Summary of CHIME's comments on the EHR Incentive Program published by the *Centers for Medicare & Medicaid Services*, January 13, 2010

Over the past several weeks, the College of Healthcare Information Management Executives (CHIME) has been crafting its response to the proposed regulation setting meaningful use objectives for the EHR Incentive Program.

CHIME's 1,400 members represent chief information officers (CIOs) and other top information technology executives at many of the nation's largest hospitals responsible for implementing clinical systems.

Members of CHIME's Policy Steering Committee, made up of top-level CIOs, along with input from the organization's Advocacy Leadership Team, have been working together to assemble CHIME's comments and positions. In addition, members of CHIME have been working collaboratively with policy experts of the American Hospital Association who are also crafting a detailed response. Our formal response is nearly complete, and we expect to file our comments by March 1. Before that time, however, we wish to share key points of our position. We expect that these views will prove useful to other organizations developing comments and will foster alignment of comments to the CMS. CHIME's strength comes from the diversity of its members. In this situation, however, CHIME must speak with a common voice in responding to significant shared concerns contained in these critically important rules and regulations.

Critical Concerns

1. The proposed "all-or-nothing" approach to defining and achieving meaningful use is too ambitious and will limit the program's impact on the economy.

We believe the EHR Incentive Program was included in stimulus legislation to promote the adoption of EHR systems and to simultaneously stimulate the economy as quickly as possible. Several aspects of the proposed regulations work at cross-purposes to this intent.

The 23 proposed objectives defining meaningful use of an EHR system in 2011 set a high bar for adoption that is unachievable by the vast majority of U.S. hospitals within this time

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frame. Regulations propose paying hospitals only after EHR systems are operational**.** The proposed regulations create a process that does not reward incremental progress. Objectives are prescriptive, removing needed flexibility in how individual organizations are implementing or will implement EHR systems. Without an approach that rewards progress or provides sufficient time, organizations with limited resources will likely have little chance of qualifying for payments, thus widening the "digital divide" in the country.

CHIME proposes the following:

- Give providers until 2017 to adequately achieve all of the components for EHR implementation.
- Develop a "suite" of core objectives for an EHR system to reach in 2017. We are in agreement with the American Hospital Association that the number of objectives should be expanded to 34. We suggest that some of these should "scale" over time to encourage growing capability (for example, a growing percentage of orders filed via CPOE and increasing use of health data exchange).
- Use an incremental approach that would deem a facility a "meaningful user" if it can achieve 25 percent of these objectives by 2011; 50 percent by 2013; 75 percent by 2015; and substantially all by 2017. (See Table 1, "Alternative Framework of Hospital Meaningful Use Objectives Over Time," and Slide 1, "Alternative Approach to Defining Meaningful Use.")
- Require a core set of hospital objectives in each time period. For 2011-2012, we recommend the following be required:
    - Drug-drug and drug-allergy checks.
    - Structured medication list.
    - Protection of electronic health information.

2. The HIT marketplace does not have the capacity to support the timeframe imposed by the proposed regulations.

Uncertainty and delays in finalizing the process by which EHR systems will be certified as capable of achieving meaningful use is delaying product development by vendors; pushing back implementation dates for providers; and increasing the likelihood that artificially imposed timelines will inflate implementation costs for the country.

Legislation requires providers to use EHR systems that are certified by an approved organization. The current product certification program provided by the Certification Commission for Health Information Technology is not sufficient, and the approach for awarding certification will change significantly. However, as of late February, a proposed rule governing EHR certification had not been issued, and a final rule governing certification may not be available until fall. Therefore, a pool of federally certified products will not be available to providers (both Eligible Hospitals and Eligible Professionals) until well after the start of the EHR Incentive Program. Additionally, providers that have implemented EHRs will need to upgrade systems to meet certification requirements, even if their current systems can perform meaningful use functions. (See Slide 2, "Uncertain Certification Process Limits

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Hospitals' Ability to Upgrade Existing Systems to Achieve Meaningful Use in a Timely Manner.")

CHIME proposes the following:

- Extend the time frame during which Stage 1 meaningful use objectives will be used for determining incentives by one more year to allow for the completion of product certification.
- Adopt a "grandfathering provision" under which existing hospital EHR systems that meet meaningful use objectives could be accepted as certified for two years; upgrades to existing systems or new systems would need to be certified.

3. Quality reporting requirements in the proposed regulations are unrealistic for the start of this program.

Most of the 35 measures proposed by the CMS cannot currently be collected through EHRs. They are in addition to the existing Medicare quality-reporting program and thus represent a dual reporting challenge for providers.

While automated quality reporting is critically important to the meaningful use of electronic health records, no EHR system in use today is able to automatically report the full set of proposed measures. Most of these measures have not yet been specified for automated reporting.

