RESOURCE AND PATIENT MANAGEMENT SYSTEM

RPMS-EHR Meaningful Use Configuration Guide: Stage 1

Vol. 2: Eligible Hospitals

Version 1.0
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Table of Contents

1.0 Introduction....1

2.0 Background....2

2.1 Meaningful Use....2
2.2 Stage 1 Meaningful Use Considerations....3

3.0 Using this Guide....4

3.1 Standard Content....4
3.2 Optional Content....5
3.3 Guidelines and Cautions....6

4.0 Eligible Hospitals and CAHs....7

4.1 Stage 1 Core Performance Measures....7
4.1.1 Computerized Provider Order Entry Medication Orders....7
4.1.2 Drug-Drug & Drug-Allergy Checks....20
4.1.3 Demographics....36
4.1.4 Problem List....43
4.1.5 Medication List....47
4.1.6 Medication Allergy List....51
4.1.7 Vital Signs....69
4.1.8 Smoking Status....75
4.1.9 Clinical Decision Support....78
4.1.10 Calculate and Transmit Clinical Quality Measures....90
4.1.11 Electronic Copy of Health Information....91
4.1.12 Electronic Copy of Discharge Instructions....96
4.1.13 Exchange Key Clinical Information....102
4.1.14 Privacy and Security....103
4.2 Stage 1 Menu Set Performance Measures....103
4.2.1 Drug-Formulary Checks....103
4.2.2 Advance Directives....109
4.2.3 Lab Results into EHR....115
4.2.4 Patient List....133
4.2.5 Patient Specific Education....136
4.2.6 Medication Reconciliation....141
4.2.7 Summary of Care....147
4.2.8 Immunization Registries....149
4.2.9 Submit Lab Results to Public Health Agencies....151
4.2.10 Syndromic Surveillance....152

Glossary....181

Acronyms....183

Contact Information....185

Preface

With the publication of the Centers for Medicare and Medicaid Services Final Rule in July of 2010, the Indian Health Service's Meaningful Use (MU) Team was formed to:

- Review the Final Rule
- Extract requirements
- Identify shortfalls in the Resource and Patient Management System (RPMS) and Electronic Health Record (EHR)
- Develop logic for software changes

The MU Team has many other responsibilities that are not directly related to EHR Training or the development of the MU Guides.

In the fall and winter of 2010, the EHR Training Team collaborated with MU Team to:

- Identify existing RPMS/EHR functionality that meets MU requirements
- Document shortfalls
- Suggest approaches to meet requirements
- Develop documentation and training to support implementation

The EHR Training Team coordinated working group sessions with subject matter experts to:

- Capture pertinent RPMS setups
- Document other configuration steps
- Gather EHR screenshots and procedure logic

1.0 Introduction

This document provides guidance to Indian Health Service (IHS) healthcare providers seeking to demonstrate meaningful use of certified Electronic Health Record (EHR) technology in a hospital environment. The target audience for this guide is the Meaningful Use (MU) coordinator for the facility.

Readers interested in this topic as it pertains to an individual provider environment should refer to ***RPMS-EHR Meaningful Use Guide: Stage 1, Vol. 1: Eligible Professionals: Stage 1***.

> There is no requirement to designate an MU coordinator, though hospitals and larger clinics and practices may realize operational benefits from doing so.

MU focuses on:

- Capturing health information electronically and in a structured format
- Using information to track key clinical conditions and communicating that information for care coordination purposes
- Implementing clinical decision support tools to facilitate disease and medication management
- Engaging patients and families
- Reporting clinical quality measures and public health information.

2.0 Background

In the American Recovery and Reinvestment Act of 2009 (ARRA), the Congress identified the broad goal of expanding the use of EHR through the term meaningful use and applied this definition to Medicare and Medicaid eligible professionals and eligible hospitals. Certified EHR technology used in a meaningful way is one piece of a broader health information technology (HIT) infrastructure needed to reform the health care system and improve health care quality, efficiency, and patient safety. The department of Health and Human Services (HHS) believes this ultimate vision of reforming the health care system and improving health care quality, efficiency, and patient safety should drive the definition of meaningful use consistent with the applicable provisions of Medicare and Medicaid law.

ARRA provides incentive payments to eligible professionals (EP), eligible hospitals, and critical access hospitals (CAH) participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology. This document attempts to describe and explain the initial criteria that eligible hospitals and CAHs must meet in order to qualify for an incentive payment.

Ultimately, meaningful use of certified EHR technology should result in health care that is patient centered, evidence-based, prevention-oriented, efficient, and equitable.

Though some functionalities are optional in Stage 1, all are considered crucial to maximize the value of certified EHR technology to the health care system. Many, if not all, of the optional functionalities will be included in Stage 2 and beyond. eligible hospitals and CAHs should be proactive in implementing all of the functionalities in order to prepare for later stages of meaningful use, particularly functionalities that improve patient care, enhance the efficiency of the health care system, and promote public and population health.

2.1 Meaningful Use

MU is defined as using certified EHR technology to:

- Improve quality, safety, and efficiency.
- Reduce health disparities.
- Engage patients and families in their healthcare.
- Improve care coordination.
- Improve population and public health.
- Maintain privacy and security.

ARRA specifies the following three components of Meaningful Use:

- Use of certified EHR in a meaningful manner.

- Use of certified EHR technology for electronic exchange of health information.
- Use of certified EHR technology to submit clinical quality measures (CQM).

EHR certification and MU are not the same:

- Certification is a formal process in which an EHR product's capabilities and performance are evaluated against established requirements:
  - For IHS-developed products, certification is the responsibility of OIT.
  - For commercial off the shelf (COTS) products, certification is the responsibility of the COTS developer or vendor.
- Attaining MU involves providing evidence of how the certified EHR is used to meet MU objectives.
- Demonstrating MU is the responsibility of providers and hospitals.

The EHR Deployment Team will deploy (implement) the certified EHR at sites that do not have it:

- The facility staff must:
  - Know the meaningful use requirements.
  - Use the EHR as needed to meet meaningful use.
- Resource and Patient Management System (RPMS) sites must be using certified EHR to meet meaningful use. In other words, sites using only RPMS roll-and-scroll will not meet meaningful use.
- Commercial vendors of EHRs are subject to the same meaningful use requirements, standards, process, and schedule as RPMS EHR.

2.2 Stage 1 Meaningful Use Considerations

- Incentive payments for hospitals are based on the Federal Fiscal Year.
- The 2011 reporting period for eligible hospitals and CAHs is any contiguous 90 calendar days in the Fiscal Year, consequently, in order to qualify for MU incentives in 2011, an eligible hospital or CAH must have a certified EHR plus all configurations and processes in place and working by the end of June 2011.
- To meet certain objectives/measures, 80% of the hospital's patients must have records in the certified EHR technology.
- Some meaningful use objectives are not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator. In this situation, the provider is excluded from having to meet that measure.

3.0 Using this Guide

Section 4.0 of this guide covers the MU Objectives applicable to an eligible hospital or CAH:

- Subsection 4.1 contains the Stage 1 Core Performance Measures. Within this subsection, individual third-level subsections describe each Core Performance Measure.
- Subsection 4.2 contains the Stage 1 Menu Set Performance Measures. Within this subsection, individual third-level subsections describe each Menu Set Performance Measure.

3.1 Standard Content

Each third-level subsection contains the following parts in the order shown:

- **Objective**: A direct quote of the Stage 1 Meaningful Use Objective for the item, taken from *42 CFR, Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule*.
- **Type of Measure**: Identifies which of the following methods is used to evaluate the provider's success in meeting the measure:
  - Attestation: The provider certifies whether the measure was met or not. With this type of measure, success is a *yes-or-no, all-or-nothing* proposition.
  - Rate: The EHR computes and reports a statistic indicating whether the measure was met or not. The factors to be counted in producing the statistic appear below the type of measure and are expressed as numerator and denominator statements separated by a horizontal line. To the right of this *fraction* is a number expressed as a percentage and preceded by a comparator (> [greater than] or ≥ [greater than or equal to]); this is the Rate that must be achieved for the provider to be considered successful in meeting the measure.

$$\frac{\text{The number of transitions of care in the denominator where medication reconciliation was performed.}}{\text{The number of transitions of care during the EHR reporting period for which the eligible hospital or CAH was the receiving party of the transition.}} > 50\%$$

This construct expresses the Rate as a quotient and compares it to the standard. In this example the measure is met when, "The number of transitions of care that included medication reconciliation divided by the total number of transitions of care is greater than 50%."

- **Threshold**: A restatement of the Stage 1 Meaningful Use Threshold for the item, taken from *42 CFR, Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule*.
- **RPMS MU Report Logic**: A fourth-level subsection to describe the program logic used by the MU report to determine if the eligible hospital or CAH is meeting the MU Performance Measure. The content of this subsection is organized in the form of pseudocode (a kind of structured English for describing algorithms) and includes one or more of the following:
  - **Measure Inclusions**: For attestation measures, provides the pseudocode describing the conditions leading to successful attainment of the Performance Measure.
  - **Numerator Inclusions**: For rate measures, provides the pseudocode describing the computation of the numerator value.
  - **Denominator Inclusions**: For rate measures, provides the pseudocode describing the computation of the denominator value.
  - **Measure Exclusion(s)**: Describes the conditions under which the provider is entirely exempt from having to meet the measure.
  - **Denominator Exclusion(s)**: Used when necessary to further describe specific data or types of data that are ignored when computing the count of items to include in the denominator.

Only those items included in the denominator are to be evaluated for inclusion in the numerator, consequently anything excluded from the denominator *is not counted* in the numerator.

3.2 Optional Content

When applicable, one or more fourth-level subsections may be included to provide step-by-step instructions on how to set up and use RPMS and/or EHR to meet the specific MU Performance Measure. Square brackets ([]) in the following list surround text that will vary depending upon the specific procedure being presented.

- **[RPMS Configuration]**: Contains instructions, illustrated with roll-and-scroll recordings, on how to configure the EHR using the RPMS roll and scroll.
- **[Other RPMS Process]**: Contains instructions, illustrated with roll-and-scroll recordings, on how to complete other RPMS processes that may be necessary to configure, arrange, or extract data for MU purposes.

Within these roll-and-scroll examples the use of an ellipsis between braces ({…}) indicates a place where a lengthy sequence of options was omitted to enhance readability and reduce the length of the example.

- **[EHR Use]**: Contains instructions, illustrated with screen captures, describing how to use the EHR graphical user interface (GUI) or how to check conformity with the MU Performance Measure via the EHR GUI.
- **[Other Process]**: Contains instructions on how to complete other processes necessary to configure, arrange, or extract data for MU purposes.

3.3 Guidelines and Cautions

Terminology: "Provider" and "eligible provider" are generic terms that encompass the terms Eligible Professional, eligible hospital, and eligible critical access hospital. When "provider," "eligible provider," or "hospital" appears in this document, it is analogous to "eligible hospital" or "eligible critical access hospital."

Enabling and Disabling Options: The configurability of RPMS makes it possible to choose setup options that will lead to failure in meeting MU. If in doubt, ask an MU expert before making changes, especially when it comes to loosening restrictive settings or disabling selection choices.

Cultural Sensitivity: When a requirement to collect certain data conflicts with cultural mores and preferences, the provider must take an approach that will meet MU requirements without offending patients' sensitivities. A simple rule to remember is, "MU-required data can be 'yes,' or 'no,' or something else entirely, but it cannot be blank."

Patient Base: Though administered by the Centers for Medicare and Medicaid Services (CMS), the MU incentives program requires that all patients be counted, not just those who are receiving Medicare or Medicaid benefits.

Transmit, Send, and Give: In general, the verb 'transmit' with its various permutations is used herein to describe the sending of information electronically; unless explicitly stated, successful receipt of the information is not part of the requirement nor is there an obligation to verify receipt. Similarly, do not over think the verbs 'send' and 'give'; a properly addressed and stamped envelope handed over to the US Postal Service qualifies as 'sent' and a printed document picked up by the patient's authorized representative is usually considered to have been 'given.'

Patient's Refusal to Answer: The provider is not penalized if a patient cannot or will not disclose information (such as the demographics asked for in Section 0); in such case, record the choice that covers the patient's response (for example, 'declined'). Again, what matters is that the field is not left empty.

Finally, this guide describes one way to configure and use RPMS and EHR to meet MU; it is likely not the only way, but it will produce the needed results.

4.0 Eligible Hospitals and CAHs

In order to meet MU requirements in Stage 1, eligible hospitals and CAHs must:

- Meet the 14 Stage 1 Core Performance Measures described in Section 4.1.
- Meet 5 of the 10 Stage 1 Menu Set Performance Measures described in Section 4.2.
- Meet 15 Clinical Quality Measures (Section 4.1.10).

4.1 Stage 1 Core Performance Measures

4.1.1 Computerized Provider Order Entry Medication Orders

Objective: "Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional authorized to enter orders into the medical record per state, local, and professional guidelines." *42 CFR Part 495.6,(d)(1)(i)*

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator who have at least one medication order entered using CPOE by a provider holding the ORES or ORELSE key and the order must be entered, signed, and released to the service.}}{\text{The number of unique patients admitted to an eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period who have at least one medication in their medication list.}} > 30\%$$

Threshold: More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE.

4.1.1.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator:

WHERE: one or more medications has a "Date Issue" during the EHR reporting period

AND WHERE: the "Nature of Order" for the counted medication is not = "written"

AND WHERE: the prescription was entered by a licensed healthcare professional holding the ORES or ORELSE key

AND WHERE: the order was entered, signed, and released to the service

Denominator Inclusions:

COUNT: each patient:

HAVING: one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

AND HAVING: one or more medications present as structured data on the patient's medication list

Measure Exclusion: None.

> All medication orders for the hospital's entire patient population are counted; not just those for Medicare and Medicaid patients.
>
> Transmission of the medication order is not required.
>
> The hospital must use the Certified EHR Technology.

4.1.1.2 Configure RPMS

1. Edit a drug for CPOE:

```
Select IHS Core Option: PDM
   Pharmacy Data Management

           CMOP Mark/Unmark (Single drug)
   DOS     Dosages ...
   DRED    Drug Enter/Edit
           Drug Interaction Management ...

Select Pharmacy Data Management Option: DRED
   Drug Enter/Edit

Select DRUG GENERIC NAME: AMOXI
  Lookup: GENERIC NAME
  1  AMOXICILLIN 250MG CAP U/D             AM111
  2  AMOXICILLIN 125MG/5ML SUSP            AM111
```

```
  3  AMOXICILLIN 250 MG DENTAL PROPHY      AM111
  4  AMOXICILLIN 250MG (30'S) CAP PREPACK  AM111
  5  AMOXICILLIN 250MG CAP                 AM111

CHOOSE 1-5: 5
   AMOXICILLIN 250MG CAP

***************************************************************************
This entry is marked for the following PHARMACY packages:
 Outpatient
 Non-VA Med
GENERIC NAME: AMOXICILLIN 250MG CAP  Replace
VA CLASSIFICATION: AM111//
DEA, SPECIAL HDLG: 6//

NATIONAL FORMULARY INDICATOR: YES
LOCAL NON-FORMULARY:
VISN NON-FORMULARY:
Select DRUG TEXT ENTRY:
Select FORMULARY ALTERNATIVE:
Select SYNONYM: 000029600632//
  SYNONYM: 000029600632//
  INTENDED USE: DRUG ACCOUNTABILITY//
  NDC CODE: 000029-6006-32//
Select SYNONYM:
MESSAGE:
RESTRICTION:
FSN: OK 4110.6-500//
INACTIVE DATE:
WARNING LABEL:
ORDER UNIT: BT//
DISPENSE UNIT: CAP//
DISPENSE UNITS PER ORDER UNIT: 500//
DISPENSE UNIT NCPDP CODE: AV
NDC: 00093-3107-05//
PRICE PER ORDER UNIT:
LAST PRICE UPDATE:
AWP PER ORDER UNIT: 118.95//
AWP PER DISP UNIT is 000000.23790
SOURCE OF SUPPLY:
DISPENSING LOCATION:
STORAGE LOCATION:
PRICE PER DISPENSE UNIT:
```

Points to AMOXICILLIN TRIHYDRATE 250MG CAP in the National Drug file.

```
This drug has already been matched and classified with the National Drug
file. In addition, if the dosage form changes as a result of rematching,
you will have to match/rematch to Orderable Item.

Do you wish to match/rematch to NATIONAL DRUG file? No//   (No)
Just a reminder...you are editing AMOXICILLIN 250MG CAP.

Strength from National Drug File match => 250    MG
Strength currently in the Drug File    => 250    MG

Strength => 250   Unit => MG
```

```
POSSIBLE DOSAGES:
   DISPENSE UNITS PER DOSE: 1         DOSE: 250MG           PACKAGE: IO

LOCAL POSSIBLE DOSAGES:

Do you want to edit the dosages? N
```

2. Mark the drug for its intended use if necessary (it should be marked as Non-VA):

```
This entry is marked for the following PHARMACY packages:
 Outpatient
 Non-VA Med

MARK THIS DRUG AND EDIT IT FOR:
O  - Outpatient
U  - Unit Dose
I  - IV
W  - Ward Stock
D  - Drug Accountability
C  - Controlled Substances
X  - Non-VA Med
A  - ALL

Enter your choice(s) separated by commas :

** You are NOW in the ORDERABLE ITEM matching for the dispense drug. **

AMOXICILLIN 250MG CAP is already matched to

     AMOXICILLIN CAP,ORAL

Do you want to match to a different Orderable Item? NO//

Select DRUG GENERIC NAME:
```

3. Create or edit the Quick Order for the drug:

```
Select IHS Core Option: EHR
   EHR MAIN MENU

   BEH    RPMS-EHR Configuration Master Menu ...
   CON    Consult Management ...
   CPRS   CPRS Manager Menu ...
   HS     Health Summary Maintenance ...
   REM    Reminder Managers Menu ...
   TIU1   TIU Menu for Clinicians ...
   TIU2   TIU Menu for Medical Records ...
   VAHS   Health Summary Overall Menu ...
          -----------------------------
   FM     VA FileMan ...
   PTCH   Display Patches for a Package
   SIG    Clear Electronic signature code
   XX     General Parameter Tools ...

Select EHR MAIN MENU Option: BEH
   RPMS-EHR Configuration Master Menu
DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                     RPMS-EHR Configuration Master Menu
```

```
   ART    Adverse Reaction Tracking Configuration ...
   CCX    Chief Complaint Configuration ...
   CON    Consult Tracking Configuration ...
   EDU    Patient Education Configuration ...
   ENC    Encounter Context Configuration ...
   EXM    Exam Configuration ...
   FRM    VueCentric Framework Configuration ...
   HFA    Health Factor Configuration ...
   IMG    VistA Imaging Extensions ...
   IMM    Immunization Configuration ...
   LAB    Lab Configuration ...
   MED    Medication Management Configuration ...
   NOT    Notification Configuration ...
   ORD    Order Entry Configuration ...
   PAT    Patient Context Configuration ...

Select RPMS-EHR Configuration Master Menu Option: ORD
   Order Entry Configuration

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                       Order Entry Configuration

   DOC    Delayed Orders Configuration ...
   KEY    Key Management ...
   MNU    Order Menu Management ...
   OCX    Order Check Configuration ...

Select Order Entry Configuration Option: MNU
   Order Menu Management

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                          Order Menu Management

   ACT    Create/Modify Actions
   DIS    Enable/Disable Order Dialogs
   GEN    Create/Modify Generic Orders
   LST    List Primary Order Menus
   MNU    Create/Modify Order Menus
   OIC    Create/Modify Orderable Items
   PAR    Menu Parameters ...
   PMT    Create/Modify Prompts
   PRI    Assign Primary Order Menu
   PRT    Convert Protocols
   QOC    Create/Modify Quick Orders
   QOR    Create/Modify QO Restrictions

Select Order Menu Management Option: QOC
   Create/Modify Quick Orders

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                        Create/Modify Quick Orders
Select QUICK ORDER NAME: PSOZ AMOXICILLIN 250MG PO TID
  Are you adding 'PSOZ AMOXICILLIN 250MG PO TID' as
    a new ORDER DIALOG? No// Y  (Yes)
TYPE OF QUICK ORDER: OUTPATIENT MEDICATIONS
NAME: PSOZ AMOXICILLIN 250MG PO TID  Replace
DISPLAY TEXT: Amoxicillin 250MG PO TID
VERIFY ORDER: Y  YES
DESCRIPTION:
  No existing text
  Edit? NO//
```

```
ENTRY ACTION:

Medication: AMOXICILLIN
     1   AMOXICILLIN CAP,ORAL
     2   AMOXICILLIN PWDR,RENST-ORAL
     3   AMOXICILLIN/CLAVULANATE PWDR,RENST-ORAL
     4   AMOXICILLIN/CLAVULANATE TAB
CHOOSE 1-4: 1
   AMOXICILLIN CAP,ORAL
Complex dose? NO//
Choose from (or enter another):
     1   250MG
     2   500MG
     3   1000MG
     4   2000MG
Dose: 1
   250MG
Route: ORAL//
Schedule: TID//

Patient Instructions: FOR INFECTION TREATMENT; TAKE UNTIL FINISHED
Include Patient Instructions in Sig? YES//
Chronic Med?// NO
Dispense as Written?// NO
Days Supply: 10
Quantity (CAP): 30
Refills (0-11): 0
Pick Up: WINDOW
Pharmacy://
SureScripts Pharmacy Information
  Edit? No//   (No)
APSP REFILL REQUEST entry//
Priority: ROUTINE//
Comments:
  No existing text
  Edit? No//   (No)
Indication://
Indication ICD9://

---------------------------------------------------------------------------
                  Medication: AMOXICILLIN CAP,ORAL  250MG
                Instructions: 250MG ORAL TID
        Patient Instructions: FOR INFECTION TREATMENT; TAKE UNTIL FINI ...
                 Days Supply: 10
              Quantity (CAP): 30
              Refills (0-11): 0
                     Pick Up: WINDOW
                    Priority: ROUTINE
---------------------------------------------------------------------------

(P)lace, (E)dit, or (C)ancel this quick order? PLACE//
Auto-accept this order? NO//

Select QUICK ORDER NAME:
```

4. Place the quick order on an order menu:

```
Menu Editor                Apr 19, 2011 13:59:56         Page:    1 of    3
Menu: PSOZM OUTPATIENT MEDS                                Column Width: 40
 1                                                   2
```

```
|   Amlodipine 5mg PO DAILY                Furosemide 20mg PO BID
|   Amoxicillin 250mg/5ml Susp 5ml PO Q8H  Glyburide 2.5mg PO QAM
|   Atorvastatin 10mg PO DAILY             Hydrochlorothiazide 25mg PO BID
|   Azithromycin 250mg PO DAILY X 10 DAYS  Ipratropium Inhale 2 Puffs QID
+   Captopril 25mg PO TID                  Lisinopril 30mg PO DAILY
|   Clonidine 0.1mg PO BID                 Metaproterenol MDI 2 Puffs Q4H
|   Clopidogrel 75mg PO Daily              Nitrofurantoin 100mg PO DAILY
|   Digoxin 0.125mg PO DAILY               Nitrofurantoin 100mg PO BID
|   Docusate 100mg PO BID                  Potassium Chloride 10mEq PO BID
1   Doxazosin 2mg PO DAILY                 Potassium Chloride 20mEq PO BID
|   Erythromycin Oral Susp 250mg PO Q6H    Spironolactone 25mg PO QID
|   Erythromycin Ethylsuccinate (EES) 400
+
|   ALL OUTPATIENT MEDICATIONS...
+         + Next Screen  - Prev Screen  ?? More Actions                >>>
  Add ...           Edit ...            Assign to User(s)   Select New Menu
  Remove ...          Toggle Display      Order Dialogs ...
Select Action: Next Screen//

  Add ...           Edit ...            Assign to User(s)   Select New Menu
  Remove ...          Toggle Display      Order Dialogs ...
Select Action: Next Screen// AD

AD   Add ...
    Menu Items                Text or Header            Row

Add: M   Menu Items
ITEM: PSOZ AMOXIC
     1   PSOZ AMOXICILLIN 250/5 5ML PO Q8H F10D
     2   PSOZ AMOXICILLIN 250MG CAPSULE TID
CHOOSE 1-2: 2  PSOZ AMOXICILLIN 250MG CAPSULE TID
ROW: 3
COLUMN: 1
There is another item in this position already!
Do you want to shift items in this column down? YES//
DISPLAY TEXT:
MNEMONIC:

ITEM:

Rebuilding menu display

Menu Editor                 Apr 19, 2011 14:15:17        Page:    1 of    3
Menu: PSOZM OUTPATIENT MEDS                                Column Width: 40
 1                                        2
|   Amlodipine 5mg PO DAILY                Furosemide 20mg PO BID
|   Amoxicillin 250mg/5ml Susp 5ml PO Q8H  Glyburide 2.5mg PO QAM
|   Amoxicillin 250MG PO TID               Hydrochlorothiazide 25mg PO BID
|   Atorvastatin 10mg PO DAILY             Ipratropium Inhale 2 Puffs QID
+   Azithromycin 250mg PO DAILY X 10 DAYS  Lisinopril 30mg PO DAILY
|   Captopril 25mg PO TID                  Metaproterenol MDI 2 Puffs Q4H
|   Clonidine 0.1mg PO BID                 Nitrofurantoin 100mg PO DAILY
|   Clopidogrel 75mg PO Daily              Nitrofurantoin 100mg PO BID
|   Digoxin 0.125mg PO DAILY               Potassium Chloride 10mEq PO BID
1   Docusate 100mg PO BID                  Potassium Chloride 20mEq PO BID
|   Doxazosin 2mg PO DAILY                 Spironolactone 25mg PO QID
|   Erythromycin Oral Susp 250mg PO Q6H
|   Erythromycin Ethylsuccinate (EES) 400
+
         + Next Screen  - Prev Screen  ?? More Actions                >>>
  Add ...           Edit ...          Assign to User(s)   Select New Menu
```

```
  Remove ...          Toggle Display      Order Dialogs ...
Select Action: Next Screen//
```

4.1.1.3 Overview of the Ordering Keys

The ORES key is typically given to providers who are, by virtue of their credentials and license, authorized to independently write orders.

The ORELSE key is typically given to providers who are, by virtue of their credentials and license, authorized to carry out orders.

If a provider (ORES key holder) enters and releases the order, it counts for CPOE regardless of how it is released.

If a nurse (ORELSE key holder) enters and releases by policy, it counts for CPOE.

Med Orders:

- Med orders entered by ORELSE key holders and signed on chart or hold until signed count against CPOE.
- Providers should not write orders in the body of their notes for meds that require transcription into the pharmacy package.
- Workflow does sometimes necessitate that some orders be entered by Pharmacy or Nursing staff and sent to provider for review and signature.

Nature of Order:

When an ORES key holder orders medications the orders are automatically marked as electronic and count as CPOE.

When an ORELSE key holder (Nurse, Pharmacist) enters orders and marks them as Policy they count as CPOE for this MU measure. “Policy” should only be used for situations when an actual policy exists that allows the order to be made in behalf of the provider.

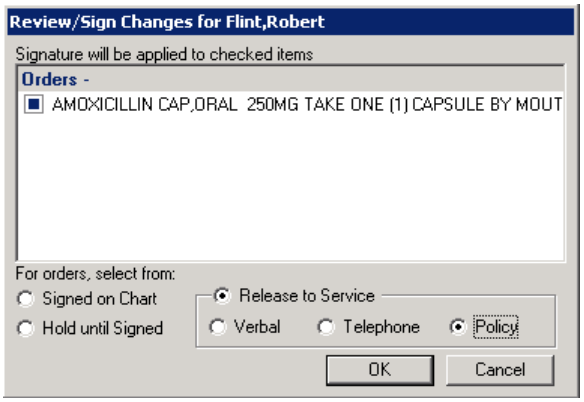


Figure 4-1: Medication order entered as Policy by a holder of the ORELSE key

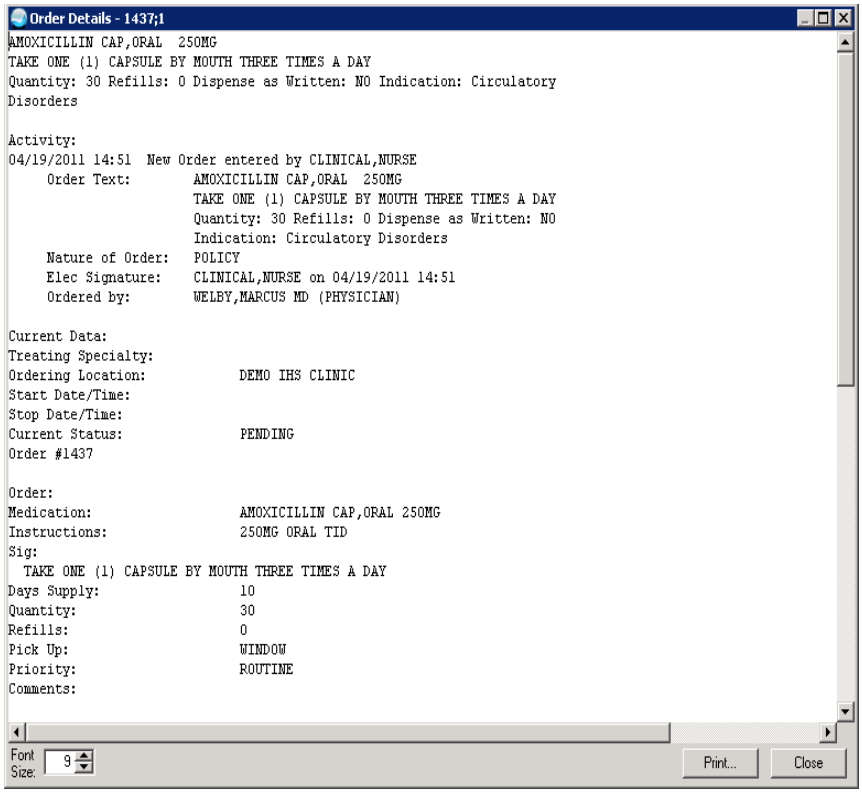


Figure 4-2: Order Details dialog showing an order that counts towards CPOE

4.1.1.4 Order a medication in EHR (preferred method)

1. Select the **Orders** tab:

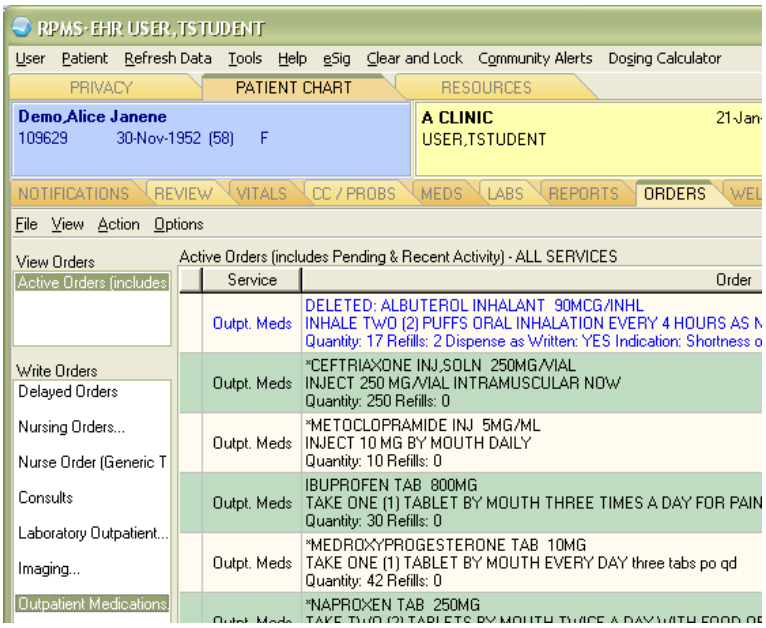


Figure 4-3: EHR Orders tab

2. Click **Outpatient Medications** in the **Write Orders** pane to display the Outpatient Medications dialog:

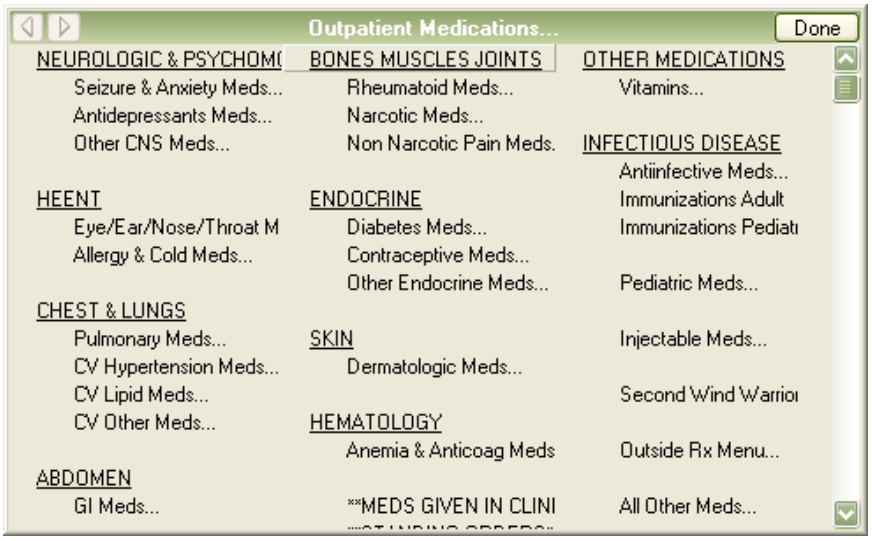


Figure 4-4: Outpatient Medications dialog

3. Navigate through the screens to find the medication or medication group (preferred method):

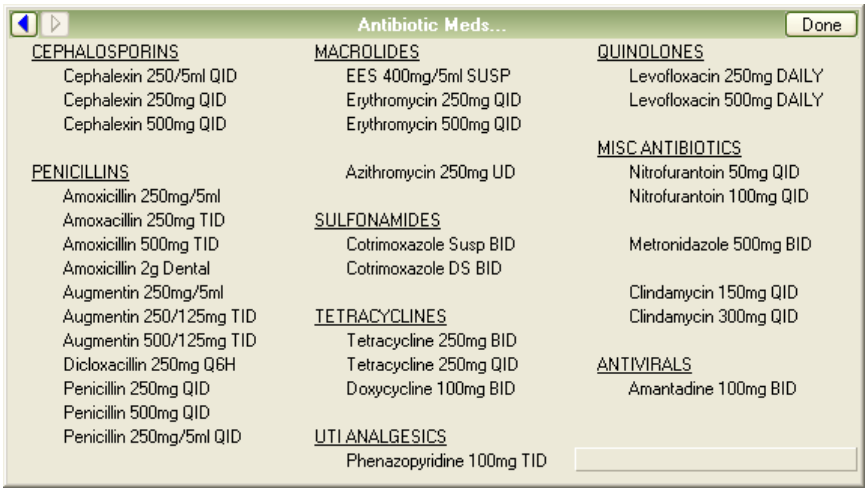


Figure 4-5: Antibiotic Medications dialog

4. Click the medication name to open the **Medication Order** dialog:

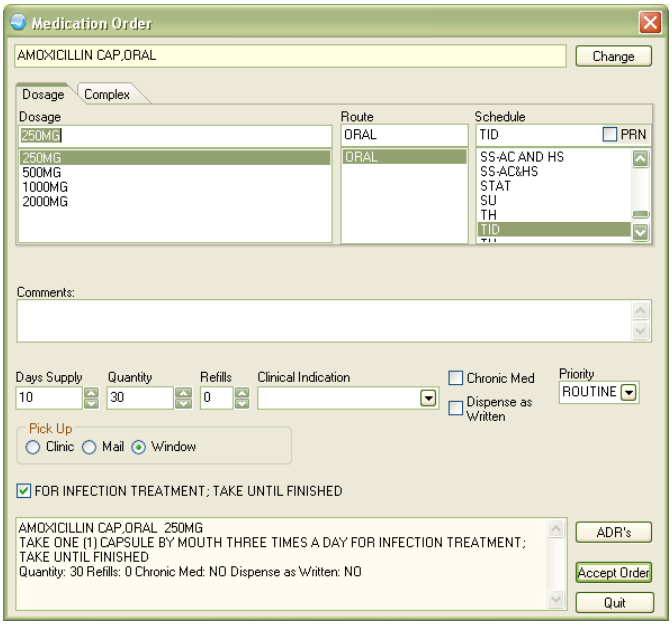


Figure 4-6: Medication Order dialog

5. Make any needed changes to the information on the Medication Order dialog.

6. Click **Accept Order** to complete the Medication Order and return to the Orders tab:

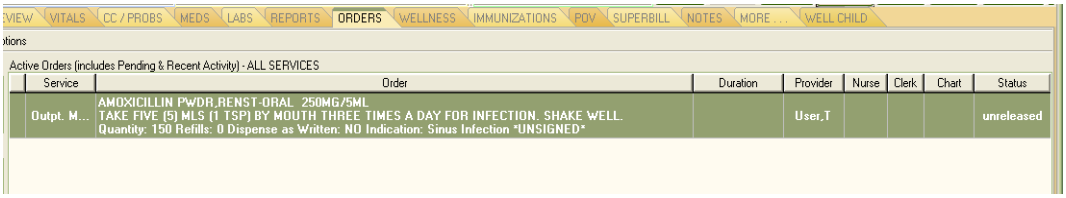


Figure 4-7: Orders tab, new Medication Order displayed

7. Review and sign the order:

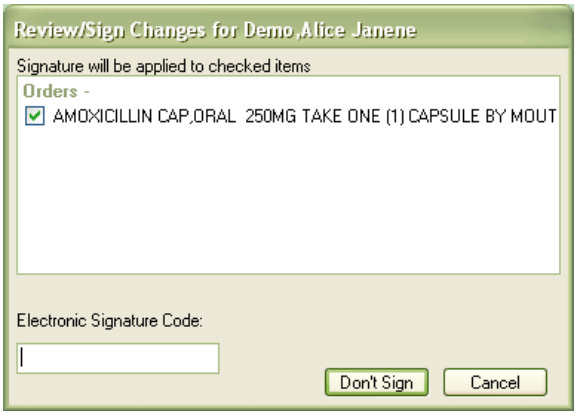


Figure 4-8: Review/Sign Changes dialog

8. The status of the Medication Order is changed to ***pending***:

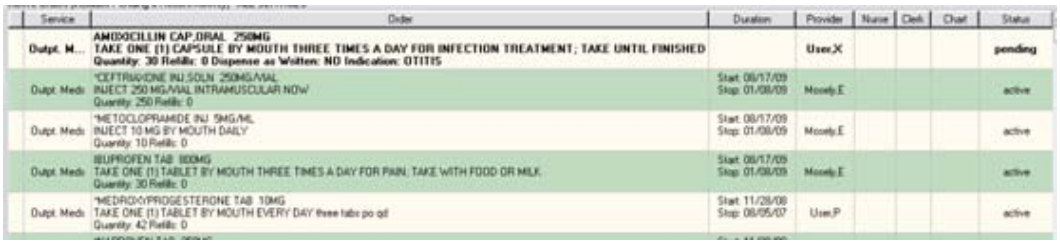


Figure 4-9: Medication List showing new pending Medication Order

4.1.1.5 Order a medication in EHR (if no quick order exists)

1. Select the **Orders** tab (see Section 4.1.1.4, Step 1).

2. Click **Outpatient Medications** in the **Write Orders** pane to display the Outpatient Medications dialog:

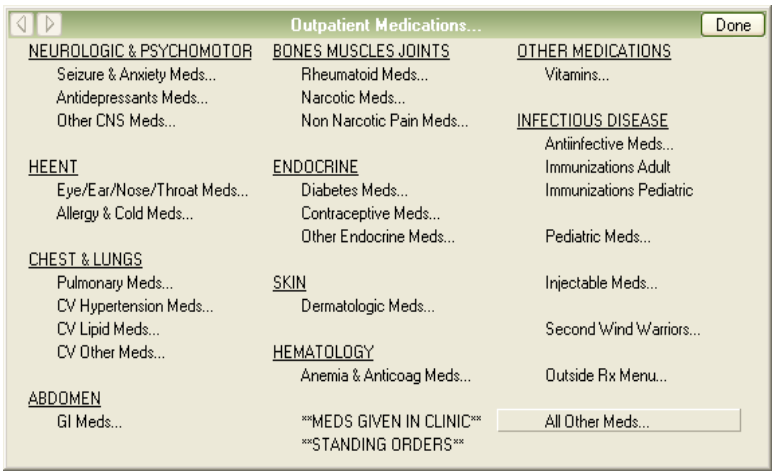


Figure 4-10: Outpatient Medications dialog

3. Click All Other Meds at the Outpatient Medications dialog to display the Medication Order selection dialog:

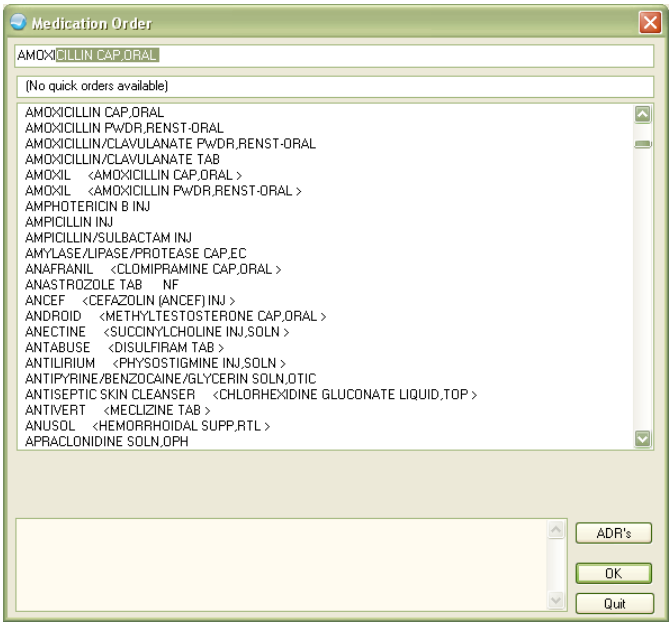


Figure 4-11: Medication Order selection dialog

4. Find a medication in the list by typing its name in the uppermost field; the list is filtered to present matching medications.

5. Click the medication in the list to open the **Medication Order** dialog:

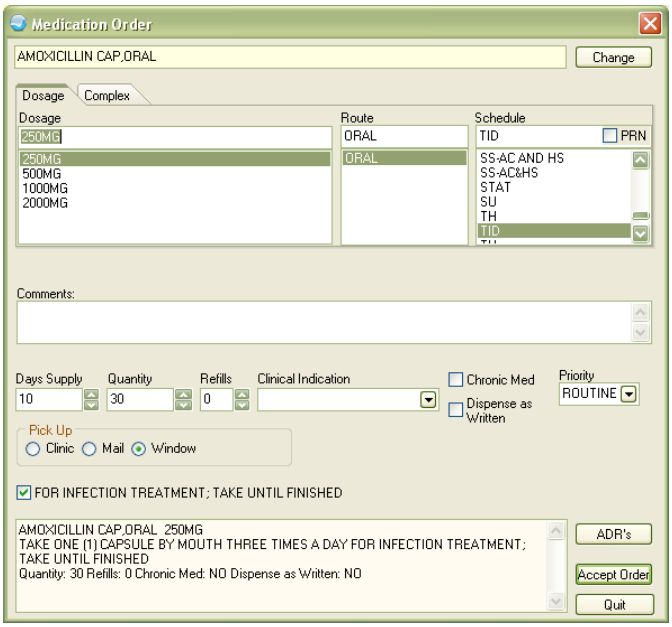


Figure 4-12: Medication Order dialog

6. Continue at Section 4.1.1.4, Step 5.

4.1.2 Drug-Drug & Drug-Allergy Checks

Objective: "Implement drug-drug and drug-allergy checks." *42 CFR Part 495.6,(d)(2)(i)*

Type of Measure: Attestation

Threshold: The provider has enabled drug-drug and drug-allergy for the entire EHR reporting period.

> The provider is not required to act on the checks in order to meet the measure.

4.1.2.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

WHO: have enabled both the drug-drug and drug-allergy checks during the entire EHR reporting period.

> The report will display "Yes" if the checks are turned on, or "No" if they are turned off.

Measure Exclusion: None.

