Meaningful Use Stage 2
Implementation Guide

kareo™
Go Practice

Table of Contents

Get Ready

Meaningful Use Attestation can seem overwhelming, particularly if you are transitioning to Stage 2. However, don't panic! Kareo EHR is here to help you on this journey to incentive program payment.

We've created the Meaningful Use Boot Camp program to provide you with the necessary information, steps and organization to get you from preparation to attestation.

Preparation

Depending on the stage and year for which you are attesting, there are specific guidelines to follow. This guide focuses on Stage 2. We've outlined the specifics for Stage 2 to help you make the best decisions for your practice and to start your reporting period.

Because it's important to stay organized, Kareo EHR has created various progress checklists to keep you on track throughout the process.

Create a Team

Achieving Meaningful Use takes the cooperation of the entire practice, so enlist the help of key personnel who are willing to meet weekly to check progress and make necessary workflow adjustments. The ideal team should include the provider(s), office manager, and a clinical assistant.

How to use this guide

At ease recruits! Your Stage 2 Boot Camp begins on pages 2 and 3. A Task List is provided to ensure you don't miss a step and to help you easily monitor your progress from Enlistment to Graduation.

We recommend printing the appropriate checklist before getting started.

Next, each step provides details to aid in decision-making and instructions and resources to help you complete the tasks.

GO!

Task List: Meaningful Use Stage 2

Print this page and use it as your master task list.

Step 1: Basic Training	☐ 17C - Clinical Quality Measures ☐ 17D – Meaningful Use Stage 2 Core & Menu Measures
Step 2: Fitness Exercises	☐ eLabs setup (Required for Stage 2) ☐ Contact Immunization Registry for transmission process ☐ Direct Message setup with Updox ☐ Practice Portal setup
Step 3: Survival Skills	☐ Kareo EHR Help Center ☐ Kareo EHR Stage 2 Progress Checklist 2014 ☐ Kareo EHR CQM Checklist 2014
Step 4: Advanced Training	☐ Select Menu Measures and CQMs ☐ Discuss Practice Workflow Changes ☐ Select Reporting Period ☐ Reporting Triggers and Tips
Step 5: Field Drills	☐ Stage 2 Functional Measures Report ☐ CQM Report ☐ Kareo EHR Stage 2 Progress Checklist ☐ Audit Preparation
Step 6: Graduation	☐ Start Your Reporting Period ☐ Complete Attestation

Basic Training

Now that you are transitioning into Stage 2, it's time for basic training. Each course gives insight into requirements, understanding thresholds, and reporting. Live training gives you the opportunity to submit questions to a Meaningful Use expert. Register for live training # 17C and #17D or watch the recorded sessions.

Resources
☐ Training #17C: Clinical Quality Measures ☐ Training #17D: Meaningful Use Stage 2 Core & Menu Measures
☐ Video: Clinical Quality Measures ☐ Video: Meaningful Use Stage 2 Core & Menu Measures

Fitness Exercises

Immunization State Registry Transmission Process

At the present time, a single patient's immunization record can be downloaded in a format that can be sent to the state registries. Not all states are able to receive electronic transmittal of immunization data.

Note that individual practices must arrange with the state registries to transmit a file. Kareo EHR provides the ability to send data via an HL7 format (version 2.5.1).

Practice Portal

Core Measure #17 requires the use of secure electronic messaging to communicate with patients on relevant health information.

Kareo EHR provides a Patient Portal that enables patients to view their health information online as well as send direct messages to their providers. If you have not done so, you will need to set up your Practice Portal before using it in order to communicate with your patients.

Direct Message

Core Measure 15 Part B requires that 10% of transitions of care must be sent electronically.

Direct Message is a secure electronic messaging system that enables transmission of protected health information (PHI) to other authenticated providers. This requires a one-time setup and authentication with Updox.

eLabs

The use of eLabs in your EHR is required in Stage 2. We recommend setting up eLabs as soon as possible since it can require some time. **Start Process**

 If you need assistance, contact Kareo EHR Support or your account manager.
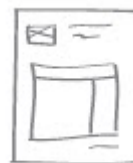
CQM Report

It is recommended that you run this report at the beginning of your reporting period and not wait until attestation. **Instructions**

The first-time run of this report is generated at 12am on the evening of your request because of the amount of data it must compile. After the initial run, this report can be generated immediately with updated data.

Survival Skills

Before moving on to selecting your Core Menu Measures and CQMs, take a moment to note the Kareo EHR resources available to support you on your journey towards attestation.

Progress Checklists

The Kareo EHR Progress Checklist 2014 and Kareo EHR CQM Checklist 2014 are designed to assist eligible providers in tracking Stage 2 measures during a reporting period.

Tracking your progress on a weekly basis is important so that you can clearly see how your practice compares to the threshold of each measure and where improvement is needed. The checklists can also be used to track your progress in anticipation of your reporting period to monitor which areas of measurement indicate a weakness.

Resources
Kareo EHR Help Center
Meaningful Use Videos
Kareo EHR Progress Checklist 2014
Kareo EHR CQM Checklist 2014
Meaningful Use Resource Library

Advanced Training

You are now ready to review all required core measures and select which menu measures and CQMs you will use for attestation. For Stage 2, eligible providers must meet and report on the following criteria:

- All 17 core objectives
- 3 menu objectives from a list of 4
- 9 clinical quality measures from a list of 19

The following pages provide tables outlining each measure and CQM requirement. Here's how to make your decisions and utilize the tables:

1. Click on a Requirement # to view detailed information that will help you determine if it's a measure or CQM you want to attest to.
2. Mark on each table the measures and CQMs to which you are attesting.
3. Use the tables that you've marked as your master guide to attestation.

