Criterions
THE PM & EHR SOLUTION

Drummond Group, Inc.

Re: Price Transparency Attestation

Organization: Criterions, LLC
Product: Criterions EHR 3.0
Product Type: Complete EHR - Ambulatory
Certification Number: A014E01O2Q8JEAB
Certification Date: 3/19/14
Date: 1/21/2016

The following costs are associated with the implementation of complete Criterions EHR 3.0

Costs and Limitations of Certified Health IT

Capability	Description of Capability	Costs or Fees	Contractual Limitations	Technical or Practical Limitations
		Types of costs or fees that a user may be required to pay to purchase, license, implement, maintain, upgrade, use, or otherwise enable and support the use of the implementation or use of the capability -OR- in connection with the data generated in the course using the capability	*Limitations of a contractual nature (including developer policies and other business practices) that a user may encounter in the implementation or use of the capability -OR- in the connection with the data generated in the course of using the capability*	*Limitations of a technical or practical nature that a user may encounter that could prevent or impair the successful implementation, configuration, maintenance, support or use of the capability -OR- prevent or limit the use, exchange or portability of any data generated in the course of using the capability*
Implementation of Criterions EHR	There is a one-time implementation fee for modules pertaining to meaningful use stage 2.	Costs are per provider with no recurrence. Clients choosing to host their own server may have additional fees dependent on Criterions responsibility for configuration, connectivity and integrations with equipment or other systems.	No Contractual Limitations	Most of our customers rely exclusively on the Criterions EHR hosted application on Criterion's HIPAA-compliant servers. Criterions will make every effort to accommodate customer's additional needs or specific requirements, if any. Customers with special hosting or archiving needs should inquire about the availability of these services and should refer to the "Additional Types of Costs or Fees" that may apply. Clients choosing to host their own server will have server capacity, format, connectivity and other specifications that must be met. Criterions does not service or maintain customer hosted servers and the customer is fully responsible for HIPAA compliancy, backups, and maintenance of their data.
Clinical Laboratory / Equipment Interface Related to **170.314(a)(1)** **170.314(b)(5)**	Interface bridges between clinical laboratories and / or equipment.	The fee to establish an interface with a clinical laboratory and/or equipment includes development, testing and implementation of the interface. Depending on the practice and the one-time fee may be covered by the laboratory.	Changes in configuration or equipment may result in additional fees.	Depending on the capabilities of a particular laboratory / equipment an interface may not be possible.
Registry Interfaces Related to **170.314(f)(2)** **170.314(f)(3)**	Data exchange interfaces with immunization registries, cancer registries, and public health agencies.	There is a one-time fee to establish an interface for reporting to immunization registries, cancer registries, and public health agencies. The fee covers implementation and development of interfaces with registries. This fee may be imposed on a per registry basis.	Changes in configuration or evolving requirements may result in additional fees.	Depending on the capabilities and requirements of a particular registry an interface may not be possible.

Maintenance / Technical Support	Support and updates for Criterions products.	Ongoing monthly fee associated with the maintenance and technical support of the Meaningful Use Stage 2 technologies. Fees are dependent on size of store required on the Criterions EHR hosted servers and number of providers licensed to use the system.	Failure to pay monthly support may result in restriction of access to the system and/or restrictions to allowed updates.	No Technical or practical limitations
Coding Database Related to **170.314(a)(5)**	Real time access to live coding database.	An ongoing annual fee for maintenance of ICD-9 and CPT/HCPCS codes and translation to HL7, ICD-10, and SNOMED standards.	Failure to pay monthly support may result in restriction of access to ICD10 database.	No Technical or practical limitations
ePrescribing Related to **170.314(a)(6)** , **170.314(a)(7)** **170.314(a)(1)** **170.314(b)(3)**	Electronic transmission of prescriptions to pharmacies, access to national drug database with coding, and drug-drug / drug allergy interactions.	An ongoing monthly fee associated with Electronic prescribing.	Failure to pay monthly support may result in restriction of access to ePrescribing. Narcotic prescribing requires the use of third party tool from NewCrop Rx and incurs additional annual fees paid directly the NewCrop Rx.	No Technical or practical limitations
Direct Messaging Related to **170.314(b)(1)** **170.314(b)(2)**	This functionality allows users to send and receive Direct-based messages to/from other users of certified health IT systems. Direct messages may include clinical data, notes, and other information, subject to the limitations noted. Our Direct offerings support related Meaningful Use and ONC requirements for sending and receiving transitions of care summary documents. We also support a range of other messaging options.	The fees are per provider and consist of an initial setup fee and annual subscription. Failure to pay these fees may result in restriction of access to direct messaging functions.	Transmission and receipt of direct messages requires the other party to maintain a certified and active direct messaging account.	Storage and archiving of Direct messages on Criterion's hosted, HIPAA-compliant servers is included with the annual licensing and subscription fee at no additional charge. Most of our customers rely exclusively on this service. Criterions will make every effort to accommodate customer's additional needs or specific requirements, if any. Customers with special hosting or archiving needs should inquire about the availability of these services and should refer to the "Additional Types of Costs or Fees" that may apply.

