

**Health Information Technology Exchange of Connecticut
Special Populations Committee Meeting Minutes**

Thursday, July 7, 2011

1:30 PM – 2:30 PM

PRESENT: Mark Masselli (Co-Chair), Brenda Kelley (Co-Chair), Ellen Andrews, Matthew Barrett, Cynthia Burns, Jennifer Carroll, Scott Cleary, Rene Gilbert (phone), Pamela Higgins, Sharon Joseph, Marlene Kurban, Catherine La Forza, Marie Mormile-Mehler (phone), Albert Miles, Sheila Molony, Mary Ann O'Brien, Egondy Onyejekwe, Beth Petroni, Thomas Rudkin, Steven Tenner (phone), Thomas Van Hoof, Barbara Parks Wolf

DPH REPRESENTATIVE: Sarju Shah

CALL TO ORDER

Mark Masselli called the meeting to order at 1:30 PM.

M. Masselli thanked Brenda Kelley for hosting the committee meeting.

INTRODUCTION: Update on HITE-CT- where it is now

By March of 2010, the Office of the National Coordinator for Health Information Technology (ONC) announced that 56 states and territories were awarded funds to rapidly build capacity to exchange health information across the health care system both within and across states. The Connecticut Department of Public Health (DPH) was awarded \$7.29 million dollars to support the development of a statewide HIE through ONC funds. DPH worked with the Health Information Technology Advisory Committee, the precursor to the Health Information Technology Exchange of Connecticut, to advise in developing a strategic and operational plan to support the building of this exchange. By October 2010, the Health Information Technology Exchange of Connecticut (HITE-CT) was established through a legislative mandate. This newly formed quasi-public agency, with the support of the DPH, is laying the pathway to move Connecticut to the universal adoption securely exchanging health information electronically, to support a nationwide health information exchange and interoperability.

For more information about the HITE-CT please go to <http://1.usa.gov/HITECT>.

PURPOSE OF THE SPECIAL POPULATIONS COMMITTEE: Priorities and Objectives

This Committee is charged with ensuring that the design of the HIE addresses the specific needs and disparities among special and vulnerable populations. This Committee is a communication vehicle that will engage and educate consumers about health information technology, its'

ability to improve the quality of health care they receive and will advocate for consumer rights related to health information technology and health information exchange.

ONC requests that, at minimum, we engage the following groups:

- Medically underserved populations;
- Newborns, children and youth, including those in foster care;
- The elderly;
- Persons with disabilities;
- Limited English Proficiency persons;
- Persons with mental and substance abuse disorders; and
- Persons in long term care.

If there is anyone missing from this list and should be represented, please contact the Co-Chairs so that they can be contacted.

The Committee is responsible for developing a Patient/Consumer Bill of Rights – to develop a set of principles that will support the consumers to participate in the coordination of their own health care; to ensure that CT’s Health Information Exchange is designed to support these rights; and to ensure that consumers know and understand their rights.

Brenda Kelley thoroughly discussed following documents, the first 3 of which were developed by the national Consumer Partnership for e-Health, a non-partisan group of consumer, patient, and labor organizations dedicated to achieving a patient-centered health care system through expanded use of health information technology. AARP has been a partner at the national level with this Partnership.

1. Consumer Partnership for eHealth: Who We are
2. Consumer Partnership for eHealth: Health Information Technology – Consumer Principles
3. Top Ten Consumer Benefits in Stage 1 of Meaningful Use
4. Stage One Meaningful Use Table

The “Consumer Principles” and the “Top Ten Consumer Benefits” documents were looked at as a starting point to support the development of the Bill of Rights. The Committee recognizes that these principles may not all be completed by the end of this year, but it is what we need to move towards both in the short and long-term.

MEMBERSHIP

To participate as a committee member, please send a brief biosketch and resume to Ms. Sarju Shah at Sarju.Shah@ct.gov by **July 21, 2011**. Please keep in mind, Dr. Mullen, the Commissioner of the Department of Public Health and Chair of the HITE-CT, approves

membership to this and all committees for the HITE-CT. All meetings are open to the public and Dr. Mullen and the Committee Co-Chairs would like to keep this process inclusive.

OPEN DISCUSSION

1. The HITE-CT does not support sharing health information haphazardly. HITE-CT has taken the stance of following current Connecticut HIPPA laws, which has led them to an “opt-out” model. E. Andrews expressed her concern with the current model and considers “opt-in” a better model. Members acknowledged both views.
2. E. Andrews suggested that a thorough evaluation happen to ensure consumers know and understand their rights. HITE-CT, providers and provider organizations should be held accountable.
3. B. Kelley mentioned that there is no standard HIPAA form and that the consumers and the HITE-CT may have the ability to standardize this.
4. M. Barrett will send the Nursing Bill of Rights to the Co-Chairs
5. K. Gerber will send the link to the Klaus Report.
6. E. Onyejekwe will submit names of organizations that should be at the table.

NEXT STEP/ MEETING SCHEDULE

The next meeting is scheduled for **Wednesday, August 3, 2011 from 3:00 – 4:30 PM**. This meeting will be held at the Department of Information Technology building located at 101 East River Drive, East Hartford, CT.

ADJOURN

The meeting was adjourned at 2:45 PM.

SCHEDULE OF MEETINGS:

August 3, 2011



Who we are

The Consumer Partnership for eHealth (CPEH) is a non-partisan coalition led by the National Partnership for Women & Families, which has been working since 2005 to ensure that efforts to drive health information technology (HIT) adoption and health information exchange (HIE) meet the information needs of patients and their families. CPEH includes members from nearly 50 consumer, patient, and labor organizations working on both the national and local levels. The combined membership of CPEH represents more than 127 million Americans.

