

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

Presented by

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CORE: CPOE:

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

ERH Demo (Yes)

EHR/Order Tab

CORE: Drug Interaction Checks

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

EHR Demo (Yes)

Notifications/Drug Interaction

Drug-Drug and Drug-Allergy check

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

Order Checks Must be Set to Enabled and Mandatory

These Order checks must be set to Enabled and Mandatory:

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

CORE: Maintain Problem List:

- * S1= More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
- * S2= Incorporated into Summary of Care
 - * No exclusions

EHR Demo (Yes)

Problem List (cont.)

EHR Documentation:

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

or:

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

or:

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

Problem List Review - Coversheet

The screenshot displays a medical software interface for a patient named "Demo, Patient Baby" (T00724, 31-Dec-2009, M). The interface includes a navigation bar with tabs for PRIVACY, PATIENT CHART, RESOURCES, RCIS, and DIRECT. Below the patient information, there are several icons and buttons, including "Cover Sheet" which is circled in blue. A table titled "Active Problem List" is shown, listing various medical conditions and their dates. Below the table, a workflow is indicated by arrows: a blue arrow labeled "1" points to a "Chart Review" button, and another blue arrow labeled "2" points to a "Reviewed" button. A "Refresh" button and "F5" are also visible. At the bottom, a status bar shows "Problem List (R)" with a green highlight, and "Nds Rvwd" buttons.

Problem	Date
Allergic asthma	29-Apr-2014 14:20
Depressive disorder	18-Aug-2014 13:08
Eating routine - finding	22-Aug-2014
Exercise-induced asthma	18-Aug-2014 13:18
Low back pain	18-Aug-2014 13:05
Purulent otitis media	18-Aug-2014 13:07

Problem List Review -Buttons

The screenshot displays a medical software interface with the following elements:

- Top Navigation:** A menu bar with 'Problem List', 'Adv React', and 'Medications'. Below it, three yellow buttons labeled 'Nds Rvwd' are visible.
- Secondary Navigation:** A row of buttons including 'Notes', 'Consults/Re', 'Reviewed', 'Summary', 'Suicide Form', and 'Reports'. A blue arrow labeled '1' points to the 'Reviewed' button.
- Dropdown Menu:** A dropdown menu is open over the 'Reviewed' button, containing the text 'Reviewed' and 'No Active Problems'. A blue arrow labeled '2' points to the 'Reviewed' option.
- Medication List:** A section titled 'Medication List' with the text 'No Medications Found' below it.
- Bottom Panel:** A status bar with 'Status' (radio buttons for 'All', 'Active') and 'Inpatient/Outpatient' (radio buttons for 'All', 'Out', 'In'). On the right, a secondary menu bar shows 'Problem List', 'Adv React', and 'Medications'. The 'Problem List' button is highlighted in green and has '(R)' next to it, which is circled in blue.

Problem List Update Problem Management –IPL

The screenshot displays a medical software interface for a patient named BARTLETT, ROBIN A. The main window shows the 'Problem List' section, which is currently expanded. The table below lists the patient's medical problems:

Status	Onset Date	Provider Narrative	Comments	Ptk	PIP	IP	ICD
Chronic		Exercise-induced asthma					493.81
Chronic	02/11/2013	Allergic asthma					493.90
Chronic		Purulent otitis media					382.4
Chronic		Depressive disorder					311.
Chronic		Low back pain					724.2
Chronic		Eating routine - finding					9999

Below the table, there is a section for 'Visit Diagnosis' with columns for SNMED CT, Provider Narrative, Provider Text, ICD, Priority, Asthma Control, Cause, Injury Date, Injury Cause, Injury Place, Modifier, and Onset Date. The interface also shows a taskbar at the bottom with various application icons and a system tray on the right displaying the time as 8:49 PM on 9/12/2014.

CORE: e-Prescribing (eRx)

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

- * Exclusions:
 1. Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
 2. Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

EHR Demo (NO)

Training Database not set for e-Prescribing

CORE: Active Medication List

- * S1= More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
- * S2= Incorporated into Summary of Care
 - * No exclusions

EHR DEMO (Yes)

Active Medication List (cont.)

EHR Documentation:

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

or:

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

or:

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

Active Medication List

No Active Medications

The screenshot displays a medical software interface for a patient named BLUE FP PRINCIPLE (BARTLETT, ROBIN A). The patient's status is Ambulatory, and the date/time is 12-Sep-2014 21:23. The interface features several navigation tabs: Problem List, Advs React, Medications, Nds Rvwrd, [RUN], and Nds Rvwrd. Below these are tabs for Notes, Consults/Referrals, Superbill, D/C Summary, Suicide Form, and Reports. The main section is titled Medication List, which currently shows No Medications Found. A context menu is open over the table area, with options: Chart Review (Reviewed), Refresh (F5), and No Active Medications. At the bottom, there are status and inpatient/outpatient filters, and a secondary set of navigation tabs: Problem List, Advs React, Medications, Nds Rvwrd, R, and [RN].

Annotations in the image include:

- A blue circle around the "Medication List" header and "No Medications Found" text.
- A blue circle around the "Medications" tab in the bottom navigation bar.
- A blue arrow labeled "1" pointing to the "Chart Review" option in the context menu.
- A blue arrow labeled "2" pointing to the "No Active Medications" option in the context menu.

Active Medication List Reviewed

• Problem List Advs React Medications
 Nds Rvwd Nds Rvwd Nds Rvwd ← 1

Notes Consults/Referrals Superbill D/C Sur Reviewed ← 2 ts
 No Active Medications

Medication	Status	Issue Date
OUTSIDE RX1	ACTIVE*	07-Jan-2008
IBUPROFEN 400MG TAB	PENDING	
IBUPROFEN 800MG TAB	PENDING	
DIMETHICONE 1.5% CREAM (4...	ACTIVE	
ALBUTEROL 90MCG (CFC-F) 20...	ACTIVE	
METOPROLOL TARTRATE 50...	ACTIVE	
OUTSIDE MED MISCELLANEO...	ACTIVE	
OUTSIDE MED MISCELLANEO...	ACTIVE	
ST JOHN'S WORT OTC CAP	ACTIVE	
OUTSIDE MED MISCELLANEO...	ACTIVE	

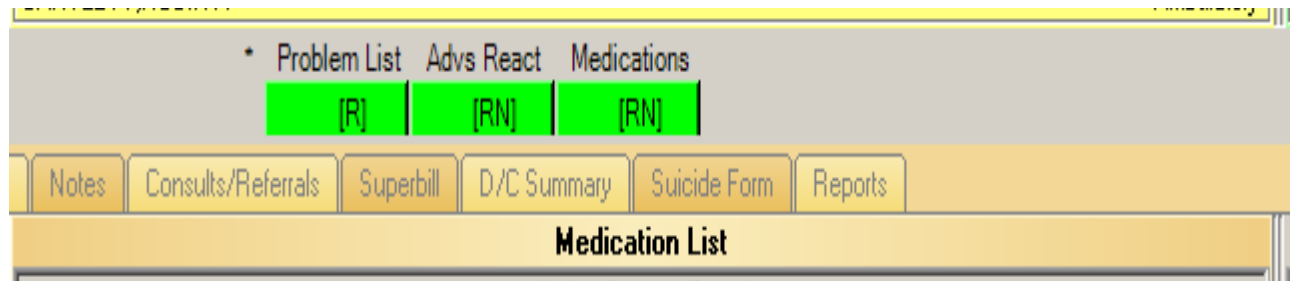
Status Inpatient/Outpatient
 All Active All Out In

