

Let's Talk...

# About The Recertified RPMS EHR

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# Overview

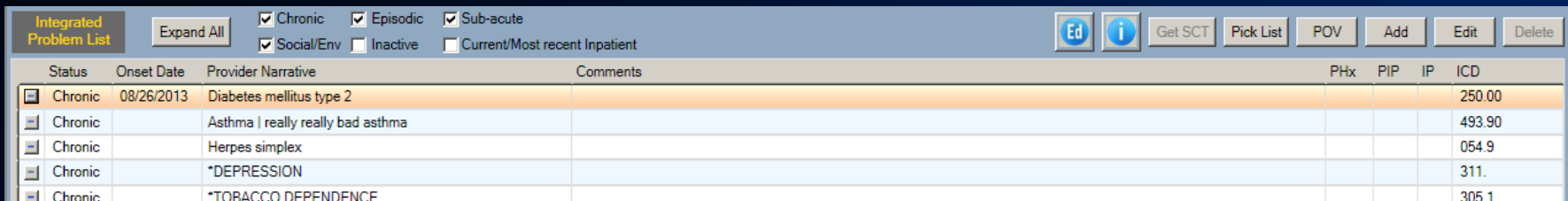
- Integrated Problem List
- Clinical Care Documents (CCD)
- Family History, Allergies, Vital Signs, Smoking Status, Infant Feeding, Refusals
- Orders, TIU Notes, Consults
- Clinical Reminders
- The Patient Portal
- Clinical Quality Measures
- Questions

# The Recertified RPMS EHR

- The recertified RPMS EHR is scheduled for release in Summer 2014 (probably July)
- It consists of approximately 70 patches
- Installation time will be 4-6 hours

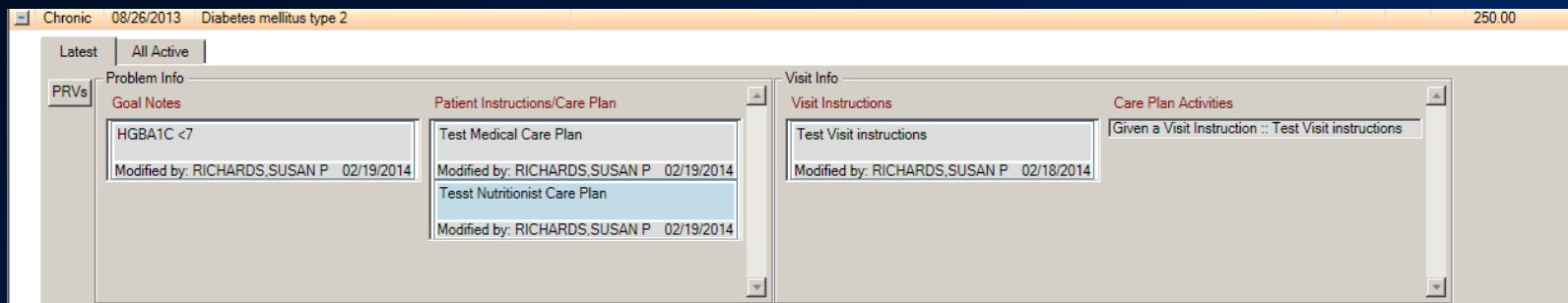
# Integrated Problem List MU Required Features

- SNOMED CT® Problem List
- Care Planning
- Treatment Regimen elements for CQM



The screenshot shows the 'Integrated Problem List' interface. At the top, there are filter checkboxes for 'Chronic', 'Episodic', 'Sub-acute', 'Social/Env', 'Inactive', and 'Current/Most recent Inpatient'. Below the filters is a table with columns for Status, Onset Date, Provider Narrative, Comments, PHx, PIP, IP, and ICD. The table contains five rows of data.

Status	Onset Date	Provider Narrative	Comments	PHx	PIP	IP	ICD
Chronic	08/26/2013	Diabetes mellitus type 2					250.00
Chronic		Asthma   really really bad asthma					493.90
Chronic		Herpes simplex					054.9
Chronic		*DEPRESSION					311.
Chronic		*TOBACCO DEPENDENCE					305.1



The screenshot shows the detailed view for a specific problem: 'Diabetes mellitus type 2' with onset date '08/26/2013' and ICD code '250.00'. The interface is divided into several sections: 'Problem Info', 'Patient Instructions/Care Plan', and 'Visit Info'. Each section contains a list of items with their respective modification dates.

**Problem Info**

- Goal Notes: HGBA1C <7 (Modified by: RICHARDS.SUSAN P 02/19/2014)

**Patient Instructions/Care Plan**

- Test Medical Care Plan (Modified by: RICHARDS.SUSAN P 02/19/2014)
- Test Nutritionist Care Plan (Modified by: RICHARDS.SUSAN P 02/19/2014)

**Visit Info**

- Visit Instructions: Test Visit instructions (Modified by: RICHARDS.SUSAN P 02/18/2014)
- Care Plan Activities: Given a Visit Instruction :: Test Visit instructions

# Integrated Problem List

## IHS Additions

1. Reverse Mapping tool to assist with updating Problem List from ICD-9 to SNOMED
2. Mapping to ICD-9 without user intervention
3. POV selection from Problem List
4. POV selection dialog
5. Patient Ed documentation
6. Expanded status
7. Nationally vetted pick lists

