Health Outcomes Policy Priority	Care Goals[1]	2011[2] Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions*		2011[1] Measures	2013 Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions*		2013 Measures	2015 Objectives Goal is to **achieve and improve** performance and support care processes and on key health system outcomes	2015 Measures
		Eligible Providers	**Hospitals**		**Eligible Providers**	**Hospitals**			
Improve quality, safety, efficiency, and reduce health disparities	• Provide access to comprehensive patient health data for patient's health care team • Use evidence-based order sets and CPOE where appropriate • Apply clinical	• Use CPOE for all orders[3] The requirement for implementing CPOE before receiving entities are required to build electronic interfaces seems backwards. This is reasonable for medications, however, unreasonable for labs and radiology. Under Medicare e-rxg incentive program eligible physicians must report one of the 3 e-rxg G-codes for 50% of their eligible services. For 2010 CMS has proposed under physician fee schedule to reduce this burden to reporting 1 G code only 25x / year. Medicare proposed modified reporting requirement since physicians found current requirements burdensome. MU requirements far exceed these. We encourage you to sync requirements with those of the Medicare e-rxg program.	• 10% of all orders (any type) directly entered by authorizing provider (e.g., MD, DO, RN, PA, NP) through CPOE[2] Can this be entered by someone other than the physician? I.E., Will a physician co-signed order placed by a nurse be considered MU? If not, is the intent to allow physician only CPOE and how will protocols apply? How will the 10% threshold be determined? This implies a manual counting of non-CPOE orders which will add significant administrative hassle and expense for physicians. • Implement drug-drug, drug-allergy,	• Report quality measures to CMS including: o % diabetics with A1c under control [EP] o % hypertensive patients with BP under control [EP] o % of patients with LDL under control [EP] o % of smokers offered smoking cessation counseling [EP, IP]	• Use CPOE for all orders Does this mean 100% CPOE or does it mean that you have to have it available for all orders? If the former, it's very aggressive to move from 10% to 100% in 2 years. And, this objective is still too aggressive for 2013. A far more reasonable objective is receipt only of lab reports and radiology images (i.e. scanned images and associated documents). • Use evidence-based order sets While every OP EHR has an evidence-based order set, not all are set up to be evidence based and many are still in the early stages of development. Therefore, we recommend you say, "Use evidence-based order sets as appropriate."	• Use CPOE for all order types • Use evidence-based order sets • Record clinical documentation in EHR • Generate and transmit permissible discharge prescriptions electronically • Manage chronic conditions using patient lists and decision support • Provide clinical decision support at	• Additional quality reports using HIT-enabled NQF-endorsed quality measures [EP, IP] • % of all orders entered by physicians through CPOE [EP, IP] • Potentially preventable Emergency Department Visits and Hospitalizations [IP]	• Achieve minimal levels of performance on quality, safety, and efficiency measures • Implement clinical decision support for national high priority conditions • Medical device inter-operability • Multimedia support (e.g.,	• Clinical outcome measures (TBD) [OP, IP] • Efficiency measures (TBD) [OP, IP] • Safety measures (TBD) [OP, IP]

[1] Not all of the specifications may be relevant to a physician in which case the physician could demonstrate meaningful use of EHR technology through the remaining pertinent specifications.
[2] The HIT Policy Committee recommends that incentives be paid according to an "adoption year" timeframe rather than a calendar year timeframe. Under this scenario, qualifying for the first-year incentive payment would be assessed using the "2011 Measures." The payment rate and phaseout of payments would follow the calendar dates in the statute, but qualifying for incentives would use the "adoption-year" approach.
[3] CPOE requires computer-based entry by providers of orders (medication, laboratory, procedure, diagnostic imaging, immunization, referral) but electronic interfaces to receiving entities are not required in 2011
[4] Race and ethnicity codes should follow federal guidelines (see Census Bureau)

