

Meaningful Use Objectives

Indiana-Health Information Technology Extension
Center



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INTRODUCTION

BACKGROUND ON PURDUE UNIVERSITY

Purdue is a land-grant university founded in 1869. It has grown to be one of the 25 largest universities in the United States. Purdue is a leading research institution with a reputation for excellent and affordable education, a member of the "Big Ten" Conference, and the home of the Purdue Boilermakers.

Purdue University's main campus is located in West Lafayette, Indiana, 65 miles northwest of Indianapolis and 126 miles southeast of Chicago.

Purdue University has a statewide system with students on five campuses and at numerous teaching and research sites throughout Indiana. There are eleven Statewide Technology sites with a total of approximately 2,000 students. The West Lafayette main campus is comprised of approximately 37,000 students and 12,000 faculty and staff members. The regional campuses have a total of approximately 27,000 students and 2,600 faculty and staff members.

On April 6th 2010, Purdue University was awarded \$12 million through a four year cooperative agreement by the Office of the National Coordinator (ONC), under the U.S. Health and Human Services (HHS) Agency. This award was given to Purdue to facilitate a regional extension center (REC) program in Indiana and is part of the federal government's stimulus funding known as the American Reinvestment and Recovery Act (ARRA). The goal of the Indiana Health Information Technology Extension Center (I-HITEC) program is to facilitate the purchase and meaningful use of electronic health records (EHRs) by primary care EPs. Specifically, I-HITEC will provide outreach, education and technical support to enrolled primary care EPs (PCPs) with a goal of assisting 2,200 PCPs in achieving Stage 1 Meaningful Use criteria within two years, and achieving sustainability by year three.

REGIONAL EXTENSION CENTERS (REC) PURPOSE

The RECs purpose is to furnish assistance, defined as education, outreach, and technical assistance, to help Eligible Professionals (EPs) in the REC's selected geographic service areas, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of health care. RECs will also help EPs exchange health information in compliance with regulatory requirements and patient preferences.

Pursuant to requirements of the HITECH Act, priority shall be given to EPs that are primary-care providers (Eligible EPs and/or other health care professionals with prescriptive privileges, such as Eligible physician assistants and nurse practitioners) in any of the following settings:

Individual and small group practices (ten or fewer professionals with prescriptive privileges) primarily focused on primary care;

Public and Critical Access Hospitals;

Community Health Centers and Rural Health Clinics; and

Other settings that predominantly serve uninsured, underinsured, and medically underserved populations

In any given REC's service area, some priority primary-care EPs (as described above) may have already acquired and/or implemented EHR technology. Such EPs remain priority primary care providers, though the technical assistance required is anticipated to be focused on movement from having an EHR, to upgrading EHR systems to meaningful use certified versions, achieving meaningful use of EHR technology, including electronic exchange of health information and reporting of quality measures using the EHR.

The ultimate measure of a REC's effectiveness will be whether it has assisted EPs in becoming meaningful users of certified EHR technology. It is expected that I-HITEC will provide individualized technical assistance to 2,200 priority primary-care EPs in the first two years of the four-year cooperative agreement project period and that over those same two years the entire cohort of RECs will, in the national aggregate, support over 100,000 priority primary-care EPs to achieve successful adoption and meaningful use of certified EHRs.

INDIANA HEALTH INFORMATION TECHNOLOGY EXTENSION CENTERS (I-HITEC) BACKGROUND

Purdue University, in conjunction with statewide partners, is using a \$12 million federal grant to establish the Indiana Health Information Technology Extension Center (I-HITEC) to serve priority primary-care EPs in 73 counties in the State of Indiana. Priority primary-care EPs are those that are in small practices with less than 10 PCP's, public or critical access hospitals, community health centers or rural health clinics, or other settings that serve the uninsured, underinsured, underserved or other at-risk populations.

Our mission is to assist the Indiana healthcare community in realizing the promise of Electronic Health Records (EHR) by facilitating EHR adoption and use. The promise of EHR includes:

Practice operations will be more efficient and revenue will increase.

A patient's comprehensive medical record will be accessible anywhere, anytime.

Medical errors will be reduced and redundant costs will decrease.

The integration of evidence into care practices will be accelerated.

Patient and population health outcomes will improve.

To help EPs switch to electronic health information technology, the center is supporting Indiana healthcare providers with direct, individualized, and onsite technical assistance in:

- Selecting a certified EHR product that offers best value for EPs' needs
- Effectively implementing a certified EHR product.
- Enhancing clinical and administrative workflows to leverage the EHR system's potential to improve quality of care and patient experience.
- Observing and complying with applicable legal, regulatory, professional, and ethical requirements to protect integrity, privacy, and security of patients' health information.

VISION AND MISSION

Vision: "The promise of EHR will be realized in the State of Indiana."

Mission: "To assist the Indiana healthcare community in realizing the promise of EHR by facilitating EHR adoption and use."

WHAT WE DO

In its role as a Regional Extension Center, I-HITEC will support health care EPs in the state of Indiana with direct, individualized, and on-site technical assistance in:

Selecting a certified EHR product that offers best value for the EPs' needs;

Achieving effective implementation of a certified EHR product;

Enhancing clinical and administrative workflows to optimally leverage an EHR system's potential to improve quality and value of care, including patient experience as well as outcome of care; and

Observing and complying with applicable legal, regulatory, professional, and ethical requirements to protect the integrity, privacy and security of patients' health information.

GUIDEBOOK TO MEANINGFUL USE FOR ELIGIBLE EPS

BACKGROUND ON MEANINGFUL USE: EP EHR INCENTIVES

Under the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA, or the “Stimulus Act”), Eligible Professionals (EPs) are eligible for financial incentives for demonstrating “meaningful use” of a certified electronic health record (EHR) system. Generally, most Medicare EPs will be eligible for up to \$44,000 in incentives paid out over 5 years beginning in 2011. A subset of Medicaid EPs will be eligible for up to \$63,750 paid out over six years. In the Medicare program, EPs will face reductions in payment beginning in 2015 if they do not demonstrate meaningful use.

Since ARRA was signed into law in February 2009, the federal Centers for Medicare and Medicaid Services (CMS) have been involved in a regulatory process to determine the final rules for what “meaningful use” entails. This process culminated in a final rule which was published on July 28, 2010.

At its core, meaningful use is a set of criteria, known as “objectives and measures,” on which EPs will have to report.

BACKGROUND ON MEANINGFUL USE: REPORTING OF OBJECTIVES AND MEASURES

The main set of items EPs and hospitals will report are known as “Objectives and Measures.” The objectives are broad policy goals based on high priority health outcomes that CMS hopes to achieve through meaningful use – such as encouraging electronic prescribing. The measures are the actual criteria that EPs and hospitals will have to meet to realize that objective.

The objectives and measures are broken into two parts, known as “core” objectives and “menu” objectives. The Core Objectives and measures are a list of fifteen items on which all EPs will have to attest. In addition to the 15 core items, EPs will select 5 additional “menu” objectives from a list of ten options.

BACKGROUND ON MEANINGFUL USE: REPORTING OF CLINICAL QUALITY MEASURES

One of the Objectives is that EPs will report on Clinical Quality Measures. EPs must report clinical quality measures to CMS or to the state, depending on whether they are receiving incentive payments via Medicare or Medicaid.

