Physicians who first participated in meaningful use in 2011 or 2012 must move on to Stage 2 in 2014. For 2014 only, physicians will attest to a calendar quarter of compliance with Stage 2 meaningful use. This is to allow physicians more time to make the upgrades necessary to meet Stage 2. Physicians who began meaningful use in 2011 can receive incentives up to $4,000 in 2014. For physicians who began meaningful use in 2012, the maximum payment is $8,000 in 2014. Failure to successfully complete meaningful use in 2014 will result in a 2 percent penalty in 2016.

Meaningful Use Stage 2 is structured identically to Stage 1. As in Stage 1, there are 3 steps to successful meaningful use reporting: Core Objectives, Menu Objectives, and Clinical Quality Measures. As in Stage 1, the Core Objectives and Menu Objectives will be submitted through the attestation portal. However, Clinical Quality Measures must now be electronically submitted either directly through your EHR vendor or through a certified EHR data submission vendor, such as the Academy’s IRIS™ Registry.

Step 1: 17 Meaningful Use Core Functional Objectives

All physicians are required to report on all 17 measures, but some exclusions are available. Please note that many of the measures require that the measure be met for over a certain percentage of patients (e.g., 30 percent). In this case, any percentage that is over 30 percent will qualify (e.g., 30.3 percent, 31 percent, 50 percent). 30 percent will not qualify.

**CORE 1: Computerized Provider Order Entry (CPOE) for Medication, Laboratory and Radiology Orders**

More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

**Measure 1: Medication Orders**

- **DENOMINATOR:** Number of medication orders created by the EP during the EHR reporting period.
- **NUMERATOR:** The number of orders in the denominator recorded using CPOE.
- **THRESHOLD:** More than 60 percent.
- **EXCLUSION:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.

**Reporting Guidance:**

Most ophthalmologists will be able to meet the objective or qualify for the exclusion.

Certified ophthalmic assistants and certified ophthalmic technicians are now permitted to enter medication, radiology, and laboratory test orders for purposes of meaningful use.
You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

In some cases, EHRs may include medication lists that are maintained by multiple physicians. In these circumstances, it may be difficult for the ophthalmologist to meet the reporting threshold due to the volume of entries for medications that are not managed by the ophthalmologist. CMS allows physicians that do not qualify for the exclusion (i.e. write 100 or more prescriptions) and maintain medication lists that include medications ordered by other providers to limit their CPOE measure calculation to only those patients for whom he or she has previously ordered a medication. Ophthalmologists facing this scenario should work with their EHR vendor to determine how to limit the measure calculation and must maintain documentation of their use of this alternate option in the event of an audit.

**Measure 2: Radiology Orders**
- **DENOMINATOR:** Number of radiology orders created by the EP during the EHR reporting period.
- **NUMERATOR:** The number of orders in the denominator recorded using CPOE.
- **THRESHOLD:** More than 30 percent.
- **EXCLUSION:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

**Reporting Guidance:**
CMS defines a radiology order as an order for any imaging service that uses electronic product radiation. Electronic product radiation includes any ionizing or non-ionizing electromagnetic or particular radiation, or any sonic, infrasonic, or ultrasonic wave that is emitted from an electronic produce as the result of the operation of an electronic circuit in such product.

The CMS definition can be interpreted to include such ophthalmic tests as OCT, ophthalmic ultrasound, and others. Ophthalmologists should check with their EHR vendor to determine if orders for these ophthalmic tests can be entered electronically. If so, they must be entered to comply with the measure.

Certified ophthalmic assistants and certified ophthalmic technicians are now permitted to enter medication, radiology, and laboratory test orders for purposes of meaningful use.

CMS allows physicians to include orders for other types of imaging services if they so choose and the vendor has this capability. Ophthalmologists should clearly document their policy for which tests must be entered using CPOE and retain this documentation in the event of an audit.

Some ophthalmologists may qualify for the exclusion.

The Academy recognizes that the CPOE requirement for radiology orders could be extremely burdensome to practice workflow, and we are presently seeking further clarification from CMS. Visit [www.aao.org/ehr](http://www.aao.org/ehr) for the latest information on the CPOE requirement.

