DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the National Coordinator for Health Information Technology
Health Information Technology; HIT Policy Committee: Request for Comment Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs)
AGENCY: Office of the National Coordinator for Health Information Technology (ONC), Department of Health and Human Services (HHS).

ACTION: Request for Comments.

SUMMARY: This document is a request for comments by the HIT Policy Committee regarding the Stage 3 definition of meaningful use of EHRs.

DATES: Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [INSERT DATE 45 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

ADDRESSES: Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments electronically (please do not submit duplicate comments). You may submit electronic comments on this request for information at http://www.regulations.gov. Follow the "Submit a comment" instructions. Attachments should be in Microsoft Word or Excel, WordPerfect, or Adobe PDF.

FOR FURTHER INFORMATION CONTACT: MacKenzie Robertson, Office of the National Coordinator, Patriots Plaza III, 355 E Street, SW., Washington, DC 20201, (202) 205-8089

SUPPLEMENTARY INFORMATION:
Inspection of Public Comments: All comments received before the close of the comment period will be available for public inspection, including any personally identifiable or confidential business information that is included in a comment. Please do not include anything in your comment submission that you do not wish to share with the general public. Such information includes, but is not limited to: A person's social security number; date of birth; driver's license number; state identification number or foreign country equivalent; passport number; financial account number; credit or debit card number; any personal health information; or any business information that could be considered to be proprietary. We will post all comments received before the close of the comment period at http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

HITPC Stage 3 Request for Comment

Background

The Health Information Technology Policy Committee (HITPC) is a federal advisory committee that advises the U.S. Department of Health and Human Services (HHS) on federal HIT policy issues, including how to define the "meaningful use" (MU) of electronic health records (EHRs) for the purposes of the Medicare and Medicaid EHR incentive programs. The HITECH portion of the American Recovery and Reinvestment Act (ARRA) of 2009 specifically mandated that incentives should be given to Medicare and Medicaid providers not for EHR adoption but for "meaningful use" of EHRs. In July of 2010 and August 2012, HHS released that program's final rule defining stage 1 and stage 2 MU respectively strongly signaling that the bar for what constitutes MU would be raised in subsequent stages in order to improve advanced care processes and health outcomes.

The HITPC held a series of public hearings and listening sessions to hear testimony from a wide range of stakeholders regarding current experience with MU, lessons learned, and what thought leaders desire in the future, including how MU should support emerging new models of care. This input helped to inform many hours of public deliberations regarding the future vision of MU. The stage 3 vision includes a collaborative model of care with shared responsibility and accountability, building upon the previous MU objectives. While the committee appreciates and recognizes today's challenges in setting up data exchanges, it is the committee's recommendation that stage 3 is the time to begin to transition from a setting-specific focus to a collaborative, patient- and family- centric approach.

To realize this vision, the HITPC used the following guiding principles. To be considered for stage 3, an objective should:

- Support new models of care (e.g., team-based, outcomes-oriented, population management)
- Address national health priorities (e.g., NQS, Million Hearts)
- Have broad applicability (since MU is a floor) to
    - provider specialties (e.g., primary care, specialty care)
    - patient health needs
    - areas of the country
- Promote advancement -- Not "topped out" or not already driven by market forces
- Be achievable – e.g. there are mature standards widely adopted or could be widely adopted by 2016
- Reflect reasonableness/feasibility of products or organizational capacity
- Prefer to have standards available if not widely adopted

The HITPC has developed a preliminary set of recommendations specifically designed to solicit additional public feedback. The goal of sending out this request for comment (RFC) early is threefold.

- Extend the public discussion of future stage MU definitions through a more formal public comment process well in advance of its formal stage 3 recommendations.
- Request input on specific questions.
- Provide some signal to the industry of potential new EHR functionalities that the HITPC may recommend to assist the industry.

Following the analysis of the comments received through the 45-day public comment period, the HITPC intends to revisit these recommendations in its public meetings in the first quarter of 2013. It is important to note that although the following RFC is being communicated via HHS and the Federal Register, it represents the preliminary thinking of the HITPC and not necessarily HHS or its various agencies.

HITPC Solicitation of Comments

This document is broken into the following sections: Meaningful Use Objectives and Measures, Quality Measures, and Privacy and Security. Details from the HITPC workgroups have been accumulated into these sections for consideration to HHS for stage 3. We want to acknowledge and thank the following workgroups for the tireless hours they have put forth to aggregate these recommendations for comment: Meaningful Use, Information Exchange, Quality Measures, and the Privacy and Security Tiger Team.

Each item that the HITPC is requesting comment on has been given an identification number in order to streamline the accumulation of comments, please use this identification number when submitting comments.

I. Meaningful Use Objectives and Measures

This section includes a grid with items from both the Meaningful Use Workgroup and the Information Exchange Workgroup. Recommendations, concepts, and questions have been organized into 6 sections that include:

1) Improving Quality, Safety, and Reducing Health Disparities
2) Engaging Patients and Families
3) Improving Care Coordination
4) Improving population and public health
5) Information Exchange
6) Overarching MU questions

HITPC Stage 3 Request for Comment

The grid below includes the following columns: stage 2 objectives and measures (for reference), stage 3 recommendations, proposed for future stage, and questions/comments. The proposed for future stage column includes items that the HITPC believes are important, but may not be feasible for stage 3; therefore comments on the readiness and feasibility of these items are appreciated. The questions/comment column provides a place for the HITPC to describe the thinking behind the objective or ask questions related to these objectives. In an effort to achieve parsimony, there are also items identified as Certification Criteria. These items are intended to create additional functionality within electronic health record (EHR) systems for providers, but there may not be use requirements associated with them. As a reminder, identification numbers are provided so that commenters can easily reference the objective when commenting. All commenters are encouraged to provide alternative solutions for achieving the goals discussed.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
		Improving quality, safety, and reducing health disparities		
SGRP 101	**EP Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **EH Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **EP/EH Measure:** More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	**Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. CPOE for medications includes DDI checking for "never" combinations as determined by an externally vetted list. **Measure:** More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE **Certification Criteria:** EHR must be able to consume an externally supplied list of "never" DDIs, using RxNorm and NDF-RT standards along with a TBD DDI reactions value set. **Certification Only for EPs** • EHRs must have the ability to identify abnormal test results and track when results are available or not completed by a certain time. • EHRs must record date/time test results are reviewed and by whom • EHR must have the ability to transmit lab orders using the lab order and results Interface guidelines produced by the S&I Framework Initiative.	Seeking externally maintained list of DDIs with higher predictive value	
SGRP 130	**New**	**Objective:** Use computerized provider order entry for referrals/transition of care orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. **Measure:** More than 20% of referrals/transition of		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
		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.		
SGRP 103	**EP/EH Objective:** Generate and transmit permissible prescriptions electronically (eRx) **Measure:** More than 50% of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT. **EH MENU Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx) **EH MENU Measure:** More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology	**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	Advanced medication reconciliation to check for formulary compliance. Medication formulary checking: • If Rx is formulary-compliant, transmit to pharmacy. • If Rx is not formulary compliant, prescriber presented with alternatives (if available through formulary database) or provided a structured prior-authorization form to complete before Rx transmitted. Capability for automatic approval of prior-auth should be available.	How to include formulary checking into EHR and connection to formulary sources (e.g., PBMs)?

