

**Improve quality safety, efficiency and reducing health disparities****e-Rx (EP – Core; EH – Menu)**

	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC Stage 2	Stage 1 Final					
CORE	EP	Generate and transmit permissible prescriptions electronically (eRx).	More than 65% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.	Increase threshold to 50%	Generate and transmit more than 40% of all permissible prescriptions electronically	<p><b>Numerator:</b> The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically.</p> <hr/> <p><b>Denominator:</b> Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.</p> <p>*CMS excludes controlled substances in the denominator</p> <ul style="list-style-type: none"> <li>Clarify 65% or 50%, because the NPRM is ambiguous (mentions 50% in the query). We agree with 65%, although there remain challenges choosing a participating pharmacy at the time of writing a prescription.</li> <li>We have some sources reporting that controlled substances should not be included in the denominator.</li> </ul> <p><b>NPRM Pg 53-59</b></p>	§170.314(b)(3) / §170.314(a)(10)	§ 170.205(b)((2) (NCPDP SCRIPT version 10.6) and § 170.207(h) (RxNorm February 6, 2012 Release)	
	<p><b>IE Workgroup Comments</b></p> <p><b>Summary Decision:</b> The workgroup agreed with the objective as stated in the NPRM: <b>Generate and transmit permissible prescriptions electronically (eRx) 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</b></p>								

## FACA Template for Input on MU Stage 2 Objectives and Measures

	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC Stage 2	Stage 1 Final					
MENU	EH  Generate and transmit permissible discharge prescriptions electronically (eRx).  ** New EH objective	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.  ** exclusion if there are no pharmacies that accept electronic prescriptions within 25 miles of hospital.	Generate and transmit more than 10% of all hospital discharge orders for permissible prescriptions electronically	NA	<p><b>Numerator.</b> The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically.</p> <hr/> <p><b>Denominator.</b> The number of new or changed prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances for patients discharged during the EHR reporting period.</p>	NPRM pg 141-144	<p style="text-align: right;">§170.314(b)(3) / §170.314(a)(10)</p> <p><u>Electronic prescribing.</u> Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with: (i) The standard specified in § 170.205(b)(2); and (ii) At a minimum, the version of the standard specified in § 170.207(h).</p> <p><u>Drug-formulary checks.</u> Enable a user to electronically check if drugs are in a formulary or preferred drug list.</p>	§ 170.205(b)(2) (NCPDP SCRIPT version 10.6) and § 170.207(h) (RxNorm February 6, 2012 Release)	
<b>Workgroup Comments</b>									

### Preamble:

- CMS agrees with the HITPC recommendation to include eRx for hospitals for discharge medications.
- CMS agrees with the HITPC recommendation that this measure be limited to new or changed prescriptions that were ordered during the course of treatment of the patient while in the hospital because prescriptions that originate prior to the hospital stay, and that remain unchanged, would be within the purview of the original prescriber, and not hospital staff or attending physicians.
- The inclusion of the comparison to at least one drug formulary enhances the efficiency of the healthcare system when clinically appropriate and cheaper alternatives may be available. This measure replaces the Stage 1 menu objective of "Implement drug-formulary checks" and is intended to provide better integration guidance both for the hospital and their supporting vendors.
- CMS is concerned with the effect this objective may have on patient preferences, thus limiting the measure to 10 percent in accordance with HITPC recommendation.

**Improve Care Coordination****Perform HIE Test**

	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC Stage 2	Stage 1 Final					
MENU	EH & EP	Removed	Removed	HIE Test eliminated in favor of use objectives	Perform at least one test of the capability to exchange key clinical information among providers of care and patient authorized entities electronically				
	<b>Workgroup Comments</b>								

