1730 M Street, NW, Suite 502
Washington, DC 20036

phone » (202) 659-9440
fax » (202) 659-9422
web » www.ahima.org

May 7, 2012

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Acting Administrator Tavenner
Attention: **CMS-0044-P**
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Tavenner:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Medicare and Medicaid Programs; Electronic Health Record Incentive Program Stage 2 a Proposed Rule (NPRM), as published in the March 7, 2012 *Federal Register* (42 CFR Parts 412,413, and 495).

AHIMA is a professional association representing more than 64,000 health information management (HIM) professionals who work throughout the healthcare industry. HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, protecting, validating the integrity of, reporting, releasing, and utilizing data vital for patient care, while making it accessible to patients, healthcare providers, authorized requestors, and appropriate researchers when it is needed most. AHIMA members are deeply involved in the development, planning, implementation and management of electronic health records, in addition to the analysis and reporting of healthcare data for secondary use.

Our detailed comments and recommendations on the NPRM follow our general comments below.

General

Alignment of quality measurement programs - AHIMA applauds CMS' direction to better align the Eligible Provider (EP) quality reporting options across federal quality programs including those for Physician Quality Reporting System (PQRS), Medicare Shared Savings and others. We trust this will result in fewer reporting burdens for EPs as well as greater comparability of quality data within the medical practices as well as across federal programs. We also support CMS' intent to leverage the six domains identified from the National Quality Strategy.

Our members have expressed concern with the increased burden the proposed Clinical Quality Measures (CQMs) will place on Eligible Hospitals (EHs), specifically Critical Access Hospitals (CAH) and pediatric hospitals and clinics. The majority of the proposed CQMs are not applicable to the CAH and pediatric practice setting, thus may discourage active participation

from these practice settings. For example, there are a number of CAHs which do not have Obstetrical Departments or neonatal intensive care units and most transfer acute myocardial infarction and stroke patients upon presentation and evaluation in the Emergency Department.

Unfortunately, for pediatric facilities the federal investment in measurement development for individuals under the age of 18 significantly lags that of the adult and, particularly, the Medicare population. At present, the low number of National Quality Forum (NQF) endorsed hospital measures that are applicable to individuals less than age 18 and included in the list of 49 candidate inpatient measures in the proposed rule will continue to present challenges to CMS and children's hospitals as they seek to implement EHRs that support meaningful quality measurement. Similarly, although the number of measures applicable to children is greater for eligible providers, these measures are largely focused on primary care or few specialties, limiting the ability to capture measures across multiple domains and measures related to specialty care. We restate our recommendation that pediatric hospitals and providers be exempted from measures that apply only to patients greater than or equal to age 18 and that case thresholds are applied to all measures.

Appeals process – AHIMA is encouraged to see that CMS has proposed establishing an appeals process within the rule. By establishing an appeals process for participants of the EHR incentive program it enables an option for recourse to address an issue that may have occurred and an infrastructure to support this.

Capability to exchange key clinical information – AHIMA supports CMS' belief that meaningful use of electronic health records (EHRs) must involve ongoing exchange of health information for care coordination. We believe this objective should further enhance the goals as outlined in the National Quality Strategy and objectives within the meaningful use program. We do not support the option to remove exchanging key clinical information as this would be detrimental to those eligible providers and hospitals that have actively been engaged in working towards that objective. We realize there are challenges associated with implementing such functions; however it is critical to maintain momentum and drive the industry forward with health information exchange.

As stated in our response letter for Stage 1, "*AHIMA strongly believes this (testing of data exchange) diverges from the true intent of the use of EHRs for patient care and it continues to support the need for a hybrid or paper record environment. Moreover, implementing and integrating EHRs into the clinical and administrative workflow should represent a holistic approach, not segmentation*."

NQF endorsed measures - CMS implies but does not clearly state that all CQMs will be NQF consensus endorsed and have electronic specifications. AHIMA strongly encourages CMS to state clearly and unambiguously in the final rules that only measures which have consensus endorsement as well as complete and accurate electronic specifications which have been made publicly available no less than six months before their required use will be included in Stage 2. Moreover, many of the quality measures use ICD-10-CM data at least at the patient population

level and in some cases for denominator calculation. Based on when CMS issues a final rule on the new compliance date for ICD-10-CM/POCS, it is still unclear how the CQMs would be transitioned from ICD-9 to ICD-10 and what that would mean to the intent and comparability of these measures.

Group reporting option – AHIMA recommends the group reporting option requirements align as closely as possible with the PQRS program. We believe this will help to reduce the burden in developing a new reporting infrastructure and alignment. We recommend requiring all providers must be beyond Stage 1 to utilize this option be removed. With large multi-specialty practices and with new providers joining practices, requiring all providers to be beyond Stage 1 is onerous, especially if the proposed reporting requirements are the same for all EPs in calendar years 2014 and 2015 regardless of whether in Stage 1 or Stage 2.

c. Clinical Quality Measures Proposed for Eligible Professionals Beginning With CY 2014 (13746)

Option 1a for selection of measures affords much greater flexibility in an EP's ability to align quality with the scope of their practice. It also addresses all domains that are important to CMS. For this reason, we recommend Option 1a over Option 1b for which there would likely be a much higher incidence of "zero denominators." However, CMS needs to ensure there is a method to verify the quality of the data.

