

|   | Eligible Professionals  | Eligible Hospitals | Eligible Professionals  | Eligible Hospitals   | Eligible Professionals   | Eligible Hospitals   | Eligible Professionals   | Eligible Hospitals   | Eligible Professionals          | Eligible Hospitals   | Stage 2 NPRM page numbers  | 2014 Edition EHR Certification Criterion |
|---|---|--------------------|---|--|--|--|--|--|---------------------------------|--|--|--|
| Health Outcomes Policy Priority   | Stage 1 Final Rule  |                    | Stage 2 - Proposed by HITPC   |  | Stage 2 NPRM   |  | Stage 2 NPRM - MU Workgroup Comments   |  |                                 |  |  |  |
| <b>INFORMATION EXCHANGE RELATED OBJECTIVES</b>  |   |                    |   |  |  |  |  |  |                                 |  |  |  |
| <b>Improve quality safety, efficiency and reducing health disparities (e-Rx)</b>                                | Generate and transmit more than 40% of all permissible prescriptions electronically   | N/A                | Increase threshold to 50%   | Generate and transmit more than 10% of all hospital discharge orders for permissible prescriptions electronically  | <b>Objective:</b> Generate and transmit permissible prescriptions electronically (eRx)<br><b>Measure:</b> More than 65 % of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.<br><b>Seeking Comment</b>   | N/A  | (1) Clarify 65% or 50%, because the NPRM is ambiguous (mentions 50% in the query). We agree with 65%, although there remain challenges choosing a participating pharmacy at the time of writing a prescription. (2) We have some sources reporting that controlled substances should not be included in the denominator. | N/A  | pp. 53-59                       | \$170.314(b)(3)/\$170.314a(i)(10)  | Electronic prescribing. Enable a user to electronically create prescriptions and prescription-related information for electronic transmission in accordance with:<br>(i) The standard specified in § 170.205(a)(2); and<br>(ii) At a minimum, the version of the standard specified in § 170.207(n).<br><br>Drug-formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.   |  |
| <b>Improve quality safety, efficiency and reducing health disparities (Incorporate Labs as Structured Data)</b> | <b>MENU:</b> Incorporate clinical lab test results into certified EHR technology as structured data for more than 40% of all clinical lab tests results ordered whose results are either in a positive/negative or numerical format |                    | Incorporate lab results as structured data for more than 40% of all clinical lab tests ordered through the EHR for a patient during the reporting period<br><i>HITSC: Use LOINC where available</i>   | Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for more than 40% of electronic orders received | <b>Objective:</b> Incorporate clinical lab-test results into EHR as structured data<br><b>Measure:</b> More than 55% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data<br><b>Seeking Comment</b>  |  | Agree. Okay to count individual tests.   | The providers depend upon hospital labs which are about 40% of the market. Speak with IE workgroup to further discuss. | pp. 85-88                       | \$170.314(b)(5)  | Incorporate laboratory tests and values/results.<br>(i) Receive results.<br>(A) Ambulatory setting only.<br>(1) Electronically receive clinical laboratory tests and values/results formatted in accordance with the standard (and implementation specifications) specified at § 170.205(a) and, at a minimum, the version of the standard specified in § 170.207(g).<br>(2) Electronically display the tests and values/results received in human readable format.<br>(B) Inpatient setting only. Electronically receive clinical laboratory tests and values/results in a structured format and electronically display such tests and values/results in human readable format.<br>(ii) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1229(c)(1) through (7).<br>(iii) Incorporate tests and values/results. Electronically incorporate a laboratory test and value/result with a laboratory order or patient record. |  |
| <b>Improve Care Coordination (HIE Test)</b>   | Perform at least one test of the capability to exchange key clinical information among providers of care and patient authorized entities electronically   |                    | HIE test eliminated in favor of use objectives  |  | N/A - Removed for an actual use case   |  |  |  |                                 |  |  |  |
