MU 2 Meeting the Measures: Presentation and Demonstration Using The Certified Electronic Health Records Technology (CEHRT)

Presented by
Emmanuel Y. Yennyemb, MBA, MCP, CSAP
California Area CAC Mentor

CORE: CPOE:

* S1= More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
* S2= More than 60% of med; more than 30% of lab; more than 30% of radiology (core)
  * No exclusions.

ERH Demo (Yes)

EHR/Order Tab

CORE: Drug Interaction Checks

* S1=The EP has enabled this functionality for the entire EHR reporting period.
* S2= Incorporated into Clinical Decision Support
  * No exclusions.

EHR Demo (Yes)

Notifications/Drug Interaction

Drug-Drug and Drug-Allergy check

* ***"The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period."***
* Enable drug-drug and drug-allergy interaction at the ***system level.***

Order Checks Must be Set to Enabled and Mandatory

These Order checks must be set to Enabled and Mandatory:

* ALLERGY-DRUG INTERACTION
* ALLERGY-CONTRAST MEDIA INTERACTION
* CRITICAL DRUG INTERACTION
* DANGEROUS MEDS FOR PT > 64
* ESTIMATED CREATININE CLEARANCE
* GLUCOPHAGE-CONTRAST MEDIA
* GLUCOPHAGE-LAB RESULTS
* NO ALLERGY ASSESSMENT
* RENAL FUNCTIONS OVER AGE 65
* ALLERGY UNASSESSIBLE

CORE: Maintain Problem List:

* S1= 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.

* S2= Incorporated into Summary of Care
  * No exclusions

EHR Demo (Yes)

Problem List (cont.)

EHR Documentation:

* **EHR Cover sheet:** Right Click on Active Problem List Component.
  * Select Reviewed or No Active Problems as appropriate

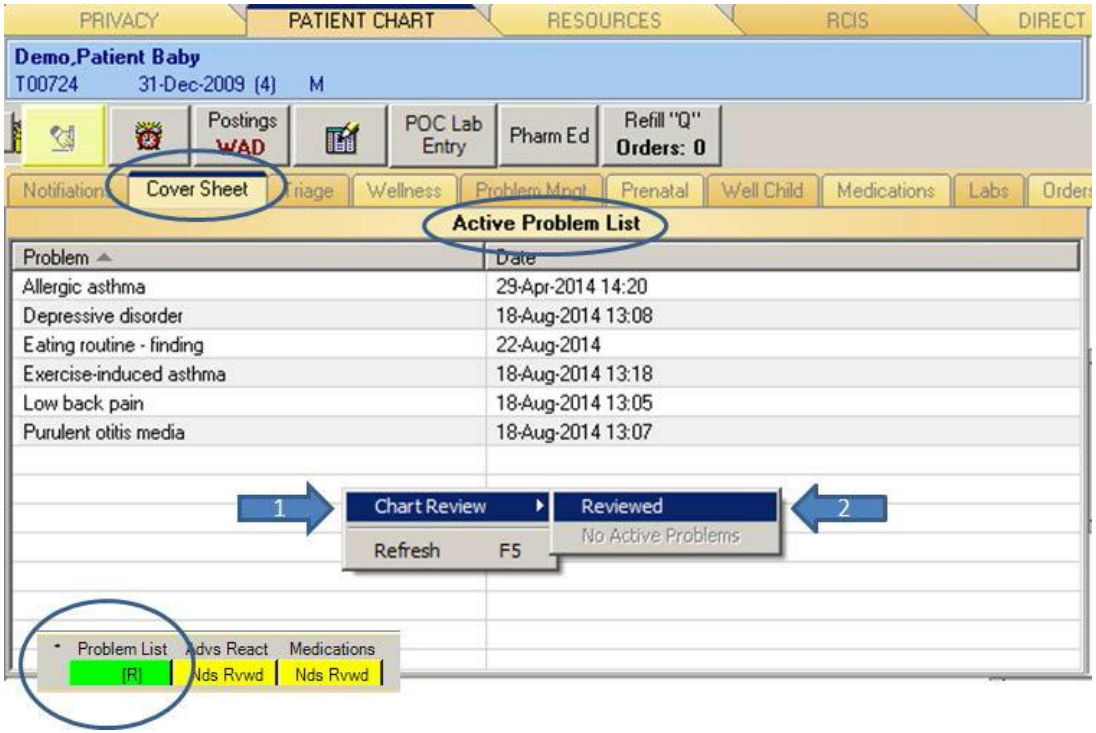
or:

  * Yellow Problem List Review buttons change to Green when reviewed or updated.

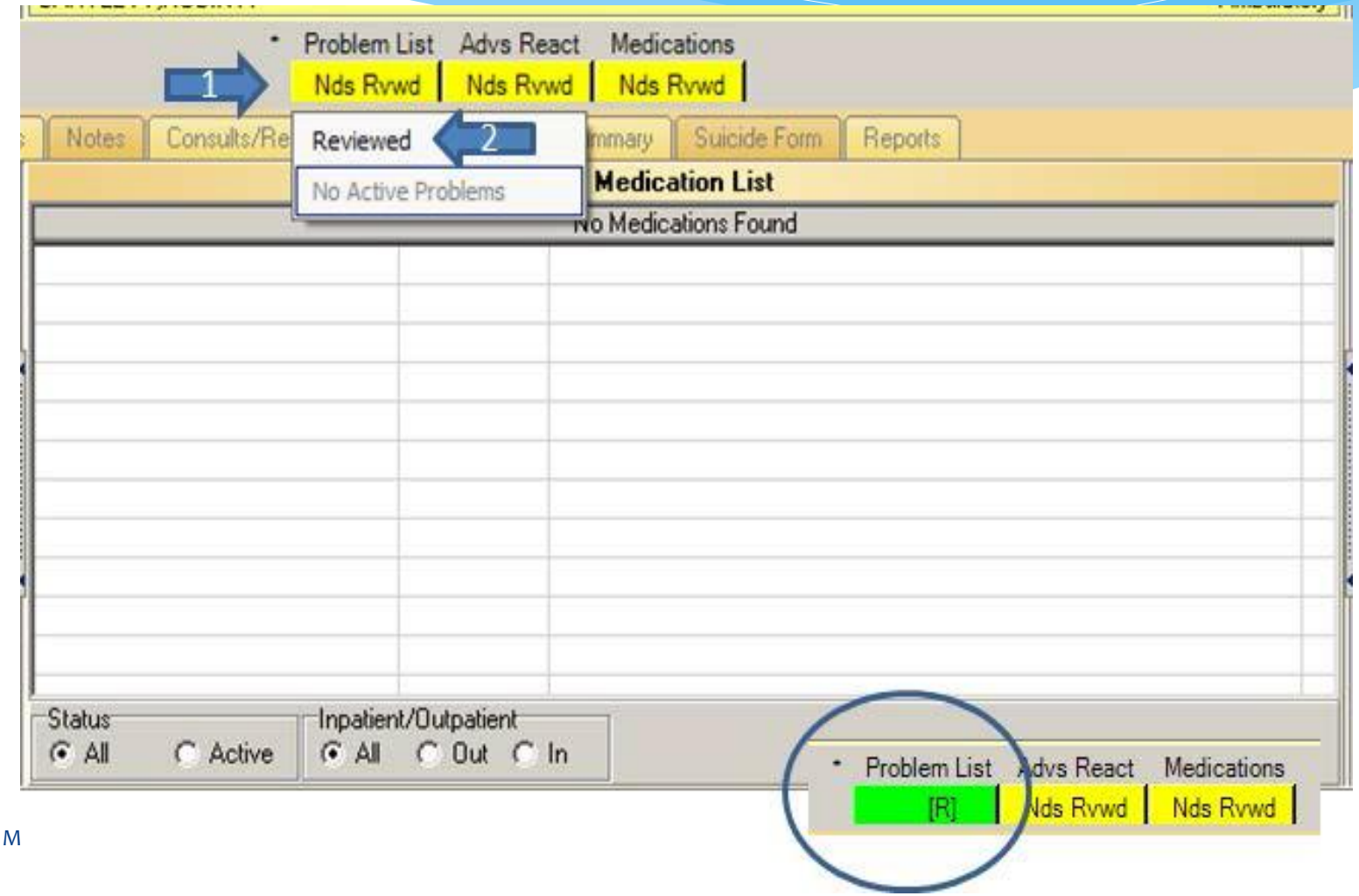
or:

  * When updates needed, go to Problem Management EHR tab to update Integrated Problem List (IPL).

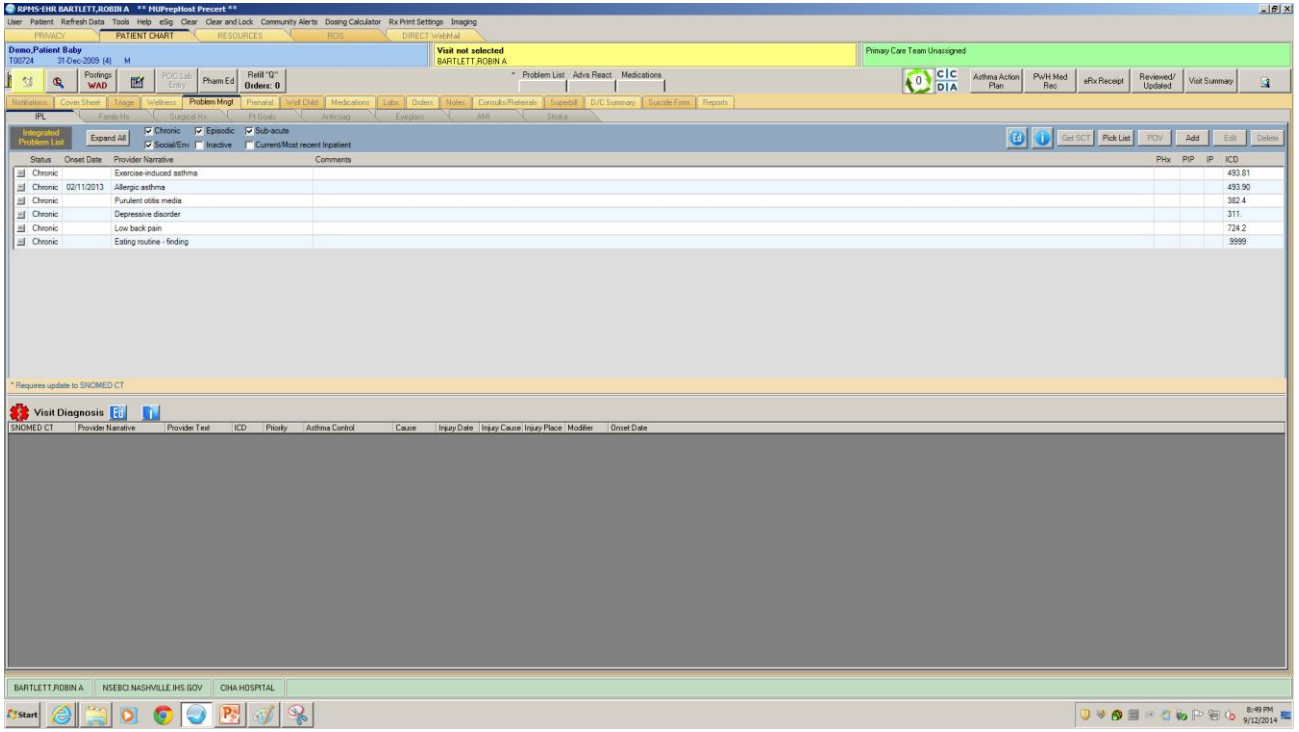
Problem List Review -Coversheet



Problem List Review -Buttons



Problem List Update Problem Management –IPL



CORE: e-Prescribing (eRx)

* S1= More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
* S2= More than 50% of all permissible prescriptions

* Exclusions:

  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.

  EHR Demo (NO)

  Training Database not set for e-Prescribing

CORE: Active Medication List

* S1= 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.
* S2= Incorporated into Summary of Care
  * No exclusions

EHR DEMO (Yes)

Active Medication List (cont.)

EHR Documentation:

* EHR Cover sheet: Right Click on Medication List Component.
  * Select Reviewed or No Active Medications as appropriate.

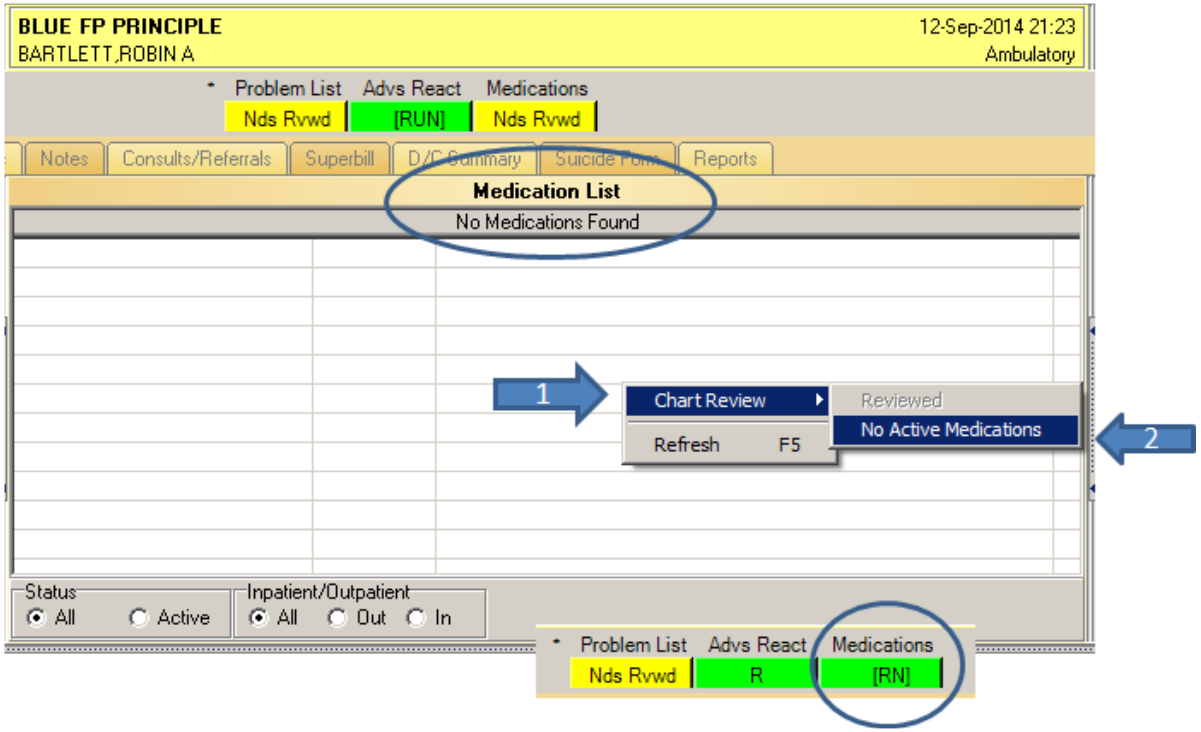
or:

  * Yellow Problem List Review buttons change to Green when reviewed or updated.

