| **Topic** | **Stage 2 Final Rule** | **Former Stage 3 Objective** | **Updated Stage 3 Objective** | **Question** | **Response** |
| --- | --- | --- | --- | --- | --- |
| **Improving quality of care and safety** | | | | | |
| **Clinical Decision Support** | **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’s  scope of practice or patient population, the clinical decision support  interventions must be related to high-priority health conditions.  **Measure 2:** The EP 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 CDS interventions or guidance related to 5 or more CQMs. **The 15 CDS interventions should include 2 or more** interventions in each of the following areas:    1. Preventive care    2. Chronic disease management    3. Appropriateness of lab/rad    4. Advanced medication CDS    5. Accuracy or completeness of the problem list 2. Enable **drug-drug and drug-allergy interaction checks**   **Certification Criteria**   1. Ability to track CDS triggers 2. Ability to flag preference-sensitive conditions and provide decision support materials for patients 3. Check for a maximum dose /weight based calculation 4. Use of structured SIG standards 5. Consume external CDS interventions 6. Use info in systems to support maintenance of lists | Demonstrate use of multiple CDS interventions that apply to quality measures **in at least 4 of the 6 NQS domains.** Recommended interventions (flexible to innovation):   * Preventive care * Chronic disease management (e.g., diabetes, coronary artery disease) * Appropriateness of lab and radiology orders * Advanced medication-related decision support (e.g., renal drug dosing) * Improving the accuracy/completeness of the problem list * Drug-drug and drug-allergy interaction checks * CDS applied to capture shared decision making   CEHRT should have the functionality to enable intervention tools such as (the intention is not to be overly prescriptive, but to encourage innovation in these areas):   1. Ability to track CDS triggers 2. Ability to flag preference-sensitive conditions and provide decision support materials for patients (IOM list of CDS flags) 3. Capture appropriate care goals to encourage shared decision making 4. Check for a maximum dose /weight based calculation 5. Use of structured SIG standards 6. Consume external CDS interventions 7. Use info in systems to support maintenance of lists | **Clinical Quality WG:** How to capture, code and use in CDS? Need feedback regarding feasibility of certification criteria.  **Implementation WG:** How do these policies get translated to certification criteria and auditing? How would this impact certification criteria and test script auditing? | **Clinical Quality WG:**   * Current certification criteria are feasible as evidenced by the fact that vendors are able to be certified.  However, the adoption of standards that have had little industry exposure prior to Meaningful Use has created some challenges. * Recommend an approach that adopts newer or draft standards as optional criteria with the intention to advance them into the core in future stages.  Such an approach avoids the need to rush to implementation, but still incents the use of these standards by including them as optional criteria.  The markets can also thus determine the importance of these criteria with respect to implementation based on demand for the capability. |
| **Care Planning** | **Objective:** Record whether a patient 65 years old or older has an advance directive.  **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 EHR reporting  period have an indication of an advance directive status recorded as structured data. | **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 (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data. | * **Core** for EHs, introduce as **Menu** for EPs * Record whether a patient 65 years old or older has an advance directive * Recommend that CEHRT has the functionality to store the document in record or include more information about the document (e.g. instructions of where to find out more about the advance directive and where to go to incorporate). |  |  |
| **Reminders** | **Objective:** Use clinically relevant information to identify patients who should receive reminders  for preventive/follow-up care and send these patients the reminders, per patient preference.  **Measure:** More than 10 percent of all unique patients who have had 2 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 clinical, social, or family history information (beyond demographics) to identify patients who should receive reminders for preventive/follow-up care. **EP Measure: More than 20% of all unique patients** who have had one office visit with the EP **within the 24 months** prior to the beginning of the EHR reporting period were sent a reminder for preventive or follow-up care (does not include appointments), in the format of the patient’s preference (e.g., telephone, text, email), if the provider has the technical capability. **Exclusion:** Specialists may be excluded for prevention reminders (could be more condition specific).  **Certification criteria:** HITSC to identify what the communication preferences options should be for this objective. Providers should have the ability to select options that are technically feasible, these could include: Email, text, patient portal, telephone, regular mail. | * **Eligible Professionals** use relevant data to identify patients who should receive reminders for preventive/follow-up care * Threshold: Low - 20% * Reminders should be shared with patients in the format of the patient’s preference. The format of options presented to the patient (e.g., telephone, text, email) is dependent upon the technical capability available to the provider. |  |  |