**Preamble:**

- We have found the objective of "capability to exchange key clinical information" to be surprisingly difficult for providers to understand, which has made the objective considerably more difficult to achieve than we envisioned in the Stage 1 final rule. As the measure for this objective is simply a test with no associated requirement for follow-up submission, we are concerned the value of this objective is not sufficient to justify the burden of compliance. However, we also strongly believe that meaningful use of EHRs must ultimately involve real and ongoing electronic health information exchange to support care coordination, as the Stage 2 objectives on this subject (described below) make clear.
- We considered four options for this objective**, and welcome comment on all four that variously reduce or eliminate the burden of the objective or increase the value of the objective.
  - The first option we considered is removal of this objective. This acknowledges our experience with Stage 1 and the limited benefit of just a test.
  - The second option is to require that the test be successful. This would increase the value of the objective and eliminate a common question we receive on what happens if the test is unsuccessful.
  - The third option is to eliminate the objective, but require that providers select either the Stage 1 medication reconciliation objective or the Stage 1 summary of care at transitions of care and referrals from the menu set. This would eliminate the burden and complexity of the test, but preserve the domain of care coordination for Stage 1.
  - The fourth option is to move from a test to one case of actual electronic transmission of a summary of care document for a real patient either to another provider of care at a transition or referral or to a patient authorized entity. This would increase the benefit of the objective and reduce the complexity of the defining the parameters of the test, but potentially increases the real burden of compliance significantly beyond what is currently included in Stage 1.
- We are proposing the first option** to remove this objective and measure from the Stage 1 core set beginning in 2013 (CY for EPs, FY for eligible hospitals/CAHs). In Stage 2, we propose to move to actual use cases of electronic exchange of health information as discussed later in this proposed rule (e.g. transitions of care), which would require significant testing in the years of Stage 1.
- We encourage comments on all four options and will evaluate them again in light of the public comment received. Starting in 2014, Certified EHR Technology will no longer be certified to the Stage 1 EP and hospital core objectives of providing patients with electronic copies of their health information and discharge instructions upon request, nor will it support the Stage 1 EP menu objective of providing patients with timely electronic access to their health information. Therefore starting in 2014, for Stage 1, we propose to replace these objectives with the new "view online, download and transmit" objectives.

**Improve quality safety, efficiency and reducing health disparities**

**Incorporate Labs as Structured Data (EP and EH – Core)**

	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/NOTE S	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC Stage 2	Stage 1 Final					
CORE EP& EH	Incorporate clinical lab-test results into Certified EHR Technology as structured data.	More than 55% of all clinical lab tests results ordered by the EP or by authorized providers of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.	Incorporate lab results as structured data for more than 40% of all clinical lab tests ordered through the EHR for a patient during the reporting period	Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests results ordered whose results are either in a positive/negative or numerical format **MENU	<p><b>Numerator:</b> Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated in Certified EHR Technology as structured data.</p> <hr/> <p><b>Denominator:</b> Number of lab tests ordered during the EHR reporting period by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.</p>	<p><b>EPs:</b></p> <ul style="list-style-type: none"> <li>Agree. Okay to count individual tests.</li> </ul> <p><b>EHS:</b></p> <ul style="list-style-type: none"> <li>The providers depend upon hospital labs which are about 40% of the market. <b>Speak with IE workgroup to further discuss.</b></li> </ul> <p><b>NPRM Pg 85-88</b></p>	<p>§170.314(b)(5)</p> <p><u>Incorporate laboratory tests and values/results.</u></p> <p>(i) <u>Receive results.</u></p> <p>(A) <u>Ambulatory setting only.</u></p> <p>(1) Electronically receive clinical laboratory tests and values/results formatted in accordance with the standard (and implementation specifications) specified at § 170.205(k) and, at a minimum, the version of the standard specified in § 170.207(g).</p> <p>(2) Electronically display the tests and values/results received in human readable format.</p> <p>(B) <u>Inpatient setting only.</u> Electronically receive clinical laboratory tests and values/results in a structured format and electronically display such tests and values/results in human readable format.</p> <p>(ii) <u>Display test report information.</u> Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7).</p> <p>(iii) <u>Incorporate tests and values/results.</u> Electronically incorporate a laboratory test and value/result with a laboratory order or patient record.</p>	<p>§ 170.205(k) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Standards and Interoperability Framework Lab Results Interface, Release 1 (US Realm)); and § 170.207(g) (LOINC version 2.38)</p>	
		<p>** Exclusion— any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.</p> <p>** No exclusions for EHs and CAHs because CMS does not believe any hospital will ever be in a situation where its authorized providers have not ordered any lab tests for admitted patients during EHR reporting period.</p> <p>**HITSC: Use LOINC where available</p>	<p>**HITSC: Use LOINC where available</p>						
<p><b>Workgroup Comments</b></p>									

