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January 14, 2013

Farzah Mostashari, MD, ScM
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Re: Neurosurgery Response to HITPC RFI on Stage 3 Meaningful Use EHR Incentive Program

Dear Dr. Mostashari,

On behalf of the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS), we appreciate the opportunity to comment on the Health Information Technology Policy Committee's (HITPC) preliminary recommendations for Stage 3 of the Electronic Health Record (EHR) Incentive Program. Since the inception of HITPC's recommendation on meaningful use, neurosurgery has voiced its concern that the program is heavily geared towards primary care, which makes it extremely difficult for neurosurgeons and other specialists to qualify for the program. Neurosurgeons are currently working towards adopting and incorporating electronic health records (EHR) into their practices to improve quality of care, provider workflow, patient safety and efficiency. However, the overly ambitious and stringent requirements do not take into consideration some of the unique aspects of providing specialty care.

We recognize that Stage 2 did offer a "menu set" of meaningful use criteria, which included a few new objectives relevant to neurosurgery, such as a new objective that would give credit for reporting to a specialized clinical data registry. In addition, Stage 2 provided new exclusions for "core set" criteria that aimed to assist specialists like neurosurgeons with meeting certain objectives and measures that were considered overly challenging or even unattainable. Nonetheless, we continue to believe Stage 3 and future recommendations proposed by HITPC do not go far enough to accommodate specialty medicine.

The proposed meaningful use criteria do not offer a broad array of "menu options" that account for the wide variety of different specialty care patient populations and practices and how they may use health information technology to improve patient care. The increased thresholds for several of the objectives also pose a challenge for neurosurgeons. We understand the need for the program to progress, but for neurosurgeons the current thresholds are difficult to achieve due neurosurgery practice patterns and lack of vendor recognition of neurosurgical needs, including for e-prescribing and clinical decision support. **[*See* attached table for specific feedback]**

We are also greatly concerned that recommendations are being made without considering how providers, especially neurosurgeons and other specialists, have fared with meeting the criteria used in Stages 1 and 2 of the EHR Incentive Program. Information needs to be collected, through validated

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survey methodologies, on how providers are doing before making recommendations for new criteria or increasing reporting thresholds in Stage 3 or future iterations of the program.

Furthermore, we are concerned with the lack of progress and development of standards to support interoperability. Interoperability is the key to transforming the country's healthcare system. It will make the difference between static and robust uses of EHR and successive health information exchange.

Alignment with CMS' Various Quality Improvement Programs

Neurosurgery has continually called for the ability of providers, especially specialists, to use a single set of criteria that simultaneously satisfies the reporting requirements of multiple CMS quality improvement programs. Although CMS is working with the Office of the National Coordinator (ONC) to better align the EHR Incentive Program with others, such as the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBPM) and shared savings programs, these programs continue to have overlapping and conflicting reporting requirements. Furthermore, the alignment that has begun to occur is not applicable to neurosurgery due to the lack of relevant measures and reporting requirements. In order to ensure robust compliance and reduce the reporting burden on specialists, it is extremely important for alignment to occur with the various government-sponsored quality improvement programs. This is particularly important given many of these overlapping programs will become punitive in future years, based on data collected in the current year. We therefore encourage the HITPC, ONC and CMS to continue collaborating on efforts to accomplish this goal.

*M**eaningful Use Quality Requirements***

Currently, the various quality programs generally produce little meaningful data. They also have yet to demonstrate improved patient outcomes. Organized neurosurgery therefore believes that prospective, systematic tracking of practice patterns and patient outcomes is the most effective mechanism by which physicians, including neurosurgeons, can improve the quality, efficiency and ultimately, the value of care. Specialists – including neurosurgeons -- are finding the profound value in reporting to, and retrieving data from, clinical data registries specific to their specialty and/or the diseases and conditions that they manage. These clinical data registries have been shown to be particularly useful in improving patient care and outcomes, encouraging clinicians to reflect upon their care and utilization patterns. The AANS, in cooperation with a broad coalition of other neurosurgical societies including the CNS, Society of Neurosurgical Surgeons (SNS), and American Board of Neurological Surgeons (ABNS), have created the National Neurosurgery Quality and Outcomes Database (N^2QOD). The N^2QOD is a comprehensive patient care registry program that was formed with the aim of measuring the real-world safety and quality of neurosurgical and spine-surgery care. The N^2QOD places a significant emphasis on patient reported outcomes, an essential quality factor that is not generally captured in the traditional medical record.

Comprehensive registry data can be used to develop specialty-specific quality and outcomes measures that will be more meaningful than current "check box" measures contained in the EHR Incentive Program. The current "one-size-fits-all" approach does not promote meaningful quality improvement in neurosurgery. Relevant tools for measuring quality and outcomes vary significantly between primary care and surgical specialties. This "patient-centered" approach is also aligned with the priorities of groups such as the Patient-Centered Outcomes Research Institute (PCORI), the Agency for Healthcare Research and Quality (AHRQ) and the Department of Health and Human Services' triple aim: care, health, and cost. Additionally, this emphasis reflects a wider trend in quality improvement (QI) science towards patient oriented outcomes measures and away from process

based measures. We encourage HITPC and CMS to continue to look for ways to better recognize those who engage in robust data collection supported by clinical data registries. The HITPC can also play a greater role in facilitating the use of clinical data registries by encouraging and developing standards for the interoperability between EHRs and registries. Presently, practices are forced to manually enter data into a registry due to no streamlined process existing and the proprietary nature of HIT products. This existing data sharing process is particularly challenging for solo and small practices; thus preventing many from participating in clinical data registries because manual data entry requires a full-time or half-time employee, which is a cost that they cannot easily absorb.

As an aside, to date, organized neurosurgery has not yet developed specialty-specific quality and outcomes measures for public-reporting programs such as for meaningful use or PQRS. The primary deterrents to creating these measures have been the significant costs associated with measure development using prevalent methodologies and a lack of high-level data to support specific process measures in our specialty. We are, however, committed to improving neurosurgical quality and outcomes, as stated above, through the collection of clinical and other patient data through a registry mechanism, which we believe to be a more cost effective and clinically relevant approach to quality improvement. We invite you to visit the N2QOD website for more information at: http://bit.ly/TaPMWc.

