

HIT Policy Committee: Meaningful Use Workgroup Stage 3 – Preliminary Recommendations

**Paul Tang, Palo Alto Medical Foundation, Chair
George Hripcsak, Columbia University, Co-Chair**

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Washington Marriott, 1221 22nd Street, NW, DC 20037

Workgroup Membership

Co-Chairs:

Paul Tang
George Hripcsak

Palo Alto Medical Foundation
Columbia University

Members:

- **David Bates**
 - Michael Barr
 - **Christine Bechtel**
 - Neil Calman
 - Tim Cromwell
 - **Art Davidson**
 - Marty Fattig
 - James Figge
 - Joe Francis
 - Leslie Kelly Hall
 - Yael Harris
 - David Lansky
 - Deven McGraw
 - Latanya Sweeney
 - Greg Pace
 - Robert Tagalicod
 - Karen Trudel
 - **Charlene Underwood**
 - Amy Zimmerman
- Brigham & Women's Hospital
American College of Physicians
National Partnership/Women & Families
Institute for Family Health
Department of Veterans Affairs
Denver Public Health
Nemaha County Hospital
NY State Dept. of Health
Veterans Administration
Healthwise
HRSA
Pacific Business Group/Health
Center/Democracy & Technology
Carnegie Mellon University
Social Security Administration
CMS/HHS
CMS
Siemens
Rhode Island Department of Health and Human Services

HITPC Stage 3 MU Timeline

- Aug, 2012 – present draft preliminary stage 3 recs
- Oct, 2012 – present pre-RFC preliminary stage 3 recs
- Nov, 2012 – RFC distributed
- Dec 21, 2012 – RFC deadline
- Jan, 2013 – ONC synthesizes RFC comments for WGs review
- Feb, 2013 – WGs reconcile RFC comments
- Mar, 2013 – present revised draft stage 3 recs
- Apr, 2013 – approve final stage 3 recs
- May, 2013 – transmit final stage 3 recommendations to HHS

Guiding Principles

MU Objectives

- Supports **new model of care** (e.g., team-based, outcomes-oriented, population management)
- Addresses **national health priorities** (e.g., NQS, Million Hearts)
- **Broad applicability** (since MU is a floor)
 - Provider specialties (e.g., primary care, specialty care)
 - Patient health needs
 - Areas of the country
- Promotes **advancement** -- Not "topped out" or not already driven by market forces
- **Achievable** -- mature standards widely adopted or could be widely adopted by 2016

Subgroup 1:
**Improve Quality Safety, Efficiency and
Reducing Health Disparities**

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP1 01	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.</p> <p>Measure: More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE</p>	<p>Reconcile % after Stage 2 final</p> <p>Objective: Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.</p> <p>Measure: More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE</p>	
SGRP1 30	Improve Quality Safety, Efficiency and Reducing Health Disparities	New for stage 3	<p>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.</p> <p>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.</p>	

Improve Quality Safety, Efficiency and Reducing Health Disparities

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SGRP1 02	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Implement drug-drug and drug-allergy interaction checks</p> <p>Consolidated with CDS</p>	<p>Consolidated with CDS</p> <p>Certification: EHRs need to be able to consume external lists of DDIs (e.g., “never” combinations).</p>	<p>Seeking externally maintained list of DDIs with higher predictive value</p>
SGRP1 03	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>EP Objective: Generate and transmit permissible prescriptions electronically (eRx)</p> <p>EP Measure: More than 65 % of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.</p> <p>EH Objective: Generate and transmit permissible discharge prescriptions electronically (eRx)</p> <p>EH Measure: More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology</p>	<p>EP Objective: Generate and transmit permissible prescriptions electronically (eRx)</p> <p>EP Measure: More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary (including generic substitutions) transmitted electronically using Certified EHR Technology.</p> <p>EH Objective: Generate and transmit permissible discharge prescriptions electronically (eRx)</p> <p>EH Measure: More than 30% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology</p>	

