

CMS Stage 2 MU Proposed Objectives and Measures for EPs		
Objective	Measure	AMIA MEMBER COMMENTS
CORE SET (EP must meet all 17 Core Set objectives)		
1. Use CPOE for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines to create the first record of the order.	More than 60 percent of medication, laboratory, and radiology orders created by the EP during the EHR reporting period are recorded using CPOE. [Measure in Stage 1 was 30 percent.]	<p>CPOE was easily meet and exceeded in Stage 1 by this group and should be at the higher criteria.</p> <p>Note that CPOE is defined as Physician Order Entry but the criterion refers to Provider Order Entry. The definition should change.</p> <p>Scribes should not be allowed to enter computer orders as they are not capable of responding to alerts. Alerts are the main driving force behind this criterion, as the intent is to improve quality.</p> <p>Denominator as stated meets the requirement as it is a percent of all the set of orders. Any change in denominator will require a change in the criterion.</p> <p>Note that the way the criterion is written a practice that phases in CPOE across the three classes described may fail given the way it is stated. Also, a practice that has few orders in a class may not need to introduce CPOE there to pass. If the intent is to have the provider doing CPOE then this form should work. If the intent is to have the provider doing the percent of CPOE on each order type it may not.</p> <p>Although CPOEs have decision support capabilities built into the ordering process, CPOE should be the responsibility of licensed care providers with advanced educational preparation (e.g. MD, DO, DNP, NP) and should not simply be relegated to non-licensed professionals to increase CPOE utilization as patient safety may be compromised in the process.</p> <p>Also: Uncertain if this means 60% of medication order, 60% of laboratory order, and 60% of radiology orders or 60% of the sum of medication, lab, and radiology orders . Recommend to keep 60% by "order type". Specify that the denominator needs to include e-orders only not paper based</p>

		order
<p>2. Generate and transmit permissible prescriptions electronically (eRx).</p>	<p>More than 65 percent of all permissible prescriptions written by the EP are compared to at least one drug formulary <u>and</u> transmitted electronically using CEHRT. [Comparable measure in Stage 1 was 40 percent.]</p>	<p>eRx was easily meet in Stage 1 and should be meet at the higher level in Stage 2.</p> <p>CMS should investigate the potential conflict that exists between MU criteria 1 and 2. The regulation for eRx require CPOE and it seems including medications in MU-1 is duplicative. It is also noted this is a observation and not a problem.</p> <p>Controlled Substances should continue to be excluded until the Government is satisfied state and local restrictions allow for universal eRx and eRx systems are certified as acceptable to DEA. Note that the requirements proposed will take some time for Providers to meet, as they require strict identity proofing.</p> <p>Situations where the eRx is not available to the provider should be excluded at this time until more experience is gained with Nursing Homes and the rates of eRx. Primary Care Providers with high levels of geriatric patients may find they do a lot of drug ordering this scenario and would be unjustly impacted. Outside of this scenario the level should work. An alternative to introducing the exclusion would be to monitor the rate and introduce in the final rule as means to</p> <p>Exclusion: suggest to state where there are no pharmacies within 3 miles of the EP practice and/or patient...i.e. 25 miles is too great. The pharmacy needs to be one that the patient can physically access and should not be dependent upon the EP location. The EP cannot control an independent pharmacy. Could lower the threshold to account for patient preference for a paper prescription.</p> <p>Increasing the percentage of e-prescribing and including the use of at least one drug formulary is viewed as a positive step towards reducing medication-related errors and adverse events.</p> <p>How is the mail order pharmacy included in this measure? This may be</p>