4.1.2.2 Configure RPMS

1. Set the Allergy Package parameters:

```
Select GMR ALLERGY SITE PARAMETERS NAME:

   1      Edit Allergy File
   2      Enter/Edit Signs/Symptoms Data
   3      Enter/Edit Site Parameters
   4      Sign/Symptoms List
   5      Allergies File List

Select Enter/Edit Site Configurable Files Option: 3
   Enter/Edit Site Parameters

Select GMR ALLERGY SITE PARAMETERS NAME: HOSPITAL

NAME: HOSPITAL// (No editing)
Select DIVISION: DEMO HOSPITAL//

The following are the ten most common signs/symptoms:

 1. ANXIETY                          6. DIARRHEA
 2. ITCHING,WATERING EYES            7. HIVES
```

```
 3. HYPOTENSION                      8. DRY MOUTH
 4. DROWSINESS                       9. ANAPHYLAXIS
 5. NAUSEA,VOMITING                 10. RASH

Enter the number of the sign/symptom that you would like to edit:

AUTOVERIFY FOOD/DRUG/OTHER: NO AUTOVERIFY// ?
     Choose from:
       0        NO AUTOVERIFY
       1        AUTOVERIFY DRUG ONLY
       2        AUTOVERIFY FOOD ONLY
       3        AUTOVERIFY DRUG/FOOD
       4        AUTOVERIFY OTHER ONLY
       5        AUTOVERIFY DRUG/OTHER
       6        AUTOVERIFY FOOD/OTHER
       7        AUTOVERIFY ALL
AUTOVERIFY FOOD/DRUG/OTHER: NO AUTOVERIFY//
AUTOVERIFY OBSERVED/HISTORICAL: NO AUTOVERIFY//
AUTOVERIFY LOGICAL OPERATOR: AND//
REQUIRE ORIGINATOR COMMENTS: NO//
MARK ID BAND FLAG: NO//
METHOD OF NOTIFICATION: BULLETIN//
ALERT ID BAND/CHART MARK: NO//
SEND CHART MARK BULLETIN FOR NEW ADMISSIONS: NO//
FDA DATA REQUIRED: NO//
ENABLE COMMENTS FIELD FOR REACTIONS THAT ARE ENTERED IN ERROR: YES

REPORTER NAME:
      ADDRESS: CHEROKEE INDIAN HOSPITAL
               HOSPITAL ROAD
         CITY: CHEROKEE
        STATE: NORTH CAROLINA
          ZIP: 28719
        PHONE: 828-497-9163
   OCCUPATION:
Do you want to edit Reporter Information shown above? No
```

2. Set the allergy parameters in EHR:

```
Select RPMS-EHR Configuration Master Menu Option: ART
Adverse Reaction Tracking Configuration

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                  Adverse Reaction Tracking Configuration

   AUT    Automatic Signature of Adverse Reaction Data
   ENT    Enable Adverse Reaction Data Entry
   VER    Allow Adverse Reaction Verification

Select Adverse Reaction Tracking Configuration Option: AUT
Automatic Signature of Adverse Reaction Data

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                  Automatic Signature of Adverse Reaction Data

Force automatic signature of ADR entries may be set for the following:

     100 User          USR    [choose from NEW PERSON]
     200 Class         CLS    [choose from USR CLASS]
     800 Division      DIV    [choose from INSTITUTION]
```

```
     900 System        SYS    [DEMO-HO.IHS.GOV]

Enter selection: 900  System   DEMO-HO.IHS.GOV

Setting Force automatic signature of ADR entries
   for System: DEMO-HO.IHS.GOV
Automatic signature of ADR entries?: NO

   AUT    Automatic Signature of Adverse Reaction Data
   ENT    Enable Adverse Reaction Data Entry
   VER    Allow Adverse Reaction Verification

Select Adverse Reaction Tracking Configuration Option: ENT
Enable Adverse Reaction Data Entry

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                       Enable Adverse Reaction Data Entry

Allow entry of adverse reaction data may be set for the following:

     100 User          USR    [choose from NEW PERSON]
     200 Class         CLS    [choose from USR CLASS]
     800 Division      DIV    [choose from INSTITUTION]
     900 System        SYS    [DEMO-HO.IHS.GOV]

Enter selection: 900
System   DEMO-HO.IHS.GOV

Setting Allow entry of adverse reaction data for System: DEMO-HO.IHS.GOV
Allow entry of adverse reaction data?: YES
```

3. Enable Order Checks:

```
EHR MAIN MENU

   BEH    RPMS-EHR Configuration Master Menu ...
   CON    Consult Management ...

Select EHR MAIN MENU Option: BEH
   RPMS-EHR Configuration Master Menu
DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                      RPMS-EHR Configuration Master Menu

   ART    Adverse Reaction Tracking Configuration ...
   CCX    Chief Complaint Configuration ...
   CON    Consult Tracking Configuration ...
   EDU    Patient Education Configuration ...
   ENC    Encounter Context Configuration ...
   EXM    Exam Configuration ...
   FRM    VueCentric Framework Configuration ...
   HFA    Health Factor Configuration ...
   IMG    VistA Imaging Extensions ...
   IMM    Immunization Configuration ...
   LAB    Lab Configuration ...
   MED    Medication Management Configuration ...
   NOT    Notification Configuration ...
   ORD    Order Entry Configuration ...
   PAT    Patient Context Configuration ...
```

```
Select RPMS-EHR Configuration Master Menu Option: ORD
   Order Entry Configuration
DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                        Order Entry Configuration
   DOC    Delayed Orders Configuration ...
   KEY    Key Management ...
   MNU    Order Menu Management ...
   OCX    Order Check Configuration ...
   PAR    Order Parameters ...

Select Order Entry Configuration Option: OCX
   Order Check Configuration
DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                           Order Check Configuration
   ACT    Activate/Inactivate Rules
   COM    Compile Rules
   ENA    Enable/Disable Order Checking System
   INQ    Expert System Inquiry
   PAR    Order Check Parameters ...

Select Order Check Configuration Option: ENA
   Enable/Disable Order Checking System

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                      Enable/Disable Order Checking System

Enable or disable order checking system. may be set for the following:
     1   Division      DIV    [choose from INSTITUTION]
     2   System        SYS    [DEMO-HO.IHS.GOV]
     3   Package       PKG    [ORDER ENTRY/RESULTS REPORTING]

Enter selection: 2
   System   DEMO-HO.IHS.GOV

Setting Enable or disable order checking system for System: DEMO-HO.IHS.GOV
Value: Enable//
```

4. Configure the ten required Order Checks:

```
Select Order Check Parameters Option: ENA
Enable/Disable an Order Check

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                      Enable/Disable an Order Check

Order Check Processing Flag may be set for the following:
     1   User          USR    [choose from NEW PERSON]
     2   Location      LOC    [choose from HOSPITAL LOCATION]
     3   Service       SRV    [choose from SERVICE/SECTION]
     4   Division      DIV    [choose from INSTITUTION]
     5   System        SYS    [DEMO-HO.IHS.GOV]
     6   Package       PKG    [ORDER ENTRY/RESULTS REPORTING]

Enter selection: 5
   System   DEMO-HO.IHS.GOV

--- Setting Order Check Processing Flag  for System: DEMO-HO.IHS.GOV ---
Select Order Check: ??

   Choose from:
```

```
   ALLERGIES UNASSESSIBLE
   ALLERGY-CONTRAST MEDIA INTERAC
   ALLERGY-DRUG INTERACTION
   AMINOGLYCOSIDE ORDERED
   BIOCHEM ABNORMALITY FOR CONTRA
   CLOZAPINE APPROPRIATENESS
   CRITICAL DRUG INTERACTION
   CT & MRI PHYSICAL LIMITATIONS
   DANGEROUS MEDS FOR PT > 64
   DISPENSE DRUG NOT SELECTED
   DUPLICATE DRUG CLASS ORDER
   DUPLICATE DRUG ORDER
   DUPLICATE OPIOID MEDICATIONS
   DUPLICATE ORDER
   ERROR MESSAGE
   ESTIMATED CREATININE CLEARANCE
   GENERIC RESULTS
   GLUCOPHAGE-CONTRAST MEDIA
   GLUCOPHAGE-LAB RESULTS
   LAB ORDER FREQ RESTRICTIONS
   MISSING LAB TESTS FOR ANGIOGRA
   NO ALLERGY ASSESSMENT
   ORDER CHECKING NOT AVAILABLE
   POLYPHARMACY
   RECENT BARIUM STUDY
   RECENT ORAL CHOLECYSTOGRAM
   RENAL FUNCTIONS OVER AGE 65
   SIGNIFICANT DRUG INTERACTION

Select Order Check: ALLERGIES UNASSESSIBLE
Are you adding ALLERGIES UNASSESSIBLE as a new Order Check? YES

Order Check: ALLERGIES UNASSESSIBLE //
   ALLERGIES UNASSESSIBLE   ALLERGIES UNASSESSIBLE
Value: Enabled//

Select Order Check: ALLERGY-CONTRAST MEDIA INTERACTION
Are you adding ALLERGY-CONTRAST MEDIA INTERACTION as a new Order Check? YES

Order Check: ALLERGY-CONTRAST MEDIA INTERACTION//
   ALLERGY-CONTRAST MEDIA INTERACTION   ALLERGY-CONTRAST MEDIA INTERACTION
Value: Enabled//

Select Order Check: ALLERGY-DRUG INTERACTION
Are you adding ALLERGY-DRUG INTERACTION as a new Order Check? YES

Order Check: ALLERGY-DRUG INTERACTION // ALLERGY-DRUG INTERACTION
   ALLERGY-DRUG INTERACTION
Value: Enabled//

Select Order Check: CRITICAL DRUG INTERACTION
Are you adding CRITICAL DRUG INTERACTION as a new Order Check? YES

Order Check: CRITICAL DRUG INTERACTION //   CRITICAL DRUG INTERACTION
CRITICAL DRUG INTERACTION
Value: Enabled//

Select Order Check: DANGEROUS MEDS FOR PT > 64
Are you adding DANGEROUS MEDS FOR PT > 64 as a new Order Check? YES
```

```
Order Check: DANGEROUS MEDS FOR PT > 64 //   DANGEROUS MEDS FOR PT > 64
DANGEROUS MEDS FOR PT > 64
Value: Enabled//

Select Order Check: ESTIMATED CREATININE CLEARANCE
Are you adding ESTIMATED CREATININE CLEARANCE as a new Order Check? YES

Order Check: ESTIMATED CREATININE CLEARANCE //   ESTIMATED CREATININE
CLEARANCE   ESTIMATED CREATININE CLEARANCE
Value: Enabled//

Select Order Check: GLUCOPHAGE-CONTRAST MEDIA
Are you adding GLUCOPHAGE-CONTRAST MEDIA as a new Order Check? YES

Order Check: GLUCOPHAGE-CONTRAST MEDIA //   GLUCOPHAGE-CONTRAST MEDIA
GLUCOPHAGE-CONTRAST MEDIA
Value: Enabled//

Select Order Check: GLUCOPHAGE-LAB RESULTS
Are you adding GLUCOPHAGE-LAB RESULTS as a new Order Check? YES

Order Check: GLUCOPHAGE-LAB RESULTS //   GLUCOPHAGE-LAB RESULTS
GLUCOPHAGE-LAB RESULTS
Value: Enabled//

Select Order Check: NO ALLERGY ASSESSMENT
Are you adding NO ALLERGY ASSESSMENT as a new Order Check? YES

Order Check: NO ALLERGY ASSESSMENT //   NO ALLERGY ASSESSMENT   NO ALLERGY
ASSESSMENT
Value: Enabled//

Select Order Check: RENAL FUNCTIONS OVER AGE 65
Are you adding RENAL FUNCTIONS OVER AGE 65 as a new Order Check? YES

Order Check: RENAL FUNCTIONS OVER AGE 65//   RENAL FUNCTIONS OVER AGE 65
RENAL FUNCTIONS OVER AGE 65
Value: Enabled//

Select Order Check:
```

5. Mark the Order Checks as Mandatory:

```
Select Order Check Parameters Option: EDT
Mark Order Checks Editable by User

DEMO HOSPITAL                 RPMS-EHR Management
Version 1.1
                       Mark Order Checks Editable by User

Order Check On/Off Editable by User may be set for the following:

     1   Division      DIV    [choose from INSTITUTION]
     2   System        SYS    [DEMO-HO.IHS.GOV]

Enter selection: 2
System   DEMO-HO.IHS.GOV

-- Setting Order Check On/Off Editable by User  for System: DEMO-HO.IHS.GOV
--
```

```
Select Order Check: ??

   Choose from:
   ALLERGIES UNASSESSIBLE
   ALLERGY-CONTRAST MEDIA INTERAC
   ALLERGY-DRUG INTERACTION
   AMINOGLYCOSIDE ORDERED
   BIOCHEM ABNORMALITY FOR CONTRA
   CLOZAPINE APPROPRIATENESS
   CRITICAL DRUG INTERACTION
   CT & MRI PHYSICAL LIMITATIONS
   DANGEROUS MEDS FOR PT > 64
   DISPENSE DRUG NOT SELECTED
   DUPLICATE DRUG CLASS ORDER
   DUPLICATE DRUG ORDER
   DUPLICATE OPIOID MEDICATIONS
   DUPLICATE ORDER
   ERROR MESSAGE
   ESTIMATED CREATININE CLEARANCE
   GENERIC RESULTS
   GLUCOPHAGE-CONTRAST MEDIA
   GLUCOPHAGE-LAB RESULTS
   LAB ORDER FREQ RESTRICTIONS
   MISSING LAB TESTS FOR ANGIOGRA
   NO ALLERGY ASSESSMENT
   ORDER CHECKING NOT AVAILABLE
   POLYPHARMACY
   RECENT BARIUM STUDY
   RECENT ORAL CHOLECYSTOGRAM
   RENAL FUNCTIONS OVER AGE 65
   SIGNIFICANT DRUG INTERACTION

Select Order Check: ALLERGIES UNASSESSIBLE
Order Check: ALLERGIES UNASSESSIBLE //   ALLERGIES UNASSESSIBLE   ALLERGIES
UNASSESSIBLE
Editable by User?: NO

Select Order Check: ALLERGY-CONTRAST MEDIA INTERACTION
Order Check: ALLERGY-CONTRAST MEDIA INTERACTION//   ALLERGY-CONTRAST MEDIA
INTERACTION   ALLERGY-CONTRAST MEDIA INTERACTION
Editable by User?: NO

Select Order Check:
ALLERGY-DRUG INTERACTION
Order Check: ALLERGY-DRUG INTERACTION//   ALLERGY-DRUG INTERACTION
ALLERGY-DRUG INTERACTION
Editable by User?: NO

Select Order Check:
CRITICAL DRUG INTERACTION
Order Check: CRITICAL DRUG INTERACTION//   CRITICAL DRUG INTERACTION
CRITICAL DRUG INTERACTION
Editable by User?: NO

Select Order Check:
DANGEROUS MEDS FOR PT > 64
Order Check: DANGEROUS MEDS FOR PT > 64 //   DANGEROUS MEDS FOR PT > 64
DANGEROUS MEDS FOR PT > 64
Editable by User?: NO

Select Order Check:
```

```
ESTIMATED CREATININE CLEARANCE
Order Check: ESTIMATED CREATININE CLEARANCE//   ESTIMATED CREATININE
CLEARANCE   ESTIMATED CREATININE CLEARANCE
Editable by User?: NO

Select Order Check:
GLUCOPHAGE-CONTRAST MEDIA
Order Check: GLUCOPHAGE-CONTRAST MEDIA//   GLUCOPHAGE-CONTRAST MEDIA
GLUCOPHAGE-CONTRAST MEDIA
Editable by User?: NO

Select Order Check:
GLUCOPHAGE-LAB RESULTS
Order Check: GLUCOPHAGE-LAB RESULTS//   GLUCOPHAGE-LAB RESULTS
GLUCOPHAGE-LAB RESULTS
Editable by User?: N
O
Select Order Check:
NO ALLERGY ASSESSMENT
Order Check: NO ALLERGY ASSESSMENT//   NO ALLERGY ASSESSMENT   NO ALLERGY
ASSESSMENT
Editable by User?: NO

Select Order Check:
RENAL FUNCTIONS OVER AGE 65
Order Check: RENAL FUNCTIONS OVER AGE 65//   RENAL FUNCTIONS OVER AGE 65
RENAL FUNCTIONS OVER AGE 65
Editable by User?: NO

Select Order Check:
```

6. Review all order checks by Division level and by individual provider; delete any that are set at the ‘User’ level.

7. Run the Allergy Cleanup Utility (requires EHR Patch 8):

```
Select Core Applications Option: ALL
   Adverse Reaction Tracking

   1      Enter/Edit Site Configurable Files ...
   2      Adverse Reaction Tracking User Menu ...
   3      Adverse Reaction Tracking Clinician Menu ...
   4      Adverse Reaction Tracking Verifier Menu ...
   5      P&T Committee Menu ...

Select Adverse Reaction Tracking Option: 1
   Enter/Edit Site Configurable Files

   1      Edit Allergy File
   2      Enter/Edit Signs/Symptoms Data
   3      Enter/Edit Site Parameters
   4      Sign/Symptoms List
   5      Allergies File List
   6      Allergy clean up utility

Select Enter/Edit Site Configurable Files Option: 6
   Allergy clean up utility

     Select one of the following:
```

```
          1         Free Text
          2         Ingredient
          3         Drug Class

Select the list you wish to work with: 1
   Free Text

The free text list was last built on Dec 03, 2010

Do you want to rebuild the list? YES
Building list of free text allergies...this may take a few minutes

Allergy Tracking Free Text Entries
    Reactant               # Active Entries
1   AC I/ARB                        1
2   ACEI                            4
3   ACTIFED                         1
4   ADVERSE DRUG REACTION H202      1
5   AKE: ACI                        1
6   ALL ANTIBIOTIC UNKNOWN          1
7   ALL DYES                        1
8   ALL EYE DROPS                   1
9   ALL NSAIDS                      1
10  ALL TAPES                       1
11  ALLERGIC TO DYE                 1
12  AMPICILLINS (ALL)               1
13  ANESTHESIA MEDS                 1
14  ANGIOGRAM DYE                   1
15  ANTI-INFLAMMATORIES DUE TO MS   1
16  ANTIBIOTIC ALLERGY              1
17  ANTIHISTAMINES                  1

+         Select one or more entries
AE  Add/Edit Allergy File      EE  Mark entered in error
DD  Detailed Display           UR  Update to new reactant

Select Item(s): DD
   Detailed Display

Allergy Tracking Free Text Entries
    Reactant               # Active Entries
1   AC I/ARB                        1
2   ACEI                            4
3   ACTIFED                         1
4   ADVERSE DRUG REACTION H202      1
5   AKE: ACI                        1
6   ALL ANTIBIOTIC UNKNOWN          1
7   ALL DYES                        1
8   ALL EYE DROPS                   1
9   ALL NSAIDS                      1
10  ALL TAPES                       1
11  ALLERGIC TO DYE                 1
12  AMPICILLINS (ALL)               1
13  ANESTHESIA MEDS                 1
14  ANGIOGRAM DYE                   1
15  ANTI-INFLAMMATORIES DUE TO MS   1
16  ANTIBIOTIC ALLERGY              1
17  ANTIHISTAMINES                  1
18  ANTIHISTIMINES                  1
19  ANTIVENOM                       1
20  APAP WITH CODEINE 30 MG TAB     1
```

```
21  ARB                             1
22  ARTHRITIS PILL ?                1
23  ASTHMA PILLS                    1
24  AVELAX                          1
25  AVENEX                          1
26  BAKERS YEAST                    1
27  BANDAIDS                        7
28  BASCTRIM                        1
29  BECLOMETHASONE INHALER          1
30  BEE STING                       2
31  BEE STINGS                      1
32  BEN-GAY                         1
33  BETABLOCKERS                    2
34  BETHOLOL                        1

         Select one or more entries
AE  Add/Edit Allergy File     EE  Mark entered in error
DD  Detailed Display          UR  Update to new reactant
Select Item(s): DD
   Detailed Display

Please choose only one entry for the detailed display.

Patient listing for reactant ARB
    Patient Name                  Last 4
1   DEMO,ALICE
Allergies: ACEI~ARB

          Select a patient                                          >>>
EE  Entered in Error                PR  Add/Edit Patient Reaction
UR  Update to new reactant          DD  Allergy Detailed Display
AE  Add/Edit Allergy File
Select Item(s): DD
Allergy Detailed Display
Select Entries from list: 1

PATIENT: DEMO,ALICE                                     REACTANT: ARB
  GMR ALLERGY: OTHER ALLERGY/ADVERSE REACTION
  ORIGINATION DATE/TIME: NOV 14, 2007@07:59
  ORIGINATOR: WOLF,JADE A                   OBSERVED/HISTORICAL: OBSERVED
  ORIGINATOR SIGN OFF: YES                            MECHANISM: UNKNOWN
  VERIFIED: YES
  VERIFICATION DATE/TIME: NOV 14, 2007@08:00:19
  VERIFIER: WOLF,JADE A                                ALLERGY TYPE: DRUG
REACTION: RASH                                    ENTERED BY: WOLF,JADE A
  DATE ENTERED: JUN 02, 2003
DATE/TIME: NOV 14, 2007@08:00:22                USER ENTERING: WOLF,JADE A

Reactant Detailed Display   Jan 06, 2011 08:27:47      Page:    1 of  1
Patient listing for reactant ARB
    Patient Name                  Last 4
1   DEMO,ALICE
Allergies: ACEI~ARB

          Select a patient                                          >>>
EE  Entered in Error                    PR  Add/Edit Patient Reaction
UR  Update to new reactant              DD  Allergy Detailed Display
AE  Add/Edit Allergy File

Select Item(s): Quit// UR
   Update to new reactant
```

```
Select Entries from list: 1

You are about to update the selected patient's ARB allergy to a new
reactant.

ARE YOU SURE? NO// YES

For patient DEMO,ALICE

Enter Causative Agent: ANGIOTEN

Checking GMR ALLERGIES (#120.82) file for matches...

Now checking the National Drug File - Generic Names (#50.6)

Now checking the National Drug File - Trade Names (#50.67)

Now checking INGREDIENT (#50.416) file for matches...

Now checking VA DRUG CLASS (#50.605) file for matches...
SIN II INHIBITOR
   ANGIOTENSIN II INHIBITOR

You selected ANGIOTENSIN II INHIBITOR
Is this correct? Y

You are about to update the entry with a selection from the VA DRUG CLASS
file.  By doing that you are limiting the information available for order
checking.

In general, it is better to choose from one of the drug related files as
that ensures that drug class and ingredient information are part of the
patient's allergy definition and will provide better allergy order
checking.

Are you sure you want to use this reactant? YES

Reactant Detailed Display   Jan 06, 2011 08:30:39      Page:    0 of    0
Patient listing for reactant ARB
    Patient Name                   Last 4

          Select a patient                                              >>>
EE  Entered in Error                     PR  Add/Edit Patient Reaction
UR  Update to new reactant               DD  Allergy Detailed Display
AE  Add/Edit Allergy File

Allergy Tracking Update    Jan 06, 2011 08:30:55       Page:    2 of   16
Allergy Tracking Free Text Entries
+   Reactant               # Active Entries
18  ANTIHISTIMINES                  1
19  ANTIVENOM                       1
20  APAP WITH CODEINE 30 MG TAB     1
21  ARB                             1
22  ARTHRITIS PILL ?                1
23  ASTHMA PILLS                    1
24  AVELAX                          1
25  AVENEX                          1
26  BAKERS YEAST                    1
27  BANDAIDS                        7
28  BASCTRIM                        1
29  BECLOMETHASONE INHALER          1
```

```
30  BEE STING                        2
31  BEE STINGS                       1
32  BEN-GAY                          1
33  BETABLOCKERS                     2
34  BETHOLOL                         1

+         Select one or more entries
AE  Add/Edit Allergy File        EE  Mark entered in error
DD  Detailed Display             UR  Update to new reactant

   1      Edit Allergy File
   2      Enter/Edit Signs/Symptoms Data
   3      Enter/Edit Site Parameters
   4      Sign/Symptoms List
   5      Allergies File List
   6      Allergy clean up utility
```

4.1.2.3 View Drug-Drug order check settings in EHR

1. Click to open the **Tools** menu and select **Options** to display the Options dialog:

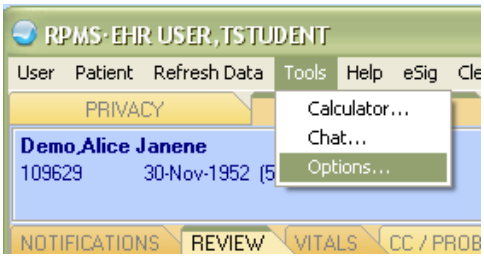


Figure 4-13: EHR Tools menu

2. Click the **Order Checks** tab:

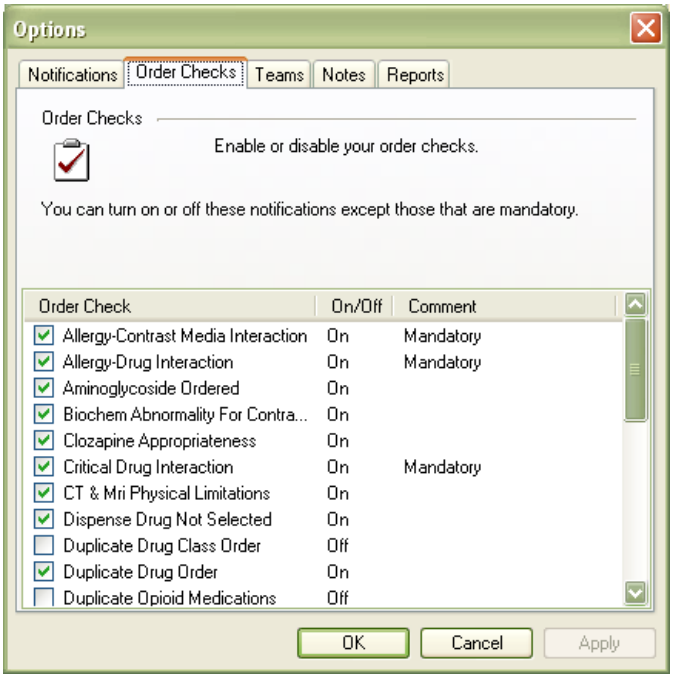


Figure 4-14: Options dialog, Order Checks tab

3. Use the scroll bar to view the list of Order Checks; each order check that was set to "Mandatory" during RPMS configuration should be so marked in the **Comment** column of this dialog.

4.1.2.4 The Order Check Report

1. Select the "Establish Meaningful Use 'Clean Date'" option to run a sub-routine in the MU report that checks all the EHR Order Check Configuration parameters that are required by Meaningful Use.

   - The Order Checking System must be enabled at the System level and not disabled at the Division level.
   - The Order Check Processing Flag must be enabled at the System level and not disabled at the Division, Service, Location, or User levels for the following order checks:

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

2. Set **Mark Order Checks Editable by User** to **No** at the System level and not disabled at the Division level for the same order checks.

   - When the "Establish Meaningful Use 'Clean Date'" is initially run, a site may see information about incorrectly set Order Check parameters.

```
                    ********************************************
**                                   PCC Management Reports                  **
**                            Meaningful Use Performance Reports    **
                    ********************************************
                             IHS PCC Suite Version 2.0

                                 2010 DEMO HOSPITAL

   M1IP   Stage 1 Interim MU Performance Report-EPs
   M1IH   Stage 1 Interim MU Performance Report-Hospitals
   MUCD   Establish Meaningful Use 'Clean Date'

Select Meaningful Use Performance Reports Option:  APCM MU CLEAN DATE     Establish
Meaningful Use 'Clean Date'

Establish Meaningful Use 'Clean Date'

No^ORK EDITABLE BY USER NOT SET TO NO FOR SYSTEM FOR ALLERGY-CONTRAST MEDIA
INTERACTION
ORK EDITABLE BY USER NOT SET TO NO FOR SYSTEM FOR RENAL FUNCTIONS OVER AGE 65
ORK EDITABLE BY USER NOT SET TO NO FOR SYSTEM FOR GLUCOPHAGE-CONTRAST MEDIA
ORK EDITABLE BY USER NOT SET TO NO FOR SYSTEM FOR DANGEROUS MEDS FOR PT > 64
ORK PROCESSING FLAG NOT ENABLED FOR SYSTEM FOR ESTIMATED CREATININE CLEARANCE
ORK PROCESSING FLAG NOT ENABLED FOR SYSTEM FOR ALLERGY-DRUG INTERACTION
ORK PROCESSING FLAG NOT ENABLED FOR SYSTEM FOR ALLERGY-CONTRAST MEDIA INTERACTION
ORK PROCESSING FLAG NOT ENABLED FOR SYSTEM FOR CRITICAL DRUG INTERACTION
ORK PROCESSING FLAG NOT ENABLED FOR SYSTEM FOR RENAL FUNCTIONS OVER AGE 65
ORK PROCESSING FLAG NOT ENABLED FOR SYSTEM FOR GLUCOPHAGE-CONTRAST MEDIA
ORK PROCESSING FLAG NOT ENABLED FOR SYSTEM FOR GLUCOPHAGE-LAB RESULTS
ORK PROCESSING FLAG NOT ENABLED FOR ALLERGY-CONTRAST MEDIA INTERACTION FOR
PPROVIDER,MARK F
ORK PROCESSING FLAG NOT ENABLED FOR ESTIMATED CREATININE CLEARANCE FOR
PPROVIDER,MARK F
                ORK PROCESSING FLAG NOT ENABLED FOR RENAL FUNCTIONS OVER AGE 65 FOR
PPROVIDER,MARK F
ORK PROCESSING FLAG NOT ENABLED FOR ESTIMATED CREATININE CLEARANCE FOR
PSUSER,RUSSELL B
```

3. Use this data to correct any discrepancies.

> The Meaningful Use Report will fail one or more of its core elements until the parameters are set properly.

4. Once the site is configured correctly, the "Establish Meaningful Use 'Clean Date'" option will run to completion and set the Meaningful Use 'Clean Date' equal to that day's date:

```
                    ******************************************
                            PCC Management Reports                  **
**                            Meaningful Use Performance Reports    **
                    ******************************************
                             IHS PCC Suite Version 2.0

                                 2010 DEMO HOSPITAL

   M1IP   Stage 1 Interim MU Performance Report-EPs
   M1IH   Stage 1 Interim MU Performance Report-Hospitals
   MUCD   Establish Meaningful Use 'Clean Date'

Select Meaningful Use Performance Reports Option: MUCD  Establish Meaningful Use
'Clean Date'

Yes

Meaningful Use 'Clean Date' set to APR 13, 2011
```

4.1.2.5 Order Check Processing, Sample Results

- When a medication order would result in a Drug-Drug Interaction, a dialog similar to the following is displayed:

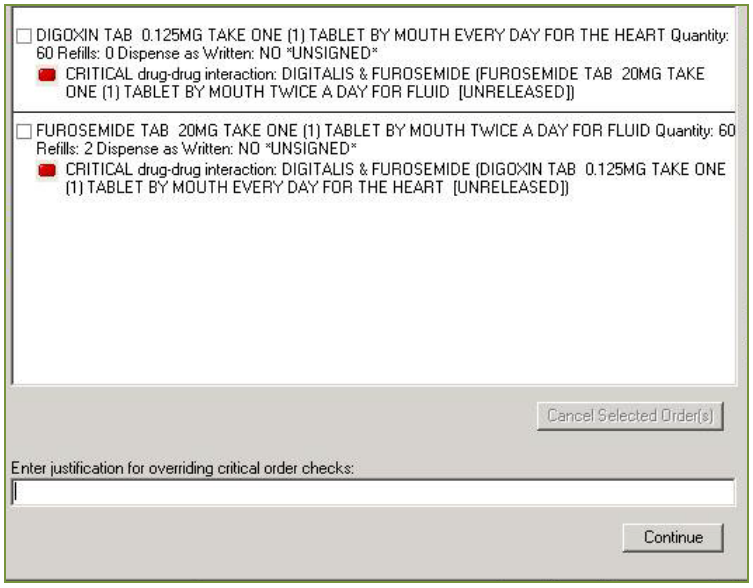


Figure 4-15: Drug Interaction Order Check dialog

- When a medication order would result in a Drug Allergy reaction, a dialog similar to the following is displayed:

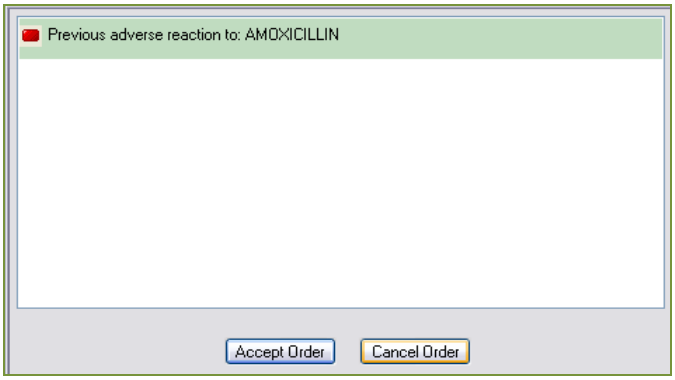


Figure 4-16: Drug Allergy Order Check dialog displaying a Drug Allergy reaction

- When a medication order would result in a Drug-Lab order check, a dialog similar to the following is displayed:

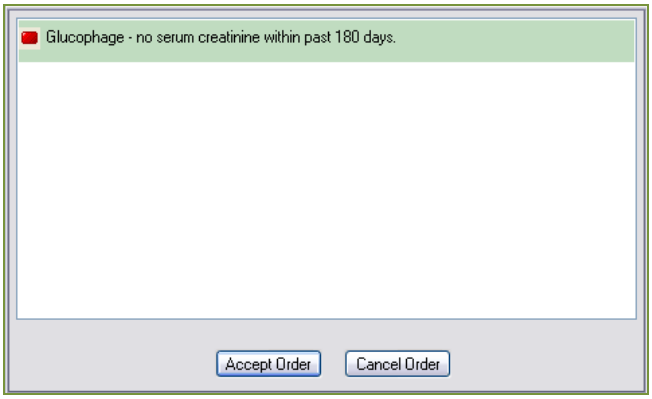


Figure 4-17: Drug-Lab Order Check dialog displaying a Drug Lab order check

- When a medication order is entered for a patient who does not have an allergy assessment entered, the following dialog is displayed:

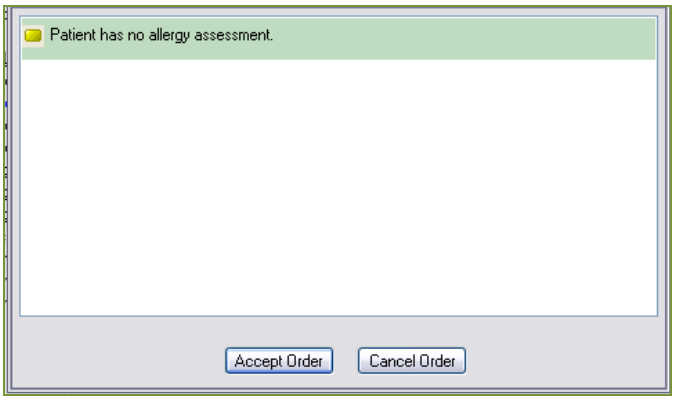


Figure 4-18: No Allergy Assessment Order Check dialog

4.1.3 Demographics

Objective: Record demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth
- In the event of mortality in the eligible hospital or CAH:
  - Date of death
  - Preliminary cause of death

42 CFR Part 495.6,(d)(7)(i)

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.}}{\text{The number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.}} > 50\%$$

Threshold: More than 50% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.

> The provider does not have to be able to communicate in the preferred language.

4.1.3.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

WHERE: structured data is present during the EHR reporting period for each of the following data elements:

Preferred language

Gender

Race

Ethnicity

Date of birth

OR WHERE: a structured data element is present indicating:

THAT: The patient declines to provide the data element information

OR THAT: Capturing the race and ethnicity is against state law

Denominator Inclusions:

COUNT: each patient

HAVING: one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

Measure Exclusion: None.

4.1.3.2 Configure RPMS

1. Set registration options:

```
OPT  Set Registration OPTIONS

                              PATIENT REGISTRATION
                                  DEMO HOSPITAL
                            Set Registration OPTIONS

Select REGISTRATION PARAMETERS SITE NAME:
SITE NAME: DEMO HOSPITAL//

Ask for TRIBAL BLOOD QUANTUM: YES//

{…}

Disp RACE,# HSHLD,HSHLD INC: YES//

{…}

Print Ethnicity on Face Sheet?: YES//

{…}

Select REGISTRATION PARAMETERS SITE NAME:
```

2. Use RPMS Patient Registration to collect patient demographics:

```
CORE  IHS Core

   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
   AGM    Patient registration ...
   AR     A/R MASTER MENU ...
   ART    Adverse Reaction Tracking ...
{…}

Select IHS Core Option: AGM
   Patient registration
                       ************************************
                       *                                  *
                       *      INDIAN HEALTH SERVICE       *
```

```
                       *   PATIENT REGISTRATION SYSTEM   *
                       *   VERSION 7.1.8, AUG 25, 2005   *
                       *                                 *
                       ***********************************

                                  DEMO HOSPITAL

   PTRG   Patient Registration ...
   AGX    Registration data- prepare for export ...
   OPT    Set Registration OPTIONS
   SIT    Reset Default Facility
   TM     Table Maintenance Menu ...
   SAMP   PATIENT File Random Sampler ...
   SSN    SSN Reports Menu ...

Select Patient registration Option: PTRG
   Patient Registration

                                PATIENT REGISTRATION
                                    DEMO HOSPITAL
                                Patient Registration

   ADD    ADD a new patient
   EPT    EDIT a patient's file
   FAC    Print a FACE SHEET
   NON    Enter NON-MANDATORY new patient information
{…}

Select Patient Registration Option: EPT
   EDIT a patient's file

                                PATIENT REGISTRATION
                                    DEMO HOSPITAL
                               EDIT a patient's file

Select PATIENT NAME: ARTERBERRY,MEGAN ANN
F 12-11-1954 XXX-XX-8752    CI 10086
6

Press the RETURN key to continue. : (upd:NOV 10, 2010)
IHS REGISTRATION EDITOR  (page 1)                            DEMO HOSPITAL
==============================================================================
ARTERBERRY,MEGAN ANN       (upd:NOV 10, 2010)          HRN:100866
==============================================================================
 1.      ELIGIBILITY STATUS : CHS & DIRECT
 2.           DATE OF BIRTH : 12/11/1954
 3.   PLACE OF BIRTH [CITY] : CHEROKEE      4.ST : NC
 5.                     SEX : FEMALE
 6.  SOCIAL SECURITY NUMBER : 999999999(Verified by SSA)
 7.          MARITAL STATUS : MARRIED
 8.       CURRENT COMMUNITY : SOCO
------------------------------------------------------------------------------
 9. STREET ADDRESS [LINE 1] : PO BOX 681
 10.STREET ADDRESS [LINE 2] :
 11.STREET ADDRESS [LINE 3] :
 12.                   CITY : CHEROKEE      13.ST : NC 14. ZIP CODE : 28719
 15.       LOCATION OF HOME :
------------------------------------------------------------------------------
 16.PHONE NUMBER [RESIDENCE] : 555-555-5390  17.WORK PHONE : 555-999-8336
 18.            OTHER PHONE :
------------------------------------------------------------------------------
```

```
==============================================================================
CHANGE which item? (1-18) NONE//: P10
IHS REGISTRATION EDITOR  (page 10)                           DEMO HOSPITAL
==============================================================================
ARTERBERRY,MEGAN ANN      (upd:NOV 10, 2010)       HRN:100866 CHS & DIRECT
==============================================================================
                              Other Patient Data
1. Ethnicity.............:
2. Race..................: AMERICAN INDIAN OR ALASKA NATIVE
3. Primary Language......:                        Interpreter required?
     Other languages spoken:
4. Preferred Language....:
------------------------------------------------------------------------------
5. Migrant Worker?.......:      Type:
6. Homeless?.............:      Type:
------------------------------------------------------------------------------
7. Internet Access.......:      Where:
8. EMAIL ADDRESS.........:
9. GENERIC HEALTH PERMISSION:         10. PREFERRED METHOD:
------------------------------------------------------------------------------
11. Number in Household...: 3
12. Total Household Income:             /
------------------------------------------------------------------------------

==============================================================================
CHANGE which item? (1-12) NONE//: 5
Migrant Worker?: NO
IHS REGISTRATION EDITOR  (page 10)                            DEMO HOSPITAL
==============================================================================
ARTERBERRY,MEGAN ANN       (upd:NOV 12, 2010)       HRN:100866 CHS & DIRECT
==============================================================================
                              Other Patient Data
1. Ethnicity.............:
2. Race..................: AMERICAN INDIAN OR ALASKA NATIVE
3. Primary Language......:                        Interpreter required?
     Other languages spoken:
4. Preferred Language....:
------------------------------------------------------------------------------
5. Migrant Worker?.......: NO   Type:                     (upd NOV 12,2010)
6. Homeless?.............:      Type:
------------------------------------------------------------------------------
7. Internet Access.......:      Where:
8. EMAIL ADDRESS.........:
9. GENERIC HEALTH PERMISSION:         10. PREFERRED METHOD:
------------------------------------------------------------------------------
11. Number in Household...: 3
12. Total Household Income:             /
------------------------------------------------------------------------------

==============================================================================
CHANGE which item? (1-12) NONE//: 6
Homeless?: NO
IHS REGISTRATION EDITOR  (page 10)                           DEMO HOSPITAL
==============================================================================
ARTERBERRY,MEGAN ANN       (upd:NOV 12, 2010)       HRN:100866 CHS & DIRECT
==============================================================================
                              Other Patient Data
1. Ethnicity.............:
2. Race..................: AMERICAN INDIAN OR ALASKA NATIVE
3. Primary Language......:                        Interpreter required?
     Other languages spoken:
```

```
4. Preferred Language....:
-----------------------------------------------------------------------------
5. Migrant Worker?.......: NO   Type:                      (upd NOV 12,2010)
6. Homeless?............: NO   Type:                      (upd NOV 12,2010)
-----------------------------------------------------------------------------
7. Internet Access.......:      Where:
8. EMAIL ADDRESS.........:
9. GENERIC HEALTH PERMISSION:         10. PREFERRED METHOD:
-----------------------------------------------------------------------------
11. Number in Household...: 3
12. Total Household Income:             /
-----------------------------------------------------------------------------

=============================================================================
CHANGE which item? (1-12) NONE//: 1
   Ethnicity: ?
    Answer with ETHNICITY NAME, or ABBREVIATION
   Choose from:
   DECLINED TO ANSWER       D
   HISPANIC OR LATINO       H
   NOT HISPANIC OR LATINO       N
   UNKNOWN BY PATIENT       U


Ethnicity: NOT HISPANIC OR LATINO      N
Method of Collection: SELF IDENTIFICATION//
IHS REGISTRATION EDITOR  (page 10)                           DEMO HOSPITAL
=============================================================================
ARTERBERRY,MEGAN ANN       (upd:NOV 12, 2010)       HRN:100866 CHS & DIRECT
=============================================================================
                              Other Patient Data
1. Ethnicity............: NOT HISPANIC OR LATINO
2. Race.................: AMERICAN INDIAN OR ALASKA NATIVE
3. Primary Language......:                        Interpreter required?
     Other languages spoken:
4. Preferred Language....:
-----------------------------------------------------------------------------
5. Migrant Worker?.......: NO   Type:                      (upd NOV 12,2010)
6. Homeless?............: NO   Type:                      (upd NOV 12,2010)
-----------------------------------------------------------------------------
7. Internet Access.......:      Where:
8. EMAIL ADDRESS.........:
9. GENERIC HEALTH PERMISSION:         10. PREFERRED METHOD:
-----------------------------------------------------------------------------
11. Number in Household...: 3
12. Total Household Income:             /
-----------------------------------------------------------------------------

=============================================================================
CHANGE which item? (1-12) NONE//: 3
Add the PRIMARY LANGUAGE spoken at home by the patient: ENGLISH
   How proficient is the patient in speaking ENGLISH?: WE  WELL
Select OTHER LANGUAGE SPOKEN:
IHS REGISTRATION EDITOR  (page 10)                           DEMO HOSPITAL
=============================================================================
ARTERBERRY,MEGAN ANN       (upd:NOV 12, 2010)       HRN:100866 CHS & DIRECT
=============================================================================
                              Other Patient Data
1. Ethnicity............: NOT HISPANIC OR LATINO
2. Race.................: AMERICAN INDIAN OR ALASKA NATIVE
3. Primary Language......: ENGLISH                Interpreter required?
```

```
     Other languages spoken:
4. Preferred Language....: ENGLISH
-----------------------------------------------------------------------------
5. Migrant Worker?.......: NO   Type:                     (upd NOV 12,2010)
6. Homeless?............: NO   Type:                     (upd NOV 12,2010)
-----------------------------------------------------------------------------
7. Internet Access.......:      Where:
8. EMAIL ADDRESS.........:
9. GENERIC HEALTH PERMISSION:         10. PREFERRED METHOD:
-----------------------------------------------------------------------------
11. Number in Household...: 3
12. Total Household Income:             /
-----------------------------------------------------------------------------

=============================================================================
CHANGE which item? (1-12) NONE//

                              PATIENT REGISTRATION

                                  DEMO HOSPITAL

                              Patient Registration

   ADD    ADD a new patient
   EPT    EDIT a patient's file
   FAC    Print a FACE SHEET
   NON    Enter NON-MANDATORY new patient information
   NAM    CORRECT the patient's NAME
   CHR    EDIT the patient's CHART NUMBER.
   INA    INACTIVATE/ACTIVATE a patient's file
   RPT    REGISTRATION REPORTS ...
   VIEW   View patient's registration data
   DEL    DELETE a patient's Health Record Number
   REV    Review and edit DECEASED or INACTIVE patient files
   EMB    Print an EMBOSSED CARD
   SCA    SCAN the patient files ...
   THR    Third Party Billing Reports ...
   IND    Print tub-file INDEX cards ...
   LBL    LABELS menu ...
   PAG    Edit one of the Patient's PAGEs ...
   FIE    print Face sheet, Index card, Embossed card
   MSP    Medicare Secondary Payer Menu ...

Select Patient Registration Option:
```

4.1.3.3 Review patient demographics in EHR

1. Click the Patient pane:

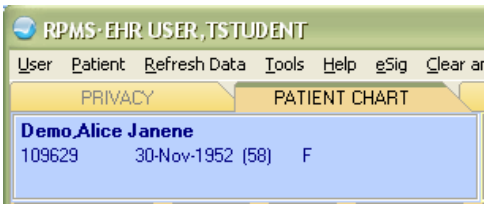


Figure 4-19: Patient pane

The **Patient Selection** dialog opens:

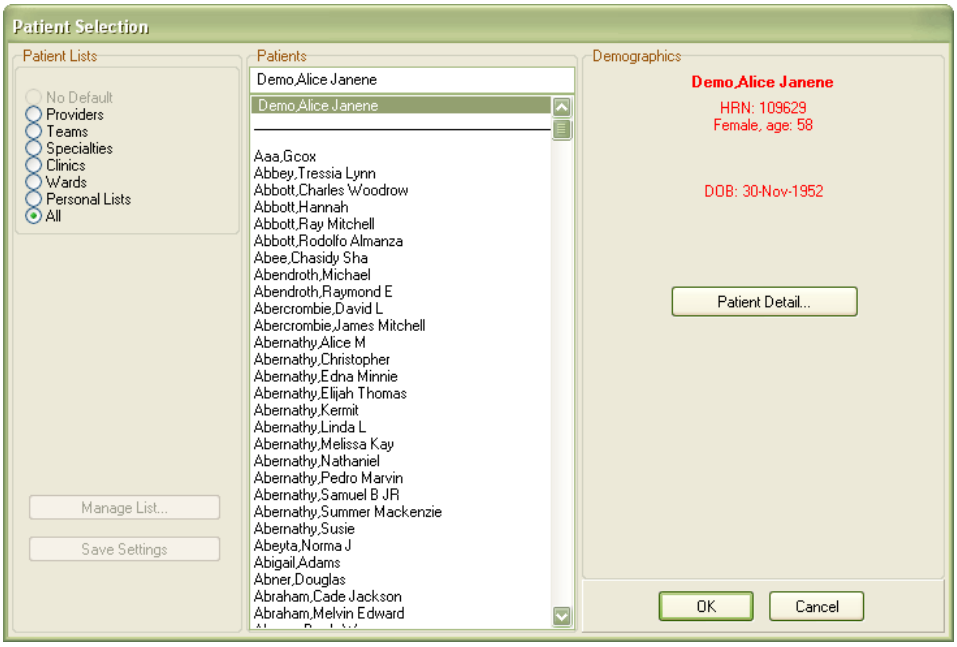


Figure 4-20: Patient Selection dialog

2. Select a patient (if not already selected) and click **Patient Detail** to display the Patient Detail dialog. This dialog displays demographic information for all data items configured in RPMS:

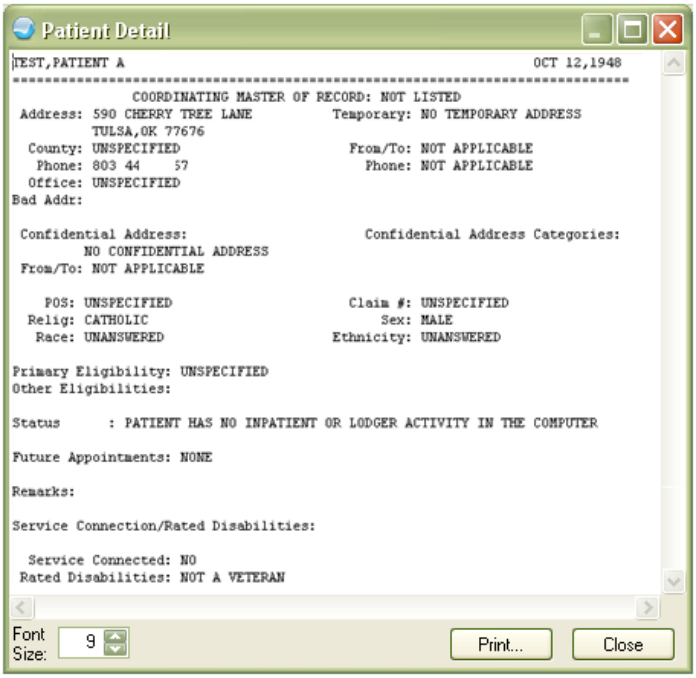


Figure 4-21: Patient Detail dialog

4.1.4 Problem List

Objective: "Maintain an up-to-date problem list of current and active diagnoses." *42 CFR Part 495.6,(d)(3)(i)*

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.}}{\text{The number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.}} > 80\%$$

Threshold: More than 80% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one entry or an indication that no problems are known for the patient recorded as structured data.

