Meaningful use glossary and requirements table

2011–2012

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Meaningful use glossary

The following spreadsheet describes the requirements an eligible professional (EP) must meet to qualify for electronic health record (EHR) incentives under Medicare and Medicaid. For 2011–2012 (Stage 1), EPs must meet all 15 core requirements and select five activities from the menu set of 10.

1. **Eligible professional (EP):** Medicare eligible professionals include doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors. Specialists are eligible if they meet one of the aforementioned criteria. EPs may not be hospital-based.

   Medicaid eligible professionals include: physicians, nurse practitioners, certified nurse-midwives, dentists, physician assistants working in a federally qualified health center (FQHC) or rural health clinic (RHC) that is so led by a physician assistant. EPs may not be hospital-based.

2. **Complete EHR:** "A complete EHR or a combination of EHR modules, each of which: (1) meets the requirements included in the definition of a qualified EHR; and (2) has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary."

3. **EHR module:** Any service, component, or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary. While the use of EHR modules may enable an eligible professional or eligible hospital to create a combination of products and services that, taken together, meets the definition of "Certified EHR Technology," this approach carries with it a responsibility on the part of the eligible professional or eligible hospital to perform additional diligence to ensure that the certified EHR modules selected are capable of working together to support the achievement of meaningful use.

4. **Unique patient:** Refers to a Medicare or Medicaid patient seen during the EHR reporting period. The term unique was added to clarify that a patient may only be counted once for reporting purposes, even if they make multiple visits during the EHR reporting period.

5. **Exclusion:** An EP may exclude particular meaningful use objectives during the reporting period 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.

6. **Data capture:** Refers to entering a specific data element into the specified health information technology application versus the paper chart.

7. **Structured data (SD):** Data that resides in fixed fields within a record or file. Structured templates, drop-down lists, radio buttons and check boxes are common ways to capture structured data. Structured data is not fully dependent on an established standard. Established standards facilitate the exchange of the information across providers by ensuring data is structured in the same way. However, structured data within certified EHR technology merely requires the system to be able to identify the data as providing specific information. For example, if a patient is taking aspirin, the system should automatically identify it as a medication and not as an order, note, or anything else. An example of unstructured data would be the word aspirin, but no ability of the system to identify it as a medication.

8. **Positive indication:** Most objectives require structured data entry. Therefore, EPs must complete a structured data entry in a discrete field for each objective for each patient. When the objective is not applicable to the patient, EPs must still enter an indication that can be tracked and reported, i.e., NKA (No known allergy) or NKP (No known problem). EPs should discuss indication options with EHR vendors.

9. **Continuity of Care Record (CCR):** A core data set of the most relevant facts about a patient's health care. The CCR provides information that is: (1) appropriate, succinct, organized and up-to-date; (2) interoperable through use of specified XML code; and (3) a necessary bridge to a different environment, often with new practitioners who know little about the patient. A physician or other eligible professional prepares the CCR at the conclusion of a health care encounter and to enable the next practitioner to readily access such information. It may be prepared, displayed and transmitted on paper or electronically.

10. **Continuity of Care Document (CCD):** An XML-based markup standard intended to specify the encoding, structure and semantics of a patient summary clinical document for exchange. It provides a means for one health care practitioner, system, or setting to aggregate all of the pertinent data about a patient and forward it to another practitioner, system or setting to support the continuity of care. Its primary use case is to provide a snapshot in time containing the pertinent clinical, demographic and administrative data for a specific patient.The CCD specification is a constraint on the HL7 Clinical Document Architecture (CDA) standard, a summary record of care as originally defined by ASTM as CCR and then jointly developed by ASTM and HL7 as CCD. The CDA specifies that the content of the document consists of a mandatory textual part (which ensures human interpretation of the document contents) and optional structured parts (for software processing). The structured part is based on the HL7 Reference Information Model (RIM) and provides a framework for referring to concepts from coding systems such as from SNOMED and LOINC.

Stage 1: Meaningful use requirements table 2011–2012

Note the key at the bottom of the page. The background color used for each objective indicates how an eligible professional should report the measure.

