PBSI-EHR – "Stimulus Ready"

HITECH/ARRA "Meaningful Use" Criteria – Final Rule

15 Core Measures - Practice must meet all 15.

Core Measures	Objective	Practice	Measurement Requirements
1 Click link for detail CMS1	**CPOE for medications**	Computerized Provider Order Entry, enter orders for medications.	Done for more than 30% unique patients with at least 1 med in their med list seen by the EP (eligible provider).
2 Click link for detail CMS2	**Drug screening**	Real-time alerts for drug-drug interactions and drug-allergy contraindications.	The EP (eligible provider) has enabled this functionality for the entire EHR reporting period.
3 Click link for detail CMS3	**Maintain problem list of current and active diagnoses**	Enable user to manage problem lists that span multiple visits.	Maintain problem list for more than 80% of unique patients seen by the EP or an indication that no problems are known
4 Click link for detail CMS4	**E-Rx Transmit prescriptions electronically**	Enable e-prescribing.	More than 40% of all permissible prescriptions transmitted electronically using certified EHR technology.
5 Click link for detail CMS5	**Maintain active medication list**	a. Enable user to manage an active medication list. b. Enable user to manage a medication history that spans multiple visits.	Maintain active medication list for more than 80% of unique patients seen by the EP or an indication that no problems are known
6 Click link for detail CMS6	**Maintain active medication allergy list**	a. Enable user to record, modify, & retrieve an active medication allergy list. b. Enable user to manage an allergy history that spans multiple visits	Maintain active allergy list for more than 80% of unique patients seen by the EP or an indication that no problems are known.
7 Click link for detail CMS7	**Record demographics**	Enable user to manage patient demographic data. a. Preferred language b. Gender c. Race d. Ethnicity e. Date of Birth	More than 50% of all unique patients seen by EP have demographics recorded as structured data.
8 Click link for detail CMS8	**Record vital signs**	Record change in vital signs: a. Height b. Weight c. Blood pressure d. Calculated body mass index (BMI) e. Patient growth charts 2-20 years old including BMI	Record vital signs as structured data for more than 50% of unique patients age 2+ seen by EP.
9 Click link for detail CMS9	**Record smoking status for patients 13 and over**	Record smoking status for patients 13 and over	Record smoking status for more than 50% of unique patients age 13+ seen by EP, recorded as structured data

Core Measures	Objective	Practice	Measurement Requirements
10 Click link for detail CMS10	**Report quality measures to CMS or states**	Must select 6 clinical quality measures (3 core & 3 additional) Link to clinical quality measures choices.	Numerator and denominator provided by attestation.
11 Click link for detail CMS11	**Implement one clinical decision support rule, other than drug-drug interactions, drug-allergy contraindications, based on demo-graphic data, diagnosis, conditions, test results, and/or medication list**	a. Real-time alerts based on rules and evidence b. Track number of alerts that were responded to	Document use of one clinical decision support rule.
12 Click link for detail CMS12	**Provide patients with an electronic copy of their information within 4 business days**	a. Test results b. Problem list c. Medication list d. Medication allergy list	Provide an electronic copy of information requested by patients within 48 business hours for at least 50% of patients. The denominator is the number of patients who request the information.
13 Click link for detail CMS13	**Provide a clinical summary for each visit**	a. Diagnostic test results b. Medication list c. Medication allergy list d. Problems	Provide clinical summary for at least 50% of office visits. The denominator is the number of unique patients seen.
14 Click link for detail CMS14	**Exchange clinical information electronically with other providers**	Receive/Send: a. diagnostic test results b. problem list c. medication list d. medication allergy list	Perform at least one test of exchanging key clinical information. Can be done at any time, including prior to the reporting period. Group practices only need to perform one test per EHR.
15 Click link for detail CMS15	**Security Risk Analysis**	a. Assign a unique identifier to users and control access b. Enable emergency access to authorized users c. Enable session timeouts. d. Encrypt per local policy e. Encrypt exchanged data per local policy f. Maintain record-level audit logs g. Verify integrity of health information sent/received h. Verify user identity i. Record disclosures for treatment, payment, and operations	Conduct or review a security risk analysis and implement security updates as necessary.

10 Menu Measures – Practice must choose and meet any 5 of 10 objectives.

(one choice must be either: Submit data to Immunization Registries or submit syndromic surveillance data to public health agencies)

Menu Measures	Objective	Practice	Measurement
1 Click link for detail Menu1	**Drug formulary checks**	Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
2 Click link for detail Menu2	**Lab results**	a. Receive structured results and display in readable format b. Display results containing LOINC codes c. Enable user to change a patient's record based on a lab result	At least 40% of test results whose result can be expressed as positive/negative or as a number are stored in the EHR as structured data. The denominator is the number of lab tests ordered.
3 Click link for detail Menu3	**Generate patient lists based on specific conditions.**	a. Patient demographics b. Medication list c. Specific conditions d. Lab results	Generate at least one report listing patients of the EP who have been diagnosed with a specific condition.
4 Click link for detail Menu4	**Send reminders to patients based on their preferences and selected by specific criteria.**	a. Patient demographics b. Medication list c. Specific conditions d. Lab results	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
5 Click link for detail Menu5	**Provide patients with electronic access to their information within 4 business days.**	a. Lab results b. Problem list c. Medication list d. Medication allergy list	Provide timely electronic access to health information for at least 10% of unique patients. The denominator is the number of patients seen.
6 Click link for detail Menu6	**Identify patient specific education resources**	Provide patient with specific education resources	Generate patient education for more than 10% of all unique patients seen by the EP.
7 Click link for detail Menu7	**Perform medication reconciliation – transfers in**	Compare and merge two or more lists into a single list	Medication reconciliation is performed for at least 50% of relevant encounters and transitions of care. The denominator is the number of relevant encounters and transitions of care.
8 Click link for detail Menu8	**Provide summary of care record**	Summary of care for transferred patients	Provide summary of care record for at least 50% of transitions of care and referrals. Denominator is the number of transitions of care for which the EP was the transferring or referring provider.
9 Click link for detail Menu9	**Submit data to immunization registries**	Record, retrieve, and transmit	Perform at least one test of submitting immunization data. Can be done at any time, including prior to the reporting period. State Medicaid requirements may supersede. Group practices only need to perform one test per EHR. Not required if the immunization registry to which the practice or hospital submits information does not have the capability to receive it electronically.

Menu Measures	Objective	Practice	Measurement
10 Click link for detail Menu10	**Submit syndromic surveillance data to public health agencies**	Record, retrieve, and transmit	Perform at least one test of submitting electronic syndromic surveillance data. Can be done at any time, including prior to the reporting period. State Medicaid requirements may supersede. Group practices only need to perform one test per EHR. Not required if the public health agencies to which the practice or hospital submits information do not have the capability to receive it electronically.

The Notice of Proposed Rule Making (NPRM) details these metrics that a physician will need to report on, in order to qualify as a Meaningful User of Electronic Health Records (EHR), along with the threshold that they would need to meet.