Improve Quality Safety, Efficiency and Reducing Health Disparities

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SGRP1 04	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Record the following demographics:</p> <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth <p>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) have demographics recorded as structured data</p> <ul style="list-style-type: none"> • (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH 	<p>Objective: Record the following in structured data:</p> <p>Demographics:</p> <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth • Occupation and industry codes <p>Clinical:</p> <ul style="list-style-type: none"> • Sexual orientation, gender identity • Disability status <p>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) have demographics recorded as structured data</p> <ul style="list-style-type: none"> • (Hospital Only) date and preliminary cause of death in the event of mortality in the eligible hospital or CAH 	

Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP1 05	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Stage 1: Maintain an up-to-date problem list of current and active diagnoses for more than 80% of all unique patients: have at least one entry or an indication that no problems are known for patient recorded as structured data</p> <p>Stage 2: Consolidated with summary of care</p>	<p>New for stage 3 Certification criteria only: EHR systems should provide functionality to help maintain up-to-date, accurate problem list</p>	<p>Stage 4: Patient input to reconciliation of problems</p>
SGRP1 06	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Stage 1: Maintain active medication list: more than 80% of all unique patients have at least one entry recorded as structured data (or indication that the patient is on no meds)</p> <p>Stage 2: Consolidated with summary of care</p>	<p>New for stage 3 Certification criteria only: EHR systems should provide functionality to help maintain up-to-date, accurate meds list</p>	
SGRP1 07	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Stage 1: Maintain active medication allergy list: More than 80% of all unique patients seen during the reporting period have at least one entry (or indication that the patient has no known medication allergies) recorded as structured data</p> <p>Stage 2: Consolidated with summary of care</p>	<p>New for stage 3 Certification criteria only: EHR systems should provide functionality to code medication allergies and link to related drug family, and code related reaction.</p>	<p>Stage 4: Contraindications that could include: adverse reactions, procedural intolerance.</p>

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SGRP1 08	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Record and chart changes in vital signs:</p> <ul style="list-style-type: none"> • Height/Length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI <p>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), blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recoded as structured data</p>	<p>Maintain as is for Stage 3 or retire as topped out measure.</p>	
SGRP1 09	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Record smoking status for patients 13 years old or older</p> <p>Measure: More than 80% 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 department (POS 21 or 23) have smoking status recorded as structured data</p>	<p>Consider retiring or incorporating into CQM</p>	

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SGRP1 10	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Stage 1: Implement drug-formulary checks with access to at least one drug formulary</p> <p>Stage 2: Consolidated - included within eRx core objective</p>	Consolidated - Moved to eRx objective.	
SGRP1 11	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Stage 1: Report ambulatory and hospital clinical quality measures to CMS or States</p> <p>Stage 2: Removed, objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6</p>	Removed	
SGRP1 12	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>EP: N/A</p> <p>EH Objective: Record whether a patient 65 years old or older has an advance directive</p> <p>EH Menu Measure: More than 50% 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.</p>	<p>Add for EPs if not included in Stage 2 and make core for EH.</p> <p>Ensure standards support in CDA by 2016</p> <p>Advanced directives hearing to further refine.</p>	

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SGRP1 13	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Use clinical decision support to improve performance on high priority health conditions</p> <p>Measure:</p> <ol style="list-style-type: none"> 1. Implement five clinical decision support interventions related to five or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. 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. 	<p>Objective: Use clinical decision support to improve performance on high priority health conditions</p> <p>Measure:</p> <ol style="list-style-type: none"> 1. Implement 15 clinical decision support interventions related to five or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. <ol style="list-style-type: none"> a. Include renal dosing checks (may need to be stage 4 due to lack of structured Sigs) b. Include CDS for appropriateness of lab or radiology orders (to avoid redundant or inappropriate orders) 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. <p>Certification criteria only:</p> <ol style="list-style-type: none"> 1. Ability to track CDS triggers and how the provider responded 2. Ability to flag preference-sensitive conditions, and provide decision support materials for patients. 	

