

A Guide to the Meaningful Use Measures for Eligible Professionals

Government Incentives for EHR Adoption
Stage I Meaningful Use

American Society of Clinical Oncology
Last Updated: October 25th, 2010
Version 1.2

Table of Contents

What is Meaningful Use?	3
General Information on Stage I	3
Important Definition	3
Core Set of Meaningful Use Objectives for Eligible Professionals (EPs)	4
1: CPOE for medication orders	5
2: Drug-drug and drug-allergy interaction checks	5
3: Generate and transmit permissible prescriptions electronically (eRx)	6
4: Record patient demographics	6
5: Maintain up-to-date problem list of current and active diagnoses	6
6: Maintain active medication list	7
7: Maintain active medication allergy list	7
8: Vital signs – record and chart changes	7
9: Smoking status recorded for patients 13 years of age or older	8
10: Implement 1 clinical decision support rule and track compliance with that rule	8
11: Report ambulatory clinical quality measures (CQM) to CMS or the States	8
12: Provide patients with an electronic copy of their health information on request	11
13: Provide clinical summaries for patients for each office visit	11
14: Exchange key clinical information among providers of care	12
15: Protection of electronic health information	12
Menu Set of Meaningful Use Objectives for Eligible Professionals (EPs)	13
1: Implement drug-formulary checks	14
2: Incorporate clinical lab-test results into EHR as structured data	14
3: Lists of patients to use for quality, reduction of disparities, research, outreach	14
4: Send reminders to patients per patient preference for preventive/follow up care	15
5: Electronic access to their health information within 4 business days	15
6: Identify patient-specific education resources and provide those resources	15
7: Medication reconciliation	16
8: Summary of care record for each transition of care or referral	16
9: Capability to submit electronic data to immunization registries	17
10: Submit electronic syndromic surveillance data to public health agencies	17

What is Meaningful Use?

Eligible professionals (EPs) must “meaningfully use” an EHR system to qualify for government incentives. This requires two major steps:

- Adopting and using a “[certified](#)” EHR.
- Using that certified EHR in a certain manner. For Stage I of meaningful use, eligible professionals are required to report that they are recording specific types of information.

The aim of the government is simple – they hope to improve the quality of care through EHRs. And to accomplish this objective, they have released this incentive program, which has 3 main stages that build upon each other. The first stage is finalized; the latter two are not and may change.

- Stage I – Requires that EPs record specific quality measures in the EHR.
- Stage II – Requires that EPs transmit information between provider groups.
- Stage III – Requires that EPs focus on using the quality measures to improve their standard of care.

This document expands upon **Stage I** of meaningful use and provides detail on what information must be captured.

General Information on Stage I

For the most part, Stage I requires EPs to report whether or not they are recording X data for a certain percentage of their patient population. For example: is an EP recording the weight for 50% of their patients? Are they recording relevant allergies for 80% of their patients? **And if they are recording this data, are they storing it in their EHR?**

Overall, Stage I requires EPs report 15 core measures and 5 out of 10 “menu” measures. While there are exceptions, most of the **core** measures follow the pattern mentioned above and require the EP to report a numerator and denominator. And the resulting number must be greater than a certain percentage to fulfill the measurement.

$$\frac{\text{Number of patients that have a specific data point recorded}}{\text{Number of unique patients that are relevant to this measure}} > X\%$$

The **menu** measures tend to be a bit more than just data collection. They focus more on the Stage II goal of transmitting information, including educational resources for patients, summary of care records, and immunization data.

Important Definition

Unique Patient: Throughout this document, one will see the term “unique patient.” This means that if an EP see a patient during the reporting period twice, the EP cannot record their weight twice and have that count towards the numerator. If the patient is seen by the EP more than once during the reporting period, then they only count once.

Core Set of Meaningful Use Objectives for Eligible Professionals (EPs)

Eligible professionals must meet all 15 objectives in the list below. Detailed information on each objective/measure follows the table.

