MEANINGFUL USE 42 CFR 495.6(d)-(e)		CERTIFICATION CRITERIA 45 CFR 170.302 & 170.304	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
§495.6(d)(1)(i) - 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. **[75 FR 44331-34]**	§495.6(d)(1)(ii) - More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. *§495.6(d)(1)(iii) - Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.*	§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. **[75 FR 44624-25]**	
§495.6(d)(2)(i) - Implement drug-drug and drug-allergy interaction checks. **[75 FR 44334-36]**	§495.6(d)(2)(ii) - The EP has enabled this functionality for the entire EHR reporting period.	§170.302(a) - **Drug-drug, drug-allergy interaction checks.** (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. **[75 FR 44600-03]**	
§495.6(d)(3)(i) - Maintain an up-to-date problem list of current and active diagnoses. **[75 FR 44336-37]**	§495.6(d)(3)(ii) - More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	§170.302(c) - **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 §170.207(a)(1); or (2) At a minimum, the version of the standard specified in §170.207(a)(2). **[75 FR 44603-04]**	***Problems.*** ▪ §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. ▪ §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version
§495.6(d)(4)(i) - Generate and transmit permissible prescriptions electronically (eRx). **[75 FR 44337-38]**	§495.6(d)(4)(ii) - More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. *§495.6(d)(4)(iii) - Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.*	§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). **[75 FR 44625-27]**	***Electronic prescribing.*** ▪ §170.205(b)(1) - NCPDP SCRIPT Version 8.1. ▪ §170.205(b)(2) - NCPDP SCRIPT Version 10.6. ***Medications.*** ▪ §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.
§495.6(d)(5)(i) - Maintain active medication list. **[75 FR 44338-39]**	§495.6(d)(5)(ii) - More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	§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. **[75 FR 44604]**	
§495.6(d)(6)(i) - Maintain active medication allergy list. **[75 FR 44339-40]**	§495.6(d)(6)(ii) - More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	§170.302(e) - **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. **[75 FR 44605]**	

CORE SET

MEANINGFUL USE 42 CFR 495.6(d)-(e)		CERTIFICATION CRITERIA 45 CFR 170.302 & 170.304	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
§495.6(d)(7)(i) - Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth. *[75 FR 44340-42]*	§495.6(d)(7)(ii) - More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	§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). *[75 FR 44627]*	*Race and Ethnicity.* ▪ §170.207(f) - The OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, October 30, 1997.
§495.6(d)(8)(i) - Record and chart changes in the following vital signs: (A) Height. (B) Weight. (C) Blood pressure. (D) Calculate and display body mass index (BMI). (E) Plot and display growth charts for children 2–20 years, including BMI. *[75 FR 44342-43]*	§495.6(d)(8)(ii) - For more than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data. *§495.6(d)(8)(iii) -Exclusion: 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.*	§170.302(f) - **Record and chart vital signs**. (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) *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. *[75 FR 44605-06]*	
§495.6(d)(9)(i) - Record smoking status for patients 13 years old or older. *[75 FR 44344-45]*	§495.6(d)(9)(ii) - More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. *§495.6(d)(9)(iii) - Exclusion: Any EP who sees no patients 13 years or older.*	§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. *[75 FR 44606-07]*	
§495.6(d)(10)(i) - Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States. *[75 FR 44348]*	§495.6(d)(10)(ii) - Subject to paragraph (c) of this section, successfully report to CMS (or, in the case of Medicaid EPs, the States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or in the case of Medicaid EPs, the States). [Preamble Reference] • For 2011, provide aggregate numerator, denominator, and exclusions through attestation as required by CMS or State. • For 2012, electronically submit the clinical quality measures as required by CMS or State.	§170.304(j) - **Calculate and submit clinical quality measures**. (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). *[75 FR 44610-12]*	*Quality reporting.* ▪ §170.205(f) - CMS PQRI 2009 Registry XML Specification. *Implementation specification:* PQRI Measure Specifications Manual for Claims and Registry.
§495.6(d)(11)(i) - Implement one clinical decision support rules relevant to specialty or high clinical priority along with the ability to track compliance with that rule. *[75 FR 44350-51]*	§495.6(d)(11)(ii) - Implement one clinical decision support rule.	§170.304(e) - **Clinical decision support**. (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. *[75 FR 44628-29]*	

