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1 February 25, 2011

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4 Paul C. Tang, M.D., M.S.
5 Meaningful Use Workgroup Chairperson
6 Health IT Policy Committee
7 U.S. Department of Health and Human Services
8 200 Independence Avenue, SW
9 Washington, DC 20201

10
11 Dear Dr. Tang:

12
13 On behalf of the Board of Directors and members of HIMSS, we are pleased to submit written
14 comments to the Health IT Policy Committee's Meaningful Use Workgroup regarding the draft
15 recommendations on Objectives for Stage 2 of Meaningful Use.

16
17 HIMSS is a cause-based, not-for-profit organization exclusively focused on providing global
18 leadership for the optimal use of information technology (IT) and management systems for the
19 betterment of healthcare. Founded 50 years ago, HIMSS and its related organizations have
20 offices in Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the
21 United States. HIMSS represents more than 35,000 individual members, of which two-thirds
22 work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes
23 over 500 corporate members and more than 120 not-for-profit organizations that share our
24 mission of transforming healthcare through the effective use of information technology and
25 management systems. HIMSS frames and leads healthcare practices and public policy through its
26 content expertise, professional development, and research initiatives designed to promote
27 information and management systems' contributions to improving the quality, safety, access, and
28 cost-effectiveness of patient care.

29
30 HIMSS appreciates the opportunity to have a public discussion on the draft objectives for
31 Meaningful Use Stage 2.

32
33 **Timeline:** With respect to the timeline for Meaningful Use Stage 2, since the passage of the
34 American Recovery and Reinvestment Act (ARRA) HIMSS has heard from our members that
35 the timeline for preparing for the next stage of Meaningful Use needs to be 18 months between
36 final rules on Meaningful Use, certification, and standards and the start of the next Stage of
37 Meaningful Use, to allow adequate time to design, update, certify, and implement software.

38
39 This past December, the HIMSS Board of Directors included the 18-month window in our Public
40 Policy Principles¹, and called for the Department to consider several approaches that can help
41 mitigate this issue, such as allowing the early adopters (providers that started in FY11) to remain
42 at Stage 1 for FY13; looking to possible congressional action to remove the requirement for

¹ [2011-2012 HIMSS Public Policy Principles](#), December 2010



43 Medicare Meaningful Use years to be successive (as is allowed in the Medicaid program);
44 shifting from three stages to two in the timeframe between now and 2015; accelerating the
45 regulatory process; and minimizing the addition of new functionality for Stage 2. Fundamentally,
46 providers and vendors need far more time than has been publicly forecast by ONC and CMS
47 between when meaningful Stage 2 standards and certification criteria are finalized and when the
48 next stage begins.

49
50 **Standardization:** One of the greatest impediments to measuring improved quality of care and
51 better patient outcomes is the lack of standardization, such as clinically specific terminologies
52 (for example, SNO-MED, LOINC and RxNorm) or the variety of standard code sets used in
53 EHRs. SNOMED is not mandated, but it is used in all quality measures. We would recommend
54 that Stage 2 MU measures establish standardized terminologies, code sets, data elements, patient
55 identifiers, etc., within the context of the Stage 2 final standards and certification criteria.

56
57 **Approach to Additional Quality Measures:** Providers and hospitals have begun to implement
58 MU clinical quality measures, that may require the development of additional data elements,
59 major work flow changes, system enhancements and code sets beyond what is specified in the
60 core MU objectives and measures. As the Workgroup considers recommending additional
61 quality measures we strongly suggest the Workgroup take into consideration whether the quality
62 measures complement improved quality of care, efficacy in care practices driven by decision
63 support, and improved patient outcomes.

64
65 **Meaningful Use Objective Categories:** With respect to the MU Objectives for each of the
66 major categories, HIMSS respectfully submits our specific comments on each objective via the
67 attached Excel Spreadsheet. Major themes for each category are as follows:

- 68 • Improving Quality, Safety, Efficiency, & Reducing Health Disparities:
 - 69 ○ Agree with the Workgroup's draft recommendations in such areas as
 - 70 expanding Computerized Provider Order Entry (CPOE) order types; raising
 - 71 the E-Prescribing threshold; maintaining Stage 1 thresholds for problem lists,
 - 72 active medication lists, active medication allergy lists, and vital signs; and the
 - 73 addition of the new Objectives for electronic structured notes and electronic
 - 74 medication administration recording.
 - 75 ○ Express concern regarding allowing any clinician besides the ordering
 - 76 provider to enter an order via CPOE
 - 77 ○ Encourage the Workgroup to consider modifications to the Clinical Decision
 - 78 Support Objectives
- 79 • Engaging Patients and Families in Their Care:
 - 80 ○ Agree with the Workgroup's draft recommendations in such areas as
 - 81 maintaining Stage 1 thresholds for providing electronic copies of health
 - 82 information upon request, and viewable information of encounters
 - 83 ○ Suggest developing an industry standard for longitudinal care plans
 - 84 ○ Endorse the adoption of one patient record summary standard to support MU
 - 85 Stage 2

- 86 ○ Express concern that certain functions are more suited for Personal Health
87 Records than Electronic Health Records, such as electronic self management
88 tools and uploading patient-generated data.
- 89 ● Improved Care Coordination:
 - 90 ○ Agree with the Workgroup's draft recommendations to require connections to
91 external providers or HIEs and moving the summary of care record to core for
92 Stage 2, with some electronic transmission required in stage 3 to accelerate
93 robust data exchange.
 - 94 ○ Request additional detail on the definition of a care team member, and
95 compliance requirements for medication reconciliation
- 96 ● Improved Population and Public Health:
 - 97 ○ Request additional detail on the what constitutes an acceptable test for
98 submitting reportable lab data and surveillance data
 - 99 ○ Suggest a four-step process to developing a Public Health Button to include a
100 HITSP specification with relevant data, CDC requirements for States, publish
101 the API specification for systems developers, and conduct pilots with HIEs.
- 102 ● Privacy and Security:
 - 103 ○ Encourage the Workgroup to work closely with the Privacy and Security
104 Tiger Team to establish Objectives for Stage 2 and 3 that address practical and
105 achievable solutions for collecting and exchanging health information.
 - 106 ○ Offer our Privacy and Security resources to the HIT Policy and Standards
107 Committees' Privacy and Security Tiger Team.

109 **Meaningful Use Workgroup's Request for Additional Comments**

111 **HIT Policy Committee Meaningful Use Workgroup Question #1: How can electronic 112 progress notes be defined in order to have adequate specificity?**

113 Progress notes are a key part of clinical documentation and also part of the clinical
114 documentation needed to support medical necessity, coding, and billing. Specificity will help
115 clarify the intent of the objective and aid in implementation. For instance, the objective says
116 electronic notes and the question is about progress notes. The description in the objective and
117 the question need to be aligned.

118
119 Given the intent is to ensure that the full content of the medical record is electronic and
120 accessible, then the real-time clinical benefit is complete physician charting online (no
121 handwritten notes; either entered or dictated, and having these available online). An incremental
122 approach to implementation is acceptable, but best practice dictates that as soon as electronic
123 notes are available, the combination of paper and electronic quickly becomes unacceptable
124 because the ability to access the entire patient record from elsewhere is lost.

