

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>Numerator: The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically.</p> <hr/> <p>Denominator: 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"> 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. We have some sources reporting that controlled substances should not be included in the denominator. <p>NPRM Pg 53-59</p>	§170.314(b)(3) /§170.314(a)(10)	<p><u>Electronic prescribing.</u> Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with:</p> <ul style="list-style-type: none"> (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><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)	
	<p>IE Workgroup Comments</p> <p><u>Consensus Points/Concerns/Questions:</u></p> <ul style="list-style-type: none"> The group had questions regarding the ability of EPs to meet higher thresholds with current and projected eRX infrastructure, in particular low penetration of eRX among mail order pharmacies What does “available” mean in terms of the formulary? How to handle situations where a formulary is not “available” for a particular plan? <p><u>Action items:</u></p> <ul style="list-style-type: none"> Larry Garber offered to dig up the details and provide clarifying language on what “available” formularies means. Chris Ross will ask for data from Surescripts on mail order pharmacies and formulary availability. 										

e-Rx (EP – Core; EH – Menu), continued

	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					
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	Numerator. The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically. Denominator. 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.	§170.314(b)(3) / §170.314(a)(10) <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). <u>Drug-formulary checks.</u> Enable a user to electronically check if drugs are in a formulary or preferred drug list.	§ 170.205(b)(2) (NCPDP SCRIPT version 10.6) and § 170.207(h) (RxNorm February 6, 2012 Release)	
	<p>Workgroup Comments</p> <p><u>Consensus Points/Concerns/Questions:</u></p> <ul style="list-style-type: none"> Hospitals may not have same numerator/denominator issues as with EPs (e.g. use of mail order pharmacies). Is “in house” pharmacy in the measure denominator? Jess confirmed that in house pharmacies are implicitly counted in the denominator. This may support a higher threshold. Questions on how mail order pharmacies impact denominator. See if Surescript data can include EHs as well as EPs. <p><u>Action items:</u></p> <ul style="list-style-type: none"> The group needs to revisit the “in house” pharmacies denominator issue. May impact the 10% threshold hospital e-Rx. 								

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					
EH & EP	Removed	Removed	HIE Test eliminat ed in favor of use objectiv es	Perform at least one test of the capability to exchange key clinical information among providers of care and patient authorized entities electronically					
MENU	<p>Workgroup Comments</p> <p><u>Consensus Points/Concerns/Questions:</u></p> <ul style="list-style-type: none"> • Since this is a Stage 1 measure, modifying it will only impact a small subset of 1st year provider attestations. • Modifying the objective could add more complexities to an already confusing objective that has received low rates of attestation anyway • Stage 1 has other HIE objectives (e.g. medication reconciliations, and summary of care transitions), which incorporate the goals of this objective • Stage 2 is likely to include other HIE objectives that move EPs to accomplish the goals of this objective <p><u>Decision Summary:</u> The IE Workgroup agrees with the CMS proposal to eliminate this objective.</p>								

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.
 1. 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.
 2. 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.

Perform HIE Test, continued

Preamble, continued

3. 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.
 4. 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/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& 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	<p>Numerator: 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> <p>Denominator: 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>EPs:</p> <ul style="list-style-type: none"> Agree. Okay to count individual tests. <p>EHs:</p> <ul style="list-style-type: none"> The providers depend upon hospital labs which are about 40% of the market. Speak with IE workgroup to further discuss. <p>NPRM Pg 85-88</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>	
		** Exclusion— any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.	**HITSC: Use LOINC where available	**MENU					

Workgroup Comments

Consensus Points/Concerns/Questions:

- The provider is not held accountable if the lab results cannot be sent in a structured format.
- Need to confirm definition of “structured” and alignment with LOINC and HL7 requirements in public health
- Group seems comfortable with 55% threshold only if the “hospital sends lab results” objective is included in Stage 2.

Action items

- Jess will pull distribution range data on Stage 1 for incorporating structured data into EHR.
- Review NPRM for definition of “structured”.