4.1.4.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

WHERE: structured data is present during the EHR reporting period indicating a problem (active or inactive) on the problem list

HAVING: an entered date on or before the end of the reporting period

OR HAVING: a deleted date on or between the first and last days of the reporting period

OR HAVING: structured data present during the reporting period that documents there are no active problems

Denominator Inclusions:

COUNT: each patient

HAVING: one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

Measure Exclusion: None.

> The list does not have to be updated at every visit to be considered up-to-date.

4.1.4.2 Configure RPMS

No RPMS configuration is required.

4.1.4.3 EHR Use

1. Select the **CC/PROBS** tab:

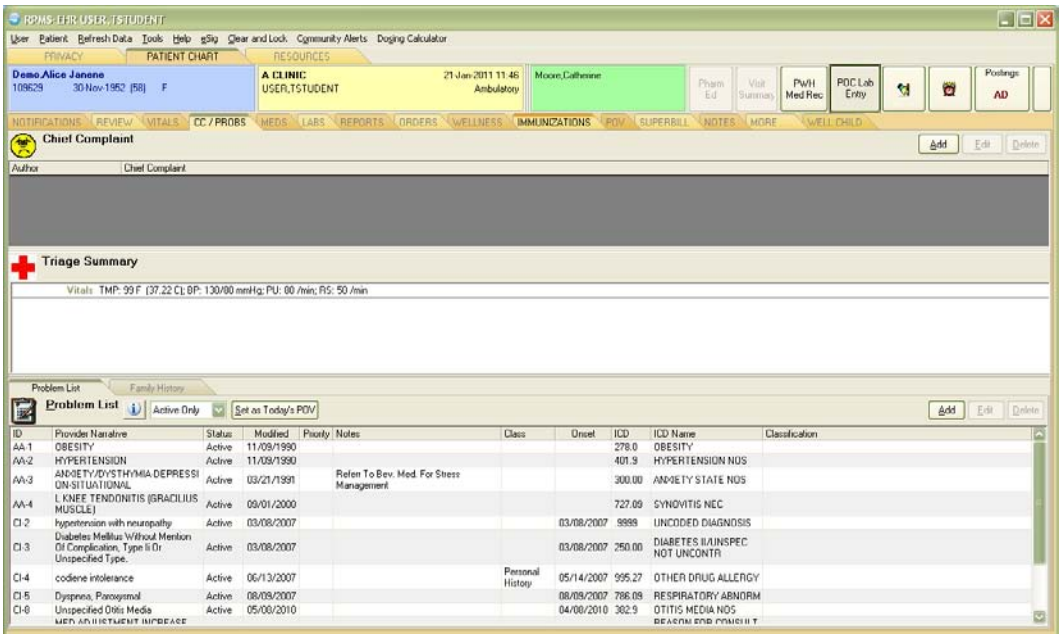


Figure 4-22: CC/PROBS tab selected in preparation for adding a problem to the Problem List

2. Click Add on the Problem List pane to display the Problem Maintenance dialog.

3. Type the first several characters of the problem name in the **ICD** field then click ellipses **(…)** to search for possible matches:

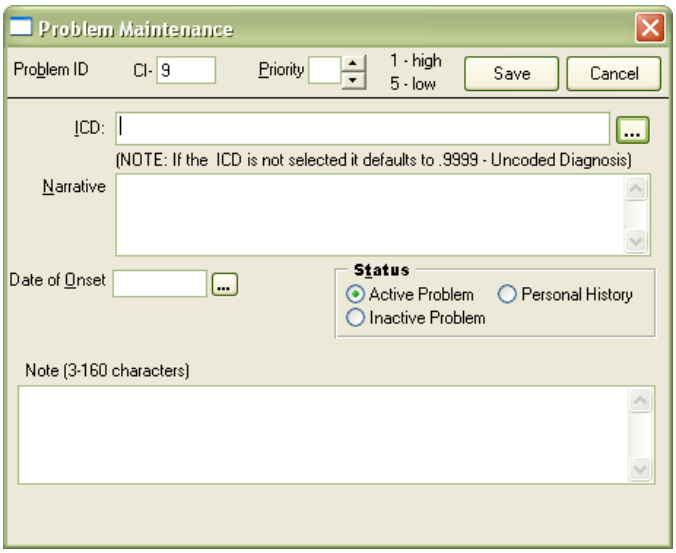


Figure 4-23: Problem Maintenance dialog

4. Results of the search are displayed in the Diagnosis Lookup dialog. Select an item from the list and click **OK**:

   - Selecting **Return Search Text as Narrative** will replace the selected item's default narrative with the **Search Value** when the problem is added to the Problem List.
   - If the lookup does not retrieve the expected results, try again by editing the **Search Value** and click **Search**.

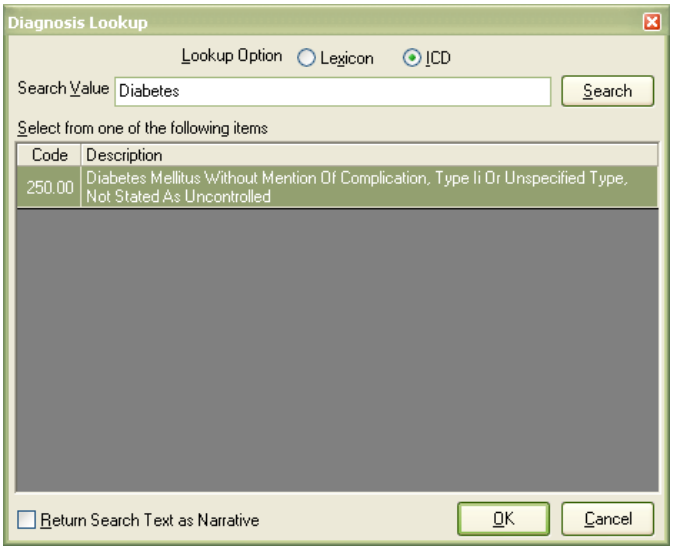


Figure 4-24: Diagnosis Lookup dialog

5. The Problem Maintenance dialog is redisplayed with the selected problem's information filled in. Edit the information on the dialog as necessary:

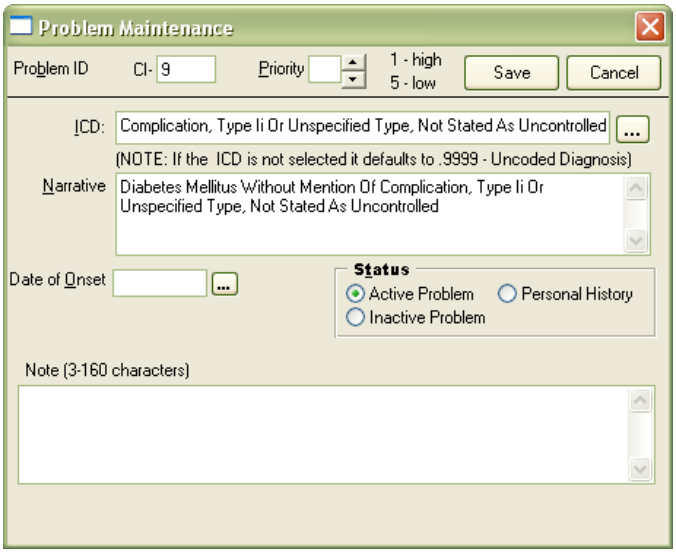


Figure 4-25: Problem Maintenance dialog displaying the selected Problem

6. To set the **Date of Onset**, type the date in the field (format: mm/dd/yyyy) or click ellipses **(…)** to display the Select Date/Time dialog:

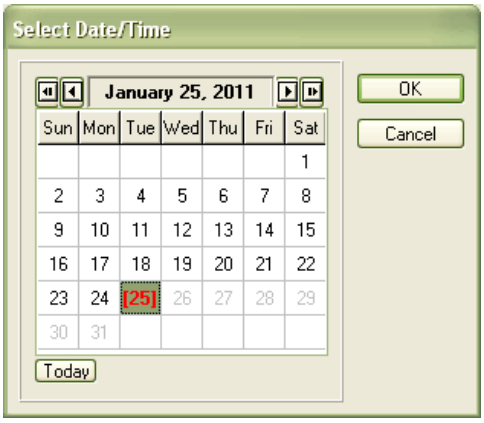


Figure 4-26: Select Date/Time dialog

- Set the date and click **OK**. The Problem Maintenance dialog redisplays with the **Date of Onset** set.

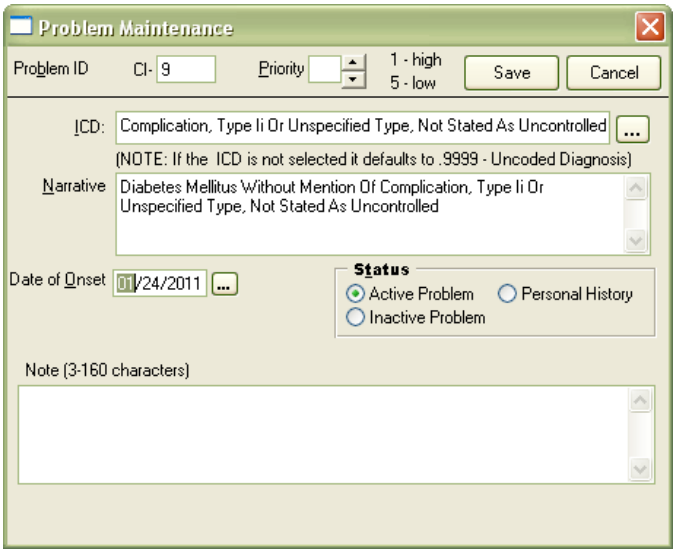
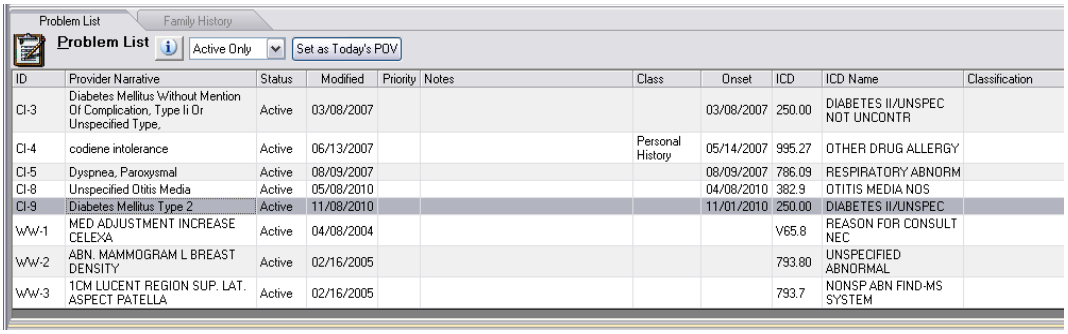


Figure 4-27: Problem Maintenance dialog with the Date of Onset added

7. Once all entries are complete, click **Save**. The newly added problem appears on the Problem List:



ID	Provider Narrative	Status	Modified	Priority	Notes	Class	Onset	ICD	ICD Name	Classification
CI-3	Diabetes Mellitus Without Mention Of Complication, Type Ii Or Unspecified Type,	Active	03/08/2007				03/08/2007	250.00	DIABETES II/UNSPEC NOT UNCONTR	
CI-4	codiene intolerance	Active	06/13/2007			Personal History	05/14/2007	995.27	OTHER DRUG ALLERGY	
CI-5	Dyspnea, Paroxysmal	Active	08/09/2007				08/09/2007	786.09	RESPIRATORY ABNORM	
CI-8	Unspecified Otitis Media	Active	05/08/2010				04/08/2010	382.9	OTITIS MEDIA NOS	
CI-9	Diabetes Mellitus Type 2	Active	11/08/2010				11/01/2010	250.00	DIABETES II/UNSPEC	
WW-1	MED ADJUSTMENT INCREASE CELEXA	Active	04/08/2004					V65.8	REASON FOR CONSULT NEC	
WW-2	ABN. MAMMOGRAM L BREAST DENSITY	Active	02/16/2005					793.80	UNSPECIFIED ABNORMAL	
WW-3	1CM LUCENT REGION SUP. LAT. ASPECT PATELLA	Active	02/16/2005					793.7	NONSP ABN FIND-MS SYSTEM	

Figure 4-28: Problem List pane showing the new problem

4.1.5 Medication List

Objective: "Maintain an active medication list." *42 CFR Part 495.6,(d)(5)(i)*

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator who have a medication (or an indication that the patient does not currently have any prescribed medication) recorded as structured data.}}{\text{The number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.}} > 80\%$$

Threshold: More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

4.1.5.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

HAVING: documentation of No Active Medications on any visit during the EHR reporting period

OR HAVING: a medication in the Prescription file

WITH: an Issue Date equal to or less than 365 days before the start of the reporting period

AND WITH: an Issue Date on or before the end of the reporting period

AND NOT WITH: a Discontinued Date before the start of the reporting period

OR HAVING: an Outside Medication in the Pharmacy Patient file

HAVING: a Documented Date on or before the end of the reporting period

AND WITH: a status of Active

OR HAVING: a Discontinued Date on or after the start of the reporting period.

Denominator Inclusions:

COUNT: each patient

HAVING: one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

> Active medication list is defined as a list of medications that a given patient is currently taking. The list does not have to be updated at every visit to be up-to-date.

Measure Exclusion: None.

4.1.5.2 Configure RPMS

Use the Configure RPMS instructions in Section 4.1.1.2.

4.1.5.3 Order a medication in EHR

Use the instructions in Section 4.1.1.4

4.1.5.4 Record an outside medication in EHR

1. Select the **MEDS** tab:

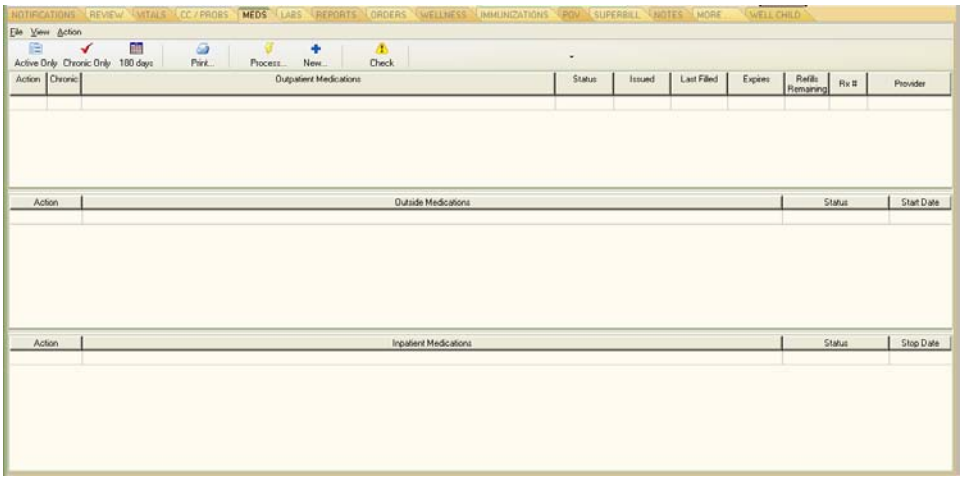


Figure 4-29: EHR MEDS tab

2. Select Outside Medications from the Meds toolbar list box:

Figure 4-30: Meds toolbar list box

3. Click **New** to open the **Document Outside Medications** dialog:

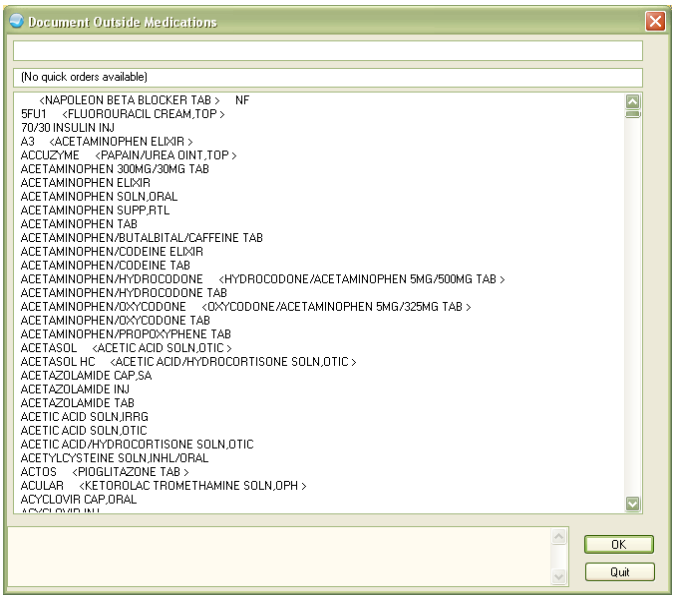


Figure 4-31: Document Outside Medications dialog, medication lookup

4. Begin typing in the medication name field to filter the list of medications.
5. Click the medication name in the list to display the dosage information:

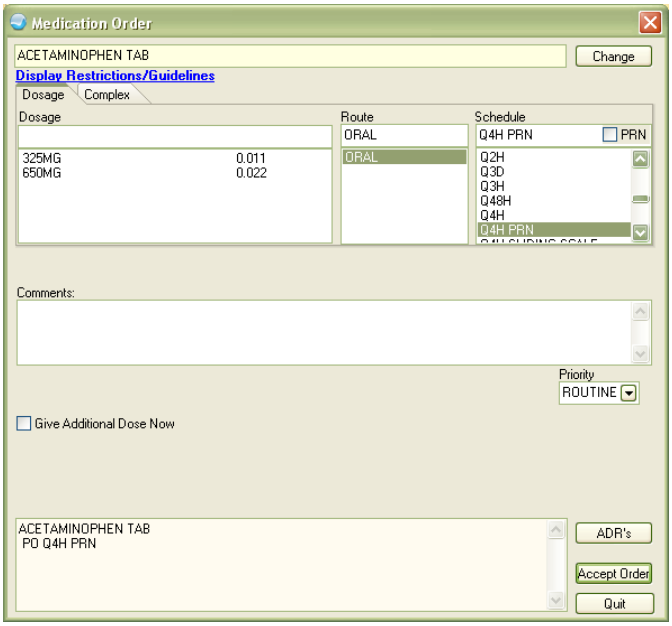


Figure 4-32: Document Outside Medications detail dialog

6. Edit the dosage information as necessary then click **Accept Order**. The new outside medication is added to the list (set in blue text):

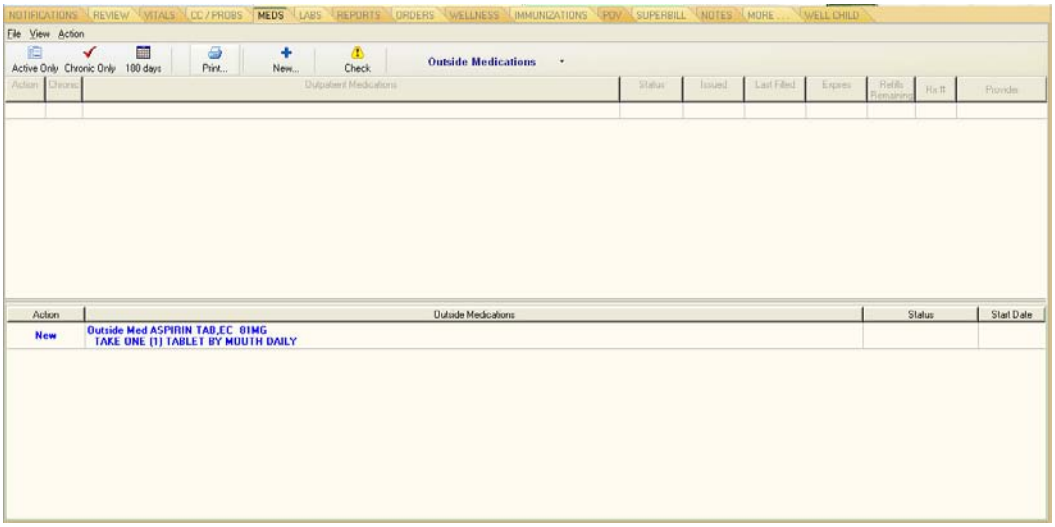


Figure 4-33: EHR MEDS tab

7. To review and sign the outside medication entry, click the Awaiting Review graphical button:

Figure 4-34: Awaiting Review graphical button

EHR displays the Review/Sign Changes dialog:

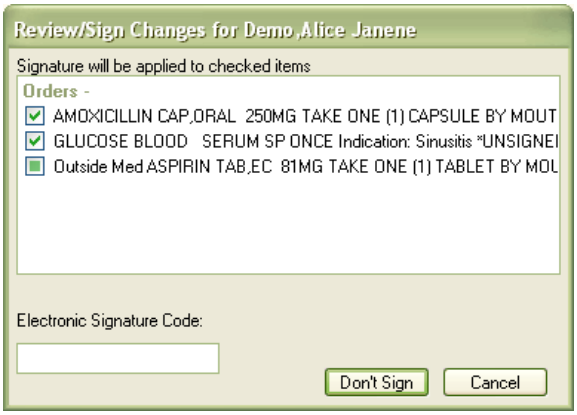


Figure 4-35: Review/Sign Changes dialog

8. Review the order, type the Electronic Signature Code, and click **OK** to close the dialog. The outside medication is marked ***Active*** on the **Outside Medications** pane.

4.1.6 Medication Allergy List

Objective: "Maintain an active medication allergy list." *42 CFR Part 495.6,(d)(6)(i)*

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator who have at least one entry (or an entry stating that the patient has no known medication allergies) recorded as structured data in their medication allergy list.}}{\text{The number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.}} > 80\%$$

Threshold: More than 80% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

4.1.6.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

HAVING: structured data present during the EHR reporting period

WHERE: an active adverse reaction to a medication is recorded

OR WHERE: a statement indicating no known allergies is recorded

Denominator Inclusions:

COUNT: each patient

HAVING: one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

> The list does not have to be updated at every visit to be up-to-date.

Measure Exclusion: None.

4.1.6.2 Configure RPMS

Use the Configure RPMS instructions in Section 4.1.2.2.

4.1.6.3 Move drug allergies to the RPMS Allergies List

> Previous practice allowed patient drug allergies to be entered on the Problem List, however to meet MU Performance Measures, all drug allergies must be recorded on the RPMS Allergies List.

The Problem List Allergy List (PLAL) report lists the entries on the patient's Problem List. The report identifies patient drug allergies that are on the patient's Problem List that need to be added to the Adverse Reaction Tracking package.

1. Run the PLAL Report:

```
Select IHS Core Option: PCC
   Patient Care Component

    HS     Generate Health Summary
    MHS    Generate Multiple Health Summaries
    SCAN   SCAN the patient files ...
    VIEW   View patient's registration data
    DISP   Display Data for a Specific Patient Visit
    ICD    ICD-9 Auto-Coding System ...
    DRG    DRG Grouper
    MGR    PCC Manager Menu ...
    ARP    PCC Management Reports ...
    ATS    Search Template System ...

Select Patient Care Component Option: ARP
```

```
   PCC Management Reports

                        **********************************
                        **   PCC Management Reports    **
                        **********************************
                            IHS PCC Suite Version 2.0

                                  DEMO HOSPITAL

   PLST   Patient Listings ...
   RES    Resource Allocation/Workload Reports ...
   INPT   Inpatient Reports ...
   QA     Quality Assurance Reports ...
   DM     Diabetes QA Audit Menu ...
   APC    APC Reports ...
   PCCV   PCC Ambulatory Visit Reports ...
   BILL   Billing Reports ...
   BMI    Body Mass Index Reports ...
   ACT    Activity Reports by Discipline Group ...
   CNTS   Dx & Procedure Count Summary Reports ...
   IMM    Immunization Reports ...
   QMAN   Q-Man (PCC Query Utility)
   DELR   Delimited Output Reports ...
   CHS    Health Summary Displaying CMS Register(s)
   BHS    Browse Health Summary
   CLM    Custom letter Management ...
   OTH    Other PCC Management Reports/Options ...
   FM     FileMan (General) ...
   STS    Search Template System ...

Select PCC Management Reports Option: ^PLAL
   Reports Listing Allergies recorded on PROBLEM LIST

                        **********************************
                        **    PCC Data Entry Module    **
                        **********************************
                            IHS PCC Suite Version 2.0
                                  DEMO HOSPITAL
                        **********************************
                        **    PCC Data Entry Module    **
                        **  Data Entry Utilities Menu  **
                        **********************************
                            IHS PCC Suite Version 2.0
                                  DEMO HOSPITAL
                **************************************************
                **            PCC Data Entry Module             **
                ** Data Entry SUPERVISOR Options and Utilities **
                **************************************************
                            IHS PCC Suite Version 2.0
                                  DEMO HOSPITAL

   PWA    List All Patients w/Allegies / NKA on Problem List
   SALP   List Pts seen in N yrs w/Problem List Allergies
   NALP   List Patients w/Allergies entered in a Date Range

Select Reports Listing Allergies recorded on PROBLEM LIST Option: PWA
   List All Patients w/Allegies / NKA on Problem List

*******  LIST OF PATIENTS WITH ALLERGIES ON PROBLEM LIST  *******
This report will produce a list of patients who have an allergy or NKA
entered on the PCC Problem List.
```

```
The pharmacy staff can use this list to add these allergies into the
Allergy Tracking module.  When you have finished processing this list you
can then run the Option 'List Patients w/Allergies entered in a Date Range'
to pick up any allergies entered onto the Problem list after you ran this
report.  Deceased patients and patients with inactive charts are not
included on this list.

This list can be very long at sites with many patients and whose providers
have been maintaining up to date problem lists. In order to make the list
more manageable at those sites you will be prompted to enter the beginning
and ending first character of the last name the patient.  You can then
print all patients whose last name begins with A through C the first time
and D through H the second, etc.
If you want all patients then when prompted to do so enter A and Z as the
beginning and ending characters.

Start with last names beginning with: A
End with last names beginning with: A
```

Always type the Start and End criteria using upper-case letters.

```
DEVICE: HOME//   VT    Right Margin: 80//
                                                                    Page 1
                                 DEMO HOSPITAL
  PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC PROBLEM
LIST
               PATIENTS WITH LAST NAMES BEGINNING WITH A through A
PATIENT NAME                    CHART #       DOB
-----------------------------------------------------------------------------

ALMOND,JOY                      100004     Dec 21, 1930
   DATE ADDED    DX     PROVIDER NARRATIVE
   ----------    --     ------------------
   JAN 21, 1997  995.2  ALLERGY TO PCN, BUT OK WITH AMPICILLIN

ARTERBERRY,MEGAN ANN            100866     Dec 11, 1954
   DATE ADDED    DX     PROVIDER NARRATIVE
   ----------    --     ------------------
   JUN 25, 1993  995.2  ALLERGIC SXT - RASH
   JUN 17, 1999  995.2  ALLERGIC TO KEFLEX (RASH)
   DEC 03, 1999  995.2  GI INTOLERANCE - GLYBURIDE/TOLAZEMIDE
   JAN 26, 2004  995.2  INTOLERANCE TO AMITRIPTYLINE
   SEP 16, 2004  995.2  RASH WITH DILTIAZEM

ALDRIDGE,FRANCES S              100870     Jan 18, 1956
   DATE ADDED    DX     PROVIDER NARRATIVE
   ----------    --     ------------------
   OCT 10, 1996  995.2  ASA ALLERGY - CHEST PAIN

ALVARADO,KALE ALEXANDER         101097     Mar 23, 1933
   DATE ADDED    DX     PROVIDER NARRATIVE
   ----------    --     ------------------
   MAY 27, 2001  995.2  MOTRIN = HIVES

ANGEL,TIFFANY LEIGH             101174     May 18, 1949
   DATE ADDED    DX     PROVIDER NARRATIVE
   ----------    --     ------------------
   AUG 04, 1998  995.2  DELAYED REACTION ON DAY 8 W/ BACTRIM
   APR 22, 2000  995.2  RASH/SWELLING ON SIMVASTATIN
   JUL 05, 2000  995.2  ALLERGY: VIT, ANTIOXIDANT
```

```
Enter RETURN to continue or '^' to exit: ^
```

2. Add a drug allergy entry to the patient's Allergies List using RPMS (this can also be accomplished using EHR; see Section4.1.6.4):

```
Enter/Edit Patient Reaction Data

Select PATIENT NAME: ARTERBERRY, MEGAN ANN
                              <A>   F 12-11-1954 XXX-XX-8752    CI 100866

                                                                 OBS/
REACTANT                            SOURCE       VER.   MECH.   HIST  TYPE
--------                            ------       ----  -------  ----  ----
AMOXICILLIN                         PATIENT       NO   ALLERGY  HIST  DRUG
WALNUTS                                           NO   UNKNOWN  HIST  FOOD
   Reactions: GI REACTION(Source: )
BEE STINGS                                       AUTO  UNKNOWN  HIST  OTHER

Enter Causative Agent: AMOXICILLIN

Checking existing PATIENT ALLERGIES (#120.8) file for matches...

                              <A>   F 12-11-1954 XXX-XX-8752    CI 100866
   AMOXICILLIN
  AMOXICILLIN   OK? Yes//

      PATIENT: DEMO,ALLERGY CHARLES     CAUSATIVE AGENT: AMOXICILLIN
  INGREDIENTS: AMOXICILLIN          VA DRUG CLASSES: PENICILLINS,AMINO DER

     SOURCE OF INFORMATION: PATIENT
   ORIGINATOR: NIESEN,MARY ANN               ORIGINATED: Apr 20, 2011@09:01
     SIGN OFF: YES                             OBS/HIST: HISTORICAL
     EVENT: DRUG ALLERGY                       CODE: 416098002

ID BAND MARKED:                         CHART MARKED: Apr 20, 2011@09:01:54

    MECHANISM: ALLERGY
Is the reaction information correct? Yes//

Enter another Causative Agent? NO

Select PATIENT NAME:
```

3. Remove the drug allergy from the patient's Problem List (this can also be accomplished using EHR, see Section 4.1.6.5):

```
Select IHS Core Option: PCC
   Patient Care Component

   HS     Generate Health Summary
   MHS    Generate Multiple Health Summaries
   SCAN   SCAN the patient files ...
   VIEW   View patient's registration data
   DISP   Display Data for a Specific Patient Visit
   ICD    ICD-9 Auto-Coding System ...
   DRG    DRG Grouper
   MGR    PCC Manager Menu ...
   ARP    PCC Management Reports ...
```

```
Select Patient Care Component Option: MGR
   PCC Manager Menu

   DATA   Patient Care Data Entry Menu ...
   UTIL   Utilities For Auto-Coding System ...
   HSM    Health Summary Maintenance ...
   QMGR   Q-Man Site Manager's Utilities
   TX     PCC Data Transmission Menu ...

Select PCC Manager Menu Option: DATA
   Patient Care Data Entry Menu

                        **********************************
                        **    PCC Data Entry Module    **
                        **********************************
                            IHS PCC Suite Version 2.0
                                  DEMO HOSPITAL

   ENT    Enter/Modify/Append PCC Data ...
   DSP    Display Data for a Specific Patient Visit
   PEF    Print a PCC Visit in Encounter Form format
   UPD    Update Patient Related/Non Visit Data ...
   DEU    Data Entry Utilities ...
   VIEN   Display a Visit by Visit IEN
   BHS    Browse Health Summary
   DVB    Display a PCC Visit w/limited Lab Display
   GHS    Generate Health Summary
   PDV    Print a PCC Visit Display to a Printer

Select Patient Care Data Entry Menu Option: UPD
   Update Patient Related/Non Visit Data
                 ************************************************
                 **          PCC Data Entry Module             **
                 **      Update Patient-Related Data           **
                 ************************************************
                            IHS PCC Suite Version 2.0
                                  DEMO HOSPITAL

   NVD    Enter Non-Visit Data
   HDI    Enter Historical or Non Visit Related Patient Data
   PRL    Problem List Update
   TP     Update Patient Treatment Plan

Select Update Patient Related/Non Visit Data Option: PRL
   Problem List Update
                           Patient Care Component (PCC)

                       ***********************************
                       * Update PCC Patient Problem List *
                       ***********************************

Select PATIENT NAME: ARTERBERRY,MEGAN ANN
               <A>   F 12-11-1954 XXX-XX-8752    CI 100866
Location where Problem List update occurred: DEMO HOSPITAL
      NASHVILLE NON-IHS     CHEROKEE     01    NM  HOSPITAL  7247

Date Problem List Updated: T  (NOV 09, 2010)Problem List Update
Nov 09, 2010 14:19:43          Page:    1 of    6
-----------------------------------------------------------------------------
Patient Name: ARTERBERRY,MEGAN ANN   DOB: DEC 11, 1954   Sex: F   HRN: 10
```

```
-----------------------------------------------------------------------------
   1) Problem ID:   AA6    DX: 250.00  Status: ACTIVE   Onset: 3/10/1990
      Provider Narrative:  TYPE 2 DIABETES
        Notes:
           AA Note#1 10/12/1995  FOOT EVALUATION Q YR DUE 10/96

   2) Problem ID:   AA7    DX: 995.2   Status: ACTIVE   Onset:
      Provider Narrative:  ALLERGIC SXT - RASH

   3) Problem ID:   AA9    DX: 562.10  Status: ACTIVE   Onset:
      Provider Narrative:  DIVERTICULOSIS (BE, 4/95)

   4) Problem ID:   AA10   DX: V65.8   Status: ACTIVE   Onset:
      Provider Narrative:  ENROLLED IN BCCCP
   5) Problem ID:   AA11   DX: 414.9   Status: ACTIVE   Onset: 9/17/1996
      Provider Narrative:  CARDIAC CATH 9/17 NL LV FUNCTION & INSIGNIFICANT

   6) Problem ID:   AA12   DX: 530.81  Status: ACTIVE   Onset:
      Provider Narrative:  GERD

   7) Problem ID:   AA13   DX: 995.2   Status: ACTIVE   Onset:
      Provider Narrative:  ALLERGIC TO KEFLEX (RASH)

   8) Problem ID:   AA15   DX: 995.2   Status: ACTIVE   Onset:
      Provider Narrative:  GI INTOLERANCE - GLYBURIDE/TOLAZEMIDE
AP   Add Problem          IP   Inactivate Problem   RN   Remove Note
EP   Edit Problem         DD   Detail Display       HS   Health Summary
DE   Delete Problem       NO   Add Note             FA   Face Sheet
AC   Activate Problem     MN   Edit Note            Q    Quit
Select Action: DE
     1   Delete Problem
     2   Detail Display
CHOOSE 1-2: 1
   Delete Problem
Delete Which Problem(s):  (1-21): 7

Deleting the following Problem(s) from MEGAN ANN ARTERBERRY's Problem List.

   7) Problem ID:   AA13   DX: 995.2   Status: ACTIVE   Onset:
      Provider Narrative:  ALLERGIC TO KEFLEX (RASH)

Are you sure you want to delete this PROBLEM(s)? YES
PROBLEM DELETED
Press return to continue....: Problem List Update           Nov 09, 2010
14:20:57          Page:    1 of    6
-----------------------------------------------------------------------------
Patient Name: ARTERBERRY,MEGAN ANN   DOB: DEC 11, 1954   Sex: F   HRN: 10
-----------------------------------------------------------------------------
 +
      Provider Narrative:  ENROLLED IN BCCCP

   5) Problem ID:   AA11   DX: 414.9   Status: ACTIVE   Onset: 9/17/1996
      Provider Narrative:  CARDIAC CATH 9/17 NL LV FUNCTION & INSIGNIFICANT

   6) Problem ID:   AA12   DX: 530.81  Status: ACTIVE   Onset:
      Provider Narrative:  GERD

   7) Problem ID:   AA15   DX: 995.2   Status: ACTIVE   Onset:
      Provider Narrative:  GI INTOLERANCE - GLYBURIDE/TOLAZEMIDE

   8) Problem ID:   AA16   DX: 401.9   Status: ACTIVE   Onset:
```

```
      Provider Narrative:  HTN - ELEVATED SYSTOLIC READINGS
 +         Enter ?? for more actions                                      >>>
AP   Add Problem          IP   Inactivate Problem   RN   Remove Note
EP   Edit Problem         DD   Detail Display       HS   Health Summary
DE   Delete Problem       NO   Add Note             FA   Face Sheet
AC   Activate Problem     MN   Edit Note            Q    Quit
Select Action: Q
   Quit
```

4. Run the Patient Allergies Not Signed Off report:

```
Select IHS Kernel Option: CORE
   IHS Core

   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
   AGM    Patient registration ...
   AR     A/R MASTER MENU ...
   ART    Adverse Reaction Tracking ...
   ARWS   Automatic Replenishment ...

Select IHS Core Option: ART
   Adverse Reaction Tracking

   1      Enter/Edit Site Configurable Files ...
   2      Adverse Reaction Tracking User Menu ...
   3      Adverse Reaction Tracking Clinician Menu ...
   4      Adverse Reaction Tracking Verifier Menu ...
   5      P&T Committee Menu ...

Select Adverse Reaction Tracking Option: 2
   Adverse Reaction Tracking User Menu

   1      Enter/Edit Patient Reaction Data
   2      Active Listing of Patient Reactions
   3      Edit Chart and ID Band
   4      List by Location of Unmarked ID Bands/Charts
   5      Patient Allergies Not Signed Off
   6      List by Location of Undocumented Allergies
   7      Print Patient Reaction Data
   8      Online Reference Card

Select Adverse Reaction Tracking User Menu Option: 5
   Patient Allergies Not Signed Off
```

Report results:

```
                  ALLERGY/ADVERSE REACTIONS TO BE SIGNED OFF
                       Run Date/Time: 1/28/11 2:30:51 pm

ORIGINATOR           PATIENT              ALLERGY          ORIGINATION DATE/TIME
-------------------------------------------------------------------------------

KUNZ,ELIZABETH   WOOTEN,MARILYN(11-43-61) SULFAMETHOXAZOLE MAY 18, 2004@10:16
KUNZ,ELIZABETH   SMITH,DIANE(10-34-04)    CODEINE          MAY 25, 2004@16:16
LAB,JESSICA LOU  WATTY,SHUSHANA(11-16-13) GABAPENTIN       JUN 04, 2004@13:35
LAB,JESSICA LOU  WATTY,SHUSHANA(11-16-13) PSEUDOEPHEDRINE  JUN 04, 2004@13:37
LAB,JESSICA LOU  LAMBERT,TONY W(12-32-68) CODEINE          JUN 07, 2004@12:50
LEONG,BARBARA A  CROWE,WILLIAM (10-60-47) TYLENOL          APR 05, 2004@12:08
LEONG,BARBARA A  STAMPER,SHAWNE(11-48-47) PEDIAZO          MAY 04, 2004@16:23
LEONG,BARBARA A  FRENCH,MICHAEL(10-00-73) FOSINOPRIL       MAY 10, 2004@11:53
LEONG,BARBARA A  CRAFT,HEATHER (10-01-72) BRETHI           MAY 10, 2004@12:08
LEONG,BARBARA A  WILNOTY,SARAH (10-10-38) NIACIN           MAY 10, 2004@17:05
LEONG,BARBARA A  DEMARCO,MELBA (10-20-33) POLYMYXIN B      MAY 11, 2004@13:09
LEONG,BARBARA A  SMITH,OLLIE(10-63-75)    LEVOFLOXACIN     MAY 12, 2004@13:09
```

5. Run the Unverified Reactions by Ward Location report:

```
Select IHS Kernel Option: CORE
   IHS Core

   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
   AGM    Patient registration ...
   AR     A/R MASTER MENU ...
   ART    Adverse Reaction Tracking ...
   ARWS   Automatic Replenishment ...

Select IHS Core Option: ART
   Adverse Reaction Tracking

   1      Enter/Edit Site Configurable Files ...
   2      Adverse Reaction Tracking User Menu ...
   3      Adverse Reaction Tracking Clinician Menu ...
   4      Adverse Reaction Tracking Verifier Menu ...
   5      P&T Committee Menu ...

Select Adverse Reaction Tracking Option: 4
   Adverse Reaction Tracking Verifier Menu

   1      Enter/Edit Patient Reaction Data
   2      Verify Patient Reaction Data
   3      Reports Menu ...
   4      Edit Chart and ID Band
   5      FDA Enter/Edit Menu ...
   6      Online Reference Card

Select Adverse Reaction Tracking Verifier Menu Option: 3
   Reports Menu

   1      Active Listing of Patient Reactions
   2      Print Patient Reaction Data
   3      Print an FDA Report for a Patient
   4      Print All FDA Events within D/T Range
   5      Print Patient FDA Exception Data
```

```
   6      Print All FDA Exceptions within a D/T Range
   7      List by Location of Unmarked ID Bands/Charts
   8      Patient Allergies Not Signed Off
   9      List by Location of Undocumented Allergies
   10     List Autoverified Reaction Data
   11     List by Location Not Verified Reactions
   12     List by Location and Date All Signed Reactions
   13     List FDA Data by Report Date

Select Reports Menu Option: 11
   List by Location Not Verified Reactions
```

Report results:

```
Report Date: Jan 28, 2011                                          Page: 1
                   List of Unverified Reactions by Ward Location
                              Ward Location: OUTPATIENT
   Origination Date/Time      Originator               Reaction
-------------------------------------------------------------------------
ABEE,CHASIDY SHA (14-54-90)
   Jun 27, 2007@14:10         USER,CSTUDENT            PENICILLIN
ABENDROTH,MICHAEL (14-56-87)
   Jan 10, 2007@11:16         USER,ASTUDENT            PENICILLIN
ANDERSON,BENJAMIN JARLIE (12-39-36)
   May 15, 2006@14:53         USER,RSTUDENT            PENICILLIN
AYERS,REBECCA (12-81-95)
   May 15, 2006@15:17         USER,FSTUDENT            SULFAMETHOXAZOLE
BABCOCK,CINDY (11-72-05)
   Jan 29, 2007@13:45         USER,BSTUDENT            SULFAMETHOXAZOLE
CARROLL,MICHAEL D (13-74-23)
   May 15, 2006@16:29         USER,ESTUDENT            METFORMIN
CASEY,CAMRYN TAHQUETTE (14-59-93)
   May 05, 2008@16:31         USER,FSTUDENT            METFORMIN HYDROCHLORIDE
   May 06, 2008@13:10         USER,FSTUDENT            PENICILLIN
COURNOYER,J T (13-26-53)
   May 15, 2006@15:31         USER,OSTUDENT            CEMILL 500MG TABS
```

6. Run the List by Location of Undocumented Allergies report:

```
Select IHS Kernel Option: CORE
   IHS Core

   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
   AGM    Patient registration ...
   AR     A/R MASTER MENU ...
   ART    Adverse Reaction Tracking ...
   ARWS   Automatic Replenishment ...

Select IHS Core Option: ART
   Adverse Reaction Tracking

   1      Enter/Edit Site Configurable Files ...
   2      Adverse Reaction Tracking User Menu ...
   3      Adverse Reaction Tracking Clinician Menu ...
   4      Adverse Reaction Tracking Verifier Menu ...
   5      P&T Committee Menu ...

Select Adverse Reaction Tracking Option: 4
   Adverse Reaction Tracking Verifier Menu
```

```
   1      Enter/Edit Patient Reaction Data
   2      Verify Patient Reaction Data
   3      Reports Menu ...
   4      Edit Chart and ID Band
   5      FDA Enter/Edit Menu ...
   6      Online Reference Card

Select Adverse Reaction Tracking Verifier Menu Option: 3
   Reports Menu

   1      Active Listing of Patient Reactions
   2      Print Patient Reaction Data
   3      Print an FDA Report for a Patient
   4      Print All FDA Events within D/T Range
   5      Print Patient FDA Exception Data
   6      Print All FDA Exceptions within a D/T Range
   7      List by Location of Unmarked ID Bands/Charts
   8      Patient Allergies Not Signed Off
   9      List by Location of Undocumented Allergies
   10     List Autoverified Reaction Data
   11     List by Location Not Verified Reactions
   12     List by Location and Date All Signed Reactions
   13     List FDA Data by Report Date

Select Reports Menu Option: 9

     1 Current Inpatients
     2 Outpatients over Date/Time range
     3 New Admissions over Date/Time range
     4 All of the above
Enter the number(s) for those groups to be used in this report: (1-4):4
 Enter date/time range in which patients were
 admitted into the hospital or seen at an outpatient clinic.

 Please note! This report will show patients as not having received an
assessment if the assessment was entered after the end date of
the range.  For this reason, it is recommended to end the range
with today. This can be done with an entry of 'T' (for Today) at
the 'Enter END Date (time optional): T//' prompt.

Enter START Date (time optional): -180  (OCT 23, 2010)
Enter END Date (time optional): T//   (APR 21, 2011)
Select Location: ALL
Do you mean ALL Locations? Yes//   (Yes)
Another Location:

QUEUE TO PRINT ON
DEVICE: Home  VIRTUAL TERMINAL  [YOU CAN NOT SELECT A VIRTUAL TERMINAL]

Previously, you have selected queueing.
Do you STILL want your output QUEUED? Yes// N  (No)
DEVICE: Home  VIRTUAL TERMINAL
```

Report results:

```
Apr 21,2011            PATIENTS NOT ASKED ABOUT ALLERGIES            PAGE 1
               CURRENT INPATIENTS / OUTPATIENTS / NEW ADMISSIONS
                       FROM Oct 23,2010   TO Apr 21,2011@24:00

PATIENT                       SSN
-------------------------------------------------------------------------------

          CLINIC: PEDS/MORALES
                        * No Patients for this Clinic *

Apr 21,2011            PATIENTS NOT ASKED ABOUT ALLERGIES            PAGE 2
               CURRENT INPATIENTS / OUTPATIENTS / NEW ADMISSIONS
                       FROM Oct 23,2010   TO Apr 21,2011@24:00

PATIENT                       SSN
-------------------------------------------------------------------------------

          CLINIC: BJB SOCSERV
                        * No Patients for this Clinic *

Apr 21,2011            PATIENTS NOT ASKED ABOUT ALLERGIES            PAGE 3
               CURRENT INPATIENTS / OUTPATIENTS / NEW ADMISSIONS
                       FROM Oct 23,2010   TO Apr 21,2011@24:00

PATIENT                       SSN
-------------------------------------------------------------------------------

          CLINIC: BJB TBH
DEMO,CHELSEA MARIE          116431
```

4.1.6.4 Enter an adverse reaction in EHR

1. Click within the **Adverse Reactions** pane and select **New Adverse Reaction** from the right-click menu:

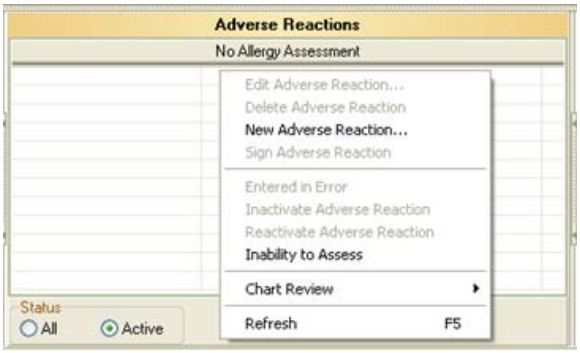


Figure 4-36: Preparing to add a new Adverse Reaction

EHR displays the **Look up Causative Agent** dialog:

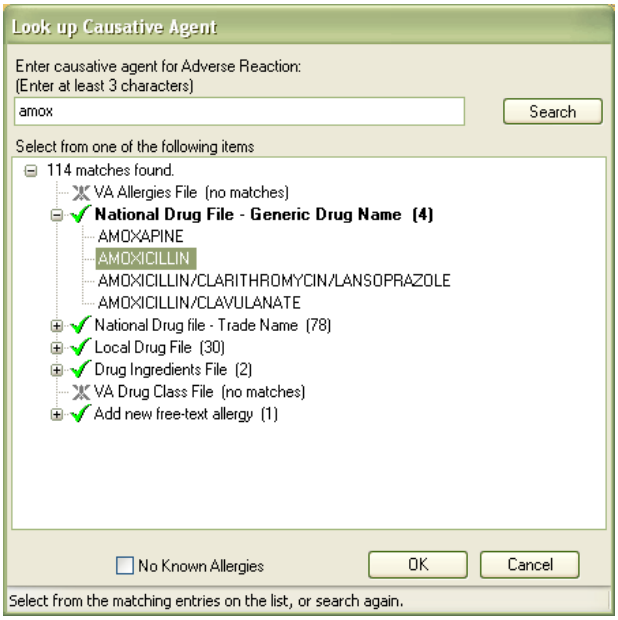


Figure 4-37: Look up Causative Agent dialog

2. Enter a few characters (at least three) in the text box on the **Look up Causative Agent** dialog and click **Search**. EHR displays a list of possible allergy items in the lower panel.

