

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)	
			Proposed Stage 2 Objective	Proposed Stage 2 Measure						
CORE	1	*	*	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.	More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	The number of orders in the denominator recorded using CPOE.	Number of medication, radiology, and laboratory orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	§170.314(a)(1)		
	<p>Workgroup Comments</p>									

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CORE	2	*	Generate and transmit permissible prescriptions electronically (eRx).	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.	The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically.	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.	§170.314(b)(3) / §170.314(a)(10) <u>Electronic prescribing.</u> Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with: (i) The standard specified in § 170.205(b)(2); and (ii) At a minimum, the version of the standard specified in § 170.207(h). <u>Drug-formulary checks.</u> Enable a user to electronically check if drugs are in a formulary or preferred drug list.	§ 170.205(b)((2) (NCPDP SCRIPT version 10.6) and § 170.207(h) (RxNorm February 6, 2012 Release)	Halamka, Ferguson
	<p>Workgroup Comments</p> <p>Discharge prescriptions filled by a pharmacy within the walls of a hospital facility frequently use HL7 v.2.x prescribing messages, however, the pharmacy inside the hospital facility frequently may be in a different legal entity from the source of the discharge medication order. Any valid HL7 v.2.x prescribing message should be included in certification and should be allowed for hospital discharge prescriptions when used inside a single hospital facility even if the pharmacy is a different legal entity.</p>								

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CORE		*	Record the following demographics: <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth 	More than 80% of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to State law) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(3) <u>Demographics.</u> (i) Enable a user to electronically record, change, and access patient demographic data including preferred language, gender, race, ethnicity, and date of birth. (A) Enable race and ethnicity to be recorded in accordance with the standard specified in § 170.207(f) and whether a patient declines to specify race and/or ethnicity. (B) Enable preferred language to be recorded in accordance with the standard specified in § 170.207(j) and whether a patient declines to specify a preferred language. (ii) <u>Inpatient setting only.</u> Enable a user to electronically record, change, and access preliminary cause of death in the event of a mortality in accordance with the standard specified in § 170.207(k).	§ 170.207(f)(OMB standards); § 170.207(j) (ISO 639-1:2002); and § 170.207(k) (ICD-10-CM)	
	3	*	Record the following demographics: <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality in the EH or CAH. 						
<p>Workgroup Comments</p> <p>Country of Birth or Nationality is suggested as an additional demographic data element. It was suggested by clinicians that this information may be more important than race and ethnicity for clinical care use cases.</p>									

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CORE	4	*	*	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. 	More than 80% 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 blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data	Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and blood pressure (ages 3 and over) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	§170.314(a)(4) <u>Vital signs, body mass index, and growth charts.</u> <ol style="list-style-type: none"> <u>Vital signs.</u> Enable a user to electronically record and change, and access recordings of a patient's vital signs including, at a minimum, height/length, weight, and blood pressure. <u>Calculate body mass index.</u> Automatically calculate and electronically display body mass index based on a patient's height and weight. <u>Optional. Plot and display growth charts.</u> Plot and electronically display, upon request, growth charts for patients. 		
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CORE	5	*	*	Record smoking status for patients 13 years old or older.	More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	The number of patients in the denominator with smoking status recorded as structured data.	Number of unique patients age 13 or older seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(11) <u>Smoking status</u> . Enable a user to electronically record, change, and access the smoking status of a patient in accordance with the standard specified at § 170.207(l).	§ 170.207(l) (smoking status types)
	Workgroup Comments								

