March 15, 2010

Collaborative Comments on the Centers for Medicare and Medicaid Services' Notice of Proposed Rulemaking for the Electronic Health Record Incentive Program (CMS-0033-P)

These comments were jointly developed with a broad array of collaborators, including the Markle Connecting for Health community, the Center for American Progress, and the Engelberg Center for Health Care Reform at Brookings.

The release of the Notice of Proposed Rulemaking (NPRM) for the Centers for Medicare and Medicaid Services' (CMS) incentive program for the Meaningful Use[1] of electronic health records (EHRs) marks a major, positive step forward in the nation's efforts to improve health and health care by putting modern information technology (IT) tools at the fingertips of medical professionals and consumers alike.

We applaud the US Department of Health and Human Services (HHS) for establishing an important set of priorities and drafting targets that are, in general, both ambitious and staged to enable broad participation. This was a very challenging and novel undertaking, and the result is an important contribution to the potential of information technology to improve the quality and efficiency of health care. In particular, the NPRM:

- states that the goal of health IT is to improve health quality and efficiency
- embraces patient engagement as a key aspect of Meaningful Use
- establishes metrics for health improvement rather than focusing merely on acquiring technology
- adopts a phased approach to allow for technology development and testing at initial stages
- largely proposes simple and easy-to-use requirements for reporting quality results
- makes progress aligning various HHS quality reporting initiatives and eliminating the need for duplicative reporting

While the NPRM takes substantial strides in the right direction, our comments offer specific suggestions for clarifying the regulations and ironing out workable implementation details to achieve the urgent priorities of this effort: improving health

[1] Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed rule. 75 Federal Register 8 (January 13, 2010), pp. 1844–2011.

and efficient use of health care resources, protecting privacy, and encouraging innovation and broad participation across many health care settings.

In this set of collaborative comments, advanced by a diverse array of health leaders, we offer our comments and recommendations on the NPRM in five distinct categories:

I. goals and quality measures
II. eligibility and reporting
III. patient engagement
IV. feedback and payment
V. clarification and technical fixes

I. Goals and Quality Measures

Recommendation 1 **Align and prioritize HITECH investments by making health goals and targets more explicit.**

ISSUE: The health goals prioritized by Meaningful Use requirements are not explicit. The objective of Meaningful Use, clearly stated in the NPRM, is to improve health care quality, efficiency, and patient safety, and not adoption of health IT as an end state. There are many quality metrics in the NPRM, but they have not been specified as a set of clear and measurable health goals the investments must achieve. In the absence of clear goals that are well understood by the provider community and the public, efforts to comply with Meaningful Use will risk becoming an exercise in satisfying process and reporting requirements rather than an opportunity to improve health and efficiency *using* both health IT and changes in care delivery.

RECOMMENDATION: Clarify and make explicit the health goals and targets for HITECH investments, centered on national priorities and the health objectives already implicit in the Meaningful Use quality measures. These goals are already implied by the clinical measures proposed in the rule; making them explicit allows CMS to set national targets for their attainment.

Goals that can already be extrapolated from the current Meaningful Use quality measures include:

- Reduce hospital readmissions.
- Improve medication management (safe medication use and effective medication management for heart disease, diabetes, asthma, mental health conditions, and hospital procedures).

- Improve care coordination and reduce gaps in care.
- Improve chronic care management, including blood pressure, diabetes, and cholesterol control.
- Improve preventive care, including healthy weight and smoking cessation.
- Improve patient safety.
- Reduce disparities.
- Increase efficiency and appropriate use of resources.
- Improve active engagement of patients in their care.

RATIONALE: The Meaningful Use regulations are an opportunity for HHS to establish a set of goals that would (1) provide meaning and context for those participating in the EHR incentive program, and (2) align and prioritize the broader set of HITECH investments.

- **Clear health goals will bring meaning and context to the staging of Meaningful Use.** The phases outlined in the NPRM recognize a learning curve for clinicians and provider organizations using health IT systems to improve health. But if the phases are unhinged from the ultimate objectives—"In Stage 1, I document structured data; in Stage 2, I implement decision support, and finally in Stage 3, let me see what impact I am having"—adopters will be less likely to achieve the anticipated impact. Each activity—from documenting structured data to implementing decision support—must be carefully and iteratively implemented with the health goals clearly in mind so that necessary process and care delivery changes are considered at each step. Explicit overarching goals are critical to achieving the Meaningful Use objectives and will encourage innovation in both care delivery and technology. Relying only on a set of quality measures or a step-by-step, process-driven approach will not substitute.

- **Health goals are necessary to align and prioritize the many areas of HITECH investment and the array of federal activities**. Clear and explicit health objectives are needed to identify and prioritize health IT requirements, related standards and certification criteria and to determine whether investments in health IT are leading to improvements in health. Clear objectives are also necessary to encourage alignment between Meaningful Use and the Beacon Grants, as well as health information exchange and state efforts, which will be important for supporting eligible professionals (EPs) and hospitals in achieving Meaningful Use. This level of coordination and alignment cannot be achieved solely through enumerating quality measures.

Recommendation 2 Prioritize quality measures.

ISSUE: The list of quality measures must be focused. The NPRM makes substantial strides in assigning relevant measures to hospitals and physician specialty groups reflecting both overarching health goals like improving preventive care and medication management, and more specific objectives relevant to each specialty. However, the current list of measures is long and risks being disconnected in purpose and process, rather than outcome-driven. This can have significant consequences for provider participation. We recommend an approach that is driven by outcomes, prioritized around explicit health goals, only uses "measures that matter" and thereby simplifies workload for providers. Measures of clinical quality, in particular intermediate and outcome measures, provide the most direct way of measuring whether health care goals have been met.

RECOMMENDATION: Prioritize quality measures for specialties for which more than five measures have been recommended. The NPRM's proposal of identifying a small number of shared measures and three to five quality measures specific to each eligible professional (EP) specialty is a good one. The current lists of measures for primary care and some other specialties need to be considerably focused around specific health goals. A focused and narrowed list of quality measure is also needed for hospitals.

We recommend narrowing the lists of quality measures based on the five criteria below:

1. Favor intermediate and outcome measures.
2. Address multiple priority health goals.
3. Be "exemplar" measures that will necessitate and demonstrate the use of critical health IT functions.
4. Be "well established" and in wide use whenever possible.
5. Eliminate redundancy (e.g., remove identical measures with different thresholds, eliminate a process measure if the related intermediate outcome measure is available, eliminate specialty specific measures already addressed by core measures).

Please see Appendix A, Recommendation 2 for one possible approach to prioritizing the quality measures using the criteria.