Notes

Core Measures
- Must meet thresholds
- Some core measures require no further action because the functionality is built into Kareo EHR:
    1. Drug-drug, drug-allergy checks
    2. Clinical decision support
- Some core measures require that the defined action is completed only once:
    1. Protect electronic health information. Find out more...
    2. Patient lists

Menu Measures
- Must meet thresholds

CQMs

- No minimum values to achieve
- Only need to report on them
- All documentation needs to be completed before a note is signed
- An E&M code must be documented on the Superbill before a note is signed

Core Menu Measures

Print this table to mark your selections.

	17 Core Measures: All are required		
Attest	**Requirement #**	**MU Requirement**	**Threshold**
Yes	Core #1	CPOE (Medications) CPOE (Radiology) CPOE (Labs)	> 60% > 30% >30%
Yes	Core #2	ePrescribing	>50%
Yes	Core #3	Demographics	> 80%
Yes	Core #4	Vital Signs	> 80%
Yes	Core #5	Smoking Status	> 80%
Yes	Core #6	#1 Clinical Decision Support #2 DDA/DAA	Yes/No
Yes	Core #7	Electronic Copy #1 Invite patients to the portal #2 Patients must view their health info in the portal	> 50% > 5%
Yes	Core #8	Clinical Summary	>50%
Yes	Core #9	Protected Electronic Health Information	Yes/No
Yes	Core #10	Lab Test Results	55%
Yes	Core #11	Patient List	Yes/No
Yes	Core #12	Preventive Care	>10%

17 Core Measures: All are required			
Attest	Requirement #	MU Requirement	Threshold
Yes	Core #13	Patient Education	10%
Yes	Core #14	Medication Reconciliation	>50%
Yes	Core #15	Summary of Care #A - Provide a Summary of Care when referring #B - Provide a Summary of Care electronically to the referring provider #C - Send Summary of Care from one EHR to another	>50% >10% Yes/No
Yes	Core #16	Immunization Registries	Yes/No
Yes	Core #17	Secure Electronic Messaging	>5%

Select Menu Measures

Print this table to mark your selections.

Menu Measures: Choose a total of 3			
Attest	Requirement #	MU Requirement	Threshold
Select 3 of the following 4 requirements:			
☐ Yes	Menu #1	Syndromic Survelliance Data	Yes / No
☐ Yes	Menu #2	Electronic Notes	> 30%
☐ Yes	Menu #3	Imaging Results	>10%
☐ Yes	Menu #4	Family Health History	> 20%

Select CQMs

Eligible providers must report on 9 out of the 19 CQMs for which Kareo is certified. CQMs are organized by CMS into recommended core sets:
- There are 9 CQMs for the adult population
- There are 9 CQMs for the pediatric population
- There are 2 additional measures that do not fall into the above two groups

You may select the 9 CQMs from either of the recommended sets but they must cover at least 3 of the National Quality Strategy domains. These are:
- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

As you make your selections, take a look at the domains in the CQM table on the next pages to ensure the 9 measures you end up with cover at least 3 domains.

Notes about CQMs
- There are no minimum values to achieve
- You report the results as generated by the EHR
- All documentation needs to be completed before a note is signed
- An E&M code must be documented on the superbill before a note is signed

Select CQMs

Print these tables to mark your selections.

		CQMs: You must particpate in reporting on 9 CQM measures		
Attest	Requirement #	MU Requirement	Threshold	Domain
		2014 CQMs Adult Recommended Core Measures		
☐ Yes	CMS 2	Preventive Care & Screening: Screening for Clinical Depression & Follow-up Plan	None	Population & Public Health
☐ Yes	CMS 50	Closing the referral loop: Receipt of Specialist Report	None	Care Coordination
☐ Yes	CMS 68	Documentation of Current Medications in the Medical Record	None	Patient Safety
☐ Yes	CMS 69*	Preventive Care & Screening: BMI Screening & follow-up	None	Population/Public Health
☐ Yes	CMS 90	Assessment for complex Chronic Conditions	None	Patient & Family Engagement
☐ Yes	CMS 138*	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	None	Population & Public Health
☐ Yes	CMS 156	Use of High-Risk Medication in the Elderly	None	Patient Safety
☐ Yes	CMS 165*	Controlling High Blood Pressure	None	Clinical Process & Effectiveness
☐ Yes	CMS 166	Use of Imaging Studies for Low Back Pain	None	Efficient Use of Healthcare Resources

2014 CQMs Pediatric Recommended Core Measures

☐ Yes	CMS 2	Preventive Care & Screening: Screening for Clinical Depression & Follow-up Plan	None	Population & Public Health
☐ Yes	CMS 75	Children who have Dental Decay or Cavities	None	Clinical Process & Effectiveness
☐ Yes	CMS 117*	Childhood Immunization Status	None	Population & Public Health
☐ Yes	CMS 126	Use of Appropriate Medications for Asthma	None	Clinical Process & Effectiveness
☐ Yes	CMS 136	ADHD: Follow-up Care for Children Prescribed ADHD Medication	None	Clinical Process & Effectiveness
☐ Yes	CMS 146	Appropriate Testing for Children with Pharyngitis	None	Efficient Use of Healthcare Resources
☐ Yes	CMS 153	Chlamydia Screening for Women	None	Population & Public Health
☐ Yes	CMS 154	Appropriate Treatment for Children with Upper Respiratory Infection	None	Efficient Use of Healthcare Resources
☐ Yes	CMS 155*	Nutrition & Physical Activity for Children and Adolescents	None	Population & Public Health

2014 CQMs Alternate Core Measures

☐ Yes	CMS 127*	Pneumonia Vaccination Status for Older Adults	None	Clinical Process & Effectiveness
☐ Yes	CMS 147*	Preventive Care & Screening: Influenza Immunization	None	Population & Public Health

*Indicates this measure was carried over from the 2011 Edition.

