

Meaningful Use

Stage 1

Core Objectives

Must Meet all 13 Objectives

1. CPOE for Medication Orders
2. Drug Interaction Checks
3. Up-To-Date Problem List
4. E-Prescribing (eRX)
5. Active Medication List
6. Medication Allergy List
7. Record Demographics
8. Record Vitals
9. Record Smoking Status
10. Clinical Decision Support Rule
11. Patient Electronic Access
12. Clinical Summaries
13. Protect Electronic Health Information

CPOE for Medication Orders

- ▶ Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
- ▶ Measure: More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
- ▶ Optional Alternate: More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
- ▶ Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period

CPOE for Medication Orders Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
- ▶ **NUMERATOR:** Number of patients in the denominator that have at least one medication order entered using CPOE.

How to Meet the Measure: CPOE for Medication Order

The screenshot shows the 'Manage Orders' window with the 'Add New Rx' tab selected. The window is divided into several sections:

- Medication Summary:** Includes 'ASSESSMENTS' with 'Prev Dx', 'Add', and 'Remove' buttons. A list shows '250.00 Diabetes mellitu' and 'N/A Other'.
- Add New Rx:** Features a search bar with 'Rx Type' set to 'All Rx' and 'Search Starts With' set to 'Standard'. Below the search bar is a table with columns: D, F, Strength, Form., Take, Route, Freq., Duration, Disp, Refill, AWP(\$).
- Selected Rx:** A table showing selected medications. The first row is '250.00 Diabetes mellitus without mention of complication' with 'Stop Date' and 'N/A Other'.

Access this feature from one of the following locations:

- Progress Notes > Treatment > Add.
- Telephone/Web Encounter > Rx tab > Select Rx.
- Telephone/Web Encounter > Virtual Visit tab > Treatment > Add.

CPOE for Medication Order Set-Up

▼ Personal Info

Last Name *	First Name *	Middle Initial	<input type="checkbox"/> Is a resource
Dalton	Gail		
Prefix	Suffix	Initials	
		GD	
Date of Birth	Social Security No	<input checked="" type="checkbox"/> Licensed Healthcare Professional or Credentialed Medical Assistant	
Mailing Address	City	State	
23 Hurst Rd	Westborough		
Zip Code	Home Phone	Mobile	
01815	555-123-5552		
Pager	Primary Service Location	Default Appointment Provider	
	Boca South		

▼ Login Info

Username *	Status
gailt	Active

Save Delete Change Password Configure My Assigned Favorites View Staff Log

Drug Interaction Checks

- ▶ Objective: Implement drug-drug and drug-allergy interaction checks.
- ▶ Measure: The EP has enabled this functionality for the entire EHR reporting period.
- ▶ Exclusion: No exclusion.
- ▶ Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

Drug Interaction Checks

The screenshot shows a window titled "Drug Interaction" with a scrollable list of results. The results are as follows:

- Drug To Drug Interaction - NONE -----
- Drug To Allergy Interaction - NONE -----
- Precaution Results - NONE -----
- Age based Criteria Results - NONE -----
- Drug To Food Interaction -----

General Warning			
Drug	Food Class	Severity	Food Warning
Zantac Oral Tablet 150 MG	Ethanol	Minor	Plasma concentrations and pharmacologic effects of Ethanol may be increased by Zantac Oral Tablet 150 MG. Clinical significance is not known.

----- Source -----

Issue Date: October 3, 2012

Database Edition: 12.4.1.001

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At the bottom of the window, there are buttons for "Notes", "Time Stamp", "Browse ...", "Check Spelling", and an "Action:" dropdown menu. Below these are "Print Preview" and "Print" buttons, and a "Close" button in the bottom right corner.

Access this feature from one of the following locations:

- Progress Notes > Current Medication > Drug Interaction.
- Progress Notes > Treatment > Interaction.

Drug Interaction Checks Set-Up

- ▶ Drug interaction checking is always enabled for all eClinicalWorks users.
- ▶ No action is required to satisfy this measure, this measure is reported by a Yes/No answer.

Up-To-Date Problem List

- ▶ Objective: Maintain an up-to-date problem list of current and active diagnoses.
- ▶ Measure: More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
- ▶ Exclusion: No exclusion.

Up-To-Date Problem List Attestation Requirements

- ▶ **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 or an indication that no problems are known for the patient recorded as structured data in their problem list.
- ▶ An EP is not required to update the problem list at every contact with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP.

How To Meet the Measure: Up-To-Date Problem List

Problem List

Patient : Hayes, Kerry

Problem List

Dx Type: All Dx Clinical Status: All ☐ No known problems **Add** Remove Copy to Medical Hx

Type	Code	Name	Specify	Notes	Risk	Onset Date	W/U Status	Clinical Stz	Added On	Modified On	Modified By	Resolved On
	401.9	Unspecified esse			Low	...	confirmed			02/27/2013	Willis, Sam	

☐ Copy View Log OK Cancel

Problem List

Patient : Hayes, Kerry

Problem List

Dx Type: All Dx Clinical Status: All ☒ No known problems **Add** Remove Copy to Medical Hx

Type	Code	Name	Specify	Notes	Risk	Onset Date	W/U Status	Clinical Stz	Added On	Modified On	Modified By	Resolved On
------	------	------	---------	-------	------	------------	------------	--------------	----------	-------------	-------------	-------------

☐ Copy View Log OK Cancel

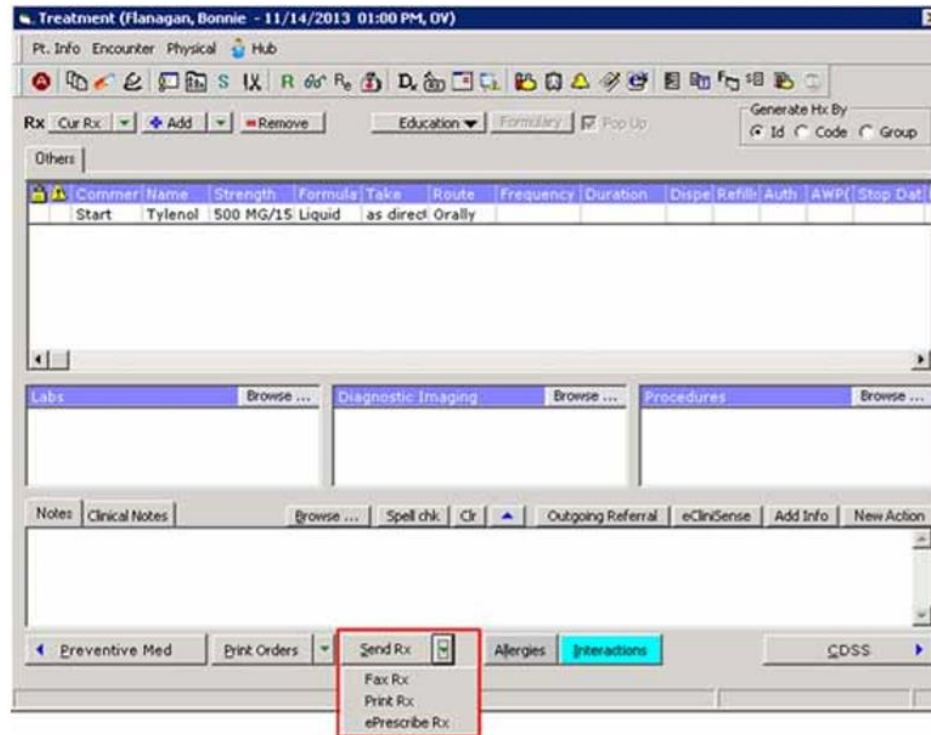
E-Prescribing (eRX)

