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### Stage 1 Objective

- **CORE SET**
  - Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

### Stage 1 Measure

- **EPs / EHs & CAHs**
  - Implement drug-drug and drug-allergy interaction checks.
  - Maintain an up-to-date problem list of current and active diagnoses.
  - Generate and transmit permissible prescriptions electronically (eRx).
  - Maintain active medication list.

### Ambulatory Setting / Inpatient Setting

#### EPs / EHs & CAHs

- **§495.6(d)(1)(ii) / §495.6(f)(1)(ii)**
  - More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.

- **§495.6(d)(3)(ii) / §495.6(f)(3)(ii)**
  - Maintain up-to-date problem list. Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types:
    - (1) Medications;
    - (2) Laboratory; and
    - (3) Radiology/imaging.

- **§495.6(d)(4)(ii)**
  - Electronic prescribing. Enable a user to electronically generate and transmit prescriptions and prescription-related information in accordance with:
    - (1) The standard specified in §170.205(b)(1) or §170.205(b)(2); and
    - (2) The standard specified in §170.207(d).

- **§495.6(d)(5)(ii) / §495.6(f)(4)(ii)**
  - More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

### Problems

- **§170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.**
- **§170.207(a)(2) - IHTSDO SNOMED CT,® July 2009 Version.**

### Electronic prescribing

- **§170.205(b)(1) - NCPDP SCRIPT Version 8.1.**
- **§170.205(b)(2) - NCPDP SCRIPT Version 10.6.**

### Medications

- **§170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.**

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

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.
## MEANINGFUL USE
42 CFR 495.6(d)-(g)

### Stage 1 Objective
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### Core Set

#### 1. 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.

- **Maintain active medication allergy list.** Enable a user to electronically record, modify, and retrieve a patient’s active medication allergy list as well as medication allergy history for longitudinal care.

#### 2. Record all of the following demographics:

- A. Preferred language.
- B. Gender.
- C. Race.
- D. Ethnicity.
- E. Date of birth.
- F. Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.

- More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH’s inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.

- **Record demographics.** Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, date of birth, and date and preliminary cause of death in the event of mortality. Enable race and ethnicity to be recorded in accordance with the standard specified at 170.207(f).

#### 3. Record and chart changes in the following vital signs:

- A. Height.
- B. Weight.
- C. Blood pressure.
- D. Calculate and display body mass index (BMI).
- E. Plot and display growth charts for children 2–20 years, including BMI.

- More than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data.

- **Record and chart vital signs.**
  1. Vital signs. Enable a user to electronically record, modify, and retrieve a patient’s vital signs including, at a minimum, height, weight, and blood pressure.
  2. Calculate body mass index. Automatically calculate and display body mass index (BMI) based on a patient’s height and weight.
  3. Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients 2–20 years old.

#### 4. Record smoking status for patients 13 years old or older.

- More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

- **Smoking status.** Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.

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

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.
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<tr>
<td>§495.6(d)(10)(ii) / §495.6(f)(9)(ii)</td>
<td>Subject to paragraph (c) of this section, successfully report to CMS (or, in the case of Medicaid EPs, the States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or in the case of Medicaid EPs, the States).</td>
<td>§170.304(j) / §170.306(j)</td>
</tr>
<tr>
<td>§495.6(d)(10)(iii) / §495.6(f)(9)(iii)</td>
<td>Subject to paragraph (c) of this section, successfully report to CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States) hospital clinical quality measures selected by CMS in the manner specified by CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States).</td>
<td>§170.304(j) / §170.306(j)</td>
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**Core Set**

Report ambulatory/hospital clinical quality measures to CMS or, in the case of Medicaid EPs/eligible hospitals, the States.

| §495.6(d)(11)(i) / §495.6(f)(10)(i) | §495.6(d)(11)(ii) / §495.6(f)(10)(ii) | §170.304(e) / §170.306(c) |

Implement one clinical decision support rule relevant to specialty or high clinical priority/related to a high priority hospital condition along with the ability to track compliance with that rule.

| §495.6(d)(11)(iii) / §495.6(f)(10)(iii) | §495.6(d)(11)(iv) / §495.6(f)(10)(iv) | §170.304(e) / §170.306(c) |

Implement one clinical decision support rule.

**Clinical decision support.**

(1) Implement rules. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in: problem list; medication list; demographics; and laboratory test results.

(2) Notifications. Automatically and electronically generate and indicate in real-time, notifications and care suggestions based upon clinical decision support rules.

**Quality reporting.**


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

Note: MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.
## MEANINGFUL USE
42 CFR 495.6(d)-(g)

### Stage 1 Objective

#### EPs / EHs & CAHs

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**Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.**

More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.

