



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Onsite RPMS Package Optimization and EHR Configuration

Agenda

May 7-11, 2012

Indian Health Service Office of Information Technology (OIT)
Alaska Native Tribal Health Consortium
and
Rural Anchorage Service Unit (RASU)

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1.0 General Information

1.1 Background

The Resource and Patient Management (RPMS) Electronic Health Record (EHR) is a suite of software applications designed to move most clinical transactions from paper-based to an electronic environment. The EHR uses upgrades of existing RPMS applications and clinical data, but provides a graphical user interface (GUI) that facilitates access to and direct entry of this data by clinical users. The two most significant clinical enhancements provided by the EHR are the direct entry of orders (pharmacy, laboratory, radiology, nursing, etc.) by providers, and the on-line documentation of clinical encounter notes. In addition, the EHR will make clinical decision support tools available to providers at the point of care, and will make the medical record immediately accessible to all authorized users.

Implementation of an electronic medical record at any health care organization is a complex and lengthy process, requiring preparation and changes in essentially all areas of a medical facility. Rolling out an electronic record system at any facility will require a considerable training effort at the time of implementation, as well as an ongoing program of training and support.

1.2 Purpose

The members of the RPMS-EHR implementation team provide ongoing operational support for certain RPMS packages that comprise and/or interface with the Electronic Health Record. This onsite technical consultation will provide EHR Team Members to include (a) Clinical Application Coordinator, (b) Pharmacy Informaticist, (c) Laboratory Information Systems Manager, (d) Health Information Manager, (e) Physician Champion, (d) Nurse Champion, (e) Information Technology Professionals, (f) Leadership, and (g) Business Office and (h) other Implementation Team Members with the opportunity to both setup and configure the Electronic Health Record for use at their facility.

For this reason, the “Onsite RPMS Package Optimization and EHR Configuration” technical consultation incorporates the principles, practices, and techniques of adult education. The site is expected to setup a computer training room for this week. All members of the “Implementation Team” are expected to be available and participate for the entire week. The Implementation Team should include representation from (a) Medical Staff (b) Nursing (c) Pharmacy; (d) Laboratory and Radiology; (e) Medical Records; (f) Information Technology; (g) Coding and Data Entry; and (h) Business Office.

2.0 Tentative Schedule, Goals, and Objectives

2.1 Day One: Monday – Life Health Center Clinic, Chickaloon, Alaska

Time: 8:30 A.M. - 12:00 P.M.
1:00 P.M. - 5:00 P.M.

- Welcome and Introductions (Life Health Center Clinic in Chickaloon and Eklutna Health Clinic in Eklutna)
- Goals, Objectives, Expectations
- EHR Business Process “walk-through”
 - The purpose of the “Walk-through” is to assess the business process for taking care of a patient at the facility. The highly configurable Electronic Health Record will be setup to align with the sites clinical and business processes. We highly suggest that the consultants and Implementation Team select a “Demo Patient” and walk-through a patient care scenario that begins with Patient Registration and ends with submitting a claim. All clinical and business processes should be observed on paper.
 - Review Patient Flow
 - Patient Registration Process
 - Scheduling, PIMS, Appointment Books
 - Nursing Triage (Documentation of (a) Chief Complaint, (b) Vital Signs, (c) Tobacco Screening, (d) Alcohol Screening, (e) Point-of-Care Labs, (f) Domestic Violence Screening, (g) Patient Education, and (i) Immunizations).
 - Medical Visit (Documentation of (a) Repeat Vital Signs; (b) History of Present Illness; (c) Review of Symptom; (d) Past Medical History; (e) Social History to include Alcohol and Tobacco; (f) Domestic Violence Screening; (g) Exams to include Diabetic Foot Exam, Pap Smear, & Breast Exam; (h) Purpose of Visit (e.g. Type 2 Diabetes Uncontrolled with Retinopathy, Nephropathy, & Neuropathy) to include E-Codes; and Evaluation & Management (E&M) Codes.
 - Orders to include Immunizations, Injections, Point-of Care Lab, Reference Lab, Pap Smear, Medications, Radiology, Mammography, Ultrasound, Fluoroscopy, & Dressing Change.
 - Laboratory to include (a) Medical Necessity; (b) Reference Lab (How are Reference Labs Ordered and Entered into RPMS); (c) Laboratory Examinations performed on a date other than the date ordered; (d) Laboratory Services (Chemistry, Hematology, Microbiology, Blood Banking, Urinalysis).
 - Radiology to include (a) Plain Films, (b) Radiology Reports (how the radiology reports are received and entered into the RPMS Radiology Package).