Discuss Practice Workflow Changes

Now that you know what measures you are including in your attestation, review your current office workflows and decide whether you need to make any changes.
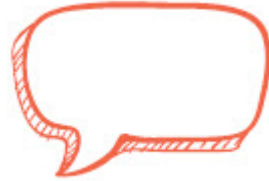
For example, if you have not been collecting patient email addresses so that you can invite them to the Patient Portal, you may need to modify the process in how you collect and confirm patient information.

Workflow	Change
Example: Patient email	Confirm or collect patient email at check-in. Add to intake form.

Select Reporting Period

A reporting period is a period of time that you must gather data. This data is what you will use to attest for Meaningful Use with CMS.

The reporting period is dependent upon where you are in the Meaningful Use timeline.

Stage 2, Year 1
- Reporting period is 90 days fixed to calendar quarters for 2014
- Attest up to February 28, 2015
- The reporting period for all subsequent years is a calendar year
- Attest to each stage for a minimum of 2 years

Reporting Triggers & Tips

It is important to make sure that all necessary information is documented adequately; you must also take into consideration the fields that trigger items in the reports.

Notes	• Signing a note establishes the relationship with the provider.
	   a. Reports scan the database for signed notes completed within the measurement period.
	   b. The provider who signed the note is considered the patient's provider.
	• Signing a note accumulates the chart summary for a report. Note the following:
	   a. For the Functional Measures report, most information added after the note is signed will be included.
	   b. For the CQM report, information added after a note is signed <u>will not</u> be included.

Superbills	• A Superbill establishes the date of the visit.
	   a. The E&M code establishes the type of visit.
	   b. The date is stamped when the note is signed.

Patient Refusal	• Document a patient's refusal by marking a response in each area:
	   a. Demographics: For Language, Race or Ethnicity, select "Decline to specify."
	   b. Vitals: When Height, Weight or Blood Pressure is blank, you will be prompted after saving to select a reason.
	   c. Immunizations: After selecting "Not administered", mark the appropriate reason.

Care Checklist	• The Care Checklist should be used to gather CQM information that is not gathered in other sections of the chart.
	   a. Counseling
	   b. Terminal illness
	   c. Reminders

Problem/Issues	• Problems/Issues:
	   a. Must include a start date as some requirements measure the length of time that the patient has had the problem/issue.
	   b. Not all variations of a problem (i.e. hypertension vs. essential hypertension) have been included in the definition of the CQMs.
	   c. A provider should document based on clinically sound judgment and not based on whether the problem/issue is included in a measure.
	   d. Pregnancy should be documented in Problems. Some CQM exceptions include pregnancy.

Immunizations	• Immunizations must include an administration date as requirements account for the patient's age when administered.

Patient Portal	• Patient Portal
	   a. Measure 7a is based on the number of patients invited within 4 business days of a signed note, not on the number of patients who register in the Patient Portal.
	   b. Measure 7b is based on the number of patients who interact with their health records by viewing, downloading and transferring electronically.
	   c. Measure 17 Secure Messaging: Patients need to engage with their healthcare provider by sending an email via the Patient Portal.
	   d. If the provider has an eLab interface, only signed labs will appear in the Patient Portal.

Field Drills

You've now determined the measures you'll be reporting on and your reporting period. It's time to ramp up and practice! Below is a list of tools that Kareo EHR provides to help you track your progress.

Functional Measures Report

- The Functional Measures report is useful to print and share with your team during a team meeting. This report identifies each core and menu measure and their results. At the end of your reporting period this is the report that you will need when you attest with CMS.

CQM Report

- The CQM report is useful to print and share with your team during a team meeting. This report identifies each CQM measure and their results. At the end of your reporting period this is the report that you will need when you attest with CMS.

Progress Checklist

- The Stage 2 Kareo Progress Checklist 2014 helps you track your progress for all measures week over week.

Audit Preparation

- If you are audited, the specifics will vary, and cannot be determined by Kareo. However, here are a few things we suggest:
- Start a folder that you can store all relevant Meaningful Use items in.
- Keep your NPPES user ID and Password so they don't get lost.
- Patient List: Print a report during your reporting period and save it in this folder.
- If your state's immunization registry or public health agency cannot accept your electronic submission, get that in writing and save in this folder.
- Save any documentation you have done to satisfy Core #9 Protected Health Information.

Graduation

Congratulations! You are now ready to start your reporting period. Below are some final recommendations so you can hit the ground running.

Start your Reporting Period

When you start your reporting period, it is recommended that you schedule weekly meetings. Meeting regularly helps address issues as they arise.

Best practices for each weekly meeting:
- ☐ Run the Stage 2 Functional Measures report
- ☐ Run the CQM report (Note that it is best to do an initial run of this report at the beginning of your reporting period. See section, Fitness Exercises.)
- ☐ Complete your Stage 2 Progress Checklist 2014
- ☐ Evaluate your progress: Identify areas that need attention
- ☐ Design workflow modifications
- ☐ Implement the modifications with your staff

Complete Attestation

At the end of your reporting period you will need to:

- Run the Functional Measures report for the date range of your reporting period.
- Run the CQM report for the date range of your reporting period.
- You will also need Kareo EHR's CMS EHR Certification ID: **A014E01NDGFDEAD**

The Functional Measures and CQM reports will provide you with all the data you will need to attest with CMS.

Attestation Site

Attestation User Guide

Core Measure #1, CPOE

Use computer provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by a licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

60/30/30%

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.

$$60\% \quad \frac{\text{Number of medication orders either prescribed or refilled by the provider during the reporting period.}}{\text{Number of medication orders either prescribed or refilled by the provider during the reporting period.}} \quad \begin{array}{l} = N_a \\ \\ = D_a \end{array}$$

Kareo EHR calculates the CPOE so that the numerator and denominator will always be identical. Therefore, the result will either be 0% or 100%.

