February 25, 2011

Joshua Seidman, PhD
Office of the National Coordinator for Health Information Technology
Mary Switzer Building
330 C Street, SW, Suite 1200
Washington, DC 20201

RE: Comments on the Health Information Technology Policy Committee's (HITPC) proposal for Stage 2 of the Meaningful Use of Electronic Health Records (EHRs)

Dear Dr. Seidman:

The undersigned organizations appreciate the opportunity to provide feedback on the Health Information Technology Policy Committee's (HITPC) proposed set of requirements for Stages 2 and 3 of the Medicare/Medicaid Electronic Health Record (EHR) meaningful use incentive programs. We understand that although the Stage 3 objectives are included in the proposal, HITPC is primarily interested in comments on the proposed Stage 2 measures. In addition to this letter, attached is a matrix that summarizes the proposed measures, and our specific comments for each proposed Stage 2 and 3 measure. In addition, we have included feedback in response to the specific questions posed by the HITPC. **Physicians are diligently working towards incorporating well-developed EHRs into their practices to improve quality of care delivery, enhance patient safety, as well as support practice efficiencies. Inflexible, overly ambitious incentive program requirements will only hinder health IT transitions underway today. Promoting greater flexibility to meet meaningful use requirements will help us achieve the desired outcome for the Medicare/Medicaid EHR incentives—accelerating the widespread use of technology to improve our nation's health care delivery system.**

We recognize that the widespread proper use of health IT will help transform health care by facilitating health information exchange, reducing inefficiencies, and improving the quality of care. Financial incentives linked to reasonable, achievable measures will encourage the use of EHRs, but aggressive, burdensome requirements will not. Even the President's Council of Advisors on Science and Technology (PCAST) report, "Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward," published on December 8, 2010, acknowledged this concern:

> **We emphasize that there is a potential concern with pushing too many requirements into meaningful use. The concern is that this will create too onerous a burden for many healthcare providers, especially smaller physician offices that already may lag behind in adoption.**

Another key barrier to health IT adoption is the fact that much of the infrastructure and the tools required to achieve the desired level of interoperability and information sharing remains to be built. The aforementioned PCAST report also states, "…current efforts at health data networking are at relatively small scale." Physicians look forward to the day when they can securely exchange information with other providers to enhance the quality and efficiency of the care that they provide to their patients. However, asking physicians to do more within an environment that is still not largely interconnected, and in which commercially available products cannot perform the required functions reliably, will simply result in additional financial and administrative burdens, including the use of time-consuming dual processes—paper and electronic. Another

important factor to consider is the financial support for creating and maintaining information exchanges and ensuring that physicians are not burdened with funding these exchanges.

While we support a staged approach to the EHR meaningful use incentive program, we believe that this approach must take into account the current technological realities and the additional financial and administrative costs that will be incurred by physicians to meet all of the measures required by the program. Therefore, in order to maximize physician participation in the Medicare and Medicaid EHR meaningful use incentive programs, we firmly believe the following actions must occur:

(1) The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) should survey physicians who elected to participate and those who elected not to participate during Stage 1 of the incentive program and identify barriers to and solutions for physician participation prior to moving to Stage 2;
(2) Measures for meeting meaningful use should factor in appropriate use. Reasonable exclusions for many requirements should be included so that a physician can opt out of the measure if the measure has little relevance to the physician's routine practice;
(3) Prior to moving a measure from the Stage 1 menu set to the core set for Stage 2, or prior to adding new measures, the expected impact, the expected value, risks (both clinical and administrative), evidence of efficacy, administrative burden, costs to physicians, and technological standards of the move should be thoroughly assessed and publicly vetted. Any proposed new measure should initially be in the menu set of options;
(4) High thresholds should be avoided for objectives that cannot be met due to the lack of available, well-tested tools or bidirectional health information exchanges; and
(5) Measures that require adherence from a party other than the physician should be removed (e.g., patient's accessing patient portal, labs reporting test results).

Evaluation of Stage 1 participation rates

We believe it will be critical for CMS and ONC to create a mechanism to evaluate the progression of meaningful use objectives and measures, as well as the costs of adoption and upgrades of technology. Evaluating both the ability of physicians, EHR vendors, and the industry as a whole to meet measures and objectives, as well as associated costs, should be part of any decision-making process to move from one stage to the next.

The evaluation should include a process that enables physicians to provide feedback on the value of the Stage 1 measures to their practice. There should also be a mechanism that allows physicians to disclose to all relevant parties, including EHR vendors, when: structured data fields are not available or are needed in order to meet measures; patient safety concerns/issues with EHR capability arise; functionality or specifications are lacking; administrative complications occur in implementation, formatting, and other usability issues are uncovered; and actual computer errors stemming from the programs themselves, as well as lack of interoperability between programs, are discovered.

Solutions for overcoming Stage 1 barriers should also be incorporated in Stage 2. For example, if survey results show that specialists decided not to take part in the Stage 1 meaningful use EHR incentive program because many of the Stage 1 measures did not apply to their routine practice, then Stage 2 should allow physicians to opt out of any measures that do not apply to their routine practice. **We recommend that CMS and ONC survey physicians who elected to participate**

<u>and</u> those who elected not to participate during Stage 1 of the incentive program and identify barriers to and solutions for participation prior to moving to Stage 2.

<u>Most measures should include an exclusion category</u>

A major criticism from physicians, especially specialists, regarding the Stage 1 meaningful use measures is the fact that many of the measures are primary care focused and lack an exclusion category for physicians who determine that the measure has little relevance to the physician's routine practice. Eight of the 15 Stage 1 core measures and 3 of the 10 Stage 1 menu options do not include an exclusion category. Many of the exclusions for measures under both the core and menu sets do not allow an exemption for physicians who do not routinely perform the activity described. From both a clinical and legal standpoint, physicians will be reluctant to take part in the Medicare or Medicaid EHR incentive program if they are being required to record data in their EHRs that they typically do not collect or that is not relevant to their scope of practice or the services that they provide to their patients. **We strongly recommend that many of the measures for Stage 2 include an exclusion option so that a physician can opt out of the measure if the measure has little relevance to the physician's routine practice**.

<u>Inclusion of each measure should be carefully evaluated</u>

HITPC is recommending that the following Stage 1 measures from the menu set be moved to the core set for Stage 2:

- Implement drug formulary checks
- Incorporate lab results as structured data
- Generate patient lists for specific conditions
- Send patient reminders
- Medication reconciliation
- Summary care record
- Submit syndromic surveillance
- Provide patient-specific educational resources

And, HITPC is also recommending inclusion of the following new measures for physicians:

- Record advance directive
- Enter electronic notes
- Use secure online messaging
- Record patient communication preference
- Offer electronic self-management tools
- Personal Health Record (PHR) data exchange
- Patient care experience reporting
- Patient capability to upload data into EHRs
- List care team members in EHR
- Record longitudinal care plan
- Submit notifiable conditions using a reportable public-health submission button
- Submit patient-generated data to public health agencies
- Submit reportable lab data

New measures should be initially placed in the menu set for Stage 2. Many of these proposed new measures (e.g., listing of care team members, recording of a longitudinal care plan) require further definition and development and need to be evaluated prior to being moved from the menu to the core set. To support the suggested pathway of accelerated use of specific features of certified EHRs as a major indication of meaningful use (e.g., incorporating lab results as structured data), the following assessment must occur and be publicly vetted before moving measures from the menu set to the core set or including new measures:

- Expected impact
- Expected value
- Risks (both clinical and administrative)
- Evidence of efficacy
- Administrative burden
- Requirements and/or candidates for standards, definitions, value sets are considered by the Health IT Standards Committee (HITSC)

Under the HITPC's proposal, there is no distinction between menu and core measures, and there are no exclusions. We strongly recommend: 1) retaining the menu option, 2) if the assessment reveals that evidence is lacking on a measure's efficacy, then Stage 1 menu measures should continue to be listed in the menu set, and 3) before any new measures are added to Stages 2 and 3, they should be fully evaluated based upon the above-mentioned assessment criteria.

