

STAGE 2 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

Quick Measure Locator Table

Core Performance Measures (17)	Menu Set Performance Measures (5)
1 of 17. CPOE for Medication, Laboratory, and Radiology Orders	1 of 5. Syndromic Surveillance Data Submission
2 of 17. e-Prescribing (eRx)	2 of 5. Electronic Progress Note
3 of 17. Record Demographics	3 of 5. Imaging Results
4 of 17. Record Vital Signs	4 of 5. Family Health History
5 of 17. Record Smoking Status	5 of 5. Specialized Registry
6 of 17. Clinical Decision Support Rule	
7 of 17. Patient Electronic Access (View/Download/Transmit)	
8 of 17. Clinical Summaries	
9 of 17. Patient Electronic Health Information	
10 of 17. Clinical Lab Test Results	
11 of 17. Patient Lists	
12 of 17. Patient Reminders (Preventative Care)	
13 of 17. Patient-Specific Education Resources	
14 of 17. Medication Reconciliation	
15 of 17. Summary of Care	
16 of 17. Immunization Registries Data Submission	
17 of 17. Secure Messaging	

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

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>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.</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p>Exclusion Any EP who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>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.</p>	<p>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.</p> <p>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.</p> <p>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.""</p>	<p>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.</p>
Core	<p>Record Demographics More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.</p>	<p>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.</p> <p>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</p>	<p>Exclusion No exclusion.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>Record Vital Signs More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.</p>	<p>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.</p> <p>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</p> <p>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</p> <p>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.</p>	<p>Exclusions: 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.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>Record Smoking Status More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.</p>	<p>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</p> <p>Numerator Inclusions: Count each patient in the denominator where structured data is present during the EHR reporting period for smoking status.</p> <p>Notes: Smoking status must be recorded with one of the following national tobacco health factors. No other health factors will count for the measure.</p> <ul style="list-style-type: none"> - 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. 	<p>Exclusion Any EP that neither sees nor admits any patients 13 years old or older.</p>
Core	<p>Clinical Decision Support Rule Measure 1:</p> <ul style="list-style-type: none"> • 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. <p>Measure 2:</p> <ul style="list-style-type: none"> • The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. 	<p>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.</p>	<p>Exclusion For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>Patient Electronic Access (View/download/transmit):</p> <p>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.</p> <p>2. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.</p>	<p>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.</p> <p>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.</p> <p>Measure A 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.).</p> <p>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.</p> <p>MEASURE B DENOMINATOR THE SAME AS “A” 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.</p> <p>Measure B Numerator Inclusions: Count the number of patients included in the denominator who have viewed their online information during the EHR reporting period, determined in the following manner: 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.</p> <p>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.</p>	<p>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.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>Clinical Summaries Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.</p>	<p>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.</p> <p>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.</p> <p>Numerator Inclusions: Count the number of visits included in the denominator who meet the following criteria on the visit date OR within 1 business day after the visit date. If multiple clinical summaries are generated for a visit, only one may be included in the numerator.</p> <ol style="list-style-type: none"> 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). <p>OR</p> <ol style="list-style-type: none"> 2. The APCC DOCUMENT LOG, DOCUMENT PRINT TYPE entry = 1 (Clinical Summary) AND the DATE AND TIME field entry is equal to or within 1 business day of the visit. <p>OR</p> <ol style="list-style-type: none"> 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 1 business day of the visit. <p>Logic Notes: If visit date is near end of reporting period, look after the reporting period end date for the 1 day 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.</p>	<p>Exclusion: Any EP who has no office visits during the EHR reporting period.</p>
Core	<p>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 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.</p>	<p>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."</p>	<p>No exclusion.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>Clinical Lab Test Results More than 55 percent of all clinical lab tests 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</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p>Exclusion Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the EHR reporting period.</p>
Core	<p>Patient Lists Generate at least one report listing patients of the EP with a specific condition.</p>	<p>Attestation Requirements YES/NO Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.</p>	No exclusions.
Core	<p>Patient Reminders (Preventive Care) More than 10 percent 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.</p>	<p>Denominator Inclusions: COUNT the number of unique patients who have had two or more visits in the 24 months prior to the beginning of the EHR reporting period with the attesting EP defined as Service Category of A, S, O, or M during the EHR reporting period AND WHERE the clinic code is NOT equal to Case Management-77, Laboratory Services-76, Radiology-63, Pharmacy-39, or Emergency Department-30. Do not include patients who have a date of death recorded or whose health record has not been inactivated as of the last day of the reporting period.</p> <p>Numerator Inclusions: Count each patient from the denominator which has a record, populated 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. (A null field = no patient preference available those are counted if reminder sent.)</p>	<p>Exclusion Any EP who has had no office visits in the 24 months before the EHR reporting period.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	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: 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.	Exclusion Any EP who has no office visits during the EHR reporting period.
Core	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 "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.