Proposed Stage 2 Objectives and Measures

Please see attached table for specific comments on individual objectives within the RFI.

Conclusion

The AANS and CNS thank HITPC for the opportunity to comment and welcome the opportunity to work with HITPC, CMS and ONC to ensure the Stage 3 meaningful use recommendations are applicable to neurosurgery. We hope HITPC seriously considers our feedback and are encouraged by efforts to incorporate more relevant criteria for specialists in the draft recommendations. By working together, the program can advance EHR adoption and ensure successful neurosurgery participation in the Medicare and Medicaid EHR Incentive programs.

Sincerely,

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ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/ Comments	Neurosurgery Comments
Improving quality, safety, and reducing health disparities					
SGRP 101	**Eligible Provider (EP)** **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 **Eligible Hospital (EH)** **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 **EP/EH Measure:** More than 60 percent of medication, We see percent of laboratory, and 30 percent of 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.	**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	Seeking externally maintained list of DDIs with higher predictive value		• Concern about increasing the threshold since many EPs still find CPOE use challenging • Exemptions needed for EPs who work in regions where HIT adoption by labs, pharmacies and radiology facilities is low. • While the objective recognizes "professionals who can enter orders into the medical record per State, local and professional guidelines," we request that the measure itself more specifically recognize "permissible" prescriptions in its definition of medication orders since e-prescribing could be considered a CPOE function, which could pose a problem for those unable to e-prescribe controlled substances due to state/local laws. • Ensure that EPs can satisfy threshold using CPOE for any combination of events (e.g., medication, lab OR radiology).

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		guidelines produced by the S&I Framework Initiative.			
SGRP 130	**New**	**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. **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.			Would orders simply have to be recorded or actually transmitted? If the latter, these capabilities may not be available by Stage 3. Health information exchange remains a significant challenge and measures requiring transmission of information should be deferred or offered only as a menu item until these capabilities are established, well tested, and widely incorporated into EHR systems.
SGRP 103	**EP/EH Objective:** Generate and transmit permissible prescriptions electronically (eRx) **Measure:** More than 50% of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT. **EH MENU Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx) **EH MENU Measure:** More than 10 percent of hospital	**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	Advanced medication reconciliation to check for formulary compliance. Medication formulary checking: • If Rx is formulary-compliant, transmit to pharmacy. • If Rx is not formulary compliant, prescriber presented with alternatives (if available through formulary database) or provided a structured prior-authorization form to complete before Rx transmitted. Capability for automatic approval	How to include formulary checking into EHR and connection to formulary sources (e.g., PBMs)?	• We support maintaining the 50% threshold since formulary information is not always available, up-to-date or reliable. • The measure should define "permissible prescriptions" and ensure that controlled substances, or any other drug that cannot be e-prescribed due to local, state, or federal laws, is not included in this definition. • Similarly, this measure should recognize that those who qualify for any of the exemptions under the e-Prescribing Program would be automatically exempt from this measure. • To ensure feasibility, it is critical that vendor certification criteria include a mechanism by which EPs can access formularies before this feature is made a requirement of the Stage 3 measure.

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	discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology	transmitted electronically using Certified EHR Technology	of prior-auth should be available.		
SGRP 104	**EP Objective: Record the following demographics** • Preferred language • Sex • Race • Ethnicity • Date of birth **EH Objective: Record the following demographics** • Preferred language • Sex • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.	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		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.	• Support retiring for Stage 3.

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SGRP 105	**Consolidated in summary of care objective** Maintain an up-to-date problem list of current and active diagnoses	**Certification criteria:** EHR systems should provide 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.	Patient input to reconciliation of problems	The implementation of these criteria will assist in achieving the CDC's goal of using EHR technology features to identify patients meeting criteria for hypertension who are not yet diagnosed and managed for the disorder. How to incorporate into certification criteria for pilot testing? The intent is that EHR vendors would provide functionality to help maintain functionality for active problem lists, not that they supply the actual knowledge for the rules.	• Support new certification criteria/functionality for Stage 3. • If patient input is added as a functionality in future years, it should be used to supplement the medical record and better inform clinical decision making. It should NOT be used as the basis of determining physician accountability, since EPs do not have direct control over patient actions.
SGRP 106	**Consolidated with summary of care -** Maintain active medication list	**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,	**Certification criteria:** Use other EHR data such as medications filled or dispensed, or free text searching for medications to support maintenance of up-to-date and accurate medication lists.	How to incorporate into certification criteria for pilot testing? The intent is that EHR vendors would provide functionality to help maintain functionality for	• Support this functionality and recommend that it be incorporated into certification criteria as soon as possible. • Certification criteria should eventually also include the ability for an EHR system to access pharmacy systems and other databases so that EPs can see a complete list of Rxs filled by the patient/prescribed by other clinicians. We recognize this may be challenging given interoperability and patient privacy issues, but we encourage the HITPC to work toward the goal of

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		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.		active medication lists, not that they supply the actual knowledge for the rules.	helping EPs access a complete picture of a patient's care.
SGRP 107	**Consolidated with summary of care -** Maintain active medication allergy list	**Certification criteria:** EHR systems should provide functionality to code medication allergies including its related drug family to code related reactions.	Contraindications that could include adverse reactions and procedural intolerance.	The intent is that EHR vendors would provide functionality to help maintain functionality for active medication allergy lists, not that they supply the actual knowledge for the rules.	• Support this functionality and encourage the HITPC to make this a requirement for certification as soon as possible.
SGRP 108	**Objective: Record and chart changes in vital signs:** • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.	• Support retiring for Stage 3.

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	(for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data				
SGRP 109	**EP/EH Objective:** Record smoking status for patients 13 years old or older **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.	• Support retiring for Stage 3.
SGRP 112	**EH MENU Objective:** Record whether a patient 65 years old or older has an advance directive **EH MENU 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.	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.			• Support for maintaining this important measure.