<u>High thresholds should be avoided for objectives that cannot be met due to the lack of bidirectional health information exchanges</u>

There must be a reliable, accurate interchange mechanism for physicians, other health care professionals, hospitals, and other health care entities to share health information about patients, otherwise all of these health care partners will be overwhelmed with manual entries of the same data, which conflicts with a main goal for using EHRs—to reduce costs, create efficiencies, and improve care coordination by allowing information to be shared more easily among physicians' offices, hospitals, and across health systems. Furthermore, adopting additional requirements that hinge on data exchange when the infrastructure necessary to support these exchanges is still very limited will deter participation in these incentive programs.

Similar to the Stage 1 measures, Stage 2 also requires a significant amount of manual data entry by physicians and their office staff in order to meet meaningful use measures. For example, both Stage 1 and Stage 2 measures include computerized physician order entry (CPOE) and do not require that the orders be transmitted electronically because of the lack of bidirectional exchange capabilities between physicians and hospitals, physicians and pharmacies, physicians and laboratories, physicians and state public health agencies, etc. Health care partners must be capable of exchanging the requisite data and that data must be presented in a way that is understandable to the physician. Until the national, regional, and local infrastructures have been substantially developed and tested to allow for the secure electronic exchange of patient health information, the threshold requirements should remain low for meeting measures that still can only be met through manual data entry. As experienced with the Medicare Physician Quality Reporting System (PQRS) incentive program implementation, high threshold requirements are problematic. Due to program errors, CMS decided to reduce the PQRS reporting sample requirement from 80 percent to 50 percent for 2011 and is adding an appeals process for those physicians who fail to qualify for incentives that they believe they are entitled to.

We recommend that the proposed high threshold requirements for CPOE, incorporating lab results, and similar measures be reduced. For example, requiring physicians to enter into their EHR at least one medication and one lab or radiology order for 60 percent of their unique patients who have at least one such order, will require physicians to expend significant time and resources to manually gather information that spans both electronic and paper-based systems. In the case of referrals, it is typical for specialists and independent labs to require their own paper form to be completed by the referring/ordering physician. Therefore, entering the order electronically through CPOE would then need to be followed up with a manual process involving a paper form. Furthermore, decision support for ambulatory EHRs is still very basic. Until there is a bidirectional exchange of data and robust decision support, we do not believe the value of CPOE can be fully realized just through manual entry of most orders. **We recommend that the thresholds for CPOE and similar measures that cannot be met due to the lack of bidirectional health information exchanges be significantly lowered.**

Measures requiring adherence from a party other than a physician should be removed

Any measure that holds physicians to an objective that is beyond their control should be removed. For example, physicians cannot force a patient to use a PHR or a patient portal. Without an incentive, many patients are unlikely to participate in this objective regardless of their ability to access the Internet. While patients should be informed of the benefits and uses of a PHR, physicians should not bear the risk of being penalized for something that is an independent decision made by the patient. **We recommend that measures that require adherence from a party other than the physician should be removed (e.g., patient's accessing patient portal, labs reporting test results).**

Responses to specific questions posed by HITPC

1. The definition for an electronic progress note should be broad and flexible enough to accommodate all specialties and all types of clinical encounters. Progress notes are written in a variety of formats and detail, depending on the clinical situation at hand and the information the physician believes is relevant to record.
2. We strongly support patients' access to their clinical information including patients with disabilities. Unfortunately, the direction HITPC has taken requires a one-size-fits-all approach to qualify for incentives. We strongly urge the HITPC to allow physicians who treat patients with disabilities as well as physicians who treat hard to reach populations (e.g., rural, homebound) to use technologies that best allow them to meet their patient's needs and allow their patients to best communicate with their physician.
3. Physicians should have the latitude to deploy methods/technologies that enable them to best meet the needs of their patients. Furthermore, they should not be required to purchase systems that contain components that they will rarely or never use. For example, physicians should be allowed to use certified EHR modules to qualify for meaningful use incentives given that such bundles of modules may be cheaper and easier to implement.
4. Physician views on PHRs are often positive, but nuanced, demonstrating awareness that PHRs pose unique risks and benefits. In a set of surveys of patients and doctors that the American Medical Association (AMA) and the Markle Foundation conducted in 2008, a large majority of those patients who had used a PHR felt they were valuable, but very few had used them and just under half said they would be interested in trying to do so. Among physicians, half thought PHRs could empower patients to participate in their care and just under half said they would be willing to use PHRs in their clinical work. Fewer than one quarter, however, agreed that using PHRs would improve their relations with

patients (one-third disagreed) and only about one third agreed with the general statement that PHRs would, "improve the quality of care." Meanwhile, large majorities worried that PHRs might contain incorrect information, that privacy protections were not adequate, and that patients might omit important information from their PHR. More recently, data from these surveys were published in *Health Affairs* (February 2011) showing that while 64 percent of physicians had never used a PHR, 42 percent indicated they would be willing to try, though there were differences according to physician location, gender and practice type. Furthermore, while many physicians are willing to try using a PHR, it is critical to note that according to HHS' own data, only 4 percent of physicians have a "fully functional" EHR and only 13 percent have a "basic system." We continue to believe that the focus of the EHR incentives should remain on adoption of well-tested, basic EHR systems.

5. While we support the idea that high performance on quality measures is consistent with meaningful use, performance thresholds have not been determined for many quality measures including all Physician Consortium for Performance Improvement (PCPI) measures. Given the current state on reporting on quality measures, we would not recommend this approach at this time.
6. Given that a group practice reporting option is available under both the Medicare e-prescribing and the Physician Quality Reporting System (PQRS) incentive programs, we support a group practice reporting option for meaningful use. This would be an opportunity for CMS to better align multiple incentive programs underway today.
7. We do not support making the advance directive measure a required measure under the core set. An exemption should be offered with the advance directive measure so that if recording an advance directive is not within the scope of a physician's practice, the physician could indicate that an exemption applies for meeting this particular measure. Please see our comments in the attached matrix on this topic.
8. We believe that attention needs to be spent on reaching consensus on the appropriate elements that should make up a care plan, clinical summary, and discharge summary. Here are potential elements for assessment purposes: (a) elements that could comprise a care plan include: care team member, diagnoses, medications, allergies, goals of care, data captured by remote monitoring devices (in and/or out of range), and interactions and interventions by care team members; (b) elements that could comprise a clinical summary include: encounter date and location, reasons for the encounter, providers, problem list, medication list, allergies, procedures, immunizations, vital signs, diagnostic test results, clinical instructions, orders (future appointment requests, referrals, scheduled tests), gender, race, ethnicity, date of birth, preferred language, advance directives, and smoking status; and (c) electronic discharge instructions could include: a statement of the patient's condition, discharge medications, activities and diet, follow-up appointments, pending tests that require follow-up, referrals, and scheduled tests.
9. Certified EHRs today must be able to accommodate any new measures for Stages 2 and 3 without requiring costly, time consuming upgrades. We recommend that new measures be initially placed in the menu set for Stage 2. Please also review our recommendations above under "Any proposed new measure should be initially placed in the menu set of options." We furthermore believe that more flexibility is needed for meeting measures to ensure that a specialist (e.g., radiologist, anesthesiologist, pathologist, home care physician, etc.) whose services do not fit neatly into the current set of proposed measures is able to participate or benefit from the incentive program. The proposed requirements will unduly exclude physicians who do not come into direct contact with patients like pathologists and radiologists. Nonetheless, these specialists' use of health IT is critical as is their ability to begin exchanging health information with other health care providers. Greater flexibility is also needed in the eligibility requirements to accommodate

hospital-based health care professionals who provide a substantial amount of services within their office-based practices so that they are also eligible for incentive payments based upon the adoption and use of qualifying EHRs in their offices. We also believe that incentives or relevant meaningful use requirements are warranted to encourage hospitals, Ambulatory Surgery Centers (ASCs), and office-based surgical practices to invest in systems such as those used by anesthesiologists (known as AIMS).

