Meaningful Use Core Measures

Provider:
Date Range:

R1: CPOE for Medication Orders

Objective: 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.
Measure: More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

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NUMERATOR: The number of patients in the denominator that have at least one medication order entered using CPOE.
DENOMINATOR: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

R2: Drug Interaction Checks

Objective: Implement drug-drug and drug-allergy interaction checks.
Measure: The EP has enabled this functionality for the entire EHR reporting period.
Exclusion: No exclusion.

Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

R3: Maintain Problem List

Objective: Maintain an up-to-date problem list of current and active diagnoses.
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Exclusion: No exclusion.

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NUMERATOR: 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 their problem list.
The number of patients in the denominator that have at least one medication order entered using CPOE.
DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

R4: Generate and Transmit eRx

Objective: Generate and transmit permissible prescriptions electronically (eRx)
Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR Technology.
Exclusion: No exclusion.

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NUMERATOR: Number of patients in the denominator whose prescription was sent electronically.

DENOMINATOR: Number of unique prescriptions written during the EHR reporting period.

R5: Active Medication List

Objective: Maintain active medication list.
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Exclusion: No exclusion.

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NUMERATOR: 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.
DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

R6: Medication Allergy List

Objective: Maintain active medication allergy list.
Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Exclusion: No exclusion.

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NUMERATOR: Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

R7: Record Demographics

Objective: Record all of the following demographics:
- (A) Preferred language
- (B) Gender
- (C) Race
- (D) Ethnicity
- (E) Date of birth

Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
Exclusion: No exclusion.

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NUMERATOR: Number of 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.
DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

R8: Record Vital Signs

Objective: Record and chart changes in the following vital signs:
- (A) Height
- (B) Weight
- (C) Blood pressure
- (D) Calculate and display body mass index (BMI)
- (E) Plot and display growth charts for children 2-20 years, including BMI

Measure: For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.
Exclusion: Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.

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NUMERATOR: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.
DENOMINATOR: Number of unique patients age 2 or over seen by the EP during the EHR reporting period.

R9: Record Smoking Status

Objective: Record smoking status for patients 13 years old or older.
Measure: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
Exclusion: Any EP who sees no patients 13 years or older.

________ **NUMERATOR:** Number of patients in the denominator with smoking status recorded as structured data.
DENOMINATOR: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.

R10: Clinical Quality Measures (CQMs)

Objective: Report ambulatory clinical quality measures to CMS.
Measure: Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.
Exclusion: No exclusion.

Eligible professionals (EPs) must attest YES to reporting to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS to meet the measure.

R11: Clinical Decision Support Rule

Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
Measure: Implement one clinical decision support rule.
Exclusion: No exclusion.

Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.

R12: Electronic Copy of Health Information

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

________ **NUMERATOR:** Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.
DENOMINATOR: Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

R13: Clinical Summaries

Objective: Provide clinical summaries for patients for each office visit.
Measure: Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion: Any EP that has no office visits during the EHR reporting period.

________ **NUMERATOR:** Number of patients in the denominator who are provided a clinical summary of their visit within three business days.

DENOMINATOR: Number of unique patients seen by the EP for an office visit during the EHR reporting period.

R14: Electronic Exchange of Clinical Information

Objective: Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Exclusion: No exclusion.

Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information during the EHR reporting period to meet this measure.

R15: Protect Electronic Health Information

Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
Measure: 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.
Exclusion: No exclusion.

Eligible professionals (EPs) must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.

O1: Drug Formulary Checks

Objective: Implement drug formulary checks.
Measure: The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Eligible professionals (EPs) must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure. An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this objective and associated measure. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

O2: Clinical Lab Test Results

Objective: Incorporate clinical lab test results into EHR as structured data.
Measure: More than 40 percent of all clinical lab test results 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.
Exclusion: An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

NUMERATOR: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
DENOMINATOR: 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.

O3: Patient Lists

Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
Measure: Generate at least one report listing patients of the EP with a specific condition.
Exclusion: No exclusion.

Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

O4: Patient Reminders

Objective: Send reminders to patients per patient preference for preventive/follow-up care.
Measure: More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
Exclusion: An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

NUMERATOR: Number of patients in the denominator who were sent the appropriate reminder.

DENOMINATOR: Number of unique patients 65 years old or older or 5 years older or younger.

O5: Patient Electronic Access

Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
Measure: At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
Exclusion: 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 as listed at 45 CFR 170.304(g)) during the EHR reporting period.

NUMERATOR: Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.
DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

O6: Patient-specific Education Resources

Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
Measure: More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
Exclusion: No exclusion.

NUMERATOR: Number of patients in the denominator who are provided patient-specific education resources.
DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.

O7: Medication Reconciliation

Objective: 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.
Measure: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.

NUMERATOR: Number of transitions of care in the denominator where medication reconciliation was performed.
DENOMINATOR: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

O8: Transition of Care Summary

Objective: The EP 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 care record for each transition of care or referral.
Measure: 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 percent of transitions of care and referrals.
Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.
DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

O9: Immunization Registries Data Submission

Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
Measure: 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).
Exclusion: An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

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.

O10: Syndromic Surveillance Data Submission

Objective Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.
Measure: 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 has the capacity to receive the information electronically).
Exclusion: 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.

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.