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SGRP 113	**EP/EH Objective:** Use clinical decision support to improve performance on high-priority health conditions **Measure:** 1. Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. 2. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	**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 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-	**Certification criteria:** Explore greater specificity for food-drug interactions *Procedure/Surgery/lab/radiology/test prior authorization v.A*: for those procedures/surgeries/lab/radiology/test with clear and objective prior authorization requirements and a structured data prior authorization form is available, clinician fill out the prior authorization form using structured data fields and prior authorization can be granted electronically and in real-time by the payor. *Procedure/Surgery/lab/radiology /test prior authorization v.B*: for those procedures/surgeries/lab/radiology/test, for which prior authorization is non-standardized and is highly individualized, a standardized form is created that collects from the clinician text fields answering an agreed upon set of medical necessity questions, standardized form is sent electronically to insurer for review, insurer responds with Approval/Denial (with rationale if denied) using a standardized format text	Ability for EHRs to consume CDS interventions from central repositories. The EHR would query (via web services) available databases to identify "trigger event" conditions (e.g., case reporting criteria, drug-drug interactions, potentially relevant trials) based on the patient's health condition, diagnoses, location, and other basic facts. The HITPC is interested in experience from payors that may contribute to CDS.	• Support the value of CDS, but express serious concern about the burden of increasing the threshold three-fold (from 5 in Stage 2 to 15 in Stage 3). • Encourage evaluation of implementation/effectiveness of this measure in earlier stages before increasing reporting threshold in Stage 3. • We have serious concerns with specialists being able to meet the measure due to the lack of available CDS for neurosurgeons. Most EHRs, for example, do not have a neurosurgery template or module so there is no way to determine the interventions to be presented through EHR technology. Similarly, using the EHR to generate preventative care prompts is usually irrelevant to specialty care and mostly geared towards primary care. Physicians should not be forced to implement low level CDS that is not meaningful to their practice to meet the objective. N/C

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		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.	document back to clinician with either approval and/or denial with rationale.		
SGRP 114	**EP/EH Objective:** Incorporate clinical lab-test results into Certified EHR Technology as structured data **Measure:** More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23	**Objective:** Incorporate clinical lab-test results into EHR as structured data **Measure:** More than 80 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results			-Oppose increasing threshold since standards to facilitate incorporation of this data have not yet been established and data regarding provider experiences using this measure have not yet been considered. -Certification criteria should also require that EHR systems provide access to other lab systems/databases so that EPs can access a complete picture of other lab tests/results ordered by other clinicians. We recognize the challenges associated with accessing such information, but still encourage the HITPC to work toward this goal.

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	during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data	are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data			
SGRP 115	**EP CORE Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach **EP CORE Measure:** Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.	**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.			• It is unclear how many "lists" would be required under this modified objective. • Recommend that lists be held to a minimum and that EPs have flexibility to select type of lists most relevant to their practice. • Request exclusions for those subspecialties that treat only a few conditions. • Certification criteria needs to first incorporate the functionality to quickly generate these lists and dashboards. • Caution against proceeding with this functionality until ICD-10 has been fully implemented. Generating these lists in the midst of the ICD-10 transition would be very complicated.
SGRP 116	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder per patient preference. **Measure:** More than 10% of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per	**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			• Exclusions should be provided for not only preventive care reminders, but also follow-up reminders since these are not necessarily applicable to specialists and procedure-concentrated specialists-who treat acute conditions. Exclusions should also account for patients that do not provide a preference.

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	patient preference when available	reminders (could be more condition specific).			
SGRP 117	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** More than 10 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.	**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 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.			N/C
SGRP 118	**MENU Objective: I**maging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **MENU Measure:** More than 10 percent of all tests whose result is one or more images 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	**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		What barriers could be encountered in moving this to core?	• Express support for the value of including this functionality, but neurosurgery recommends that this measure remain in the menu set since vendors continue to face challenges with this functionality and it was new for Stage 2 so evaluation needs to be made. ONC should instead focus efforts on developing standards to facilitate the exchange of radiology information prior to recommending the migration of this measure to the core set. • We understand the intent of the measure, but the threshold is too high. The pure volume of data that will be required to be stored for radiology orders requires tripling practices storage servers to hold all the data images. • We also do not support the proposal that 10 percent of all scans and tests whose result is one or more images ordered by the EP during the EHR reporting period and accessible through Certified

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	Certified EHR Technology.				EHR Technology be exchanged with another provider of care. The images that are created may not be accessible due to the system of the EP or other health care provider who creates the images. It would be burdensome for the ordering EP to figure out which other providers have the ability to receive the images electronically since secure health information exchanges and interfaces do not readily exist. Furthermore, in some specialties, such as neurosurgery, often there is not another physician involved in the care so the necessity to exchange is not there.
SGRP 119	**MENU Objective:** Record patient family health history as structured data **MENU Measure:** More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives	**CORE Objective:** Record high priority family history data **CORE Measure:** Record high priority family history in 40 percent 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).			We support the importance of this data, but make an overall request that thresholds not be increased and that measures not be moved to the core set until CMS first evaluates provider experiences with measures during earlier stages.
SGRP 120	**EP/EH MENU Objective:** Record electronic notes in patient records **EP MENU Measure:** Enter at least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of unique patient office visits. Notes must be text-searchable. Non-searchable scanned notes do	Record electronic notes in patient records for more than 30 percent of office visits within four calendar days.			Support maintaining this measure as part of the menu set.

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	not qualify but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure. **EP MENU Measure:** Enter at least one electronic progress note created, edited, and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable, scanned notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure.				
SGRP 121	**EH MENU Objective:** Provide structured electronic lab results to ambulatory providers **EH MENU Measure:** Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of	**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.			N/C