Active Medication List Updates Medication Tab

Action		Chronic	Outpatient Medications	Status	Process	Issued	Last Filled	Expires	Refills Remaining	Rx #	Provider
<input checked="" type="checkbox"/>			METFORMIN HCL 500MG SA TAB Qty: 60 Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY TAKE WITH FOOD FOR DIABETES TREATMENT	Pending							
<input checked="" type="checkbox"/>			MORPHINE SULFATE 60MG *SR* TAB Qty: 20 Sig: TAKE ONE TABLET BY MOUTH EVERY 12 HOURS FOR PAIN, MAY CAUSE DROWSINESS	Pending							
			AMOXICILLIN 250MG/5ML PwDR, RENT-ORAL Qty: 100 Sig: TAKE 2.5ML BY MOUTH TWICE A DAY FOR INFECTION. SHAKE WELL.	Pending							
			CHLORHEXIDINE GLUCONATE 0.12% MOUTHWASH Qty: 473 Sig: RINSE 1 OUNCE BY MOUTH TWICE A DAY AFTER BREAKFAST AND BEFORE BEDTIME	Pending							
			FLUTICASON/SALMETEROL 250-50MCG INHL, ORAL Qty: 60 Sig: INHALE 1 PUFF BY MOUTH TWICE A DAY	Pending							
			HYDROCODONE/APAP 10MG/325MG TAB Qty: 15 Sig: TAKE 1 TABLET BY MOUTH EVERY 6 HOURS IF NEEDED FOR PAIN	Pending							
			IBUPROFEN 400MG TAB Qty: 40 Sig: TAKE ONE TABLET BY MOUTH FOUR TIMES A DAY FOR PAIN; TAKE WITH FOOD OR MILK	Pending							
			LORAZEPAM 1MG TAB Qty: 4 Sig: TAKE TWO TABLETS BY MOUTH AT BEDTIME THEN TAKE TWO TABLETS 1 HOUR PRIOR TO APPOINTMENT	Pending							
			MONTELUKAST NA 4MG CHEW TAB Qty: 90 Sig: CHEW ONE TABLET BY MOUTH EVERY DAY	Pending							
			SODIUM HYPOCHLORITE 0.125% TOP SOLN Qty: 473 Sig: SOLUTION TO AFFECTED AREA TWICE A DAY	Pending							
Action			Non-DIHA Medications	Status							Start Date
			FISH OIL CAP, ORAL BY MOUTH	Active							
			FLUOCINONIDE 0.05% CREAM LARGE AMOUNT TO AFFECTED AREA	Active							
	Validate		OUTSIDE MED MISCELLANEOUS	Active							
			OUTSIDE MED MISCELLANEOUS TAB FISH OIL BY MOUTH TWICE A DAY Patient buys OTC/Herbal product without medical advice.	Active							
			OUTSIDE MED MISCELLANEOUS TAB VITAMIN C 500 MG BY MOUTH ONCE A WEEK	Active							
Action			Inpatient Medications	Status							Stop Date

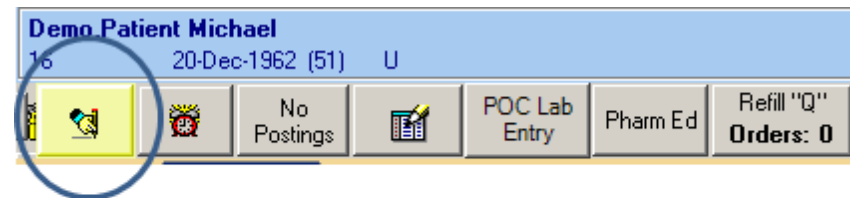
EHR Documentation

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



EHR Documentation (cont.)

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



Review/Sign Changes for Demo, Patient Michael

Signature will be applied to checked items

Chart Review

- Problem List - Reviewed
- No Active Medications
- Medications - Reviewed
- No Active Adverse Reactions
- Adverse Reactions - Reviewed

Electronic Signature Code:
xxxxxxxxxx

If processing Surescripts, signature will be applied after action selected.

Sign Cancel

CORE: Medication Allergy List

- * S1= More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
- * S2= Incorporated into Summary of Care
 - * No exclusions

EHR DEMO (Yes)

Medication Allergy List (cont.)

EHR Documentation:

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

or:

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

Medication Allergy List Review Coversheet

Adverse Reactions

Agent ▲	Type	Reaction	Status	InAct Date
AMOXI...	Drug	RASH	Verified	
HYDRO...	Drug	ITCHI...	Verified	
LANSO...	Drug	ABDO...	Verified	
LISINO...	Drug	DIZZI...	Verified	
MORP...	Drug	RASH	Verified	
PEANU...	Drug, F...	RASH	Verified	
PENCIC...	Drug	ANAP...	Verified	
PENICI...	Drug	RASH	Verified	
POVID...	Drug, F...	RASH	Verified	
SOY	Drug, F...	DRY M...	Verified	
SULFA ...	Drug	ANGIO...	Verified	

All Active

Edit Adverse Reaction...
 Delete Adverse Reaction
 New Adverse Reaction...
 Sign Adverse Reaction
 Entered in Error
 Inactivate Adverse Reaction
 Reactivate Adverse Reaction
 Inability to Assess

Chart Review Reviewed
 Refresh F5 No Active Allergies

• Problem List Advs React Medications
 Nds Rvwld [R] Nds Rvwld

Medication Allergy List Review Buttons

The image illustrates the process of reviewing medication allergies in a software interface. It shows two states of the interface:

- Initial State:** A navigation bar contains 'Problem List', 'Advx React', and 'Medications'. Below these are three yellow buttons labeled 'Nds Rvwd'. A dropdown menu is open under 'Advx React', showing 'Reviewed' and 'No Active Allergies'. A blue arrow labeled '1' points to the first 'Nds Rvwd' button, and a blue arrow labeled '2' points to the 'Reviewed' option in the dropdown.
- Final State:** The 'Advx React' button now contains the text '[R]', indicating that the allergy has been reviewed. This button is circled in blue.

Medication Allergy List

No Allergy Assessment Scenario

The screenshot displays a software interface for managing adverse reactions. At the top, a yellow header bar contains the text "Adverse Reactions". Below this, a grey bar displays "No Allergy Assessment". The main area is a grid with a context menu overlaid on it. The menu includes options: "Edit Adverse Reaction...", "Delete Adverse Reaction", "New Adverse Reaction...", "Sign Adverse Reaction", "Entered in Error", "Inactivate Adverse Reaction", "Reactivate Adverse Reaction", "Inability to Assess", "Chart Review", "Refresh", and "Reviewed". A blue arrow labeled "1" points to the "Chart Review" option. Below the grid, a "Status" section has radio buttons for "All" and "Active". A blue arrow labeled "2" points to the "No Active Allergies" button. Below the status section is a "Reminders" section with a table:

Problem List	Advs React	Medications
Nds Rvwd	[RN]	Nds Rvwd

Below the reminders is another "Adverse Reactions" section with a yellow header and a grey bar displaying "No Allergy Assessment". A blue circle highlights the "Advs React" column in the reminders table, and another blue circle highlights the "No Allergy Assessment" text in the bottom section.

Medication Allergy List Update No Known Allergy Documentation

The screenshot illustrates the workflow for updating a medication allergy list when there is no known allergy documentation. It is divided into three main sections:

- Top Section: Adverse Reactions Table**
 - Header: **Adverse Reactions** (yellow bar)
 - Sub-header: **No Allergy Assessment**
 - Table: An empty table with columns for patient information and reaction details.
 - Context Menu: A right-click menu is open over the table. A blue arrow labeled '1' points to the **New Adverse Reaction...** option.
 - Footer: Includes a **Status** filter (radio buttons for **All** and **Active**), a **Refresh** button, and the keyboard shortcut **F5**.
- Right Section: Look up Causative Agent**
 - Header: **Look up Causative Agent** (blue bar)
 - Text: **Enter causative agent for Adverse Reaction: (Enter at least 3 characters)**
 - Form: A text input field with a **Search** button.
 - Footer: A blue arrow labeled '2' points to the **No Known Allergies** checkbox, which is checked. A blue arrow labeled '3' points to the **OK** button.
- Bottom Section: Summary and Navigation**
 - Header: **Adverse Reactions** (yellow bar)
 - Text: **No Known Allergies** (circled in blue)
 - Navigation Bar: Includes **Problem List**, **Advs React** (circled in blue), and **Medications**. Below these are buttons for **Nds Rvw**, **[RUN]** (circled in blue), and **Nds Rvw**.

Medication Allergy List Update

New Adverse Reaction Entry

Adverse Reactions No Allergy Assessment

1 → Edit Adverse Reaction...
Delete Adverse Reaction
New Adverse Reaction...
Sign Adverse Reaction

Entered in Error
Inactivate Adverse Reaction
Reactivate Adverse Reaction
Inability to Assess

Chart Review ▶

Refresh F5

Status
 All Active

Look up Causative Agent
Enter causative agent for Adverse Reaction:
(Enter at least 3 characters)
PENICILLIN Search

Look up Causative Agent
Enter causative agent for Adverse Reaction:
(Enter at least 3 characters)
PENICILLIN Search

Select from one of the following items

48 matches found:

- VA Allergies File (no matches)
- National Drug File - Generic Drug Name (2)**
 - PENICILLIN**
 - PENICILLIN/PROBENECID
- National Drug file - Trade Name (41)
- Local Drug File (no matches)
- Drug Ingredients File (1)
- VA Drug Class File (4)
- Add new free-text allergy (1)

5 → OK Cancel

Select from the matching entries on the list, or search again.

