ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions
		Improving quality, safety, and reducing health disparities		
SGRP 101	**EP Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **EH Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **EP/EH Measure:** More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	**Objective:** Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. CPOE for medications includes DDI checking for "never" combinations as determined by an externally vetted list. **Measure:** More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE **Certification Criteria:** EHR must be able to consume an externally supplied list of "never" DDIs, using RxNorm and NDF-RT standards along with a TBD DDI reactions value set. **Certification Only for EPs** • EHRs must have the ability to identify abnormal test results and track when results are available or not completed by a certain time. • EHRs must record date/time test results are reviewed and by whom. • EHR must have the ability to transmit lab orders using the lab order and results Interface guidelines produced by the S&I Framework Initiative.	Seeking externally maintained list of DDIs with higher predictive value	
SGRP 130	New	**Objective:** Use computerized provider order entry for referrals/transition of care orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order. **Measure:** More than 20% of referrals/transition of care orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded.		
SGRP 103	**EP/EH Objective:** Generate and transmit permissible prescriptions electronically (eRx) **Measure:** More than 50% of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT. **EH MENU Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx). **EH MENU Measure:** More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.	**EP Objective:** Generate and transmit permissible prescriptions electronically (eRx) **EP Measure:** More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary (reviewed for generic substitutions) transmitted electronically using Certified EHR Technology. **EH Objective:** Generate and transmit permissible discharge prescriptions electronically (eRx). **EH Measure:** More than 30% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.	Advanced medication reconciliation to check for formulary compliance. **Medication formulary checking:** • If Rx is formulary-compliant, transmit to pharmacy. • If Rx is not formulary compliant, prescriber presented with alternatives (if available through formulary database) or provided a structured prior-authorization form to complete before Rx transmitted. Capability for automatic approval of prior-auth should be available.	How to include formulary checking into EHR and connection to formulary sources (e.g., PBMs)?

SGRP 104	**EP Objective:** Record the following demographics
	• Preferred language
	• Sex
	• Race
	• Ethnicity
	• Date of birth
	
	EH Objective: Record the following demographics
	• Preferred language
	• Sex
	• Race
	• Ethnicity
	• Date of birth
	• Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.
	
	Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.
		Retire prior demographics objective because it is topped out (achieved 80% threshold).
		
		Certification criteria:
		• Occupation and industry codes
		• Sexual orientation, gender identity (optional fields)
		• Disability status
		  • Differentiate between patient reported & medically determined
		  • Need to continue standards work
				Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.

SGRP 105	Consolidated in summary of care objective - Maintain an up-to-date problem list of current and active diagnoses.	**Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate problem list. **Certification criteria only:** Use of lab test results, medications, and vital signs (BP, ht, wt, BMI), to support clinicians' maintenance of up-to-date accurate problem lists. Systems provide decision support about additions, edits, and deletions for clinicians' review and action. For example, if diabetes is not on the problem list but hypoglycemic medications are on the medication list: the EHR system might ask the provider whether diabetes should be on the problem list. It would not automatically add anything to the problem list without professional action.	Patient input to reconciliation of problems	The implementation of these criteria will assist in achieving the CDC's goal of using EHR technology features to identify patients meeting criteria for hypertension who are not yet diagnosed and managed for the disorder. How to incorporate into certification criteria for pilot testing? The intent is that EHR vendors would provide functionality to help maintain functionality for active problem lists, not that they supply the actual knowledge for the rules.
SGRP 106	Consolidated with summary of care - Maintain active medication list	**Certification criteria only:** EHR systems should provide functionality to help maintain up-to-date, accurate medication list. **Certification criteria only:** Use of problems and lab test results to support clinicians' maintenance of up-to-date accurate medication lists. Systems provide decision support about additions, edits, and deletions for clinicians' review. For example, an antibiotic (not for acne) has been on the medication list for over say a month, the EHR system might ask the provider whether the medication is a chronic medication. The system will not make any changes without professional approval.	**Certification criteria:** Use other EHR data such as medications filled or dispensed, or free text searching for medications to support maintenance of up-to-date and accurate medication lists.	How to incorporate into certification criteria for pilot testing? The intent is that EHR vendors would provide functionality to help maintain functionality for active medication lists, not that they supply the actual knowledge for the rules.