RATIONALE: A prioritized list of outcome-oriented measures will deliver more useful information to CMS and concentrate and focus the quality improvement activities—including effective use of health IT—of hospitals and EPs. This approach has the potential to make the measures more meaningful to physicians, allow for needed flexibility and thereby increase the number of providers likely to participate.

Recommendation 3 **Identify new quality measures to fill gaps.**

ISSUE: There are gaps in measures in several key areas. The current list of quality measures is lacking compelling outcome metrics for several priority areas, including patient engagement, efficiency and overuse, and care coordination.

RECOMMENDATION: Rapidly develop new quality measures for Stage 2, addressing priority health goals such as overuse and efficiency, care coordination, patient safety, and patient engagement for which strong outcome-oriented measures are lacking. Preference should be given to the development of intermediate and outcome measures, and viable risk-adjustment approaches. In addition, measures that reflect patient progress and outcomes across the care continuum and settings are critical and should be developed. These measures give providers and hospitals critical information about patient progress across groups of clinicians that may care for them.

RATIONALE: Immediate efforts are needed in rapid and effective measure development to ensure that outcome-oriented measures can be deployed in the near future. The goal is not rapid expansion of the number of measures, but judicious focus on outcome measures that can show clear improvement towards priority health goals. Too many measures will not necessarily yield better quality and can result in measure fatigue, lack of participation, and loss of focus.

II. Eligibility and Reporting

Recommendation 4 **Re-evaluate the all-or-none payment approach.**

ISSUE: The NPRM requires EPs and hospitals to fulfill all requirements in order to receive Meaningful Use incentives. This approach to payment will be too rigid in that it gives CMS little room to iteratively implement such a large and complex program (i.e., making necessary refinements based on feedback and early experience). It also risks discouraging participation by providers who can meet the vast majority of the requirements, but not every one. This problem may be particularly salient for providers in small-practice settings. What will happen if a physician misses by one measure? What if a measure proves impossible to achieve, or needs to be redefined? Rigorous requirements need to be matched with a degree of flexibility and ample room to reflect early implementation experience in ongoing program improvements.

RECOMMENDATION: CMS should allow EPs and hospitals to qualify for incentive payments for achieving a high proportion of, but not all, measures in the first year.

Please see Appendix A, Recommendation 4 for one potential specific strategy to allow flexibility in how EPs and hospitals will achieve Meaningful Use while maintaining rigorous requirements.

RATIONALE: The NPRM outlines ambitious aims for Meaningful Use, including the requirement of meeting more than 20 specific measures. It is difficult to predict which measures will be most challenging to achieve. The all-or-none payment approach risks discouraging overall participation, especially among providers in small-practice settings and those with limited IT support or experience. Keeping rigorous requirements while introducing a degree of flexibility will improve participation levels because it will leave room for some provider discretion based on practice type and inevitable variations in adoption levels and IT capabilities.

Recommendation 5 Simplify and streamline the functional measures.

ISSUE: Significant reporting burden is created by requiring numerator/denominator results for a large array of functional measures, some of which are only currently calculable through manual tracking. Our prior collaborative comments underscored that measures to demonstrate Meaningful Use should be outcome-oriented, reportable as an automatic output of qualified health IT and chosen to avoid creating unneeded administrative burdens for physicians and hospitals or making reporting into a compliance, rather than a true quality improvement, effort.

The NPRM lists a series of "functional" measures, calling on EPs and hospitals to demonstrate use of particular health IT capabilities such as recording patient vitals and demographics, sending preventive care reminders and using e-prescribing. These functions are critical foundational elements, and are necessary prerequisites for demonstrating Meaningful Use of health IT to improve quality, efficiency, and patient safety. But the NPRM places too much emphasis on calculating and reporting a specific performance level for each one of these capabilities, potentially creating unnecessary reporting burdens for physicians without clear evidence that they will result in quality improvements. A particular concern is the measures that require cumbersome manual tallying of paper-based processes to calculate the denominator.

Many of the functional capabilities are required to calculate quality results (e.g., demographics, vitals, problems). In early stages it is important to reinforce accurately capturing this core information. Over time, compelling clinical measures that depend on this core information should replace functional measures whenever possible.

RECOMMENDATION: Simplify the functional measures to reduce burden and de-emphasize process reporting.

We propose that the requirement to report a calculated numerator/denominator and achieve specific performance thresholds should only be retained for functional measures:

- in areas that are clearly aligned with health goals and where intermediate or outcome measures are lacking
- that are foundational to tracking, improving, and reporting quality of care for groups of patients (e.g., vitals, demographics, problem list, medication list, medication allergies)
- that can be reported directly from electronic systems, without manual counts

Please see Appendix A, Recommendation 5 for a potential approach to narrow the number of functional measures that require a calculated numerator/denominator and performance thresholds.

RATIONALE: There must be a balance between reducing the reporting burdens so that providers can focus their energies on using information to improve care *and* on encouraging providers to capture structured data in electronic systems as a foundation for future efforts. There is an inherently high level of dependency between certain types of structured information (e.g., vitals, problem lists and demographics), and efforts to track, improve, and report quality. In the short run, there is value in encouraging accurate documentation of this information as a strong foundation for quality improvement. But once electronic quality reporting begins and the required thresholds have been met, these functional measures are no longer necessary and the requirements can be phased out quickly to avoid burden and duplication.

Recommendation 6 — Establish effective quality reporting mechanisms.

ISSUE: A feasible strategy is needed for quality reporting of summary results. We strongly support the NPRM's recommendation that, starting in 2012 EPs and hospitals will electronically report summary results for quality measures on all patients to CMS. This process should be specified in a way that:

- recognizes that providers need access to detailed patient-level information for quality measures to track and improve care, but CMS only needs summary statistics reflecting the aggregate experience of an EP or hospital's patient population to quantify the quality of care measures for a particular provider

- is easily implemented across a broad range of providers and technology settings. There should be simple and easy-to-use requirements for electronically reporting summary results

- provides timely acknowledgement to providers and allows for testing of submission capabilities before they are implemented

RECOMMENDATION: Establish electronic reporting mechanisms that are easy-to-implement in the near term and rely on approaches that are already in demonstrated use across an array of providers.

- Clarify that providers will submit summary statistics for each quality measure to CMS, defined as simple numerators/denominators reflecting the experience of the provider's entire patient population (e.g., 5/7 of Dr. Smith's patients with hypertension have controlled blood pressure).