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

Edit Adverse Reaction (Verified)

Reaction
Causative agent: PENICILLIN

Nature of Reaction: Drug

Event Code: DRUG ALLERGY

Source of Information: PATIENT

Observed

Observer: [dropdown]

Reaction Date/Time: [dropdown]

Severity: [dropdown]

Signs/Symptoms

Available: RASH, ITCHING, WATERING EYES, HYPOTENSION, DROWSINESS, NAUSEA, VOMITING, DIARRHEA, HIVES, DRY MOUTH, ANAPHYLAXIS

Selected: RASH Oct 10, 2008 @ 12:05

Imprecise Date

Date/Time: 10-Oct-2008 12:05

Source: [dropdown]

Comments

Current OK Cancel

CORE: Record Demographics

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

Record the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth.
 - * No exclusions
EHR Demo (No)
RPMS REG-Pack /Practice Management Application Suite

CORE: Record Vital Signs

- * S1= For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
 - * S2= More than 80%, BP recorded (for patients age 3 and older), and/or height and weight recorded (for all ages)
 - * **Exclusions**
 - Any EP who:
 1. Sees no patients 3 years or older is excluded from recording blood pressure;
 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them;
 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or
 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.
- EHR Demo (Yes)

Vital Signs

RPMS-EHR ** EHR P13 **

User Patient Refresh Data Tools Help gSg Clear Clear and Lock Community Alerts Dosing Calculator Rx Print Settings Imaging

PRIVACY PATIENT CHART RESOURCES RCIS DIRECT WebMail

Patient: Demo7 147545 20-Mar-1964 (50) M DEMO CLINIC DOCTOR.DEMO1 26-Aug-2014 09:23 Ambulatory Primary Care Team Unassigned

Postings A POC Lab Entry Pharm Ed Refill "Q" Orders: 0 Problem List F Adv React Nds Rvwrd Medications 2 C/C D/J/A Asthma Action Plan PwH Med Rec eRx Receipt Reviewed/Updated Visit Summary

Notifications Cover Sheet Triage Wellness Problem Mngt Prenatal Well Child Medications Labs Orders Notes Consults/Referrals Superbill D/C Summary Suicide Form Reports

Chief Complaint

Author: Chief Complaint

Reproductive history Infant Feeding Personal Health PHN

Reproductive Factors

Not Applicable

Adverse Reactions

Agent	Type	Reaction	Status	InAct Date
CEFAC...	Drug	ANAP...	Verified	
IBUPR...	Drug	HIVES...	Verified	
LEVEMIR	Drug	FACIA...	Verified	
PENICI...	Drug	DIZZI...	Verified	
SULFA...	Drug	WHEE...	Verified	

Status: All Active

Vital Entry

Default Units	28-Aug-2014 09:42	Range	Units
Temperature			F
Pulse		60 - 100	/min
Respirations			/min
O2 Saturation			%
Blood Pressure		90 - 150	mmHg
Height			in
Weight			lb
Pain			

New Date/Time Update Reset

DOCTOR.DEMO1 2013-DEMO.NA.IHS.GOV 2013 DEMO HOSPITAL 28-Aug-2014 09:47

Record Vital Signs

Vital Entry	Vital Display		
Default Units	26-Aug-2014 11:53	Range	Units
Blood Pressure	For ages 3 and up	90 - 150	mmHg
Height	For all ages		in
Weight	For all ages		lb

CORE: Record Smoking Status

- * S1= More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
- * S2= More than 80% for patients age 13 and older
 - * **Exclusion**
Any EP who sees no patients 13 years or older.

EHR Demo (Yes)

Smoking Status

RPMS-EHR ** EHR P13 **

User Patient Refresh Data Tools Help eSig Clear Clear and Lock Community Alerts Dosing Calculator Rx Print Settings Imaging

PRIVACY PATIENT CHART RESOURCES RCIS DIRECT WebMail

Demo Patient7 147545 20-Mar-1964 (50) M **DEMO CLINIC** DOCTOR.DEMO1 26-Aug-2014 09:23 Ambulatory Primary Care Team Unassigned

Postings A POC Lab Entry Pharm Ed Refill "Q" Orders: 0 Problem List R Advs React Nds Rvw'd Medications Nds Rvw'd CIC DIA Asthma Action Plan P/WH Med Rec eRx Receipt Reviewed/Updated Visit Summary

Notifications Cover Sheet Triage Wellness Problem Mngt Prenatal Well Child Medications Labs Orders Notes Consults/Referrals Superbill D/C Summary Suicide Form Reports

Ed/Exams/HF Imms/Skin Tests

Education Show Standard Add Edit Delete

Visit Date	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length	Type	Location	Code
08/26/2014	Benign Prostatic Hyperplasia-Lifestyle Adap								DEMO HOSPITAL	266569009
08/26/2014	Benign Prostatic Hyperplasia-Nutrition								DEMO HOSPITAL	266569009

Add Health Factor Add Cancel

- Items
- TOBACCO (EXPOSURE)
- TOBACCO (SMOKELESS - CHEWING/DIP)
- TOBACCO (SMOKING)
 - CEREMONIAL USE ONLY
 - CESSATION-SMOKER
 - CURRENT SMOKER, EVERY DAY
 - CURRENT SMOKER, SOME DAY
 - CURRENT SMOKER, STATUS UNKNOWN
 - HEAVY TOBACCO SMOKER
 - LIGHT TOBACCO SMOKER
 - NEVER SMOKED
 - PREVIOUS (FORMER) SMOKER
 - SMOKING STATUS UNKNOWN

Comment

Exams Add Edit Delete

Visit Date	Exams

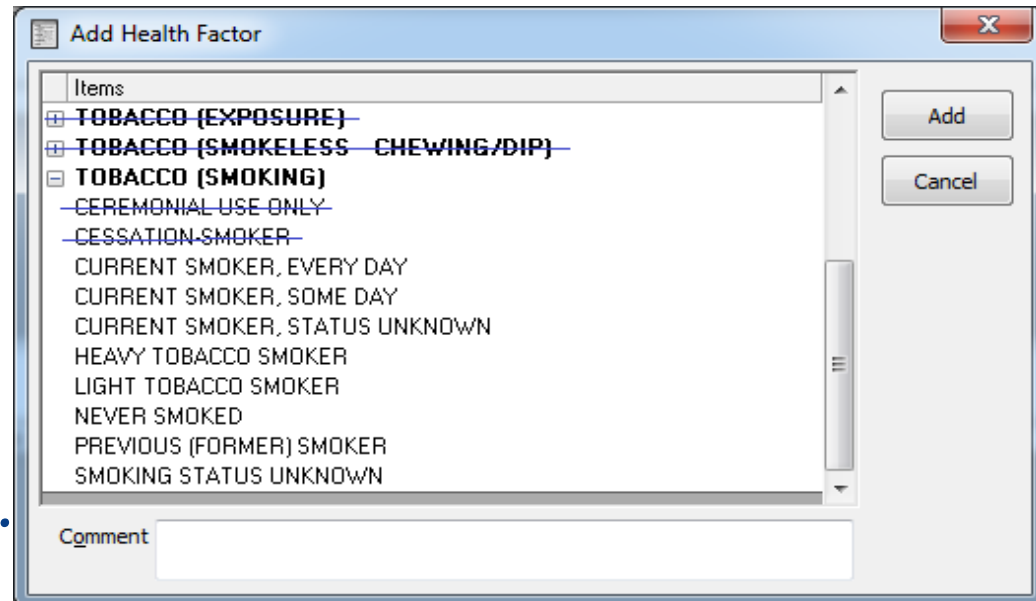
Health Factors Add Edit Delete

Visit Date	Health Factor	Category	Comment
08/26/2014	Smoking Status Unknown	Tobacco	

DOCTOR.DEMO1 2013-DEMO.NA.IHS.GOV 2013 DEMO HOSPITAL 28-Aug-2014 10:09

Record Smoking Status

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



CORE: Clinical Decision Support:

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

- * EHR Demo (NO)

Prioritize Reminders You Need to Attest for MU2

* “Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period.”

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

CORE: Patient Electronic Access

* (View/Download/Transmit):

S1= More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, and transmit to a third party.

