2014 STAGE 1 ELIGIBLE PROFESSIONALS

MEANINGFUL USE PERFORMANCE MEASURES AND RPMS LOGIC FOR

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

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

	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	**CPOE:** More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.	**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.	No exclusions.
Core	**Drug Interaction Checks:** The EP has enabled this functionality for the entire EHR reporting period.	**Attestation Requirements**. YES/NO	No exclusions.
Core	**Maintain Problem List:** More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	**Denominator Inclusions:** Count each patient with one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M during the EHR reporting period. **Numerator Inclusions:** Count each patient in the Denominator WHERE structured data is present during the EHR reporting period specifying either an active or inactive problem on the problem list a) with an entered date on or before the end of the reporting period OR b) with a deleted date on or between the first and last days of the reporting period OR c) has structured data present during the reporting period that documents there are no active problems.	No exclusions.
Core	**e-Prescribing (eRx):** More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	**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. **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.""	1. Any EP who writes fewer than 100 prescriptions during the EHR reporting period. 2. Any EP who 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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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	**Active Medication List:** More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	**Denominator Inclusions:** Count each patient with one or more face-to-face visits with the eligible professional, defined as Service Category of A, S, O or M during the EHR reporting period. **Numerator Inclusions:** Count each patient in the Denominator WHERE: 1. There is documentation of No Active Medications on any visit during the EHR reporting period OR 2. There is a medication in the Prescription file with an Issue Date equal to or less than 365 days before the start of the reporting period AND an Issue Date on or before the end of the reporting period AND NOT a Discontinued Date before the start of the reporting period OR 3. An Outside Medication in the Pharmacy Patient file with a Documented Date on or before the end of the reporting period AND with a status of Active OR a Discontinued Date on or after the start of the reporting period.	No exclusions.
Core	**Medication Allergy List:** More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	**Denominator Inclusions:** Count each patient with one or more face-to-face visits with the professional, defined as Service Category of A, S, O or M during the EHR reporting period. **Numerator Inclusions:** Count each patient in the Denominator WHERE structured data is present during the EHR reporting period specifying either an active adverse reaction to a medication OR has structured data present that documents there are no known allergies.	No exclusions.
Core	**Record Demographics:** More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data. Record the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth.	**Denominator Inclusions:** COUNT each patient HAVING one or more face-to-face visits with the eligible professional, where the eligible professional was the primary provider, defined as Service Category of A, S, O, or M during the EHR reporting period WHERE the clinic code is NOT equal to Case Management-77, Laboratory Services-76, Radiology-63, Pharmacy-39, or Emergency Department-30. **Numerator Inclusions:** Count each patient in the Denominator WHERE structured data is present during the EHR reporting period for each of the following data elements (A-E) OR a structured data element is present notating: a) that the patient declines to provide the data element information and/or b) if capturing the race and ethnicity is against state law. (A) Preferred language (B) Sex (C) Race (D) Ethnicity (E) Date of birth	No exclusions.