3. Select one of the retrieved allergy items and click the **OK** button to open the **Create Adverse Reaction** dialog:

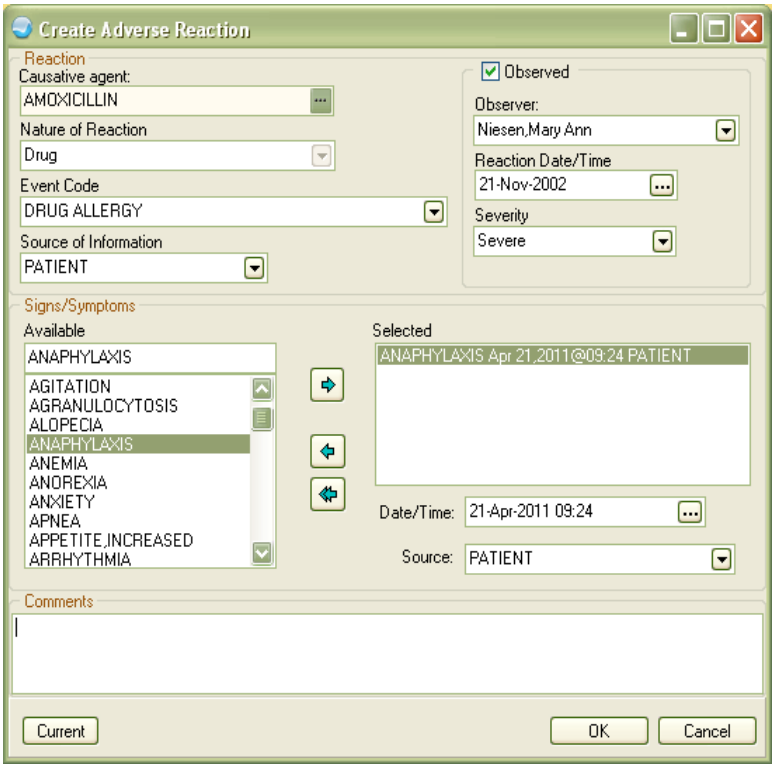


Figure 4-38: Create Adverse Reaction dialog

4. If the reaction was observed by the clinician, select the **Observed** check box to enable the associated fields (**Observer**, **Reaction Date/Time**, and **Severity**); select from the available values in these three fields to describe the observed reaction.

5. Complete this dialog.

   - Clicking **Current** displays a dialog listing the patient's current allergies.

6. Click **OK**. The newly-entered adverse reaction is now shown in the Adverse Reactions pane with a Status of ***Unsigned***:

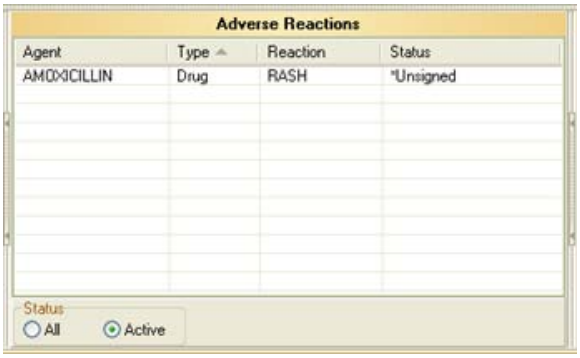


Figure 4-39: New, unsigned Adverse Reaction

7. Review and sign the outside medication entry, click the Awaiting Review graphical button:

Figure 4-40: Awaiting Review graphical button

EHR displays the **Review/Sign Changes** dialog.

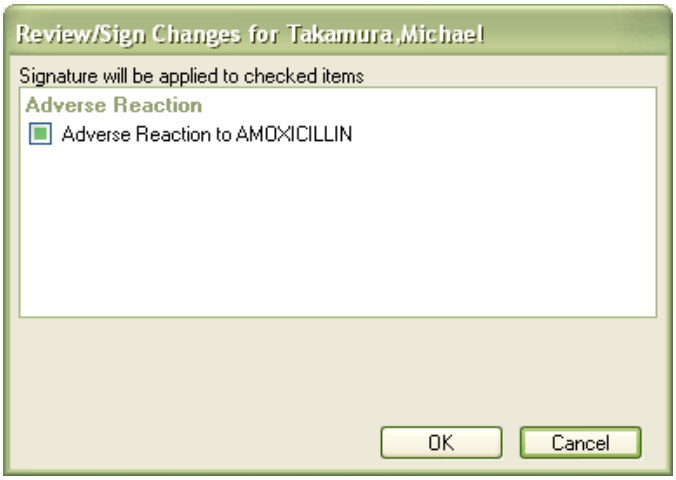


Figure 4-41: Review/Sign Changes dialog

8. Sign the change by clicking **OK**. The adverse reaction is now shown in the **Adverse Reactions** pane with a Status of ***Nonverified***:

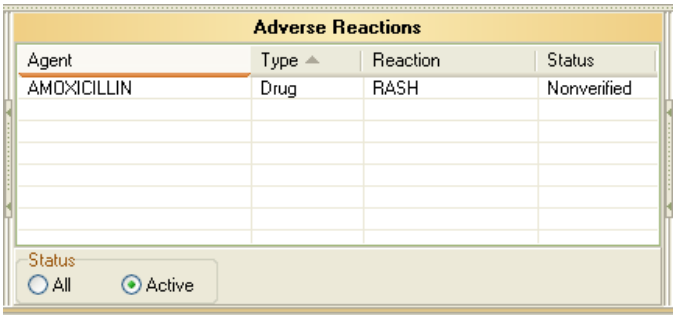


Figure 4-42: Signed, nonverified Adverse Reaction

4.1.6.5 Remove a Drug Allergy from the Problem List in EHR

1. Click the **CC/PROBS** tab to display the Problem List.

2. Click to highlight the drug allergy in the Problem List:

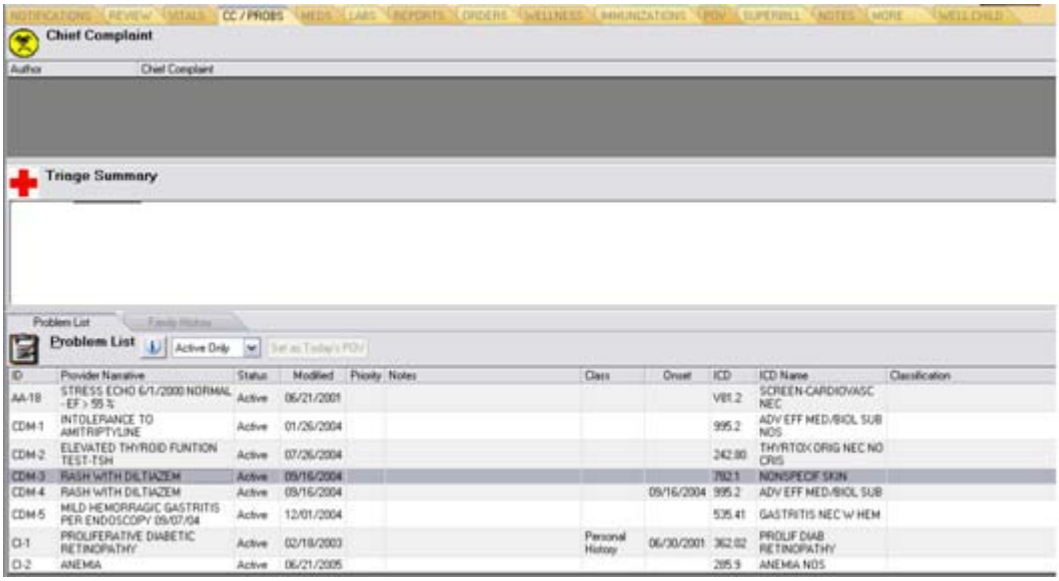


Figure 4-43: CC/PROBS tab with drug allergy highlighted in the Problem List

3. Click **Delete** (located in the upper right corner of the Problem List pane):

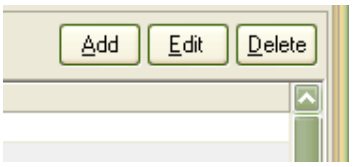
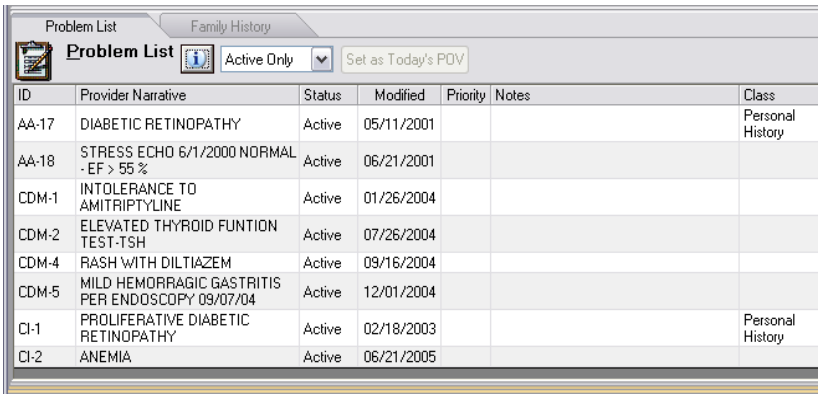


Figure 4-44: Problem List command buttons

4. Click **Yes** at the Delete Problem? dialog:

   The Problem List redisplays with the deleted drug allergy removed.



ID	Provider Narrative	Status	Modified	Priority	Notes	Class
AA-17	DIABETIC RETINOPATHY	Active	05/11/2001			Personal History
AA-18	STRESS ECHO 6/1/2000 NORMAL - EF > 55 %	Active	06/21/2001			
CDM-1	INTOLERANCE TO AMITRIPTYLINE	Active	01/26/2004			
CDM-2	ELEVATED THYROID FUNTION TEST-TSH	Active	07/26/2004			
CDM-4	RASH WITH DILTIAZEM	Active	09/16/2004			
CDM-5	MILD HEMORRAGIC GASTRITIS PER ENDOSCOPY 09/07/04	Active	12/01/2004			
CI-1	PROLIFERATIVE DIABETIC RETINOPATHY	Active	02/18/2003			Personal History
CI-2	ANEMIA	Active	06/21/2005			

Figure 4-45: Updated Problem List

4.1.6.6 Enter No Known Allergies in EHR

1. Enter ***No Known Allergies*** by right-clicking within the Adverse Reactions pane and selecting New Adverse Reaction from the right-click menu:

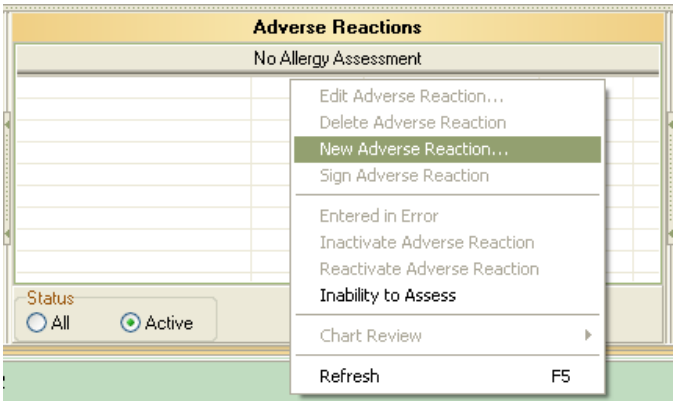


Figure 4-46: Preparing to add No Known Allergies

2. Select the **No Known Allergies** checkbox on the Look up Causative Agent dialog and click **OK**:

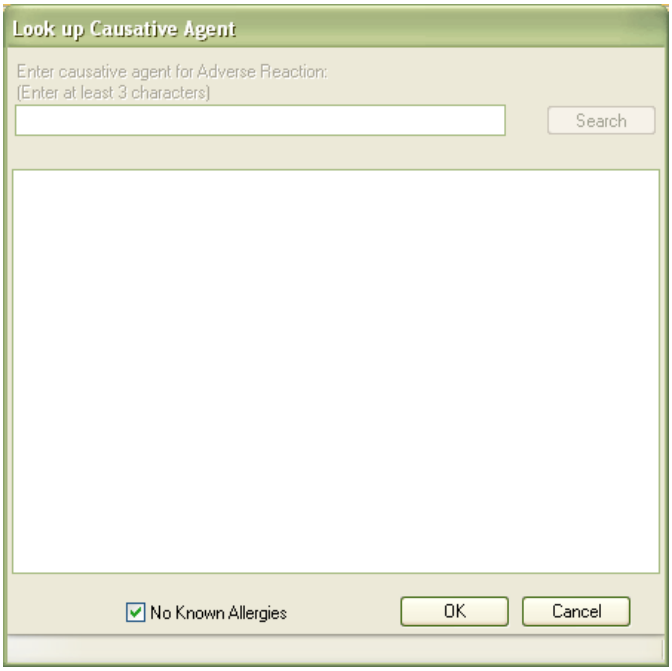


Figure 4-47: Look up Causative Agent dialog with **No Known Allergies** selected

> If the patient already has allergies recorded, the **No Known Allergies** checkbox will not be visible.

A notation of ***No Known Allergies*** is now shown in the Adverse Reactions pane:

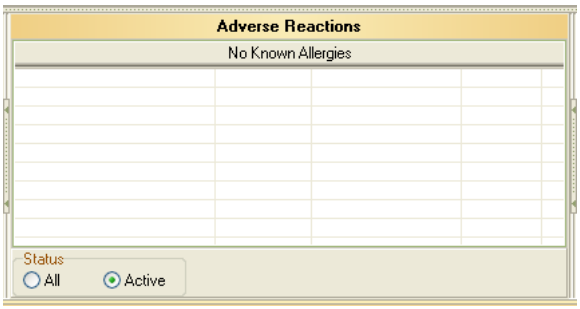


Figure 4-48: Notation of No Known Allergies

4.1.7 Vital Signs

Objective: "Record and chart changes in the following vital signs: Height, weight, and blood pressure and calculate and display body mass index (BMI) for ages 2 and older, plot and display growth charts for children 2-20 years, including BMI." *42 CFR Part 495.6,(d)(8)(i)*

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator who have at least one entry of their height, weight, and blood pressure recorded as structured data.}}{\text{The number of unique patients age 2 or older admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.}} > 50\%$$

Threshold: For more than 50% of all unique patients age 2 and over admitted to eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period, height, weight, and blood pressure are recorded as structured data.

4.1.7.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

WHERE: structured data is present during the EHR reporting period for each of the following data elements:

Height

Weight

Blood Pressure

Denominator Inclusions:

COUNT: each patient who is 2 years old or older at the beginning of the EHR reporting period

HAVING: the patient had one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

> Vital signs do not have to be updated at every visit to be up-to-date, nor do data elements have to be recorded on the same visit. A provider who believes that all three vital signs of their patients have no relevance to their scope of their practice may be excluded from this measure and will have to attest to this in separate documentation to CMS.

> The report will not take any potential exclusion of this measure into account.

Measure Exclusion: None

4.1.7.2 Configure RPMS

1. Configure the **Vitals** tab for EHR data entry:

```
Select EHR MAIN MENU Option: BEH
   RPMS-EHR Configuration Master Menu

                        RPMS-EHR Configuration Master Menu

   ART    Adverse Reaction Tracking Configuration ...
   CCX    Chief Complaint Configuration ...
{…}
   SPL    Spellchecking Configuration ...
   TIU    TIU Configuration ...
   VIT    Vital Measurement Configuration ...

Select RPMS-EHR Configuration Master Menu Option: VIT
   Vital Measurement Configuration
                         Vital Measurement Configuration

   CVR    Measurements Listed on Cover Sheet
   ERR    User access to Vitals Error Report
   OVR    Override Default Units
   PER    Data Entry Permissions
   TPL    Data Entry Templates

Select Vital Measurement Configuration Option: TPL
   Data Entry Templates
                               Data Entry Templates

Vital Measurement Input Template may be set for the following:

     100 User          USR    [choose from NEW PERSON]
     200 Class         CLS    [choose from USR CLASS]
     300 Service       SRV    [choose from SERVICE/SECTION]
     400 Location      LOC    [choose from HOSPITAL LOCATION]
     500 Division      DIV    [choose from INSTITUTION]
     900 System        SYS    [DEMO-HO.IHS.GOV]

Enter selection: SYS
   System   DEMO-HO.IHS.GOV

-- Setting Vital Measurement Input Template  for System: DEMO-HO.IHS.GOV --
Select Sequence: 5
Are you adding 5 as a new Sequence? Yes//   YES

Sequence: 5//    5
Measurement: TEMPERATURE
Select Sequence: 10

Sequence: 10//    10
Measurement: PULSE//   PULSE
Select Sequence: 15
```

```
Sequence: 15//    15
Measurement: RESPIRATIONS
Select Sequence: 20

Sequence: 20//    20
Measurement: BLOOD PRESSURE
Select Sequence: 25

Sequence: 25//    25
Measurement: HEIGHT
Select Sequence: 30

Sequence: 30//    30
Measurement: WEIGHT

Sequence  Value
--------  -----
5         TEMPERATURE
10        PULSE
15        RESPIRATIONS
20        BLOOD PRESSURE
25        HEIGHT
30        WEIGHT
```

2. Create a template for display of measurements in EHR:

```
Select RPMS-EHR Configuration Master Menu Option: VIT
   Vital Measurement Configuration
                        Vital Measurement Configuration

   CVR    Measurements Listed on Cover Sheet
   ERR    User access to Vitals Error Report
   OVR    Override Default Units
   PER    Data Entry Permissions
   TPL    Data Entry Templates

Select Vital Measurement Configuration Option: CVR
   Measurements Listed on Cover

                       Measurements Listed on Cover Sheet

Vital signs list for cover sheet may be set for the following:

     100 User          USR    [choose from NEW PERSON]
     200 Class         CLS    [choose from USR CLASS]
     300 Service       SRV    [choose from SERVICE/SECTION]
     400 Location      LOC    [choose from HOSPITAL LOCATION]
     500 Division      DIV    [choose from INSTITUTION]
     900 System        SYS    [DEMO-HO.IHS.GOV]

Enter selection: SYS  System   DEMO-HO.IHS.GOV

- Setting Vital signs list for cover sheet  for System: DEMO-HO.IHS.GOV -
Select Sequence: 5
Are you adding 5 as a new Sequence? Yes//   YES

Sequence: 5//    5
Measurement: TEMPERATURE
Select Sequence: 10
```

```
Sequence: 10//    10
Measurement: PULSE//   PULSE
Select Sequence: 15

Sequence: 15//    15
Measurement: RESPIRATIONS
Select Sequence: 20

Sequence: 20//    20
Measurement: BLOOD PRESSURE
Select Sequence: 25

Sequence: 25//    25
Measurement: HEIGHT
Select Sequence: 30

Sequence: 30//    30
Measurement: WEIGHT

Sequence  Value
--------  -----
5         TEMPERATURE
10        PULSE
15        RESPIRATIONS
20        BLOOD PRESSURE
25        HEIGHT
30        WEIGHT
```

3. Assign data entry permission to providers:

```
Select Vital Measurement Configuration Option: PER
   Data Entry Permissions
                              Data Entry Permissions

Can enter vital measurements? may be set for the following:

     100 User          USR    [choose from NEW PERSON]
     200 Class         CLS    [choose from USR CLASS]
     300 Service       SRV    [choose from SERVICE/SECTION]
     400 Location      LOC    [choose from HOSPITAL LOCATION]
     500 Division      DIV    [choose from INSTITUTION]
     900 System        SYS    [DEMO-HO.IHS.GOV]

Enter selection: 200
   Class   USR CLASS
Select USR CLASS NAME: PROVIDER

----- Setting Can enter vital measurements?  for Class: PROVIDER ---------
Can enter vital measurements?: YES//

   CVR    Measurements Listed on Cover Sheet
   ERR    User access to Vitals Error Report
   OVR    Override Default Units
   PER    Data Entry Permissions
   TPL    Data Entry Templates
```

4.1.7.3 EHR Use

1. Enter vital signs on the EHR Vitals tab:

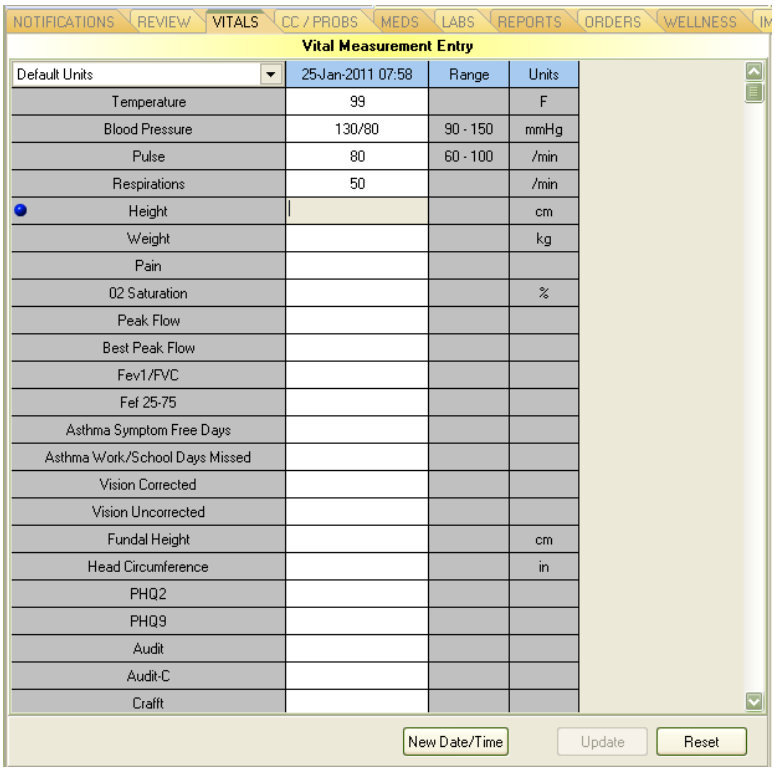


Figure 4-49: EHR Vitals tab

2. To view the height chart, click an **HT** entry in the Vitals pane:

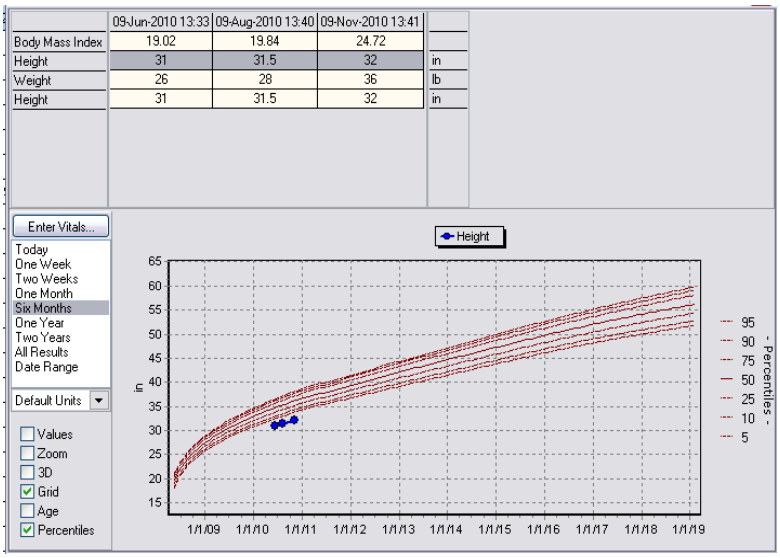


Figure 4-50: Height growth chart

3. To view the weight chart, click a **WT** entry in the Vitals pane:

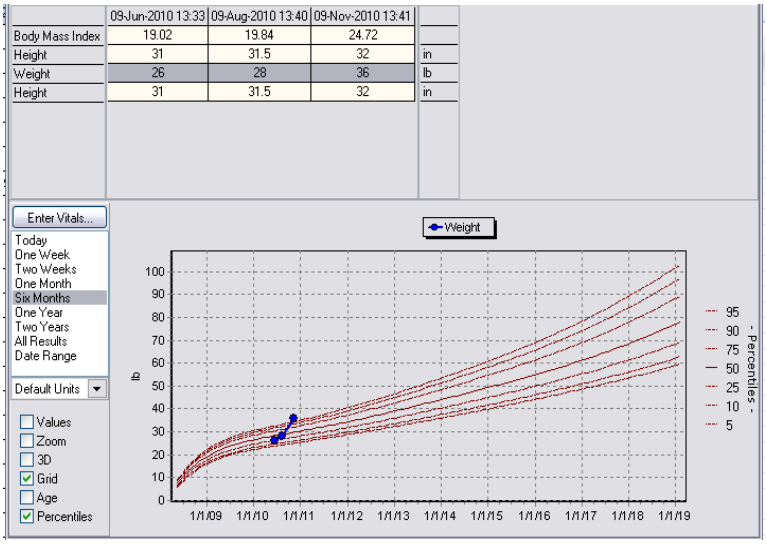


Figure 4-51: Weight growth chart

4. To view the Body Mass Index chart, click a **BMI** entry in the Vitals pane:

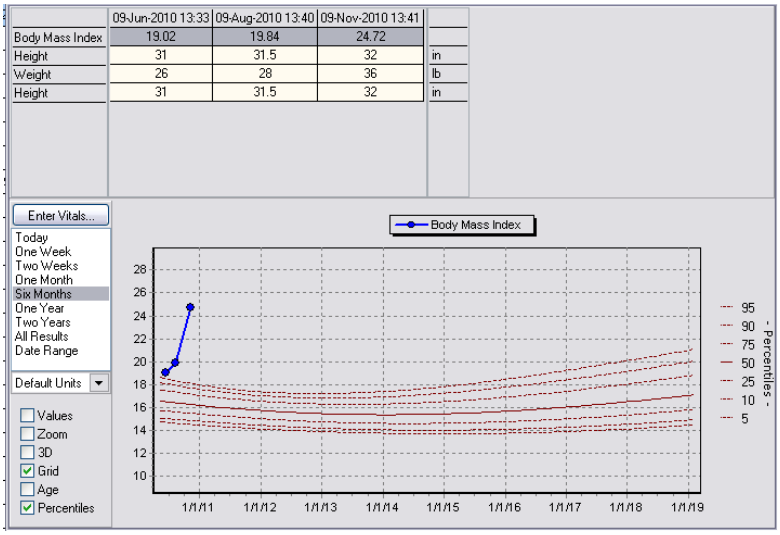


Figure 4-52: Body Mass Index chart

4.1.8 Smoking Status

Objective: "Record smoking status for patients 13 years or older."*42 CFR Part 495.6,(d)(9)(i)*

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator with smoking status recorded as structured data.}}{\text{The number of unique patients age 13 and older admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.}} > 50\%$$

Threshold: More than 50% of all unique patients 13 years old or older or admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.

> Smoking status must be recorded with one of the following National Tobacco Health Factors:
>
> - Current smoker, every day
> - Current smoker, some day
> - Current smoker, status unknown
> - Previous (former) smoker
> - Never smoked
> - Smoking status unknown

4.1.8.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

WHERE: structured data describing the patient's smoking status is present during the EHR reporting period

Denominator Inclusions:

COUNT: each patient who is 13 years old or older at the beginning of the EHR reporting period

HAVING: the patient had one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

> The list does not have to be updated at every visit to be considered up-to-date.

Measure Exclusion: Eligible hospitals or CAHs who admit no patients 13 years old or older are excluded from this measure.

4.1.8.2 Configure RPMS

No RPMS configuration is required.

4.1.8.3 Enter smoking status on the EHR Wellness tab.

1. Click the Wellness tab to display patient wellness data:

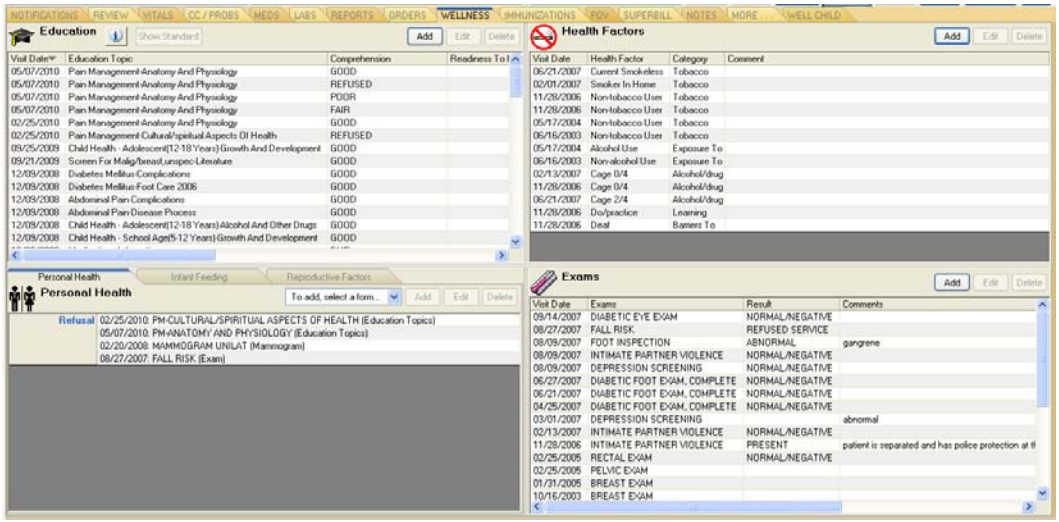
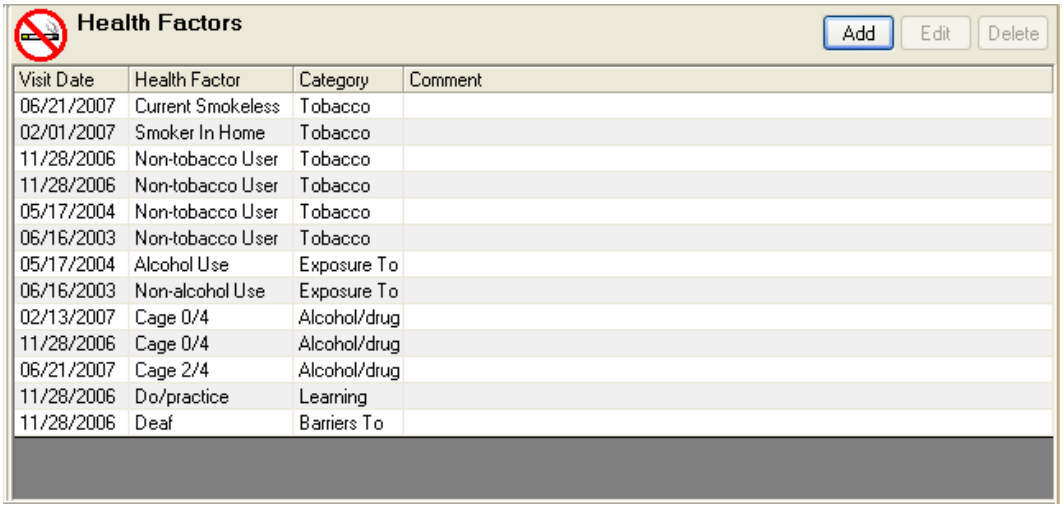


Figure 4-53: EHR Wellness tab

Smoking health factors are listed in the Health Factors pane on the Wellness tab:



Health Factors

Add Edit Delete

Visit Date	Health Factor	Category	Comment
06/21/2007	Current Smokeless	Tobacco	
02/01/2007	Smoker In Home	Tobacco	
11/28/2006	Non-tobacco User	Tobacco	
11/28/2006	Non-tobacco User	Tobacco	
05/17/2004	Non-tobacco User	Tobacco	
06/16/2003	Non-tobacco User	Tobacco	
05/17/2004	Alcohol Use	Exposure To	
06/16/2003	Non-alcohol Use	Exposure To	
02/13/2007	Cage 0/4	Alcohol/drug	
11/28/2006	Cage 0/4	Alcohol/drug	
06/21/2007	Cage 2/4	Alcohol/drug	
11/28/2006	Do/practice	Learning	
11/28/2006	Deaf	Barriers To	

Figure 4-54: Health Factors pane

2. Click **Add** to enter a new smoking status. The Add Health Factor dialog is displayed:

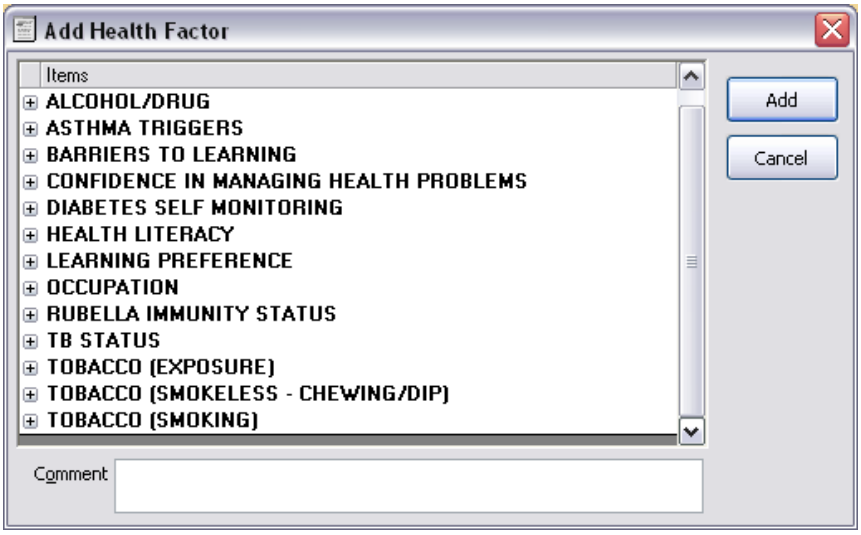


Figure 4-55: Add Health Factor dialog

3. Locate the **TOBACCO [SMOKING]** category.

4. Click [+] to expand the category:

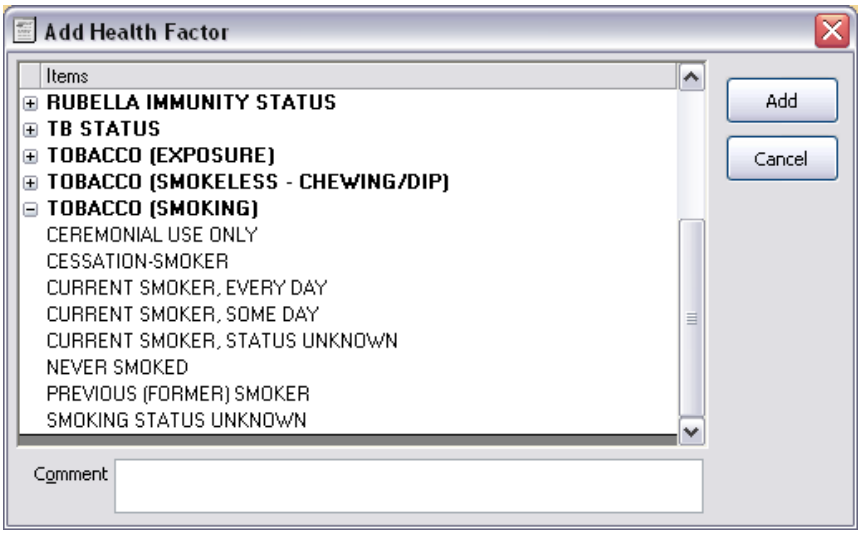


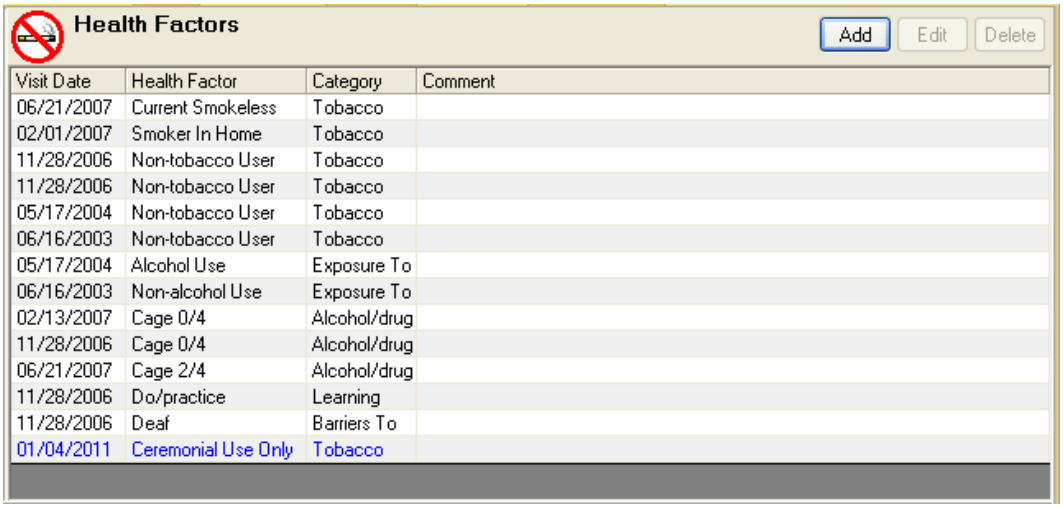
Figure 4-56: Add Health Factor dialog - Tobacco category expanded

5. Click to highlight the Health Factor.

> The first two factors in the Tobacco (Smoking) category, **Ceremonial Use Only** and **Cessation-Smoker**, are not counted for MU.

6. Optionally, type additional information in the **Comments** field.

7. Click **Add** on the Add Health Factor dialog to save the selected Health Factor. The new Health Factor is added to the list in the Health Factors pane:



Visit Date	Health Factor	Category	Comment
06/21/2007	Current Smokeless	Tobacco	
02/01/2007	Smoker In Home	Tobacco	
11/28/2006	Non-tobacco User	Tobacco	
11/28/2006	Non-tobacco User	Tobacco	
05/17/2004	Non-tobacco User	Tobacco	
06/16/2003	Non-tobacco User	Tobacco	
05/17/2004	Alcohol Use	Exposure To	
06/16/2003	Non-alcohol Use	Exposure To	
02/13/2007	Cage 0/4	Alcohol/drug	
11/28/2006	Cage 0/4	Alcohol/drug	
06/21/2007	Cage 2/4	Alcohol/drug	
11/28/2006	Do/practice	Learning	
11/28/2006	Deaf	Barriers To	
01/04/2011	Ceremonial Use Only	Tobacco	

Figure 4-57: Health Factor dialog with new entry

4.1.9 Clinical Decision Support

Objective: "Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule." *42 CFR Part 495.6,(f)(10)(i)*

Type of Measure: Attestation

Threshold: Implement one clinical decision support rule.

4.1.9.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

HAVING: at least one of the following implemented during the entire EHR reporting period:

Clinical Reminders package installed and national reminders configured

Diabetes Supplement configured at the EHR Reports tab

Pre-Diabetes Supplement configured at the EHR Reports tab

Asthma Supplement configured at the EHR Reports tab

Anti-coagulation Supplement configured at the EHR Reports tab

Women's Health Supplement configured at the EHR Reports tab

Immunization Package Forecasting configured at the EHR Reports tab

Health Maintenance Reminders configured at the EHR Reports tab.

AND HAVING: implemented at least one disease-specific admission menu

The MU Report will display "Yes" if any of the above are found to be installed, or "No" if none of the above are found to be installed.

Measure Exclusion: None.

4.1.9.2 Configure RPMS for Immunization Forecasting

The following instructions describe how to set up an immunization forecasting rule to meet the Clinical Decision Support Performance Measure. This example may not be useful in some settings (dental practice, optometry clinic, etc.); the provider should choose a relevant alternative when appropriate.

1. Navigate to the Immunization Forecasting options:

```
Select RPMS-EHR Configuration Master Menu Option: IMM
   Immunization Menu

                           MAIN MENU at DEMO HOSPITAL

   PAT    Patient Menu ...
   REP    Reports Menu ...
   MGR    Manager Menu ...

Select Immunization Menu Option: MGR
   Manager Menu

   ERR    Edit Patient Errors
   CMG    Add/Edit Case Manager
   CMT    Transfer a Case Manager's Patients
   SCN    Scan For Patients
          ------------------------------
   ESP    Site Parameters Edit
   PKG    Package Setup Information
   LET    Form Letters Add/Edit
   LOT    Lot Number Add/Edit
   VAC    Vaccine Table Edit
   RES    Restandardize Vaccine Table
   EXP    Export Immunizations
   KEY    Allocate/Deallocate Imm Menu Keys

Select Manager Menu Option: ESP
   Site Parameters Edit

                           *  EDIT SITE PARAMETERS  *

   Select SITE/FACILITY: DEMO HOSPITAL
        NASHVILLE NON-IHS       CHEROKEE
       01                      NM  HOSPITAL  7247
```

```
         ...OK? Yes//   (Yes)

     Edit Site Parameters for: DEMO HOSPITAL
   1) Default Case Manager.........: TSUI,GLEN M
   2) Other Location...............: DEMO HOSPITAL   NASHVILLE NON-IHS
   3) Standard Imm Due Letter .....: Official Immunization Record
   4) Official Imm Record Letter...: Official Immunization Record
   5) Facility Report Header.......: CIHA HOSPITAL
   6) Host File Server Path........: /m/
   7) Minimum Days Last Letter.....: 30 days
   8) Minimum vs Recommended Age...: Recommended Age
   9) ImmServe Forecasting Option..: #3, WITH 4-Day Grace, HPV through 18
  10) Lot Number Options...........: NOT Required, Default Low Supply
Alert=50
  11) Pneumo & Flu Parameters......: Pneumo: 65 yrs  Flu: All ages (>6
mths)
  12) Forecasting (Imms Due).......: Enabled
  13) Chart# with dashes...........: No Dashes (123456)
  14) User as Default Provider.....: Yes
  15) ImmServe Directory...........: C:\Program Files\Immserve84\
  16) GPRA Communities.............: 2 Communities selected for GPRA.
  17) Inpatient Visit Check........: Disabled  18) High Risk Factor
Check.......: Enabled (Smoking not included in Pneumo)     19) Import CPT-
coded Visits......: Disabled  20) Visit Selection Menu.........: Disabled
(Link Visits automatically) Select Action: 9
```

2. Set forecasting options and rules:

```
                        *  SELECT FORECASTING OPTIONS  *

   Versions 1, 3, 5 and 11 forecast the first vaccines series at 6 wks;
   the others beginning at 2 mths.  All versions forecast Rotavirus at
   2 (6 wks), 4, and 6 mths, and Influenza between Sept 15 and March 15
   for infants 6 months-18 years (or all ages).  Options 3,4 & 6 forecast
   Hep A starting at 12 months, while options 1,2,5 and 11 forecast Hep A
   at 15 months.  Option 11 does not forecast Hep A or Hep B in persons
   over 18 years, regardless of prior doses. All options forecast Tdap,
MCV4,
   and HPV for adolescents per ACIP recs.

   Please select an Option below by entering the its corresponding number:

      Option    6 Mths         12 Mths                      15 Mths
      ------    ------  ----------------------------      ----------
       1) ...   IPV     Hib, MMR, Pn, Var ..........      DTaP, HepA
       2) ...   ....    Hib, IPV, MMR, Pn, Var ......      DTaP, HepA
       3) ...   IPV     DTaP, Hib, MMR, Pn, Var, HepA
       4) ...   ....    DTaP, Hib, IPV, MMR, Pn, Var, HepA
       5) ...   IPV     Hib, MMR, Var ..............      DTaP, Pn, HepA
       6) ...   IPV     Hib, MMR, Var, HepA.........      DTaP, Pn
      11) ...   IPV     Hib, MMR, Pn, Var ..........      DTaP, HepA

     Select Forecasting Rules: 3

                        *  SELECT FORECASTING RULES  *

     The ACIP recommends that vaccine doses administered 4 days or less
     before the minimum interval or age be counted as valid.  (Not all
     states accept this “4-Day Grace Period.”)
```

```
     Below, choose “Yes” if you would like to screen using the 4-Day Grace
     Period.  Choose “No” to adhere strictly to the recommended intervals.
     B
     Note: The 4-Day Grace Period will not affect vaccine forecasting, only
     screening for the validity of the dose administered.

     Do you wish to implement a 4-Day Grace Period? YES

                         *  SELECT FORECASTING RULES  *

     The ACIP recommends HPV for females 11-12 years with catch up for
     13-26 year olds.  But HPV is provided by the Vaccine for Children's
     Program only for 9-18 year olds.

     Please select whether HPV should forecast from age 11 through 18 years
     or age 11 through 26 years.

     Select 1 (18 yrs) or 2 for (26 yrs): 1
Nov 10, 2010 09:08:35          Page:    1 of    2

     Edit Site Parameters for: DEMO HOSPITAL
   1) Default Case Manager.......: TSUI,GLEN M
   2) Other Location.............: DEMO HOSPITAL   NASHVILLE NON-IHS
   3) Standard Imm Due Letter ...: Official Immunization Record
   4) Official Imm Record Letter.: Official Immunization Record
   5) Facility Report Header.....: CIHA HOSPITAL
   6) Host File Server Path......: /m/
   7) Minimum Days Last Letter...: 30 days
   8) Minimum vs Recommended Age.: Recommended Age
   9) ImmServe Forecasting Option: #3, WITH 4-Day Grace, HPV through 18
  10) Lot Number Options.........: NOT Required, Default Low Supply Alrt=50
  11) Pneumo & Flu Parameters....: Pneumo: 65 yrs  Flu: All ages (>6 mths)
  12) Forecasting (Imms Due).....: Disabled
  13) Chart# with dashes.........: No Dashes (123456)
  14) User as Default Provider...: Yes
  15) ImmServe Directory.........: C:\Program Files\Immserve84\
  16) GPRA Communities...........: 2 Communities selected for GPRA.
  17) Inpatient Visit Check......: Disabled  18) High Risk Factor
Check.....: Enabled (Smoking not included in Pneumo)  19) Import CPT-coded
Visits....: Disabled  20) Visit Selection Menu.......: Disabled (Link
Visits automatically)
Select Action: Quit// 12
```

3. Enable forecasting:

```
                        *  ENABLE/DISABLE FORECASTING  *

     If the ImmServe Forecasting Utility is properly installed and
     Immunizations Due should be forecast when viewing and editing
     patient histories, printing Due Lists, etc., choose “Enable” below.
     If the ImmServe Utility is not installed, choose “Disable” below.

     NOTE: If at any point in the software an <XCALL> error occurs,
           this is due to the ImmServe Utility being called without
           it being installed.  In this case, either the ImmServe
           Utility should be installed (see Installation Notes in
           the Technical Manual), or this parameter should be Disabled.

     Please select either Enable or Disable: Enable
Nov 10, 2010 09:08:57          Page:    1 of    2
```

```
     Edit Site Parameters for: DEMO HOSPITAL
   1) Default Case Manager.......: TSUI,GLEN M
   2) Other Location.............: DEMO HOSPITAL   NASHVILLE NON-IHS
   3) Standard Imm Due Letter ...: Official Immunization Record
   4) Official Imm Record Letter.: Official Immunization Record
   5) Facility Report Header.....: CIHA HOSPITAL
   6) Host File Server Path......: /m/
   7) Minimum Days Last Letter...: 30 days
   8) Minimum vs Recommended Age.: Recommended Age
   9) ImmServe Forecasting Option: #3, WITH 4-Day Grace, HPV through 18
  10) Lot Number Options.........: NOT Required, Default Low Supply Alrt=50
  11) Pneumo & Flu Parameters....: Pneumo: 65 yrs  Flu: All ages (>6 mths)
  12) Forecasting (Imms Due).....: Enabled
  13) Chart# with dashes.........: No Dashes (123456)
  14) User as Default Provider...: Yes
  15) ImmServe Directory.........: C:\Program Files\Immserve84\
  16) GPRA Communities...........: 2 Communities selected for GPRA.
  17) Inpatient Visit Check......: Disabled
Select Action: Quit
```

4.1.9.3 View Immunization Forecasting in EHR

View the Immunization Forecast in the Immunization Record pane of the EHR Immunizations tab. The patient's upcoming and overdue immunizations are listed in the Forecast field.