- Adapt and use the PQRI registry XML for electronic reporting of numerator/denominator for quality measures in Stage 1. To date there has been too little experience with QRDA level III—which supports reporting of summary results--to determine if this standard will be an easy-to-use and implement mechanism for quality reporting from a variety of electronic systems in Stage 1.

- We recommend that CMS simplify both the reporting and feedback interaction between providers and CMS, even for Stage 1, offering a mechanism where a report from a provider can be uploaded and immediately tested for accuracy of format and consistency of content, similar to e-filing results from the IRS (see Recommendation 9 Provide Timely Feedback to Physicians). In future stages, it may be advantageous to implement ongoing monitoring of quality from provider care processes, something that can be performed by a variety of entities including third parties, health information exchanges, research entities, and vendors, among others.

- It should be possible for groups of physicians working together to improve care quality and safety to report collectively rather than as single providers.

- The model for reporting described in the NPRM in which detailed health information is retained locally in individual EP or eligible hospital EHRs, and only summary reports are submitted to CMS is neither an "alternative" nor a "network of distributed EHRs" and this reference can be confusing. This model is the required and most viable way of accomplishing the quality reporting objectives of Meaningful Use while limiting disclosure of identifiable information. There is a need in other population health areas to address distributed methods

for research, public health, and other quality measurement activities where it is necessary to look at composite information across the network.

RATIONALE: The NPRM indicates that EPs and hospitals will use the PQRI registry XML for quality reporting in 2012, and requests comment on whether the QRDA CDA standard should be adopted for quality reporting in future years.

The PQRI registry XML is a good template; it is in wide use, is easy to implement, and CMS is already accepting numerator/denominator results using this mechanism. The template can be rapidly updated and scaled to support direct submission from electronic systems. The Office of the National Coordinator's popHealth prototype software for reporting summary quality measures or data to public health is a very positive step in leveraging established standards and Web-based tools for quality reporting across an array of providers.

By contrast, experience with the QRDA standard is much more limited. A patient-level version of the standard has been used in CMS's PQRI EHR demo, and an alternative version of the standard supports population health reporting, but has not been broadly implemented. In addition, it is not clear that the detail and complexity of the standard is necessary to support the numerator/denominator reporting for quality measures required in Stage 1 by the NPRM.

Finally, for quality improvement, qualified health IT must have the capacity to generate summary measures for providers on demand and give them the capacity to readily produce the detailed underlying data for their own quality efforts and to support improvements in care delivery.

Recommendation 7 Refine and test e-measure specifications.

ISSUE: The NPRM does not describe how testing of quality measure specifications and reporting will be conducted. The NPRM indicates that detailed specifications for e-measures will be released in April 2010, but little information is provided about how these e-measures will be developed or tested.

RECOMMENDATION: Initiate a process and timeline for providers to test quality measure specifications and submission capabilities before they are put into use for electronic reporting in 2012. The definitions should be reviewed and tested to be sure they satisfy the following requirements before they are finalized and deployed for electronic reporting in 2012, and systems should be tested for whether they can successfully submit them:

- **Electronic measure specifications must be clear, as simple as possible, and consistent with standards recommendations in the IFR.**

It will be necessary to outline the "logic" of how electronic systems need to calculate the measures, without overspecifying the exact processes and mechanisms electronic systems will use for measure calculation.

- **Testing will be required to demonstrate that qualified health IT systems can implement and use the specifications to accurately calculate measures.** This will require testing across a variety of systems to identify issues before specifications are finalized as well as testing calculation of measures in each system as part of certification.

- **Testing will be required to assure that providers can accurately calculate measures and report them to CMS.** This will require mechanisms for providers to test measure calculation in their systems, validate source data, and test roundtrip submissions to CMS (i.e., sending data and receiving confirmation). Providers must also have the ability to monitor and assess their own progress on demand using their electronic systems.

RATIONALE: Testing of e-measures across a variety of provider settings and technology platforms will provide an early warning of any issues that need to be resolved and an opportunity to iteratively refine and improve the specifications before they are finalized and deployed. This process will increase EP and hospital confidence and reduce the risk of frustration during initial stages of quality reporting.

III. Patient Engagement

Recommendation 8 — Allow low-burden means to achieve Stage 1 patient engagement.

ISSUE: The patient engagement requirements in the NPRM affirm the core expectation that the individual should have ready access to copies of personal health information in a useful electronic format. The ability for an individual to obtain certain personal health information in electronic format is now firmly rooted in federal law. And given the public investment in health IT in the Recovery Act, it is a core requirement for Meaningful Use.

The NPRM appropriately prioritizes critical information such as after-visit and discharge instructions, lab results, and lists of problems, medications, and allergies to be made electronically accessible to individuals. We strongly support this as a priority Stage 1 Meaningful Use requirement.

None of the health goals implicit in the NPRM—improving care coordination, controlling chronic diseases, addressing disparities, reducing smoking, improving

medication safety, or using health care resources efficiently—can be achieved without the participation and support of patients and consumers. Requiring qualified health IT to enable providers to provide individuals with printed care summaries or the option to download electronic copies of their personal health information will not, by itself, cement patient activation toward these important national aims, but it is a necessary start.

We encourage HHS to steer future stages of Meaningful Use toward a broader vision of patient engagement with the aid of health IT.

The vision should:

- Consider individuals as information participants—not as mere recipients, but as information contributors, knowledge creators, and shared decision makers and care planners.
- Shift paradigms so that information is not provided to individuals only upon request, but is delivered routinely after every visit in a format that matches the individual's needs and wishes.
- Encourage the extension of communication and feedback cycles among individuals and care teams beyond episodic, office-based encounters.
- Enable individuals to compile copies of their information on a timely basis and share it through a wide variety of applications and services of their choosing.
- Research and develop new patient engagement performance measures that are directly tied to health improvement goals.

In general, the Stage 1 patient engagement priorities in the NPRM provide basic building blocks for this vision. However, given the aggressive timelines and the imperative for broad participation by providers and hospitals, the specific requirements could be more powerful if they were simplified and permissive of low-burden means of attainment.

We recommend below that CMS consolidate and simplify the different requirements for "timely electronic access," "electronic copies," and summaries or instructions to be delivered to patients after doctor or hospital visits.

RECOMMENDATIONS:

(1) HHS should modify the NPRM and the IFR to clarify that a secure download capability is an allowable option to provide "electronic copies" of

information, "timely electronic access" to records, and clinical summaries (for eligible professional) and discharge instructions (for hospitals).

