Eligible Professional EHR Incentive Program Objectives and Measures for 2016 Table of Contents

Date updated: February 4, 2016

Eligible Professional Objectives and Measures	
(1)	Protect electronic protected health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.
(2)	Use clinical decision support to improve performance on high-priority health conditions.
(3)	Use computerized provider order entry 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.
(4)	Generate and transmit permissible prescriptions electronically (eRx).
(5)	Health Information Exchange -The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
(6)	Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.
(7)	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
(8)	Patient electronic access - 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.
(9)	Use secure electronic messaging to communicate with patients on relevant health information.
(10)	Public Health Reporting -The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

View or download all of the EP modified objectives and measures for meaningful use in 2016.

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Objective 1 of 10

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Protect Patient Health Information	
Objective	Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities.
Measure	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT 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 EP's risk management process.

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Attestation Requirements

YES/NO

Eligible professionals (EPs) must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary and correcting identified security deficiencies to meet this measure.

Additional Information

- EPs must conduct or review a security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once each calendar year and attest to conducting the analysis or review.
- An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each EHR reporting period. Any security updates and deficiencies that are identified should be included in the provider's risk management process and implemented or corrected as dictated by that process.
- It is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be unique for each EHR reporting period, the scope must include the full EHR reporting period, and the analysis or review must be conducted prior to the date of attestation.
- The parameters of the security risk analysis are defined 45 CFR 164.308(a)(1), which was created by the HIPAA Security Rule. Meaningful use does not impose new or expanded requirements on the HIPAA Security Rule nor does it require specific use of every certification and standard that

is included in certification of EHR technology. More information on the HIPAA Security Rule can be found at http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/.

- HHS Office for Civil Rights (OCR) has issued guidance on conducting a security risk analysis in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule: http://www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html.
- Additional free tools and resources available to assist providers include a Security Risk Assessment (SRA) Tool developed by ONC and OCR: http://www.healthit.gov/providers-professionals/security-risk-assessment-tool

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii). For further discussion please see 80 FR 62793.
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.314(d)(4), (d)(2), (d)(3), (d)(7), (d)(1), (d)(5), (d)(6), (d)(8), and optionally (d)(9).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 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 paragraph (d)(1)(i) of this section, and the actions the user is permitted to perform with the EHR technology.
§ 170.314(d)(2) Auditable events and tamper resistance	(i) Record actions. EHR technology must be able to: (A) Record actions related to electronic health information in accordance with the standard specified in § 170.210(e)(1); (B) Record the audit log status (enabled or disabled) in accordance with the standard specified in § 170.210(e)(2) unless it cannot be disabled by any user; and (C) Record the encryption status (enabled or disabled) of electronic health information locally stored on end-user devices by EHR technology in accordance with the standard specified in § 170.210(e)(3) unless the EHR technology prevents electronic health information from being locally stored on end-user devices (see 170.314(d)(7) of this section). (ii) Default setting. EHR technology must be set by default to perform the capabilities specified in paragraph (d)(2)(i)(A) of this section and, where applicable, paragraphs (d)(2)(i)(B) or (C), or both paragraphs (d)(2)(i)(B) and (C). (iii) When disabling the audit log is permitted. For each capability specified in paragraphs (d)(2)(i)(A) through (C) of this section that EHR technology permits to