**Preamble:**

- Although the HIT Policy Committee did not recommend an increase in the threshold for this measure, our initial data on Stage 1 of meaningful use shows high compliance with this measure for those providers individually selecting the objective from the menu set. Therefore we are proposing to increase the threshold of this objective to 55 percent for Stage 2.
- Reducing the risk of entry error is one of the primary reasons we lowered the measure threshold to 40 percent for Stage 1, during which providers are changing their workflow processes to accurately incorporate information into EHRs through either electronic exchange or manual entry. However, for this measure, we do not limit the EP, eligible hospital or CAH to only counting structured data received via electronic exchange, but count in the numerator all structured data.
- The measure in Stage 1 and Stage 2 counts lab tests individually, not as panels or groups in both the numerator and the denominator for the very complications illustrated by the inquiries that occur when this is not done. However, we solicit comment on whether such individual accounting is infeasible. We note that this in no way precludes the use of grouping and panels when ordering labs. While we are not proposing to move beyond numeric and yes/no tests, we request comments on whether standards and other capabilities would allow us to expand the measure to all quantitative results (all results that can be compared on as a ratio or on a difference scale).

**Hospital Labs Send Results (EH)****(CMS Not Proposing as Measure)**

	MEANINGFUL USE			NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITSC					
EH	Provide structured electronic laboratory results to eligible professionals.  ** New objective, but not currently included in CMS proposal.	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.	Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic lab orders received.  ** HITSC: Use LOINC where available	N/A	<ul style="list-style-type: none"> <li>MU WG seeks feedback from the IE workgroup since objective was originally proposed by this workgroup.</li> <li>NPRM pg 152-153</li> </ul>	§170.314(b)(6)  <u>Inpatient setting only. Transmission of electronic laboratory tests and values/results to ambulatory providers.</u> Enable a user to electronically create laboratory tests and values/results for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(k); and (ii) At a minimum, the version of the standard specified in § 170.207(g).	§ 170.205(k) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Standards and Interoperability Framework Lab Results Interface, Release 1 (US Realm); and § 170.207(g) (LOINC version 2.38)	
<b>Workgroup Comments</b>								

**Preamble:**

- ONC has proposed that for certification, ambulatory EHR technology would need to be able to incorporate lab test results formatted in the same standard and implementation specifications to which inpatient EHR technology would need to be certified as being able to create.
- CMS not proposing objective under meaningful use for following reasons:
  - This measure **assumes that over 40 percent of the ordering providers would be utilizing Certified EHR Technology**, and there implications for exchange beyond the established standards.
  - Although hospital labs supply nearly half of all lab results to EPs, they are not the predominant vendors for providers who do not share or cannot access their technology (the independent and office laboratories are). **We are concerned that imposing this requirement on hospital labs would unfairly disadvantage them in this market.**
  - Not all hospitals offer these services so **it would create a natural disparity in meaningful use between those hospitals offering these services and those that do not.**
  - All other aspects of meaningful use in Stage 1 and Stage 2 focuses on the inpatient and emergency departments of a hospital, and **this objective is not related to these departments**, in fact, it explicitly excludes services provided in these departments.

