| **ID #** | **Stage 2 Final Rule** | **Stage 3 Recommendations** | **Proposed for Future Stage** | **HITPC Questions / Comments** |
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| **Improving quality, safety, and reducing health disparities** | | | | |
| **SGRP112** | **EH MENU Objective: R**ecord whether a patient 65 years old or older has an advance directive **EH MENU Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data. | Ensure standards support in CDA by 2016  **EP MENU/EH Core Objective:** Record whether a patient 65 years old or older has an advance directive  **EP MENU/EH Core Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data. |  |  |
| **PUBLIC COMMENTS:**  **Summary Statement:** Commenters were strongly supportive of this objective with some providing suggested revisions to the measure percentage and whether it should be core/menu. Commenters also provided suggestions to enhance the objective through lowering the age requirement, including the actual directive and other documents, and establishing a standard for recording and transmitting an advance directive.  **Key Points**:   * Percentage: some said raise (e.g. 80%) and other said lower it (25%) since it was new for EPs * Core for hospitals was supported (e.g. AHA), but menu for EPs since it would be new (e.g. AMA). * A commenter requested that the age threshold be raised, but AARP and others requested it be lowered (patients 50 or older or even 18 or older). Because individuals could lose cognitive function at any time and for a number of reasons, it is appropriate for all adults to plan ahead. * Commenters pointed out that this would likely not be applicable to many specialists * Include ***the*** advance directive (that is the important content)   + Scanned copy (via a hyperlink)   + Structured data via a standard (w/ implementation guide) or at least specified fields * Standard   + Concerned the CDA standard may not exist by 2016   + EHRA/NextGen***:*** We suggest that the standards to support the exchange of advance directive information reflect the fact that the relevant C-CDA document only needs to contain an indication of the presence of an advance directive, but is not required to embed the actual advance directive. * Patient Input - One way to achieve the maintenance of advance directives in medical records may be to allow patients to submit them directly into their EHRs as is contemplated in SGRP 204B. According to AHRQ, between 65 and 76 percent of physicians whose patients had an advance directive were not aware that it existed. * ***American Bar Association***   + Recommend that the Stage 3 meaningful use criteria include the objective “Record advance care planning status,” which is met by the following measure: more than 50 percent of all patients who die in an eligible hospital or CAH inpatient department during the reporting period have at least one of the following in the record: a copy of the patient’s advance directive, advance care planning notes, or a copy of a POLST form (***many*** commenters recommend the use of POLST or state initiative such as MOLST).   + Recommend that the record documents the length of time before death that the planning documentation was created. Please see full ABA comment for analysis and rationale. * Directive should contain the identity and contact information of a patient’s healthcare decision-maker * JCAHO requires Federally Qualified Health Centers to meet the HITPC proposed new measure * Legal Points   + This seems to create dangerous partial information knowing that a person “has” an advance directive without knowing its content creates liability and the obligation to pursue getting that information without having a place to put it in the record   + It would be worthwhile to inventory state laws and devise an objective and measure that reflects the diversity of laws. Many states have state laws specifying “psychiatric advance directives,” and any ONC requirement applicable to persons with mental illness must be consistent with these state laws | | | | |
| **HITSC COMMENTS:**  Agree with need to ensure standards support in CDA by 2016. | | | | |
| **SGRP 113** | **EP/EH Objective:** Use clinical decision support to improve performance on high-priority health conditions **Measure:**  1. Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. 2. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. | **Objective:** Use clinical decision support to improve performance on high priority health conditions **Measure:** 1. Implement 15 clinical decision support interventions or guidance related to five (5) or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period.  The 15 CDS interventions should include one or more interventions in two or more of the following areas, as applicable to the EP's specialty:   * Preventive care (including immunizations) * Chronic disease management, including hypertension\* (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 or completeness of the problem list for one or more chronic conditions   2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.  **Certification criteria:** 1. Ability to track CDS triggers, how the provider responded, and the reason for overriding (as appropriate) to improve the effectiveness of CDS interventions  2. Ability to flag preference-sensitive conditions, and provide decision support materials for patients.  3. Capability to check for a maximum dose in addition to a weight based calculation.  4. Use of structured SIG standards  5. Ability for EHRs to consume external CDS interventions (e.g., rules for drug-drug interactions, immunization recommendations and rules, preference-sensitive care lists)  \* This will assist in achieving the CDC’s goal of improvements in hypertension control.  \*\*[Kuperman, GJ. (2007)Medication-related clinical decision support in computerized provider order entry systems a review. *Journal of the American Medical Informatics Association*: JAMIA, 14(1):29-40.](http://jamia.bmj.com/content/14/1/29)  [\*\*\* Phansalkar, S., van der Siis, H., Tucker, A., Desai, A., Bell, D., Teich, J., Middleton, B., Bates, D (2012). Drug–drug interactions that should be noninterruptive](http://jamia.bmj.com/search?submit=yes&fulltext=drug+interaction&format=condensed&hits=10&sortspec=relevance&submit=Go)  [in order to reduce alert fatigue in electronic health records. Journal of the American Medical Informatics Association: JAMIA, 2013;20:3 489-493](http://jamia.bmj.com/search?submit=yes&fulltext=drug+interaction&format=condensed&hits=10&sortspec=relevance&submit=Go) | **Certification criteria:** Explore greater specificity for food-drug interactions  *Procedure/Surgery/lab/radiology/test prior authorization v.A*: for those procedures/surgeries/lab/radiology/test with clear and objective prior authorization requirements and a structured data prior authorization form is available, clinician fill out the prior authorization form using structured data fields and prior authorization can be granted electronically and in real-time by the payor.  *Procedure/Surgery/lab/radiology /test prior authorization v.B*: for those procedures/surgeries/lab/radiology/test, for which prior authorization is non-standardized and is highly individualized, a standardized form is created that collects from the clinician text fields answering an agreed upon set of medical necessity questions, standardized form is sent electronically to insurer for review, insurer responds with Approval/Denial (with rationale if denied) using a standardized format text document back to clinician with either approval and/or denial with rationale. | Ability for EHRs to consume CDS interventions from central repositories The EHR would query (via web services) available databases to identify “trigger event” conditions (e.g., case reporting criteria, drug-drug interactions, potentially relevant trials) based on the patient’s health condition, diagnoses, location, and other basic facts.  The HITPC is interested in experience from payors that may contribute to CDS. |
| **PUBLIC COMMENTS:**  **High-level Summary**   * Approximately the same number expressed favor/opposition to increasing to 15 interventions   + Concerns included: alert fatigue, lack of CDS interventions relevant to specialty practice (especially ones related to the CQMs).   + Clarification needed regarding whether the 15 interventions are to be at the practice/group level or the provider level (which could be burdensome for larger organizations). * Comments were varied about the tie to CQMs and focus areas   + Some opposed, viewing it as too burdensome or not enough relevant CQMs available   + A few contended that the links and focus areas were "too arbitrary" and detracted from targeted QI   + A few suggested that ONC focus on outcomes and let providers pick what CDS they need to improve CQMs * Most opposed the DDI requirement (noted as a source of alert fatigue) * Many expressed concern that standards will not be available for structured SIG * Few commenters were in favor of tracking provider responses to CDS * Clarification was requested related to preference-sensitive conditions and vendors indicated concern about modularity of patient versus provider-facing CDS * The criterion for the ability to consume CDS interventions was generally met with support   + Concern about readiness of standards and the cost of content subscriptions to providers. * There were only a couple of comments related to food-drug interactions and were concerned about the specificity of information likely to be available in an EHR. | | | | |
| **HITSC COMMENTS:**  Defer or reconsider in are areas of certification criteria. Central repositories of CDS interventions do not exist and the standards for representation of rules and data for rules are immature. More tracking, flagging, and alerts may make CDS more detrimental than useful. Recommend instead a more flexible acceptance of tools that are adaptable to different practice patterns and that allow established clinical workflows. A multi-year workplan is needed for research and for standards development.  Proposed certification criterion #5 “Ability for EHRs to consume CDS interventions from central repositories (e.g., rules for drug-drug interactions, rules for reporting diseases for public health departments, preference-sensitive care lists)” dictates design (central repository). Certification criteria should specify what the EHR needs to do and not how it should be implemented within an enterprise. A central rules repository is just one way of implementing CDS. Suggest change to “Ability for EHRs to consume CDS rules as structured data using xxx standard” (standard TBD)  • CDS needs to be congruent with clinician workflow requirements, it needs to be appropriate, tunable, fast and reliable to work in a clinical workflow setting -  • EPs, EHs, and Vendors should be able to access central repositories but the certification requirements should not assume that they exist in all areas for all 15 of the CDS interventions. There needs to be an alternative to central repositories to meet this requirement.  • Reporting and follow-up items need to be managed and handled properly  • Payor experience that may contribute to CDS should be solicited from the payor community via hearings, town halls or surveys | | | | |
| **SGRP116** | **EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder per patient preference. **Measure:** More than 10% of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available | **EP Objective:** Use 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, in the format of the patient’s preference, if the provider has the technical capability **Exclusion:** Specialists may be excluded for prevention reminders (could be more condition specific). |  |  |
| **PUBLIC COMMENTS:**   * Summary statement: Commenters partially agree with the proposed changes:   + Specifity requested on ‘clinically relevant’   + agreement on increase in threshold   + disagreement with decrease in office visit from two visits to one in a 24 mo period   + specificity requested for reminder and patient preference terms. * Key Points   + Commenters wanted specificity on what would be clinically relevant and provided suggestions   + Will this objective/measure remain menu or core   + Commenters suggested raising threshold higher than 20%   + Commenters asked if it will meet MU to send reminders from non-CEHRT systems   + Commenters wondered if MU is met if patient opts out from reminders   + Most commenters suggesting keeping the two visits requirement   **Exclusion:** Specialists may be excluded for prevention reminders (could be more condition specific).   * Summary statement: Commenters agree with inclusion, but want more specificity * Key Points   + Recommend that the exclusion category be broad enough to cover physicians for whom routine patient reminders would not be contextually relevant or appropriate.   + Certain specialists should not be excused from such measures because they provide preventive care. | | | | |
| **HITSC COMMENTS:**  This should be an initial percentage increasing over several years to 95% of patients for whom a preventive/follow-up reminder is appropriate being sent a reminder via their preferred communication channel. (Many will have moved and be effectively impossible to reach.) | | | | |
| **SGRP117** | **EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR) **Measure:** More than 10 percent of 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. |  |  |
| **PUBLIC COMMENTS:**  **Measure:** More than 30% 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.   * Summary: Commenters agree with increasing the threshold * Key Points   + Evaluate experience with Meaningful Use Stage 2 before increasing threshold   + Increase the threshold higher than 30%   **Measure:** Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked for use in quality improvement.   * Summary: Commenters agree with inclusion, but want more specificity * Key Points   + Some commenters already track mismatches, but outside of eMAR   + Specificity of the terms: mismatch, not intended dosing, tracked, intention of measure | | | | |
| **HITSC COMMENTS:**  Increasing to 95%. | | | | |
| **SGRP118** | **MENU Objective: I**maging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **MENU Measure:** More than 10 percent of all tests whose result is one or more images ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology. | **EP MENU/EH CORE Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology.  **EP MENU/EH CORE Measure:** More than 10 images (e.g. radiology, photographs, images of ECG), ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible (e.g. viewed directly in the EHR or a link to a separate system reached via the EHR) through Certified EHR Technology  **Certification criteria:** Systems should provide the capability to show imaging and radiation dosing exposure. | Identify how to present to the patient. Capture the things needed for a radiologist to calculate the dose that the patient has had – need information in a structured for**m**. | What barriers could be encountered in moving this to core? |
| **PUBLIC COMMENTS:**   * Summary statement: Commenters do not agree with changing this objective & measure to core * Key Points   + Having a report should be core. Having the image should be menu.   + Stage 2 adoption data should be reviewed in determining feasibility for core in Stage 3.   + Especially difficult for EPs who are still adopting CEHRT   + Lack of clarity over term ‘accessible’ in CEHRT   + Exclusion criteria needed if moving from menu to core   What barriers could be encountered in moving this item from menu to core?   * Summary statement: Numerous barriers were described and are summarized * Key Points   + Cost of interfaces & availability are still a barrier, especially to EP   + Type of images have been expanded beyond RIS/PACS which widens scope of objective & measure   + Evaluation needed of networking, transmission, and storage impacts of large image files   + Lack of control over getting images from the various image systems   + Lack of high resolution displays may compromise adequate result viewing   + Clarity over term ‘accessible’ in CEHRT is required | | | | |
| **HITSC COMMENTS:**  Reframe objective as an HIE objective to share images, in a stage subsequent to MU3. Clarify that EKGs are not images but could be useful to caregivers. The ability to access images is not a core EHR function, but can be enabled by linked access to imaging systems, image archives, by image exchange/sharing functions or by other means.  • Cost of achieving interoperability with image source should be recognized. Definitions of image within the EHRs, and the relevance of actual images to the clinician are barriers..  • Considering the necessity of the use of the image, this should be considered only as a menu item.  • The summary/report of imaging is always important; the actual image is only sometimes important and can be accessed for clinical purposes as needed without being stored in the core EHR.  • Continue this as a menu measure with a 10% threshold. | | | | |
| **SGRP119** | **MENU Objective:** Record patient family health history as structured data **MENU Measure:** More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives | **MENU Objective:** Record high priority (i.e. cardiac disease, breast cancer, and colon cancer) family history data  **MENU Measure:** Record high priority family history in 40% of patients seen during reporting period  **Certification criteria:** Make sure that every appropriate CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach). |  |  |
| **SGRP120** | **MENU Objective:** Record electronic notes in patient records  **MENU Measure:** Enter at least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of unique patient office visits. Notes must be text-searchable. Non-searchable scanned notes do not qualify but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure.  **MENU Measure:** Enter at least one electronic progress note created, edited, and signed by an authorized provider of the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH’s inpatient or emergency department during the EHR reporting period.  Electronic progress notes must be text-searchable. Non-searchable, scanned notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure. | **CORE** EP/EH objective: Record electronic notes in patient records  **EP:** Record electronic progress note, authored by the eligible professional for more than 30 percent of unique patient office visits **within four business days**. 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  **EH:** Enter at least one 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 percent of unique patients **within** **four business days of admission** to the eligible hospital or CAH’s inpatient or emergency department during the EHR reporting period. |  |  |