Incorporate Labs as Structured Data (EP and EH – Core), continued**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).
- 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 Send Lab Results (EH)**(CMS Not Proposing Objective)**

	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					
EH	Provide structured electronic laboratory results to eligible professionals. 7 ** 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"> MU WG seeks feedback from the IE workgroup since objective was originally proposed by this workgroup. NPRM pg 152-153 	§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)	
Workgroup Comments <u>Consensus Points/Concerns/Questions:</u> <ul style="list-style-type: none"> Members noted that there would be some support among hospital leadership as well as hospital labs for this requirement. The workgroup feels this objective is critical since EPs are being required to incorporate lab results as structured data, and vendors are getting certified to consume structured, codified lab results. The workgroup noted that major commercial labs already send structured, codified labs upon request. The costs of meeting this requirement have been lowered by the establishment of a minimal LOINC vocabulary of most commonly ordered tests and the S&I framework work on lab interface specification. Structured codified labs are an important factor for purposes of quality measurement and clinical decision support. <u>Summary Decision/Action Items:</u> <ul style="list-style-type: none"> The IE workgroup unanimously recommended including this objective in Stage 2. Refer issue to the Implementation WG to consider whether the S&I Framework LRI specification could be a possible standard companion to this MU objective. Need to consider whether there should be an exclusionary criteria for this objective. 								

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)

	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					
CORE 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> <p>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.</p> <p>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.</p> <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>	<p>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</p> <p>2. Record care plan goals and patient instructions in the care plan for more than 10% of all active patients</p> <p>3. Record team member, including primary care practitioner, for at least 10% of patients.</p>	Provide a summary of care record for more than 50% of all transitions and referrals of care	<p>**Menu</p> <p>Numerator:</p> <p>1. The number of transitions of care and referrals in the denominator where a summary of care record was the transferring or referring provider.</p> <p>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.</p> <p>Denominator:</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> 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. In order to support the measure, the provider needs to capture the fact that a transition is about to occur. We agree with the requirement for measure 2 that the transmitted summary of care document should cross organizational barriers. 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. The group was divided on whether to support a countable number of electronic transmissions or a percent of all transitions. <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>	

Transitions of Care and Summary Care Record (EP and EH Core), continued

Workgroup Comments

Consensus Points/Concerns/Questions:

Summary Decision/Action Items:

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.
- 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
 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.
- 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

Transitions of Care and Summary Care Record (EP and EH Core), continued

Preamble, continued

CMS Seeking Comments on:

- In order to foster standards based-exchange across organizational and vendor boundaries, we propose **and seek comment** on limiting the numerator by only permitting electronic transmissions to count towards the numerator if they are made to recipients that are -- (1) not within the organization of the transmitting provider; and (2) do not have Certified EHR Technology from the same 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.
- 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.
- 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%.
- CMS is **soliciting comments** on the appropriateness of limiting this measure to only those transport standards finalized by ONC.
- 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.
- 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.
- 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.