# Integrated Problem List

## Pick List Examples

**PickList Selection**

Manage PickLists

PickList SNOMEDCT Desc

11

- Alcoholism
- Chronic major depressive disorder, single episode
- Family tension
- Generalized anxiety disorder
- Home unsettled
- Insomnia
- Juvenile
- Major depression single episode, in partial remission
- Major depressive disorder
- Noncompliance with treatment
- Severe depression

**CARDIAC**

- Acute infarction of papillary muscle
- Aortic valve disorder
- Atrial fibrillation and flutter
- Benign hypertension
- Chronic atrial fibrillation
- High output heart failure
- Hypertensive disorder
- Left coronary artery occlusion
- Moderate left ventricular systolic dysfunction
- Myocardial infarction

**ENDOCRINE**

- Diabetes mellitus
- Diabetes mellitus type 2

ABNORMAL FINDINGS \*  
CASE MANAGEMENT  
CQM Problems  
CQM PROBLEMS  
CQM Problems for test  
DIABETIC RETINOPATHY  
Eye General  
EYE GENERAL  
IMMUNIZATIONS  
MAN test picklist  
New  
New Picklist  
New Picklist 1  
NIST PROBLEMS  
NUTRITION  
PICK Prenatal - Problem Pregnancy  
PICK Public Health Nursing  
PICK Womens Health  
Prenatal - Care  
Test Import Subset  
Test Picklist  
Test Picklist womens health  
Test Picklist2

**PickList Selection**

Manage PickLists

PickList SNOMEDCT Desc

17

- Combined hepatitis A and B vaccination
- Drug declined by patient - patient beliefs
- Human vaccination
- Immunization consent not given
- Immunization contraindicated
- Immunization refused
- Immunization/vaccination management
- Influenza vaccination
- Measles mumps and rubella booster vaccination
- Medical C/I - immunization
- Pneumococcal vaccination
- Poliomyelitis vaccination
- Tetanus diphtheria vaccination
- Vaccination for diphtheria, pertussis, and tetanus
- Vaccination with third dose of human papillomavirus
- Vaccines allergy
- Varicella vaccination

ABNORMAL FINDINGS \*  
CASE MANAGEMENT  
CQM Problems  
CQM PROBLEMS  
CQM Problems for test  
DIABETIC RETINOPATHY  
Eye General  
EYE GENERAL  
Immunizations  
IMMUNIZATIONS  
MAN test picklist  
New  
New Picklist  
New Picklist 1  
NIST PROBLEMS  
Nutrition  
NUTRITION  
PICK Prenatal - Problem Pregnancy  
PICK Public Health Nursing  
PICK Womens Health  
Prenatal - Care  
Test Import Subset  
Test Picklist  
Test Picklist womens health  
Test Picklist2

Cancel Save

# Preparing for Transition

## Clean up problem lists

1. Remove/consolidate redundant problem entries
2. Remove entries that don't belong on the problem list
3. Inactivate resolved problems
4. Code the un-coded problems

# Transition of Care MU Required Features

Generate ToC  
Customize ToC  
Transmit ToC



## Transitions of Care from 2013 DEMO HOSPITAL

**Patient:**  
Date of Birth: May 1, 1947  
Race: White  
Preferred Language: English

**HR#:** XFA: 147190  
**Sex:** Female  
**Ethnicity:** Not Hispanic or Latino

**Visit Date:** February 13, 2014  
**Visit Location:** 2013 DEMO HOSPITAL; UPTOWN USA; ALBUQUERQUE, NE 89701

### Table of Contents

- [Problems/Encounter Diagnoses](#)
- [Allergies, Adverse Reactions, Alerts](#)
- [Medications](#)
- [Procedures](#)
- [Reason for Referral](#)
- [Plan of Care](#)
- [Functional/Cognitive Status](#)
- [Social History \(Smoking Status\)](#)
- [Recent Lab Results](#)
- [Immunizations](#)
- [Recent Vital Signs](#)
- [Care Team](#)

### Problems/Encounter Diagnoses

Active:

- \*Community acquired pneumonia | [385093006]; 08/06/2012

Inactive (personal history):

- Asthma | [195967001]; 02/18/2014

\*Reasons for today's visit

### Allergies, Adverse Reactions, Alerts

Active allergies:

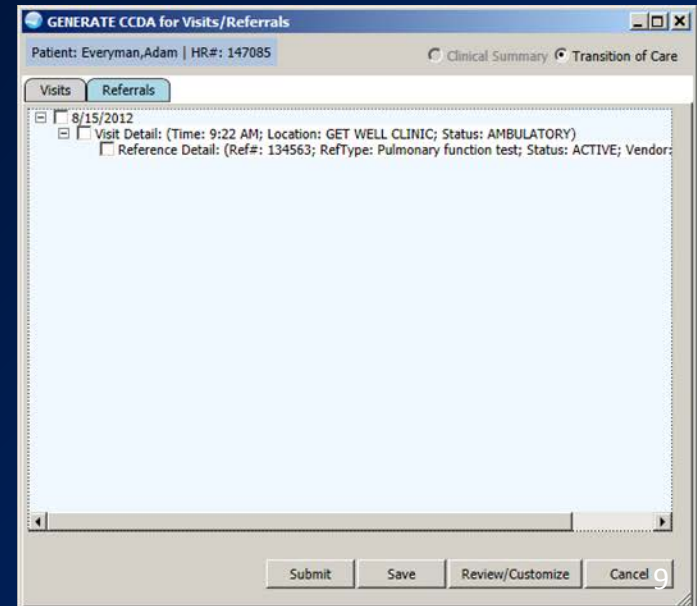
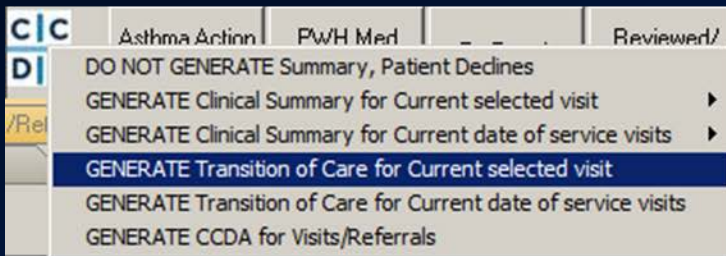
The screenshot shows the 'CCDA - Transition of Care' window for patient HILMykyla (HR#: 141177) on February 18, 2014. The interface is split into two main panes. The left pane, titled 'Clinical Document', displays a tree view of medical data with checkboxes for inclusion: 'Problems/Encounter Diagnoses' (Active), 'Allergies, Adverse Reactions, Alerts' (Active), 'Medications' (Active), and 'Outpatient Medications' (Active). The right pane, titled 'Transitions of Care from 2013 DEMO HOSPITAL', mirrors the patient information and table of contents from the left pane, showing active and inactive diagnoses, allergies, and medications. At the bottom, there are navigation buttons (Back, Forward, Document 1 of 1) and a 'Finalized' status indicator.



# Transition of Care IHS Additions

Smart tool allows:

- Generation by visit(s) or RCIS referral
- Defaults to print, fax, or transmit based on data in Vendor file of RCIS



# MU Requirement

Clinical summaries must be provided to patient within *one business day* for *more than 50%* of office visits

# Measure

## Transition of Care (TOC)

**Measure 1:** An EP who transitions or refers their patient to another setting of care or provider of care *provides a summary of care* record for more than **50 percent** of transitions of care and referrals.

**Measure 2:** An EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than **10 percent** of such transitions and referrals *electronically transmitted* using certified EHR technology (CEHRT) to a recipient

**Measure 3:** An EP must satisfy **ONE** of the following criteria:

1. Conducts one or more successful electronic exchanges of a summary of care document with a recipient who has EHR technology that was developed designed by a different certified EHR technology developer
2. Conducts one or more successful tests with the CMS designated test EHR

# Viewing Summary Documents

View CCD and scanned summaries  
View CCDA summaries



CIR Tool - Stuart, James D

Generated by CCDA

Select	Source	Responsible Party	Encounter Date	Created	Class	Reconciled
<input checked="" type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From January 06, 2014	1/2/2014 4:22:48 PM	CCD	
<input type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From March 25, 2010	12/20/2013 4:20:17 PM	CCD	
<input type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From March 25, 2010	12/20/2013 4:00:26 PM	CCD	
<input type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From March 25, 2010	11/19/2013 1:44:21 PM	CCD	

Problems Adverse Reactions Medications

**Continuity of Care Record**

Date Created: 25, 2010 at 01:15 PM UTC-05:00  
From: Thomas Henry MD (Personal)  
To: Interested AnyPerson (Interested)  
Purpose: Transfer of Care

**Patient Demographics**

Name	Date of Birth	Gender	Identification Numbers
John Stuart	15, 1953	Male	9996799589

**Alerts**

Type	Type Code	Date	Code
Drug Allergy	416098002 (SNOMED CT)	6/27/96	293597001 (RxNorm)
Drug Allergy	416098002 (SNOMED CT)	3/25/04	2943620004

**Problems**

Type	Date	Code
Finding	5/5/06	414.01 (ICD9-CM) 53741008 (SNOMED CT)
Symptom	5/5/06	401.9 (ICD9-CM) 59621000 (SNOMED CT)

Reconciled Problems

Problem	Status	Insert
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CIR Tool - Stuart, James D

Generated by CCDA

Select	Source	Responsible Party	Encounter Date	Created	Class	Reconciled
<input checked="" type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From January 06, 2014	1/2/2014 4:22:48 PM	CCD	
<input type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From March 25, 2010	12/20/2013 4:20:17 PM	CCD	
<input type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From March 25, 2010	12/20/2013 4:00:26 PM	CCD	
<input type="checkbox"/>	Metropolitan Clinic	Thomas Henry MD	From March 25, 2010	11/19/2013 1:44:21 PM	CCD	

Problems Adverse Reactions Medications

**Patient Summary - Ambulatory**

Patient: James Stuart  
Date of birth: February 15, 1953, 11:20:05  
Contact info: 5729 Hazel Street, Williamsport, PA 17701  
Sex: Male  
Patient ID#: 9996799589 METROCLINIC

Document ID: 6459f494-25e2-88c3-f6cc38f0ef-2.16.840.1.113883.3.72  
Document Created: April 5, 2010, 13:09:45, EST  
Author: Thomas Henry, MD, Metropolitan Clinic  
Contact info: 5544 Sutter Street, Williamsport, PA 17701

