



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# **RPMS-EHR Meaningful Use Configuration Guide: Stage 1**

## **Vol. 1: Eligible Professionals**

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## Preface

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

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

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

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

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

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

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

## 1.0 Introduction

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

Readers interested in this topic as it pertains to a hospital environment should refer to *RPMS-EHR Meaningful Use Configuration Guide: Stage 1, Vol. 2: Hospitals & Critical Access Hospitals*.

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

MU focuses on:

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

## 2.0 Background

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

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

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

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

## 2.1 Meaningful Use

MU is defined as using certified EHR technology to:

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

ARRA specifies the following three components of Meaningful Use:

- Use of certified EHR in a meaningful manner.

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

EHR certification and MU are not the same:

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

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

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

## 2.2 Stage 1 Meaningful Use Considerations

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

## 3.0 Using this Guide

Section 4.0 of this guide details the MU Performance Measures applicable to an EP:

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

### 3.1 Standard Content

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

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

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

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

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

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

## 3.2 Optional Content

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

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

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



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

### 3.3 Guidelines and Cautions

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

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

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

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

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

**Patient’s Refusal to Answer:** The provider is not penalized if a patient cannot or will not disclose information (such as the demographics asked for in Section 4.1.4); in such case, record the choice that covers the patient’s response (for example, ‘declined’). Again, what matters is that the field is not left empty.

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

## 4.0 Eligible Professionals

In order to meet MU requirements in Stage 1, an EP must:

- Meet the 15 Stage 1 Core Performance Measures described in Section 4.1.
- Meet 5 of the 10 Stage 1 Menu Set Performance Measures described in Section 4.2.
  - At least one must be a Public Health Measure
- Meet six Clinical Quality Measures (Section 4.1.11):
  - Three Core or Alternate Core
  - Three out of 38 from the Menu set

### 4.1 Stage 1 Core Performance Measures

#### 4.1.1 Computerized Provider Order Entry Medication Orders

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

**Type of Measure:** Rate

The number of unique patients in the denominator who have at least one medication order entered using CPOE.	>30%
The number of unique patients seen by the EP during the EHR reporting period who have at least one medication in their medication list.	

**Threshold:** More than 30% of all unique patients with at least one medication in their medication list seen by the provider during the EHR reporting period have at least one medication order entered using CPOE.

##### 4.1.1.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient in the Denominator:

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

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

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

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

**Denominator Inclusions:**

COUNT: each patient:

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

AND WHERE: the patient had one or more face-to-face visits with the eligible provider, (Service Category of A, S, O, or M)

**Measure Exclusion:** EPs who write (enter) fewer than 100 prescriptions during the EHR reporting period are excluded from this measure.

All medication orders for the provider's entire patient population will be counted; not just those for Medicare and Medicaid patients.

Transmission of the medication order is not required.

The provider must use the Certified EHR Technology.

**4.1.1.2 Configure RPMS**

1. Edit a drug for CPOE:

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

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

Select Pharmacy Data Management Option: DRED
  Drug Enter/Edit

Select DRUG GENERIC NAME: AMOXI
Lookup: GENERIC NAME
1  AMOXICILLIN 250MG CAP U/D           AM111
2  AMOXICILLIN 125MG/5ML SUSP        AM111
3  AMOXICILLIN 250 MG DENTAL PROPHY  AM111
4  AMOXICILLIN 250MG (30'S) CAP PREPACK AM111
5  AMOXICILLIN 250MG CAP             AM111

CHOOSE 1-5: 5
  AMOXICILLIN 250MG CAP

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

NATIONAL FORMULARY INDICATOR: YES
```

```

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

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

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

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

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

Strength => 250    Unit => MG

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

LOCAL POSSIBLE DOSAGES:

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

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

```

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

MARK THIS DRUG AND EDIT IT FOR:
O - Outpatient
U - Unit Dose
I - IV
W - Ward Stock
    
```

```

D - Drug Accountability
C - Controlled Substances
X - Non-VA Med
A - ALL

Enter your choice(s) separated by commas :

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

AMOXICILLIN 250MG CAP is already matched to

    AMOXICILLIN CAP,ORAL

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

Select DRUG GENERIC NAME:
    
```

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

```

Select IHS Core Option: EHR
EHR MAIN MENU

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

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

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

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

```

DEMO HOSPITAL                RPMS-EHR Management                Version 1.1
                             Order Entry Configuration

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

Select Order Entry Configuration Option: MNU
Order Menu Management

DEMO HOSPITAL                RPMS-EHR Management                Version 1.1
                             Order Menu Management

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

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

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

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

```

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

-----

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

-----

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

Select QUICK ORDER NAME:
    
```

4. Place the quick order on an order menu:

```

Menu Editor                Apr 19, 2011 13:59:56                Page: 1 of 3
Menu: PSOZM OUTPATIENT MEDS                Column Width: 40
  1                                          2
|  Amlodipine 5mg PO DAILY                Furosemide 20mg PO BID
|  Amoxicillin 250mg/5ml Susp 5ml PO Q8H  Glyburide 2.5mg PO QAM
|  Atorvastatin 10mg PO DAILY              Hydrochlorothiazide 25mg PO BID
|  Azithromycin 250mg PO DAILY X 10 DAYS  Ipratropium Inhale 2 Puffs QID
+  Captopril 25mg PO TID                   Lisinopril 30mg PO DAILY
|  Clonidine 0.1mg PO BID                  Metaproterenol MDI 2 Puffs Q4H
|  Clopidogrel 75mg PO Daily               Nitrofurantoin 100mg PO DAILY
|  Digoxin 0.125mg PO DAILY                Nitrofurantoin 100mg PO BID
|  Docusate 100mg PO BID                   Potassium Chloride 10mEq PO BID
1  Doxazosin 2mg PO DAILY                  Potassium Chloride 20mEq PO BID
|  Erythromycin Oral Susp 250mg PO Q6H    Spironolactone 25mg PO QID
|  Erythromycin Ethylsuccinate (EES) 400
+
|  ALL OUTPATIENT MEDICATIONS...
+  + Next Screen - Prev Screen  ?? More Actions                >>>
  Add ...                Edit ...                Assign to User(s)  Select New Menu
  Remove ...                Toggle Display                Order Dialogs ...
Select Action: Next Screen//
    
```

```

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

AD  Add ...
    Menu Items                Text or Header                Row

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

ITEM:

Rebuilding menu display

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

### 4.1.1.3 Overview of the Ordering Keys

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

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

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

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



**Med Orders:**

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

**Nature of Order:**

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

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

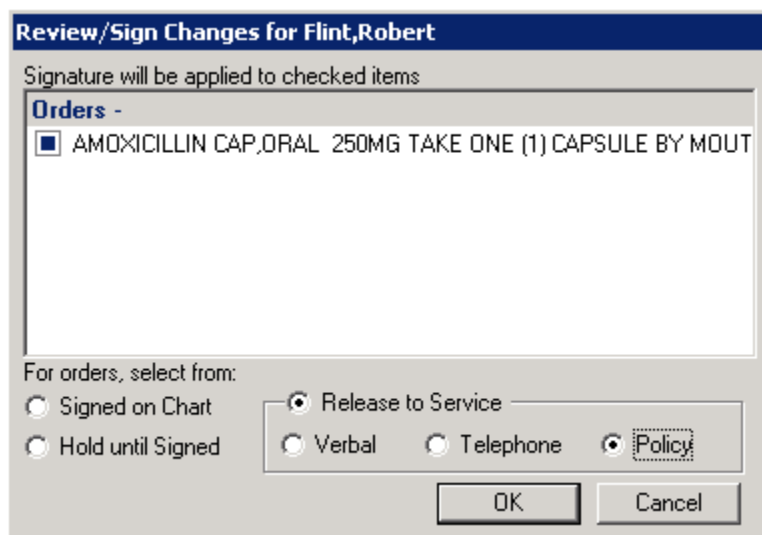


Figure 4-1: Medication order entered as Policy by a holder of the ORELSE key

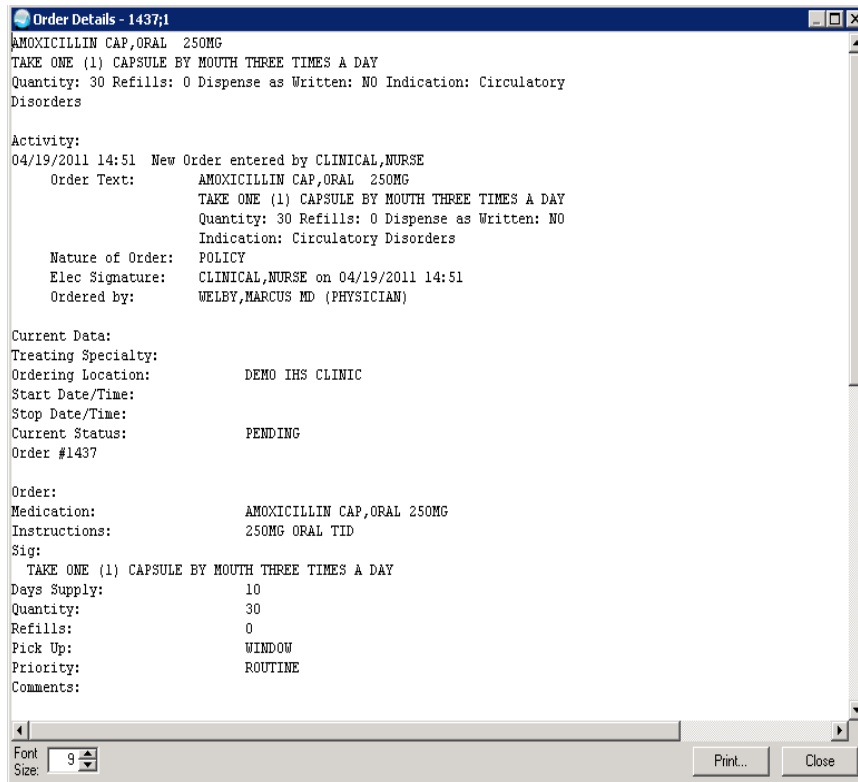


Figure 4-2: Order Details dialog showing an order that counts towards CPOE

#### 4.1.1.4 Order a medication in EHR (preferred method)

1. Select the **Orders** tab:

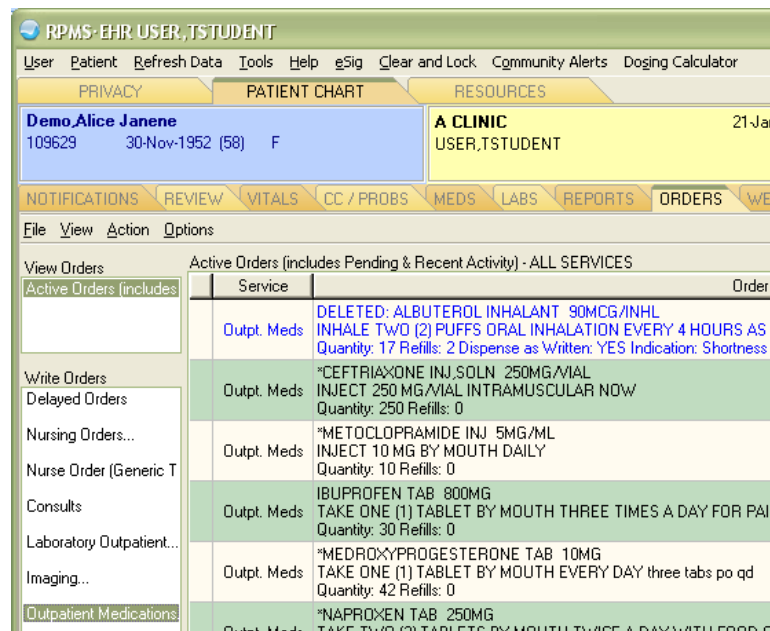


Figure 4-3: EHR Orders tab

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

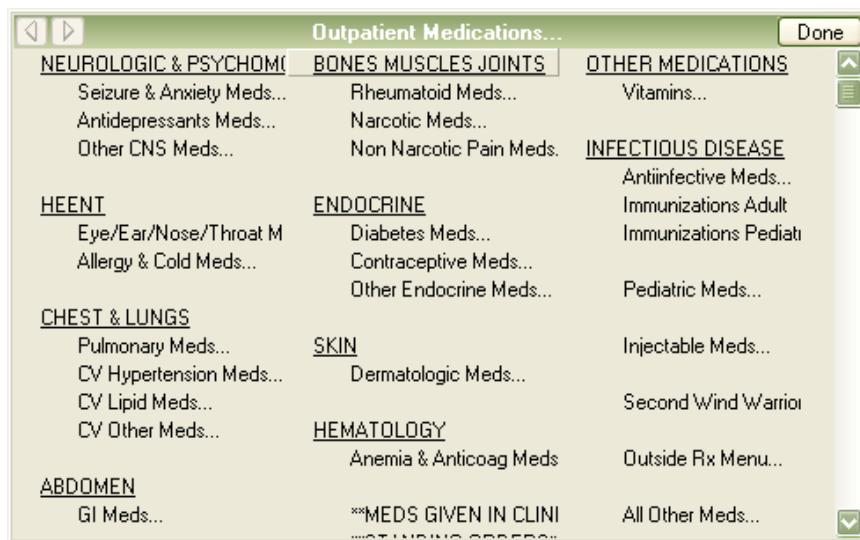


Figure 4-4: Outpatient Medications dialog

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

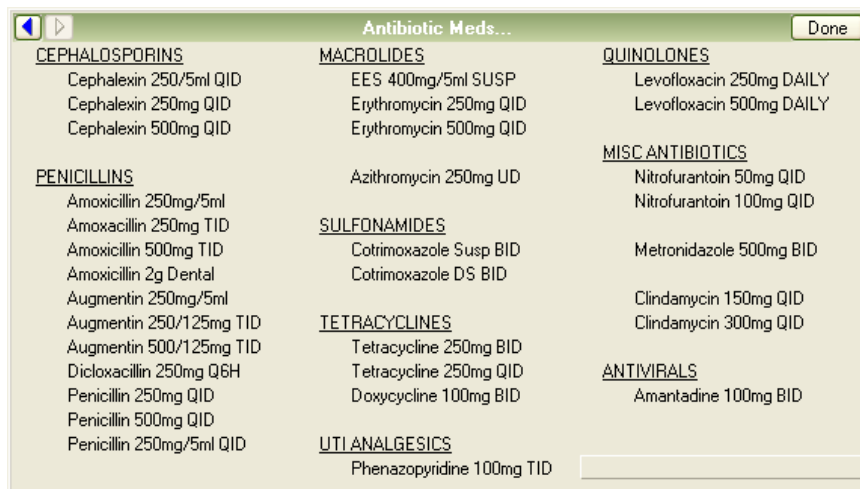


Figure 4-5: Antibiotic Medications dialog

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

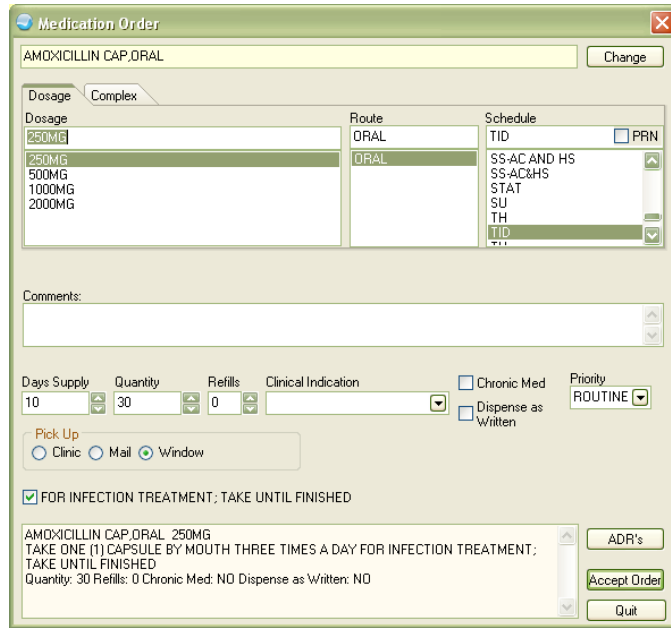


Figure 4-6: Medication Order dialog

5. Make any needed changes to the information on the Medication Order dialog.
6. Click **Accept Order** to complete the Medication Order and return to the Orders tab:



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

7. Review and sign the order:

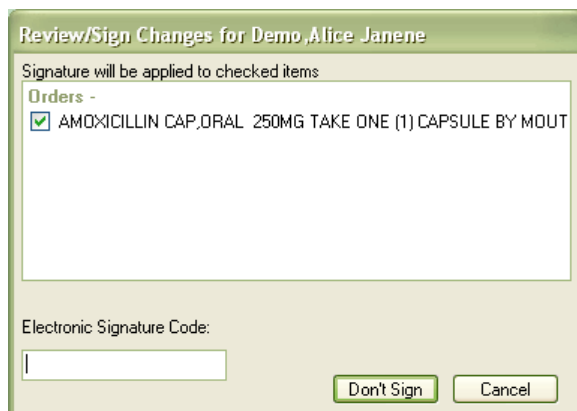


Figure 4-8: Review/Sign Changes dialog

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

Service	Order	Duration	Provider	Nurse	Chk	Chat	Status
Outpt. M...	AMOXICILLIN CAP,ORAL 250MG TAKE ONE (1) CAPSULE BY MOUTH THREE TIMES A DAY FOR INFECTION TREATMENT; TAKE UNTIL FINISHED Quantity: 30 Refills: 0 Dispense as Written: NO Indication: OTITIS		User X				pending
Outpt. Meds	CEFTRIAZONE INJ SOLN 250MG/50ML INJECT 250 MG/50ML INTRAMUSCULAR NOW Quantity: 250 Refills: 0	Start: 08/17/09 Stop: 01/08/09	Moody, E				active
Outpt. Meds	METOCLOPRAMIDE INJ 5MG/ML INJECT 10 MG BY MOUTH DAILY Quantity: 10 Refills: 0	Start: 08/17/09 Stop: 01/08/09	Moody, E				active
Outpt. Meds	SULFISODIUM TAB 800MG TAKE ONE (1) TABLET BY MOUTH THREE TIMES A DAY FOR PAIN; TAKE WITH FOOD OR MILK Quantity: 30 Refills: 0	Start: 08/17/09 Stop: 01/08/09	Moody, E				active
Outpt. Meds	MEDROXYPROGESTERONE TAB 10MG TAKE ONE (1) TABLET BY MOUTH EVERY DAY three tabs po qd Quantity: 42 Refills: 0	Start: 11/28/08 Stop: 08/05/07	User P				active

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

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

1. Select the **Orders** tab (see Section 4.1.1.4, Step 1).
2. Click **Outpatient Medications** in the **Write Orders** pane to display the Outpatient Medications dialog:

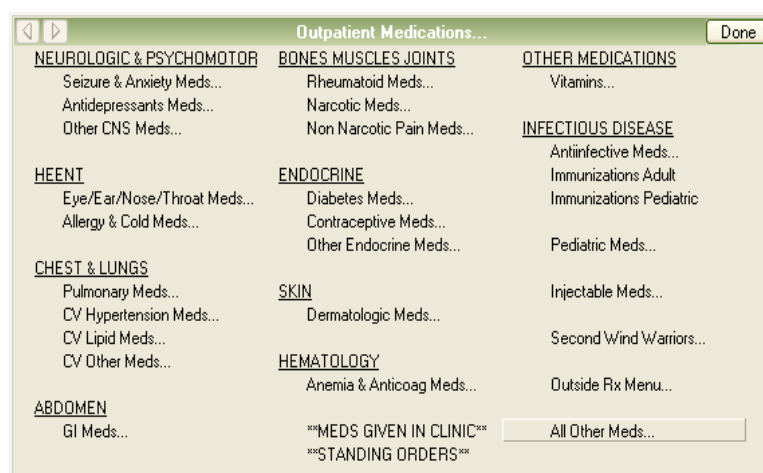


Figure 4-10: Outpatient Medications dialog

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

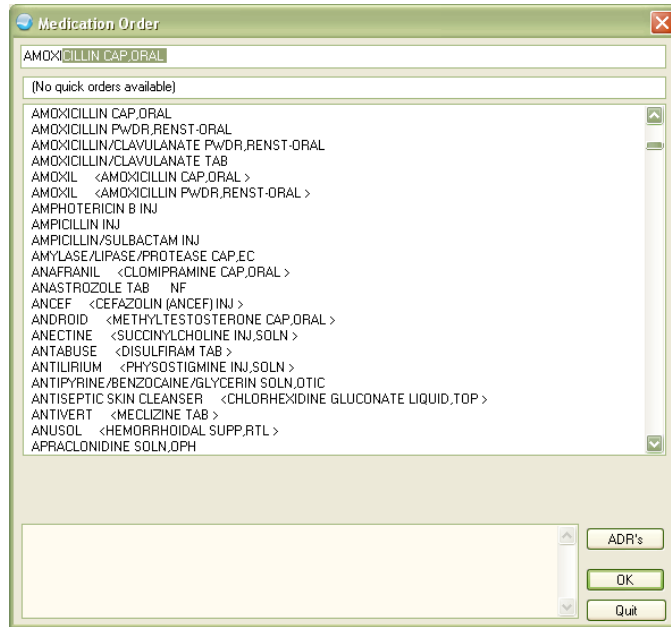


Figure 4-11: Medication Order selection dialog

- Find a medication in the list by typing its name in the uppermost field; the list is filtered to present matching medications.
- Click the medication in the list to open the **Medication Order** dialog:

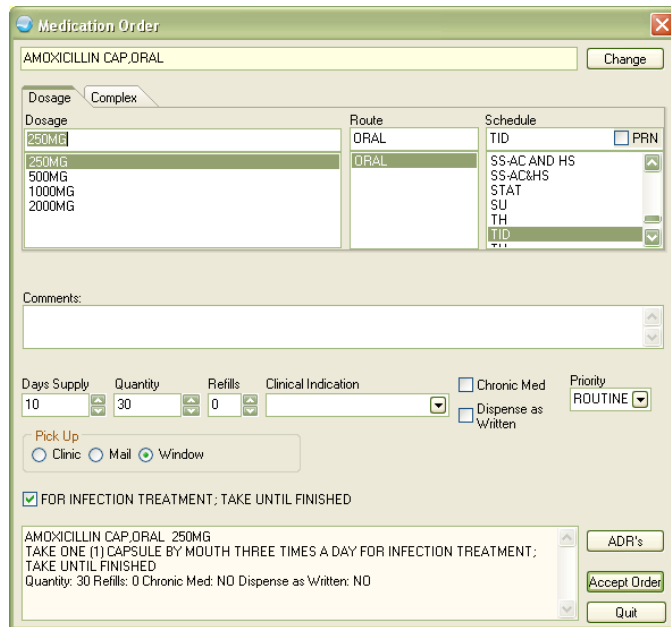


Figure 4-12: Medication Order dialog

6. Continue at Section 4.1.1.4, Step 5.

### 4.1.2 Drug-Drug & Drug-Allergy Checks

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

**Type of Measure:** Attestation

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

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

#### 4.1.2.1 RPMS MU Report Logic

**Measure Inclusions:**

COUNT: eligible providers

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

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

**Measure Exclusion:** None.

#### 4.1.2.2 Configure RPMS

1. Set the Allergy Package parameters:

```
Select GMR ALLERGY SITE PARAMETERS NAME:

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

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

Select GMR ALLERGY SITE PARAMETERS NAME: HOSPITAL

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

The following are the ten most common signs/symptoms:

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

```

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

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

AUTOVERIFY FOOD/DRUG/OTHER: NO AUTOVERIFY// ?
  Choose from:
    0      NO AUTOVERIFY
    1      AUTOVERIFY DRUG ONLY
    2      AUTOVERIFY FOOD ONLY
    3      AUTOVERIFY DRUG/FOOD
    4      AUTOVERIFY OTHER ONLY
    5      AUTOVERIFY DRUG/OTHER
    6      AUTOVERIFY FOOD/OTHER
    7      AUTOVERIFY ALL

AUTOVERIFY FOOD/DRUG/OTHER: NO AUTOVERIFY//
AUTOVERIFY OBSERVED/HISTORICAL: NO AUTOVERIFY//
AUTOVERIFY LOGICAL OPERATOR: AND//
REQUIRE ORIGINATOR COMMENTS: NO//
MARK ID BAND FLAG: NO//
METHOD OF NOTIFICATION: BULLETIN//
ALERT ID BAND/CHART MARK: NO//
SEND CHART MARK BULLETIN FOR NEW ADMISSIONS: NO//
FDA DATA REQUIRED: NO//
ENABLE COMMENTS FIELD FOR REACTIONS THAT ARE ENTERED IN ERROR: YES

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

2. Set the allergy parameters in EHR:

```

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

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

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

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

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

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

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



```

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

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

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

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

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

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

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

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

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

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

3. Enable Order Checks:

```

EHR MAIN MENU

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

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

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

```

Select RPMS-EHR Configuration Master Menu Option: ORD
  Order Entry Configuration
DEMO HOSPITAL                RPMS-EHR Management                Version 1.1
                              Order Entry Configuration

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

Select Order Entry Configuration Option: OCX
  Order Check Configuration
DEMO HOSPITAL                RPMS-EHR Management                Version 1.1
                              Order Check Configuration

  ACT    Activate/Inactivate Rules
  COM    Compile Rules
  ENA    Enable/Disable Order Checking System
  INQ    Expert System Inquiry
  PAR    Order Check Parameters ...

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

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

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

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

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

4. Configure the ten required Order Checks:

```

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

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

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

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

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

Choose from:
    
```

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

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

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

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

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

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

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

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

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

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

```

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

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

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

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

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

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

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

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

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

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

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

Select Order Check:
    
```

5. Mark the Order Checks as Mandatory:

```

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

DEMO HOSPITAL                RPMS-EHR Management
Version 1.1

                                Mark Order Checks Editable by User

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

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

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

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

Select Order Check: ??

Choose from:

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

Select Order Check: ALLERGIES UNASSESSIBLE

Order Check: ALLERGIES UNASSESSIBLE // ALLERGIES UNASSESSIBLE ALLERGIES UNASSESSIBLE

Editable by User?: NO

Select Order Check: ALLERGY-CONTRAST MEDIA INTERACTION

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

Editable by User?: NO

Select Order Check:

ALLERGY-DRUG INTERACTION

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

ALLERGY-DRUG INTERACTION

Editable by User?: NO

Select Order Check:

CRITICAL DRUG INTERACTION

Order Check: CRITICAL DRUG INTERACTION// CRITICAL DRUG INTERACTION

CRITICAL DRUG INTERACTION

Editable by User?: NO

Select Order Check:

DANGEROUS MEDS FOR PT > 64

Order Check: DANGEROUS MEDS FOR PT > 64 // DANGEROUS MEDS FOR PT > 64

DANGEROUS MEDS FOR PT > 64

Editable by User?: NO

Select Order Check:

```

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

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

Select Order Check:
GLUCOPHAGE-LAB RESULTS
Order Check: GLUCOPHAGE-LAB RESULTS// GLUCOPHAGE-LAB RESULTS
GLUCOPHAGE-LAB RESULTS
Editable by User?: N
O

Select Order Check:
NO ALLERGY ASSESSMENT
Order Check: NO ALLERGY ASSESSMENT// NO ALLERGY ASSESSMENT NO ALLERGY
ASSESSMENT
Editable by User?: NO

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

Select Order Check:
    
```

6. Review all order checks by Division level and by individual provider; delete any that are set at the 'User' level.
7. Run the Allergy Cleanup Utility (requires EHR Patch 8):

```

Select Core Applications Option: ALL
Adverse Reaction Tracking

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

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

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

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

Select one of the following:
    
```

```

1      Free Text
2      Ingredient
3      Drug Class

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

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

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

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

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

Select Item(s): DD
Detailed Display

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

```

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

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

Please choose only one entry for the detailed display.