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	6	*	*	Use clinical decision support to improve performance on high-priority health conditions.	1. Implement 5 clinical decision support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. 2. The EP, EH or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.		<p style="text-align: right;">§170.314(a)(8) / §170.314(a)(2)</p> <p><u>Clinical decision support.</u></p> <ul style="list-style-type: none"> (i) <u>Evidence-based decision support interventions.</u> Enable a user to select (or activate) one or more electronic clinical decision support interventions (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in each one or any combination of the following: <ul style="list-style-type: none"> (A) Problem list; (B) Medication list; (C) Medication allergy list; (D) Demographics; (E) Laboratory tests and values/results; and (F) Vital signs. (ii) <u>Linked referential clinical decision support.</u> <ul style="list-style-type: none"> (A) Enable a user to retrieve diagnostic or therapeutic reference information in accordance with the standard specified at § 170.204(b)(1). (B) Enable a user to access the reference information specified in paragraph (ii)(A) relevant to patient context based on the data elements included in each one or any combination of the following: <ul style="list-style-type: none"> (1) Problem list; (2) Medication list; (3) Medication allergy list; (4) Demographics; (5) Laboratory tests and values/results; and (6) Vital signs. (iii) <u>Configure clinical decision support.</u> <ul style="list-style-type: none"> (A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) to be configured by an identified set of users (e.g., system administrator) based on each one of the following: <ul style="list-style-type: none"> (1) A user's role; (2) Clinical setting; and (3) Identified points in the clinical workflow. (B) Enable interventions to be triggered, based on the data elements specified in paragraph (a)(8)(i), when a summary care record is incorporated pursuant to § 170.314(b)(1). (iv) <u>Automatically and electronically interact.</u> Interventions selected and configured in accordance with paragraphs (a)(8)(i)-(iii) must automatically and electronically occur when a user is interacting with EHR technology. (v) <u>Source attributes.</u> Enable a user to review the attributes for each intervention or reference source for all clinical decision support resources including: <ul style="list-style-type: none"> (A) Bibliographic citation (clinical research/guideline) including publication; (B) Developer of the intervention (translation from clinical research/guideline); (C) Funding source of the intervention development technical implementation; and (D) Release and, if applicable, revision date of the intervention. <p><u>Drug-drug, drug-allergy interaction checks</u></p> <ul style="list-style-type: none"> (i) <u>Interventions.</u> Before a medication order is placed during computerized provider order entry (CPOE), interventions must automatically and electronically indicate to a user at the point of care of drug-drug and drug-allergy contraindications based on medication list and medication allergy list. (ii) <u>Adjustments.</u> <ul style="list-style-type: none"> (A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted. (B) Limit the ability to adjust severity levels to an identified set of users or available as a system administrative function. 	§ 170.204(b)(1) (HL7 Context-Aware Knowledge Retrieval ("Infobutton") Standard, International Normative Edition 2010)	
<p>Workgroup Comments</p> <p>HL7 Infobutton is a useful standard for information retrieval and should be required in certification for this purpose, however, simple web links should be added to certification and also should be able to be used for information retrieval. Enabling information retrieval and linked references, while important, should not be classified as a clinical decision support intervention alongside interventions such as an alert or a reminder. The key distinction is for EHR technology to have the ability to enable a user to act (e.g. to retrieve information), versus having the ability to require a user to act (e.g. to click through an alert or reminder).</p>									

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CORE	7	*	*	Incorporate clinical lab-test results into Certified EHR Technology as structured data.	More than 55% of all clinical lab tests results ordered by the EP or by authorized providers of the EH 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.	Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated in Certified EHR Technology as structured data.	Number of lab tests ordered during the EHR reporting period 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) whose results are expressed in a positive or negative affirmation or as a number.	§170.314(b)(5)	
	<p>Workgroup Comments</p>								

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CORE	8	*	*	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.				
	<p align="right">§170.314(a)(14)</p> <p><u>Patient lists.</u> Enable a user to electronically select, sort, access, and create lists of patients according to, at a minimum, the data elements included in:</p> <ul style="list-style-type: none"> (i) Problem list; (ii) Medication list; (iii) Demographics; and (iv) Laboratory tests and values/results. 								
<p>Workgroup Comments</p>									

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CORE	9	*	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.	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.	Number of patients in the denominator who were sent a reminder per patient preference during the EHR reporting period.	Number of unique patients who have had an office visit with the EP in the 24 months prior to the beginning of the EHR reporting period.	<p style="text-align: right;">§170.314(a)(15)</p> Ambulatory setting only. Patient reminders. Enable a user to electronically create a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data elements included in: <ul style="list-style-type: none"> (i) Problem list; (ii) Medication list; (iii) Medication allergy list; (iv) Demographics; and (v) Laboratory tests and values/results. 		
	Workgroup Comments								

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CORE	10		*	Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).	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.	The number of orders in the denominator tracked using eMAR.	Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	<p style="text-align: right;">§170.314(a)(17)</p> <p><u>Inpatient setting only. Electronic medication administration record.</u></p> <ul style="list-style-type: none"> (i) In combination with an assistive technology that provides automated information on the "rights" specified in paragraphs (i)(A) through (i)(D), enable a user to electronically verify the following before administering medication(s): <ul style="list-style-type: none"> (A) <u>Right patient.</u> The patient to whom the medication is to be administered matches the medication to be administered. (B) <u>Right medication.</u> The medication to be administered matches the medication ordered for the patient. (C) <u>Right dose.</u> The dose of the medication to be administered matches the dose of the medication ordered for the patient. (D) <u>Right route.</u> The route of medication delivery matches the route specified in the medication order. (ii) <u>Right time.</u> Electronically record the time and date in accordance with the standard specified at § 170.210(g), and user identification when a medication is administered. 	§ 170.210(g) (synchronized clocks)	
	<p>Workgroup Comments</p> <p>(This will be the subject of a subsequent work group meeting.)</p>									

