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May 27, 2015

Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health & Human Services
Attention: CMS-0044-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically to http://www.regulations.gov

Re: **Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3. Proposed Rule. 80 FR 16731 (March 30, 2015). CMS–3310–P/RIN 0938-AS26.**

Dear Acting Administrator Slavitt:

The American Nurses Association (ANA) welcomes the opportunity to offer comments on the proposed rule specifying the meaningful use (MU) Stage 3 criteria, which eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must meet in order to qualify for Medicare and/or Medicaid electronic health record (EHR) incentive payments.

As the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses (RNs), ANA is privileged to speak on behalf of its state and constituent member associations, organizational affiliates, and individual members. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide screening, assessments, and coordinate patient-driven evidence-based care. RNs engage and educate patients, their families, other caregivers, and even the public in self-care for prevention, maintaining wellness, and managing various health conditions. Finally, RNs provide emotional support to patients and their family members.[1] ANA members also include the four advanced practice registered nurse (APRN) roles: nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists.[2]

ANA supports the proposed rule's vision of Meaningful Use (MU) Stage 3, to focus on the advanced use of EHR technology to promote improved patient outcomes and health information exchange. In addition, ANA supports the proposal to continue to improve program efficiency,

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[1] Nursing Alliance for Quality Care Whitepaper (2013), Fostering Successful Patient and Family Engagement: Nursing's Critical Role. http://www.naqc.org/Main/Resources/Publications/March2013-FosteringSuccessfulPatientFamilyEngagement.pdf (accessed May 20, 2015).

[2] The Consensus Model for APRN Regulation defines four APRN roles: certified nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist. In addition to defining the four roles, the Consensus Model describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

effectiveness, and flexibility by making changes to the Medicare and Medicaid EHR Incentive Programs that simplify reporting requirements and reduce program complexity. (Page 16734)

ANA is committed to the goal of advancing the quality and safety of patient care in a rapidly changing and transforming health care system. Steps to achieve this include utilizing HIT and EHRs to improve care coordination; standardizing the electronic capture of nursing's contributions to care (including the electronic capture of quality measures that reflect nursing's contributions to improving patient outcomes); and support interoperability and standardized representation of nursing in EHRs, including the attribution of nurses. We believe it is also essential that meaningful use support incentives for APRN-led practice.

ANA has worked collaboratively to develop ANA's comments on this proposed rule with support from APRN member feedback, informatics nurse specialists, including the Alliance of Nursing in Informatics (ANI), the nursing informatics working groups at the American Medical Informatics Association (AMIA), the Healthcare Information and Management Systems Society (HIMSS), interprofessional experts across the national quality enterprise, and experts appointed to the ONC Federal Advisory Committees (FACAs). ANA has evaluated these complex proposed regulations using the lens of the nation's tri-part aim (i.e., better care, healthier people/communities, and lower cost) to improve healthcare through achieving the goals related to the six priorities articulated in the National Quality Strategy (NQS) and the Measure Application Partnership (MAP) recommendations as the overarching evaluation criteria.

ANA comments on this proposed rule focus on:

- General ANA Comments
- Proposed Reduction in Program Complexity
- Eight Meaningful Use Objectives and Measures
- Clinical Quality Measurement Reporting

General ANA Comments: Uneven treatment of APRNs who are enrolled as Part B providers and/or Medicaid providers

ANA has been concerned since the passage of the ACA about the uneven treatment of APRNs who are enrolled as Part B providers and/or Medicaid providers. Although NPs, in particular, have been found to be more likely than physicians to accept dual eligible patients, many of the Medicare provisions of the ACA omit mention of APRNs or only include one or two of the APRN roles rather than all four. With respect to EHRs, APRNs will interact with physicians and other clinicians concerning individual patients. However, it makes little sense to provide EHR incentives for some but not all of the clinicians whose care and treatment decisions must be coordinated, especially when RNs and APRNs play a pivotal and essential role in coordinating care through interactions with all clinicians and members of the treatment team as well as the patients, family members and designated caregivers.