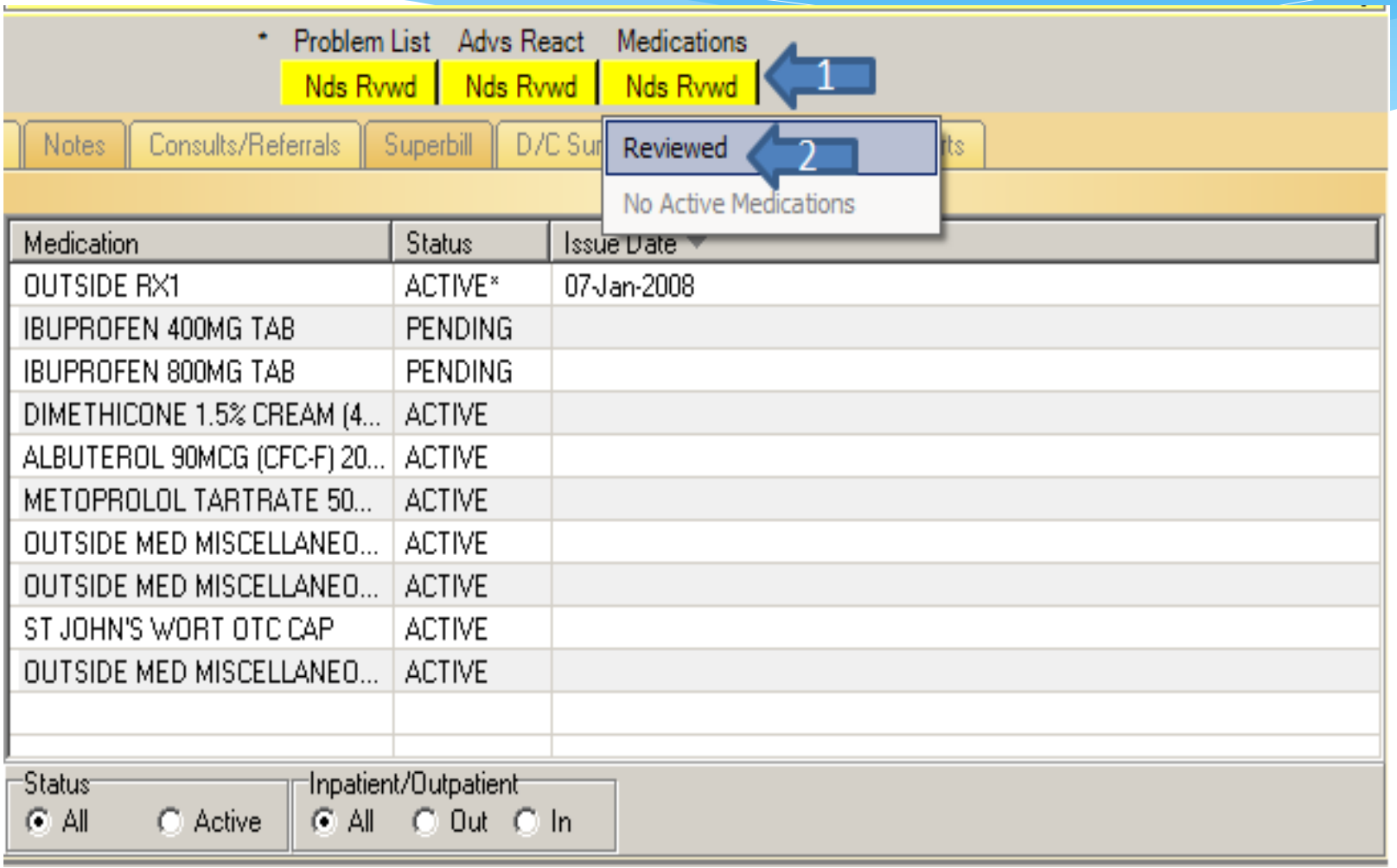
or:

  * When updates needed, go to EHR Medications tab to Order Medications.

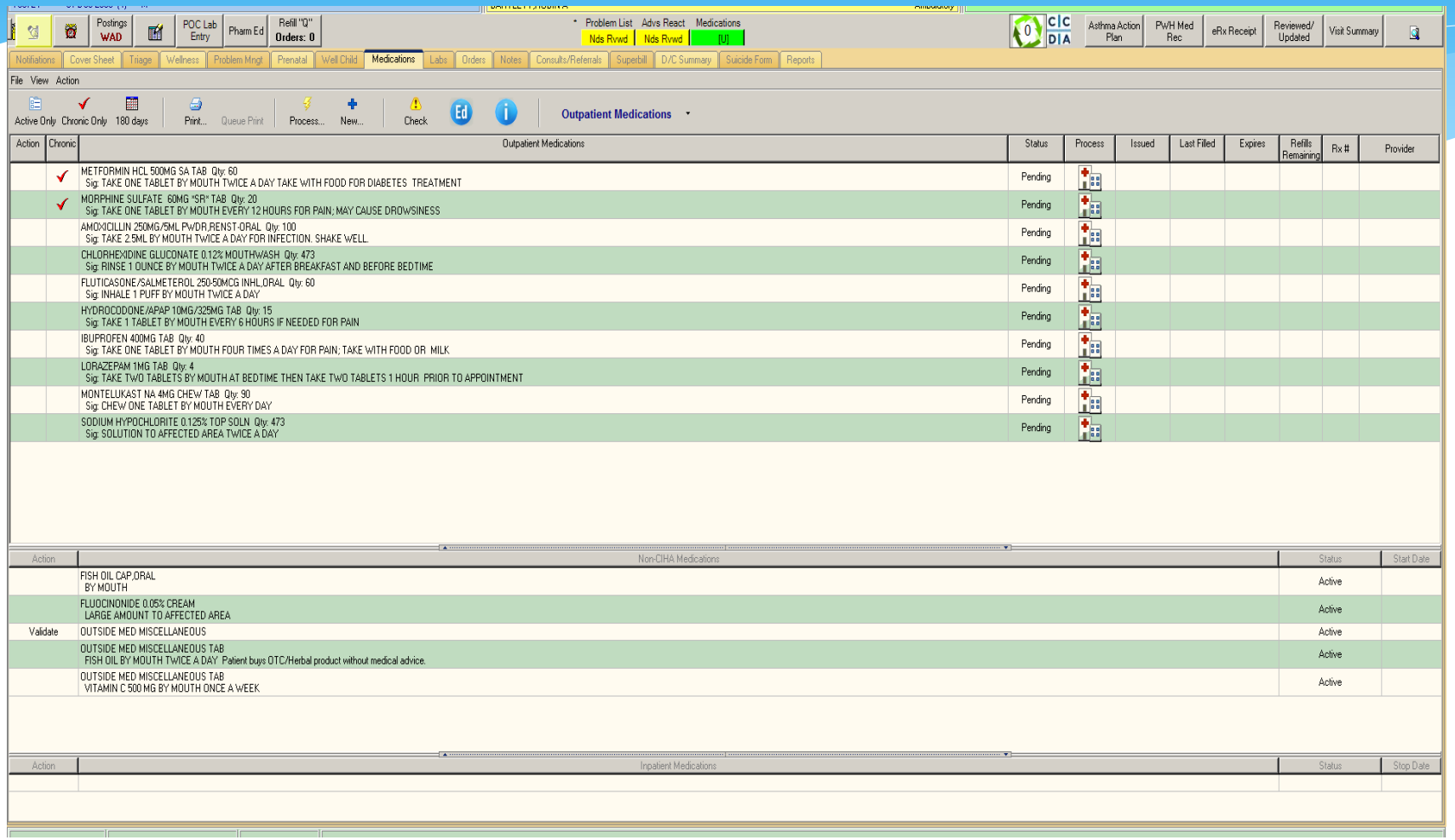
Active Medication List
No Active Medications



Active Medication List Reviewed

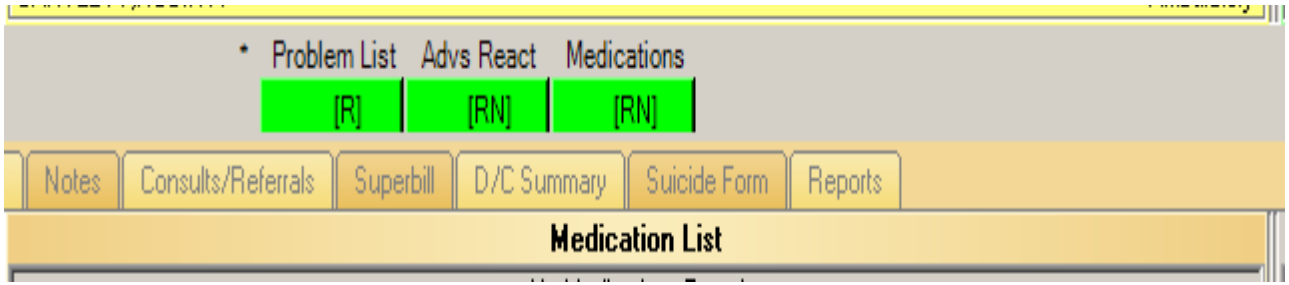


Active Medication List Updates Medication Tab



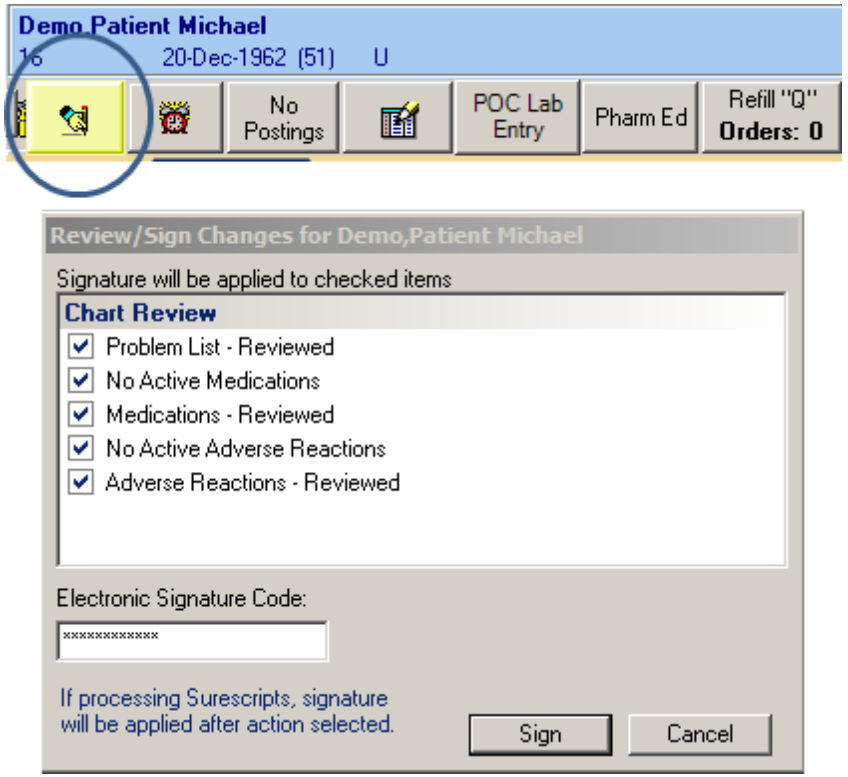
EHR Documentation

* Green buttons indicate Problem List, Adverse Reactions, and Medications have been updated or reviewed.
* R = Reviewed.
* U = Updated.
* N = None.



EHR Documentation (cont.)

* Select Yellow Hand with Pencil or Select new patient to prompt for electronic signature to sign off on updates



CORE: Medication Allergy List

* S1= 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.
* S2= Incorporated into Summary of Care
  * No exclusions

EHR DEMO (Yes)

Medication Allergy List (cont.)

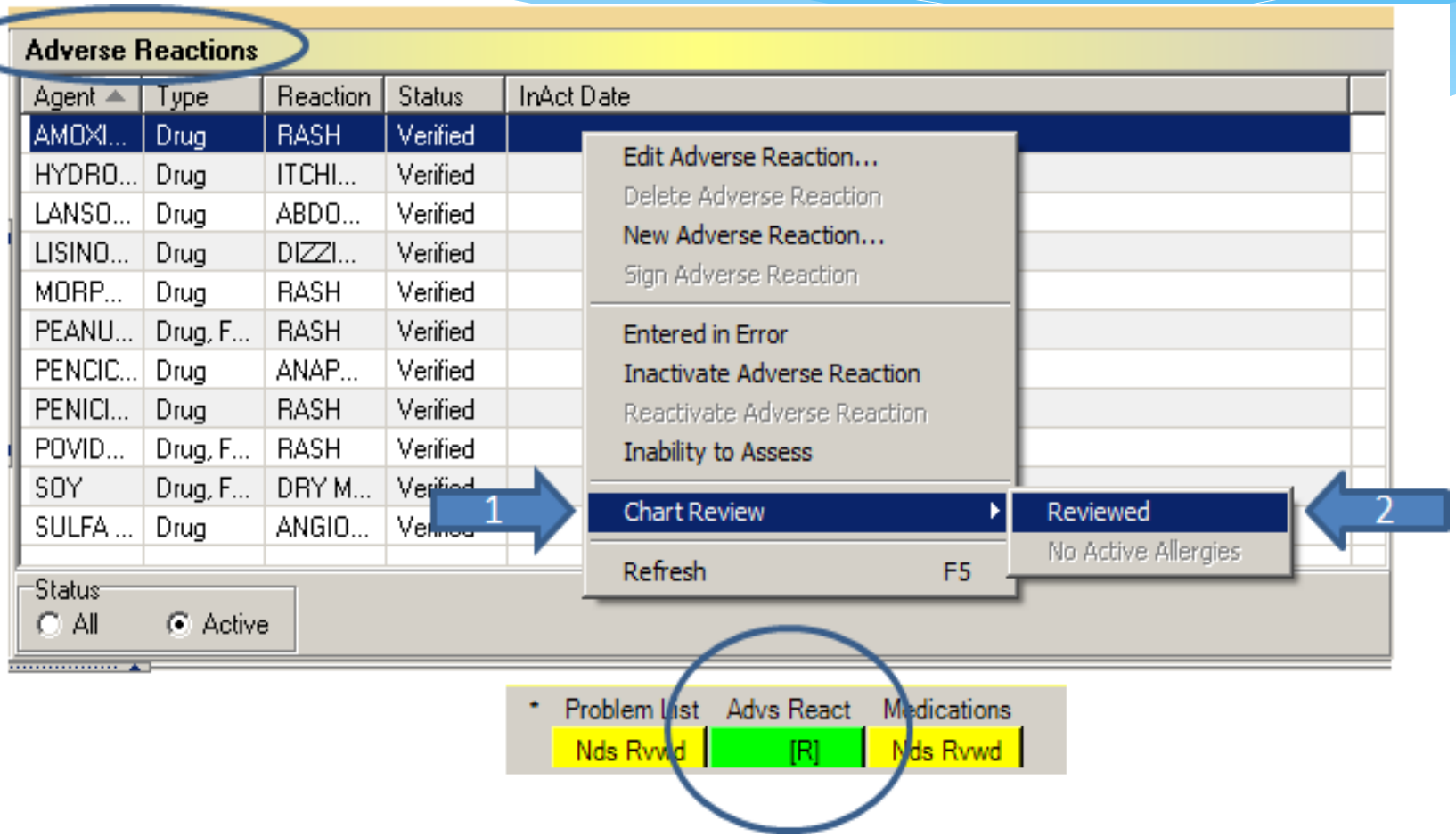
EHR Documentation:

* EHR Cover sheet: Right Click on Adverse Reactions Component.
* Select Reviewed or No Active Allergies as appropriate.
* When No Allergy Assessment, Select New Adverse Reaction to document No Known Allergies.
* Right Click on Adverse Reactions and Select Enter New Adverse Reaction to Update Medication Allergy List.

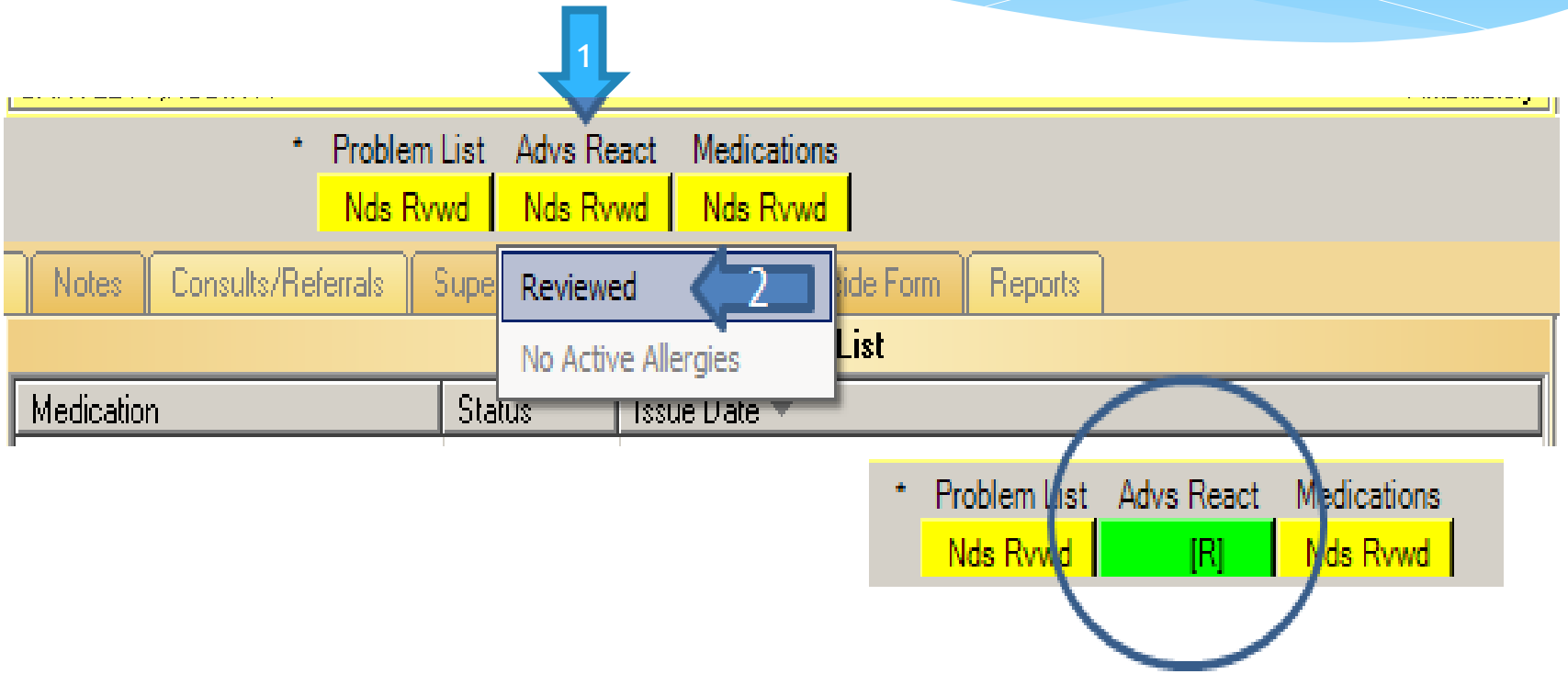
or:

* Yellow Adverse (Advs) Reaction Review buttons change to Green when reviewed or updated.

