

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals eligible hospital	Certification criteria to support the achievement of meaningful use Stage 1
	A Complete EHR or HER Module must include the capability to:	
Use Computerized Provider Order Entry (CPOE)	Enable a user to electronically record, store, retrieve, and manage. at a minimum, the following order Types: 1. Medications; 2. Laboratory; 3. Radiology/imaging; and 4. Provider Referrals	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order Types: 1. Medications; 2. Laboratory; 3. Radiology imaging; and 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.	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 contraindication 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 in accordance with the standard specified in Table 2A row 2_ 3 Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking. 4 Automated 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 SNOMEDCT@.	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.	
Generate and transmit permissible prescriptions electronically.	Enable a user to electronically transmit medication orders (prescriptions) for patients In accordance with the standards specified in Table 2A row 3.	No Associated Proposed Meaningful Use Stage 1 Objective.
Maintain active medication list.	Enable a user to electronically record, modify, and retrieve a patients 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.	
Maintain active medication allergy 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).	
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, ethnically, date of birth and date of cause of death in the event of mortality
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.	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. 3. Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2-20 years old.	

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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 result into HER as structured data.	<ol style="list-style-type: none"> 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® codes. 3 Electronically display all the information for a test report specified at 42 CFR 493.1291 (c)(1) through (7) 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.	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.	
Report quality measures to CMS of the States	<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. 	
Send reminders to patients per patient preference for preventative/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.	No Associated Proposed Meaningful Use Stage 1 Objective.
Implement 5 clinical decision support rules	<ol style="list-style-type: none"> 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. 	<ol style="list-style-type: none"> 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 specified in Table 2A row 4.	
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 specified in Table 2A row 4.	
Provide patients with an electronic copy of 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 in: (1) Human readable format; and (2) accordance with the standards specified in Table 2A row 1 to provide to patient on electronic media, or through some means.	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, discharge summary, and procedures 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.
Provide patients with an electronic copy of the discharge instructions and procedures for at time of discharge, upon request.	No Associated Proposed Meaningful Use Stage 1 Objective.	Enable a user to create an electronic copy of their discharge instructions and procedures 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.

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Provide patients with timely electronic access to their health information (including, lab results, problem list, medication lists, list, 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 medication list, medication allergy list, immunizations, and procedures	No Associated Proposed Meaningful Use Stage 1 Objective.
Provide clinical summaries for patients for each office Visit.	<p>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 result, medication list, medication allergy list, procedures, problem list, and 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>	No Associated Proposed Meaningful Use Stage 1 Objective.
Capability to exchange key clinical information among providers of care and record, from other providers and patient authorized entities electronically	<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 test, 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</p>	<p>1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, discharge summary, 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</p> <p>2. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards specified in Table 2A row 1.</p>
Provide summary care record for each transition of care and referral	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.	
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 or in accordance with the applicable state-designated standard format.	
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.	Electronically record, retrieve, and transmit re-reportable clinical lab results to public health agencies in accordance with the standards specified in Table 2A row 6.
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 specified in Table 2A row 7.	

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<p>Protect electronic health information created or maintained by the certified EHR technology through The implementation of appropriate technical capabilities.</p>	<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, auto log-on/off) in accordance with the standard specified in Table 28 row 1. 5. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in Table 2B row 2. 6. Record actions (e.g., deletion) related to electronic health information in accordance with the standard specified in Table 28 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. 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 B row 4. 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 specified in Table 2B row 5. 10. Record disclosures made for treatment, payment and health care operation in accordance with the standard specified in Table 2B row 6. 	