- ▶ Objective: Generate and transmit permissible prescriptions electronically (eRx).
- ▶ Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
- ▶ Exclusion: 1. Any EP who writes fewer than 100 prescriptions during the EHR reporting period. 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.

E-Prescribing (eRX) Attestation Requirements

- ▶ **DENOMINATOR:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
- ▶ **NUMERATOR:** Number of prescriptions in the denominator generated and transmitted electronically.
- ▶ **Exclusion 1.** Any EP who writes fewer than 100 prescriptions during the EHR reporting period. **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.

How To Meet the Measure: E-Prescribing (eRX)



Access this feature from one of the following locations:

- Progress Notes > Treatment.
- Telephone/Web Encounter > Virtual Visit tab > Treatment.

E-Prescribing Set-Up

Link to ePrescription Pharmacy Database

Local Pharmacy Database

City: Service level: Name: New Update Delete

M	NCPDPID	Store Name	Service Level	Address Line1	Add	City	State	Zip	Ph
		167 Street Pharmacy		112 E 167th Street		Bronx	NY	10452	71
		16th ave pharmacy		4408 16th ave		brooklyn	NY	11204	71
E	3368328	1746 PHARMACY CORP		524 CLARKSON AVE		BROOKLYN	NY	11203	71
E	3331941	181 Pharmacy, Inc.		565 W. 181st Street	BTW	New York	NY	10033	21
E	4931502	1st Ave Pharmacy		6 East 1st Ave		Spokane	WA	99202	50
E	0556540	AARP	NewRx,RefillRx						80
		Absolute Pharmacy		7235 Whipple Ave		North Cant	OH	44720	80
		Access Diabetic Supply		2101 NW 23rd St		Pompano E	FL	33069	80
E	4436920	Accredo		1640 Century Center		Memphis	TN	38134	90
E	3636339	Acme		1835 W Market		Akron	OH	44313	33

Source - Surescripts

ePrescription Pharmacy Database E-Prescribing Fax Only Link Unlink << >>

City: Service level: Name:

	NCPDPID	Store Name	Service Level	Address Line1	Add	City	State	Zip	Phone
	5902590	#1 Pharmacy	NewRx,RefillRx,RxChg	6609 W Sam Houston	Ste 5	Houston	TX	77072	1641 8328
	1032678	#1 Rx Liberty Pharmacy Discount	NewRx,RefillRx	972 E. 25 Street		Hialeah	FL	33013	3056
	4551796	* Rex Pharmacy	NewRx,RefillRx	11110 East Freeway	Suite	Houston	TX	77029	8327
	5647601	**DR. KNOPKE OFFICE** Raincross	NewRx,RefillRx	4646 Brockton Avenr	Suite	Riverside	CA	92506	9517
	4590104	**UHS - SE Pharmacy	NewRx,RefillRx	1055 ADA St		San Antoni	TX	78223	2103
	4537796	**UHS-Discharge Pharmacy	NewRx,RefillRx	4502 Medical Dr		San Antoni	TX	78229	2103
	5904556	**UHS-Pavilion Pharmacy	NewRx,RefillRx	4647 MEDICAL DR		San Antoni	TX	78229	2103
	4538229	**UHS-RBGC Pharmacy	NewRx,RefillRx	903 W MARTIN ST		San Antoni	TX	78207	2103
	4587501	**UHS-SW Pharmacy	NewRx,RefillRx	2121 SW 36th ST		San Antoni	TX	78237	2103
	4509557	**UHS-TDI (UCCH) Pharmacy	NewRx,RefillRx	701 S Zarzamora		San Antoni	TX	78207	2103

Import Selected Into Pharmacy Data Close << >>

Active Medication List

- ▶ Objective: Maintain active medication list.
- ▶ Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
- ▶ Exclusion: No exclusion.

Active Medication List Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients seen by the EP during the HER reporting period.
- ▶ **NUMERATOR:** Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

How To Meet the Measure: Active Medication List

A medication has been recorded in the Current Medication section of the Progress Notes:

The screenshot shows the 'Medication Reconciliation' window with the 'Current Medication' tab selected. The 'Verified' checkbox is checked. Below the tabs, there are two rows of medication information:

Medication	Start Date	Stop Date	Notes	Source	Status
Sprintec 28 0.25-35 MG-MCG Tablet 1 tablet On...	10/10/2012	Stop Date	Notes	Source	T N U D
Minocycline 100 MG Tablet 1 tablet every 12 hrs	Start Date	Stop Date	Notes	Source	T N U D

Access this feature from: Progress Notes > Current Medication.

The *Verified* box is checked in the Current Medication section of the Progress Notes:

The screenshot shows the 'Medication Reconciliation' window with the 'Current Medication' tab selected. The 'Verified' checkbox is checked. Below the tabs, there are two rows of medication information:

Medication	Start Date	Stop Date	Notes	Source	Status
Sprintec 28 0.25-35 MG-MCG Tablet 1 tablet On...	10/10/2012	Stop Date	Notes	Source	T N U D
Minocycline 100 MG Tablet 1 tablet every 12 hrs	Start Date	Stop Date	Notes	Source	T N U D

Access this feature from: Progress Notes > Current Medication.

Medication Allergy List

- ▶ Objective: Maintain active medication allergy list.
- ▶ Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
- ▶ Exclusion: No exclusion.

Medication Allergy List Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- ▶ **NUMERATOR:** Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

Medication Allergy List

The screenshot shows a software window titled "Past Medical History (Hayes, Kerry - 05/19/2014 10:00 AM, AV - Femal) *". The window has a menu bar with "Pt. Info", "Encounter", "Physical", and "Hub". Below the menu bar is a toolbar with various icons. The main content area is divided into two sections: "Medical Hx" and "Allergies".