125
126 It is important to specify these requirements to include such fields as note author (name of
127 provider, internal or external source (same facility, external facility, or HIE); and electronic note
128 format. The progress note needs to accurately represent the progress of the patient, and more
129 important the decision making process of the physicians and other professionals involved with



130 the patient's care. However, the content of the note should be left to the discretion of the
131 provider or hospital.

132
133 **HIT Policy Committee Meaningful Use Workgroup Question #2: For patient/family access**
134 **to personal health information, what standards should exist regarding accessibility for**
135 **people with disabilities (e.g., interoperability with assistive technologies to support those**
136 **with hearing, visual, speech, or mobile impairments)?**

137
138 Increased focus on accessibility is an opportunity to engage all patients as consumers to improve
139 their individual healthcare quality and outcomes. We suggest that the Workgroup consider
140 leveraging national standards and regulations, to include Section 508 of the Americans with
141 Disabilities Act of 1990, but with a careful focus on what is achievable and the applicable
142 timeline to determine whether eligible hospitals and eligible professionals should be required to
143 meet the requirements in Stage 2 or Stage 3.

144
145 **HIT Policy Committee Meaningful Use Workgroup Question # 3: What strategies should**
146 **be used to ensure that barriers to patient access – whether secondary to limited internet**
147 **access, low health literacy and/or disability?**

148
149 We are mindful that our membership and others in the healthcare community are keenly aware of
150 importance of accessible accommodations in the healthcare setting. We recognize that the
151 awareness needs to expand to the health IT components of care delivery, particularly as we move
152 to engage the patient as a consumer of the healthcare. Issues that will be important to address
153 include patient health literacy, physical and mental capability, cultural competency, and patient
154 education between provider visits. One of the huge benefits of HIT is that the cost of producing
155 information in variable languages and in a culturally appropriate manner is less than in the
156 current paper environment. This provides opportunities for variations of consistent messages
157 through culturally-appropriate mechanisms. We look forward to working with the Department
158 and the U.S. Access Board to further educate our membership on this important topic.

159
160 **HIT Policy Committee Meaningful Use Workgroup Question #4: What are providers' and**
161 **hospitals' experiences with incorporating patient-reported data (e.g., data self-entered into**
162 **PHRs, electronically collected patient survey data, home monitoring of biometric data,**
163 **patient suggestions of corrections to errors in the record) into EHRs?**

164
165 Patient involvement in their care coordination and inclusion of patient-entered data should be
166 included in the process, as long as it is properly labeled and reviewable by the clinician. The
167 general notion that patient self-entered data can be useful to the clinical decision making is valid.
168 HIMSS encourages an ongoing dialogue on what should be considered useful data and the logic
169 for incorporation into the chart if MU criteria are to be applied. For example, consideration needs
170 to be given to the amount of time typically available for an encounter, and how the time needed
171 for the provider to digest the patient-supplied data may impact clinical assessment time with the
172 patient.

173

174 In addition, there are real-world examples of portals that have the ability to send patient-reported
175 data, patient-requested corrections, etc. to EHRs. This data is transmitted as patient-entered data
176 to be reviewed by the provider organizations prior to incorporating into an EHR. Data is clearly
177 marked as 'patient-entered data' so that the provider and staff users clearly see that information
178 was provided by the patient. This allows the patient supplied data to be reviewed and approved
179 by the clinician before it is incorporated in the patient's medical record.

180
181 Finally, the system needs to ensure that available standards need to be utilized to ensure
182 appropriate sharing between the patient portal or Personal Health Record and the Electronic
183 Health Record; templates should be made available in EHR's to support and streamline data
184 capture; and patient entered data needs to be flagged appropriately. In addition, standard
185 development and standards harmonization of standards must occur to ensure that all data can be
186 portable to support tethered and untethered patient personal health information (PHI).

187
188 **HIT Policy Committee Meaningful Use Workgroup Question #5: For future stages of**
189 **Meaningful Use assessment, should CMS provide an alternative way to achieve Meaningful**
190 **Use based on demonstration of high performance on clinical quality measures (e.g., can**
191 **either satisfy utilization measures for recording allergies, conducting CPOE, drug-drug**
192 **interaction checking, etc, or demonstrate low rates of adverse drug events)?**

193
194 There are many ways to improve the overall standard of care for an organization, and the stated
195 MU criteria may not always reward the best behavior. If, in the example given, the organization
196 can attain significant reductions to near zero in adverse drug events, then that achieves the
197 intended standard of care, regardless of how it was actually achieved.

198
199 Nonetheless, supporting alternate methods of Meaningful Use demonstration would impose
200 additional software requirements in an already compressed and dangerous development timeline
201 for Stage 2 and 3. Moreover, it is uncertain how such an approach would work in practice or
202 whether it could be implemented in a way that achieves congressional goals and is fair to all
203 participants.

204
205 Such alternate means should be considered on a highly targeted basis only, relative to very
206 specific Meaningful Use criteria. For example, those related to drug safety, and linked to
207 specific areas of EHR functionality. It is essential, however, that providers be required to
208 possess certified EHR technology that meets all applicable Meaningful Use derived certification
209 criteria; a primary focus on outcomes should be the province of value-based payment and
210 accountable care organizations. We have concerns that this approach be implemented in a way
211 that is practical and ensures consistent measurement.

212
213 Achieving improvements in healthcare efficiencies must be accomplished. Value is often defined
214 as quality divided by cost, with improved quality outcomes, leading to greater efficiencies and
215 the decrease in overall costs to the system. Electronic data capture in concert with real-time
216 decision support will facilitate this value equation. Embracing improved processes, such as the
217 elements required as part of the patient centered medical home, and benchmarking outcomes
218 against State and National Standards, will level set achievement of quality, cost, and ultimately



219 value. If Meaningful Use is evaluated against outcomes measures, as opposed to process
220 measures, participants would truly demonstrate how cost and quality are being improved.

221
222 **HIT Policy Committee Meaningful Use Workgroup Question #6: Should Stage 2 allow for**
223 **a group reporting option to allow group practices to demonstrate Meaningful Use at the**
224 **group level for all EPs in that group?**

225
226 A review of group-level reporting could inform the healthcare community as the healthcare
227 system continues to move forward on such initiatives as the Patient-Centered Medical Home and
228 Accountable Care Organization care delivery models.

229
230 Most assuredly, group reporting would require different report specifications than individual
231 reporting and could require substantial development, particularly for quality measures. We
232 suggest that group reporting be assessed for potential impacts on quality, and do not support its
233 inclusion in Stage 2.

234
235 The results will help determine if such an approach would be more suited to introduction in
236 Stage 3 if at all.