Forty-six pages of the NPRM are devoted to the provisions of the proposed regulations, but only three pages deal specifically and directly with the Medicaid EHR Incentive Program under which NPs and CNMs are eligible to earn incentive payments. On the last page of that section, CMS proposes that states would not be required to include information about certain providers in their reports, namely, those who are eligible for the Medicaid EHR Incentive Program on the basis of

being a nurse practitioner, certified nurse-midwife, or physician assistant. CMS appears to suggest that the Medicaid EHR activities of those APRNs are not important, despite the fact that through February 2015 37,519 NPs and 4,504 CNMs have received Medicaid EHR incentive payments totaling more than $717 million**.** CMS appears to suggest that APRNs will continue to be at most an afterthought in deliberations regarding Medicare and Medicaid health policy. Further, Medicaid enrollees and some Medicare beneficiaries may fail to recognize APRNs as sources of primary care and specialty services even though APRN health care services are explicitly recognized in the legislated benefit packages of both Medicare and Medicaid.

ANA recommends that CMS should continue to recognize APRNs and publicize their accomplishments in providing essential health benefit services to patients benefiting from either or both of those programs. Based on the historical experience of RN services under DRG payments for Medicare Part A and "incident to" services provided by RNs and APRNs billed to Medicare Part B, if there is no record of services provided, those services were not provided. In other words, if the event is not recorded, it didn't happen.

Proposed Reduction in Program Complexity

ANA supports the CMS proposal to streamline criteria for meaningful use by creating a single stage of meaningful use objectives and measures, but respectfully requests flexibility regarding clinical quality measures for eligible professionals (EPs) and practices that have a unique patient population (e.g. mental health EPs). A single stage of objectives may present a challenge for some providers depending on their patient population and needs.

ANA is supportive of the removal of measures that are topped out, duplicative or redundant. There seems to be a lack of consensus regarding changing the EHR reporting period to a full calendar year for all providers. Some APRNs reported reliability issues with the quality reporting programs using certified health IT for clinical quality measurement that have required manual abstraction and indicated that a 90-day EHR reporting period (rather than a full year) would be preferable. ANA has received positive feedback from some APRNs suggesting that aligning meaningful use with other CMS quality reporting programs using certified health IT such as PQRS and Hospital IQR for clinical quality measurement would help simplify the process and reduce burden. In addition to the reduction in burden on quality reporting, electronic reporting of eMeaures will mitigate the retrospective abstraction of data. ANA supports moving to a full calendar year for synchronization among providers to facilitate health information exchange (HIE), but recognizes the concerns that have been expressed by other experts about the timeline for transitioning to Stage 3 in 2017 and 2018. If a shorter reporting period is considered, ANA supports the recommendation of the Advanced Health Models and Meaningful Use Work Group[3] to the Health IT Policy Committee of "keeping the (shortened) reporting period synchronized (versus any 90-days) among providers to facilitate electronic HIE." ANA also supports the Work Group's comment that, "a period of 18-months should be allowed for EHR vendor implementation, certification and roll-out to providers, as well as provider implementation."

[3] See http://www.healthit.gov/facas/sites/faca/files/HITPC_AHMWG_MU3_NPRM_2015-05-12_v3.pdf (accessed May 21, 2015).

Eight Meaningful Use Objectives and Measures

Objective 1: Protect Patient Health Information

Proposed Objective: Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.

Proposed Measure:

1. Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.

ANA Comments

ANA supports the recommendations and concerns presented in the Privacy and Security Workgroup Presentation[4] and the Privacy and Security Workgroup MU3 Comments[5] on May 12, 2015 to the Health IT Policy Committee. Specifically, the Workgroup supported the proposal to increase the opportunities for patient access to information through the use of View, Download, and Transmit (VDT) technologies as well as open Application Programming Interfaces (APIs). ANA supports the Workgroup's concerns about the potential privacy and security risks associated with increasing patient access to health information electronically.

ANA has also received input from EPs stating that these requirements are difficult for small practices that do not have information technology experts on staff. Therefore, the recommended guidance would be beneficial to EPs.

Objective 2: Electronic Prescribing

Proposed Objective: Eligible Professionals (EPs) must generate and transmit permissible prescriptions electronically, and eligible hospitals and CAH's must generate and transmit permissible discharge prescriptions electronically (eRx).