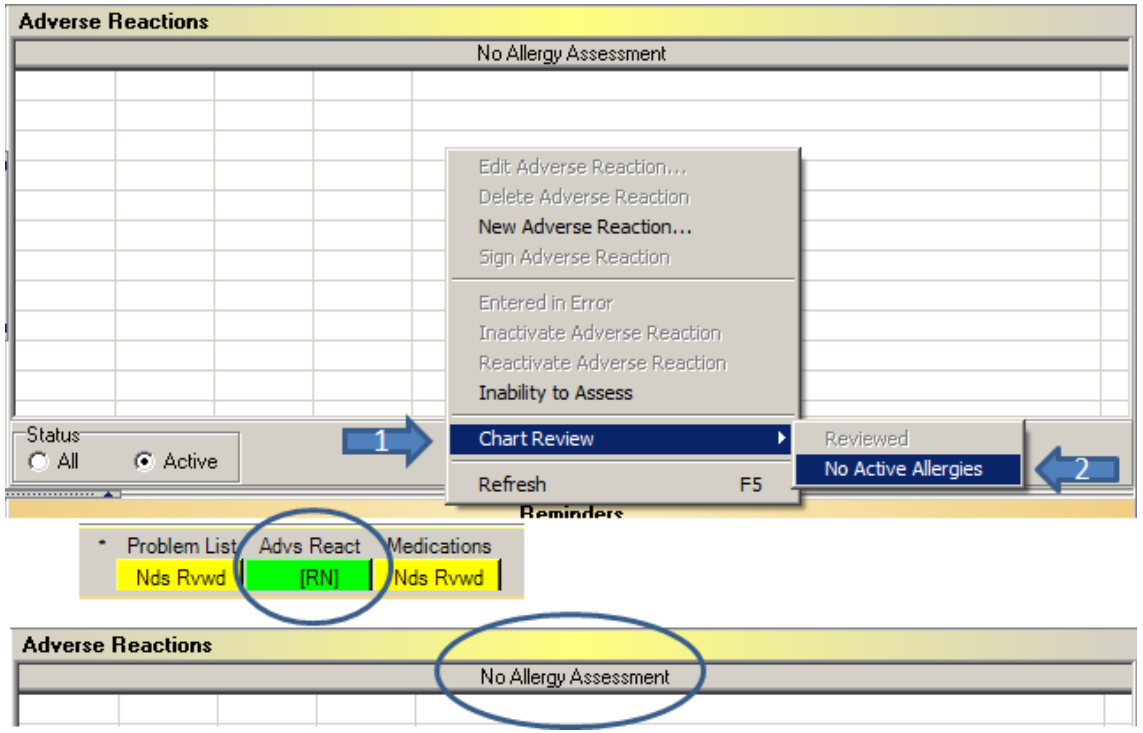
Medication Allergy List Review Coversheet



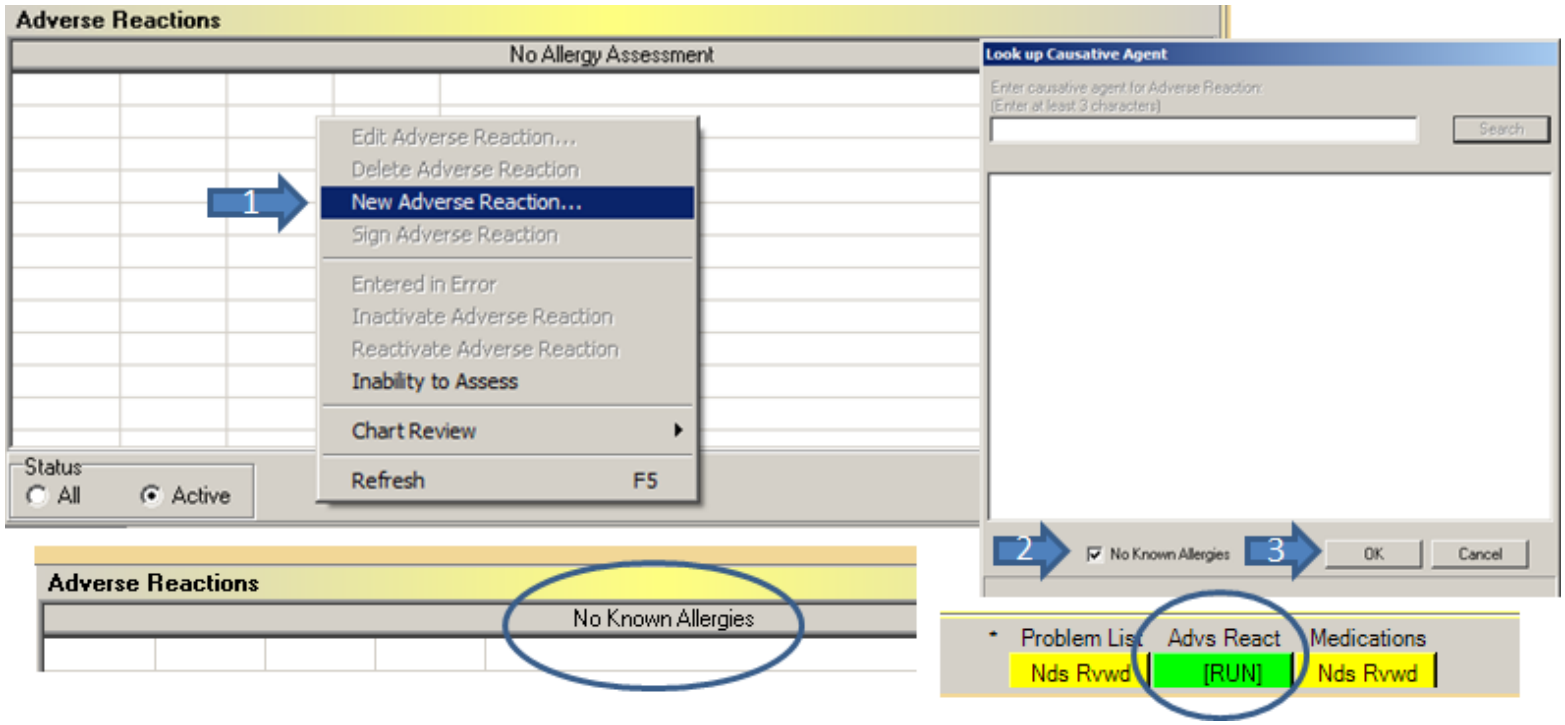
Medication Allergy List Review Buttons



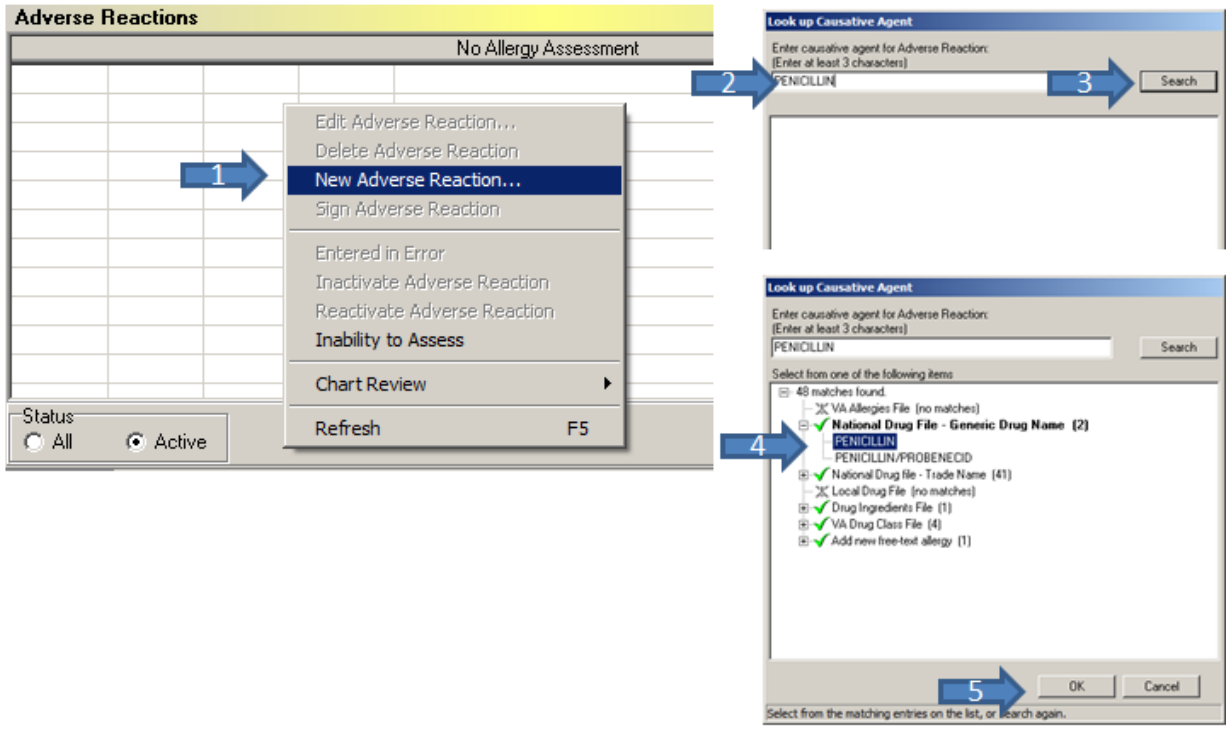
Medication Allergy List
No Allergy Assessment Scenario



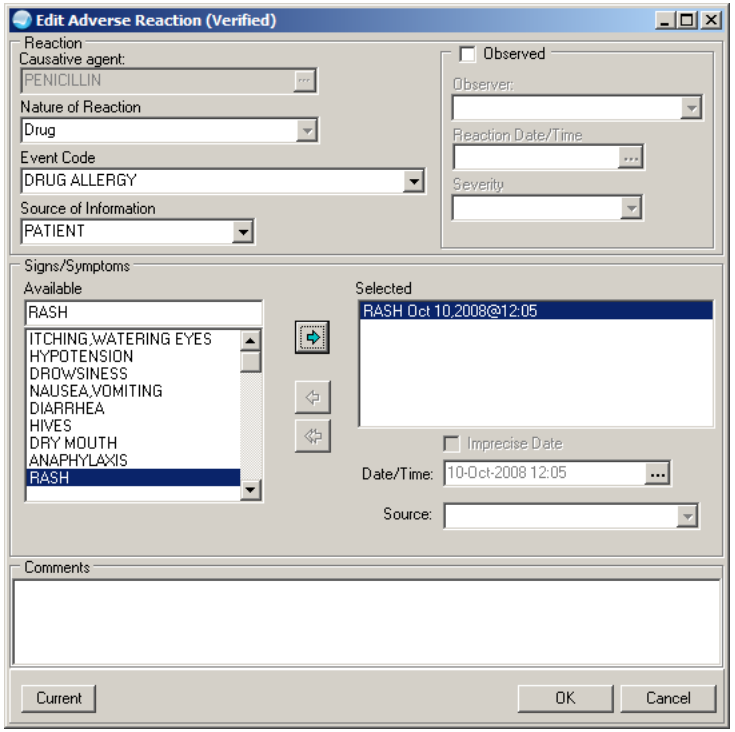
Medication Allergy List Update
No Known Allergy Documentation



Medication Allergy List Update
New Adverse Reaction Entry



Medication Allergy List Update
New Adverse Reaction Entry (cont.)



CORE: Record Demographics

* S1= More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
* S2= More than 80% (core)

Record the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth.
  * No exclusions

  EHR Demo (No)

  RPMS REG-Pack /Practice Management Application Suite

CORE: Record Vital Signs

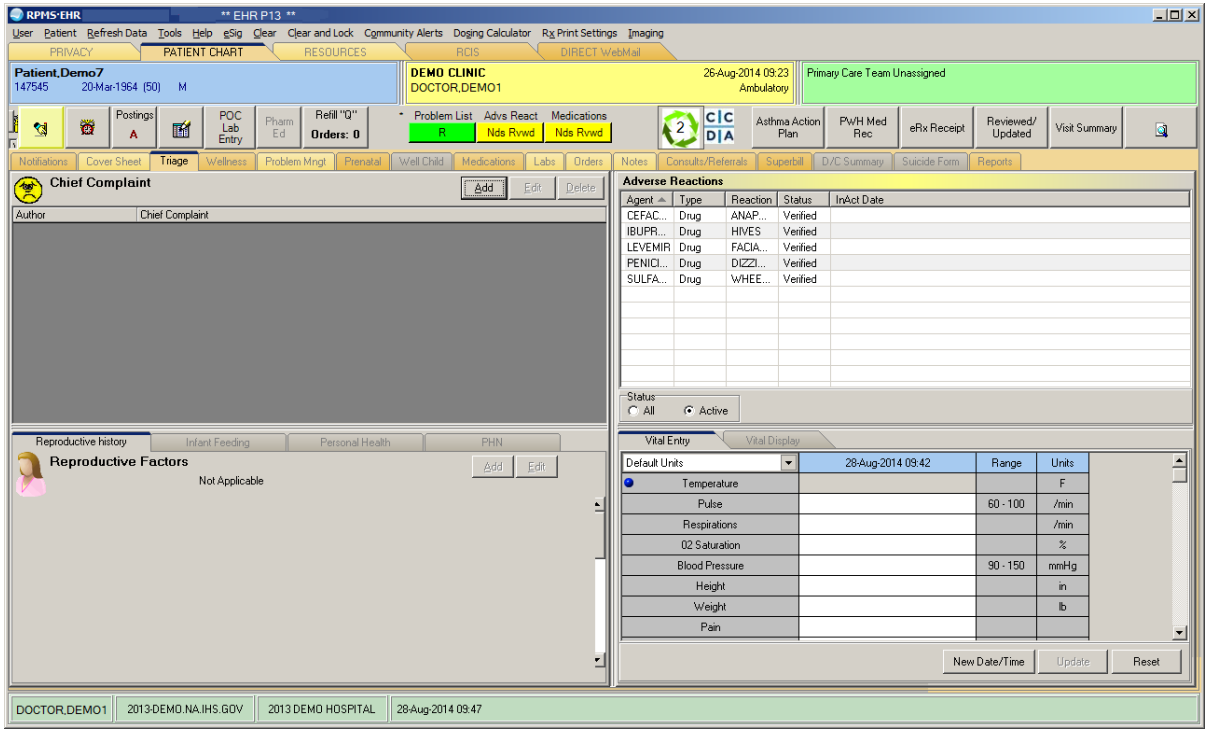
* S1= For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
* S2= More than 80%, BP recorded (for patients age 3 and older), and/or height and weight recorded (for all ages)
* **Exclusions**

  Any EP who:

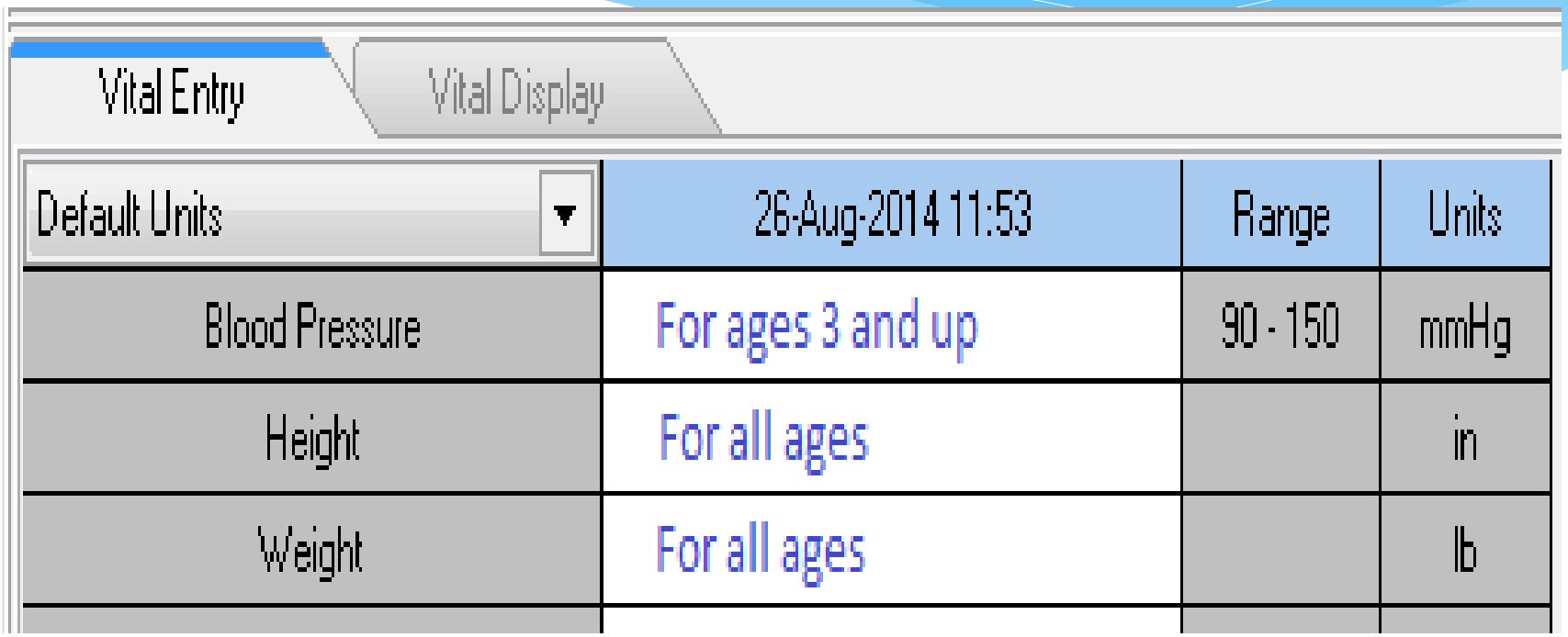
  1. Sees no patients 3 years or older is excluded from recording blood pressure;
  2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;
  3. Believes that height and weight are relevant to their scope 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.

  EHR Demo (Yes)

Vital Signs


RPMS-EHR
** EHR P13 **
User Patient Refresh Data Tools Help eSig Clear Clear and Lock Community Alerts Dosing Calculator Rx Print Settings Imaging
PRIVACY PATIENT CHART RESOURCES RCIS DIRECT WebMail
Patient,Demo7
147545 20-Mar-1964 (50) M
DEMO CLINIC
DOCTOR,DEMO1
26-Aug-2014 09:23
Ambulatory
Primary Care Team Unassigned
Postings A
POC Lab Entry
Pharm Ed
Refill "Q" Orders: 0
Problem List R
Advs React Nds Rvwd
Medications Nds Rvwd
Asthma Action Plan
PWH Med Rec
eRx Receipt
Reviewed/ Updated
Visit Summary
Notifications Cover Sheet Triage Wellness Problem Mngt Prenatal Well Child Medications Labs Orders Notes Consults/Referrals Superbill D/C Summary Suicide Form Reports
Chief Complaint
Add Edit Delete
Author Chief Complaint
Adverse Reactions
Agent Type Reaction Status InAct Date
CEFAC... Drug ANAP... Verified
IBUPR... Drug HIVES Verified
LEVEMIR Drug FACIA... Verified
PENICI... Drug DIZZI... Verified
SULFA... Drug WHEE... Verified
Status All Active
Reproductive history Infant Feeding Personal Health PHN
Reproductive Factors
Not Applicable
Add Edit
Vital Entry Vital Display
Default Units 28-Aug-2014 09:42 Range Units
Temperature F
Pulse 60 - 100 /min
Respirations /min
02 Saturation %
Blood Pressure 90 - 150 mmHg
Height in
Weight lb
Pain
New Date/Time Update Reset
DOCTOR,DEMO1 2013-DEMO.NA.IHS.GOV 2013 DEMO HOSPITAL 28-Aug-2014 09:47

Record Vital Signs



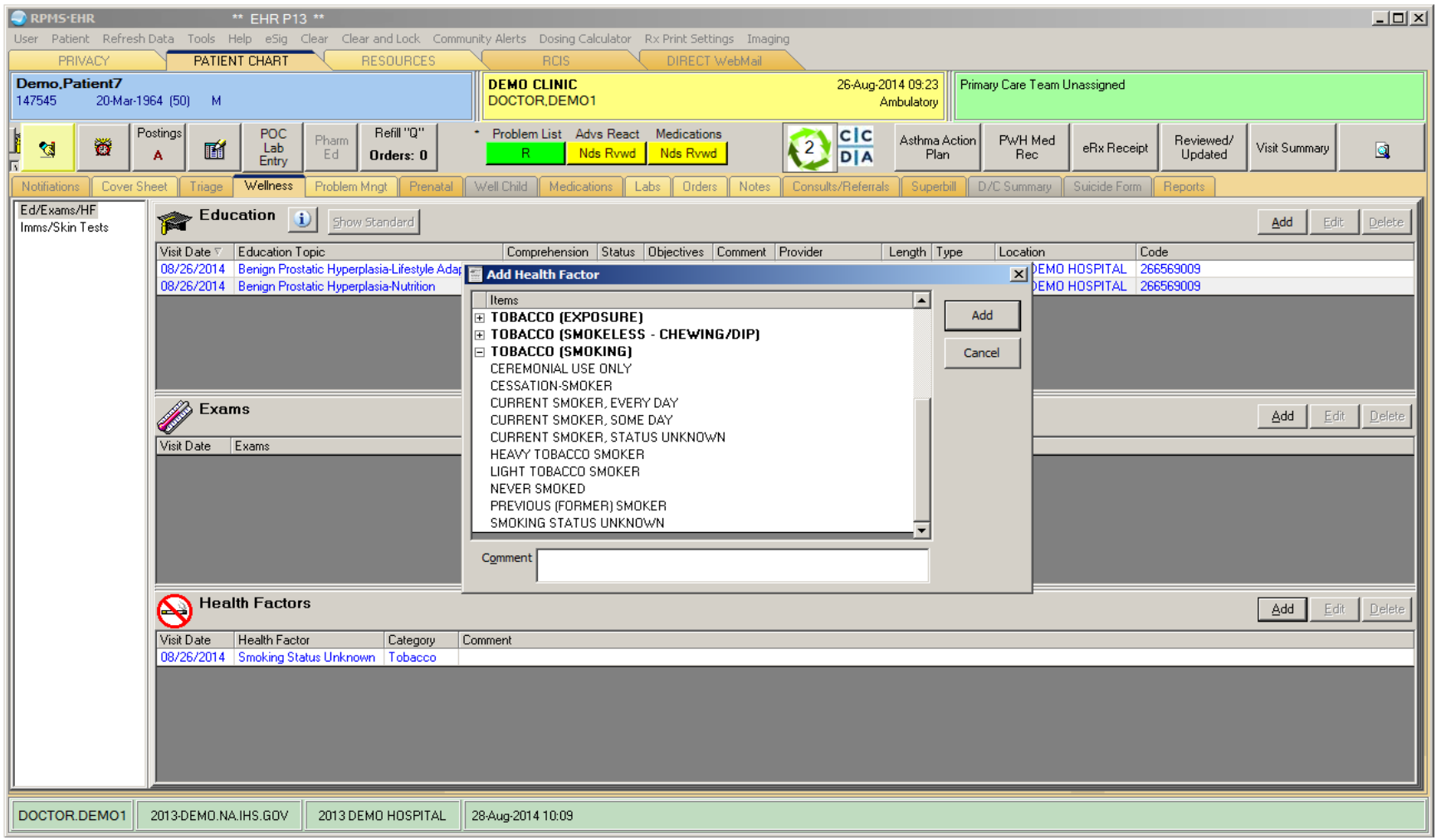
CORE: Record Smoking Status

* S1= More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
* S2= More than 80% for patients age 13 and older
  * **Exclusion**

    Any EP who sees no patients 13 years or older.

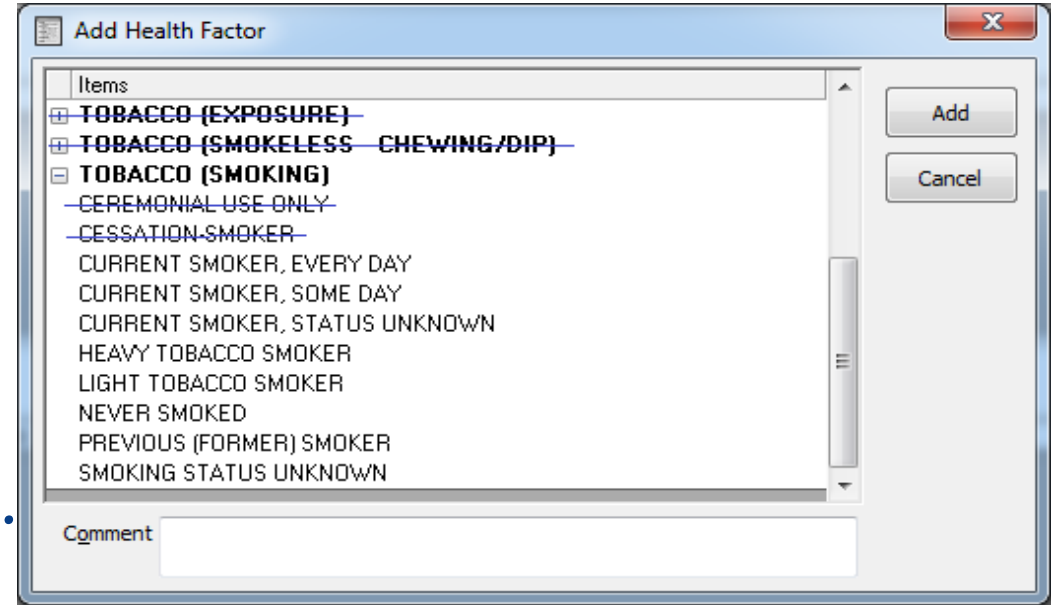
EHR Demo (Yes)

Smoking Status



Record Smoking Status

* **Smoking status must be recorded with one of the following national tobacco health factors. No other health factors will count for the measure.**
* Current every day smoker.
* Current some day smoker.
* Smoker, current status unknown.
* Heavy tobacco smoker.
* Light tobacco smoker.
* Never smoker.
* Former smoker.
* Unknown if ever smoked.



CORE: Clinical Decision Support:

* S1= Implement 1 CDS support rule.
* S2= 1. Implement 5 CDS interventions related to 4 or more CQMs. (Yes/No) 2. Functionality enabled for drug-drug and drug-allergy interaction checks (Yes/No)
* No exclusions
* YES/NO **Attestation Requirements.**

* EHR Demo (NO)

Prioritize Reminders You Need to Attest for MU2

* *"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."*

	A	B	C	D	E
1	REMINDER/DIALOGS	CMS	NQF	CQM Name	Other Measures/Guidelines
2	IHS-ACTIVITY SCREEN 2013				Million hearts, HP 2020 - PA
3	IHS-ALCOHOL SCREEN 2013				GPRA, USPSTF, HP 2020 - SA
4	IHS-ALLERGY 2013				
5	IHS-ANTICOAG DURATION OF TX 2013				US American College of Chest Physicians Antithrombotic Therapy and Prevention of Thrombosis Panel
6	IHS-ANTICOAG INR GOAL 2013				US American College of Chest Physicians Antithrombotic Therapy and Prevention of Thrombosis Panel
7	IHS-ANTICOAG THERAPY END DATE 2013				US American College of Chest Physicians Antithrombotic Therapy and Prevention of Thrombosis Panel
8	IHS-ASTHMA ACTION PLAN 2013	26	338	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	NHBLI Asthma Guidelines, HP 2020 - RD 7
9	IHS-ASTHMA CONTROL 2013				NHBLI Asthma Guidelines, HP 2020 - RD 7
10	IHS-ASTHMA PRIM PROV 2013				NHBLI Asthma Guidelines, HP 2020 - RD 7
11	IHS-ASTHMA RISK EXACERBATION 2013				NHBLI Asthma Guidelines, HP 2020 - RD 7
12	IHS-ASTHMA SEVERITY 2013				NHBLI Asthma Guidelines, HP 2020 - RD 7
13	IHS-ASTHMA STEROID 2013	126	0036	Use of Appropriate Medications for Asthma	NHBLI Asthma Guidelines, HP 2020 - RD 7
14	IHS-BLOOD PRESSURE 2013	165	0018	Controlling High Blood Pressure	Million hearts, HP 2020 - HDS
15	IHS-CHLAMYDIA SCREEN 2013	153	0033	Chlamydia Screening for Women	USPSTF, HP 2020 - STI
16	IHS-COLON CANCER 2013	130	0034	Colorectal Cancer Screening	HP 2020 - Cancer, GPRA
17	IHS-CVD 2013	30	639	AMI-10 Statin Prescribed at Discharge	GPRA, Million hearts, ATP III 2004, Million hearts, HP 2010 – HDS
18	IHS-DENTAL VISIT 2013				HP 2020 - Oral Health
19	IHS-DEPO PROVERA 2013				HP 2020 - FP
	IHS-DEPRESSION SCREENING 2013	2	0418	Preventive Care and Screening: Screening for Clinical Depression and	GPRA, HP 2020 - MHMD

CORE: Patient Electronic Access

* **(View/Download/Transmit):**

S1= 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.

* S2= 1. More than 50% of all unique patients are provided online access to their health information within 4 business days 2. More than 5% of all unique patients view, download, or transmit their health information 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.

EHR Demo (NO)

CORE: Clinical Summaries

* S1= Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
* S2= Provided for more than 50% of all office visits within 1 business day

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

EHR Demo (NO)

PHR not available at this time

CORE: Protect Electronic Health Information

* S1= 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.
* S2= Conduct or review SRA, including addressing the encryption/security of data stored in CEHRT, and implement updates as necessary

  No exclusions.
* YES/NO **Attestation Requirements**.

EHR Demo (NO)

CORE: RPMS DIRECT Secure Messaging

* S1 = N/A
* S2= More than 5% of unique patients sent a secure electronic message
  * Exchange structured information among Providers and Patients.
  * Electronic transmission of patient care summaries across multiple settings.
  * More patient controlled data
* EHR Demo (NO)

DIRECT Requirements for Stage 2

1. CPOE
2. E-Prescribing
3. Record demographics
4. Record vitals
5. Record smoking status
6. Use clinical decision support
7. Patients view, download, transmit
8. Clinical summaries to patients
9. Protect electronic health information
10. Incorporate lab results
11. Generate patient lists
12. Reminders for follow-up care
13. Patient educational resources
14. Medication reconciliation
15. Transmit care summaries for transitions of care
16. Report immunizations
17. Secure messaging with patients plus menu items…
18. Report syndromic data
19. Record electronic notes
20. Imaging results
21. Record family history
22. Report cancer cases
23. Report other registry cases

MENU: Clinical Lab Test Results

* S1= 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.
* S2= More than 55% (core)

* **Exclusion**
  * An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

EHR Demo (YES)

MENU: Patient Lists

* S1=Generate at least one report listing patients of the EP with a specific condition.
* S2= Generate at least 1 report --Yes/No (core)
  * No exclusion.
* YES/NO **Attestation Requirements**.

EHR Demo (NO)

MENU: Patient Reminders

* S1= 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.
* S2= More than 10% of all unique patients with 2 or more office visits in the last 24 months (core)
* 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.

EHR Demo (NO)

ICARE REMINDER NOTIFICATIONS

MENU: Patient-Specific Education Resources

* S1= More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
* S2= More than 10% of all unique patients provided patient-specific education resources (core)
* No exclusions.