- Pharmacy to include (a) e-Prescribing Process; (b) Over-the-Counter Medications; (c) Documentation of Patient Education; (d) Documentation of Medications Picked Up and Medication Counseling when patient or proxy picks up medications on a date other than processed; (e) Phone Refills; (k) Verbal and Telephone Orders.
- Ancillary Services to include (a) Nutrition; (b) Diabetes Education; (c) Specialty Clinics.
- Examination of Current Patient Health Medical Records to include (a) Amazing Charts and (b) Relationship to Medisoft.
- ICD-9 and CPT Coding Process to Include (a) Data Entry Mnemonics; (b) International Classification of Diseases-9 (ICD-9) Coding; (c) E-Codes; (d) Current Procedural Terminology (CPT) Coding; (e) Evaluation and Management (E&M) Codes, (f) Utilization of PCC Form when Data Entry is Complete; (f) Error Reports; (g) Orphan Lab, Pharmacy, Radiology, and Immunization Reports; (h) Uncoded Diagnoses Reports; (i) Use of Super Bill; and (j) Allergies vs. Adverse Tracking.
- EHR Entry of (a) tobacco use; (b) CAGE; (c) Interpersonal Violence; (d) Elder Care; (e) Barriers to Learning; (f) Learning Preference; (g) Patient Education; (h) Refusals; (i) Historical Information; (j) Diabetes Foot Exam; (k) Diabetes Eye Exam; (l) PAP Smears; (m) Mammograms; (m) Immunizations; (o) Historical Immunizations.
- Third Party Billing Process to include (a) PCC Form; (b) Utilization of Superbills; (c) ICD-9, CPT, E&M Coding; (d) Billing Reports; (e) Denials; (f) Accounts Receivable.

2.2 Day Two: Tuesday – Life Health Center Clinic and Eklutna Health Clinic

Time: 8:30 A.M. - 12:00 P.M.
1:00 P.M. - 5:00 P.M.

At the end of this session EHR Implementation Team Members will have completed:

- TIU User Classes
- Security Keys OE/RR
- Note Titles
- Business Rules
- TIU Parameters
- Ordering
- Administration
- Review PCC Master Index Control, all package links activated
- Notifications Configuration
- Order Check Configuration
- Remaining Master EHR Parameter Configuration
- Identify In-house Consult Services, teams, and network printer names
- Information Systems (current patches/applications/packages installed)

2.3 Day Three: Wednesday – Life Center Health Clinic and Ekluta Health Clinic

Time: 8:30 A.M. - 12:00 P.M.
1:00 P.M. - 5:00 P.M.

- Medication Orders
- Medication Reconciliation
- POV
- Other Topics as identified
- Review Templates
- Review Picklists and Superbills
- Vuecentric Template
- Health Summaries and Reports
- Review Medical Record Issues
- Review Registration Issues
- Continue to Review Lab

2.4 Day Four Thursday – Life Center Health Clinic and Eklutna Health Clinic

Time: 8:30 A.M. - 12:00 P.M.
1:00 P.M. - 5:00 P.M.

- Review Case Management Issues
- Continue to Review Pharmacy
- Continue to Review Lab
- Continue Topics as needed.
- Review EHR National Team Recommendations
- EHR Team and Consultants Develop EHR Implementation Plan and Closeout

2.5 Day Five: Friday – Eklutna Health Clinic

Time: 8:30 A.M – 12:00 P.M.

