

# Meaningful Use Criteria for Eligible Professionals

## NOTES from Specification Sheets

Provided by:



Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

## CORE MEASURES

	Objective	Measure	Exclusion
1	Use computerized physician order entry (CPOE) for medication orders	More than 30% of all unique patients with at least one medication in their list have at least one medication order entered using CPOE	Any EP who writes fewer than 100 prescriptions during the EHR reporting period
	<p><b>Computerized Provider Order Entry (CPOE) –</b> CPOE entails the provider’s use of computer assistance to directly enter medication orders from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization.</p> <p><b>The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.</b></p>	<p>Any <u>licensed</u> healthcare professionals can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can enter the order per state, local and professional guidelines.</p> <p>The order must be entered by <u>someone who could exercise clinical judgment</u> in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that the CPOE occurs when the order first becomes part of the patient’s medical record and before any action can be taken on the order.</p>	<p><u>Electronic transmittal of the medication order to the pharmacy, laboratory, or diagnostic imaging center is <u>not</u> a requirement for meeting the measure of this objective.</u></p> <p><u>However, a separate objective (EPCMU 04) addresses the <u>electronic transmittal of prescriptions</u> and is a requirement for EPs to meet Meaningful Use.</u></p>
2	Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period	No exclusion
	<p><i>Drug-drug and drug-allergy interaction alerts <u>cannot</u> be used to meet the meaningful use objective for implementing one clinical decision support rule.</i></p>	<p><i>EPs must implement one clinical decision support rule <u>in addition to</u> drug-drug and drug-allergy interaction checks.</i></p>	

3	Maintain an up-to-date <b>problem list</b> of current and active diagnoses	More than 80% of all unique patients have at least one entry or an indication that no problems are known for the patient recorded as structured data	No exclusion
---	--	--	--------------

<p><b>Problem List</b> – A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.</p> <p><b>Up-to-date</b> – The term “up-to-date” means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient.</p>	<p><i>The <u>initial diagnosis</u> can be recorded in <u>lay terms</u> and <u>later converted to standard structured data</u> or can be initially entered using standard structured data.</i></p> <p><i>For patients with no current or active diagnoses, <u>an entry must still be made</u> to the problem list indicating that <u>no problems are known</u>.</i></p>	<p><i>An EP is <u>not required to update the problem list at every contact</u> with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances.</i></p>
--	--	--

4	Generate and transmit permissible prescriptions electronically ( <b>eRx</b> )	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	Any EP who writes fewer than 100 prescriptions during the EHR reporting period
---	---	--	--

<p><b>Prescription</b> – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.</p> <p><b>Permissible Prescriptions</b> – The concept of only permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at <u>  </u>). Any prescription not subject to these restrictions would be permissible.</p> <p><b><i>The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.</i></b></p>	<p><i>Authorizations for items such as <u>durable medical equipment</u>, or other items and services that may require EP authorization before the patient could receive them, are <u>not included in the definition of prescriptions</u>. These are excluded from the numerator and the denominator of the measure.</i></p> <p><i>Instances where <u>patients specifically request a paper prescription</u> may <u>not be excluded</u> from the denominator of this measure. The denominator includes all prescriptions written by the EP during the EHR reporting period.</i></p> <p><i>For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur constructively if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.</i></p>	<p><i>Although the Department of Justice recently published an Interim Final Rule that allows the <u>electronic prescribing of controlled substances</u>, these recent guidelines <u>could not be incorporated</u> into the Medicare and Medicaid EHR Incentive Programs. The determination of whether a prescription is a "permissible prescription" for purposes of this measure should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010.</i></p> <p><i>EPs <u>cannot</u> receive incentive payments for e-prescribing under both the <u>Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)</u> and the Medicare EHR Incentive Program for the same year. However, EPs <u>can</u> receive payments from both the MIPPA E-Prescribing Incentive Program and the Medicaid EHR Incentive Program for the same year.</i></p>
--	---	---