Within the Clinical Quality Measure Objective, three of the quality measures will be “core” measures on which all EPs will have to report – Adult Weight Screening and Follow-up, Hypertension: Blood Pressure Management, and Tobacco Screening and Cessation. If an EP demonstrates that the objective is not applicable by reporting a 0 denominator for one of these core measures, then that

EP may report on one of three “alternate core” quality measures – Influenza Screening for Patients over the Age of 50, Weight Assessment and Counseling for Children and Adolescents, and Childhood Immunization Status.

In addition, EPs will select three clinical quality measures from a list of 38 options. For example, EPs may choose to report on the percentage of their female patients who receive breast cancer screening, or the percentage of their patients who receive proper asthma treatments. This will give EPs the flexibility to select measures that are most applicable to their practice specialty.

A complete list of core, alternate core, and optional quality measures is available by clicking on the “Report clinical quality measures to CMS or states” tab on the chart on the next page.

HOW TO USE THIS GUIDEBOOK

This guidebook is intended to walk EPs through the details of gathering the correct data for reporting on the objectives and measures necessary for determining meaningful use. On the following page is a chart of the “core” and “menu” objectives that EPs will report. Clicking on the measure will take the EP to a page with the following headings:

Description

This is a very high-level description of the objective and measure.

Objective

This is the objective, as described in the final rule.

Measure

The measure is the actual specification (including numerator and denominator) that EPs will have to report, as described in the final rule.

Calculation

Many of the objectives and measures on which EPs will report are based on percentages. For example, EPs will report on “40% of permissible prescriptions are transmitted electronically.”

The calculation of any percentage involves a numerator and a denominator:

$$\text{Numerator/Denominator} * 100 = \text{Percentage}$$

Most of the content of this guidebook is meant to help EPs determine, for all measures based on percentages, what numbers to include in the numerator and the denominator. For 2011, these two numbers, the numerator and the denominator, will be all that the EP reports to CMS or to the State of Indiana.

For example, consider an EP who is trying to achieve the measure “*Transmit at least 40% of permissible prescriptions electronically.*” That EP would take the total number of prescriptions

transmitted electronically (the numerator) divided by the total number of prescriptions written (the denominator) and multiply by 100. If the resulting percentage is more than 40%, the EP has achieved that measure.

Exclusions and Other Considerations

In addition to defining the objectives and measures on which EPs will report, the final rule also lays out a series of exclusions and other rules governing how the percentage is calculated, which patients to include, and other considerations. Almost all of the objectives and measures have some “ground rules” governing how they are implemented and reported.

Building off of the previous example, the EP in this case would have several exclusions and considerations to consider. For example, the denominator would only include *permissible* prescriptions. As of the writing of this rule, federal regulations allowing for electronic prescribing of Schedule II drugs have not been finalized. Therefore, those prescriptions are not included when calculating the percentage.

This guidebook is intended to help EPs walk through the exclusions and considerations for every measure, in order to gain the most accurate calculation possible. Most of these special considerations are intended to make the rules easier to achieve for EPs.

DEFINITIONS OF KEY TERMS

There are several key terms that are important for EPs and their practices to understand prior to using this guidebook. These terms are described below.

Certified EHR Technology

In order to achieve meaningful use, an EP will have to use EHR technology that has been certified by entities named by the Federal Government.

The rules for how EHRs will be certified have been defined in a concurrent federal rulemaking process.

While certifications will somewhat limit the EPs choices regarding the EHR systems they select, it will also give EPs confidence that their EHR system contains the functionality that will enable them to achieve meaningful use. Throughout this guidebook there are references to functions that any certified EHR system will be required to perform. By using these functions, the process of achieving some aspects of meaningful use can be automated.

EHR Reporting Period

For the first year in which EPs hope to demonstrate meaningful use, they will only have to report on objectives and measures for a continuous 90 days. For that first year, a continuous 90 days is the EHR reporting period. This period stays the same no matter which year the EP begins to demonstrate meaningful use.

Continuing with the example of electronic prescribing, the EP would only count (for the numerator and the denominator) prescriptions written during that 90-day period.

After that first year, the reporting period is the entire calendar year.

The first year of the Medicaid program is called AIU (Adopt, Implement, or Upgrade). Full attestation of meaningful use is not required yet. Providers who are eligible for the Medicaid incentive program need to provide documentation that they have either adopted, implemented or upgraded their certified software, as part of completing the attestation process for AIU (the certified software does not need to be live, only legally contracted for implementation or upgrade in 2011).

Unique Patients versus Patient Encounters

Finally, it is important for EPs to note that some objectives are based on unique patients; regardless of how many times an individual patient is seen. For example, recording any particular patient's height and weight only needs to be done once during the EHR reporting period.

Other objectives, on the other hand, are based on patient encounters. For example, the objective "provide clinical summaries" is based on office visits, even if the same patient is seen multiple times during the EHR reporting period.

The Federal Register

“WE SAID THAT FOR STAGE 1 CRITERIA, IT WILL NOT INCLUDE THE ELECTRONIC TRANSMITTAL OF THAT ORDER TO THE PHARMACY, LABORATORY, OR DIAGNOSTIC IMAGING CENTER.” (P. 44332)

“CPOE IS A FOUNDATIONAL ELEMENT TO MANY OF THE OTHER OBJECTIVES OF MEANINGFUL USE INCLUDING EXCHANGE OF INFORMATION AND CLINICAL DECISION SUPPORT... CPOE HAS BEEN A MAJOR INITIATIVE OF US HOSPITALS FOR OVER A DECADE AND IS A FOUNDATIONAL FUNCTIONALITY TO MANY OF THE ACTIVITIES THAT FURTHER THE HEALTH CARE POLICY PRIORITIES OF MEANINGFUL USE. FOR EXAMPLE, ENTERING A MEDICATION ORDER USING CPOE ALLOWS THE EHR TO PROVIDE FEEDBACK ON WHETHER THE MEDICATION MAY HAVE ADVERSE REACTIONS WITH OTHER MEDICATIONS THE PATIENT IS TAKING. ANOTHER BENEFIT OF CPOE IS THAT GREATLY SIMPLIFIES THE WORKFLOW PROCESS OF INPUTTING INFORMATION INTO CERTIFIED EHR TECHNOLOGY IN A STRUCTURED WAY TO POPULATE THE PATIENT RECORD.” (P. 44332)

Computer EP Order Entry (CPOE)

Use computerized EP 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 (p.44567)

What is CPOE?