**Measure 3: Laboratory Orders**
- **DENOMINATOR:** Number of laboratory orders created by the EP during the EHR reporting period.
- **NUMERATOR:** The number of orders in the denominator recorded using CPOE.
- **THRESHOLD:** More than 30 percent.
- **EXCLUSION:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

**Reporting guidance:**
Most ophthalmologists will qualify for the exclusion.

**CORE 2: E- Prescribing** - Generate and transmit permissible prescriptions electronically.

**Measure 1: E-prescribing** - More than 50% of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

- **DENOMINATOR:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.
- **NUMERATOR:** The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.
- **THRESHOLD:** More than 60 percent.
- **EXCLUSION 1:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.
- **EXCLUSION 2:** Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his/her EHR reporting period.

**Reporting Guidance:**
Most ophthalmologists will be able to meet the objective or qualify for the exclusion.

You must answer either “yes” or “no” to both exclusions. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

Instances where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the EHR period.

Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of CEHRT to the intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.

**CORE 3: Record Demographics** - More than 80% of all unique patients seen by the EP have demographics recorded as structured data.

**Measure 1: Record Demographics**
- **DENOMINATOR:** Number of unique patients seen by the EP during the EHR Reporting period.
- **NUMERATOR:** The number of patients in the denominator who have all the elements of demographics recorded as structured data.
• THRESHOLD: More than 80 percent.

Reporting Guidance:
If a patient declines to provide all or part of the demographic information, or if capturing a patient’s ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure. If patients do not know their ethnicity, EPs should treat them as patients who decline to provide race or ethnicity (i.e., identify in the patient record that the patient declined to provide this information).

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or White.
Ethnicity: "Hispanic or Latino," or "Not Hispanic or Latino."

CORE 4: Record Vital Signs - More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and or height and weight (for all ages) recorded as structured data.

Measure 1: Vital Signs
• DENOMINATOR: Number of unique patients seen by the EP during the EHR Reporting period.
• NUMERATOR: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.
• THRESHOLD: More than 80 percent.
• EXCLUSION 1: Any EP who sees no patients 3 years or older is excluded from recording blood pressure.
• EXCLUSION 2: Any EP who believes that all 3 vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.
• EXCLUSION 3: Any EP who believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
• EXCLUSION 4: Any EP who believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

Reporting Guidance:
You must answer either “yes” or “no” to all exclusions. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

Most ophthalmologists will answer “yes” to exclusion 2. Some ophthalmologists who believe that blood pressure is relevant will answer “yes” to exclusion 4.

Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make a determination based on the patient’s individual circumstances as to whether height, weight, and blood pressure need to be updated.

Vital sign information can be entered into the patient’s medical record in a number of ways including: direct entry by the EP; entry by a designated individual from the EP’s staff; data transfer from another provider electronically, through an HIE or through other methods; or data entered directly by the
patient through a portal or other means. Some of these methods are more accurate than others, and it is up to the EP to determine the level of accuracy needed to care for their patient and how best to obtain this information.

**CORE 5: Record Smoking Status** - More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

**Measure 1: Smoking Status**
- **DENOMINATOR:** Number of unique patients age 13 or older seen by the EP during the EHR Reporting period.
- **NUMERATOR:** Number of patients in the denominator with smoking status recorded as structured data.
- **THRESHOLD:** More than 80 percent.
- **EXCLUSION:** Any EP who sees no patients 13 years or older.

**Reporting Guidance:**
You must answer either “yes” or “no” to the exclusion question. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

Smoking status does not have to be updated by the EP at every patient encounter. The EP can make a determination based on the patient’s individual circumstances as to whether smoking status needs to be updated.

**CORE 6: Clinical Decision Support Rule**

**Measure 1: Clinical Decision Support**
- Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

**Measure 2: Drug-Drug and Drug-Allergy Interactions**
- The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
- **EXCLUSION:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.

**Reporting Guidance:**
Consult with your vendor to determine the clinical decision support rule(s) your EHR has the capability to implement. All ophthalmologists should implement the appropriate rules and check “Yes” on the attestation form.

**CORE 7: Patient Electronic Access** - Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.
**Measure 1:** More than 50% 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.

- **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- **NUMERATOR:** Number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information.
- **THRESHOLD:** More than 50 percent.