This download function should:

- Be accessible to the patients of an eligible professional or a hospital from a secure online site. Examples of such sites include patient portals or personal health records, but also could be nothing more than a secure way for patients to log in and download copies of their information.
- Be a required capability of qualified health IT. The technical requirements should include automation of counts of basic utilization (e.g., number of clinical summaries and hospital discharge instructions delivered, number of patients who log in, number of electronic downloads requested and delivered.)
- Make available appropriate priority information, enumerated in the patient engagement sections of the NPRM and IFR, for example:
    - lists of problems, medications, allergies, immunizations, and procedures
    - laboratory and diagnostic test results
- Be offered in lieu of paper or in addition to paper, based on individual patient choice.
- Be offered as a preferred alternative to compact disc or USB drive (except for images) because of security and interoperability concerns related to portable storage devices.
- Encourage standardized clinical summary formats listed in the IFR (e.g., CCD or CCR), and require human readability and commonly used software file formats (e.g., text, spreadsheet, PDF) in Stage 1 to accommodate patient preference.

By recommending that this capability be made an allowable option to satisfy the Stage 1 patient engagement requirements, we do not suggest that it be the only such option. If an EHR is being used to meet the requirements in the NPRM, (e.g., has a functioning patient portal that displays the information but no download option), that should not prevent the provider from using it to achieve Stage 1 Meaningful Use in the patient engagement category.

However, we do recommend that the download capability be added to the criteria for qualified health IT. Thus, it should be an *allowable option for providers* in Stage 1, and be *required* as a criterion for deeming health IT qualified.

(2) CMS should set a general expectation around the timeframe that providers should share electronically with patients the priority information types listed in the patient engagement sections of the NPRM and IFR.

We acknowledge CMS' challenge in finding an appropriate compromise for the maximum lag time between when the information is available to the provider and when it must be available electronically to the patient. From the perspective of patients and their advocates in the Internet age, there should be little or no lag time. Rapid delivery of information can help avoid complications and save lives. On the other hand, many providers have workflow issues that make immediate turnaround times difficult to routinely achieve in Stage 1. In addition, many providers feel they have a professional obligation to avoid releasing certain types of information, such as new diagnoses, immediately to patients because the provision of raw information without interpretation and counseling from a clinician may be harmful to some patients. There is legitimacy to each view. The general goal, however, should be for the federal investments in health IT to speed up the delivery of useful information to patients.

As written, the NPRM does not clearly delineate when information falls under "electronic copies" (with a 48-hour requirement for turnaround to patients) or "timely electronic access" (with a 96-hour turnaround). CMS should set a general expectation and avoid confusion that would result from having several different requirements for different types information. We recommend setting expectations around two types of information listed in the patient engagement sections of the NPRM and IFR:

- **Information that should be shared at the end of each clinical encounter:** After-visit clinical summaries and hospital discharge instructions should be offered at the end of each clinical encounter or discharge.

- **Information that should be shared within two business days:** All other Stage 1 patient engagement information example types in the NPRM (problems, medications, allergies, lab results, etc.) should be available for electronic download to an EP's or hospital's patients no later than two business days after the information is available to the EP or hospital. If a download capability were a function of qualified health IT, we believe that two business days from when the information is available to providers is a reasonable expectation for the maximum lag time before it should become available for electronic download by patients.

(3) Simple attestation will be the most practical means for providers and hospitals to report attainment of the patient engagement requirements in Stage 1. Because of the novelty of this approach and the complexities of defining a denominator that could be used to calculate thresholds, the patient engagement requirements should not require specific thresholds in Stage 1. They should require only

a few basic counts tallied by the qualified IT system (e.g., numbers of clinical summaries and discharge instructions delivered, number of patients who initiate secure access accounts, number of electronic downloads delivered).

(4) To signal the future direction in later stages, CMS should set clear threshold percentages for patient engagement (e.g., clinical summaries delivered in X percent of visits, Y percent of patients registering on a secure Web site where downloads of electronic copies are available). However, the reporting requirements to demonstrate achievement of those thresholds should be phased in after the first reporting year. CMS should also make clear that those future thresholds will take into account an EP's or hospital's patient engagement activities during the Stage 1 period. In summary, providers and hospitals should be motivated to engage as many patients as possible during the Stage 1 years, but it is too early to require them to report their numerators and denominators to satisfy the patient engagement components of Meaningful Use during that time.

5) Historic records that have not been converted to electronic format, or entire medical files beyond the Stage 1 patient-engagement information types, should not be subject to the expectation for online access in Stage 1 of Meaningful Use. Of course, patients will remain entitled to request and receive their full medical records under HIPAA.

RATIONALE:

- **A download capability is a big step forward for most people.** A standard, secure access, download function would allow patients to leave a doctor's office or hospital with the option to log in afterward to retrieve pertinent copies of information. Most Americans do not have such an option today. Not all people will be able or willing to download copies of their information online, and nothing in the regulation should discourage people from requesting and receiving paper copies of their information if that is the format they request. However, those who are willing and able to receive their information through an online download button can drive improvements in service and timeliness that eventually benefit everyone.

- **A download capability is a low-burden means for providers and hospitals to improve service and coordination of care.** Rather than spending time measuring how many patients request information electronically and the percentage of those requests that are fulfilled, it would be more meaningful if providers simply had built into their system the capability for patients to download copies of their information, and for that capability to be offered routinely to all patients. The capability should have embedded means for

tracking delivery of information to patients and should be minimally disruptive to clinical workflow and back office burdens.

- **A download capability is a low-burden means for health care entities to comply with laws and regulations.** As the NPRM notes, Section 13405 (e) of HITECH establishes an individual's ability to request certain information in electronic format from EHRs and have it sent to a service of the individual's choosing. Including the option for patients to download information online in the Meaningful Use regulation would help participating providers meet legal requirements for individual access to information in electronic format.

- **A download capability reduces the burden of many user interface decisions.** If Stage 1 patient engagement requirements can be met with a download button, providers and vendors need not invest a great deal of time early in the adoption cycle concerned about how each page of a patient portal will look like or function for their patients. Supporting and implementing a patient portal may not be a practical endeavor for many providers, particularly those in small-practice settings. Not every vendor and provider is suited to or capable of supporting patient portals, developing high value applications for patients to use, and dealing with implementation and adoption challenges. In fact, it is not desirable to see every holder of a patient's data also as the purveyor of patient-facing portals or applications. This may be untenable for patients and providers alike. Rather, we recommend that HHS support the individual's ability to use services to compile and make use of copies of health information from multiple providers and sources. We describe the vision, architecture, and recommended practices for such services (which we call Consumer Access Services) in the Markle Connecting for Health Common Framework for Networked Personal Health Information.[2]

- **A download capability is relatively easy to add to EHR systems.** Patient portals are increasingly bundled with EHR systems. It should not be difficult for most vendors or technology departments to add a download option to a patient portal or secure access site, particularly if Stage 1 of Meaningful Use identifies this option for satisfying patient engagement requirements. It should also be made easier because other vital components of the NPRM already require EHR systems to be able to extract data sets to support care transitions.

