Meaningful Use

Stage 1

Core Objectives

Must Meet all 13 Objectives

1. CPOE for Medication Orders
2. Drug Interaction Checks
3. Up-To-Date Problem List
4. E-Prescribing (eRX)
5. Active Medication List
6. Medication Allergy List
7. Record Demographics
8. Record Vitals
9. Record Smoking Status
10. Clinical Decision Support Rule
11. Patient Electronic Access
12. Clinical Summaries
13. Protect Electronic Health Information

CPOE for Medication Orders

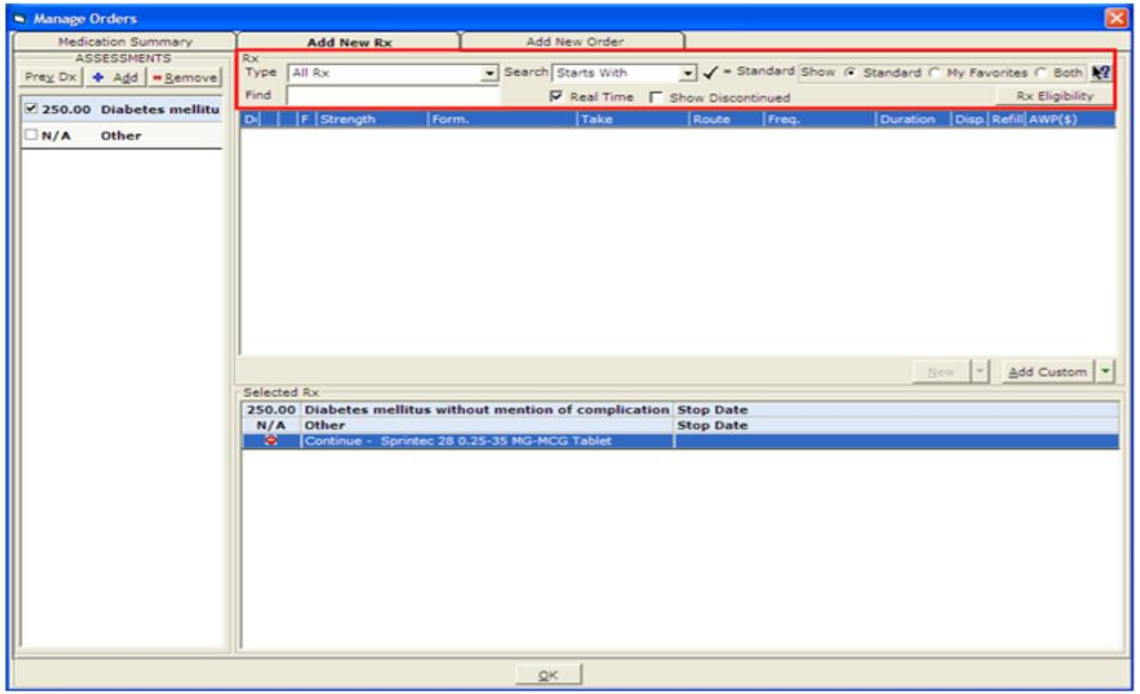
- Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
- Measure: More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
- Optional Alternate: More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
- Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period

CPOE for Medication Orders Attestation Requirements

- DENOMINATOR: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

- NUMERATOR: Number of patients in the denominator that have at least one medication order entered using CPOE.

How to Meet the Measure: CPOE for Medication Order



Access this feature from one of the following locations:

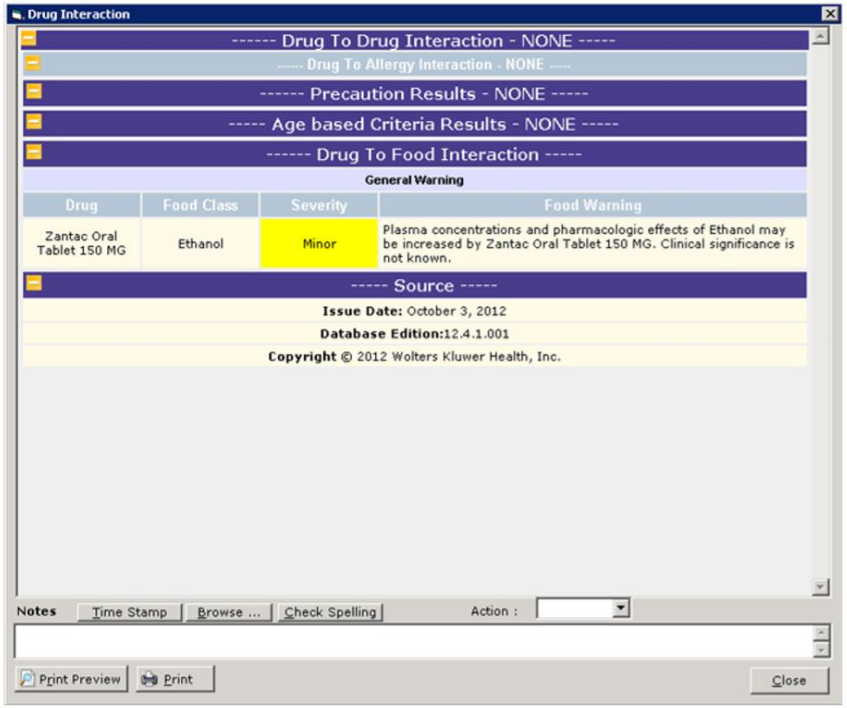
- Progress Notes > Treatment > Add.
- Telephone/Web Encounter > Rx tab > Select Rx.
- Telephone/Web Encounter > Virtual Visit tab > Treatment > Add.

CPOE for Medication Order Set-Up

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.

Drug Interaction Checks



Access this feature from one of the following locations:

- Progress Notes > Current Medication > Drug Interaction.
- Progress Notes > Treatment > Interaction.

Drug Interaction Checks Set-Up

- Drug interaction checking is always enabled for all eClinicalWorks users.
- No action is required to satisfy this measure, this measure is reported by a Yes/No answer.

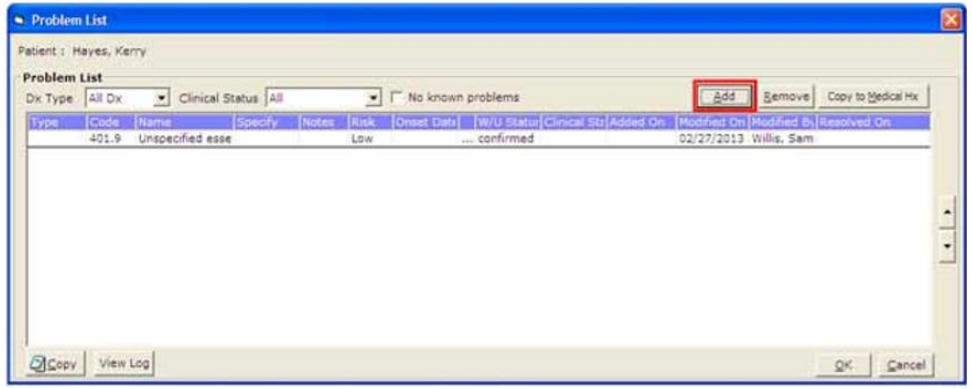
Up-To-Date Problem List

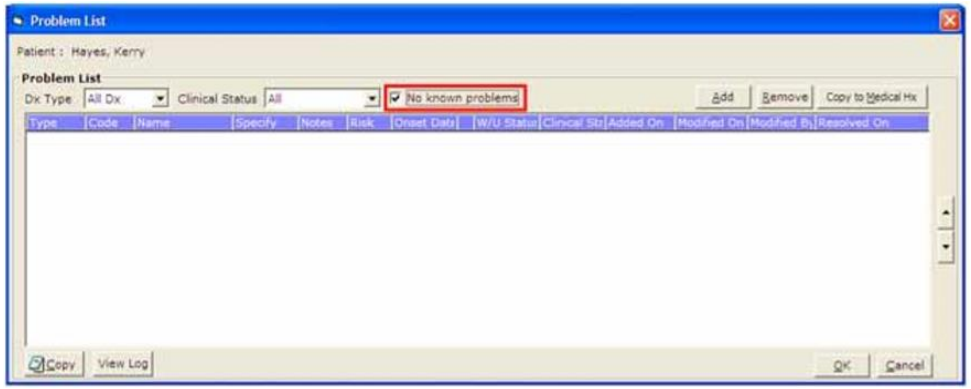
- Objective: Maintain an up-to-date problem list of current and active diagnoses.
- Measure: More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
- Exclusion: No exclusion.

Up-To-Date Problem List Attestation Requirements

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- 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.
- An EP is not required to update the problem list at every contact with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP.

How To Meet the Measure: Up-To-Date Problem List





E-Prescribing (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: 1. Any EP who writes fewer than 100 prescriptions during the EHR reporting period. 2. Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

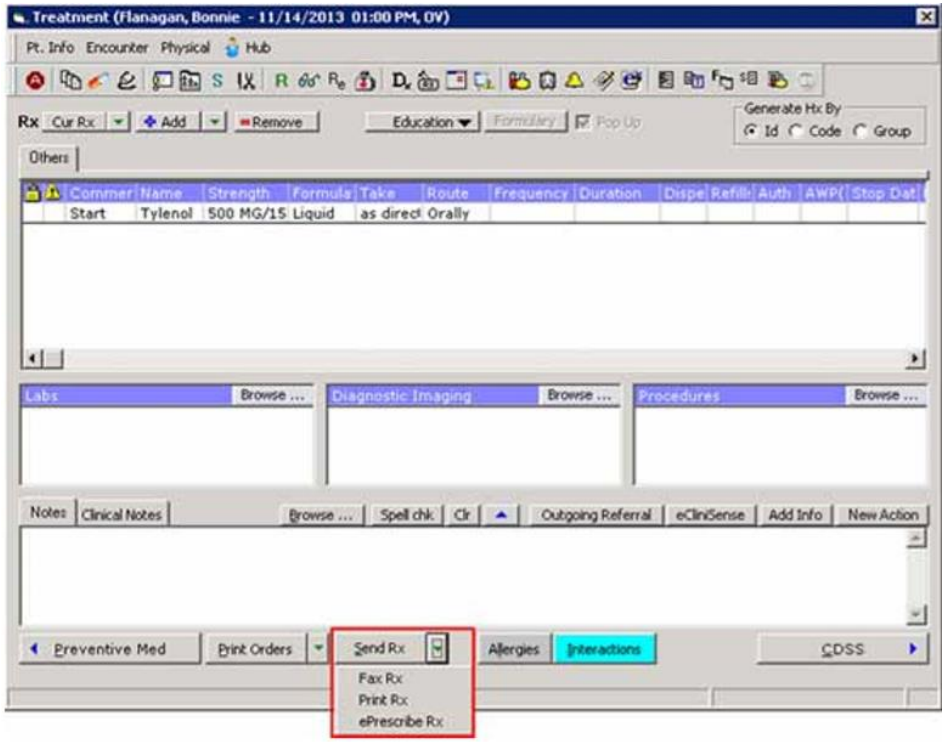
E-Prescribing (eRX) Attestation Requirements

- DENOMINATOR: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.

