



All Meaningful Use Criteria for which InfoCare is certified as a 'Complete EHR'.

	Criteria	Summary Description
1	170.302 (a)	Drug-drug, drug-allergy interaction checks (1) Notifications. Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE). (2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.
2	170.302(b)	Drug-formulary checks: Enable a user to electronically check if drugs are in a formulary or preferred drug list.
3	170.302 (c)	Maintain up-to-date problem list: Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care.
4	170.302 (d)	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.
5	170.302 (e)	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.
6	170.302 (f)(1)	Vital signs: Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, and blood pressure.
7	170.302 (f)(2)	Calculate body mass index: Automatically calculate and display body mass index (BMI) based on a patient's height and weight.
8	170.302 (f)(3)	Plot and display growth charts: Plot and electronically display, upon request, growth charts for patients 2-20 years old.
9	170.302 (g)	Smoking status: Enable a user to electronically record, modify, and retrieve the smoking status of a patient.
10	170.302 (h)	Incorporate laboratory test results. Receive and display results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format.
11	170.302 (i)	Generate patient lists: Enable a user to electronically select, sort, retrieve, and generate lists of patients according to, at a minimum, the data elements included in: (1) Problem list, (2) Medication list, (3) Demographics and (4) Laboratory test results.
12	170.302 (j)	Medication Reconciliation: Enable a user to electronically compare two or more medication lists.
13	170.302 (k)	Submission to immunization registries: Electronically record, modify, retrieve, and submit immunization information.
14	170.302 (l)	Public health surveillance: Electronically record, modify, retrieve, and submit



		syndrome-based public health surveillance information.
15	170.302 (m)	Patient-specific education resources: Enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient's problem list, medication list and laboratory test results as well as provide such resources to the patient.
16	170.302 (n)	Automate measure calculation: For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.
17	170.302 (o)	Access Control: 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.
18	170.302 (p)	Emergency Access: Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.
19	170.302 (q)	Automatic log-off: Terminate an electronic session after a predetermined time of inactivity.
20	170.302 (r)	Audit log.: (1) Record Actions. Record actions related to electronic health information. (2) Generate audit log. Enable a user to generate an audit log for a specific time period and to sort entries in the audit log.
21	170.302 (s)	Integrity: (1) Create an electronic patient record. (2) Create a 'hash value' of the above data. (3) After transmitting the electronic record, create 'hash value' again. Compare the two hash values to show that the electronic record has not been altered..
22	170.302 (t)	Authentication: Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
23	170.302 (u)	General encryption: Encrypt and decrypt electronic health information.
24	170.302 (v)	Encryption when exchanging electronic health information: Encrypt and decrypt electronic health information when exchanged.
25	170.304 (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
26	170.304 (b)	Electronic prescribing: Enable a user to electronically generate and transmit prescriptions and prescription-related information.



27	170.304 (c)	Record demographics: Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, and date of birth.
28	170.304 (d)	Patient Reminders: Enable a user to electronically generate a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data elements included in: <ol style="list-style-type: none">1. Problem list;2. Medication list;3. Medication allergy list;4. Demographics; and5. Laboratory test results
29	170.304 (e)	Clinical decision support.: <ol style="list-style-type: none">(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.
30	170.304 (f)	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, and medication allergy list in: <ol style="list-style-type: none">1. Human readable format; and2. On electronic media in CCD/CCR formats.
31	170.304 (g)	Timely access: Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, and medication allergy list.
32	170.304 (h)	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 both in a human readable format and in CCD/CCR format.
33	170.304 (i)	Exchange clinical information and patient summary record: (1) Electronically receive and display a patient's summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, and medication allergy list in CCD/CCR 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, and medication allergy list in CCD/CCR format.
34	170.304(j)	Calculate and electronically submit three core, three alternate core and three optional clinical quality measures.



There are 16 measures mentioned in 170.302(n) above that along with other criteria are required to show a meaningful use of the EHR software. These are as follows:

- 1) Up-to-date problem list
 - 1) Numerator: patients with at least one problem list entry or an indication that no problems are known for the patient.
 - 2) Denominator: all unique patients seen during the reporting period.
 - 3) Threshold: >80%
- 2) Active medication list
 - 1) Numerator: patients with at least one medication entry or an indication that the patient is not currently prescribed any medication.
 - 2) Denominator: all unique patients seen during the reporting period.
 - 3) Threshold: >80%
- 3) Active medication allergy list
 - 1) Numerator: patients with at least one medication allergy entry or an indication that the patient has no known medication allergies.
 - 2) Denominator: all unique patients seen during the reporting period.
 - 3) Threshold: >80%
- 4) Record demographics
 - 1) Numerator: patients with all required demographic elements recorded.
 - 2) Denominator: all unique patients seen during the reporting period.
 - 3) Threshold: >50%
- 5) Patient-specific education
 - 1) Numerator: patients provided patient-specific education resources.
 - 2) Denominator: all unique patients seen during the reporting period.
 - 3) Threshold: >10%
- 6) CPOE (Computerized Provider Order Entry)
 - 1) Numerator: patients with a medication order entered using CPOE.
 - 2) Denominator: all unique patients with at least one medication in their medication list
 - 3) Threshold: >30%
- 7) Vitals, BMI, Growth charts
 - 1) Numerator: patients 2 and over with height, weight and blood pressure recorded.
 - 2) Denominator: all unique patients age 2 and over seen during the reporting period.
 - 3) Threshold: >50%
- 8) Record smoking status
 - 1) Numerator: unique patients 13 years or older with smoking status recorded.
 - 2) Denominator: all unique patients 13 years or older seen during the reporting period.
 - 3) Threshold: >50%
- 9) Incorporate lab test results
 - 1) Numerator: clinical lab tests with positive/negative or numeric format results incorporated into EHR.
 - 2) Denominator: all clinical lab tests ordered during the reporting period.
 - 3) Threshold: >40%
- 10) Electronic copy of patient health information
 - 1) Numerator: patients who request an electronic copy of their health information receive within 3 business days.
 - 2) Denominator: all patients who request an electronic copy of their health information
 - 3) Threshold: >50%
- 11) Medication reconciliation
 - 1) Numerator: Number of transitions of care in the denominator where medication reconciliation



was performed.

- 2) Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
 - 3) NOTE: Transition of Care is defined as the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another
 - 4) Threshold: >50%
- 12) Patient Summary Record
- 1) Numerator: Number of transitions of care and referrals in the denominator where a summary of care record was provided.
 - 2) Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
 - 3) NOTE: Transition of Care is defined as the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another
 - 4) Threshold: >50%
- 13) Timely Access
- 1) Numerator: electronic access of health information provided to seen patients within 4 business days of being made available to EP and updated into their EHR.
 - 2) Denominator: all unique patients seen during the reporting period.
 - 3) Threshold: >10%
- 14) Generate and transmit eRx
- 1) Numerator: permissible prescriptions transmitted electronically.
 - 2) Denominator: all permissible prescriptions.
 - 3) Threshold: >40%
- 15) Clinical Summaries
- 1) Numerator: clinical summaries of office visits provided to patients within 3 business days.
 - 2) Denominator: all office visits
 - 3) Threshold: >50%
- 16) Patient reminders
- 1) Numerator: appropriate reminders sent to patients 65 years or older or 5 years old or younger during the reporting period.
 - 2) Denominator: all unique patients 65 years or older or 5 years old or younger.
 - 3) Threshold: >20%

InfoCare automatically calculates all above measures at any given time giving you a status of where you are in recording required data and in demonstrating the Meaningful Use.