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Meaningful Use Attainment Guide and Workflows
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Meaningful Use Attainment Guide and Workflows

The Federal Government, via the American Recovery and Reinvestment Act (ARRA) is providing some $19 billion to help accelerate the adoption and Meaningful Use of electronic health records (EHR) and health information technology (HIT) in doctors’ offices and hospitals. For individual providers, this translates into incentive payments ranging from $44,000 to $63,750 for those that qualify as “Meaningful Users” of electronic health records. This is by far the most significant EHR incentive program that has ever been offered—and is unlikely to be repeated in the future. This document will outline how an e-MDs user can meet these measures utilizing the e- MDs Solution Series Software. Specifically it will go into detail on each individual measure.
Introduction

The ARRA EHR incentive program is part of the administration’s plan to use healthcare information technology (HIT) and electronic health records in particular, to help reduce medical costs, improve the quality of care provided to patients, and implement technologies and tools that enable patients to be more proactive in their own preventive healthcare. While the program encompasses both ambulatory practices and hospital care, we will focus exclusively on the impact on providers in ambulatory settings.

The government wants practices to act now: the incentive programs are time sensitive, giving the greatest reward to those that participate by 2011 and 2012. Because it takes a while to select, implement and become proficient with an EHR, and because many industry vendors will have implementation capacity problems, practices that have not started the process run the risk of missing out on the opportunity. The Meaningful Use requirements are also easier to achieve in the first years. Let’s get started!

Do I qualify for participation in the ARRA EHR incentive program?

The government is offering providers the opportunity to participate in the ARRA program either through Medicare or Medicaid. As such, it is specifically intended for practices that are actively seeing Medicare, Medicaid, or non-Medicaid low-income patients as a standard part of their practice.

If you are not seeing patients in either of these programs, your practice is not likely to be eligible for these ARRA financial incentives. The payments and rules for the Medicare program differ from those for the Medicaid program; we will discuss these differences in more detail below. If you happen to qualify for both programs, you must choose to participate in either Medicare or Medicaid. This document can also help you make that important decision.

What is Meaningful Use (MU)?

Meaningful Use is a term that refers to a set of EHR usage requirements that qualified providers must meet in order to receive incentive payments. The intent of Meaningful Use is to help ensure that providers using electronic health records implement the software in a manner that supports higher quality and more efficient delivery of healthcare.

In other words, it is not enough to simply purchase and implement an EHR; in order to qualify for incentive payments, a practice and its providers must demonstrate that they are using an EHR in a manner that supports the quality and efficiency objectives of the program.

Providers at practices that currently have an EHR can receive incentive payments—if they, and their EHR, meet the Meaningful Use requirements. This will require reviewing their current processes, possibly upgrading or replacing their EHR, and implementing new features such as computerized physician order entry.

Practices that are in the process of considering an EHR need to be careful to select a system that has the feature set that allows them to meet the regulations. They will also be required to deploy and use the newly purchased EHR in a specific way. This puts a premium on selecting EHR vendors that not only have the requisite features but also have a track record of successfully guiding practices through the implementation process.

Meaningful Use will be discussed in greater detail below; let’s first review the details of the Medicare and Medicaid programs.
Medicare
How much incentive money is available and what is necessary to qualify?
Physicians that treat Medicare patients are eligible for up to $44,000 per physician over a five-year period beginning in 2011. The amount you are eligible to receive is a function of both your level of Medicare billing and the date that you first file with the government as a Meaningful User of an EHR (the time table is shown below).

On the first point, each physician’s annual incentive is calculated by multiplying allowable charges to Medicare by 75% up to the capped maximum incentive amount for each year of distribution.

For instance, to receive the maximum 2011 incentive payment of $18,000, a physician must have submitted allowable charges of at least $24,000 (i.e. 75% of $24K= $18K). If your allowable charges are less than $24,000, you will still be able to participate, but you would receive a payment less than the full $18,000 available. This rule applies regardless of whether you are practicing on a part-time or full-time basis.

As you can see from the schedule below, the program rewards practices that act sooner rather than later. For example: physicians that file as Meaningful Users in 2011 or 2012 are eligible for a maximum incentive of $44,000; those that file in 2014 are only eligible for a maximum of $24,000. Practices that file in 2015 will not be eligible for any incentive payments. It pays to start now!

**Medicare ARRA Program Payment Schedule**

<table>
<thead>
<tr>
<th>Year you first file</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<tr>
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<td>$0</td>
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</tr>
</tbody>
</table>

How are allowable charges calculated under the Medicare program?
Allowable Medicare charges for use in calculating incentive payments are as follows:

- Part B claims for the Fee for Service program
- Items in the Medicare Physician’s fee schedule
- Only “professional” components are included, not the “technical”
- Only services delivered by the eligible provider

Are there any additional incentives for physicians that are working in underserved areas?
Physicians operating in a “Health Provider Shortage Area” (HPSA) will be eligible for an incremental increase of 10% in their Medicare EHR incentive payments, up to a total of $48,400.

Health Professional Shortage Areas are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Medically Underserved areas/populations are areas/populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population.
Are only physicians eligible to receive payments under the Medicare plan?
No—besides MDs and DOs, other eligible providers (EP) that qualify include podiatrists, chiropractors, optometrists, and dentists. However, unlike the Medicaid program, nurse practitioners and physician assistants are not eligible to receive payments under the Medicare program. This program is primarily targeted at ambulatory care physicians: if 90% of more of an EP's services are performed in a hospital-based setting (inpatient, emergency room), then the provider does not qualify.

Can I receive bonus payments for both the EHR incentive program and the Medicare Improvement for Patients and Provider Act (MIPPA) e-prescribing program?
No, you cannot receive bonus payments for both the Medicare EHR incentive program and the MIPPA e-prescribing program. You must pick one or the other. The MIPPA program offers bonus payments for practices that utilize e-prescribing. However, if you qualify for the Medicaid program, you can participate in both MIPPA and the EHR incentive program.

Can I participate in the ARRA EHR program and the Physicians Quality Reporting Initiative (PQRI)?
Yes. The ARRA regulation only specifically excludes the e-prescribing program as described above; physicians can participate in both the PQRI and the EHR incentive programs.

Are there penalties for practices that do not participate in the ARRA program?
Yes. Starting in 2015, practices that are not “Meaningful Users” of EHRs will be subject to a 1% reduction in the Medicare care fee schedule. This increases to a 2% reduction in 2016 and a 3% reduction in 2017. The penalties can increase up to 5% for every year that meaningful use is not demonstrated. Note: the Medicaid program does not incorporate any decreases in Medicaid compensation for practices that do not participate in the program.

When does the Medicare program start?
The first year of the program kicks off officially on January 1, 2011. This means that beginning in calendar year 2011, physicians can report to the government that they are Meaningful Users of EHRs and receive the first installment of their incentive payment.

During the first year, you must complete 90 days of continuous EHR Meaningful Use within the calendar year before reporting to the government. This means the earliest you would be able to file in 2011 is after March 31 (representing use in January, February, and March). It also means that the latest you could initiate using your EHR for reporting in 2011 is October 1 (allowing use in October, November, and December). You cannot submit data for use that crosses calendar years (i.e. November, December of 2011 and January 2012).

How do I report that I am a Meaningful User?
In years 2011 and 2012, reporting will be via attestation—the provider’s self-reporting of their compliance with Meaningful Use criteria. In subsequent years, the Centers for Medicare and Medicaid Services (CMS) has alluded to an electronic method based on extracting data directly from the Certified EHR—but this has not been defined yet.

How is the incentive payment paid to physicians?
Under the Medicare plan, eligible providers will receive a one-time, annual lump sum payment from their Medicare contractor. Payments will be distributed after providers have complied with the reporting requirements for Meaningful Use and they have reached the threshold for maximum payment ($24,000 in allowable Medicare charges for 2011 or 2012).

As noted above, in the first year of participation in the program it is only necessary to demonstrate Meaningful Use for a continuous 90 day period, which means that physicians and practices that file in 2011 could receive payment in 2011. However, for Years 2-5, practices will be required to demonstrate and report Meaningful Use for an entire year, meaning that payment will be received after the completion of the calendar year.

There is no limitation to payment based on group size—all eligible providers in groups large and small are entitled to the incentive as long as they demonstrate Meaningful Use.
This sounds like a potentially lucrative program; how do I sign up?

CMS has established the following web site: [www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms) to give you all the information required you need to get started. You will be required to register through this web site. There are some specific requirements to participate. As noted on the CMS web site: “All eligible hospitals and Medicare eligible professionals must have a National Provider Identifier (NPI), and be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS) to participate in the EHR incentive program. Most providers also need to have an active user account in the National Plan and Provider Enumeration System (NPPES). CMS will use these systems’ records to verify Medicare enrollment prior to making Medicare EHR incentive program payments.

**Medicaid**

**How much incentive money is available and what is necessary to qualify?**

The Medicaid program offers a higher payout than Medicare. Under Medicaid, eligible providers can receive up to $63,750 over six years.

To qualify, 30% of all of your patient encounters must be attributable to Medicaid over any continuous 90-day period within the most recent calendar year. This does not include short-term, temporary Medicaid outreach programs. To maintain participation in the incentive program, you will be required to re-attest that you meet patient volume thresholds each year.

Note: Pediatricians can qualify at the 20% Medicaid patient volume level, but would receive a 33% lower incentive payment, or $42,500. They are eligible for the full incentive if their Medicaid patient volume is 30% or higher.

If you are a provider working part-time at a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), you will be eligible for incentive payments if you practice more than 50% of your time at the FQHC or RHC and at least 30% of your patient volume consists of “needy” individuals. Needy individuals are defined as receiving uncompensated care or care at a reduced cost, or those who are Medicaid or CHIP patients.

**What is the schedule for Medicaid program incentive payments?**

Under the Medicaid plan, qualified eligible providers would receive $21,250 in their first year of participation, followed by $8,500 annually for years 2-6. In order to receive the incentive, providers must start participation by 2016; since the program is six years from start of participation, no incentive payments will be made after 2021. The table below provides an overview of the payment schedule.
Medicaid ARRA Program Payment Schedule (CY=Calendar Year)

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Are only physicians eligible to receive payments under the Medicaid plan?
No—besides MDs and DOs, other eligible providers (EP) that qualify include dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in a FQHC or RHC that is being led by a physician assistant. This is different than the Medicare program, which specifically excludes NPs and PAs.

Does the Medicaid program also require that you demonstrate Meaningful Use?
Yes, but under the Medicaid plan, you are not required to demonstrate Meaningful Use until Year 2. The Year 1 requirement is demonstration of “efforts to adopt, implement, or upgrade certified EHR technology.”

How are the Medicaid incentive payments paid to physicians?
In the Medicaid program, eligible providers will receive a one-time, annual lump sum payment. It will be distributed through the state Medicaid agency or their designated intermediary.

As indicated above, in the first year of participation in the Medicaid program, it is only necessary to demonstrate efforts to adopt, implement, or upgrade to a certified EHR prior to receiving payment. Also, in the first year it is only necessary to demonstrate these efforts for a continuous 90 day period, which means that physicians and practices that file in 2011 could receive payment in 2011. However, for Years 2-5, practices will be required to demonstrate and report Meaningful Use for an entire year, meaning that payment will be received after the completion of the calendar year.

When does the Medicaid program start?
Practices that initiate EHR implementation in 2010 (i.e. establishment of hardware network, installation, and configuration of software) may qualify for receipt of funds in 2010, if their state has completed the necessary administrative tasks to formally participate in the incentive program. For states that have not completed these tasks, the Medicaid program will officially start on January 1, 2011. During the first year of participation, you must have completed 90 days of continuous EHR activity within that calendar year before reporting to the government. This means that the earliest you would be able to file in 2011 is after March 31 (representing use in January, February, and March). It also means that the latest you could file in 2011 is December 31 (allowing use in October, November, and December).
CHANGING BETWEEN MEDICARE AND MEDICAID INCENTIVE PROGRAMS?