**Improve Care Coordination**

**Transitions of Care and Summary Care Record (EP and EH Core)**

CORE	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC	Stage 1 Final					
EP & EH	The EP, EH, or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	<p>EPs, EHs, and CAHs must satisfy both measures in order to meet the objective:</p> <ol style="list-style-type: none"> <li>1. The EP, EH, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65% of transitions of care and referrals.</li> <li>2. The EP, EH, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10% of transitions of care and referrals.</li> </ol> <p>** Exclusion – any EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.</p> <p>** 2nd measure is new.</p>	<ol style="list-style-type: none"> <li>1. Record and provide (by paper or electronically) a summary of care record for more than 50% of transitions of care for the referring EP or EH</li> <li>2. Record care plan goals and patient instructions in the care plan for more than 10% of all active patients</li> <li>3. Record team member, including primary care practitioner, for at least 10% of patients.</li> </ol>	<p>Provide a summary of care record for more than 50% of all transitions and referrals of care</p> <p>**Menu</p>	<p><b>Numerator:</b></p> <ol style="list-style-type: none"> <li>1. The number of transitions of care and referrals in the denominator where a summary of care record was the transferring or referring provider.</li> <li>2. The number of transitions of care and referrals in the denominator where a summary of care record was electronically transmitted using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender.</li> </ol> <hr/> <p><b>Denominator:</b></p> <ol style="list-style-type: none"> <li>1. Number of transitions of care and referrals during the EHR reporting period for which the EP or EH's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.</li> <li>2. Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.</li> </ol>	<ul style="list-style-type: none"> <li>In order to facilitate timely and meaningful referrals, we recommend that the care plan section of the summary of care document include the reason(s) for referral or transition and the results of the referral. <b>In order to support the measure, the provider needs to capture the fact that a transition is about to occur.</b></li> <li>We agree with the requirement for measure 2 that the transmitted summary of care document should cross organizational barriers. <b>However, we believe that while it is essential that the exchange of information comply with prescribed standards, we believe that requiring that the transmission occur between different vendor systems may cause unintended consequences in some regions geographic regions where a few vendors may have a dominant market share.</b></li> <li><b>The group was divided on whether to support a countable number of electronic transmissions or a percent of all transitions.</b></li> </ul> <p>NPRM pg 106-118</p>	<p>170.314(b)(1) / §170.314(b)(2)</p> <p><u>Transitions of care - incorporate summary care record.</u> Upon receipt of a summary care record formatted according to the standard adopted at § 170.205(a)(3), electronically incorporate, at a minimum, the following data elements: Patient name; gender; race; ethnicity; preferred language; date of birth; smoking status; vital signs; medications; medication allergies; problems; procedures; laboratory tests and values/results; the referring or transitioning provider's name and contact information; hospital admission and discharge dates and locations; discharge instructions; reason(s) for hospitalization; care plan, including goals and instructions; names of providers of care during hospitalization; and names and contact information of any additional known care team members beyond the referring or transitioning provider and the receiving provider.</p> <p><u>Transitions of care - create and transmit summary care record</u></p> <p>(i) Enable a user to electronically create a summary care record formatted according to the standard adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s):</p> <p>(A) Patient name; gender; date of birth; medication allergies; vital signs; laboratory tests and values/results; the referring or transitioning provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions;</p> <p>(B) <u>Race and ethnicity.</u> The standard specified in § 170.207(f);</p> <p>(C) <u>Preferred language.</u> The standard specified in § 170.207(j);</p> <p>(D) <u>Smoking status.</u> The standard specified in § 170.207(1);</p> <p>(E) <u>Problems.</u> At a minimum, the version of the standard specified in § 170.207(a)(3);</p> <p>(F) <u>Encounter diagnoses.</u> The standard specified in § 170.207(m);</p> <p>(G) <u>Procedures.</u> The standard specified in § 170.207(b)(2) or § 170.207(b)(3);</p> <p>(H) <u>Laboratory test(s).</u> At a minimum, the version of the standard specified in § 170.207(g);</p> <p>(I) <u>Laboratory value(s)/result(s).</u> The value(s)/results of the laboratory test(s) performed;</p> <p>(J) <u>Medications.</u> At a minimum, the version of the standard specified in § 170.207(h); and</p> <p>(ii) <u>Inpatient setting only.</u> Hospital admission and discharge dates and location; names of providers of care during hospitalization; discharge instructions; and reason(s) for hospitalization.</p> <p>(iii) <u>Transmit.</u> Enable a user to electronically transmit the summary care record created in paragraph (i) in accordance with:</p> <p>(A) The standards specified in § 170.202(a)(1) and (2). <u>Optional.</u> The standard specified in § 170.202(a)(3).</p>	<p>§ 170.205(a)(3) (Consolidated CDA); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); and § 170.202(a)(1) (Applicability Statement for Secure Health Transport); § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.202(a)(3) (SOAP-Based Secure Transport RTM version 1.0)</p>	
<p><b>Workgroup Comments</b></p>									

