January 14, 2013
Farzad Mostashari, MD, ScM
National Coordinator for Health Information Technology
Department of Health and Human Services
Submitted electronically at http://www.regulations.gov

Re: Request for Comments Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records

Dear Dr. Mostashari:

The College of Healthcare Information Management Executives (CHIME) appreciates the opportunity to submit comments regarding the Stage 3 definition of meaningful use of electronic health records (EHRs) for consideration by the HIT Policy Committee. The attached tables provide our comments regarding specific issues and options and our responses to questions posed by the HIT Policy Committee. Below, we also offer several, more general, introductory comments, and we highlight a number of important message points.

CHIME's over 1,450 members represent chief information officers (CIOs) and other top information technology executives at hospitals and clinics across the nation. CHIME members have frontline experience in implementing the kinds of clinical and business IT systems needed to realize healthcare transformation. Healthcare CIOs share the vision of an e-enabled healthcare system as described by the many efforts underway at the Department of Health and Human Services.

Introductory Comments

CHIME devoted considerable resources to the preparation of these comments. We assembled several working groups and held numerous conference calls, even over the holiday period. We do, however, believe that it was unfortunate that stakeholders were given so little time to develop their comments and that the request for comments necessarily had to compete with many important end-of-year professional obligations faced by CHIME members.

We also wish to acknowledge the difficulty of commenting on a number of the proposed objectives and measures for Stage 3 and related issues at a time when there is still limited information regarding Stage 1 and no real experience under Stage 2. Suffice it to say that it will be important to re-assess the reasonableness of proposed Stage 3 objectives and measures in light of actual experience under prior stages. We see no value in setting unrealistic performance thresholds or expectations before current evaluations of what we have accomplished have been undertaken. The goal should remain as is: to provide incentives for eligible hospitals

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(EHs) and eligible professionals (EPs) to undertake the tough work involved in adopting and using certified health information technology.

In this regard, CHIME's strongly held view is that every desirable EHR-related objective cannot feasibly be met by 2016, nor do we see any value in attempting the rushed adoption of various EHR uses by that time. Instead, verifiable and continuous progress should be the goal. We, therefore, urge both the HIT Policy Committee and the Department of Health and Human Services to be guided by thorough evaluations and reasonable expectations of what hospitals, health professionals and EHR vendors are capable of accomplishing over time so that more informed recommendations can be made regarding Stage 3 measures and objectives.

We wish also to underscore our concerns that with each successive Stage of meaningful use, significant costs are incurred to upgrade and maintain solutions. Each new objective outlined in this RFC translates to more time, money and staffing resources expended by providers to meet meaningful use; meanwhile, EHR Incentive Payments are structured to decline over time. This dynamic makes participation in subsequent Stages less and less palatable for providers, jeopardizing the fundamental aim of bringing the nation's healthcare system into the 21st Century.

CHIME also would like to take this opportunity to express our concern over what appears to be growing turmoil in the EHR vendor space. As we move from Stage 1 to Stage 2 and beyond, it appears that many hospitals and health professionals may have little or no choice but to transition from one vendor's EHR product to another vendor's product, due to vendor business failures, vendor consolidation, vendor decisions not to seek certification for products capable of meeting requirements beyond those adopted for Stage 1, and even vendor performance problems. As you know, such transitions are challenging under the best of circumstances. More importantly, in the context of EHR payment incentives and payment adjustments, such transitions risk disadvantaging affected hospitals and health professionals. We, therefore, urge the HIT Policy Committee and the Department to consider what might be done to provide some protection or accommodation for hospitals and health professionals that must undertake such EHR product transitions at the same time that they are expected to progress from one stage of meaningful use to another.

CHIME also believes that our detailed comments regarding certain questions posed by the HIT Policy Committee warrant some emphasis. We wish to call special attention to the following points, which are elaborated upon in the attached tables:

- We agree with the concept of allowing EPs and hospitals to demonstrate meaningful use by meeting a large number but not necessarily all the specified measures.
- We strongly caution policy makers not to expect that health professionals will be willing and able to capture significant amounts of structured data—unreasonable expectations in this regard are not only likely to compromise patient care (by unduly interfering with physician-patient interactions) but also lead to an anti-EHR response by the physician community.
- We believe it would be a very serious mistake to impose a health IT safety risk assessment requirement for the foreseeable future—rather than worrying about how EHRs are being used by providers, policy makers should focus on care outcomes.
- Actual and proven HIE operations and interoperability, combined with a standard and highly-reliable way to identify patients, is mandatory to achieve the goals of Stage 3, and even stage 2. We encourage that the time frames for Stage 3 be linked to and preceded by proven HIE capabilities.

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- We urge policy makers to ensure that EHR certification requirements yield vendor products that allow EPs and hospitals to fully and easily satisfy any meaningful use documentation and audit requirements—such functionality must be inherent to certified EHR technology. We also urge that audit measures be standardized to be based clearly on the certification requirements, and not subject to auditor variation.

Lastly, CHIME is concerned that asymmetric auditing efforts that exceed certification requirements could risk hospital and EP loss of EHR incentive payments. In our view, audits should be primarily focused on uncovering fraudulent activities, not honest mistakes in documentation, especially at this early juncture in EHR meaningful use and when documentation requirements are being specified or made clear only after the fact. Instead, the Department needs to be collaborating with the hospitals and health professionals who are making good-faith efforts to adopt and meaningfully use certified EHR technology, and this collaboration should extend to the identification of "common sense" ways for documenting that meaningful use requirements have been met. We fully understand the desire to ensure that EHR incentive payments are flowing to those who have qualified to receive them but this desire must not translate into unreasonable auditing efforts that will simply demoralize the hospitals and health professionals that have formed the vanguard in EHR meaningful use. We also think that more work is needed to ensure that auditing efforts are properly structured, demonstrate more consistency, employ adequately trained personnel, and are guided by common sense criteria. In addition, where EP or hospital attestation was required, we think that auditors need to demonstrate some flexibility with respect to acceptable documentation, especially at this early point in the EHR Incentive Program.

Please see below for CHIME responses to specific questions posed by the Health IT Policy Committee.

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ID #	HITPC Stage 3 Recommendations	CHIME Comments
SGRP 101	**Objective:** 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. CPOE for medications includes drug-drug interaction (DDI) checking for "never" combinations as determined by an externally vetted list. **Measure:** More than 60% 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 **Certification Criteria:** EHR must be able to consume an externally supplied list of "never" DDIs, using RxNorm and NDF-RT standards along with a TBD DDI reactions value set. **Certification Criteria for EPs** • EHR must have the ability to transmit lab orders using the lab order and results Interface guidelines produced by the S&I Framework Initiative.	The increased threshold for laboratory orders could be a problem for physician practices, since they typically deal with multiple laboratories. There should be a very careful assessment made before consideration is given to raising the threshold above 60 percent.
SGRP 130	**Objective:** Use computerized provider order entry for referrals/transition of care 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.	CHIME supports this proposed new measure.