	be disabled, the ability to do so must be restricted to a limited set of identified users. (iv) Audit log protection. Actions and statuses recorded in accordance with paragraph (d)(2)(i) of this section must not be capable of being changed, overwritten, or deleted by the EHR technology. (v) Detection. EHR technology must be able to detect whether the audit log has been altered.
§ 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 data specified in the standards at § 170.210(e).
§170.314(d)(4) Amendments	Enable a user to electronically select the record affected by a patient's request for amendment and perform the capabilities specified in paragraphs (d)(4)(i) or (ii) of this section. (i) Accepted amendment -For an accepted amendment, append the amendment to the affected record or include a link that indicates the amendment's location. (ii) Denied amendment -For a denied amendment, at a minimum, append the request and denial of the request to the affected record or include a link that indicates this information's location.
§ 170.314(d)(5) Automatic log off	Prevent a user from gaining further access to an electronic session after a predetermined time of inactivity.
§ 170.314(d)(6) Emergency access	Permit an identified set of users to access electronic health information during an emergency.
§ 170.314(d)(7) End user device encryption	Paragraph (d)(7)(i) or (ii) of this section must be met to satisfy this certification criterion. (i) EHR technology that is designed to locally store electronic health information on end-user devices must encrypt the electronic health information stored on such devices after use of EHR technology on those devices stops. (A) Electronic health information that is stored must be encrypted in accordance with the standard specified in § 170.210(a)(1). (B) Default setting. EHR technology must be set by default to perform this capability and, unless this configuration cannot be disabled by any user, the ability to change the configuration must be restricted to a limited set of identified users. (ii) EHR technology is designed to prevent electronic health information from being locally stored on end-user devices after use of EHR technology on those devices stops.
§ 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.
§ 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).

Standards Criteria	
§ 170.210(e)(1), § 170.210(e)(2) and § 170.210(e)(3) Record actions related to electronic health information, audit log status, and encryption status	(i) The audit log must record the information specified in sections 7.2 through 7.4, 7.6, and 7.7 of the standard specified at § 170.210(h) when EHR technology is in use. (ii) The date and time must be recorded in accordance with the standard specified at § 170.210(g). The audit log must record the information specified in sections 7.2 and 7.4 of the standard specified at § 170.210(h) when the encryption status of electronic health information locally stored by EHR technology on end-user devices is changed. The date and time each action occurs in accordance with the standard specified at § 170.210(g).
§ 170.210(a)(1) Encryption and decryption of electronic health information	Any encryption algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the Federal Information Processing Standards (FIPS) Publication 140-2 (incorporated by reference in §170.299).
§ 170.210(c) Create message digest	A hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm) as specified by the National Institute of Standards and Technology (NIST) in FIPS PUB 180-4 (March, 2012) must be used to verify that electronic health information has not been altered.
§ 170.210(d) Record treatment, payment, and health care operations disclosures	The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations, as these terms are defined at 45 CFR 164.501.

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Date updated: February 4, 2016

Clinical Decision Support	
Objective	Use clinical decision support to improve performance on high-priority health conditions.
Measures	EPs must satisfy both of the following measures in order to meet the objective: • Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. • Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
Exclusion	For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.

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Definition of Terms

Clinical Decision Support – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

Attestation Requirements

YES/NO/EXCLUSION

- **MEASURE 1:** EPs must attest YES to implementing five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period.

- **MEASURE 2:** EPs must attest YES to enabling and implementing the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

- **EXCLUSION**: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

Additional Information

- If there are limited CQMs applicable to an EP's scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for the high-priority health conditions relevant to their specialty and patient population.
- Drug-drug and drug-allergy interaction alerts are separate from the 5 clinical decision support interventions and do not count toward the 5 required for this first measure.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(2)(i). For further discussion please see 80 FR 62795.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(8) and (a)(2).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§170.314(a)(8) Clinical decision support	(i) Evidence-based decision support interventions. Enable a limited set of identified users to select (i.e., activate) one or more electronic clinical decision support interventions (in addition to drug-drug and drug-allergy contraindication checking) based on each one and at least one combination of the following data: (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) EHR technology must be able to: a. Electronically identify for a user diagnostic and therapeutic reference information; or b. Electronically identify for a user diagnostic and therapeutic reference information in accordance with the standard specified at § 170.204(b) and the implementation specifications at § 170.204 (b)(1) or (2). (B) For paragraph (a)(8)(ii)(A) of this section, EHR technology must be able to electronically identify for a user diagnostic or therapeutic reference information based on each one and at least one combination of the following data referenced in paragraphs (a)(8)(i)(A) through (F) of this section: (iii) Clinical decision support configuration. (A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) of this section to be configured by a limited set of identified users (e.g., system administrator) based on a user's role. (B) EHR technology must enable interventions to be electronically triggered:

a. Based on the data referenced in paragraphs (a)(8)(i)(A) through (F) of this section.
b. When a patient's medications, medication allergies, and problems are incorporated from a transition of care/referral summary received pursuant to paragraph (b)(1)(iii) of this section.
c. Ambulatory setting only. When a patient's laboratory tests and values/results are incorporated pursuant to paragraph (b)(5)(i)(A)(1) of this section.