Proposed Measure:

1. Proposed EP Measure: More than 80% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
2. Proposed hospital CAH Measure: More than 25% of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.
3. Continue to exclude OTC medicines in this objective for Stage 3

[4] See http://www.healthit.gov/facas/sites/faca/files/HITPC_PSWG_Meeting_Slides_2015-05-22_Final.pptx (accessed May 21, 2015).

[5] See http://www.healthit.gov/facas/sites/faca/files/HITPC_MUNPRM_PSWG_Comment_Template_Final_5_2015-05-22.docx (accessed May 21, 2015).

ANA Comments
ANA supports the rationale that allowing (but not requiring) OTC medications to be ePrescribed and to count toward meaningful use would enhance providers' ability to ensure that patients are prescribed the right medications (including OTCs) and potentially allow providers access to additional information such as fill histories and drug interactions.

During a meeting on May 12, 2015, the Advanced Health Models and Meaningful Use Work Group made a number of recommendations to the Health IT Policy Committee. They recommended against measuring only new and changed prescriptions. They also disagreed with the proposed removal of refill prescriptions, as it is "important to encourage patient-centered practice to renew medication at discharge for a patient who needs one and a prescriber who is comfortable providing one." ANA supports these recommendations.

Objective 3: Clinical Decision Support
Proposed Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Proposed Measures:

1. The EP, eligible hospital and CAH must implement five clinical decision support interventions related to four or more Clinical Quality Measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs 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.
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.

ANA Comments
ANA supports the following recommendations presented by the Advanced Health Models and Meaningful Use Work Group to the Health IT Policy Committee on May 12, 2015:

- For Measure 1, CMS should provide more guidance about the definition of "high priority health conditions." (Not clearly synonymous with "CMS Encouraged" areas).
- For Measure 2, CMS should provide more guidance about how providers may calibrate/filter drug-drug interaction alerts, e.g. to optimize usability by focusing on high priority alerts, while still meeting measure.
- Consider behavioral health as an additional priority area.

Objective 4: Computerized Provider Order Entry
Proposed Objective: Use Computerized Provider Order Entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistance; who can enter orders into the medical record per state, local, and professional guidelines.

Proposed Measures:

1. More than 80% of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient emergency department during the EHR reporting period are recorded using CPOE.
2. More than 60% of laboratory orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient emergency department during the EHR reporting period are recorded using CPOE.
3. More than 60% of diagnostic imaging orders created by the EP or authorized providers of the EH or CAH's inpatient emergency department during the EHR reporting period are recorded using CPOE.

ANA Comments

ANA respectfully requests further clarification from CMS regarding the statement from page 16751,

"However, as stated in the Stage 2 final rule at 77 FR 53986, it is apparent that the prevalent time when CDS interventions are presented is when the order is entered into CEHRT, and that not all EHRs also present CDS when the order is authorized (assuming such a multiple step ordering process is in place). This means that the person entering the order would be required to enter the order correctly, evaluate a CDS intervention either using their own judgment or through accurate relay of the information to the ordering provider, and then either make a change to the order based on the information provided by the CDS intervention or bypass the intervention. The execution of this role represents a significant impact on patient safety; therefore, we continue to maintain for Stage 3 that a layperson is not qualified to perform these tasks. We believe that the order must be entered by a qualified individual. We further propose that if the individual entering the orders is not the licensed healthcare professional, the order must be entered with the direct supervision or active engagement of a licensed healthcare professional" (Page 16751).

A licensed healthcare professional may also include non-providers (LVN, LPN, RN, PT, OT, ST, LCSW). Credentialed medical assistants and certain licensed healthcare professionals may not have the legal right to add, modify, or delete medications, allergies, or problems. Further clarification is needed.

Objective 5: Patient Electronic Access to Health Information

Proposed Objective: The EP, eligible hospital or CAH provides access for patients to view, download, and transmit their health information, or retrieve their health information through an application-program interface (API), within 24 hours of its availability.