CHIME proposes the following:

- Delay implementation of quality reporting until 2012, when CMS will be ready to receive electronic data.
- Report quality measures directly from EHRs only if those measures have been tested and only after CMS successfully completes its ongoing pilot program.
- Coordinate measures reported electronically with those now required by Medicare's quality reporting program.
- Eliminate the requirement in the proposed rules that Medicare Eligible Professionals and Eligible Hospitals attest to the use of a certified EHR system to capture data elements and calculate results for the applicable quality measures.

4. Changes are needed in the specific objectives and HIT functionality measures included in the proposed regulations.

Changes are needed to make these measures more relevant to the inpatient environment and decrease the reporting burden. Two measures – automated claims submission and automated insurance eligibility checking – address administrative functions and should be removed. Reporting HIT functionality measures also adds significantly to providers' workload, and the regulation underestimates the extent of that effort. (See Table 2, "Detailed Comments on Proposed Stage 1 Objectives and Measures of Meaningful Use for Eligible Hospitals.")

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CHIME proposes the following:

- Remove the requirements that automated claims submissions and insurance eligibility checking be performed through EHRs.
- Relax reporting requirements related to CPOE.
- Regarding medication reconciliation, limit the objective to include only processes within an institution and not across settings of care. According to most surveys reported in the literature, less than 25 percent of physicians are currently using an electronic health record, thus suggesting that such data exchange capabilities won't be fully utilized immediately.
- Clarify which electronic data/discharge instructions providers need to give to patients so that they are in compliance.
- Clarify and standardize the data that providers must submit to public health agencies, and to which agencies they must be supplied.
- Eliminate requirements that HIT functionality measure data be submitted if it cannot be derived easily from the EHR.

Clarifications Needed

1. Hospital-based professionals: Along with several other professional and hospital groups, CHIME is concerned that the proposed rule contains an exclusive definition of hospital-based professionals that will prevent about 30 percent of physicians from receiving stimulus payments. This excludes too many physicians and will hamper care coordination and the continuity of care. *We recommend the rule include all physicians practicing in ambulatory clinics, no matter who owns the ambulatory EMR system, so that more physicians will be able to access funding for their critical transition to digital records.*

2. The vast majority of EHR systems are not one product, but instead incorporate different systems from multiple vendors. Additionally, some of the most advanced users of EHR have built their EHRs using in-house resources, (for example, Partners HealthCare and Intermountain Healthcare). Many organizations combine both vendor and in-house programs to provide clinical IT solutions. As such, certifying a hospital's "system" against all meaningful use objectives will be challenging. *Further guidance is needed on how organizations will be able to achieve site certification of any collection of individually certified systems to validate use of an EHR system and qualify for stimulus fund reimbursement.*

3. More details are needed on how the EHR Incentive Program will work, particularly regarding attestation, data submission, payments and provider eligibility determinations.

4. Health information exchange is still only in its earliest stages in the U.S., and data sharing among providers is beset by other issues, such as developing a sustainable financial model, defining patient privacy and consent requirements, and resolving governance concerns. *To eliminate chances for mistakes in matching patients to records, we continue to strongly recommend the development and widespread use of a national patient identifier.*

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5. Impact analyses in the rule seriously underestimate the total cost of ownership for these systems, and overstate the amount of incentive payments in aggregate that will be paid if the proposed rules are implemented. *We recommend that EHR acquisition and ongoing expenses be reassessed to help individuals and organizations who will need to prepare budgets not only for implementation, but for ongoing operations.*

CHIME is providing this summary for your information prior to release of its full response to the regulations. For more information regarding these positions, please refer to CHIME's detailed final comments, which it expects to release by March 1. We expect that these views will prove useful to other organizations developing comments and will foster alignment of comments to the CMS. For more information on CHIME and its position on EHRs, please contact Sharon Canner, Senior Director of Advocacy, at scanner@cio-chime.org.

About CHIME

The College of Healthcare Information Management Executives (CHIME) is an executive organization dedicated to serving chief information officers and other senior healthcare IT leaders. With more than 1,400 CIO members and over 70 healthcare IT vendors and professional services firms, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate the effective use of information management to improve the health and healthcare in the communities they serve. For more information, please visit www.cio-chime.org.