What is not clear is how long it will take to align electronically reported measures with the ones currently being collected and how long hospitals would have to conduct dual reporting. We request further clarification regarding this initiative as the longer this process takes we believe the number of measures EHs/CAHs have to report under meaningful use should be limited.

We believe that both CMS and The Joint Commission currently have a threshold (small numbers) where hospitals do not have to submit patient level data for a measure. We believe it is five or less cases in the initial patient population for a quarter. If CMS does allow case thresholds, then we think they should be consistent with what the current rules are for both EH and EP measures. This data is verified by the Initial Patient Population (IPP) aggregate data that is submitted. We would not restrict to certain types of hospitals because that would then need to be re-examined each time new measures were added.

(b) Reporting Methods Beginning With FY 2014

AHIMA recommends a consistent approach with the hospital inpatient quality reporting (IQR) program in selecting the "Sampling-all payer" reporting method. We also encourage CMS to assess the ability and the options for electronic reporting for the Hospital IQR Program as we believe this would support CMS' initiative to reduce reporting burden and align with the EHR Incentive Program as well as other quality measurement programs.

Data is currently uploaded to Quality Net using XML files so we request further clarification regarding the intent to report by 'electronic' means. However, as stated previously, we do believe that priority should be placed to align the Hospital IQR Program with the EHR Incentive

Program with respect to measures, collection of data and data reporting to help ease the burdens created by EH's trying to participate in both programs.

Table 1 and 2 - The tables below summarize AHIMA's comments regarding the specific EPs and EHs HIT Functionality objectives and measures.

Table 1: HIT Functionality Measures—Eligible Providers

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.	More than 60 percent of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	AHIMA supports the expansion of order types by the EPs and EHs. We appreciate recognition that the Stage 1 method of counting CPOE by the number of patients with at least one medication order has been confusing; EPs and EHs manage CPOE adoption at an order level, not at a patient level. The proposed method of counting CPOE-generated orders as compared to the total orders is more straightforward, however, because it is potentially very burdensome for EPs and EHs to be required to include non-EHR orders in the denominator. EPs or EHs who have written paper orders will have a substantial, manual measurement burden. We request further clarification regarding the definition of "authorized providers" or "licensed healthcare professionals". Define whether this includes pharmacists, RNs entering under protocol, scribes? We encourage CMS to include pharmacists, RNs, etc. as scribes. We request further clarification regarding if order is not entered via the CPOE, how will the EHR identify the existence of order? Are all non-CPOE orders eventually entered in the EHR? It will be challenging to include non-EHR orders in the denominator and increases the burden to include paper orders. Please provide clarification as to whether this is 60% individually for meds, labs, radiology or if this is a cumulative 60%.
Generate and transmit permissible prescriptions electronically (eRx)	More than 65 percent of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted	AHIMA supports the use of NCPDP if transmitted externally, however hospitals that use HL7 transmissions standards within the organization may send Rx to pharmacy physically located inside the organization but is a separate legal entity. The Health Information

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
	electronically using Certified EHR Technology.	Technology Standards Committee (HITSC) recommended certain HL7 standards be adopted for exchange within a legal entity.[1] As noted in the preamble of the proposed rule, it is inconsistent with standards for the exchange of health information between different legal entities. While the hospital uses HL7 standard internally, it will be required to use NCPDP to transmit the discharge script to a pharmacy that is physically inside the hospital but a different legal entity. There must be a mechanism to distinguish between new orders versus previous orders refilled at discharge. This information is generally not known and can't be distinguished for reporting. Must measure all eRx against all prescriptions. **General Comments** • Recommend consideration of the requirement of e-prescribing of controlled substances as optional additional criterion for MU Stage 2 and potentially required in Stage 3. • Measuring denominator with volume of paper scripts. There is no single recognized entry point. • Consideration for patient preference for paper scripts especially in geriatric settings. • Our members have expressed concern regarding the comparison of script/patient to drug formulary – this is a big step from Stage 1. Formularies are not always available to all scripts/patients. We request clarification of intent to link formulary to script/patient.
Record the following demographics • Preferred language	More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's	AHIMA suggests specifying "or documentation of patient refusal to provide demographics" in measure. Numerator definition allows for the patient to decline.

