| **ID #** | **Stage 2 Final Rule** | **Stage 3 Recommendations** | **Proposed for Future Stage** | **HITPC Questions / Comments** |
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| **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 - medication allergies - problems  **EP / EH / CAH Measure:** The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than 10% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23).  **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)  **Certification Criteria:** Standards work needs to be done to support the valuing and coding of contraindications. | Feasibility to add additional fields for reconciliation e.g. social history? 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 ofwhich is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii) (B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was developed by a different EHR technology developer than the sender’s EHR technology certified to 45 CFR 170.314(b)(2); or  (B) conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period. | **EP/ EH / CAH Objective:** EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care  Provide a summary of care record for each site transition or referral when transition or referral occurs with available information.  Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant):  1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral)  2. Setting-specific goals  3. Instructions for care during transition and for 48 hours afterwards  4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF (**D**irect care provision, **E**motional support, **C**are coordination, **A**dvocacy, and **F**inancial))  **Measure:** The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30%\* electronically).  **Certification Criteria #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:** Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which and are expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013:  1) Consultation Request (Referral to a consultant or the ED)  2) Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency)  Additional items added here:  ● Status of pending referral (requires use of CPOE -SGRP130)  ● Indication of an advance directive for patients 65 or older (not removing as a separate objective)  ● Include high priority family history |  | \*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.   + Commentors 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:** EPto 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 10% of patients with a significant healthcare event (arrival at an Emergency Department (ED), admission to a hospital, discharge from an ED or hospital, or death), EH/CAH will send an electronic notification to at least one key member of the patient’s care team, such as the primary care provider, referring provider or care coordinator, with the patient’s consent if required, within 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. | | | | |