text) and discrete to be computable (for banking it is Quicken, XLS but for health care it would be CCD). Data must remain in its raw clinical form so that if it is passed to a downstream physician they can use it accordingly (repeated at Policy meeting this week). * Transmit PDSN follows the use case where specific information is selected and/or part of a patient standing preference to be sent to one or more patient designated recipients (e.g. PHR, PCP, medical home, ACO, condition/disease registry, clinical research, etc.) via a Direct address or other mechanism. Processes to support setting this up would need to be set-up by patient self-service in the portal or within the registration process of the admission/encounter. * The concept of CCD was introduced which provides a standing preference (patient order) that any information action (care summary, Rx, education materials) is sent to the patient or the designated proxy. This is distinct and separate from view, download but similar to Transmit. The standard for CCME and Transmit could potentially use the same standard. * Data consent usability . Raw clinical data is translated to patient health literacy level of the consumer/patient interface point so that the clinical context is not lost. For example, if a paper copy is handed to the patient, the translation is done when this happens. If the raw data is sent to the patient's PHR and they want to use the info by itself or aggregated with other data, the translation is done there. * Link document usability . Data must be transferred at the level it is captured and tracked. If discrete field level then move data that way, do not allow data to be rolled into level/document "banks" that make the data uncomparable. * Link document usability . Diet and exercise are key to planning for and measuring outcomes related to better health. For stage 2 core add EHR and data exchange formats for both exercise and diet (see separate document). Both have been introduced within the ONC S&I Care Planning group. For stage 2 menu/stage 3 core require these fields to be able to be moved from a patient controlled system to the EHR. * Stage 2 Menu/Stage 3 Core . Transmit must include a mechanism to have discrete electronic information also transmitted from the patient to the provider. patient-sourced med list for med rec, biometric such as weight, blood pressure, glucose, surveys such as health risk assessments, depression, ADHD, observations of daily living (mood, pain, exercise) should be able to be acquired through forms on the patient web portal and/or (patient's choice) through the transmission from a patient controlled system such as a PHR.
Engage patients and families in their care TEAM 2 Jim/Heidi	N/A	N/A	N/A	N/A	PATIENT DIRECT INVOLVEMENT Objective: Provide patients the ability to view online and download information about a hospital encounter. NEW Measure: 1. More than 50 percent of all patients who are discharged from the hospital or emergency department (POS 23 or 22) at an eligible hospital or CCM are able to view their information available to them within 90 days of discharge. 2. More than 10 percent of all patients who are discharged from the hospital or emergency department (POS 23 or 22) at an eligible hospital or CCM are able to download or transmit to a third party their information during the reporting period.	N/A	I am a contributing care team member Nothing about me, without me Patient-facing systems are not limited by legacy transactional systems	Patient generated data is relevant to care I can contribute to CDM success: <i>effective self-management, counseling, education, and adherence</i> Data should be viewable, downloadable and transmittable in a computable, transferable, easily moveable way to be trended, and at the data element level and human readable level of the patient's preference.	Patient generated data is relevant to care I can contribute to CDM success: <i>effective self-management, counseling, education, and adherence</i> Data should be viewable, downloadable and transmittable in a computable, transferable, easily moveable way to be trended, and at the data element level and human readable level of the patient's preference.	pp. 149 -150	§170.314(a)(3) View, download, and transmit to 3rd party. (1) 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: (i) 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; reasons 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; (5) A file in a human readable format that includes, at a minimum: (i) Ambulatory setting only. All of the data elements specified in paragraph (a)(1)(i)(A)-(I); (ii) Inpatient setting only. All of the data elements specified in paragraphs (a)(1)(i)(A)-(I) and (a)(1)(i)(II)(A)-(C); (2) A summary care record formatted according to the standards adopted at § 170.205(a)(5) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standards:(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; (9) Race and ethnicity. The standard specified in § 170.207(a); (10) Preferred language. The standard specified in § 170.207(a); (11) Smoking status. The standard specified in § 170.207(a); (12) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (13) Encounter diagnoses. The standard specified in § 170.207(a)(1); (14) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(5); (15) Laboratory tests. At a minimum, the version of the standard specified in § 170.207(a); (16) Laboratory