**Measure 2:** More than 5% 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.

- **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- **NUMERATOR:** Number of patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient’s health information.
- **THRESHOLD:** More than 5 percent.
- **EXCLUSION 1:** Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for “Patient name” and “Provider’s name and office contact information”, may exclude both measures.
- **EXCLUSION 2:** Conducts 50% or more of his or her patient encounters in a county that does not have 50% 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 may exclude only the second measure.

**Reporting Guidance:**
The following information must be made available online: Patient name, provider’s name and office contact information, current and past problem list, procedures, laboratory test results, current medication list and medication history, current medication allergy list and medication allergy history, vital signs, smoking status, demographic information, care plan fields including goals and instructions, and any known care team members including the PCP of record unless the information is not available in the EHR or is restricted from disclosure by law.

Ophthalmologists can employ a variety of strategies to encourage patients to access their information online, such as showing patients how to access the portal in the office.

**CORE 8: Clinical Summaries**

**Measure 1:** Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50% of office visits.

- **DENOMINATOR:** Number of office visits conducted by the EP during the EHR reporting period.
- **NUMERATOR:** Number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one business day.
- **THRESHOLD:** More than 50 percent.
- **EXCLUSION:** Any EP who has no office visits during the EHR reporting period.
Reporting Guidance:
Office visits include separate, billable encounters that result from evaluation and management services provided to the patient.

The clinical summary can be provided through a PHR, patient portal on the website, secure e-mail, electronic media such as CD or USB fob, or printed copy. If the EP has a patient portal available to meet CORE 7 and updates the portal no more than one business day after the patient visit, they have satisfied CORE 8. If the EP chooses an electronic media, they would be required to provide the patient a paper copy upon request.

EPs may also default to providing paper copies, in which case an electronic form of the EP’s choice would need to be provided upon request.

Providers may not charge patients a fee to provide this information.

CORE 9: Protect Electronic Health Information

Measure 1: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process for EPs.

Reporting Guidance:
All ophthalmologists should review the security of their system in compliance with the HIPAA Security Rule, and take action to resolve any issues identified in the review. Additional resources for conducting a security risk analysis are available on EHR Central.

The Security Risk Analysis must occur during the EHR reporting period to count for meaningful use. Documentation of the Security Risk Analysis indicating the date completed during the EHR Reporting period will be required in the event of an audit.

CORE 10: Clinical Lab-Test Results

Measure 1: More than 55% 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 a structured data.

- **DENOMINATOR:** Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
- **NUMERATOR:** Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.
- **THRESHOLD:** More than 55 percent.
**EXCLUSION:** Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the EHR reporting period.

**Reporting Guidance:**
Many ophthalmologists will be able to qualify for the exclusion. If even one lab test is ordered for a patient during the reporting period, the ophthalmologist must report the measure.

**CORE 11: Patient Lists**

**Measure 1:** Generate at least one report listing patients of the EP with a specific condition.

**Reporting Guidance:**
The EP or a member of the staff can generate a list of patients with a specific condition to meet this measure. Retain the report with the date it was generated as documentation in the event of an audit.

Each EHR reporting period should be identified with a different report. Reports generated in past EHR reporting periods cannot be used to satisfy this measure in the current EHR reporting period.

**CORE 12: Preventative 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.

**Measure 1:** More than 10% of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

- **DENOMINATOR:** Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period.
- **NUMERATOR:** Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period.
- **THRESHOLD:** More than 10 percent.
- **EXCLUSION:** Any EP who has had no office visits in the 24 months before the EHR reporting period.

**Reporting Guidance:**
To count for the measure, reminders for preventive/follow-up care must be for care that the patient is not already scheduled to receive.

Reminders for referrals or to engage in certain health activities do count for the measure.

**CORE 13: Patient-Specific Education Resources** - Use clinically relevant information from Certified EHR Technology to identify patient specific education resources and provide those resources to the patient.
Measure 1: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period.

- **DENOMINATOR:** Number of unique patients with office visits seen by the EP during the EHR reporting period.
- **NUMERATOR:** Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology.
- **THRESHOLD:** More than 10 percent.
- **EXCLUSION:** Any EP who has no office visits during the EHR reporting period.

**Reporting Guidance:**
Education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology (CEHRT) in a manner where the technology suggests patient-specific educational resources based on the information stored in the CEHRT. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.