Exclusions
Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Core Measure #1, CPOE continued...

30%

Number of HLO imaging/radiology orders ordered by an EP during the reporting period. $= N_b$

Number of HLO imaging/radiology orders ordered by an EP during the reporting period. $= D_b$

30%

- Number of lab orders ordered by an EP during the reporting period
- HLO or eLabs

$= N_c$

- Number of lab orders ordered by an EP during the reporting period
- HLO or eLabs

$= D_c$
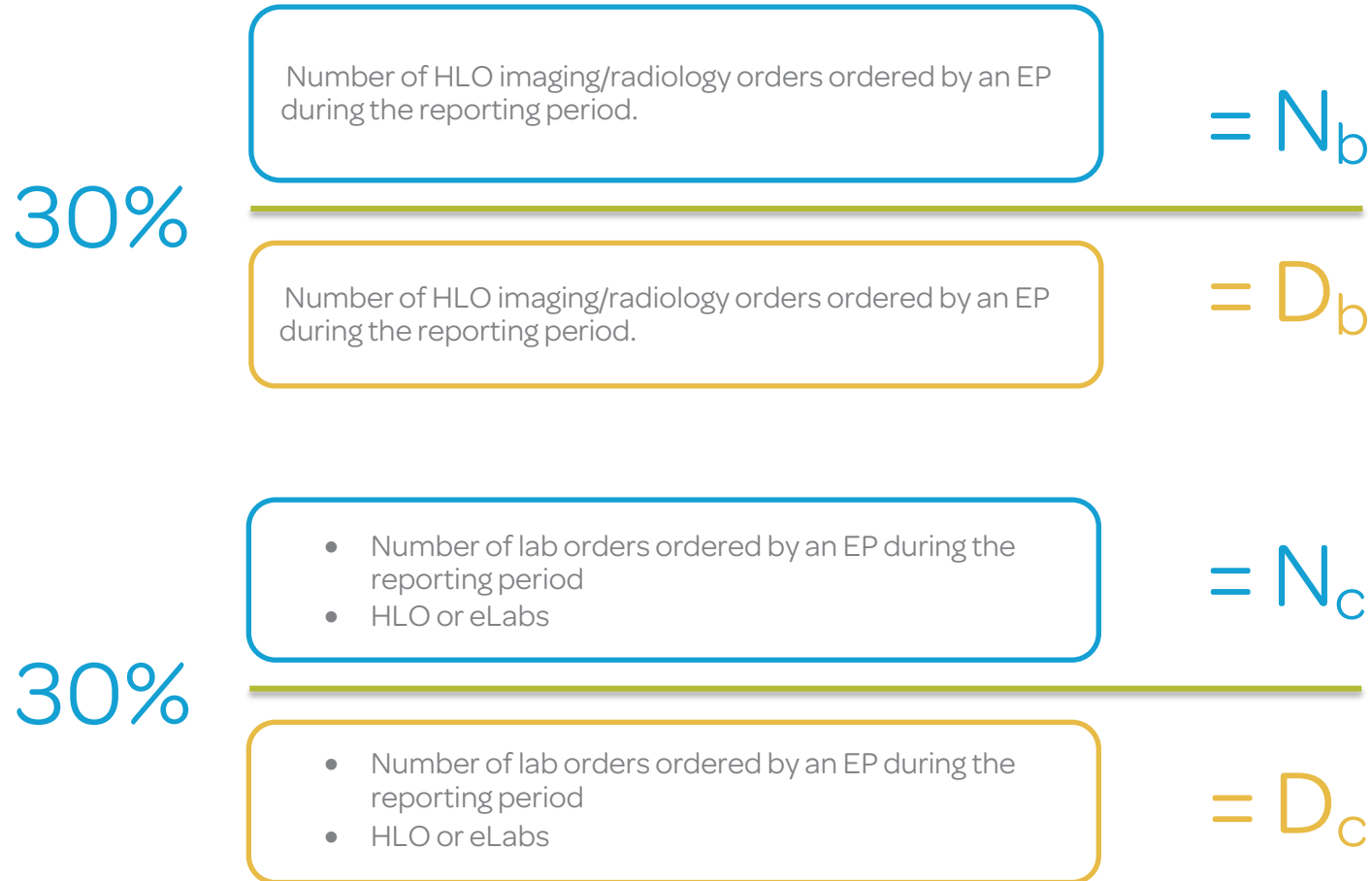
Core Measure #2, ePrescribing

Generate and transmit permissible prescriptions electronically (eRx).

50% 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.

Any patient who during the reporting period:
- Had a prescription generated
- Was queried for a drug formulary
- Was transmitted electronically

$= N$

Any patient who has a new prescription or a refill prescribed by the provider during the reporting period.

$= D$

Exclusions
- Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
- Any EP who: Does not have a pharmacy within their organization and there are no pharmacies that accept eRx within 10 miles of the EP's practice at the start of the reporting period.

Core Measure #3, Record Demographics

Record the following demographics: preferred language, sex, race, ethnicity, date of birth, gender.

80%   More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.

- For whom all 5 demographics are recorded
- Or "Declined to Specify" was recorded

$= N$

Number of unique patients with a signed note during the reporting period.

$= D$

Exclusions
None

Core Measure #4, Record Vitals

Record and chart changes in vital signs:
- Height (No age limit)
- Weight (No age limit)
- Blood pressure (Age 3 and over)
- Calculate & display body mass index (BMI)
- Plot & display growth charts for children 2-20 years

80% More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height/length and weight (for all ages) recorded as structured data.

Exclusions
- Any EP who: Sees no patients 3 years or older is excluded from recording blood pressure.
- Any EP who: 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.
- Any EP who: Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
- Any EP who: 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.

Core Measure #4, Record Vitals continued...

