



RESOURCE AND PATIENT MANAGEMENT SYSTEM

EHR CAC Review Course

Announcement and Agenda

April 16th – 20th, 2012

Office of Information Technology (OIT)
Albuquerque, New Mexico (Accredited Sponsor)
and
Aberdeen Area (Sioux Falls VA),
Bemidji Area Office,
California Area Office
Oklahoma City Area Office,
Navajo Area Office (Gallup),

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 3.2 Aberdeen Area (Sioux Falls):

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1.0 General Information

1.1 Purpose of Training

According to the Health Information Management Systems Society (HIMSS), “integration of clinical workflow and business strategies of any healthcare organization will spell success for the providers of the future”. Efficient exchange of data and information is essential for this merger, and information technology is the tool with which to accomplish the consolidation.

Clinical Informatics is the combination of clinical knowledge and data used to increase quality of care. In addition, informatics conveys the understanding and integration of information technology into healthcare to ensure the effective provision and to support the business objectives of clinicians in healthcare industries. Nursing Informatics applies information technology to the work of nurses in healthcare while Medical Informatics is the name given to the application of information technology to medicine. The informaticist focuses on application of technology, medical care, nursing care, and pharmaceutical care in (a) supporting, (b) streamlining, (c) improving interactions between people and their workflow, and (d) increasing patient safety with best practices and reliable systems.

Because more of medicine is data-driven and computer assisted, there has been a growing demand for nurses, physicians, and other health care professionals to acquire knowledge and experience in the principles, practices, and techniques of informatics. This five-day course will further prepare the informaticist for the advanced application of the Resource Patient Management System Electronic Health Record (RPMS EHR) within the patient care setting through optimization of certified electronic health record technology to meet Meaningful Use (MU) and advance clinical quality care through the utilization of clinical applications.

The objective of this hands-on classroom course is to explore advanced informaticist concepts for electronic health record processes and practices with specific roles in the Clinical Application Coordinator (CACs) informaticist arena. All classroom sessions are Monday thru Friday from 8:30 AM - 4:30 PM Mountain Time.

This training will use WebEx® Videoconferencing and Collaboration Technology to connect classrooms located throughout the Indian Health Care System. All students will be participating from one of the designated training locations. Instructors and facilitators will teach via WebEx® using the educational techniques of lecture, discussion, scripts, and “hands-on” computer experience.

DISCLAIMER: This class is for Electronic Health Record-related knowledge. There are many RPMS clinical applications (i.e., Reminders, Pharmacy and iCare) that have separate training sessions. This class is focused on the EHR application. Please see the RPMS Training Web Site for a forthcoming training in your area.

Prerequisites

This class will be oriented towards Clinical Application Coordinators, Pharmacy Informaticist, Laboratory Informaticist, HIM Professionals, Site Managers, “EHR” Implementation Team Leaders” and other “EHR Team Members” involved with the set-up and implementation of EHR at their facility. Facilities that have loaded Pharmacy 5/7 and EHR at their facility prior to this class will be able to work on their own systems during the training. This advanced course assumes that participants are Intermediate to Advanced RPMS Users and have experience with RPMS Packages to include (a) Patient Registration (b) Scheduling (c) Pharmacy, (d) Laboratory, (e) Radiology, (f) Patient Tracking (g) Diabetes Management System, (h) Immunization, (i) Women’s Health, (j) Clinical Reporting System, (k) Q-Man, and (l) PCC Management Reports.

Accreditation

Guidelines for Receiving Continuing Education Certificate

To receive a certificate of completion, you must attend the educational event in its entirety and successfully complete an on-line evaluation of the seminar within 15 days of the activity.

