1

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

Patient Engagement Power Team
Leslie Kelly Hall, Chair: Arien Malec, Jim Hansen and Liz Johnson co-leads, sub-teams

Overall Comments:
Patient Engagement is still evolving/taking shape in practice, in HIT and in Meaningful Use. Consequently, the HITSC patient engagement power team spent considerable time and energy determining what commentary would qualify as in scope and what would not. The team returned to the overarching CMS theme of "Engaging Patients and Their Families in Care" and focused on ensuring Meaningful Use 2 standards meet current opportunities as well as anticipate future policy that encourages engagement. In the case where standards exist and policy does not, we recommend modifications to standards to encourage engagement. Conversely where policy exists and standards do not exist, we are suggesting standards be defined as a requirement of Meaningful Use 2. Finally, where standards are required, and not yet defined, the standards developed should include patient-facing systems and patient and/or patient designee(s) as roles within the standard. This will provide HIT vendors the opportunity for development efficiencies and encourage innovative thinking.
The comments will incorporate three complementary approaches: 1) Overarching principles of patient engagement, 2) Specific themes or rationale for changes, 3) Specific recommendations for the standards. Specific reasons behind comments are consistent across many of the objectives. For clarity, however, we have highlighted the most relevant. We encourage the review of all specific rationales in relation to each objective. The goal is to inform future objectives and standards as a bellwether for patient engagement.
Although this team was not charged with commenting on clinical quality measures, we felt that patient engagement may easily be incorporated as each quality measure is considered. A patient specific report card that answers the question, "How does my care compare" helps meet the overall goal of making quality information meaningful to patients. We encourage the development of a patient-facing structure that can accommodate this critical information and be used globally with CQM.

Technology Green-Field
Because the use of PHRs was not envisioned in the inception of EHRs, there is opportunity for the use of standards to help drive innovation in this "Green Field" development area. The team recommends that terms like PHR or patient portal be more broadly defined as Patient-Facing Systems, in order for innovation and future development to be encouraged and current system constructs not encumber efforts. Furthermore, prescriptive approaches for "lists" should be replaced by more advanced technology options, (like a patient API) in order to have flexibility for reporting and patient outreach.

Transitions of Care:
The transition of Care S&I framework has been meeting for a year and this work can inform many of the patient engagement and care coordination themes in this document. The consolidated CDA is a strong foundation for future patient generated data. Initial efforts could include structured approaches for patient responses to clinician requested information, with an eye to the future.

Advanced Directives
Making advanced directives available in the records is simply the right thing to do. Today, when a provider asks if a directive exists, the next question is, "do you have a copy?". The copy is retained in the chart. Making this existing workflow electronic is a logical outcome and enhances the ability for these directives to be acted upon. Additionally the work required will be material for any patient generated data in the future, to include patient direction, legal documents, and any documents where revisions are needed to be tracked. Patient directives will require some additional standards work as an example:

Directives Extension:

a. Identify location
b. Attach copy of Directive document(s)
c. New specific fields: Stage 2: CPR & intubation (C-CDA / SNOMED CT);
d. Stage 3: all supported C-CDA fields related to Directives and associated documents
e. Versioning

View, Download, and Transmit
Effective view, download and transmit capabilities are foundational tenants of not only patient engagement, but in supporting the transformational shift to a learning health and health care system. Each function (view, download and transmit) plays a complementary role in addressing the required use scenarios. Core principals emerged from the Power Team discussions in support of this premise:

- Designated proxy - The patient has the right to designate a proxy for themselves in which interactions traditionally intended for the patient are handled by the designee with and/or instead of the patients themselves. Thus all comments related to patients below also apply to their designee, if any.
- CC:ME - Any health information that is shared with providers, and/or with the patient as a discussion item, transition document, or handout should be made available on demand (or as a standing order) in the same format electronically, based on patient preferences and including links to patient specific education.
- Incorporation of patient generated data – Much of the information required to inform care decisions is gathered in a variety of inefficient and ad-hoc ways which can be significantly streamlined for efficiency. Standards developed for surveys of patient experience of care can be used in other applications.
- Fully computable, human comprehensible – electronic distribution should be computable and comprehensible, to include contextual linkages to patient specific education, all metadata and raw computable data.

(Attachment Consumer/Patient Preference EHR Enhancement Standards Document provides further clarity)

Metadata Retention and Reconciliation
As data is exchanged to patient facing systems (and between providers), the attachment of and retention of key metadata is important. Those metadata elements need to be specified, and where they do not exist they need to be fostered as key patient safety and coordination of care issues.

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The SCC NPRM puts forth the concept of "clinical information reconciliation" with respect to medication list, medication allergy list, and problem list. The importance of these lists does not need to be restated. We endorse the importance of reconciliation being a part of certification, particularly with respect to medication lists. Reconciliation is a critical process and involves the patient and caregivers, particularly with respect to medication lists.

Care Team Roster

The inclusion of a proposed requirement to list care team members in the NPRM is very important. Traditionally, the concept of a care team was the individuals in an inpatient facility or ambulatory practice involved in an individual's care. That list of individuals could be assembled from the EHR system of that entity to the extent that they had access to that individual's record. However, the concept of care team in MU and in PCMH efforts is a patient-centered care team that extends beyond an institution or single EHR system and includes the patient and caregivers, as well as non-physician providers in the community. The minimum dataset for this patient-centered care team roster that is part of patient demographics needs to include a unique identifier for the team member, the role on the care team, and contact information for the team member, including the potential data element that is an electronic endpoint address for the team member. That unique identifier might be the NPI and would thereby enable access to information about that individual care team member's qualifications and licensure from the publicly available NPI database. There is also the potential to leverage the current efforts to develop federated provider directories and services associated with those that facilitate privacy and security in exchange. The concepts of individual identity, contact information and patients and family members as participants are part of existing standards. But the required minimum dataset for a care team roster needs to be defined in the final rule.

Shared Decision Making: CDS

CDS design of the future should include the patient and their designee(s) in shared decision making. This shared decision making should focus on preference sensitive care areas where patient values and preferences provide material and relevant information to care and care plans. Additionally, patient preferences may inform clinical decision making and future alert design should accommodate patient directives. Examples: blood products, religious preferences etc.