(iv) Automatically and electronically interact. Interventions triggered in accordance with paragraphs (a)(8)(i) through (iii) of this section must automatically and electronically occur when a user is interacting with EHR technology.

(v) Source attributes. Enable a user to review the attributes as indicated for all clinical decision support resources:

(A) For evidence-based decision support interventions under paragraph (a)(8)(i) of this section:
a. Bibliographic citation of the intervention (clinical research/guideline);
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(s) of the intervention or reference source.

(B) For linked referential clinical decision support in paragraph (a)(8)(ii) of this section and drug-drug, drug-allergy interaction checks in paragraph(a)(2) of this section, the developer of the intervention, and where clinically indicated, the bibliographic citation of the intervention (clinical research/guideline).

170.314 (a)(2) Drug drug, drug allergy interaction checks

(i) Interventions. Before a medication order is completed and acted upon during computerized provider order entry (CPOE), interventions must automatically and electronically indicate to a user drug-drug and drug-allergy contraindications based on a patient's 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.

Standards Criteria	
§ 170.204(b) Reference source	HL7 Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299).
§ 170.204 (b)(1) or (2). Implementation specifications	HL7 Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299). (1) Implementation specifications. HL7 Version 3 Implementation Guide: URL-Based Implementations of the Context-Aware Information Retrieval (Infobutton) Domain, (incorporated by reference in § 170.299). (2) Implementation specifications. HL7 Version 3 Implementation Guide: Context-Aware Knowledge Retrieval (Infobutton) Service-Oriented Architecture Implementation Guide, (incorporated by reference in § 170.299).

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Date updated: February 4, 2016

Computerized Provider Order Entry (CPOE)	
Objective	Use computerized provider order entry 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.
Measures	An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective: • Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. • Measure 2: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. • Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.
Exclusions	• Measure 1: Any EP who writes fewer than 100 medication orders during the EHR reporting period. • Measure 2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. • Measure 3: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.
Alternate Exclusions	• Alternate Exclusion for Measure 2: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016. • Alternate Exclusion for Measure 3: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

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Definition of Terms

Computerized Provider Order Entry (CPOE) – A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Laboratory Order – An order for any service provided by a laboratory that could not be provided by a non-laboratory.

Laboratory – A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order – An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire EHR reporting period.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION/ALTERNATE EXCLUSION

MEASURE 1:

- DENOMINATOR: Number of medication orders created by the EP during the EHR reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 60 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

MEASURE 2:

- DENOMINATOR: Number of laboratory orders created by the EP during the EHR reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 30 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.
- ALTERNATE EXCLUSION: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

MEASURE 3:

- DENOMINATOR: Number of radiology orders created by the EP during the EHR reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 30 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

- ALTERNATE EXCLUSION: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- The CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order to count in the numerator.
- In some situations, it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure.
- Any licensed healthcare professionals and clinical staff credentialed to and with the duties equivalent of a medical assistant, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. It is up to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions (or both).
- Orders involving tele-health or remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the objective and measures.
- Providers may exclude orders that are predetermined for a given set of patient characteristics or for a given procedure (also known as "protocol" or "standing orders") from the calculation of CPOE numerators and denominators. Note this does not require providers to exclude this category of orders from their numerator and denominator (77 FR 53986).
- CPOE is the entry of the order into the patient's EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(3)(i). For further discussion please see 80 FR 20359.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(1).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314(a)(1) Computerized provider order entry	Enable a user to electronically record, change, and access the following order types, at a minimum: • Medications; • Laboratory; and • Radiology/imaging.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria
N/A

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Electronic Prescribing (eRx)	
Objective	Generate and transmit permissible prescriptions electronically (eRx).
Measure	More than 50 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
Exclusions	Any EP who: • Writes fewer than 100 permissible prescriptions during the EHR reporting period; or • Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

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Definition of Terms

Prescription – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.