We agree to notify Drummond Group of any and all future changes to our price transparency language for this certified product-version.

We understand and agree that the ONC HIT Certification Program Final Rule statement gives Drummond Group, as an ONC-ACB, the sole responsibility for ensuring compliance and determining appropriate consequences if EHR technology developers fail to disclose accurate price transparency information.

We understand and agree to provide Drummond Group copies of or give access to any and all websites, marketing materials, communication statements, and other assertions made by our organization regarding the ONC certification status of the product in a reasonable time to ensure the price transparency information is being accurately disclosed.

Signature: _____
Andrew Cohen
5/9/2016

Ambulatory Certification for

- **170.314(a)(1)** COMPUTERIZED PROVIDER ORDER ENTRY

  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.
- **170.314(a)(2)** DRUG-DRUG, DRUG-ALLERGY INTERACTION CHECKS
  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. (ii) Adjustments. (A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted. (B) Limit the ability to adjust severity levels to an identified set of users or available as a system administrative function

- **170.314(a)(3)** DEMOGRAPHICS

  Demographics. (i) Enable a user to electronically record, change, and access patient demographic data including preferred language, sex, race, ethnicity, and date of birth. (A) Enable race and ethnicity to be recorded in accordance with the standard specified in § 170.207(f) and whether a patient declines to specify race and/or ethnicity. (B) Enable preferred language to be recorded in accordance with the standard specified in § 170.207(g) and whether a patient declines to specify a preferred language. (ii)
- **170.314(a)(4)** VITAL SIGNS, BODY MASS INDEX, AND GROWTH CHARTS
  Vital signs, body mass index, and growth charts. (i) Vital signs. Enable a user to electronically record, change, and access, at a minimum, a patient's height/length, weight, and blood pressure. Height/length, weight, and blood pressure must be recorded in numerical values only. (ii) Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient's height and weight. (iii) Optional: Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.

- **170.314(a)(5)** PROBLEM LIST

  Problem list. Enable a user to electronically record, change, and access a patient's active problem list: (i) Ambulatory setting. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3)

- **170.314(a)(6)** MEDICATION LIST

  Medication list. Enable a user to electronically record, change, and access a patient's active medication list as well as medication history: (i) Ambulatory setting. Over multiple encounters

- **170.314(a)(7)** MEDICATION ALLERGY LIST

  Medication allergy list. Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history: (i) Ambulatory setting. Over multiple encounters;

