§ 170.305 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. 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.

(d) Electronic copy of health information. 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:

(1) In human readable format; and
(2) 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:

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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: (a) Clinical. (1) Computerized provider order entry. Enable a user to electronically record, change, and access the following order types, at a minimum:

(i) Medications;
(ii) Laboratory; and
(iii) Radiology/imaging.

(2) Drug-drug, drug-allergy interaction checks. (i) Interventions. Before a medication order is completed and acted upon during computerized provider order entry (CPOE), interventions must automatically and electronically indicate to a user drug-drug and drug-allergy contraindications based on a patient's medication list and medication allergy list.

(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.

(i) 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).