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	electronic lab orders received				
SGRP 122	**NEW**	**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 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			• Express overall support for this measure pending the development of appropriate certification criteria to ensure this functionality. • Since this is a new measure, recommend that it be added to the menu set (not the core set). • Request clarification on how HITPC would define "acknowledged."
Engage patients and families in care					
SGRP 204A	**EP Objective:** Provide patients the ability to view online, download, and transmit (VDT) their health information within 4 business days of the information being available to the EP. **EP Measure:** 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold	• EPs should make info available within 24 hours if generated during course of visit • 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	Building on Automated Transmit: 1a. Create the ability for providers to review patient-transmitted information and accept updates into EHR. 1b. Related certification criteria: Standards needed for provider directories in order to facilitate more automated transmissions per patients' designations.	Explore the readiness of vendors and the pros and cons of including certification for the following in this objective: • Images (actual images, not just reports) • Radiation dosing information from tests	• CMS has released data showing that patients are not accessing their health information to the extent desired by federal agencies. Furthermore, neurosurgeons continue to have concerns about being held accountable for actions outside their direct control. While it is reasonable to hold neurosurgeons accountable for making information available to patients, it is unreasonable to hold neurosurgeons accountable for actions taken voluntarily by the patient. • HITPC needs to evaluate the reasonableness and burdensome nature of the 24-hour turnaround time required by this measure prior to moving from 4-business days to 24-hours. Physicians already follow standards for communicating medical information to patients and know best how the patient will accept and react to the information, etc. Therefore, physicians should

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	certain information. 2. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information. **EH Objective:** Provide patients the ability to view online, download, and transmit information about a hospital admission 1. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge 2. More than 5 percent of all patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period.	**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,		involving radiation exposure in a structured field so that patients can view the amount of radiation they have been exposed to Add a MENU item to enable patients to view provider progress notes (re: Open Notes: Doctors and Patients Signing On. *Ann Intern Med*. 20 July 2010;153(2):121-125)	have the ability to make these decisions based on the physician-patient relationship. The volume of patient information that has to be made available within 24-hours for the entire calendar year would be extraordinary for most practices and their staff to manage. This rigid measure does not take into account the realities of running a practice. Technological glitches, staffing shortages due to vacations, holidays, and other unforeseen circumstances that occur throughout the calendar year and could cause a delay in providing the patient information within the required time frame. While patients deserve full access to their medical record, the HITPC must balance the need for informed decision-making with the risk of overloading patients with too much information or information that is too technical and will simply confuse the patient. Seek clarification regarding this suggested menu item. Was this functionality not included as part of the original measure? What functionalities were included in earlier stages to ensure that patients could view/download/transmit this information?

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		in addition to considering public comments received.		What is the best way to ensure that individuals who access their health information through the view/download/transmit capability are provided with transparency and education about the benefits and potential risks of downloading health information, consistent with the HIT Policy Committee's recommendations of August 16, 2011? Is certification an appropriate vehicle for ensuring such transparency is part of CEHRT? If so, what would the certification requirement look like? If not, what are other mechanisms for ensuring transparency to consumers using the view/download/transmit capabilities?	Perhaps recommend a "pop-up" disclaimer, as has been recommended In the past for patients trying to access data on CMS' Physician Compare web site.

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				In its recent final rule, and in response to comments, ONC adopted Level A conformance as the standard for the accessibility web content in accordance with the Web Content Accessibility Guidelines (WCAG). ONC indicated per commenter's suggestions that WCAG Level AA conformance would be considered for the next edition of certification criteria. Given that all EHR technologies certified to the view, download, transmit to a 3rd party certification criterion will have met Level A, how difficult would it be for EHR technology to have to meet Level AA conformance?	N/C

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SGRP 204B	**New**	**MENU:** Provide 10% of patients with the ability to submit patient-generated health information to improve 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.		Readiness of standards to include medical device data from the home? What information would providers consider most valuable to receive electronically from patients? What information do patients think is most important to share electronically with providers? How can the HITECH incentive program support	• Express appreciation for this measure, but caution that current standards to facilitate such data capture are not yet available/have not yet been adequately tested. • Express concern about challenges of collecting patient generated notes in a standardized manner. • Also express concern about the availability of validated tools for capturing this type of patient-generated health information in an electronic environment. Survey instruments that have been validated to capture information through other media (paper, mail, phone, in-person survey) may not be validated for use in the electronic environment. • If this measure is adopted, it should include appropriate exclusions to account for situations when such data collection is not relevant to a practice or when they are already collecting such information through a separate practice website or patient portal that is not able to synch with the EHR. It should also be part of the menu set and should only assess whether the patient was provided with the ability to submit such data and not whether the patient actually took action since that is beyond the control of the EP.

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				allowing doctors and patients to mutually agree on patient-generated data flows that meet their needs, and should the functionality to collect those data be part of EHR certification? Please provide published evidence or organizational experience to support suggestions.	
SGRP 204D	**New**	**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.			Request additional clarification on this objective, particularly the definition of "an obvious manner."
SGRP 205	**EP Objective:** Provide clinical summaries for patients for each office visit **EP Measure:** Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits.	The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.		What specific information should be included in the after visit summary to facilitate the goal of patients having concise and clear access to information about their most recent health and care, and understand what they can do next, as well as when to call the	• Request clarification on to what extent summary needs to be "pertinent to office visit." Also, what needs to be included, contained and what constitutes an adverse event. • Seek clarification on whether the 1 business day is maintained. If so, it is still problematic. We are supportive of physicians providing patients with clinical summaries, but the 24 hour timeline is not realistic. Turn-around time for dictations may require greater than 24 hours of time and will be difficult to reach, unless the summary is not reconciled and will likely be useless summation complied solely from the EHR. Care plans and complete dictation in a surgical practice usually happen after the patient leaves and the chart

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				doctor if certain symptoms/events arise?	note is completed.
SGRP 206	**EP/EH Objective:** Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient **EP CORE Measure:** Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period **EH CORE Measure:** More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology	**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.			• Express concern about the financial burden of requiring that this information be translated into 5 non-English languages. Will the functionality to accomplish this be included in the certification requirements for the EHR? If not, who is responsible for funding the translation? • Educating the patient on the treatment or disease for the encounter is important, but it should be at the discretion of the EP to determine which resources are best suited for the patient and if they are needed. The EHR should not be dictating the resources the physician chooses to provide to the patient. The addition of this feature will be an additional cost to the provider as educational resources associated with the EHR are typically add-on features.
SGRP 207	**EP Objective:** Use secure electronic messaging to communicate with patients on relevant health information **EP Measure:** A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of	**Measure:** More than 10 percent* of patients use secure electronic messaging to communicate with EPs	Create capacity for electronic episodes of care (telemetry devices, etc.) and to do e-referrals and e-consults	*What would be an appropriate increase in threshold based upon evidence and experience?	• Grave concern over the proposal to increase this threshold and to maintain it as a core measure. • Again, EPs should not be held accountable for actions beyond their control. EPs are already deferring patient engagement objectives due to related challenges. • Request clarification on the meaning and intent of the recommendation to create capacity for e-episodes of care, e-referrals and e-consults. How would this differ from the functionalities currently being built into CPOE systems? HITPC should also