EHR Demo (YES)

Patient-Specific Education

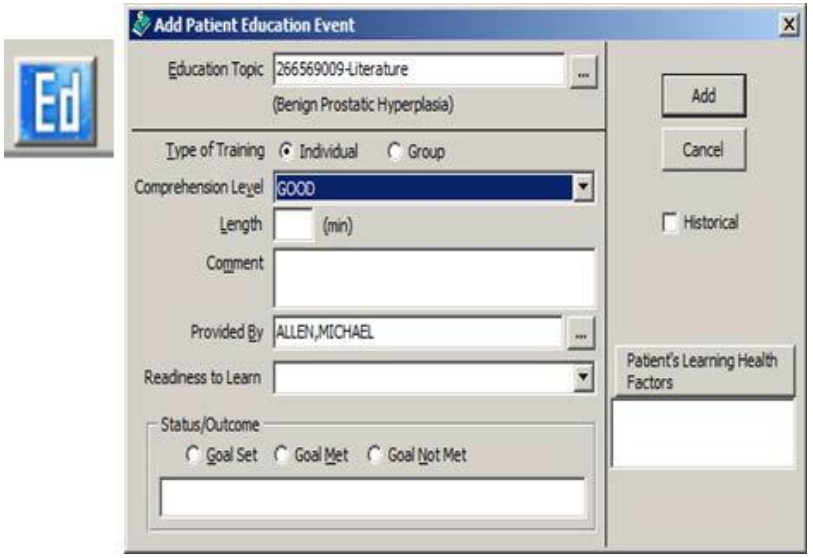
* Optional Menu Set Measure with MU Stage 1.
* Required MU2 Core Measure:
  * More than 10% of all unique patients with office visits are provided patient-specific education resources.

Documenting Patient Education for MU (1)

* Document Literature (L) in a face-to-face patient encounter.
* Can be done by anyone on the care team.
* Can be done multiple ways. Patient Ed button:

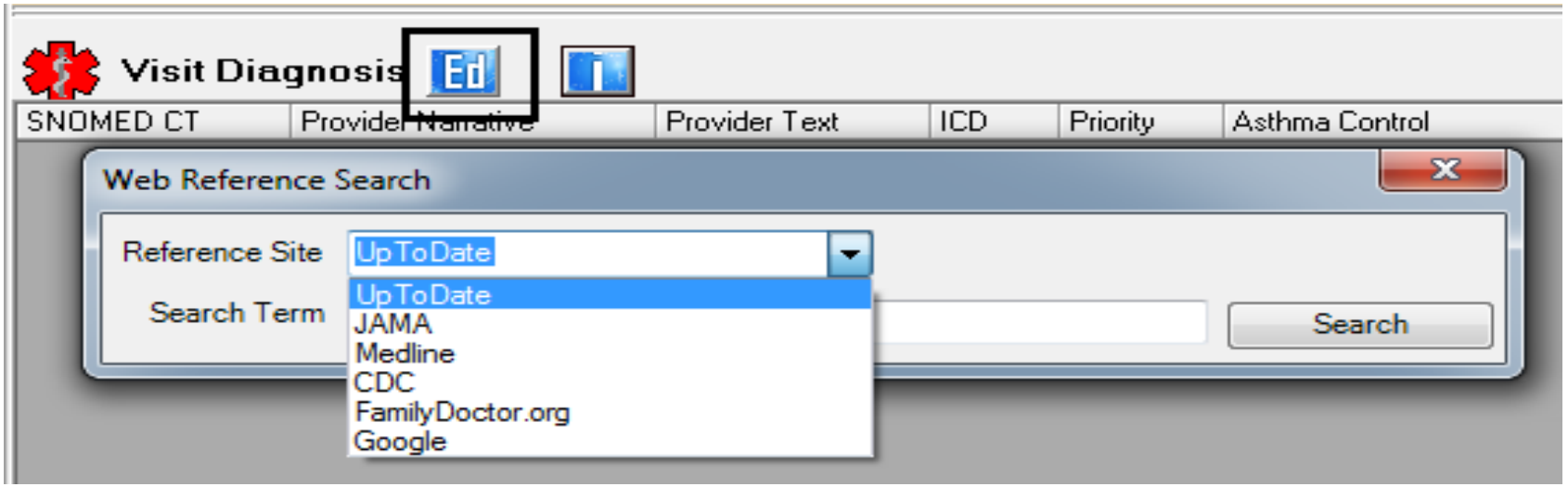
Documenting Patient Education for MU (1)

* Document Literature (L) in a face-to-face patient encounter.
* Can be done by anyone on the care team.
* Can be done multiple ways.
  * Patient Ed button:



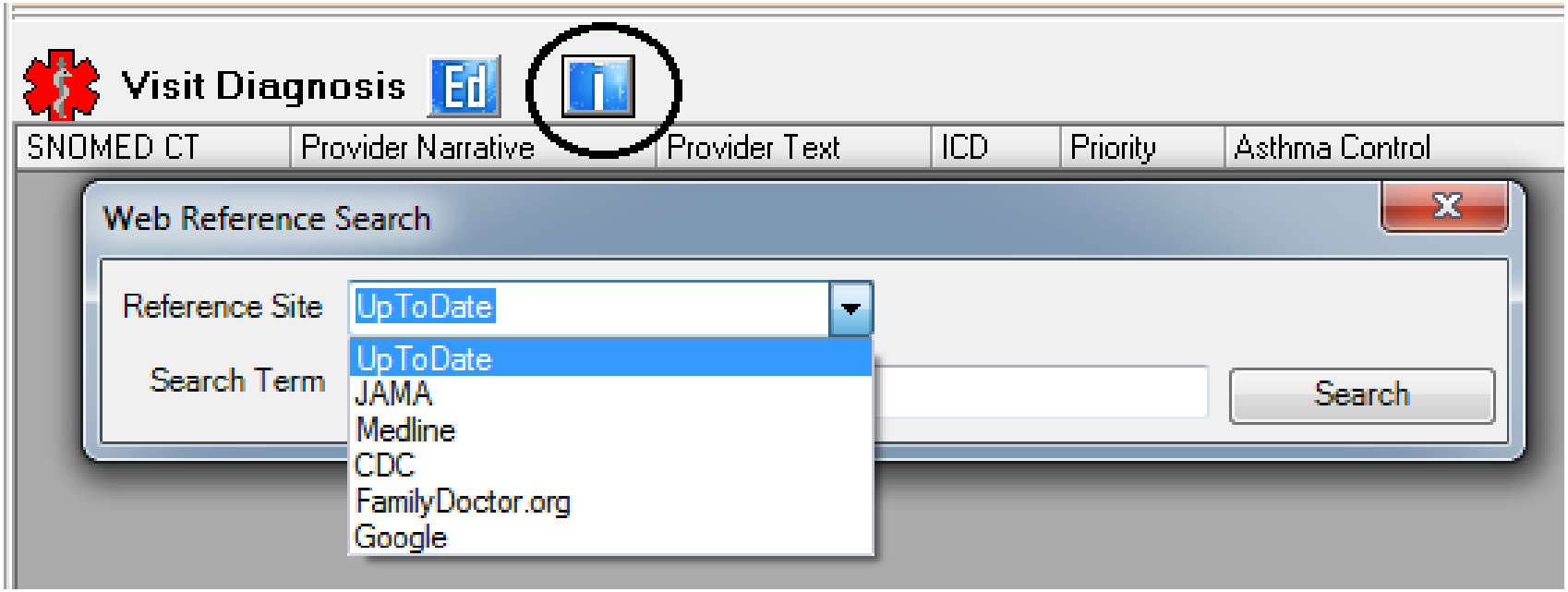
Documenting Patient Education for MU (2)

* "Ed" button added to retrieve MedlinePlus Patient Education.

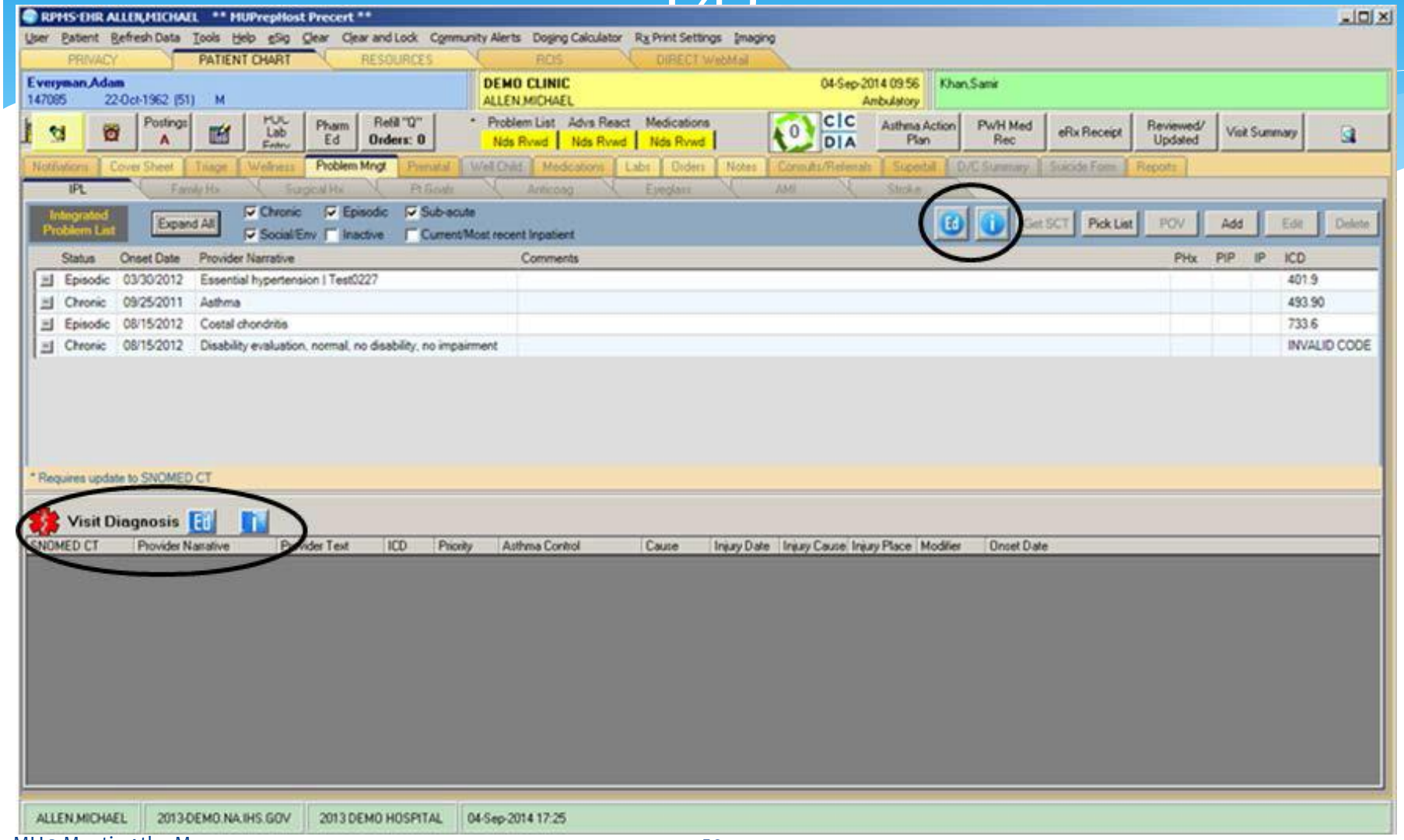


Documenting Patient Education for MU (3)

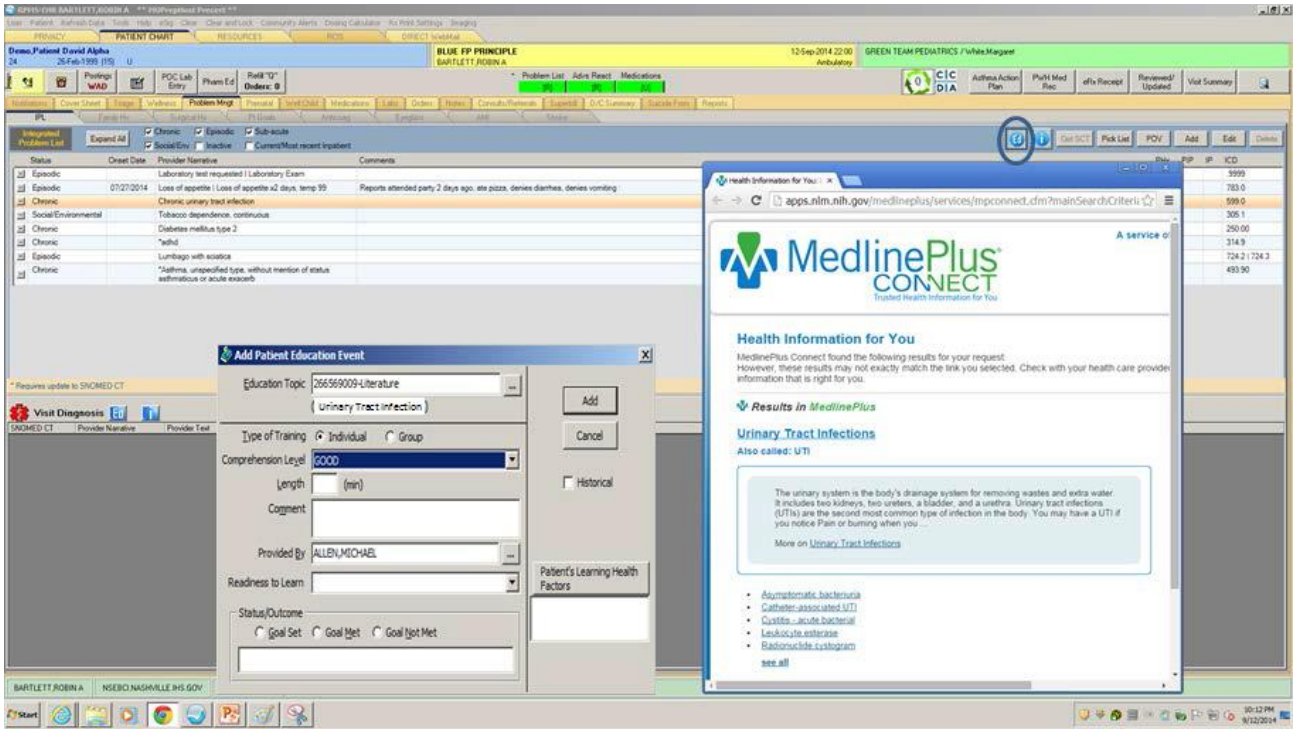
* "i" button will retrieve ClinicalKeyclinical info.