- §495.6(d)(12)(iii) - Exclusion: Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
- §495.6(f)(11)(iii) - Exclusion: Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

**Electronic copy of health information.**

1. Enable a user to create an electronic copy of a patient’s clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, and procedures:
   - (1)(i) Human readable format; and
   - (2)(ii) On electronic media or through some other electronic means in accordance with:
     - (A) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and
     - (B) For the following data elements the applicable standard must be used:
       - (1) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);
       - (2) Procedures. The standards specified in §170.207(b)(1) or §170.207(b)(2);
       - (3) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and
       - (4) Medications. The standard specified in §170.207(d).
2. Enable a user to create an electronic copy of a patient’s discharge summary in human readable format and on electronic media or through some other electronic means.

- §170.304(h) / §170.306(d)

**Patient summary record.**

- §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.

**Problems.**

- §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.
- §170.207(a)(2) - IHTSDO SNOMED CT,® July 2009 version.

**Procedures.**

- §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2),
- §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5).

**Laboratory test results.**

- §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.

**Medication.**

- §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

**Electronic copy of discharge instructions.** Enable a user to create an electronic copy of the discharge instructions for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.

- §170.304(h) / §170.306(e)

More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

- §495.6(f)(12)(iii) - Exclusion: Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period.

**Electronic copy of discharge instructions.** Enable a user to create an electronic copy of the discharge instructions for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.

- §170.304(h) / §170.306(e)

## STANDARDS
45 CFR 170.205, 170.207, & 170.210

### Stage 1 Objective

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### Epic / EHs & CAHs

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**Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.**

More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

- §495.6(f)(12)(iii) - Exclusion: Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period.

**Electronic copy of discharge instructions.** Enable a user to create an electronic copy of the discharge instructions for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.

- §170.304(h) / §170.306(e)

**Patient summary record.**

- §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.

**Problems.**

- §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.
- §170.207(a)(2) - IHTSDO SNOMED CT,® July 2009 version.

**Procedures.**

- §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2),
- §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5).

**Laboratory test results.**

- §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.

**Medication.**

- §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

**Electronic copy of discharge instructions.** Enable a user to create an electronic copy of the discharge instructions for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.

- §170.304(h) / §170.306(e)

More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

- §495.6(f)(12)(iii) - Exclusion: Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period.

**Electronic copy of discharge instructions.** Enable a user to create an electronic copy of the discharge instructions for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.

- §170.304(h) / §170.306(e)

**Patient summary record.**

- §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.

**Problems.**

- §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.
- §170.207(a)(2) - IHTSDO SNOMED CT,® July 2009 version.

**Procedures.**

- §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2),
- §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5).

**Laboratory test results.**

- §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.

**Medication.**

- §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.
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### Stage 1 Objective

**Core Set**

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#### §495.6(d)(13)(i)

- **Clinical summaries.** Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list. If the clinical summary is provided electronically it must be:
  1. Provided in human readable format; and
  2. Provided on electronic media or through some other electronic means in accordance with:
     - (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and
     - (ii) For the following data elements the applicable standard must be used:
       - Problems. The standard specified in §170.207(a)(1)
       - Laboratory test results. At a minimum, the version of the standard specified in §170.207(d); and
       - Medications. The standard specified in §170.207(d).

#### §495.6(d)(14)(i)

- **Exchange clinical information and patient summary record.**
  1. Electronically receive and display a patient's summary record from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list, and procedures in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.
  2. Electronically transmit. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list, and procedures in accordance with:
     - (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and
     - (ii) For the following data elements the applicable standard must be used:
       - Problems. The standard specified in §170.207(a)(1)
       - Laboratory test results. At a minimum, the version of the standard specified in §170.207(d); and
       - Medications. The standard specified in §170.207(d).

#### §495.6(d)(14)(ii)

- **Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.**

#### §495.6(d)(14)(iii)

- **Exclusion: Any EP who has no office visits during the EHR reporting period.**

**Note:** MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.
**Unofficial Recitations of Portions of 42 CFR Part 495 and 45 CFR Part 170**

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

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<td>§495.6(d)(15)(i) / §495.6(f)(14)(i)</td>
<td>§170.302(o)</td>
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- **Access control**: Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.
  
  - §170.302(o)

- **Emergency access**: Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.
  
  - §170.302(p)

- **Automatic log-off**: Terminate an electronic session after a predetermined time of inactivity.
  
  - §170.302(q)

- **Audit log**
  
  1. Record actions. Record actions related to electronic health information in accordance with the standard specified in §170.210(b).
  2. Generate audit log. Enable a user to generate an audit log for a specific time period and to sort entries in the audit log according to any of the elements specified in the standard at §170.210(b).

