

Meaningful Use: Stage 2, 2014 Performance Measures

Eligible Professionals (EPs), Eligible Hospitals (EHs), and Critical Access Hospitals (CAHs) must use 2014 ONC certified EHR technology by the start of their 2014 EHR reporting period, regardless of the MU stage or year. Per CMS, the 2014 reporting period is three months to allow providers adequate time to implement their 2014 CEHRT. To meet MU for Stage 2, 2014, the following criteria must be met:

Eligible Professionals (EPs)

- 17 core objectives (Performance Measures)
- 3 out of 6 objectives (Performance Measures) from menu set
- 9 CQMs

Eligible Hospitals (EHs) – Note: EH measures are also applicable to CAHs.

- 16 core objectives (Performance Measures)
- 3 out of 6 objectives (Performance Measures) from menu set
- 16 approved CQMs

EP	EH	MEASURE NAME	CORE MEASURES
•	•	CPOE	More than 60% of medication, more than 30% of Laboratory and more than 30% of Radiology orders created during the reporting period are recorded using CPOE.
•	•	Record Demographics	More than 80% of all unique patients seen by the EP or admitted to the EH's inpatient or emergency department* have demographics recorded as structured data.
•	•	Vital Signs	More than 80% of all unique patients seen by the EP or admitted to the EH's inpatient or emergency department* 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.
•	•	Clinical Decision Support	 Implement 5 CDS interventions related to 4 or more CQMs at a relevant point in patient care for the entire reporting period. The EP/EH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire reporting period. (Yes/No)
•	•	Patient Electronic Access (View online, Download and Transmit)	 More than 50% of all unique patients seen by the EP or admitted to the EH's inpatient or emergency department* during the EHR reporting period are provided timely access within 4 business days for EPs and within 36 hours of discharge from EH. More than 5% of all unique patients seen by the EP or admitted to the EH's inpatient or emergency department* during the EHR reporting period view, download or transmit to a third party their health information.
•	•	Smoking Status	More than 80% of all unique patients 13 years old or older seen or admitted to the EH's inpatient or emergency department* have smoking status recorded as structured data.
•	•	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)
•	•	Clinical Lab Test Results	More than 55% of all clinical lab tests results ordered by the EP or EH 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.
•	•	Patient Lists	Generate at least one report listing patients of the EP/EH with a specific condition. (Yes/No)
•	•	Patient Education	More than 10% of all unique patients seen by the EP or admitted to the EH's inpatient or emergency department* are provided patient-specific education resources identified by CEHRT.
•	•	Medication Reconciliation	Medication reconciliation is performed for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the EH's inpatient or emergency department*.
•	•	Immunization Registries	Successful ongoing submission of electronic immunization data from CEHRT to an immunization information system for the entire reporting period. (Yes/No)

EP	EH	MEASURE NAME	CORE MEASURES
•	•	Summary of Care	 Provides a summary of care record for more than 50% of transitions of care and referrals. Provides a summary of care record using electronic transmission through CEHRT or eHealth Exchange participant for more than 10% of transitions of care and referrals. At least one summary care record must be electronically transmitted to a recipient with a different EHR vendor or to the CMS test EHR.
•		Clinical Summaries	Clinical summaries provided to patients for more than 50% of all office visits within 1 business days.
•		e-RX	More than 50% of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using certified EHR technology.
•		Patient Reminders	More than 10% 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.
•		Secure Electronic Messaging	More than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period sent a secure electronic message.
	•	Electronic Reportable Laboratory Results	Successful ongoing submission of electronic reportable laboratory results from CEHRT to a public health agency for the entire reporting period. (Yes/No)
	•	Electronic Medication Administration Record	More than 10% of medication orders created by the EH's inpatient or emergency department* during the EHR reporting period for which all doses are tracked using Electronic Medication Administration Record (eMar).
	•	Syndromic Surveillance	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire reporting period. (Yes/No)

EP	EH	MEASURE NAME	MENU SET MEASURES
•	•	Imaging	More than 10% of all tests whose result is one or more images ordered during the EHR reporting period are accessible through CEHRT.
•	•	Family History	More than 20 % of all unique patients seen by the EP or admitted to the EH's inpatient or emergency department* during the EHR reporting period have a structured data entry for one or more first-degree relatives.
•	•	Electronic Notes	More than 30% of unique patients seen by the EP or admitted to the EH's inpatient or emergency department* have at least one electronic progress note created, edited and signed by an authorized provider during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.
	•	Advance Directives	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's inpatient department* have an indication of an advance directive status recorded as structured data
	•	Discharge eRX	More than 10% of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using certified EHR technology.
•		Syndromic Surveillance	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire reporting period.
•		Specialized Registry	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.
	•	Lab Results **	Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received.
•		Cancer Registry **	Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.

^{*}Inpatient and emergency room departments are defined as POS 21 and POS 23.

**The 2014 Certified version of RPMS EHR <u>will not</u> support the Lab Results and Cancer Registry measures.