| **PUBLIC COMMENTS:**   * Summary statement: 2/3rds of the commenters wanted additional specificity before providing an opinion on inclusion of this change. Of the 1/3 who provided an opinion, most agreed with the proposed changes. * Key Points   + Many commenters wanted clarification on whether this will remain a menu item or will it become core   + Many commenters wanted clarification on whether the objective & measure applies to EH/CAH, EP or Both   + Many commenters suggested a change to four business days from four calendar days   + Commenters wondered if the language change from ‘unique’ to ‘office’ was intentional   + Commenters suggested clarifying the ‘created/edited/signed’ language based on MU2 experience requiring further clarification | | | | |
| **HITSC COMMENTS:**  Retain as menu set (offset to recommendation to retain demographics, etc.) and need to define “high priority data” based on an explicit value case analysis.  It is critically important that the family history required is evidence-based, in the sense that it is validated in a clinical trial as informing improved patient care. Whether or not each datum involves a first-degree relative is irrelevant to this. | | | | |
| **SGRP121** | **EH MENU Objective:** Provide structured electronic lab results to ambulatory providers **EH MENU Measure:** Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of electronic lab orders received | **EH CORE Objective:** Provide structured electronic lab results to eligible professionals.  **EH CORE Measure:** Hospital labs send (directly or indirectly using LOINC) structured electronic clinical lab results to the ordering provider for more than 50% of electronic lab orders received. |  |  |
| **PUBLIC COMMENTS:**   * Summary statement: Most commenters disagreed with the move to core and the increase in threshold, and want specificity on new terms * Key Points   + Many commenters recommended not moving to core until MU2 results are assessed; if it does move to core, keep threshold at 20%   + Many commenters expressed concern with the jump in threshold from 20% to 80%; if it does stay menu, increase threshold to 30%   + Specificity requested on changes to terms     - Does ambulatory provider to eligible professionals coincide with definition of an EP     - Define directly or indirectly | | | | |
| **HITSC COMMENTS:**  Why not require LOINC by name? It is clearly mature enough and has been recommended for this by HITSC. | | | | |
| **SGRP122** | **NEW** | **EP Objective:** The EHR is able to assist with follow-up on test results to improve the management of test results.  **EP Measure:** 10% of test results (e.g. laboratory, radiology, pathology) are acknowledged within 3 business days of when the test was 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 test * notify the ordering providers when results are available or not completed by a certain time * record date and time that test results are reviewed and by whom |  |  |
| **PUBLIC COMMENTS:**   * Summary statement: Half of the commenters wanted additional specificity before considering inclusion at Stage 3. Commenters who did provide an opinion were divided equally between inclusion/exclusion at Stage 3. * Key Points   + Clarify who this applies to: EH or EP or both EH/CAH/EP   + Clarify the intent of the measure, what kinds of tests are included, and what it means to acknowledge.   + Specificity requested around the term abnormal   + Specificity requested around the 3 days: calendar or business; from date or order or date of result report; preliminary or final, how to determine whether an order needs to be followed up as ‘not done’ | | | | |
| **HITSC COMMENTS:**  Is this 3 working days? Three week days? If 72 hours is meant, we should say that. Increasing to 95% over time | | | | |
| **SGRP 123** |  | **MENU objective: EPs and EHs** should record the FDA Unique Device Identifier (UDI) when patients have devices implanted for the first time  **MENU Measure**: EPs and EHs should record the UDI for 80% of patients seen within the EHR reporting period.  **Definition of a Medical Device (FD&C Act) Section 201(h): “A medical device is: an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:**   * **recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them,** * **intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or**   **intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes."** |  |  |
| **SGRP101** | **Eligible Provider (EP) Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **Eligible Hospital (EH) Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **EP/EH Measure:** More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. | **Certification Criteria ONLY**  **Certification Criteria:** EHR must be able to consume an externally supplied list of “never” DDIs, using RxNorm and NDF-RT standards along with a TBD DDI reactions value set.  **Certification Criteria for EPs**  EHR must have the ability to transmit lab orders using the lab order and results Interface guidelines produced by the S&I Framework Initiative. | Seeking externally maintained list of DDIs with higher predictive value |  |
| **PUBLIC COMMENTS:**  Commenters expressed overall support for the objective, with a range of views on increasing and decreasing the percentage thresholds for the measure (more leaned towards not increasing, particularly for labs and rads). Commenters also focused on and expressed concerned about the concept of external DDI checking – implementation, usefulness, reliability, cost and administrative efficiencies, and maintenance/authority of an external list.   * External List of DDIs   + Include more information on drug-drug interaction (DDI) maintenance of never combinations, as well as drug-food, drug-disease, drug-genetic map, and drug-age interactions. Include HL7 V3 Nutrition Order Clinical Messages.   + Some commenters suggested removing DDI checking (already included in EHR). The proposed certification criteria adds complexity and potentially clinical risk by requiring a standard for receiving values because EHRs are already obtaining this information today from third parties. Implementation would likely not be optimal. “On the fly” query would not always be possible – Assume that the ”never DDI” list would be provided along with medication content from third parties   + ***EHRA*** - Confusion about RxNorm and NDF-RT standards for DDIs. EHR developers would like more information about the standards for supplying the DDI list.     - This creates a shift from multum codes to RxNorm codes for DDIs?     - Would medication orders also need to map to RxNorm codes since the current CPOE is based on multum codes?   + Will this come from database vendors? Johns Hopkins University has built a list of Never DDIs that CMS may be able to refer to as an example for further objective refinement.   + One list? - how will the list be updated and maintained? Who/What has authority over list(s)?   + Need agreed upon list and levels of significance   + Would it only include DDIs that indicate certain medications should never be active orders at a single time regardless of a patient’s condition?   + Undue reliance on this list will diminish the screening of other DDIs that may not make the list, but can be just as harmful to patients.   + As seen with the CQMs – any requirement to adopt clinical standards from any third party requires a significant amount of communication, transparency, and wide acceptance on the authority/reliability of the third party.   + Difficult/unlikely feasible in the near future. In particular, there is insufficient indication that there is or will be clarity in -content standards (NDDF, RXNorm, etc) or technical standards (deployment, real-time use, API, etc.). | | | | |
| **HITSC COMMENTS:**  Agree with deferral for future stages. The “externally vetted list” must be better defined before it can be standardized, and methods to reduce false positives - to avoid alert fatigue - should be developed.  Kaiser has a carefully developed, operational list. | | | | |
| **SGRP103** | **EP/EH Objective:** Generate and transmit permissible prescriptions electronically (eRx) **Measure:** More than 50% of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT. **EH MENU Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx) **EH MENU Measure:** More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology | **Certification criteria:**   1. Ability to electronically transmit permissible prescriptions using CEHRT. 2. The ability to compare prescriptions to at least one drug formulary and identify generic substitutions is enabled for the entire reporting period. | Advanced medication reconciliation to check for formulary compliance.  Medication formulary checking:   * If Rx is formulary-compliant, transmit to pharmacy. * If Rx is not formulary compliant, prescriber presented with alternatives (if available through formulary database) or provided a structured prior-authorization form to complete before Rx transmitted. Capability for automatic approval of prior-auth should be available. | How to include formulary checking into EHR and connection to formulary sources (e.g., PBMs)? |
| **SGRP104** | **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. | Retire prior demographics objective because it is topped out (achieved 80% threshold).  **Certification criteria:**   * Patient preferred method of communication in compliance with privacy and security requirements (i.e., E-mail, postal mail, text, patient portal, telephone) * Occupation and industry codes * Sexual orientation, gender identity (optional fields) * Disability status and date of status * Differentiate between patient reported & medically determined   Need to continue standards work |  | Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to. |
| **PUBLIC COMMENTS:**   * Commenters suggested a number of additional data elements to require/collect: Housing status (4), organ donor status (2), school lunch status, fertility status, marital status, place of birth, veteran status, hobbies and interests (2), number of guns in the household, and a variety of end-of-life care measures. * Some commenters requested more specificity on race/ethnicity data collection, including using ACA section 4302 and >7 'Asian' and >4 'native Hawaiian/islander' categories.   **Certification criteria: Occupation and industry codes (192 comments)**   * Summary: Commenters overwhelmingly support adding these, but many expressed concern about coding and standards. * Some expressed agreement with the addition for certification criteria, but would like there to be a use case so that practices actually capture this information. * A few commenters opposed these data elements, who were not sure of how relevant or useful the data would be to care, and one association, which contended that I/O data "do not bear enough relevance to a patients’ ongoing eye care" and thus oppose inclusion * Commenters expressed some concern about the cost of maintaining I/O data, of updating EHR systems to capture it, and the complexity of system development * A few commenters requested clarification on the data standards to be used, if I/O would be two fields or one or more, and the feasibility of collecting sufficiently detailed information * A couple commenters discussed including dates and keeping a longitudinal record – and note the need to distinguish 'usual' versus current occupation   **Sexual orientation, gender identity (optional fields)**   * Summary: Most commenters agreed with inclusion, but want more specificity as to data standards, definitions (e.g., "more than two genders"), and whether/how the data will affect other parts of EHR systems. One commenter offered detailed training suggestions to address providers' discomfort with the subject (0545) * A large number supported inclusion and recommended that they be mandatory and/or included as a use case, not just certification criteria. Some opposed inclusion and expressed discomfort with or concern about the sensitivity of the subject. * A number of those opposed did not believe these data to be relevant to care * A few did not feel that these data should be demographics, because front desk staff usually collect that and this sort of 'sensitive' data should be collected by members of the care team. * EHR vendors and provider organizations expressed concern about the complexity of development for these elements, see EHRA.   **Disability status**   * Summary: There were only a few comments on this element, but they were broadly supportive. However, commenters did raise a number of concerns, particularly concerning the availability and viability of data standards, provider burden, EHR development/upgrade cost, and relevance to practice. * The American College of Occupational and Environmental Medicine (ACOEM) would prefer that we use the term "functional status" or "workability." * Some commenters felt this element should be in clinical, not demographic data, and were concerned about increasing provider burden * Some commenters expressed concern about the standard readiness, technical costs of developing this, and upgrade costs. A number suggested that ONC collaborate with NCHS/NCBDDD to determine data standards. | | | | |
| **HITSC COMMENTS:**  Disagree. Although a high level of demographic data recording has been achieved, discontinuing the requirement could diminish collection of foundational data. Sensitive data such as sexual orientation and disability status should be omitted.  No other sector would consider 80% to be optimal performance on an important quality measure, nor should healthcare.  • Agree with the retirement of the topped out measures (Original demographic measures)  • Agree with the addition of the new updated demographic measures  • Structured data will be captured and not codified data at this time  • What is the definition of Disability Status? Federal definition or patient identification, or otherwise  • Question on how sexual orientation will or can be codified  • Introduce as a general comment about Disability status being included as long as it can be captured  • Date of disability status and inclusion of functional status should be included  Note: CMS has established Healthcare CommonProcedure Code Set and modifier coding requirements for reporting functional status and degree of impairment for therapy services claims, and explicitly requires them to be documented into the medical record. Any CMS requirement for that kind of information for meaningful use Stage 3 should take that into account and leverage it at least where the two requirements overlap – not impose additional requirement. The CMS claims requirement impacts all manners of therapy services providers including hospitals and physicians | | | | |
| **SGRP105** | **Consolidated in summary of care objective** Maintain an up-to-date problem list of current and active diagnoses | **Certification criteria:** EHR systems should provide functionality to help maintain up-to-date, accurate problem list  **Certification criteria:** Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians’ maintenance of up-to-date accurate problem lists. Systems provide decision support about additions, edits, and deletions for clinicians’ review and action. For example, if diabetes is not on the problem list but hypoglycemic medications are on the medication list: the EHR system might ask the provider whether diabetes should be on the problem list. It would not automatically add anything to the problem list without professional action. | Patient input to reconciliation of problems | The implementation of these criteria will assist in achieving the CDC’s goal of using EHR technology features to identify patients meeting criteria for hypertension who are not yet diagnosed and managed for the disorder.  How to incorporate into certification criteria for pilot testing?  The intent is that EHR vendors would provide functionality to help maintain functionality for active problem lists, not that they supply the actual knowledge for the rules. |
| **PUBLIC COMMENTS:**  Overall, commenters were concerned that this item, as written, is too vague. Many commenters simply did not support it because of this (or other reasons), but even among those who supported it (or pieces of it), a good proportion also noted concerns about vagueness. A number of commenters suggested integrating this requirement with CDS, indicating that it is duplicative or redundant, and one suggested retiring this measure in favor of enhanced CDS. A few suggested integrating it with the other 'list' items (SGPR 106, 107), and one supported using it in conjunction with 405, submission to registries. Commenters were also concerned about the potential burden on providers of additional alerts or verification requirements, one requesting that the criteria require that reviewing/adding/declining-to-add items to list is a minimally invasive 'one-click' function. Specialty organizations were particularly concerned that full problem lists would fall outside their scope of practice and place undue burden upon them.  Another common thread among multiple comments was that ONC ensure full testing and vetting before requiring these functionalities. Multiple commenters noted the need for standards in various aspects of this item, including one who suggested convening a TEP to study/establish standards for patient involvement in EHR, portals, etc. Similarly, the VA commented in detail that they feel that this is too complex to be achieved by stage 3. In fact, they comment that they have thus far been unable to implement such functionality (see comment below). | | | | |
