

eClinicalWorks

MEANINGFUL USE STAGE 2 USERS GUIDE

V10 - July 2015



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MEANINGFUL USE STAGE 2 INTRODUCTION

This guide contains scenario-based examples of the workflow needed to become compliant for Meaningful Use Stage 2 measures. Some of the most common scenarios are outlined here, although the methods used may not always be the only way to complete a given task.

Note: It is required that the technology certified for 2014 is used to satisfy these measures. Version 10 of eClinicalWorks is the 2014 certified technology.

The Final Rule Meaningful Use objectives are split into three groups:

- **Core Objectives** - These 17 objectives must all be satisfied in to fulfill the Meaningful Use requirements.
- **Menu Set Objectives** - Providers can select three (3) out of these six (6) objectives that they wish to satisfy to fulfill the Meaningful Use requirements.

Note: While there are exclusions provided for some of the Menu Set objectives, users cannot select one of these objectives and claim the exclusion if there are other Menu Set objectives that they can report on instead.

- **Clinical Quality Measures** - Formerly a Core Measure, it has been removed as redundant, but providers are still required to report on Clinical Quality Measures to achieve Meaningful Use. Beginning in 2014, eligible professionals must select and report on nine (9) of a possible list of 64 approved CQMs for the EHR Incentive Programs. There is also a new requirement in 2014 that the CQMs selected must cover at least three (3) of the six (6) available National Quality Strategy (NQS) domains

IMPORTANT! There are two types of measures: percentage-based and self-attest. Self-attest measures require users to meet the criteria and report with a Yes or No while percentage-based measures require calculations to determine the numerator and denominator. The MAQ Dashboards are a reporting tool that can be used to determine how well you are satisfying the percentage based Meaningful Use measures with eClinicalWorks.

The recommended methods of satisfying Meaningful Use measures are detailed in this guide, but there may be other methods of satisfying certain measures using the eClinicalWorks EMR/PM system. For more information on all features available when using eClinicalWorks, refer to the HelpHub, which can be accessed from within the eClinicalWorks application at: Help > HelpHub.

Certain Visit Types, Visit Statuses, and patients are excluded from all Meaningful Use calculations. For more information on the processes related to excluding visits, statuses, and patients, refer to the following sections:

- [Excluding Visit Types from Meaningful Use Calculations](#)
- [Excluding Visit Statuses from Meaningful Use Calculations](#)
- [Excluding Inactive and Deceased Patients from Meaningful Use Calculations](#)

Note: Visit Type and Visit Status exclusions only affect Core and Menu Set objective measures and not Clinical Quality Measures.

Excluding Visit Types from Meaningful Use Calculations

Certain visit types can be automatically excluded from Meaningful Use calculations. Any visits with these visit types are ignored by the system when calculating compliance percentages for all measures.

IMPORTANT! If providers are seeing patients using a visit type, then it should not be excluded from reporting.

To exclude visit types from Meaningful Use calculations:

1. From the *Admin* band in the left navigation pane, click *Admin*.
The Admin login window opens.
2. Enter your administrator password and click *Login*.
The Admin window opens.
3. Click the *User Admin* folder in the left pane.
The items in the User Admin folder display in the left pane.
4. Click *Visit Type Codes* in the left pane.
The Visit Type Codes options display in the right pane.
5. Click *Add*.
The Visit Codes options display in the right pane.

6. Check the *Exclude from Meaningful Use Reporting* box:

Visit Codes

Name

Description

Chart Title

Color

Visit Type

Visit Type Duration(In Mins)

OBGYN History PhysicalTherapy
 Requires Claim Requires Copay
 Pregnancy Visit Vision Visit
 Orthopaedic Visit
 Care Plan Visit Care Mgmt Visit
 Worksheet Visit CCMR Visit
 Referral Required

Status
 Active Inactive

Exclude from Meaningful Use Reporting
 Do not display Appointments with this visit type in 'Progress Notes' visits Drop Down
 Synchronize this visit type to patient portal
 Medication reconciliation not necessary. 

7. Enter any remaining information here as appropriate.
8. Click *Save*.

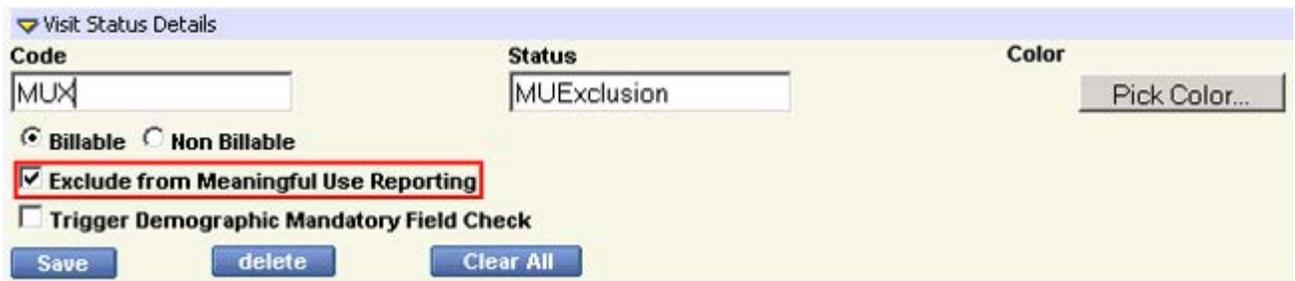
This new Visit Type is created. Any encounter using this Visit Type is not included in the calculations for any Meaningful Use measure.

Excluding Visit Statuses from Meaningful Use Calculations

Certain visit statuses can be automatically excluded from Meaningful Use calculations. Any visits with these visit statuses are ignored by the system when calculating compliance percentages for all measures.

To exclude visit statuses from Meaningful Use calculations:

1. From the *Admin* band in the left navigation pane, click *Admin*.
The Admin login window opens.
2. Enter your administrator password and click *Login*.
The Admin window opens.
3. Click the *User Admin* folder in the left pane.
The items in the User Admin folder display in the left pane.
4. Click *Visit Status Codes* in the left pane.
The Visit Status Codes options display in the right pane.
5. Click *Add*.
The Visit Codes options display in the right pane.
6. Check the *Exclude from Meaningful Use Reporting* box:



The screenshot shows a web form titled "Visit Status Details". It has three columns: "Code", "Status", and "Color". The "Code" field contains "MUX", the "Status" field contains "MUExclusion", and the "Color" field has a "Pick Color..." button. Below these fields are radio buttons for "Billable" (selected) and "Non Billable". A checkbox labeled "Exclude from Meaningful Use Reporting" is checked and highlighted with a red box. Below it is an unchecked checkbox labeled "Trigger Demographic Mandatory Field Check". At the bottom are three buttons: "Save", "delete", and "Clear All".

7. Enter the rest of the information here as appropriate.
8. Click *Save*.
This new Visit Status is created. Any encounter using this Visit Status is not included in the calculations for any Meaningful Use measure.

Excluding Inactive and Deceased Patients from Meaningful Use Calculations

Any patients that are marked as Inactive or Deceased are excluded from Meaningful Use calculations.

Marking a Patient as Inactive

Patients that no longer go to your practice may be marked as Inactive from the Patient Information window.

To mark a patient as Inactive:

1. Click the Patient Lookup icon at the top of the application.
The Patient Lookup window opens.
2. Search for and highlight the inactive patient, then click *Patient Info*.
The Patient Information window opens.
3. Click *Additional Info*.
The additional Patient Information window opens.
4. Check the *Inactive* box:

The screenshot shows the 'Patient Information' window for 'Smith, James'. At the top, there are checkboxes for 'Don't Send Statements', 'Inactive' (which is checked and highlighted with a red box), and 'Don't add finance charge'. Below this are tabs for 'General Information', 'Student Information', and 'Structured'. The main area contains several sections: 'Street Address (if different from mailing)' with fields for Address Line 1, Address Line 2, City, State, and Zip; 'Employer Address' with similar fields; 'Leave Message' options for Home and Cell; 'Residence Type', 'Race' (Asian), 'Ethnicity' (Refused to R), and 'Birth Order'; 'VFC Eligibility'; 'Deceased' checkbox; 'Mail Order Member ID', 'Plan Type', 'Default Facility', 'MRN(External System)', 'Default Lab Company', and 'Default DI Company'; 'Language' (English), 'Translator', 'Exclude From Registry Search', and 'Use Street Address for Prescription' checkboxes; and 'Registered On' date (11/23/2013). At the bottom, there are tabs for 'Pharmacies', 'Contacts', 'Attorneys', 'Case Manager', and 'Circle of Care', along with 'Add' and 'Remove' buttons. A table with columns 'E', 'M', 'P', 'Pharmacy Name', 'Address Line 1', 'City', 'State', 'Zip', 'Tel', and 'Fax' is visible. At the very bottom are buttons for 'Patient Docs', 'Consult Notes', 'Adv Directive', 'Add Student Info', 'OK', and 'Cancel'.

5. Click *OK*.

The additional Patient Information window closes.

6. Click *OK*.

The Patient Information window closes and this patient is marked Inactive.

Marking a Patient as Deceased

Deceased patients may be marked as such from the Patient Information window.

To mark a patient as deceased:

1. Click the Patient Lookup icon at the top of the application.

The Patient Lookup window opens.

2. Search for and highlight the inactive patient, then click *Patient Info*.

The Patient Information window opens.

3. Click *Additional Info*.

The additional Patient Information window opens.

4. Check the *Deceased* box.

The Date and Notes fields display in the Deceased section:

The screenshot shows the 'Patient Information' window for 'Smith, James'. The window has tabs for 'General Information', 'Student Information', and 'Structured'. The 'General Information' tab is active. The 'Deceased' section is highlighted with a red box. It contains a checked 'Deceased' checkbox, a 'Date' dropdown set to '11/14/2013', and a 'Notes' text area containing 'Acute Myocardial Infarction'. Other fields include 'Street Address', 'Employer Address', 'Race' (Asian), 'Ethnicity' (Refused to R), 'VFC Eligibility', 'Language' (English), and 'Registered On' (11/23/2013). The bottom of the window has a 'Pharmacies' section with a table and buttons for 'Patient Docs', 'Consult Notes', 'Adv Directive', 'Addl Student Info', 'OK', and 'Cancel'.

E	M	P	Pharmacy Name	Address Line 1	City	State	Zip	Tel	Fax

5. Enter the date this patient died in the *Date* field (in mm/dd/yyyy format).
6. Enter any applicable notes concerning this patient's death (such as the manner) in the *Notes* field.
7. Click *OK*.

The additional Patient Information window closes.

8. Click *OK*.

The Patient Information window closes and this patient is marked Deceased.

Requesting a Direct Address

A Direct Address is required for practices to electronically transmit clinical information to a third party. This is necessary to satisfy aspects of Core Measure 15, and can also optionally be used for Core Measure 7.

Note: Non-eCW providers can go to <http://www.jointhenetwork.com> to request an eClinicalWorks-issued Direct Address.

To request a Direct Address:

1. From the *Admin* band, click *eCW P2P Admin*:



The P2P Admin window opens.

2. If you are already on Join the Network (JTN), click *Edit Settings*:

Provider Registration Facility Registration

Search Name:

Previous Next

<input type="checkbox"/>	Provider Name	E-mail	NPI	Zip Code	
<input type="checkbox"/>	Willis, Sam	d@d.com	1033412739	33433-2345	Edit Settings Edit Profile

If you are not yet on JTN, click *Register* to Join the Network.

The P2P Account Settings window opens.

- In the *HISP - Direct* section, enter all applicable information:

community or from your friend to add them to your contacts.

Invitation Key:

Save

HISP - Direct

As an ONC-Certified EMR vendor and HISP, eClinicalWorks provides services required for the exchange of health information as defined by the Direct Project for Meaningful Use Stage 2.

- Provide Direct Addresses
- Publish and find digital certificates
- Facilitate management of trusted exchange relationships
- Secure health information in transit using S/MIME and certificates
- Route and transport Direct Messages using Direct Addresses and SMTP
- Provide the portal for Direct Messages

Using the naming convention and example below, check the availability of your desired Direct Address:
 Convention: <First name>.<Last name>@<Organization Abbreviation>.eclinicaldirectpilot.com
 Sample Provider Name: Sam Willis
 Sample Organization Name: Westborough Medical Associates
 Sample Organization Abbreviation: WMA
 Sample Direct Address: sam.willis@wma.eclinicaldirectpilot.com

Contact Email Address:
 All communications regarding direct request will be sent to this email.

First Name: **Last Name:**

Your organization name: **Abbreviation for your organization:**

Check Availability

There is no cost to participate in eCW HISP for MU 2 attestation purpose.

Enterprise customers who may need us to help them with the request process, will have onboarding cost (\$60 per provider annual cost to set up direct address and mailbox)

Terms and Conditions :

- The 'free of cost' model is to help providers attest for MU2, and is applicable only till the end of 2014.
- Renewal Process: Users can renew their certificates and direct address every calendar year annually through JTN.

- Click *Check Availability*.

The availability of your organization name is checked against the database. If your chosen name is unavailable, change it and click *Check Availability* again until Address Available displays:

Sample Direct Address: sam.willis@wma.eclinicaldirectpilot.com

Contact Email Address:
All communications regarding direct request will be sent to this email.

testprovider@gmail.com

First Name: Sam-900penMSSQL **Last Name:** Willis

Your organization name: 000 **Abbreviation for your organization:** 000

Address available.

Check Availability

5. Click *Submit*.

Sample Direct Address: sam.willis@wma.eclinicaldirectpilot.com

Contact Email Address:
All communications regarding direct request will be sent to this email.

testprovider@gmail.com

First Name: Sam-900penMSSQL **Last Name:** Willis

Your organization name: 000 **Abbreviation for your organization:** 000

Address available.

Check Availability

There is no cost to participate in eCW HISP for MU 2 attestation purpose.

Enterprise customers who may need us to help them with the request process, will have onboarding cost (\$60 per provider annual cost to set up direct address and mailbox)

Terms and Conditions :

- The 'free of cost' model is to help providers attest for MU2, and is applicable only till the end of 2014.
- Renewal Process: Users can renew their certificates and direct address every calendar year annually through JTN.

Out-of-Network Exchange:
 For communication and data exchange with out-of-network providers who have a Direct Address. Please complete the form below and we will contact you shortly for the setup of the Out-of-Network Exchange.

Submit

The HISP - Direct status is marked as Pending. A Direct Address is issued within five (5) business days. Once issued, the HISP-Direct status is marked as Confirmed.

CORE MEASURES

All 17 of these objectives must be satisfied in order to fulfill the Meaningful Use requirements.

The following objectives are Core Measures:

- Core 1: Using CPOE for Medication, Laboratory, and Radiology Orders
- Core 2: Generating and Transmitting e-Prescriptions
- Core 3: Recording Demographics
- Core 4: Recording Vital Signs
- Core 5: Recording Smoking Status
- Core 6: Clinical Decision Support Rule
- Core 7: Patient Electronic Access
- Core 8: Providing Clinical Summaries
- Core 9: Protect Electronic Health Information
- Core 10: Incorporating Lab Test Results as Structured Data
- Core 11: Patient Lists
- Core 12: Preventive Care
- Core 13: Patient-Specific Education Resources
- Core 14: Medication Reconciliation
- Core 15: Summary of Care
- Core 16: Submitting Electronic Data to Immunization Registries
- Core 17: Use Secure Electronic Messaging

Note: For more information on all features referenced in this guide, refer to the HelpHub, which can be accessed from within the eClinicalWorks application from the Help menu.

Core 1: Using CPOE for Medication, Laboratory, and Radiology Orders

Objective

Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Measure

More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

IMPORTANT! To restrict non-licensed healthcare professionals from entering orders on your behalf, ensure that the security setting *Treatment - Allows access to the treatment plan from Progress Notes* is unchecked for those non-licensed users. This restricts their access to the Treatment section on the Progress Notes.

Core 1-1

Denominator

Medications are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have been created with a Start status by an EP or a member of the EP's staff during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Progress Notes > Treatment > Add ■ Telephone/Web Encounter > Rx tab > Select Rx ■ Telephone/Web Encounter > Virtual Visit tab > Treatment > Add <p>Note: CPOE involves all methods of recording medications in a structured manner. This includes any use of Order Sets, Templates, e-Prescription, eCliniSense, and any other methods of manually ordering medications on the Treatment window of Progress Notes or the Rx tab/Virtual Visit Treatment section of a Telephone/Web Encounter</p>

Numerator

Medications that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have been entered by a licensed healthcare professional or credentialed medical assistant.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Admin > Staff > select staff member > check the Licensed Medical Professional or Credentialed Medical Assistant box ■ Progress Notes > Treatment > Add ■ Telephone/Web Encounter > Rx tab > Select Rx ■ Telephone/Web Encounter > Virtual Visit tab > Treatment > Add

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have ordered less than 100 medications during the reporting period.	This exclusion criteria is reported by self-attestation.

