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

Stage 1 Objectives — Eligible Professionals: Blue text indicates added information beyond FINAL rule language. Hospitals: Blue text indicates added information beyond FINAL rule language. Stage 1 Measures: Red text indicates change in wording from NRPM and FINAL rule.

Core Set Measures based on % Threshold — Numerator / Denominator / Exclusions for % based Measures

Certification Language — FINAL RULE - Certification Language: Red text indicates change in wording from NRPM and FINAL rule. Blue text indicates added information beyond FINAL rule language.

Health Outcomes Policy Priority	Meaningful Use Category	EPs	Hospitals	Measure Brief	Eligible Professionals	Hospitals	Stage 1 Measures	Numerator	Denominator	Threshold	Exclusion	FINAL RULE - Certification Language
Improving quality, safety, efficiency, and reducing health disparities	CPOE - Computerized provider order entry	●	●	> 30%	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	The number of patients in the denominator that have at least one medication order entered using CPOE	Number of unique patients with at least one medication in their medication list seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period	The resulting percentage must be more than 30 percent in order for an EP, eligible hospital or CAH to meet this measure.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period. For Stage 2 CPOE - Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	Final Rule Text: EP §170.304 (a) and Eligible Hospitals and CAH §170.306 (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.
	ePrescribing *[EP only]*	●	n/a	> 40%	Generate and transmit permissible prescriptions electronically (eRx)	n/a	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	The number of prescriptions in the denominator generated and transmitted electronically	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.	The resulting percentage must be more than 40 percent in order for an EP, eligible hospital, or CAH to meet this measure	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	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 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	The number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period. A unique patient is discussed under the objective of CPOE.	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure. Most EPs and all eligible hospitals and CAHs would have access to this information through direct patient access.	Some EPs without direct patient access would have this information communicated as part of the referral from the EP who identified the service as needed by the patient. Therefore, we did not include an exclusion for this objective and associated measure.	Final Rule Text: EP §170.304 (c) and Eligible Hospitals and CAH §170.306 (b) 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). Additional in §170.306 (b) ONLY - date and preliminary cause of death in the event of mortality in the eligible hospital or CAH
	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	Numerator: The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.	Denominator: Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	Threshold: The resulting percentage must be more than 80 percent in order for an EP, eligible hospital, or CAH to meet this measure.	We do not believe that any EP, eligible hospital, or CAH would be in a situation where they would not need to know at least one active diagnosis for a patient they are seeing or admitting to their hospital. Therefore, there are no exclusions for this objective and its associated measure.	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. [NOTE - Text from Interim final rule reads - 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(a)(2)(i)(A); or (2) At a minimum, the version of the standard specified in §170.205(a)(2)(i)(B).]
	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	The number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient	The resulting percentage must be more than 80 percent in order for an EP, eligible hospital, or CAH to meet this measure. Detailed discussion of the more than 80 percent threshold can be found under the objective of maintaining an up-to-date problem list.	There are no exclusions for this objective and its associated measure	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	The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period. The definition of "a unique patient" is provided under the objective of CPOE	The percentage must be more than 80 percent in order for an EP, eligible hospital, or CAH to meet this measure.	We do not believe that any EP, eligible hospital or CAH would be in a situation where they would not need to know whether their patients have medication allergies and therefore do not establish an exclusion for this measure.	Final Rule Text: Unchanged Now §170.302(e) [NOTE - The text from Interim Final Rule reads - "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."]
	Vital Signs	●	●	> 50%	Record and chart changes in vital signs: • Height • Weight • Blood pressure • Plot and display growth charts for children 2-20 years, including BMI • Calculate and display BMI	Record and chart changes in vital signs: • Height • Weight • Blood pressure • Plot and display growth charts for children 2-20 years, including BMI • Calculate and display 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	The number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structure data.	Number of unique patients age 2 or over seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure.	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.	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 [NOTE - The (2) and (3) Text from Interim Final Rule reads - (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.]
	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	The number of patients in the denominator with smoking status recorded as structured data.	Number of unique patients age 13 or older seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period. A unique patient is discussed under the objective of maintaining an up-to-date problem list.	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure.	Any EP who sees no patients 13 years or older. Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23).	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.
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	The number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.	The number of patients of the EP or eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.	Final Rule Text: EP §170.304 (f) and Eligible Hospitals and CAH §170.306 (d)(1)(2)- See Detail Hightlight Inset below in this matrix for detailed language
	Electronic Copy of Discharge Instructions *[Hospital only]*	n/a	●	> 50%	n/a	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	The number of patients in the denominator who are provided an electronic copy of discharge instructions.	Number of patients discharged from an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) who request an electronic copy of their discharge instructions and procedures during the EHR reporting period.	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure.	Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period.	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]*	●	n/a	> 50%	Provide clinical summaries for patients for each office visit	n/a	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	Number of patients in the denominator who are provided a clinical summary of their visit within three business days.	Number of unique patients seen by the EP for an office during the EHR reporting period. A unique patient is discussed under the objective of using CPOE.	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure	Any EP who has no office visits during the EHR reporting period.	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, and medication allergy list. If the clinical summary is provided electronically it 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(c); and (C) Medications. The standard specified in §170.207(d).

