Office Practicum
Meaningful Use Stage 2 Roadmap

Version 2.2, last updated December 1, 2015

2015 marks the fourth year in which funding is available for Eligible Professionals (EPs) to acquire or upgrade Certified EHR Technology (CEHRT), and the second year for which Stage 2 funding is available for EPs who have already completed two years in Stage 1. This document describes the process of qualifying and applying for funding in both active stages, as well as the specific ways in which both Office Practicum and *you* need to change in order to establish and continue Meaningful Use. Connexin's goal is to ensure that you understand all of the requirements in sufficient detail to qualify for the full cycle of three stages over six program years, if your practice's Medicaid population meets the minimum statutory thresholds.

What is "Meaningful Use"?

In an effort to improve healthcare delivery, integration and costs, the Office of the National Coordinator (ONC) has made clear that it is not enough just to implement EHR technology; healthcare providers must demonstrate on an annual basis that the technology is being used "meaningfully." There has been a multistage process involving multiple stakeholders to determine the evolution of Meaningful Use standards. Stage 1 began in 2011 and established the baseline. Stage 2 began in 2014 for providers who had already completed two years in Stage 1. Modified Stage 2 takes effect in July 2015 and unifies every participant around a common set of reduced requirements through 2017. Stage 3 will begin as an option in 2017 and become mandatory in 2018. Public funding for the entire MU process is projected to end in 2021.

The stated goal of Stage 1 was to enable data capture and sharing; in other words, to get health care providers comfortable with collecting medical data electronically. Stage 2 has more ambitious goals centered around improving patient care through advanced clinical processes and true data exchange. This involves better clinical decision support, care coordination, and patient engagement in the form of more robust communications and a truly shared chart.

Do I Qualify?

Good question, and one that is not always easily answered. Since most Office Practicum users are pediatricians, this document focuses on the Medicaid qualification requirements. Contact us directly if you believe your basis for qualification is more likely focused on your Medicare patient population.

If you have already received Stage 1 funding, it is likely - but not automatic - that you will continue to qualify for Stage 2 funding. The reason for the uncertainty is that you must continue to meet minimum Medicaid patient visit thresholds to stay in the funding cycle, and states have discretion over which claim submission stages (primary, secondary, etc.) qualify. If your practice has experienced a significant change in its volume of Medicaid encounters, you might find that you no longer qualify, or that you now qualify when you didn't before. (With Medicaid payment parity in many states, you

might have opened and/or expanded your Medicaid panel.) In addition, as of 2014 you may include CHIP encounters for Title 19 and 21 expansion (previously only Title 19 was allowed), as well as zero-pay claims. Standalone CHIP is still excluded. The only way to know for certain is to code your patients' insurance policies accurately and do the math.

The rules state that the amount of available funding for Medicaid providers depends on your patient *visit* volumes. Medicaid thresholds should be measured by a ratio of the total number of Medicaid patient encounters in all allowed claim stages over any representative continuous 90-day period in the most recent calendar year, to the total number of patient encounters during that same 90-day period. The threshold numbers and how they are calculated for individual EPs in relation to specific practices, as well as the use of mid-level providers, does vary from state to state. It is important to contact your state Medicaid Director's office to obtain specific information about how your state will calculate this metric, which must be reported to the federal government. Connexin has received reports that some states use stricter guidelines, such as picking exactly which quarter must be used for this calculation. Take the time to do this right, because Medicaid is serious about cracking down on fraudulent attestations of visit volumes. Connexin has assisted in many provider audits over the past few years.

How Much Funding is Available for Qualified Providers?

Eligible Providers whose Medicaid patient *visit* volume is at least 30% of total visits qualify for the following amounts:

Year 1	$21,250
Years 2-6	$8,500 per year

If you qualify during the entire six-year cycle, that is a total of $63,750. Eligible Providers whose Medicaid patient *visit* volume is between 20% and 30% of total visits qualify for 2/3 of those amounts:

Year 1	$14,167
Years 2-6	$5,667 per year

If you qualify at this second tier for the entire period, that is a total of $42,500. In both cases, ARRA funding is classified as *income.* Unless you are organized as a non-profit corporation – and don't all pediatricians feel that way at some point during their careers? – you will need to report it on your tax returns and find sufficient expenses to offset it, lest it be taxed away. If you are acquiring an EHR for the first time, that is relatively easy. If you are upgrading a system you bought prior to the MU process, you might want to talk to your accountant about the implications of receiving a large lump sum. Depending on the age of your system, it might be time to invest in some new hardware.

Unfortunately for pediatricians in areas with low Medicaid populations, there is *no* Meaningful Use funding available for providers who conduct less than 20% of their visits with Medicaid patients. However, keep in mind that funding and Meaningful Use measures are calculated on a per-provider basis, *not* at the practice level. If you are part of a larger group that sees at least 10% Medicaid patients, you may find that by concentrating your Medicaid visits to a specific provider or providers,

you can get at least part of your group to qualify for funding. Something is better than nothing!

When Does Funding Start?

The Medicaid side of the Meaningful Use process is based on "program years." Unlike Medicare, there is no rush to "use it or lose it" by a particular date. If you have not already started, you can apply anytime between now and the end of 2016, and you will qualify for the full six-year funding cycle described above. In addition, you do not need to provide Meaningful Use measures for the *first* program year of Stage 1 funding. You simply need to attest that you have acquired and implemented Certified EHR Technology (trained staff, deployed tools, exchanged data), *or* that you have upgraded and/or expanded functionality or interoperability of a certified EHR that you already owned. Again, states are given discretion, so how they implement these rulings may vary slightly. For specific details, contact your state Medicaid office and consult the website where you apply for funding.

After the first program year, you will move into Modified Stage 2 until 2017 or 2018. The version of Office Practicum certified to 2014 standards is capable of supporting you until December 31, 2017, by which time you will be required to move up to a future version to be certified to Stage 3 standards.

Is Office Practicum a "certified EHR"?

