

# Meaningful Use - Phase 1 for 2011 and 2012

CMS Notice of Proposed Rulemaking, Released 12/30/09

1. **Use CPOE**  
Use CPOE for orders involving medications, laboratory, radiology, and referrals. Orders do not have to be sent electronically to labs, pharmacy, or diagnostic imaging center in 2011 or 2012. Practices must enter 80% of their total orders directly by the clinician into the CPOE system.
2. **Implement Drug-Drug, Drug-Allergy, Drug-Formulary Checks**  
Enable this functionality.
3. **Maintain an Up-to-Date Problem List**  
Current and active diagnoses based on ICD-9-CM or SNOMED CT ®.  
80% of unique patients must have at least one coded problem/diagnosis, with “none” being an allowed entry.
4. **Generate and Transmit Prescriptions Electronically**  
Must send 75% of all permissible prescriptions electronically.
5. **Maintain an Active Medication List**  
80% of unique patients must have at least one coded entry, with “none” being an allowed entry.
6. **Maintain an Active Medication Allergy List**  
80% of unique patients must have at least one coded entry, with “none” being an allowed entry.
7. **Record Demographics**  
Such as: preferred language, insurance type, gender, race, ethnicity, and data of birth.  
80% of patients must have demographics recorded as structured data.
8. **Record and Chart Changes in Vital Signs**  
Height, weight, BP, calculate and display BMI, growth charts for patients age 2 and over.  
80% of patients aged 2 and over must have blood pressure and BMI entered.  
Children 2-20 must have a growth chart plotted and displayed.
9. **Record Smoking Status**  
Record if current smoker, former smoker, or never smoked. Must be recorded for 80% of patients 13 years old or older.

10. **Incorporate Clinical Lab-Test Results into EHR as Structured Data**  
Must record (as structured EHR data) 50% of all results that are delivered in positive/negative or numeric format.
11. **Generate Lists of Patients by Specific Conditions**  
Use for quality improvement, reduction of disparities, and outreach.  
Generate at least one report listing patients with a specific condition.
12. **Report Ambulatory Quality Measures to CMS**  
Calculate, display, and submit quality measure results for CORE and specialty measures.
13. **Send Patient Reminders**  
Issue based on patient preferences, demographics, conditions, and medication list.  
Send to 50% of patients age 50 and over.
14. **Implement Five Clinical Decision Support Rules**  
Relevant to specialty or high clinical priority and quality metrics; including diagnostic test ordering, along with the ability to track compliance with those rules.
15. **Check Insurance Eligibility Electronically from Public and Private Payers**  
Allow user to record and display based on eligibility response from insurer. Must cover 80% of unique patients.
16. **Submit Claims Electronically to Public and Private Payers**  
Must submit 80% of all claims filed electronically.
17. **Provide Electronic Copy of Health Information to Patients**  
Must provide an electronic copy of health information (test results, problem list, medication list, medication allergy list, immunizations, and procedures) to requesting patients within 48 hours.
18. **Provide Timely Patient Access to Health Information**  
Provide patients with timely electronic access to test results, problem list, medication list, medication allergy list, immunizations, and procedures within 96 hours of availability.  
Must provide to 10% of unique patients.
19. **Provide Clinical Summary for Each Patient for Each Office Visit**  
Must provide for 80% of office visits.
20. **Enable Information Exchange**  
Enable electronic sending and receiving of diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures. Must conduct at least one test of exchanging information.

**21. Perform Medication Reconciliation**

To be done at relevant encounters and each transition of care. Must be performed in 80% of encounters and care transitions.

**22. Provide Summary of Care Record**

Provide summary care record for each transition of care and referral.  
Must be recorded for 80% of transitions of care and referrals.

**23. Submit Data to Immunization Registries**

Must conduct at least one test of EHR technology's capacity to submit electronic data to immunization registries.

**24. Submit Syndrome Surveillance Data to Public Health Agencies**

Must conduct at least one test of EHR technology's capacity to provide syndromic surveillance data to public health agencies.

**25. Protect Electronic Health Information Created or Maintained by the EHR**

Must conduct a security risk analysis and implement security updates.