Eligible Providers are able to switch from one program to another, but may only do this once. For this reason it is important that you research each program thoroughly and review each against your patient population as it stands today and where it might be for each year of the program. If you switch, you will placed in the same incentive year you would have been in had you been in the other program. It is worth noting that the Medicare program enforces consecutive years so if you qualify for a payment in year 1, but not in year 2, in the next year you would still be considered to be in year 3 for the next incentive payment. For Medicaid, an EP that does not qualify in year 2 would still qualify for an additional 4 years, with the limitation that the program ends in 2021.

Meaningful Use

As noted above, to qualify for federally incentive payments, an eligible provider will need to demonstrate “Meaningful Use.” The regulations also require that eligible providers utilize an EHR that has been certified by a federally accredited certification body.

The intent of Meaningful Use is to help ensure that providers using electronic health records implement the software in a manner that supports higher quality and more efficient delivery of healthcare. The government has outlined five broad goals for “Meaningful Use”:

1. Improve quality, safety, efficiency, and reduce health disparities
2. Engage patients and families
3. Improve care coordination
4. Ensure adequate privacy and security protections for Personal Health Information (PHI)
5. Improve population and public health

Because these overall goals of the program are ambitious and will require a number of changes by practices and providers, CMS has divided attainment of Meaningful Use into three progressive stages, starting with Stage 1 and ending with Stage 3. So far, only the requirements for Stage 1 have been proposed. Criteria for Stage 2 and Stage 3 have not yet been defined, but are anticipated to build on the Meaningful Use criteria established in Stage 1.

It may be useful for you to review the proposed rule directly. See the following link for access:

Can you give me more detail about Stage 1 requirements?

The Stage 1 Meaningful use requirements consists of a set of 15 core objectives that all eligible providers will be required to meet, plus an additional 5 objectives that providers can select from a menu of options.

For each core objective, there is also a “measurement” requirement, which defines the extent to which the core objective must be achieved within the practice.

Example:

- **Core objective**: Record patient demographics (sex, race, ethnicity, date of birth, preferred language)
- **Measurement**: More than 50% of patients’ demographic data recorded as structured data

The core objectives relate to how you store data within your EHR and the type of features that you use (such as e-prescribing or clinical decision support), as well as reporting requirements. The term “structured data” noted above refers to clinical or patient demographic information such as age, sex, diagnosis, or lab values that are stored as a discreet data element within a database. Structured data provides the basis for reporting on quality measures.

The core set of objectives and the measurement requirements are all listed in Exhibit A.

The “menu” set of objectives consists of a list of 10 additional Meaningful Use functions; unlike the core objectives, you can select any 5 from the “menu” of 10 for compliance. The menu objectives are designed to offer providers some flexibility in how they achieve Meaningful Use. They are also listed in Exhibit A.
Do I have to meet all of these requirements to qualify for the incentives?
Yes. The rule currently requires you to demonstrate compliance with all 15 of the core objectives plus 5 objectives from the menu list.

Are there specific quality measures that I will need to report on?
Yes. Eligible providers will be required to report on “core” measures for any applicable patients. There are just 3 core measures: 1) tobacco status, 2) blood pressure level, and 3) adult weight screening and follow-up.

If these core measures are not applicable for a provider, they can select weight assessment and counseling for children and adolescents, preventive care and screening for influenza immunization for patients 50 or older and/or childhood immunization status.

The rule will also require eligible providers to report on 3 additional clinical measures, selected from a list of 38 different measures covering a broad range of disease management or preventative screening activities. These are listed under Table 6 in the final rule.

When do Stage 2 requirements start?
That depends on when practices/providers start their Stage 1 reporting. Practices that report on Stage 1 in either 2011 or 2012 will each be able to report on Stage 1 criteria for two years, before progressing to Stage 2. This means that they would report on Stage 2 beginning in 2013 (for those that filed in 2011) and 2014 (for those that filed in 2012).

In contrast, practices that begin reporting in 2013 would only have one year to report on Stage 1, before having to progress to Stage 2. This is another incentive that the government is providing to induce practices to start the process now.

Registration and Attestation

In order to register and attest to Meaningful Use, EP's must request the “CMS EHR Certification ID” for e-MDs Solution Series.

To request the ID:
- Navigate to the CMS Certified Health IT Product List
- Click Ambulatory Practice Type
- From the dropdown menu, select Vendor Name
- Type e-MDs into the search box and click Search
- e-MDs will be the only returned result. Click Add to Cart
- Click CMS EHR Certification ID
- e-MDs CMS EHR Certification ID will be displayed
Adding e-MDs Solution Series to your Cart
**STEP 4: REQUEST CMS EHR CERTIFICATION ID**

Certification Bar Summary

The bar below provides a summary of the criteria that are met by items in your cart. Criteria highlighted in blue have been met by products in the cart, criteria in gray have not.

Note: Certification criterion 170.302(a) is optional for the purposes of certification. If it is gray in the bar below, the products in your cart can still meet 100% of the required certification criteria.

Place your mouse over the individual letters to learn more about each criterion.

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<th>Ambulatory Criteria (170.304)</th>
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</table>

Requesting Your CMS EHR Certification ID

If the products in your cart meet 100% of the required criteria, you can now obtain a CMS EHR Certification ID.

If the products in your cart do not meet 100% of the required criteria, select the “Return to Search” link and continue adding products to your cart until your cart meets 100% of the required criteria.

Get CMS EHR Certification ID

Percentage of criteria currently met: 100%

**PRODUCTS IN CART**

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<th>Product Classification</th>
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<td>e-MDs, Inc.</td>
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<td>7</td>
<td>Complete EHR</td>
<td>Email software</td>
</tr>
</tbody>
</table>

**Requesting the CMS EHR Certification ID for e-MDs Solution Series**

**Registration:**
- With the CMS EHR Certification ID navigate to the [Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#)
- NPPES information will be used to register

**Attestation:**
- Select a 90 day reporting period
- Meet the 15 Meaningful Use Core Measures during the selected reporting period
- Meet the 5 Meaningful Use Menu Set Measures during the selected reporting period
- Submit this data to CMS
ABOUT e-MDs

Is e-MDs certified for Meaningful Use?
Yes we are! Our certification ID is 11122010-6910-8 and the following statement applies to our status. e-MDs Solution Series 7.0: This Complete EHR is 2011/2012 compliant and has been certified by an ONC-ATCB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services or guarantee the receipt of incentive payments.


NOTE: e-MDs was the first EHR vendor to certify on all 44 Clinical Quality Measures, a testament to the extremely robust data collection capabilities of the system for many specialties.

Does e-MDs provide the products and tools that I need to meet Meaningful Use?
Yes. e-MDs provides a comprehensive EHR and Practice Management platform that practices can use to achieve Meaningful Use. Additionally, as noted above we are fully committed to meeting emerging and new standards as they develop. We also provide our users with free training webinars, the Video Learning Library on e-MDs Support Center which covers each core and menu set criteria, technical guides and, of course, access to our support department and client user forums to get advice from other e-MDs users.

The incentive program requires practices to move fast. Can e-MDs implement our practice quickly to meet the incentive deadlines?
Yes. Our implementation process is designed to move rapidly from contract signing to go-live. The project kick off call is usually within days of the contract date so you’ll be progressing quickly towards your go live and meaningful use attainment. Our products are specifically designed to help practices implement quickly—without compromising workflow improvements or the robust functionality that you need to meet Meaningful Use.

I am already using e-MDs; will I be able to qualify for the incentives?
Yes! Existing e-MDs EHR users will be eligible as long as you meet the requirements of either the Medicare or Medicaid program. Like all ARRA participants, you will need to meet the Meaningful Use guidelines specified in the final rule. e-MDs is fully committed to supporting all of our customers in achieving Meaningful Use.
I am shopping for an EHR; why should I consider e-MDs?
e-MDs offers a combination of affordability, a full feature set, rapid implementation, and a proven track record of service and support that is unique in the industry. As testimony to our focus on ease of use and functionality, e-MDs has ranked at the top of all independent, unbiased, physician surveys thus far. For practices that are looking to implement rapidly without compromising functionality and to do so in a financially prudent fashion with a proven performer, e-MDs is the right choice. There is a reason why e-MDs is one of the top selected systems by RECs whose stringent processes are designed to identify companies with stability, product and service excellence and experienced needed to help practices achieve technology goals.

Background on e-MDs
e-MDs is a leading developer of healthcare software solutions and is headquartered in Austin, Texas. The company, founded in 1996 by a primary care physician, remains physician and clinical informaticist managed and actively participates in national health information technology and interoperability efforts. e-MDs Solution Series™, with more than 31,000 users nationwide, is the standard for affordable and integrated EHR and PRACTICE MANAGEMENT software solutions - including clinical, financial, and document management modules designed to automate medical practice processes and chart management. In addition to offering the full integrated Solution Series, customers can also purchase the EHR or Practice Management as separate modules.

The e-MDs Solution Series' comprehensive suite of products facilitates improvements in clinical care, a reduction in medical errors, and optimization of business practices. We help you rediscover the joy of practicing medicine. For more information, please visit www.e-mds.com.

e-MDs will continue to educate its customers and partners on the American Recovery and Reinvestment Act of 2009, HITECH, and new initiatives and criteria as they emerge from the Office of the National Coordinator of Health Information Technology. Additional and updated information can be found at www.e-mds.com and www.ehrdiscussions.com.

Additional RESOURCES:
EHR Incentive Program final rule: http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf
Blumenthal, Tavenner, New England Journal of Medicine, July 13, 2010
http://content.nejm.org/cgi/content/full/NEJMp1006114
CMS EHR Incentive web site: http://www.cms.gov/EHRIncentivePrograms

e-MDs
RESOURCES
www.e-mds.com and www.ehrdiscussions.com
Facebook | Twitter
Meaningful Use Core Measures
1. CPOE (Computerized Physician Order Entry) for Medication Orders

Computerized Physician Order Entry (CPOE) of Medications 170.304(a)

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for CPOE of medication orders within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 30%

Meaningful Use Requirement for Stage 1

More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. This applies to new prescriptions and refills.

Patient Qualification

Denominator:
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99395, 99396, 99397, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99450, 99455, 99456, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. Patients included have at least one medication in their medication list entered using computerized order entry (EHR). The medication order must be entered directly by a licensed healthcare professional (MD, DO, DPM, CNP, CRPN, PA, PA-C, RN, LVN, LPN). It only includes new prescriptions and a refill prescribed and/or performed by licensed healthcare professionals and does not include recorded medications. If a patient does not have any medications in their medication list, but is prescribed a medication during the qualifying visit date, the patient will qualify for the numerator.
Medications can be ordered from the Current Medications list in the patient’s Health Summary and in the Visit Note via manual entry or templates. Providers are designated as licensed healthcare professionals via the Licensure tab in Staff Demographics.

In order to meet this requirement:
- Staff members must be designated as licensed healthcare professionals per state guidelines by selecting their certification via the Licensure tab in their demographics*. To select a certification for staff members,
  - Click Demographics
  - Highlight Providers & Staff
  - Select the category of staff member being modified
  - Click Search
  - Highlight the staff member and click Edit
  - Click Licensure
  - Select the proper certification from the dropdown menu

*Reports will also pull from the provider record for license information entered. If a provider has a state license entered in but no certification, this provider will still count as a licensed healthcare professional.
• New prescriptions and refills entered into the system by these users will now count towards the 30% reporting requirement.
• These medication orders must be submitted via ScriptWriter accessed from the patient Health Summary or Plan section of a Visit Note.
• To access ScriptWriter from the Health Summary, click the “Rx Pad” located within the Current Medications list.
• To access ScriptWriter from a Visit Note, click “Prescriptions” in the Plan or click to prescribe a medication embedded within a Plan template.
Accessing ScriptWriter

Reporting

Run Crystal Report “CPOE” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 1-2 CPOE and Interaction Checks” located in the Video Learning Library section of supportcenter.e-mds.com

CMS CPOE for Medication Orders
2. Drug Interaction Checks

Drug Interaction Checks 170.302(a)

The EP has enabled this functionality for the entire EHR reporting period

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for Drug Interaction Checks within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: Attestation

Meaningful Use Requirement for Stage 1

The EP has enabled the drug-drug and drug-allergy interaction check functionality throughout the entire reporting period.