**Preamble:**

- The **purpose of this objective** is to ensure a summary of care record is provided to the receiving provider when a patient is transitioning to a new provider or has been referred to another provider while remaining under the care of the referring provider.
- This objective consolidates “exchange of key clinical information” objective by including clinical information as part of the summary of care when it is part of the patient’s electronic record.
- **Summary of care record will include the following:**
  1. Care plan fields, including goals and instructions
  2. Patient Name
  3. Team members:
    - a. Primary care practitioner
    - b. Referring or transitioning provider’s name and office contact information
    - c. Any additional known care team members beyond the referring or transitioning provider and the receiving provider
  4. Procedures
  5. Relevant past diagnoses
  6. Laboratory test results
  7. Vital signs (height, weight, blood pressure, BMI, growth charts)
  8. Smoking status
  9. Demographic information
  10. Provider must verify the following fields are not blank:
    - a. Up-to-date problem list of current and active diagnoses
    - b. Active medication list
    - c. Active medication allergy list
- **CMS is seeking comment on definition of “care plan”.** Proposes:
  1. Problem (focus of care plan)
  2. Goal (target of outcome)
  3. Instructions that the provider has given to the patient.
- **CMS is seeking comment on whether the problem list should be extended to include**, “when applicable, functional and cognitive limitations” or whether a separate list should be included for functional and cognitive limitations.
- Transport protocols – CMS is proposing to limit the numerator for this second measure to only count electronic transmissions which conform to the transport standards ONC proposes for adoption at 45 CFR 170.202. These protocols will allow every provider with certified EHR technology to have the tools in place to share critical information when patients are discharged or referred, representing a critical step forward toward interoperability.
- In order to successfully meet the 2nd measure, the provider must use Certified EHR Technology to:
  1. Create a summary record with the required information outlined above; and
  2. Transmit the summary record using the specified transport protocols
  3. Transmitting to a provider not within the same organization; and not using the same Certified EHR Technology vendor.
- **CMS is soliciting comments on the appropriateness of limiting this measure** to only those transport standards finalized by ONC.
- **CMS is soliciting comments permitting a provider to electronically transmit summary of care records to support patient transitions using an organization that follows NwHIN specifications.** This could include organizations that are part of the NwHIN Exchange as well as any organization identified through a governance mechanism ONC would establish through rulemaking.
- **CMS is soliciting comments on whether additional standards identified by ONC through an off-cycle rulemaking would further the goal of true health information exchange.**

## FACA Template for Input on MU Stage 2 Objectives and Measures

- CMS is soliciting comment on the potential concern in meeting this objective if there are an insufficient number of providers in a given geographic location that have EHR technology certified to the transport standards ONC is proposing; or because a large organization that uses one EHR vendor dominates the market thus making it difficult to exchange health information with a different EHR vendor.
- HITPC recommended different thresholds for EPs and hospitals for the electronic exchange transmission measure, with a threshold of only 25 instances for EPs. We solicit comment on whether there are significant barriers to EPs meeting the 10% threshold for measure 1.
- The HITPC recommended maintaining the 50% threshold from Stage 1. CMS believes the higher 65% threshold is appropriate because the majority of both EPs and hospitals was well above the Stage 1 threshold of 50%.

**Improve Care coordination**

**eMAR (EP and EH Core)**

	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC Stage 2	Stage 1 Final					
CORE	EP & EH	<p>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>The EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</p>	<p>The EP, EH or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).</p> <p>**Exclusion -- any EP who was not the recipient of any transitions of care during the EHR reporting period.</p>	<p>Move Objective to core.</p>	<p>Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH</p> <p>** Menu</p>	<p><b>Numerator:</b> The number of transitions of care in the denominator where medication reconciliation was performed.</p> <hr/> <p><b>Denominator:</b> Number of transitions of care during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.</p>	<p>NPRM pg 104-106</p>	<p>§170.314(b)(4)</p> <p><u>Clinical information reconciliation</u>. Enable a user to electronically reconcile the data elements that represent a patient's active medication, problem, and medication allergy list as follows. For each list type:</p> <p>(i) Electronically display the data elements from two or more sources in a manner that allows a user to view the data elements and their attributes, which must include, at a minimum, the source and last modification date.</p> <p>(ii) Enable a user to merge and remove individual data elements.</p> <p>(iii) Enable a user to review and validate the accuracy of a final set of data elements and, upon a user's confirmation, automatically update the list.</p>	
	<p><b>Workgroup Comments</b></p>								

