Final Rule Meaningful Use Objectives and Measures –Stage 1

Adapted from Table 2 and Table 3: Stage 1 Meaningful Use Objectives and Associated Measures Sorted by Core and Menu Set from CMS Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule 7/28/10
and the ONC Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology Final Rule 7/28/10

CORE SET – Eligible Professionals, Eligible Hospital, or CAH required to satisfy all core set of objectives

Health Outcomes Policy Priority	Meaningful Use Category	EPs	Hospitals	Measure Brief	Change from Proposed NPRM	POS 23	Unique Patients Denominator	Actions in a Certified EHR Denominator	Yes/No Attestation	Stage 1 Objectives: Eligible Professionals	Stage 1 Objectives: Hospitals	Stage 1 Measures	Certification Criteria: NRPM Certification Language	Certification Criteria: FINAL RULE - Certification Language
Improving quality, safety, efficiency, and reducing health disparities	CPOE - Computerized provider order entry	●	●	30%	↑ % and ↓ order type	■		✣		Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) **have at least one medication order entered using CPOE**	**Interim Final Rule Text:** Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: (1) Medications; (2) Laboratory; (3) Radiology/imaging; and (4) Provider referrals.	**Final Rule Text: §170.304(a)** Computerized provider order entry. Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types: **(1) Medications; (2) Laboratory; and (3) Radiology/imaging.**
	Implement drug-drug and drug allergy interaction checks	●	●	Enabled	↔				✓	Implement drug-drug and drug-allergy interaction checks	Implement drug-drug and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period	**Interim Final Rule Text:** (1)Alerts. Automatically and electronically generate and indicate in real-time, alerts at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, age, and computerized provider order entry (CPOE). (3)Customization. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking. (4)Alert statistics. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	**Final Rule Text: §170.302(a)** (1) Notifications. Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE). (2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.
	ePrescribing *[EP only]*	●		40%	↓			✣		Generate and transmit permissible prescriptions electronically (eRx)		More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	**Interim Final Rule Text:** Enable a user to electronically transmit medication orders (prescriptions) for patients in accordance with the standards specified in §170.205(c).	**Final Rule Text: §170.304(b)** Electronic prescribing. Enable a user to electronically generate and transmit prescriptions and prescription-related information in accordance with: (1) The standard specified in §170.205(b)(1) or §170.205(b)(2); and (2) The standard specified in 170.207(d).
	Demographics	●	●	50%	↓	■	♦			Record demographics ●preferred language ●gender ● race ● ethnicity ● date of birth	Record demographics ●preferred language ●gender ● race ● ethnicity ● date of birth ● date of birth of date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50% 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) have demographics recorded as structured data	**Interim Final Rule Text:** Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, and date of birth.	**Final Rule Text: §170.304(c)** Record demographics. Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, and date of birth. Enable race and ethnicity to be recorded in accordance with the standard specified at 170.207(f).
	Problem List	●	●	80%	↔	■	♦			Maintain an up-to-date problem list of current and active diagnoses	Maintain an up-to-date problem list of current and active diagnoses	More than 80% 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) have at least one entry or an indication that no problems are known for the patient recorded as structured data	**Interim Final Rule Text:** Maintain up-to-date problem list. Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care in accordance with: (1) The standard specified in §170.205(d)(2)(iv); or (2) At a minimum, the version of the standard specified in §170.205(a)(2)(v)(B).	**Final Rule Text: §170.302(c)** Final rule text remains the same as Interim Final Rule text, except for references to adopted standards, which have been changed.
	Medication List	●	●	80%	↔	■	♦			Maintain active medication list	Maintain active medication list	More than 80% 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)have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	**Interim Final Rule Text:** Maintain active medication list. Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care in accordance with the standard specified in §170.205(a)(2)(v).	**Final Rule Text: §170.302(d)** Maintain active medication list. Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care.
