								B: Stage 1 Meaningful Use Objectives and Associated Measures Sorted by Core and Menu Sont Health Information Technology: Initial Set of Standards, Implementation Specifications	Set from CMS Medicare and Medicaid Programs; Electronic Health Record Incentive Prog	ram Final Rule 7/28/10								
				CORE S	SET – Eligible Pro	fessionals, Eligible Hospital, or CAH required to satis		Certification Criteria				Standards Standa						
Health Outcomes Policy Priority	Meaningful Use Category	EPs Hospitals Measure Brief	Change from Proposed NPRM	POS 23	Unique Patients Denominator Actions in a Certifled EHR Denominator Yes/No Attestation	Stage 1 Obje Eligible Professionals	Hospitals	Stage 1 Measures	NRPM Certification Language	FINAL RULE - Certification Language	Logical Observation Identifiers Names and Codes (LOINC*) version 2.27 Any source vocabulary that is included in RaNorm (First Dabbank, Micromedex, MediSpan, Gold Standard Alchemy, and Multurm) Systematized Nomendature of Systematized Nomendature of	(SNOMED CT*) July 2009 ICD-9 CPT-4 and HCPCS HZ Standard Code Set CVX -	2009 version Ethnicity and Race The Office of Management and Budget Standard sfor Maintaining, Collecting, and Presenting Federal Dala on Race and Ethnicity, Statistia Policy Directive No. 15, October 30,	HIZ 2.3. HIZ 2.5.1 NCPDP 8.3 NCPDP 10.8 Implementation	Guide HLZ 2.5.1 Implementation Guide for Immunization Messaging Release 1.0	Implementation builder or implementation builder or immunization Data Transactions using Version 2.3.1 of the HIZ Standard Protocol Implementation Guide HIZ Version 2.5.1 implementation Specification to Public Health Information Network HIZ 2.5 Message CCR - Continuity of Care Record	CCD - Continuity of Care Document (HL7 CDA R2) HTSP 32 Implementation specifications - Implementation specifications - Initiative Measure Specifications Manual for Claims and Registry The CMS Physician Quality Reporting Initiative (PQRI) 2009 Registry XML Specification NOTATION ON CONTENT - Problems, Medication List and Lab Results Required	
	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 patate, 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		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	● ● Enable	d ↔		~	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 th 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 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.									
	ePrescribing [EP only]	40%	1		*	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%	1	-	•	Record demographics • preferred language • race • date of birth • date	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 includir 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).	3		•					
	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 retreate a patient's problem list for longitudinal care in accordance with: (1) The standard specified in §170.205(a)(2)(i)(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.								
Improving quality, safety,	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 retrie patient's active medication list as well as medication history for longitudinal care in accordance with the standard specified in §170.205(a)(2)(iv).		•							
efficiency, and reducing health	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, an 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)								
disparities	Vital Signs	• • 50%	1	-	*	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 vitated 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 display growth charts. Plot and electronically display, upon request, growth charts for patients 2-20 years old.	ss (1)Vital signs. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a and minimum, height, weight, and blood pressure.								
	Smoking Status	• • 50%	1	-	*	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 smokin 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	e ↓		✓	Implement one clinical decision support rule relevant to specialty or high clinical priority along we the ability to track compliance that rule	rith Implement one clinical decision support rule relevant to specialty or his clinical priority along with the ability to track compliance that rule	gh Implement one clinical decision support rule	demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list. (2	(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								
	Calculate and Transmit CMS Quality Measures					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	Interim Final Rule Text: (1) Display. Calculate and electronically display quality measures as specified by CMS 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).	(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								
	Quality Modebures	Hospitals (CAH -15 EP - 6	electronic transmission and J	ı	v2011 submit electroni 2012			For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule		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) (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).							• •	
	Electronic Copy of Health Information	• 50%	1		*	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	minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures (1) Human readable format; and (2) On electronic media or through some other electronic means in accordance with One of the standards specified in §170.205(a)(1); (ii) The standard specified in §170.205(a)(2)(i)(A), or, at a minimum	a 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)(2) or, at a minimum, the version of the standard specified in §170.207(c); and (C) Medications. The standard specified in §170.207(d).	•					•		
Engage patients and families in	S Electronic Copy of Discharge Instructions	• 50%	1	-	*		Provide patients with an electronic copy of their discharge instruction 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 procedure: a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.	s for 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.								
