

## Meaningful Use

“The meaningful use rule strikes a balance between acknowledging the urgency of adopting EHRs to improve our health care system and recognizing the challenges that adoption will pose to health care providers.”

Basic Framework for Meaningful Use:

1. Using Certified EHR Technology in a meaningful manner (which included e-prescribing for EPs)
2. Connecting Certified EHR Technology in a manner that provides for the electronic exchange of health information to improve the quality of care
3. Using the technology to submit to CMS information on clinical quality measures and other measures selected by CMS

HITECH limited incentive payments to an EP that is a “Meaningful EHR User”, defined as a provider that met the Notice of Proposed Rule Making’s (NPRM) meaningful use objectives and measures.

Here is some information regarding requirement to meet meaningful use. This will be updated as we received additional information

### Requirements to Participate:

- ✓ A National Provider Identifier (NPI) and Taxpayer Identification Number (TIN)
- ✓ If you currently have an electronic health record, contact your vendor to make sure they are certified for the incentive program
- ✓ If you are implementing an EHR for the first time, or if you are upgrading your current EHR in order to meet the program’s requirements, you are not required to achieve the meaningful use requirement in order to receive the Year 1 incentive payment.

### Qualifying for Meaningful Use – Core Set

*Providers must meet all criteria in this set*

**Objective: Improve quality, safety, and efficiency and reducing health disparities**

- For at least 30% of your patients that have at least 1 medication in their medication list, use 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. ( You are excluded from this measure if you write less than 100 prescriptions during the reporting period)
- Enable drug-drug and drug-allergy checking within your electronic prescribing program

- Using structured data; maintain an up-to-date problem list of current and active diagnoses for at least 80% of patients seen during the reporting period. For healthy patients, the problem list should include an indication that no problems are known.
- Transmit at least 40% of permissible prescriptions electronically. (You are excluded from this measure if you write less than 100 prescriptions during the reporting period)
- Using structured data, maintain and active medication list for at least 80% of the patients seen during the reporting period. If a patient is not currently on any medication (including-over-the-counter medication) indicate, “none”.
- Using structured data, maintain an active medication allergy list for at least 80% of patients seen during the reporting period. If patient does not have any medication allergies, indicate, “none”.
- Using structured data, record the following demographic information in your EHR for at least 50% of patients seen during the reporting period:
  - Preferred language
  - Gender
  - Race
  - Ethnicity
  - Date of Birth
- For at least 50% of patients age 2 years and older who were seen during the reporting period, record height, weight, blood pressure, calculate and display BMI, and plot and display growth charts (age 2-20), in your EHR as structured data. (You are excluded from this measure if you do not see any patients 2 years and older or if you believe these vital signs have no relevance to your scope of practice)
- For at least 50% of patients age 13 years and older who were seen during the reporting period, record smoking status.
- Use your EHR to implement 1 clinical decision support rule that addresses a high clinical priority for your practice.

**Objective: Engage Patients and Family in their healthcare**

- When patients request an electronic copy of their health information, at least 50% are provided it within 3 business days. The use of a patient portal or secure e-mail would fulfill this requirement. (You are excluded from this measure if no patients request electronic copies of the their health information during the reporting period)
- Use your EHR to provide a clinical summary to at least 50% of patients within 3 business days of their visit. The summary can be printed or provided through an electronic person health record (PHR), patient portal, secure e-mail, CD-ROM, flash drive, or other electronic media. The summary should contain an updated medication

list, laboratory and other diagnostic test orders, procedures and other instruction based on clinical discussion that took place during the visit.

**Objective: Improve Care Coordination**

- Perform at least 1 test of your practice’s ability to provide key clinical information (egg, using an electronic Continuity of Care Document (CCD) or Continuity of Care Record (CCR) to another healthcare provider outside of your practice.

**Objective: Ensure Adequate Privacy And Security Protection For Personal Health Information**

- Conduct a risk analysis to ensure your practice is compliant with the HIPAA Security Rule. If your practice has already conducted a risk analysis, review it. Update your practice’s security measures and correct deficiencies if necessary.

**Qualifying for Meaningful Use – Menu of Functional Requirements**

*Providers must meet a minimum of 5 of these requirements and may defer up to 5 criteria in this set*

**Objective: Improve quality, safety, and efficiency and reducing health disparities**

- ❖ Enable access to at least 1 internal or external formulary and implement drug-formulary checks
- ❖ For clinical lab test results that are received electronically in positive/negative or numerical format, incorporate the result for more than 40% of the lab tests as structured data (i.e., not just an image of the report) into your EHR
- ❖ Generate at least one listing of patients with a specific conditions to use for quality improvement, reduction of disparities, research, or outreach
- ❖ Send reminders to patients per patient preference for preventative or follow-up care. At least 20% of all unique patients 5 years of age and younger
- ❖ % of patients regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit

**Objective: Engage Patients and Family in their healthcare**

- ❖ Provide at least 10% of all unique patients with timely electronic access to their health information (including lab results, problem list, medication lists, and medication allergies) within 4 business days of the information being available to provider
- ❖ Use certified EHR technology to identify at least 10% of unique patients, for patient-specific education resources and provide those resources to the patient if appropriate.

**Objective: Improve Care Coordination**

- ❖ The provider who receives a patient from another setting or provider of care or believes an encounter is relevant should perform medical reconciliation. The provider performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the provider.
- ❖ The provider 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 at least 50% of each transition of care or referral.

**Objective: Improve Population and Public Health**

- ❖ Capability to submit electronic data to immunization Information Systems and actual submission in accordance with applicable law and practice. Perform at least 1 test of EHR'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 provider submits such information have the capacity to receive the information electronically)
- ❖ Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission in accordance with applicable law and practice. Perform at least 1 test of the EHR'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 immunization registries to which the provider submits such information have the capacity to receive the information electronically).