Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
1	Protect Patient Health Information	Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.	Conduct or review a security risk analysis (SRA) in accordance with the requirements under the Health Insurance Portability and Accountability Act (HIPAA) Rules, including addressing the security (including encryption) of data stored in CEHRT, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.	None	>*When do you need to conduct a SRA?* Upon installation of CEHRT or upon upgrade to a new Edition of CEHRT. In subsequent years, at a minimum of once per EHR reporting period, review the SRA and the administrative, physical, and technical safeguards implemented, and make updates to its analysis as necessary. The initial SRA and testing may occur prior to the beginning of the first EHR reporting period using that certified EHR technology. >*Available Resources:* OCR's broad scale guidance on SRA requirements; ONC's guidance and a SRA tool; the SRA Tool is a self-contained application available at no cost to the provider. >*Audit Logs:* The proposed rule includes an auditable events and tamper-resistance criterion which is known as an "audit log" which can be a valuable resource in ensuring the protection of ePHI. CMS strongly recommend physicians ensure this function is enabled at all times when the CEHRT is in use.
2	Electronic Prescribing (eRx)	**EPs, EHs, and CAHs**: Generate and transmit permissible prescriptions electronically and EHs and CAHs would need to	**EP Measure:** More than **80%** of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using	**EP:** Any EP who: (1) writes fewer than 100 permissible prescriptions during the EHR reporting period; or (2) does not have a pharmacy within their	>CMS has proposed that providers who practice in a state where controlled substances may be electronically prescribed may include these for meeting MU. >They also propose to continue to define "prescription" as the authorization by a provider to dispense a drug that would

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
		generate and transmit permissible discharge prescriptions electronically (eRx).	CEHRT. (increase from Stage 2's 50% threshold) **EH Measure:** More than **25%** of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions only) are queried for a drug formulary and transmitted electronically using CEHRT. (increase from Stage 2's 10% threshold)	organization and there are no pharmacies that accept electronic prescriptions within10 miles of the EP's practice location at the start of the EHR reporting period. **EH:** Any EH or CAH that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of their EHR reporting period.	not be dispensed without such authorization. This includes authorization for refills of previously authorized drugs. >OTC medicines will still not be allowed to be counted but CMS seeks comment on this exclusion.
3	Clinical Decision Support (CDS)	Implement CDS interventions focused on improving performance on high-priority health conditions.	**EPs, EHs, & CAHs must meet both measures** **Measure 1**: Implement **5** CDS interventions related to 4 or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent 4 CQMs related to an EP, EH, or CAH's	**Measure 1:** None **Measure 2:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.	>Interventions must be presented in the CEHRT to a health care professional who can exercise clinical judgment about the CDS before action is taken on the patient. Providers should implement the CDS intervention at a relevant point in clinical workflows when the intervention can influence clinical decision making before diagnostic or treatment action is taken in response to the intervention. CDS is not intended to replace clinician judgment. >Examples of CDS – see p. 16749

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Measure 2**: Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.		>In alignment with the HHS National Quality Strategy goals, providers are encouraged to implement CDS related to quality measurement and improvement goals on the following areas: • Preventive care. • Chronic condition management. • Heart disease and hypertension. • Appropriateness of diagnostic orders or procedures such as labs, diagnostic imaging, genetic testing, pharmacogenetic and pharmacogenomic test result support or other diagnostic testing. • Advanced medication-related decision support, to include pharmacogenetic and pharmacogenomic test result support.
4	Computer-ized Provider Order Entry (CPOE)	Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any **licensed** healthcare professional, **credentialed** medical assistant, or a medical staff member **credentialed** to and performing the equivalent	**Must meet all three measures** **Measure 1**: More than **80%** of medication orders created by the EP or authorized providers of the EH's or CAH's inpatient or emergency department (ED) during the EHR reporting period are recorded using computerized provider order entry; (an increase from Stage 2's	Any EP who writes fewer than 100 (medication, laboratory, or diagnostic imaging, individually) orders during the EHR reporting period would be excluded from the respective measure.	>CMS is proposing to expand the objective to include diagnostic imaging, which is a broader category including other imaging tests such as ultrasound, magnetic resonance, and computed tomography in addition to traditional radiology. >Orders entered by any licensed healthcare professional or credentialed medical assistant would count toward this objective. A credentialed medical assistant may enter orders if they are credentialed to perform the duties of a medical assistant by a credentialing body other than the employer. If a staff member of the eligible provider is