Office Practicum 11 was certified in May 2011 as a Complete Ambulatory EHR under the 2011 MU standards. Office Practicum 14 was certified in October 2014 as a Complete Ambulatory EHR under 2014 guidelines. If you participated in the MU program prior to 2014, you used OP 11 to meet the requirements from 2011 to 2013. The certificate for OP 11 expired on December 31, 2013, because new standards came into effect as of January 1, 2014. However, in August 2014, ONC published a Revised Final Rule to allow products certified under 2011 guidelines to remain in use through the end of 2014. As such, you may have kept using OP 11 to compile and submit MU statistics for the 2014 program year. All 2015 statistics must be compiled and submitted using OP 14.

What Can I Do to Ensure Success in 2015?

The final rule published on October 6, 2015, reduced the 2015 reporting period to 90 days, which means you *must* have upgraded to a full implementation of OP 14 no later than October 1, 2015 to generate at least three months of supporting data for the 2015 program year. Based on the requirement of using OP 14.1 to produce and submit ICD-10 claims as of October 1, all active OP 14 users met that deadline. New participants in 2016 and 2017 will also be able to report on 90-periods in their first year of eligibility, but all other users will be required to compile and submit full years in 2016 and 2017.

Take inventory of what features you already own. Aside from the main program, a certified OP 14 Complete installation must contain the following elements:

- e-Prescribing
- Patient Portal (*not* optional under 2014 criteria)
- Interface to your state's Immunization Registry (if available)
- DIRECT secure email account for inbound/outbound transitions of care

Meaningful Use report bundle for the QIC module

As always, the core OP application is covered by your Support Level Agreement, and there is no charge for the upgraded features that make it “Meaningful Use capable.” If you already have the 2011 MU report bundle, then the upgrade to the 2014 edition is included at no extra charge.

The final preparatory step is to read the rest of this document carefully and start a conversation in your practice about how to implement the changes that some of these measures require. Many of the changes to support Meaningful Use are driven by office procedures, *not* Office Practicum. Regardless of which EHR vendor you use, you need to rethink certain processes that may be ingrained but are incompatible with Meaningful Use requirements. We hope the remainder of this roadmap will give you plenty to think about and decide *before* you begin (or continue) this journey.

Summary of Modified Stage 2 EP Objectives for Providers Classified as Stage 1 in 2015

The following objectives constitute the 2015 Modified Stage 2 Meaningful Use measure set for providers who would have been classified as Stage 1 in 2015. (This grace period only applies to 2015; in 2016, all providers must meet the standards on the next page.) Some measures are attest-only and are covered only briefly in this document. Any measure computed by Office Practicum or requiring work within the EHR is covered in detail in the following sections.

Core - all 9 are required

1. **CPOE** - Use CPOE for more than 30% of medication orders
2. **E-Prescribing** - Use E-Rx for more than 40% of medication orders
3. **Clinical Decision Support Interventions** - Implement 1 clinical decision support rule, plus **Drug/Drug and Drug/Allergy Interaction Checking** enabled for entire period
4. **Patient Electronic Access** - Provide online access to health information within 4 business days for more than 50% of patients, with at least 1 patient actually accessing in 2015 and 2016 (will increase to 5% in 2017)
5. **Security Analysis** - Conduct or review security analysis and risk management process
6. **Education Resources** - Provide education resources more than 10% of patients seen. May choose to exclude in 2015 only.
7. **Rx Reconciliation** - Medication reconciliation at more than 50% of transitions of care. May choose to exclude in 2015 only.
8. **Health Information Exchange (was Summary of Care)** - Create summary of care using CEHRT and exchange electronically for more than 10% of transitions of care and referrals. May choose to exclude in 2015 only.
9. **Secure Messages** - attest that functionality is fully enabled such that patients can send secure messages to their EP (will increase to “at least one patient” in 2016 and 5% in 2017). May choose to exclude in 2015 only.

Public Health - “active engagement”, choose 1 of 3

1. **Immunizations** - including bidirectional if available
2. **Syndromic Surveillance**
3. **Specialized Registry Reporting** (up to 2 of this type) - other than IIS

Summary of Modified Stage 2 EP Objectives for Providers Classified as Stage 2 in 2015

The following objectives constitute the Stage 2 Meaningful Use measure set for providers who would have been classified as Stage 2 in 2015, as well as *all* providers in 2016 and 2017. Some measures are attest-only and are covered only briefly in this document. Any measure computed by Office Practicum or requiring work within the EHR is covered in detail in the following section.

Core - all 9 are required

1. **CPOE** - Use CPOE for more than 60% of medication, 30% of laboratory, and 30% of radiology
2. **E-Rx** - Use E-Rx for more than 50% of medication orders with formulary enabled/checked
3. **Interventions** - Implement 5 clinical decision support interventions + drug/drug/allergy
4. **Patient Electronic Access** - Provide online access to health information within 4 business days for more than 50% of patients, with at least 1 patient actually accessing in 2015 and 2016 (will increase to 5% in 2017)
5. **Security Analysis** - Conduct or review security analysis and risk management process
6. **Education Resources** - Use EHR to identify and provide education resources more than 10%
7. **Rx Reconciliation** - Medication reconciliation at more than 50% of transitions of care
8. **Health Information Exchange (was Summary of Care)** - Create summary of care using CEHRT and exchange electronically for more than 10% of transitions of care and referrals
9. **Secure Messages** - attest that functionality is fully enabled such that patients can send secure messages to their EP (will increase to “at least one patient” in 2016 and 5% in 2017)

Public Health - “active engagement”, choose 2 of 3

1. **Immunizations** - including bidirectional if available
2. **Syndromic Surveillance**
3. **Specialized Registry Reporting** (up to 2 of this type) - other than IIS

Sample Measure

The remainder of this document provides a detailed listing of all Meaningful Use measures that Eligible Providers are required to document on an annual basis for Stages 1 and 2. Remember, Medicaid providers need not calculate and submit these measures in order to qualify for their initial year of funding (although they are allowed to do so). However, funding in years 2-6 is dependent on passing *all* measures at the scoring thresholds documented below.

For each measure, the following details are provided:

Applicable Stages Which stage(s) this measure applies/applied to. When both are listed, this means the require differs based on which stage a provider was classified as at the start of the 2015 program year.

Passing Score The minimum performance threshold that must be achieved in order to prove that this aspect of the system has attained Meaningful Use. For measures that are required in both stages, there may be a different threshold for each.

Exclusions The conditions under which the EP may be excluded from reporting the measure. This is a new subsection as of the October 2015 version of this roadmap.

