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February 24, 2011

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Attention: Joshua Seidman
Mary Switzer Building
330 C St. S.W., Suite 1200
Washington, D.C. 20201

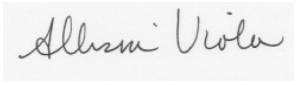
Dear Mr. Seidman,

The American Health Information Management Association (AHIMA) would like to submit to you comments and recommendations on the future vision and the interim stepping stone of Stage 2 draft recommendations for the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program that was published on January 18, 2011 [76FR2910] and on the Office of the National Coordinator for Health Information Technology (ONC) webpage. 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 61,000 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, MBA, RHIA
Director, Federal Relations

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

HIT Policy Committee Meaningful Use Workgroup
Request for Comments Meaningful Use Stage 2

A. General Comments and Recommendations

1. When a provider chooses not to adhere to clinical decision support (CDS) during the point of care, we suggest the provider must document why they chose not to follow a certain workflow. When the treatment of care deviates from the direction guided by the CDS, this should be captured and included in the reporting for meaningful use.

2. As the adoption and implementation of health records continues to migrate towards increased use of online personal health records (PHRs) and health information exchanges (HIE), they will become part of the legal health process and procedures. During Stage 3, the HIT Policy Committee is proposing the requirement to accept and integrate externally generated health information. This external information must be uniformly flagged or differentiated from the health information internally generated within the hospital or provider setting for a variety of reasons. There must be a uniform, consensus standard for such flagging and given the meaningful use timetable, this vocabulary set must be developed as soon as possible.

3. Health information stored within a HIE may encounter state laws impacting the process of redisclosing information originating from another source. Organizations must understand their redisclosure responsibilities under all relevant federal and state laws; there is a web of state laws to consider in this process. Please refer to "*Redisclosure of Patient Health Information (Updated)*" Journal of AHIMA 80, no.2 (February 2009): 51-54. This practice brief explores the issues associated with varying state laws and provides guidance on how they can be addressed.

4. Regarding privacy and security of a patient's health record, certain services may be restricted by individuals for disclosure. We support the capability to place restrictions on certain data that has been merged into an EHR from various sources. For example, a patient receives genetic testing and would like to make sure this test and results are not submitted to their insurance company. Also, state laws may preempt the disclosure of behavioral issue (diagnosis, prescriptions, etc.) requiring the hospital or provider to restrict this information from being disclosed. We suggest there be careful coordination with the HIPAA regulation expansion.

5. AHIMA urges the HIT Policy Committee to consider the current regulatory environment as the year 2013 draws near. There are a number of other regulatory initiatives developing with a compliance timeframe of 2013 and we suggest aligning these programs to allow for a coordinated approach to implementation and production.

HIT Policy Committee Meaningful Use Workgroup
Request for Comments Meaningful Use Stage 2

B. Proposed Stage 2 and 3 Comments and Recommendations

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**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 (by licensed professional) for at least 1 medication, and 1 lab or radiology order for 60% of unique patients who have at least 1 such order (order does not have to be transmitted electronically)	CPOE (by licensed professional) for at least 1 medication, and 1 lab or radiology order on 80% of patients who have at least 1 such order (order does not have to be transmitted electronically)	AHIMA members 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. We request the HIT Policy Committee provide a clear definition for "*licensed healthcare professional*" and "*transmitted*." We also request further clarification regarding when orders are conducted electronically (nurse) but is signed off manually/paper. Please explain if this will be included in the count.
Implement drug-drug and drug-allergy interaction checks	Implement drug-drug and drug-allergy interaction checks	Employ drug-drug interaction checking and drug allergy checking on appropriate evidence- based interactions	Employ drug-drug interaction checking, drug allergy checking, drug age checking (medications in the elderly), drug dose checking	We suggest the provision of a definition for "*appropriate evidence* "and who would determine what this represents. We also request further clarification on how the EHR is expected to demonstrate "*appropriate*."

