The implementation of these criteria will assist in achieving the Certification criteria only:

Questions

EP/EH Objective:

Consolidated with summary of care - Maintain active medication list

Objectives:

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 credentialed 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.

EP Objective:

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 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.

Certification criteria only: EHR systems should provide functionality to help maintain up-to-date, accurate problem list.

EP Objective:

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.

EP Objective:

Generate and transmit permissible prescriptions electronically (eRx)

EP 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.

EP Objective:

Certification Only for EPs

Certification Only for EPs

EP Objective:

Certification criteria:

How to incorporate into certification criteria for pilot testing?

Certification criteria:

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.

Certification criteria:

How to incorporate into certification criteria for pilot testing?

Certification criteria:

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.

Certification criteria:

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.

Certification criteria:

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.

Certification criteria:

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.
EP Objective: Record whether a patient 65 years old or older has an advance directive.

Measure: More than 55 percent of all clinical lab tests results ordered by the EP or by authorized providers 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.

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.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.


EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure: 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. At least 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.

1. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-drug allergy interaction checks for the entire EHR reporting period.

2. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-drug allergy interaction checks for the entire EHR reporting period.

3. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-drug allergy interaction checks for the entire EHR reporting period.

4. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-drug allergy interaction checks for the entire EHR reporting period.

5. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-drug allergy interaction checks for the entire EHR reporting period.

EP MENU/EH Core Objective: Use clinical decision support to improve performance on high-priority health conditions.


EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure: 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:

- Prevention 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)
- The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug-drug allergy interaction checks for the entire EHR reporting period.

EP MENU/EH Core Objective: Use clinical decision support to improve performance on high-priority health conditions.

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.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

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 smoking status recorded as structured data.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure: More than 50 percent of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have blood pressure (age 3 and over) and height/length and weight (for all ages) recorded as structured data.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure: More than 50 percent of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have smoking status recorded as structured data.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure: More than 50 percent of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have smoking status recorded as structured data.

EP MENU/EH Core Objective: Use clinical decision support to improve performance on high-priority health conditions.

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.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

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 smoking status recorded as structured data.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

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 smoking status recorded as structured data.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

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 smoking status recorded as structured data.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

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 smoking status recorded as structured data.

EP CORE Objective: Use clinical decision support to improve performance on high-priority health conditions.

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 smoking status recorded as structured data.
**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:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period have a record available to the ordering provider for more than 30 percent of electronic lab orders received.

**Certification Criteria:**
- Provide structured electronic lab results to ambulatory providers.
- Provide structured electronic lab results to the ordering provider for more than 30 percent of electronic lab orders received.

**Certification Timeframe:**
- Timeframe to be set by ONC.

**Core Objective:** Provide structured electronic lab results to eligible providers.

**Core Measure:** Hospital labs send structured electronic lab results to the ordering provider for more than 80 percent of electronic lab orders received.

**Core Certification:**
- Certification is required for core.
- Certification is not required for core.

**Possible Outcomes:**
- Patients have access to their health information.
- Patients do not have access to their health information.

**Potential Risks:**
- Patients may not be able to access their health information.
- Patients may be able to access their health information.

**Engaging Patients and Families in Their Care:**
- Patients feel empowered and involved in their care.
- Patients feel disconnected from their care.

**Building on Automated Solutions:**
- Create the ability for providers to view patient-generated information and accept updates into EHR.
- Related certification criteria: Standards needed for provider directions in order to facilitate more automated transmissions per patients’ designations.

**Questions:**
- What barriers could be encountered in moving this to core?
- How do the requirements in Stage 3 differ from Stage 2?
- How canCertified EHR Technology ensure transparency?
- How will providers ensure patient access to their health information?
- How will certification ensure patient access to their health information?

**Proposed for Future Stage:**
- Will the requirements change in future stages?
- Will the threshold for compliance increase in future stages?

**Chapter 2: Final Rule**
- Stage 2 Final Rule.
- Stage 3 Recommendations.

**MENU Objective:** Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

**Menu Measure:** More than 30 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.

**Certification Criteria:**
- Certification is required for menu.
- Certification is not required for menu.

**Possible Outcomes:**
- Patients have access to their health information.
- Patients do not have access to their health information.

