CCDA Questions

Will the CR32 component be removed from our servers?

The C32 application will be shut down with the installation of C32 Patch 4 (which is required by CCDA if the C32 application has previously been installed). A later C32 patch will remove the entire C32 application. Sites should NOT remove the C32 application on their own, as we need to purge the C32 Audit Log prior to the removal of the C32 application in order to satisfy HIPAA requirements.

Will the C32 CCD keys be applicable?

No new keys are required. The CCDA application checks for keys that would be held by site managers, which are the same keys that were needed by C32.

What version of Ensemble is necessary to use with the recertified EHR to meet MU requirements?

The CCDA and some of the other MU applications require Ensemble 2012.2.5.

Does the CCDA pull its information from PCC or directly from the individual packages? For example, with labs: is it coming from PCC or from the lab package?

Both. PCC is the roll-and-scroll option, but it also includes the V files. Some sections use the V files (PCC), some sections use package-specific files, and some sections use both.

Can I fax using the CCDA button to another clinic office for transition of care?

You can transmit a CCDA to another facility as long as they can receive a DIRECT transmission – so it depends on their capabilities. You can fax as well, but faxing does not count for the transmission of Transition of Care (ToC) measure.

Who can print (provider, nurse, pharmacist, etc.)? Does it matter when it is printed?

Like the Patient Wellness Handout (PWH), anyone with the CCDA button on their EHR GUI can print the clinical summary. It must be printed within one day of the outpatient visit.

All of our users use the GUI template. Is there a permission/security key that can govern the printing ability?

No, this would be an enhancement request.

Can a clerk check at the end of the day to see if clinical summaries were generated/declined/etc., so they can follow up on those visits?

This is not an option at this time. Please enter a formal RPMS Feedback Request so that it can be captured and tracked.

Can you remove individual meds or just the med grouping?

Both.

Can you always suppress data such as the BCP info so that it never shows up for anyone?

No. The group explored ways to do this, but state laws differ and it is difficult to know in many circumstances. BCPs, for example, can be used for many non-contraceptive indications such as dysmenorrhea, menorrhagia, PCOS, acne, etc.

With a CHS Outside Referral Approval Process, would someone in CHS vs. the actual providers send the CCDA after approval?

The transition of care (ToC) document can be generated in many places during the process. Providers may print a ToC at the time they enter a referral. When the referral coordinator sets up the appointment, he or she is then selecting the vendor. At this time, a ToC should be generated and transmitted if possible, regardless whether a paper summary was previously printed. Remember there are two measures here: 1) 50 percent generated which is easy to meet, particularly if providers are printing some of these; and 2) 10 percent are transmitted via DIRECT, which is much more difficult to meet. The system does not know where to transmit until the vendor is selected by the referral coordinator.

Aren't some transitions of care within the outpatient setting? It seems like one of the Stage 1 menu measures (i.e., medication reconciliation) looked at that. Does that come into play with the new CCDA functionality?

Transition of care (ToC) can be outpatient to outpatient (clinic to outside provider, physical therapy, etc.), outpatient to nursing home, outpatient to ED, outpatient to inpatient. It can also be inpatient to inpatient (from IHS facility to outside hospital), inpatient to rehab, inpatient to outpatient, etc. The key is that a transition occurs outside the system that the EHR supports. For example, if a patient is admitted from a PIMC outpatient clinic to PIMC hospital, it does not require ToC because all the data is accessible to the hospital. However, if the patient is sent to a non-IHS hospital in the area, then it would require a ToC.

Is one of the items on the clinical summary (future visits within the facility) similar to the object that was on the PWH?

Yes, it displays future appointments.

Is there a place to free-text in the clinical summary?

No.

How do the current check boxes about including items with the referral in the RCIS component of the EHR interact with the CCDA?

The check boxes are not related to the CCDA, but the contents may pull pieces in the ToC document. This additional documentation can go with the referral.

Will the current check boxes still be needed?

Yes, they may be necessary since an X-ray film would not be part of the ToC.

Is it true that verification that the transmission of the CCDA for a ToC via fax counts as electronic transmission and can go to providers that are not in the DIRECT system?

No. The only type of transmission that counts for the ToC "Transmission" measure is sending via DIRECT.

Would it be appropriate for users other than providers to use CIR (for example, if a pharmacy addressed the medications section only)?