Permissible Prescriptions – "Permissible prescriptions" may include or not include controlled substances based on provider selection and where allowable by state and local law.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSIONS

- DENOMINATOR: Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.
- NUMERATOR: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSIONS: Any EP who:
    - Writes fewer than 100 permissible prescriptions during the EHR reporting period; or
    - Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the numerator and the denominator of the measure.
- Instances where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the EHR reporting period.
- As electronic prescribing of controlled substances is now possible, providers may choose to include these prescriptions in their permissible prescriptions where feasible and allowable by state and local law.
- An EP needs to use CEHRT as the sole means of creating the prescription, and when transmitting to an external pharmacy that is independent of the EP's organization such transmission must use standards adopted for EHR technology certification.
- EPs should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective.
- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur concurrently if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.
- Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of CEHRT to the intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.
- Prescriptions transmitted electronically within an organization (the same legal entity) do not need to use the NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be CEHRT. For more information, refer to ONC's FAQ at https://www.healthit.gov/policy-researchers-implementers/22-question-12-10-022.
- Providers may limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required. If a query using the function of their CEHRT is not possible or shows no result, a provider is not required to conduct any further manual or paper-based action in order to complete the query, and the provider may count the prescription in the numerator.
- EPs practicing at multiple locations are eligible for the exclusion if any of their practice locations that are equipped with CEHRT meet the exclusion criteria.
- EPs who are part of an organization that owns or operates its own pharmacy within the 10 mile radius are not eligible for the exclusion regardless of whether that pharmacy can accept electronic prescriptions from EPs outside of the organization.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i). For further discussion please see 80 FR 62800.
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.314(b)(3) and (a)(10).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314(b)(3) 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(d)(2).
§ 170.314(a)(10) Drug formulary checks	EHR technology must automatically and electronically check whether a drug formulary (or preferred drug list) exists for a given patient and medication.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§170.205(b)(2) Electronic Prescribing	NCPDP SCRIPT Version 10.6.
§170.207(d)(2) Medications	RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, August 6, 2012 Release (incorporated by reference in § 170.299)

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Health Information Exchange	
Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
Measures	The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

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Definition of Terms

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record – All summary of care documents used to meet this objective must include the following information if the provider knows it:

- Patient name
- Referring or transitioning provider's name and office contact information (EP only)
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral (EP only)
- Current problem list (Providers may also include historical problems at their discretion)*
- Current medication list*

- Current medication allergy list*

**Note: An EP must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies..*

Current problem lists – At a minimum a list of current and active diagnoses.

Active/current medication list – A list of medications that a given patient is currently taking.

Active/current medication allergy list – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan – The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
- THRESHOLD: The percentage must be more than 10 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

Additional Information

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- This exchange may occur before, during or after the EHR reporting period but must take place no earlier than the start of the same calendar year as the EHR reporting period and no later than the date of attestation in order to count in the numerator.
- Apart from the three fields noted as required (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to populate one or more of the fields listed (because the EP does not record such information or because there is no information to record), the EP may leave the field(s) blank and still meet the objective and its associated measure.
- A provider must have the ability to transmit all data pertaining to laboratory test results in the summary of care document, but may work with their system developer to establish clinically

relevant parameters for the most appropriate results for the given transition or referral. This policy is limited to laboratory test results.