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	decision support at the point of care • Generate lists of patients who need care and use them to reach out to patients (e.g., reminders, care instructions, etc.) • Report to patient registries for quality improvement, public reporting, etc.	• Implement drug-drug, drug-allergy, drug-formulary checks • Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED Is this just for medications? Since ICD-10 will be implemented starting in 2013, after 2011 this requirement will need to use ICD-10. Also, some medical specialty societies have developed specialty-specific controlled vocabularies, which would be appropriate for maintaining the problem list referenced here. As an example, Dermatology has developed DermLex (can be found at http://www.aad.org/dermlex). Therefore we recommend amending this requirement to say, "...or SNOWMED or specialty-specific vocabularies."	drug-formulary checks • Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED • Maintain active medication list • Maintain active medication allergy list • Record demographics: o preferred language o insurance type, o gender o race[3] o ethnicity	• % of patients with recorded BMI [EP] • % eligible surgical patients who receive VTE prophylaxis [IP] • % of orders (for medications, lab tests, procedures, radiology, and referrals) entered directly by physicians through CPOE Unclear why 1st item on 2011 objectives calls for using CPOE for all orders and here it simply says a percentage. Also, regarding term "entered by a physician," can	• Manage chronic conditions using patient lists and decision support It's unclear whether all products will have the capability to create patient lists. E-rxg for decision support however, is feasible. • Provide clinical decision support at the point of care (e.g., reminders, alerts) • Specialists report to relevant external disease (e.g., cardiology, thoracic surgery, cancer) or device registries, approved by CMS We are concerned that this requirement is too aggressive. Some specialties are much further ahead than others (i.e. thoracic surgeons). Pursuant to our earlier comments, we do not envision that it is	the point of care (e.g., reminders, alerts) • Specialists report to relevant external disease (e.g., cardiology, thoracic surgery, cancer) or device registries • Conduct closed loop medication management, including eMAR and computer-assisted administration	• Inappropriate use of imaging (e.g., MRI for acute low back pain) [EP, IP] • Other efficiency measures (TBD) [EP, IP]	x-rays)	

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		• Generate and transmit permissible prescriptions electronically (eRx) • Maintain active medication list Only way to get medication lists is to use e-rxg. SureScripts network may have but it also may be incomplete (i.e. won't include med lists from independent pharmacies). • Maintain active medication allergy list • Record demographics: o preferred language o insurance type o gender o race[4] o ethnicity • Record advance directives This could create an administrative burden if an	• Record advance directives • Record vital signs: o height o weight o blood pressure Calculate and display: o BMI • Record smoking status • Incorporate lab-test results into EHR as structured data • Generate lists of patients by specific conditions	medical scribes enter this information? What about other health care providers? • Use of high-risk medications (Re: Beers criteria) in the elderly • % of patients over 50 with annual colorectal cancer screenings [EP] • % of females over 50 receiving annual mammogram [EP] • % patients at high-risk for cardiac events	feasible for these activities to occur for all specialties until 2015. Disease or device specific registries hold great potential and value but the development and implementation of these systems are not insignificant and we suspect that while this area will grow we do not assume that all specialists will have registries to which they can report available by 2013.				

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		EHR does not have the capacity to capture this information electronically (i.e. doctor has to scan in PDF file). Furthermore, not all specialties typically record advanced directives (i.e. dermatology). • Record vital signs: o height o weight o blood pressure Calculate and display: o BMI • Record smoking status • Incorporate lab-test results into EHR as structured data This seems contrary to what is required on page 1 for CPOE for electronic interfaces (footnote 2). Is the intent to require a manual intervention to add the lab values/results?	• Report hospital quality measures to CMS • Implement one clinical decision rule related to a high priority hospital condition • Check insurance eligibility electronically from public and private payers, where possible • Submit claims electronically to	on aspirin prophylaxis [EP] • % of patients who received flu vaccine [EP] • % lab results incorporated into EHR in coded format [EP, IP] • Stratify reports by gender, insurance type, primary language, race ethnicity [EP, IP] • % of all medications, entered into EHR as generic, when generic options					

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		• Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach Conditions should be interpreted as ICD, SNOMED, or other controlled vocabulary (as referenced above) coded diagnoses. List generation should also be enabled by medication or diagnosis. • Report ambulatory quality measures to CMS We are concerned that this broad requirement cannot be accomplished by 2011. Before external reporting is required, physicians should first be able to create their own reports on a set of defined measures and patient populations. To ensure providers are successful in submitting quality reporting information to CMS through an EHR, the CMS system must be able to handle such	public and private payers.	exist in the relevant drug class [EP, IP] What if patient insists on brand name medication? • % of orders for high-cost imaging services with specific structured indications recorded [EP, IP] How will "high cost imaging services" be defined and guidance imbedded into a metric that considers the patient-specific needs and clinical challenges of diagnosis and management of patients? • % claims submitted electronically to all payers [EP, IP]					