	Objective *(what an EP and/or staff must do with the EHR)*	**Measure** *(frequency of data capture or action)*	**Structured data to capture** *(unless otherwise indicated)*	**Suggested certified technology** *(EP could use to complete objective)*	**Suggested work flow step** *(when to capture the data/complete the task in a typical practice process)*	**Work performed by** *(who typically captures data/ completes the task)*
	Core set					
1	**Record patient demographics**	More than 50% of unique patients have demographics recorded as structured data* **Exclusion:** None.	• Preferred language • Gender • Race • Ethnicity (*Hispanic or Latino; Not Hispanic or Latino*) • Date of birth	Practice management software (PMS) module or integrated PMS/EHR Verify: •That you can electronically record, modify and retrieve patient demographic information • That the fields are discrete, i.e., not entered in an open text box • That you integrate your PMS (or other certified technology where you capture demographic information) to avoid duplicate entry	Demographics captured and entered into (PMS) during patient visit check-in at front office When data exists in paper form, demographics must be entered into EHR technology; data may be entered during pre-system go-live or upon patients' first visit using EHR	Front office staff, clerical staff or potentially temporary staff, when preparing to roll-out PMS/EHR technology
2	**Record and chart changes in vital signs**	More than 50% of unique patients age 2 and over; have height, weight and blood pressure recorded as structured data **Exclusion:** Any EP who either sees 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 during the EHR reporting period qualifies for an exclusion from this objective/measure.	• Height (may be self-reported) • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2–20 years, including BMI	EHR Verify: • That you can electronically record, modify and retrieve patient vital signs. • Use of discrete fields for height/weight to enable tracking/charting • That your system calculates BMI and can display pediatric growth charts (if applicable)	Vital signs captured and entered in EHR (formerly captured through paper flow sheet) during patient visit EHR technology should calculate and generate BMI and growth charts **Note:** EP could also accept transfer of the information electronically or otherwise from another provider or entered directly by the patient through a portal or other means. Therefore, any EP that sees/admits the patient and has access to height, weight and blood pressure information on the patient can put that patient in the numerator.	Nurses, medical assistant
3	**Maintain active medication allergy list**	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 **Exclusion:** None.	1+ allergy or an indication of no allergies for each patient	ePrescribing module or ePrescribing within EHR: Verify: • That you can electronically record, modify and retrieve a patient's active medication allergy list • That the allergy fields are discrete, i.e., not entered in notes, problem list or other free text box	Allergies captured in EHR during patient visit When data exists in paper form, allergies must be entered into EHR technology. Data may be entered during pre-system go-live or upon patients' first visit using EHR.	Physician, physician assistant, nurses, medical assistant (physician to verify allergy versus intolerance. Advise on whether recording intolerances is the same, amounts, etc.)

REPORTING METHOD:

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- Attestation.
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4	**Maintain an up-to-date problem list of current and active diagnoses**	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 **Exclusion:** None.	1+ problem, active diagnosis or indication (i.e., "none") of no known problem for each patient	Practice management software module or EHR Verify: • That the problem list fields are based on ICD or SNOMED and discrete, i.e., not entered as notes or free form text • How to set up a query to search for/report on problems/active diagnoses	Problems/active diagnoses captured during patient visit When data exists in paper form, problems must be entered into EHR technology. Data may be entered during pre-system go-live or upon patients' first visit using EHR.	Physician (or eligible professional)
5	**Maintain active medication list**	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 medications) recorded as structured data **Exclusion:** None.	1+ medication or an indication (i.e., "None") that the patient is not currently prescribed any medication	ePrescribing module or ePrescribing component of an EHR. Certified ePrescribing modules and the prescribing component of complete EHRs will generate a medication list. Verify: • That you can electronically record, modify and retrieve a patient's active medication list as well as medication history (system shows modifications to previous medications) for longitudinal care • That the medication list is a discrete field, i.e., not included in notes or free form text, to ensure search/reporting capability • That your ePrescribing system is integrated with your EHR if using a standalone ePrescribing system to avoid duplicate entry and to ensure accurate threshold calculations	Medications captured during patient visit When data exists in paper form, medications must be entered into certified EHR technology; medications may be entered during pre-system go-live or upon patients' first visit using EHR	Nurse, medical assistant
6	**Use computerized physician order entry (CPOE) for medication orders**	More than 30% of all unique patients seen by the EP with at least one medication in list must have one medication order entered using CPOE **Exclusion:** EP who writes <100 prescriptions during EHR reporting period. **Note:** CPOE is a separate requirement from the electronic transmission of prescriptions.	1+ medication order	Medication orders are typically captured using an ePrescribing system or by using the ePrescribing component of an EHR. Hospital-based eligible professionals will use either an EHR or CPOE system. Verify: • That you can electronically record, modify retrieve and manage medication orders • That your ePrescribing system is integrated with your EHR, if currently using a standalone ePrescribing system	Medication order entered during patient visit	Physician (or eligible professional); any licensed healthcare professional within the state