| **HITSC COMMENTS:**  Clinical Operations WG  Recommend against standardizing at this time. Best practice advisories, alternative recommendations, and alerts should qualify as helpful tools but should not be mandated. Patient input could be used e.g. to reconcile problem list but introduces new issues in data integrity and validity.  The diabetes example is based on knowledge. How would this work otherwise? In any case, this functionality is not well enough characterized to be a certification criterion.  • Our question is how incorporate into certification criteria on using computer logic related to provide assistance in determining problems not on the list based on data like lab findings or medications. For purposes of certifiying this functionality the testing scripts and data sets would have to being clinical relevant and included ‘clue data’ that would lead to additional problems. This represents advanced software logic – The point here is that you want straightforward connections between findings (interventions and diagnostics) and a ‘problem.  • Limit the certification criteria and therefore pilot testing to high importance, low ambiguity cases.  • Chronic nationwide issues are most feasible. Consider limitation to the top 10  • Nothing in making this a certification criteria that prevents vendors from adding this functionality into their system without this requirement  • The Healthcare industry as a whole may not be ready for this functionality right now  • This type of requirement will create significant challenges with the test scripts. | | | | |
| **SGRP106** | **Consolidated with summary of care -** Maintain active medication list | **Certification criteria:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list  **Certification criteria:** Use of problems and lab test results to support clinicians’ maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians’ review. For example, an antibiotic (not for acne) has been on the medication list for over say a month, the EHR system might ask the provider whether the medication is a chronic medication. The system will not make any changes without professional approval. | **Certification criteria:** Use other EHR data such as medications filled or dispensed, or free text searching for medications to support maintenance of up-to-date and accurate medication lists. | How to incorporate into certification criteria for pilot testing?  The intent is that EHR vendors would provide functionality to help maintain functionality for active medication lists, not that they supply the actual knowledge for the rules. |
| **PUBLIC COMMENTS:**  Many commenters expressed support for this additional functionality. Equally, commenters expressed concern for a variety of reasons, with the primary concerns being the vagueness of the certification criteria, the potential for alert fatigue, and additional costs and complexity for providers. Additionally, various specialty interests were expressed. A few options were given for testing and standards. | | | | |
| **HITSC COMMENTS:**  Recommend against standardizing at this time, see above response on Problem List. Integration of external data sources e.g. for fill status introduces new concerns with data validation that need to be resolved first.  • Expansions of the measures as explained in certification criteria is of concern due to physician workflow, varying vendor functionality and clear definitions of timelines and factors related to the triggering events.  • 105 and 106 should be tied together and the use can be linked together   * Link the two together so that we understand the difference between filled and dispensed - The concern expressed related to the standards/process to provide the information of a medication being filled then dispensed back to the primary care provider (EP).   • Good idea for long term, but may not be appropriate right now  • Consider testing CDS in the real world with input from actual providers and workers, before it is added as an expanded measure.  • Great for the future, but difficult to do right now  • More clarity can be added with the use cases to produce adequate testing and then the establishment of certification criteria | | | | |
| **SGRP107** | **Consolidated with summary of care -** Maintain active medication allergy list | **Certification criteria:** EHR systems should provide functionality to code medication allergies including its related drug family to code related reactions. | Contraindications that could include adverse reactions and procedural intolerance. | The intent is that EHR vendors would provide functionality to help maintain functionality for active medication allergy lists, not that they supply the actual knowledge for the rules. |
| **PUBLIC COMMENTS:**  Commenters generally supported these proposals. Commenters pointed out the need for a clear and precise certification criteria, which would enable more specific comments. Commenters also pointed out the need for standards with some recommendations given. Commenters also suggested the inclusion of other allergens and the need to differentiate allergy intolerances and adverse reactions. A few commenters were concerned about alert fatigue and costs due to this additional functionality. | | | | |
| **HITSC COMMENTS:**  See comments on SGRP 105, 106. Advisories and alerts should qualify as helpful tools but should not be mandated. Patient supplied data could be helpful but would introduce new issues with data validity, reliability, and integrity. | | | | |
| **SGRP108** | **Objective: Record and chart changes in vital signs:** • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI  **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data | Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018 |  | Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to. |
| **PUBLIC COMMENTS:**  Comments were mixed on whether to retire or not. | | | | |
| **HITSC COMMENTS:**  Agree with retiring the measure.  SUMMARY COMMENT: Retiring this measure makes sense because attestation is of limited use at this stage of MU, but measures should demonstrate the use of such data, not its collection. In general, retiring attestation measures is reasonable provided the intent is that the data is transitioning to data use.  Comments: Floyd: This objective should be a requirement for the EHR to automatically report the frequency of each item among all visits rather than a requirement for attestation. There is no certification requirement for EHRs to perform functional process utilization. While there should be such a requirement, without it the objective remains an attestation element and adds to unnecessary work on the part of providers.   * Continue blood pressure and BMI with increasing performance standard (to 95%) over 3 years. Perform evidence review regarding the age up to which growth-chart calculation is clinically important. * Agree with retiring   Discussion:   * Ideally would capture the actual values for the measure – if you wouldn’t do that then there is no reason to retain * Healthcare is the only place where 80% would be “topped out” * BP is measured in one of the MU2 measures—BMI is also covered for some patients therefore probably not needed * Only BP would be measured if this is eliminated * This measure looks at capture of data—not USE of data—need to move beyond capture to utilization | | | | |
| **SGRP109** | **EP/EH Objective:** Record smoking status for patients 13 years old or older  **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data | Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028 |  | Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to. |
| **PUBLIC COMMENTS:**  Comments were mixed on retirement. | | | | |
| **HITSC COMMENTS**  Agree with retiring the measure  SUMMARY COMMENT: Retiring this measure makes sense because attestation is of limited use at this stage of MU, but measures should demonstrate the use of such data, not its collection. In general, retiring attestation measures is reasonable provided the intent is that the data is transitioning to data use.  Comments:   * This objective should be a requirement for the EHR to automatically report the frequency of each item among all visits rather than a requirement for attestation. There is no certification requirement for EHRs to perform functional process utilization. While there should be such a requirement, without it the objective remains an attestation element and adds to unnecessary work on the part of providers. * Continue measure with increasing performance standard (to 95%) over 3 years. * Agree with retiring   Discussion: See discussion for SGRP 108 | | | | |
| **SGRP114** | **EP/EH Objective:** Incorporate clinical lab-test results into Certified EHR Technology as structured data  **Measure:** More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data | **Objective:** Incorporate clinical lab-test results into EHR as structured data **Measure:** More than 80% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data |  |  |
| **PUBLIC COMMENTS:**   * Summary statement:   + Commenters agree with the increase in threshold to 80% but want more specificity * Key Points   + Clarify if this measure is menu or core   + Many commenters raised concern regarding the higher threshold affecting EPs, specialists and CAH because of the increased interface burden they face to meet this threshold   + Suggestion to evaluate experience in meeting 55% threshold in Stage 2 before increasing threshold to 80%   + Consider exclusion criteria at this threshold | | | | |
| **HITSC COMMENTS**  Clinical Ops WG: Increased threshold should be workable with existing standards. | | | | |
| **SGRP115** | **EP CORE Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach **EP CORE Measure:** Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition. | **EP Objective:** Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports. Dashboards are incorporated into the EHR’s clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report. |  |  |
| **PUBLIC COMMENTS:**  Generate lists of patients for multiple specific conditions   * Summary statement: Most commenters agreed with the intent of this measure * Key Points   + Many commenters requested specificity on the number of lists to meet MU criteria   + Additional comments received on what the lists should include and when they should be used   Present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports.   * Summary statement: Most commenters agreed that the language in this part of the measure was not specified well-enough to offer recommendation on inclusion or exclusion * Key Points   + Numerous comments were received requesting definition of terms used in the objective   + Commenters suggested MU Stage 2 data is evaluated prior to increasing threshold   + Exemption criteria should be defined   Dashboards are incorporated into the EHR’s clinical workflow for the care coordinator or the provider.   * Summary statement: Commenters were divided on whether this should be included in the measure * Key Points   + Commenters requested more specificity in the types of information presented on the dashboard and where it fits into clinical workflow   + Question raised over how this would be measurable as proposed   + Additional details on the intent of this objective would be helpful in assessing its feasibility.   It is actionable and not a retrospective report.   * Summary statement: Commenters were evenly divided on whether this should be included in the measure * Key Points   + Definition of actionable needs specificity   + Cannot describe data as ‘not retrospective’ as lists and dashboard may be built on data from that day and previously | | | | |
| **HITSC COMMENTS:**  Need to specifically define near-real-time, and “actionable” to assist standards selection.  As a form of presentation layer, dashboards are fundamentally limited—to a static set of just a few elements. Dashboards should not be specified in certification or elsewhere.  Apt EP Objective: Present to EPs (and other clinicians) usable, actionable patient-specific information in time to improve care processes. | | | | |
| **PUBLIC COMMENTS:**   * Summary statement: Commenters disagreed with the move to core and the change in wording * Key Points   + Agree with the intent to capture family history data, but not details   + Too many changes – menu to core and changing what is being captured   + Many commenters suggested evaluating experience from MU Stage 2 first before making changes to move to core or to threshold   + The change in wording caused many comments and confusion     - The term “high priority” needs clarification   + Many commenters wondered if it would still be structured data?   + If move to core, then need to develop exclusion criteria | | | | |
| **HITSC COMMENTS:**  Retain as menu set (offset to recommendation to retain demographics, etc.) and need to define “high priority data” based on an explicit value case analysis.  It is critically important that the family history required is evidence-based, in the sense that it is validated in a clinical trial as informing improved patient care. Whether or not each datum involves a first-degree relative is irrelevant to this. | | | | |
| **SGRP 130** | **New** | **Objective:** Use computerized provider order entry for referrals/transition of care orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.  **Measure:** More than 20% of referrals/transition of care orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded. |  |  |
| **Public Comment**   * General support for this proposal * Many expressed confusion as to whether this proposal simply required the recording of the referrals/transition of care orders created by the EP or whether it actually required the electronic transmission of these orders.   + For actual electronic transmission, concerned about the lack of interoperability and standards, including the ability of post-acute care facilities to receive the orders   + Define recorded | | | | |
| **HITSC Comment**  Unclear how referral order workflow would work. Would an order initiate an X12 administrative referral/auth transaction, send a clinical message to the next provider of care, and initiate a closed loop referral management process etc? | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **PUBLIC COMMENTS:**  Commenters expressed overall support for the objective, with a range of views on increasing and decreasing the percentage thresholds for the measure (more leaned towards not increasing, particularly for labs and rads). Commenters also focused on and expressed concerned about the concept of external DDI checking – implementation, usefulness, reliability, cost and administrative efficiencies, and maintenance/authority of an external list.   * External List of DDIs   + Include more information on drug-drug interaction (DDI) maintenance of never combinations, as well as drug-food, drug-disease, drug-genetic map, and drug-age interactions. Include HL7 V3 Nutrition Order Clinical Messages.   + Some commenters suggested removing DDI checking (already included in EHR). The proposed certification criteria adds complexity and potentially clinical risk by requiring a standard for receiving values because EHRs are already obtaining this information today from third parties. Implementation would likely not be optimal. “On the fly” query would not always be possible – Assume that the ”never DDI” list would be provided along with medication content from third parties   + ***EHRA*** - Confusion about RxNorm and NDF-RT standards for DDIs. EHR developers would like more information about the standards for supplying the DDI list.     - This creates a shift from multum codes to RxNorm codes for DDIs?     - Would medication orders also need to map to RxNorm codes since the current CPOE is based on multum codes?   + Will this come from database vendors? Johns Hopkins University has built a list of Never DDIs that CMS may be able to refer to as an example for further objective refinement.   + One list? - how will the list be updated and maintained? Who/What has authority over list(s)?   + Need agreed upon list and levels of significance   + Would it only include DDIs that indicate certain medications should never be active orders at a single time regardless of a patient’s condition?   + Undue reliance on this list will diminish the screening of other DDIs that may not make the list, but can be just as harmful to patients.   + As seen with the CQMs – any requirement to adopt clinical standards from any third party requires a significant amount of communication, transparency, and wide acceptance on the authority/reliability of the third party.   + Difficult/unlikely feasible in the near future. In particular, there is insufficient indication that there is or will be clarity in -content standards (NDDF, RXNorm, etc) or technical standards (deployment, real-time use, API, etc.). | | | | | | | **HITSC COMMENTS:**  Agree with deferral for future stages. The “externally vetted list” must be better defined before it can be standardized, and methods to reduce false positives - to avoid alert fatigue - should be developed.  Kaiser has a carefully developed, operational list. | | | | | | | **SGRP103** | **EP/EH Objective:** Generate and transmit permissible prescriptions electronically (eRx) **Measure:** More than 50% of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT. **EH MENU Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx) **EH MENU Measure:** More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology | **Certification criteria:**   1. Ability to electronically transmit permissible prescriptions using CEHRT. 2. The ability to compare prescriptions to at least one drug formulary and identify generic substitutions is enabled for the entire reporting period. | Advanced medication reconciliation to check for formulary compliance.  Medication formulary checking:   * If Rx is formulary-compliant, transmit to pharmacy. * If Rx is not formulary compliant, prescriber presented with alternatives (if available through formulary database) or provided a structured prior-authorization form to complete before Rx transmitted. Capability for automatic approval of prior-auth should be available. | | How to include formulary checking into EHR and connection to formulary sources (e.g., PBMs)? | | **SGRP104** | **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. | Retire prior demographics objective because it is topped out (achieved 80% threshold).  **Certification criteria:**   * Patient preferred method of communication in compliance with privacy and security requirements (i.e., E-mail, postal mail, text, patient portal, telephone) * Occupation and industry codes * Sexual orientation, gender identity (optional fields) * Disability status and date of status * Differentiate between patient reported & medically determined   Need to continue standards work |  | | Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to. | | **PUBLIC COMMENTS:**   * Commenters suggested a number of additional data elements to require/collect: Housing status (4), organ donor status (2), school lunch status, fertility status, marital status, place of birth, veteran status, hobbies and interests (2), number of guns in the household, and a variety of end-of-life care measures. * Some commenters requested more specificity on race/ethnicity data collection, including using ACA section 4302 and >7 'Asian' and >4 'native Hawaiian/islander' categories.   **Certification criteria: Occupation and industry codes (192 comments)**   * Summary: Commenters overwhelmingly support adding these, but many expressed concern about coding and standards. * Some expressed agreement with the addition for certification criteria, but would like there to be a use case so that practices actually capture this information. * A few commenters opposed these data elements, who were not sure of how relevant or useful the data would be to care, and one association, which contended that I/O data "do not bear enough relevance to a patients’ ongoing eye care" and thus oppose inclusion * Commenters expressed some concern about the cost of maintaining I/O data, of updating EHR systems to capture it, and the complexity of system development * A few commenters requested clarification on the data standards to be used, if I/O would be two fields or one or more, and the feasibility of collecting sufficiently detailed information * A couple commenters discussed including dates and keeping a longitudinal record – and note the need to distinguish 'usual' versus current occupation   **Sexual orientation, gender identity (optional fields)**   * Summary: Most commenters agreed with inclusion, but want more specificity as to data standards, definitions (e.g., "more than two genders"), and whether/how the data will affect other parts of EHR systems. One commenter offered detailed training suggestions to address providers' discomfort with the subject (0545) * A large number supported inclusion and recommended that they be mandatory and/or included as a use case, not just certification criteria. Some opposed inclusion and expressed discomfort with or concern about the sensitivity of the subject. * A number of those opposed did not believe these data to be relevant to care * A few did not feel that these data should be demographics, because front desk staff usually collect that and this sort of 'sensitive' data should be collected by members of the care team. * EHR vendors and provider organizations expressed concern about the complexity of development for these elements, see EHRA.   **Disability status**   * Summary: There were only a few comments on this element, but they were broadly supportive. However, commenters did raise a number of concerns, particularly concerning the availability and viability of data standards, provider burden, EHR development/upgrade cost, and relevance to practice. * The American College of Occupational and Environmental Medicine (ACOEM) would prefer that we use the term "functional status" or "workability." * Some commenters felt this element should be in clinical, not demographic data, and were concerned about increasing provider burden * Some commenters expressed concern about the standard readiness, technical costs of developing this, and upgrade costs. A number suggested that ONC collaborate with NCHS/NCBDDD to determine data standards. | | | | | | | **HITSC COMMENTS:**  Disagree. Although a high level of demographic data recording has been achieved, discontinuing the requirement could diminish collection of foundational data. Sensitive data such as sexual orientation and disability status should be omitted.  No other sector would consider 80% to be optimal performance on an important quality measure, nor should healthcare.  • Agree with the retirement of the topped out measures (Original demographic measures)  • Agree with the addition of the new updated demographic measures  • Structured data will be captured and not codified data at this time  • What is the definition of Disability Status? Federal definition or patient identification, or otherwise  • Question on how sexual orientation will or can be codified  • Introduce as a general comment about Disability status being included as long as it can be captured  • Date of disability status and inclusion of functional status should be included  Note: CMS has established Healthcare CommonProcedure Code Set and modifier coding requirements for reporting functional status and degree of impairment for therapy services claims, and explicitly requires them to be documented into the medical record. Any CMS requirement for that kind of information for meaningful use Stage 3 should take that into account and leverage it at least where the two requirements overlap – not impose additional requirement. The CMS claims requirement impacts all manners of therapy services providers including hospitals and physicians | | | | | | | **SGRP105** | **Consolidated in summary of care objective** Maintain an up-to-date problem list of current and active diagnoses | **Certification criteria:** EHR systems should provide functionality to help maintain up-to-date, accurate problem list  **Certification criteria:** Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians’ maintenance of up-to-date accurate problem lists. Systems provide decision support about additions, edits, and deletions for clinicians’ review and action. For example, if diabetes is not on the problem list but hypoglycemic medications are on the medication list: the EHR system might ask the provider whether diabetes should be on the problem list. It would not automatically add anything to the problem list without professional action. | Patient input to reconciliation of problems | | The implementation of these criteria will assist in achieving the CDC’s goal of using EHR technology features to identify patients meeting criteria for hypertension who are not yet diagnosed and managed for the disorder.  How to incorporate into certification criteria for pilot testing?  The intent is that EHR vendors would provide functionality to help maintain functionality for active problem lists, not that they supply the actual knowledge for the rules. | | **PUBLIC COMMENTS:**  Overall, commenters were concerned that this item, as written, is too vague. Many commenters simply did not support it because of this (or other reasons), but even among those who supported it (or pieces of it), a good proportion also noted concerns about vagueness. A number of commenters suggested integrating this requirement with CDS, indicating that it is duplicative or redundant, and one suggested retiring this measure in favor of enhanced CDS. A few suggested integrating it with the other 'list' items (SGPR 106, 107), and one supported using it in conjunction with 405, submission to registries. Commenters were also concerned about the potential burden on providers of additional alerts or verification requirements, one requesting that the criteria require that reviewing/adding/declining-to-add items to list is a minimally invasive 'one-click' function. Specialty organizations were particularly concerned that full problem lists would fall outside their scope of practice and place undue burden upon them.  Another common thread among multiple comments was that ONC ensure full testing and vetting before requiring these functionalities. Multiple commenters noted the need for standards in various aspects of this item, including one who suggested convening a TEP to study/establish standards for patient involvement in EHR, portals, etc. Similarly, the VA commented in detail that they feel that this is too complex to be achieved by stage 3. In fact, they comment that they have thus far been unable to implement such functionality (see comment below). | | | | | | | **HITSC COMMENTS:**  Clinical Operations WG  Recommend against standardizing at this time. Best practice advisories, alternative recommendations, and alerts should qualify as helpful tools but should not be mandated. Patient input could be used e.g. to reconcile problem list but introduces new issues in data integrity and validity.  The diabetes example is based on knowledge. How would this work otherwise? In any case, this functionality is not well enough characterized to be a certification criterion.  • Our question is how incorporate into certification criteria on using computer logic related to provide assistance in determining problems not on the list based on data like lab findings or medications. For purposes of certifiying this functionality the testing scripts and data sets would have to being clinical relevant and included ‘clue data’ that would lead to additional problems. This represents advanced software logic – The point here is that you want straightforward connections between findings (interventions and diagnostics) and a ‘problem.  • Limit the certification criteria and therefore pilot testing to high importance, low ambiguity cases.  • Chronic nationwide issues are most feasible. Consider limitation to the top 10  • Nothing in making this a certification criteria that prevents vendors from adding this functionality into their system without this requirement  • The Healthcare industry as a whole may not be ready for this functionality right now  • This type of requirement will create significant challenges with the test scripts. | | | | | | | **SGRP106** | **Consolidated with summary of care -** Maintain active medication list | **Certification criteria:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list  **Certification criteria:** Use of problems and lab test results to support clinicians’ maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians’ review. For example, an antibiotic (not for acne) has been on the medication list for over say a month, the EHR system might ask the provider whether the medication is a chronic medication. The system will not make any changes without professional approval. | **Certification criteria:** Use other EHR data such as medications filled or dispensed, or free text searching for medications to support maintenance of up-to-date and accurate medication lists. | | How to incorporate into certification criteria for pilot testing?  The intent is that EHR vendors would provide functionality to help maintain functionality for active medication lists, not that they supply the actual knowledge for the rules. | | **PUBLIC COMMENTS:**  Many commenters expressed support for this additional functionality. Equally, commenters expressed concern for a variety of reasons, with the primary concerns being the vagueness of the certification criteria, the potential for alert fatigue, and additional costs and complexity for providers. Additionally, various specialty interests were expressed. A few options were given for testing and standards. | | | | | | | **HITSC COMMENTS:**  Recommend against standardizing at this time, see above response on Problem List. Integration of external data sources e.g. for fill status introduces new concerns with data validation that need to be resolved first.  • Expansions of the measures as explained in certification criteria is of concern due to physician workflow, varying vendor functionality and clear definitions of timelines and factors related to the triggering events.  • 105 and 106 should be tied together and the use can be linked together   * Link the two together so that we understand the difference between filled and dispensed - The concern expressed related to the standards/process to provide the information of a medication being filled then dispensed back to the primary care provider (EP).   • Good idea for long term, but may not be appropriate right now  • Consider testing CDS in the real world with input from actual providers and workers, before it is added as an expanded measure.  • Great for the future, but difficult to do right now  • More clarity can be added with the use cases to produce adequate testing and then the establishment of certification criteria | | | | | | | **SGRP107** | **Consolidated with summary of care -** Maintain active medication allergy list | **Certification criteria:** EHR systems should provide functionality to code medication allergies including its related drug family to code related reactions. | Contraindications that could include adverse reactions and procedural intolerance. | | The intent is that EHR vendors would provide functionality to help maintain functionality for active medication allergy lists, not that they supply the actual knowledge for the rules. | | **PUBLIC COMMENTS:**  Commenters generally supported these proposals. Commenters pointed out the need for a clear and precise certification criteria, which would enable more specific comments. Commenters also pointed out the need for standards with some recommendations given. Commenters also suggested the inclusion of other allergens and the need to differentiate allergy intolerances and adverse reactions. A few commenters were concerned about alert fatigue and costs due to this additional functionality. | | | | | | | **HITSC COMMENTS:**  See comments on SGRP 105, 106. Advisories and alerts should qualify as helpful tools but should not be mandated. Patient supplied data could be helpful but would introduce new issues with data validity, reliability, and integrity. | | | | | | | **SGRP108** | **Objective: Record and chart changes in vital signs:** • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI  **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data | Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018 |  | | Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to. | | **PUBLIC COMMENTS:**  Comments were mixed on whether to retire or not. | | | | | | | **HITSC COMMENTS:**  Agree with retiring the measure.  SUMMARY COMMENT: Retiring this measure makes sense because attestation is of limited use at this stage of MU, but measures should demonstrate the use of such data, not its collection. In general, retiring attestation measures is reasonable provided the intent is that the data is transitioning to data use.  Comments: Floyd: This objective should be a requirement for the EHR to automatically report the frequency of each item among all visits rather than a requirement for attestation. There is no certification requirement for EHRs to perform functional process utilization. While there should be such a requirement, without it the objective remains an attestation element and adds to unnecessary work on the part of providers.   * Continue blood pressure and BMI with increasing performance standard (to 95%) over 3 years. Perform evidence review regarding the age up to which growth-chart calculation is clinically important. * Agree with retiring   Discussion:   * Ideally would capture the actual values for the measure – if you wouldn’t do that then there is no reason to retain * Healthcare is the only place where 80% would be “topped out” * BP is measured in one of the MU2 measures—BMI is also covered for some patients therefore probably not needed * Only BP would be measured if this is eliminated * This measure looks at capture of data—not USE of data—need to move beyond capture to utilization | | | | | | | **SGRP109** | **EP/EH Objective:** Record smoking status for patients 13 years old or older  **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data | Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028 |  | | Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to. | | **PUBLIC COMMENTS:**  Comments were mixed on retirement. | | | | | | | **HITSC COMMENTS**  Agree with retiring the measure  SUMMARY COMMENT: Retiring this measure makes sense because attestation is of limited use at this stage of MU, but measures should demonstrate the use of such data, not its collection. In general, retiring attestation measures is reasonable provided the intent is that the data is transitioning to data use.  Comments:   * This objective should be a requirement for the EHR to automatically report the frequency of each item among all visits rather than a requirement for attestation. There is no certification requirement for EHRs to perform functional process utilization. While there should be such a requirement, without it the objective remains an attestation element and adds to unnecessary work on the part of providers. * Continue measure with increasing performance standard (to 95%) over 3 years. * Agree with retiring   Discussion: See discussion for SGRP 108 | | | | | | | **SGRP114** | **EP/EH Objective:** Incorporate clinical lab-test results into Certified EHR Technology as structured data  **Measure:** More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data | **Objective:** Incorporate clinical lab-test results into EHR as structured data **Measure:** More than 80% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data |  | |  | | **PUBLIC COMMENTS:**   * Summary statement:   + Commenters agree with the increase in threshold to 80% but want more specificity * Key Points   + Clarify if this measure is menu or core   + Many commenters raised concern regarding the higher threshold affecting EPs, specialists and CAH because of the increased interface burden they face to meet this threshold   + Suggestion to evaluate experience in meeting 55% threshold in Stage 2 before increasing threshold to 80%   + Consider exclusion criteria at this threshold | | | | | | | **HITSC COMMENTS**  Clinical Ops WG: Increased threshold should be workable with existing standards. | | | | | | | **SGRP115** | **EP CORE Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach **EP CORE Measure:** Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition. | **EP Objective:** Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports. Dashboards are incorporated into the EHR’s clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report. |  | |  | | **PUBLIC COMMENTS:**  Generate lists of patients for multiple specific conditions   * Summary statement: Most commenters agreed with the intent of this measure * Key Points   + Many commenters requested specificity on the number of lists to meet MU criteria   + Additional comments received on what the lists should include and when they should be used   Present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports.   * Summary statement: Most commenters agreed that the language in this part of the measure was not specified well-enough to offer recommendation on inclusion or exclusion * Key Points   + Numerous comments were received requesting definition of terms used in the objective   + Commenters suggested MU Stage 2 data is evaluated prior to increasing threshold   + Exemption criteria should be defined   Dashboards are incorporated into the EHR’s clinical workflow for the care coordinator or the provider.   * Summary statement: Commenters were divided on whether this should be included in the measure * Key Points   + Commenters requested more specificity in the types of information presented on the dashboard and where it fits into clinical workflow   + Question raised over how this would be measurable as proposed   + Additional details on the intent of this objective would be helpful in assessing its feasibility.   It is actionable and not a retrospective report.   * Summary statement: Commenters were evenly divided on whether this should be included in the measure * Key Points   + Definition of actionable needs specificity   + Cannot describe data as ‘not retrospective’ as lists and dashboard may be built on data from that day and previously | | | | | | | **HITSC COMMENTS:**  Need to specifically define near-real-time, and “actionable” to assist standards selection.  As a form of presentation layer, dashboards are fundamentally limited—to a static set of just a few elements. Dashboards should not be specified in certification or elsewhere.  Apt EP Objective: Present to EPs (and other clinicians) usable, actionable patient-specific information in time to improve care processes. | | | | | | | **PUBLIC COMMENTS:**   * Summary statement: Commenters disagreed with the move to core and the change in wording * Key Points   + Agree with the intent to capture family history data, but not details   + Too many changes – menu to core and changing what is being captured   + Many commenters suggested evaluating experience from MU Stage 2 first before making changes to move to core or to threshold   + The change in wording caused many comments and confusion     - The term “high priority” needs clarification   + Many commenters wondered if it would still be structured data?   + If move to core, then need to develop exclusion criteria | | | | | | | **HITSC COMMENTS:**  Retain as menu set (offset to recommendation to retain demographics, etc.) and need to define “high priority data” based on an explicit value case analysis.  It is critically important that the family history required is evidence-based, in the sense that it is validated in a clinical trial as informing improved patient care. Whether or not each datum involves a first-degree relative is irrelevant to this. | | | | | | | **SGRP 130** | **New** | **Objective:** Use computerized provider order entry for referrals/transition of care orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.  **Measure:** More than 20% of referrals/transition of care orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded. | |  |  | | **Public Comment**   * General support for this proposal * Many expressed confusion as to whether this proposal simply required the recording of the referrals/transition of care orders created by the EP or whether it actually required the electronic transmission of these orders.   + For actual electronic transmission, concerned about the lack of interoperability and standards, including the ability of post-acute care facilities to receive the orders   + Define recorded | | | | | | | **HITSC Comment**  Unclear how referral order workflow would work. Would an order initiate an X12 administrative referral/auth transaction, send a clinical message to the next provider of care, and initiate a closed loop referral management process etc? | | | | | | | **SGRP204B** | **New** | **MENU:** Provide the ability to electronically submit patient-generated health information through structured or semi-structured questionnaires for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period. | |  | Readiness of standards to include medical device data from the home?  What information would providers consider most valuable to receive electronically from patients?  What information do patients think is most important to share electronically with providers? How can the HITECH incentive program support allowing doctors and patients to mutually agree on patient-generated data flows that meet their needs, and should the functionality to collect those data be part of EHR certification? Please provide published evidence or organizational experience to support suggestions. | | **PUBLIC COMMENTS:**   * Summary statement: Most commenters supported this measure, but needed clarification on the definition of high priority health conditions and how the EP and EH are to measure this. Concerns were also presented about providers being accountable for patient actions and burdening providers with too much information. Commenters also voiced concerns about the availability of standards to differentiate between provider and patient data. There was a wide disparity in comments related to the timing of this measure, some wanted it pushed to core, others thought menu was appropriate, and still others thought it should be pushed out to a future stage. * Key Points   + 36 of the 47 comments received directly supported this measure with 11 comments directly not supporting this measure.   + Commenters requested clarification regarding whether this was both an EP and EH measure.   + Commenters asked for a definition of high priority health conditions.   + Some commenters were split as to the threshold some felt it was too high, while others thought it was not high enough.   + Commenters requested direction on how they were supposed to measure this recommendation.   + Commenters were very concerned with providers being accountable for patient actions.   + A number of commenters were concerned that with having standards available to differentiate between provider and patient entered data.   + Commenters were concerned with the burdening providers with too much information which could become a legal issue.   + There was a wide disparity in comments related to the timing of this measure, some wanted it pushed to core, others thought menu was appropriate, and still others thought it should be pushed out to a future stage.   + 21 comments about medical device data and 18 of those did not feel that standards were ready to include medical device data. | | | | | | | **HITSC COMMENTS:**  Multiple issues.  1. Applicable device messaging standards must mature further before being mandated.  2. Device ID is needed first, before including device data standards in MU. Defer home device data until after FDA UDI final rule and align MU dates with UDI implementation for Class III devices.  3. Processes and policies for incorporation of external device data is needed and not sufficiently mature.  Need to define “high priority health conditions” ( e.g. cancer, diabetes, heart disease ?) in order to define relevant standards. Standards and policies are immature and this should be a multiyear work plan item for HITSC.  This is too immature and fluid for specification. Evidence of the usefulness of the information must be factored in with patient and clinician preferences. | | | | | | | **SGRP205** | **EP Objective:** Provide clinical summaries for patients for each office visit  **EP Measure:** Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits. | The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.  **EP Objective:** An office-visit summary is provided to a patient with relevant and actionable information and instructions pertaining to the visit in the format requested by the patient (e.g., available online, via email, print out of summary, etc), if the provider has the technical capability  EP Measure: An office visit summary is provided to a patient or patient-authorized representative within 1 business day for more than 50 percent of office visits.  **Certification criteria:** Intent is to make sure the EHR can dynamically draw from the range of existing specified list of elements and enable providers to include and exclude elements based upon patient needs. **Monitor stage 2 implementation experience.** | |  | What specific information should be included in the after visit summary to facilitate the goal of patients having concise and clear access to information about their most recent health and care, and understand what they can do next, as well as when to call the doctor if certain symptoms/events arise? | | **PUBLIC COMMENTS:**   * Summary statement: Commenters were supportive of evaluating this measure to ensure that the clinical summary is pertinent to the office visit. Many commenters provided lists of items that should be included which the workgroup can dive into, but one common theme was to provide patients with information that facilitates the goal of patients having concise and clear access to information about their most recent health and care, and understand what they can/should do next. Commenters were concerned about the current format of many vendor summaries, these concerns included: summaries being too long, not in plain language, and language limitations. Quite a few commenters were confused as to what the HITPC was actually asking and wanted clarification on what “pertinent to the office visit actually meant”.   In reference to the question posted regarding what specific information should be included in the after visit summary include changes in the treatment regimen, medications, BMI (weight), immunizations, reason for visit and findings, assessments, goals, outcomes, when to call the provider, future appointments and wellness reminders. | | | | | | | **HITSC COMMENTS:**  To identify standards please clarify that clinical summary content should include only specific pertinent visit information – i.e. what was done, what patient needs to do, any tests to be done by specified dates, patient instructions related to goals and follow up care. Also need to ensure this is not duplicative of care plan requirements, progress note requirements, etc.  S: patient-reported signs and symptoms (including those prompting the visit)  O: clinician observations (including test results  A: clinician’s assessment of the patient’s clinical situation  P: the care plan negotiated by the patient and clinician (short-term and long-term) | | | | | | | **SGRP206** | **EP/EH Objective:** Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient **EP CORE Measure:** Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period **EH CORE Measure:** More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology | **Objective:** Provide patient specific educational materials identified by CEHRT 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 educational material to one patient in the patient’s preferred non-English language identified by CEHRT and in the patient’s preferred format (e.g. online, print out),  **Certification criteria:** 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). | |  |  | | **PUBLIC COMMENTS:**   * Summary statement: There are several key themes regarding this recommendation. Many comments referenced that this recommendation needs to be reworded to reference the top 5 non-English languages in the EP/EH/CAP’s local population not the top 5 nationally. There are areas within the nation that the top 5 non-English languages are not in the top 5 national non-English languages. Many healthcare and provider organizations have voiced a concern regarding a financial burden as well as how they would measure this recommendation. Suggestions were provided for improvement and clarification of this recommendation. There were several suggestions that pertained to the fact that many non-English speaking patients may not be able to read the materials or the materials may be printed at too high of a reading level. Another suggestion was the importance of adding visual/pictorial materials as well as Braille. There were three comments which supported this recommendation and suggested increasing the threshold. The majority of the other comments that supported this recommendation suggested changing the non-English language from the top 5 national to the top 5 local. | | | | | | | **HITSC COMMENTS:**  95% of patients are offered to usable, useful electronic messaging. (The percent of users varies in research, depending on the patient’s perceived need and access to electronic communications.) | | | | | | | **SGRP207** | **EP Objective:** Use secure electronic messaging to communicate with patients on relevant health information   **EP Measure:** A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period | **EP Objective:** Use secure electronic messaging to communicate with patients on relevant health information  **EP 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) | | Create capacity for electronic episodes of care (telemetry devices, etc) and to do e-referrals and e-consults | \*What would be an appropriate increase in threshold based upon evidence and experience? | | **PUBLIC COMMENTS:**   * Summary statement: The majority of the comments for this recommendation were to not increase the threshold. The greatest rational was not knowing the success of Meaningful Use Stage 2. The commenters suggested research to identify the actual percentage from stage 2 and then identify a threshold. There was also clarification requests and suggestions made to include family members, caregivers, healthcare agents as well as include staff from the EP’s practice in the measure. Of the comments that supported this measure many also recommended including family, and caregivers in the measure. Only 7 recommended an increase in the threshold (2 -50%, 3 – 30%, 3 – 20%). Comments that did not identify support or not support and those that clearly did not support the measure identified concerns about the providers being held accountable for the actions of patients. A couple of responses suggested a bidirectional assessment with measuring the timing of the EP’s response to the patient, family or caregiver. | | | | | | | **HITSC COMMENTS:**  We recognize that this measure is intended to motivate EPs to encourage their patients to use secure electronic messaging. But we have no evidence or experience that might inform what an appropriate increase in threshold might be.   * Providers using patient portals are nowhere near 10% threshold * We do not think the threshold should be increased above 10%. Definitely an ambitious goal to keep in mind * Current threshold is 5 and recommend leaving the threshold at 5%. | | | | | | | | | | |
| **SGRP204D** | **New** | **Objective: Provide patients with an easy way to request an amendment to their record online (e.g., offer corrections, additions, or updates to the record)** |  |  |
| * The majority of commentors support this item, multiple without challenge but most seeking clarification * Multiple commentors disagreed with the measure and suggested removal altogether due to lack of clarity and perceived redundancy of existing functionality * Multiple commentors suggested defining “in an obvious manner” and documentation requirements * Multiple questions on whether or not the provider must accept all amendments * Many seeking clarification of what parts of the record could have amendments submitted   + Address the differences between requests for changes to clinical data vs. administrative data and potential safety impact on amended data   + In the event that a patient’s amendment is not accepted, suggest patients be given an explanation as to why   + Record should display what is patient versus provider data * Multiple commentors sought clarification that this measure is in line with current HIPAA standards and not in addition to it * Many sought clarification on what the measure and subsequent threshold would be   + Would the provider be required to notify other providers of record amendments? * Many commentors raised concern that this threshold is duplicative of the ability to send direct messages. Some believe can be accomplished currently through patient portal. * Some concerns raised on the functionality of EHRs to meet this and need for this measure to be incorporated into EHR certification standards | | | | |
| **SGRP208** | **Not included separately (in reminder objective)** | **Certification criteria:** HITSC to identify what the communication preferences options should be for the clinical summary, reminders, patient educational material objectives. Providers should have the option to select options that are technically feasible for them, these could include: Email, regular mail, text, patient portal, telephone. |  |  |
| **PUBLIC COMMENTS:**   * The vast majority of commenters support this requirement to document communication preferences and agree that it is a necessary requirement in order to ensure people receive information in a medium that engages them. However, many commenters urged constraint around the menu of communication types to avoid workflow challenges and suggested that certification criteria be developed to specify the menu of options for “preferences” and “purposes”. | | | | |
| **HITSC COMMENTS:**  Increasing to 95%. Include updating annually. | | | | |
| **SGRP209** | **New** | **Certification Criteria:** Capability for EHR to query clinicaltrial.gov for research enrollment systems to identify available clinical trials. No use requirements until future stages.  Not doing eligibility checking, but identification of options.  Not sure how to connect to clinicaltrials.gov, query the EHR for patients that may qualify  Structured data capture initiative, remote form with eligibility criteria that could be prepopulated with data in the EHR, see if those patients exist. See if the EHR data has patients that match a trial.  Define criteria better. A way to query EHRs to see if patients match clinicaltrials that are listed in . need matching capability, set of eligibility criteria, see if protocols in clinicaltrials.gov, patients in the EHR that match the protocol. Capability to query EHRs for a subset of patients who could qualify for a clinical trial. Don’t limit to clinicaltrials.gov. base set of 10-20 that would get a subset to look at further. Eligibility criteria – the first cut, age, gender, disorder, then dive deeper to see if the patients actually exist. Could do the first cut will eligibility criteria. City of Hope in LA has done this. Potentially eligible patients, don’t need to find the exact match, could do through the structure data capture initiative – bounce a form against it and identify those that match the eligibility criteria |  | The goal of this objective is to facilitate identification of patients who might be eligible for a clinical trial, if they are interested.  The EHR would query available clinical trial registries and identify potentially relevant trials based on patient’s health condition, location, and other basic facts. Ultimately, the EHR would not be able to determine final eligibility for the trial; it would only be able to identify possibly relevant trial opportunities. |