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11	*		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>EPs must satisfy both measures in order to meet the objective:</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 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. 	<ol style="list-style-type: none"> The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information online. The number of unique patients (or their authorized representatives) in the denominator who have viewed online or downloaded or transmitted to a third party the patient's health information. 	<ol style="list-style-type: none"> Number of unique patients seen by the EP during the EHR reporting period. Number of unique patients seen by the EP during the EHR reporting period. 	<p>§170.314(e)(1)</p> <p><u>View, download, and transmit to 3rd party.</u></p> <ol style="list-style-type: none"> Enable a user to provide patients (and their authorized representatives) with online access to do all of the following: <ol style="list-style-type: none"> <u>View</u>. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data elements: <ol style="list-style-type: none"> Patient name; gender; date of birth; race; ethnicity; preferred language; smoking status; problem list; medication list; medication allergy list; procedures; vital signs; laboratory tests and values/results; provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; and care plan, including goals and instructions. <u>Inpatient setting only</u>. Admission and discharge dates and locations; reason(s) for hospitalization; names of providers of care during hospitalization; laboratory tests and values/results (available at time of discharge); and discharge instructions for patient. <u>Download</u>. Electronically download: <ol style="list-style-type: none"> A file in human readable format that includes, at a minimum: <ol style="list-style-type: none"> Ambulatory setting only. All of the data elements specified in paragraph (e)(1)(i)(A)(1). Inpatient setting only. All of the data elements specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2). A summary care record formatted according to the standards adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): <ol style="list-style-type: none"> Patient name; gender; date of birth; medication allergies; vital signs; the provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; Race and ethnicity. The standard specified in § 170.207(f); Preferred language. The standard specified in § 170.207(j); Smoking status. The standard specified in § 170.207(l); Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); Encounter diagnoses. The standard specified in § 170.207(m); Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; Medications. At a minimum, the version of the standard specified in § 170.207(h); and Inpatient setting only. The data elements specified in paragraph (e)(1)(i)(A)(2). Images formatted according to the standard adopted at § 170.205(j). <u>Transmit to third party</u>. Electronically transmit the summary care record created in paragraph (e)(1)(i)(B)(2) or images available to download in paragraph (e)(1)(i)(B)(3) in accordance with: <ol style="list-style-type: none"> The standard specified in § 170.202(a)(1); and The standard specified in § 170.202(a)(2). Patient accessible log. <ol style="list-style-type: none"> When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A)-(C), the following information must be recorded and made accessible to the patient: <ol style="list-style-type: none"> The electronic health information affected by the action(s); The date and time each action occurs in accordance with the standard specified at § 170.210(g); The action(s) that occurred; and User identification. EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient. 	<p>§ 170.204(a) (Web Content Accessibility Guidelines (WCAG) 2.0, Level AA Conformance); § 170.205(a)(3) (Consolidated CDA); § 170.205(j) (DICOM PS 3—2011); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); § 170.202(a)(1) (Applicability Statement for Secure Health Transport) and § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.210(g) (synchronized clocks)</p>	
		*		Provide patients the ability to view online, download, and transmit information about a hospital admission.	<p>EHs and CAHs must satisfy both measures in order to meet the objective:</p> <ol style="list-style-type: none"> More than 50% 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% 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. 	<ol style="list-style-type: none"> The number of patients in the denominator whose information is available online within 36 hours of discharge. The number of patients in the denominator who view, download or transmit to a third party the information provided by the eligible hospital or CAH online during the EHR reporting period. 	<ol style="list-style-type: none"> Number of unique patients seen by the EP during the EHR reporting period. Number of unique patients seen by the EP during the EHR reporting period. 		
<p>Workgroup Comments</p> <ol style="list-style-type: none"> Patient download capability should be required to use Consolidated CDA. This format can meet the requirements for individual empowerment i.e. to enable individuals to print, view, and store their information while at the same time its use advances interoperability by also enabling incorporation of discrete structured data into other systems in useful ways that simple free text (e.g. Blue Button) cannot. Standards citation for XDM and XDR should refer to "IHE XDM" and "IHE XDR". TLS HTTPS should be added to certification requirements and should be sufficient transport for the portal use case. 									