		<p>difficult for rural areas without large pharmacies. How will the EHR be able to track the fact that the pharmacy is unable to take/support e-prescribing?</p> <p>Support this measure but recommend defining the role of mail order pharmacies in this measure and identifying a method for rural providers to meet with measure or receive an exception if no pharmacy e-prescribes.</p> <p>Exclusions: for drugs e-Prescribed but don't receive from a pharmacy and receive from a different source...e.g. HIV drug</p>
<p>3. Record all of the following demographics: (A) Preferred language; (B) Gender; (C) Race; (D) Ethnicity; (E) Date of Birth.</p>	<p>More than 80 percent of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data. [Comparable measure in Stage 1 was 50 percent.]</p>	<p>Inclusion of Race and Ethnicity is always an issue with regard to accuracy of the data. It is subject to individual interpretation regardless of if it is observational or self-reported. As the criterion just applies to the act of recording and say nothing about the accuracy it is acceptable at the increased level.</p> <p>Disability status should remain off the list of required demographics. It adds information that is not applicable for most patients. When it is applicable it would be transmitted in other areas.</p> <p>The same reasoning applies for gender identity and sexual orientation. Additionally these characteristics are considered offensive by some to ask and an invasion of privacy by others to universally collect. They should not be a general requirement.</p> <p>We question whether providers should face a penalty, not meeting MU levels, when forced to collect information they do not need for care. The only justification given for the existence of this criterion is to gather data for Public Health.</p> <p>Finally, though this is not a medical requirement, many of these criteria depend on the patient being electronically connected. Perhaps a demographic indicating this in order? It might make determining denominator data easier and the percentage more meaningful.</p>

		<p>Are these data to be self report? Does this include data interfaced from an ADT system? How is disability status defined and determined, e.g. Social security vs. perceived by the patient?</p> <p>What is the purpose of documenting sexual orientation and gender identity?</p> <p>Who would report? We do not feel this is appropriate to require and could be considered a violation of patient privacy.</p>
4. Record and chart changes in the following vital signs: (A) Height/Length; (B) Weight; (C) Blood pressure (ages 3 and over); (D) Calculate and display body mass index (BMI); (E) Plot and display growth charts for patients 0-20 years, including BMI.	More than 80 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients 3 and over only) and height/length and weight (for all ages) recorded as structured data. [Comparable measure in Stage 1 was 50 percent.]	The way it is written is such that if a patient had vitals' recorded once during the reporting period is serves to meet the criterion regardless of how often they visit. Also the exclusions read such that if you don't feel you need any of the measurements in your practice you don't need to record it. The exclusion makes sense in that many specialties do not need all of the listed vitals.
5. Record smoking status for patients 13 years old and older.	More than 80 percent of all unique patients 13 years old or older seen by the EP during the EHR reporting period have smoking status recorded as structured data. [Comparable measure in Stage 1 was 50 percent.]	<p>We believe that a similar exclusion to vitals should apply to this criterion. Not all specialties need to know smoking status. Providers should not, in general, be forced to gather information they do not need (see comment #3).</p> <p>Harmonize this measure to other measures collected by quality organizations. Also, recommend changing from smoking status to tobacco use.</p> <p>Agree with the change in the measure numerator. The smoking status values adopted do not align with those used in the quality measures in Stage 1 and are also proposed for Stage 2, such as NQF 0028, Preventive Care and Screening: Tobacco Use: "Screening and Cessation Intervention (percentage of patients aged 18 years and older who were screened for</p>

		<p>tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user”.</p> <p>Given that NQF 0028 goes beyond documenting smoking status to encouraging cessation counseling, we suggest alleviating reporting burdens by aligning on a single tobacco use value set. We also urge that common definitions be used whenever possible for the measurement of MU and for quality measurement. This will promote the value of all measures and support correlation between quality measures and MU of EHRs</p>
<p>6. Use clinical decision support to improve performance on high priority health conditions.</p>	<p>(1) Implement five clinical decision support interventions related to five or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period; and (2) The EP has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. [Comparable measure in Stage 1 was one clinical decision support intervention.]</p>	<p>CDS as a separate criterion is confusing and duplicative. CPOE and eRx have CDS as an essential component. Many will meet the basic term “high priority health conditions.”</p> <p>We suggest that CMS rename this criterion to make it clear that the use here refers to the use in CQM measures. The term “high priority health conditions” is confusing in this regard. Many of the CQM measures relate to process quality improvement and not outcome results. And may not be considered a high priority health conditions outside payment requirements.</p> <p>There is a need to provide clearer definitions relating to clinical decision support. How will these measures be tracked? For some EHR vendors meeting these measures includes a third party program.</p> <p>We agree that a focus on interventions related to clinical quality measures (CQM) is appropriate and agree that generally EPs and EHRs should be encouraged to use CDS interventions to improve quality on priority conditions, as established by a linkage to a nationally established CQM.</p> <p>However, we are concerned with and oppose the specific proposal that “[p]roviders would implement [five] clinical decision support interventions that they believe will result in improvement in performance for [five] or more of the clinical quality measures on which they report.”</p>

