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January 6, 2011

Office of the National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Suite 729-D
Washington, D.C. 20201

Dear Dr. Tang, Dr. Hripcsak and members of the HIT Policy Committee Meaningful Use Workgroup,

The American Health Information Management Association (AHIMA) would like to submit to you comments and recommendations on the Stage 2 draft recommendations for the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program that were presented during the December 13, 2010 Health Information Technology (HIT) Committee. We appreciate the amount of time that you have spent on the draft recommendations trying to find a sense of balance for the eligible providers and hospitals as well as other stakeholders, such as our members.

AHIMA is a not-for-profit professional association representing more than 60,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most. We respectfully submit our comments as our members are and will continue to be active participants in the implementation, maintenance, and compliance of this program.

If AHIMA can provide further information or if there are any questions regarding our recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or Dan Rode, vice president, policy and government relations, at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Allison Viola

Allison Viola, MBA, RHIA
Director, Federal Relations

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations

HIT Policy Committee Meaningful Use Workgroup
Draft Recommendations for Stage 2 and 3

General Comment – AHIMA appreciates the workgroup's consideration for developing on-ramp opportunities for the healthcare community by phasing in objectives through increases in threshold requirements. We do; however, believe some objectives that have marginal increases by Stage 3 do a disservice to the community and ultimately may impact patient safety. For example, objectives such as recording demographics, problem lists, active medication lists, and reminders to patients should reflect 100%. If the meaningful user can achieve 80-90% by Stage 2 we support and encourage taking that next step.

CORE SET					
Health Outcomes Policy Priority	**Stage 1 Objectives**		**Proposed Stage 2**	**Proposed Stage 3**	**AHIMA Comments**
	Eligible Professionals	**Eligible Hospitals and CAHs**			
Improving quality, safety, efficiency, and reducing health disparities	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	CPOE for 60% of Rx, lab, and radiology orders entered by licensed professionals (not specify transmission mode)	CPOE for 80% of Rx, lab, radiology, and referral orders entered by licensed professional (not specify transmission mode)	We are concerned there may be redundancy issues associated with changing from "more than 30% *unique patients*" in Stage 1 to "60% of Rx, lab, and radiology *orders*…" This is a significant change in the way the objective is calculated in Stage 2 and adds complexity and administrative burden in capturing orders not documented electronically. We request further guidance be developed on the numerator/denominator calculations and how certification rules associated with this objective will be defined and tested.
	Implement drug-drug and drug-allergy interaction checks	Implement drug-drug and drug-allergy interaction checks	Employ drug interaction (drug-drug, drug-allergy) checking on appropriate evidence-based interactions	Employ drug interaction (drug-drug, drug-allergy) checking on appropriate evidence-based interactions	No comments at this time.
	Generate and	N/A	60% of orders	90% of orders	We recommend adding this objective to the

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	transmit permissible prescriptions electronically (eRx)		(outpatient and hospital discharge) transmitted as eRx if fits patient preference	(outpatient and hospital discharge) transmitted as eRx if fits patient preference	EH as there may be situations where an independent practice management system will not be connected to a hospital in order to conduct eRx. The addition of the terms “outpatient and hospital discharge” creates some uncertainty how to comply with this measure.
	Record demographics: ○ preferred language ○ gender ○ race ○ ethnicity ○ date of birth	Record demographics: ○ preferred language ○ gender ○ race ○ ethnicity ○ date of birth ○ date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	80% of patients have demographics recorded and can use them to produce stratified quality reports	90% of patients have demographics recorded (including IOM categories) and can use them to produce stratified quality reports	No comments at this time.
	Maintain an up-to-date problem list of current and active diagnoses	Maintain an up-to-date problem list of current and active diagnoses	Continue Stage 1	80% problem lists are up-to-date	We recommend the workgroup refer to Joint Commission’s requirements for maintaining problem lists and how they are to be readily available to all practitioners as needed.