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>Summary of Care EPs must satisfy both of the following measures in order to meet the objective:</p> <p>Measure 1:</p> <ul style="list-style-type: none"> 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. <p>Measure 2:</p> <ul style="list-style-type: none"> 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 NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN. <p>Measure 3: An EP must satisfy one of the following criteria:</p> <ul style="list-style-type: none"> Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in ""measure 2"" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period. 	<p>Measure 1:</p> <p>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.</p> <p>Denominator Inclusions: Count # of referrals for the visit in the 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:</p> <ol style="list-style-type: none"> There is an entry for the visit in the V Referral file AND The RCIS Referral file field REFERRAL TYPE entry is not equal to "N" (In-House) AND 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. <p>Numerator Inclusions:</p> <ol style="list-style-type: none"> 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 an entry in RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT, DATE-TIME PRINTED OR TX-FILE, that is not equal to or between the DATE APPROVED field values, 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. 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 or 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. <p>Measure 2: Take the results of # 2 (Transmitted Documents) above and check for acknowledgement.</p> <p>Denominator Inclusions: Same as Measure 1</p> <p>Numerator: 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. AND There is a value in the RCIS Referral sub-file 600, TRANSITION OF CARE DOCUMENT, sub-field 90001.6,.03, DATE-TIME TX ACKNOWLEDGED which is equal to or between the value in the DATE APPROVED field and the last day of the EHR reporting period.</p>	<p>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.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Core	<p>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.</p>	<p>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.</p>	<p>Exclusions: See attestation column</p>
Core	<p>Secure Messaging 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.</p>	<p>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 sent a secure electronic message to the EP/Message Agent during the EHR Reporting Period. The message must be received by the EP/Message Agent using Certified EHR Technology determined in the following manner: 1. RPMS sends EHR reporting period date range and Patient ID from denominator and queries API BPHRMUM (located in namespace BPHR). 2. PHR API BPHRMUM returns: The last date the patient used secure messaging.</p>	<p>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.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Menu	<p>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.</p>	<p>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.</p>	<p>Exclusion: See attestation column.</p>
Menu	<p>Electronic Progress Note 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</p>	<p>Denominator Inclusions: 1. The number of unique patients with one or more visits during the EHR reporting period where the EP as primary provider and is a member of one of the following provider classes: 00 PHYSICIAN, 11 PHYSICIAN ASSISTANT, 16 PEDIATRIC NURSE PRACTITIONER, 17 NURSE MIDWIFE, 21 NURSE PRACTITIONER, 41 CONTRACT OB/GYN, 44 TRIBAL PHYSICIAN, 45 OSTEOPATHIC MEDICINE, 52 DENTIST, 64 NEPHROLOGIST, 68 EMERGENCY ROOM PHYSICIAN, 70 CARDIOLOGIST, 86 DERMATOLOGIST, A1 SPORTS MEDICINE PHYSICIAN, A4 NATUROPATH PHYSICIAN, A9 HEPATOLOGIST, B1 GASTROENTEROLOGIST, B2 ENDOCRINOLOGIST, B3 RHEUMATOLOGIST, B4 ONCOLOGIST HEMATOLOGIST, B5 PULMONOLOGIST, B6 NEUROSURGEON AND the visit meets the following criteria: 1. The visit is defined as Service Category of A, S, O, or M. 2. The clinic code is NOT equal to Case Management-77, Laboratory Services-76, Radiology-63, Pharmacy-39, or Emergency Department-30. Numerator Inclusions: The number of unique patients in the denominator who have at least one electronic progress note recorded during the reporting period (by ANY EP) as text searchable data in the TIU DOCUMENT file (8925) which meets the following criteria: 1. The EP is the note author (TIU Document field 1202) (can be any EP) and 2. The EP is the note signer (recorded in the TIU Document file field "1502 Signed by") OR 3. The EP is the note co-signer (recorded in the TIU Document file field 1508 "COSIGNED BY") and the note author and signer are in the TIU user class "Student" AND 4. Field #2, "Report Text," does not contain "VistA Imaging - Scanned Document." Note: A note may only be counted one time, if edited by original author and signer, do not count.</p>	<p>No exclusion.</p>

[Return to top](#)

	MU Performance Measure	Stage 2 EP RPMS Logic for Numerator and Denominator	Exclusion
Menu	Imaging Results 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.	Denominator Inclusions: Count the number of entries (exams) in the Rad/Nuc Med Patient file (#70) which meet the following criteria: 1. Ordered by the EP(EP name is in Requesting Physician field (70.03,14)) during the EHR reporting period AND 2. Have an Exam Status (70.03,3) of either Examined or Complete AND 3. The associated patient's class = outpatient and the patient location is not = to ED location (30). Numerator Inclusions: Count the number of entries from the denominator where the Rad/NUC Report file image field (2005) is not null.	Exclusion 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.
Menu	Family Health History 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.	Denominator Inclusions: Count the number of unique patients seen by the EP during the EHR Reporting period with a visit 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 with a structured data entry in the Family History file "Relation/Family Member" field which contains "Natural" OR "Unknown." (NATURAL BROTHER, NATURAL CHILD, NATURAL DAUGHTER, NATURAL FATHER, NATURAL MOTHER NATURAL PARENT, NATURAL SISTER, NATURAL SON)	Exclusion Any EP who has no office visits during the EHR reporting period.
Menu	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

[Return to top](#)