Improve Care coordination

Medication Reconciliation (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	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.	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). **Exclusion – any EP who was not the recipient of any transitions of care during the EHR reporting period.	Move Objective to core.	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 ** Menu	<p>Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.</p> <p>Denominator: 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>	NPRM pg 104-106	§170.314(b)(4) Clinical information reconciliation. 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: (iii) 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. (ii) Enable a user to merge and remove individual data elements. (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.		
	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>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></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	Proposed Stage 2 Objective	Proposed Stage 2 Measure	HITPC Stage 2	Stage 1 Final	NUMERATOR/DENOMINATOR	MU WG COMMENTS/NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS	WG LEAD
CORE	EP	<p>EPs must satisfy both measures in order to meet the objective:</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 (New measure).</p> <p>** Exclusions:</p> <ul style="list-style-type: none"> Any EP who neither orders nor creates any of the information listed for inclusion as part of this measure may exclude both measures. Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure. 	<p>EPs 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>EHs 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>Information should be available to the patient through online access within 4 business days of the information being available to the EP through either the receipt of final lab results or a patient encounter that updates the EP's knowledge of the patient's health.</p>	<p>Numerator:</p> <ol style="list-style-type: none"> 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. 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>Denominator:</p> <ol style="list-style-type: none"> Number of unique patients seen by the EP during the EHR reporting period. Number of unique patients seen by the EP during the EHR reporting period. 	<ul style="list-style-type: none"> 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). 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." To what extent is the provider accountability for patient engagement? Should this objective be included in EH menu, if not core? <p>NPRM pg pp. 91 -100; pp. 144 - 149</p>	<p>§170.314(e)(1)</p> <p><u>View, download, and transmit to 3rd 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> <ol style="list-style-type: none"> 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. <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>(B) <u>Download</u>. Electronically download:</p> <ol style="list-style-type: none"> A file in human readable format that includes, at a minimum: <ol style="list-style-type: none"> <u>Ambulatory setting only</u>. All of the data elements specified in paragraph (e)(1)(i)(A)(1). <u>Inpatient setting only</u>. All of the data elements specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(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): <ol style="list-style-type: none"> 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; <u>Race and ethnicity</u>. The standard specified in § 170.207(f); <u>Preferred language</u>. The standard specified in § 170.207(j); <u>Smoking status</u>. The standard specified in § 170.207(l); <u>Problems</u>. At a minimum, the version of the standard specified in § 170.207(a)(3); <u>Encounter diagnoses</u>. The standard specified in § 170.207(m); <u>Procedures</u>. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); <u>Laboratory test(s)</u>. At a minimum, the version of the standard specified in § 170.207(g); <u>Laboratory value(s)/result(s)</u>. The value(s)/results of the laboratory test(s) performed; <u>Medications</u>. At a minimum, the version of the standard specified in § 170.207(h); and <u>Inpatient setting only</u>. The data elements specified in paragraph (e)(1)(i)(A)(2). <p>(3) Images formatted according to the standard adopted at § 170.205(j).</p> <p style="text-align: right;">Continued on the next page</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>	

Engage patients and families in their care

VIEW & DOWNLOAD (EP – Core), Proposed 2014 Edition EHR Certification Criteria, continued

	MEANINGFUL USE				NUMERATOR/ DENOMINATOR	MU WG COMMENTS/ NOTES	Proposed 2014 Edition EHR CERTIFICATION CRITERIA, continued	
	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.	See previous page				Continued from the previous page, (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: (1) The standard specified in § 170.202(a)(1); and (2) The standard specified in § 170.202(a)(2). (ii) <u>Patient accessible log</u> . (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: (1) The electronic health information affected by the action(s); (2) The date and time each action occurs in accordance with the standard specified at § 170.210(g); (3) The action(s) that occurred; and (4) User identification. (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>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></p>								

Preamble:

- The goal of this objective is to allow patients easy access to their health information as soon as possible so that they can make informed decisions regarding their care or share their most recent clinical information with other health care providers and personal caregivers as they see fit. The patient must be able to access this information on demand, such as through a patient portal or personal health record (PHR).
- This objective replaces the Stage 1 core objective for EPs of "Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request" and the Stage 1 menu objective for EPs of "Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP."