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	unique patients (or their authorized representatives) seen by the EP during the EHR reporting period				take into consideration the fact that consults are no longer payable under Medicare, nor are e-visits reimbursed. • In satisfying the requirement of this measure, EPS should be able to indicate that a patient did not express a particular preference despite outreach.
SGRP 208	**Not included separately (in reminder objective)**	**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, reminders for follow up and preventive care, referrals, after visit summaries and test results).			
SGRP 209	**New**	**Certification Criteria:** Capability for EHR to query research enrollment systems to identify available clinical trials. No use requirements until future Stages.		The goal of this objective is to facilitate identification of patients who might be eligible for a clinical trial, if they are interested. The EHR would query available clinical trial registries and identify potentially relevant trials based on patient's health condition, location, and other basic facts. Ultimately, the EHR would not be able to determine final eligibility for the trial; it would only be able to identify	Express support for this functionality by Stage 3, and for the recommendation that use requirements not be considered until future stages.

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				possibly relevant trial opportunities.	
			Improve Care Coordination		
SGRP 302	**EP/EH CORE Objective:** The EP/EH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. **EP/EH CORE Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than 50% 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)	**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).	Reconciliation of contraindications (any medical reason for not performing a particular therapy; any condition, clinical symptom, or circumstance indicating that the use of an otherwise advisable intervention in some particular line of treatment is improper, undesirable, or inappropriate) **Certification Criteria:** Standards work needs to be done to support the valuing and coding of contraindications.	Feasibility to add additional fields for reconciliation e.g. social history? Is anyone currently doing reconciliation outside of meds, med allergies, and problems and what has the experience been?	Oppose any changes to this objective until data on provider experiences from prior stages of meaningful use are available, analyzed, and demonstrate that providers are ready for such changes.
SGRP 303	**EP/EH CORE Objective:** The EP/EH/CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides summary care	**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		*What would be an appropriate increase in the electronic threshold based upon evidence and experience?	Oppose increasing this threshold until standards to support health information exchange are available and until more provider experience data is collected and evaluated.

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	record for each transition of care or referral. **CORE Measure:** 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. 2. The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. 3. An EP, eligible hospital or CAH must satisfy one of the two following criteria: (A) conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure	Provide a summary of care record for each site transition 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 (**D**irect care provision, **E**motional support, **C**are coordination, **A**dvocacy, and **F**inancial)) **Measure:** The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (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			

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	2" (for EPs the measure at §495.6(j)(14)(ii) (B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was developed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or (B) conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.	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 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)			

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SGRP 304	**New**		**EP/ EH / CAH Objective:** EP/ EH/CAH who transitions their patient to another site of care or refers their patient to another provider of care For each transition of site of care, provide the care plan information, including the following elements <u>as applicable:</u> •Medical diagnoses and Stages •Functional status, including ADLs •Relevant social and financial information (free text) •Relevant environmental factors impacting patient's health (free text) •Most likely course of illness or condition, in broad terms (free text) •Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver •The patient's long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals •Specific advance care plan (Physician Orders for Life-Sustaining Treatment	How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care, and includes the patient and their non-professional caregivers? Interested in experience to date and the lessons learned. Think through these priority use cases: 1. Patient going home from an acute care hospital admission 2. Patient in nursing home going to ED for emergency assessment and returning to nursing home 3. Patient seeing multiple ambulatory specialists needing care coordination	• Support electronic shared care planning and collaboration tools as a longer-term goal so long as exclusions are included and appropriately account for circumstances beyond a physician's control. • HITPC must also recognize that this measure will be costly to comply with due to the additional staff time needed to comply with the additional data collected. • For most neurosurgeons, their dominant referral to another provider of care is a facility for surgery.

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			(POLST)) and the care setting in which it was executed. For each referral, provide a care plan if one exists **Measure:** The EP, eligible hospital, or CAH that transitions or refers their patient to another site of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver. **Certification Criteria:** Develop standards for a shared care plan, as being defined by S&I Longitudinal Coordination of Care WG. Some of the data elements in the shared care plan overlap content represented in the CDA. Adopt standards for the structured recording of other data elements, such as patient goals and related interventions.	with primary care 4. Patient going home from either hospital and / or nursing some and receiving home health services What are the most essential data elements to ensuring safe, effective care transitions and ongoing care management? How might sharing key data elements actually improve the communication? Consider health concerns, patient goals, expected outcomes, interventions, including advance orders, and care team members. What data strategy and terminology are required such that the data populated by venue specific EHRs can be exchanged. How might existing terminologies be	

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				reconciled? What are the requirements (legal, workflow, other considerations) for patients and their identified team to participate in a shared care plan? Is it useful to consider role-based access as a technical method of implementing who will have access to and be able to contribute to the care plan? How will such access be managed?	
SGRP 305	**New**	**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	Continue working to close the loop with an acknowledgement of order receipt and tracking for completion.	The HITPC would appreciate comments on the return of test results to the referring provider.	While "closing the referral loop" is important, this would be more appropriate for future stages of MU when interoperability standards and certification criteria have been tested and are in place.

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		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)			
SGRP 127	**New**	**New**	Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care		Support
SGRP 125	**New**	**New**	Medication reconciliation: create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring)		Support, as noted earlier, and encourage the same for laboratory and imaging systems/databases, as well.

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			Vendors need an approach for identifying important signals such as: identify data that patient is not taking a drug, patient is taking two kinds of the same drug (including detection of abuse) or multiple drugs that overlap. **Certification criteria:** EHR technology supports streamlined access to prescription drug monitoring programs (PDMP) data. For example: ▪ Via a hyperlink or single sign-on for accessing the PDMP data ▪ Via automated integration into the patient's medication history Leveraging things like single sign on or functionality that could enable the linkage between PDMPs and prescribers and EDs?		
SGRP 308	**New**	**EH Objective:** The EH/CAH will send electronic 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			It is unclear which EPs would be held accountable under this measure. It seems it would disproportionately affect some types of providers over others.