**Table of Contents**

- Problems
- Medications
- Allergies and Adverse Reactions
- Test Results

**Problems**

Type	ICD-9 Code	SNOMED CT	Problem	Date Diagnosed	Status
Finding	414.01	53741008	Coronary Artery Disease (CAD), Coronary Arteriosclerosis	05/05/2006	Active
Symptom	401.9	59621000	Hypertension, Essential	5/5/2006	Active
Diagnosis	493.00	195967001	Asthma	12/22/2002	Active

Reconciled Problems

Problem	Status	Insert	Action
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# View Summaries in CIR Tool

CIR Tool

Restore Visit CCDAsource

Generated by CCDAsource

Select	Source	Responsible Party	Encounter Date	Created	Class	Reconciled
<input checked="" type="checkbox"/>	Get Well Clinic	Dr Henry Seven	From August 06, 2012	1/8/2014 4:20:47 PM	CCDA	A/G/10/20
<input type="checkbox"/>	Get Well Clinic	Dr Henry Seven	From August 06,		FULL CCDA	
<input type="checkbox"/>	Get Well Clinic	Dr Henry Seven	From August 06,		ALLERGIES, ADVERSE REACTIONS, ALERTS	
<input type="checkbox"/>	Get Well Clinic	Dr Henry Seven	From August 06,		ENCOUNTERS	

Problems Adverse Reactions Medications

RPMS

Problem	Status	Onset
+ Hypoxemia	INACTIVE	08/06/2012
+ Community acquired pneumonia	CHRONIC	08/06/2012
+ Asthma	INACTIVE	01/03/2007

ALLERGIES, ADVERSE REACTIONS, ALERTS  
ENCOUNTERS  
IMMUNIZATIONS  
Medications  
CARE PLAN  
REASON FOR REFERRAL  
PROBLEMS  
PROCEDURES  
FUNCTIONAL STATUS  
RESULTS  
SOCIAL HISTORY  
VITAL SIGNS



CCDA - Clinical Summary

### Get Well Clinic: Health Summary

**Patient:** Isabella Jones **HR#:**  
**Date of Birth:** May 1, 1947 **Sex:** Female  
**Race:** White **Ethnicity:** Not Hispanic or Latino  
**Preferred Language:** English

**Visit Date:** August 6, 2012, 00:28 +0500 to August 6, 2012, 00:58 +0500  
**Visit Location:**

#### Table of Contents

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- [Medications](#)
- [CARE PLAN](#)
- [REASON FOR REFERRAL](#)
- [PROBLEMS](#)
- [PROCEDURES](#)
- [FUNCTIONAL STATUS](#)
- [RESULTS](#)
- [SOCIAL HISTORY](#)
- [VITAL SIGNS](#)
- [Care Team](#)

#### ALLERGIES, ADVERSE REACTIONS, ALERTS

Substance	Reaction	Severity	Status
Penicillin G benzathine	Hives	Moderate to severe	Inactive
Codaine	Shortness of	Moderate	Active

Close

# Incorporation of CCDA Data

## MU Required Features

Data to be incorporated from CCDA:

*Problems*

*Allergies*

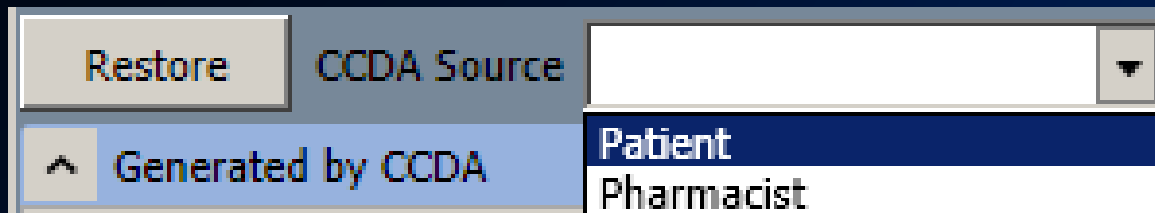
*Medications*



View on single screen data from EHR/RPMS and incoming CCDA

# Incorporation of CCDA IHS Additions

- Ability to incorporate data from other sources such as patient report, caregiver.
- Site can add with site determined sources



- Add button or right click may be used to edit the RPMS list



# Medication Reconciliation Measure

An eligible provider performs medication reconciliation for **more than 50 percent** of transitions of care in which the patient is transitioned **into** the care of the eligible provider



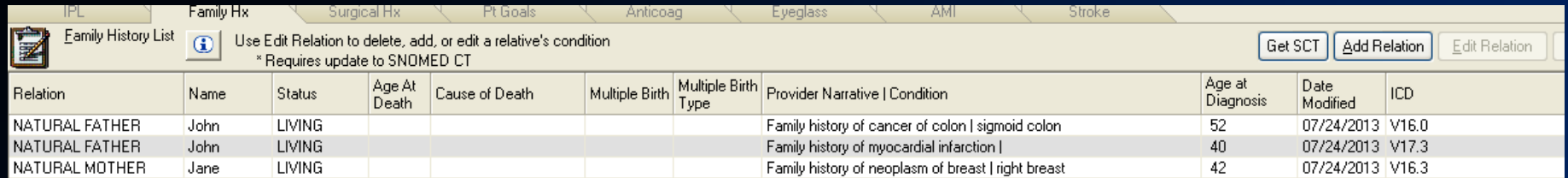
# Family Health History Measure

More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

# Family History

## MU Required Features

### SNOMED CT for Family History conditions



The screenshot shows a software interface for managing family history. At the top, there are tabs for 'IPL', 'Family Hx', 'Surgical Hx', 'Pt Goals', 'Anticoag', 'Eyeglass', 'AMI', and 'Stroke'. The 'Family Hx' tab is active. Below the tabs, there is a header area with a clipboard icon, the text 'Family History List', an information icon, and instructions: 'Use Edit Relation to delete, add, or edit a relative's condition' and '\* Requires update to SNOMED CT'. To the right of the instructions are three buttons: 'Get SCT', 'Add Relation', and 'Edit Relation'. Below this is a table with the following data:

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Provider Narrative   Condition	Age at Diagnosis	Date Modified	ICD
NATURAL FATHER	John	LIVING					Family history of cancer of colon   sigmoid colon	52	07/24/2013	V16.0
NATURAL FATHER	John	LIVING					Family history of myocardial infarction	40	07/24/2013	V17.3
NATURAL MOTHER	Jane	LIVING					Family history of neoplasm of breast   right breast	42	07/24/2013	V16.3

# Family History IHS Additions

Actual or “approximate” age of onset

**Family History Condition** [X]

Family Health Condition:

ICD Code(s): **V16.3** Change Condition...

SNOMED Description:

Family history of malignant neoplasm of breast

Provider Text:

bilateral

Age at Diagnosis:   Approximate Save Cancel

# Preparing for Transition

Update family history as needed to prepare for the transition

# Allergies

## MU Required Features

- Causative agents - RxNorm, UNII
- Signs/Symptoms - SNOMED CT®
- Drug/reaction combinations - SNOMED CT®

# Preparing for Transition

- Review Policies & Procedures
- Review Package settings
- Ensure reactions are documented in the Adverse Reaction package
- Review Adverse Reaction “clean up” lists

# Vital Signs

## MU Required Features

- Ability to enter height, weight and blood pressure
- LOINC and SNOMED CT encoding

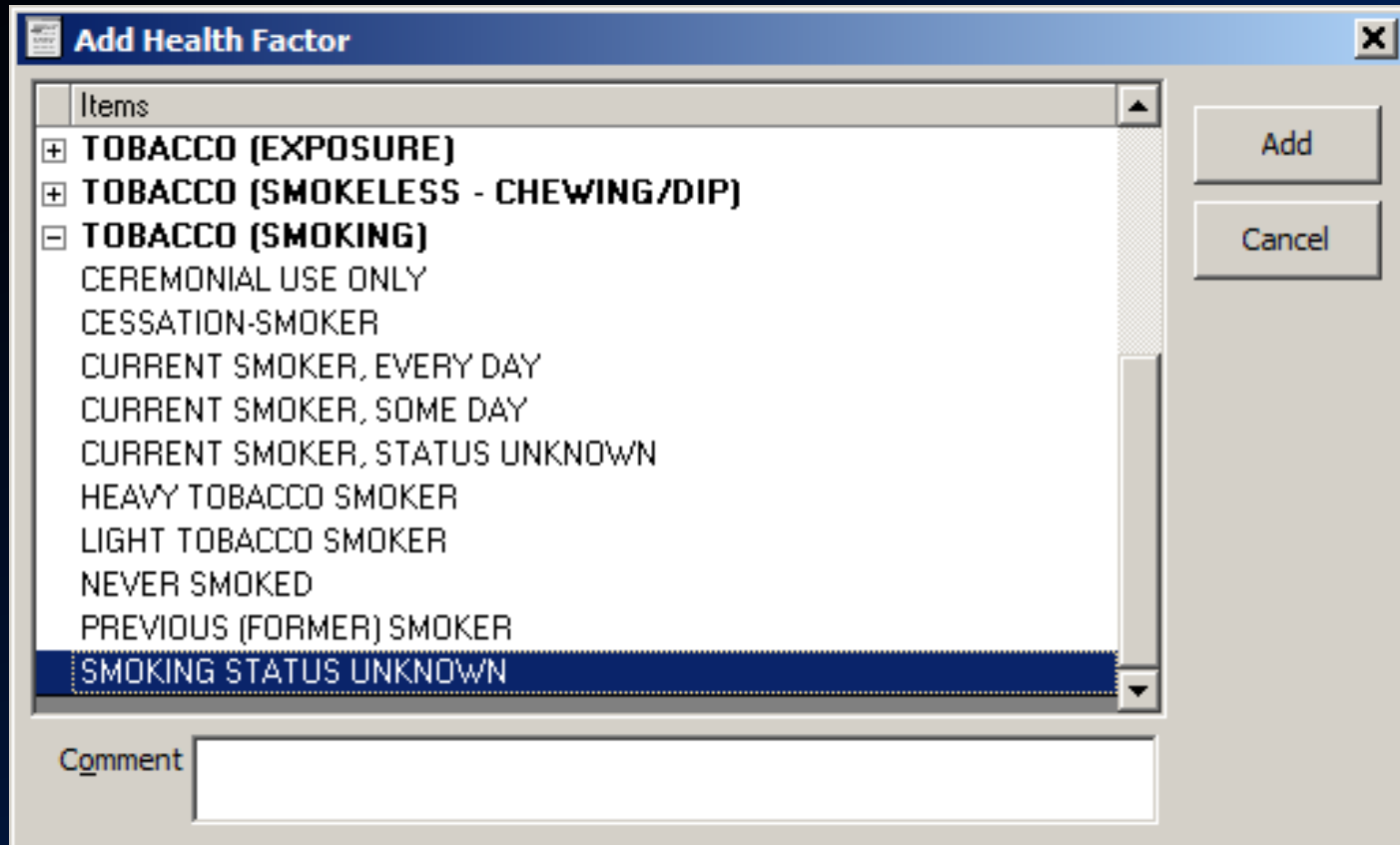
# Vital Signs Measure

More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.