237
238 **HIT Policy Committee Meaningful Use Workgroup Question #7: In stage 1, as an optional**
239 **menu objective, the presence of an advance directive should be recorded for over 50% of**
240 **patients 65 years of age or older. We propose making this objective required and to**
241 **include the results of the advance-directive discussion, if available. We invite public**
242 **comment on this proposal, or to offer suggestions for alternative criteria in this area.**

243
244 HIMSS supports expanding the capture of advance directives as a measure that should be used
245 for Meaningful Use, as Medicare already requires the information, and encourage the
246 requirement to be that “advance- directives discussed” should be a requirement with a “yes” /
247 “no” response option. It is important to note that such a requirement will need to account for
248 state and federal laws for validity, as many laws require registering the advance-directives within
249 a formal registry to be valid.

250
251 **HIT Policy Committee Meaningful Use Workgroup Question #8: What are the reasonable**
252 **elements that should make up a care plan, clinical summary, and discharge summary?**

253
254 The Workgroup is best served to review information from organizations such as the Case
255 Management Society of America and The Joint Commission. From a standards perspective, the
256 Clinical Document Architecture Standard Release 2.0 from HL7 provides an exchange model for
257 clinical documents that should be considered and we support a consensus-based approach to
258 determine how best to utilize these standards for definition of these specific documents for
259 Meaningful Use purposes.

260
261 **HIT Policy Committee Meaningful Use Workgroup Question #9: What additional**
262 **meaningful-use criteria could be applied to stimulate robust information exchange?**

263



264 Given the need for more robust health information exchange (HIE) in Stages 2 and 3, ONC and
265 CMS should focus on greater use of Stage 1 capabilities for data exchange and also require a
266 material, but achievable, level of electronic transmission of patient summaries in Stage 2, not
267 waiting until Stage 3 to focus on electronic transmission. ONC should focus its work on its
268 Standards and Interoperability Framework, the NW-HIN, the Direct Project, and state HIE
269 funding to facilitate the use of specific standards and standards-based transport mechanisms
270 needed for exchange.

271
272 In addition, while encouraging the use of electronic transmission of patient summaries, we do
273 urge the HITPC, CMS, and ONC to reevaluate proposed measurements for these categories to
274 ensure that measurement does not inappropriately penalize certain proven modes of exchange
275 (such as query-based exchange) and certain providers who work in areas where EHR adoption is
276 low in their referral network.

277
278 From a Standards and Certification standpoint, as well as the ONC Standards and
279 Interoperability Framework, it is important to continue to refine and certify on the HITSP C32
280 (and C83) specifications. It will also be very important to have progress on standards for patient
281 matching and patient consent.

282
283 **HIT Policy Committee Meaningful Use Workgroup Question #10: There are some new**
284 **objectives being considered for stage 3 where there is no precursor objective being**
285 **proposed for stage 2 in the current matrix. We invite suggestions on appropriate stage 2**
286 **objectives that would be meaningful stepping-stone criteria for the new stage 3 objectives.**

287
288 HIMSS is concerned about the potential impact of adding Stage 2 objectives for the referenced
289 new Stage 3 objectives. Given the burden of change already underway, as part of preparing for
290 Stage 3 for these items, substantial public work that can serve as a valid and reliable signal to the
291 market should take place including:

- 292
- 293 • Electronic self-management tools: Define the set of tools, and require one. Otherwise we
- 294 have less time to develop for Stage 3
- 295 • Exchange information with PHR: Define the message. Patient's capability to report
- 296 experience: Define the data to be collected and how/what will be reported. Stage 3 would
- 297 then be how to provide patient access.
- 298 • Upload and incorporate patient-generated data: Define what data will be received, the
- 299 message format(s) and transport. Test one for certification.
- 300 • Public Health Button: Define "notifiable conditions", the outbound message format and
- 301 transport. Define the inbound alerts, follow-up requests, and any specifics on how the
- 302 alerts are expected to be displayed... also the nature and expected action to be taken on
- 303 follow-up requests.
- 304 • Patient-generated data to public health agencies: Define what needs to be gathered, and
- 305 how (during visit or via portal), and the message format and transport standards for
- 306 submission.
- 307



308 **Other issues for Meaningful Use Stage 2 Consideration**

309

310 Nursing Sensitive Additional Clinical Measure

311 We support the joint Alliance for Nursing Informatics and American Nurses Association call for
312 a New Nursing Sensitive Measure [Pressure Ulcer Risk and Prevention Measures for Stage 2 and](#)
313 [Stage 3 Meaningful Use.](#)

314

315 Financial Systems, Healthcare Transformation, and Meaningful Use

316

317 In addition to Meaningful Use, the healthcare transformation underway via federal regulations
318 includes 5010 implementation, ICD-10 transformation, and the creation and mandated
319 implementation of operating rules. For the vast majority of small providers attempting to
320 comply with these regulations, such transformation touches on many areas of the enterprise or
321 practice. These changes are complex and can be overwhelming. Still, their inclusion in the
322 overall transaction practice can be beneficial to savings efforts.

323

324 Force Majeure Exemptions

325 As the Workgroup prepares to finalize recommendations for MU Stage 2, HIMSS strongly
326 recommends the Workgroup consider our position on force majeure exemptions for hospitals and
327 other healthcare organizations.

328

329 Adequate disaster recovery plans and backup power are required by the HIPAA Security Rule as
330 well as licensing and accreditation standards. However, emergencies and other uncontrollable
331 events are likely to make systems unavailable for hospitals and clinical practices at some point in
332 time – despite implementation of disaster recovery and backup systems. In addition, downtime
333 may be necessary to perform routine maintenance and to implement system upgrades or entire
334 new systems.

335

336 HIMSS notes that system upgrades are likely to be necessary to implement technology to satisfy
337 Stages 2 and 3 of the Meaningful Use criteria, so this issue will be faced by the vast majority of
338 those trying to establish Meaningful Use. From a patient safety perspective, it is important to
339 adequately test new systems and upgrades before they are used in a live environment and to
340 quickly revert to a less automated workflow if there are questions of clinical quality, data
341 integrity or possible security breaches with the electronic system.

342

343 It is impossible to predict every situation for which an exception will be appropriate so it should
344 be drafted broadly and providers should not be liable if they make a good faith effort to qualify
345 for the specific standards set forth in the rule. At a minimum, the exception should include the
346 following:

347

- 348 ▪ Orders, prescriptions and other activities that are not conducted electronically as a result
349 of a force majeure event should be excluded from denominators and other requirements
350 of Meaningful Use. “Force majeure” or “Act of God” is often defined as any event
351 which the affected party cannot reasonably control. It should include as examples fires,
352 floods, extreme weather conditions, epidemics, riots, civil unrest, terrorist attack, war,

- 353 operation of private facilities by government entities in emergency situations, acts of a
354 public enemy, civil or military authority, strikes, lockouts, unavailability of third party
355 services such as Internet connectivity, shortages or power interruptions that exceed
356 reasonable backup power capability.
- 357 ■ Service by eligible professionals at a hospital in emergency situations should not be
358 counted in determining whether the eligible professional is “hospital based.” Shortages
359 of hospital personnel could be caused by an emergency due to any force majeure event.
 - 360 ■ From the hospital’s perspective, if it needs to use the services of physicians, nurses or
361 others who are not trained on its EHR during an emergency, the non-electronic orders,
362 prescriptions and other activities of those temporary personnel should not be counted.
 - 363 ■ Orders, prescriptions and other activities that occur during planned or emergency system
364 downtime to address technical or clinical issues with the system and connections to the
365 Internet should not be counted in the denominator when computing percentages or
366 otherwise be considered when determining if an element of Meaningful Use has been
367 satisfied. The downtime would include time spent testing current or new functionality
368 and downtime required for implementation of upgrades or new systems or functionality.

