



## edgeMED Stimulus Series



### Meaningful Use Objectives Criteria & Exclusions

## Final Rule - Meaningful Use

Objective	Core/Menu	Measure	Reporting Requirements	Exclusions	Allscripts Enabled?
Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	Core	More than 30%  Note: Electronic transmittal of that order to the pharmacy is not required	<u>Numerator</u> : The number of patients in the denominator that have at least one medication order entered using CPOE <u>Denominator</u> : Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period	Any EP who writes fewer than one hundred prescriptions during the EHR reporting period	✓
Implement drug-drug and drug-allergy checks	Core	Implement drug-drug and drug-allergy checks for the entire EHR reporting period	Yes/No Attestation	Any EP who writes fewer than one hundred prescriptions during the EHR reporting period	✓
Maintain an up-to-date problem list of current and active diagnoses	Core	More than 80% of all unique patients seen by the EP have at least one entry or and indication that no problems are known for the patient recorded as structured data	<u>Numerator</u> : The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in the problem list. <u>Denominator</u> : The number of unique patients seen by the EP during the EHR reporting period	None	✓
Generate and transmit permissible prescriptions electronically (eRx)	Core	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	<u>Numerator</u> : The number of prescriptions in the denominator generated and transmitted electronically. <u>Denominator</u> : The number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.	Any EP who writes fewer than one hundred prescriptions during the EHR reporting period	✓
Maintain active medication list	Core	More than 80% of all unique patients seen by the EP who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data	<u>Numerator</u> : The number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data. <u>Denominator</u> : The number of unique patients seen by the EP during the EHR reporting period.	None	✓

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Maintain active medication allergy list	Core	More than 80% of all unique patients seen by the EP who have at least one entry (or an indication that patient has no known medication allergies) recorded as structured data in their medication allergy list.	<p><u>Numerator:</u> The number of unique patients in the denominator who have at least one entry (or an indication that patient has no known medication allergies) recorded as structured data in their medication allergy list.</p> <p><u>Denominator:</u> The number of unique patients seen by the EP during the EHR reporting period.</p>	None	✓
Record the following demographics: preferred language, gender, race and ethnicity, and date of birth	Core	More than 50% of all unique patients seen by the EP have demographics recorded as structured data	<p><u>Numerator:</u> The number of unique patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.</p> <p><u>Denominator:</u> The number of unique patients seen by the EP during the EHR reporting period.</p>	None	✓
Record and chart vital signs	Core	More than 50% of all unique patients age 2 and over seen by the EP have recorded height, weight and blood pressure	<p><u>Numerator:</u> The number of patients in the denominator who have at least one entry of their height, weight and blood pressure recorded as structured data.</p> <p><u>Denominator:</u> The number of unique patients age 2 or over seen by the EP during the EHR reporting period.</p>	<p>Any EP who sees only patients 2 years old or younger</p> <p>Any EP who believes that all three vital signs of height, weight and blood pressure have no relevance to their scope of practice may attest and be excluded</p>	✓
Record smoking status for patients 13 and over	Core	More than 50% of all unique patients 13 years old or older seen by the EP have "smoking status" recorded as structured data	<p><u>Numerator:</u> The number of patients in the denominator with smoking status recorded as structured data.</p> <p><u>Denominator:</u> The number of unique patients age 13 or older seen by the EP during the EHR reporting period.</p>	None	✓