values/results. The values/results of the laboratory tests performed; (17) Medications. At a minimum, the version of the standard specified in § 170.207(b); and (18) Inpatient setting only. The data elements specified in paragraph (a)(1)(i)(A)-(I); (19) Images formatted according to the standard adopted at § 170.205(a); (20) Transmit to third party. Electronically transmit the summary care record created in paragraph (a)(1)(i)(B)(2) or images available to download in paragraph (a)(1)(i)(B)(3) in accordance with: (1) The standard specified in § 170.205(a)(1), and (2) The standard specified in § 170.202(a)(1); and (3) Patient accessible log. (A) When electronic health information is viewed, downloaded, or transmitted to a third party using the capabilities included in paragraphs (a)(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(a); (3) The action(s) that occurred; and (4) User identification. (B) EHR technology presented for certification may demonstrate compliance with paragraph (a)(1)(i)(A) if it is also certified to the certification criterion adopted at § 170.314(a)(2) and the information required to be recorded in paragraph (a)(1)(i)(A) is accessible by the patient.	Content: General Comments from first full team, team #1 call and Policy Cms mtg related to view, download & transmit: * Link document are associated with the use case of a person collecting existing records from their provider(s) portal to print or aggregate them in a PDF or other tool (PULL). The consumer paradigm that this follows is on-line banking where the user selects date ranges, date types, etc. as well as output formats for both readable (PDF, text) and discrete to be computable (for banking it is Quicken, XLS but for health care it would be CCD). Data must remain in its raw clinical form so that if it is passed to a downstream physician they can use it accordingly (repeated at Policy meeting this week). * Transmit PDSN follows the use case where specific information is selected and/or part of a patient standing preference to be sent to one or more patient designated recipients (e.g. PHR, PCP, medical home, ACO, condition/disease registry, clinical research, etc.) via a Direct address or other mechanism. Processes to support setting this up would need to be set-up by patient self-service in the portal or within the registration process of the admission/encounter. * The concept of CCD was introduced which provides a standing preference (patient order) that any information action (care summary, Rx, education materials) is sent to the patient or the designated proxy. This is distinct and separate from view, download but similar to Transmit. The standard for CCME and Transmit could potentially use the same standard. * Data consent usability . Raw clinical data is translated to patient health literacy level of the consumer/patient interface point so that the clinical context is not lost. For example, if a paper copy is handed to the patient, the translation is done when this happens. If the raw data is sent to the patient's PHR and they want to use the info by itself or aggregated with other data, the translation is done there. * Link document usability . Data must be transferred at the level it is captured and tracked. If discrete field level then move data that way, do not allow data to be rolled into level/document "banks" that make the data uncomparable. * Link document usability . Diet and exercise are key to planning for and measuring outcomes related to better health. For stage 2 core add EHR and data exchange formats for both exercise and diet (see separate document). Both have been introduced within the ONC S&I Care Planning group. For stage 2 menu/stage 3 core require these fields to be able to be moved from a patient controlled system to the EHR. * Stage 2 Menu/Stage 3 Core . Transmit must include a mechanism to have discrete electronic information also transmitted from the patient to the provider. patient-sourced med list for med rec, biometric such as weight, blood pressure, glucose, surveys such as health risk assessments, depression, ADHD, observations of daily living (mood, pain, exercise) should be able to be acquired through forms on the patient web portal and/or (patient's choice) through the transmission from a patient controlled system such as a PHR.
Engage patients and families in their care TEAM 2 Jim/Heidi	Provide clinical summaries 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 the (electronically accessible for viewing users)	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 the (electronically accessible for viewing users)	N/A	PATIENT DIRECT INVOLVEMENT Objective: Provide clinical summaries for patients for each office visit. NEW Measure: Clinical summaries are provided to patients within 24 hours for more than 50% of office visits.	N/A	I am a contributing care team member Nothing about me, without me Patient-facing systems are not limited by legacy transactional systems	Patient generated data is relevant to care I can contribute to CDM success: <i>effective self-management, counseling, education, and adherence</i> Data should be viewable, downloadable and transmittable in a computable, transferable, easily moveable way to be trended, and at the data element level and human readable level of the patient's preference.	