# Smoking Status

## MU Required Features



# Smoking Status IHS Additions

- SNOMED CT<sup>®</sup> is stored in background when smoking status is stored by Health Factor component, Superbill association, reminder dialog
- NO SIGNIFICANT CHANGE for users
- EHR Reminder Dialogs updated

# Smoking Status Measure

- More than **80 percent** of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data

# Infant Feeding

## MU Required Features

- SNOMED CT<sup>®</sup> encoded feeding choices
- Added secondary fluids

**Infant Feeding Choice** [X]

Exclusively Breastfeed

1/2 Breast 1/2 Formula

Formula only

Mostly Breastfeed

Mostly Breastfeed, some Formula

Mostly Formula, some Breastfeed

Mostly Formula

Save Cancel

Secondary Fluids

<input type="checkbox"/> Milk	<input type="text"/>
<input type="checkbox"/> Fruit juice	<input type="text"/>
<input checked="" type="checkbox"/> Carbonated drink	<input type="text"/>
<input type="checkbox"/> Sports drink	<input type="text"/>
<input type="checkbox"/> Glucose	<input type="text"/>
<input type="checkbox"/> Water	<input type="text"/>

# Refusals (Reasons Service Not Done)

## MU Required Features

- SNOMED CT<sup>®</sup> encoded reasons not done
- Exposed in Personal Health, Clinical Reminder dialogs, Immunizations, Exams
- Also exposed in components that will be enabled in EHRp14 – AMI and Stroke

# Reasons Not Done

The image shows a software interface with a dropdown menu open. The dropdown menu lists the following reasons:

- (None selected)
- Absent response to treatment
- Complication of medical care
- Considered and not done
- Contraindicated
- Delay in receiving benefits
- Discontinued
- Finding related to health insurance issues
- Loss of benefits
- Medical care unavailable
- Medical contraindication
- Not entitled to benefits
- Not indicated
- Patient defaulted from follow-up
- Patient noncompliance - general
- Patient non-compliant - refused access to services
- Patient on waiting list
- Patient requests alternative treatment
- Patient transfer
- Refusal of treatment by patient
- Refused**
- Treatment not available
- Uninsured medical expenses

The background interface includes the following elements:

- Buttons: Add, Edit, Cancel
- Field: Refusal Type
- Field: Reason (with dropdown arrow)
- Field: Date Refused (with date 12/09/2013 and a calendar icon)
- Field: Comment (text area)
- Section: Enter Servi
- Section: Personal Health

# Orders

## MU Required Features

Computerized provider order entry (CPOE) is required for lab, radiology, medications

# Orders

## IHS Additions

Selection of Clinical Indication

Clinical Indication added for Consult order

Reason for referral added for RCIS referral

Otherwise no significant change for clinicians



# Computerized Provider Order Entry Measure

More than

- ***60 percent of medication***
- ***30 percent of laboratory***
- ***30 percent of radiology orders***

created by the EP must be recorded using CPOE

# Text Integration Utility (TIU) /Notes

## MU Required Features

- Create electronic notes
- Text searchable notes

# TIU/Notes

## IHS Additions

New TIU objects to support new IPL features

RPMS EHR upgrade required incorporation of numerous VA TIU patches

# TIU object

## “Active Problems Without Dates”

### Chronic Problems:

Obesity | Can add clarification

Chronic otitis externa | right

Diabetes mellitus type 2 |

Asthma |

Lactoceles | This is a test

Abnormal findings diagnostic imaging heart+coronary circulation |

Closed fracture of proximal ulna, comminuted | left, traumatic acute, swelling and hematoma at site

# TIU Object “V Problem List”

Problem: PCOS - Polycystic ovarian syndrome |

Mapped ICD:256.4 Status: CHRONIC

-Instruction Date: 3/12/2014@12:51:21

-Signed by:

-INSTRUCTIONS:

Test instruction

Problem: Well woman health examination |

Mapped ICD:.9999 Status: EPISODIC

Problem: Nontraumatic rotator cuff tear | right

Mapped ICD:727.61 Status: SUB-ACUTE

Problem: Pelvic pain | muscle pain, exquisitely tender left obturator internis

Mapped ICD:789.09 Status: EPISODIC

-Instruction Date: 3/12/2014@17:53:40

-Signed by: RICHARDS,SUSAN P

-INSTRUCTIONS:

Referral to pelvic PT. Use vaginal muscle relaxers at night as needed.

# Electronic Notes Measure

- At least one electronic progress note must be created, edited and signed by an eligible provider for **more than 30 percent** of unique patients with **at least one office visit** during the EHR reporting period.
- The text of the electronic note must be text searchable and may contain drawings and other content.