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
			(e.g., pediatric dosing, chemotherapy dosing), drug lab checking, and drug condition checking (including pregnancy and lactation) on appropriate evidence- based interactions	
Generate and transmit permissible prescriptions electronically (eRx)	N/A	50% of orders (outpatient and hospital discharge) transmitted as eRx	80% of orders (outpatient and hospital discharge) transmitted as eRx	AHIMA recommends adding this objective to the EH as there may be situations when 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. The measure should exclude from the denominator any patient that requests not to have eRx, and there should be an exception when local pharmacies (rural) cannot receive a transmitted eRx. We also request consistency in the use of "*POS 21 or 23*."
Record demographics: ○ preferred language ○ gender ○ race ○ ethnicity	Record demographics: ○ preferred language ○ gender ○ race ○ ethnicity	80% of patients have demographics recorded and can use them to produce stratified quality reports.	90% of patients have demographics recorded (including IOM categories[i]) and can use them to produce stratified quality reports.	The final regulation for the EHR Incentive Program Stage 1 did not specify a vocabulary or classification system for capturing the "*date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.*" We suggest there be a requirement for the use of a standard for this information.

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
○ date of birth	○ date of birth ○ date and preliminary cause of death in the event of mortality in the eligible hospital or CAH			
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. We request the HIT Policy Committee provide a definition for the terms, "*current*" and "*active*," and "*up-to-date*." Please explain if this will apply to all EPs since some EPs do not see the patient directly – radiology, pathology, etc.
Maintain active medication list	Maintain active medication list	Continue Stage 1	80% medication lists are up-to-date	AHIMA supports the workgroup's recommendation to continue the objective and measure for Stage 2 and the increased threshold for this objective in Stage 3. Please explain whether this includes drugs taken at home at their dosage level, or only the drugs and dosage level taken within an inpatient admission. We request a definition for the term "*active*."

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
Maintain active medication allergy list	Maintain active medication allergy list	Continue Stage 1	80% medication allergy lists are up-to- date	
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 unique patients have vital signs recorded	80% of unique 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*." AHIMA members 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.
Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	80% of unique patients have smoking status recorded	90% of unique 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	Implement one	Use CDS to improve	Use CDS to improve	The attributes listed for the CDS in Stages 2 and 3

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	performance on high- priority health conditions. Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action	performance on high-priority health conditions. Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action	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 quality measurement reporting. Our concerns are as follows: 1. AHIMA is unsure 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. AHIMA is unsure 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 certification and place in the comments area or other placeholder so as not to confuse the two initiatives (CMS meaningful use quality measurement reporting versus ONC certification). 4.The threshold indicates high priority health conditions, however we request further clarity on which health conditions fall into this category and how many will be required. We suggest additional clarification on this core objective and associated measures for Stages 2 and 3.
Report	Report hospital	Continue as per	Continue as per	AHIMA support CMS' approach toward Stage 1 by

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
ambulatory clinical quality measures to CMS or the States	clinical quality measures to CMS or the States	Quality Measures Workgroup and CMS	Quality Measures Workgroup and CMS	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 manually 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 additional stages of measures with other reporting initiatives throughout the CMS. Also, the identification of measures should allow time for the vendor community an appropriate amount of time to build systems that will enable the users to capture data within the EHR and report accordingly.
Engage patients and families in their health care				
Provide patients with an electronic copy of their health information (including diagnostic test	Provide patients with an electronic copy of their health information (including diagnostic test results, problem	Continue Stage 1	90% of patients have timely access to copy of health information from electronic health record, upon request	AHIMA understands 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

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
results, problem list, medication lists, medication allergies), upon request	list, medication lists, medication allergies, discharge summary, procedures), upon request			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 differentiates from the menu set objective "*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. Patient should be able to filter or organize information by date, encounter, etc. Data are available in a uniformly structured form by 2015 (HIT Standards Committee 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	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least	Electronic discharge instructions for hospitals (which are given as the patient is leaving the	AHIMA members 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

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Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
	instructions at time of discharge, upon request	80% of patients (patients may elect to receive only a printed copy of the instructions)	hospital) are offered to at least 90% of patients in the common primary languages[ii] (patients may elect to receive only a printed copy of the instructions)	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. We also have concerns regarding the ability for patients to obtain an electronic copy of their discharge instructions. We request further clarification regarding the need for the patient to provide the electronic media or whether the hospital will provide the electronic media with the instructions downloaded within a structured format or other standard way. Although we support the movement toward electronic health data, we do believe this may cause significant workflow disruption if the patient expects the provider to provide this information or it will create a nuisance for the patient to travel to the HIM department for the information. The burden of this objective can be and will be significantly reduced when patients will have the ability to obtain this information through future portals.
Provide clinical summaries for patients for	N/A	Patients have the ability to view and download relevant information about a clinical	Patients have the ability to view and download relevant information about a clinical	AHIMA is 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