SGRP 107	Consolidated with summary of care - Maintain active medication allergy list	**Certification criteria only:** EHR systems should provide functionality to code medication allergies and link to related drug family, and code related reaction.	Contraindications that could include adverse reactions and procedural intolerance. **Certification criteria:** Explore greater specificity for food-drug interactions.	The intent is that EHR vendors would provide functionality to help maintain functionality for active medication allergy lists, not that they supply the actual knowledge for the rules.

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions
SGRP 108	**Objective:** Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI. **Measure:** More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0018.		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.
SGRP 109	**EP/EH Objective:** Record smoking status for patients 13 years old or older **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.	Retire measure because it is topped out (achieved 80% threshold). Track progress to improve outcomes via CQM NQF 0028.		Do commenters agree with retiring the measure, or should we continue this objective? Continuing the measure would mean an additional number of objectives that providers will need to attest to.
SGRP 112	**EH MENU Objective:** Record whether a patient 65 years old or older has an advance directive. **EH MENU Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	Ensure standards support in CDA by 2016. **EP MENU/EH Core Objective:** Record whether a patient 65 years old or older has an advance directive. **EP MENU/EH Core Measure:** More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.		
SGRP 113	**EP/EH Objective:** Use clinical decision support to improve performance on high-priority health conditions. **Measure:** 1. Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. 2. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	**Objective:** Use clinical decision support to improve performance on high priority health conditions. **Measure:** 1. Implement 15 clinical decision support interventions or guidance related to five or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period. The 15 CDS interventions should include one or more interventions in each of the following areas, as applicable to the EP's specialty: • Preventative care (including immunizations) • Chronic disease management (e.g., diabetes, hypertension, coronary artery disease) • Appropriateness of lab and radiology orders • Advanced medication-related decision support* (e.g., renal drug dosing). 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. **Certification criteria only:** 1. Ability to track CDS triggers and how the provider responded ** 2. Ability to flag preference-sensitive conditions, and provide decision support materials for patients. 3. Capability to check for a maximum dose in addition to a weight based calculation. 4. Use of structured SIG standards 5. Ability for EHRs to consume CDS interventions from central repositories (e.g., rules for drug-drug interactions, rules for reporting diseases for public health departments, preference-sensitive care lists). * This will assist in achieving the CDC's goal of improvements in hypertension control. **Kuperman, GJ. (2007)Medication-related clinical decision support in computerized provider order entry systems a review. Journal of the American Medical Informatics Association: JAMIA, 14(1):29-40.	**Certification criteria: Explore greater specificity for food-drug interactions** **Procedure/Surgery/lab/radiology/test prior authorization v.A:** for those procedures / surgeries / lab / radiology / test with clear and objective prior authorization requirements and a structured data prior authorization form is available, clinician fill out the prior authorization form using structured data fields and prior authorization can be granted electronically and in real-time by the payor. **Procedure/Surgery/lab/radiology/test prior authorization v.B:** for those procedures / surgeries / lab / radiology / test, for which prior authorization is nonstandardized and is highly individualized, a standardized form is created that collects from the clinician text fields answering an agreed upon set of medical necessity questions, standardized form is sent electronically to insurer for review, insurer responds with Approval/Denial (with rationale if denied) using a standardized format text document back to clinician with either approval and/or denial with rationale.	Ability for EHRs to consume CDS interventions from central repositories The EHR would query (via web services) available databases to identify "trigger event" conditions (e.g., case reporting criteria, drug-drug interactions, potentially relevant trials) based on the patient's health condition, diagnoses, location, and other basic facts. The HITPC is interested in experience from payors that may contribute to CDS.