The EP can provide these educational resources to patients in a useful format for the patient (such as, electronic copy, printed copy, electronic link to source materials, through a patient portal or PHR).

**CORE 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.

Measure 1: The EP performs reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

- **DENOMINATOR:** Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
- **NUMERATOR:** Number of transitions of care in the denominator where medication reconciliation was performed.
- **THRESHOLD:** More than 50 percent.
- **EXCLUSION:** Any EP who was not the recipient of any transitions of care during the EHR reporting period.

**CORE 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.

Measure 1: 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% of transitions of care and referrals.
DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.

THRESHOLD: More than 50 percent.

EXCLUSION: 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.

Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care providers a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the 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 establishes for the NwHIN.

DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the 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 establishes for the nationwide health information network. The organization can be a third-party or the sender’s own organization.

THRESHOLD: More than 10 percent.

EXCLUSION: 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.

Measure 3: An EP must satisfy one of the following criteria:

1. Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in “Measure 2” with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender’s EHR technology.

2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

EXCLUSION: 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.

Reporting Guidance:
Most ophthalmologists will be able to meet the objective or qualify for the exclusion.

A transition of care is defined as the movement of a patient from one setting of care (hospital, primary care practice, specialty care practice, long-term care, home health, rehabilitation facility, etc) to another.
To count in the numerator of any measure, the EP must verify these three fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP or hospital as of the time of generating the summary of care document.

For Measure 1 only, the EP may provide a paper copy of the summary of care.

**CORE 16: Immunization Registries Data Submission** - Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

**Measure 1:** Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

- **EXCLUSION 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.
- **EXCLUSION 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.
- **EXCLUSION 3:** The EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data.
- **EXCLUSION 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.

**Reporting guidance:**
You must answer either “yes” or “no” to all exclusions. Leaving “no” unchecked and providing acceptable numerator and denominator data will create an error message.

Ophthalmologists who do not administer any immunizations will answer “yes” to exclusion 1.

**CORE 17: Use Secure Electronic Messaging** - Use secure electronic messaging to communicate with patients on relevant health information.

**Measure 1:** A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

- **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- **NUMERATOR:** Number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period.
- **THRESHOLD:** More than 5 percent.
• **EXCLUSION:** Any EP who has no office visits during the EHR reporting period or any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% 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.

**Reporting guidance:**
The measure requires that more than 5 percent of patients send a message to the EP. Ophthalmologists can encourage patients to communicate electronically by requesting acknowledgement or follow-up to messages they send.

Messages can be sent via any secure electronic communication tool, such as secure email or the electronic messaging function of a patient portal.

There is not an expectation that the EP must personally respond to electronic messages to the patient. An EP of staff member could decide that a follow-up telephone call or office visit is more appropriate to address the concerns raised in the electronic message.

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**Step 2: Choose 3 of the 6 Meaningful Use Menu Measures**

Ophthalmologists must choose 3 measures from the 6 menu options for Stage 2 of meaningful use. Ophthalmologists should first choose measures that they are not excluded from. EPs are only permitted to report exclusions for measures in the menu set if they are excluded from 4 or more of the available measures.

The Academy has put together a suggested menu set for ophthalmology. Most ophthalmologists should be able to report on 3 of the following measures:

- MENU 2: Electronic Notes
- MENU 3: Imaging Results
- MENU 4: Family Health History
- MENU 6: Report Specific Cases to a Specialized Registry

**MENU 1: Syndromic Surveillance Data Submission** - Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

**Measure 1:** EPs must attest YES to successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period. Either:

1. Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.
2. Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the HER reporting period) and ongoing submission was achieved.

- **EXCLUSION 1:** The EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period.
- **EXCLUSION 2:** The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period.
- **EXCLUSION 3:** The EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data.
- **EXCLUSION 4:** The EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

**Reporting guidance:**
Ophthalmologists who registered with a public health agency during stage 1 of meaningful use and continue to transmit data have met this measure and may choose it as one of their menu options.

Ophthalmologists who meet the exclusion criteria should only select this measure after choosing measures that they are not excluded from.

CMS is developing a centralized repository that EPs can consult to determine if a public health agency in their area is able to accept electronic submissions. If the PHA fails to provide information to this centralized repository by the CMS-established deadline, the provider could claim Exclusion 3.