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

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

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

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

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

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



```

Select Entries from list: 1

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

ARE YOU SURE? NO// YES

For patient DEMO,ALICE

Enter Causative Agent: ANGIOTEN

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

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

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

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

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

You selected ANGIOTENSIN II INHIBITOR
Is this correct? Y

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

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

Are you sure you want to use this reactant? YES

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

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

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

```

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

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

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

### 4.1.2.3 View Drug-Drug order check settings in EHR

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

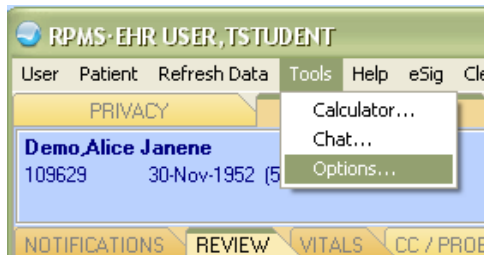


Figure 4-13: EHR Tools menu

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

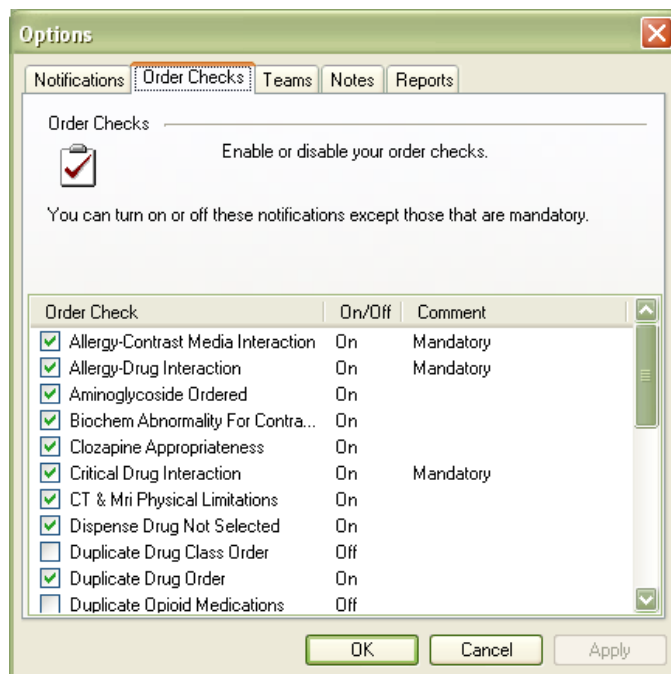


Figure 4-14: Options dialog, Order Checks tab

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

#### 4.1.2.4 The Order Check Report

- Select the “Establish Meaningful Use ‘Clean Date’” option to run a sub-routine in the MU report that checks all the EHR Order Check Configuration parameters that are required by Meaningful Use.
  - The Order Checking System must be enabled at the System level and not disabled at the Division level.
  - The Order Check Processing Flag must be enabled at the System level and not disabled at the Division, Service, Location, or User levels for the following order checks:

```

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

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

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

```

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

2010 DEMO HOSPITAL

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

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

Establish Meaningful Use 'Clean Date'

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

3. Use this data to correct any discrepancies.

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

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

```

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

                2010 DEMO HOSPITAL

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

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

Yes

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

#### 4.1.2.5 Order Check Processing, Sample Results

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

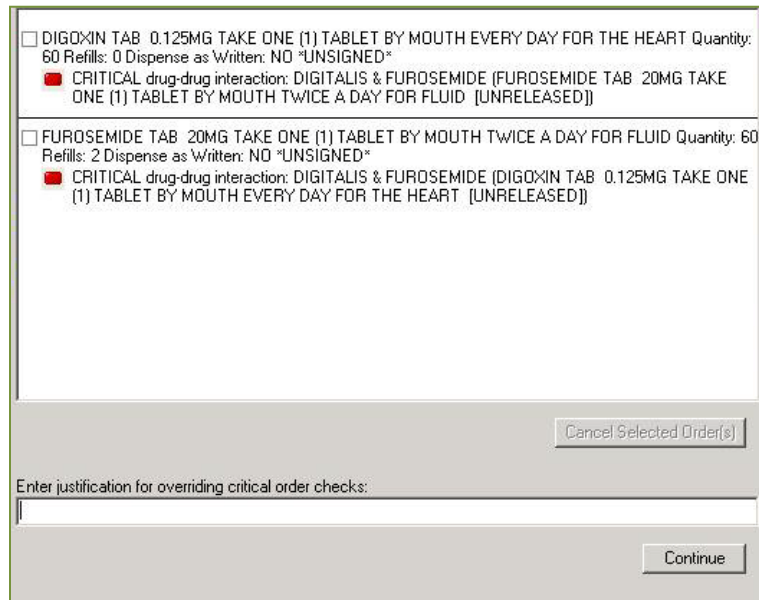


Figure 4-15: Drug Interaction Order Check dialog

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

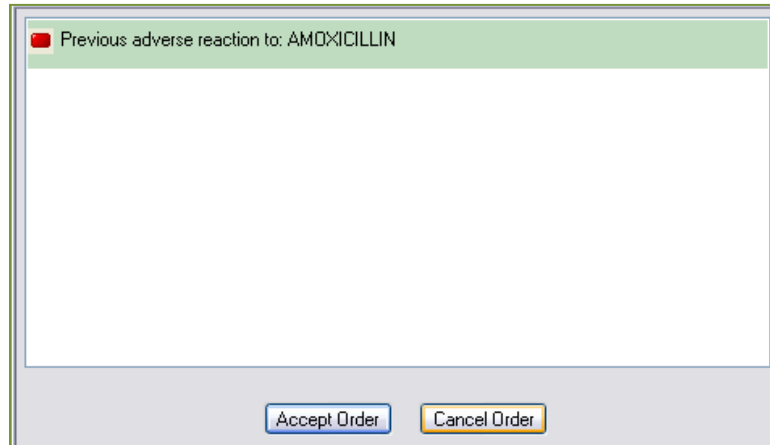


Figure 4-16: Drug Allergy Order Check dialog displaying a Drug Allergy reaction

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

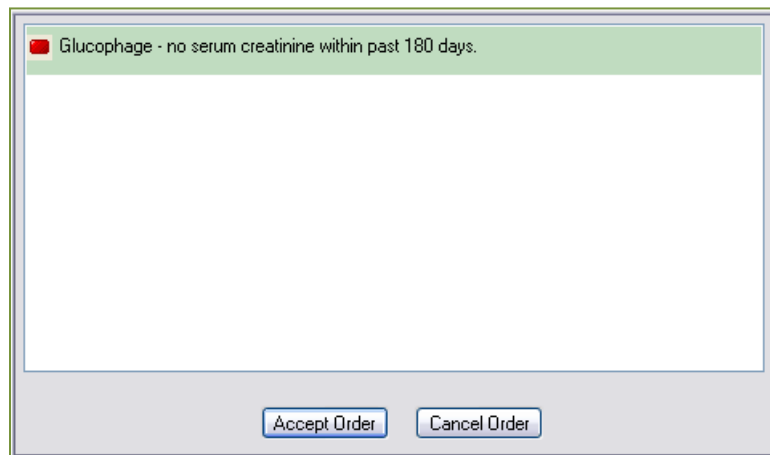


Figure 4-17: Drug-Lab Order Check dialog displaying a Drug Lab order check

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

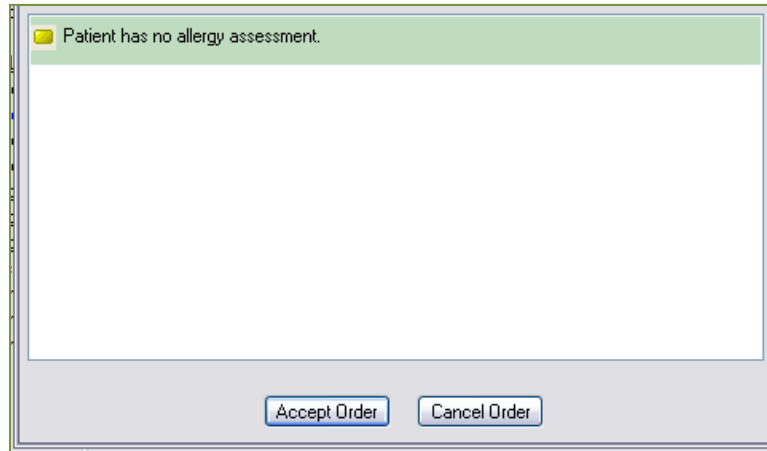


Figure 4-18: No Allergy Assessment Order Check dialog

### 4.1.3 ePrescribing

**Objective:** “Generate and transmit permissible prescriptions electronically.” *42 CFR Part 495.6,(d)(4)(i)*

**Type of Measure:** Rate

The number of prescriptions in the denominator generated and transmitted electronically.

The number of prescriptions written by the EP for drugs requiring a prescription in order to be dispensed, other than controlled substances, for patients whose records are in the certified EHR during the EHR reporting period. >40%

**Threshold:** More than 40% of all permissible prescriptions written by the provider during the EHR reporting period are transmitted electronically using certified EHR technology.

Successful receipt of the order at a pharmacy is not required for this measure.

### 4.1.3.1 RPMS MU Report Logic

#### Numerator Inclusions:

COUNT: each prescription in the denominator

WHERE: the prescription number:

IS: numeric

AND: the Nature of Order does not = “written”

OR THAT: starts with “X”

AND: the comment in the activity log contains “E-Prescribe”

#### Denominator Inclusions:

COUNT: each prescription electronically entered by the eligible provider

WHERE: the issue date falls during the EHR reporting period

AND WHERE: it was filled by an on-site pharmacy, off-site pharmacy, or on-site COTS pharmacy

AND WHERE: a prescription number exists

**Measure Exclusion:** EPs who write (enter) fewer than 100 prescriptions during the EHR reporting period are excluded from this measure.

#### Denominator Exclusions:

- Any entries of any type in the outside medication component.
- Any prescription which has a remark that contains “Administered in Clinic.”
- Any prescription for a Controlled Substance identified by DEA special handling code of 1, 2, 3, 4, or 5.

### 4.1.3.2 Configure RPMS

Sites without pharmacy use the Configure RPMS for CPOE instructions in Section 4.1.1.2

### 4.1.3.3 EHR Use

To view a report of successfully transmitted e-Prescriptions, click **eRx Receipt**:

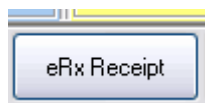


Figure 4-19: ePrescribing button



### 4.1.4 Demographics

**Objective:** “Record all of the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth.”

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

**Type of Measure:** Rate

The number of unique patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

>50%

---

The number of unique patients seen by the EP during the EHR reporting period.

**Threshold:** More than 50% of all unique patients seen by the provider during the EHR reporting period have demographics recorded as structured data.

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

#### 4.1.4.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient in the Denominator

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

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth

OR WHERE: a structured data element is present indicating:

THAT: The patient declines to provide the data element information

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

**Denominator Inclusions:**

COUNT: each patient

HAVING: one or more face-to-face visits with the eligible provider (defined as Service Category of A, S, O, or M) during the EHR reporting period

**Measure Exclusion:** None.

**4.1.4.2 Configure RPMS**

1. Set registration options:

```

OPT  Set Registration OPTIONS

                                PATIENT REGISTRATION
                                DEMO HOSPITAL
                                Set Registration OPTIONS

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

Ask for TRIBAL BLOOD QUANTUM: YES//

{...}

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

{...}

Print Ethnicity on Face Sheet?: YES//

{...}

Select REGISTRATION PARAMETERS SITE NAME :
    
```

2. Use RPMS Patient Registration to collect patient demographics:

```

CORE  IHS Core

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

Select IHS Core Option: AGM
    Patient registration
                                *****
                                *
                                *      INDIAN HEALTH SERVICE      *
                                *      PATIENT REGISTRATION SYSTEM  *
                                *      VERSION 7.1.8, AUG 25, 2005   *
                                *
                                *****

                                DEMO HOSPITAL
    
```

```

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

Select Patient registration Option: PTRG
Patient Registration

                                PATIENT REGISTRATION
                                DEMO HOSPITAL
                                Patient Registration

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

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

                                PATIENT REGISTRATION
                                DEMO HOSPITAL
                                EDIT a patient's file

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

Press the RETURN key to continue. : (upd:NOV 10, 2010)
IHS REGISTRATION EDITOR (page 1)                                DEMO HOSPITAL
=====
ARTERBERRY,MEGAN ANN      (upd:NOV 10, 2010)                    HRN:100866
=====
1. ELIGIBILITY STATUS : CHS & DIRECT
2. DATE OF BIRTH : 12/11/1954
3. PLACE OF BIRTH [CITY] : CHEROKEE      4.ST : NC
5. SEX : FEMALE
6. SOCIAL SECURITY NUMBER : 999999999(Verified by SSA)
7. MARITAL STATUS : MARRIED
8. CURRENT COMMUNITY : SOCO
-----
9. STREET ADDRESS [LINE 1] : PO BOX 681
10.STREET ADDRESS [LINE 2] :
11.STREET ADDRESS [LINE 3] :
12. CITY : CHEROKEE      13.ST : NC 14. ZIP CODE : 28719
15. LOCATION OF HOME :
-----
16.PHONE NUMBER [RESIDENCE] : 555-555-5390  17.WORK PHONE : 555-999-8336
18. OTHER PHONE :
-----
=====
CHANGE which item? (1-18) NONE//: P10
IHS REGISTRATION EDITOR (page 10)                                DEMO HOSPITAL
=====
ARTERBERRY,MEGAN ANN      (upd:NOV 10, 2010)                    HRN:100866 CHS & DIRECT
=====
                                Other Patient Data
    
```

```

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

```

```

9. GENERIC HEALTH PERMISSION:          10. PREFERRED METHOD:
-----
11. Number in Household...: 3
12. Total Household Income:           /
-----

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

  Ethnicity: NOT HISPANIC OR LATINO      N
  Method of Collection: SELF IDENTIFICATION//
  IHS REGISTRATION EDITOR (page 10)                                DEMO HOSPITAL
=====
ARTERBERRY,MEGAN ANN      (upd:NOV 12, 2010)      HRN:100866 CHS & DIRECT
=====

                                Other Patient Data
1. Ethnicity.....: NOT HISPANIC OR LATINO
2. Race.....: AMERICAN INDIAN OR ALASKA NATIVE
3. Primary Language.....: Interpreter required?
   Other languages spoken:
4. Preferred Language....:

-----
5. Migrant Worker?.....: NO      Type:           (upd NOV 12,2010)
6. Homeless?.....: NO      Type:           (upd NOV 12,2010)
-----

7. Internet Access.....:          Where:
8. EMAIL ADDRESS.....:
9. GENERIC HEALTH PERMISSION:          10. PREFERRED METHOD:
-----
11. Number in Household...: 3
12. Total Household Income:           /
-----

=====
CHANGE which item? (1-12) NONE//: 3
Add the PRIMARY LANGUAGE spoken at home by the patient: ENGLISH
  How proficient is the patient in speaking ENGLISH?: WE WELL
Select OTHER LANGUAGE SPOKEN:
IHS REGISTRATION EDITOR (page 10)                                DEMO HOSPITAL
=====
ARTERBERRY,MEGAN ANN      (upd:NOV 12, 2010)      HRN:100866 CHS & DIRECT
=====

                                Other Patient Data
1. Ethnicity.....: NOT HISPANIC OR LATINO
2. Race.....: AMERICAN INDIAN OR ALASKA NATIVE
3. Primary Language.....: ENGLISH           Interpreter required?
   Other languages spoken:
4. Preferred Language....: ENGLISH

-----
5. Migrant Worker?.....: NO      Type:           (upd NOV 12,2010)
6. Homeless?.....: NO      Type:           (upd NOV 12,2010)
-----

7. Internet Access.....:          Where:
8. EMAIL ADDRESS.....:

```

```

9. GENERIC HEALTH PERMISSION:          10. PREFERRED METHOD:
-----
11. Number in Household...: 3
12. Total Household Income:           /
-----

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

                                PATIENT REGISTRATION

                                DEMO HOSPITAL

                                Patient Registration

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

Select Patient Registration Option:
    
```

### 4.1.4.3 Review patient demographics in EHR

1. Click the Patient pane:

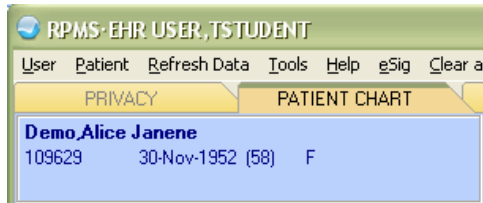


Figure 4-20: Patient pane

The **Patient Selection** dialog opens:

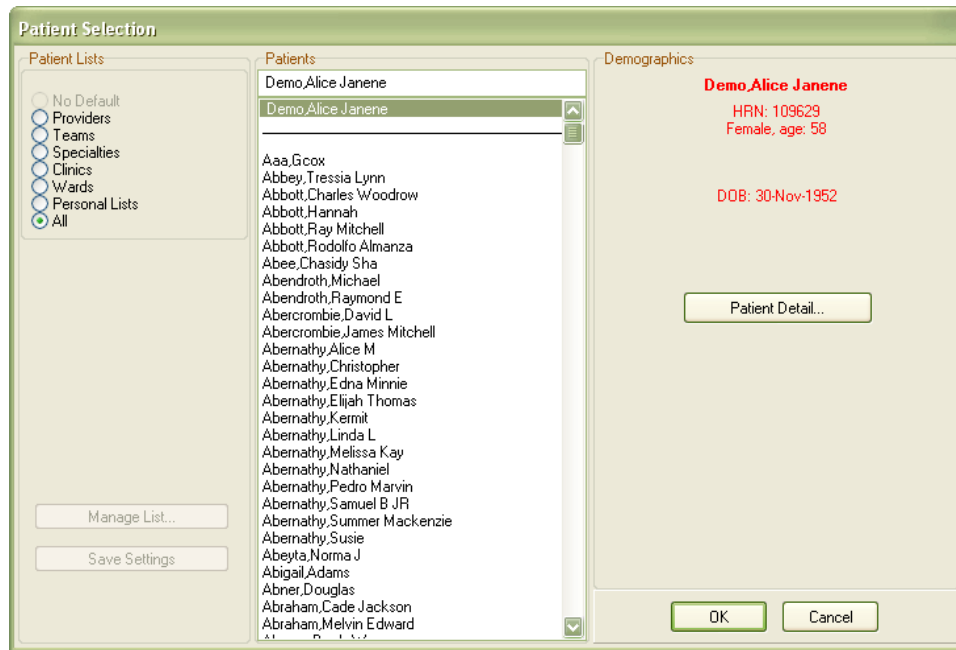


Figure 4-21: Patient Selection dialog

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

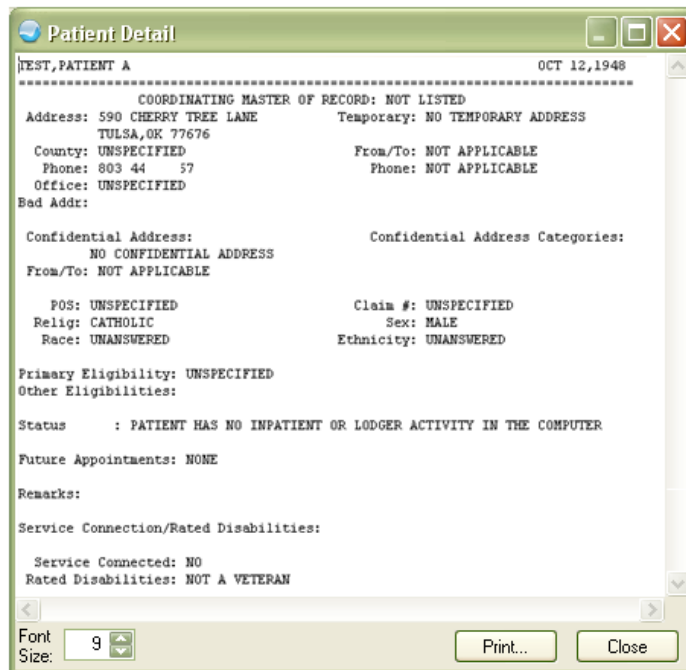


Figure 4-22: Patient Detail dialog

#### 4.1.5 Problem List

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

**Type of Measure:** Rate

The number of unique patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.	>80%
<hr style="width: 80%; margin: 0 auto;"/> The number of unique patients seen by the EP during the EHR reporting period.	

**Threshold:** More than 80% of all unique patients seen by the provider during the EHR reporting period have at least one entry or an indication that no problems are known for the patient recorded as structured data.

##### 4.1.5.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient in the Denominator

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

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

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

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

**Denominator Inclusions:**

COUNT: each patient

HAVING: one or more face-to-face visits with the eligible provider (Service Category of A, S, O, or M) during the EHR reporting period

**Measure Exclusion:** None.

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

##### 4.1.5.2 Configure RPMS

No RPMS configuration is required.

##### 4.1.5.3 EHR Use

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



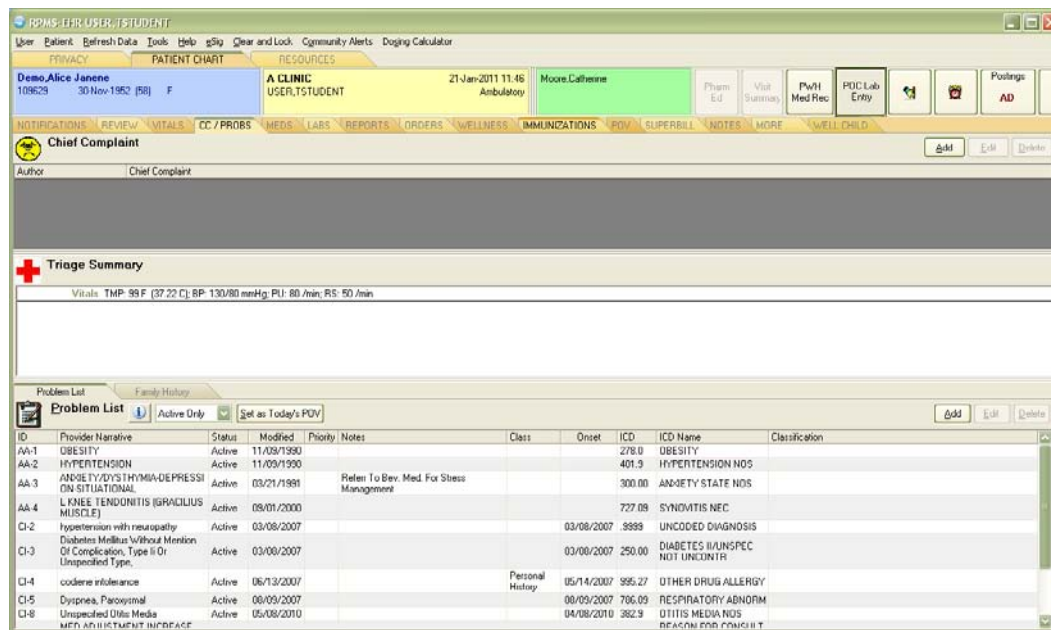


Figure 4-23: CC/PROBS tab selected in preparation for adding a problem to the Problem List

2. Click Add on the Problem List pane to display the Problem Maintenance dialog.
3. Type the first several characters of the problem name in the **ICD** field then click ellipses (...) to search for possible matches:

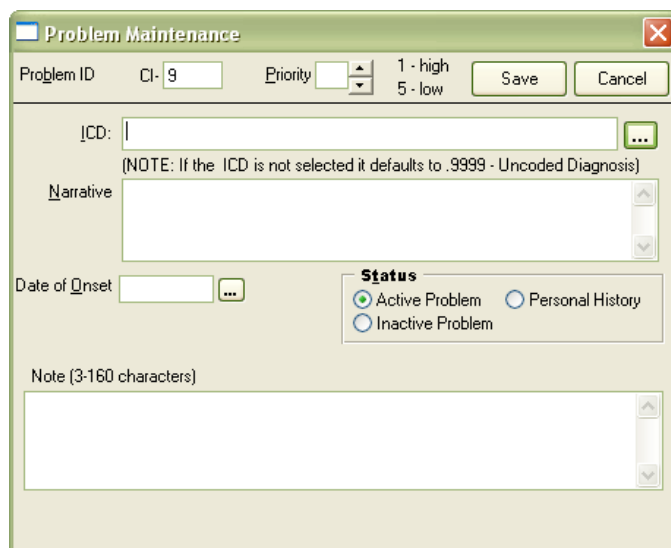


Figure 4-24: Problem Maintenance dialog

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

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

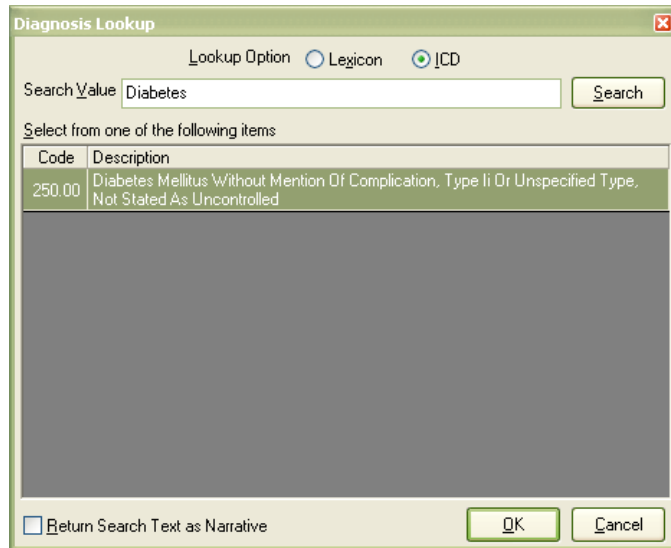


Figure 4-25: Diagnosis Lookup dialog

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

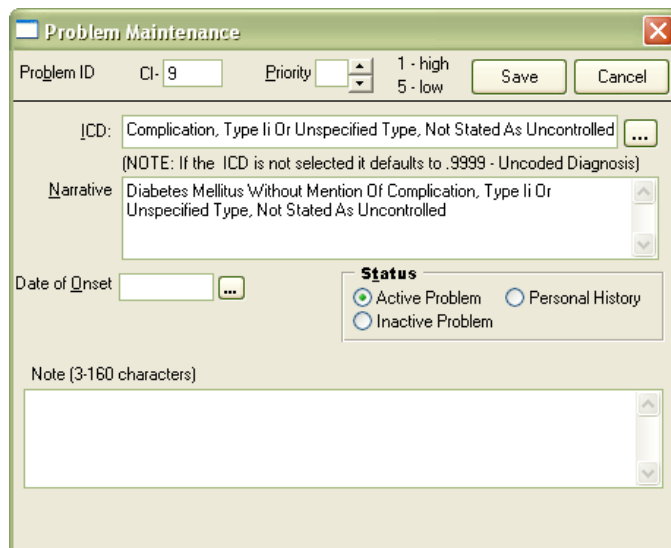


Figure 4-26: Problem Maintenance dialog displaying the selected Problem

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

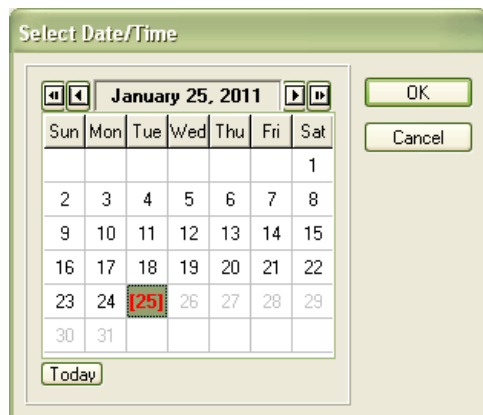


Figure 4-27: Select Date/Time dialog

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

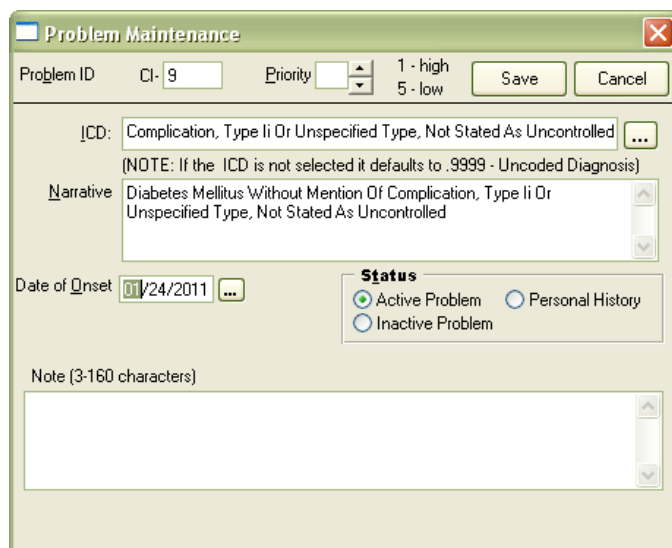


Figure 4-28: Problem Maintenance dialog with the Date of Onset added

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

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

Figure 4-29: Problem List pane showing the new problem

#### 4.1.6 Medication List

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

**Type of Measure:** Rate

The number of unique patients in the denominator who have a medication (or an indication that the patient does not currently have any prescribed medication) recorded as structured data. >80%

---

The number of unique patients seen by the EP during the EHR reporting period.

**Threshold:** More than 80 percent of all unique patients seen by the provider have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

##### 4.1.6.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient in the Denominator

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

OR HAVING: a medication in the Prescription file

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

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

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

OR HAVING: an Outside Medication in the Pharmacy Patient file

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

AND WITH: a status of Active

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

**Denominator Inclusions:**

COUNT: each patient

HAVING: one or more face-to-face visits with the eligible provider (Service Category of A, S, O, or M) during the EHR reporting period

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

**Measure Exclusion:** None.

**4.1.6.2 Configure RPMS**

Use the Configure RPMS instructions in Section 4.1.1.2.

**4.1.6.3 Order a medication in EHR**

Use the instructions in Section 4.1.1.4.

**4.1.6.4 Record an outside medication in EHR**

1. Select the **MEDS** tab:

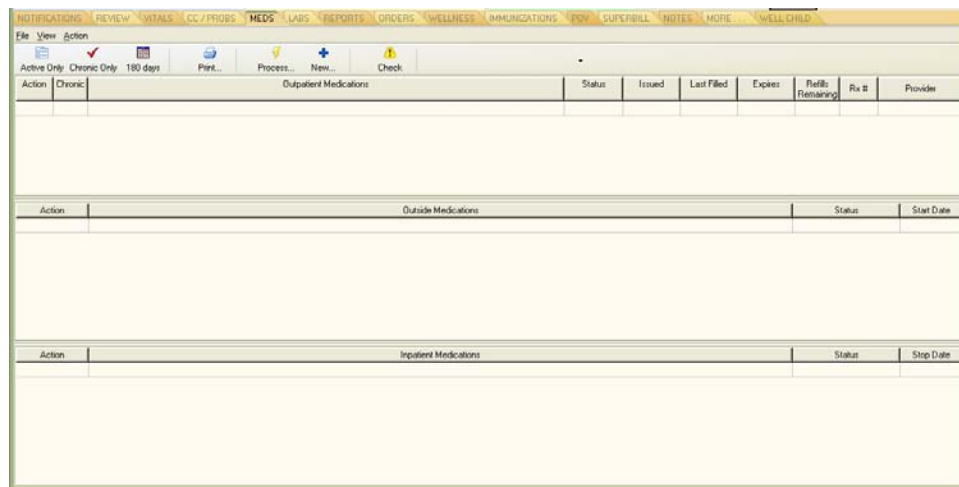


Figure 4-30: EHR MEDS tab

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



Figure 4-31: Meds toolbar list box

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

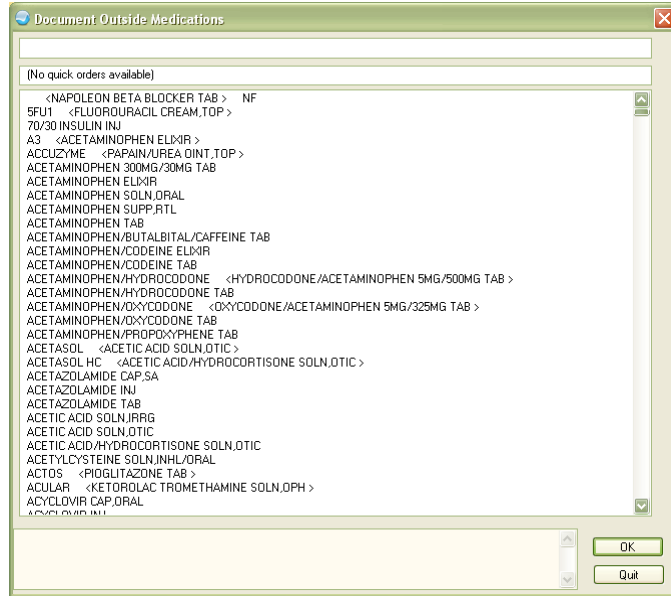


Figure 4-32: Document Outside Medications dialog, medication lookup

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

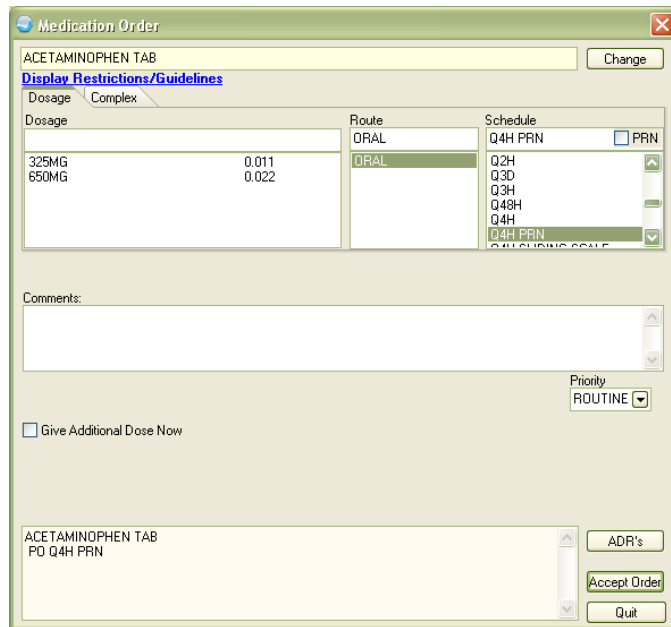


Figure 4-33: Document Outside Medications detail dialog

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

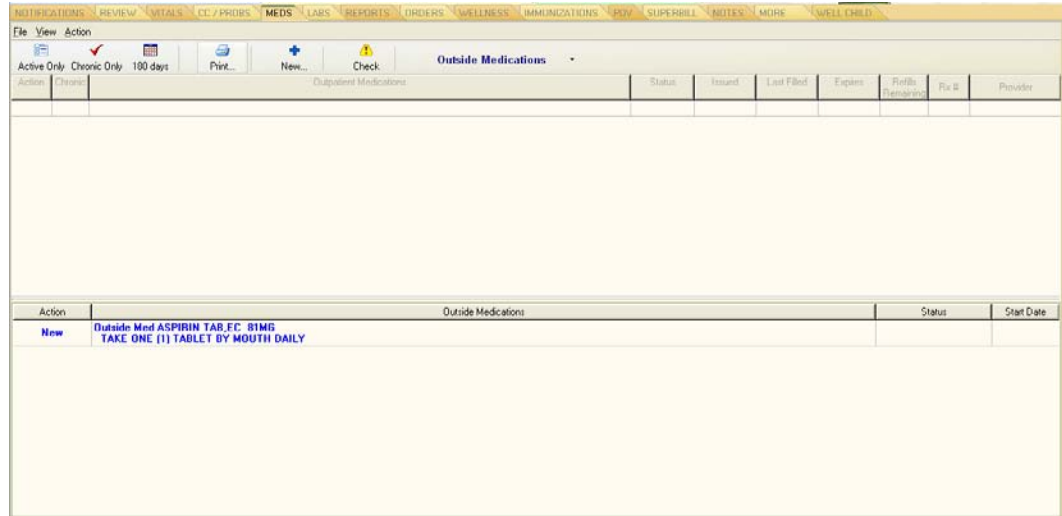


Figure 4-34: EHR MEDS tab

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



Figure 4-35: Awaiting Review graphical button

EHR displays the Review/Sign Changes dialog:

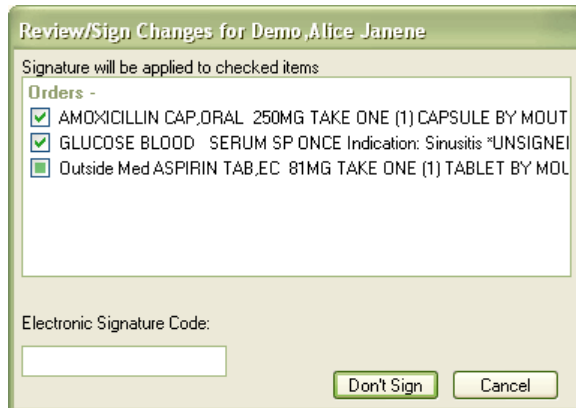


Figure 4-36: Review/Sign Changes dialog

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

#### 4.1.7 Medication Allergy List

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

**Type of Measure:** Rate

The number of unique patients in the denominator who have at least one entry (or an entry stating that the patient has no known medication allergies) recorded as structured data in their medication allergy list. >80%

---

The number of unique patients seen by the EP during the EHR reporting period.

**Threshold:** More than 80% of all unique patients seen by the provider during the EHR reporting period have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

##### 4.1.7.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient in the Denominator

HAVING: structured data present during the EHR reporting period

WHERE: an active adverse reaction to a medication is recorded

OR WHERE: a statement indicating no known allergies is recorded

**Denominator Inclusions:**

COUNT: each patient

HAVING: one or more face-to-face visits with the provider (Service Category of A, S, O, or M) during the EHR reporting period

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

**Measure Exclusion:** None.

##### 4.1.7.2 Configure RPMS

Use the Configure RPMS instructions in Section 4.1.2.2.

##### 4.1.7.3 Move drug allergies to the RPMS Allergies List

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

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



1. Run the PLAL Report:

```

Select IHS Core Option: PCC
Patient Care Component

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

Select Patient Care Component Option: ARP
PCC Management Reports

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

DEMO HOSPITAL

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

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

*****
**      PCC Data Entry Module      **
*****
IHS PCC Suite Version 2.0
DEMO HOSPITAL
*****
**      PCC Data Entry Module      **
**      Data Entry Utilities Menu  **
*****
IHS PCC Suite Version 2.0
DEMO HOSPITAL
    
```

```

*****
**                               PCC Data Entry Module                               **
** Data Entry SUPERVISOR Options and Utilities **
*****

IHS PCC Suite Version 2.0
DEMO HOSPITAL

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

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

***** LIST OF PATIENTS WITH ALLERGIES ON PROBLEM LIST *****
This report will produce a list of patients who have an allergy or NKA
entered on the PCC Problem List.
The pharmacy staff can use this list to add these allergies into the
Allergy Tracking module. When you have finished processing this list you
can then run the Option 'List Patients w/Allergies entered in a Date Range'
to pick up any allergies entered onto the Problem list after you ran this
report. Deceased patients and patients with inactive charts are not
included on this list.

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

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

DEVICE: HOME// VT Right Margin: 80//
Page 1
DEMO HOSPITAL
PATIENTS WITH ALLERGIES OR DOCUMENTED NO KNOWN ALLERGIES ON PCC PROBLEM
LIST
PATIENTS WITH LAST NAMES BEGINNING WITH A through A
PATIENT NAME CHART # DOB
-----
ALMOND,JOY 100004 Dec 21, 1930
DATE ADDED DX PROVIDER NARRATIVE
-----
JAN 21, 1997 995.2 ALLERGY TO PCN, BUT OK WITH AMPICILLIN

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

ALDRIDGE,FRANCES S 100870 Jan 18, 1956
DATE ADDED DX PROVIDER NARRATIVE

```

```

-----
OCT 10, 1996  995.2  ASA ALLERGY - CHEST PAIN

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

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

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

2. Add a drug allergy entry to the patient's Allergies List using RPMS (this can also be accomplished using EHR; see Section 4.1.7.4):

```

Enter/Edit Patient Reaction Data

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

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

Enter Causative Agent: AMOXICILLIN

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

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

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

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

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

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

Enter another Causative Agent? NO

Select PATIENT NAME:
    
```

3. Remove the drug allergy from the patient's Problem List (this can also be accomplished using EHR, see Section 4.1.7.5):

```

Select IHS Core Option: PCC
Patient Care Component

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

Select Patient Care Component Option: MGR
PCC Manager Menu

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

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

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

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

Select Patient Care Data Entry Menu Option: UPD
Update Patient Related/Non Visit Data

*****
**      PCC Data Entry Module      **
**      Update Patient-Related Data  **
*****
                IHS PCC Suite Version 2.0
                DEMO HOSPITAL

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

Select Update Patient Related/Non Visit Data Option: PRL
    
```

```

Problem List Update
                Patient Care Component (PCC)

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

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

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

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

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

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

4) Problem ID:  AA10     DX: V65.8   Status: ACTIVE  Onset:
   Provider Narrative:  ENROLLED IN BCCCP

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

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

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

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

AP  Add Problem          IP  Inactivate Problem  RN  Remove Note
EP  Edit Problem         DD  Detail Display     HS  Health Summary
DE  Delete Problem       NO  Add Note           FA  Face Sheet
AC  Activate Problem     MN  Edit Note          Q   Quit

Select Action: DE
    1  Delete Problem
    2  Detail Display
CHOOSE 1-2: 1
Delete Problem
Delete Which Problem(s): (1-21): 7

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

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

```

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

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

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

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

8) Problem ID:  AA16  DX: 401.9  Status: ACTIVE  Onset:
   Provider Narrative:  HTN - ELEVATED SYSTOLIC READINGS

+          Enter ?? for more actions                                >>>

AP  Add Problem          IP  Inactivate Problem  RN  Remove Note
EP  Edit Problem        DD  Detail Display    HS  Health Summary
DE  Delete Problem      NO  Add Note          FA  Face Sheet
AC  Activate Problem    MN  Edit Note         Q   Quit

Select Action: Q
Quit
    
```

4. Run the Patient Allergies Not Signed Off report:

```

Select IHS Kernel Option: CORE
IHS Core

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

Select IHS Core Option: ART
Adverse Reaction Tracking

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

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

```

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

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

Report results:

ALLERGY/ADVERSE REACTIONS TO BE SIGNED OFF				
Run Date/Time: 1/28/11 2:30:51 pm				
ORIGINATOR	PATIENT	ALLERGY	ORIGINATION DATE/TIME	
-----				
KUNZ, ELIZABETH	WOOTEN, MARILYN(11-43-61)	SULFAMETHOXAZOLE	MAY 18,	2004@10:16
KUNZ, ELIZABETH	SMITH, DIANE(10-34-04)	CODEINE	MAY 25,	2004@16:16
LAB, JESSICA LOU	WATTY, SHUSHANA(11-16-13)	GABAPENTIN	JUN 04,	2004@13:35
LAB, JESSICA LOU	WATTY, SHUSHANA(11-16-13)	PSEUDOEPHEDRINE	JUN 04,	2004@13:37
LAB, JESSICA LOU	LAMBERT, TONY W(12-32-68)	CODEINE	JUN 07,	2004@12:50
LEONG, BARBARA A	CROWE, WILLIAM (10-60-47)	TYLENOL	APR 05,	2004@12:08
LEONG, BARBARA A	STAMPER, SHAWNE(11-48-47)	PEDIAZO	MAY 04,	2004@16:23
LEONG, BARBARA A	FRENCH, MICHAEL(10-00-73)	FOSINOPRIL	MAY 10,	2004@11:53
LEONG, BARBARA A	CRAFT, HEATHER (10-01-72)	BRETHI	MAY 10,	2004@12:08
LEONG, BARBARA A	WILNOTY, SARAH (10-10-38)	NIACIN	MAY 10,	2004@17:05
LEONG, BARBARA A	DEMARCO, MELBA (10-20-33)	POLYMYXIN B	MAY 11,	2004@13:09
LEONG, BARBARA A	SMITH, OLLIE(10-63-75)	LEVOFLOXACIN	MAY 12,	2004@13:09

5. Run the Unverified Reactions by Ward Location report:

```

Select IHS Kernel Option: CORE
IHS Core

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

Select IHS Core Option: ART
Adverse Reaction Tracking

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

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

1      Enter/Edit Patient Reaction Data
2      Verify Patient Reaction Data
3      Reports Menu ...
    
```

```

4      Edit Chart and ID Band
5      FDA Enter/Edit Menu ...
6      Online Reference Card

Select Adverse Reaction Tracking Verifier Menu Option: 3
Reports Menu

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

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

Report results:

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

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

```

Select IHS Kernel Option: CORE
IHS Core

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



```

Select IHS Core Option: ART
  Adverse Reaction Tracking

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

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

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

Select Adverse Reaction Tracking Verifier Menu Option: 3
  Reports Menu

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

Select Reports Menu Option: 9

  1 Current Inpatients
  2 Outpatients over Date/Time range
  3 New Admissions over Date/Time range
  4 All of the above

Enter the number(s) for those groups to be used in this report: (1-4):4
Enter date/time range in which patients were
admitted into the hospital or seen at an outpatient clinic.

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

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

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

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

Report results:

Apr 21,2011	PATIENTS NOT ASKED ABOUT ALLERGIES	PAGE 1
	CURRENT INPATIENTS / OUTPATIENTS / NEW ADMISSIONS	
	FROM Oct 23,2010 TO Apr 21,2011@24:00	
PATIENT	SSN	
-----		
	CLINIC: PEDS/MORALES	
	* No Patients for this Clinic *	
Apr 21,2011	PATIENTS NOT ASKED ABOUT ALLERGIES	PAGE 2
	CURRENT INPATIENTS / OUTPATIENTS / NEW ADMISSIONS	
	FROM Oct 23,2010 TO Apr 21,2011@24:00	
PATIENT	SSN	
-----		
	CLINIC: BJB SOCSERV	
	* No Patients for this Clinic *	
Apr 21,2011	PATIENTS NOT ASKED ABOUT ALLERGIES	PAGE 3
	CURRENT INPATIENTS / OUTPATIENTS / NEW ADMISSIONS	
	FROM Oct 23,2010 TO Apr 21,2011@24:00	
PATIENT	SSN	
-----		
	CLINIC: BJB TBH	
DEMO,CHELSEA MARIE	116431	

4.1.7.4 Enter an adverse reaction in EHR

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

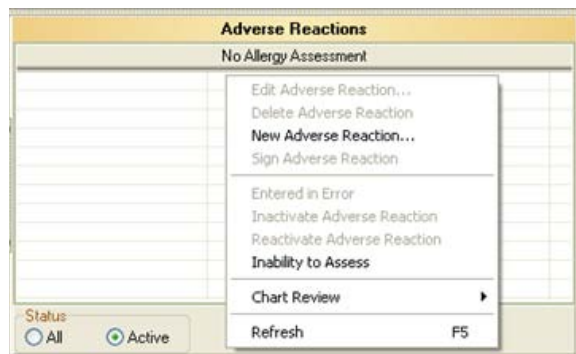


Figure 4-37: Preparing to add a new Adverse Reaction

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

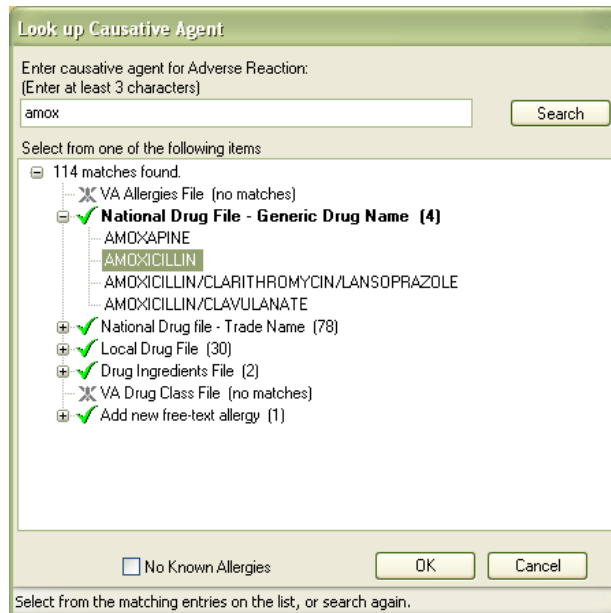


Figure 4-38: Look up Causative Agent dialog

2. Enter a few characters (at least three) in the text box on the **Look up Causative Agent** dialog and click **Search**. EHR displays a list of possible allergy items in the lower panel.
3. Select one of the retrieved allergy items and click the **OK** button to open the **Create Adverse Reaction** dialog:

Figure 4-39: Create Adverse Reaction dialog

4. If the reaction was observed by the clinician, select the **Observed** check box to enable the associated fields (**Observer**, **Reaction Date/Time**, and **Severity**); select from the available values in these three fields to describe the observed reaction.
5. Complete this dialog.
  - Clicking **Current** displays a dialog listing the patient’s current allergies.
6. Click **OK**. The newly-entered adverse reaction is now shown in the Adverse Reactions pane with a Status of *\*Unsigned*:

Agent	Type	Reaction	Status
AMOXICILLIN	Drug	RASH	*Unsigned

Status:  All  Active

Figure 4-40: New, unsigned Adverse Reaction

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



Figure 4-41: Awaiting Review graphical button

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

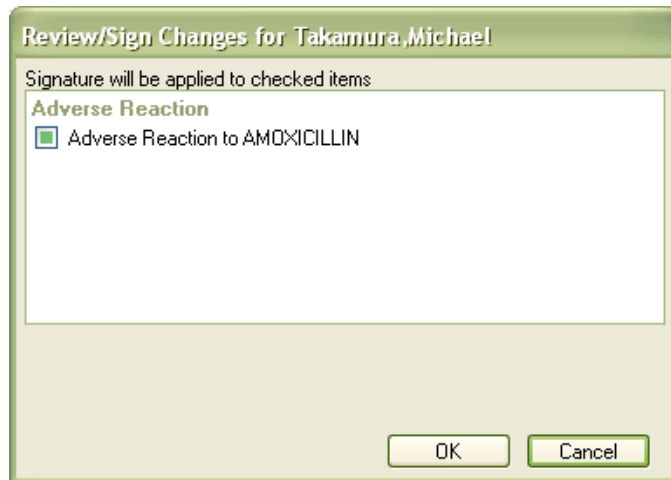


Figure 4-42: Review/Sign Changes dialog

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

Adverse Reactions			
Agent	Type	Reaction	Status
AMOXICILLIN	Drug	RASH	Nonverified

Status:  All  Active

Figure 4-43: Signed, nonverified Adverse Reaction

#### 4.1.7.5 Remove a Drug Allergy from the Problem List in EHR

- Click the **CC/PROBS** tab to display the Problem List.
- Click to highlight the drug allergy in the Problem List:

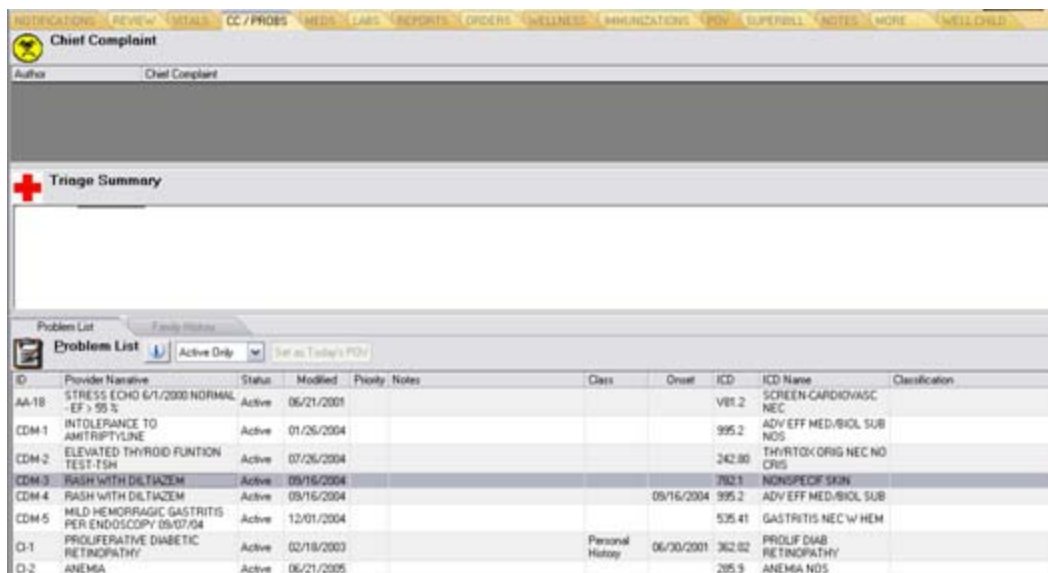


Figure 4-44: CC/PROBS tab with drug allergy highlighted in the Problem List

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

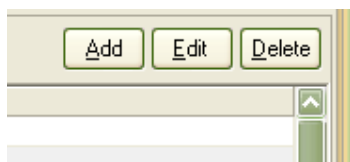


Figure 4-45: Problem List command buttons

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

The Problem List redisplay with the deleted drug allergy removed.

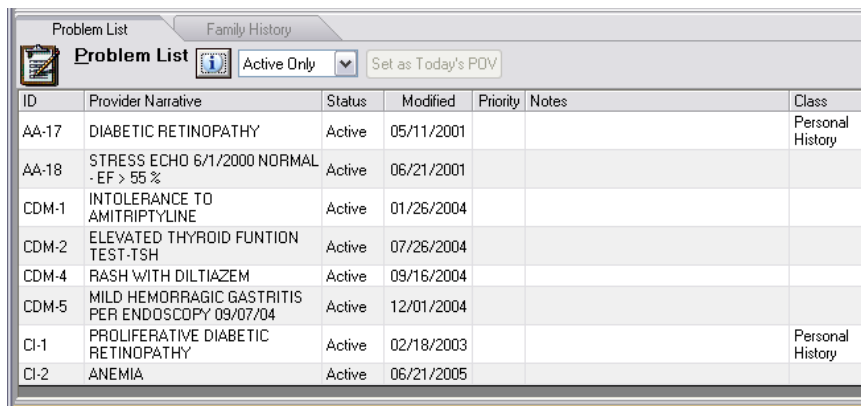


Figure 4-46: Updated Problem List

#### 4.1.7.6 Enter No Known Allergies in EHR

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

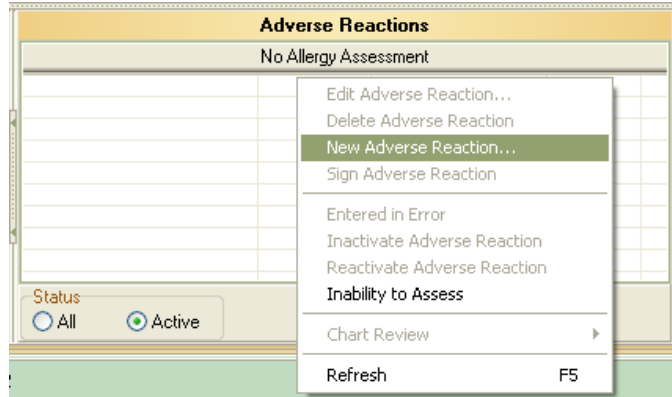


Figure 4-47: Preparing to add No Known Allergies

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

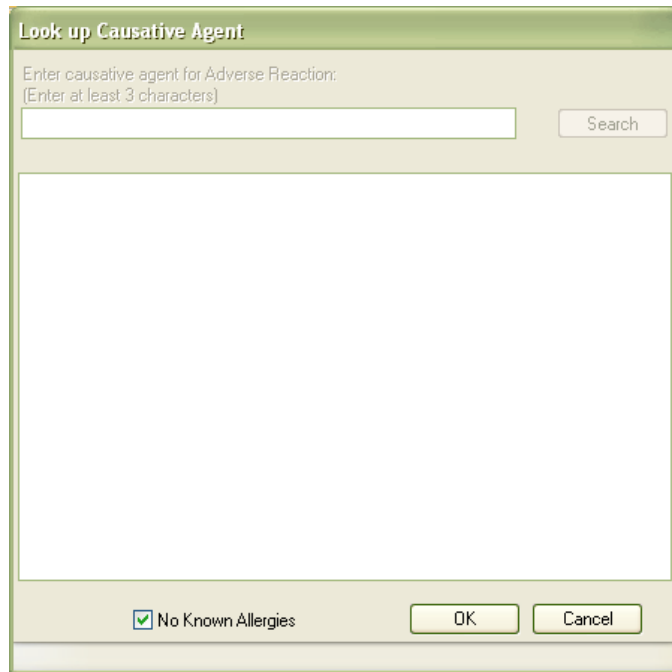


Figure 4-48: Look up Causative Agent dialog with **No Known Allergies** selected

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

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

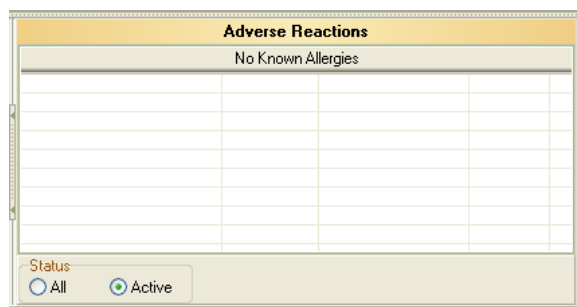


Figure 4-49: Notation of No Known Allergies

### 4.1.8 Vital Signs

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

**Type of Measure:** Rate

The number of unique patients in the denominator who have at least one entry of their height, weight, and blood pressure recorded as structured data. >50%  

$$\frac{\text{The number of unique patients in the denominator who have at least one entry of their height, weight, and blood pressure recorded as structured data.}}{\text{The number of unique patients age 2 or older seen by the EP during the EHR reporting period.}}$$

**Threshold:** For more than 50% of all unique patients age 2 and older seen by the provider during the EHR reporting period, height, weight, and blood pressure are recorded as structured data.

#### 4.1.8.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient in the Denominator

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

- Height
- Weight
- Blood Pressure



**Denominator Inclusions:**

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

**HAVING:** one or more face-to-face visits with the eligible provider (Service Category of A, S, O, or M) during the EHR reporting period

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

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

**Measure Exclusion:** EPs who see no patients who were two years old or older at the beginning of the EHR reporting period are excluded from this measure.