SGRP 114	**EP/EH Objective:** Incorporate clinical lab-test results into Certified EHR Technology as structured data. **Measure:** More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23 during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data.	**Objective:** Incorporate clinical lab-test results into EHR as structured data. **Measure:** More than 80% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.		
SGRP 115	**EP CORE Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. **EP CORE Measure:** Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.	**EP Objective:** Generate lists of patients for multiple specific conditions and present near real-time (vs. retrospective reporting) patient-oriented dashboards to use for quality improvement, reduction of disparities, research, or outreach reports. Dashboards are incorporated into the EHR's clinical workflow for the care coordinator or the provider. It is actionable and not a retrospective report.		
SGRP 116	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder per patient preference. **Measure:** More than 10% of all unique patients who have had two or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.	**EP Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care. **EP Measure:** More than 20% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference. **Exclusion:** Specialists may be excluded for prevention reminders (could be more condition specific).		

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions
SGRP 117	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR). **Measure:** More than 10 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.	**EH Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR). **Measure:** 1) More than 30% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR. 2) Mismatches (situations in which a provider dispenses a medication and/or dosing that is not intended) are tracked for use in quality improvement.		
SGRP 118	**MENU Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **MENU Measure:** More than 10 percent of all tests whose result is one or more images ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology.	**CORE Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through Certified EHR Technology. **CORE Measure:** More than 10 percent of all tests whose result is an image (including ECGs) ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through Certified EHR Technology.		What barriers could be encountered in moving this to core?
SGRP 119	**MENU Objective:** Record patient family health history as structured data. **MENU Measure:** More than 20 percent of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.	**CORE Objective:** Record high priority family history data. **CORE Measure:** Record high priority family history in 40% of patients seen during reporting period. **Certification criteria:** Make sure that every appropriate CDS intervention can take into account family history for outreach (need to move that functionality along as part of preventative outreach).		
SGRP 120	**EP/EH MENU Objective:** Record electronic notes in patient records. **EP MENU Measure:** Enter at least one electronic progress note created, edited and signed by an eligible professional for more than 30 percent of unique patient office visits. Notes must be textsearchable. Non-searchable scanned notes do not qualify but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure. **EP MENU Measure:** Enter at least one electronic progress note created, edited, and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable, scanned notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with text notes under this measure.	Record electronic notes in patient records for more than 30% of office visits within four calendar days.		
SGRP 121	**EH MENU Objective:** Provide structured electronic lab results to ambulatory providers **EH MENU Measure:** Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of electronic lab orders received.	**EH CORE Objective:** Provide structured electronic lab results to eligible professionals. **EH CORE Measure:** Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 80% of electronic lab orders received.		
SGRP 122	New	**Objective:** The EHR is able to assist with follow-up on test results **Measure:** 10% of test results, including those which were not completed are acknowledged within 3 days **Certification Criteria:** • EHRs must have the ability to identify abnormal test results and to to notify the ordering providers when results are available or not completed by a certain time. • EHRs must record date/time test results are reviewed and by whom		
		Engage patients and families in their care		
SGRP 204A	**EP Objective:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP. **EP Measure:** 1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. 2. More than 5 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. **EH Objective:** Provide patients the ability to view online, download, and transmit information about a hospital admission. 1. More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge. 2. More than 5 percent of all patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period.	