**MENU 2: Electronic Notes - Record electronic notes in patient records.**

**Measure 1:** Enter at least one electronic progress note created, edited and signed by an EP for more than 30% 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 or other content.

- **DENOMINATOR:** Number of unique patients with at least one office visit during the EHR reporting period.
- **NUMERATOR:** Number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data.
- **THRESHOLD:** More than 30 percent.

**Reporting guidance:**
An EP or authorized provider may author, edit and sign the note in any manner including dictation, conversion of written notes to text searchable notes, direct entry into the EHR or any other method as long as the end result is a text searchable note that is the information that the EP or authorized provider wanted to note.

Drawings and other content can be included with searchable text notes under this measure.
**MENU 3: Imaging results** - Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

**Measure 1:** More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.

- **DENOMINATOR:** Number of texts whose result is one or more images ordered by the EP during the EHR reporting period.
- **NUMERATOR:** The number of results in the denominator that are accessible through CEHRT.
- **THRESHOLD:** More than 10 percent.
- **EXCLUSION:** 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.

**Reporting guidance:**
There are no limitations on the resolution of the image.

Ophthalmologists who are excluded from this measure should only select the measure after selecting measures from which they are not excluded.

Images and imaging results that are scanned into the CEHRT may be counted in the numerator of this measure.

**MENU 4: Family Health History** - Record patient family health history as structured data.

**Measure 1:** More than 20% 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.

- **DENOMINATOR:** Number of unique patients see by the EP during the EHR reporting period.
- **NUMERATOR:** Number of unique patients in the denominator with a structured data entry for one or more first-degree relatives.
- **THRESHOLD:** More than 20 percent.
- **EXCLUSION:** Any EP who has no office visits during the EHR reporting period.

**Reporting guidance:**
For patients who are asked about their family health history, but do not know their family history, it is acceptable for the provider to record the patient’s family history as “unknown.” Either a structured data entry of “unknown” or any structured data entry identified as part of the patient’s family history will count in the numerator of the measure.

**MENU 5: Report Cancer Cases** - Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.
**Measure 1:** EPs must attest to successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period. Either:
1. Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.
2. Registration with the body to which the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.

- **EXCLUSION 1:** The EP does not diagnose or directly treat cancer
- **EXCLUSION 2:** The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period.
- **EXCLUSION 3:** The EP operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic cancer case information.
- **EXCLUSION 4:** The EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.

**Reporting guidance:**
Many ophthalmologists could attest to exclusion 1. However, ophthalmologists who are excluded from this measure should only select the measure after selecting measures from which they are not excluded.

**MENU 6: Report Specific Cases** - Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

**Measure 1:** Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period. Either:
1. Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.
2. Registration with the body to which the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.
3. Registration of intent to initiate ongoing submission was made by the deadline and the EP is still engaged in testing and validation of ongoing electronic submission.
4. Registration of intent to initiate ongoing submission was made by the deadline and the EP is awaiting invitation to begin testing and validation.

- **EXCLUSION 1:** The EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction.
- **EXCLUSION 2:** The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving
electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period.

- **EXCLUSION 3:** The EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries.

- **EXCLUSION 4:** The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable or receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional EPs.

**Reporting guidance:**

Ophthalmologists who currently participate in the Academy’s IRIS™ Registry or who contract and initiate the process to participate in the IRIS™ Registry within 60 days of the start of their EHR reporting period may attest YES to this measure. More information on IRIS™ Registry can be found at [www.aao.org/irisregistry](http://www.aao.org/irisregistry).

The specialized registry cannot be duplicative of any of the other registries included in the meaningful use objectives and measures. This means than an EP cannot meet the immunization, syndromic surveillance, or cancer objectives by reporting to the same registry.

**Step 3: Choose 9 CQMs in 3 Domains**

To meet the requirements of Meaningful Use Stage 2, ophthalmologists must choose a total of 9 clinical quality measures (CQMs) that cover at least 3 of the National Quality Strategy measurement “domains”: patient and family engagement, patient safety, care coordination, population and public health, efficient user of health care resources, and clinical process/effectiveness.

Unlike in Stage 1, where CQMs were submitted through attestation, CQMs for meaningful use Stage 2 must be submitted electronically either directly through your EHR or through a certified “EHR data submission vendor” such as the Academy’s IRIS™ Registry. The electronic measure submission period will be open from Jan. 1 – Feb. 28 of the year following the meaningful use reporting period. Though physicians are only required to submit one calendar quarter of CQM data in 2014, submitting a full year of data can help the physician to qualify for the Physician Quality Reporting System incentive payment (see below).