#	Objective Name	Objective Description	Measures	Exclusions	Notes
		duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines.	60% threshold) **Measure 2**: More than **60%** of laboratory orders created by the EP or authorized providers of the EH's or CAH's inpatient or ED during the EHR reporting period are recorded using computerized provider order entry; (an increase from Stage 2's 30% threshold) and **Measure 3**: More than **60%** of diagnostic imaging orders created by the EP or authorized providers of the EH's or CAH's inpatient or ED during the EHR reporting period are recorded using CPOE. (an increase from Stage 2's 30% threshold)		appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, orders entered by that staff member would be included in this objective. Medical staff whose organizational or job title, or the title of their credential, is other than medical assistant may enter orders if these staff are credentialed to perform the equivalent duties of a credentialed medical assistant by a credentialing body other than their employer and perform such duties as part of their organizational or job title. CMS defers to the provider's discretion to determine the appropriateness of the credentialing of staff to ensure that any staff entering orders have the clinical training and knowledge required to enter orders for CPOE. This determination must be made by the EP or representative of the EH or CAH based on: • Organizational workflows; • Appropriate credentialing of the staff member by an organization other than the employing organization; • Analysis of duties performed by the staff member in question; and • Compliance with all applicable federal, state, and local laws and

Stage 3 Meaningful Use - Proposed Objectives and Measures

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					professional guidelines. >If the individual entering the orders is not the licensed healthcare professional, the order must be entered with the direct supervision or active engagement of a licensed healthcare professional. >Execution of CPOE represents a significant impact on patient safety and therefore a layperson is not qualified to perform these tasks. >CPOE function should be used the first time the order becomes part of the patient's medical record and before any action can be taken on the order. >For this objective, “protocol” or “standing” orders may be excluded.
5	Patient Electronic Access to Health Information	EPs, EHs, or CAHs provide access for patients to view online, download, and transmit their health information, or retrieve their health information through an API, within 24 hours of its availability.	**Must meet both measures** **Measure 1**: For more than **80%** of all unique patients seen by the EP or discharged from the EH or CAH inpatient or ED (an increase from Stage 2’s 50% threshold): <u>Option 1:</u> The patient (or patient-authorized representative) is provided access to view online, download, and transmit their	**Measure 1 & 2 Exclusions:** • If there are no office visits for the EP during the reporting period. • If the EP conducts 50% or more of their patient encounters in a county without 50% or more of its housing units with 4 megabits per second (Mbps) broadband availability	>Patients must be able to access this information on demand, such as through a patient portal or API and have everything necessary to access the information (including any necessary instructions) even if they opt out. >This objective should not require the provider to make extraordinary efforts to assist patients in use or access of the information, but the provider must inform patients of these options, and provide sufficient guidance so that all patients could leverage this access. >All three functionalities (view, download, and transmit) or an API must be present and accessible to meet the measure. The functionality must support a patient's right to have his or her

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			health information within **24 hours** of its availability to the provider; **or** <u>Option 2:</u> The patient (or patient-authorized representative) is provided access to an ONC-certified API that can be used by third-party applications or devices to provide patients (or patient-authorized representatives) access to their health information, within **24 hours** of its availability to the provider. (For both options this is a decrease in the patient wait time for the availability of information from Stage 2's 4 business days to within 24 hours.) **Measure 2**: The EP, EH or CAH must use clinically relevant information from CEHRT to identify	according to the Federal Communications Commission (FCC) on first day of reporting period. • -If the EH or CAH is located in county without 50% or more of its housing units with 4Mbps broadband availability according to FCC on first day of reporting period.	protected health information sent directly to a third party designated by the patient consistent with the provision of access requirements of HIPAA privacy requirements. >Provider is only required to provide access to the information through these means. The patient is not required to take action in order for the provider to meet this objective. >Provider would not be required to separately purchase or implement a "patient portal," nor would they need to implement or purchase a separate mechanism to provide the secure download and transmit functions for their patients because the API would provide the patient the ability to download or transmit their health information to a third party. >If the provider elects to implement an API, the provider would only need to fully enable the API functionality, provide patients with detailed instructions on how to authenticate, and provide supplemental information on available applications which leverage the API. >Certification criteria would require vendors to make available this capability.

