

Final Stage 1 Meaningful Use Objectives for Eligible Professionals



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The Electronic Health Record (EHR) Incentive Program – a product of the American Recovery and Reinvestment Act (ARRA) passed in February 2009 – earmarks several billion dollars for eligible professionals. To qualify for the Meaningful Use incentive program for individual providers, Eligible Professionals (EPs) must demonstrate that they have achieved 15 required core objectives as well as 5 out of 10 menu set objectives. The chart below outlines how NaviNet EMR meets these requirements and gets your practice on the road to Meaningful Use.

MEANINGFUL USE OBJECTIVES FOR ELIGIBLE PROFESSIONALS

MEANINGFUL USE: 15 REQUIRED CORE OBJECTIVES	NAVINET EMR SOLUTION
Computerized physician order entry (CPOE) of medications.	CPOE functionality for medications integrated with the MediSpan drug database.
Generate and transmit permissible prescriptions electronically (eRx).	Advanced CPOE functionality for medications via Surescripts Gold Certified eRx for electronic prescribing.
Report a total of 6 ambulatory clinical quality measures to CMS (Medicare EHR Incentive Program) or States (Medicaid EHR Incentive Program).	Reporting functionality to create a Clinical Quality Performance Report that can be printed or exported in an XML format to required agencies.
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Create and report on clinical decision support rules relevant for your practice via the EMR clinical decision support functionality.
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	Patient can print a Clinical Summary Report from the Patient Portal as needed.
Provide clinical summaries for patients for each office visit.	Printing of the Clinical Summary Report from the EMR for the patient that provides a summary of their office visit.
Drug-drug and drug-allergy interaction checks.	Drug database alerts on drug-drug and drug-allergy interactions during the medication ordering process via the MediSpan drug database.
Record demographics: <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth 	Demographics, insurance information, contact names and preferences can be added and modified via the Patient Profile.
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®.	Add new diagnoses and update old diagnoses via Diagnoses (Problem List) functionality.
Maintain the patient's active medication list.	Part of CPOE functionality for medications.
Maintain the patient's active medication allergy list.	Add new medication allergies and update old allergies via Allergies functionality.
Record and chart changes in vital signs: <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display: BMI • Plot and display growth charts for children 2-20 years, including BMI 	Record vital sign information via Vitals functionality.
Record smoking status for patients 13 years old or older.	Record smoking information as part of the patient's Social History.
Capability to exchange key clinical information among providers of care and patient-authorized entities electronically.	Import and export a Continuity of Care Document (CCD) or Continuity of Care Record (CCR) via required standards such as HL7 2.5 EDI format.
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Via security and access control.



MEANINGFUL USE OBJECTIVES FOR ELIGIBLE PROFESSIONALS

MEANINGFUL USE: 10 MENU SET OBJECTIVES	NAVINET EMR SOLUTION
Drug-formulary checks.	Advanced CPOE functionality for drug-formulary checking via Surescripts Gold Certified eRX.
Document clinical lab test results as structured data.	Integration to Laboratory Information Systems (LIS) using HL7 format or other vendor-specific formats.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Standard reporting functionality to create a report of patients with specific conditions such as a diagnosis of Hypertension.
Send reminders to patients per patient preference for preventive/follow up care.	Patients can opt in to get various reminders (such as appointment reminders). Ability to create system rules to generate reminders to patients who have opted in.
Provide patients with timely electronic access to their health information within four business days of the information being available to the eligible professional.	Clinical Summary Report available for viewing or printing from the Patient Portal.
Use certified EHR technology to identify patient-specific education resources and provide to patient if appropriate.	Provided via proprietary educational materials for printing and discussion with the patient.
The eligible professional who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform Medication reconciliation.	Medication report functionality for review of current and past medications.
Summary of care record for each transition of care/referrals.	Clinical Summary Report.
Capability to submit electronic data to immunization registries of Immunization Information Systems.	Standard reporting functionality to create an Immunization Report that can be printed or exported to required agencies.
Capability to provide electronic syndromic surveillance data to public health agencies.	Standard reporting functionality to create a Syndrome Based Report focused on specific diagnoses (such as HIV), that can be printed or converted to HL7 format for sending to required public health agencies.



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