  - §170.302(r)

- **Integrity**
  
  1. Create a message digest in accordance with the standard specified in §170.210(c).
  2. Verify in accordance with the standard specified in §170.210(c) upon receipt of electronically exchanged health information that such information has not been altered.
  3. Detection. Detect the alteration of audit logs.

  - §170.302(s)

- **Authentication**: Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.

  - §170.302(t)

- **General encryption**: Encrypt and decrypt electronic health information in accordance with the standard specified in §170.210(a)(1), unless the Secretary determines that the use of such algorithm would pose a significant security risk for Certified EHR Technology.

  - §170.302(u)

**Record actions related to electronic health information**

- §170.210(b) - The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which action(s) occurred and by whom must also be recorded.

**Verification that electronic health information has not been altered in transit**

- §170.210(c) - A hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm (SHA-1) as specified by the National Institute of Standards and Technology (NIST) in FIPS PUB 180-3 (October, 2008) must be used to verify that electronic health information has not been altered.

**Encryption and decryption of electronic health information**


CORE SET

- 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) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

[75 FR 44368-69]

**Note:**

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

#### 42 CFR 495.6(d)-(g)

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<tr>
<td><strong>CORE SET</strong></td>
<td>§495.6(d)(15)(i) / §495.6(f)(14)(i)</td>
<td>Encryption when exchanging electronic health information. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in §170.210(a)(2). [75 FR 44621-23]</td>
</tr>
<tr>
<td></td>
<td>§495.6(d)(15)(ii) / §495.6(f)(14)(ii)</td>
<td>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process. [75 FR 44623-24]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(1)(i) / §495.6(g)(1)(i)</td>
<td>Implement drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list. [75 FR 44334-36]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(1)(ii) / §495.6(g)(1)(ii)</td>
<td>The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period. [75 FR 44334-36]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(1)(iii) / §495.6(g)(1)(iii)</td>
<td>Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. [75 FR 44334-36]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(2)(i) / §495.6(g)(2)(i)</td>
<td>Record advance directives for patient 65 years old or older. [75 FR 44345-46]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(2)(ii) / §495.6(g)(2)(ii)</td>
<td>Advance directives. Enable a user to electronically record whether a patient has an advance directive. [75 FR 44641]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(2)(iii) / §495.6(g)(2)(iii)</td>
<td>Exclusion: An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period. [75 FR 44345-46]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(3)(i) / §495.6(g)(3)(i)</td>
<td>Incorporate clinical lab-test results into EHR as structured data. [75 FR 44346-47]</td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(3)(ii) / §495.6(g)(3)(ii)</td>
<td>Incorporate laboratory test results. (1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. (2) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (3) Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record. [75 FR 44600-03]</td>
</tr>
</tbody>
</table>

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

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<td><strong>EPs / EHs &amp; CAHs</strong></td>
<td>§495.6(e)(3)(ii) / §495.6(g)(4)(i)</td>
<td>§170.302(i)</td>
</tr>
<tr>
<td><strong>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</strong></td>
<td>$Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition.</td>
<td></td>
</tr>
<tr>
<td>[75 FR 44347-48]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Send reminders to patients per patient preference for preventive/follow-up care.</strong></td>
<td>§495.6(e)(4)(ii)</td>
<td>§170.304(d)</td>
</tr>
<tr>
<td></td>
<td>More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(4)(iii) – Exclusion: An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.</td>
<td></td>
</tr>
<tr>
<td>[75 FR 44348-49]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP.</strong></td>
<td>§495.6(e)(5)(i)</td>
<td>§170.304(g)</td>
</tr>
<tr>
<td></td>
<td>At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>§495.6(e)(5)(iii) – Exclusion: Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.</td>
<td></td>
</tr>
<tr>
<td>[75 FR 44356-58]</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.</strong></td>
<td>§495.6(e)(6)(i) / §495.6(g)(5)(i)</td>
<td>§170.302(m)</td>
</tr>
<tr>
<td></td>
<td>More than 10% of all unique patients seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources.</td>
<td></td>
</tr>
<tr>
<td>[75 FR 44359-60]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**42 CFR 495.6(d)-(g)**

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

---

### Stage 1 Objective

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<tr>
<th>EPs / EHs &amp; CAHs</th>
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<tbody>
<tr>
<td>§495.6(e)(7)(ii) / §495.6(g)(6)(i)</td>
<td>§495.6(e)(7)(iii) / §495.6(g)(6)(ii)</td>
</tr>
</tbody>
</table>

The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

*Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.*

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<table>
<thead>
<tr>
<th>EPs / EHs &amp; CAHs</th>
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<tr>
<td>§495.6(e)(8)(ii) / §495.6(g)(7)(i)</td>
<td>§495.6(e)(8)(iii) / §495.6(g)(7)(ii)</td>
</tr>
</tbody>
</table>

The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.

*Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.*

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### Stage 1 Measure

**45 CFR 170.302, 170.304, & 170.306**

**STANDARD(S)**

45 CFR 170.205, 170.207, & 170.210

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<thead>
<tr>
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<tbody>
<tr>
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<td>§495.6(e)(7)(iii)</td>
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<td>§495.6(e)(8)(iii)</td>
<td>§495.6(e)(8)(iv)</td>
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<tr>
<td>§495.6(g)(6)(i)</td>
<td>§495.6(g)(6)(ii)</td>
<td>§495.6(g)(7)(i)</td>
<td>§495.6(g)(7)(ii)</td>
<td>§495.6(g)(7)(iii)</td>
</tr>
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</table>

**CERTIFICATION CRITERIA**

- **42 CFR 495.6(d)-(g)**
- **45 CFR 170.302**
- **45 CFR 170.304**
- **45 CFR 170.306**

**MEANINGFUL USE**

**Ambulatory Setting**

- **EPs / EHs & CAHs**

**Stage 1 Objective**

**Stage 1 Measure**

| §495.6(e)(7)(ii) | §495.6(e)(7)(iii) | §495.6(g)(6)(i) | §495.6(g)(6)(ii) |
| §495.6(e)(8)(ii) | §495.6(e)(8)(iii) | §495.6(g)(7)(i) | §495.6(g)(7)(ii) |

**Section 495.6(d)-(g)**

**CERTIFICATION CRITERIA**

- **42 CFR 495.6(d)-(g)**
- **45 CFR 170.302**
- **45 CFR 170.304**
- **45 CFR 170.306**

**STANDARD(S)**

- **45 CFR 170.205, 170.207, & 170.210**

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<td>§495.6(e)(7)(iii)</td>
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<td>§495.6(e)(8)(iii)</td>
<td>§495.6(e)(8)(iv)</td>
</tr>
<tr>
<td>§495.6(g)(6)(i)</td>
<td>§495.6(g)(6)(ii)</td>
<td>§495.6(g)(7)(i)</td>
<td>§495.6(g)(7)(ii)</td>
<td>§495.6(g)(7)(iii)</td>
</tr>
</tbody>
</table>

**Exchange clinical information and patient summary record.**

1. **Electronically receive and display.** Electronically receive and display a patient’s summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list, and procedures in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.

2. **Electronically transmit.** Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, and procedures in accordance with:

   (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and

   (ii) For the following data elements the applicable standard must be used:

   (A) **Problems.** The standard specified in §170.207(a)(1) or §170.207(a)(2); and

   (B) **Procedures.** The standard specified in §170.207(b)(1) or §170.207(b)(2);

   (C) **Laboratory test results.** At a minimum, the version of the standard specified in §170.207(c); and

   (D) **Medications.** The standard specified in §170.207(d).

**Patient summary record.**

- §170.205(a)(1) - HL7 CDA Release 2, CCD.
- §170.205(a)(2) - ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.
- §170.205(a)(3) - LOINC® version 2.27.
- §170.205(a)(4) - IHTSDO SNOMED CT®.

**Problems.**

- §170.207(a)(1) - The code set specified at 45 CFR 162.1002(a)(1) for the indicated conditions.
- §170.207(a)(2) - IHTSDO SNOMED CT®, July 2009 version.

**Procedure.**

- §170.207(b)(1) - The code set specified at 45 CFR 162.1002(a)(2).
- §170.207(b)(2) - The code set specified at 45 CFR 162.1002(a)(5).

**Laboratory test results.**

- §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.

**Medications.**

- §170.207(d) - Any source vocabulary that is included in RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine.

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**Exchange clinical information and patient summary record.**

1. **Electronically receive and display.** Electronically receive and display a patient’s summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list, and procedures in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.