Patient Engagement Themes

Overarching Theme Nothing About Me Without Me *Specific Rationale*	Overarching Theme I am a Contributing Care Team Member *Specific Rationale*	Overarching Theme Many EHR actions have a corresponding or correlating patient facing system reaction *Specific Rationale*	Overarching Theme: Patient Facing Systems are not limited by legacy transactional systems *Specific Rationale*	Overarching Theme How Does My Care Compare to CQM's? *Specific Rationale*
Understandable to me, plain language	I am a credible source of information and generate meaningful and material data for my care • Demographics • Vital signs • Family history • Medication adherence • Care adherence • Diet/exercise • Observations of Daily Living • Smoking Status • Patient Intolerance • Health History • Surgical History • Allergy • Advanced Directives • Patient response • Adherence • Pre-visit preparation • Preferences • Decisions	Structured data will empower patients through interoperable patient facing systems	Innovation can be encouraged beyond transactional systems with optional advanced standards. • E.g. Patient Facing API • Social media • Portable devices	Patient specific report cards for all clinical quality measures should be included within CQM standards
Understandable to me, my language	Patient generated data is relevant to care • Real-time • Historically • Iteratively • Prospectively	Current workflow can be adapted to support patient engagement	Transactional approaches should be the minimum standard	Patient quality alerts like device recalls and changes should be required.
My preferred communication method is used to contact me	My care goals may be: • Episodic • Chronic • Quality of Life	Standards should be expanded for patient facing systems and harmonized	Data should be VDT in a computable, transferable, moveable way able to be trended, and at the data element level and human readable level at the patient's preference	I know what I am enrolled or what opportunities there are for me in research
CC: ME or my designee(s)	I can contribute to CQM success • Counseling • Education • Adherence	Create once use often in both EHR and patient facing systems	Patient generated data should be able to be broadcast to all care participants based upon patient preference • create once use often	Use of system to proactively identify that I am getting the services that I should, when I should, compared to industry standards and/or people like me
Privacy and security for what I download is within my authority. Download patient directed/ patient protected	EHR should assume multiple providers in the care team including patient and their designee(s)	View and Transmits should be patient directed/provider protected.	Data standards should be accelerated where patient generated data is anticipated	
I can download or transmit none, some or all of my records within my authority:	I am a necessary and important safety checkpoint	Many orders by clinicians are directed to patients and/or are components of care plans	VDT should include links to patient specific education materials: IB standard.	
I expect my information within the EHR is secure and private: Patient directed: provider protected.	I am a health data exchange of one	Patient generate meaningful adherence information, (close the loop)	Single standard vocabularies should be harmonized in patient, EHR and CQM systems.	
Patient preferences inform care, safety and decisions	I am an important part of shared decision-making where preference sensitive care exists	Clinical information reconciliation needs to accommodate patient as participant	Design in "green field" areas like transitions of care should include patient and designee(s)	
My access should be immediate (as available to EP) or at my direction/preference, but no greater than 2 business days.	Secure messaging informs care and should be part of the care record.	Metadata needs to be preserved when communicating with patient facing systems		

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CORE

WG Leads:
- Leslie Kelly Hall-chair
- Jim Hansen
- Arien Malec
- Liz Johnson

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
1	EP	EH	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local and professional guidelines to create the first record of the order.	More than 60% of medication, laboratory, and radiology orders created by the EP or authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	The number of orders in the denominator recorded using CPOE.	Number of medication, radiology, and laboratory orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(1)** Computerized provider order entry. Enable a user to electronically record, change, and access the following order types, at a minimum: Laboratory recommendation re Medications (; and Radiology/imaging.	MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records.

Workgroup Comments: Nothing About Me Without Me: I am a Contributing Care Team Member: Many EHR actions have a corresponding or correlating patient facing system reaction:
CC: ME or my designee(s): current workflow can be adapted to support patient engagement: standard should be expanded for patient facing systems and harmonized: many orders by clinicians are directed to patients and or are components of care plans:

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CORE, continued

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2	EP		Generate and transmit permissible prescriptions electronically (eRx).	More than 65% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.	The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically.	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.	**§170.314(b)(3) /§170.314(a)(10)** Electronic prescribing. Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with: The standard specified in § 170.205(b)(2); and At a minimum, the version of the standard specified in § 170.207(h). Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.	§ 170.205(b)((2) (NCPDP SCRIPT version 10.6) and § 170.207(h) (RxNorm February 6, 2012 Release) MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU3: patient generated adherence questionnaires based on LOINC and SNOMED-CT are integrated back into the record RxNorm

Workgroup Comments: nothing about me without me: many EHR actions have a corresponding or correlating patient facing system reaction

cc me(including formulary): patient preferences inform care, safety and decisions (pharmacy preference):structured data will empower patients through interoperable patient facing systems; current is workflow can be adapted to support patient engagement: patients generate meaningful adherence information (close the loop): I am a health data exchange of one (need to inform others): EHR should assume multiple providers in the care team including patient and their designee(s)

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CORE, continued

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3	EP		Record the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 80% of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to State law) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(3)** Demographics. (i) Enable a user to electronically record, change, and access patient demographic data including preferred language, gender, race, ethnicity, and date of birth. (A) Enable race and ethnicity to be recorded in accordance with the standard specified in § 170.207(f) and whether a patient declines to specify race and/or ethnicity. (B) Enable preferred language to be recorded in accordance with the standard specified in § 170.207(j) and whether a patient declines to specify a preferred language. (ii) Inpatient setting only. Enable a user to electronically record, change, and access preliminary cause of death in the event of a mortality in accordance with the standard specified in § 170.207(k).	§ 170.207(f)(OMB standards); § 170.207(j) (ISO 639-1:2002); and § 170.207(k) (ICD-10-CM) MU2:Patient generated questionnaire answers are incorporated into standard. MU2:CDC or more granular definitions are encouraged MU3: standard increased to include family history, medication adherence, care adherence, diet and exercise, observations of daily living, smoking status, patient intolerances, health history, surgical history, allergies, advanced directives.
3		EP	Record the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality in the EH or CAH.	More than 80% of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to State law) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(3)** Demographics. (i) Enable a user to electronically record, change, and access patient demographic data including preferred language, gender, race, ethnicity, and date of birth. (A) Enable race and ethnicity to be recorded in accordance with the standard specified in § 170.207(f) and whether a patient declines to specify race and/or ethnicity. (B) Enable preferred language to be recorded in accordance with the standard specified in § 170.207(j) and whether a patient declines to specify a preferred language. (ii) Inpatient setting only. Enable a user to electronically record, change, and access preliminary cause of death in the event of a mortality in accordance with the standard specified in § 170.207(k).	§ 170.207(f)(OMB standards); § 170.207(j) (ISO 639-1:2002); and § 170.207(k) (ICD-10-CM) MU2:Patient generated questionnaire answers are incorporated into standard. MU2:CDC or more granular definitions are encouraged MU3: standard increased to include family history, medication adherence, care adherence, diet and exercise, observations of daily living, smoking status, patient intolerances, health history, surgical history, allergies, advanced directives.

Workgroup Comments: I am a Contributing Care Team Member: nothing about me without me

I am a credible source of information and generate meaningful and material data for my care: patient generated data is relevant to care; real-time, historically, iteratively, and prospectively. Structured data will empower patients through interoperable patient facing systems: Current workflow can be adapted to support patient engagement: Standards should be expanded for patient facing systems and harmonized. CC: me or my designee(s). Create once use often in both EHR and patient facing systems. Metadata needs to be preserved when communicating with patient facing systems. I am a health data exchange of one. EHR should assume multiple providers in the care team including patient and their designee(s). Data standards should be accelerated where patient generated data is anticipated.

CORE, continued

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4	EP	EH	Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0–20 years, including BMI.	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 blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data	Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and blood pressure (ages 3 and over) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(4)** Vital signs, body mass index, and growth charts. (i) Vital signs. Enable a user to electronically record and change, and access recordings of a patient's vital signs including, at a minimum, height/length, weight, and blood pressure. (ii)Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient's height and weight. (iii) Optional. Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.	MU2:Patient generated questionnaire answers are incorporated into standard. MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU2:Add pain scale MU3: standard increased to include family history, medication adherence, care adherence, diet and exercise, observations of daily living, patient intolerances, health history, surgical history, allergies, advanced directives. Support patient device data for patient self-management and ongoing management.

Workgroup Comments: I am a Contributing Care Team Member: nothing about me without me

I am a credible source of information and generate meaningful and material data for my care: patient generated data is relevant to care; real-time, historically, iteratively, and prospectively. Structured data will empower patients through interoperable patient facing systems: Current workflow can be adapted to support patient engagement: Standards should be expanded for patient facing systems and harmonized. CC: me or my designee(s). Create once use often in both EHR and patient facing systems. Metadata needs to be preserved when communicating with patient facing systems. I am a health data exchange of one. EHR should assume multiple providers in the care team including patient and their designee(s). Data standards should be accelerated where patient generated data is anticipated.