- NUMERATOR: Number of prescriptions in the denominator generated and transmitted electronically.

- Exclusion 1. Any EP who writes fewer than 100 prescriptions during the EHR reporting period. 2. Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

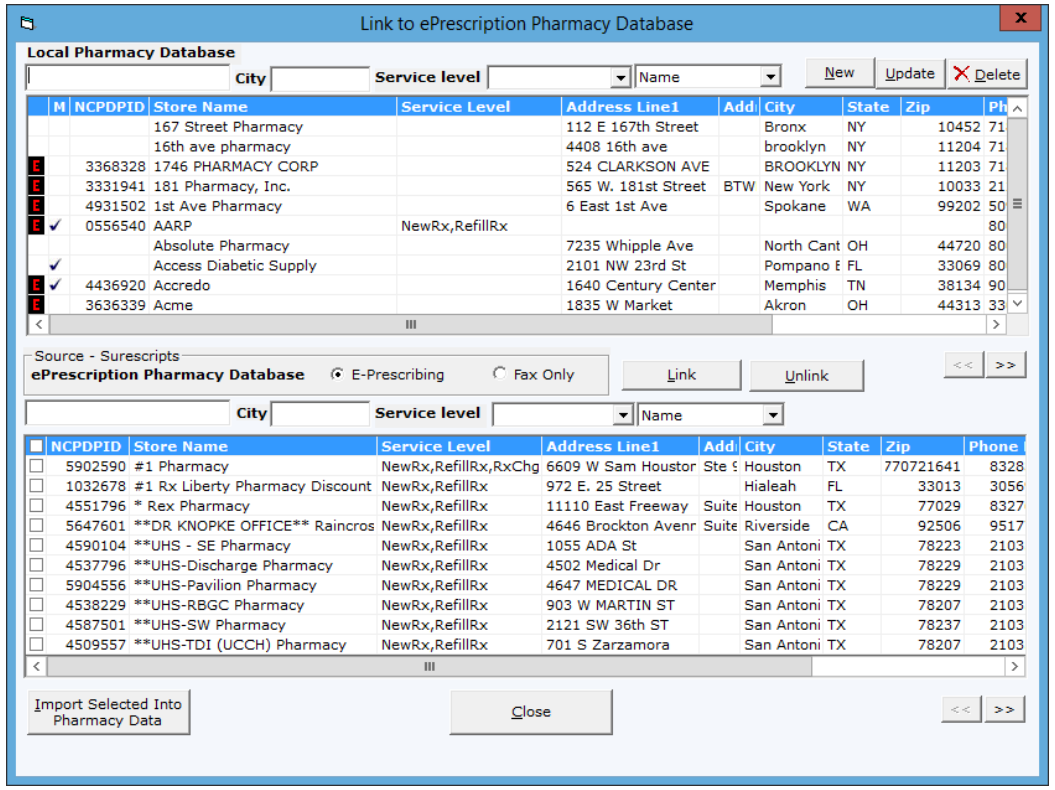
How To Meet the Measure: E-Prescribing (eRX)



Access this feature from one of the following locations:

- Progress Notes > Treatment.
- Telephone/Web Encounter > Virtual Visit tab > Treatment.

E-Prescribing Set-Up



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.

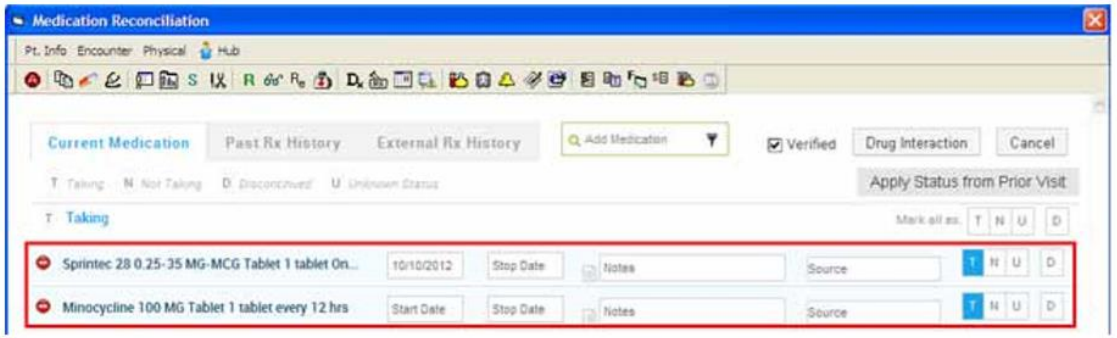
Active Medication List Attestation Requirements

- DENOMINATOR: Number of unique patients seen by the EP during the HER reporting period.

- 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.

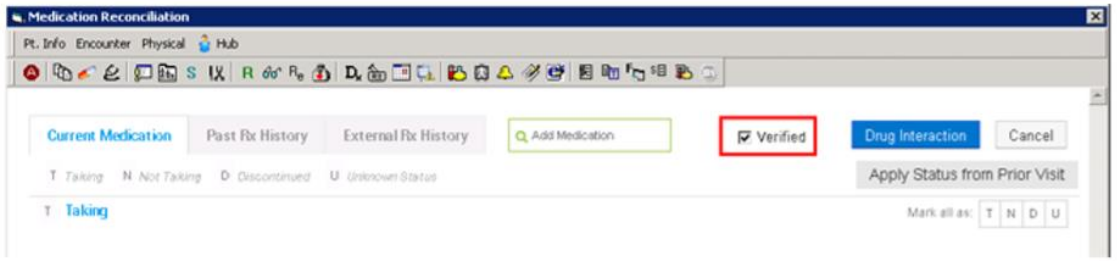
How To Meet the Measure: Active Medication List

A medication has been recorded in the Current Medication section of the Progress Notes:



Access this feature from: Progress Notes > Current Medication.

The *Verified* box is checked in the Current Medication section of the Progress Notes:



Access this feature from: Progress Notes > Current Medication.

Medication Allergy List

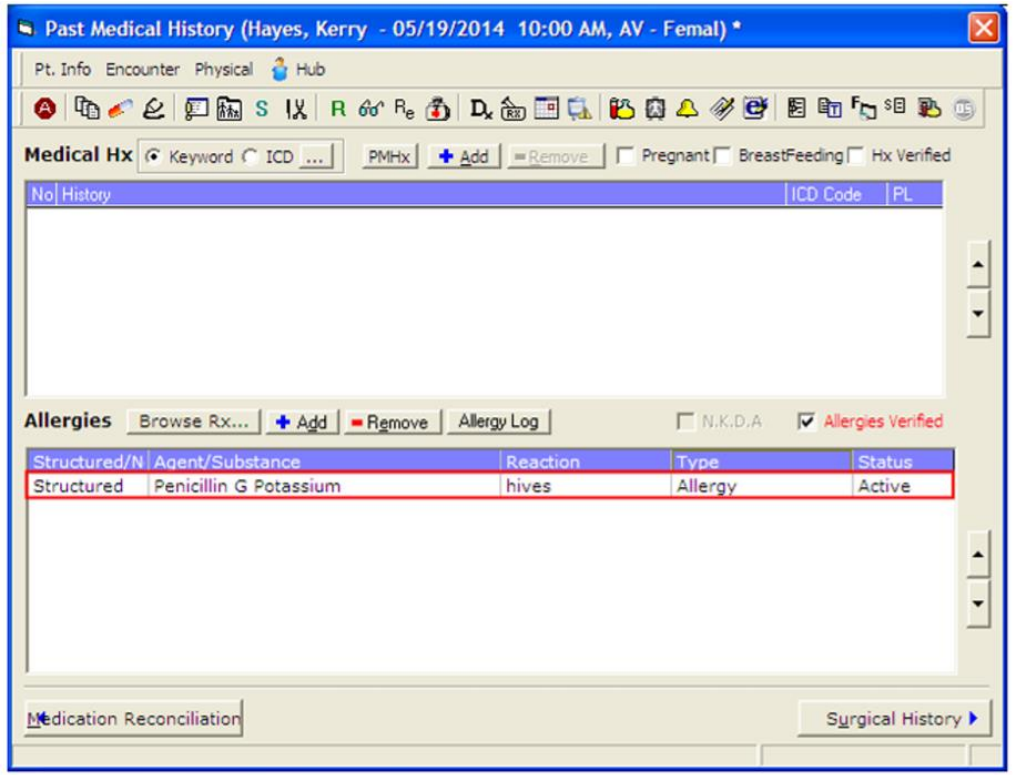
- Objective: Maintain active medication allergy list.
- Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
- Exclusion: No exclusion.

Medication Allergy List Attestation Requirements

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

- 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.

Medication Allergy List



Access this feature from: Progress Notes > Allergies.

Record Demographics

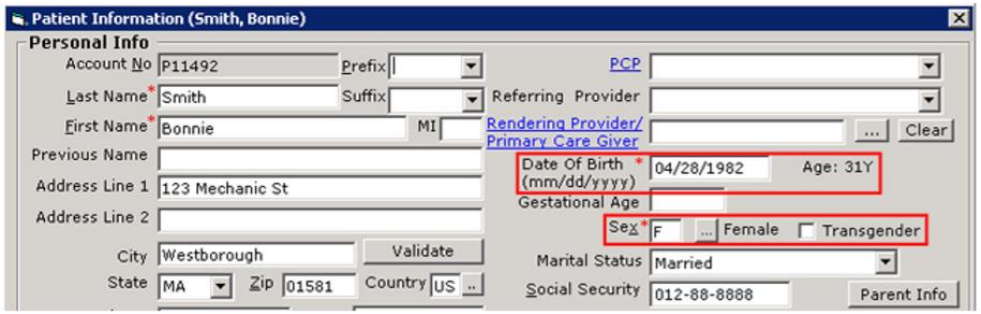
- Objective: Record all of the following demographics:
  - Preferred language
  - Gender
  - Race
  - Ethnicity
  - Date of birth
- Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
- Exclusion: No exclusion.