Proposed Measures:

1. For more than 80% of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department: (1) The patient (or patient-authorized representative) is provided access to view online, download, and transmit their health information within 24 hours of its availability to the provider; or (2) The patient (or patient-authorized representative) is provided access to an ONC-certified API that can

be used by third-party applications or devices to provide patients (or patient-authorized representatives) access to their health information, within 24 hours of its availability to the provider.

2. The EP, eligible hospital or CAH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35% of unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department during the EHR reporting period.

ANA Comments

ANA generally supports providing access to the patient (or patient-authorized representative) to view online, download, and transmit their health information within 24 hours of its availability to the provider, when deemed clinically appropriate by the provider. ANA members have provided feedback that the proposed measure to provide electronic access to patient-specific education resources to more than 35% of unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department during the EHR reporting period may be problematic for rural based clinics and clinics where the patient population is not amenable to the use of technology or receiving electronic materials. Additional feedback indicated that this requirement may contribute to an increase in wait times.

Objective 6: Coordination of Care through Patient Engagement

Proposed Objective: Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patient's care.

Proposed Measures:

1. During the EHR reporting period, more than 25% of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department actively engage with the electronic health record made accessible by the provider.
2. For more than 35% of all unique patients seen by the EP or discharged from the eligible hospital or CAH inpatient or emergency department during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient's authorized representatives), or in response to a secure message sent by the patient (or the patient's authorized representative).
3. Patient generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than 15% of all unique patients seen by the EP or discharged by the eligible hospital or CAH inpatient or emergency department during the EHR reporting period.

ANA Comments

ANA supports permitting incorporation of patient generated health data or data from non-clinical settings into the certified EHR technology, but agrees with the following recommendations from the Consumer Work Group Electronic Health Record Incentive Program[6] that were presented to the Health IT Policy Committee on May 12, 2015:

[6] See http://www.healthit.gov/facas/sites/faca/files/HITPC_Consumer_WG_MU3_2015-05-12_0.pdf.

- Measure 1: Lower the threshold for view, download or transmit to 10%.
- Measure 2: Agree with the proposed measure, that a secure message be sent to more than 35% of all unique patients using the electronic messaging function of CEHRT or in response to a secure message sent by the patient.
- Measure 3: Modification: Patient-generated health data is incorporated into the certified EHR technology for more than 10% of all unique patients. The modification is moving "or data from a non-clinical setting" to the HIE objective.
- In addition, ANA supports the Workgroups comments regarding having "provider-requested" Patient Generated Health Data (PGHD).
- Overall Comment: Agree with not allowing administrative or financial data to count as patient-centered communication towards secure message threshold.

ANA members provided feedback that having the provider be held accountable for a patient's use of technology would be challenging in situations where the patient is either unwilling or unable to participate electronically with their provider. There may be a myriad of reasons for the patient not being able to communicate electronically with their EP (e.g. language barriers, limited or lack of access to technology). ANA respectfully asks for CMS to consider flexibility in these scenarios and provide further guidance to providers with these concerns.

With respect to the request for comments regarding data capture and the incorporation of functions, ANA recommends that the data require verification by an authorized provider. Data should be incorporated in the CEHRT with provider verification.

Objective 7: Health Information Exchange

Proposed Objective: The EP, eligible hospital, or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of certified EHR technology.

Proposed Measures:

1. For more than 50% of transitions of care and referrals, the EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care: (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.
2. For more than 40% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital or CAH incorporates into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system.
3. For more than 80% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital, or CAH performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: Medication, Medication allergy, and Current Problem list.

ANA Comments

ANA, in consultation with expert members, has identified a number of issues regarding the capture of information concerning eCare Plans and care coordination.