SGRP 104	**EP Objective: Record the following demographics**
	• Preferred language
	• Sex
	• Race
	• Ethnicity
	• Date of birth
	
	EH Objective: Record the following demographics
	• Preferred language
	• Sex
	• Race
	• Ethnicity
	• Date of birth
	• Date and preliminary cause of death in the event of mortality in the eligible
		Retire prior demographics objective because it is topped out (achieved 80% threshold).
		Certification criteria:
		• Occupation and industry codes
		• Sexual orientation, gender identity (optional fields)
		• Disability status
		  • Differentiate between patient reported & medically determined
		  • Need to continue standards work		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	hospital or CAH **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.			
SGRP 105	**Consolidated in summary of care objective** - Maintain an up-to-date problem list of current and active diagnoses	**Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate problem list **Certification criteria only:** Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians' maintenance of up-to-date accurate problem lists. Systems provide decision support about additions, edits, and deletions for clinicians' review and action. For example, diabetes is not on the problem list but hypoglycemic medications are on the medication list: the EHR system will prompt the provider that the patient may need diabetes added to the problem list, but it will not be put on the list automatically.	Patient input to reconciliation of problems	How to incorporate into certification criteria for pilot testing?
SGRP 106	**Consolidated with summary of care** - Maintain active medication list	**Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list **Certification criteria only:** Use of problems and lab test results to support clinicians' maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians' review. For example, an antibiotic (not for acne) has been on the medication list for a year: the EHR system will prompt the provider that medication may need to be removed from the med list, but it will not be automatically removed.	**Certification criteria:** Use other EHR data such as medications filled or dispensed, or free text searching for medications to support maintenance of up-to-date and accurate medication lists.	How to incorporate into certification criteria for pilot testing?
SGRP	**Consolidated with summary of care -**	**Certification criteria only:** EHR systems should	Contraindications that could include adverse	

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
107	Maintain active medication allergy list	provide functionality to code medication allergies and link to related drug family, and code related reaction. Systems provide decision support about additions, edits, and deletions for clinicians' review and action.	reactions and procedural intolerance. **Certification criteria:** Explore greater specificity for food-drug interactions	
SGRP 108	**Objective: Record and chart changes in vital signs:** • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018		
SGRP 109	**EP/EH Objective:** Record smoking status for patients 13 years old or older **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018		
SGRP 112	**EH MENU Objective: R**ecord whether a patient 65 years old or older has an advance directive **EH MENU Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the	Ensure standards support in CDA by 2016 **EP MENU/EH Core Objective:** Record whether a patient 65 years old or older has an advance directive **EP MENU/EH Core Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	EHR reporting period have an indication of an advance directive status recorded as structured data.	(POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.		
SGRP 113	**EP/EH Objective:** Use clinical decision support to improve performance on high-priority health conditions **Measure:** 1. Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. 2. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	**Objective:** Use clinical decision support to improve performance on high priority health conditions **Measure:** 1. Implement 15 clinical decision support interventions or guidance related to five or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 CDS interventions should include one or more interventions in each of the following areas, as applicable to the EP's specialty: • Preventative care (including immunizations) • Chronic disease management (e.g., diabetes, hypertension, coronary artery disease) • Appropriateness of lab and radiology orders • Advanced medication-related decision support* (e.g., renal drug dosing) 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. **Certification criteria 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. 3. Capability to check for a maximum dose in addition to a weight based calculation. 4. Use of structured SIG standards 5. Ability for EHRs to consume CDS interventions from central repositories (e.g., rules for drug-drug interactions, rules for reporting diseases for public health departments, preference-sensitive care lists) *Kuperman,GJ. (2007). Medication-related clinical decision support in computerized provider order entry systems: a review. *Journal of the American Medical Informatics Association: JAMIA, 14*(1):29-40. **this is used to improve the effectiveness of CDS interventions	*Procedure/Surgery/lab/radiology/test prior authorization v.A*: for those procedures/surgeries/lab/radiology/test with clear and objective prior authorization requirements and a structured data prior authorization form is available, clinician fill out the prior authorization form using structured data fields and prior authorization can be granted electronically and in real-time by the payor. *Procedure/Surgery/lab/radiology /test prior authorization v.B*: for those procedures/surgeries/lab/radiology/test, for which prior authorization is non-standardized and is highly individualized, a standardized form is created that collects from the clinician text fields answering an agreed upon set of medical necessity questions, standardized form is sent electronically to insurer for review, insurer responds with Approval/Denial (with rationale if denied) using a standardized format text document back to clinician with either approval and/or denial with rationale.	The goal of this objective is to create EHR capability to introduce efficiencies into process for providers. The EHR should have capacity to query (via web services) available databases to identify "trigger events" conditions (e.g., case reporting criteria, drug-drug interactions, potentially relevant trials) based on patient's health condition, diagnoses, location, and other basic facts). The EHR should be able to identify these trigger events and then assist clinicians to act on that information.
SGRP	**EP/EH Objective:** Incorporate clinical lab-	**Objective:** Incorporate clinical lab-test results into EHR		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
114	test results into Certified EHR Technology as structured data **Measure:** More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data	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		
SGRP 115	**EP CORE Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach **EP CORE Measure:** Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.	**EP Objective:** Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports. Dashboards are incorporated into the EHR's clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report.		
SGRP 116	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder per patient preference. **Measure:** More than 10% of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available	**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).		
SGRP 117	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** More than 10 percent of	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** 1) More than 30% of medication orders created by authorized providers of the eligible hospital's or CAH's		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.	inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR. 2) Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked for use in quality improvement.		
SGRP 118	**MENU Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **MENU Measure:** More than 10 percent of all tests whose result is one or more images ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology.	**CORE Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **CORE Measure:** More than 10 percent of all tests whose result is an image (including ECGs) ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology		What barriers could be encountered in moving this to core?
SGRP 119	**MENU Objective:** Record patient family health history as structured data **MENU Measure:** More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives	**CORE Objective:** Record high priority family history data **CORE Measure:** Record high priority family history in 40% of patients seen during reporting period **Certification criteria:** Make sure that every appropriate CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach).		
SGRP 120	**EP/EH MENU Objective:** Record electronic notes in patient records **EP MENU Measure:** Enter at least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of unique patient office visits. Notes must be text-searchable. Non-searchable scanned notes do not qualify but this does not mean that all of	Record electronic notes in patient records for more than 30% of office visits within four calendar days.		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	the content has to be character text. Drawings and other content can be included with text notes under this measure. **EP MENU Measure:** Enter at least one electronic progress note created, edited, and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable, scanned notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure.			
SGRP 121	**EH MENU Objective:** Provide structured electronic lab results to ambulatory providers **EH MENU Measure:** Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of electronic lab orders received	**EH CORE Objective:** Provide structured electronic lab results to eligible professionals. **EH CORE Measure:** Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 80% of electronic lab orders received.		
Engage patients and families in their care				
SGRP 204A	**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. **EP Measure:** 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the	• EPs should make info available within 24 hours if generated during course of visit • For labs or other types of info not generated within course of visit, it is made available to pts within four business days of info becoming available to EPs • Potential to increase both thresholds (% offer and	Building on Automated Transmit: 1a. Create the ability for providers to review patient-transmitted information and accept updates into EHR. 1b. Related certification criteria: Standards needed for provider directories in order to facilitate more automated transmissions per patients' designations.	Explore the readiness of vendors and the pros and cons of including certification for the following in this objective: • Images (actual images, not just reports) • Radiation dosing information from tests