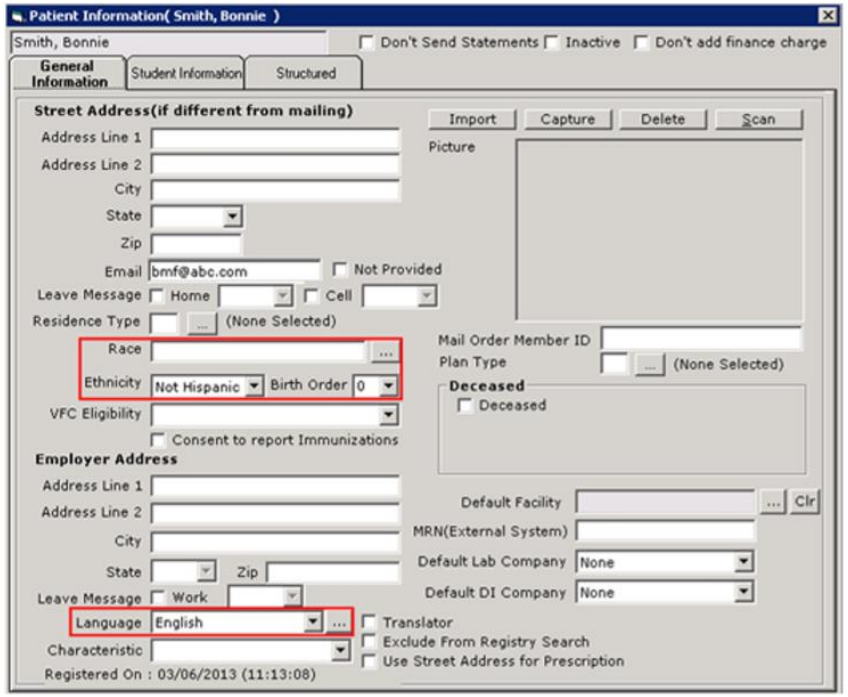
Record Demographics Attestation Requirements

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

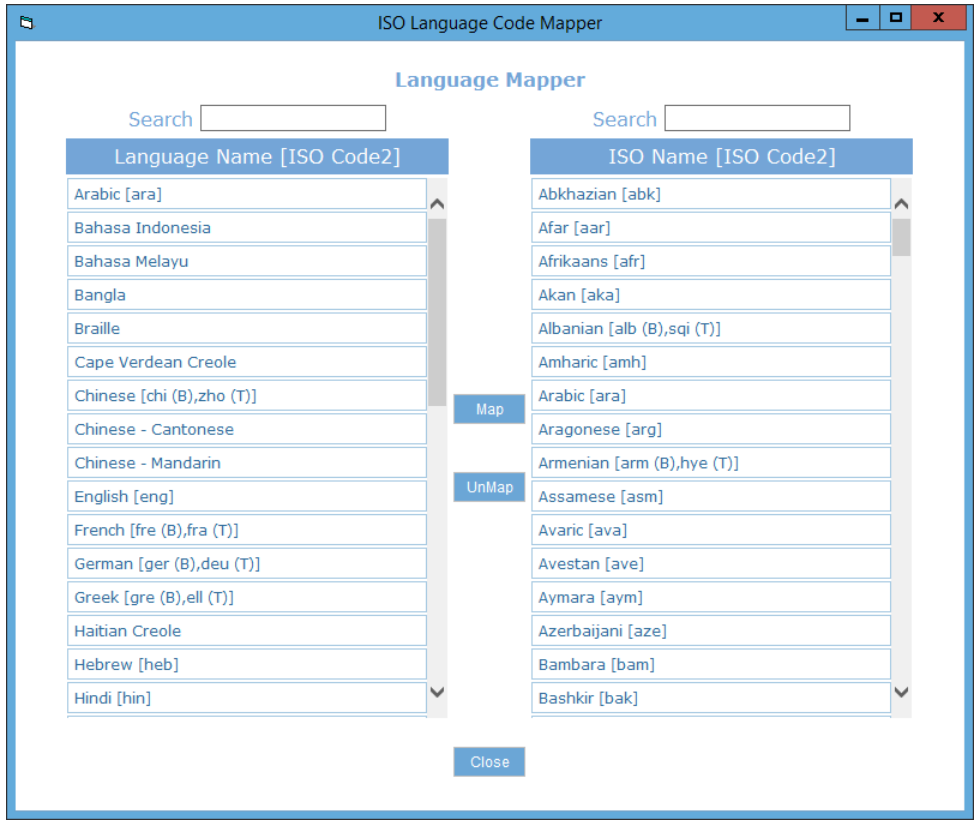
- NUMERATOR: Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

How To Meet the Measure: Record Demographics





Record Demographics Set-Up



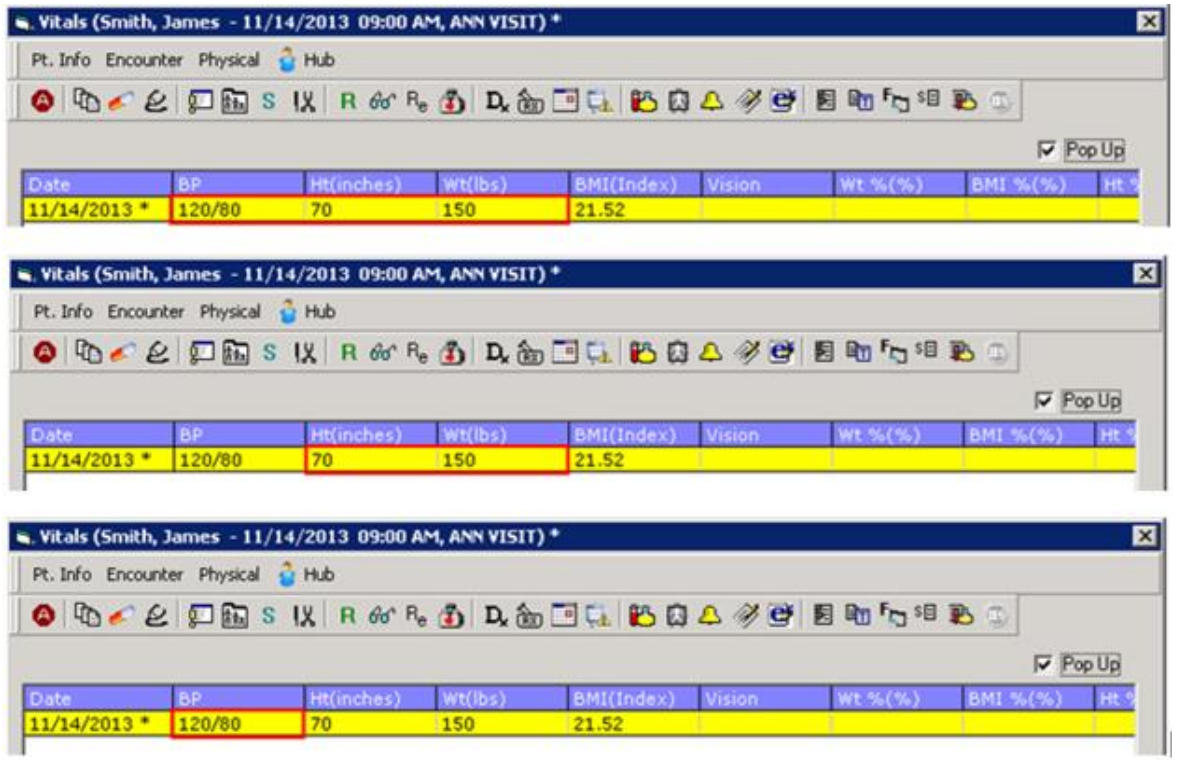
Record Vitals

- Objective: Record and chart changes in the following vital signs:
  - Height
  - Weight
  - Blood pressure
  - Calculate and display body mass index (BMI)
  - Plot and display growth charts for children 0-20 years, including BMI
- Measure: For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.

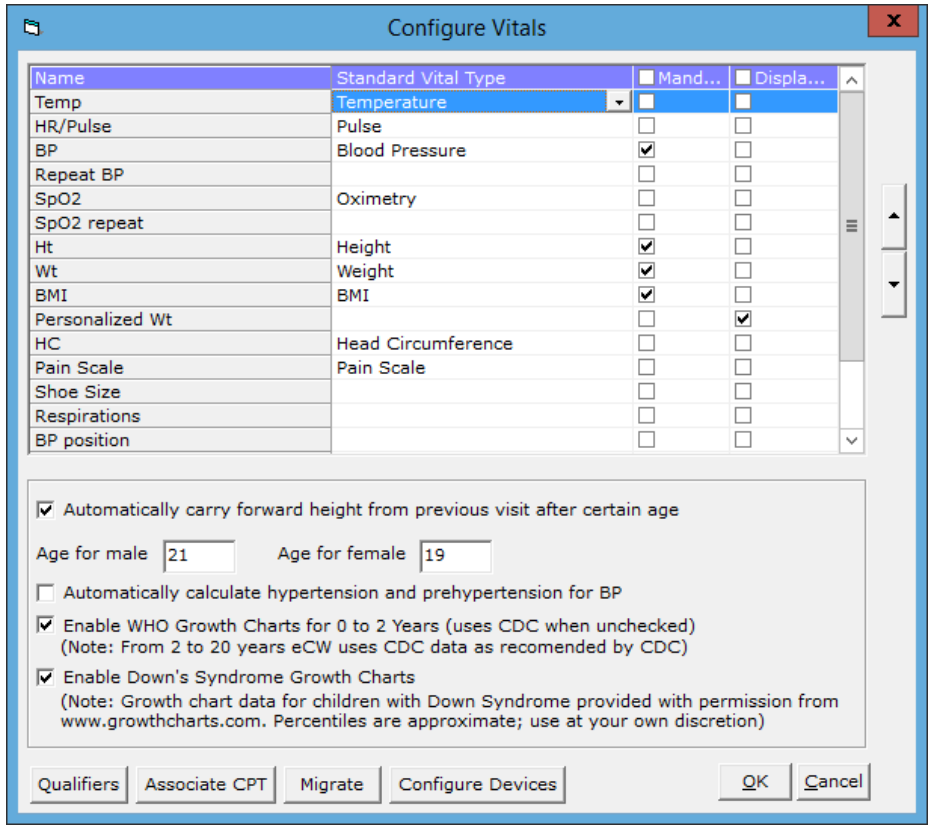
Record Vitals Attestation Requirements

- DENOMINATOR: Number of unique patients (age 3 or over for blood pressure) seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure (ages 3 and over) recorded as structured data.
- EXCLUSION: Any EP who
  - 1. Sees no patients 3 years or older is excluded from recording blood pressure;
  - 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;
  - 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or
  - 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