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	Measure: More than 20% of referrals/transition of care 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.	
SGRP 103	**EP Objective:** Generate and transmit permissible prescriptions electronically (eRx) **EP Measure:** More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary **(reviewed for generic substitutions)** transmitted electronically using Certified EHR Technology. **EH Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx) **EH Measure:** More than **30%** 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	It is not clear how much is implied by altering the language from querying a formulary to comparing prescriptions to "at least one" drug formulary. In many cases, it may not be possible to access a formulary that is relevant to a given patient. If this proposed measure assumes that such access is nearly always possible, it may be difficult to achieve. For example, ready access to a formulary for Medicaid patients may not be possible in some States and thus a practice with many Medicaid patients could find the proposed 50 percent threshold difficult to meet. The same could be true for patients covered by other payers.
SGRP 104	Retire prior demographics objective because it is topped out (achieved 80% threshold). **Certification criteria:** • Occupation and industry codes • Sexual orientation, gender identity (optional fields) • Disability status • Differentiate between patient reported & medically determined • Need to continue standards work	CHIME believes it would be reasonable to retire this measure. We believe that most EPs and hospitals would continue to collect demographic information. However, we want to make sure that in the case of "retired" measures, auditors only examine EHs and EPs against the stage they are attesting – not previous stages where the measure was "active." We presume that the proposed new certification criteria do not imply any new obligations for EPs and providers. We do not believe it would be reasonable to expect collection of occupation, sexual orientation, and disability status as structured data for the foreseeable future.
SGRP 105	**Certification criteria:** EHR systems should provide	CHIME is concerned about the potential for new EHR functionality

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	functionality to help maintain up-to-date, accurate problem list **Certification criteria:** Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians' maintenance of up-to-date accurate problem lists. Systems provide decision support about additions, edits, and deletions for clinicians' review and action. For example, if diabetes is not on the problem list but hypoglycemic medications are on the medication list: the EHR system might ask the provider whether diabetes should be on the problem list. It would not automatically add anything to the problem list without professional action.	requirements to add to the cost of certified EHR technology. We are also concerned that such new functionality, when and if activated, would contribute to the problem of alert fatigue.
SGRP 106	**Certification criteria:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list **Certification criteria:** Use of problems and lab test results to support clinicians' maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians' review. For example, an antibiotic (not for acne) has been on the medication list for over say a month, the EHR system might ask the provider whether the medication is a chronic medication. The system will not make any changes without professional approval.	CHIME is concerned about the potential for new EHR functionality requirements to add to the cost of certified EHR technology. We are also concerned that such new functionality, when and if activated, would contribute to the problem of alert fatigue. Additionally, there is a significant cost risk for professional staff to grow and maintain the wide range of alerts that could be required, quickly exceed available budget, especially for the large majority of smaller organizations.
SGRP 107	**Certification criteria:** EHR systems should provide functionality to code medication allergies including its related drug family to code related reactions.	CHIME supports the idea behind this certification criterion, but we also echo concerns that such new functionality, when and if activated, would contribute to the problem of alert fatigue.
SGRP 108	Retire **Vital Signs** Recording measure because it is topped out (achieved 80% threshold). Track progress to	Vital signs are important in patient management decisions and having this information available as structured data is valuable. CHIME is thus more

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	improve outcomes via CQM NQF 0018	hesitant about retiring this measure.
SGRP 109	Retire **Smoking Status** Recording measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028.	CHIME believes it would be reasonable to retire this measure. We agree that there is a limit to the total number of EHR meaningful use requirements that can reasonably be imposed on EPs and hospitals.
SGRP 112	Ensure standards support in CDA by 2016 **EP MENU/EH Core Objective:** Record whether a patient 65 years old or older has an advance directive **EP MENU/EH Core Measure:** 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 EHR reporting period have an indication of an advance directive status recorded as structured data.	CHIME supports this proposed measure.
SGRP 113	**Objective:** Use clinical decision support to improve performance on high priority health conditions **Measure:** 1. Implement 15 clinical decision support interventions or guidance related to five or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 CDS interventions should include one or more interventions in each of the following areas, as applicable to the EP's specialty: • Preventative care (including immunizations) • Chronic disease management, including hypertension* (e.g., diabetes, coronary artery disease) • Appropriateness of lab and radiology orders • Advanced medication-related decision support** (e.g., renal drug dosing) 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction	CHIME believes that the proposed minimum of 15 clinical decision support interventions would likely to be too much for smaller physician practices. We also believe that ever increasing thresholds risk worsening alert fatigue and could compromise physician support for EHRs, especially if physicians begin to believe that a computer is dictating how they should practice medicine. With respect to the proposed certification criteria, we are concerned that they may imply that EPs and hospitals will need to subscribe to expensive external data bases (in order to "consume CDS interventions from central repositories"). We are concerned about the potential costs of such subscriptions as well as the overall cost of certified EHR technology. If the central repositories are government or other data bases available without charge, these concerns would obviously be lessened.

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	checks for the entire EHR reporting period. **Certification criteria:** 1. Ability to track CDS triggers and how the provider responded to improve the effectiveness of CDS interventions 2. Ability to flag preference-sensitive conditions, and provide decision support materials for patients. 3. Capability to check for a maximum dose in addition to a weight based calculation. 4. Use of structured SIG standards 5. Ability for EHRs to consume CDS interventions from central repositories (e.g., rules for drug-drug interactions, rules for reporting diseases for public health departments, preference-sensitive care lists) * This will assist in achieving the CDC's goal of improvements in hypertension control. **Kuperman, GJ. (2007)Medication-related clinical decision support in computerized provider order entry systems a review. Journal of the American Medical Informatics Association: JAMIA, 14(1):29-40.	
SGRP 114	**Objective:** Incorporate clinical lab-test results into EHR as structured data **Measure:** More than 80% 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	CHIME believes that the proposed threshold would be problematic for many physician practices, especially those who deal with multiple laboratories (requiring multiple interfaces).

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SGRP 115	**EP Objective:** Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports. Dashboards are incorporated into the EHR's clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report.	More details are needed regarding what is intended, how it would work in practice, and what value it would bring. Several specific examples would be helpful in assessing the reasonableness of this proposed EP objective. We fear that the leap to "near real-time" functionality and "dashboards" could present significant work flow issues for EPs.
SGRP 116	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care **EP Measure:** More than 20% 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 **Exclusion:** Specialists may be excluded for prevention reminders (could be more condition specific).	CHIME generally supports this proposed measure, and we also believe that once a physician practice begins using patient reminders, it will tend to do so broadly. However, the HITPC needs to understand that some patients do not wish to receive reminders, and that physician practices also face the potential public relations problem of possibly sending reminders to deceased patients (that is, patients who saw a physician once in the past 24 months and subsequently died without the physician necessarily being aware of such death). In short, sending patient reminders is not necessarily a problem-free undertaking. Also, given patient mobility, sending reminders to patients who infrequently visit a physician practice (only once over the past 24 months) could entail considerable wasted effort. In this regard, no explanation is provided for changing the denominator to apply to all patients with a single office visit within the previous 24 months rather than the current two or more visits. With respect to the proposed exclusion, we believe that it would be reasonable to exclude specialists from prevention reminders.
SGRP 117	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** 1) More than 30% of medication orders created by authorized providers of the eligible hospital's or CAH's	CHIME generally supports this proposed objective and measure.

