MODIFIED STAGE 2 ELIGIBLE PROFESSIONALS

MEANINGFUL USE PERFORMANCE MEASURES AND RPMS LOGIC FOR APCM v1 p9

INDIAN HEALTH SERVICE (IHS) 2014 RESOURCE AND PATIENT MANAGEMENT SYSTEM (RPMS) ELECTRONIC HEALTH RECORD (EHR)

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Eligible Professionals report on 10 Objectives including their associated performance measures.

*A,S,O,M represents Ambulatory, Day Surgery, Observation, and Telemedicine service categories.

MU Performance Measure	Modified Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Protect Electronic Health Information: Conduct or review a security risk analysis in accordance with the requirements in 45CFR 164.312(a)(2)(iv) and 45CFR 164.306 (d)(3), and implement security updates as necessary and correct identified deficiencies as part of the EP, EH or CAH's risk management process.	**Attestation Requirements** YES/NO Eligible professionals (EPs) must attest YES to conducting or reviewing a security risk analysis and implementing security updates as needed to meet this measure."	No exclusion.
Clinical Decision Support Rule **Measure 1:** • 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. Absent four 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. Measure 2: • The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	**Attestation Requirements** YES/NO EPs must attest YES to implementing five clinical decision support interventions and enabling and implementing functionality for drug-drug and drug-allergy interaction to meet this measure.	**Exclusion** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.

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CPOE for Medication, Laboratory and Radiology Orders More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	**Medications** **Denominator Inclusions:** Count each medication order during the EHR reporting period in the orders file where the EP is the ordering provider, the patient class = outpatient, the patient location is not = to ED location (30) and the first entry in the Order file “Action” multiple field is not equal to service correction. **Numerator Inclusions:** Count each medication order in the denominator where ""Nature of Order"" for the counted medication does not = ""written"" AND the order was entered by a licensed healthcare professional. **Laboratory** **Denominator Inclusions:** Count each laboratory order in the lab order file (#69), entered during the EHR reporting period, where the EP is the ordering provider, the patient class = outpatient and the patient location is not = to ED location (30). **Numerator Inclusions:** Count each laboratory order in the denominator where the “Nature of Order” does not = “written” OR “Service Correction” and the order was entered by a licensed healthcare professional. **Radiology** **Denominator Inclusions:** Count each radiology order in the radiology order file (#100), entered during the EHR reporting period where the EP is the ordering provider, the patient class= outpatient and the patient location sis not = to ED location (30). **Numerator Inclusions:** Count each Radiology/Nuclear Medicine order in the denominator where the “Nature of Order” does not = “written” and the order was entered by a licensed healthcare professional.	**Exclusion** Any EP who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting
e-Prescribing (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 CEHRT.	**Denominator Exclusions:** 1. Any entries of any type in the outside medication component. 2. Any prescription which has a remark that contains ""Administered in Clinic."" 3. Any prescription for a Controlled Substance identified by DEA special handling code of 1-5. 4. Any prescription with the Discharge Medication field set to “Yes” (1). **Denominator Inclusions:** Count each prescription electronically entered by the eligible provider with an issue date during the EHR reporting period AND filled by an on-site pharmacy, off-site pharmacy or on-site COTS pharmacy AND that has an Rx# in the prescription file. **Numerator Inclusions:** Count each prescription in the denominator that has an Rx# in the prescription file that meets at least one of the conditions below: 1. Is numeric AND the ""Nature of Order"" does not = ""written."" 2. Starts with “X” AND the activity log comment field contains ""E-Prescribe or eRX.""	**Exclusion** 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.