Our Advocacy

We feel strongly that health reform should result in an information-rich, patient-centered health care system, and that HIT is a critical tool for providing patient-centered care. The expanded use of HIT and HIE has enormous potential to improve health outcomes by improving clinical care, decreasing disparities, enhancing access to care, and improving research and public health. HIT is also critical for addressing consumers' biggest concerns about their experiences with the health care system: poor communication and care coordination, as well as the resulting medical errors, inaccurate diagnoses, and redundancies in care. As a tool for meeting the information needs of patients and their families and for connecting them to the health care system, HIT also has the potential to significantly increase patient engagement in the management of their health. When implemented in ways that protect the privacy and security of individuals' health information, HIT can help patients and their caregivers make better use of information to meet their health goals. Effective use of HIT – when coupled with broader system reforms – will also result in significant reductions in cost growth.

Our History

The CPEH began as a group of consumer advocates who were concerned about privacy and security implications of a piece of federal legislation that was introduced in 2005. The organizations involved in the early work of the CPEH agreed that HIT was essential to improving the quality and safety of health care, but that in order for electronic health information systems to be trusted, they must be implemented with strong privacy protections. Since then, this core group of consumer advocates has been joined by other consumer and patient organizations that are equally enthusiastic about pursuing HIT adoption as a key strategy for reforming the health care system into one that is truly patient-centered.

CPEH members working on the federal level had a significant impact on the crafting of the American Recovery and Reinvestment Act of 2009 (ARRA), which included a number of provisions that stimulate the adoption of HIT, protect privacy, and allocate significant public funding for these provisions. The CPEH has also successfully advocated patient-centered criteria, such as care coordination, patient access to information, and the collection of race, ethnicity, and primary language data, to be included in the requirements for federal incentive dollars created by ARRA. Without the strong, unified voice of CPEH at the table, the criteria for these incentives would provide very little value to patients and their families. CPEH members continue to advocate on both the state and national levels to advance HIT through a combination of strong policies and technology innovations, which both protect the privacy and security of individuals' health information and support the appropriate flow of information to those who need it.

We view HIT as fundamental not only to delivery system reform, but also to payment reform, since full and effective implementation of HIT is necessary to align payment for health care with the quality of that care. CPEH continues to be the leading consumer voice on HIT issues – a voice that's needed now more than ever before if we are to ensure that public and private resources are used to implement HIT in ways that support patient-centered health reform and the elimination of disparities in care.

Coalition members include:

- AARP
- AFL-CIO
- American Association of People with Disabilities (AAPD)
- American Diabetes Association
- American Federation of State, County, and Municipal Employees (AFSCME)
- American Federation of Teachers (AFT)
- American Hospice Foundation
- Asian & Pacific Islander American Health Forum
- Bazelon Center for Mental Health Law
- Black Women's Health Imperative
- California Health Collaborative
- California Office of Health Information Integrity
- California Privacy and Security Board
- Campaign for Mental Health Reform
- Center for Advancing Health
- Center for Democracy & Technology
- Center for Medical Consumers
- Center for Medicare Advocacy
- Childbirth Connection
- Children and Adults with Attention Deficit/Hyperactivity Disorder
- The Children's Partnership
- Citizen Action – Wisconsin
- Connecticut Health Policy Project
- Consumers Union
- Consumer Coalition for Quality Health Care
- Department for Professional Employees, AFL-CIO
- Disability Rights Legal Center
- Family Violence Prevention Fund
- Health Care For All
- Health Access California
- Healthwise
- The Informed Patient Institute
- Institute for Health, Law and Ethics
- International Union, United Auto Workers
- Legal Action Group
- Legal Services of Eastern Missouri
- March of Dimes
- Mental Health America
- Mental Health America - Wisconsin
- National Alliance for Hispanic Health
- National Association of People with AIDS
- National Breast Cancer Coalition
- National Caucus and Center on Black Aged, Inc.
- National Center on Domestic and Sexual Violence
- National Coalition for Cancer Survivorship
- National Committee to Preserve Social Security and Medicare (NCPSSM)
- National Consumers League (NCL)
- National Family Caregivers Association
- National Health Law Program
- National Partnership for Women & Families
- North Carolina Consumer Advisory Council on Health Information
- Piedmont Health Care Consortium
- Service Employees International Union (SEIU)
- The Society for Participatory Medicine
- Summit Health Institute for Research and Education (SHIRE)
- Title II Community AIDS National Network
- UHCAN Ohio
- United American Nurses
- United Auto Workers
- United Steelworkers International Union

For more information contact:

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National Partnership for Women & Families

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Email: epowell@nationalpartnership.org

Web: www.nationalpartnership.org/hit

The Consumer Partnership for e-Health is a non-partisan group of consumer, patient, and labor organizations dedicated to improving health care quality and achieving a patient-centered health care system through expanded use of information technology and knowledge sharing. The work of the Consumer Partnership for eHealth is generously supported by The Markle Foundation and The California Endowment.

Health Information Technology – Consumer Principles

2009

An interoperable system of electronic health information holds many potential benefits for consumers, including: better coordination of health care regardless of patient location, higher quality and more efficient care, increased system transparency, and patient access to information about providers that allows them to make better decisions. At the same time, such a system raises serious concerns among consumers about personal privacy, data security, and the potential misuse of their information. And while an interoperable system of electronic health information holds great promise, the many possible benefits will not be realized unless appropriate policy measures are established up front.