1:00 P.M. - 5:00 P.M.

- Review Case Management Issues
- Continue to Review Pharmacy
- Continue to Review Lab
- Continue Topics as needed.
- Review EHR National Team Recommendations
- EHR Team and Consultants Develop EHR Implementation Plan and Closeout

3.0 OIT USET & ANTHC EHR Consultants Biographical Sketches

Kimiko Gosney, MS, CC(NRCC)
Alaska Native Tribal Health Consortium (ANTHC)

Kimiko Gosney is the Clinical Applications Coordinator for the Alaska Native Tribal Health Consortium. She is a registered Clinical Chemist and also holds a masters degree in Computer Science. She has over 25 years experience with managing and supporting healthcare information systems, including clinical laboratory, anatomic pathology, hospital billing, a state-wide immunization repository and RPMS.

CAPT (ret) David R. Taylor, MHS, RPh, PA-C, RN, NCPS
EHR Training and Deployment Manager
IHS Office of Information Technology (Tucson)

David Taylor is a retired Commissioned Officer from the United States Public Health Service and is a certified physician assistant, registered pharmacist, and registered nurse. Mr. holds more than 35 years of public health, clinical, and clinico-administrative experience in the Indian Health Service (IHS). During his commission, he has served as a pharmacist, physician assistant, quality manager, risk manager, and compliance officer for the Pine Ridge, South Dakota and Cherokee, North Carolina Indian Hospitals. He has also served as an HIV/AIDS/STD consultant, performance improvement consultant, pharmacy consultant, and diabetes clinical consultant for the Nashville Area Indian Health Service. At this time, he is the EHR Training and Deployment Manager for the Indian Health Service Office of Information Technology and has been charged with both training and deployment of the Electronic Health Record throughout the entire Indian Health Care system. Captain (ret) Taylor has been awarded the PHS Meritorious Service Medal (MSM) in recognition for his accomplishments in the EHR arena.

Janna Morris, MPA, MT (ASCP)
OIT USET EHR Laboratory Consultant
IHS Office of Information Technology (Tucson)
United South and Eastern Tribes (USET) Regional Extension Center

Janna Morris is a Medical Technologist in the United States Public Health Service and has worked in the Indian Health Service since 1982. Janna is a certified Medical Technologist and formally served as the Laboratory Manager at Rapid City Indian Hospital. Janna has been involved in reference lab interfacing since the early 1990s, and is now currently assigned to OIT and United South and Eastern Tribes (USET)

Regional Extension Center (REC) as a National Laboratory Medical Informatics Consultant.

Philip Taylor, RN
Contractor (Medsphere)

Phil is a Clinical Consultant for Medsphere Systems Corporation. Phil has been a Registered Nurse for over 30 years. He holds a degree in Nursing from Vincennes University and a B.A. in Classical Studies from Indiana University. Phil provided clinical application support to VA Medical center staff using the VistA electronic medical record system for over 12 years prior to joining Medsphere. Phil's clinical history was primarily in Psychiatric Nursing. Currently Phil's primary responsibilities are providing training support (such as Basic CAC School and EHR for Inpatient) and configuration/setup support to OpenVista/EHR installations.

CAPT(ret) Carlene McIntyre, PharmD, MPH
(Contractor) Alaska Native Tribal Health Consortium

Carlene is a retired Commissioned Officer from the US Public Health Service. Upon nearing the twentieth year of her distinguished service with the IHS, she transferred from the OIT Pharmacy Consultant position in Albuquerque to an ARRA EHR Pharmacy Consultant position in Anchorage. Upon her recent retirement, she contracted with the ANTHC Regional Extension Center as their EHR Pharmacy Consultant.

4.0 The American Recovery and Reinvestment Act of 2009

4.1 Background

On February 17, 2009, President Barack H. Obama signed the ARRA into law. ARRA provides incentives to encourage hospitals and office-based physicians to adopt EHRs and other health information technology (HIT) solutions that reduce costs by improving quality, safety, and efficiency. ARRA contains numerous technology and privacy provisions with aggressive timelines for completion. Many of these ARRA milestones relate to the standards and work of the Healthcare Information Technology Standards Panel.