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	Maintain active medication list	Maintain active medication list	Continue Stage 1	80% medication lists are up-to-date	We support the workgroup's recommendation to continue the objective and measure for Stage 2 and the increased threshold for this objective in Stage 3.
	Maintain active medication allergy list	Maintain active medication allergy list	Continue Stage 1	80% medication allergy lists are up-to-date	No comments at this time.
	Record and chart changes in vital signs: o Height o Weight o Blood pressure o Calculate and display BMI o Plot and display growth charts for children 2-20 years, including BMI	Record and chart changes in vital signs: o Height o Weight o Blood pressure o Calculate and display BMI o Plot and display growth charts for children 2-20 years, including BMI	80% of patients have vital signs recorded	80% of patients have vital signs recorded	We believe the last bullet that describes the use of a growth chart should be modified to include "for the period the child is under the care of the provider or healthcare organization." We encourage the workgroup to re-evaluate the age range for pediatrics from 6 mos. to 18 years. This is consistent with other processes such as release of information, consent to treatment unless a guardian or developmentally disabled.

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	Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	80% of patients have smoking status recorded	90% of patients have smoking status recorded	We support the workgroup's recommendation to continue the objective and measure for Stage 2 and the increased threshold for this objective in Stage 3. We propose that you modify the term "smoking" to "tobacco use" which may also include chewing tobacco and/or smoking.
	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Use CDS to improve performance on high priority health conditions. Set CDS attributes (to be used for certification): 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow for use; 7. Integrated with EHR; 8. Presented to the appropriate party who can take	Use CDS to improve performance on high priority health conditions. Set CDS attributes (to be used for certification): 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow for use; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action.	The attributes that are listed for the CDS in Stages 2 and 3 require additional clarity as it is unclear whether these attributes are to be used for the Office of the National Coordinator (ONC) certification criteria or will be used for reporting of measures. Our concerns are as follows: 1. It is not clear who will be creating/supplying the criteria for CDS attributes. Providers should be included in the process of defining the criteria or they may not be adopted. 2. It is unclear what measures are being proposed for this objective in Stages 2 and 3 and how it should be reported. We recommend the workgroup further define the threshold and provide clarity on what will be reported. 3. The comments included in parens "to be used for certification" imply this is reserved for ONC certification criteria. If this is so, we recommend removing any and all criteria that will be used for ONC

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			action.		certification and place in the comments area or other placeholder so as not to confuse the two initiatives. 4. The threshold indicates high priority health conditions, however it is unclear which health conditions fall into this category and how many will be required. We recommend clarity on this CORE objective and associated measures for Stages 2 and 3.
	Report ambulatory clinical quality measures to CMS or the States	Report hospital clinical quality measures to CMS or the States	Continue as per QM WG and CMS	Continue as per QM WG and CMS	AHIMA support CMS' approach toward Stage 1 by selecting only those measures with electronic specifications. In the current environment there continues to be challenges for both providers and hospitals to have data entered appropriately in the patient's record thus requiring increased administrative burden by hiring abstractors to hand enter data into an abstract system to capturing data in the correct fields. We understand this is a clinical documentation improvement process that needs to be addressed by the providers and hospitals; however we encourage CMS to review feedback resulting from Stage 1 reporting and balance the continued stages with concerns expressed by the community.

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Health Outcomes Policy Priority	**Stage 1 Objectives**		**Proposed Stage 2**	**Proposed Stage 3**	**AHIMA Comments**
	Eligible Professionals	**Eligible Hospitals and CAHs**			
Engage patients and families in their health care	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	Continue Stage 1	90% of patients have timely access to copy of health information from electronic health record	We understand from the comment supplied by the Meaningful Use workgroup matrix the information provided to patients will only apply to the information already stored in the EHR. We believe it would be helpful to the community participating in this initiative to further clarify in the objective to state "…a copy of their health information that is available at the time of the request and stored in the EHR including diagnostic test results, problem list, etc. (as noted in this Objective) This objective indicates Stage 1 and 2 require the provider and hospital to provide patients with an "*electronic copy*" of their health information. The Stage 3 measure is modified to all "*timely access to copy of health information*." It is unclear how the objective during this stage is different from the menu set objective (see page 12-13 of this document) "*Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP*" with a corresponding measure of "*Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice.*