- **170.314(a)(8)** CLINICAL DECISION SUPPORT

Clinical decision support. (i) Evidence-based decision support interventions. Enable a limited set of identified users to select (i.e., activate) one or more electronic clinical decision support interventions (in addition to drug-drug and drug-allergy contraindication checking) based on each one and at least one combination of the following data: (A) Problem list; (B) Medication list; (C) Medication allergy list; (D) Demographics; (E) Laboratory tests and values/results; and (F) Vital signs. (ii) Linked referential clinical decision support. (A) EHR technology must be able to: (1) Electronically identify for a user diagnostic and therapeutic reference information; or (2) Electronically identify for a user diagnostic and therapeutic reference information in accordance with the standard specified at § 170.204(b) and the implementation specifications at § 170.204 (b)(1) or (2). (B) For paragraph (a)(8)(ii)(A) of this section, EHR technology must be able to electronically identify for a user diagnostic or therapeutic reference information based on each one and at least one combination of the following data referenced in paragraphs (a)(8)(i)(A) through (F) of this section: (iii) Clinical decision support configuration. (A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) of this section to be configured by a limited set of identified users (e.g., system administrator) based on a user's role. (B) EHR technology must enable interventions to be electronically triggered: (1) Based on the data referenced in paragraphs (a)(8)(i)(A) through (F) of this section. (2) When a patient's medications, medication allergies, and problems are incorporated from a transition of care/referral summary received pursuant to paragraph (b)(1)(iii) of this section. (3) Ambulatory setting only. When a patient's laboratory tests and values/results are incorporated pursuant to paragraph (b)(5)(i)(A)(1) of this section. (iv) Automatically and electronically interact. Interventions triggered in accordance with paragraphs (a)(8)(i) through (iii) of this section must automatically and electronically occur when a user is interacting with EHR technology. (v) Source attributes. Enable a user to review the attributes as indicated for all clinical decision support resources: (A) For evidence-based decision support interventions under paragraph (a)(8)(i) of this section: (1) Bibliographic citation of the intervention (clinical research/guideline); (2) Developer of the intervention (translation from clinical research/guideline); (3) Funding source of the intervention development technical implementation; and (4) Release and, if applicable, revision date(s) of the intervention or reference source. (B) For linked referential clinical decision support in paragraph (a)(8)(ii) of this section and drug-drug, drug-allergy interaction checks in paragraph(a)(2) of this section, the developer of the intervention, and where clinically indicated,

- **170.314(a)(9)** ELECTRONIC NOTES
  Electronic notes. Enable a user to electronically record, change, access, and search electronic notes.

- **170.314(a)(10)** DRUG-FORMULARY CHECKS
  Drug-formulary checks. EHR technology must automatically and electronically check whether a drug formulary (or preferred drug list) exists for a given patient and medication.

- **170.314(a)(11)** SMOKING STATUS
  Smoking status. Enable a user to electronically record, change, and access the smoking status of a patient in accordance with the standard specified at § 170.207(h).

- **170.314(a)(12)** IMAGE RESULTS
  Image results. Electronically indicate to a user the availability of a patient's images and narrative interpretations (relating to the radiographic or other diagnostic test(s)) and enable electronic access to such images and narrative interpretations.

- **170.314(a)(13)** FAMILY HEALTH HISTORY
  Family health history. Enable a user to electronically record, change, and access a patient's family health history according to: (i) At a minimum, the version of the standard specified in § 170.207(a)(3); or (ii) The standard specified in § 170.207(j).

- **170.314(a)(14)** PATIENT LIST CREATION
  Patient list creation. Enable a user to electronically and dynamically select, sort, access, and create patient lists by: date and time; and based on each one and at least one combination of the following data: (i) Problems; (ii) Medications; (iii) Medication allergies; (iv) Demographics; (v) Laboratory tests and values/results; and (vi) Ambulatory setting only. Patient communication preferences.

- **170.314(a)(15)** PATIENT-SPECIFIC EDUCATION RESOURCES

Patient-specific education resources. EHR technology must be able to electronically identify for a user patient-specific education resources based on data included in the patient's problem list, medication list, and laboratory tests and values/results: (i) In accordance with the standard specified at Â§ 170.204(b) and the implementation specifications at Â§ 170.204(b)(1) or (2); and (ii) By any means other than the method specified in paragraph (a)(15)(i) of this section.

- **170.314(b)(1)** TRANSITIONS OF CARE - RECEIVE, DISPLAY, AND INCORPORATE TRANSITION OF CARE/REFERRAL SUMMARIES

  Transitions of care â€" receive, display, and incorporate transition of care/referral summaries. (i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with: (A) The standard specified in Â§ 170.202(a). (B) Optional. The standards specified in Â§ 170.202(a) and (b). (C) Optional. The standards specified in Â§ 170.202(b) and (c). (ii) Display. EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: Â§ 170.205(a)(1), Â§ 170.205(a)(2), and Â§ 170.205(a)(3). (iii) Incorporate. Upon receipt of a transition of care/referral summary formatted according to the standard adopted at Â§ 170.205(a)(3), EHR technology must be able to: (A) Correct patient. Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient. (B) Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s): (1) Medications. At a minimum, the version of the standard specified in Â§ 170.207(d)(2); (2) Problems. At a minimum, the version of the standard specified in Â§ 170.207(a)(3); (3) Medication allergies. At a minimum, the version of the standard specified in Â§ 170.207(d)(2). (C) Section views. Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at Â§ 170.205(a)(3).