Yes, many clinicians (nursing, pharmacy, etc.) can and do participate in information reconciliation.

How do I know an incoming CCDA is waiting?

The CCDA will not specifically be waiting, but the CIR tool will be red and have a number in it to let you know that that one or more documents have not been reconciled via the CIR tool. Hovering over the number will provide more information.

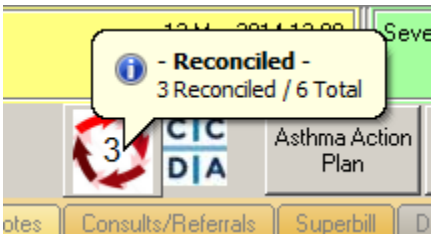

Figure 1: CIR tool

Is the medication list on the CCDA pulling the orderable item or the dispense drug from RPMS?

The medication list pulls RxNorm for the dispense drug on Medication, and the RxNorm or UNII for the ingredient on Allergies in CCDA.

SNOMED Questions

Will SNOMED will be part of the Certified EHR for Stage 2?

Yes, SNOMED is a required standard that must be used in a 2014-certified EHR.

Also, will sites need to add anything?

Yes, CACs will need to add new components.

Will SNOMED codes be present in the software?

Yes, they are stored in the background in the visit and other files where captured.

What prevents someone other than the provider from migrating the problem list to SNOMED? Is this locked down? Couldn't a coder do this from within the EHR?

EHR is designed for clinical users while PCC is designed for data entry/coding. SNOMED is intended to be used by clinicians to capture signs, symptoms, findings, diagnostic impressions, etc. Coders are not trained to interpret clinician documentation and translating it to SNOMED; they are trained to do this for ICD-9 and ICD-10. It is not appropriate to delegate this to a coder.

How soon will SNOMED become available? When will training begin? Will it be in-person or remote training?

SNOMED will be part of the EHR p13 release. Training will begin with Grand Rounds and an IPL overview. An Office Hours presentation for CACs will also occur as well as open Office Hours. The schedule is still being determined.

Why is there a date in the SNOMED search tool?

The search date defaults to NOW. The date is important for the transition between ICD-9 and ICD-10. Users don’t need to be concerned with the date, but the system needs to know to retrieve either ICD-10 or ICD-9 mappings based on the date. The system will be smart enough to send the correct ICD mapped code to the POV based on visit date.

Does SNOMED include behavioral health (BH) diagnoses?

Yes, it is very inclusive with BH related pick lists. However, the BH GUI will not be SNOMED.

Can a reminder dialogue be used for any of these functions?

No.

Should sites be educating their providers about ICD-10 or SNOMED?

Clinicians need to understand SNOMED to document in the problem list, while billing personnel will use ICD-10 for coding/billing.

Is the IPL an appropriate place to enter things like "Patient ineligible for narcotics" or "violent patient"?

It will be up to the sites. Many find that clinical warnings or flags are more appropriate, depending on who needs to see what in the workflow. SNOMED terms for things like drug-seeking behavior and non-compliance can be used if desired by a provider to document on the problem list. Lots of information, including problems, will be transparent to patients on the PHR.

Where will Care Plans entered via IPL appear? Does this supersede use of Progress Notes templates for Care Plans?

They appear on the problem list itself, in problem details, in reports, on the clinical summaries and on transition of care documents. They could potentially supersede the use of progress notes for care plans, but the care planning in IPL is rudimentary at this point. Requirements for a care plan have not been developed or released by standard development workgroups. Continue to use note templates for more detailed and complete documentation at this time.

For the clinical indication for lab/pharmacy order dialogs, will it still pull up the active problem list as the first item in the drop down menu?

Yes, chronic, sub-acute, and episodic will be listed along with an “other” option for to search for a SNOMED term.

You said that Qualifiers are optional for IPL, but these items are important to Coding.

True, but it is not mandatory for a provider to select a qualifier from a dropdown. Rather it is required that providers document what is needed for the medical record and to support coding. They may choose to put laterality, severity, or other relevant information in the Provider Text or encounter note.

If problem is entered for a one-time event, it is still recorded as "episodic." Does it need to be inactivated manually later? Is another status a possibility?

Each site is given the option to leave it as episodic or change it to inactive.