How To Meet the Measure: Record Vitals



Record Vital Set-Up



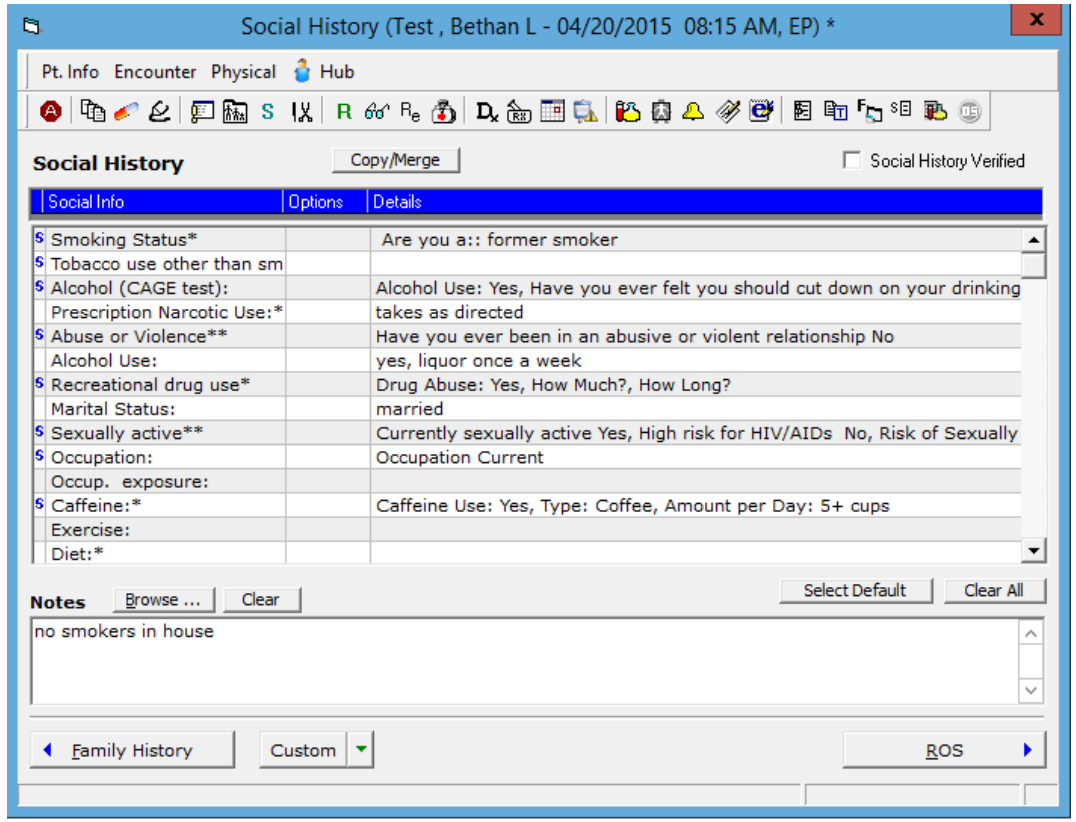
Record Smoking Status

- 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

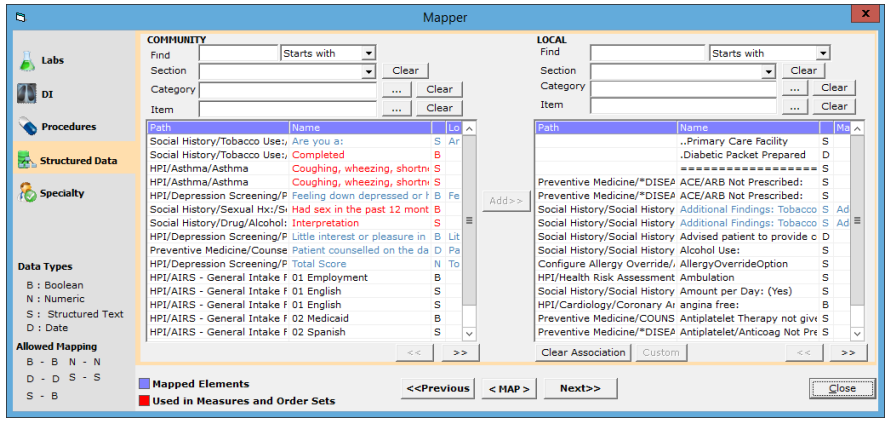
Record Smoking Status Attestation Requirements

- DENOMINATOR: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator with smoking status recorded as structured data.
- EXCLUSION: An EP who sees no patients 13 years or older would be excluded from this requirement. EPs must enter ‘0’ in the Exclusion box to attest to exclusion from this requirement.

How To Meet the Measure: Record Smoking Status



Record Smoking Status Set-Up



IMPORTANT! This local Structured Data item must be mapped to the are you a: community item (from Community > Mappings > Structured Data) to satisfy this measure. The following options satisfy this measure:

- Current smoker
- Former smoker
- Never smoker
- Current every day smoker
- Current some day smoker
- Smoker, current status unknown
- Unknown if ever smoked
- Light tobacco smoke
- Heavy tobacco smoker

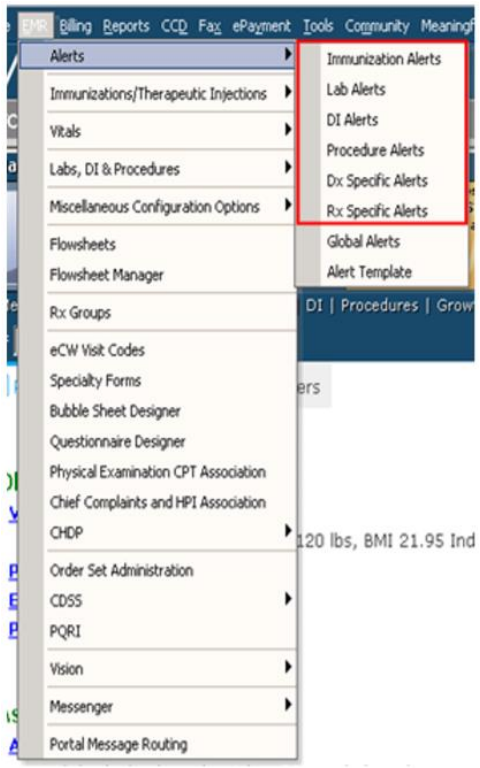
Clinical Decision Support Rule

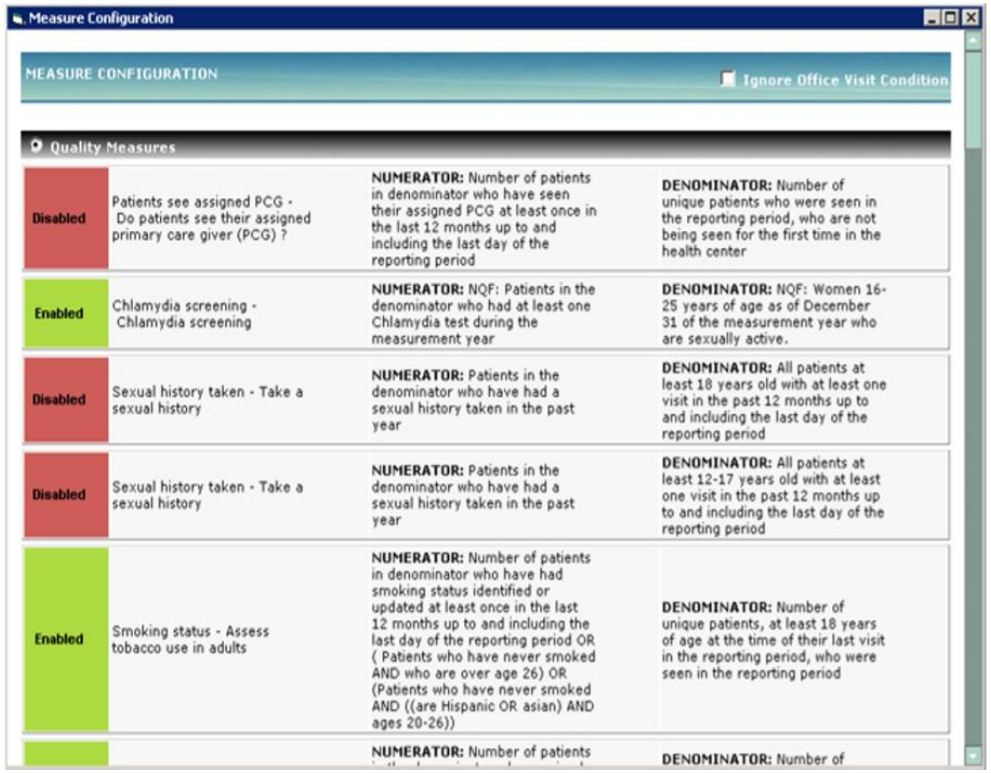
- Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
- Measure: Implement one clinical decision support rule.
- Exclusion: No exclusion.

Clinical Decision Support Rule Attestation Requirements

- YES / NO
- 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.