| **PUBLIC COMMENTS:**   * Commenters see the value in the EHR being able to query clinical trials database and the intent of this criteria to improve enrollment in trials. However, they expressed a number of concerns regarding the feasibility of including this criteria in Stage 3 citing implementation challenges, including the complex functionality that would be required to query multiple sources and to match up fields; the lack of specification about what fields to query; current lack of standards or a defined use case; workflow challenges; a lack of broad applicability to practitioners (more relevant to specialists) and patients (only a small minority are eligible for the trials); ethical concerns about providers recommending patients for certain studies. Consensus emerged for further study before including this in certification criteria. Some potential intermediary recommendations were to conduct an S&I Initiative to explore this further; to require the EHR to point to one, centralized data source like clinicaltrials.gov rather than to query several databases. Concern that there would need to be interfaces on both ends and that the disease registries may not be able to comply with the requirement. Some discussion about who should have access to this information—some suggested opening it up to researchers or allowing patients to also query. | | | | |
| **Improve Care Coordination** | | | | |
| **SGRP302** | **EP/EH CORE Objective:** The EP/EH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. **EP/EH CORE Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) | **EP / EH / CAH Objective:** The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform reconciliation for:  - medications  **EP / EH / CAH Measure:** The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23).  **Certification Criteria:** Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e. severity). | Reconciliation of contraindications (any medical reason for not performing a particular therapy; any condition, clinical symptom, or circumstance indicating that the use of an otherwise advisable intervention in some particular line of treatment is improper, undesirable, or inappropriate)  **Standards work is necessary to address these gaps:**   * **There is no defined standard “domain” model for allergy/intolerance/condition/problem or any practice model that supports a distinction.  While folks can articulate differences, there are complex relationships.**   **There are no well defined universal codes or use of them. The codes in stage 2 like RxNorm and SNOMED are not widely used and not appropriately tailored and in practice, often conflict with codes used for other work / documentation.** | Feasibility to add additional fields for reconciliation e.g. social history? Is anyone currently doing reconciliation outside of meds, med allergies, and problems and what has the experience been? |
| **PUBLIC COMMENTS:**  Overall, commenters were supportive of this measure. There were concerns about the ability to measure outcomes, differences of opinion on the percentage needed to obtain the objective, and requests for clarification.   * Summary statement: Many commenters recommended increasing the percentage of the measures.   + Key Points     - Medication:       * Increase the percentage of meds reconciled to 80%; patient safety needs demand that we get med rec right by Stage 3.       * Medication reconciliation should be performed for 100% of transitions of care in both the acute and ambulatory setting.       * We strongly support the increase in the threshold for medication reconciliation to 50 percent in Stage 3.     - Med Allergy:       * Recommend increasing all-allergy/adverse reaction/intolerance recon to 50%. Patient safety also drives allergy recon for ALL allergies, not just med allergies.       * Increase the EP/EH/CAH measure criterion for reconciliation of med allergies, and problems to at least 30% of care transitions, as 10% is too low a bar.     - Problem: Recommend same 50% target for problem reconciliation - Quality and safety driver: every provider has to know at least ALL the active med problems each patient has. * Summary Statement: Some commenters recommended increasing the number of categories for reconciliation.   + Key Points:     - Add the following high-value categories for reconciliation: Caregiver name, contact information, and role; Medications being taken, including over-the-counter medications and supplements; Problems/complaints; Advanced directive status and content; Sources of treatment (i.e. primary care, specialists, ER, retail clinics, etc.).     - Adding caregiver names and numbers is a critical field not yet included.     - The required data elements should include advance care wishes, demographics including next-of-kin/caregiver, medications, allergies, problem list, and summary of events from current care facility. * Summary: Some commenters recommended *not* adding additional fields for reconciliation:   + Key Points:     - We agree that providers should be reconciling medications, allergies and problems. However; each individual reconciliation requires additional “clicks” for providers and should be limited to those items that are critical. Too much reduces the value of the reconciliation. * Summary: Several commenters urged the HITPC to clarify the meaning of “reconciliation” and “transition of care.”   + Key Points:     - Define reconciliation of “problems” – that is less specific than medications/allergies. If the patient has a long “problem list” of active, inactive, chronic/acute, relevant/irrelevant to current situation – do we want EPs/EHs held responsible for reconciling all of this     - We would like to see some additional clarity about how a ‘transition of care’ is defined. Also some more specificity about what is needed for a ‘reconciliation’ would be helpful.     - Must fully define transitions of care. Need to be sure to allow for any provider within their scope of practice. Pharmacists need to be included. Support problems being added but do not support social history as a base requirement.     - The HITPC should clarify the definition of the term “encounter” in the recommended objective. * Summary: Some commenters urged the HITPC to include patients in this measure.   + Key Points:     - Opportunities to engage patients and caregivers in information reconciliation include: Medications actually taken (including over-the-counter drugs and herbal supplements); Caregiver name, contact information, and role; Problems/complaints; Advance directive status and content; Additional care team members (primary care, specialists, ER, retail clinics, etc.) * Summary: Some commenters noted the difficulty in measuring this objective.   + Key Points:     - How will this be measured?     - We have heard industry debate on how reconciliation is measured. For example, if updates are made to the problem list when the patient is admitted, does that indicate it is reconciled? Or is it necessary for a clinician to make some special designation that reconciliation has happened? We have questions on the measurement of reconciliation. For example, if updates are made to the problem list when the patient is admitted, does that indicate it is reconciled? Or is it necessary for a clinician to make some special designation that reconciliation has happened? This will need to be clarified in the final definition. * Summary: Some commenters noted that this measure should be removed as a draft certification criterion until it can be further developed.   + Key Points:     - The responsibility should be limited to EPs, who have access to the most complete information.     - Decisions pertaining to the relevance of subjective information should be left to the physician based on that engagement that both parties need to ensure high quality patient care     - We maintain that providers should have discretion to decide when such reconciliations should be performed. The objective should support good clinical judgment, and not impose a “button click” just to satisfy a measure threshold.     - This seems premature – we need to establish workable standards for representing all these things – so far, we do medications somewhat well and maybe problem lists; these others are all terra incognita.     - Although pharmacists are capturing this information, they need electronic bidirectional exchange with EPs, EHs, CAHs, and other providers to share and resolve problems related to patients’ medications, particularly at the transition of care level, which is not included in this objective. Transition of care involves more than EPs and eligible hospitals. Pharmacists are involved in the transition of care and medication reconciliation.     - We oppose any changes to these criteria until data on provider experiences from prior stages of meaningful use are available, analyzed, and demonstrate that providers are ready for such changes.     - In addition, the HITPC should address whether providers other than physicians (RNs, pharmacists, etc.) will be permitted to perform reconciliation for Medication Allergies and Problem Lists.     - We are concerned about the workflow needed to support problem reconciliation. The collective experience from medication reconciliation from the past 10 years is that this is a multi-disciplinary challenge that is tackled partly by technology and partly by workflow redesign. We do not believe the workflow redesign needed to support effective problem reconciliation has begun in earnest around the country. | | | | |
| **HITSC COMMENTS:**  Defer this item. Allergy and problem reconciliation is immature and should be further developed, with a value case. More work needs to be done to define medication allergies and problems in relation to reconciliation as well as the vocabulary for contraindications for certain medication therapies, allergy severity, etc. | | | | |
| **SGRP303** | **EP/EH CORE Objective:** The EP/EH/CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides summary care record for each transition of care or referral.  **CORE Measure:** 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. 2. The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. 3. An EP, eligible hospital or CAH must satisfy one of the two following criteria:  (A) conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii) (B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was developed by a different EHR technology developer than the sender’s EHR technology certified to 45 CFR 170.314(b)(2); or  (B) conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period. | **EP/ EH / CAH Objective:** EP/EH/CAH who transitions their patient to another setting of care or requests a consultation from another provider of care  Provide a summary of care record for each transition that must include the following:   1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral) 2. Contact information for care team members, including primary care provider and caregiver name, role and contact info, placeholder for advancing care planning in the future (free text is permissible) 3. Indication of whether there is a designated family caregiver who is playing a significant role in the patient’s care (Yes/No)   For transfers of care and the others as clinically relevant:  4. Overarching patient goals and/ or problem specific goals (free text is permissible)  5. Patient Instructions and / or orders for care during transition and / or for 48 hours afterwards (free text is permissible)  **Measure:** The EP, eligible hospital, or CAH that site transitions their patient to another setting of care (including home) or requests a consult from a provider in another setting of care, provides a summary of care record for 50% of transitions of care and/or referrals and at least 10%\* electronically.  **Types of transitions:**   * **Consult note (e.g. ER note, consult note)** * **Consult request (e.g., PCP to consulting physician, PC to ED)** * **Transfers of care (e.g., hospital to PCP, transition from one site of care to another, PCP to a new PCP, major transition)**   **Certification Criteria #1:** EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral.  **Certification criteria #2:** Ability to automatically populate a referral 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 |  | \*What would be an appropriate increase in the electronic threshold based upon evidence and experience? |
| **PUBLIC COMMENTS (119):**  **Measure Summary:** Strong support for the intent, but commenters expressed concern regarding the burden imposed by the objective, the lack of existing standards, and the lack of experience from Stage 2 MU.  **Key Points:**   * Clarification requested on definition of DECAF. Several commenters noted DECAF is not appropriate for all transitions and lack of widespread use. * Clarification requested on details of the four required elements ( e.g., what is meant by setting specific goals, instructions?) * Commenters expressed concern over the prescriptive nature of the four required items (for transitions) and suggested careful consideration about the reality and relevance of these items particularly in the ambulatory space. * Commenters noted the potential administrative and cost burden of this measure on the transferring provider; commenters overwhelmingly suggested the burden should be placed on the EHR and data should be reused from other sources such as clinical summaries, care plans, or progress notes. * Some commenters requested adding information such as family health history, psycho-social information, functional status /ADLs, or independent living services and supports. * **Threshold**   + Concern that the threshold should be lowered; noting that a 30% electronic threshold requirement may influence referral patterns (e.g., referral to providers using same the EHR software).   + Several supported a threshold of at least 80 percent of patients have summary of care records, with no less than 65 percent transmitted electronically. * Concerns about the lack of CEHRT in settings outside of the incentive program (e.g. nursing homes). * **Narrative certification criteria #1**   + Need to clarify the phrase, "that allows the provider to prioritize clinically relevant information". Recommendations included: Focus on the need for additional clarity on the question being asked of a provider, like "suspect gastric ulcer, please perform EGD”. * **Auto populate certification criteria #2**   + Strong support.   + Commenters supportive of the ability to make referrals directly to the quit line and receive feedback reports from quit lines about services delivered and patient progress. * Request to revise terminology to include: “referrals to quit lines and other community cessation resources.” There is limited funding for state quit lines (there may be insufficient capacity to serve all providers who wish to refer patients to their state-funded quit line). * **Certification criteria #3** * Support forS&I Longitudinal Coordination of Care WG noted; however, commenters expressed concern regarding readiness of standard for MU3 and experience with standard implementation. | | | | |
| **HITSC COMMENTS:**   * The increase in functional requirements in Stage 3 are themselves a challenge requiring changes in workflow and perhaps job definitions for clinical personnel. It will be a substantial achievement to implement the new functionality at the 50% level already required for Stage 2. Also upping the measure to 65% may be perceived as an unnecessary addition to the workload for Stage 3. Likewise, the proposed stage 3 rule eliminates the option of satisfying the requirement for electronic transmission by testing with CMS-designated test sites. This is a substantial challenge for many EPs or hospitals. Upping the measure from 10% to 30% significantly compounds the difficulty in implementation and risk that an EP or hospital fails to meet MU measures due to difficulty working with organizations not directly impacted by MU requirements. * More information available when a patient is transferred is better (100% should be the goal) * Suggestion: that requirement is that data is sent, and the receipt is not factored/calculated in the same way * When an EH or EP places a record in a centralized repository, is the percentage calculated based on successfully placing the record in the repository, or whether it is accessed by the EH or EP it was intended for (or another EH or EP)?   Transitions for which this is appropriate should be rationalized, and a threshold should depend on new classification and definitions of transitions. Need to ensure the definition of numerator and denominator for transitions allows for shared patient records and shared case management tools shared by all care team members (e.g. multiple specialties and primary care), not only for fragmented physician record scenarios that may require transmission of data. | | | | |
| **SGRP304** | **New** |  | **EP/ EH / CAH Objective:** EP/ EH/CAH who transitions their patient to another site of care or refers their patient to another provider of care  For each transition of site of care, provide the care plan information, including the following elements as applicable:  •Medical diagnoses and stages  •Functional status, including ADLs  •Relevant social and financial information (free text)  •Relevant environmental factors impacting patient’s health (free text)  •Most likely course of illness or condition, in broad terms (free text)  •Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver  •The patient’s long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals  •Specific advance care plan (Physician Orders for Life-Sustaining Treatment (POLST)) and the care setting in which it was executed.  For each referral, provide a care plan if one exists  **Measure:** The EP, eligible hospital, or CAH that transitions or refers their patient to another site of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver.  **Certification Criteria:** Develop standards for a shared care plan, as being defined by S&I Longitudinal Coordination of Care WG. Some of the data elements in the shared care plan overlap content represented in the CDA. Adopt standards for the structured recording of other data elements, such as patient goals and related interventions. | How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care, and includes the patient and their non-professional caregivers? Interested in experience to date and the lessons learned.  Think through these priority use cases:   1. Patient going home from an acute care hospital admission 2. Patient in nursing home going to ED for emergency assessment and returning to nursing home 3. Patient seeing multiple ambulatory specialists needing care coordination with primary care 4. Patient going home from either hospital and / or nursing some and receiving home health services   What are the most essential data elements to ensuring safe, effective care transitions and ongoing care management? How might sharing key data elements actually improve the communication? Consider health concerns, patient goals, expected outcomes, interventions, including advance orders, and care team members. What data strategy and terminology are required such that the data populated by venue specific EHRs can be exchanged. How might existing terminologies be reconciled?  What are the requirements (legal, workflow, other considerations) for patients and their identified team to participate in a shared care plan? Is it useful to consider role-based access as a technical method of implementing who will have access to and be able to contribute to the care plan? How will such access be managed? |