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Table 1: Alternative Framework of Hospital Meaningful Use Objectives Over Time

2011/2012 *Meet 25% (8) of:*[a,b]	*2013/2014* *Meet 50% (17) of:*[a]	*2015/2016* *Meet 75% (24) of:*[a]	*2017* *Meet substantially all of:*[a]
1. CPOE (10% or more)	1. CPOE (10% or more)	1. CPOE (50% or more)	1. CPOE (substantially all)
2. Drug-drug/drug-allergy checks	2. Drug-drug/drug-allergy checks	2. Drug-drug/drug-allergy checks	2. Drug-drug/drug-allergy checks
3. Drug-formulary checks	3. Drug-formulary checks	3. Drug-formulary checks	3. Drug-formulary checks
4. Structured problem list	4. Structured problem list	4. Structured problem list	4. Structured problem list
5. Structured medication list	5. Structured medication list	5. Structured medication list	5. Structured medication list
6. Structured medication allergy list	6. Structured medication allergy list	6. Structured medication allergy list	6. Structured medication allergy list
7. Record demographics	7. Record demographics	7. Record demographics	7. Record demographics
8. Record vital signs	8. Record vital signs	8. Record vital signs	8. Record vital signs
9. Record smoking status	9. Record smoking status	9. Record smoking status	9. Record smoking status
10. Incorporate structured clinical-lab data (50%)	10. Incorporate structured clinical-lab data (50%)	10. Incorporate structured clinical-lab data (75%)	10. Incorporate structured clinical-lab data (subst. all)
11. Patient lists by condition	11. Patient lists by condition	11. Patient lists by condition	11. Patient lists by condition
12. 5 clinical decision support rules	12. 5 clinical decision support rules	12. 25 clinical decision support rules	12. 25 clinical decision support rules
13. Electronic copy of health information to patients on request	13. Electronic copy of health information to patients on request	13. Electronic copy of health information to patients on request (CCD)	13. Electronic copy of health information to patients on request (CCD)
14. Electronic copy of discharge instructions and procedures at discharge, upon request	14. Electronic copy of discharge instructions and procedures at discharge, upon request	14. Electronic copy of discharge instructions and procedures at discharge, upon request	14. Electronic copy of discharge instructions and procedures at discharge, upon request
15. Exchange key clinical information	15. Exchange key clinical information	15. Exchange key clinical information (CCD)	15. Exchange key clinical information (CCD)
16. Summary care record	16. Summary care record	16. Summary care record	16. Summary care record
17. Immunization registries (capability)	17. Immunization registries (capability)	17. Immunization registries (submit data if possible)	17. Immunization registries (submit data if possible)
18. Reportable lab results (capability)	18. Reportable lab results (capability)	18. Reportable lab results (submit data if possible)	18. Reportable lab results (submit data if possible)
19. Syndromic surveillance data	19. Syndromic surveillance data	19. Syndromic surveillance data	19. Syndromic surveillance data

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2011/2012 Meet 25% (8) of:[a,b]	***2013/2014 Meet 50% (17) of: [a]***	***2015/2016 Meet 75% (24) of: [a]***	***2017 Meet substantially all of: [a]***
(capability)	(capability)	(submit data if possible)	(submit data if possible)
20. Security protections	20. Security protections	20. Security protections	20. Security protections
21. Use of evidence-based order sets (1 department)	*21. Use of evidence-based order sets (3 departments)*	*21. Use of evidence-based order sets (5 departments)*	*21. Use of evidence-based order sets (substantially all dept)*
22. Electronic medication administration record (eMAR) (1 department)	*22. Electronic medication administration record (eMAR) (3 departments)*	*22. Electronic medication administration record (eMAR) (5 departments)*	*22. Electronic medication administration record (eMAR) (substantially all dept)*
23. Bedside medication administration support (barcode/RFID) (1 department)	*23. Bedside medication administration support (barcode/RFID) (3 departments)*	*23. Bedside medication administration support (barcode/RFID) (5 departments)*	*23. Bedside medication administration support (barcode/RFID) (substantially all dept)*
24. Record nursing assessment in EHR (1 department)	*24. Record nursing assessment in EHR (3 departments)*	*24. Record nursing assessment in EHR (5 departments)*	*24. Record nursing assessment in EHR (substantially all departments)*
25. Record nursing plan of care in EHR (1 department)	*25. Record nursing plan of care in EHR (3 departments)*	*25. Record nursing plan of care in EHR (5 departments)*	*25. Record nursing plan of care in EHR (substantially all departments)*
26. Record physician assessment in EHR (1 department)	*26. Record physician assessment in EHR (3 departments)*	*26. Record physician assessment in EHR (5 departments)*	*26. Record physician assessment in EHR (substantially all departments)*
27. Record physician notes in EHR (1 department)	*27. Record physician notes in EHR (3 departments)*	*27. Record physician notes in EHR (5 departments)*	*27. Record physician notes in EHR (substantially all departments)*
28. Multimedia/Imaging integration (e.g., X-Ray viewing)	*28. Multimedia/imaging integration (e.g., X-Ray viewing)*	*28. Multimedia/imaging integration (e.g., X-Ray viewing)*	*28. Multimedia/imaging integration (e.g., X-Ray viewing)*
29. Generate permissible discharge prescriptions electronically	*29. Generate permissible discharge prescriptions electronically*	*29. Generate and transmit permissible discharge prescriptions electronically*	*29. Generate and transmit permissible discharge prescriptions electronically*
30. Contribute data to a PHR	*30. Contribute data to a PHR*	*30. Contribute data to a PHR*	*30. Contribute data to a PHR*
31. Record patient preferences (language, etc.)	*31. Record patient preferences (language, etc.)*	*31. Provide electronic access to patient-specific educational resources*	*31. Provide electronic access to patient-specific educational*
32. Provide el ectronic access to patient-specific educational resources	*32. Provide electronic access to patient-specific educational resources*	*32. Record patient preferences (language, etc.)*	