**4.1.8.2 Configure RPMS**

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

```

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

                                RPMS-EHR Configuration Master Menu

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

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

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

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

Vital Measurement Input Template may be set for the following:

100 User      USR      [choose from NEW PERSON]
200 Class     CLS      [choose from USR CLASS]
    
```

```

300 Service      SRV      [choose from SERVICE/SECTION]
400 Location     LOC      [choose from HOSPITAL LOCATION]
500 Division     DIV      [choose from INSTITUTION]
900 System       SYS      [DEMO-HO.IHS.GOV]

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

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

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

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

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

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

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

Sequence: 30// 30
Measurement: WEIGHT

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

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

```

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

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

Select Vital Measurement Configuration Option: CVR
Measurements Listed on Cover

Measurements Listed on Cover Sheet
    
```

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

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

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

- Setting Vital signs list for cover sheet for System: DEMO-HO.IHS.GOV -

Select Sequence: 5

Are you adding 5 as a new Sequence? Yes// YES

Sequence: 5// 5

Measurement: TEMPERATURE

Select Sequence: 10

Sequence: 10// 10

Measurement: PULSE// PULSE

Select Sequence: 15

Sequence: 15// 15

Measurement: RESPIRATIONS

Select Sequence: 20

Sequence: 20// 20

Measurement: BLOOD PRESSURE

Select Sequence: 25

Sequence: 25// 25

Measurement: HEIGHT

Select Sequence: 30

Sequence: 30// 30

Measurement: WEIGHT

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

### 3. Assign data entry permission to providers:

Select Vital Measurement Configuration Option: PER  
Data Entry Permissions

Data Entry Permissions

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

100 User	USR	[choose from NEW PERSON]
200 Class	CLS	[choose from USR CLASS]
300 Service	SRV	[choose from SERVICE/SECTION]
400 Location	LOC	[choose from HOSPITAL LOCATION]

```

500 Division      DIV      [choose from INSTITUTION]
900 System        SYS      [DEMO-HO.IHS.GOV]

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

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

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

### 4.1.8.3 EHR Use

1. Enter vital signs on the EHR Vitals tab:

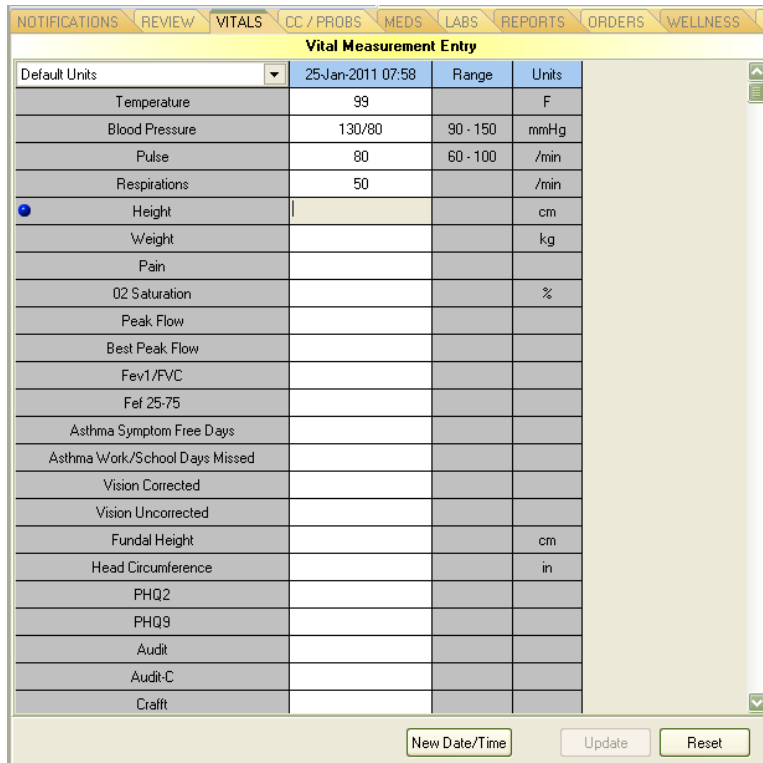


Figure 4-50: EHR Vitals tab

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

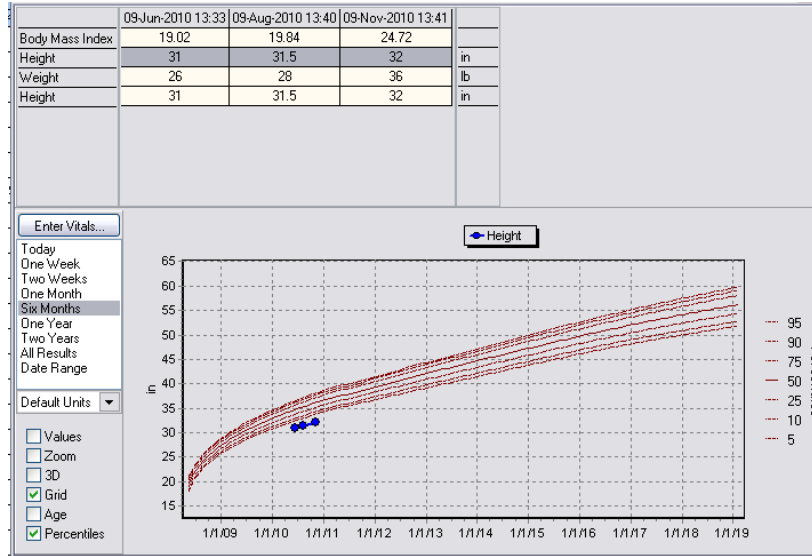


Figure 4-51: Height growth chart

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

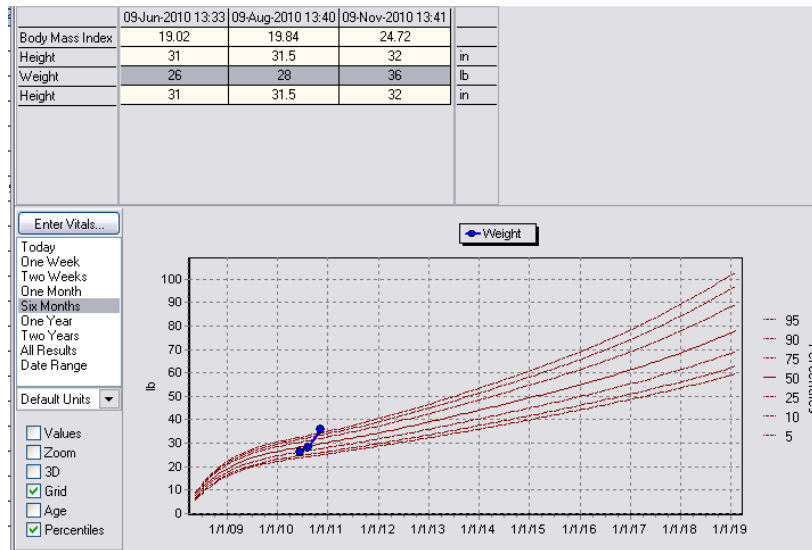


Figure 4-52: Weight growth chart

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

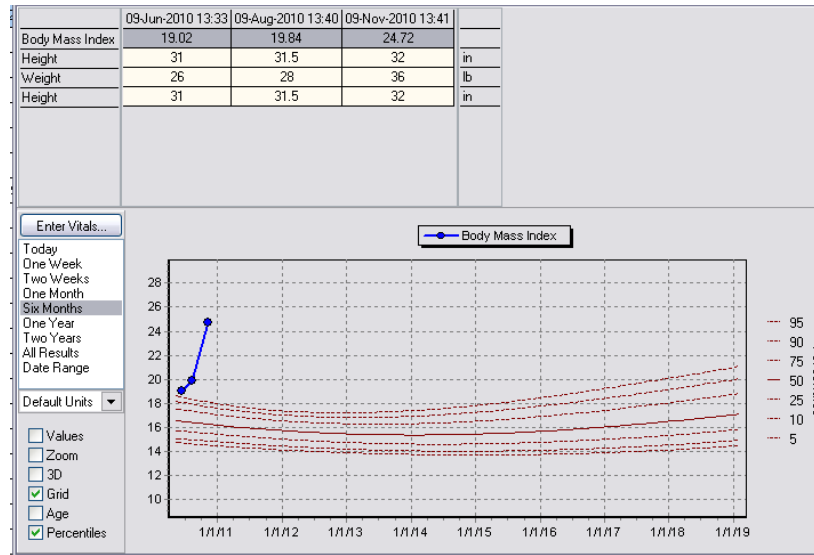


Figure 4-53: Body Mass Index chart

### 4.1.9 Smoking Status

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

**Type of Measure:** Rate

The number of unique patients in the denominator with smoking status recorded as structured data.

The number of unique patients age 13 and older seen by the EP during the EHR reporting period. >50%

**Threshold:** More than 50% of all unique patients 13 years old or older seen by the provider during the EHR reporting period have smoking status recorded as structured data.

Smoking status must be recorded with one of the following National Tobacco Health Factors:

- Current smoker, every day
- Current smoker, some day
- Current smoker, status unknown
- Previous (former) smoker
- Never smoked
- Smoking status unknown

### 4.1.9.1 RPMS MU Report Logic

#### Numerator Inclusions:

COUNT: each patient in the Denominator

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

#### Denominator Inclusions:

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

HAVING: one or more face-to-face visits with the eligible provider (Service Category of A, S, O, or M) during the EHR reporting period

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

**Measure Exclusion:** EPs who see no patients 13 years old or older are excluded from this measure.

### 4.1.9.2 Configure RPMS

No RPMS configuration is required.

### 4.1.9.3 Enter smoking status on the EHR Wellness tab.

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

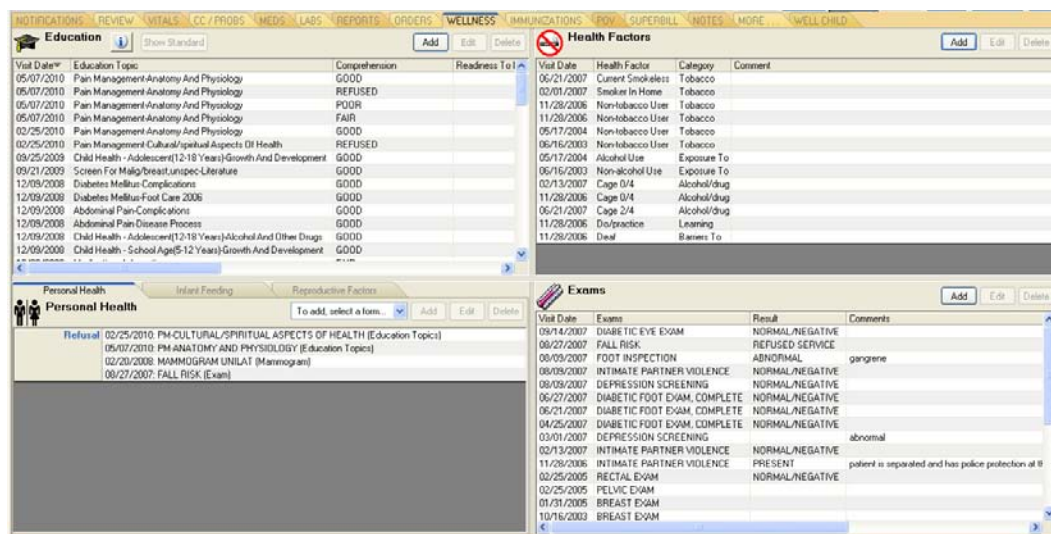


Figure 4-54: EHR Wellness tab

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

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

Figure 4-55: Health Factors pane

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

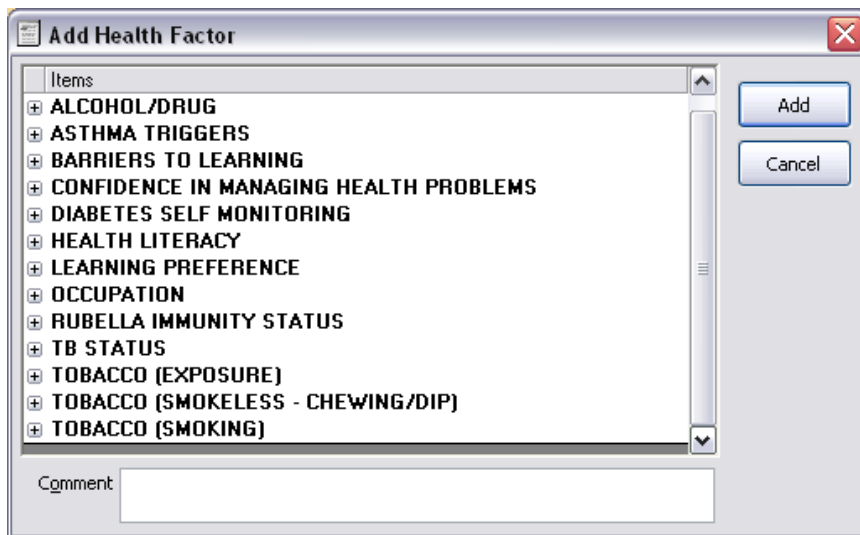


Figure 4-56: Add Health Factor dialog

3. Locate the **TOBACCO [SMOKING]** category.
4. Click [+] to expand the category:



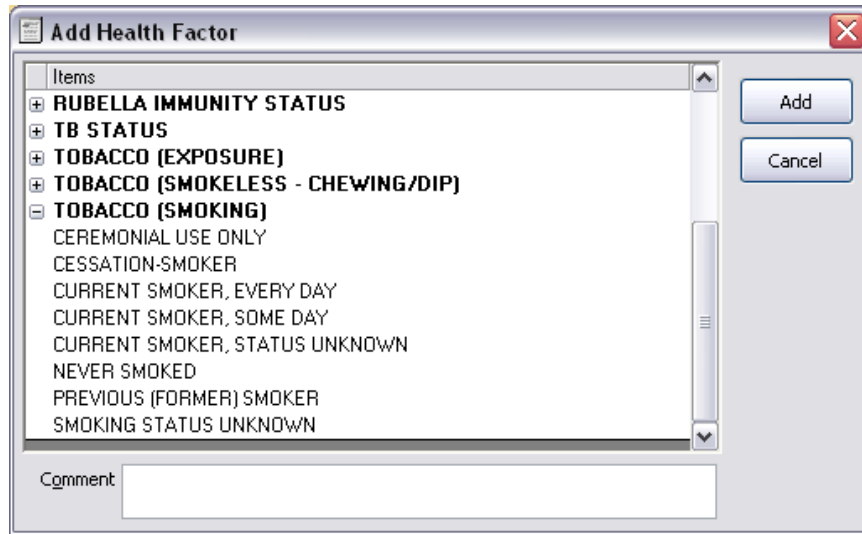


Figure 4-57: Add Health Factor dialog - Tobacco category expanded

5. Click to highlight the Health Factor. Optionally, type additional information in the **Comments** field.
6. Click **Add** on the Add Health Factor dialog to save the selected Health Factor. The new Health Factor is added to the list in the Health Factors pane:

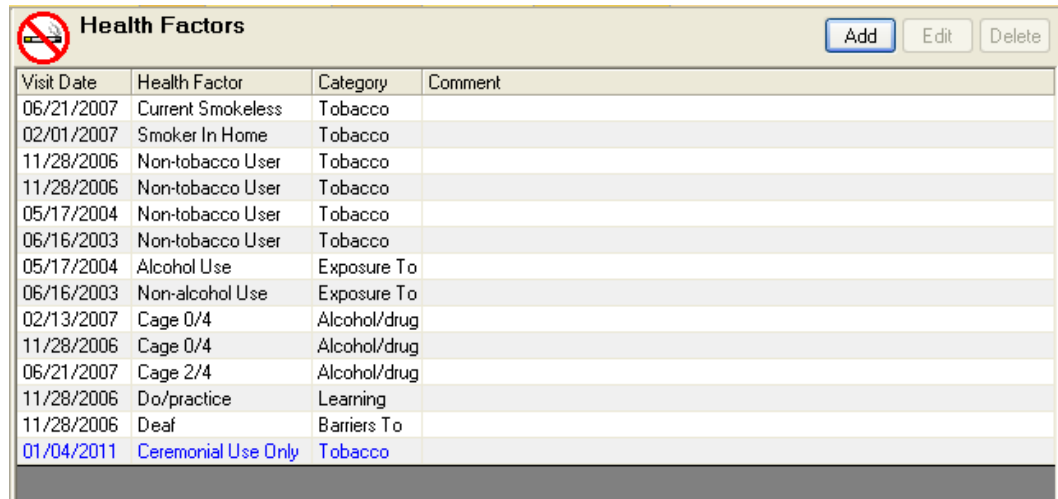


Figure 4-58: Health Factor dialog with new entry

#### 4.1.10 Clinical Decision Support

**Objective:** “Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.” *42 CFR Part 495.6,(d)(11)(i)*

**Type of Measure:** Attestation

**Threshold:** Implement one clinical decision support rule.

##### 4.1.10.1 RPMS MU Report Logic

**Measure Inclusions:**

COUNT: eligible providers

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

Clinical Reminders package installed and national reminders configured

Diabetes Supplement configured at the EHR Reports tab

Pre-Diabetes Supplement configured at the EHR Reports tab

Asthma Supplement configured at the EHR Reports tab

Anti-coagulation Supplement configured at the EHR Reports tab

Women's Health Supplement configured at the EHR Reports tab

Immunization Package Forecasting configured at the EHR Reports tab

Health Maintenance Reminders configured at the EHR Reports tab.

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

**Measure Exclusion:** None.

##### 4.1.10.2 Configure RPMS for Immunization Forecasting

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

1. Navigate to the Immunization Forecasting options:

Select RPMS-EHR Configuration Master Menu Option: IMM

```

Immunization Menu

                                MAIN MENU at DEMO HOSPITAL

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

Select Immunization Menu Option: MGR
Manager Menu

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

Select Manager Menu Option: ESP
Site Parameters Edit

                                *  EDIT SITE PARAMETERS  *

Select SITE/FACILITY: DEMO HOSPITAL
      NASHVILLE NON-IHS      CHEROKEE
      01                      NM HOSPITAL  7247
      ...OK? Yes// (Yes)

Edit Site Parameters for: DEMO HOSPITAL

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

```

17) Inpatient Visit Check.....: Disabled
18) High Risk Factor Check.....: Enabled (Smoking not included in
Pneumo)
19) Import CPT-coded Visits.....: Disabled
20) Visit Selection Menu.....: Disabled (Link Visits automatically)

Select Action: 9
    
```

2. Set forecasting options and rules:

```

* SELECT FORECASTING OPTIONS *

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

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

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

Select Forecasting Rules: 3

```

* SELECT FORECASTING RULES *

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

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

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

```

* SELECT FORECASTING RULES *

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

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

```

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

Edit Site Parameters for: DEMO HOSPITAL

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

Select Action: Quit// 12
    
```

3. Enable forecasting:

```

* ENABLE/DISABLE FORECASTING *

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

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

Please select either Enable or Disable: Enable

Nov 10, 2010 09:08:57          Page:    1 of    2

Edit Site Parameters for: DEMO HOSPITAL

1) Default Case Manager.....: TSUI,GLEN M
2) Other Location.....: DEMO HOSPITAL   NASHVILLE NON-IHS
3) Standard Imm Due Letter ...: Official Immunization Record
4) Official Imm Record Letter.: Official Immunization Record
5) Facility Report Header.....: CIHA HOSPITAL
6) Host File Server Path.....: /m/
7) Minimum Days Last Letter...: 30 days
8) Minimum vs Recommended Age.: Recommended Age
9) ImmServe Forecasting Option: #3, WITH 4-Day Grace, HPV through 18
10) Lot Number Options.....: NOT Required, Default Low Supply Alrt=50
    
```

```

11) Pneumo & Flu Parameters....: Pneumo: 65 yrs  Flu: All ages (>6 mths)
12) Forecasting (Imms Due).....: Enabled
13) Chart# with dashes.....: No Dashes (123456)
14) User as Default Provider...: Yes
15) ImmServe Directory.....: C:\Program Files\Immserve84\
16) GPRA Communities.....: 2 Communities selected for GPRA.
17) Inpatient Visit Check.....: Disabled

Select Action: Quit
    
```

### 4.1.10.3 View Immunization Forecasting in EHR

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

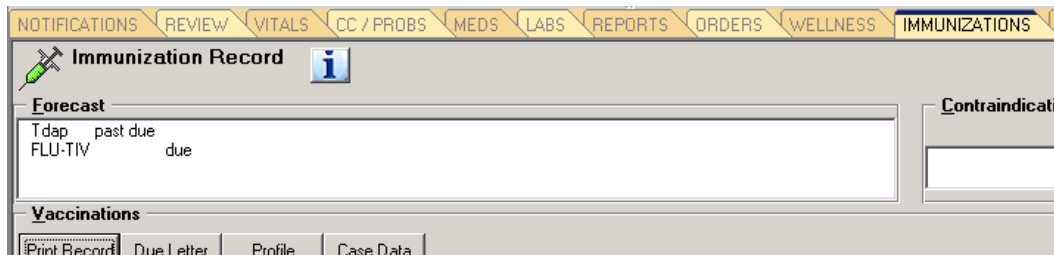


Figure 4-59: EHR Immunizations tab, Forecast pane

### 4.1.10.4 Configure RPMS for IHS Health Summary Supplements

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

1. Navigate to the IHS Health Summary Configuration:

```

Select IHS Kernel Option: CORE
IHS Core

AD      Abbreviations Dictionary
ADT     ADT Menu ...
AGM     Patient registration ...
AR      A/R MASTER MENU ...
ART     Adverse Reaction Tracking ...
ARWS    Automatic Replenishment ...
ASTH    Asthma Register ...
BDP     Designated Specialty Prov Mgt System ...
BH      Behavioral Health Information System ...
BVP     View Patient Record
BYPX    Pyxis Management Menu ...
CASE    Case Management System ...
CHR     Community Health Representative System ...
CHS     Contract Health System ...
    
```

```

CIMC  McCallie System Upload to RPMS ...
CRS   IHS Clinical Reporting System (CRS) Main Menu ...
DDS   Dental Data System Menu ...
DMS   Diabetes Management System ...
EHR   EHR MAIN MENU ...

Select IHS Core Option: EHR
      EHR MAIN MENU

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

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

                                RPMS-EHR Configuration Master Menu

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

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

                                Report Configuration

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

Select Report Configuration Option: HSM
      Health Summary Configuration

                                Health Summary Configuration

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

```

VHA      VHA Health Summary Configuration ...

Select Health Summary Configuration Option: IHS
IHS Health Summary Configuration

                IHS Health Summary Configuration

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

2. Name the new Health Summary type:

```

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

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

                Create/Modify Health Summary Type

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

Select HEALTH SUMMARY TYPE NAME: DIABETES SUPPLEMENT MU

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

NAME: DIABETES SUPPLEMENT MU  Replace

Health Summary: DIABETES SUPPLEMENT MU

STRUCTURE:
Order Component                               Max occ Time Alternate Title

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

MEASUREMENT PANELS:
    
```



<none>

LAB TEST PANELS:

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

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

Select Action: MS  
Modify Structure

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

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

CHOOSE 1-4: 2  
DEMOGRAPHICS - BRIEF

COMPONENT NAME: DEMOGRAPHICS - BRIEF//  
ALTERNATE TITLE:

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

Health Summary: DIABETES SUPPLEMENT MU

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

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

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

Select Action: SP  
Supplements

```

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

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

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

SUPPLEMENT PANEL SEQUENCE SUPPLEMENT PANEL TYPE: DIABETIC CARE SUMMARY

SUPPLEMENT PANEL TYPE: DIABETIC CARE SUMMARY//

TIME LIMIT FOR MED DISPLAY: 1Y

Health Summary: DIABETES SUPPLEMENT MU

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

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

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

### 4.1.10.5 Make the report available at the EHR Reports tab

The following instructions describe how to make the Health Summary Supplement (configured in section 4.1.10.4) available for selection on the EHR Reports tab. The example shows creation of *Diabetes Supplement MU*. The process to set up any of the other four types is essentially the same, just change the title of the Health Summary type.

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

```

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

Select IHS Kernel Option: CORE
IHS Core

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

Select IHS Core Option: EHR
EHR MAIN MENU

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

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

RPMS-EHR Configuration Master Menu

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

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

Report Configuration

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

Select Report Configuration: SYS
    
```

```

System Display Parameters

                        System Display Parameters

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

List of lab reports
-----

Select Sequence:
    
```

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

```

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

Select Report Configuration: HSM
Health Summary Configuration

                        Health Summary Configuration

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

Select Health Summary Configuration Option: IHS
IHS Health Summary Configuration

                        IHS Health Summary Configuration

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

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

                        IHS Health Summary Types
    
```

```
Allowable Health Summary Types may be set for the following:

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

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

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

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

Sequence: 12//

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

Select Sequence:
```

### 4.1.10.6 Find the Health Summary report on the EHR Reports tab

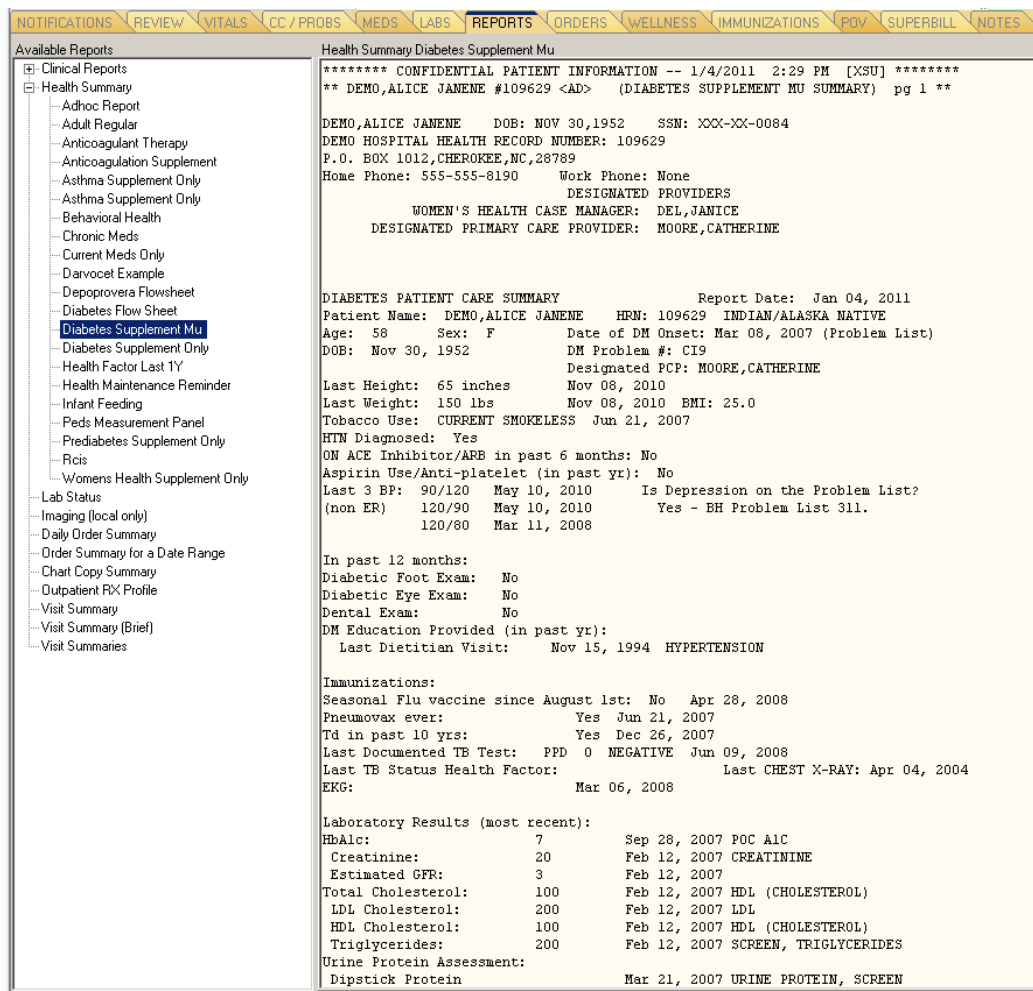


Figure 4-60: EHR Reports tab with the Diabetes Supplement MU report displayed

### 4.1.11 Calculate and Transmit Clinical Quality Measures

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

**Type of Measure:** Attestation

**Threshold:** Provide aggregate numerator, denominator, and exclusions through attestation (Calendar Year 2011 for EPs).

#### 4.1.11.1 RPMS MU Report Logic

##### Measure Inclusions:

COUNT: eligible providers

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

AND HAVING: done so in the manner specified by CMS

##### Additional CMS Final Rule Information:

The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

**Measure Exclusion:** None.

#### 4.1.11.2 The MU Performance Report

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

CRS Version 11.0 Patch 2 will include reporting for nine new EP measures, including:

- The three *Core Set* measures:
  - Adult Weight Screening and Follow- Up
  - Adult hypertension: blood pressure measurement
  - Adult tobacco use assessment and cessation intervention
- The three *Alternate Core Set* measures:
  - Influenza immunization for patients 50 years old and older
  - Weight assessment and counseling for children and adolescents
  - Childhood immunization status
- Three of the *Menu Set* measures:
  - Cervical cancer screening
  - Breast cancer screening
  - Colorectal cancer screening

Reporting of the remaining 35 EP menu set measures will be included in CRS Version 11.1.

**4.1.11.3 Demonstrate MU****Year One:**

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

**Year Two and beyond:**

3. Run the CRS report.
4. Submit the results electronically to CMS or to the State.

**4.1.12 Electronic Copy of Health Information**

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

**Type of Measure:** Rate

The number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

The number of patients of the EP who request an electronic copy of their electronic health information not less than four business days prior to the end of the EHR reporting period. >50%

**Threshold:** More than 50% of all patients of the provider who request an electronic copy of their health information during the EHR reporting period are provided it within three business days.

**4.1.12.1 RPMS MU Report Logic****Numerator Inclusions:**

COUNT: each patient in the Denominator

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



**Denominator Inclusions:**

COUNT: each patient

HAVING: at least one face-to-face visit with the eligible provider (Service Category of A, S, O, or M) in the 365 days prior to the end of the EHR reporting period

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

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

**Measure Exclusion:** EPs who have no patients in the denominator are excluded.

**4.1.12.2 Configure RPMS**

```

Select PCC Manager Menu Option: HSM
Health Summary Maintenance

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

                DEMO HOSPITAL

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

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

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

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

Health Summary: ASTHMA SUPPLEMENT ONLY

STRUCTURE:
    
```

Order Component Max occ Time Alternate Title

GENERAL:

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

MEASUREMENT PANELS:

<none>

LAB TEST PANELS:

Enter ?? for more actions

MS	Modify Structure	FS	Flow Sheets	GI	General Info
MP	Mod Meas Panel	HF	Health Factors	HS	Sample Health

Summary

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

Select Action: +// MS  
 Modify Structure

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

Select SUMMARY ORDER: 5

STRUCTURE COMPONENT NAME: DEMOGRAPHICS - BRIEF

- 1 DEMOGRAPHICS - BRIEF
- 2 DEMOGRAPHICS - BRIEF W/ADV DIRECTIVES

CHOOSE 1-2: 1 DEMOGRAPHICS - BRIEF

COMPONENT NAME: DEMOGRAPHICS - BRIEF//

ALTERNATE TITLE:

Select SUMMARY ORDER: 10

STRUCTURE COMPONENT NAME: SUPPLEMENTS

COMPONENT NAME: SUPPLEMENTS//

ALTERNATE TITLE:

Select SUMMARY ORDER:

Create/Modify Summary Type Nov 09, 2010 15:09:57

Page: 1 of

3

Health Summary: ASTHMA SUPPLEMENT ONLY

STRUCTURE:

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

GENERAL:

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

MEASUREMENT PANELS:

<none>

```

Enter ?? for more actions                               Nov 09, 2010 15:09:57
MS  Modify Structure      FS  Flow Sheets           GI  General Info
MP  Mod Meas Panel        HF  Health Factors        HS  Sample Health
Summary
LP  Lab Panel             PC  Provider Class Scrn  Q   Quit
HM  Health Main Remind    CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +// SP  Supplements

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

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

Example of the table format:

```

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

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

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

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

### 4.1.12.3 View a Health Summary report in EHR

1. Select the **Reports** tab:

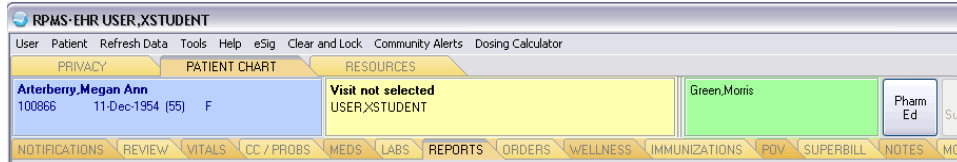


Figure 4-61: EHR tab set

- Expand the **Health Summary** structure in the Available Reports pane:

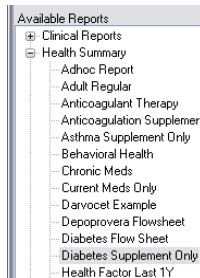


Figure 4-62: Reports tab, Available Reports pane

- Select the Health Summary report to display:

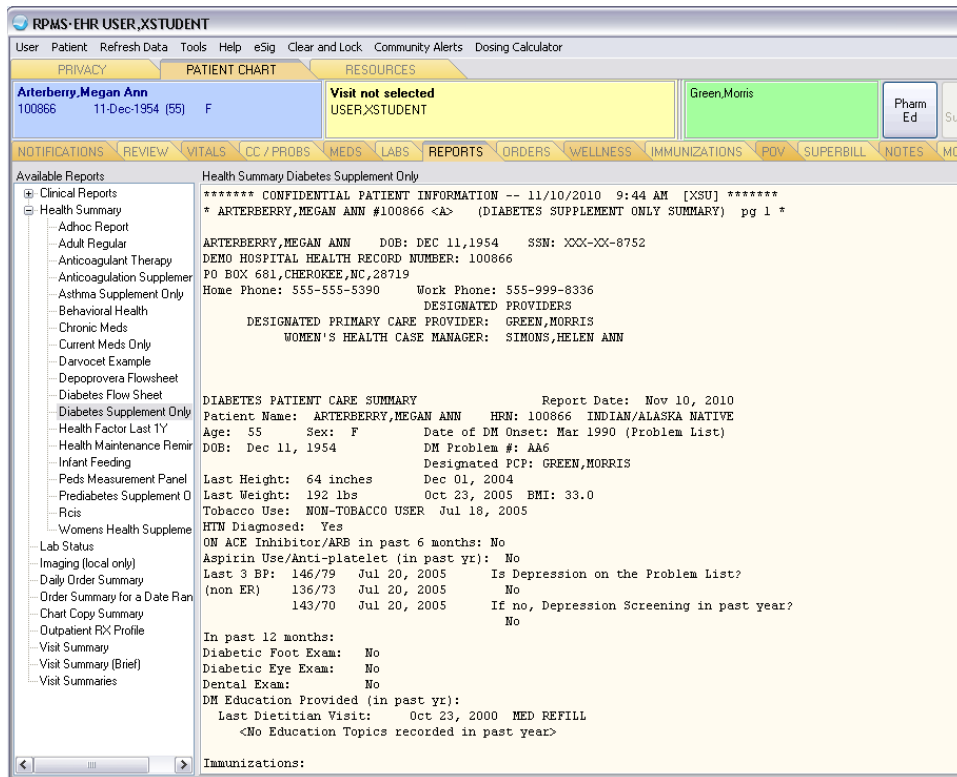


Figure 4-63: EHR Reports tab with selected Health Summary report

### 4.1.13 Clinical Summaries

**Objective:** “Provide clinical summaries for patients for each office visit.” *42 CFR Part 495.6,(d)(13)(i)*

**Type of Measure:** Rate

$$\frac{\text{Number of office visits in the denominator for which the patient is provided a clinical summary within three business days}}{\text{Number of office visits by the EP during the EHR reporting period.}} >50\%$$

**Threshold:** Clinical summaries provided to patients for more than 50% of all office visits during the EHR reporting period within three business days.

#### 4.1.13.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient face-to-face visit in the denominator

WHERE: a Patient Wellness Handout (PWH) was generated on or after the visit date/time but within three business days of the visit

**Denominator Inclusions:**

COUNT: each patient face-to-face visit with a provider (Service Category of A, S, O, or M)

WHERE: the visit occurred on or after the first day of the EHR reporting period

AND WHERE: the visit occurred on or before the fourth business day prior to the end of the EHR reporting period

- Logic example for a single patient with multiple provider visits in one day:

Provider A sees the patient at 9:00 am, Provider B sees the same patient at 11:00 am, and Provider C sees the same patient at 1:00 pm. Each visit will be counted in each provider's Denominator.

If the PWH is generated at 9:30 am, the patient would be counted in the numerator for Provider A only. If the PWH is generated at 1:30 pm, the visit will be counted in each provider's numerator calculation.

All types of PWHs will be included.

**Measure Exclusion:** EPs who have no office visits during the EHR reporting period are excluded from this measure.

#### 4.1.13.2 Configure RPMS

1. Create a Patient Wellness Handout using the VA Health Summary:

```

Health Summary Maintenance Menu [GMTS IRM/ADPAC MAINT MENU]
  1   Disable/Enable Health Summary Component
  2   Create/Modify Health Summary Components
  3   Edit Ad Hoc Health Summary Type
  4   Rebuild Ad Hoc Health Summary Type
  5   Resequence a Health Summary Type
  6   Create/Modify Health Summary Type
  7   Edit Health Summary Site Parameters
  8   Health Summary Objects Menu ...
  9   CPRS Reports Tab 'Health Summary Types List' Menu ...
 10   CPRS Health Summary Display/Edit Site Defaults ...