| <b>Improve Care Coordination (Summary Care)</b>   | <b>MENU:</b> Provide a summary of care record for more than 50% of all transitions and referrals of care  |                    | 1. Record and provide (by paper or electronically) a summary of care record for more than 50% of transitions of care for the referring EP or EH<br>2. Record care plan goals and patient instructions in the care plan for more than 10% of all active patients |  | <b>Objective:</b> The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.<br><b>Measure:</b> 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 % of transitions of care and referrals.<br>2. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 % of transitions of care and referrals.<br><b>Seeking Comment</b> | <b>Objective:</b> The 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 care record for each transition of care or referral.<br><b>Measure:</b> 1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 % of transitions of care and referrals.<br>2. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 % of transitions of care and referrals.<br><b>Seeking Comment</b> |  | pp. 106-118  | \$170.314(b)(1)/\$170.314(b)(2) | Transitions of care - incorporate summary care record. Upon receipt of a summary care record formatted according to the standard adopted at § 170.205(a)(3), electronically incorporate, at a minimum, the following data elements: Patient name, gender, race, ethnicity, preferred language, date of birth, smoking status, vital signs, medications, medication allergies, problems, procedures, laboratory tests and values/results; the referring or transitioning provider's name and contact information; hospital admission and discharge dates and locations; discharge instructions; reason(s) for hospitalization; care plan, including goals and instructions; names of providers of care during hospitalization; and names and contact information of any additional known care team members beyond the referring or transitioning provider and the receiving provider.<br>Transitions of care - create and transmit summary care record<br>(i) Enable a user to electronically create a summary care record formatted according to the standard adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements exposed, where applicable, according to the specified standard(s):<br>(A) Patient name, gender, date of birth, medication allergies, vital signs, laboratory tests and values/results; the referring or transitioning provider's name and contact information; names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider; care plan, including goals and instructions;<br>(B) Race and ethnicity. The standard specified in § 170.207(f);<br>(C) Preferred language. The standard specified in § 170.207(j);<br>(D) Smoking status. The standard specified in § 170.207(i);<br>(E) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3);<br>(F) Encounter diagnoses. The standard specified in § 170.207(m);<br>(G) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3);<br>(H) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(a);<br>(I) Laboratory value(s)/result(s). The value(s)/result(s) of the laboratory test(s) performed;<br>(J) Medications. At a minimum, the version of the standard specified in § 170.207(n); and<br>(K) Inpatient setting only: Hospital admission and discharge dates and locations; names of providers of care during hospitalization; discharge instructions; reason(s) for hospitalization; and indication of whether an advance directive exists.<br>(iii) Transmit. Enable a user to electronically transmit the summary care record created in paragraph (i) in accordance with:<br>(A) The standards specified in § 170.202(a)(1) and (2).<br>Optional: The standard specified in § 170.202(a)(5). |  |  |
| <b>Improve population and public health (Immunization)</b>  | <b>MENU:</b> Perform at least one test of the capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice              |                    | Attest to at least one submission of data in accordance with applicable law and practice  |  | <b>Objective:</b> Capability to submit electronic data to immunization registries or immunization information systems <b>except where prohibited</b> , and in accordance with applicable law and practice<br><b>Measure:</b> Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period  | <b>Objective:</b> Capability to submit electronic data to immunization registries or immunization information systems <b>except where prohibited</b> , and in accordance with applicable law and practice<br><b>Measure:</b> Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period  |  |  | pp. 121-123                     | \$170.314(f)(1) / \$170.314(f)(2)  | Immunization information. Enable a user to electronically record, change, and access immunization information.<br><br>Transmission to immunization registries. Enable a user to electronically create immunization information for electronic transmission in accordance with:<br>(i) The standard and applicable implementation specifications specified in § 170.205(a)(3); and<br>(ii) At a minimum, the version of the standard specified in § 170.207(j).   |  |

**INFORMATION EXCHANGE RELATED OBJECTIVES, continued**

|   | Eligible Professionals  | Eligible Hospitals   | Eligible Professionals  | Eligible Hospitals  | Eligible Professionals  | Eligible Hospitals   | Eligible Professionals               | Eligible Hospitals | Eligible Professionals | Eligible Hospitals | Stage 2 NPRM page numbers            | 2014 Edition EHR Certification Criterion   |
|---|---|--|---|---|---|--|--------------------------------------|--------------------|------------------------|--------------------|--------------------------------------|--|
| Health Outcomes Policy Priority   | Stage 1 Final Rule  |  | Stage 2 - Proposed by HITPC   |   | Stage 2 NPRM  |  | Stage 2 NPRM - MU Workgroup Comments |                    |                        |                    |                                      |  |