CORE SET

MEANINGFUL USE 42 CFR 495.6(d)-(e)		CERTIFICATION CRITERIA 45 CFR 170.302 & 170.304	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
CORE SET §495.6(d)(12)(i) - Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies), upon request. *[75 FR 44353-55]*	§495.6(d)(12)(ii) - More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days. *§495.6(d)(12)(iii) - Exclusion: Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.*	§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). *[75 FR 44629-30]*	***Patient summary record.*** ▪ §170.205(a)(1) - HL7 CDA Release 2, CCD. *Implementation specifications:* HITSP Summary Documents Using HL7 CCD Component HITSP/C32. ▪ §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369. ***Problems.*** ▪ §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. ▪ §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version. ***Laboratory test results.*** ▪ §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. ***Medication.*** ▪ §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.
§495.6(d)(13)(i) - Provide clinical summaries for patients for each office visit. *[75 FR 44358-59]*	§495.6(d)(13)(ii) - Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. *§495.6(d)(13)(iii) - Exclusion: Any EP who has no office visits during the EHR reporting period.*	§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). *[75 FR 44631-32]*	***Patient summary record.*** ▪ §170.205(a)(1) - HL7 CDA Release 2, CCD. *Implementation specifications:* HITSP Summary Documents Using HL7 CCD Component HITSP/C32. ▪ §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369. ***Problems.*** ▪ §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. ▪ §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version. ***Laboratory test results.*** ▪ §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. ***Medication.*** ▪ §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

MEANINGFUL USE 42 CFR 495.6(d)-(e)		CERTIFICATION CRITERIA 45 CFR 170.302 & 170.304	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
CORE SET §495.6(d)(14)(i) - Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically. *[75 FR 44360-62]*	§495.6(d)(14)(ii) - Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	§170.304(i) - **Exchange clinical information and patient summary record.** (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(c); and (C) *Medications.* The standard specified in §170.207(d). *[75 FR 44632-35]*	***Patient summary record.*** ▪ §170.205(a)(1) - HL7 CDA Release 2, CCD. *Implementation specifications:* HITSP Summary Documents Using HL7 CCD Component HITSP/C32. ▪ §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369. ***Problems.*** ▪ §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. ▪ §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version. ***Laboratory test results.*** ▪ §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. ***Medication.*** ▪ §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.
§495.6(d)(15)(i) - Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. *[75 FR 44368-69]*	§495.6(d)(15)(ii) - Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	§170.302(o) - **Access control.** Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information. *[75 FR 44617]* §170.302(p) - **Emergency access**. Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency. *[75 FR 44617]* §170.302(q) - **Automatic log-off**. Terminate an electronic session after a predetermined time of inactivity. *[75 FR 44617-18]*	

MEANINGFUL USE 42 CFR 495.6(d)-(e)		CERTIFICATION CRITERIA 45 CFR 170.302 & 170.304	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
CORE SET [Repeat] §495.6(d)(15)(i) - Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. *[75 FR 44368-69]*	§495.6(d)(15)(ii) - Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	§170.302(r) - **Audit log**. (1) *Record actions.* Record actions related to electronic health information in accordance with the standard specified in §170.210(b). (2) *Generate audit log.* Enable a user to generate an audit log for a specific time period and to sort entries in the audit log according to any of the elements specified in the standard at §170.210(b). *[75 FR 44618-20]*	***Record actions related to electronic health information.*** ▪ §170.210(b) - The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which actions(s) occurred and by whom must also be recorded.
		§170.302(s) - **Integrity**. (1) Create a message digest in accordance with the standard specified in §170.210(c). (2) Verify in accordance with the standard specified in §170.210(c) upon receipt of electronically exchanged health information that such information has not been altered. (3) *Detection.* Detect the alteration of audit logs. *[75 FR 44620-21]*	***Verification that electronic health information has not been altered in transit.*** ▪ §170.210(c) - A hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm (SHA-1) as specified by the National Institute of Standards and Technology (NIST) in FIPS PUB 180-3 (October, 2008) must be used to verify that electronic health information has not been altered.
		§170.302(t) - **Authentication**. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information. *[75 FR 44621]*	
		§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. *[75 FR 44621-23]*	***Encryption and decryption of electronic health information.*** ▪ §170.210(a)(1) - Any encryption algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the Federal Information Processing Standards (FIPS) Publication 140-2 (incorporated by reference in §170.299).
		§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). *[75 FR 44621-23]*	***Encryption and decryption of electronic health information.*** ▪ §170.210(a)(2) - Any encrypted and integrity protected link.
		§170.302(w) - **Optional. Accounting of disclosures**. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in §170.210(d). *[75 FR 44623-24]*	***Record treatment, payment, and health care operations disclosures.*** ▪ §170.210(d) - The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations, as these terms are defined at 45 CFR 164.501.