• EPs should make info available within 24 hours if generated during course of visit. • For labs or other types of info not generated within course of visit, it is made available to pts within four business days of info becoming available to EPs. • Potential to increase both thresholds (% offer and % use) based on experience in Stage 2. **Note:** Depending on experience in Stage 2, CMS may want to give credit to some providers (e.g. specialists) for view/download/transmit where the patient has requested that they prefer info to be sent to a location they specify (such as another provider portal or PHR), rather than only making available information on the provider's portal. **MENU item:** Automated Transmit*: (builds on "Automated Blue Button Project"): Provide 50% of patients the ability to designate to whom and when (i.e. pre-set automated & on-demand) a summary of care document is sent to patientdesignated recipient** (for example, a one-time request to send information from specialist to primary care, or a standing request to always send an updated care summary when certain events arise, such as a change in medication or the completion of new tests or procedures). *Subject to the same conditions as view, download, transmit. **Before issuing final recommendations in May 2013, HITPC will also review the result of Automated Blue Button pilots, in addition to considering public comments received.	**Building on Automated Transmit:** 1a. Create the ability for providers to review patient-transmitted information and accept updates into EHR. 1b. Related certification criteria: Standards needed for provider directories in order to facilitate more automated transmissions per patients' designations.	Explore the readiness of vendors and the pros and cons of including certification for the following in this objective: • Images (actual images, not just reports) • Radiation dosing information from tests involving radiation exposure in a structured field so that patients can view the amount of radiation they have been exposed to Add a MENU item to enable patients to view provider progress notes (re: Open Notes: Doctors and Patients Signing On. Ann Intern Med. 20 July 2010;153(2):121-125) What is the best way to ensure that individuals access their health information through the view/download/transmit capability are provided with transparency and education about the benefits and potential risks of downloading health information, consistent with the HIT Policy Committee's recommendations of August 16, 2011? Is certification an appropriate vehicle for ensuring such transparency is part of CEHRT? If so, what would the certification requirement look like? If not, what are other mechanisms for ensuring transparency to consumers using the view/download/transmit capabilities? In its recent final rule, and in response to comments, ONC adopted Level A conformance as the standard for the accessibility web content in accordance with the Web Content Accessibility Guidelines (WCAG). ONC indicated per commenters suggestions that WCAG Level AA conformance would be considered for the next edition of certification criteria. Given that all EHR technologies certified to the view, download, transmit to a 3rd party certification criterion will have met Level A, how difficult would it

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SGRP 204B	New	**MENU:** Provide 10% of patients with the ability to submit patient-generated health information to improve performance on high priority health conditions, and/or to improve patient engagement in care (e.g. patient experience, pre-visit information, patient created health goals, shared decision making, advance directives, etc.). This could be accomplished through semi-structured questionnaires, and EPs and EHs would choose information that is most relevant for their patients and/or related to high priority health conditions they elect to focus on. Based upon feedback from HITSC this should be a MENU item in order to create the essential functionality in certified EHRs.		Readiness of standards to include medical device data from the home? What information would providers consider most valuable to receive electronically from patients? What information do patients think is most important to share electronically with providers? How can the HITECH incentive program support allowing doctors and patients to mutually agree on patient-generated data flows that meet their needs, and should the functionality to collect those data be part of EHR certification? Please provide published evidence or organizational experience to support suggestions.
SGRP 204D	New	**Objective:** Provide patients with the ability to request an amendment to their record online (e.g., offer corrections, additions, or updates to the record)through a patient portal in an obvious manner.		
SGRP 205	**EP Objective:** Provide clinical summaries for patients for each office visit. **EP Measure:** Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits.	The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.		What specific information should be included in the after visit summary to facilitate the goal of patients having concise and clear access to info about their most recent health and care, and understand what they can do next, as well as when to call the doctor if certain symptoms/events arise?
SGRP 206	**EP/EH Objective:** Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient. **EP CORE Measure:** Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period. **EH CORE Measure:** More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology.	**Additional language support:** For the top 5 non-English languages spoken nationally, provide 80% of patient-specific education materials in at least one of those languages based on EP's or EH's local population, where publically available.		
SGRP 207	**EP Objective:** Use secure electronic messaging to communicate with patients on relevant health information. **EP Measure:** A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.	**Measure:** More than 10% of patients use secure electronic messaging to communicate with EPs* * Assess readiness of raising threshold to 30% based on experience in Stage 2.	Create capacity for electronic episodes of care (telemetry devices, etc) and to do e-referrals and e-consults.	*What would be an appropriate increase in threshold based upon evidence and experience?