- A provider who limits the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e. all lab results as opposed to a subset).
- The referring provider must have reasonable certainty of receipt by the receiving provider to count the action toward the measure.
- The exchange must comply with the privacy and security protocols for ePHI under HIPAA.
- In cases where the providers share access to an EHR, a transition or referral may still count toward the measure if the referring provider creates the summary of care document using CEHRT and sends the summary of care document electronically. If a provider chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(5)(i). For further discussion please see 80 FR 62806.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (a)(5), (a)(6) and (a)(7).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314 (b) (1) Transitions of care – receive, display, and incorporate transition of care/referral summaries	(i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with: (A) The standard specified in § 170.202(a). (B) Optional. The standards specified in § 170.202(a) and (b). (C) Optional. The standards specified in § 170.202(b) and (c). (ii) Display. EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: § 170.205(a)(1), § 170.205(a)(2), and § 170.205(a)(3). (iii) Incorporate. Upon receipt of a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3), EHR technology must be able to: (A) Correct patient. Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient. (B) Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s): • Medications. At a minimum, the version of the standard specified in § 170.207(d)(2); • Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); • Medication allergies. At a minimum, the version of the standard specified in § 170.207(d)(2). (C) Section views. Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at § 170.205(a)(3).
§ 170.314(b)(2) Transitions of care – create and transmit transition of care/referral summaries	(i) Create. Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): (A) Encounter diagnoses. The standard specified in § 170.207(i) or, at a minimum, the version of the standard specified § 170.207(a)(3); (B) Immunizations. The standard specified in § 170.207(e)(2); (C) Cognitive status; (D) Functional status; and (E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. (F) Inpatient setting only. Discharge instructions.

	(ii) Transmit. Enable a user to electronically transmit the transition of care/referral summary created in paragraph (b)(2)(i) of this section in accordance with: (A) The standard specified in § 170.202(a). (B) Optional. The standards specified in § 170.202(a) and (b). (C) Optional. The standards specified in § 170.202(b) and (c).
§ 170.314(a)(5) Problem list	Enable a user to electronically record, change, and access a patient's problem list: (i) Ambulatory setting. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3); or (ii) Inpatient setting. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3).
§ 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.
§ 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: (i) Ambulatory setting. Over multiple encounters; or (ii) Inpatient setting. For the duration of an entire hospitalization.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Additional certification criteria may apply. Review the ONC 2015 Edition Final Rule for more information.

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport (incorporated by reference in § 170.299).
§ 170.202(b) Transport standards	ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in § 170.299).
§ 170.202(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in § 170.299).
§ 170.205(a)(1)	HL7 Implementation Guide for CDA® Release 2, CCD. Implementation specifications: HITSP Summary Documents Using HL7 CCD Component HITSP/C32.

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Date issued: October 6, 2015

Patient Specific Education	
Objective	Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.
Measure	Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.
Exclusion	Any EP who has no office visits during the EHR reporting period.
Alternate Exclusion	Provider may claim an exclusion for the measure of the Stage 2 Patient Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective.

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Definition of Terms

Patient-Specific Education Resources Identified by CEHRT – Resources or a topic area of resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term "unique patient" relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION/ALTERNATE EXCLUSION

- DENOMINATOR: Number of unique patients with office visits seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.
- THRESHOLD: The resulting percentage must be more than 10 percent in order for an EP to meet this measure.

- EXCLUSION: Any EP who has no office visits during the EHR reporting period.
- ALTERNATE EXCLUSION: Provider may claim an exclusion for the measure of the Stage 2 Patient Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective.

Additional Information

- Unique patients with office visits means that to count in the denominator a patient must be seen by the EP for one or more office visits during the EHR reporting period, but if a patient seen by the EP more than once during the EHR reporting period, the patient only counts once in the denominator.
- The EP must use elements within certified EHR technology (CEHRT) to identify educational resources specific to patients' needs. Certified EHR technology is certified to use the patient's problem list, medication list, or laboratory test results to identify the patient-specific educational resources. The EP may use these elements or may use additional elements within CEHRT to identify educational resources specific to patients' needs. The EP can then provide these educational resources to patients in a useful format for the patient (such as, electronic copy, printed copy, electronic link to source materials, through a patient portal or PHR).
- The education resources or materials do not have to be stored within or generated by the CEHRT.
- There is no universal "transitive effect" policy in place for this objective and measure. It may vary based on the resources and materials provided and the timing of that provision. If an action is clearly attributable to a single provider, it may only count in the numerator for that provider. However, if the action is not attributable to a single provider, it may be counted in the numerator for all providers sharing the CEHRT who have the patient in their denominator for the EHR reporting period.
- The action may occur before, during or after the EHR reporting period but must take place no earlier than the start of the same calendar year as the EHR reporting period and no later than the date of attestation in order to count in the numerator.
- A provider may use an alternate calculation for an EHR reporting period in 2015 if that calculation is part of their CEHRT.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(6)(i). For further discussion please see 80 FR 62807.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (a)(15).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314(a)(15) Patient-specific education resources	EHR technology must be able to electronically identify for a user patient-specific education resources based on data included in the patient's problem list, medication list, and laboratory tests and values/results: (i) In accordance with the standard specified at § 170.204(b) and the implementation specifications at § 170.204(b)(1) or (2); and (ii) By any means other than the method specified in paragraph (a)(15)(i) of this section.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.204(b) Reference source	Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299).
§ 170.204(b)(1) or (2) Implementation Specifications	Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299). (1) Implementation specifications. HL7 Version 3 Implementation Guide: URL-Based Implementations of the Context-Aware Information Retrieval (Infobutton) Domain, (incorporated by reference in § 170.299) (2) Implementation specifications. HL7 Version 3 Implementation Guide: Context-Aware Knowledge Retrieval (Infobutton) Service-Oriented Architecture Implementation Guide, (incorporated by reference in § 170.299).