How To Meet the Measure: Clinical Decision Support Rule





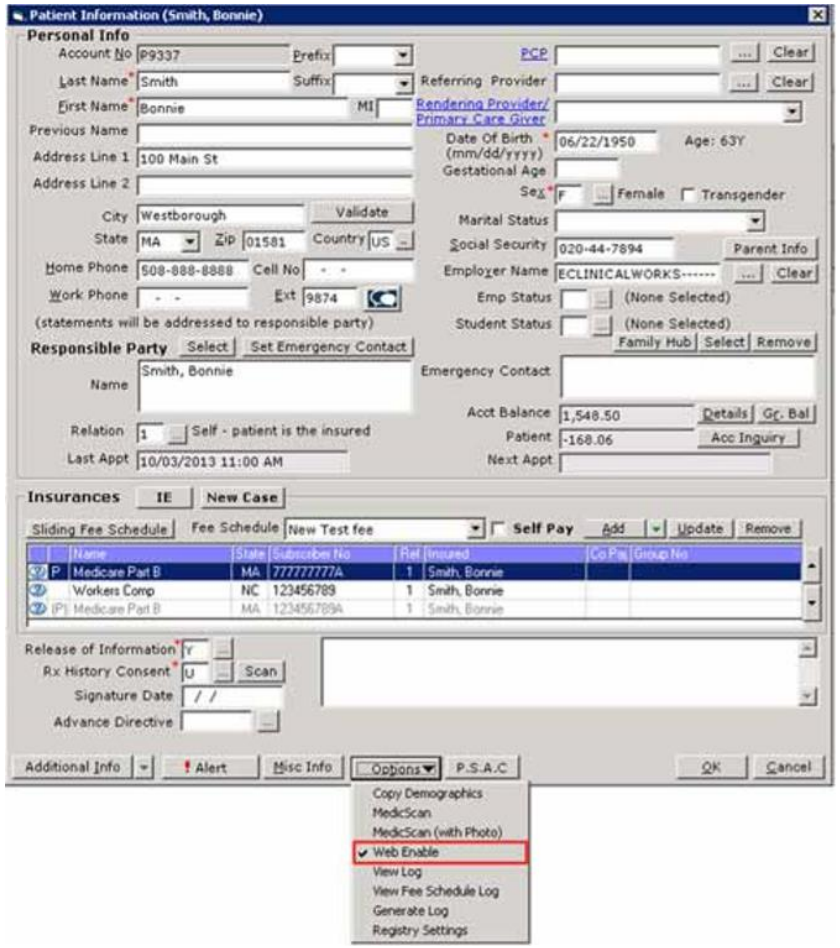
Patient Electronic Access

- Objective: Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.
- Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, and transmit to a third party.
- Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information, may exclude the measure

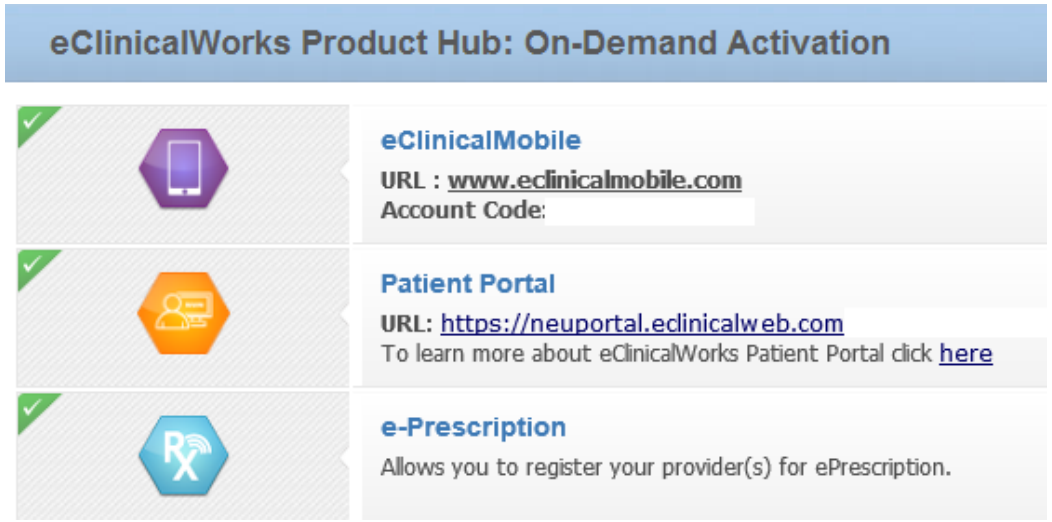
Patient Electronic Access Attestation Requirements

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information to view, download, and transmit to a third party.
- EXCLUSION: Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information."

How To Meet the Measure: Patient Electronic Access



Patient Electronic Access Set-Up



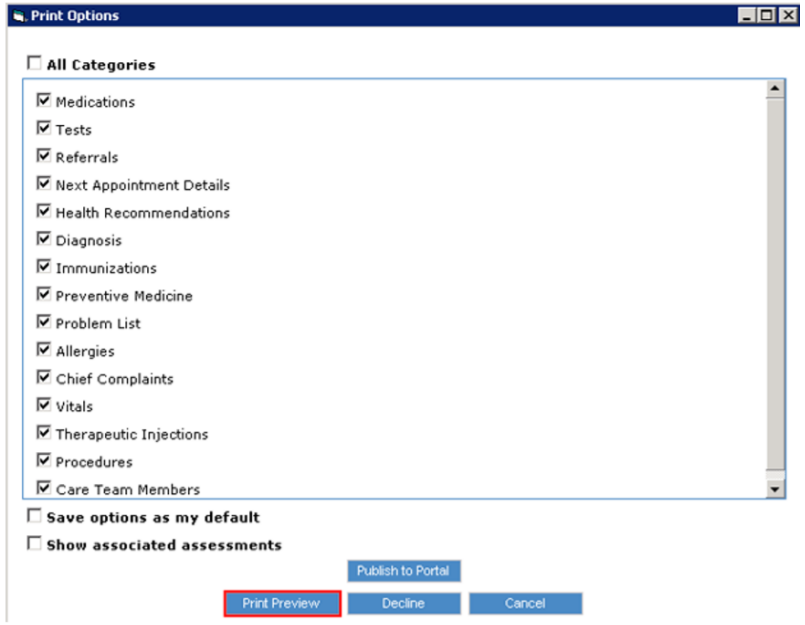
Clinical Summaries

- 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 who has no office visits during the EHR reporting period.

Clinical Summaries Attestation Requirements

- DENOMINATOR: Number of office visits by the EP during the EHR reporting period.
- NUMERATOR: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.
- EXCLUSION: EPs who have no office visits during the EHR reporting period would be excluded from this requirement. EPs must enter ‘0’ in the Exclusion box to attest to exclusion from this requirement.

How To Meet the Measure: Clinical Summaries



Access this feature from one of the following locations:

- Progress Notes > arrow next to Print > Print Visit Summary.
- Practice band > Resource Scheduling icon > right-click on appointment slot > Print Visit Summary.

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.

Protect Electronic Health Information Attestation Requirements

- YES / NO

- 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.

Menu Objectives

Must Meet 5 of the 9 Objectives

1. Drug Formulary Checks
2. Clinical Lab Test Results
3. List of Patients
4. Patient Reminders
5. Patient Education
6. Medication Reconciliation
7. Summary of Care
8. Immunization Registry
9. Syndromic Surveillance Data

Drug Formulary Checks

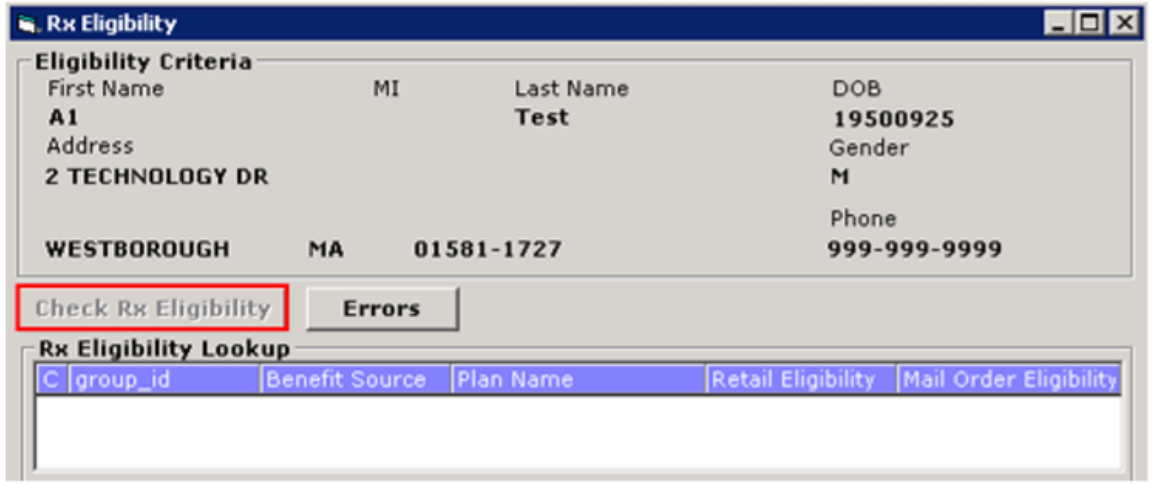
- Objective: Implement drug formulary checks.
- Measure: The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
- Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Drug Formulary Check Attestation Requirements

- YES / NO

- 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.

How to Meet the Measure: Drug Formulary Check



Access this feature from one of the following locations:

- Progress Notes > Treatment > green arrow next to Send Rx > ePrescribe Rx > Rx Eligibility.
- Appointment window > Rx Eligibility > Check Rx Eligibility.
- Progress Note > Treatment > Add > Rx Eligibility > Check Rx Eligibility.
- Telephone/Web Encounter > Rx tab > Rx Eligibility > Check Rx Eligibility.
- eRefill > Rx Eligibility > Check Rx Eligibility.