If height/length, weight and blood pressure (all) within scope of practice.

Patients 3 yrs or older in the denominator for whom height/length, weight and blood pressure are recorded. $= N_1$

Patients younger than 3 yrs in the denominator for whom height/length and weight are recorded. $= N_2$

$= N_{Sum}$

Unique patient with a signed note during the reporting period. $= D$

Continued on next page...

Core Measure #4, Record Vitals continued...

If height/length and weight (only) within scope of practice.

Patients in the denominator for whom height/length and weight are recorded.

$$= N$$

Unique patient with a signed note during the reporting period.

$$= D$$

If blood pressure (only) within scope of practice.

Patients in the denominator for whom blood pressure was recorded.

$$= N$$

Unique patient 3 years of age or older with a signed note during the reporting period.

$$= D$$

Core Measure #5, Record Smoking Status

Record smoking status for patients 13 years and older.

80% More than 80% of all unique patients 13 years or older seen by the EP have smoking status recorded as structured data.

Who has smoking status recorded under Social History. $= N$

Unique patient age 13 years or older with a signed note during the reporting period. $= D$

Exclusions
Based on ALL patient records: Any EP who did not see patients 13 years or older.

Core Measure #6, Clinical Decision Support

Use clinical decision support to improve performance on high-priority health conditions.

Yes/No

Measure 1:
Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care.

Yes/No

Measure 2:
The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks.

YES!

This measure does not require any further action because this functionality is incorporated in the Kareo EHR.

Exclusions
For Measure 2: Any EP who writes fewer than 100 medication orders during the reporting period.

Core Measure #7, Patient Electronic Access

Provide patients the ability to view online, download and transmit their health information within four (4) business days of the information being available to the EP.

50% Measure 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.

- Patient whose email has been entered into Demographics AND
- Invited to the Patient Portal

$= N_1$

Unique patient with a signed note during the reporting period.

$= D_1$

Exclusions
None

Continued on next page...

Core Measure #7, Patient Electronic Access continued...

Provide patients the ability to view online, download and transmit their health information within four (4) business days of the information being available to the EP.

Measure 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.

5%

- Patient viewed health information in the portal, or
- Patient downloaded health information from the portal, or
- Patient transmitted health information from the portal

$$= N_2$$

Unique patient with a signed note during the reporting period.

$$= D_2$$

Exclusions
None

Core Measure #8, Clinical Summaries

Provide clinical summaries for patients for each office visit.

50% Clinical summaries provided to patients for more than 50 percent of all office visits within one (1) business day.

- Number of office visits where a clinical summary was:
- Printed, OR
- Sent to the Patient Portal, OR
- "Patient Refused the Summary" box is checked

$= N$

Number of office visits during the reporting period with a signed note.

$= D$

Exclusions
Based on ALL patient records: Any EP who has no office visits during the EHR reporting period would be excluded from this requirement.

Core Measure #9, Protect Electronic Health Information

Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Yes/No Have you conducted or reviewed a security risk analysis per 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies as part of your risk management process?

This measure is independent of Kareo EHR. The security risk is completed by the EP. Refer to the CMS website for additional information or find out more here…

Exclusions
None

Core Measure #10, Clinical Lab Test Results

Note: You must use eLabs within Kareo EHR to meet this measure!

Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data.

55% 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.

- Results were expressed in a positive or negative affirmation, or
- Results were expressed as a numeric result

$= N$

- Any labs ordered during the reporting period
- Must use eLabs

$= D$

Exclusions
Any EP who orders no lab tests where the results are either in a positive/negative affirmation or numeric format during the EHR reporting period.

Core Measure #11, Patient List

Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.

Yes/No   Generate at least one report listing patients of the EP with a specific condition. The final rule defines specific conditions as those conditions listed in the patient's active problem list.

- The ability to generate a patient list by condition (problem) is found on the Reports tab, under Patient List report.
- Only one report needs to be generated based on one condition. No further action is required. (Save this report in case of an Audit.)

Exclusions
None

Core Measure #12, Preventive Care

Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.

10% 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.

- Indicated that a reminder was sent during the reporting period
- Care Checklist

= N

Unique Patient with 2 or more office visits with signed notes in the 2 years prior to the reporting period.

= D

Exclusions
Any EP who has had no office visits in the 24 months before the EHR reporting period.

Core Measure #13, Patient Specific Education

Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

10% More than 10 percent of all unique patients seen by the EP during the EHR Reporting Period are provided patient-specific education resources.

Received printed patient specific education. $= N$

Unique patient with a signed note during the reporting period. $= D$

Exclusions
Any EP who has had no office visits during the EHR reporting period.

Core Measure #14, Medication Reconciliation

The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

50% 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.

Any patient who has the "Medication Reconciliation Performed" Box checked under Medications.

= N

- Any patient with a signed note during the reporting period
- The signed note has the "Transition of Care-Receiving" box checked

= D

Exclusions
Based on ALL patient records: Any EP who has not been on the receiving end of any transition of care during the EHR reporting period.

Core Measure #15, Summary of Care

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

50% Measure A:
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.

Summary of Care record provided. $= N_a$

- Any patient with a signed note during the reporting period
- Referral ordered by the EP

$= D_a$

Exclusions
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.

Core Measure #15, Summary of Care continued...

Note: You must set up and use Direct Messaging within Kareo EHR to meet this measure!

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

10%

Measure B:
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 a 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 established for the NwHIN.

A summary of care was provided as part of the referral sent electronically (Updox).

$= N_b$

- Any patient with a signed note during the reporting period
- Referral generated by the EP

$= D_b$

Exclusions
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.

Core Measure #15, Summary of Care continued...

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Yes/No

Measure C:
Conducts one or more successful electronic exchanges of a summary of care document as part of which is counted in "measure" (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.