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Date updated: February 4, 2016

Medication Reconciliation	
Objective	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
Measure	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Exclusion	Any EP who was not the recipient of any transitions of care during the EHR reporting period.

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Definition of Terms

Medication Reconciliation – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

Transition of Care - The movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Referral - Cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well.

Denominator for Transitions of Care and Referrals: The denominator includes transitions of care and referrals (as finalized in the Stage 2 rule where the definition of transitions of care includes: "When the EP is the recipient of the transition or referral, first encounters with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving EP"(77 FR 53984).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

- DENOMINATOR: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
- NUMERATOR: The number of transitions of care in the denominator where medication reconciliation was performed.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Additional Information

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- In the case of reconciliation following transition of care, the receiving EP should conduct the medication reconciliation.
- The electronic exchange of information is not a requirement for medication reconciliation.
- The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.
- We define "new patient" as a patient never before seen by the provider. A provider may use an expanded definition of "new patient" for the denominator that includes a greater number of patients for whom the action may be relevant within their practice, such as inclusion of patients not seen in 2 years.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(7)(i). For further discussion please see 80 FR 62811.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (b)(4).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314 (b)(4) Clinical Information Reconciliation	Enable a user to electronically reconcile the data that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically and simultaneously display (i.e., in a single view) the data from at least two list sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to create a single reconciled list of medications, medication allergies, or problems. (iii) Enable a user to review and validate the accuracy of a final set of data and, upon a user's confirmation, automatically update the list.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria
N/A

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Date updated: February 4, 2016

Patient Electronic Access	
Objective	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.
Measures	EPs must satisfy both measures in order to meet this objective: • Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. • Measure 2: For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.
Exclusions	Measure 1: Any EP who: • Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information." Measure 2: Any EP who: • Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or • Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

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Definition of Terms

Provide Access – When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

View – The patient (or authorized representative) accessing their health information online.

Download – The movement of information from online to physical electronic media.
Transmission – This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Business Days – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

MEASURE 1:

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."

MEASURE 2:

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.
- THRESHOLD: The numerator and denominator must be reported, and the numerator must be equal to or greater than 1.
- EXCLUSIONS: Any EP who— (a) Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or (b) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Additional Information

- In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:

- Patient name
- Provider's name and office contact information
- Current and past problem list
- Procedures
- Laboratory test results
- Current medication list and medication history
- Current medication allergy list and medication allergy history
- Vital signs (height, weight, blood pressure, BMI, growth charts)
- Smoking status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field(s), including goals and instructions
- Any known care team members including the primary care provider (PCP) of record

