Health Outcome Priority One: Improving quality, safety, efficiency and reducing Health disparities

Care Goals: Provide access to comprehensive individual health data for pt's health care team
Care Goals: Use evidence based order sets and computerized provider order entry (CPOE)
Care Goals: Apply clinical decision support at the point of care
Care Goals: Generate lists of individuals who need care and use them to reach out to those individuals
Care Goals: Report information for quality improvement and public reporting

Objectives: Elements to implement	Stage I Healthcare IT Functionality Measure	Definition	Numerator	Denominator
Use CPOE	CPOE is used for at least 80% of all orders	Provider uses computer to directly enter medical orders (for example, medications, consultation with other providers, lab services, imaging studies and other auxiliary services); Order captured in digital, structured format for improving safety and organization. Electronic transmittal not needed until Stage II	Orders issued by the provider using CPOE functionality during the reporting period	All orders issued for all individuals by provider during the EHR reporting period
Implement drug-drug, drug-allergy, drug-formulary checks	This functionality has been enabled			
Maintain an up to date problem list of current and active diagnoses based on ICD9 or SNOMed CT	At least 80% of all unique individuals seen by the provider have at least one entry or an indication of none recorded as structured data	Problem list is list of current and active diagnoses as well as past diagnoses relevant to the current care of the individual; unique person means that even if a person is seen multiple times during the reporting period they are only counted once.	Number of unique individuals seen by a provider that falls under the eligible reporting period that have at least one entry in the problem list	Number of unique individuals seen by that provider that falls during this reporting period
Generate and transmit permissible prescriptions electronically	At least 75% of all permissible prescriptions written by the provider are transmitted electronically	Permissible prescriptions refers to the restrictions established by the DEA on eRx of controlled substances	Number of prescriptions for other than controlled substances generated and transmitted electronically during the period	Number of prescriptions written for other than controlled substances during the reporting period

Maintain an active medication list	At least 80% of all unique individuals seen by the provider have at least one entry (or indication of "none" if the individual is not currently prescribed any medication) recorded as structured data	unique person means that even if a person is seen multiple times during the reporting period they are only counted once.	Number of unique individuals seen by a provider who have at least on entry or an indication of "none" if the individual is not currently prescribed any medication recorded as structured data in the medication list	Number of unique individuals seen by that provider that falls during this reporting period
Maintain an active medication allergy list	At least 80% of all unique individuals seen by the provider have at least one entry (or indication of "none" if the individual has no medication allergy) recorded as structured data	unique person means that even if a person is seen multiple times during the reporting period they are only counted once.	Number of unique individuals seen by a provider who have at least on entry or an indication of "none" recorded as structured data in the allergy list	Number of unique individuals seen by that provider that falls during this reporting period
Record the following demographics: preferred language, insurance type, gender, race and ethnicity and date of birth	At least 80% of all unique individuals seen by the provider have demographics recorded as structured data	Race and ethnicity codes should follow current federal standards published by the Office of Management and Budget. unique person means that even if a person is seen multiple times during the reporting period they are only counted once.	Number of unique individuals seen by a provider who have all required demographic elements (preferred language, insurance type, gender, race and ethnicity, date of birth) recorded as structured data in the allergy list	Number of unique individuals seen by that provider that falls during this reporting period
Record and chart changes in the following: vital signs, height, weight and blood pressure and calculate and display body mass index for ages 2 and over; plot and display growth charts for children 2 - 20 years, including BMI	At least 80% of all unique individuals age 2 and over seen by the provider record blood pressure and BMI; additional plot growth chart for children age 2-20	unique person means that even if a person is seen multiple times during the reporting period they are only counted once.	Number of unique individuals age 2 and over seen by a provider who have a record of their blood pressure and BMI (growth chart for children 2-20) in their record	Number of unique individuals age 2 or over seen by that provider that falls during this reporting period
Record smoking status for persons 13 years and older	At least 80% of all unique individuals age 13 and over seen by the provider have "smoking status" recorded	unique person means that even if a person is seen multiple times during the reporting period they are only counted once.	Number of unique individuals age 13 and over seen by a provider who have a record of their smoking status	Number of unique individuals age 13 or over seen by that provider that falls during this reporting period