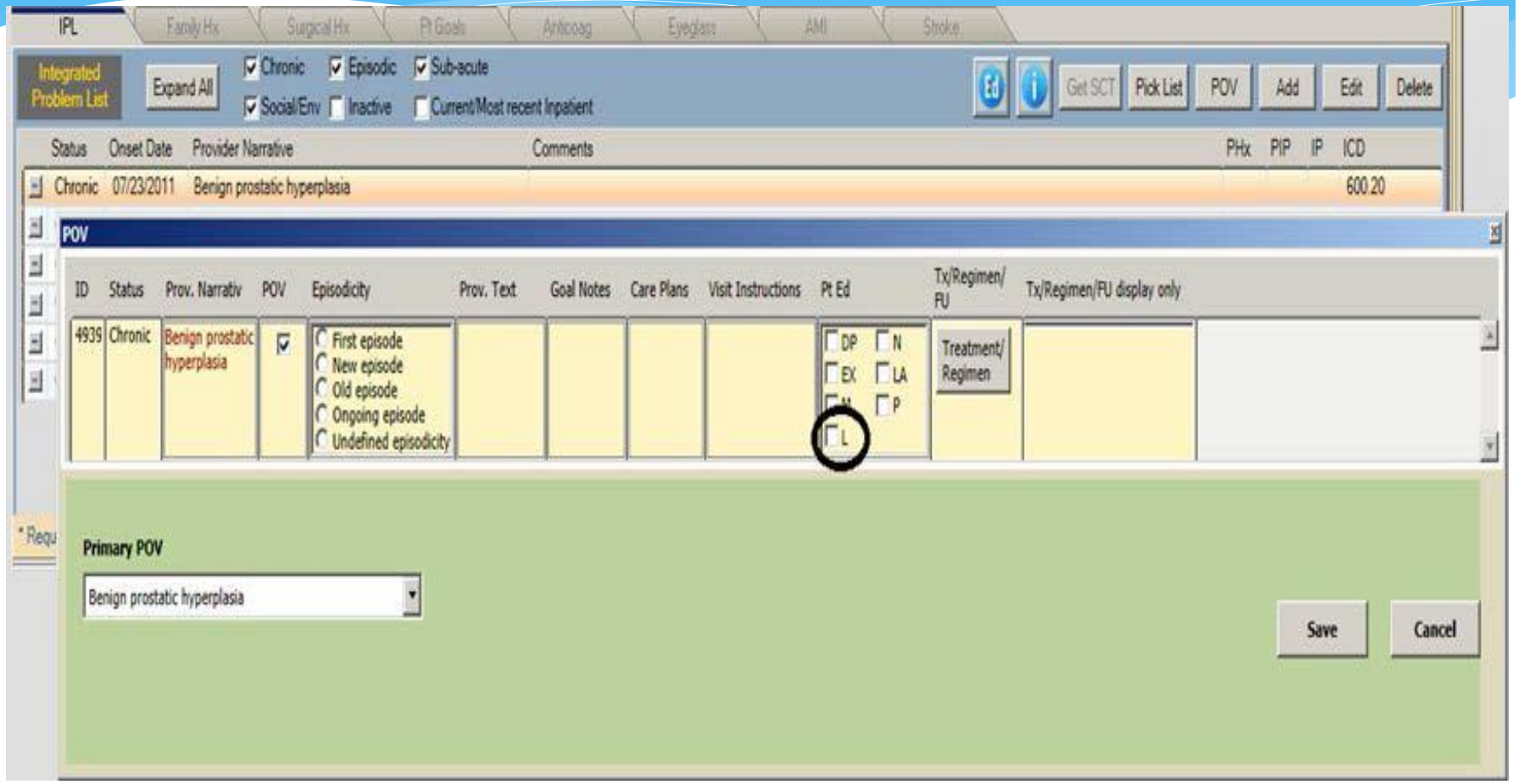
Documenting Patient Education for MU (4)



Documenting Patient Education for MU (5)

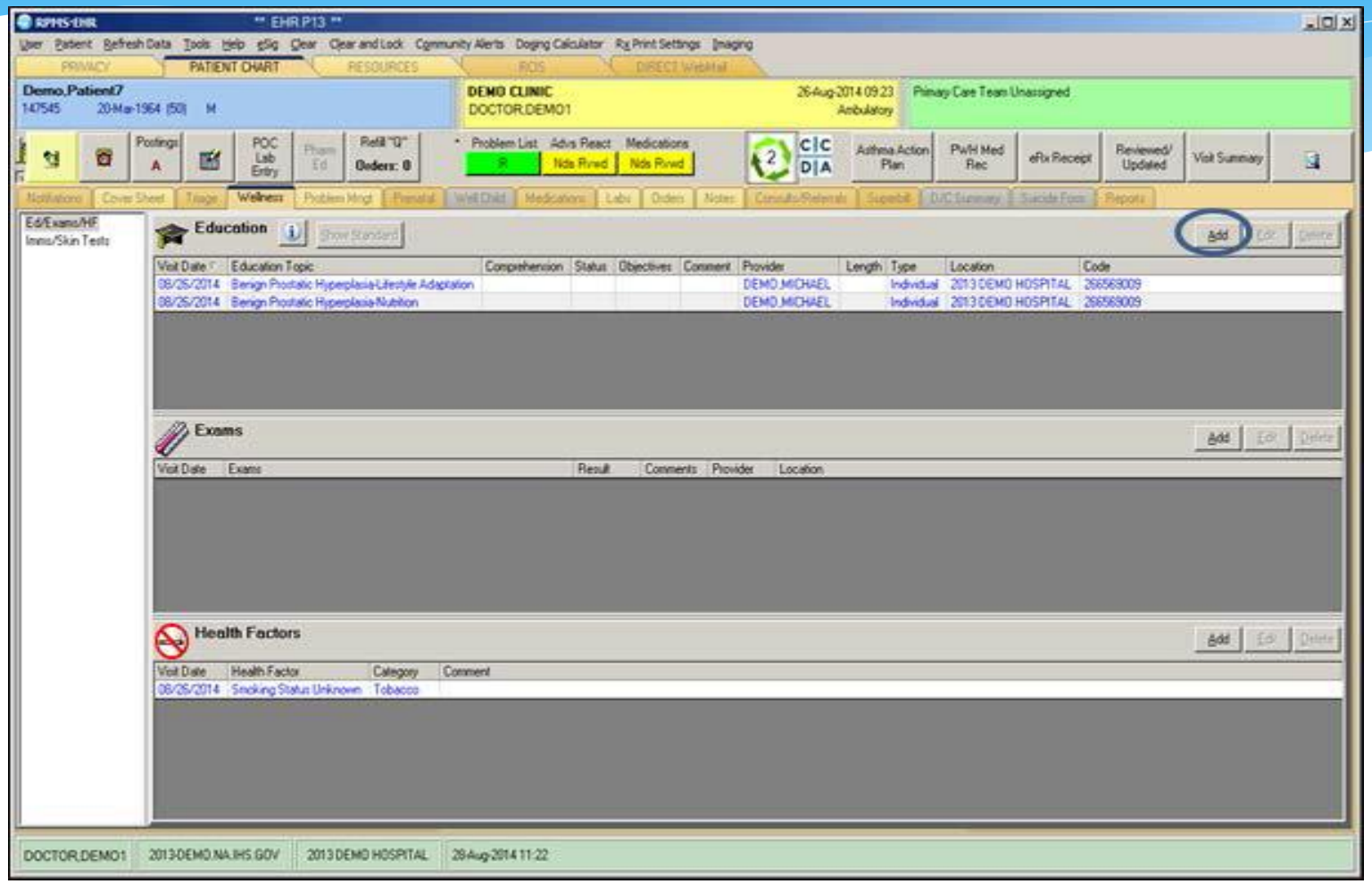


Documenting Patient Education for MU (6)



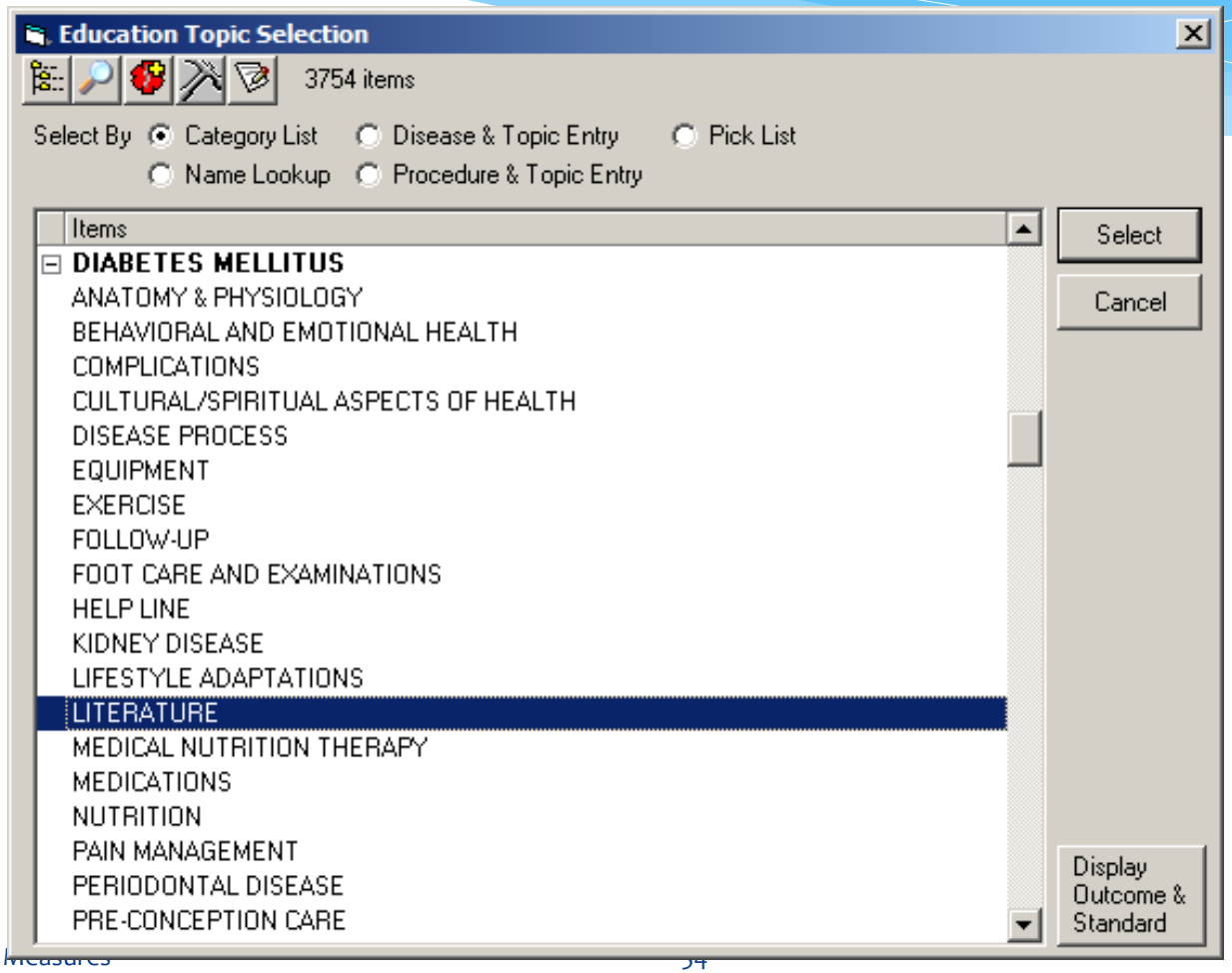
Documenting Patient Education for MU (7)

- Education on Wellness tab.



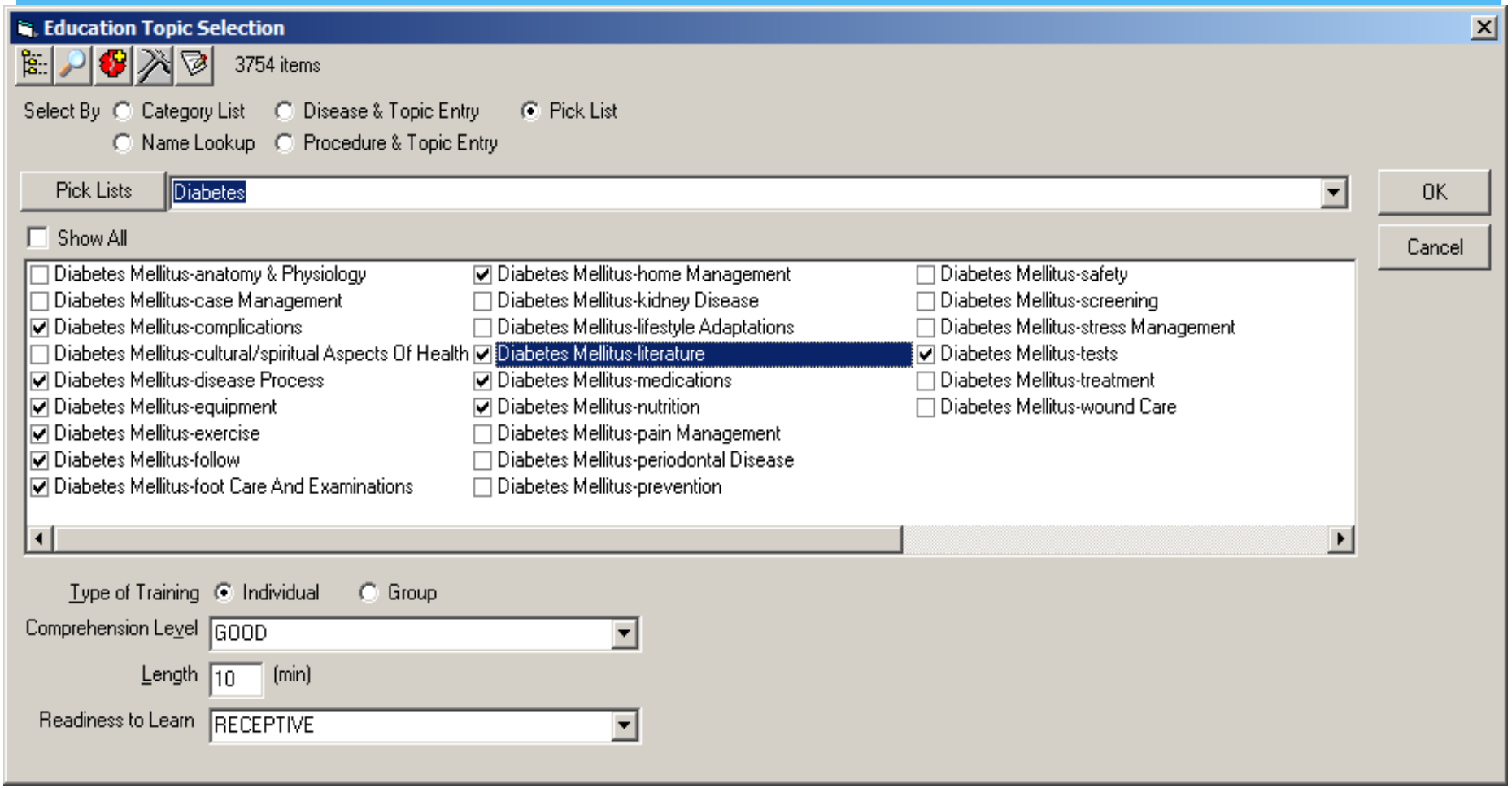
Documenting Patient Education for MU (8)

* Education on Wellness tab – Category List.



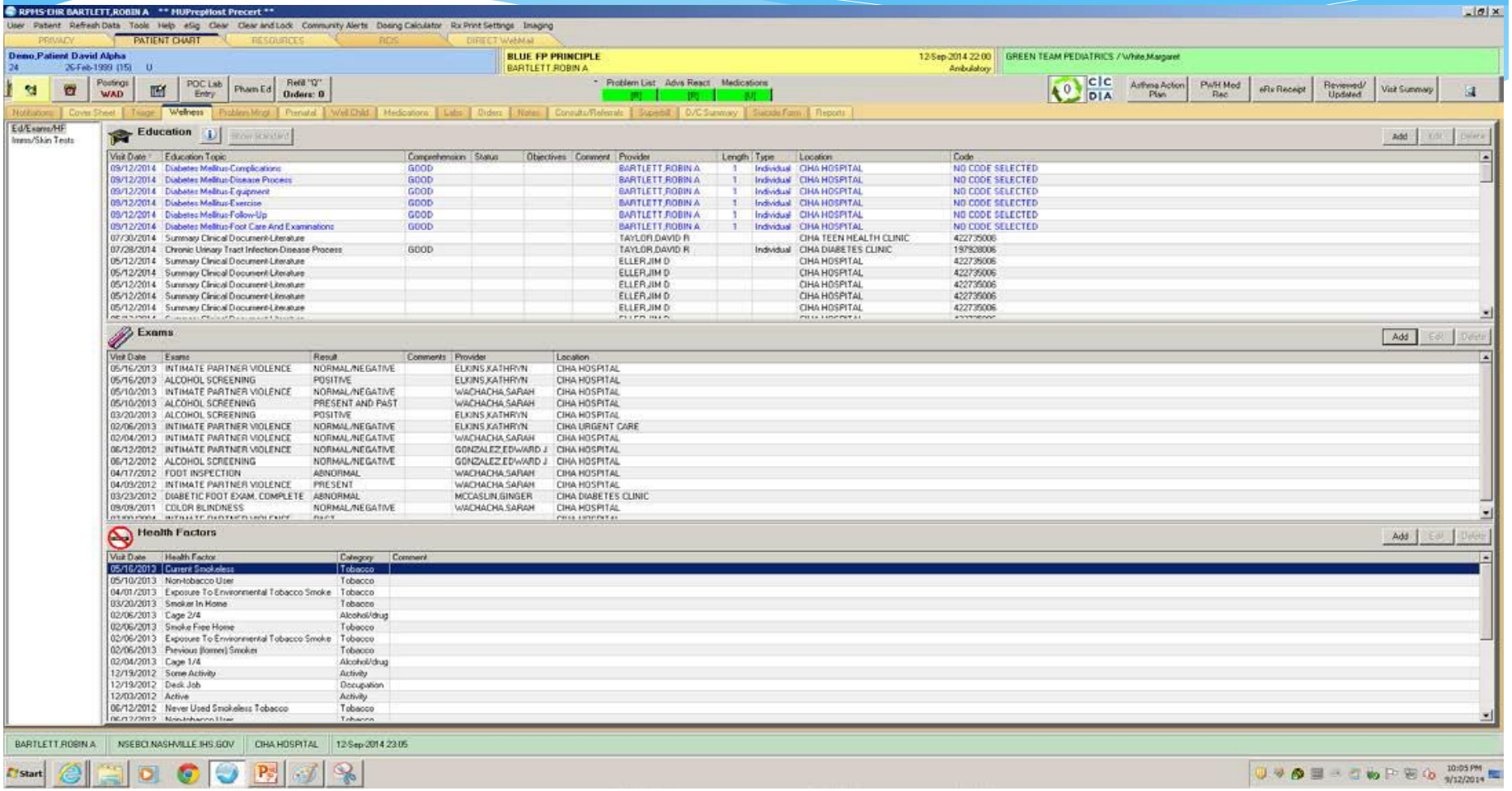
Documenting Patient Education for MU (9)

- Education on Wellness tab -Pick List.



