Meaningful Use Measures:

Quick Reference Guide Stage 2 (2014 and Beyond)

Core Measures

Required: All 17 objectives

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
1. **Computerized Provider Order Entry (CPOE)**	More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	Any EP who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period.	- Documenting medications through the Medication button - Documenting orders through a Procedure Checklist in a chart note	Configure the "Type" field for laboratory/radiology procedures through Edit > System Tables > Conditions > Procedures. Add Medication button and Procedure Checklist(s) to your template(s).	☐
2. **Generate and Transmit Permissible Prescriptions Electronically (eRx)**	More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using certified EHR technology.	Any EP who: (1) Writes fewer than 100 permissible prescriptions during the EHR reporting period. (2) Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.	Documenting medications through the Medication button and selecting the Transmission of "E-Prescribe" ▪ Note: You do not need an office code in the note for it to count as a permissible script. You could add the prescription via the Facesheet or through a chart note and Clinical will consider it 'permissible'.	Add Medication button to your template(s). If not yet e-prescribing, enroll at: www.sticomputer.com > Customers > ChartMaker Clinical > Surescripts Enrollment or http://tinyurl.com/lp56ewb	☐
3. **Record Demographics**	More than 80% of all unique patients seen by the EP have demographics (Preferred language, Gender, Race, Ethnicity and Date of birth) recorded as structured data.	None	Documenting applicable fields in Practice Manager (Patient tab) or in Clinical (ID tab)	(Optional) Set applicable fields as "required" in Practice Manager if desired. Go to Administration > Preferences > Screen Config > Patient.	☐
4. **Record Vital Signs**	More than 80% of all unique patients seen by the EP have one of the following 3 options recorded as structured data: ▪ Blood pressure, for patients age 3 and older, and height and weight for all ages ▪ Blood pressure only, for all patients age 3 and older ▪ Height and weight, for patients of all ages	Any EP who: (1) Sees no patients 3 years or older is excluded from recording blood pressure. (2) Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them. (3) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. (4) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.	Documenting applicable vitals using the Vitals button in a chart note	Add Vitals button to your template(s). (Optional) For practices seeing patients age 3-20, setup Growth Charts. Call Clinical Support for assistance.	☐
5. **Record Smoking Status**	More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Any EP that neither sees nor admits any patients 13 years old or older.	Documenting smoking status ("Smoking History" and "Smoking Status") using the Smoking History button in a chart note	Add the Smoking History button to your template(s). (Optional) Add section on Face Sheet to display last date documented.	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
6. Clinical Decision Support Rule	- Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. - Enable the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.	- Configuring 5 rules by going to Edit > System Tables > DSS Rule Builder - Enabling interaction checks by going to Edit > Preferences > Prescription	Create 5 Decision Support Rules in Clinical and mark as Active. Check Drug Interaction setting under each provider's login.	☐
7. View, Download, Transmit (Patient Electronic Access)	- More than 50% of all unique patients seen are provided online access to their health information within 4 business days after the information is available to the EP. - More than 5% of all unique patients seen (or their authorized representatives) view, download or transmit to a third party their health information.	Any EP who: (1) Neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information, may exclude both measures. (2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure.	- ChartMaker® PatientPortal usage (Authorize patient through PatientPortal button on Patient tab in Practice Manager; and Patient submitting Refill Request or Health Question through Messages menu on PatientPortal) - Note signing within 4 business days - Attaching SNOMED codes to applicable Diagnoses	Enroll with STI PatientPortal (Log into www.sticomputer.com through the "Customer" link and then click PatientPortal). Enter the patient's Email address in Practice Manager on the Patient tab or in Clinical on the ID tab.	☐
8. Clinical Summaries	Clinical summaries provided to patients for more than 50% of all office visits within **one** business day.	Any EP who has no office visits during the EHR reporting period.	Using the "Export" button or Chart > Export Patient Data in Clinical Or Using the "Print Clinical Summary" option in Practice Manager ▪ Notes: A valid CPT code must be selected in the office note. You will receive credit for generating the Clinical Summary for **registered** PatientPortal users without physically printing it as long as the progress note is signed within 1 business day.	Nothing to setup. (Optional) The option to exclude information on a Clinical Summary can be configured through Chart > Export > Patient Data.	☐