		<p>We believe this proposed change introduces unnecessary inflexibility.</p> <ol style="list-style-type: none"> 1. Providers might not know exactly which clinical quality measures they intend to report until the conclusion of the reporting period when they can determine conclusively that measures have non-zero denominators. Yet, they will be asked to implement clinical decision support interventions prior to the start of the reporting period. If they implement clinical decision support related to a selection of five of the quality measures to work on improving performance and decide later to report to CMS on a different selection of quality measures, we believe they should still receive credit for this objective and measure. We propose that, while selected interventions should be associated with one or more of the final set of CMS CQMs (assuming that this final set has sufficient breadth and depth), CMS should not require that the interventions be linked to CQMs reported by the EP. In addition, given that the breadth and depth of the final set of CQMs is yet to be determined, we suggest that CMS consider requiring such an association for no more than three out of the five interventions. 2. Providers might wish to change their interventions mid-reporting period, based on how they are doing with an intervention or changes in clinical priorities. We suggest that CMS clarify that providers could modify or replace interventions during the reporting period and still meet this objective and measure so long as they use at least five interventions throughout the reporting period. <p>In addition, the only standard identified by ONC for CDS functionality is §170.204(b)(1) (HL7 Context-Aware Knowledge Retrieval (“Infobutton”) Standard, International Normative Edition 2010) (see page 13847). We do not think that either CMS or ONC intends that providers would only use the Infobutton standard as their sole method of clinical decision support interventions to meet meaningful use. Although the Infobutton standard might be helpful in some cases, it is not sufficient or appropriate for use with all CDS interventions, given that it is a standard that permits</p>
--	--	--

		<p>carrying of context when doing referential searching.</p>
<p>7. Incorporate clinical lab-test results into CEHRT as structured data.</p>	<p>More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either a positive/negative or numerical format are incorporated in CEHRT as structured data. [Comparable measure in Stage 1 (which was in the Menu and not Core set) was 40 percent.]</p>	<p>Standardized data elements and terminology (ONC doc). Lab systems should be certified as well.</p> <p>There are several measurement challenges with this objective, which include:</p> <ol style="list-style-type: none"> 1. To generate an accurate denominator, the EHR must know which lab tests are expected to return a numeric or positive/negative result, and which results were returned in this way, even if they were not returned electronically. How does the EHR know which lab orders are in this category? For example, some allergy tests will return a numeric result if sent to a particular lab and a text result if sent to a different lab. Attempting to have the EHR determine if the result is numeric is very complex. <p>CMS requested feedback on the feasibility of counting lab tests individually, not as panels or groups in both the numerator and the denominator, which would mean reporting by each test component rather than orders. This reporting approach is not feasible. The number of test components within a panel is variable depending on the lab that results that test, and sometimes dependent on the actual result. There is no way for the EHR to accurately count the denominator using these methods</p> <p>Raising the percent from 40% to 55% is dependent on if the laboratory can report electronically. Most national and it is suspected many local laboratories can as the mechanism has been well established for years. To ensure quality input of laboratory information, which is sometimes difficult to do without error manually, the increase is justified.</p> <p>Counting should be done at the individual test level as proposed. Doing it in this fashion will remove any issues in timely reporting of all components in a panel and differences that might relate to numeric and non-numeric tests in the panel. It, however, introduces an issue in counting panels that involve reflex testing not known at time of order.</p>