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<tr><td>Incorporate clinical lab test results into EHR as structured data</td><td>At least 50% of all clinical lab tests ordered whose results are in a positive/ negative or numerical format are incorporated in an EHR as structured data</td><td>CMS proposes to add the option to report directly to the states or providers participating in the Medicaid EHR incentives</td><td>Number of lab tests ordered during the EHR reporting period by the provider whose results are expressed in a positive or negative affirmation or as a number and are incorporated as structured data</td><td>Number of lab test ordered during the EHR reporting period by the provider</td></tr>
<tr><td>Generate lists of persons by specific conditions to use for quality improvement, reduction of disparities, research and outreach.</td><td>Generate at least one report listing individuals of the providers with a specific condition</td><td colspan="3">Capability to generate lists of patients by specific conditions and must be able to generate this list at least once during the EHR reporting period so this info would be available to them for their use. A provider is best positioned to determine which reports are most useful to their care efforts. Providers will attest to the ability of the provider that they have actually generated this list at least once.</td></tr>
<tr><td>Report ambulatory measures to CMS</td><td colspan="4">For 2011 provide aggregate numerator and denominator through attestation. For 2012, electronically submit the measures</td></tr>
<tr><td>Send reminders to individuals per person preference for preventive / follow up care</td><td>Reminder sent to at least 50% of all unique individuals seen by the provider that are age 50 or older</td><td>Person preference refers to the pt's choice of delivery method between internet based delivery or delivery not requiring internet access unique person means that even if a person is seen multiple times during the reporting period they are only counted once.</td><td>Number of unique individuals age 50 or older seen by the provider during the EHR reporting period who are provided reminders</td><td>Number of unique individuals age 50 or over seen by the provider during the EHR reporting period</td></tr>
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Implement 5 clinical decision support rules relevant to specialty or high clinical priority including for diagnostic test ordering, along with the ability to track compliance with these rules	Implement 5 clinical decision support rules relevant to specialty or high clinical quality metrics the provider is responsible for	HIT functionality that builds upon the foundation of an EHR to provide persons involved in the care processes with the general and person specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care. Establishing decision support for a small set of high priority condition ideally linked to quality measures being reported is feasible and desirable without causing alert fatigue. Five clinical decision support rules relevant to the clinical quality metrics need to be attested to by the provider.		
Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique individuals seen by the provider	unique person means that even if a person is seen multiple times during the reporting period they are only counted once.	Number of unique individuals seen by the provider during the EHR reporting period whose insurance eligibility is checked electronically	Number of unique individuals seen by the provider during the EHR reporting period whose insurer allows for electronic verification of eligibility.
Submit claims electronically to public and private payers	At least 80% of all claims filed electronically by the provider		Number of claims submitted electronically for individuals seen by the provider during the EHR reporting period.	Number of claims filed for individuals seen by the provider during the EHR reporting period.
Health Outcome Priority Two: Engage individuals and families in their health care				
Care Goals: Provide individuals and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health				
Objectives: Elements to implement	**Stage I Healthcare IT Functionality Measure**	**Definition**	**Numerator**	**Denominator**
Provide individuals with an electronic copy of their health information (including diagnostic test results, problem list, medication list, allergies) upon request	At least 80% of all individuals who request an electronic copy of their health information are provided it within 48 hours	A disclosure made to a family member of person's guardian consistent with Federal and State law may substitute for a disclosure to the individual. Electronic copies may be provided through a number of secure electronic methods for example, personal health record, pt portal, CD, USB drive)	Number of individuals seen by the provider during the EHR reporting period that request an electronic copy of their health information and receive it within 48 hours.	Number of individuals seen by the provider during the EHR reporting period that request an electronic copy of their health information .

Provide individuals with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the provider	At least 10% of all unique individuals seen by the provide4r are provided timely access to their health information	Electronic Access may be provided through a number of secure electronic methods for example, personal health record, pt portal, CD, USB drive). Timely is defined as within 96 hours of the info being available to the provider either through the receipt of final lab results or a pt interaction that updates the providers knowledge of the pt's health.	Number of unique individuals seen by the provider during the EHR reporting period who have timely electronic access to their health information (for example have established a user account and password on a patient portal)	Number of unique individuals seen by the provider during the EHR reporting period
Provide clinical summaries for individuals for each office visit	Clinical summaries are provided for at least 80% of all office visits	Not meant to apply to alternative encounters such as telephone or web visits. The clinical summary can be provided through a PHR, patient portal on the web site, secure email, electronic media such as CD, USB fob or printed copy. The after visit clinical summary contains an updated med list, lab and other diagnostic test orders, procedures and other instructions based on clinical discussions that took place during the office visit	Number of unique individuals seen by the provider during the EHR reporting period who are provided a clinical summary of their visit	Number of unique individuals seen by the provider during the EHR reporting period