Consumer protections and potential benefits from health information technology (HIT) should not be left to chance. The success of efforts to promote widespread adoption of HIT, including electronic connectivity and data exchange across health care institutions, ultimately will depend on the willingness of consumers to accept the technology. Given the pervasive concerns expressed by the public about unauthorized disclosure and use of their health information, it is critical to build a foundation of public trust. To that end, as efforts move forward to develop networks for the electronic exchange of information between institutions, there must be a clear, deliberate, and open forum for addressing and setting matters of policy. As organizations representing a broad and diverse set of consumer interests, we believe that the following set of principles should underpin such efforts.

Principles

Individuals should be able to access their personally identifiable health information conveniently and affordably.

- Individuals should have a means of direct, secure access to their electronic health information that does not require physician or institutional mediation.
- Individuals should have access to all electronic records pertaining to themselves (except in cases of danger to the patient or another person).
- Individuals should be able to supplement, request correction of, and share their personally identifiable health information without unreasonable fees or burdensome processes.

Individuals should know how their personally identifiable health information may be used and who has access to it.

- Individuals should receive easily understood information identifying the types of entities with access to their personal health information and all the ways it may be used or shared. The explanation should include any sharing for purposes other than the immediate care of the individual, and should explicitly identify intentions for data use such as public health protection, quality improvement, prevention of medical errors, medical research or commercial purposes.

- Access to personal health information must be limited to authorized individuals or entities.
- Tracking and audit trail systems should be in place that permit individuals to review which entities have entered, accessed, modified and/or transmitted any of their personally identifiable health information.

Individuals should have control over whether and how their personally identifiable health information is shared.

- Individuals should be able to opt out of having their personally identifiable health information – in whole or in part – shared across an electronic health information network.
- Individuals should be able to limit the extent to which their health information (with or without personal identifiers) is made available for commercial purposes.
- Individuals should be able to designate someone else, such as a family member, caregiver or legal guardian, to have access to and exercise control over how records are shared, and also should be able to rescind this designation.

Systems for electronic health data exchange must protect the integrity, security, privacy and confidentiality of an individual's information.

- Personally identifiable health information should be protected by reasonable safeguards against such risks as loss or unauthorized access, destruction, use, modification, or disclosure of data. These safeguards must be developed at the front end and must follow the information as it is accessed or transferred.
- Individuals should be notified in a timely manner if their personally identifiable health information is subject to a security breach or privacy violation.
- Meaningful legal and financial remedies should exist to address any security breaches or privacy violations.
- Federal privacy standards that restrict the use and disclosure of personally identifiable health information should apply to all entities engaged in health information exchanges.

The governance and administration of electronic health information networks should be transparent, and publicly accountable.

- Independent bodies, accountable to the public, should oversee electronic health information sharing.
- Consumers should have equal footing with other stakeholders.

Recognizing the potential of electronic patient data to support quality measurement, provider and institutional performance assessment, relative effectiveness and outcomes research, prescription drug monitoring, patient safety, public health, informed decisionmaking by patients and other public interest objectives, systems should be designed to fully leverage that potential, while protecting patient privacy.

Implementation of any regional or national electronic health information network should be accompanied by a significant consumer education program so that people understand how the network will operate, what information will and will not be available on the network, the value of the network, its privacy and security protections, how to participate in it, and the rights, benefits

and remedies afforded to them. These efforts should include outreach to those without health insurance coverage.

AARP

AFL-CIO

American Federation of State, County and Municipal Employees

American Federation of Teachers

Bazelon Center for Mental Health Law

Center for Democracy and Technology

Center for Medical Consumers

Communications Workers of America

Consumers Union

Department for Professional Employees, AFL-CIO

Childbirth Connection

Health Care for All

International Association of Machinists and Aerospace Workers

International Union, United Auto Workers

March of Dimes

Mental Health America

National Coalition for Cancer Survivorship

National Committee to Preserve Social Security and Medicare

National Consumers League

National Partnership for Women & Families

Service Employees International Union

The Children's Partnership

Title II Community AIDS National Network

United Steelworkers International Union (USW)

This product generously supported by the Markle Foundation.

Top Ten Consumer Benefits in Stage 1 of Meaningful Use

FACT SHEET

On July 13, 2010 the Centers for Medicare & Medicaid Services (CMS) released a final rule detailing incentive payments for the meaningful use of certified Electronic Health Record (EHR) technology. With this rule, CMS has ensured that tax-payer-funded incentive payments do not simply go to digitizing paper records but to actually improving the quality of care.

The final rule builds a foundation for meaningful changes in our health care system by promoting tangible advancements in quality, safety and value, including many direct benefits to patients and their caregivers.

1. Patient Access to Their Personal Health Information.

One of the most immediate needs patients and their caregivers have is direct access to health information that supports them in better managing and coordinating their care and making informed health care decisions. The final rule moves us in the right direction by ensuring that patients can receive electronic copies of their medical record within three business days – a huge improvement over the 30 days allowed for paper records. It also requires practice-based physicians to provide comprehensive summaries of a patient's care within three days of an office visit, and requires hospitals to deliver discharge instructions electronically upon request. It also calls on both physicians and hospitals to provide patients with ongoing, timely electronic access to their health information (such as through a patient portal or Personal Health Record).¹

In Stage One, the rule only requires that providers give patients electronic copies of their health information *upon request (this applies to copies of medical records and hospital discharge summaries)*. Many patients will not know that this is an option and not make such a request. Stakeholders should educate the public about the availability of this information in electronic formats.

2. Protection from Dangerous Drug Interactions and other Medical Errors.

Chronic illness is a growing problem as Americans live longer, but sicker, lives. To help maintain their health and quality of life, many Americans take multiple prescription drugs – in worst-case scenarios, up to 50 or more prescriptions a year.² The final rule calls on providers and hospitals to maintain active medication and medication allergy lists for their patients and perform medication reconciliation* (a process for identifying the most accurate list of all medications the patient is currently taking) at each transition of care to protect patients from dangerous drug interactions. Plus, by requiring physicians to enter electronic orders for medications for appropriate patients, the final rule will help reduce the number of errors caused by illegible handwriting.