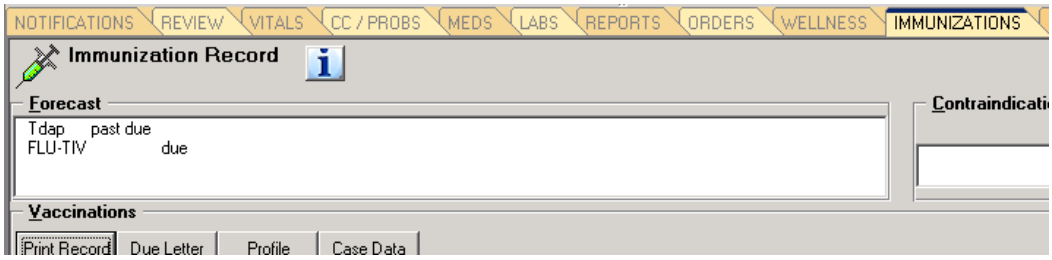


Figure 4-58: EHR Immunizations tab, Forecast pane

4.1.9.4 Configure RPMS for IHS Health Summary Supplements

The following instructions describe how to set up a Diabetes Health Summary Supplement in RPMS to meet the Clinical Decision Support Performance Measure. This example shows creation of ***Diabetes Supplement MU***. The process to create any of the other four types is essentially the same; just change the title of the Health Summary type and choose appropriate options.

1. Navigate to the IHS Health Summary Configuration:

```
Select IHS Kernel Option: CORE
   IHS Core

   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
   AGM    Patient registration ...
```

```
   AR     A/R MASTER MENU ...
   ART    Adverse Reaction Tracking ...
   ARWS   Automatic Replenishment ...
   ASTH   Asthma Register ...
   BDP    Designated Specialty Prov Mgt System ...
   BH     Behavioral Health Information System ...
   BVP    View Patient Record
   BYPX   Pyxis Management Menu ...
   CASE   Case Management System ...
   CHR    Community Health Representative System ...
   CHS    Contract Health System ...
   CIMC   McCallie System Upload to RPMS ...
   CRS    IHS Clinical Reporting System (CRS) Main Menu ...
   DDS    Dental Data System Menu ...
   DMS    Diabetes Management System ...
   EHR    EHR MAIN MENU ...

Select IHS Core Option: EHR
   EHR MAIN MENU

   BEH    RPMS-EHR Configuration Master Menu ...
   CON    Consult Management ...
   CPRS   CPRS Manager Menu ...

Select EHR MAIN MENU Option: BEH
   RPMS-EHR Configuration Master Menu

                        RPMS-EHR Configuration Master Menu

   ART    Adverse Reaction Tracking Configuration ...
   CCX    Chief Complaint Configuration ...
   CON    Consult Tracking Configuration ...
   EDU    Patient Education Configuration ...
   ENC    Encounter Context Configuration ...
   EXM    Exam Configuration ...
   FRM    VueCentric Framework Configuration ...
   HFA    Health Factor Configuration ...
   IMG    VistA Imaging Extensions ...
   IMM    Immunization Configuration ...
   LAB    Lab Configuration ...
   MED    Medication Management Configuration ...
   NOT    Notification Configuration ...
   ORD    Order Entry Configuration ...
   PAT    Patient Context Configuration ...
   PHX    Personal Health Hx Configuration ...
   PLS    Problem List Configuration ...
   POV    POV Configuration ...
   PRC    Procedure Configuration ...
   REM    Reminder Configuration ...
   RPT    Report Configuration ...
   SPL    Spellchecking Configuration ...
   TIU    TIU Configuration ...
   VIT    Vital Measurement Configuration ...

Select RPMS-EHR Configuration Master Menu Option: RPT
   Report Configuration

                                Report Configuration

   FMT    Print Formats
   HSM    Health Summary Configuration ...
```

```
   PAR    Report Parameters ...
   SYS    System Display Parameters
   USR    User Display Parameters

Select Report Configuration Option: HSM
   Health Summary Configuration

                           Health Summary Configuration

   ALL    List All Health Summaries
   IHS    IHS Health Summary Configuration ...
   VHA    VHA Health Summary Configuration ...

Select Health Summary Configuration Option: IHS
   IHS Health Summary Configuration

                         IHS Health Summary Configuration

   DF     Delete Health Summary Flowsheet
   DI     Delete Health Summary Flowsheet Item
   DM     Delete Measurement Panel Definition
   DS     Delete Health Summary Type
   FMMT   Create/Modify Health Summary Type using Fileman
   HM     Health Maintenance Reminders ...
   HS     Generate Health Summary
   HSSP   Update Health Summary Site Parameters
   IS     Inquire About a Health Summary Type
   LC     List Health Summary Components
   LF     List Health Summary Flowsheets
   LI     List Health Summary Flowsheet Items
   LM     List Measurement Panel Types
   LS     List Health Summary Types
   MF     Create/Modify Flowsheet
   MI     Create/Modify Flowsheet Item
```

2. Name the new Health Summary type:

```
   MM     Create/Modify Measurement Panel
   MS     Create/Modify Health Summary Type
   PP     Print Health Maintenance Item Protocols
   PWH    Print Patient Wellness Handout
   TYP    IHS Health Summary Types

Select IHS Health Summary Configuration Option: MS
Create/Modify Health Summary

                        Create/Modify Health Summary Type

This option will allow you to create a new or modify an existing
health summary type.

Select HEALTH SUMMARY TYPE NAME: DIABETES SUPPLEMENT MU

  Are you adding 'DIABETES SUPPLEMENT MU' as a new HEALTH SUMMARY TYPE
   (the 2ND)? No// Y  (Yes)

NAME: DIABETES SUPPLEMENT MU  Replace

Health Summary: DIABETES SUPPLEMENT MU
```

```
STRUCTURE:
Order Component                                Max occ Time Alternate Title

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
<none>

LAB TEST PANELS:
```

3. Select and set the order of the Health Summary's components:

```
MS Modify Structure      FS Flow Sheets          GI General Info
MP Mod Meas Panel        HF Health Factors       HS Sample Health Summary
LP Lab Panel             PC Provider Class Scrn  Q  Quit
HM Health Main Remind    CS Clinic Screen
BP Best Practice Prompts SP Supplements

Select Action: MS
   Modify Structure

You can add a new component by entering a new order number and
component name.  To remove a component from this summary type select the
component by name or order and then enter an '@'.

Select SUMMARY ORDER: 5
   STRUCTURE COMPONENT NAME: DEMOGRAPHIC
     1   DEMOGRAPHIC DATA
     2   DEMOGRAPHICS - BRIEF
     3   DEMOGRAPHICS - BRIEF W/ADV DIRECTIVES
     4   DEMOGRAPHICS - W/O REMARKS

CHOOSE 1-4: 2
   DEMOGRAPHICS – BRIEF

  COMPONENT NAME: DEMOGRAPHICS - BRIEF//
  ALTERNATE TITLE:

Select SUMMARY ORDER: 10
  STRUCTURE COMPONENT NAME: SUPPLEMENTS
  COMPONENT NAME: SUPPLEMENTS//
  ALTERNATE TITLE:

Health Summary: DIABETES SUPPLEMENT MU

STRUCTURE:
Order Component                                Max occ Time Alternate Title
5     DEMOGRAPHICS - BRIEF
10    SUPPLEMENTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
```

```
Provider Initials displayed on Medication components:

MS Modify Structure      FS Flow Sheets          GI General Info
MP Mod Meas Panel        HF Health Factors       HS Sample Health Summary
LP Lab Panel             PC Provider Class Scrn  Q  Quit
HM Health Main Remind    CS Clinic Screen
BP Best Practice Prompts SP Supplements

Select Action: SP
   Supplements

Select SUPPLEMENT PANEL SEQUENCE: 5
  Are you adding '5' as a new SUPPLEMENT PANEL SEQUENCE (the 1ST for this
HEALTH SUMMARY TYPE)? No// Y  (Yes)

   SUPPLEMENT PANEL SEQUENCE SUPPLEMENT PANEL TYPE: ?
 Answer with HEALTH SUMMARY SUPPLEMENT NAME OF SUPPLEMENT
 Do you want the entire 13-Entry HEALTH SUMMARY SUPPLEMENT List? Y  (Yes)

   Choose from:
   ACTION PROFILE
   ANTICOAGULATION THERAPY
   ASTHMA PATIENT CARE SUMMARY
   CHRONIC MED REORDER DOC-DATE
   CHRONIC MED REORDER DOC-NAME
   CHRONIC MED REORDER SHORT FORM
   CHRONIC PAIN AGREEMENT
   DIABETIC CARE SUMMARY
   HMS PATIENT CARE SUPPLEMENT
   MEDICATION REORDER DOC BY DATE
   MEDICATION REORDER DOC BY NAME
   PRE-DIABETES CARE SUMMARY
   WOMEN'S HEALTH PROFILE

SUPPLEMENT PANEL SEQUENCE SUPPLEMENT PANEL TYPE: DIABETIC CARE SUMMARY

SUPPLEMENT PANEL TYPE: DIABETIC CARE SUMMARY//

TIME LIMIT FOR MED DISPLAY: 1Y

Health Summary: DIABETES SUPPLEMENT MU

STRUCTURE:
Order Component                         Max occ Time Alternate Title
5     DEMOGRAPHICS - BRIEF
10    SUPPLEMENTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
<none>
+         Enter ?? for more actions
<none>
+         Enter ?? for more actions
MS Modify Structure       FS Flow Sheets          GI General Info
MP Mod Meas Panel         HF Health Factors       HS Sample Health Summary
```

```
LP Lab Panel              PC Provider Class Scrn  Q  Quit
HM Health Main Remind     CS Clinic Screen
BP Best Practice Prompts  SP Supplements
```

4.1.9.5 Make the report available at the EHR Reports tab

The following instructions describe how to make the Health Summary Supplement (configured in section 4.1.9.4) available for selection on the EHR Reports tab. The example shows creation of ***Diabetes Supplement MU***. The process to set up any of the other four types is essentially the same, just change the title of the Health Summary type.

1. Determine the current configuration of the EHR Reports tab:

```
   CORE   IHS Core ...
   MM     Menu Management ...
   UM     User Management ...
   DEV    Device Management ...
   TM     Taskman Management ...
   PROG   Programmer Options ...

Select IHS Kernel Option: CORE
   IHS Core

   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
{…}
   DDS    Dental Data System Menu ...
   DMS    Diabetes Management System ...
   EHR    EHR MAIN MENU ...

Select IHS Core Option: EHR
   EHR MAIN MENU

   BEH    RPMS-EHR Configuration Master Menu ...
   CON    Consult Management ...

Select EHR MAIN MENU Option: BEH
   RPMS-EHR Configuration Master Menu

                        RPMS-EHR Configuration Master Menu

   ART    Adverse Reaction Tracking Configuration ...
   CCX    Chief Complaint Configuration ...
   CON    Consult Tracking Configuration ...
{…}
   PRC    Procedure Configuration ...
   REM    Reminder Configuration ...
   RPT    Report Configuration ...
   SPL    Spellchecking Configuration ...

Select RPMS-EHR Configuration Master Menu Option: RPT
   Report Configuration

                                Report Configuration

   FMT    Print Formats
```

```
   HSM    Health Summary Configuration ...
   PAR    Report Parameters ...
   SYS    System Display Parameters
   USR    User Display Parameters

Select Report Configuration: SYS
   System Display Parameters

                            System Display Parameters

GUI Reports - System for System: DEMO-HO.IHS.GOV
-------------------------------------------------------------------------------
List of reports          1                    ORRP ADHOC HEALTH SUMMARY
                         2                    ORRPW REPORT CATEGORIES
                         3                    ORRP HEALTH SUMMARY
                         4                    ORRP LAB STATUS
                         5                    ORRP IMAGING
                         9                    ORRP DAILY ORDER SUMMARY
                         10                   ORRP ORDER SUM FOR A DATE RNG
                         11                   ORRP CHART COPY SUMMARY
                         12                   ORRP OUTPATIENT RX PROFILE
                         25                   BEHOEN VISIT SUMMARY1
                         30                   BEHOEN VISIT SUMMARY2
                         35                   BEHOEN VISIT SUMMARIES
List of lab reports
-------------------------------------------------------------------------------

Select Sequence:
```

2. Add the Health Summary report to the Reports tab of the EHR GUI:

```
   FMT    Print Formats
   HSM    Health Summary Configuration ...
   PAR    Report Parameters ...
   SYS    System Display Parameters
   USR    User Display Parameters

Select Report Configuration: HSM
   Health Summary Configuration

                           Health Summary Configuration

   ALL    List All Health Summaries
   IHS    IHS Health Summary Configuration ...
   VHA    VHA Health Summary Configuration ...

Select Health Summary Configuration Option: IHS
   IHS Health Summary Configuration

                         IHS Health Summary Configuration

   DF     Delete Health Summary Flowsheet
   DI     Delete Health Summary Flowsheet Item
   DM     Delete Measurement Panel Definition
   DS     Delete Health Summary Type
   FMMT   Create/Modify Health Summary Type using Fileman
   HM     Health Maintenance Reminders ...
   HS     Generate Health Summary
   HSSP   Update Health Summary Site Parameters
   IS     Inquire About a Health Summary Type
```

```
   LC     List Health Summary Components

Select IHS Health Summary Configuration: IS
   Inquire About a Health Summary Type

                            IHS Health Summary Types

Allowable Health Summary Types may be set for the following:

     2   User          USR    [choose from NEW PERSON]
     4   System        SYS    [DEMO-HO.IHS.GOV]

Enter selection: 4
   System   DEMO-HO.IHS.GOV

-- Setting Allowable Health Summary Types  for System: DEMO-HO.IHS.GOV

Select Sequence: 12
Are you adding 12 as a new Sequence? Yes//   YES

Sequence: 12//

Sequence: 12//    12
Health Summary: DIABETES SUPPLEMENT MU

Select Sequence:
```

4.1.9.6 Find the Health Summary report on the EHR Reports tab

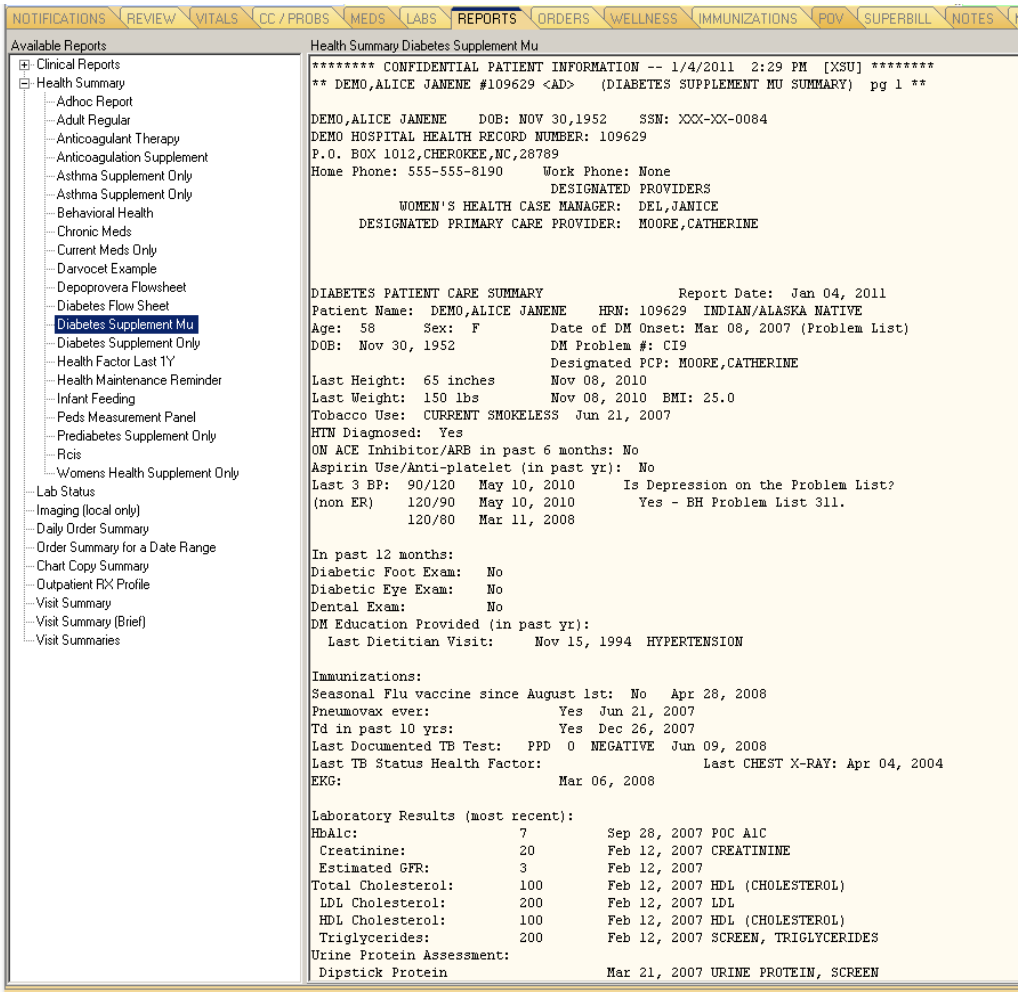


Figure 4-59: EHR Reports tab with the Diabetes Supplement MU report displayed

4.1.10 Calculate and Transmit Clinical Quality Measures

Objective: Report [on 15] ambulatory clinical quality measures to CMS (or for EHs seeking the Medicaid incentive payment, the States). *42 CFR Part 495.6,(d)(10)(i)*

Type of Measure: Attestation

Threshold: Provide aggregate numerator, denominator, and exclusions through attestation (Fiscal Year 2011 for eligible hospitals and CAHs).

4.1.10.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

HAVING: successfully reported to CMS the ambulatory clinical quality measures selected by CMS during the EHR reporting period

AND HAVING: done so in the manner specified by CMS

> Additional CMS Final Rule Information:
>
> The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

Measure Exclusion: None.

4.1.10.2 The MU Performance Report

A new MU Performance Report is being developed for inclusion in Patient Care Component Management Reports and in iCare. To meet this Performance Measure, the report will answer ***Yes*** if the facility has installed the appropriate Clinical Reporting System (CRS) version and patch that adds the new MU clinical quality measures.

CRS Version 11.0 Patch 3 will include reporting for 15 new eligible hospital and CAH measures.

4.1.10.3 Demonstrate MU

Year One:

1. Run the CRS report.
2. Submit the results by attestation to CMS or to the State; include: aggregate denominator, numerator, and exclusion data.

Year Two and beyond:

1. Run the CRS report.
2. Submit the results electronically to CMS or to the State.

4.1.11 Electronic Copy of Health Information

Objective: "Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and medication allergies) upon request." *42 CFR Part 495.6,(d)(11)(i)*

Type of Measure: Rate

The number of patients in the denominator who receive an electronic copy of their electronic health information within three business days. / The number of patients of the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) who request an electronic copy of their electronic health information not less than four business days prior to the end of the EHR reporting period.	>50%

Threshold: More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information during the EHR reporting period are provided it within 3 business days.

4.1.11.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

WHERE: the patient was given an electronic copy of the health information within three business days from the request date (determined by the Release of Information (ROI) fields of Record Dissemination where the value is “Electronic,” and Disclosure Date)

Denominator Inclusions:

COUNT: each patient

HAVING: one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) in the 365 days prior to the end of the EHR reporting period

AND HAVING: requested an electronic copy of their health information, (the Patient/Agent Request Type value in the ROI package is equal to “Electronic”)

WHERE: the request for their health information was made at any time from the first day of the EHR reporting period through four business days prior to the end of the EHR reporting period (determined by the Date Request Initiated field in ROI)

Measure Exclusion: Eligible hospitals and CAHs that have no patients in the denominator are excluded.

4.1.11.2 Configure RPMS

```
Select PCC Manager Menu Option: HSM
   Health Summary Maintenance

                      ************************************
                      **        IHS Health Summary       **
```

```
                      ** Health Summary Maintenance Menu **
                      ************************************
                            IHS PCC Suite Version 2.0

                                  DEMO HOSPITAL

   IS     Inquire About a Health Summary Type
   HM     Health Maintenance Reminders ...
   PP     Print Health Maintenance Item Protocols
   LS     List Health Summary Types
   LC     List Health Summary Components
   LM     List Measurement Panel Types
   LF     List Health Summary Flowsheets
   LI     List Health Summary Flowsheet Items
   MS     Create/Modify Health Summary Type
   MM     Create/Modify Measurement Panel

Select Health Summary Maintenance Option: MS
   Create/Modify Health Summary Type

This option will allow you to create a new or modify an existing
health summary type.

Select HEALTH SUMMARY TYPE NAME: ASTHMA SUPPLEMENT ONLY
   Are you adding 'ASTHMA SUPPLEMENT ONLY' as
    a new HEALTH SUMMARY TYPE (the 79TH)? No// Y  (Yes)
NAME: ASTHMA SUPPLEMENT ONLY  Replace
LOCK:

Health Summary: ASTHMA SUPPLEMENT ONLY

STRUCTURE:
Order Component                             Max occ Time Alternate Title

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
<none>

LAB TEST PANELS:
    Enter ?? for more actions

MS   Modify Structure     FS   Flow Sheets          GI   General Info
MP   Mod Meas Panel       HF   Health Factors       HS   Sample Health
Summary
LP   Lab Panel            PC   Provider Class Scrn  Q    Quit
HM   Health Main Remind   CS   Clinic Screen
BP   Best Practice PromptsSP   Supplements
Select Action: +// MS
   Modify Structure

You can add a new component by entering a new order number and
component name.  To remove a component from this summary type select the
component by name or order and then enter an '@'.

Select SUMMARY ORDER: 5
```

```
   STRUCTURE COMPONENT NAME: DEMOGRAPHICS - BRIEF
     1   DEMOGRAPHICS - BRIEF
     2   DEMOGRAPHICS - BRIEF W/ADV DIRECTIVES
CHOOSE 1-2: 1  DEMOGRAPHICS - BRIEF
  COMPONENT NAME: DEMOGRAPHICS - BRIEF//
  ALTERNATE TITLE:
Select SUMMARY ORDER: 10

   STRUCTURE COMPONENT NAME: SUPPLEMENTS
  COMPONENT NAME: SUPPLEMENTS//
  ALTERNATE TITLE:
Select SUMMARY ORDER:

Create/Modify Summary Type  Nov 09, 2010 15:09:57          Page:    1 of
3
Health Summary: ASTHMA SUPPLEMENT ONLY

STRUCTURE:
Order Component                                  Max occ Time Alternate
Title
5     DEMOGRAPHICS - BRIEF
10    SUPPLEMENTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
<none>
         Enter ?? for more actions          Nov 09, 2010 15:09:57

MS   Modify Structure     FS   Flow Sheets          GI   General Info
MP   Mod Meas Panel       HF   Health Factors       HS   Sample Health
Summary
LP   Lab Panel            PC   Provider Class Scrn  Q    Quit
HM   Health Main Remind   CS   Clinic Screen
BP   Best Practice PromptsSP   Supplements
Select Action: +// SP   Supplements

Select SUPPLEMENT PANEL SEQUENCE: 5
  Are you adding '5' as a new SUPPLEMENT PANEL SEQUENCE (the 1ST for this
HEALTH SUMMARY TYPE)? No// Y  (Yes)
   SUPPLEMENT PANEL SEQUENCE SUPPLEMENT PANEL TYPE: ASTHMA PATIENT CARE
SUMMARY

  SUPPLEMENT PANEL TYPE: ASTHMA PATIENT CARE SUMMARY//
  TIME LIMIT FOR MED DISPLAY:
Select SUPPLEMENT PANEL SEQUENCE:
```

Example of the table format:

```
-----------------------------------------------------------------------------
Create/Modify Summary Type    Nov 09, 2010 15:15:49       Page:  1 of    3
Health Summary: ASTHMA SUPPLEMENT ONLY

STRUCTURE:
Order Component                                  Max occ Time Alternate Title
```

```
5     DEMOGRAPHICS - BRIEF
10    SUPPLEMENTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
<none>
+         Enter ?? for more actions
MS   Modify Structure     FS   Flow Sheets          GI   General Info
MP   Mod Meas Panel       HF   Health Factors       HS   Sample Health
Summary
LP   Lab Panel            PC   Provider Class Scrn  Q    Quit
HM   Health Main Remind   CS   Clinic Screen
BP   Best Practice PromptsSP   Supplements
Select Action: +//
```

4.1.11.3 View a Health Summary report in EHR

1. Select the **Reports** tab:

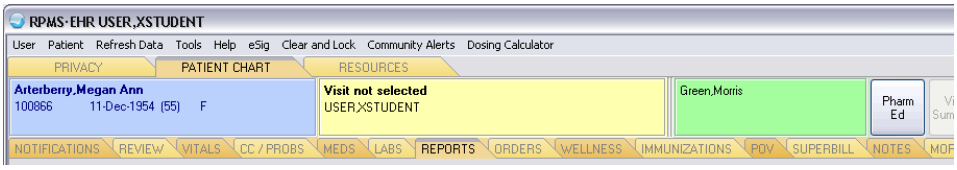


Figure 4-60: EHR tab set

2. Expand the **Health Summary** structure in the Available Reports pane:

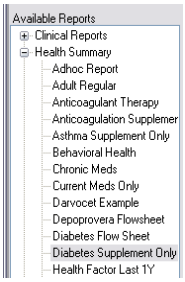


Figure 4-61: Reports tab, Available Reports pane

3. Select the Health Summary report to display:

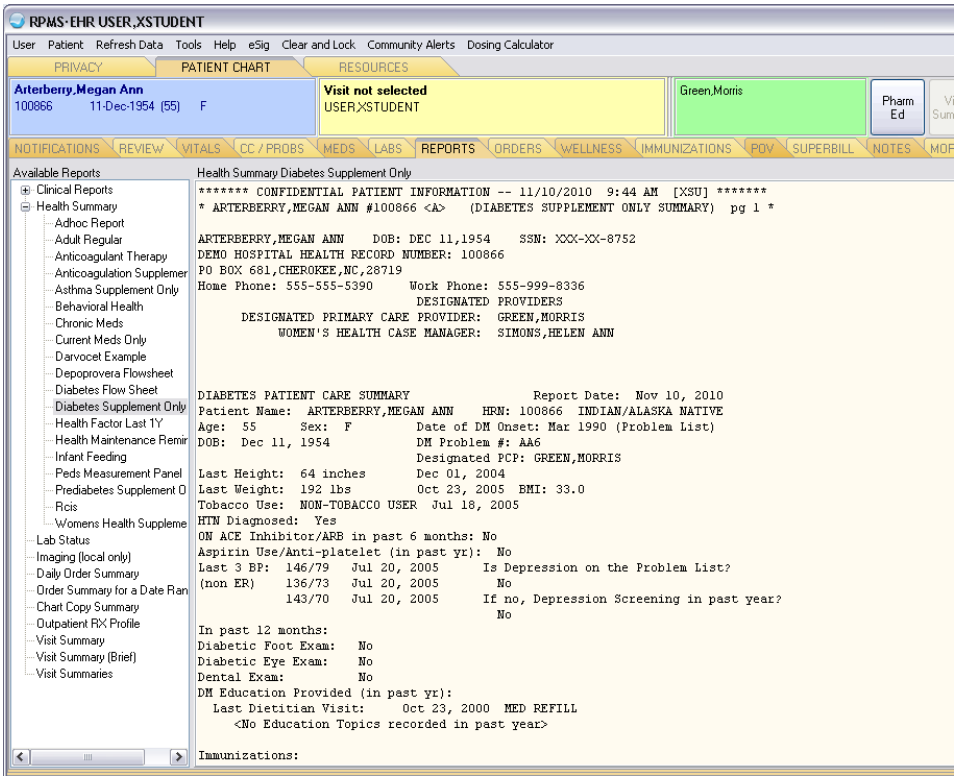


Figure 4-62: EHR Reports tab with selected Health Summary report

4.1.12 Electronic Copy of Discharge Instructions

Objective: "Provide patients with an electronic copy of their discharge instructions at the time of discharge, upon request." *42 CFR Part 495.6,(d)(11)(i)*

Type of Measure: Rate

The number of patients in the denominator who are provided an electronic copy of discharge instructions.	
The number of patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) who request an electronic copy of their discharge instructions and procedures during the EHR reporting period.	>50%

Threshold: More than 50% of all patients who are discharged from an eligible hospital or CAH inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions during the EHR reporting period are provided it.

4.1.12.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

WHERE: a TIU note title of "E-copy discharge instr received" is found

Denominator Inclusions:

COUNT: each patient

HAVING: one or more hospitalizations (Service Category of H) during the EHR reporting period

HAVING: a Discharge Type of one of the following:

Regular Discharge

Transferred

Irregular Discharge

OR HAVING: one or more emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the EHR reporting period

AND HAVING: either of the following TIU notes in the visit file:

"E-copy discharge instr received"

"E-copy discharge instr not received"

HAVING: an Entry Date/Time stamp on the day of the discharge

OR HAVING: and Entry Date/Time stamp on the day after the discharge

> The presence of a "received" or "not received" note IS the indication of the request. The type of note is the indicator of fulfilling the request.

Measure Exclusion: Eligible hospitals and CAHs that have no requests from patients for an electronic copy of discharge instructions during the EHR reporting period are excluded.

4.1.12.2 Verify that the TIU patch's Post-Install Routine was run

1. Select the Notes tab on the EHR window.

2. Click **New Note** to open the Progress Note Properties dialog:

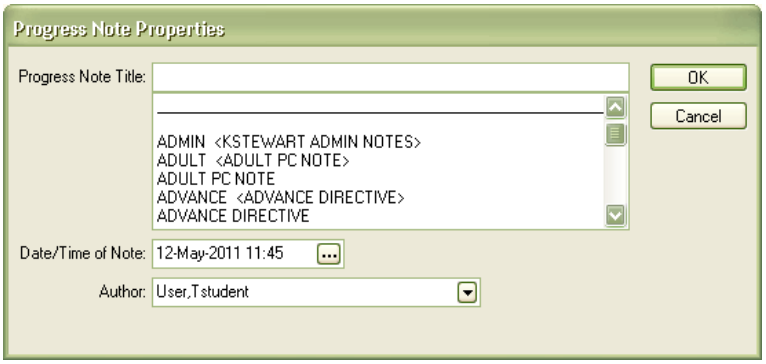


Figure 4-63: Progress Note Properties dialog

3. Type DISCHARGE in the **Progress Note Title** field to filter the list:

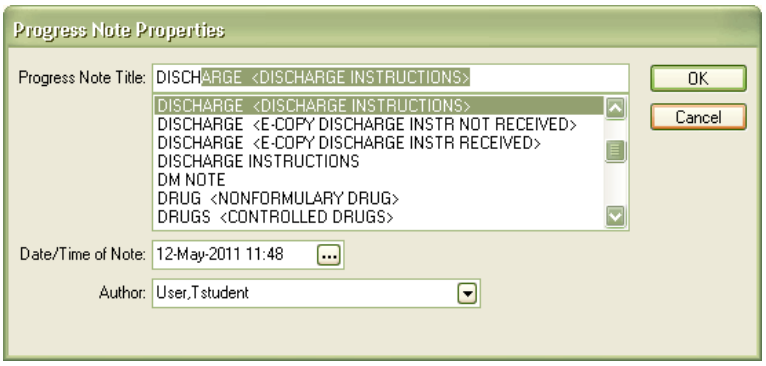


Figure 4-64: Progress Note Properties dialog, filtered

4. Look for the Progress Note Titles:
   - DISCHARGE <DISCHARGE INSTRUCTIONS>
   - ECOPY DISCHARGE INSTR RECEIVED
   - ECOPY DISCHARGE INSTR NOT RECEIVED
5. If any are not found, notify the site manager.
6. Click **Cancel** to close the dialog.

4.1.12.3 Import the E-Copy Templates into EHR

1. At the Notes tab, select Edit Shared Templates from the Options menu:

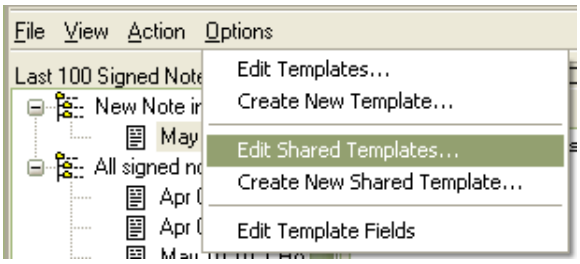


Figure 4-65: Options menu

2. The Template Editor dialog opens:

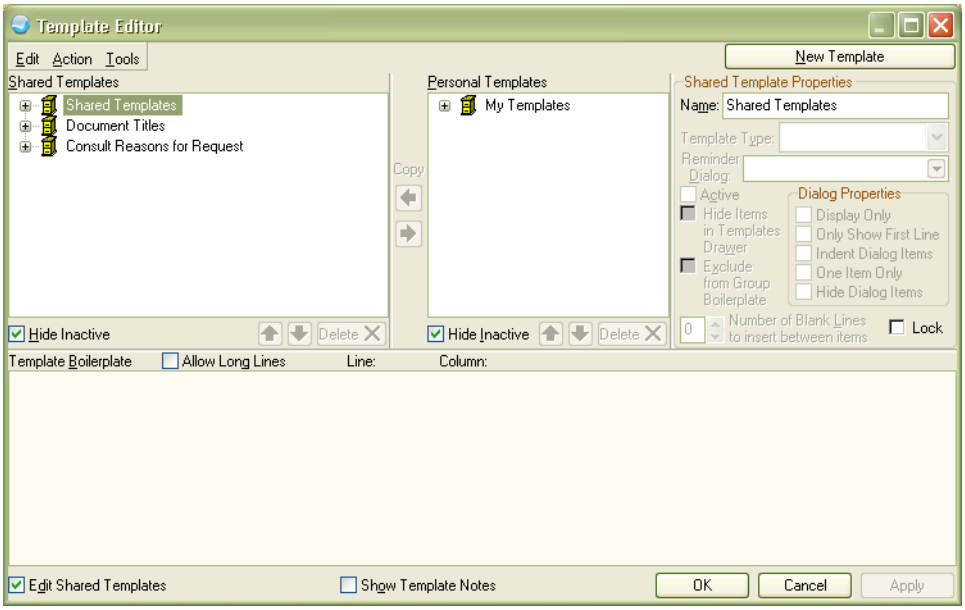


Figure 4-66: Template Editor dialog

3. Select Import Template from the Tools menu to display the File Open dialog:

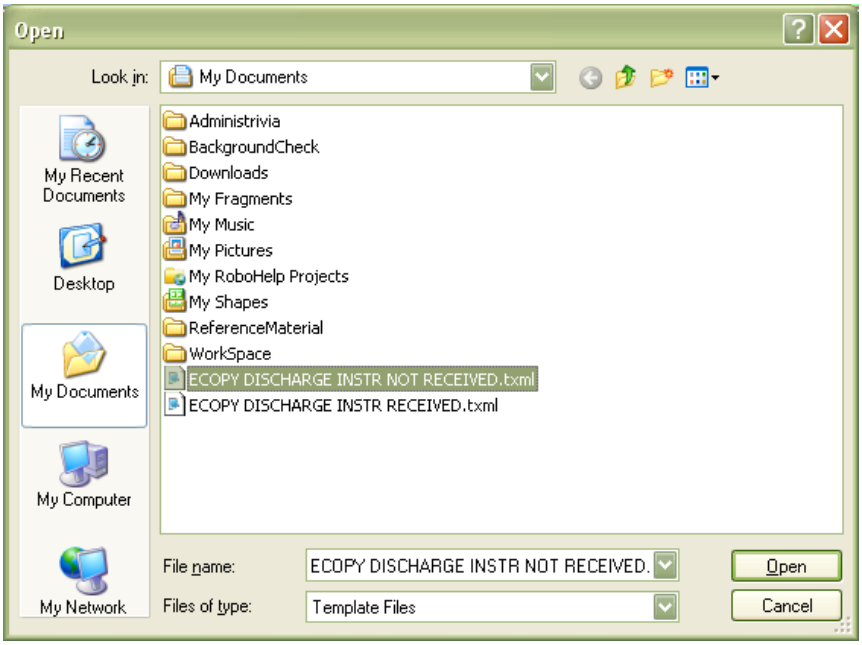


Figure 4-67: File Open dialog

4. Locate the file ECOPY DISCHARGE INSTR RECEIVED.txml; select it and click **Open**.

5. Repeat Steps 3 and 4 to import the file ECOPY DISCHARGE INSTR NOT RECEIVED.txml.

4.1.12.4 Attach E-Copy Templates to Note Titles in EHR

1. Click [+] to expand the structure of the Shared Templates file cabinet in the Shared Templates pane:

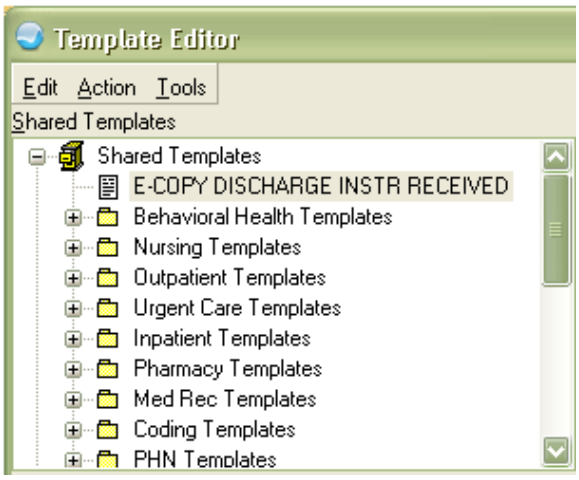


Figure 4-68: Template Editor dialog, Shared Templates file cabinet expanded

2. Click and hold ECOPY DISCHARGE INSTR RECEIVED and drag it to the Document Titles file cabinet; release the mouse button:

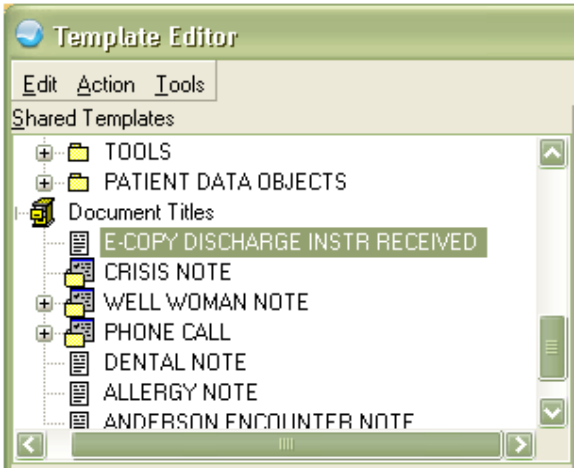


Figure 4-69: Template Editor dialog, Shared Templates file cabinet expanded

3. Select ECOPY DISCHARGE INSTR RECEIVED from the Associated Title list:

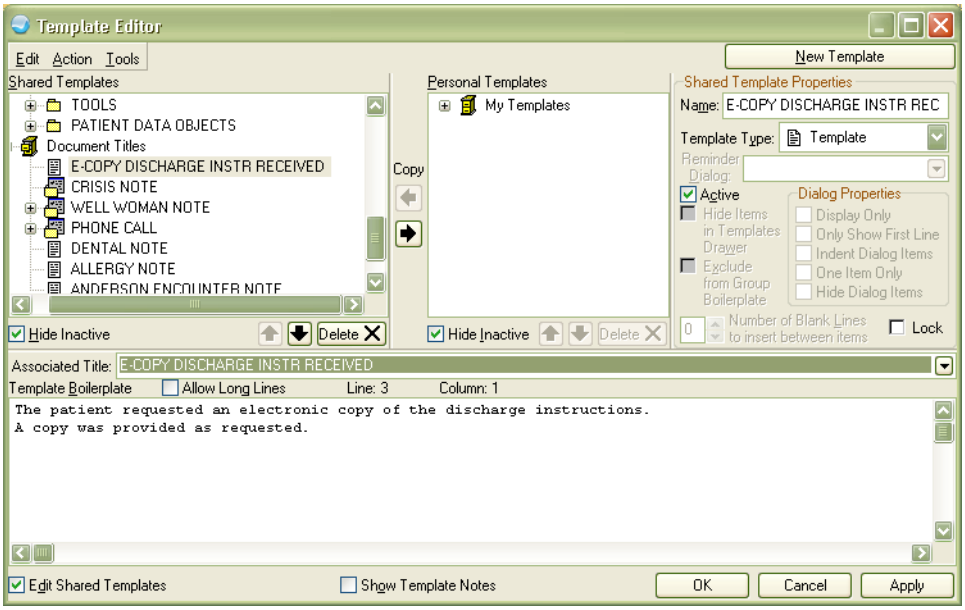


Figure 4-70: Template Editor dialog

4. Click **Apply**.

5. Repeat Steps 2 through 4 to move ECOPY DISCHARGE INSTR NOT RECEIVED to the Document Titles file cabinet.

4.1.12.5 Create a note in EHR

1. Select the Notes tab on the EHR window.

2. Click **New Note** to open the Progress Note Properties dialog.

3. Select E-COPY DISCHARGE INSTR NOT RECEIVED from the **Progress Note Title** field:

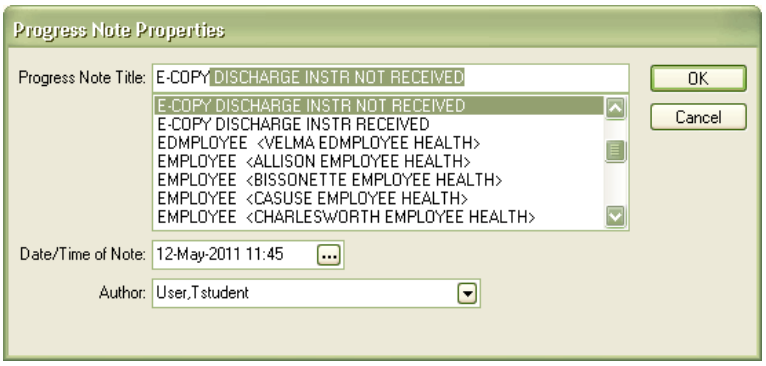


Figure 4-71: Progress Note Properties dialog, filtered

4. Click **OK** to close the dialog and display the ECOPY DISCHARGE INSTR NOT RECEIVED dialog:

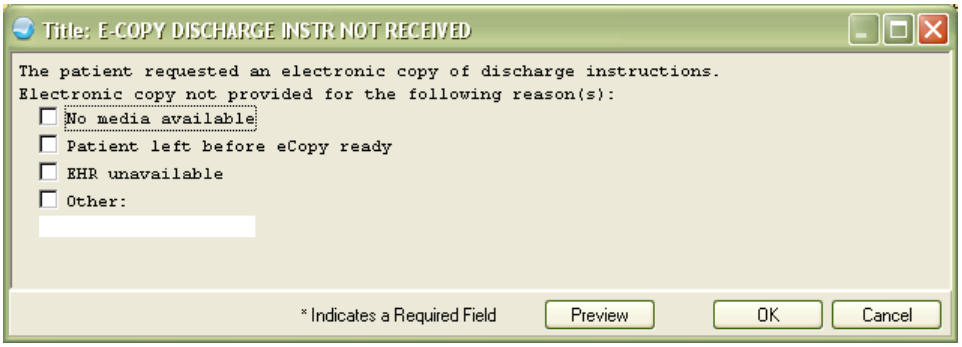


Figure 4-72: ECOPY DISCHARGE INSTR NOT RECEIVED dialog

5. Select one or more reasons.

6. Click **OK** to save the note, closing the dialog.

4.1.13 Exchange Key Clinical Information

Objective: "Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patients authorized entities electronically." *42 CFR Part 495.6,(d)(14)(i)*

Type of Measure: Attestation

Threshold: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

4.1.13.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

THAT: conduct at least one test of the certified EHR technology's capacity to electronically exchange key clinical information during the EHR reporting period

There is no RPMS configuration or EHR demonstration applicable to this Performance Measure.