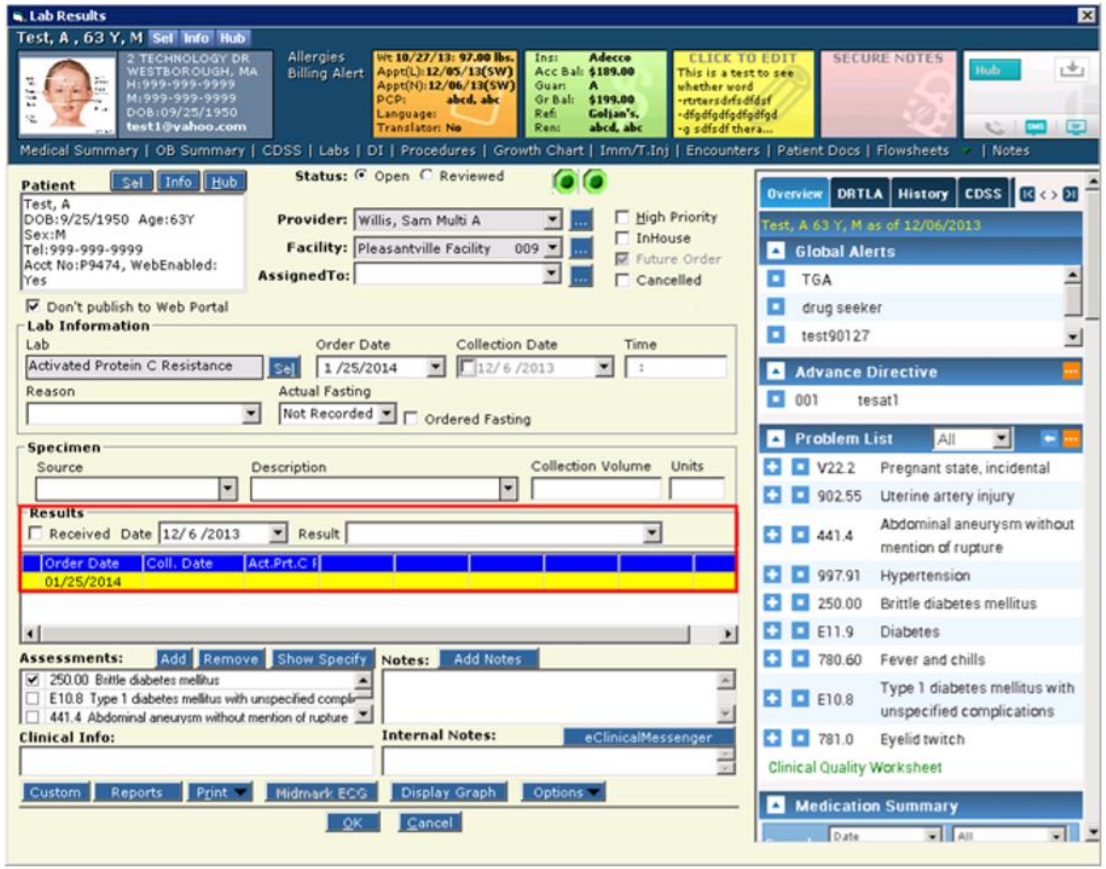
Clinical Lab Test Results

- 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.

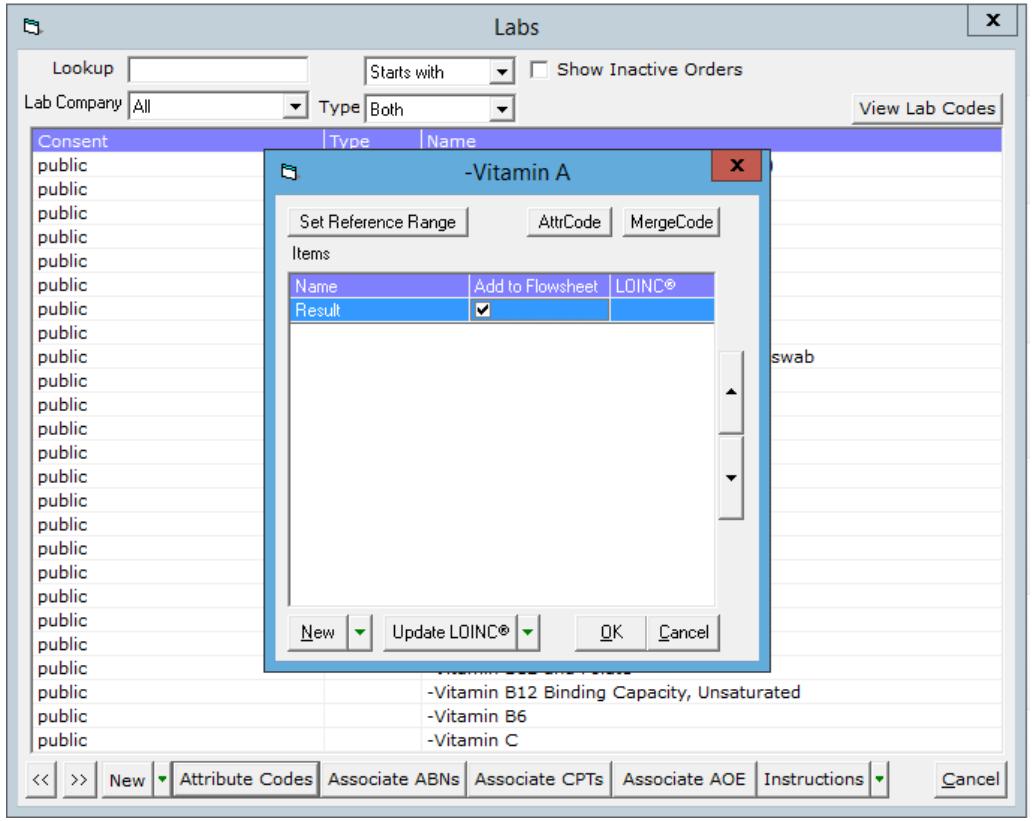
Clinical Lab Test Results Attestation Requirements

- 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: 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.
- EXCLUSION: If an EP orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

How to Meet the Measure: Clinical Lab Test Results



Clinical Lab Test Results Set-Up



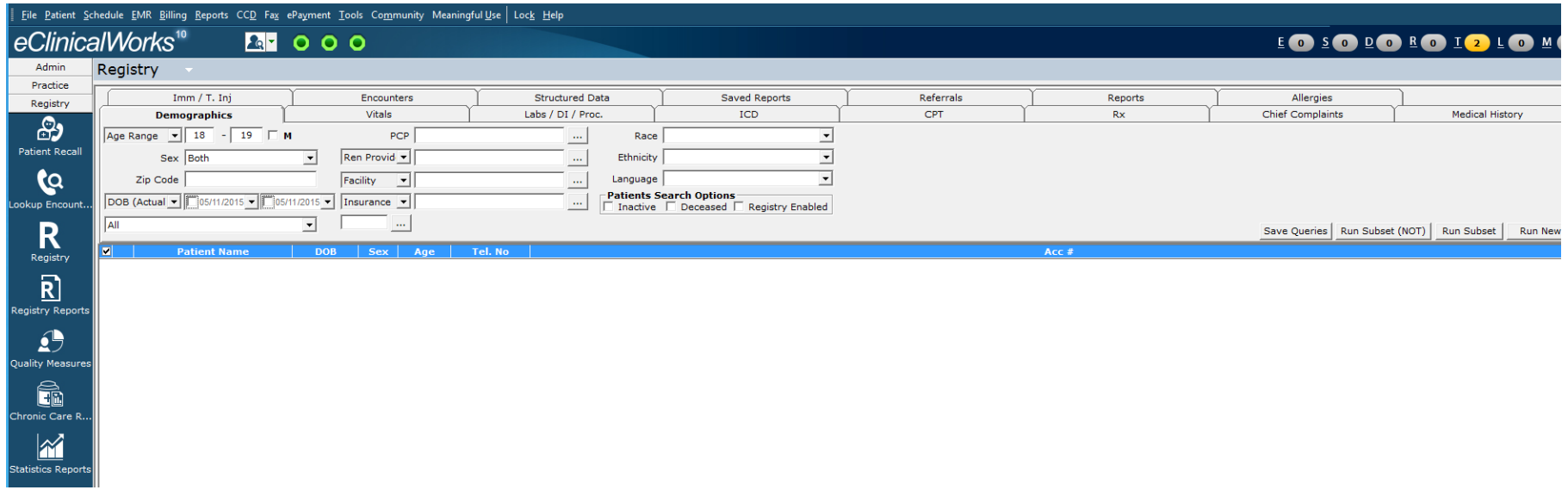
Patient List

- 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.

Patient List Attestation Requirements

- YES / NO
- 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.

Patient List



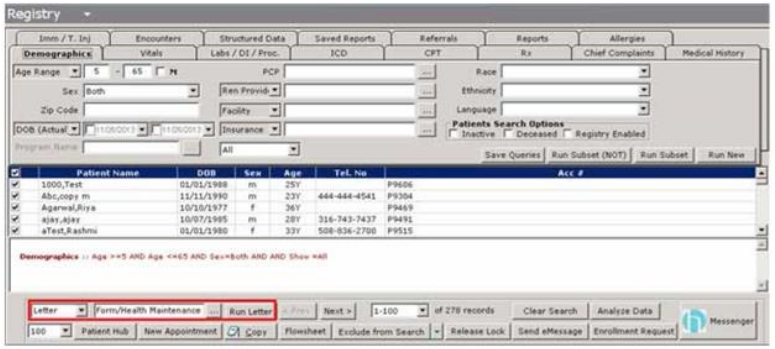
Patient Reminders

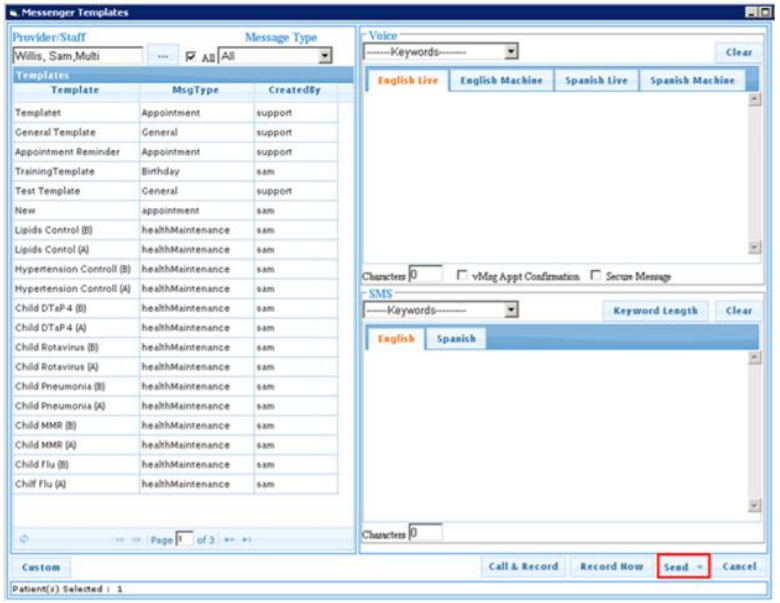
- Objective: Send reminders to patients per patient preference for preventive/follow-up care.
- Measure: More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
- Exclusion: An EP who has no patients 65 years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