# Consults

## MU Required Features

Use SNOMED CT for type of referral  
Clinical Indication

The screenshot shows a software window titled "Order a consult" with the following fields and options:

- Consult to Service/Specialty:** A list box containing "ANTICOAGULATION (OUTPATIENT)".
- Urgency:** A dropdown menu set to "ROUTINE".
- Attention:** An empty dropdown menu.
- Patient will be seen as an:** Radio buttons for "Inpatient" and "Outpatient", with "Outpatient" selected.
- Place of Consultation:** A dropdown menu set to "CONSULTANT'S CHOII".
- Clinical Indicator:** A dropdown menu with "Angina | 413.9" selected and "Other..." visible below it.
- Reason for Request:** A large empty text area.
- Summary:** A text field at the bottom left containing "ANTICOAGULATION (OUTPATIENT) Cons CONSULTANT'S CHOICE".
- Buttons:** "Accept Order" and "Quit" buttons at the bottom right.

# Clinical Decision Support (CDS) MU Required Features

HL7 info “I” button retrieves UpToDate clinical info

Drug-Drug/Drug-Allergy interaction



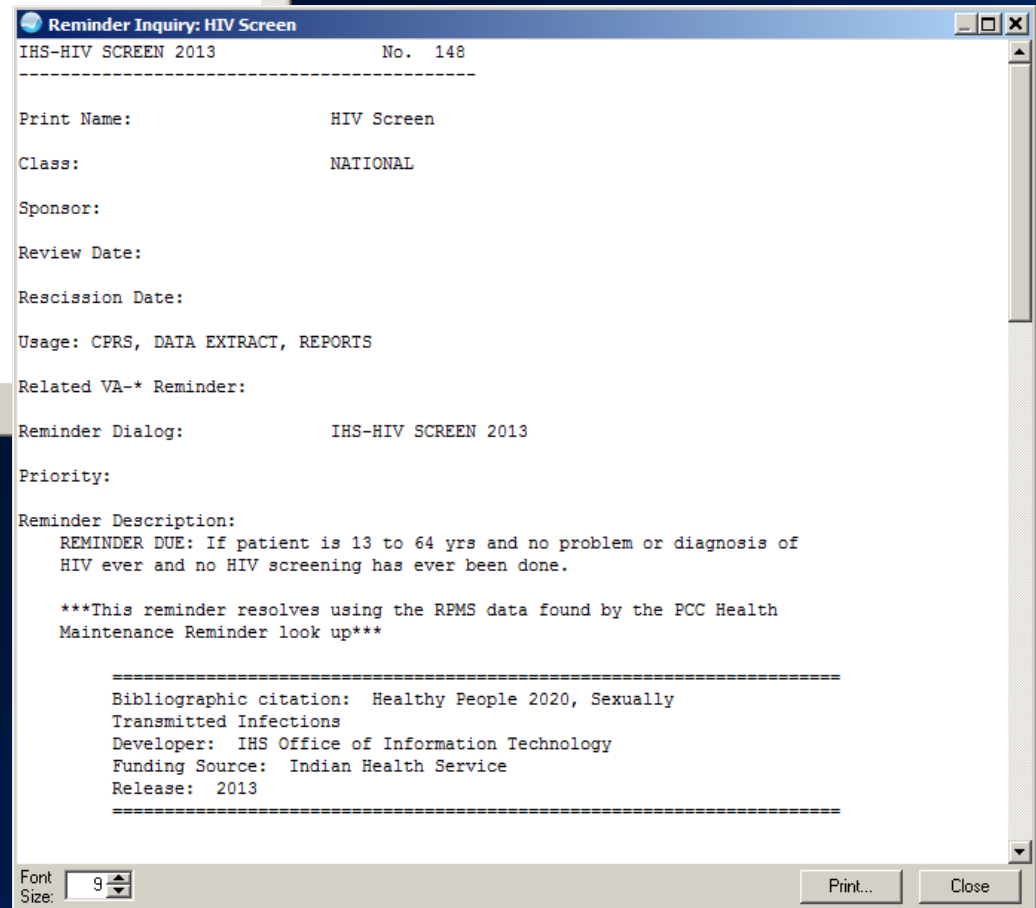
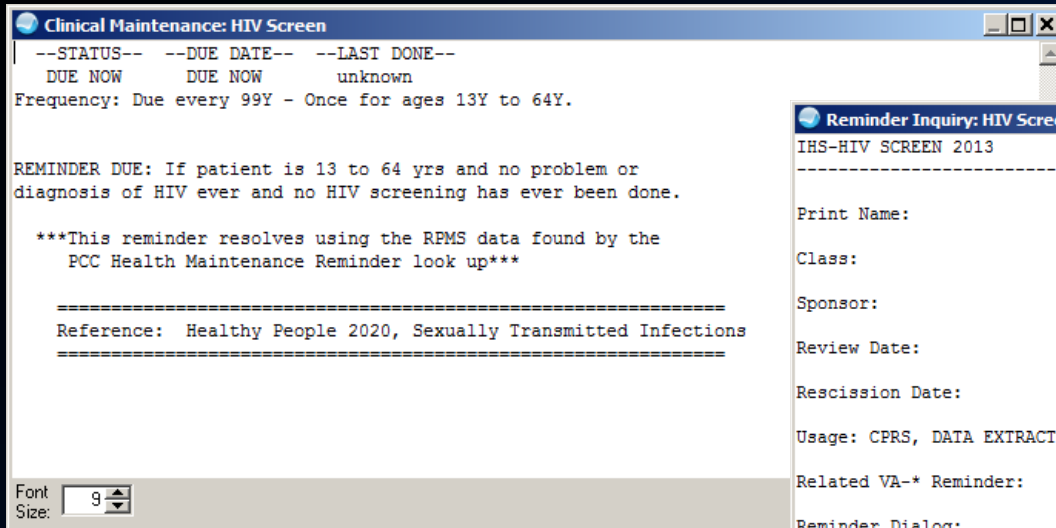
# Reminders 2.0

- Conversion includes 8+ years of fixes/enhancements
- Lots of new functionality
- Same look and feel in EHR but some enhanced functionality
- Installing new reminders is a “little” different
- Installed reminders will still work but formatting may be a bit changed

**You cannot install any v1.5 reminders once you have loaded 2.0**

# Reminders 2.0

## IHS Modifications



# Clinical Decision Support Measure

Implement **5** clinical decision support interventions ***related to 4 or more clinical quality measures***, if applicable, at a relevant point in patient care for the entire EHR reporting period.

