VERMONT INFORMATION TECHNOLOGY LEADERS

Checklist for Stage I Meaningful Use Criteria

STAGE I, PRIORITY I--Improve quality, safety, efficiency; reduce health disparities

Care Goals:

1. Access to comprehensive patient health data
2. Use of evidence based order sets and Computer-based Provider Order Entry (CPOE)
3. Apply clinical decision support at the point of care
4. Generate lists of patients who need care and use them to reach out to patients
5. Report information for quality improvement and public reporting

Objective	Definition	NO	YES	P*	N/A
Use of CPOE for 80% of orders	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP); CPOE is used for at least 80% of all orders				
Implement drug-drug, drug-allergy, drug-formulary checks	The EP** has enabled this functionality				
Up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED	At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data				
EPrescribing	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology				
Maintain active medication list	At least 80% of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data				

Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data				
Record demographics -Gender -Date of Birth -Insurance -Preferred language -Race -Ethnicity	At least 80% of all unique patients seen by the EP have demographics recorded as structured data				
Record and chart changes in vital signs: -Height -Weight -Blood Pressure -Calculate and display BMI -Plot and display growth charts for children 2-20 years, including BMI	For at least 80% of all unique patients age 2 and over seen by the EP record blood pressure and BMI; additionally plot growth chart for children age 2-20				
Record Smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP have "smoking status" recorded (e.g., “current user”, “past user”, “never”)				
Incorporate clinical lab-test results into EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR as structured data				
Generate lists of patients by specific conditions to use for quality improvement reduction of disparities, and outreach	Generate at least one report listing patients of the EP with a specific condition				

Report ambulatory quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule (SEE "MEANINGFUL USE TULES TABLES 4-19); For 2012, electronically submit the measures				
Send reminders to patients per patient preference for preventive/ follow up care	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over				
Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for				
Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital				
Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital				

***Partially completed or in progress **Eligible professional**

STAGE I, PRIORITY II-- Engage patients and families in their health care

Care Goal: Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health

Objective	Definition	NO	YES	P*	N/A
Provide patients/families with an electronic copy of their health information(including diagnostic test results, problem list, med list, allergies) upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours				
Provide patients 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 EP	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information				
Provide clinical summaries for patients for each office visit	Clinical summaries are provided for at least 80% of all office visits				

***Partially completed or in progress**

STAGE I, PRIORITY III-- Improve care coordination

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

Objective	Definition	NO	YES	P*	N/A
Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information				
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 (how will you demonstrate this?)				
Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals				

*Partially completed or in progress

2011: STAGE I, PRIORITY IV-- Improve population and public health

Care Goal: Communicate with public health agencies

Objective	Definition	NO	YES	P*	N/A
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries				
Capabilityto provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	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 an EP or eligible hospital submits such information have the capacity to receive the information electronically)				

***Partially completed or in progress**

2011: STAGE I, PRIORITY V—Ensure adequate privacy and security for personal health information

Care Goals:

1. Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law
2. Provide transparency of data sharing to patient

Objective	Definition	NO	YES	P*	N/A
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				

***Partially completed or in progress**