The "Medical Hx" section has a search bar with "Keyword" and "ICD" options, and buttons for "PMHx", "+ Add", and "= Remove". It also has checkboxes for "Pregnant", "BreastFeeding", and "Hx Verified". Below this is a table with columns "No", "History", "ICD Code", and "PL". The table is currently empty.

The "Allergies" section has a search bar with "Browse Rx..." and buttons for "+ Add", "- Remove", and "Allergy Log". It also has checkboxes for "N.K.D./A" and "Allergies Verified". Below this is a table with columns "Structured/N", "Agent/Substance", "Reaction", "Type", and "Status". The table contains one row: "Structured", "Penicillin G Potassium", "hives", "Allergy", and "Active".

At the bottom of the window, there are tabs for "Medication Reconciliation" and "Surgical History".

No	History	ICD Code	PL
----	---------	----------	----

Structured/N	Agent/Substance	Reaction	Type	Status
Structured	Penicillin G Potassium	hives	Allergy	Active

Access this feature from: Progress Notes > Allergies.

Record Demographics

- ▶ Objective: Record all of the following demographics:
 - Preferred language
 - Gender
 - Race
 - Ethnicity
 - Date of birth
- ▶ Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
- ▶ Exclusion: No exclusion.

Record Demographics Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- ▶ **NUMERATOR:** Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

How To Meet the Measure: Record Demographics

Patient Information (Smith, Bonnie)

Personal Info

Account No: P11492 Prefix: [] PCP: []

Last Name: Smith Suffix: [] Referring Provider: []

First Name: Bonnie MI: [] Rendering Provider/Primary Care Giver: [] Clear

Previous Name: []

Address Line 1: 123 Mechanic St Date Of Birth: 04/28/1982 Age: 31Y

Address Line 2: [] Gestational Age: []

City: Westborough Validate Sex: F Female Transgender

State: MA Zip: 01581 Country: US Marital Status: Married

Social Security: 012-88-8888 Parent Info: []

Patient Information(Smith, Bonnie)

Smith, Bonnie [] Don't Send Statements [] Inactive [] Don't add finance charge

General Information Student Information Structured

Street Address(if different from mailing)

Address Line 1: [] Import Capture Delete Scan

Address Line 2: [] Picture: []

City: []

State: []

Zip: []

Email: bmf@abc.com [] Not Provided

Leave Message: [] Home [] Cell []

Residence Type: [] (None Selected)

Race: []

Ethnicity: Not Hispanic Birth Order: 0

VFC Eligibility: []

Consent to report Immunizations: []

Employer Address

Address Line 1: []

Address Line 2: []

City: []

State: [] Zip: []

Leave Message: [] Work []

Language: English []

Characteristic: []

Registered On: 03/06/2013 (11:13:08)

Mail Order Member ID: []

Plan Type: [] (None Selected)

Deceased: []

Default Facility: [] Clr

MRN(External System): []

Default Lab Company: None

Default DI Company: None

Translator: []

Exclude From Registry Search: []

Use Street Address for Prescription: []

Record Demographics Set-Up

ISO Language Code Mapper

Language Mapper

Search

Search

Language Name [ISO Code2]	ISO Name [ISO Code2]
Arabic [ara]	Abkhazian [abk]
Bahasa Indonesia	Afar [aar]
Bahasa Melayu	Afrikaans [afr]
Bangla	Akan [aka]
Braille	Albanian [alb (B),sqi (T)]
Cape Verdean Creole	Amharic [amh]
Chinese [chi (B),zho (T)]	Arabic [ara]
Chinese - Cantonese	Aragonese [arg]
Chinese - Mandarin	Armenian [arm (B),hye (T)]
English [eng]	Assamese [asm]
French [fre (B),fra (T)]	Avaric [ava]
German [ger (B),deu (T)]	Avestan [ave]
Greek [gre (B),ell (T)]	Aymara [aym]
Haitian Creole	Azerbaijani [aze]
Hebrew [heb]	Bambara [bam]
Hindi [hin]	Bashkir [bak]

Map

UnMap

Close

Record Vitals

- ▶ Objective: Record and chart changes in the following vital signs:
 - ▶ Height
 - ▶ Weight
 - ▶ Blood pressure
 - ▶ Calculate and display body mass index (BMI)
 - ▶ Plot and display growth charts for children 0-20 years, including BMI
- ▶ Measure: For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.

Record Vitals Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients (age 3 or over for blood pressure) 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, weight and blood pressure (ages 3 and over) recorded as structured data.
- ▶ **EXCLUSION:** Any EP who
 - ▶ 1. Sees no patients 3 years or older is excluded from recording blood pressure;
 - ▶ 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;
 - ▶ 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or
 - ▶ 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

How To Meet the Measure: Record Vitals

Vitals (Smith, James - 11/14/2013 09:00 AM, ANN VISIT) *

Pt. Info Encounter Physical Hub

☒ Pop Up

Date	BP	Ht(inches)	Wt(lbs)	BMI(Index)	Vision	Wt %(%)	BMI %(%)	Ht %
11/14/2013 *	120/80	70	150	21.52				

Vitals (Smith, James - 11/14/2013 09:00 AM, ANN VISIT) *

Pt. Info Encounter Physical Hub

☒ Pop Up

Date	BP	Ht(inches)	Wt(lbs)	BMI(Index)	Vision	Wt %(%)	BMI %(%)	Ht %
11/14/2013 *	120/80	70	150	21.52				

Vitals (Smith, James - 11/14/2013 09:00 AM, ANN VISIT) *

Pt. Info Encounter Physical Hub

☒ Pop Up

Date	BP	Ht(inches)	Wt(lbs)	BMI(Index)	Vision	Wt %(%)	BMI %(%)	Ht %
11/14/2013 *	120/80	70	150	21.52				

Record Vital Set-Up

Name	Standard Vital Type	<input type="checkbox"/> Mand...	<input type="checkbox"/> Displa...
Temp	Temperature	<input type="checkbox"/>	<input type="checkbox"/>
HR/Pulse	Pulse	<input type="checkbox"/>	<input type="checkbox"/>
BP	Blood Pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Repeat BP		<input type="checkbox"/>	<input type="checkbox"/>
SpO2	Oximetry	<input type="checkbox"/>	<input type="checkbox"/>
SpO2 repeat		<input type="checkbox"/>	<input type="checkbox"/>
Ht	Height	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Wt	Weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>
BMI	BMI	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Personalized Wt		<input type="checkbox"/>	<input checked="" type="checkbox"/>
HC	Head Circumference	<input type="checkbox"/>	<input type="checkbox"/>
Pain Scale	Pain Scale	<input type="checkbox"/>	<input type="checkbox"/>
Shoe Size		<input type="checkbox"/>	<input type="checkbox"/>
Respirations		<input type="checkbox"/>	<input type="checkbox"/>
BP position		<input type="checkbox"/>	<input type="checkbox"/>