CORE, continued

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5	EP	EH	Record smoking status for patients 13 years old or older.	More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	The number of patients in the denominator with smoking status recorded as structured data.	Number of unique patients age 13 or older seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(11)** Smoking status. Enable a user to electronically record, change, and access the smoking status of a patient in accordance with the standard specified at § 170.207(l).	§ 170.207(l) (smoking status types) MU2:Patient generated questionnaire answers based on LOINC and SNOMED-CT . MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records

Workgroup Comments: I am a Contributing Care Team Member: nothing about me without me

I am a credible source of information and generate meaningful and material data for my care: patient generated data is relevant to care; real-time, historically, iteratively, and prospectively. Structured data will empower patients through interoperable patient facing systems: Current workflow can be adapted to support patient engagement: Standards should be expanded for patient facing systems and harmonized. CC: me or my designee(s). Create once use often in both EHR and patient facing systems. Metadata needs to be preserved when communicating with patient facing systems. I am a health data exchange of one. EHR should assume multiple providers in the care team including patient and their designee(s). Data standards should be accelerated where patient generated data is anticipated.

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6	EP	EH	Use clinical decision support to improve performance on high-priority health conditions.	1. Implement 5 clinical decision support interventions related to 5 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. 2. The EP, EH or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for th 33 e entre EHR reporting period.			**§170.314(a)(8) / §170.314(a)(2)** Clinical decision support. (i) Evidence-based decision support interventions. Enable a user to select (or activate) one or more electronic clinical decision support interventions (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in each one or any combination of the following: (A) Problem list; (B) Medication list; (C) Medication allergy list; (D) Demographics; (E) Laboratory tests and values/results; and (F) Vital signs. (ii) Linked referential clinical decision support. (A) Enable a user to retrieve diagnostic or therapeutic reference information in accordance with the standard specified at § 170.204(b)(1). (B) Enable a user to access the reference information specified in paragraph (ii)(A) relevant to patient context based on the data elements included in each one or any combination of the following: a. Problem list; b. Medication list; c. Medication allergy list; d. Demographics; e. Laboratory tests and values/results; and f. Vital signs. (iii) Configure clinical decision support. (A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) to be configured by an identified set of users (e.g., system administrator) based on each one of the following: a. A user's role; b. Clinical setting; and c. Identified points in the clinical workflow. (B) Enable interventions to be triggered, based on the data elements specified in paragraph (a)(8)(i), when a summary care record is incorporated pursuant to § 170.314(b)(1). (iv) Automatically and electronically interact. Interventions selected and configured in accordance with paragraphs (a)(8)(i)-(iii) must automatically and electronically occur when a user is interacting with EHR technology. (v) Source attributes. Enable a user to review the attributes for each intervention or reference source for all clinical decision support resources including: (A) Bibliographic citation (clinical research/guideline) including publication; (B) Developer of the intervention (translation from clinical research/guideline); (C) Funding source of the intervention development technical implementation; and (D) Release and, if applicable, revision date of the intervention. Drug-drug, drug-allergy interaction checks (i) Interventions. Before a medication order is placed during computerized provider order entry (CPOE), interventions must automatically and electronically indicate to a user at the point of care of drug-drug and drug-allergy contraindications based on medication list and medication allergy list. (ii) Adjustments. (A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted. (B) Limit the ability to adjust severity levels to an identified set of users or available as a system administrative function.	§ 170.204(b)(1) (HL7 Context-Aware Knowledge Retrieval ("Infobutton") Standard, International Normative Edition 2010 MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU3: patient preferences should be included in clinical decision support alerts and actions. Preference sensitive care, conditions, treatments, tests should incorporate patient preferences of care and incorporate shared decision-making. Patient attribution accommodated. MU2:Clinical information reconciliation needs to accommodate a specific data element that indicates that the information (lists or individual) has been reconciled with time stamp and clinician responsible. Adherence can also be included with the reconciliation and provided by the patient, (or designee) and also time date stamped with author. Metadata should carry with all data transactions.

Workgroup Comments; nothing about me without me: I'm a contributing care team member: many EHR actions have a corresponding or correlating patient facing system reaction

CC:me, EHR should assume multiple providers in the care team including patient and their designee(s): many orders by clinicians are directed to patients and or are components of care plans: I am a necessary and important safety checkpoint: Structured data will empower patients through interoperable patient facing systems. Current workflow can be adapted to support patient engagement Structured data will empower patients through interoperable patient facing systems. Patient generated data is relevant to care, Real-time, Historically, Iteratively, Prospectively. Standards should be expanded for patient facing systems and harmonized. My care goals may be: Episodic, Chronic, Quality of Life. I am an important part of shared decision-making where preference sensitive care exists: Standards should be expanded for patient facing systems and harmonized

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7	EP	EH	Incorporate clinical lab-test results into Certified EHR Technology as structured data.	More than 55% of all clinical lab tests results ordered by the EP or by authorized providers of the EH 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.	Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated in Certified EHR Technology as structured data.	Number of lab tests ordered during the EHR reporting period by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.	**§170.314(b)(5)** Incorporate laboratory tests and values/results. (i) Receive results. (A) Ambulatory setting only. a. Electronically receive clinical laboratory tests and values/results formatted in accordance with the standard (and implementation specifications) specified at § 170.205(k) and, at a minimum, the version of the standard specified in § 170.207(g). b. Electronically display the tests and values/results received in human readable format. (B) Inpatient setting only. Electronically receive clinical laboratory tests and values/results in a structured format and electronically display such tests and values/results in human readable format. (ii) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (iii) Incorporate tests and values/results. Electronically incorporate a laboratory test and value/result with a laboratory order or patient record.	§ 170.205(k) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Standards and Interoperability Framework Lab Results Interface, Release 1 (US Realm)); and § 170.207(g) (LOINC version 2.38) MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU2:Incorporate InfoButton standard for all patient facing systems.

Workgroup Comments; nothing about me without me: I'm a contributing care team member: many EHR actions have a corresponding or correlating patient facing system reaction

CC:me, my access should be immediate (as available to EP) or at my direction/preference or no later than two business days. I am a health data exchange of one. Current workflow can be adapted to support patient engagement. Standards should be expanded for patient facing systems and harmonized. Many orders by clinicians are directed to patients and or/are components of care plans. Innovation can be encouraged beyond transactional systems with optional advanced standards. Metadata needs to be preserved when communicating with patient facing systems. Current workflow can be adapted to support patient engagement. My preferred communication method is used to contact me.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
8	EP	EH	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.			**§170.314(a)(14)** Patient lists. Enable a user to electronically select, sort, access, and create lists of patients according to, at a minimum, the data elements included in: (i) Problem list; (ii) Medication list; (iii) Demographics; and (iv) Laboratory tests and values/results.	MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU3 : Query framework to provide on demand patient lists using any previously identified data element standard. MU3: Patient preference should be considered in data elements.

Workgroup Comments: How does my care compare to the CQMs?

I can contribute to CQM success where counseling, education, and adherence are incorporated. My care goals may be episodic, chronic, or quality of life. Patient specific report cards for all clinical quality measures should be included within the CQM standards. I know what I am enrolled or what opportunities there are for me in research. Use of system to proactively identify that I am getting the services that I should, when I should, compared to industry standards and/or people like me. My preferred communication method is used to contact me.