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Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
each office visit		encounter within 24 hours of the encounter. Follow-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 human- readable and structured forms (HITSC to define). **EPs:** 20% of patients use a web-based portal[iii] to access their information (for an encounter or for the longitudinal record) at least once. **Exclusions:** patients without ability to access the Internet	encounter within 24 hours of the encounter. Follow-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 human readable and structured forms (HITSC to define). **EPs:** 30% of patients use a web-based portal[iii] to access their information (for an encounter or for the longitudinal record) at least once. **Exclusions:** patients without ability to access the Internet	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 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). We request further guidance if something changes after the 24 hours but before the 4 days. Is there consideration being given to the requirement for an alert or some other indication for the updated information? We request further clarification. The "*4 days*" should be modified to reflect "*4* ***business*** *days*." We request the HIT Policy Committee provide a definition for the term "*longitudinal record*."
Improve care coordination				

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
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 three external providers in ―primary referral network‖ (but outside delivery system that uses the same EHR) 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	AHIMA believes 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 request for comment period (RFC) 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. Please explain or provide a definition for the term, "*primary referral network*." As care models continue to emerge or change we would like CMS to clarify if this includes HIEs, Accountable Care Organizations (ACOs), or the medical home model. We suggest the measures for this objective include the function of actual successful transmission and receipt of the data. If this process is not successful, CMS should provide guidance on the chance of the HIE not functioning during the time of transactions, what the alternative(s) will be.
Ensure adequate privacy and security protections for personal health information				

HIT Policy Committee Meaningful Use Workgroup
Request for Comments Meaningful Use Stage 2

CORE SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Additional privacy and security objectives under consideration via the HIT Policy Committee's Privacy & Security Tiger Team	Additional privacy and security objectives under consideration via the HIT Policy Committee's Privacy & Security Tiger Team	AHIMA suggests expanding the privacy and security components to address the quality and integrity of the data in terms of "*cut and paste*" of the data. We believe this functionality may create privacy issues where providers copy information from one patient's record to another without validating the data to ensure there is not identifiable information that has been copied.

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Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
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	***Make core Requirement.*** **For EP and EH:** 50% of patients ≥ 65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	**For EP and EH:** 90% of patients ≥65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	AHIMA believes 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-test results into certified EHR technology as	Incorporate clinical lab-test results into certified EHR technology as	***Move current measure to core, but only where results are available***	90% of lab results electronically ordered by EHR are stored as structured data in the EHR and are reconciled with structured lab	We recommend the workgroup provide further definition of "*but only where results are available*." We also suggest additional information on what terminology the lab data should be provided in the

MENU SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
structured data	structured data		orders, where results and structured orders available	requirement. We support the use of standards for this functionality. In today's HIT environment providers and hospitals continue to experience challenges with implementing lab interfaces as there are a variety of lab vendors that required different interfaces be developed and there are no standards to support a consistency. We believe more can be accomplished when standards have been developed and we appreciate the work that has been undertaken by the Standards and Interoperability Lab Results Interface Initiative. We agree the cost and time to implement interfaces prohibits broader adoption and implementation of such interfaces.
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	***Move to core*** Generate patient lists for multiple patient- specific parameters	Patient lists are used to manage patients for high-priority health conditions	We recommend for Stage 3 the measure should be modified to reflect 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). We suggest the HIT Policy Committee define "*patient-specific parameters*" and "*high priority health conditions*."
Send reminders to patients per patient preference for	N/A	***Move to core***	20% of active patients who prefer to receive reminders electronically receive preventive or follow-	No comments at this time.

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Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
preventive/follow up care			up reminders	
Engage patients and families in their health care				
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	N/A	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. Patient should be able to filter or organize information by date, encounter, etc. Data are available in human-readable and structured forms (HITSC to define). **EPs:** 20% of patients use a web-based portal[iii] to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet	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. Patient should be able to filter or organize information by date, encounter, etc. Data are available in human readable and structured forms (HITSC to define).structured forms (HITSC to define). **EPs:** 30% of patients use a web-based portal[iii] to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the	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 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. For this measure, AHIMA recommends that patients who would like access to their information should follow release of information protocols currently in use in order to monitor access to the data. We also suggest the Meaningful Use workgroup provide additional information regarding the definition of "access to the record." Defining the limits on how the patient is able to gain access into the systems, databases, etc. is critical in determining and developing security protocols for logical access to their data. The "*4 days*" should be modified to reflect "*4* ***business*** *days*." We suggest leveraging the CCD as the means by which

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Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
			Internet	data is captured and stored in a structured form.
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[ii]	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 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	The EP, 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	Medication reconciliation conducted at 80% of care transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)	Medication reconciliation conducted at 90% of care transitions by receiving provider	We believe this objective is particularly challenging given the impact and work 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. We request further clarification on the term and use of "*relevant*."