their health care	e [Hospital only] Clinical Summaries for each office visit [EP only]	• 50%	1		*	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	and procedures. (2) Provided electronically. If the clinical summary is provided electronically it must be: (i) Provide human readable format; and (ii) On electronic media or through some other electronic means in accordance with One of the standards specified in §170.205(a)(1); (B) The standard specified in §170.205(a)(2)(i)(B); (C) One of the standards specified in §170.205(a)(2)(i)(B); (C) One of the standards specified in	tions 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 lists. If the clinical summary is provided electronically if the clinical summary is provided electronically if the clinical summary is provided electronically.	•					•	•	
Improve care	Exchange Key Clinical Information					Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patie authorized entities electronically	Capability to exchange key clinical information (for example, problem lient medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	st, 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 minimu diagnostic test results, problem list, medication list, medication allergy list, immunizations, procedures, and discharge summa 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):	(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:								
coordination Ensure adequate	Drivoov / Soovrity	One tes	st ↔	-	*	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	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessal and correct identified security deficiencies as part of its risk management process	(ii) The standard specified in §170.205(a)(2)(i)(A), or, at a minimum, the version of the standard specified in §170.205(a)(2)(i)(B) (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)(iii); and (v) The standard specified in §170.205(a)(2)(iv). ary Interim Final Rule Text: (1) General. Encrypt and decrypt electronic health information according to user-define preferences in accordance with the standard specified in §170.210(a)(1). (2) Exchange. Encrypt and decrypt	(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. d Final Rule Text: §170.302(u) General encryption. Encrypt and decrypt electronic health information in accordance with the standard specified in	For complete Privacy / Security Standards		ment of Health and Human	Services, Office of the Secretary 45 CFR Pr	art 170 Health Inform	ttion Technology: Initial Set of Standards, Implemen	tation Specifications, and Certification Criteria for Electronic	
privacy and security		Conduct of review Secu				2. In Contrology Unough the Importantian of appropriate technical expansion	technical capabilities	and deficed administration for the formula agents in process	electronic health information when exchanged in accordance with the standard specified in §170.210(a)(2).	§170.210(a)(1), unless the Secretary determines that the use of such algorithm would pose a significant security rist 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).	(FIPS) Publication 140-2 - For data es	health information — In genera change - Any encrypted and in	 Any encryption algorithm grity protected link 	identified by the National Institute of S	Standards and Technol		Annex A of the Federal Information Processing Standards ted; and an indication of which action(s) occurred and by	
protections for personal health information		risk analys	is								(NIST) in FIPS PUB 180-3 (October, 2008) must be used to verify that el	tronic health information	nas not been altered.	-		by the National Institute of Standards and Technology payment, and health care operations, as these terms are	
	Implement drug-formulary	● ● Enable		IENU SET	- Select 5 Measu	res that includes one from Population Health - The otlemplement drug-formulary checks	her 5 Measures defer to Stage 2 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		or 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.				Standa	rds			
	checks Advance Directives [Hospital only]	• 50%	1		*		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.								
Improving quality, safety, efficiency, and reducing health	Lab Results into EHR	• 40%	1	-	*	Incorporate clinical lab-test results into certified EHR technology as structured data	Incorporate clinical lab-test results into certified EHR technology as structured data	CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting perio whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	(2) Display codes in readable format. Electronically display in human readable format any clinical laboratory tests that have be- received with LOINC® codes. (3) Display test report information. Electronically display all the information for a test report speci 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	(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 patien record.								
reducing health disparities	n Patient List	One Lis	st 😝		✓	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 of patients and patients' clinical information, based on user-defined demographic data, medication list, and specif conditions.	list 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.								
	Patient Reminders [EP only]	• 20%	1		*	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	care according to patient preferences based on demographic data, specific conditions, and/or medication list.	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 patient	Timely Electronic Access to Health Information [EP only]	• 10%	1		•	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 busines 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 procedure									
and families in their health care	Health Information [EP only] Patient Specific Education	• • 10%	1	-	•	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.								
	Medication Reconciliation	• • 50%	1	-	*	care or believes an encounter is relevant should perform medication reconciliation	setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergen department (POS 21 or 23)	time.	Medication reconciliation. Enable a user to electronically compare two or more medication lists.								