There are concerns with how the care plan is being represented in the MU3 document. Simply requiring a Care Plan "field" is inadequate as this approach downplays the needs and the importance of the patient-driven care plan used by the interprofessional team. It is analogous to the concept of a care plan "section" in a physician's note. There are differences between physicians and other care providers in the approach taken to care planning. Some physicians view the care plan as a section in their (primarily retrospective) note that usually only includes the orders and follow up instructions. Other disciplines often approach the care plan as a unique and distinct (prospective) document that includes not just the upcoming orders and follow up plans but also contextual data surrounding the overall patients care such as care barriers, e.g. homelessness. While we recognize and commend CMS in calling for the inclusion of patient-driven goals and instructions (usually seen in care plan documents, not care plan "sections"), we believe this will be inadequate to effectively coordinate and administer patient-centered care. The testing requirements for MU2 called for creation of a small number of specific goals (such as weight loss and smoking cessation) and patient instructions. The requirements did not call for progress towards goals, or other related goal tracking and care plan data as test data. As a result, care plans and care planning may be deemed sufficient based on these few items. The approach proposed in the MU3 document may lead to a "check box" approach of including a goal or two, along with a few instructions. Such an approach would entirely miss the intent of true interdisciplinary coordinated, patient directed care. Efforts to capture care plan data should be in alignment with Health Level Seven (HL7) Standards identified in the Care Plan Group[7] presented in the ONC eCare Planning session on April 20, 2015 and the recommendations from the National Quality Forum for advancing health IT data infrastructure to support quality measurement of care planning during transitions of care.[8] The document could be improved in this area by simply removing the word "field" and instead calling for "care plan, including goals and instructions".

In addition, ANA supports the feedback from an ANA expert that nursing, social work and case managers contribute significantly to the care plan not only in the areas of medication reconciliation and medication lists but from screening and assessments which define risks, gaps and barriers to patients achieving optimal health outcomes.

Nurses fulfill many critical care coordination roles and often lead care coordination on interprofessional teams. Nurses document critical information in the care plan which is used as an essential tool in effective and efficient care coordination. This data is important to inform the patient, family, and interprofessional team and promote team communication and collaboration. The information gathered through the assessment process must be incorporated

[7] See http://wiki.hl7.org/index.php?title=Care_Plan_Project_-_PCWG (accessed May 20, 2015).

[8] National Quality Forum. (2012). Critical Paths for Creating Data Platforms: Care Coordination. http://www.qualityforum.org/Publications/2012/11/Critical_Paths_for_Creating_Data_Platforms__Care_Coordination.aspx (accessed May 20, 2015).

into the e-care plan with attribution to the clinician. Continued monitoring and care plan revisions are essential for adherence to medications, clinical treatments, other self-care, and outcome improvement. Continued monitoring and care plan revision facilitates escalation of clinical care and other services when appropriate to achieve patient-driven outcomes, prevent harm, and avoidable advancement of illness and loss of function. Care plan revisions are extremely important to share and communicate with the interdisciplinary team at the point of transition within settings and across settings. The care plan is an essential tool supporting care coordination for use by the patient, family/caregivers and interprofessional team. Consistent, timely assessments and revisions can prevent errors of omission and commission and advance patient goals across the healthcare continuum.

There is a question posed in the MU3 NPRM asking if credentialed medical assistants should be allowed to reconcile medications, allergies and problems. If approved, this will count towards obtaining MU 3 Measure 3: Reconcile clinical information for 80% of transitions or referrals of new patients of Objective 7: Health Information Exchange.

ANA would like to request further clarification from CMS regarding the definition being used for reconciliation of medications, allergies and problems. Is the intent for allowing credentialed medical assistants to reconcile medications, allergies and problems translate into the actions of having non-EPs add, modify or delete this information from the EHR? Based upon feedback received from expert ANA members, there may be foundational issues with allowing anyone other than EPs to perform this task:

1. Non-EPs (credentialed MA, LVN, LPN, RN, PT, OT, ST, LCSW) may not have the legal right to add modify, or delete medications, allergies, or problems. Non-providers can, and do, routinely participate in improving medication safety and ensure adherence by reviewing medications, allergies, and problems with patients and note duplication, lack of adherence etc., but, until a provider validates and reconciles this data, it should not be deemed final. Therefore, the reconciliation process should be seen as an interdisciplinary process that includes ongoing review of patient's medications, allergies and/or problems by both EPs and Non-EPs. ANA also supports the inclusion of Pharmacists in the reconciliation interdisciplinary process. The reconciliation process of the information is the responsibility of the EP.
2. Clinical Decision Support (CDS) systems are built with the expectation of accurate data - if incorrect data is entered into the medical record, automated CDS alerts may or may not trigger appropriately. This could lead to patient harm.
3. Other members of the interdisciplinary health care team (providers and non-providers) expect accurate data when they review the medical record. If the data is incorrect, treatment plans may or may not be developed based on misinformation found in the medical record; this too, could lead to patient harm.