4.1.14 Privacy and Security

Objective: "Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities." *42 CFR Part 495.6,(d)(15)(i)*

Type of Measure: Attestation

Threshold: Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) of the certified EHR technology, and implement security updates and correct identified security deficiencies as part of its risk management process.

4.1.14.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

THAT: conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) prior to or during the EHR reporting period

AND THAT: implement security updates as necessary prior to or during the EHR reporting period

AND THAT: correct identified security deficiencies prior to or during the EHR reporting period

There is no RPMS configuration or EHR demonstration applicable to this Performance Measure.

4.2 Stage 1 Menu Set Performance Measures

4.2.1 Drug-Formulary Checks

Objective: "Implement drug-formulary checks." *42 CFR Part 495.6,(e)(1)(i)*

Type of Measure: Attestation

Threshold: The eligible hospital or CAH has enabled drug formulary checks and has access to at least one internal or external formulary for the entire EHR reporting period.

4.2.1.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

HAVING: the drug-formulary check enabled during the entire EHR reporting period.

> All providers using the RPMS EHR for pharmacy CPOE meet this measure because this check is always enabled.
>
> The provider is not required to act on the check.
>
> An eligible hospital or CAH must have at least one formulary that can be queried. It may be an internally-developed or external.
>
> The formularies should be relevant for patient care during the prescribing process.

Measure Exclusion: None.

4.2.1.2 Configure RPMS

```
PDM
   Pharmacy Data Management

           CMOP Mark/Unmark (Single drug)
   DOS     Dosages ...
   DRED    Drug Enter/Edit
           Drug Interaction Management ...
           Electrolyte File (IV)
           Lookup into Dispense Drug File
           Medication Instruction File Add/Edit
           Medication Route File Enter/Edit
   OIM     Orderable Item Management ...
           Orderable Item Report
           Formulary Information Report
           Drug Text Enter/Edit
           Drug Text File Report
           Pharmacy System Parameters Edit
           Standard Schedule Edit
           Synonym Enter/Edit
           Controlled Substances/PKI Reports ...

Select Pharmacy Data Management Option: DRED
Drug Enter/Edit

Select DRUG GENERIC NAME: SILDENAFIL 50MG TAB
Are you adding 'SILDENAFIL 50MG TAB' as a new DRUG (the 3065TH)? No// Y
(Yes)
```

```
   DRUG NUMBER: 86036//
   DRUG VA CLASSIFICATION:
   DRUG FSN:
   DRUG NATIONAL DRUG CLASS:
   DRUG CURRENT INVENTORY:
   DRUG LOCAL NON-FORMULARY: 1  N/F
   DRUG INACTIVE DATE:
   DRUG MESSAGE:
   DRUG RESTRICTION:
GENERIC NAME: SILDENAFIL 50MG TAB// SILDENAFIL 50MG TAB N/L
VA CLASSIFICATION:
DEA, SPECIAL HDLG: 6P

NATIONAL FORMULARY INDICATOR: Not Matched To NDF
LOCAL NON-FORMULARY: N/F//
VISN NON-FORMULARY:
Select DRUG TEXT ENTRY:
Select FORMULARY ALTERNATIVE:
Select SYNONYM: VIAGRA
  INTENDED USE: 1  QUICK CODE
  NDC CODE:
Select SYNONYM:
MESSAGE:
RESTRICTION:
FSN:
INACTIVE DATE:
WARNING LABEL:
ORDER UNIT: BOTTLE
DISPENSE UNIT: TA
DISPENSE UNITS PER ORDER UNIT: 50
DISPENSE UNIT NCPDP CODE: TA
     1   TABLESPOON  Y2     Tablespoon
     2   TABLET  U2     Tablet
CHOOSE 1-2: ??
     NCPDP code corresponding to the DISPENSE UNIT field.
     QUANTITY QUALIFIER CODES ONLY
DISPENSE UNIT NCPDP CODE: U2       Tablet
NDC:
PRICE PER ORDER UNIT:
LAST PRICE UPDATE:
AWP PER ORDER UNIT:
AWP PER DISP UNIT is 0.000
SOURCE OF SUPPLY:
DISPENSING LOCATION:
STORAGE LOCATION:
PRICE PER DISPENSE UNIT: 0.0000

Do you wish to match/rematch to NATIONAL DRUG file? Yes//   (Yes)

Deleting Possible Dosages...

Match local drug  SILDENAFIL 50MG TAB N/F                       N/F    with
                                          ORDER UNIT: BT
                         DISPENSE UNITS/ORDER UNITS: 50
                                      DISPENSE UNIT: TA
No NDC to match...

     I will attempt to match the NDCs from your SYNONYMS.

Match made with SILDENAFIL 50MG TAB N/F                       N/F
  Now select VA Product Name
```

```
1 SILDENAFIL CITRATE 100MG TAB    TAB  GU900  S0241
2 SILDENAFIL CITRATE 20MG TAB    TAB  CV490  S0449
3 SILDENAFIL CITRATE 25MG TAB    TAB  GU900  S0239
4 SILDENAFIL CITRATE 50MG TAB    TAB  GU900  S0264

Enter your choice: 4
          Is this a match  < Reply Y, N or press return to continue > :  Y

CHOOSE FROM:
  1    30  BOTTLE
  2    100  BOTTLE
  3    OTHER  OTHER
          Enter Package Size & Type Combination: 3

Local drug SILDENAFIL 50MG TAB N/F
matches    SILDENAFIL CITRATE 50MG TAB
PACKAGE SIZE: OTHER
PACKAGE TYPE: OTHER

< Enter "Y" for yes >
< Enter "N" for no >                              OK? :
LOCAL DRUG NAME: SILDENAFIL 50MG TAB N/F                          N/F
                                          ORDER UNIT: BT
                         DISPENSE UNITS/ORDER UNITS: 50
                                      DISPENSE UNIT: TA

VA PRODUCT NAME: SILDENAFIL CITRATE 50MG TAB
VA PRINT NAME: SILDENAFIL CITRATE 50MG TAB               CMOP ID: S0264
VA DISPENSE UNIT: TAB                                    MARKABLE FOR CMOP:
YES
     PACKAGE SIZE: OTHER
     PACKAGE TYPE: OTHER
VA CLASS: GU900  GENITO-URINARY AGENTS,OTHER
CS FEDERAL SCHEDULE:
INGREDIENTS:
     SILDENAFIL CITRATE 50 MG
NATIONAL FORMULARY INDICATOR: NO
NATIONAL FORMULARY RESTRICTION:

< Enter "Y" for yes, "N" for no >

          Is this a match ? Y

You have just VERIFIED this match and MERGED the entry.

Resetting Possible Dosages..

Press Return to continue:
Just a reminder...you are editing SILDENAFIL 50MG TAB N/F.

Strength from National Drug File match => 50    MG
Strength currently in the Drug File    => 50    MG

Strength => 50   Unit => MG

POSSIBLE DOSAGES:
   DISPENSE UNITS PER DOSE: 1         DOSE: 50MG            PACKAGE: IO
   DISPENSE UNITS PER DOSE: 2         DOSE: 100MG           PACKAGE: IO

LOCAL POSSIBLE DOSAGES:
```

```
Do you want to edit the dosages? N// O

MARK THIS DRUG AND EDIT IT FOR:
O  - Outpatient
U  - Unit Dose
I  - IV
W  - Ward Stock
D  - Drug Accountability
C  - Controlled Substances
X  - Non-VA Med
A  - ALL

Enter your choice(s) separated by commas : O,X
                                           O - Outpatient
                                           X - Non-VA Med
** You are NOW editing OUTPATIENT fields. **

AN Outpatient Pharmacy ITEM? No// Y  (Yes)
CORRESPONDING INPATIENT DRUG:
MAXIMUM DOSE PER DAY:
LOCAL NON-FORMULARY: N/F//
NORMAL AMOUNT TO ORDER:
SOURCE OF SUPPLY:
CURRENT INVENTORY:
ACTION PROFILE MESSAGE (OP):
MESSAGE:
QUANTITY DISPENSE MESSAGE:
OP EXTERNAL DISPENSE:

Do you wish to mark to transmit to CMOP?
Enter Yes or No: NO

Do you wish to mark/unmark as a LAB MONITOR or CLOZAPINE DRUG?
Enter Yes or No: NO
** You are NOW Marking/Unmarking for NON-VA MEDS. **

A Non-VA Med ITEM? No// Y  (Yes)

** You are NOW in the ORDERABLE ITEM matching for the dispense drug. **

   Dosage Form -> TAB

Match to another Orderable Item with same Dosage Form? NO//

   Dosage Form   -> TAB
   Dispense Drug -> SILDENAFIL 50MG TAB N/F

Orderable Item Name: SILDENAFIL//

Matching SILDENAFIL 50MG TAB N/F
   to
SILDENAFIL TAB

Is this OK? YES//
Match Complete!

   Now editing Orderable Item:
   SILDENAFIL   TAB

FORMULARY STATUS: N/F//   (No Editing)
```

```
Select OI-DRUG TEXT ENTRY:
INACTIVE DATE:
DAY (nD) or DOSE (nL) LIMIT:
MED ROUTE:
SCHEDULE TYPE:
SCHEDULE: AS DIRECTED

Outpatient Expansion:
AS DIRECTED

PATIENT INSTRUCTIONS:

Select SYNONYM: VIAGRA
Are you adding 'VIAGRA' as a new SYNONYM (the 1ST for this PHARMACY
ORDERABLE ITEM)? No// Y  (Yes)

SYNONYM: VIAGRA//

Select SYNONYM:

Select DRUG GENERIC NAME:
```

4.2.1.3 Check operation of Drug Formulary Checks

Order a medication that is not on the formulary:

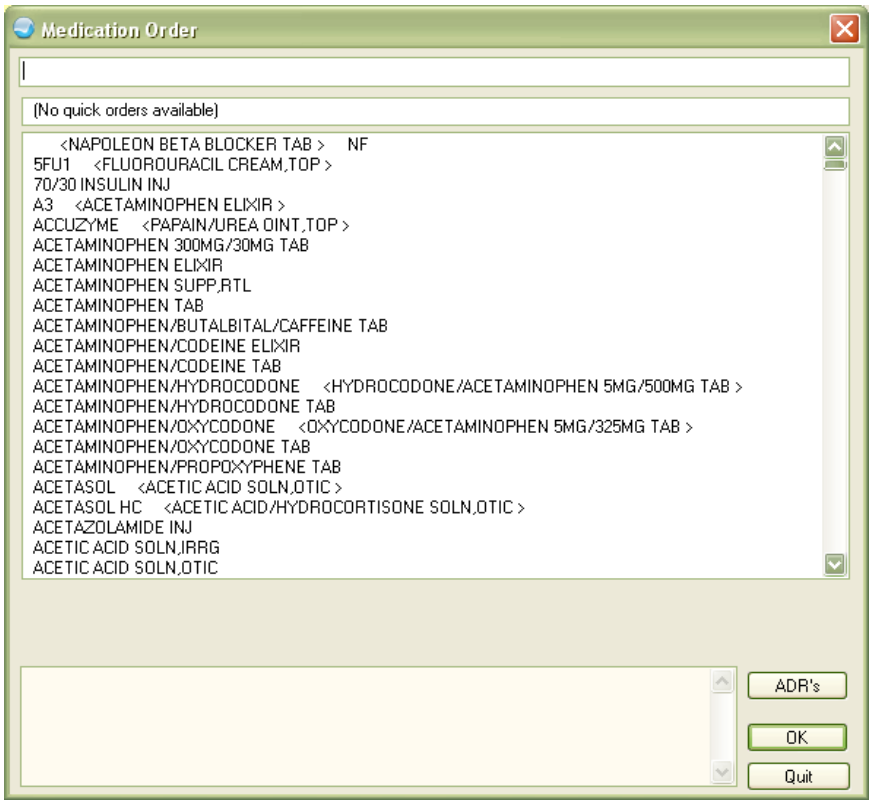


Figure 4-73: Medication Order dialog

EHR displays the Formulary Alternatives dialog:

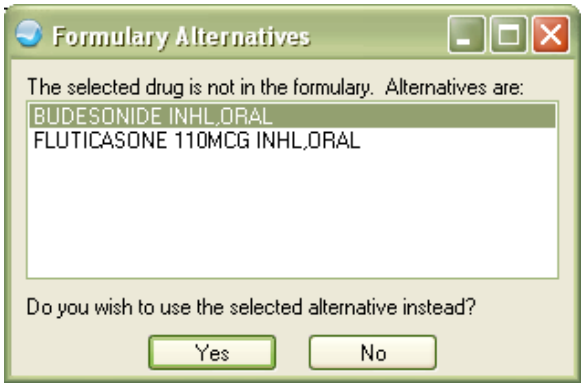


Figure 4-74: Formulary Alternatives dialog

Alternatively, EHR displays the No Formulary Alternatives dialog:

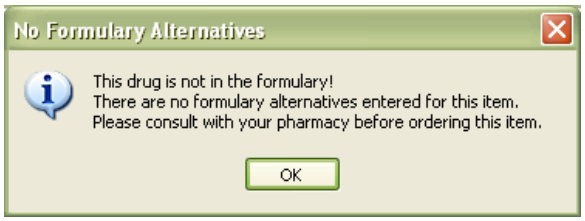


Figure 4-75: No Formulary Alternatives dialog

4.2.2 Advance Directives

Objective: "Record advance directives for patients 65 years old or older." *42 CFR Part 495.6,(e)(2)(i)*

Type of Measure: Rate

$$\frac{\text{The number of unique patients in the denominator with an indication of an advanced directive entered using structured data.}}{\text{The number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.}} > 50\%$$

Threshold: More than 50% of all unique patients 65 years old or older admitted to the EH's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.

4.2.2.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the Denominator

WHERE: structured data is present indicating one or more of the following:

A note title in the TIU Document Class of “Advance Directive.”

An Advance Directive value of “Yes” or “No.”

Denominator Inclusions:

COUNT: each patient

HAVING: an age of 65 years or older on date of admission

AND HAVING: one or more admission dates to a hospital's or CAH's inpatient department (POS 21) defined as Service Category of H during the EHR reporting period

Measure Exclusion: Eligible hospitals and CAHs who have no patient admissions for patients with an age of less than or equal to 65 years on date of admission during the EHR reporting period are excluded.

4.2.2.2 Configure RPMS

The TIU Document Class "Advance Directive" is created when TIU is installed in RPMS. This National Document Class does not allow editing of Status and cannot be Inactivated or Deleted.

1. Check that the note title “Advance Directive” is active:

```
Edit Document Definitions     Jul 18, 2011 13:36:36      Page:    1 of    1
                                     BASICS

       Name                                                              Type
1      CLINICAL DOCUMENTS                                                CL
2       +PROGRESS NOTES                                                  CL
3       +ADDENDUM                                                        DC
4       +DISCHARGE SUMMARY                                               CL
5        CLINICAL PROCEDURES                                             CL
6       +LR LABORATORY REPORTS                                           CL

          ?Help   >ScrollRight   PS/PL PrintScrn/List   +/-             >>>
    Expand/Collapse         Detailed Display/Edit   Items: Seq Mnem MenuTxt
     Jump to Document Def      Status...                 Delete
     Boilerplate Text          Name/Owner/PrintName...   Copy/Move
Select Action: Quit// EX   Expand/Collapse
Select Entry:  (1-6): 2
```

```
---------------------------------------------------------------------------
Edit Document Definitions    Jul 18, 2011 13:38:25       Page:    1 of    2
                                     BASICS

+      Name                                                            Type
2        PROGRESS NOTES                                                CL
3         +ADVANCE DIRECTIVE                                           DC
4         +ADVERSE REACTION/ALLERGY                                    DC
5         +CRISIS NOTE                                                 DC
6         +CLINICAL WARNING                                            DC
7         +SAMPLE TITLES                                               DC
8         +LR LABORATORY REPORTS                                       CL
9         +CONSULTS                                                    DC
10        +DIABETES                                                    DC
11        +DICTATED DOCUMENTS                                          DC
12        +DISCHARGE INSTRUCTIONS                                      DC
13        +ID CHILD                                                    DC
14        +ID PARENT                                                   DC
15        +NURSING                                                     DC
+         ?Help   >ScrollRight   PS/PL PrintScrn/List   +/-             >>>
    Expand/Collapse         Detailed Display/Edit   Items: Seq Mnem MenuTxt
     Jump to Document Def      Status...                 Delete
     Boilerplate Text          Name/Owner/PrintName...   Copy/Move
Select Action: Next Screen// EX   Expand/Collapse
Select Entry:  (2-15): 3

---------------------------------------------------------------------------
Edit Document Definitions     Jul 18, 2011 13:44:41       Page:   1 of    2
                                     BASICS

+      Name                                                            Type
2        PROGRESS NOTES                                                CL
3          ADVANCE DIRECTIVE                                           DC
4            ADVANCE DIRECTIVE                                         TL
5         +ADVERSE REACTION/ALLERGY                                    DC
6         +CRISIS NOTE                                                 DC
7         +CLINICAL WARNING                                            DC
8         +SAMPLE TITLES                                               DC
9         +LR LABORATORY REPORTS                                       CL
10        +CONSULTS                                                    DC
11        +DIABETES                                                    DC
12        +DICTATED DOCUMENTS                                          DC
13        +DISCHARGE INSTRUCTIONS                                      DC
14        +ID CHILD                                                    DC
15        +ID PARENT                                                   DC
+         ?Help   >ScrollRight   PS/PL PrintScrn/List   +/-             >>>
     Expand/Collapse        Detailed Display/Edit   Items: Seq Mnem MenuTxt
     Jump to Document Def      Status...                 Delete
     Boilerplate Text          Name/Owner/PrintName...   Copy/Move
Select Action: Next Screen// DET   Detailed Display/Edit
Select Entry:  (2-15): 4

 Entry is National; Limited Actions

Press RETURN to continue or '^' or '^^' to exit:
```

2. If the Status is Inactive, activate this title:

```
---------------------------------------------------------------------------
Detailed Display          Jul 18, 2011 13:46:27          Page:    1 of    3
```

```
                              Title ADVANCE DIRECTIVE

  Basics            Note: Values preceded by * have been inherited
            Name:   ADVANCE DIRECTIVE
    Abbreviation:   ADIR
      Print Name:   ADVANCE DIRECTIVE
            Type:   TITLE
             IFN:   8
        National
        Standard:   YES
          Status:   INACTIVE
           Owner:   CLINICAL COORDINATOR
          In Use:   YES
  Suppress Visit
       Selection: * NO

  Items
+         ? Help       +, - Next, Previous Screen     PS/PL
     Basics                     (Technical Fields)        Find
     Items: Seq Mnem MenuTxt   Edit Upload               Quit
     Boilerplate Text          Try
Select Action: Next Screen//BASICS

 Edit Abbreviation and Status only: Entry is National Title.
ABBREVIATION: ADIR//
STATUS: (A/I/T): INACTIVE// ACTIVE

---------------------------------------------------------------------------
Detailed Display          Jul 18, 2011 13:49:19          Page:    1 of    3
                              Title ADVANCE DIRECTIVE

  Basics            Note: Values preceded by * have been inherited
            Name:   ADVANCE DIRECTIVE
    Abbreviation:   ADIR
      Print Name:   ADVANCE DIRECTIVE
            Type:   TITLE
             IFN:   8
        National
        Standard:   YES
          Status:   ACTIVE
           Owner:   CLINICAL COORDINATOR
          In Use:   YES
  Suppress Visit
       Selection: * NO

  Items
+         ? Help       +, - Next, Previous Screen     PS/PL
     Basics                     (Technical Fields)        Find
     Items: Seq Mnem MenuTxt   Edit Upload               Quit
     Boilerplate Text          Try
Select Action: Next Screen//
```

4.2.2.3 RPMS Use

Enter Advance Directive Information on Page 9 of the IHS Registration Editor:

```
---------------------------------------------------------------------------
IHS REGISTRATION EDITOR  (page 9)                              DEMO HOSPITAL
===========================================================================
DEMO,PATIENT NANCY         (upd:JUL 18, 2011)       HRN:48381  CHS & DIRECT
```

```
==============================================================================
                        CHS Eligibility & Document Summary
1.REASON FOR CHS & DIRECT :
------------------------------------------------------------------------------
2. STATUS OF MEDICAL RECORD :
3. OTHER LEGAL DOCUMENTS :
4. ADVANCE DIRECTIVES :
------------------------------------------------------------------------------
5.REL OF INFORMATION :                  6.ASSIGNMENT OF BENEFITS :
------------------------------------------------------------------------------
7.NOTICE OF PRIVACY PRACTICES (NPP) REC'D BY PATIENT :  NO
8.ACKNOWLEDGEMENT OF RECEIPT OF NPP SIGNED :  YES
9.RESTRICTED HEALTH INFORMATION :
==============================================================================
------------------------------------------------------------------------------
Last edited by: TAYLOR,PHILIP K on Jul 18, 2011
CHANGE which item? (1-9) NONE// : 4

Select DATE OF ENTRY: T   JUL 18, 2011
  Are you adding 'JUL 18, 2011' as a new DATE OF ENTRY (the 1ST for this
ADVANCE DIRECTIVE)? No// Y (Yes)

  ADVANCE DIRECTIVE: ?  <==Record "Yes" if Patient has Advance Directive
     Choose from:          Or "No" if Patient does not
       Y        YES
       N        NO
  ADVANCE DIRECTIVE: YES  YES
  TYPE: ?
     Enter ADVANCE DIRECTIVE NOTICE
 Answer with ELIGIBILITY MODIFIERS MODIFIER DESCRIPTION
 Do you want the entire ELIGIBILITY MODIFIERS List? Y  (Yes)
   Choose from:
   LIVING WILL        A
   POWER OF ATTORNEY        A

  TYPE: LIVING WILL       A

------------------------------------------------------------------------------
IHS REGISTRATION EDITOR  (page 9)                            DEMO HOSPITAL
==============================================================================
DEMO,PATIENT NANCY         (upd:JUL 18, 2011)       HRN:48381  CHS & DIRECT
==============================================================================
                        CHS Eligibility & Document Summary
1.REASON FOR CHS & DIRECT :
------------------------------------------------------------------------------
2. STATUS OF MEDICAL RECORD :
3. OTHER LEGAL DOCUMENTS :
4. ADVANCE DIRECTIVES :  YES            DATE: JUL 18, 2011
   TYPE:LIVING WILL
5.REL OF INFORMATION :
6.ASSIGNMENT OF BENEFITS :
7.NOTICE OF PRIVACY PRACTICES (NPP) REC'D BY PATIENT :  NO
8.ACKNOWLEDGEMENT OF RECEIPT OF NPP SIGNED :  YES
9.RESTRICTED HEALTH INFORMATION :
```

4.2.2.4 EHR Use

Use the advance directive note title to document the presence of an advance directive:

1. Select the Notes tab:

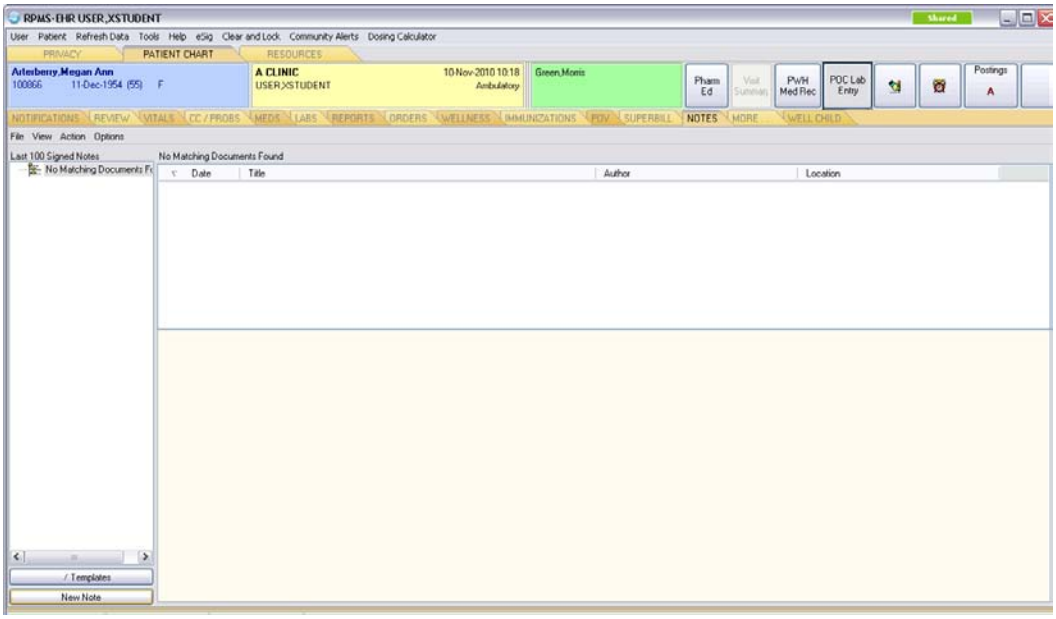


Figure 4-76: EHR Notes tab

2. Click **New Note** to display the Progress Note Properties dialog:

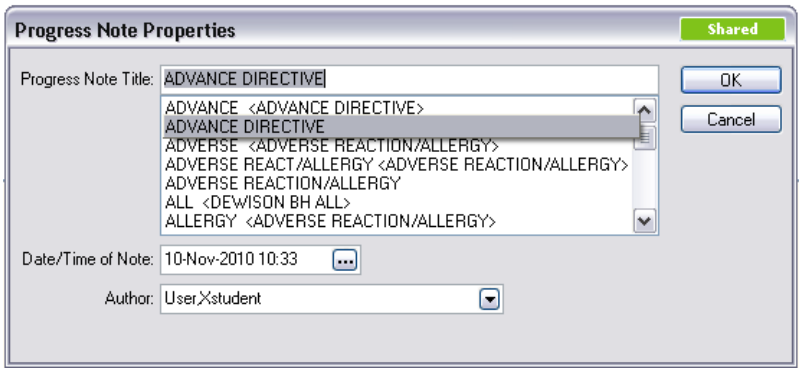


Figure 4-77: Progress Note Properties dialog

3. Select the Advance Directive **Progress Note Title**.

4. Click **OK** to display the advance directive note:

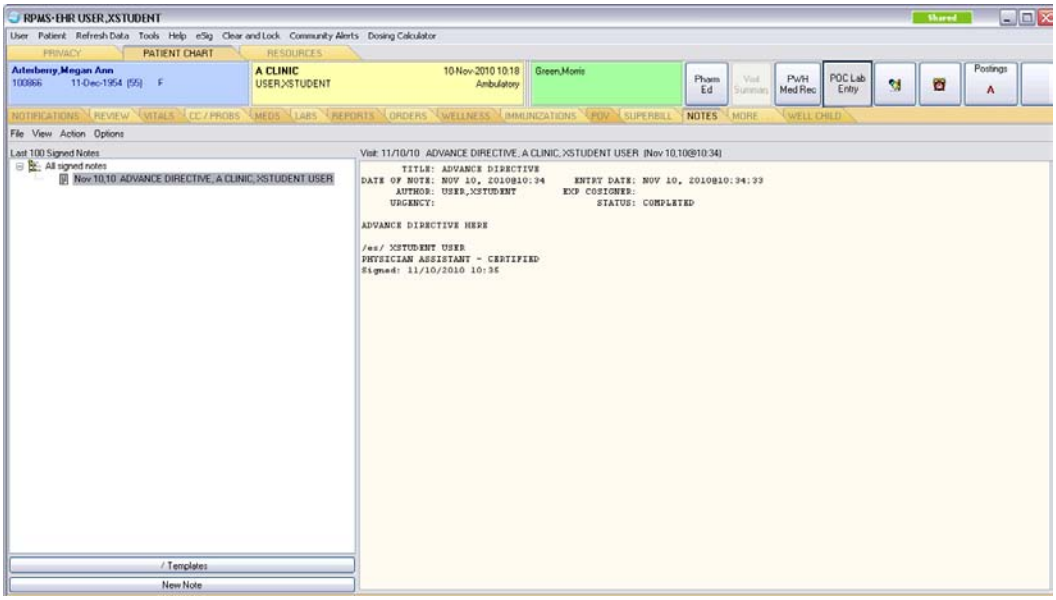


Figure 4-78: EHR Notes tab with in-process advance directive note

5. Complete the advance directive note and sign it; the advance directive note is listed on the Alerts pane:

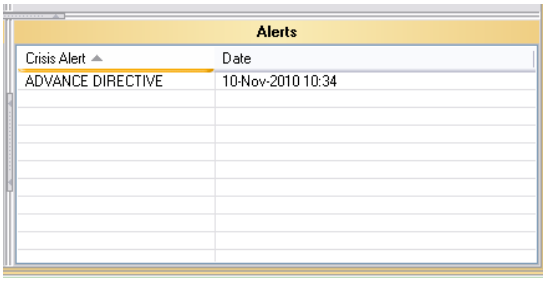


Figure 4-79: EHR Alerts pane on the Review tab

4.2.3 Lab Results into EHR

Objective: "Incorporate clinical lab-test results into certified EHR technology as structured data." *42 CFR Part 495.6,(e)(2)(i)*

Type of Measure: Rate

$$\frac{\text{The number of lab test results whose results are expressed in a positive or negative affirmation or as a number, which are incorporated as structured data.}}{\text{The number of lab tests ordered during the EHR reporting period by authorized providers of the eligible hospital or CAH for patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 \& 23) whose results are expressed in a positive or negative affirmation or as a number.}} \quad >40\%$$

Threshold: More than 40% of all clinical lab test results ordered by an authorized provider of the eligible hospital or CAH has for patients admitted to its inpatient or emergency department (POS 21 or 23) 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.

> A laboratory package must be installed and configured. Sites without structured POC labs and a reference lab interfaced with EHR will not be able to meet this Performance Measure.

4.2.3.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each test in the denominator

WHERE the status flag is RESULTED

WHERE: RESULTS does not equal "comment"

OR WHERE: RESULTS = "comment"

AND WHERE: COMMENTS does not equal null

Denominator Inclusions:

COUNT: each V LAB entry ordered during the EHR reporting period

DURING: a hospitalization (Service Category of H) or emergency department visit (Clinic Code of Emergency Department-30 and Service Category of A)

WHERE: the lab test is NOT a Pap Smear, determined by using the BGP PAP SMEAR TEST lab taxonomy

AND WHERE: the result of the test is not equal to "canc" (canceled)

Measure Exclusions: All Pap smears ordered using any of the following Current Procedural Terminology (CPT) codes: 88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 (because results are expressed using text).

4.2.3.2 Create a Lab Test in RPMS

1. Create a Data Name

```
Select IHS Kernel Option: CORE  IHS Core

   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
   AGM    Patient registration ...
   AR     A/R MASTER MENU ...
   ART    Adverse Reaction Tracking ...
   ARWS   Automatic Replenishment ...
```

```
   ASTH   Asthma Register ...
   BDP    Designated Specialty Prov Mgt System ...
   BH     Behavioral Health Information System ...
   BVP    View Patient Record
   BYPX   Pyxis Management Menu ...
   CASE   Case Management System ...
   CHR    Community Health Representative System ...
   CHS    Contract Health System ...
   CIMC   McCallie System Upload to RPMS ...
   CRS    IHS Clinical Reporting System (CRS) Main Menu ...
   DDS    Dental Data System Menu ...
   DMS    Diabetes Management System ...
   EHR    EHR MAIN MENU ...
   ERS    Emergency Room System ...
   FHS    Dietetics Management ...
   FLAG   Patient Record Flags Main Menu ...
   FM     VA FileMan ...
   HEAL   Health Systems ...
   HWS    Hospital Wide Survey
   IIMM   Immunization Interchange Management Menu ...
   ILAB   IHS Short Lab Main Menu ...
   IMM    Immunization Menu ...
   IVM    IV Menu ...
   LAB    Laboratory DHCP Menu ...
   NDF    National Drug File Menu ...

Select IHS Core Option: LAB
   Laboratory DHCP Menu

   1      Phlebotomy menu ...
   2      Accessioning menu ...
   3      Process data in lab menu ...
   4      Quality control menu ...
   5      Results menu ...
   6      Information-help menu ...
   7      Ward lab menu ...
   8      Anatomic pathology ...
   9      Blood bank ...
   10     Microbiology menu ...
   11     Supervisor menu ...
   BLR    IHS Lab Main Support Menu ...
   LSM    Lab Shipping Menu ...

Select Laboratory DHCP Menu Option: 11
   Supervisor menu

           Add/edit QC name &/or edit test means
           Change Load/Work list type.
           Changes in verified lab data
           Cumulative menu ...
           Documentation for lab options
           Edit atomic tests
           Edit control placement on load/work list
           Edit controls added to the accessions each day
           Edit cosmic tests
           Edit the default parameters Load/Work list.
           Edit the Load/Work list profile
           Infection warning edit
           Inquiry to LAB TEST file
           Lab interface menu ...
           Lab liaison menu ...
```

```
          Lab statistics menu ...

Select Supervisor menu Option: LAB LIA
   Lab liaison menu

   ANT    Add a new internal name for an antibiotic
   BCF    Lab Bar Code Label Formatter
   BCZ    Lab Zebra Label Utility
   DATA   Add a new data name
   LNC    LOINC Main Menu ...
   MOD    Modify an existing data name
   SMGR   Lab Shipping Management Menu ...

Select Lab liaison menu Option: DATA
   Add a new data name

This option will add a new data name to the lab package.

DATA NAME: GLUCOSE
ARE YOU ADDING GLUCOSE AS A NEW DATA NAME? No// Y  (Yes)

Enter data type for test: (N)umeric, (S)et of Codes, or (F)ree text? N
Minimum value: : 1//
Maximum value: : 1// 1000
Decimal value: : 1// 0

'GLUCOSE' added as a new data name

Data Name: GLUCOSE    Subfield #: 7247042    Type: NUMERIC
Minimum value: 1
Maximum value: 1000
Maximum # decimal digits: 0

You must now add a new test in the LABORATORY TEST file and use
GLUCOSE as the entry for the DATA NAME field.
```

2. Create a Lab Test in the Laboratory Test File (File 60):

```
   AD     Abbreviations Dictionary
   ADT    ADT Menu ...
   AGM    Patient registration ...
   AR     A/R MASTER MENU ...
   ART    Adverse Reaction Tracking ...
   ARWS   Automatic Replenishment ...
   ASTH   Asthma Register ...
   BDP    Designated Specialty Prov Mgt System ...
   BH     Behavioral Health Information System ...
   BVP    View Patient Record
   BYPX   Pyxis Management Menu ...
   CASE   Case Management System ...
   CHR    Community Health Representative System ...
   CHS    Contract Health System ...
   CIMC   McCallie System Upload to RPMS ...
   CRS    IHS Clinical Reporting System (CRS) Main Menu ...
   DDS    Dental Data System Menu ...
   DMS    Diabetes Management System ...
   EHR    EHR MAIN MENU ...
   ERS    Emergency Room System ...
   FHS    Dietetics Management ...
   FLAG   Patient Record Flags Main Menu ...
```

```
   FM     VA FileMan ...
   HEAL   Health Systems ...

Select IHS Core Option: FM
   FM  VA FileMan

          VA FileMan Version 22.0

          Enter or Edit File Entries
          Print File Entries
          Search File Entries
          Modify File Attributes
          Inquire to File Entries
          Utility Functions ...
          Data Dictionary Utilities ...
          Transfer Entries
          Other Options ...

Select VA FileMan Option: ENTER
   Enter or Edit File Entries

INPUT TO WHAT FILE: PCC MASTER CONTROL// 60  LABORATORY TEST
                                          (1593 entries)
EDIT WHICH FIELD: ALL//

Select LABORATORY TEST NAME: GLUCOSE
  Are you adding 'GLUCOSE' as a new LABORATORY TEST (the 1594TH)? Yes
   LABORATORY TEST LABTEST IEN: 9999242//
   LABORATORY TEST SUBSCRIPT: CH  CHEM, HEM, TOX, SER, RIA, ETC.
   LABORATORY TEST HIGHEST URGENCY ALLOWED: ??
     Enter the urgency with the lowest number allowed for this test.
   LABORATORY TEST HIGHEST URGENCY ALLOWED: STAT
   LABORATORY TEST PRINT NAME: GLUCOSE             1
   LABORATORY TEST DATA NAME: GLUCOSE
TEST COST:
Select SYNONYM:
TYPE: B
   BOTH
SUBSCRIPT: CHEM, HEM, TOX, SER, RIA, ETC.//
LOCATION (DATA NAME): CH;7247042;1//   (No Editing)
Select INSTITUTION:
DEMO HOSPITAL     NASHVILLE NON-IHS       CHEROKEE
01                            NM  HOSPITAL  7247
  ACCESSION AREA: CH  CHEMISTRY
UNIQUE ACCESSION #:
UNIQUE COLLECTION SAMPLE:
LAB COLLECTION SAMPLE: B
   BLOOD
     1   BLOOD       BLOOD     GENERAL
     2   BLOOD       BLOOD     ROYAL BLUE
     3   BLOOD       BLOOD     YELLOW
     4   BLOOD       PLASMA     GREEN
     5   BLOOD       PLASMA     LAVENDER
     6   BLOOD       BLOOD     GRAY-CELITE
     7   BLOOD       BLOOD     GREEN
     8   BLOOD       BLOOD     PLAIN RED
     9   BLOOD       SERUM     TIGER
     10  BLOOD       SERUM     MARBLE

CHOOSE 1-10: 10
   BLOOD     SERUM     MARBLE
```

```
REQUIRED TEST: Y  YES
PROCEDURE (SNOMED):
*QUICK INDEX:
EXTRA LABELS:
HIGHEST URGENCY ALLOWED: STAT//
FORCED URGENCY:
PRINT NAME: GLU 1//
Reserved:
PRINT CODE:
PRETTY PRINT ENTRY:
PRETTY PRINT ROUTINE:
PRINT ORDER:
NATIONAL VA LAB CODE:
RESULT NLT CODE:
CATALOG ITEM:
EDIT CODE:
*BATCH DATA CODE:
EXECUTE ON DATA REVIEW:
Select SITE/SPECIMEN: BLOOD
     1   BLOOD       0X000
     2   BLOOD BAND CELL       0X161
     3   BLOOD BASOPHIL       0X180
     4   BLOOD EOSINOPHIL       0X170
     5   BLOOD ERYTHROCYTE       0X120
CHOOSE 1-5: 1
   BLOOD
  Are you adding 'BLOOD' as a new SITE/SPECIMEN
   (the 1ST for this LABORATORY TEST)? No// Y  (Yes)
  REFERENCE LOW: 70
  REFERENCE HIGH: 110
  CRITICAL LOW: 40
  CRITICAL HIGH: 400
  INTERPRETATION:
  UNITS: mg/dL
  TYPE OF DELTA CHECK:
  DELTA VALUE:
  DEFAULT VALUE:
  THERAPEUTIC LOW:
  THERAPEUTIC HIGH:
  Select *AMIS/RCS 14-4:
  CPT CODE:
  PANEL (CPT):
  Select FOREIGN COMPUTER SYSTEM:
  LOINC CODE:
Select SITE/SPECIMEN:
GENERAL PROCESSING INST.:

Select LAB TEST:
Select COLLECTION SAMPLE: BLOOD
     1   BLOOD       BLOOD     GENERAL
     2   BLOOD       BLOOD     ROYAL BLUE
     3   BLOOD       BLOOD     YELLOW
     4   BLOOD       PLASMA     GREEN
     5   BLOOD       PLASMA     LAVENDER
     6   BLOOD       BLOOD     GRAY-CELITE
     7   BLOOD       BLOOD     GREEN
     8   BLOOD       BLOOD     PLAIN RED
     9   BLOOD       SERUM     TIGER
     10  BLOOD       SERUM     MARBLE
CHOOSE 1-10: 10
   BLOOD     SERUM     MARBLE
```

```
  FORM NAME/NUMBER:
  MIN VOL (in mls.):
  MAX. ORDER FREQ.:
  SINGLE DAY MAX ORDER FREQ:
  WARD REMARKS:
  LAB PROCESSING INSTRUCTIONS :
  REQUIRED COMMENT:
  Select SAMPLE WKLD CODE:
Select COLLECTION SAMPLE:
GENERAL WARD INSTRUCTIONS:
REQUIRED COMMENT:
DATA NAME: GLUCOSE//
CULTURE ID PREFIX:
Select VERIFY WKLD CODE:
Select ACCESSION WKLD CODE:
*ASK AMIS/CAP CODES:
COMBINE TEST DURING ORDER:
CIS TEST CODE:
Select SITE NOTES DATE: T   JAN 26, 2011
  Are you adding 'JAN 26, 2011' as a new SITE NOTES DATE
   (the 1ST for this LABORATORY TEST)? No// y  (Yes)
  TEXT:
  1>CREATED FOR TEST BB
  2>
EDIT Option:
IHS PCC DISPLAY FLAG:

Select LABORATORY TEST NAME:

          Enter or Edit File Entries
          Print File Entries
          Search File Entries
          Modify File Attributes
          Inquire to File Entries
          Utility Functions ...
          Data Dictionary Utilities ...
          Transfer Entries
          Other Options ...
```

3. Add the test to a Load/Work List File:

```
Select VA FileMan Option: ENTER
   Enter or Edit File Entries

INPUT TO WHAT FILE: LABORATORY TEST// LOAD/WORK LIST
                                          (13 entries)
EDIT WHICH FIELD: ALL//

Select LOAD/WORK LIST NAME: ?
 Answer with LOAD/WORK LIST NAME
 Do you want the entire 13-Entry LOAD/WORK LIST List? Y  (Yes)
   Choose from:
   ACL 7000
   AXYSM
   CLINITEK 200
   COULTER ONYX
   EKTACHEM 500
   HEMATOLOGY
   HEME-CELL DYN
   MANUAL CHEMISTRY
```

```
   OLD COULTER JT3
   TOSOH
   VITEK
   VITROS

        You may enter a new LOAD/WORK LIST, if you wish
        Answer must be 2-30 characters in length.

Select LOAD/WORK LIST NAME: VITROS
NAME: VITROS//
LOAD TRANSFORM: UNIVERSAL//
TYPE: TRAY,CUP//
CUPS PER TRAY: 10//
FULL TRAY'S ONLY: NO//
EXPAND PANELS ON PRINT: NO//
INITIAL SETUP:
VERIFY BY: ACCESSION//
SUPPRESS SEQUENCE #:
INCLUDE UNCOLLECTED ACCESSIONS: NO//
SHORT TEST LIST:
AUTO MICRO EDIT TEMPLATE:
WKLD METHOD: VITROS 250//
MAJOR ACCESSION AREA: EKTACHEM//
LAB SUBSECTION: CHEMISTRY//
WORK AREA:
DATE OF SETUP: AUG 10,2005//
FIRST TRAY: 5//
STARTING CUP: 1//
LAST TRAY: 5//
LAST CUP: 4//
BUILDING IN PROGRESS: NO//
Select PROFILE: vitros//
  PROFILE: vitros//
  Select TEST: ESTIMATED GFR//
    TEST: ESTIMATED GFR//
    SPECIMEN:
    BUILD NAME ONLY: YES//
    POC WKLD METHOD:
    POC COLLECTION SAMPLE:
  Select TEST: GLUCOSE
    SPECIMEN:
    BUILD NAME ONLY: YES// NO  NO
    POC WKLD METHOD:
    POC COLLECTION SAMPLE:
  Select TEST:
  ACCESSION AREA: EKTACHEM//
  UID VERIFICATION:
  STORE DUPLICATE COMMENTS:
  DEFAULT REFERENCE LABORATORY:
  Select TRAY #:
  Select Specimens to EXCLUDE!:
  Select CONTROLS TO BEGIN WORKLIST:
  Select CONTROLS TO END WORKLIST:
Select PROFILE:
USER ACCESS AUTHORIZATION:
Select ADDITIONAL LAB TESTS:

Select LOAD/WORK LIST NAME:
```

4. Add the test to an Auto Instrument File (UI Test Code is obtained from manufacturer):

```
INPUT TO WHAT FILE: LOAD/WORK LIST// AUTO
     1   AUTO INSTRUMENT                  (106 entries)
     2   AUTO/LIABILITY                   (56 entries)
CHOOSE 1-2: 1
   AUTO INSTRUMENT            (106 entries)

EDIT WHICH FIELD: ALL//

Select AUTO INSTRUMENT NAME: VITROS
NAME: VITROS//
VENDOR CARD ADDRESS:
SHORT ACCESSION # LENGTH:
WKLD METHOD: DIRECTAGEN NOS//
ECHO DEVICE:
PROGRAM: VITROS//
LOAD/WORK LIST: VITROS//
ENTRY for LAGEN ROUTINE: Accession cross-reference
CROSS LINKED BY: IDE//
MESSAGE CONFIGURATION: UNIVERSAL INTERFACE//
*ECHO ALL INPUT:
METHOD: VITROS 250//
DEFAULT ACCESSION AREA: EKTACHEM//
OVERLAY DATA: YES//
STORE REMARKS:
NEW DATA:
RESTART:
HANDSHAKE RESPONSE:
ACK TRIGGER VALUE:
ACK RESPONSE VALUE:
DIRECT DEVICE:
Select TEST: FASTING GLUCOSE//
  TEST: FASTING GLUCOSE//
  PARAM 1:
  PARAM 2:
  PARAM 3:
  UI TEST CODE:  //
  ACCESSION AREA:
  SPECIMEN:
  URGENCY:
  NUMBER OF DECIMAL PLACES:
  CONVERT RESULT TO REMARK:
  ACCEPT RESULTS FOR THIS TEST: YES//
  DOWNLOAD TO INSTRUMENT: YES//
  IGNORE RESULTS NOT ORDERED:
  REMOVE SPACES FROM RESULT:
  STORE REMARKS:
  REMARK PREFIX:
  STORE PRODUCER'S ID:
  STORE REFERENCE RANGE:
  STORE ABNORMAL FLAGS:
Select TEST: GLUCOSE  ....
  Are you adding 'GLUCOSE' as a new CHEM TESTS
   (the 41ST for this AUTO INSTRUMENT)? No// Y  (Yes)
   CHEM TESTS NUMBER: 42//
  PARAM 1:
  PARAM 2:
  PARAM 3:
```

```
  UI TEST CODE: MFG
  ACCESSION AREA:
  SPECIMEN:
  URGENCY:
  NUMBER OF DECIMAL PLACES: 0
  CONVERT RESULT TO REMARK:
  ACCEPT RESULTS FOR THIS TEST: Y  YES
  DOWNLOAD TO INSTRUMENT:
  IGNORE RESULTS NOT ORDERED:
  REMOVE SPACES FROM RESULT: ^DOWNLOAD TO INSTRUMENT
  DOWNLOAD TO INSTRUMENT: Y  YES
  IGNORE RESULTS NOT ORDERED:
  REMOVE SPACES FROM RESULT:
  STORE REMARKS: Y  YES
  REMARK PREFIX:
  STORE PRODUCER'S ID:
  STORE REFERENCE RANGE: Y  YES
  STORE ABNORMAL FLAGS: Y  YES
Select TEST:
LOAD CHEM TESTS:
Select ALARM TERMINAL:
Select MICRO CARD TYPE:
INTERFACE NOTES:
  1>
DOWNLOAD ENTRY:
DOWNLOAD PROTOCOL ROUTINE:
FILE BUILD ENTRY: EN//
FILE BUILD ROUTINE: LA7UID//
SEND TRAY/CUP LOCATION:
QUEUE BUILD:
MICRO INTERPRETATION CHECK:
AUTO DOWNLOAD: YES//
METH NAME:
MEAN DATA VALUE 1:
MEAN DATA VALUE 2:
MEAN DATA VALUE 3:
MICRO AUTO APPROVAL METHOD:
DEFAULT AUTO MICRO TEST:
Select SITE NOTES DATE:
Select ACCESSION:

Select AUTO INSTRUMENT NAME:
```