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	inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR. 2) Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked for use in quality improvement.	
SGRP 118	**CORE Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **CORE Measure:** More than 10 percent of all tests whose result is an image (including ECGs) 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	CHIME believes that the proposed measure would be problematic for many physician practices and perhaps even for some critical access hospitals. In the case of small physician practices, costly interfaces would likely be necessary to facilitate compliance. We note that the proposed measure would apply to more than just radiology tests. It will be essential to provide further clarity about what "images" are intended to be included so as to avoid any misunderstanding by stakeholders.
SGRP 119	**CORE Objective:** Record high priority family history data **CORE Measure:** Record high priority family history in 40% of patients seen during reporting period **Certification criteria:** Make sure that every appropriate CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach).	It is difficult to provide thoughtful feedback about this proposed objective and measure given the limited experience to date in recording family history as structured data. Also, the proposal does not explain what is meant by "high priority" family history. Converting a menu set measure into a core measure while doubling the patient threshold and changing the requirement to apply to "high priority" family history strikes us as trying to do too much at one time.
SGRP 120	Record electronic notes in patient records for more than 30% of office visits within four calendar days.	The comparable Stage 2 measure is part of the menu set and applies to both EPs and hospitals. We presume the intent is to make this measure part of the core set for Stage 3 but this is not clear. Also, since the language refers only to "office visits," it is not clear whether and how the measure would apply to hospitals. All of this makes it difficult for us to

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		offer thoughtful input at this time.
SGRP 121	**EH CORE Objective:** Provide structured electronic lab results to eligible professionals. **EH CORE Measure:** Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 80% of electronic lab orders received.	The comparable Stage 2 objective speaks about providing structured lab results to ambulatory providers, and we presume that the Stage 3 objective should as well. We do not believe that community physicians wish to receive the results of all tests conducted on patients admitted to the hospital. Thus, we presume the intent is for this measure to apply when the hospital is serving as a reference lab. We are also concerned about the possibility that a hospital could fail to meet the measure because physicians are unable to receive laboratory results electronically (even if they have submitted the lab order electronically). For example, we believe that a hospital furnishing laboratory results via a health information exchange (HIE) should be able to satisfy the measure even if not all physicians ordering laboratory tests have chosen to join the HIE. In any event, our uncertainty about what exactly is intended by the proposed objective and measure makes it difficult for us to provide thoughtful input regarding the measure threshold.
SGRP 122	**Objective:** The EHR is able to assist with follow-up on test results **Measure:** 10% of test results, including those which were not completed are acknowledged within 3 days **Certification Criteria:** • EHRs must have the ability to identify abnormal test results and to to notify the ordering providers when results are available or not completed by a certain time. • EHRs must record date/time test results are reviewed and by whom	More information is needed regarding this proposed objective and measure. Is this objective and measure intended only for EPs or for both EPs and hospitals? Whose EHR system must have the acknowledgement and other related functionalities? What does the objective and measure mean, if anything, if it is not possible to notify an EP electronically (for example, because an EP has chosen not to participate in a health information exchange)? CHIME agrees that the proposed functionality and process would have great value but we are still uncertain about some of the particulars, including vendor capability to meet the proposed certification criteria.
SGRP 204A	• EPs should make info available within 24 hours if generated during course of visit	CHIME remains uncomfortable with the concept of holding EPs and hospitals accountable for actions taken or not taken by individuals over whom EPs and hospitals have no real control, including patients and

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	• For labs or other types of info not generated within course of visit, it is made available to pts within four business days of info becoming available to EPs • Potential to increase both thresholds (% offer and % use) based on experience in Stage 2 **Note:** Depending on experience in Stage 2, CMS may want to give credit to some providers (e.g. specialists) for view/download/transmit where the patient has requested that they prefer info to be sent to a location they specify (such as another provider portal or PHR), rather than only making available information on the provider's portal. **MENU item:** Automated Transmit*: (builds on Automated Blue Button Initiative (ABBI)): Provide 50% of patients the ability to designate to whom and when (i.e. pre-set automated & on-demand) a summary of care document is sent to patient-designated recipient** (for example, a one-time request to send information from specialist to primary care, or a standing request to always send an updated care summary when certain events arise, such as a change in medication or the completion of new tests or procedures). *Subject to the same conditions as view, download, transmit **Before issuing final recommendations in May 2013, HITPC will also review the result of Automated Blue Button pilots, in addition to considering public comments received.	their caregivers. We agree that EPs and hospitals should be expected to make more information available electronically, but we do not believe that they should suffer negative consequences if patients and others do not take advantage of such availability. In terms of the new menu item on Automated Transmit, would patients be required to give their preferences or would providers receive credit for giving them the ability to state their preference? Would the concept of opting out apply? This menu item could involve considerable hospital costs if providing information via an HIE is insufficient.
SGRP 204B	**MENU:** Provide 10% of patients with the ability to submit patient-generated health information to improve	The wording of this proposed menu item is problematic in that it refers providing patients the ability to submit patient-generated information but

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	performance on high priority health conditions, and/or to improve patient engagement in care (e.g. patient experience, pre-visit information, patient created health goals, shared decision making, advance directives, etc.). This could be accomplished through semi-structured questionnaires, and EPs and EHs would choose information that is most relevant for their patients and/or related to high priority health conditions they elect to focus on. Based upon feedback from HITSC this should be a MENU item in order to create the essential functionality in certified EHRs.	may well imply that a certain minimum proportion of them must actually do so. As noted above, CHIME remains uncomfortable with the concept of holding EPs and hospitals accountable for actions taken or not taken by individuals over whom EPs and hospitals have no real control, including patients and their caregivers. We also remain concerned about potential legal issues surrounding the incorporation of patient-generated information into EHRs, especially if such information conflicts with health professional-generated information. If the HIT Policy Committee continues to explore this concept, we believe that EPs and hospitals should be given credit for incorporating data generated from the patient's home, such as patient weights, blood pressure readings, blood glucose levels, and other information that is relevant to remote patient monitoring, and not restrict qualifying input to the results of patient questionnaires. We also believe that careful consideration must be given to the expected burden on providers associated with capturing patient-generated data, including, for example, staff time needed to assist patients in completing questionnaires.
SGRP 204D	**Objective:** Provide patients with the ability to request an amendment to their record online (e.g., offer corrections, additions, or updates to the record) through VDT in an obvious manner.	More information about this proposed objective is needed. For example, is this intended to be an EP and/or hospital objective, and is it intended to be part of the menu or core set? Will this objective be met via attestation, since it is quite possible that no patient would request an amendment to their record online during a reporting period? If a patient should request amendment relating to information received from another source (for example, a test result in an EP EHR that was received from a hospital), would the EP's obligation be restricted to his or her own EHR? We presume that separate requests for amendment would need to go to each relevant record holder. We further presume that any requests received should be documented in the EHR (although this is not explicitly stated in the proposed objective). However, would an EP or

