

February 18, 2011

Office of the National Coordinator for Health Information Technology  
Department of Health and Human Services  
Attention: Joshua Seidman  
Mary Switzer Building  
330 C Street, SW, Suite 1200  
Washington, DC 20201

Submitted electronically at <http://www.regulations.gov>

Re: Health Information Technology Policy Committee Request for Comments Regarding  
Meaningful Use Stage 2

Dear Mr. Seidman:

The College of Healthcare Information Management Executives (CHIME) appreciates the opportunity to respond to the request for comments regarding meaningful use (MU) Stage 2, as reflected in the preliminary thinking of the Health Information Technology Policy Committee (HITPC) and its Meaningful Use Workgroup.

CHIME's 1,400 members represent chief information officers (CIOs) and other top information technology executives at many of the nation's largest hospitals. CHIME members have front-line experience in implementing clinical systems, and have learned by trial and error what works and what doesn't in implementing such electronic systems and optimizing the value derived from them. Healthcare CIOs share the vision of an e-enabled healthcare system as described by the HITPC, the Office of the National Coordinator (ONC) for Health Information Technology (HIT), and the Centers for Medicare & Medicaid Services (CMS).

As requested, the comments that follow focus on the proposed Stage 2 objectives and criteria, notwithstanding the fact that the document made available for comment also includes proposed Stage 3 objectives and criteria. In the matrix shown below, the first two columns are drawn verbatim from the HITPC matrix and the last column provides CHIME's comments on each MU topic. The order of the matrix is the same as that found in the HITPC document except that we have not included issues being deferred to a later time (that is, quality measures and privacy and security protections). In addition, we have not included new objectives being considered for Stage 3 for which suggestions on "stepping-stone" Stage 2 criteria were invited (these matters are addressed later in these comments in response to question #10 posed by the HITPC). Finally, proposed Stage 2 objectives and criteria for which CHIME has no suggestions or concerns are also omitted. For example, not listed in the following matrix are certain

objectives for which the HITPC proposal for Stage 2 is to “Continue Stage 1” or “Move to core”; such omissions should be interpreted as CHIME’s agreement with the general approach proposed for Stage 2. Immediately following the matrix, we respond to additional, specific questions posed by the HITPC.

Before providing comments regarding the proposed meaningful use objectives and measures for Stage 2, CHIME would like to make a few important observations. First, we think it would be far preferable to be in a position to evaluate actual experience under MU Stage 1 prior to considering potential MU objectives and measures for Stage 2. Absent such an assessment, we greatly fear that the HITPC’s proposals for Stage 2 may be unduly ambitious, even unattainable, for many eligible hospitals (EHs) and eligible professionals (EPs). We recognize the HITPC is planning to review the comments received on its proposed objectives and measures “in the context of the early feedback from providers on experience with Stage 1 MU,” but we are concerned that the request for comments on the HITPC’s matrix is a bit like “putting the cart before the horse.”

Second, as further consideration is given to Stage 2 MU objectives and criteria and the related timeline, CHIME believes that it would be prudent not to move to Stage 2 until about 30 percent of EHs and EPs have been able to demonstrate EHR MU under stage 1. We believe this approach would strike a reasonable balance between the desire to push EHR adoption and MU as quickly as possible and the recognition that unreasonable expectations could end up discouraging EHR adoption if providers conclude that it will be essentially impossible for them to qualify for incentives. Similarly, so as not to discourage EHR adoption, we recommend that the Medicare program allow EHs and EPs to “skip a year” if they are not fully prepared to move to the next stage as is allowed in the Medicaid program. Further, CHIME sees no value to imposing some artificial deadline on the movement to stage 2 and urges ONC and CMS to take all the time needed to produce clear and understandable policies. We consider this better than rushing the rulemaking process only to have to repeatedly issue frequently asked questions (and answers) and other policy clarifications and explanations to address provider and EHR vendor confusion and uncertainty.