5	<b>Maintain active medication list</b>	More than 80% of all unique patients have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	No exclusion
<b>Active Medication List</b> – A list of medications that a given patient is currently taking.		<i>For patients with no active medications, an entry must still be made to the active medication list indicating that there are <u>no active medications</u>.</i>	<i>An EP is <u>not required to update this list at every contact with the patient</u>. The EP can then use his or her clinical judgment to decide when additional updating is required.</i>
6	<b>Maintain active medication allergy list</b>	More than 80% of all unique patients have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	No exclusion
<b>Allergy</b> – An exaggerated immune response or reaction to substances that are generally not harmful.  <b>Active Medication Allergy List</b> – A list of medications to which a given patient has known allergies.		<i>For patients with no active medication allergies, an entry must still be made to the active medication allergy list indicating that there are no active medication allergies.</i>	<i>An EP is <u>not required to update this list at every contact with the patient</u>. The measure ensures that the EP has not ignored having a medication allergy list for patients seen during the EHR reporting period and that at least one piece of information on medication allergies is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances at hand.</i>

7	<p>Record all of the following <b>demographics</b>:</p> <ul style="list-style-type: none"> <li>a) preferred language</li> <li>b) gender</li> <li>c) race</li> <li>d) ethnicity</li> <li>e) date of birth</li> </ul>	<p>More than 50% of all unique patients have demographics recorded as structured data</p>	<p>No exclusion</p>
---	---	---	---------------------

<p><b>Preferred Language</b> – The language by which the patient prefers to communicate.</p> <p><i>EPs are not required to communicate with the patient in his or her preferred language in order to meet the measure of this objective</i></p> <p><u>Race and ethnicity codes should follow current federal standards published by the Office of Management and Budget (<a href="http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr">http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr</a>).</u></p>	<p><b>SOURCE:</b> <a href="http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_app-a-update.pdf">http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_app-a-update.pdf</a></p> <p>To provide flexibility and ensure data quality, separate questions shall be used wherever feasible for reporting race and ethnicity. When race and ethnicity are collected separately, ethnicity shall be collected first. If race and ethnicity are collected separately, the minimum designations are:</p> <p>Race:</p> <ul style="list-style-type: none"> <li>-- American Indian or Alaska Native</li> <li>-- Asian</li> <li>-- Black or African American</li> <li>-- Native Hawaiian or Other Pacific Islander</li> <li>-- White</li> </ul> <p>Ethnicity:</p> <ul style="list-style-type: none"> <li>-- Hispanic or Latino</li> <li>-- Not Hispanic or Latino</li> </ul>	<p><i>If a patient declines to provide all or part of the demographic information, or if capturing a patient's ethnicity or race is prohibited by state law, such a <u>notation entered as structured data</u> would count as an entry for purposes of meeting the measure. In regards to patients who do not know their ethnicity, EPs should treat these patients the same way as patients who decline to provide race or ethnicity—identify in the patient record that the patient declined to provide this information</i></p>
--	---	--

8	<p>Record and chart changes in the following <b>vital signs</b>:</p> <ul style="list-style-type: none"> <li>a) height</li> <li>b) weight</li> <li>c) blood pressure (BP)</li> <li>d) calculate and display body mass index (BMI)</li> <li>e) plot and display growth charts for children 2-20 years, including BMI</li> </ul>	<p>For more than 50% of all unique patients age 2 and over, height, weight, and BP are recorded as structured data</p>	<p>Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and BP have no relevance to their scope of practice</p>
---	---	--	---

*The only information required to be inputted by the provider is the height, weight, and blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.*

*Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make the determination based on the patient's individual circumstances as to whether height, weight, and blood pressure need to be updated.*

***The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.***

*Height, weight, and blood pressure can get into the patient's medical record as structured data in a number of ways. Some examples include entry by the EP, entry by someone on the EP's staff, transfer of the information electronically or otherwise from another provider or entered directly by the patient through a portal or other means.*

9	<p>Record <b>smoking status</b> for patients 13 years old or older</p>	<p>More than 50% of all unique patients 13 years or older have smoking status recorded as structured data</p>	<p>Any EP who sees no patients 13 years or older</p>
---	--	---	--

*This is a check of the medical record for patients 13 years old or older. If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community.*