...To capture orders for medications, laboratory or diagnostic imaging (p. 44332)

“However, after careful consideration of the comments, we are adopting an incremental approach by only requiring medication orders for Stage 1.” (p. 44332)

Key Information

Utilizing CPOE will positively impact the objectives of e-prescribe, drug-drug, and drug-allergy checks

Improve patient safety because of the alignment of ordering medications in a structured data format

Will enable EPs to create registries of patients for potential medical recalls

Greatly simplifies the workflow process of inputting the information into certified EHR technology in a structured way to populate the patient record

The Federal Register

“WE... RECOMMEND ALLOWING ANY LICENSED HEALTHCARE PROFESSIONAL TO ENTER ORDERS USING CPOE. WE FURTHER REFINE THIS RECOMMENDATION TO BE THAT ANY LICENSED HEALTHCARE PROFESSIONAL CAN ENTER ORDERS INTO THE MEDICAL RECORD PER STATE, LOCAL AND PROFESSIONAL GUIDELINES. WHILE WE UNDERSTAND THAT THIS POLICY MAY DECREASE OPPORTUNITIES FOR CLINICAL DECISION SUPPORT AND ADVERSE INTERACTION, WE BELIEVE IT BALANCES THE POTENTIAL WORKFLOW IMPLICATIONS OF REQUIRING THE ORDERING PROVIDER TO ENTER EVERY ORDER DIRECTLY, ESPECIALLY IN THE HOSPITAL SETTING.” (P. 44332)

EXCLUSION:

“ANY EP WHO WRITES FEWER THAN 100 PRESCRIPTIONS DURING THE EHR REPORTING PERIOD.” (P. 44567)

Who can enter into the CPOE?

Any licensed healthcare professional can enter orders into the medical record per state, local and professional guidelines. (p. 44332)

By following this guideline, the possibility of clinical decision support and advance interaction alerts presented to those without clinical judgment will be potentially removed. (p.44332)

Threshold/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 (p. 44567)

Denominator

Number of unique patients with at least one medication in their medication list seen by the EP or admitted to an eligible hospital’s or CAH’s inpatient or emergency department during the EHR reporting period (p. 44334)

Numerator

The number of patients in the denominator that have at least one medication order entered using CPOE (p. 44334)

The Federal Register

“IDEALLY, THIS CHECK WOULD BE PERFORMED AGAINST ANY FORMULARY THAT MAY AFFECT THE PATIENT’S WELFARE, INFORM THE PROVIDER AS TO THE BEST DRUG TO PRESCRIBE OR PROVIDE THE PATIENT AND PROVIDER INFORMATION ON THE DRUG’S COST TO BOTH THE PATIENT AND ANY THIRD PARTY PAYER. WE RECOGNIZE, HOWEVER, THAT NOT EVERY AVAILABLE THIRD PARTY PAYER, PHARMACY BENEFIT MANAGEMENT, PREFERRED DRUG LIST IS STANDARDIZED AND MADE AVAILABLE FOR QUERY THROUGH CERTIFIED EHR TECHNOLOGY. AS WE CANNOT THROUGH THIS REGULATION IMPOSE SUCH A REQUIREMENT ON EVERY DEVELOPER OF A FORMULARY, WE DO NOT REQUIRE THAT AN EP/ELIGIBLE HOSPITAL/CAH WOULD HAVE TO ACCOMMODATE EVERY FORMULARY IN THEIR IMPLEMENTATION.” (P. 44334)

“WE ... SPECIFY THAT IN ORDER TO MEET THIS OBJECTIVE AND MEASURE, AN EP, ELIGIBLE HOSPITAL, OR CAH MUST USE THE CAPABILITIES CERTIFIED EHR TECHNOLOGY INCLUDES AS SPECIFIED AND STANDARDS AT 45 CFR 170.302(A). THE ABILITY TO CALCULATE THE MEASURE IS INCLUDED IN CERTIFIED EHR TECHNOLOGY.” (P. 44335)

Drug-Drug and Drug-Allergy Checks

Implement drug-drug and drug-allergy interaction check (p. 44567)

What is the Objective Requirement?

EP would be required to enable this functionality. While this does not ensure that an EP is considering the information provided by the check, it does ensure that the information is available. (p. 44335)

Key Information

Capability of conducting automated drug-drug, drug-allergy checks is included in the certification criteria for certified EHR technology. This automated check provides information to advise the EP’s decisions in prescribing drugs to a patient. (p. 44335)

Measure

The EP has enabled this functionality for the entire EHR reporting period (p. 44567)

The Federal Register

“WE DID NOT AND DO NOT INTEND THAT CODING OF THE DIAGNOSIS BE DONE AT THE POINT OF CARE. THIS CODING COULD BE DONE LATER AND BY INDIVIDUALS OTHER THAN THE DIAGNOSING PROVIDER.” (P.44336)

Up-to-Date Problem List

Maintain an up-to-date¹ problem list of current and active diagnosis (p. 44567)

What is a Problem List?

List of current and active diagnoses as well as past diagnoses reviewed at the point of care (p. 44336)

Threshold/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 data² (p. 44567)

Denominator

Number of unique patients seen by the EP during the EHR reporting period (p. 44337)

Numerator

The 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 (p. 44337)

¹ “THE TERM “UP-TO-DATE” MEANS THE LIST IS POPULATED WITH THE MOST RECENT DIAGNOSIS KNOWN BY THE EP, ELIGIBLE HOSPITAL, OR CAH.” (P. 44336)

² “STRUCTURED DATA WITHIN CERTIFIED EHR TECHNOLOGY MERELY REQUIRES THE SYSTEM TO BE ABLE TO IDENTIFY THE DATA AS PROVIDING SPECIFIC INFORMATION. THIS IS COMMONLY ACCOMPLISHED BY CREATING FIXED FIELDS WITHIN A RECORD OR FILE, BUT NOT SOLELY ACCOMPLISHED IN THIS MANNER.” (P. 44346)

The Federal Register

“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. (THE SUBSTANCES IN SCHEDULE II CAN BE FOUND AT HTTP://WWW.DEADIVERSION.US DOJ.GOV/SCHEDULE/ORANGEBOOK/E_CS_SCHED.PDF). ANY PRESCRIPTION NOT SUBJECT TO THESE RESTRICTIONS WOULD BE PERMISSIBLE.” (P. 44337)

“NONPARTICIPATION BY PHARMACIES WAS PRESENTED BY COMMENTERS AS A MAJOR BARRIER TO E-PRESCRIBING.... IN REGARDS TO THE FIRST ARGUMENT, WE DO NOT HAVE THE ABILITY TO IMPOSE REQUIREMENTS ON PHARMACIES THROUGH THE HITECH LEGISLATION.” (P. 44338)

“THE SECOND IS PATIENT PREFERENCE FOR A PAPER PRESCRIPTION.... IN REGARDS TO THE SECOND ARGUMENT, WE ALSO HAVE NEITHER THE ABILITY NOR THE DESIRE TO LIMIT PATIENT PREFERENCE.” (P. 44338)

Electronic Prescribing (eRx)

Generate and transmit permissible prescriptions electronically (p. 44567)

What is Electronic Prescribing?

An electronic exchange of an authorized prescription from an eligible EP that a pharmacist would not dispense to the patient without such authorization (p. 44337)

What prescriptions would be included?

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. (p. 44338)

Do not include authorizations for items such as durable medical equipment or other items and services that may require EP authorization before the patient could receive them. These are excluded from the numerator and the denominator (p. 44338)

What if pharmacies do not accept prescriptions sent electronically?

EPs are dependent upon an external receiver of electronic health data. These pharmacies not accepting electronic prescriptions are beyond the scope of the EP. (p. 4433)

What if a patient insists that the prescription is written on paper?