10. The following new objectives being considered for Stage 3 are ambitious:
    - Offer electronic self-management tools to patients with high priority health conditions
    - EHRs have capability to exchange data with PHRs using standards-based data exchange
    - Patients offered capability to report experience of care online
    - Offer capability to upload and incorporate patient-generated data into EHRs and clinician workflow
    - Public health button. E-reporting if possible, otherwise generate another form (e-fax) and send
    - Patient-generated data submitted to public health agencies
    - Submit reportable lab data

The assumptions for these aforementioned objectives are that: the majority of physicians, hospitals, and other health care professionals are using certified EHR technology, bidirectional data exchange capabilities amongst health care partners readily exist, and the majority of patients are using PHRs, accessing their health information online, communicating with their health care providers online, using electronic self-management tools, and understand measures relevant to their care. The above-mentioned activities must occur in order for the proposed new objectives for Stage 3 to be achievable.

Conclusion

We thank you for the opportunity to provide feedback on HITPC's proposed measures for Stages 2 and 3. Encouraging physician participation in the EHR meaningful use incentive program is critical to ensuring widespread EHR use; however, the requirements for participation must be realistic and attainable. We are committed to significantly increasing EHR adoption and ensuring that all eligible practices, especially smaller practices, are able to take advantage of the EHR incentives. Should you have questions about these comments, they can be directed to Mari Savickis at mari.savickis@ama-assn.org or 202-789-7414.

Sincerely,

American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Ophthalmology
American Association of Neurological Surgeons
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Sleep Medicine

American Association of Clinical Endocrinologists
American College of Emergency Physicians
American College of Osteopathic Surgeons
American College of Physicians
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Osteopathic Association
American Osteopathic Academy of Orthopedics
American Psychiatric Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
Congress of Neurological Surgeons
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Interventional Radiology
Society for Vascular Surgery
The Endocrine Society

REQUIREMENTS PROPOSED IN JANUARY 2011 RFI BY HEALTH IT POLICY COMMITTEE FOR STAGES 2-3

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
Improving quality, safety, efficiency and reducing health disparities	**CPOE**	Use CPOE for **30%** of medication orders	Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure	CPOE (by licensed professional) for at least 1 medication, and 1 lab or radiology order for **60%** of unique patients who have at least 1 such order (order does not have to be transmitted electronically)	CPOE (by licensed professional) for at least 1 medication, and 1 lab or radiology order **on 80%** of patients who have at least 1 such order (order does not have to be transmitted electronically)		**Hospital Requirement:** o We are concerned about the current ability of many hospitals to meet CPOE requirements given the complexity associated with its implementation, including the length of time it takes to train physicians to use CPOE. **EP Requirement:** o We are also concerned with the proposed 60% and 80% thresholds for EPs, especially the proposal to apply this requirement to labs and radiology orders. o First, medication orders are very different from other non-medication orders. Retaining this proposal will decrease, not increase, physician efficiency. Well trained staff working within established policies and procedures, within the decision support structure of the EHR should be able to build and submit an order in advance of the provider's review and authorizing signature. o Second, it should be noted that the language: "…orders entered by licensed professionals…" could be overly restrictive. Under current workflow situations, most physicians rely heavily on assistants to fill orders. o Third, today there is little if any ability for most physicians to exchange lab and other information with others electronically. While this capability is expected in the future, it does not exist widely today and could take years before it is tested and for most physicians to be able to engage in this type of data exchange. o Fourth, it is our understanding that there is no requirement for certified EHRs to integrate CPOE with clinical decision support (CDS). If most EHRs

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							did link CPOE and CDS together, there would be some value for entering lab and radiology orders electronically even if they were not able to be exchanged. Most of the cost savings that are generally attributable to the use of CPOE involve systems that are integrated with CDS. Therefore, in the absence of this functionality, it is unclear to us how patient safety, quality of care, and efficiency can be achieved or the requirement for including lab and radiology orders can be justified at this time. It is important to consider that the safety and value of lab and radiology orders entered electronically is still being studied. o Fifth, it is also our understanding that CPOE modules must contain the ability to handle all three order types – medications, lab, and radiology – in order to be certified for the EHR program, however, stand alone CPOE systems that handle medications, lab and radiology separately are more robust. Stand alone radiology CPOE systems for example are far more robust than certified modules that handle all three order types. o ***We recommend either removing the lab and radiology requirements for Stage 2, or decreasing the proposed threshold requirement substantially by retaining the Stage 1 threshold for medication orders but only requiring that one lab and one radiology order have been entered electronically (via attestation).***
	Drug-drug and drug-allergy checks	The EP has enabled this functionality for the entire EHR	None	Employ drug-drug interaction checking and drug allergy checking on	Employ drug-drug interaction checking, drug allergy checking, drug age	Reporting of drug interaction checks to be defined by quality measures workgroup	

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
		reporting period		appropriate evidence-based interactions	checking (medications in the elderly), drug dose checking (e.g., pediatric dosing, chemotherapy dosing), drug lab checking, and drug condition checking (including pregnancy and lactation) on appropriate evidence-based interactions		
	e-Prescribing	More than **40 %** of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology (Note: only non-controlled substances are	Any EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion from this objective/measure	**50%** of orders (outpatient and hospital discharge) transmitted as eRx	**80%** of orders (outpatient and hospital discharge) transmitted as eRx	If receiving pharmacy cannot accept eRx, automatically generating electronic fax to pharmacy OK	o We seek clarification on whether the intent for this measure is to require physician thresholds to be established using both outpatient and hospital discharge data. We are also unclear how a physician could be expected to meet thresholds that contain hospital discharge data. We do not believe a physician should be held to thresholds that rely on the physician obtaining hospital data as this is outside their control***. We recommend removing any requirement that calls for physicians to rely on meeting thresholds using hospital data.*** o We are also seeking clarification on how certain situations would be handled. For example: o If a surgeon spends 80% of their time in the hospital (does not meet hospital-based eligible professional) and 20% in private practice, how

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
		permissible)					would they be able to meet this threshold? Would they have to rely on the hospital to provide them this data? How would the data be provided? Even if they received the data how could they easily integrate this with their outpatient data? What if the hospital did not have an EHR? o ***We strongly urge inclusion of certain exclusions for this requirement:*** o We agree that controlled substances should be exempt because while the e-prescribing of controlled substances is now permitted under law, the infrastructure to handle these e-scripts still does not exist. o There remain situations when it is not practical to e-prescribe. For example, prescribing immunomodulating agents like interferons require extensive paperwork from the individual companies that then serves as the script. o We also agree there must be an exception for when a pharmacy is unable to accept the prescriptions electronically. o Physicians should also be able to exclude prescriptions when a when patient does not want the prescription to be sent electronically or if physicians are able to accommodate the patient's request. We recognize the need for patient preference when it comes to how a prescription should be communicated to a pharmacy assuming systems that physicians are using are able to accommodate such requests. o ARRA calls for synchronizing the various incentive program requirements. The program requirements for current incentive programs (e.g., e-prescribing, meaningful use of EHRs, PQRS) vary significantly. ***We***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
							strongly urge CMS to synchronize the EHR incentive program requirements with the requirements for the Medicare e-prescribing and PQRS programs to alleviate confusion, reduce administrative and financial burdens, and to promote efficiencies: o First, the Medicare e-prescribing incentive program requirements (physicians only have to report at least 25 e-prescriptions in 2010 and 2011) differ significantly from and are less burdensome to meet in comparison to the e-prescribing requirements for EHR Stage 1 and what is being proposed for EHR Stages 2 and 3. o Second, in addition to the varying thresholds, there is a considerable lack of coordination between the way incentives and penalties have been structured. The Medicare e-prescribing penalty program requires physicians to e-prescribe and report the e-prescribing G code 10 times during the first six months of 2011 to avoid 2012 penalties and a total of 25 times during 2011 to avoid 2013 penalties. Physicians who want to take part in the EHR incentive program are being forced to purchase and adopt a stand-alone e-prescribing system solely to avoid the 2012 and 2013 e-prescribing penalties. ***Therefore, we urge HHS to allow physicians who intend to participate in the EHR incentive program, which includes an e-prescribing measure, to be exempt from the Medicare e-prescribing penalties.*** Please refer to the letter we issued to HHS on this matter at: http://www.ama-assn.org/ama1/pub/upload/mm/472/erx-penalties-sign-on-letter.pdf. o Third, it should also be noted that while the Policy