5. Add a CPT Code for the test:

```
          Enter or Edit File Entries
          Print File Entries

Select VA FileMan Option: ENTER
   Enter or Edit File Entries

INPUT TO WHAT FILE: AUTO INSTRUMENT// IHS LAB CPT
     1   IHS LAB CPT ACTION CODE          (0 entries)
     2   IHS LAB CPT CODE                 (482 entries)
     3   IHS LAB CPT REVIEW CODE          (0 entries)
CHOOSE 1-3: 2
   IHS LAB CPT CODE           (482 entries)
EDIT WHICH FIELD: ALL//

Select IHS LAB CPT CODE NAME: GLUCOSE
```

```
  Are you adding 'GLUCOSE' as a new IHS LAB CPT CODE? No// Y  (Yes)

LAB SECTION: CHEMISTRY
CREATE DATE: N  (JAN 26, 2011@10:50:04)
DATE/TIME ACTIVE:
DATE/TIME INACTIVE: ^DATE
     1   DATE/TIME ACTIVE
     2   DATE/TIME INACTIVE
CHOOSE 1-2: 1  DATE/TIME ACTIVE
DATE/TIME ACTIVE: N  (JAN 26, 2011@10:50:31)
DATE/TIME INACTIVE:
PANEL/TEST: GLUCOSE
INACTIVE FLAG:
Select CPT CODE: 82947    ASSAY, GLUCOSE, BLOOD QUANT
       Glucose; quantitative, blood (except reagent strip)
         ...OK? Yes// Y  (Yes)

  Are you adding '82947' as a new CPT CODE
   (the 1ST for this IHS LAB CPT CODE)? No// Y  (Yes)
  LAB LIST COST:
  REVIEW CODE:
  ACTION CODE:
  Select MODIFIER:
  Select QUALIFIER:
Select CPT CODE:
DESCRIPTION:
  1>
```

6. Create a Quick Order for the test:

```
Select IHS Core Option: EHR
   EHR MAIN MENU

   BEH    RPMS-EHR Configuration Master Menu ...
   CON    Consult Management ...
   CPRS   CPRS Manager Menu ...

Select EHR MAIN MENU Option: BEH
   RPMS-EHR Configuration Master Menu

DEMO HOSPITAL              RPMS-EHR Management              Version 1.1
                     RPMS-EHR Configuration Master Menu

   ART    Adverse Reaction Tracking Configuration ...
   CCX    Chief Complaint Configuration ...
   CON    Consult Tracking Configuration ...
   EDU    Patient Education Configuration ...
   ENC    Encounter Context Configuration ...
   EXM    Exam Configuration ...
   FRM    VueCentric Framework Configuration ...
   HFA    Health Factor Configuration ...
   IMG    VistA Imaging Extensions ...
   IMM    Immunization Configuration ...
   LAB    Lab Configuration ...
   MED    Medication Management Configuration ...
   NOT    Notification Configuration ...
   ORD    Order Entry Configuration ...
   PAT    Patient Context Configuration ...

Select RPMS-EHR Configuration Master Menu Option: ORD
```

```
   Order Entry Configuration

DEMO HOSPITAL             RPMS-EHR Management                Version 1.1
                       Order Entry Configuration

   DOC    Delayed Orders Configuration ...
   KEY    Key Management ...
   MNU    Order Menu Management ...
   OCX    Order Check Configuration ...

Select Order Entry Configuration Option: MNU
   Order Menu Management

DEMO HOSPITAL              RPMS-EHR Management                Version 1.1
                         Order Menu Management

   ACT    Create/Modify Actions
   DIS    Enable/Disable Order Dialogs
   GEN    Create/Modify Generic Orders
   LST    List Primary Order Menus
   MNU    Create/Modify Order Menus
   OIC    Create/Modify Orderable Items
   PAR    Menu Parameters ...
   PMT    Create/Modify Prompts
   PRI    Assign Primary Order Menu
   PRT    Convert Protocols
   QOC    Create/Modify Quick Orders
   QOR    Create/Modify QO Restrictions

Select Order Menu Management Option: QOC
   Create/Modify Quick Orders

DEMO HOSPITAL              RPMS-EHR Management                  Version 1.1
                        Create/Modify Quick Orders

Select QUICK ORDER NAME: LRZ GLUCOSE
  Are you adding 'LRZ GLUCOSE' as a new ORDER DIALOG? No// Y  (Yes)

TYPE OF QUICK ORDER: LAB  LABORATORY
NAME: LRZ GLUCOSE//
DISPLAY TEXT: Glucose1
VERIFY ORDER: Y  YES
DESCRIPTION:
  1>
ENTRY ACTION:
Lab Test: GLUCOSE
SEND TO LAB - Means the patient is ambulatory and will be sent to the
Laboratory draw room to have blood drawn.
WARD COLLECT - Means that either the physician or a nurse will be
collecting the sample on the ward.
LAB BLOOD TEAM - Means the phlebotomist from Lab will draw the blood on the
ward.  This method is limited to laboratory defined collection times.

     SP        Send patient to lab
     WC        Ward collect & deliver
     LC        Lab blood team
Collected By:
Collection Sample: BLOOD//
Collection Date/Time: T  (JAN 26, 2011)
Urgency:
How often: ONCE  ONCE
```

```
Indication://
Indication ICD9://

---------------------------------------------------------------------------
                    Lab Test: GLUCOSE
           Collection Sample: BLOOD
                    Specimen: SERUM
        Collection Date/Time: TODAY
                   How often: ONCE
---------------------------------------------------------------------------

(P)lace, (E)dit, or (C)ancel this quick order? PLACE//
Auto-accept this order? NO//

Select QUICK ORDER NAME:
```

7. Make the quick order available on the Lab menu:

```
   ACT    Create/Modify Actions
   DIS    Enable/Disable Order Dialogs
   GEN    Create/Modify Generic Orders
   LST    List Primary Order Menus
   MNU    Create/Modify Order Menus
   OIC    Create/Modify Orderable Items
   PAR    Menu Parameters ...

Select Order Menu Management Option: MNU
   Create/Modify Order Menus

DEMO HOSPITAL              RPMS-EHR Management                 Version 1.1
                        Create/Modify Order Menus
Select ORDER MENU: LRZ CHEMISTRY QUICKMENU

Menu Editor              Jan 26, 2011 11:00:41          Page:    1 of    3
Menu: LRZ CHEMISTRY QUICKMENU                            Column Width: 28
 1                           2                           3
|  A1C today                 Electrolytes Today          Sodium Today
|  Albumin Today             Ethanol Today               T4 Today
|  ALT/SPGT Today            Fasting Glucose             Triglyceride Today
|  Ammonia Today             Glucose today               Troponin Today
+  Amylase Today             GTT 1 Hr. Today             TSH Today
|  AST/SGOT Today            GTT 3 Hr. Today             Uric Acid
|  Bilirubin Total           Hep B Surf Ag Today
|  BMP Today                 Hepatitis Panel Today
|  BUN Today                 HIV Today
1  Calcium Today             Lipid Profile Today
|  Chloride Today            Magnesium Today
|  Cholesterol Today         Phosphate Today
|  CKMB Today                Potassium Today
|  CMP Today                 Protein Total Today
+  CO2 Today                 PT & INR Today
|  Creatinine Today          PTT Today              Other Labs
+         + Next Screen  - Prev Screen  ?? More Actions                >>>
  Add ...           Edit ...          Assign to User(s)   Select New Menu
  Remove ...        Toggle Display    Order Dialogs ...
Select Action: Next Screen// ADD
   Add ...
    Menu Items                Text or Header            Row

Add: M
```

```
   Menu Items
ITEM: LRZ GLUCOSE
ROW: 5
COLUMN: 2
There is another item in this position already!
Do you want to shift items in this column down? YES// YES
DISPLAY TEXT:
MNEMONIC:

ITEM:

Rebuilding menu display ...

Menu Editor              Jan 26, 2011 11:00:41          Page:    1 of    3
Menu: LRZ CHEMISTRY QUICKMENU                            Column Width: 28
 1                           2                           3
|  A1C today                 Electrolytes Today          Sodium Today
|  Albumin Today             Ethanol Today               T4 Today
|  ALT/SPGT Today            Fasting Glucose             Triglyceride Today
|  Ammonia Today             Glucose today               Troponin Today
+  Amylase Today             Glucose                     TSH Today
|  AST/SGOT Today            GTT 1 Hr. Today             Uric Acid
|  Bilirubin Total           GTT 3 Hr. Today
|  BMP Today                 Hep B Surf Ag Today
|  BUN Today                 Hepatitis Panel Today
1  Calcium Today             HIV Today
|  Chloride Today            Lipid Profile Today
|  Cholesterol Today         Magnesium Today
|  CKMB Today                Phosphate Today
|  CMP Today                 Potassium Today
+  CO2 Today                 Protein Total Today
|  Creatinine Today          PT & INR Today              Other Labs
|                            PTT Today
+         + Next Screen  - Prev Screen  ?? More Actions                >>>
  Add ...           Edit ...          Assign to User(s)   Select New Menu
  Remove ...        Toggle Display    Order Dialogs ...
Select Action: Next Screen//
```

4.2.3.3 Implement the Reference Lab Interface in RPMS

Create reference lab tests in a similar fashion and add them to the Auto Instruments and Load/Work List files using the Sendout Accession area. Tests are uniquely mapped and coded to the specified reference lab. Contact the laboratory consultant for further information.

4.2.3.4 Configure the Point of Care Lab in RPMS

1. Create Point of Care accession area using VA FileMan (if not previously created):

```
Select ACCESSION AREA:   POINT OF CARE
AREA: POINT OF CARE//
LR SUBSCRIPT: CHEM, HEM, TOX, RIA, SER, etc.//
COMMON ACCESSION #'S WITH AREA:
ACCESSION TRANSFORM: DAILY//
ACC CODE: S LRAD=DT//
VERIFICATION CODE:
VER CODE:
```

```
*IDENTITY CONTROL:
PRINT ORDER: 39//
BYPASS ROLLOVER: NO//
ABBREVIATION: POC//

Select ASSOCIATED DIVISION: IHS HOSPITAL//
TYPE OF ACCESSION NUMBER:
*LAB SECTION: CHEMISTRY//
NON LAB ACCESSION AREA:
RESPONSIBLE OFFICIAL: DR. PAUL H. STEVENS//
INHIBIT AREA LABEL PRINTING: YES//
LAB DIVISION: CLINICAL PATHOLOGY//
NUMERIC IDENTIFIER: 55//
Lock for load/work list build: YES//
LAB OOS LOCATION:
USER ACCESS AUTHORIZATION: AMCHZUSER//
Select INSTRUMENTATION CONTROLS:
Select DATE: JAN 26,2011//
  DATE: JAN 26,2011//
Select LRDFN: ^
BAR CODE PRINT:
BAR CODE PAD:
ALTERNATE LABEL ENTRY:
ALTERNATE LABEL ROUTINE:
Reserved:
WORK AREA:
WORKLOAD ON:
COLLECT STD/QC/REPEATS:

Select ACCESSION AREA:
```

2. Create Point of Care test:

```
   CORE   IHS Core ...
   MM     Menu Management ...
   UM     User Management ...
   DEV    Device Management ...
   TM     Taskman Management ...
   PROG   Programmer Options ...
   SM     Operations Management ...
   VAF    VA FileMan ...
   SEC    Information Security Officer Menu ...

Select IHS Kernel Option: VAF
   VA FileMan

           VA FileMan Version 22.0

           Enter or Edit File Entries
           Print File Entries

Select VA FileMan Option: ENTER
   Enter or Edit File Entries

INPUT TO WHAT FILE: ACCESSION// 60  LABORATORY TEST  (1594 entries)
EDIT WHICH FIELD: ALL//

Select LABORATORY TEST NAME: POC GLUCOSE
NAME: POC GLUCOSE//
TEST COST: 17.00//
```

```
Select SYNONYM: GLUCOMETER//
TYPE: BOTH//
SUBSCRIPT: CHEM, HEM, TOX, SER, RIA, ETC.//
LOCATION (DATA NAME): CH;7247018;1//   (No Editing)
Select INSTITUTION: DEMO HOSPITAL//
  INSTITUTION: DEMO HOSPITAL//
  ACCESSION AREA: POINT OF CARE//
UNIQUE ACCESSION #: NO//
UNIQUE COLLECTION SAMPLE: YES
LAB COLLECTION SAMPLE: CAPILLARY BLOOD
REQUIRED TEST: YES//
PROCEDURE (SNOMED):
*QUICK INDEX:
EXTRA LABELS:
HIGHEST URGENCY ALLOWED: STAT//
FORCED URGENCY:
PRINT NAME: POC GLU//
Reserved:
PRINT CODE:
PRETTY PRINT ENTRY:
PRETTY PRINT ROUTINE:
PRINT ORDER: 13//
NATIONAL VA LAB CODE:
RESULT NLT CODE:
CATALOG ITEM:
EDIT CODE:
*BATCH DATA CODE:
EXECUTE ON DATA REVIEW:
Select SITE/SPECIMEN: BLOOD//
  SITE/SPECIMEN: BLOOD//
  REFERENCE LOW: 65//
  REFERENCE HIGH: 105//
  CRITICAL LOW: 50//
  CRITICAL HIGH: 500//
  INTERPRETATION:
  1>
  UNITS: MG/DL//
  TYPE OF DELTA CHECK:
  DELTA VALUE:
  DEFAULT VALUE:
  THERAPEUTIC LOW:
  THERAPEUTIC HIGH:
  Select *AMIS/RCS 14-4:
  CPT CODE:
  PANEL (CPT):
  Select FOREIGN COMPUTER SYSTEM:
  LOINC CODE:
Select SITE/SPECIMEN:
GENERAL PROCESSING INST.:
  1>
Select LAB TEST:
Select COLLECTION SAMPLE: CAPILLARY BLOOD//
  COLLECTION SAMPLE: CAPILLARY BLOOD//
  FORM NAME/NUMBER:
  MIN VOL (in mls.):
  MAX. ORDER FREQ.:
  SINGLE DAY MAX ORDER FREQ:
  WARD REMARKS:
  1>
  LAB PROCESSING INSTRUCTIONS :
  1>
```

```
  REQUIRED COMMENT:
  Select SAMPLE WKLD CODE:
Select COLLECTION SAMPLE:
GENERAL WARD INSTRUCTIONS:
  1>
REQUIRED COMMENT:
DATA NAME: POC GLUCOSE//
CULTURE ID PREFIX:
Select VERIFY WKLD CODE:
Select ACCESSION WKLD CODE:
*ASK AMIS/CAP CODES:
COMBINE TEST DURING ORDER:
CIS TEST CODE:
Select SITE NOTES DATE:
IHS PCC DISPLAY FLAG:

Select LABORATORY TEST NAME:
```

3. Add the Point of Care test to BLR BEHO POC Control File

```
          Enter or Edit File Entries
          Print File Entries

Select VA FileMan Option: ENTER
   Enter or Edit File Entries

INPUT TO WHAT FILE: LABORATORY TEST// BLR
     1   BLR BEHO POC CONTROL             (1 entry)
     2   BLR LOCK                         (0 entries)
     3   BLR MASTER CONTROL               (6 entries)
     4   BLR REFERENCE LAB                (8 entries)
     5   BLR REFERENCE LAB IMPORT/EXPORT LOG    (0 entries)

CHOOSE 1-5: 1
   BLR BEHO POC CONTROL       (1 entry)
EDIT WHICH FIELD: ALL//

Select BLR BEHO POC CONTROL NAME:    DEMO HOSPITAL
         ...OK? Yes//   (Yes)

NAME: DEMO HOSPITAL//
ENFORCE RESTRICT TO LOCATION:
ENFORCE RESTRICT TO USER:
Select LAB TEST: POC GLUCOSE
Are you adding 'POC GLUCOSE' as a new LAB TEST? No// Y  (Yes)

  Select RESTRICT TO LOCATION:
  Select RESTRICT TO USER:
Select LAB TEST:
Select AVAILABLE LAB DESCRIPTIONS:

Select BLR BEHO POC CONTROL NAME:
```

4.2.3.5 Create the Lab Point of Care Button in EHR

To use the Lab Point of Care feature, add the **Lab Point of Care** button to the EHR toolbar:

1. Press and hold the **Ctrl** and **Alt** keys, then press **D** to enter ***Design Mode***.
2. Right-click in the space above the buttons to display the right-click menu:

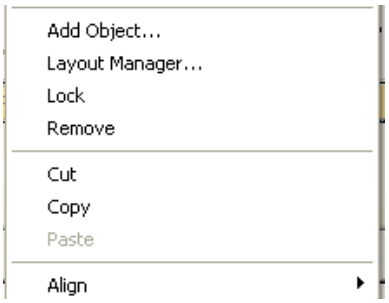


Figure 4-80: Design Mode right-click menu

3. Select **Add Object** to open the **Add an Object** dialog:

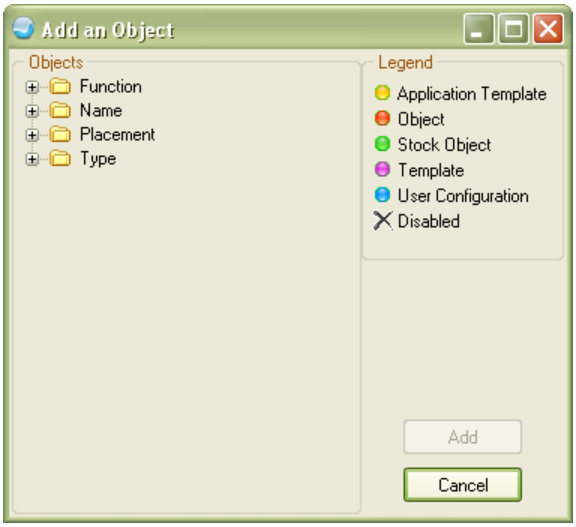


Figure 4-81: Add an Object dialog

4. Click [+] next to **Name** in the **Objects** panel to expand the list.

5. Scroll through the list and select **Lab Point of Care Data Entry**:

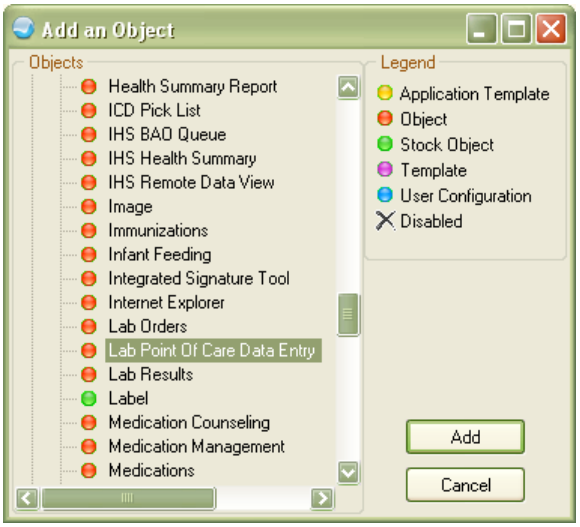


Figure 4-82: Add an Object dialog, object selected

6. Click **Add** to add the POC Lab Entry button to the toolbar; resize and reorganize the buttons to suit:

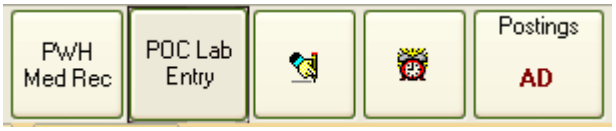


Figure 4-83: POC Lab Entry button on toolbar

7. On the **Design** menu, select **Save As Template**.

8. Press and hold the **Ctrl** and **Alt** keys, then press **D** to exit ***Design Mode***.

4.2.4 Patient List

Objective: "Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach." *42 CFR Part 495.6,(e)(3)(i)*

Type of Measure: Attestation

Threshold: Generate at least one report listing patients of the EH or CAH with a specific condition.

4.2.4.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: the generation of one Patient List Report during the EHR reporting period (if count = 1, report "Yes," if count = 0, report "No")

> The report could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP. Conditions in the patient list should be the same definitions as used in the problem list.
>
> This is a measure for which a State can submit modifications to CMS for approval.

Measure Exclusion: None.

4.2.4.2 Configure RPMS

No RPMS configuration is required.

4.2.4.3 Generate Patient Lists in RPMS

For detailed instructions on accessing report functions on RPMS packages refer to the package-specific manual.

1. Generate a Patient List from the Asthma package (BAT):

```
PATIENTS DUE OR OVERDUE FOR FOLLOWUP

This report will produce a list of all patients on the register
who are due for followup. You will select the age range of
interest and the date range for which the patient is due.

List Patients with which Register Status: A//
   ACTIVE

Enter Beginning Due Date: 010100 (JAN 01, 2000) (pick a very early date, go
way back)

Enter Ending Due Date: 090101 (SEP 01, 2001) (enter a date that is a month
or two from the present)

Would you like to restrict the report by Patient age range? YES// NO

Select one of the following:
N Patient Name
D Patient AGE
V Patient's Next Asthma Visit Due Date
A Last Asthma Severity
L Last Asthma Visit

Sort List by: N//
   Patient Name

Select one of the following:
P PRINT Output
B BROWSE Output on Screen

Do you wish to: P//
   PRINT Output
```

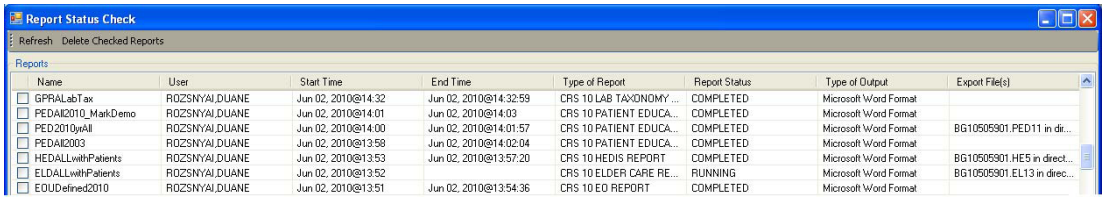
```
DEVICE: HOME// Right Margin: 80//

LAB Apr 24, 2001 Page 1

DEMO HOSPITAL/CLINIC
*** ASTHMA REGISTER PATIENTS DUE OR OVERDUE FOR FOLLOWUP ***

Due Dates: Jan 01, 2010 to Sep 01, 2010
Register Status: ACTIVE
PATIENT NAME HRN AGE LAST SEVERITY LAST VISIT NEXT DUE
-----------------------------------------------------------------------------
DEMO, ALICE J 111111 10 YRS 3-MODERATE PERSIS Feb 08, 2001 Aug 07, 2001
DEMO,LORI W 222222 11 YRS 3-MODERATE PERSIS Jan 08, 2001 Jul 07, 2001
DEMO,RONALD A 777777 13 YRS 3-MODERATE PERSIS Feb 01, 2000 Jul 30, 2000
```

2. Generate a Patient List from the Clinical Reporting System package (BGP):

```
DEMO INDIAN HOSPITAL
Report Period: Jan 01, 2010 to Dec 31, 2010
Entire Patient List
-----------------------------------------------------------------------------
Source:
HP 2010 3-4
UP=User Pop; AC=Active Clinical; AD=Active Diabetic; AAD=Active Adult
Diabetic
PREG=Pregnant Female; IMM=Active IMM Pkg Pt; IHD=Active Ischemic Heart
Disease

Cancer Screening: Pap Smear Rates:
List of women 21-64 with documented Pap smear or refusal, if any.

PATIENT NAME HRN COMMUNITY SEX AGE DENOMINATOR NUMERATOR
-----------------------------------------------------------------------------
PATIENT,CRSAA 106885 BRAGGS F 21 UP,AC 05/05/02 795.0
PATIENT,CRSBB 116282 BRAGGS F 21 UP
PATIENT,CRSJL 900265 BRAGGS F 21 UP,AC
PATIENT,CRSOA 900384 BRAGGS F 21 UP
PATIENT,CRSCC 109555 BROKEN ARROW F 22 UP,AC 10/31/01 Lab
PATIENT,CRSDD 107131 BROKEN ARROW F 22 UP,AC 07/25/03 Lab
PATIENT,CRSEE 122087 CHECOTAH F 22 UP,AC 09/10/03 Lab
PATIENT,CRSFF 128663 CHECOTAH F 22 UP,AC
PATIENT,CRSGG 171055 CHECOTAH F 22 UP,AC 06/26/03 Lab

Total # of Patients on list: 19
```

4.2.4.4 Generate Patient Lists in Visual CRS

The Visual CRS **Report Status Check** window lists the reports run by CRS and stored on the computer. To display the **Report Status Check** window, click **Report Status**.



Name	User	Start Time	End Time	Type of Report	Report Status	Type of Output	Export File(s)
GPRALabTax	ROZSNYAI,DUANE	Jun 02, 2010@14:32	Jun 02, 2010@14:32:59	CRS 10 LAB TAXONOMY ...	COMPLETED	Microsoft Word Format	
PEDAll2010_MarkDemo	ROZSNYAI,DUANE	Jun 02, 2010@14:01	Jun 02, 2010@14:03	CRS 10 PATIENT EDUCA...	COMPLETED	Microsoft Word Format	
PED2010yrAll	ROZSNYAI,DUANE	Jun 02, 2010@14:00	Jun 02, 2010@14:01:57	CRS 10 PATIENT EDUCA...	COMPLETED	Microsoft Word Format	BG10505901.PED11 in dir...
PEDAll2003	ROZSNYAI,DUANE	Jun 02, 2010@13:58	Jun 02, 2010@14:02:04	CRS 10 PATIENT EDUCA...	COMPLETED	Microsoft Word Format	
HEDALLwithPatients	ROZSNYAI,DUANE	Jun 02, 2010@13:53	Jun 02, 2010@13:57:20	CRS 10 HEDIS REPORT	COMPLETED	Microsoft Word Format	BG10505901.HE5 in direct...
ELDALLwithPatients	ROZSNYAI,DUANE	Jun 02, 2010@13:52		CRS 10 ELDER CARE RE...	RUNNING	Microsoft Word Format	BG10505901.EL13 in direc...
EOUDefined2010	ROZSNYAI,DUANE	Jun 02, 2010@13:51	Jun 02, 2010@13:54:36	CRS 10 EO REPORT	COMPLETED	Microsoft Word Format	

Figure 4-84: Visual CRS Report Status window

Reports that are queued to be run at a later time or are being run when the **Report Status Check** window is opened show the word ***RUNNING*** in the **Report Status** column. Reports that have already been run show the word ***COMPLETED*** in this column.

- Select a row to view the associated report.
- To delete one or more reports, select the check box of each, and click **Delete Checked Reports**.
- Click **Refresh** to refresh the list of reports.

4.2.5 Patient Specific Education

Objective: "Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate." *42 CFR Part 495.6,(e)(6)(i)*

Type of Measure: Rate

$$\frac{\text{The number of patients in the denominator who are provided patient education specific resources.}}{\text{The number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.}} > 10\%$$

Threshold: More than 10% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources.

4.2.5.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each patient in the denominator

HAVING: at least one entry of the patient and family education subtopic of literature (L) during the EHR reporting period

Denominator Inclusions:

COUNT: each patient

HAVING: one or more hospitalizations (Service Category of H) or emergency department visits (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

> The patient specific education resources must use the capabilities of the certified EHR technology and the EHR must calculate the measure.
>
> The provider can decide which, if any, resources are applicable.
>
> Each provider who sees the patient during the reporting period will be given a numerator inclusion if any provider has issued literature during the EHR reporting period. This eliminates the necessity for each provider to provide duplicate literature to a patient in order to meet Meaningful Use.

Measure Exclusion: None.

4.2.5.2 Configure RPMS

No RPMS configuration is required.

4.2.5.3 Associate an Education Code to a Charge in EHR

To facilitate documenting of patient literature distribution, create an association between a charge and an education code:

1. Select the **Superbill** tab:

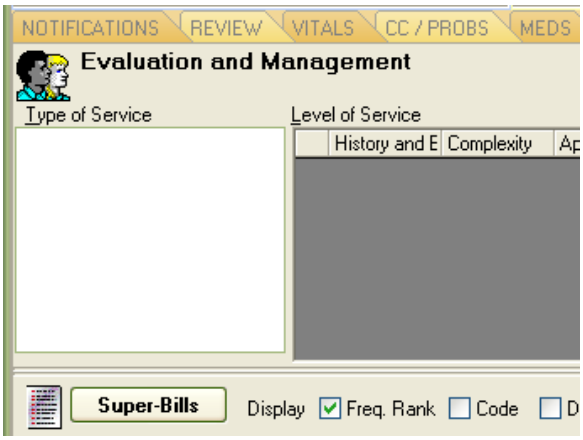


Figure 4-85: EHR Superbills tab

2. Click **Super-Bills** to open the Manage Super-Bills dialog:

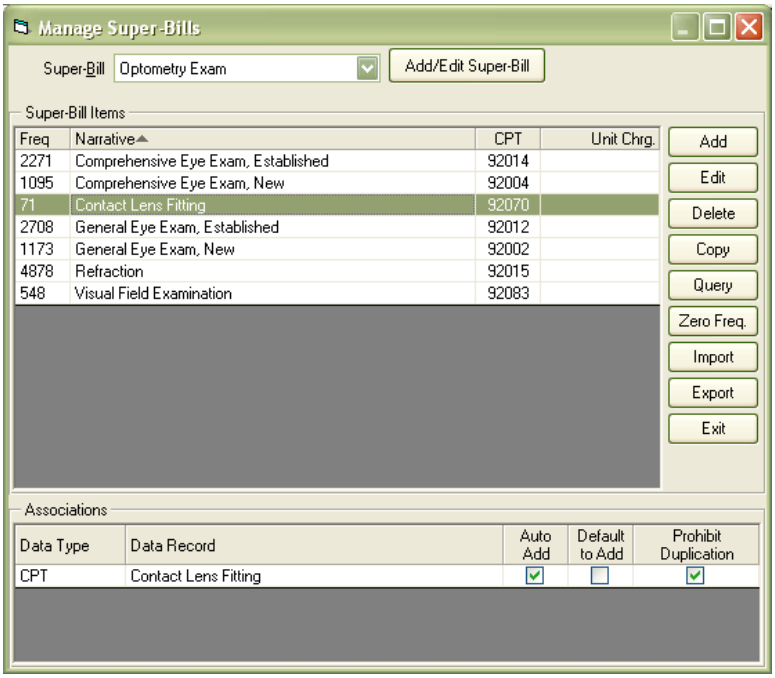


Figure 4-86: Manage Super-Bills dialog

3. Select a category from the Super-Bill list to display the associated Super-Bill Items.

4. Double-click the Super-Bill Item to open the Edit Pick List Item dialog:

Figure 4-87: Edit Pick List Item dialog

5. Click **Add** to open the Add/Edit Pick List Association dialog:

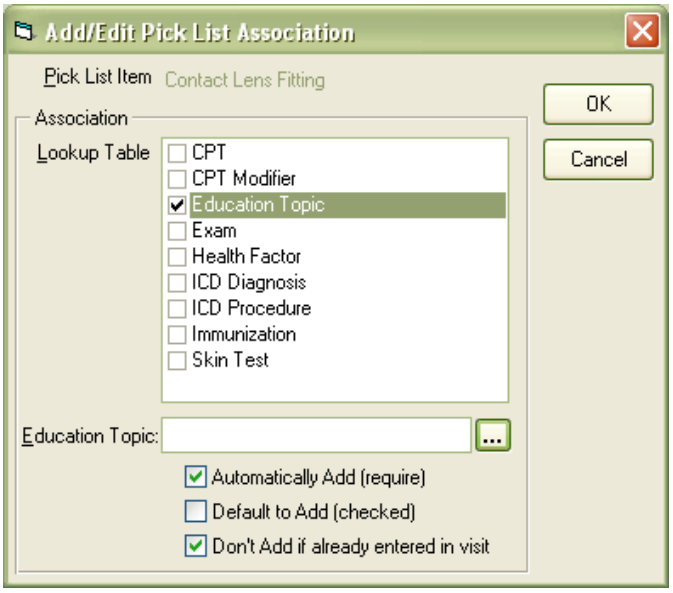


Figure 4-88: Add/Edit Pick List Association dialog

6. Select **Education Topic** in the Lookup Table pane to open the Education Topic Selection dialog:

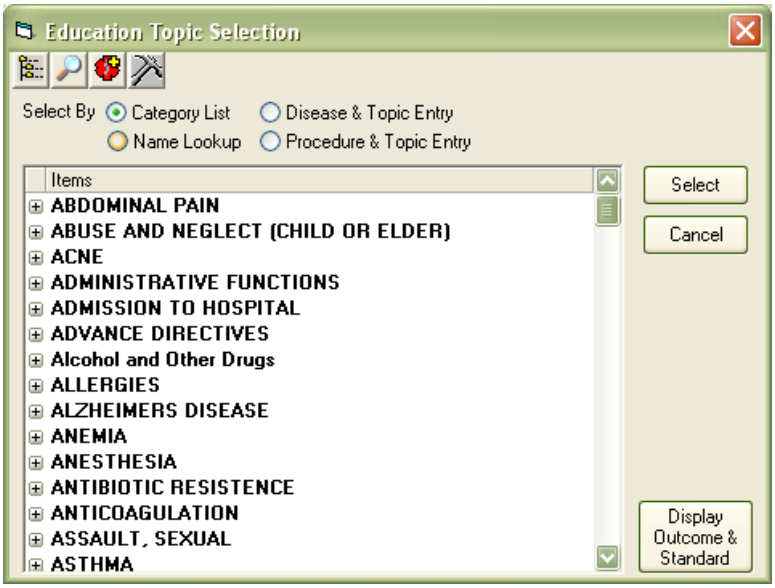


Figure 4-89: Education Topic Selection dialog, Category List view

7. Select one of the **Select By** options:

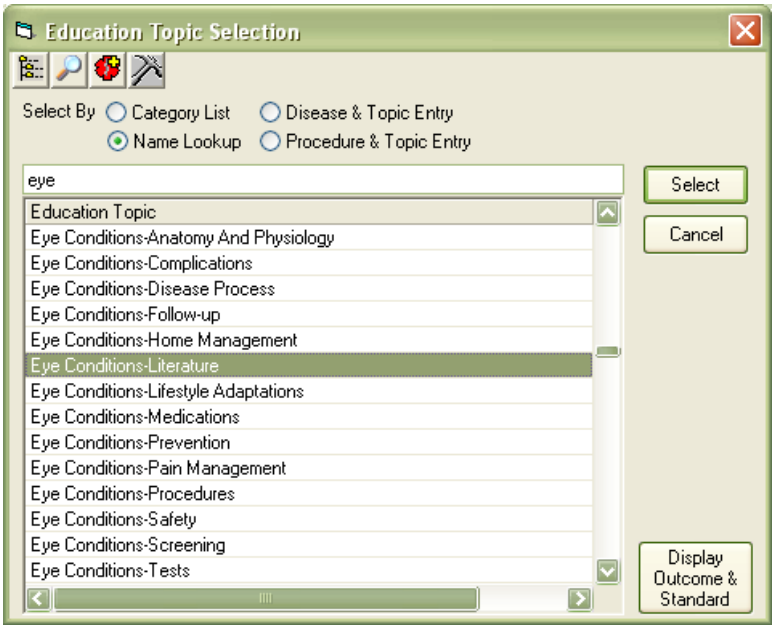


Figure 4-90: Education Topic Selection dialog, Name Lookup view

8. Select the education topic to associate; to meet the measure, the selection should involve Literature.

9. Click **Select** to close the dialog and return to the Edit Pick List Item dialog:

Figure 4-91: Edit Pick List Item dialog with Education Topic associated

10. Click **OK** to close the Edit Pick List Item dialog.

11. Click **Exit** to close the Manage Super-Bills dialog.

4.2.5.4 View and print patient education using the 'i' button in EHR

Patient education information may be viewed wherever the button appears in EHR:

1. Select an item in the list or on the pane.

2. Click to open the web browser to the Medline web site; Medline will use the item test to search for pertinent information.

3. View and print the information directly from the browser to a local printer.

4.2.6 Medication Reconciliation

Objective: "The eligible provider or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation." *42 CFR Part 495.6,(e)(7)(i)*

Type of Measure: Rate

$$\frac{\text{The number of transitions of care in the denominator where medication reconciliation was performed.}}{\text{The number of transitions of care during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.}} > 50\%$$

Threshold: The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

4.2.6.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each visit in the denominator

HAVING: a Patient Education Code of M-MR documented on the day of the hospital admission or emergency department visit

OR HAVING: a Patient Education Code of M-MR documented on the day after the hospital admission or emergency department visit

> In the event the patient has multiple visits on the same day, a medication reconciliation (i.e. Patient Education Code of M-MR) needs only to occur once on the day of the visit.

Denominator Inclusions:

COUNT: each hospitalization (Service Category of H) during the reporting period

HAVING: an admission type of:

Trans-Non IHS Admission

Trans-IHS Admission

Referred Admission

AND COUNT: each emergency department visit (Clinic Code of Emergency Department-30 and Service Category of A) during the reporting period

HAVING: "Yes" in the "Was the patient transferred from another facility" field in the ER Visit file

Measure Exclusions: None.

4.2.6.2 Configure RPMS

No RPMS configuration is required.

4.2.6.3 Set up Education Pick Lists in EHR

1. Select the **Wellness** tab.
2. Click **Add** to display the Education Topic Selection dialog.

3. Select **Pick List**:

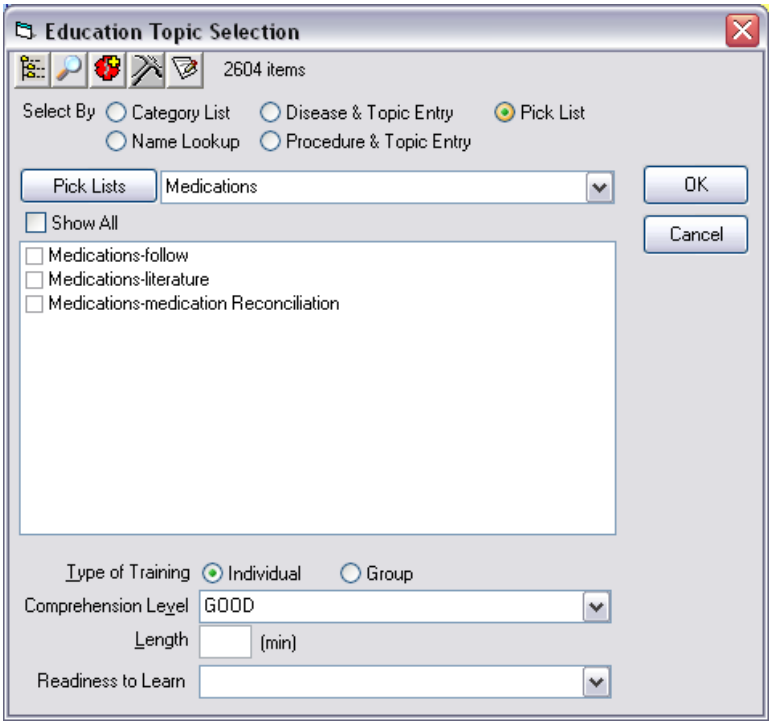


Figure 4-92: Education Topic Selection dialog

4. Click **Pick Lists** to display the Manage Education Quick Picks dialog:

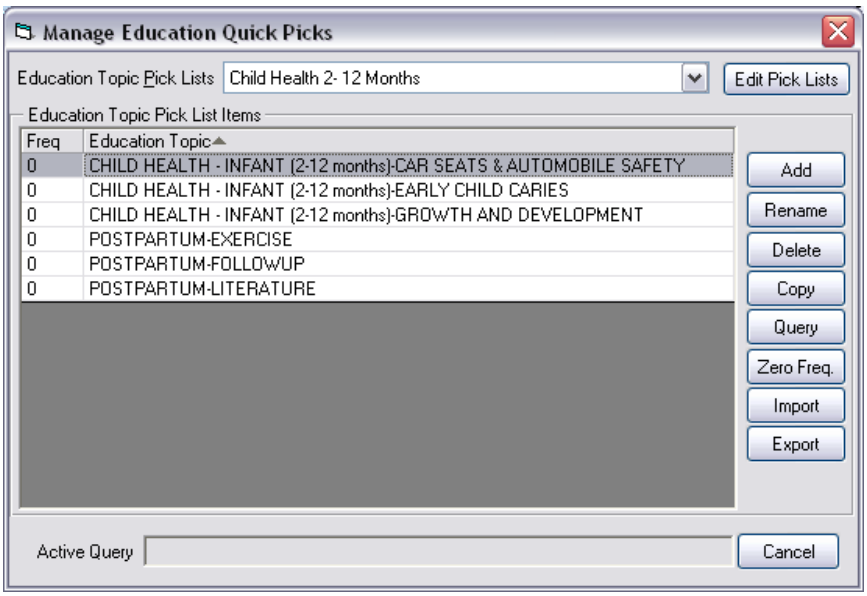


Figure 4-93: Manage Education Quick Picks dialog

5. Click **Edit Pick Lists** to open the Manage Categories dialog:

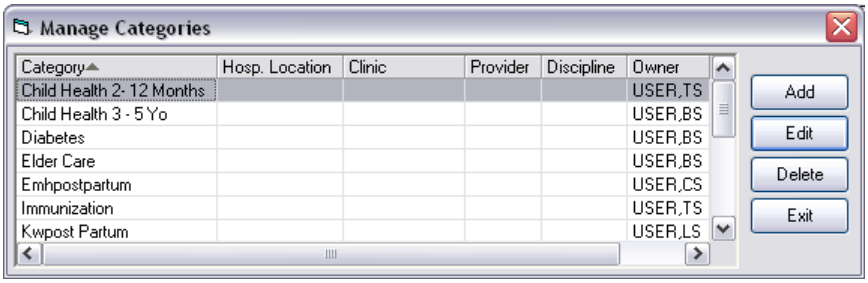


Figure 4-94: Manage Categories dialog

6. Click **Add** to open the Add Category dialog:

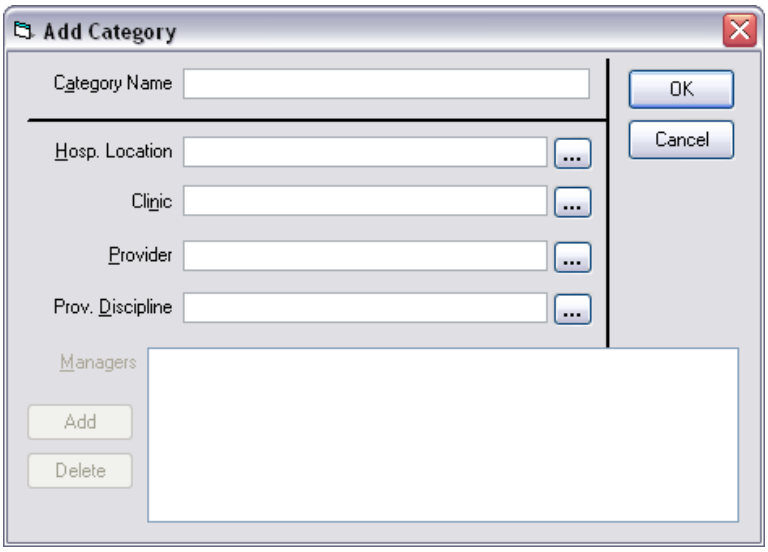


Figure 4-95: Add Category dialog

7. Type **Medications** in the Category Name field.
8. Click **OK** to close the dialog.
9. Click **Exit** to close the Manage Categories dialog.

10. Click **Add** to open the Education Topic Selection dialog:

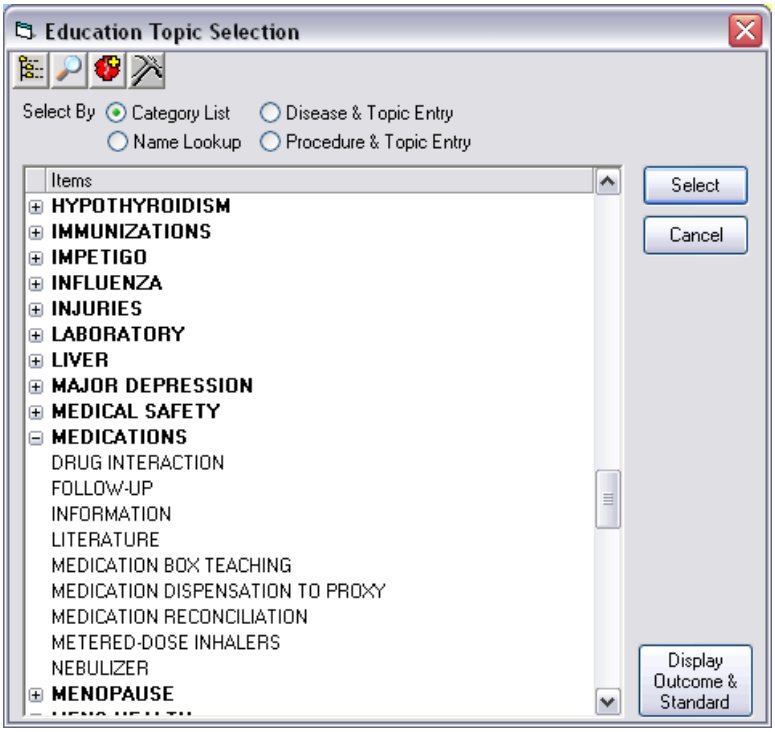


Figure 4-96: Education Topic Selection dialog

11. Scroll through the list to Medications; click **[+]** to expand the list.
12. Select **Medication Reconciliation**.
13. Click **Select**.
14. Click **Cancel**.

4.2.6.4 Document the Education Code in EHR

1. Select the **Wellness** tab.
2. Click **Add** to display the Education Topic Selection dialog.
3. Select **Pick List**:
4. Select **Medications-medication Reconciliation**.
5. Select **Length** and **Readiness to Learn** values.
6. Click **OK** to close the dialog.