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

Exclusion:

- * Any EP who neither orders nor creates any of the information listed for inclusion, except for "Patient name" and "Provider's name and office contact information, may exclude the measure.

EHR Demo (NO)

CORE: Clinical Summaries

- * S1= Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
- * S2= Provided for more than 50% of all office visits within 1 business day
- * **Exclusion**
 - * Any EP who has no office visits during the EHR reporting period.

EHR Demo (NO)

PHR not available at this time

CORE: Protect Electronic Health Information

- * S1= Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- * S2= Conduct or review SRA, including addressing the encryption/security of data stored in CEHRT, and implement updates as necessary
No exclusions.
- * **YES/NO Attestation Requirements.**
EHR Demo (NO)

CORE: RPMS DIRECT Secure Messaging

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

DIRECT Requirements for Stage 2

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

MENU: Clinical Lab Test Results

- * S1= More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
- * S2= More than 55% (core)
- * **Exclusion**
 - * An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

EHR Demo (YES)

MENU: Patient Lists

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

EHR Demo (NO)

MENU: Patient Reminders

- * S1= More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
- * S2= More than 10% of all unique patients with 2 or more office visits in the last 24 months (core)
- * Exclusion:
 - * An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

EHR Demo (NO)

ICARE REMINDER NOTIFICATIONS

MENU: Patient-Specific Education Resources

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

EHR Demo (YES)

Patient-Specific Education

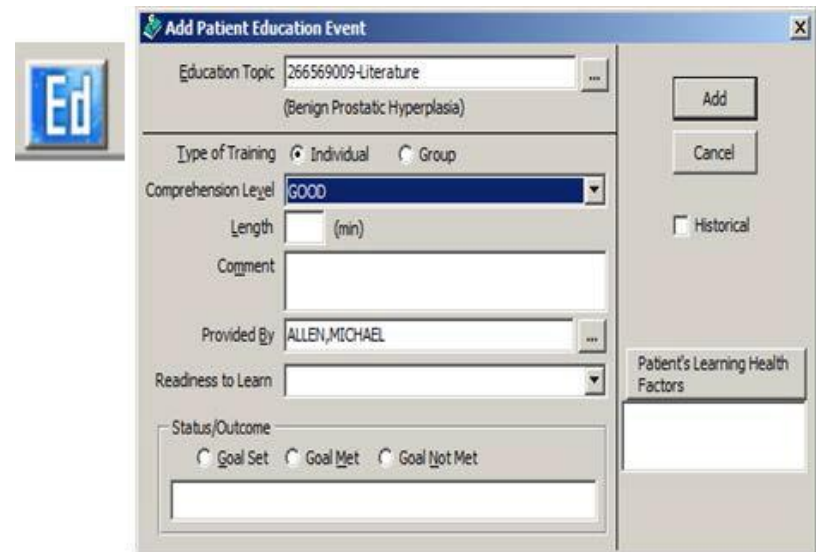
- * Optional Menu Set Measure with MU Stage 1.
- * Required MU2 Core Measure:
 - * More than 10% of all unique patients with office visits are provided patient-specific education resources.

Documenting Patient Education for MU (1)

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

Documenting Patient Education for MU (1)

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

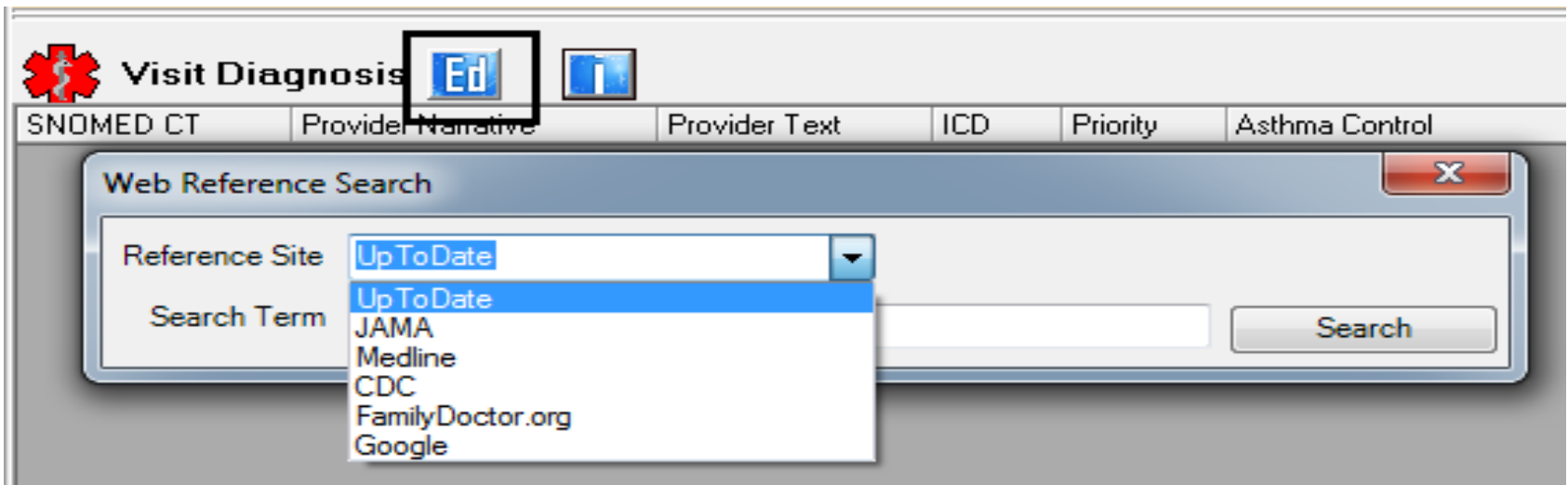


The screenshot shows a software window titled "Add Patient Education Event". To the left of the window is a small blue square button with the white letters "Ed". The window contains the following fields and options:

- Education Topic:** 266569009-Literature (Benign Prostatic Hyperplasia)
- Type of Training:** Radio buttons for Individual (selected) and Group.
- Comprehension Level:** A dropdown menu with "GOOD" selected.
- Length:** A text input field followed by "(min)".
- Comment:** A large text area.
- Provided By:** ALLEN, MICHAEL
- Readiness to Learn:** A dropdown menu.
- Status/Outcome:** Radio buttons for Goal Set, Goal Met, and Goal Not Met.
- Buttons:** Add, Cancel, and a checkbox for Historical.
- Section:** Patient's Learning Health Factors with a text area below it.

Documenting Patient Education for MU (2)

- * “Ed” button added to retrieve MedlinePlus Patient Education.



Documenting Patient Education for MU (3)

- * “i” button will retrieve ClinicalKeyclinical info.

The screenshot shows a software interface for documenting patient education. At the top, there is a red cross icon and the text "Visit Diagnosis". To the right of this text are two buttons: "Ed" and "i". The "i" button is circled in black. Below this is a horizontal menu with several options: "SNOMED CT", "Provider Narrative", "Provider Text", "ICD", "Priority", and "Asthma Control". A "Web Reference Search" dialog box is open, featuring a "Reference Site" dropdown menu with "UpToDate" selected, a "Search Term" input field, and a "Search" button. The dropdown menu lists several options: "UpToDate", "JAMA", "Medline", "CDC", "FamilyDoctor.org", and "Google".