SGRP 208	Not included separately (in reminder objective)	**EP and EH Measure:** Record communication preferences for 20% of patients, based on how (e.g., the medium) patients would like to receive information for certain purposes (including appointment reminders, reminders for follow up and preventive care, referrals, after visit summaries and test results).		
SGRP 209	New	**Certification Rule Only:** Capability for EHR to query research enrollment systems to identify available clinical trials. No use requirements until future stages.		The goal of this objective is to facilitate identification of relevant clinical trials for an individual patient, subject to patient interest. The EHR would query available clinical trial registries and identify potentially relevant trials based on patient's health condition, location, and other basic facts. Ultimately, the EHR would not be able to determine final eligibility for the trial; it would only be able to identify possibly relevant trial opportunities.
		Improve Care Coordination		
SGRP 302	**EP/EH CORE Objective:** The EP/EH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. **EP/EH CORE Measure:** The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	**EP / EH / CAH Objective:** The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform reconciliation for: - medications - medication allergies - problems **EP / EH / CAH Measure:** The EP, EH, or CAH performs reconciliation for medications for more than 50% of transitions of care, and it performs reconciliation for medication allergies, and problems for more than 10% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23). **SC&C Recommendation:** Standards work needs to be done to adapt and further develop existing standards to define the nature of reactions for allergies (i.e. severity).	Reconciliation of contraindications (any medical reason for not performing a particular therapy; any condition, clinical symptom, or circumstance indicating that the use of an otherwise advisable intervention in some particular line of treatment is improper, undesirable, or inappropriate). **SC&C Recommendation:** Standards work needs to be done to support the valuing and coding of contraindications.	Feasibility to add additional fields for reconciliation e.g. social history? Is anyone currently doing reconciliation outside of meds, med allergies, and problems and what has the experience been?

ID #	Stage 2 Final Rule	Stage 3 Recommendations	Proposed for Future Stage	Questions
SGRP 303	**EP/EH CORE Objective:** The EP/EH/CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides summary care record for each transition of care or referral. **CORE Measure:** 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. 2. The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. 3. An EP, eligible hospital or CAH must satisfy one of the two following criteria: (A) conducts one or more successful electronic exchanges of a summary of care document, as part ofwhich is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii) (B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was developed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or (C) conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.	**EP/ EH / CAH Objective:** EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care. Provide a summary of care record for each site transition or referral when transition or referral occurs with available information. Must include the following four for transitions of site of care, and the first for referrals (with the others as clinically relevant): 1. Concise narrative in support of care transitions (free text that captures current care synopsis and expectations for transitions and / or referral) 2. Setting-specific goals 3. Instructions for care during transition and for 48 hours afterwards 4. Care team members, including primary care provider and caregiver name, role and contact info (using DECAF). **Measure:** The EP, eligible hospital, or CAH that site transitions or refers their patient to another setting of care (including home) or provider of care provides a summary of care record for 65% of transitions of care and referrals (and at least 30% electronically). **Certification Criteria:** EHR is able to set aside a concise narrative section in the summary of care document that allows the provider to prioritize clinically relevant information such as reason for transition and/or referral. **Certification Criteria:** Inclusion of data sets being defined by S&I Longitudinal Coordination of Care WG, which and are expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: 1) Consultation Request (Referral to a consultant or the ED) 2) Transfer of Care (Permanent or long-term transfer to a different facility, different care team, or Home Health Agency		*What would be an appropriate increase in the electronic threshold based upon evidence and experience?