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
9	EP		Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.	More than 10% of all unique patients who have had an office visit with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference.	Number of patients in the denominator who were sent a reminder per patient preference during the EHR reporting period.	Number of unique patients who have had an office visit with the EP in the 24 months prior to the beginning of the EHR reporting period.	**§170.314(a)(15)** Ambulatory setting only. Patient reminders. Enable a user to electronically create a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data elements included in: (i) Problem list; (ii) Medication list; (iii) Medication allergy list; (iv) Demographics; and (v) Laboratory tests and values/results.	MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU2:Patient facing systems should include Info button standard to attach patient specific education materials. MU2:Patient generated questionnaire answers are incorporated into standard MU3 : Query framework to provide on demand patient lists using any previously identified data element standard. MU3: Patient preference should be considered in data elements MU3: Evidence based medicine care plans with rules engine standard developed to provide clinically significant reminders.

Workgroup Comments: I am a Contributing Care Team Member, Nothing About Me Without Me

can contribute to CQM success where counseling, education, and adherence are incorporated. My care goals may be episodic, chronic, or quality of life. I know what I am enrolled in or what opportunities there are for me in research. Use of system to proactively identify that I am getting the services that I should, when I should, compared to industry standards and/or people like me. My preferred communication method is used to contact me. I am a credible source of information and generate meaningful and material data for my care.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
10		EP	Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).	More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR.	The number of orders in the denominator tracked using eMAR.	Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(17)** Inpatient setting only. Electronic medication administration record. (i) In combination with an assistive technology that provides automated information on the "rights" specified in paragraphs (i)(A) through (i)(D), enable a user to electronically verify the following before administering medication(s): (A) Right patient. The patient to whom the medication is to be administered matches the medication to be administered. (B) Right medication. The medication to be administered matches the medication ordered for the patient. (C) Right dose. The dose of the medication to be administered matches the dose of the medication ordered for the patient. (D) Right route. The route of medication delivery matches the route specified in the medication order. (ii) Right time. Electronically record the time and date in accordance with the standard specified at § 170.210(g), and user identification when a medication is administered.	§ 170.210(g) (synchronized clocks) Right patient. The patient to whom the medication is to be administered matches the medication to be administered and the patient (where able) acknowledges.

Workgroup Comments: I am a Contributing Care Team Member

I'm and necessary and important safety checkpoint

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
11	EP		Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	EPs must satisfy both measures in order to meet the objective: 1) More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. 2) More than 10 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information.	1) The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information online. 2) The number of unique patients (or their authorized representatives) in the denominator who have viewed online or downloaded or transmitted to a third party the patient's health information.	1) Number of unique patients seen by the EP during the EHR reporting period. 2) Number of unique patients seen by the EP during the EHR reporting period.	**§170.314(e)(1)** View, download, and transmit to 3rd party. (i) Enable a user to provide patients (and their authorized representatives) with online access to do all of the following: (A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data elements: 1) Patient name; gender; date of birth; race; ethnicity; preferred language; smoking status; problem list; medication list; medication allergy list; procedures; vital signs; laboratory tests and values/results; provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; and care plan, including goals and instructions. 2) Inpatient setting only. Admission and discharge dates and locations; reason(s) for hospitalization; names of providers of care during hospitalization; laboratory tests and values/results (available at time of discharge); and discharge instructions for patient. (B) Download. Electronically download: 1) A file in human readable format that includes, at a minimum: *(i)* Ambulatory setting only. All of the data elements specified in paragraph (e)(1)(i)(A)(1). *(ii)* Inpatient setting only. All of the data elements specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2). 2) A summary care record formatted according to the standards adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): *(i)* Patient name; gender; date of birth; medication allergies; vital signs; the provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; *(ii)* Race and ethnicity. The standard specified in § 170.207(f); *(iii)* Preferred language. The standard specified in § 170.207(j); *(iv)* Smoking status. The standard specified in § 170.207(l); *(v)* Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); *(vi)* Encounter diagnoses. The standard specified in § 170.207(m); *(vii)* Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); *(viii)* Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); *(ix)* Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; *(x)* Medications. At a minimum, the version of the standard specified in § 170.207(h); and *(xi)* Inpatient setting only. The data elements specified in paragraph (e)(1)(i)(A)(2). 3) Images formatted according to the standard adopted at § 170.205(j). (C) Transmit to third party. Electronically transmit the summary care record created in paragraph (e)(1)(i)(B)(2) or images available to download in paragraph (e)(1)(i)(B)(3) in accordance with: 1) The standard specified in § 170.202(a)(1); and 2) The standard specified in § 170.202(a)(2). (ii) Patient accessible log. (A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A)-(C), the following information must be recorded and made accessible to the patient: 1) The electronic health information affected by the action(s); 2) The date and time each action occurs in accordance with the standard specified at § 170.210(g); 3) The action(s) that occurred; and 4) User identification. (B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.	§ 170.204(a) (Web Content Accessibility Guidelines (WCAG) 2.0, Level AA Conformance); § 170.205(a)(3) (Consolidated CDA); § 170.205(j) (DICOM PS 3—2011); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); § 170.202(a)(1) (Applicability Statement for Secure Health Transport) and § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.210(g) (synchronized clocks) MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU2: Incorporate InfoButton standard for all patient facing systems. MU3: Top 5 languages in top 50 conditions (EH) in patient specific education materials. MU3: VDT standard should include patient preference options similar to the banking industry e.g. Excel, DIREC direct, my patient facing system, PDF, social networking.

Workgroup Comments: nothing about me without me: I am contributing care team member many EHR actions have a corresponding or call relating patient facing system reaction: patient facing systems are not limited by legacy transactional systems:

My access should be immediate or at my direction/preference or no later than 2 days from EP receipt. Understandable to me, my language understandable to me, plain language: I can download or transmit none, some or all of my records within my authority: my preferred communication method is used to contact me: cc me: I am health data exchange of one. View and transmit should be patient directed and provider protected. Innovation can be encouraged beyond transactional systems with optional advanced standards. Transactional approaches should be a minimum data standard. Data should be VDT in computable transferable, movable way able to be trended, at the data element level and human readable level at the patient's preference. Data standards should be accelerated or patient participation or patient generated data is anticipated. VDT should include links to patient specific education materials: IB standard. Single standard vocabularies should be harmonized in patient facing, EHR, and CQM systems. Design in "Greenfield" areas like transitions of care should include patients and their designees.

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
11		EH	Provide patients the ability to view online, download, and transmit information about a hospital admission.	EHs and CAHs must satisfy both measures in order to meet the objective: 1. More than 50% of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge. 2. More than 10% of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period.	1. The number of patients in the denominator whose information is available online within 36 hours of discharge. 2. The number of patients in the denominator who view, download or transmit to a third party the information provided by the eligible hospital or CAH online during the EHR reporting period.	1. Number of unique patients seen by the EP during the EHR reporting period. 2. Number of unique patients seen by the EP during the EHR reporting period.	**§170.314(e)(1)** View, download, and transmit to 3rd party. (iii) Enable a user to provide patients (and their authorized representatives) with online access to do all of the following: (A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data elements: 1) Patient name; gender; date of birth; race; ethnicity; preferred language; smoking status; problem list; medication list; medication allergy list; procedures; vital signs; laboratory tests and values/results; provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; and care plan, including goals and instructions. 2) Inpatient setting only. Admission and discharge dates and locations; reason(s) for hospitalization; names of providers of care during hospitalization; laboratory tests and values/results (available at time of discharge); and discharge instructions for patient. (B) Download. Electronically download: 1) A file in human readable format that includes, at a minimum: *(i)* Ambulatory setting only. All of the data elements specified in paragraph (e)(1)(i)(A)(1). *(ii)* Inpatient setting only. All of the data elements specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2). 2) A summary care record formatted according to the standards adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): *(i)* Patient name; gender; date of birth; medication allergies; vital signs; the provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; *(ii)* Race and ethnicity. The standard specified in § 170.207(f); *(iii)* Preferred language. The standard specified in § 170.207(j); *(iv)* Smoking status. The standard specified in § 170.207(l); *(v)* Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); *(vi)* Encounter diagnoses. The standard specified in § 170.207(m); *(vii)* Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); *(viii)* Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); *(ix)* Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; *(x)* Medications. At a minimum, the version of the standard specified in § 170.207(h); and *(xi)* Inpatient setting only. The data elements specified in paragraph (e)(1)(i)(A)(2). 3) Images formatted according to the standard adopted at § 170.205(j). (C) Transmit to third party. Electronically transmit the summary care record created in paragraph (e)(1)(i)(B)(2) or images available to download in paragraph (e)(1)(i)(B)(3) in accordance with: 1) The standard specified in § 170.202(a)(1); and 2) The standard specified in § 170.202(a)(2). (iv) Patient accessible log. (A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A)-(C), the following information must be recorded and made accessible to the patient: 1) The electronic health information affected by the action(s); 2) The date and time each action occurs in accordance with the standard specified at § 170.210(g); 3) The action(s) that occurred; and 4) User identification. (B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.	§ 170.204(a) (Web Content Accessibility Guidelines (WCAG) 2.0, Level AA Conformance); § 170.205(a)(3) (Consolidated CDA); § 170.205(j) (DICOM PS 3—2011); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); § 170.202(a)(1) (Applicability Statement for Secure Health Transport) and § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.210(g) (synchronized clocks) MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU2: Incorporate InfoButton standard for all patient facing systems. MU3: Top 5 languages in top 50 conditions (EH) in patient specific education materials. MU3: VDT standard should include patient preference options similar to the banking industry e.g. Excel, DIREC direct, my patient facing system, PDF, social networking.