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[2] *Markle Common Framework for Networked Personal Health Information, Overview and Principles*, Markle Foundation, June 2008. Available online at the following URL: http://www.connectingforhealth.org/phti/reports/overview.html.

- **A download capability provides an easier path to interoperability.** The download feature clearly separates data from applications (i.e., the patient can access and keep copies of the information without being locked into a particular portal or application). This critical separation makes it technically easier for various services of the patient's choosing to parse and use the downloaded information. In general, the IFR implicitly supports the basic idea of a download *capability,* but we recommend that both the NPRM and the IFR explicitly identify that option for Stage 1 compliance for providers and make it a criterion for qualified health IT.

- **A download capability is likely to build market pressure for standardization.** Ultimately, structured data is a dramatic accelerator for the development of applications that may use the information for the consumer's benefit. The consumer finance and online banking sectors demonstrate that making personal information directly accessible to consumers increases demands for standards to improve industry efficiency.

- **A download capability is likely to build patient demand for aggregative and value-added services.** The consumer finance and banking sectors also demonstrate that when individuals get to download their personal information into applications, they demand services that help pull together information from various accounts and institutions. A first step is simply making the information available. This, in turn, increases expectations and demand. Innovation will follow.

- **A download capability clarifies patient responsibilities.** In the digital age, all electronically obtained information is essentially a copy. Whenever patients download a copy of information from a provider's Web site, they must be advised that they are responsible for the management of that information. Providers, of course, remain responsible for managing the copies of the information in their own EHR systems. But they are not responsible for any decisions that the individual makes with respect to the copy that the individual downloads and possesses.

IV. Feedback and Payment

Recommendation 9 Provide timely feedback to physicians.

ISSUE: The process for demonstrating Meaningful Use must foster provider confidence. Other than stating that payment will be made on a rolling basis, the NPRM does not

address the mechanisms, timing, or content for CMS to acknowledge or provide feedback on Meaningful Use results providers send. It is important for providers to get information back from CMS on whether the transmission was successful, whether there were any problems with the information, whether Meaningful Use was achieved, and, over time, information about trends and peer benchmarks.

RECOMMENDATION: Establish specific timelines and processes for CMS to provide timely and relevant acknowledgment, payment and feedback to EPs and hospitals, and time and resources for adequate testing of all submission mechanisms and reporting processes.

CMS should specify timelines, processes, and testing mechanisms for:

- accepting and confirming successful receipt of information, including date CMS received the file, that the TaxID/NPI exists for the provider, summary statistics of the content and confirmation of acceptable format and numbers
- identifying and addressing any problems in submission
- promptly paying providers based on achievement of Meaningful Use
- providing trend and benchmark information (Stage 2)

These steps would not need to occur all at once, but can be sequenced.

RATIONALE: Providing timely and useful feedback to participants as well as interfaces to test information submission will help avoid a repeat of early PQRI implementation experience in which problems with data reporting mechanisms and information feedback to physicians contributed to low participation rates. In 2007, only 16 percent of eligible physicians participated in the incentive program and only half of those who participated qualified for payment. Feedback was difficult to obtain and not that helpful, according to the results of one physician survey. This survey indicated that in 2008 fewer than half of participating physicians succeeded in obtaining a copy of the feedback report from CMS, it took an average of nine hours to download the reports, and two-thirds of the physician sample judged the feedback reports to be unhelpful to guide improvements in care.[3]

[3] *MGMA Physician Quality Reporting Initiative LEARN*, Medical Group Management Association, February 2010. Available online at the following URL: http://www.mgma.com/WorkArea/mgma_downloadasset.aspx?id=32796

V. Clarification and Technical Fixes

Recommendation 10 — Clarify eligibility rules to encourage participation of hospital-based physicians.

ISSUE: The NPRM can be interpreted to state that physicians who are hospital-based will not receive EP incentives. Clarification is needed so as not to penalize physicians who provide ambulatory care from a hospital setting and/or are employed by hospitals or hospital networks. This does not imply that hospitals would be paid twice for the same thing. Rather, certain hospital-based physicians would be eligible for EP incentives for using ambulatory-oriented EHRs to meet EP Meaningful Use requirements. Hospitals would still be eligible for incentives based on meeting Meaningful Use requirements for hospitals.

RECOMMENDATION: Clarify participation of hospital-based physicians. Physicians who are hospital-employed and/or working in a hospital-based facility but primarily providing ambulatory care should be eligible for EP incentives.

RATIONALE: This clarification would recognize that different EHR and workflow capabilities and metrics are needed for outpatient and inpatient care and could avoid unintentional consequences:

- The current restriction could significantly affect safety net hospitals and the patients served by their outpatient clinics.
- Hospitals would likely choose not to make investments in Emergency Department and outpatient-oriented health IT, given that the hospital Meaningful Use requirements are inpatient-focused, and hospital-employed or hospital-based physicians engaged in Emergency Department and outpatient services would have no incentives or penalties to participate in the program.

Recommendation 11 — Clarify care coordination requirements.

ISSUE: The NPRM lists care coordination requirements that could be interpreted to depend on functionality being in place in recipient systems. There are two requirements in the care coordination section—that a summary of care record should be shared for transitions and referrals, and that a test is performed to electronically exchange key information—that, as written, may risk penalizing Doctor A's efforts to meet the requirements because of a lack of technology or capability at Doctor B's office.

RECOMMENDATION: Clarify the NPRM to provide flexibility so that eligible professionals and hospitals may get "credit" for coordinating care when they send

summary care records through channels other than direct computer-to-computer exchange among providers. In some cases, other forms of secure electronic sharing may be the most practical format for recipient systems. If the eligible provider or hospital extracts the information via qualified health IT, it should not matter in Stage 1 how the information is received by the next practice. CMS should emphasize that the goal is for information to follow the patient to the next encounter. In some cases, the most efficient means by which the information may flow to the next provider will be by providing the electronic information to the patient. (See Recommendation 8: Allow low-burden means to achieve Stage 1 patient engagement.)

The NPRM metric requiring one test of the capacity to electronically exchange key information is not of high consequence and should be deprioritized as a noncritical process measure.