Compliance with Solution Series

When medications are prescribed, Drug-Drug and Drug-Allergy checks are performed. Contraindication information is pulled from the patient’s current allergies and medications lists at the time of prescription and eligible professionals are notified with an alert pop-up window. In order for interaction alerts to function, the patient’s Current Medications list must be updated with structured medication items, i.e. no “custom created drugs.”

A Drug Interaction Alert
In order to meet this requirement:
- Each EP must turn on the drug-drug interaction alerts for their e-MDs login. To turn this option on,
  - From Chart, click File then Options
  - Click the “ScriptWriter tab”
  - Check the box next to “Auto-Check Drug-Drug Interactions.” Severity is not regulated.
  - Keep this option active throughout the entire reporting period in order to attest to meeting this measure. This option needs to be set in the Chart Options for each eligible professional.

**Activate drug-drug interaction alerts in Chart Options for each EP. Severity of interaction is not regulated.**

**Drug-allergy checks are always on in Solution Series**

**Workflow Alert:** Ensure these interaction checks are running throughout the entire reporting period

Prescribe new medications using ScriptWriter to ensure utilization of the interaction alerts

Maintain an active and up to date Current Medications list using structured medications

**Interaction alerts run throughout the entire period?**

- [ ] N
- [x] Y

**Activate interaction alerts**

**Attest to CMS**

[Diagram shows a workflow with decision points for activating interaction alerts and attesting to CMS.]
In order for interaction alerts to function properly, the Current medications list must be maintained with structured medications. This is accomplished by ensuring that each medication entered, whether a new prescription or existing medication, is entered from the e-MDs drug formulary and not as a “custom-created drug.”

![Screenshot of e-MDs software](image1)

**Prescribing a structured medication**

![Screenshot of e-MDs software](image2)

**Adding an existing structured medication**
Reporting

This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 1-2 CPOE and Interaction Checks” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Drug Interaction Checks
3. e-Prescribing

**e-Prescribing 170.304(b)**

*More than 40% of all permissible prescriptions written by the EP are transmitted electronically*

*When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for e-Prescribing within Solution Series; Version 7.0 or later.*

**Provider Goal for Stage 1:** 40%

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**Meaningful Use Requirement for Stage 1**

*More than 40% of all permissible prescriptions written by the EP are transmitted electronically*

**Qualification**

**Denominator:**
The prescription must meet the following criteria to be considered for the denominator section of this measure:

- Prescriptions will be grouped under the provider responsible for the prescription therefore; the same patient having different prescriptions may qualify with multiple providers within the same clinic.
- Custom created drugs will be not included in this report.
- Prescriptions for DME (durable medical equipment) will not be included in either the numerator or denominator for this report.
- Schedule II – V prescriptions are not included in the report query.

**Numerator:**
The prescription must meet the following criteria to be considered for the Numerator section of this measure:

- The prescription will qualify for the numerator of this report if it was generated and transmitted electronically (eRX via SureScripts).
- The report query reads the AUDIT trails for the send method of prescriptions, so it is imperative that the chart Audit trails remain ON at all times during the reporting period.
Compliance with Solution Series

e-MDs is certified as a SureScripts Solutions Provider and member of the SureScripts Vendor Advisory Council. The Pharmacy Health Information Exchange™, operated by SureScripts is the largest network to link electronic communications between pharmacies and physicians, allowing the electronic exchange of prescription information.

In order to meet this requirement, pharmacies capable of receiving electronic prescriptions must be added to the e-MDs database. This is accomplished through the SureScripts Administration Pharmacy Matching tab. New prescriptions and refills will need to be submitted utilizing ScriptWriter to select the Electronic send method.

Pharmacy set up

To add SureScripts pharmacies:

- From Chart, click Tools and SureScripts Administration
- Click the Pharmacy Matching tab
- Pharmacies can be filtered by zip code, area code or an entire phone/fax number.
- If filtering by zip code, one at a time, type each zip code into the top search box and click add. If filtering by area code or phone/fax number, type this into the bottom search box.
- Click Show next to the utilized filter to see a list of participating pharmacies.
- Displayed on the left is the demographic information that SureScripts has for the listed pharmacy. Listed on the right is the demographic information in the e-MDs database for the listed pharmacy. To create the e-Prescribing link for this pharmacy, check the box in the Save column and click Save in the bottom left corner.
- Pharmacies with None listed in the right column can be added to e-MDs as a new pharmacy by clicking the dropdown arrow and selecting the New Pharmacy option. Check the box in the Save column and click Save in the bottom left corner.
Adding pharmacies via SureScripts

**Electronic Transmission**

To submit medication orders electronically, ScriptWriter will need to be utilized,

- To access ScriptWriter from the Health Summary, click the “Rx Pad” located within the Current Medications list.
- To access ScriptWriter from a Visit Note, click “Prescriptions” in the Plan or click to prescribe a medication embedded within a Plan template.
- Type in the drug to be prescribed, highlight and click Prescribe.
- Once all drugs to be prescribed have been selected, click Next to access the ScriptWriter for these medications.
- In the Send column, click the down arrow and select the Electronic send method*.
- In the Pharmacy Column, click the down arrow and select the pharmacy to electronically receive this prescription. If the pharmacy does not appear, click the magnifying glass to search for a pharmacy*.
- Click Save then Send to electronically transmit this prescription.
Manually modifying the Send method to Electronic

Selecting the pharmacy to receive this prescription

*The Send method for each user can be defaulted to electronic in their Chart Options. From Chart click File>Options>ScriptWriter and change the default send method here. Patients can have pharmacies set as default in their demographics. Open a patient’s demographics and click the Facilities tab. Pharmacies previously selected for each patient will also be stored for quick future selection when writing a prescription.
Run Crystal Report “e-Prescribing” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 3 e-Prescribing” located in the Video Learning Library section of supportcenter.e-mds.com

CMS e-Prescribing (eRx)
4. Active Problem List

*Active Problem List 170.302(c)*

Maintain an up-to-date problem list of current and active diagnoses based on ICD–9–CM or SNOMED CT®

*When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for maintenance of the problem list within Solution Series; Version 7.0 or later.*

**Provider Goal for Stage 1:** 80%

**Meaningful Use Requirement for Stage 1**

More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.

**Patient Qualification**

**Denominator:**
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

*Qualifying E&M Codes:*
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99450, 99455, 99456, 99499

**Numerator:**
The patient must meet the following criteria to be considered for the Numerator section of this measure. The Patient will appear in the numerator of this report if they have at least one problem in their problem list in the Visit/HS section of the chart. If the patient does not have any problems, the box for No Current Problems (NCP) may be checked and the patient will be included.
e-MDs provides a Health Summary for each patient that contains an active problem list as well as the ability to designate the patient has no current problems. This list is available via the panel to the left of the most recent Visit Note for the patient.

In order to meet this requirement, the problem list must be kept up-to-date and active. To be considered active and up-to-date there must be at least one entry made for this list during the reporting period or an indication that the patient currently has no information pertaining to that particular list.

To access the Problem list:
- Click the Visit/HS tab from a patient’s Chart
- Click the black “+” sign to the left of Current Problems to expand the problem list
- Click the box neck to “NCP” to denote that this patient has no current problems
- To add a new problem, click the yellow “+” at the top of the list of icons on the right hand side
- Search out and select the diagnosis to add
Reporting

Run Crystal Report “Problem List Maintenance” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 4-6 Problem-Medication-Medication Allergy Lists” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Maintain Problem List
5. Active Medication List

Active Medication List 170.302(d)

Maintain the patient’s active medication list

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for maintenance of the medication list within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 80%

Meaningful Use Requirement for Stage 1

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

Patient Qualification

Denominator:
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99450, 99455, 99456, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. The Patient will appear in the numerator of this report if they have at least one medication in their medication list in the Visit/HS section of the chart. If the patient does not have any medications, the box for No Known Medications (NKM) may be checked and the patient will be included.
Compliance with Solution Series

e-MDs provides a Health Summary for each patient that contains an active medication list as well as the ability to designate the patient has no current medications. This list is available via the panel to the left of the most recent Visit Note for the patient.

Maintain an active and up-to-date medication list for each patient seen during the reporting period

Add medications not being prescribed today with the yellow “+” in the Current Medications list

Medications prescribed using ScriptWriter will automatically be added to the Current Medications list

Workflow Alert: Do not leave the medications list blank for patients with no medications. Denote this with the checkbox next to “NKM”

Run Crystal Report “Medication List Maintenance” to track compliance throughout the reporting period

80% reporting threshold met at reporting period conclusion?

Workflow Alert: Do not leave the medications list blank for patients with no medications. Denote this with the checkbox next to “NKM”

Clinic workflow assessment

Submit data to CMS

In order to meet this requirement, the medications list must be kept up-to-date and active. To be considered active and up-to-date there must be at least one entry made for this list during the reporting period or an indication that the patient currently has no information pertaining to that particular list.

To access the Medication list:

- Click the Visit/HS tab from a patient’s Chart
- Click the black “+” sign to the left of Current Medications to expand the medication list
- Click the box neck to “NKM” to denote that this patient has no current medications
- To add a new medication, click the yellow “+” at the top of the list of icons on the right hand side
- Search out and select the medication to add
- Medications prescribed through ScriptWriter will automatically be added as a current medication
Accessing the Current Medications list

**Reporting**

Run Crystal Report “Medication List Maintenance” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

**References**

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 4-6 Problem-Medication-Medication Allergy Lists” located in the Video Learning Library section of supportcenter.e-mds.com

**CMS Active Medication List**
6. Medication Allergy List

**Active Allergy List 170.302(e)**

Maintain the patient’s active medication allergy list

*When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for maintenance of the medication allergy list within Solution Series; Version 7.0 or later.*

**Provider Goal for Stage 1:**  
80%

### Meaningful Use Requirement for Stage 1

More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

### Patient Qualification

**Denominator:**
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

*Qualifying E&M Codes:*

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99246, 99254, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99450, 99455, 99456, 99499

**Numerator:**
The patient must meet the following criteria to be considered for the Numerator section of this measure. The Patient will appear in the numerator of this report if they have at least one medication allergy in their medication allergy list in the Visit/HS section of the chart. If the patient does not have any medication allergies, the box for No Known Drug Allergies (NKDA) may be checked and the patient will be included.
e-MDs provides a Health Summary for each patient that contains an active medication allergy list as well as the ability to designate the patient has no current medication allergies. This list is available via the panel to the left of the most recent Visit Note for the patient.

In order to meet this requirement, the medication allergy list must be kept up-to-date and active. To be considered active and up-to-date there must be at least one entry made for this list during the reporting period or an indication that the patient currently has no information pertaining to that particular list.

To access the Medication Allergy list:
- Click the Visit/HS tab from a patient’s Chart
- Click the black “+” sign to the left of Allergies to expand the Medication Allergies list*
- Click the box neck to “NKDS” to denote that this patient has no current allergies
- To add a new allergy, click the yellow “+” at the top of the list of icons on the right hand side
- Select the Drug allergy
- Click the yellow “+” next to the Reactions box to add allergic reactions for this allergy and click Save
- This list will now provide contraindication information when prescribing medications
Reporting

Run Crystal Report “Allergy List Maintenance” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 4-6 Problem-Medication-Medication Allergy Lists” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Medication Allergy List
7. Record Demographics

Record Demographics 170.304(c)

Enable a user to electronically record, modify and retrieve patient demographic data including preferred language, gender, race, ethnicity and date of birth.