Core Objective		Measure
1	CPOE for medication orders	> 30% of unique patients with at least 1 medication have at least 1 order entered using CPOE
2	Drug-drug and drug-allergy interaction checks	Functionality is enabled for the entire reporting period
3	Generate and transmit permissible prescriptions electronically (eRx)	> 40% of all prescriptions are transmitted electronically
4	Record patient demographics	> 50% of all unique patients have demographics recorded as structured data
5	Maintain up-to-date problem list of current and active diagnoses	> 80% of all unique patients have at least one entry (or an N/A) recorded
6	Maintain active medication list	> 80% of all unique patients have at least one entry (or an N/A) recorded
7	Maintain active medication allergy list	> 80% of all unique patients have at least one entry (or an N/A) recorded
8	Vital signs – record and chart changes	> 50% of all unique patients (\geq age 2), height, weight, and BP are recorded
9	Smoking status – recorded for patients 13 years of age or older	> 50% of all unique patients (\geq age 13) have smoking status recorded
10	Implement 1 clinical decision support rule relevant to specialty or high clinical priority, along with ability to track compliance with that rule	Implement 1 clinical decision support rule
11	Report ambulatory clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation; for 2012, submit clinical quality measures electronically
12	Provide patients with an electronic copy of their health information upon request	> 50% of all patients who request an electronic copy of their health information are provided it within 3 business days
13	Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for > 50% of all office visits within 3 business days
14	Capability to exchange key clinical information among providers of care and patient authorized entities electronically	Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information
15	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 and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Core Objective 1: CPOE for medication orders

EPs must meet the following measure:

<p>Patients that have at least one medication order entered using CPOE</p> <hr/> <p>Number of unique patients (whose records are maintained using EHR technology) with at least one medication in their list seen during the reporting period</p>	<p>> 30%</p>
---	-----------------

- Must use a computer or mobile device to enter medical orders.
- Medical orders are defined as medications, consultations with other providers, lab services, imaging studies, or other auxiliary services.
- Medication order is documented or captured in a digital, structure, and computable format.
- Does not require that this order is e-transferred to the pharmacy, lab, or diagnostic imaging center.
- Any licensed healthcare professional (vs. anybody) can enter the orders into the record per state, local, and professional guidelines.
- **Numerator is only the unique patients (opposed to every patient encounter) with at least one medication order entered using CPOE. If the patient is seen by the EP more than once during the reporting period, then they only count once. This definition is applicable to other measures that cite “unique patients.”**
- *EXCLUSION:* If an EP writes fewer than 100 prescriptions during the reporting period, they are excluded from this measurement.
- *STAGE 2:* For stage 2, this measure will probably require a 60% threshold.

Core Objective 2: Drug-drug and drug-allergy interaction checks

EPs must meet the following measure:

<p>Functionality is enabled for drug-drug and drug-allergy checks for the entire EHR reporting period</p>

- Many EHR technologies have the option to disable these checks, and the certification process does not require the removal of this option. However, to meet the objective, the EP must enable this functionality for the entire reporting period.
- *EXCLUSION:* If an EP writes fewer than 100 prescriptions during the reporting period, they are excluded.
- *STAGE 2:* Expect the measure will be expanded to be counted on a transactional basis for future stages.

Core Objective 3: Generate and transmit permissible prescriptions electronically (eRx)

EPs must meet the following measure:

$$\frac{\text{Prescriptions in the denominator generated and transmitted electronically}}{\text{Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period}} > 40\%$$

- This includes ALL prescriptions, except for drugs on the [controlled substances](#) list.
- Does not include durable medical equipment or other items and services.

Core Objective 4: Record patient demographics, including their preferred language, gender, race, ethnicity, and date of birth

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who have ALL demographic fields recorded}}{\text{Number of **all** unique patients seen during the reporting period}} > 50\%$$

- Information must be stored as structured data, meaning no free text boxes or uploaded images.
- Race and ethnicity codes should follow [OMB standards](#).
- A patient can decline to provide this data, and that can be noted instead.