3. Improved Coordination and Communication.

Transitioning from one care setting to another can be one of the most perilous scenarios for vulnerable patients. Often key information is lost in the shuffle between different physicians, hospitals and/or home. To receive meaningful use incentives in Stage One, physicians and hospitals have the option of ensuring that a summary care record* is communicated to the patient's other providers during a care transition.* In addition, to lay the groundwork for robust information exchange among care team members in the future, all meaningful users in 2011 will establish and test their ability to exchange important clinical information with another provider.

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- 4. *Fostering Patient Engagement in Their Care.*** Patient engagement, through partnership and shared decision-making with providers, is a crucial component of high-quality patient-centered care. Research has shown that engaged patients not only have better health outcomes, but also better experiences of care.³ The final rule opens the door for increased patient engagement by calling on physicians to provide their patients with condition-specific educational resources.* EHR systems can be designed to act as mini-search engines by using information stored in the patient's health record to find resource materials that match their unique health needs. These resources will play an important role in helping patients and family caregivers understand their health conditions and facilitate self-management and efficacy.

In addition, the final rule calls on hospitals to record the presence of advance directives for patients 65 and older.* This will not only provide information vital to following a patient's wishes for his or her care, but also will create opportunities to have important discussions with patients and families. In future stages, it will be important for all providers, both practice-based and hospital-based, to record this information.

- 5. *Reducing Health Disparities.*** The first step to improving care for vulnerable populations is acquiring better information to identify health disparities and develop strategies to reduce and eliminate them. In Stage One, providers are required to record patient demographic data, including race, ethnicity, preferred language and gender. With this information, providers can and should pinpoint gaps in care for underserved and vulnerable populations and make improvements. For Medicaid providers, states have the option to strengthen this criterion for Stage One by also requiring that providers actually use this information, such as by stratifying lists of patients with specific conditions by demographic variables in order to identify and reduce disparities in those areas of care.
- 6. *Patient Reminders for Preventive and Follow-Up Care.*** The health care system needs to begin engaging patients and their families, so they can take the necessary steps to stay healthy or, if chronically ill, to manage their conditions to maximize their quality of life. A critical first step is letting patients know when they need preventive and follow-up care. For Stage One, the final rule calls on providers to send patients age 65 and older and parents of children 5 and under reminders for such care.* This is a good starting place and may encourage providers to send clinically-appropriate reminders to all patients who need and want them, regardless of age.
- 7. *Enhancing Patient Privacy and Security.*** As the health care system moves from paper to electronic records, patients need to know that their personal health information will be secure and private. The final rule requires providers to conduct security risk assessments of their EHR systems and correct any deficiencies identified. In addition, all EHR systems will have to meet a set of privacy and security technical standards to be certified. Moving forward, CMS and the Office of the National Coordinator for Health Information Technology (ONC) should help providers understand and adopt best practices in privacy and security, as well as ensure that any providers that violate federal or state privacy laws are ineligible for meaningful use incentives.
- 8. *Meaningful Quality Reporting.*** Quality reporting helps providers evaluate the overall quality of care they provide and identify where improvements are needed. It also helps patients make informed decisions about where to get the best treatment and allows them to have confidence that new delivery and payment models will not skimp on care to cut costs. Quality measurement is essential to knowing whether the meaningful use of health IT is delivering on its promise to improve the quality of our health care system.

CMS has chosen a streamlined set of measures for Stage One that will ensure that every practice-based physician, regardless of specialty, reports on a core group of three measures related to obesity, hypertension and smoking, as well as on three additional measures of the provider's choosing that best reflect the nature of the provider's practice. Hospitals will be required to report on a core set of 15 measures. While the specific clinical measures chosen are relatively basic, their inclusion will give providers experience with reporting on these measures electronically and set the stage to include those more meaningful to patients and families – such as outcomes, functional status and patient experience – in the future.

9. **Reducing Costs.** The final rule includes many provisions that will greatly improve the efficiency of our health care system and help reign in out-of-control costs. By fostering better coordination and communication and making all of a patient's relevant health information available to providers in real time, the rule lays the groundwork for reducing the number of repeat tests and medical errors patients have to endure. In addition, with electronic access to their health information and educational resources, patients will be better able to manage their own health and have fewer costly encounters with the health care system.
10. **Rejecting the Status Quo and Transforming the Health Care System.** Instead of reinforcing the status quo by just digitizing paper records, the final rule requires providers who receive incentive payments to put in place innovative and transformational processes and strategies that move us closer to a patient-centered health care system, ensuring that the expenditure of these taxpayer dollars will ultimately benefit the American public. The final rule strikes a good balance between being transformative yet achievable, building the foundation for reform essential to successful implementation of the Affordable Care Act.

For more information, contact Christine Monahan, (202) 986-2600, cmohan@nationalpartnership.org or visit www.nationalpartnership.org/hit

* The final rule divides Stage One objectives into a core and menu set. All core objectives are mandatory. Of the menu objectives, providers can defer up to five. All Stage One core and menu objectives will be mandatory in Stage Two. In this fact sheet, all menu objectives are indicated with stars.

¹ Berenson, R. & Horvath, J. (2002). The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform. Prepared for: The Center for Medicare Advocacy Conference on Medicare Coordinated Care, Washington, DC. Retrieved September 24, 2009, from www.partnershipforsolutions.org.