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CORE	12	*	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients within 24 hours for more than 50 % of office visits.	Number of office visits in the denominator where the patient is provided a clinical summary of their visit within 24 hours.	Number of office visits conducted by the EP during the EHR reporting period.	<p style="text-align: right;">§170.314(e)(2)</p> <p><u>Ambulatory setting only. Clinical summaries.</u> Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, the following data elements: provider's name and office contact information; date and location of visit; reason for visit; patient's name; gender; race; ethnicity; date of birth; preferred language; smoking status; vital signs and any updates; problem list and any updates; medication list and any updates; medication allergy list and any updates; immunizations and/or medications administered during the visit; procedures performed during the visit; laboratory tests and values/results, including any tests and values/results pending; clinical instructions; care plan, including goals and instructions; recommended patient decision aids (if applicable to the visit); future scheduled tests; future appointments; and referrals to other providers. If the clinical summary is provided electronically, it must be:</p> <ul style="list-style-type: none"> (i) Provided in human readable format; and (ii) Provided in a summary care record formatted according to the standard adopted at § 170.205(a)(3) with the following data elements expressed, where applicable, according to the specified standard(s): <ul style="list-style-type: none"> (A) Race and ethnicity. The standard specified in § 170.207(f); (B) Preferred language. The standard specified in § 170.207(j); (C) Smoking status. The standard specified in § 170.207(l); (D) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (E) Encounter diagnoses. The standard specified in § 170.207(m); (F) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); (G) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); (H) Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; and (iii) Medications. At a minimum, the version of the standard specified in § 170.207(h). 	<p>§ 170.205(a)(3) (Consolidated CDA); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); and § 170.207(h) (RxNorm February 6, 2012 Release)</p>	
	<p>Workgroup Comments</p> <ol style="list-style-type: none"> The workgroup recommends RxNORM has matured substantially and should be used to the extent possible for medication-related terminology including generic drugs, drug classes, active and inactive ingredients. Allergy vocabulary should use RxNORM RxCUI identifiers for ingredient allergies and drug class instead of UNII and NDF-RT. Encounter diagnosis should adopt SNOMED CT instead of ICD-10. The preamble indicates the intent is to capture and represent the data primarily for clinical purposes and clinical accuracy where SNOMED CT is most appropriate, not for billing classification and other administrative purposes where ICD would be most appropriate. A program of education and outreach should inform eligible professionals, hospitals, and vendors of certified EHR Technology of the availability of relevant vocabulary resources from federal offices and agencies, i.e. NLM's crossmaps, online vocabulary lookup tools, vocabulary subsets and value sets e.g. enumerated lists of codes required for quality measures. 								

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CORE	13	*	*	Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10% of all office visits by the EP.	Number of patients who had office visits during the EHR reporting period who were subsequently provided patient-specific education resources identified by Certified EHR Technology.	Number of office visits by the EP during the EHR reporting period.	§170.314(a)(16) <u>Patient-specific education resources</u> . Enable a user to electronically identify and provide patient-specific education resources according to: (i) At a minimum, each one of the data elements included in the patient's: problem list; medication list; and laboratory tests and values/results; and (ii) The standard specified at § 170.204(b)(1).	§ 170.204(b)(1) (HL7 Context-Aware Knowledge Retrieval (Infobutton) Standard, International Normative Edition 2010)
					More than 10% of all unique patients admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.	Number of patients in the denominator who are subsequently provided patient-specific education resources identified by Certified EHR Technology.	Number of unique patients admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.		
<p>Workgroup Comments</p> <p>Simple web links should be required in certification and should be allowed to be used to meet the requirements, in addition to HL7 Infobutton.</p>									

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	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
CORE	14	*	Use secure electronic messaging to communicate with patients on relevant health information.	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.	The number of patients in the denominator who send a secure electronic message to the EP using the electronic messaging function of Certified EHR Technology during the EHR reporting period.	Number of unique patients seen by the EP during the EHR reporting period.	<p style="text-align: right;">§170.314(e)(3)</p> <p><u>Ambulatory setting only. Secure messaging.</u> Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures:</p> <ul style="list-style-type: none"> (i) Both the patient and EHR technology are authenticated; and (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f). 	§ 170.210(f) Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the Federal Information Processing Standards (FIPS) Publication 140-2.	
	Workgroup Comments								

	EP	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)	
			Proposed Stage 2 Objective	Proposed Stage 2 Measure						
CORE	15	*	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.	The EP, EH 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).	The number of transitions of care in the denominator where medication reconciliation was performed.	Number of transitions of care during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.	§170.314(b)(4) <u>Clinical information reconciliation</u> . Enable a user to electronically reconcile the data elements that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically display the data elements from two or more sources in a manner that allows a user to view the data elements and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to merge and remove individual data elements. (iii) Enable a user to review and validate the accuracy of a final set of data elements and, upon a user's confirmation, automatically update the list.			
		*	The EH 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>Workgroup Comments</p> <p>This will be the subject of a subsequent workgroup call. Concern has been expressed about proposed certification requirement (ii) with regard to merging/removing data elements.</p>										