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. 2. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information. **EH Objective:** Provide patients the ability to view online, download, and transmit information about a hospital admission 1. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge 2. More than 5 percent of all patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period.	% use) based on experience in Stage 2 **Note:** Depending on experience in Stage 2, CMS may want to give credit to some providers (e.g. specialists) for view/download/transmit where the patient has requested that they prefer info to be sent to a location they specify (such as another provider portal or PHR), rather than only making available information on the provider's portal. **MENU item:** Automated Transmit*: (builds on "Automated Blue Button Project"): Provide 50% of patients the ability to designate to whom and when (i.e. pre-set automated & on-demand) a summary of care document is sent to patient-designated recipient** (for example, a one-time request to send information from specialist to primary care, or a standing request to always send an updated care summary when certain events arise, such as a change in medication or the completion of new tests or procedures). *Subject to the same conditions as view, download, transmit **Before issuing final recommendations in May 2013, HITPC will also review the result of Automated Blue Button pilots, in addition to considering public comments received.		involving radiation exposure in a structured field so that patients can view the amount of radiation they have been exposed to • MENU: Progress notes (re: OpenNotes project)
SGRP 204B	**New**	**MENU:** Provide 10% of patients with the ability to submit patient-generated health information to improve performance on high priority health conditions, and/or to improve patient engagement in care (e.g. patient experience, pre-visit information, patient created health goals, shared decision making, advance directives, etc.). This could be accomplished through semi-structured questionnaires, and EPs and EHs would choose information that is most relevant for their patients and/or related to high priority health		Readiness of standards to include medical device data from the home?

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
		conditions they elect to focus on. Based upon feedback from HITSC this should be a MENU item in order to create the essential functionality in certified EHRs.		
SGRP 204D	**New**	**Objective:** Offer patients the ability to request an amendment to their information (e.g., offer corrections, additions or updates to the record)		
SGRP 205	**EP Objective:** Provide clinical summaries for patients for each office visit **EP Measure:** Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits.	The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.		What specific information should be included in the after visit summary to facilitate the goal of patients having concise and clear access to info about their most recent health and care, and understand what they can do next, as well as when to call the doctor if certain symptoms/events arise?
SGRP 206	**EP/EH Objective:** Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient **EP CORE Measure:** Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period **EH CORE Measure:** More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology	**Additional language support:** For the top 5 non-English languages spoken nationally, provide 80% of patient-specific education materials in at least one of those languages based on EP's or EH's local population, where publically available.		
SGRP 207	**EP Objective:** Use secure electronic messaging to communicate with patients on relevant health information	**Measure:** More than 10% of patients use secure electronic messaging to communicate with EPs*	Create capacity for electronic episodes of care (telemetry devices, etc) and to do e-referrals and e-consults	

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	EP Measure: A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period	* Assess readiness of raising threshold to 30% based on experience in Stage 2.		
SGRP 208	**Not included separately (in reminder objective)**	**EP and EH Measure:** Record communication preferences for 20% of patients, based on how (e.g., the medium) patients would like to receive information for certain purposes (including appointment reminders, reminders for follow up and preventive care, referrals, after visit summaries and test results).		
SGRP 209	**New**	**Certification Rule Only:** Capability for EHR to query research enrollment systems to identify available clinical trials. No use requirements until future stages.		The goal of this objective is to facilitate identification of relevant clinical trials for an individual patient, subject to patient interest.
		Improve Care Coordination		
SGRP 302	**EP/EH CORE Objective:** The EP/EH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. **EP/EH CORE Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	**EP / EH / CAH Objective:** The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform reconciliation for: - medications - medication allergies - problems **EP / EH / CAH Measure:** The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than10% 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). **SC&C Recommendation:** Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e. severity).	Reconciliation of contraindications (any medical reason for not performing a particular therapy; any condition, clinical symptom, or circumstance indicating that the use of an otherwise advisable intervention in some particular line of treatment is improper, undesirable, or inappropriate) **SC&C Recommendation:** Standards work needs to be done to support the valuing and coding of contraindications.	Feasibility to add additional fields for reconciliation e.g. social history?
SGRP 303	**EP/EH CORE Objective:** The EP/EH/CAH who transitions their patient to another	**EP/ EH / CAH Objective:** EP/EH/CAH who transitions		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	setting of care or provider of care or refers their patient to another provider of care provides summary care record for each transition of care or referral. **CORE Measure:** 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. 2. The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. 3. An EP, eligible hospital or CAH must satisfy one of the two following criteria: (A) conducts one or more successful electronic exchanges of a summary of care document, as part ofwhich is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii) (B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was developed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or (B) conducts one or more successful tests with the CMS designated test EHR during	their patient to another setting of care or refers their patient to another provider of care Provide a summary of care record for each site transition or referral when transition or referral occurs with available information Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant): 1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral) 2. Setting-specific goals 3. Instructions for care during transition and for 48 hours afterwards 4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF) **Measure:** The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30% electronically). **Certification Criteria:** EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral. **Certification Criteria:** Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which and are expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: 1) Consultation Request (Referral to a consultant or		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	the EHR reporting period.	the ED) 2) Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency)		
SGRP 304	**New**		**EP/ EH / CAH Objective:** EP/ EH/CAH who transitions their patient to another site of care or refers their patient to another provider of care For each transition of site of care, provide the care plan information, including the following elements <u>as applicable:</u> •Medical diagnoses and stages •Functional status, including ADLs •Relevant social and financial information (free text) •Relevant environmental factors impacting patient's health (free text) •Most likely course of illness or condition, in broad terms (free text) •Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver •The patient's long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals •Specific advance care plan (POLST) and the care setting in which it was executed For each referral, provide a care plan if one exists **Measure:** The EP, eligible hospital, or CAH that transitions or refers their patient to another site of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver.	How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care, and includes the patient and their non-professional caregivers? Think through these priority use cases: 1. Patient going home from an acute care hospital admission 2. Patient in nursing home going to ED for emergency assessment and returning to nursing home 3. Patient seeing multiple ambulatory specialists needing care coordination with primary care 4. Patient going home from either hospital and / or nursing some and receiving home health services What are the most essential data elements to ensuring safe, effective care transitions and ongoing care management? How might sharing key data elements actually improve the communication? Consider health concerns, patient goals, expected outcomes, interventions,