		<p>Reflux testing introduces a factor that might have been considering in establishing the percentage. In these one test is ordered but have many results returned as the result in one test may cascade into one or more other tests automatically inflating the percentage. The reflux test is now standard in laboratory testing and is done provide more timely results and prevent additional sample collection when the next test can be anticipated based on the previous result. CMS provides for this type of test in Medicare payment rules. To more accurately set a percentage taking reflux testing into account will require more detailed study. It is suggested that the impact is small and the guess at a percentage made here suffices.</p>
<p>8. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p>	<p>Generate at least one report listing patients of the EP with a specific condition. [Comparable measure in Stage 1 was the same (one report) but the measure was a Menu, not a Core one.]</p>	<p>We suggest that if the EHR can generate one list it can generate many. Hence, greater than one would be acceptable but an upper-limit would be hard to determine. Therefore, it is best kept at one to show capability. It is noted that this report has privacy considerations not addressed by the criterion. Addressing them here would be inappropriate.</p> <p>Providers are already generating lists, but suggest that CMS is more specific in the intent of how the lists should be used.</p> <p>Agree that “many EPs and eligible hospitals would use these reports in combination with one of the selected quality measures and decision support interventions to improve quality for a high priority issue”. Agree CMS should not dictate the specific report to be generated. Suggest measure is core and suggest the number of lists not be dictated, but rather aligned with the clinical quality measures the EP, eligible hospital, or CAH are reporting. For example, if the EP is reporting diabetes, ischemic vascular disease, hypertension, and coronary artery disease measures, the EP should generate four lists. If the hospital is reporting, AMI and pneumonia measures, the hospital should generate two lists</p>
<p>9. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.</p>	<p>More than 10 percent of all unique patients who have had an office visit with the EP within the 24 months before the beginning of the EHR reporting period were sent a</p>	<p>With the inclusion of per patient preference, we support this.</p> <p>What about language?</p>

	<p>reminder, per patient preference. [Comparable measure in Stage 1 was 20 percent, but measure was in the Menu rather than Core set.]</p>	
<p>10. Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p>	<p>(1) More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their information subject to the EP's discretion to withhold certain information; and (2) More than 10 percent of all unique patients (or their authorized representatives) seen by the EP during the EHR reporting period view, download or transmit to a third party their health information. [This is a new measure for Stage 2.]</p>	<p>Until we have true consensus on standards for the data requested this should be a menu option. The criterion is standard natural but the act of passing information to the patient would be confusing if different providers used differing standards. While an accompanying NPRM focuses on the standards, today the ones recommended are not widely used in many cases and the imposition of true standard based information may be delayed. Testing of this needed criterion should continue by making a menu option.</p> <p>Also, as noted, presenting the information for patient use is stage one and that stage is not very helpful. The true benefits occur when the patient accesses and uses the information. CMS notes this is an emerging area by assigning a 10% usage level as a passing level. It indicates the intent is to promulgate usage by making the provider responsible for awareness knowledge. We believe that this is a societal issue and the provider should not be penalized if their patient group is unwilling to access or use the information.</p> <p>Lastly, the criterion ignores the biphasic nature of this information. There is no requirement for the provider to accept information from patient provided information. Until we can shorten the new patient information transfer electronically we will have little patient acceptance of these systems.</p> <p>Basically, this is a criterion still in development and should be left as a menu option, with the second part dropped. As a menu option, increasing the level for the first part is fine.</p> <p>Language and health literacy becomes an issue. How do you address these issues? Is the information useful if it is not comprehensible?</p> <p>This will not provide the patient with a complete picture of their health</p>