**Potential Risks:**
- Patients may not be able to access their health information.
- Patients may be able to access their health information.

**Engaging Patients and Families in Their Care:**
- Patients feel empowered and involved in their care.
- Patients feel disconnected from their care.

**Building on Automated Solutions:**
- Create the ability for providers to view patient-generated information and accept updates into EHR.
- Related certification criteria: Standards needed for provider directions in order to facilitate more automated transmissions per patients’ designations.

**Questions:**
- What barriers could be encountered in moving this to core?
- How do the requirements in Stage 3 differ from Stage 2?
- How canCertified EHR Technology ensure transparency?
- How will providers ensure patient access to their health information?
- How will certification ensure patient access to their health information?

**Proposed for Future Stage:**
- Will the requirements change in future stages?
- Will the threshold for compliance increase in future stages?

**Chapter 2: Final Rule**
- Stage 2 Final Rule.
- Stage 3 Recommendations.
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<th>Proposed for Future Stage</th>
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<tr>
<td>SGRP 203B New</td>
<td><strong>MENU</strong>: 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.</td>
<td></td>
<td>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 providers think is most important to share electronically with providers? How can the HITSC incentive program support allowing doctors and patients to mutually agree on patient generated data flow 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.</td>
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<tr>
<td>SGRP 204D New</td>
<td>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.</td>
<td>Create capacity for electronic episodes of care (telemetry devices, etc) and to do e-referrals and e-consults.</td>
<td>What would be an appropriate increase in threshold based upon evidence and experience?</td>
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<tr>
<td>SGRP 205 <strong>EP Objective</strong>: Provide clinical summaries for patients for each office visit. <strong>EP Measure</strong>: Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits.</td>
<td>The clinical summary should be pertinent to the office visit, not just an abstract from the medical record.</td>
<td></td>
<td><em>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?</em></td>
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<td>SGRP 206 <strong>EP/EH Objective</strong>: Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient. <strong>EP CORE Measure</strong>: 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. <strong>EH CORE Measure</strong>: 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 Health Technology.</td>
<td>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 EPs or EH’s local population, where publicly available.</td>
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</table>
**SGRP 303**

**EP/EH/CAH 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 such transitions 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 percent of such transitions and referrals.

**Measure:** 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 each transition of care or referral when transition or referral occurs with available information.

**Recommendation:**
- Provide a summary of care record for each site transition or referral when transition or referral occurs with available information.

**Proposed for Future Rule:**
- What would be an appropriate increase in the electronic threshold based on evidence and experience?

**SGRP 304**

**EP/EH/CAH Objective:** 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 electronic exchange of a summary of care document, as part which is counted in “measure 2” for EP’s the measure at §495.43(b)(4)(2).

**Certification Criteria:**
- EP/EH/CAH must satisfy one of the two following criteria:
  1. Conducts one or more successful electronic exchanges of a summary of care document, as part which is counted in “measure 2” for EP’s the measure at §495.43(b)(4)(2).
  2. Transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals.

**SGRP 305**

**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.

**Measure:**
- For each transition of care, provide the care plan information, including the following elements as applicable:
  - Medical diagnoses and stages
  - Functional status, including ADLs
  - 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 caregivers
  - The patient's long-term plan goals 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

**Certification Criteria:**
- For each referral, provide a care plan if one exists.
- The EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care.
- 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:
  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)

**SGRP 306**

**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.

**Measure:**
- 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:
  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)

**Proposed for Future Rule:**
- How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allow for and encourages team-based care, and includes the patient and their nonprofessional caregivers?

**SGRP 307**

**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.

**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:
  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)

**Proposed for Future Rule:**
- How might we advance the concept of an electronic shared care planning and collaboration tool that crosses care settings and providers, allow for and encourages team-based care, and includes the patient and their nonprofessional caregivers?

