Core

Must meet all 17 measures

CPOE	60% of orders. But there's a change to denominator. Now it will only include patients that have an order for a medication, lab or radiology order. Currently the denominator includes patients with a medication on their med list and so if you don't order or refill the medication during the visit it would count against you.
Electronic prescribing	65% of prescriptions compared to one drug formulary and sent electronically. This means you need RxHub.
Demographics	have to reach more than 80%
Vital signs	Need 80% for this on unique patients (so only once during the reporting period). A few changes for this — Height/length, weight on all ages (was 2 and older). BP on ages 3 and greater (Was 2 and older). Calculate BMI all ages and plot, display growth charts for 0-20 including BMI. Problem: there aren't standards for BMI for ages 0-2. Only weight for length which isn't BMI.
Smoking status	80% of unique patients now (was 50%)
Clinical Decision Support	this is a little different — they are doing away with the Clinical quality measure objective… well sort of. You have to up with 5 clinical decision support interventions related to 5 or more clinical quality measures that you will be reporting on. i.e. You decide to do flu immunizations on patients older the age 50 — you submit for PQRI and then develop a rule in e-MDs to remind you to do this. Idea is to link the clinical decision support system to the measures you submit for PQRI. Second part of this is having drug-drug- and drug-allergy interactions active.
Lab-test results as structured data	55% now. Was menu, now core.
Clinical Reminders	10% of those patients receive a reminder for preventive care/follow up by their preferred preference. Denominator will only include all patients (all ages) seen in the last 24 months. This is to try and capture only active patients. Was menu, now core.
Online Access to Health record	**1.** 50% of all unique patients seen are provided online access to their health record within 4 business days. **2.** 10% or more patients actually use the online record (view, download or transmit it to a third party). So, we will be relying on patients to actually use it to meet this criterion. Was menu, now core.
Visit Summaries	Summaries provided for more the 50% of office visits within 24 hours (was 72 hours)
Patient Education	10%, but will allow for electronic content not in the certified EHR. So e-MDs will have to allow us a way to document that. Was menu, now core.
Secure electronic messaging	10% of unique patients will send a secure message to their EP containing health relevant information. This actually requires the patient to send you a message. I assume this would be through portal.
Med Reconciliation	65% now. Was menu, now core.

Core	Must meet all 17 measures
Transition of care	**1.** A summary of care is provided 65% of the time when referring a patient to another setting (ER, Hospital, NH) or provider (consultant or back to the primary care doc). This can be either paper or electronic and has specifics to what should be included. **2.** >10% of these referrals to another provider or setting have to be electronically transmitted to a recipient with no organizational affiliation and using a different Certified EHR. The transmission of these care summaries have to be by certain standards spelled out by ONC and CMS. Not sure how it would happen — secure messaging (direct) or HIEs? Was menu, now core
Immunization registry	Has to be successful and real data not just a test. Was menu, now core.
Security Audit	seems similar to Stage 1 except they emphasize encryption/security of data at rest.

Menu	Must meet 3 out of 5
Syndromic Data	has to be successful submission of actual data.
Cancer Registry	submit successfully to a cancer registry electronically
Specific Case Information	successful electronic submission to another non cancer registry
Imaging results and info	40% of all scans and tests whose result is an image ordered by the EP are accessible through Certified EHR technology. So, I believe this actually means the images themselves have to be accessible not just the report. They do allow for the ability for the EHR to link to the images rather than storing them and the images can be scanned in but this still seems crazy difficult to implement. This would mean partnering with the hospitals/radiology standalone centers to allow transmission or access to the images in our offices. CMS is also thinking about a second objective — electronically exchanging the images among providers 10% of the time.
Family History	20% of unique patients seen have structured data entry for 1 or more 1st degree relatives. This probably means we will need to re-enter family history in e-MDs to meet this