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DRAFT Meaningful Use: Stage 1 Final Rule and				Public Comment
<i>Note highlighting and formatting was added from the original document for ease of reading. NEW! highlighted in green</i>				
Improving Quality, Safety, Efficiency & Reducing Health Disparities				
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3	Comments	
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)	CPOE (by licensed professional) for at least 1 medication, and 1 lab or radiology order on 80% of patients who have at least 1 such order (order does not have to be transmitted electronically)		
Drug-drug/drug-allergy interaction checks	Employ drug-drug interaction checking and drug allergy checking on appropriate evidence-based interactions	Employ drug-drug interaction checking, drug allergy checking, drug age checking (medications in the elderly), drug dose checking (e.g., pediatric dosing, chemotherapy dosing), drug lab checking, and drug condition checking (including pregnancy and lactation) on appropriate evidence-based interactions	Reporting of drug interaction checks to be defined by quality measures workgroup	
E-prescribing (eRx) (EP) (40%)	50% of orders (outpatient and hospital discharge) transmitted as eRx	80% of orders (outpatient and hospital discharge) transmitted as eRx	If receiving pharmacy cannot accept eRx, automatically generating electronic fax to pharmacy OK	
Record demographics (50%)	80% of patients have demographics recorded and can use them to produce stratified quality reports	90% of patients have demographics recorded (including IOM categories) and can use them to produce stratified quality reports		

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Report CQM electronically	Continue as per Quality Measures Workgroup and CMS	Continue as per Quality Measures Workgroup and CMS	The HIT Policy Committee's Quality Measures Workgroup issued a request for comment in December; new measures will be considered after review of public comments	
Maintain problem list (80%)	Continue Stage 1	80% problem lists are up-to-date	Expect to drive list to be up-to-date by making it part of patient visit summary and care plans	
Maintain active med list (80%)	Continue Stage 1	80% medication lists are up-to-date	Expect to drive list to be up-to-date via medication reconciliation	
Maintain active medication allergy list (80%)	Continue Stage 1	80% medication allergy lists are up-to-date	Expect to drive the list to be up-to-date by making it part of visit summary	
Record vital signs (50%)	80% of unique patients have vital signs recorded	80% of unique patients have vital signs recorded		
Record smoking status (50%)	80% of unique patients have smoking status recorded	90% of unique patients have smoking status recorded		
Implement 1 CDS rule	Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action	Establish CDS attributes for purposes of certification: 1. Authenticated (source cited); 2. Credible, evidence-based; 3. Patient-context sensitive; 4. Invokes relevant knowledge; 5. Timely; 6. Efficient workflow; 7. Integrated with EHR; 8. Presented to the appropriate party who can take action		

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Implement drug formulary checks*	Move current measure to core	80% of medication orders are checked against relevant formularies	What is the availability of formularies for eligible professionals?	
Record existence of advance directives (EH) (50%)*	Make core requirement. For EP and EH: 50% of patients >=65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	For EP and EH: 90% of patients >=65 years old have recorded in EHR the result of an advance directive discussion and the directive itself if it exists	Potential issues include: state statutes; challenges in outpatient settings; age; privacy; specialists; needs to be accessible and certifiable; need to define a standard	
Incorporate lab results as structured data (40%)*	Move current measure to core, but only where results are available	90% of lab results electronically ordered by EHR are stored as structured data in the EHR and are reconciled with structured lab orders, where results and structured orders available		
Generate patient lists for specific conditions*	Make core requirement. Generate patient lists for multiple patient-specific parameters	Patient lists are used to manage patients for high-priority health conditions		
Send patient reminders (20%)*	Make core requirement.	20% of active patients who prefer to receive reminders electronically receive preventive or follow-up reminders	How should —active patientll be defined?	
(NEW)!	30% of visits have at least one electronic EP note	90% of visits have at least one electronic EP note	Can be scanned, narrative, structured, etc.	
(NEW)!	30% of EH patient days have at least one electronic note by a physician, NP, or PA	80% of EH patient days have at least one electronic note by a physician, NP, or PA	Can be scanned, narrative, structured, etc.	
(NEW)!	30% of EH medication orders automatically tracked via electronic medication administration recording	80% of EH inpatient medication orders are automatically tracked via electronic medication administration recording		
Provide electronic copy of health information, upon request (50%)	Continue Stage 1	90% of patients have timely access to copy of health information from electronic health record, upon request	Only applies to information already stored in the EHR	