2. **Electronically transmit.** Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, and procedures in accordance with:

   (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and

   (ii) For the following data elements the applicable standard must be used:

   (A) **Problems.** The standard specified in §170.207(a)(1) or §170.207(a)(2); and

   (B) **Procedures.** The standard specified in §170.207(b)(1) or §170.207(b)(2);

   (C) **Laboratory test results.** At a minimum, the version of the standard specified in §170.207(c); and

   (D) **Medications.** The standard specified in §170.207(d).
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<tr>
<td><strong>EPs / EHs &amp; CAHs</strong></td>
<td><strong>MENU SET</strong></td>
<td><strong>Ambulation Setting / Inpatient Setting</strong></td>
</tr>
<tr>
<td>§495.6(e)(9)(i) / §495.6(g)(8)(ii)</td>
<td>§170.302(k)</td>
<td><strong>Electronic submission to immunization registries.</strong></td>
</tr>
<tr>
<td>Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.</td>
<td>§495.6(e)(9)(ii) / §495.6(g)(8)(ii)</td>
<td>(1) The standard (and applicable implementation specifications) specified in §170.205(e)(1) or §170.205(e)(2); and</td>
</tr>
<tr>
<td></td>
<td>§170.207(e)</td>
<td>(2) At a minimum, the version of the standard specified in §170.207(e).</td>
</tr>
<tr>
<td>§495.6(e)(9)(iii) – Exclusion: An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.</td>
<td>§495.6(g)(9)(ii)</td>
<td><strong>Immunizations.</strong></td>
</tr>
<tr>
<td>§495.6(g)(8)(iii) – Exclusion: An eligible hospital or CAH that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.</td>
<td>§170.306(g)</td>
<td>(1) §170.205(e)(1) - HL7 2.3.1. Implementation specifications: Implementation Guide for Immunization Data Transactions using Version 2.3.1 of the HL7 Standard Protocol Implementation Guide Version 2.2.</td>
</tr>
<tr>
<td>§170.205(c) - HL7 2.5.1. Implementation specifications: HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0.</td>
<td></td>
<td>(2) §170.205(e)(2) - HL7 2.5.1. Implementation specifications: HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0.</td>
</tr>
<tr>
<td>§170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.</td>
<td></td>
<td>Immunizations.</td>
</tr>
<tr>
<td><strong>Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission according to applicable law and practice.</strong></td>
<td>§495.6(g)(9)(ii)</td>
<td>(1) §170.205(c) - HL7 2.5.1. Implementation specifications: HL7 Version 2.5.1. Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm).</td>
</tr>
<tr>
<td></td>
<td>§495.6(g)(9)(i)</td>
<td>(2) §170.207(c) - LOINC® version 2.27, when such codes were received within an electronic transaction from a laboratory.</td>
</tr>
<tr>
<td>§495.6(g)(9)(iii) – Exclusion: No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.</td>
<td>§170.306(g)</td>
<td><strong>Reportable lab results.</strong> Electronically record, modify, retrieve, and submit reportable clinical lab results in accordance with:</td>
</tr>
<tr>
<td></td>
<td>§495.306(g)</td>
<td>(1) The standard (and applicable implementation specifications) specified in §170.205(c) and, at a minimum, the version of the standard specified in §170.207(c).</td>
</tr>
<tr>
<td></td>
<td>§495.306(g)</td>
<td>(2) At a minimum, the version of the standard specified in §170.207(c).</td>
</tr>
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**Note:** MU measures may be subject to paragraph (c) of 495.6 and exclusions to measures may be subject to either paragraph (a) (eligible professionals) or paragraph (b) (eligible hospitals and CAHs) of section 495.6.
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<th>STANDARD(S)</th>
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<tr>
<td><strong>MEANINGFUL USE</strong></td>
<td><strong>CERTIFICATION CRITERIA</strong></td>
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<td></td>
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<tr>
<td>42 CFR 495.6(d)-(g)</td>
<td>45 CFR 170.302, 170.304, &amp; 170.306</td>
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<tr>
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<td>§495.6(e)(10)(ii) / §495.6(g)(10)(ii)</td>
<td>§170.302(l)</td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.</strong></td>
<td><strong>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.</strong></td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>§495.6(e)(10)(iii) - Exclusion: An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.</td>
<td>§495.6(g)(10)(iii) - Exclusion: No public health agency to which the eligible hospital or CAH submits information has the capacity to receive the information electronically.</td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>§495.6(e)(10)(iii) - Exclusion: No public health agency to which the eligible hospital or CAH submits information has the capacity to receive the information electronically.</td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>N/A</strong></td>
<td><strong>N/A</strong></td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Public health surveillance.</strong> Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard specified in §170.205(d)(1) or §170.205(d)(2).</td>
<td><strong>Public health surveillance.</strong> Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard specified in §170.205(d)(1) or §170.205(d)(2).</td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Automated measure calculation.</strong> 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.</td>
<td><strong>Automated measure calculation.</strong> 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.</td>
<td><strong>Electronic submission to public health agencies for surveillance or reporting.</strong></td>
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