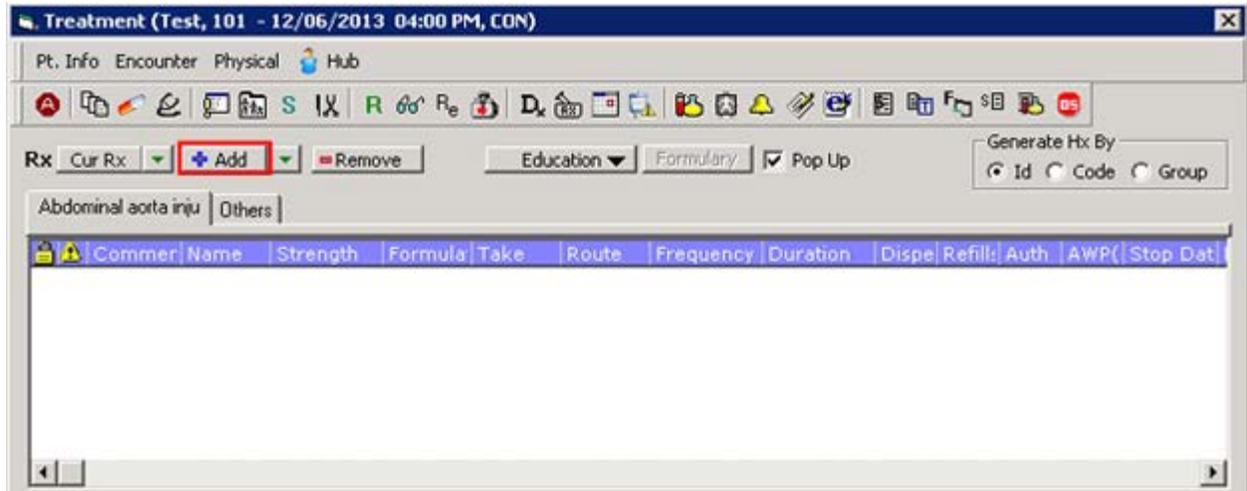
Features Related to Core 1-1

The following features are related to satisfying Core Measure 1-1:

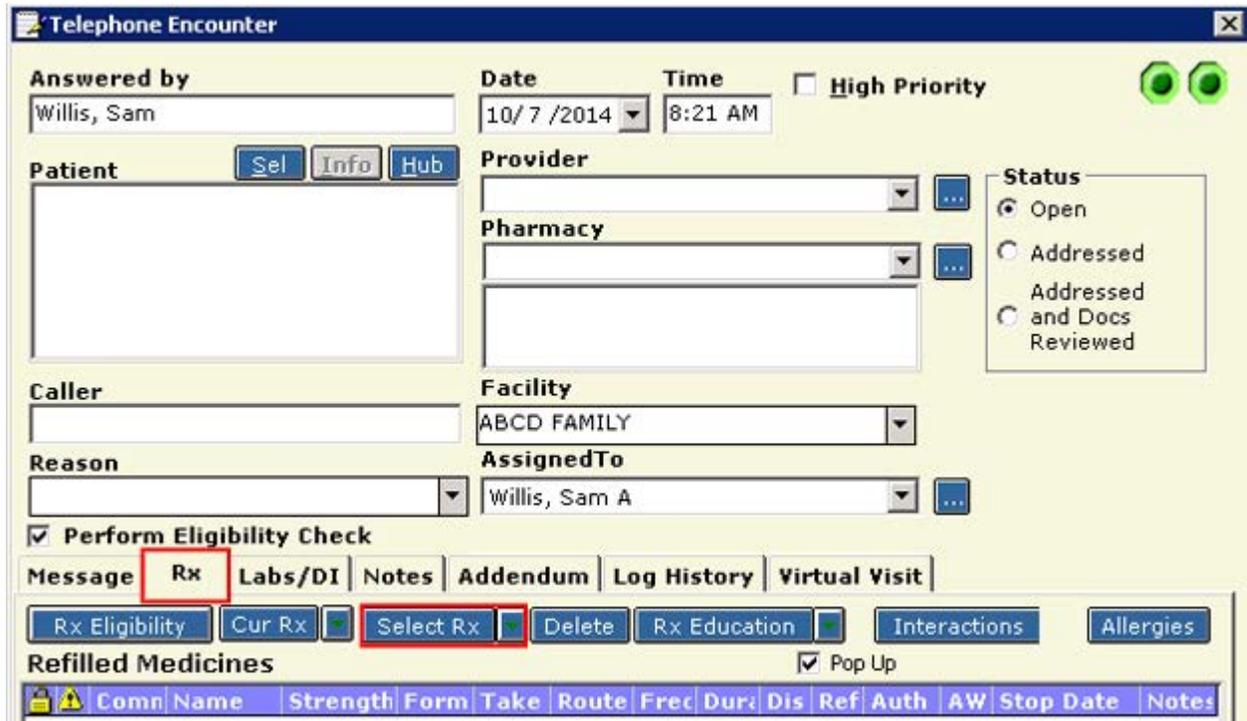
- [Recording Medications](#)
- [Setting Up Staff Members as Licensed Healthcare Professionals/Credentialed Medical Assistants](#)

Recording Medications

- Progress Notes > Treatment > Add



- Telephone/Web Encounter > Rx tab > Select Rx



- Telephone/Web Encounter > Virtual Visit tab > Treatment > Add

The screenshot displays the 'Telephone Encounter' window with the following fields and options:

- Answered by:** Willis, Sam
- Date:** 10/7/2014
- Time:** 8:21 AM
- High Priority:**
- Patient:** Smith, James (DOB: 11/11/1980, Age: 33Y, Sex: M, Tel: 508-475-0450, Acct No: AB11975, WebEnabled: No, Elgb Status:)
- Provider:** Willis, Sam A
- Pharmacy:** (Empty field)
- Status:**
 - Open
 - Addressed
 - Addressed and Docs Reviewed
- Caller:** (Empty field)
- Facility:** ABCD FAMILY
- AssignedTo:** Willis, Sam A
- Reason:** (Empty dropdown)
- Perform Eligibility Check:**
- Message Options:** Message, Rx, Labs/DI, Notes, Addendum, Log History, **Virtual Visit** (checked and highlighted with a red box), Fax
- Plan:** Treatment (highlighted with a red box), Procedures

Below the main window, a 'Treatment (Test, 101 - 12/06/2013 04:00 PM, CON)' window is visible, showing a toolbar with an 'Add' button (highlighted with a red box) and a table header for medication orders:

Commer	Name	Strength	Formula	Take	Route	Frequency	Duration	Dispe	Refill	Auth	AWP	Stop Dat
--------	------	----------	---------	------	-------	-----------	----------	-------	--------	------	-----	----------

Setting Up Staff Members as Licensed Healthcare Professionals/ Credentialed Medical Assistants

This is a one-time setup that must be performed for each staff member that will be recording medications in the system:

- Admin > Staff > select staff member > check the *Licensed Medical Professional or Credentialed Medical Assistant* box

Core 1-2

Denominator

Diagnostic Imaging orders are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
<p>They have been created by an EP or a member of the EP’s staff during the reporting period.</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> Progress Notes > Diagnostic Imaging Progress Notes > Treatment > Browse in the Diagnostic Imaging section Telephone/Web Encounter > Labs/DI tab > select Imaging from drop-down list > New Telephone/Web Encounter > Virtual Visit tab > Diagnostic Imaging Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Diagnostic Imaging section Patient Hub > DI > New

Numerator

Diagnostic Imaging orders that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have been entered by a licensed healthcare professional or credentialed medical assistant.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Admin > Staff > select staff member > check the Licensed Medical Professional or Credentialed Medical Assistant box ■ Progress Notes > Diagnostic Imaging ■ Progress Notes > Treatment > Browse in the Diagnostic Imaging section ■ Telephone/Web Encounter > Labs/DI tab > select Imaging from drop-down list > New ■ Telephone/Web Encounter > Virtual Visit tab > Diagnostic Imaging ■ Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Diagnostic Imaging section ■ Patient Hub > DI > New

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have ordered less than 100 diagnostic imaging orders during the reporting period.	This exclusion criteria is reported by self-attestation.

Features Related to Core 1-2

The following features are related to satisfying Core Measure 1-2:

- Recording Diagnostic Imaging Orders
- Setting Up Staff Members as Licensed Healthcare Professionals/Credentialed Medical Assistants

Recording Diagnostic Imaging Orders

- Progress Notes > Diagnostic Imaging

Plan:

[Treatment:](#)

[Procedures:](#)

[Immunizations:](#)

[Therapeutic Injections:](#)

[Surgical Posting:](#)

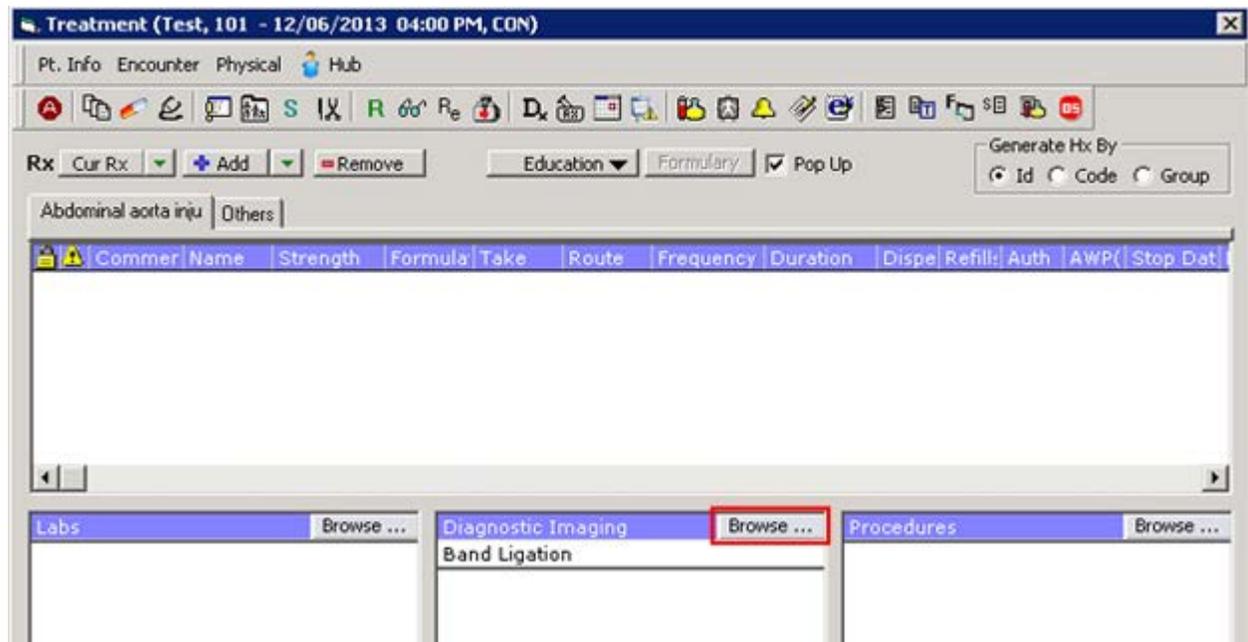
[Diagnostic Imaging:](#)

[Lab Reports:](#)

[Disposition & Communication:](#)

[Next Appointment:](#)

- Progress Notes > Treatment > Browse in the Diagnostic Imaging section



- Telephone/Web Encounter > Labs/DI tab > select Imaging from drop-down list > New

Telephone Encounter *

Answered by: Willis, Sam Date: 10/7/2014 Time: 8:21 AM High Priority

Patient: Smith, James (DOB: 11/11/1980, Age: 33Y, Sex: M, Tel: 508-475-0450, Acct No: AB11975, WebEnabled: No, Elgb Status:) **Provider:** Willis, Sam A

Pharmacy: **Status:** Open, Addressed, Addressed and Docs Reviewed

Caller: **Facility:** ABCD FAMILY

Reason: **AssignedTo:** Willis, Sam A

Perform Eligibility Check

Message | Rx | **Labs/DI** | Notes | Addendum | Log History | Virtual Visit

Imaging (selected in dropdown) New Update Delete

Date	Name	Reason	Received	Result	Reviewed
------	------	--------	----------	--------	----------

- Telephone/Web Encounter > Virtual Visit tab > Diagnostic Imaging

Telephone Encounter *

Answered by: Willis, Sam Date: 10/7/2014 Time: 8:21 AM High Priority

Patient: Smith, James (DOB: 11/11/1980, Age: 33Y, Sex: M, Tel: 508-475-0450, Acct No: AB11975, WebEnabled: No, Elgb Status:) **Provider:** Willis, Sam A

Pharmacy: **Status:** Open, Addressed, Addressed and Docs Reviewed

Caller: **Facility:** ABCD FAMILY

Reason: **AssignedTo:** Willis, Sam A

Perform Eligibility Check

Message | Rx | Labs/DI | Notes | Addendum | Log History | **Virtual Visit** (checked)

Fax

Plan:

- [Treatment:](#)
- [Procedures:](#)
- [Immunizations:](#)
- [Therapeutic Injections:](#)
- [Surgical Posting:](#)
- [Diagnostic Imaging:](#)**
- [Lab Reports:](#)
- [Preventive Medicine:](#)

- Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Diagnostic Imaging section

The screenshot shows the 'Telephone Encounter' window with the following details:

- Answered by:** Willis, Sam
- Date:** 10/7/2014
- Time:** 8:21 AM
- High Priority:**
- Patient:** Smith, James (DOB: 11/11/1980, Age: 33Y, Sex: M, Tel: 508-475-0450, Acct No: AB11975, WebEnabled: No, Elgb Status:)
- Provider:** Willis, Sam A
- Pharmacy:** (Empty)
- Status:** Open, Addressed, Addressed and Docs Reviewed
- Caller:** (Empty)
- Facility:** ABCD FAMILY
- Reason:** (Empty)
- AssignedTo:** Willis, Sam A
- Perform Eligibility Check:**
- Message:** Rx, Labs/DI, Notes, Addendum, Log History, **Virtual Visit** (checked and highlighted with a red box)
- Plan:** Treatment (highlighted with a red box), Procedures

The 'Treatment' window below shows:

- Header:** Treatment (Test, Document - 01/01/2014 02:39 PM, NP)
- Buttons:** Add, Remove, Education, Formulary, Pop Up
- Table:** A table with columns: Comme, Name, Strength, Formul, Take, Route, Frequenc, Duration, Dispi, Refill, Auth, AWP, Stop De, No.
- Bottom Navigation:** Labs, Browse ..., **Diagnostic Imaging**, Browse ... (highlighted with a red box), Procedures, Browse ...

- Patient Hub > DI > New

The screenshot shows the 'Patient Hub (Test, Test)' interface with the following details:

- Navigation Tabs:** Labs, **DI** (highlighted with a red box), Procedures, Imm/T.Inj, Referrals, Allergies, CDSS, Alerts, Notes, Overview, DRTLA, History
- Buttons:** Show CC List, Show Cancelled Orders, **New** (highlighted with a red box), Delete, Cumulative Report
- Table Headers:** HM S O, W, Order Date, Coll Date, Result Date, Labs, Reason, Result, Received, Reviewed

Setting Up Staff Members as Licensed Healthcare Professionals/ Credentialed Medical Assistants

This is a one-time setup that must be performed for each staff member that will be recording medications in the system:

- Admin > Staff > select staff member > check the *Licensed Medical Professional or Credentialed Medical Assistant* box

The screenshot shows the 'Admin' interface for setting up a staff member. The left sidebar has a 'Staff' icon highlighted with a red box. The main form has a 'Personal Info' section with fields for Last Name, First Name, Middle Initial, Prefix, Suffix, Initials, Date of Birth, Social Security No, Mailing Address, City, State, Zip Code, Home Phone, and Mobile. A checkbox labeled 'Licensed Healthcare Professional or Credentialed Medical Assistant' is highlighted with a red box. Below this is a 'Login Info' section with fields for Username, Password, Confirm Password, and Status (Active). There is also an 'eClinicalMobile Access' section with checkboxes for 'Enable eClinicalMobile Access' and 'On Call Provider'. At the bottom, there are buttons for 'Save', 'Configure My Assigned Favorites', and 'View Staff Log'.

Core 1-3

Denominator

Lab orders are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have been created by an EP or a member of the EP's staff during the reporting period.	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> Progress Notes > Lab Reports Progress Notes > Treatment > Browse in the Labs section Telephone/Web Encounter > Labs/DI tab > select Labs from drop-down list > New Telephone/Web Encounter > Virtual Visit tab > Lab Reports Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Labs section Patient Hub > Labs > New

Numerator

Lab orders that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have been entered by a licensed healthcare professional or credentialed medical assistant.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Admin > Staff > select staff member > check the Licensed Medical Professional or Credentialed Medical Assistant box ■ Progress Notes > Lab Reports ■ Progress Notes > Treatment > Browse in the Labs section ■ Telephone/Web Encounter > Labs/DI tab > select Labs from drop-down list > New ■ Telephone/Web Encounter > Virtual Visit tab > Lab Reports ■ Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Labs section ■ Patient Hub > Labs > New

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have ordered less than 100 lab orders during the reporting period.	This exclusion criteria is reported by self-attestation.