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Provide electronic copy of discharge instructions (EH) at discharge (50%)	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 80% of patients (patients may elect to receive only a printed copy of the instructions)	Electronic discharge instructions for hospitals (which are given as the patient is leaving the hospital) are offered to at least 90% of patients in the common primary languagesii (patients may elect to receive only a printed copy of the instructions)	Electronic discharge instructions should include a statement of the patient's condition, discharge medications, activities and diet, follow-up appointments, pending tests that require follow up, referrals, scheduled tests [we invite comments on the elements listed above]	
EHR-enabled patient-specific educational resources (10%)	Continue Stage 1	20% offered patient-specific educational resources online in the common primary languagesii		
(NEW for EH)!	80% of patients offered the ability to view and download via a web-based portaliii, within 36 hours of discharge, relevant information contained in the record about EH inpatient encounters. Data are available in human-readable and structured forms (HITSC to define).	80% of patients offered the ability to view and download via a web-based portaliii, 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).	Inpatient summaries include: hospitalization admit and discharge date and location; reason for hospitalization; providers; problem list; medication lists; medication allergies; procedures; immunizations; vital signs at discharge; diagnostic test results (when available); discharge instructions; care transitions summary and plan; discharge summary (when available); gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status. [we invite comments on the elements listed above]	

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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)	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 following encounter data are included (where relevant): encounter date and location; reasons for encounter; provider; problem list; medication list; medication allergies; procedures; immunizations; vital signs; diagnostic test results; clinical instructions; orders: future appointment requests, referrals, scheduled tests; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status. [we invite comments on the elements listed above]	
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 are available in human-readable and structured forms (HITSC to define).	Patients have the ability to view and download (on demand) relevant information contained in the longitudinal record, which has been updated within 4 days of the information being available to the practice. Patient should be able to filter or organize information by date, encounter, etc. Data are available in human readable and structured forms (HITSC to define).	The following data elements are included: encounter dates and locations; reasons for encounters; providers; problem list; medication list; medication allergies; procedures; immunizations; vital signs; diagnostic test results; clinical instructions; orders; longitudinal care plan; gender, race, ethnicity, date of birth; preferred language; advance directives; smoking status. [we invite comments on the elements listed above]	

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This objective sets the measures for —Provide timely electronic 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	EPs: 30% 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		
(NEW)!	EPs: online secure patient messaging is in use	EPs: online secure patient messaging is in use		
(NEW)!	Patient preferences for communication medium recorded for 20% of patients	Patient preferences for communication medium recorded for 80% of patients	How should —communication medium be delineated?	
		Offer electronic self-management tools to patients with high priority health conditions	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	
		EHRs have capability to exchange data with PHRs using standards-based health data exchange	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	
		Patients offered capability to report experience of care measures online	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	
		Offer capability to upload and incorporate patient-generated data (e.g., electronically collected patient survey data, biometric home monitoring data, patient suggestions of corrections to errors in the record) into EHRs and clinician workflow	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	

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Perform test of HIE	Connect to at least three external providers in —primary referral networkll (but outside delivery system that uses the same EHR) or establish an ongoing bidirectional connection to at least one health information exchange	Connect to at least 30% of external providers in —primary referral networkll or establish an ongoing bidirectional connection to at least one health information exchange	Successful HIE will require development and use of infrastructure like entity-level provider directories (ELPD)	
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)	Medication reconciliation conducted at 90% of care transitions by receiving provider		
Provide summary of care record (50%)*	Move to Core	Summary care record provided electronically for 80% of transitions and referrals		
(NEW)!	List of care team members (including PCP) available for 10% of patients in EHR	List of care team members (including the PCP) available for 50% of patients via electronic exchange		
(NEW)!	Record a longitudinal care plan for 20% of patients with high-priority health conditions	Longitudinal care plan available for electronic exchange for 50% of patients with high-priority health conditions		
Improve Population and Public Health				
Stage 1 Final Rule	Proposed Stage 2	Proposed Stage 3		
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	EH and EP: Mandatory test. Immunizations are submitted to IIS, if accepted and as required by law. During well child/adult visits, providers review IIS records via their EHR.		