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Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
reconciliation				
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 summary of care record for each transition of care or referral	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 summary of care record for each transition of care or referral	***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 the exchange of electronic data as recommended in Stage 3 will still be in the development stages for entities such as nursing homes and home health providers who are not eligible for Meaningful Use incentives. Therefore, we suggest allowing for either option. We also suggest the workgroup provide some guidance on the timeframe allowable for when the information should be provided.
Improve population and public health				
Capability to submit electronic data to immunization	Capability to submit electronic data to immunization registries or	**EH and EP:** Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information	**EH and EP:** Mandatory test. Immunizations are submitted to IIS, if accepted and as required	AHIMA recommends 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.

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Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Immunization Information Systems and actual submission in accordance with applicable law and practice	System (IIS), if accepted and as required by law	by law. During well child/adult visits, providers review IIS records via their EHR.	We also suggest the HIT Policy Committee determine is a standard data set exists for such information to be submitted.
N/A	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	**EH:** move Stage 1 to core **EP:** lab reporting menu. For EPs, ensure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law).	Mandatory test. **EH:** submit reportable lab results and reportable conditions if accepted and as required by law. Include complete contact information (e.g., patient address, phone and municipality) in 30% (EH) of reports. **EP:** ensure that reportable lab results and reportable conditions are submitted to public health agencies either directly or through performing labs (if accepted and as required by law)	AHIMA agrees with this objective and 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. We also suggest the HIT Policy Committee determine is a standard data set exists for such information to be submitted.

MENU SET				
Stage 1 Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
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	AHIMA agrees with this objective. 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 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.	AHIMA recommends the workgroup provide further clarification on the term "*public health button*" and the expectations and security for this functionality.
			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.

NEW Objectives				
Stage 1Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
(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	AHIMA supports 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.
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.
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				

NEW Objectives				
Stage 1Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
N/A		80% of patients offered the ability to view and download via a web-based portal[iii], within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human-readable and structured forms (HITSC to define).	80% of patients offered the ability to view and download via a web-based portal[iii], within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human readable and structured forms (HITSC to define).	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. Additionally, the discharge summary is usually 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. We believe this objective is very similar to the 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. We suggest the HIT Policy Committee define the

NEW Objectives				
Stage 1Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
				term "*relevant*" and what data the patient is allowed to view.
	N/A	EPs: Online secure patient messaging is in use	EPs: Online secure patient messaging is in use	The proposed objective will certainly be critical in the new era of accountable care organizations, medical home, and perhaps other care models where messaging with patients will be necessary. We recommend further clarification regarding the requirements and expectations as this function is currently not reimbursable nor are there standards to support this.
		Patient preferences for communication medium recorded for 20% of patients	Patient preferences for communication medium recorded for 80% of patients	We recommend this objective align with the Joint Commission's "*Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care*"[1] as this concept overlaps with some elements of the roadmap. We also would like to highlight hospitals the practicality of implementing and using this function for patient preference in hospitals is challenging and we recommended conducting a test or pilot to assess the ability of conducting this function.

[1] "Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care," The Joint Commission, accessed February 17, 2011, http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf.

NEW Objectives				
Stage 1Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
			Offer electronic self-management tools to patients with high priority health conditions	We suggest the HIT Policy Committee provide a definition for the terms "self-management tools" and "high priority health conditions."
			EHRs have capability to exchange data with PHRs using standards-based health data exchange	We support this functionality but standards need to be adopted and appropriate consent provided. We suggest the HIT Policy Committee clarify whether PHRs must be certified to exchange data with EHRs.
			Patients offered capability to report experience of care measures online	We request further clarification on this objective and what the measurement will be.
			Offer capability to upload and incorporate patient-generated data (e.g., electronically collected patient survey data, biometric home monitoring data, patient suggestions of corrections to errors in the record) into EHRs and clinician workflow	We believe this functionality may impact data integrity and we are concerned there will potentially be virus and other data integrity issues associated with this capability. We recommend further analysis and consideration for this new objective before incorporating it into the meaningful use program.
(NEW) Improve care coordination				

NEW Objectives				
Stage 1Objectives		**Stage 2 RFC**	**Stage 3 RFC**	**AHIMA Comments**
Eligible Professionals	**Eligible Hospitals and CAHs**			
		List of care team members (including PCP) 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.
		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.