A patient can insist on a paper prescription. (p. 44338)

The Federal Register

EXCLUSION

“ANY EP WHO WRITES FEWER THAN 100 PRESCRIPTIONS DURING THE EHR REPORTING PERIOD” (P. 44567)

Threshold/Measure

More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology (p. 44567)

Denominator

Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period (p. 44338)

Numerator

The number of prescriptions in the denominator generated and transmitted electronically (p. 44338)

The Federal Register

“WE CLARIFY THAT THE INDICATION OF “NONE” SHOULD DISTINGUISH BETWEEN A BLANK LIST THAT IS BLANK BECAUSE A PATIENT IS NOT ON ANY KNOWN MEDICATIONS AND A BLANK LIST BECAUSE NO INQUIRY OF THE PATIENT HAS BEEN MADE.” (P. 44338-44339)

“WE DO NOT BELIEVE THAT ANY EP, ELIGIBLE HOSPITAL OR CAH WOULD BE IN A SITUATION WHERE THEY WOULD NOT NEED TO KNOW WHETHER THEIR PATIENTS ARE TAKING ANY MEDICATIONS. THEREFORE, THERE ARE NO EXCLUSIONS FOR THIS OBJECTIVE AND ITS ASSOCIATED MEASURE.” (P. 44339)

Active Medication List

Maintain an active medication list³ (p. 44567)

What is an Active Medication List?

This is a list of medications a patient is currently taking; reviewed at each visit (p. 44338)

What if a patient is not currently taking any medication?

An EP is able to select the choice of “none” in a certified EHR technology. This will qualify for the measure. (p. 44339)

Threshold/Measure

More than 80 percent of all unique patients seen by the EP have at least once entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data (p. 44567)

Denominator

Number of unique patients seen by the EP during the EHR reporting period (p. 44339)

Numerator

The 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 (p. 44339)

³ “WE DEFINE AN ACTIVE MEDICATION LIST AS A LIST OF MEDICATIONS THAT A GIVEN PATIENT IS CURRENTLY TAKING.” (P. 44338)

The Federal Register

“WHILE WE AGREE THAT COLLECTING ALL ALLERGIES WOULD BE AN IMPROVEMENT, CURRENT MEDICATION ALLERGY STANDARDS EXISTS IN A STRUCTURED DATA FORMAT THAT MAY BE IMPLEMENTED IN STAGE 1... [HOWEVER] WE BELIEVE EP/ELIGIBLE HOSPITALS/CAHS SHOULD CONTINUE TO DOCUMENT ALL ALLERGIES, REGARDLESS OF ORIGIN, CONSISTENT WITH STANDARD OF CARE PRACTICE FOR THAT EP/ELIGIBLE HOSPITAL/CAH.” (P 44339-44340)

Active Medication Allergy List

Maintain an active medication allergy list.
(p. 44567)

What is an Active Medication Allergy List?

This is a list of known medication allergies (p. 44340)

What is to be recorded to meet this measure for Stage 1?

Any medication allergy known to the patient should be recorded as structured data in the certified EHR technology (p. 44340)

Threshold/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 (p. 44567)

Denominator

Number of unique patients seen by the EP during the EHR reporting period (p. 44340)

Numerator

The 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 (p. 44340)

The Federal Register

“...WE DO REQUIRE THAT ALL DEMOGRAPHIC ELEMENTS THAT ARE LISTED IN THE OBJECTIVE BE INCLUDED IN A PATIENT’S RECORD IN CERTIFIED EHR TECHNOLOGY. HOWEVER, WE DO NOT DESIRE, NOR COULD WE REQUIRE, THAT A PATIENT PROVIDE THIS INFORMATION IF THEY ARE OTHERWISE UNWILLING TO DO SO. SIMILARLY, WE DO NOT SEEK TO PREEMPT ANY STATE LAWS PROHIBITING EPs, ELIGIBLE HOSPITALS, OR CAHS FROM COLLECTING INFORMATION ON A PATIENT’S ETHNICITY AND RACE. THEREFORE IF A PATIENT DECLINES TO PROVIDE THE INFORMATION OR IF CAPTURING A PATIENT’S ETHNICITY OR RACE IS PROHIBITED BY STATE LAW, SUCH A NOTATION ENTERED AS STRUCTURED DATA WOULD COUNT AS AN ENTRY FOR PURPOSES OF MEETING THE MEASURE.” (P. 44341)

“PREFERRED LANGUAGE IS THE LANGUAGE BY WHICH THE PATIENT PREFERS TO COMMUNICATE. THIS IS JUST A RECORD OF THE PREFERENCE. WE DO NOT HAVE THE AUTHORITY UNDER THE HITECH ACT TO REQUIRE PROVIDERS TO ACTUALLY COMMUNICATE WITH THE PATIENT IN HIS OR HER PREFERRED LANGUAGE.” (P. 44341)

Patient Demographic Data

Record all of the following demographics:

- A) Preferred Language
- B) Gender
- C) Race
- D) Ethnicity
- E) Date of Birth (p. 44567)

What are the standards for Race and Ethnicity?

“The revised standards will have five minimum categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There will be two categories for data on ethnicity: ‘Hispanic or Latino’ and ‘Not Hispanic or Latino.’”

These standards are published by the Office of Management and Budget.

(www.whitehouse.gov/omb/inforeg_statpolicy/#dr)

What if a patient declines to answer demographic information?

A notation stating that patient declined to give information must be entered as structured data and this would count as an entry for purposes of meeting this measure. (p. 44342)

The Federal Register

“MOST EPS ... WOULD HAVE ACCESS TO THIS INFORMATION THROUGH DIRECT PATIENT ACCESS. SOME EPS WITHOUT DIRECT PATIENT ACCESS WOULD HAVE THIS INFORMATION COMMUNICATED AS PART OF THE REFERRAL FROM THE EP WHO IDENTIFIED THE SERVICE AS NEEDED BY THE PATIENT. THEREFORE, WE DID NOT INCLUDE AN EXCLUSION FOR THIS OBJECTIVE AND ASSOCIATED MEASURE.” (P. 44342)

Threshold/Measure

More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data (p. 44567)

Denominator

Number of unique patients seen by the EP during the EHR reporting period (p. 44342)

Numerator

The 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 (p. 44342)

The Federal Register

“THE INFORMATION 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.” (P. 44343)

“WE AGREE AND WOULD ALLOW HEIGHT SELF-REPORTED BY THE PATIENT TO BE USED.” (P. 44343)

Changes in Vital Signs

Record and chart changes in the following vital signs:

- A) *Height*
- B) *Weight*
- C) *Blood Pressure*
- D) *Calculate and display Body Mass Index*
- E) *Plot and display growth charts for*

children 2-20 years of age, including BMI (p. 44567)

How is the growth chart obtained?

The growth chart will be plotted and displayed for children ages 2-20 years using certified EHR technology. (p. 44343)

Who can enter vital sign data into the EHR?