- An EP can make available additional information and still align with the objective.
- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.
- The patient must be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through VDT, the measure does not replace the covered entity's responsibilities to meet the broader requirements under HIPAA to provide an individual, upon request, with access to PHI in a designated record set.
- Providers should also be aware that while meaningful use is limited to the capabilities of CEHRT to provide online access there may be patients who cannot access their EHRs electronically because of a disability. Providers who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, patient health information needs to be made available to each patient for view, download, and transmit within 4 business days of the information being available to the provider for each and every time that information is generated whether the patient has been "enrolled" for three months or for three years.
- A patient who has multiple encounters during the EHR reporting period, or even in subsequent EHR reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.
- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to "opt out" of participation, the provider may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the provider.
- For Measure 2, the patient action may occur before, during or after the EHR reporting period but must take place no earlier than the start of the same calendar year as the EHR reporting period and no later than the date of attestation in order to count in the numerator.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(8)(i). For further discussion please see 80 FR 62815.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (e)(1).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§170.314(e)(1) View, download, and transmit to third party	(i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f). (A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data: (1) The Common MU Data Set** (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set). (2) Ambulatory setting only. Provider's name and office contact information. (3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization. (B) Download. (1) Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set): (i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2) of this section. (ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(3) of this section. (2) Inpatient setting only. Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section). (C) Transmit to third party. (1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is

[redacted]

requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in § 170.202(a).

(2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in § 170.202(a).

(ii) Activity history 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) through (C) of this section, the following information must be recorded and made accessible to the patient:

(1) The action(s) (i.e., view, download, transmission) that occurred;

(2) The date and time each action occurred in accordance with the standard specified at § 170.210(g); and

(3) The user who took the action.

(B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section 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.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Additional certification criteria may apply. Review the ONC 2015 Edition Final Rule for more information.

Standards Criteria*	
§ 170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).
§ 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 FIPS Publication 140-2 (incorporated by reference in § 170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation. The use of the "unstructured document" document-level template is prohibited.
§ 170.202(a)	Applicability Statement for Secure Health Transport.
§ 170.210(g)	The data and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, or (RFC 5905) Network Time Protocol Version 4.

Additional standards criteria may apply. Review the ONC 2015 Edition Final Rule for more information.

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Date updated: February 4, 2016

Secure Electronic Messaging	
Objective	Use secure electronic messaging to communicate with patients on relevant health information.
Measures	For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.
Exclusion	Any EP who has no office visits during the EHR reporting period; or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

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Definitions of Terms

Secure Message – Any electronic communication between a provider and patient that ensures only those parties can access the communication. This electronic message could be email or the electronic messaging function of a PHR, an online patient portal, or any other electronic means.

Fully Enabled - The function is fully installed, any security measures are fully enabled, and the function is readily available for patient use.

Attestation Requirements

YES/NO/EXCLUSION

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).
- THRESHOLD: The numerator and denominator must be reported, and the numerator must be equal to or greater than 1.
- EXCLUSION: Any EP who has no office visits during the EHR reporting period; or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50

percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Additional Information

- The thresholds for this measure increase over time between to allow providers to work incrementally toward a high goal. This is consistent with our past policy in the program to establish incremental change from basic to advanced use and increased thresholds over time. The measure threshold for this objective was "fully enabled" for 2015, and is at least one patient for 2016, and a threshold of 5 percent for 2017 to build toward the Stage 3 threshold.
- Provider initiated action and interactions with a patient-authorized representative, are acceptable for the measure and are included in the numerator.
- A patient-initiated message would only count toward the numerator if the provider responds to the patient.
- The action for the numerator must occur within the calendar year but may occur before, during, or after the EHR reporting period if that period is less than one full calendar year.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(9)(i). For further discussion please see 80 FR 62816.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(e)(3).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314(e)(3) 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 (or authorized representative) and EHR technology user 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).

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.210(f) Encryption and hashing of electronic health information	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 FIPS Publication 140-2 (incorporated by reference in § 170.299.)

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Date updated: February 4, 2016

Public Health Reporting	
Objective	The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.
Measure Options	• Measure 1 - Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data. • Measure 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data. • Measure 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry.
Exclusions	• Measure 1 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP— o Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period; o Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or o Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period. • Measure 2 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP-- o Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; o Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or o Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. • Measure 3 Exclusions: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP -- o Does not diagnose or treat any disease or condition associated with, or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period; o Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or

[redacted]

- Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

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Definition of Terms

Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.

Active Engagement Option 1–Completed Registration to Submit Data:
The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2 - Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3 – Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

Production data refers to data generated through clinical processes involving patient care, and it is used to distinguish between data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers.