Third, the HITPC’s proposal for stage 2 leaves uncertain whether the concept of a menu set of MU objectives will be retained. CHIME believes that stage 2 should continue to include both core and menu objectives and that many, if not all of, the new MU objectives for stage 2 should be introduced as menu objectives. This would allow EHs and EPs to select those menu set objectives that best mesh with their own strategic priorities and internal capabilities. Our assessment of the proposed stage 2 objectives and measures, especially where the entry for an existing menu objective is simply “Continue Stage 1” (which we assume means continuing with the existing menu item), is heavily dependent upon retention of a menu set of objectives and measures.

Fourth, for a number of proposed stage 2 measures, there is a notation that the HIT Standards Committee (HITSC) is “to define” important parameters. As we note in the following matrix in several places, it is not possible for stakeholders to comment on unknown standards or other policies the HITSC might recommend. CHIME believes it will be important for any such

standards or policies to pass a “practicality test.” In other words, they should be based on realistic expectations of what motivated providers, including busy physicians and other health professionals, will be able to accomplish, especially with respect to entering information in a coded or structured fashion.

Finally, since the HITPC’s preliminary thinking about Stage 2 was provided in matrix form, we often found it difficult to understand what exactly was being proposed or why. In a number of cases, the brief entry in a cell describing the HITPC’s proposal was vague, used terms with several possible meanings, did not make clear whether proposed criteria were intended for EHS or EPs only, or for both EHS and EPs, or did not offer much in the way of rationale or intentions. Below our comments identify these kinds of issues. We recognize, of course, that stakeholders will have another opportunity to comment on proposed Stage 2 MU objectives and criteria, as part of the formal rulemaking process, but we take this opportunity to encourage ONC and CMS to ensure that, when these proposed objectives and criteria are next presented for public comment, every effort has been made to provide specific, detailed explanations regarding each proposed objective and criterion. Absent this level of specificity and detail, stakeholders’ ability to provide meaningful comments can be severely hampered.

**Proposed Meaningful Use Objectives and Measures for Stage 2**

Stage 1 Final Rule	Proposed Stage 2	CHIME Comments
<b>Improving Quality, Safety, Efficiency &amp; Reducing Health Disparities</b>		
CPOE for medication orders (30%)	CPOE (by licensed professional) for at least 1 medication, and 1 lab or radiology order for 60% of unique patients who have at least 1 such order (order does not have to be transmitted electronically)	Electronic transmission of orders <u>internal</u> to a hospital or EP’s office should be expected. Otherwise, the value of CPOE would be seriously diminished. The proposed percentage of unique patients seems appropriate.
Drug-drug/allergy interaction checks	Employ drug-drug interaction checking and drug allergy checking on appropriate evidence-based interactions	It is not clear what the intended difference is between Stage 1 (where the operative word is “enable”) and proposed Stage 2 (where the operative word is “employ”). Reference to “appropriate” evidence-based interactions begs the question of who will be expected to decide what is appropriate, the EHR vendor, the EH or the EP, and/or what factors must be taken into account in reaching such a decision. It is also not clear how compliance will be assessed and whether that will depend on how many times the