Select Health Summary Maintenance Menu Option: PWH Local Name
Are you adding 'PWH Med Rec' as a new HEALTH SUMMARY TYPE (the 78th)?
No// y YES

NAME: PWH Local Name//
TITLE:
SUPPRESS PRINT OF COMPONENTS WITHOUT DATA:

Do you wish to copy COMPONENTS from an existing Health Summary Type?
YES// NO

Select COMPONENT: PWS
PW HANDOUT SELECTED PWS
SUMMARY ORDER: 5// 5
HEADER NAME: Handout Selected//

No selection items chosen.

Select new items one at a time in the sequence you want them displayed.
You may select any number of items.

Select SELECTION ITEM: Local Name

      Searching for a PWH TYPES, (pointed-to by SELECTION ITEM)

      Searching for a PWH TYPES
LOCAL NAME
      ...OK? Yes// y (Yes)

Are you adding 'LOCAL NAME' as a new SELECTION ITEM (the 1ST for this
STRUCTURE)? No// y (Yes)

Select SELECTION ITEM:
    
```

2. Find the record number in FileMan:

```

  1   Search File Entries
  2   Print File Entries
  3   Inquire to File Entries
  4   Statistics
  5   List File Attributes

Select FileMan (General) Option: Inquire to File Entries

OUTPUT FROM WHAT FILE: VA HEALTH SUMMARY TYPE//

Select VA HEALTH SUMMARY TYPE NAME:      PWH Local Name
ANOTHER ONE:
    
```

```
STANDARD CAPTIONED OUTPUT? Yes// (Yes)

Include COMPUTED fields: (N/Y/R/B): NO// BOTH Computed Fields and Record
Number
(IEN)

NUMBER: 80 NAME: PWH Local Name
OWNER: RICHARDS,SUSAN P
SUMMARY ORDER: 5 COMPONENT NAME: PW HANDOUT SELECTED
HEADER NAME: Handout Selected
SELECTION ITEM: LOCAL NAME
TIMESTAMP: 61759,54656

Select VA HEALTH SUMMARY TYPE NAME:
```

### 4.1.13.3 Create the Health Summary Button in EHR

1. Press and hold the **Ctrl** and **Alt** keys, then press **D** to enter *Design Mode*.
2. Right-click in the space above the buttons to display the right-click menu:

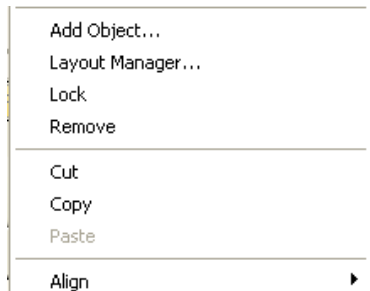


Figure 4-64: Design Mode right-click menu

3. Select **Add Object** to open the **Add an Object** dialog:

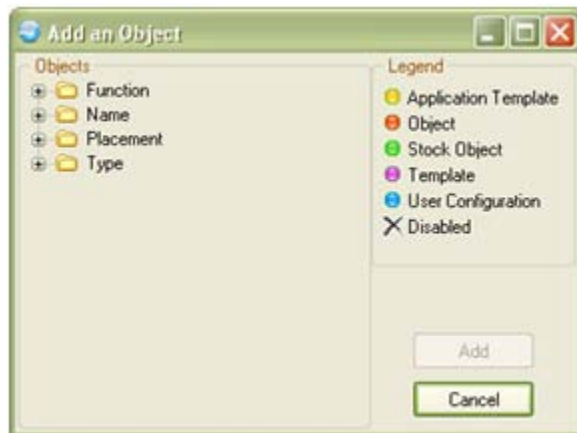


Figure 4-65: Add an Object dialog

4. Click **[+]** next to **Name** in the **Objects** panel to expand the list.
5. Scroll through the list and select **Health Summary Report**:

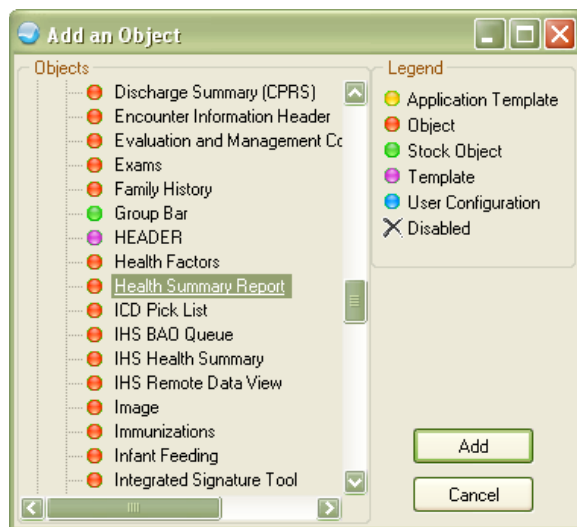


Figure 4-66: Add an Object dialog, object selected

6. Click **Add** to add the **Health Summary Report** button to the toolbar.
7. Right-click the button and select **Properties** to open the Properties for Health Summary Report dialog:



Figure 4-67: Properties for Health Summary Report dialog

8. Type the **Caption** and the **Title**.
9. Type the **Report** number in the following format:



**1<sup>n</sup>** where *n* = the number obtained in Step 2 of Section 4.1.13.1.

10. Click **OK** to close the dialog.

11. Resize and reorganize the buttons to suit:



Figure 4-68: Patient Wellness Handout button on toolbar

12. On the **Design** menu, select **Save As Template**.

13. Press and hold the **Ctrl** and **Alt** keys, then press **D** to exit *Design Mode*.

#### 4.1.13.4 Generate a Patient Wellness Handout in EHR

Select PWH Med Rec:

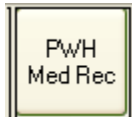


Figure 4-69: PWH Med Rec button

The PWH Med Rec dialog displays:

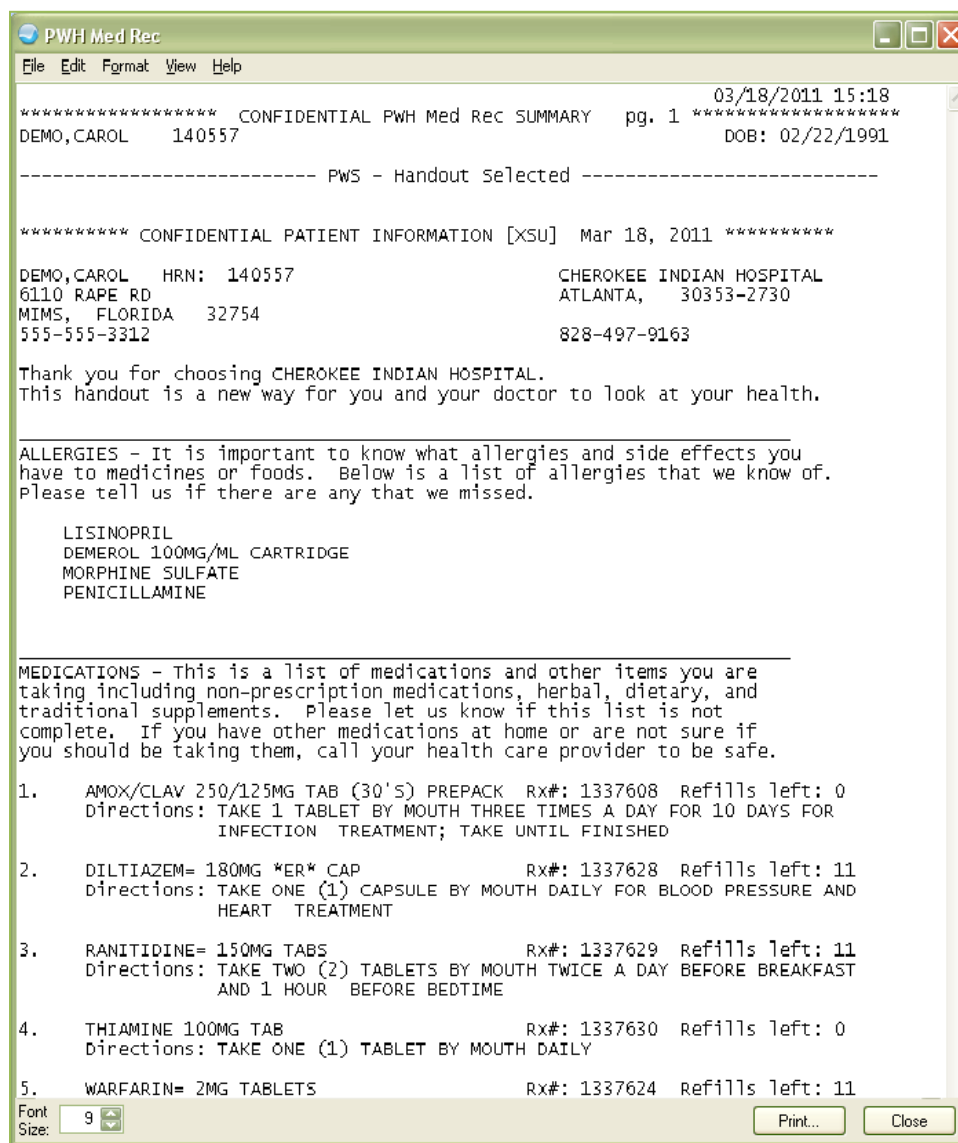


Figure 4-70: PWH Med Rec dialog

#### 4.1.14 Exchange Key Clinical Information

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

**Type of Measure:** Attestation

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

#### 4.1.14.1 RPMS MU Report Logic

**Measure Inclusions:**

COUNT: eligible providers

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

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

#### 4.1.15 Privacy and Security

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

**Type of Measure:** Attestation

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

#### 4.1.15.1 RPMS MU Report Logic

**Measure Inclusions:**

COUNT: eligible providers

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

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

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

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

## 4.2 Stage 1 Menu Set Performance Measures

### 4.2.1 Drug-Formulary Checks

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

**Type of Measure:** Attestation

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

#### 4.2.1.1 RPMS MU Report Logic

**Measure Inclusions:**

COUNT: eligible providers

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

All EPs using the RPMS EHR for pharmacy CPOE meet this measure because this check is always enabled.

The EP is not required to act on the check.

An EP must have at least one formulary that can be queried. It may be an internally-developed or external.

The formularies should be relevant for patient care during the prescribing process.

**Measure Exclusion:** EPs who order <100 prescriptions during the EHR reporting period are excluded from this measure.

#### 4.2.1.2 Configure RPMS

```

PDM
  Pharmacy Data Management

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

Select Pharmacy Data Management Option: DRED
Drug Enter/Edit

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

```

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

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

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

Deleting Possible Dosages...

Match local drug SILDENAFIL 50MG TAB N/F N/F with
                    ORDER UNIT: BT
                    DISPENSE UNITS/ORDER UNITS: 50
                    DISPENSE UNIT: TA

No NDC to match...

    I will attempt to match the NDCs from your SYNONYMS.

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

```

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

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

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

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

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

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

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

      Is this a match ? Y

You have just VERIFIED this match and MERGED the entry.

Resetting Possible Dosages..

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

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

Strength => 50    Unit => MG

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

LOCAL POSSIBLE DOSAGES:

```

```

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

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

Enter your choice(s) separated by commas : O,X
                                           O - Outpatient
                                           X - Non-VA Med

** You are NOW editing OUTPATIENT fields. **

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

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

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

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

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

    Dosage Form -> TAB

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

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

Orderable Item Name: SILDENAFIL//

Matching SILDENAFIL 50MG TAB N/F
to
SILDENAFIL TAB

Is this OK? YES//
Match Complete!

    Now editing Orderable Item:
    SILDENAFIL  TAB

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

```

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

Outpatient Expansion:
AS DIRECTED

PATIENT INSTRUCTIONS:

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

SYNONYM: VIAGRA//

Select SYNONYM:

Select DRUG GENERIC NAME:
    
```

### 4.2.1.3 Check operation of Drug Formulary Checks

Order a medication that is not on the formulary:

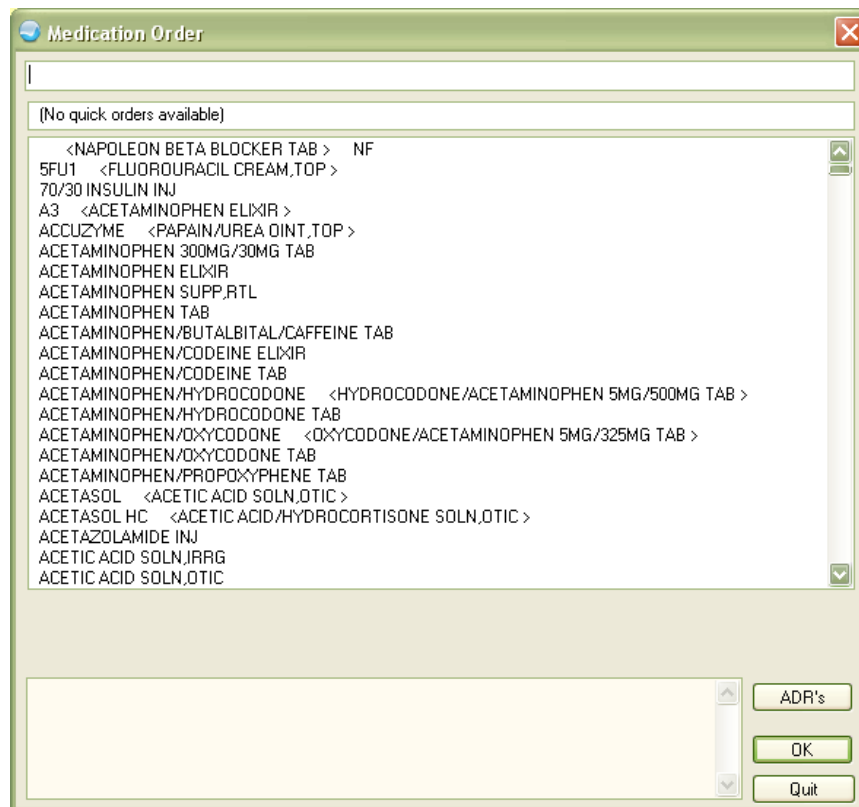


Figure 4-71: Medication Order dialog



EHR displays the Formulary Alternatives dialog:

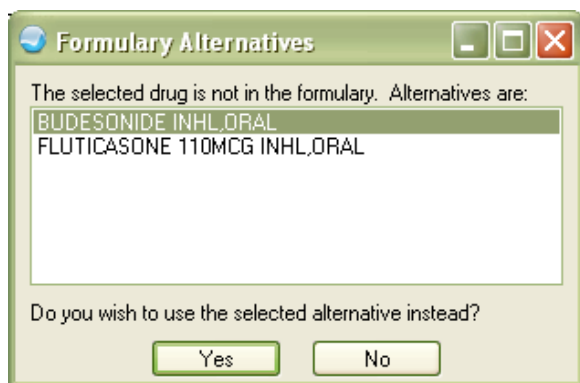


Figure 4-72: Formulary Alternatives dialog

Alternatively, EHR displays the No Formulary Alternatives dialog:

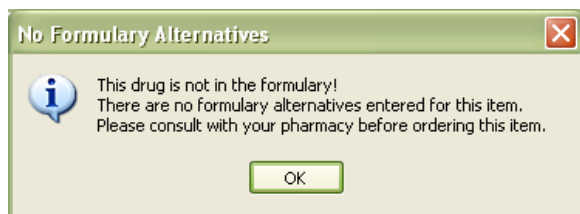


Figure 4-73: No Formulary Alternatives dialog

### 4.2.2 Lab Results into EHR

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

**Type of Measure:** Rate

The number of lab test results whose results are expressed in a positive or negative affirmation or as a number, which are incorporated as structured data.

The number of lab tests ordered by the EP during the EHR reporting period whose results are expressed in a positive or negative affirmation or as a number. >40%

**Threshold:** More than 40% of all clinical lab test results ordered by the provider during the EHR reporting period, the results of which are either in a positive/negative or numerical format, are incorporated in certified EHR technology as structured data.

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

### 4.2.2.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each test in the denominator

WHERE: the status flag is RESULTED

WHERE: RESULTS does not equal “comment”

OR WHERE: RESULTS = “comment”

AND WHERE: COMMENTS does not equal null

**Denominator Inclusions:**

COUNT: each V LAB entry ordered by an eligible provider during the EHR reporting period

WHERE: the ordering provider on the V LAB entry is the provider for which the report is being run

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

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

**Measure Exclusions:**

- EPs who order no lab tests having results that are displayed in either a positive/negative or numeric format during the EHR reporting period are excluded from this measure.
- All Pap smears ordered using any of the following Current Procedural Terminology (CPT) codes: 88141-88167, 88174-88175, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 (because results are expressed using text).

### 4.2.2.2 Create a Lab Test in RPMS

1. Create a Data Name

```

Select IHS Kernel Option: CORE  IHS Core

AD      Abbreviations Dictionary
ADT     ADT Menu ...
AGM     Patient registration ...
AR      A/R MASTER MENU ...
ART     Adverse Reaction Tracking ...
ARWS    Automatic Replenishment ...
ASTH    Asthma Register ...
BDP     Designated Specialty Prov Mgt System ...
BH      Behavioral Health Information System ...
BVP     View Patient Record
BYPX    Pyxis Management Menu ...
CASE    Case Management System ...
CHR     Community Health Representative System ...
CHS     Contract Health System ...
    
```

```

CIMC  McCallie System Upload to RPMS ...
CRS   IHS Clinical Reporting System (CRS) Main Menu ...
DDS   Dental Data System Menu ...
DMS   Diabetes Management System ...
EHR   EHR MAIN MENU ...
ERS   Emergency Room System ...
FHS   Dietetics Management ...
FLAG  Patient Record Flags Main Menu ...
FM    VA FileMan ...
HEAL  Health Systems ...
HWS   Hospital Wide Survey
IIMM  Immunization Interchange Management Menu ...
ILAB  IHS Short Lab Main Menu ...
IMM   Immunization Menu ...
IVM   IV Menu ...
LAB   Laboratory DHCP Menu ...
NDF   National Drug File Menu ...

```

```

Select IHS Core Option: LAB
Laboratory DHCP Menu

```

```

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

```

```

Select Laboratory DHCP Menu Option: 11
Supervisor menu

```

```

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

```

```

Select Supervisor menu Option: LAB LIA
Lab liaison menu

```

```

ANT    Add a new internal name for an antibiotic
BCF    Lab Bar Code Label Formatter
BCZ    Lab Zebra Label Utility

```

```

DATA  Add a new data name
LNC   LOINC Main Menu ...
MOD   Modify an existing data name
SMGR  Lab Shipping Management Menu ...

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

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

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

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

'GLUCOSE' added as a new data name

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

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

```

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

```

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

Select IHS Core Option: FM
FM     VA FileMan

      VA FileMan Version 22.0

```

```

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

Select VA FileMan Option: ENTER
Enter or Edit File Entries

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

Select LABORATORY TEST NAME: GLUCOSE
Are you adding 'GLUCOSE' as a new LABORATORY TEST (the 1594TH)? Yes
LABORATORY TEST LABTEST IEN: 9999242//
LABORATORY TEST SUBSCRIPT: CH  CHEM, HEM, TOX, SER, RIA, ETC.
LABORATORY TEST HIGHEST URGENCY ALLOWED: ??
Enter the urgency with the lowest number allowed for this test.
LABORATORY TEST HIGHEST URGENCY ALLOWED: STAT
LABORATORY TEST PRINT NAME: GLUCOSE          1
LABORATORY TEST DATA NAME: GLUCOSE

TEST COST:
Select SYNONYM:
TYPE: B
    BOTH
SUBSCRIPT: CHEM, HEM, TOX, SER, RIA, ETC.//
LOCATION (DATA NAME): CH;7247042;1// (No Editing)
Select INSTITUTION:
DEMO HOSPITAL      NASHVILLE NON-IHS      CHEROKEE
01                NM HOSPITAL 7247
    ACCESSION AREA: CH  CHEMISTRY
UNIQUE ACCESSION #:
UNIQUE COLLECTION SAMPLE:
LAB COLLECTION SAMPLE: B
    BLOOD
    1  BLOOD      BLOOD      GENERAL
    2  BLOOD      BLOOD      ROYAL BLUE
    3  BLOOD      BLOOD      YELLOW
    4  BLOOD      PLASMA     GREEN
    5  BLOOD      PLASMA     LAVENDER
    6  BLOOD      BLOOD      GRAY-CELITE
    7  BLOOD      BLOOD      GREEN
    8  BLOOD      BLOOD      PLAIN RED
    9  BLOOD      SERUM      TIGER
   10 BLOOD      SERUM      MARBLE

CHOOSE 1-10: 10
    BLOOD      SERUM      MARBLE
REQUIRED TEST: Y YES
PROCEDURE (SNOMED):
*QUICK INDEX:
EXTRA LABELS:
HIGHEST URGENCY ALLOWED: STAT//
FORCED URGENCY:
PRINT NAME: GLU 1//
Reserved:
    
```

```

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

Select LAB TEST:
Select COLLECTION SAMPLE: BLOOD
  1  BLOOD      BLOOD      GENERAL
  2  BLOOD      BLOOD      ROYAL BLUE
  3  BLOOD      BLOOD      YELLOW
  4  BLOOD      PLASMA     GREEN
  5  BLOOD      PLASMA     LAVENDER
  6  BLOOD      BLOOD      GRAY-CELITE
  7  BLOOD      BLOOD      GREEN
  8  BLOOD      BLOOD      PLAIN RED
  9  BLOOD      SERUM      TIGER
 10  BLOOD      SERUM      MARBLE
CHOOSE 1-10: 10
  BLOOD      SERUM      MARBLE
FORM NAME/NUMBER:
MIN VOL (in mls.):
MAX. ORDER FREQ.:
SINGLE DAY MAX ORDER FREQ:
WARD REMARKS:
LAB PROCESSING INSTRUCTIONS :
REQUIRED COMMENT:
Select SAMPLE WKLD CODE:
    
```

```

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

Select LABORATORY TEST NAME:

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

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

```

Select VA FileMan Option: ENTER
  Enter or Edit File Entries

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

Select LOAD/WORK LIST NAME: ?
Answer with LOAD/WORK LIST NAME
Do you want the entire 13-Entry LOAD/WORK LIST List? Y  (Yes)
  Choose from:
  ACL 7000
  AXYSM
  CLINITEK 200
  COULTER ONYX
  EKTACHEM 500
  HEMATOLOGY
  HEME-CELL DYN
  MANUAL CHEMISTRY
  OLD COULTER JT3
  TOSOH
  VITEK
  VITROS

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

```

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

Select LOAD/WORK LIST NAME:

```

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

```

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

```



```
EDIT WHICH FIELD: ALL//

Select AUTO INSTRUMENT NAME: VITROS
NAME: VITROS//
VENDOR CARD ADDRESS:
SHORT ACCESSION # LENGTH:
WKLD METHOD: DIRECTAGEN NOS//
ECHO DEVICE:
PROGRAM: VITROS//
LOAD/WORK LIST: VITROS//
ENTRY for LAGEN ROUTINE: Accession cross-reference
CROSS LINKED BY: IDE//
MESSAGE CONFIGURATION: UNIVERSAL INTERFACE//
*ECHO ALL INPUT:
METHOD: VITROS 250//
DEFAULT ACCESSION AREA: EKTACHEM//
OVERLAY DATA: YES//
STORE REMARKS:
NEW DATA:
RESTART:
HANDSHAKE RESPONSE:
ACK TRIGGER VALUE:
ACK RESPONSE VALUE:
DIRECT DEVICE:
Select TEST: FASTING GLUCOSE//
  TEST: FASTING GLUCOSE//
  PARAM 1:
  PARAM 2:
  PARAM 3:
  UI TEST CODE:  //
  ACCESSION AREA:
  SPECIMEN:
  URGENCY:
  NUMBER OF DECIMAL PLACES:
  CONVERT RESULT TO REMARK:
  ACCEPT RESULTS FOR THIS TEST: YES//
  DOWNLOAD TO INSTRUMENT: YES//
  IGNORE RESULTS NOT ORDERED:
  REMOVE SPACES FROM RESULT:
  STORE REMARKS:
  REMARK PREFIX:
  STORE PRODUCER'S ID:
  STORE REFERENCE RANGE:
  STORE ABNORMAL FLAGS:
Select TEST: GLUCOSE ....
Are you adding 'GLUCOSE' as a new CHEM TESTS
(the 41ST for this AUTO INSTRUMENT)? No// Y (Yes)
  CHEM TESTS NUMBER: 42//
  PARAM 1:
  PARAM 2:
  PARAM 3:
  UI TEST CODE: MFG
  ACCESSION AREA:
  SPECIMEN:
  URGENCY:
  NUMBER OF DECIMAL PLACES: 0
  CONVERT RESULT TO REMARK:
  ACCEPT RESULTS FOR THIS TEST: Y YES
  DOWNLOAD TO INSTRUMENT:
  IGNORE RESULTS NOT ORDERED:
  REMOVE SPACES FROM RESULT: ^DOWNLOAD TO INSTRUMENT
```

```

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

Select AUTO INSTRUMENT NAME:
    
```

5. Add a CPT Code for the test:

```

          Enter or Edit File Entries
          Print File Entries

Select VA FileMan Option: ENTER
          Enter or Edit File Entries

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

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

LAB SECTION: CHEMISTRY
CREATE DATE: N (JAN 26, 2011@10:50:04)
DATE/TIME ACTIVE:
DATE/TIME INACTIVE: ^DATE
  1  DATE/TIME ACTIVE
  2  DATE/TIME INACTIVE
CHOOSE 1-2: 1 DATE/TIME ACTIVE
DATE/TIME ACTIVE: N (JAN 26, 2011@10:50:31)
    
```

```

DATE/TIME INACTIVE:
PANEL/TEST: GLUCOSE
INACTIVE FLAG:
Select CPT CODE: 82947    ASSAY, GLUCOSE, BLOOD QUANT
                    Glucose; quantitative, blood (except reagent strip)
                    ...OK? Yes// Y (Yes)

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

6. Create a Quick Order for the test:

```

Select IHS Core Option: EHR
EHR MAIN MENU

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

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

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

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

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

DEMO HOSPITAL                RPMS-EHR Management                Version 1.1
                             Order Entry Configuration

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

```

Select Order Entry Configuration Option: MNU
  Order Menu Management

DEMO HOSPITAL                RPMS-EHR Management                Version 1.1
                             Order Menu Management

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

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

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

Select QUICK ORDER NAME: LRZ GLUCOSE
  Are you adding 'LRZ GLUCOSE' as a new ORDER DIALOG? No// Y (Yes)

TYPE OF QUICK ORDER: LAB LABORATORY
NAME: LRZ GLUCOSE//
DISPLAY TEXT: Glucose1
VERIFY ORDER: Y YES
DESCRIPTION:
  1>
ENTRY ACTION:
Lab Test: GLUCOSE
SEND TO LAB - Means the patient is ambulatory and will be sent to the
Laboratory draw room to have blood drawn.
WARD COLLECT - Means that either the physician or a nurse will be
collecting the sample on the ward.
LAB BLOOD TEAM - Means the phlebotomist from Lab will draw the blood on the
ward. This method is limited to laboratory defined collection times.

      SP      Send patient to lab
      WC      Ward collect & deliver
      LC      Lab blood team

Collected By:
Collection Sample: BLOOD//
Collection Date/Time: T (JAN 26, 2011)
Urgency:
How often: ONCE ONCE
Indication://
Indication ICD9://

-----
                        Lab Test: GLUCOSE
                        Collection Sample: BLOOD
                        Specimen: SERUM
Collection Date/Time: TODAY
                        How often: ONCE
-----

```

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

Select QUICK ORDER NAME:
```

7. Make the quick order available on the Lab menu:

```
ACT    Create/Modify Actions
DIS    Enable/Disable Order Dialogs
GEN    Create/Modify Generic Orders
LST    List Primary Order Menus
MNU    Create/Modify Order Menus
OIC    Create/Modify Orderable Items
PAR    Menu Parameters ...