SGRP 304	New		**EP/ EH / CAH Objective:** EP/ EH/CAH who transitions their patient to another site of care or refers their patient to another provider of care. For each transition of site of care, provide the care plan information, including the following elements as applicable: • Medical diagnoses and stages • Functional status, including ADLs • Relevant social and financial information (free text) • Relevant environmental factors impacting patient's health (free text) • Most likely course of illness or condition, in broad terms (free text) • Cross-setting care team member list, including the primary contact from each active provider setting, including primary care, relevant specialists, and caregiver • The patient's long-term goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals • Specific advance care plan (POLST) and the care setting in which it was executed For each referral, provide a care plan if one exists. **Measure:** The EP, eligible hospital, or CAH that transitions or refers their patient to another site of care or provider of care provides the electronic care plan information for 10% of transitions of care to receiving provider and patient/caregiver. **Certification Criteria:** Develop standards for a shared care plan, as being defined by S&I Longitudinal Coordination of	How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allows for and encourages team based care, and includes the patient and their nonprofessional caregivers? Think through these priority use cases: 1. Patient going home from an acute care hospital admission 2. Patient in nursing home going to ED for emergency assessment and returning to nursing home 3. Patient seeing multiple ambulatory specialists needing care coordination with primary care 4. Patient going home from either hospital and / or nursing some and receiving home health services What are the most essential data elements to ensuring safe, effective care transitions and ongoing care management? How might sharing key data elements actually improve the communication? Consider health concerns, patient goals, expected outcomes, interventions, including advance orders, and care team members. What data strategy and terminology are required such what the data populated by venue specific EHRs can be exchanged. How might existing terminologies be reconciled? What are the requirements (legal, workflow, other considerations) for patients and their identified team to participate in a shared care plan? Is it useful to consider role-based access as a technical method of implementing who will have access to and be able to contribute to the care plan? How will such access be managed?
SGRP 305	New	**EP / EH / CAH Objective:** EP/EH/CAH to whom a patient is referred acknowledges receipt of external information and provides referral results to the requesting provider, thereby beginning to close the loop. **Measure:** For patients referred during an EHR reporting period, referral results generated from the EHR, 50% are returned to the requestor and 10% of those are returned electronically. **Certification Criteria:** Include data set defined by S&I Longitudinal Coordination of Care WG and expected to complete HL7 balloting for inclusion in the C-CDA by Summer 2013: Shared Care Encounter Summary (Consultation Summary, Return from the ED to the referring facility, Office Visit). **Certification criteria:** Include standards for referral requests that require authorizations (or pre-certifications) for procedure, surgery, lab, radiology, test orders. *This builds upon the clinical quality measure (CQM) in stage 2 for closing the referral loop,CMS50v1 (NQF TBD)	Continue working to close the loop with an acknowledgement of order receipt and tracking for completion.	The HITPC would appreciate comments on the return of test results to the referring provider.
SGRP 127	New	New	Ability to maintain an up-to-date interdisciplinary problem list inclusive of versioning in support of collaborative care.	

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SGRP 125	New	New	**Medication reconciliation:** Create ability to accept data feed from PBM (Retrieve external medication fill history for medication adherence monitoring). Vendors need an approach for identifying important signals such as: identify data that patient is not taking a drug, patient is taking two kinds of the same drug (including detection of abuse) or multiple drugs that overlap. Certification criteria: EHR technology supports streamlined access to prescription drug monitoring programs (PDMP)data. For example: Via a hyperlink or single sign-on for accessing the PDMP data Via automated integration into the patient's medication history Leveraging things like single sign on or functionality that could enable the linkage between PDMPs and prescribers and EDs?	
SGRP 308	New	**EH Objective:** The EH/CAH will send electronic notification of a significant healthcare event in a timely manner to key members of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required. **EH Measure:** For 10% of patients with a significant healthcare event (arrival at an Emergency Department (ED), admission to a hospital, discharge from an ED or hospital, or death), EH/CAH will send an electronic notification to at least one key member of the patient's care team, such as the primary care provider, referring provider or care coordinator, with the patient's consent if required, within 2 hours of when the event occurs.		