| **eMAR** | **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 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. | **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 50% of medication orders** created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR.  2) Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked for use in quality improvement. | * **Eligible Hospitals** automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) * It is recommended that CEHRT provide the ability to track mismatches for quality improvement (e.g. situations in which a provider administers a medication and/or dosing that is not intended) |  |  |
| **Imaging** | **Objective:** Imaging results consisting of the image itself and any explanation or other  accompanying information are accessible through CEHRT.  **Measure:** More than 10 percent of all tests whose result is one or more images ordered by the  EP during the EHR reporting period are accessible through CEHRT. | **EP MENU/EH CORE Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT  **EP MENU/EH CORE Measure:** More than 10 imaging study encounters (anything associated with an order, e.g., radiology, photographs, images of ECG), ordered are accessible (e.g. viewed directly in the EHR or a link to a separate system reached via the EHR) through CEHRT  **Certification criteria:** CEHRT should be able to display with the image the radiation exposure associated with the imaging study. | * For both **Eligible Professionals and** Hospitals imaging results should be assessable through CEHRT. Results consisting of the image itself and any explanation or other accompanying information * Recommended as a **Menu Item for EPs and Core for EHs** | **Awaiting feedback from Clinical Operations.** |  |
| **Family History** | **Objective:** Record patient family health history as structured data.  **Measure:** More than 20 percent of all unique patients seen by the EP during the EHR reporting  period have a structured data entry for one or more first-degree relatives. | **MENU Objective:** Record patient family history as structured data **MENU Measure:** More than 20 percent 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  **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). | * **Eligible Professionals and Hospitals** record patient family health history as structured data for one or more first-degree relatives * It is recommended that this objective remain a **Menu** item * Recommend that CEHRT have the capability to take family history into account for CDS interventions |  |  |
| **Electronic Notes** | **Objective:** Record electronic notes in patient records.  **Measure:** Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR Measure reporting period. The text of the electronic note must be text searchable and may  contain drawings and other content | **CORE** EP/EH objective: Record electronic notes in patient records  **EP: Within 4 calendar days,** record an electronic progress note, authored by the eligible professional, for **more than 30 % of unique patient office visits.**  **EH:** Within 4 calendar days of admission, record an electronic progress note (excluding the discharge summary) 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% of unique patients.  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 | * **Eligible Professionals** record an electronic progress note, authored by the eligible professional. * Electronic progress notes (excluding the discharge summary) should be created, edited, and signed by an authorized provider of the **Eligible Hospital or CAH**   + 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 |  |  |
| **Hospital Labs** | **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 EPs **EH CORE Measure:** Hospital labs send (directly or indirectly using LOINC) structured electronic clinical lab results to the ordering provider for more than **50% of electronic lab orders received.**   * Address threshold based upon stage 2 experience. | * **Eligible Hospitals** provide structured electronic lab results (directly or indirectly using LOINC) to ordering providers |  |  |
| **Order Tracking** | **\*\*New\*\*** | **EP Objective:** The EHR is able to assist with follow-up on orders to improve the management of results.  **EP Measure: 10% of results** (e.g., consult requests (referrals), lab, rad, pathology) are acknowledged within 3 business days of when the request/test is resulted.  **Certification Criteria:**  EHRs must have the ability to:   * identify abnormal test results as determined by the laboratory * provide the option at ordering time for the provider to indicate a due date for any order * notify the ordering provider when results are available or not completed by a certain time * record date and time that results are reviewed and by whom | * **Eligible Professionals** use CEHRT to assist with follow-up on orders (e.g., consult requests (referrals), lab, rad, pathology) to improve the management of results * Recommend acknowledgement of results **within 3 business days** of when orders are resulted * Recommended functionality   + Identification of abnormal tests as indicated in the lab result message   + Ability to indicate a due date for orders when entering the order   + Notifications when results are available or not completed by a certain time   + Record of date and time that results are reviewed and by whom * Threshold: Low – 10% |  |  |
| **Unique Device Identifier (UDI)** | **\*\*New\*\*** | **MENU objective:** EPs and EHs should record the FDA Unique Device Identifier (UDI) when patients have devices implanted for each newly implanted device.  **MENU Measure:** EPs and EHs should record the UDI when patients have the device implanted for **80% of patients seen within the EHR reporting period.** | * **Eligible providers and hospitals** should record the FDA Unique Device Identifier (UDI) when patients have devices implanted for each newly implanted device * Threshold: High – 80% |  |  |
