Modified Final Rule for 2015-2017

Meaningful Use Measures: Quick Reference Guide – Stage 2 (2014 and Beyond)

Measures Required: All 10 objectives

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
1. **Protect Electronic Health Information**	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's 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.	☐
2. **Clinical Decision Support Rule**	- Implement 5 clinical decision support interventions related to 4 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent 4 clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. - 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.	☐ ☐
3. **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).	☐ ☐ ☐
4. **Electronic Prescribing (eRx)**	More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	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 by clicking the "Enrollments" link on www.sticomputer.com	☐

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5. Health Information Exchange **(Previously Transition of Care Summary)**	The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.	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.	- Producing electronic Transition of Care Summaries via Direct Project by going to To-Do > Direct Messaging > Send New Message in Clinical - 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).	☐
6. Patient-Specific Education Resources	Patient specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period.	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.	☐
7. 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).	☐
8. Patient Electronic Access (VDT)	- More than 50% of all unique patients seen by the EP during the reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. - For an EHR reporting period in 2015, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.	Any EP who: (1) Neither orders nor creates any of the information listed for inclusion as part of the measures, or (2) Conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.	- ChartMaker® PatientPortal usage (Authorize patient through PatientPortal button on Patient tab in Practice Manager; and the Patient viewing, downloading or transmitting their information to a third party.) - Attaching SNOMED codes to applicable Diagnoses	Enroll with STI PatientPortal (Click the "Enrollments" link on www.sticomputer.com). Enter the patient's Email Address in Practice Manager on the Patient tab or in Clinical on the ID tab.	☐ ☐
9. Secure Electronic Messaging	For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period.	Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.	ChartMaker® PatientPortal usage (Message menu)	Configure the users who will receive PatientPortal messages by going to To-Do > New Message/Task…. Click "To", highlight the PatientPortal Distribution List and click "Edit".	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
10.Public Health and Clinical Data Registry Reporting	*The EP must meet **TWO** of the 3 measures. An exclusion for a measure does not count toward the total of 2 measures.* **Note**: The EP must register with the public health agency no later than 60 days from the first day of their reporting period. **Option 1 – Immunization Registry Reporting**: The EP is in active engagement with a public health agency to submit immunization data. **Option 2 – Syndromic Surveillance Reporting**: The EP is in active engagement with a public health agency to submit syndromic surveillance data. **Option 3 – Specialized Registry Reporting**: The EP is in active engagement to submit data to a specialized registry.	Any EP meeting one or more of the following criteria may be excluded from the measure if the EP: **Option 1** (1) Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period; (2) Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the (3) Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period. **Option 2** (1) Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; (2) Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. **Option 3** (1) Does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the EHR reporting period; (2) Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.	**Option 1** - 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 **Option 2** - 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 **Option 3** - Registering with CECity specialized registry - Submitting ongoing case information to CECity for the entire reporting period	**Option 1** Install PC Vaccine module (call Clinical Support for assistance). Add Procedure Checklist(s) for documenting immunization information to your template(s). **Option 2** Add Diagnosis button to your template(s). Register with your state's registry. **Option 3** 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.	☐ ☐

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:	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

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

* 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.