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					Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly structured form by 2015 (HITSC to define; e.g., use of CCD or CCR)." We recommend further examination to determine if they address separate issues or can be merged.
	N/A	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 80% of patients. (Patients may elect to receive a printed copy of the instructions.)	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 90% of patients in the common primary languages. (Patients may elect to receive a printed copy of the instructions.	We believe the measure for this objective would better reflect the priority of engaging patients and their families by capturing the percentage of patients who actually understand the discharge instructions reviewed with them and their family members or whoever is providing support during the time of discharge. We are concerned that just capturing the number of times that electronic discharge instructions are offered does not represent quality of care. We suggest modifying this measure to reflect our recommended change which is the number or percentage of patients who agree and understand their discharge instructions.
	Provide clinical summaries for patients for each office visit	N/A	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to	We are concerned that meeting the 24-hour requirements as identified for Stages 2 and 3 will create an unrealistic timeframe to allow patients the ability to download **a full** clinical encounter data. EPs who dictate their visit notes will most likely not have the documents authenticated by the author before the patient would have access to the information. We

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			up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in a uniformly human-readable form by 2013 (HITSC to define; eg, use of PDF or text).	encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in a uniformly structured form by 2015 (HITSC to define; eg, use of CCD or CCR).	encourage the workgroup to retain the 3 business day timeframe from Stage 1 as physicians may not close their notes until test results are available or have the ability to have some information available within 24 hours to provide interim information (med dosage, side effects, med instructions, and patient instructions).

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	Eligible Professionals	**Eligible Hospitals and CAHs**			
Improve care coordinatio n	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Connect to at least one external provider in "primary referral network" or establish an ongoing bidirectional connection to at least one health information exchange	Connect to at least 30% of external providers in "primary referral network" or establish an ongoing bidirectional connection to at least one health information exchange	We believe the threshold as defined in Stage 3 is a substantial increase from 1 provider to 30%. The participation, reporting challenges, and adoption rates of EHRs is still in the early stages. We recommend reducing the threshold for Stage 3 and perhaps change it during the RFI or proposed rulemaking period for Stage 3 to allow for further development and progress in this area. We also recommend that as objectives are further expanded to include areas involving protections for HIV and behavioral health records, to work closely with the Privacy and Security Policy workgroup to align needs and requirements for both groups.
Ensure adequate privacy and security protections for personal health information	Protect electronic health information created or maintained by the certified EHR technology through the implementatio	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical	Continue Stage 1		No comments at this time.

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	n of appropriate technical capabilities	capabilities			
				Provide online views of accounting for disclosures	The requirement for this objective warrants further clarification. For example, information such as what data will be reported to CMS regarding this measure, what will be the timeframe online views must be made available following a patient request, etc. will assist AHIMA in better understanding how to fulfill this component of meaningful use. We will look forward to the requirements published by the Office of Civil Rights (OCR) to assist in better understanding of this objective.

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Improving quality, safety, efficiency, and reducing health disparities	Implement drug-formulary checks	Implement drug-formulary checks	***Move current measure to core***	80% of medication orders are checked against relevant formularies	We request further definition on what the provider is checking and when he/she should be checking. We believe the measures for Stages 2 and 3 are vague and should be further clarified.
	N/A	Record advance directives for patients 65 years old or older	**For EP and EH**: 50% of patients >=65 have recorded the result of an advance directive discussion and the directive itself if it exists	**For EP and EH**: 90% of patients >=65 have recorded the result of an advance directive discussion and the directive itself if it exists	We believe the measure and associated objectives will be extremely challenging for EHs to comply with. We recommend the workgroup provide clarification on how this information is to be captured. Also, there are many issues associated with the latter portion of the measure by obtaining "the directive itself if it exists" primarily, defining what format this should be stored in the EHR. We recommend modifying the measure to just reflect the fact of having the discussion with the patient and having provided them with information if they do not have one. We also support the comments made by the workgroup there is value in conducting a public hearing on these issues to address state statutes, ambulatory, age, privacy, and specialists.
	Incorporate clinical lab-	Incorporate clinical lab-test	***Move current measure to core, but only where***	90% of lab results are stored as structured	We recommend the workgroup provide further definition on what is meant by