Stage 1 Final Rule	Proposed Stage 2	CHIME Comments
		“checking” will identify issues or concerns. EHs and EPs should have the option to use one of the national drug data banks to satisfy this criterion.
E-prescribing (eRx) (EP) (40%)	50% of orders (outpatient and hospital discharge) transmitted as eRx	We are uncertain about the intentions behind this proposed criterion. For EPs, the proposed criterion is problematic in that it would appear to require an EP to combine data relating to in-office eRx as well as eRx relating to hospital discharges, for which a hospital’s eRx system would be used. We believe this is a very complicated approach, even unrealistic. Also, the higher percentage fails to appreciate that some patients do not want an eRx. We presume the proposed criterion is not intended to apply to EHs, despite mention of hospital discharges.
Record vital signs (50%)	80% of unique patients have vital signs recorded	We presume the proposed criterion would be met by recording a single set of vital signs at any time during a hospital admission or patient encounter. This should be made clear. If more than a single set of vital signs is intended, the proposed percentage would be too high.
Record smoking status (50%)	80% of unique patients have smoking status recorded	Multiple EPs sharing a single EHR (for example, when there are several encounters on the same day) should be allowed to satisfy this criterion by entering smoking status once.
Implement 1 CDS rule	Use CDS to improve performance on high-priority health conditions. Establish CDS for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who	It is not clear what is intended. We presume that this criterion would not require a specific level of improved performance but simply the use of CDS expected to produce such improvement. We also presume that EHs and EPs would only be expected to use a reasonable number of CDS rules (say 3) to satisfy the criterion. The goal at this point should not be use of a large number of CDS rules but effective use of a smaller number. We further presume that EHs and EPs would have the flexibility to decide what the high-priority health conditions are for their patients and communities, and not be forced to comply with some national decree. We believe it would be a serious mistake to adopt EHR certification criteria that presume that EHR vendors will be making clinical judgments about whether there is

Stage 1 Final Rule	Proposed Stage 2	CHIME Comments
	can take action	credible evidence for a particular CDS rule or imposing specific CDS rules on EHRs and EPs. Instead, EHR technology should be capable of implementing CDS rules identified as appropriate by EHRs and EPs, and MU criteria should not become a “back door” means for the federal government to interfere with the practice of medicine. Finally, it is far from clear how the 8 proposed certification criteria would be measured.
Implement drug formulary checks*	Move current measure to core	The proposed change would only be feasible if EHRs and EPs continue to retain the option to use an internal formulary, and not be expected to use one or more external formularies.
Record existence of advance directives (EH) (50%) <sup>1</sup>	Make core requirement. For EP and EH: 50% of patients >=65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	CHIME has serious concerns about any attempt to go beyond requiring the recording of whether a patient has an advance directive. First, recording the results of a discussion about an advanced directive discussion would not be appropriate as an EH criterion since the discussion in question is one that would typically occur between the patient and his or her attending physician, not with hospital personnel. There are also serious legal considerations, such as potential legal liability if action is taken on the basis of what is later learned to be an outdated advance directive, or on the basis of discussions that occur but the actual advance directive document is not provided by the patient (and might be at odds with what was actually discussed). If there is a desire to prod additional progress on the topic of advanced directives, one option would be to increase the percentage of patients >=65 years old for which recording of the existence of advance directives would be required.
Generate patient lists for specific conditions*	Make core requirement. Generate patient lists for multiple patient-specific parameters	We presume the proposed criterion would be satisfied by generating two or more patient lists, and not some unreasonably high number of lists. Further, we presume that EHRs and EPs would retain the flexibility of deciding what specific

<sup>1</sup> Menu option for Stage 1

Stage 1 Final Rule	Proposed Stage 2	CHIME Comments
		lists should be generated, taking into account their individual patient care goals and circumstances.
Send patient reminders (20%)*	Make core requirement	This objective applies only to EPs under Stage 1 and we presume that the proposed criterion for Stage 2 would apply only to EPs. We do not believe that this criterion should apply to EHs.
(NEW)	30% of visits have at least one electronic EP note	It is unclear what visits are intended (for example, EP office visits, or visits in hospital inpatient or outpatient settings). We believe it is premature to focus on electronic notes, largely due to a lack of physician readiness. Further, any need to provide notes in a structured or coded fashion would only complicate the situation further.
(NEW)	30% of EH patient days have at least one electronic note by a physician, NP, or PA.	The proposed measure is unduly complicated by referring to percentage of patient days rather than a percentage of unique patients. More importantly, for the foreseeable future, we believe it is much more important to focus attention on CPOE (especially with CDS) than on electronic notes. Objectives relating to electronic notes strike us as premature mainly because a sufficient proportion of physicians are not prepared to enter notes electronically. This lack of physician readiness would be significantly compounded if the information in electronic notes needed to be provided in some structured or coded fashion. If ONC elects to proceed with such a measure, we would urge that, for EHs, it refer to a lesser percentage (say 10%) of unique patients.
(NEW)	30% of EH medication orders automatically tracked via electronic medical administration recording	A more explicit definition of what is meant by “electronic medical administration recording” would help stakeholders assess whether this proposed criterion is reasonable.
<b>Engage Patients and Families in Their Care</b>		
Provide electronic copy of discharge instructions	Electronic discharge instructions for hospitals (which are given as the patient is	We presume this criterion applies only to patients being discharged from an inpatient stay. We are concerned that the word “offer” might imply that EHs must pre-generate some specific

