(b) **Clinical summaries.** Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list. If the clinical summary is provided electronically it must be:

(1) Provided in human readable format; and

(2) Provided on electronic media or through some other electronic means in accordance with:

(i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and

(ii) For the following data elements the applicable standard must be used:

(A) **Problems.** The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2);

(B) **Laboratory test results.** At a minimum, the version of the standard specified in §170.207(c); and

(C) **Medications.** The standard specified in §170.207(d).

(j) **Calculate and submit clinical quality measures**—(1) **Calculate** (i) Electronically calculate all of the core clinical measures specified by CMS for eligible professionals.

(ii) Electronically calculate, at a minimum, three clinical quality measures specified by CMS for eligible professionals, in addition to those clinical quality measures specified in paragraph (1)(i).

(2) **Submission.** Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in §170.205(f).

§ 170.306 Specific certification criteria for Complete EHRs or EHR Modules designed for an inpatient setting.

The Secretary adopts the following certification criteria for Complete EHRs or EHR Modules designed to be used in an inpatient setting. Complete EHRs or EHR Modules must include the capability to perform the following functions electronically and in accordance with all applicable standards and implementation specifications adopted in this part:

(a) **Computerized provider order entry.** Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types:

(1) Medications;

(2) Laboratory; and

(3) Radiology/imaging.

(b) **Record demographics.** Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, date of birth, and date and preliminary cause of death in the event of mortality. Enable race and ethnicity to be recorded in accordance with the standard specified at §170.207(f).

(c) **Clinical decision support**—(1) **Implement rules.** Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) based

on the data elements included in: problem list; medication list; demographics; and laboratory test results.

(2) Notifications. Automatically and electronically generate and indicate in real-time, notifications and care suggestions based upon clinical decision support rules.

(d) Electronic copy of health information. (1) 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, and procedures:

(i) In human readable format; and

(ii) On electronic media or through some other electronic means in accordance with:

(A) The standard (and applicable implementation specifications) specified in § 170.205(a)(1) or § 170.205(a)(2); and

(B) For the following data elements the applicable standard must be used:

(1) Problems. The standard specified in § 170.207(a)(1) or, at a minimum, the version of the standard specified in § 170.207(a)(2);

(2) Procedures. The standard specified in § 170.207(b)(1) or § 170.207(b)(2);

(3) Laboratory test results. At a minimum, the version of the standard specified in § 170.207(c); and

(4) Medications. The standard specified in § 170.207(d).

(2) Enable a user to create an electronic copy of a patient’s discharge summary in human readable format and on electronic media or through some other electronic means.

(e) Electronic copy of discharge instructions. Enable a user to create an electronic copy of the discharge instructions for a patient, in human readable format, at the time of discharge on electronic media or through some other electronic means.

(f) Exchange clinical information and patient summary record—(1) Electronically receive and display. Electronically receive and display a patient’s summary record from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, and procedures in accordance with the standard (and applicable implementation specifications) specified in § 170.205(a)(1) or § 170.205(a)(2).

Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format.

(2) Electronically transmit. Enable a user to electronically transmit a patient’s summary record to other providers and organizations including, at a minimum, diagnostic results, problem list, medication list, medication allergy list, and procedures in accordance with:

(i) The standard (and applicable implementation specifications) specified in § 170.205(a)(1) or § 170.205(a)(2); and

(ii) For the following data elements the applicable standard must be used:

(A) Problems. The standard specified in § 170.207(a)(1) or, at a minimum, the version of the standard specified in § 170.207(a)(2);

(B) Procedures. The standard specified in § 170.207(b)(1) or § 170.207(b)(2);

(C) Laboratory test results. At a minimum, the version of the standard specified in § 170.207(c); and

(D) Medications. The standard specified in § 170.207(d).

(g) Reportable lab results. Electronically record, modify, retrieve, and submit reportable clinical lab results in accordance with the standard (and applicable implementation specifications) specified in § 170.205(c) and, at a minimum, the version of the standard specified in § 170.207(c).

(h) Advance directives. Enable a user to electronically record whether a patient has an advance directive.

(1) Calculate and submit clinical quality measures—(1) Calculate. Electronically calculate all of the clinical quality measures specified by CMS for eligible hospitals and critical access hospitals.

(2) Submission. Enable a user to electronically submit calculated clinical quality measures in accordance with the standard and implementation specifications specified in § 170.205(f).


The Secretary adopts the following certification criteria for Complete EHRs or EHR Modules. Complete EHRs or EHR Modules must include the capability to perform the following functions electronically, unless designated as optional, and in accordance with all