Course Learning Objectives

This hands-on class provides an overview of the RPMS packages and preparation required for EHR implementation. Included in this course, participants are provided with the knowledge, skills, and abilities to fully utilize the EHR and instruct other clinicians in its use and offer participants the tools necessary for setting up the EHR. At the end of this session participants will be able to:

- Provide an overview of the Resource Patient Management System Electronic Health Record (RPMS EHR)
- Review RPMS Package Optimization
- Examine the EHR framework
- Define the expectations, roles and responsibilities of the (a) “Clinical Application Coordinator” (CAC), (b) EHR “Super User”, (c) Site Manager, (d) RPMS Informaticist and (e) other EHR Implementation Team Members.
- Delineate effective project management processes and techniques essential for EHR implementation and success.
- Navigate throughout EHR tabs
- Process “Notifications”
- Review “Cover Sheet” Information
- Enter “Allergies” and “Vital Signs”
- Enter and correct “Progress Notes”
- Document “Exams”, “Health Factors”, “Patient Education”, and “Immunizations”
- Enter “Consult” requests
- Complete a “Consult”
- Perform pharmacy, laboratory, and radiology “Order Entry”
- Assign a “Purpose of Visit”
- Update the “Problem List”
- Document “Historical Services”
- Summarize basic EHR setup

- Set up a “User”
- Turn specific “Notifications” on or off
- Set, enable and disable “Order Checks”
- Enter and edit “Order Menus” and “Quick Orders”
- Set up basic document “Parameters”
- Create, edit, finish, and import a Text Integration Utility (TIU) “Template” and create TIU data objects
- Set up a “Consult” service
- Set up keys and parameters needed to enter Patient Care Component (PCC) data to include making a Super Bill and create an ICD-9 pick-list and patient education
- Utilize Associations for Super Bills
- Review Design Mode
- Create a VA Health Summary

1.2 Albuquerque, NM (OIT)

- Phil Taylor, RN, Clinical Consultant (Contractor Medsphere)
- David R. Taylor MHS, RPh, PA-C, RN, OIT EHR Training and Deployment Manager
- Theresa Tsosie-Robledo, MS, RN-BC, OIT EHR ARRA Nurse Consultant
- Wil Darwin, PharmD, Albuquerque Area Clinical Application Coordinator

1.3 Aberdeen Area (Sioux Falls):

- Leslye Rauth, MPH, RD, CDE, Clinical Application Coordinator - Aberdeen
- Martin Hall, Sioux Falls/Aberdeen Area Tier 2

1.4 Bemidji Area:

- Teresa Chasteen, RHIT, Bemidji Area Clinical Application Coordinator

1.5 Oklahoma City Area Office:

- Amy Rubin, PharmD, Oklahoma Clinical Application Coordinator

1.6 Navajo Area Office—Gallup:

- Andrea Scott, MBA, BS, Navajo Area Clinical Applications Coordinator

1.7 California Area Office

- Steve Viramontes, RN, California Area Clinical Applications Coordinator

2.0 Detailed Agenda

All times are Mountain Time!

Monday – April 16 –		
8:30	<p>All Welcome and Introductions Leslye Rauth Theresa Tsosie -Robledo Definitions and Roles of the Informaticist and Informatician At the end of this session participants should be able to:</p> <ul style="list-style-type: none"> • Review the use of ThinkTank® collaboration software • Review the principles, practices, and techniques for collecting ideas using collaboration tools and technology • Identify participant needs and expectations using ThinkTank® collaboration technology software • Define Health Information Technology, Informaticist, and Informatician • Compare and contrast roles and responsibilities of the Clinical Application Coordinator, Site Manager, Nurse Informaticist, Medical Informaticist, EHR Super End User, EHR User, and EHR Team 	Tab 01
9:30	<p>David Taylor, Mollie Ayala and Jennifer Appel Downs Indian Health Care System Electronic Health Record Learning Community At the end of this session participants should be able to:</p> <ul style="list-style-type: none"> • Examine the concepts of Learning Communities where groups are linked by shared interests, goals, interactions, and acquisition of knowledge • Explore the EHR Learning Community tools available to include (a) IHS EHR Web Page, (b) ftp site, (c) listserv archive, (d) RPMS enhancement request, and (e) RPMS Training Page • Analyze best practices for workflow and business strategies as it applies to each facility's RPMS CPOE MU Performance Reports 	
10:00	Break	
10:15	<p>Joanne Hawkins & Chris Lamer Meaningful Use (MU) Performance Measure and Clinical Quality Measures At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Examine Meaningful Use Stage 1 Guidelines • Compare and contrast Meaningful Use (a) Patient Volume Reports, (b) Performance Reports and (c) Clinical Quality Measures <p>Evaluate each facility's plan for meeting Medicare and/or Medicaid Eligibility for Meaningful Use incentives</p>	Tab 02
11:30	Lunch Monday – April 16 –	
1:00	<p>Joanne Hawkins & Chris Lamer & Cathy Whaley</p> <ul style="list-style-type: none"> • Meaningful Use Stage 2 • Review proposed Health Information Technology Committee Stage 2 Guidelines for Meaningful Use • Scavenger Hunt • 	Tab 02
2:00	Yvonne Epps-Giddings, MSN, MSA, RN-C	Tab 03