[1] http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__standards_past_meetings/1817

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
• Gender • Race • Ethnicity • Date of birth	inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	CMS asks that we comment on the ability & burden of including disability status for patients as part of demographic data collection. Because they don't give a solid definition of "disability status" it is hard to comment however, since most of these demographics are recorded by registration staff, disability status (as prelim cause of death) does not fit. It is awkward to inquire about disability status during registration. It could potentially be captured by social services or on initial nursing interview but it is difficult to envision how we would use this information to improve care coordination outside what we are already doing for the patients. We certainly do support the intent of care coordination and the value it brings to patient care; however we suggest further analysis or consideration in the development of this term and how the corresponding elements would be defined. CMS is also seeking comments on whether recording of gender identity/sexual orientation should be included. We do not believe this should be a demographic in the sense that it is captured by registration staff. If necessary and we are not sure that it is, it must be a measure that requires it be captured by staff in a private setting such as the patient room.
Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI	More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data	AHIMA applauds CMS' attempt to be directly responsive to EPs who take care of children and this also underscores importance of HL&W at any age. We believe capturing the blood pressure for age >3 is appropriate. The "plot and display growth charts for patients 0-20, including BMI" can be interpreted as required. We suggest adding language "if height/weight is not recorded as structured data" then the provider

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
• Plot and display growth charts for patients 0-20 years, including BMI		does not meet the objective. There is a statement that we interpret to mean that since the height/weight are entered as structured data then the provider does not have to plot the growth charts unless needed as long as the EHR has the functionality.
Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Currently, there are no standards to capture smoking status and the current definitions are not intuitive for providers. We suggest the use of defined specific wording/terms to be included in the rule. This objective is duplicative with quality measures on smoking, NQF 0028 Age 18 years and older. However, the CQM for tobacco use has a different age range and includes all tobacco use. Other quality measurement programs that use this same measure are PQRS, ACO, and Group Reporting PQRS. AHIMA suggests removing one of the measures as this information overlaps, is inconsistent, and burdensome. We believe this approach is counter to CMS' intent to align reporting programs and reduce burden for providers.
Use clinical decision support to improve performance on high-priority health conditions	**1.** Implement 5 clinical decision support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. **2.** The EP, eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entre EHR reporting period.	The proposed rule states on page 13714, "*Each clinical decision support intervention must enable the provider to review all of the following attributes: developer, bibliographic citation, funding source and release revision date*". Clinical evidence to support the decision support intervention is kept in a content management system – not during a provider workflow where most interventions are at the point of care. Most providers will not view this information during their workflows and could be considered "clutter". We suggest enabling links to somewhere in the EHR so providers can access as needed, but not included in the clinical documentation flow. On page 13715 of the proposed rule, "...*intervention must be presented to a licensed healthcare professional*…" We request a definition of

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
		the licensed healthcare professional. More definition and clarity is needed for when the provider can report/attest with interventions that are not related to 5 clinical quality measures. We are concerned about the proposed one-to-one link between the CDS and the CQMs that the provider will be reporting and believe that should be reconsidered. We suggest that providers be allowed to determine which CDS interventions would offer the greatest benefit to their patients rather than requiring them to implement interventions according to a fixed list of CQMs. If it is a priority for CMS to *physically relate* CDS interventions to CQMs, we suggest that they do so based on all of the CQMs in the final set to provide significantly more flexibility for the provider.
Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data	Today, many labs do not have the ability to electronically transmit structured test results and until more widely available and standard, many EP offices will hand enter/transcribe the results which has a risk of transcription error. There continues to be a lack of standard data exchanges for lab results performed outside the EP facility. Therefore we propose that laboratories be required by CMS to use standards-based submission of data to EHRs, and that this objective be delayed until beyond Stage 2. AHIMA also requests defining if this addresses internal and external labs. If external lab results are meant to be included, including the data as structured data will require a "two-write" system, as CLIA currently requires the retention of the lab results in the original output format received from the lab somewhere in the official patient record.
Generate lists of patients by	Generate at least one report listing	Our understanding of the intent of this measure is to move towards

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
specific conditions to use for quality improvement, reduction of disparities, research, or outreach	patients of the EP, eligible hospital or CAH with a specific condition.	demonstrating improvement. We recommend correlating this measure with the clinical quality measures. Perhaps recommend more specificity with this measure by requiring five reports listing patients related to five of the clinical quality measures. This is similar to the proposed measure for interventions needing to be related to clinical quality measures. We don't believe that increasing either the number or frequency of patient lists generated will meet the objective of this measure. Truly moving this measure forward will require review and action on the generated list.
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care	More than 10 percent of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference	AHIMA supports this objective and associated measure.
Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	**1.** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information **2.** More than 10 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives)	We believe that 10% is too high for well patients and elderly patients given the consideration for the patient's role effecting the EP's attestation. There must also be consideration for patients who refuse to use technology or have disabilities that prevent them from using technology. AHIMA supports the objective of engaging patients in their care with increased access to their health information. We do question the ability for EPs to manage patient access to their health information and whether this is the best use of a provider's time and resources if they need to actively engage patients to view online download and/or transmit their health information. Perhaps an alternative to this measure is to track provider communication to the patient informing