Improve care coordination	Summary of Care	• 50%	↓		*	The EP, eligible hospital or CAH who transitions their patient to another setting of care or provide 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	organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list, immunizations, ar procedures in accordance with §170.205(a) and upon receipt of a patient summary record formatted in an alternate standard specified §170.205(a)(1), display it in human readable format. (2) Electronically transmit. Enable a user to electronically transmit a patient summ 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); (iii)The standard specified in §170.205(a)(2)(i)(B); (iii)One of the standard specified in §170.205(a)(2)(i)(B); (iii)One of the standard	(1) Electronically receive and display. Electronically receive and display a patient's summary record, from other providers and organization 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 innimum, diagnostic test results, problem list, medication list, and medication allergy list in accordance with: (i) The standard (and applicable implementation specification 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)						•		
lmnra: :-	Immunization Registries	One tes	et ↔		~	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 accordan with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registrice and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eliging hospital or CAH submits such information have the capacity to receive the information electronically)		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: §170.302(k) Submission to immunization registries. Electronically record, modify, retrieve, and submit immunization information 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).				• •	•	•		
Improve population and public health	7 190110100	One tes	st ↔		✓			or Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable la 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)		h 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).	•			•		•		
Paolio rieditri	Syndromic Surveillance	One tes	st +		✓	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 dat 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 §170.205(g).	Final Rule Text: §170.302(I)				• •		•		
	Record demographics	Record demographics	I			Record and chart changes in vital signs:	Requirement for Certification by an Authorized Testing and Certification Body (ATCI	uired Data Elements for Corresponding Meaningful Use Object	Summary of care record for each transition of care or referral in data elements corresponding specified standards noted above									
	Gender Race Chinicity Date of Birth Charles thinking Date of Birth Charles thinking Date of Birth Charles thinking Date of Birth Charles thinking Date of Birth Date of Birth Date of Birth Charles thinking Date of Birth Date of Birth Charles thinking Date of Birth Charles thinking Date of Birth D						## ADDITIONAL NOTE - Item not in the NPRM - New criteria required for successfully completing ARRA Certification of an EHR or retrieve, and monthly, at a minimum, the following order types: (1) Need criteria and incident of an element of the numerator and deposition of an element of the numerator and deposition of an element of the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable measure, electronically record the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator. **Meaningful Use Stage 1 Final Rule, The White Board Story" – Version 1 – July 28, 2010 **This poster is dedicated in honor of all those who have lost loved ones since the IOM Study "To Err is Human" was published in 1999, to all those victims of Katrina who suffered or died since we could not share their records with another location, to my mom who died because she did not have the benefits of an interoperable EHR and her doctors could not share lab results across doctors and across visits, and for my nephew who is paralyzed from a medical error **Please tell this mention in the PPMM – New criteria required for successfully completing distributed in EHR to EHR Mode altering to the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator and denominator and generate a report including the numerator and denominato					Special Thanks To the national leadership of David Blumenthal, MD, MPP, Jonathan Perlin, MD, PhD, MSHA, FACP, FACMI, John D. Halamka, MD, MS, Paul Tang, M.D., M.S, the members of the HIT Policy Committee and HIT Standards Committee, the entire staff of ONC, and to Tony Trenkle, Karen Trudel and the entire CMS team — for your tireless efforts and thousands upon thousands of hours of work and spirited discussions in the working groups to make the final rules come to life so this great Meaningful Use White Board Story can be told.						
													A extra special thanks to John Halamka, MD, MS for his great blog http://geekdoctor.blogspot.com/ and keeping a entire nation informed in plain English and to the entire "HITSP Nation", "HITSP Tiger Teams", and support from the HITSP Education, Communication and Outreach Committee for their technical expertise to					
		 Denominator of Unique Measures with a Deno Text indicated "Unique ✓ Yes/No Attestation 	e Patients Regard minator of Based o Patients" is the den	dless of Whether the on Counting Action : nominator section o	ne Patient's Records Are Maintain ns for Patients whose Records are of "Counting Actions for Patients v	d Using Certified EHR Technology Maintained Using Certified EHR Technology hose Records are Maintained Using Certified EHR Technology	Please tell this meaningful use story with all the energy and passion that it will take to transform a country We have a big job to do and this is just Stage 1 Let's get going! Disclaimer - This chart is not an official federal document and has been created for public use and convenience of seeing the "big picture" in one large "white board" created by Robin Raiford, RN-BC, CPHIMS, FHIMSS as a volunteer follow on work done as part of the HITSP Communication, Education and Outreach Committee. Any omissions or corrections, please contact Robin Raiford on Linked In. Other useful companion posters can be located at www.hitsp.org and click the Education and Outreach tab at the top of the website.					"Think Big, Act Small, Start Now"						

Final Rule Meaningful Use Objectives and Measures -Stage 1