**Preamble:**

- Using electronic exchange of information following the transition of care of a patient is the most efficient method of performing medication reconciliation. With that said, CMS also realizes it is unlikely that an automated process within the EHR will fully supplant the medication reconciliation conducted between the provider and the patient. **Therefore, the electronic exchange of information is not a requirement for medication reconciliation.**

**Engage patients and families in their care**

**VIEW & DOWNLOAD (EP – Core)**

	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition HER CERTIFICATION CRITERIA	STANDARDS	WG LEAD
	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC Stage 2	Stage 1 Final					
CORE EP	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><u>EPs must satisfy both measures in order to meet the objective:</u></p> <p>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.</p> <p>2. More than 10 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information.</p> <p>** New measure</p>	<p><b>EPs</b> More than 10% of patients and families view and have the ability to download their longitudinal health information; information is available to all patients within 24 hours of an encounter (or within 4 days after the information is available to EPs)</p> <p><b>EHs</b> More than 10% of patients and families view and have the ability to download information about a hospital admission; information is made available within 36 hours of discharge. Information available for view and download should include discharge instructions, which are available immediately upon discharge</p>	<p>Provide more than 10% of all unique patients timely electronic access to their health information subject to the EP's discretion to withhold certain information</p>	<p><b>Numerator:</b></p> <p>1. The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information online.</p> <p>2. The number of unique patients (or their authorized representatives) in the denominator who have viewed online or downloaded or transmitted to a third party the patient's health information.</p> <p><b>Denominator:</b></p> <p>1. Number of unique patients seen by the EP during the EHR reporting period.</p> <p>2. Number of unique patients seen by the EP during the EHR reporting period.</p>	<ul style="list-style-type: none"> <li>We appreciate and agree with the intent to keep the timeliness criterion simple (1 timeline). However, we believe there is value in providing the patient with prompt access to the summary of an encounter (which we define as an office visit or other contact in which an order is generated).</li> <li>We propose that a single timeliness criterion be applied, and that it be shortened to "within two business days of information becoming available to the EP."</li> <li>To what extent is the provider accountability for patient engagement?</li> <li>Should this objective be included in EH menu, if not core?</li> </ul> <p><b>NPRM pg pp. 94 -100; pp. 144 - 149</b></p>	<p>§170.314(e)(1)</p> <p><u>View, download, and transmit to 3<sup>rd</sup> party.</u></p> <p>(i) Enable a user to provide patients (and their authorized representatives) with online access to do all of the following:</p> <p>(A) <u>View</u>. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data elements:</p> <p>(1) Patient name; gender; date of birth; race; ethnicity; preferred language; smoking status; problem list; medication list; medication allergy list; procedures; vital signs; laboratory tests and values/results; provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; and care plan, including goals and instructions.</p> <p>(2) <u>Inpatient setting only</u>. Admission and discharge dates and locations; reason(s) for hospitalization; names of providers of care during hospitalization; laboratory tests and values/results (available at time of discharge); and discharge instructions for patient.</p> <p>(B) <u>Download</u>. Electronically download:</p> <p>(1) A file in human readable format that includes, at a minimum:</p> <p>(i) <u>Ambulatory setting only</u>. All of the data elements specified in paragraph (e)(1)(i)(A)(1).</p> <p>(ii) <u>Inpatient setting only</u>. All of the data elements specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2).</p> <p>(2) A summary care record formatted according to the standards adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s):</p> <p>(i) Patient name; gender; date of birth; medication allergies; vital signs; the provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions;</p> <p>(ii) <u>Race and ethnicity</u>. The standard specified in § 170.207(f);</p> <p>(iii) <u>Preferred language</u>. The standard specified in § 170.207(j);</p> <p>(iv) <u>Smoking status</u>. The standard specified in § 170.207(l);</p> <p>(v) <u>Problems</u>. At a minimum, the version of the standard specified in § 170.207(a)(3);</p> <p>(vi) <u>Encounter diagnoses</u>. The standard specified in § 170.207(m);</p> <p>(vii) <u>Procedures</u>. The standard specified in § 170.207(b)(2) or § 170.207(b)(3);</p> <p>(viii) <u>Laboratory test(s)</u>. At a minimum, the version of the standard specified in § 170.207(g);</p> <p>(ix) <u>Laboratory value(s)/result(s)</u>. The value(s)/results of the laboratory test(s) performed;</p> <p>(x) <u>Medications</u>. At a minimum, the version of the standard specified in § 170.207(h); and</p> <p>(xi) <u>Inpatient setting only</u>. The data elements specified in paragraph (e)(1)(i)(A)(2).</p> <p>(3) Images formatted according to the standard adopted at § 170.205(j).</p> <p>(C) <u>Transmit to third party</u>. Electronically transmit the summary care record created in paragraph (e)(1)(i)(B)(2) or images available to download in paragraph (e)(1)(i)(B)(3) in accordance with:</p> <p>(1) The standard specified in § 170.202(a)(1); and</p> <p>(2) The standard specified in § 170.202(a)(2).</p> <p>(ii) <u>Patient accessible log</u>.</p> <p>(A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A)-(C), the following information must be recorded and made accessible to the patient:</p> <p>(1) The electronic health information affected by the action(s);</p> <p>(2) The date and time each action occurs in accordance with the standard specified at § 170.210(g);</p> <p>(3) The action(s) that occurred; and</p> <p>(4) User identification.</p> <p>(B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.</p>	<p>§ 170.204(a) (Web Content Accessibility Guidelines (WCAG) 2.0, Level AA Conformance ); § 170.205(a)(3) (Consolidated CDA); § 170.205(j) (DICOM PS 3–2011); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); § 170.202(a)(1) (Applicability Statement for Secure Health Transport) and § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.210(g) (synchronized clocks)</p>	