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7	**Generate and transmit electronic prescriptions for non-controlled substances**	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology **Exclusion:** Any EP who writes <100 prescriptions during the EHR reporting period.		ePrescribing or EHR. Medication orders are transmitted using an ePrescribing system or by using an ePrescribing component in an EHR. Hospital-based eligible professionals will use either an EHR or CPOE system. Verify: • That you can generate and transmit electronic prescriptions through a seamless integration with Surescripts for subscribed retail and mail order pharmacies • That your ePrescribing system is integrated with your EHR, if you were using a standalone ePrescribing system	1. Medication order transmitted during patient visit 2. Telephone encounter 3. E-visit 4. Portal message 5. Pharmacy renewal request	Physician (or eligible professional); can be delegated to staff acting on behalf of EP
8	**Implement drug-drug/drug-allergy interaction checks**	Functionality enabled (entire reporting period) **Exclusion:** None.		ePrescribing module or ePrescribing component of an EHR Verify: • That you have real-time medication interaction screening that runs when prescribing medications	At point of care during prescription process	System
9	**Record adult smoking status**	More than 50% of all unique patients 13 years or older seen by the EP have "smoking status" recorded **Exclusion:** Any EP who sees no patients 13 years or older during the EHR reporting period.		EHR Verify: • That you have the ability to electronically record, modify and retrieve patient smoking status	During patient visit	Nurse, medical assistant

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10	**Provide clinical summaries for patients for each office visit**	More than 50% of patients receive clinical summary within three business days after office visit **Exclusion:** Any EP who has no office visits during the EHR reporting period An office visit is defined as any billable visit that includes: (1) concurrent care or transfer of care visits, (2) consultant visits and (3) prolonged physician service without direct (face-to-face) patient contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. **Note:** EP could choose any of the listed means: PHR, patient portal on a website, secure e-mail, electronic media such as CD or USB fob, or printed copy. EP who chooses an electronic media is also required to provide the patient a paper copy upon request. Both forms should be produced by certified EHR technology.	• Problem list • Medication list • Allergies • Diagnostic test results **Note:** Information shared in format referred to as continuity of care record or CCR or continuity of care document or CCD.	EHR Verify: • That you can electronically generate a clinical summary or a continuity of care document (CCD) and transmit to patients in one of the formats listed to the left under Note in the "Measure" column	Post-patient visit	Physician captures relevant information. Nurse, MA can pull report. Front/back office staff may distribute.
11	**On request, provide patients with an electronic copy of their health information**	More than 50% of requesting patients receive electronic copy within three business days **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 qualifies for an exclusion from this objective/measure. **Note:** Includes diagnostic test results, problem list, medication lists, allergies. Electronic copy must be in an electronic form—patient portal, PHR, CD, USB, PDF via e-mail per patient preference, etc.		EHR Verify: • That you can electronically generate either the patient's choice of a full chart summary or a continuity of care document (CCD) or continuity of care record (CCR) and transmit in one of the formats listed under Note in the "Measure" column	Post-patient visit	System enables report of CCR/CCD created by information captured by physician (eligible professional)