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for required demographics within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 50%

Meaningful Use Requirement for Stage 1

More than 50% of all unique patients seen by the EP have demographics recorded as structured data.

Patient Qualification

Denominator:
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99205, 99207, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99246, 99247, 99248, 99249, 99250, 99251, 99252, 99253, 99254, 99255, 99256, 99257, 99258, 99259, 99260, 99261, 99262, 99263, 99264, 99265, 99266, 99267, 99268, 99269, 99270, 99271, 99272, 99273, 99274, 99275, 99276, 99277, 99278, 99279, 99280, 99281, 99282, 99283, 99284, 99285, 99286, 99287, 99288, 99289, 99290, 99291, 99292, 99293, 99294, 99295, 99296, 99297, 99298, 99299, 99300, 99301, 99302, 99303, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99311, 99312, 99313, 99314, 99315, 99316, 99317, 99318, 99319, 99320, 99321, 99322, 99323, 99324, 99325, 99326, 99327, 99328, 99329, 99330, 99331, 99332, 99333, 99334, 99335, 99336, 99337, 99338, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350, 99351, 99352, 99353, 99354, 99355, 99356, 99357, 99358, 99359, 99360, 99361, 99362, 99363, 99364, 99365, 99366, 99367, 99368, 99369, 99370, 99371, 99372, 99373, 99374, 99375, 99376, 99377, 99378, 99379, 99380, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99388, 99389, 99390, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99398, 99399, 99400, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 99408, 99409, 99410, 99411, 99412, 99413, 99414, 99415, 99416, 99417, 99418, 99419, 99420, 99421, 99422, 99423, 99424, 99425, 99426, 99427, 99428, 99429, 99430, 99431, 99432, 99433, 99434, 99435, 99436, 99437, 99438, 99439, 99440, 99441, 99442, 99443, 99444, 99445, 99446, 99447, 99448, 99449, 99450, 99451, 99452, 99453, 99454, 99455, 99456, 99457, 99458, 99459, 99460, 99461, 99462, 99463, 99464, 99465, 99466, 99467, 99468, 99469, 99470, 99471, 99472, 99473, 99474, 99475, 99476, 99477, 99478, 99479, 99480, 99481, 99482, 99483, 99484, 99485, 99486, 99487, 99488, 99489, 99490, 99491, 99492, 99493, 99494, 99495, 99496, 99497, 99498, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. The patient must have an entry for each of the following items recorded in his/her demographics:
- Preferred language
- Gender
- Race
- Ethnicity
- Date of Birth

If a patient declines to provide information or if documentation of this information is contrary to state laws, mark the selection "declined" from within the appropriate field to meet this measure.
Each of the 5 meaningful use required fields are located under the General tab of patient demographics. To facilitate meeting this measure a new Demographics Settings option has been added to allow these fields to be marked as mandatory for each patient.

In order to meet this measure, the 5 required demographic fields Race, Ethnicity, Date of Birth, Preferred Language and Gender must be taken for each patient seen during the reporting period. These fields are located in the General tab of a patient’s demographics.

To access patient demographics:
- From Chart, click Demographics and Patients
- Search for the patient and click Edit
- The 5 required fields are located under the General tab*
Accessing patient demographics

*Patients can be recorded as declining to give their Race and Ethnicity and still meet this measure

The demographics settings module can be utilized to set these fields as required to be taken by all patients. To access this module:

- From Chart, click Demographics and Demographics Settings
  - Demographics Settings allows for the creation of custom groups of users with user-defined required demographic fields.
  - Groups of users appear in the leftmost column, users within each group in the middle column and required demographic fields for that group in the rightmost column.

To modify required fields:

- Highlight the group to be modified
- Click the checkbox next to the demographic field to be required and select the modules to require it within.
- These demographic fields will now be required to be taken for each patient accessed by these users within the selected modules.
Modifying required demographics

**Reporting**

Run Crystal Report “*Required Demographics Recorded*” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

**References**

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 7 Demographics” located in the Video Learning Library section of supportcenter.e-mds.com

[CMS Record Demographics](#)
8. Record Vital Signs

Record Vital Signs 170.302(f)

Record and chart changes in vital signs:
- Height
- Weight
- Blood pressure
- Calculate and display: BMI

Plot and display growth charts for children 2–20 years, including BMI

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for required vitals within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 50%

Meaningful Use Requirement for Stage 1

For more than 50% of all unique patients age 2 and over seen by the EP, the height, weight and blood pressure are recorded as structured data

Patient Qualification

Denominator:
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99204, 99205, 99206, 99207, 99208, 99209, 99210, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 99408, 99409, 99410, 99411, 99412, 99429, 99450, 99455, 99456, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. The Patient will appear in the numerator of this report if they have height, weight and blood pressure recorded in the vitals section of their chart. This does not require that these vitals are recorded in every visit. The height may be self-reported by the patient and entered in as structured data by the clinic staff.
Vital signs can be recorded within a Visit Note or from the patient’s chart to be pulled into a Visit Note. Height, weight and blood pressure are entered; BMI and growth charts are automatically calculated based on the height and weight entered for the patient.

In order to meet this measure, the vitals must be entered into a Visit Note for the patient. To access patient vitals:

- Click the blue word “Vitals” in a visit note for the patient and Add New Vitals, or click the thermometer icon in the patient’s chart*
- Enter the height, weight and blood pressure for the patient
- BMI and Growth Charts are auto-calculated upon entering the height and weight**
Accessing patient vitals

*Vitals entered using the thermometer icon must be pulled into a visit note using the “Add Existing Vitals” option
**Growth charts are only accessible from patient’s charts within the age range of 2-20. These are auto-calculated upon recording the patient’s height and weight.**

**Accessing growth charts**

<table>
<thead>
<tr>
<th>Vital Signs for Florencia Welton</th>
<th>Weight</th>
<th>Lb</th>
<th>Kg</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>27.22</td>
<td>18.57</td>
<td></td>
</tr>
</tbody>
</table>

**Height**

<table>
<thead>
<tr>
<th>Ft</th>
<th>In</th>
<th>Cm</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>4</td>
<td>132.08</td>
<td>23.29</td>
</tr>
</tbody>
</table>

**Body Mass Index**

<table>
<thead>
<tr>
<th>Kg/m^2</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.6</td>
<td>23.14</td>
</tr>
</tbody>
</table>

**Blood Pressure**

<table>
<thead>
<tr>
<th>Location</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left arm</td>
<td>Sitting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulse</th>
<th>Location</th>
<th>Position</th>
<th>Regularity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Creatinine</th>
<th>GFR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Using the K/P's recommended formula for children, Schwartz, to calculate GFR.</td>
</tr>
</tbody>
</table>

\[ GFR = \frac{\text{Kidney Function}}{\text{Body Surface Area}} \]

\[ \text{BSA} = 1.73 \times \left(\frac{\text{Weight}}{\text{Height}}\right)^{0.5} \]

**Accessing growth charts**

[Image of software interface]
Run Crystal Report “Vital Signs Recorded” to obtain numerator/denominator information for attestation. Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 8 Vital Signs” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Record Vital Signs
9. Record Smoking Status

Record Smoking Status 170.302(g)

Record smoking status for patients 13 years old or older

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for smoking status documentation within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 50%

Meaningful Use Requirement for Stage 1

More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Patient Qualification

Denominator:
The denominator of this report will query patients aged 13 to 110 years old by default. However, the user may select a different age range to utilize this report for purposes besides Meaningful Use. The denominator for this objective is the number of unique patients aged 13 to 110 years old that were seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99405, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99450, 99455, 99456, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. Date smoking status is documented must on or before the report end date. Smoking Status of the patient must be documented in the medical record as structured data using the custom codes indicated below. A specific set of custom codes has been created for the Smoking Status Documented criteria. These custom smoking status codes are as follows:
1. SMOK01 Current every day smoker
2. SMOK02 Current some day smoker
3. SMOK03 Former smoker (defined by having smoked 100 or less cigarettes during lifetime)
4. SMOK04 Never smoker
5. SMOK05 Smoker, current smoking status unknown
6. SMOK09 Unknown if patient has ever smoked

These custom codes are located in the Tobacco/Alcohol/Supplements History template and are designated by the new MU extended attribute (a burnt orange star is directly in front of the item). For convenience, a “Jump to
Tobacco/Alcohol/Supplements* has been placed in all plan templates contained in master content; however, the codes may be added to any template to document smoking status.

Compliance with Solution Series

Smoking status can be recorded in the patient’s Health Summary or within the Plan section of a Visit Note.

To enable this documentation as structured data, custom CPT codes associated with each smoking status have been added to the system.

To document smoking status from the Health Summary:
- Click Visit/HS from a patient’s chart
- Click the black “+” next to Tobacco/Alcohol/Supplements, and click the checkbox next to this section
- Click the Tobacco/Alcohol/Supplements template to open
- Click the option Tobacco Status MU/PQRI. Each of the 6 Meaningful Use smoking statuses are located here*
Documenting smoking status from the Health Summary

*Tobacco Status MU/PQRI and each smoking status are in this template are tagged with an orange star. Orange stars in e-MDs denote template items required for a Meaningful Use measure.

Plan templates contain links to the Tobacco/Alcohol/Supplements section of the patient’s Health Summary. Documentation of Smoking Status in the Plan will also be reflected in the patient health summary eliminating double data entry and allowing for this measure to be met both while updating the health summary or during the documentation of a patient encounter within a visit note.

To document smoking status from the Plan:

- At least one diagnosis must be present within the note. Click the checkbox next to the diagnosis to open a list of templates
- Click the Plan template name to be used
- Click the chain icon to the right of the “Jump to Tobacco/Alcohol/Supplements” option. This will open up the Tobacco/Alcohol/Supplements template allowing for documentation of smoking status
Documenting smoking status within the Plan

Reporting

Run Crystal Report “Smoking Status Documented” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 9 Smoking Status” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Record Smoking Status
10. Clinical Quality Measures (CQM)

Clinical Quality Measures (CQM) 170.304(j)

Report a total of 6 ambulatory clinical quality measures to CMS (Medicare EHR Incentive Program) or States (Medicaid EHR Incentive Program)

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for reporting on clinical quality measures within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: **Attestation**

Meaningful Use Requirement for Stage 1

For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of this final rule

For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule

Compliance and Reporting with Solution Series

e-MDs has been certified on all 44 clinical quality measures and have developed reports to display the aggregate numerator and denominator for each measure categorized by provider. Reports display a visual representation as to whether each provider met this measure, a calculated percentage, numerator/denominator and a detailed breakdown of both numerator and denominator values.
The 6 core clinical quality measures are broken down into core and alternate core categories. Eligible professionals are required to report on the 3 core clinical quality measures.

If the denominator for one of these 3 measures is a 0, meaning no patients eligible for that criteria were seen so there is no applicable information to report on, then there are 3 alternate core measures to choose from to satisfy the total requirement of 3. 3 of these 6 must be chosen to report on.