Select Order Menu Management Option: MNU
Create/Modify Order Menus

DEMO HOSPITAL                RPMS-EHR Management                Version 1.1
                             Create/Modify Order Menus
Select ORDER MENU: LRZ CHEMISTRY QUICKMENU

Menu Editor                Jan 26, 2011 11:00:41                Page: 1 of 3
Menu: LRZ CHEMISTRY QUICKMENU                Column Width: 28
 1                    2                    3
|  A1C today                Electrolytes Today                Sodium Today
|  Albumin Today            Ethanol Today                    T4 Today
|  ALT/SPGT Today          Fasting Glucose                  Triglyceride Today
|  Ammonia Today           Glucose today                    Troponin Today
+  Amylase Today           GTT 1 Hr. Today                  TSH Today
|  AST/SGOT Today          GTT 3 Hr. Today                  Uric Acid
|  Bilirubin Total         Hep B Surf Ag Today
|  BMP Today               Hepatitis Panel Today
|  BUN Today               HIV Today
1  Calcium Today           Lipid Profile Today
|  Chloride Today          Magnesium Today
|  Cholesterol Today       Phosphate Today
|  CKMB Today              Potassium Today
|  CMP Today               Protein Total Today
+  CO2 Today               PT & INR Today
|  Creatinine Today        PTT Today                        Other Labs
+  + Next Screen - Prev Screen ?? More Actions                >>>
  Add ...                Edit ...                Assign to User(s)    Select New Menu
  Remove ...            Toggle Display          Order Dialogs ...
Select Action: Next Screen// ADD
  Add ...
    Menu Items                Text or Header                Row
Add: M
  Menu Items
ITEM: LRZ GLUCOSE
ROW: 5
COLUMN: 2
There is another item in this position already!
Do you want to shift items in this column down? YES// YES
DISPLAY TEXT:
MNEMONIC:
ITEM:
```

```

Rebuilding menu display ...

Menu Editor          Jan 26, 2011 11:00:41          Page:    1 of    3
Menu: LRZ CHEMISTRY QUICKMENU                      Column Width: 28
  1                2                3
|  A1C today        Electrolytes Today          Sodium Today
|  Albumin Today    Ethanol Today              T4 Today
|  ALT/SPGT Today   Fasting Glucose          Triglyceride Today
|  Ammonia Today    Glucose today            Troponin Today
+  Amylase Today    Glucose                  TSH Today
|  AST/SGOT Today   GTT 1 Hr. Today          Uric Acid
|  Bilirubin Total  GTT 3 Hr. Today
|  BMP Today        Hep B Surf Ag Today
|  BUN Today        Hepatitis Panel Today
1  Calcium Today    HIV Today
|  Chloride Today   Lipid Profile Today
|  Cholesterol Today Magnesium Today
|  CKMB Today       Phosphate Today
|  CMP Today        Potassium Today
+  CO2 Today        Protein Total Today
|  Creatinine Today PT & INR Today          Other Labs
|                  PTT Today
+          + Next Screen - Prev Screen ?? More Actions      >>>
  Add ...          Edit ...          Assign to User(s)   Select New Menu
  Remove ...      Toggle Display    Order Dialogs ...
Select Action: Next Screen//

```

#### 4.2.2.3 Implement the Reference Lab Interface in RPMS

Create reference lab tests in a similar fashion and add them to the Auto Instruments and Load/Work List files using the Sendout Accession area. Tests are uniquely mapped and coded to the specified reference lab. Contact the laboratory consultant for further information.

#### 4.2.2.4 Configure the Point of Care Lab in RPMS

1. Create Point of Care accession area using VA FileMan (if not previously created):

```

Select ACCESSION AREA:  POINT OF CARE
AREA: POINT OF CARE//
LR SUBSCRIPT: CHEM, HEM, TOX, RIA, SER, etc.//
COMMON ACCESSION #'S WITH AREA:
ACCESSION TRANSFORM: DAILY//
ACC CODE: S LRAD=DT//
VERIFICATION CODE:
VER CODE:
*IDENTITY CONTROL:
PRINT ORDER: 39//
BYPASS ROLLOVER: NO//
ABBREVIATION: POC//

Select ASSOCIATED DIVISION: IHS HOSPITAL//
TYPE OF ACCESSION NUMBER:
*LAB SECTION: CHEMISTRY//
NON LAB ACCESSION AREA:
RESPONSIBLE OFFICIAL: DR. PAUL H. STEVENS//

```

```

INHIBIT AREA LABEL PRINTING: YES//
LAB DIVISION: CLINICAL PATHOLOGY//
NUMERIC IDENTIFIER: 55//
Lock for load/work list build: YES//
LAB OOS LOCATION:
USER ACCESS AUTHORIZATION: AMCHZUSER//
Select INSTRUMENTATION CONTROLS:
Select DATE: JAN 26,2011//
    DATE: JAN 26,2011//
Select LRDFN: ^
BAR CODE PRINT:
BAR CODE PAD:
ALTERNATE LABEL ENTRY:
ALTERNATE LABEL ROUTINE:
Reserved:
WORK AREA:
WORKLOAD ON:
COLLECT STD/QC/REPEATS:

Select ACCESSION AREA:
    
```

2. Create Point of Care test:

```

CORE   IHS Core ...
MM     Menu Management ...
UM     User Management ...
DEV    Device Management ...
TM     Taskman Management ...
PROG   Programmer Options ...
SM     Operations Management ...
VAF    VA FileMan ...
SEC    Information Security Officer Menu ...

Select IHS Kernel Option: VAF
    VA FileMan

        VA FileMan Version 22.0

            Enter or Edit File Entries
            Print File Entries

Select VA FileMan Option: ENTER
    Enter or Edit File Entries

INPUT TO WHAT FILE: ACCESSION// 60  LABORATORY TEST  (1594 entries)
EDIT WHICH FIELD: ALL//

Select LABORATORY TEST NAME: POC GLUCOSE
NAME: POC GLUCOSE//
TEST COST: 17.00//
Select SYNONYM: GLUCOMETER//
TYPE: BOTH//
SUBSCRIPT: CHEM, HEM, TOX, SER, RIA, ETC.//
LOCATION (DATA NAME): CH;7247018;1//  (No Editing)
Select INSTITUTION: DEMO HOSPITAL//
    INSTITUTION: DEMO HOSPITAL//
    ACCESSION AREA: POINT OF CARE//
UNIQUE ACCESSION #: NO//
UNIQUE COLLECTION SAMPLE: YES
LAB COLLECTION SAMPLE: CAPILLARY BLOOD
    
```

```
REQUIRED TEST: YES//
PROCEDURE (SNOMED):
*QUICK INDEX:
EXTRA LABELS:
HIGHEST URGENCY ALLOWED: STAT//
FORCED URGENCY:
PRINT NAME: POC GLU//
Reserved:
PRINT CODE:
PRETTY PRINT ENTRY:
PRETTY PRINT ROUTINE:
PRINT ORDER: 13//
NATIONAL VA LAB CODE:
RESULT NLT CODE:
CATALOG ITEM:
EDIT CODE:
*BATCH DATA CODE:
EXECUTE ON DATA REVIEW:
Select SITE/SPECIMEN: BLOOD//
  SITE/SPECIMEN: BLOOD//
  REFERENCE LOW: 65//
  REFERENCE HIGH: 105//
  CRITICAL LOW: 50//
  CRITICAL HIGH: 500//
  INTERPRETATION:
  1>
  UNITS: MG/DL//
  TYPE OF DELTA CHECK:
  DELTA VALUE:
  DEFAULT VALUE:
  THERAPEUTIC LOW:
  THERAPEUTIC HIGH:
  Select *AMIS/RCS 14-4:
  CPT CODE:
  PANEL (CPT):
  Select FOREIGN COMPUTER SYSTEM:
  LOINC CODE:
Select SITE/SPECIMEN:
GENERAL PROCESSING INST.:
  1>
Select LAB TEST:
Select COLLECTION SAMPLE: CAPILLARY BLOOD//
  COLLECTION SAMPLE: CAPILLARY BLOOD//
  FORM NAME/NUMBER:
  MIN VOL (in mls.):
  MAX. ORDER FREQ.:
  SINGLE DAY MAX ORDER FREQ:
  WARD REMARKS:
  1>
  LAB PROCESSING INSTRUCTIONS :
  1>
  REQUIRED COMMENT:
  Select SAMPLE WKLD CODE:
Select COLLECTION SAMPLE:
GENERAL WARD INSTRUCTIONS:
  1>
  REQUIRED COMMENT:
  DATA NAME: POC GLUCOSE//
  CULTURE ID PREFIX:
  Select VERIFY WKLD CODE:
  Select ACCESSION WKLD CODE:
```



```
*ASK AMIS/CAP CODES:
COMBINE TEST DURING ORDER:
CIS TEST CODE:
Select SITE NOTES DATE:
IHS PCC DISPLAY FLAG:

Select LABORATORY TEST NAME:
```

### 3. Add the Point of Care test to BLR BEHO POC Control File

```
Enter or Edit File Entries
Print File Entries

Select VA FileMan Option: ENTER
Enter or Edit File Entries

INPUT TO WHAT FILE: LABORATORY TEST// BLR
  1  BLR BEHO POC CONTROL          (1 entry)
  2  BLR LOCK                      (0 entries)
  3  BLR MASTER CONTROL           (6 entries)
  4  BLR REFERENCE LAB            (8 entries)
  5  BLR REFERENCE LAB IMPORT/EXPORT LOG (0 entries)

CHOOSE 1-5: 1
  BLR BEHO POC CONTROL          (1 entry)
EDIT WHICH FIELD: ALL//

Select BLR BEHO POC CONTROL NAME: DEMO HOSPITAL
...OK? Yes// (Yes)

NAME: DEMO HOSPITAL//
ENFORCE RESTRICT TO LOCATION:
ENFORCE RESTRICT TO USER:
Select LAB TEST: POC GLUCOSE
Are you adding 'POC GLUCOSE' as a new LAB TEST? No// Y (Yes)

  Select RESTRICT TO LOCATION:
  Select RESTRICT TO USER:
Select LAB TEST:
Select AVAILABLE LAB DESCRIPTIONS:

Select BLR BEHO POC CONTROL NAME:
```

#### 4.2.2.5 Create the Lab Point of Care Button in EHR

To use the Lab Point of Care feature, add the **Lab Point of Care** button to the EHR toolbar:

1. Press and hold the **Ctrl** and **Alt** keys, then press **D** to enter *Design Mode*.
2. Right-click in the space above the buttons to display the right-click menu:

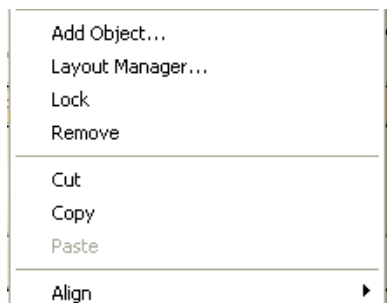


Figure 4-74: Design Mode right-click menu

3. Select **Add Object** to open the **Add an Object** dialog:

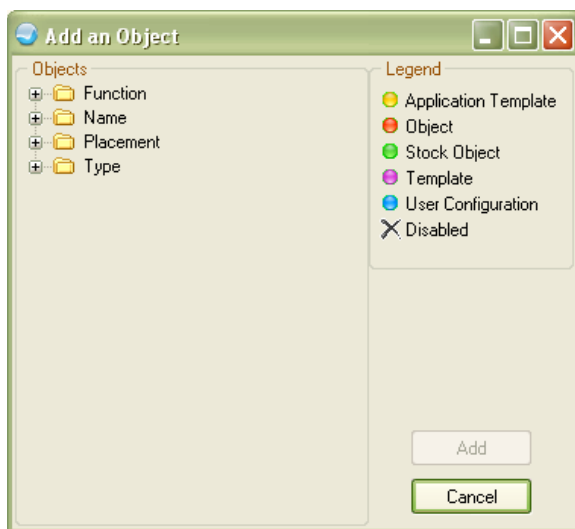


Figure 4-75: Add an Object dialog

4. Click [+] next to **Name** in the **Objects** panel to expand the list.
5. Scroll through the list and select **Lab Point of Care Data Entry**:

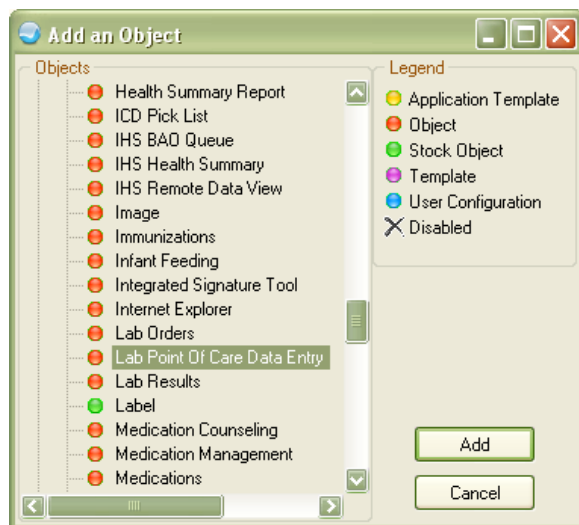


Figure 4-76: Add an Object dialog, object selected

6. Click **Add** to add the POC Lab Entry button to the toolbar; resize and reorganize the buttons to suit:



Figure 4-77: POC Lab Entry button on toolbar

7. On the **Design** menu, select **Save As Template**.
8. Press and hold the **Ctrl** and **Alt** keys, then press **D** to exit *Design Mode*.

### 4.2.3 Patient Lists

**Objective:** “Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.” *42 CFR Part 495.6,(e)(3)(i)*

**Type of Measure:** Attestation

**Threshold:** Generate at least one report listing patients of the provider with a specific condition.

#### 4.2.3.1 RPMS MU Report Logic

**Measure Inclusions:**

COUNT: the generation of one Patient List Report during the EHR reporting period (if count = 1, report “Yes,” if count = 0, report “No”)

The report could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP. Conditions in the patient list should be the same definitions as used in the problem list.

This is a measure for which a State can submit modifications to CMS for approval.

**Measure Exclusion:** None.

#### 4.2.3.2 Configure RPMS

No RPMS configuration is required.

#### 4.2.3.3 Generate Patient Lists in RPMS

For detailed instructions on accessing report functions on RPMS packages refer to the package-specific manual.

##### 1. Generate a Patient List from the Asthma package (BAT):

PATIENTS DUE OR OVERDUE FOR FOLLOWUP

This report will produce a list of all patients on the register who are due for followup. You will select the age range of interest and the date range for which the patient is due.

List Patients with which Register Status: A//  
ACTIVE

Enter Beginning Due Date: 010100 (JAN 01, 2000) (pick a very early date, go way back)

Enter Ending Due Date: 090101 (SEP 01, 2001) (enter a date that is a month or two from the present)

Would you like to restrict the report by Patient age range? YES// NO

Select one of the following:

N Patient Name  
D Patient AGE  
V Patient's Next Asthma Visit Due Date  
A Last Asthma Severity  
L Last Asthma Visit

Sort List by: N//  
Patient Name

Select one of the following:

P PRINT Output  
B BROWSE Output on Screen

Do you wish to: P//  
PRINT Output

```

DEVICE: HOME// Right Margin: 80//

LAB Apr 24, 2001 Page 1

DEMO HOSPITAL/CLINIC
*** ASTHMA REGISTER PATIENTS DUE OR OVERDUE FOR FOLLOWUP ***

Due Dates: Jan 01, 2010 to Sep 01, 2010
Register Status: ACTIVE
PATIENT NAME HRN AGE LAST SEVERITY LAST VISIT NEXT DUE
-----
DEMO, ALICE J 111111 10 YRS 3-MODERATE PERSIS Feb 08, 2001 Aug 07, 2001
DEMO,LORI W 222222 11 YRS 3-MODERATE PERSIS Jan 08, 2001 Jul 07, 2001
DEMO,RONALD A 777777 13 YRS 3-MODERATE PERSIS Feb 01, 2000 Jul 30, 2000
    
```

2. Generate a Patient List from the Clinical Reporting System package (BGP):

```

DEMO INDIAN HOSPITAL
Report Period: Jan 01, 2010 to Dec 31, 2010
Entire Patient List
-----
Source:
HP 2010 3-4
UP=User Pop; AC=Active Clinical; AD=Active Diabetic; AAD=Active Adult
Diabetic
PREG=Pregnant Female; IMM=Active IMM Pkg Pt; IHD=Active Ischemic Heart
Disease

Cancer Screening: Pap Smear Rates:
List of women 21-64 with documented Pap smear or refusal, if any.

PATIENT NAME HRN COMMUNITY SEX AGE DENOMINATOR NUMERATOR
-----
PATIENT,CRSAA 106885 BRAGGS F 21 UP,AC 05/05/02 795.0
PATIENT,CRSBB 116282 BRAGGS F 21 UP
PATIENT,CRS JL 900265 BRAGGS F 21 UP,AC
PATIENT,CRSOA 900384 BRAGGS F 21 UP
PATIENT,CRSCC 109555 BROKEN ARROW F 22 UP,AC 10/31/01 Lab
PATIENT,CRSDD 107131 BROKEN ARROW F 22 UP,AC 07/25/03 Lab
PATIENT,CRSEE 122087 CHECOTAH F 22 UP,AC 09/10/03 Lab
PATIENT,CRSFF 128663 CHECOTAH F 22 UP,AC
PATIENT,CRSGG 171055 CHECOTAH F 22 UP,AC 06/26/03 Lab

