STAGE 1 OF MEANINGFUL USE

15 CORE MEANINGFUL USE CRITERIA & 10 MENU MEANINGFUL USE CRITERIA

15 Core Meaningful Use Criteria

1. Record patient demographics (including gender, race and ethnicity, date of birth, preferred language)
2. Record vital signs (height, weight, blood pressure, body mass index, and growth charts for children)
3. Maintain up-to-date problem lists
4. Maintain active medication lists
5. Maintain active medication allergy lists
6. Record smoking status for patients older than 13 years of age
7. Provide patients with a clinical summary for each office visit within 3 business days
8. On request, provide patients with an electronic copy of their health information (including test results, problem lists, meds lists, allergies) within 3 business days
9. Generate electronic prescriptions (note: Chiropractors exempt from criteria)
10. Use Computerized Physician Order Entry (CPOE) for medication orders at least 30% of the time. (note: Chiropractors exempt from criteria)
11. Implement drug-drug and drug-allergy interaction checks
12. Be able to exchange key clinical information among providers by performing at least one test of the EMR's ability to do this.
13. Implement one clinical decision support rule, and ability to track compliance with the rule (this is reduced from the previous 5 rules to the final 1 rule)
14. Implement systems that protect privacy and security of patient data in the EMR, by conducting or reviewing a security risk analysis, and taking corrective step if needed
15. Report clinical quality measures to CMS or states – for 2011 provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures (this refers to PQRI measures)

10 Menu Meaningful Use Criteria *(must demonstrate at least five)*

1. Implement drug-formulary checking
2. Incorporate lab test data into the EMR as structured data
3. Generate lists of patients by specific conditions (to use for quality improvement, reduce disparities, research, or outreach)
4. Use EMR technology to identify patient-specific education resources, and provide those to the patient as appropriate
5. Provide medication reconciliation between care settings

6. Provide summary of care record for patients transferred to another provider or setting
7. Submit electronic immunization data to local registries (performing at least one test of data submission, where registries can accept them)
8. Submit electronic syndromic surveillance to public health agencies (perform at least one test, where local agencies can accept them)
9. Send reminders to patients (per patient preference) for preventive and follow-up care
10. Provide patients with timely electronic access to their health information

CONTACT US FOR MORE INFORMATION!

CALL: 1-866-286-5315 ext. 1
EMAIL: info@acomhealth.com