¹¹ For example, see Hibbard, J. Engaging Health Care Consumers to Improve the Quality of Care. *Medical Care* 2003; 41(1) Supplement: I-61-I-70; Lorig K, Sobel DS, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. *Med Care* 1999;37:5-14; Greenfield S, Kaplan S, Ware JE. Expanding patient involvement in care: effects on patient outcomes. *Ann Intern Med* 1985;102:520-528; or, Greenfield S, Kaplan S, Ware JE, et al. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes. *J Gen Intern Med* 1988;3:448-457.

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p>§495.6(d)(1)(i) / §495.6(f)(1)(i)</p> <p>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.</p> <p>[75 FR 44331-34]</p>	<p>§495.6(d)(1)(ii) / §495.6(f)(1)(ii)</p> <p>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.</p> <p>§495.6(d)(1)(iii) - Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</p>	<p>§170.304(a) / §170.306(a)</p> <p>Computerized provider order entry. Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types:</p> <p>(1) Medications; (2) Laboratory; and (3) Radiology/imaging.</p> <p>[75 FR 44624-25] [75 FR 44635-36]</p>	
<p>§495.6(d)(2)(i) / §495.6(f)(2)(i)</p> <p>Implement drug-drug and drug-allergy interaction checks.</p> <p>[75 FR 44334-36]</p>	<p>§495.6(d)(2)(ii) / §495.6(f)(2)(ii)</p> <p>The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period.</p>	<p>§170.302(a)</p> <p>Drug-drug, drug-allergy interaction checks.</p> <p>(1) <i>Notifications.</i> 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) <i>Adjustments.</i> Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.</p> <p>[75 FR 44600-03]</p>	
<p>§495.6(d)(3)(i) / §495.6(f)(3)(i)</p> <p>Maintain an up-to-date problem list of current and active diagnoses.</p> <p>[75 FR 44336-37]</p>	<p>§495.6(d)(3)(ii) / §495.6(f)(3)(ii)</p> <p>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.</p>	<p>§170.302(c)</p> <p>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:</p> <p>(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).</p> <p>[75 FR 44603-04]</p>	<p>Problems.</p> <ul style="list-style-type: none"> §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.
<p>§495.6(d)(4)(i)</p> <p>Generate and transmit permissible prescriptions electronically (eRx).</p> <p>[75 FR 44337-38]</p>	<p>§495.6(d)(4)(ii)</p> <p>More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.</p> <p>§495.6(d)(4)(iii) - Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</p>	<p>§170.304(b)</p> <p>Electronic prescribing. Enable a user to electronically generate and transmit prescriptions and prescription-related information in accordance with:</p> <p>(1) The standard specified in §170.205(b)(1) or §170.205(b)(2); and (2) The standard specified in §170.207(d).</p> <p>[75 FR 44625-27]</p>	<p>Electronic prescribing.</p> <ul style="list-style-type: none"> §170.205(b)(1) - NCPDP SCRIPT Version 8.1. §170.205(b)(2) - NCPDP SCRIPT Version 10.6. <p>Medications.</p> <ul style="list-style-type: none"> §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.
<p>§495.6(d)(5)(i) / §495.6(f)(4)(i)</p> <p>Maintain active medication list.</p> <p>[75 FR 44338-39]</p>	<p>§495.6(d)(5)(ii) / §495.6(f)(4)(ii)</p> <p>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.</p>	<p>§170.302(d)</p> <p>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.</p> <p>[75 FR 44604]</p>	

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
§495.6(d)(6)(i) / §495.6(f)(5)(i) Maintain active medication allergy list. [75 FR 44339-40]	§495.6(d)(6)(ii) / §495.6(f)(5)(ii) 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.	§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.	
§495.6(d)(7)(i) / §495.6(f)(6)(i) Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth. (F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH. [75 FR 44340-42]	§495.6(d)(7)(ii) / §495.6(f)(6)(ii) 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.	§170.304(c) / §170.306(b) Record demographics. Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, date of birth, and date and preliminary cause of death in the event of mortality. Enable race and ethnicity to be recorded in accordance with the standard specified at 170.207(f). [75 FR 44627] [75 FR 44636]	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) / §495.6(f)(7)(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) / §495.6(f)(7)(ii) 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. §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) <i>Vital signs.</i> Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, height, weight, and blood pressure. (2) <i>Calculate body mass index.</i> Automatically calculate and display body mass index (BMI) based on a patient's height and weight. (3) <i>Plot and display growth charts.</i> Plot and electronically display, upon request, growth charts for patients 2–20 years old. [75 FR 44605-06]	
§495.6(d)(9)(i) / §495.6(f)(8)(i) Record smoking status for patients 13 years old or older. [75 FR 44344-45]	§495.6(d)(9)(ii) / §495.6(f)(8)(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. §495.6(f)(8)(iii) – Exclusion: Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23).	§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]	