		<p>information. What about information from other providers? This is a community issue to achieve the complete picture.</p> <p>This can require the EHR to integrate with other products- costs and time become a concern.</p> <p>Are portals a solution for this? Can portals track this information? Can portals provide information from the EHR and other products to meet this measure?</p> <p>In terms of no internet access (4Mbps broadband), mobile access needs to be taken into account. If “X%” of people have smartphones/mobile access, the opt out should be changed to reflect this capability as well. Most EHRs and patient portals have or will have mobile access to data and they are HIPAA compliant. Therefore the access to and transmission of data is secure and doable.</p> <p>Patient portals are a solution to the requirement. There is portal capability in the market to send CCDs to the EHRs from health forms patients fill out in the portal. They will also be receiving CCDs from the EHR and will then import the document into the patient’s PHR. The patient then has the ability to share that CCD (electronically if possible or in print) with another provider. This can reduce burden on the provider practice while assuring integration.</p> <p>Consider language that includes a “by mutual consent (between patient and EP), information to be shared is determined. Consider a waiver that says basically “the patient agrees to the provider share information other providers”.</p>
<p>11. Provide clinical summaries for patients for each office visit.</p>	<p>Clinical summaries provided to patients within 24 hours for more than 50 percent of office visits. [Comparable measure in Stage 1 was 50 percent.]</p>	<p>Except for the time involved, 24 hours versus 4 days, the difference between this criterion and number 10 above is hard to realize. We note that most providers do give a clinical summary at the end of visit, the timeframe in which it has the most utility. Shortening the timeframe from 3 days to 24 hours is acceptable, with modification. It should be 1 business day. Prior items make a note of the use of the term business day so that days the practice is not open are not counted. The same criterion</p>

		<p>should apply here.</p> <p>It is unclear what the word “provided” means in this criterion. The implication seems to be that patient gets the summary document automatically with no indication on their desire to have it. Could it also mean that on checkout the office staff notes it is available and asks if the patient wants it, how and when?</p> <p>Note that this report contains a vast amount of PHI. If all the patient is going to do is discard it insecurely it could compromise patient privacy and confidentiality. Indiscriminately providing a readable version of the information might then be considered a security breach by the provider. Only giving the report to patients who affirm they want it could eliminate any provider responsibility as once the report is voluntarily in the patient’s hands the security of that information in that form is no longer their responsibility.</p> <p>Finally, these reports can be quite lengthy and daunting to many patients. While they are seen as needed by the Policy Committee the utility by much of the population is questioned. This criterion indicates they are mandated in all but a few cases. It is unclear if that is desirable.</p> <p>Given the relative immaturity of state HIE’s and EP automation including advanced clinical documentation capabilities to easily compile target elements of the record and move to a summary of episode/CCD, we are concerned this standard to complete within 24 hrs will be burdensome. Consider specific categories of urgent/emergent care vs routine services be prioritized for CCD generation within 24 hrs.</p> <p>However, we do support the overall intent of the objective, but seek clarification on the following questions:</p> <ul style="list-style-type: none"> • How to address updates to the clinical summaries. We suggest those to be excluded from both denominator and numerator. • Which visits should have a clinical summary? E.g., should a visit for a flu shot have a clinical summary? If not all, please clarify
--	--	--

		<p>what characteristics should be used to include/exclude visits. Would level 2-5 CPT coded visits be appropriate?</p> <ul style="list-style-type: none"> • What are considered patient decision aids? <p>Additionally we suggest to synchronize definitions and terminology across this objective and the View, Download, and Transmit objective (§ 495.6(j)(10), § 495.6(l)(8)) as discussed.</p> <p>We are concerned with the inclusion of future appointments and future scheduled tests as the EHR may not include Scheduling capabilities as they are not within the scope of the proposed CEHRT. We suggest that this data may not be communicated through the clinical summary at all times.</p> <p>We request clarification on when fields can be left blank or require an explicit notation that no information is available. Current language on the View, Download, and Transmit objectives, Provide Clinical Summary objective, and the Summary of Care Record on Transition of Care objective appear to contain contradictory language in that regard.</p> <p>How to define requirements that do not become a burden to the provider and minimize ambiguity. Prioritize requirements so the document provides utility and meaning.</p>
<p>12. Use CEHRT to identify patient-specific education resources and provide those resources to the patient.</p>	<p>Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all office visits by the EP. [In Stage 1 measure was in Menu, not Core, set.]</p>	<p>Providing patient educational material, either directly or by reference, is an essential component of today's medical practice. Having it as Core is desirable. The material should be patient unique, meaning literacy level and cultural factors should be considered.</p> <p>The percent is questionable. Need for educational material is visit and disease sensitive. For example, in diabetes management initial contact requires heavy reference to educational material but follow-up visits should not. A PCP seeing someone for a cold may not see the need for educational material at that visit. Hence the percent should be low. The 10% proposed here seems satisfactory but may require refinement with experience</p>