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			patient-specific educational resources and provide electronic access to those materials to more than **35%** of unique patients seen by the EP or discharged from the EH or CAH inpatient or ED during the EHR reporting period. (an increase from Stage 2's 10% threshold)		
6	Coordination of Care through Patient Engagement	Use communications functions of certified EHR technology to engage with patients or their authorized representatives about the patient's care.	**Must attest to the numerator and denominator for all three measures but only required to meet the threshold for 2 out of the 3 measures.** **Measure 1:** During the EHR reporting period, more than **25%** (an increase from Stage 2's 5% threshold) of all unique patients seen by the EP or discharged from the EH or CAH inpatient or ED actively engage with the electronic health record made accessible by the	**All Measures & Options:** • Any EP who has no office visits during the EHR reporting period may exclude from the measure. • Any EP, EH or CAH that conducts 50 % or more of his or her patient encounters in a county that does not have 50 % or more of its housing units with 4Mbps broadband availability according to the latest information	>For measure 1, for the API option, CMS proposes providers must attest that they have enabled an API and that at least one application which leverages the API is available to patients (or the patient-authorized representatives) to retrieve health information from the provider's certified EHR. >For measure 2, "communicate" means when a provider sends a message to a patient (or the patient's authorized representatives) or when a patient (or the patient's authorized representatives) sends a message to the provider. In patient-to-provider communication, the provider must respond to the patient (or the patient's authorized representatives). >For measure 2, CMS proposes to include in the measure numerator situations where providers communicate with other care team members using the

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			provider. An EP, EH or CAH may meet the measure by **either:** Option 1: More than **25%** of all unique patients (or patient-authorized representatives) seen by the EP or discharged from the EH or CAH inpatient or ED during the EHR reporting period view, download or transmit to a third party their health information; **or** Option 2: More than **25%** of all unique patients (or patient-authorized representatives) seen by the EP or discharged from the EH or CAH inpatient or ED during the EHR reporting period access their health information through the use of an ONC-certified API that can be used by third-party applications or devices.	available from the FCC on the first day of the EHR reporting period may exclude from the measure.	secure messaging function of certified EHR technology, and the patient is engaged in the message and has the ability to be an active participant in the conversation between care providers. >For secure messages CMS says they must contain relevant health information specific to the patient in order to meet the measure of this objective. They assert providers are the best judge of what health information should be considered relevant in this context. They propose messaging content may include, but is not limited to, questions about test results, problems, and medications; suggestions for follow-up care or preventative screenings; confirmations of diagnosis and care plan goals; and information regarding patient progress. However, they note that messages with content exclusively relating to billing questions, appointment scheduling, or other administrative subjects should not be included in the numerator. >For measure 3, the use of the term "clinical" means for purposes of this measure only, that a non-clinical setting shall be defined as a setting with any provider who is not an EP, EH or CAH as defined for the Medicare and Medicaid EHR Incentive Programs. This may include, but is not limited to, health and care-related data from care providers such as nutritionists, physical

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			Measure 2: For more than **35%** of all unique patients seen by the EP or discharged from the EH or CAH inpatient or ED during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient's authorized representatives), or in response to a secure message sent by the patient (or the patient's authorized representative). **Measure 3:** Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for more than **15%** of all unique patients seen by the EP or discharged by the EH or CAH during the EHR reporting period.		therapists, occupational therapists, psychologists, and home health care providers as well as data obtained from patients themselves. >The sources of data vary and may include mobile applications for tracking health and nutrition, home health devices with tracking capabilities such as scales and blood pressure monitors, wearable devices such as activity trackers or heart monitors, patient reported outcome data, and other methods of input for patient and non-clinical setting generated health data. CMS emphasizes that these represent several examples of the data types that could be covered under this measure. The scope of data covered by this measure is broad but it may not include data related to billing, payment, or other insurance information. >CMS proposed that patient engagement may include patient-centered communication between and among providers facilitated by authorized representatives of the patient and of the EP, EH or CAH.

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
7	Health Information Exchange (HIE)	The EP, EH, or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of certified EHR technology.	**Must attest to the numerator and denominator for all three measures but only required to meet the threshold for 2 out of the 3 measures.** **Measure 1:** For more than **50%** of transitions of care and referrals, the EP, EH or CAH that transitions or refers their patient to another setting of care or provider of care: (1) creates a summary of care record using CEHRT; **and** (2) electronically exchanges the summary of care record. **Measure 2:** For more than **40%** of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, EH or CAH incorporates into	**All Measures:** • An EP, EH, or CAH neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period. • An EP, EH, or CAH for whom their total of transitions or referrals received and patient encounters in which provider has never before encountered patient, is fewer than 100 during the reporting period. • Any EP, EH, or CAH that conducts 50% or more of their patient encounters in a county without 50% or more of its housing units with 4Mbps broadband availability	>For the first measure, data must be captured in a structured format with the EHR to generate a summary of care document. >All summary of care documents must contain the most recent and up-to-date information on all elements. >In the event that there are no current diagnoses for a patient, the patient is not currently taking any medications, or the patient has no known medication allergies; the EP, EH, or CAH must record or document within the required fields that there are no problems, no medications, or no medication allergies recorded for the patient to satisfy the measure of this objective. >For summary of care documents at transitions of care, while a current problem list must always be included, the provider can use his or her judgment in deciding which items historically present on the problem list, medical history list (if it exists in the CEHRT), or surgical history list are relevant given the clinical circumstances. >The provider has the discretion to define the relevant clinical notes or relevant laboratory results to send as part of the summary of care record, providers must be able to provide all clinical notes or laboratory results through an electronic transmission of a summary of care document if that level