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
	view, download , or transmit to a third party their health information	them of this capability thus transitioning the ability to control this measure from the patient to the provider. We seek further guidance regarding the transmit requirement. If EPs are participating in Health Information Exchanges, will participation in such an exchange satisfy the patient requirement to transmit their health information to another provider? AHIMA requests information regarding these processes and EPs' ability to satisfy the transmission requirement within this NPRM.
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients within 24 hours for more than 50 percent of office visits.	AHIMA supports CMS' proposal to provide clinical summaries of patients' office visits and believes this further engages them into their care and fosters an improved relationship with their providers. Regarding a statement written within the proposed rule on page 13715, "*…HIT Policy Committee recommended that the EP have 4 business days to* ***make the information known to the patient****. We concur that EPs should make this information known to the patient…*" We request further clarification regarding the intent to make the information known to the patient and how CMS expects this to occur. Does CMS expect the EP to contact the patient or the certified EHR to submit an electronic message to the patient indicating the information is available? Additional guidance for this objective would be helpful in better understanding the expectations in order to meet the measures. We request information on what is required by a provider to be able to count provision of a clinical summary – it is unclear as written whether it will be counted if a provider posts the summary to a patient portal or even simply posts notice of the availability of the summary. Requiring that a patient log-in to the portal for this to count would seem to be duplicative in intent with the measure related to View,

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
		Download and Transmit, so we urge CMS to clarify that the provider's act of posting the clinical summary, if being done electronically, will satisfy this requirement.
Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all office visits by the EP. More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology	AHIMA requests additional clarification regarding "provided patient-specific education resources identified by certified EHR technology." Does this mean that EHs/CAHs will have limits on the source of patient education materials that are used? On page 13720, the proposed rule states "...*EHR must ID pt specific education resources but these resources/materials do not have to be stored within or generated by the EHR*." As for CMS' request whether a hospital could provide education resources at appropriate literacy levels and cultural competencies through the EHR, it would be challenging to meet this type of objective. Although EHs/CAHs collect preferred language and it is becoming more common for systems to automatically convert documents to Spanish there are no means-by-which to automatically address literacy.
Use secure electronic messaging to communicate with patients on relevant health information	A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 percent of unique patients seen during the EHR reporting period	If EPs are able to incorporate secure messaging into their scope of practice whether it is behavioral health or general practice the issues of securing the messages has to be in place beforehand and tested. E-mail should never be considered private once it is sent. The EPs who do decide to use secure messaging, should develop an action plan concerning the use of e-mail as a form of clinical documentation foremost addressing patient confidentiality and informed consent. Patients should be given instructions on the proper structure, permissible content, and sensitivity needs of e-mail as a form of clinical communication. Organizations should also establish processes to incorporate the e-mail into the existing health record whether paper based or electronic in format, so that the record is a true

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
		and correct reflection of the patient's care. Some EP's population of patients (such as Geriatric and Internal Medicine) is made up of aging adults who may not be as apt to use electronic messaging. We believe those EPs may be challenged in meeting the 10% of patients seen in reporting period if the mix of patients are older and do not use email as a main form of communication. The percentage may need to be lower as they may not be able to meet the 10% threshold. As the proposed objective states, there is no specification as to how the EP is to communicate back to the patient nor does it state that the EP has to document his or her response as a condition of meeting this measure. We believe this would be a challenge in determining the numerator/denominator however, it is important to document how and what information was relayed to patient via email or whatever transmission occurs between doctor and patient.
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP, eligible hospital or CAH performs medication reconciliation for more than 65 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	As CMS states in the proposed rule, the majority chose to defer this objective in Stage 1. We believe this should indicate that more analysis is needed to determine the cause and what is reasonable for EPs to reach with Stage 2 without putting them at risk for failure to attest Stage 2. AHIMA recommends moving this objective from menu to core but make it 10% or keep within menu for one more stage. We also recognize the CQM section for EPs includes a measure, ***NQF 0097 Title: Medication Reconciliation*** that is similar to this objective. As noted in the smoking measure, it is unclear what the purpose is to propose similar measures when the intent of reporting in this program

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
		is to align efforts and prevent the burden of reporting from increasing.
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	**1.** The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 percent of transitions of care and referrals. **2.** The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals.	We request guidance on the timeframe for the summary of care document to be provided to the receiving provider. There are EPs in certain parts of the country having issue meeting even the 10% threshold due to the fact that many in certain areas use the SAME EHR vendors. We suggest this be revisited for the areas that have EPs who are in a geographic area that have one main EHR vendor as they will not be able to attest if they miss this one measure. We do believe that network physicians who use only those EPs in their network could be excluded but if an EP refers out to a physician who is not an affiliated network EP they should be counted and the EP should not be able to take the exclusion for the second measure. AHIMA is concerned with the inclusion of the care plan fields and team members in this core objective. EHRs have not focused on the inclusion of care plans to the point that this should be included in a core objective. We recommend adding this function as a separate menu objective so vendors can begin the design/programming process. It is unclear if this is the care plan that is developed when the patient is first admitted by the care team or if this is a care plan that is designed for the patient at discharge. On page 13722 the proposed rule states, "*Any additional known care team members beyond the referring or transitioning provider and the receiving provider*." We request further clarity regarding the information required for this objective. Does this require specific names or generic information regarding the clinician/other providers?