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SGRP1 14	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Incorporate clinical lab-test results into EHR as structured data</p> <p>Measure: More than 55% 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</p>	<p>Objective: Incorporate clinical lab-test results into EHR as structured data</p> <p>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</p>	
SGRP1 15	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>EP Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach</p> <p>EP Measure: Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.</p>	<p>EP Objective: Generate lists of patients for multiple specific conditions and present real-time dashboards to use for quality improvement, reduction of disparities, research, or outreach</p>	

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SGRP1 16	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>EP Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care</p> <p>EP Measure: More than 10% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference</p>	<p>EP Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care</p> <p>EP Measure: More than 20% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference</p> <p>Exclusion: Specialists may be excluded for prevention reminders (could be more condition specific).</p>	
SGRP1 17	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>EH Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)</p> <p>Measure: More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR.</p>	<p>EH Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)</p> <p>Measure:</p> <ol style="list-style-type: none"> 1) More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR. 2) Mismatches are tracked and acted upon (self-report policies and practices on handling reports of mismatches). 	

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SGRP1 18	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Incorporate imaging results and information into Certified EHR Technology</p> <p>Menu Measure: More than 40% of all scans and tests whose result is an image 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 incorporated into or accessible through Certified EHR Technology</p>	Move to core, pending Stage 2 Final Rule	
SGRP1 19	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective: Record patient family health history as structured data</p> <p>Menu Measure: More than 20% 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 or an indication that family health history has been reviewed</p>	<p>Objective: Record high priority family history data (including colon cancer, breast, glaucoma, MI, diabetes)</p> <p>Measure: Record high priority family history in 40% of patients seen during reporting period</p> <p>Certification criteria: Make sure that every CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach).</p>	

Objective Not Included in Stage 2 NPRM - Improve Quality Safety, Efficiency and Reducing Health Disparities

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP1 20	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Objective/Measure: Record electronic notes in patient records for more than 30 percent of office visits. While we believe that medical evaluation entries by providers are an important component of patient records that can provide information not otherwise captured within standardized fields, we believe there is evidence to suggest that electronic notes are already widely used by providers of Certified EHR Technology and therefore do not need to be included as a meaningful use objective.</p>	<p>Record electronic notes in patient records for more than 30% of office visits within four calendar days.</p>	
SGRP1 21	Improve Quality Safety, Efficiency and Reducing Health Disparities	<p>Hospital Objective: Provide structured electronic lab results to eligible professionals.</p> <p>Hospital Measure: Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 40 percent of electronic lab orders received.</p>	<p>Hospital Objective: Provide structured electronic lab results to eligible professionals.</p> <p>Hospital Measure: Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 70% of electronic lab orders received.</p>	

Improve Quality Safety, Efficiency and Reducing Health Disparities

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SGRP1 22	Improve Quality Safety, Efficiency and Reducing Health Disparities	New for stage 3	<p>EH: Explore Timely transition document (elements need to be fleshed out) that is available electronically within four calendar days for when a transition occurs between sites.</p>	

Subgroup 2: Engage Patients and Families

Engage Patients and Families

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP2 04A	Engage Patients and Families	<p>EP Objective: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p> <p>EP Measure:</p> <ol style="list-style-type: none"> 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information 2. More than 10 % of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download , or transmit to a third party their health information <p>EH Objective: Provide patients the ability to view online and download information about a hospital admission</p> <p>EH Measure:</p> <ol style="list-style-type: none"> 1. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge 2. More than 10 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period 	<p>Objective: Retain View/Download/Transmit</p> <p>Explore further in RFC: Provide 50% of patients the ability to designate to whom and when (i.e. auto blue-button & on-demand) a summary of care document is sent to specific care team members (across settings/providers), and create ability of providers to review/accept updates.</p>	

Engage Patients and Families

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP2 04B	Engage Patients and Families	New for Stage 3	<p>Option 1: Provide 10% of patients with ability to submit information (provider chooses one or more of these information types according to what is most appropriate to their practice) such as:</p> <ol style="list-style-type: none"> 1. Family Health History [as per Surgeon General] 2. ODLs [as per How's Your Health] 3. Caregiver status and role [as per DECAF] 4. Functional status [as per PROMIS 10] 5. Patient-created health goals (needs a standard, also in care summary and plan) 6. Medical device: Glucose level* 7. Medical device: Blood Pressure* 8. Medical device: Weight* <p>*[SNOMED/LOINC]</p> <p>Option 2: Provide 10% of patients with ability to submit information using:</p> <ol style="list-style-type: none"> 1) A generic semi-structured questionnaire platform and 2) capability to receive uploads from home devices (e.g., glucometer, BP device, scale) that accommodate the data above. 	