MENU SET					
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	Eligible Professionals	**Eligible Hospitals and CAHs**			
	test results into certified EHR technology as structured data	results into certified EHR technology as structured data	***results are available***	data in the EHR and are reconciled with structured lab orders, where results and structured orders available	"*but only where results are available*." We also request additional information on whether the laboratory providers must provide the lab data to EP/EH in a structured format.
	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	***Generate patient lists for multiple patient-specific parameters (move to core)***	Patient lists are used to manage patients for high priority health conditions	We recommend that for Stage 3 the measure should be modified to reflect the patient lists are used internally to manage patients for high priority health conditions. Any of these lists created and used will be provided for quality improvement initiatives, research, etc. without identifiers (when appropriate).
	Send reminders to patients per patient preference for preventive/follow up care	N/A	***Move to core.***	20% of active patients who prefer to receive reminders electronically receive preventive care or follow up reminders	No comments at this time.
Engage patients and families in their health care	Provide patients with timely electronic access to their health	N/A	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal	The implementation timeframe for Stage 2 closely aligns with the ICD-10-CM/PCS implementation date and we believe this will cause critical challenges for the industry with the change in the coding system by requiring further

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Health Outcomes Policy Priority	Stage 1 Objectives		Proposed Stage 2	Proposed Stage 3	AHIMA Comments
	Eligible Professionals	Eligible Hospitals and CAHs			
	information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP		within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly human-readable form by 2013 (HITSC to define; e.g., use of PDF or text).	record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly structured form by 2015 (HITSC to define; e.g., use of CCD or CCR).	system modifications. We recommend for Stage 2 the measure threshold remain at the Stage 1 level and move the current Stage 2 proposal to Stage 3. We suggest leveraging the CCD as the means by which data is captured and stored in a structured form. Additionally, we recommend the workgroup continue to monitor requirements established by OCR and align future thresholds.
	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Continue Stage 1	20% offered patient-specific educational resources online in the common primary languages	We believe the measure for Stage 3 should be limited to online resources. We recommend modifying the measure to be written as “20% offered patient specific educational resources in the common primary languages (either online or on paper per patient preference).
Improve care coordination	The EP, eligible	The EP, eligible	Medication reconciliation conducted at 80% of	Medication reconciliation	We believe this objective is particularly challenging given the impact and work

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	hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)	conducted at 90% of transitions by receiving provider	associated with workflow processes and coordination that need to be planned, developed, tested, and implemented. We recommend maintaining the measure at 50% and then perhaps increase the threshold in Stage 3 of the program.
	The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide	The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide	***Move to core***	Summary care record provided electronically for 80% of transitions and referrals	We support the workgroup's recommendation to maintain the measure as it stands in Stage 1, per the description in the meaningful use final regulation [75FR44364] "*Therefore, an EP, eligible hospital, or CAH could send an **electronic or paper copy** of the summary care record directly to the next provider or could provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so.*" We are concerned however, that the exchange of electronic data as recommended in Stage 3 will still be in