OP Calculation The exact method the Office Practicum Quality Improvement Calculation (QIC) module will use to calculate your performance. For several measures that are required in both stages, the calculation method may be different for each.

OP Changes A list of changes to Office Practicum that were required in order to satisfy the requirements of this measure.

Usage Changes A list of factors you may need to consider changing in your daily use of Office Practicum or your office workflow/protocols in order to reach the performance threshold for this measure.

Let's get to it, shall we?

CPOE

Applicable Stages 1 and 2

Passing Score Stage 1: More than 30% of medication orders written during the reporting period are recorded using CPOE.
Stage 2: More than 60% of medication, 30% of laboratory, and 30% of radiology orders created during the reporting period are recorded using CPOE.

Exclusions For each of the order types, any EP who writes fewer than 100 orders of that type during the reporting period. For EPs who would have been Stage 1 during 2015, laboratory and radiology may be excluded entirely.

OP Calculation Stage 1: For medications written during the reporting period, calculate what percentage were tagged with the Purpose "Med – to dispense" or "Med – office sample" or "Med – office administered".
Stage 2: For medications, same as Stage 1, but threshold increases to 60%. For labs and radiology, calculate what percentage of *requisitions* of each type were written prior to the recording of *results*. This has the effect of disqualifying requisitions that were generated automatically to match results coming back in a lab importer or scanned item.

OP Changes For medications, none. This is nearly a circular loop in Office Practicum, since by definition the only way to get a medication into the system is to use CPOE. For labs and radiology, orders are now classified under major headings to distinguish between different types (labs, radiology, screening, and procedures).

Usage Changes For new medication orders, always use the Med Finder Form (or a saved favorite that was generated from the Med Finder Form) to construct prescriptions to be dispensed or sampled. Do not use the deprecated "Med – unformatted" Purpose; these do not qualify as CPOE.
For labs and radiology in Stage 2, always create a requisition in OP as part of an encounter, even if you hand it to the patient or check off panels on a paper form. Among other benefits, you will know whether the patient gets the work done, since the requisition will stay pended until you later match results to it.

Electronic Prescribing

Applicable Stages 1 and 2

Passing Score Stage 1: At least 40% of all qualified prescriptions are transmitted electronically.
Stage 2: At least 50% of all qualified prescriptions are compared to at least one formulary, then transmitted electronically.

Exclusions Any EP who writes fewer than 100 qualified prescriptions during the reporting period, or if there are no pharmacies that accept ERX within 10 miles of the EP practice location as of the start of the reporting period.

OP Calculation Stage 1: For all records in the MEDICATIONS table whose Purpose is "Med – to dispense" or "Med – unformatted" that are *not* controlled substances (DEA Schedule is blank or null), calculate what percentage have an e-RX ID.
Stage 2: In addition to Stage 1 calculation, note whether formulary checking was active at the time a medication was selected on the Med Finder or refilled. It is not required that the patient actually has formulary records to review, only that you made an attempt to check within the bounds of available information.

OP Changes In Stage 2, add a field to the MEDICATIONS table to track when the Formulary checkbox is checkmarked on the Med Finder Form.

Usage Changes None for providers who already use the built-in e-RX functionality and allow formulary checking when a medication is selected. Those who still rely heavily on printed prescriptions will need to ensure they do not fall below the required threshold if they continue to print for selected patients or pharmacies. The "Med – unformatted" Purpose is excluded from the calculation to penalize those who continue to use it, because such prescriptions cannot be sent electronically.

Clinical Decision Support Rules

Applicable Stages	1 and 2
Passing Score	Stage 1: Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with that rule. Stage 2: Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. In addition, enable drug-drug and drug-allergy checks while writing medication orders.
Exclusions	Any EP who writes fewer than 100 medication orders during the reporting period may be excluded from drug-drug and drug-allergy checks.
OP Calculation	None. These are “attest” measures, but you have to perform the work.
OP Changes	In OP 14, the Care Plan engine was completely rewritten to make it much easier to adopt and write care plans for medical conditions that are referenced in the 2014 list of authorized clinical quality measures. In addition, if you enter any data on a patient chart that would seem to quality her for a new care plan, the system will intervene and ask if you would like to enroll them.
Usage Changes	Enable or write an appropriate number of care plan interventions, based on the CQMs you have decided to report. Although you are mostly on your honor to do so, the intent of this measure is to align the interventions you receive while reviewing a patient’s chart with the CQMs that demonstrate continuous quality improvement in the care delivered.

Patient Electronic Access

Applicable Stages	1 and 2
Passing Score	More than 50% of all unique patients seen during the reporting period are provided timely (within 4 business days) online access to view, download, and transmit their health information. In addition, at least one patient seen during the reporting period (or their authorized representatives) actually views, downloads, or transmits to a third party their health information.
Exclusions	VDT element is not required for any EP who conducts >50% of encounters in a county with <50% of housing units having at least 4Mbps broadband access on the first day of the reporting period.
OP Calculation	For the access element, count unique patients seen who are associated with at least one active record in the WEB_USER table (REGSTRTN_IND=1). This only means that they registered successfully, not that they subsequently logged into or used the portal. For the VDT element, the Patient Portal will track when records are actually viewed. Since every workflow begins with View, we do not need to separately report downloading and transmitting.
OP Changes	The Patient Portal is no longer optional, and it does all the work. It allows patients to view/download/transmit and keeps track of who actually does so.
Usage Changes	Provide a Patient Portal, and encourage/teach patients to use it.

Patient-Specific Education Resources

Applicable Stages 1 (optional) and 2

Passing Score More than 10% of all unique patients seen during the reporting period were provided patient-specific education resources identified by CEHRT.

Exclusions Stage 1 providers may exclude themselves completely from this measure in 2015 if they did not intend to select this measure as a Menu objective.

OP Calculation For all patients who had at least one sick or well visit during the reporting period, calculate what percentage have at least one encounter where the Resources Given checkbox was checked, or at least one Resource order generated from the Order Worksheet. The resources need *not* have been given during the reporting period.