RATIONALE: With regard to sharing of summary of care records, eligible professionals and hospitals in some parts of the country may have few options to exchange information electronically for care coordination if nearby practices have not adopted health IT. It is therefore important to permit flexibility on the means by which information to coordinate care is delivered.

Although we understand the intent behind wanting an actual metric for at least one test of electronic exchange of information, it is not well defined and therefore may invite confusion. A single successful test between any two random endpoints may not be indicative of any general capability to share information electronically in an environment where interoperability exchange standards are unevenly implemented. Rather, setting clear priorities on coordination requirements (i.e., sending summary of care records upon actual referrals or reconciling medication lists) will have more significant impact in achieving the Meaningful Use goals.

Recommendation 12 Engage providers, patients and the public.

ISSUE: The NPRM does not specify how Meaningful Use results will be shared, built upon or used.

RECOMMENDATION: Begin to evaluate mechanisms to use quality results to engage providers, patients and the public.

RATIONALE: Meaningful Use health objectives and results can be an important opportunity to mobilize the entire spectrum of participants in improving health care quality.

Please see Appendix A, Recommendation 5 for additional suggested changes to clarify certain functional measures.

These comments were jointly developed with a broad array of collaborators, including the Markle Connecting for Health Community, the Center for American Progress, and the Engelberg Center for Health Care Reform at Brookings. The comments are submitted by the following supporters:

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Appendix A

The collaborative comments outline recommendations for prioritizing, clarifying, and specifying the functional and quality measures in the NPRM. We recognize there may be several ways to accomplish the goals we have identified in our comments. For the purpose of demonstrating in greater depth how the recommendations can be applied, we offer the following specific implementation options, while also recognizing there may be other strategies that are also viable.

Recommendation 2 Prioritize quality measures.

The collaborative comments recommend narrowing the lists of quality measures based on the five criteria below:

1. Favor intermediate and outcome measures.
2. Address multiple priority health goals.
3. Be "exemplar" measures that will necessitate and demonstrate the use of critical health IT functions.
4. Be "well established" and in wide use whenever possible.
5. Eliminate redundancy (e.g., remove identical measures with different thresholds, eliminate a process measure if the related intermediate outcome measure is available, eliminate EP-specific measures already addressed by core measures).

SPECIFIC OPTION FOR CONSIDERATION

The following suggests one possible way to prioritize quality measures in the NPRM using the criteria outlined above.

A revised set of **four core quality measures** would apply to every EP:

1. controlling high blood pressure (NQF 0018)
2. advising smokers to quit (PQRI 115, NQF 0027)
3. body mass index (BMI) screening and follow-up (PQRI 128, NQF 0421)
4. drugs to be avoided in the elderly:
    a. patients who receive at least one drug to be avoided
    b. patients who receive at least two different drugs to be avoided (NQF 0022)

The core set reflects key health goals outlined, including achieving healthy weight and smoking cessation as well as improving medication and chronic care management. The revisions we propose make the core measures more outcome-oriented. For instance, tracking whether blood pressure is controlled is more valuable than simply recording whether blood pressure was measured (the core metric suggested in the NPRM). While not every provider is responsible for *managing* blood pressure, every physician should be aware of this information and communicate it to patients. Likewise, identifying smokers *and also* advising them to quit is a higher value and more outcome-oriented metric than simply recording smoking status (the measure recommended in the NPRM).

An EP to whom one or more core measures do not apply (e.g., a radiologist who does not take blood pressure readings in the course of clinical care) can attest that one or more core measures are not relevant for his/her scope of practice. But any EP who documents these values in the context of clinical care would be expected to report the measures.

We suggest that EPs and hospitals be required to report the priority measures summarized in the table below, narrowed from the longer list of measures proposed in the NPRM, based on the five criteria above. It will be important to define all measures in a way that is reflective of the provider's responsibilities and the care provided to their patients (e.g., defining which patients should be included for each of the measures).

In addition to the core quality measures, each EP would be required to report up to five specialty-specific quality measures. Where more than five measures have been prioritized, EPs can select which five measures they will report. We agree with the recommendation in the NPRM that EPs to whom none of the specialty groups in the NPRM apply, can be exempted from reporting specialty-specific quality measures.

SUGGESTED PRIORITY QUALITY MEASURES

Provider Type	Health Goals	Suggested Priority Quality Measures
Cardiology NPRM included 10 quality measures We suggest that 4 of those measures be prioritized and reported by physicians[4]	• Improve medication management • Improve preventive care	1. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) 2. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD 3. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) 4. Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
Pulmonology NPRM included 8 quality measures We suggest that 3 of those measures be prioritized and reported by physicians	• Improve medication management • Improve preventive care • Increase efficiency and appropriate use of resources	1. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older 2. Use of Appropriate Medications for People with Asthma 3. Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
Endocrinology NPRM included 9 quality measures We suggest that 5 of those measures be prioritized and reported by physicians	• Improve medication management • Improve chronic care management • Improve preventive care	1. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus 2. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus 3. Comprehensive Diabetes Care: HbA1c Control (<8.0 percent) 4. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient 5. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

[4] PQRI 128 (BMI) lists "follow-up plan"; more specificity is required. Additionally, 'Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol' (PQRI 197) is listed in the proposed rule as appearing in both the Cardiology and Primary Care measure groups. It appears that this measure, while included in Primary Care, was mistakenly removed and should be included for Cardiology.

Provider Type	Health Goals	Suggested Priority Quality Measures
Oncology NPRM included 6 quality measures We suggest that all six of those measures be prioritized Physicians can select five of the 6 priority measures to report in Stage 1 We suggest retaining the first three measures if they can be clarified as "surveillance". If that is not possible, we suggest eliminating them as measures for oncology.	• Improve medication management • Improve preventive care • Increase efficiency and appropriate use of resources	1. Preventive Care and Screening: Screening Mammography 2. Preventive Care and Screening: Colorectal Cancer Screening 3. Cervical Cancer Screening 4. Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer 5. Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients 6. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
Surgery NPRM included 6 quality measures We suggest that 3 of those measures be prioritized and reported by physicians	• Improve medication management • Reduce hospital readmissions • Improve patient safety	1. Surgical Site Infection Rate 2. 30-day Readmission Rate 3. Perioperative Care: Selection of Prophylactic Antibiotic, First OR Second Generation Cephalosporin