Table 1: Alternative Framework of Hospital Meaningful Use Objectives Over Time

2011/2012 Meet 25% (8) of:[a,b]	***2013/2014 Meet 50% (17) of:[a]***	***2015/2016 Meet 75% (24) of:[a]***	***2017 Meet substantially all of:[a]***
33. Medication reconciliation within hospital *34. Quality reporting through RHQDAPU*	*33. Medication reconciliation across settings of care (pilot)* *34. Reporting of some RHQDAPU measures through EHR*	*33. Medication reconciliation across settings of care (if possible)* *34. Reporting of some RHQDAPU measures through EHR*	*resources* *32. Record patient preferences (language, etc.)* *33. Medication reconciliation across settings of care* *34. Reporting of RHQDAPU measures through EHR*

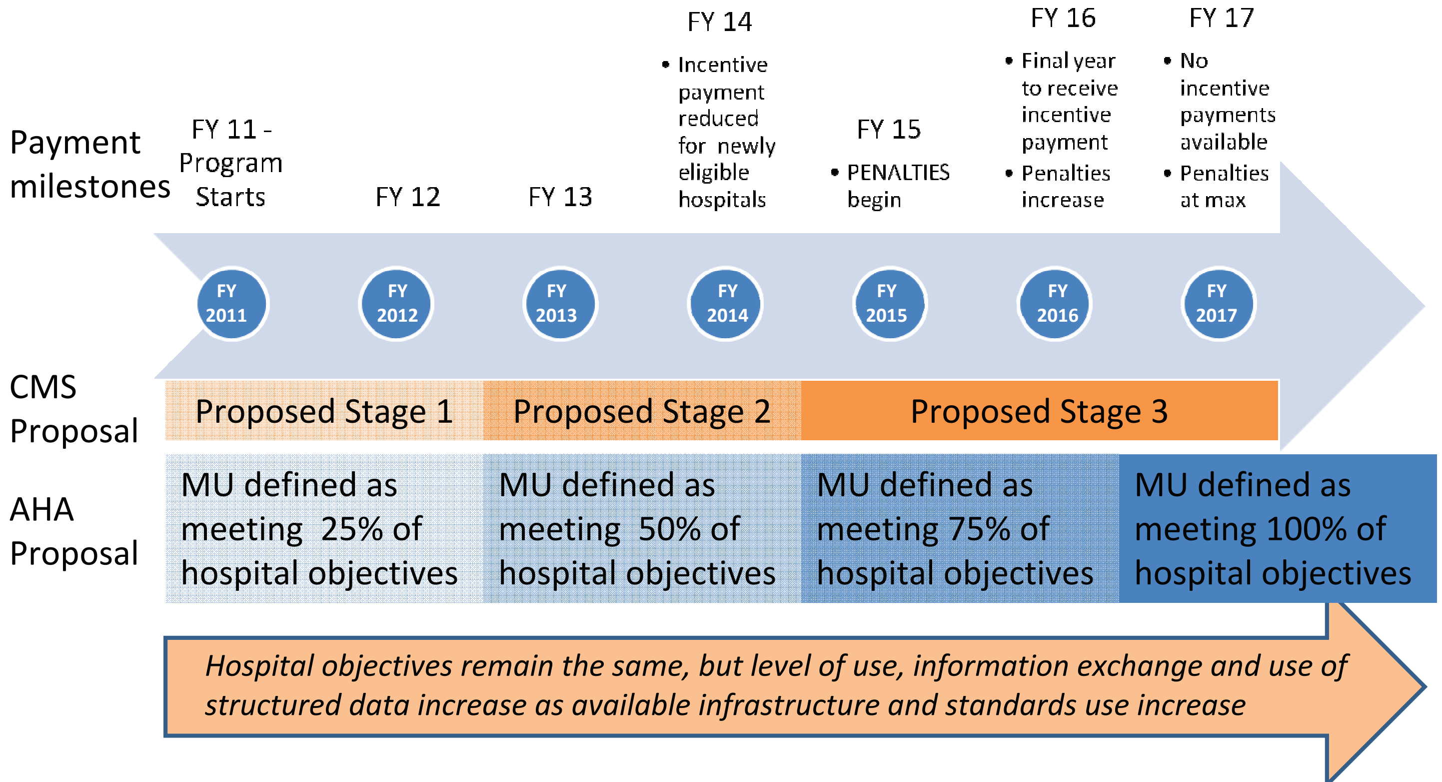
Notes:

a. *Italicized* objectives are from HIT PC recommendations for 2013 and 2015 (with exception of measure 34 on quality reporting)

b. **BOLD** objectives would be required in 2011/2012. Required objectives for future years would be decided through annual rule-making.