OP Changes A new checkbox was added to the Plan section of sick and well encounter notes indicating that the patient was given resources as part of the visit. When resources are ordered with the Order Worksheet, this flag is self-maintaining; it can also be manually checked for resources which exist only on paper yet need to be tracked. Resource orders assigned to the new Patient department will automatically appear on the Patient Portal so the patient can review on demand. Right-click access to the AAP "bookmark library" has also been expanded to make it easier to find relevant resources in more contexts. In OP 14, "info buttons" connected to the National Library of Medicine have been added to the problem list, medication allergy, medication, and lab result grids.

Usage Changes Most pediatric offices give handouts at all or most well visits, so this alone should meet the threshold. The key is embedding that knowledge in Office Practicum so you don't need to document individually for each visit. Connexin recommends adding your most popular handouts to the Resource tab in the Order Template section of your well visit templates, and make them Standing orders for the Patient department. That will add them to your notes automatically when the encounter is first opened.

On sick visits, consider adding Resources to your templates, and make them Standing for the Patient department so they will be added when the diagnostic template is chosen.

Medication Reconciliation for Transitions of Care

Applicable Stages 1 (optional) and 2

Passing Score More than 50% of all inbound transitions of care include medication reconciliation by the receiving provider

Exclusions Any EP who did not receive any transitions of care during the reporting period. Stage 1 providers may exclude themselves completely from this measure in 2015 if they did not intend to select this measure as a Menu objective.

OP Calculation For all inbound referral responses and tracking entries created during the reporting period, calculate what percentage included new medications and were reconciled accordingly.

OP Changes The existing Referral Letter capability has been enhanced to encompass the concept of "Transitions of Care." When scanning or reviewing images of referral responses, ER summaries, and new patient record transfers, Office Practicum will allow the user to map a scanned item to a "response" or "tracking" referral form so the user can synopsize the external actions that are documented and describe how they were reconciled back to the local chart. The existing Referral Letter Form has been simplified to make this process easier to complete on an expedited basis.

OP 14 incorporates support for DIRECT messaging with attachments between EPs. When such documents are received and opened, numerous sections can be reconciled to the patient's existing chart, and credit is automatically granted when merge operations are confirmed.

Usage Changes Like Clinical Summaries, this measure may create profound workflow implications for most practices, which likely do not create "cover sheets" for every inbound referral letter or fax from an ER or transferred medical record. Simply put, you have two choices: reexamine your workflows and start doing this on a routine basis, or get on DIRECT and encourage your colleagues in the medical community to start sending encounter and discharge notes electronically. Otherwise Office Practicum will not be able to assign credit for the work that you are probably doing now, but in a less formally documented way.

Health Information Exchange (was Summary of Care)

Applicable Stages 1 (optional) and 2

Passing Score Stages 1 and 2: More than 10% of all outbound summary of care records are created using CEHRT and exchanged electronically.

Exclusions Any EP who transfers or refers patients to other settings less than 100 times during the reporting period. Stage 1 EPs may exclude themselves completely from this measure in 2015.

OP Calculation For all outbound Summary of Care records created during the reporting period, calculate what percentage were created and transmitted electronically.

OP Changes As discussed in the previous measure, the existing Referral Letter capability has been enhanced to encompass the concept of "Transitions of Care." For outbound referrals, a checkbox has been added to keep track of when and whether a Summary of Care was created and attached to the referral. In OP 11, a [Print Summary] button was added to generate a patient summary directly from the Referral Letter form, using a standard Event Chronology report criteria set. The "Summary of Care created" flag is set automatically when that button is clicked. In OP 14, a [Send] button was added to create a message with the Summary of Care record as an attachment. The "Summary of Care created" and "Summary of Care transmitted" flags are set automatically when that button is clicked, *without reference to whether the record successfully reached the intended recipient*.

Usage Changes This has the potential to create profound workflow implications for most practices, which likely do not create referrals for every outbound transfer of care. As with outbound, you have two choices: reexamine your workflows and start doing this on a routine basis, or get on DIRECT and encourage your colleagues in the medical community to start sending encounter and discharge notes electronically. Otherwise Office Practicum will not be able to assign credit for the work that you are probably doing now, but in a less formally documented way.

Secure Electronic Messaging

Applicable Stages	1 (optional) and 2
Passing Score	Secure electronic messaging functionality is fully enabled in your certified EHR technology.
Exclusions	Any EP who conducts >50% of encounters in a county with <50% of housing units having at least 4Mbps broadband access on the first day of the reporting period. Stage 1 EPs may exclude themselves completely from this measure in 2015.
OP Calculation	None, attest-only in 2015.
OP Changes	None. The OP Patient Portal has always supported secure messaging.
Usage Changes	This measure caused a lot of consternation when it was first proposed, because you had to find a way to encourage patients to contact you electronically. Just don't "hide" the messaging function in your Patient Portal deployment.

Public Health Reporting

Applicable Stages 1 and 2

Passing Score Stage 1: Active engagement with at least 1 qualified PHA or CDR.
Stage 2: Active engagement with at least 2 qualified PHAs and/or CDRs.

OP Calculation None, attest-only to "active engagement".

OP Changes None. OP has supported connectivity to immunization registries for many years. We will connect to other PHAs and CDRs as required.

Usage Changes This measure requires "active engagement" with public health agencies and/or clinical data repositories. The definition of active engagement is very broad. Option 1 is simply attesting that you registered within within 60 days after the start of the EHR reporting period (or in a prior period), and you are awaiting an invitation from the PHA or CDR to begin testing. Option 2 is that you are in the process of testing and validating data submission. Option 3 is that you are in "production" and submitting electronic data on a routine basis.

The following options are available for inclusion in this measure:

Immunization Registry - may exclude if EP doesn't administer immunizations to any part of the population for which data is collected, or if there is no reportable registry that meets CEHRT requirements as of the beginning of the reporting period, or if there is no reportable registry that has declared readiness to receive data

Syndromic Surveillance - may exclude if EP is not in the category of providers from which ambulatory data is collected, or if there is no reportable PHA that meets CEHRT requirements as of the beginning of the reporting period, or if there is no reportable PHA that has declared readiness to receive data

Specialized Registry - may exclude if EP does not diagnose or treat any disease or condition that is required by a specialized registry in their jurisdiction, or if there is no specialized registry that meets CEHRT requirements as of the beginning of the reporting period, or if there is no specialized registry that has declared readiness to receive data

Clinical Quality Measures

The requirements for Clinical Quality Measures changed a lot in 2014. Unlike the original 2011 criteria, reporting of CQMs is considered part of the base use of CEHRT. Thankfully, all EPs in all MU stages report on CQMs in the same way, using the same available measures. You must report on nine CQMs (out of a total of 64) which come from at least three of six policy domains: Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, and Clinical Processes/Effectiveness. That sounds complicated, but CMS has prepackaged a set of nine pediatric measures that meet this requirement. (Although in OP's humble opinion, these nine are probably not the most inclusive subset for the patient mix in most pediatric practices.) You are not required to use the entire pediatric set if they don't apply to you - or if you want to report something else - but they do form a common acceptable baseline.