For this structured data entry, the following have the authorization to enter the vital sign information into the EHR:

Entry by EP, eligible hospital, or CAH

Entry by someone on the staff

Transfer of information electronically

Entered directly by the patient through a portal or other means (p. 44343)

The Federal Register

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.” (P. 44567)

Threshold/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 (p. 44567)

Denominator

Number of unique patients age 2 or over seen by the EP during the EHR reporting period (p. 44343)

Numerator

The number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structure data (p. 44343)

The Federal Register

“IF THIS INFORMATION IS ALREADY IN THE MEDICAL RECORD AVAILABLE THROUGH CERTIFIED EHR TECHNOLOGY, WE DO NOT INTEND THAT AN INQUIRY BE MADE EVERY TIME A PROVIDER SEES A PATIENT 13 YEARS OLD OR OLDER.” (P. 44344)

“IN ORDER TO ACCURATELY MEASURE AND THEREBY ASSURE MEANINGFUL USE, FOR THIS OBJECTIVE WE BELIEVE THAT THE AGE LIMIT NEEDS TO BE HIGH ENOUGH SO THAT THE INQUIRY IS APPROPRIATE FOR ALL PATIENTS. THEREFORE, WE ARE MAINTAINING THE AGE LIMITATION AT 13 YEARS OLD OR OLDER.” (P. 44344)

Record Smoking Status

Record smoking status for patients 13 years of age and older (p. 44567)

At what age do EPs begin inquiring about patient’s smoking status?

This measure requires that inquiries should be made to patients 13 years of age and older. (p. 44344)

How often does the inquiry need to be made?

The objective states that smoking status does not have to be made known on every visit. The frequency is left to the EP with the guidance from sources from the medical community. (p. 44344)

What are the Smoking Status Codes?

Current, Every Day Smoker

Individual has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes EVERYDAY

Current, Some Day Smoker

Individual has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes PERIODICALLY YET CONSISTENTLY

Former Smoker

Individual who has smoked at least 100 cigarettes during his/her lifetime but does NOT CURRENTLY SMOKE

The Federal Register

EXCLUSION

“ANY EP WHO SEES NO PATIENTS
13 YEARS OR OLDER.” (P.
44567)

Never Smoker

Individual who has NOT smoked at least 100 cigarettes during his/her lifetime (for info go to site at bottom of screen)

Smoker Current Status Unknown

Individuals who were known to have smoked at least 100 cigarettes in the past, but whether they currently still smoke is unknown

Unknown If Ever Smoked

Self-Explanatory (44606-44607)

(http://www.cdc.gov/nchs/nhis/tobacco/tobacco_recodes.htm)

Threshold/Measure

More than 50 percent of all unique patients 13 years of age or older seen by the EP have “smoking status” recorded (p. 44567)

Denominator

Number of unique patients age 13 or older seen by the EP during the EHR reporting period (p. 44345)

Numerator

The number of patients in the denominator with smoking status recorded as structured data (p. 44345)

The Federal Register

“WE... REQUIRE EPS TO REPORT ON ALL THREE CORE MEASURES AND THREE ADDITIONAL CLINICAL QUALITY MEASURES.” (P. 44409).

“THE THREE CORE MEASURES THAT EPS WILL BE REQUIRED TO REPORT ARE: [NQF 0013: HYPERTENSION: BLOOD PRESSURE MANAGEMENT; NQF 0028: PREVENTATIVE CARE AND SCREENING MEASURE PAIR: A. TOBACCO USE ASSESSMENT B. TOBACCO CESSATION INTERVENTION; AND NQF0421/PQRI 128: ADULT WEIGHT SCREENING AND FOLLOW-UP]. INsofar AS THE DENOMINATOR FOR ONE OR MORE OF THE CORE MEASURES IS ZERO, EPS WILL BE REQUIRED TO REPORT RESULTS FOR UP TO THREE ALTERNATE CORE MEASURES [NQF 0041/PQRI 110: PREVENTATIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION FOR PATIENTS ≥50 YEARS OLD; NQF 0024: WEIGHT ASSESSMENT AND COUNSELING FOR CHILDREN AND ADOLESCENTS; AND NQF 0038: CHILDHOOD IMMUNIZATION STATUS]. WE BELIEVE THIS FINAL SET OF CORE CLINICAL QUALITY MEASURES PROVIDES EPS A GREATER OPPORTUNITY FOR SUCCESSFUL REPORTING.” (P.44409-44410)

Report on Clinical Quality Measures

Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States. (p. 44567)

How many measures must EPs report?

EPs must complete three core measures and 3 alternate measures. (p. 44409)

Measure

For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of the Final Rule.

For 2012, electronically submit the measures as discussed in section II(A)(3) of the Final Rule. (p. 44567)

All Core Clinical Quality Measures are Required (Alternative Core Measures Marked with *)		
NQF #	Measures	Description
421	Adult Weight Screening and Follow-Up.	Percentage of patients aged 18 years and older with a calculated BMI in the past six 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.
13	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, with blood pressure (BP) recorded.
28	Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention	Percentage of patients aged 18 years and 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. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
38	*Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertusis (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 nine separate combination rates
41	*Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
24	*Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year

Additional Clinical Quality Measures: Diabetes		
NQF #	Measures	Description
59	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.
575	Diabetes: Hemoglobin A1c Control (<8.0%).	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c < 8.0%.
64	Diabetes: Low Density Lipoprotein (LDL) Management and Control	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100mg/dL).

61	Diabetes: Blood Pressure Management	Percentage of Patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure < 140/90mmHg
88	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits with 12 months.
89	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care.	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
55	Diabetes: Eye Exam.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal eye exam (no evidence of retinopathy) by an eye care professional.
62	Diabetes: Urine Screening	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
56	Diabetes: Foot Exam	The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).

Additional Clinical Quality Measures: Heart Conditions		
NQF #	Measures	Description
81	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy
70	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy
67	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy
83	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.

75	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100mg/dL.
74	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
84	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation.	Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.
73	Ischemic Vascular Disease (IVD): Blood Pressure Management.	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and whose recent blood pressure is in control (< 140/90mmHg).
68	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic.	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PCTA) FROM January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and who had documentation of the use of aspirin or another antithrombotic during the measurement year.

Additional Clinical Quality Measures: Women's Health

NQF #	Measures	Description
12	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV).	Percentage 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.

14	Prenatal Care: Anti-D Immune Globulin.	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
32	Cervical Cancer Screening.	Percentage of women 21-64 years of age, who received one of more Pap tests to screen for cervical cancer.
33	Chlamydia Screening for Women.	Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
387	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.
31	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer

Additional Clinical Quality Measures: Cancer		
NQF #	Measures	Description
34	Colorectal Cancer Screening.	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
385	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients.	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period
389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients.	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Additional Clinical Quality Measures: Asthma		
NQF #	Measures	Description
47	Asthma Pharmacologic Therapy.	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.

1	Asthma Assessment.	Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
36	Use of Appropriate Medications for Asthma.	Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).

Additional Clinical Quality Measures: Miscellaneous		
NQF #	Measures	Description
52	Low Back Pain: Use of Imaging Studies.	Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.
105	Anti-depressant medication management (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment.	The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
86	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.	Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.
43	Pneumonia Vaccination Status for Older Adults.	Percentage of patients 65 years of age or older who have ever received a pneumococcal vaccine.
18	Controlling High Blood Pressure.	The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
2	Appropriate Testing for Children with Pharyngitis.	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
27	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smoking and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies.	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods, or strategies.