Core Objective 5: Maintain up-to-date problem list of current and active diagnoses

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who have at least one entry recorded or an indication that no problems are known}}{\text{Number of **all** unique patients seen during the reporting period}} > 80\%$$

- Information must be stored as structured data, meaning no free text boxes or uploaded images.
- Problem list will be based on ICD-9 or SNOMED-CT®.
- “Up-to-date” means the list is populated with the most recent diagnosis known by the care provider (from previous records, other providers, or simply asking the patient).
- List does not need to be updated with every patient encounter.

Core Objective 6: Maintain active medication list

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who have a medication recorded or an indication that no medications are currently active}}{\text{Number of all unique patients seen during the reporting period}} > 80\%$$

- Information must be stored as structured data, meaning no free text boxes or uploaded images.

Core Objective 7: Maintain active medication allergy list

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who have a medication allergy recorded or an indication that there are no known allergies}}{\text{Number of all unique patients seen during the reporting period}} > 80\%$$

- Information must be stored as structured data, meaning no free text boxes or uploaded images.
- *STAGE 2*: Measurement will probably expand to include non-medication allergies.

Core Objective 8: Vital signs – record and chart changes

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who have at least one entry of their height, weight, and blood pressure recorded}}{\text{Number of unique patients (age } \geq 2 \text{ and whose records are maintained using EHR technology) seen during the reporting period}} > 50\%$$

- Information must be stored as structured data, meaning no free text boxes or uploaded images.
- Certified EHR technology will automatically calculate BMI and growth chart, if applicable.
- Does not need to be updated at every patient visit.
- Data can come from different sources – entry by EP, entry by staff, from another provider, or entered directly by the patient through an online portal or other means. As long as the care provider can access the data, they can place that patient in the numerator.
- *EXCLUSION*: EPs who do not see patients over 2 years of age are excluded from this requirement.
- *EXCLUSION*: EPs who believe that measuring/recording height, weight, or blood pressure have no relevance can say so and be excluded.

Core Objective 9: Smoking status recorded for patients 13 years of age or older

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who have their smoking status recorded}}{\text{Number of unique patients (age } \geq 13 \text{ and whose records are maintained using EHR technology) seen during the reporting period}} > 50\%$$

- Information must be stored as structured data, meaning no free text boxes or uploaded images.
- Uses [CDC's standard recodes](#) to determine smoking status.

Core Objective 10: Implement 1 clinical decision support rule relevant to specialty or high clinical priority, along with ability to track compliance with that rule

EPs must meet the following measure:

Implement 1 clinical decision support rule

- CMS is deliberately vague with this measurement, preferring that every EP decide what is an appropriate clinical decision support rule.

Core Objective 11: Report ambulatory clinical quality measures (CQM) to CMS or the States

EPs must meet the following measure:

For 2011: provide aggregate numerator, denominator, and exclusions via attestation
For 2012: submit clinical quality measures electronically

- See next page for more detail.
- Information that is reported depends on the selected clinical quality measures.
- To fulfill objective, EPs must fulfill 3 core set of QCMs and choose another 3 CQMs from a set of 38.
- Most CQMs will not be applicable to oncology practices.

Fulfilling Core Objective 11: Reporting Clinical Quality Measures

Step 1: Report 3 core clinical quality measures.

Set of Core Clinical Quality Measures

1. NQF 0013: Hypertension, Blood Pressure Measurement
2. NQF 0028: Preventive Care and Screening Measure Pair (Tobacco Use Assessment and Tobacco Cessation Intervention)
3. NQF 0421: Adult Weight Screening & Follow-up (PQRI 128)

If the measures above do not apply, then an EP can replace them with alternate core measures below:

Alternate Set of Core Clinical Quality Measures

1. NQF 0024: Weight Assessment and Counseling for Children & Adolescents
2. NQF 0028: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 years (PQRI 110)
3. NQF 0038: Childhood Immunization Status

Step 2: Report on 3 additional quality measures from the list below. There are three oncology specific measurements (numbers 18-20).