Features Related to Core 1-3

The following features are related to satisfying Core Measure 1-3:

- [Recording Labs](#)
- [Setting Up Staff Members as Licensed Healthcare Professionals/Credentialed Medical Assistants](#)

Recording Labs

- Progress Notes > Lab Reports

Plan:

[Treatment:](#)

[Procedures:](#)

[Immunizations:](#)

[Therapeutic Injections:](#)

[Surgical Posting:](#)

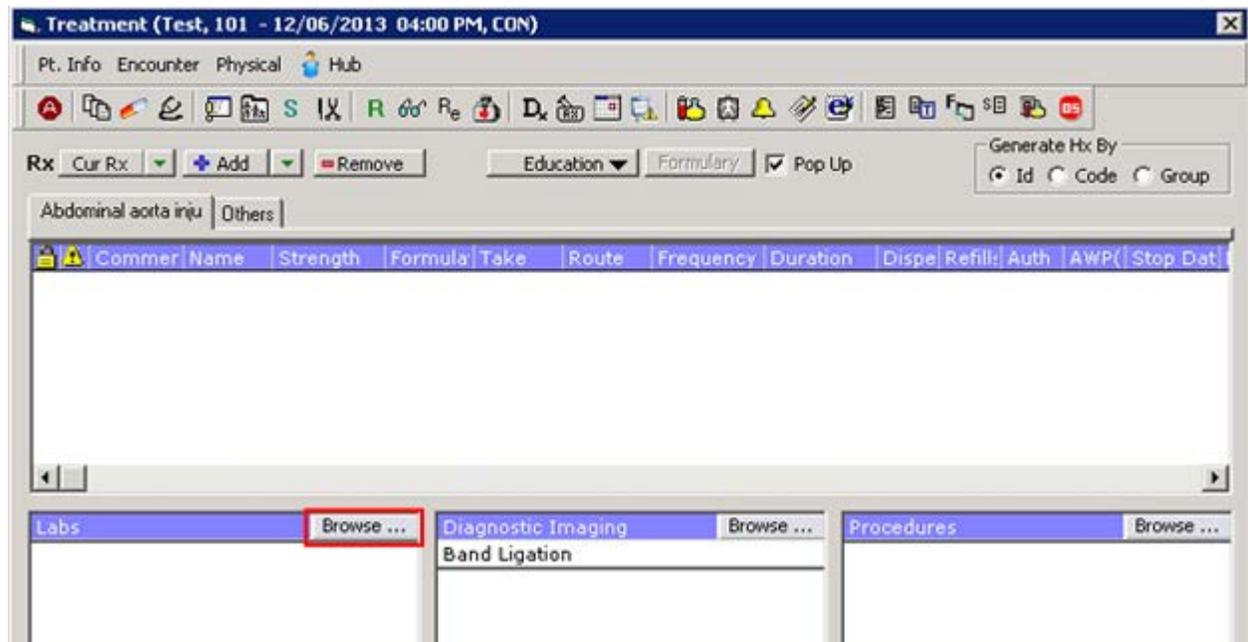
[Diagnostic Imaging:](#)

[Lab Reports:](#)

[Disposition & Communication:](#)

[Next Appointment:](#)

- Progress Notes > Treatment > Browse in the Labs section



- Telephone/Web Encounter > Labs/DI tab > select Labs from drop-down list > New

Telephone Encounter

Answered by: Willis, Sam Date: 10/7/2014 Time: 8:21 AM High Priority

Patient: Smith, James (DOB: 11/11/1980, Age: 33Y, Sex: M) Provider: Willis, Sam A

Caller: Facility: ABCD FAMILY

Reason: AssignedTo: Willis, Sam A

Perform Eligibility Check

Message | Rx | **Labs/DI** | Notes | Addendum | Log History | Virtual Visit

Labs [New] [Update] [Delete]

Date	Name	Reason	Received	Result	Reviewed
11/14/2013	17-Hydroxycortico:				
11/14/2013	1-Methyl-histidine,				

- Telephone/Web Encounter > Virtual Visit tab > Lab Reports

Telephone Encounter

Answered by: Willis, Sam Date: 10/7/2014 Time: 8:21 AM High Priority

Patient: Smith, James (DOB: 11/11/1980, Age: 33Y, Sex: M) Provider: Willis, Sam A

Caller: Facility: ABCD FAMILY

Reason: AssignedTo: Willis, Sam A

Perform Eligibility Check

Message | Rx | Labs/DI | Notes | Addendum | Log History | **Virtual Visit**

[Fax]

Plan:

- [Treatment:](#)
- [Procedures:](#)
- [Immunizations:](#)
- [Therapeutic Injections:](#)
- [Surgical Posting:](#)
- [Diagnostic Imaging:](#)
- [Lab Reports:](#)**
- [Preventive Medicine:](#)

- Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Labs section

Telephone Encounter *

Answered by: Willis, Sam Date: 10/7/2014 Time: 8:21 AM High Priority

Patient: Smith, James (DOB: 11/11/1980, Age: 33Y, Sex: M, Tel: 508-475-0450, Acct No: AB11975, WebEnabled: No, Elgb Status:) **Provider:** Willis, Sam A

Pharmacy: **Status:** Open, Addressed, Addressed and Docs Reviewed

Caller: **Facility:** ABCD FAMILY

Reason: **AssignedTo:** Willis, Sam A

Perform Eligibility Check

Message | Rx | Labs/DI | Notes | Addendum | Log History | **Virtual Visit**

Plan: **Treatment** Procedures

- Patient Hub > Labs > New

Patient Hub (Test, Test)

Labs | DI | Procedures | Imm/T.Inj | Referrals | Allergies | CDSS | Alerts | Notes | Overview | DRTL | History

Test: Test Sal Info Name: 500-614-5040

Category: All

Show CC List Show Cancelled Orders **New** | Delete | Cumulative Report

HM S O W Order Date Coll Date Result Date Labs Reason Result Received Reviewed

Setting Up Staff Members as Licensed Healthcare Professionals/ Credentialed Medical Assistants

This is a one-time setup that must be performed for each staff member that will be recording medications in the system:

- Admin > Staff > select staff member > check the *Licensed Medical Professional or Credentialed Medical Assistant* box

The screenshot shows a web-based form for setting up a staff member. The left sidebar has a 'Staff' icon highlighted with a red box. The main form area has several sections:

- Personal Info:** Fields for Last Name, First Name, Middle Initial, Prefix, Suffix, Initials, Date of Birth, Social Security No., Mailing Address, City, State, Zip Code, Home Phone, and Mobile. A checkbox for 'Licensed Healthcare Professional or Credentialed Medical Assistant' is checked and highlighted with a red box.
- Is a resource:** A checkbox that is currently unchecked.
- Login Info:** Fields for Username, Password, Confirm Password, and Status (set to Active).
- eClinicalMobile Access:** Checkboxes for 'Enable eClinicalMobile Access' and 'On Call Provider'.
- Copy Options set in 'My Settings' from Staff:** A dropdown menu labeled 'Select Staff'.

Buttons at the bottom include 'Save', 'Configure My Assigned Favorites', and 'View Staff Log'.

Core 2: Generating and Transmitting e-Prescriptions



Enhanced Feature

Objective

Generate and transmit permissible prescriptions electronically (eRx).

Measure

More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

Note: Based on additional clarification from CMS, Rx eligibility must be verified prior to e-prescribing (including responding to refill requests) to get credit for this measure.

This change is effective for the May 1, 2015 reporting period; past data will not be affected.

Per this clarification, eligibility checks performed on past prescriptions cannot be reused since the formulary could have changed. A new eligibility check must be performed each time (or within three days before the prescription date) to retrieve the latest formulary information prior to e-prescribing or responding to refill requests.

Failure to follow the recommended workflow to perform eligibility checks for each prescription and refill request will result in a drop in numerator numbers for this measure.

If provider performance rates have dropped for this measure, it could be the result of one of the following reasons:

- Recommended workflow to perform eligibility checks prior to each e-prescription or response to refill requests is not being followed.
- Eligibility checks have not been performed for prescriptions and refill requests in the reporting period.

Denominator

Prescriptions are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have been printed, faxed, or transmitted electronically	Record this information from the following locations: <ul style="list-style-type: none"> ■ Progress Notes > Treatment ■ Telephone/Web Encounter > Rx Tab ■ Telephone/Web Encounter > Virtual Visit tab > Treatment
	<p>IMPORTANT! The following medications are excluded from being included in the denominator:</p> <ul style="list-style-type: none"> ■ Duplicate medications (re-printed, re-faxed, re-transmitted, or printed and also transmitted) ■ Non-permissible (controlled) medications

Numerator

Prescriptions that satisfy the denominator are included in the numerator if they satisfy all of the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
<p>They have been queried for a drug formulary from the Rx Eligibility window.</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Progress Notes > Treatment > green arrow next to Send Rx > ePrescribe Rx > Rx Eligibility ■ Appointment window > Rx Eligibility > Check Rx Eligibility ■ Progress Notes > Treatment > Add > Rx Eligibility > Check Rx Eligibility: ■ Telephone/Web Encounter > Rx tab > Rx Eligibility > Check Rx Eligibility ■ Telephone/Web Encounter > Telephone/Web Encounter > Rx tab > green arrow next to Send Rx > ePrescribe Rx > Rx Eligibility ■ eRefill > Rx Eligibility > Check Rx Eligibility <p>IMPORTANT! Rx eligibility must be verified for all patients, including self-pay patients, every time a prescription is sent. Whenever an Rx Eligibility check is performed in eClinicalWorks, the check lasts for three (3) days. Prescriptions and refill requests created within the three days after an eligibility check has been performed are considered verified. Any prescription or refill request created after these three days requires that a new eligibility check be performed in order to satisfy this measure.</p> <p>Note: A Scheduled Job can also be run every night (for scheduled appointments only). You must verify Rx Eligibility manually before e-Prescribing for walk-in appointments, Telephone/Web Encounter orders, and eRefill requests</p>
<p>They have been transmitted using e-Prescription from the ePrescribe Rx window</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ E quick-launch link > Refill Rx or Error/Failed Rx ■ Progress Notes > Treatment > green arrow next to Send Rx > ePrescribe Rx ■ Telephone/Web Encounter > Rx tab > green arrow next to Send Rx > ePrescribe Rx ■ Telephone/Web Encounter > Virtual Visit > Treatment> green arrow next to Send Rx > ePrescribe Rx ■ Progress Notes > Send

Exclusions

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They write fewer than 100 permissible prescriptions during the EHR reporting period.	This exclusion criteria is reported by self-attestation.
They do not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.	This exclusion criteria is reported by self-attestation.

Features Related to Core 2

The following features are related to satisfying Core Measure 2:

- [Transmitting Prescriptions](#)
- [Checking Rx Eligibility](#)
- [e-Prescribing Medications](#)

Transmitting Prescriptions

- Progress Notes > Treatment

Treatment (Test, Test - 03/19/2014 01:00 PM, ANN VISIT)

Pt. Info Encounter Physical Hub

Rx Cur.Rx Add Remove Education Formulary Pop Up Generate Hx By Id Code Group

Diabetes mellitus wi Diabetes with ketoac Others

Comme	Name	Strength	Formul.	Take	Route	Frequenc	Duration	Dispi	Refill	Auth	AWP	Stop Da	No
Start	Spryce	100 MG	Tablet	1 tablet	Orally	Once a d	30 day(s)	30			1029		
Start	Synthroid	88 MCG	Tablet	1 tablet	Orally	Once a d	30 day(s)	30			20.7		

Labs Browse ... Diagnostic Imaging Browse ... Procedures Browse ...

Notes Clinical Notes Browse ... Spell chk Clr Outgoing Referral eCliniSense Add Info New Action

Preventive Med Print Orders Send Rx Allergies Interactions CDSS

Fax Rx
Print Rx
ePrescribe Rx

- Telephone/Web Encounter > Rx Tab

Perform Eligibility Check

Message **Rx** Labs/DI Notes Addendum Log History Virtual Visit

Rx Eligibility Cur Rx Select Rx Delete Rx Education Interactions Allergies

Refilled Medicines Pop Up

Comn	Name	Strength	Form	Take	Route	Frec	Dur	Dis	Ref	Auth	AW	Stop Date	Notes
Start	Lisinopri	40 MG	Tablet	1 tab	Orally	Onci	30 d	30			.80		

Print Script **Send Rx** Print Report Progress Notes Document

Fax Script ePrescription Rx OK Cancel

- Telephone/Web Encounter > Virtual Visit tab > Treatment

History **Virtual Visit**

Diagnostic Imaging Browse ... Procedures Browse ...

Once a day, 30 day(s), 30

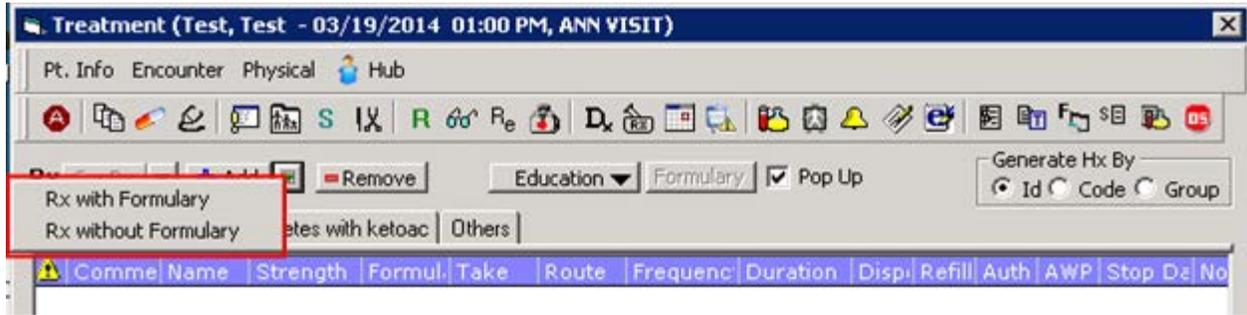
Spell chk Clr Outgoing Referral eCliniSense Add Info New Action

Send Rx Allergies Interactions CDSS Document

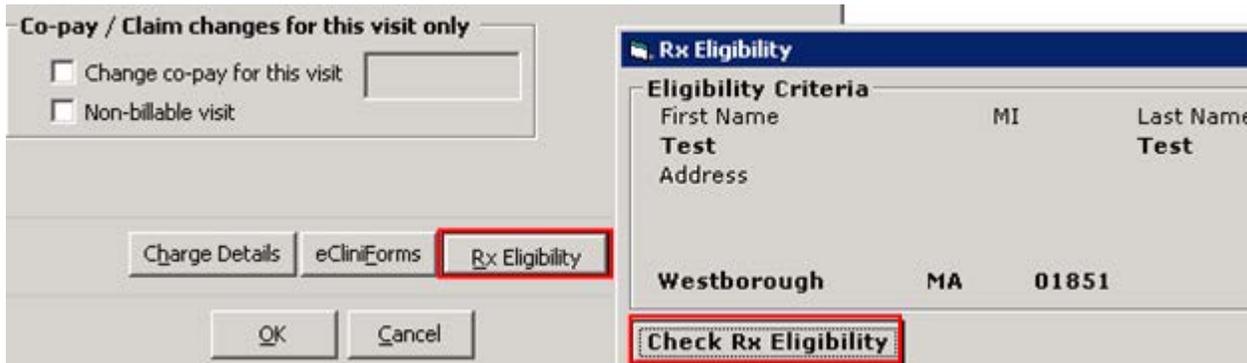
Fax Rx Print Rx ePrescribe Rx OK Cancel

Checking Rx Eligibility

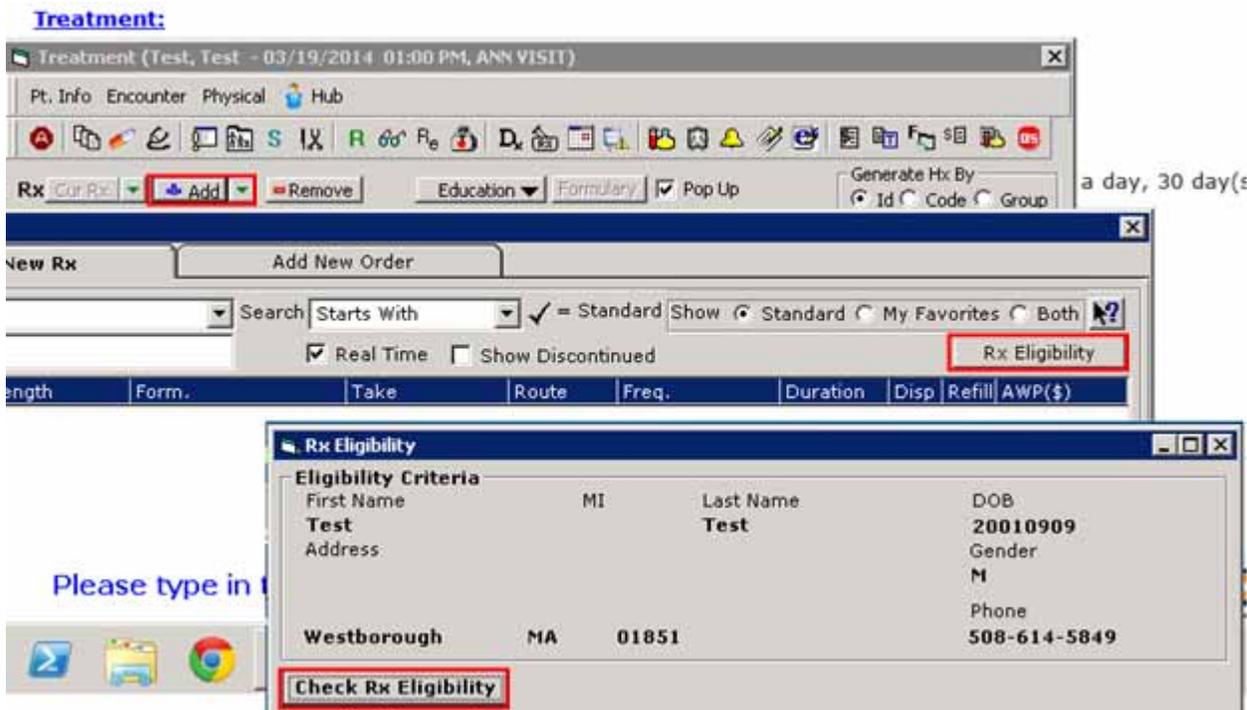
- Progress Notes > Treatment > green arrow next to Send Rx > ePrescribe Rx > Rx Eligibility