Patient Reminders Attestation Requirements

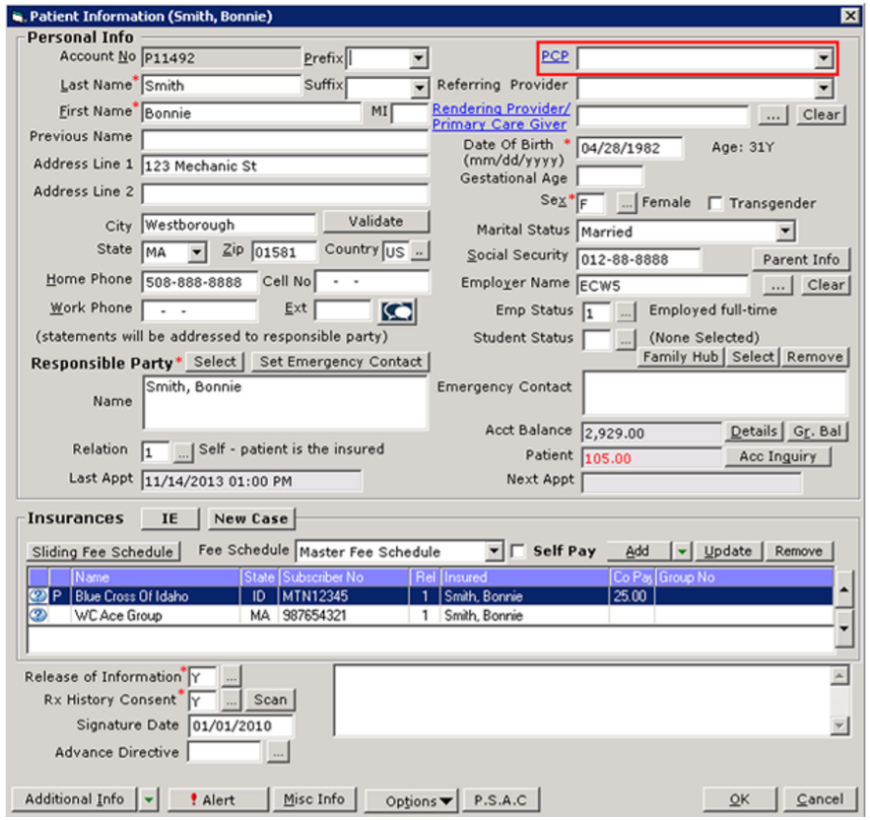
- DENOMINATOR: Number of unique patients 65 years old or older or 5 years older or younger.
- NUMERATOR: Number of patients in the denominator who were sent the appropriate reminder.
- EXCLUSION: If an EP has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

How to Meet the Measure: Patient Reminders





Patient Reminder Set-Up



Patient Education

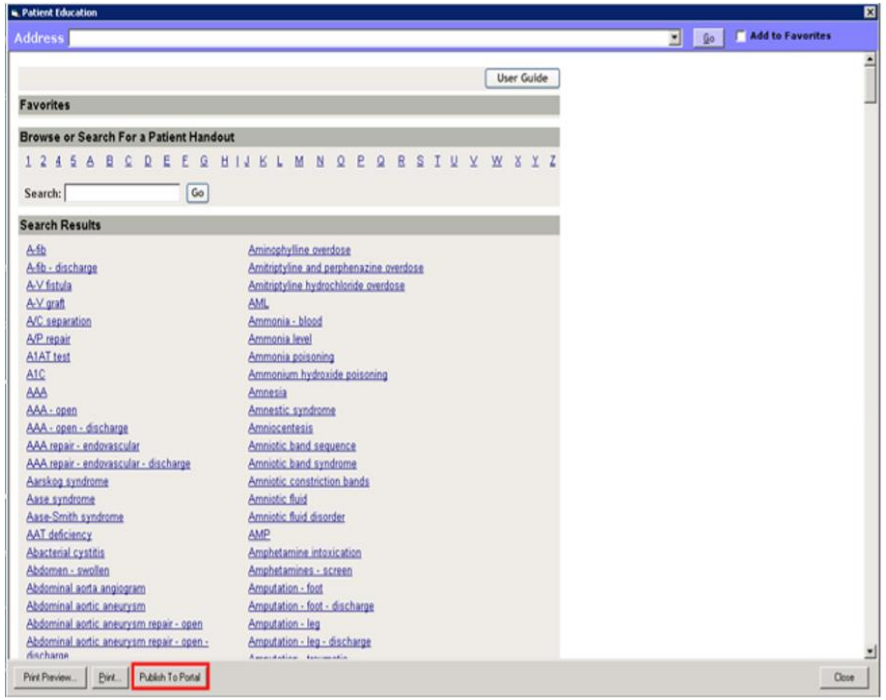
- Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
- Measure: More than 10 percent of all unique patients seen by the EP are provided patient specific education resources.
- Exclusion: No exclusion

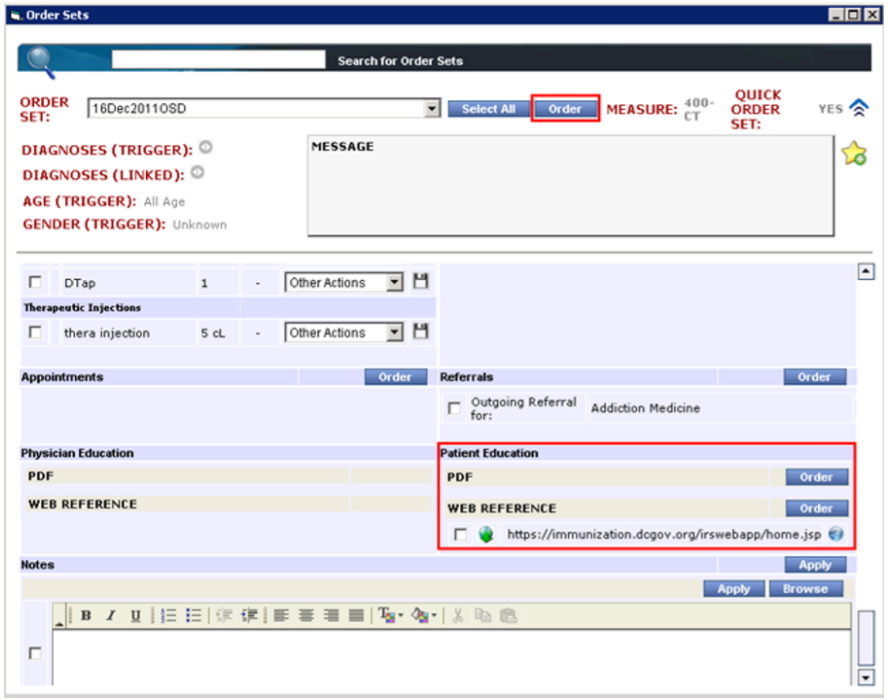
Patient Education Attestation Requirements

- 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-specific education resources

Patient Education





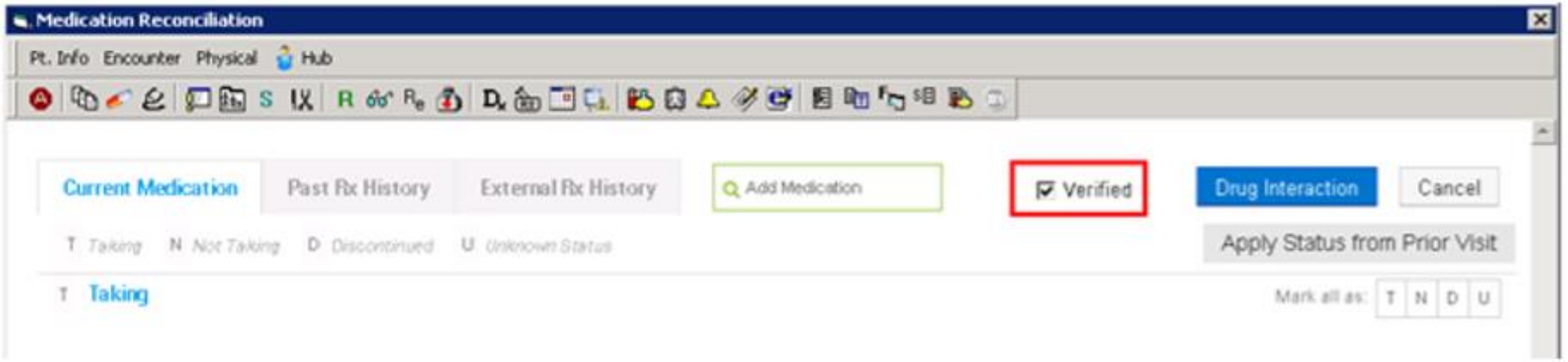
Medication Reconciliation

- 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.

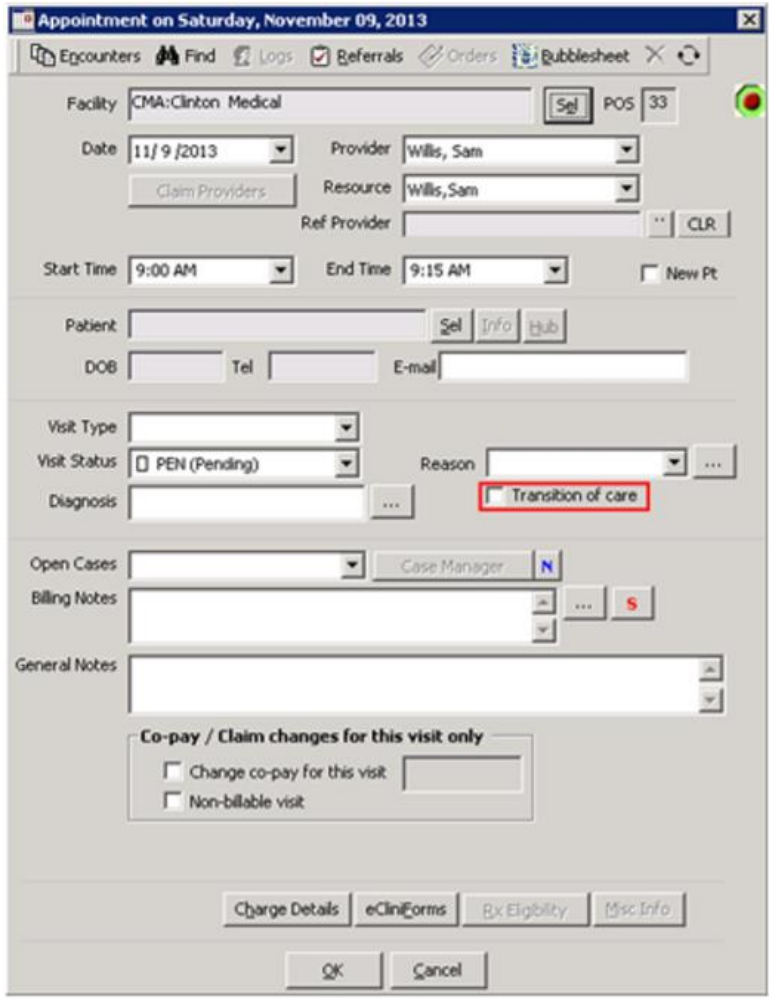
Medication Reconciliation Attestation Requirements