4	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement.	The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
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The Federal Register

“IN THE PROPOSED RULE, WE DESCRIBED CLINICAL DECISION SUPPORT AS 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. WE PURPOSEFULLY USED A DESCRIPTION THAT WOULD ALLOW A PROVIDER SIGNIFICANT LEEWAY IN DETERMINING THE CLINICAL DECISION SUPPORT RULES THAT ARE MORE RELEVANT TO THEIR SCOPE OF PRACTICE AND BENEFIT THEIR PATIENTS IN THE GREATEST WAY.” (P. 44350)

Clinical Decision Support Tools

Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule (p. 44567)

What does “Clinical Decision Support Tool” entail?

These tools could include, but are not limited to, evidenced base medicine templates, decision trees, reminders, linked online resources, scientific evidence and consensus. (p. 44350)

Measure

Implement one clinical decision support rule (p. 44567)

The Federal Register

“IN THE PROPOSED RULE WE INDICATED THAT ELECTRONIC COPIES MAY BE PROVIDED THROUGH A NUMBER OF SECURE ELECTRONIC RECORDS SUCH AS PATIENT PORTAL, CD OR USB.” (P. 44353)

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.” (P. 44567)

Patient Copies of Health Information upon Request

Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication list, medication allergies) upon request. (p.44567)

How should this information be provided to the patient?

“As this is for use by the patient, the form and format should be human readable and comply with the HIPAA Privacy Rule...” (p. 44353)

Measure

More than 50 percent of all patients of the EP who request an electronic copy of their health information are provided it within three business days (p. 44567)

Denominator

The number of patients of the EP who request an electronic copy of their electronic health information three business days prior to the end of the EHR reporting period (p. 44355)

Numerator

The number of patients in the denominator who receive an electronic copy of their electronic health information within three business days (p. 44355)

The Federal Register

“WE DEFINE CLINICAL SUMMARY AS AN AFTER-VISIT SUMMARY THAT PROVIDES A PATIENT WITH RELEVANT AND ACTIONABLE INFORMATION AND INSTRUCTIONS CONTAINING, BUT NOT LIMITED TO, THE PATIENT NAME, PROVIDER’S OFFICE CONTACT INFORMATION, DATE AND LOCATION OF VISIT, AN UPDATED MEDICATION LIST AND SUMMARY OF CURRENT MEDICATIONS, 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 TESTING PATIENT NEEDS TO SCHEDULE WITH CONTACT INFORMATION, RECOMMENDED PATIENT DECISION AIDS, LABORATORY AND OTHER DIAGNOSTIC TEST ORDERS, TEST/LABORATORY RESULTS (IF RECEIVED BEFORE 24 HOURS AFTER VISIT), AND SYMPTOMS.” (P. 44358)

Clinical Summaries

Provide clinical summaries for patients for each office visit (p.44567)

How does this summary have to be provided?

The summary can be given to a patient through a patient portal, electronic media such as CD or USB drive, or printed copy. (p. 44358)

Measure

Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days (p. 44567)

Denominator

Number of office visits by the EP for an office during the EHR reporting period (p. 44359)

Numerator

Number of office visits in the denominator for which the patient is provided clinical summary within three business days (p. 44359)

The Federal Register

“BY ‘CLINICAL INFORMATION’, WE MEAN ALL DATA NEEDED TO DIAGNOSE AND TREAT DISEASE, SUCH AS BLOOD TESTS, MICROBIOLOGY, URINALYSIS, PATHOLOGY TESTS, RADIOLOGY, CARDIAC IMAGING, NUCLEAR MEDICINE TESTS, AND PULMONARY FUNCTION TESTS. WE LEAVE IT TO THE PROVIDER’S CLINICAL JUDGMENT AS TO IDENTIFYING 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.” (P. 44360)

“WE ALSO SAID THAT IF MULTIPLE EPS ARE USING THE SAME CERTIFIED EHR TECHNOLOGY IN A SHARED PHYSICAL SETTING, THE TESTING WOULD ONLY HAVE TO OCCUR ONCE FOR A GIVEN CERTIFIED EHR TECHNOLOGY, AS WE DO NOT SEE ANY VALUE TO RUNNING THE SAME TEST MULTIPLE TIMES JUST BECAUSE MULTIPLE EPS USE THE SAME CERTIFIED EHR TECHNOLOGY.” (P. 44361)

Information Exchange

Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among EPs of care and patient authorized entities electronically (p. 44568)

To whom is the information exchanged?

“...We attempted to define an ‘exchange’ as the clinical information must be sent between different clinical entities with distinct certified EHR technology and not between organizations that share a certified EHR.” (p. 44361)

How can key clinical information be exchanged?

“We expect that this information, when exchanged electronically, would be exchanged in structured electronic format when available (for example, drug and clinical lab data). However, where the information is available only in unstructured electronic formats (for example, free text and scanned images), we would allow the exchange of unstructured information. We believe that the electronic exchange of information is most efficient when it is exchanged from a provider’s certified EHR technology to another certified EHR technology either directly, or through an entity facilitating health information exchange using structured data that can be automatically identified by the receiving system and integrated into the receiver’s records. However, we know that much information cannot currently be, and may never be, transmitted in the way we just described.” (p. 44360)

Measure

Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information (p. 44568)

The Federal Register

“WE SAID THAT WHILE CERTIFIED EHR TECHNOLOGY PROVIDES TOOLS FOR PROTECTING HEALTH INFORMATION, IT IS NOT A FULL PROTECTION SOLUTION. PROCESSES AND POSSIBLY TOOLS OUTSIDE THE SCOPE OF CERTIFIED EHR TECHNOLOGY ARE REQUIRED. THEREFORE, FOR THE STAGE 1 CRITERIA OF MEANINGFUL USE WE PROPOSE THAT EPS AND ELIGIBLE HOSPITALS CONDUCT OR REVIEW A SECURITY RISK ANALYSIS OF CERTIFIED EHR TECHNOLOGY AND IMPLEMENT UPDATES 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 EHR REPORTING PERIOD. THIS IS TO ENSURE THAT THE CERTIFIED EHR TECHNOLOGY IS PLAYING ITS ROLE IN THE OVERALL STRATEGY OF THE EP OR ELIGIBLE HOSPITAL IN PROTECTING HEALTH INFORMATION.” (PAGE 44369)

“...THE PROPER VEHICLE FOR ENSURING PRIVACY AND SECURITY IS THE HIPAA PRIVACY AND SECURITY ACT AND THAT WE SOUGHT WITH THIS OBJECTIVE TO ENSURE THAT CERTIFIED EHR TECHNOLOGY DOES NOT IMPEDE AN EP’S, ELIGIBLE HOSPITAL’S OR CAH’S ABILITY TO COMPLY WITH HIPAA.” (PAGE 44368)

Privacy and Security

Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities (p. 44568)

What does this mean?

The practice must conduct a risk analysis to identify the potential risks, vulnerabilities; integrity and availability of electronic protect health information, create a risk management plan, and mitigate identified issues.