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
			Certification Criteria: Develop standards for a shared care plan, as being defined by S&I Longitudinal Coordination of Care WG. Some of the data elements in the shared care plan overlap content represented in the CDA. Adopt standards for the structured recording of other data elements, such as patient goals and related interventions.	including advance orders, and care team members. What data strategy and terminology are required such that the data populated by venue specific EHRs can be exchanged. How might existing terminologies be reconciled? What are the requirements (legal, workflow, other considerations) for patients and their identified team to participate in a shared care plan? Is it useful to consider role-based access as a technical method of implementing who will have access to and be able to contribute to the care plan? How will such access be managed?
SGRP 305	**New**	**EP / EH / CAH Objective:** EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby beginning to close the loop. **Measure:** For patients referred during an EHR reporting period, referral results generated from the EHR, 50% are returned to the requestor and 10% of those are returned electronically **Certification Criteria:** Include data set defined by S&I Longitudinal Coordination of Care WG and expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Shared Care Encounter Summary (Consultation Summary, Return from the ED to the referring facility, Office Visit)	Continue working to close the loop with an acknowledgement of order receipt and tracking for completion. Certification criteria: Include standards for referral requests that require authorizations (or pre-certifications) for procedure, surgery, lab, radiology, test orders.	
SGRP 127	**New**	**New**	Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care	

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
SGRP 125	**New**	**New**	Medication reconciliation: create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring) 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.	
SGRP 308	**New**	**EH Objective:** The EH/CAH will send electronic notification of a significant healthcare event in a timely manner to key members of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required. **EH Measure:** For 10% of patients with a significant healthcare event (arrival at an Emergency Department (ED), admission to a hospital, discharge from an ED or hospital, or death), EH/CAH will send an electronic notification to at least one key member of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required, within 2 hours of when the event occurs.		
		Improve population and public health		
SGRP 401A	**EP/EH Objective:** Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period	**EP/ EH Objective:** Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period.	**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.	

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
		Exclusion: EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories. **Certification criteria**: EHR is able to receive and present a standard set of structured, externally-generated, immunization history and capture the act and date of review within the EP/EH practice.		
SGRP 401B	**New**	**EP/EH Objective:** Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy. **Measure:** Implement an immunization recommendation system that: 1) establishes baseline recommendations (e.g., Advisory Committee on Immunization Practices), and 2) allows for local/state variations. For 20% of patients receiving an immunization, the EP/EH practice receives the recommendation before giving an immunization. **Exclusion:** EPs and EHs that administer no immunizations. **Certification criteria:** EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.		
SGRP 402A	**EH Objective:** Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice **Measure:** Successful ongoing submission of	**EH Objective (unchanged):** No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period.			
SGRP 402B	**New**	**New**	**EP Objective:** Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice. **Measure:** Attestation of submission of standardized initial case reports to public health agencies on 10% of all reportable disease or conditions during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit. Could similar standards be used as those for clinical trials (SGRP209)?	
SGRP 403	**EP MENU Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice **EH Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing	No change from current requirements.		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period			
SGRP 404	**EP only MENU Objective:** Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period	**EH/EP Objective:** Capability to electronically participate and send standardized (i.e. data elements and transport mechanisms), commonly formatted reports to a mandated jurisdictional registry (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to either local/state health departments, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to prior requirements for submission to an immunization registry. **Measure:** Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated registry, maintain an audit of those reports, and track total number of reports sent. **Exclusion:** where local or state health departments have no mandated registries or are incapable of receiving these standardized reports		
SGRP 405	**EP only MENU Objective:** Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of specific case	**EP Objective:** Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements (e.g., immunizations, cancer, early hearing detection and intervention, and/or children with special needs). Registry examples include hypertension, diabetes, body mass index, devices, and/or other diagnoses/conditions) from the Certified EHR to a jurisdictional, professional or other aggregating		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
	information from Certified EHR Technology to a specialized registry for the entire EHR reporting period	resources (e.g., HIE, ACO), except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** EHR is able to build and send a standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent.		
SGRP 407	**New**	**EH Objective:** Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of successful electronic transmission of standardized healthcare acquired infection reports to the NHSN from the Certified EHR Technology. Total numeric count of HAI in the hospital and attestation of Certified EHR electronic submission of at least 10% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria**: EHR is able to sending a standard HAI message to NHSN, maintain an audit and track total number of reports sent.		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
SGRP 408	**New**	**New**	**EH/EP Objective:** Capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. **Measure:** Attestation of successful electronic transmission of standardized adverse event reports to the FDA/CDC from the Certified EHR Technology. Total numeric count (null is acceptable) of adverse event reports from the EH/EP submitted electronically during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to build and send a standardized adverse event report message to FDA/CDC and maintain an audit of those reports sent to track number of reports sent (Common Format).	
		Information Exchange		
IEWG 101	**New**	**Certification criteria:** The EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a health information exchange, or an entity on the NwHIN Exchange, for example. This query may consist of three transactions: a) Patient query based on demographics and other available identifiers, as well as the requestor and purpose of request. b) Query for a document list based for an identified patient c) Request a specific set of documents from the returned document list When receiving inbound patient query, the EHR must be able to:		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions / Comments
		a) Tell the querying system whether patient authorization is required to retrieve the patient's records and where to obtain the authorization language*. (E.g. if authorization is already on file at the record-holding institution it may not be required). b) At the direction of the record-holding institution, respond with a list of the patient's releasable documents based on patient's authorization c) At the direction of the record-holding institution, release specific documents with patient's authorization The EHR initiating the query must be able to query an outside entity* for the authorization language to be presented to and signed by the patient or her proxy in order to retrieve the patient's records. Upon the patient signing the form, the EHR must be able to send, based on the preference of the record-holding institution, either: 1. a copy of the signed form to the entity requesting it 2. an electronic notification attesting to the collection of the patient's signature *Note:* The authorization text may come from the record-holding EHR system, or, at the direction of the patient or the record-holding EHR, could be located in a directory separate from the record-holding EHR system, and so a query for authorization language would need to be directable to the correct endpoint.		
IEWG 102	**New**	**Certification criteria**: The EHR must be able to query a Provider Directory external to the EHR to obtain entity-level addressing information (e.g. push or pull addresses).		Are there sufficiently mature standards in place to support this criteria? What implementation of these standards are in place and what has the experience been?
IEWG	**New**	**Certification criteria**: Enable a user to electronically		What criteria should be added to