Engage Patients and Families

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SGRP2 04C	Engage Patients and Families	New for Stage 3	<p>Certification criteria only: Create capability to accept pre-visit prep tools into the EHR (e.g., the ability to consent to treatment, fill out administrative forms) (and also could send to other EHRs)</p>	
SGRP2 04D	Engage Patients and Families	New for Stage 3	<p>Objective: Offer 10% of patients the ability to update/correct information</p>	

Engage Patients and Families

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SGRP2 05	Engage Patients and Families	<p>EP Objective: Provide clinical summaries for patients for each office visit</p> <p>Measure: Clinical summaries provided to patients within 24 hours for more than 50 % of office visits.</p>	Retain. May need to update content requirements after stage 2 FR	
SGRP2 06	Engage Patients and Families	<p>EP/EH Objective: Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient</p> <p>EP Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all office visits by the EP.</p> <p>EH Measure: More than 10% 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</p>	<p>Retain objective</p> <p>Add language support:</p> <p>Option 1: Of those patients who speak one of the top 5 nationally prevalent languages, 80% of materials must be provided in the language according to patient's preference, where materials are publicly available</p> <p>Option 2: For one non-English speaking population, provide patient education materials in that language, where materials are publicly available</p>	

Engage Patients and Families

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP2 07	Engage Patients and Families	<p>Objective: Use secure electronic messaging to communicate with patients on relevant health information</p> <p>Measure: A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 % of unique patients seen during the EHR reporting period</p>	Measure: More than 15% of patients use secure electronic messaging to communicate with EPs	Stage 4: Create capacity for electronic episodes of care (telemetry devices, etc) and to do e-referrals and e-consults
SGRP2 08	Engage Patients and Families	<p>EP Objective/Measure: Record patient preferences for communication medium for more than 20 % of all unique patients seen during the EHR reporting period. We believe that this requirement is better incorporated with other objectives that require patient communication and is not necessary as a standalone objective.</p>	Retain, pending stage 2 FR	

Objective not included - Engage Patients and Families

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP2 09	Engage Patients and Families	New for stage 3	Explore For Certification Rule Only: Capability for EHR to query research enrollment systems to identify available clinical trials.	No use requirements until Stage 4.
SGRP2 10	Engage Patients and Families	Placeholder for Stage 4	Placeholder for Stage 4	Patients receive alerts for drug recalls, devices or other safety alerts; set preferences for receiving alerts.

Subgroup 3: Improve Care Coordination

Improve Care Coordination

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP3 01	Improve Care Coordination	Removed for an actual use case	Eliminate for Stage 3 in favor of use cases.	N/A
SGRP3 02	Improve Care Coordination	<p>EP Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</p> <p>EP Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)</p> <p>EH Objective: The 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 medication reconciliation</p> <p>EH Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)</p>	<p>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:</p> <ul style="list-style-type: none"> - medications - medication allergies - problems <p>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).</p>	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)

Improve Care Coordination

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP3 03	Improve Care Coordination	<p>EP Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</p> <p>EH Objective: The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</p> <p>EP/EH /CAH Measure:</p> <ol style="list-style-type: none"> 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 65 % 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 electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 % of transitions of care and referrals. 	<p>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</p> <ul style="list-style-type: none"> - Provide a summary of care record for each site transition or referral when transition or referral occurs with available information <p>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).</p> <p>Certification Criteria: EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral.</p> <p>Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant):</p> <ol style="list-style-type: none"> 1. Concise narrative in support of care transitions (free text that captures reason for referral or transition) 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) 	

Improve Care Coordination

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SGRP3 04	Improve Care Coordination	New for Stage 3	<p>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</p> <p>For each transition of site of care, provide the care plan information, including the following elements <u>as applicable</u>:</p> <ul style="list-style-type: none"> •Medical diagnoses and stages •Functional status, including ADLs •Relevant social and financial information (free text) •Relevant environmental factors impacting patient’s health (free text) •Most likely course of illness or condition, in broad terms (free text) •Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver •The patient’s long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals •Specific advance care plan (POLST) and the care setting in which it was executed <p>For each referral, provide a care plan if one exists</p> <p>Measure: The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver.</p>	
SGRP3 05	Improve Care Coordination	New for Stage 3	<p>EP / EH / CAH Objective (new): EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby closing the loop on information exchange.</p> <p>Measure: For 10% of patients referred during an EHR reporting period, referral results generated from the EHR are returned to the requestor (e.g. via scan, printout, fax, electronic CDA Care Summary and Consult Report).</p>	