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							Committee has recommended allowing electronically generated faxes, an exception for allowing these faxes is only in place until January 1, 2012, under the Medicare e-prescribing incentive program. ***We strongly recommend that CMS permit acceptance of e-prescriptions which result in a fax and extend the exception under the Medicare e-prescribing incentive program and the EHR program until the vast majority of pharmacies are able to receive these prescriptions electronically (without the need for a fax).*** o We believe that the threshold for Stage 2 should remain the same as Stage 1—percentages should be based upon patients whose records are already in the EHR (denominator) and should not include patients whose records are still maintained on paper. o HHS still has not adopted the remaining e-prescribing standards recommended by NCVHS, including prior authorization. Prior authorization ability is needed to determine what drugs are on which insurers' formulary. In addition to formulary checking, if a particular drug is indicated to require prior authorization, that information must be transmitted to the physician's EHR with a function that allows the physician to obtain the insurer's approval at the point of care; this saves time for the physician and patient, and minimizes unnecessary delays in providing much needed medication to the patient. ***We strongly urge HHS to publish the remaining e-prescribing standards.***
`	**Record demographics**	More than **50 %** of all unique patients seen by the EP	None	**80%** of patients have demographics recorded and can use them to	**90%** of patients have demographics recorded (including IOM		o We support the collection and use of demographic data to improve quality and address disparities, but we have some concerns with requiring physicians to produce stratified reports in the absence of: (1) user supports to ensure valid data collection; (2) easy mechanisms to

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
		have demographics recorded as structured data		produce stratified quality reports	categories) and can use them to produce stratified quality reports		produce stratified reports; and (3) a better understanding of how to interpret and use these reports. o It is unclear whether the demographic data being proposed for Stages 2 and 3 is the same as for Stage 1. o It is important that for the appropriate data elements and values to be collected and that the collection take place in an evidence-based manner to yield reliable data. Recent disparities research has demonstrated that much of the demographic data collected today is inappropriate or insufficient to answer key public policy questions. o The appropriate use of stratified quality reports to reduce disparities is not known in many contexts, and especially for small practices. For example, what would be the utility of such a report in a practice with a homogeneous patient population? o The cost of producing such reports should be considered. Most current EHR products cannot produce quality reports stratified by demographics without substantial technical expertise, including programming and statistics expertise that is beyond the scope of most physician offices. There must be functional products on the market that can reliably and easily perform these functions if they are to be required. o We are also unclear how this requirement will be measured. o We are concerned that producing stratified quality reports cannot be easily achieved by all EHR systems particularly when an EHR is interfaced with a Practice Management System (PMS). **Demographic data collection is *largely performed today using a PMS,***

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							therefore, we recommend this requirement be changed to permit collection of this data in either the PMS or the EHR. o ***We also recommend that the requirements for Stages 2 and 3 be applied to patients seen within the current year or a reasonable time frame and not patients seen over the last five or ten year period.***
	Report ambulatory quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation. For 2012, electronically submit the measures	None	Continue as per Quality Measures Workgroup and CMS	Continue as per Quality Measures Workgroup and CMS	The HIT Policy Committee's Quality Measures Workgroup issued a request for comment in December; new measures will be considered after review of public comments	o Please note that the AMA and individual specialty societies provided feedback in response to the December RFI.
	Maintain an up-to-date problem list of current and active diagnoses	More than **80 %** of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured	None	Continue Stage 1	**80%** problem lists are up-to-date	Expect to drive list to be up-to-date by making it part of patient visit summary and care plans	o We support maintaining an up-to-date problem list and current and active diagnoses, however, we do not see an efficient and effective way to automatically measure and track meeting this requirement. o It should also be acknowledged that fully updating a medication list is simply not something that every clinician does each time they see a patient. For example, when a patient sees a urologist or an ophthalmologist, these specialists do not generally "reconcile" a previously created list of medications with a patient. Likewise, a family physician does not generally update comprehensive problem lists during focused visits (e.g., patient seen for same-day appointment for sore throat or ankle sprain).

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
		data					Performing comprehensive visits at each and every encounter with a patient in order to capture information to meet EHR measures is problematic. o We are unclear why the language from the requirement under Stage 1 concerning unique patients is not retained in Stage 3? In the final rule for Stage 1, CMS says, ""the reason we propose to base the measure on unique patients as opposed to every patient encounter, is that a problem list would not necessarily have to be updated at every visit.'' Please clarify. o ***We recommend changing the threshold to 50% for Stage 3 and retaining the Stage 1 language concerning unique patient in Stages 2 and 3.***
	Maintain active medication list	More than **80 %** of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	None	Continue Stage 1	**80%** medication lists are up to-date	Expect to drive list to be up-to-date via medication reconciliation	o We seek clarification on what the term "active" means.

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	Maintain active medication allergy list	Maintain active medication allergy list	None	Continue Stage 1	**80%** medication allergy lists are up-to-date	Expect to drive the list to be up-to-date by making it part of visit summary	o ***The timeline for "up-to-date" must be clarified. We recommend that the term be defined as "the last time the physician prescribed for the patient."*** o It should also be noted that many claims based record systems run up to 3 month delays.
	Record vital signs	For more than **50%** of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period qualifies for an exclusion from this objective/measure	**80%** of unique patients have vital signs recorded	**80%** of unique patients have vital signs recorded		o ***We support the use of health IT to promote public health goals but we continue to believe that recording vital signs should be removed from the list of health IT requirements and moved to the clinical quality measures section.*** o Furthermore, these requirements are aimed largely at primary care physicians, and the 80% reporting threshold is too high for many specialists as they generally see patients for acute or specific conditions during a discrete period of time. We are concerned that this requirement will also be very disruptive for some specialists and could interrupt workflow. o ***If these requirements are not moved to the clinical quality section, we recommend at the very least modifying this criterion to state, "Record and chart changes in the appropriate vital signs (based on EP's specialty). Retaining the language as written is simply too prescriptive and in many cases will have no relevance to a physician's scope of practice or the service that they are providing.***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	Record smoking status for patients	More than **50** % of all unique patients 13 years old or older seen by the EP have "smoking status" recorded	Any EP who sees no patients 13 years or older during the EHR reporting period qualifies for an exclusion from this objective/measure	**80%** of unique patients have smoking status recorded	**90%** of unique patients have smoking status recorded		o We support recording smoking status for those physicians for whom collecting such data is relevant to the care that they provide, and do not believe this requirement should be applied to all physicians for all services. How will this data be expected to be used to improve care for those physicians who do not typically collect this information today? o ***We furthermore recommend removing this from the list of health IT requirements and moving it to the clinical quality measures section.***
	Implement clinical decision support	Implement one clinical decision support rule	None	Use CDS to improve performance on high-priority health conditions. Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the	Use CDS to improve performance on high-priority health conditions. Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the		o ***We oppose the expansion of this requirement for a number of reasons.*** o First, many clarifications are needed. For example: o What conditions constitute "high priority"? o If this definition is intentionally left vague, who decides what health conditions are considered high priority? o When setting CDS attributes, we also believe that a more general statement on these attributes should be used in place of the current menu of 8 attributes. Alternatively, the attributes listed should be clarified as to how they are defined and by whom. o Second, using CDS to "improve performance" is unrealistic based on the evidence to date; it has only been proven to help improve performance in a few carefully controlled study settings in hospitals. Recent analyses suggest no consistent relationship between use of CDS and improved quality in ambulatory settings (*Arch Intern Med.* Published online January 24, 2011. doi:10.1001/archinternmed.2010.527). Therefore, the expectation implied by the metric as written, that