Slide 1
Alternative Approach to Defining Meaningful Use

Recommendation: CMS should identify a single, expanded set of meaningful use objectives to be achieved between 2011 and 2017. Hospitals would be considered meaningful EHR users and qualify for the full EHR incentive payment if they meet a specified share of the hospital objectives in a given fiscal year. The required share would increase over time. The payment schedule would not change.



Slide 2

Uncertain Certification Process Limits Hospitals' Ability to Upgrade Existing Systems to Achieve Meaningful Use in a Timely Manner

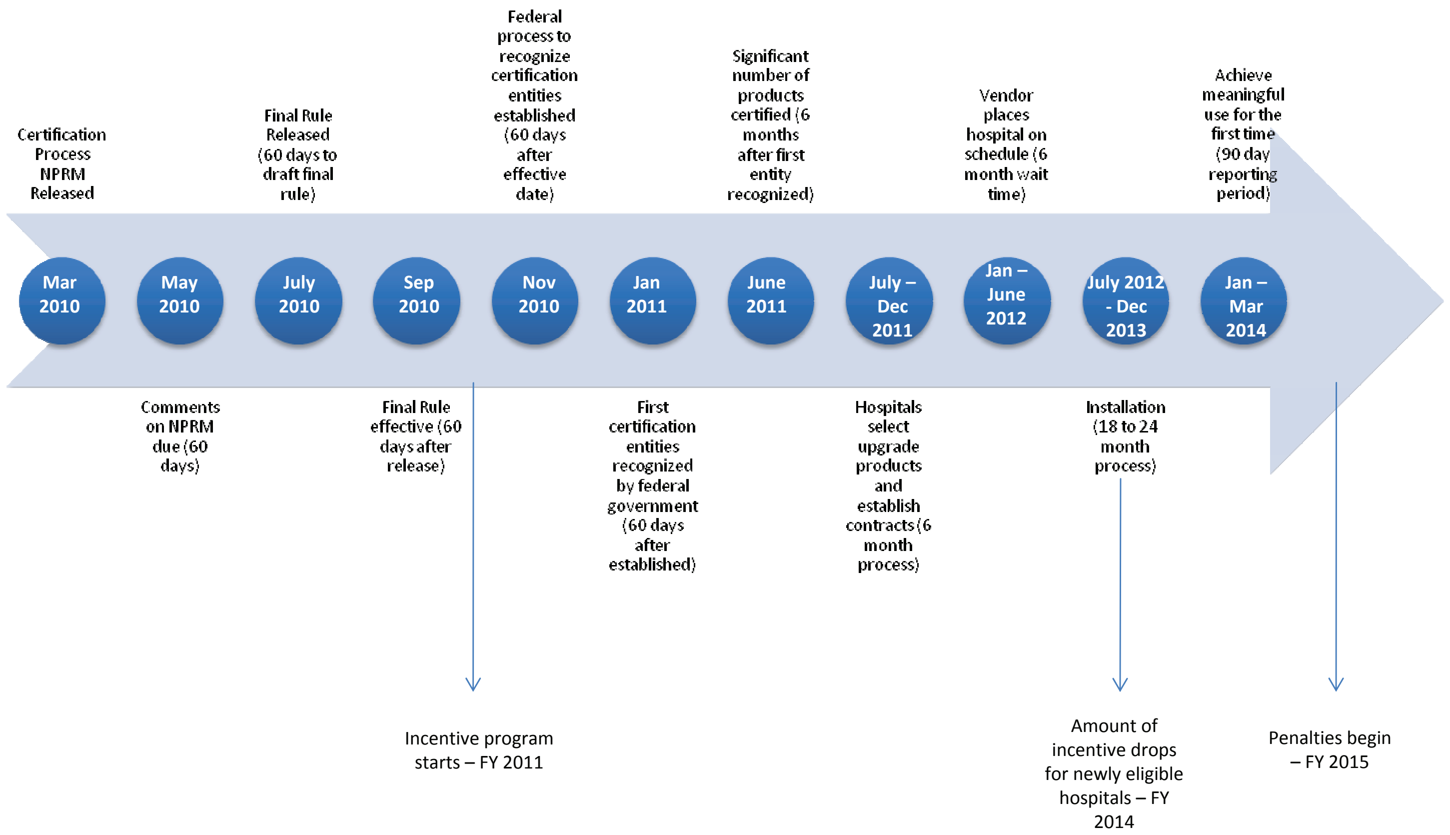


Table 2: Detailed Comments on Proposed Stage 1 Objectives and Measures of Meaningful Use for Eligible Hospitals