| <b>Improve population and public health (Syndromic Surveillance)</b>        | Perform at least one test of the capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice |  | Attest to at least one submission in accordance with applicable law and practice  |   | <b>Objective:</b> Capability to submit electronic syndromic surveillance data to public health agencies and actual submission <b>except where prohibited</b> and in accordance with applicable law and practice<br><b>Measure: MENU</b> - Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period   | <b>Objective:</b> Capability to submit electronic syndromic surveillance data to public health agencies and actual submission <b>except where prohibited</b> and in accordance with applicable law and practice<br><b>Measure CORE</b> - Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period   |                                      |                    |                        |                    | pp. 124 -127                         | \$170.314(f)(4) / \$170.314(f)(4)<br>Public health surveillance. Enable a user to electronically record, change, and access syndrome-based public health surveillance information.<br>Transmission to public health agencies. Enable a user to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with:<br>(i) Ambulatory setting only.<br>(A) The standard specified in § 170.205(d)(2).<br>(B) Optional. The standard (and applicable implementation specifications) specified in § 170.205(d)(3).<br>(ii) Inpatient setting only. The standard (and applicable implementation specifications) specified in § 170.205(d)(3).  |
| <b>Improve population and public health (Syndromic Surveillance)</b>        | N/A   | Perform at least one test of the capability to submit electronic data on reportable lab results to public health agencies and actual submission in accordance with applicable law and practice | N/A   | Attest to submitting to at least one organization in accordance with applicable law and practice  | N/A   | <b>Objective:</b> Capability to submit electronic reportable laboratory results to public health agencies, <b>except where prohibited</b> , and in accordance with applicable law and practice<br><b>NEW Measure:</b> Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice.   |                                      |                    |                        |                    | pp. 123 -124                         | 170.314(f)(5) / \$170.314(f)(6)<br>Inpatient setting only. Reportable laboratory tests and values/results. Enable a user to electronically record, change, and access reportable clinical laboratory tests and values/results.<br><br>Inpatient setting only. Transmission of reportable laboratory tests and values/results. Enable a user to electronically create reportable laboratory tests and values/results for electronic transmission in accordance with:<br>(i) The standard (and applicable implementation specifications) specified in § 170.205(g); and<br>(ii) At a minimum, the versions of the standards specified in § 170.207(a)(3) and § 170.207(g).   |
| <b>Improve population and public health (Report to Cancer Registry)</b>     | N/A   | N/A  |   |   | <b>Objective:</b> Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice.<br><b>NEW Measure: MENU</b> - Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period   | N/A  |                                      |                    |                        |                    | pp. 132 -134                         | \$170.314(f)(7) / \$170.314(f)(8)<br>Ambulatory setting only. Cancer case information. Enable a user to electronically record, change, and access cancer case information.<br><br>Ambulatory setting only. Transmission to cancer registries. Enable a user to electronically create cancer case information for electronic transmission in accordance with:<br>(i) The standard (and applicable implementation specifications) specified in § 170.205(i); and<br>(ii) At a minimum, the versions of the standards specified in § 170.207(a)(4)(E) and § 170.207(g).   |
| <b>Improve population and public health (Report to Non-Cancer Registry)</b> | N/A   | N/A  | N/A   |   | <b>Objective:</b> Capability to identify and report specific cases to a specialized registry ( <b>other than a cancer registry</b> ), except where prohibited, and in accordance with applicable law and practice.<br><b>New Measure: MENU</b> - Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period   | N/A  |                                      |                    |                        |                    | pp. 134 -135                         | General usage of Certified EHR Technology (No specific certification criteria).  |