Documenting Patient Education for MU

(4)

RPMS-EHR ALLER, MICHAEL ** MUPrepMost Precent **

User Patient Refresh Data Tools Help Log Clear Clear and Lock Community Alerts Dosing Calculator Rx Print Settings Imaging

PRIVACY PATIENT CHART RESOURCES RDS DIRECT WebMail

Everyman, Adam 147085 22-Oct-1962 (51) M DEMO CLINIC ALLEN, MICHAEL 04-Sep-2014 09:56 Ambulatory Khan, Samir

Postings A PUL Lab Entry Pharm Ed Refill "Q" Orders: 0 Problem List Advx React Medications Nds Rvw'd Nds Rvw'd Nds Rvw'd CIC DIA Asthma Action Plan PwH Med Rec eRx Receipt Reviewed/Updated Visit Summary

Notifications Cover Sheet Triage Wellness Problem Mngt Prenatal Well Child Medications Labs Orders Notes Consults/Referrals Superbill D/C Summary Suicide Form Reports

IPL Family Hx Surgical Hx Pt Goals Anticoag Eyeglass AMI Stroke

Integrated Problem List Expand All Chronic Episodic Sub-acute Social/Env Inactive Current/Most recent Inpatient Ed i Get SCT Pick List POV Add Edit Delete

Status	Onset Date	Provider Narrative	Comments	PHx	PIP	IP	ICD
Episodic	03/30/2012	Essential hypertension Test0227					401.9
Chronic	09/25/2011	Asthma					493.90
Episodic	08/15/2012	Costal chondritis					733.6
Chronic	08/15/2012	Disability evaluation, normal, no disability, no impairment					INVALID CODE

* Requires update to SNOMED CT

Visit Diagnosis Ed i

SNOMED CT	Provider Narrative	Provider Text	ICD	Priority	Asthma Control	Cause	Injury Date	Injury Cause	Injury Place	Modifier	Onset Date
-----------	--------------------	---------------	-----	----------	----------------	-------	-------------	--------------	--------------	----------	------------

ALLEN, MICHAEL 2013-DEMO.NA.IHS.GOV 2013 DEMO HOSPITAL 04-Sep-2014 17:25

Documenting Patient Education for MU (5)

The screenshot displays a medical software interface with a patient chart for David Alpha. The chart includes a list of problems such as 'Episodic Laboratory test requested | Laboratory Exam', 'Chronic Urinary tract infection', and 'Social/Environmental Tobacco dependence, continuous'. A dialog box titled 'Add Patient Education Event' is open, showing the following details:

- Education Topic: 26556009-Literature (Urinary Tract Infection)
- Type of Training: Individual
- Comprehension Level: GOOD
- Length: (min)
- Comment: (empty)
- Provided By: ALLEN, MICHAEL
- Readiness to Learn: (empty)
- Status/Outcome: Goal Set, Goal Met, Goal Not Met

Overlaid on the right is a MedlinePlus search result for 'Urinary Tract Infections'. The result includes a definition: 'The urinary system is the body's drainage system for removing wastes and extra water. It includes two kidneys, two ureters, a bladder, and a urethra. Urinary tract infections (UTIs) are the second most common type of infections in the body. You may have a UTI if you notice Pain or burning when you ...' and a list of related conditions: Asymptomatic bacteriuria, Catheter-associated UTI, Cystitis -acute bacterial, Leukocyte esterase, and Bacteriologic cystogram.

Documenting Patient Education for MU (6)

The screenshot displays a medical software interface for documenting patient education. At the top, there are tabs for various medical conditions: IFL, Family Hx, Surgical Hx, Pt Goals, Anticoag, Eyeglass, AMI, and Stroke. Below these is an 'Integrated Problem List' section with an 'Expand All' button and several checkboxes: Chronic, Episodic, Sub-acute, Social/Env, Inactive, and Current/Most recent Inpatient. To the right of these checkboxes are buttons for 'Ed', 'i', 'Get SCT', 'Pick List', 'POV', 'Add', 'Edit', and 'Delete'.

The main table lists patient education items. The first row is highlighted in orange and shows a 'Chronic' status, an onset date of '07/23/2011', and a provider narrative of 'Benign prostatic hyperplasia'. The ICD code '600.20' is visible in the rightmost column.

Below the main table is a 'POV' (Patient Education) window. It contains a table with columns: ID, Status, Prov. Narrativ, POV, Episodicity, Prov. Text, Goal Notes, Care Plans, Visit Instructions, Pt Ed, Tx/Regimen/FU, and Tx/Regimen/FU display only. The first row in this table has ID '4939', Status 'Chronic', and Prov. Narrativ 'Benign prostatic hyperplasia'. The 'Pt Ed' column contains several checkboxes: DP, EX, M, L, N, LA, and P. The checkbox for 'L' is circled in black.

At the bottom of the 'POV' window, there is a 'Primary POV' section with a dropdown menu currently showing 'Benign prostatic hyperplasia'. To the right of this dropdown are 'Save' and 'Cancel' buttons.

Documenting Patient Education for MU (7)

Education on Wellness tab.

The screenshot displays an EHR interface for a patient named 'Demo Patient 7'. The 'Wellness' tab is active, and the 'Education' sub-tab is selected. The 'Education' section contains a table with the following data:

Visit Date	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length	Type	Location	Code
08/25/2014	Benign Prostatic Hyperplasia-Lifestyle Adaptation					DEMO MICHAEL		Individual	2013 DEMO HOSPITAL	266568009
08/25/2014	Benign Prostatic Hyperplasia-Nutrition					DEMO MICHAEL		Individual	2013 DEMO HOSPITAL	266568009

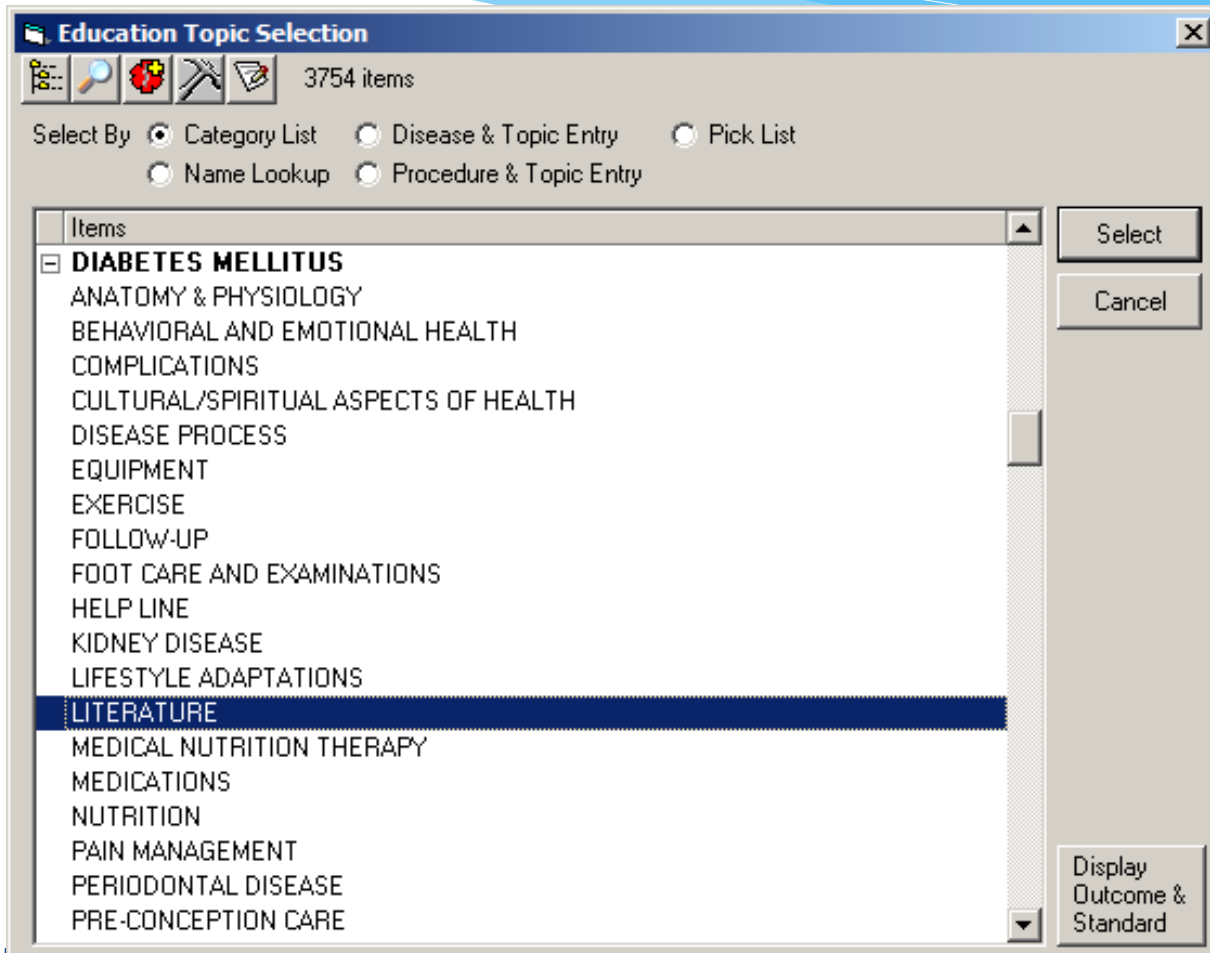
Below the Education table, there are sections for 'Exams' and 'Health Factors', each with an 'Add' button. The 'Health Factors' table has one entry:

Visit Date	Health Factor	Category	Comment
08/25/2014	Smoking Status Unknown	Tobacco	

Documenting Patient Education for MU

(8)

- Education on Wellness tab - Category List.