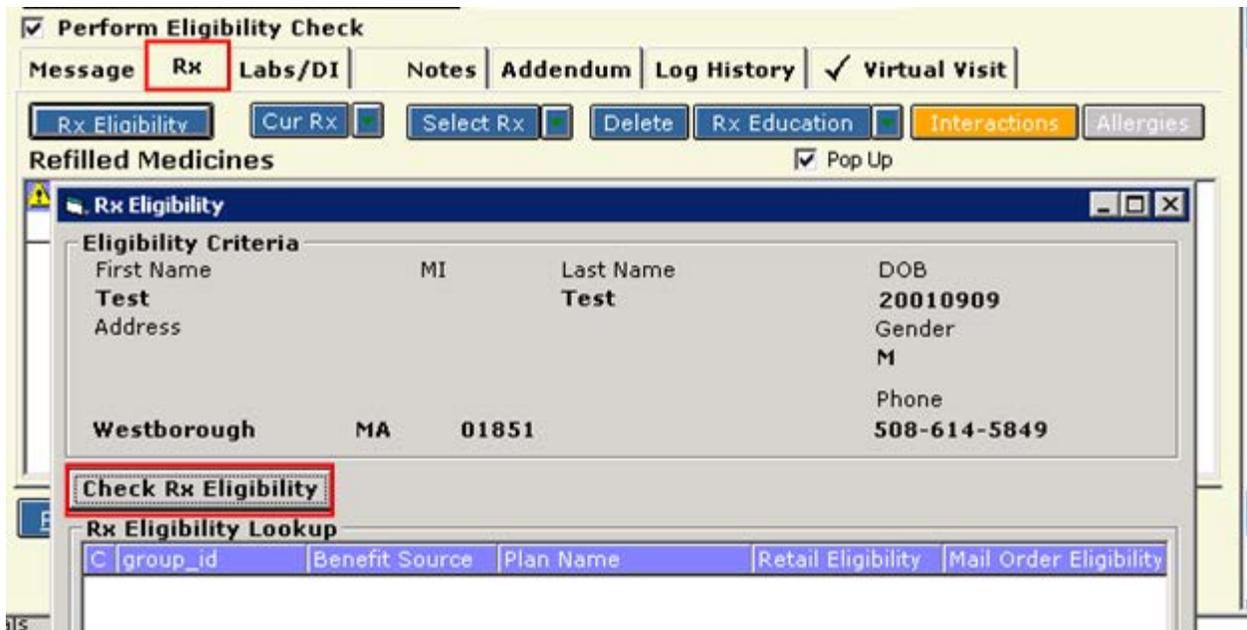
- Appointment window > Rx Eligibility > Check Rx Eligibility



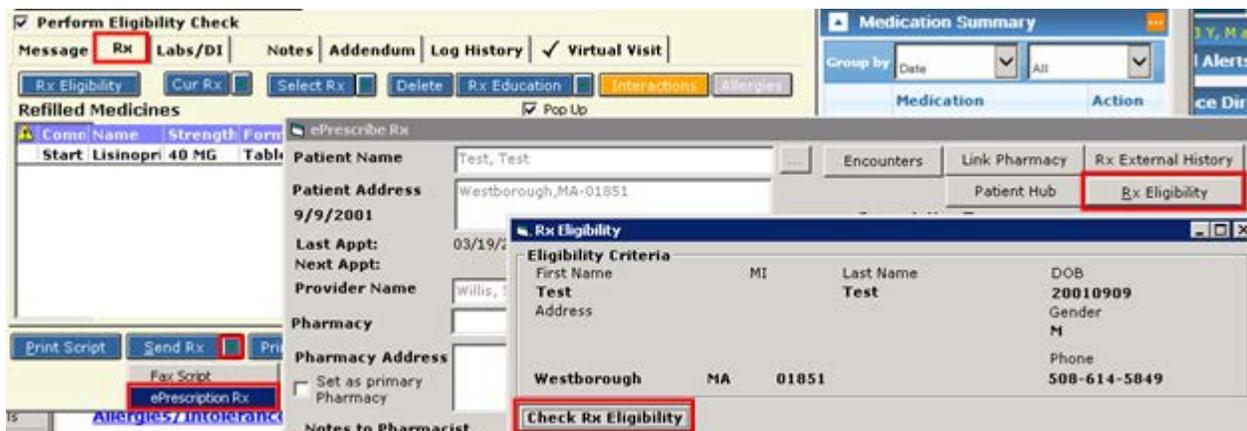
- Progress Notes > Treatment > Add > Rx Eligibility > Check Rx Eligibility:



- Telephone/Web Encounter > Rx tab > Rx Eligibility > Check Rx Eligibility



- Telephone/Web Encounter > Telephone/Web Encounter > Rx tab > green arrow next to Send Rx > ePrescribe Rx > Rx Eligibility

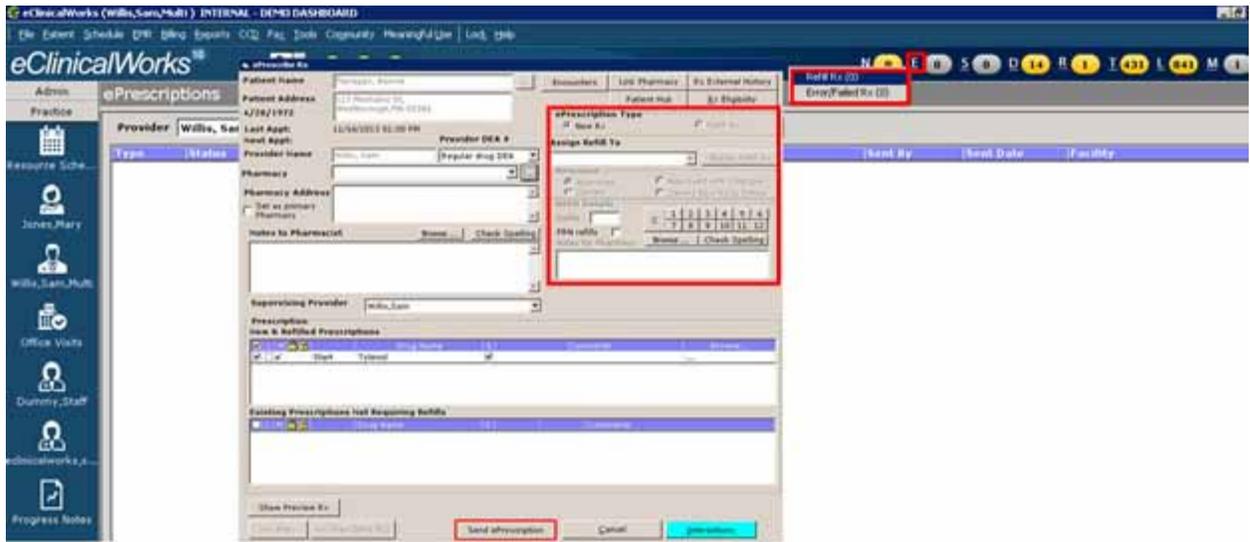


- eRefill > Rx Eligibility > Check Rx Eligibility

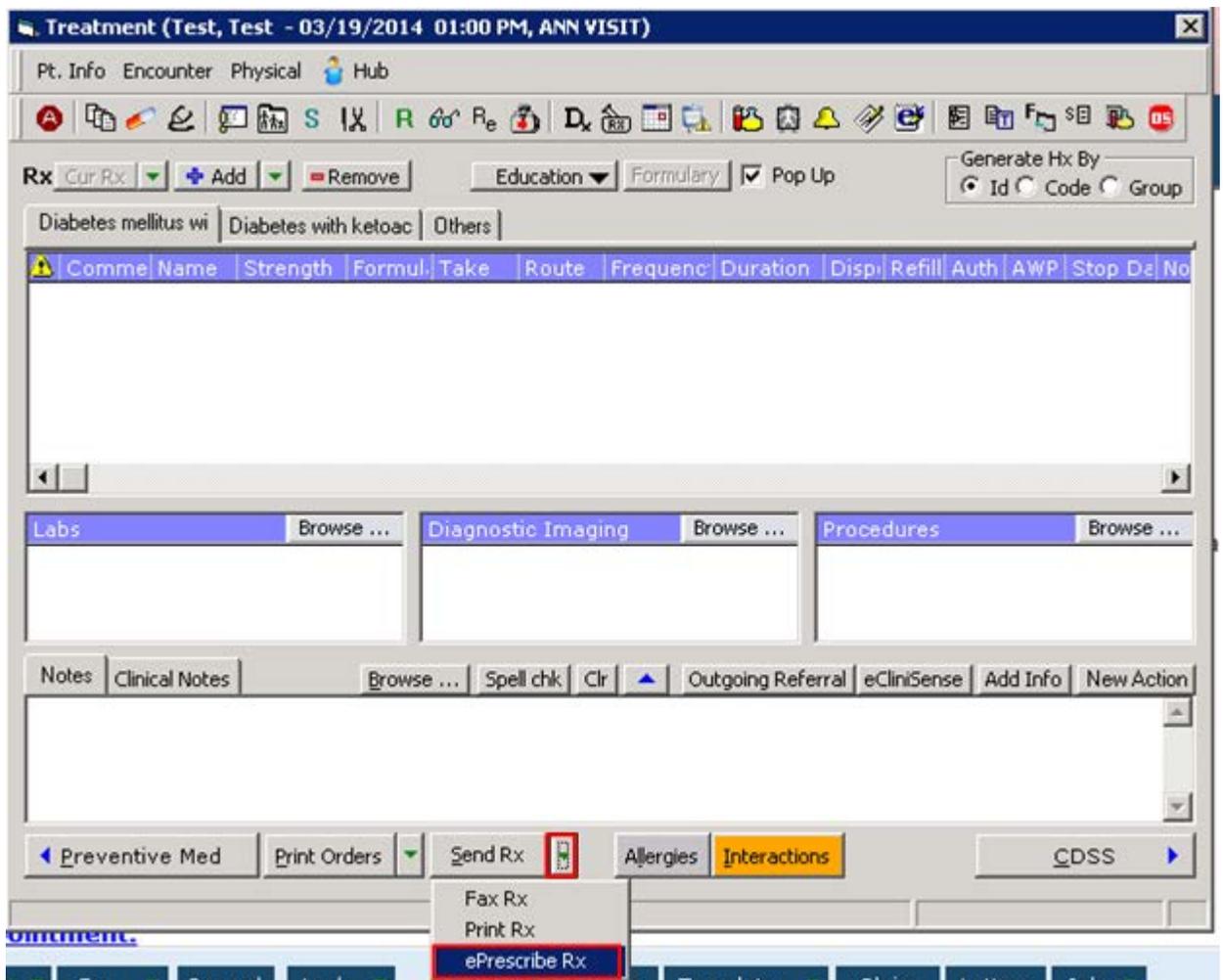


e-Prescribing Medications

- E quick-launch link > *Refill Rx* or *Error/Failed Rx*



- Progress Notes > Treatment > green arrow next to Send Rx > ePrescribe Rx



- Telephone/Web Encounter > Rx tab > green arrow next to Send Rx > ePrescribe Rx

Telephone Encounter

Answered by: Dummy, Staff Date: 4 / 4 /2014 Time: 11:47 AM High Priority

Patient: Test, Test **Provider:** Willis, Sam,Multi
 DOB: 9/9/2001 Age: 13Y Sex: M
 Tel: 508-614-5849
 Acct No: 9114, WebEnabled: Yes
 Elqb Status:

Pharmacy: **Status:** Open
 Addressed
 Addressed and Docs Reviewed

Caller: **Facility:** Internal - DEMO DASHBOARD (PM)

Reason: **AssignedTo:** Dummy, Staff

Perform Eligibility Check

Message **Rx** Labs/DI Notes Addendum Log History Virtual Visit

Rx Eligibility Cur Rx Select Rx Delete Rx Education Interactions Allergies

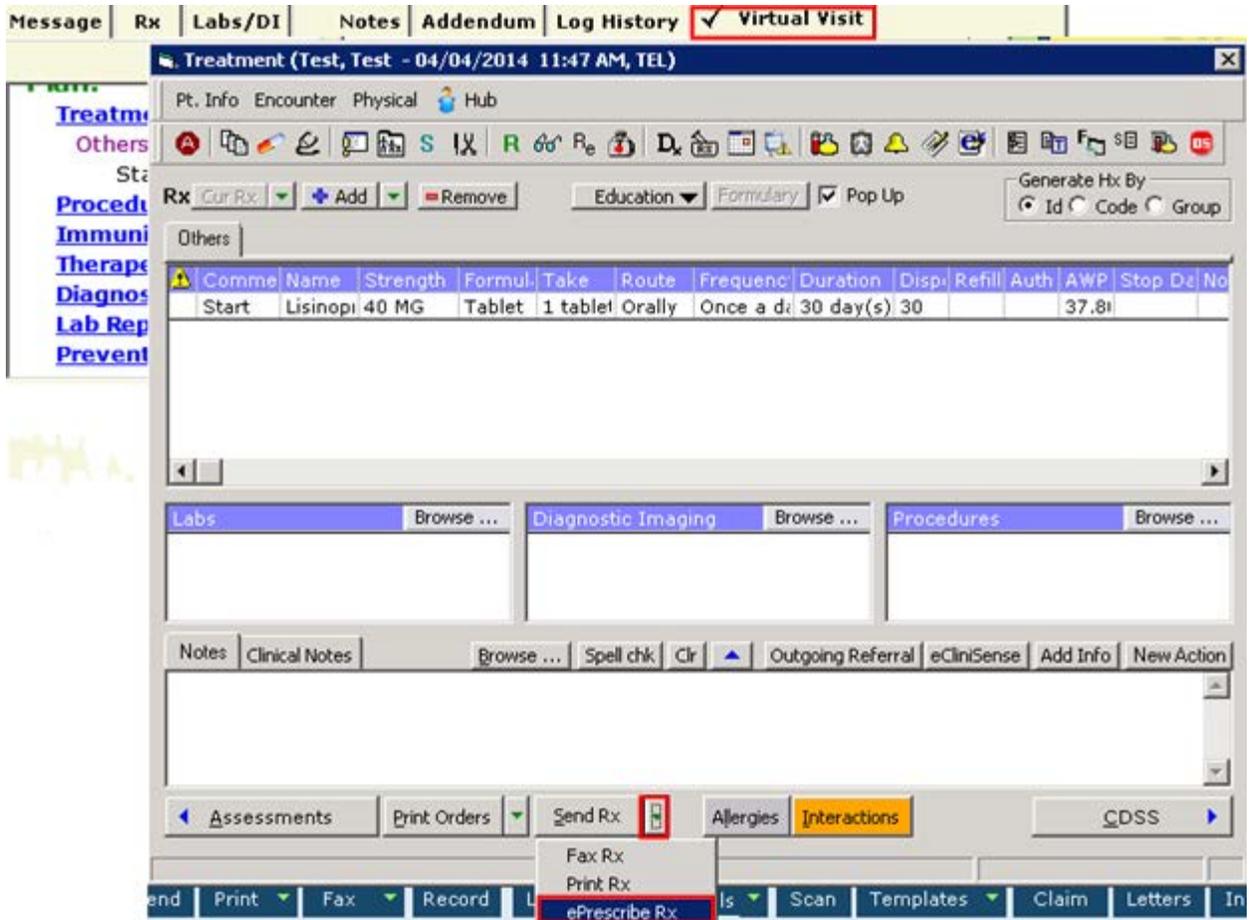
Refilled Medicines Pop Up

⚠	Comn	Name	Strength	Form	Take	Route	Freq	Dur	Dis	Ref	Auth	AW	Stop Date	Notes
	Start	Lisinopri	40 MG	Tablet	1 tab	Orally	Onci	30 d	30			.80		

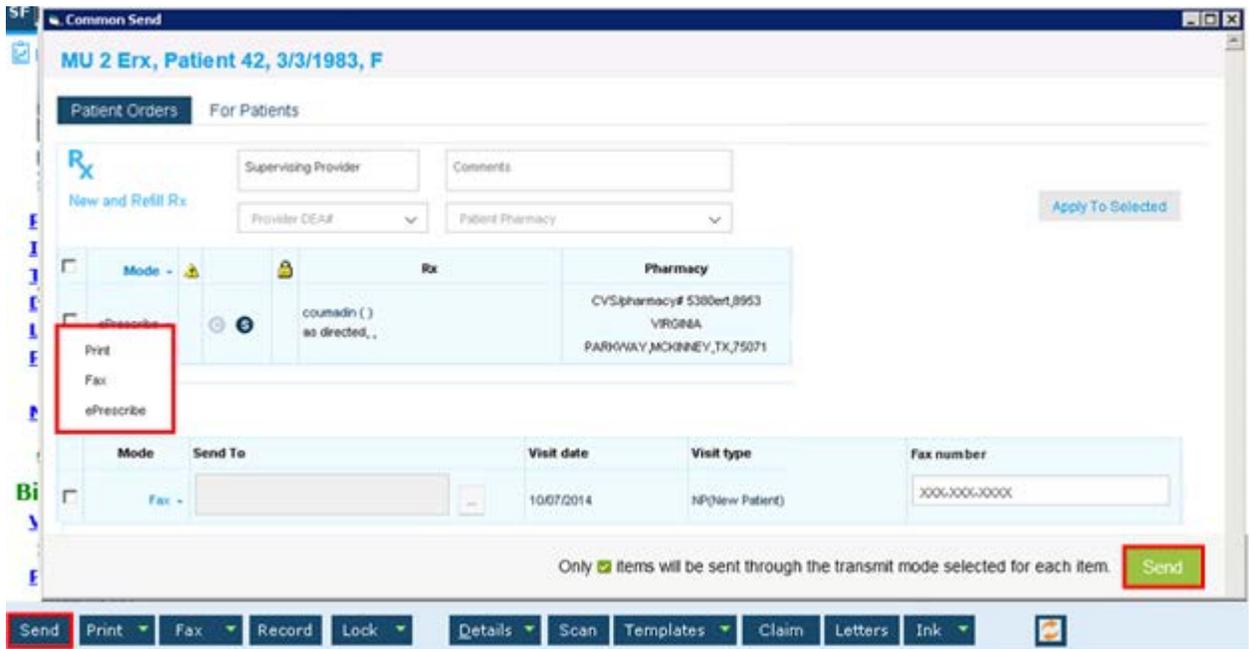
Print Script **Send Rx** Print Report Progress Notes Document

Fax Script ePrescription Rx OK Cancel

- Telephone/Web Encounter > Virtual Visit > Treatment> green arrow next to Send Rx > ePrescribe Rx



- Progress Notes > Send



Core 3: Recording Demographics

Objective

Record the following demographics: preferred language, sex, race, ethnicity, and date of birth.