☒ Automatically carry forward height from previous visit after certain age
Age for male Age for female

☐ Automatically calculate hypertension and prehypertension for BP

☒ Enable WHO Growth Charts for 0 to 2 Years (uses CDC when unchecked)
(Note: From 2 to 20 years eCW uses CDC data as recommended by CDC)

☒ Enable Down's Syndrome Growth Charts
(Note: Growth chart data for children with Down Syndrome provided with permission from www.growthcharts.com. Percentiles are approximate; use at your own discretion)

Qualifiers Associate CPT Migrate Configure Devices OK Cancel

Record Smoking Status

- ▶ Objective: Record smoking status for patients 13 years old or older.
- ▶ Measure: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
- ▶ Exclusion: Any EP who sees no patients 13 years or older

Record Smoking Status Attestation Requirements

- ▶ **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.
- ▶ **EXCLUSION:** An EP who sees no patients 13 years or older would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

How To Meet the Measure: Record Smoking Status

Social History (Test , Bethan L - 04/20/2015 08:15 AM, EP) *

Pt. Info Encounter Physical Hub

☐ Social History Verified

Social Info	Options	Details
Smoking Status*		Are you a:: former smoker
Tobacco use other than sm		
Alcohol (CAGE test):		Alcohol Use: Yes, Have you ever felt you should cut down on your drinking
Prescription Narcotic Use:*		takes as directed
Abuse or Violence**		Have you ever been in an abusive or violent relationship No
Alcohol Use:		yes, liquor once a week
Recreational drug use*		Drug Abuse: Yes, How Much?, How Long?
Marital Status:		married
Sexually active**		Currently sexually active Yes, High risk for HIV/AIDs No, Risk of Sexually
Occupation:		Occupation Current
Occup. exposure:		
Caffeine:*		Caffeine Use: Yes, Type: Coffee, Amount per Day: 5+ cups
Exercise:		
Diet:*		

Notes

no smokers in house

Family History Custom ROS

Record Smoking Status Set-Up

The screenshot shows the 'Mapper' application window. On the left is a sidebar with icons for Labs, DI, Procedures, Structured Data (highlighted), and Specialty. Below the sidebar are 'Data Types' (B: Boolean, N: Numeric, S: Structured Text, D: Date) and 'Allowed Mapping' (B - B, N - N, D - D, S - S, S - B). The main area is divided into 'COMMUNITY' and 'LOCAL' sections. Each section has search filters (Find, Section, Category, Item) and a list of items with columns for Path, Name, and Log. In the COMMUNITY list, 'Social History/Tobacco Use; Are you a:' is highlighted. In the LOCAL list, 'Social History/Social History Additional Findings: Tobacco' is highlighted. An 'Add >>' button is between the lists. At the bottom are navigation buttons: '<<Previous', '<MAP>', 'Next>>', and 'Close'.

IMPORTANT! This local Structured Data item must be mapped to the are you a: community item (from Community > Mappings > Structured Data) to satisfy this measure. The following options satisfy this measure:

- Current smoker
- Former smoker
- Never smoker
- Current every day smoker
- Current some day smoker
- Smoker, current status unknown
- Unknown if ever smoked
- Light tobacco smoke
- Heavy tobacco smoker

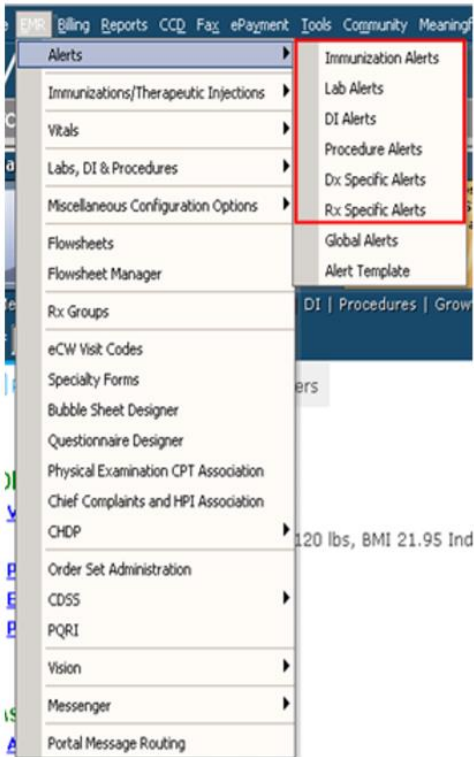
Clinical Decision Support Rule

- ▶ Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
- ▶ Measure: Implement one clinical decision support rule.
- ▶ Exclusion: No exclusion.

Clinical Decision Support Rule Attestation Requirements

- ▶ YES / NO
- ▶ Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.

How To Meet the Measure: Clinical Decision Support Rule



MEASURE CONFIGURATION			
Ignore Office Visit Condition			
Quality Measures			
Disabled	Patients see assigned PCG - Do patients see their assigned primary care giver (PCG) ?	NUMERATOR: Number of patients in denominator who have seen their assigned PCG at least once in the last 12 months up to and including the last day of the reporting period	DENOMINATOR: Number of unique patients who were seen in the reporting period, who are not being seen for the first time in the health center
Enabled	Chlamydia screening - Chlamydia screening	NUMERATOR: NQF: Patients in the denominator who had at least one Chlamydia test during the measurement year	DENOMINATOR: NQF: Women 16-25 years of age as of December 31 of the measurement year who are sexually active.
Disabled	Sexual history taken - Take a sexual history	NUMERATOR: Patients in the denominator who have had a sexual history taken in the past year	DENOMINATOR: All patients at least 18 years old with at least one visit in the past 12 months up to and including the last day of the reporting period
Disabled	Sexual history taken - Take a sexual history	NUMERATOR: Patients in the denominator who have had a sexual history taken in the past year	DENOMINATOR: All patients at least 12-17 years old with at least one visit in the past 12 months up to and including the last day of the reporting period
Enabled	Smoking status - Assess tobacco use in adults	NUMERATOR: Number of patients in denominator who have had smoking status identified or updated at least once in the last 12 months up to and including the last day of the reporting period OR (Patients who have never smoked AND who are over age 26) OR (Patients who have never smoked AND ((are Hispanic OR asian) AND ages 20-26))	DENOMINATOR: Number of unique patients, at least 18 years of age at the time of their last visit in the reporting period, who were seen in the reporting period
		NUMERATOR: Number of patients	DENOMINATOR: Number of

Patient Electronic Access

- ▶ Objective: 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: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, and transmit to a third party.
- ▶ Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information, may exclude the measure

Patient Electronic Access Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- ▶ **NUMERATOR:** The 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 to view, download, and transmit to a third party.
- ▶ **EXCLUSION:** Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information."