C. Specific Questions for Public Comment

#	Meaningful Use Workgroup Questions	AHIMA Response
1.	How can electronic progress notes be defined in order to have adequate specificity?	We request further clarity on the information being requested, for example is the HIT Policy Committee seeking recommendations for data elements or standards, for example, to further refine the data that is captured? We believe this would be helpful in developing a response.
2.	For patient/family access to personal health information, what standards should exist regarding accessibility for people with disabilities (e.g., interoperability with assistive technologies to support those with hearing, visual, speech, or mobile impairments)?	We encourage the HIT Policy Committee and ONC to identify accomplishments in the area and identify best practices or lessons learned to implement programs that support patient/family access to personal health information. We also suggest referring to information regarding Section 508, as amended, specifically requires that, when Federal agencies develop, procure, maintain, or use electronic and information technology (EIT), (1) individuals with disabilities who are Federal employees have access to and use of information and data that is comparable to the access to and use of the information and data by Federal employees who

#	Meaningful Use Workgroup Questions	AHIMA Response
		are not individuals with disabilities; and (2) individuals with disabilities who are members of the public seeking information or services from a Federal department or agency have access to and use of information and data that is comparable to the access to and use of the information and data by such members of the public who are not individuals with disabilities (FAR 39.201 and 36 CFR 1194.1). Recommend what has been accomplished to identify best practices, lessons learned. [2] Refer to 508 compliance activities. http://www.section508.gov/.
3.	What strategies should be used to ensure that barriers to patient access – whether secondary to limited internet access, low health literacy and/or disability – are appropriately addressed?	We encourage CMS and ONC to evaluate the use of an ombudsman to work with public, patient safety net, public hospitals, and critical access hospitals in to support patient understanding and support the resolution of issues as they arise.
4.	What are providers' and hospitals' experiences with incorporating patient-reported data (e.g., data self-entered into PHRs, electronically collected patient survey data, home monitoring of biometric data, patient suggestions of corrections to errors in the record) into EHRs?	AHIMA's membership has experienced a wide variety of circumstances ranging from low-adoption rates to a fully integrated workflow. One experience reported is a portal implementation is being conducted in a pilot phase with select data (lab, immunization, medications) however; transcribed documents have not been included. In the future this project will be upgraded to allow patients to add personal information. Despite this program development there has not been much participation from the patients. This functionality does have a key impact on operations/workflow within the organization as the intake methodology must be developed to allow data entry from patient, rather than manual capture of the data. Another organization experienced as more data is posted, patients are more active in ensuring their data is accurate.
5.	For future stages of meaningful use assessment, should CMS provide an alternative way to achieve meaningful use based on demonstration of high performance on clinical quality measures (e.g., can either satisfy utilization measures for recording allergies, conducting CPOE, drug-drug interaction checking, etc, or demonstrate low rates of adverse drug events)?	We encourage CMS to not provide an alternative; we believe the industry must continue to move forward with the adoption and implementation of EHRs.
6.	Should Stage 2 allow for a group reporting	We suggest CMS provide the option to select group reporting for Stage 2 and define acceptable group

[2] "CMS Policy for Section 508 Compliance," last modified March 28, 2008, https://www.cms.gov/InfoTechGenInfo/Downloads/Section508Policy.pdf.