Stage 1 Final Rule	Proposed Stage 2	CHIME Comments
(EH) at discharge (50%)	leaving the hospital) are offered to at least 80% of patients (patients may elect to receive only a printed copy of the instructions)	electronic copy as part of the offer process. We would oppose this. Patients now generally receive a printed copy of discharge instructions and we see no value in making the receipt of printed copies a part of EHR MU criteria. We would also hope that the requirement could be satisfied by making discharge instructions available on a web portal for those patients interested in receiving an electronic copy. Finally, the proposed percentage is too high. If hospitals must actively offer an electronic option to a high proportion of patients, this has work flow implications far different from those involving provision of an electronic copy to patients requesting one.
(NEW for EH)	80% of patients offered the ability to view and download via a web-based portal, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human-readable and structured forms (HITSC to define)	The criterion should incorporate a proviso allowing for health professional discretion in terms of what information is made available to a patient outside of a face-to-face or other personal communication. We are unable to comment about the reasonableness of any human readable or structured form requirements the HITSC might specify. The proposed application of this criterion to a large percentage of patients fails to appreciate the legal complexities involved with parent access to information relating to children, especially adolescents. The percentage of patients also needs to be reduced in order to make this criterion less burdensome for Stage 2. It is not clear to us that the list of data elements needs to be so long. For example, we do not understand why it is necessary to specify data elements well known by the patient, such as the patient's gender, race, ethnicity, date of birth, preferred language or smoking status, as opposed to other information of greater value, such as diagnostic test results, procedures, and discharge instructions. Long laundry lists of data elements would only serve to complicate compliance and the assessment of compliance. In addition, it will be critically important that the included elements can all be contained in the Continuity

Stage 1 Final Rule	Proposed Stage 2	CHIME Comments
		of Care (CCD) document rather than require an additional reporting form.
Provide clinical summaries for each office visit (EP) (50%)	Patients have the ability to view and download relevant information about a clinical encounter within 24 hours of the encounter. Follow-up tests that are linked to encounter orders but not ready during the encounter should be included in future summaries of that encounter, within 4 days of becoming available. Data are available in human-readable and structured forms (HITSC to define)	The criterion should incorporate a proviso allowing for health professional discretion in terms of what information is made available to a patient outside of a face-to-face or other personal communication. We are unable to comment about the reasonableness of any human readable or structured form requirements the HITSC might specify. It is not clear to us that the list of items proposed for the clinical summary needs to be so long. For example, we do not understand why it is necessary to include data elements well known by the patient, such as the patient’s gender, race, ethnicity, date of birth, preferred language or smoking status, as opposed to other information of greater value, such as scheduled tests, orders, and vital signs. Long laundry lists of data elements would only serve to complicate compliance and the assessment of compliance. In addition, it will be critically important that the included elements can all be contained in the Continuity of Care (CCD) document rather than require an additional reporting form.
Provide timely electronic access (EP) (10%)	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data area available in human-readable and	The criterion should incorporate a proviso allowing for health professional discretion in terms of what information is made available to a patient outside of a face-to-face or other personal communication. We are unable to comment about the reasonableness of any human readable or structured form requirements the HITSC might specify. The proposed requirement that patients be allowed to filter or organize information by various factors may not be attainable using available web portal technology. It is not clear to us that the list of data elements for the longitudinal record needs to be so long. For example, we do not understand why it is necessary to specify data elements well known by the patient, such as the patient’s gender, race, ethnicity, date of birth, preferred language or smoking status, as