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	EP	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)	
			Proposed Stage 2 Objective	Proposed Stage 2 Measure						
CORE	16	*	*	<p>The EP, EH, 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>EPs, EHs, and CAHs must satisfy both measures in order to meet the objective:</p> <ol style="list-style-type: none"> The EP, EH, 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, EH, 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. 	<ol style="list-style-type: none"> The number of transitions of care and referrals in the denominator where a summary of care record was the transferring or referring provider. The number of transitions of care and referrals in the denominator where a summary of care record was electronically transmitted using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender. 	<ol style="list-style-type: none"> Number of transitions of care and referrals during the EHR reporting period for which the EP or EH's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider. Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider. 	<p style="text-align: right;">170.314(b)(1) / §170.314(b)(2)</p> <p><u>Transitions of care - incorporate summary care record.</u> Upon receipt of a summary care record formatted according to the standard adopted at § 170.205(a)(3), electronically incorporate, at a minimum, the following data elements: Patient name; gender; race; ethnicity; preferred language; date of birth; smoking status; vital signs; medications; medication allergies; problems; procedures; laboratory tests and values/results; the referring or transitioning provider's name and contact information; hospital admission and discharge dates and locations; discharge instructions; reason(s) for hospitalization; care plan, including goals and instructions; names of providers of care during hospitalization; and names and contact information of any additional known care team members beyond the referring or transitioning provider and the receiving provider.</p> <p><u>Transitions of care - create and transmit summary care record</u></p> <ol style="list-style-type: none"> Enable a user to electronically create a summary care record formatted according to the standard adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): <ol style="list-style-type: none"> Patient name; gender; date of birth; medication allergies; vital signs; laboratory tests and values/results; the referring or transitioning provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; <u>Race and ethnicity.</u> The standard specified in § 170.207(f); <u>Preferred language.</u> The standard specified in § 170.207(j); <u>Smoking status.</u> The standard specified in § 170.207(1); <u>Problems.</u> At a minimum, the version of the standard specified in § 170.207(a)(3); <u>Encounter diagnoses.</u> The standard specified in § 170.207(m); <u>Procedures.</u> The standard specified in § 170.207(b)(2) or § 170.207(b)(3); <u>Laboratory test(s).</u> At a minimum, the version of the standard specified in § 170.207(g); <u>Laboratory value(s)/result(s).</u> The value(s)/results of the laboratory test(s) performed; <u>Medications.</u> At a minimum, the version of the standard specified in § 170.207(h); and <u>Inpatient setting only.</u> Hospital admission and discharge dates and location; names of providers of care during hospitalization; discharge instructions; reason(s) for hospitalization; and indication of whether an advance directive exists. <u>Transmit.</u> Enable a user to electronically transmit the summary care record created in paragraph (i) in accordance with: <ol style="list-style-type: none"> The standards specified in § 170.202(a)(1) and (2). <p><u>Optional.</u> The standard specified in § 170.202(a)(3).</p>	<p>§ 170.205(a)(3) (Consolidated CDA); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); and § 170.202(a)(1) (Applicability Statement for Secure Health Transport); § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.202(a)(3) (SOAP-Based Secure Transport RTM version 1.0)</p>	

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)	
			Proposed Stage 2 Objective	Proposed Stage 2 Measure						
CORE	17	*	*	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	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.			<p>§170.314(f)(1) / §170.314(f)(2)</p> <p><u>Immunization information.</u> Enable a user to electronically record, change, and access immunization information.</p> <p><u>Transmission to immunization registries.</u> Enable a user to electronically create immunization information for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (i) The standard and applicable implementation specifications specified in § 170.205(e)(3); and (ii) At a minimum, the version of the standard specified in § 170.207(i). 	§ 170.205(e)(3) (HL7 2.5.1 and Implementation Guide for Immunization Messaging Release 1.3); and § 170.207(i) (CVX code set: August 15, 2011 version)	
	<p>Workgroup Comments</p> <p>It would be useful to have a standard for updating registries with groups or lists of patients instead of only individual patient transactions. Standards organizations (i.e. HL7 for the v.2.5.1 message) should be consulted to recommend the most appropriate standard specification for these “batch” updates.</p>									