- Generate a Summary of Care
- Test capability to upload into a non-Kareo EHR
- Can use CMS designated test EHR at:
  https://ehr-randomizer.nist.gov/ehr-randomizer-app/#/home

Exclusions
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.

Core Measure #16, Immunization Registries

Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.

Yes/No Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

- Export Immunization record
- Contact local immunization registry for upload instructions

Exclusions
1. The EP 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. The EP 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. The EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data.
4. The EP 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.

Core Measure #17, Secure Electronic Messaging

Use secure electronic messaging to communicate with patients on relevant health information.

5% 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.

- Patient must have a portal account
- Patient must send a message to the EP
- Practice must have a portal account
- Portal.Kareo.com

$= N$

_____

Unique patients with a signed note during the reporting period.

$= D$

Exclusions
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.

Menu Measure Details

Menu Measure #1, Syndromic Surveillance Data

Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

Yes/No

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 have the capacity to receive the information electronically).

- Providers need to chart immunizations for one patient, either real or fake
- Providers need to download the patient's immunization using Export Syndromic Surveillance on the Exchange button in the Kareo EHR
- Providers will need to check with their local public agency to determine if they have the capacity to receive the downloaded summary electronically

Exclusions
1. Based on ALL patient records: Any EP who does not perform immunizations during the EHR reporting period.
2. Based on ALL patient records: If there is no Public Health agency that has the capacity to receive the information electronically.

Menu Measure #2, Electronic Notes

Record electronic notes in patient records.

30% 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.

Unique patients with a signed note during the reporting period. $= N$

Unique patients with a signed note during the reporting period. $= D$

Exclusions
None

Menu Measure #3, Imaging Results

Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

10%

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.

Number of orders with images attached. $= N$

Number of HLO image orders. $= D$

Exclusions
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 Measure #4, Family Health History

Record patient family health history as structured data.

20% 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.

- Has patient health history recorded for first-degree relatives, or
- Has recorded as "Patient health history unknown"

= N

Unique patients with a signed note during the reporting period.

= D

Exclusions
Any EP who has no office visits during the EHR reporting period.

CQM Details

Adult Core Set

CMS 2, Screening for Clinical Depression & Follow-up Plan

Percentage of patients aged 18 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.

- Document that depression screen was positive and a follow-plan was provided in the Care Checklist, or
- Document that depression screen was Negative in the Care Checklist, or
- Document that patient refuse treatment in the Care Checklist

$= N$

- All patients aged 18 years and older prior to the reporting period
- Signed note during the reporting period
- E & M code on the superbill
- Document in the Care Checklist "If patient screened for depression, was standardized tool used?"

$= D$

Domain: Population & Public Health

CMS 50, Closing the Referral Loop: Receipt of Specialist Report

Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

- Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
- Mark "consult received" in doc tab in patient chart

$= N$

- Number of patients, regardless of age
- Signed note during the reporting period
- E & M code on the superbill
- Select "Send a Referral" in the note

$= D$

Domain: Care Coordination

CMS 68, Documentation of Current Medications in the Medical Record

Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

- Patients for whom Medications were reviewed during each visit
- Indicated by documenting "Medication Reconciliation" performed in the medication tab

$= N$

- Patients 18 years or older
- Signed note within the last 12 months
- E & M code on the superbill

$= D$

Domain: Patient Safety

CMS 69, Body Mass Index (BMI) Screening and Follow-up

Percentage of patients ages 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. The guidelines for BMI are separated into two (2) age groups.

- For ages 65 and older, the BMI parameters are 1) less than (<) 22 kg/m2 or 2) greater than (>) 30 kg/m2.
- For ages 18 to 64, the BMI parameters are 1) less than (<) 18.5 kg/m2 or 2) greater than (>) 25 kg/m2.

The CQM Report will show these as two separate percentages but it considered one CQM measure.

Exclusion (must be documented)

- Patient is terminally ill for six or less months from the encounter date;
- Patient is pregnant; diagnosis on Problems list
- Physical exam not done because of patient's refusal;
- Physical exam not done because of a medical reason;
- Physical exam not done because of a system reason.

Domain: Population & Public Health

CMS 69, Body Mass Index (BMI) Screening and Follow-up continued...

- Any patient who has a BMI recorded; AND
- the BMI must be less than (<)18.5 kg/m2 OR greater than (>) 25 kg/m2; AND
- BMI Follow-up Plan or Dietary Consultation indicated on the Care Checklist

$= N_1$

- Patients 18 years or older but younger than 65
- Seen once in the 6 months prior to the reporting period end date with a signed note
- E & M code on the superbill

$= D_1$

- Any patient who has a BMI recorded; AND
- the BMI must be less than (<) 22 kg/m2 OR greater than (>) 30 kg/m2; AND
- BMI Follow-up Plan or Dietary Consultation indicated on the Care Checklist

$= N_2$

- Patients 65 years or older
- Seen once in the 6 months prior to the reporting period end date with a signed note
- E & M code on the superbill

$= D_2$

CMS 90, Functional Status Assessment for Complex Chronic Conditions

Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments.

- Patients with patient reported functional status assessment results
- Test was administered at least two weeks before or during each visit
- Documented in the Care Checklist

$$= N$$

- Adults aged 65 years and older who had two office visits within the last 12 months from the start of the reporting period with a signed note
- (The first visit was during the first 185 days of the measurement year)
- (The second visit was at least 30 days but no more than 180 days after first visit)
- An active diagnosis of heart failure
- E & M code on the superbill

$$= D$$

Domain: Patient & Family Engagement

CMS 138, Tobacco Use: Screening and Cessation Intervention

Percentage of patients aged 18 years or older identified as tobacco user within the past 24 months who received cessation intervention.