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	structured forms (HITSC to define)	opposed to other information of greater value, such as clinical instructions, orders, and a longitudinal care plan. Long laundry lists of data elements would only serve to complicate compliance and the assessment of compliance.
This objective sets the measures for “Provide timely access (EP)” and for “Provide clinical summaries for each office visit (EP)”	EPs: 20% of patients use a web-based portal to access their information (for an encounter or for the longitudinal record) at least once. Exclusions: patients without ability to access the Internet	We consider it unreasonable to impose a criterion over which an EP has no direct control (that is, whether his or her patients wish to use a web-based portal). We also consider it unreasonable to expect an EP to ask about and document information about the internet access capabilities of his or her patients. We consider this whole approach problematic.
(NEW)	EPs online secure patient messaging is in use	Patient messaging raises serious legal, work flow, and other issues. In addition, many public and private payers do not reimburse for EP time spent in reading and responding to electronic messages. This proposed criterion is not appropriate for Stage 2, particularly as a core objective. Also, what is meant by “in use” is unclear as a physician practice might welcome patient e-mails only for selected purposes (such as prescription renewal).
(NEW)	Patient preferences for communication medium recorded for 20% of patients	This proposed criterion raises work flow issues and strikes us as a lower priority matter. We recommend that this proposed criterion be dropped from further consideration for purposes of Stage 2. If it is retained, it should be fully aligned with current Joint Commission or other similar requirements. Further, any measure should be simple (e.g., it should not expect an EH or EP to assess patient communication preferences on some topic by topic basis).
<b>Improve Care Coordination</b>		
Perform test of HIE	Connect to at least three external providers in “primary referral network” (but	CHIME is extremely concerned about this proposed measure. Whether there is a functioning HIE in an area is totally beyond the control of EHs and EPs. Even if there is a

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	outside delivery system that uses the same EHR) or establish an ongoing bidirectional connection to at least one health information exchange	functioning HIE, it may not be accessible to critical access and rural hospitals. Moreover, establishing a connection to an HIE could prove to be expensive. The same is likely to be true in the case of the alternative of connecting to three external providers. In short, we believe that an EH or EP should be able to opt out of the HIE requirement if reasonable access to an HIE is not possible. And if the long-term goal is to move to HIEs, we believe requirements involving independent connections to external providers in one's network would be counterproductive. Having an alternative means of meaningful use compliance would inject some necessary competitiveness into the HIE landscape and fulfill the promise of more efficient patient care through adoption of EHRs.
Perform medication reconciliation (50%)*	Medication reconciliation conducted at 80% of care transitions by receiving provider (transitions from another setting of care, or from another provider of care, or the provider believes it is relevant)	It is not clear whether the proposed Stage 2 measure is intended to be a menu item or a core item. We would recommend that the measure be moved to core but left at the existing 50%. We believe this would be a more than adequate progression in MU. Also, reference to "relevant" transitions, especially in the case of a core measure, strikes us as problematic. Current CMS guidance notes that an encounter is relevant if the EP judges it to be so and then adds that "relevant" encounters are <u>not</u> included in the numerator or denominator of the measure. Given this, we do not see the value of even referring to "relevant" transitions in the measure.
(NEW)	List of care team members (including PCP) available for 10% of patients in EHR	The goal of this objective is far from clear, which makes it difficult to comment. CHIME is very concerned about this measure as a large number of individuals are necessarily part of a patient's care team in an inpatient hospital setting (for example, several shifts of nurses and aides) and we believe it would be impractical to use the EHR to record all this information, especially in a coded or structured manner. CHIME opposes application of such a measure to EHRs, especially if the intent is to capture information about