CORE SET – Attestation by Yes / No - There are no exclusions to these measures

Health Outcomes Policy Priority	Meaningful Use Category	EPs	Hospitals	Measure Brief	Eligible Professionals	Hospitals	Stage 1 Measures	FINAL RULE - Certification Language
Improving quality, safety, efficiency, and reducing health disparities	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	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.
	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 with that rule	Implement one clinical decision support rule	Final Rule Text: §170.304 (e) and §170.306 (c) (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	Report ambulatory clinical quality measures to CMS or the States. NOTE - Attestation of actual numerator/denominator is required for some clinical quality measures in 2011. NOTE - Can exclude from a measure by a denominator of zero indicating no cases.	Report hospital clinical quality measures to CMS or the States. NOTE - Attestation of actual numerator/denominator is required for some clinical quality measures in 2011. NOTE - Can exclude from a measure by a denominator of zero indicating no cases.	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. NOTE - Attestation for the Quality Measures and entering the actual numerator/denominator and any exclusions occurs in the listing of each individual clinical quality measure listing in the attestation tool.	Final Rule Text: §170.304(j) Eligible Professionals (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(f). §170.306(i) Eligible Hospitals and CAH (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).
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, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test	Final Rule Text: EP §170.304 (i) and Eligible Hospitals/CAH §170.306 (f) Exchange clinical information and patient summary record [illegible]
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	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). Additional Security Requirements for Certified EHR Technology: §170.302 (o) Access control; §170.302 (p) Emergency access; §170.302 (q) Automatic log-off; §170.302 (r) Audit log; §170.302 (s) Integrity; §170.302 (t) Authentication; §170.302 (u) General encryption; §170.302 (v) Encryption when exchanging electronic health information; §170.302 (w) Accounting of disclosures (optional)

Detail Hightlists for Vocabulary and Content Standard for Electronic Copy of Health Information

§ 170.207 Vocabulary standards for representing electronic health information

The Secretary adopts the following code sets, terminology, and nomenclature as the vocabulary standards for the purpose of representing electronic health information:

(a) Problems
(1) Standard. The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. [*ICD-9]
(2) Standard. International Health Terminology Standards Development Organization (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CTR) July 2009 version (incorporated by reference in § 170.299).
(b) Procedures
(1) Standard. The code set specified at 45 CFR 162.1002(a)(2). [*ICD-9]
(2) Standard. The code set specified at 45 CFR 162.1002(a)(5). [*CPT-4]
(c) Laboratory test results
Standard. Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transmission from a laboratory (incorporated by reference in § 170.299).
(d) Medications
Standard. Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

Source – Page 44650 of ONC Standards Final Rule and *extract from 45 CFR 162.1002 Medical data code sets

Electronic Copy of Health Information

Final Rule Text: § 170.304(f). NIST Certification Criteria §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(c); and (C) Medications. The standard specified in §170.207(d).

Final Rule Text: § 170.306(d). Hospital NIST Certification Criteria §170.306 (d)(1) and §170.306 (d)(2)
(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, and procedures:
(i) In human readable format; and
(ii) 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.

Source - ONC Standards Final Rule, pp. 44629, 44637 and http://healthcare.nist.gov