***The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.***

10	Report <b>ambulatory clinical quality measures</b> to CMS	Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS (In 2011-Attest, in 2012-Electronic)	No exclusion
<p><i>Attesting to the measure of this objective indicates that the EP will submit complete ambulatory clinical quality measure information as required during the attestation process. During attestation, EPs will also attest to the numerators, denominators, and exclusions for individual ambulatory clinical quality measures.</i></p> <p><i>For requirements and electronic specifications related to individual ambulatory clinical quality measures, EPs should refer to:</i></p> <p><a href="http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage">http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage</a></p> <p><b>The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.</b></p>			
11	Implement one <b>clinical decision support rule</b> relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule (Attest)	No exclusion
<p><b>Clinical Decision Support</b> – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.</p> <p><i>Drug-drug and drug-allergy interaction alerts <u>cannot</u> be used to meet the meaningful use objective for implementing one clinical decision support rule. EPs must implement one clinical decision support rule <u>in addition to</u> drug-drug and drug-allergy interaction checks.</i></p> <p><i>CMS will not issue additional guidance on the selection of appropriate clinical decision support rules for Stage 1 Meaningful Use. This determination is best left to the EP taking into account their workflow, patient population, and quality improvement efforts.</i></p>			

12	Provide patients with an <b>electronic copy</b> of their health information (including diagnostic test results, problem list, medication lists, medication allergies) <b>upon request</b>	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period
----	---	---	--

<p><b>Business Days</b> – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.</p> <p><b>Diagnostic Test Results</b> – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.</p> <p><i>An EP <u>may withhold information</u> from the electronic copy of a patient’s health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.</i></p> <p><b>The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.</b></p>	<p><i>When responding to patient requests for information, the EP should accommodate patient requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524, Access of individuals to protected health information. HIPAA contains requirements for providing patients copies of their health information.</i></p> <p><i>Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, this would include the elements listed in the ONC final rule at 45 CFR 170.304(f) for EPs and 45 CFR 170.306(d) for eligible hospitals and CAHs as required for EHR technology to become certified.</i></p> <p><i>An EP should provide a patient with <u>all of the health information they have available electronically</u>, subject to withholding as described in the HIPAA Privacy Rule, as specified at in 45 CFR 164.524.</i></p> <p><i>Form and format should be <u>human readable</u> and comply with the HIPAA Privacy Rule, as specified at 45 CFR 164.524(c). <b><u>The media could be any electronic form such as patient portal, PHR, CD, USB fob, etc.</u></b> EPs are expected to make reasonable accommodations for <u>patient preference</u> as outlined in 45 CFR 164.522(b).</i></p>	<p><i>The <u>charging of fees</u> for this information is governed by the HIPAA Privacy Rule at 45 CFR 164.524(c)(4) (which only permits HIPAA covered entities to <u>charge an individual a reasonable, cost-based fee</u> for a copy of the individual’s health information).</i></p> <p><i>If provision of the copy involves the mailing of physical electronic media, then it would need to be <u>mailed by at least the third business day</u> following the request of the patient or their agents.</i></p> <p><b>Third-Party Requests:</b> Only specific third-party requests for information are included in the denominator. Providing the copy to a family member or patient’s authorized representative consistent with federal and state law may substitute for a disclosure of the information to the patient and count in the numerator. A request from the same would count in the denominator. All other third-party requests are not included in the numerator or the denominator.</p>
---	---	---

13	Provide <b>clinical summaries</b> for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	Any EP who has no office visits during the EHR reporting period
<p><b>Clinical Summary</b> – An after-visit summary that provides a patient with relevant and actionable information and instructions containing <u>the patient name, provider’s office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results</u> (if received before 24 hours after visit), and <u>symptoms</u>.</p> <p><b>Office Visit</b> – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.</p> <p><i>The EP must include all of the items listed under “Clinical Summary” in the above “Definition of Terms” section that can be populated into the clinical summary by certified EHR technology. If the EP’s certified EHR technology cannot populate all of these fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):</i></p> <ul style="list-style-type: none"> <li><b>o Problem List</b></li> <li><b>o Diagnostic Test Results</b></li> <li><b>o Medication List</b></li> <li><b>o Medication Allergy List</b></li> </ul> <p><i>The provision of the clinical summary is limited to the information contained within certified EHR technology.</i></p> <p><i>Providers should <u>not charge patients a fee</u> to provide this information.</i></p> <p><b><i>The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, electronic media such as CD or USB fob, or printed copy. If the EP chooses an electronic media, they would be required to provide the patient a paper copy upon request.</i></b></p> <p><i>If an EP believes that <u>substantial harm may arise from the disclosure of particular information, an EP may choose to withhold that particular information</u> from the clinical summary.</i></p> <p><i>When a patient visit lasts several days and the patient is seen by multiple EPs, a <u>single clinical summary at the end of the visit</u> can be used to meet the meaningful use objective for “provide clinical summaries for patients after each office visit.</i></p> <p><b><i>The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.</i></b></p>			