How To Meet the Measure: Patient Electronic Access

Patient Information (Smith, Bonnie)

Personal Info

Account No: P9337 Prefix: [v] PCD [v] Clear
Last Name: Smith Suffix: [v] Referring Provider: [v] Clear
First Name: Bonnie MI: [v] Rendering Provider/Primary Care Giver: [v]
Previous Name: [v]
Address Line 1: 100 Main St Date Of Birth (mm/dd/yyyy): 06/22/1950 Age: 63Y
Address Line 2: [v] Gestational Age: [v]
City: Westborough State: MA ZIP: 01581 Country: US Sex: ☒ Male ☐ Female ☐ Transgender
Home Phone: 508-888-8888 Cell No: [v] Marital Status: [v]
Work Phone: [v] Ext: 9874 Social Security: 020-44-7894 Parent Info: [v]
Employer Name: ECLINICALWORKS----- Emp Status: [v] (None Selected)
Student Status: [v] (None Selected) Family Hub: [v] Select Remove
(statements will be addressed to responsible party)

Responsible Party Select Set Emergency Contact
Name: Smith, Bonnie
Relation: ☒ Self - patient is the insured
Last Appt: 10/03/2013 11:00 AM
Emergency Contact: [v]
Acct Balance: 1,548.50 Details Gr. Bal
Patient: -168.06 Acc Inquiry

Insurances IE New Case
Sliding Fee Schedule Fee Schedule New Test fee [v] Self Pay Add Update Remove



Name	State	Subscriber No	Rel	Insured	Co Pay	Group No
P Medicare Part B	MA	777777772A	1	Smith, Bonnie		
Workers Comp	NC	123456789	1	Smith, Bonnie		
(P) Medicare Part B	MA	123456789A	1	Smith, Bonnie		

Release of Information: [v]
Rx History Consent: [v] Scan
Signature Date: [v]
Advance Directive: [v]

Additional Info [v] Alert Misc Info Options P.S.A.C
Copy Demographics
MediScan
MediScan (with Photo)
☒ Web Enable
View Log
View Fee Schedule Log
Generate Log
Registry Settings

Patient Electronic Access Set-Up

eClinicalWorks Product Hub: On-Demand Activation

	eClinicalMobile URL : www.eclinicalmobile.com Account Code: <input type="text"/>
	Patient Portal URL: https://neuportal.eclinicalweb.com To learn more about eClinicalWorks Patient Portal click here
	e-Prescription Allows you to register your provider(s) for ePrescription.

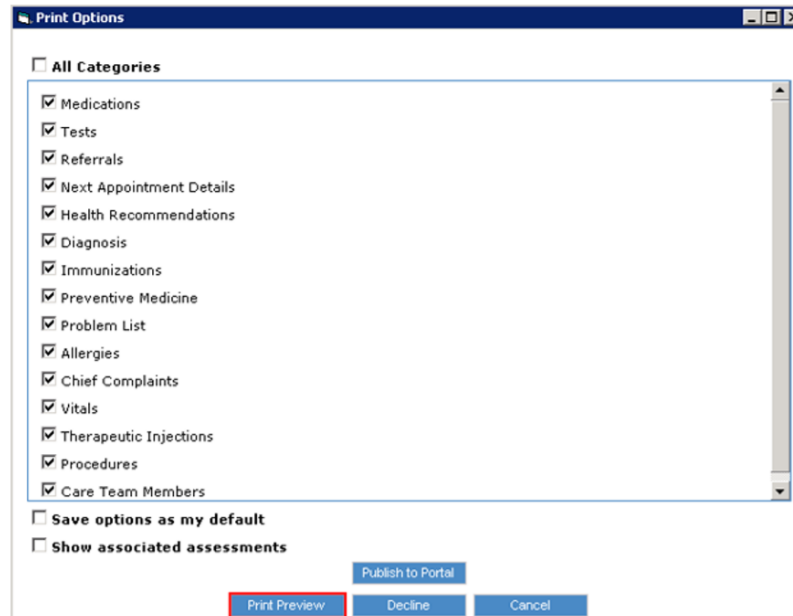
Clinical Summaries

- ▶ Objective: Provide clinical summaries for patients for each office visit.
- ▶ Measure: Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
- ▶ Exclusion: Any EP who has no office visits during the EHR reporting period.

Clinical Summaries Attestation Requirements

- ▶ **DENOMINATOR:** Number of office visits by the EP during the EHR reporting period.
- ▶ **NUMERATOR:** Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.
- ▶ **EXCLUSION:** EPs who have no office visits during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

How To Meet the Measure: Clinical Summaries



Access this feature from one of the following locations:

- ◆ Progress Notes > arrow next to Print > Print Visit Summary.
- ◆ Practice band > Resource Scheduling icon > right-click on appointment slot > Print Visit Summary.

Protect Electronic Health Information

- ▶ Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
- ▶ Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- ▶ Exclusion: No exclusion.

Protect Electronic Health Information Attestation Requirements

- ▶ YES / NO
- ▶ Eligible professionals (EPs) must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.

Menu Objectives

Must Meet 5 of the 9 Objectives

1. Drug Formulary Checks
2. Clinical Lab Test Results
3. List of Patients
4. Patient Reminders
5. Patient Education
6. Medication Reconciliation
7. Summary of Care
8. Immunization Registry
9. Syndromic Surveillance Data

Drug Formulary Checks

- ▶ Objective: Implement drug formulary checks.
- ▶ Measure: The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
- ▶ Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

Drug Formulary Check Attestation Requirements

- ▶ YES / NO
- ▶ Eligible professionals (EPs) must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure.

How to Meet the Measure: Drug Formulary Check

Rx Eligibility

Eligibility Criteria

First Name	MI	Last Name	DOB
A1		Test	19500925
Address			Gender
2 TECHNOLOGY DR			M
			Phone
WESTBOROUGH	MA	01581-1727	999-999-9999

Check Rx Eligibility **Errors**

Rx Eligibility Lookup

C	group_id	Benefit Source	Plan Name	Retail Eligibility	Mail Order Eligibility
---	----------	----------------	-----------	--------------------	------------------------

Access this feature from one of the following locations:

- Progress Notes > Treatment > green arrow next to Send Rx > ePrescribe Rx > Rx Eligibility.
- Appointment window > Rx Eligibility > Check Rx Eligibility.
- Progress Note > Treatment > Add > Rx Eligibility > Check Rx Eligibility.
- Telephone/Web Encounter > Rx tab > Rx Eligibility > Check Rx Eligibility.
- eRefill > Rx Eligibility > Check Rx Eligibility.