Documenting Patient Education for MU (9)

Education on Wellness tab -Pick List.

Education Topic Selection 3754 items

Select By Category List Disease & Topic Entry Pick List
 Name Lookup Procedure & Topic Entry

Pick Lists **Diabetes**

Show All

<input type="checkbox"/> Diabetes Mellitus-anatomy & Physiology	<input checked="" type="checkbox"/> Diabetes Mellitus-home Management	<input type="checkbox"/> Diabetes Mellitus-safety
<input type="checkbox"/> Diabetes Mellitus-case Management	<input type="checkbox"/> Diabetes Mellitus-kidney Disease	<input type="checkbox"/> Diabetes Mellitus-screening
<input checked="" type="checkbox"/> Diabetes Mellitus-complications	<input type="checkbox"/> Diabetes Mellitus-lifestyle Adaptations	<input type="checkbox"/> Diabetes Mellitus-stress Management
<input type="checkbox"/> Diabetes Mellitus-cultural/spiritual Aspects Of Health	<input checked="" type="checkbox"/> Diabetes Mellitus-literature	<input checked="" type="checkbox"/> Diabetes Mellitus-tests
<input checked="" type="checkbox"/> Diabetes Mellitus-disease Process	<input checked="" type="checkbox"/> Diabetes Mellitus-medications	<input type="checkbox"/> Diabetes Mellitus-treatment
<input checked="" type="checkbox"/> Diabetes Mellitus-equipment	<input checked="" type="checkbox"/> Diabetes Mellitus-nutrition	<input type="checkbox"/> Diabetes Mellitus-wound Care
<input checked="" type="checkbox"/> Diabetes Mellitus-exercise	<input type="checkbox"/> Diabetes Mellitus-pain Management	
<input checked="" type="checkbox"/> Diabetes Mellitus-follow	<input type="checkbox"/> Diabetes Mellitus-periodontal Disease	
<input checked="" type="checkbox"/> Diabetes Mellitus-foot Care And Examinations	<input type="checkbox"/> Diabetes Mellitus-prevention	

Type of Training Individual Group

Comprehension Level **GOOD**

Length **10** (min)

Readiness to Learn **RECEPTIVE**

OK Cancel

Documenting Patient Education for MU (10)

Education on Wellness tab.

The screenshot displays a medical software interface for patient education documentation. The patient is identified as David Alpha, with a date of birth of 26-Feb-1999. The current visit is on 12-Sep-2014 at 2:00 PM, conducted by BLUE FP PRINCIPLE (BARTLETT, ROBIN A.).

The **Education** table lists the following records:

Visit Date	Education Topic	Comprehension	Status	Objectives	Comment	Provider	Length	Type	Location	Code
09/12/2014	Diabetes Mellitus-Complications	GOOD				BARTLETT,ROBIN A	1	Individual	OHA HOSPITAL	NO CODE SELECTED
09/12/2014	Diabetes Mellitus-Disease Process	GOOD				BARTLETT,ROBIN A	1	Individual	OHA HOSPITAL	NO CODE SELECTED
09/12/2014	Diabetes Mellitus-Equipment	GOOD				BARTLETT,ROBIN A	1	Individual	OHA HOSPITAL	NO CODE SELECTED
09/12/2014	Diabetes Mellitus-Exercise	GOOD				BARTLETT,ROBIN A	1	Individual	OHA HOSPITAL	NO CODE SELECTED
09/12/2014	Diabetes Mellitus-Follow-Up	GOOD				BARTLETT,ROBIN A	1	Individual	OHA HOSPITAL	NO CODE SELECTED
09/12/2014	Diabetes Mellitus-Foot Care And Examinations	GOOD				BARTLETT,ROBIN A	1	Individual	OHA HOSPITAL	NO CODE SELECTED
07/30/2014	Summary Clinical Document/Literature					TAYLOR,DAVID R			OHA TEEN HEALTH CLINIC	422735006
07/28/2014	Chronic Urinary Tract Infection Disease Process	GOOD				TAYLOR,DAVID R		Individual	OHA DIABETES CLINIC	157928006
05/12/2014	Summary Clinical Document/Literature					ELLER,JIM D			OHA HOSPITAL	422735006
05/12/2014	Summary Clinical Document/Literature					ELLER,JIM D			OHA HOSPITAL	422735006
05/12/2014	Summary Clinical Document/Literature					ELLER,JIM D			OHA HOSPITAL	422735006
05/12/2014	Summary Clinical Document/Literature					ELLER,JIM D			OHA HOSPITAL	422735006
05/12/2014	Summary Clinical Document/Literature					ELLER,JIM D			OHA HOSPITAL	422735006

The **Exams** table lists the following records:

Visit Date	Exams	Result	Comments	Provider	Location
05/16/2013	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		ELKINS,KATHRYN	OHA HOSPITAL
05/16/2013	ALCOHOL SCREENING	POSITIVE		ELKINS,KATHRYN	OHA HOSPITAL
05/10/2013	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		WACHACHA,SARAH	OHA HOSPITAL
05/10/2013	ALCOHOL SCREENING	PRESENT AND PAST		WACHACHA,SARAH	OHA HOSPITAL
03/20/2013	ALCOHOL SCREENING	POSITIVE		ELKINS,KATHRYN	OHA HOSPITAL
02/06/2013	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		ELKINS,KATHRYN	OHA URGENT CARE
02/04/2013	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		WACHACHA,SARAH	OHA HOSPITAL
06/12/2012	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		GONZALEZ,EDWARD J	OHA HOSPITAL
06/12/2012	ALCOHOL SCREENING	NORMAL/NEGATIVE		GONZALEZ,EDWARD J	OHA HOSPITAL
04/17/2012	FOOT INSPECTION	ABNORMAL		WACHACHA,SARAH	OHA HOSPITAL
04/09/2012	INTIMATE PARTNER VIOLENCE	PRESENT		WACHACHA,SARAH	OHA HOSPITAL
03/29/2012	DIABETIC FOOT EXAM COMPLETE	ABNORMAL		MCCASLIN,GINGER	OHA DIABETES CLINIC
08/08/2011	COLOR BLINDNESS	NORMAL/NEGATIVE		WACHACHA,SARAH	OHA HOSPITAL

The **Health Factors** table lists the following records:

Visit Date	Health Factor	Category	Comment
05/16/2013	Current Smokeless	Tobacco	
05/10/2013	Non-tobacco User	Tobacco	
04/01/2013	Exposure To Environmental Tobacco Smoke	Tobacco	
03/20/2013	Smoker In Home	Tobacco	
02/06/2013	Page 2/4	Alcohol/Drug	
02/06/2013	Smoke Free Home	Tobacco	
02/06/2013	Exposure To Environmental Tobacco Smoke	Tobacco	
02/06/2013	Previous (former) Smoker	Tobacco	
02/04/2013	Page 1/4	Alcohol/Drug	
12/19/2012	Some Activity	Activity	
12/19/2012	Desk Job	Occupation	
12/03/2012	Active	Activity	
06/12/2012	Never Used Smokeless Tobacco	Tobacco	
06/12/2012	Non-tobacco User	Tobacco	

MENU: Medication Reconciliation

- * S1= The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
- * S2= Med rec for more than 50% of transitions of care (core)
- * **Exclusion**
 - * An EP who was not the recipient of any transitions of care during the EHR reporting period.

EHR Demo (YES)

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

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

MENU: Transition of Care Summary (Summary of Care)

- * S1= The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
- * S2=
 1. Provides a summary of care record for more than 50% of transitions of care and referrals
 2. Provides a summary of care record using electronic transmission through CEHRT eHealth exchange for more than 10% for transitions of care and referrals
 3. Transmits at least 1 summary of care record electronically to a recipient with a different EHR vendor or to the CMS test EHR (core)
- * **Exclusion**
 - * An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

EHR Demo (NO)

Transition of Care/Summary of Care Patient Summary

Get Well Clinic: Health Summary

Created On: August 6, 2012

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

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[ALLERGIES, ADVERSE REACTIONS, ALERTS](#)

TOC -Provide Summary Record (1)

Measure 1:

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

Measure 2:

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

or:

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

Measure 3:

- * EPs must also satisfy one of the following criteria:
- * Conduct one or more successful electronic exchanges of a summary of care document, as part of which is counted in “measure 2” with a recipient who has EHR technology that was developed/ designed by a different EHR technology developer than the sender’s EHR technology.
- * Conduct one or more successful tests with the CMS designated test EHR during the EHR reporting period.