14	<p><b>Capability to exchange key clinical information</b> (for example, problem list, medication list, medication allergies, and diagnostic test results) <b>among providers of care and patient authorized entities electronically</b></p>	<p><b>Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information</b></p>	<p><b>No exclusion</b></p>
<p><b>Diagnostic Test Results</b> – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.</p> <p><b>Different Legal Entities</b> – A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.</p> <p><b>Distinct Certified EHR Technology</b> – Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.</p> <p><b>Exchange</b> – Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. The exchange of information requires that the eligible professional must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.</p> <p><b>Patient Authorized Entities</b> – Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities.</p> <p><i>An EP should <u>test their ability</u> to send the minimum information set in the HIT Standards and Criteria rule at 45 CFR 170.304(i). If the EP continues to exchange information beyond the initial test, then the provider may decide what information should be exchanged on a case-by-case basis.</i></p> <p><i>EPs <u>must test their ability to electronically exchange key clinical information at least once</u> prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Every payment year requires its own, unique test. If <u>multiple EPs</u> are using the same certified EHR technology in a shared physical setting, <u>testing would only have to occur once</u> for a given certified EHR technology.</i></p> <p><i>The <u>test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are not acceptable to satisfy this objective.</u></i></p> <p><i>The <u>transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.</u></i></p> <p><i>When the clinical information is available in a structured format it should be transferred in a structured format. However, <u>if the information is unavailable in a structured format, the transmission of unstructured data is permissible.</u></i></p> <p><i>EPs can use their <u>clinical judgment</u> to identify what clinical information is considered key clinical information for purposes of exchanging clinical information about a patient at a particular time with other providers of care. A minimum set of information is identified in the HIT Standards and Criteria rule at 45 CFR 170.304(i), and is <u>generally outlined in this objective as: problem list, medication list, medication allergies, and diagnostic test results.</u> An EP's determination of key clinical information could include <u>some or all</u> of this information, <u>as well as information not included here.</u></i></p> <p><i>An <u>unsuccessful test</u> of electronic exchange of key clinical information will be <u>considered valid</u> for meeting the measure of this objective.</i></p>			

15	<b>Protect electronic health information</b> created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	No exclusion
----	---	---	--------------

<p><b>Appropriate Technical Capabilities</b> – A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified EHR technology or outside systems and programs that support the privacy and security of certified EHR technology.</p>	<p><i>EPs <u>must conduct or review a security risk analysis</u> of certified EHR technology and <u>implement updates</u> as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.</i></p>	<p><i>A <u>security update would be required</u> if any security deficiencies were identified during the risk analysis. A security update could be updated software for certified EHR technology to be implemented as soon as available, changes in workflow processes or storage methods, or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis.</i></p>
--	---	---