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		more than the physicians and other clinical decision makers who were directly involved in the patient’s care. We also doubt that this issue should be addressed through EHR MU at this time, but instead left to those involved in developing new payment models, such as medical homes and accountable care organizations, where care coordination will require information about <u>certain</u> individuals involved in patient care, not every single member of what might be considered a “care team.”
(NEW)	Record a longitudinal care plan for 20% of patients with high-priority health conditions	It is not clear whether this measure is intended to apply to EPs only or to EHS also. It would be unreasonable to expect an EH to maintain a longitudinal care plan when the hospital might only be episodically involved in the patient’s care. Even if this measure is intended only for EPs, we believe it should not be included for Stage 2, certainly not as a core measure, especially since it is not clear to us that an EP could meet this measure on his or her own (e.g., without input from a hospital). We would also point out that the proposed objective and measure imply that medical home (MH) or accountable care organization (ACO)-type data are stored for patients; many of the systems that do the care pathways or systems of care for MHs or ACOs do so in a separate repository or tool, not the EHR itself. This could present a problem if these additional systems will also need to be certified.
<b>Improve Population and Public Health</b>		
Submit immunization data*	EH and EP: Mandatory test. Some immunizations are submitted on an ongoing basis to Immunization Information System (IIS) if accepted and as required by law	There appears to be some inconsistency between the expectation that at least some immunization data is submitted to IIS and the notation that submission is required only “if accepted and as required by law.” Perhaps the HITPC means that some data in the aggregate will be submitted and not that each EH or EP will have to submit such data “no matter what” but this is not clear.
Submit reportable lab	EH: move Stage 1 to core	The proposed progression from menu to core for EHS seems reasonable.

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data*	EP: lab reporting menu. For EPs, ensure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs (if accepted and as required by law)	In the case of EPs, it is not clear whether the word “menu” is intended to indicate that the measure would be a menu item for them or refers to the menu of reportable lab tests. The proposed reporting would be extremely challenging for EPs even as a menu item. CHIME strongly opposes making the proposed measure a core requirement for EPs.

### **CHIME Responses for Questions Posed by the HITPC**

Below CHIME is pleased to provide input regarding the additional, specific questions posed by the HITPC.

#### **1. How can electronic progress notes be defined in order to have adequate specificity?**

CHIME is concerned about any attempt to be overly prescriptive about progress notes at this point, since we believe that flexibility will be important to obtain physician “buy-in.” Thus, we do not believe that it would be prudent at this time to specify the contents of a physician progress note, demand the incorporation of standard codes into such notes or otherwise impinge on the professionalism of the physicians and other health professionals entering such notes.

#### **2. For patient/family access to personal health information, what standards should exist regarding accessibility for people with disabilities (e.g., interoperability with assistive technologies to support those with hearing, visual, speech, or mobile impairments)?**

CHIME believes that the primary focus should be on providing incentives for the meaningful use of electronic health records by hospitals and health professionals. Any issues affecting patient access to health information technology should be addressed separately and not “shoe horned” into certification standards for EHRs or meaningful use objectives and criteria applicable to hospital and health professionals. Further, patient use of web portals should remain at the patient’s discretion.

#### **3. What strategies should be used to ensure that barriers to patient access — whether secondary to limited internet access, low health literacy and/or disability — are appropriately addressed?**

As noted above, CHIME believes that the primary focus should be on providing incentives for the meaningful use of electronic health records by hospitals and health professionals. Any issues affecting patient access to health information technology should be addressed separately and not “shoe horned” into certification standards for EHRs or meaningful use objectives and criteria applicable to hospital and health professionals. Over the longer term, if the patient’s principal language will be viewed as a barrier to patient access to information, we caution against imposing unrealistic expectations on EHR vendors or on the hospitals and health professionals using EHRs. We worry, for example, that hospitals will be expected to address the needs of individuals with many different languages as an integral part of their EHR adoption and maintenance efforts. Any language-related EHR meaningful objectives or criteria should not impose unreasonable burdens on EHR vendors, hospitals or health professionals. Reference to common languages should involve a limited number of languages other than English and should be approached from a national not a regional perspective in order to facilitate EHR vendor action. In addition, expectations might be addressed through translation service requirements rather than through additional EHR certification standards.