		Improve population and public health		
SGRP 401A	**EP/EH Objective:** Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice. **EP/EH Measure:** Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.	**EP/ EH Objective:** Capability to receive a patient's immunization history supplied by an immunization registry or immunization information system, and to enable healthcare professionals to use structured historical immunization events in the clinical workflow, except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of timely and successful electronic receipt by the Certified EHR Technology of vaccine history (including null results) from an immunization registry or immunization information system for 30% of patients who received immunizations from the EP/EH during the entire EHR reporting period. **Exclusion:** EPs and EHs that administer no immunizations or jurisdictions where immunization registries/immunization information systems cannot provide electronic immunization histories. **Certification criteria:** EHR is able to receive and present a standard set of structured, externally generated, immunization history and capture the act and date of review within the EP/EH practice.	**EP/EH Objective:** Add submission of vaccine contraindication(s) and reason(s) for substance refusal to the current objective of successful ongoing immunization data submission to registry or immunization information systems.	
SGRP 401B	New	**EP/EH Objective:** Capability to receive, generate or access appropriate age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy. **Measure:** Implement an immunization recommendation system that: 1) establishes baseline recommendations (e.g., Advisory Committee on Immunization Practices), and 2) allows for local/state variations. For 20% of patients receiving an immunization, the EP/EH practice receives the recommendation before giving an immunization. **Exclusion:** EPs and EHs that administer no immunizations. **Certification criteria:** EHR uses a standard (e.g., national, state and/or local) rule set, plus patient age, gender, and prior immunization history to recommend administration of immunizations; capture the act and date/time of recommendation review.		
SGRP 402A	**EH Objective:** Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice. **Measure:** Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period.	**EH Objective (unchanged):** No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system.		

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SGRP 402B	New	New	**EP Objective:** Capability to use externally accessed or received knowledge (e.g. reporting criteria) to determine when a case report should be reported and then submit the initial report to a public health agency, except where prohibited, and in accordance with applicable law and practice. **Measure:** Attestation of submission of standardized initial case reports to public health agencies on 10% of all reportable disease or conditions during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** The EHR uses external data to prompt the end-user when criteria are met for case reporting. The date and time of prompt is available for audit. Standardized (e.g., consolidated CDA) case reports are submitted to the state/local jurisdiction and the data/time of submission is available for audit. Could similar standards be used as those for clinical trials (SGRP 209)?	
SGRP 403	**EP MENU Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice. **EH Objective:** Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice. **EP/EH Measure**: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.	No change from current requirements.		
SGRP 404	**EP only MENU Objective:** Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure:** Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period	**EH/EP Objective:** Capability to electronically participate and send standardized (i.e. data elements and transport mechanisms), commonly formatted reports to a mandated jurisdictional registry (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to either local/state health departments, except where prohibited, and in accordance with applicable law and practice. This objective is in addition to prior requirements for submission to an immunization registry. **Measure:** Documentation of ongoing successful electronic transmission of standardized reports from the Certified EHR Technology to the jurisdictional registry. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to build and then send a standardized report (e.g., standard message format) to an external mandated registry, maintain an audit of those reports, and track total number of reports sent. **Exclusion:** where local or state health departments have no mandated registries or are incapable of receiving these standardized reports.		
SGRP 405	**EP only MENU Objective:** Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice. **EP only MENU Measure**: Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.	**EP Objective:** Capability to electronically submit standardized reports to an additional registry beyond any prior meaningful use requirements (e.g., immunizations, cancer, early hearing detection and intervention, and/or children with special needs). Registry examples include hypertension, diabetes, body mass index, devices, and/or other diagnoses/conditions) from the Certified EHR to a jurisdictional, professional or other aggregating resources (e.g., HIE, ACO), except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of successful ongoing electronic transmission of standardized (e.g., consolidated CDA) reports from the Certified EHR Technology to a jurisdictional, professional or other aggregating resource. Attestation of submission for at least 10% of all patients who meet registry inclusion criteria during the entire EHR reporting period as authorized, and in accordance with applicable state/local law and practice. **Certification criteria:** EHR is able to build and send a standardized message report format to an external registry, maintain an audit of those reports, and track total number of reports sent.		