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		hospital have any specific obligation to acknowledge receipt of the request?
SGRP 205	The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.	The HIT Policy Committee asks what specific information should be included in the after-visit summary so that patients will know when to call the doctor if certain symptoms/events arise or otherwise have the advice they need. Current EHR products do not address this specific issue and we wonder about vendor capability to do so. Many ambulatory EHR vendors have gone out of business or are not certifying products beyond Stage 1.
SGRP 206	**Additional language support:** For the top 5 non-English languages spoken nationally, provide 80% of patient-specific education materials in at least one of those languages based on EP's or EH's local population, where publically available.	CHIME is concerned about the potential cost implications of this functionality. Also, is the intent to only certify EHR products that are inherently capable of meeting the language requirement? If not, and if EPs and hospitals are expected to be able to do so "on their own," we believe that the language requirement could be prohibitively expensive. Obviously, the ability to meet the requirement is dependent on the availability of foreign language materials from government and other sources or through some kind of translation service. In this regard, we believe that an 80 percent threshold would be far too high as an initial expectation. Further, we wonder about the value of this requirement in locales where a language other than one of the "top five" nationally is a commonly spoken "second" language.
SGRP 207	**Measure:** More than 10%* of patients use secure electronic messaging to communicate with EPs	This proposal appears reasonable but should be assessed further based on experience under Stage 2. Also, we presume the intent is to retain the current exclusions related to broadband availability and patients without a single office visit during the reporting period. Further, as the threshold is increased, it may be necessary to adopt an additional exclusion for physician specialties where patient follow-up is less frequent (for example, where patients are treated for "one-time" acute conditions).
SGRP 208	**EP and EH Measure:** Record communication preferences for 20% of patients, based on how (e.g., the medium) patients would like to receive information for certain purposes (including appointment reminders,	Identifying patient communication preferences appears to make sense but still raises a number of questions. Must there be a standard list of "preferences" from which to choose or will each EP and EH be allowed to develop such a list. Similarly, would there be a standard list of

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	reminders for follow up and preventive care, referrals, after visit summaries and test results).	"purposes" or would each EP or EH be able to generate their own list. Also, would an EP or EH be bound to use the patient's preferred mode of communication in all cases, even when a particular communication mode might be inappropriate for a given purpose?
SGRP 209	**Certification Criteria:** Capability for EHR to query research enrollment systems to identify available clinical trials. No use requirements until future stages.	CHIME is concerned that this functionality might require expensive subscription to some external service or database. It would also likely require a standard way to query that would not violate patient privacy.
SGRP 302	**EP / EH / CAH Objective:** 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 reconciliation for: - medications - medication allergies - problems **EP / EH / CAH Measure:** The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than 10% 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). **Certification Criteria:** Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e. severity).	CHIME appreciates the desire to expand reconciliation requirements beyond medication reconciliation but remains uncertain about how well even medication reconciliation is working currently, especially for EPs.
SGRP 303	**EP/ EH / CAH Objective:** EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care Provide a summary of care record for each site transition	This issue should be assessed once there is some experience under Stage 2. Also, as the threshold for electronic transmission increases, the issue of reception capability grows in importance. We believe this is another example where an EH or CAH should receive credit if it makes summary of care records available through an HIE even if all physicians in the

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	or referral when transition or referral occurs with available information Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant): 1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral) 2. Setting-specific goals 3. Instructions for care during transition and for 48 hours afterwards 4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF (Direct care provision, Emotional support, Care coordination, Advocacy, and Financial)) **Measure**: The E(including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30%* electronically). **Certification Criteria**: EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral. **Certification criteria**: Ability to automatically populate a referral form for specific purposes, including a referral to a smoking quit line. **Certification Criteria**: Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which and are expected to complete HL7 balloting for	community do not participate in such HIE. CHIME remains concerned about the relatively vague references to "care team," since this term appears to be open to multiple interpretations, some of which we would consider unreasonable. For example, some might argue that the term should include every hospital staff person who played a role in the care of a patient during an entire admission. We would strongly oppose such a broad interpretation of the term "care team."

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	inclusion in the C-CDA by Summer 2013: 1) Consultation Request (Referral to a consultant or the ED) 2) Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency)P, eligible hospital, or CAH that site transitions or refers their patient to another setting of care	
SGRP 305	**EP / EH / CAH Objective:** EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby beginning to close the loop. **Measure:** For patients referred during an EHR reporting period, referral results generated from the EHR, 50% are returned to the requestor and 10% of those are returned electronically* **Certification Criteria:** Include data set defined by S&I Longitudinal Coordination of Care WG and expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Shared Care Encounter Summary (Consultation Summary, Return from the ED to the referring facility, Office Visit) **Certification Criteria**: Include standards for referral requests that require authorizations (or pre-certifications) for procedure, surgery, lab, radiology, test orders *This builds upon the clinical quality measure (CQM) in stage 2 for closing the referral loop,CMS50v1 (NQF TBD)	We acknowledge the importance of "closing the loop" to improve care and reduce costs. To this end, CHIME recommends this Objective be considered as a menu item for Stage 3. We have concerns regarding HIE penetration among referring parties and we worry that Meaningful Use is being extended into areas that would be suited for regulation under the Shared Savings Program, Patient Centered Medical Homes and Advanced Managed Care initiatives. We further recommend that the HITPC focus on rules that will promote adoption and standardization of EHRs so that the system can share more seamlessly and more completely.
SGRP 308	**EH Objective:** The EH/CAH will send electronic	In keeping with previous recommendations regarding new Objectives in

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	notification of a significant healthcare event in a timely manner to key members of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required. **EH Measure:** For 10% of patients with a significant healthcare event (arrival at an Emergency Department (ED), admission to a hospital, discharge from an ED or hospital, or death), EH/CAH will send an electronic notification to at least one key member of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required, within 2 hours of when the event occurs.	Meaningful Use, we believe this should be a menu item. Having said that, CHIME recommends that an "electronic notification" encompass simple, text message-type, alerts. We do not believe this Objective needs summary of care or CCD-style information to have the desired impact. We also note two additional complexities: one, surrounding consent and how such issues play into the measurement of meeting this Objective and the other around encryption. Further clarification is needed.
SGRP 401A	**EP/ EH Objective:** Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period. **Exclusion:** EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot	While we support the goal this Objective seeks to achieve, we are concerned that many immunization registries across the country will simply not have this capability in time for Stage 3. We recommend that subsequent versions of the Objective continue to include clear exemptions for those EPs and EHs that are in areas where this functionality does not exist on behalf of their immunization registry. Further, we are concerned that many standards, beyond those needed by the EHR to incorporate such data, need developed. For example, how is data for 30 percent of patients who received immunizations going to be correctly linked from the registry to the EHR? Patient data matching continues to be problematic and it is, perhaps, highlighted nowhere better than this Objective.