| **PUBLIC COMMENTS (89):**   * Generally commenters noted the objective is broad as written, suggested a focused, defined approach and the need to define terms clearly * Some concerns regarding over specification, lack of standards, lack of experience and burden on providers * Several commenters recommended soliciting more feedback on this objective possibly through a HITPC working group sessions or other format * Several commenters recommended combining SGRP 303 and 304 * **Key points:**   + Agreement that structured data should be used in place of free text, to the extent possible.   + The minimum dataset which is determined should be codified using one of the existing meaningful use standards.   + Concern regarding over-specification, lack of existing standards, and burden on provider (Too prescriptive, labor intense for referring, transferring provider).   + Standards specifically designed for care planning are not widely adopted, thus no “real world” experience exists. Recommendation to move forward carefully due to lack of information available.   + Need for interoperable care plans to provide a roadmap for achieving the best possible outcomes, as defined by both clinical and individual patient goals. * **Question 1:** How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care, and includes the patient and their non-professional caregivers? Interested in experience to date and the lessons learned.   + Varying care plan concepts recommended, such as universal care record across multiple platforms (cloud based, PCMH based or a Gantt chart that captures prioritized problems (as they shift over time), functional status, goal attainment, collaborative decisions and milestones over time, color-coded by care setting, with details in "hover-overs" and links to documentation in the EHR.   + Additional use case suggestions includes: Discharge or admission to other long term post acute setting such as long term acute care, acute inpatient rehabilitation, nursing facility after an acute care episode   + Experience of Health Share of Oregon, demonstrates that population health tools face significant adoption challenges such as confusion related to Dual-documentation (EHR vs community-wide) and challenges with multiple log-ins and workflows. * **Question 2 -** What are the most essential data elements to ensuring safe, effective care transitions and ongoing care management? How might sharing key data elements actually improve the communication?   + Commentors recommended structured data instead of free text for social and financial information, environmental factors, and functional status. Text fields are not easily searchable and cannot be easily monitored and tracked to evaluate progress and improvement.   + Commenters recommended including medications, specifying name, dose, route of administration, and frequency; and treatments/orders.   + Recommendation for including problems, goals, treatment modality, assigned provider for each modality, frequency of treatment, target completion dates, and actual completion dates, as these are instrumental in ensuring that the care for patients with multiple providers is integrated. * **Question3 -** What are the requirements (legal, workflow, other considerations) for patients and their identified team to participate in a shared care plan? Is it useful to consider role-based access as a technical method of implementing who will have access to and be able to contribute to the care plan? How will such access be managed? * Support for role-based access, but commenter noted the need to specify level of access to protect HIPPA-protected or 42 CFR data. | | | | |
| **HITSC COMMENTS:**  Goals for the clinical documents should be more specifically defined, additional data collection by caregivers should be justified, and existing data should be reused to the extent possible. To encourage team based care unnecessary and burdensome data transmission should be avoided and shared information tools or shared document solutions should be enabled and developed.  Today the most essential information elements are problems, medications, allergies, and current labs. Other items are immature.  Standards development is necessary to ensure consistent and reliable capture of data elements for care transitions. S&I framework should be involved in recommendations on care transitions. Parsimony is a critical consideration.  Longitudinal care plan should be fundamentally different from short term or simple care plans and would be expected to span time, discipline, and care team member which adds to the challenge of collecting and coordinating such data. This data clearly exists in some space between the hospital and EP care—all members of the team should be involved in creation of the care plan. It may not be reasonable at this time to expect SNF/outpatient care facilities to achieve this level of coordination but there should be action toward that aim.  For the first stage, a simple list of essential elements is reasonable:  1. Patient goals identified for > 50% of health concerns identified in the transition summary  2. Expected outcomes identified for > 50% of interventions identified in the transition summary  3. Advance orders (or recommended orders) with identification of the related health concern for > 50% of such advance orders  Metadata might be used to record the responsibilities and roles of the individual team members, but at this time it is not a reasonable request of the electronic record. Care team members might object to the inclusion of this level of responsibility electronically but it is clinically and quality-wise extremely important.  Comments:   * In the absence of a standard definition for care plan and management of health concerns, this element is too expansive. It might be more reasonable to identify essential functions that the EHR should accomplish (certification) and that should occur in clinical practice using the EHR (by measuring elements on transition of care documents if they can be structured) for:  1. Patient goals identified for > 50% of health concerns identified in the transition summary 2. Expected outcomes identified for > 50% of interventions identified in the transition summary 3. Advance orders (or recommended orders) with identification of the related health concern for > 50% of such advance orders  * Stages should be part of diagnoses (e.g., “CKD Stage 3”) Would need validated terms for patient preferences and goals. Parsimony needed—e.g, ADLs (and IADLs) may belong in accessible database, not this data set, patient goals should be limited to high-level (e.g., “for cure”, “for prevention of complications,” “for symptom control.” Scan for standard terms for psychosocial support. EPs should know and document key care-team members, e.g., PCP, care manager, consultants, but could not know many of the team. * Measure: What percent of the specified data must be provided 10% of the time? 80%? * Strongly encourages ONC to include provision of care plan information as part of its criteria for meaningful use Stage 3, rather than delaying implementation of such a requirement. By the time Stage 3 requirements begin to be implemented, it will be 2016 – the last year that eligible professionals may begin participating in the Medicaid EHR Incentive Program. As technology continues its rapid evolution and as providers search for even more ways to achieve greater efficiencies in order to counter ongoing fiscal challenges. There will be an increase in the use of software solutions like those offered by LTPAC IT companies. With so many factors driving LTPAC providers toward greater IT adoption, there should not be any lag in LTPAC HIT-readiness to dissipate by 2016, which it is urged that ONC to include LTPAC in several of the Stage 3 meaningful use criteria. * In the Request for Comment notice, respondents are asked “to think through these priority cases,” and yet the most common patient discharge case requiring provider follow up – the case of a patient who is discharged from a hospital to a nursing facility, home care agency or other LTPAC setting after an acute care episode – is not listed among the so-called “priority cases.” To correct for that oversight it is recommended changing this objective to include transfer to or from the LTPAC setting among the priority cases. * NASL also recommends that the SGRP 304 measure for Stage 3 be similarly amended to read, “The EP, EH or CAH that site transitions or refers patients to, or receives from an LTPAC setting or provider of care provides the electronic care plan information for 30% of transitions of care to receiving provider and patient/caregiver.” * In addition, it is recommended that the standards for a shared care plan should follow the S&I Longitudinal Coordination of Care Framework. S&I Framework’s Transitions of Care Workgroup agrees that functional status and cognition, along with skin issues, are key determinants of safe and efficient care transitions. * There is value in shared care planning and collaboration and direct ONC’s attention to the existing standardized assessment tools, which offer evidence of this value. As stated above, functional and cognitive status are essential elements of the patient’s care record and are captured in the Continuity Assessment Record and Evaluation (CARE) tool. Given the variety of standard assessment tools already used by LTPAC. LTPAC Associations like the National Support of Long Term Care ( NASL) believe that ONC should explore how to leverage LTPAC expertise in providing longitudinal care to promote shared care planning and greater collaboration across care settings and providers. NASL would welcome the opportunity to discuss how we might assist ONC in this capacity.   Discussion:   * Important to determine validated terms for functional status and ADLs. Certainly should attempt to record the care team members but this is very challenging in that the care team is dynamic and might be difficult to capture without disturbing workflow. * Care transitions and goal are not well defined in practice. See above for hypothesized goals. * There is not really good guidance for how to use the data even when it’s captured. Floyd’s examples above are very reasonable. * Need the care plan and should reference what the long term care plan committee has identified as critically important. It is necessary to reference the S&I framework when responding to this question. Unclear how data is or would be transmitted back to the hospital. * All of the comments find consensus that there needs to be greater identification of elements. * Using the term care plan can be interpreted differently by different care team members. Care plan coordination must include clear roles for each member and it is unclear whether that can be done at this stage in any consistent or meaningful way. The S&I framework might address this moving forward. Ultimately the care plan would include the responsibilities and roles of care team members. * Might be asked to implement the care plan after the hospital discharge—might be inappropriate to allow hospital to determine long term care plan because they might not have the same level of knowledge of the patient’s long term care situation. * Working towards MU3 voluntary care plan measures—in the QMWG they have been looking at criteria that could be examined in the long term care setting. | | | | |
| **SGRP305** | **New** | **EP Objective:** EP/EH/CAH to whom a patient is referred provides referral results to the requesting provider, thereby beginning to close the loop.  **Measure:** For patients referred during an EHR reporting period, referral results generated from the EHR, 50% are returned to the requestor and 10% of those are returned electronically\*  **Certification Criteria:** Include data set defined by S&I Longitudinal Coordination of Care WG and expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Shared Care Encounter Summary (Consultation Summary, Return from the ED to the referring facility, Office Visit)  **Certification Criteria**: Include standards for referral requests that require authorizations (or pre-certifications) for procedure, surgery, lab, radiology, test orders  \*This builds upon the clinical quality measure (CQM) in stage 2 for closing the referral loop,CMS50v1 (NQF TBD) | Continue working to close the loop with an acknowledgement of order receipt and tracking for completion. | The HITPC would appreciate comments on the return of test results to the referring provider. |
| **PUBLIC COMMENTS:**   * 93 comments * Be clearer in defining referrals, especially what that means for EHs. * How does a hospital determine whether a patient was referred? This measure is very problematic for EHs, perhaps an EP only measure? * Consultations should be excluded from the measure. * Means of identifying/counting “referrals” should not add a counting burden * Threshold recommendations to both increase and decrease. Recommendations between 30% -80% for referrals and 5->10 electronically. Some also suggested adding timing (e.g. within 3 business days) * The measure language needs refinement as it is currently confusing as to what is to be completed and then measured. * What does “acknowledgment” mean? Received? Reviewed? Signed? * If exchanged electronically, isn’t the absence of a bounce back acceptable for “received”? * For “reviewed” isn’t the provision of a consultation note back to the referring provider sufficient to prove that the consultant reviewed and used the data sent? Why is the committee trying to force additional confirmations when the product of the work should be sufficient proof? * Does this item address referral loops between primary care providers and public health providers? For example, one community-based TB prevention model refers people with TB infection back to their community health center (after TB infection is confirmed and active TB is ruled out). | | | | |
| **HITSC COMMENTS:**   * Support measure. * Will need to ensure the software computing functionality now required performing these types of calculations and how to count when files are sent, be included in the certification testing. * For some results this is critical; for others it is minimally useful (tests which require specialist interpretation). | | | | |
| **SGRP127** | **New** | **New** | Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care |  |
| **PUBLIC COMMENTS:**   * 54 Comments * Summary: Overall, most commenters supported this objective, pending further development and clarification. However, some commenters thought the measure was premature and/or unhelpful. * Key points   + The majority of commenters support this measure but would like to see more information and clarification, including definitions of the terms versioning and interdisciplinary. Enhance the criterion to include a versioning standard or definition, as the existing text is vague.   + Replace“interdisciplinary” with “interprofessional,” as the former term infers specialties while the latter term incorporates other professions, including OT, PT, Social Work, Nursing, and others.   + The fractured nature of care today limits the benefit of interdisciplinary problem lists, especially when compared to the burden imposed by the requirement. Instead, physicians will be overwhelmed by the amount of unnecessary information they receive.   + Suggest adding requirement to CEHRT before being incorporated into attestation requirements for future stages | | | | |
| **HITSC COMMENTS:**   * Need further description about how this would work. Do we expect that external sources of problem list data would be incorporated into the EHR? If so, we have data integrity concerns, as described in SGRP 105,106 | | | | |
| **SGRP125** | **New** | **New** | Medication reconciliation: create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring)  Vendors need an approach for identifying important signals such as: identify data that patient is not taking a drug, patient is taking two kinds of the same drug (including detection of abuse) or multiple drugs that overlap.  **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? |  |
| **PUBLIC COMMENTS:**   * Majority of commenters supported the additional requirement to create the ability to accept data feeds from PBM * Some caveats included:   + Data sources must be highly accurate/up-to-date   + MU measure should have a low threshold and be a menu item   + Concerns about additional burden on providers   + Commenters suggested additional requirements that should be considered such as including feeds from external (i.e., non-PBM feeds) data sources. Commenters also listed a number of concerns for the HITPC to take into consideration. * Majority of commenters were supportive of a new certification criterion for EHR technology to support streamlined access to PDMP   + A majority of those supporters recommended accelerating the proposed certification criteria into Stage 3 to encourage provider access to and use of PDMP data | | | | |
| **HITSC COMMENTS:**  Recommend against standardizing at this time. Best practice advisories, alternative recommendations, and alerts should qualify as helpful tools but should not be mandated. | | | | |