Provider Type	Health Goals	Suggested Priority Quality Measures
Primary care NPRM included 29 quality measures We suggest that 7 of those measures be prioritized Primary care physicians can select 5 of the 7 priority measures to report in Stage 1 Primary care physicians serving both children and adults can report a mix of primary care and pediatrics measures reflecting their patient mix.	• Improve medication management • Improve chronic care management • Improve preventive care	1. Ischemic Vascular Disease (IVD) Low-Density Lipoprotein Control 2. Comprehensive Diabetes Care: HbA1c control (<8 percent) 3. Preventive Care and Screening: Screening Mammography 4. Preventive Care and Screening: Colorectal Cancer Screening 5. Cervical Cancer Screening 6. Ischemic Vascular Disease: Use of Aspirin or other Antithrombotic 7. Use of Appropriate Medications for People with Asthma
Pediatrics NPRM included 9 quality measures We suggest that 4 of those measures be prioritized and reported by physicians *We also recommend the addition of one measure not included in the pediatrics list in the NPRM: use of appropriate medications for people with asthma	• Improve medication management • Increase efficiency and appropriate use of resources • Improve preventive care	1. Appropriate Testing for Children with Pharyngitis 2. ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication 3. Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Antibiotic Use 4. Childhood Immunization Status 5. *Use of Appropriate Medications for People with Asthma[5]

[5] We suggest that this asthma measure from Primary Care be added to Pediatrics and prioritized.

Provider Type	Health Goals	Suggested Priority Quality Measures
Obstetrics and Gynecology NPRM included 9 quality measures We suggest that 5 of those measures be prioritized and reported by physicians	• Increase efficiency and appropriate use of resources • Improve preventive care • Reduce hospital readmissions	1. Chlamydia Screening in Women 2. 30-day Readmission Rate following deliveries 3. Cesarean Rate for Low-risk First Birth Women (aka NTSV CS rate) 4. Cervical Cancer Screening 5. Preventive Care and Screening: Screening Mammography
Neurology NPRM included 5 quality measures We suggest that 4 of those measures be prioritized and reported by physicians	• Improve medication management • Improve chronic care management	1. Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL–C) Control 2. Ischemic Vascular Disease (IVD): Blood Pressure Management Control 3. Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge 4. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
Psychiatry NPRM included 6 quality measures We suggest that 5 of those measures be prioritized and reported by physicians	• Improve medication management • Improve preventive care	1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement 2. New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment,(c)Effective Continuation Phase Treatment 3. Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD 4. Major Depressive Disorder (MDD): Diagnostic Evaluation 5. Major Depressive Disorder (MDD): Suicide Risk Assessment

Provider Type	Health Goals	Suggested Priority Quality Measures
Radiology NPRM included 7 quality measures We suggest that 2 of those measures be prioritized and reported by physicians[6]		1. Radiology: Exposure Time Reported for Procedures Using Fluoroscopy 2. Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening
Ophthalmology NPRM included 3 quality measures We suggest that all 3 of those measures be prioritized and reported by physicians	• Improve chronic care management	1. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation 2. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy 3. Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care
Podiatry NPRM included 3 quality measures We suggest that all 3 of those measures be prioritized and reported by physicians	• Improve chronic care management	1. Diabetes Mellitus: Foot Exam 2. Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention, Evaluation of Footwear 3. Diabetic Foot Care and Patient Education Implemented
Gastroenterology NPRM included 6 quality measures We suggest that 5 of those measures be prioritized and reported by physicians	• Improve medication management • Improve preventive care • Increase efficiency and appropriate use of resources • Improve chronic care management	1. Preventive Care and Screening: Colorectal Cancer Screening 2. Hepatitis C: Antiviral Treatment Prescribed 3. Hepatitis C: Hepatitis A Vaccination in Patients with HCV 4. Hepatitis C: Hepatitis B Vaccination in Patients with HCV 5. Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps, Avoidance of Inappropriate Use

[6] While imaging for low back pain is a good efficiency measure, this is not an appropriate measure for radiologists as they carry out but do not order these tests

Provider Type	Health Goals	Suggested Priority Quality Measures
Nephrology NPRM included 6 quality measures We suggest that 4 of those measures be prioritized and reported by physicians	• Improve medication management • Improve chronic care management	1. Chronic Kidney Disease (CKD): Blood Pressure Management 2. End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients 3. End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis 4. Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)
Hospitals NPRM included 35 quality measures We suggest that 11 of those measures be prioritized and reported by hospitals	• Reduce readmissions[7] • Improve patient safety	1. Hospital Specific 30-day Readmission Rate following AMI Admission 2. Hospital Specific 30-day Readmission Rate following Heart Failure Admission 3. Hospital Specific 30-day Readmission Rate following Pneumonia Admission 4. Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients 5. Primary PCI Received Within 90 Minutes of Hospital Arrival 6. Emergency Department Throughput—admitted patients median time from ED arrival to ED departure for admitted patients 7. Emergency Department Throughput—admitted patients Admission decision time to ED departure time for admitted patients 8. Emergency Department Throughput—discharged patients median Time from ED Arrival to ED Departure for Discharged ED Patients 9. Incidence of potentially preventable VTE 10. Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients 11. Central line catheter-associated blood stream infection rate for ICU and high-risk nursery (HRN) patients

[7] Readmission rates reported by hospitals will reflect patients discharged from and readmitted to that hospital. Hospitals are not obligated to seek readmission information from other hospitals.

Recommendation 4 Re-evaluate the all-or-none payment approach.

The collaborative comments recommend that CMS should allow EPs and hospitals to qualify for incentive payments for achieving a high proportion of, but not all, measures in 2011.

SPECIFIC OPTION FOR CONSIDERATION

The following specific suggestions outline one possible way to allow EPs and hospitals to achieve Meaningful Use by meeting the majority of Meaningful Use measures in the first year.

Given their foundational importance to Meaningful Use and quality improvement and reporting, reporting of certain measures should be mandatory.[8]

- We recommend that some measures **(13 for EPs and 11 for hospitals)** be required of all applicable providers, including reporting quality results, clinical lists, patient engagement measures, and risk assessment. As shown in the table below, the mandatory list includes at least one measure from each Meaningful Use category, except improving population and public health.
- **EPs and hospitals would be required to meet at least 7 of the remaining measures** (see table below).

This approach eliminates the requirement to report any measure that is impossible to achieve given conditions external or outside the influence of the practice (e.g., a test of sending reportable labs was not possible because the state public health department had not established the needed interfaces).

[8] As proposed in the NPRM, in Stage 1, all results will be demonstrated through attestation except the quality measures in 2012.

The table includes all Meaningful Use criteria included in the NPRM, organized by the five policy priorities (e.g., improving quality, engage patients, etc.) used in the regulations.