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	provide electronic immunization histories. **Certification criteria**: EHR is able to receive and present a standard set of structured, externally-generated, immunization history and capture the act and date of review within the EP/EH practice.	
SGRP 401B	**EP/EH Objective:** Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy. **Measure:** Implement an immunization recommendation system that: 1) establishes baseline recommendations (e.g., Advisory Committee on Immunization Practices), and 2) allows for local/state variations. For 20% of patients receiving an immunization, the EP/EH practice receives the recommendation before giving an immunization. Exclusion: EPs and EHs that administer no immunizations. **Certification criteria**: EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.	CHIME recommends that there needs to be evidence-based/best practices to respond appropriately to outbreak alerts.
SGRP 402A	**EH Objective (unchanged):** No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system	We support this Objective
SGRP 403	No change from current requirements regarding electronic submission of syndromic surveillance data.	We support this Objective

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SGRP 404	**EH/EP Objective:** Capability to electronically participate and send standardized (i.e. data elements and transport mechanisms), commonly formatted reports to a mandated jurisdictional registry (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to either local/state health departments, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to prior requirements for submission to an immunization registry. **Measure:** Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated registry, maintain an audit of those reports, and track total number of reports sent. Exclusion: where local or state health departments have no mandated registries or are incapable of receiving these standardized reports	We support this Objective
SGRP 405	**EP Objective**: Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements (e.g., immunizations, cancer, early hearing detection and intervention, and/or children with special needs). Registry examples include hypertension, diabetes, body mass index, devices, and/or	CHIME does not believe this objective should be part of meaningful use requirements and certainly not at this time. Registries have a wide range of format requirements and their data requirements cannot always be satisfied by information contained within EHRs. While we believe this objective is well intentioned, we think it would have a disruptive effect. A certification criteria making it possible for an EP to send a

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	other diagnoses/conditions) from the Certified EHR to a jurisdictional, professional or other aggregating resources (e.g., HIE, ACO), except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** EHR is able to build and send a standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent.	standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent would certainly be useful (if technically feasible). However, making it mandatory for EPs to report to some additional registry, in the name of EHR meaningful use, would be going too far. Where sending reports to a jurisdictional, professional or other aggregating resource makes sense from a patient care and/or business case perspective, providers will do this. But we do not believe it should be part of the Meaningful Use regime.
SGRP 407	**EH Objective:** Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. **Measure**: Documentation of successful electronic transmission of standardized healthcare acquired infection reports to the NHSN from the Certified EHR Technology. Total numeric count of HAI in the hospital and attestation of Certified EHR electronic submission of at least 10% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.	CHIME generally supports this Objective, however we are concerned that this and previous measures necessitate a lot of additional technology. We worry that electric reporting is being pushed to the detriment of workflow and real-time surveillance or real-time quality improvement.

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	Certification criteria: EHR is able to sending a standard HAI message to NHSN, maintain an audit and track total number of reports sent.	
IEWG 101	**MENU** objective: For patients transitioned without a care summary, an individual in the practice should query an outside entity. The intent of this objective is to recognize providers who are proactively querying. **Certification criteria:** The EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a health information exchange, or an entity on the NwHIN Exchange, for example. This query may consist of three transactions: a) Patient query based on demographics and other available identifiers, as well as the requestor and purpose of request. b) Query for a document list based for an identified patient c) Request a specific set of documents from the returned document list When receiving inbound patient query, the EHR must be able to: a) Tell the querying system whether patient authorization is required to retrieve the patient's records and where to obtain the authorization language*. (E.g. if authorization is already on file at the record-holding institution it may not be required).	CHIME believes it is premature to add this objective, even as part of a menu set. This objective envisions that given the ability to query other systems, hospitals and doctors will choose not to. Whether this assumption is true or not, we do not believe there is a demonstrated need for such a requirement at this time, as the capability to query is still in its infancy. We recommend that further input be gained from ongoing demonstration projects, such as Query Health (with information on propensity of users to query when information is absent), before deciding appropriate next steps.

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	b) At the direction of the record-holding institution, respond with a list of the patient's releasable documents based on patient's authorization c) At the direction of the record-holding institution, release specific documents with patient's authorization The EHR initiating the query must be able to query an outside entity* for the authorization language to be presented to and signed by the patient or her proxy in order to retrieve the patient's records. Upon the patient signing the form, the EHR must be able to send, based on the preference of the record-holding institution, either: 1. a copy of the signed form to the entity requesting it 2. an electronic notification attesting to the collection of the patient's signature *Note: The authorization text may come from the record-holding EHR system, or, at the direction of the patient or the record-holding EHR, could be located in a directory separate from the record-holding EHR system, and so a query for authorization language would need to be directable to the correct endpoint.	
IEWG 102	**Certification criteria**: The EHR must be able to query a Provider Directory external to the EHR to obtain entity-level addressing information (e.g. push or pull addresses).	We wonder who would be expected to develop and maintain the provider directories in question. We note that even the data base relating to national provider identifiers is not always updated in a timely manner.
IEWG 103	**No specific Stage 3 recommendations but the following question is posed:** What criteria should be added to the next phase of EHR Certification to further facilitate healthcare providers'	CHIME believes that this is a matter that may need to wait until an EHR meaningful use stage beyond Stage 3. We agree that EPs and EHs will find it necessary to switch EHR products, especially given turmoil in the current EHR vendor space. We also believe that this issue may be easier

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	ability to switch from using one EHR to another vendor's EHR?	to address in the case of ambulatory EHRs. There is the obvious issue of how much data to export (that is, how far back to go in the patient's record). A related long-term matter is whether the EHR should continue to be viewed as the central repository of a patient's entire medical record or whether this storage function might be better assigned elsewhere.