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12	**Implement capability to electronically exchange clinical information among care providers and patient authorized entities**	Perform at least one test to electronically exchange key clinical information **Note:** Use of test information about a fictional patient identical in form to what would be sent about an actual patient would satisfy this objective.	• Problem list • Medication list • Allergies • Diagnostic test results **Note:** Information exchanged in format referred to as continuity of care record or CCR or continuity of care document or CCD.	EHR, Clinical Messaging module Verify: • That you can electronically generate and transmit a patient's CCR/CCD to another provider/entity in care continuum	EHR/entity point-to-point interfaces, clinical messaging capability, or connection to health information exchange (HIE)	System enables report of CCR/CCD created by information captured by physician (eligible professional)
13	**Implement one clinical decision support rule relevant to specialty or high clinical priority with the ability to track compliance to that rule**	One CDS rule implemented		EHR, clinical decision support module Verify: • That you have access to real-time clinical decision support (CDS) via CDS rules that are imbedded in your system. CDS rules will likely be organized into categories such as health maintenance and disease management. Examples of health maintenance rules include adult/pediatric immunization schedules, colorectal and cervical cancer screenings. Disease management may include diabetes management and cholesterol management schedules.	Pre-purchase/implementation decision	Physician (eligible professional)
14	**Implement systems to protect privacy and security of patient data in EHR**	Conduct or review security risk analysis, implement security updates as necessary, and correct identified security deficiencies **Note:** Testing can occur prior to the beginning of reporting period. A security update could be updated software for certified EHR technology to be implemented as soon as available, changes in workflow processes, or storage methods or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis.		All certified technology used Verify: • That technology used meets or exceeds HIPAA standards and compliance • That vendor conducts regular security, privacy risk analysis assessments of the technology (applications/infrastructure) itself • Physicians and other staff handling protected health information (PHI) understand HIPAA privacy and security requirements (visit www.ama-assn.org/go/hipaa for more information)	During system implementation and periodically thereafter according to practice's plan	Front/back office staff

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15	**Report clinical quality measures to CMS (for Medicare) or states (for Medicaid)**	2011: Provide aggregate numerator and denominator through attestation 2012: Electronically submit measures	Varies depending on clinical quality measure	Verify: • That you are using/reporting the three core clinical quality measures: (1) Hypertension: blood pressure measurement (NQF 0013); (2) Preventative care and screening pair: tobacco use assessment (NQF 0028a) and tobacco cessation intervention (NQF 0028b); and (3) Adult weight and screening and follow-up (NQF 0421) Or, that you are substituting from the three alternate core measures to comprise the three core measures, if necessary: (1) Preventive care and screening: Influenza (NQF 0041); (2) Immunization for patients ≥ 50 years old, weight assessment and counseling for children and adolescents (NQF 0024); and (3) Childhood immunization status (NQF 0038) • That you are using/reporting three additional clinical quality measures (from a list of 38) that are clinically relevant to your specialty • That if, after reviewing the specifications for the additional 38 measures, you find that fewer than three measures apply to your practice, your EHR demonstrates that the measures do not apply to your practice by showing zero patients in the denominator for all measures	Internal system calculation (of core and selected clinical quality measures) and on demand reporting	2011: Physician (eligible professional) or staff/practice manager 2012: System

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	Menu set					
1	**Implement drug formulary checks**	Drug formulary check system enabled and access to one or more internal or external drug formulary (entire reporting period) **Exclusion:** None.	Not applicable	ePrescribing module or complete EHR	Internal system process at point of care	System
2	**Incorporate clinical lab test results in EHR**	More than 40% of numerical or positive/negative results incorporated in EHR technology (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.	lab results	EHR	EHR/entity point-to-point interfaces, clinical messaging capability, or connection through HIE	System
3	**Generate patient lists by specific conditions to use for quality improvement, reduction of disparities, research or outreach**	Generate at least one report listing patients of the EP with a specific condition **Exclusion:** None.	Not applicable	EHR or patient registry module	System on demand reporting	System
4	**Use EHR technology to identify patient-specific education resources and provide to patients, if appropriate**	More than 10% of all unique patients seen by the EP are provided patient-specific education resources **Exclusion:** None.	Not applicable	EHR, patient portals, clinical reference module	Post-patient visit	System
5	**Perform medication reconciliation between care settings**	Medication reconciliation performed for more than 50% of transitions of care **Exclusion:** An EP who was not the recipient of any transitions of care during the EHR reporting period.	Not applicable	ePrescribing module, patient registry module, EHR/entity point-to-point interfaces, clinical messaging capability, or connection through HIE	During patient visit, system enables online comparison of two medication lists (the one included in patient's current EHR and an external list)	Physician, physician assistant, nurse, medical assistant
6	**Provide summary of care for patients referred or transitioned to another provider or setting**	Summary of care record for is provided for more than 50% of patient transitions or referrals **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.	Not applicable	EHR/entity point-to-point interfaces, patient registry module, clinical messaging capability, or connection through HIE	Post-patient visit	Front/back office staff