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Submit reportable lab data*	EH: move Stage 1 to core	Mandatory test.		
	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).	<p>EH: submit reportable lab results and reportable conditions if accepted and as required by law.</p> <p>Include complete contact information (e.g., patient address, phone and municipality) in 30% (EH) of reports.</p> <p>EP: ensure that reportable lab results and reportable conditions are submitted to public health agencies either directly or through performing labs (if accepted and as required by law)</p>		
Submit syndromic surveillance data*	Move to core.	Mandatory test; submit if accepted		
		Public Health Button for EH and EP: Mandatory test and submit if accepted. Submit notifiable conditions using a reportable public-health submission button. EHR can receive and present public health alerts or follow up requests.	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	
		Patient-generated data submitted to public health agencies	We are seeking comment on what steps will be needed in stage 2 to achieve this proposed stage 3 objective	

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Conduct security review analysis & correct deficiencies			Additional privacy and security objectives under consideration via the HIT Policy Committee's Privacy & Security Tiger Team	

[See footnotes contained in the ONC document](#)

D. Additional Specific Questions for Public Comment

The Health Information Technology Policy Committee welcomes public comment on all

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

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<p>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?</p>				
<p>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.</p>				
<p>8. What are the reasonable elements that should make up a care plan, clinical summary, and discharge summary?</p>				
<p>9. What additional meaningful-use criteria could be applied to stimulate robust information exchange?</p>				
<p>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.</p>				
<p>E. Evidence Base/Rationale for Proposed New Objectives</p>				
<p>The HITPC identified proposed new objectives because of their potential impact on the five health outcome priorities to be achieved through the meaningful use of EHRs. Some of the relevant evidence to these proposed objectives is reflected below.</p>				
<p>Qualitative data analysis of provider impressions of a patient centered CDSS (Patient Assessment, Care and Education) designed to increase identification and treatment of chemotherapy related symptoms affirmed the increased awareness of underreported symptoms and additional benefits such as better communication with patients.v</p>				

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<p>A retrospective cross-sectional study analyzing the adoption of and patient satisfaction with a PHR reported 25% of patients registered with PHR and reported over 90% satisfaction with the PHR, with greatest satisfaction with test results, medication refills, and secure messaging.^{.vi,1}</p>				
<p>A CDSS electronic checklist specifically aimed to improve delivery of evidence based discharge instructions for patients with heart failure (HF) or acute myocardial infarction (AMI) was evaluated to be effective in increasing delivery of discharge instructions (from 37.2% pre-intervention to 93.0% post-intervention). In addition, prescription of ACEI or ARB in patients with HF and AMI improved to 96.7% from 80.7% and to 100% from 88.1%, respectively.^{.vii}</p>				
<p>An interventional study assessing the effect of patient messaging reminding patients of screening, diagnostic and monitoring tests in accordance with evidence based guidelines found an increase in adherence to clinical recommendations by 12.5% (p<0.001).^{.viii}</p>				

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<p>A randomized control trial of 246 patients who were newly diagnosed with breast cancer assessed the effect of a home-based computer system with information, decision-making and emotional support. The study found that patients in the intervention group were significantly more competent in seeking information, more comfortable participating in care, and more confident in their interactions with physicians at two months post intervention and had better social support and information competence at five months post intervention. Furthermore, the relative benefits in the intervention group were greater for patients in underserved populations.^{ix}</p>				
Patient and Family Engagement				
<p>In a randomized control trial assessing the efficacy of a home-based computer system in providing information and decision support as well as expert and other patient contacts to patients with HIV, findings were significant for improved quality of life indicators such as cognitive function, social support and participation in their health care, and also for decreased time spent during ambulatory visits, fewer phone calls to providers, and decreased number and length of hospitalizations.^{iv}</p>				
<p>Qualitative data analysis of provider impressions of a patient centered CDSS (Patient Assessment, Care and Education) designed to increase identification and treatment of chemotherapy related symptoms affirmed the increased awareness of underreported symptoms and additional benefits such as better communication with patients.^v</p>				
<p>A retrospective cross-sectional study analyzing the adoption of and patient satisfaction with a PHR reported 25% of patients registered with PHR and reported over 90% satisfaction with the PHR, with greatest satisfaction with test results, medication refills, and secure messaging.^{vi,1}</p>				

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<p>An interventional study assessing the effect of patient messaging reminding patients of screening, diagnostic and monitoring tests in accordance with evidence based guidelines found an increase in adherence to clinical recommendations by 12.5% (p<0.001).viii</p>				
<p>A randomized control trial of 246 patients who were newly diagnosed with breast cancer assessed the effect of a home-based computer system with information, decision-making and emotional support. The study found that patients in the intervention group were significantly more competent in seeking information, more comfortable participating in care, and more confident in their interactions with physicians at two months post intervention and had better social support and information competence at five months post intervention. Furthermore, the relative benefits in the intervention group were greater for patients in underserved populations.ix</p>				
Quality and Safety				
<p>A randomized control trial evaluating effect of CDSS alerting physicians to order venous thromboembolism (VTE) prophylaxis showed the intervention resulted in 41% decreased risk for VTE at 90 days.x</p>				
<p>Using CDS to alert physicians and pharmacists to 8 critical drug interactions resulted in 31% decrease in dispensed drugs known to have adverse interactions.xi</p>				
<p>A prospective analysis of an antimicrobial surveillance system using evidence based guidelines in a children's hospital showed successful identification of prescribing errors allowing for early intervention.xii</p>				

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<p>Analysis of a CDS system intervention aimed at improving asthma documentation and management in the emergency department found that asthma severity, asthma precipitants, ICU admission history and smoking status were recorded significantly more often with the CDSS. Additionally, 76% of patients received a discharge asthma plan compared with 16% before the intervention.xiii</p>				
<p>A prospective cohort study assessed efficacy of CDSS in identifying patients with acute lung injury (ALI) compared to physician diagnosis alone. This study is significant because early treatment of ALI is critical to overall prognosis. The CDSS had a sensitivity of 96.3% and specificity of 89.4% whereas physician diagnosis was 26.5% sensitive and 99.5% specific. Although the CDSS was less specific, physician diagnosis alone missed 239 cases while the CDSS missed 12.xiv</p>				
<p>A survey of ambulatory care providers assessed attitudes toward CPOE and e-prescribing systems and found that the majority reported improved quality of care and efficiency, prevention of medical errors, and increased patient satisfaction as advantages to the system. More than one third reported that in the last month they had avoided a medication error because of system alerts In addition, slightly less than half reported better counseling of adverse effects and improved monitoring. (Despite this only 47% reported satisfaction with the system. Complaints included alerts regarding medications discontinued, alert fatigue, and alerts inappropriately identifying drug interactions.)xv</p>				
<p>Implementation of a web-based laboratory information system to treat multi-drug resistant tuberculosis patients in Peru greatly improved timely access to lab results and user satisfaction. The system was expanded to other institutions based on its success to serve a network for over 3.1 million patients. The system is at relatively low cost amounting to 1% of National Peruvian Tuberculosis annual budget.xvi,1</p>				
Population Health				

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<p>Population based surveillance system in a large multicenter primary care network identified patients overdue for mammography screening. The interventional study showed that providers successfully contacted 63% of over 3,000 patients at risk.xvii</p>				
<p>A computer based smoking cessation program designed after extensive review of the literature on the barriers associated with such a program, was found to be effective, inexpensive and required little time or skill from staff. The program was continued following the conclusion of the study because of the satisfaction rates from providers and patients.xviii</p>				
<p>Study showed feasibility and reliability of EHR based chronic kidney disease (CKD) registry composed of 57,276 patients in accurately relaying demographics and most comorbidities when compared to individual EHR chart review ($\kappa >0.80$). Study concluded such a registry has the potential to improve quality of care in this patient population and contribute to the development of a national CKD surveillance project.xix</p>				
Care Coordination				
<p>A study assessing the effect of a medication reconciliation program in an ambulatory oncology clinic found at least one error in 81% of all patients' medication lists. In the group that received the intervention, 90% of incorrect medication lists were corrected, while only 2% were corrected in the control group ($p < 0.001$).xx</p>				
<p>2007 cross-sectional survey of US home health and hospice agencies found 33% increase in use of EHRs since 2000. The agencies used available EHR functionalities in general, including telemedicine and information sharing.xxi</p>				
Efficiency				

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<p>Antibiotic approval system guiding use of 28 restricted antibiotics improved appropriate use of antibiotics and led to increased susceptibility of <i>S. aureus</i> to methicillin and of <i>pseudomonas</i> to several antibiotics. Patients with gram negative bacteremia did not suffer increased adverse outcomes as a result.xxii</p>				
<p>An interventional study (n=2200) compared RBC transfusions in critically ill patients before and after evidence based CDS intervention significant decrease in number of RBC transfusions per patient and percentage of patients transfused (p = 0.045 and p = 0.01 respectively) and net savings of almost \$60,000 (n=1100 patients).xxiii</p>				

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