Documenting Patient Education for MU (10)

- Education on Wellness tab.



MENU: Medication Reconciliation

* S1= 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.
* S2= Med rec for more than 50% of transitions of care (core)

* **Exclusion**
  * An EP who was not the recipient of any transitions of care during the EHR reporting period.

EHR Demo (YES)

*Count each patient visit in the denominator where SNOMED Code 428191000124101(Documentation of current medications (procedure)) is present in the SNOMED CT field of the V Updated/Reviewed file for a visit during the reporting period.

And the Event Date and Time entry in the V Updated/Reviewed file field is during the reporting period *

MENU: Transition of Care Summary (Summary of Care)

* S1= 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.
* S2= 1. Provides a summary of care record for more than 50% of transitions of care and referrals

2. Provides a summary of care record using electronic transmission through CEHRT eHealth exchange for more than 10% for transitions of care and referrals

3. Transmits at least 1 summary of care record electronically to a recipient with a different EHR vendor or to the CMS test EHR (core)

* **Exclusion**
  * An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

EHR Demo (NO)

Transition of Care/Summary of Care Patient Summary

Get Well Clinic: Health Summary

Created On: August 6, 2012

Patient:	Isabella Demo 1357 Amber Drive Beaverton, OR, 97006 tel:(816)276-6909	**MRN:** 1	
Birthdate:	May 1, 1947	**Sex:** Female	
Guardian:		**Next of Kin:**	

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ALLERGIES, ADVERSE REACTIONS, ALERTS

TOC -Provide Summary Record (1)

Measure 1:

* Provide a summary of care record for more than 50% of transitions of care and referrals.

Measure 2:

* Provide a summary of care record for more than 10% of the total number of transitions and referrals either: Electronically transmitted using CEHRT to a recipient.

or:

* Where the recipient receives the summary of care record via exchange facilitated by an organization that is an eHealth Exchange (formerly NwHIN exchange) participant or in a manner that is consistent with the governance mechanism ONC establishes for the eHealth Exchange.

Measure 3:

* EPs must also satisfy one of the following criteria:
* Conduct 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.
* Conduct one or more successful tests with the CMS designated test EHR during the EHR reporting period.

TOC -Provide Summary Record (2)

What that means for you:

* For over half of the patients you refer to another provider or transfer to another setting of care (e.g., nursing home), you have to send the next provider of care either an electronic or paper summary of care document that is generated by your certified EHR.
* Of those summary of care documents you send, more than 10% must be sent electronically—either directly to a recipient or using the eHealth Exchange standards.
* At least one of the summary of care documents that are sent electronically must be sent to someone who is using a completely different EHR vendor or to the CMS designated test EHR.

Are you excluded from doing this?

* You can be excluded from all three measures if you transfer a patient to another setting or refer a patient to another provider less than 100 times during the reporting period.

TOC -Provide Summary Record (3)

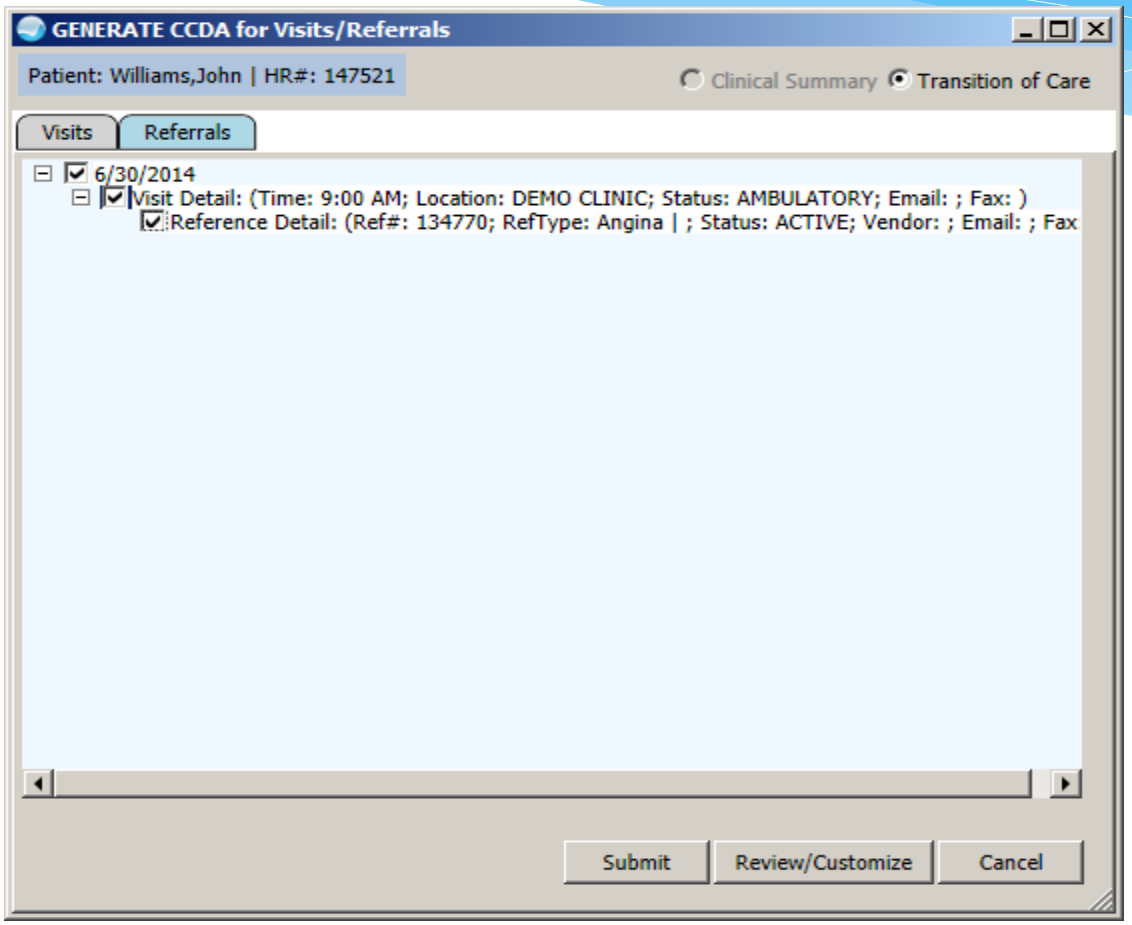
* This measure only counts for outside referrals (not Consults).
* The measure evaluates referrals initiated during face-to-face visits within the reporting period.
* To be in the denominator, a referral must be approved during the reporting period and have an appointment date entered in the RCIS system.
* To count in the numerator there must be a TOC printed or transmitted after the referral is approved.

Transmit TOC

* Generating, customizing, and printing TOC are essentially the same as CS.
* A TOC must accompany each referral in RCIS.
* Senders and receivers of TOCs must have a Direct email account which is secure.
* Never transmit protected health information (PHI) through unsecured processes.

TOC Dialog for Vendors With Direct Messaging

Notice the new **Submit** button.



TOC Demonstration

* EHR.
* Patient with qualifying referral.
* Place the cursor over the CCDA button.
* TOC for selected referral:
  * Choose referral.
  * Submit.
* Print to PDF.

Receiving CCDA Documents

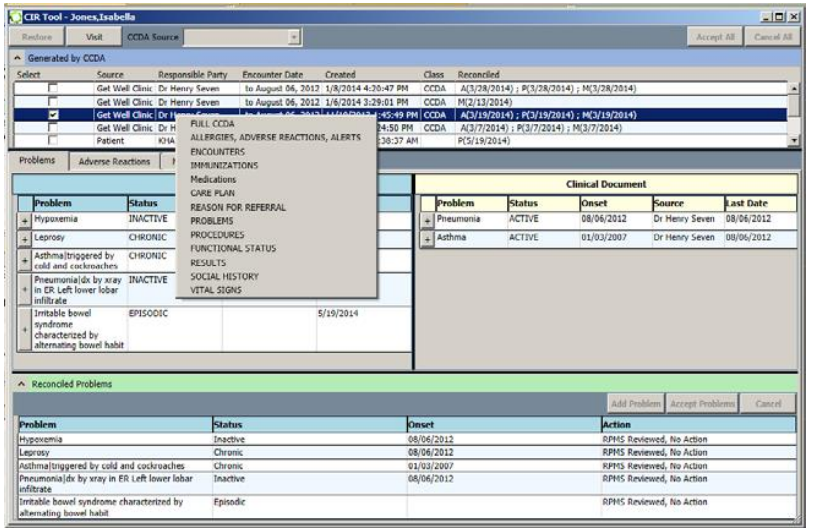
* When a C-CDA document is received, it is stored in Vista Imaging and linked to the patient in RPMS via Medical Records.
* Records are reviewed and reconciled using the Clinical Information Reconciliation (CIR) tool.
* If a patient has any unreconciled received C-CDA documents the CIR icon will turn red and display the number of unreconciled documents.
* Placing the cursor over the icon will display the total number of documents.

CIR Tool

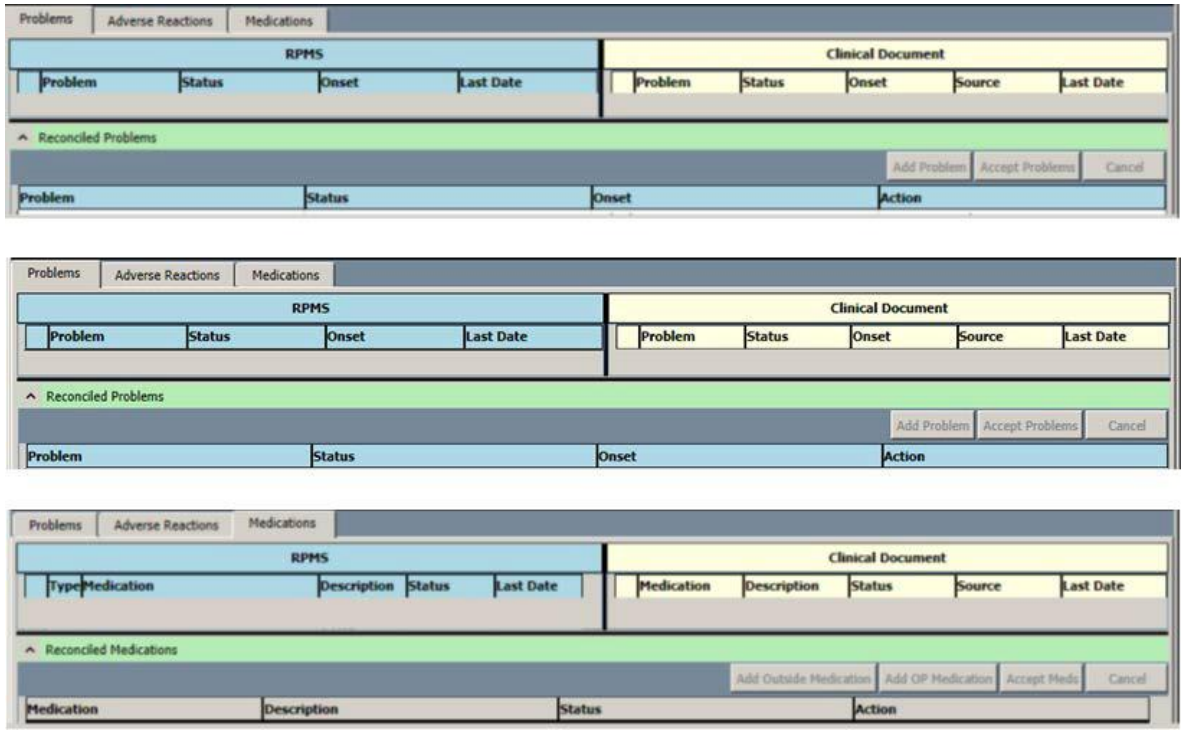
* Clicking the CIR icon will open the reconciliation window.
* The top section lists the available documents: Reconciliation data is listed with each entry.
* The left section lists information from the selected incoming document: Multiple documents may be selected.
* The bottom section populates with reconciled information.

Selecting and Viewing Documents

* Clicking a document loads it into the display.
* Right-clicking a document displays a menu that will allow viewing of the entire document.

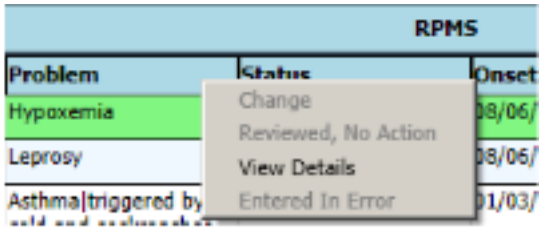


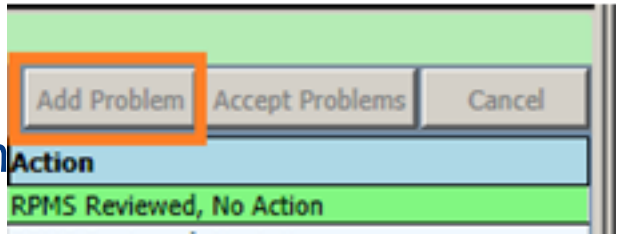
Tabs: Problems, Adverse Reactions, and Medications



Reconciling Elements From Incoming Document

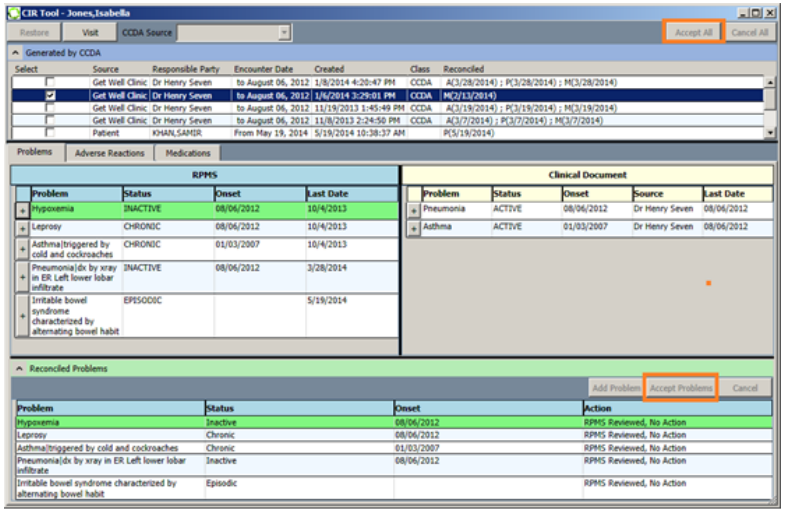
* Right-clicking elements on the right and left sections will display context-sensitive menus:
  * Use these options to reconcile the respective lists.
* Actions on these tabs will be recorded as reconciliation of those elements in RPMS.
* Each reconciliation adds to the bottom list.
* Each tab also has an **Add** button on the bottom section for easy addition of any new problems discovered in this process.

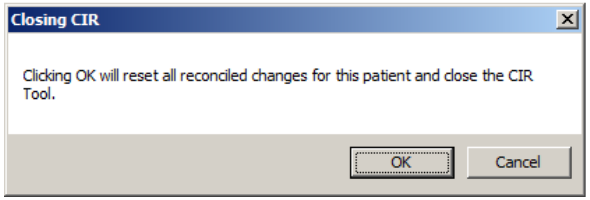




The Finished Product

- When finished, click Accept.
  - Use the button for each tab.
  - or:
  - Select all by using the button at the top.
- A signature dialog will open.
- Signed changes will be saved in RPMS.
- Unsigned changes will be lost when the CIR tool is closed.





Notes

* The CIR tool is not for regular maintenance of problem lists, adverse reactions, or medications.
* The focus of the tool is to import information from C-CDA documents.
* To add problems, medications, and allergies, use the normal EHR entry processes:
  * Medication ordering dialog.
  * Add problem dialog.
  * Add allergy dialog.