Patient generated data is relevant to care I can contribute to CDM success: <i>effective self-management, counseling, education, and adherence</i> Data should be viewable, downloadable and transmittable in a computable, transferable, easily moveable way to be trended, and at the data element level and human readable level of the patient's preference.	pp. 76 - 82	§170.314(a)(2) ** See comments to call to the right ** Ambulatory setting only. Clinical summaries. Enable a user to provide clinical summaries to patients for each office visit that includes, 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)(5) with the following data elements expressed, where applicable, according to the specified standards:(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; (9) Race and ethnicity. The standard specified in § 170.207(a); (10) Preferred language. The standard specified in § 170.207(a); (11) Smoking status. The standard specified in § 170.207(a); (12) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (13) Encounter diagnoses. The standard specified in § 170.207(a)(1); (14) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(5); (15) Laboratory tests. At a minimum, the version of the standard specified in § 170.207(a); (16) Laboratory values/results. The values/results of the laboratory tests performed; (17) Medications. At a minimum, the version of the standard specified in § 170.207(b); and (18) Inpatient setting only. The data elements specified in paragraph (a)(1)(i)(A)-(I); (19) Images formatted according to the standard adopted at § 170.205(a); (20) Transmit to third party. Electronically transmit the summary care record created in paragraph (a)(1)(i)(B)(2) or images available to download in paragraph (a)(1)(i)(B)(3) in accordance with: (1) The standard specified in § 170.205(a)(1), and (2) The standard specified in § 170.202(a)(1); and (3) Patient accessible log. (A) When electronic health information is viewed, downloaded, or transmitted to a third party using the capabilities included in paragraphs (a)(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(a); (3) The action(s) that occurred; and (4) User identification. (B) EHR technology presented for certification may demonstrate compliance with paragraph (a)(1)(i)(A) if it is also certified to the certification criterion adopted at § 170.314(a)(2) and the information required to be recorded in paragraph (a)(1)(i)(A) is accessible by the patient.	Content: General Comments from first full team, team #1 call and Policy Cms mtg related to view, download & transmit: * Link document are associated with the use case of a person collecting existing records from their provider(s) portal to print or aggregate them in a PDF or other tool (PULL). The consumer paradigm that this follows is on-line banking where the user selects date ranges, date types, etc. as well as output formats for both readable (PDF, text) and discrete to be computable (for banking it is Quicken, XLS but for health care it would be CCD). Data must remain in its raw clinical form so that if it is passed to a downstream physician they can use it accordingly (repeated at Policy meeting this week). * Transmit PDSN follows the use case where specific information is selected and/or part of a patient standing preference to be sent to one or more patient designated recipients (e.g. PHR, PCP, medical home, ACO, condition/disease registry, clinical research, etc.) via a Direct address or other mechanism. Processes to support setting this up would need to be set-up by patient self-service in the portal or within the registration process of the admission/encounter. * The concept of CCD was introduced which provides a standing preference (patient order) that any information action (care summary, Rx, education materials) is sent to the patient or the designated proxy. This is distinct and separate from view, download but similar to Transmit. The standard for CCME and Transmit could potentially use the same standard. * Data consent usability . Raw clinical data is translated to patient health literacy level of the consumer/patient interface point so that the clinical context is not lost. For example, if a paper copy is handed to the patient, the translation is done when this happens. If the raw data is sent to the patient's PHR and they want to use the info by itself or aggregated with other data, the translation is done there. * Link document usability . Data must be transferred at the level it is captured and tracked. If discrete field level then move data that way, do not allow data to be rolled into level/document "banks" that make the data uncomparable. * Link document usability . Diet and exercise are key to planning for and measuring outcomes related to better health. For stage 2 core add EHR and data exchange formats for both exercise and diet (see separate document). Both have been introduced within the ONC S&I Care Planning group. For stage 2 menu/stage 3 core require these fields to be able to be moved from a patient controlled system to the EHR. * Stage 2 Menu/Stage 3 Core . Transmit must include a mechanism to have discrete electronic information also transmitted from the patient to the provider. patient-sourced med list for med rec, biometric such as weight, blood pressure, glucose, surveys such as health risk assessments, depression, ADHD, observations of daily living (mood, pain, exercise) should be able to be acquired through forms on the patient web portal and/or (patient's choice) through the transmission from a patient controlled system such as a PHR.

