15 Mandatory Objectives

PRIORITY 1: Ensure adequate privacy and security for personal health information		
Objective	**Details**	**Required System and Security Settings for Approved Users**
1. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	• Document Access to Clinical Data – Record Disclosure • When? Who? Why? To Whom? – Access Confidential Patient Data in an Emergency • Control and Monitor Data – Control Access to Patient Data – Run the Disclosure Management Report – Monitor the Audit Trail – Encrypt Data and Ensure Integrity • Configure Disclosure and Confidentiality Override – Configure Disclosure – Enable Confidentiality Override • Session Timeout – Configure Session Timeout	• Configure Patient Reminders • Enable Confidentiality override capabilities • Enable ability to create Drug-to-Drug Screenin Exclusions • Configure Disclosure and ability to create a Custom Note • Configure session timeout for the entire pract • Configure Clinical Decision Support System (C • Configure “Release of Information” (used to generate CCD documents)

PRIORITY 2: Improve quality, safety, efficiency and reduce health disparities	
Objective	**Details**
2. Use of CPOE for 30% of orders. ***Exclusions:* Any EP who writes <100 Rx during the EHR reporting period**	• Ensure Proper Compliance – Only medication orders will be measured and reported for Stage 1. – The system shall use medication order or medication create date and not the medication start date – The provider shall be the provider who actually entered the prescription and not the one who signed the note – Medication orders directly entered by any licensed healthcare professional who can enter orders into the med record per state, local and professional guidelines will be included in the calculation – Orders that were entered in the EHR while tracking history will not be counted in the numerator. • Order a Medication
3. Implement drug-drug and drug-allergy checks. ***Exclusions:* Any EP who writes <100 Rx during the EHR reporting period**	• Ensure Proper Compliance – The reporting tool shall collect whether the formulary eligibility interface is enabled for each provider during t entire reporting period – If the EP cannot turn drug-formulary interface off, suggest “Yes” for the attestation response. – If the EP has had the drug-formulary interface on for the entire reporting period, suggest “Yes”, otherwise “No • Order a Medication • Configure Drug Screening • Create Exclusions • Control Access to Drug Interaction Exclusions

PRIORITY 2: Improve quality, safety, efficiency and reduce health disparities	
Objective	**Details**
4. Up-to-date problem list of current/active diagnoses based on ICD-9 or SNOMED	• Ensure Proper Compliance – More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems known for the patient recorded as structured data – Specific indication of no problem will vary by EHR. Each EHR uses a different means to indicate no active probl – Active problem must consist of ICD-9 or SNOMED CT • Maintain a Problem List
5. Generate and transmit permissible prescriptions electronically (eRx) Exclusions: Any EP who writes <100 Rx during the EHR reporting period	• Ensure Proper Compliance – More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified technology – The system shall use prescription create date and not the prescription start date – The provider shall be the ordering provider and the not the one who signed the note – Only prescriptions with a status of new and refill shall be included in this measure – If a prescription is sent electronically but fails during transmission and is subsequently printed or faxed, it shal be counted in the numerator. The subsequent print of fax shall not be included in the denominator. – Controlled substance must be excluded • Order a Medication
6. Maintain active medication list	• Ensure Proper Compliance – At least 80% of unique patients seen have at least one entry or “none” recorded as structured data – The numerator shall not include patients who have a NULL medication list – Specific indication of no active medications will vary by EHR. Each EHR uses a different nomenclature to indica no active medication at any point during the reporting period • MUST indicate Patient is on “No Medications” if applicable • Maintain Medication List • Reconcile Medication Lists
7. Maintain active allergy list	• Ensure Proper Compliance – More than 80% of all unique patients seen by the EP who have at least one entry (or an indication that patient no known allergies) recorded as structured data in their allergy list. • Maintain Allergy List
8. Record demographics	• Ensure Proper Compliance – Record the following demographics: preferred language, gender, race and ethnicity, and date of birth – At least 50% of unique patient encounters by the eligible provider have current demographics data. – Only include in the numerator patients who have every demographics item from the numerator recorded – Exclude from the numerator patients whose Race and Ethnicity values are not in structured format