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			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
CORE	18	*	Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized.			<p style="text-align: right;">170.314(f)(5) / §170.314(f)(6))</p> <p><u>Inpatient setting only. Reportable laboratory tests and values/results.</u> Enable a user to electronically record, change, and access reportable clinical laboratory tests and values/results.</p> <p><u>Inpatient setting only. Transmission of reportable laboratory tests and values/results.</u> Enable a user to electronically create reportable laboratory tests and values/results for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (i) The standard (and applicable implementation specifications) specified in § 170.205(g); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g). 	§ 170.205(g) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) with errata); § 170.207(a)(3) (SNOMED CT® International Release January 2012); and § 170.207(g) (LOINC version 2.38)	
	<p>Workgroup Comments</p>								

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			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
CORE	19	*	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.			<p style="text-align: right;">§170.314(f)(3) / §170.314(f)(4)</p> <p><u>Public health surveillance.</u> Enable a user to electronically record, change, and access syndrome-based public health surveillance information.</p> <p><u>Transmission to public health agencies.</u> Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (i) <u>Ambulatory setting only.</u> <ul style="list-style-type: none"> (A) The standard specified in §170.205(d)(2). (B) <u>Optional.</u> The standard (and applicable implementation specifications) specified in §170.205(d)(3). (ii) <u>Inpatient setting only.</u> The standard (and applicable implementation specifications) specified in § 170.205(d)(3). 	§ 170.205(d)(2) (HL7 2.5.1) and § 170.205(d)(3) (HL7 2.5.1 and the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data HL7 Version 2.5.1)	
	Workgroup Comments								

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			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
CORE	20	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(1) <u>Authentication, access control, and authorization.</u> (i) Verify against a unique identifier(s) (e.g., username or number) that a person seeking access to electronic health information is the one claimed; and (ii) Establish the type of access to electronic health information a user is permitted based on the unique identifier(s) provided in (d)(1)(i), and the actions the user is permitted to perform with the EHR technology.	
	Workgroup Comments								

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CORE	E	P	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
				Proposed Stage 2 Objective	Proposed Stage 2 Measure					
								§170.314(d)(2) <u>Auditable events and tamper-resistance.</u> (i) Enabled by default. The capability specified in paragraph (d)(2)(ii) must be enabled by default (i.e., turned on) and must only be permitted to be disabled (and re-enabled) by a limited set of identified users. (ii) Record actions. Record actions related to electronic health information, audit log status and, as applicable, encryption of end-user devices in accordance with the standard specified in § 170.210(e). (iii) Audit log protection. Actions recorded in accordance with paragraph (d)(2)(ii) must not be capable of being changed, overwritten, or deleted. (iv) Detection. Detect the alteration of audit logs.	§ 170.210(e) Record actions related to electronic health information, audit log status, and encryption of end-user devices. (i) When EHR technology is used to record, create, change, access, or delete electronic health information, the following information must be recorded: (A) The electronic health information affected by the action(s); (B) The date and time each action occurs in accordance with the standard specified at § 170.210(g); (C) The actions(s) that occurred; (D) Patient identification; and (E) User identification. (ii) When the audit log is enabled or disabled, the following must be recorded: (A) The date and time each action occurs in accordance with the standard specified at § 170.210(g); and (B) User identification. (iii) As applicable, when encryption of electronic health information managed by EHR technology on end-user devices is enabled or disabled, the following must be recorded: (A) The date and time each actions occurs in accordance with the standard specified at § 170.210(g); and (B) User identification.	
	21	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.					
Workgroup Comments										

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	E	P	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
				Proposed Stage 2 Objective	Proposed Stage 2 Measure					
CORE	22	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			<p>§170.314(d)(3)</p> <p><u>Audit report(s)</u>. Enable a user to create an audit report for a specific time period and to sort entries in the audit log according to each of the elements specified in the standard at § 170.210(e).</p>	<p>§ 170.210(e) Record actions related to electronic health information, audit log status, and encryption of end-user devices.</p> <p>(iv) When EHR technology is used to record, create, change, access, or delete electronic health information, the following information must be recorded:</p> <p>(A) The electronic health information affected by the action(s);</p> <p>(B) The date and time each action occurs in accordance with the standard specified at § 170.210(g);</p> <p>(C) The actions(s) that occurred;</p> <p>(D) Patient identification; and</p> <p>(E) User identification.</p> <p>(v) When the audit log is enabled or disabled, the following must be recorded:</p> <p>(A) The date and time each action occurs in accordance with the standard specified at § 170.210(g); and</p> <p>(B) User identification.</p> <p>(vi) As applicable, when encryption of electronic health information managed by EHR technology on end-user devices is enabled or disabled, the following must be recorded:</p> <p>(A) The date and time each actions occurs in accordance with the standard specified at § 170.210(g); and</p> <p>(B) User identification.</p>	
	Workgroup Comments									