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		submissions and the EHRs must be able to transmit the data as directed. Under AMA's cardio HIT project the six practices who participated - all of whom are sophisticated EHRs users with dedicated IT staff - would not have been able to successfully submit data to a centralized data warehouse if they had been required to transmit data using the desired HL-7 format. In addition, physicians will not be able to meet the above requirement without significant costs. Therefore, flexibility in the way measures are reported is necessary and CMS should announce the measures they plan on using so that vendors have time to incorporate them into EHRs. • Send reminders to patients per patient preference for preventive/ follow up care • Implement one clinical decision rule relevant to specialty or high clinical		• % patient encounters with insurance eligibility confirmed [EP, IP]					

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		priority • Document a progress note for each encounter We are unclear what is meant by a "progress note". Clarification on this objective would be helpful. • Check insurance eligibility electronically from public and private payers, where possible We have concern with the addition of claims submission and checking eligibility since they are purely administrative functions performed by administrative staff, not clinicians. EHR software programmers typically do not have the expertise to efficiently add these administrative functions into the clinical EHR workflow. On the other hand, prior-authorization and referral request, while administrative in functions, could be performed by physicians and							

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		they relate directly to the medical record process. Therefore, it may make sense to incorporate prior-authorization and referral functionality into an EHR work flow. • Submit claims electronically to public and private payers. Same comment above applies here.							
Engage patients and families	• Provide patients and families with timely access to data, knowledge, and tools to make informed	• Provide patients with an electronic copy of their health information (including lab results, problem list, medication lists, allergies) upon request[5] "Upon request" results in all physicians meeting this requirement. We feel this is an aggressive timeline. A	• Provide patients with an electronic copy of their health information (including lab results, problem list, medication lists, allergies, discharge summary, procedures), upon request[4] • Provide patients	• % of all patients with access to personal health information electronically [EP, IP] Use of PHRs should not be part of the MU requirements. This is outside a physician's control and furthermore exceeds the intent of ARRA.	• Access for all patients to PHR populated in real time with health data While we recognize the need for patients to have timely access to their medical information, the requirements in law for meeting MU criteria are aimed at physicians sharing data with patients and do not call for physicians to provide patients with data to populate their PHRs. When	• Access for all patients to PHR populated in real time with patient health data • Provide access to patient-specific educational resources in common primary languages	• % of patients with full access to PHR populated in real time with EHR data [OP, IP] An expectation that a physician should provide real time EHR data will require several potentially different interfaces at a cost to physicians.	• Patients have access to self-management tools • Electronic reporting on experience of care	• NPP quality measures, related to patient and family engagement [OP, IP] •

[5] Electronic access to and copies of may be provided by a number of secure electronic methods (e.g., PHR, patient portal, CD, USB drive)

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	decisions and to manage their health	suggestion for 2011 would be a clinical paper summary or electronically but not solely an electronic method. This requirement should be amended to say "electronic or paper copy of their health information." Any requirements that exceed printing or PDF'ing files should not be mandated. • Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)[4] We presume you are referring to a "patient portal" whereby patient logs on and can access test results online. This will create an additional expense for physicians because they will need to purchase this capacity and associated technical support. Furthermore, physicians in many cases will want to speak with patients prior to sharing	with an electronic copy of their discharge instructions and procedures at time of discharge, upon request[4] How will this be accomplished? • Provide access to patient-specific education resources	• % of all patients with access to patient-specific educational resources [EP, IP] It's unclear how this can be measured. • % of encounters for which clinical summaries were provided [EP]	patients ask for data, physicians should share appropriate information in a manner that is suitable for meeting their workflow / practice needs. • Offer secure patient-provider messaging capability E-rxg can be a module of an EHR. Use of secure email today, however, is uncommon. It is not standardized in EHRs. This is another cost to physicians and it is questionable whether this can be achieved on a widespread basis by 2013. Vendors will first need to update systems that do not have this functionality. • Provide access to patient-specific educational resources in common primary languages • Record patient preferences (e.g.,	• Record patient preferences (e.g., preferred communication media, advance directive, health care proxies, treatment options) • Documentation of family medical history, in compliance with GINA	• Additional patient access and experience reports using NQF-endorsed HIT-enabled quality measures [EP, IP] • % of patients with access to secure patient messaging [EP] • % of educational content in common primary languages [EP, IP] How can this be measured? • % of all patients with preferences		