The remaining 3 clinical quality measures to report on will be chosen from the additional clinical quality measures category. These measures are somewhat specialty specific, however it is not required that the eligible professional choose a measure based on their specialty. The following is a complete list of the clinical quality measures available to choose from.
### Core Measures

<table>
<thead>
<tr>
<th>NQF 0421</th>
<th>Adult Weight Screening and Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRI 128</td>
<td></td>
</tr>
<tr>
<td>NQF 0028</td>
<td>Preventive Care and Screening Measure Pair:</td>
</tr>
<tr>
<td></td>
<td>1. Tobacco Use Assessment,</td>
</tr>
<tr>
<td></td>
<td>2. Tobacco Cessation Intervention</td>
</tr>
<tr>
<td>NQF 0013</td>
<td>Hypertension: Blood Pressure Measurement</td>
</tr>
</tbody>
</table>

### Alternative Core Measures (Substitute one for every Core Measure where denominator is 0)

<table>
<thead>
<tr>
<th>NQF 0024</th>
<th>Weight Assessment and Counseling for Children and Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF0041</td>
<td>Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older</td>
</tr>
<tr>
<td>PQRI 110</td>
<td></td>
</tr>
<tr>
<td>NQF 0038</td>
<td>Childhood Immunization Status</td>
</tr>
</tbody>
</table>

### Additional Measures (Choose any three, in addition to the Core Measures)

<table>
<thead>
<tr>
<th>NQF 0059</th>
<th>Diabetes: Hemoglobin A1c Poor Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRI 1</td>
<td></td>
</tr>
<tr>
<td>NQF 0064</td>
<td>Diabetes: Low Density Lipoprotein (LDL) Management and control</td>
</tr>
<tr>
<td>PQRI 2</td>
<td></td>
</tr>
<tr>
<td>NQF 0061</td>
<td>Diabetes: Blood Pressure Management</td>
</tr>
<tr>
<td>PQRI 3</td>
<td></td>
</tr>
<tr>
<td>NQF 0081</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LSVD)</td>
</tr>
<tr>
<td>PQRI 5</td>
<td></td>
</tr>
<tr>
<td>NQF 0070</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction</td>
</tr>
<tr>
<td>PQRI 7</td>
<td></td>
</tr>
<tr>
<td>NQF</td>
<td>PQRI</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>0043</td>
<td>111</td>
</tr>
<tr>
<td>0031</td>
<td>112</td>
</tr>
<tr>
<td>0034</td>
<td>113</td>
</tr>
<tr>
<td>0067</td>
<td>6</td>
</tr>
<tr>
<td>0083</td>
<td>8</td>
</tr>
<tr>
<td>0105</td>
<td>9</td>
</tr>
<tr>
<td>0086</td>
<td>12</td>
</tr>
<tr>
<td>0088</td>
<td>18</td>
</tr>
<tr>
<td>0089</td>
<td>19</td>
</tr>
<tr>
<td>0047</td>
<td>53</td>
</tr>
<tr>
<td>0001</td>
<td>64</td>
</tr>
<tr>
<td>0002</td>
<td>66</td>
</tr>
<tr>
<td>0387</td>
<td>71</td>
</tr>
<tr>
<td>0385</td>
<td>72</td>
</tr>
<tr>
<td>0389</td>
<td>102</td>
</tr>
<tr>
<td>0055</td>
<td>117</td>
</tr>
<tr>
<td>0062</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PQRI 119</td>
<td></td>
</tr>
<tr>
<td>NQF 0056</td>
<td>Diabetes: Foot Exam</td>
</tr>
<tr>
<td>PQRI 163</td>
<td></td>
</tr>
<tr>
<td>NQF 0074</td>
<td>Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol</td>
</tr>
<tr>
<td>PQRI 197</td>
<td></td>
</tr>
<tr>
<td>NQF 0084</td>
<td>Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation</td>
</tr>
<tr>
<td>PQRI 200</td>
<td></td>
</tr>
<tr>
<td>NQF 0073</td>
<td>Ischemic Vascular Disease (IVD): Blood Pressure Management</td>
</tr>
<tr>
<td>PQRI 20</td>
<td></td>
</tr>
<tr>
<td>NQF 0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
</tr>
<tr>
<td>PQRI 204</td>
<td></td>
</tr>
<tr>
<td>NQF 0004</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:</td>
</tr>
<tr>
<td></td>
<td>1. Initiation</td>
</tr>
<tr>
<td></td>
<td>2. Engagement</td>
</tr>
<tr>
<td>NQF 0012</td>
<td>Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)</td>
</tr>
<tr>
<td>NQF 0014</td>
<td>Prenatal Care: Anti-D Immune Globulin</td>
</tr>
<tr>
<td>NQF 0018</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>NQF 0032</td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td>NQF 0033</td>
<td>Chlamydia Screening for Women</td>
</tr>
<tr>
<td>NQF 0036</td>
<td>Use of Appropriate Medications for Asthma</td>
</tr>
<tr>
<td>NQF 0075</td>
<td>Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control</td>
</tr>
<tr>
<td>NQF 0575</td>
<td>Diabetes: Hemoglobin A1c Control (&lt;8.0%)</td>
</tr>
<tr>
<td>NQF 0052</td>
<td>Low Back Pain: Use of Imaging Studies</td>
</tr>
</tbody>
</table>

For 2011:
- EP’s will run an individual Crystal Report for each of the 6 clinical quality measures chosen to be reported on
- From Chart click Reports and Crystal Reports. Highlight the Clinical Quality Reporting (CQR) category to see all 44 reports
- For each report, highlight, click Run and enter the parameters
- Numerator and denominator values will be generated for attestation to CMS for this measure*
Accessing the Clinical Quality Measures Crystal Reports

*Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

For 2012 and beyond reporting on clinical quality measures must be completed electronically. In Solution Series this will be accomplished by utilizing the Clinical Quality Measure Module.

To access the Clinical Quality Measure Module:
- From Chart, click Reports then Clinical Quality Measures
- Choose a destination for the file location
- Select a reporting period
- Select a provider
- Choose the 6 clinical quality measures to report on
- Click Build

This will build an XML file for electronic submission with hard-coded parameters and save it to the location specified under file location. The XML file can be compared to the crystal report for the same measure, however, since the XML parameters are hard-coded, the parameters in the crystal report will have to be entered exactly the same as the XML in order for the reports to match.
Clinical Quality Measures Module
XML file for electronic submission

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 11 Quality Reporting” located in the Video Learning Library section of supportcenter.e-mds.com

The 2011 Physician Quality Reporting System Measures Groups Specifications Manual contains detailed descriptions for each quality measure within each measures group. This manual can also help to determine if a particular measures group is applicable to Medicare services the practice provides.


CMS PQRI Statute/Regulations/Program Instructions

CMS Clinical Quality Measures (CQM)
11. Clinical Decision Support Rule

Clinical Decision Support Rules 170.304(e)

Implement one clinical decision support rule

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for clinical decision support within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1:  

Meaningful Use Requirement for Stage 1

Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule

Compliance with Solution Series

Clinical decision support rules are located within the Rule Manager module. Each rule comes defaulted as active, but must be manually run or set up to run automatically as a scheduled task. When run, each rule will pop up as a clinical reminder to notify staff of patient healthcare priorities in multiple locations throughout e-MDs.
To access Rule Manager:
- Click Run then Rule Manager
- Once Rule Manager has been accessed, the module will open with a list of all the rules in the system. Eligible professionals are only required to implement one clinical decision support rule from this list. To activate/inactivate a rule, click on the rule name to highlight and click Edit Rule
- To activate, click the checkbox next to Rule Active, to inactivate deselect this box
- Users can move through the list of rules, activating and inactivating each as applicable, keeping in mind that at least one must be active to satisfy this measure.
Accessing Rule Manager and editing a rule
Activating a rule

To run a rule:
- Click the rule name to highlight and click Run Selected to run an individual rule manually. The selected rule will run for all patients it applies to based on the rule parameters. Click Run All to run all rules set to active.

To have all active rules run automatically, a scheduled task can be set up. The instructions for setting this up can be found on the e-MDs support center. e-MDs highly recommends setting up a scheduled task to run all active rules every night to ensure that each patient chart has the most up-to-date health maintenance information while avoiding possible reduction in system performance due to running rules while the clinic is conducting patient encounters.

If the user has previously been running rules and wishes to restore all patient charts so that only the rules activated for this measure will appear, contact e-MDs support to conduct this system refresh.
In order to track patient compliance with the implemented rule, eligible professionals can run the crystal reports “Overdue Rules Report” and “Clinical Rules Compliance Report”.

To run these reports:

- From the Chart module click Reports then Crystal Reports.
- Scroll through the list of reports and highlight the report to be run and click Run.
- Enter the parameters for this report; parameters include date range, provider and what rule to report on.
- The Overdue Rules Report will show all patients overdue for the selected rule. Clinical Rules Compliance will show all patients who took care of the rule (compliant patients) as well as those who denied the rule (non-compliant patients).
- Non-compliant patients will also have their demographic information displayed.
Running the Overdue Rules Report

Reporting

This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet this measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 10 CDS” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Clinical Decision Support Rule
12. Electronic Copy of Health Information

Electronic Copy of Health Information 170.304(ff)

Provide patients with an electronic copy of their health information, upon request

*When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for providing electronic copies of health information upon request within Solution Series; Version 7.0 or later.*

**Provider Goal for Stage 1:** 50%

**Meaningful Use Requirement for Stage 1**

More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days of the request

**Patient Qualification**

**Denominator:**
The patient must meet the following criteria to be considered for the denominator section of this measure.

- Patient must request an electronic copy of health information
- When a patient requests an electronic copy of their healthcare records, the user will create a Telephone/Log/Rx Note with the box selected next to Electronic Copy of Health Info (Patient Summary) Request associated with their chart.

**Numerator:**
The patient must meet the following criteria to be considered for the Numerator section of this measure. Patient qualifies for the numerator of this report if the patient’s Chart Summary (CCD) has been exported from their chart within three business days of the creation of the original Telephone/Log/Rx Note. Since there is not a way to assign an electronic request to a provider, each provider in the database who has seen the patient in the last 3 years shall get credit for each patient who requested the electronic copy of healthcare records. Potentially, a patient could call more than one time within three days, therefore creating more than one request for their healthcare information. If the user exports the Chart Summary (CCD) within 3 days of both requests the user gets credit in the numerator for both requests. The report will query for the audit record description of CCD-Chart Summary. It is imperative that the Chart Audit remain on at all times to ensure the capture of this information.
Chart Summary CCD’s (Continuity of Care Documents) will be provided to all patients who request an electronic copy of their health information. Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology. Chart Summaries will include the patient problems list, medication list, medication allergy list and diagnostic test results. Each section of the chart summary is pulled from the patient Health Summary except for diagnostic test results which will be any diagnostic test results in the patient chart that were received in HL7 format from a lab interface. It is important to note that electronic health information must be provided to 50% of all patients who request it, not necessarily to all patients seen by the eligible professional during the reporting period.

A new option has been added to log/phone notes to identify a patient request for an electronic copy of their Health information. Selecting this option when creating a new log/phone note from within the patient chart will document when this request occurred within the system.
To document a request:

- From a patient’s chart, click the “New Note” note icon and Telephone/Log/RxNote
- Provide documentation pertaining to the request and check the box “Electronic Copy of Health Info (Patient Summary) Request

Creating a new Telephone/Log/Rx Note

Documenting the patient request for an electronic copy of health information

The Chart Summary must then be generated within 3 business days of this request documentation. Business days are defined as Monday through Friday excluding federal or state holidays on which the eligible professional or their respective administrative staff is unavailable. While national holidays are written into the system, clinic staff will need to utilize the holiday feature in the schedule module to record local holidays so that they will be taken into account when generating reports for this measure.