Engage patients and families in their care

VIEW & DOWNLOAD (EP – Core), continued

- The **HIT Policy Committee recommended** that EPs be required to make information resulting from a patient encounter available within 24 hours instead of 4 business days. They also recommended continuing the 4 business day timeframe for updates following the receipt of new information. We believe that splitting the timeframes in this manner adds unnecessary complexity to this objective and associated measure. We believe that 4 business days remains a reasonable timeframe and limits the needs for updating. To the extent that Certified EHR Technologies enable a quicker posting time we expect that this will be workflow benefit to the providers and they will utilize this quicker time regardless of the threshold timeline in meaningful use.
- Consistent with the **recommendations of the HIT Policy Committee**, we are proposing a threshold of more than 10 percent for patients (or their authorized representatives) to view, download or transmit to a third party health information. An EP has any number of ways to make this information available online. The EP can host a patient portal, contract with a vendor to host a patient portal, connect with an online PHR or other means. As long as the patient can view, download, and transmit the information using a standard web browser and internet connection, the means is at the discretion of the EP.
- “View” defined as a patient who views their information online, downloads it from the internet or uses the internet to transmit it to a third party (how numerator is calculated).
- We note that this new measure does not focus solely on access and instead requires action by patients or their authorized representatives in order for the EP to meet it. While this is a departure from most meaningful use measures, which are dependent solely on actions taken by the EP, we believe that requiring a measurement of patient use ensures that the EP will promote the availability and active use of electronic health information by the patient or their authorized representatives. Furthermore, we believe that accountable care should extend to meaningful use objectives that encourage patient and family engagement. **We invite comment** on this new measure and whether the 10 percent threshold is too high or too low given the patient's role in achieving it.
- In order to make the information available to patients online consistent with the information provided during transitions of care, we are aligning the information required to meet this objective with the information provided in the summary of care record for each transition of care or referral (see requirements for summary of care record in “transition of care” objective above). The EP is not required to fill in all data fields if: 1) the EP is excluded from recording such information; or 2) there is no information to record.
- Within the confines of laws governing patient access to their medical records, we defer to an EP's judgment as to whether to hold information back in anticipation of an actual encounter or conversation between the EP or a member of their staff and the patient. Furthermore, for purposes of meeting this objective, an EP may withhold information from being accessible electronically if its disclosure would cause substantial harm to the patient or another individual.
- CMS is **soliciting comment** on the whether EHs and CAHs should also meet this objective as well. If made a core measure, CMS is soliciting comment on the information that must be made available as part of the objective (see sub bullets below). A hospital has any number of ways to make this information available online. The hospital can host a patient portal, contract with a vendor to host a patient portal, connect with an online PHR or other means. As long as the patient can view and download the information using a standard web browser and internet connection, the means is at the discretion of the hospital.
 - Objective: Provide patients the ability to view online, download, and transmit information about a hospital admission.
 - Admit and discharge date and location.
 - Reason for hospitalization.
 - Providers of care during hospitalization.
 - Problem list maintained by the hospital on the patient.
 - Relevant past diagnoses known by the hospital.
 - Medication list maintained by the hospital on the patient (both current admission and historical).
 - Medication allergy list maintained by the hospital on the patient (both current admission and historical).
 - Vital signs at discharge.
 - Laboratory test results (available at time of discharge).

Engage patients and families in their care

VIEW & DOWNLOAD (EP – Core), continued

- Care transition summary and plan for next provider of care (for transitions other than home).
- Discharge instructions for patient, and
- Demographics maintained by hospital (gender, race, ethnicity, date of birth, preferred language, smoking status).
- Proposed Measure:
 - 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.
 - 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.
- Exclusion: Any eligible hospital or CAH will be excluded from the second measure if it is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period is excluded from the second measure.

Engage patients and families in their care

Secure Messaging (EP – Core) (Complimentary objective to View and Download)

	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	HITP Stage 2	Stage 1 Final						
CORE	EP	Use secure electronic messaging to communicate with patients on relevant health information.	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 (New measure). **Exclusion: Any EP who has no office visits during the EHR reporting period.	Offer secure online messaging to patients: at least 25 patients have sent secure messages online	NA	<p>Numerator. The number of patients in the denominator who send a secure electronic message to the EP using the electronic messaging function of Certified EHR Technology during the EHR reporting period.</p> <hr/> <p>Denominator. Number of unique patients seen by the EP during the EHR reporting period.</p>	<ul style="list-style-type: none"> We are concerned about 10% being too high to achieve by Stage 2. We recommend lowering the threshold to 5% (which is 10% of the necessary 50% with portal access) for patient-initiated messages. The patient-initiated message could be a response to a provider message. <p>NPRM Pg 135-138</p>	<p>§170.314(e)(3)</p> <p><u>Ambulatory setting only. Secure messaging.</u> Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures:</p> <ul style="list-style-type: none"> (i) Both the patient and EHR technology are authenticated; and (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f). 	<p>§ 170.210(f) Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the Federal Information Processing Standards (FIPS) Publication 140-2.</p>	
	<p>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></p>									

Preamble:

- Electronic messaging is very inexpensive on a transactional basis and allows for communication even when the provider and patient are not available at the same moment in time; however, the use of common email services and the security measures that may be used when they are sent may not be appropriate for the exchange of protected health information. Therefore, the exchange of health information through electronic messaging requires additional security measures while maintaining its ease of use for communication.
- While e-mail with the necessary safeguards is probably the most widely used method of electronic messaging, for the purposes of meeting this objective, secure electronic messaging could also occur through functionalities of patient portals, PHRs, or other stand-alone secure messaging applications.
- We specify that the secure messages sent should contain relevant health information specific to the patient in order to meet the measure of this objective. We also note that there is an expectation that the EP would respond to electronic messages sent by the patient, although we do not specify the method of response or require the EP to document his or her response as a condition of meeting this measure.
- CMS seeks comment on whether there may be special concerns with this objective in regards to behavioral health.
- This measure requires action by patients in order for the EP to meet it, and CMS invites comment on this new measure and whether EPs believe that the 10 percent threshold is too high or too low given the patient's role in achieving it.