Total # of Patients on list: 19
    
```

### 4.2.3.4 Generate Patient Lists in Visual CRS

The Visual CRS **Report Status Check** window lists the reports run by CRS and stored on the computer. To display the **Report Status Check** window, click **Report Status**.

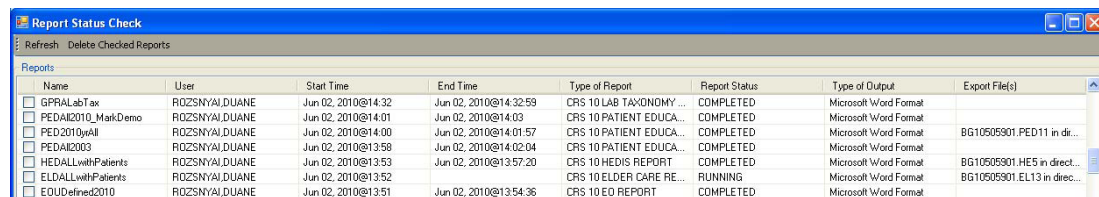


Figure 4-78: Visual CRS Report Status window

Reports that are queued to be run at a later time or are being run when the **Report Status Check** window is opened show the word **RUNNING** in the **Report Status** column. Reports that have already been run show the word **COMPLETED** in this column.

- Select a row to view the associated report.
- To delete one or more reports, select the check box of each, and click **Delete Checked Reports**.
- Click **Refresh** to refresh the list of reports.

### 4.2.4 Patient Reminders

**Objective:** “Send reminders to patients per patient preference for preventive/follow-up care.” *42 CFR Part 495.6,(e)(4)(i)*

**Type of Measure:** Rate

$$\frac{\text{The number of unique patients in the denominator who were sent the appropriate reminder during the EHR reporting period.}}{\text{The number of unique patients 65 years old or older or 5 years old or younger.}} >20\%$$

**Threshold:** 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.

#### 4.2.4.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: Count each patient in the denominator

HAVING: one or more Patient Wellness Handouts generated during the EHR reporting period

**Denominator Inclusions:**

COUNT: each patient

HAVING: an active health record at the beginning of the EHR reporting period

AND HAVING: no date of death recorded at the beginning of the EHR reporting period

HAVING: age of 5 years old and younger at the beginning of the EHR reporting period

OR HAVING: age of 65 years old and older at the beginning of the EHR reporting period

This Performance Measure is not counting patient visits during the EHR reporting period, only PWHs that were generated during the EHR reporting period. The method in which the letter was provided is not considered for this measure. The PWH included for this Performance Measure will include at a minimum: problem list, most recent labs, medication list, and medication allergies list.

This measure is reported for the entire facility, not just for the specified EP, since the patient is not required to have a visit with the EP during the EHR reporting period.

**Measure Exclusion:** The EP is excluded from this measure if the facility does not have any patients in the database who are:

- 5 years old or younger
- 65 years or older

**4.2.4.2 Configure RPMS**

Use the Configure RPMS instructions in Section 4.1.13.2

**4.2.5 Timely Electronic Access to Health Information**

**Objective:** “Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP.” *42 CFR Part 495.6,(e)(5)(i)*

**Type of Measure:** Rate

The number of unique patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.  $\geq 10\%$

The number of unique patients seen by the EP during the EHR reporting period.

**Threshold:** At least 10% of all unique patients seen by the provider during the EHR reporting period are provided timely (available to the patient within four 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.

**4.2.5.1 RPMS MU Report Logic****Numerator Inclusions:**

COUNT: each patient in the denominator

WHEN: EP answers "Yes" to having access to the Personal Health Record (PHR)

If the EP answers "Yes" the numerator equals the denominator.  
If the EP answers "No" the numerator equals 0.

**Denominator Inclusions:**

COUNT: each patient

HAVING: one or more face-to-face visits with the provider (Service Category of A, S, O, or M) during the EHR reporting period

Patient information is available through the PHR patient portal as the information is entered into the EHR and can be accessed by all patients who wish to establish an account; therefore, the four business days requirement is met immediately. Some information may be withheld or delayed as in keeping with HIPAA and assuring optimal patient care services.

**Measure Exclusions:** A provider who neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) may be excluded from this measure and will have to attest to this in separate documentation to CMS. This report will not take any potential exclusion of this measure into account.

**4.2.5.2 Configure RPMS**

No RPMS configuration is required.



### 4.2.6 Patient Specific Education

**Objective:** “Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.” *42 CFR Part 495.6,(e)(6)(i)*

**Type of Measure:** Rate

$$\frac{\text{The number of unique patients in the denominator who are provided patient education specific resources.}}{\text{The number of unique patients seen by the EP during the EHR reporting period.}} >10\%$$

**Threshold:** More than 10% of all unique patients seen by the provider during the EHR reporting period are provided patient-specific education resources.

#### 4.2.6.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each patient in the denominator

HAVING: at least one entry of the patient and family education subtopic of literature (L) during the EHR reporting period

**Denominator Inclusions:**

COUNT: each patient

HAVING: one or more face-to-face visits with the provider (Service Category of A, S, O, or M) during the EHR reporting period

The patient specific education resources must use the capabilities of the certified EHR technology and the EHR must calculate the measure.

The provider can decide which, if any, resources are applicable.

Each provider who sees the patient during the reporting period will be given a numerator inclusion if any provider has issued literature during the EHR reporting period. This eliminates the necessity for each provider to provide duplicate literature to a patient in order to meet Meaningful Use.

**Measure Exclusion:** None.

#### 4.2.6.2 Configure RPMS

No RPMS configuration is required.

### 4.2.6.3 Associate an Education Code to a Charge in EHR

To facilitate documenting of patient literature distribution, create an association between a charge and an education code:

1. Select the **Superbill** tab:

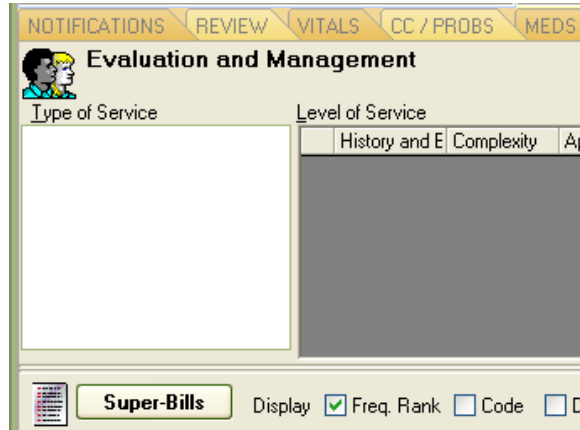


Figure 4-79: EHR Superbills tab

2. Click **Super-Bills** to open the Manage Super-Bills dialog:

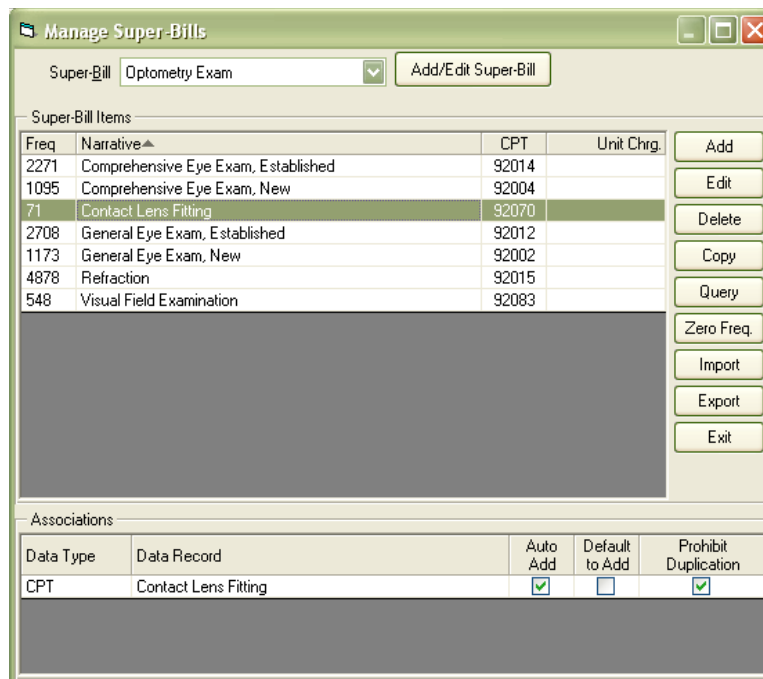


Figure 4-80: Manage Super-Bills dialog

3. Select a category from the Super-Bill list to display the associated Super-Bill Items.
4. Double-click the Super-Bill Item to open the Edit Pick List Item dialog:



Figure 4-81: Edit Pick List Item dialog

5. Click **Add** to open the Add/Edit Pick List Association dialog:

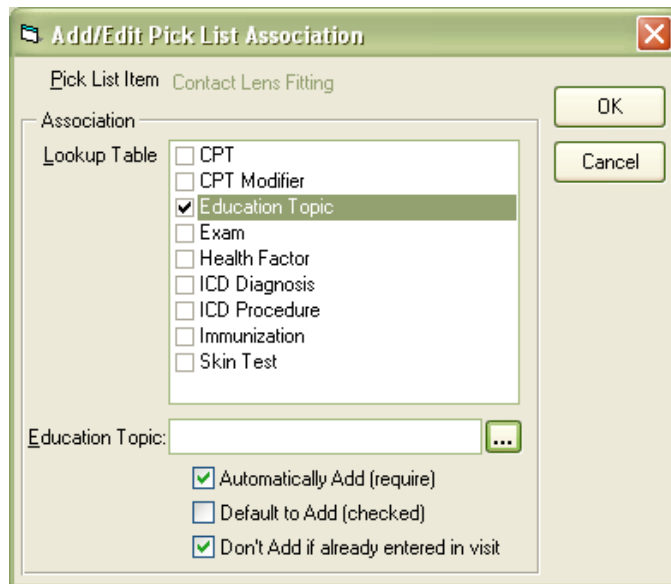


Figure 4-82: Add/Edit Pick List Association dialog

6. Select **Education Topic** in the Lookup Table pane to open the Education Topic Selection dialog:

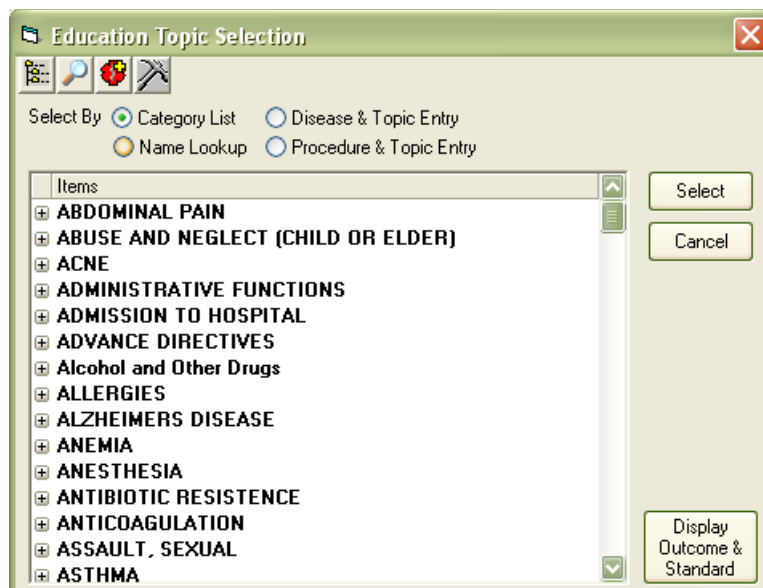


Figure 4-83: Education Topic Selection dialog, Category List view

7. Select one of the **Select By** options:

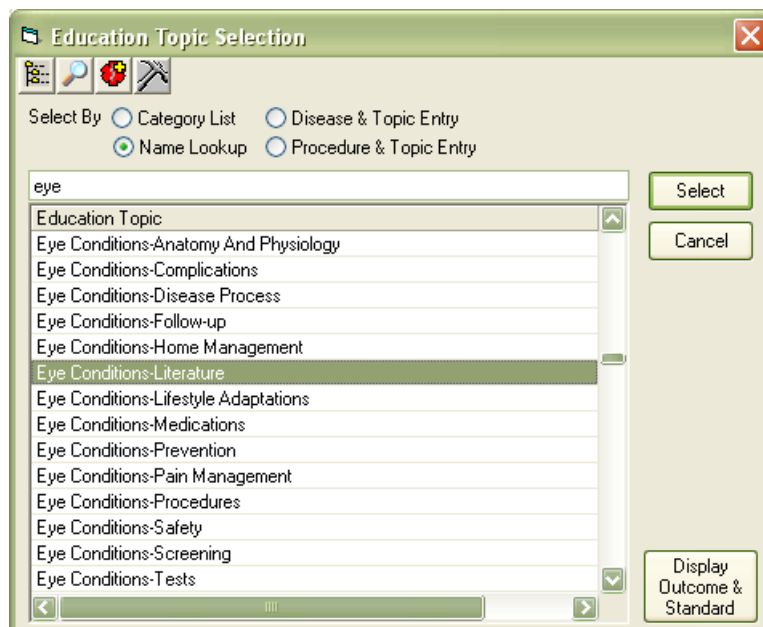


Figure 4-84: Education Topic Selection dialog, Name Lookup view

8. Select the education topic to associate; to meet the measure, the selection should involve Literature.
9. Click **Select** to close the dialog and return to the Edit Pick List Item dialog:



Figure 4-85: Edit Pick List Item dialog with Education Topic associated

10. Click **OK** to close the Edit Pick List Item dialog.
11. Click **Exit** to close the Manage Super-Bills dialog.

#### 4.2.6.4 View and print patient education using the ‘i’ button in EHR

Patient education information may be viewed wherever the button appears in EHR:

1. Select an item in the list or on the pane.
2. Click to open the web browser to the Medline web site; Medline will use the item text to search for pertinent information.
3. View and print the information directly from the browser to a local printer.

#### 4.2.7 Medication Reconciliation

**Objective:** “The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.”  
*42 CFR Part 495.6,(e)(7)(i)*

**Type of Measure:** Rate

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

**Threshold:** The provider performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the provider during the EHR reporting period.

#### 4.2.7.1 RPMS MU Report Logic

##### **Numerator Inclusions:**

COUNT: each visit in the denominator

HAVING: a Patient Education Code of M-MR documented on the day of the visit

In the event the patient has multiple visits on the same day, a medication reconciliation (i.e. Patient Education Code of M-MR) needs only to occur once on the day of the visit.

##### **Denominator Inclusions:**

COUNT: each patient visit with the provider (Service Category of A, S, O, or M) during the EHR reporting period

HAVING: a clinic code not equal to one of the following: 09, 11, 12, 14, 18, 21, 22, 33, 34, 35, 36, 39, 40, 41, 42, 43, 45, 51, 52, 53, 54, 55, 60, 61, 66, 67, 68, 71, 74, 76, 77, 78, 82, 86, 90, 91, 93, 94, 95 or 98, A1, A3, A8, A9, B1, B2, B4, B7, C4, C5, C8, C9, D1, D2, D3, D4

**Measure Exclusions:** EPs who only had encounters during the report period for the following clinic codes are excluded from this measure: 09, 11, 12, 14, 18, 21, 22, 33, 34, 35, 36, 39, 40, 41, 42, 43, 45, 51, 52, 53, 54, 55, 60, 61, 66, 67, 68, 71, 74, 76, 77, 78, 82, 86, 90, 91, 93, 94, 95 or 98, A1, A3, A8, A9, B1, B2, B4, B7, C4, C5, C8, C9, D1, D2, D3, D4.

Encounters to these clinics are not defined as a transition of care.

#### 4.2.7.2 Configure RPMS

No RPMS configuration is required.

#### 4.2.7.3 Set up Education Pick Lists in EHR

1. Select the **Wellness** tab.
2. Click **Add** to display the Education Topic Selection dialog.

3. Select **Pick List**:

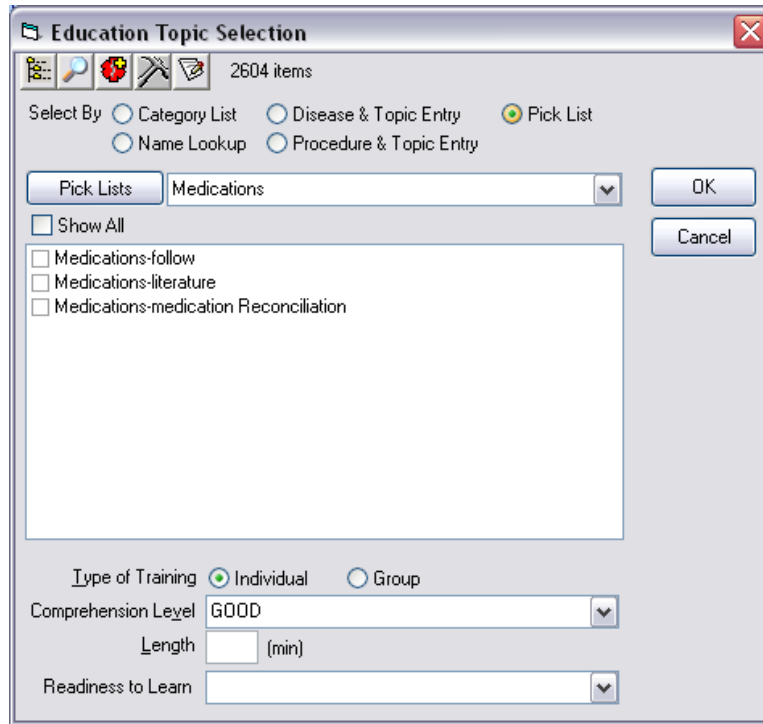


Figure 4-86: Education Topic Selection dialog

4. Click **Pick Lists** to display the Manage Education Quick Picks dialog:

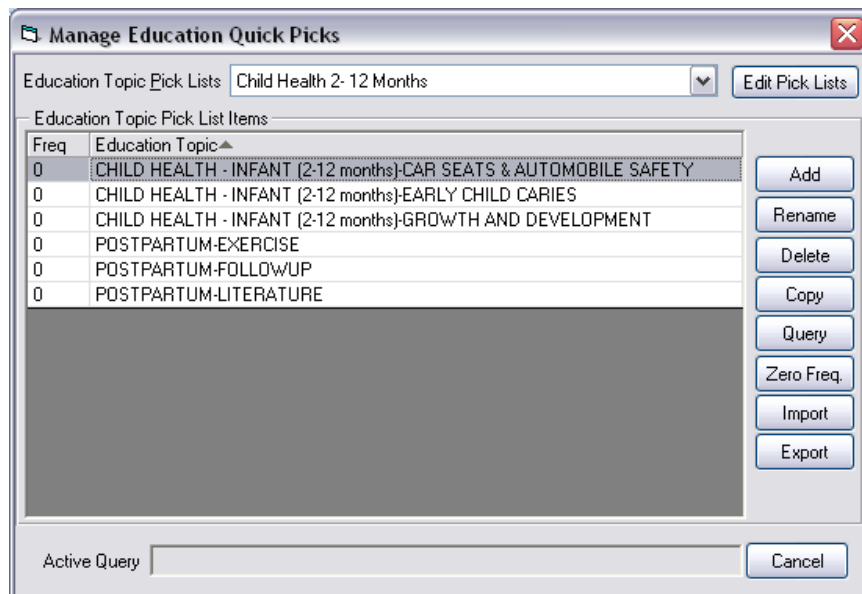


Figure 4-87: Manage Education Quick Picks dialog

5. Click **Edit Pick Lists** to open the Manage Categories dialog:

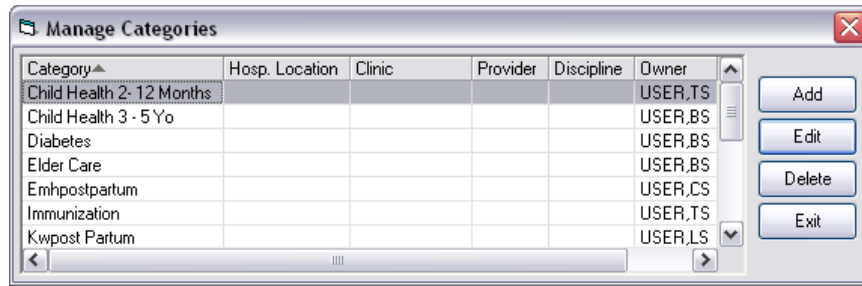


Figure 4-88: Manage Categories dialog

6. Click **Add** to open the Add Category dialog:

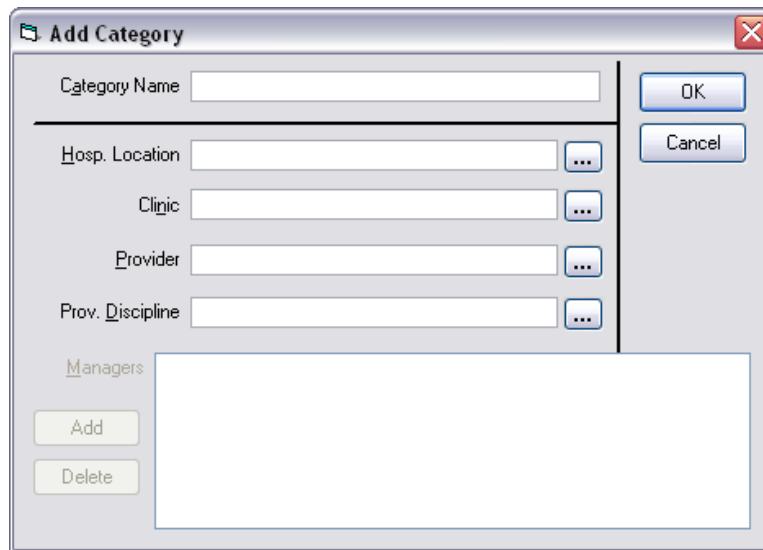


Figure 4-89: Add Category dialog

7. Type **Medications** in the Category Name field.
8. Click **OK** to close the dialog.
9. Click **Exit** to close the Manage Categories dialog.
10. Click **Add** to open the Education Topic Selection dialog:



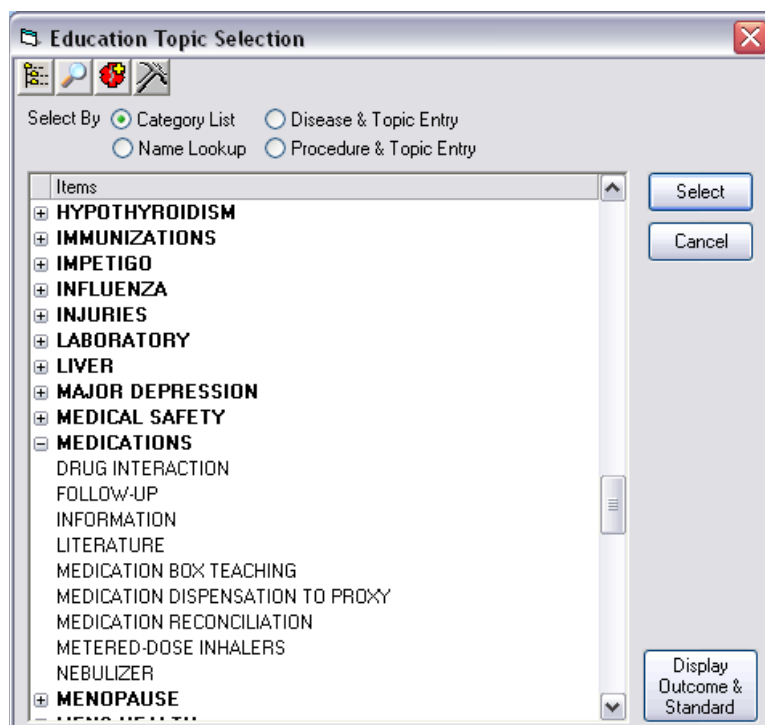


Figure 4-90: Education Topic Selection dialog

11. Scroll through the list to Medications; click [+] to expand the list.
12. Select **Medication Reconciliation**.
13. Click **Select**.
14. Click **Cancel**.

#### 4.2.7.4 Document the Education Code in EHR

1. Select the **Wellness** tab.
2. Click **Add** to display the Education Topic Selection dialog.
3. Select **Pick List**:
4. Select **Medications-medication Reconciliation**.
5. Select **Length** and **Readiness to Learn** values.
6. Click **OK** to close the dialog.
7. The entry is displayed on the Education pane:

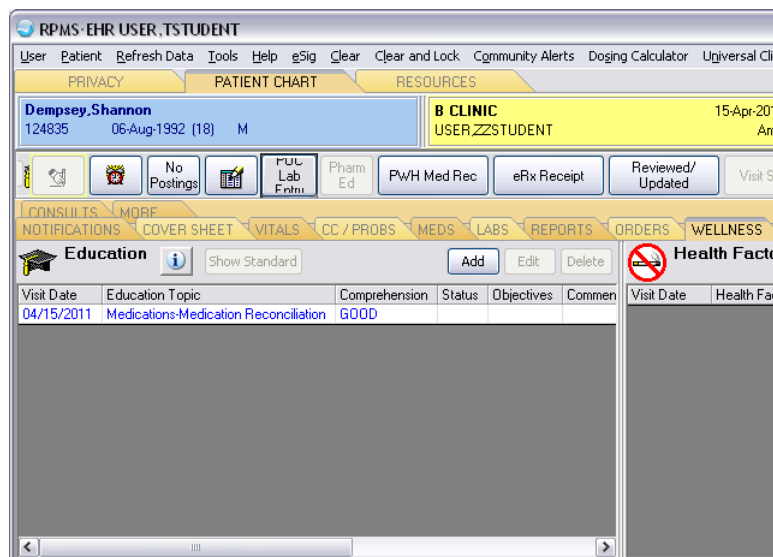


Figure 4-91: EHR Wellness tab, Education pane

#### 4.2.7.5 View a Patient Wellness Handout in EHR

Use the instructions in Section 4.1.13.4.

#### 4.2.8 Summary of Care

**Objective:** “The EP...that 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.” *42 CFR Part 495.6,(e)(8)(i)*

**Type of Measure:** Rate

The number of transitions of care and referrals in the denominator where a summary of care record was provided.

The number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

>50%

**Threshold:** The provider who transitions or refers their patient to another setting of care or provider of care during the EHR reporting period provides a summary of care record for more than 50% of transitions of care and referrals.

##### 4.2.8.1 RPMS MU Report Logic

**Numerator Inclusions:**

COUNT: each event in the Denominator

WHERE: the Summary of Care (C32) was printed within 14 days of the referral initiated date.

Note: The printing of the Summary of Care record (C32) does NOT preclude the provider or CHS clerk from printing and/or electronically transmitting the RPMS Health Summary or any additional information or documentation that may be useful for the receiver of the patient.

**Denominator Inclusions:**

COUNT: each referral

WHERE: the requesting provider is the EP for which we are running the report

AND WHERE: the referral has a Date Initiated between the first day of the EHR reporting period through 14 days before the last day of the EHR reporting period

AND WHERE: the status of Referral is equal to "A" (active) or "C1" (closed completed).

**Measure Exclusions:** EPs that have no referrals meeting the conditions described in the Denominator Inclusions are excluded from this measure.

**Denominator Exclusions:** All in-house referrals.

**4.2.8.2 Configure RPMS**

No RPMS configuration is required.

**4.2.8.3 Generate a Patient Wellness Handout in EHR**

Use the instructions in Section 4.1.13.4.

**4.2.9 Immunization Registries**

**Objective:** “Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.” *42 CFR Part 495.6,(e)(9)(i)*

**Type of Measure:** Attestation

**Threshold:** Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).

#### 4.2.9.1 RPMS MU Report Logic

##### Measure Inclusions:

COUNT: eligible providers

HAVING: performed at least one test of the certified EHR technology's capacity to submit electronic data to immunization registries during the EHR reporting period

AND HAVING: performed follow-up submission if the test was successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) during the EHR reporting period

##### Additional CMS Final Rule Information:

Test data about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.

A failed attempt will meet the measure.

Where no immunization registry exists that has the capacity to receive information electronically during the EHR reporting period, a provider may be excluded from this measure and will have to attest to this in separate documentation to CMS.

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

**Measure Exclusion:** EPs who do not administer one or more immunizations during the EHR reporting period are excluded from this measure.

#### 4.2.9.2 Configure the BYIM Export/Import Group in MailMan

For a complete discussion of the Immunization Interface and the processes it supports, refer to the Immunization Interface Management (BYIM) User Manual.

Add the e-mail addresses of each person who should be notified when an HL7 Immunization Data Export file is ready to be sent to the state registry.

#### 4.2.9.3 Create an HL7 Immunization Data Export file

```
Select Immunization Interchange Management Menu Option: IZDE
Start Immunization Data Export
```

Evaluation of immunizations of children 0-19 for export to the State Immunization registry may take several minutes.

```

Do you want to proceed? NO// YES

The last Immunization export ran on JAN 24,2011
Children 19 and under were born after JAN 24,1992

This export will include all children who have had a visit since the last
export ran or after the date you specify below.

You can enter another date if you want to run the export for another date
range.

Last Immunization export ran on JAN 24,2011
Children 19 and under were born after JAN 24,1992
Export Immunizations starting on JAN 24,2011: JAN 24,2011// 01/01/2010

Requested Start Time: NOW// (JAN 24, 2011@13:20:30)

The immunizations for 375 children 0-19 were evaluated in 2 seconds.

The file 'izdata20070124.dat' will now be created in the HIPAA-compliant
directory. This may take several minutes.

It can be retrieved from this directory for transfer to the State
registry.

Select Immunization Interchange Management Menu Option:

```

#### 4.2.9.4 Transmit the HL7 Immunization Data Export file.

The permissions, processes, and procedures involved in sending updates to a state registry are unique to each State and could also vary from site to site within the same state. Site personnel should work closely with State contacts to ensure that the process is designed and implemented correctly.

RPMS supports both manual and automatic transmission of the file:

- Manual transmission can be done by someone having both the appropriate security clearance and a valid state registry supplied username and password.
- Automatic transmission requires HL7 Communications Bridge software, a commercial third-party software, to be installed and configured at the site.

#### 4.2.10 Syndromic Surveillance

**Objective:** “Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.” *42 CFR Part 495.6,(e)(7)(i)*

States may modify this objective.

**Type of Measure:** Attestation

**Threshold:** Perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which the provider submits such information have the capacity to receive the information electronically).

#### 4.2.10.1 RPMS MU Report Logic

##### Measure Inclusions:

COUNT: eligible providers

HAVING: performed at least one test of the certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies during the EHR reporting period

AND HAVING: performed follow-up submission if the test was successful (unless none of the public health agencies to which the EP submits such information has the capacity to receive the information electronically) during the EHR reporting period

##### Additional CMS Final Rule Information:

A public health agency is an entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, or State, city, or county level administration that serves a public health function.

Test must involve a real submission but may use test data that is identical to a fictional patient. A failed attempt will meet the measure. The test could be started before the start of the EHR reporting period and must be completed prior to the end of the EHR reporting period.

Each payment year would require its own unique test. The test must be conducted with the certified EHR technology in accordance with the standards specified in the ONC rule at 45 CFR 170.302(l).

Where no public health agency exists that has the capacity to receive information electronically during the EHR reporting period, a hospital or CAH may be excluded from this measure and will have to attest to this in separate documentation to CMS. This report will not take any potential exclusion of this measure into account.

**Measure Exclusion:** EPs who do not collect any reportable syndromic surveillance information on patients during the EHR reporting period are excluded from this measure.

#### 4.2.10.2 Participate in the IHS Influenza Awareness System

In order to meet the MU Performance Measure, the site must participate in the IHS Influenza Awareness System. To participate:

1. Install PCC Management Reports (namespace APCL) Version 3.0 Patch 27, which includes the RPMS Influenza-Like Illness (ILI)/H1N1 Surveillance Export.
2. Ensure that data is being sent to the IHS Division of Epidemiology and Disease Prevention by setting up an e-mail export file receipt notification:
  - a. Find the Area - Service Unit - Facility (ASUFAC) code for your site at: [http://www.ihs.gov/scb//index.cfm?module=W\\_FACILITY&option=list&num=38&newquery=1](http://www.ihs.gov/scb//index.cfm?module=W_FACILITY&option=list&num=38&newquery=1) (in the column titled 'code').
  - b. Prepare an e-mail to the IHS Help Desk ([support@ihs.gov](mailto:support@ihs.gov)) with the subject line:  
**Flu Illness Reporting System - export file receipt**
  - c. Include in the body of the message:

```
"Helpdesk - this request should be routed to the ILI Contact Request Support personnel.
```

```
Please add the e-mail address(es):
```

```
[list e-mail address(es)]
```

```
to the list of users who automatically receive an e-mail after an export file is sent to the IHS Data Integration Service.
```