Responses to HITPC Questions

ID#	Question	CHIME Response
MU01	Currently, providers have to meet all MU criteria to receive incentives. Is there flexibility in achieving a close percentage of the objectives, but not quite achieving all of them? What is the downside of providing this additional flexibility? How will it impact providers who are achieving all of the MU criteria? If there is additional flexibility of this type, what are the ways this can be constructed so that it is not harmful to the goals of the program and advantageous to others?	CHIME believes there is value in further exploring the idea of a meaningful use "grading system" other than the current "all or nothing" one for core measures, especially as it becomes more and more difficult to meet meaningful use requirements. In particular, we are concerned that EPs and EHs that have made a good-faith effort to achieve meaningful use might be found upon an audit to have insufficient documentation, perhaps as a result of an honest mistake, regarding their having met as few as a single core measure and thereby risk the loss of all EHR incentive payments for a year. One option would be to assign points for meeting each measure (both core and menu) and provide incentives to those with at least some minimum number of total points. We recognize that this approach might still necessitate designating certain measures as mandatory. Another option would be to give EPs and EHs an opportunity to rectify certain types of problems found during an audit rather than face the loss of all EHR incentive payments for a given reporting period.
MU02	What is the best balance between ease of clinical documentation and the ease of practice management efficiency?	CHIME is concerned that unreasonable expectations regarding how much information healthcare professionals can capture as structured data will ultimately cause physicians to rebel against EHRs. It is simply unreasonable to expect busy physicians to document, in a structured way, huge numbers of data points during the course of their day-to-day management of patients.

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ID#	Question	CHIME Response
		We, therefore, urge policy makers to exercise reasonable restraint when crafting meaningful use requirements that have significant work flow implications.
MU03	To improve the safety of EHRs, should there be a MU requirement for providers to conduct a health IT safety risk assessment? Are there models or standards that we should look to for guidance?	CHIME believes it would be premature to impose a health IT safety risk assessment requirement at this time. We believe that doing so could have a chilling effect, since EPs and EHs are already challenged by other meaningful use requirements. We instead urge the Department to continue to pursue other initiatives, such as dissemination of best practices regarding HIT use, mining adverse event reports for useful information and making it easier for clinicians to report patient safety events and risks using EHR technology, incorporating safety into certification criteria for HIT products (as was done with the Stage 2 certification criteria relating to user-centered design and quality management systems), and funding relevant research and pilot projects. We believe these alternatives would be more fruitful in the near-term than imposition of yet another regulatory requirement.
MU04	Some federal and state health information privacy and confidentiality laws, including but not limited to 42 CFR Part 2 (for substance abuse), establish detailed requirements for obtaining patient consent for sharing certain sensitive health information, including restricting the recipient's further disclosure of such information. • How can EHRs and HIEs manage information that requires patient consent to disclose so that populations receiving care covered by these laws are not excluded from health information exchange? • How can MU help improve the capacity of EHR infrastructure to record consent, limit the disclosure of this information to those providers and organizations specified on a consent form, manage consent expiration and consent revocation, and communicate the limitations on use and restrictions on re-disclosure to receiving providers?	CHIME believes that all of this is made more complicated by the lack of consistent policies across the country with respect to patient consent and the exchange of information. We also believe that failure to share sensitive information could have very serious consequences for patient health and safety, especially if unaccompanied by some workable "break the glass" feature in emergency situations. There is also much uncertainty regarding the relative responsibilities of hospitals and HIEs (for example, with respect to redaction of patient records). We urge more study of how HIEs might efficiently handle sensitive patient data. The current limited nature of information sharing leaves many unanswered questions.

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ID#	Question	CHIME Response
	• Are there existing standards, such as those identified by the Data Segmentation for Privacy Initiative Implementation Guide, that are mature enough to facilitate the exchange of this type of consent information in today's EHRs and HIEs?	
MU05	The HITECH ACT has given a lot of emphasis to EHRs as the central distribution channel for health information, but there may be limits on how much we can add on to EHR technologies. As additional program demands are added onto EHRs, what can be done to foster innovation to share information and receive intelligence from other, non-EHR applications and services that could be built on top of that data architecture? For example, Is it possible to create an application programming interface (API) to make available the information defined in a CCDA so that systems can communicate it with each other? Is the information defined in the CCDA the appropriate content for other uses of clinical information? Are the standards used to communicate between EHR systems (e.g. Direct, Exchange) adequate for communication between EHRs and other kinds of systems? What other technologies, standards or approaches could be implemented or defined to facilitate the sharing of clinical knowledge between EHRs and other systems?	CHIME believes that it would make sense to provide for data analysis to occur external to the EHR rather than expecting the EHR to do all the work. We also believe that the standards used to communicate between EHR systems will not be adequate for communication between EHRs and other kinds of systems (e.g., payer systems, post-acute care providers, etc.). Ideally, at some point, it will be possible to extract data from EHRs and merge them with other sources of information but much more work is needed to permit this to be done efficiently and with adequate privacy protections.
MU06	What can be included in EHR technology to give providers evidence that a capability was in use during the EHR reporting period for measures that are not percentage based. This capability will need to support measures that	To begin with, CHIME believes that evidence expectations should be able to be satisfied by certified EHR technology, rather than expecting EPs and EHs to assemble proof independently and with little official guidance. In other words, if EPs and EHs are expected to show proof of some

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ID#	Question	CHIME Response
	occur in all stages of MU (e.g. there are yes/no measures in stage 1 that still need to be supported). Are there objectives and measures that should be prioritized to assist providers in showing that the capability was enabled during the reporting period?	functionality or activity during the course of an audit, that capability needs to be assured through EHR certification criteria. Further, we believe that policy makers need to be reasonable when setting evidence bars. For example, rather than expecting an EP or EH to be able to prove that some EHR functionality was enabled every single day of a reporting period, it would be more reasonable to expect them to be able to demonstrate evidence that the functionality was in regular use during the reporting period (such as through EHR-generated reports of the number of alerts/flags that occurred over various time intervals).

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Clinical Quality Measures

In addition to answering questions posed by the HIT Policy Committee regarding Stage 3 Measures and Objectives, CHIME also convened a working group to address the high-priority questions related to clinical quality measurement. We appreciate the questions put forward by the HIT Policy Committee and offer comments to several of them. While we tried to answer as many questions as possible, the short deadline, in conjunction with the holiday season, made full and complete responses difficult. Before turning to responses to individual questions, we would like to offer some general comments.

Over the past several years, the Centers for Medicare and Medicaid Services, the Office of the National Coordinator and other agencies inside the US Department of Health and Human Services has demonstrated an increasing ability to convene public and private sector stakeholders to harmonize disparate health IT system requirements, technical standards and disseminate best practices. Meaningful Use is, perhaps, the best example of such policy approaches. However, CHIME believes that such harmonization with regards to CQMs is overdue – and we believe that time is of the essence.