Health Outcome Priority Three: Improve Care Coordination

Care Goals: Exchange meaningful clinical information among professional health care team

Objectives: Elements to implement	Stage I Healthcare IT Functionality Measure	Definition	Numerator	Denominator

Capability to exchange key clinical information (for example problem list, medication list, allergies, diagnostic test results) among providers of care and individuals authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	Diagnostic results means all data needed to diagnose and treat disease such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests and pulmonary function tests. Where available in structured electronic format we expect that this would be exchanged in electronic format. However, where the information is available only in unstructured electronic formats (free text and scanned docs) we allow the exchange of unstructured info. Pt authorized entities could include any individual or org to which the pt has granted access to their clinical information. Ex include insurance company that covers the pt or a personal health record vendor identified by the pt.		
Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care	Med reconciliation as the process of identifying the most accurate list of all meds that the pt is taking, including name, dose, freq and route by comparing the medical record to an externally list of meds obtained from a pt, hospital or other provider. Transition of care as transfer of a pt from one clinical setting (inpt, outpt, physician office, home health, rehab, long term care facility, etc.) to another or from on provider to another. Relevant encounter would be any encounter that the provider judges to perform a med reconciliation due to new med or long gaps in time between pt encounter or other reasons determined by the provider	Number of relevant encounters and transitions of care for which the provider was a participant during the EHR reporting period where med reconciliation was performed.	Number of relevant encounters and transitions of care for which the provider was a participant during the EHR reporting period

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<tr><td>Provide summary care record for each transition of care and referral</td><td>Provide summary of care record for at least 80% of transitions of care and referrals</td><td>Referrals and transitions require the sharing of pt care summary from one provider to another communication important info that the pt may not have been able to provide and can significantly improve the quality and safety of referral care and reduce unnecessary and redundant testing. Summary of care record can be provided through an electronic exchange, accessed through a secure portal, secure email, electronic media such as CD or USB fob or printed copy</td><td>Number of transitions of care and referrals for which the provider was a participant during the EHR reporting period where a summary of care record was provided</td><td>Number of transitions of care and referrals for which the provider was a participant during the EHR reporting period</td></tr>
<tr><th colspan="5">Health Outcome Priority Four: Improve population and public health</th></tr>
<tr><th colspan="5">Care Goals: Communicate with public health agencies</th></tr>
<tr><th>Objectives: Elements to implement</th><th>Stage I Healthcare IT Functionality Measure</th><th>Definition</th><th>Numerator</th><th>Denominator</th></tr>
<tr><td>Capability to submit electronic data to immunization registries and actual submission where required and accepted</td><td>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries</td><td colspan="3">Testing could occur prior to the beginning of the EHR reporting period. Providers in a group setting using identical EHR technology would only need to conduct a single test not one test per provider. This is one example of a possible state proposed modification to meaningful use in the Medicaid EHR incentive program. States may propose any modifications or additions to CMS</td></tr>
<tr><td>Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice</td><td>Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which a provider submits such information have the capacity to receive the information electronically)</td><td colspan="3">Testing could occur prior to the beginning of the EHR reporting period. Providers in a group setting using identical EHR technology would only need to conduct a single test not one test per provider. This is one example of a possible state proposed modification to meaningful use in the Medicaid EHR incentive program. States may propose any modifications or additions to CMS</td></tr>
<tr><th colspan="5">Health Outcome Priority Five: Ensure adequate privacy and security protections for personal health information</th></tr>
<tr><th colspan="5">Care Goals: Ensure privacy and security protections for confidential information through operation policies, procedures and technologies and compliance with the</th></tr>
<tr><th colspan="5">Care Goals: Provide transparency of data sharing to individual</th></tr>
<tr><th>Objectives: Elements to implement</th><th>Stage I Healthcare IT Functionality Measure</th><th>Definition</th><th>Numerator</th><th>Denominator</th></tr>
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Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164-308 and implement security updates as necessary	While EHR technology provides tools for protecting health info it is not a full protection solution. Processes and possibly tools outside the scope of EHR are required. Propose that providers conduct or review a security risk analysis of EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review.