# Adoption/Use of Electronic Health Records (EHR)

*This measure is to be reported at **each** visit occurring during the reporting period for all patients, regardless of age. This measure may be reported by clinicians who have adopted and are using certified/qualified health information technology.*

## Measure description

Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified EHR. For the purpose of this measure, a certified/qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified[1], the system must be capable of all of the following:

- Ability to manage a medication list
- Ability to manage a problem list
- Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
- Ability to meet basic privacy and security elements

## What will you need to report for each visit for this measure?

If you select this measure for reporting, you will report:

- Whether or not the patient encounter was documented using either a CCHIT certified EHR or other qualified non-CCHIT certified EHR (as described above)

## What if the EHR was not used for this visit?

Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

[1]If CCHIT certification is available (in primary care or a specialty) on or before August 1, 2008, the EHR in use must be CCHIT certified on or before August 1, 2011 or another CCHIT certified product must be in use for compliance after August 1, 2011.