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Summary of Care/HIE The EP, eligible hospital or CAH 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 percent of transitions of care and referrals. .	**IHS Denominator Exclusions:** Denominator: Exclusions: Emergency Room (clinic code 30), In-house referrals, and service category H. Count each referral which meets the following criteria: 1. The RCIS Referral file Requesting Provider field (.06) entry is equal to the EP for whom the report is being generated. AND 2. The RCIS Referral file Date Initiated field (.01) entry is within the EHR reporting period. AND 3. The RCIS Referral file contains a value in the DATE APPROVED field that is within the EHR Reporting period. AND 4. The RCIS Referral file field REFERRAL TYPE field (.04) entry is not equal to "N" (In-House). AND 5. The RCIS Referral file field CPT SERVICE CATEGORY (.13) does not equal DIAGNOSTIC IMAGING, PATHOLOGY AND LABORATORY, TRANSPORTATION, OR DURABLE MEDICAL EQUIPMENT. **Numerator Inclusions:** Transmitted documents - count each referral in the Denominator which meets the following criteria: The RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT, sub-field 90001.6,.04, DOCUMENT TYPE = CT (CCDA TRANSMITTED). AND 2015,2016: here is a value in the RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT, sub-field 90001.6, .01, DATE-TIME TX SENT, which is between January 1 of the reporting year and the date the report is generated. 2017: There is a value in the RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT, sub-field 90001.6, .01, DATE-TIME PRINTED OR TX-FILE, which is between January 1, 2017 and December 31, 2017. AND 2016: There is a value in the RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT, sub-field 900001.6, .03, DATE-TIME TX ACKNOWLEDGED which is between the January 1 of the reporting year and the date the report is generated. 2017: There is a value in the RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT, sub-field 900001.6, .03, DATE-TIME ACKNOWLEDGED which is between January 1, 2017 and December 31, 2017.	**Exclusion** 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.
Patient-Specific Education Resources Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.	**Denominator Inclusions:** COUNT each patient HAVING one or more face-to-face visits with the eligible professional during the EHR reporting period, where the eligible professional was the primary provider, defined as Service Category of A, S, or O and WHERE the clinic code is NOT equal to Case Management-77, Laboratory Services-76, Radiology-63, Pharmacy-39, or Emergency Department-30. **Numerator Inclusions:** 20115,2016: COUNT the number of patients in the denominator WHERE the patient has one or more entries of the patient and family education subtopic of literature (L) recorded on Jan 1st of the report period year begin date the user enters through the day the report is generated. 2017: 1. If the report is generated after December 31, 2017, count the number of patients included in the denominator who have viewed their online information up to December 31, 2017. 2. If the date the report is generated is within 2017, count to the date the report is generated	**Exclusion** Any EP who has no office visits during the EHR reporting period.

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MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Medication Reconciliation The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	**Denominator Inclusions:** Count each patient visit for the eligible provider during the EHR reporting period which meet the following criteria: 1. the eligible provider was the primary provider 2. the visit Service Category is A, S, O or M 3. the clinic code is NOT equal to one of the following: 09,11, 12, 14, 21, 22, 30, 33, 34, 35, 36, 39, 40, 41, 42, 43, 45, 51,52, 53, 54, 55, 60, 61, 63, 66, 67, 68, 71, 74, 76, 77, 78, 82, 86, 90,91, 93, 94, 95 or 98, A1, A3, A8, A9, B1, B2, B4, B7, C4, C5, C8, C9, D1, D2, D3, D4. 4. the visit is a new patient visit (identified by E&M code entry in range 99201-99205 (new outpatient office visit) or 99381-99387 (preventive visit new patients) in the V CPT File) OR 5. the visit is NOT a new patient and meets the following criteria: - the patient is found in the IMAGE file (object name field or patient name field) - the" Type Index" field is equal to "CCD-Summary" and - the Capture Application field (8.1) is NOT equal to "I" (Import API) and - the "Date/Time Image Saved" field has an entry which is before the visit date/time. AND - the visit is the first ambulatory patient visit with the EP after the date in the "Date/Time Image Saved" field. **Numerator Inclusion:** 1. Count each patient visit in the denominator where SNOMED Code 428191000124101(Documentation of current medications (procedure)) is present in the SNOMED CT field of the V Updated/Reviewed file for a visit during the reporting period. And the 2. Event Date and Time entry in the V Updated/Reviewed file field is within the reporting period.	**Exclusion** Any EP who was not the recipient of any transitions of care during the EHR reporting period.