To generate the Chart Summary

- From a patient’s chart, click the CCD button and “Export Chart Summary”
- Choose the HIPAA reason for exporting this document and attach a password if needed via the “Password Protect File” option
- Choose a location to save the file to and click Save
Once generated for a patient, Chart Summaries will be available to be exported to a jump drive or sent via e-mail. Because the criterion is to provide the patient health information electronically, the Chart Summary cannot be printed from Solution Series.
Run Crystal Report “Electronic Copy of Health Information Upon Request” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 12 Electronic Health Information” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Electronic Copy of Health Information
13. Clinical Summaries

Clinical Summaries 170.304(h)

Provide clinical summaries for patient for each office visit

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for providing clinical summaries for each patient within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1:  

Meaningful Use Requirement for Stage 1

Clinical summaries provided to patients for more than 50% of all office visits within 3 business days of the visit

Patient Qualification

Denominator:
The patient must meet the following criteria to be considered for the denominator section of this measure. The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99450, 99455, 99456, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. Patient qualifies for the numerator of this report if the patient was provided a Visit Summary within 3 days of the encounter. The Visit Summary can be provided thru:
- Printing the Visit Summary at Note Conclusion
- Exporting the Visit Summary (CCD) at Note Conclusion
- Printing the Visit Summary from DocMan after the Visit Note has been signed off
- Exporting the Visit Summary to Patient Portal after Visit Note has been signed off
- The report query reads the AUDIT trail to determine if the Visit Summary was printed/exported, so it is imperative that the chart Audit trails remain ON at all times during the reporting period.
Clinical summaries will be provided for patients via a Visit Summary. Visit Summaries will be provided as a printable/exportable option at the Note Conclusion window. These will be available in CCD format and able to be sent to the patient portal. Visit summaries contain information pulled from the visit note created during the patient encounter as well as information pulled from the patient Health Summary.

To generate a Visit Summary:
- At Visit Note conclusion, choose to print or electronically export the Visit Summary.
- If electronically exporting, the user has the option to attach a password to the generated file.
- If the patient is a portal patient, the system will prompt the user asking if they would like to send the Visit Summary to the patient portal. This prompt will only appear if the note is being permanently signed off at note conclusion and likewise, the visit summary can only be sent to the patient portal if the note is to be permanently signed off on*.
- If the visit note is concluded and permanently signed off, a copy of the Visit Summary will be sent to the patient’s DocMan module regardless of whether or not the option to generate was selected so that it can be printed or exported within the required 3 business days. Leaving a note open still offers the option to print or electronically export the Visit Summary but does not send a copy to DocMan.

*Workflow Alert: If the visit note is concluded and permanently signed off, a copy of the Visit Summary will be sent to the patient’s DocMan module regardless of whether or not the option to generate was selected so that it can be printed or exported within the required 3 business days.
Generating the Visit Summary

Information contained within the Visit Summary:

- Sections Pulled From the Note:
  - Chief Complaint
  - HPI
  - Vitals
  - Lab/Test
  - Plan

- Sections Pulled From the Health Summary:
  - Current Problems
  - Current Medications
  - Current Allergies
## Patient Visit Summary

*When the Visit Summary is sent to the patient portal, it will show up as a message to the patient within their portal.*
*Sending the Visit Summary to Patient Portal

Visit Summary in Patient Portal
Opening the Visit Summary in Portal

Reporting

Run Crystal Report “Visit Summary Provided To Patient” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 13 Clinical Summary” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Clinical Summaries
14. Electronic Exchange of Clinical Information

Electronic Exchange of Clinical Information 170.304(i)

Capability to exchange key clinical information among providers of care and patient-authorized entities electronically

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for exchanging clinical information within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: **Attestation**

Meaningful Use Requirement for Stage 1

Performed at least one test to electronically exchange key clinical information

Compliance with Solution Series

**Additional Software Required--E-mail Software**

e-MDs provides the ability to import/export a CCD within a patient’s Chart or DocMan module. Exported CCD’s can be encrypted for security of patient health information.

Key clinical health information to be exchanged includes:

- Diagnostic test results
- Problem list
- Medication list
- Medication allergy list

Clinical information will be exchanged utilizing the Chart Summary for a patient referenced in core measure 12. Generating and exporting the CCD allows for the transmission of clinical information in order to meet this measure.
Export a chart summary CCD for a patient by clicking the CCD button in a patient’s chart and “Export Chart Summary”

Import a CCD for a patient by clicking the CCD button in a patient’s chart and “Import CCD”

Imported CCD’s are stored as a DocMan file in the patient’s chart

*Note: In order to meet this measure, the EP must be able to generate the Chart Summary and have a method to send it. Importing is not required by this measure*

To generate the Chart Summary
- From a patient’s chart, click the CCD button and “Export Chart Summary”
- Choose the HIPAA reason for exporting this document and attach a password if needed via the “Password Protect File” option
- Choose a location to save the file to and click Save

*Workflow Alert:* Encrypting the exported CCD creates an executable file, incapable of e-mail transmission. In order to e-mail, do not password protect the file and transmit using an encrypted e-mail network.

Perform at least one test of the certified EHR technology’s capacity to electronically exchange key clinical information during the reporting period?

Submit data to CMS

Exporting the Chart Summary
The password entered here will be required to open the file. Note that encrypting the file creates an executable file type, incapable of e-mail attachment. In order to transmit via e-mail, do not encrypt the file and use an encrypted e-mail network.

**Reporting**

This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having performed at least one test of the certified EHR technology’s capacity to electronically exchange key clinical information during the reporting period.

**References**

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 14-15 Protecting and Exchanging Clinical Information” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Electronic Exchange of Clinical Information
15. Protect Electronic Health Information

Protect Electronic Health Information 170.302(o)-(w)

Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for protecting health information within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: Attestation

Meaningful Use Requirement for Stage 1

Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Compliance with Solution Series

e-MDs Solution Series meets the proper security requirements as defined by the National Institute of Standards and Technology test procedure 170.302.

- 170.302 (v) Encrypted Health Information Exchange
- 170.302 (s) Integrity – Secure Hash (SHA) 256
- 170.302 (u) General Encryption (AES, TDEA, and EES)

Practices should correct any security deficiencies identified during their risk analysis for the designated reporting period.
Reporting

This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Core Criteria 14-15 Protecting and Exchanging Clinical Information” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Protect Electronic Health Information
Meaningful Use Menu Set

Measures
1. Access to Drug Formulary Checks

**Access to Drug Formulary Checks -170.302(b)**

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for Access to Drug Formulary Checks within Solution Series; Version 7.0 or later.

**Provider Goal for Stage 1:**

Attestation

Meaningful Use Requirement for Stage 1

The eligible professional has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.

**Compliance with Solution Series**

e-MDs is certified as a SureScripts Solutions Provider and member of the SureScripts Vendor Advisory Council. The Pharmacy Health Information Exchange™, operated by SureScripts is the largest network to link electronic communications between pharmacies and physicians, allowing the electronic exchange of prescription information.

[Diagram of workflow]

- Obtain training and implement RxHub
- Run script to enable mail-order pharmacies
- Select proper options in Chart
- Create a "scheduled task" on the server
- Perform drug-formulary checks for patients throughout the reporting period
- Submit data to CMS
- Clinic workflow assessment
- Access to a drug formulary throughout the reporting period?
- Set up a Schedule check-in task for the Medication History consent form

Meaningful Use Requirement for Stage 1

1. **Access to Drug Formulary Checks**
Generating the list of therapeutic alternatives

In order to meet this requirement:

- Selecting Chart options:
  - Click Chart
  - File
  - Options
  - ScriptWriter tab
  - check the boxes titled
    - Auto Check Formularies
    - Display Alternatives for off formulary drugs
    - Display coverage/copay information
- Setting Access to Medication History in patient demographics:
  - Access patient demographics
  - Click misc tab
  - Set medication history consent option
Modifying patient Medication History Consent
This downloads formulary benefit data for that patient and displays it in the Pharmacy Coverage Pane.

Pharmacy Coverage information

**Reporting**

This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

**References**

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 1 Drug Formulary Checks” located in the Video Learning Library section of supportcenter.e-mds.com.

**CMS Drug Formulary Checks**
2. Clinical Lab Results as Structured Data

Clinical Lab Results as Structured Data 170.302(h)

Document clinical lab test results as structured data

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for entering clinical lab results as structured data within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 40%

Meaningful Use Requirement for Stage 1

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

Patient Qualification

Denominator:
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report. Labs must meet the following criteria to be considered for the denominator section of this measure. All lab tests ordered during the EHR reporting period by the EP with CPT codes that are in the CPT range from 80000 – 88741. CPT codes that do not return results as positive, negative or numeric are excluded. The CPT codes excluded are: 80500-80502, 86850-86999, 88000-88399. The report also excludes any CPT that is not due during the reporting period, and does not have a result documented as structured data. (If the lab is not due but does have a result and structured data it will place it in the denominator and numerator.)

Numerator:
Labs must meet the following criteria to be considered for the Numerator section of this measure.

- If the Lab comes back through a Lab Interface:
  Labs from the denominator qualify for the numerator of this report if the lab results come back from the lab and are attached to the original lab order and signed off.

- If the Lab results come back through a Manual Process (fax, scan, etc.):
Labs from the denominator qualify for the numerator of this report if the lab results (scanned in image) are attached to the original order and a FlowSheet is created from the image of the lab results. These labs will only appear in the numerator if the lab order is linked to the lab result image and if the lab result image is linked to the FlowSheet.

- **If a result is manually entered into a FlowSheet but not linked to an image:** *(This can happen within 14 days of the original Visit of the patient. You can still get credit after 14 days if you use one of the 2 other processes which include linking the result to the original order.)*
  - The FlowSheet data element must be linked to a Master Lab Code.
  - The Master Lab Code (MLC) must be linked to a CPT.
  - The lab order must exist in the visit note and be represented by a CPT code.
  - The report will query for the existence of a result in a FlowSheet that is linked to a CPT (via the MLC) in the patient’s chart.
  - If a result exists whose data element is linked to a CPT code AND the result was entered within 14 days (excluding weekends and holidays) of the order, the patient will be included in the numerator of this report even if not linked to an image.

**Compliance with Solution Series**

Lab results can be captured as structured data through the use of patient FlowSheets. Manual updates to these FlowSheets are available in patient charts or Visit Notes. To enhance this process, lab results received via a lab interface will automatically update FlowSheets, reducing errors in manual data entry.
In order to meet this requirement:

- Match lab codes to CPT codes:
  
  - Open the Lab Code Library and match Lab codes to master codes

- Select needed flowsheets in patient chart:
  
  - Access patient chart
  - Click the Flowsheets Tab
  - Use the blue plus sign to open any new flowsheet to be tracked for this patient
Updating FlowSheets from a visit note

These results can also be pulled into a visit note from the Lab Results section.
Reporting

Run Crystal Report “Lab Results in EHR as structured data” to obtain numerator/denominator information for attestation.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 2 Incorporate Clinical Lab Results into the EHR” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Clinical Lab Test Results
3. Patient List by Condition

Patient List by Condition 170.302(i)

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for generating a patient list by condition within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: Attestation

Meaningful Use Requirement for Stage 1

The eligible professional has the capability to generate at least one report listing patients with a specific condition.

Compliance with Solution Series

Patient lists will be generated by utilizing the Registry Processor. Reports querying user-specifed data parameters can be created with the Registry Processor. These listings are then used to generate reports, and to send mailings or electronic reminders to patients.

Meaningful Use Requirement for Stage 1

3. Patient List by Condition

Compliance with Solution Series

Workflow Alert: Ensure staff are entering the Preferred Reminder Method in patient demographics

At least one patient list by condition generated during the reporting period?

Yes

No

Create Registry Processor reports

Run reports on a consistent basis

Submit data to CMS

Clinic workflow assessment

Y

N

Send out reminders for patients via their Preferred Reminder Method shown in the patient list

Submit data to CMS
In order to meet this requirement:

- Create needed Registry Processor Report(s):
  - Click Chart
  - Reports
  - Registry Processor
  - New
  - Set needed fields for the report
    - Report Name
    - Report Parameters
    - Etc.
Creating a Registry Processor report

- Run this report as often as needed to generate a new list of patients
  - Chart
  - Reports
  - Registry Processor
  - Highlight report and click run
This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

Please reference the Crystal Reports section of this guide for further instruction on reporting for each measure.