| **Medication Adherence** | **\*\*New\*\*** | Medication adherence: create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring) 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.  **Certification criteria**: EHR technology supports streamlined access to prescription drug monitoring programs (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 * Leveraging things like single sign on or functionality that could enable the linkage between PDMPs and prescribers and EDs? | * CEHRT has the ability to accept data feeds from PBMs to retrieve external medication fill history for medication adherence monitoring * Recommend that CEHRT have the functionality to identify that patients are not taking a drug, taking two kinds of the same drug (including detection of abuse) or multiple drugs that overlap. * Recommended as **certification criteria only** | **EHRA:** Feedback on the level of effort will help MU WG decide whether Stage 3 or Future?  **Clinical Quality:** feedback on the readiness of standards will help determine whether this could be a certification criteria item or should be pushed out to a future stage. | **EHRA:** It is challenging to estimate the effort to accept data feeds without knowing which standards would be selected. We have questions about the requirements to “identify patients not taking a drug, taking two kinds of the same drug, etc.” Some systems already have features that are part of clinical decision support or list generation that can show patients in these scenarios. If further development is proposed, we are concerned that it could be complex.  Given the knowledge we do have, we suggest that the projects might have the following development estimates:  **Overall estimate: Large to Jumbo (combination of 1 large and 1 small, and 1 medium project)**   * Large: External medication fill history * Small: Identify patients not taking a medication * Medium: Identify patients taking two kinds of same medication or multiple overlaps   Summary:  Not well understood  Unclear standards/needs standards work  Workflow and usability implications |
| **Engaging patients and families in their care** | | | | | |
| **View, Download, Transmit (VDT)** | **Objective:** Provide patients the ability to view online, download and transmit their health  information within four business days of the information being available to the EP.  **Measure 1:**  More than 50 percent of all unique patients seen by the EP during the EHR  reporting period are provided timely (available to the patient within 4  business days after the information is available to the EP) online access to  their health information.  **Measure 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. | EPs should make information **available within 24 hours** if generated during the course of a visit   * For **labs or other types of information** not generated within the course of the visit, it is made available to patients **within 4 days of** becoming available * **Potential to increase both thresholds (% offer and % use) based upon experience in Stage 2** * Add optional item: family history * **Certification Criteria:** CEHRT should provide the ability for patients to designate to whom and when a summary of care document is sent to a patient-designated recipient, building upon Blue Button. | * **Eligible Professionals** provide patients the ability to view online, download, and transmit (VDT) their health information within **24 hours** if generated during the course of a visit   + **Labs or other types of information** not generated within the course of the visit should be made available to patients **within four (4) business days** of information becoming available   + Add family history to list of items included * Recommend that CEHRT provide the ability for patients to designate to whom and when a summary of care document is sent to a patient-designated recipient, building upon Blue Button | **Consumer Technology WG**: Certification criteria around translating medical information into plain language (e.g. MedlinePlus)  Mobile access to VDT? | Would not want to have a prescriptive standard for mobile devices at this point. Device agnostic approaches for consumers, but shouldnot be mandated. |
| **Amendments** | **\*\*New\*\*** | * Provide patients with an easy way to request an amendment to their record online (e.g., offer corrections, additions, or updates to the record) | * EHR technology should have the functionality to allow providers to receive, review, respond (acknowledge), and record PGHD, including amendments and corrections * Recommended as **certification criteria only** |  |  |
| **Patient Generated Health Data** | **\*\*New\*\*** | **EP/EH MENU Objective:** Patients have the ability to electronically submit PGH information  **EP/EH MENU Measure:** Provide the ability to electronically submit PGH information through structured or semi-structured questionnaires (e.g., screening questionnaires, intake forms, risk assessment, functional status) for more than **10 % of all unique patients seen by the EP** during the EHR reporting period.  Standards work needed: Certification criteria for devices, continue to work with HITSC. | * **Eligible Providers and Hospitals** provide the capability for patients to electronically submit patient-generated health information through structured or semi-structured questionnaires (e.g., screening questionnaires, intake forms, risk assessment, functional status) using CEHRT * Give providers additional options for incorporating PGHD through secure messaging and provider-selected devices\*, in addition to structured and semi-structured questionnaires * EHR technology should have the functionality to allow providers to receive, review, respond (acknowledge), and record PGHD * Recommended as a **Menu** item * Low threshold (e.g. 10%) |  |  |