- **170.314(b)(2)** TRANSITIONS OF CARE - CREATE AND TRANSMIT TRANSITION OF CARE/REFERRAL SUMMARIES

  Transitions of care â€" create and transmit transition of care/referral summaries. (i) Create. Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at Â§ 170.205(a)(3) that includes, at a minimum, the Common MU Data Set and the following data expressed, were applicable, according to the specified standard(s): (A) Encounter diagnoses. The standard specified in Â§ 170.207(i) or, at a minimum, the version of the standard specified Â§ 170.207(a)(3); (B) Immunizations. The standard specified in Â§ 170.207(e)(2); (C) Cognitive status; (D) Functional status; and (E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. (F)

- **170.314(b)(3)** ELECTRONIC PRESCRIBING
  Electronic prescribing. Enable a user to electronically create prescriptions and prescription related information for electronic transmission in accordance with: (i) The standard specified in Â§ 170.05(b)(2); and (ii) At a minimum, the version of the standard specified in Â§ 170.207(d)(2).

- **170.314(b)(4)** CLINICAL INFORMATION RECONCILIATION
  Clinical information reconciliation. Enable a user to electronically reconcile the data that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically and simultaneously display (i.e., in a single view) the data from at least two list sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to create a single reconciled list of medications, medication allergies, or problems. (iii) Enable a user to review and validate the accuracy of a final set of data and, upon a user's confirmation, automatically update the list.

- **170.314(b)(5)** INCORPORATE LABORATORY TESTS AND VALUES/RESULTS
  Incorporate laboratory tests and values/results. (i) Receive results. (A) Ambulatory setting only. (1) Electronically receive and incorporate clinical laboratory tests and values/results in accordance with the standard specified in Â§ 170.205(j) and, at a minimum, the version of the standard specified in Â§ 170.207(c)(2). (2) Electronically display the tests and values/results received in human readable format. (B) Inpatient setting only. Electronically receive clinical laboratory tests and values/results in a structured format and electronically display such tests and values/results in human readable format. (ii) Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (iii) Electronically attribute, associate, or link a laboratory test and value/result with a laboratory order or patient record.

- **170.314(b)(7)** DATA PORTABILITY

  Data portability. Enable a user to electronically create a set of export summaries for all patients in EHR technology formatted according to the standard adopted at § 170.205(a)(3) that represents the most current clinical information about each patient and includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): (i) Encounter diagnoses. The standard specified in § 170.207(i) or, at a minimum, the version of the standard at § 170.207(a)(3); (ii) Immunizations. The standard specified in § 170.207(e)(2); (iii) Cognitive status; (iv) Functional status; and (v) Ambulatory setting only. The reason for referral; and referring or transition in provider's name and office contact information.

- **170.314(c)(1)** CLINICAL QUALITY MEASURES - CAPTURE AND EXPORT

  Clinical Quality Measures capture and export. (i) Capture. For each and every CQM for which the EHR technology is presented for certification, EHR technology must be able to electronically record all of the data identified in the standard specified at § 170.204(c) that would be necessary to calculate each CQM. Data required for CQM exclusions or exceptions must be codified entries, which may include specific terms as defined by each CQM, or may include codified expressions of patient reason, system reason, or medical reason. (ii) Export. EHR technology must be able to electronically export a data file formatted in accordance with the standards specified at § 170.205(h) that includes all of the data captured for each and every CQM to which EHR technology was certified under paragraph (c)(1)(i) of this section.

- **170.314(c)(2)** CLINICAL QUALITY MEASURES - IMPORT AND CALCULATE

  Clinical quality measures import and calculate. (i) Import. EHR technology must be able to electronically import a data file formatted in accordance with the standard specified at § 170.205(h) and use such data to perform the capability specified in paragraph (c)(2)(ii) of this section. EHR technology presented for certification to all three of the certification criteria adopted in paragraphs (c)(1) through (3) of this section is not required to meet paragraph (c)(2)(i). (ii) Calculate. EHR technology must be able to electronically calculate each and every clinical quality measure for which it is presented for certification.

- **170.314(c)(3)** CLINICAL QUALITY MEASURES - ELECTRONIC SUBMISSION

  Clinical quality measures electronic submission. Enable a user to electronically create a data file for transmission of clinical quality measurement data: (i) In accordance with the standards specified at § 170.205(h) and (k); and (ii) That can be electronically accepted by CMS.