Two "gotchas" with CQM reporting are that you can only submit measures for which your CEHRT has been tested and approved, and you must specify an *entire calendar year* as the reporting period, regardless of any reduced 90-day windows for Automated Measures. Office Practicum certified the core pediatric set, and a short list of adult and pediatric alternatives. If there is anything else you would like to use in your practice in the future, please let us know. As to measurement periods, please be aware that many CQMs assess performance over multiple visits, and some - like Influenza Immunization - are based on relative date windows that assume the start date is January 1 of the reporting year. Alternate date ranges are not guaranteed to generate accurate results.

Each measure below provides a brief description of its purpose and covered populations, as well as which chart elements determine the denominator, numerator, and exclusions. Where applicable, the description includes other QI programs that are known to support this measure and which policy domain is satisfied. CMS has a stated goal of harmonizing MU CQMs with other established QI initiatives to minimize overall reporting burden for providers. If you are subject to multiple QI programs, such as PCMH or CHIPRA or an ACO, you should take this into consideration when you choose your set.

2014 Pediatric CMS-Recommended Core CQMs

CMS 146 **Appropriate Testing for Children with Pharyngitis**

This component assesses how many children aged 2-18 years who presented with a complaint of pharyngitis were prescribed an antibiotic only if a group A strep test was ordered. The denominator only includes patients with a diagnosis of pharyngitis or tonsilitis *and* who received a new prescription during the visit or within three days after. Patients are excluded from the denominator if they were already taking an antibiotic within 30 days prior to the encounter. The numerator is those with a GAS test result within three days before or after the encounter. Also used by PQRS and CHIPRA. Satisfies Efficient Use of Healthcare Resources

domain.

CMS 155 **Weight Assessment and Counseling for Children and Adolescents**

Percentage of patients aged 3-17 years whose BMI was measured and calculated, with documented counseling for nutrition and physical activity during the reporting period. Denominator is all patients with an encounter during the reporting period. Numerator 1 is those who had height, weight, and BMI recorded. Numerator 2 is those who received nutritional counseling, based on a specific list of diagnosis codes. Numerator 3 is those who received physical activity counseling, also based on a specific list of diagnosis codes. All three numerators are reported for three age strata - all pediatric (3-17 years)l, child only (3-11 years), and adolescent only (12-17 years) - for a total of nine calculations. Also used by PQRS and UDS. Satisfies Population/Public Health domain.

CMS 153 **Chlamydia Screening for Women**

Percentage of sexually active women aged 16-24 years who had at least one chlamydia test during the reporting period. The denominator only includes patients who are presumed to be sexually active based on specific lists of diagnoses, medications, and/or lab tests. Numerator is those who had at least one lab order for chlamydia screening during the measurement period. Numerator is reported for three age strata: 16-24 years, 16-20 years, and 21-24 years. Also used by PQRS, CHIPRA, HEDIS, PCMH, and some states. Satisfies Population/Public Health domain.

CMS 126 **Use of Appropriate Medications for Asthma**

Percentage of patients aged 5-64 years who were identified with persistent asthma and appropriately prescribed medication during the reporting period. Denominator is limited to patients with an active diagnosis of some grade of persistent asthma (excludes mild intermittent). Numerator is those with a prescription from a specific list of controller medications. Also used by PQRS and PCMH. Satisfies Efficient Use of Healthcare Resources domain.

CMS 117 **Childhood Immunization Status**

Also known as the “Every Child By Two” criteria that many practices already submit as a HEDIS measurement. Denominator is every patient who turned 2 years of age during the reporting period. Numerator is those who had four DTaP; three polio (IPV), one MMR; three HiB; three hepatitis B; one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A; two or three rotavirus; and two influenza (flu) vaccines by their second birthday. Based on dose counting, rather than valid doses as computed by Office Practicum VacLogic. Doses administered after two years of age are not considered, so a child could be fully

immunized as of today but *not* satisfy the numerator. Also used by PQRS and UDS. Satisfies Population/Public Health domain.

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. Denominator is every patient who had an encounter with a diagnosis of URI. Encounters are excluded if there was a co-morbid diagnosis from a long list of competing respiratory conditions, or if the patient was already taking an antibiotic. Numerator is those who did *not* receive a prescription for an antibiotic on or within three days of the encounter. Also used by PQRS and PCMH. Satisfies Efficient Use of Healthcare Resources domain.

CMS 136 **Follow-Up Care for Children Newly Prescribed ADHD Medication**

Percentage of children 6-12 years of age and *newly* dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. The denominator only includes patients who were not already taking medication for ADHD at least 90 days before the start of the measurement period, so it will be lower than the total number of patients being treated for ADHD in your practice. Two numerators are reported: those with a 30-day follow-up visit, and those with 210 days of medication therapy accompanied by at least two additional visits. Due to these durations, reporting periods of less than a year will not lead to accurate numerators. Satisfies Clinical Process/ Effectiveness domain.

CMS 2 **Screening for Clinical Depression and Follow-Up Plan**

Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age-appropriate standardized screening tool, *and* if positive, follow-up plan documented on the date of the positive screen. Denominator is all patients who had a well visit during the reporting period. Numerator is those who either took a survey from a specific list or had depression risk assessment documented. Also used by PQRS and ACO. Satisfies Population/Public Health domain.

CMS 75 **Children with Dental Decay or Cavities**

Percentage of children aged 0-20 years who have had tooth decay or cavities during the measurement period. Denominator includes all patients who had an encounter (sick or well) during the reporting period. Numerator is those with a diagnosis of dental decay either in the encounter or on their problem list, not just an abnormal tooth exam element. Satisfies Clinical Process/Effectiveness.

