Stage Two

Meaningful Use Measures for Eligible Professionals

GENERAL REQUIREMENT FOR ELIGIBLE PROFESSIONALS

Objective	Measure	Numerator, Denominator, & Exclusion	Application Tips
Required by the Final Rule	At least 50 percent of all encounters during the Electronic Health Record (EHR) reporting period occurred at locations utilizing certified EHR.	Exclusion: None.	Complete Additional Documentation (AD) form if more than one location is using different Certified Electronic Health Record Technology (CEHRT) or if any locations do not use CEHRT. If EP rendered at more than one location utilizing CEHRT, the EP needs the reports from all practices to add the numerators and denominators together.
Required by the Final Rule	At least 80 percent of unique patients must have records in the certified EHR technology.	Exclusion: None.	All providers complete this section of the Additional Documentation form.

CORE MEASURES FOR ELIGIBLE PROFESSIONALS

Objective	Measure	Numerator, Denominator, & Exclusion	Application Tips
COMPUTERIZED ORDER ENTRY (CPOE) FOR MEDICATION, LABORATORY, AND RADIOLOGY ORDERS Use CPOE for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than: 60 percent of medication, 30 percent of laboratory, & 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	Numerator: Number of orders in the denominator recorded using CPOE. Denominator 1: Number of medication orders created by the EP during the EHR reporting period. Denominator 2: Number of radiology orders created by the EP during the EHR reporting period. Denominator 3: Number of laboratory orders created by the EP during the EHR reporting period. Exclusion 1: Any EP who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period.	Complete AD form to report number of medication, laboratory, and/or radiology orders if excluding.

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E-PRESCRIBING (eRX) Generate and transmit permissible prescriptions electronically (eRx).	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using certified EHR technology.	<u>Numerator:</u> Number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT. <u>Denominator:</u> Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period. <u>Exclusion 1</u>: Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period. <u>Exclusion 2</u>: An EP that 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.	Complete AD form with reason for excluding or information on pharmacies and eRX service. A drug formulary is a list of prescription drugs, both generic and brand name, that are preferred by a health plan. Patients who request a paper prescription may not be excluded from the denominator. Permissible prescriptions are prescriptions other than controlled substances in Schedule II-V. *http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf*
RECORD DEMOGRAPHICS Record all of the following demographics: A. Preferred language B. Gender C. Race D. Ethnicity E. Date of birth	More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.	<u>Numerator:</u> Number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data. <u>Denominator:</u> Number of unique patients seen by the EP during the EHR reporting period. <u>Exclusion:</u> None.	Denominator should match denominators for all unique patient measures. Race and ethnicity codes should follow current federal standards published by the Office of Management and Budget.
RECORD VITAL SIGNS Record and chart changes in the following vital signs: A. Height (H) B. Weight (W) C. Blood pressure (BP) D. Calculate and display body mass index (BMI) E. Plot and display growth charts for children 2-20 years, including BMI.	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.	<u>Numerator:</u> Number of patients in the denominator who have at least one entry of their height, weight, and BP (ages 3 and over) recorded as structured data. <u>Denominator:</u> Number of unique patients (age 3 or over for BP) seen by the EP during the EHR reporting period. <u>Exclusions:</u> One of the following: -Sees no patients 3 years or older is excluded from recording BP. -Believes that all three vital signs of H, W, and BP have no relevance to their scope of practice. -Believes that height and weight are relevant but BP is not, is excluded from recording BP. -Believes that BP is relevant but H and W are not, is excluded from recording height and weight.	Height, weight and blood pressure do not have to be updated at every patient encounter. The EP can make the determination based on the individual's circumstances as to whether height, weight and blood pressure should be updated. Only the second exclusion allows the EP to exclude from entering a numerator and denominator.