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CORE	23	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(4)	
	<p>Workgroup Comments</p>								

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CORE	24	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(5) Automatic log-off. Terminate an electronic session after a predetermined time of inactivity.	
	Workgroup Comments								

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CORE	25	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(6) <u>Emergency access.</u> Permit an identified set of users to access electronic health information during an emergency.	
	Workgroup Comments								

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CORE	26	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			<p style="text-align: right;">§170.314(d)(7)</p> <p><u>Encryption of data at rest.</u> Paragraph (d)(7)(i) or (d)(7)(ii) must be met to satisfy this certification criterion.</p> <ul style="list-style-type: none"> (i) If EHR technology manages electronic health information on an end-user device and the electronic health information remains stored on the device after use of the EHR technology on that device has stopped, the electronic health information must be encrypted in accordance with the standard specified in § 170.210(a)(1). This capability must be enabled by default (i.e., turned on) and must only be permitted to be disabled (and re-enabled) by a limited set of identified users. (ii) Electronic health information managed by EHR technology never remains stored on end-user devices after use of the EHR technology on those devices has stopped. 	
	Workgroup Comments								

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CORE	27	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(8) <u>Integrity.</u> (i) Create a message digest in accordance with the standard specified in 170.210(c). (ii) Verify in accordance with the standard specified in 170.210(c) upon receipt of electronically exchanged health information that such information has not been altered.	
	Workgroup Comments								

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CORE	28	*	*	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(9) Optional. Accounting of disclosures. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in §170.210(d).	
	Workgroup Comments								

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MENU	29		*	Record whether a patient 65 years old or older has an advance directive	More than 50% of all unique patients 65 years old or older admitted to the EH'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.	The number of patients in the denominator who have an indication of an advance directive status entered using structured data.	Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.	§170.314(a)(18) <u>Inpatient setting only. Advance directives.</u> Enable a user to electronically record whether a patient has an advance directive.	
	Workgroup Comments								

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MENU	30	*	*	Imaging results and information are accessible through Certified EHR Technology.	More than 40% of all scans and tests whose result is an image ordered by the EP or by an authorized provider of the EH 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.	The number of results in the denominator that are accessible through Certified EHR Technology.	Number of scans and tests whose result is one or more image ordered by the EP or by an authorized provider on behalf of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period.	§170.314(a)(12) <u>Imaging</u> . Electronically indicate to a user the availability of a patient's images and/or narrative interpretations (relating to the radiographic or other diagnostic test(s)) and enable immediate electronic access to such images and narrative interpretations.	
	Workgroup Comments								

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MENU	31	*	*	Record patient family health history as structured data.	More than 20% of all unique patients seen by the EP or admitted to the EH 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.	The number of patients in the denominator with a structured data entry for one or more first-degree relatives.	Number of unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(13) <u>Family health history</u> . Enable a user to electronically record, change, and access a patient's family health history.	
	<p>Workgroup Comments</p>								

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MENU	32	*	Generate and transmit permissible discharge prescriptions electronically (eRx).	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.	The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically.	The number of new or changed prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances for patients discharged during the EHR reporting period.	<p>§170.314(b)(3) /§170.314(a)(10)</p> <p><u>Electronic prescribing.</u> Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (i) The standard specified in § 170.205(b)(2); and (ii) At a minimum, the version of the standard specified in § 170.207(h). <p><u>Drug-formulary checks.</u> Enable a user to electronically check if drugs are in a formulary or preferred drug list.</p>	§ 170.205(b)((2) (NCPDP SCRIPT version 10.6) and § 170.207(h) (RxNorm February 6, 2012 Release)	
	Workgroup Comments								

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	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
MENU	33	*	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.			<p>§170.314(f)(3) /§170.314(f)(4)</p> <p><u>Public health surveillance.</u> Enable a user to electronically record, change, and access syndrome-based public health surveillance information.</p> <p><u>Transmission to public health agencies.</u> Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (i) <u>Ambulatory setting only.</u> <ul style="list-style-type: none"> (A) The standard specified in § 170.205(d)(2). (B) Optional. The standard (and applicable implementation specifications) specified in § 170.205(d)(3). (ii) <u>Inpatient setting only.</u> The standard (and applicable implementation specifications) specified in § 170.205(d)(3). 		
	Workgroup Comments								