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<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>p. 241-242</p>	<p><i>Support an option, but need to think about what comprises a group. No way to get beneath the TIN level at the moment. Could work well for Kaiser, but in other scenarios it could be hard to do lumping. Keep on table for stage 3 and hear testimony from practices that might be doing this.</i></p> <p><i>Withdraw previous recommendation. CMS once receive public comments may hear the same thing. Have hearing around this and how this will be done for stage 3. Policy committee would need to have the hearing. Batchfile to report individual numerators and denominators from each EP, creating one entry point into submission of data. CQM, proposing an option for group reporting of CQMs Information from stage 1 regarding why people want this.</i></p> <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 tot move forward with group reporting at the CQM level because recognize that there is a lot of complexity and unanswered questions. We would propose that if not moving forward in stage 2, will do further hearings on this to discuss future benefits.</i></p>

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<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	<i>Information Exchange Workgroup</i>
<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	<i>Quality Measures WG</i>
<p>EHR safety (in certification rule - Quality management process, user centered design, common-format reporting)</p>	pp. 38-43 of standards nprm	
<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	
<p>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>	p. 110	<i>This is like any other health indication for the patient, it would appear when applicable.</i>

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<p>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.</p>	pp. 16-17	
<p>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>	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>
<p>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>	p. 50	
<p>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>	p. 52	
<p>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>	p. 54	
<p>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>	p. 55	
<p>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>	p. 58	
<p>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>	p. 61	

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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	
Encourage public comment on the age limitations of vital signs.	p. 65	
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	
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	
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	
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	
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	<i>Information Exchange Workgroup</i>
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	<i>Information Exchange Workgroup</i>
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).		<i>Information Exchange Workgroup</i>
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	

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<p>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:</p> <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. <p>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:</p> <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. <p>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.</p>	<p>pp. 108 - 109</p>	
<p>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>	<p>p. 114</p>	<p><i>Information Exchange Workgroup</i></p>
<p>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...</p>	<p>pp. 111 - 118</p>	<p><i>Information Exchange Workgroup</i></p>
<p>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>	<p>p. 120</p>	<p><i>Information Exchange Workgroup</i></p>

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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	
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>
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
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
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	
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	
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>

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HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments
<p>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:</p> <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). <p>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.</p>	<p>pp.146 - 147</p>	
<p>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.</p>		<p><i>Information Exchange Workgroup</i></p>
<p>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.</p>	<p>pp. 146 - 148</p>	<p><i>Information Exchange Workgroup</i></p>

HITPC_Comments Solicited

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HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments
<p>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>	p. 150	
<p>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>	p. 151	<i>Reference: Stage 2 Comparison'!E19</i>
<p>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:</p> <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>
<p>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.</p>	pp.167 - 168	<i>Quality Measures WG and Information Exchange Workgroup</i>
<p>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>	p. 168	<i>Quality Measures WG</i>
<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>

HITPC_Comments Solicited

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HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments
<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>
<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>
<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>
<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>
<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>
<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>

HITPC_Comments Solicited

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HITPC Recommendations / Comments Solicited in NPRM	Page	MU WG Comments
<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</i> <i>Information Exchange Workgroup</i></p>
<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>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	

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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)	

Proposed Changes_to_Stage 1 Workgroup to support its ongoing discussions and does not represent HHS policy or opinion

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)	

Proposed payment years

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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 -- Locations

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
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