The following policies/procedures should be implemented:

1. Employee sanction policy
2. Information system activity review
3. Authorization/supervision of access
4. Termination
5. Protection from malicious software
6. Login monitoring
7. Password management
8. Response and reporting for security incidents
9. Data backup
10. Disaster recovery
11. Emergency mode operation
12. Business associate contract
13. Facility security
14. Disposal of hardware
15. Unique user identification
16. Emergency access procedure
17. Automatic logoff
18. Encryption and decryption
19. Audit controls
20. Transmission security

Measure

Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process (p. 44568)

The Federal Register

“THE FORMULARIES SHOULD BE RELEVANT FOR PATIENT CARE DURING THE PRESCRIBING PROCESS.” (P. 44335)

Drug-Formulary Checks

Implement drug-formulary checks (p. 44568)

Key Points

The only action required by the EP is to consider the information. (p. 44335)

Measure

The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period (p. 44568)

The Federal Register

“WE ENCOURAGE EVERY EP, ELIGIBLE HOSPITAL AND CAH TO UTILIZE ELECTRONIC EXCHANGE OF THE RESULTS WITH THE LABORATORY BASED ON THE CERTIFICATION AND STANDARDS CRITERIA IN THE 45 CFR 170.302(H). IF RESULTS ARE NOT RECEIVED IN THIS MANNER, THEN THEY ARE PRESUMABLY RECEIVED IN ANOTHER FORM SUCH AS FAX, TELEPHONE CALL, MAIL, ETC. THESE RESULTS THEN MUST BE INCORPORATED INTO THE PATIENT’S MEDICAL RECORD IN SOME WAY.” (P. 44346)

“THE FOCUS OF THIS OBJECTIVE IS TO GET AS MANY LAB RESULTS AS POSSIBLE INTO A PATIENT’S ELECTRONIC HEALTH RECORD AS STRUCTURED DATA. LIMITING THE OBJECTIVE TO A SPECIFIC TYPE OF LABORATORY WOULD NOT FURTHER THIS OBJECTIVE SO THEREFORE WE LEAVE IT OPEN TO ALL LAB TESTS AND LABORATORIES.” (P. 44346)

EXCLUSION

“AN EP WHO ORDERS NO LAB TESTS WHOSE RESULTS ARE EITHER IN A POSITIVE/NEGATIVE OR NUMERIC FORMAT DURING THE EHR REPORTING PERIOD.” (P. 44568)

Clinical Lab Test Results

Incorporate clinical lab-test results into EHR as structured data (p. 44568)

In what forms can the clinical lab test results be received?

While it is highly encouraged that every EP is connected to a health information exchange, there are other ways to incorporate clinical lab test results in an EHR. This could include, but not limited to, fax, mail or telephone call recorded as structured data.

What type of laboratories can generate lab reports?

All classifications of laboratories can generate lab results. There are no limitations of what lab results can and should be incorporated.

Threshold/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.

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

Numerator

The 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

The Federal Register

“...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 A SUBSET OF THOSE PATIENTS AT THE DISCRETION OF THE EP, ELIGIBLE HOSPITAL OR CAH.” (P. 44347)

“...WE ARE NOT REQUIRING SUBMISSION OF THE REPORT TO CMS, THE STATES OR LOCAL HEALTH DEPARTMENTS FOR STAGE 1 OF MEANINGFUL USE.” (P. 44348)

“WE BELIEVE AN EP, ELIGIBLE HOSPITAL, OR CAH IS BEST POSITIONED TO DETERMINE WHICH REPORTS ARE MOST USEFUL TO THEIR CARE EFFORTS. THEREFORE, WE DO NOT PROPOSE TO DIRECT CERTAIN REPORTS BE CREATED.” (P.44348)

Lists of Patients with a Specific Condition

Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research and outreach (p. 44568)

Key Point

EPs are required to compile one report per EHR reporting period of patients with specific medical conditions listed in the "Active Patient Problem List".

Measure

Generate at least one report listing patients of the EP with a specific condition

The Federal Register

“WE BELIEVE THAT OLDER PATIENT POPULATIONS ARE MORE LIKELY TO HAVE HEALTH STATUSES THAT WILL INDICATE THE NEED FOR REMINDERS TO BE SENT AND THIS SEGMENT OF THE POPULATION IS HAVE HIGHER RATES OF CHRONIC DISEASES WHICH WILL REQUIRE COORDINATION IN PREVENTIVE CARE SUCH AS VACCINE REMINDERS. LIKewise, THE 5 YEARS OLD AND UNDER POPULATION WILL REQUIRE A MULTITUDE OF CHILDHOOD VACCINATIONS SUCH AS INFLUENZA AND WILL BENEFIT FROM REMINDERS.” (P. 44349)

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.” (P. 44568)

Reminders Sent to Patients

Send reminders to patients per patient preference for preventive/follow-up care (p. 44568)

Measure

More than 20 percent of all unique patients 65 years of age or older or 5 years of age or younger were sent an appropriate reminder during the EHR reporting period

Denominator

Number of unique patients 65 years old or older or 5 years old or younger

Numerator

The number of patients in the denominator who were sent the appropriate reminder

The Federal Register

“IT WAS OUR INTENTION THAT THIS BE INFORMATION THAT THE PATIENT COULD ACCESS ON DEMAND SUCH AS THROUGH A PATIENT PORTAL OR PHR. WE DID NOT INTEND FOR THIS TO BE ANOTHER OBJECTIVE FOR PROVIDING AN ELECTRONIC COPY OF HEALTH INFORMATION UPON REQUEST.” (P.44356)

“THE DIFFERENCE BETWEEN ELECTRONIC ACCESS AND AN ELECTRONIC COPY IS THAT A PATIENT WITH ELECTRONIC ACCESS CAN ACCESS THE INFORMATION ON DEMAND AT ANYTIME WHILE A PATIENT MUST AFFIRMATIVELY REQUEST AN ELECTRONIC COPY FROM THE EP, ELIGIBLE HOSPITAL OR CAH AT A SPECIFIC TIME AND THE INFORMATION IN THE COPY IS CURRENT ONLY AS OF THE TIME THAT THE COPY IS TRANSFERRED FROM THE PROVIDER TO THE PATIENT.” (P. 44356)

“BUSINESS DAYS ARE DEFINED AS MONDAY THROUGH FRIDAY EXCLUDING FEDERAL OR STATE HOLIDAYS ON WHICH THE EP, ELIGIBLE HOSPITAL OR CAH OR THEIR RESPECTIVE ADMINISTRATIVE STAFFS ARE UNAVAILABLE.” (P.44357)

EXCLUSION

“ANY EP THAT NEITHER ORDERS NOR CREATES ANY OF THE INFORMATION LISTED... DURING THE EHR REPORTING PERIOD.” (P. 44568)

Provide Patients with Timely Access

Provide patients with timely electronic access to their health information (including lab results, problem list, medication list, and allergies) within 4 business days of the information being available to the EP (p. 44568)

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

Denominator

The number of unique patients seen by the EP during the EHR reporting period

Numerator

The 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

The Federal Register

“WE AGREE WITH THE HIT POLICY COMMITTEE AND OTHERS THAT THE OBJECTIVE AND ASSOCIATED MEASURE SHOULD MAKE CLEAR THAT THE EP, ELIGIBLE HOSPITAL OR CAH SHOULD UTILIZE CERTIFIED EHR TECHNOLOGY IN A MANNER WHERE THE TECHNOLOGY SUGGESTS PATIENT-SPECIFIC EDUCATIONAL RESOURCES BASED ON THE INFORMATION STORED IN THE CERTIFIED EHR TECHNOLOGY.” (P.44329)

Education Resources

Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate (p. 44568)

What are examples of education material?