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
		We have referred to the ONC Standards and Certification proposed rule and no guidance is provided for this requirement. Regarding the situation when there may be pending lab tests (for example) what is expected of the provider and of the CEHRT? Should the summary of care document simply leave that data off or should there be a flag indicating this information is pending? We request guidance on this issue. We question the necessity of including the growth chart itself on the summary of care document. If the height/weight is included then the receiving provider can enter in their CEHRT and produce a growth chart. As well, the growth chart indicates percentile of height and weight which can be added as narrative to the summary of care document in place of the entire graphed growth chart. AHIMA recommends as the decision on the status of smoking vs tobacco use is decided in the record demographic objective, this should carry over to the requirement on the summary of care document. The requirement to include an up-to-date problem list of current and active diagnoses implies that this process needs to be in the physician's arena. Currently many hospitals have their case management or HIM departments maintain the problem list based on physician documentation. As a result it is not always a concurrent process. Assuming that the summary of care document needs to be a concurrent document and prepared and sent with the patient on the transition of care/referral, this moves maintenance of the problem list.
Capability to submit electronic	Successful ongoing submission of	AHIMA supports the move from Menu to Core objective. However,

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice	electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.	we suggest that CMS allow for testing again in Stage 2 and meet the objective. It is a tremendous amount of work to put an interface with a PHA in place. Stage I assumed that if it could be accomplished one objective then EHs would be able to do it with all the public health reporting objectives. This is a true assumption but what it does not take in to account is the amount of work it takes to put that just one interface in place. By moving the objective to core it requires that EHs/CAHs work with the PHA to put the interface in place and test but does not penalize the hospital if there are bugs that require programming, testing, retesting, etc. which may occur over the course of months. We also urge CMS to develop a common national data submission standard in order to limit the burden on providers and vendors operating in multiple states and connecting to multiple registries or other public health organizations. It is important to note that progress in this area is dependent on state investments, which in the current environment presents real obstacles to success and limitations on the number of providers who will have sufficient choices available to them.
Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified	AHIMA strongly supports the encryption requirement in Stage 2, however we recommend CMS collaborates with ONC to allow for immediate access to a patient's record when an urgent need is required such as in an emergency situation.

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
	security deficiencies as part of the provider's risk management process.	
Imaging results and information are accessible through Certified EHR Technology.	More than 40 percent of all scans and tests whose result is an image ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology	We agree that allowing a link to the image is a very reasonable option for this new menu objective. As for requiring that 10% of the images be exchanged via CEHRT with another provider of care, this is a large undertaking. Without an area HIE to send the images point to point, EPs are required to implement custom interfaces with other providers which is a monumental task, both from a financial and workforce perspective. We urge CMS to consider patient privacy in the sharing of images. Patient informed consent to share images is vital and the patient's ability to revoke said consent.
Record patient family health history as structured data	More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives	The inclusion of family members in your direct blood line who have a health condition that could potentially affect the patient that is being evaluated should be included in the record. Affinity is the relation of people by marriage and a patient is not affected by an in-law or their health problems unless they are communicable illnesses which would need to be reported to the EP.
Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period	We suggest that the syndromic surveillance submission needs to remain in the menu for EP for Stage 2. If the implementation guide is not expected until the third quarter 2012 from the Centers for Disease Control (CDC), we believe that this will cause undue stress as far as implementation is concerned from a EP standpoint as this is not a standard public health practice now. This may also create a development challenge with vendors regarding the modification to their CEHRT in a timely manner that are currently being used to capture the needed data.

Objectives	Stage 2 Measures	Eligible Providers—Issues/Comments and Recommendations
Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period	AHIMA supports this objective and associated measure.
Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period	AHIMA supports this objective and associated measure.

Table 2: HIT Functionality Measures—Eligible Hospitals

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.	More than 60 percent of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	AHIMA supports the expansion of order types by the EPs and EHs. We appreciate recognition that the Stage 1 method of counting CPOE by the number of patients with at least one medication order has been confusing; EPs and EHs manage CPOE adoption at an order level, not at a patient level. The proposed method of counting CPOE-generated orders as compared to the total orders is more straightforward, however, because it is potentially very burdensome for EPs and EHs to be required to include non-EHR orders in the denominator. EPs or EHs who have written paper orders will have a substantial, manual measurement burden.

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
		We request further clarification regarding the definition of "authorized providers" or "licensed healthcare professionals". Define whether this includes pharmacists, RNs entering under protocol, scribes? We encourage CMS to include pharmacists, RNs, etc. as scribes. We would like to highlight for CMS' consideration that some hospitals/CAH use what may be termed as "fake"/communication only orders that should not be counted in the numerator or denominator. **Example I:** Remove Duragesic patch in 72 hours goes in as a medication order to fall on the MAR when in reality this is a nursing order. **Example II:** A pharmacy order for the internal key when the nurse needs to have the narcotic box key for tracking purposes. CMS should take this in to account and require there be a way to exclude these items from the statistics. Page 13709 of the CPOE objective discusses the point in the ordering proves when CPOE must be utilized. This statement "*….give an electronic or written order that must not be retained in any way once the CPOE function has been utilized*." We request further clarity on whether this implies that if the provider writes an order and CMS allows other authorized licensed persons to enter the written order in CPOE then we must not keep the written order in the medical record? Please provide clarification as to whether this is 60% individually for meds, labs, radiology or if this is a cumulative 60%.