| <b>Engage patients and families in their care (View and Download)</b>       | Provide more than 10% of all unique patients timely electronic access to their health information subject to the EP's discretion to withhold certain information                            | N/A  | More than 10% of patients and families view and have the ability to download their longitudinal health information; information is available to all patients within 24 hours of an encounter (or within 4 days after the information is available to EPs) | More than 10% of patients and families view and have the ability to download information about a hospital admission; information is made available within 36 hours of the encounter | <b>Objective:</b> Provide patients the ability to view online, download and transmit their health information within 24 hours of an encounter or within four business days of the information being available to the EP.<br><b>NEW Measure: 1.</b> More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information<br><b>2.</b> More than 10 % of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download , or transmit to a third party their health information | <b>Objective:</b> Provide patients the ability to view online and download information about a hospital admission<br><b>NEW Measure: 1.</b> More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge <b>2.</b> More than 10 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period |                                      |                    |                        |                    | p. 76<br>pp. 94 -100<br>pp. 144 -149 | \$170.314(a)(1)<br>View, download, and transmit to 3rd party.<br>(i) Enable a user to provide patients (and their authorized representatives) with online access to do all of the following:<br>(A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data elements:<br>(1) Patient name, gender, date of birth, race, ethnicity, preferred language, smoking status, problem list, medication list, medication allergy list, procedures, vital signs, laboratory tests and values/results, provider's name and contact information, names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider, and care plan, including goals and instructions.<br>(2) Inpatient setting only. Admission and discharge dates and locations, reason(s) for hospitalization, names of providers of care during hospitalization, laboratory tests and values/results (available at time of discharge), and discharge instructions for patient.<br>(B) Download. Electronically download:<br>(1) A file in human readable format that includes, at a minimum:<br>(i) Ambulatory setting only. All of the data elements specified in paragraph (a)(1)(A)(1).<br>(ii) Inpatient setting only. All of the data elements specified in paragraphs (a)(1)(A)(1) and (a)(1)(A)(2).<br>(2) A summary care record formatted according to the standards adopted at § 170.205(a)(3) and that includes, at a minimum, the following data elements represented, where applicable, according to the specified standard(s):<br>(i) Patient name, gender, date of birth, medication allergies, vital signs, the provider's name and contact information, names and contact information of any additional care team members beyond the referring or transitioning provider and the receiving provider, care plan, including goals and instructions.<br>(ii) Race and ethnicity. The standard specified in § 170.207(f).<br>(iii) Preferred language. The standard specified in § 170.207(g).<br>(iv) Smoking status. The standard specified in § 170.207(h).<br>(v) Problems. At a minimum, the version of the standard specified in § 170.207(b)(3).<br>(vi) Encounter diagnosis. The standard specified in § 170.207(b).<br>(vii) Laboratory tests. At a minimum, the version of the standard specified in § 170.207(g).<br>(viii) Laboratory values/results. The values/results of the laboratory test(s) performed.<br>(A) Medications. At a minimum, the version of the standard specified in § 170.207(b).<br>(ix) Inpatient setting only. The data elements specified in paragraph (a)(1)(A)(2).<br>(3) Images formatted according to the standard adopted at § 170.205(i).<br>(C) Transmitted to third party. Electronically transmit the summary care record created in paragraph (a)(1)(B)(2) or images available to download in paragraph (a)(1)(B)(2) in accordance with:<br>(1) The standard specified in § 170.202(a)(2), and<br>(2) The standard specified in § 170.202(a)(2).<br>(B) Patient accessible link.<br>(A) When electronic health information is viewed, downloaded, or transmitted to a third party using the capabilities included in paragraphs (a)(1)(A)(1)-(3), the following information must be recorded and made accessible to the patient:<br>(1) The electronic health information affected by the action(s).<br>(2) The date and time each action occurs in accordance with the standard specified at § 170.210(g).<br>(3) The action(s) that occurred, and<br>(4) User identification.<br>(B) EHR technology presented for certification may demonstrate compliance with paragraph (a)(1)(B)(3) if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (a)(1)(B)(3) is accessible by the patient. |

**INFORMATION EXCHANGE RELATED OBJECTIVES, continued**

| Health Outcomes Policy Priority  | Eligible Professionals   |     | Eligible Hospitals  |     | Eligible Professionals  |     | Eligible Hospitals |  | Eligible Professionals               |  | Eligible Hospitals |             | Stage 2 NPRM page numbers  | 2014 Edition EHR Certification Criterion |
|--|--|-----|---|-----|---|-----|--------------------|--|--------------------------------------|--|--------------------|-------------|--|--|
|  | Stage 1 Final Rule   |     |   |     |   |     |                    |  | Stage 2 NPRM - MU Workgroup Comments |  |                    |             |  |  |