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

Menu Set Measures based on % Threshold

Health Outcomes Policy Priority	Meaningful Use Category	EPs	Hospitals	Measure Brief	Eligible Professionals	Hospitals	Stage 1 Measures	Numerator	Denominator	Threshold	Exclusion	FINAL RULE - Certification Language
Improving quality, safety, efficiency, and reducing health disparities	Advance Directives *[Hospital only]*	n/a	●	> 50%	n/a	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	The number of patients in the denominator with an indication of an advanced directive entered using structured data	Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period. A unique patient is discussed under the objective of CPOE	The resulting percentage must be more than 50 percent in order for eligible hospital or CAH to meet this measure	An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.	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	The number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data	Number of lab tests ordered during the EHR reporting period by the EP or authorized providers of the eligible hospital or CAH for patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 & 23) whose results are expressed in a positive or negative affirmation or as a number.	The resulting percentage must be more than 40 percent in order for an EP, eligible hospital, or CAH to meet this measure.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.	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. [NOTE - Interim Final Rule Text for (1) reads: (1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format]
	Patient Reminders *[EP only]*	●	n/a	> 20%	Send reminders to patients per patient preference for preventive/ follow up care	n/a	More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period	The number of patients in the denominator who were sent the appropriate reminder.	Number of unique patients 65 years old or older or 5 years older or younger.	The resulting percentage must be more than 20 percent in order for an EP to meet this measure.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.	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]*	●	n/a	> 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	n/a	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	The number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.	Number of unique patients seen by the EP during the EHR reporting period.	The resulting percentage must be at least 10 percent in order for an EP to meet this measure.	Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.	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	Number of patients in the denominator who are provided patient education specific resources	Number of unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	The resulting percentage must be more than 10 percent in order for an EP, eligible hospital, or CAH to meet this measure.	NOTE - There are no exclusions stated in the final rule for this measure.	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)	The number of transitions of care in the denominator where medication reconciliation was performed.	Number of transitions of care during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 to 23) was the receiving party of the transition.	The resulting percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure.	An EP who was not the recipient of any transitions of care during the EHR reporting period.	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	The number of transitions of care and referrals in the denominator where a summary of care record was provided.	Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.	The percentage must be more than 50 percent in order for an EP, eligible hospital, or CAH to meet this measure.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.	Same certification as list above in Exchange Key Clinical Information. Final Rule Text: EP §170.304 (i) and Eligible Hospitals/CAH §170.306 (f) Exchange clinical information and patient summary record

Standards note (Lab Results into EHR): ● if LOINC sent from the lab

MENU SET Continued with Attestation by Yes / No

Health Outcomes Policy Priority	Meaningful Use Category	EPs	Hospitals	Measure Brief	Eligible Professionals	Hospitals	Stage 1 Measures	Exclusions	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	No Exclusions to this measure	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.
	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	No Exclusions to this measure	Final Rule Text: §170.302(i) 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.
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 and 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)	EP - An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically. Eligible Hospitals/CAH - An eligible hospital or CAH that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.	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]*	n/a	●	One test	n/a	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)	No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.	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	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)	EP - An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically. Eligible Hospitals/CAH - No public health agency to which the eligible hospital or CAH submits information has the capacity to receive the information electronically.	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(d)(1) or §170.205(d)(2).

Detail Highlights - Certification Required for Complete EHR

Certifications required for both EP and Eligible Hospitals and CAH to attest to utilizing "Certified EHR Technology"

- §170.302 (a) Drug-drug, drug-allergy interaction checks
- §170.302 (b) Drug formulary checks
- §170.302 (c) Maintain up-to-date problem list
- §170.302 (d) Maintain active medication list
- §170.302 (e) Maintain active medication allergy list
- §170.302 (f)(1) Vital signs
- §170.302 (f)(2) Calculate body mass index
- §170.302 (f)(3) Plot and display growth charts
- §170.302 (g) Smoking status
- §170.302 (h) Incorporate laboratory test results
- §170.302 (i) Generate patient lists
- §170.302 (j) Medication reconciliation
- §170.302 (k) Submission to immunization registries
- §170.302 (l) Public health surveillance
- §170.302 (m) Patient specific education resources
- §170.302 (n) Automated measure calculation

Source for information in next grid to the right

Certifications required for Eligible Professionals to attest to utilizing "Certified EHR Technology"

- §170.304 (a) Computerized provider order entry
- §170.304 (b) Electronic Prescribing
- §170.304 (c) Record demographics
- §170.304 (d) Patient reminders
- §170.304 (e) Clinical decision support
- §170.304 (f) Electronic copy of health information
- §170.304 (g) Timely access
- §170.304 (h) Clinical summaries
- §170.304 (i) Exchange clinical information and patient summary record
- §170.304 (j) Calculate and submit clinical quality measures

Source for certification detail highlights - National Institute of Science and Technology (NIST) Approved Test Procedures Version 1.1

http://healthcare.nist.gov/use_testing/effective_requirements.html

Certifications required for Eligible Hospitals/CAH to attest to utilizing "Certified EHR Technology"

- §170.306 (a) Computerized provider order entry
- §170.306 (b) Record demographics
- §170.306 (c) Clinical decision support
- §170.306 (d)(1) Electronic copy of health information
- §170.306 (d)(2) Electronic copy of health information - for discharge summary
- §170.306 (e) Electronic copy of discharge instructions
- §170.306 (f) Exchange clinical information and patient summary record
- §170.306 (g) Reportable lab results
- §170.306 (h) Advance directives
- §170.306 (i) Calculate and submit clinical quality measures

Source for information in grid to the immediate left

"Meaningful Use Stage 1 Final Rule, The White Board Story" – Version 2 – With Numerators / Denominators / Exclusions and Detail Highlights – June 5, 2011

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