Secret to Meaningful Use Success

15 Core Objectives

Eligible Professionals

1. *Computerized physician order entry (CPOE) — 30% of medication orders for unique patients with at least one medication in their medication list entered using CPOE. "Unique patients with at least one medication on their lists" provides for enhanced flexibility in meeting the measure.*
2. *E-Prescribing (eRx) — More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.*
3. *Report ambulatory clinical quality measures to CMS/States — For 2011, an EP would provide the aggregate numerator and denominator through attestation. Electronically calculate all of the core clinical measures, all core clinical quality measures. For 2012, an EP would electronically submit the measures are discussed in section II.A.3. of this proposed rule.*
4. *Implement one clinical decision support rule — Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.*
5. *Provide patients with an electronic copy of their health information, upon request — More than 50% of all patients of the EP who request an electronic copy of their health information within three business days.*
6. *Provide clinical summaries for patients for each office visit — Clinical summaries provided to patients for at least 80% of all office visits.*
7. *Drug-drug and drug-allergy interaction checks — Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE) Exclusion: If an EP writes fewer than one hundred prescriptions during the EHR reporting period they would be excluded from this requirement.*
8. *Record demographics — More than 50% of all unique patients seen by the EP demographics recorded as structured data. Preferred language, gender, race and date of birth.*
9. *Maintain an up-to-date problem list of current and active diagnoses — More than 80% of all unique patients seen by the EP maintain an up-to-date problem list of current and active diagnoses and have at least one entry or an indication that no problems are known for the patient recorded as structured data.*
10. *Maintain active medication list — 80% of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.*
11. *Maintain active medication allergy list — 80% of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data.*
12. *Record and chart changes in vital signs — More than 50% of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; and plot growth chart for children age 2 to 20.*
13. *Record smoking status for patients 13 years or older — More than 50% of all unique patients 13 years or older have "smoking status" recorded. Current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.*
14. *Capability to exchange key clinical information among providers of care and patient-authorized entities electronically — Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.*
15. *Protect electronic health information — 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.*

Clinical Quality Measures (CQM)

Eligible Professionals

Core, Alternate Core and Additional CQM sets

1. EPs must report on 3 required core CQM, and if the denominator of one or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures.
2. EPs also must select 3 additional CQM from a set of 38 CQM (other than the core/alternate core measures).
3. In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures. A maximum of 9 measures would be reported if the EP needed to attest to the 3 required core, the three alternate core, and the 3 additional measures.

To view the 44 measure specifications, visit:
http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp

CQM: Core Set for EPs

1. Hypertension: Blood Pressure Measurement: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits.
2. Preventive Care and Screening Measure Pair:
   a) Tobacco Use Assessment: Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.
   b) Tobacco Cessation Intervention: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months who received cessation intervention.
3. Adult Weight Screening and Follow-up: Percentage of patients aged 18 years and older with a calculated BMI in the past 6 months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

CQM: Alternate Core Set for EPs

- Weight Assessment and Counseling for Children and Adolescents: Percentage of patients 2-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
- Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old and Older: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (Sept. - Feb.).
- Childhood Immunization Status: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Menu Set Objectives

Eligible Professionals

1. *Drug-formulary checks.*
2. *Incorporate clinical lab test results as structured data — More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.*
3. *Generate lists of patients by specific conditions — Generate at least one report listing patients of the EP with a specific condition. Only one report is required for any given EHR reporting period. The report could cover every patient whose records are maintained using certified EHR technology or subsets of those patients at the discretion of the [provider]. CMS does not require submission of the report to CMS…" (i.e. the provider creates the report and attests to its creation, but submission of the actual report is not required).*
4. *Send reminders to patients per patient preference for preventive/follow up care — More than 20% of all patients 65 years or older or 5 years old or younger.*
5. *Provide patients with timely electronic access to their health information — At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information.*
6. *Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate — More than 10% of all unique patients seen by the EP are provided patient specific educational resources.*
7. *Medication reconciliation — Perform medication reconciliation for at least 80% of relevant encounters and transitions of care.*
8. *Summary of care record for each transition of care/referrals — Clinical summaries provided to patients for more than 50% of all office visits within three business days. The EP could choose patient portal on a website, secure Email, electronic media such as CD or USB fob, or printed copy.*
9. *Capability to submit electronic data to immunization registries/systems* — Perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.*
10. *Capability to provide electronic syndromic surveillance data to public health agencies* — Perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically).*

*At least one public health objective must be selected.

Description Terms

- Unique Patient: Means that if the patient is seen more than once during the reporting period, he or she only counts once in the denominator, which means that the objective has been met if the medication list is maintained during at least one of the patient encounters.
- Denominator: Number of Unique Patients seen by the EP during the EHR reporting period.
- Numerator: Number of Unique Patients in the denominator who have recorded as structured data
- The Ability to Calculate: Measures will be included in the certified EHR technology as a certification requirement.