370 HIMSS suggests this exception should be drafted broadly enough to apply to an eligible hospital
371 or eligible professional that is indirectly affected by a force majeure event at another location.
372 For example, a fire at hospital/practice “A” that results in patients, nurses and physicians being
373 relocated to hospital/practice “B” which uses an EHR on which the hospital/practice. Any
374 personnel that have not been trained should be considered under a force majeure event with
375 respect to both hospitals or practices.

376
377 **Conclusion:**

378 Finally, HIMSS appreciates the opportunity to provide public comments to the HIT Policy
379 Committee Meaningful Use Workgroup on this important Request for Public Comment. We
380 look forward to continued dialogue between HIMSS members and the Department, in order to
381 achieve the benefits of an interoperable healthcare system. If you have any additional questions
382 please [Thomas M. Leary](#), Senior Director, Federal Affairs, at 703.562.8814.

383
384
385 Sincerely,
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389 C. Martin Harris, MD, MBA, FHIMSS
390 Chief Information Officer and
391 Chairman, Information Technology Division
392 Cleveland Clinic
393 Executive Director, e-Cleveland Clinic
394 HIMSS Chairman of the Board



H. Stephen Lieber, CAE
President/CEO
HIMSS



Meaningful Use: Stage 1 Final Rule and Proposed Objectives for Stages 2 and 3

Improving Quality, Safety, Efficiency & Reducing Health Disparities

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
CPOE for medication orders (30%)	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)		<p>HIMSS agrees with expansion of order types and that it is appropriate to maintain Stage 1 metric of measuring by patient (and not by orders) given the burden of counting paper orders to assemble an “all orders” denominator. If “unique patient” denominator is maintained, percentages given appropriate.</p> <p>In addition, in Stage 1, there has been confusion about the definition of “licensed professionals”; a clear and consistent definition is needed. We agree with not changing the denominator to all orders due to the reporting burden of counting paper orders. Also, it is important to be clear on how “transmission” of orders is defined, especially in hospitals</p> <p>HIMSS members have expressed concern that allowing any licensed professional to enter orders on behalf of the ordering provider in Stage 3 really negates the purpose of decision support that some with CPOE consider higher volume of lab, meds, and radiology orders by CPOE by stage 3 done by the ordering provider</p> <p>Finally, there is some concern regarding the WGs statement on "transmitted electronically" if the ordering system is different from the ancillary system (Pharmacy/Radiology/Laboratory) then the order will go through an interface into the ancillary system.. Having this is necessary for CPOE to work as interfaces have to be working in parallel with CPOE. You can not have CPOE, without the orders being sent (electronically) to the ancillary systems.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Drug-drug/drug-allergy interaction checks	Employ drug-drug interaction checking and drug allergy checking on appropriate evidence-based interactions	Employ drug-drug interaction checking, drug allergy checking, drug age 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	Reporting of drug interaction checks to be defined by quality measures workgroup	<p>Define the appropriate evidence interactions and make sure they are not pharmacy based. Legal considerations are making too much clinical "noise" and threaten to cause alert fatigue for the provider.</p> <p>The objective and measure should remain at Stage 1 levels. HIMSS is concerned about the vagueness of the word "appropriate," specifically for who is determining the appropriateness of an alert. "Appropriateness" should be determined by the EP or hospital. If there is to be a standard definition of "appropriate" should be available with enough lead time for vendors to program, test, and release corresponding features, and for providers to implement those features. For Stage 3, some of the proposed items may not be appropriate. Look to what is in 2011 CCHIT for some guidance.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
eRx (eRx) (EP) (40%)	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	<p>HIMSS agrees with the recommendation for Eligible Providers as this is already a function they are performing. For Eligible Hospitals, this is not part of Stage 1. This will be new to them for Stage 2. This will take planning regarding hospital workflow and making sure the current systems in the hospital can do this. This is important for a patient safety point of view.</p> <p>In addition, there is some concern among HIMSS members that the draft objective seems to be have % requirements that are inconsistent with CPOE requirements.</p> <p>Finally, our members are supportive of the current efforts to develop an universal electronic standard for narcotics.</p>
Record demographics (50%)	80% of patients have demographics recorded and can use them to produce stratified quality reports	90% of patients have demographics recorded (including IOM categories) and can use them to produce stratified quality reports		<p>HIMSS agrees with retaining the Stage 1 demographics categories for Stage 2. We are concerned that the proposal for Stage 3 is vague and could represent a large development effort. Sufficient detail must be available with enough lead time for vendors to program, test, and release corresponding features, and for healthcare providers to implement those features.* How is “can use them to produce stratified quality reports” measured?</p> <p>HIMSS requests that the Workgroup clarify what you mean by "stratified quality reports"., including advice on methods for capturing races/ethnicities . There needs to be a single, clear, consistent set of demographics from an agreed upon source.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Report CQM electronically	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	<p>Reporting of clinical quality measures is of great concern for HIMSS Members for Meaningful Use Stage 2 and 3. We are very concerned that given the lack of details at this time (February 2011) that the required degree of detailed specification for measures will not be provided with enough lead time for vendors to program, test, release, and for healthcare providers to implement.</p> <p>Because of the timeframe to identify valid measures, develop and test measures in EHRs, and implement the required clinical workflows that capture necessary information, we advise no additional quality measures in Stage 2, other than those needed to address material deficiencies for specific physician specialties, and that work on additional quality measures be established for Stage 3 so that measures can be implemented efficiently.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Maintain problem list (80%)	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	<p>Early Meaningful Use adopters have found that the problem list 80% threshold is one of the most difficult to achieve. Therefore, we agree with not raising the threshold or changing the method of measurement in Stage 2. Also, the ability for such coding to occur after the clinical encounter by coding professionals should be clearly permissible in all stages of Meaningful Use.</p> <p>In addition, we request the WG work with the government to clarify "up-to-date" or "useful" problem lists (discharge lists, care summaries, etc.). We suggest that a measure be included regarding the documentation of family history, which could be used to follow up and generate patient reminders. If a patient has a positive family history of cancer, for example, it can impact on-going care. We feel that chronic problems don't always need to be on the problem list -- relevant problem lists should help identify and prioritize problems. What are the expectations for recording relevant items in the Active Problem List and retiring active problems to Past Medical/Surgical history, etc.?</p> <p>Finally, the NCQA recommended that the industry adopt SNOMED in a report issued over 5 years ago;. There has been considerable discussion in the industry on including ICD9/ICD10 and SNOMED as part of MU, yet there's remains no mention in the MU criteria. It would be reasonable to expect some discussion of the transition from ICD9 to ICD10 in Stage 3 since ICD10 implementation is 10/1/2013. It should also be noted that structured charting which is an antecedent to maintaining up-to-date problem lists virtually requires SNOMED concept coding.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Maintain active med list (80%)	Continue Stage 1	80% medication lists are up-to-date	Expect to drive list to be up-to-date via medication reconciliation	HIMSS agrees with using Stage 1 levels for Stage 2. For Stage 3, define “up-to-date” with enough lead time to program, test, release, and implementation.
Maintain active medication allergy list (80%)	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	HIMSS agrees with using Stage 1 levels for Stage 2. For Stage 3, define “up-to-date” with enough lead time for vendors to program, test, release, and for healthcare providers to implement.