TOC -Provide Summary Record (2)

What that means for you:

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

Are you excluded from doing this?

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

TOC -Provide Summary Record (3)

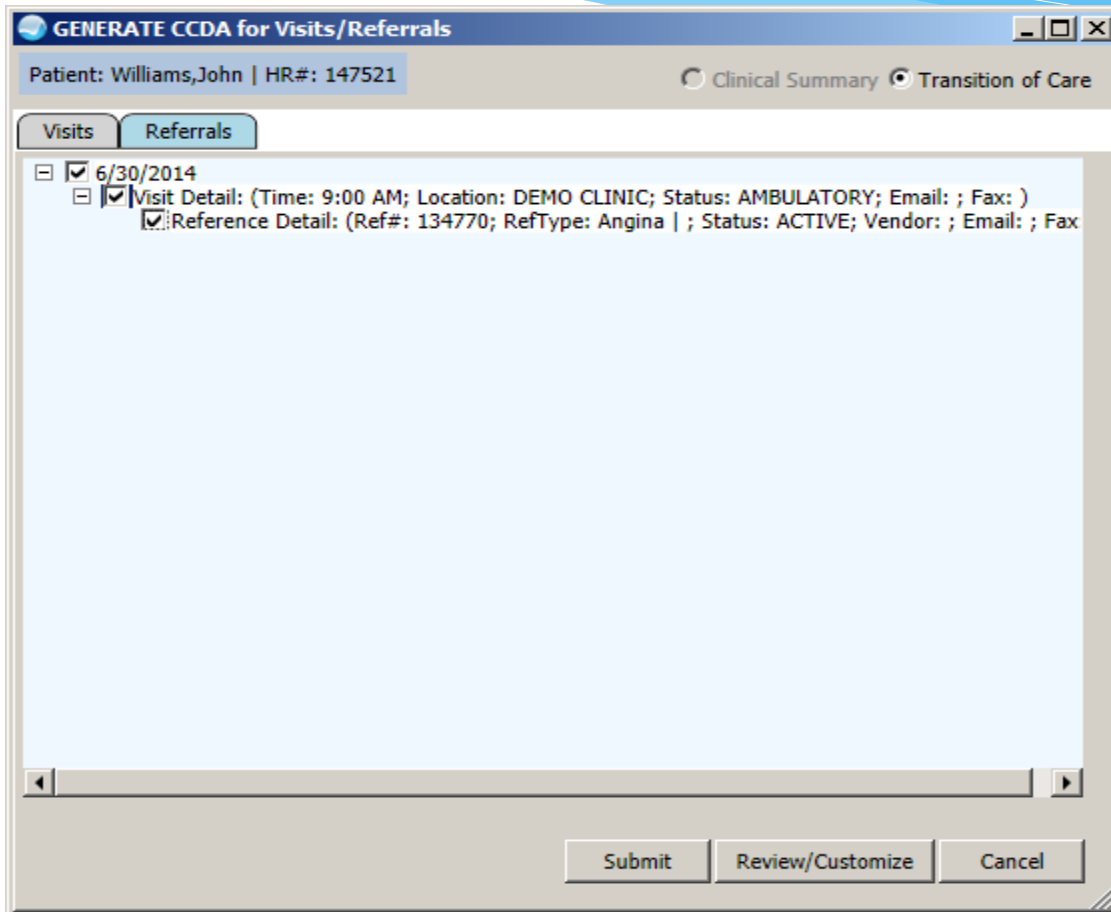
- * This measure only counts for outside referrals (not Consults).
- * The measure evaluates referrals initiated during face-to-face visits within the reporting period.
- * To be in the denominator, a referral must be approved during the reporting period and have an appointment date entered in the RCIS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

Transmit TOC

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

TOC Dialog for Vendors With Direct Messaging

Notice the new **Submit** button.



TOC Demonstration

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

Receiving CCDA Documents

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



CIR Tool

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

Selecting and Viewing Documents

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

The screenshot shows the CIR Tool interface for a patient named Jones, Isabella. The main window displays a table of documents generated by CCDA. A right-click context menu is open over one of the documents, showing options like 'FULL CCDA', 'ALLERGENS, ADVERSE REACTIONS, ALERTS', 'ENCOUNTERS', 'IMMUNIZATIONS', 'MEDICATIONS', 'CARE PLAN', 'REASON FOR REFERRAL', 'PROBLEMS', 'PROCEDURES', 'FUNCTIONAL STATUS', 'RESULTS', 'SOCIAL HISTORY', and 'VITAL SIGNS'. Below the document list, there is a 'Clinical Document' table and a 'Reconciled Problems' table.

Problem	Status	Onset	Source	Last Date
Pneumonia	ACTIVE	08/06/2012	Dr Henry Seven	08/06/2012
Asthma	ACTIVE	01/03/2007	Dr Henry Seven	08/06/2012

Problem	Status	Onset	Action
Hypoxemia	Inactive	08/06/2012	RPMS Reviewed, No Action
Leptosy	Chronic	08/06/2012	RPMS Reviewed, No Action
Asthma(triggered by cold and cockroaches	Chronic	01/03/2007	RPMS Reviewed, No Action
Pneumonia(dx by xray in ER Left lower lobar infiltrate	Inactive	08/06/2012	RPMS Reviewed, No Action
Irritable bowel syndrome characterized by alternating bowel habit	Episodic		RPMS Reviewed, No Action

Tabs: Problems, Adverse Reactions, and Medications

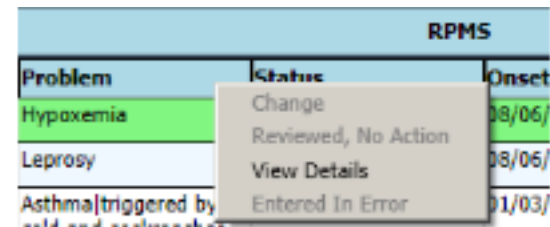
Problems					Adverse Reactions					Medications				
RPMS					Clinical Document									
Problem	Status	Onset	Last Date	Problem	Status	Onset	Source	Last Date						
^ Reconciled Problems														
								Add Problem	Accept Problems	Cancel				
Problem	Status	Onset	Action											

Problems					Adverse Reactions					Medications				
RPMS					Clinical Document									
Problem	Status	Onset	Last Date	Problem	Status	Onset	Source	Last Date						
^ Reconciled Problems														
								Add Problem	Accept Problems	Cancel				
Problem	Status	Onset	Action											

Problems					Adverse Reactions					Medications				
RPMS					Clinical Document									
Type	Medication	Description	Status	Last Date	Medication	Description	Status	Source	Last Date					
^ Reconciled Medications														
								Add Outside Medication	Add OP Medication	Accept Meds	Cancel			
Medication	Description	Status	Action											

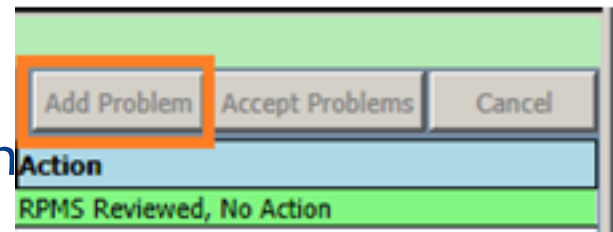
Reconciling Elements From Incoming Document

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



The screenshot shows a table titled "RPMS" with three columns: "Problem", "Status", and "Onset". The "Hypoxemia" row is highlighted in green. A context menu is open over this row, showing options: "Change", "Reviewed, No Action", "View Details", and "Entered In Error".

Problem	Status	Onset
Hypoxemia	Reviewed, No Action	08/06/
Leprosy	View Details	08/06/
Asthma triggered by cold and seasonal	Entered In Error	01/03/



The Finished Product

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

The screenshot shows the CIR Tool interface for patient Jones, Isabella. At the top, there are buttons for 'Accept All' and 'Cancel All'. Below this is a table of generated problems with columns for Source, Responsible Party, Encounter Date, Created, Class, and Reconciled. The 'Reconciled Problems' table is as follows:

Problem	Status	Onset	Last Date	Action
Hypoxemia	Inactive	08/06/2012	10/4/2013	RPMS Reviewed, No Action
Leprosy	Chronic	08/06/2012	10/4/2013	RPMS Reviewed, No Action
Asthma(triggered by cold and cold/flu)	Chronic	01/03/2007	10/4/2013	RPMS Reviewed, No Action
Pneumonia(dx by xray in ER Left lower lobar infiltrate)	Inactive	08/04/2012	3/28/2014	RPMS Reviewed, No Action
Irritable bowel syndrome characterized by alternating bowel habit	Episodic		5/19/2014	RPMS Reviewed, No Action

The 'Closing CIR' dialog box contains the following text: "Clicking OK will reset all reconciled changes for this patient and close the CIR Tool." Below the text are 'OK' and 'Cancel' buttons.