#	Meaningful Use Workgroup Questions	AHIMA Response
	option to allow group practices to demonstrate meaningful use at the group level for all EPs in that group?	practices.
7.	In stage 1, as an optional menu objective, the presence of an advance directive should be recorded for over 50% of patients 65 years of age or older. We propose making this objective required and to include the results of the advance-directive discussion, if available. We invite public comment on this proposal, or to offer suggestions for alternative criteria in this area.	We do not believe providing a binary answer of "*yes*" or "*no*" regarding the knowledge of an advance directive demonstrates the movement towards improving care as it does not provide any useful information. It is difficult to track a patient's advance directive and the status of the choices made. We suggest the approaches currently under development by the State of Maryland to develop an online repository solution. We understand that maintaining an accurate and actionable, therefore we believe developing an online solution would prove the most valuable in improving care. For more information about this project, please go to http://mhcc.maryland.gov/electronichealth/challenge_theme_response_report.pdf. Vermont also maintains an advance directive registry to provide an online portal for tracking and maintaining this information, http://healthvermont.gov/vadr/index.aspx.
8.	What are the reasonable elements that should make up a care plan, clinical summary, and discharge summary?	**Care Plan:** Patient problems or needs including psychosocial and family needs (hopefully encoded using SNOMED) Corresponding patient goals related to the identified problems and needs The timeframe for goal achievement The services that will be rendered to support goal achievement and in what settings Planning for disposition of the patient (i.e. home, LTC, rehabilitation, SNF, etc.) An evaluation of the patient's progress in relation to each goal and the ability to revise the care plan as patient needs change. **Discharge Summary:** Attending Doctor Admission and discharge dates Reason for hospitalization Final diagnoses Invasive procedures performed Summary of the care, treatment, and services provided Patient's condition on discharge Patient's disposition at discharge Information provided to patient/family regarding discharge instructions (medications, activities, diet, and any special instructions) Provisions for follow up care

#	Meaningful Use Workgroup Questions	AHIMA Response
		Clinical Summary: Attending doctor Date of the service Reason for the visit Known patient problems Known patient allergies Immunization data Discharge instructions (medications, activities, diet, and any special instructions) Reconciliation of the patients meds (stop taking, continue taking & start taking) Follow up appointment(s) with provider or other providers within the practice
9.	What additional meaningful-use criteria could be applied to stimulate robust information exchange?	We suggest criteria begin to include elements from the medical home model, ACOs, and legal health record considerations. We also recommend integrating the capture of patient consent information. We also suggest providing clarification of documents and their formats to be exchanged. i.e. transcribed documents in .pdf or RTF format, choose either CCD or CCR, not both as this causes uncertainty, confusion and requirements for vendors to support both which is unnecessary.
10.	There are some new objectives being considered for stage 3 where there is no precursor objective being proposed for stage 2 in the current matrix. We invite suggestions on appropriate stage 2 objectives that would be meaningful stepping- stone criteria for the new stage 3 objectives.	**New Objectives identified for Stage 3** 1. *Offer electronic self-management tools to patients with high priority health conditions* – Please see our comments above regarding this proposed measure. 2. *EHRs have capability to exchange data with PHRs using standards-based health data exchange* – We suggest developing a structure of defining what information should be exchanged. We support and suggest the promotion of the use of standards-based data exchange, limited data sets for exchange and determine what would be sent. We suggest the data, where the source is the PHR should remain in a non-alterable state thus resulting in the inability to change PHR data that has been integrated into the EHR. This opens up a large number of reliability of data, legal and HIPAA concerns, therefore Stage 2 would be helpful if the certification criteria reflected the ability to easily identify and segregate PHR collected data. 3. *Patients offered capability to report experience of care measures online* – We encourage the ability to provide real-time or near real-time feedback for providers versus the use of paper based which may be out of date by the time the provider receives it.

#	Meaningful Use Workgroup Questions	AHIMA Response
		4. *Offer capability to upload and incorporate patient-generated data (e.g., electronically collected patient survey data, biometric home monitoring data, patient suggestions of corrections to errors in the record) into EHRs and clinician workflow* – We recommend CMS and ONC consider how the patient would make corrections within given a timeframe and when the provider should respond. We suggest referencing HIPAA guidelines. We suggest considering allowing patients to make entries into a designated section of the health record or some kind of repository within a structured way. There must be consideration on how the physician would be notified of the desire to make a change, whether it is through an alert or some other mechanism. We suggest continuing to follow HIPAA, to preserve legal integrity of the record. We strongly suggest the use of standards for the exchange of health data. Patient suggestions of corrections to errors should be fully consistent with HIPAA Amendment processes, therefore certification criteria should mandate fully compliant HIPAA processes for amendments and corrections be implemented by any vendor seeking certification. This data is not really a part of any record; therefore it is not really EHR data per se, but data about the data within an EHR and therefore should be segregated accordingly.