4.2 Health Information Technology for Economic and Clinical Health Act

The Health Information Technology for Economic and Clinical Health Act (HITECH) is a focal point of ARRA and represents an investment of more than \$19 billion towards healthcare information technology (IT)-related initiatives. The \$19 billion dedicated to HITECH is divided into two portions: (a) \$17 billion toward a Medicare/Medicaid incentive reimbursement program for both healthcare organizations and providers who can demonstrate “meaningful use” of an approved EHR; and (b) \$2 billion available to providers located in qualifying rural areas, providers serving underserved urban communities, and providers serving underserved Indian tribes. Meaningful use of an approved EHR is required in order for providers to qualify for, and continue to receive, incentives.

4.3 Incentive Payments

ARRA will provide incentive payments through Medicare and Medicaid reimbursement systems to encourage providers and hospitals to adopt EHRs and HIT. Incentive payments are triggered when a provider or hospital demonstrates that it has become a “meaningful EHR user.” The highest incentive payments will be granted to hospitals that adopt EHR technology in the years 2011, 2012, or 2013. Reduced incentive payments are granted to hospitals that adopt EHR technology in the years 2014 or 2015, while no incentive payments are granted to hospitals that adopt EHR technology after 2015. Providers and hospitals that fail to meet this time limit will be subject to penalties in the form of reduced Medicare reimbursement payments beginning in 2017.

4.4 Meaningful Use

Meaningful use is a term used by the Centers for Medicare and Medicaid Services (CMS) to ensure that providers and hospitals that have adopted certified EHR are using the technology to further the goals of information exchange among health care professionals. EPs (eligible providers) and EHs (eligible hospitals) will achieve meaningful use if they: (a) demonstrate use of certified EHR technology in a meaningful manner, (b) demonstrate the certified EHR technology provides for electronic exchange of health information to improve quality of care, and (c) use certified EHR technology to submit information on clinical quality and other measures.

Achieving meaningful use will be accomplished in three stages. Stage 1 will begin in 2011, Stage 2 will begin in 2013, and Stage 3 will begin in 2015. The criteria for achieving meaningful use will increase with each stage and will build upon the prior stage. Medicare and/or Medicaid incentives are available to providers and hospitals who become meaningful users of certified EHR technology, with the maximum incentives being given to EPs and hospitals that become meaningful users in Stage 1. Hospitals may be eligible for both Medicare and Medicaid incentives but EPs must choose between the two incentive programs.

In order to achieve Meaningful Use, an EP must report on 15 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the EP's chosen menu set measures must be a designated Public Health Objective. Eligible hospitals must report on 14 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the selected menu set performance measures must be a designated Public Health Objective.

For demonstrating Meaningful Use through the Medicare EHR Incentive Program, the reporting period for the first year is any continuous 90-day period. In subsequent years, the EHR reporting period is the entire year. Under the Medicaid program, performance measures and incentive payments may be awarded for merely adopting, implementing or upgrading certified EHR technology. Consequently, there is no Medicaid reporting period for year one – all subsequent reporting periods are a full year.

4.5 Meaningful Use Performance Measures

As required to achieve MU, eligible hospitals and EPs must report their performance on two types of measures:

- Performance Measures
- Clinical Quality Measures

The performance measures aim to improve quality, safety, efficiency and reduce health disparities. There are two types of performance measures: 1) Rate measures are

numerically calculated with numerator and denominator data, 2) Attestation measures must be answered with a yes or no question.