How will a problem indicate laterality and specificity for ICD 10 requirements?

This can be indicated in the provider text or chart documentation. Anatomic location will be added in a future patch, as it will require significant work by the terminologist to develop this subset.

Regarding the three separate areas to document goals in the EHR, please explain how I should use these components: 1) Patient Education Goals 2) Patient Goals and 3) Goal Notes.

1. Patient education goals are outdated and will be phased out one day.
2. Patient goals are what the patient wants to do.

3. Problem List goals are set by the clinician (goal A1C less than (<) 7, BP goal less than (<) 150/90, etc.).

Lab and Radiology Questions

In RPMS Roll and Scroll, I can set the default parameter for Nature of Order during pharmacy back-door entry. Do I need to make sure it doesn't default to written?

This decision would be made locally, based on your workflow. If the pharmacy primarily finishes orders from CPOE and occasionally puts in a verbal or telephone order, the default Nature of Order could be changed to verbal or telephone or left blank, and the pharmacist would be required to enter one. When completing orders from OERR, the pharmacist is not asked Nature of Order.

Please clarify how the Service Correction nature of order counts (or does not count) for CPOE of medications in particular.

For all three types of orders—labs, medications, and radiology—the report generator only looks at the first action on an order (when it was first put in). If the nature of order is "Service Correction" for medications, the order is ignored and will not appear in either the denominator or numerator. In other words, only the original order—not the corrected order—is in the numerator or denominator.

General MU Questions

In October 2013, I started our Medicare attestation for two of our providers. They were not accepted because they do not meet the measures fully. I have uploaded several different times, and each time they do not meet the measure. Will they still be penalized in 2014?

If the provider did not meet MU in CY 2013, he or she will be subject to the payment adjustment in CY 2015.

Will EPs in their first year have to meet and attest to MU by October 1, 2014?

Yes, EPs must attest to MU no later than October 1, 2014, to avoid payment adjustments in 2015.

Can EHs skip or miss a year for Medicare and receive the incentive the following year?

Yes; however, they will miss the payment for the year skipped, and the incentive payment will decrease for hospitals that start receiving payments in 2014 and later.

Will the long list of Clinical Summary requirements apply to both Stage 1 and Stage 2 providers?

Yes, the 2014 EHR certification criteria require 16 data sets for both Stage 1 and Stage 2 providers.

Will an electronic clinical summary apply for Stage 1 providers, or will they still need a printed PWH?

Beginning in 2014, a clinical summary will apply for Stage 1 providers.

Will the CQMs remain the same list for Stage 1 EPs?

Beginning in 2014, EPs must report on nine CQMS from three of six National Quality Strategy Domains, regardless of stage.

Assuming we need an exception, can providers still attest after October 1 and receive their 2014 incentive?

Yes, providers who apply for a hardship exception will still be able to attest and receive incentives for 2014.

Will I be able to report CQMs to state Medicaid as well? Or does CMS send to state?

CMS does not send CQM reports to State Medicaid. If the State requires the report to be sent in an electronic format, OIT would most likely be able to incorporate the transmission protocols into the tool. However, if the State requires submission in a different way (e.g., completing a form on their site or emailing the report as an attachment), you would be responsible for printing, completing, and submitting it.

Is the ability to submit electronically only to CMS? In addition, states may or may not accept electronic reports?

As far as OIT is aware, CMS is the only agency requiring electronic submission. Some states may accept electronic submissions, but OIT is not aware of them.

Do we need to use the eCQM for everyone regardless of MU stage or does this apply for Stage 2 only?

The CQM engine is for everyone, regardless of MU stage.

Can this tool generate a file that can be uploaded to CMS as a "batch?"

CMS has specific requirements for transmitting CQM reports. These reports are in a Quality Reporting Data Architecture (QRDA) format: Category 1 for individual patient data and Category 3 for aggregated results.

Will access to this tool be key based?

Access to the CQM engine will be menu/key based. A new key will be created for the CQM engine.

Can you talk a little about the Immunization Exchange requirements for MU Stage 2?

Stage 2 requires the successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

Do facilities need to use RCIS in order to meet MU requirements?

Yes, facilities must use Version 4.0 Patch 8.

Do we need to have clinical reminders in use to meet Stage 2?