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Patient Electronic Access (View/download/transmit): **Measure 1:** 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 4 business days after the information is available to the EP) online access to their health information. **Measure 2:** **For 2015 and 2016:** For an EHR reporting period in 2015 and 2016, 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. **For 2017**: For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.	**Measure Exclusions:** Case Management (clinic code 77), Laboratory Services (clinic code 76), Radiology (clinic code 63), Pharmacy (clinic code 39), and Emergency Room (clinic code 30) visits are excluded. **Denominator Inclusions:** The number of unique patients with one or more face-to-face visits with the EP as primary provider during the EHR reporting period, where the visit has a Service Category of A, S, O or M. Search for all visits up to the last day of EHR Reporting Period. **Measure 1 Numerator Inclusions:** The number of patients included in the denominator who meet the following criteria: 1. A patient education code of AF-PHR is documented in the V PATIENT ED file AND the Visit File Event date and Time field contains a date before or during the reporting period (can be after visit date). OR the PHR HANDOUT field (9000001.8901,.02)In the Patient file contains " 1" (Yes) and the PHR HANDOUT DATE (9000001.8901,.01) field contains a date before or during the reporting period (can be after visit date). AND 2. A CCDA receipt confirmation from the HIE is logged within 4 business days of the visit (original document) or 4 business days of the date/time last modified (information is updated, lab results update etc.). **Note:** 1. If there is more than 1 document transmitted for a visit within the 4 day timeframe only the first document sent should count in the numerator. For example, the provider modifies and this triggers a resend. **MEASURE 2 DENOMINATOR THE SAME AS "1"** The number of unique patients with one or more face-to-face visits with the EP as primary provider during the EHR reporting period, where the visit has a Service Category of A, S, O or M. Search for all visits up to the last day of EHR Reporting Period. **Measure 2 Numerator Inclusions:** 2015, 2016: Count the number of patients included in the denominator who have viewed their online information up to the date the report is generated. 2017: 1. If the report is generated after December 31, 2017, count the number of patients included in the denominator who have viewed their online information up to December 31, 2017. 2. If the date the report is generated is within 2017, count to the date the report is generated. The count is determined in the following manner for all years: 1. RPMS sends EHR reporting period date range and Patient ID from denominator and queries API BPHRMUM (located in namespace BPHR). 2. API BPHRMUM returns: Patients recorded as having access to PHR and Date PHR Accessed. **Notes:** 1. Includes all visits up to the last day of EHR Reporting Period and includes CCDA confirmation for 4 business days following. 2. If more than 1 document is transmitted for a visit within the 4 day timeframe only the first document sent will count in the numerator. For example, the provider modifies and this triggers a resend.	**Exclusion** 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.

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Secure Messaging **For 2015**: 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. **For 2016:** For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period. **For 2017**: For an EHR reporting period in 2017, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.	**Attestation Requirements**. For 2015: Yes/No For 2016 and 2017: **IHS Measure Exclusions:** Case Management (clinic code 77), Laboratory Services (clinic code 76), Radiology (clinic code 63), Pharmacy (clinic code 39), and Emergency Room (clinic code 30) visits are excluded. **Denominator Inclusions:** The number of unique patients with one or more face-to-face visits with the EP as primary provider during the EHR reporting period, where the visit has a Service Category of A, S, O or M. Search for all visits up to the last day of EHR Reporting Period. **Numerator Inclusions:** Count the number of patients in the denominator who were sent a secure electronic message by the EP/Message Agent anytime between January 1 and December 31st of the calendar year. The message must be sent using Certified EHR Technology determined in the following manner: 1. RPMS sends EHR calendar year and Patient Internal Entry Number (DFN) for patients returned in denominator and queries API BPHRMUM (located in namespace BPHR). 2. PHR API BPHRMUM returns: Signed up for PHR (0=No, 1=Yes)^date^Accessed PHR (0=No, 1=Yes)^last date^Used secure messaging (0=No, 1=Yes)^last date^direct address	**Exclusion** 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.
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.	**Attestation Requirements**. Yes/No **Exclusion:** Any EP that meets one or more of the following criteria may be excluded from this objective: (1) 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) 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) Operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or (4) 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.	**Exclusions:** See attestation column

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Syndromic Surveillance Data Submission Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	**Attestation Requirements** YES / NO **Exclusion:** 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.	**Exclusion:** See attestation column.
Specialized Registry Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	**Attestation Requirements** YES/NO **Exclusions** 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.	**Exclusions** See attestation column

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