Workgroup Comments: nothing about me without me: I am contributing care team member many EHR actions have a corresponding or call relating patient facing system reaction: patient facing systems are not limited by legacy transactional systems:

My access should be immediate or at my direction/preference or no later than 2 days from EP receipt. Understandable to me, my language understandable to me, plain language: I can download or transmit none, some or all of my records within my authority: my preferred communication method is used to contact me: cc me: I am health data exchange of one. View and transmit should be patient directed and provider protected. Innovation can be encouraged beyond transactional systems with optional advanced standards. Transactional approaches should be a minimum data standard. Data should be VDT in computable transferable, movable way able to be trended, at the data element level and human readable level at the patient's preference. Data standards should be accelerated or patient participation or patient generated data is anticipated. VDT should include links to patient specific education materials: IB standard. Single standard vocabularies should be harmonized in patient facing, EHR, and CQM systems. Design in "Greenfield" areas like transitions of care should include patients and their designees.

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
12	EP		Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients within 24 hours for more than 50 % of office visits.	Number of office visits in the denominator where the patient is provided a clinical summary of their visit within 24 hours.	Number of office visits conducted by the EP during the EHR reporting period.	**§170.314(e)(2)** Ambulatory setting only. Clinical summaries. Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, the following data elements: provider's name and office contact information; date and location of visit; reason for visit; patient's name; gender; race; ethnicity; date of birth; preferred language; smoking status; vital signs and any updates; problem list and any updates; medication list and any updates; medication allergy list and any updates; immunizations and/or medications administered during the visit; procedures performed during the visit; laboratory tests and values/results, including any tests and values/results pending; clinical instructions; care plan, including goals and instructions; recommended patient decision aids (if applicable to the visit); future scheduled tests; future appointments; and referrals to other providers. If the clinical summary is provided electronically, it must be: (i) Provided in human readable format; and (ii) Provided in a summary care record formatted according to the standard adopted at § 170.205(a)(3) with the following data elements expressed, where applicable, according to the specified standard(s): (A) Race and ethnicity. The standard specified in § 170.207(f); (B) Preferred language. The standard specified in § 170.207(j); (C) Smoking status. The standard specified in § 170.207(l); (D) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (E) Encounter diagnoses. The standard specified in § 170.207(m); (F) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); (G) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); (H) Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; and (ii) Medications. At a minimum, the version of the standard specified in § 170.207(h).	§ 170.205(a)(3) (Consolidated CDA); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); and § 170.207(h) (RxNorm February 6, 2012 Release) MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU2:Incorporate InfoButton standard for all patient facing systems. MU2:clinical information reconciliation needs to include patient as a participant. MU3: VDT standard should include patient preference options similar to the banking industry e.g. Excel, DIREC direct, my patient facing system, PDF, social networking.

Workgroup Comments: nothing about me without me: I am contributing care team member: many EHR actions have a corresponding or call relating patient facing system reaction: patient facing systems are not limited by legacy transactional systems:

My access should be immediate or at my direction/preference or no later than 2 days from EP receipt. Clinical information reconciliation needs to accommodate patient as participant. Understandable to me, my language understandable to me, plain language: I can download or transmit none, some or all of my records within my authority: my preferred communication method is used to contact me: cc me: I am health data exchange of one. View and transmit should be patient directed and provider protected. Innovation can be encouraged beyond transactional systems with optional advanced standards. Transactional approaches should be a minimum data standard. Data should be VDT in computable transferable, movable way able to be trended, at the data element level and human readable level at the patient's preference. Data standards should be accelerated or patient participation or patient generated data is anticipated. VDT should include links to patient specific education materials: IB standard. Single standard vocabularies should be harmonized in patient facing, EHR, and CQM systems. Design in "Greenfield" should include patients and their designees. Patient generated data is relevant to care. I can contribute to CQM success: effective self-management, counseling, education, and adherence.

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
13	EP	EH	Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10% of all office visits by the EP.	Number of patients who had office visits during the EHR reporting period who were subsequently provided patient-specific education resources identified by Certified EHR Technology.	Number of office visits by the EP during the EHR reporting period.	**§170.314(a)(16)** Patient-specific education resources. Enable a user to electronically identify and provide patient-specific education resources according to: (i) At a minimum, each one of the data elements included in the patient's: problem list; medication list; and laboratory tests and values/results; and (ii) The standard specified at § 170.204(b)(1).	§ 170.204(b)(1) (HL7 Context-Aware Knowledge Retrieval (Infobutton) Standard, International Normative Edition 2010) MU2:Include Info button in patient facing systems accommodate response back to record of what was provided. MU3:. Preference sensitive care, conditions, treatments, tests should incorporate patient preferences of care and incorporate shared decision-making. Includes goals that the patient agrees with (SDM) MU2:Incorporate top 5 languages for top 50 discharge instructions.(EH)
13	EP	EH	Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.	More than 10% of all unique patients admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.	Number of patients in the denominator who are subsequently provided patient-specific education resources identified by Certified EHR Technology.	Number of unique patients admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(16)** Patient-specific education resources. Enable a user to electronically identify and provide patient-specific education resources according to: (i) At a minimum, each one of the data elements included in the patient's: problem list; medication list; and laboratory tests and values/results; and (ii) The standard specified at § 170.204(b)(1).	§ 170.204(b)(1) (HL7 Context-Aware Knowledge Retrieval (Infobutton) Standard, International Normative Edition 2010) MU2:Include Info button in patient facing systems accommodate response back to record of what was provided. MU3:. Preference sensitive care, conditions, treatments, tests should incorporate patient preferences of care and incorporate shared decision-making. Includes goals that the patient agrees with (SDM) MU2:Incorporate top 5 languages for top 50 discharge instructions.(EH)