Yes, in Stage 2, clinical reminders is a core measure. However, you can just implement five reminders to satisfy meaningful use attestation.

Isn't the immunization forecaster the "easy" one?

Yes.

Do plans exist to add the functionality for the Electronic Notes Menu measure?

The electronic note functionality is included in the 2014 CEHRT. (Text-searchable notes were included in EHR patch 11.)

Does the CPOE number go down if the nurse (ORELSE) enters a med on behalf of the provider as verbal or telephonic?

Assuming that by “CPOE number” you mean the numerator, here is how it works: orders entered by the nurse holding the ORELSE key count in the numerator, and therefore “for” the provider if the nature of order is verbal or telephonic.

Under Reaction Type, is there another option for "other" instead of hypersensitivity?

For numerator inclusions, count each medication order in the denominator where "Nature of Order" for the counted medication does not equal “written” or “service correction” AND the order was entered by a licensed healthcare professional holding the ORES or ORELSE key. Note that the CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order to count in the numerator.

How do I determine the difference between light and heavy smokers?

A light smoker is less than (<) 10 cig/day while a heavy smoker is 10 or more per day.

Does this performance measure include medical marijuana in addition to tobacco?

No, the measure is only applicable to tobacco.

How are electronic cigarettes documented?

There is no way to document electronic cigarettes since they can be used for a variety of reasons.

PHR Questions

Will inactive problems be available for patients to view on their PHR?

No, inactive problems are not included in the PHR; only active problems will appear.

Are behavioral health intakes available to view?

Behavioral health information is not available in the PHR at this time.

Will behavioral health information (i.e., diagnoses) appear in the PHR, or will they be suppressed?

Behavioral health information is not available in the PHR at this time.

eRX Questions

How, specifically, is medication reconciliation going to change?

It depends on whether we must use the NF flag in order to meet MU. Right now, we do not; we just use a text flag in QOs to indicate to our prescribers which drugs in the QO menu are for our one formulary, which is CHS.

Does the NF pop-up come up for Outside Meds?

Yes.

HIE/MPI Questions

What do sites do that have already performed the patient merge before it was halted?

Audit logs are turned on at install (not in Roll and Scroll at registration) and are only accessible by site managers. The data is stored in a separate data file and is required to limit access to it. Logs are to be kept seven years, and how they are archived needs to be discussed with your IT office.

Is the auditing only going to be available in the Scheduling and Patient Registration GUIs? I have been told that auditing will not be available for the RPMS scheduling and patient registration.

Scheduling GUI is no longer supported.

Can these reports be run from RPMS?

In the 2011 RPMS EHR, you can run the CQM report in RPMS under the **CRS menu** > **C114** > **RPT** > **MUR**. In the 2014 REPM EHR, the CQM engine will be the only place where the MU CQMs can be calculated and viewed.

Will I be able to see the reminders letter from iCare in EHR?

Yes, iCare uses TIU, so letters are visible in both places.

Other Questions

The MU measures in iCare will not change, but the CQM measures will be retrieved via the tab in BMW. Is that correct?

Moving forward, iCare will no longer be the tool for CQMs. The CQM engine will be accessed via a menu option in the BMW.

Will the CRS menu still be useable for running CQMs?

No, it will not be useable for CQMs.

So the MU report in CRS will not work after BMW is installed?

CQM reports will be generated in the eCQM engine. Performance measures are separate from CQMs.

Can I get the TIU Note mapping information?

This information is contained in the TIU patch manual.

Are the local templates with the care plans for specific disease states exportable?

Yes, they use TIU templates so they can be shared.

Are some care plan templates available for sites to tweak or will they have to build everything from scratch?

OIT may provide a few samples that [functionally] seem to work well, but content is up to the clinicians. MU Stage 2 required the creation of a field to capture “care plan” with no other explanation of what that care plan should look like. It is up to the field of clinical users to innovate. As sites develop successful documentation tools and best practices, they should be shared.

Do I still have to assign the patient chart number?

Yes, currently a chart number still has to be assigned.

Do I have to update the Advanced Directives each time an inpatient is admitted, even if s/he is admitted, discharged, and then readmitted three weeks later?

This information only needs to be updated if the type of advanced directive has changed.

Where do I enter the patient's preferred method of communication?

Go to the demographics tab, address section, and click address button.