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RECORD SMOKING STATUS Record smoking status for patients 13 years old or older.	More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	<u>Numerator:</u> Number of patients in the denominator with smoking status recorded as structured data. <u>Denominator:</u> Number of unique patients age 13 or older seen by the EP during the EHR reporting period. <u>Exclusion:</u> Any EP who neither sees nor admits patients 13 years or older.	Providers should be aware of where in their CHERT to record smoking status so that it is counted towards meaningful use.
CLINICAL DECISION SUPPORT RULE Use clinical decision support (CDS) to improve performance on high-priority health conditions.	<u>Measure 1</u>: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period, if no CQMs related to EPs practice or patient population, CDS related to high-priority health conditions. <u>Measure 2</u>: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	Yes or no. <u>Exclusion for Measure 1:</u> None <u>Exclusion for Measure 2:</u> An EP who writes fewer than 100 medication orders during the EHR reporting period.	Documentation supporting this functionality should be maintained for auditing purposes e.g. screen shot or audit trail and include a list of all clinical decision support interventions implemented for the EHR reporting period.
PATIENT ELECTRONIC ACCESS Provide patients the ability to view online, download, and transmit their health information within four business days of the information being available to the EP.	<u>Measure 1</u>: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within four business days after the information is available to the EP) online access to their health information <u>Measure 2</u>: More than five percent of all unique patients seen by the EP, or their authorized representatives, during the EHR reporting period view, download, **or** transmit their health information to a third party.	<u>Numerator</u>: Number of patients in the denominator who have timely access (within four business days after the information is available to the EP) online access to their health information to view, download, and transmit to a third party. <u>Denominator</u>: Number of unique patients seen by the EP during the EHR reporting period. <u>Exclusion 1</u>: Any EP who 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. <u>Exclusion 2</u>: 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 may exclude **only** the second measure.	Denominator should match denominators for all unique patient measures. Complete AD form indicating who provides the patient portal or Personal Health Record (PHR). Patients must be given all the information necessary to access the information including providing patients with instruction, tools, or materials that patients need in order to view, download, or transmit information. Patients should not have to contact the provider for access instructions.

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CLINICAL SUMMARIES Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients or patient authorized representatives within one business day for more than 50 percent of office visits.	<u>Numerator:</u> Number of office visits in the denominator for which the patient is provided a clinical summary within one business day. <u>Denominator:</u> Number of office visits conducted by the EP during the EHR reporting period. <u>Exclusion:</u> Any EP who has no office visits during the EHR reporting period.	Can provide via PHR, patient portal, CD, USB fob, or printed copy.
PROTECT ELECTRONIC HEALTH INFORMATION Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	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 stored 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 provider's risk management process for EPs.	Yes or no. <u>Exclusion:</u> None.	Report on AD form name, title and date of Security Risk Analysis or the review. MUST occur during the program year and prior to attestation. Cannot use security risk assessment used for prior program year. MUST take place no earlier than the start of the EHR reporting year and no later than the provider attestation date. CMS tip sheet: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAssessment_FactSheet_Updated20131122.pdf
CLINICAL LAB TEST RESULTS Incorporate clinical lab test results into CEHRT as structured data.	More than 55 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in CEHRT as structured data.	<u>Numerator:</u> Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data. <u>Denominator:</u> Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or number. <u>Exclusion:</u> An EP that orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.	Complete AD form to indicate how results were incorporated into the EHR.
PATIENT LISTS Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition. Specific conditions are those conditions listed in the active patient problem list	Yes or no. <u>Exclusion:</u> None.	Document specific condition on AD form. A new list must be generated prior to the end of each reporting period. A copy of the list should be kept for auditing purposes.

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PREVENTIVE CARE Use clinically relevant information to identify patients who should receive reminders for preventative/follow up care and send these patients reminders, per patient preference when available.	More than 10 percent of all unique patients who have had two 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.	Numerator: Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period. Denominator: Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period. Exclusion: An EP who has had no office visits in the 24 months before the EHR reporting period.	Reminder must be for care not already scheduled. Reminders for referrals or to engage in certain activities are also included.
PATIENT-SPECIFIC EDUCATION RESOURCES Use of clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to patients.	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.	Numerator: Number of patients in the denominator who are provided patient-specific education resources identified by the Certified EHR technology. Denominator: Number of unique patients seen by the EP during the EHR reporting period. Exclusion: An EP who has no office visits during the EHR reporting period.	Denominator should match denominators for all unique patient measures. Education resources must be suggested by the EHR but do not have to be generated by the EHR. Document on AD form how you identify patient resources.
MEDICATION RECONCILLATION The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	Numerator: Number of transitions of care in the denominator where medication reconciliation was performed. Denominator: Number of transactions of care during the EHR reporting period for which the EP was the receiving party of the transition. Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.	Medication reconciliation: the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.
SUMMARY OF CARE The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. Must satisfy measure 1 and 2 and one of the measures under 3: Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a	Numerator: Number of transitions of care and referrals in the denominator where a summary of care record was provided. Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was transferring or referring provider. Exclusion: Any EP who transfers a patient to 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.	Transition of Care: movement of a patient from one clinical setting to another or from one EP to another. For Measure 1 summary of care can be sent electronically, faxed, or given to patient to deliver. For Measure 2 and criteria 1 of Measure 3 if the provider receiving the patient has access to the medical record, do not include patient in denominator.

summary of care record for more than 50 percent of transitions of care and referrals.

Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent 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 a eHealth Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

Measure 3: An EP must satisfy one of the following criteria:
(1) Conducts 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.
(2) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

Objective	Measure	Numerator, Denominator, & Exclusion	Application Tips
IMMUNIZATION REGISTRIES DATA SUBMISSION Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.	**The EP must attest YES to meeting one of the following criteria under the umbrella of ongoing submission. Refer to last page for criteria. Exclusion: There are four exclusions but only the first exclusion applies for Florida providers: An EP that 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.	EPs must submit documentation from Florida Shots unless they exclude. Complete AD form indicating reason if excluding.
USE SECURE ELECTRONIC MESSAGING Use secure electronic messaging to communicate with patients on relevant health information.	A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.	Numerator: The number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period. Denominator: Number of unique patients seen by the EP during the EHR reporting period. Exclusion 1: Any EP who has no office visits during the EHR reporting period Exclusion 2: An 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	Not an expectation that the EP personally respond to messages. A phone call or office visit may be more appropriate to address the concerns raised in the message.

MENU MEASURES FOR ELIGIBLE PROFESSIONALS

Exclusions no longer count toward meeting the required 3 menu measures.   EPs who exclude from any menu measure will be required to answer all menu measures.

Objective	Measure	Numerator, Denominator, & Exclusion	Application Tips
SYNDROMIC SURVEILLANCE DATA SUBMISSION Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	**The EP must attest YES to meeting one of the following criteria under the umbrella of ongoing submission. Refer to last page for criteria. Exclusion: ***Refer to last page for exclusion criteria.	The Florida Department of Health is only accepting syndromic surveillance data electronically from Urgent Care Clinics.
ELECTRONIC NOTES Record electronic notes in patient records.	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.	Numerator: The number of unique patients in the denominator that who have at least one electronic progress note from an eligible professional recorded as text searchable data. Denominator: Number of unique patients with at least one office visit during the EHR reporting period for EPs during the EHR reporting period. Exclusion: Any EP who has no office visits during the EHR reporting period.	Non-searchable notes do not qualify – but the entire note does not have to be text.
IMAGING RESULTS Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.	Numerator: The number of results in the denominator that are accessible through CEHRT. Denominator: Number of tests who result is one or more images ordered by the EP during the EHR reporting period. Exclusion 1: Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; Exclusion 2: Any EP who has no access to electronic imaging results at the start of the EHR reporting period.	Image may be stored in the CEHRT or the EHR may have a link to the image and accompanying information.

Objective	Measure	Numerator, Denominator, & Exclusion	Application Tips
FAMILY HEALTH HISTORY Record patient family health history as structured data.	More than 20 percent 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.	Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives. Denominator: Number of unique patients seen by the EP during the EHR reporting period. Exclusion: Any EP who has no office visits during the EHR reporting period.	Denominator should match denominators for all unique patient measures. First degree relatives include parents, offspring, and siblings. This measure is a minimum and not a limitation on the health history that can be recorded.
CANCER CASE REPORTING Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	**The EP must attest YES to meeting one of the following criteria under the umbrella of ongoing submission. Refer to last page for criteria. Exclusion: ***Refer to last page for exclusion criteria.	Complete AD form if excluding. Upload documentation from Florida Cancer Registry. Florida cancer registry is accepting electronic reporting. The registration form is on their website. http://fcds.med.miami.edu/inc/MU2FLCancer Reporting.shtml .
SPECIALIZED REGISTRY REPORTING Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	**The EP must attest YES to meeting one of the following criteria under the umbrella of ongoing submission. Refer to last page for criteria. Exclusion: ***Refer to last page for exclusion criteria.	EPs will need to upload documentation from the specialized registry if attesting to the criteria. Submission must be electronic meaning the EHR produces a file and the EHR sends the file to the registry via the transport mechanism required by the specialized registry. Complete AD form if excluding.

** Reporting Criterion for Ongoing Submission:
- Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period using either the current standard at 45 CFR 170.314(f)(1) and (f)(2) or the standards included in the 2011 Edition EHR certification criteria adopted by ONC during the prior EHR reporting period when ongoing submission was achieved.
- Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engage in testing and validation of ongoing electronic submission.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation

***Exclusion Criterion:
(1) For Immunization Registries Data Submission: The EP does 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;
(1) For Syndromic Surveillance: The EP is not in a category of providers that collect ambulatory syndromic surveillance information for on their patients during the EHR reporting period;
(1) For Cancer Cases: The EP does not diagnose or directly treat cancer;
(1) For Identify and Report Specific Cases: 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 PHAs in their jurisdiction;

(2) The EP operates in a jurisdiction for which no PHA or specialized registry 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 PHA or specialized registry provides information timely on capability to receive information; or
(4) The EP operates in a jurisdiction for which no PHA or specialized registry 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

For complete information on Meaningful Use requirements, visit: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html