Improve Population and Public Health

Immunizations (EP and EH Core)

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					
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. ** Any EP, eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective: (1) the EP, eligible hospital or CAH does not administer any of the immunizations to any of the populations for which data is collected by the jurisdiction's immunization registry or immunization information system during the EHR reporting period; (2) the EP, eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of receiving electronic immunization data in the specific for Certified HER Technology at the start of their EHR reporting period; or (3) the EP, eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for Certified EHR Technology at the start of their EHR reporting period.	Attest to at least one submission of data in accordance with applicable law and practice	MENU: Perform at least one test of the capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice		We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. NPRM Pg 121-123	§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)	
<p>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></p>									

Preamble:

- CMS is proposing to require actual submission of immunization data in Stage 2, and not simply testing the capability to submit immunization data (Stage 1).
- Stage 3 is likely to enhance this functionality to permit clinicians to view the entire immunization registry/immunization information system record and support bi-directional information exchange.
- The HIT Policy Committee recommended making this a core objective for Stage 2 for EPs and hospitals, and we are adopting their recommendation.
- CMS invites comment on the challenges that moving this objective from the menu set to the core set would present for EPs and hospitals.
- Modification to Stage 1
 - CMS proposes to modify the Stage 1 objective to add "except where prohibited" because we want to encourage all EPs, eligible hospitals, and CAHs to submit electronic immunization data, even when not required by State/local law. This is because there are a few instances where some EPs, eligible hospitals, and CAHs are not authorized or cannot submit to a State/local immunization registry.

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	HITPC Stage 2	Stage 1 Final					
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. **Exclusion criteria: The eligible hospital or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required by ONC for EHR certification at the start of the EHR reporting period.	Attest to submitting to at least one organization in accordance with applicable law and practice	Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies and actual submission in accordance with applicable law and practice	We understand that it may be challenging for public health departments to be fully prepared to accept electronic submissions of all three public health objectives by 2014. If HHS needs to maintain flexibility (e.g., retain menu option), we recommend that immunization registries be the highest priority. NPRM Pg 123-124	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)	
	<p>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></p>								

Preamble:

- CMS is proposing to require actual submission of laboratory data in Stage 2, and not simply testing the capability to submit laboratory data to public health (Stage 1).
- The same rationale for the changes between this proposed objective and that of Stage 1 are discussed earlier under the immunization registry objective.

Improve Population and Public Health

Syndromic Surveillance (EH Core; EP Menu)

	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					
<p>EH CORE</p> <p>EP MENU</p>	<p>Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.</p>	<p>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>** Exclusions: Any EP, eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective:</p> <p>(1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period (we expect that the CDC will be issuing (in Spring 2013) the CDC PHIN Messaging Guide for Ambulatory Syndromic Surveillance and we relay on this guide to determine which categories of EPs would not collect such information);</p> <p>(2) the eligible hospital or CAH does not have an emergency or urgent care department;</p> <p>(3) the EP, eligible hospital, or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by ONC for EHR certification for 2014 at the start of their EHR reporting period; or</p> <p>(4) the EP, eligible hospital, or CAH operates in a jurisdiction for which no public health agency is capable of accepting the specific standards required for Certified EHR Technology at the start of their EHR reporting period.</p>	<p>Attest to at least one submission in accordance with applicable law and practice.</p>	<p>Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice</p>		<p style="text-align: right;">§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). (ii) <u>Inpatient setting only.</u> The standard (and applicable implementation specifications) specified in § 170.205(d)(3).</p> <p><u>Public health surveillance.</u> Enable a user to electronically record, change, and access syndrome-based public health surveillance information.</p>	<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)</p>		

Workgroup Comments

Consensus Points/Concerns/Questions:

Summary Decision/Action Items:

Syndromic Surveillance (EH Core; EP Menu), continued**Preamble:**

- This objective is in the Stage 2 core set for eligible hospitals and CAHs and the Stage 2 menu set for EPs.
- It is our understanding from hospitals and the CDC that many hospitals already send syndromic surveillance data.
- The CDC has issued the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data [<http://www.cdc.gov/ehrmeaningfuluse/Syndromic.html>] as cited in the ONC proposed rule on EHR standards and certification. However, per the CDC and a 2010 survey completed by the Association of State and Territorial Health Officials (ASTHO), very few public health agencies are currently accepting syndromic surveillance data from ambulatory providers, and there is no corresponding implementation guide at the time of this proposed rule.
- CDC is working with the syndromic surveillance community to develop a new implementation guide for ambulatory reporting of syndromic surveillance information, which it expects will be available in the fall of 2012.
- CMS anticipate that Stage 3 might include syndromic surveillance for EPs in the core set if the collection of ambulatory syndromic data becomes a more standard public health practice in the interim.
- The HIT Policy Committee recommended making this a core objective for Stage 2 for EPs and hospitals. However, we are not proposing to adopt their recommendation for EPs. CMS **invites comment** on the proposal to leave syndromic surveillance in the menu set for EPs, while requiring it in the core set for eligible hospitals and CAHs.

Improve Population and Public Health

Cancer Registry Reporting (EP Menu)

MENU	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					
EP	Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.	<p>Measure: Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period.</p> <p>** Exclusions: Any EP that meets at least 1 of the following criteria may be excluded from this objective:</p> <p>(1) The EP does not diagnose or directly treat cancer; or</p> <p>(2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required under Stage 2 at the beginning of their EHR reporting period.</p>	NA	NA		NPRM pp 132-134	<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> <p>(i) The standard (and applicable implementation specifications) specified in § 170.205(i); and</p> <p>(ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g).</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>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></p>									

Preamble:

- In the past most cancers were diagnosed and/or treated in a hospital setting and data were primarily collected from this source. However, medical practice is changing rapidly and an increasing number of cancer cases are never seen in a hospital.
- Data collection from EPs presents new challenges since the infrastructure for reporting is less mature than it is in hospitals. Certified EHR technology can address this barrier by identifying reportable cancer cases and treatments to the EP and facilitating electronic reporting either automatically or upon verification by the EP.
- We include "except where prohibited and in accordance with applicable law" because we want to encourage all EPs to submit cancer cases, even in rare cases where they are not required to by State/local law. Legislation requiring cancer reporting by EPs exists in 49 States with some variation in specific requirements, per the 2010 Council of State and Territorial Epidemiologists (CSTE) State Reportable Conditions Assessment (SRCA). "In accordance with applicable law and practice" reflects that some public health jurisdictions may have unique requirements for reporting, and that some may not currently accept electronic provider reports.

Improve Population and Public Health

Specialized Registry Reporting (EP Menu)

	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					
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.	<p>Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.</p> <p>**Exclusions: Any EP that meets at least 1 of the following criteria may be excluded from this objective:</p> <p>(1) The EP does not diagnose or directly treat any disease associated with a specialized registry; or</p> <p>(2) the EP operates in a jurisdiction for which no registry is capable of receiving electronic specific case information in the specific standards required under Stage 2 at the beginning of their EHR reporting period.</p>	NA	NA		<p>We are in agreement with the objective. Need to consider whether sufficient standards are available to support the interfaces between EHRs and commercial registries. Panelists at our hearing also expressed concern about the proprietary nature of some registries, which affects the costs to participate, and in some cases places contractual restrictions on use of data and ability to participate in other registries.</p> <p>NPRM pp 134-135</p>	<p><i>General usage of Certified EHR Technology (No specific certification criteria).</i></p>		
<p>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></p>									

Preamble:

- We believe that reporting to registries is an integral part of improving population and public health. The benefits of this reporting are not limited to cancer reporting. We include cancer registry reporting as a separate objective because it is more mature in its development than other registry types, not because other reporting is excluded from meaningful use. We have included this objective to provide more flexibility in the menu objectives that EPs can choose.

Clinical Quality 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					
EP&EH	NA	NA					<p>§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)	
<p>Workgroup Comments</p> <p>Consensus Points/Concerns/Questions:</p> <p><u>Summary Decision/Action Items:</u></p>									