- **170.314(d)(1)** AUTHENTICATION, ACCESS CONTROL, AND AUTHORIZATION

  Authentication, access control, and authorization. (i) Verify against a unique identifier(s) (e.g., username or number) that a person seeking access to electronic health information is the one claimed; and (ii) Establish the type of access to electronic health information a user is permitted based on the unique identifier(s) provided in paragraph (d)(1)(i) of this section, and the actions the user is permitted to perform with the EHR technology.

- **170.314(d)(2)** AUDITABLE EVENTS AND TAMPER-RESISTANCE

  Auditable events and tamper-resistance. (i) Record actions. EHR technology must be able to: (A) Record actions related to electronic health information in accordance with the standard specified in § 170.210(e)(1); (B) Record the audit log status (enabled or disabled) in accordance with the standard specified in § 170.210(e)(2) unless it cannot be disabled by any user; and (C) Record the encryption status (enabled or disabled) of electronic health information locally stored on end-user devices by EHR technology in accordance with the standard specified in § 170.210(e)(3) unless the EHR technology prevents electronic health information from being locally stored on end-user devices (see 170.314(d)(7) of this section). (ii) Default setting. EHR technology must be set by default to perform the capabilities specified in paragraph (d)(2)(i)(A) of this section and, where applicable, paragraphs (d)(2)(i)(B) or (C), or both paragraphs (d)(2)(i)(B) and (C). (iii) When disabling the audit log is permitted. For each capability specified in paragraphs (d)(2)(i)(A) through (C) of this section that EHR technology permits to be disabled, the ability to do so must be restricted to a limited set of identified users. (iv) Audit log protection. Actions and statuses recorded in accordance with paragraph (d)(2)(i) of this section must not be capable of being changed, overwritten, or deleted by the EHR technology. (v) Detection. EHR technology must be able to detect whether the audit log has been altered.

- **170.314(d)(3)** AUDIT REPORT(S)

Audit report(s). Enable a user to create an audit report for a specific time period and to sort entries in the audit log according to each of the data specified in the standards at § 170.210(e).

- **170.314(d)(4)** AMENDMENTS

Amendments. Enable a user to electronically select the record affected by a patient's request for amendment and perform the capabilities specified in paragraphs (d)(4)(i) or (ii) of this section. (i) Accepted amendment. For an accepted amendment, append the amendment to the affected record or include a link that indicates the amendment's location. (ii) Denied amendment. For a denied amendment, at a minimum, append the request and denial of the request to the affected record or include a link that indicates this information's location.

- **170.314(d)(5)** AUTOMATIC LOG-OFF

Automatic log-off. Prevent a user from gaining further access to an electronic session after a predetermined time of inactivity.

- **170.314(d)(6)** EMERGENCY ACCESS

Emergency access. Permit an identified set of users to access electronic health information during an emergency.

- **170.314(d)(7)** END-USER DEVICE ENCRYPTION

End-user device encryption. Paragraph (d)(7)(i) or (ii) of this section must be met to satisfy this certification criterion. (i) EHR technology that is designed to locally store electronic health information on end-user devices must encrypt the electronic health information stored on such devices after use of EHR technology on those devices stops. (A) Electronic health information that is stored must be encrypted in accordance with the standard specified in § 170.210(a)(1). (B) Default setting. EHR technology must be set by default to perform this capability and, unless this configuration cannot be disabled by any user, the ability to change the configuration must be restricted to a limited set of identified users. (ii) EHR technology is designed to prevent electronic health information from being locally stored on end-user devices after use of EHR technology on those devices stops.

- **170.314(d)(8)** INTEGRITY

Integrity. (i) Create a message digest in accordance with the standard specified in § 170.210(c). (ii) Verify in accordance with the standard specified in § 170.210(c) upon receipt of electronically exchanged health information that such information has not been altered.

- **170.314(d)(9)** ACCOUNTING OF DISCLOSURES (OPTIONAL)

Accounting of disclosures. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in § 170.210(d).