Measure

More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if all of the following information is recorded for them:

Numerator Criteria	Area to Document within eClinicalWorks
They have had their date of birth, gender (sex), language, race, and ethnicity entered in patient demographics.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Community > Mappings > Language ■ Patient Information > Date of Birth and Sex ■ Patient Information > Additional Info > Race, Ethnicity, and Language <p>Note: Preferred languages must be recorded in accordance with ISO 639-2 alpha-3 codes standards.</p>

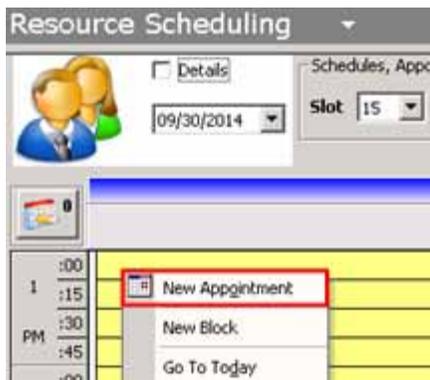
Features Related to Core 3

The following features are related to satisfying Core Measure 3:

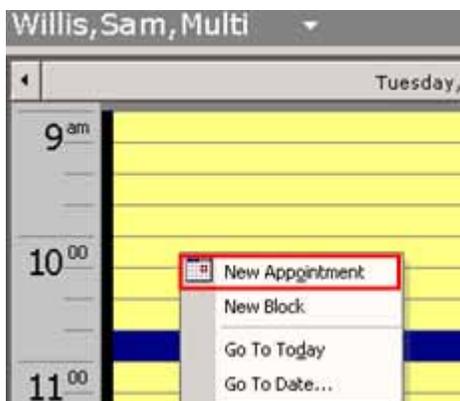
- Recording Appointments
- Recording E&M Codes
- Mapping Community Languages
- Recording Demographic Information

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

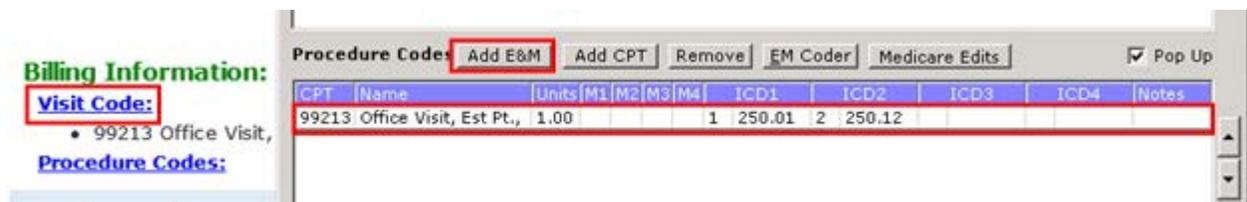


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



Recording E&M Codes

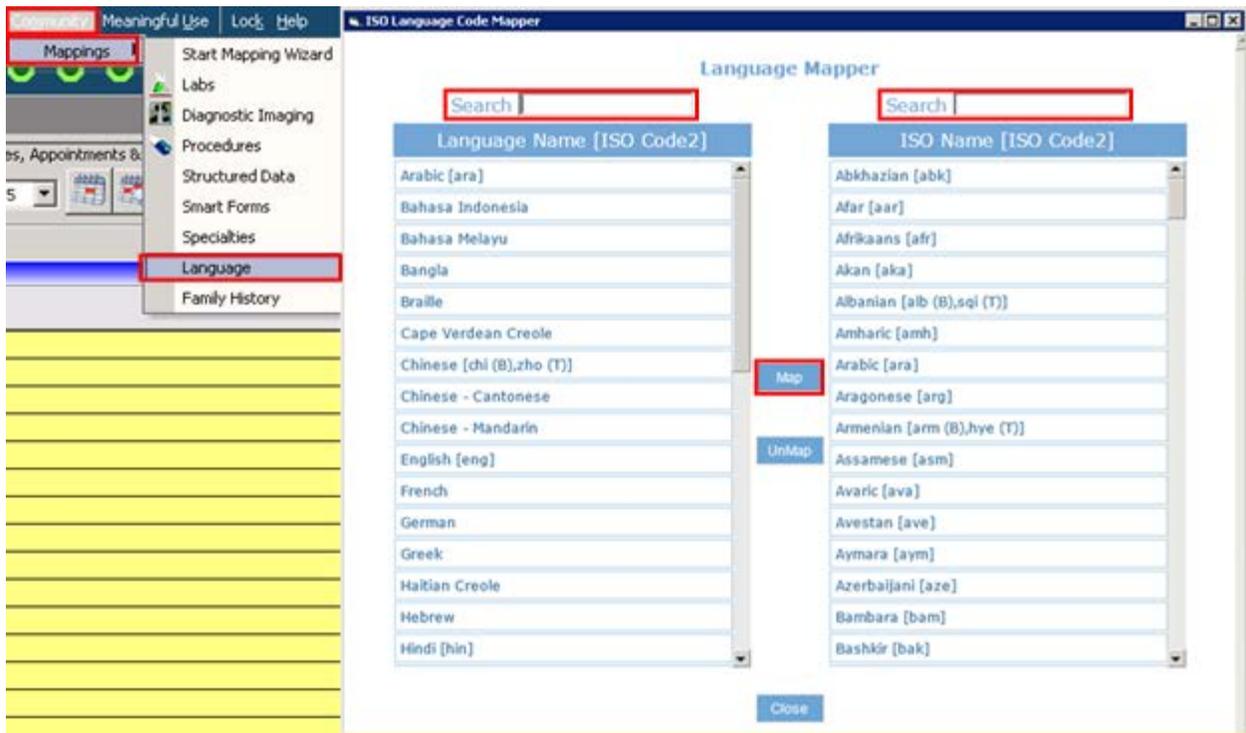
- Progress Notes > Visit Code > Add E&M



Mapping Community Languages

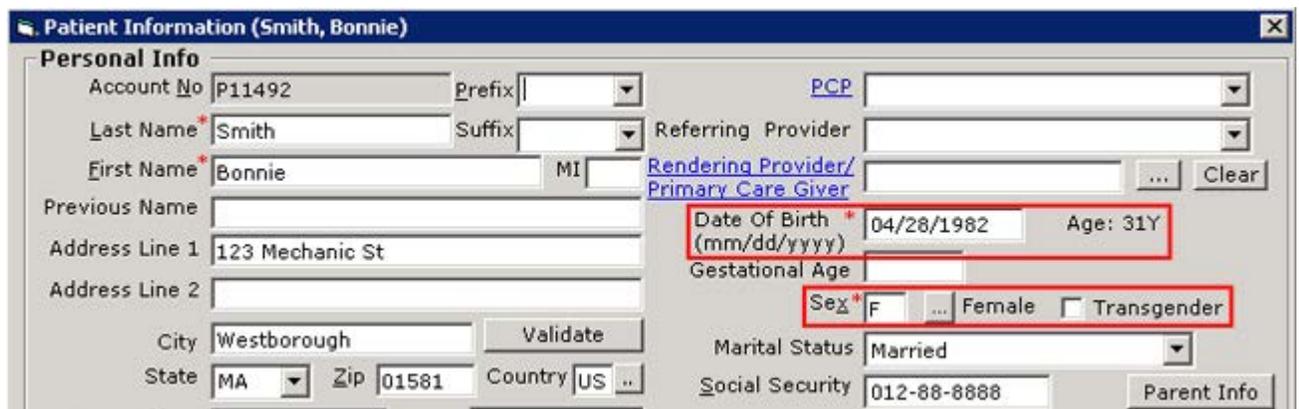
This is a one-time setup that must be performed for each language used:

- Community > Mappings > Language



Recording Demographic Information

- Patient Information > Date of Birth and Sex



- Patient Information > Additional Info > Race, Ethnicity, and Language

The screenshot shows a software window titled "Patient Information(Smith, Bonnie)". The window has several tabs: "General Information", "Student Information", and "Structured". The "General Information" tab is active. At the top, there are checkboxes for "Don't Send Statements", "Inactive", and "Don't add finance charge". Below this, there are buttons for "Import", "Capture", "Delete", and "Scan".

The form is divided into several sections:

- Street Address(if different from mailing):** Includes fields for Address Line 1, Address Line 2, City, State (dropdown), Zip, and Email (bmf@abc.com). There are also checkboxes for "Not Provided", "Home", and "Cell".
- Race and Ethnicity:** The "Race" dropdown is highlighted with a red box. Below it, the "Ethnicity" dropdown is set to "Not Hispanic" and "Birth Order" is set to "0".
- Employer Address:** Includes fields for Address Line 1, Address Line 2, City, State (dropdown), and Zip. The "Language" dropdown is set to "English" and is highlighted with a red box.
- Other Fields:** Includes "VFC Eligibility", "Consent to report Immunizations", "Mail Order Member ID", "Plan Type", "Deceased" checkbox, "Default Facility", "MRN(External System)", "Default Lab Company", and "Default DI Company".

At the bottom, there is a "Registered On" timestamp: "03/06/2013 (11:13:08)".

Core 4: Recording Vital Signs

Objective

Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.

Measure

More than 80 percent of all unique patients seen by the EP have blood pressure (for patients aged three years and over only) and/or height and weight (for all ages) recorded as structured data.

Core 4-1

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have had their height, weight, and blood pressure recorded (blood pressure is only applicable to patients three years of age and older)	Record this information from the following locations: <ul style="list-style-type: none"> ■ EMR > Vitals > Configure Vitals ■ Progress Notes > Vitals
	Note: The required vitals do not all have to be recorded in the same encounter, nor do they have to be recorded during the reporting period. They can be recorded over multiple encounters at any time, as long as all three are recorded during office visits.
	IMPORTANT! These Vitals categories must be associated with the corresponding Vital Types (from EMR > Vitals > Configure Vitals) for patients to be counted in the numerator.

Exclusions

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They believe all three vital signs (height, weight, and blood pressure) are not relevant to the scope of their practice	This exclusion criteria is reported by self-attestation.

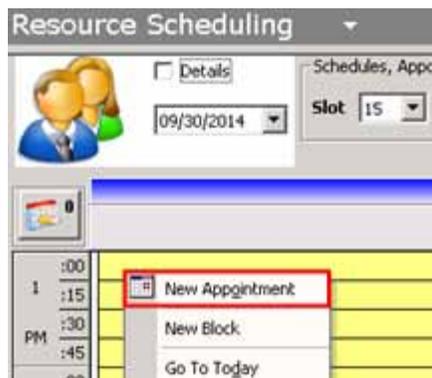
Features Related to Core 4-1

The following features are related to Core Measure 4-1:

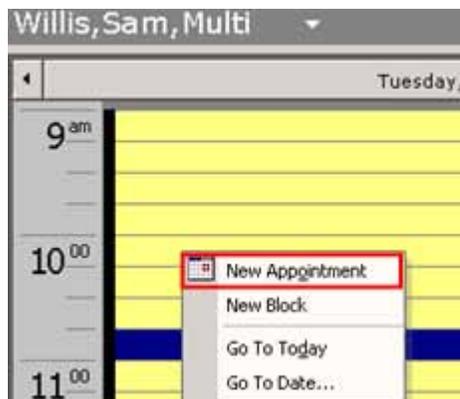
- Recording Appointments
- Recording E&M Codes
- Configuring Vitals
- Recording Height, Weight, and Blood Pressure

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

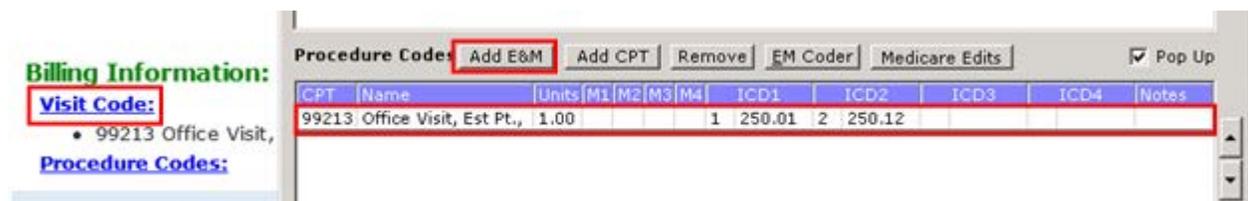


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



Recording E&M Codes

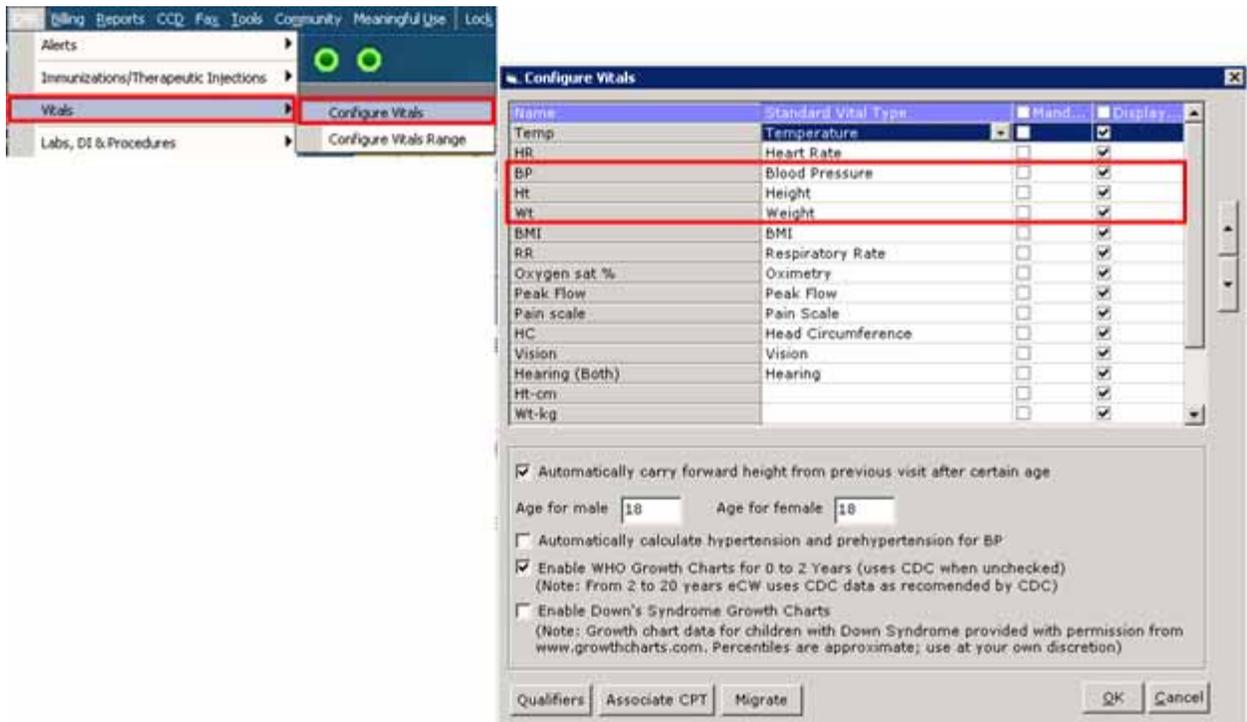
- Progress Notes > Visit Code > Add E&M



Configuring Vitals

Each vital must be linked to the appropriate standard vital type once to satisfy this measure:

- EMR > Vitals > Configure Vitals



Recording Height, Weight, and Blood Pressure

- Progress Notes > Vitals



Core 4-2

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have had their height and weight recorded	Record this information from the following locations: <ul style="list-style-type: none"> ■ EMR > Vitals > Configure Vitals ■ Progress Notes > Vitals
	Note: The required vitals do not all have to be recorded in the same encounter, nor do they have to be recorded during the reporting period. They can be recorded over multiple encounters at any time, as long as all three are recorded during office visits.
	IMPORTANT! These Vitals categories must be associated with the corresponding Vital Types (from EMR > Vitals > Configure Vitals) for patients to be counted in the numerator.

Exclusions

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They believe that blood pressure is relevant to their scope of practice, but height/length and weight are not, they are excluded from recording height/length and weight	This exclusion criteria is reported by self-attestation.
They believe all three vital signs (height, weight, and blood pressure) are not relevant to the scope of their practice, they are excluded from this measure entirely	This exclusion criteria is reported by self-attestation.