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
				appropriate party who can take action	appropriate party who can take action		the use of CDS will improve quality, is inappropriate and could lead to requirements that are not based on the available evidence. More research needs to be done with respect to documenting the effectiveness of CDS in EHRs. Rushing a process into practice that is not ready for primetime with the potential to affect the practice of medicine can be detrimental to patient care. We also do not feel comfortable with vendors hurriedly creating these CDS tools because they lack the expertise to develop and test relevant tools for specialty physicians. The tools are much like developing quality measures and need to be tied to evidence. When a tool is not relevant to the treatment of the patient, physicians will not utilize it. o Third, implementing CDS requires the development of EHR hardware and software and should be a criterion for vendors of EHRs. Once a platform for a specialty exists, it is still a formidable task and burdensome to document even with the best systems. Good CDS measures for all specialties are not currently available, and the technology does not currently exist to efficiently record and report CDS and other quality measures. ***We strongly recommend the current Stage 1 requirement for CDS be maintained for Stages 2 and 3 and that no additional CDS requirements should be included until more robust, clinically relevant and proven CDS tools are available.***

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	Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	None	Move current measure to core	**80%** of medication orders are checked against relevant formularies	What is the availability of formularies for eligible professionals?	o The 80% threshold may not be achievable for all practice settings. We recommend that the requirement be revised to read, "50% of medication orders where formulary information is readily accessible through the certified e-prescribing application".
	Record Advance Directive	**50%** (Hospital Requirement only)	n/a	Make core requirement. For EP and EH: **50%** of patients >=65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	For EP and EH: **90%** of patients >=65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	Potential issues include: state statutes; challenges in outpatient settings; age; privacy; specialists; needs to be accessible and certifiable; need to define a standard	o While we support the recording of advance directives, we do not believe this is a requirement that should be required of all physicians. This is largely a primary care function and is not something typically done by many specialists unless they possibly are the only physician caring for a patient. It many cases though, it would be inappropriate for specialists to discuss advance directives with their patients if they do not manage their overall care. ***We urge the inclusion of an exception for this requirement be included.***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	Incorporate clinical lab-test results into EHR as structured data	More than **40 %** of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data WAS MENU	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period qualifies for an exclusion from this objective/measure	Move current measure to core, but only where results are available	**90%** of lab results electronically ordered by EHR are stored as structured data in the EHR and are reconciled with structured lab orders, where results and structured orders available		• We have a few concerns with this proposed requirement. • We recommend that the requirement specify which lab results the objective is referring to. For example, do the results of allergy skin testing have to be recorded as structured data? What about providers who perform RAST testing, a blood test used to determine to what substances a person is allergic in the office? Will they have to modify their equipment to enter results into their records as structured data? What about audiology testing results? • We also believe that it is premature to recommend a 90% threshold for Stage 3 when few physicians have lab interfaces today, and unless this can be achieved by Stage 3, this requirement will result in a significant volume of manual work for physicians. • ***The 90% threshold could represent a significant administrative burden. For physicians who do not have lab interfaces, this could mean a significant amount of data entry. We strongly recommend the threshold for Stage 3 be reduced significantly.***
	Generate lists of patients by specific conditions	Generate at least one report listing patients of the EP with a specific condition	None	Make core requirement. Generate patient lists for multiple patient-specific parameters	Patient lists are used to manage patients for high-priority health conditions		o ***This requirement is vague and so we recommend more details be provided and clarification of what is expected.*** o ***We also recommend allowing physicians to create patient lists that include clinical trial criteria.***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	Send reminders to patients	More than **20 %** of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology qualifies for an exclusion from this objective/measure	Make core requirement.	**20%** of active patients who prefer to receive reminders electronically receive preventive or follow-up reminders	How should "active patient" be defined?	o We have some comments on the proposed Stage 3 requirement. o ***First, we urge retaining the exclusion from Stage 1 for Stages 2 and 3.*** o Second, we believe further clarification is needed. If a fraction of a physician's patients request electronic reminders and the rest request paper ones, does the physician have to track the handful of patients who want reminders electronically and separately track those who want paper?
	NEW (for EP) **Electronic Note**	n/a	n/a	**30%** of visits have at least one electronic EP note	**90%** of visits have at least one electronic EP note	Can be scanned, narrative, structured, etc.	o We support allowing a variety of formats for electronic notes. o While some notes can be reduced to structured data, doing so will limit the detail and clarity of them in many situations and we do not envision all electronic notes taking a structured format. Free text fields (e.g., typed or transcribed) seem to be more likely to be useful in many clinical situations. o We recognize there are patient safety concerns associated with the legibility of scanned notes, but the current environment is not ready for purely structured data or transcribed data, nor are many aspects of clinical care amenable to structured data entry and retrieval. Therefore, for the time being we support allowing the use of scanned notes. ***We urge clarifying this requirement to explicitly permit the use of scanned notes for now.***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	NEW (for hospital) **Electronic Note**	n/a	n/a	**30%** of EH patient days have at least one electronic note by a physician, NP, or PA	**80%** of EH patient days have at least one electronic note by a physician, NP, or PA	Can be scanned, narrative, structured, etc.	o We believe there should already be a daily progress note every day for every patient. ***We recommend while transitioning to the electronic note that for Stage 2 this requirement be placed on the menu set.***
	NEW (for hospital) **Medication orders tracked electronically**	n/a	n/a	**30%** of EH medication orders automatically tracked via electronic medication administration recording	**80%** of EH inpatient medication orders are automatically tracked via electronic medication administration recording		
Engage Patients and Families in Their Care	**Provide patients with an electronic copy of their health information**	More than **50 %** of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period qualifies for an exclusion from this objective/measure	Continue Stage 1	**90%** of patients have timely access to copy of health information from electronic health record, upon request	Only applies to information already stored in the EHR	o We continue to believe that current laws already adequately account for requirements to provide patients with copies of their medical records. o Requiring physicians to produce this information within 3 days could be extremely burdensome for many physicians and may not be practical or appropriate. Physicians need sufficient time to complete a clinical summary after a patient visit, collect and review relevant health information, including test results, and discuss results with their patients if appropriate, prior to providing a patient with access to their medical records. ***We recommend physicians only be required to provide copies of medical records in accordance with time limits established under federal and/or state laws (e.g., HIPAA calls for 30 days).***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	Discharge Instructions **(Hospitals only)**	Provide electronic copy of discharge instructions (EH) at discharge (50%)	n/a	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least **80%** of patients (patients may elect to receive only a printed copy of the instructions)	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least **90%** of patients in the common primary languages (patients may elect to receive only a printed copy of the instructions)	Electronic discharge instructions should include a statement of the patient's condition, discharge medications, activities and diet, follow-up appointments, pending tests that require follow up, referrals, scheduled tests [we invite comments on the elements listed above]	o Some clarification is needed regarding what format electronic discharge instructions should take. Scanned discharge instructions that are then printed and given to patients do not take legibility into account. We believe the goal is to migrate away from handwritten documents whenever possible, and, instead, use "structured" data or, as appropriate, typed "free text." ***With legibility being an important factor for patient safety, we recommend that for this standard "electronic" be defined as keyed data.***
	Provide patient-specific education resources	More than **10 %** of all unique patients seen by the EP are provided patient specific education resources	None	Continue Stage 1	**20%** offered patient-specific educational resources online in the common primary languages		o While we appreciate the need for patients to receive educational resources in their primary language, this is an unfunded mandate that physicians, especially small practices, will have difficulty meeting. This requirement also raises a number of questions: o Will vendors be required to retool their systems to provide these resources? Relatively few EHRs have patient education tools built in at present. o What are "the common primary languages"? If a product includes 5 languages but a patient's primary language is not among these, will the physician need to purchase a costly upgrade? o ***We recommend removing the portion of the requirement that says, "in the common primary***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
							languages."
	Patient able to download hospital information **NEW (for hospitals)**	n/a	n/a	**80%** of patients offered the ability to view and download via a web-based portal, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human-readable and structured forms (HITSC to define).	**80%** of patients offered the ability to view and download via a web-based portal, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human readable and structured forms (HITSC to define).	Inpatient summaries include: hospitalization admit and discharge date and location; reason for hospitalization; providers; problem list; medication lists; medication allergies; procedures; immunizations; vital signs at discharge; diagnostic test results (when available); discharge instructions; care transitions summary and plan; discharge summary (when available); gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status. [we invite comments on the elements listed above]	o We support the inclusion of discharge summaries, however we have concerns with the Stage 3 requirements. o ***The 80% threshold may be too aggressive for some hospitals, therefore, we recommend the percentage be changed to 50% for Stage 2.*** o ***We also recommend that since patient access to information in a timely manner continues to be an issue because the documents need to be completed, that this requirement should be driven by the documentation date and should not be driven by the date of the encounter.*** o ***We also recommend care be taken to ensure that both the human readable form and the structured form are produced in an electronic format that is readily available to most computer users.*** To be sure patients are able to view this information from a home computer it would be best if the information is made available in at least two common formats. For example, a patient should be able to view documents in both text and PDF; the patient can then determine which format works best with their personal computer. Older model computers and dated computer software, which many patients are likely to be using, may not accept documents created in the newest technological formats. This concern applies to all measures requiring patient participation from home computers. o Lastly, we have concerns with the number of items that are being included in Stage 3 and we caution that this could result in a very long summary. ***We recommend revisiting this proposed requirement***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
							to ensure the information provided to patients is not so voluminous as to be overwhelming.
	Provide clinical summaries for patients	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days. An office visit is defined as any billable visit that includes: 1) Concurrent care or transfer of care visits, 2) Consultant visits and 3) Prolonged Physician Service without Direct (Face-To-Face) Patient	Any EP who has no office visits during the EHR reporting period.	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in human-readable and structured forms (HITSC to define)	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in human readable and structured forms (HITSC to define		o ***We strongly urge consideration to be given to combining this requirement with the one calling for patient access to their health information electronically. Nonetheless, we provide our specific comments on each proposed requirement below.*** o While we support the objective for providing patients with copies of their clinical summaries, we have significant concerns with the proposed requirement as written. o Patient demand for this functionality is not well established. o The proposed requirement calling for 24 hour accessibility to a clinical encounter is exceedingly impractical in routine clinical settings and does not account for the variability in practice settings such as emergencies that interrupt workflow, care provided in rural or hard to reach areas, situations when a physician is on-call and must work extended hours, holidays, or computer downtime/ failure. Or, physicians simply may not have completed their notes in that amount of time such as in the case of creating detailed patient visit documentation and care plans. Additionally, the 24 hour requirement fails to take into account situations when some information should only be provided to patients during face-to-face encounters. Receiving a bad test result electronically and without