	<ul style="list-style-type: none"> • AHRQ Tool Kit for Medication Reconciliation - 	
2:30	BREAK	
2:45 – 4:30	<p>Phil Taylor Kendall Van Tyle, PharmD RPMS Clinical Application Optimization – At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Understand the uses of Patient Wellness Handout to promote patient self managed Care • Assimilate AHRQC guidelines to yield a configurable PWH(S)/ Medication Reconciliation • Explain the importance of precise information technology setup, configuration and maintenance • Review the clinical components of an electronic health record and how proper configuration and optimization impact end-user functionality. • Discuss the importance of identifying "owners" who will accept responsibility for on-going maintenance of individual components of an electronic health record • Work collaboratively across disciplines to define, discuss and plan a process for updating and maintaining components of an electronic health record and the importance of communicating changes and updates to end-users 	Tab 04
4:30	Adjournment	

Tuesday – April 17 –		
8:30	Review Previous Days Training All David Taylor, Mollie Ayala & Jennifer Appel Downs Think Tank (Review Entries)	
9:00	Phil Taylor Electronic Health Record Customization and Workflow (Parameters) At the end of this session, participants should be able to: <ul style="list-style-type: none"> • Align the electronic health record clinical work flow process through configuration and parameter settings • Ensure electronic health record security requirements and control access to various components of the electronic health record using parameter settings • Customize components of an electronic health record to improve end-user usability • Examine the importance of adopting a standardized process for setting and editing parameters within an electronic health record • Apply parameter configuration to specific levels to meet the needs of users and the institution 	Tab 05
10:00	Break	
10:15	Mary Ann Niesen Electronic Health Record Customization and Workflow (User Setup and Personal Preferences) <i>The CSI activity will be done at individual sites (phones muted)</i> At the end of this session, participants should be able to: <ul style="list-style-type: none"> • Customize electronic health record configuration to meet the unique needs of end users through utilization of (a) New person file, (b) Provider File, (c) User Class, (d) Person Class, (e) Ordering Keys (f) Electronic Signatures , and (g) Clinical Application Keys • Populate NPI Number, DEA Number, Professional Licensure into the correct structured data fields • Compare and contrast the unique roles of users that enter orders into an electronic health record • Empower individual users to further customize their electronic health record using the Personal Preferences options • Solve Computer Scene Investigation (CSI) activity 	Tab 06
11:30	Lunch –	
1:00	Phil Taylor – Notifications Alerts and Ensuring Patient Safety And Order Checks At the end of this session, participants should be able to: <ul style="list-style-type: none"> • Identify processes by which customizable notifications can be constructed to alert specific individuals when a certain event occurs in an electronic health record (e.g. a patient is placed in restraints) for ensuring patient safety and effective communication • Configure electronic health record notifications to promote effective and timely communication of pertinent clinical information to end-users • Categorize the types of notifications that can be used in an electronic health record and how these can help end-users in having needed information available to complete documentation 	Tab 07