Improve Care Coordination

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP1 27	Improve Care Coordination	Placeholder for Stage 4	Placeholder for Stage 4	Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care
SGRP1 25	Improve Care Coordination	Placeholder for Stage 4	Placeholder for Stage 4	Medication reconciliation: create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring)

Objectives Not Included - Improve Care Coordination

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP3 06	Improve Care Coordination	<p>Objective/Measure: Record health care team members (including at a minimum PCP, if available) for more than 10 percent of all patients seen during the reporting period; this information can be unstructured. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.</p>	<p>Added into care summary</p>	
SGRP3 07	Improve Care Coordination	<p>Objective/Measure: Record care plan goals and patient instructions in the care plan for more than 10 percent of patients seen during the reporting period. We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.</p>	<p>Added into care summary</p>	

Subgroup 4: Improve Population and Public Health

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 01A	Improve Population and Public Health	<p>Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice</p> <p>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</p>	<p>EP/ EH Objective (New): 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.</p> <p>Measure: Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period.</p> <p>Exclusion: EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories.</p> <p>Certification criteria: EHR is able to receive and present a standard set of structured, externally-generated, immunization history and capture the act and date of review within the EP/EH practice.</p>	<p>Stage 4 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.</p>

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 01B	Improve Population and Public Health	New for Stage 3	<p>EP/EH Objective (New): 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.</p> <p>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.</p> <p>Exclusion: EPs and EHs that administer no immunizations.</p> <p>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.</p>	

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 02A	Improve Population and Public Health	<p>EH Objective: Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice</p> <p>Measure: Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.</p>	<p>EH Objective (unchanged): No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system</p>	

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 02B	Improve Population and Public Health	New for Stage 3	<p>Objective presented for comment (Stage undetermined): EP Objective (new): Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice.</p> <p>Measure: Attestation of submission of standardized initial case reports to public health agencies on 20% of all reportable disease or conditions during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice.</p> <p>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</p>	

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 03	Improve Population and Public Health	<p>Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice</p> <p>EH CORE Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period</p> <p>Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice</p> <p>EP MENU Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period</p>	No change from current requirements.	

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 04	Improve Population and Public Health	<p>EP Objective: Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.</p> <p>EP Menu Measure: Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period</p>	<p>EH/EP Objective (New, pending Stage 2 Rule): Capability to electronically participate and send standardized, commonly formatted reports to a mandated jurisdictional registry (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to either local/state health departments, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to prior requirements for submission to an immunization registry.</p> <p>Measure: Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. Attestation of submission for at least 20% 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.</p> <p>Certification criteria: EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated registry, maintain an audit of those reports, and track total number of reports sent.</p> <p>Exclusion: where local or state health departments have no mandated registries or are incapable of receiving these standardized reports</p>	

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 05	Improve Population and Public Health	<p>EP 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.</p> <p>EP Menu Measure: Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period</p>	<p>Objective presented for comment (Stage undetermined): EP Objective (New, pending Stage 2 Rule): 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.</p> <p>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 20% 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.</p> <p>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.</p> <p>Note: This objective is the same as the previous, but adds a second registry and does not need to be jurisdictional.</p>	

Improve Population and Public Health

ID	Subgroup Category	Stage 2 NPRM	Stage 3 Recommendations	Stage 4 Placeholder
SGRP4 07	Improve Population and Public Health	New for Stage 3	<p>EH Objective (new): 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.</p> <p>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 20% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.</p> <p>Certification criteria: EHR is able to sending a standard HAI message to NHSN, maintain an audit and track total number of reports sent.</p>	
SGRP4 08	Improve Population and Public Health	New for Stage 3	<p>Objective presented for comment (Stage undetermined):</p> <p>EH/EP Objective (new): 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.</p> <p>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.</p> <p>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</p>	