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
1. Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	1. For eligible hospitals, CPOE is used for 10% of all orders	• Need definition of denominator – what is included in orders of "any type"? ONC IFR lists 11 types. • As currently specified, the denominator combines paper and electronic processes. Measurement would require manual review of 100 percent of paper charts to count all orders and distinguish those placed through verbal/paper means from orders placed through CPOE. Efficient chart review for quality reporting takes approximately 20 minutes per chart, resulting in tremendous burden. A hospital with 15,000 discharges would spend 5,000 hours per year reviewing charts. • There are times when scribes are necessary and their use should be counted (such as during surgery or when an on-call physician places a verbal order to address an emergent problem). • Order sets should be "unpacked" to count individual orders • Orders placed in the ED for patients that are subsequently admitted should be included in the measure calculation.	• Do NOT use a measure with a denominator that requires review of paper charts. • Replace the proposed measure with one of the following alternatives: • Hospital has CPOE activated (preferred) • At least 10% of unique patients have had at least one order placed through CPOE • At least 10% of medication orders placed through CPOE (can be calculated from pharmacy information system) • If option 2 or 3 is chosen, require measure calculation as part of EHR certification process

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
2. Implement drug-drug, drug-allergy, drug-formulary checks	2. The eligible hospital has enabled this functionality	• This measure combines two clinical alerts with an efficiency alert. We recommend separating them. • Drug-drug and drug-allergy checks happen in both pharmacy information systems and as part of CPOE. Both approaches contribute significantly to medication safety. • For inpatient settings, the drug-formulary check is generally defined as checking against the hospital's formulary, not external insurer formularies.	Create two measures: • Hospital has implemented drug-drug and drug-allergy checks (clinical) • Hospital has implemented drug-formulary checks (efficiency)
3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	3. At least 80% of all unique patients seen admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data	• Currently installed EHRs generally use text or proprietary coding today, so there will be an adjustment process. Physician-facing screens will likely continue to be in more "accessible" language than structured codesets, with mapping to standards. Mapping systems must be built and deployed. During transitions, mapping to ICD-9 may happen at the end of a stay. • The HIPAA transactions standards require a move to ICD-10-CM in 2013. The measure should be updated over time to harmonize with this change.	• Require measure calculation as part of EHR certification process

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
4. Maintain active medication list	4. At least 80% of all unique patients admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data	•	• Require measure calculation as part of EHR certification process
5. Maintain active medication allergy list	5. At least 80% of all unique patients admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data	•	• Require measure calculation as part of EHR certification process
6. Record demographics: • preferred language • insurance type • gender • race • ethnicity • date of birth • date and cause of death in the event of mortality	6. At least 80% of all unique patients admitted to the eligible hospital have demographics recorded as structured data	• All fields may not be complete for all patients. For instance, some patients may not be willing to report race and ethnicity. Insisting that this data be provided could interfere with care delivery process. Therefore, missing data in two or three of the 7 fields should not disqualify a record from counting toward the numerator. • In Massachusetts, field experience with reporting race and ethnicity according to specific standards (such as OMB definitions) found that significant training across many different staff members is required to achieve	• Require measure calculation as part of EHR certification process • Allow records with two to three missing fields to count toward the numerator • Remove cause of death

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
		uniformity. While clearly important for evaluating and addressing disparities in care, the time and resources required to achieve uniform recording of race and ethnicity data should not be underestimated. • Cause of death is determined by the coroner and is not generally available to the hospital at the time of death. Considerable coordination with coroner is required to obtain this data and timely receipt may be beyond the hospital's control. • Date of death is known only when the death occurs at the reporting hospital.	
7. Record and chart changes in vital signs: • height • weight • blood pressure • Calculate and display: BMI • Plot and display growth charts for children 2-20 years, including BMI.	7. For at least 80% of all unique patients age 2 and over admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20	• General acute care inpatient setting not appropriate for plotting growth charts, and most children are admitted infrequently, so no trend data are available. Growth chart is useful in children's hospitals. • Patients admitted to the hospital are not necessarily routinely measured for height. Including this measure would change the requirements for nursing assessments. If maintained as a vital sign for inpatient care, estimated or reported height may be recorded. • Other vital signs are more appropriate to the inpatient setting, such as temperature, blood oxygen levels, heart rate, and glucose levels. EHRs should be capable of showing trend for these values (hourly to daily). • As currently specified, this is a test of 3	• Remove growth charts for children for general hospitals. Add temperature, blood oxygen levels, heart rate, and glucose levels, with capacity to trend values • Allow records missing two or three of the bundled fields and processes to be included in the numerator. • Require measure