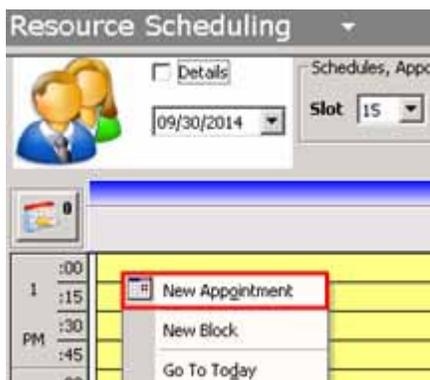
Features Related to Core 4-2

The following features are related to Core Measure 4-2:

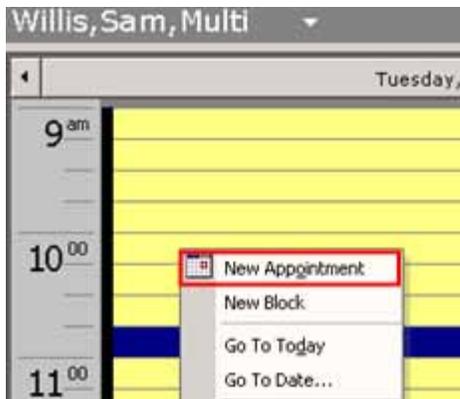
- Recording Appointments
- Recording E&M Codes
- Configuring Vitals
- Recording Height and Weight

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

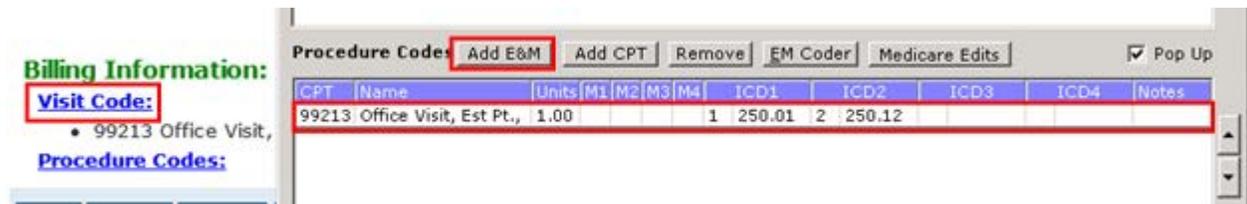


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



Recording E&M Codes

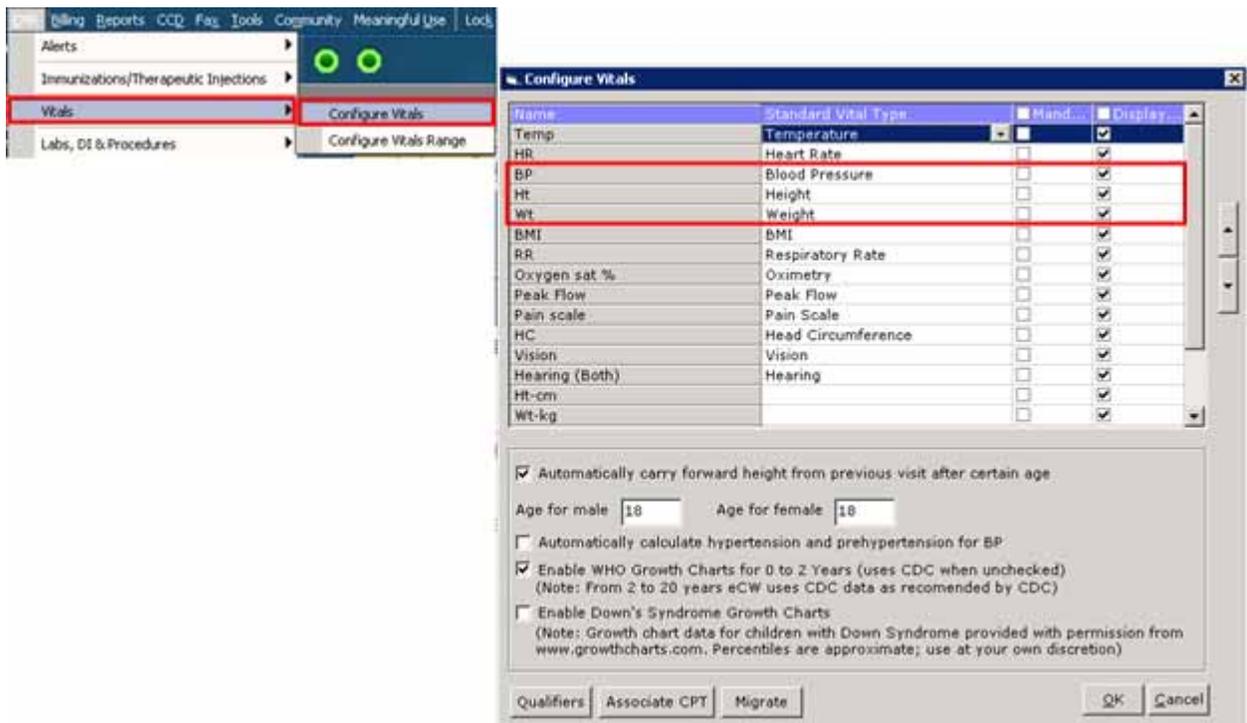
- Progress Notes > Visit Code > Add E&M



Configuring Vitals

Each vital must be linked to the appropriate standard vital type once to satisfy this measure:

- EMR > Vitals > Configure Vitals



Recording Height and Weight

- Progress Notes > Vitals

Date	BP	Ht(inches)	Wt(lbs)	BMI(Index)	Vision	Wt(%)	BMI(%)	Ht(%)
11/14/2013 *	120/80	70	150	21.52				

Core 4-3

Denominator

Patients are included in the denominator if they satisfy ALL of the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They are three years of age or older during the reporting period	Patient Information
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have had their blood pressure recorded	Record this information from the following locations: <ul style="list-style-type: none"> EMR > Vitals > Configure Vitals Progress Notes > Vitals
	Note: This vital does not have to be recorded during the reporting period.
	IMPORTANT! These Vitals categories must be associated with the corresponding Vital Types (from EMR > Vitals > Configure Vitals) for patients to be counted in the numerator.

Exclusions

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They see no patients three (3) years of age or older, they are excluded from recording blood pressure	This exclusion criteria is reported by self-attestation.
They believe that height/length and weight are relevant to the scope of their practice, but blood pressure is not, they are excluded from recording blood pressure	This exclusion criteria is reported by self-attestation.
They believe all three vital signs (height, weight, and blood pressure) are not relevant to the scope of their practice, they are excluded from this measure entirely	This exclusion criteria is reported by self-attestation.

Features Related to Core 4-3

The following features are related to Core Measure 4-3:

- Recording Date of Birth
- Recording Appointments
- Recording E&M Codes
- Configuring Vitals
- Recording Blood Pressure

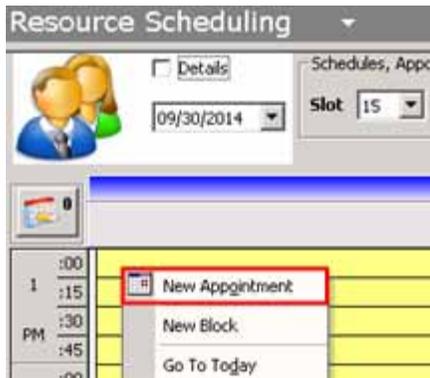
Recording Date of Birth

- Patient Information

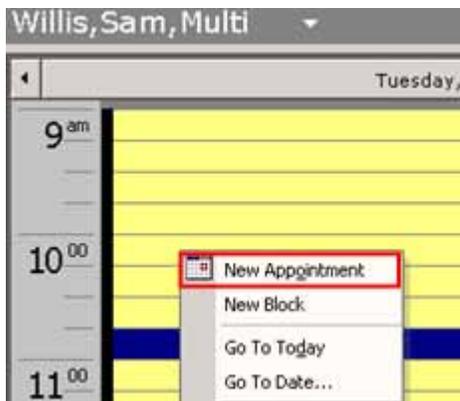
The screenshot shows a 'Patient Information (Smith, Bonnie)' window. Under the 'Personal Info' section, the 'Date of Birth' field is highlighted with a red box. The date entered is '04/28/1982' and the calculated age is '31Y'. Other visible fields include Account No (P11492), Last Name (Smith), First Name (Bonnie), Address Line 1 (123 Mechanic St), and Sex (F).

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

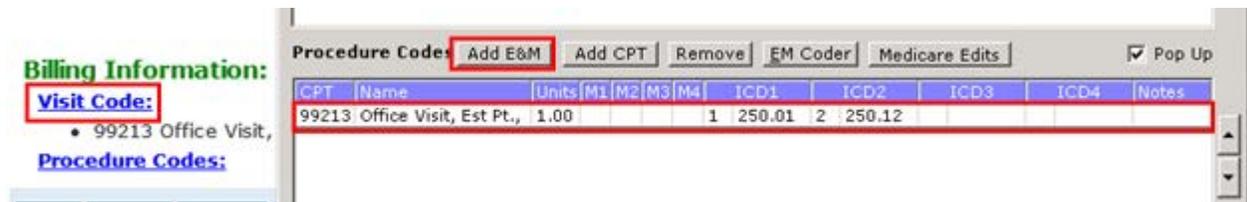


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



Recording E&M Codes

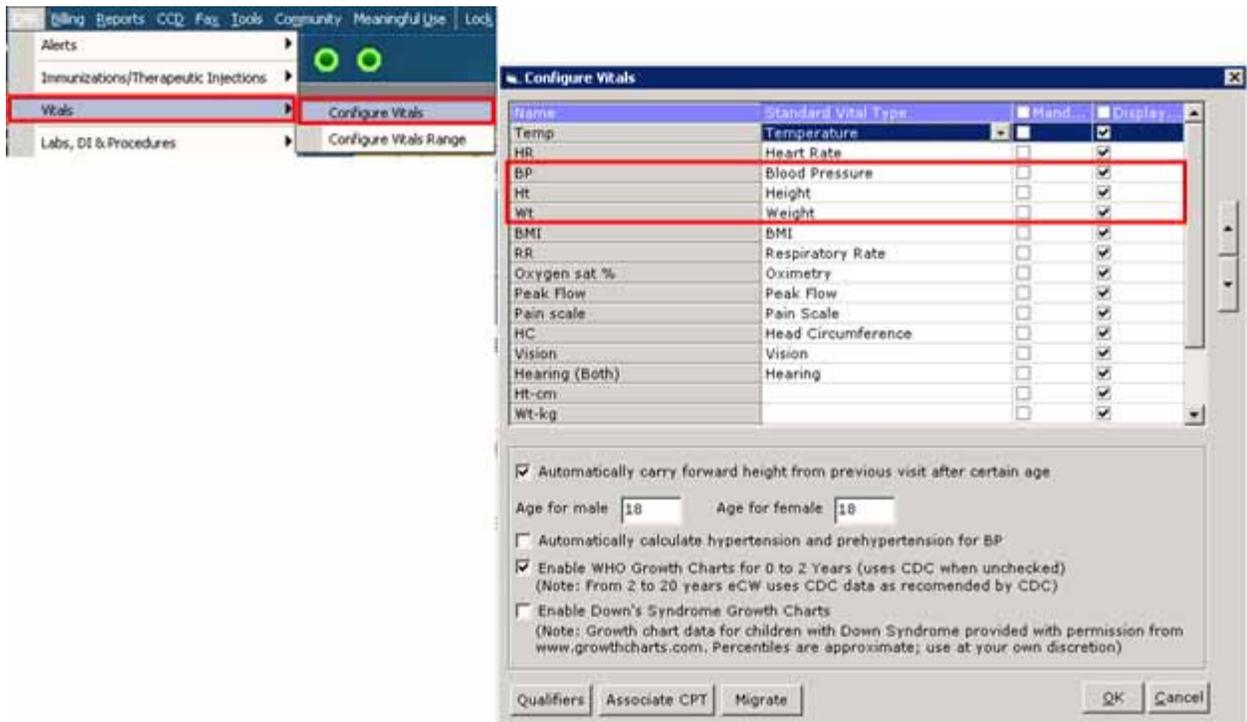
- Progress Notes > Visit Code > Add E&M



Configuring Vitals

Each vital must be linked to the appropriate standard vital type once to satisfy this measure:

- EMR > Vitals > Configure Vitals



Recording Blood Pressure

- Progress Notes > Vitals



Core 5: Recording Smoking Status

Objective

Record smoking status for patients 13 years old or older.

Measure

More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have had their smoking status recorded as structured data.	<p>Configure options related to this measure from the following locations:</p> <ul style="list-style-type: none"> ■ Community > Mappings > Structured Data <p>OR</p> <ul style="list-style-type: none"> ■ Community > Mappings > Smart Forms <p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Progress Notes > Social History <p>OR</p> <ul style="list-style-type: none"> ■ Progress Notes > SF drop-down list > Tobacco Control <p>IMPORTANT! The following options satisfy this measure:</p> <ul style="list-style-type: none"> ■ Current smoker ■ Heavy tobacco smoker ■ Light tobacco smoker ■ Former smoker ■ Never smoker ■ Current every day smoker ■ Current some day smoker ■ Smoker, current status unknown <p>Unknown if ever smoked</p> <p>Note: The Tobacco Use Smart Form can also be used to satisfy this measure.</p>

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They performed no encounters for patients over the age of 13 during the reporting period.	This exclusion criteria is reported by self-attestation.

Features Related to Core 5

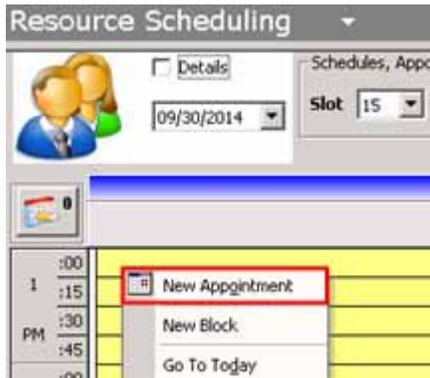
The following features are related to Core Measure 5:

- [Recording Appointments](#)
- [Recording E&M Codes](#)

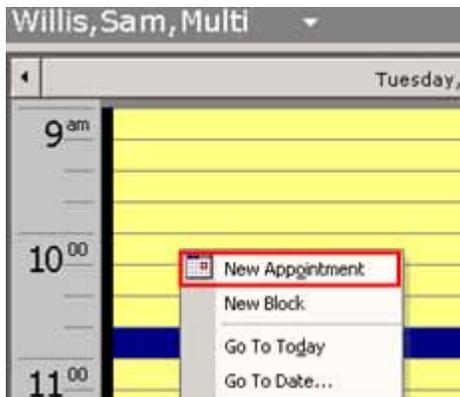
- Mapping Community Structured Data
- Mapping Smart Forms
- Recording Smoking Status