9. Protect Electronic Health Information	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	None	**This is not completed through the EMR**. A separate manual documenting all that you do to protect patient information, as well as a Security Risk Analysis, is required.	Create a manual documenting the process your practice takes to secure patient data. Request STI or your IT Vendor conduct a Security Risk Analysis.	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
10.Clinical Lab Test Results	More than 55% of all clinical lab tests ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.	Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the EHR reporting period.	- Documenting labs ordered in a chart note using a Procedure Checklist - Tracking incoming lab results using the Orders functionality (Status = "Completed" or "Reviewed") - Incorporating an electronic lab interface (if applicable) or manual entry of lab results	Configure lab procedures through Edit > System Tables > Conditions > Procedures ("Type" set to Lab; "Track Order" checked and "In-house" checked if applicable). Add Procedure Checklist(s) for documenting lab orders to your template(s). Map LOINC codes if manually entering lab results. (Optional) Sign up for an electronic lab interface and/or create a template for documenting lab results.	☐
11.Patient Lists	Generate at least one report listing patients of the EP with a specific condition.	None	Generating a list by going to Reports > Reports ("Choose Column" – Provider Name)	Nothing to setup.	☐
12.Preventive Care (Patient Reminders)	More than 10% of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.	Any EP who has had no office visits in the 24 months before the EHR reporting period.	- Designating the patient's Reminder Preference in Clinical or Practice Manager - Using Recall button in Clinical or Practice Manager - Generating Letters from Practice Manager and/or updating the Reminder Method field on the Recall	Create a Recall Letter in Practice Manager to use during the reporting period. Add Recall button to Clinical template if provider intends to enter/view Recalls through the chart.	☐
13.Patient-Specific Education Resources	More than 10% of all unique patients with face-to-face office visits are provided patient-specific education resources.	Any EP who has no office visits during the EHR reporting period.	Documenting educational materials given through the Education Materials button in a chart note	Setup handouts in Clinical by going to Edit > System Tables > Educational Materials.	☐
14.Medication Reconciliation	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	Any EP who was not the recipient of any transitions of care during the EHR reporting period.	Documenting that reconciliation was performed through the Medication Reconciliation button in a chart note	Add Medication Reconciliation button to your template(s).	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
15. Transition of Care Summary	- Provide a summary of care record for more than 50% of transitions of care and referrals. - Provide a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is an eHealth Exchange (formerly NwHIN exchange) participant or in a manner that is consistent with the governance mechanism ONC establishes for the eHealth Exchange. - EPs must also satisfy one of the following criteria: ▪ Conduct one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" with a recipient who has EHR technology that was developed/ designed by a different EHR technology developer than the sender's EHR technology. ▪ Conduct one or more successful tests with the CMS designated test EHR during the EHR reporting period.	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.	- Producing the Transition of Care Summary (printed and/or electronic) by going to Chart > Export Patient Data - Producing electronic Transition of Care Summaries via Direct Project by going to To-Do > Direct Messaging > Send New Message in Clinical - Conducting an exchange with another EMR not using STI's product or CMS's "EHR Randomizer" (ehr-randomizer.nist.gov) - Using the Referral button in a chart note (optional) - Attaching SNOMED codes to applicable information	Enroll for a Direct Messaging address on sticomputer.com > Customers > ChartMaker Clinical > Surescripts (Optional) Add Referral button to your template(s).	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
16. Immunization Registries Data Submission	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.	Any EP that meets one or more of the following criteria may be excluded from this objective: (1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period; (2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or (4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.	- Entering immunization information in Clinical through a Procedure Checklist in a chart note - Registering with your state immunization registry and sending immunization data on an ongoing basis - Generating immunization batch files from within Practice Manager	Install PC Vaccine module (call Clinical Support for assistance). Add Procedure Checklist(s) for documenting immunization information to your template(s).	☐
17. Secure Electronic Messaging	A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.	Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.	ChartMaker® PatientPortal usage (Message types of “Refill Request” or “Health Question” are the only two that will count)	Configure the users who will receive PatientPortal messages by going to To-Do > New Message/Task…. Click “To”, highlight the Distribution List (Patient Portal Health Questions and Patient Portal Refill Requests) and click “Edit”.	☐