PRIORITY 2: Improve quality, safety, efficiency and reduce health disparities	
Objective	**Details**
	• Add Patient Demographics
9. Record and chart changes in vital signs ***Exceptions: Any EP who sees only patients <2 years old and any EP where height, weight and blood pressure have no relevance to their scope of practice may attest and be excluded***	• Ensure Proper Compliance – More than 50% of all unique patients age 2 and over seen by the EP have recorded height, weight and blood pressure • Enter vital signs in patient chart
10. Record Smoking status for patients 13 years old or older	• Ensure Proper Compliance – IMPORTANT NOTE: While there are not "exclusions" in writing for this objective, any EP who sees no patients years or older is excluded from reporting measures for this objective – More than 50% of all unique patients 13 years old or older seen by the EP have "smoking status" recorded as structured data – CMS does not intend that an inquiry be made every time a provider sees a patient 13 years old or older • Record Smoking Status
11. Report Clinical Quality Measures to CMS	• Ensure Proper Compliance – For 2011, an EP would provide the aggregate numerator and denominator through attestation. – For 2012, and EP would electronically submit the measures. • Report Clinical Quality Measurements Core Quality Measures • **NQF 0013 (Core):** Hypertension: Blood Pressure Measuremen • **NQF 0028 (Core):** Preventative Care and Screening Measure F – **0028a:** (a) Tobacco Use Assessment – **0028b:** (b) Tobacco Cessation Intervention • **NQF 0421 (Core):** Adult Weight Screening and Follow Up Choose 3 additional a-la-carte measures.
12. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	• Ensure Proper Compliance – The reporting tool shall collect whether an EP was provided clinical decision support • Respond to Clinical Decision Support System • Configure Clinical Decision Support • Create/Modify CDS Actions • Create/Modify CDS Rules

Part 3: Engage patients and families in their health care	
Objective	**Details**
13. Provide patients with an electronic copy of their health information ***Exceptions: Any EP with no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period***	• Ensure Proper Compliance – More than 50% of all patients of the EP who request an electronic copy of their health information are provide within 3 business days. • Generate a CCD (Continuity of Care Document)
14. Clinical summaries provided to patients for all office visits ***Exceptions: Any EPs with office visits during the EHR reporting period***	• Ensure Proper Compliance – Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. – The clinical summary can be provided through a PHR, patient portal on the web site, secure email, electronic media such as CD or USB, or printed copy. – The after-visit clinical summary contains an updated medication list, laboratory and other diagnostic test orde procedures and other instructions based on clinical discussions that took place during the office visit. – Exclude weekends, national and state holidays when calculating 3 business days • Provide Clinical Summaries for each Office Visit

Part 4: Improve care coordination	
Objective	**Details**
15. Capability to exchange key clinical information among providers of care and patient authorized entities electronically	• Ensure Proper Compliance – Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information – The reporting tool shall collect whether an EP exchanged clinical information – All EHRs can identify patients whose clinical information was exchanged. – The FR also indicates that a test patient may be used to prove this capability. Therefore it is not necessary to establish a patient to provider relationship.

Menu of Optional Requirements — Five Required for Meaningful Use

Objective	Details
Incorporate test results into EHR as structured data	• More than 40 percent of lab results expressed as a number or positive/negative are incorporated into the EHR.
Generate list of patients with specific conditions	• Generate at least one report.
Implement drug formulary checks on medication orders	• Implemented with access to at least one internal or external formulary for entire reporting period.
Provide timely access to new results	• More than 10 percent of all patients seen have access to lab results, problem list, medication and allergy lists with days of availability in the EHR.
Send reminders for preventive/ follow-up care Send reminders (in patient-preferred format	• Send reminders (in patient-preferred format) for preventive/ follow-up care to 20 percent of patients age 65+ or less t 5 years of age.
Perform medication reconciliation	• Provide at least 50 percent of transitions in care and relevant encounters.
Provide summary record at transitions in care and referrals	• Provide summary care record at 50 percent of transitions in care and referrals.
Information to immunization registries submitted electronically	• Perform at least one test of the capability to submit data to immunization registries or immunization information syst and follow-up submission (where agencies can accept electronic submission).
Electronic reporting of syndromic surveillance data	• Perform at least one test of the capability to submit data and follow-up submission (where public health agencies can accept electronic data).
Use EHR technology to identify patient-specific educational resources and provide to patients as appropriate	• More than 10 percent of patients are provided patient specific educational resources using the EHR.