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

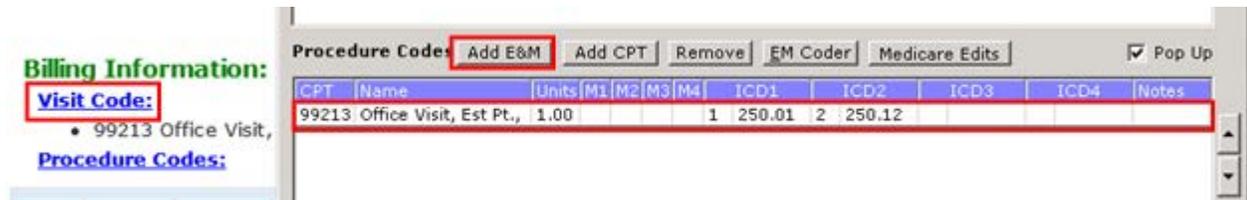


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



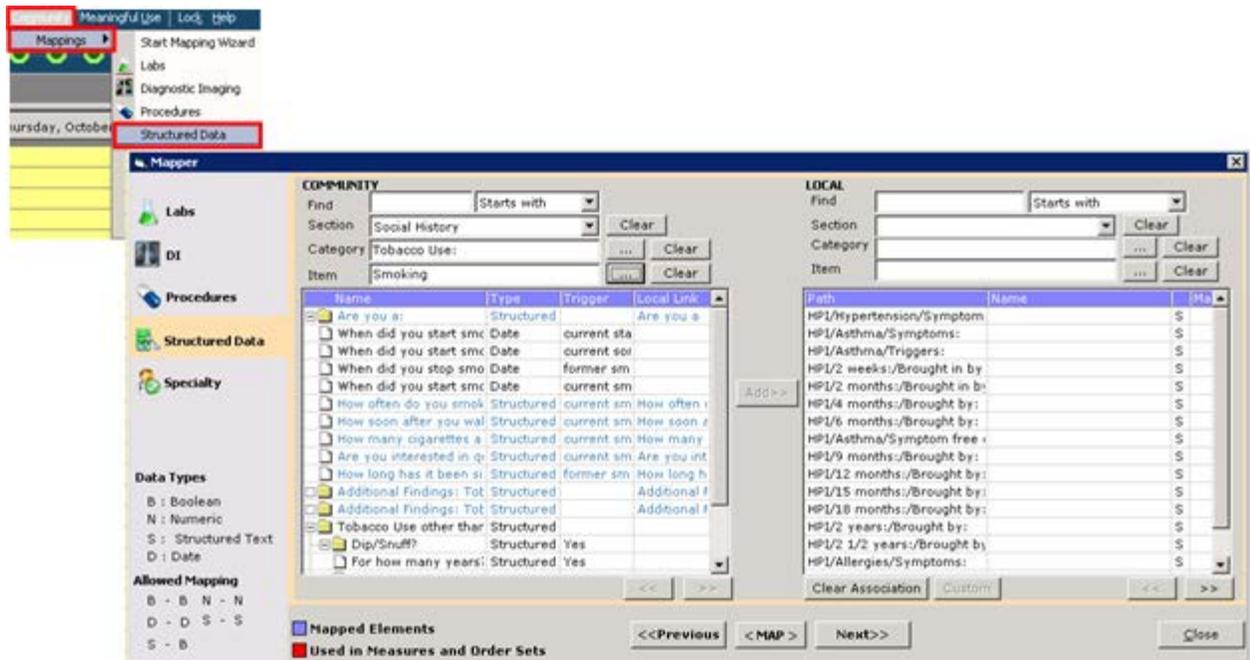
Recording E&M Codes

- Progress Notes > Visit Code > Add E&M



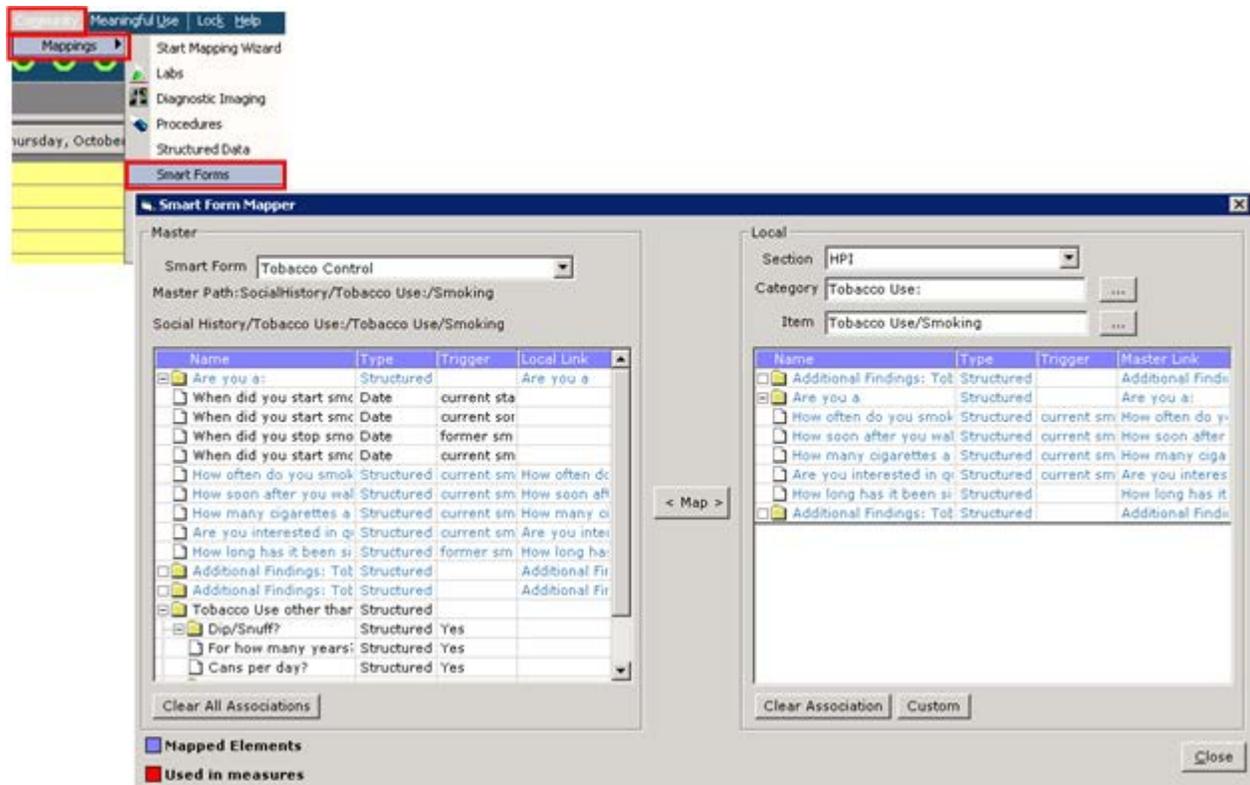
Mapping Community Structured Data

- Community > Mappings > Structured Data



Mapping Smart Forms

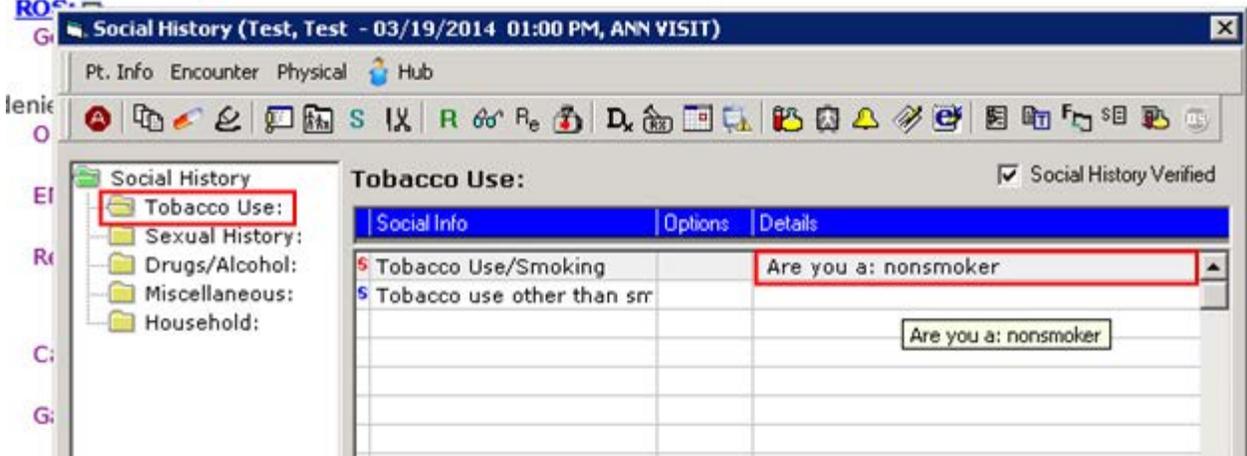
- Community > Mappings > Smart Forms



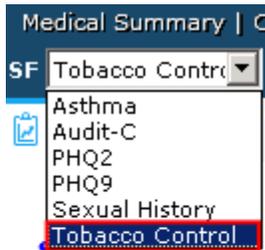
Recording Smoking Status

- Progress Notes > Social History

Social History:



- Progress Notes > SF drop-down list > Tobacco Control



Are you a

current smoker

former smoker

nonsmoker

current every day smoker

current some day smoker

Smoker, current status unknown

unknown if ever smoked

light tobacco smoker

heavy tobacco smoker

Core 6: Clinical Decision Support Rule

Objective

Use clinical decision support to improve performance on high-priority health conditions.

Measure 1

Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Measure 2

The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

Core 6 Measure 1

The following features are available to assist in decision-making:

Feature	Area to Document within eClinicalWorks
Classic Alerts	EMR > Alerts
Registry Alerts	Registry band > Registry icon > run a query > Save Queries
CDSS Alerts	EMR > CDSS > Measure Configuration

Note: For more information on using these features, refer to the *Electronic Medical Records Users Guide* or the HelpHub.

Features Related to Core 6 Measure 1

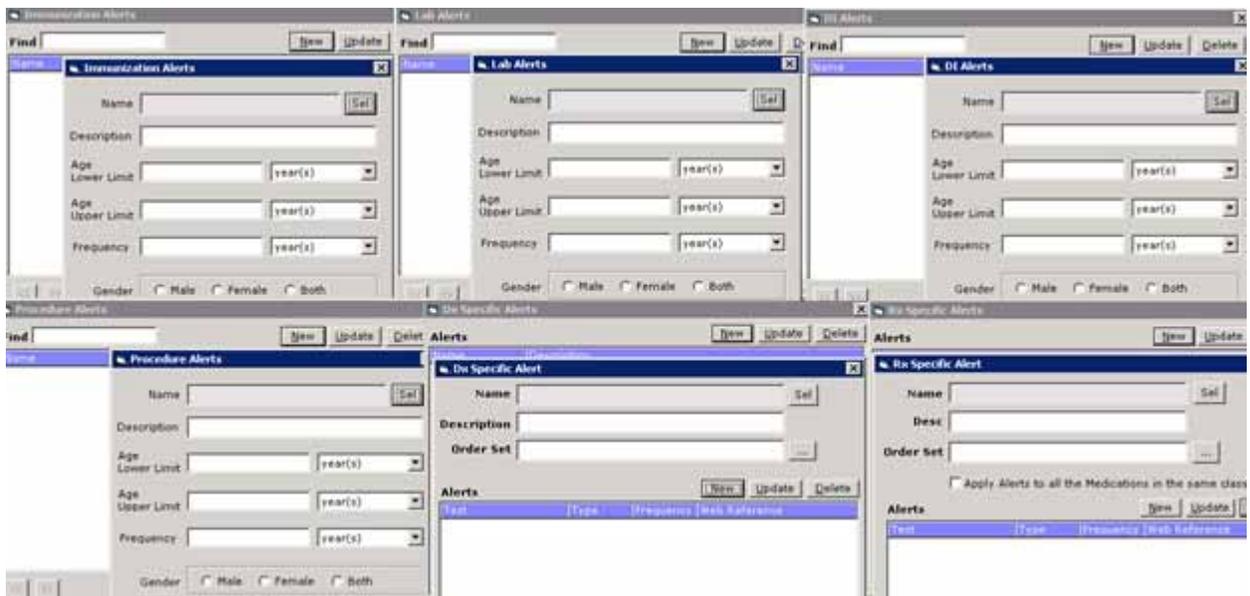
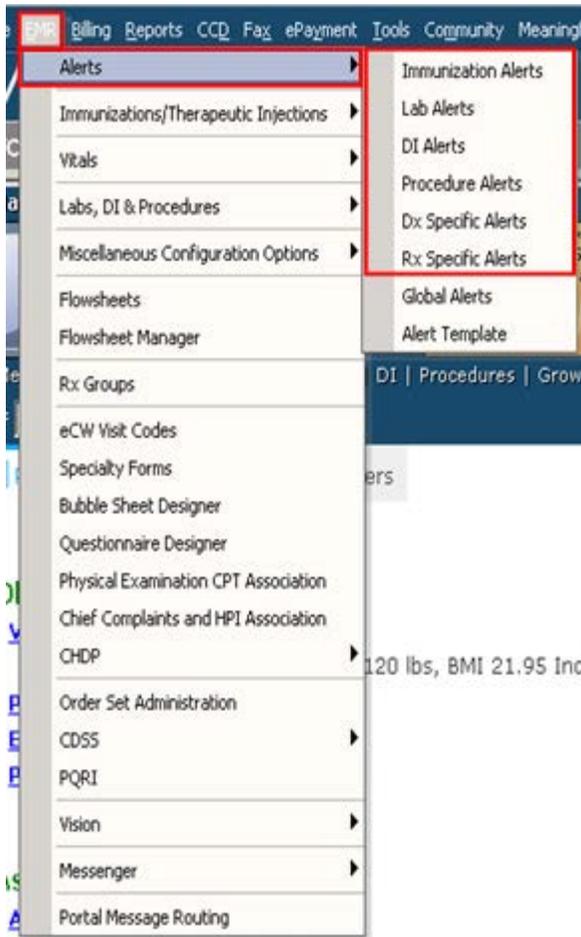
The following features are related to Core 6 Measure 1:

- [Configuring Classic Alerts](#)
- [Configuring Registry Alerts](#)
- [Configuring CDSS Alerts](#)

Configuring Classic Alerts

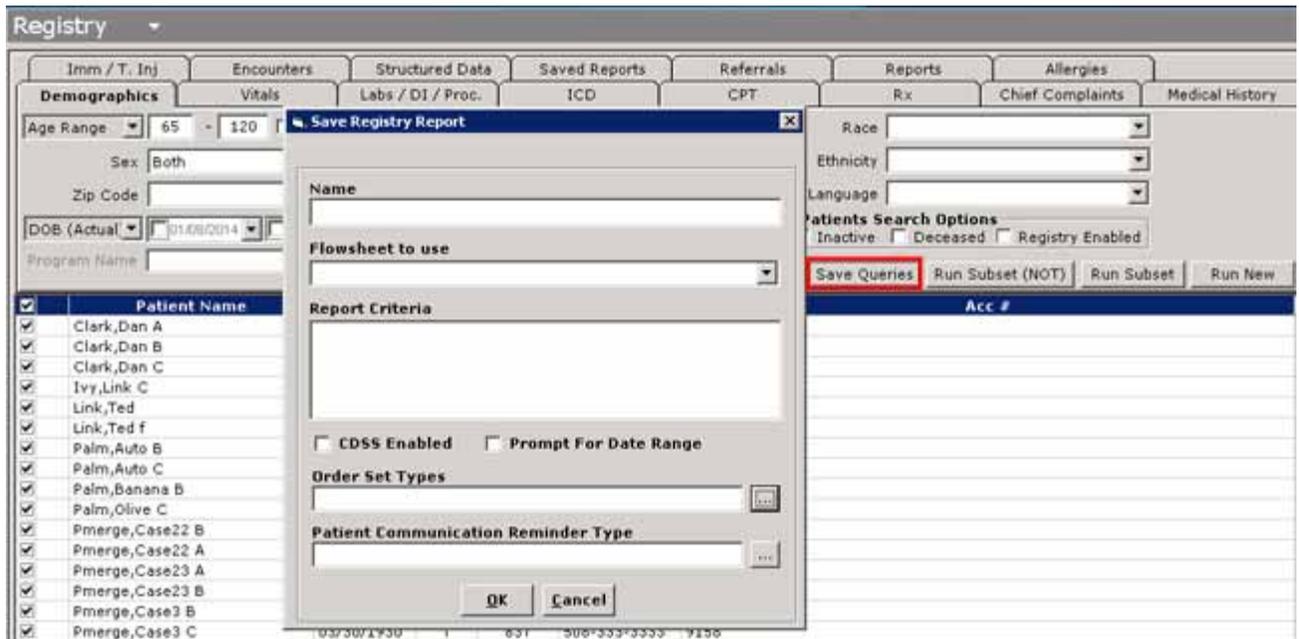
This is a one-time setup process, with periodic maintenance as needed:

- EMR > Alerts



Configuring Registry Alerts

- Registry band > Registry icon > run a query > Save Queries



Configuring CDSS Alerts

This is a one-time setup process, with yearly maintenance:

- EMR > CDSS > Measure Configuration



Core 6 Measure 2

The following features are available to assist in decision-making:

Feature	Area to Document within eClinicalWorks
Drug Interaction Checks	Access this feature from one of the following locations: <ul style="list-style-type: none"> Progress Notes > Current Medication > Drug Interaction Progress Notes > Treatment > Interaction

Note: For more information on using these features, refer to the *Electronic Medical Records Users Guide* or the HelpHub.

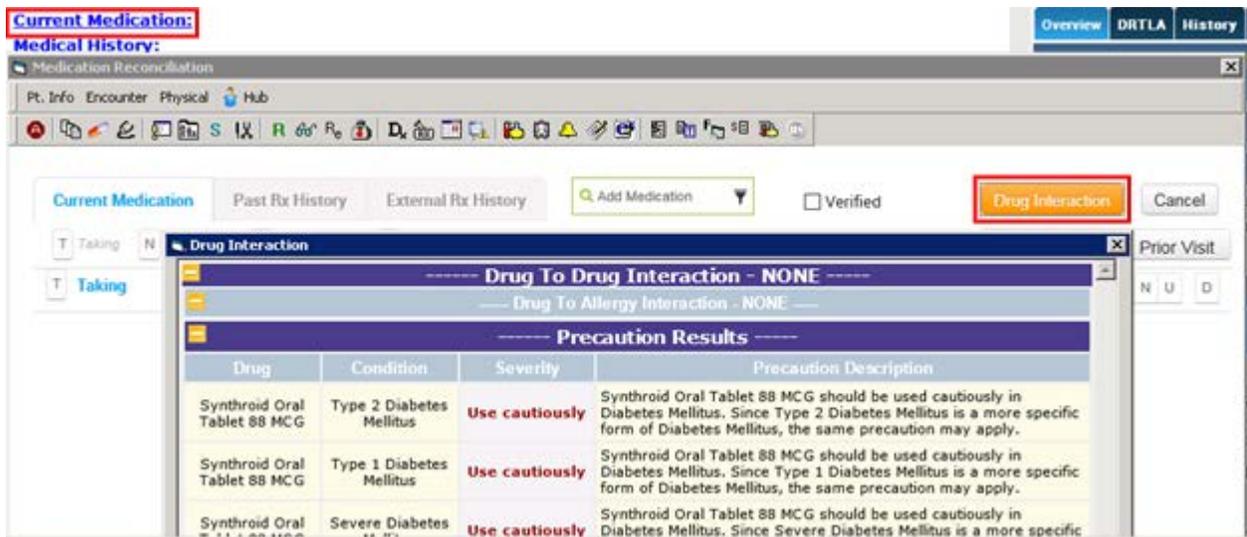
Features Related to Core 6 Measure 2

The following features are related to Core 6 Measure 1:

- Using Drug Interaction Checking

Using Drug Interaction Checking

- Progress Notes > Current Medication > Drug Interaction



- Progress Notes > Treatment > Interaction

The screenshot displays a patient's electronic health record (EHR) interface. On the left, the 'Progress Notes' section is visible, showing a patient named 'Test, Test, 13 Y, M'. The 'Treatment' section is highlighted, listing 'Diabetes mellitus' and 'Diabetes with ketoac'. Below this, there are sections for 'Lab/CBC', 'Referral', 'Procedures', and 'Immunizations'. On the right, the 'Drug Interaction' report is displayed, showing a table of drug interactions. The table has columns for 'Drug', 'Condition', 'Severity', and 'Precaution/Direction'. The interactions listed are for 'Synthroid Oral Tablet 88 MCG' with conditions like 'Type 2 Diabetes Mellitus', 'Type 1 Diabetes Mellitus', 'Severe Diabetes Mellitus', and 'Diabetic Ketoacidosis', all with a severity of 'Use cautiously'. Below the table, there are sections for 'Age based Criteria Results - NONE', 'Drug To Food Interaction - NONE', and 'Source' information, including the issue date (October 3, 2012) and database edition (12.4.1.001).

Core 7: Patient Electronic Access

Objective

Provide patients the ability to view online, download, and transmit their health information within four business days of the information being available to the EP.

Core 7-1

Measure

More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within four (4) business days after the information is available to the EP) online access to their health information.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy ONE of the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have been web-enabled any time before, during, or within four (4) business days of the appointment.	Record this information from one of the following locations: <ul style="list-style-type: none"> ■ Patient Information > Options > Web Enable ■ Appointment window > W check box
The patient is unwilling to disclose their e-mail address.	Patient Information > Additional Info > Email drop-down list and Not Provided check box

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They neither order nor create any of the information listed for inclusion as part of this measure, except for <i>Patient name</i> and <i>Provider's name</i> and office contact information, may be excluded from this measure.	This exclusion criteria is reported by self-attestation.