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
Record the following 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	More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	AHIMA suggests specifying "or documentation of patient refusal to provide demographics" in measure. Numerator definition allows for the patient to decline. Is there a timeframe in which cause of death needs to be documented? Per page 13712 of the rule, recording of preliminary cause of death does not have to occur within a specified timeframe from the death. Most of the time, this is not documented in "demographics" area of an EHR. Our members have pointed out that this information may be recorded in several places within the system by nursing, coding, clerical staff. We suggest that by considering it a demographic that it has to be documented in the demographic area of the EHR. Wherever this is captured, consideration needs to be made in how to follow up if the PCOD is not provided in a "timely" manner (timely to be defined). CMS asks that we comment on the ability & burden of including disability status for patients as part of demographic data collection. Because they don't give a solid definition of "disability status" it is hard to comment however, since most of these demographics are recorded by registration staff, disability status (as prelim cause of death) does not fit. It is awkward to inquire about disability status during registration. It could potentially be captured by social services or on initial nursing interview but it is difficult to envision how we would use this information to improve care coordination outside what we are already doing for the patients. CMS is also seeking comments on whether recording of gender identity/sexual orientation should be included. AHIMA does not

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		believe this should be a demographic data element in the sense that it is captured by registration staff. If necessary and we are not sure that it is, it must be a measure that requires it be captured by staff in a private setting such as the patient room.
Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data	The "plot and display growth charts for patients 0-20, including BMI" can be interpreted as required. We suggest adding language "if height/weight is not recorded as structured data." If height/weight is not recorded as structured data then the provider does not meet the objective. There is a statement that we interpret to mean that since the height/weight are entered as structured data then the provider does not have to plot the growth charts unless needed as long as the EHR has the functionality. We believe capturing the blood pressure for age >3 is appropriate.
Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Currently, there are no standards to capture smoking status and the current definitions are not intuitive for providers. We suggest the use of defined specific wording/terms to be included in the rule. At this time because exposure to second hand smoke is subjective and hard to define what constitutes exposure, we recommend that it not be included in this objective.
Use clinical decision support to improve performance on high-priority health conditions	**1.** Implement 5 clinical decision support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. **2.** The EP, eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug	The proposed rule states on page 13714, "*Each clinical decision support intervention must enable the provider to review all of the following attributes: developer, bibliographic citation, funding source and release revision date*". Clinical evidence to support the decision to support intervention is kept in a content management system – not during a provider workflow where most interventions are at the point of care. Most providers will not view this information during their workflows and could be

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	allergy interaction checks for the entre EHR reporting period.	considered "clutter". We suggest enabling links to somewhere in the EHR so providers can access as needed, but not included in the clinical documentation flow. On page 13715 of the proposed rule, "*…intervention must be presented to a licensed healthcare professional…*" We request a definition of the licensed healthcare professional. We are concerned about the proposed one-to-one link between the CDS and the CQMs that the hospitals will be reporting and believe that should be reconsidered. We suggest that hospitals be allowed to determine which CDS interventions would offer the greatest benefit to their patients rather than requiring them to implement interventions according to a fixed list of CQMs. If it is a priority for CMS to *physically relate* CDS interventions to CQMs, we suggest that they do so based on all of the CQMs in the final set to provide significantly more flexibility for hospitals. Referring to the current CQM from Stage I, we are concerned that EHs/CAHs would be able to put 5 interventions in place to match 5 CQM. CAHs do not have an ICU which excludes some of the measures. Typically ischemic stroke patients unless they are DNR are transferred from the ED. This leaves interventions for NQF Measure 372, 373, 374, 375, 376 as well as the ED throughput measures. Reviewing Stage II CQM there are more included however, the list of 49 measures is reduced greatly for CAHs who transfer acute MI, ischemic strokes, don't have an ICU, don't do much if any inpatient surgery, and don't have OB. We recommend the ability for choosing the five that will have an effect on that

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
		population but want this to be a consideration.
Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data	AHIMA supports this objective and associated measure. AHIMA also requests defining if this addresses internal and external labs. If external lab results are meant to be included, including the data as structured data will require a "two-write" system, as CLIA currently requires the retention of the lab results in the original output format received from the lab somewhere in the official patient record.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.	Our understanding of the intent of this measure is to move towards demonstrating improvement. We recommend correlating this measure with the clinical quality measures. Perhaps recommend more specificity with this measure by requiring five reports listing patients related to five of the clinical quality measures. This is similar to the proposed measure for interventions needing to be related to clinical quality measures. We don't believe that increasing either the number or frequency of patient lists generated will meet the objective of this measure. Truly moving this measure forward will require review and action on the generated list.
Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)	More than 10 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are	AHIMA supports this objective and associated measure.