2014 Adult CMS-Recommended Core CQMs

CMS 165 **Controlling High Blood Pressure**

Percentage of patients 18-85 years of age with an active diagnosis of hypertension whose blood pressure was adequately controlled (<140/90mmHg). Denominator is all patients with hypertension on their active problem list no later than six months into the measurement period and seen at least once during the period. Numerator is those who had a measurement in the normal range during the period. Also used by PQRS, ACO, and UDS. Satisfies Clinical Process/Effectiveness domain. Possible alternative CQM in pediatric settings if you have enough hypertensive patients over 18 years of age.

CMS 156 **Use of High-Risk Medications in the Elderly**

Percentage of patients 66 years of age and older who were ordered high-risk medications. Denominator is all patients with at least one encounter during the measurement period. Two numerators are reported: Percentage of patients with at least one high-risk medication order, and percentage of patients with at least two *different* high-risk medication orders. Also used by PQRS. Satisfies Patient Safety domain. Not really pediatric but in the core adult set.

CMS 138 **Preventive Care and Screening Pair: Tobacco Use Assessment and Tobacco Cessation Intervention**

Percentage of patients aged 18 years and older for whom smoking status has been recorded at least once in the past 24 months, *and* cessation intervention has been performed for those with positive statuses. Denominator is all patients with either one well or two sick encounters during the reporting period. Numerator is those with a smoking risk assessment during the prior 24 months that either indicates non-use, or an assessment of tobacco use with accompanying cessation intervention documented via specific CPTs performed or medications prescribed. Also used by PQRS, ACO, and UDS. Satisfies Population/Public Health domain. Since you should be assessing smoking risk starting at age 13 years in order to satisfy an original MU automated measure, this is a natural alternative CQM for pediatric settings if you have enough patients over 18 years.

CMS 2 **Screening for Clinical Depression and Follow-Up Plan**

Same measure described above in Pediatric measures, also applies to adults.

CMS 68 **Documentation of Current Medications**

Percentage of 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. Must include *all* prescriptions, OTCs, herbals, and

vitamin/mineral/dietary (nutritional) supplements, and must contain the medication name, dosage, frequency and route of administration. Denominator includes all patients with an encounter during the reporting period. Numerator is those for whom the "Medications Reviewed" checkbox was clicked during the encounter, keeping in mind the level of detail described above. Also used by PQRS. Satisfies Patient Safety domain. If you document medications carefully and usually click the "Medications Reviewed" checkbox at every visit, this is another alternative CQM for pediatric settings if you have enough patients over 18 years.

CMS 69 **Adult Weight Screening and Follow-Up**

This is the adult version of CMS 155 (above). Denominator is all patients seen during the reporting period. Numerator is those for whom BMI was recorded within the past six months, and if out of range, follow up care was documented through a specific list of diagnoses. Numerator is reported in two strata: 18-64 years, and 65+ years. Also used by PQRS, ACO, and UDS. Satisfies Population/Public Health domain. You might consider using it if you have a sizable population aged 18 years and older for whom you provide ongoing counseling about weight management issues.

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. Denominator is all patients with an outbound referral during the reporting period. Numerator is those for which a referral response is documented (*not* just a scanned item). Also used by PCMH. Satisfies Care Coordination domain. Another excellent alternative Pediatric measure, since it is not age-specific.

2014 Pediatric OP-Recommended Alternate CQMs

If you can't find nine CQMs that suit your practice from those listed above, here are a few more that might work depending on your patient population and needs.

CMS 147 **Influenza Immunization**

Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization *or* who reported previous receipt of an influenza immunization. This measure must be calculated relative to a full calendar year reporting period. Denominator is all patients with an encounter 3 months before or after the start of the reporting period. Numerator is those with a flu vaccine documented from 5 months before to 3 months after the start date. Satisfies Population/Public Health domain. A natural

alternative for pediatrics.

CMS 148 **Hemoglobin A1c Test for Pediatric Patients**

Percentage of patients 5-17 years of age with a diagnosis of diabetes who had an HgbA1c diagnostic test during the measurement period. Denominator is patients with an active diagnosis of diabetes and an established relationship (first seen at least 12 months prior to the most recent visit). Numerator is those for whom a Hemoglobin A1C result is documented during the measurement period. Satisfies Clinical Process/Effectiveness domain. A good alternative if you have a large enough panel of diabetic patients.

CMS 82 **Maternal Depression Screening**

Percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life. Denominator is all patients who turned 6 months of age during the reporting period. Numerator is those for whom at least one maternal depression screen was administered, based on a specific list of surveys. Satisfies Population/Public Health domain. A good alternative for pediatrics if you routinely perform Edinbergh or PHQ-2 surveys at early infant visits.

CMS 74 **Primary Caries Prevention Intervention**

Percentage of children aged 0-20 years who received a fluoride varnish application during the measurement period. Applies to PCPs and/or dentists. Denominator is all patients seen at least once during the reporting period. Numerator is those who had fluoride varnish applied and documented through a specific list of CPT codes. Satisfies Clinical Process/Effectiveness domain. May work for your practice if you have a large Medicaid population for whom you already provide this service.

Summary of Non-Reportable EP Objectives, Modified Stage 2

The following “redundant, duplicative, or topped-out measures” have been removed from reporting in 2015 under Modified Stage 2 guidelines. CMS reasoned that most healthcare providers have fully integrated these basic chart-keeping tasks into their workflows, so there is no need to monitor ongoing specific performance. They remain in this document because you still need to *do* them, so we are recommending the best workflows and internal standards you should adopt. Also, if your practice is enrolled in NCQA Patient Centered Medical Home or other QI initiatives, you may find that some or all of these measures are still required for those programs.

1. **Problem List** (was only Stage 1 in 2015)
2. **Medication Allergies** (was only Stage 1 in 2015)
3. **Medication List** (was only Stage 1 in 2015)
4. **Record demographics**
5. **Record vital signs**
6. **Record smoking status**
7. **Clinical Summaries**
8. **Structured lab results**
9. **Patient List**
10. **Patient Reminders**
11. **Summary of Care**
12. **Electronic Notes**
13. **Imaging Results**
14. **Family Health History**

Record Demographics

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to collect the required data. A good internal benchmark is 50-80%.