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		Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider					context could be potentially very stressful for a patient and could be contrary to good medical practice. ***We strongly urge changing the timeframe to "a reasonable period of time in accordance with federal/and or state law. Under no circumstances, however, should physicians be required to supply this information any sooner than three days."*** o In addition to the timing issues, the degree to which patients might desire summaries of their clinical visits is unknown. Physicians are already obligated under HIPAA to provide all of the listed information and more upon a patient's request, therefore this list of specific data elements has the potential to become a needless and excessive administrative burden to physicians. Physicians and patients are in the best position to determine what records are needed and when they are needed. o ***We also recommend including "orders" in this requirement.*** o We are also unclear how this requirement can be measured and urge clarification on this point.
	Provide patients with electronic access to their health information	More than **10 %** of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in	Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) (e.g., lab test results, problem list, medication list, medication	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice.	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice.	The following data elements are included: encounter dates and locations; reasons for encounters; providers; problem list; medication list; medication allergies; procedures; immunizations; vital signs; diagnostic	o While the goal of providing patients with the ability to view and download their information is laudable, the demand for this information by patients is not well established. We believe certain patients will find this functionality more helpful than others. o ***Since patient access to information in a timely manner continues to be an issue because the documents need to be completed, we recommend this requirement be driven by the documentation date and should not be driven by the date of the encounter.*** o The proposed requirement calls for giving patients the ability to filter and organize the information by a series

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
		the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information	allergy list, immunizations, and procedures) during the EHR reporting period qualifies for an exclusion from this objective/measure	Patient should be able to filter or organize information by date, encounter, etc. Data are available in human-readable and structured forms (HITSC to define).	Patient should be able to filter or organize information by date, encounter, etc. Data are available in human readable and structured forms (HITSC to define).	test results; clinical instructions; orders; longitudinal care plan; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status. [we invite comments on the elements listed above]	of criteria that surround either their own demographic or the date of the encounter. This part of the objective needs to be substantially clarified. For example, how far back is information expected to go? o Clarification is also needed to acknowledge that some physician notes are critical to the clinical record, but may adversely impact patient compliance or otherwise be detrimental to the patient. The physician should have the ability to select the data that is available for viewing by the patient. Absent this capacity, some physicians will choose not to record potentially important information out of concern that doing so could harm the patient; yet failing to record all relevant information for the use of other care providers might also harm the patient. This was accounted for in Stage 1. Why was it omitted in the proposal for Stages 2 and 3? o Why do data on patient's race, date of birth, preferred language, and smoking status need to be included – this information is already well known to the patient. If these data are being included so that they know they are getting the correct record, we do not believe this is the correct way to address that problem. o There is also no recognition about the patient education component necessitated by this requirement. This will require practices to educate patients on what they are viewing so they can understand the information.
	This objective sets the measures for "Provide timely electronic access (EP)"			EPs: **20%** of patients use a web-based portal to access their information (for an encounter or for the	EPs: **30%** of patients use a web-based portal to access their information (for an encounter or for the		o ***We adamantly oppose this requirement and any similar requirement where a physician must rely on someone else to meet a target. Under no circumstances should physicians be held to a requirement that is outside their control. We outline our numerous concerns with this objective below.***

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	and for "Provide clinical summaries for each office visit (EP)"			longitudinal record) at least once. Exclusions: patients without ability to access the Internet	longitudinal record) at least once. Exclusions: patients without ability to access the Internet		o It is unreasonable to expect that physicians or practices be held accountable for patients accessing personal health records (PHRs). Accessing such records by patients is a choice and is beyond the control of anyone other than the individual. While patients could be informed of the potential benefits and uses of a PHR, physicians should not be penalized for something that is an independent decision made by the patient. Research suggests that some patients might find web-based access to their information helpful, but many others have no interest in such functionality. o How will physicians ensure patients use a PHR? o How will this be measured/tracked? o How will CMS ensure that patients sign up to use a portal or with a PHR vendor? o A physician does not know whether the patient has access to the internet. o Will physicians be expected to keep track of who has access to the internet and who does not? o How will this be tracked? Will the EHR be certified to track this? o Without an incentive, many patients are unlikely to participate in this objective regardless of their ability to access the internet. o Today federal health care efforts involving sharing patient information electronically are still very basic such as the new Blue Button initiative and Medicare's PHR demonstration. More data are needed detailing the outcomes of these basic initiatives before something more robust like the requirements proposed here can be considered. o Not all information is appropriate for sharing with patients and or their appointed guardian. For example, information regarding mental health status, patient