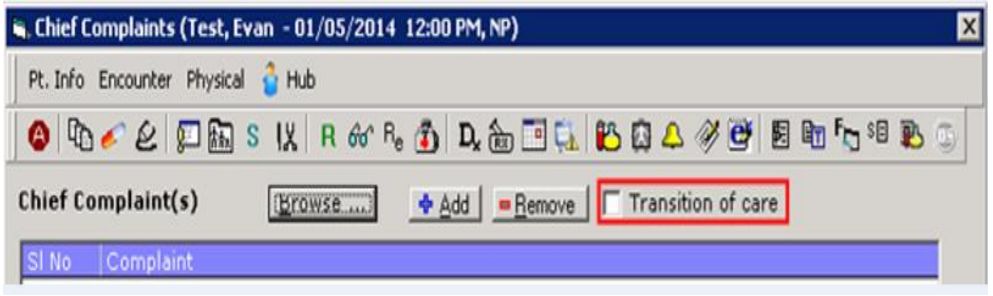
- DENOMINATOR: Number of transactions of care during the EHR reporting period for which the EP was the receiving party of the transition.
- NUMERATOR: Number of transitions of care in the denominator where medication reconciliation was performed.
- EXCLUSION: If an EP was not on the receiving end of any transition of care during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion

How to Meet the Measure: Medication Reconciliation



Medication Reconciliation Set-Up





Summary of Care

- 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.

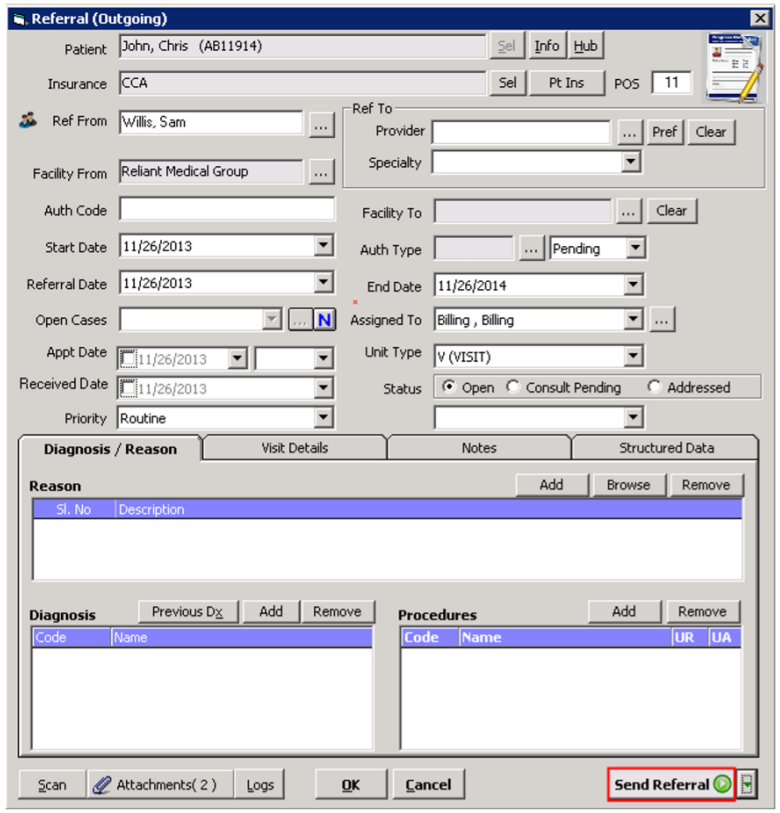
- Measure: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.

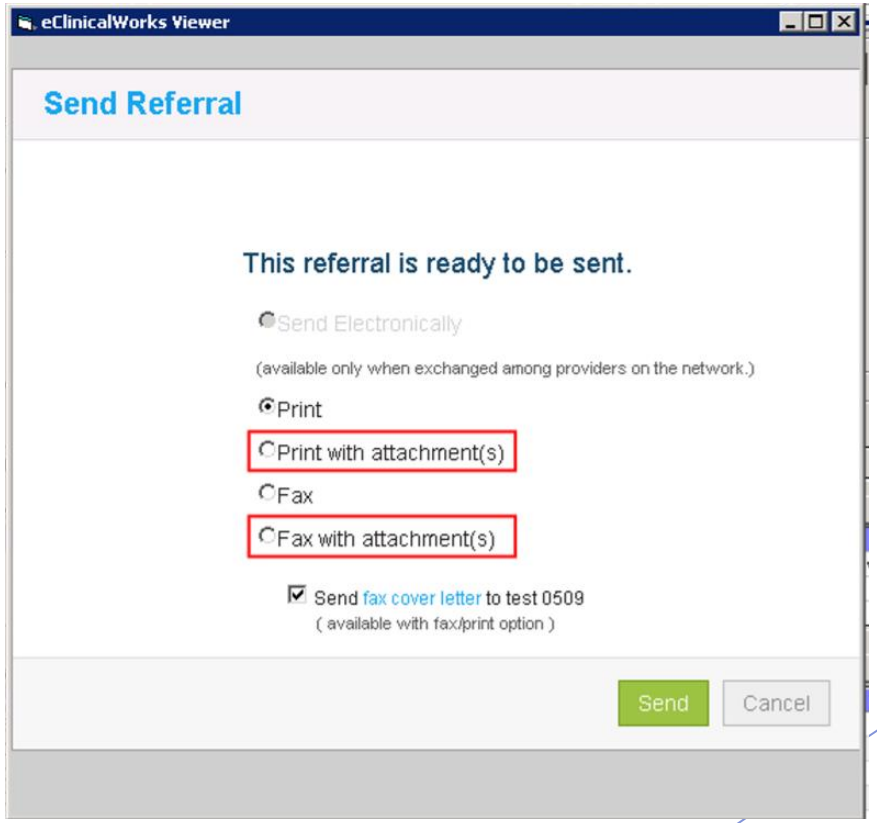
- Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

Summary of Care Attestation Requirements

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.
- EXCLUSION: If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period then they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

How to Meet the Measure: Summary of Care





Immunization Registry

- 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), except where prohibited.
- Exclusion: An EP who administers no immunizations during the EHR reporting period, where no immunization registry has the capacity to receive the information electronically, or where it is prohibited.

Immunization Registry Attestation Requirements

- YES / NO
- 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) except where prohibited, to meet this measure.
- EXCLUSION: If an EP does not perform immunizations during the EHR reporting period, if there is no immunization registry that has the capacity to receive the information electronically, or if it is prohibited, then the EP would be excluded from this requirement. EPs must select NO next to the appropriate exclusion(s), then click the APPLY button in order to attest to the exclusion(s).

Immunization Registry

https://odhgateway.odh.ohio.gov/Impact/Public/EmrEhr.aspx

Immunization Data Transfer

Federal government incentives for Meaningful Use (MU) of an Electronic Health Record (EHR) have sparked interest in exchanging electronic immunization messages with ImpactSIIS.

A medical practice using an EHR can submit immunization data to ImpactSIIS in batch files of HL7 messages for versions 2.3 through 2.5.1. ImpactSIIS is also able to send a patient's immunization history to an EHR with a response to a query sent in HL7 version 2.5.1.

As of January 1, 2014, Ohio's Immunization Registry is now accepting test files for MU Stages 1 and 2 from Hospitals and Eligible Professionals.

Providers who administer immunizations and are interested in sending HL7 test messages to the immunization registry are now able to do so, whether they intend to establish ongoing reporting at this time or not. A practice that administers immunizations may request enrollment with ImpactSIIS. Providers who do not administer immunizations may attest to being excluded from the immunization reporting measure.
While logged in to make the enrollment request, a test file can be submitted there that could fulfill MU Stage 1 requirements and provide feedback about changes that will be required before ongoing reporting can be established. Directions for this process are found here.
EHR vendors and others wishing to test messages without enrolling as providers may still do so using the link at the bottom of this page.

- Policy for ImpactSIIS and Meaningful Use
- Establish an EMR/EHR link to ImpactSIIS
- Documentation for ImpactSIIS Upload
- Registration for HL7 VXU Format Testing Tool
- Meaningful Use Frequently Asked Questions

Syndromic Surveillance Data

- 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) except where prohibited.
- Exclusion: An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or if it is prohibited.

Syndromic Surveillance Data Attestation Requirements

- YES / NO
- 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), except where prohibited, to meet this measure.
- EXCLUSION: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, if no public health agency that has the capacity to receive the information electronically, or if it is prohibited, then the EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

Syndromic Surveillance Data

https://www.odh.ohio.gov/healthstats/HIT/Syndromic%20Surveillance.aspx

Eligible Professionals (EPs) (Effective 1/1/2014)

Meaningful Use (MU) Stage 1: EPs may take an exclusion for the syndromic surveillance menu option.

Meaningful Use (MU) Stage 2: EPs must report all data elements using HL7 2.5.1 on a continued, ongoing basis to meet the Stage 2 public health reporting menu option. Resources are limited; therefore, the Ohio Department of Health (ODH) may not be able to immediately accept syndromic data from all EPs who register their intent. In the situation where an EP is waiting on invitation from ODH to onboard, the EP is able to attest to meeting this public health reporting measure under the following option:

- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.

Registration of Intent

An entity may register the intent of its EPs and EHs to meet MU public health objectives at www.OhioPublicHealthReporting.info

Medicaid Meaningful Use

In addition to all the aforementioned requirements, Medicaid attestation requires the Patient Encounter Report. Since eClinicalWorks can only generate the number of patients seen using the eClinicalWorks application, if any patient was seen using paper chart or at another facility, that number must be manually added to the denominator. If the practice has used the eClinicalWorks application only, the numerator would match the denominator for both of the following reports.

IMPORTANT! These are state-specific requirements. Practices should check with their states for specific Medicaid Meaningful Use requirements.

Patient Encounter Report

50% of All Patient Encounters Occurred at a Facility Using Certified EHR Technology

Use the denominator of the Clinical Visit Summaries (encounter - New MU Spec) to get the numerator of this report.

80% of All Unique Patient Encounters Occurred at a Facility Using Certified EHR Technology

Use the denominator of Record Demographics/Active Medication List/Active Medication Allergy List to get the numerator of this report.