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

In an attempt to focus on outcomes and performance improvement, would it be possible to focus on a specific health issue? Meaningful Use could be used to improve performance on cardiovascular disease which is the leading cause of premature death, and leads health care spending. In September 2011, the Department of Health and Human Services launched the Million Hearts initiative to prevent one million heart attacks and strokes in the next five years through improved community and clinical prevention. All health care providers who provide direct patient care have a role to play in improving high blood pressure control and cardiovascular health in the United States. Systematic, information-driven quality improvement can yield great impact; therefore, the HITPC specifically recommends the following objectives be integrated into Meaningful Use:

ID#	Recommended objective	Inclusion in stage 3
MU01	Use EHR technology features (such as structured recording of vital signs and registry capabilities) to identify patients meeting criteria for hypertension who are not yet diagnosed and managed for the disorder. In some studies, up to 30 percent of patients with hypertension remain undiagnosed.	Certification criteria related to problem list maintenance
MU02	Use EHR technology features (registries, clinical decision support, patient reminders) to achieve improvements in hypertension control across their practice.	Specifically include in the CDS objective as a high priority condition: SGRP113

ID#	Recommended objective	Inclusion in stage 3
MU03	Report the adequacy of blood pressure control in their practice populations using NQF measure 0018. In Stage 1 and the NPRM for Stage 2 this is a menu (optional) "core" clinical quality measure. Because of its importance to the Million Hearts focus, it should be made mandatory in Stage 3.	Maintain NQF 0018 in recommended core set. Providers will track progress to improve outcomes.
MU04	Eligible professionals and hospitals should use EHR technology to refer tobacco users to public health sponsored tobacco quit-line services. This objective could potentially be supported using the recommended new objective establishing the capacity to exchange referral documents (recommendation SGRP3-03). Because of the importance of tobacco cessation to the Million Hearts campaign, an objective should specifically include quit-line referrals.	Certification criteria: Ability to automatically populate a referral form for specific purposes, including a referral to a smoking quit line.
MU05	Reducing tobacco use is critical to achieving the Million Hearts goal, and CDC opposes retiring the objective that eligible professionals and hospitals record patient smoking status in the EHR. Eligible professionals and hospitals need to record and respond to tobacco use in patients, whether or not they have elected to report on the smoking-cessation clinical quality measure. CDC understands the need to revise the associated specification to make this EHR data harmonious with that used in tobacco-related clinical quality measures and clinical decision support, and so it better reflects non-cigarette tobacco use and tobacco use by minors.	Maintain NQF 0028 in recommended core set. Providers will track progress to improve outcomes.

In addition to the questions above, the HITPC would also appreciate comment on the following questions.

ID#	Question
MU06	Currently, providers have to meet all MU criteria to receive incentives. Is there flexibility in achieving a close percentage of the objectives, but not quite achieving all of them? What is the downside of providing this additional flexibility? How will it impact providers who are achieving all of the MU criteria? If there is additional flexibility of this type, what are the ways this can be constructed so that it is not harmful to the goals of the program and advantageous to others?

II. Quality Measures

The Health IT Policy Committee, in the October 2010 "Tiger Team Summary Report", the December 2010 Request for Comment, and the August 2011 Transmittal Letter, described the intention to support the development of HIT-sensitive, parsimonious, longitudinal, outcomes-focused CQMs for the EHR Incentive Program. In advance of Stage 2 the HITPC recommended eCQM sub-domains and concepts for development and implementation. In advance of Stage 3, the committee intends to focus more broadly on the measure components (logic and value sets), the environment in which the measures operate and the extent to which the measures support quality improvement.

HITPC Stage 3 Request for Comment

We understand the fundamental mission of the EHR Incentive Program CQM set is to promote the capabilities of EHRs to capture relevant data and to calculate and report measures used by public recognition and payment programs as efficiently and reliably as possible in order to improve the quality of care and experience of care for providers and patients

1. The measures should leverage, to the greatest extent possible, data routinely captured in the EHR and PHR during the process of care, while minimizing data-collection burden on the part of providers
2. The measures set should address measures for public reporting and quality improvement, and be meaningful at the point of care.
3. CQMs should not be "hard coded" into the EHR. Doing so may negatively impact local workflow.
    - Providers should be able to configure the CQM calculation to use data elements appropriate to local workflow
    - When part of EHR the CQM should calculate automatically.
4. An end goal is to shift quality measurement and reporting from sampled retrospective/human chart reviews/ accounting to concurrent/ machine-automated/ improvement while recognizing that there will remain a place for human abstracted quality measurement.
5. Support for CQM calculations should be flexible and adaptive to future requirements, which may include new measures or changes to measure definitions at minimal cost and resources.

Please use the identification numbers below to comment on the appropriateness of the fundamental mission and five key attributes described above for the stage 3 clinical quality measures.

A. **Patient Centeredness: Broaden Stakeholder Input**

The HITPC intends to capture insights broadly from providers, patients, lay caregivers and other stakeholder groups across the healthcare landscape that have been previously less engaged in HIT policymaking but actively engaged as providers, purchases and recipients of care.

ID #	Questions
QMWG01	How can the HITPC and QMWG capture input from a wide variety of providers, patients, organizations and societies?
QMWG02	What additional channels for input should we consider?

B. **Patient Centeredness: Patient-reported and Patient-Directed Data**

The HITPC recognizes that both patients and providers generate and consume clinical quality data. The committee anticipates that consumer generated and directed data is most useful if the data spans settings and is oriented to outcomes. We appreciate that performance data is important for both quality improvement and for shared decision making. Contributors have challenged the workgroup to develop CQMs that accommodate personal care goals in addition to guideline-directed care goals. This is a commendable aspiration; still significant barriers to integration of patient-generated data with EHR clinical data remain.

ID #	Questions
QMWG03	Please comment with guidance on how consumer-reported data can be incorporated into CQMs. What examples are there of EHR-enabled quality measures that use data directly entered by patients?
QMWG04	Please provide examples of how patient-directed data is informing shared decision making. How does the public view the integration of EHR derived data with patient generated data for quality measurement? How important is it to keep this data separate? Should it be separate?