OP Calculation For all records in the REGISTER table where the patient had at least one encounter (sick or well) during the reporting period, calculate what percentage of these patients have *all* five fields populated with non-null values.

OP Changes Fields for race and ethnicity were added to Register Form. In MU-Aware mode, all five required fields are highlighted as being necessary. Patient portal prompts for all required fields when patient records are created and edited.

Usage Changes Emphasize to front staff that it is important to obtain/update a complete set of demographic information during the check-in process. If the patient declines to answer, record that fact rather than leaving a field blank.

Up-to-date Problem List

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to collect the required data. A good internal benchmark is 80%.

OP Calculation For all qualifying patients, calculate what percentage have at least one row of data in the CHARTNOTES table where PROBLEM_LIST is “Y” or “T”, and ARCHIVED is “N”; or have the NO_PL_INDICATOR indicator populated in the MEDHIST table.

OP Changes The F8 Chart form has been redesigned so the user’s attention is drawn to an empty problem list, and a new [None] button has been added to make it easy to set the “patient has no problems” status.
OP 11 focused on the ICD-9 fields for problem coding. As of MU2, OP 14 enforces SNOMED as the required coding system for problems and history.

Usage Changes Clinical users – especially providers – should make a habit of reviewing this area when they open the F8 Chart form for every patient seen, and either populate problems or click the [None] button. For new patients, add this to the protocol for how paper charts or inbound records are abstracted.

Active Medication List

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to collect the required data. A good internal benchmark is 80%.

OP Calculation For all qualifying patients, calculate what percentage have at least one row of data in the MEDICATIONS table where ONGOING is "Y", or have the NO_MEDS indicator populated in the MEDHIST table.

OP Changes F8 Chart form has been redesigned so the user's attention is drawn to an empty medication list, and a new [None] button has been added to make it easy to set the "patient takes no medications" status there. The NO_MEDS indicator has been reinterpreted to mean "patient takes no *chronic* medications," which means it will *not* reset when short-term prescriptions for acute problems are written. (Otherwise it would be a constant struggle to reset this indicator every time a 10-day course of antibiotics was completed.)

Usage Changes Clinical users – especially providers – should make a habit of reviewing this area when they open the F8 Chart form for every patient seen, and either populate medications or click the [None] button. For new patients, add chronic meds to the protocol for how paper charts or inbound records are abstracted.

For both old and new records, establish a habit of using the Med Finder Form when adding reference medications , not the deprecated "Med – Unformatted" option. Use the advanced e-RX [Med Hist] feature to build new patient medication lists with a minimum of retyping.

Active Medication Allergy List

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to collect the required data. A good internal benchmark is 80%.

OP Calculation For all qualifying patients, calculate what percentage have at least one row of data in the CHARTNOTES table where SECTION_SUBHEADING is "MEDICATION ALLERGY" or "ALLERGIES", ARCHIVED is "N", and ICD-9 or Allergy Group or NDCID has been specified; or NKDA_INDICATOR has been set in MEDHIST table.

OP Changes The F8 Chart form has been redesigned so the user's attention is drawn to an empty medication allergy list, and a new [None] button has been added to make it easy to set the "patient has no medication allergies" status. The detailed Chart Note for allergies has a new field where specific medications and SNOMED codes, not just allergy groups, can be entered.

Usage Changes Clinical users – especially providers – should make a habit of reviewing this area when they open the F8 Chart form for every patient seen, and either populate medication allergies or click the [None] button. For new patients, add this to the protocol for how paper charts or inbound records are abstracted.

For existing records, change the deprecated "ALLERGIES" subsection to either "MEDICATION ALLERGY" or "NON-MEDICATION ALLERGY" so warnings about issues like peanuts and hay fever do not cause spurious popup warnings over the medication list. In addition, ensure that all medication allergy notes are supported by some combination of SNOMED, Allergy Group, and/or NDCID codes.

Vital Signs and Growth Charts

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to collect the required data when appropriate. A good internal benchmark is 80%.

OP Calculation For patients had at least one sick or well encounter during the reporting period, calculate what percentage have at least one height *and* one weight (*and* one blood pressure measurement, if older than 3 years of age) on their chart. Measurements need not have occurred during the reporting period.

OP Changes None

Usage Changes Since you only get credit for older children who have at least one measurement of all three types, be especially aware with new patients to either collect all three at their first visit, or adopt a protocol to transcribe at least one of each type when the patient's paper chart is abstracted. Otherwise patients who come in only once during the reporting period for sick care might reduce your performance.

This measure also includes the action of plotting and displaying growth charts for children 2-20 years of age, including BMI. Connexin certifies that Office Practicum can generate growth charts – our specialty! – but you do not need to document how often you generate them. We will continue to record this in the disclosure log, so it is a computable measure if you need it.

Smoking Status

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to collect the required data. A good internal benchmark is 50-80%.

OP Calculation For all patients over 13 years old who had at least one sick or well encounter during the reporting period, calculate what percentage have a RISK_ASSESSMENT record with a non-null answer for “Smoking Status”.

OP Changes A new section entitled “Risk Assessment” has been added to the patient chart. The 2014 version includes a few additional choices in the pulldown but otherwise works the exact same way. Although this will initially gather smoking status and a few other common risk factors like lead exposure and PPD/TB exposure, over time this section will grow to encompass additional items such as alcohol use and propensity for certain medical conditions based on patient and family history.

Usage Changes Clinical users – especially providers – should make a habit of reviewing this area when they open the F8 Chart form for every patient seen, and populate missing risk assessment items. Since all data must be coded against a specific list of answers, there is no [None] option.

Clinical Summaries

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to provide clinical summaries to patients. A good internal benchmark is 50 within 3 business days.

OP Calculation For all records in the ENC_NOTE and PHYSICAL tables, calculate what percentage have a patient exit note in the PATIENT_VISIT_SUMMARY table that was generated either on paper or electronically within the mandated days after the encounter date. For the purposes of this measure, "business days" will be interpreted to exclude weekends but not holidays. The performance threshold is only 50%, so this should not be a material factor in attaining the goal.

