Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures
Measure 3 of 11

Stage 1 (2014 Definition)
Last updated: May 2014

Maintain Problem List	
Objective	Maintain an up-to-date problem list of current and active diagnoses.
Measure	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Exclusion	No exclusion.

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Definition of Terms

Admitted to the Emergency Department – There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators.

Observation Services method. The denominator should include the following visits to the ED:

- The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use.

- The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Details on observation services can be found in the Medicare

Benefit Policy Manual, Chapter 6, Section 20.6. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator.

All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use.

Problem List – A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.

Unique Patient – If a patient is admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Up-to-date – The term ''up-to-date'' means the list is populated with the most recent diagnosis known by the eligible hospital or CAH. This knowledge could be ascertained from previous records, transfer of information from other providers, or querying the patient.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

- NUMERATOR: Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an eligible hospital or CAH to meet this measure.

Additional Information

- The Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 or SNOMED-CT® for the entry of structured data for this measure and made this a requirement for EHR technology to be certified. Therefore, eligible hospitals and CAHs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 or SNOMED-CT® as a basis for structured data in certified EHR technology in order to meet the measure for this objective.

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§170.314(a)(5) Problem list	Enable a user to electronically record, change, and access a patient's problem list: (i) Ambulatory setting. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in §170.207(a)(3);or (ii) Inpatient setting. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in §170.207(a)(3).

*Additional certification criteria may apply. Review the ONC 2014 Edition EHR Certification Criteria Grid Mapped to Meaningful Use Stage 1 for more information.

Standards Criteria	
§170.207(a)(3)	IHTSDO SNOMED CT® International Release, July 2012; and US Extension to SNOMED CT®, March 2012.