- Was screened for smoking status AND
- IF has a smoking status of one of the following recorded in Social History: "Current every day smoker", "Current some day smoker", or "Smoker, current status unknown,"
- Received cessation counseling which has been recorded in Care Checklist
- Has at least one active smoking cessation agent on their Medications list

$= N$

- Any patient 18 years or older; AND
- Has been seen once in the 24 months prior to the reporting period end date with a signed note
- E&M code on superbill

$= D$

Domain: Population & Public Health

CMS 156, Use of High-risk Medications in the Elderly

Percentage of patients 66 years of age and older who were ordered high-risk medication. Two rates are reported:
- % of patients who were ordered at least one (1) high-risk medication.
- % of patients who were ordered at least two (2) different high-risk medications

Patients with an order for at least one high-risk medication on Medication List $= N_1$

Patients with an order for at least two different high-risk medication on Medication List $= N_2$

- Any patient 66 years or older
- Signed note during the reporting period
- E&M code on the superbill

$= D$

Domain: Patient Safety

CMS 165, Controlling High Blood Pressure

Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement.

- Any patient who has a diastolic blood pressure < 90 mmHg recorded at the recent visit; AND
- A systolic blood pressure < 140 mmHg recorded at the recent visit.

= N

- Any patient who is 18 years or older but 85 years or younger; AND
- Who has an <u>active</u> diagnosis of Essential Hypertension with a start date of ≤ reporting period end date AND
- Seen at least once during the reporting period with a signed note
- E&M Code in the superbill

= D

Domain: Clinical Process & Effectiveness

CMS 166, Use of Imaging Studies for Low Back Pain

Percentage of patients 18-49 years of age with a diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.

- Patients **without an imaging study** conducted on the date of the outpatient visit or in the 28 days following the outpatient visit
- High level order requested for image study

$= N$

- Patients 18-49 years of age
- With a problem of low back pain
- Signed note
- E & M code on the superbill

$= D$

Domain: Efficient Use of Healthcare Resources

Pediatric Core Set

CMS 2, Screening for Clinical Depression & Follow-up Plan

Percentage of patients aged 12 years and older but less than 18 years screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.

- Document that depression screen was positive and a follow-plan was provided in the Care Checklist, or
- Document that depression screen was Negative in the Care Checklist, or
- Document that patient refuse treatment in the Care Checklist

= N

- All patients aged 12-17 years prior to the reporting period
- Signed note during the reporting period.
- E & M code on the superbill
- Document in the Care Checklist "If patient screened for depression, was standardized tool used?"

= D

Domain: Population & Public Health

CMS 75, Children Who Have Dental Decay or Cavities

Percentage of children, ages 0-19 years, who have had tooth decay or cavities during the reporting period.

Children who had cavities and/or tooth indicated under Problems.

$= N$

- Children, age 0-19 years,
- Signed note during the reporting period
- E & M code on the superbill

$= D$

Domain: Clinical Process & Effectiveness

CMS 117, Childhood Immunizations Status

The percentage of children 2 years of age who had
- Four diphtheria, tetanus and acellular pertussis (DTaP);
- Three polio (IPV);
- One measles, mumps and rubella (MMR);
- Two H influenza type B (HiB);
- Three hepatitis B (Hep B);
- One chicken pox (VZV);
- Four pneumococcal conjugate (PCV);
- Two hepatitis A (Hep A);
- Two or three rotavirus (RV); and
- Two influenza (flu) vaccines by their second birthday.
- The measure calculates a rate for each vaccine and two separate combination rates.

Domain: Population & Public Health

CMS 117, Childhood Immunizations Status continued...

- A patient must have four (4) DTaP vaccines documented under Immunizations.
- All four DTaP vaccines must have been administered between $\geq$ 42 days of age and $\leq$ 2 years of age
- A patient may <u>not</u> have encephalopathy or progressive neurological disorder documented on the Problems List
- A patient may <u>not</u> have an allergy to DTaP vaccine documented on the Allergies List

$= N_1$

- A patient must have three (3) IPV vaccines documented under Immunizations
- All three IPV vaccines must have been administered between $\geq$ 42 days of age and $\leq$ 2 years of age
- A patient may <u>not</u> have an allergy to IPV vaccine, neomycin, streptomycin or polymyxin documented on the Allergies List

$= N_2$

- A patient must have four (4) DTaP vaccines documented under Immunizations
- All four DTaP vaccines must have been administered between $\geq$ 42 days of age and $\leq$ 2 years of age
- A patient may <u>not</u> have encephalopathy or progressive neurological disorder documented on the Problems List
- A patient may <u>not</u> have an allergy to DTaP vaccine documented on the Allergies List

$= N_3$

CMS 117, Childhood Immunizations Status continued...

- A patient must have four (4) pneumococcal vaccines documented under Immunizations
- All four pneumococcal vaccines must have been administered between $\geq$ 42 days of age and $\leq$ 2 years of age
- A patient may <u>not</u> have an allergy to pneumococcal vaccine documented on the Allergies List

$= N_7$

- A patient must have two (2) hepatitis A vaccines documented under Immunizations
- Both hepatitis A vaccines must have been administered $\leq$ 2 years of age
- A patient may <u>not</u> have an allergy to hepatitis A vaccine documented on the Allergies List

$= N_8$

- A patient must have two (2) rotavirus vaccines documented under Immunizations
- Both rotavirus vaccines must have been administered between $\geq$ 42 days of age and $\leq$ 2 years of age
- A patient may <u>not</u> have an allergy to rotavirus vaccine documented on the Allergies List

$= N_9$

CMS 117, Childhood Immunizations Status continued...

- A patient must have two (2) influenza vaccines documented under Immunizations
- Both influenza vaccines must have been administered between $\geq$ 180 days of age and $\leq$ 2 years of age
- A patient may <u>not</u> have cancer of lymphoreticular or histiocytic tissue, asymptomatic HIV, multiple myeloma, leukemia or immunodeficiency documented on the Problems List
- A patient may <u>not</u> have an allergy to influenza vaccine documented on the Allergies List

$= N_{10}$

All patients included in numerators 1, 2, 3, 5 and 6 above.