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		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.			
Improve population and public health					
SGRP 401A	**EP/EH Objective:** Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	**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	**EP/EH Objective:** Add submission of vaccine contraindication(s) and reason(s) for substance refusal to the current objective of successful ongoing immunization data submission to registry or immunization information systems.		• Since the proposed Stage 3 objective transitions from capability to *submit* immunization data to capability to *receive* such data, it is critical that certification criteria first ensure this modified function before holding EPs accountable. • Also critical that exclusions be maintained.

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SGRP 401B	**New**	jurisdictions where immunization registries/immunization information systems cannot 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. **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			Would it be the responsibility of the EP or the EHR vendor? It would be reasonable to expect the EP to access and consider recommendations before giving an immunization, but actually implementing such a system seems like a large responsibility for the EP.

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		age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.			
SGRP 402A	**EH Objective:** Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice **Measure:** Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period.	**EH Objective (unchanged):** No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system			N/C
SGRP 402B	**New**	**New**	**EP Objective:** Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice. **Measure:** Attestation of submission of standardized initial case reports to public health agencies on 10% of all reportable disease or conditions during the entire		Support as a menu set option for future stages of MU so long as it includes exclusions to protect EPs for which this is not relevant.

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			EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit. Could similar standards be used as those for clinical trials (SGRP209)?		
SGRP 403	**EP MENU Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice **EH Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing submission of electronic syndromic	No change from current requirements.			Support maintaining this menu objective so long as there is accompanying certification criteria to ensure this functionality, as well as appropriate exclusions for those who lack the capability to exchange this information and for those to which this measure is simply not relevant.

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	surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period				
SGRP 404	**EP only MENU Objective:** Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period	**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			Support maintaining this in the menu set, but seek additional guidance on how EPs can implement this objective. Also recommend that this measure include appropriate exclusions that not only account for lack of capability to exchange this information, but also for physician practices to which this measure is simply not relevant.

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		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			
SGRP 405	**EP only MENU Objective:** Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period	**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 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			• Express strong support for this objective/measure so long as this functionality is built into EHRs by Stage 3 and so long as the measure includes appropriate exclusions that not only account for lack of capability to exchange this information, but also for physician practices to which this measure is not relevant. • We cannot overemphasize the need for interoperability standards to facilitate exchange of data between EHRs and registries, Currently, physicians must manually enter data from EHRs into registries due to the lack of a streamlined/standardized process and the proprietary nature of HIT systems. Standards need to be in place and required as part of federal certification criteria before this measure can be implemented • Clarify terms "jurisdictional, professional or other aggregating resource." Is HITPC referring to actual clinical data registries here (e.g., a specialty society sponsored registry) or ACOs and HIEs? These are considerably different.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/ Comments	Neurosurgery Comments
		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.			
SGRP 407	**New**	**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			Support as a menu set option so long as functionalities are available and appropriate exclusions included.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/ Comments	Neurosurgery Comments
		practice. **Certification criteria**: EHR is able to send a standard HAI message to NHSN, maintain an audit and track total number of reports sent.			
SGRP 408	**New**	**New**	**EH/EP Objective:** Capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. **Measure:** Attestation of successful electronic transmission of standardized adverse event reports to the FDA/CDC from the Certified EHR Technology. Total numeric count (null is acceptable) of adverse event reports from the EH/EP submitted electronically 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 send a standardized adverse event report message to FDA/CDC and maintain an audit of those reports sent to track		• Support as a menu set measure in future years when this functionality has been developed and tested and so long as appropriate exclusions are included • Also question the readiness of FDA to collect this data from EHRs directly, given the fact that the Unique Device Identification (UDI) system has yet to be finalized.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/ Comments	Neurosurgery Comments
			number of reports sent (Common Format).		
			Information Exchange		
IEWG 101	**New**	**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		Should the measure for this MENU objective be for a number of patients (e.g.25 patients were queried) or a percentage (10% of patients are queried)?	• Express support for concept, but given the complex systematic requirements regarding patient authorizations, etc., perhaps this should be delayed until after Stage 3. • When it is implemented, it would seem more logical to base it on percentages of transitioned patients without a care summary that were queried rather than a set number of such patients since this number will vary from practice to practice.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/ Comments	Neurosurgery Comments
		demographics and other available identifiers, as well as the requestor and purpose of request. b) Query for a document list based on 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). 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		What is the best way to identify patients when querying for their information?	Based on HIE discussions the top fields should be name, DOB, SSN, Age, Sex, perhaps a city. However, using SSN to identify a patient is not the most secure and something medicine should be moving away from.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/ Comments	Neurosurgery Comments
		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	**New**	**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).		Are there sufficiently mature standards in place to support these criteria? What implementation of these standards is in place and what has the experience been?	While an admirable goal, it's unclear what HITPC envisions in terms of future objectives/measures.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	HITPC Questions/ Comments	Neurosurgery Comments
IEWG 103	**Certification criteria**: Enable a user to electronically create a set of export summaries for all patients in EHR technology formatted according to the standard adopted at § 170.205(a)(3) that represents the most current clinical information about each patient and includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): (i) *Encounter diagnoses.* The standard specified in § 170.207(i) or, at a minimum, the version of the standard at § 170.207(a)(3); (ii) *Immunizations.* The standard specified in § 170.207(e)(2); (iii) Cognitive status; (iv) Functional status; and (v) *Ambulatory setting only.* The reason for referral; and referring or transitioning provider's name and office contact information. (vi) *Inpatient setting only.* Discharge instructions.			What criteria should be added to the next phase of EHR Certification to further facilitate healthcare providers' ability to switch from using one EHR to another vendor's EHR?	Recommend that ONC work to ensure there are interoperability standards and that they are incorporated into the certification criteria.

Additional Questions from the HITPC

ID#	Questions	Neurosurgery Comments
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?	Recommend that menu options exceed core requirements, which would allow practices to choose which functionality are most meaningful and actionable to improving quality and efficiency in their patient population and practice.
MU02	What is the best balance between ease of clinical documentation and the ease of practice management efficiency?	
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?	Recognize the work/progress of private sector groups and the ONC.
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? • 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?	N/C
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	

ID#	Questions	Neurosurgery Comments
	EHRs and other systems?	
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 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?	Recommend that ONC certification require all EHRs to have clearly formatted dashboards and reminders to make it easier for users to monitor their compliance with meaningful use. Reports should be easy to run and review.