In several of our responses, we urge regulators to keep a few fundamental tenets in mind: Future measure sets should always tie back to care delivery quality and clinical efficacy; they should be expansive enough to allow clinical flexibility based on population characteristics; and regulators across federal, state, local and private sector reporting organizations should convene to understand what collection and reporting requirements will allow for optimal care quality improvement. We also wish to highlight, upfront, that even the most minute changes to specifications can present a tremendous workflow and monetary burden on providers; a sensible approach to future measure set development allows for evolution in technology in a way that minimizes such burdens on providers. Finally, we wish to reiterate that more does not equal better. Simply increasing the availability or, less preferably, the required number of CQMs will not lead to improved care quality. Instead, a concerted effort in the near-term should focus on improving data collection, abstraction and reporting on current generation CQMs.

We remain optimistic and excited about what the future state of quality measurement could look like. But it will require leadership across all levels of government and private sector stakeholders. CHIME is committed to being a resource and offers the following comments to the HIT Policy Committee Request for Comment.

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ID #	eCQM Questions	CHIME Response
QMWG01	As we propose to expand the features of the eCQM measure set, how can it be done in ways to minimize health care costs and reduces burden on health care providers?	CHIME believes there are a number of key tenets the HITPC should embrace in developing future eCQM measure sets. The measure set should be expansive enough to allow physicians flexibility in choosing the most relevant measure for their specialty; the measure set should be easily abstractable from both structured and unstructured documentation; the measure set should tie back to care delivery quality and clinical efficacy; the measure set should also be harmonized across reporting regimes, federal programs, state initiatives and, where possible, be concordant with private sector reporting organizations, such as the Joint Commission. It is important to recognize that more measures do not equate to improved quality of care and that developing the processes and technology to incorporate new measures into a clinical setting is expensive and time-consuming. Simply stated, data collected as the byproduct of usual care documentation is not data that is collected as the result of a added step/form that has no relevance to the care being delivered. CHIME believes rule-makers could strike the appropriate balance by taking an approach that first focuses attention on measures that are already collected and submitted by EHs (i.e. CMS Core Measures), and for EPs and smaller providers (i.e. PQRI, Health Resource and Services Administration's Core Clinical Measure set (http://www.hrsa.gov/healthit/coreclinicalmeasures.pdf). Rulemakers should consider how to incorporate quality measures already in use by all providers. Another source of potential measures currently in use could be obtained from a review of commercial measures will be important as many small and rural providers only report on what is required by the payers in their area. The main goal is to avoid redundancy of effort. Next, CHIME recommends that new measure sets be compared to the needs of specialists; if there is a gross deficit in a subspecialty, there should be a process to identify ways to supplement the measure set.

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ID #	eCQM Questions	CHIME Response
QMWG02	Furthermore, when considering the finite resources available to technology developers, what measures, types of measures or attributes of measures should be a high priority?	As was true for the key tenets mentioned in the first question, it will be important to focus measures on areas where structured code sets already exist and identify gaps. Careful attention should be paid to the prudency of expanding the required eCQM, for each new requirement depends on third party integration, which translates to more time and more complexity. Measures that are captured as the result of care delivery will be the most effective capture of data for use to measure opportunities for improvement of care. Fundamental to the application of clinical quality measurement is making sure the measure set describes levels of quality; CHIME believes there should not be a dilution of current provider efforts by adding more disparate measures. If the rules include too many measures, the risk increases that providers won't complete all of them. The focus should be on improving outcomes for current measures.
QMWG03	Are there innovations or technological capabilities for measure development or specification that the HITPC could support that would reduce the burden on technology developers?	We believe that the ripest place for innovation concerns the ability to abstract clinical quality data from unstructured documentation. As reporting burdens become greater and greater, there needs to be a shift to facilitate provider adoption and we believe unstructured documentation should be the primary focus. We are concerned that if we get to Stage 3 Meaningful Use and still cannot abstract information from unstructured data, we will have a significant problem. Technology related to natural language processing (NLP) and application program interfaces (APIs) seem to hold the most promise. While prominent in other sectors of the technology world, APIs are a nascent concept in healthcare. We also note that advances in NLP technology, as evidenced in a recent study on colonoscopy measures at the University of Pittsburgh (see http://www.ncbi.nlm.nih.gov/pubmed/22482913) could inform future innovations. We note, however, that NLP is in need of further development before it is integrated into EHRs, or even friendly to EHR integration. It will also be important for regulators to make sure that innovation does not move too far away from standardization. For example, there are no standards to describe severity of allergy reaction and that level of granular standard will need to be pervasive for real gains in quality to be made. Finally, we note that technologies that have the capability described above carries with it a significant price tag. We would suggest that regulators look for ways to propagate technical capabilities without tremendous cost.

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ID #	eCQM Questions	CHIME Response
		Clinical Intelligence leveraging algorithms can allow technology developers to extract relevant data from structured & unstructured documentation to reliably report on eCQM measures with high level of confidence. This exercise that combines analytics technologies well adopted in other industries (e.g. Retail) availed by industry vendors for many years and clinical logic structured by eCQM standards will allow care givers to offer care with confidence and lay a foundation for population quality measures with greater assurance.
QMWG04	Meaningful Use program has used menu objectives and menu CQMs to provide flexibility for providers. Should there be core CQMs for high priority health conditions, such as controlling hypertension?	CHIME does not recommend the development of a core set of CQMs focused on high priority health conditions. Flexibility, e.g. menu CQMs only, gives providers the ability to focus on their population and allows them to report on the issues that their populations are enduring. For example, while obesity is absolutely a priority condition for the nation and is important for primary care physicians to monitor, it has no significance for oncologists or oncology hospitals. The focus should always remain on care improvement for a clinician's population. While we understand the principle of comparability, we believe it would be counterproductive to develop core CQMs that all providers would need to abide.
QMWG05	How can the HITPC and QMWG capture input from a wide variety of providers, patients, organizations and societies?	HITPC and QMWG can capture input by holding town hall meetings and hearings; via Requests for Information (RFIs); or established forums such as NQF. The aim should be to get input from communities across the county with experience that is representative of America's healthcare landscape.
QMWG06	What additional channels for input should we consider?	You can consider the same methodologies that have been used to date. Web input through blogs, and the options listed in question 5.
QMWG07	Please comment with guidance on how consumer-reported data can be incorporated into CQMs. What examples are there of EHR-enabled quality measures that use data directly entered by patients?	We are not aware of any CQMs that currently, seamlessly integrate patient-generated data into EHRs as part of the measurement process. However, we do believe there exists a set of data that would have the highest chance of success. Discrete data that have a longtime history of patients self-reporting and have associated measures that are well defined should be the primary focus. Examples of such data include blood pressure readings, blood sugar levels, weight and waist size.

