Health Information Technology (HIT) Toolkit for Family Physicians

Summary of Meaningful Use (MU) Objectives for Eligible Professionals

Final Rule Issued for Meaningful Use

On Tuesday, July 13, 2010 the Centers for Medicare and Medicaid Services (CMS) announced the release of the final rule defining how health care providers can demonstrate "meaningful use" of electronic health records (EHRs) to qualify for federal incentive payments under the American Recovery and Reinvestment Act of 2009 (ARRA). This final rule governs what providers must do with their EHRs to be considered meaningful users in 2011 and 2012, the first two years of this multiyear incentive program; subsequent rules will govern later phases.

Family physicians and other health care providers can draw on incentive payments through Medicare (up to $44,000) and Medicaid (up to $63,750) over five years if they meet certain eligibility requirements. ARRA required that providers meet specific "meaningful use" criteria to obtain these incentive payments and called on the Secretary of Health and Human Services to develop and promulgate them.

The final rule requires providers to meet 15 core measures and five additional measures from a "menu" of ten options. Core objectives comprise basic functions that enable EHRs to support improved health care, including the entry of basic data, the use of clinical decision support tools and providing patients with electronic versions of their health information. The menu items include capacities to perform drug formulary checks, incorporate clinical laboratory results into EHRs and provide reminders to patients for needed care.

For most of the core and menu items, the rule also specifies the rates at which providers will have to use particular functions to be considered meaningful users.

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Core Objectives

Objective	Measure
Record patient demographics (sex, race, ethnicity, date of birth, preferred language and, in the case of hospitals, date and preliminary cause of death in the event of mortality)	More than 50 percent of patients' demographic data recorded as structured data
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50 percent of patients two years of age or older have height, weight and blood pressure recorded as structured data
Maintain up-to-date problem list of current and active diagnoses	More than 80 percent of patients have at least one entry recorded as structured data
Maintain active medication list	More than 80 percent of patients have at least one entry recorded as structured data
Maintain active medication allergy list	More than 80 percent of patients have at least one entry recorded as structured data
Record smoking status for patients 13 years of age or older	More than 50 percent of patients 13 years of age or older have smoking status recorded as structured data
For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for more than 50 percent of all office visits within three business days; more than 50 percent of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it
Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	More than 40 percent are transmitted electronically using certified EHR technology
Computer provider order entry (CPOE) for medication orders	More than 30 percent of patients with at least one medication in their medication list have at least one medication ordered through CPOE
Implement drug–drug and drug–allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR's capacity to electronically exchange information
Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary and correct identify security deficiencies
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures

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Menu Set

Objective	Measure
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period
Incorporate clinical laboratory test results into EHRs as structured data	More than 40 percent of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one listing of patients with a specific condition
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10 percent of patients are provided patient-specific education resources
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50 percent of transitions of care
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50 percent of patient transitions or referrals
Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20 percent or patients 65 years of age or older or five years of age or younger are sent appropriate reminders
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10 percent of patients are provided electronic access to information within 4 days of its being updated in the EHR

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