Additional Clinical Quality Measures

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
11. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
18. **Oncology Breast Cancer:** Hormonal Therapy for Stage IC-IIIC ER/PR Positive Breast Cancer
19. **Oncology Colon Cancer:** Chemotherapy for Stage III Colon Cancer Patients
20. **Prostate Cancer:** Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
21. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
22. Diabetes: Eye Exam

23. Diabetes: Urine Screening
24. Diabetes: Foot Exam
25. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
26. Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
27. Ischemic Vascular Disease (IVD): Blood Pressure Management
28. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
29. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
30. Prenatal Care: Screening for HIV
31. Prenatal Care: Anti-D Immune Globulin
32. Controlling High Blood Pressure
33. Cervical Cancer Screening
34. Chlamydia Screening for Women
35. Use of Appropriate Medications for Asthma
36. Low Back Pain: Use of Imaging Studies
37. Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
38. Diabetes: Hemoglobin A1c Control (<8.0%)

Step 2A: More Detail on the Oncology-Specific Measurements

Clinical Quality Measure	Description
Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC ER/PR Positive Breast Cancer NQF 0387 PQRI 71	Percentage of female patients (≥ 18 years old) with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor during the reporting period.
Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients NQF 0385 PQRI 72	Percentage of female patients (≥ 18 years old) with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor during the reporting period.
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients NQF 0389 PQRI 102	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Core Objective 12: Provide patients with an electronic copy of their health information (including test results, problem list, medication lists, medication allergies) upon request

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who receive an e-copy of their health information within 3 business days}}{\text{Number of patients (whose records are maintained using EHR technology) who request an e-copy of their health information 4 business days before the end of the reporting period}} > 50\%$$

- Only information already in an e-format is required to be transferred electronically.
- Can in any electronic form, such as a patient portal, personal health record, CD, USB fob, etc. EPs are expected to make a reasonable accommodation for patient preference.
- A provider can withhold information as appropriate, in accordance with [45 CFR 164.524](#).
- At a minimum, the data provided would include diagnostic test results, list of problems, medications, medication allergies, immunizations and procedures. See [45 CFR 170.304\(f\)](#) for more detail.
- Fees can be charged for a copy; this is ultimately governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. EPs can only charge “reasonable, cost-based fees.”
- Can provide the copy to a family member or the patient’s authorized representative instead.

Core Objective 13: Provide clinical summaries for patients for each office visit

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who receive a clinical summary of their visit within 3 business days}}{\text{Number of unique patients (whose records are maintained using EHR technology) seen for an office visit during the reporting period}} > 50\%$$

- See [ASCO’s Treatment Plans and Summaries](#).
- Summary can be given via a personal health record, patient portal, email, CD, USB, or printed copy.
- Office visit defined as any billable visit that includes 1) concurrent care or transfer of care visits, 2) consultant visits, 3) prolonged physician service with face-to-face patient contact (i.e. “tele-health”)
- Clinical summary is defined as instructions containing at least the following:
 - The patient’s name, provider’s office contact information
 - Date and location of visit
 - An updated medication list and summary of current medications
 - Updated vitals, reason(s) for visit, procedures and other instructions
 - Any updates to a problem list
 - Immunizations or medications administered during visit
 - Summary of topics covered/considered during visit
 - Time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled
 - List of other appointments and testing patient needs to schedule with contact information
 - Recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.
- **EXCLUSION:** EPs who have no visits during reporting period are excluded from this requirement.

Core Objective 14: Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically

EPs must meet the following measure:

Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information

- Up to the EP's judgment on what is considered to be "key clinical information." All certified products will be able to exchange a minimal set of information, mandated by the Office of National Coordinator. The provider can use some or all of this information. See [45 CFR 170.304\(j\)](#) for more detail.
- Patient authorized entities are any individuals or organizations that have been authorized by the patient to receive info. Can include insurance companies, personal health record vendors, etc.
- If available, data should be exchanged in a structured data format; otherwise, unstructured (free text, scanned images) is fine.
- Dummy data can be used to perform the test.
- Data must be sent to a different legal entity with a distinct certified EHR technology or other system, and not between organizations that share certified EHR technology.
- Testing can occur prior to the beginning of the reporting period. Every payment year must have its own unique test.
- If an EP fails the test, they will still fulfill the criteria.