		<p>Agree to hold at 10% for EP. Agree that appropriate educational material resources are provided to the patient should be documented in the CEHRT. The actual educational documents do not need to be stored in the EHR. Seems that it would be more impactful to document patient understanding of education and resources through a “teach back” approach.</p> <p>Thinking in terms of patient involvement and centeredness, it might be beneficial that not only EPs but also their PATIENTS would have access to this information. It might be included in the objective #9 “View, download and transmit data”. This will help healthcare consumers to actively and knowledgeably engage in the decisions about treatments and procedures provided.</p> <p>Suggest for stage 3 that Outcomes of patient understanding of education and “teach back” be incorporated to include literacy and cultural aspects</p>
<p>13. Use secure electronic messaging to communicate with patients on relevant health information.</p>	<p>A secure message was sent using the electronic messaging function of CEHRT by more than 10 percent of unique patients seen during the EHR reporting period. [This is a new measure for Stage 2.]</p>	<p>Electronic messaging should reduce patient visits and is an essential component of modern medicine. The percentage is dependent on the provider’s patient base that uses electronic messaging. The 10% figure noted here is an acceptable starting point as any number would be a guesstimate and is also heavily practice dependent.</p> <p>Note that no criteria proposed as the question if the patient is competent regarding electronic communication. Many of the criteria, like this one, seem to require that at some level. Perhaps it should be considered to ask the question as part of demographics and based the MU level on the percent of patients who indicate they can communicate electronically. Generally offices do this today by asking for an email address so they are already collecting the information.</p> <p>Clarity is needed on this measure. What if the communication is initiated by the patient, what if the patient opts out of this method? Does the</p>

		<p>denominator exclude those who do not prefer this method of communication? The term secure message needs to be defined. Minnesota’s research has shown that some feel their standard email is secure messaging.</p> <p>In order for secure messaging to be efficient, there need to be processes in place, responsible parties to manage the email, timeframes upon when emails will be responded to and of course warnings about “if this is an emergency, etc... you need to call the office or 911”.</p> <p>The threshold is hard to nail down – a lot depends on the patient population. It is unlikely a geriatric practice is going to have a lot of email or text traffic. On the other hand, a primary care practice or pediatric practice will have a great deal.</p>
14. The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP performs medication reconciliation for more than 65 percent of all transitions of care in which the patient is transitioned into the care of the EP. [Comparable measure in Stage 1 (which was in the Menu set) was 50 percent.]	<p>Any relevant encounter should be included for medication reconciliation.</p> <p>Certification of the EHR for this measure does not equate usability</p>
15. The EP who transitions a patient to another setting of care or provider of care or refers the patient to another provider of care should provide summary care record for each transition of care or referral.	<p>(1) The EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 percent of transitions of care and referrals</p> <p>(2) The EP that transitions or refers their patient to another setting of care or provider of care electronically transmits using CEHRT to a recipient with no organizational affiliation and using a different CEHRT vendor than the sender a summary of care record for more than 10 percent of transitions of care and referrals. [Comparable measure (A) in Stage 1 (which was in the Menu set) was 50 percent. For</p>	<p>There is an implication in this criterion that the receiver is to post the information received to their EHR, either in a holding area until confirmed or directly unconfirmed. Until a clear specification of the intent of the criterion with respect to the user is made proscription on the standards used is difficult. It is noted that if direct storage in the receiving EHR is not the intent then fax, as is used today, could meet this criterion.</p> <p>NHIN and other accepted HIE communication standards must be considered acceptable to this standard until, or even after, universal acceptance is give to the ONC standards. Conversion between standards can result in loss of medical fidelity resulting in a mistaken input and no improvement in quality. In this regard, transmission between providers in an integrated healthcare environment should be allowed to use private standards, especially terminology, in their transition of care documents, as they may not have direct access to the parent EHR.</p>