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	Eligible Professionals	**Eligible Hospitals and CAHs**			
	summary of care record for each transition of care or referral	summary of care record for each transition of care or referral			the development stages for entities such as nursing homes and home health providers. Therefore, we suggest allowing for either option. We also suggest the workgroup provide some guidance on the timeframe allowable for this transaction to occur.
Improve population and public health	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	EH and EP: Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS), if accepted and as required by law	EH and EP: Mandatory test. Immunizations are submitted to IIS, if accepted and as required by law. During well child/adult visits, providers review IIS records via their EHR.	We recommend this objective remain on the menu set of objectives/measures for Stage 2 and then re-evaluate for Stage 3 thus allowing registries or IIS' additional time to demonstrate their ability to move beyond testing and transition into production.
	N/A	Capability to submit electronic data on reportable (as required by	***For EH make Stage 1 core.*** ***For EP make lab reporting menu.***	Mandatory test. For EHs, submit if accepted and as required by law. For EPs, ensure that	We recommend this objective remain on the menu set of objectives/measures for both EP/EH Stage 2 and then re-evaluate for Stage 3 thus allowing registries or IIS' additional time to demonstrate their

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		state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice		reportable lab results are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law). Include complete contact information (e.g., patient address, phone and municipality) in 30% (EH) of reports.	ability to move beyond testing and transition into production.
	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	***Move to core.***	Mandatory test; submit if accepted	We recommend this objective remain on the menu set of objectives/measures for both EP/EH Stage 2 and then re-evaluate for Stage 3 thus allowing registries or IIS' additional time to demonstrate their ability to move beyond testing and transition into production.
				Public Health Button	We recommend the workgroup provide

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				for EH and EP: Mandatory test and submit if accepted. Submit notifiable conditions using a reportable public-health submission button. EHR can receive and present public health alerts or follow up requests.	further clarification on the term "public health button" and its expectations.
				Patient-generated data submitted to public health agencies	This statement is unclear regarding the requirements for the EP/EH. We recommend you provide additional information in order to fully understand what is required of the participant in the meaningful use program.

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NEW Objectives					
Health Outcomes Policy Priority	Objectives				
	Eligible Professionals	Eligible Hospitals and CAHs	Proposed Stage 2	Proposed Stage 3	AHIMA Comments
(NEW) Improving quality , safety, efficiency & reducing health disparities		N/A	30% of visits have at least one electronic EP note	90% of visits have at least one electronic EP note	We support the progress toward capturing and using electronic notes; however we discourage the process of scanning written notes or other types of notes that could be scanned into the EHR. We recommend this measure require the EP to enter the note or be dictated and entered into the EHR when transcribed. We also recommend the workgroup consider notes entered by nurse practitioners and/or physician assistants, such as the next objective.
(NEW) Improving quality , safety, efficiency & reducing health disparities	N/A		30% of EH patient days have at least one electronic note by a physician, NP, or PA	80% of EH patient days have at least one electronic note by a physician, NP, or PA	We support the movement toward the capture and use of electronic notes; however we discourage the process of scanning written notes or other types of notes that could be scanned into the EHR. We recommend this measure require the EP to enter the note or be dictated and entered into the EHR when transcribed.

NEW Objectives					
Health Outcomes Policy Priority	**Objectives**				
	Eligible Professionals	**Eligible Hospitals and CAHs**	**Proposed Stage 2**	**Proposed Stage 3**	**AHIMA Comments**
(NEW) Improving quality , safety, efficiency & reducing health disparities	N/A		30% of EH medication orders automatically tracked via electronic medication administration recording	80% of EH inpatient medication orders are automatically tracked via electronic medication administration recording	No comments at this time.
(NEW) Engage patients and families in their care	N/A		80% of patients offered the ability to view and download, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in a uniformly human-readable form (HITSC to define; e.g., use of PDF or text).	80% of patients offered the ability to view and download, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in a uniformly structured form (HITSC to define; e.g., use of CCD or CCR).	The comments by the workgroup indicate the information would include a list of providers and procedures. Procedures typically are not discrete data until coded by a coder, and coding is not always performed within 36 hours of discharge. Regarding "providers" we are unclear what defines a provider to be included in this listing, therefore we suggest further definition be provided on this term. Not every member of the care team may access the patient's record, so how else would this get recorded as discrete data? Additionally, the discharge summary is typically dictated and transcribed, and may not be ready within 36 hours of discharge. Even if completed within this timeframe, it may not yet be authenticated by the author.