**4. What are providers’ and hospitals’ experiences with incorporating patient-reported data (e.g., data self-entered into PHRs, electronically collected patient survey data, home monitoring of biometric data, patient suggestions of corrections to errors in the record) into EHRs?**

CHIME’s impression is that physicians are extremely leery of incorporating patient-reported, electronic data (especially data self-entered into PHRs) because of concerns that the data may be incomplete or misleading. The problem is exacerbated by the attempt to allow patients to omit certain data based on privacy preferences. Also, such data have not had the benefit of a health professional’s interpretation based on direct, preferably face-to-face interaction with the patient. Such data, once incorporated into an EHR, could take on a life of their own, and the data’s origin and limitations could easily be lost, forgotten or misunderstood. We believe it is premature to impose demands on hospitals and health professionals with respect to the incorporation and use of patient-reported data.

The results of structured electronic surveys and objective data collected by biometric devices are likely to be trusted.

**5. For future stages of meaningful use assessment, should CMS provide an alternative way to achieve meaningful use based on demonstration of high performance on clinical quality measures (e.g., can either satisfy utilization measures for recording allergies, conducting CPOE, drug-drug interaction checking, etc., or demonstrate low rates of adverse drug events)?**

CHIME agrees that it would be advisable to provide an alternative way to achieve meaningful use based on demonstration of high performance on relevant quality or other performance measures. Quality metrics are far more meaningful than features and functions supported by an EHR.

**6. Should stage 2 allow for a group reporting option to allow group practices to demonstrate meaningful use at the group level for all EPs in that group?**

CHIME strongly supports a group reporting option. Among other things, such an option would be more efficient, one of the overall goals for adopting EHR in the first place.

**7. In stage 1, as an optional menu objective, the presence of an advance directive should be recorded for over 50% of patients 65 years of age or older. We propose making this objective required and to include the results of the advance-directive discussion, if available. We invite public comment on this proposal, or to offer suggestions for alternative criteria in this area.**

This question was addressed in the preceding matrix.

**8. What are the reasonable elements that should make up a care plan, clinical summary, and discharge summary?**

CHIME's principal concern is that the elements ultimately identified be easily accommodated through, for example, the Continuity of Care Document (CCD) and not require some additional document type. In addition, we believe that any list of elements should not be unduly long, at least for the foreseeable future, and restricted to truly essential elements. We believe that long, inflexible lists of elements would be a disincentive to adoption and use of EHRs.

**9. What additional meaningful-use criteria could be applied to stimulate robust information exchange?**

CHIME believes that the matrix released by the HITPC provides a sufficiently large menu from which to choose an appropriate set of MU objectives and criteria for Stage 2. We see no need to offer or consider additional objectives or measures at this time.

**10. There are some new objectives being considered for stage 3 where there is no precursor objective being proposed for stage 2 in the current matrix. We invite suggestions on appropriate stage 2 objectives that would be meaningful stepping-stone criteria for the new stage 3 objectives.**

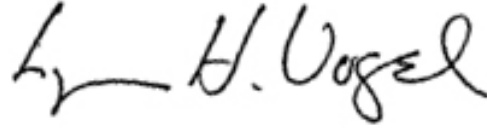
As noted in response to question #9, CHIME believes that the matrix released by the HITPC provides a sufficiently large menu from which to choose an appropriate set of MU objectives and criteria for Stage 2. Further, we believe it is premature to discuss the Stage 3 MU objectives and criteria tentatively proposed by the HITPC or to contemplate "stepping stone" criteria for those objectives and criteria as part of Stage 2.

We hope these comments are helpful. If you have any questions about our comments or need more information, please contact Sharon Canner at [scanner@cio-chime.org](mailto:scanner@cio-chime.org).

Sincerely,



Richard A. Correll, President & CEO  
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