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
	tracked using eMAR.	
Provide patients the ability to view online, download, and transmit information about a hospital admission	**1.** More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge **2.** More than 10 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period	We believe that 10% is too high for well patients and elderly patients given the consideration for the patient's role effecting the EP's attestation. There must also be consideration for patients who refuse to use technology or have disabilities that prevent them from using technology. AHIMA supports the objective of engaging patients in their care with increased access to their health information. We do question the ability for EHs/CAHs to manage patient access to their health information and whether this is the best use of a provider's time and resources if they need to actively engage patients to view online, download and/or transmit their health information. Perhaps an alternative to this measure is to track provider communication to the patient informing them of this capability thus transitioning the ability to control this measure from the patient to the provider. Also, we request further clarification regarding who would be responsible for communicating, tracking, and managing this effort. The concept of a patient portal seems feasible. What concerns AHIMA is a method whereby the provider can denote that the results are not in a pending status and available for viewing by the patient via the portal. The caveat on lab test results (available at time of discharge) implies that if the results are pending at discharge then there are >36 hours by which to make the results available on the portal. In a dynamic system, unsure how this information would be tracked. Also, 36 hours does not allow for

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		weekend discharges processing by the Health Information Department in regards to accuracy of information (completeness, signatures, correct results on correct patient, etc. all the things we do on assembly and analysis). The strictest regulations require the discharge summary to be completed within seven days according to Healthcare Facilities Accreditation Program (HFAP). The HFAP surveys hospitals for compliance with the Medicare Conditions of Participation and Coverage. Without alignment with this regulation, HIM departments will be required to change physician practice and HIM roles to accommodate having the problem list completed and available within 36 hours. We seek further guidance regarding the transmit requirement. If EHs are participating in Health Information Exchanges, does participation in such an exchange satisfy the patient requirement to transmit their health information to another provider? AHIMA requests information regarding these processes and EHs' ability to satisfy the transmission requirement within this NPRM.
Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all office visits by the EP. More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific	AHIMA requests additional clarification regarding "provided patient-specific education resources identified by certified EHR technology." Does this mean that EHs/CAHs will have limits on the source of patient education materials that are used? On page 13720, the proposed rule states "…*EHR must ID pt specific education resources but these resources/materials do not have to be stored within or generated by the EHR*." As for CMS' request whether a hospital could provide education resources at appropriate literacy levels and cultural competencies

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	education resources identified by Certified EHR Technology	through the EHR, it would be challenging to meet this type of objective. Although EHs/CAHs collect preferred language and it is becoming more common for systems to automatically convert documents to Spanish there are no means-by-which to automatically address literacy.
The eligible 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	The eligible hospital or CAH performs medication reconciliation for more than 65 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	As CMS states in the proposed rule, the majority chose to defer this objective in Stage 1. We believe this should indicate that more analysis is needed to determine the cause and what is reasonable for EPs to reach with Stage 2 without putting them at risk for failure to attest Stage 2. AHIMA recommends moving this objective from menu to core but make it 10% or keep within menu for one more stage.
The 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 summary care record for each transition of care or referral.	**1.** The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 percent of transitions of care and referrals. **2.** The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10	We request guidance on the timeframe for the summary of care document to be provided to the receiving provider. AHIMA is concerned with the inclusion of the care plan fields and team members in this core objective. EHRs have not focused on the inclusion of care plans to the point that this should be included in a core objective. We recommend adding this function as a separate menu objective so vendors can begin the design/programming process. It is unclear if this is the care plan that is developed when the patient is first admitted by the care team or if this is a care plan that is designed for the patient at discharge. On page 13722 the proposed rule states, "*Any additional known care team members beyond the referring or transitioning*

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	percent of transitions of care and referrals.	*provider and the receiving provider*." We request further clarity regarding the information required for this objective. Does this require specific names or generic information regarding the clinician/other providers? We have referred to the ONC Standards and Certification proposed rule and no guidance is provided for this requirement. Regarding the situation when there may be pending lab tests (for example) what is expected of the provider and of the CEHRT? Should the summary of care document simply leave that data off or should there be a flag indicating this information is pending? We request guidance on this issue. We question the necessity of including the growth chart itself on the summary of care document. If the height/weight is included then the receiving provider can enter in their CEHRT and produce a growth chart. As well, the growth chart indicates percentile of height and weight which can be added as narrative to the summary of care document in place of the entire graphed growth chart. AHIMA recommends as the decision on the status of smoking vs tobacco use is decided in the record demographic objective, this should carry over to the requirement on the summary of care document. The requirement to include an up-to-date problem list of current and active diagnoses implies that this process needs to be in the physician's arena. Currently many hospitals have their case management or HIM departments maintain the problem list based on physician documentation. As a result it is not always a