$= N_{11}$

All patients included in numerators 1, 2, 3, 5, 6 and 7 above.

$= N_{12}$

- Any patient age 2, and
- Seen at least once during the reporting period with a signed note
- E & M Code on the superbill

$= D_{1-12}$

CMS 126, Use of Appropriate Medications for Asthma

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Patients who were dispensed at least one prescription for a preferred therapy during the reporting period.

$= N$

- 5-11 years of age
- Signed note during the reporting period
- Persistent asthma documented in the problems list with a start date
- E & M code on the superbill

$= D$

Domain: Clinical Process & Effectiveness

CMS 126, Use of Appropriate Medications for Asthma continued...

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Patients who were dispensed at least one prescription for a preferred therapy during the reporting period.

$= N$

- 12-18 years of age
- Signed note during the reporting period
- Persistent asthma documented in the problems list with a start date
- E & M code on the superbill

$= D$

CMS 126, Use of Appropriate Medications for Asthma continued...

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Patients who were dispensed at least one prescription for a preferred therapy during the reporting period. **= N**

- 19-50 years of age
- Signed note during the reporting period
- Persistent asthma documented in the problems list with a start date
- E & M code on the superbill

= D

CMS 136 Follow-up Care for Children Prescribed ADHD Medication

Definitions	
Intake Period	5 month period starting 90 days prior to the start of the reporting period and ending 60 days after the start of the reporting period.
Index prescription start date (IPSD)	The earliest prescription dispensing date for an ADHD medication where the date is in the Intake period and an ADHD medication was not dispensed during the 120 days prior.
Continuation and Maintenance Phase	The 31-300 days following the IPSD.
Cumulative Medication Duration	Is an individuals total # of medication days over a specific period.

Domain: Clinical Process & Effectiveness

CMS 136 Follow-up Care for Children Prescribed ADHD Medication continued...

Measure A
Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.

Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD.

$= N_a$

- Children 6-12 years of age
- Signed note during the reporting period
- Who were dispensed an ADHD medication during the intake period
- E & M code on the superbill

$= D_a$

CMS 136 Follow-up Care for Children Prescribed ADHD Medication continued...

Measure B
Percentage of children who remained on ADHD medication for at least 210 days and who in addition to the visit in the initiation phase had as least 2 additional follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

- Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase
- And at least two follow-up visits during the Continuation and Maintenance Phase

$= N_b$

- Children 6-12 years of age
- Signed note during the reporting period
- Who were dispensed an ADHD medication during the intake period and
- Who remained on the medication for at least 210 day out of the 300 days following the IPSD
- E & M code on the superbill

$= D_b$

CMS 146, Appropriate Testing for Children with Pharyngitis

Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.

- Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis
- eLab request (**Requires elabs)**

$= N$

- Children age 2-18 years
- Signed note during the reporting period
- With a diagnosis of pharyngitis with a start date
- An antibiotic ordered on or within three days of the visit

$= D$

Domain: Efficient Use of Healthcare Resources

CMS 153, Chlamydia Screening for Women

Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

- Women with at least one chlamydia test during the reporting period
- eLab test ordered **(must use eLab)**

$= N$

- Women 16-24 years of age
- Active problems that identify sexually active women would include: pregnancy, sexually transmitted infections, other reproductive conditions
- Signed note during the reporting period.
- E & M code on the superbill

$= D$

Domain: Population & Public Health

CMS 154, Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.

Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection.

= N

- Children age 3 months to 18 years
- Signed note during the reporting period
- With a diagnosis of Upper Respiratory infection documented in the problems list with a start date during the reporting period
- E & M code on the superbill

= D

Domain: Efficient Use of Healthcare Resources

CMS 155, Weight Assessment and Counseling for Children and Adolescents

The percentage of patients 3-17 years of age who had a visit with a PCP or OB/GYN and who had evidence height, weight and BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement period.

Patients who had a height, weight and BMI percentile recorded during the reporting period through Vitals.

$$= N_1$$

Any patient who has Nutrition Counseling documented in Care Check list.

$$= N_2$$

$$\rangle = N_{4Sum}$$

Any patient who has Physical Activity Counseling documented in Care Check list.

$$= N_3$$

- Any patient 3 years and older but younger than 18 years old
- Who does not have pregnancy on the active problem list
- Signed note during the reporting period
- E&M code on the superbill

$$= D$$

Domain: Population & Public Health

Additional Measures

CMS 127, Pneumonia Vaccination for Older Adults

The percentage of patients 65 years of age and older prior to the reporting period who have ever received a pneumococcal vaccine.

Any patient who has a pneumococcal vaccine documented under Immunizations.

$= N$

- Any patient 65 years and older; AND
- Seen at least once during the reporting period with a signed note
- E&M code on the superbill

$= D$

Domain: Clinical Process & Effectiveness

CMS 147, Influenza Immunizations

Percentage of patients ages > 6 months who received an influenza immunization during the flu season (Oct 1st through March 31st).

Any patient who has an influenza vaccine documented under Immunizations that was administered between Oct 1st through March 31st.

$= N$

- Any patient 6 months or older; AND
- Patient who does not have active influenza on the Problem list within the last four months; AND
- Seen at least once during the reporting period with a signed note
- E&M code on the superbill

$= D$

Exclusion (must be documented)
- Influenza immunization contraindication (i.e. allergic to egg derived vaccine)
- Influenza immunization declined
- Influenza immunization not given due to patient reason
- Influenza immunization not given due to medical reason
- Influenza immunization not given due to system reason

Domain: Population & Public Health