C. **CQM Pipeline: Process and Outcome Measures**

The HITPC Quality Measure Workgroup has previously described, in the October 2010 "Tiger Team Summary Report" and the December 2010 Request for Comment, our intention to support the development of HIT-sensitive, parsimonious, longitudinal outcomes-focused CQMs for the EHR Incentive Program. The HITPC also recognizes that there remains value in developing near real-time, point-of-care, process measures for clinical use that can contribute nuance to performance demonstrated by value-oriented, outcomes measures.

ID #	Questions
QMWG05	Please provide comment on how the HITPC should proceed with our focus on clinical outcomes. Should the HITPC focus its efforts on building point-of-care process measures or value-centered outcome measures?
QMWG06	Is this a false or unnecessary dichotomy? Should we instead consider a third approach, to promote process-outcome measure "suites", combinations of end outcome measures that are potentially associated with process measures? For example, Stage 2 eCQM set will include three HIV measures. The outcome of viral load suppression is accompanied by two related process measures for an HIV medical visit and for Pneumocystis Pneumonia prophylaxis.

D. **CQM Pipeline: Measure Development Lifecycle**

The HITPC is considering recommendations both on the types of measures that are developed on the process for measure development. The QMWG has heard from eCQM measure developers, that "retooling", the process of translating existing quality measures, originally based on administrative and claims data and chart abstraction, into XML code may not fully preserve the original intent of the legacy measures and measure components (logic and value sets). Furthermore, retooled measures often do not take full advantage of the richness of clinical data in the EHR, and do not reach out to collect data from patients that are possible through the use of PHRs. Consequently, the QMWG is considering recommending that HHS efforts shift from retooling paper chart/claims measures to designing de novo EHR-enabled measures. The QMWG supports development of de novo measures that stay faithful to high priority quality measurement concepts.

ID #	Questions
QMWG07	Please comment on challenges and ambiguities in retooling legacy paper abstracted and claims based eCQMs.
QMWG08	Is this a shift away from retooling legacy paper-based CQMs in exchange for designing CQMs de novo a reasonable course of action?
QMWG09	Please comment on the provider/payer/patient experience with using retooled measures as opposed to experience with de novo measures designed and intended for EHR-based measurement.

E. **CQM Pipeline: MU Alignment with Functional Objectives**

The HITPC understands that EHRs are a powerful tool with the potential to increase clinical efficiency. However, with EHR adoption and implementation there is also a risk of increasing provider administrative burden as well. The HITPC recognizes that successful attestation weighs an administrative burden on providers and their staff. For Stage 3, the workgroup intends to alleviate administrative burden by further aligning the eCQMs logic and value sets with EHR Incentive Program Functional Objectives. For example, care coordination CQMs can be refined/or designed de novo to better align with the Summary of Care objective. Our goal is not only to mitigate increased burden but to guide users on leveraging efficient and meaningful use. The HITPC seeks comments to guide our recommendations for Stage 3 in this area. The HITPC continues to support HHS-wide efforts to align CQMs across quality assessment programs (PQRS, MU,IQR, etc).

ID #	Questions
QMWG10	Please comment on aligning CQMs with MU Objectives. Would eCQM-MU Objective alignment be clinically valuable to providers or might this be a redundant exercise in shifting resources?
QMWG11	Which measures and objectives, in particular, have the greatest potential to maximize meaningful alignment? Please recommend eCQM/Objective alignment opportunities.

F. **CQM Pipeline: Domains and Exemplars**

The HITPC continues to encourage development and release of eCQMs that cover the six priority domains identified by the National Quality Strategy. The HITPC intends to identify exemplar measures/concepts that both address underrepresented NQS priority domains and leverage the current and near future capabilities of EHRs.

ID #	Questions
QMWG12	Which, if any, high priority domains should receive prioritized attention in Stage 3? What measure concepts, addressing these domains, should be considered for development? What EHR capabilities should be leveraged to realize these concepts?

ID #	Questions
QMWG13	Are there EHR based exemplar measures that exist, or that are being conceptualized or developed, that address these domains and theses concepts? What scientific evidence, if any, supports these concepts and exemplars?

G. **CQM Pipeline: MU and Innovation**

The HITPC recognizes that some health systems, ACOs, and other provider networks have developed, tested and deployed locally generated CQMs that address high priority conditions or processes relevant to their local patient population or organizations. Usually, health systems do not submit these self-developed CQMs for endorsement by NQF because they do not consider themselves to be a measure developer. However, these locally developed measures may be useful to many other organizations in the country.

In order to leverage some of the innovation by health systems in creating measures that leverage data from the EHR, the QMWG has discussed a proposal to allow EPs or EHs to submit a locally developed CQM as a menu item in partial fulfillment of MU requirements (in lieu of one of the existing measures specified in the MU program). Health care organizations choosing this optional menu track would be required to use a brief submission form that describes some of the evidence that supports their measure and how the measure was used in their organization to improve care. The healthcare organization benefits by reporting on something that it feels is important in partial completion of MU qualification. CMS benefits from learning about CQMs developed by EHR users in the field, and may use this pipeline of innovative CQMs as a stimulus for new-measure development.

As the EHR Incentive Program is currently an attestation and not accountability program, we see this program as a valuable opportunity to encourage provider-level CQM innovation and perform provider-level CQM testing. If we can set reasonable criteria, then we can use this program for more developmental and innovative work. We have received comments that recommend individual providers that have designed/developed their own measures should be allowed to submit these measures and data as part of attestation.

ID #	Questions
QMWG14	Please comment on the desirability and feasibility of such an innovation track as a voluntary, optional component of the MU CQM requirement.
QMWG15	The QMWG has considered two approaches to institution-initiated eCQMs. A conservative approach might allow "Certified CQM Development Organizations", such as professional societies and IDNs to design, develop, release and report proprietary CQMs for MU. An alternate approach might open the process to any EP/EH but constrain allowable eCQMs with certain design standards. There are advantages and disadvantages to both. Please submit comments on either, both or unique approaches.
QMWG16	What information should be submitted with a locally developed CQM to help CMS and other healthcare providers assess the innovative measure? For example, should the submission form include a brief description of: 1) importance/rationale of the measure domain; 2)evidence basis for the specific measure; 3) feasibility, and 4) usefulness of the measure?
QMWG17	What constraints should be in place? Should individual providers have an option to choose and/or design their own measures outside of the established CQM EHR Incentive Program set? Should these "practice-level" measures be required to conform to the Quality Data Model data elements and/or entered

ID #	Questions
	into the Measure Authoring Tool or conform to a simplified HQMF XML?
QMWG18	What precautions might be necessary to mitigate fraud, waste and abuse and to avoid submission of trivial new measures that are unlikely to advance the field ?
QMWG19	For the existing and/or in the proposed expanded institution-initiated CQMs, how can federal agencies better support consistent implementation of measures for vendors and local practices (e.g., test case patients, template workflow diagrams, defined intent of measure and valueset)?
QMWG20	Stage 3 may increase the number of measures EPs and EHs calculate and report. Considering provider burden, is there a limit to the number of measures that a provider should be expected to calculate? Is there evidence to support a limit?