| **SGRP**  **308** | **New** | **EH Objective:** The EH/CAH will send electronic notification of a significant healthcare event in a timely manner to key members of the patient’s care team, such as the primary care provider, referring provider or care coordinator, with the patient’s consent if required.  **EH Measure:** For # of patients with a significant healthcare event that includes:   1. Arrival at an Emergency Department (ED) 2. Admission to a hospital 3. Discharge from an ED or hospital, **or** 4. 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 4hours of when the event occurs. |  |  |
| **PUBLIC COMMENTS:**   * 82 Comments * Some commenters thought a two hour window was too short and suggested lengthening the time frame.   + The two-hour period might be too burdensome, particularly in cases in which the patient is non-communicative due to the injury/illness. Opening the period to four hours might enhance compliance.   + There may be an issue with the patient’s ability to accurately identify a member of their care team and the hospital’s ability to quickly notify the provider within the 2 hour time frame. This is especially true if the patient is admitted to an EH/ED that is not within their care team’s network. We also do not believe the 2 hour time frame is realistic. There also needs to be clarification on the type of information that is to be communicated and the means of communication. * The 10% threshold may be too low * Concern about privacy implications and the patient’s role in consent. * Greater discussion needed related to privacy and confidentiality ramifications and requirements, mechanisms to obtain explicit patient consent, how the communications are completed, and the definition of “key members”. * Define “significant” * Inefficient technological infrastructure to support this measure. | | | | |
| **HITSC COMMENTS:**  For certification criteria, a specific event would need to be specified (i.e. inpatient admission) to ensure the appropriate standards are available. | | | | |
| **Improve population and public health** | | | | |
| **SGRP401A** | **EP/EH Objective:** Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice **EP/EH Measure:** Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period | **EP/ EH Objective:** Capability to receive a patient’s immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice.  **Measure:** Documentation of 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. | **EP/EH Objective:** Add submission of vaccine contraindication(s) and reason(s) for substance refusal to the current objective of successful ongoing immunization data submission to registry or immunization information systems. |  |
| **PUBLIC COMMENTS:**   * Concerns   + This objective requires CEHRT and health department readiness   + Readiness/maturity of bidirectional information exchange capabilities, as well as data and interoperability standards   + Excessive burden for providers with patients from different states with different immunization requirements. * Threshold   + At the provider level or organization level?   + Mixed support for the 30% threshold, some suggest we make this a measure by attestation rather than a threshold, since it is new; others suggested a higher threshold | | | | |
| **HITSC COMMENTS:**  At present there is not a vocabulary standard for describing adverse events/contraindications, but the Standards Committee agrees this is an important gap to resolve. | | | | |
| **SGRP402A** | **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. | **EH Objective (unchanged):** No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system |  |  |
| **PUBLIC COMMENTS:**   * Summary statement: Most commenters agree to keep this measure unchanged although the standards and Implementation Guide for this measure should be updated to reflect current Public Health requirements. * Key Points   + Most agree to keeping as core   + An updated Implementation Guide needs to be developed with strict enforcement of LOINC and SNOMED   + Some feel that Laboratory functions should not be part of Meaningful Use and that this requirement should be removed   + Many commenters also mention that capacity at the state level is still an issue and that states require additional resources to ensure that they can receive this data. | | | | |
| **SGRP402B** | **New** | **New** | **Certification criteria:** The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit. |  |
| **PUBLIC COMMENTS:**   * **Summary statement**: Majority of commenters support the inclusion of this objective in either Stage 3 core set or the future stages of Meaningful Use, with some concerns expressed about- the readiness of public health agencies to receive this data electronically, the maturity and availability of content (say Consolidated CDA) and vocabulary standards (LOINC mapping to lab results) for receiving knowledge or accessing this knowledge and why eligible hospitals (EHs) are not included for this objective? * **Key Points** * This recommendation isn’t specific to a specific reportable disease, CDC should work closely with the Council of State and Territorial Epidemiologists to define the cases which would be reported electronically. Commenters have provided pointers to pilots conducted earlier by CDC (in New York State, San Diego County and Delaware) and Public Health Data Standards Consortium (PHDSC). * References have been provided to current work in progress, the Reportable Conditions Knowledge Management System (RCKMS) through collaboration between CDC and CSTE, which can serve as a source of information on reporting criteria used by an EHR system. * The Standards & Interoperability Public Health Reporting Initiative (PHRI) has developed draft implementation guide for public health reporting based on Consolidated CDA (cCDA), which is likely to be pilot tested in Spring 2013, and will provide the necessary standards for electronic case reporting in 2016 for Stage 3 MU. * Some commenters have recommended that case reporting from EHRs to meet the Stage 3 Meaningful Use objective need to include, only the basic level of information traditionally received via paper forms such as the “***public health card***.” Including only this core information for initial reports would allow a generalized approach to case reporting functionality in EHR systems that could apply to any reportable disease or condition. * Certification criteria for public health case reporting should allow for different methods for EHR systems to utilize “externally accessed or received knowledge.” Depending on clinician needs and preferences, these methods might range from fully automated detection of reportable diseases and submission of reports to use of clinical decision support that prompts providers to manually submit reports. * Clarity requested on whether this would be 10% of all infectious disease cases that should be reported or whether this would include 100% of reporting for 10% of all diseases. Additionally, it is unclear to majority of commenters how this would be evaluated. | | | | |
| **HITSC COMMENTS:**  See SGRP 105,106 | | | | |
| **SGRP403** | **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 | No change from current requirements. |  |  |
| **PUBLIC COMMENTS:**   * Summary statement: Most commenters agree that this measure should remain unchanged. However, several commenters point out that the standards are still not mature, especially for EPs; many states are not ready and that states need additional funding to implement this measure.   + Many commenters want better standards and more efforts aimed at state readiness. Also the providers that the measure pertains to need to be clarified including the addition of inpatient hospital reporting. | | | | |
| **SGRP404** | **EP only MENU Objective:** Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.  **EP only MENU Measure:** Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period | **EP Objective:** Capability 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) from the Certified EHR Technology, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to and does not replace prior requirements for submission to an immunization registry.  **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.  Registries examples include: 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.  **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.  **Exclusion:** where local or state health departments have no mandated registries or are incapable of receiving these standardized reports.  **EH Objective:**   Capability 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) from the Certified EHR Technology, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to and does not replace prior requirements for submission to an immunization registry.  **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.  Registries include: cancer, health-care associated infections, 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) should maintain the registry  **Certification criteria:** EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated or voluntary registry, maintain an audit of those reports, and track total number of reports sent.  **Exclusion:** where local or state health departments have no mandated registries or are incapable of receiving these standardized reports |  |  |
| **PUBLIC COMMENTS:**   * Commenters concerned about the expansion of the scope beyond cancer registries * Key Points   + Many commenters did not want the scope expanded to include other registries   + Commenters concerned about the impact on the cancer registry from the expansion to include EH, as many already have established reporting mechanisms in place   + Uniform reporting needs to be adopted prior to including other registries   + Keep in menu set if including other registries, but recommend core if limiting to cancer registry   + Recommend exclusions (e.g. exclude those who have existing reporting mechanisms from hospital cancer registries to public health central cancer registries)      * Cancer registry concerns   + Concerns that by “lumping” cancer reporting with other registry reporting, it could diminish the cancer cases that are reported to public health   + Keeping a separate item for cancer is preferable – this allows cancer registry to be moved to core while other registries are added as menu   + The cancer registry community may not be prepared to change the current reporting systems from hospital, which is quite extensive   + Cancer reporting is well established and has a set of national standards, while other registries are much less defined. * Standardize reporting requirement concerns   + Suggestions for a national effort to standardize the formats of state registries   + In practice this is proving to be difficult because of inconsistent standards. We encourage maintaining tight standards for sending and receiving systems in Stage 3   + The certification criteria leave a lot of room for the vendor to generate the files in various formats yet the actual state or federal bodies (mostly state) require very specific formats that are not met by the vendors since the vendors most likely will not develop formats for all states   + This objective is premature since many receiving registries are not yet ready for the data stream   + Need to work on capability to have registry information returned to consumer and provider (bi-directional feedback) | | | | |
| **HITSC COMMENTS:**  Standards to submit data from an EHR to a registry are not yet mature. Need to clarify what a "mandated" registry means | | | | |
| **SGRP408** | **New** | **New** | **EH/EP Objective:** Capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR, except where prohibited, and in accordance with applicable law and practice.  **Measure:** Attestation of successful electronic transmission of standardized adverse event reports to the FDA/CDC from the Certified EHR Technology. Total numeric count (null is acceptable) of adverse event reports from the EH/EP submitted electronically during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.  **Certification criteria:** EHR is able to build and send a standardized adverse event report message to FDA/CDC and maintain an audit of those reports sent to track number of reports sent (Common Format). |  |
| **PUBLIC COMMENTS:**  The majority of comments were supportive of requiring the capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR. The main benefits of such requirement were identified as promotion of increased number of reports received and increase quality of the content. Some noted this as a crucial function for patient safety and public health and argued that it not be delayed until future- Stage 4. Several comments noted the presence of this functionality in several current EHRs and that it was a positive feature in these systems.  Comments not supportive of this item noted this function was not known to be present in any current systems, concerns that the FDA and CDC were not ready or capable of receiving these reports, and concerns that reporting should not be a function of electronic records as this was often currently done using an outside system or module and that completion of adverse events reports in the electronic health record would be discoverable and not secure.  Several theme areas where clarification is needed were noted. Many comments indicated a need to clearly define what is meant by an adverse event and what needs to be reported. Concern expressed that it may lead to more reporting requirements and concern that these will not align with current reporting requirements. Clarification is needed to indicate that the electronic record is a source for the information and not to complete the function of reporting. | | | | |
| **HITSC COMMENTS:**  At present adverse event reporting systems and not EHRs support this functionality. Unclear if EHR workflow would support such a function. | | | | |
| **HITSC COMMENTS:**  Building a sophisticated parsing algorithm could limit the quality of information by applying too many filters. May not be applicable to many patients in any case. A low impact approach would simply enable access to “clinicaltrials.gov” from the EHR.  Before this was made a measure, evidence would be needed that it improves the patient’s care or health.  While I support the intent of this proposed criterion, implementation would require knowledge of the service interfaces of all relevant research enrollment systems (since we can’t impose MU standards on them). I think that may be unrealistic. On the other hand, if EHRs implemented a standard service interface to query clinical trials system, developers of these trials system would be encouraged to conform to those standards. So I recommend that ONC sponsor the development of a service interface standard to enable EHRs to query clinical trials systems. (Perhaps CDISC could lead this development?) | | | | |
| **SGRP401B** | **New** | **EP/EH Objective:** Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy. **Measure:** Implement an immunization recommendation system that: 1) establishes baseline recommendations (e.g., Advisory Committee on Immunization Practices), and 2) allows for local/state variations. For 20% of patients receiving an immunization, the EP/EH practice receives the recommendation before giving an immunization. **Exclusion:** EPs and EHs that administer no immunizations.   **Certification criteria:** EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review. |  |  |
| **PUBLIC COMMENTS:**   * Commenters were generally supportive of the objective, but expressed concern about the feasibility of achieving it (and meeting the measure target threshold) in the Stage 3 timeframe. Many were concerned with the lack of available standards, the readiness of technology, etc. One major objection shared by multiple commenters was that the measure would incentivize the wrong behavior – reviewing history might not necessarily lead to improvements in immunization rates. | | | | |
| **HITSC COMMENTS:**  At present there is no standard to represent immunization rules | | | | |
| **SGRP405** | **EP only MENU Objective:** Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period | **EP Objective**: Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements (e.g., immunizations, cancer, early hearing detection and intervention, and/or children with special needs). Registry examples include hypertension, diabetes, body mass index, devices, and/or other diagnoses/conditions) from the Certified EHR to a jurisdictional, professional or other aggregating resources (e.g., HIE, ACO), except where prohibited, and in accordance with applicable law and practice.  **Measure:** Documentation of successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** EHR is able to build and send a standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent. |  |  |
| **PUBLIC COMMENTS:**  Support for changes, but more specificity needed. | | | | |
| **HITSC COMMENTS:**  Need to clarify what a "non-mandated" registry means. It may be very difficult to certify products to support this criteria since "non-mandated" registries are likely to be niche/non-standard. | | | | |
| **SGRP407** | **New** | **EH Objective:** Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice.  **Measure:** Documentation of successful electronic transmission of standardized healthcare acquired infection reports to the NHSN from the Certified EHR Technology. Total numeric count of HAI in the hospital and attestation of Certified EHR electronic submission of at least 10% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.  **Certification criteria**: EHR is able to send a standard HAI message to NHSN, maintain an audit and track total number of reports sent. |  |  |
| **PUBLIC COMMENTS:**  Comments for SGRP 407 - Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice- was split between favorable and unsupportive.  Comments in favor of this sited that this function was already in place and operating within some electronic health records. They also noted that it was aligned with the Federal goals of decreasing HAIs.  Negative comments noted the need for more Federal funding and support of implementation of this function. They noted that determining an HAI by NHSN criteria was not a simple function for an electronic health record and that it usually involved manual review of data and chart audit. Multiple comments also felt it was premature as the pilot of electronic transmission to NHSN is currently only conceptualized, and has not yet been competed or produced results. | | | | |
| **HITSC COMMENTS:**  Hospital Acquired Infection content standards are low maturity | | | | |