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			the patient's EHR an electronic summary of care document from a source other than the provider's EHR system. **Measure 3:** For more than **80%** of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, EH, or CAH performs a clinical information reconciliation. The provider would perform reconciliations for the following three clinical information sets: • Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. • Medication allergy. Review of the patient's known allergic medications.	according to FCC on the first day of the reporting period.	of detail is subsequently requested by a provider receiving a transition of care or referral or the patient is transitioning to another setting of care. >For both the first and second measures, CMS proposed that a provider may use a wide range of health IT exchange to receive or send an electronic summary of care document but must use their certified EHR technology to create the summary of care document. >They also proposed that the receipt of the summary of care document (CCDA) may be passive (provider is sent the CCDA and incorporates it) or active (provider requests a direct transfer of the CCDA or provider queries an HIE for the CCDA). > This objective would allow the inclusion of transition of care and referrals in which the recipient provider may already have access to the medical record maintained in the referring provider's CEHRT, as long as the providers have different billing identities (such as a different National Provider Identifiers (NPI) or hospital CMS Certification Numbers (CCN)) in the EHR Incentive Program. >For the transition or referral to be included in the numerator, if the receiving provider has access to the CEHRT of the initiating provider of the

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			• Current Problem list. Review of the patient's current and active diagnoses.		transition or referral, just accessing the patient's health information would not count towards meeting the objective. If the initiating provider sent a summary of care document (CCD), the transition can be included in the denominator and the numerator, as long as the transition is counted consistently across the organization. >The rule proposes that providers would need to actively seek, as a recipient of a transition or referral, an electronic summary of care document in a patient's record when a patient is referred to them or otherwise transferred to them for care. >Clinical information reconciliation is defined as the process of creating the most accurate patient-specific information in one or more of the specified categories by using the clinical information reconciliation capability of their CEHRT which would compare the "local" information to external/incoming information that is being incorporated into the CEHRT from any external source.
8	Public Health and Clinical Data Registry Reporting	The EP, EH, or CAH is in *active engagement* with a PHA or CDR to submit electronic public health data in a meaningful way using	**EP must choose from measures 1 through 5 and successfully attest to any combination of 3 measures** **EHs and CAHs must**	**All 6 Measures:** Any EP, EH, or CAH meeting one or more of the following criteria may be excluded from the respective measure: (1) operates in a	>CMS proposed the removal of the prior "ongoing submission" requirement and replacing it with an "active engagement" requirement. >For purposes of meeting this new objective, "active engagement" means that the provider is in the process of moving towards sending "production

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
		certified EHR technology, except where prohibited, and in accordance with applicable law and practice.	**choose from measures 1 through 6, and would be required to successfully attest to any combination of 4 measures**. The measures are as shown in **Table 5 (below).** As noted, measures four and five for Public Health Registry Reporting and Clinical Data Registry (CDR) Reporting may be counted more than once if more than one Public Health Registry or CDR is available. **Measure 1 – Immunization Registry Reporting:** The EP, EH, or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization	jurisdiction for which no PHA/CDR is capable of receiving the respective data at the start of the EHR reporting period; or (2) operates in a jurisdiction where no PHA/CDR has declared readiness to receive the respective data at the start of the EHR reporting period. **Additional Exclusions Per Measure-** **Measure 1:** Any EP, EH, or CAH that does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period. **Exclusion for EPs**	data" to a PHA or CDR, or— is sending production data to a PHA or CDR. CMS notes that the term "production data" refers to data generated through clinical processes involving patient care, and it is here used to distinguish between this data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers. > It is proposed that "active engagement" may be demonstrated by any of the following options: *Active Engagement Option 1-* Completed Registration to Submit Data: The EP, EH, or CAH would register to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration would be completed within 60 days after the start of the EHR reporting period; and the EP, EH, and CAH would be awaiting an invitation from the PHA or CDA to begin testing and validation. *Active Engagement Option 2-* Testing and Validation: The EP, EH, or CAH would be in the process of testing and validation of the electronic submission of data and would need to respond to requests from PHA or where applicable CDR within 30 days. Failure to respond twice within reporting period would result in provider not meeting measure. *Active Engagement Option 3-*

