Core

17 Measures must be met

CPOE	**Threshold:** >60% of orders. **Changes:** Denominator will include all orders for labs, radiology, medications and numerator will be be those that are entered via CPOE. Question is how does one measure orders given that are not in our EHR such as orders given after a results comes back (i.e. Chest xray and needs CT scan now).
Electronic prescribing	**Threshold:** >65%. **Changes:** 65% of prescriptions have to be compared to one drug formulary before being sent electronically. This means you need RxHub.
Demographics	**Threshold:** >80%. **Changes:** None
Vital signs	**Threshold:** >80%. **Change:** Height/length, weight on all ages now (was 2 and older). BP on ages 3 and greater (Was 2 and older). Calculate BMI for all ages and plot, display growth charts for 0-20 including BMI. I see a problem – there aren't standards for BMI for ages 0-2. Only weight for length which isn't BMI.
Smoking status	**Threshold:** >80%. **Changes:** none
Clinical Decision Support	**Threshold:** 5 Interventions. **Changes:** this is a little different – CMS is doing away with the Clinical quality measure objective from Stage 1…well sort of. 2 parts: **1.** 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 for PQRS (Quality Measure) and then develop a rule in your EHR to remind you to do this (Clinical Decision Support). The Idea is to link the clinical decision support intervention to the measures you submit for PQRS. **2.** Turn on drug-drug- and drug-allergy interactions.
Lab results as structured data	**Threshold:** >55%. **Changes:** Core requirement now was menu.
Generate Patient List	**Threshold:** 1 list. **Changes:** none
Clinical Reminders	**Threshold:** >10% receive reminder on preventive care/follow up by their preferred method. **Changes:** It is core now not menu; denominator will only include all patients (all ages) seen in the last 24 months. This is to try and capture only active patients.
Online Access to Health record	**Threshold: 1.** > 50% provided access; **2.** >10% actually use it. **Changes:** This is core now and will require Portal. 2 parts of this you have to meet – **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.
Visit Summaries	**Threshold:** >50%. **Changes:** Summaries provided within 24 hours (not 3 days) .
Patient Education	**Threshold:** >10%. **Changes:** It is core set now, not a menu item. CMS will allow for electronic content not in the certified EHR, so the EHR will have to allow us a way to document that.

Core

Must meet all 17 measures

Secure electronic messaging	**Threshold:** >10%. **Changes:** This is new and a core item. It actually requires the patient to send a message securely to their EP containing health related information. I assume this will be through portal, and again, requires the patient to do it, not us, other then encouraging it.
Med Reconciliation	**Threshold:** >65%. **Changes:** Now core, not menu
Transition of care	**Threshold: 1.** >65% - summary of care provided; **2.** >10% are transmitted electronically. **Changes:** It is core now not menu. 2 objectives: **1.** A summary of care is provided when referring a patient to another setting (ER, Hospital, NH) or provider (consultant or back to the primary care doc) 65% of the time. This can be either paper or electronic, and CMS has specifics to what should be included. **2.** >10% of these summaries to another provider or setting have to be electronic ally 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. I think this second objective will be hard to meet and will take a lot of effort on EHR vendors to comply. Not sure how it would happen – secure messaging (direct) or HIEs?
Immunization registry	**Threshold:** Successful transmission of actual data. **Changes:** It is core now, not menu.
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	**Threshold:** Successful transmission of actual data. **Changes:** Has to be successful submission of actual data, not just a test.
Cancer Registry	**Threshold:** Successful transmission of actual data. **Changes:** New for EP's. Has to be successful submission of actual data, not just a test.
Specific Case Information	**Threshold:** Successful transmission of actual data **Changes:** New for EP's. Has to be successful submission of actual data, not just a test.
Imaging results and info	**Threshold:** >40%. **Changes:** New item which requires >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 EMR 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, and somehow transmitting that link to our EMR. CMS is also thinking about a second objective – electronically exchanging the images among providers 10% of the time.
Family History	**Threshold:** >20%. **Changes:** New item requiring 20% of unique patients seen having structured data entry for 1 or more 1st degree relatives. This probably means we will need to re-enter family history in our EHR to meet this just like we had to do for smoking history. (Other EHRs may not require re-entry.)