TABLE 1—MEANINGFUL USE AND EHR CERTIFICATION CRITERIA

MEANINGFUL USE STAGE 1 OBJECTIVES	CERTIFICATION CRITERIA TO SUPPORT THE ACHIEVEMENT OF MEANINGFUL USE STAGE 1 BY ELIGIBLE PROFESSIONALS
Use Computerized Provider Order Entry (CPOE)	A Complete EHR or EHR Module must include the capability to enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications 2. Laboratory 3. Radiology/imaging 4. Provider referrals
Implement drug-drug, drug-allergy, drug-formulary checks.	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 list. 3. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking. 4. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.
Maintain an up-to-date problem list of current and active diagnoses based on ICD–9–CM or SNOMED CT™.	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.
Generate and transmit permissible prescriptions electronically (eRx).	Enable a user to electronically transmit medication orders (prescriptions) for patients in accordance with the standards.
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 applicable standards.
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).
Record demographics[i]	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, and date of birth.
Record and chart changes in vital signs: • *Height* • *Weight* • *Blood pressure*	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 height and weight.

• *Calculate and display:* ▪ *BMI* ▪ *Plot and display growth charts for children 2–20 years including BMI.*	3. Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2–20 years old on demographic data, specific conditions, and/or medication list.
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.
Incorporate clinical lab-test results into EHR as structured data.	1. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. 2. Electronically display in human readable format any clinical laboratory tests that have been received with LOINC [reg]codes. 3. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7).[ii] 4. Enable a user to electronically update a patient's record based upon received laboratory test results.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.	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.
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.
Implement 5 clinical decision support rules[iii]	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 results and/or patient medication list. 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. 3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.
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 standards.
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 standards.
Provide patients with an electronic copy of their health information upon request[iv].	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 in: 1. Human readable format 2. Accordance with the standards 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.
Provide clinical summaries for patients for each office visit.	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 immunizations. 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 to provide to a patient on electronic media, or through some other electronic means.
Capability to exchange key clinical information among providers of care and patient authorized entities electronically[v] *Provide summary care record for each transition of care and referral.*	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, displaying it in human readable format. 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.
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.
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.	No Associated Proposed Meaningful Use Stage 1 Objective for Providers (Eligible Hospitals only).
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	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.
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	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. 5. Encrypt and decrypt electronic health information when exchanged in accordance with the standard 6. Record actions (*e.g.,* deletion) related to electronic health information in accordance with the standard (*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. 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. 8. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information. 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. 10. Record disclosures made for treatment, payment, and health care operations in accordance with the standard.

[i] For eligible professionals the full proposed meaningful use Stage 1 objective is: ''record demographics: preferred language, insurance type, gender, race, ethnicity, date of birth.''

[ii] 42 CFR 493.1291(b) specifies that ``[t]he test report information maintained as part of the patient's chart or medical record must be readily available to the laboratory and to CMS or a CMS agent upon request." 42 CFR 493.1291(c) specifies the required test report information.

[iii] For eligible professionals the full proposed meaningful use Stage 1 objective is ``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"

[iv] For eligible professionals the full proposed meaningful use Stage 1 objective is ``Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request"

[v] For eligible professionals the full proposed meaningful use Stage 1 objective is ``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."

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