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
							compliance and or neglect or abuse. And, some medical record information may cause more patient confusion than benefit and this must be acknowledged. o There are also significant costs associated with the creation and expense of offering a patient portal and managing the information that will be shared. Few software packages that are available/affordable for small, independent physician groups currently have patient portal capabilities. And, there are also concerns about whether physicians will be able to comply with these requirements if online communications with patients are not properly reimbursed. o Creation of patient portal and download capabilities cause concern regarding security of patient information that must be addressed. Patients must understand that once information leaves the physician's EHR it becomes the responsibility of the patient to ensure its security. Physicians cannot ensure that data in a PHR held by the patient will remain safe. Patients must be educated on this and this responsibility should not fall solely to physicians. o ***We believe the emphasis during all stages of the EHR incentive program should focus on increasing physician use and successful adoption of EHRs. We adamantly oppose this requirement and any similar requirement where a physician must rely on someone else to meet a target. Under no circumstances should physicians be held to a requirement that is outside their control.***
	Secure online messaging **NEW**	n/a	n/a	EPs: online secure patient messaging is in use	EPs: online secure patient messaging is in use		o While we support physician use of secure online messaging and recognize that there are patient convenience issues, we are opposed to an objective that mandates this.

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							o If mandated, this requirement will drive up physician costs and will essentially result in physicians working even longer hours by requiring them to constantly be "on." Practicing physicians do not sit behind a desk all day like many other professionals; their time is consumed by patient visits and, increasingly, administrative work. Making such an objective mandatory will extend what are increasingly already long workdays. o If this objective is adopted, it will be another unfunded mandate for physicians. ***It should be noted that Medicare does not reimburse for online consults. Under no circumstances should this be mandated while Medicare's policies do not provide payment for time spent in responding to patients' online communications. In lieu of the proposed requirement, we strongly recommend that it be replaced with one that permits reimbursed e-visits.*** o Aside from our above objections, it is not clear what constitutes "secure patient messaging." o Would a text message qualify? o Could patients expect physicians to use online social media sites like Facebook to communicate? o How many vendors with certified products offer this capability?

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	Patient Communication Preference **NEW**	n/a	n/a	Patient preferences for communication medium recorded for **20%** of patients	Patient preferences for communication medium recorded for **80%** of patients	How should "communication medium" be delineated?	o While we support flexibility for patient communication purposes, if this objective is adopted, it will be another unfunded mandate for physicians and so we strongly object to its inclusion**. *We believe the EHR incentive requirements should focus on EHR adoption and that it is premature to focus on PHR related requirements. Therefore, we do not support this requirement.*** o In addition, while we understand the patient convenience issues, there are a number of important factors that have not been adequately considered such as cost and physician time. For example, if a patient prefers unsecure texting should that be permitted? Who is responsible for the cost of the texting? Will CMS reimburse physicians for this time? o What other communication preferences would need to be offered? Would there be a minimum standard set of acceptable communication media, with standard data entry fields? If not, how would the patient's preference be recorded and monitored? If so, who will create these standards? How many currently available EHRs offer any such a data field, or any tools for responding to patient communication preferences? Most importantly, have there been any studies to suggest this is an important feature to patients, or that it is safe and effective to implement a system of multi-modal communications according to patient preferences? o Until issues associated with reimbursement, data collection and management, and patient safety are resolved, this requirement remains simply unworkable.

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	Electronic Self-management Tools **NEW**	n/a	n/a	n/a	Offer electronic self-management tools to patients with high priority health conditions	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	o While we believe that self-management represents an important component to patient care, we have significant concerns with this proposed requirement. o This objective would demand another costly interface between a physician's EHR and a patient's PHR or other tools, most of which do not exist at present. o How many interfaces will a physician be expected to purchase and maintain? o Will EHR vendors be required to accommodate this functionality?
	PHR data exchange **NEW**	n/a	n/a	n/a	EHRs have capability to exchange data with PHRs using standards-based health data exchange	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	o As indicated earlier, we have significant concerns about the costs associated with requirements involving PHRs. We believe the focus for all stages of the EHR incentive program should focus on EHR adoption. If the proposed requirement is retained it should be optional or there should be exclusion criteria.
	Patient Care Experience Reporting **NEW**	n/a	n/a	n/a	Patients offered capability to report experience of care measures online	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	o ***Since a PHR or patient portal will be needed to obtain this data, given our previous outlined comments detailing our concerns about PHR related requirements, we do not support this requirement.*** Furthermore, it should be noted that the various levels of complexity of PHRs should be considered before any requirement like this can be added.

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
	Patient Capability to upload data into EHRs **NEW**	n/a	n/a	n/a	Offer capability to upload and incorporate patient-generated data (e.g., electronically collected patient survey data, biometric home monitoring data, patient suggestions of corrections to errors in the record) into EHRs and clinician workflow	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	o This is another proposed unfunded mandate that would require interfaces with PHRs. Pursuant to our above outlined comments, we are significantly concerned with the costs associated with this requirement. Further concerns that physicians have expressed regarding patient-uploaded data include the possible legal ramifications of patients adding data to their record between visits and the reliability and accuracy of patient submitted data.
Improve Care Coordination	**Exchange key clinical information**	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	None	Connect to at least three external providers in "primary referral network" (but outside delivery system that uses the same EHR) or establish an ongoing bidirectional connection to at least one health information exchange	Connect to at least **30%** of external providers in "primary referral network" or establish an ongoing bidirectional connection to at least one health information exchange	Successful HIE will require development and use of infrastructure like entity-level provider directories (ELPD)	o This is another proposed objective that will require a physician to rely on another entity to meet a target, which poses significant concerns. o We believe that the requirement adopted for Stage 1 is already aggressive enough, and that anything that goes beyond the Stage 1 requirement is completely unrealistic for most physicians, for whom the infrastructure to exchange data remains unavailable. While we recognize that several efforts are underway to increase exchange capabilities, this requirement if adopted necessitates each physician participating in the incentive program to have access to a "primary referral network" something that does not exist today and is unlikely to exist for all physicians by 2013, when Stage 2 starts. The same applies for bidirectional exchange; we believe this requirement will remain premature until regional information exchange networks

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							are available to all physicians. o ***We strongly recommend retaining the requirements for Stage 1 in lieu of the proposed Stage 2 measure.***
	Medication reconciliation	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. "Relevant encounter" is an encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons	An EP who was not the recipient of any transitions of care during the EHR reporting period qualifies for an exclusion from this objective/measure	Medication reconciliation conducted at **80%** of care transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)	Medication reconciliation conducted at **90%** of care transitions by receiving provider		o While medication reconciliation can significantly reduce medical errors, we have a number of concerns with the proposed requirement as written. o First, not every physician involved in a patient's care should be required to do medication reconciliation. We believe attention should be focused on defining those encounters where medication reconciliation is clinically appropriate. "Transitions of care" does not adequately capture this complexity as defined under the proposed requirements. We believe that with time, ideally CDS will improve and EHRs can screen the medications automatically and flag urgent dangers and reminders while minor matters can be left to the appropriate encounters. ***At a minimum we recommend that this requirement be limited to "critical care transitions" (e.g., when hospitalizing a patient, when discharging a patient to another care center (e.g., rehab, nursing) or back to a provider or when there is a transfer of care between providers (e.g., patient wants to be treated by someone else).*** o Second, while some physicians can get information from pharmacy data to initiate this function, for most it will still be a big challenge to meet the 80% and 90% thresholds. For those who must do medication reconciliation manually, it will be exceedingly burdensome. Since most hospitals today can not perform electronic medication reconciliation, it is hard

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		determined appropriate by the EP. Essentially an encounter is relevant if the EP, judges it to be so. "Transition of care" is the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. When conducting medication reconciliation during a transfer of					to imagine how physicians in a small practice will make the leap this quickly. o Third, it is not clear that certified EHRs will be required to handle electronic medication reconciliations. Will the CPOE functionality be required to communicate with the e-prescribing functionality? How many EHRs have this capacity at present? It is not realistic to require something of physicians when the tools needed to achieve the task do not readily exist.