```
I am requesting export file receipt notifications for the site [site name here] with ASUFAC code [ASUFAC code here]."
```

- d. Send the e-mail message.

# Appendix A: “Cheat Sheet”

## A.1 Core Measures

For Stage 1, Eligible Professionals (EP) must report on all measures shown in the Core Set, unless the EP meets measure exclusions. Use the “Stage 1 Interim Meaningful Use (MU) Performance Report-EPs” in the Patient Care Component (PCC) Management Reports to monitor measure performance.

The EP must ensure that all versions and patches of the software that comprise the certified Resource and Patient Management System (RPMS) Electronic Health Record (EHR) are installed. The versions and patches required for each Measure are shown in the Software Requirements column of this appendix; an integrated list may be viewed at: [\[http://www.ihs.gov/recovery/documents/CertEHR-MUAppChecklist.pdf\]](http://www.ihs.gov/recovery/documents/CertEHR-MUAppChecklist.pdf).

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
<p>Computer Provider Order Entry (CPOE) Medication: &gt;30% of all unique patients with at least one medication in their medication list seen by the EP during reporting period have at least one medication order entered using CPOE.</p> <p>NOTE: In Stage 2, the measure target increases to 60%.</p> <p>Exclusion: EPs who enter &lt;100 prescriptions during the EHR reporting period.</p>	<p>Section 4.1.1 Maintain and clean up Drug file Configure medications for CPOE in Pharmacy Data Management (PDM) and OE/RR Quick Orders and Menus CPOE of a medication through EHR Ensure only licensed healthcare professionals are assigned the ORES or ORELSE keys What Lowers Your Rate for this Measure? Medication orders entered by ORELSE key holders and signed on chart or hold until signed Orders entered by Pharmacy or Nursing staff and sent to provider for review/signature – this is NOT CPOE</p>	<p>EHR v1.1 patch 8 PCC patch 6</p>	<p>1. Select Meds tab 2. Order a Medication</p>	<p>N/A</p>



Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Drug-Drug & Drug-Allergy Checks: The EP has enabled this functionality for the entire reporting period. (Yes/No answer, determined by report)	<p>Section 4.1.2</p> <p>Ensure both checks are enabled at the facility</p> <p>Enable and set to mandatory ten order checks to include Allergy-Contrast Media Interaction, Estimated Creatinine Clearance, Allergy-Drug Interaction, Allergy-Contrast Media Interaction, Critical Drug Interaction, Renal Functions Over Age 65, Glucophage-Contrast Media, Glucophage-Lab Results, Dangerous Meds for Patient &gt;64, No Allergy Assessment, and Allergy Unassessible.</p> <p>Review the 10 order checks for individual providers and delete if previously configured or enabled</p>	EHR v1.1 patch 8 PCC patch 6	<ol style="list-style-type: none"> <li>1. Select Options from Tools menu</li> <li>2. Select Order Checks tab</li> <li>3. Scroll through list to verify that all required Adverse Reaction order checks are enabled</li> </ol>	N/A
E-Prescribing: >40% of all EP's permissible prescriptions written during reporting period are transmitted using certified EHR technology. Exclusion: EPs who enter <100 prescriptions during the EHR reporting period.	<p>Section 4.1.3</p> <p>Configure medications for ePrescribing in PDM and OE/RR Quick Orders and Menus</p> <p>Order/transmit scripts electronically, regardless of whether the pharmacy is on- or off-site</p> <p>What Lowers your Rate for this Measure? Prescriptions with a wet signature</p>	ePrescribing PCC patch 6	<ol style="list-style-type: none"> <li>1. Order a Medication through the Orders tab.</li> <li>2. Click the ePrescribing Receipt button.</li> </ol>	N/A
Demographics: >50% of unique patients seen by EP during reporting period have all demographics recorded as structured data.	<p>Section 4.1.4</p> <p>Set Patient Registration options to mandatory for Preferred Language, Race, Ethnicity, Sex, Date of Birth</p> <p>Patient Registration to review and update Preferred Language, Race, Ethnicity, Sex, Date of Birth at each patient encounter</p> <p>Preferred Language is NOT the same as Primary Language (two separate fields)</p>	Patient Registration patch 9 PCC patch 6	<ol style="list-style-type: none"> <li>1. Click the Patient Detail button</li> <li>2. View: <ul style="list-style-type: none"> <li>• Preferred Language</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Sex</li> <li>• Date of Birth</li> </ul> </li> </ol>	<p>Enter and view:</p> <ul style="list-style-type: none"> <li>• Preferred Language</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Sex</li> <li>• Date of Birth</li> </ul>

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
Problem List: >80% of unique patients seen by EP during reporting period have active problem on problem list or indication of no active problems.	Section 4.1.5 Medical staff to delineate guidelines for maintaining active and inactive Problem Lists If patient has no active problems, you must use functionality for entering No Active Problems	EHR v1.1 patch 8 PCC patch 6	<ol style="list-style-type: none"> <li>1. Select Cover Sheet</li> <li>2. Right Click Active Problem List</li> <li>3. Select Chart Review:</li> <li>4. Select Reviewed to review active problems</li> <li>5. Select No Active Problems to set structured data</li> </ol>	<ol style="list-style-type: none"> <li>1. Select Problem List tab</li> <li>2. Click: <ul style="list-style-type: none"> <li>• Add Problem</li> <li>• Edit Problem</li> <li>• Delete Problem</li> </ul> </li> </ol>
Medication List: >80% of unique patients seen by EP during reporting period have entry of active medications on medication list or indication of no active medications.	Section 4.1.6 Optimize the Pharmacy suite of applications to include the outside medication option and medication reconciliation Maintain and clean up Drug file Configure medications for CPOE in PDM and OE/RR Quick Orders and Menus	EHR v1.1 patch 8 PCC patch 6	<ol style="list-style-type: none"> <li>1. Select Cover Sheet</li> <li>2. Right Click Medication List</li> <li>3. Select Chart Review:</li> <li>4. Select Reviewed to review active problems</li> <li>5. Select No Active Medications to set structured data</li> </ol>	<ol style="list-style-type: none"> <li>1. Select PCC tab</li> <li>2. Select Type =Medications</li> </ol>

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
<p>Medication Allergy Lists: &gt;80% of unique patients seen by EP during reporting period have active medication allergy on medication allergy list or indication of no active medication allergies.</p>	<p>Section 4.1.7 Configure Adverse Reaction Tracking Package parameters Enable Order Checks in OE/RR Package Document allergies to include no known allergies through EHR The Problem List Allergy List (PLAL) Report can be used to identify patient drug allergies that are on the patient's Problem List but not on their Allergies List Pharmacy to generate Adverse Reaction tracking non-verified allergies report and verify unverified allergies What Lowers your Rate for this Measure? Entering adverse reactions in the Problem List and not in Adverse Reaction Tracking Package</p>	<p>EHR v1.1 patch 8 PCC patch 6</p>	<ol style="list-style-type: none"> <li>1. Right Click in Adverse Reactions</li> <li>2. Review the following:                             <ul style="list-style-type: none"> <li>• Edit Adverse Reaction</li> <li>• Delete Adverse Reaction</li> <li>• New Adverse Reaction</li> <li>• Sign Adverse Reaction</li> <li>• Select Inability to Assess</li> <li>• Select a Reason</li> </ul> </li> <li>3. Select Chart Review: Select Reviewed to review active problems Select No Active Medications to set structured data</li> </ol>	<ol style="list-style-type: none"> <li>1. Select Summ/Sup tab</li> <li>2. Select Type=Patient Wellness Handout</li> <li>3. Select Medication Reconciliation from second list.</li> </ol>

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
<p>Vital Signs: &gt;50% of unique patients age two years or older seen by EP during reporting period have all vital signs recorded as structured data.</p> <p>Exclusion: EPs who see no patients two years or older during the EHR reporting period.</p>	<p>Section 4.1.8</p> <p>Create a vital signs template for EHR data entry</p> <p>Create a template for display of measurements on EHR Cover Sheet</p> <p>Assign data entry permission to appropriate providers and user classes</p> <p>Ensure each patient has their blood pressure, weight, AND height recorded at each encounter</p>	<p>EHR v1.1 patch 8</p> <p>PCC patch 6</p>	<ol style="list-style-type: none"> <li>1. Select Vitals tab</li> <li>2. Click New Date/Time</li> <li>3. Select Now</li> <li>4. Enter vitals:                             <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood pressure</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>1. Select Snapshot tab</li> <li>2. View Measurements pane</li> </ol>
<p>Smoking Status: &gt;50% of unique patients age 13+ seen by EP during reporting period have smoking status recorded as structured data.</p> <p>Exclusion: EPs who see no patients 13 years or older during the EHR reporting period.</p>	<p>Section 4.1.9</p> <p>Ensure all patients seen during the reporting period have been screened for tobacco status</p>	<p>EHR v1.1 patch 8</p> <p>PCC patch 6</p>	<ol style="list-style-type: none"> <li>1. Select Wellness tab</li> <li>2. Locate Health Factors pane</li> <li>3. Click Add</li> <li>4. Click '+' to expand:                             <ul style="list-style-type: none"> <li>• Select a Status</li> <li>• Tobacco (Exposure)</li> <li>• Tobacco (Smokeless ...)</li> <li>• Tobacco (Smoking)</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>1. Select PCC tab</li> <li>2. Select Type=Health Factors</li> <li>3. View Smoking Status</li> </ol>

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
<p>Clinical Decision Support: Implement one clinical decision support rule. (Yes/No answer, provided by person running report)</p>	<p>Section 4.1.10 Ensure Clinical Reminders installed and national reminders configured and/or Have at least one of the following configured on the EHR Reports tab: Diabetes, Pre-Diabetes, Asthma, Anti-coagulation, or Women's Health Supplement; Immunization Package Forecasting; or Health Maintenance Reminders The report will automatically display "Yes" if any of the above are found to be installed, or "No" if none of the above are found to be installed</p>	<p>EHR v1.1 patch 8 Clinical Reminders v1.5 patch 1007 PCC patch 6</p>	<ol style="list-style-type: none"> <li>1. Select Reports tab</li> <li>2. Select a supplement: <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Pre-Diabetes</li> <li>• Asthma</li> <li>• Anti-coagulation</li> <li>• Women's Health</li> </ul> </li> <li>3. View the report</li> </ol>	<ol style="list-style-type: none"> <li>1. Select Summ/Sup tab</li> <li>2. Select Type= Supplements</li> <li>3. Select from second list: <ul style="list-style-type: none"> <li>• Asthma</li> <li>• Diabetes</li> <li>• Pre-diabetes</li> <li>• Women's Health</li> </ul> </li> </ol>
<p>Clinical Quality Measures: Report 9 MU EP measures to CMS (for Medicare) or the state (for Medicaid-starting in year 2 of MU). (Yes/No answer, provided by person running report)</p>	<p>Section 4.1.11 Ensure Clinical Reporting System v11.0 Patch 2 is installed. Run EP Performance Measure Report for a selected 90-day period during the first participation year or the full calendar year for subsequent participation years Choose the Selected Measures (User Defined) report Choose all core and alternate core measures (marked with (C) and (A)) and three other measures If any of the core measures have denominator=0, report all three alternate core measures If any of the other measures have denominator=0, select three other measures that do not have denominator=0. There are no performance targets that must be met for Stage 1 MU Save report since the information will need to be provided to CMS or the State (details to be provided in April 2011)</p>	<p>CRS v11 patch 2, PCC patch 6 NOTE: If you have a denominator equal to zero for any of the three menu set measures included in CRS v11 patch 2, you will need to wait until CRS v11.1 is released that will have additional EPs measure selections.</p>	<p>Generate the Clinical Quality Measures Report in RPMS Roll and Scroll.</p>	<p>N/A</p>

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
<p>Electronic Copy of Health Information: &gt;50% of patients of the EP who request an electronic copy of their health information are provided it within three business days.                      Exclusion: EPs who have no requests for electronic copy of health information.</p>	<p>Section 4.1.12                      Configure PCC Health Summary, Patient Wellness Handout, Discharge Summary, and Discharge Instructions within the EHR                      Provide the information electronically to the patient, such as by CD, encrypted e-mail, or on a memory stick provided by the facility                      Document in Release of Information (ROI) requests for electronic copy of health information (enter as Patient/Agent Request Type=Electronic)                      Document in ROI information was provided electronically (enter as Record Dissemination =Electronic) and record the Disclosure Date</p>	<p>EHR v1.1 patch 8                      C32 v1                      PCC patch 6                      ROI v2 patch 3</p>	<p>[C32 button]</p>	<p>N/A</p>
<p>Clinical Summaries: Clinical summaries provided to patients for &gt;50% of all office visits within three business days.                      Exclusion: EPs who have no office visits during the EHR reporting period.</p>	<p>Section 4.1.13                      Configure PCC Health Summary and Patient Wellness handout within the EHR                      Provide patients their Patient Wellness handout at each patient encounter                      Monitor Patient Wellness handout count report</p>	<p>EHR v1.1 patch 8                      C32 v1                      PCC patch 6</p>	<p>1. Click PWH button                      2. Print</p>	<p>N/A</p>

Core Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCARE Scavenger Hunt
<p>Exchange Key Clinical Information: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. (Yes/No answer, provided by person running report)</p>	<p>Section 4.1.14                      This will be accomplished using a C32 format that is just being delivered and a print/receive/transmit function that is being developed by MedSphere for EHR                      All federal sites will perform the test by submitting their C32s to the IHS national repository                      The IHS Office of Information Technology will notify the Area MU Coordinators of the results of this test                      Tribal RPMS sites have the option to perform the test as described above or with another entity (e.g. a state Health Information Exchange (HIE))</p>	<p>Universal Client for Continuity of Care Record (CCR),                      C32 for Continuity of Care Document (CCD),                      EHR v1.1 patch 8</p>	<p>N/A</p>	<p>N/A</p>
<p>Privacy/Security: Conduct or review a security risk analysis of the certified EHR, implement security updates, and correct deficiencies. (Yes/No answer, provided by person running report)</p>	<p>Section 4.1.15                      Conduct security risk analysis (RA) by using the OIT-developed template:  <a href="http://www.ihs.gov/recovery/documents/MURiskAnalysisOffice2003.doc">http://www.ihs.gov/recovery/documents/MURiskAnalysisOffice2003.doc</a>                      Correct deficiencies noted as part of the RA.                      Ensure a sanction policy is adopted (required for federal sites; tribal/urban sites may elect to adopt IHS policy). If your site adopts sections from Part 8 of the IHS Manual, in whole or in part and IHS SOPs and appropriate SGMS, this will meet the requirements of adopting a sanction policy                      Review Logs and Incident Reports: Use Tipping Point or the logs implemented through RPMS to support MU</p>	<p>VanDyke for AIX                      IPSEC for Windows                      Winhasher 1.6                      Security assessment                      Symantec 8.0</p>	<p>N/A</p>	<p>N/A</p>

## A.2 Menu Set Measures

For Stage 1, EPs must report on five measures shown in the Menu Set below unless the EP meets measure exclusions.

EPs must choose at least one of the two public health measures, which are preceded with an asterisk "\*" in the left column below.

The EP must ensure that all versions and patches of the software that comprise the certified RPMS EHR are installed. The versions and patches required for each Measure are shown in the Software Requirements column of this appendix; an integrated list may be viewed at: <http://www.ihs.gov/recovery/documents/CertEHR-MUAppChecklist.pdf>.

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
<p>Drug-Formulary Checks: The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. (Yes/No answer, determined by report)</p> <p>Exclusion: EPs who order &lt;100 prescriptions during the EHR reporting period.</p>	<p>Section 4.2.1</p> <p>Use the RPMS EHR for pharmacy CPOE (drug-formulary check is always enabled).</p> <p>Mark non-formulary drugs as "non-formulary" in the drug file.</p>	<p>EHR v1.1 patch 8</p> <p>PCC v2 patch 6</p> <p>Pharmacy v7.0 patch 1010,</p>	<ol style="list-style-type: none"> <li>1. Select Meds tab</li> <li>2. Order a Medication</li> <li>3. Select a non-formulary med ('NF' is appended to the name)</li> <li>4. Formulary Alternatives dialog displays</li> </ol>	<p>N/A</p>



Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
<p>Lab Results into EHR: &gt;40% of all clinical lab results ordered by EP during reporting period whose results are either in a positive/negative or numerical format are incorporated in the certified EHR as structured data.</p> <p>Exclusion: EPs who orders no lab tests with results that are displayed in either a positive/negative or numeric format during the EHR reporting period.</p>	<p>Section 4.2.2</p> <p>Sites Using RPMS Lab Package to Order &amp; Result Lab Tests</p> <p>Use and maintain Lab package for use with EHR.</p> <p>If not using Data Innovations in-house interface for in-house labs, order labs using RPMS EHR but manually enter test results into RPMS Lab package.</p> <p>Use Bi-directional Reference Lab Interface for labs that are performed by a reference lab (e.g. Quest, LabCorp).</p> <p>If NOT using the bi-directional interface for Send-out labs, order labs using RPMS EHR but manually enter test results into RPMS Lab package.</p> <p>If using the unidirectional interface data is entered directly into PCC.</p> <p>Configure the EHR Point of Care lab button.</p> <p>Sites Not Using RPMS Lab Package to Order &amp; Result Lab Tests</p> <p>Manually enter lab results into PCC.</p>	<p>EHR v1.1 patch 8</p> <p>PCC patch 6</p> <p>Lab Package v5.2 patch 1027</p>	<ol style="list-style-type: none"> <li>1. Select Lab tab</li> <li>2. Review Laboratory Results</li> </ol>	<ol style="list-style-type: none"> <li>1. Select PCC tab</li> <li>2. Select Type=Labs</li> <li>3. View Lab Results</li> </ol>

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
<p>Patient List: Generate at least one report listing the EP's patients with a specific condition. (Yes/No answer, provided by person running report)</p>	<p>Section 4.2.3                      Generate at least one list of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.                      Examples of reports include Diabetes, Asthma, Women's Health, Adverse Reaction Tracking, Immunizations, Obesity Prevalence, Clinical Report System, and iCare.                      Save the list to a file, if desired, as proof of its generation.</p>	<p>PCC patch 6,                      iCare v2.1,                      CRS 11 patch 2</p>	<p>Generate a List using the RPMS Roll and Scroll for:</p> <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Asthma</li> <li>• Women's Health</li> <li>• Adverse Reaction Tracking</li> <li>• Immunizations</li> <li>• Obesity Prevalence</li> <li>• Clinical Report System</li> </ul>	<ol style="list-style-type: none"> <li>1. Select Panel List tab</li> <li>2. Click New</li> <li>3. Select Ad Hoc Search</li> <li>4. Type the Panel Name</li> <li>5. Select the Patient filter</li> <li>6. Select the Diagnostic Tag filter</li> <li>7. Click Edit</li> <li>8. Select the diagnosis</li> <li>9. Click Add to move the selection to Current Selections</li> <li>10. Click OK</li> <li>11. Set additional filters as desired</li> <li>12. Click OK</li> <li>13. View the panel</li> </ol>
<p>Patient Reminders: &gt;20% of unique patients 65+ or &lt;=5 were sent an appropriate reminder during the reporting period.                      Exclusion: The facility that does not have any patients in the database who are 1) five years old or younger or 2) 65 years or older, the EP is excluded from this measure.</p>	<p>Section 4.2.4                      Generate and provide a Patient Wellness Handout (PWH) to patients 65+ or &lt;=5 who are due for a screening/care.                      NOTE: While not required for this measure, we encourage sites to collect patients' e-mail addresses during patient registration.</p>	<p>EHR v1.1 patch 8                      PCC patch 6                      iCare v2.1                      Optional: Patient Registration v7.1 patch 9</p>	<ol style="list-style-type: none"> <li>1. Click the PWH button</li> <li>2. Print</li> </ol>	<p>N/A – PWH available however printing is not tallied</p>

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
Timely Electronic Access to Health Information: At least 10% of unique patients seen by EP are provided timely (available within four business days) electronic access to their health information. NOTE: Measure rate will be set to 100% if person running report indicates the site is connected to the Personal Health Record (PHR); otherwise, it will be set to 0%.	Section 4.2.5 Ensure facility is connected to the Personal Health Record.  Ensure patients are informed they know how to sign up for the PHR to obtain information on their lab results, problem list, medication list, and medication allergies.	Personal Health Record v1, PCC patch 6	N/A	N/A
Patient-specific Education: >10% of unique patients seen by EP are provided patient-specific education resources.	Section 4.2.6 Provide printed patient education materials to patients and Document education with a sub-topic of "Literature," for example, Diabetes Mellitus-Literature.	EHR v1.1 patch 8, PCC patch 6	1. Click "I" 2. Print information 3. Document education at the Add Patient Education dialog.	N/A
Medication Reconciliation: EP performs medication reconciliation for >50% of transitions of care in which the patient is transitioned into the care of the EP.	Section 4.2.7 Configure the medication reconciliation patient wellness handout according to the configuration instructions for EHR v 1.1 patch 6 & patch 7. Perform the medication reconciliation for transitions of care and  In the Education component (normally in the Wellness tab), add patient education by selecting Name Lookup, type Medications, and selecting Medications-Medication Reconciliation (Patient Education Code of M-MR).	EHR v1.1 patch 8, PCC patch 6	1. Select the Meds tab 2. Find and Print the Medication Reconciliation Patient Wellness Handout.	N/A

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
<p>Summary of Care: EP who transitions or refers their patient to another care setting/provider gives summary of care for &gt;50% of transitions of care/referrals.                      Exclusion: EPs that have no referrals during the EHR reporting.</p>	<p>Section 4.2.8                      Print C32 Summary of Care record for all active referrals and give to patient and/or receiving provider:                      Access the RCIS tab (next to Resources tab) to view list of referrals, including those that have not had a C32 printed                      To print a C32, select the patient, click Referrals tab, click the referral, and click the "Print C32 for Referral" button (above the Referral Date From/To row)                      OR                      RCIS staff views a list of active referrals for which C32s need to be printed by running the "Active Referrals without a Printed C32" report from the Administrative Reports menu. They can then login to the RPMS EHR to print the C32 for a specific referral and provide to the patient and/or receiving provider</p>	<p>EHR v1.1 patch 8,                      PCC patch 6                      RCIS v4.0 patch 7t1,</p>	<p>[C32 button]</p>	<p>N/A</p>
<p>*Immunization Registries: Perform at least one test of certified EHR's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful. NOTE: EPs should not choose this measure if their respective state does not have an immunization registry and/or does not have the capacity to receive the information electronically. (Yes/No answer, provided by person running report)</p>	<p>Section 4.2.9                      A single test for all of IHS will be performed with a state immunization registry.                      The IHS Office of Information Technology will notify the Area MU Coordinators of the results of this test.</p>	<p>Immunization Exchange v2 patch 1,                      PCC patch 6</p>	<p>N/A</p>	<p>N/A</p>

Menu Set Measure	How to Meet it Using RPMS EHR	Software Requirements	EHR Scavenger Hunt	iCare Scavenger Hunt
<p>*Syndromic Surveillance: Perform at least one test of certified EHR's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful. (Yes/No answer, provided by person running report)</p>	<p>Section 4.2.10 Ensure the facility is transmitting the revised RPMS ILI/H1N1 Surveillance Export to the IHS Division of Epidemiology and Disease Prevention. This requires installation of PCC Reports (APCL) Version 3.0 Patch 27. Sign up to receive an e-mail export file receipt notification. Receipt of the e-mail confirmation export file receipt will serve as the attestation of this measure for MU.</p>	<p>Package Version Patch Level PCC patch 6</p>	<p>N/A</p>	<p>N/A</p>

## Appendix B: Meaningful Use Reports

These reports will calculate and determine if the minimum requirements to achieve Meaningful Use (MU) have been met. For Stage 1 of the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program, there are 15 core Performance Measures for Eligible Professionals (EP) that must be met simultaneously during the EHR reporting period. Additionally, EPs must meet five of the ten menu set Performance Measures simultaneously, one of which must be designated as a Public Health Performance Measure. Public Health measures are marked with an asterisk throughout the report.

```

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

DEMO IHS CLINIC

M1IP  Stage 1 Interim MU Performance Report-EPs
PLP Stage 1 Interim MU Patient List-EPs
M1IH  Stage 1 Interim MU Performance Report-Hospitals
PLH Stage 1 Interim MU Patient List-Hospitals

Select Meaningful Use Performance Reports Option:
    
```

### B.1 Estimated Run Time

Generate these reports during a period of low system usage. The run time will depend on the size of the site’s database.

### B.2 Produce the Interim Meaningful Use Performance Reports for EPs (M1IP)

Choosing the Stage 1 Interim MU Performance Report for EPs displays the following message:

```

*** IHS 2011 Stage 1 Interim Meaningful Use Performance Report for EPs ***

This report determines if primary and secondary providers have met the
minimum requirements to achieve Meaningful Use. The report identifies the
15 Core Performance Measures and 10 Menu Set Performance Measures
designated by the CMS Final Rule for Stage 1, July 28, 2010.

In order to achieve Meaningful Use, a provider must meet all 15 Core
Performance Measures simultaneously. They must also meet 5 of the 10 Menu
Set Performance Measures simultaneously, one of which must be a designated
Public Health Performance Measure. Public Health measures are identified
within the report by an asterisk.

Press Enter to Continue:
    
```

The following sections describe the steps to take after the report is selected.

## B.2.1 Eligibility Notice for EPs

This interim report does not verify participation eligibility.

This report can indicate that a professional who is not eligible to participate in the program has achieved MU.

Eligibility is determined by running the MU Patient Volume Report for Eligible Professionals (PVP) located in the Third-Party Billing application. The notice below displays before the option to run the report is given:

```
***** IMPORTANT NOTICE *****  
  
This interim report does not verify CMS Medicare or Medicaid EHR Incentive  
Program eligibility. Please speak to your Area Meaningful Use Coordinator  
for guidance in determining eligibility.  
  
Do you wish to continue to report? Y//
```

Type **Yes** to open the Patient List set up; type **No** to return to the main menu.

## B.2.2 Full Report or Summary Report Selection

Two versions of the report are available:

- Full Report includes the Cover Page and details on each Performance Measure along with corresponding logic. The Full Report also includes a Summary Report.
- The Summary Report does not include programming logic.

Both reports display previous and current performance results as well as Stage 1 targets.

```
A full report will include an itemized listing of all Performance Measures  
and will include a summary report. The summary report excludes itemized  
data. The full report will produce approximately 40 pages of data for each  
provider. Please take this into consideration when running print jobs,  
ensuring dedicated time on your printer and sufficient paper supplies to  
complete your job.
```

```
Select one of the following:
```

```
      F          Full Report  
      S          Summary Report
```

```
Enter Selection: F//
```

### B.2.3 Report Period Selection

The report may be run for a full year or for a 90-day period. These two options coincide with the CMS program parameters for reporting periods.

```
Report may be run for a 90-day or a one year period.
```

```
Select one of the following:
```

- ```
A  January 1 - December 31
B  User Defined 90-Day Report
```

```
Select Report Period: [A/B]
```

This report can be run for any date; however, per CMS guidelines, MU cannot be achieved with the RPMS EHR prior to its date of certification and installation.

For example, if the certified version of RPMS EHR was installed on July 27th, the report may be run for periods prior to this date, but MU can only be achieved on performance for a period that begins on or after July 28th.

#### B.2.3.1 Calendar Year Selection

The MU program for EPs runs on a calendar year. Enter a calendar year for which to run the report.

```
Enter Calendar Year for which report is to be run. Use a 4 digit year, e.g.
2011.
```

```
Enter Year: [CCYY]
```

#### B.2.3.2 User Defined 90-Day Report Selection

Enter a start date for the 90-day report.

```
Enter Start Date for the 90-day Report (e.g. 01/01/2011):
```

### B.2.4 Provider Selection

Choose one of the provider options below.

```
Select one of the following:
```

- ```
IP Individual Provider
SEL Selected Providers (User Defined)
TAX Provider Taxonomy List
```

```
Enter Selection: [XXX]
```



**B.2.4.1 Individual Provider (IP)**

If Individual Provider is chosen, type the provider name. Either the full or summary report as previously selected will be generated for the designated provider.

Enter the name of the provider for whom the Meaningful Use Report will be run.

Enter PROVIDER NAME: [Provider Name]

This report does not verify that the selected provider is eligible to participate.

**B.2.4.2 Selected Providers (SEL)**

If Selected Providers is chosen, type multiple provider names. Either the full or summary report as previously selected will be generated for each designated provider.

Enter the name of the provider for whom the Meaningful Use report will be run.

Enter PROVIDER NAME: [Provider Name]  
 Enter PROVIDER NAME: [Provider Name]  
 Enter PROVIDER NAME: [Provider Name]  
 Enter PROVIDER NAME: [Provider Name]  
 Enter PROVIDER NAME: [Provider Name]

This report does not verify that the selected provider is eligible to participate.

**B.2.4.3 Provider Taxonomy List (TAX)**

If taxonomy list is chosen, type the taxonomy list name. Either the full or summary report as previously selected will be generated for each provider on the list.

Enter PROVIDER TAXONOMY NAME: [Taxonomy List Name]

**B.2.5 Demo Patient Selection**

Choose to include or exclude demo patients in the report:

Select one of the following:  
 I Include ALL Patients  
 E Exclude DEMO Patients  
 O Include ONLY DEMO Patients  
 Demo Patient Inclusion/Exclusion: E//

### B.2.6 Attestation Performance Measures for EPs

The interim version of the MU report calculates all rate performance measures – measures that have a numerator and denominator. For all attestation measures, the software will prompt for an answer of **Yes** or **No** to each attestation question for each provider for whom the report is being run.

```
Clinical Quality Measures: Were ambulatory quality measures reported to CMS
during the EHR reporting period?
Does Provider Name attest to this? Y//Y
Do you wish to continue? Y//
```

Although Timely Electronic Access to Health Information is a rate measure, it is being answered via attestation at this time.

### B.2.7 Output Selection

A summary of the selections the user made in the previous steps displays. Choose from the following output selections:

- P: Print Report on Printer or Screen
- D: Create Delimited output file (for use in Excel)
- B: Both a Printed Report and Delimited File

```
SUMMARY OF 2011 MEANINGFUL USE REPORT TO BE GENERATED

The date ranges for this report are:
  Report Period: [Specified Report Period]
  Previous Period: [Period Immediately Preceding Specified Report Period]

Providers:

[Provider Name]
[Provider Name]

Please choose an output type. For an explanation of the delimited file
please see the user manual.

Select one of the following:

P Print Report on Printer or Screen
D Create Delimited output file (for use in Excel)
B Both a printed Report and Delimited File

Select an Output Option: P//
```

At the “Device” prompt, specify the device on which to print/display the report.

## B.3 Patient List for Eligible Providers (PLP)

The PLP option provides a patient list in addition to a Full or Summary report for EPs (MIIP). The Patient List includes patient-specific information for each measure that is selected. Define which measures to include in the report and select from the following options for each selected performance measure:

- Include patients who met the measure.
- Include patients who did not meet the measure.
- Include patients who met and did not meet the measure.

After choosing the Patient List options, the software guides through the steps in Section B.2 to run the EP reports.

### B.3.1 Steps to Run the Patient List for Eligible Providers (PLP)

Choosing the PLP report displays the following message.

```
*** IHS 2011 Stage 1 Interim Meaningful Use Patient List for EPs ***

This Patient List will display patient-specific data used to calculate the
results documented in the Meaningful Use Performance Report. One or more
lists may be selected.

Press Enter to Continue:
```

#### B.3.1.1 Eligibility Notice for EPs

The message below displays before the EP is able to set up a Patient List and run the EP report. This interim report does not verify participation eligibility. Eligibility is determined by running the MU Patient Volume Report for Eligible Professionals (PVP) located in the Third-Party Billing application.

At the “Do you wish to continue to report” prompt, type **Yes** to open the Patient List setup and **No** to return to the main menu.

```
***** IMPORTANT NOTICE *****

This interim report does not verify CMS Medicare or Medicaid EHR Incentive
Program eligibility. Please speak to your Area Meaningful Use Coordinator
for guidance in determining eligibility.

Do you wish to continue to report? Y//
```

This report can indicate a professional who is not eligible to participate in the program has achieved MU.

### B.3.1.2 Patient List Type Selection

Select a patient list type.

```
Select one of the following reports:

      S  Selected set of MU Performance Measures
      A  All MU Performance Measures

Run the report on: S//
```

#### Selected set of MU Performance Measures for EPs

Select for which of the 16 rate-calculated performance measures to generate a patient list. If no measure is selected, processing returns to the Full or Summary report Selection in order to run MU Performance Report for EPs without a patient list. Available choices are:

- All measures
- Individual measures
- All core measures
- All menu set measures

Although Timely Electronic Access to Health Information is a rate measure, it is being answered via attestation at this time and will not appear in this list.

```
PERFORMANCE MEASURE SELECTION Mar 15, 2011 15:29:50           Page:      1 of
2
IHS MU PERFORMANCE MEASURE
* Indicates the Performance Measure has been selected.

1)  CPOE Medications
2)  e-Prescribing
3)  Demographics
4)  Problem List
5)  Medication List
6)  Medication Allergy List
7)  Vital Signs
8)  Smoking Status
9)  Electronic Copy of Health Information
10) Clinical Summaries
11) Drug-Drug & Drug-Allergy Checks
12) Clinical Decision Support
13) Exchange of Key Clinical Information
14) Privacy/Security
15) Clinical Quality Measures
16) Lab Results into EHR
+   Enter ?? for more actions
S   Select Measure           C   Core Measure
D   De Select Measure       M   Menu Set Measures
Select Action: +//
```

## All MU Performance Measures for EPs

Specify if patient lists are desired for any of the measures:

- Type **No** to open the Full or Summary Report Selection in the M1IP report. Complete the selection criteria to run the MU Performance Report for EPs with a Patient List.
- Type **Yes** to display the MU Measure List Selection. Choose the measures for which a patient list is desired.

```
PATIENT LISTS
Do you want patient lists for any of the measures? N//
```

## Appendix C: MON Report

Outpatient sites need 80% CPOE (which at this point does not include Policy orders). So there is room to adjust processes and eliminate problem areas. Sites need to take a hard look at their processes and identify the problem areas.

If an ORELSE key holder enters an order and does any of the following, it counts against CPOE:

- Hold until signed (ELE with ORES No)
- Verbal (VE)
- Telephone (TE)
- Signed on chart (WRI): This is also RPMS entered “written on chart” through pharmacy and lab package, or entered “written” in POC lab:
  - Verbal, Telephone, and Signed on chart should be the exception rather than the rule in an ambulatory outpatient clinic. If your numbers are high in these areas they require scrutiny to eliminate any that are not essential to patient care.
  - Hold until signed is sometimes necessary to optimize workflow. The decision when and how to use this function needs to be carefully determined at the sites. This is often used for nurses fielding medication renewal requests for instance. If this type of order is high, then it is wise to look at workflow, scheduling, and other issues that may prevent patients from seeing their providers in a timely manner.

## Glossary

### **Advance directive**

Instructions, typically written, given by an individual to specify what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. Living will, health care proxy, and medical power of attorney are three examples of advance directives.

### **Attest, attestation**

To certify that a measure was achieved.

### **Certified EHR technology**

A complete electronic health record (EHR) or a combination of EHR modules, each of which:

- Meets the requirements included in the definition of a Qualified EHR.
- Has been tested and certified in accordance with the certification program as having met all applicable certification criteria.

### **Clinical decision support**

An interactive decision support system designed to assist healthcare professionals with decision making tasks by using two or more items of patient data to generate case-specific advice using information stored in a computerized clinical knowledge base

### **Computerized Provider Order entry (CPOE)**

An automated system that provides for electronic entry of medical practitioner instructions for the treatment of patients (particularly hospitalized patients).

### **Critical access hospital (CAH)**

A designation created by the federal government to denote certain small, rural hospitals. For the purposes of this document, “CAH” and “eligible CAH” are interchangeable.

### **EHR reporting period**

- First payment year: Any continuous 90-day period falling entirely within the first payment year.
- Subsequent payment years: The entire payment year.

**Eligible provider**

A person or entity eligible to receive incentive payments for participating in Medicare and Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology. Eligible providers include eligible professionals (EPs), eligible hospitals, and eligible critical access hospitals (CAHs).

**Graphical User Interface (GUI)**

A human-computer interface that allows the user to select commands, call up files, start programs, and do other tasks by using a pointing device to point to pictorial symbols (icons) or lists of menu choices on the screen as opposed to having to type in text commands. RPMS EHR is a GUI; RPMS *roll-and-scroll* is not.

**Measure (MU)**

A specific statement describing the success criteria that must be met to achieve meaningful use as it pertains to an MU Objective.

**Objective (MU)**

A generalized statement describing a desired healthcare delivery outcome.

**Permissible prescription**

A prescription (order) to dispense a medication that is neither a controlled substance nor an over-the-counter medicine.

**Qualified EHR**

An electronic record of health-related information on an individual that:

- Includes patient demographic and clinical health information, such as medical history and problem lists.
- Has the capacity to:
  - Provide clinical decision support
  - Support provider order entry
  - Capture and query information relevant to health care quality
  - Exchange electronic health information with, and integrate such information from other sources

**Syndromic surveillance**

Using health-related data that precedes diagnosis to signal a sufficient probability of a case or an outbreak thereby warranting further response by public health authorities.



**Transition of care**

The act of transferring a patient between health care practitioners and settings as his or her condition and care needs change during the course of a single, continuous visit. Generally, any change that results in the suspension, cessation, initiation, or reestablishment of care (e.g., admittance, discharge, leaving against medical advice) is not a transition of care.

**Unique patient**

A single, distinct person having a patient record in the certified EHR (regardless of the number of visits with a provider).

## Acronyms

<b>APCL</b>	PCC Management Reports
<b>ARRA</b>	American Recovery and Reinvestment Act of 2009
<b>ASUFAC</b>	Area - Service Unit - Facility
<b>BMI</b>	Body Mass Index
<b>BYIM</b>	Immunization Interface Management
<b>CAH</b>	Critical Access Hospital
<b>CCD</b>	Continuity of Care Document
<b>CCR</b>	Continuity of Care Record
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>COTS</b>	Commercial Off-the-Shelf
<b>CPOE</b>	Computerized Provider Order Entry
<b>CPT</b>	Current Procedural Terminology
<b>CQM</b>	Clinical Quality Measures
<b>CRS</b>	Clinical Reporting System
<b>EHR</b>	Electronic Health Record
<b>EP</b>	Eligible Professional
<b>GUI</b>	Graphical User Interface
<b>HHS</b>	Department of Health and Human Services
<b>HIE</b>	Health Information Exchange
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996

---

<b>HIT</b>	Health Information Technology
<b>IHS</b>	Indian Health Service
<b>ILI</b>	Influenza-like Illness
<b>MU</b>	Meaningful Use
<b>OIT</b>	Office of Information Technology
<b>PCC</b>	Patient Care Component
<b>PDM</b>	Pharmacy Data Management
<b>PHR</b>	Personal Health Record
<b>PLAL</b>	Problem List Allergy List
<b>POS</b>	Place of Service
<b>PVP</b>	Patient Volume Report
<b>PWH</b>	Patient Wellness Handout
<b>RA</b>	Risk Analysis
<b>ROI</b>	Release of Information
<b>RPMS</b>	Resource and Patient Management System

## Contact Information