I. Quality Measures

ID #	Questions	Neurosurgery Comments
QMWG 01	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?	Standardizing certain aspects of EHR templates across EHR systems and pushing that subset of data to the EHR/Outcomes platform would be ideal. Often the data collectors (often coders) do not recognize the full range of complications. Linking outcomes collection systems to billing data is not the ideal way to progress because it does not capture complications appropriately.
QMW G02	Furthermore, when considering the finite resources available to technology developers, what measures, types of measures or attributes of measures should be a high priority?	
QMW G03	Are there innovations or technological capabilities for measure development or specification that the HITPC could support that would reduce the burden on technology developers?	N/C
QMW G04	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?	Suggest that if this were to proceed, core CQMS should be established for high priority health conditions by specialty, rather than across the board, since more specialized specialties and subspecialties do not have control over what some may view as a national high priority health conditions. HITPC should also ensure there are appropriate exclusions for conditions that may not apply to a provider's practice.

A. Patient Centeredness: Broaden Stakeholder Input

ID #	Questions	Neurosurgery Comments
QMWG05	How can the HITPC and QMWG capture input from a wide variety of providers, patients, organizations and societies?	Recommend proactive outreach to specialty societies and coalitions of specialty societies; convening of focus groups; and ensuring that each specialty is represented.
QMWG06	What additional channels for input should we consider?	Recommend convening focus groups and ensuring that each specialty is represented.

B. Patient Centeredness: Patient-Reported and Patient-Directed Data

ID #	Questions	Neurosurgery Comments
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?	Recommend that consumer-reported data be used to inform the development of new CQMs. Suggest that the entire suite of CAHPS surveys be validated for patient experience data collection via patient portals or other electronic means that could be captured by practices for improved patient experience and satisfaction, which would likely improve overall cost and quality. However, patient reported data must NOT be the sole entity for measuring quality.
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?	Through neurosurgery's registry, the National Outcomes and Quality Database (N2QOD), the data from our prospective registries that contains patient reported outcomes (outcomes that likely are of great importance and relevance to patients-not typically found in the standard medical record) will be used to help better inform patients and their families about the risks and potential benefits of various procedures. In this way, the patients can be more meaningfully involved in a shared decision making process. Combining EHR data with patient reported outcomes data is the ideal platform to yield the most accurate and valuable data. That is, patients MUST be the ones who report on quality of life, pain and disability (longitudinal outcomes), but are not good at accurately reporting safety/morbidity data. Therefore, in theory, the best system would collect everyday EHR data on safety of care and linked to longitudinal patient reported tools (effectiveness) and the system would process the data and feed it back as decision aids to patients, surgeons, and payers. This is how we can start the development of a "Learning Health System".

C. CQM Pipeline: Process and Outcome Measures

ID #	Questions	Neurosurgery Comments
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?	• Suggest a combination of both. While outcome measures are ideal, there will always be a need for a mix of measures that accommodate different patient populations and practice settings. While we should continue to work to develop better outcome measures, it is also critical that process measures support positive outcomes. Measure groups that support overall outcomes, but include some process measures, are also valuable. • We also recommend that Meaningful Use move away from quality measures and towards registry reporting for supporting quality improvement. We believe that prospective, systematic tracking of practice patterns and patient outcomes is the most effective mechanism by which physicians, including neurosurgeons, can improve the quality, efficiency and ultimately, the value of care. Therefore, neurosurgeons have found profound value in reporting to and retrieving data from

ID #	Questions	Neurosurgery Comments
		clinical data registries specific to their specialty and/or the diseases and conditions they manage. Clinical data registries have been shown to be particularly useful in improving patient care and outcomes, encouraging clinicians to reflect upon their care and utilization patterns.
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.	See above.

D. CQM Pipeline: Measure Development Lifecycle

ID #	Questions	Neurosurgery Comments
QMWG11	Please comment on challenges and ambiguities in retooling legacy paper abstracted and claims based eCQMs.	N/C
QMWG12	Is this a shift away from retooling legacy paper-based CQMs in exchange for designing CQMs de novo a reasonable course of action?	N/C
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.	N/C

E. CQM Pipeline: MU Alignment with Functional Objectives

ID #	Questions	Neurosurgery Comments
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?	Support continued efforts to align eCQMs and MU Objectives in order to minimize reporting burden, duplication of effort, and confusion. Given the increasingly diverse number of available quality measures and the increasing frequency with which they are being e-specified, there seems to be an opportunity to incorporate relevant CQMs into the reporting requirements of certain objectives (i.e., going forward, CQMs do not necessarily need to remain a separate and unique reporting requirement, but can instead be matched up with and listed as part of specific MU objectives).
QMWG15	Which measures and objectives, in particular, have the greatest potential to maximize meaningful alignment? Please recommend eCQM/Objective alignment opportunities.	Specialists should be able to meet eCQM and objectives when they report and participate in a clinical data registry. The current "one-size-fits-all" approach does not promote meaningful quality improvement in neurosurgery. Specifically, relevant tools for measuring quality and outcomes can vary significantly between primary care and surgical specialties.

F. CQM Pipeline: Domains and Exemplars

ID #	Questions	Neurosurgery Comments
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?	Suggest improving quality and safety and improving population health as priorities.
QMWG17	Are there EHR based exemplar measures that exist, or that are being conceptualized or developed, that address these domains and theses concepts? What scientific evidence, if any, supports these concepts and exemplars?	