MEANINGFUL USE 42 CFR 495.6(d)-(e)		CERTIFICATION CRITERIA 45 CFR 170.302 & 170.304	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
MENU SET §495.6(e)(1)(i) - Implement drug-formulary checks. *[75 FR 44334-36]*	§495.6(e)(1)(ii) - The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period *§495.6(e)(1)(iii) - Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.*	§170.302(b) - **Drug-formulary checks**. Enable a user to electronically check if drugs are in a formulary or preferred drug list. *[75 FR 44600-03]*	
§495.6(e)(2)(i) - Incorporate clinical lab-test results into EHR as structured data. *[75 FR 44346-47]*	§495.6(e)(2)(ii) - More than 40% of all clinical lab tests results ordered by the EP 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. *§495.6(e)(2)(iii) - Exclusion: Any EP who orders no lab tests whose results are either in a positive/ negative or numeric format during the EHR reporting period.*	§170.302(h) - **Incorporate laboratory test results.** (1) *Receive results.* Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. (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. *[75 FR 44607-09]*	
§495.6(e)(3)(i) - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. *[75 FR 44347-48]*	§495.6(e)(3)(ii) - Generate at least one report listing patients of the EP with a specific condition.	§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. *[75 FR 44609-10]*	
§495.6(e)(4)(i) - Send reminders to patients per patient preference for preventive/follow-up care. *[75 FR 44348-49]*	§495.6(e)(4)(ii) – More than 20% of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. *§495.6(e)(4)(iii) – Exclusion: An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.*	§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. *[75 FR 44627-28]*	
§495.6(e)(5)(i) - Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP. *[75 FR 44356-58]*	§495.6(e)(5)(ii) - At least 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. *§495.6(e)(5)(iii) - Exclusion: Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.*	§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. *[75 FR 44630-31]*	

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Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
MENU SET			
§495.6(e)(6)(i) - Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. *[75 FR 44359-60]*	§495.6(e)(6)(ii) - More than 10% of all unique patients seen by the EP are provided patient-specific education resources.	§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. *[75 FR 44642]*	
§495.6(e)(7)(i) - The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. *[75 FR 44362-63]*	§495.6(e)(7)(ii) - The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP. *§495.6(e)(7)(iii) - Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.*	§170.302(j) - **Medication reconciliation.** Enable a user to electronically compare two or more medication lists. *[75 FR 44613-14]*	
§495.6(e)(8)(i) - The EP 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 care record for each transition of care or referral. *[75 FR 44363-64]*	§495.6(e)(8)(ii) - The EP 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. *§495.6(e)(8)(iii) - Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.*	§170.304(i) - **Exchange clinical information and patient summary record.** (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, 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, 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(c); and (C) *Medications.* The standard specified in §170.207(d). *[75 FR 44632-35]*	***Patient summary record.*** ▪ §170.205(a)(1) - HL7 CDA Release 2, CCD. *Implementation specifications.* HITSP Summary Documents Using HL7 CCD Component HITSP/C32. ▪ §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369. ***Problems.*** ▪ §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions. ▪ §170.207(a)(2) - IHTSDO SNOMED CT® July 2009 version. ***Laboratory test results.*** ▪ §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. ***Medication.*** ▪ §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

MEANINGFUL USE 42 CFR 495.6(d)-(e)		CERTIFICATION CRITERIA 45 CFR 170.302 & 170.304	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs		Ambulatory Setting	
§495.6(e)(9)(i) - Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. **[75 FR 44364-66]**	§495.6(e)(9)(ii) - 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 submits such information has the capacity to receive the information electronically). *§495.6(e)(9)(iii) – Exclusion: An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.*	§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). **[75 FR 44614-15]**	***Electronic submission to immunization registries.*** ▪ §170.205(e)(1) - HL7 2.3.1. *Implementation specifications.* Implementation Guide for Immunization Data Transactions using Version 2.3.1 of the HL7 Standard Protocol. Implementation Guide Version 2.2. ▪ §170.205(e)(2) - HL7 2.5.1. *Implementation specifications.* HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0. ***Immunizations.*** §170.207(e) - HL7 Standard Code Set CVX—Vaccines Administered, July 30, 2009 version.
§495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. **[75 FR 44367-68]**	§495.6(e)(10)(ii) - 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 submits such information has the capacity to receive the information electronically). *§495.6(e)(10)(iii) - Exclusion: 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.*	§170.302(l) - **Public health surveillance**. Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard specified in §170.205(d)(1) or §170.205(d)(2). **[75 FR 44615-16 and 62687-88]**	***Electronic submission to public health agencies for surveillance or reporting.*** ▪ §170.205(d)(1) - HL7 2.3.1. ▪ §170.205(d)(2) - HL7 2.5.1.
N/A	N/A	§170.302(n) - **Automated measure calculation**. For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure. **[75 FR 44642-43]**	

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