**SGRP 308**

**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.

**Measure:**
- For each transition of care, provide the care plan information, including the following elements as applicable:
  - Medical diagnoses and stages
  - Functional status, including ADLs
  - 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 caregivers
  - The patient’s long-term plan goals 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

**Certification Criteria:**
- For each referral, provide a care plan if one exists.
- The EP/EH/CAH who transitions their patient to another setting of care or refers their patient to another provider of care.
- 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:
  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)
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<tr>
<td>SGRP 125</td>
<td>New</td>
<td></td>
<td></td>
<td>Medication reconciliation: Create ability to accept data feeds from PBMs 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 (remove): EHR technology supports streamlined access to prescription drug monitoring programs (PDMP) data. For example: - Via hypertext 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 facilitates the linkage between PDMPs and prescribers and EDs.</td>
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<tr>
<td>SGRP 308</td>
<td>New</td>
<td>EH Objective: The EHR/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 90% 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), EHR/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.</td>
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<tr>
<td>SGRP 401A</td>
<td>New</td>
<td>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 to Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.</td>
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<tr>
<td>SGRP 401B</td>
<td>New</td>
<td>EP/EH Objective: Capability to receive, generate or access age-, gender- and immunization history-based recommendations (including immunization events from immunization registries or immunization information systems) as applicable by local or state policy. EP/EH 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: EP/EH 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.</td>
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<tr>
<td>SGRP 402A</td>
<td>New</td>
<td>EH Objective: Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice. EH Objective (unchanged): No change from current requirement for electronic lab reporting which generally is sent from the laboratory information system. EH Objective: Improvement in population and public health. EH Measure: Successful ongoing submission of electronic reportable laboratory results to Certified EHR Technology to public health agencies for the entire EHR reporting period.</td>
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<tr>
<td>SGRP 402B</td>
<td>New</td>
<td>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.</td>
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<tr>
<td>402B</td>
<td>New</td>
<td>EP Objective: Capability to electronically submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.</td>
<td>EP Objective: Capability to electronically submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.</td>
<td>EP Objective: Capability to electronically submit electronic syndromic surveillance data to public health agencies, 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 (i.e., consolidated CDA) case reports are submitted to the state/local jurisdiction and the date/time of submission is available for audit. Could similar standards be used in those for clinical trials (SGRP 209)?</td>
</tr>
<tr>
<td>403</td>
<td>New</td>
<td>EP Objective: Capability to identify and report specific cases to a specialized 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 Certified EHR Technology to a specialized registry for the entire EHR reporting period.</td>
<td>EH/EP Objective: Capability to electronically participate and send standardized (i.e., data elements and transport mechanisms) community formatted reports to a jurisdictional registry (e.g., cancer, children with special needs, and/or early hearing detection and intervention) from Certified EHR to other 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. Certification criteria: 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 send a 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.</td>
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<tr>
<td>404</td>
<td>New</td>
<td>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 Certified EHR Technology to a jurisdictional registry for the entire EHR reporting period.</td>
<td>EP Objective: Capability to electronically participate and send standardized (i.e., data elements and transport mechanisms), commonly formatted, consolidated CDA reports from the Certified EHR, except where prohibited, and in accordance with applicable law and practice. Measure: Certification criteria: Attestation of submission of standardized initial case 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. 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. Exclusion: Where local or state health departments have no mandated registries or are incapable of receiving these standardized reports.</td>
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<tr>
<td>405</td>
<td>New</td>
<td>EP Objective: Capability to electronically submit 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: Certification criteria: Attestation of submission 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/local law and practice. Certification criteria: EHR is able to build and send a standardized HAI message to NHSN, maintain an audit and track total number of reports sent.</td>
<td>EH/EP 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: Certification criteria: Attestation of submission 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/local law and practice. Certification criteria: EHR is able to build and send a standardized HAI message to NHSN, maintain an audit and track total number of reports sent.</td>
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<tr>
<td>SGRP 408</td>
<td>New</td>
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<td>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 from the FDA/CDC via 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: EH/EP 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).</td>
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<td>IEWG 101</td>
<td>New</td>
<td>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 requester and purpose of request. b) Query for a document list based on the 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: 1. A copy of the signed form to the entity requesting it 2. An electronic certification 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 directed to the correct endpoint.</td>
<td>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?</td>
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<td>IEWG 102</td>
<td>New</td>
<td>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).</td>
<td>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?</td>
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<td>IEWG 103</td>
<td>New</td>
<td>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) Inpatient setting only.</td>
<td>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?</td>
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