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		We believe that personal health records could be an appropriate mechanism to relay information, as well as patient portals. We can foresee opportunities in the future for patient-generated data to report the onset of symptoms, track progress (or lack thereof) across the care continuum and help describe post-care events. But we also note that attribution of data will be a central concern; making sure that patient- versus provider-generated data is identifiable is paramount. Increasingly, consumer technology – especially in the world of mobile applications – is expanding the world of patient-generated data. But we strongly urge regulators to be mindful of the difficulty associated with incorporating such patient-generated data directly into an EHR, as well as, the burdens to provider workflow. Before providers are burdened with patient-generated data, there should be significant evidence that the particular measure set improves quality. Demonstration projects in this arena are strongly encouraged.
QMWG08	Please provide examples of how patient-directed data is informing shared decision making. How does the public view the integration of EHR derived data with patient generated data for quality measurement? How important is it to keep this data separate? Should it be separate?	We understand that depending on how providers practice medicine, there is some division on the efficacy of integrating EHR derived data with patient-generated data for quality measurement. We do agree with the principle, however, that both patient-generated and EHR-derived data be maintained together – as long as the proper attribution of the data can be tagged. We believe there is additional work that needs to be done to accomplish the kind of tagging needed, as many tagging technologies are user interface dependent and archaic.
QMWG09	Please provide comment on how the HITPC should proceed with our focus on clinical outcomes. Should the HITPC focus its efforts on building point-of-care process measures or value-centered outcome measures?	CHIME believes this is a false dichotomy; we believe both are needed. Process measures get you to outcome measures, but current "outcome measures" do not accurately reflect true outcomes. We believe that process measures are needed to get to that intermediate measure, such as cholesterol level or weight, and outcomes (measured) are more reflective of longitudinal care. A complete understanding of the 'quality' of care requires both. In essence, it is recognized that all of the data required to determine an outcome is not currently in the CEHRT so we recommend an approach which builds from process measures to outcome measures to be required in the future.

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QMWG10	Is this a false or unnecessary dichotomy? Should we instead consider a third approach, to promote process-outcome measure "suites", combinations of end outcome measures that are potentially associated with process measures? For example, Stage 2 eCQM set will include three HIV measures. The outcome of viral load suppression is accompanied by two related process measures for an HIV medical visit and for Pneumocystis Pneumonia prophylaxis.	Yes, this is a false dichotomy; please see response to question 9.
QMWG11	Please comment on challenges and ambiguities in retooling legacy paper abstracted and claims based eCQMs.	CHIME believes it's not a matter of changing paper-based measures, but it's a matter of making that data available for electronic extraction. This will require the specifications for the data elements be standardized and available for inclusion in our current software products.
QMWG12	Is this a shift away from retooling legacy paper-based CQMs in exchange for designing CQMs de novo a reasonable course of action?	See response to QMWG11.
QMWG13	Please comment on the provider/payer/patient experience with using retooled measures as opposed to experience with de novo measures designed and intended for EHR-based measurement.	The critical issue in answering this question is simple. Today, providers are abstracting data both manually and electronically. This burden must be reduced by ensuring harmonization of data requirements for all required measures from the myriad of requesting agencies and organizations.

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QMWG14	Please comment on aligning CQMs with MU Objectives. Would eCQM-MU Objective alignment be clinically valuable to providers or might this be a redundant exercise in shifting resources?	CHIME not only recommends the alignment of CQMs with the MU Objectives but equally as important is the alignment of all measures required for quality reporting. The resource consumption of reporting on multiple measures detracts from the focus on using those valuable resources to focus on a unified set of measures designed to determine opportunities for quality of care improvement.
QMWG16	Which, if any, high priority domains should receive prioritized attention in Stage 3? What measure concepts, addressing these domains, should be considered for development? What EHR capabilities should be leveraged to realize these concepts?	CHIME assumes that the concept of high priority domains infers that those domains would supersede a more flexible approach for the EPs and EHSs. This response is similar to the discussion on OMWG04; we encourage regulators not do not narrowly define high priority domains, because not all specific conditions are priority for all EHs and EPs.
QMWG19	The QMWG has considered two approaches to institution-initiated eCQMs. A conservative approach might allow "Certified CQM Development Organizations", such as professional societies and IDNs to design, develop, release and report proprietary CQMs for MU. An alternate approach might open the process to any EP/EH but constrain allowable eCQMs with certain design standards. There are advantages and disadvantages to both. Please submit comments on either, both or unique approaches.	CHIME recommends the MU Stage 3 not engage in the development of new quality measures but instead relay on quality standards organizations for the development of new measures.

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QMWG23	For the existing and/or in the proposed expanded institution-initiated CQMs, how can federal agencies better support consistent implementation of measures for vendors and local practices (e.g., test case patients, template workflow diagrams, defined intent of measure and valueset)?	Federal agencies can better support consistent implementation of measures for vendors and local practices by giving clear standards and limiting the focus on the standards that already exist. CHIME requests that agencies harmonize data definitions.
QMWG24	Stage 3 may increase the number of measures EPs and EHs calculate and report. Considering provider burden, is there a limit to the number of measures that a provider should be expected to calculate? Is there evidence to support a limit?	CHIME believes no evidence exists for or against a limit to the number of CQMs EPs and EHs must calculate and report. We are not aware of verifiable evidence suggesting that ever-increasing numbers of CQMs improves quality of care. However, we do acknowledge the value that quality measures bring to bear on care outcomes. We, again, emphasize that additional burdens to the provider should be minimized. CHIME suggests as an alternative to increasing the number of required measures, a focus should be to help EHs and EPs do a better job with current measures. We believe it could be beneficial to explore a rewards program for providers who improve data for current measures. Another option would be to offer a menu set for those providers who demonstrate actual improvements in quality measurement.
QMWG25	Please comment on the value and feasibility of the eCQM and EHR features listed below: - Ability to accept downloaded specifications for new measures with little tailoring or new coding - Minimal manual data collection or manipulation - Ability to aggregate measure data to varying business units (practice, episode, ACO, medical home, MA plan, etc) - Ability to build measures that incorporate cross-setting records for episodes, medical homes, outcomes (e.g., readmissions) - Ability	Most, if not all of these abilities are ones that are technically feasible, however the increased resources needed – specifically the analytical software – is expensive and the availability of competent resources are clear challenges. This is particularly critical as we look to small hospital and small practice settings.

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	to build multi-source data records, including claims, patient reported data - Ability to implement machine-readable HQMF that minimizes manual vendor coding	
QMWG28	Please comment on the value and feasibility of the CQM Population Management Platforms. Is there an evidence basis for clinical population management platform use? Is there a business case? Is this an area that could benefit from HITPC policy guidance or will the market mature and evolve without input?	Given the immaturity of this market, CHIME believes it is better to let the market evolve without further federal involvement at this time. The technology is not currently available, and there would be additional cost.

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We hope the above comments are helpful. If there are any questions about our comments or more information is needed, please contact Sharon Canner at scanner@cio-chime.org or (703) 562-8834. CHIME looks forward to a continuing dialogue with the HIT Policy Committee, the Department of Health and Human Services, and other stakeholders regarding Stage 3 of EHR meaningful use and other important matters.

Sincerely,

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