Workgroup Comments: I am a contributing member of my care team. Nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Understandable to me, my language: understandable to me, plain language: my preferred communication method is used to contact me: cc me: I am health data exchange of one. View and transmit should be patient directed and provider protected. Patient generated data is relevant to care. I can contribute to CQM success: effective self-management, counseling, education, and adherence.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
14	EP		Use secure electronic messaging to communicate with patients on relevant health information.	A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10% of unique patients seen during the EHR reporting period.	The number of patients in the denominator who send a secure electronic message to the EP using the electronic messaging function of Certified EHR Technology during the EHR reporting period.	Number of unique patients seen by the EP during the EHR reporting period.	**§170.314(e)(3)** Ambulatory setting only. Secure messaging. Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures: (i) Both the patient and EHR technology are authenticated; and (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f).	§ 170.210(f) Any encryption and hashing 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. MU2:Information Button standard available in the workflow for education materials MU2:Demographics need to include patient preference in communication and correlating address MU2:Incorporate InfoButton standard for all patient facing systems. MU2:Care Team needs to be included in demographics with corresponding secure email address and role of participant MU2:Secure messaging informs care and should be part of the care record. MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records

Workgroup Comments

Nothing without Me about Me. Understandable to me, plain language, Patient Direct/Provider Protected

Secure messaging informs care and should be part of the care record. My preferred communication method is used to contact me: cc me: I am health data exchange of one. View and transmit should be patient directed and provider protected. Patient generated data is relevant to care. I can contribute to CQM success: effective self-management, counseling, education, and adherence.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
15	EP		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.	The EP, EH or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	The number of transitions of care in the denominator where medication reconciliation was performed.	Number of transitions of care during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.	**§170.314(b)(4)** Clinical information reconciliation. Enable a user to electronically reconcile the data elements that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically display the data elements from two or more sources in a manner that allows a user to view the data elements and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to merge and remove individual data elements. (iii) Enable a user to review and validate the accuracy of a final set of data elements and, upon a user's confirmation, automatically update the list.	MU2:Clinical information reconciliation needs to accommodate a specific data element that indicates that the information (lists or individual) has been reconciled with time stamp and clinician responsible. Adherence can also be included with the reconciliation and provided by the patient, (or designee) and also time date stamped with author. Metadata should carry with all data transactions. MU2:patient generated adherence questionnaires based on LOINC and SNOMED-CT integrated back into the record
15		EH	The EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP, EH or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	The number of transitions of care in the denominator where medication reconciliation was performed.	Number of transitions of care during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.	**§170.314(b)(4)** Clinical information reconciliation. Enable a user to electronically reconcile the data elements that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically display the data elements from two or more sources in a manner that allows a user to view the data elements and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to merge and remove individual data elements. (iii) Enable a user to review and validate the accuracy of a final set of data elements and, upon a user's confirmation, automatically update the list.	MU2:Clinical information reconciliation needs to accommodate a specific data element that indicates that the information (lists or individual) has been reconciled with time stamp and clinician responsible. Adherence can also be included with the reconciliation and provided by the patient, (or designee) and also time date stamped with author. Metadata should carry with all data transactions. MU2:patient generated adherence questionnaires based on LOINC and SNOMED-CT integrated back into the record

Workgroup Comments: I am contributing care team member. Nothing about me without me.

My preferred communication method is used to contact me: cc me: I am health data exchange of one. Patient generated data is relevant to care. I can contribute to CQM success: effective self-management, counseling, education, and adherence. I am a credible source of information, care history, goals for care. Information should be created once used often. I am an necessary and important safety checkpoint.

FACA Template for Input on the Certification Criteria to Support MU Stage 2 Objectives and Measures

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
16	EP	EH	The EP, EH, 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 care record for each transition of care or referral.	EPs, EHs, and CAHs must satisfy both measures in order to meet the objective: 1. The EP, EH, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65% of transitions of care and referrals. 2. The EP, EH, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10% of transitions of care and referrals.	1. The number of transitions of care and referrals in the denominator where a summary of care record was the transferring or referring provider. 2. The number of transitions of care and referrals in the denominator where a summary of care record was electronically transmitted using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender.	1. Number of transitions of care and referrals during the EHR reporting period for which the EP or EH's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider. 2. Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.	**170.314(b)(1) /§170.314(b)(2)** Transitions of care - incorporate summary care record. Upon receipt of a summary care record formatted according to the standard adopted at § 170.205(a)(3), electronically incorporate, at a minimum, the following data elements: Patient name; gender; race; ethnicity; preferred language; date of birth; smoking status; vital signs; medications; medication allergies; problems; procedures; laboratory tests and values/results; the referring or transitioning provider's name and contact information; hospital admission and discharge dates and locations; discharge instructions; reason(s) for hospitalization; care plan, including goals and instructions; names of providers of care during hospitalization; and names and contact information of any additional known care team members beyond the referring or transitioning provider and the receiving provider. Transitions of care - create and transmit summary care record (i) Enable a user to electronically create a summary care record formatted according to the standard adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements expressed, where applicable, according to the specified standard(s): (A) Patient name; gender; date of birth; medication allergies; vital signs; laboratory tests and values/results; the referring or transitioning provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions; (B) Race and ethnicity. The standard specified in § 170.207(f); (C) Preferred language. The standard specified in § 170.207(j); (D) Smoking status. The standard specified in § 170.207(1); (E) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); (F) Encounter diagnoses. The standard specified in § 170.207(m); (G) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3); (H) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g); (I) Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; (J) Medications. At a minimum, the version of the standard specified in § 170.207(h); and (ii) Inpatient setting only. Hospital admission and discharge dates and location; names of providers of care during hospitalization; discharge instructions; reason(s) for hospitalization; and indication of whether an advance directive exists. (iii) Transmit. Enable a user to electronically transmit the summary care record created in paragraph (i) in accordance with: (A) The standards specified in § 170.202(a)(1) and (2). Optional. The standard specified in § 170.202(a)(3).	§ 170.205(a)(3) (Consolidated CDA); § 170.207(f) (OMB standards for the classification of federal data on race and ethnicity); § 170.207(j) (ISO 639-1:2002 (preferred language)); § 170.207(l) (smoking status types); § 170.207(a)(3) (SNOMED-CT® International Release January 2012); § 170.207(m) (ICD-10-CM); § 170.207(b)(2) (HCPCS and CPT-4) or § 170.207(b)(3) (ICD-10-PCS); § 170.207(g) (LOINC version 2.38); § 170.207(h) (RxNorm February 6, 2012 Release); and § 170.202(a)(1) (Applicability Statement for Secure Health Transport); § 170.202(a)(2) (XDR and XDM for Direct Messaging); and § 170.202(a)(3) (SOAP-Based Secure Transport RTM version 1.0) MU2:Standard that defines two types of care teams: institutional care team and patient centered care team. Institutional care team may be hospital focused for acute event, and can accommodate the patient and designee(s) e.g. patient generated data. Patient centered care team assumes multiple institutions, providers, setting, designees and patient in design. MU3:. Preference sensitive care, conditions, treatments, tests should incorporate patient preferences of care and incorporate shared decision-making. Includes goals that the patient agrees with (SDM) MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records.

Workgroup Comments: I am contributing member of my care team. Nothing about me without me.

