AMERICAN OSTEOPATHIC ASSOCIATION

1090 Vermont Ave., Ste. 510 Washington, D.C. 20005
ph 202.414.0140 | 800.962.9008
fax 202.544.3525 | www.osteopathic.org | do-online.org

ISSUE BRIEF

Meaningful Use Objectives

The purpose of the electronic health records (EHR) incentive program is not so much the adoption of health information technology (HIT), but rather how HIT can further the goals of improving health outcomes. This is the concept of meaningful use.

An eligible physician will be considered a meaningful EHR user if he/she meets three requirements:

- Uses certified EHR technology in a meaningful manner; i.e. computerized physician order entry (CPOE), e-prescribing.
- Participates in electronic exchange of health information to improve quality of care, such as promoting care coordination;
- Submits information on clinical quality measures to CMS (or to a state if a Medicaid program)

The Centers for Medicare and Medicaid Services (CMS) is implementing a phased approach to meaningful use criteria, involving three stages (See chart below). The criteria become more stringent with each stage.

Stage 1 meaningful use criteria focuses on electronically capturing health information in a structured format; using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible); consistent with other provisions of Medicare and Medicaid law, implementing clinical decision support tools to facilitate disease and medication management; using EHRs to engage patients and families; and reporting clinical quality measures and public health information. Stage 1 is the criteria for all payment years until updated by future rulemaking. Physicians whose first payment year is 2011 must satisfy the requirements of the Stage 1 criteria of meaningful use in their first and second payment years (2011 and 2012) to receive the incentive payments.

Stage 2 meaningful use criteria, consistent with other provisions of Medicare and Medicaid law, expand upon the Stage 1 criteria to encourage the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using computerized provider order entry (CPOE) and the electronic transmission of diagnostic test results (such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests and other such data needed to diagnose and treat disease).

Stage 3 meaningful use criteria are, consistent with other provisions of Medicare and Medicaid law, to focus on promoting improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data and improving population health.

First Payment Year	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD

Please note that the number of payment years available and the last payment year that can be the first payment year for an eligible professional or hospital varies between the EHR incentive programs.

CMS eliminated the “all or nothing criteria” in which eligible professionals were expected to meet 25 objectives. The AOA, along with several physician associations, urged CMS in comments to scale back the criteria because the all or nothing approach would be too difficult to achieve particularly for small practices. For Stage 1, the final rule divides the objectives into a “core” group of 15 required objectives and a “menu set” of 10 procedures from which physicians can choose five and defer the rest. According to CMS, the “two track” approach ensures that the most basic elements of meaningful EHR use will be met by all providers qualifying for incentive payments, while at the same time allowing latitude in other areas to reflect providers’ varying needs and their individual paths to full EHR use.

An EP may exclude a particular objective if the EP meets all of the following requirements:
(A) Must ensure that the objective includes an option for the EP to attest that the objective is not applicable; (B) Meets the criteria in the applicable objective that would permit the attestation; and (C) Attests. An exclusion will reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply. For example, an EP that has an exclusion from one of the objectives must meet four (and not five) objectives of the EP’s choice from the menu set to meet the definition of a meaningful EHR user.

Core Criteria

[1] **Objective:** Use 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: CPOE is used for more than 30% of all unique patients with at least one medication in their medication list seen by the Eligible Professional (EP) have at least one medication order entered using CPOE. (Exclusion: Any EP who writes fewer than 100 prescriptions during the E HR reporting period)

[2] **Objective:** Implement drug-drug and drug-allergy interaction checks.
Measure: The EP has enabled this functionality for the entire E HR reporting period.

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

[4] **Objective:** Generate and transmit permissible prescriptions electronically (eRx).
Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

[5] **Objective:** Maintain active medication list.
Measure: More than 80% 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.

[6] **Objective:** Maintain active medication allergy list.
Measure: More than 80% 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.

[7] **Objective:** Record the following demographics: preferred language, gender, race, ethnicity, date of birth.
Measure: More than 50% of all unique patients seen by the EP have demographics recorded as structured data.

[8] **Objective:** Record and chart changes in vital signs: height, weight, blood pressure, calculate and display body mass, plot and display growth charts for children 2-20 years, including BMI.
Measure: For more than 50% of all unique patients age 2 and over seen by the EP, height, weight, blood pressure are recorded as structured data. (**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 have not relevance to their scope of practice.)

[9] **Objective:** Record smoking status for patients 13 years old or older.
Measure: More than 50% 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)

[10] **Objective:** Report ambulatory quality measures to CMS or the states.
Measure: Successfully report to CMS (or States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or States).

[11] **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.

[12] **Objective:** Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request.
Measure: More than 50% of all patients who request an electronic copy of their health information are provided it within three business days. (**Exclusion:** Any EP that has no requests from patients or their agents for an electronic copy of the patient health information during the E HR reporting period.)

[13] **Objective:** Provide clinical summaries to patients for each office visit.
Measure: Clinical summaries provided to patients for more than 50% of all office visits within three business days. (**Exclusion:** Any EP who has no office visits during the E HR reporting period)

[14] **Objective:** Capability to exchange key clinical information (for example, problem list, medication list, allergies and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

[15] **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.

Menu Set Criteria

An EP must meet five of the following objectives and associated measures, one of which must be either (9) or (10), except that the required number of objectives and associated measures is reduced by an EP's exclusions specified in this section:

[1] **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.

[2] **Objective:** Incorporate clinical lab-test results into EHR as structured data.

Measure: More than 40 percent of all clinical lab tests 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 E HR 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.

[3] **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.

[4] **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 E HR technology.

[5] **Objective:** Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
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 E HR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. (**Exclusion:** Any EP that neither orders nor creates any of the information listed during the EHR reporting period.)

[6] **Objective:** Use certified E HR 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.

[7] **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 E HR reporting period.)

[8] **Objective:** The EP who transitions his/her patient to another setting of care or provider of care or refers his/her 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 his/her 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 E HR reporting period.)

[9] **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). (**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.)

[10] **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). (**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.