Menu Set Measures

Required: 3 out of 6 objectives

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
1. Syndromic Surveillance Data Submission	The EP performs successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	Any EP that meets one or more of the following criteria may be excluded from this objective: (1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period; (2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or (4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.	- Documenting the CDC Status field on the Diagnosis dialog - Registering with your state syndromic surveillance registry (if in existence) and submitting ongoing Syndromic Surveillance data - Generating syndromic surveillance batch information by going to Chart > Export > Public Surveillance Data	Add Diagnosis button to your template(s). Register with your state's registry.	☐
2. Electronic Notes in Patient Records	Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients with at least one office visit during the EHR reporting period. Electronic progress notes must be text-searchable.	None	Entering electronic chart notes that include patient diagnoses linked to SNOMED codes and an applicable encounter code	Add a Procedure Checklist to your template(s). NOTE: Refer to Edit > System Tables > Meaningful Use Encounter Codes for a list of codes that will count as an Encounter.	☐
3. Imaging Results Accessible through EHR	More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.	Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period.	- Documenting orders in a chart note using a Procedure Checklist - Implementing Orders Tracking (and status of "completed with image" or "reviewed with image" used) - Incorporating image results in the EMR	Configure image procedures through Edit > System Tables > Conditions > Procedures ("Type" set to Radiology; "Track Order" checked and "In-house" checked if applicable). Add Procedure Checklist(s) for documenting image orders to your template(s).	☐
4. Record Patient Family Health History	More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.	Any EP who has no office visits during the EHR reporting period.	Documenting applicable information in the Family History button in a chart note ▪ NOTE: Unstructured information will not count towards this measure. Legacy data must be converted to structured data.	Add Family History button to your template(s).	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
5. Report Cancer Cases to State Registry	Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.	Any EP that meets at least 1 of the following criteria may be excluded from this objective: (1) The EP does not diagnose or directly treat cancer; (2) The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period; (3) The EP operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or (4) The EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.	Doing nothing. **This will NOT be an option for you to select as one of your Menu measures as STI is not partnered with any cancer registries at this time.**	Nothing to setup at this time.	❑
6. Report Other Cases to Specialized Registry	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	Any EP that meets at least 1 of the following criteria may be excluded from this objective: (1) The EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction; (2) The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period; (3) The EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries; or (4) The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional EPs.	- Registering with CECity specialized registry - Submitting ongoing case information to CECity for the entire reporting period	Review what information is applicable and should be documented in the patient's chart by the (CECity) Genesis Registry in the Meaningful Use Stage 2 2014 User Manual. More information can also be found at http://info.cecity.com.	❑

Additional Suggestions:

- ☐ Sign up for free STI University webinars on Meaningful Use Stage 2 - 2014 (on sticomputer.com)
- ☐ Sign up for free STI University webinars on PatientPortal and Patient Engagement
    - ☐ Collect email addresses for each patient (entered in Practice Manager on the Patient tab or Clinical on the ID tab)
    - ☐ Create in-house strategies for patient engagement/PatientPortal use
- ☐ Watch free videos available on STI website

  (Login by going to Customers and then clicking STI University > Videos)
- ☐ Save configurations for each provider in the Meaningful Use Dashboard

  (To facilitate running your statistics on a regular basis)
- ☐ Print and save a copy of your Dashboard statistics when collecting final numbers for attestation

  (To be kept in case of an audit.)

Clinical Quality Measures

Required: 9 out of 64 objectives, covering 3 of the 6 National Quality Strategy (NQS) Domains

To view a complete list of the 64 available CQMs, visit: http://tinyurl.com/nqd7orc

Listed below are the CQMs that ChartMaker® Clinical is currently certified for. You must select your 9 CQMs from this list:

NQF DOMAIN:	Efficient Use of Healthcare Resources
Measure Title	**NQF**
Appropriate Testing for Children with Pharyngitis	0002
Use of Imaging Studies for Low Back Pain	0052
Appropriate Treatment for Children with Upper Respiratory Infection (URI)*	0069

NQF DOMAIN:	Patient Safety
Measure Title	**NQF**
Use of High-Risk Medications in the Elderly	0022
Documentation of Current Medications in the Medical Record*	0419

NQF DOMAIN:	Population / Public Health
Measure Title	**NQF**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*	0028
Chlamydia Screening for Women*	0033
Preventive Care and Screening: Influenza*	0041
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*	0421

NQF DOMAIN:	Clinical Process / Effectiveness
Measure Title	**NQF**
Controlling High Blood Pressure	0018
Breast Cancer Screening*	0031
Cervical Cancer Screening	0032
Colorectal Cancer Screening	0034
Use of Appropriate Medications for Asthma*	0036
Pneumonia Vaccination Status for Older Adults*	0043
Diabetes: Eye Exam*	0055
Diabetes: Foot Exam*	0056
Diabetes: Hemoglobin A1c Poor Control*	0059
Hemoglobin A1c Test for Pediatric Patients*	0060
Diabetes: Urine Protein Screening*	0062
Diabetes: Low Density Lipoprotein (LDL) Management & Control*	0064
Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control*	0075
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*	0081
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*	0083
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy*	0088
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication*	0108
HIV/AIDS: Medical Visit	0403
Children Who Have Dental Decay or Cavities	NULL
Hypertension: Improvement in Blood Pressure*	NULL

NQF DOMAIN:	Patient and Family Engagement
Measure Title	**NQF**
Functional Status Assessment for Complex Chronic Conditions*	NULL

NQF DOMAIN:	Care Coordination
Measure Title	**NQF**
Closing the Referral Loop: Receipt of Specialist Report	NULL

* SNOMED codes may be required to be linked in order to meet the requirements of this measure. For details, see our Meaningful Use User Manual.