I am a credible source of information and generate meaningful and material data from my care. I am a health data exchange of one. I am an important part of shared decision-making where preference sensitive care exists

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
17	EP	EH	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.			**§170.314(f)(1) / §170.314(f)(2)** Immunization information. Enable a user to electronically record, change, and access immunization information. Transmission to immunization registries. Enable a user to electronically create immunization information for electronic transmission in accordance with: (i) The standard and applicable implementation specifications specified in § 170.205(e)(3); and (ii) At a minimum, the version of the standard specified in § 170.207(i).	§ 170.205(e)(3) (HL7 2.5.1 and Implementation Guide for Immunization Messaging Release 1.3); and § 170.207(i) (CVX code set: August 15, 2011 version) MU3: Patient notification

Workgroup Comments: I am contributing care team member: nothing about me without me: many EHR actions have a corresponding correlating patient facing system reaction: how does my care compare to CQM's

Clinical information reconciliation needs to include patient as a participant. Patient specific report cards for all clinical quality measures should be included within the CQM standards. Patient quality alerts like device recalls or public health issues should be required

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
18		EH	Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized.			**170.314(f)(5) / §170.314(f)(6))** Inpatient setting only. Reportable laboratory tests and values/results. Enable a user to electronically record, change, and access reportable clinical laboratory tests and values/results. Inpatient setting only. Transmission of reportable laboratory tests and values/results. Enable a user to electronically create reportable laboratory tests and values/results for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(g); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g).	§ 170.205(g) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) with errata); § 170.207(a)(3) (SNOMED CT® International Release January 2012); and § 170.207(g) (LOINC version 2.38) MU3: Patient notification

Workgroup Comments: I am contributing care team member: nothing about me without me: many EHR actions have a corresponding correlating patient facing system reaction: how does my care compare to CQM's

Clinical information reconciliation needs to include the date patient as a participant. Patient specific report cards for all clinical quality measures should be included within the CQM standards. Patient quality alerts like device recalls or public health issues should be required

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
19		EH	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.			**§170.314(f)(3) / §170.314(f)(4)** Public health surveillance. Enable a user to electronically record, change, and access syndrome-based public health surveillance information. Transmission to public health agencies. Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with: i. Ambulatory setting only. (A) The standard specified in § 170.205(d)(2). (B) Optional. The standard (and applicable implementation specifications) specified in §170.205(d)(3). ii. Inpatient setting only. The standard (and applicable implementation specifications) specified in §170.205(d)(3).	§ 170.205(d)(2) (HL7 2.5.1) and § 170.205(d)(3) (HL7 2.5.1 and the PHIN Messaging Guide for Syndromic Surveillance: Emergency Department and Urgent Care Data HL7 Version 2.5.1) MU3: Patient notification

Workgroup Comments: I am contributing care team member: nothing about me without me: many EHR actions have a corresponding correlating patient facing system reaction: how does my care compare to CQM's

Clinical information reconciliation needs to include the date patient as a participant. Patient specific report cards for all clinical quality measures should be included within the CQM standards. Patient quality alerts like device recalls or public health issues should be required

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
20	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(1) Authentication, access control, and authorization. (i) Verify against a unique identifier(s) (e.g., username or number) that a person seeking access to electronic health information is the one claimed; and (ii) Establish the type of access to electronic health information a user is permitted based on the unique identifier(s) provided in (d)(1)(i), and the actions the user is permitted to perform with the EHR technology.	MU2:Standards should include patient and designee(s) as recipients MU2:Patient generated data questionnaires responses MU3: Patient generated and initiated data.

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
21	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(2) Auditable events and tamper-resistance. (i) Enabled by default. The capability specified in paragraph (d)(2)(ii) must be enabled by default (i.e., turned on) and must only be permitted to be disabled (and re-enabled) by a limited set of identified users. (ii) Record actions. Record actions related to electronic health information, audit log status and, as applicable, encryption of end-user devices in accordance with the standard specified in § 170.210(e). (iii) Audit log protection. Actions recorded in accordance with paragraph (d)(2)(ii) must not be capable of being changed, overwritten, or deleted. (iv) Detection. Detect the alteration of audit logs.	§ 170.210(e) Record actions related to electronic health information, audit log status, and encryption of end-user devices. (1)When EHR technology is used to record, create, change, access, or delete electronic health information, the following information must be recorded: (i) The electronic health information affected by the action(s); (ii) The date and time each action occurs in accordance with the standard specified at § 170.210(g); (iii) The actions(s) that occurred; (iv) Patient identification; and (v) User identification. (2)When the audit log is enabled or disabled, the following must be recorded: (i) The date and time each action occurs in accordance with the standard specified at § 170.210(g); and (ii) User identification. (3) As applicable, when encryption of electronic health information managed by EHR technology on end-user devices is enabled or disabled, the following must be recorded: (i) The date and time each actions occurs in accordance with the standard specified at § 170.210(g); and (ii) User identification. MU2:Standards should include patient and designee(s) as recipients MU2:Patient generated data questionnaires responses MU3: Patient generated and initiated data.

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
22	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(3) Audit report(s). Enable a user to create an audit report for a specific time period and to sort entries in the audit log according to each of the elements specified in the standard at § 170.210(e).	§ 170.210(e) Record actions related to electronic health information, audit log status, and encryption of end-user devices. (1) When EHR technology is used to record, create, change, access, or delete electronic health information, the following information must be recorded: (i) The electronic health information affected by the action(s); (ii) The date and time each action occurs in accordance with the standard specified at § 170.210(g); (iii) The actions(s) that occurred; (iv) Patient identification; and (v) User identification. (2)When the audit log is enabled or disabled, the following must be recorded: (i) The date and time each action occurs in accordance with the standard specified at § 170.210(g); and (ii) User identification (3) As applicable, when encryption of electronic health information managed by EHR technology on end-user devices is enabled or disabled, the following must be recorded: (i) The date and time each actions occurs in accordance with the standard specified at § 170.210(g); and (ii) User identification MU2:Standards should include patient and designee(s) as recipients MU2:Patient generated data questionnaires responses MU3: Patient generated and initiated data.

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
23	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			**§170.314(d)(4)** Amendments. (i) Enable a user to electronically amend a patient's health record to: (A) Replace existing information in a way that preserves the original information; and (B) Append patient supplied information, in free text or scanned, directly to a patient's health record or by embedding an electronic link to the location of the content of the amendment. (ii) Enable a user to electronically append a response to patient supplied information in a patient's health record.	MU2:Standards should include patient and designee(s) as recipients MU2:Patient generated data questionnaires responses MU3: Patient generated and initiated data.

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
24	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			**§170.314(d)(5)** Automatic log-off. Terminate an electronic session after a predetermined time of inactivity.	MU2:Patient facing systems should accommodate patient preferences

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
25	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			**§170.314(d)(6)** Emergency access. Permit an identified set of users to access electronic health information during an emergency.	MU2:Standards should include patient and designee(s) as recipients

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
26	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(7) Encryption of data at rest. Paragraph (d)(7)(i) or (d)(7)(ii) must be met to satisfy this certification criterion. (i) If EHR technology manages electronic health information on an end-user device and the electronic health information remains stored on the device after use of the EHR technology on that device has stopped, the electronic health information must be encrypted in accordance with the standard specified in § 170.210(a)(1). This capability must be enabled by default (i.e., turned on) and must only be permitted to be disabled (and re-enabled) by a limited set of identified users. (ii) Electronic health information managed by EHR technology never remains stored on end-user devices after use of the EHR technology on those devices has stopped.	MU2:Standards should include patient and designee(s) as recipients MU2:Patient generated data questionnaires responses MU3: Patient generated and initiated data.

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
27	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			**§170.314(d)(8)** Integrity. (i) Create a message digest in accordance with the standard specified in 170.210(c). (ii) 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.	M MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records. MU2:Standards should include patient and designee(s) as recipients MU2:Patient generated data questionnaires responses MU3: Patient generated and initiated data.

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

CORE, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
28	EP	EH	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.			§170.314(d)(9) Optional. Accounting of disclosures. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in §170.210(d).	MU2: CC:ME On demand. Building on the infobutton standard, an on demand cc: function to send any part of the record to patient or designee(s), including metadata and maintaining data fidelity and patient and provider specific context. (IB) (DIRECT) (CCD) MU2: CC:ME preference. Standing patient preference for communication of records.