G. CQM Pipeline: MU and Innovation

ID #	Questions	Neurosurgery Comments
QMWG18	Please comment on the desirability and feasibility of such an innovation track as a voluntary, optional component of the MU CQM requirement.	Express support for ability of EPs to submit a locally or professional society- developed CQM as a menu item in partial or full fulfillment of MU requirements. This would promote more flexible approaches that better recognize local needs and the needs of specific patient populations and settings. It would also allow CMS to learn more about CQMs developed by EHR users in the field, which may stimulate new and more appropriate measure development.
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.	• Pros of the conservative approach: encourages adoption and use of EHRs by ensuring more relevant and feasible CQMs while also ensuring a minimum level of quality and consistency among members of the same specialty so that the data could be analyzed over time for trends and patterns related to performance and adherence. • Pros of allowing any EP to develop a measure: promotes more flexibility and innovative forms of measurement that more precisely meet the needs of local populations, but requires minimum standards (e.g. minimum sample sizes or use by a minimum number of practices). • Recommendation: While neurosurgery supports flexibility in QI strategies and individual EP selection of CQMs would be ideal, it would be difficult to evaluate the effectiveness and feasibility of measures when so many different measures are being used by so few practices.
QMWG20	What information should be submitted with a locally developed CQM to help CMS and other healthcare providers assess the innovative measure? For example, should the submission form include a brief description of: 1) importance/rationale of the measure domain; 2) evidence basis for the specific measure; 3) feasibility, and 4) usefulness of the measure?	Suggest that a *brief* description of the listed elements would help to ensure a minimum quality standard, but do not necessarily recommend applying the rigorous testing requirements of the National Quality Forum (NQF) process, which requires heavy investments of time and resources. Encourage the ONC to develop guidelines or minimum standards for entities to initially follow when they are developing these alternative measures.
QMWG21	What constraints should be in place? Should individual providers have an option to choose and/or design their own measures outside of the established CQM EHR Incentive Program set? Should these "practice-level" measures be required to conform to the Quality Data Model data	Support proposal to allow providers to submit a locally or professional-society developed CQM as a menu item in partial fulfillment of MU requirements. This would promote more flexibility, while also allowing CMS to learn more about CQMs developed by EHR users in

ID #	Questions	Neurosurgery Comments
	elements and/or entered into the Measure Authoring Tool or conform to a simplified HQMF XML?	the field, which may stimulate new and more appropriate measure development.
QMWG22	What precautions might be necessary to mitigate fraud, waste and abuse and to avoid submission of trivial new measures that are unlikely to advance the field?	
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 value set)?	Note support for the strategies listed as examples, as well as other guidelines or recognized standards, such as those developed by the American National Standards Institute (ANSI), if available.
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?	• Request better alignment between EHR program and other federal reporting programs, such as PQRS, so that one measure set can be reported across programs. • Increasing the number of measures to report does not necessarily necessitate quality improvement if the measures have little to no relevance to the practice or improve outcomes. HITPC should recommend more flexibility in reporting, as opposed to forcing providers to report in specific domains. • Providers should be able to meet CQM reporting if they participate in a clinical data registry. It provides more meaningful information to the provider and a provider is not just reporting on de-facto measures that may not have much relevance to their practice.

H. Quality Improvement Support: Architecture and Standards

ID #	Questions	Neurosurgery Comments
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 to build multi-source data records, including claims, patient reported data - Ability to implement machine-readable HQMF that minimizes manual vendor coding - Ability to drill-down on reported measures for QI analyses	• Highlight the tremendous value of each of these items, but express concern over the ability of vendors to manage this and the lack of standards to help support this activity.
QMWG26	What other features, if any, should be considered? Please make suggestions.	Suggest the ability to query this information in real-time.
QMWG27	What is the role of muliti-source data exchange in achieving these features?	N/C

I. Quality Improvement Support: CQM Population Management Platform

ID #	Questions	Neurosurgery Comments
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?	
QMWG29	What information or features might be present in a basic clinical CQM population management view (population score, denominator members, patient-level data element drill down, provider comparison, risk adjustment, ad-hoc queries, etc)?	N/C
QMWG30	What are the technological challenges to widespread release and adoption? Can the HITPC encourage technology in this area without being prohibitively prescriptive? Should the HITPC and HHS pursue avenues outside of regulation to support this technology: e.g. design open source prototypes, challenge grants, demonstration projects, guidance document, etc?	Support less prescriptive options that allow for testing and evaluation, such as challenge grants and demonstrations.

II. Privacy and Security

ID #	Questions	Neurosurgery Comments
PSTT01	How can the HITPC's recommendation be reconciled with the National Strategy for Trusted Identities in Cyberspace (NSTIC) approach to identification which strongly encourages the re-use of third party credentials?	N/C
PSTT02	How would ONC test the HITPC's recommendation in certification criteria?	N/C
PSTT03	Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third party authentication service provider?	N/C

Feedback on security requirement next steps

ID #	Questions	Neurosurgery Comments
PSTT04	What, if any, security risk issues (or Health Insurance Portability and Accountability Act (HIPAA) Security Rule provisions) should be subject to Meaningful Use attestation in Stage 3? For example, the requirement to make staff/workforce aware of the HIPAA Security Rule and to train them on Security Rule provisions is one of the top 5 areas of Security Rule noncompliance identified by the HHS Office for Civil Rights over the past 5 years. In addition, entities covered by the Security Rule must also send periodic security reminders to staff. The HITPC is	• Recommend preservation of the requirement that meaningful users meet HIPAA Security Rule requirements. • To ensure compliance, HITPC should develop tools, such as webinars, PowerPoint presentations and YouTube videos to assist with understanding the HIPAA Security Rules.

ID #	Questions	Neurosurgery Comments
	considering requiring EPs/EHs/CAHs to attest to implementing HIPAA Security Rule provisions regarding workforce/staff outreach & training and sending periodic security reminders; we seek feedback on this proposal.	

Feedback on standards for accounting for disclosures

ID #	Questions	Neurosurgery Comments
PSTT05	Is it feasible to certify the compliance of EHRs based on the prescribed standard?	N/C
PSTT06	Is it appropriate to require attestation by meaningful users that such logs are created and maintained for a specific period of time?	This question is confusing. The EHR system should include functionality to query this data. If this functionality were in place, wouldn't the provider be able to provide this information at any time, so long as they continue to use the same EHR system?
PSTT07	Is there a requirement for a standard format for the log files of EHRs to support analysis of access to health information access multiple EHRs or other clinical systems in a healthcare enterprise?	N/C
PSTT08	Are there any specifications for audit log file formats that are currently in widespread use to support such applications?	N/C