Clinical Lab Test Results

- ▶ Objective: Incorporate clinical lab test results into EHR as structured data.
- ▶ Measure: More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
- ▶ Exclusion: An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

Clinical Lab Test Results Attestation Requirements

- ▶ **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 whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
- ▶ **EXCLUSION:** If an EP orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

How to Meet the Measure: Clinical Lab Test Results

Lab Results

Test, A, 63 Y, M **Set Info Hub**

2 TECHNOLOGY DR
WESTBOROUGH, MA
H: 999-999-9999
M: 999-999-9999
DOB: 09/25/1950
test1@yahoo.com

Allergies: Biting Alert

Wt: 10/27/13: 97.00 lbs.
App(L): 12/05/13(SW)
App(R): 12/06/13(SW)
PCP: abcd, abc
Language: Translation No

Ins: Adecco
Acc Bal: \$189.00
Guan: A
Gr Bal: \$199.00
Ref: Goljan's
Ren: abcd, abc

CLICK TO EDIT
This is a test to see whether word -rtrtrsdfrsddfr -dfrdfrdfrdfrdfrdfr -g sdrsdfr there...

SECURE NOTES

Hub

Medical Summary | OB Summary | CDSS | Labs | DI | Procedures | Growth Chart | Imm/T.Inj | Encounters | Patient Docs | Flowsheets | Notes

Patient **Set Info Hub**

Test, A
DOB: 9/25/1950 Age: 63Y
Sex: M
Tel: 999-999-9999
Acot No: P9474, WebEnabled: Yes

Status: ☒ Open ☐ Reviewed

Provider: Willis, Sam Multi A ☐ High Priority
Facility: Pleasantville Facility 009 ☐ InHouse
Assigned To: ☒ Future Order ☐ Cancelled

☒ Don't publish to Web Portal

Lab Information

Lab: Activated Protein C Resistance Order Date: 1/25/2014 Collection Date: 12/6/2013 Time: :
Reason: Actual Fasting: ☐ Not Recorded ☐ Ordered Fasting

Specimen

Source	Description	Collection Volume	Units

Results

☐ Received Date: 12/6/2013 Result:

Order Date	Coll. Date	Act. Prt. C I
01/25/2014		

Assessments: **Notes:**

☒ 250.00 Brittle diabetes mellitus
☐ E10.8 Type 1 diabetes mellitus with unspecified complications
☐ 441.4 Abdominal aneurysm without mention of rupture

Clinical Info: **Internal Notes:** eClinicalMessenger

Overview DRTLA History CDSS

Test, A 63 Y, M as of 12/06/2013

Global Alerts

- TGA
- drug seeker
- test90127

Advance Directive

- 001 tesat1

Problem List All

- V22.2 Pregnant state, incidental
- 902.55 Uterine artery injury
- 441.4 Abdominal aneurysm without mention of rupture
- 997.91 Hypertension
- 250.00 Brittle diabetes mellitus
- E11.9 Diabetes
- 780.60 Fever and chills
- E10.8 Type 1 diabetes mellitus with unspecified complications
- 781.0 Eyelid twitch

Clinical Quality Worksheet

Medication Summary

Date: All

Clinical Lab Test Results Set-Up

[illegible]

Patient List

- ▶ Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
- ▶ Measure: Generate at least one report listing patients of the EP with a specific condition.
- ▶ Exclusion: No exclusion.

Patient List Attestation Requirements

- ▶ YES / NO
- ▶ Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

Patient List

eClinicalWorks¹⁰ E O S O D O R O I 2 L O M

File Patient Schedule EMR Billing Reports CCD Fax ePayment Tools Community Meaningful Use Lock Help

Admin
Practice
Registry

Registry

Imm / T. Inj Encounters Structured Data Saved Reports Referrals Reports Allergies
Vitals Labs / DI / Proc. ICD CPT Rx Chief Complaints Medical History

Demographics

Age Range 18 - 19 M
Sex Both
Zip Code
DOB (Actual) 05/11/2015 05/11/2015
Insurance
PCP
Ren Provid
Facility
Race
Ethnicity
Language
Patients Search Options
☐ Inactive ☐ Deceased ☐ Registry Enabled

All

Save Queries Run Subset (NOT) Run Subset Run New

<input checked="" type="checkbox"/>	Patient Name	DOB	Sex	Age	Tel. No	Acc #
-------------------------------------	--------------	-----	-----	-----	---------	-------

Patient Reminders

- ▶ Objective: Send reminders to patients per patient preference for preventive/follow-up care.
- ▶ Measure: More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
- ▶ Exclusion: An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

Patient Reminders Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients 65 years old or older or 5 years older or younger.
- ▶ **NUMERATOR:** Number of patients in the denominator who were sent the appropriate reminder.
- ▶ **EXCLUSION:** If an EP has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

How to Meet the Measure: Patient Reminders

Registry

Demographics

Age Range: 5-65, Sex: Both, Race: , Ethnicity: , Language: , Facility: , Insurance: , Patients Search Options: Inactive, Deceased, Registry Enabled

DOB	Patient Name	DOB	Sex	Age	Tel. No	Acc #
10/01/1988	1000,Test	01/01/1988	m	25Y	444-444-4541	P9456
11/11/1990	Abc,copy m	11/11/1990	m	23Y	444-444-4541	P9304
10/10/1977	Agarwal,Riya	10/10/1977	f	36Y	316-743-7437	P9459
10/07/1995	ajay,ajay	10/07/1995	m	28Y	508-836-2700	P9451
01/01/1980	aTest,Rashmi	01/01/1980	f	33Y		P9515

Demographics :: Age >=5 AND Age <=65 AND Sex=Both AND Show All

Letter, Form/Health Maintenance, Run Letter, Next, 1-100 of 278 records, Clear Search, Analyze Data, Messenger

Messenger Templates

Provider/Staff: Willis, Sam Multi

Message Type: All

Template	MsgType	CreatedBy
Templatet	Appointment	support
General Template	General	support
Appointment Reminder	Appointment	support
TrainingTemplate	Birthday	sam
Test Template	General	support
New	appointment	sam
Lipids Control (B)	healthMaintenance	sam
Lipids Control (A)	healthMaintenance	sam
Hypertension Control (B)	healthMaintenance	sam
Hypertension Control (A)	healthMaintenance	sam
Child DTaP4 (B)	healthMaintenance	sam
Child DTaP4 (A)	healthMaintenance	sam
Child Rotavirus (B)	healthMaintenance	sam
Child Rotavirus (A)	healthMaintenance	sam
Child Pneumonia (B)	healthMaintenance	sam
Child Pneumonia (A)	healthMaintenance	sam
Child MMR (B)	healthMaintenance	sam
Child MMR (A)	healthMaintenance	sam
Child Flu (B)	healthMaintenance	sam
Child Flu (A)	healthMaintenance	sam

English Live, English Machine, Spanish Live, Spanish Machine

Keywords: , Clear

Character: 0, vMsg Appt Confirmation, Secure Message

SMS: Keywords: , Keyword Length, Clear

English, Spanish

Character: 0

Call & Record, Record Now, Send, Cancel

Patient(s) Selected : 3

Portal eMsg

From: Willis, Sam Multi A, M.D.