Table 1: Summary Overview of Meaningful Use Core Set Measures

Short Name	Objective:	Measure:
Demographics	Record demographics: preferred language, gender, race and ethnicity, date of birth, and date of death and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospitals or CAH's inpatient or emergency departments (POS 21 or 23) have demographics recorded as structured data. (EPs, EHs & CAHs)
Vital signs	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 over, plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23), height, weight, and blood pressure are recorded as structured data. (EPs, EHs & CAHs)
Problem List	Maintain up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP or 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 no problems are known for the patient recorded as structured data. (EPs, EHs & CAHs)
Medication List	Maintain active medication list.	More than 80% of all unique patients seen by the EP or 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. (EPs, EHs & CAHs)

Short Name	Objective:	Measure:
Medication Allergy List	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP or 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 has no known medication allergies) recorded as structured data. (EPs, EHs & CAHs)
Smoking Status	Record smoking status for patients age 13 or older.	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have smoking status recorded as structured data. (EPs, EHs & CAHs)
Clinical Summaries	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. (EPs Only)
Electronic Copy of Health Information	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.	More than 50% of all patients seen by the EP or of the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days. (EPs, EHs & CAHs)
ePrescribing	Generate and transmit permissible prescriptions electronically.	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. (EPs Only)
CPOE Medication	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	<p>More than 30% of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE.</p> <p>NOTE: In Stage 2, the measure target increases to 60%. (EPs, EHs & CAHs)</p>

Short Name	Objective:	Measure:
Drug-Drug & Drug-Allergy Checks	Implement drug-drug and drug-allergy interaction checks.	Functionality is enabled for these checks for the entire reporting period. <i>(EPs, EHs & CAHs)</i>
Clinical Decision Support	For EPs, implement one clinical decision support rule relevant to specialty or high clinical priority. For eligible hospital or CAH implement one related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule. <i>(EPs, EHs & CAHs)</i>
Privacy/Security	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	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. <i>(EPs, EHs & CAHs)</i>
CQM	Report ambulatory and hospital clinical quality measures to CMS or, in the case of Medicaid, to the States.	Successfully report to CMS (or, in the case of Medicaid, to the States) ambulatory and hospital clinical quality measures selected by CMS in the manner specified by. <i>(EPs, EHs & CAHs)</i>
Exchange of Key Clinical Information	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient's authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. <i>(EPs, EHs & CAHs)</i>
Electronic Copy of Discharge Instructions	Provide patients with an electronic copy of their discharge instructions at the time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it. <i>(Hospitals Only)</i>

Table 2: Summary Overview of Menu Set Meaningful Use Measures

Short Name	Objective:	Measure:
Drug-Formulary Checks	Implement drug formulary checks.	The EP, eligible hospital/CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. <i>(EPs, EHs & CAHs)</i>

Short Name	Objective:	Measure:
Lab Results into EHR	Incorporate clinical laboratory test results in EHRs as structured data.	More than 40% of all clinical lab test results ordered by an EP or authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency departments (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. <i>(EPs, EHs & CAHs)</i>
Patient List	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition. <i>(EPs, EHs & CAHs)</i>
Patient-Specific Education	Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate.	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources. <i>(EPs, EHs & CAHs)</i>
Medication Reconciliation	The EP, EH 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.	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23). <i>EPs, EHs & CAHs)</i>
Summary of Care	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The EP, EH or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. <i>(EPs, EHs & CAHs)</i>
Advance Directives	Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data. <i>(Hospitals Only)</i>

Short Name	Objective:	Measure:
*Immunization Registries	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP, EH or CAH submits such information have the capacity to receive the information electronically.) (<i>EPs, EHs & CAHs</i>)
Patient Reminders	Send reminders to patients per patient preference for preventive/follow-up care.	More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. (<i>EPs Only</i>)
Timely Electronic Access to Health Information	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four (4) business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four (4) business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. (<i>EPs Only</i>)
*Submit Lab Results to Public Health Agencies	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.	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.) (<i>Hospitals Only</i>)

Short Name	Objective:	Measure:
*Syndromic Surveillance	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	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 EP, EH or CAH submits such information have the capacity to receive the information electronically.). (<i>EPs, EHs & CAHs</i>)
* All EPs, EHs and CAHs must choose at least one of these populations and public health measures to demonstrate as part of the menu sets.		