The eligible provider has ***enabled the functionality for drug-drug and drug-allergy interaction*** checks for the entire EHR reporting period

# How to Meet the Measure...

Enable drug-drug and drug-allergy interaction at the *system level*

Review the MU2\_CDS Reminders and if needed install additional reminders to ensure 5 are deployed

# Patient Portal

**The Personal Health Record (PHR) consists of**

1. The patient portal for viewing health information
2. The administration application links the patient's PHR account and medical record

# Preparing for the Patient Portal

## Identify

- 1. PHR Registrar** — connects a patient's PHR account with his or her medical record. The PHR registrar will provide ongoing support to patients and will be able to reset passwords or other support activities.
- 2. PHR Administrator** — assigns and removes registration privileges; may also serve as PHR registrar.
- 3. Message Agent** - receives secure email messages from patients. This person triages the messages and shares them as appropriate.

# Portal Registration

- Who will register patients?
- At what point during the visit will the patient be registered?
- Will the PHR registrar be a full-time position or have other assigned duties?
- How will patients know whom to contact?

# Message Agent(s)

- Create a plan and policy for assigning message agents.
- How will message agents distribute information to the appropriate clinical staff?
- Will providers contact patients directly, or will the message agent send all messages?
- In what time frame will patient messages be reviewed and acted upon?
- What is the plan for forwarding messages when the message agent is out of the office?



# Giving Access to Patients

Patient access is defined as providing the patient with information needed to be able to create a PHR account

# Documenting Patient Portal Access

- Patient registration staff provide and document s information handouts in the registration
- Clinical staff provide information and document that education was provided
- Performance Measures Report will automatically capture other information

# Clinical Quality Measures

## Data Capture - MU Required Features

Requires that many of our data fields be represented in the following standard vocabularies

- SNOMED
- LOINC
- ICD9/ICD10
- RxNorm
- UNII
- Majority of data is stored in the background directly (problem list) or through background mapping
- Two new components to document AMI and Stroke data were developed and delivered disabled due to edit issues. These will be corrected and delivered enabled in EHRp14.

# Medicare Payment Adjustment update (as of March 2014)

- We recognize that the release date of Patch 13 will not permit EP/EH seeking their first year of MU in FY/CY 2014 to successfully attest in time to avoid the 2015 Medicare payment adjustment.
- CMS is offering a hardship exception for EP and EH that meet specific criteria.

# Tentative Training Schedule for Re-certified EHR (as of April 2014)

Ongoing MU Office Hours biweekly

Ongoing EHR Office Hours

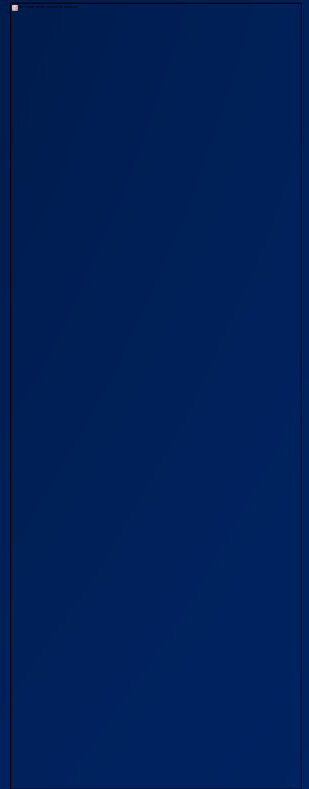
Ongoing Specialized/Spot training/demos

- June 1 Anticipated EHR/DIRECT ATO
- June 1 - June 30 PHR/DIRECT beta testing
- June 30 - July 4 First EHR Installation/Configuration training
- July 1 - July 30 ICD-10 Beta Testing
- July 1 - Sept 30 Final attestation period for EH
- July 1 EHR Deployment
- July 7 - July 9 Second Basic 2014 EHR & MU Training
- Aug 11 - Aug 15 Second EHR Installation/Configuration training
- Aug 18 - Aug 20 Third Basic 2014 EHR & MU Training
- Oct 1 - Dec 31 Final attestation period for EP
- Sept 22 - Sept 26 End User Training

# National Indian Regional Extension Center Grant

## Extension until March 31, 2015

- 80 of 270 Eligible providers left to meet MU
  - ✓ Requesting reports
  - ✓ Fund services (varies by clinic)
  - ✓ Provide guidance and assistance



# NIREC-CA MU Support

- Review MU reports for improvements
- Support EHR/MU team meetings
- Sharing Best Practices / workflows
- Security Risk Analysis guides
- NextGen and other commercial EHRs
- National MU Team updates
- Annual Provider Attestations National and State Level Registry

# Questions

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