To: 1000,Test; Abc,copy m; Agarwal,Riya; ajay,ajay; aTest,Rashmi; B,B; being,biller; Billing,Bill

Subject:

☒ Preventive / Follow-up care message

Templates

Load, Save, Save As

Patient Reminder Set-Up

Patient Information (Smith, Bonnie)

Personal Info

Account No: P11492 Prefix: [] PCP: []
Last Name: Smith Suffix: [] Referring Provider: []
First Name: Bonnie MI: [] Rendering Provider/
Primary Care Giver: [] Clear
Previous Name: [] Date Of Birth: 04/28/1982 Age: 31Y
Address Line 1: 123 Mechanic St Gestational Age: []
Address Line 2: [] Sex: ☒ Male ☐ Female ☐ Transgender
City: Westborough Validate Marital Status: Married
State: MA Zip: 01581 Country: US Social Security: 012-88-8888 Parent Info: []
Home Phone: 508-888-8888 Cell No: - - Employer Name: ECWS Clear
Work Phone: - - Ext: [] Emp Status: 1 Employed full-time
(statements will be addressed to responsible party) Student Status: (None Selected)
Responsible Party Select Set Emergency Contact Family Hub Select Remove
Name: Smith, Bonnie Emergency Contact: []
Relation: 1 Self - patient is the insured Acct Balance: 2,929.00 Details Gr. Bal
Last Appt: 11/14/2013 01:00 PM Patient: 105.00 Acc Inquiry
Next Appt: []

Insurances IE New Case
Sliding Fee Schedule Fee Schedule Master Fee Schedule Self Pay Add Update Remove

	Name	State	Subscriber No	Rel	Insured	Co Pay	Group No
P	Blue Cross Of Idaho	ID	MTN12345	1	Smith, Bonnie	25.00	
W	WC Ace Group	MA	987654321	1	Smith, Bonnie		

Release of Information: ☒ Y
Rx History Consent: ☒ Y Scan
Signature Date: 01/01/2010
Advance Directive: []
Additional Info: [] Alert Misc Info Options P.S.A.C. OK Cancel

Patient Education

- ▶ Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
- ▶ Measure: More than 10 percent of all unique patients seen by the EP are provided patient specific education resources.
- ▶ Exclusion: No exclusion

Patient Education Attestation Requirements

- ▶ **DENOMINATOR:** Number of unique patients seen by the EP during the EHR reporting period.
- ▶ **NUMERATOR:** Number of patients in the denominator who are provided patient-specific education resources

Patient Education

Patient Education

Address Go

User Guide

Favorites

Browse or Search for a Patient Handout

1 2 3 4 5 6 7 8 9 10 11 12 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Search: Go

Search Results

A-fib	Aminophylline overdose
A-fib - discharge	Amphetamine and perphenazine overdose
A-V fistula	Amphetamine hydrochloride overdose
A-V graft	AML
A/C separation	Ammonia - blood
A/P repair	Ammonia level
AIAT test	Ammonia poisoning
AI/C	Ammonium hydroxide poisoning
AAA	Amnesia
AAA - open	Amniotic syndrome
AAA - open - discharge	Amniocentesis
AAA repair - endovascular	Amniotic band sequence
AAA repair - endovascular - discharge	Amniotic band syndrome
Akroeg syndrome	Amniotic constriction bands
Akse syndrome	Amniotic fluid
Akse-Smith syndrome	Amniotic fluid disorder
AAT deficiency	AMP
Abacterial cystitis	Amphetamine intoxication
Abdomen - swollen	Amphetamines - screen
Abdominal aorta angiogram	Amputation - foot
Abdominal aortic aneurysm	Amputation - foot - discharge
Abdominal aortic aneurysm repair - open	Amputation - leg
Abdominal aortic aneurysm repair - open - discharge	Amputation - leg - discharge

Print Preview... Print Close

Order Sets

Search for Order Sets

ORDER SET: 16Dec2011OSD MEASURE: 400-CT QUICK ORDER SET: YES

DIAGNOSES (TRIGGER): MESSAGE

DIAGNOSES (LINKED):

AGE (TRIGGER): All Age

GENDER (TRIGGER): Unknown

☐ DTap 1 -

Therapeutic Injections

☐ thera injection 5 cL -

Appointments Referrals

☐ Outgoing Referral for: Addiction Medicine

Physician Education

PDF

WEB REFERENCE

Patient Education

PDF

WEB REFERENCE

☐ <https://immunization.dcgov.org/irswebapp/home.jsp>

Notes

Medication Reconciliation

- ▶ Objective: 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: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
- ▶ Exclusion: An EP who was not the recipient of any transitions of care during the EHR reporting period.

Medication Reconciliation Attestation Requirements

- ▶ **DENOMINATOR:** Number of transactions 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.
- ▶ **EXCLUSION:** If an EP was not on the receiving end of any transition of care during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion

How to Meet the Measure: Medication Reconciliation

The screenshot displays the 'Medication Reconciliation' window. At the top, there is a navigation bar with tabs for 'Pt. Info', 'Encounter', 'Physical', and 'Hub'. Below this is a toolbar containing various icons for medical functions. The main interface features three tabs: 'Current Medication' (selected), 'Past Rx History', and 'External Rx History'. To the right of these tabs are buttons for 'Add Medication' (with a magnifying glass icon), 'Verified' (highlighted with a red box and containing a checked checkbox), 'Drug Interaction', and 'Cancel'. Below the tabs, there is a legend for medication status: 'T Taking', 'N Not Taking', 'D Discontinued', and 'U Unknown Status'. A 'Mark all as:' dropdown menu is also present, currently showing 'T Taking'. The 'Verified' button is the key element for meeting the measure, indicating that the medication status has been confirmed.

