

Meaningful Use Summary

In order to qualify as a meaningful EHR user, an EP, eligible hospital, or CAH must successfully meet the measure for each objective in the core set and all but five of the objectives in the menu set. With one limitation, an EP, eligible hospital, or CAH may select any five objectives from the menu set to be removed from consideration for the determination of qualifying as a meaningful EHR user. (CMS-0033-F, Page 57)

Core Set

1. Use Computerized Provider Order Entry for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines. More than 30% of patients with at least one medication in their medication list must have at least one medication ordered through CPOE.
2. Implement drug-drug and drug-allergy interaction checks. The EP or hospital/CAH has this functionality enabled for the entire reporting period.
3. Generate and transmit permissible prescriptions electronically (eRx). More than 40% of permissible prescriptions are transmitted electronically using certified EHR technology.
4. Record demographics: preferred language, gender, race, ethnicity, date of birth, date and preliminary cause of death in the event of mortality for a hospital/CAH. More than 50% of all unique patients seen by the EP or admitted to hospital's/CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.
5. Maintain an up-to-date problem list of current and active diagnoses. More than 80% of all unique patients seen by the EP or hospital/CAH's inpatient or emergency department have at least one entry or an indication that no problems are known for the patient recorded as structured data.
6. Maintain an active medication list. More than 80% of all unique patients seen by the EP or admitted to hospital/CAH's inpatient or emergency department have least one entry or an indication that the patient is not currently prescribed any medication recorded as structured data.
7. Maintain an active medication allergy list. More than 80% of all unique patients seen by the EP or admitted hospital/CAH's inpatient or emergency department have at least one entry or an indication that the patient has no known medication allergies recorded as structured data.

8. Record and chart changes in vital signs: height; weight; blood pressure; body mass index; growth charts for children 2-20, including BMI. More than 50% of all unique patients 2 years of age or older must have height, weight and blood pressure recorded as structured data.
9. Record smoking status for patients 13 and older. More than 50% of all unique patients age 13 or older have smoking status recorded as structured data.
10. Implement one clinical decision support rule relevant to specialty or high clinical priority and track compliance with that rule. One rule must be implemented.
11. Report clinical quality measures to CMS or states.
 - 11.1 For 2011, provide aggregate numerator and denominator through attestation.
 - 11.2 For 2012, electronically submit clinical quality measures as discussed in section II(A)(3) of this final rule.
12. Upon request, provide patients with an electronic copy of their health information. (including diagnostic test results, problem list, medication list, medication allergies, and for hospitals discharge summary and procedures) More than 50% of requesting patients must receive an electronic copy within 3 business days.
13. **Hospitals and CAH Only:** hospitals provide an electronic copy of hospital discharge instructions at the time of discharge upon request. More than 50% of all patients who are discharged and who request an electronic copy of their discharge instructions are provided it.
14. **EP Only:** Provide patients with clinical summaries for each office visit upon request; Clinical summaries are provided to patients for more than 50% of all visits within 3 business days.
15. Implement capability to electronically exchange key clinical information (for example, problem list, medication list, medication allergies, dx test results) among providers and patient-authorized entities. Must perform at least one test of the EHR's capacity to electronically exchange information.
16. Implement systems to protect privacy and security of patient data in the EHR. Must conduct or review a security risk analysis, implement security updates as necessary and correct identified security deficiencies.

Menu Set (5 of 10)

1. Implement Drug Formulary Checks. The EP or CAH has enabled this functionality and has access to at least one internal and external drug formulary for the entire EHR reporting period.
2. **Hospital Only:** Record advance directives for patients 65 years or older. More than 50% of all unique patients 65 and older admitted to the eligible hospital/CAH's inpatient department have an indication of an advanced directive status recorded.
3. Incorporate clinical lab-test results into certified EHR technology as structured data. More than 40% of all test results ordered by the EP or an authorized provider or eligible hospital/ CAH for patients whose results are either positive/negative or numerical format are incorporated in certified EHR as structured data.
4. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach. Generate at least one report listing patients of the EP with a specific condition.
5. **EP Only:** Send reminders to patients per patient preference for preventive/follow-up care. More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during EHR reporting period.
6. **EP Only:** Provide patient with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to EP. More than 10% of all unique patients seen by EP have access subject to EP's discretion to withhold certain information.
7. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. More than 10% of all unique patients seen by EP are provided patient-specific education resources.
8. The EP or eligible hospital/CAH, who receives a patient from another or believes an encounter is relevant should perform medication reconciliation. The EP or hospital/CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital/CAH's inpatient or emergency department.

9. The EP or hospital/CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral. The EP or hospital/CAH 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.

10. The capability to submit electronic data to immunization registries or Immunization Information System and actual submission in accordance with applicable law and practice. Perform at least one test of certified EHR's capacity to submit electronic data to registries and follow up to ensure a successful test.

11. **Hospital only:** Capability to submit electronic data on reportable lab results to public health agencies. Perform at least one test of certified EHR's capacity to submit electronic data to public health agencies and follow up to ensure a successful test.

12. Capability to submit electronic syndromic surveillance data to public health agencies. Performed at least one test of certified EHR's capacity to submit electronic data to public health agencies and follow up to ensure a successful test.