**Workgroup Comments**

**VIEW & DOWNLOAD (EP – Core)**

	MEANINGFUL USE		NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure					
CORE	EP	Provide clinical summaries for patients for each office visit.	<p>Clinical summaries provided to patients within 24 hours for more than 50 % of office visits.</p> <hr/> <p><b>Numerator:</b> Number of office visits in the denominator where the patient is provided a clinical summary of their visit within 24 hours.</p> <p><b>Denominator:</b> Number of office visits conducted by the EP during the EHR reporting period.</p>	NPRM pp. 76 - 82	<p>§170.314(e)(2)</p> <p><u>Ambulatory setting only. Clinical summaries.</u> Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, the following data elements: provider's name and office contact information; date and location of visit; reason for visit; patient's name; gender; race; ethnicity; date of birth; preferred language; smoking status; vital signs and any updates; problem list and any updates; medication list and any updates; medication allergy list and any updates; immunizations and/or medications administered during the visit; procedures performed during the visit; laboratory tests and values/results, including any tests and values/results pending; clinical instructions; care plan, including goals and instructions; recommended patient decision aids (if applicable to the visit); future scheduled tests; future appointments; and referrals to other providers. If the clinical summary is provided electronically, it must be:</p> <ul style="list-style-type: none"> <li>(i) Provided in human readable format; and</li> <li>(ii) Provided in a summary care record formatted according to the standard adopted at § 170.205(a)(3) with the following data elements expressed, where applicable, according to the specified standard(s):                             <ul style="list-style-type: none"> <li>(A) Race and ethnicity. The standard specified in § 170.207(f);</li> <li>(B) Preferred language. The standard specified in § 170.207(j);</li> <li>(C) Smoking status. The standard specified in § 170.207(l);</li> <li>(D) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3);</li> <li>(E) Encounter diagnoses. The standard specified in § 170.207(m);</li> <li>(F) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3);</li> <li>(G) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g);</li> <li>(H) Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; and</li> <li>(i) Medications. At a minimum, the version of the standard specified in § 170.207(h).</li> </ul> </li> </ul>	<p>§ 170.205(a)(3) (Consolidated CDA); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); and § 170.207(h) (RxNorm February 6, 2012 Release)</p>	
	<b>Workgroup Comments</b>						