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 3-4 Generate Lists and Send Reminders” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Generate List of Patients
4. Sending Clinical Reminders

*Sending Clinical Reminders 170.304(d)*

Send reminders to patients per patient preference for preventive/follow up care

*When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for sending clinical reminders within Solution Series; Version 7.0 or later.*

**Provider Goal for Stage 1:** 20%

**Meaningful Use Requirement for Stage 1**

More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period

**Patient Qualification**

**Denominator:**
The patient must meet the following criteria to be considered for the denominator section of this measure. The patients who are queried for this report are in the following age ranges:
- 0-5 years
- 65-110 years

The age ranges are defaulted in the crystal report parameters, however these may be edited so that the report may be run for the entire patient set for tracking clinical reminders if desired. Each staff provider shall get credit for each patient in this measure.

**Numerator:**
The patient must meet the following criteria to be considered for the Numerator section of this measure.
- Patient qualifies for the numerator of this report if there is evidence of at least one clinical reminder sent to the patient during the EHR reporting period. The clinical reminder is created using the Registry Processor, accessed from the Chart > Reports or Bill > Reports menu.
- The 7.0 Utilities User Guide, pages 107-114 has complete instructions on the Registry Processor. When generating a patient list to send clinical reminders, you must check the box that states “This is a clinical reminder report” in order to set a flag that this report queries to separate clinical reminders intended for the Meaningful Use measure and other reminder lists generated by a clinic.
Patient lists will be generated by utilizing the Registry Processor. Reports querying user-specified data parameters can be created with the Registry Processor. These listings are then used to generate reports, and to send mailings or electronic reminders to patients.

Ensure Preferred Reminder Method is set in patient demographics

Run Registry Processor report to generate list of patients age 5 and under/65 and over in need of a clinical reminder

Send reminders based on the Preferred Reminder Method for each patient

Workflow Alert: When sending reminders via the Log/Phone note method, remember to manually check the “Status” box to mark this patient as reminded

Clinic workflow assessment

Submit data to CMS

20% reporting threshold met at reporting period conclusion?

Run the Crystal Report “Clinical Reminders” to track compliance throughout the reporting period

In order to meet this requirement:

- Run Registry Processor Report:
  - Click Chart
  - Reports Menu
  - Registry Processor
  - Select needed report
  - Click Run
Reminders via phone

- To send out Reminders:
  - Use the Log/Phone note button to document a phone conversation
  - Check the status column so the system sees this reminder as being satisfied
  - Another option here is to send out Letters or notification via patient portal from Notice Processor letters
Reporting

Run Crystal Report “Clinical Reminders” to obtain numerator/denominator information for attestation.

References

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 3-4 Generate Patient Lists and Send Reminders” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Patient Reminders
5. Timely Electronic Access to Health Information

Document Timely Electronic Access to Health Information 170.304(g)

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for timely electronic access to health information within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 10%

Meaningful Use Requirement for Stage 1

More than 10% of all unique patients seen by the EP 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.

Patient Qualification

Denominator:
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating qualifying E&M codes from chart visit notes, listed below. The patient must have at least one “qualifying visit code(s)” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99429, 99450, 99455, 99456, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. A patient in the denominator automatically qualifies for the numerator of this report if they are a registered portal patient.

- If the Provider orders no labs during the visit for a Portal Patient
  - If the patient during the reporting period had NO Labs during the Visit the patient is automatically placed in the numerator because the patient will have Timely Access through portal to the Medication List, Problem List, and Medication Allergy List.
**If the Provider orders labs during the visit for a Portal Patient**

- If a provider orders labs for a patient during the visit the provider is responsible for providing some information regarding those labs to the patient. Patients with labs ordered the provider must at least send one Taskman message to the patient’s portal account with the Portal Lab/Test Result box selected within 4 business days of the lab being signed off. (The CMS does not state that the provider has to send the results but some information must be given about the labs). Sending one Taskman message with Portal Lab/Test Result checked with or without the results attached within 4 business days of the labs will meet this criterion.

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**Compliance with Solution Series**

e-MDs Patient Portal: An integrated, secure internet-based solution that enhances the physician-patient relationship, improves quality of care and reduces operational expenses. Clinics can share lab results, appointments and health maintenance reminders directly with patients. Patients can view and update health summaries, schedule appointments and request refills and referrals, via any internet connection.

In order to meet this requirement:

- Order Labs in visit notes
- Sign off on lab results by provider which will begin the 4 day requirement
- Upon sending Taskman message to patient check the box indication it is a Portal Lab/Test Result which is the end point of the data capture.
Sending lab results to Patient Portal
Reporting

Run Crystal Report “Timely Electronic Access to Health Information” to obtain numerator/denominator information for attestation.

References

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 5 Provide Electronic Access to Health Information” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Timely Electronic Access to Health Information
6. Patient Specific Education Resources

Patient Specific Education Resources 170.302(m)

Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for providing patient-specific education resources within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 10%

Meaningful Use Requirement for Stage 1

More than 10% of all unique patients seen by the EP are provided patient-specific education resources.

Patient Qualification

Denominator:
The denominator for this objective is the number of unique patients seen by the EP during the EHR reporting period. In order to establish that the patient was seen by an eligible professional, the report is calculating a chart visit note using specific E&M codes as a qualifying visit, listed below. The patient must have at least one “qualifying visit” within the reporting period in order to be counted in the denominator of this report.

Qualifying E&M Codes:
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99288, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99394, 99395, 99396, 99397, 99398, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99499

Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure. The patient must have been provided with patient-specific education resources. The education provided may be Patient Education or Krames Education documents. The Patient Education must be printed at note-conclusion while the Krames Education must be printed from within the launched Krames window. The report will query the audit report for the insertion and print action of Patient Education and Krames Education, so it is imperative that the chart audit is on at all times during the reporting period.
e-MDs provides a customizable internal database of both patient Rx and diagnosis specific education resources as well as free access to external patient education resources through an interface with KRAMES®.

Customize e-MDs patient education as needed

Insert and print or fax e-MDs patient education at note conclusion. Krames patient education can also be printed from the Plan section of a visit note

Workflow Alert: Ensure that patient education is being printed or faxed at note conclusion. Being added to the visit note only is not enough to satisfy this measure

Clinic workflow assessment

Submit data to CMS

10% reporting threshold met at reporting period conclusion?

Run the Crystal Report “Patient Specific Education Resources Provided” to track compliance throughout the reporting period

In order to meet this requirement:

- From the Plan section access patient education within the visit note.
- Decide if you want to use e-MDs education or Krames
- If e-MDs education select the needed item and click accept
- If Krames click Krames button and select needed item
- At note conclusion select the box to print education materials selected
Adding patient education to a visit note

Printing patient education at Note Conclusion
Run Crystal Report “Patient Specific Education Resources Provided” to obtain numerator/denominator information for atestation.

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 6 Patient-Specific Education” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Patient Specific Education Resources
7. Medication Reconciliation

*Medication Reconciliation 170.302(j)*

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for performing a medication reconciliation within Solution Series; Version 7.0 or later.

**Provider Goal for Stage 1:**

| 50% |

**Meaningful Use Requirement for Stage 1**

The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP

**Patient Qualification**

**Denominator:**
The patient must meet the following criteria to be considered for the denominator section of this measure. A new custom code (CPT-No Note TCARE) has been added to chief complaint templates to ease the documentation of these types of transitions. This code is under the item Transition of Care (a burnt orange star is directly in front of the item indicating Meaningful Use criterion).

Once the code has been added to the patient’s record the patient qualifies for the denominator. The text describing the transition will generate in the chief complaint portion of the visit note, but no CPT code will be visible or transferred to an invoice.

- The transition of care CPT Codes are:
  - TCARE1 Transfer of Care from Emergency Department
  - TCARE2 Transfer of Care from Inpatient Hospital
  - TCARE3 Transfer of Care from Skilled Nursing Facility
  - TCARE4 Transfer of Care from Specialist

**Numerator:**
The patient must meet the following criteria to be considered for the Numerator section of this measure.

- New functionality has been added to the Health Summary under current medications. A new icon named labeled Med Rec allows the user to perform medication reconciliation. Once medication reconciliation has been performed, the patient qualifies for the numerator. The medication reconciliation can occur before or after the TCARE CPT-No Note has been added to the note through the CC. The report queries for the performance of a medication reconciliation when the TCARE code is used in the chief complaint. This action may be performed by any user.

- The Med Rec must be performed on the same day as the Transition of Care.
• The report query reads the AUDIT trail to determine if a Med Rec was performed, so it is imperative that the chart Audit trails remain ON at all times during the reporting period.

Compliance with Solution Series

e-MDs provides a Health Summary for each patient that contains an active medication list. Medication reconciliation is performed from this list easily and effectively by importing medication information as an internal file or externally through SureScripts®.

Workflow Alert: Consult letters with medications prescribed can be imported next to the patient’s current med list to facilitate reconciliation. Ensure staff are scanning these in if patient presents with them. If participating in RxHub, the patient’s Medication History can also be imported.

In order to meet this requirement:

• Notate in the Chief Complaint section of a visit there has been a transition of care. Choices include:
  - From emergency department
  - From inpatient hospital
  - From skilled nursing facility
  - From specialist provider
Documenting the inbound transition

- Access the Visit H/S tab within the patient chart and click the Medication Reconciliation button.
  - Click File
  - Import from Docman OR
  - Import from Medication History (RxHub)
  - Use the yellow plus sign or the red stop sign to add or remove any medication changes
Click the medication reconciliation button
Use the yellow plus or red stop sign to update the patient’s medication list.
Run Crystal Report “Medication Reconciliation” to obtain numerator/denominator information for attestation.

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 7 Medication Reconciliation” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Medication Reconciliation
8. Provide Summary of Care Record

Provide Summary of Care Record 170.304(i)

Summary of care record for each transition of care/referrals

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for providing a summary of care record within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: 50%

Meaningful Use Requirement for Stage 1

The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.

Patient Qualification

Denominator:
The patient must meet the following criteria to be considered for the denominator section of this measure.

- A set of new custom CPT codes (CPT-No Note ADMIT) have been added to Plan templates to ease the documentation of these types of transitions. These codes are under the item “Admits” in the plan template (a burnt orange star is directly in front of the item indicating meaningful use criterion). Once one of the template items from the “Admits” code has been added to the patient’s record the patient qualifies for the denominator. The ADMIT code may also be manually entered to the patient chart into Other Orders if desired.
  - The codes used for ADMIT are:
    1. ADMIT1 Transfer of Care to the Emergency Department
    2. ADMIT2 Transfer of Care to Inpatient Hospital
    3. ADMIT3 Transfer of Care to Skilled Nursing Facility
    4. This report will also query for any CPT code beginning with ADMIT; regardless of what follows in the case that a clinic chooses to create additional ADMIT codes for tracking purposes.

- REFER codes will also qualify the patient for the denominator of this report. The report will query for the following REFER codes documented in a visit note within the reporting period. Like the ADMIT codes, this may be documented in the CPT-NO NOTE section if desired.
  1. REFER Referral
  2. RFALRG Allergist Referral
  3. RFBONE Orthopedist Referral

Meaningful Use Attainment Guide and Workflows
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v.2011.5.5.1
Numerator:
The patient must meet the following criteria to be considered for the Numerator section of this measure.

- The Patient qualifies for the numerator section of this report if the patient’s Chart Summary (CCD) has been exported from their chart within 30 days of an ADMITS or REFER documentation.

- When a provider transitions a patient to the care of another provider, an electronic copy of their records should be sent to the receiving facility or given to the patient to provide to the provider that they are transitioning to. The Chart Summary or CCD is an exportable copy of the patient’s medical record that will provide the necessary information to properly continue the care of the patient, therefore should be provided in an adequate amount of time from the transition.