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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	**Record Vital Signs:** For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.	**Denominator Inclusions:** Count the number of unique patients seen by the EP during the reporting period who have one or more face-to-face visits with the eligible professional, where the eligible professional was the primary provider. Visits defined as Service Category A, S, O or M. **1. Numerator Inclusions: (Height, Weight and BP)** If user answers **N** to the input question: "I believe that all three vital signs of height, weight, and blood pressure have NO relevance to my scope of practice." Count each patient (any age) included in the Denominator where structured data is present for (A) Height (B) Weight AND Count each patient 3 years or older at the beginning of the EHR reporting period in the Denominator WHERE structured data is present during the EHR reporting period for the data element: (C) Blood Pressure Numerator Output Summary Total = A +B +C Patients: all ages height and weight Patients 3 years or older: BP Denominator Output Summary Total = Total # of patients **2. Numerator Inclusion: (Height & Weight only)** If user answers **Y** to the input question "I believe that height and weight are relevant to my scope of practice, but blood pressure is not." OR "I only see patients under the age of 3 years and therefore do not record blood pressure." Count each patient (any age) included in the Denominator where structured data is present for (A) Height (B) Weight Numerator Output Summary Total = A + B Patients of any age with height and weight recorded. Denominator Output Summary Total = Total # of patients **3. Numerator Inclusion: (BP only)** If user answers **Y** to the input question: "I believe that blood pressure is relevant to my scope of practice but height and weight are not." Count each patient 3 years or older at the beginning of the EHR reporting period in the Denominator WHERE structured data is present during the EHR reporting period for the data element : Blood Pressure Numerator Output Summary Total = Patients 3 years and older with BP recorded. Denominator Output Summary Total = Total # of patients excluding patients under 3.	Any EP who: 1. Sees no patients 3 years or older is excluded from recording blood pressure; 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	**Record Smoking Status:** More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	**Denominator Inclusions:** COUNT each patient who is 13 years old or older at the beginning of the EHR reporting period HAVING one or more face-to-face visits with the eligible professional, where the eligible professional was the primary provider, defined as Service Category of A, S, O, or M during the EHR reporting period WHERE the clinic code is NOT equal to Case Management-77, Laboratory Services-76, Radiology-63, Pharmacy-39, or Emergency Department-30 **Numerator Inclusions:** Count each patient in the denominator where structured data is present during the EHR reporting period for smoking status. **Notes:** Smoking status must be recorded with one of the following national tobacco health factors. No other health factors will count for the measure. • Current every day smoker recorded as structured data. • Current same day smoker recorded as structured data. • Former smoker recorded as structured data. • Never smoker recorded as structured data. • Smoker, current status unknown recorded as structured data. • Unknown if ever smoked recorded as structured data. • Heavy tobacco smoker recorded as structured data. • Light tobacco smoker recorded as structured data.	Any EP who sees no patients 13 years or older.
Core	**Clinical Decision Support:** Implement one clinical decision support rule.	YES/NO **Attestation Requirements**.	No exclusions.

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Numerator and Denominator</th><th>Exclusion</th></tr>
<tr><td>Core</td><td>Patient Electronic Access (View/Download/Transmit):
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, with the ability to view, download, and transmit to a third party.</td><td>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:
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.).
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.</td><td>Exclusion:
Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information, may exclude the measure.</td></tr>
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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	**Clinical Summaries:** Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.	**Denominator Exclusions:** Exclude eligible professionals who have no office visits during the EHR reporting period. 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:** Count each patient face-to-face visit with a provider during the EHR reporting period, where the provider was the primary provider on the visit, and the Service Category is A, S, O, M. Search for all visits up to the last day of EHR Reporting Period. **Numerator Inclusions:** Count the number of visits included in the denominator who meet the following criteria on the visit date OR within 3 business days after the visit date. If multiple clinical summaries are generated for a visit, only one may be included in the numerator. 1. There is a “1” (yes) entry in the Patient file (#9000001), PHR ACCESS field (8801,.01) and a date, on or before the visit date, in the PHR ACCESS DATE field (8801, . 02) (These entries indicate patient has an active PHR account). OR 2. The APCC DOCUMENT LOG, DOCUMENT PRINT TYPE entry = 1 (Clinical Summary) AND the DATE AND TIME field entry is equal to or within 3 business days of the visit. OR 3. There is an entry in the PATIENT REFUSALS FOR SERVICE/NMI file, Service Type field (.01) = to “SNOMED” AND SNOMED CODE , 422735006 (Clinical Summary document)is present in the CONCEPT ID FOR REFUSED SERVICE field (1301) AND The DATE DECLINED/NOT INDICATED field (.03) has an entry equal to or within 3 business days of the visit. **Logic Notes:** If visit date is near end of reporting period, look after the reporting period end date for the 3 days window. Only one instance of clinical summary generated per visit counts in the numerator. For example, PHR access and also printed and handed to patient counts as 1 in the numerator.	Any EP who has no office visits during the EHR reporting period.
Core	**Protect Electronic Health Information:** Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	YES/NO **Attestation Requirements**.	No exclusions.
Menu	**Drug Formulary Checks:** The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	YES/NO **Attestation Requirements**.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Menu	**Clinical Lab Test Results:** More than 40 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 certified EHR technology as structured data.	**Denominator Exclusion:** Pap smears ordered using any of the following CPT codes: [88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091]. The results for these orders are expressed with text and are excluded from the measure. **Denominator Inclusions:** COUNT each V LAB entry ordered by an eligible professional during the EHR reporting period that meets all of the following criteria: 1. Is defined as Service Category A, S, O or M during the EHR reporting period WHERE the clinic code is not equal to Emergency Department-30; AND 2. WHERE the ordering provider on the V LAB entry is the primary provider for which the report is being run; AND 3. WHERE the lab test is not a Pap Smear, determined by using the BGP PAP SMEAR TEST lab taxonomy; AND 4. WHERE the result of the test is not equal to "canc" (these tests were cancelled); AND 5. Where the lab test is a single test or a panel. When the order is a panel, count each individual test included in the panel as a single test order. **Numerator Inclusions:** COUNT each single test in the denominator where the status flag is RESULTED; AND 1. WHERE RESULTS does not equal "comment"; OR 2. If RESULTS = "comment" THEN COMMENTS does not equal null. AND COUNT each test in a panel where the status flag is RESULTED AND 1. WHERE RESULTS does not equal "comment"; OR 2. If RESULTS = "comment" THEN COMMENTS does not equal null.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
Menu	**Patient Lists:** Generate at least one report listing patients of the EP with a specific condition.	YES/NO **Attestation Requirements**.	No exclusion.