H. Quality Improvement Support: Architecture and Standards

The HITPC recognizes that there is an opportunity, in the next stage of Meaningful Use, to design measures that improve the user experience and leverage technologic capability of certified EHR software to affect quality improvement. The workgroup considers the features below for eCQMs and EHRs to valuable both for users and meaningful in clinical practice.

ID #	Questions
QMWG21	Please comment on the value and feasibility of the eCQM and EHR features listed below: - Ability to accept downloaded specifications for new measures with little tailoring or new coding - Minimal manual data collection or manipulation - Ability to aggregate measure data to varying business units (practice, episode, ACO, medical home, MA plan, etc) - Ability to build measures that incorporate cross-setting records for episodes, medical homes, outcomes (e.g., readmissions) - Ability to build multi-source data records, including claims, patient reported data - Ability to implement machine-readable HQMF that minimizes manual vendor coding - Ability to drill-down on reported measures for QI analyses
QMWG22	What other features, if any, should be considered? Please make suggestions.
QMWG23	What is the role of muliti-source data exchange in achieving these features?

I. **Quality Improvement Support: CQM Population Management Platform**

The HITPC intends to encourage the development and expansion of HIT tools that leverage use of eCQMs for population management. The work group is especially interested in development of CQM population mapping and task-management platforms such as, clinical quality measure dashboard or business process management software and workflow engines that allow users to respond to actionable data on clinical care gaps and assign tasks both to individual patients and for user-determined cohorts. The workgroup understands that this technology is desired by providers and requests comments on the potential role of the HITPC and HHS in this space.

ID #	Questions
QMWG24	Please comment on the value and feasibility of the CQM Population Management Platforms. Is there an evidence basis for clinical population management platform use? Is there a business case? Is this an area that could benefit from HITPC policy guidance or will the market mature and evolve without input?
QMWG25	What information or features might be present in a basic clinical CQM population management view (population score, denominator members, patient-level data element drill down, provider comparison, risk adjustment, ad-hoc queries, etc)?
QMWG26	What are the technological challenges to widespread release and adoption? Can the HITPC encourage technology in this area without being prohibitively prescriptive? Should the HITPC and HHS pursue avenues outside of regulation to support this technology: e.g. design open source prototypes, challenge grants, demonstration projects, guidance document, etc?

III. Privacy and Security

In September 2012, the HITPC recommended that EHRs should be able to accept two factor (or higher) authentication for provider users to remotely access protected health information (PHI) in stage 3. [1] This included recommending that organizations/entities, as part of their HIPAA security risk analysis, should identify any other access environments that may require multiple factors to authenticate an asserted identity, and that organizations/entities should continue to identity proof provider users in compliance with Health Insurance Portability and Accountability Act (HIPAA). The HITPC would like input on the following questions related to multi-factor provider authentication:

[1] Remote access includes the following scenarios: a) Access from outside of an organization's/entity's private network; b) Access from an IP address not recognized as part of the organization/entity or that is outside of the organization/entity's compliance environment; and c) Access across a network, any part of which is or could be unsecure (such as across the open Internet or using an unsecure wireless connection).

ID #	Questions
PSTT 01	How can the HITPC's recommendation be reconciled with the National Strategy for Trusted Identities in Cyberspace (NSTIC) approach to identification which strongly encourages the re-use of third party credentials?
PSTT 02	How would ONC test the HITPC's recommendation in certification criteria?
PSTT 03	Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third party authentication service provider?

In addition to considering provider user authentication, the HITPC has assessed the success of the security requirement included in Stage 1 of Meaningful use and is looking for feedback on the logical next steps. In Stages 1 and 2 of Meaningful Use, EPs/EHs/CAHs are required to attest to completing a HIPAA security risk analysis (and addressing deficiencies): In Stage 2, they are required to attest to specifically addressing encryption of data at rest in Certified EHR Technology.

ID #	Questions
PSTT 04	What, if any, security risk issues (or Health Insurance Portability and Accountability Act (HIPAA) Security Rule provisions) should be subject to Meaningful Use attestation in Stage 3? For example, the requirement to make staff/workforce aware of the HIPAA Security Rule and to train them on Security Rule provisions is one of the top 5 areas of Security Rule noncompliance identified by the HHS Office for Civil Rights over the past 5 years. In addition, entities covered by the Security Rule must also send periodic security reminders to staff. The HITPC is considering requiring EPs/EHs/CAHs to attest to implementing HIPAA Security Rule provisions regarding workforce/staff outreach & training and sending periodic security reminders; we seek feedback on this proposal.

Feedback on standards for accounting for disclosures would also be appreciated. Accounting for disclosures, surveillance for unauthorized access or disclosure and incident investigation associated with alleged unauthorized access is a responsibility of organizations that operate EHRs and other clinical systems. Currently, the 2014 Edition for Certified EHR Technology specifies the use of ASTM E-2147-01. This specification describes the contents of audit file reports but does not specify a standard format to support multiple-system analytics with respect to access. The HITPC requests comment on the following related questions:

ID #	Questions
PSTT 05	Is it feasible to certify the compliance of EHRs based on the prescribed standard?
PSTT 06	Is it appropriate to require attestation by meaningful users that such logs are created and maintained for a specific period of time?
PSTT 07	Is there a requirement for a standard format for the log files of EHRs to support analysis of access to health information access multiple EHRs or other clinical systems in a healthcare enterprise?

HITPC Stage 3 Request for Comment

ID #	Questions
PSTT 08	Are there any specifications for audit log file formats that are currently in widespread use to support such applications?