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			information system (IIS). **Measure 2 – Syndromic Surveillance Reporting**: The EP, EH, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting for EPs, or an emergency or urgent care department for EH's and CAHs. **Measure 3 - Case Reporting**: The EP, EH, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. **Measure 4 - Public Health Registry Reporting**: The EP, EH, or CAH is in active engagement with a public health agency to	**for Measure 2:** Any EP that does not treat or diagnose or directly treat any disease or condition associated with a syndromic surveillance system in their jurisdiction. **Exclusion for EHs/CAHs for Measure 2:** Any EH or CAH that does not have an emergency or urgent care department. **Measure 3:** Any EP, EH, or CAH that does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period. **Measure 4:** Any EP, EH, or CAH that does not diagnose or directly treat any disease or condition associated with a	Production: The EP, EH, or CAH would have completed testing and validation of the electronic submission and would be electronically submitting production data to the PHA or CDR. >CMS also proposed to provide support to providers seeking to meet the requirements of this objective by creating a centralized repository of national, state, and local PHA and CDR readiness. They expect that the centralized repository will include readiness updates for PHAs and CDRs at the state, local, and national level. >For EPs, CMS proposed an exclusion for a measure does not count toward the total of three measures. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than three, the EP can meet the objective by meeting all of the remaining measures available to them and claiming the applicable exclusions. >Measure 1: CMS proposed that to successfully meet the requirements of this measure, bidirectional data exchange between the provider's certified EHR technology and the immunization registry/IIS is <u>required</u>. > Measure 3: it is proposed that a reportable condition would be defined by state, territorial and local PHAs to monitor disease trends and support management of outbreaks.

Stage 3 Meaningful Use - Proposed Objectives and Measures

#	Objective Name	Objective Description	Measures	Exclusions	Notes
			submit data to public health registries. **Measure 5 – Clinical Data Registry Reporting:** The EP, EH, or CAH is in active engagement to submit data to a CDR. **Measure 6 – Electronic Reportable Laboratory Result Reporting:** The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results. This measure is available to EH's and CAHs only.	public health registry in their jurisdiction during the EHR reporting period. **Measure 5:** Any EP, EH, or CAH that does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the EHR reporting period. **Measure 6:** Any EH or CAH that does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period.	>Measure 4: CMS proposed that a public health registry is defined as a registry that is administered by, or on behalf of, a local, state, territorial, or national PHA and which collects data for public health purposes. They propose to keep immunization registry reporting separate from the public health registry reporting measure, as it was in Stage 2. >Measure 5: CMS proposed to further differentiate between clinical data registries and public health registries as follows: for the purposes of meaningful use, "public health registries" are those administered by, or on behalf of, a local, state, territorial, or national public health agencies; and "clinical data registries" are administered by, or on behalf of, other non-public health agency entities, which can be used to monitor health care quality and resource use, and records information about health status of patients and health care they receive over varying periods of time. >Any EP, EH, or CAH may report to more than one public health registry to meet the total number of required measures for the objective. For example, if a provider meets this measure through reporting to both the National Hospital Care Survey and the National Healthcare Safety Network registry, the provider could get credit for meeting two measures.

Stage 3 Meaningful Use - Proposed Objectives and Measures

TABLE 4: MEASURES FOR OBJECTIVE 8: PUBLIC HEALTH AND CLINICAL DATA REGISTRY REPORTING OBJECTIVE

Measure	Maximum times measure can count towards objective for EP	Maximum times measure can count towards objective for EH or CAH
1 – Immunization Registry Reporting	1	1
2 – Syndromic Surveillance Reporting	1	1
3 – Case Reporting	1	1
4 – Public Health Registry Reporting*	3	4
5 – Clinical Data Registry Reporting**	3	4
6 – Electronic Reportable Laboratory Results	N/A	1

*EPs, EHs, and CAHs may choose to report to more than one public health registry to meet the number of measures required to meet the objective. For example, if a provider meets this measure through reporting to both the National Hospital Care Survey and the National Healthcare Safety Network registry, the provider could get credit for meeting two measures.

**EPs, eligible hospitals, and CAHs may choose to report to more than one CDR to meet the number of measures required to meet the objective.