| **Visit Summary/ Clinical Summary** | **Objective:** Provide clinical summaries for patients for each office visit.  **Measure:** Clinical summaries provided to patients or patient-authorized representatives within  one business day for more than 50 percent of office visits | The visit summary should be pertinent to the office visit, not just an abstract from the medical record.  **EP Objective:** An office-visit summary is provided to a patient or patient-authorized representative with relevant and actionable information and instructions pertaining to the visit in the format indicated by the patient.  **EP Measure:** An office visit summary is provided to a patient or patient-authorized representative with relevant and actionable information and instructions pertaining to the visit in the format requested as indicated by the patient (e.g., available online, via email, print out of summary, etc.), if the provider has the technical capability within 1 business day for more than 50 percent of office visits.  **Certification criteria #1**: Intent is to make sure the EHR can draw from the range of existing specified information and enable providers to include and exclude data based upon patient needs.  **Certification criteria #2**: HITSC to identify what the communication preferences options should be. Providers should have the ability to select options that are technically feasible, these could include: Email, patient portal, regular mail. | * **Eligible Professionals** provide office-visit summaries to patients or patient-authorized representatives with relevant, actionable information, and instructions pertaining to the visit in the format indicated by the patient   + Summaries should be shared in the format of the patient’s preference (e.g., telephone, email), if the provider has the technical capability * Recommend that CEHRT draw from existing specified information enabling providers to include and exclude data based upon patient needs * **Threshold:** High – 50% |  |  |
| **Patient Education** | **Objective:** Use clinically relevant information from Certified EHR Technology to identity patient-specific education resources and provide those resources to the client.  **Measure:** Patient-specific education resources identified by Certified EHR Technology 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. | **Objective:** Provide patient specific educational material in at least one non-English language, in the format preferred by the patient, if the provider has the technical capability  **Measure:** Deliver **at least one patient specific educational material to one patient in that patient’s preferred non-English language** identified by CEHRT and in the patient’s preferred format (e.g., online, print-out from CEHRT).  **Certification criteria #1:** Expand the InfoButton standard to include disability status. Disability status needs to be defined and flagged at the point of entry (e.g. registration or appointment gathering).  **Certification criteria #2:** HITSC to identify what the communication preferences options should be. Providers should have the ability to select options that are technically feasible, these could include: Email, patient portal, regular mail. | * **Eligible Providers and Hospitals use** CEHRT to provide or track patient specific educational material in the patient’s preferred non-English language and preferred format (e.g., online, print-out from CEHRT) * **Certification criteria:** Recommend that disability status needs are defined and flagged at the point of entry (e.g. registration or appointment gathering) using InfoButton * Thresholds   + At least one patient receives educational material in that patient’s non-English language   + Low % (e.g. 10) of patients receive educational material (by the providers own selection) |  |  |
| **Secure Messaging** | **Objective:** Use secure electronic messaging to communicate with patients on relevant health  Information  **Measure:** A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP  during the EHR reporting period. | **Measure:** More than 5% of patients use secure electronic messaging to communicate with EPs    **Certification requirement:** Provide the capability to:   1. measure and report the response timeframe 2. for the patient to indicate that no response is needed 3. mode of response (e.g., telephone, secure message) | * **Eligible Professionals** use CEHRT to provide patients with the ability to use secure electronic messaging for communication * It is recommended that CEHRT include functionalities that assist the provider by providing a means to:   + Measure and report response times to patients   + Indicate whether a response is needed   + Identify the mode the response was provided in (e.g., telephone, secure message) * Threshold: Low (e.g. 5%) | **EHRA:** Why Jumbo? The more details provided will help MU WG make less burdensome. What assumptions are being made in feedback?  **Original Response:**  **Overall estimate: Jumbo**  Additional tracking of response timeframe including multiple modes of response – large.   * Patient indication of no response needed – small. * Tracking of mode of response – small. (See first estimate for support for multiple modes of response.) Updated reporting for revised measure. | **EHRA:** The Jumbo estimate was the sum of the other projects estimated within this proposal.  **Overall estimate: Jumbo (sum of 1 large and 3 small projects)**   * Large: Additional tracking of response timeframe including multiple modes of response. * Small: Patient indication of no response needed. * Small: Tracking of mode of response. (See first estimate for support for multiple modes of response.) * Small: Updated reporting for revised measure.   The large estimate is based on the variety of workflows that might be used to respond to a patient message, and attempting to track the method that was used and the time that the response (or responses) happened in a structured format. These responses are not necessarily documented in a structured format currently. Narrowing the scope to eliminate response tracking will reduce the development estimate to small. Triggers on all messages would be required and then the rules logic to track, respond, audit, and report would be need to be designed and developed. This, plus the additional database and user interface features to support it, would definitely take this project into the jumbo area.  Note that these requirements must have a development focus on usability. We will need to ensure that administrative documentation requirements for the measures are not burdensome as compared to that required for the clinical process of patient education. It would be beneficial to our customers and our development teams to fully understand the expected benefits/outcomes of these features so that usability approach can be tailored appropriately.  We have a minor concern relative to the previously proposed threshold and measurement change. If the threshold and measurement metrics remain the same as in Stage 2, that portion could be minimized.  The previous proposal did not include reporting response times to patients. Providing that feature will also require development contributing to the overall total.  Summary:  New area  Workflow and usability implications |
| **Open Notes** |  |  | Functionality to share notes with patients, similar to the Open Notes project. |  |  |
| **Improving care coordination** | | | | | |
| **Medication Reconciliation** | **Objective:** The EP who receives a patient from another setting of care or provider of care or  believes an encounter is relevant should perform medication reconciliation.  **Measure:** The EP who performs medication reconciliation for more than 50 percent of  transitions of care in which the patient is transitioned into the care of the EP. | EP / EH / CAH Objective: The EP, EH, 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  EP / EH / CAH Measure: The EP, EH, or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs reconciliation for medications for more than 50% of those patients.  **Certification criteria**: CDS intelligence to ensure lists are accurate (see SGRP113 as well) | * **Eligible Professionals, Hospitals, and CAHs** who receive patients from another setting of care, provider of care performs reconciliation for medications. As an alternative, reconciliation may also be performed for all encounters. * Recommend that CEHRT include the ability to use CDS intelligence to assist in maintaining the accuracy of medication lists |  |  |
| **Summary of Care** | **Objective:** The EP who transitions their patient to another setting of care or provider of care or  refers their patient to another provider of care should provide summary care record  for each transition of care or referral.  EPs must satisfy both of the following measures in order to meet the objective:  **Measure 1:**  **•** The EP who 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.  **Measure 2:**  The EP who transitions or refers their patient to another setting of care or  provider of care provides a summary of care record for more than 10 percent  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 NwHIN.  **Measure 3:**  An EP must satisfy one of the following criteria:  Conducts one or more successful electronic exchanges of a summary of care  document, as part of which is counted in "measure 2" (for EPs the measure at  §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was  developed designed by a different EHR technology developer than the  sender's EHR technology certified to 45 CFR 170.314(b)(2).  Conducts one or more successful tests with the CMS designated test EHR  during the EHR reporting period | **EP/ EH / CAH Objective**: EP/EH/CAH who transfers their patient to another setting of care (including home), requests a consult from a provider in another setting of care, or provides consultation results to a provider in another setting of care provides a summary of care record that pertains to the type of transition:   * Transfers of care from one site of care to another (e.g.. Hospital to SNF, PCP, HHA, etc…; SNF, PCP, etc… to HHA; PCP to new PCP) * Consult (referral) request (e.g., PCP to Specialist; PCP, SNF, etc… to ED) * Consult result note (e.g. ER note, consult note)   **Measure:** The EP, EH, or CAH that transfers their patient to another setting of care (including home), requests a consult from a provider in another setting of care, or provides consultation results to a provider in another setting of care, provides a summary of care record for 50% of transitions (consult note, consult request, transfer of care, as indicated above) and at least 10%\* electronically.    **Certification criteria #1:** EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to document clinically relevant rationale such as reason for transition and / or consult request.  **Certification criteria #2:** Ability to automatically populate a consult request form for specific purposes, including a referral to a smoking quit line. Certification criteria #3: Care team should include all care team members as defined in the consolidated CDA | EPs/EHs/CAHs provide a summary of care\* record pertaining to the type of transition when transferring patients to another setting of care (including home), requests a consult from a provider in another setting of care, or provides consultation results to a provider in another setting.  