

## Meaningful Use Stage One

### **MENU** Measures for Eligible Professionals Program Year 2013



Objective	Measure	Exclusion	Numerator	Denominator
<p><b>DRUG FORMULARY CHECKS</b> Implement drug formulary checks.</p>	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	Answer Yes or No	
<p><b>CLINICAL LAB TEST RESULTS</b> Incorporate clinical lab test results into EHR as structured data.</p>	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.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.	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.	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.
<p><b>PATIENT LISTS</b> Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p>	Generate at least one report listing patients of the EP with a specific condition.	No exclusion.	Answer Yes or No	
<p><b>PATIENT REMINDER</b> Send reminders to patients per patient preference for preventive/follow-up care.</p>	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.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.	Number of patients in the denominator who were sent the appropriate reminder.	Number of unique patients 65 years old or older or 5 years old or younger.
<p><b>PATIENT ELECTRONIC ACCESS</b> 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.</p>	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.	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.	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.	Number of unique patients seen by the EP during the EHR reporting period.

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<p><b>PATIENT-SPECIFIC EDUCATION RESOURCES</b> Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.</p>	More than 10 percent of all unique patients seen by the EP are provided patient specific education resources.	No exclusion.	Number of patients in the denominator who are provided patient-specific education.	Number of unique patients seen by the EP during the EHR reporting period.
<p><b>MEDICATION RECONCILLATION</b> 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 defined as: 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.</p>	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.	An EP who was not the recipient of any transitions of care during the EHR reporting period.	Number of transitions of care in the denominator where medication reconciliation was performed.	Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
<p><b>TRANSITION OF CARE SUMMARY</b> 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. The provider can limit the measure to records maintained using certified EHR.</p>	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.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.	Number of transitions of care and referrals in the denominator where a summary of care record was provided.	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
<p><b>PUBLIC HEALTH MEASURE/IMMUNIZATION REGISTRIES DATA SUBMISSION</b> Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.</p>	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).	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.	If not excluding, EP answers Yes or No to did you perform at least one test.	
<p><b>PUBLIC HEALTH MEASURE/SYNDROMIC SURVEILLANCE DATA SUBMISSION</b> Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.</p> <p>Program details can be found at <a href="http://www.ahca.myflorida.com/medicaidehr">www.ahca.myflorida.com/medicaidehr</a>.</p>	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).	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 agency that has the capacity to receive the information electronically.	If not excluding, EP answers Yes or No to did you perform at least one test.	