	Medication Allergy List	●	●	80%	↔	■	♦			Maintain active medication allergy list	Maintain active medication allergy list	More than 80% 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) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	**Interim Final Rule Text:** Maintain active medication allergy list. Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care.	**Final Rule Text: Unchanged Now §170.302(e)**
	Vital Signs	●	●	50%	↓	■		✣		Record and chart changes in vital signs: o Height o Weight o Blood pressure o Calculate and display BMI o Plot and display growth charts for children 2-20 years, including BMI	Record and chart changes in vital signs: o Height o Weight o Blood pressure o Calculate and display BMI o Plot and display growth charts for children 2-20 years, including BMI	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data	**Interim Final Rule Text:** (1)Vital signs. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse. (2)Calculate body mass index. Automatically calculate and display body mass index (BMI) based on a patient's height and weight. (3) Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients 2-20 years old.	**Final Rule Text: §170.302(f)** (1)Vital signs. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, height, weight, and blood pressure. (2) Unchanged (3) Unchanged
	Smoking Status	●	●	50%	↓	■		✣		Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	More than 50% 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 department (POS 21 or 23) have smoking status recorded	**Interim Final Rule Text:** Smoking status. Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current smoker, former smoker, or never smoked.	**Final Rule Text: §170.302(g)** Smoking status. Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.
	Clinical Decision Support	●	●	One rule	↓				✓	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule	Implement one clinical decision support rule	**Interim Final Rule Text:** (1) Implement rules. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to specialty or clinical priorities that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list. (2) Alerts. Automatically and electronically generate and indicate in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade. (3) Alert statistics. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	**Final Rule Text: §170.304(e)** (1) Implement rules. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in: problem list; medication list; demographics; and laboratory test results. (2) Notifications. Automatically and electronically generate and indicate in real-time, notifications and care suggestions based upon clinical decision support rules.
	Calculate and Transmit CMS Quality Measures	●	●	Hospitals or CAH – 15 EP – 6	↑ 6 include 2011 electronic transmission and ↓ measure count				✓2011 submit electronic 2012	Report ambulatory clinical quality measures to CMS or the States	Report hospital clinical quality measures to CMS or the States **For 2011**, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of this final rule **For 2012**, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule	**Interim Final Rule Text:** (1) Display. Calculate and electronically display quality measures as specified by CMS or states. (2) Submission. Enable a user to electronically submit calculated quality measures in accordance with the standard and implementation specifications specified in §170.205(e).	**Final Rule Text: §170.304(j)** **(1) Calculate**. (i) Electronically calculate all of the core clinical measures specified by CMS for eligible professionals. (ii) Electronically calculate, at a minimum, three clinical quality measures specified by CMS for eligible professionals, in addition to those clinical quality measures specified in paragraph (1)(i). **(2) Submission.** Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in §170.205(e). **§170.306(j) (1) Calculate**. Electronically calculate all of the clinical quality measures specified by CMS for eligible hospitals and critical access hospitals. (2) Submission. Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in §170.205(f).
Engage patients and families in their health care	Electronic Copy of Health Information	●	●	50%	↓	■		✣		Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days	**Interim Final Rule Text:** Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in: (1) Human readable format; and (2) On electronic media or through some other electronic means in accordance with: (i) One of the standards specified in §170.205(a)(1); (ii) The standard specified in §170.205(a)(2)(iii)(A), or, at a minimum, the version of the standard specified in §170.205(a)(2)(iii)(B); (iii) One of the standards specified in §170.205(a)(2)(iv); (iv) At a minimum, the version of the standard specified in §170.205(a)(2)(ii); and (v) The standard specified in §170.205(a)(2)(v).	**Final Rule Text: §170.304(f)** Electronic copy of health information. Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list in: (1) Human readable format; and (2) On electronic media or through some other electronic means in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: **(A) Problems.** The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); **(B) Laboratory test results**. At a minimum, the version of the standard specified in §170.207(a)(2); and **(C) Medications.** The standard specified in §170.207(d).
	Electronic Copy of Discharge Instructions *[Hospital only]*		●	50%	↓	■		✣			Provide patients with an electronic copy of their **discharge instructions** at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it	**Interim Final Rule Text:** Enable a user to create an electronic copy of the discharge instructions and procedures for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.	**Final Rule Text: §170.306(e)** Electronic copy of discharge instructions. Enable a user to create an electronic copy of the discharge instructions for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.