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Record vital signs (50%)	80% of unique patients have vital signs recorded	80% of unique patients have vital signs recorded		<p>HIMSS agrees with using Stage 1 levels for Stage 2. Please clarify that the vital signs that must be captured are the same as those in Stage 1 (height, weight, and blood pressure) but also reconcile the objective and measure to avoid any confusion.</p> <p>HIMSS encourages the Workgroup to review the process for allowing an attestation for practices that will indicate this is out of scope.</p> <p>Finally, HIMSS points out that there may be some inconsistency between the 80% threshold for this requirement and the 90% smoking cessation in Stage 3. ?</p>
Record smoking status (50%)	80% of unique patients have smoking status recorded	90% of unique patients have smoking status recorded		<p>HIMSS agrees with using Stage 1 levels for Stage 2. Clarify that smoking status is intended to be captured using the same standards and measurement metrics as specified in Stage 1 and that new standards are not to be introduced. If new standards are to be introduced, they should be defined with enough lead time for vendors to program, test, release, and for healthcare providers to implement. Given the difficulty of effectively addressing all edge cases, we suggest that the Stage 3 proposed threshold be changed from 90% to 80%.Also, this is an objective that may not necessarily need to be applied to every EP specialty and an exclusion should be allowed.</p> <p>HIMSS encourages the Workgroup to review the process for allowing an attestation for practices that will indicate this is out of scope.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Implement 1 CDS rule	Use CDS to improve performance on high-priority health conditions.	Use CDS to improve performance on high-priority health conditions.		<p>HIMSS suggests the Workgroup consider escalating and focusing CDS use by specifying an increased number of rules or conditions addressed and also via linkage to quality measures used by the provider. We are very concerned that the proposed CDS EHR requirements seem to go well beyond what an EHR should be programmed to do. CDS features with an EHR should allow EPs and hospitals flexibility in designing CDS. By allowing them to customize their CDS alerts and advisories, they can create specific and targeted decision support based on criteria specific to their practice. It would be inefficient for an EHR vendor to hard-code CDS rules into the system. Instead, this is an opportunity to identify a framework that allows EPs and hospitals to create their own clinical decision support rules.</p> <p>In addition, each of these terms needs to be defined in the 8 criteria, and examples of "authenticated", "credible", "evidence based" - then certification needs to meet this criteria as well - without full CPOE required by the responsible party - not the licensed surrogate- this requirement negates "Presented to the appropriate party who can take action "</p> <p>Within this context, it would be impossible for an EHR to control whether CDS is "authenticated" or "evidence-based". The EHR could, however provide a method of displaying a source to a clinician. We are also concerned with the vagueness of "high-priority health conditions." Because CDS should be flexible, conditions and other CDS criteria should be left to the discretion of the EP or hospital and not determined by CMS or other government body. If you do define "high priority health conditions," such a clarification should be published with enough lead time for vendors to program, test, release, and for healthcare providers to implement.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
	<p>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. Integrate with HER; 8. Presented to the appropriate party who can take action</p>	<p>Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action</p>		<p>HIMSS suggests rewording as follows: 1. EHR provides a method of displaying to the provider the source/citation of the CDS. (revision of 1 and 2) 2. EHR allows rules to be configured to enable decision support based on the patient's context (clinic visit, currently admitted). (revision of 3) 3. EHR rules respond to information in the chart about the patient's problems, allergies, medications, demographics, and vitals. (revision of 4) 4. EHR allows rules to be configured to present decision support at a specific point during the clinical workflow. (revision of 5) 5. EHR allows rules to be configured to present decision support to users of certain roles. (revision of 8) 6. CDS can be integrated with other with other applicable EHR functionality (Revision of 7).</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Implement drug formulary checks*	Move current measure to core	80% of medication orders are checked against relevant formularies	What is the availability of formularies for eligible professionals?	<p>HIMSS agrees with the move to core for Stage 2. Importing and maintaining formulary information can be very time consuming, depending on the way formulary information is provided to the provider. When moving to an aggressive percentage for Stage 3 (80% of all orders), you are requiring that a large quantity of patients have formularies available in the system. This level will be very difficult for certain providers who see patients with a large variety of insurance plans and separate formularies, or who see patients whose formularies are not readily available. It is inappropriate to penalize providers for some of these circumstances beyond their control.</p> <p>There are two important , disconcerting changes -- the change from a yes/no threshold, and the requirement is now to check all med orders against in-and out-patient formularies (need to be implemented). Since formularies are usually payer-specific, in order to reach 80%, a provider might need to have 80-100 formularies, which isn't feasible. SureScripts formularies are frequently challenging in terms of their usefulness and usability. Need PBMs to standardize and improve data presentation and usability to end-users.</p> <p>Finally, HIMSS suggests that the objective for Stage 3 be "80 % of medication orders are checked against relevant formularies when the formulary is available for the patient via the e-prescribing hub the provider uses ".</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Record existence of advance directives (EH) (50%)*	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	<p>HIMSS agree on the shift to core for this item. Define the standards to be used in the EHR for the discussion result and the directive with enough lead time for vendors to program, test, release, and for healthcare providers to implement. In a non-urgent setting many patients and physicians might feel that it seems most appropriate for a patient to discuss their advance directive decisions with his or her primary care physician, since that physician is most familiar with the patient's medical history. Because of this, we recommend that specialists be allowed to attest that this requirement is inappropriate to their practice and to be able to claim an exclusion.</p> <p>We also encourage a process for recording directives earlier in life specifically in the area of organ / tissue donor recruitment. It would also be wise to implement processes in PHR linked to EHR, as patients might be more likely to complete one, to put in their current preferences, and help address the critical shortage of organs available for transplantation when young people die without having indicated their preferences in this regard.</p> <p>HIMSS suggests that there are 3 separate conditions embedded in one item: does an advanced directive exist; is the advanced directive copy on file; what are the results of the advanced directive discussion. Will having the three criteria embedded in one item add to the complexity of measurement and scoring?</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
				<p>HIMSS agrees that the vendor should provide this capability. Recording the existence and location in the system is reasonable, but recording them accurately could be complex and error-prone so we wouldn't encourage a requirement to record them in detail. Eventually we need to address the currency and relevance of advance directives in EHRs. However, documentation that a discussion occurred, that information was given (i.e., thinking started about ADs) is useful.</p> <p>HIMSS suggests that this is only required in Stage 1 in POS 21 - consider also including in POS 23 for Stage 2 as well as EP.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Incorporate lab results as structured data (40%)*	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		HIMSS observes that it is unclear what “but only where results are available” means for Stage 2. This phrase must be clearly defined to ensure accurate reporting across sites. Is this a necessary distinction for eligible hospitals? Be careful to require only numerators and denominators to be reported that can be measured. For example, if a lab order and result are inappropriately written in an EHR in unstructured format, it is not possible to report that they are not structured because the lack of structure means the EHR is not aware that this information is supposed to be a lab order and result. Also, for Stage 3, the volume of unsolicited results could complicate reconciliation and measurement.