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
		care, the EP, that receives the patient into their care that should conduct the medication reconciliation					
	Provide summary care record for each transition of care and referral	The EP who transitions or refers their patient to another setting of care or provider of care should provide summary of care record for more than 50 percent of transitions of care and referrals	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period qualifies for an exclusion from this objective/measure	Move to Core	Summary care record provided electronically for **80%** of transitions and referrals		

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	Care Team Members **NEW**	n/a	n/a	List of care team members available for **10%** of patients in EHR	List of care team members (including the PCP) available for **50%** of patients via electronic exchange		o We believe this proposed requirement is very vague and needs substantial clarification. o ***It is unclear how "care team members" is being defined, therefore the required list of care team members should be clearly defined to indicate who is or should be included in the care team.*** <u>All</u> care team members may not be realistic for any EP/EH to report/include as this might mean nursing aides, patient care coordinators, patient transporters, etc. This rule also does not state whether this will apply to EP, or EH, or both. o We are also seeking clarification on whether this objective will apply to phone calls, e-mails, and/or office visits. o We are also concerned that to some degree a physician would be relying on a patient to obtain information about caregivers outside the office. o How will CMS check this information for accuracy? o Would a physician who was part of a patient's care team in the past (e.g., two years ago) need to be included as part of a patient's care team? o We are concerned that maintaining this information could become overly burdensome for a practice and for Stage 3 relies on electronic data exchange. As we have stated earlier, we have significant concerns with requirements that force physicians to rely on the actions of another party to meet the requirement. If the intent is for patients to populate this information using a PHR connected to a physician's EHR, this poses all of the concerns noted above, such as the cost of such interfaces. Also, how will CMS ensure that patients enter this data. If the expectation is that this data will come from other sources, the data exchange capabilities are still largely unavailable and it is

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							premature to determine whether this will widely exist by Stage 3.
	Longitudinal Care Plan **NEW**	n/a	n/a	Record a longitudinal care plan for **20%** of patients with high-priority health conditions	Longitudinal care plan available for electronic exchange for **50%** of patients with high-priority health conditions	What elements should be included in a longitudinal care plan including: care team members; diagnoses; medications; allergies; goals of care; other elements?	o ***While a longitudinal care plan makes sense in some cases and is appropriate in some practice situations, we have concerns with this objective being applied across the board and believe it is very vague and recommend that it be clarified.*** o The language in this section needs to be further clarified as the concept of the care plan is very hospital centric and it is focused largely on primary care. o Clarification is needed on how specialists who do not generally get involved with longitudinal care plans would be expected to address this requirement. o What happens when a specialist makes a modification to a PCP plan or what happens when there are multiple plans for the same patient condition? o It is also unclear whether this objective is aimed at the inpatient plan, the outpatient plan, or both. o The term “longitudinal care plan” needs further clarification. o For example, does it represent a set of intended interventions and intervals adjusted to the patients’ unique circumstances? o How would these plans be recorded? Are they expected to be in some type of uniform structure, or

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							would a simple sentence of free text suffice? o Clarification is also needed on the term “high-priority conditions”? Which conditions qualify as high priority health conditions and how they will be updated and checked?
Improve Population and Public Health	**Submit electronic data to immunization registries**	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure	EH and EP: Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), if accepted and as required by law	EH and EP: Mandatory test. Immunizations are submitted to IIS, if accepted and as required by law. During well child/adult visits, providers review IIS records via their EHR.	Stage 2 implies at least some data is submitted to IIS. EH and EP may choose not, for example, to send data through IIS to different states in Stage 2. The goal is to eventually review IIS-generated recommendations	o ***We recommend that the requirement for Stage 1 be carried over to Stage 2, given the lack of interfaces between physicians and public health agencies.*** o ***We furthermore recommend that the proposed requirement for Stage 3 be removed. We object to the stage 3 requirement because it requires a physician to rely on another party to meet the objective.*** o ***We recommend that the requirement proposed under Stage 2 be moved to Stage 3.*** o We are also seeking clarification on the term “some”—does at least one immunization count or is it more? A minimum number should be included. We recommend no more than three immunizations be required to be submitted.

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		receive the information electronically)					
	Submit reportable lab data **(For Stage 1 was for hospitals only)**	(EH Only) Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure	EH: move Stage 1 to core EP: lab reporting menu. For EPs, ensure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law).	Mandatory test. EH: submit reportable lab results and reportable conditions if accepted and as required by law. Include complete contact information (e.g., patient address, phone and municipality) in 30% (EH) of reports. EP: ensure that reportable lab results and reportable conditions are submitted to public health agencies either		o ***While lab reporting by physicians to public health agencies is desirable, we do not think this proposed requirement for EPs is ready to be adopted. We recommend retaining what is required under Stage 1 for Stages 2 and 3.*** o Very few physicians have lab interfaces and so they will need to manually enter their data into their systems in a structured format which will be overly burdensome. o Also, if the expectation is that the physician could rely on the performing lab to submit such data, then the physician must rely on another entity in order to meet this objective, which is an approach we do not support. o We are particularly unclear as to how physicians can be expected to ensure that labs submit their data to public health agencies?

Health Outcome Policy Priority	Requirement	Stage 1 Measure	Stage 1 Exclusions	Proposed Stage 2	Proposed Stage 3 Measure	Policy Wkgrp Comments	Comments
		information have the capacity to receive the information electronically)			directly or through performing labs (if accepted and as required by law)		
	Provide electronic syndromic surveillance data to public health agencies	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically qualifies for an exclusion from this objective/measure	Move to core.	Mandatory test; submit if accepted.		o ***Reliable interfaces between physician offices and public health agencies still do not readily exist, therefore, we can not support this objective for providing electronic syndromic surveillance.*** We strongly support syndromic surveillance. We also appreciate the exclusion statement regarding if "none" of the public health agencies has the capacity to receive information electronically. But it is not clear what public health agencies are included nor what comprises such a capacity. Might a fax machine count as "the capacity to receive the information electronically"? In short, until public health agencies broadly are prepared to receive these data, it is not realistic to require that physicians test methods of sending the data.

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		have the capacity to receive the information electronically)					
	Submit notifiable conditions using a reportable public-health submission button. **NEW**	n/a	n/a	n/a	Public Health Button for EH and EP: Mandatory test and submit if accepted. Submit notifiable conditions using a reportable public-health submission button. EHR can receive and present public health alerts or follow up requests.	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	o ***We believe it is premature to add any further public health reporting requirements when interfaces between physicians and public health agencies are lacking.***
	Submit patient-generated data to public health agencies **NEW**				Patient-generated data submitted to public health agencies	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	o ***As stated above, we believe it is premature to add any further public health reporting requirements when interfaces between physicians and public health agencies are lacking.*** o It is also not clear what is meant by “patient generated” and believe more clarity on this is needed.

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Ensure Adequate Privacy and Security Protections for Personal Health Information	**Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities**	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	None			Additional privacy and security objectives under consideration via the HIT Policy Committee's Privacy & Security Tiger Team	o ***We strongly support the need for a security risk analysis and strongly urge HHS to develop tools that can be used by physicians, especially small practices, to meet this goal.***

Blue shading indicates hospital requirement.
Red indicates new requirement.