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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Menu	**Patient Reminders:** More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	**Denominator Exclusions:** If the facility does not have any patients in the database who are 1) 5 years old or younger or 2) 65 years or older, the EP is excluded from this measure. **Denominator Inclusions:** Count each patient who meets the following criteria: • Is under 5 years of age at the beginning of the EHR reporting period OR over 65 years of age at the beginning of the reporting period. • Does not have a date of death recorded as of the last day of the reporting period. • Has an active medical record as of the last day of the reporting period. • Had a visit in service category A, S, O or M with the attesting EP anytime in their lifetime before the end of the report period where the EP was the primary provider on the visit. • The clinic code is NOT equal to Case Management-77, Laboratory Services-76, Radiology-63, Pharmacy-39, or Emergency Department-30. **Numerator Inclusions:** Count each patient from the denominator which has an entry, during the EHR reporting period, in the ICARE REMINDER NOTIFICATIONS file (#90509.4) where the PREFERRED REMINDER METHOD is the same value as the NOTIFICATION field or the PREFERRED REMINDER METHOD is null and the notification field has an entry.	Exclusion: An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
Menu	**Patient-Specific Education Resources:** More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.	**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, O, or M 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:** 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 the first day of the EHR reporting period until the day the report is generated.	No exclusions.

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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Menu	**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.	**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. **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 during the reporting period.	An EP who was not the recipient of any transitions of care during the EHR reporting period.

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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Menu	**Transition of Care Summary (Summary of Care):** 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.	**IHS Denominator Exclusions:** Exclude the following: Case Management (clinic code 77), Laboratory Services (clinic code 76), Radiology (clinic code 63), Pharmacy (clinic code 39), and Emergency Room (clinic code 30). In-house referrals are excluded. **IHS Denominator** Count each visit during the EHR reporting period where the primary provider is the EP for which the report is being run, the clinic code is NOT equal to Case Management (clinic code 77), Laboratory Services (clinic code 76), Radiology (clinic code 63), Pharmacy (clinic code 39), or Emergency Room (clinic code 30) and the visit meets the following criteria: 1. There is an entry for the visit in the V Referral file AND 2. The RCIS Referral file field REFERRAL TYPE entry is not equal to "N" (In-House) AND 3. The RCIS Referral file contains a value in the DATE APPROVED field that is within the EHR Reporting period AND there is a value in the EXPECTED BEGIN DOS field. **Numerator Inclusions:** 1. **Printed 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 = CP (CCDA PRINTED). AND 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 equal to or between the value in the DATE APPROVED field and the last day of the EHR reporting period. OR If there is no entry in RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT , there is an entry in the APCC Document Log File, Document Type Field of "2" (Transition of Care) AND an entry in the APCC DOCUMENT LOG file DATE/ TIME field equal to the visit date. 2. **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 There is a value in the RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT , sub-field 90001.6,.06, DATE-TIME TX SENT, which is equal to or between the value in the DATE APPROVED field and the last day of the EHR reporting period.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

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	MU Performance Measure	Stage 1 EP RPMS Logic for Numerator and Denominator	Exclusion
Menu	**Immunization Registries Data Submission:** Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful, (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically), except where prohibited.	YES/NO **Attestation Requirements**.	An EP who administers no immunizations during the EHR reporting period, where no immunization registry has the capacity to receive the information electronically, or where it is prohibited.
Menu	**Syndromic Surveillance:** Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful, (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically) except where prohibited.	YES/NO **Attestation Requirements**.	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or if it is prohibited.

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