**Suggested CQMs for Ophthalmology**

There are a total of 64 CQMs in the meaningful use program. However, not all EHR systems will be capable of submitting all of the available CQMs. You can verify the available CQMs for your system by checking the Certified Health IT Product List (CHPL): [http://onchpl.force.com/ehrcert?q=chpl](http://onchpl.force.com/ehrcert?q=chpl)
The Academy has compiled a suggested list of CQMs that will meet the requirement to report 9 CQMs in at least 3 domains. If your EHR is unable to report the Academy-recommended list, you can still qualify for meaningful use by reporting the measures that are available in your system. As in Stage 1 of meaningful use, it is acceptable to report measures that have zero values in the numerator and/or denominator as long as you first select measures for which you have non-zero values.

<table>
<thead>
<tr>
<th>Measure No.</th>
<th>Measure Title and Description</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
<td><strong>Closing the Referral Loop: Receipt of Specialist Report</strong>&lt;br&gt;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.</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>NQF 0018</td>
<td><strong>Controlling High Blood Pressure</strong>&lt;br&gt;Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90mmHg) during the measurement period.</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0022</td>
<td><strong>Use of High-Risk Medications in the Elderly</strong>&lt;br&gt;Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported.&lt;br&gt;  a. Percentage of patients who were ordered at least one high-risk medication.&lt;br&gt;  b. Percentage of patients who were ordered at least two different high-risk medications.</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>NQF 0028</td>
<td><strong>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</strong>&lt;br&gt;Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>NQF 0055</td>
<td><strong>Diabetes: Eye Exam</strong>&lt;br&gt;Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the past 12 months prior to the measurement period.</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0086</td>
<td><strong>Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</strong>&lt;br&gt;Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months.</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0088</td>
<td><strong>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</strong>&lt;br&gt;Percentage of patients aged 18 years and older with a diagnosis</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0089</td>
<td>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</td>
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<tr>
<td></td>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.</td>
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<tr>
<th>NQF 0101</th>
<th>Falls: Screening for Future Fall Risk</th>
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<tbody>
<tr>
<td></td>
<td>Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.</td>
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<thead>
<tr>
<th>NQF 0419</th>
<th>Documentation of Current Medications in the Medical Record</th>
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<tbody>
<tr>
<td></td>
<td>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-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements and must contain the medication’s name, dosage, frequency and route of administration.</td>
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<tr>
<th>NQF 0421</th>
<th>Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</th>
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<tbody>
<tr>
<td></td>
<td>Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI ≥ 23 and &lt; 30; Age 18-64 years BMI ≥ 18.5 and &lt; 25.</td>
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<table>
<thead>
<tr>
<th>NQF 0564</th>
<th>Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures</th>
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<tbody>
<tr>
<td></td>
<td>Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.</td>
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<tr>
<th>NQF 0565</th>
<th>Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</th>
</tr>
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</table>
|           | Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no
significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.

*Not reportable through IRIS™ Registry

**Physician Quality Reporting System**

Clinical Quality Measures reported for meaningful use can be used to satisfy the physician’s obligation to report measures for the Medicare Physician Quality Reporting System. In order for CQM reporting to count for PQRS and well as for meaningful use, at least one measure must have non-zero performance data in both the numerator and the denominator. If the EP is reporting at least one measure that meets this criterion, their electronically submitted CQMs can also be used for PQRS.

Group practices that are attesting for more than one physician have the option to submit group data for the CQMs in lieu of individual EP data to improve the likelihood of having measures with non-zero values in both the numerator and the denominator. Groups that wish to utilize this option should register for the PQRS Group Practice Reporting Option (GPRO) through the PV-PQRS portal and work with their EHR vendor or a data submission vendor, such as the IRIS™ Registry to ensure timely submission of all of the necessary data.

Though the 2014 meaningful use reporting period is one calendar quarter, physicians must submit a full year of CQM data if they wish to also qualify for the PQRS incentive.

For additional resources on Meaningful Use, visit EHR Central: [www.aao.org/ehr](http://www.aao.org/ehr).