Workgroup Comments: nothing about me without me. Many EHR actions have a corresponding or correlating patient facing system reaction. Patient facing systems are not limited by legacy transactional systems.

Privacy and security for what I download is within my authority. I expect my information within the EHR is secure and private: Patient directed: provider protected.

MENU

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
29		**EP**	Record whether a patient 65 years old or older has an advance directive	More than 50% of all unique patients 65 years old or older admitted to the EH's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	The number of patients in the denominator who have an indication of an advance directive status entered using structured data.	Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.	**§170.314(a)(18)** Inpatient setting only. Advance directives. Enable a user to electronically record whether a patient has an advance directive.	MU2:Standard modified to accommodate scanned copies with reconciliation and version control. MU3: Patient generated legal document management standard for all patient level directives. I

Workgroup Comments: nothing about me without me: I am contributing care team member: many EHR actions have a corresponding or correlating: patient facing system reaction:

I am a credible source of information and generate meaningful material data for my care. My preferred communication method is used to contact me. CC:ME or my designee(s). Patient preferences informed care, safety and decisions

MENU, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
31	EP	EH	Record patient family health history as structured data.	More than 20% of all unique patients seen by the EP or admitted to the EH or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.	The number of patients in the denominator with a structured data entry for one or more first-degree relatives.	Number of unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(13) Family health history. Enable a user to electronically record, change, and access a patient's family health history.	MU2:Patient generated questionnaire answers are incorporated into record. MU3: standard increased to include family history, medication adherence, care adherence, diet and exercise, observations of daily living, smoking status, patient intolerances, health history, surgical history, allergies, advanced directives.

Workgroup Comments: I am a contributing member of my care team. Nothing about me without me,
I am a credible source of information and generate meaningful and material data for my care.
Patient generated data is relevant to care; In care real-time, Historically, Iteratively, Prospectively. I am and necessary and important safety checkpoint. Create one use often in both EHR and patient facing systems. I am a health data exchange of one. I can contribute to CQM success, counseling, education, and adherence.

MENU, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
32		EH	Generate and transmit permissible discharge prescriptions electronically (eRx).	More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.	The number of prescriptions in the denominator generated, compared to a drug formulary and transmitted electronically.	The number of new or changed prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances for patients discharged during the EHR reporting period.	**§170.314(b)(3) /§170.314(a)(10)** Electronic prescribing. Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with: (i) The standard specified in § 170.205(b)(2); and (ii) At a minimum, the version of the standard specified in § 170.207(h). Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.	§ 170.205(b)((2) (NCPDP SCRIPT version 10.6) and § 170.207(h) (RxNorm February 6, 2012 Release)

Workgroup Comments

MENU, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
33	EP		Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.			**§170.314(f)(3) /§170.314(f)(4)** Public health surveillance. Enable a user to electronically record, change, and access syndrome-based public health surveillance information. Transmission to public health agencies. Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with: (i) Ambulatory setting only. (A) The standard specified in § 170.205(d)(2). (B) Optional. The standard (and applicable implementation specifications) specified in § 170.205(d)(3). (ii) Inpatient setting only. The standard (and applicable implementation specifications) specified in § 170.205(d)(3).	

Workgroup Comments

MENU, continued

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
34	EP		Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period.			**§170.314(f)(7) /§170.314(f)(8)** Ambulatory setting only. Cancer case information. Enable a user to electronically record, change, and access cancer case information. Ambulatory setting only. Transmission to cancer registries. Enable a user to electronically create cancer case information for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(i); and (ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g).	§ 170.205(i) (HL7 CDA, Release 2 and Implementation Guide for Healthcare Provider Reporting to Central Cancer Registries, Draft, February 2012); § 170.207(a)(3) (SNOMED CT® International Release January 2012); and § 170.207(g) (LOINC version 2.38)

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
35	EP		Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.			*General usage of Certified EHR Technology (No specific certification criteria).*	

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
36	EP	EH	N/A	N/A			§170.314(g)(1) Automated numerator recording. For each meaningful use objective with a percentage-based measure, electronically record the numerator.	

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
37	EP	EH	N/A	N/A			§170.314(g)(2) 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.	

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
38	EP	EH	N/A	N/A			§170.314(g)(3) Non-percentage-based measure use report. (i) For each capability included in EHR technology that is also associated with a meaningful use objective and measure that is not percentage based, electronically record the date and time in accordance with the standard specified at § 170.210(g) when the capability was enabled, disabled, and/or executed. (ii) Enable a user to electronically create a report of the information recorded as part of paragraph (g)(3)(i).	

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
39	EP	EH	N/A	N/A			**§170.314(g)(4)** Safety-enhanced design. User-centered design processes must be applied to each capability an EHR technology includes that is specified in the following certification criteria: § 170.314(a)(1); § 170.314(a)(2); § 170.314(a)(6); § 170.314(a)(7); § 170.314(a)(8); § 170.314(a)(17); § 170.314(b)(3); and § 170.314(b)(4).	

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
40	EP	EH	N/A	N/A			§170.314(c)(1)-(3) Clinical quality measures – capture and export. (i) Capture. Electronically record all of the data elements that are represented in the standard specified in § 170.204(c). (ii) Export. Electronically export a data file that includes all of the data elements that are represented in the standard specified in § 170.204(c). Clinical quality measures – incorporate and calculate. (i) Incorporate. Electronically incorporate all of the data elements necessary to calculate each of the clinical quality measures included in the EHR technology. (ii) Calculate. Electronically calculate each clinical quality measure that is included in the EHR technology. Clinical quality measures – reporting. Enable a user to electronically create for transmission clinical quality measurement results in a data file defined by CMS.	§ 170.204(c) (NQF Quality Data Model)

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
41	EP	EH	Record electronic notes in patient records. *(Not proposed by CMS)*	Record electronic notes in patient records for more than 30 percent of office visits.			§170.314(a)(9) Electronic notes. Enable a user to electronically record, change, access, and search electronic notes.	

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
42		EH	Provide structured electronic laboratory results to eligible professionals. *(Not proposed by CMS)*	Hospital labs send (directly or indirectly) structured electronic clinical lab results to the ordering provider for more than 40 percent of electronic lab orders received.			**§170.314(b)(6)** Inpatient setting only. Transmission of electronic laboratory tests and values/results to ambulatory providers. Enable a user to electronically create laboratory tests and values/results for electronic transmission in accordance with: (i) The standard (and applicable implementation specifications) specified in § 170.205(k); and (ii) At a minimum, the version of the standard specified in § 170.207(g).	§ 170.205(k) (HL7 2.5.1 and HL7 Version 2.5.1 Implementation Guide: Standards and Interoperability Framework Lab Results Interface, Release 1 (US Realm); and § 170.207(g) (LOINC version 2.38)

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
43	EP	EH	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	**§170.314(a)(5)** Problem list. Enable a user to electronically record, change, and access a patient's problem list for longitudinal care in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3).	§ 170.207(a)(3) (SNOMED CT® International Release January 2012)

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
44	EP	EH	Maintain active medication list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	The number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(6) Medication list. Enable a user to electronically record, change, and access a patient's active medication list as well as medication history for longitudinal care.	

Workgroup Comments

#	EP	EH	MEANINGFUL USE Proposed Stage 2 Objective	MEANINGFUL USE Proposed Stage 2 Measure	NUMERATOR	DENOMINATOR	Proposed 2014 Edition EHR CERTIFICATION CRITERIA	STANDARDS
45	EP	EH	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.	Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	§170.314(a)(7) Medication allergy list. Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history for longitudinal care.	

Workgroup Comments