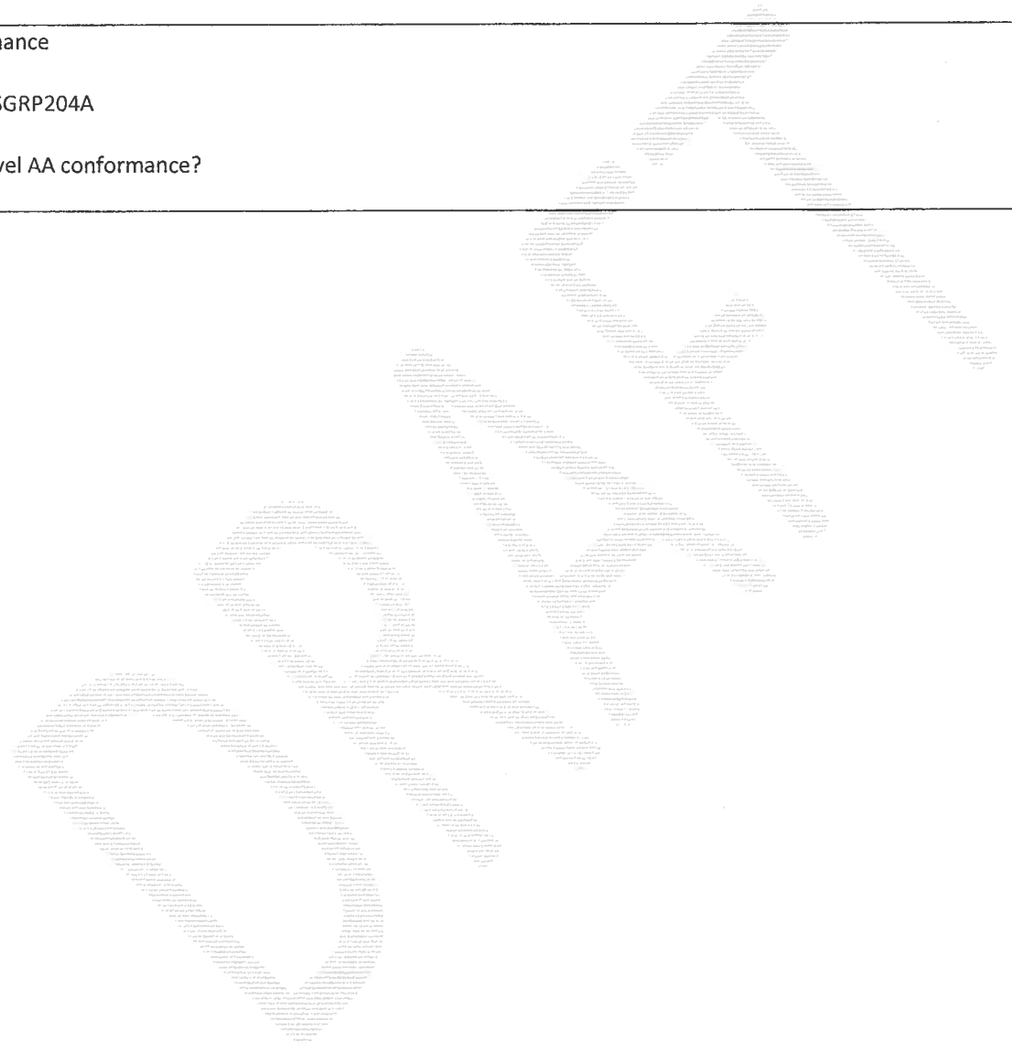
ONC Addendum

In addition to the items detailed by the HITPC, the Office of the National Coordinator would appreciate comment on the following items.

ONC01	**Subject area:** Query For the item identified as IEWG101 – **Certification criteria:** The EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a health information exchange, or an entity on the NwHIN Exchange, for example. Could a **MENU** objective be added to recognize providers who are proactively querying (e.g. For patients transitioned without a care summary, an individual in the practice should query an outside entity). Should the measure be for a number of patients or a percentage of patients?
ONC02	**Subject area:** Identity matching What could facilitate identify matching – query e.g. maintain external patient id, standards for matching attributes?
ONC03	**Subject area:** Transitions of Care For the objective identified as SGRP303 - 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). Could the electronic threshold be raised to 50% for this measure?
ONC04	**Subject area:** Patient Generated Data For the objective identified as SGRP204B - Provide 10% of patients with the ability to submit patient-generated health information to improve performance on high priority health conditions, and/or to improve patient engagement in care… What information would providers consider most valuable to receive electronically from patients? What information do patients think is most important to share electronically with providers? What data would be most valuable as an initial minimum set for patients to send to providers electronically outside the clinical visit? What other data could be added in the future?
ONC05	**Subject area:** Clinical documentation What is the best balance between ease of clinical documentation and the ease of practice management efficiency?
ONC06	**Subject area:** Test tracking Could an additional objective be added for test tracking (e.g. 10% of test results are acknowledged within 3 days)?

ONC Addendum

ONC07	**Subject area:** Safety risk assessment To ensure the safety of EHRs, should there be a MU requirement for providers to conduct a health IT safety risk assessment? Are there models or standards that we should look to for guidance?
ONC08	**Subject area:** Consent management Some federal and state health information privacy and confidentiality laws, including but not limited to 42 CFR Part 2 (for substance abuse), establish detailed requirements for obtaining patient consent for sharing certain sensitive health information, including restricting the recipient's further disclosure of such information. • How can EHRs and HIEs manage information that requires patient consent to disclose so that populations receiving care covered by these laws are not excluded from health information exchange? • How can MU help improve the capacity of EHR infrastructure to record consent, limit the disclosure of this information to those providers and organizations specified on a consent form, manage consent expiration and consent revocation, and communicate the limitations on use and restrictions on re-disclosure to receiving providers? • Are there existing standards, such as those identified by the Data Segmentation for Privacy Initiative Implementation Guide, that are mature enough to facilitate the exchange of this type of consent information in today's EHRs and HIEs?
ONC09	**Subject area:** Application programming interface There are many cases where EHR systems supply clinical information to other systems e.g. registries, accountable care organizations. Is it possible to create an application programming interface (API) to represent the information defined in a CCDA so that systems can communicate with each other? Is the information defined in the CCDA the appropriate content for other uses of clinical information?
ONC10	**Subject area:** Prescription drug monitoring For the objective identified as SGRP113 - Use clinical decision support to improve performance on high priority health conditions... Could certification criteria be added for EHR access to prescription drug monitoring programs(PDMP)? Certification criteria: EHR technology supports streamlined access to the PDMP data For example: ▪ Via a hyperlink or single sign-on for accessing the PDMP data ▪ Via automated integration into the patient's medication history
ONC11	**Subject area:** Non-percentage based measures What can be included in EHR technology to give providers evidence that a capability was in use during the EHR reporting period for measures that are not percentage based. This capability will need to support measures that occur in all stages of MU (e.g. there are yes/no measures in stage 1 that still need to be supported). Are there objectives and measures that should be prioritized to assist providers in showing that the capability was enabled during the reporting period?
ONC12	**Subject area:** Referral tracking For the objective identified as SGRP305 - EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider,

ONC Addendum

	thereby beginning to close the loop. Add receipt of test results?
ONC13	**Subject area:** Level AA conformance For the objective identified as SGRP204A Add certification criteria for Level AA conformance?