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Report ambulatory clinical quality measures to CMS (or, for EPs seeking the Medicaid incentive payment, the states)	Core	For 2011, an EP would provide the aggregate numerator and denominator through attestation. For 2012, an EP would electronically submit the measures.	An eligible provider would provide the aggregate numerator and denominator through attestation	None	✓
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Core	Implement one clinical decision support rule	Yes/No Attestation	None	✓
Provide patients with an electronic copy of their health information	Core	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days.	<u>Numerator:</u> The number of patients in the denominator who receive a copy of their health information within 3 business days.  <u>Denominator:</u> The number of patients of the EP who request an electronic copy of their health information four days prior to the end of the EHR reporting period.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period	✓
Clinical summaries provided to patients for all office visits	Core	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.  The clinical summary can be provided through a PHR, patient portal on the web site, secure email, electronic media such as CD or USB, or printed copy. The after-visit clinical summary contains an updated medication list, laboratory and other diagnostic test orders, procedures and other instructions based on clinical discussions that took place during the office visit.	<u>Numerator:</u> The number of patients in the denominator who are provided a clinical summary of their visit within three business days  <u>Denominator:</u> The number of unique patients seen by an EP for an office visit during the EHR reporting period.	Any EPs who have no office visits during the EHR reporting period.	✓
Capability to exchange key clinical information among providers of care and patient authorized entities electronically	Core	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	Yes/No Attestation	None	✓

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Protect Health Information	Core	Conduct or review a security risk analysis per CFR 164.308 (a) (1) of the certified EHR technology and implement updates and correct identified security deficiencies as part of its risk management process.	Yes/No Attestation	None	✓
Implement drug-formulary checks	Menu	The EP has enabled drug-formulary functionality and has access to at least one internal or external formulary for the entire EHR reporting period	Yes/No Attestation	Any EP who writes fewer than one hundred prescriptions during the EHR reporting period	✓
Lab results	Menu	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider fo whose results are in a positive/negative or numerical format are incorporated in certified EHR technology	<p><u>Numerator:</u> The number of lab test results whose results are expressed in a positive or negative affirmation or as a number and are incorporated as structured data.</p> <p><u>Denominator:</u> The number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number</p>	Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period	✓
Generate lists of patient based on specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Menu	Generate at least one report listing patients of the EP with a specific condition.	Yes/No Attestation	None	✓
Send reminders to patients based on patient preferences and selected by specific criteria	Menu	Reminder sent to at least 20% of all unique patients seen by the EP that are greater than or equal to 65 years of age or less than or equal to 5 years of age	<p><u>Numerator:</u> The number of patients in the denominator who were sent the appropriate reminders</p> <p><u>Denominator:</u> The number of unique patients 65 years old or older or 5 years old or younger.</p>	Any EP who has no patients 65 years old or older or 5 years old or younger	✓

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Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP	Menu	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being uploaded in the certified EHR technology) electronic access to their health information subject to the EPs discretion to withhold certain information.	<p><u>Numerator:</u> The number of patients in the denominator who have timely (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information online.</p> <p><u>Denominator:</u> The number of unique patients seen by the EP during the EHR reporting period.</p>	Any EP that neither orders nor creates any of the information listed in the ONC final rule 45 CFR 170.304 (g). (lab test results, problem list, medication list and medication allergy list)	✓
Provide access to patient-specific education resources upon request  (New in final rule)	Menu	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.	<p><u>Numerator:</u> The number of patients in the denominator who are provided patient education specific resources</p> <p><u>Denominator:</u> The number of unique patients seen by an EP during the EHR reporting period.</p>	None	✓
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	Menu	<p>The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.</p> <p>Medication reconciliation is described as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.</p> <p>Transition of care is clarified 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. We also clarify that the receiving eligible hospital or EP would conduct the medication reconciliation.</p>	<p><u>Numerator:</u> The number of transitions of care in the denominator where medication reconciliation was performed.</p> <p><u>Denominator:</u> The number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.</p>	Any EP that was not on the receiving end of any transition of care during the EHR reporting period.	✓

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Provide summary care record for each transition of care	Menu	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	<p><u>Numerator:</u> The number of transitions of care and referrals in the denominator where a summary of care record was provided.</p> <p><u>Denominator:</u> The number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</p>	Any EP that does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period.	✓
Capability to submit electronic data to immunization registries	Menu	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	Yes/No Attestation	Any EP that has not given any immunizations during the EHR reporting period	✓
Capability to submit electronic syndromic surveillance data to public health agencies	Menu	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)	Yes/No Attestation	Any EP that does not collect any reportable syndromic information on their patients during the EHR reporting period.	✓