- **170.314(e)(1)** VIEW, DOWNLOAD, AND TRANSMIT TO 3RD PARTY

View, download, and transmit to 3rd party. (i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f). (A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data: (1) The Common MU Data Set (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set). (2) Ambulatory setting only. Provider's name and office contact information. (3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization. (B) Download. (1) Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set): (i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1) and (2) of this section. (ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1) and (3) of this section. (2) Inpatient setting only. Electronically

download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section). (C) Transmit to third party. (1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in Â§ 170.202(a). (2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in Â§ 170.202(a). (ii) Activity history log. (A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section, the following information must be recorded and made accessible to the patient: (1) The action(s) (i.e., view, download, transmission) that occurred; (2) The date and time each action occurred in accordance with the standard specified at Â§ 170.210(g); and (3) The user who took the action. (B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section

- **170.314(e)(2)** CLINICAL SUMMARY
Clinical summary. (i) Create. Enable a user to create a clinical summary for a patient in human readable format and formatted according to the standards adopted at Â§ 170.205(a)(3). (ii) Customization. Enable a user to customize the data included in the clinical summary. (iii) Minimum data from which to select. EHR technology must permit a user to select, at a minimum, the following data when creating a clinical summary: (A) Common MU Data Set (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set) (B) The provider's name and office contact information; date and location of visit; reason for visit; immunizations and/or medications administered during the visit; diagnostic tests pending; clinical instructions; future appointments; referrals to other providers; future scheduled tests; and recommended patient decision aids.

- **170.314(e)(3)** SECURE MESSAGING
Secure messaging. Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures: (i) Both the patient (or authorized representative) and EHR technology user are authenticated; and (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at Â§ 170.210(f).

- **170.314(f)(1)** IMMUNIZATION INFORMATION
Immunization information. Enable a user to electronically record, change, and access immunization information.

- **170.314(f)(2)** TRANSMISSION TO IMMUNIZATION REGISTRIES
Transmission to immunization registries. EHR technology must be able to electronically create immunization information for electronic transmission in accordance with: (i) The standard and applicable implementation specifications specified in Â§ 170.205(e)(3); and (ii) At a minimum, the version of the standard specified in Â§ 170.207(e)(2).

- **170.314(f)(3)** TRANSMISSION TO PUBLIC HEALTH AGENCIES - SYNDROMIC SURVEILLANCE
Transmission to public health agencies syndromic surveillance. EHR technology must be able to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with: (i) Ambulatory setting only. (A) The standard specified in Â§ 170.205(d)(2). (B) Optional. The standard (and applicable implementation specifications) specified in Â§ 170.205(d)(3). (ii) Inpatient setting only. The standard (and applicable implementation specifications) specified in Â§ 170.205(d)(3).

- **170.314(g)(2)** AUTOMATED MEASURE CALCULATION
Automated measure calculation. For each meaningful use objective with a percentage-based measure that is supported by a capability included in an EHR technology, electronically record the numerator and denominator and create a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.

- **170.314(g)(3)** SAFETY-ENHANCED DESIGN
Safety-enhanced design. User-centered design processes must be applied to each capability an EHR technology includes that is specified in the following certification criteria: Â§ 170.314(a)(1), (2), (6) through (8), and (16) and (b)(3) and (4).

- **170.314(g)(4)** QUALITY MANAGEMENT SYSTEM

Quality management system. For each capability that an EHR technology includes and for which that capability's certification is sought, the use of a Quality Management System (QMS) in the development, testing, implementation and maintenance of that capability must be identified. (i) If a single QMS was used for applicable capabilities, it would only need to be identified once. (ii) If different QMS were applied to specific capabilities, each QMS applied would need to be identified. This would include the application of a QMS to some capabilities and none to others. (iii) If no QMS was applied to all applicable capabilities such a response is acceptable to satisfy this certification criterion.

Certified Clinical Quality Measures

- **CMS122** DIABETES: HEMOGLOBIN A1C POOR CONTROL

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

- **CMS126** USE OF APPROPRIATE MEDICATIONS FOR ASTHMA

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

- **CMS134** DIABETES: URINE PROTEIN SCREENING

The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.

- **CMS138** PREVENTIVE CARE AND SCREENING: TOBACCO USE: SCREENING AND CESSATION INTERVENTION

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

- **CMS146** APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS

Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.

- **CMS148** HEMOGLOBIN A1C TEST FOR PEDIATRIC PATIENTS

Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period

- **CMS154** APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION (URI)

Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.

- **CMS165** CONTROLLING HIGH BLOOD PRESSURE

Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

- **CMS166** USE OF IMAGING STUDIES FOR LOW BACK PAIN

Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

This Criterions EHR 3.0 is 2014 Edition compliant and has been certified by an ONC-ACB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services.