OP Changes The previously deprecated "Followup" text field was restored with a new name and purpose – patient instructions. These instructions are available at the template level, which makes them available for immediate use even if ROS and Exam have not been completed.

A field was added to the tab that creates exit notes with a second report criteria rule to generate a patient-friendly exit note. This note can be generated at the same time as the primary summary note, or it can be constructed for the patient to take along even before full medical documentation for the "official" exit note has been completed. "Patient friendly" mode was added to the Event Chronology note generation engine. The patient version of exit notes is available on the patient portal, thus satisfying this measure for patients who have portal accounts.

Usage Changes Providers may not be accustomed to completing their notes while the patient is still in the office. In that case, they would have to figure out a way to put this information in their patients' hands after the fact (usually via the patient portal). Since most well visits come with standard patient follow-up instructions, and sick templates can include condition-specific instructions, we recommend populating these fields with appropriate values and using templates as frequently as possible to speed the completion of patient-oriented exit notes.

Clinical Lab Test Results

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to record lab results as structured data as often as possible. A good internal benchmark is 50%, depending on availability.

OP Calculation For all diagnostic test requisitions written during the reporting period, calculate how many have at least one result row with a result expressed in positive/negative or numeric format. (This methodology excludes hearing and vision screens as results that need to be considered. It also disregards legacy data, because that is not associated with a requisition order.)

OP Changes None in OP 11. OP 14 formally segregates lab tests from radiology, screens, and procedures, so this measure can be computed more cleanly. It also allows each test to be tagged with an expected result type.

Usage Changes An external lab results interface is not required for this measure, but it helps. Results for in-house labs like quick strep and hemoglobin tests are naturally recorded as +/- or numeric data, so they count in your favor. On the other hand, if you scan lots of lab results and attach them to requisitions without transcribing at least some of the data, then those orders won't count.

If you don't have or don't want a lab result interface, you should consider writing your diagnostic test requisitions for a generic "outside lab" where the order and result rows are pre-populated with everything but the actual results. That way, when the paperwork comes back, it is relatively easy to go down the line and fill in the results manually.

Patient Lists

Applicable Stages	All (not reported)
Passing Score	Though this measure is no longer reported in Modified Stage 2, it's still a great idea to perform patient recalls on a regular basis.
OP Calculation	None, attest-only.
OP Changes	The existing Recall Form has been enhanced to support more options, and the "All Patient" mode of Event Chronology has been split to a separate form that also provides more options for aggregating practice-wide statistics.
Usage Changes	Begin performing regular recalls for lapses in well care and late immunizations, or to find patients with specific demographic or other characteristics.

Patient Reminders

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, it's still a great idea to perform patient recalls and reminders on a regular basis.

OP Calculation For all qualifying patients, calculate what percentage have at least one administrative message of Recall or Reminder type that was sent during the reporting period. For the purposes of calculating this measure, Office Practicum will include both reminders for previously scheduled appointments and recalls for missing care plan items that need to be scheduled.

OP Changes A new form was added to Office Practicum 11 on which customized bulk message distribution can be managed, using the preferences specified on the Contacts tab of the F2 Register form. This Message Distribution Center can be accessed from the calendar (to send appointment reminders) and all recall forms (to send notices about lapses in care). These administrative messages are also displayed on the Patient Portal to document the reminder history.

The existing Recall Form was enhanced to support more options, and the "All Patient" mode of Event Chronology was split to a separate form that also provides more options for aggregating practice-wide statistics.

Usage Changes In lieu of calling patients individually for appointment reminders, establish new protocols to sweep the forward calendar on a daily basis, then use the Message Distribution Center to decide the best way to contact people. If you don't want to send reminders electronically, you can still get credit for this measure by flagging them as Manual when you create them. They will drop to the chart and be visible from the patient portal, but your staff can initiate the actual contact.

Begin performing regular recalls for lapses in well care and late immunizations, then use the Message Distribution Center to contact patients who are falling through the cracks in these important areas.

Record Electronic Notes

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to record encounter notes electronically as often as possible. A good internal benchmark is 30%.

OP Calculation For all patients with SCHEDULE appointments during the reporting period, count how many have at least one finalized record in the ENC_NOTES and/or PHYSICAL table. The note need *not* have been written during the reporting period.

OP Changes None.

Usage Changes If you are routinely using OP to create electronic sick and well encounters, there is nothing new to do (other than ensuring you finalize them). On the other hand, if you have been writing encounter notes on paper and scanning to the chart, you'll have to stop doing that and learn how to write electronic notes.

Imaging Results

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to capture imaging results as structured data (or links to the actual images) as often as possible. A good internal benchmark is 10-20%, depending on availability.

OP Calculation For all qualified radiology results, count how many are linked to a record in the scanned image table. The link can point to an actual imaging result, a narrative interpretation, or an URL to an external system where the result is stored. (In the latter case, there is no requirement for single sign-on to view the result, just that you land in the external system so you can continue the retrieval process.)

OP Changes None. OP has always allowed diagnostic test results to be attached to scanned images. OP 14 formally segregates radiology results from lab tests, screens, and procedures, so this measure can be computed more cleanly.

Usage Changes When you order imaging studies, make sure you scan the results into the system when they come back and attach them to the original order.

Family Health History

Applicable Stages All (not reported)

Passing Score Though this measure is no longer reported in Modified Stage 2, you are still expected to collect structured family history for first-degree relatives as often as possible. A good internal benchmark is 20-50%, depending on availability.

OP Calculation For all qualifying patients, count how many have at least one record in the FAMILY_HX table, or at least one encounter during the reporting period where the [Family] checkbox was checkmarked in "History sections reviewed." For the FAMILY_HX table, history need *not* have been taken during the reporting period.

OP Changes In OP 14, a distinct Family History tab was added to the History section of the chart. This replaces the prior Family History section in the bulleted history.

Usage Changes The new Family History in OP 14 represents a significant improvement over OP 11 because each entry is attributed to an individual. In this way, the entire history can be grouped by either the family member or the documented condition. This also allows the creation of family trees to assist in tracking genetic conditions through multiple generations. The downside is that the new approach is mostly incompatible with the prior approach, so much of the family history will need to be rewritten at each patient's next visit. The old history is mapped to a certain extent, but you will probably want to enhance it when you get the chance.