Core Objective 15: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

EPs must meet the following measure:

Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

- Testing could occur prior to the beginning of the EHR reporting period.
- Security updates can include updated software, changes in workflow process, etc.
- Measure is somewhat vague – look for more information from CMS in the future.

Menu Set of Meaningful Use Objectives for Eligible Professionals (EPs)

EPs can choose 5 out of the 10 objectives in the list below. Detailed information on each objective/measure follows the table. EPs must choose one of the two public health objectives (menu objectives 9 and 10).

Menu Objective		Measure
1	Implement drug-formulary checks	Functionality is enabled for entire reporting period
2	Incorporate clinical lab-test results into EHR as structured data	> 40% of all clinical lab tests 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
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least 1 report listing patients with a specific condition
4	Send reminders to patients per patient preference for preventive/follow up care	> 20% of all unique patients (\geq age 65 or \leq age 5) were sent an appropriate reminder during the EHR reporting period
5	Provide patients with timely electronic access to their health information within 4 business days of the information being available to the EP	> 10% of all unique patients are provided timely electronic access to their health information, subject to the EP's discretion to withhold certain information
6	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	> 10% of all unique patients are provided patient-specific education resources
7	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	EP performs medication reconciliation for > 50% of transitions of care in which the patient is transitioned into the care of the EP
8	The EP should provide summary of care record for each transition of care or referral	Summary of care record provided for > 50% of transitions of care and referrals
9	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission	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
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission	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

For Stage 2 meaningful use, all of these measures will probably become mandatory.

Menu Objective 1: Implement drug-formulary checks

EPs must meet the following measure:

This functionality is enabled and the EP has access to at least 1 internal or external drug formulary for the entire reporting period

- Ideally, the check is against at least one formulary that may affect the patient's welfare, inform the provider as to the best drug to prescribe, or provide the patient and provider information on the drug's cost to both the patient and any 3rd party payer.
- Many EHR technologies have the option to disable these checks, and the certification process does not require the removal of this option. However, to meet the objective, the EP must enable this functionality for the entire reporting period.
- This may be an internally developed or external formulary, as long as they are relevant for patient care during the prescribing process.
- **EXCLUSION:** Any EP who writes fewer than 100 prescriptions during the reporting period is excluded from this measure.
- **STAGE 2:** Expect the measure will be expanded to be counted on a transactional basis for future stages.

Menu Objective 2: Incorporate clinical lab-test results into EHR as structured data

EPs must meet the following measure:

Number of lab test results, expressed as either a yes/no or number value, which are incorporated as data

Number of lab tests ordered during reporting period

> 40%

- Information must be stored as structured data, meaning no free text boxes or uploaded images.
- Not limited to electronic exchanges. For example, lab results transmitted to EP by paper need to be entered into the EHR as well.

Menu Objective 3: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach

EPs must meet the following measure:

Generate at least 1 report listing patients with a specific condition

- Only one report is required per reporting period.
- Report should cover every patient whose records are maintained in the EHR or a subset of those patients. The ultimate list is left to the discretion of the EP.
- "Conditions" should correspond to items listed in the active patient problem list (Core Objective 5).
- Take a look at [ASCO's QOPI Program](#).

Menu Objective 4: Send reminders to patients per patient preference for preventive/follow up care

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who were sent the appropriate reminder}}{\text{Number of all unique patients that are } \geq 65 \text{ years OR } \leq 5 \text{ years (whose records are maintained using EHR technology)}} > 20\%$$

- EPs meet the aspect of “per patient preference” if they are accommodating reasonable requests as defined under HIPAA. See [45 CFR 164.522b](#) for more details.
- For some care givers, this function may not be part of the EHR, and instead may be part of a “practice management” or “patient management” system. These systems would have to be separately certified by a testing body.
- EP can determine the frequency, means of transmission, and form of the reminder.

