



Eligible Professional Meaningful Use Menu Set Measures Measure 1 of 10

Stage 1

Date issued: November 7, 2010

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.

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Definition of Terms

None

Attestation Requirements

YES / NO / EXCLUSION

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.

An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this objective and associated measure. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

Additional Information

- At a minimum an EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.



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Stage 1

Date issued: November 7, 2010

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.

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- Definition of Terms
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- Additional Information

Definition of Terms

None

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- **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.

The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to to labs ordered for those patients whose records are maintained using certified EHR technology.
- Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
- Lab results are not limited to any specific type of laboratory or to any specific type of lab test.
- The Medicare and Medicaid EHR Incentive Programs do not specify the use of code set standards in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory, for the entry of structured data for this measure and made this a requirement for EHR technology to be certified.





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Stage 1

Date issued: November 7, 2010

Patient Lists	
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.

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Definition of Terms

Specific Conditions -- Those conditions listed in the active patient problem 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.

Additional Information

- This objective does not dictate the report(s) which must be generated. An EP is best positioned to determine which reports are most useful to their care efforts.
- The report generated could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP.
- The report generated is required to include only patients whose records are maintained using certified EHR technology.



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Stage 1

Date issued: November 7, 2010

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.

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Definition of Terms

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients 65 years old or older or 5 years old 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.

The resulting percentage (Numerator ÷ Denominator) must be more than 20 percent in order for an EP to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- EPs meet the aspect of “per patient preference” of this objective if they are accommodating reasonable requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), which is the guidance established for accommodating patient requests.
- EP has the discretion to determine the frequency, means of transmission, and form of the reminder limited only by the requirements the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), and any other applicable federal, state or local regulations that apply to them.



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Stage 1

Date issued: November 7, 2010

Patient Electronic Access	
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 EHR 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 lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.

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Definition of Terms

Business Days – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.

- **EXCLUSION:** If an EP neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) 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.

The resulting percentage (Numerator ÷ Denominator) must be at least 10 percent in order for an EP to meet this measure.

Additional Information

- Online electronic access through either a patient portal or personal health record (PHR) will satisfy the measure of this objective.
- An EP may decide that electronic access to a portal or PHR is not the best forum to communicate results. Within the confines of laws governing patient access to their medical records, we would defer to EP's judgment as to whether to hold information back in anticipation of an actual encounter between the provider and the patient.
- Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, certified EHR technology makes available lab test results, problem list, medication list, and medication allergy list.
- An EP may withhold information from the electronic copy of a patient's health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.
- The objective and measure focus on the availability of access and the timeliness of data, not utilization. The EP is not responsible for ensuring that 10 percent request access or have the means to access, only that 10 percent of all unique patients seen by the EP could access the information if they so desired.



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Stage 1

Date issued: November 7, 2010

Patient-specific Education Resources

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.

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- Definition of Terms
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Definition of Terms

Patient-Specific Education Resources – Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- 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.

The resulting percentage (Numerator ÷ Denominator) must be more than 10 percent in order for an EP to meet this measure.

Additional Information

- Certified EHR technology is certified to use either the patient's problem list, medication list, or laboratory test results to identify the patient-specific educational resources. These or additional elements can be used in the identification of educational resources that are specific to the patient's needs.
- Education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.



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Stage 1

Date issued: November 7, 2010

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.

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- Definition of Terms
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Definition of Terms

Medication Reconciliation -- The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Relevant Encounter – An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.)

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- **DENOMINATOR:** Number of transitions 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.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.
- In the case of reconciliation following transition of care, the receiving EP should conduct the medication reconciliation.
- The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.





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Stage 1

Date issued: November 7, 2010

Transition of Care Summary

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.

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- Definition of Terms
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Definition of Terms

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- **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.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.
- The transferring party must provide the summary care record to the receiving party.
- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably be expected to do so.
- If the provider to whom the referral is made or to whom the patient is transitioned has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient should not be included in the denominator for transitions of care.



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Stage 1

Date issued: November 7, 2010

Immunization Registries Data Submission	
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.

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- Definition of Terms
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- Additional Information

Definition of Terms

None.

Attestation Requirements

YES / NO / EXCLUSION

- 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) to meet this measure.
- **EXCLUSION:** If an EP does not perform immunizations during the EHR reporting period, or if there is no immunization registry that has the capacity to receive the information electronically, 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).

Additional Information

- The test to meet the measure of this objective must involve the actual submission of information to a registry or immunization information system, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of actual patient information is not required for the purposes of a test. 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.
- If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
- An unsuccessful test to submit electronic data to immunization registries or immunization information systems will be considered valid and would satisfy this objective.
- If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
- The transmission of immunization information must use the standards at 45 CFR 170.302(k).



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Stage 1

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Syndromic Surveillance Data Submission	
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.

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Definition of Terms

Public Health Agency -- An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.

Attestation Requirements

YES / NO / EXCLUSION

- 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) to meet this measure.
- **EXCLUSION:** If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period or if no public health agency that has the capacity to receive the information electronically, 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.

Additional Information

- The test to meet the measure of this objective must involve the actual submission of electronic syndromic surveillance data to public health agencies, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of electronic syndromic surveillance data is not required for the purposes of a test. 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.
- An unsuccessful test to submit electronic syndromic surveillance data to public health agencies will be considered valid and would satisfy this objective.
- If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
- EPs must test their ability to submit electronic syndromic surveillance data to public health agencies at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Each payment year requires its own unique test.
- If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
- The transmission of syndromic surveillance information must use the standards at 45 CFR 170.302(l).