- The report will query for the audit record description of CCD-Chart Summary. The provision of one Summary of Care can satisfy multiple referrals as long as it is provided within 30 days of the transition of care order. It is imperative that the Chart Audit remain on at all times to ensure the capture of this information.
Chart Summary CCD’s (Continuity of Care Documents) will be provided for all patients transitioned to another setting of care.

In order to meet this requirement:

- From the Plan section choose the “admit” or referral type.
- Within 30 days of this visit generate a CCD by clicking the CCD button in the patient chart.
- Once this is generated a copy of the CCD should be sent to the receiving facility or given to the patient to provide to the provider that they are transitioning via print, electronic, or saved to a flash drive.
Notate from the Plan there has been a referral or admit to another setting of care.

Generate the CCD by clicking the CCD button within the patient chart.
When a CCD is generated a copy is automatically saved to the patients DocMan that can later be accessed if needed.

**Chart Summary**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Mr. Andy Brown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth</td>
<td>September 01, 1970</td>
</tr>
<tr>
<td>Contact info</td>
<td>Primary Home: 1212 Riverway Dr., Cedar Falls, IA 50613 Tel: #123-456-7890</td>
</tr>
<tr>
<td>Account</td>
<td>ORG00001</td>
</tr>
</tbody>
</table>

**Document Id**

<table>
<thead>
<tr>
<th>Document Id</th>
<th>227929F7C-9777-4608-842E-6EC547F4D0F7</th>
</tr>
</thead>
</table>

**Document Created**

| April 12, 2011 |

**Performer**

| Dr. Kelsey Kidder |

**Author**

| Dr. Bernard Bowling |

**Document maintained by**

**Reference**

- Diagnostic Test Results
- Problem list
- Medication list
- Allergy list

**Reporting**

Run Crystal Report “Summary of Care Provided” to obtain numerator/denominator information for attestation.

**References**

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 8 Provide Summary of Care Record” located in the Video Learning Library section of supportcenter.e-mds.com

**CMS Provide Summary of Care Record**
9. Submit Immunization Data to Public Registries

Submit Immunization Data To Public Registries 170.302(k)

Capability to submit electronic data to immunization registries/systems (public health objective)

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for submitting immunization data to public registries within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: Attestation

Meaningful Use Requirement for Stage 1

Performed at least one test to submit electronic data to immunization registries and follow up submission if the test is successful where accepted and required.

Compliance with Solution Series

e-MDs Interface Engine provides the ability to report electronic data to state immunization registries and public health agencies.

Purchase and install e-MDs Interface Engine

Create file path in which immunization logs will be sent

Generate the spoke parameters

Workflow Alert: Document immunizations in the patient’s immunization log via the “syringe” icon in their chart

Submit data to CMS

Attempt to upload the HL7 file to your state’s Immunization Registry

Upload attempted?

Y

N

Clinic workflow assessment
In order to meet this requirement:

- Open the interface engine:
  - Enter Spoke information
  - Ensure the directory path is saved in top left corner
  - Click Save

The spoke will generate a HL7 file.
This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having attempted to upload the HL7 file to the states immunization registry and if it was successful.

References

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 9-10 Immunization Registries and Syndromic Surveillance” located in the Video Learning Library section of supportcenter.e-mds.com.

CMS Immunization Registries Data Submission
10. Syndromic Surveillance Data Submission

Syndromic Surveillance Data Submission 170.302(l)

Capability to provide electronic syndromic surveillance data to public health agencies (public health objective) –

When you have completed this lesson, you will understand the steps necessary to meet the Meaningful Use requirement for submitting immunization data to public registries within Solution Series; Version 7.0 or later.

Provider Goal for Stage 1: Attestation

Meaningful Use Requirement for Stage 1

Performed at least one test to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful where accepted and required

Compliance with Solution Series

e-MDs Interface Engine provides the ability to report electronic data to state immunization registries and public health agencies.
In order to meet this requirement:

- Open the interface engine:
  - Enter Spoke information
  - Ensure the directory path is saved in top left corner
  - Click Save

The spoke will generate a HL7 file.
File to be uploaded to the public health agency.

Reporting

This measure is met by YES / NO attestation. Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology’s capacity to submit electronic syndromic surveillance data to public health agencies and 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) to meet this measure.

References

For step by step instructions on meeting this measure, please reference the training video “MU Menu Set 9-10 Immunization Registries and Syndromic Surveillance” located in the Video Learning Library section of supportcenter.e-mds.com

CMS Syndromic Surveillance Data Submission
Eligible professionals receive meaningful use reporting credit from each patient based on the provider listed as the Health Care Professional for the qualifying visit. The provider listed here will receive the credit for compliance with each measure required for that qualifying visit.

A patient may be excluded from the denominator if they are marked “exempt from reports” in their demographics. This will prevent any test patients from being counted in the numerator and denominator calculation, therefore will not count against the EP if the objective is not met. The exempt patients will not show up on any of the Meaningful Use Reports. Please note that there is not a list of the patients with this exemption, as they are simply excluded from all calculations. To mark a test patient exempt from reports, edit their demographics and select this checkbox under the miscellaneous tab.

To Run a Crystal Report:
- In the Chart Module, click Reports from the menu at the top of the window and click Crystal Reports from the dropdown
- In the top portion of the Find Report by Category screen, scroll down to the Category Description Meaningful Use Reporting
- The complete set of reports, used for the 16 Meaningful Use criteria that require numerator/denominator reporting, will display in the bottom portion of the window
- Select a report from the list at the bottom of the window and click the Edit to read the full description. Ensure you have privileges to run this report
**Accessing Crystal Reports**

**Running a Meaningful Use Crystal Report**

To enable a user to run this report:

- Click Add on the lower right hand side of the screen and select the user from the list and click Save.
- Click Save at the top left corner of the Report Maintenance window to save your settings.
• Ensure the report desired is selected in the lower portion of the screen and click Run. It will take a few seconds for the parameter selection screen to open.

Entering Parameters:
• The beginning date range is the first date the query will report. If the reporting period is 90 days, choose the first day of the 90 day period for this parameter. If reporting on an entire year, choose January 1 of the report year. This date must be entered in mm/dd/yyyy format or click the calendar icon and use the arrows at the top left and top right to adjust the year and month. Click the date on the calendar to select and then OK.
• The ending date range is the last date the query will report. If the reporting period is 90 days, choose the last day of the 90 day period for this parameter. If reporting on an entire year, choose December 31 of the report year. This date must be entered in mm/dd/yyyy format or click the calendar icon and use the arrows at the top left and top right to adjust the year and month. Click the date on the calendar and then OK.
• Provider name (last name, first name) or leave blank for ALL
  o These reports can be run by all providers by leaving this field blank. Each provider will be listed separately with the specific patient list related to that provider displayed as a sub report. If running this report for a specific provider, type that provider’s last name, first name (example: Cardio, Kevin) in this field labeled Enter a Value. Only patients qualifying for inclusion with this provider will display on the report.
• Enter the insurance class
  o If running this report for Meaningful Use reporting, do not select an insurance class. If running this report for a specific insurance class, enter the insurance class (example: MDC) in the field labeled Enter a Value.
• Enter the minimum age
  o Meaningful Use criteria contain age parameters which have been set as the default for this field. If desired, another age range can be typed into the Enter a Value field; otherwise, the report will automatically run for the minimum age defaulted and displayed in the field.
• Enter the maximum age:
  o Meaningful Use criteria contain age parameters which have been set as the default for this field. If desired, another age range can be typed into the Enter a Value field, otherwise, the report will automatically run for the minimum age defaulted and displayed in the field.
• On the Enter Parameters screen, click OK. The Meaningful Use reports display in the Crystal Report viewer.
Entering report parameters

Generated reports will provide a numerator, denominator and percentage reflecting user status for this measure. The denominator represents the total number of patients seen during the selected reporting period that were eligible for this measure, and the numerator represents the total number of patients seen during this period that were both eligible and met this measure. Percentages are automatically calculated to facilitate tracking compliance with the measure being reported on. Reports can be run as often as desired during the reporting period to track user status.

The pageheader provides an overview of the progress towards meeting this measure. The numerator, denominator and percentage for each provider are provided here as well as indication as to whether each provider has met the measure.
Selecting a provider will give a breakdown of each patient eligible for this measure broken down into 2 categories. Category 1 contains information for each patient meeting this measure.

Patients meeting this measure for the selected provider

<table>
<thead>
<tr>
<th>Acct. #</th>
<th>Patient Name</th>
<th>DOB</th>
<th>Gender</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Language</th>
<th>Qualifying Visit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADAA000001</td>
<td>Adams, Aznus</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>04/20/2011</td>
</tr>
<tr>
<td>HEAHEA0001</td>
<td>Head, Heather</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>03/23/2011</td>
</tr>
</tbody>
</table>

Category 2 contains information for each patient not meeting this measure. For patients not meeting this measure, a red “X” will indicate missing information which will aid in the capture of this data for the patient.

Patients not meeting this measure for the selected provider

<table>
<thead>
<tr>
<th>Acct. #</th>
<th>Patient Name</th>
<th>DOB</th>
<th>Gender</th>
<th>Race</th>
<th>Ethnicity</th>
<th>Language</th>
<th>Qualifying Visit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONNHAR0001</td>
<td>Congreve, Harold</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>03/33/2011</td>
</tr>
</tbody>
</table>
In the measures that require that the patient is seen by an eligible professional, there must be a visit note present in the patient chart with a qualifying E&M code. This ensures that there are no rounds visits or nurse visits included in the report query. Please refer to the e-MDs Meaningful Use Reports Dictionary for detailed information such as qualifying E&M codes pertaining to each of the 16 crystal reports. This user guide gives a complete detailed description on how each report is developed in order to provide the most up to date, accurate information for meaningful use reporting.

**MU Dashboard**

The MU dashboard crystal report is a tool for providers to view their Meaningful Use progress in a snapshot view.

User parameters include DOS start date; DOS end date, DOS provider, and "additional licensed healthcare professional.” The additional licensed healthcare professional parameter is used for the CPOE report when other healthcare professionals that are listed in clinical staff should be included, according to your state and local guidelines.

The summary page lists each provider followed by the progress of each of the meaningful use criterion which has a corresponding report.

![Meaningful Use Dashboard](image)

**Summary Page**

Clicking on the provider name will generate a sub-report with a detailed pie-chart view of each individual measure.
Meaningful Use Dashboard

CPOE (Core 1)
- Actual: 52%
- Stage 1 MU Threshold: 30%
- Numerator: 8
- Denominator: 13

Problem List Maintenance (Core 3)
- Actual: 77%
- Stage 1 MU Threshold: 80%
- Numerator: 17
- Denominator: 22

e-Prescribing (Core 4)
- Actual: 9%
- Stage 1 MU Threshold: 40%
- Numerator: 0
- Denominator: 38

Medication List Maintenance (Core 5)
- Actual: 64%
- Stage 1 MU Threshold: 80%
- Numerator: 14
- Denominator: 22

Provider Sub-Reports

Allergy List Maintenance (Core 6)
- Actual: 41%
- Stage 1 MU Threshold: 80%
- Numerator: 9
- Denominator: 22

Required Demographics Recorded (Core 7)
- Actual: 18%
- Stage 1 MU Threshold: 50%
- Numerator: 4
- Denominator: 22

Vital Signs Recorded (Core 8)
- Actual: 5%
- Stage 1 MU Threshold: 56%
- Numerator: 1
- Denominator: 21

Smoking Status Documented (Core 9)
- Actual: 11%
- Stage 1 MU Threshold: 50%
- Numerator: 2
- Denominator: 19

Provider Sub-Reports