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
		concurrent process. Assuming that the summary of care document needs to be a concurrent document and prepared and sent with the patient on the transition of care/referral, this moves maintenance of the problem list.
Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	AHIMA supports the move from Menu to Core objective. However we suggest that CMS allow for testing again in Stage 2 and meet the objective. It is a tremendous amount of work to put an interface with a PHA in place. Stage I assumed that if it could be accomplished 1 objective then EHs would be able to do it with all the public health reporting objectives. This is a true assumption but what it does not take in to account is the amount of work it takes to put that just one interface in place. By moving the objective to core it requires that EHs/CAHs work with the PHA to put the interface in place and test but does not penalize the hospital if there are bugs that require programming, testing, retesting, etc. which may occur over the course of months. We also urge CMS to develop a common national data submission standard in order to limit the burden on hospitals and vendors operating in multiple states and connecting to multiple registries or other public health organizations. It is important to note that progress in this area is dependent on state investments, which in the current environment presents real obstacles to success and limitations on the number of providers who will have sufficient choice available to them.
Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law	Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR	AHIMA is concerned with the statement on page 13725, "*We expect that CMS, CDC and public health agencies (PHA) will establish a process where PHAs will be able to provide letters affirming that the EP, eligible hospital or CAH was able to submit the relevant public health data to the PHA*." This

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
and practice	reporting period as authorized.	function puts the responsibility of meeting the requirement for this objective on the PHA and removes control from the EH/CAH to the PHA. This also adds an additional administrative paper process (potentially) to this workflow and we see opportunities for errors in this information getting lost. We suggest another method for confirming receipt such as an automatic response from the system or some other electronic means to achieve this objective. AHIMA supports the move from Menu to Core objective. However we suggest that CMS allow for testing again in Stage 2 and meet the objective. It is a tremendous amount of work to put an interface with a PHA in place. Stage I assumed that if it could be accomplished 1 objective then EHs would be able to do it with all the public health reporting objectives. This is a true assumption but what it does not take in to account is the amount of work it takes to implement an interface. By moving the objective to core it requires that EHs/CAHs work with the PHA to put the interface in place and test but does not penalize the hospital if there are bugs that require programming, testing, retesting, etc. which may occur over the course of months.
Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period	AHIMA supports the move from Menu to Core objective. However we suggest that CMS allow for testing again in Stage 2 and meet the objective. It is a tremendous amount of work to put an interface with a PHA in place. Stage I assumed that if it could be accomplished 1 objective then EHs would be able to do it with all the public health reporting objectives. This is a true assumption but what it does not take in to account is the amount of work it takes to put that just one interface in place. By moving the objective to core it requires that EHs/CAHs work with the

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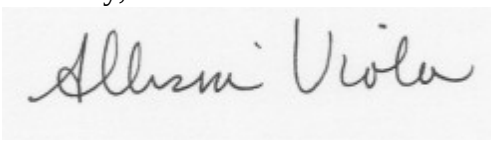
		PHA to put the interface in place and test but does not penalize the hospital if there are bugs that require programming, testing, retesting, etc. which may occur over the course of months. We request further guidance on how this measure will affect the hospital/CAH if the observation method is chosen - meaning that only EDs that are admitted are included in the denominator. CDC PHIN Messaging Guide for Syndromic Surveillance is for the ED and Urgent Care. Will this contain the necessary information for inpatient submission?
Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 64.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.	AHIMA strongly supports the encryption requirement in Stage 2 however we recommend CMS collaborates with ONC to allow for immediate access to a patient's record when an urgent need is required such as in an emergency situation.
Record whether a patient 65 years old or older has an advance directive	More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the HER reporting period have an indication of an advance directive status recorded as structured data.	AHIMA supports this objective and associated measure.

Objectives	Stage 2 Measures	Eligible Hospitals—Issues/Comments and Recommendations
Imaging results and information are accessible through Certified EHR Technology.	More than 40 percent of all scans and tests whose result is an image ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology	We agree that allowing a link to the image is a very reasonable option for this new menu objective. As for requiring that 10% of the images be exchanged via CEHRT with another provider of care, this is a large undertaking. Without an area HIE to send the images point to point, EPs are required to implement custom interfaces with other providers which is a monumental task, both from a financial and workforce perspective. We urge CMS to consider patient privacy in the sharing of images. Patient informed consent to share images is vital and the patient's ability to revoke said consent.
Record patient family health history as structured data	More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives	The inclusion of family members in your direct blood line who have a health condition that could potentially affect the patient that is being evaluated should be included in the record. Affinity is the relation of people by marriage and a patient is not affected by an in-law or their health problems unless they are communicable illnesses which would need to be reported.
Generate and transmit permissible discharge prescriptions electronically (eRx)	More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology	Refills to patients at discharge for medications they were taking prior to arrival are not technically an altered prescription thus if these are intended to be included in the % they would need to be specifically addressed. We believe that once a facility implements eRx, it will include these medications in addition to new or altered prescriptions thus not adding a burden

We thank you for the opportunity to provide comments on the proposed regulation and if AHIMA can provide any further information or if there are any questions regarding this letter and its recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or AHIMA's vice president, advocacy and policy, Dan Rode, at (202) 659-9440 or dan.rode@ahima.org. If we can be of further assistance to you in your efforts, we would welcome the opportunity to provide support.

Sincerely,



Allison Viola, MBA, RHIA
Senior Director, Federal Relations

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