	<p>measure (B), the HIT Policy Committee recommended a threshold of 25 instances for EPs, rather than a percentage-based measure.]</p>	<p>It is not clear how or why EPs should be basing their referral or transfer decisions on whether or which CEHRT vendor is used. If CMS is mostly interested in encouraging interoperability between CEHRT vendor systems, we suggest that certification criteria be developed that address this as a requirements. Providers' referrals or transfers should be based on patients' care needs and provider preferences.</p> <p>There is presumption in this criterion that a communication system is robust enough (common protocols, acceptable security, etc) to make this possible at the levels envisioned. Given the high level of exclusions in Stage 1 it is suggested this is not the case. Moving this criterion forward more robustly is not indicated.</p> <p>Having noted issues with ability to fulfill this criterion, it is noted that list of items appears appropriate. Functional and cognitive status should not be required. For those patients where the status is appropriate they should appear as items in the Problem List.</p>
<p>16. Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice</p>	<p>Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period. [Comparable measure in Stage 1 (which is in the Menu set) required at least one test, which need not be successful, and follow up submission if the test is successful.]</p>	<p>Again, this is a biphasic criterion. To be useful providers should be able to query an immunization registry to see patient protection status and avoid unnecessary vaccinations.</p> <p>We note that the Immunization Registry system, despite approximately 30 years of development by CDC and local health departments is not robust enough to fully handle this criterion. In Stage 1 45% meet the criterion by exclusion implying poor coverage. In particular the query function is poorly developed, especially when multiple registries are involved.</p> <p>Other than the need for PH improvement in the system, the criterion should stand as presented. The criterion should have been core in Stage 1 and placing it there in Stage 2 fine. Moving to core may provide an incentive to PH to improve the system.</p> <p>The proposed measure seems quite burdensome until such time as CDC and public health agencies formalize the support of public health MU measures and mechanisms to automate data exchange to support</p>

		immunization tracking. There needs to be harmonization between federal and state and state to state requirements for reporting.
17. Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process. [Stage 1 measure called for a security risk analysis but did not emphasize encryption of data, either in transit or at rest.]	
MENU SET (EP must meet 3 of 5 Menu Set objectives; exclusions no longer count toward meeting Menu objectives)		
1. Imaging results and information are accessible through CEHRT.	More than 40 percent of all scans and tests whose result is an image ordered by the EP are accessible through CEHRT. [This is a new measure for Stage 2.]	<p>It is noted that this is untested and the percentage, which seems reasonable, might be a bit high for this early stage.</p> <p>The criterion for exchange should be deferred until a more robust exchange system is in place. Note that many complex image studies are now exchanged by CD/DVD through mail or hand carried due to image size. Providing links in these cases may not be appropriate for security reasons.</p> <p>This requirement would be of particular value to EPs as doing so enhances the availability of imaging results and related information when patients ends up being seen at another facility for their care.</p> <p>There needs to be concrete guidelines on the image format that is acceptable for use in order to support true electronic exchange of the imaging results.</p> <p>With regards to the issue of accessibility of the imaging results and information, is it really feasible to base it on the number of imaging tests</p>