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		this information (i.e. lab results). The implementation time associated with developing a patient portal is also very long. Northwestern has one and it took them years to develop this functionality. While it might be a reasonable objective over the long-term for a large academic medical center, it is not a reasonable objective for a physician's office. • Provide access to patient-specific education resources Greater clarity is needed on this objective. • Provide clinical summaries for patients for each encounter Clarification is needed on definition of "clinical summary". This should not require a Continuity of Care Document (CCD) for each encounter.			preferred communication media, advance directive, health care proxies, treatment options) Most OP systems don't have these capabilities. Also, under the examples listed, recording treatment options is distinctly different from listing preferred communication media. Also, since this would likely be captured in an open notes section it's unclear how this provides a benefit. It's also unclear how the requirement for capturing advance directives under 2013 varies from the 2011 requirement. • Documentation of family medical history, in compliance with GINA Most systems do some family medical history, but, it's unclear how this will work with respect to meeting the Genetic Information Non-Discrimination Act.		recorded [IP] • % of transitions where summary care record is shared [EP, IP] • Implemented ability to incorporate data uploaded from home monitoring devices [EP]		

Health Outcomes Policy Priority	Care Goals[4]	2011[2] Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions*		2011[1] Measures	2013 Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions*		2013 Measures	2015 Objectives Goal is to achieve and improve performance and support care processes and on key health system outcomes	2015 Measures
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					• Upload data from home monitoring device The intent of this requirement is unclear. For example, the feasibility of uploading data in the form of a PDF from a USB drive is vastly different from importing structured data into appropriate fields as we are considerably further away from autopopulatd records.				
Improve care coordination	• Exchange meaningful clinical information among professional health care team	• Capability to exchange key clinical information (e.g., problem list, medication list, allergies, test results), among providers of care and patient authorized entities electronically [6] It's unclear why footnote #2 on page does not require use of interfaces in 2011 yet this objective calls for a capability to exchange information. We strongly recommend this	• Capability to exchange key clinical information (e.g., discharge summary, procedures, problem list, medication list, allergies, test results), among providers of care and patient authorized entities electronically[5] • Perform medication	• Report 30-day readmission rate [IP] • % of encounters where med reconciliation was performed [EP, IP] • Implemented ability to exchange health information	• Retrieve and act on electronic prescription fill data • Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge) We recommend either the word "electronic" be removed or that is read "electronic or paper" since the functionality to do this electronically may not exist and there may be	• Retrieve and act on electronic prescription fill data • Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge) • Perform medication reconciliation at each transition of care from one	• Access to comprehensive patient data from all available sources • 10 % reduction in 30-day readmission rates for 2013 compared to 2012 Is this requirement for IP only?	• Access comprehensive patient data from all available sources	• Aggregate clinical summaries from multiple sources available to authorized users [OP, IP] • NQF-endorsed Care Coordinati

[6] Health information exchange capability and demonstrated exchange to be specified by Health Information Exchange Work Group of HIT Policy Committee.
[7] Transition of care defined as moving from one health care setting or provider to another

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		requirement be modified so that it is limited for e-prescribing to drug interaction alerts and that any lab requirements be removed for 2011. This timeline is aggressive and requires interface creation. This requirement should only exist if physicians have someone with which to exchange data. • Perform medication reconciliation at relevant encounters and each transition of care[7] Medication reconciliation still requires a physician to query a patient about their meds. This requirement should only apply to applicable physicians. Therefore, we recommend adding to the end of this objective, "by the appropriate physician." For example, for many specialists this is not routinely done.	reconciliation at relevant encounters and each transition of care[6]	with external clinical entity (specifically labs, care summary and medication lists) [EP, IP] • % of transitions in care for which summary care record is shared (e.g., electronic, paper, e-Fax) [EP, IP]	providers involved who do not have the ability to accept things electronically. • Perform medication reconciliation at each transition of care from one health care setting to another See comments for 2011	health care setting to another	• Improvement in NQF-endorsed measures of care coordination.		on Measures (TBD)