7. The entry is displayed on the Education pane:

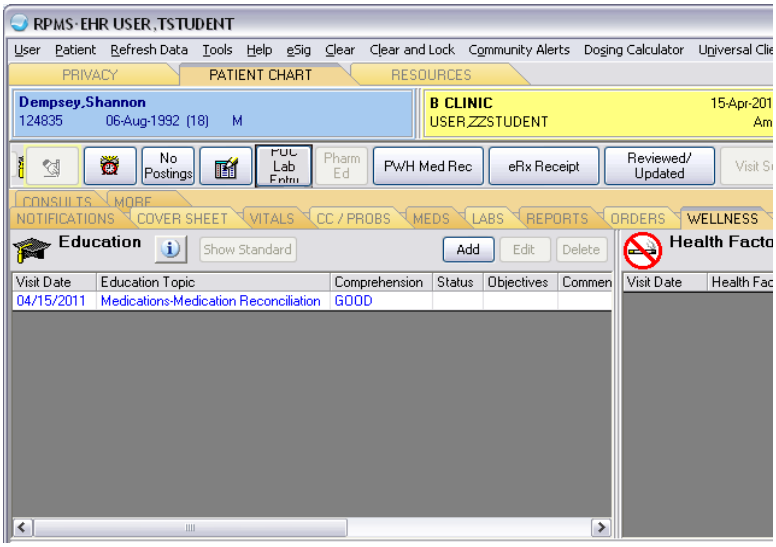


Figure 4-97: EHR Wellness tab, Education pane

4.2.6.5 View a Patient Wellness Handout in EHR

Select PWH Med Rec:

Figure 4-98: PWH Med Rec button

The PWH Med Rec dialog displays:

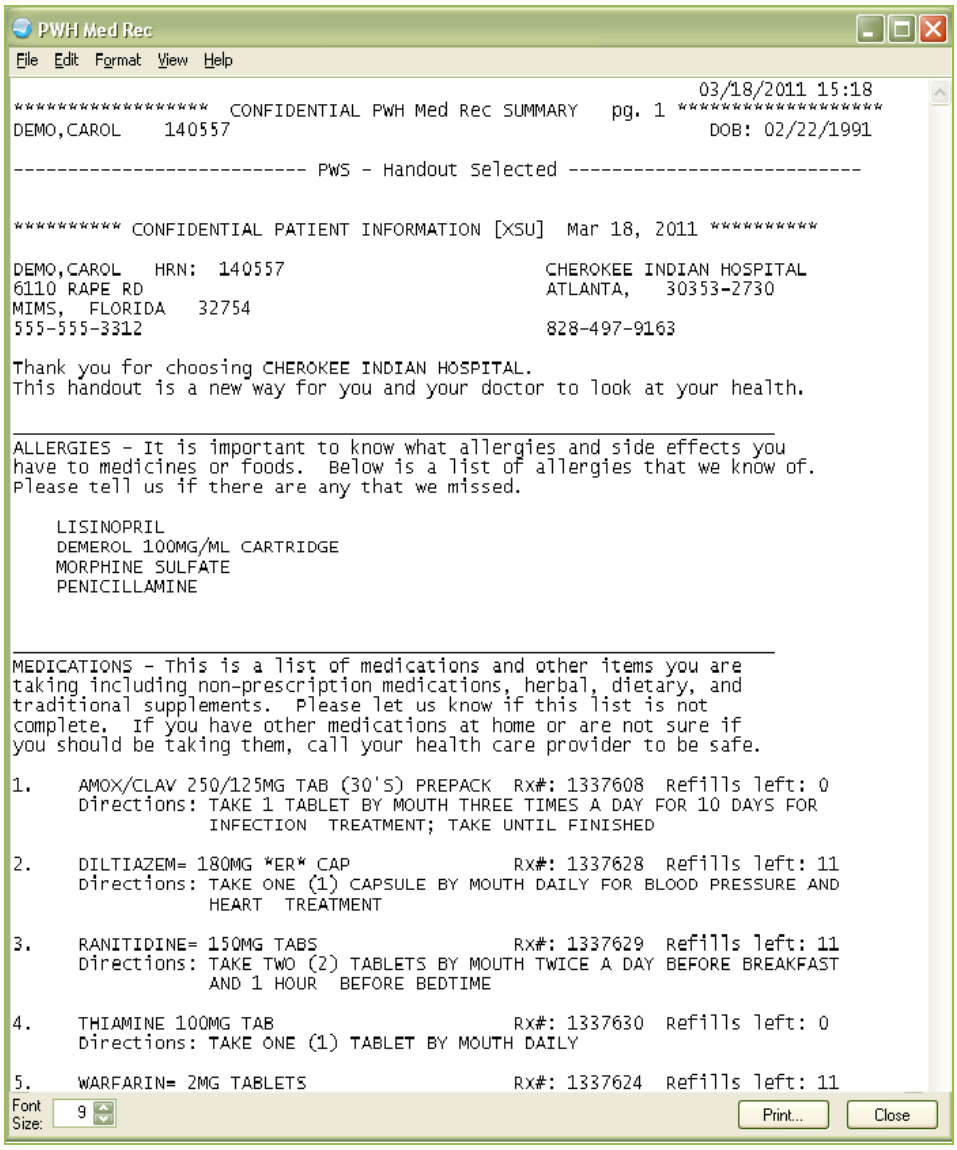


Figure 4-99: PWH Med Rec dialog

4.2.7 Summary of Care

Objective: "The eligible hospital or CAH that transitions a patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral." *42 CFR Part 495.6,(e)(8)(i)*

Type of Measure: Rate

$$\frac{\text{The number of transitions of care and referrals in the denominator where a summary of care record was provided.}}{\text{The number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.}} > 50\%$$

Threshold: The eligible hospital or CAH who transitions or refers a patient to another setting of care or provider of care during the EHR reporting period provides a summary of care record for more than 50% of transitions of care and referrals.

4.2.7.1 RPMS MU Report Logic

Numerator Inclusions:

COUNT: each event in the Denominator

WHERE: the Summary of Care (C32) was printed within 14 days of the referral initiated date.

> Note: The printing of the Summary of Care record (C32) does NOT preclude the provider or CHS clerk from printing and/or electronically transmitting the RPMS Health Summary or any additional information or documentation that may be useful for the receiver of the patient.

Denominator Inclusions:

COUNT: each referral

WHERE: the referral has a Date Initiated occurring from the date of admission through the date of discharge

AND WHERE: the status of Referral is equal to “A” (active) or “C1” (closed completed).

AND WHERE: the referral

CONSISTED OF: a hospitalization during the EHR reporting period defined as Service Category of H

HAVING: a Discharge Type of Transferred

OR CONSISTED OF: an emergency department visit during the EHR reporting period defined as Clinic code of Emergency Department-30 and Service Category of A

HAVING: an ERS Disposition value of “Referred to Another Service”

OR HAVING: an ERS Disposition value of “Transferred to Another Facility”

Measure Exclusions: Eligible hospitals and CAHs that have no referrals meeting the conditions described in the Denominator Inclusions are excluded from this measure.

Denominator Exclusions: All in-house referrals.

4.2.7.2 Configure RPMS

No RPMS configuration is required.

4.2.7.3 View a Patient Wellness Handout in EHR

Use the instructions in Section 4.2.6.5.

4.2.8 Immunization Registries

Objective: "Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice." *42 CFR Part 495.6,(e)(9)(i)*

Type of Measure: Attestation

Threshold: 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 eligible hospital or CAH submits such information have the capacity to receive the information electronically.

4.2.8.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

HAVING: performed at least one test of the certified EHR technology's capacity to submit electronic data to immunization registries during the EHR reporting period

AND HAVING: performed follow-up submission if the test was successful (unless none of the immunization registries to which the provider submits such information has the capacity to receive the information electronically) during the EHR reporting period

> Additional CMS Final Rule Information:
>
> Test data about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
>
> A failed attempt will meet the measure.

> Where no immunization registry exists that has the capacity to receive information electronically during the EHR reporting period, a provider may be excluded from this measure and will have to attest to this in separate documentation to CMS.
>
> This report will not take any potential exclusion of this measure into account.

Measure Exclusion: Eligible hospitals and CAHs who do not administer one or more immunizations during the EHR reporting period are excluded from this measure.

4.2.8.2 Configure the BYIM Export/Import Group in MailMan

> For a complete discussion of the Immunization Interface and the processes it supports, refer to the Immunization Interface Management (BYIM) User Manual.

Add the e-mail addresses of each person who should be notified when an HL7 Immunization Data Export file is ready to be sent to the state registry.

4.2.8.3 Create an HL7 Immunization Data Export file:

```
Select Immunization Interchange Management Menu Option: IZDE
   Start Immunization Data Export

Evaluation of immunizations of children 0-19 for export to the State
Immunization registry may take several minutes.

Do you want to proceed? NO// YES

The last Immunization export ran on JAN 24,2011
Children 19 and under were born after JAN 24,1992

This export will include all children who have had a visit since the last
export ran or after the date you specify below.

You can enter another date if you want to run the export for another date
range.

Last Immunization export ran on JAN 24,2011
Children 19 and under were born after JAN 24,1992
Export Immunizations starting on JAN 24,2011: JAN 24,2011// 01/01/2010

Requested Start Time: NOW// (JAN 24, 2011@13:20:30)

   The immunizations for 375 children 0-19 were evaluated in 2 seconds.

   The file 'izdata20070124.dat' will now be created in the HIPAA-compliant
   directory. This may take several minutes.

   It can be retrieved from this directory for transfer to the State
   registry.
```

```
Select Immunization Interchange Management Menu Option:
```

4.2.8.4 Transmit the HL7 Immunization Data Export file.

> The permissions, processes, and procedures involved in sending updates to a state registry are unique to each State and could also vary from site to site within the same state. Site personnel should work closely with State contacts to ensure that the process is designed and implemented correctly.

RPMS supports both manual and automatic transmission of the file:

- Manual transmission can be done by someone having both the appropriate security clearance and a valid state registry supplied username and password.
- Automatic transmission requires HL7 Communications Bridge software, a commercial third-party software, to be installed and configured at the site.

4.2.9 Submit Lab Results to Public Health Agencies

Objective: "Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice." *42 CFR Part 495.6(g)(9)(i)*

Type of Measure: Attestation

Threshold: Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically).

4.2.9.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

HAVING: performed at least one test of the certified EHR technology's capacity to submit electronic data on reportable lab results to public health agencies during the EHR reporting period (unless none of the public health agencies to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically)

> Additional CMS Final Rule Information:
>
> Test data that is identical in form to actual data may be used.

A failed attempt will meet the measure.

Where no public health agency exists that has the capacity to receive lab results electronically during the EHR reporting period, a hospital or CAH may be excluded from this measure and will have to attest to this in separate documentation to CMS.

This report will not take any potential exclusion of this measure into account.

4.2.9.2 Configure RPMS

No RPMS configuration is required.

4.2.10 Syndromic Surveillance

Objective: "Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice." *42 CFR Part 495.6,(e)(7)(i)*

Type of Measure: Attestation

Threshold: Perform 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 eligible hospital or CAH submits such information have the capacity to receive the information electronically).

4.2.10.1 RPMS MU Report Logic

Measure Inclusions:

COUNT: eligible providers

HAVING: performed at least one test of the certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies during the EHR reporting period

AND HAVING: performed follow-up submission if the test was successful (unless none of the public health agencies to which the provider submits such information has the capacity to receive the information electronically) during the EHR reporting period

Additional CMS Final Rule Information:

Public health agency is an entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.

Test must involve a real submission but may use test data that is identical to a fictional patient. A failed attempt will meet the measure. The test could be started before the start of the EHR reporting period and must be completed prior to the end of the EHR reporting period.

Where no public health agency exists that has the capacity to receive information electronically during the EHR reporting period, a hospital or CAH may be excluded from this measure and will have to attest to this in separate documentation to CMS. This report will not take any potential exclusion of this measure into account.

4.2.10.2 Participate in the IHS Influenza Awareness System

In order to meet the MU objective, the site must participate in the IHS Influenza Awareness System. To participate:

1. Install PCC Management Reports (namespace APCL) Version 3.0 Patch 27, which includes the RPMS Influenza-Like Illness (ILI)/H1N1 Surveillance Export.
2. Ensure that data is being sent to the IHS Division of Epidemiology and Disease Prevention by setting up an e-mail export file receipt notification:
   a. Find the Area - Service Unit - Facilty (ASUFAC) code for your site at: http://www.ihs.gov/scb//index.cfm?module=W_FACILITY&option=list&num=38&newquery=1 (in the column titled 'code').
   b. Prepare an e-mail to the IHS Help Desk (support@ihs.gov) with the subject line:
      Flu Illness Reporting System - export file receipt
   c. Include in the body of the message:

```
"Helpdesk - this request should be routed to the ILI Contact Request
Support personnel.

Please add the e-mail address(es):
[list e-mail address(es)]
to the list of users who automatically receive an e-mail after an export
file is sent to the IHS Data Integration Service.

I am requesting export file receipt notifications for the site [site name
here] with ASUFAC code [ASUFAC code here]."
```

   d. Send the e-mail message.

Appendix A: "Cheat Sheet"

A.1 Core Measures

For Stage 1, Eligible hospitals and eligible Critical Access Hospitals (CAH) must report on all measures shown in the Core Set, unless the provider meets measure exclusions. Use the "Stage 1 Meaningful Use (MU) Performance Report- Eligible Hospital and CAHs" in the Patient Care Component (PCC) Management Reports to monitor measure performance.

The facility must ensure that all versions and patches of the software that comprise the certified Resource and Patient Management System (RPMS) Electronic Health Record (EHR) are installed. The versions and patches required for each Measure are shown in the Software Requirements column of this appendix; an integrated list may be viewed at: [http://www.ihs.gov/recovery/documents/CertEHR-MUAppChecklist.pdf].

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Computerized Physician Order Entry Medication Orders: More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE. NOTE: In Stage 2, the measure target increases to 60%.	Section 4.1.1 • Maintain and clean up Drug file. • Configure medications for CPOE in Pharmacy Data Management (PDM) and OE/RR Quick Orders and Menus. • CPOE of a medication through EHR. • Ensure only licensed healthcare professionals are assigned the ORES or ORELSE keys. What Lowers Your Rate for this Measure? • Medication orders entered by ORELSE key holders and signed on chart. • Orders entered by Pharmacy or Nursing staff and sent to provider for review/signature – they must be entered by the provider to count as CPOE.	EHR v1.1 patch 8 PCC patch 6	1. Select Meds tab 2. Order a Medication	N/A

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Drug-Drug & Drug-Allergy Checks: The provider has enabled drug-drug and drug-allergy for the entire EHR reporting period. (Yes/No answer, determined by report).	Section 4.1.2 • Enable and set to mandatory ten order checks to include Allergy-Contrast Media Interaction, Estimated Creatinine Clearance, Allergy-Drug Interaction, Allergy-Contrast Media Interaction, Critical Drug Interaction, Renal Functions Over Age 65, Glucophage-Contrast Media, Glucophage-Lab Results, Dangerous Meds for Patient >64, No Allergy Assessment, and Allergy Unassessible. • Run the Clean Date system check on the Meaningful Use Performance Report in PCC to verify order checks are configured correctly. What Lowers your Rate for this Measure? • Not having your order checks configured during the entire reporting period (90 days year one, 365 days thereafter).	EHR v1.1 patch 8 PCC patch 6	1. Select Options from Tools menu 2. Select Order Checks tab 3. Scroll through list to verify that all required Adverse Reaction order checks are enabled	N/A

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Demographics: More than 50% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.	Section 4.1.3 • Set Patient Registration options to mandatory for Preferred Language, Race, Ethnicity, Sex, Date and Preliminary Cause of Death in the event of mortality in the hospital. (Sex, Date of Birth are already mandatory fields). • Cause of death is the preliminary cause as indicated by the hospital, not on the death certificate issued by the DOH or coroner's office. • Cause of Death is entered through PCC using mnemonic UCD (Underlying Cause of Death) or in the ADT package. • Patient Registration to review and update Preferred Language, Race, Ethnicity, Sex, Date of Birth. • Preferred Language is NOT the same as Primary Language (two separate fields). What Lowers your Rate for this Measure? • Skipping ANY demographic element will eliminate the patient from your count.	Patient Registration patch 9 PCC patch 6	1. Click the Patient Detail button 2. View: • Preferred Language • Race • Ethnicity • Sex • Date of Birth	Enter and view: • Preferred Language • Race • Ethnicity • Sex • Date of Birth

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Problem List: More than 80% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Section 4.1.4 • Maintain active and inactive Problem List for each patient. • Delete any non Problem List-related entries. • If patient has no active problems, you must use functionality for entering No Active Problems. • Health Information Management.	EHR v1.1 patch 8 PCC patch 6	1. Select Cover Sheet 2. Right Click Active Problem List 3. Select Chart Review: 4. Select Reviewed to review active problems 5. Select No Active Problems to set structured data	1. Select Problem List tab 2. Click: • Add Problem • Edit Problem • Delete Problem
Medication List: More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Section 4.1.5 • Optimize the Pharmacy suite of applications to include the outside medication option and medication reconciliation. • Maintain and clean up Drug file. • Configure medications for CPOE in PDM and OE/RR Quick Orders and Menus. • Document No Active Meds in the Cover Sheet or click the Medication Chart Review button.	EHR v1.1 patch 8 PCC patch 6	1. Select Cover Sheet 2. Right Click Medication List 3. Select Chart Review: 4. Select Reviewed to review active problems 5. Select No Active Medications to set structured data	1. Select PCC tab 2. Select Type =Medications

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Medication Allergy List: More than 80% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Section 4.1.6 • Configure Adverse Reaction Tracking Package parameters • Enable Order Checks in OE/RR Package. • Document allergies to include no known allergies through EHR. • The Problem List Allergy List (PLAL) Report can be used to identify patient drug allergies that are on the patient's Problem List but not on their Allergies List. • Pharmacy to generate Adverse Reaction tracking non-verified allergies report and verify unverified allergies. What Lowers your Rate for this Measure? • Entering adverse reactions in the Problem List and not in Adverse Reaction Tracking Package.	EHR v1.1 patch 8 PCC patch 6	1. Right Click in Adverse Reactions 2. Review the following: • Edit Adverse Reaction • Delete Adverse Reaction • New Adverse Reaction • Sign Adverse Reaction • Select Inability to Assess • Select a Reason 3. Select Chart Review: Select Reviewed to review active problems Select No Active Medications to set structured data	1. Select Summ/Sup tab 2. Select Type=Patient Wellness Handout 3. Select Medication Reconcilliation from second list.
Vital Signs: For more than 50% of all unique patients age 2 and over admitted to eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period, height, weight, and blood pressure are recorded as structured data.	Section 4.1.7 • Create a vital signs template for EHR data entry. • Create a template for display of measurements on EHR Cover Sheet. • Assign data entry permission to appropriate providers and user classes. • Ensure each patient has their blood pressure, weight, AND height recorded at each encounter.	EHR v1.1 patch 8 PCC patch 6	1. Select Vitals tab 2. Click New Date/Time 3. Select Now 4. Enter vitals: • Height • Weight • Blood pressure	1. Select Snapshot tab 2. View Measurements pane

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Smoking Status: More than 50% of all unique patients 13 years old or older or admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.	Section 4.1.8 • Ensure all patients seen during the reporting period have been screened for tobacco status. • Use tobacco health factors.	EHR v1.1 patch 8 PCC patch 6	1. Select Wellness tab 2. Locate Health Factors pane 3. Click Add 4. Click '+' to expand: • Select a Status • Tobacco (Exposure) • Tobacco (Smokeless…) • Tobacco (Smoking)	1. Select PCC tab 2. Select Type=Health Factors 3. View Smoking Status
Clinical Decision Support: Implement one clinical decision support rule. (Yes/No answer, provided by person running report).	Section 4.1.9 • Ensure Clinical Reminders installed and national reminders configured. • Have at least one of the following configured on the EHR Reports tab: Diabetes, Pre-Diabetes, Asthma, Anti-coagulation, or Women's Health Supplement; Immunization Package Forecasting; or Health Maintenance Reminders. • The report will automatically display "Yes" if any of the above are found to be installed, or "No" if none of the above are found to be installed. • Implement at least one disease-specific admission menu.	EHR v1.1 patch 8 Clinical Reminders v1.5 patch 1007 PCC patch 6	1. Select Reports tab 2. Select a supplement: • Diabetes • Pre-Diabetes • Asthma • Anti-coagulation • Women's Health 3. View the report	1. Select Summ/Sup tab 2. Select Type= Supplements 3. Select from second list: • Asthma • Diabetes • Pre-diabetes • Women's Health

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Calculate and Transmit Clinical Quality Measures: Provide aggregate numerator, denominator, and exclusions through attestation (Fiscal Year 2011 for eligible hospitals and CAHs). (Yes/No answer, provided by person running report).	Section 4.1.10 • Ensure Clinical Reporting System v11.0 Patch 2 is installed. • Run Eligible Hospital/CAH Performance Measure Report for a selected 90-day period during the first participation year or the full federal fiscal year for subsequent participation years. • Choose the All Hospital Measures report. • If any measure has denominator=0, you must still report the measure. • There are no performance targets that must be met for Stage 1 MU. • Save report since the information will need to be provided to CMS or the State (details to be provided in April 2011). The information needed will be obtained from the Clinical Quality Measures Performance Summary, which is the last page of the report. • Run the Clean Date system check on the Meaningful Use Performance Report in PCC to verify order checks are configured correctly. What Lowers your Rate for this Measure? • Not having your order checks configured during the entire reporting period (90 days year one, 365 days thereafter).	CRS v11 patch 2, PCC patch 6 NOTE: If you have a denominator equal to zero for any of the three menu set measures included in CRS v11 patch 2, you will need to wait until CRS v11.1 is released that will have additional measure selections.	Generate the Clinical Quality Measures Report in RPMS Roll and Scroll.	N/A

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Electronic Copy of Health Information: More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information during the EHR reporting period are provided it within 3 business days. Exclusion: providers who have no requests for electronic copy of health information.	Section4.1.11 • Configure PCC Health Summary, Patient Wellness Handout, Discharge Summary, and Discharge Instructions within the EHR. • Provide the information electronically to the patient, such as by CD, encrypted e-mail, or on a memory stick provided by the facility. • Document in Release of Information (ROI) requests for electronic copy of health information (enter as Patient/Agent Request Type=Electronic). • Document in ROI information was provided electronically (enter as Record Dissemination =Electronic) and record the Disclosure Date.	EHR v1.1 patch 8 C32 v1 PCC patch 6 ROI v2 patch 3	[C32 button]	N/A

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Electronic Copy of Discharge Instructions: More than 50% of all patients who are discharged from an eligible hospital or CAH inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions during the EHR reporting period are provided it.	Section 4.1.12 • Ensure the post-install routine from the TIU patch (TIU1008 DOCUMENT DEFS) gets run. • Create or import a TIU Discharge Instruction template and attach to the Discharge Instruction Note Title. • Create or import the e-copy templates and tie them to the appropriate Note Title. • Use TIU Note Titles to document either “E-copy discharge instr received” OR “E-copy discharge instr not received”. • Consider using Quick Notes functionality (see EHR patch 7 release notes). What Lowers your Rate for this Measure? • Not providing the requested electronic copy with 3 business days. An entry with a date/time stamp is made in the visit file for each TIU note. • Using the wrong TIU Note Title.	EHR v1.1 patch 8, PCC patch 6		

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Exchange Key Clinical Information: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. (Yes/No answer, provided by person running report).	Section 4.1.13 • - This will be accomplished using the EHR and HIE viewer to retrieve and print C32 documents from external facilities and to enable delivery of C32 documents to requesting organizations. • All federal sites will perform the test by submitting their C32s to the IHS national repository. • The IHS Office of Information Technology will notify the Area MU Coordinators of the results of this test. • Results from this OIT test should be entered as a “Yes” or “No” in the Stage 1 MU Performance Report for Hospitals & CAHs for the purposes of attestation. • Tribal RPMS sites have the option to perform the test as described above or with another entity (e.g. a state Health Information Exchange (HIE).	EHR v1.1 patch 8 NHIE 1.0 C32 v1	N/A	N/A

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Privacy and Security: Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) of the certified EHR technology, and implement security updates and correct identified security deficiencies as part of its risk management process. (Yes/No answer, provided by person running report).	Section 4.1.14 • Conduct security risk analysis (RA) by using the OIT-developed template: http://www.ihs.gov/recovery/documents/MURiskAnalysisOffice2003.doc • Correct deficiencies noted as part of the RA. • Ensure a sanction policy is adopted (required for federal sites; tribal/urban sites may elect to adopt IHS policy). If your site adopts sections from Part 8 of the IHS Manual, in whole or in part and IHS SOPs and appropriate SGMS, this will meet the requirements of adopting a sanction policy. • Review Logs and Incident Reports: Use Tipping Point or the logs implemented through RPMS to support MU. • Use Secure Fusion reports for vulnerability identification.	VanDyke for AIX IPSEC for Windows Winhasher 1.6 Security assessment Symantec 8.0	N/A	N/A

A.2 Menu Set Measures

For Stage 1, eligible hospital and CAHs must report on five measures shown in the Menu Set below unless the facility meets measure exclusions.

Eligible Hospital and CAHs must choose at least one of the two public health measures, which are preceded with an asterisk "*" in the left column below.

Eligible Hospital and CAHs must ensure that all versions and patches of the software that comprise the certified RPMS EHR are installed. The versions and patches required for each Measure are shown in the Software Requirements column of this appendix; an integrated list may be viewed at: [http://www.ihs.gov/recovery/documents/CertEHR-MUAppChecklist.pdf].

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
Drug-Formulary Checks: The eligible hospital or CAH has enabled drug formulary checks and has access to at least one internal or external formulary for the entire EHR reporting period. (Yes/No answer, determined by report).	Section 4.2.1 • Use the RPMS EHR for pharmacy CPOE (drug-formulary check is always enabled). • Mark non-formulary drugs as "non-formulary" in the drug file.	EHR v1.1 patch 8 PCC v2 patch 6 Pharmacy v7.0 patch 1010,	1. Select Meds tab 2. Order a Medication 3. Select a non-formulary med ('NF' is appended to the name) 4. Formulary Alternatives dialog displays	N/A

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
Advance Directives: More than 50% of all unique patients 65 years old or older admitted to the EH's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data. Exclusion: Eligible hospitals and CAHs who have no patient admissions for patients with an age of ≥65 years on date of admission during the EHR reporting period.	Section 4.2.2 In the Patient Registration Package there is a field for capturing Advance Directives: • Activate the class and document of Advance Directives. • Activate the Note Title of Advance Directives. • Utilize the Advance Directives Note Title for documenting the presence of an Advance Directive. • HIM staff must search Advance Directives Note Titles at least month, and if they are incorrect, reassign to correct Note Title. What Lowers your Rate for this Measure? • Not capturing the presence of Advance Directives in Patient Registration. • Using Note Title.	EHR Alerts Package		

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
Lab Results into EHR: More than 40% of all clinical lab test results ordered by an authorized provider of the eligible hospital or CAH has for patients admitted to its inpatient or emergency department (POS 21 or 23) 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.	Section 4.2.3 Sites Using RPMS Lab Package to Order & Result Lab Tests: • Use and maintain Lab package for use with EHR. • Data Innovations in-house interface is not required for in-house labs. If not using, order labs using RPMS EHR but manually enter test results into RPMS Lab package • Use Bi-directional Reference Lab Interface for labs that are performed by a reference lab (e.g. Quest, LabCorp). • If NOT using the bi-directional interface for Send-out labs, order labs using RPMS EHR but manually enter test results into RPMS Lab package. • If using the unidirectional interface data is entered directly into PCC. • Configure the EHR Point of Care lab button. What Lowers your Rate for this Measure? • Not Using RPMS Lab Package for laboratory orders and results. • Using a uni-directional interface, because orders are not entered into RPMS, nor are results populated into the Lab Package.	EHR v1.1 patch 8 PCC patch 6 Lab Package v5.2 patch 1027	1. Select Lab tab 2. Review Laboratory Results	1. Select PCC tab 2. Select Type=Labs 3. View Lab Results

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
Patient List: Generate at least one report listing patients of the EH or CAH with a specific condition. (Yes/No answer, provided by person running report).	Section 4.2.4 • Generate at least one list of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach. • Examples of reports include Diabetes, Asthma, Women's Health, Adverse Reaction Tracking, Immunizations, Obesity Prevalence, Clinical Report System, and iCare. • Another way to create lists is through Qman by including the following data elements at a minimum: problem list, medication list, demographics, and laboratory test results. For example, use QMan to generate a list of patients 2-64 years of age with a visit to the EP in the past year who have diabetes indicated on their problem list. • Save the list to a file, if desired, as proof of its generation.	PCC patch 6, iCare v2.1, CRS 11 patch 2	Generate a List using the RPMS Roll and Scroll for: • Diabetes • Asthma • Women's Health • Adverse Reaction Tracking • Immunizations • Obesity Prevalence • Clinical Report System	1. Select Panel List tab 2. Click New 3. Select Ad Hoc Search 4. Type the Panel Name 5. Select the Patient filter 6. Select the Diagnostic Tag filter 7. Click Edit 8. Select the diagnosis 9. Click Add to move the selection to Current Selections 10. Click OK 11. Set additional filters as desired 12. Click OK 13. View the panel
Patient Specific Education: More than 10% of all unique patients admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources.	Section 4.2.5 • Provide printed patient education materials to patients. • In the Education component (normally on the Wellness tab), add patient education by selecting the applicable category/disease/procedure and a sub-topic of "Literature." For example, Diabetes Mellitus-Literature.	EHR v1.1 patch 8, PCC patch 6	1. Click "I" 2. Print information 3. Document education at the Add Patient Education dialog.	N/A

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
Medication Reconciliation: Perform medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	Section 4.2.6 - Provide patients with medication reconciliation patient wellness handout. • Perform the medication reconciliation for transitions of care. • Document Medication Reconciliation (Patient Education Code of M-MR).	EHR v1.1 patch 8, PCC patch 6	1. Select the Meds tab 2. Find and Print the Medication Reconciliation Patient Wellness Handout.	N/A
Summary of Care: The eligible hospital or CAH who transitions or refers a patient to another setting of care or provider of care during the EHR reporting period provides a summary of care record for more than 50% of transitions of care and referrals. Exclusion: Eligible hospitals and CAHs that have no referrals during the EHR reporting.	Section 0 Print C32 Summary of Care record for all active referrals and give to patient and/or receiving provider: • Access the RCIS tab (next to Resources tab) to view list of referrals, including those that have not had a C32 printed. • To print a C32, select the patient, click Referrals tab, click the referral, and click the “Print C32 for Referral” button (above the Referral Date From/To row) OR: • RCIS staff views a list of active referrals for which C32s need to be printed by running the “Active Referrals without a Printed C32” report from the Administrative Reports menu. They can then login to the RPMS EHR to print the C32 for a specific referral and provide to the patient and/or receiving provider.	EHR v1.1 patch 8, PCC patch 6 RCIS v4.0 patch 7t1,	[C32 button]	N/A

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
***Immunization Registries**: 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. NOTE: Hospitals should not choose this measure if their respective state does not have an immunization registry and/or does not have the capacity to receive the information electronically. (Yes/No answer, provided by person running report).	Section 4.2.8 • Contact registry for instructions on test submission. • USE BYIM TEST command to generate test file. • A single test per RPMS facility will be performed with a state immunization registry. • The IHS Office of Information Technology will notify the Area MU Coordinators of the results of this test. Results from this OIT test should be entered as a “Yes” or “No” in the Stage 1 Meaningful Use Performance Report for EPs for the purposes of attestation. • States with no immunization registry or registries which cannot receive HL7 messages are excluded. • The Immunizations MU Guide and the MU map can be accessed on the Meaningful Use Resources web page (http://www.ihs.gov/meaningfuluse/index.cfm?module=resources).	Immunization Exchange v2 patch 1, PCC patch 6	N/A	N/A

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
Submit Lab Results to Public Health Agencies: Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically). (Yes/No answer, provided by person running report.) Exclusion: Eligible hospitals and CAHs that have no public health agency with the capacity to receive electronic information during the EHR reporting period.	Section 4.2.9 • Ensure the facility is transmitting the revised RPMS Reportable Labs Export to the IHS Division of Epidemiology and Disease Prevention. This requires installation of PCC Reports (APCL) Version 3.0 Patch 27. • Sign up to receive an e-mail export file receipt notification. • A copy of the e-mail confirmation export file receipt will serve as the attestation of this measure for MU.	PCC Patch 6 PCC Reports (APCL) Version 3.0 Patch 27		

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
***Syndromic Surveillance**: Perform 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 eligible hospital or CAH submits such information have the capacity to receive the information electronically). (Yes/No answer, provided by person running report).	Section 4.2.10 • Ensure the facility is transmitting the revised RPMS ILI/H1N1 Surveillance Export to the IHS Division of Epidemiology and Disease Prevention. This requires installation of PCC Reports (APCL) Version 3.0 Patch 27. • Sign up to receive an e-mail export file receipt notification. • Receipt of the e-mail confirmation export file receipt will serve as the attestation of this measure for MU.	PCC Reports (APCL) Version 3.0 Patch 27 PCC patch 6	N/A	N/A

Appendix B: Meaningful Use Reports

These reports will calculate and determine if the minimum requirements to achieve Meaningful Use (MU) have been met. For Stage 1 of the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program, there are 14 core Performance Measures for eligible hospitals and Critical Access Hospitals (CAH) that must be met simultaneously during the EHR reporting period. Additionally, eligible hospitals must meet five of the ten menu set Performance Measures simultaneously, one of which must be designated as a Public Health Performance Measure. Public Health measures are marked with an asterisk throughout the report.

```
****************************************
**          PCC Management Reports     **
** Meaningful Use Performance Reports **
****************************************
IHS PCC Suite Version 2.0

DEMO IHS CLINIC

   M1IP   Stage 1 Interim MU Performance Report-EPs
   PLP Stage 1 Interim MU Patient List-EPs
   M1IH   Stage 1 Interim MU Performance Report-Hospitals
   PLH Stage 1 Interim MU Patient List-Hospitals

Select Meaningful Use Performance Reports Option:
```

B.1 Estimated Run Time

Generate these reports during a period of low system usage. The run time will depend on the size of the site's database.

B.2 Produce the Interim MU Performance Report-Hospitals (M1IH)

Choose the Stage 1 Interim MU Performance Report for Eligible Hospitals to display the following message:

```
*** IHS 2011 Stage 1 Interim MU Performance Report for Hospitals & CAHs ***

This report determines if a hospital or CAH has met the minimum
requirements to achieve Meaningful Use. Primary and secondary providers are
included in Meaningful Use calculations. The report identifies the 14 Core
Performance Measures and 10 Menu Set Performance Measures designated by the
CMS Final Rule for Stage 1, July 28, 2010.

In order to achieve Meaningful Use, a hospital or CAH must meet all 14 Core
Performance Measures simultaneously. They must also meet 5 of the 10 Menu
Set Performance Measures simultaneously, one of which must be a designated
Public Health Performance Measures. Public Health measures are identified
within the report by an asterisk.
```

```
Press Enter to Continue:
```

The following sections describe the steps to take after the report is selected.

B.2.1 Eligibility Notice for Eligible Hospitals and CAHs

This interim report does not verify participation eligibility.

> This report can indicate that a facility that is not eligible to participate in the program has achieved MU.

Eligibility is determined by running the MU Patient Volume Report for Eligible Hospitals (PVH) located in the Third-Party Billing application. The notice below displays before the option to run the report is given:

```
******** IMPORTANT NOTICE ********

This interim report does not verify CMS Medicare or Medicaid EHR Incentive
Program eligibility. Please speak to your Area Meaningful Use Coordinator
for guidance in determining eligibility.

Do you wish to continue to report? Y//
```

Type **Yes** to open the Patient List set up; type **No** to return to the main menu.

B.2.2 Full Report or Summary Report Selection

Two versions of the report are available:

- Full Report includes the Cover Page and details on each Performance Measure along with corresponding logic. The Full Report also includes a Summary Report.
- The Summary Report does not include programming logic.

Both reports display previous and current performance results as well as Stage 1 targets.

```
A full report will include an itemized listing of all Performance Measures
and will include a summary report. The summary report excludes itemized
data. The full report will produce approximately 40 pages of data for the
facility. Please take this into consideration when running print jobs,
ensuring dedicated time on your printer and sufficient paper supplies to
complete your job.

     Select one of the following:

          F         Full Report
          S         Summary Report

Enter Selection: F//
```

B.2.3 Report Period Selection

The report may be run for a full year or for a 90-day period. These two options coincide with the CMS program parameters for reporting periods.

```
Report may be run for a 90-day or a one year report period.

   Select one of the following:

       A   October 1 – September 30
       B   User Defined 90-Day Report

Select Report Period: [A/B]
```

This report can be run for any date; however, per CMS guidelines, MU cannot be achieved with the Resource and Patient Management System (RPMS) EHR prior to its date of certification and installation.

For example, if the certified version of RPMS EHR was installed on July 27th, the report may be run for periods prior to this date, but MU can only be achieved on performance for a period that begins on or after July 28th.

B.2.3.1 Federal Fiscal Year Selection

The MU program for eligible hospitals/CAHs runs on a fiscal year. Enter the fiscal year for which to run report.

```
Enter the Federal Fiscal Year for which report is to be run. Use a year,
e.g. 2011.

Enter Year: [FFYY]
```

B.2.3.2 User Defined 90-Day Report

Enter a start date for the 90-day report.

```
Enter Start Date for the 90-day Report (e.g. 01/01/2011):
```

B.2.4 Hospital or CAH Selection

Specify the Hospital or CAH to include in the report.

```
Select Hospital or CAH: DEMO IHS CLINIC//
```

B.2.5 Demo Patient Selection

Choose to include or exclude demo patients in the report:

```
Select one of the following:
```

```
      I  Include ALL Patients
      E  Exclude DEMO Patients
      O  Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E//
```

B.2.6 Attestation Performance Measures for Hospitals

The interim version of the MU report calculates all rate performance measures – measures that have a numerator and denominator. For all attestation measures, the software will prompt for an answer of **Yes** or **No** to each attestation question for each provider for whom the report is being run.

```
Several Stage 1 Meaningful Use Performance Measures require an attestation
of Yes or No for each provider for which the report is being run.

Do you wish to continue? Y//
```

B.2.7 Output Selection

A summary of the selections the user made in the previous steps displays. Choose from the following output selections:

- P: Print Report on Printer or Screen
- D: Create Delimited output file (for use in Excel)
- B: Both a Printed Report and Delimited File

```
SUMMARY OF 2011 MEANINGFUL USE REPORT TO BE GENERATED

The date ranges for this report are:
   Report Period:   [Specified Report Period]
   Previous Period: [Period Immediately Preceding Specified Report Period]

Hospital: DEMO ISH CLINIC

Please choose an output type. For an explanation of the delimited file
please see the user manual.

Select one of the following:

P  Print Report on Printer or Screen
D  Create Delimited output file (for use in Excel)
B  Both a printed Report and Delimited File

Select an Output Option: P//
```

At the “Device” prompt, specify the device to print/display the report.

B.3 Patient List for Eligible Hospitals and CAHs (PLH)

The PLH option provides users with a patient list in addition to a Full or Summary report for hospitals/CAH (M1IH). The Patient List includes patient-specific information for each measure that is selected. Define which measures to include in the report and select from the following options for each selected performance measure:

- Include patients who met the measure.
- Include patients who did not meet the measure.
- Include patients who met and did not meet the measure.
- After choosing the Patient List options, the software guides through the steps in Section **Error! Reference source not found.** to run the reports.

B.3.1 Steps to Run the Patient List for Eligible Hospitals and CAHs (PLH)

Choosing the PLH report displays the following message.

```
*** IHS 2011 Stage 1 Interim MU Patient List for Hospitals & CAHs ***

This report will enable a provider to review his or her Meaningful Use
performance by patient-specific data. You will be asked to select one or
more Performance Measures on which to report.

Press enter to continue.
```

B.3.1.1 Eligibility Notice for Eligible Hospitals and CAHs

The following message displays before the option is given to run the report. This interim report does not verify participation eligibility. Eligibility is determined by running the MU Patient Volume Report for Eligible Hospitals (PVH) located in the Third-Party Billing application.

At the “Do you wish to continue to report” prompt, type **Yes** to open the Patient List setup and **No** to return to the main menu.

```
******** IMPORTANT NOTICE ********

This interim report does not verify CMS Medicare or Medicaid EHR Incentive
Program eligibility. Please speak to your Area Meaningful Use Coordinator
for guidance in determining eligibility.

Do you wish to continue to report? Y//
```

This report can indicate that a facility not eligible to participate in the program has achieved MU.

B.3.1.2 Patient List Type Selection

Select a patient list type.

```
Select one of the following reports:

      S   Selected set of MU Performance Measures
      A   All MU Performance Measures

Run the report on: S//
```

Selected set of MU Performance Measures for Eligible Hospitals and CAHs

Select for which of the 16 rate-calculated performance measures to generate a patient list. If no measure is selected, processing returns to the Full or Summary report Selection in order to run MU Performance Report for eligible hospitals without a patient list. Available choices are:

- All measures
- Individual measures
- All core measures
- All menu set measures

```
PERFORMANCE MEASURE SELECTION Mar 15, 2011 15:57:36          Page:    1 of
2
IHS MU PERFORMANCE MEASURE
* Indicates the Performance Measure has been selected.

1)  CPOE Medications
2)  Demographics
3)  Problem List
4)  Medication List
5)  Medication Allergy List
6)  Vital Signs
7)  Smoking Status
8)  Electronic Copy of Health Information
9)  Electronic Copy of Discharge Instructions
10) Drug-Drug & Drug-Allergy Checks
11) Clinical Decision Support
12) Exchange of Key Clinical Information
13) Privacy/Security
14) Clinical Quality Measures
15) Advance Directives
16) Lab Results into EHR
+         Enter ?? for more actions
S    Select Measure       D    De Select Measure
Select Action:+//
```

All MU Performance Measures for Eligible Hospitals and CAHs

Specify if patient lists are desired for any of the measures:

- Type **No** to open the Full or Summary Report Selection in the M1IP report. Complete the selection criteria to run the MU Performance Report for Eligible Hospitals and CAHs with a Patient List.

- Type **Yes** to display the MU Measure List Selection. Choose the measures for which a patient list is desired.

```
PATIENT LISTS
Do you want patient lists for any of the measures? N//
```

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Appendix C: MON Report

Outpatient sites need 80% CPOE (which at this point does not include Policy orders). So there is room to adjust processes and eliminate problem areas. Sites need to take a hard look at their processes and identify the problem areas.

If an ORELSE key holder enters an order and does any of the following, it counts against CPOE:

- Hold until signed (ELE with ORES No)
- Verbal (VE)
- Telephone (TE)
- Signed on chart (WRI): This is also RPMS entered "written on chart" through pharmacy and lab package, or entered "written" in POC lab:
  - Verbal, Telephone, and Signed on chart should be the exception rather than the rule in an ambulatory outpatient clinic. If your numbers are high in these areas they require scrutiny to eliminate any that are not essential to patient care.
  - Hold until signed is sometimes necessary to optimize workflow. The decision when and how to use this function needs to be carefully determined at the sites. This is often used for nurses fielding medication renewal requests for instance. If this type of order in high, then it is wise to look at workflow, scheduling, and other issues that may prevent patients from seeing their providers in a timely manner.

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Glossary

Advance directive

Instructions, typically written, given by an individual to specify what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. Living will, health care proxy, and medical power of attorney are three examples of advance directives.

Attest, attestation

To certify that a measure was achieved.

Certified EHR technology

A complete electronic health record (EHR) or a combination of EHR modules, each of which:

- Meets the requirements included in the definition of a Qualified EHR.
- Has been tested and certified in accordance with the certification program as having met all applicable certification criteria.

Clinical decision support

An interactive decision support system designed to assist healthcare professionals with decision making tasks by using two or more items of patient data to generate case-specific advice using information stored in a computerized clinical knowledge base

Computerized Provider Order entry (CPOE)

An automated system that provides for electronic entry of medical practitioner instructions for the treatment of patients (particularly hospitalized patients).

Critical access hospital (CAH)

A designation created by the federal government to denote certain small, rural hospitals. For the purposes of this document, “CAH” and “eligible CAH” are interchangeable.

EHR reporting period

- First payment year: Any continuous 90-day period falling entirely within the first payment year.
- Subsequent payment years: The entire payment year.

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Eligible provider

A person or entity eligible to receive incentive payments for participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology. Eligible providers include eligible professionals (EPs), eligible hospitals, and eligible critical access hospitals (CAHs).

Graphical User Interface (GUI)

A human-computer interface that allows the user to select commands, call up files, start programs, and do other tasks by using a pointing device to point to pictorial symbols (icons) or lists of menu choices on the screen as opposed to having to type in text commands. RPMS EHR is a GUI; RPMS *roll-and-scroll* is not.

Measure (MU)

A specific statement describing the success criteria that must be met to achieve meaningful use as it pertains to an MU Objective.

Objective (MU)

A generalized statement describing a desired healthcare delivery outcome.

Permissible prescription

A prescription (order) to dispense a medication that is neither a controlled substance nor an over-the-counter medicine.

Qualified EHR

An electronic record of health-related information on an individual that:

- Includes patient demographic and clinical health information, such as medical history and problem lists.
- Has the capacity to:
  - Provide clinical decision support
  - Support provider order entry
  - Capture and query information relevant to health care quality
  - Exchange electronic health information with, and integrate such information from other sources

Syndromic surveillance

Using health-related data that precedes diagnosis to signal a sufficient probability of a case or an outbreak thereby warranting further response by public health authorities.

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Transition of care

The act of transferring a patient between health care practitioners and settings as his or her condition and care needs change during the course of a single, continuous visit. Generally, any change that results in the suspension, cessation, initiation, or reestablishment of care (e.g., admittance, discharge, leaving against medical advice) is not a transition of care.

Unique patient

A single, distinct person having a patient record in the certified EHR (regardless of the number of visits with a provider).

Acronyms

APCL	PCC Management Reports
ARRA	American Recovery and Reinvestment Act of 2009
ASUFAC	Area - Service Unit - Facilty
BMI	Body Mass Index
BYIM	Immunization Interface Management
CAH	Critical Access Hospital
CCD	Continuity of Care Document
CCR	Continuity of Care Record
CMS	Centers for Medicare & Medicaid Services
COTS	Commercial Off-the-Shelf
CPOE	Computerized Provider Order Entry
CPT	Current Procedural Terminology
CQM	Clinical Quality Measures
CRS	Clinical Reporting System
EHR	Electronic Health Record

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EP	Eligible Professional
GUI	Graphical User Interface
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
IHS	Indian Health Service
ILI	Influenza-like Illness
MU	Meaningful Use
OIT	Office of Information Technology
PCC	Patient Care Component
PDM	Pharmacy Data Management
PHR	Personal Health Record
PLAL	Problem List Allergy List
POS	Place of Service
PVP	Patient Volume Report
PWH	Patient Wellness Handout
RA	Risk Analysis
ROI	Release of Information
RPMS	Resource and Patient Management System

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Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

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If you have any questions or comments during the development of this document (Versions 0.1 through 0.9), please contact Blaine Bachman.

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