

ACTION LIST

Project:

Team:

Dates: Tuesdays over lunch 11:30-12:30

Location:

Document Location: (On Network)

What	Details/Measure	Who	Due Date	How Submitted to CMS via EHR	Notes/Status
PQRI					
					1.
E-Prescribe					
Meaningful Use					

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Timeline	Fall 2010 Certification of EHR Vendors. 2011-2012 Clinicians can begin using a certified EHR in a meaningful manner. Jan 2011: Registration with CMS begins. April 2011: Attestation of meaningful use begins. May 2011: CMS payments will begin.				
Which do we want to register for Medicare or Medicaid? If Medicaid, their website won't be online for registration until February, for Medicare, we can register now.					
Do we want payments to go to the individual doctors or to CIG? In the registration process, there is an area to fill in if we want to assign payments, even though we will register each doctor individually. We need a TIN, NPI and group name for CIG as they appear on the NPPES website.					
DETAILS					
1. To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology					
2. EP's have to report on 20 of 25					

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MU objectives.					
3. EHR Reporting period – 90 days for first year, one year subsequently.					
Reporting by attestations required in 2011, electronic reporting to CMS required in 2012					
Core Set – All					Note Policy Number below
1. Use computerized order entry for medication orders.	More than 30% of patients with a least one medication in their medication list have a least one medication ordered through CPOE				CIG Nursing 24.43,24.44,24.51 GE EMR 21.xxx
2. Implement drug-drug ad drug-allergy checks.	Functionality is enabled for these checks for the entire reporting period.				
3. Generate and transmit permissible prescriptions electronically (EP's only)	More than 40% are transmitted electronically using certified EHR technology.				
4. Record patient demographics-gender, race, ethnicity, date of birth, preferred language. Hospitals and mortality date and cause of death.	More than 50% of patient's demographic data recorded as structured data.				
5. Maintain and up to date problem list of current and active diagnoses.	More than 80% of patients have at least one entry recorded as structured data.				
6. Maintain active medication list.	More than 80% of patients have at least one entry recorded as structured data.				
7. Maintain active medication allergy list.	More than 80% of patients have at least one entry recorded as structured data.				
8. Record and chart changes in	More than 50% of patients, 2				

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vital signs (height, weight, blood pressure, BMI)	years old and older have height, weight, blood pressure recorded as structured data.				
9. Record smoking status for patients 13 years or older.	More than 50% of patients 13 years of age and older have smoking status recorded as structured data.				
10. Implement one clinical decision support rule and ability to track compliance with the rule.	One clinical decision support rule implemented.				
11. Report Clinical Quality Measures (CQMs) to CMS or the States.	2011: Provide aggregate numerator and denominator through attestation; 2012: electronically submit measures.				
12. Provide patients with an electronic copy of their health information upon request – diagnostic test results, problem list, medication lists, medication allergies, Hospitals and discharge summary and procedures.	More than 50% of requesting patients receive electronic copy with 3 business days.				
13. Provide patients with an electronic copy of their discharge instructions at time of discharge.	More than 50% of all patients who are discharged who request an electronic copy of their discharge instructions are provided it.				
14. Provide clinical summaries to patients for each office visits (EP's only).	Clinical summaries are provided to patients for more than 50% of all office visits within 3 business days.				
15. To exchange key clinical information electronically among providers and patient authorized entities.	Perform at least one test of EHR's capacity to electronically exchange key clinical information				
16. Protect electronic health	Conduct or review a security risk				

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information (privacy and security).	analysis; implement security updates as necessary; correct identified security deficiencies.				
MU Final Rule Measures – Menu Set – Pick 5					
1. Implement drug formulary checks.	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period.				
2. Incorporate clinical lab-test results into certified EHR as structured data.	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHR as structured data.				
3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research and outreach.	Generate at least one listing of patients with a specific condition.				
4. Send reminders to patients for patient preference for preventive/follow-up care (EP's only).	More than 20% of patients \geq 65 years old or $</+ 5$ years old are sent appropriate reminders.				
5. Provide patients with timely electronic access to their health information including lab results, problem list, medication list, allergies.	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR.				
6. Use certified EHR to identify patient specific education resources and provide to patient if appropriate.	More than 10% of patients are provided patient-specific education resources.				
7. Perform medication reconciliation in relevant	Medication reconciliation is performed for more than 50% of				

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(between care settings).	transitions of care.				
8. Provide summary care record for transitions in care or referrals.	Summary of care record is provided for more than 50% of patient transitions or referrals.				
9. Capability to submit electronic data to immunization registries and actual submission.	Perform at least one test of data submission and follow-up submission (where registries can accept electronic data).				
10. Capability to provide electronic syndromic surveillance data to public health agencies and actual submission.	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data).				

Resources:



EPQuickRefGuideDiagram508Compliant06.pdf



MEANINGFUL USE.pdf



PQRI Group Option.pdf

HDM Daily [mailto:healthdatamanagement@e.healthdatamanagement.com]