	Clinical Summaries for each office visit *[EP only]*	●		50%	↓			✣		Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	**Interim Final Rule Text:** (1) Provision. Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations and procedures. (2) Provided electronically. If the clinical summary is provided electronically it must be: (i) Provided in human readable format; and (ii) On electronic media or through some other electronic means in accordance with: (A) One of the standards specified in §170.205(a)(1); (B) The standard specified in §170.205(a)(2)(iii), or, at a minimum, the version of the standard specified in §170.205(a)(2)(iii); (C) One of the standards specified in §170.205(a)(2)(iii); (D) At a minimum, the version of the standard specified in §170.205(a)(2)(iii); and (E) The standard specified in §170.205(a)(2)(v).	**Final Rule Text: §170.304(h)** Clinical summaries. Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in an electronic format. At the time of data extraction, the data must be electronically if must be: (1) Provided in human readable format; and (2) Provided on electronic media or through some other electronic means in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: **(A) Problems.** The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); **(B) Laboratory test results**. At a minimum, the version of the standard specified in §170.207(a); and **(C) Medications**. The standard specified in §170.207(d).
Improve care coordination	Exchange Key Clinical Information	●	●	One test	↔				✓	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test	**Interim Final Rule Text:** Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, procedures, and discharge summary in: (1) Human readable format; and (2) On electronic media or through some other electronic means in accordance with: In One of the standards specified in §170.205(a)(1); (ii) The standard specified in §170.205(a)(2)(iii), or, at a minimum, the version of the standard specified in §170.205(a)(2)(iii); (iii) One of the standards specified in §170.205(a)(2)(iii); (iv) At a minimum, the version of the standard specified in §170.205(a)(2)(ii); and (v) The standard specified in §170.205(a)(2)(v).	**Final Rule Text: §170.302(i)** (1) Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, procedures, and discharge summary in human readable format and on electronic media or through some other electronic means in accordance with: (A) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (B) For the following data elements the applicable standard must be used: (1) **Problems.** The standard specified in §170.207(a)(1) or at a minimum, the version of the standard specified in §170.207(a)(2); (2) **Procedures**. The standard specified in §170.207(b)(1) or §170.207(b)(2); (3) **Laboratory test results**. At a minimum, the version of the standard specified in §170.207(c); and (4) **Medications**. The standard specified in §170.207(d). (2) Enable a user to create an electronic copy of a patient's discharge summary in human readable format and on electronic media or through some other electronic means.
Ensure adequate privacy and security protections for personal health information	Privacy / Security	●	●	Conduct or review Security risk analysis	↔				✓	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	**Interim Final Rule Text:** (1) General. Encrypt and decrypt electronic health information according to user-defined preferences in accordance with the standard specified in §170.210(a)(1). (2) Exchange. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in §170.210(a)(2).	**Final Rule Text: §170.302(u)** General encryption. Encrypt and decrypt electronic health information in accordance with the standard specified in §170.210(a)(1), unless the Secretary determines that the use of such algorithm would pose a significant security risk for Certified EHR Technology. §170.302(v). Encryption when exchanging electronic health information. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in §170.210(a)(2).

MENU SET – Select 5 Measures that includes one from Population Health – The other 5 Measures defer to Stage 2

Health Outcomes Policy Priority	Meaningful Use Category	EPs	Hospitals	Measure Brief	Change from Proposed NPRM	POS 23	Unique Patients Denominator	Actions in a Certified EHR Denominator	Yes/No Attestation	Stage 1 Objectives: Eligible Professionals	Stage 1 Objectives: Hospitals	Stage 1 Measures	Certification Criteria: NRPM Certification Language	Certification Criteria: FINAL RULE - Certification Language
Improving quality, safety, efficiency, and reducing health disparities	Implement drug-formulary checks	●	●	Enabled	↑				✓	Implement drug-formulary checks	Implement drug-formulary checks	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	**Interim Final Rule Text:** (2)Formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list in accordance with the standard specified in §170.205(b).	**Final Rule Text: §170.302(b)** Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.