Objective 8: Public Health and Clinical Data Registry Reporting

Proposed Objective: The EP, eligible hospital, or CAH is in active engagement with a Public Health Agency (PHA) or Clinical Data Registry (CDR) to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Proposed Measure:

1. Proposing a total of six possible measures for this objective; EPs would be required to choose from measures 1 through 5, and would be required to successfully attest to any combination of three measures.
    1) Immunization Registry Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
    2) Syndromic Surveillance Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs, or an emergency or urgent care department for eligible hospitals and CAHs.
    3) Case Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. This is a new reporting option that was not part of Stage 2.
    4) Public Health Registry Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit data to public health registries.
    5) Clinical Data Registry Reporting: The EP, eligible hospital, or CAH is in active engagement to submit data to a clinical data registry.
    6) Electronic Reportable Laboratory Result Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results. This measure is available to eligible hospitals and CAHs only. Electronic reportable laboratory result reporting to PHAs is required for eligible hospitals and CAHs in Stage 2 (77 FR 54021). We propose to retain this measure for Stage 3 to promote the exchange of laboratory results between eligible hospitals/CAHs and PHAs for improved timeliness, reduction of manual data entry errors, and more complete information.

ANA Comments

ANA generally agrees with the goals of the Objective 8 measures and supports the concerns of the Advanced Health Models and Meaningful Use Work Group that were presented to the Health IT Policy Committee on May 12, 2015. The Workgroup suggested that there is a need for more clarity around the timing of these measures and clarification of what qualifies as eligible. There is also a focus on unidirectional reporting to PHA when bi-direction exchange may be required for timely tangible benefits to patients and communities.

Clinical Quality Measurement Reporting

ANA supports the right mix of structure, process and outcome measures as eMeasures to inform a Learning Health System.[9] NQS has identified nine levers that stakeholders can use to align their core business or organizational functions to drive improvement on the NQS aims and priorities and advance achievement of the NQS. These nine levers include: Payment; Public Reporting; Learning and Technical Assistance; Certification, Accreditation and Regulation;

[9] Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, 260, 1743-1748

Consumer Incentives and Benefit Designs; Measurement and Feedback; Health Information Technology; Workforce Development; and Innovation and Diffusion.[10] ANA supports the nine levers to advance the NQS goals in the context of the clinical quality measurement cited in this NPRM, particularly public reporting, measurement and feedback, and health information technology.

As mentioned earlier in this document, ANA supports the efforts by CMS to align quality measure reporting between quality programs such as MU, IQR, and PQRS to reduce the existing reporting burden. ANA supports the concerns expressed by an ANA member who is expert in eMeasure development, reporting, and certification that often the language within a CQM does not lend itself to being built in a CEHRT. The expert expressed concerns that eCQMs are not being updated as frequently as needed to be in alignment with evidenced-based practice, thus, the measures would require a provider to meet standards that are no longer considered best practice. CMS should ensure that CQMs are accurate and valid, and that the review process is agile enough to incorporate best practices within a reasonable time to support a Learning Health System.[11]

We appreciate the opportunity to share our views on this matter and welcome the opportunity to discuss these issues in greater detail. If you have questions, please contact Kelly Cochran at kelly.cochran@ana.org or 301.628.5040.

Sincerely,

Debbie D. Hatmaker, PhD, RN, FAAN
Executive Director

cc: Pamela Cipriano, PhD, RN, NEA-BC, FAAN, ANA President
Marla Weston, PhD, RN, FAAN, ANA Chief Executive Officer

[10] See http://www.ahrq.gov/workingforquality/reports/nqsleverfactsheet.htm (accessed May 21, 2015).

[11] IOM (Institute of Medicine). 2012. Best care at lower cost: The path to continuously learning health care in America.