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EP Meaningful Use Objectives



Medicare EP Meaningful Use Objectives Stage 1

A Medicare Eligible Professional must meet all of the Core Set of Objectives to successfully attest to meaningful use. Six meaningful use core objectives have exclusions that can be taken as meeting the objective. For details and specifications on each objective, download the [CMS Stage 1 EP Objectives TOC](#) (2014 Definition).

Meaningful Use Core Objectives

1. Use computerized provider order entry for medication orders directly entered by any licensed healthcare provider who can enter orders into the medical record per state, local and provider guidelines

Measure: more than 30 percent of all unique patients with at least one (1) medication in their medication list seen by the EP have at least one (1) medication order entered using CPOE **Exclusions:** Any EP who writes fewer than one hundred (100) prescriptions during the EHR reporting period

2. Implement drug-drug and drug-allergy interaction checks

Measure: the EP has enabled this functionality for the entire Electronic Health Record reporting period. **Exclusions:** None

3. Maintain an up-to-date problem list of current and active diagnoses

Measure: more than 80% of all unique patients seen by the EP have at least one (1) entry or an indication that no problems are known for the patient recorded as structured data **Exclusions:** None

4. Generate and transmit permissible prescriptions electronically (eRx)

Measure: more than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified Electronic Health Record Technology **Exclusions:** Any EP who writes fewer than one hundred (100) prescriptions during the EHR reporting period

5. Maintain an active medication list

Measure: more than 80% of all unique patients seen by the EP have at least one (1) entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data **Exclusions:** None

6. Maintain active medication allergy list

Measure: More than 80% of all unique patients seen by the EP have at least one (1) entry (or an indication that the patient has no known medication allergies) recorded as structured data **Exclusions:** None

7. Record all of the following demographics: Preferred language, Gender, Race, Ethnicity, Date of Birth

Measure: More than 50% of all unique patients seen by the EP have demographics recorded as structured data **Exclusions:** None

8. Record and chart changes in vital signs: height, weight, blood pressure; calculate and display the Body Mass Index; plot and display growth chart for children 2-20 years, including BMI

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

9. Record smoking status for patients 13 years or older

Measure: more than 50% of all unique patients 13 years or older seen by the EP have smoking status recorded as structured data **Exclusions:** Ar who sees no patient 13 years or older

10. Implement one (1) clinical decision support rule

Measure: Implement one (1) clinical decision support rule **Exclusions:** None

11. Provide patients the ability to view online, download, and transmit information within four business days of the information being available to t

Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patie within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, transmit to a third party.

Exclusions: Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name a office contact information, may exclude the measure.

12. Provide clinical summaries for patient for each office visit

Measure: clinical summaries provided to patients for more than 50% of all office visits within 3 business days **Exclusions:** Any EP who has no off visits during the EHR reporting period

13. Protect electronic health information created or maintained by the certified Electronic Health Record technology through the implementation c appropriate technical capabilities

Measure: Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identifie security deficiencies as part of its risk management process **Exclusions:** None

Menu Objectives

Eligible Professionals must meet 5 Menu Set Objectives from the list of 9. Of the objectives being used, you must include one public health objective #8 or #9.

1. Implement drug-formulary checks

Measure: The EP enabled this functionality and has access to at least one (1) internal or external formulary for the entire Electronic Health Recc reporting period **Exclusions:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

2. Incorporate clinical lab-test results into Electronic Health Record as structured data

Measure: more than 40% of all clinical lab tests results ordered by the EP during the Electronic Health Record reporting period whose results ar either in a positive/negative or numerical format are incorporated in certified Electronic Health Record technology as structured data **Exclusio** EP who orders no lab tests whose results are either in a positive/negative or numerical format during the EHR reporting period

3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach

Measure: generate at least one (1) report listing patients of the EP with a specific condition **Exclusions:** None

4. Send reminders to patients per patient preference for preventive/follow up care

Measure: More than 20% of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the Electronic Hea Record reporting period **Exclusions:** An EP who has no patients 65 years or older or 5 years old or younger with recorded maintained using certi

EHR technology

5. 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. **Exclusions:** None

6. 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% of all transitions of care in which the patient is transitioned into the car the EP **Exclusions:** An EP who was not the recipient of any transitions of care during the EHR reporting period

7. Provide a 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 mor

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% of transitions of care and referrals **Exclusions:** An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period

8. 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 (1) test of certified Electronic Health Record technology's capacity to submit electronic data to immunization registries and follow up submission if test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically) **Exclusions:** An EP who administers no immunizations during the EHR reporting period or whose immunization registry has the capacity to receive the information electronically

9. Capacity to submit electronic syndrome surveillance data to public health agencies and actual transmission according to applicable law and practice

Measure: Performed at least one (1) test of the certified Electronic Health Record technology's capacity to provide electronic syndrome surveillance data to public health agencies and follow up submission if test is successful (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) **Exclusions:** An EP does not collect any reportable syndrome 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