CORE SET

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p style="text-align: right;">§495.6(d)(10)(i) / §495.6(f)(9)(i)</p> <p>Report ambulatory/hospital clinical quality measures to CMS or, in the case of Medicaid EPs/eligible hospitals, the States.</p> <p style="text-align: right;">[75 FR 44348]</p>	<p style="text-align: right;">§495.6(d)(10)(ii) / §495.6(f)(9)(ii)</p> <p>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).</p> <p>Subject to paragraph (c) of this section, successfully report to CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States) hospital clinical quality measures selected by CMS in the manner specified by CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States).</p> <p>[Preamble Reference]</p> <ul style="list-style-type: none"> 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. 	<p style="text-align: right;">§170.304(j) / §170.306(i)</p> <p>Calculate and submit clinical quality measures.</p> <p>(1) <i>Calculate.</i></p> <p>(i) Electronically calculate all of the core clinical measures specified by CMS for eligible professionals.</p> <p>(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).</p> <p>(2) <i>Submission.</i> Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in §170.205(f).</p> <hr/> <p>Calculate and submit clinical quality measures.</p> <p>(1) <i>Calculate.</i> Electronically calculate all of the clinical quality measures specified by CMS for eligible hospitals and critical access hospitals.</p> <p>(2) <i>Submission.</i> Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in §170.205(f).</p> <p style="text-align: right;">[75 FR 44610-12] [75 FR 44610-12]</p>	<p>Quality reporting.</p> <ul style="list-style-type: none"> §170.205(f) - CMS PQRI 2009 Registry XML Specification. <i>Implementation specification:</i> PQRI Measure Specifications Manual for Claims and Registry.
<p style="text-align: right;">§495.6(d)(11)(i) / §495.6(f)(10)(i)</p> <p>Implement one clinical decision support rule relevant to specialty or high clinical priority/related to a high priority hospital condition along with the ability to track compliance with that rule.</p> <p style="text-align: right;">[75 FR 44350-51]</p>	<p style="text-align: right;">§495.6(d)(11)(ii) / §495.6(f)(10)(ii)</p> <p>Implement one clinical decision support rule.</p>	<p style="text-align: right;">§170.304(e) / §170.306(c)</p> <p>Clinical decision support.</p> <p>(1) <i>Implement rules.</i> 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.</p> <p>(2) <i>Notifications.</i> Automatically and electronically generate and indicate in real-time, notifications and care suggestions based upon clinical decision support rules.</p> <p style="text-align: right;">[75 FR 44628-29] [75 FR 44636-37]</p>	

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p>§495.6(d)(12)(i) / §495.6(f)(11)(i)</p> <p>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.</p> <p>[75 FR 44353-55]</p>	<p>§495.6(d)(12)(ii) / §495.6(f)(11)(ii)</p> <p>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.</p> <p>§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.</p> <p>§495.6(f)(11)(iii) - Exclusion: 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.</p>	<p>§170.304(f) / §170.306(d)</p> <p>Electronic copy of health information.</p> <p>(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:</p> <p>(1)(i) Human readable format; and</p> <p>(2)(ii) On electronic media or through some other electronic means in accordance with:</p> <p>(i)(A) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and</p> <p>(ii)(B) For the following data elements the applicable standard must be used:</p> <p>(A)(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);</p> <p>(2) Procedures. The standards specified in §170.207(b)(1) or §170.207(b)(2);</p> <p>(B)(3) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and</p> <p>(C)(4) Medications. The standard specified in §170.207(d).</p> <p>(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.</p> <p>[75 FR 44629-30] [75 FR 44637-38]</p>	<p>Patient summary record.</p> <ul style="list-style-type: none"> §170.205(a)(1) - HL7 CDA Release 2, CCD. <i>Implementation specifications:</i> 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. <p>Problems.</p> <ul style="list-style-type: none"> §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. <p>Procedures.</p> <ul style="list-style-type: none"> §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2). §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5). <p>Laboratory test results.</p> <ul style="list-style-type: none"> §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. <p>Medication.</p> <ul style="list-style-type: none"> §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.
<p>§495.6(f)(12)(i)</p> <p>Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.</p> <p>[75 FR 44355-56]</p>	<p>§495.6(f)(12)(ii)</p> <p>More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.</p> <p>§495.6(f)(12)(iii) - Exclusion: 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.</p>	<p>§170.306(e)</p> <p>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.</p> <p>[75 FR 44638-39]</p>	

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

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MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p>§495.6(d)(13)(i)</p> <p>Provide clinical summaries for patients for each office visit.</p> <p>[75 FR 44358-59]</p>	<p>§495.6(d)(13)(ii)</p> <p>Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.</p> <p>§495.6(d)(13)(iii) - Exclusion: Any EP who has no office visits during the EHR reporting period.</p>	<p>§170.304(h)</p> <p>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:</p> <p>(1) Provided in human readable format; and</p> <p>(2) Provided on electronic media or through some other electronic means in accordance with:</p> <p>(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and</p> <p>(ii) For the following data elements the applicable standard must be used:</p> <p>(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);</p> <p>(B) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and</p> <p>(C) Medications. The standard specified in §170.207(d).</p> <p>[75 FR 44631-32]</p>	<p>Patient summary record.</p> <ul style="list-style-type: none"> §170.205(a)(1) - HL7 CDA Release 2, CCD. <i>Implementation specifications:</i> 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. <p>Problems.</p> <ul style="list-style-type: none"> §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. <p>Laboratory test results.</p> <ul style="list-style-type: none"> §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. <p>Medication.</p> <ul style="list-style-type: none"> §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.
<p>§495.6(d)(14)(i) / §495.6(f)(13)(i)</p> <p>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.</p> <p>[75 FR 44360-62]</p>	<p>§495.6(d)(14)(ii) / §495.6(f)(13)(ii)</p> <p>Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.</p>	<p>§170.304(i) / §170.306(f)</p> <p>Exchange clinical information and patient summary record.</p> <p>(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, and procedures 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.</p> <p>(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, and procedures in accordance with:</p> <p>(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and</p> <p>(ii) For the following data elements the applicable standard must be used:</p> <p>(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);</p> <p>(B) Procedure. The standard specified in §170.207(b)(1) or §170.207(b)(2);</p> <p>(B)(C) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and</p> <p>(C)(D) Medications. The standard specified in §170.207(d).</p> <p>[75 FR 44632-35] [75 FR 44639-40]</p>	<p>Patient summary record.</p> <ul style="list-style-type: none"> §170.205(a)(1) - HL7 CDA Release 2, CCD. <i>Implementation specifications:</i> 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. <p>Problems.</p> <ul style="list-style-type: none"> §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. <p>Procedure.</p> <ul style="list-style-type: none"> §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2). §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5). <p>Laboratory test results.</p> <ul style="list-style-type: none"> §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. <p>Medication.</p> <ul style="list-style-type: none"> §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.