Medication Reconciliation Set-Up

Appointment on Saturday, November 09, 2013

Facility: CMA:Clinton Medical [Sel] POS: 33

Date: 11/9/2013 Provider: Willis, Sam
Resource: Willis, Sam
Ref Provider: [CLR]

Start Time: 9:00 AM End Time: 9:15 AM [New Pt]

Patient: [Sel] [Info] [Hub]
DOB: [Tel: [E-mail: [

Visit Type: [Visit Status: ☐ PEN (Pending)] Reason: [Transition of care]

Diagnosis: [Transition of care]

Open Cases: [Case Manager] [N]
Billing Notes: [S]
General Notes: [

Co-pay / Claim changes for this visit only
☐ Change co-pay for this visit []
☐ Non-billable visit

Charge Details eClinForms Bx Eligibility Misc Info

OK Cancel

Chief Complaints (Test, Evan - 01/05/2014 12:00 PM, NP)

Pt. Info Encounter Physical Hub

Chief Complaint(s) [Browse] [Add] [Remove] [Transition of care]

Sl No	Complaint
-------	-----------

Summary of Care

- ▶ Objective: 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: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
- ▶ Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

Summary of Care Attestation Requirements

- ▶ **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.
- ▶ **EXCLUSION:** If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period then they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

How to Meet the Measure: Summary of Care

Referral (Outgoing)

Patient: John, Chris (AB11914) [Sel] [Info] [Hub]

Insurance: CCA [Sel] [Pt Ins] POS: 11

Ref From: Willis, Sam [...]

Facility From: Reliant Medical Group [...]

Auth Code: []

Start Date: 11/26/2013

Referral Date: 11/26/2013

Open Cases: [] [N]

Appt Date: 11/26/2013

Received Date: 11/26/2013

Priority: Routine

Ref To:

Provider: [] [Pref] [Clear]

Specialty: []

Facility To: [] [Clear]

Auth Type: [] [Pending]

End Date: 11/26/2014

Assigned To: Billing, Billing []

Unit Type: V (VISIT)

Status: ☒ Open ☐ Consult Pending ☐ Addressed

Diagnosis / Reason [Visit Details] [Notes] [Structured Data]

Reason [Add] [Browse] [Remove]

Sl. No	Description
--------	-------------

Diagnosis [Previous Dx] [Add] [Remove]

Code	Name
------	------

Procedures [Add] [Remove]

Code	Name	UR	UA
------	------	----	----

[Scan] [Attachments(2)] [Logs] [OK] [Cancel] **Send Referral** []

eClinicalWorks Viewer

Send Referral

This referral is ready to be sent.

☐ Send Electronically
(available only when exchanged among providers on the network.)

☒ Print

☐ Print with attachment(s)

☐ Fax

☐ Fax with attachment(s)

☒ Send fax cover letter to test 0509
(available with fax/print option)

[Send] [Cancel]


Immunization Registry

- ▶ Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
- ▶ Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful, (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically), except where prohibited.
- ▶ Exclusion: An EP who administers no immunizations during the EHR reporting period, where no immunization registry has the capacity to receive the information electronically, or where it is prohibited.

Immunization Registry Attestation Requirements

- ▶ YES / NO
- ▶ Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful, (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) except where prohibited, to meet this measure.
- ▶ EXCLUSION: If an EP does not perform immunizations during the EHR reporting period, if there is no immunization registry that has the capacity to receive the information electronically, or if it is prohibited, then the EP would be excluded from this requirement. EPs must select NO next to the appropriate exclusion(s), then click the APPLY button in order to attest to the exclusion(s).

Immunization Registry

 <https://odhgateway.odh.ohio.gov/Impact/Public/EmrEhr.aspx>

Immunization Data Transfer

Federal government incentives for Meaningful Use (MU) of an Electronic Health Record (EHR) have sparked interest in exchanging electronic immunization messages with ImpactSIIS.

A medical practice using an EHR can submit immunization data to ImpactSIIS in batch files of HL7 messages for versions 2.3 through 2.5.1. ImpactSIIS is also able to send a patient's immunization history to an EHR with a response to a query sent in HL7 version 2.5.1.

As of January 1, 2014, Ohio's Immunization Registry is now accepting test files for MU Stages 1 and 2 from Hospitals and Eligible Professionals.

Providers who administer immunizations and are interested in sending HL7 test messages to the immunization registry are now able to do so, whether they intend to establish ongoing reporting at this time or not. A practice that administers immunizations may [request enrollment with ImpactSIIS](#). Providers who do not administer immunizations may attest to being excluded from the immunization reporting measure.

While logged in to make the enrollment request, a test file can be submitted there that could fulfill MU Stage 1 requirements and provide feedback about changes that will be required before ongoing reporting can be established. Directions for this process are found [here](#).

EHR vendors and others wishing to test messages without enrolling as providers may still do so using the link at the bottom of this page.

- [Policy for ImpactSIIS and Meaningful Use](#)
- [Establish an EMR/EHR link to ImpactSIIS](#)
- [Documentation for ImpactSIIS Upload](#)
- [Registration for HL7 VXU Format Testing Tool](#)
- [Meaningful Use Frequently Asked Questions](#)



Syndromic Surveillance Data

- ▶ Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.
- ▶ Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful, (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically) except where prohibited.
- ▶ Exclusion: An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or if it is prohibited.

Syndromic Surveillance Data Attestation Requirements

- ▶ YES / NO
- ▶ Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test was successful (unless none of the public health agencies to which the EP submits such information has the capacity to receive the information electronically), except where prohibited, to meet this measure.
- ▶ **EXCLUSION:** If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, if no public health agency that has the capacity to receive the information electronically, or if it is prohibited, then the EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

Syndromic Surveillance Data

 <https://www.odh.ohio.gov/healthstats/HIT/Syndromic%20Surveillance.aspx>

Eligible Professionals (EPs) (Effective 1/1/2014)

Meaningful Use (MU) Stage 1: EPs may take an exclusion for the syndromic surveillance menu option.

Meaningful Use (MU) Stage 2: EPs must report all data elements using HL7 2.5.1 on a continued, ongoing basis to meet the Stage 2 public health reporting menu option. Resources are limited; therefore, the Ohio Department of Health (ODH) may not be able to immediately accept syndromic data from all EPs who register their intent. In the situation where an EP is waiting on invitation from ODH to onboard, the EP is able to attest to meeting this public health reporting measure under the following option:

- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.

Registration of Intent

An entity may register the intent of its EPs and EHs to meet MU public health objectives at www.OhioPublicHealthReporting.info

Medicaid Meaningful Use

In addition to all the aforementioned requirements, Medicaid attestation requires the Patient Encounter Report. Since eClinicalWorks can only generate the number of patients seen using the eClinicalWorks application, if any patient was seen using paper chart or at another facility, that number must be manually added to the denominator. If the practice has used the eClinicalWorks application only, the numerator would match the denominator for both of the following reports.

IMPORTANT! These are state-specific requirements. Practices should check with their states for specific Medicaid Meaningful Use requirements.

Patient Encounter Report

50% of All Patient Encounters Occurred at a Facility Using Certified EHR Technology

Use the denominator of the Clinical Visit Summaries (encounter - New MU Spec) to get the numerator of this report.

80% of All Unique Patient Encounters Occurred at a Facility Using Certified EHR Technology

Use the denominator of Record Demographics/Active Medication List/Active Medication Allergy List to get the numerator of this report.