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Generate patient lists for specific conditions*	Make core requirement. Generate patient lists for multiple patient-specific parameters	Patient lists are used to manage patients for high-priority health conditions		<p>HIMSS agrees with the move to core in Stage 2. The terms “patient-specific parameters” and “high-priority health conditions” are unclear. For patient-specific parameters, it is unclear whether a single list must be generated based on multiple parameters, such as a diagnosis and a medication, or whether multiple lists for a single parameter are allowed, such as one list for patients with a specific diagnosis and another list for patients on a specific medication. We suggest that this objective align with data already captured in earlier requirements, such as "Record demographics."</p> <p>It is also unclear how an EP or hospital will be required to report on whether a list was used to manage patient care. Without further clarification, we suggest that this objective remain attestation only.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Send patient reminders (20%)*	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?	<p>HIMSS agree with the move to core in Stage 2. Please clarify that the age restriction in Stage 1 will remain in Stages 2 and 3 and that this remains an EP measure. It will be important to define "active patients" and how this will be measured with enough lead time for vendors and providers. We suggest that EPs have discretion here but are also concerned about consistent measurement across systems. Another concern about defining active patients is the need to send reminders to patients who have not been seen during the reporting period, though most MU reporting is based on the patient population that had encounters during the reporting period. Also, what does "electronically" mean?</p> <p>We suggest that the specifics of this definition be left open to allow for innovation, to include portals, PHRs, texting, email, etc.</p> <p>In Stage 1, there is some confusion in the marketplace about what is intended by "reminders." For example, are appointment reminders included? There is a need to define "preventive or follow-up care reminders" but we suggest that EPs are given discretion in this area.</p> <p>Finally, it may be helpful to define active patients as those patients who have an active visit or primary relations with a provider in the past year, as defined by Medicaid.</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
(NEW)	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.	<p>HIMSS agrees with the addition of this objective and measure for Stage 2, as it is key to moving to a paperless record and to providing rich clinical context in the EHR. We recommend that scanned notes not be counted for this measure. Scanned notes introduce potential handwriting illegibility and errors. At least notes that are entered as free-text can still be searched by an EHR for a specific detail written in the note. Scanned notes do not, in most cases, provide such search capabilities. It would also be helpful to further define "narrative" and "structured." Please clarify that narrative notes must be searchable. The "note" needs to be precisely defined, which may be precision on the range of permissible formats.</p> <p>There is some concern that definition should not be overly prescriptive</p> <p>HIMSS members suggest that by Stage 3 consideration should be to having electronic structured notes</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
(NEW)	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.	<p>HIMSS agrees with the addition of this objective and measure for Stage 2, as it is key to moving to a paperless record and to providing rich clinical context in the EHR. We recommend that scanned notes not be counted for this measure. Scanned notes introduce potential handwriting illegibility and errors. At least notes that are entered as free-text can still be searched by an EHR for a specific detail written in the note. Scanned notes do not, in most cases, provide such search capabilities. It would also be helpful to further define "narrative" and "structured." Please clarify that narrative notes must be searchable. The "note" needs to be precisely defined, which may be precision on the range of permissible formats.</p> <p>Though scan documents allow access via electronic means the long term objective should be to get to a structured document that supports the data capture needed to improve quality and performance.</p> <p>Consider NOT allowing scanning in Stage 3. Security of data is compromised , and patient confidentiality can be compromised with scanning</p>

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Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
(NEW)	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		<p>HIMSS agrees with the addition of this objective and measure for Stage 2, as it is a major component of patient safety. The jump from 30% to 80% is very great. We recommend 30% for Stage 2 and 60% for Stage 3. The measure for Stage 3 includes the clarification that this applies only to inpatient medication orders. It would be helpful to specify this detail for Stage 2 as well to explicitly exclude any interpretation that discharge prescriptions would be counted. Please clarify what "automatically" means, as well as that the intention of this objective and measure could include bar-coding, RFID, or similar technologies used for medication administration. We need specific clarification on which technologies are acceptable.</p> <p>Finally, it may be helpful to define active patients as those patients who have an active visit or primary relations with a provider in the past year, as defined by Medicaid.</p>



Meaningful Use: Stage 1 Final Rule and Proposed Objectives for Stages 2 and 3

Engage Patients and Families in Their Care

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Provide electronic copy of health information, upon request (50%)	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	HIMSS agrees with continuing Stage 1 to Stage 2.

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Provide electronic copy of discharge instructions (EH) at discharge (50%)	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]	HIMSS suggests that the Workgroup clarify whether this requirement can be met through timely portal access. Stage 1 has shown that the issue with this objective is not the EHR, which has this capability, but rather the hardware and training requirements to provide the summary as the patient is leaving. Organizations will need to decide how and in what manner they will provide secure data to patients upon request

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
EHR-enabled patient-specific educational resources (10%)	Continue Stage 1	20% offered patient-specific educational resources online in the common primary languages		HIMSS agrees with continuing Stage 1 for Stage 2. Regarding common languages, we appreciate the definition offered by the Office of Civil Rights.
(NEW for EH)	80% of patients offered the ability to view and download via a web-based portlier, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human-readable and structured forms (<i>HITSC to define</i>).	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 (<i>HITSC to define</i>).	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.	<p>HIMSS agrees with making available both human readable and structured data for Stage 2, building off of the Stage 1 approach. Clarify that 80% means that 80% could have this access if they want it (able to sign up for a portal) vs. actually signing up. For patients discharged to a nursing home, it might also make sense to have the portal available to a caretaker. Clarify that only information from the most recent discharge is expected to be included. 36 hours is not sufficient for the complexity of the hospital data to be included.</p> <p>HIMSS suggests that the Workgroup have the objective focus on the discharge format, not the inpatient summary.</p> <p>Many organizations have not yet addressed the infrastructure requirements to support patient portal technologies, therefore, while setting the direction to support timely patient access, the % of patients who can access and within what time frame should be cautiously considered. The content for consideration for inclusion is appropriate to support care coordination activities.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
<p>Provide clinical summaries for each office visit (EP) (50%)</p>	<p>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)</p>	<p>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)</p>	<p>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</p>	<p>HIMSS agrees with making available both human readable and structured data for Stage 2, building off of the Stage 1 approach. Clarify that 80% means that 80% could have this access if they want it (able to sign up for a portal) vs. actually signing up. For patients discharged to a nursing home, it might also make sense to have the portal available to a caretaker. Clarify that only information from the most recent discharge is expected to be included. 36 hours is not sufficient for the complexity of the hospital data to be included.</p> <p>HIMSS suggests that the Workgroup have the objective focus on the discharge format, not the inpatient summary.</p> <p>Many organizations have not yet addressed the infrastructure requirements to support patient portal technologies, therefore, while setting the direction to support timely patient access, the % of patients who can access and within what time frame should be cautiously considered. The content for consideration for inclusion is appropriate to support care coordination activities.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Provide timely electronic access (EP) (10%)	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in human-readable and structured forms (<i>HITSC to define</i>).	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in human-readable and structured forms (<i>HITSC to define</i>).	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 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]	