Types of transitions:   * Transfers of care from one site of care to another (e.g.. Hospital to SNF, PCP, HHA, home, etc…; SNF, PCP, etc… to HHA; PCP to new PCP) * Consult (referral) request (e.g., PCP to Specialist; PCP, SNF, etc… to ED) * Consult result note (e.g. ER note, consult note)   Summary of care may include:   1. A narrative that includes a synopsis of current care and expectations for consult/transition 2. Overarching patient goals and/or problem specific goals 3. Patient instructions, suggested interventions for care during transition 4. Information about known care team members (including a designated caregiver)   \* An electronic summary is preferred | **Seeking additional feedback from EHRA, based upon updated objective.**  **Original Response from EHRA:**  **Overall estimate: Large to Jumbo**  Adding consult result workflows, large or jumbo, see entry in next row also.  Auto-consult request forms, small.  Narrative in CCDA, small.  Updated reporting for revised measure. | **EHRA**: We have updated our estimates given the scope changes for the proposed objective.  This measure appears to require the request for consult/transfer. What form will that request take? Will the request be electronic and/or structured? Are there defined standards for such a request? Is infrastructure in place in the request destinations? Do requests have an HIE behavior? Many areas are utilizing HIE strategies to ensure nursing homes and other care venues have access to patient data and requests, and yet HIE interaction has not been appropriately measured in Stage 2.  Secondly, we note that we are already hearing feedback that the CCDA is unwieldy in length. Additional sections (as proposed here) will need to be carefully considered for usability.  **Overall estimate: Large to Jumbo (combination of 1 large and 2 small projects)**   * Adding consult result workflows. * Narrative in CCDA, small. * Updated reporting for revised measure.   Summary:   * New area * Not well understood * Unclear standards/needs standards work * Workflow and usability implications |
| **Notifications** | **\*\*New\*\*** | * **MENU 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. * **Significant events include:** * Arrival at an Emergency Department (ED) * Admission to a hospital * Discharge from an ED or hospital * Death * **EH Measure: For 25 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 24 hours of when the event occurs.   **Certification Criteria:** Ability to send/receive notification of a significant healthcare event | * **Eligible Hospitals and CAHs** send electronic notifications of significant healthcare events in a timely manner to key members of the patient’s care team (e.g., the primary care provider, referring provider, or care coordinator) with the patient’s consent if required * Significant events include:   + Arrival at an Emergency Department (ED)   + Admission to a hospital   + Discharge from an ED or hospital   + Death * Recommended as a **Menu** item * Low threshold (e.g. 25 patients) | **Question to EHRA**: If ED and admissions are prioritized, will this be more manageable?  **EHRA Original Response: Overall estimate: Jumbo**  Estimate depends on approach and the availability of standards. Would have both development and implementation impact.   * Identification of appropriate triggers * Sending the notification * Capture who the patient wants to send notifications to * Capturing patient consent for sending the notifications * Tracking/auditing of notifications * Directory of recipients of notifications * Reporting for new measure.   We would be happy to further discuss appropriate standards with the HITSC. | **EHRA**: We agree that approaching this new area with a reduced scope is wise, but we still estimate there to be a jumbo quantity of development necessary. This proposal will require new monitoring programs, and some vendors speculate that the processing power required could increase the hardware needs of users.  **Overall estimate: Jumbo**   * Estimate depends on approach and the availability of standards. Would have both development and implementation impact. * Identification of appropriate triggers. * Sending the notification. * Capture who the patient wants to send notifications to. * Handling patient privacy concerns with varying approaches across the country. * Capturing patient consent/restrictions/opt in for sending the notifications. * Tracking/auditing of notifications. * Directory of recipients of notifications. * Reporting for new measure. |
| **Improving population and public health** | | | | | |
| **Immunization history** |  | * **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 at least 10 query results received by the EHR from the immunization registry or immunization information system within the reporting period.  **Exclusion:** EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories. **Certification criteria #1:** 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.   Certification criteria #2: Ability to generate a report that the functionality was enabled for the entire reporting period. | * **Eligible Professionals, Hospitals, and CAHs** receive a patient’s immunization history supplied by an immunization registry or immunization information system, allowing healthcare professionals to use structured historical immunization information in the clinical workflow * Recommended CEHRT Functionality   + Ability 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 |  |  |