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p style="text-align: center;">§495.6(d)(15)(i) / §495.6(f)(14)(i)</p> <p>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.</p> <p style="text-align: right;">[75 FR 44368-69]</p>	<p style="text-align: center;">§495.6(d)(15)(ii) / §495.6(f)(14)(ii)</p> <p>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.</p>	<p style="text-align: right;">§170.302(o)</p> <p>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.</p> <p style="text-align: right;">[75 FR 44617] §170.302(p)</p> <p>Emergency access. Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.</p> <p style="text-align: right;">[75 FR 44617] §170.302(q)</p> <p>Automatic log-off. Terminate an electronic session after a predetermined time of inactivity.</p> <p style="text-align: right;">[75 FR 44617-18] §170.302(r)</p> <p>Audit log.</p> <p>(1) <i>Record actions.</i> Record actions related to electronic health information in accordance with the standard specified in §170.210(b).</p> <p>(2) <i>Generate audit log.</i> 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).</p> <p style="text-align: right;">[75 FR 44618-20] §170.302(s)</p> <p>Integrity.</p> <p>(1) Create a message digest in accordance with the standard specified in §170.210(c).</p> <p>(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.</p> <p>(3) <i>Detection.</i> Detect the alteration of audit logs.</p> <p style="text-align: right;">[75 FR 44620-21] §170.302(t)</p> <p>Authentication. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.</p> <p style="text-align: right;">[75 FR 44621] §170.302(u)</p> <p>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.</p> <p style="text-align: right;">[75 FR 44621-23]</p>	<p>Record actions related to electronic health information.</p> <ul style="list-style-type: none"> §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. <p>Verification that electronic health information has not been altered in transit.</p> <ul style="list-style-type: none"> §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. <p>Encryption and decryption of electronic health information.</p> <ul style="list-style-type: none"> §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).

CORE SET

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

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MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p style="text-align: center;">§495.6(d)(15)(i) / §495.6(f)(14)(i)</p> <p>[Repeat]</p> <p>§495.6(d)(15)(i) - Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.</p> <p style="text-align: right;">[75 FR 44368-69]</p>	<p style="text-align: center;">§495.6(d)(15)(ii) / §495.6(f)(14)(ii)</p> <p>§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.</p>	<p style="text-align: right;">§170.302(v)</p> <p>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).</p> <p style="text-align: right;">[75 FR 44621-23] §170.302(w)</p> <p>Optional. Accounting of disclosures. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in §170.210(d).</p> <p style="text-align: right;">[75 FR 44623-24]</p>	<p>Encryption and decryption of electronic health information.</p> <ul style="list-style-type: none"> §170.210(a)(2) - Any encrypted and integrity protected link. <p>Record treatment, payment, and health care operations disclosures.</p> <ul style="list-style-type: none"> §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.
<p style="text-align: center;">§495.6(e)(1)(i) / §495.6(g)(1)(i)</p> <p>Implement drug-formulary checks.</p> <p style="text-align: right;">[75 FR 44334-36] §495.6(g)(2)(i)</p>	<p style="text-align: center;">§495.6(e)(1)(ii) / §495.6(g)(1)(ii)</p> <p>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.</p> <p style="text-align: center;">§495.6(e)(1)(iii) - Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</p>	<p style="text-align: right;">§ 170.302(b)</p> <p>Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.</p> <p style="text-align: right;">[75 FR 44600-03]</p>	
<p style="text-align: center;">§495.6(g)(2)(i)</p> <p>Record advance directives for patient 65 years old or older.</p> <p style="text-align: right;">[75 FR 44345-46] §495.6(g)(2)(i)</p>	<p style="text-align: center;">§495.6(g)(2)(ii)</p> <p>Subject to paragraph (c) of this section, more than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient (POS 21) have an indication of an advance directive status recorded as structured data.</p> <p style="text-align: center;">§495.6(e)(2)(iii) - Exclusion: An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.</p>	<p style="text-align: right;">§170.306(h)</p> <p>Advance directives. Enable a user to electronically record whether a patient has an advance directive.</p> <p style="text-align: right;">[75 FR 44641]</p>	
<p style="text-align: center;">§495.6(e)(2)(i) / §495.6(g)(3)(i)</p> <p>Incorporate clinical lab-test results into EHR as structured data.</p> <p style="text-align: right;">[75 FR 44346-47]</p>	<p style="text-align: center;">§495.6(e)(2)(ii) / §495.6(g)(3)(ii)</p> <p>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.</p> <p style="text-align: center;">§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.</p>	<p style="text-align: right;">§170.302(h)</p> <p>Incorporate laboratory test results.</p> <ol style="list-style-type: none"> Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record. <p style="text-align: right;">[75 FR 44607-09]</p>	

