

Certification Criteria for Meaningful Use Requirements

Stage 1 Objectives	Criteria for Eligible Professionals (EPs)	Criteria for Hospitals
Use Computerized Provider Order Entry (CPOE)	<p>Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types:</p> <ol style="list-style-type: none"> 1. Medications; 2. Laboratory; 3. Radiology/imaging; and 4. Provider referrals. 	<p>Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types:</p> <ol style="list-style-type: none"> 1. Medications; 2. Laboratory; 3. Radiology/imaging; 4. Blood bank; 5. Physical therapy; 6. Occupational therapy; 7. Respiratory therapy; 8. Rehabilitation therapy; 9. Dialysis; 10. Provider consults; and 11. Discharge and transfer.
Implement drug-drug, drug-allergy, drug formulary checks	<ol style="list-style-type: none"> 1. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, age, and CPOE. 2. Enable a user to electronically check if drugs are in a formulary or preferred drug 	Same as EPs.

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	<p>list in accordance with the Part D standards.</p> <p>3. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking.</p> <p>4. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</p>	
<p>Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT</p>	<p>Enable a user to electronically record, modify, and retrieve a patient’s problem list for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standards specified in Table 2A row 1 (the Rule’s table on content exchange and vocabulary standards and includes multiple standards and code sets based on function including HL7, ICD9 and 10, CPT 4, Rx Norm).</p>	<p>Same as EPs. Standards in Table 2A reflect differences in EP and Hospitals as appropriate.</p>
<p>Generate and transmit Permissible prescriptions electronically (eRx)</p>	<p>Enable a user to electronically transmit medication orders (prescriptions) for patients in accordance with the standards specified in Table 2A row 3 (Rx Norm, NCPDP SCRIPT 8.1 or 10.6).</p>	<p>Not applicable.</p>

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Maintain active medication list	Enable a user to electronically record, modify, and retrieve a patient’s active medication list as well as medication history for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standard specified in Table 2A row 1 (the Rule’s table on content exchange and vocabulary standards and includes multiple standards and code sets based on function including HL7, ICD9 and 10, CPT 4, Rx Norm).	Same as EPs.
Maintain active medication allergy list	Enable a user to electronically record, modify, and retrieve a patient’s active medication allergy list as well as medication allergy history for longitudinal care (i.e., over multiple office visits).	Same as EPs.
Record demographics	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, and date of birth.	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, date of birth, and date and cause of death in the event of mortality.
Record and chart changes in vital signs: <ul style="list-style-type: none"> • Height • Weight • blood pressure • calculate and display BMI 	<ol style="list-style-type: none"> 1. Enable a user to electronically record, modify, and retrieve a patient’s vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse. 2. Automatically calculate and display body mass index (BMI) based on a patient’s 	Same as EPs.

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<ul style="list-style-type: none"> plot and display growth charts for children 2-20 years, including BMI 	<p>height and weight.</p> <p>3. Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2-20 years old.</p>	
Record smoking status for patients 13 years old or older	Enable a user to electronically record, modify, and retrieve the smoking status of a patient to current smoker, former smoker, or never smoked.	Same as EPs.
Incorporate clinical lab-test results into EHR as structured data	<ol style="list-style-type: none"> Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. Electronically display in human readable format any clinical laboratory tests that have been received with LOINC® codes. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7) (that a lab report be made available to the lab or to CMS or an agent of CMS on request). Enable a user to electronically update a patient's record based upon received laboratory test results. 	Same as EPs.

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Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Enable a user to electronically select, sort, retrieve, and output a list of patients and patients' clinical information, based on user defined demographic data, medication list, and specific conditions.	Same as EPs
Report ambulatory quality measures to CMS or the States for EPs or hospital quality measures to CMS or the States for hospitals.	<ol style="list-style-type: none"> 1. Calculate and electronically display quality measure results as specified by CMS or states. 2. Enable a user to electronically submit calculated quality measures in accordance with the standard specified in Table 2A row 5 (PQRI standards for Medicare program). 	Same as EPs.
Send reminders to patients per patient preference for preventive/ follow up care	Electronically generate, upon request, a patient reminder list for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list.	Not applicable.
Implement clinical decision support rules	1. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to specialty or clinical priorities that use demographic data, specific patient diagnoses, conditions, diagnostic test	1. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to a high priority hospital condition that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient

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	<p>results and/or patient medication list.</p> <p>2. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real time, alerts and care suggestions based upon clinical decision support rules and evidence grade.</p> <p>3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</p>	<p>medication list.</p> <p>2. Same as EPs.</p> <p>3. Same as EPs.</p>
Check insurance eligibility electronically from public and private payers	Enable a user to electronically record and display patients' insurance eligibility, and submit insurance eligibility queries to public or private payers and receive an eligibility response in accordance with the applicable HIPAA transaction standards.	Same as EPs.
Submit claims electronically to public and private payers.	Enable a user to electronically submit claims to public or private payers in accordance with the applicable HIPAA transactions standards.	Same as EPs.
Provide patients with an electronic copy of their health information upon request.	Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures:	Same as EPs except includes discharge summary.

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	<ol style="list-style-type: none"> 1. in human readable format; and 2. in accordance with the standard specified in Table 2A row 1 (multiple code sets and standards) to provide to a patient on electronic media, or through some other electronic means. 	
Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	Not applicable.	Enable a user to create an electronic copy of the discharge instructions and procedures for a patient, in human readable format, at the time of discharge to provide to a patient on electronic media, or through some other electronic means.
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 eligible professional	Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, medication allergy list, immunizations, and procedures.	Not applicable.
Provide clinical summaries for patients for each office visit	<ol style="list-style-type: none"> 1. Enable a user to provide clinical summaries to patients (in paper or electronic form) for each office visit that include, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and 	Not applicable.

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	<p>immunizations.</p> <p>2. If the clinical summary is provided electronically (i.e., not printed), it must be provided in: 1) human readable format; and 2) accordance with the standards specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.</p>	
<p>Capability to exchange key clinical information among providers of care and patient authorized entities electronically and provide summary care record for each transition of care and referral</p>	<p>1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format.</p> <p>2. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards specified in Table 2A row 1 (multiple code sets and</p>	<p>1. Same as EPs, but includes discharge summary</p> <p>2. Same as EPs, but includes discharge summary.</p>

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	standards based on functionality).	
Perform medication reconciliation at relevant encounters and each transition of care	Electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time.	Same as EPs.
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with the standards specified in Table 2A row 8 (HL7 2.3.1 or 2.5.1 or CVX) or in accordance with the applicable state-designated standard format.	Same as EPs.
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	Not applicable.	Electronically record, retrieve, and transmit reportable clinical lab results to public health agencies in accordance with the standards specified in Table 2A row 6 (HL7 2.5.1, LOINC, UCUM and SNOWMED CT).
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to	Electronically record, retrieve, and transmit syndrome-based (e.g., influenza like illness) public health surveillance information to public health agencies in accordance with the standards specified in Table 2A row 7 (HL7 2.3.1 or 2.5.1	Same as EPs.

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applicable law and practice	or according to State Public Health agencies).	
Protect electronic health information created or maintained by the certified HER technology through the implementation of appropriate technical capabilities	<ol style="list-style-type: none"> 1. Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information. 2. Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency. 3. Terminate an electronic session after a predetermined time of inactivity. 4. Encrypt and decrypt electronic health information according to user-defined preferences (e.g., backups, removable media, at log-on/off) in accordance with the standard specified in Table 2B row 1 (a 128 bit algorithm capable of encryption). 5. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in Table 2B row 2 (an implemented encrypted and integrity protected link). 	Same as EPs.

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	<p>6. Record actions (e.g., deletion) related to electronic health information in accordance with the standard specified in Table 2B row 3 (i.e., audit log), provide alerts based on user defined events, and electronically display and print all or a specified set of recorded information upon request or at a set period of time.</p> <p>7. Verify that electronic health information has not been altered in transit and detect the alteration and deletion of electronic health information and audit logs in accordance with the standard specified in Table 2B row 4 (a secure hashing algorithm, SHA 1 or higher).</p> <p>8. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.</p> <p>9. Verify that a person or entity seeking access to electronic health information across a network is the one claimed and is authorized to access such information in accordance with the standard specified in Table 2B row 5 (IHE Cross Enterprise</p>	

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	<p>User Assertion (XUA) with SAML identity assertions).</p> <p>10. Record disclosures made for treatment, payment, and health care operations with date, time, patient ID, user ID and a description of the disclosure.</p>	
<p><i>Source: 45 CFR 170. Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, December 30, 2009</i></p>		