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
		measurements being taken, 2 calculations being performed, and two displays viewed. Not all fields may be complete for all patients. Missing two or three of these steps should not disqualify a patient from the numerator. • Do EHRs provide tag that calculations have been performed and displays viewed?	calculation as part of EHR certification process, including tags that indicate when BMI calculation has been performed and plot has been displayed.
8. Record smoking status for patients 13 years old or older	8. At least 80% of all unique patients 13 years old or older seen admitted to the eligible hospital have "smoking status" recorded	•	• Require measure calculation as part of EHR certification process
9. Incorporate clinical lab-test results into EHR as structured data	9. At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	• This measure is poorly specified. Requires specific definitions of tests that are positive/negative and in numeric format. • Automated measurement would require flags in EHR for when a result is in positive/negative or numerical form. • Very challenging to calculate. Unless limited to tests in the EHR, would require looking across electronic and paper processes. • ONC IFR specified LOINC codes, which CHIME survey data indicates is used by 40.5 percent of its members' institutions.	• Revise objective to read: At least 50 percent of all clinical lab tests incorporated into the EHR whose results are in a positive/negative or numerical format are incorporated into certified EHR technology as structured data • Require measure calculation as part of EHR certification process

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
10. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	10. Generate at least one report listing patients of the eligible hospital with a specific condition.	• In the hospital setting, analysis of patient data often drives off of post-discharge coding of diagnoses and procedures, rather than problem lists.	
11. Report hospital quality measures to CMS or the States	11. For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of the proposed rule For 2012, electronically submit the measures as discussed in section II(A)(3) of the proposed rule	• Many concerns, addressed separately	• Multiple, addressed separately
12. Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	12. Implement 5 clinical decision support rules relevant to the clinical quality metrics the eligible hospital is responsible for as described further in section II(A)(3) of the proposed rule.	• The medication alert measures are also clinical decisions support rules. • Use of order-sets is a form of clinical decision support. • Tracking compliance can be challenging, as specific clinical scenarios warrant different responses. For instance, patients in an intensive care unit may receive combinations and doses of medications that would be inappropriate in other departments. • Hospitals sometimes implement rules that cannot be over-ridden, so that there is no measure of compliance (clinician has not made an accept/over-ride choice).	

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
13. Check insurance eligibility electronically from public and private payers	13. Insurance eligibility checked electronically for at least 80% of all unique patients admitted to the eligible hospital	• Billing systems are not generally part of the hospital EHR system, although they are almost always integrated. • Covered under HIPAA administrative simplification regulations • Major concern that if this is maintained, will require these systems to be certified, which is unnecessary and wasteful	• Remove this objective and measure.
14. Submit claims electronically to public and private payers.	14. At least 80% of all claims filed electronically by the eligible hospital	• Billing systems are not generally part of the hospital EHR system, although they are almost always integrated. • Covered under HIPAA administrative simplification regulations • Major concern that if this is maintained, will require these systems to be certified, which is unnecessary and wasteful	• Remove this objective and measure.
15. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	15. At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours	• Requires separate tracking of who requests copy and when (date stamp) • Use of portable media such as USB presents security problems for the hospital (both security of PHI on the portable media and security of the hospital's IT systems when portable media are introduced). • Use of structured data for this purpose (such as CCD) will be valuable in the future, but not possible for most providers in the near term. • To ensure patients can read the information without needing special software, most likely format in near term is a PDF of electronic/scanned chart. The time period	• Require measure calculation as part of EHR certification process • Revise to be electronic copy of health information "maintained in electronic form" (rationale: consistent with ARRA privacy provision) • Drop the time requirement in favor

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
		(48 hours) is too short and more proscriptive than HIPAA requirements. Clinicians must review information and ensure that they have received all test results and discussed sensitive results with the patient before release, per CLIA and state laws. Staff must be available to receive and fulfill requests, and required workforce may not be available on weekends and holidays.	of existing HIPAA policies on providing patients with copies of medical records.
16. Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	16. At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it	• Requires separate tracking of who requests copy and when (date stamp); such tracking is not currently part of EHR systems • Use of portable media such as USB presents security problems for hospitals (both security of PHI on the portable media and security of the hospital's IS systems when portable media are introduced) • Formats likely to include pdf and Word documents	• Require measure calculation as part of EHR certification process
17. Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	17. Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	• Specificity? Does this need to be a "live" test? • The definition of "key clinical information" should be expanded to include test results and dictated documents (H&P, operative report, diagnostic report, etc.), which are the most in demand by physicians. • The test should involve the specific subset of key clinical information that is most appropriate to meet current local needs and HIE infrastructure (for example, in the context of a local HIE, a collaboration with local	• Require providers to perform this test only for the subset of clinical information that is most appropriate to meet current local needs and HIE infrastructure, not all listed clinical information.