# MENU MEASURES

**\*NOTE: At least 1 public health objective must be selected (Menu #9 or Menu #10)**

	Objective	Measure	Exclusion
1	Implement <b>drug formulary</b> checks	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period	Any EP who writes fewer than 100 prescriptions during the EHR reporting period
	<p><b>Drug formularies</b> are databases of approved medications in drug therapy categories and include information on recipe for the preparation, safety, effectiveness, and cost. A formulary includes both generic and name-brand drugs.</p>	<p><i>At a minimum an EP must have <u>at least one formulary</u> that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.</i></p>	
2	Incorporate <b>clinical lab test results</b> into EHR as structured data	More than 40% of all clinical lab test results are ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period
	<p>Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.</p>	<p><i>Lab results are <u>not limited</u> to any specific type of laboratory or to any specific type of lab test.</i></p>	<p><b>The provider is permitted, but not required, to limit the measure of this objective to labs ordered for those patients whose records are maintained using certified EHR technology.</b></p>
3	Generate lists of <b>patients by specific conditions</b> 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	No exclusion
	<p><b>Specific Conditions</b> -- Those conditions listed in the active patient problem list.</p> <p><i>This objective does not dictate the report(s) which must be generated. An EP is best positioned to determine which reports are <u>most useful</u> to their care efforts.</i></p>	<p><i>The report generated could cover every patient whose records are maintained using certified EHR technology <u>or a subset</u> of those patients <u>at the discretion</u> of the EP.</i></p>	<p><i>The report generated is required to include only patients whose records are maintained using certified EHR technology.</i></p>

4	Send <b>reminders to patients</b> <u>per patient preference</u> for preventive/follow-up care	More than 20% of all patients 65 years or older or 5 years or younger were sent an appropriate reminder during the EHR reporting period	An EP who has no patients 65 years old or older or 5 years or younger with records maintained using certified EHR technology
<p><i>EPs meet the aspect of “per patient preference” of this objective if they are accommodating reasonable requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), which is the guidance established for accommodating patient requests.</i></p>		<p><i>EP has the <u>discretion to determine the frequency, means of transmission, and form of the reminder</u> limited only by the requirements the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), and any other applicable federal, state or local regulations that apply to them.</i></p>	<p><b><i>The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.</i></b></p>
5	Provide patients with <b>timely electronic access to their health information</b> (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP	At least 10% of all unique patients are provided timely (available to the patient within 4 business days of being updated in the EHR technology) electronic access to their health information subject to the EP’s discretion to withhold certain information	Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information) during the EHR reporting period
<p><b>Business Days</b> – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.</p> <p><i>The objective and measure focus on the availability of access and the timeliness of data, not utilization. The EP is not responsible for ensuring that 10 percent request access or have the means to access, <u>only that 10 percent of all unique patients seen by the EP could access the information if they so desired.</u></i></p>		<p><i>Online electronic access through <u>either a patient portal or personal health record (PHR)</u> will satisfy the measure of this objective.</i></p> <p><i>Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, certified EHR technology makes <u>available lab test results, problem list, medication list, and medication allergy list.</u></i></p>	<p><i>An EP <u>may withhold information</u> from the electronic copy of a patient’s health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.</i></p> <p><i>An EP <u>may decide that electronic access to a portal or PHR is not the best forum to communicate results.</u> Within the confines of laws governing patient access to their medical records, we would <u>defer to EP’s judgment as to whether to hold information back in anticipation of an actual encounter</u> between the provider and the patient.</i></p>

6	Use certified EHR technology to <b>identify patient-specific education resources and provide those resources to the patient</b> if appropriate	More than 10% of all unique patients are provided patient-specific education resources (The resources do not have to be stored within or generated by the EHR)	No exclusion
<p><b>Patient-Specific Education Resources</b> – Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.</p>		<p><i>Certified EHR technology is certified to use either the patient’s problem list, medication list, or laboratory test results to <u>identify the patient-specific educational resources</u>. These or additional elements can be used in the identification of educational resources that are specific to the patients needs.</i></p>	<p><i>Education resources or materials <u>do not have to be stored within or generated by the certified EHR</u>. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources <u>based on the information stored in the certified EHR technology</u>. The <u>provider can make a final decision</u> on whether the education resource is <u>useful and relevant</u> to a specific patient.</i></p>
7	The EP who <u>receives a patient</u> from another setting of care or believes an encounter is relevant should perform <b>medication reconciliation</b>	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	An EP who was not the recipient of any transitions of care during the EHR reporting period
<p><b>Medication Reconciliation</b> -- 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><b>Transition of Care</b> – 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.</p>		<p><b>Relevant Encounter</b> – An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.)</p>	<p><i>Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.</i></p> <p><i>In the case of reconciliation following transition of care, the <u>receiving EP</u> should conduct the medication reconciliation.</i></p> <p><i>The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.</i></p>