| <b>Engage patients and families in their care</b><br><a href="#">(View and Download)</a> | Provide clinical summaries for more than 50% of all office visits within 3 business days | N/A | Provide clinical summaries to patients for more than 50% of all office visits within 24 hours; pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs; (electronically accessible for viewing counts) | N/A | <b>Objective:</b> Provide clinical summaries for patients for each office visit<br><b>Measure:</b> Clinical summaries provided to patients within 24 hours for more than 50 % of office visits. | N/A |                    |  |                                      |  |                    | pp. 76 - 82 | §170.314(e)(2)<br>Ambulatory setting only. Clinical summaries. Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, the following data elements: provider's name and office contact information; date and location of visit; reason for visit; patient's name; gender; race; ethnicity; date of birth; preferred language; smoking status; vital signs and any updates; problem list and any updates; medication list and any updates; medication allergy list and any updates; immunizations and/or medications administered during the visit; procedures performed during the visit; laboratory tests and values/results, including any tests and values/results pending; clinical instructions; care plan, including goals and instructions; recommended patient decision aids (if applicable to the visit); future scheduled tests; future appointments; and referrals to other providers. If the clinical summary is provided electronically, it must be:<br>(i) Provided in human readable format; and<br>(ii) Provided in a summary care record formatted according to the standard adopted at § 170.205(a)(3) with the following data elements expressed, where applicable, according to the specified standard(s):<br>(A) Race and ethnicity. The standard specified in § 170.207(f);<br>(B) Preferred language. The standard specified in § 170.207(i);<br>(C) Smoking status. The standard specified in § 170.207(j);<br>(D) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3);<br>(E) Encounter diagnoses. The standard specified in § 170.207(m);<br>(F) Procedures. The standard specified in § 170.207(b)(2) or § 170.207(b)(3);<br>(G) Laboratory test(s). At a minimum, the version of the standard specified in § 170.207(g);<br>(H) Laboratory value(s)/result(s). The value(s)/results of the laboratory test(s) performed; and<br>(I) Medications. At a minimum, the version of the standard specified in § 170.207(n). |  |

**NON INFORMATION EXCHANGE RELATED OBJECTIVES THAT WORKGROUP COMMENTED ON**

|   |   |  |   |           |   |  |  |  |  |  |  |               |   |
|---|---|--|---|-----------|---|--|--|--|--|--|--|---------------|---|
| <b>Improve quality safety, efficiency and reducing health disparities</b><br><a href="#">(Quality Measures)</a> | Report ambulatory clinical quality measures to CMS or States  | Report Hospital Clinical quality measures to CMS or the States | No change   | No change | <b>Removed</b> - Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6 - <b>Seeking Public Comment</b>  |  |  |  |  |  |  | p. 71         |   |
| <b>Improve Care Coordination</b><br><a href="#">(Record Health Care Team Members)</a>                           |   | N/A  | Record health care team members (including at a minimum PCP, if available) for more than 10% of all patients seen during the reporting period; this information can be unstructured |           | <b>N/A Seeking Public Comment</b><br><b>Objective/Measure:</b> Record health care team members (including at a minimum PCP, if available) for more than 10 percent of all patients seen during the reporting period; this information can be unstructured.<br>We believe that this requirement is better incorporated with other objectives that require summary of care documents and is not necessary as a standalone objective.  | N/A  |  |  |  |  |  | p. 154        |   |
| <b>Improve Care Coordination</b><br><a href="#">(Medication Reconciliation)</a>                                 | <b>MENU:</b> Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP, eligible hospital, or CAH |  | Move to core.   |           | <b>Objective:</b> The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.<br><b>Measure:</b> The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) | <b>Objective:</b> The 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<br><b>Measure:</b> The EP, eligible hospital or CAH performs medication reconciliation for more than 65% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) |  |  |  |  |  | pp. 104 - 106 | §170.314(b)(4)<br>Clinical information reconciliation. Enable a user to electronically reconcile the data elements that represent a patient's active medication, problem, and medication allergy list as follows. For each list type:<br>(i) Electronically display the data elements from two or more sources in a manner that allows a user to view the data elements and their attributes, which must include, at a minimum, the source and last modification date.<br>(ii) Enable a user to merge and remove individual data elements.<br>(iii) Enable a user to review and validate the accuracy of a final set of data elements and, upon a user's confirmation, automatically update the list. |