Comparison of Meaningful Use Objectives Between the Proposed Rule to the Final Rule (Released July 13, 2010)

	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	**EP:** Use CPOE **Hospital:** Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	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	Core
Measure	**EP:** CPOE is used for at least 80% of all orders **Eligible Hospital:** CPOE is used for 10% of all orders	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE	EPs who order less than 100 medications during the EHR reporting periods
Objective	Implement drug-drug, drug-allergy, drug-formulary checks	Implement drug-drug and drug-allergy interaction checks Implement drug formulary checks	Core Menu
Measure	The EP/eligible hospital has enabled this functionality	The EP/eligible hospital/CAH has enabled this functionality The EP/eligible hospital has enabled this functionality and has access to at least one internal or external drug formulary	None None
Objective	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT	Maintain an up-to-date problem list of current and active diagnoses	Core
Measure	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	None
Objective	**EP:** Generate and transmit permissible prescriptions electronically (eRx)	Generate and transmit permissible prescriptions electronically (eRx)	Core
Measure	**EP:** At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	EPs who order less than 100 medications during the EHR reporting periods

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	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	Maintain active medication list	Maintain active medication list	Core
Measure	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data	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	None
Objective	Maintain active medication allergy list	Maintain active medication allergy list	Core
Measure	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data	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	None
Objective	**EP:** Record demographics ○ preferred language ○ insurance type ○ gender ○ race ○ ethnicity ○ date of birth **Hospital:** Record demographics ○ preferred language ○ insurance type ○ gender ○ race ○ ethnicity ○ date of birth ○ date and cause of death in the event of mortality	**EP:** Record demographics ○ preferred language ○ gender ○ race ○ ethnicity ○ date of birth **Hospital:** Record demographics ○ preferred language ○ gender ○ race ○ ethnicity ○ date of birth ○ date and preliminary cause of death in the event of mortality	Core
Measure	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data	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	None

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	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	Record and chart changes in vital signs: ○ height ○ weight ○ blood pressure ○ Calculate and display: BMI ○ Plot and display growth charts for children 2-20 years, including BMI.	Record and chart changes in vital signs: ○ height ○ weight ○ blood pressure ○ Calculate and display: BMI ○ Plot and display growth charts for children 2-20 years, including BMI.	Core
Measure	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data	For 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 structure data	EPs who see no patients age 2 or over or who believe e that the vital signs have no relevance on their scope of practice
Objective	Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	Core
Measure	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have "smoking status" recorded	More than 50 percent of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	EP that sees no patients 13 years old or older during the EHR reporting period
Objective	**EP:** Report ambulatory quality measures to CMS or the States **Hospital:** Report hospital quality measures to CMS or the States	**EP:** Report ambulatory clinical quality measures to CMS or the States **Hospital:** Report hospital clinical quality measures to CMS or the States	Core
Measure	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule	See clinical quality measures discussion in the Final Rule (75 FR 44380-44434.

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	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	**EP:** Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules **Hospital:** Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	**EP:** Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule **Hospital:** Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Core
Measure	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3).	Implement one clinical decision support rule	None
Objective	**EP:** Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request **Hospital:** Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	**EP:** Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request **Hospital:** 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	Core
Measure	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days	EPs/EHs who receive no requests during the EHR reporting period
Objective	**Hospital:** Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	**Hospital:** Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	Core
Measure	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it	More than 50 percent of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it	EPs/EHs who receive no requests during the EHR reporting period

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	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	**EP:** Provide clinical summaries for patients for each office visit	**EP:** Provide clinical summaries for patients for each office visit	Core
Measure	**EP:** Clinical summaries provided for at least 80% of all office visits	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days or emergency department (POS 21 or 23) have at least one medication order entered using CPOE	EPs who have no office visits during the EHR reporting period
Objective	**EP:** Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically **Hospital:** Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	**EP:** Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically **Hospital:** Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Core
Measure	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	None
Objective	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Core
Measure	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	None
Objective	N/A (Advance directive)	**Hospital:** Record advance directives for patients 65 years old or older	Menu
Measure	N/A	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded	EH that admits no patients 65 years old or older

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	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab-test results into EHR as structured data	Menu
Measure	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	EPs who orders no tests that would included in the denominator during the EHR reporting period
Objective	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Menu
Measure	Generate at least one report listing patients of the EP or eligible hospital with a specific condition.	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition	None
Objective	**EP:** Send reminders to patients per patient preference for preventive/ follow up care	**EP:** Send reminders to patients per patient preference for preventive/ follow up care	Menu
Measure	**EP:** Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over	**EP:** 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	EPs with no patients with records maintained in their certified EHR technology in the designated age categories
Objective	Check insurance eligibility electronically from public and private payers	N/A	N/A
Measure	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital	N/A	N/A

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	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	Submit claims electronically to public and private payers	N/A	N/A
Measure	At least 80% of all claims filed electronically by the EP or the eligible hospital	N/A	N/A
Objective	**EP:** Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP	**EP:** 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	Menu
Measure	**EP:** At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information	**EP:** More than 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	EPs creates non of the data listed in certification as capable to be provided online by certified EHR technology
Objective	N/A (Patient Specific Education Resources)	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Menu
Measure	N/A	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) during the EHR reporting period are provided patient-specific education resources	None
Objective	Perform medication reconciliation at relevant encounters and each transition of care	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	Menu
Measure	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	EP who does not receive any transitions of care

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	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	Provide summary care record for each transition of care and referral	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	Menu
Measure	Provide summary of record for at least 80% of transitions of care and referrals	The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	EP who neither refers nor transitions patients to other settings of care
Objective	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Menu
Measure	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	EP/EH/CAH who administers no immunizations during the EHR reporting period
Objective	**Hospital:** Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	**Hospital:** Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	Menu
Measure	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)	Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)	None

Comparison of Meaningful Use Objectives Between the Proposed Rule to the Final Rule (Released July 13, 2010)

	Proposed Rule (January 2010)	Final Rule (July 2010)	Core/Menu Set for Objective or Exclusion for Measure
Objective	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Menu
Measure	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	EP that does not collect any reportable syndromic information on their patients during the EHR reporting period