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
<p>This objective sets the measures for "Provide timely electronic access (EP)" and for "Provide clinical summaries for each office visit (EP)" </p>	<p>EPs: 20% of patients use a web-based portal to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet</p>	<p>EPs: 30% of patients use a web-based portal to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet</p>		<p>HIMSS suggests there is not an industry standard for what is contained in a "longitudinal care plan." We suggest that this item be removed from the requirement until there is an accepted standard. Clarify that the ability to download lab results does not prohibit the provider from reviewing the lab and procedure results prior to releasing them to the patient online. What is intended by "longitudinal" -- this term must be carefully defined. We suggest clarifying that encounters older than one year do not need to be displayed (though they could be displayed optionally).</p> <p>In addition, it may be inappropriate for an EP to be held accountable for criteria beyond his/her immediate control, and we have concerns that this objective is measured based on patient behavior. We prefer the measure proposed for the hospital equivalent of this objective, focused on a percentage of patients offered access. If the exclusion criterion for this measure is maintained, we are concerned about the ability of an EHR to accurately determine whether a patient has access. The only way to report on such information would be to require clinicians to document this information, which places an additional documentation requirement, with no clinical value.</p> <p>Finally, HIMSS suggests that patients who do not have internet access may not really be different from any patients who decline access to a portal for any reasons. We suggest that all patients who decline be excluded.</p>
<p>(NEW)</p>	<p>EPs: online secure patient messaging is in use</p>	<p>EPs: online secure patient messaging is in use</p>		<p>There is concern among HIMSS members that this is should not be included in EHR functionality.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
(NEW)	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?	HIMSS requests the Workgroup define communication medium. In addition, HIMSS suggests that details, including value sets, must be specified with enough lead time for EHRs to incorporate such values in their features and for providers to adjust to the new values and map over any old data. If you do not intend to dictate what values should be used, specifying that that will be to the EHR developer or provider's discretion early on would be a valuable signal to the marketplace. We suggest that the communication medium options be left to the provider's discretion and should be able to be bounded. Also, please specify if there are requirements for how the preference is to be recorded. The jump from 20% to 80% is very great. We recommend 20% for Stage 2 and 60% for Stage 3.
		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	There is concern among HIMSS members that this should not be included in EHR functionality.
		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	HIMSS endorses the adoption of one patient record summary standard to support MU Stage 2

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
		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	There is concern among HIMSS members that this is should not be included in EHR functionality.
		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	There is concern among HIMSS members that this is should not be included in EHR functionality.



Meaningful Use: Stage 1 Final Rule and Proposed Objectives for Stages 2 and 3

Improved Care Coordination

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Perform test of HIE	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)	<p>HIMSS agrees with the increase in the required connections to external providers or HIEs for Stage 2. The term "primary referral network" is unclear and needs to be clearly defined to ensure consistent interpretation of this measure. We suggest that production connection to the NHIN (and at least one successful transmission of a real patient clinical summary) should qualify for the HIE connection and use of The Direct Project with the proposed number of external providers to send and receive actual (real) patient clinical summaries should be considered sufficient to meet the objective.</p> <p>It is important to define the concept "connection" as the Direct Project is secure e-mail and not a "connection" per se. Also, please define "bidirectional" and encourage the ability to query the HIE. Define a connection to require usage of the certified HIE functionality.</p> <p>ELPD should content agree on protocols and standards (CCD/CDA, CCR, HL7, IHE). Regarding protocols and standards, options need to be narrowed, then users and vendors will be more focused, and costs will be less; accommodating all options is too costly and too inefficient.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Perform medication reconciliation (50%)*	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		<p>The "transitions" needs to be clearer with detail. For example (hospitals) the Admission Reconciliation, the Transfer Reconciliation (ICU and the floor, OR and the ICU), and the Discharge Reconciliation (this is the most important). Being able to perform the Discharge Reconciliation for Stage 2 would be good. For Stage 3, consider also adding the Admission Reconciliation (including the Home pre-admission medications) and Transfer Reconciliations.</p> <p>HIMSS suggests that this measure needs to be clearly defined, so that reporting does not become burdensome. The EHR does not necessarily “know” when a transition in care is taking place for reporting. The EHR may record that a patient was seen today and seen again next week but does not “know” if there was a transition where the patient was seen by another physician later this week if that encounter takes place in a different EHR or on paper. In such a scenario, it’s most effective for an EP to treat all new encounters as a transition in care. Also, do not go to 80% in Stage 2 or plan for 90% Stage 3 given edge cases and measurement issues.</p> <p>Updating a med list seems at least as important as a Problem List, so evidence of medication reconciliation even within a practice seems reasonable at some interval (e.g., every 3rd visit, once yearly, etc.) We have concern that the majority of current available EHRs do not offer the capability to ensure these systems are interoperable and can support this requirement. This should be included as a core, rather than a menu item. We are concerned that the majority of current EHRs do not offer interoperability functionality.</p> <p>Finally, we suggest the Workgroup clarify whether retail pharmacy transactions will be required for compliance.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Provide summary of care record (50%)*	Move to Core	Summary care record provided electronically for 80% of transitions and referrals		HIMSS agrees with moving this to Core and suggests that this measure needs to be clearly defined, so that reporting does not become burdensome.
(NEW)	List of care team members (including PCP) available for 10% of patients in EHR	List of care team members (including the PCP) available for 50% of patients via electronic exchange		<p>HIMSS members expressed concern over the definition of a care team member. We recommend limiting the reporting requirement to be that at least one person be documented as a member of the patient care team as structured data for 10% of patients seen by the EP.</p> <p>In addition, documentation of a patient's care team can be a useful objective for Meaningful Use. However, to support inclusion in Stage 2, more specific requirements would need to be published with enough time for to design, develop, and release corresponding features and implement those features. Additionally, it is unclear what necessitates a clinician being added to the documented care team. It would be inappropriate to include every clinician that the patient sees, but without such a broad measure, it's unclear where a line could be drawn for reporting purposes.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
(NEW)	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?	<p>HIMSS members expressed concern over the definition of a care team member</p> <p>HIMSS agrees that including a longitudinal plan of care could be greatly beneficial for coordinating care. However, to support inclusion, more specific requirements would need to be published with enough time for vendors to design, develop, and release corresponding features and for EPs and hospitals to implement those features. We are very concerned that the degree of development needed to create high quality tools for documenting a plan of care based on an unknown set of criteria could be too large to perform for the initial periods of Stage 2. We suggest that this objective be defined early but not required for certification until Stage 3. Also, please clearly define "high priority.</p> <p>Possible additional elements to Longitudinal Care plan Social and family history -- functional status, and significant events, DMEs and Supplies ADLs Follow up care Safety Measures Diet and Nutrition Functional Limitations Activity Permitted Orders for Follow up care and Treatment Any home care visits ordered- PT/OT/Speech/Home Health Aide Goals Rehabilitation Potential Discharge plans</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
			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	