| **Electronic lab reporting** | **Objective:** Capability to submit electronic reportable laboratory results to public health agencies,  where except where prohibited, and in accordance with applicable law and practice.  **Measure:** Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to a public health agency for the entire EHR reporting period. | **No Change from Stage 2**  **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 electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period. | * **Eligible Hospitals and CAHs** submit electronic reportable laboratory results, for the entire reporting period, to public health agencies, except where prohibited, and in accordance with applicable law and practice |  |  |
| **Case Reports** |  | **Certification criteria ONLY:** 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. | * CEHRT 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. * Recommended as **certification criteria only** | **Clinical Quality**:   1. Is the proposed ONC standard data capture (SDC) method sufficiently mature to allow providers to use as a common means for case reporting. 2. What is the status of Health eDecision and EHR ability to consume an external set of data (i.e., Reportable Conditions Knowledge Management System [RCKMS]) to support trigger mechanisms for clinical decision support (for case reporting) CSTE and CDC are developing and proposing methods to share the RCKMS. (i.e., LOINC lab tests and SNOMED lab results for 60+ reportable conditions). 3. Is it reasonable to expect EHR functionality to generate a case report (c-CDA message) directed to the state or local health agency? CSTE is currently pilot testing some case reporting functionality. |  |
| **Syndromic Surveillance** | **Objective:** Capability to submit electronic syndromic surveillance data to public health agencies  except where prohibited, and in accordance with applicable law and practice  **Measure:** Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period | **No Change from Stage 2**  **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 submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period | * **Eligible Hospitals and CAHs** submit syndromic surveillance data for the entire reporting period from CEHRT to public health agencies, except where prohibited, and in accordance with applicable law and practice |  |  |
| **Registries** |  | **EP Objective:**  Capability to electronically submit standardized commonly formatted reports to two registries from the CEHRT.  **Measure:** Documentation (or registry acknowledgement) of ongoing successful electronic transmission of Standardized reports from the CEHRT to two registries (either mandated or voluntary)).  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 a registry, maintain an audit of those reports, and track total number of reports sent. | * **EPs/EHs** use CEHRT to electronically submit standardized (i.e., data elements, structure and transport mechanisms), commonly formatted reports to two registries (e.g., local/state health departments, professional or other aggregating resources) * **EP/EH Registries examples:** cancer, children with special needs, and/or early hearing detection and intervention or external entities that maintain the registry (e.g., hypertension, diabetes, body mass index, devices, and/or other diagnoses/conditions) that could include accountable care organization, public health agency, professional society, or specialty community. EHs Only: health-care associated infections | **Clinical Quality:**   * Does the committee have recommendations about registry standards – especially ‘specialized’ registries housed at various specialty societies or advocacy groups? |  |
| **Affordable Care** | | | | | |
| **Clinical Decision Support** |  |  | * Demonstrate use of multiple CDS interventions that apply to quality measures in each of the six NQS domains. Recommended interventions include:   + Preventive care   + Chronic disease management (e.g., diabetes, coronary artery disease)   + Appropriateness of lab and radiology orders   + Advanced medication-related decision support (e.g., renal drug dosing)   + Improving the accuracy/completeness of the problem list   + Drug-drug and drug-allergy interaction checks * CEHRT should provide tools that enable the ability to provide these interventions * Related work that can inform: S&I HealtheDecisions, HITSC Clinical Quality WG |  |  |
| **Reducing Health Disparities** | | | | | |
| **Additional Patient Information** | **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 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. | Certification criteria:   * Patient preferred method of communication * Occupation and industry codes * Sexual orientation, gender identity (optional fields) * Disability status * Differentiate between patient reported & medically determined * Need to continue standards work   **Certification criteria:** HITSC to identify what the communication preferences options should be for the clinical summary, reminders, patient educational material objectives (this will correlate to the patient’s preferred format in each of these objectives). Providers should have the ability to select options that are technically feasible for them, these could include: Email, text, patient portal, telephone, regular mail. | * CEHRT provides the ability to capture   + - Patient preferred method of communication\*     - Occupation and Industry codes     - Sexual orientation, gender identity (optional fields)     - Disability status * Differentiate between patient reported & medically determined * Communication preferences will be applied to the clinical summary, reminders, and patient education objectives * Providers should have the ability to select options that are technically feasible for them, these include: Email, text, patient portal, telephone, regular mail * Recommended as **certification criteria only** |  |  |