	<ul style="list-style-type: none"> • Demonstrate the process of using a surrogate recipient of notifications to ensure continuity care when a provider must be absent • Produce notification reports that can assist in troubleshooting efforts to properly maintain a complete and accurate health record 	
2:30	Break	
2:45 - 4:30	<p>Phil Taylor Complete and Accurate Note Documentation (Advanced TIU Note Templates)</p> <p>At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Create advanced, structured electronic note documentation tools to (a) facilitate communication (b) promote quality patient care and patient safety and (c) meet professional and legal standards • Increase efficiency in documentation through utilization of structured entry of information into progress notes via templates and the use of "point and click" elements • Ensure completeness, accuracy and standardization of an electronic health record by inclusion of necessary data elements that can be accomplished via structured input templates • Demonstrate the process of importing specific data automatically into progress notes to reduce "double entry" of data by end-users • Demonstrate use of template components (data objects and template fields) to add clinically pertinent information to electronic orders and consult requests to improve quality of documentation. • Describe the process for sharing note templates between facilities and how to obtain prior-built note templates from the external resources. 	Tab 08
4:30	Adjournment	

Wednesday – April 18		
8:30	<p>All Review Previous Days Training David Taylor, Mollie Ayala & Jennifer Appel Downs Think Tank (Review Entries)</p>	
9:00	<p>Robin Bartlett Consults and Effective Communication At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Recognize how uses of electronic consults promote patient tracking technologies and foster interdisciplinary care • Examine the electronic health record consult process from beginning to end • Develop advanced electronic patient consult tools to promote coordination of care and collaboration between interdisciplinary providers • Review and discuss the electronic consult process • Utilize a structured input template to ensure that needed information is included when sending an electronic template • Generate a consult tracking report to ensure closed loop communication and a complete and accurate record • Control user access of resulting electronic consults 	Tab 09
10:00	Break	
10:15	<p>Phil Taylor Computer Provider Order Entry (CPOE), and Patient Safety At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Strengthen clinical decision support utilizing electronic health record order checks to improve patient safety • Articulate the advantages of using properly constructed "quick orders" and carefully designed order menus in an electronic health record to improve accuracy, efficiency and safety. • Emphasize the importance of well designed order menus and quick orders that meet provider's needs and support improved usability of an electronic health record. <p>Evaluate various types of quick orders and order menus used within an electronic health record, their similarities and their differences.</p>	Tab 10
11:30	Lunch	
1:00	Computer Provider Order Entry (CPOE), and Patient Safety -Continued	
2:30	Break	
2:45	<p>Phil Taylor Computer Provider Order Entry using Complex Text Orders (Generic Orders) At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Compare and contrast use of simple text quick orders versus complex text orders. • Articulate the applications of complex text orders and their advantages. Create custom prompts to construct complex text orders to meet the specific needs of patients and providers. 	Tab 11
3:15 – 4:30	<p>Leslye Rauth & Toni Potts Advanced Informaticist Management Tools</p>	Tab 12

	<p>At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Implement solutions that assure confidentiality, security and integrity while maximizing the accessibility of protected health information • CAC Tools – Menus and Keys to be effective as an Advanced CAC • Demonstrate VC Manager <p>Chris Saddler & Phil Taylor</p> <ul style="list-style-type: none"> • Overview of VA Fileman • Demonstration of VA Fileman – inquire, search and print options <p>Mary Ann Niesen (after 4 pm)</p> <ul style="list-style-type: none"> • Overview of Trace Log • Overview use of Trace Log <p>Mary Ann Niesen</p> <ul style="list-style-type: none"> • Overview of Taskman • Overview of Taskman management options • Introduction to GRU 	
<p>3:00 – 4:30</p>		
<p>4:30</p>	<p>Adjournment</p>	