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
MENU	34	*	Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period.			<p>§170.314(f)(7) / §170.314(f)(8)</p> <p><u>Ambulatory setting only. Cancer case information.</u> Enable a user to electronically record, change, and access cancer case information.</p> <p><u>Ambulatory setting only. Transmission to cancer registries.</u> Enable a user to electronically create cancer case information for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (i) The standard (and applicable implementation specifications) specified in § 170.205(i); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g). 	§ 170.205(i) (HL7 CDA, Release 2 and Implementation Guide for Healthcare Provider Reporting to Central Cancer Registries, Draft, February 2012); § 170.207(a)(3) (SNOMED CT® International Release January 2012); and § 170.207(g) (LOINC version 2.38)	
	<p>Workgroup Comments</p>								

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
35	*		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.	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.			<i>General usage of Certified EHR Technology (No specific certification criteria).</i>		
Workgroup Comments									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
36	*	*	N/A	N/A			§170.314(g)(1) <u>Automated numerator recording.</u> For each meaningful use objective with a percentage-based measure, electronically record the numerator.		
Workgroup Comments									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
37	*	*	N/A	N/A			§170.314(g)(2) <i>Automated measure calculation.</i> For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.		
Workgroup Comments									

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	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
38	*	*	N/A	N/A			§170.314(g)(3) <u>Non-percentage-based measure use report.</u> (i) For each capability included in EHR technology that is also associated with a meaningful use objective and measure that is not percentage based, electronically record the date and time in accordance with the standard specified at § 170.210(g) when the capability was enabled, disabled, and/or executed. (ii) Enable a user to electronically create a report of the information recorded as part of paragraph (g)(3)(i).		
<p>Workgroup Comments</p>									

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	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
39	*	*	N/A	N/A			§170.314(g)(4) Safety-enhanced design. User-centered design processes must be applied to each capability an EHR technology includes that is specified in the following certification criteria: § 170.314(a)(1); § 170.314(a)(2); § 170.314(a)(6); § 170.314(a)(7); § 170.314(a)(8); § 170.314(a)(17); § 170.314(b)(3); and § 170.314(b)(4).		
Workgroup Comments									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
40	*	*	N/A	N/A			§170.314(c)(1)-(3) <u>Clinical quality measures – capture and export.</u> (i) Capture. Electronically record all of the data elements that are represented in the standard specified in § 170.204(c). (ii) Export. Electronically export a data file that includes all of the data elements that are represented in the standard specified in § 170.204(c). <u>Clinical quality measures – incorporate and calculate.</u> (i) Incorporate. Electronically incorporate all of the data elements necessary to calculate each of the clinical quality measures included in the EHR technology. (ii) Calculate. Electronically calculate each clinical quality measure that is included in the EHR technology. <u>Clinical quality measures – reporting.</u> Enable a user to electronically create for transmission clinical quality measurement results in a data file defined by CMS.	§ 170.204(c) (NQF Quality Data Model)	
<p>Workgroup Comments</p>									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
41	*	*	Record electronic notes in patient records. <i>(Not proposed by CMS)</i>	Record electronic notes in patient records for more than 30 percent of office visits.			§170.314(a)(9) <u>Electronic notes</u> . Enable a user to electronically record, change, access, and search electronic notes.		
Workgroup Comments									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	BH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Proposed Stage 2 Objective	Proposed Stage 2 Measure					
42		*	Provide structured electronic laboratory results to eligible professionals. <i>(Not proposed by CMS)</i>	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.			<p>§170.314(b)(6)</p> <p><u>Inpatient setting only. Transmission of electronic laboratory tests and values/results to ambulatory providers.</u> Enable a user to electronically create laboratory tests and values/results for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (i) The standard (and applicable implementation specifications) specified in § 170.205(k); and (ii) At a minimum, the version of the standard specified in § 170.207(g). 	§ 170.205(k) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Standards and Interoperability Framework Lab Results Interface, Release 1 (US Realm); and § 170.207(g) (LOINC version 2.38)	
<p>Workgroup Comments</p>									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Stage 1 Objective	Stage 1 Measure					
43	*	*	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% 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 at least one entry or an indication that no problems are known for the patient recorded as structured data.	The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	§170.314(a)(5) <u>Problem list</u> . Enable a user to electronically record, change, and access a patient's problem list for longitudinal care in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3).	§ 170.207(a)(3) (SNOMED CT® International Release January 2012)	
Workgroup Comments									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Stage 1 Objective	Stage 1 Measure					
44	*	*	Maintain active medication list.	More than 80% 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 at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	The number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(6) <u>Medication list</u> . Enable a user to electronically record, change, and access a patient's active medication list as well as medication history for longitudinal care.		
<p>Workgroup Comments</p>									

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

	EP	EH	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
			Stage 1 Objective	Stage 1 Measure					
45	*	*	Maintain active medication allergy list.	More than 80% 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 at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(7) <u>Medication allergy list</u> . Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history for longitudinal care.		
Workgroup Comments									