Clinical Summary and Transfer of Care Documents

* In Meaningful Use Stage 2 (MU2) the Patient Wellness Handout and C32 are replaced by the Clinical Summary (CS) and Transfer of Care (TOC) documents.
* CS is intended to be used as a visit summary to give the patient at the conclusion of the provider encounter.
* TOC is intended to transmit patient information to a referred provider.

Consolidated Clinical Document Architecture (CCDA)

* The Consolidated Clinical Document Architecture (C-CDA) is a prescribed document format that includes defined elements in a specific structure.
* Dictates elements for both CS and TOC.
* Because of this common format, both documents are generated and printed from the same menu in EHR.
* TOC is meant to be transmitted from provider to provider and can be transmitted electronically via secure messaging:
  * Because of the prescribed format, transmitted TOCs received by referral providers who use a MU2 Certified EMR should be able to import them directly into their system.

Clinical Summaries

Get Well Clinic: Health Summary

Created On: August 6, 2012

Patient:	Isabella Demo 1357 Amber Drive Beaverton, OR, 97006 tel:(816)276-6909	**MRN:** 1	
Birthdate:	May 1, 1947	**Sex:** Female	
Guardian:		**Next of Kin:**	

Table of Contents

ALLERGIES, ADVERSE REACTIONS, ALERTS

Provide Clinical Summaries

What this measure requires:

* Clinical Summaries provided to patients within one business day for more than 50% of office visits.

What that means for you:

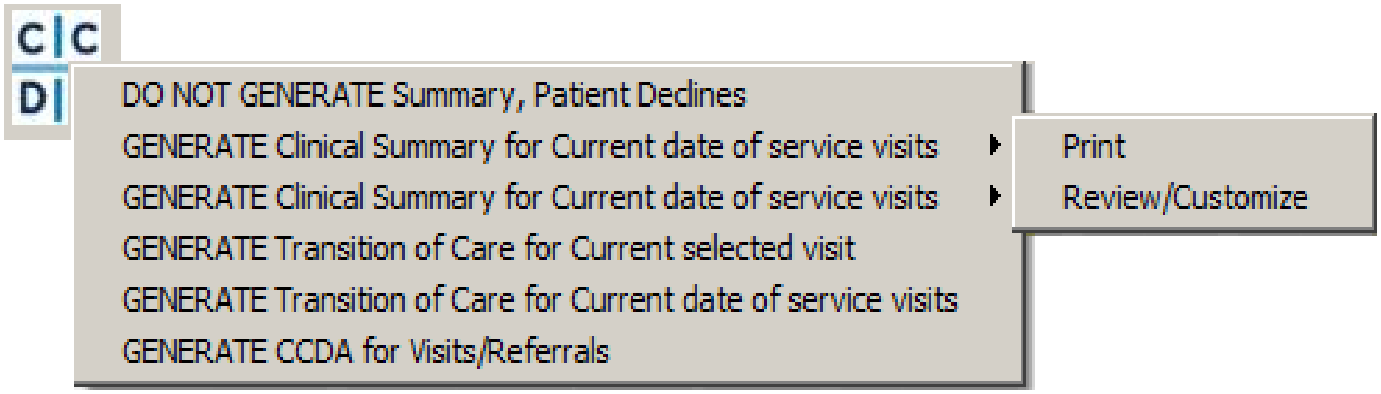
* For more than half of your office visits, patients receive a clinical summary within one day of the visit.

Are you excluded from doing this?

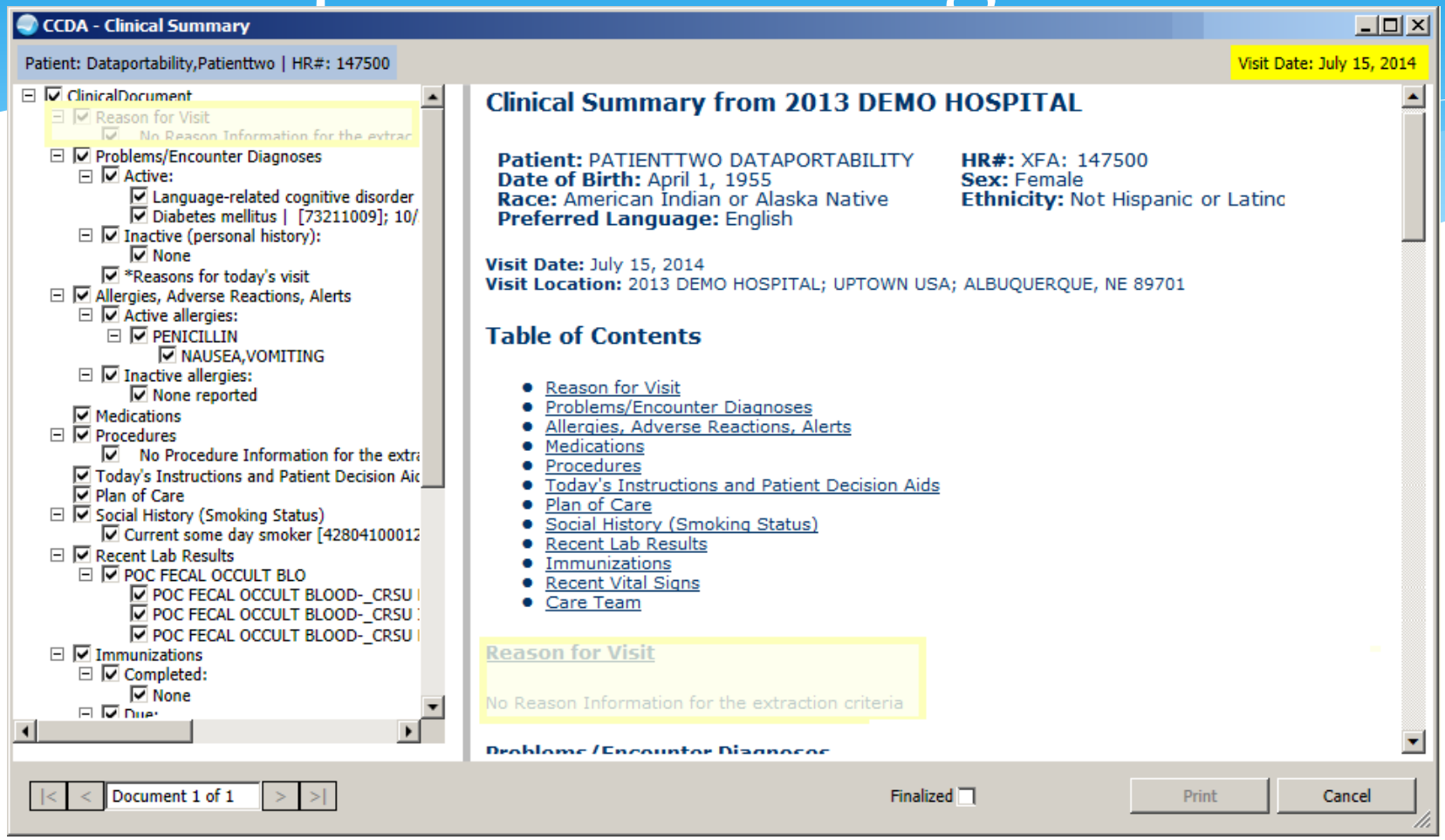
* If you do not conduct any office visits, you can be excluded from meeting this objective.

Generating a Clinical Summary

* EHR will have a CCDA icon.
* Place the cursor over the icon and a menu appears.
* Mouse over the selection and the menu expands.
* Selecting **Patient Declines** or **Print** will count towards the measure.
* Select **Review/Customize** to edit the summary but it must still be printed.



Sample Customizing Screen



When finished, select **Finalized** and click **Print.** The EHR print dialog displays.

MENU: Immunization Registries Data Submission

* S1= 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.
* S2= Successful ongoing submission for the entire EHR reporting period (core)

* **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.
* YES/NO **Attestation Requirements**

EHR Demo (NO)

MENU: Syndromic Surveillance

* S1= 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.
* S2= Successful ongoing submission for the entire EHR reporting period (menu)
* **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.

  YES/NO **Attestation Requirements**.

  EHR Demo (NO)

MENU: Record Electronic Notes

S1= N/A

S2= What this measure requires:

* 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. Electronic progress notes must be text-searchable. Non-searchable notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable text notes under this measure.

What that means for you:

* For over 30%of your patients, you must enter progress notes into the electronic health record. Your EHR will have the capability for those notes to be text searchable.

Are you excluded from doing this?

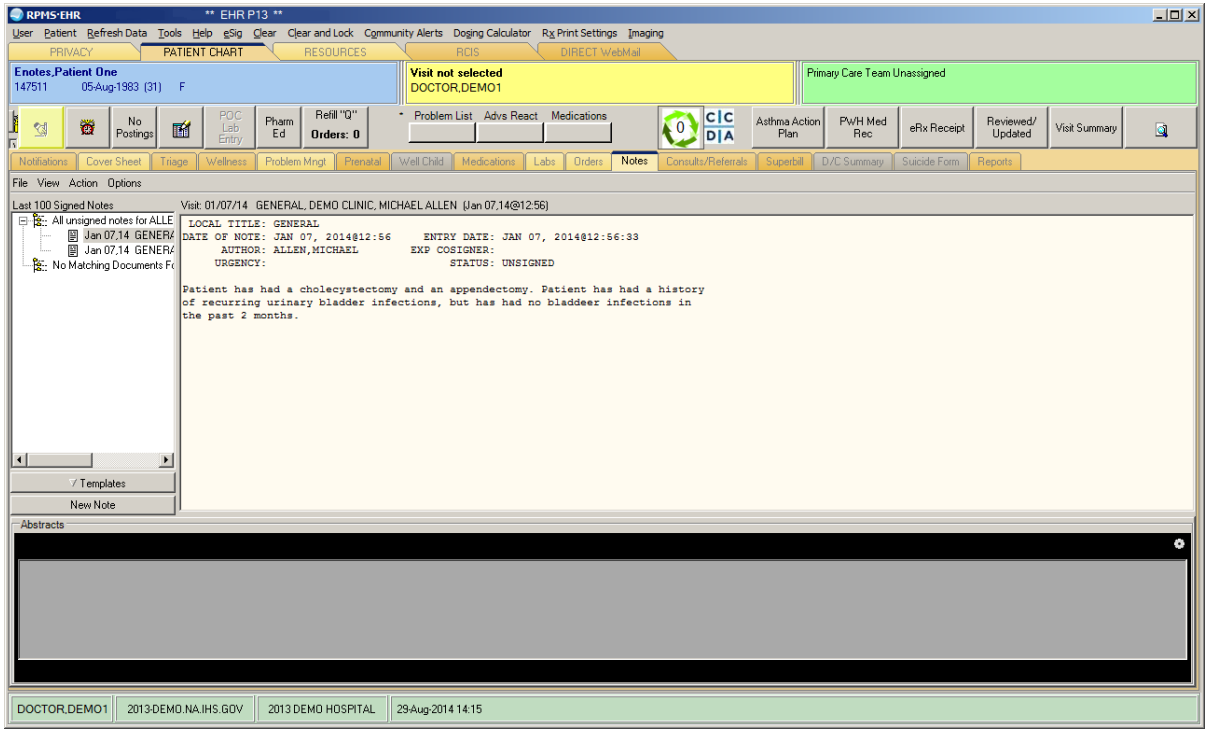
* There are no exclusions. Everyone who selects this measure must meet this objective.

EHR Demo (YES)

Record Electronic Notes

* The report counts patients.
* The provider must have a face to face visit with the patient.
* For patients to count in the numerator:
  * The provider must be the author and signer of a note
  * The provider may be a cosigner of a student's note
* The requirement of the notes being searchable is satisfied by the EHR's requirement to make notes searchable for certification.

Record Electronic Notes



MENU: Imaging

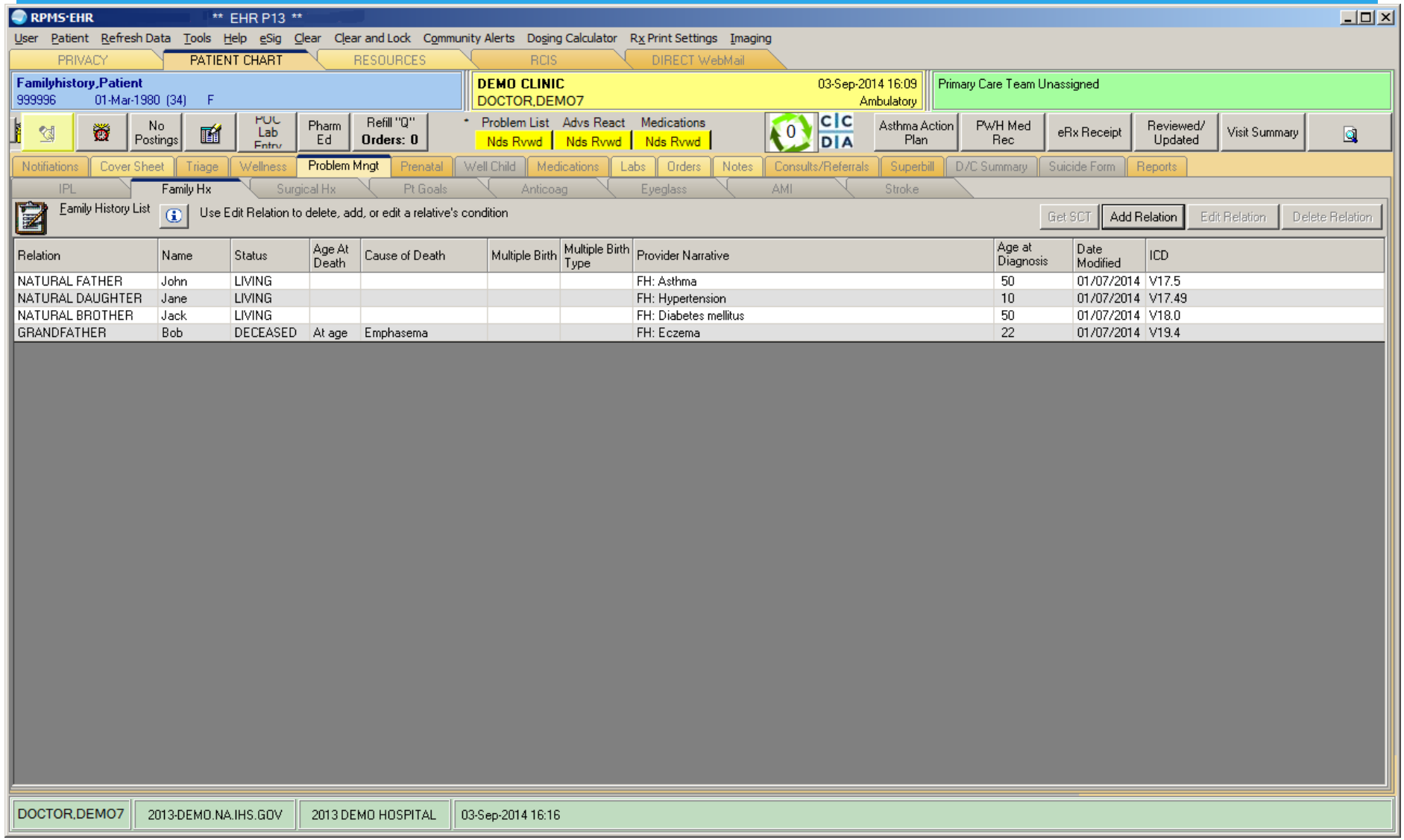
* S1= N/A
* S2= More than 10% of all tests accessible through CEHRT (menu)

* EHR Demo (YES)

MENU: Patient Family Health History

* S1= N/A
* S2= More than 20% of all unique patients have a structured data entry for 1 or more first-degree relatives or an indication that family health history has been reviewed
* This measure is counting patients
* Enter health conditions on first degree (blood) relatives
* EHR Demo (YES)

Family Health History



MENU: Specialized registry

* S1= N/A
* S2= Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period

EHR Demo (NO)

References

* http://www.ihs.gov/meaningfuluse/includes/themes/newihstheme/pdf/EPComparisonTableStage1and2_2014.pdf
* http://www.ihs.gov/meaningfuluse/includes/themes/newihstheme/pdf/EP2014Stage1RPMSPerfMeasureLogic.pdf

Contact Information:
Emmanuel Yennyemb, CAC Mentor California Area
252-412-5730
Emmanuel.yennyemb@ihs.gov

QUESTIONS ????