**Improve Population and Public Health****Immunizations (EP and EH Core)**

	MEANINGFUL USE		NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)	
	Proposed Stage 2 Objective	Proposed Stage 2 Measure						
CORE	EP & EH	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.			§170.314(f)(1) / §170.314(f)(2)  <u>Immunization information.</u> Enable a user to electronically record, change, and access immunization information.  <u>Transmission to immunization registries.</u> Enable a user to electronically create immunization information for electronic transmission in accordance with: (i) The standard and applicable implementation specifications specified in § 170.205(e)(3); and (ii) At a minimum, the version of the standard specified in § 170.207(i).	§ 170.205(e)(3) (HL7 2.5.1 and Implementation Guide for Immunization Messaging Release 1.3); and § 170.207(i) (CVX code set: August 15, 2011 version)	
	<b>Workgroup Comments</b>							

**Improve Population and Public Health**

**Lab Reporting (EH core)**

	MEANINGFUL USE		NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)	
	Proposed Stage 2 Objective	Proposed Stage 2 Measure						
CORE	EH	Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized.			170.314(f)(5) / §170.314(f)(6)  <u>Inpatient setting only. Reportable laboratory tests and values/results.</u> Enable a user to electronically record, change, and access reportable clinical laboratory tests and values/results.  <u>Inpatient setting only. Transmission of reportable laboratory tests and values/results.</u> Enable a user to electronically create reportable laboratory tests and values/results for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(g); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g).	§ 170.205(g) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) with errata); § 170.207(a)(3) (SNOMED CT® International Release January 2012); and § 170.207(g) (LOINC version 2.38)	
	<b>Workgroup Comments</b>							

**Improve Population and Public Health**

**Syndromic Surveillance (EH Core; EP Menu)**

	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)	
	Proposed Stage 2 Objective	Proposed Stage 2 Measure						
CORE	EH	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.			<p>§170.314(f)(3) / §170.314(f)(4)</p> <p><u>Public health surveillance.</u> Enable a user to electronically record, change, and access syndrome-based public health surveillance information.</p> <p><u>Transmission to public health agencies.</u> Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with:</p> <p>(i) <u>Ambulatory setting only.</u>                      (A) The standard specified in § 170.205(d)(2).                      (B) <u>Optional.</u> The standard (and applicable implementation specifications) specified in § 170.205(d)(3).</p> <p>(ii) <u>Inpatient setting only.</u> The standard (and applicable implementation specifications) specified in § 170.205(d)(3).</p>	§ 170.205(d)(2) (HL7 2.5.1) and § 170.205(d)(3) (HL7 2.5.1 and the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data HL7 Version 2.5.1)	
	<b>Workgroup Comments</b>							

## FACA Template for Input on MU Stage 2 Objectives and Measures

	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure					
MENU	EP	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.			<p>§170.314(f)(3) / §170.314(f)(4)</p> <p><u>Public health surveillance.</u> Enable a user to electronically record, change, and access syndrome-based public health surveillance information.</p> <p><u>Transmission to public health agencies.</u> Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with:</p> <p>(i) <u>Ambulatory setting only.</u></p> <p>(A) The standard specified in § 170.205(d)(2).</p> <p>(B) <u>Optional.</u> The standard (and applicable implementation specifications) specified in § 170.205(d)(3).</p> <p>(ii) <u>Inpatient setting only.</u> The standard (and applicable implementation specifications) specified in § 170.205(d)(3).</p>	
	<b>Workgroup Comments</b>						

**Improve Population and Public Health**

**Cancer Registry Reporting (EP Menu)**

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

**Improve Population and Public Health**

**Specialized Registry Reporting (EP Menu)**

	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure					
EP	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.			<i>General usage of Certified EHR Technology (No specific certification criteria).</i>		
<b>Workgroup Comments</b>							

## Clinical Quality Measures

	MEANINGFUL USE		NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD(s)
	Proposed Stage 2 Objective	Proposed Stage 2 Measure					
EP	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.			<i>General usage of Certified EHR Technology (No specific certification criteria).</i>		
<b>Workgroup Comments</b>							

Clinical Quality Measures

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