Examples of this educational material could include, but is not limited to, smoking cessation information, well-child care information, diabetes specific information, and so on.

This information must be available in a wide variety of languages.

Measure

More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources

Denominator

Number of unique patients seen by the EP during the EHR reporting period

Numerator

Number of patients in the denominator who are provided patient education specific resources

The Federal Register

“WHEN CONDUCTING MEDICATION RECONCILIATION DURING A TRANSFER OF CARE, WE BELIEVE THAT IT IS THE EP, ELIGIBLE HOSPITAL OR CAH THAT RECEIVES THE PATIENT INTO THEIR CARE THAT SHOULD CONDUCT THE MEDICATION RECONCILIATION. IT IS FOR THIS PROVIDER THAT THE INFORMATION IS MOST CRUCIAL, AS THEY WILL BE MAKING THE FUTURE CLINICAL JUDGMENTS REGARDING THE PATIENT.” (P.44362)

“WE FINALIZE OUR PROPOSAL BY DEFINING “RELEVANT ENCOUNTER” AS AN ENCOUNTER DURING WHICH THE EP, ELIGIBLE HOSPITAL OR CAH 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, ELIGIBLE HOSPITAL OR CAH. ESSENTIALLY AN ENCOUNTER IS RELEVANT IF THE EP, ELIGIBLE HOSPITAL, OR CAH JUDGES IT TO BE SO.” (P. 44362)

**EXCLUSION
AN EP WHO WAS NOT THE RECIPIENT OF ANY TRANSITIONS OF CARE DURING THE EHR REPORTING PERIOD.” (44568)**

Medication Reconciliation

The EP who receives a patient from another setting of care or EP of care or believes an encounter is relevant should perform medication reconciliation (p. 44568)

Who is responsible for performing the medication reconciliation?

The EP receiving the patient is responsible for performing the medication reconciliation⁴.

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

Denominator

Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition

Numerator

The number of transitions of care in the denominator where medication reconciliation was performed

⁴ “WE DESCRIBED ‘MEDICATION RECONCILIATION’ AS 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. 44362)

The Federal Register

“THE GOAL IS TO GET THE SUMMARY CARE RECORD INTO THE NEXT PROVIDER’S POSSESSION. WHILE WE HIGHLY ENCOURAGE ALL EPS, ELIGIBLE HOSPITALS, AND CAHS TO EXPLORE WAYS TO ACCOMPLISH THE TRANSFER USING ELECTRONIC EXCHANGE, WE REALIZE THAT THIS CAPABILITY IS STILL IN THE DEVELOPMENT STAGES. THEREFORE, AN EP, ELIGIBLE HOSPITAL, OR CAH COULD SEND AN ELECTRONIC OR PAPER COPY OF THE SUMMARY CARE RECORD DIRECTLY TO THE NEXT PROVIDER OR COULD PROVIDE IT TO THE PATIENT TO DELIVER TO THE NEXT PROVIDER, IF THE PATIENT CAN REASONABLY EXPECTED TO DO SO. CERTIFIED EHR TECHNOLOGY WOULD BE USED TO GENERATE THE SUMMARY OF CARE RECORD AND TO DOCUMENT THAT IT WAS PROVIDED TO THE PATIENT OR RECEIVING PROVIDER.” (P. 44364)

EXCLUSION

“AN EP WHO NEITHER TRANSFERS A PATIENT TO ANOTHER SETTING NOR REFERS A PATIENT TO ANOTHER PROVIDER DURING THE EHR REPORTING PERIOD.” (P. 44568)

Summary Care Report

The EP who transitions their patient to another setting of care or EP of care or refers their patient to another EP of care should provide summary care record for each transition of care or referral (p. 44568)

Definition: "Transition of Care"

Transfer of a patient from one clinical setting to another or from one EP to another, movement of a patient from one setting of care to another.

Measure

The EP who transitions or refers their patients to another setting of care or EP of care should provide summaries of care record for more than 50 percent of transitions of care and referrals

Denominator

Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring EP

Numerator

The number of transitions of care and referrals in the denominator where a summary of care record was provided

The Federal Register

“OUR MEASURE FOR MEETING THIS OBJECTIVE IS ONE TEST OF ELECTRONIC DATA SUBMISSION AND IF THE TEST IS SUCCESSFUL FOLLOW UP SUBMISSION TO THAT ONE ENTITY. WE DO NOT SEEK TO ENFORCE THROUGH MEANINGFUL USE EVERY LAW AND PRACTICE THAT MAY REQUIRE SUBMISSION OF IMMUNIZATION DATA.” (P. 44365)

“THIS TEST MUST INVOLVE THE ACTUAL SUBMISSION OF INFORMATION TO A REGISTRY OR IMMUNIZATION INFORMATION SYSTEM, IF ONE EXISTS THAT WILL ACCEPT THE INFORMATION.” (P. 44365)

“WE HAD INDICATED IN THE PROPOSED RULE THAT ONLY ONE TEST IS REQUIRED FOR EPS PRACTICING IN A GROUP SETTING THAT SHARES THE SAME CERTIFIED EHR TECHNOLOGY. WE MAINTAIN THAT PROPOSAL FOR THE FINAL RULE.” (P. 44365)

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.” (P. 44568)

Immunization Registries

Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice (p. 44568)

Key Points

If an EP has given immunizations during the reporting period, they should then attempt to locate a register or IIS with whom to conduct a test of the submission of electronic data.

“Test” or “dummy” data is permissible to meet the requirements of this data.

If a test is preformed and failed, the objective is still met

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 immunizations registries to which the EP submits such information have the capacity to receive the information electronically)

The Federal Register

“A PUBLIC HEALTH AGENCY IS 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.” (P. 44366)

“...THE REQUIRED FREQUENCY OF A TEST IN STAGE 1 FOR EPS, ELIGIBLE HOSPITALS, AND CAHS IS AT LEAST ONCE PRIOR TO THE END OF THE EHR REPORTING PERIOD. WE FURTHER CLARIFY THAT EACH PAYMENT YEAR WOULD REQUIRE ITS OWN UNIQUE TEST.” (P. 44366)

“WE HAD INDICATED IN THE PROPOSED RULE THAT ONLY ONE TEST IS REQUIRED FOR EPS PRACTICING IN A GROUP SETTING THAT SHARES THE SAME CERTIFIED EHR TECHNOLOGY. WE MAINTAIN THAT PROPOSAL FOR THE FINAL RULE.” (P. 44368)

Syndromic Surveillance

Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice (p. 44568)

Key Points

Test must involve the actual submission of information to a public health agency, if one exists that will accept the information.

The use of test information of a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.

EP’s, eligible hospitals, or CAH’s should attempt to identify at least one public health agency with whom to conduct a test of the submission of electronic data.

“Test” or “dummy” data is permissible to meet the requirements of this data.

If a test is preformed and failed, the objective is still met

Yes/No attestation to CMS

Term- Public Health Agency

An entity under the jurisdiction of the US Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.

The Federal Register

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.” (P. 44568)

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 have the capacity to receive the information electronically)