	Advance Directives *[Hospital only]*		●	50%	↑			✣			Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded	Not in the NPRM other than as a part of a Continuity of Care Document (CCD)	**Final Rule Text: §170.306(h)** Advance directives. Enable a user to electronically record whether a patient has an advance directive.
	Lab Results into EHR	●	●	40%	↓	■		✣		Incorporate clinical lab-test results into certified EHR technology as structured data	Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results 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 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	**Interim Final Rule Text:** (1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. (2) Display codes in readable format. Electronically display in human readable format any clinical laboratory tests that have been received with LOINC® codes. (3) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (4) Update. Enable a user to electronically update a patient's record based upon received laboratory test results.	**Final Rule Text: §170.302(h)** (1) Unchanged (2) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (3) Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record.
	Patient List	●	●	One List	↔				✓	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition	**Interim Final Rule Text:** Generate patient lists. Enable a user to electronically select, sort, retrieve, and output a list of patients and patients' clinical information, based on user-defined demographic data, medication list, and specific conditions.	**Final Rule Text: §170.302(l)** Generate patient lists. Enable a user to electronically select, sort, retrieve, and generate lists of patients according to, at a minimum, the data elements included in: **(1) Problem list; (2) Medication list; (3) Demographics; and (4) Laboratory test results.**
	Patient Reminders *[EP only]*	●		20%	↓			✣		Send reminders to patients per patient preference for preventive/ follow up care		More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	**Interim Final Rule Text:** Electronically generate, upon request, a patient reminder list for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list.	**Final Rule Text: §170.304(d)** Patient reminders. Enable a user to electronically generate a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data elements included in: **(1) Problem list; (2) Medication list; (3) Medication allergy list; (4) Demographics; and (5) Laboratory test results.**
Engage patients and families in their health care	Timely Electronic Access to Health Information *[EP only]*	●		10%	↓		♦			Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP		More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information	**Interim Final Rule Text:** Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, medication allergy list, immunizations, and procedures.	**Final Rule Text: §170.304(g)** Timely access. Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, and medication allergy list.
	Patient Specific Education	●	●	10%	↑	■	♦			Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% 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) are provided patient-specific education resources	Not in the NPRM	**Final Rule Text: §170.302(m)** Patient-specific education resources. Enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient's: problem list; medication list; and laboratory test results; as well as provide such resources to the patient.
Improve care coordination	Medication Reconciliation	●	●	50%	↓	■		✣		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 medication reconciliation	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 medication reconciliation	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).	**Interim Final Rule Text:** Medication reconciliation. Electronically complete medication reconciliation of two or more medication lists by comparing and merging into a single medication list that can be electronically displayed in real-time.	**Final Rule Text:** §170.302(j) Medication reconciliation. Enable a user to electronically compare two or more medication lists.
	Summary of Care	●	●	50%	↓			✣		The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals	**Interim Final Rule Text:** (1) Electronically receive and display. Electronically receive a patient's summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with: (i)One of the standards specified in §170.205(a)(1); (ii)The standard specified in §170.205(a)(2)(iii), display it in human readable format. (2)Electronically transmit. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with: (i)One of the standards specified in §170.205(a)(1); (ii)The standard specified in §170.205(a)(2)(iii); or, at a minimum, the version of the standard specified in §170.205(a)(2)(iii); (iii)One of the standards specified in §170.205(a)(2)(iii); (iv)At a minimum, the version of the standard specified in §170.205(a)(2)(ii); and (v)The standard specified in §170.205(a)(2)(v).	**Final Rule Text: §170.304(i)** (1) Electronically receive and display. Electronically receive and display a patient's summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, and medication allergy list in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format. (2) Electronically transmit. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: **(A) Problems.** The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); **(B) Laboratory test results**. At a minimum, the version of the standard specified in §170.207(a); and **(C) Medications**. The standard specified in §170.207(d).
Improve population and public health	Immunization Registries	●	●	One test	↔				✓	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries or follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	**Interim Final Rule Text:** Submission to immunization registries. Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with: (1) One of the standards specified in §170.205(h)(1) and, at a minimum, the version of the standard specified in §170.205(h)(2); or (2) The applicable state designated standard format.	**Final Rule Text: §170.302(k)** Submission to immunization registries. Electronically record, modify, retrieve, and submit immunization information in accordance with: (1) The standard (and applicable implementation specifications) specified in §170.205(e)(1) or §170.205(e)(2); and (2) At a minimum, the version of the standard specified in §170.207(e).