8	The EP who <u>transitions their patient</u> to another setting of care or provider of care or <u>refers their patient</u> to another provider of care should provide <b>summary care record</b> for each transition of care or referral	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	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period
---	---	--	---

<p><b>Transition of Care</b> – 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.</p> <p><i>Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.</i></p>	<p><i>The <u>transferring party</u> must provide the summary care record to the receiving party.</i></p> <p><i>The EP can <u>send an electronic or paper copy</u> of the summary care record <u>directly</u> to the next provider <u>or</u> can provide it to the <u>patient to deliver</u> to the next provider, if the patient can reasonably expected to do so.</i></p>	<p><i>If the provider to whom the referral is made or to whom the patient is transitioned to <u>has access</u> to the medical record maintained by the referring provider, then the summary of care record would <u>not need to be provided</u>, and that patient should not be included in the denominator for transitions of care.</i></p>
---	--	--

9	*Capability to submit electronic data to <b>immunization registries</b> or immunization information systems and actual submission according to applicable law and practice	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 has the capacity to receive the information electronically)	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically
---	--	---	---

	For information and/or instructions on where to submit your public health-related data, please contact your local or state public health agencies and immunization registries. The EHR Incentive Programs include public health objectives for submitting electronic data to immunization registries or immunization information systems, submitting electronic syndromic surveillance data to public health agencies, and (for eligible hospitals and CAHs only) submitting electronic data on reportable lab results to public health agencies.	Eligible professionals (EPs) must attest YES to having 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 was successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.	<b>EXCLUSION:</b> If an EP does not perform immunizations during the EHR reporting period, or if there is no immunization registry that has the capacity to receive the information electronically, then the EP would be excluded from this requirement. EPs must select NO next to the appropriate exclusion(s), then click the APPLY button in order to attest to the exclusion(s).
--	---	---	---

<p><i>The <u>test</u> to meet the measure of this objective must involve the <u>actual submission of information</u> to a registry or immunization information system, if one exists that will accept the information. <u>Simulated transfers of information are <b>not</b> acceptable</u> to satisfy this objective.</i></p> <p><i>An <u>unsuccessful test</u> to submit electronic data to immunization registries or immunization information systems will be considered <u>valid</u> and would satisfy this objective.</i></p>	<p><i>The <u>transmission of actual patient information is <b>not</b> required for the purposes of a test.</u> The use of test information about a <u>fictional patient</u> that would be identical in form to what would be sent about an actual patient would <u>satisfy</u> this objective.</i></p>	<p><i>If the test is successful, then the EP should institute regular <u>reporting</u> with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.</i></p> <p><i>If <u>multiple EPs</u> are using the same certified EHR technology in a shared physical setting, testing would <u>only have to occur once</u> for a given certified EHR technology.</i></p>
--	--	--

10	*Capability to submit electronic <b>syndromic surveillance data</b> to public health agencies and actual submission according to applicable law and practice	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 the EP submits such information has the capacity to receive the information electronically)	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically
----	--	---	---

	<b>Public Health Agency</b> -- An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.	Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test was successful (unless none of the public health agencies to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.	<b>EXCLUSION:</b> If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period or if no public health agency that has the capacity to receive the information electronically, then the EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.
--	---	--	---

<p><b>Syndromic surveillance</b> uses individual and population health indicators that are available before confirmed diagnoses or laboratory confirmation to identify outbreaks or health events and monitor the health status of a community.</p> <p>The <u>test</u> to meet the measure of this objective <u>must involve the actual submission of electronic syndromic surveillance data to public health agencies</u>, if one exists that will accept the information. <u>Simulated transfers of information are not acceptable</u> to satisfy this objective.</p> <p>An <u>unsuccessful test</u> to submit electronic syndromic surveillance data to public health agencies will be considered <u>valid</u> and would satisfy this objective.</p>	<p><u>If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.</u></p> <p><u>If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.</u></p>	<p><u>EPs must test their ability to submit electronic syndromic surveillance data to public health agencies at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Each payment year requires its own unique test.</u></p> <p><u>The transmission of electronic syndromic surveillance data is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.</u></p>
---	---	--