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		Eligible Providers	Hospitals		Eligible Providers	Hospitals			
		We also recommend this requirement be clarified to indicate that medication reconciliation be defined as a reconciled med list that includes all new meds, meds that should be continued or discontinued, and any allergies or adverse reactions.							
Improve population and public health	• Communicate with public health agencies	• Capability to submit electronic data to immunization registries and actual submission where required and accepted.[8] Immunization registries are maintained by the states and do not follow a standard format. This requirement would mean each EHR vendor would have to comply with each state immunization registry which could pose additional costs. In order to rectify, CMS could work with state organizations to reconcile the immunization requirements. • Capability to	• Capability to submit electronic data to immunization registries and actual submission where required and accepted.[7] • Capability to provide electronic submission of reportable lab results to public health agencies and actual submission where it can be received. • Capability to	• Report up-to-date status for childhood immunizations [EP][7] • % reportable lab results submitted electronically [IP]	• Receive immunization histories and recommendations from immunization registries[7] This requirement is appropriate and feasible but there must be an acknowledgment that there is also a state component involved. • Receive health alerts from public health agencies We are unclear how this will work? Will it be an e-mail to a physician's office? • Provide sufficiently	• Receive immunization histories and recommendations from immunization registries[7] • Receive health alerts from public health agencies • Provide sufficiently anonymized electronic syndrome surveillance data to public health agencies with capacity to link to personal identifiers	• % of patients for whom an assessment of immunization need and status has been completed during the visit [EP][7] • % of patients for whom a public health alert should have triggered and audit evidence that a trigger appeared during the	• Use of epidemiologic data • Automated real-time surveillance (adverse events, near misses, disease outbreaks, bioterrorism • Clinical dashboards • Dynamic and Ad hoc	• HIT-enabled population measures [OP, IP] • HIT-enabled surveillance measure [OP, IP]

[8] Applicability to Medicare versus Medicaid meaningful use is to be determined

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		provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice We are unclear what are you looking for. The earlier this can be clarified by CMS the faster the vendors can incorporate. Seems to require interface creation and suggest movement of electronic submission to 2013.	provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice		anonymized electronic syndrome surveillance data to public health agencies with capacity to link to personal identifiers The intent of this requirement is unclear. If the intent is for physicians to send an anonymized list of patients with a particular illness (i.e. TB) to a public health agency who would send them back data and require the physician to connect the data to the anonymized patient list then this is not feasible. But, if the intent is simply for physicians to send the state agency a list of patients with TB then this is a reasonable requirement.		encounter	quality reports	
Ensure adequate privacy and security protectio	• Ensure privacy and security protections for confidenti	• Compliance with HIPAA Privacy and Security Rules[9],[10] We disagree with adding this to the MU objectives as this is duplicative since physicians are already required to comply with HIPAA. Furthermore,	• Compliance with HIPAA Privacy and Security Rule[8, 9] • Compliance with fair data sharing	• Full compliance with HIPAA Privacy and Security Rules • Conduct or	• Use summarized or de-identified data when reporting data for population health purposes (e.g., public health, quality reporting,		• Provide summarized or de-identified data when reporting data for health purposes (e.g.,	• Provide patients, on request, with an accounting of treatment, payment, and	• Provide patients, on request, with a timely accountin

[9] The HIT Policy Committee recommends that CMS withhold meaningful use payment for any entity until any confirmed HIPAA privacy or security violation has been resolved
[10] The HIT Policy Committee recommends that state Medicaid administrators withhold meaningful use payment for any entity until any confirmed state privacy or security violation has been resolved

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ns for personal health information	al information through operating policies, procedures, and technologies and compliance with applicable law. • Provide transparency of data sharing to patient.	imposing the requirements named in footnotes 9 and 10 are unworkable. It can take several weeks to months to determine if a violation exists. This requirement exceeds the intent of the requirements outlined in the law. Compliance with fair data sharing practices set forth in the Nationwide Privacy and Security Framework	practices set forth in the Nationwide Privacy and Security Framework	update a security risk assessment and implement security updates as necessary	and research), where appropriate, so that important information is available with minimal privacy risk.		public health, quality reporting, and research), where appropriate, so that important information is available with minimal privacy risk.	health care operations disclosures • Protect sensitive health information to minimize reluctance of patient to seek care because of privacy concerns.	g of disclosures for treatment, payment, and health care operations, in compliance with applicable law. • Incorporate and utilize tech-nology to segment sensitive data