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
		ambulatory physician groups, or a pilot to provide data to long-term care facilities).	
18. Perform medication reconciliation at relevant encounters and each transition of care Medication reconciliation = the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider. Transition of care = transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another or from one EP or eligible hospital (as	18. Perform medication reconciliation for at least 80% of relevant encounters and transitions of care The numerator for this objective is the number of relevant encounters and transitions of care for which the EP or an inpatient facility/department (POS21) that falls under the eligible hospital's CCN was a participant during the EHR reporting period where medication reconciliation was performed. The denominator for this	• The proposed definition does not match current hospital medication reconciliation processes. • Medication reconciliation is not an automated EHR process. It is a human workflow process that is supported by the EHR. • Availability of a single medication list in the EHR that is available to all clinicians at the point of care makes medication reconciliation within the institution unnecessary. • The term "transitions of care" includes an array of transfers across the continuum of care that are not currently supported by information exchange among providers. Consequently, medication reconciliation as defined is not possible. Med rec across settings (hospital to LTC or hospital to physician office, etc) not possible given current levels of information exchange • Calculation of this measure across all admissions would be overly burdensome to	• Measures on medication reconciliation should be limited to appropriate transfer points internal to hospital, such as ED to ICU, ICU to general med/surg unit, etc. (including on admission and discharge) • Recommended alternative measure: Hospital is using EHR to support medication reconciliation • If a percentage measure is included, a sampling

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
defined by CCN) to another. Relevant encounter = any encounter that the EP or eligible hospital judges performs a medication reconciliation due to new medication or long gaps in time between patient encounters or other reasons determined by the EP or eligible hospital. We encourage comments on whether our descriptions of 'transition of care'' and ''relevant encounter'' are sufficiently clear and medically relevant.	objective is the number of relevant encounters and transitions of care for which the EP or an inpatient facility/ department (POS 21) that falls under the eligible hospital's CCN was a participant during the EHR reporting period.	report. Inclusion of ED in measurement is important as many patients enter hospital via ED and first discuss current medications in that setting. • Electronic med rec tools in use today do not generally include a flag or other measure to indication that med rec was done or done accurately, so not currently easy to calculate. • The Joint Commission is currently revising its National Patient Safety Goal on medication reconciliation. CMS should not attempt to define medication reconciliation processes and requirements separately and differently from The Joint Commission. Doing so will cause confusion and could actually slow efforts to build and spread best practice models of medication reconciliation.	methodology should be developed to reduce reporting burden. • If a percentage measure is included, require measure calculation as part of EHR certification process
19. Provide summary care record for each transition of care and referral Transition of care = transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another or from one EP or eligible hospital (as defined by CCN) to another. Referral is not defined.	19. Provide summary of care record for at least 80% of transitions of care and referrals The numerator for this objective is the number of transitions of care and referrals for which the EP or an inpatient facility/department (POS 21) that falls under the eligible hospital's CCN was	• How does this measure relate to the inpatient setting? How is transition of care different from discharge? Would discharge instructions and summary care record both be required when a patient leaves the hospital? • What is a referral in context of an inpatient stay? Would specialty consult during a stay require provision of a summary care record? For referrals post-discharge, it is unclear how hospital could do this before a patient has a visit scheduled or even has selected a specific provider selected from a short list of referrals. • Who does the summary care record go to? The patient or the next provider to care for the	• The concept behind this measure and its measurement must be clarified, particularly in the context of inpatient care. If something other than discharge is intended, require provision of summary care record on request only • Require measure calculation as part of

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
	the transferring or referringprovider during the EHR reporting period where a summary of care record was provided. The summary of care record can be provided through an electronic exchange, accessed through a secure portal, secure e-mail, electronic media such as CD or USB fob, or printed copy. The denominator for this objective is the number of transitions of care for which the EP or an inpatient facility/department (POS 21) that falls under the eligible hospital's CCN was the transferring or referring provider during the EHR reporting period.	patient? • How do you count transitions of care and referrals? • Use of portable media such as USB presents security problems for the hospital (both security of PHI on the portable media and security of the hospital's IS systems) • Use of structured data for this purpose (such as CCD) will be valuable in the future, but not possible for most providers in the near term.	EHR certification process?

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
20. Capability to submit electronic data to immunization registries and actual submission where required and accepted	20. Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries	• Does this need to be a "live" test? • Who decides when actual submission is required and accepted?	
21. Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	21. Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)	• Does this need to be a "live" test? • Who decides when actual submission is required and accepted?	

Proposed Objective	Proposed Measure	Clarifying Comments	Recommendation
22. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	22. Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an eligible hospital submits such information have the capacity to receive the information electronically)	• Does this need to be a "live" test? • Who decides when actual submission is required and accepted? • Public health departments at local, state and national levels must move toward standard data elements, formats, and information exchange protocols. Hospitals currently submitting electronic data to public health are overwhelmed by overlapping and conflicting requests from multiple agencies, resulting in significant burden. For instance, some syndromic surveillance systems rely on demographic and limited symptom data, while other systems want real time lab and pharmacy feeds.	• Require test for submission to a single public health agency only • Require actual submission of only demographic information and key lab findings.
23. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	23. Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary		