

Status	ID #	Policy Priority	Stage 1 Final Rule	Stage 2 NPRM	Stage 2 Comments	Stage 3 Recommendations	Standards Input	Stage 4 Recommendations (If applicable)
Stage 3	SGRP101	Improve quality, safety, efficiency and reducing health disparities	Medication only: More than 30% of unique patients seen during the reporting period with at least one medication in their medication list have at least one medication order entered using CPOE	Objective: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. Measure: More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE	The NPRM appears to include all orders in the denominator, including orders written on paper. If this interpretation is correct, and if CMS and ONC decide (e.g., based on public input) that counting paper orders is too difficult, then we recommend as an alternative that the denominator be something that is calculated automatically: <ul style="list-style-type: none"> • Medications on the med list • Resulted lab tests, and • Resulted radiology tests. The numerator would be the number of CPOE orders entered by the authorizing provider. As proposed, orders for medications, laboratory tests, and radiology procedures are aggregated, and the 60% threshold applies to the aggregate percent. In theory, a provider could aggregate the results of medication and laboratory test orders and get a "bye" on radiology procedure orders. Consequently, we recommend applying the 60% threshold to each order type separately. As a point of clarification, the previously submitted HITPC recommendations did call for lab test orders to be counted. Only radiology procedure orders were recommended to be a yes/no attestation.	Reconcile % after Stage 2 final Objective: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. Measure: More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE		
Stage 3	SGRP130	Improve quality, safety, efficiency and reducing health disparities	New for stage 3	New for stage 3	New for stage 3	Objective: Use computerized provider order entry for referrals/transition of care orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. Measure: More than 20% of referrals/transition of care orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded.		

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Stage 3	SGRP102	Improve quality safety, efficiency and reducing health disparities	Implement drug-drug and drug-allergy interaction checks	Implement drug-drug and drug-allergy interaction checks Consolidated with CDS	(1) We agree with the consolidation, especially because DDI is still separate in the consolidated objective. (2) We believe DDI deserves special attention because current commercial DDI databases are well known to have high false positives, which contribute to alert fatigue. Providers should be able to revise DDI rules.	Consolidated with CDS Certification: EHRs need to be able to consume external lists of DDIs (e.g., “never” combinations).	Certification: EHRs need to be able to consume external lists of DDIs (e.g., “never” combinations). Answer: Would need to harmonize SNOMED-CT, Structured Product Labeling, and RxNorm. There are no current standards to represent DDIs.	Seeking externally maintained list of DDIs with higher predictive value
Stage 3	SGRP103	Improve quality safety, efficiency and reducing health disparities	EP only: Generate and transmit more than 40% of all permissible prescriptions electronically	EP Objective: Generate and transmit permissible prescriptions electronically (eRx) EP Measure: More than 65 % of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology. EH Objective: Generate and transmit permissible discharge prescriptions electronically (eRx) EH Measure: More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology	65% may be high due to patient preference and pharmacy capabilities in certain geographies; we recommend 50%.	EP Objective: Generate and transmit permissible prescriptions electronically (eRx) EP Measure: More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary (reviewed for generic substitutions) transmitted electronically using Certified EHR Technology. EH Objective: Generate and transmit permissible discharge prescriptions electronically (eRx) EH Measure: More than 30% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology		

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Stage 3	SGRP104	Improve quality safety, efficiency and reducing health disparities	<p>Record demographics as structured data for more than 50% of all unique patients:</p> <ul style="list-style-type: none"> Preferred language Gender Race Ethnicity Date of birth (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH 	<p>Objective: Record the following demographics:</p> <ul style="list-style-type: none"> Preferred language Gender Race Ethnicity Date of birth <p>Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data</p> <ul style="list-style-type: none"> (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH 	<p>Agree with 80%. Would recommend adoption of CDC demographic standards, which are more granular than (but can be mapped to) 1997 OMB standards.</p>	<p>Objective: Record the following in structured data: Demographics:</p> <ul style="list-style-type: none"> Preferred language Gender Race Ethnicity Date of birth Occupation and industry codes <p>Clinical:</p> <ul style="list-style-type: none"> Sexual orientation, gender identity Disability status <p>Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data</p> <ul style="list-style-type: none"> (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH 	<p>HITSC: Are mature standards ready for adoption for functional status and gender identity. Is there a standard list for disability status? Are there emerging standards for other scales, such as depression. Answer: I am unaware of a vocabulary/code set describing functional status. Of course there are instruments like the SF-36, but no standard way to represent the scoring. I am unaware of vocabulary/code set values classifying disability status or depression. #3 There are existing code sets for administrative and phenotypic gender (male, female, unknown, other) #1.</p>	
Stage 3	SGRP105	Improve quality safety, efficiency and reducing health disparities	<p>Maintain an up-to-date problem list of current and active diagnoses for more than 80% of all unique patients: have at least one entry or an indication that no problems are known for patient recorded as structured data</p>	<p>Consolidated with summary of care</p>	<p>We recommend keeping these three lists as separate objectives for the following reasons:</p> <ol style="list-style-type: none"> they were and still will be important motivators for clinicians to enter and maintain accurate lists; the stage 1 requirement is very minimal; we were planning to add more rigorous capabilities in stage 3 to facilitate maintaining complete and accurate lists just having these elements in a transition of care document (which may be difficult or impossible for clinicians to access) does not give the information the visibility it deserves; removing the objectives sends a signal that these 3 items are less important than other items like demographics and vital signs. 	<p>New for stage 3 Certification criteria only: EHR systems should provide functionality to help maintain up-to-date, accurate problem list</p>	<p>There are mature standards for problem lists, meds and allergies. There are no standards for computer assisted coding.</p>	<p>Stage 4: Patient input to reconciliation of problems</p>

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Stage 3	SGRP106	Improve quality, safety, efficiency and reducing health disparities	Maintain active medication list: more than 80% of all unique patients have at least one entry recorded as structured data (or indication that the patient is on no meds)	Consolidated with summary of care	We recommend keeping these 3 lists as separate objectives for the following reasons: 1) they were and still will be important motivators for clinicians to enter and maintain accurate lists; 2) the stage 1 requirement is very minimal; we were planning to add more rigorous capabilities in stage 3 to facilitate maintaining complete and accurate lists 3) just having these elements in a transition of care document (which may be difficult or impossible for clinicians to access) does not give the information the visibility it deserves; 4) removing the objectives sends a signal that these 3 items are less important than other items like demographics and vital signs.	New for stage 3 Certification criteria only: EHR systems should provide functionality to help maintain up-to-date, accurate meds list	Structured SIG is evolving. Drug category is already part of RxNorm, #1	
Stage 3	SGRP107	Improve quality, safety, efficiency and reducing health disparities	Maintain active medication allergy list: More than 80% of all unique patients seen during the reporting period have at least one entry (or indication that the patient has no known medication allergies) recorded as structured data	Consolidated with summary of care	We recommend keeping these 3 lists as separate objectives for the following reasons: 1) they were and still will be important motivators for clinicians to enter and maintain accurate lists; 2) the stage 1 requirement is very minimal; we were planning to add more rigorous capabilities in stage 3 to facilitate maintaining complete and accurate lists 3) just having these elements in a transition of care document (which may be difficult or impossible for clinicians to access) does not give the information the visibility it deserves; 4) removing the objectives sends a signal that these 3 items are less important than other items like demographics and vital signs.	New for stage 3 Certification criteria: EHR systems should provide functionality to code medication allergies and link to related drug family, and code related reaction.	There are SNOMED-CT descriptions of allergies to substances #1. To my knowledge there is not a value set for the type of reaction, but there likely will be (#2) by 2016. There are no standards for overriding an alert #4	Stage 4: Contraindications that could include: adverse reactions, procedural intolerance.

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Stage 3	SGRP108	Improve quality safety, efficiency and reducing health disparities	Record and chart changes in vital signs: more than 50% of all unique patients age 2 and over have vital signs recorded as structured data <ul style="list-style-type: none"> Height Weight Blood pressure Calculate and display BMI Plot and display growth charts for children 2-20 years, including BMI 	Objective: Record and chart changes in vital signs: <ul style="list-style-type: none"> Height/Length Weight Blood pressure (age 3 and over) Calculate and display BMI Plot and display growth charts for patients 0-20 years, including BMI Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recoded as structured data	Agree.	Maintain as is for Stage 3 or retire as topped out measure.		
Stage 3	SGRP109	Improve quality safety, efficiency and reducing health disparities	Record smoking status for patients 13 years old and older: more than 50% of all unique patients seen during the reporting period 13 years or older have smoking status recorded as structured data	Objective: Record smoking status for patients 13 years old or older Measure: More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Agree.	Consider retiring or incorporating into CQM	HITSC: Is there a mature standard for coding smoking status? May consider retiring the objective because captured within CQMs. Answer: Yes, already part of MU code sets. #1	
Stage 3	SGRP110	Improve quality safety, efficiency and reducing health disparities	MENU: Implement drug-formulary checks with access to at least one drug formulary	Consolidated - included within eRx core objective	Agree. HITPC commented to maintain this measure	Consolidated - Moved to eRx objective.		
Stage 3	SGRP111	Improve quality safety, efficiency and reducing health disparities	Report ambulatory and hospital clinical quality measures to CMS or States	Removed - Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6	Agree.	Removed		

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Stage 3	SGRP112	Improve quality safety, efficiency and reducing health disparities	EH MENU: Record advanced directives for more than 50% patients 65 years old or older	EP: N/A EH Objective: Record whether a patient 65 years old or older has an advance directive EH Menu Measure: More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	EP: We recommend adding a Menu requirement - More than 10% of patients who are 65 or older seen during the reporting period have an indication of an advance directive status recorded as structured data. We strongly recommend moving this proposed menu requirement to core for Stage 3. EH: This is an important objective and we recommend the original stage 1 objective should be moved to core for hospitals in stage 2.	Add for EPs if not included in Stage 2 and make core for EH. Ensure standards support in CDA by 2016 Advanced directives hearing to further refine.	HITSC: Where does AD fit with CDA? Answer: Although there is no current standard for advanced directives, it is likely there will be a CDA format by 2016. #2	
Stage 3	SGRP113	Improve quality safety, efficiency and reducing health disparities	EP: Implement one clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance with that rule EH: Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Objective: Use clinical decision support to improve performance on high priority health conditions Measure: 1. Implement five clinical decision support interventions related to five or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	In addition to DDI, require an additional decision support function addressing efficiency such as reducing overuse of high-cost imaging or use of generic medications. We recommend use of the original HITPCs recommendation for five CDS attributes. We note that these attributes are incorporated into the certification NPRM, with two exceptions: a. We recommend simplifying the citation of the basis of a CDS intervention to include the reference source and any external funding of the development or implementation of the CDS intervention. b. We recommend not having a special call-out for "linked references" since it is just one type of CDS intervention and our goal was to be flexible and not prescriptive	Objective: Use clinical decision support to improve performance on high priority health conditions Measure: 1. Implement 15 clinical decision support interventions related to five or more clinical quality measures , if applicable, at a relevant point in patient care for the entire EHR reporting period. a. Include renal dosing checks (may need to be stage 4 due to lack of structured Sigs) b. Include CDS for appropriateness of lab or radiology orders (to avoid redundant or inappropriate orders) 2. The EP, eligible hospital, or CAH has enabled the functionality for drug- drug and drug-allergy interaction checks for the entire EHR reporting period. Certification criteria only: 1. Ability to track CDS triggers and how the provider responded 2. Ability to flag preference-sensitive conditions, and provide decision support materials for patients.	There are no current standards for this. Ability = certification requirements	
Stage 3	SGRP114	Improve quality safety, efficiency and reducing health disparities	MENU: Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests results ordered whose results are either in a positive/negative or numerical format	Objective: Incorporate clinical lab-test results into EHR as structured data Measure: More than 55% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data	Agree. Okay to count individual tests.	Objective: Incorporate clinical lab-test results into EHR as structured data Measure: More than 80% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data		

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Stage 3	SGRP1 15	Improve quality safety, efficiency and reducing health disparities	MENU: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	EP Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach EP Measure: Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.	Agree. We recommend that queries for patient lists be able to accommodate multiple specific conditions (e.g., health condition, disparity variables) to ensure that EHRs were certified to handle more than one variable.	EP Objective: Generate lists of patients for multiple specific conditions and present real-time dashboards to use for quality improvement, reduction of disparities, research, or outreach		
Stage 3	SGRP1 16	Improve quality safety, efficiency and reducing health disparities	EP MENU: Send preventive or follow-up reminders to more than 20% of all unique patients 65+ years old or 5 years old or younger	EP Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care EP Measure: More than 10% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference	EP: Agree. It may require exclusions for some specialists, such as surgeons who do not require follow up after the initial post-op visit or manage preventive services.	EP Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care EP Measure: More than 20% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference Exclusion: Specialists may be excluded for prevention reminders (could be more condition specific).		
Stage 3	SGRP1 17	Improve quality safety, efficiency and reducing health disparities	N/A	EH Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) Measure: More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR.	Agree.	EH Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) Measure: 1) More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR. 2) Mismatches are tracked and acted upon (self-report policies and practices on handling reports of mismatches).		

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Stage 3	SGRP1 18	Improve quality safety, efficiency and reducing health disparities	N/A	<p>Objective: Incorporate imaging results and information into Certified EHR Technology</p> <p>Menu Measure: More than 40% of all scans and tests whose result is an image ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are incorporated into or accessible through Certified EHR Technology</p>	<p>(1) We agree with the proposed objective, but would recommend a 10% threshold with an exclusion if they have no access to electronic images (e.g., local imaging centers do not offer electronic access).</p> <p>(2) Re: question about a potential measure requiring exchanging images for 10%. While we agree with the spirit of the potential measure, we believe that Stage 2 is too soon to expect EPs and EAs to share images with outside providers.</p>	Move to core, pending stage 2 FR		
Stage 3	SGRP1 19	Improve quality safety, efficiency and reducing health disparities	N/A	<p>Objective: Record patient family health history as structured data</p> <p>Menu Measure: More than 20% of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been reviewed</p>	Agree with this measure as a menu item.	<p>Objective: Record high priority family history data (including colon cancer, breast, glaucoma, MI, diabetes)</p> <p>Measure: Record high priority family history in 40% of patients seen during reporting period</p> <p>Certification criteria: Make sure that every CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach).</p>	<p>HITSC: Is there a mature standard for family history? HL7 Pedigree or SNOMED-CT?</p> <p>Answer: No mature standards but there is the surgeon general's XML format. #2</p>	

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Stage 3	SGRP1 20	Improve quality safety, efficiency and reducing health disparities	N/A	Objective not included – asked for comment Objective/Measure: Record electronic notes in patient records for more than 30 percent of office visits. While we believe that medical evaluation entries by providers are an important component of patient records that can provide information not otherwise captured within standardized fields, we believe there is evidence to suggest that electronic notes are already widely used by providers of Certified EHR Technology and therefore do not need to be included as a meaningful use objective.	Because some certified EHRs do not have clinical documentation, and we believe that having a complete record, including progress notes, is required to deliver high quality, efficient care, we recommend that provision for recording progress notes should be a meaningful use objective, as originally recommended by HITPC: EP: Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of unique visits during the reporting period (non-searchable, scanned notes do not qualify). Notes should be text-searchable. EH: Enter at least one electronic note by a physician, physician assistant, or nurse practitioner, broadly defined, for more than 30% of eligible hospital days (non-searchable, scanned notes do not qualify). Notes should be text-searchable. Support the NPRM language on text-searchable notes in certification.	Record electronic notes in patient records for more than 30% of office visits within four calendar days.		
Stage 3	SGRP1 21	Improve quality safety, efficiency and reducing health disparities	N/A	Objective not included – asked for comment Hospital Objective: Provide structured electronic lab results to eligible professionals. Hospital Measure: Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 40 percent of electronic lab orders received.	We reconfirm our initial recommendation for hospitals to send structured lab results electronically to ambulatory providers using certified electronic health record technology: Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic lab orders received. LOINC should be used where available.	Hospital Objective: Provide structured electronic lab results to eligible professionals. Hospital Measure: Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 70% of electronic lab orders received.		
Stage 3	SGRP1 22	Improve quality safety, efficiency and reducing health disparities	New for stage 3	New for stage 3	New for stage 3	EH: Explore Timely transition document (elements need to be fleshed out) that is available electronically within four calendar days for when a transition occurs between sites.	NEW HITSC: What is included in CDA?	

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Stage 3	SGRP2 04A	Engage patients and families in their care	N/A	<p>EP Objective: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p> <p>EP Measure:</p> <ol style="list-style-type: none"> More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information More than 10 % of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download , or transmit to a third party their health information <p>EH Objective: Provide patients the ability to view online and download information about a hospital admission</p> <p>EH Measure:</p> <ol style="list-style-type: none"> More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge More than 10 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period 	<ul style="list-style-type: none"> We appreciate and agree with the intent to keep the timeliness criterion simple (ie, have only 1 timeline). However, we believe there is value in providing the patient with prompt access to the summary of an encounter (which we define as an office visit or other contact in which an order is generated). We propose that a single timeliness criterion be applied, and that it be shortened to "within two business days of information becoming available to the EP." Denominator: All active patients seen within the last 2 years, less those in the adolescent category (will vary for provider due to individual state laws) Numerator: Number of patients or proxies (e.g. parent, child) that have logged in at any time prior to attestation. The threshold would be 10% or greater. Exclusion allowed for low broadband access (according to FCC) and special hardship cases (e.g. Amish). Information of that record is viewed, downloaded, transmitted in a way that is successful to the patient (transmit can include transmission from one provider to patient's personal record or another provider if the patient chooses). 	<p>Objective: Retain View/Download/Transmit</p> <p>Explore further in RFC: Provide 50% of patients the ability to designate to whom and when (i.e. auto blue-button & on-demand) a summary of care document is sent to specific care team members (across settings/providers), and create ability of providers to review/accept updates.</p>		

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Stage 3	SGRP2 04B	Engage patients and families in their care	New for stage 3	New for stage 3	New for stage 3	<p>Option 1: Provide 10% of patients with ability to submit information (provider chooses one or more of these information types according to what is most appropriate to their practice) such as:</p> <ol style="list-style-type: none"> 1. Family Health History [as per Surgeon General] 2. ODLs [as per How's Your Health] 3. Caregiver status and role [as per DECAF] 4. Functional status [as per PROMIS 10] 5. Patient-created health goals (needs a standard, also in care summary and plan) 6. Medical device: Glucose level* 7. Medical device: Blood Pressure* 8. Medical device: Weight* <p>*[SNOMED/LOINC]</p> <p>Option 2: Provide 10% of patients with ability to submit information using:</p> <ol style="list-style-type: none"> 1) A generic semi-structured questionnaire platform and 2) capability to receive uploads from home devices (e.g., glucometer, BP device, scale) that accommodate the data above. 	<p>HITSC: Available standards? Answer: Family History -surgeon general's format. #2 ODL's - no standards. #4 Caregiver status - no standards #4 Functional Status #3 as above Health goals - no standards #4 Medical device for glucose/blood pressure, weight - IEEEE standards plus SNOMED/LOINC #2</p>	
Stage 3	SGRP2 04C	Engage patients and families in their care	New for stage 3	New for stage 3	New for stage 3	<p>Certification criteria only: Create capability to accept pre-visit prep tools into the EHR (e.g., the ability to consent to treatment, fill out administrative forms) (and also could send to other EHRs)</p>	Care team members - no standard	
Stage 3	SGRP2 04D	Engage patients and families in their care	New for stage 3	New for stage 3	New for stage 3	<p>Objective: Offer 10% of patients the ability to update/correct information</p>	Prep visit tools - no standard	

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Stage 3	SGRP2 05	Engage patients and families in their care health disparities	EP: Provide clinical summaries for more than 50% of all office visits within 3 business days	EP Objective: Provide clinical summaries for patients for each office visit Measure: Clinical summaries provided to patients within 24 hours for more than 50 % of office visits.	The NPRM says that HITPC recommended that for clinical summaries information be made available within 24 hrs or within 4 business days of info becoming available. The HITPC actually recommended that for clinical summaries information be made available within 24 hrs or within 4 (calendar) days of becoming available. To be consistent with the view/download/transmit objective, we recommend that a single timeline of 2 business days be applied to this objective as well	Retain. May need to update content requirements after stage 2 FR		
Stage 3	SGRP2 06	Engage patients and families in their care health disparities	MENU: Use certified EHR technology to identify patient-specific educational resources for more than 10% of all unique patients and provide those resources to the patient if appropriate	EP/EH Objective: Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient EP Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all office visits by the EP. EH Measure: More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology	Agree.	Retain objective Add language support: Option 1: Of those patients who speak one of the top 5 nationally prevalent languages, 80% of materials must be provided in the language according to patient's preference, where materials are publicly available Option 2: For one non-English speaking population, provide patient education materials in that language, where materials are publicly available		
Stage 3	SGRP2 07	Engage patients and families in their care health disparities	N/A	Objective: Use secure electronic messaging to communicate with patients on relevant health information Measure: A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 % of unique patients seen during the EHR reporting period	<ul style="list-style-type: none"> We are concerned that 10% is too high to achieve by Stage 2. We recommend lowering the threshold to 5% (which is 10% of the necessary 50% with portal access) for patient- initiated messages. The patient-initiated message could be a response to a provider message. Exclusion allowed for low broadband access (according to FCC) and special hardship cases (e.g. Amish). 	Measure: More than 15% of patients use secure electronic messaging to communicate with EPs		Stage 4: Create capacity for electronic episodes of care (telemetry devices, etc) and to do e-referrals and e-consults

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Stage 3	SGRP2 08	Engage patients and families in their care health disparities	N/A	Objective not included – asked for comment EP Objective/Measure: Record patient preferences for communication medium for more than 20 % of all unique patients seen during the EHR reporting period. We believe that this requirement is better incorporated with other objectives that require patient communication and is not necessary as a standalone objective.	We recommend inclusion of this objective as a Core measure. HITPC's intent was to capture a patient's preferred communication method in order for the system to use that media for future non-urgent communication. This respects the patient's wishes and is more efficient for the provider. We recommend that the preferred communication field support multiple message types (e.g., non-urgent clinical, administrative) and preferred media (e.g., electronic, phone, SMS message).	Retain, pending stage 2 FR		
Stage 3	SGRP2 09	Engage patients and families in their care health disparities	New for stage 3	New for stage 3	New for stage 3	Explore For Certification Rule Only: Capability for EHR to query research enrollment systems to identify available clinical trials.		No use requirements until Stage 4.
Stage 4	SGRP2 10	Engage patients and families in their care health disparities	PLACEHOLDER for stage 4	PLACEHOLDER for stage 4	PLACEHOLDER for stage 4	Placeholder for Stage 4		Patients receive alerts for drug recalls, devices or other safety alerts; set preferences for receiving alerts.
Stage 3	SGRP3 01	Improve Care Coordination	Perform at least one test of the capability to exchange key clinical information	Removed for an actual use case	We agree with eliminating the test for Stage 2. For Stage 1, we suggested option 4 (actual electronic transmission of a summary of care document).	Eliminate for stage 3 in favor of use cases.		

Status	ID #	Policy Priority	Stage 1 Final Rule	Stage 2 NPRM	Stage 2 Comments	Stage 3 Recommendations	Standards Input	Stage 4 Recommendations (If applicable)
Stage 3	SGRP302	Improve Care Coordination	<p>MENU: Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH</p>	<p>EP Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</p> <p>EP Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) EH</p> <p>Objective: The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation</p> <p>EH Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)</p>	<p>Meaningful Use workgroup:</p> <ul style="list-style-type: none"> Criteria to document that the transition is about to or has occurred is needed. Agree with the definition of a transition. Recommend that the threshold remains at 50%. 	<p>EP / EH / CAH Objective: The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform reconciliation for:</p> <ul style="list-style-type: none"> medications medication allergies problems <p>EP / EH / CAH Measure: The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than 10% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).</p>	<p>HITSC: Available standards? Answer: No accepted standard for reconciling medication lists or contraindications other than existing allergy vocabularies. #3</p>	<p>Stage 4: Reconciliation of contraindications (any medical reason for not performing a particular therapy; any condition, clinical symptom, or circumstance indicating that the use of an otherwise advisable intervention in some particular line of treatment is improper, undesirable, or inappropriate)</p>

Status	ID #	Policy Priority	Stage 1 Final Rule	Stage 2 NPRM	Stage 2 Comments	Stage 3 Recommendations	Standards Input	Stage 4 Recommendations (If applicable)
Stage 3	SGRP303	Improve Care Coordination	<p>MENU: Provide a summary of care record for more than 50% of all transitions and referrals of care</p>	<p>EP Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</p> <p>EH Objective: The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</p> <p>Measure:</p> <ol style="list-style-type: none"> The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 % 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 electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 % of transitions of care and referrals. 	<ul style="list-style-type: none"> Care plan section of the summary of care document should include the reason(s) for referral or transition and the results of the referral (recommendations). To support the measure, the provider needs to capture the fact that a transition is about to occur. We agree with the requirement for measure 2 that the transmitted summary of care document should cross organizational barriers. However, we believe that while it is essential that the exchange of information comply with prescribed standards, we believe that requiring that the transmission occur between different vendor systems may cause unintended consequences in some geographic regions where a few vendors may have a dominant market share. The group was divided on countable number vs. percent. One ongoing electronic connection between two different organizations should be required unless less than 5 transitions occurred in the year. 	<p>EP/ EH / CAH Objective: EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care</p> <ul style="list-style-type: none"> Provide a summary of care record for each site transition or referral when transition or referral occurs with available information <p>Measure: The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30% electronically).</p> <p>Certification Criteria: EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral.</p> <p>Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant):</p> <ol style="list-style-type: none"> Concise narrative in support of care transitions (free text that captures reason for referral or transition) Setting-specific goals Instructions for care during transition and for 48 hours afterwards Care team members, including primary care provider and caregiver name, role and contact info (using DECAF) 		

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Stage 3	SGRP304	Improve Care Coordination	New for stage 3	New for stage 3	New for stage 3	<p>EP/ EH / CAH Objective: EP/ EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care</p> <p>For each transition of care, provide the care plan information, including the following elements <u>as applicable</u>:</p> <ul style="list-style-type: none"> • Medical diagnoses and stages • Functional status, including ADLs • Relevant social and financial information (free text) • Relevant environmental factors impacting patient's health (free text) • Most likely course of illness or condition, in broad terms (free text) • Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver • The patient's long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals • Specific advance care plan (POLST) and the care setting in which it was executed <p>For each referral, provide a care plan if one exists</p> <p>Measure: The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver.</p>	We have consolidated CDA which enables templates for problems, medications, allergies, notes, labs, and care plans. There are no standards to support the structured recording of anything else you've listed. #4	
Stage 3	SGRP305	Improve Care Coordination	New for stage 3	New for stage 3	New for stage 3	<p>EP / EH / CAH Objective (new): EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby closing the loop on information exchange.</p> <p>Measure: For 10% of patients referred during an EHR reporting period, referral results generated from the EHR are returned to the requestor (e.g. via scan, printout, fax, electronic CDA Care Summary and Consult Report).</p>		
Stage 4	SGRP127	Improve Care Coordination	PLACEHOLDER for stage 4		Stage 4: Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care			

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Stage 4	SGRP1 25	Improve Care Coordination	PLACEHOLDER for stage 4	PLACEHOLDER for stage 4	PLACEHOLDER for stage 4	Placeholder for Stage 4		<p>Stage 4: Medication reconciliation: create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring)</p> <p>Vendors need an approach for identifying important signals such as: identify data that patient is not taking a drug, patient is taking two kinds of the same drug (including detection of abuse) or multiple drugs that overlap.</p>
Stage 3	SGRP3 06	Improve Care Coordination	N/A	Objective not included – asked for comment Objective/Measure: Record health care team members (including at a minimum PCP, if available) for more than 10 percent of all patients seen during the reporting period; this information can be unstructured. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.	Okay to leave as part of the summary of care document.	Add into care summary		
Stage 3	SGRP3 07	Improve Care Coordination	N/A	Objective not included – asked for comment Objective/Measure: Record care plan goals and patient instructions in the care plan for more than 10 percent of patients seen during the reporting period. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.	Okay to leave as part of the summary of care document.	Add into care summary		

Status	ID #	Policy Priority	Stage 1 Final Rule	Stage 2 NPRM	Stage 2 Comments	Stage 3 Recommendations	Standards Input	Stage 4 Recommendations (If applicable)
Stage 3	SGRP4 01A	Improve population and public health	MENU: Perform at least one test of the capability to submit electronic data to immunization registries or Immunization Information systems and actual submission in accordance with applicable law and practice	Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice Measure: Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	<ul style="list-style-type: none"> We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. Need clarification on "except where prohibited." Participation should be encouraged beyond transfers required by law, but we are concerned about unintended consequences (e.g., temptation to pass new laws prohibiting transfer to avoid penalizing local health providers). 	<p>EP/ EH Objective (New): Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period.</p> <p>Exclusion: EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories.</p> <p>Certification criteria: EHR is able to receive and present a standard set of structured, externally-generated, immunization history and capture the act and date of review within the EP/EH practice.</p>	The HL7 implementation guide for submitting immunizations is well adopted #1. There are well described, but not widely implemented query standards. #2	Stage 4 EP/EH Objective: Add submission of vaccine contraindication(s) and reason(s) for substance refusal to the current objective of successful ongoing immunization data submission to registry or immunization information systems.

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Stage 3	SGRP4 01B	Improve population and public health	New for stage 3	New for stage 3	New for stage 3	<p>EP/EH Objective (New): Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy.</p> <p>Measure: Implement an immunization recommendation system that:</p> <ol style="list-style-type: none"> 1) establishes baseline recommendations (e.g., Advisory Committee on Immunization Practices), and 2) allows for local/state variations. For 20% of patients receiving an immunization, the EP/EH practice receives the recommendation before giving an immunization. <p>Exclusion: EPs and EHs that administer no immunizations.</p> <p>Certification criteria: EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.</p>	No standards to represent immunization rules exist.	
RFC	SGRP4 02A	Improve population and public health	Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies and actual submission in accordance with applicable law and practice	<p>EH Objective: Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice</p> <p>Measure: Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.</p>	<ul style="list-style-type: none"> • We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. • Need clarification on "except where prohibited." Participation should be encouraged beyond transfers required by law, but we are concerned about unintended consequences (e.g., temptation to pass new laws prohibiting transfer to avoid penalizing local health 	<p>EH Objective (unchanged): No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system</p>	No such jurisdiction specific case report standards exist. #4	

Status	ID #	Policy Priority	Stage 1 Final Rule	Stage 2 NPRM	Stage 2 Comments	Stage 3 Recommendations	Standards Input	Stage 4 Recommendations (If applicable)
RFC	SGRP4 02B	Improve population and public health	More information from RFC - New for stage 3	More information from RFC - New for stage 3	More information from RFC - New for stage 3	<p>Objective presented for comment (Stage undetermined):</p> <p>EP Objective (new): Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Attestation of submission of standardized initial case reports to public health agencies on 20% of all reportable disease or conditions during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice.</p> <p>Certification criteria: The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit</p>	No standards which parse external data generated requests exist, although Query Health may help. #3	
Stage 3	SGRP4 03	Improve population and public health	Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	<p>Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice</p> <p>EP Menu Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period</p> <p>Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice</p> <p>EH CORE Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period</p>	<ul style="list-style-type: none"> We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. Need clarification on "except where prohibited." Participation should be encouraged beyond transfers required by law, but we are concerned about unintended consequences (e.g., temptation to pass new laws prohibiting transfer to avoid penalizing local health providers). 	No change from current requirements.		

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Stage 3	SGRP4 04	Improve population and public health	N/A	<p>EP Objective: Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.</p> <p>EP Menu Measure: Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period</p>	<ul style="list-style-type: none"> Recommend consolidating two registry objectives (cancer and specialty registry) into one menu objective. Out of HIT policy committee meeting 4/4 – wondering why we chose cancer, think more about what should be the registry options. Important to establish national comparative data that can be done with registries Supportive of cancer registry because it is prevalent Need to consider whether sufficient standards are available to support the interfaces between EHRs and registries. Panelists at our hearing also expressed concern about the proprietary nature of some registries, which affects the costs to participate, and in some cases places contractual restrictions on use of data and ability to participate in other registries. Concern about requiring all EHRs to interface all data with all registries. 	<p>EH/EP Objective (New, pending Stage 2 Rule): Capability to electronically participate and send standardized, commonly formatted reports to a mandated jurisdictional registry (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to either local/state health departments, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to prior requirements for submission to an immunization registry.</p> <p>Measure: Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. Attestation of submission for at least 20% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.</p> <p>Certification criteria: EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated registry, maintain an audit of those reports, and track total number of reports sent.</p> <p>Exclusion: where local or state health departments have no mandated registries or are incapable of receiving these standardized reports</p>	No such standards exist. To my knowledge the cancer registry standards you cite have not been implemented in any commercial product.	

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Stage 3	SGRP4 05	Improve population and public health	N/A	<p>EP Objective: Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.</p> <p>EP Menu Measure: Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period</p>	<ul style="list-style-type: none"> Recommend consolidating two registry objectives (cancer and specialty registry) into one menu objective. Important to establish national comparative data that can be done with registries Need to consider whether sufficient standards are available to support the interfaces between EHRs and registries. Panelists at our hearing also expressed concern about the proprietary nature of some registries, which affects the costs to participate, and in some cases places contractual restrictions on use of data and ability to participate in other registries. Concern about requiring all EHRs to interface all data with all registries. We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. Need clarification on “except where prohibited.” Participation should be encouraged beyond transfers required by law, but we are concerned about unintended consequences (e.g., temptation to pass new laws prohibiting transfer to avoid penalizing local health providers). 	<p>Objective presented for comment (Stage undetermined):</p> <p>EP Objective (New, pending Stage 2 Rule): Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements (e.g., immunizations, cancer, early hearing detection and intervention, and/or children with special needs).</p> <p>Registry examples include hypertension, diabetes, body mass index, devices, and/or other diagnoses/conditions) from the Certified EHR to a jurisdictional, professional or other aggregating resources (e.g., HIE, ACO), except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Documentation of successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. Attestation of submission for at least 20% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice.</p> <p>Certification criteria: EHR is able to build and send a standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent.</p> <p>Note: This objective is the same as the previous, but adds a second registry and does not need to be jurisdictional.</p>	<p>HITSC: as in previous recommendation, is there a standardized message format that may be used across a variety of registries for public health reporting?</p> <p>Answer: No such standards exist.</p>	

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Stage 3	SGRP407	Improve population and public health	New for stage 3	New for stage 3	New for stage 3	<p>EH Objective (new): Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Documentation of successful electronic transmission of standardized healthcare acquired infection reports to the NHSN from the Certified EHR Technology. Total numeric count of HAI in the hospital and attestation of Certified EHR electronic submission of at least 20% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.</p> <p>Certification criteria: EHR is able to sending a standard HAI message to NHSN, maintain an audit and track total number of reports sent.</p>	The CDC has created an HAI specific CDA document implementation guide. No HAI standard has been incorporated into any commercial product to my knowledge. #2	
RFC	SGRP408	Improve population and public health	New for stage 3	New for stage 3	New for stage 3	<p>Objective presented for comment (Stage undetermined):</p> <p>EH/EP Objective (new): Capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR, except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Attestation of successful electronic transmission of standardized adverse event reports to the FDA/CDC from the Certified EHR Technology. Total numeric count (null is acceptable) of adverse event reports from the EH/EP submitted electronically during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.</p> <p>Certification criteria: EHR is able to build and send a standardized adverse event report message to FDA/CDC and maintain an audit of those reports sent to track number of reports sent</p>	It is unclear that an EHR would contain the data elements needed for an adverse event report. Germany article suggested use of ICD-10 coding.	