Notes

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

Clinical Summary and Transfer of Care Documents

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

Consolidated Clinical Document Architecture (CCDA)

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

Clinical Summaries

Get Well Clinic: Health Summary

Created On: August 6, 2012

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

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[ALLERGIES, ADVERSE REACTIONS, ALERTS](#)

Provide Clinical Summaries

What this measure requires:

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

What that means for you:

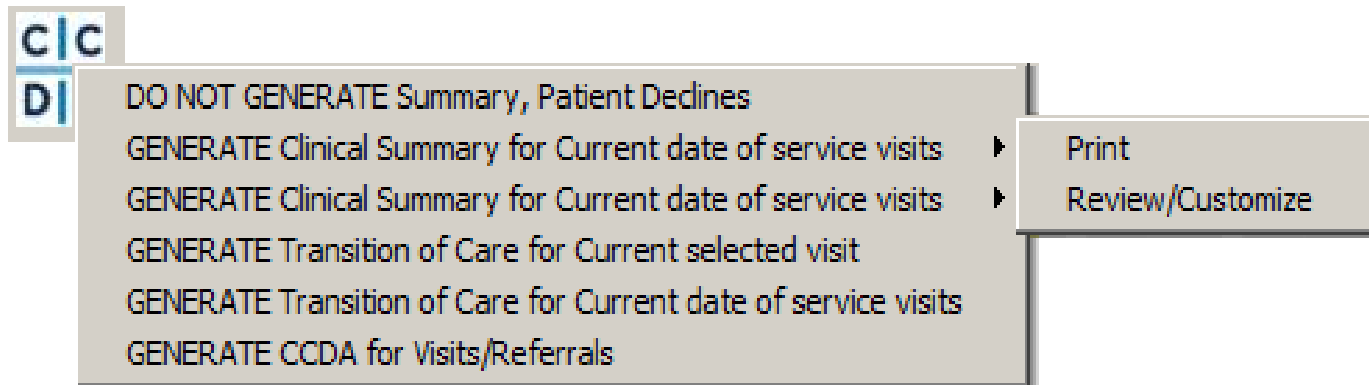
- * For more than half of your office visits, patients receive a clinical summary within one day of the visit.

Are you excluded from doing this?

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

Generating a Clinical Summary

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



Sample Customizing Screen

The screenshot shows a software window titled "CCDA - Clinical Summary". The patient information is "Dataportability, Patienttwo" with HR# 147500. The visit date is July 15, 2014. The main content area is titled "Clinical Summary from 2013 DEMO HOSPITAL" and contains patient details: PATIENTTWO DATAPORTABILITY, HR#: XFA: 147500, Date of Birth: April 1, 1955, Sex: Female, Race: American Indian or Alaska Native, and Preferred Language: English. It also lists the visit date and location. A "Table of Contents" section lists various clinical categories with hyperlinks. A "Reason for Visit" section is highlighted in yellow, showing "No Reason Information for the extraction criteria". The bottom of the window has a "Document 1 of 1" indicator, a "Finalized" checkbox, and "Print" and "Cancel" buttons.

CCDA - Clinical Summary

Patient: Dataportability, Patienttwo | HR#: 147500

Visit Date: July 15, 2014

Clinical Summary from 2013 DEMO HOSPITAL

Patient: PATIENTTWO DATAPORTABILITY **HR#:** XFA: 147500
Date of Birth: April 1, 1955 **Sex:** Female
Race: American Indian or Alaska Native **Ethnicity:** Not Hispanic or Latino
Preferred Language: English

Visit Date: July 15, 2014
Visit Location: 2013 DEMO HOSPITAL; UPTOWN USA; ALBUQUERQUE, NE 89701

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- [Reason for Visit](#)
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- [Allergies, Adverse Reactions, Alerts](#)
- [Medications](#)
- [Procedures](#)
- [Today's Instructions and Patient Decision Aids](#)
- [Plan of Care](#)
- [Social History \(Smoking Status\)](#)
- [Recent Lab Results](#)
- [Immunizations](#)
- [Recent Vital Signs](#)
- [Care Team](#)

Reason for Visit

No Reason Information for the extraction criteria

Problems / Encounter Diagnoses

Document 1 of 1 Finalized Print Cancel

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

MENU: Immunization Registries Data Submission

- * S1= Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful, (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically), except where prohibited.
- * S2= Successful ongoing submission for the entire EHR reporting period (core)
- * **Exclusion**
 - * An EP who administers no immunizations during the EHR reporting period, where no immunization registry has the capacity to receive the information electronically, or where it is prohibited.
- * **YES/NO Attestation Requirements**
EHR Demo (NO)

MENU: Syndromic Surveillance

- * S1= Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful, (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically) except where prohibited.
- * S2= Successful ongoing submission for the entire EHR reporting period (menu)
- * **Exclusion**
 - * An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or if it is prohibited.

YES/NO Attestation Requirements.

EHR Demo (NO)

MENU: Record Electronic Notes

S1= N/A

S2= What this measure requires:

- * Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients with at least one office visit during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable text notes under this measure.

What that means for you:

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

Are you excluded from doing this?

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

EHR Demo (YES)

Record Electronic Notes

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

Record Electronic Notes

The screenshot displays the RPMS-EHR interface for a patient named Michael Allen. The main window shows a note titled "GENERAL" dated 01/07/14. The note content includes a patient history: "Patient has had a cholecystectomy and an appendectomy. Patient has had a history of recurring urinary bladder infections, but has had no bladder infections in the past 2 months." The interface also shows a toolbar with various clinical tools like "Problem List", "Advx React", "Medications", and "Orders: 0". The status bar at the bottom indicates the patient is "DOCTOR_DEMO1" and the system is "2013-DEMO.NA.IHS.GOV".

MENU: Imaging

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

MENU: Patient Family Health History

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

Family Health History

RPMS-EHR ** EHR P13 **

User Patient Refresh Data Tools Help eSig Clear Clear and Lock Community Alerts Dosing Calculator Rx Print Settings Imaging

PRIVACY PATIENT CHART RESOURCES RCIS DIRECT WebMail

Familyhistory.Patient 999996 01-Mar-1980 (34) F DEMO CLINIC DOCTOR_DEMO7 03-Sep-2014 16:09 Ambulatory Primary Care Team Unassigned

No Postings PUL Lab Entry Pharm Ed Refill "Q" Orders: 0 Problem List Nds Rvw Adv React Nds Rvw Medications Nds Rvw CIC DIA Asthma Action Plan PWH Med Rec eRx Receipt Reviewed/Updated Visit Summary

Notifications Cover Sheet Triage Wellness Problem Mngt Prenatal Well Child Medications Labs Orders Notes Consults/Referrals Superbill D/C Summary Suicide Form Reports

IPL Family Hx Surgical Hx Pt Goals Anticoag Eyeglass AMI Stroke

Family History List Use Edit Relation to delete, add, or edit a relative's condition Get SCT Add Relation Edit Relation Delete Relation

Relation	Name	Status	Age At Death	Cause of Death	Multiple Birth	Multiple Birth Type	Provider Narrative	Age at Diagnosis	Date Modified	ICD
NATURAL FATHER	John	LIVING					FH: Asthma	50	01/07/2014	V17.5
NATURAL DAUGHTER	Jane	LIVING					FH: Hypertension	10	01/07/2014	V17.49
NATURAL BROTHER	Jack	LIVING					FH: Diabetes mellitus	50	01/07/2014	V18.0
GRANDFATHER	Bob	DECEASED	At age	Emphasema			FH: Eczema	22	01/07/2014	V19.4

DOCTOR_DEMO7 2013-DEMO.NA.IHS.GOV 2013 DEMO HOSPITAL 03-Sep-2014 16:16

MENU: Specialized registry

- * S1= N/A
 - * S2= Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period
- EHR Demo (NO)

References

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

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QUESTIONS ????