	Lab Results to Public Health Agencies *[Hospital only]*		●	One test	↔				✓		Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)	**Interim Final Rule Text:** Electronically record, retrieve, and transmit reportable clinical lab results to public health agencies in accordance with the standard specified in §170.205(f)(1) and, at a minimum, the version of the standard specified in §170.205(f)(2).	**Final Rule Text: §170.306(g)** Reportable lab results. Electronically record, modify, retrieve, and submit reportable clinical lab results in accordance with the standard (and applicable implementation specifications) specified in §170.205(c) and, at a minimum, the version of the standard specified in §170.207(c).
	Syndromic Surveillance	●	●	One test	↔				✓		Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	**Interim Final Rule Text:**Public health surveillance. Electronically record, retrieve, and transmit syndrome-based public health surveillance information to public health agencies in accordance with one of the standards specified in §170.205(g).	**Final Rule Text: §170.302(l)** Public health surveillance. Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard (and applicable implementation specifications) specified in §170.205(b)(1) or §170.205(b)(2).

Standards

Meaningful Use Category	Vocabulary: Medical Observations LOINC® (Version 2.17 Release Date June 2.27)	Vocabulary: Any source vocabulary that is mapped to Standard Vocabulary, Medication Vocabulary, and SNOMED CT®	Vocabulary: Medication Dose Form Vocabulary (Version 1.0 Medication Route Vocabulary (Version 1.0)	Vocabulary: ICD-9	Vocabulary: CPT-4 and HCPCS	Vocabulary: HL7 Standard Code Set CDC Vaccine Administered, July 26, 2010	Vocabulary: Medication Dose Form Vocabulary (Version 1.0) Medication Route Vocabulary (Version 1.0)	Transmission and Implementation Specifications: HL7 2.3.1	Transmission and Implementation Specifications: HL7 2.3.1	Transmission and Implementation Specifications: HL7 Version 2.5 Implementation Guide: Immunization, Final Follow-Up Release (V2.5)	Transmission and Implementation Specifications: HL7 Version 2.5 Implementation Guide: Immunization, Implementation Guide Supplement: Clinical Guidance (V2.5)	Transmission and Implementation Specifications: HL7 Version 2.5 Implementation Guide: Immunization, Implementation Guide Supplement: Clinical Guidance (V2.5) Jurisdiction-specific Implementation Guide (V2.5)	Transmission and Implementation Specifications: HL7 Version 2.5 Implementation Guide: Immunization, Implementation Guide Supplement: Clinical Guidance (V2.5) Immunization Information System Interface Implementation Guide (V2.5)	Transmission and Implementation Specifications: HL7 Version 2.5 Implementation Guide: Immunization, Implementation Guide Supplement: Clinical Guidance (V2.5) Public Health Laboratory Interface Implementation Guide (V2.5)	Transmission and Implementation Specifications: HL7 Version 2.5 Implementation Guide: Immunization, Implementation Guide Supplement: Clinical Guidance (V2.5) Public Health Immunization Registry Implementation Guide (V2.5)	Content: CCR - Continuity of Care Record	Content: CCD - Continuity of Care Document	Content: HITSP C32	Content: HITSP 32	Content: Implementation Specifications: Electronic Reporting of Laboratory-Based Clinical Quality Measures	Content: Implementation Specifications: Electronic Reporting of Clinical Quality Measures (eCQM)	Content: The CMS Premium Quality Measures Implementation Guide 2010 Reporting Web Specification	Content: ISO/IEC 11179 Metadata Registry Web Specification	SOTA/ONC ON CONTENT: Standard and Jurisdiction Specific Data Elements Required
Improving quality, safety, efficiency, and reducing health disparities		●																					
Improving quality, safety, efficiency, and reducing health disparities																●	●						
Improving quality, safety, efficiency, and reducing health disparities																