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NEW Objectives					
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	Eligible Professionals	**Eligible Hospitals and CAHs**	**Proposed Stage 2**	**Proposed Stage 3**	**AHIMA Comments**
					We believe this objective is very similar to the previous objective for EPs under the Menu Set "*Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and medication allergies) within four business days of the information being available to the EP*" and are unclear about the distinct differentiation between the two. We believe these two objectives could be combined with some modification, thus reducing confusion and duplication by having separate objectives that are similar.
(NEW) Engage patients and families in their care		N/A	EPs: 20% of patients use a personal health record (includes patient portal) to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet.	EPs: 30% of patients use a personal health record (includes patient portal) to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet.	We agree that this objective's goal is to engage patients and families in their care; however we believe there are several challenges associated with meeting this requirement. 1. We believe this measure will be difficult to manage and track, particularly as this functionality is not in control by the EP. 2. It will be a challenge to determine which patients have a PHR unless the patient actually has an appointment with the EP and the question is presented to them during the time of treatment. We are unsure

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NEW Objectives					
Health Outcomes Policy Priority	**Objectives**				
	Eligible Professionals	**Eligible Hospitals and CAHs**	**Proposed Stage 2**	**Proposed Stage 3**	**AHIMA Comments**
					how the EP will determine usage of PHRs for those patients that are not seen by the EP within the specified timeframe. 3. We believe this is repetitive of the following objective, "*Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and medication allergies) within four business days of the information being available to the EP*" as this function could be conducted through a PHR. 4. We request further clarification on the definition of what the definition of a PHR is. These are just a few of the challenges we have associated with capturing information in the patient's EHR and tracking it. We request the workgroup revisit this objective and provide clarification on the requirements that must be met to achieve compliance.
(NEW) Engage patients and families in their care		N/A	EPs:30% offered secure patient messaging online	EPs:90% offered secure patient messaging online	We suggest rewording the measure to reflect, "*Offer online secure patient messaging to at least 30% of the unique patients treated*" during this stage.

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NEW Objectives					
Health Outcomes Policy Priority	**Objectives**				
	Eligible Professionals	**Eligible Hospitals and CAHs**	**Proposed Stage 2**	**Proposed Stage 3**	**AHIMA Comments**
(NEW) Engage patients and families in their care			Patient preferences for communication medium recorded for 20% of patients	Patient preferences for communication medium recorded for 80% of patients	No comments at this time.
				Offer electronic self-management tools to patients with high priority health conditions	No comments at this time.
				EHRs have capability to exchange data with PHRs using standards-based health data exchange	No comments at this time.
				Patients offered capability to report experience of care measures online	No comments at this time.
				Offer capability to upload and incorporate patient-generated data into EHRs and clinician workflow	We believe this functionality may impact data integrity and we are concerned there will potentially be virus issues associated with this capability. We recommend further analysis and consideration for this new objective before incorporating it into the meaningful use program.

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NEW Objectives					
Health Outcomes Policy Priority	**Objectives**				
	Eligible Professionals	**Eligible Hospitals and CAHs**	**Proposed Stage 2**	**Proposed Stage 3**	**AHIMA Comments**
(NEW) Improve care coordination			List of care team members available for 10% of patients in EHR	List of care team members (including the PCP) available for 50% of patients via electronic exchange	We believe this proposed objective requires further analysis and development as we are uncertain about the definition for "care team members" and what information should be captured in the patient's EHR. Additionally we recommend Stage 2 reflect the inclusion of the PCP as is indicated in the Stage 3 objective.
(NEW) Improve care coordination			Record a longitudinal care plan for 20% of patients with high priority health conditions	Longitudinal care plan available for electronic exchange for 50% of patients with high priority health conditions	We support this proposed objective; however we recommend the workgroup further define what "high priority health conditions" are.

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