Thursday – April 19		
8:30	<p>All Review Previous Days Training David Taylor, Mollie Ayala & Jennifer Appel Downs Think Tank (Review Entries)</p>	
9:00	<p>David Taylor Customizing ICD-9 Diagnoses, CPT Procedures and Patient Education Picklists At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Customize and maintain picklists for ICD-9 Diagnosis Codes, E/M Services, CPT Procedure Codes, and Patient Education Codes to optimize accuracy of clinical documentation • Import and export best practice picklists for the purpose of standardization • Compare and contrast BGO versus BEH Components • Identify the parameters associated with the creation and editing of Superbills and Picklists • Assign appropriate keys needed to create and edit Superbills and Picklists • Examine the menu options and features available to customize Superbills and Picklists • Create a Superbill and Picklist for your facility 	Tab 13
10:00	Break	
10:15	<p>Phil Taylor and Elvira Mosely Customizing the EHR Graphical User Interface for facilitating workflow (Advanced Design Mode) At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Customize the graphical user interface (GUI) to align the electronic health record with workflow changes • Explore the needs of various users of an electronic health record and how "one size fits all" can reduce usability and efficiency • Identify components required by end users to design a template based on these assessed needs of end users • Construct an electronic health record configuration (a "template") that meets the identified needs of a specific type of electronic health record user • Delineate a maintenance process for an electronic health record template that may be required as software changes and updates occur <p>Develop a process to apprise end users of significant changes to the graphic user interface (GUI)</p>	Tab 14
11:30	Lunch	
1:00	– Continued Customizing the EHR Graphical User Interface for facilitating workflow	
2:45-3:00	Break	
3:00 – 4:30	<p>Mary Ann Niesen Advanced Patient Care Documentation (Quick Notes) At the end of this session, participants should be able to:</p> <ul style="list-style-type: none"> • Define Quick Notes and their most appropriate use • Configure Quick Notes • Demonstrate set up and implementation: • Patient Goals • Group Notes 	TAB 15

	Delineate steps for implementation and training of both Quick Notes and Flowsheets	
4:30	Adjournment	

Friday – April 20		
8:30	<p>All Examination of Advance Course Content Review Previous Days Training *THINK TANK DISCUSSION & OVERVIEW OF RESPONSES* David Taylor, Mollie Ayala & Jennifer Appel Downs Think Tank (Review Entries)</p>	
10:00	Break	
10:15	<p>All EHR Advanced CAC Trouble Shooting</p> <ul style="list-style-type: none"> • Further develop troubleshooting skills for complex electronic health record issues • Identify complex errors associated with the utilization of an electronic health record. • Review the “Electronic Health Record Installation and Troubleshooting v1.1 Revised Guide” and Bonus Materials 	Tab 16
11:00	<p>All EHR Advanced CAC Overview, Wrap-up and Evaluation: At the end of this session, participants will:</p> <ul style="list-style-type: none"> • Reexamine Course Objectives and evaluate personal learning outcomes • Evaluate participants application and comprehension of course objectives • Complete the Survey Monkey® evaluation • Ask questions and receive answers • Discuss “where do we go from here” – • Schedule Office Hours for continuing advancement of informatics skills and electronic health record dissemination 	
12:00	Lunch	
1:00-4:30	“Optional” Site specific for “one-on-one” troubling shooting	
4:30	Adjournment	

5.0 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.

5.1 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.

5.2 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.

5.3 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.

Meaningful Use Standards and 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 hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have demographics recorded as structured data. (<i>EPs, EHs & CAHs</i>)
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. (<i>EPs, EHs & CAHs</i>)
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. (<i>EPs, EHs & CAHs</i>)
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. (<i>EPs, EHs & CAHs</i>)
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. (<i>EPs, EHs & CAHs</i>)
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. (<i>EPs, EHs & CAHs</i>)
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. (<i>EPs Only</i>)
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. (<i>EPs, EHs & CAHs</i>)

Short Name	Objective:	Measure:
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. <i>(EPs Only)</i>
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.	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. NOTE: In Stage 2, the measure target increases to 60%. <i>(EPs, EHs & CAHs)</i>
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>)
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>)
*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>)

Short Name	Objective:	Measure:
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>
*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.		