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7	**Submit electronic immunization data to immunization registries or immunization information systems**	Perform 1 or more test of data submission and follow-up submission (if the test is successful), unless no immunization registry to which the EP submits have the capacity to receive 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 qualifies for an exclusion from this objective/measure. **Note:** The use of test information about a fictional patient identical in form to what would be sent about an actual patient would satisfy this objective.	Not applicable	EHR or patient registry module	EHR/registry point-to-point interface, or connection through HIE	System
8	**Submit electronic syndromic surveillance data to public health agencies**	Perform one or more test of data submission and follow-up submission (if the test is successful), unless no public health agency to which an EP submits such information have the capacity to receive 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. **Note:** The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.	Not applicable	EHR or patient registry module	EHR/registry point-to-point interface, or connection through HIE	System
9	**Send reminders to patients (per patient preference) for preventitive and follow-up care**	More than 20% of patients 65 years old or older or 5 years old or younger are sent appropriate reminders **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 qualifies for an exclusion from this objective/measure	Not applicable	PMS module, patient communication tools, clinical messaging module	Pre-patient visit	Front/back office staff, system

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10	**Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)**	More than 10% of patients are provided timely electronic access within four business days of its being updated in EHR **Exclusion:** Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) (e.g., lab test results, problem list, medication list, medication allergy list) during the EHR reporting period qualifies for an exclusion from this objective/measure. **Note:** Subject to the EP's discretion to withhold certain information. CCR/CCD must be certified, but a printed copy in human readable format is acceptible for meaningful use upon patient request.	• Problem list • Medication list • Allergies • Diagnostic test results **Note:** Information exchanged in format referred to as continuity of care record or CCR or continuity of care document or CCD.	EHR, patient portals, clinical messaging module, USB	Post-patient visit	System or manual release

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Meaningful use exclusions

Core	Exclusions *(Applies to reporting period. Ninety (90) continuous days in year one and a full calendar year each subsequent year.)*
Demographics	None
Vital signs/chart changes	EP who sees no patients 2 years of age or older, or who believes all three vital signs of height, weight and blood pressure have no relevance to scope of practice
Problem list/active diagnoses	None
Medication list	None
Allergy list	None
Computerized physician order entry (CPOE)	EP who writes <100 prescriptions
Electronic prescriptions	EP who writes <100 prescriptions
Drug-drug/drug-allergy interaction checks	None
Adult smoking status	EP who sees no patients 13 years of age or older
Clinical summaries	EP has no office visits
Electronic copy of health information	EP has no patient requests
Exchange electronic clinical information	None
Clinical decision support rule	None
Data privacy and security	None
Clinical quality measures	None

Menu	Exclusions *(Applies to reporting period. Ninety (90) continuous days in year one and a full calendar year each subsequent year.)*
Drug formulary checks	None
Clinical lab test results	EP orders no lab tests with results in positive/negative or numeric format
Patient lists by condition	None
Patient-specific education resources	None
Medication reconciliation	EP was not recipient of any transitions of care
Summary of care for transferred patients	EP neither transfers a patient to another setting nor refers a patient
Electronic immunization data	EP who administers no immunizations or where no immunization registry can receive electronic information
Electronic epidemiology data	EP who does not collect reportable syndromic information on patients
Patient care reminders	EP has no patients age 65+ or <five years with records maintained in EHR
Provide electronic access to health information	EP neither orders nor creates any lab test results, problem list, medication list, medication allergy list