SGRP 407	New	**EH Objective:** Capability to electronically send standardized Healthcare Associated Infection (HAI) reports to the National Healthcare Safety Network (NHSN) using a common format from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. **Measure:** Documentation of successful electronic transmission of standardized healthcare acquired infection reports to the NHSN from the Certified EHR Technology. Total numeric count of HAI in the hospital and attestation of Certified EHR electronic submission of at least 10% of all reports during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. **Certification criteria:** EHR is able to sending a standard HAI message to NHSN, maintain an audit and track total number of reports sent.		

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SGRP 408	New	New	EH/EP Objective: Capability to electronically send adverse event reports (e.g., vaccines, devices, EHR, drugs or biologics) to the Federal Drug Administration (FDA) and/or Centers for Disease Control and Prevention (CDC) from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. Measure: Attestation of successful electronic transmission of standardized adverse event reports to the FDA/CDC from the Certified EHR Technology. Total numeric count (null is acceptable) of adverse event reports from the EH/EP submitted electronically during the entire EHR reporting period as authorized, and in accordance with applicable State law and practice. Certification criteria: EHR is able to build and send a standardized adverse event report message to FDA/CDC and maintain an audit of those reports sent to track number of reports sent (Common Format).	
IEWG 101	New	**MENU objective:** For patients transitioned without a care summary, an individual in the practice should query an outside entity. The intent of this objective is to recognize providers who are proactively querying. **Certification criteria:** The EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a health information exchange, or an entity on the NwHIN Exchange, for example. This query may consist of three transactions: a) Patient query based on demographics and other available identifiers, as well as the requestor and purpose of request. b) Query for a document list based for an identified patient. c) Request a specific set of documents from the returned document list. When receiving inbound patient query, the EHR must be able to: a) Tell the querying system whether patient authorization is required to retrieve the patient's records and where to obtain the authorization language*. (E.g. if authorization is already on file at the record-holding institution it may not be required). b) At the direction of the record-holding institution, respond with a list of the patient's releasable documents based on patient's authorization. c) At the direction of the record-holding institution, release specific documents with patient's authorization. The EHR initiating the query must be able to query an outside entity* for the authorization language to be presented to and signed by the patient or her proxy in order to retrieve the patient's records. Upon the patient signing the form, the EHR must be able to send, based on the preference of the recordholding institution, either: 1. a copy of the signed form to the entity requesting it 2. an electronic notification attesting to the collection of the patient's signature *Note: The authorization text may come from the record-holding EHR system, or, at the direction of the patient or the record-holding EHR, could be located in a directory separate from the record-holding EHR system, and so a query for authorization language would need to be directable to the correct endpoint.		Should the measure for this MENU objective be for a number of patients (e.g.25 patients were queried) or a percentage (10% of patients are queried)? What is the best way to identify patients when querying for their information?
IEWG 102	New	**Certification criteria:** The EHR must be able to query a Provider Directory external to the EHR to obtain entity-level addressing information (e.g. push or pull addresses).		Are there sufficiently mature standards in place to support this criteria? What implementation of these standards are in place and what has the experience been?
IEWG 103	New	**Certification criteria:** Enable a user to electronically create a set of export summaries for all patients in EHR technology formatted according to the standard adopted at § 170.205(a)(3) that represents the most current clinical information about each patient and includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): (i) Encounter diagnoses. The standard specified in § 170.207(i) or, at a minimum, the version of the standard at § 170.207(a)(3); (ii) Immunizations. The standard specified in § 170.207(e)(2); (iii) Cognitive status; (iv) Functional status; and (v) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. (vi) Inpatient setting only. Discharge instructions.		What criteria should be added to the next phase of EHR Certification to further facilitate healthcare providers' ability to switch from using one EHR to another vendor's EHR?