Menu Objective 5: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who have timely (within 4 business days of being updated in the EHR) electronic access to their information online}}{\text{Number of all unique patients seen during the reporting period}} > 20\%$$

- This is not another e-copy of health information upon request (that is core objective 12). The difference is that, for this objective, the patient can access the continually updated information anytime. In objective 12, the patient must request an e-copy from the EP.
- Information can be accessed on demand through a patient portal or personal health record.
- The data that must be minimally provided is specified in [45 CFR 170.304\(g\)](#).

Menu Objective 6: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate

EPs must meet the following measure:

$$\frac{\text{Number of patients in the denominator who receive patient education specific resources}}{\text{Number of all unique patients seen during the reporting period}} > 10\%$$

- See ASCO’s [Cancer.net](#) for patient education material.

Menu Objective 7: 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

EPs must meet the following measure:

$$\frac{\text{Number of transmissions of care in the denominator where medication reconciliation was performed}}{\text{Number of transitions of care for patients (whose records are maintained using EHR technology) during the reporting period}} > 50\%$$

- Medication reconciliation means identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical records to an external list of medications obtained from a patient, hospital, or other provider.
- Transition of care is defined as moving from one clinical setting to another (hospital, ambulatory primary care practice, specialty care practice, long-term care, home health, rehabilitation facility).

Menu Objective 8: The EP should provide summary of care record for each transition of care or referral

EPs must meet the following measure:

$$\frac{\text{Number of transmissions of care and referrals in the denominator where a summary of care was provided}}{\text{Number of transitions of care and referrals during the reporting period}} > 50\%$$

- Summary of care record can either be in an electronic or paper format.
- Transition of care is defined as moving from one clinical setting to another (hospital, ambulatory primary care practice, specialty care practice, long-term care, home health, rehabilitation facility).

The next two menu objectives are considered “public health objectives.” EPs must select one of these objectives to include into their 5 menu objectives.

Menu Objective 9: Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice

EPs must meet the following measure:

Perform 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 the immunization registry cannot accept electronic information)

- Dummy data can be used for the test
- A failed attempt meets the measure.
- Only one test is necessary.
- Testing can occur before the beginning of the EHR reporting period.
- *EXCLUSION:* Measure only applies to EPs that administer one or more immunizations during the reporting period.

Menu Objective 10: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice

EPs must meet the following measure:

Perform 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 the immunization registry cannot accept electronic information)

- Dummy data can be used for the test.
- A failed attempt meets the measure.
- Only one test is necessary.
- Testing can occur before the beginning of the EHR reporting period.
- *EXCLUSION:* If an EP does not collect any reportable syndromic information on their patients, they are excluded from this measure.

More Information

For the latest updates on government policies or other health information technology related-information, visit asco.org/ehr. There, one can find specific information on the EHR-meaningful use incentive program, including sections describing the incentive payments, what defines an eligible professional, and more.

Connect and communicate with peers about their EHR experience at ASCO Connection, ASCO's new social networking website.

Finally, the government has vast resources about its incentive program. Start at their main page for the latest information:

<http://cms.gov/EHRIncentivePrograms/>

Document History

This document has undergone the following revisions:

- Version 1.2: October 25th – Addition of Introduction and More Information sections.
- Version 1.1: October 13th – Minor typo corrections.
- Version 1.0: September 30th – Original document.

Trouble with EHRs? ASCO's Field Guide can Help

The Oncology Electronic Health Record Field Guide: Selecting and Implementing an EHR is



ASCO's unique oncology-specific handbook that reviews the steps you need to take to have a successful EHR experience.

asco.org/ehrfieldguide

Questions? Spot a typo or error? Email ehr@asco.org



American Society of Clinical Oncology

Making a world of difference in cancer care