EPs and hospitals that meet all mandatory measures and seven of the remaining measures would be eligible for incentives in the first year	
Mandatory measures (13 for EPs, 11 for hospitals)	**Providers must meet 7 of remaining measures**
Improving Quality, Safety, Efficiency and Reducing Health Disparities	
• Demographics • Problem list • Active medication list • Active medication allergy list • Vitals • E-prescribing (EP only) • Drug-drug/drug-allergy checks • Reporting quality results	• Smoking status • Reminders (EP only) • Clinical decision support • CPOE • Structured lab data • Electronic insurance eligibility • Electronic claims • Lists of patients with specific conditions
Engage Patients and Families in their Health Care	
• Provide patients with timely electronic access to health information (EP only) • Provide patients with electronic copies of their health information • Provide patients with clinical summaries/discharge instructions	
Improve Care Coordination	
• Summary of care record at transitions/referrals	• Medication reconciliation • Electronic exchange of clinical data
Improve Population and Public Health	
	• Electronic syndromic surveillance • Reportable lab results to public health agencies (Hospital only) • Immunization registries
Ensure Adequate Privacy and Security Protections for Personal Health Information	
• Risk analysis	

Any measure not met in the first reporting year would need to be met in the second reporting year.

In recommendation 5 below (Simplify and Focus the Functional Measures to Reduce Reporting Burden) we discuss reducing reporting burden on providers by requiring that

values be calculated (using numerator/denominator) and specific thresholds be met only for certain measures.

Recommendation 5 Simplify and streamline the functional measures.

The collaborative comments recommend simplifying the functional measures to reduce burden and de-emphasize process reporting and propose that the requirement to report a calculated numerator/denominator and achieve specific performance thresholds should only be retained for functional measures:

- in areas that are clearly aligned with health goals and where intermediate or outcome measures are lacking
- that are foundational to tracking, improving, and reporting quality of care for groups of patients (e.g., vitals, demographics, problem list, medication list, medication allergies)
- that can be reported directly from electronic systems, without manual counts

Specific Option for Consideration

The following specific suggestions outline one possible way to simplify the functional measures in the NPRM using the criteria.

We suggest retaining numerator/denominator reporting and performance thresholds for the following functional measures for Stage 1, to be phased out in Stage 2. All of these measures are also included in the mandatory reporting set, outlined in Recommendation 4 (Re-evaluate the All-or-None Payment Approach).

- Problem list
- Vitals
- Active medication list
- Active medication allergy list
- Demographics
- Summary of care record at transitions/referrals

The performance thresholds for these measures should be lowered in the first year and may be increased to 80 percent in year two.

Please see Recommendation 8 (Allow Low-Burden Means to Achieve Stage 1 Patient Engagement) for specific recommendations for patient engagement requirements (i.e., clinical summaries to patients after visits/electronic discharge instructions, copies of

electronic information and electronic access). In these areas we recommend that basic counts replace calculation and reporting of threshold levels to maintain strong focus on these information sharing requirements but avoid cumbersome manual tracking and uncertainty about the denominators that need to be addressed.

Quality results will also be reported using numerators and denominators but no thresholds. Quality reporting should continue in all phases of Meaningful Use.

For Stage 1, providers should be able to satisfy the remaining functional measures for which the NPRM currently requires numerators/denominators and performance thresholds by attesting that they have and routinely use the function, subject to audit. If audited, providers would be required to demonstrate use of the function that formed the basis of the attestation. This approach signals that the functions are important and should be used to achieve Meaningful Use, without requiring detailed and burdensome reporting:

- Smoking status
- CPOE
- E-prescribing
- Structured lab data
- Electronic insurance eligibility
- E-claims
- Reminders
- Medication reconciliation

Clarifications and Fixes

SPECIFIC OPTION FOR CONSIDERATION

The following revisions to functional measures will clarify these requirements:

- Electronic hospital discharge instructions should be routinely offered to patients at discharge rather than being supplied only on request.

- EPs should determine the age and target group for preventive care reminders based on their patient populations (not simply all patients seen during a measure year) and the quality measures they report, rather than sending reminders only for patients over 50 years old. Reminders can include prompts for follow-up care, as preventive care reminders may not be relevant or appropriate for all specialties.

- Documentation of advance directives should be a requirement for Meaningful Use for hospitals. Maintaining these preferences in hospital electronic systems may make it easier for providers to support patient choices and more likely that those preferences will be followed.

- To satisfy the privacy and security requirements of Meaningful Use, providers should complete a risk analysis and mitigate any risks identified, including addressing any deficiencies in use of the security capabilities identified in the IFR (e.g., encryption, audit trail, etc.).

- The problem list is currently defined as including current/active diagnoses as well as past diagnoses relevant to the care of the patient. While some providers use a problem list in this fashion, many include ONLY current/active diagnoses, and use a separate "Past Medical History" field for prior relevant diagnoses. The NPRM should not attempt to redefine these accepted practices. The NPRM also mentions that the word "none" should be recorded as structured data if there are no active problems in the problem list. While "none" can be displayed in the field where appropriate, it is not a structured entry for a coded problem list.

- Medication reconciliation is defined as comparing two medication lists. This is valid ONLY when medication reconciliation is done between two settings of care, which would be the minority of time that EPs would perform medication reconciliation. Medication reconciliation should be clarified as either comparing two lists when the patient changes settings of care, OR verifying the active medication list when the patient is within the same setting of care.

- BMI for ages 2 to 18 is currently defined as requiring a BMI *and* a printed growth chart. As the printing of a growth chart may be difficult to track electronically, it is recommended that this be redefined as BMI and a printed growth chart if available, or BMI and the BMI percentile.

- Demographics for hospitals should ONLY include the date and cause of death when the patient dies during a hospitalization.

- The capability for the EHR to generate lists of patients is described as both a function for EPs and hospitals. However, the clinical relevance of this metric for hospitals is not clear and should be clarified by CMS. If not clarified, it should be removed from consideration for hospitals.

- The summary of care record (for transitions of care) is defined as being either a CCD or CCR document, but the clinical fields contained within the summary of care record are not defined, and should either be defined or clarified as left to the discretion of the provider/hospital.

- The implementation of drug-drug and drug-allergy checking is currently described as including the ability of certain users to “deactivate, modify, and add rules…” Most such systems allow administrative users the right ONLY to set the threshold level of checking, and modify the content of the alerts. This should be clarified by CMS.

- The metric for maintenance of the medication allergy list includes the phrase “medication allergy history.” Such a term has significance for medication history, but there is no parallel application yet for medication allergies. This should be clarified by CMS. This metric also states that the word “none” should be used if there are no medication allergies. Current medical practice is to use the term NKMA or NKDA, and the definition should be expanded to include these terms.