		<p>ordered as compared to the actual number of imaging scans and results available and accessible? Would doing so present an unreasonable reporting burden to an organization? Like the idea of a secondary measures using the 10% threshold. Hopefully, with more care providers becoming acclimated to the value of such electronic exchange, we can count on their becoming strong advocates for supporting (and actually manually adding an image and accompanying information in the absence of electronic exchange) for this particular meaningful use requirement.</p>
<p>2. Record patient family health history as structured data.</p>	<p>More than 20 percent of all unique patients seen by the EP have a structured data entry for one or more first-degree relatives. [This is a new measure for Stage 2.]</p>	<p>The criterion should be deferred, even as a menu option. Without standards it is unclear how CEHRT could comply with the criterion and we would not want to start use at any level in an ad hoc fashion, which is implied</p> <p>What if the patient was adopted and/or has no access to family Hx?</p> <p>What if the patient identification is unknown? It's also unrealistic to assume that even if the technology can support it, that patients will be able to contribute to the record. Their illness/injury can preclude their ability to do so. In addition, they may not be aware of the specifics or they may not be correct.</p> <p>Exactly what structured data elements would be expected? I think it's very unrealistic to implement this standard at this point.</p> <p>In addition to standardizing the data elements, terminology needs to be standardized.</p>
<p>3. Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.</p>	<p>Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period. [Comparable measure in Stage 1 (which is also in the Menu set) referred to at least one test which need not be successful and follow-up submission if the test is successful.]</p>	<p>Until PH accepts syndromic surveillance as a routine tool CMS should not require it as Core item. It is noted that, as the criterion also observed, this is not the case and most likely will not be for the next decade or beyond. Cost to PH of developing the system is outside the funds foreseeable to either local PH or to the CDC in these tight budget times.</p> <p>Having it as a menu item is also problematic. In Stage 1 most noted a deferral indicating lack of capability in moving forward due to PH. Until PH is available as a receiver and uses of the information the criterion</p>

		<p>occupies a menu slot that might be better used for a criterion worthy of testing. Note that menu item 2 is noted not capable reducing the number of menu items available.</p> <p>According to FR the CDC states that very few public health agencies accept syndromic surveillance data from ambulatory providers. CDC is working on this, so this may be a core item for EP in stage 3 recommend to keep on the menu</p> <p>Agree with exclusions and the ability to use a letter as an audit. Note that a failed attempt in Stage 2 will not suffice. Encouraged that CMS has noted that ‘very few public health agencies are accepting’ these data from EPs. This is an issue for a number of states</p>
<p>4. Capability to identify and report cancer case information from CEHRT to a cancer registry, except where prohibited, and in accordance with applicable law and practice.</p>	<p>Successful ongoing submission of cancer case information from CEHRT to a cancer registry for the entire EHR reporting period. [This is a new measure for Stage 2.]</p>	<p>Note that the criterion only refers to capability and provides no measure of success outside of a binary yes/no. It is suggested that this is insignificant and an objective measure be used.</p> <p>It is then noted that an objective measure is difficult to develop. Cancer statistics depend on case finding, validation and tracking. This criterion only is concerned with case finding and in an EP. The EP maybe capable of validation and tracking but that introduces a new burden on their responsibilities. It is noted that validation and tracking in an EH is usually done by dedicated staff not found in an EP.</p> <p>A PCP may detect the tumor during an exam and refer the patient to a specialist who diagnosis and treats. Where is the reporting responsibility with respect to MU in this situation? Note that the PCP may only have a presumption that the tumor is cancer. In this scenario it may be possible that multiple reports on the same patient from different locations go to the State. It is not clear if State Registries prepared to handle this type of reporting.</p> <p>The conclusion is that this criterion needs more development before introduction.</p>
<p>5. Capability to identify and report specific cases to a</p>	<p>Successful ongoing submission of specific case information from CEHRT to a</p>	<p>This is a reasonable requirement as doing so will support public health and surveillance of health conditions that are of epidemiologic interest to</p>

<p>specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.</p>	<p>specialized registry for the entire EHR reporting period. [This is a new measure for Stage 2.]</p>	<p>support proactive population health. However, we recommend that guidelines be provided to EPs on available registries so that there is no ambiguity as to what registry is currently available and how to go about reporting specific cases.</p> <p>Similar comments to this criterion appear in item 4 above. At this time it is too vague to be implementable beyond the binary stage.</p>
--	---	---