Meaningful Use: Stage 1 Final Rule and Proposed Objectives for Stages 2 and 3

Improved Population and Public Health

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Submit immunization data*	<p><u>EH and EP:</u> Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), if accepted as required by law</p>	<p><u>EH and EP:</u> 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.</p>	<p>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</p>	<p>This is a challenge for medical practices today because many state organizations do not have the infrastructure/capability to receive the data. The IIS will need to ensure or provide a method or capability to accept the data from disparate systems e.g. open architecture solution. Providers question the appropriateness of a mandated record review as part of this measure; it is inappropriate process from a clinicians perspective.</p> <p>All immunizations should be automatically sent to the proper registry. Either with the local (City) or with the State. This will depend on the immunization. It would also be good, to make sure the registry (IIS) can be queried so the clinicians can check to see if the data has been received and been appropriately acknowledged.</p> <p>To avoid industry uncertainty, HIMSS requests additional guidance on what constitutes an acceptable test for this objective and what is appropriate documentation that an acceptable test has been performed. Also, please change the language of this objective to read "as required by the state" not as required by law. In this regard, it is essential that there is much more state standardization on policies and use of standards.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Submit reportable lab data*	EH: move Stage 1 to core	Mandatory test.		HIMSS requests additional guidance on what constitutes an acceptable test for this objective and what is appropriate documentation that an acceptable test has been performed. Also, if the requirement is on the hospital, be clear that the submission responsibility is only for lab results for tests that are ordered by hospitals and not those received from HIEs or direct exchange). Given measurement issues, this should be an attestation item and not one that must be tracked by the EHR. We also have concerns about the readiness of the public health infrastructure.
	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).	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.		HIMSS requests additional guidance on what constitutes an acceptable test for this objective and what is appropriate documentation that an acceptable test has been performed. Also, if the requirement is on the hospital, be clear that the submission responsibility is only for lab results for tests that are ordered by hospitals and not those received from HIEs or direct exchange). Given measurement issues, this should be an attestation item and not one that must be tracked by the EHR. We also have concerns about the readiness of the public health infrastructure. In addition, EH need the option to send reports "through their performing labs" since sometimes certain tests are done off-premises, and even within an EH the laboratory information management systems (LIMS) in practice often sends confirming results directly to public health without sending it through the EHR system first.

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
		<p>EP: ensure that reportable lab results and reportable conditions are submitted to public health agencies either directly or through performing labs (if accepted and as required by law)</p>		<p>For EPs, HIMSS agrees with moving this to core objectives and that it is appropriate that reportable labs can be submitted from a laboratory system (and not through the EHR). Ensure that this is aligned with certification requirements (which do not apply to laboratory systems).</p> <p>To avoid industry uncertainty, we request additional guidance on what constitutes an acceptable test for this objective and what is appropriate documentation that an acceptable test has been performed. Also, if the requirement is on the EP, be clear that the submission responsibility is only for lab results for tests that are ordered by the EP and not those received from HIEs or direct exchange). Given measurement issues, this should be an attestation item and not one that must be tracked by the EHR.</p>
Submit syndromic surveillance data*	Move to core.	Mandatory test; submit if accepted		<p>To avoid industry uncertainty, we request additional guidance on what constitutes an acceptable test for this objective and what is appropriate documentation that an acceptable test has been performed. Given variability in public health infrastructure, this item should remain a menu item.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
		<p>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.</p>	<p>We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective</p>	<p>This objective is overly prescriptive regarding EHR design by specifying that there should be a public-health “button” rather than clarifying the goal of the objective. The objective should be rewritten to clarify the goal and needed functionality and leave the design to marketplace innovation. In terms of the focus on reporting notifiable conditions, it is not clear how this is different that syndromic surveillance and perhaps these requirements can be combined if applicable standards and public health infrastructure exists. here should be a separate objective and measure for the ability to “receive and present public health alerts or follow up requests.”</p> <p>If such testing is mandatory reminders need to be in place in the physician's EMR (EP or EH). Results of such tests should be in physician's EMR and automatically sent to local and state authorities. Physician should be able to query local or state database to verify data is in place.</p> <p>HIMSS members observe that the service would necessarily be hosted by the state's (not the county) PH agency based on criteria being generated by the CDC, The service would accept through an HTTPS push a modified C32 with regular C32 subject areas plus additional subject areas as defined by CDC (a new standard spec is needed). The service would contain all of the logic needed to evaluate the supplied data and determine if the case is reportable under then current rules. If reportable, the data received would be filed as the "report", and an acknowledgement of a filed report would be returned to the physician along with any accompanying instructions on disease management or containment. If the event is determined to not be reportable, then a negative acknowledgement would be returned. The transaction would be executed within one HTTPS session, and the data stored by the PH application only if determined to be reportable.</p>

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
				<p>Suggested steps to achieve the process:</p> <ol style="list-style-type: none"> 1) define a HITSP specification that contains all data relevant to the testing. 2) have the CDC publish E13a specification for the service as described above for the states to develop, and encourage the CDC to create an open source implementation of the specification similar to CONNECT which the states can pick up and use. 3) publish the API specification to the EHR vendors and require them to build the "button" into their EHR applications. Require the EHR vendors to produce the expanded C32 CDC spec and interoperate with the API specification as a condition of certification. 4) Design and run pilots of the capability with EHRs and HIEs.
		<p>Patient-generated data submitted to public health agencies</p>	<p>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</p>	<p>HIMSS suggests that the objective needs clarification and identification of the data set and the expected data source. It is not clear what type of patient-generated data would be appropriate for direct submission to public health and the veracity of the data.</p> <p>In addition, patient-generated data would necessarily come from PHRs. There is no current provider workflow that would be expected to intake any patient-generated data, review its content and make that content presentable and usable for PH purposes. This criteria makes no sense without significant additional information. This criteria, once it is fully defined, should be included as part of the certification criteria for PHRs and not included here.</p>



Meaningful Use: Stage 1 Final Rule and Proposed Objectives for Stages 2 and 3

Ensure Adequate Privacy and Security Protections for

Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	HIMSS Comments
Conduct security review analysis & correct deficiencies			Additional privacy and security objectives under consideration via the HIT Policy Committee's Privacy & Security Tiger Team	<p>HIMSS has engaged our Privacy and Security resources with the HIT Policy and Standards Committees' Privacy and Security Tiger Team. Resources that are available to the Tiger Team and the healthcare community colleagues include the subject matter expertise of our Privacy and Security Committee, and work products such as the Privacy and Security Toolkit, Patient Identity Integrity White Paper, and Annual Security Survey</p> <p>HIMSS encourages the Meaningful Use Workgroup to work closely with the Tiger Team to establish Objectives for Meaningful Use Stages 2 & 3 that address practical and achievable solutions to this important component of healthcare information collection and exchange.</p>
			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	