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p>§495.6(e)(3)(i) / §495.6(g)(4)(i)</p> <p>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p> <p>[75 FR 44347-48]</p>	<p>§495.6(e)(3)(ii) / §495.6(g)(4)(ii)</p> <p>Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.</p>	<p>§170.302(i)</p> <p>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:</p> <ol style="list-style-type: none"> (1) Problem list; (2) Medication list; (3) Demographics; and (4) Laboratory test results. <p>[75 FR 44609-10]</p>	
<p>§495.6(e)(4)(i)</p> <p>Send reminders to patients per patient preference for preventive/follow-up care.</p> <p>[75 FR 44348-49]</p>	<p>§495.6(e)(4)(ii)</p> <p>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.</p> <p>§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.</p>	<p>§170.304(d)</p> <p>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:</p> <ol style="list-style-type: none"> (1) Problem list; (2) Medication list; (3) Medication allergy list; (4) Demographics; and (5) Laboratory test results. <p>[75 FR 44627-28]</p>	
<p>§495.6(e)(5)(i)</p> <p>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.</p> <p>[75 FR 44356-58]</p>	<p>§495.6(e)(5)(ii)</p> <p>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.</p> <p>§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.</p>	<p>§170.304(g)</p> <p>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.</p> <p>[75 FR 44630-31]</p>	
<p>§495.6(e)(6)(i) / §495.6(g)(5)(i)</p> <p>Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.</p> <p>[75 FR 44359-60]</p>	<p>§495.6(e)(6)(ii) / §495.6(g)(5)(ii)</p> <p>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.</p>	<p>§170.302(m)</p> <p>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.</p> <p>[75 FR 44642]</p>	

Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p>§495.6(e)(7)(i) / §495.6(g)(6)(i)</p> <p>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.</p> <p>[75 FR 44362-63]</p>	<p>§495.6(e)(7)(ii) / §495.6(g)(6)(ii)</p> <p>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).</p> <p>§495.6(e)(7)(iii) - Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.</p>	<p>§170.302(j)</p> <p>Medication reconciliation. Enable a user to electronically compare two or more medication lists.</p>	
<p>§495.6(e)(8)(i) / §495.6(g)(7)(i)</p> <p>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.</p> <p>[75 FR 44363-64]</p>	<p>§495.6(e)(8)(ii) / §495.6(g)(7)(ii)</p> <p>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.</p> <p>§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.</p>	<p>§170.304(i) / §170.306(f)</p> <p>Exchange clinical information and patient summary record.</p> <p>(1) <i>Electronically receive and display.</i> 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, and procedures 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.</p> <p>(2) <i>Electronically transmit.</i> 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, and procedures in accordance with:</p> <p>(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and</p> <p>(ii) For the following data elements the applicable standard must be used:</p> <p>(A) <i>Problems.</i> The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);</p> <p>(B) <i>Procedures:</i> The standard specified in §170.207(b)(1) or §170.207(b)(2);</p> <p>(B)(C) <i>Laboratory test results.</i> At a minimum, the version of the standard specified in §170.207(c); and</p> <p>(C)(D) <i>Medications.</i> The standard specified in §170.207(d).</p> <p>[75 FR 44632-35] [75 FR 44639-40]</p>	<p>Patient summary record.</p> <ul style="list-style-type: none"> §170.205(a)(1) - HL7 CDA Release 2, CCD. <i>Implementation specifications:</i> 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. <p>Problems.</p> <ul style="list-style-type: none"> §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. <p>Procedure.</p> <ul style="list-style-type: none"> §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2). §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5). <p>Laboratory test results.</p> <ul style="list-style-type: none"> §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory. <p>Medication.</p> <ul style="list-style-type: none"> §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)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210
Stage 1 Objective	Stage 1 Measure		
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting	
<p>Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.</p> <p style="text-align: right;">[75 FR 44364-66]</p>	<p>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).</p> <p><i>§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.</i></p> <p><i>§495.6(g)(8)(iii) – Exclusion: 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.</i></p> <p style="text-align: right;">[75 FR 44614-15]</p>	<p>§170.302(k)</p> <p>Submission to immunization registries. Electronically record, modify, retrieve, and submit immunization information in accordance with:</p> <p>(1) The standard (and applicable implementation specifications) specified in §170.205(e)(1) or §170.205(e)(2); and</p> <p>(2) At a minimum, the version of the standard specified in §170.207(e).</p> <p style="text-align: right;">[75 FR 44614-15]</p>	<p>Electronic submission to immunization registries.</p> <ul style="list-style-type: none"> • §170.205(e)(1) - HL7 2.3.1. <i>Implementation specifications:</i> 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. <i>Implementation specifications:</i> HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0. <p>Immunizations.</p> <ul style="list-style-type: none"> • §170.207(e) - HL7 Standard Code Set CVX– Vaccines Administered, July 30, 2009 version.
<p>Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission according to applicable law and practice.</p> <p style="text-align: right;">[75 FR 44366-67]</p>	<p>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 an eligible hospital or CAH submits such information has the capacity to receive the information electronically).</p> <p><i>§495.6(g)(9)(iii) – Exclusion: No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.</i></p> <p style="text-align: right;">[75 FR 44640-41]</p>	<p>§170.306(g)</p> <p>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).</p> <p style="text-align: right;">[75 FR 44640-41]</p>	<p>Electronic submission of lab results to public health agencies.</p> <ul style="list-style-type: none"> • §170.205(c) - HL7 2.5.1. <i>Implementation specifications:</i> HL7 Version 2.5.1. Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm). • §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.

MENU SET

MEANINGFUL USE 42 CFR 495.6(d)-(g)		CERTIFICATION CRITERIA 45 CFR 170.302, 170.304, & 170.306	STANDARD(S) 45 CFR 170.205, 170.207, & 170.210	
Stage 1 Objective	Stage 1 Measure			
EPs / EHs & CAHs		Ambulatory Setting / Inpatient Setting		
MENU SET	§495.6(e)(10)(i) / §495.6(g)(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) / §495.6(g)(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, eligible hospital or CAH submits such information have the capacity to receive the information electronically). <i>§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.</i> <i>§495.6(g)(10)(iii) - Exclusion: No public health agency to which the eligible hospital or CAH submits information has the capacity to receive the information electronically.</i> [75 FR 44615-16 and 62687-88]	§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. <ul style="list-style-type: none"> ▪ §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]	