Attestation Requirements

YES/NO/EXCLUSIONS

MEASURE 1:

- YES/NO: The EP must attest YES to being in active engagement with a public health agency to submit immunization data.
- EXCLUSIONS: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP--

- Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period;
- Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
- Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

MEASURE 2:

- YES/NO: THE EP must attest YES to being in active engagement with a public health agency to submit syndromic surveillance data.
- EXCLUSIONS: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—
  - Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
  - Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

MEASURE 3:

- YES/NO: The EP must attest YES to being in active engagement to submit data to a specialized registry.
- EXCLUSIONS: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP –
  - Does not diagnose or treat any disease or condition associated with, or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;
  - Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

Additional Information

- Providers who have previously registered, tested, or begun ongoing submission of data to registry do not need to "restart" the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In order to meet this objective an EP would need to meet two of the total number of measures available to them.
- An exclusion for a measure does not count toward the total of two measures. If an EP excludes from a measure, they must meet or exclude from the remaining measures in order to meet the

objective. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the one remaining measure available to them. If no measures remain available, the EP can meet the objective by meeting the requirements for exclusion from all three measures.

- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 2, an exclusion does not apply if an entity designated by public health agency can receive electronic syndromic surveillance data submissions. For example, if the public health agency cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 3, a provider may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.
- In determining whether an EP meets the first exclusion, the registries in question are those sponsored by the public health agencies with jurisdiction over the area where the EP practices and national medical societies covering the EP's scope of practice. Therefore an EP must complete two actions in order to determine available registries or claim an exclusion:
    - Determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry; and,
    - Determine if a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry.
- We continue to allow registries such as Prescription Drug Monitoring Program reporting and electronic case reporting registries to be considered specialized registries for purposes of reporting the EHR Reporting period in 2016.
- EPs who were previously planning to attest to the cancer case reporting objective, may count that action toward the Specialized Registry reporting measure. EPs who did not intend to attest to the cancer case reporting menu objective are not required to engage in or exclude from cancer case reporting in order to meet the specialized registry reporting measure.
- Providers may use electronic submission methods beyond the functions of CEHRT to meet the requirements for the Specialized Registry Reporting measure.
- A specialized registry cannot be duplicative of any of the other registries or reporting included in other meaningful use requirements.
- If a provider is part of a group which submits data to a registry, but the provider does not contribute to that data (for example they do not administer immunizations), the provider should not attest to meeting the measure but instead should select the exclusion. The provider may then select a different more relevant measure to meet.
- If a provider does the action that results in a data element for a registry in the normal course of their practice and is in active engagement to submit to a registry, but simply has no cases for the reporting period, the provider is not required to take the exclusion and may attest to meeting the measure.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i). For further discussion please see 80 FR 62824.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (f)(1), (f)(2) and (f)(3).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 170.314(f)(1) Immunization information	Enable a user to electronically record, change, and access immunization information.
§ 170.314(f)(2) Transmission to immunization registries	EHR technology must be able 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) (ii) At a minimum, the version of the standard specified in § 170.207(e)(2).
§ 170.314(f)(3) Transmission to public health agencies syndromic surveillance	EHR technology must be able 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 implantation specifications) specified in § 170.205(d)(3).

Standards Criteria	
§ 170.205(e)(3)	HL7 2.5.1 (incorporated by reference in § 170.299). Implementation specifications. HL7 2.5.1 Implementation Guide for Immunization Messaging, Release 1.4, (incorporated by reference in § 170.299).
§ 170.207(e)(2) Immunizations	HL7 Standard Code Set CVX -- Vaccines Administered, updates through July 11, 2012 (incorporated by reference in § 170.299).
§ 170.205(d)(2)	HL7 2.5.1
§ 170.205(d)(3)	HL7 2.5.1 (incorporated by reference in § 170.299). Implementation specifications. PHIN Messaging Guide for Syndromic Surveillance (incorporated by reference in § 170.299) and Conformance Clarification for EHR Certification of Electronic Syndromic Surveillance, Addendum to PHIN Messaging Guide for Syndromic Surveillance.