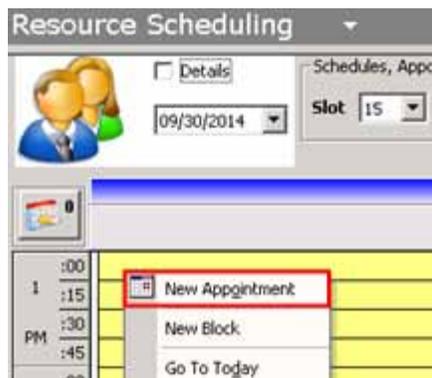
Features Related to Core 7-1

The following features are related to Core Measure 7-1:

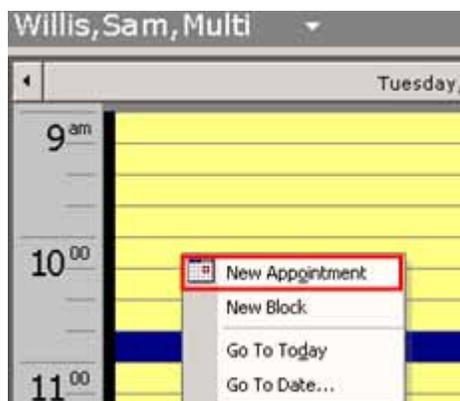
- Recording Appointments
- Recording E&M Codes
- Web-Enabling Patients
- Recording Patients' e-Mail Addresses

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

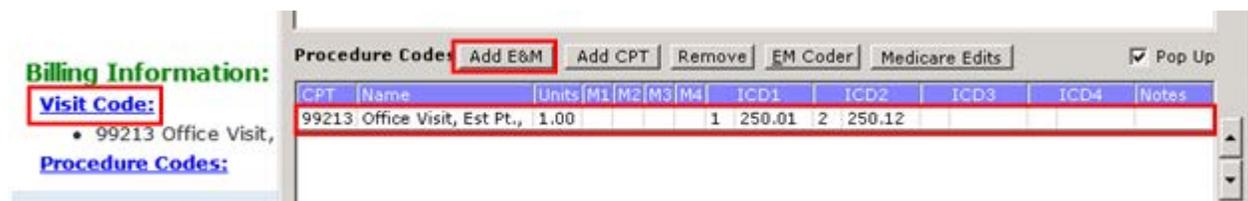


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



Recording E&M Codes

- Progress Notes > Visit Code > Add E&M



Web-Enabling Patients

- Patient Information > Options > Web Enable

Patient Information (Smith, Bonnie)

Personal Info

Account No: P9337 Prefix: [] PCP: [] Clear

Last Name: Smith Suffix: [] Referring Provider: [] Clear

First Name: Bonnie MI: [] Rendering Provider/Primary Care Giver: []

Previous Name: [] Date Of Birth (mm/dd/yyyy): 06/22/1950 Age: 63Y

Address Line 1: 100 Main St Gestational Age: []

Address Line 2: [] Sex: Female Transgender

City: Westborough Validate Marital Status: []

State: MA ZIP: 01581 Country: US Social Security: 020-44-7894 Parent Info

Home Phone: 508-888-8888 Cell No: [] Ext: 9874 Employer Name: ECLINICALWORKS----- Clear

Work Phone: [] Emp Status: [] (None Selected)

(statements will be addressed to responsible party) Student Status: [] (None Selected)

Responsible Party Select Set Emergency Contact Family Hub Select Remove

Name: Smith, Bonnie Emergency Contact: []

Relation: 1 Self - patient is the insured Acct Balance: 1,548.50 Details Gr. Bal

Last Appt: 10/03/2013 11:00 AM Patient: -168.06 Acc Inquiry

Next Appt: []

Insurances IE New Case

Sliding Fee Schedule Fee Schedule New Test fee Self Pay Add Update Remove

	Name	State	Subscriber No	Rel	Insured	Co Pay	Group No
P	Medicare Part B	MA	77777777A	1	Smith, Bonnie		
	Workers Comp	NC	123456789	1	Smith, Bonnie		
PI	Medicare Part B	MA	123456789A	1	Smith, Bonnie		

Release of Information: Rx History Consent: Scan Signature Date: / / Advance Directive: []

Additional Info Alert Misc Info Options P.S.A.C OK Cancel

Options

- Copy Demographics
- MediScan
- MediScan (with Photo)
- Web Enable
- View Log
- View Fee Schedule Log
- Generate Log
- Registry Settings

- Appointment window > W check box

Appointment on Monday, October 06, 2014

Encounters Find Logs Referrals Orders Bubblesheet X Refresh

Facility: Internal - DEMO DASHBOARD (PM) Sel POS: 11

Date: 10/6/2014 Provider: Willis, Sam, Multi

Claim Providers Resource: Willis, Sam, Multi

Start Time: 10:00 AM End Time: 10:15 AM New Pt

Patient: Test, Document Sel Info Hub Elig Sts

DOB: 03/02/1973 Tel: [] E-mail: test2@gmail.com W

Recording Patients' e-Mail Addresses

- Patient Information > Additional Info > Email drop-down list and Not Provided check box

The screenshot shows a patient information form with tabs for 'General Information', 'Student Information', and 'Structured'. The 'General Information' tab is active. Under the heading 'Street Address(if different from mailing)', there are input fields for 'Address Line 1', 'Address Line 2', 'City', 'State', and 'Zip'. Below these is the 'Email' field, which has a dropdown menu currently showing 'Will Not Disclose'. To the right of the dropdown is a checked checkbox labeled 'Not Provided'. Below the email field are fields for 'Leave Message' (Home and Cell), 'Residence Type', and 'Race'. There are also buttons for 'Import' and 'Picture' on the right side of the form.

Core 7-2

Measure

More than five (5) percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit their health information to a third party.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have viewed their health information by logging into the Patient Portal	Web browser > URL > enter information in Username and Password fields > Sign In
They have downloaded their PHR or Visit Summary from the Patient Portal	Patient Portal > left navigation menu or Request PHR button
They have transmitted their health information to a third party from one of the links in the Medical Records section of the left navigation pane on the Patient Portal	Patient Portal > Medical Record > Personal Health Share > Share
	IMPORTANT! Transmitting health information to a third party requires the patient to enter the direct address of the provider. Providers can request direct address after enrolling in JTN (Join the Network) from the following web address: https://my.eclinicalworks.com/eCRM/jsp/productJoinTheNetwork.jsp?pgId=7&prodId=3 . For more information, refer to Requesting a Direct Address .

Note: For more information on the options available to patients from the Patient Portal, refer to the *Patient Portal Users Guide* or the HelpHub.

Exclusions

Providers may be excluded from this measure under the following circumstances:

Exclusion Criteria	Area to Document within eClinicalWorks
They neither order nor create any of the information listed for inclusion as part of this measure, except for <i>Patient name</i> and <i>Provider's name</i> and office contact information.	This exclusion criteria is reported by self-attestation.
They conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability, according to the latest information available from the FCC on the first day of the EHR reporting period.	This exclusion criteria is reported by self-attestation. Information on broadband availability can be found at: http://www.broadbandmap.gov/

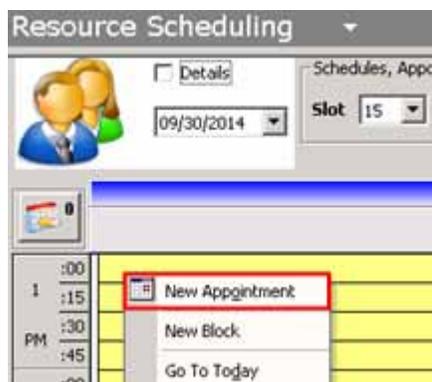
Features Related to Core 7-2

The following features are related to Core Measure 7-2:

- Recording Appointments
- Recording E&M Codes
- Logging Into the Patient Portal
- Downloading PHRs or Visit Summaries
- Transmitting Health Information

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

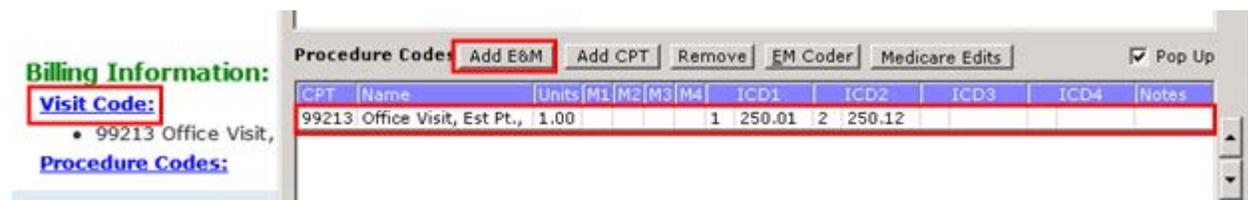


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



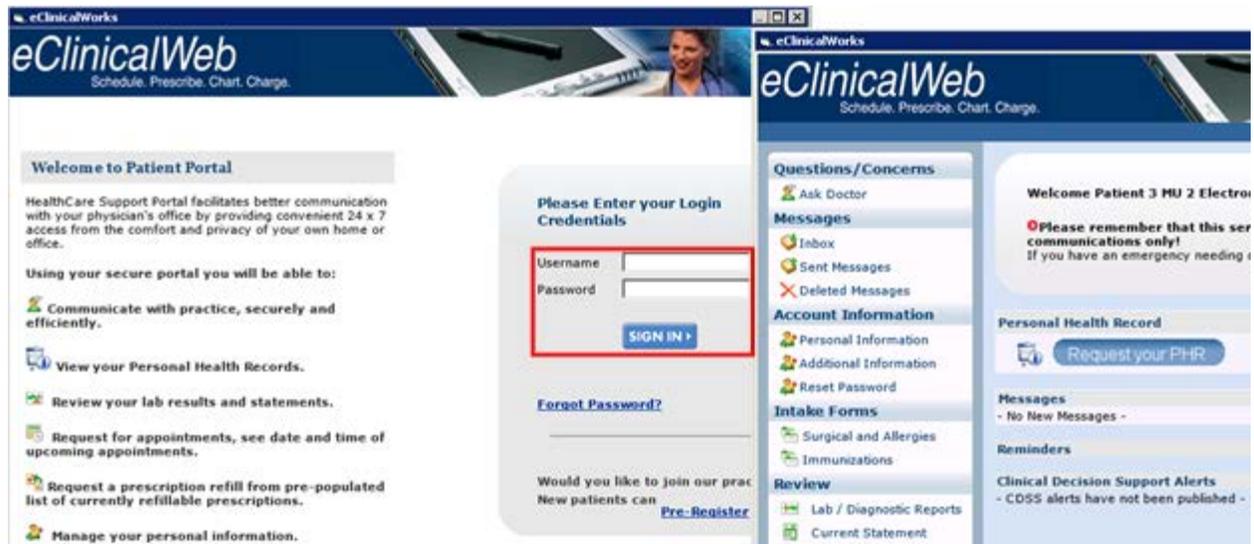
Recording E&M Codes

- Progress Notes > Visit Code > Add E&M



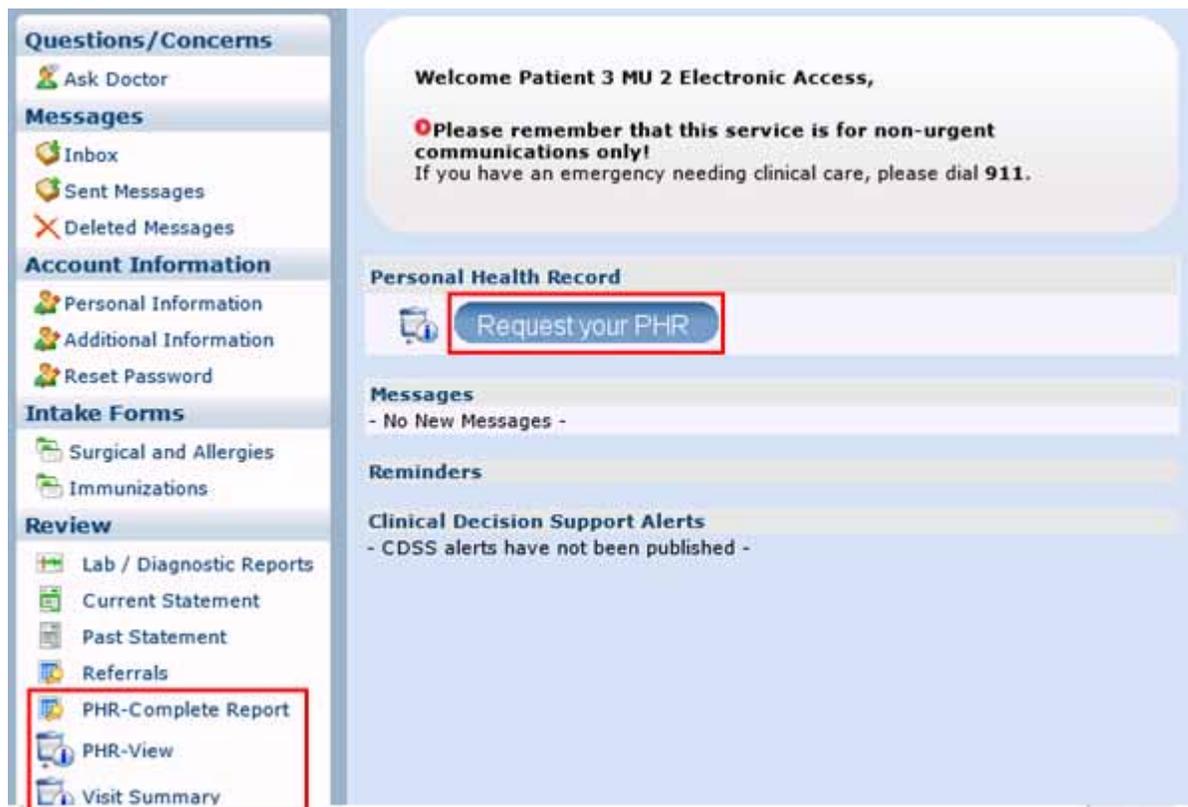
Logging Into the Patient Portal

- Web browser > URL > enter information in Username and Password fields > Sign In



Downloading PHRs or Visit Summaries

- Patient Portal > left navigation menu or Request PHR button



Transmitting Health Information

- Patient Portal > Medical Record > Personal Health Share > Share

My Account
Messages
Appointments
Questionnaires
Health Tracker
My Devices

Table Of Content

- PROBLEMS
- ALLERGIES
- SOCIAL HISTORY
- PLAN OF CARE
- VITAL SIGNS
- MEDICATIONS
- RESULTS
- PROCEDURES

PROBLEMS
Unknown Problems

ALLERGIES

Substance	Reaction	Event Type	Date	Status
N.K.D.A	Unknown	Non Drug Allergy	Unknown	Unknown

SOCIAL HISTORY
No smoking Hx information available

PLAN OF CARE

VITAL SIGNS

MEDICATIONS
Unknown Medications

RESULTS

PROCEDURES

Powered by eClinicalWorks

Patient Name: Patient 24 MU 2 Electronic Access Date of Birth: March 3, 1983 Created On: October 13, 2014

Share

Core 8: Providing Clinical Summaries

Objective

Provide clinical summaries for patients for each office visit.

Measure

Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they meet ONE of the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have a printed visit summary within one (1) business day (excluding federal, but not state, holidays) of their encounter.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Progress Notes > arrow next to the Print button > Print Visit Summary > Print Options > Print Preview or Decline ■ Practice band > Resource/Provider Scheduling icon > right-click on appointment > Print Visit Summary > Print Preview or Decline ■ Progress Notes > Send
	IMPORTANT! Printing the Progress Notes does NOT satisfy this measure. The Visit Summary must be printed to receive credit.
They have been web-enabled before, during, or within one (1) business day (excluding federal, but not state, holidays) of their encounter	Record this information from the following locations: <ul style="list-style-type: none"> ■ Admin > Patient Portal Settings > Feature Settings ■ Patient Information > Options > Web Enable ■ Appointment window > W check box

Exclusion

Providers are excluded from satisfying this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have no appointments recorded during the reporting period.	This exclusion criteria is reported by self-attestation.

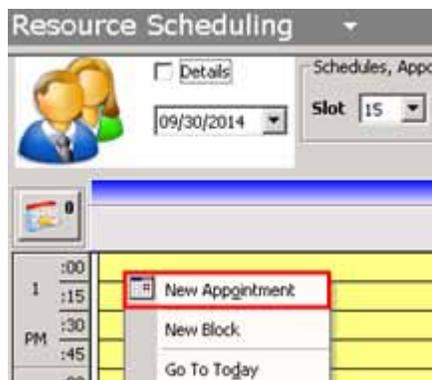
Features Related to Core 8

The following features are related to Core Measure 8:

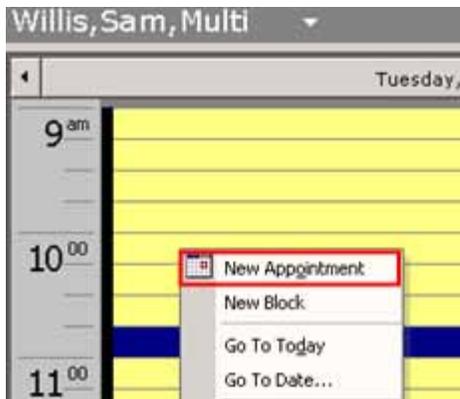
- Recording Appointments
- Recording E&M Codes
- Printing a Visit Summary
- Enabling Visit Summaries on the Patient Portal
- Web Enabling Patients

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

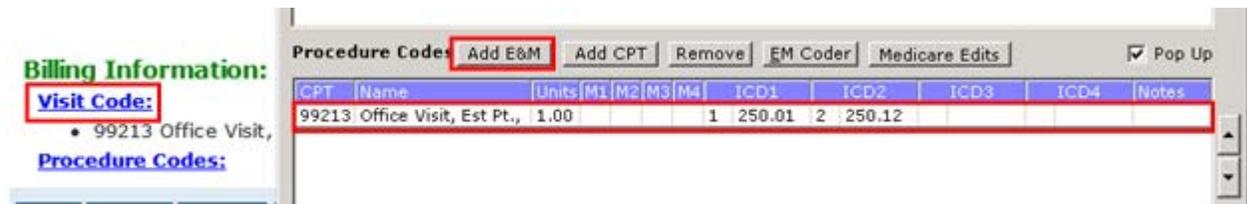


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



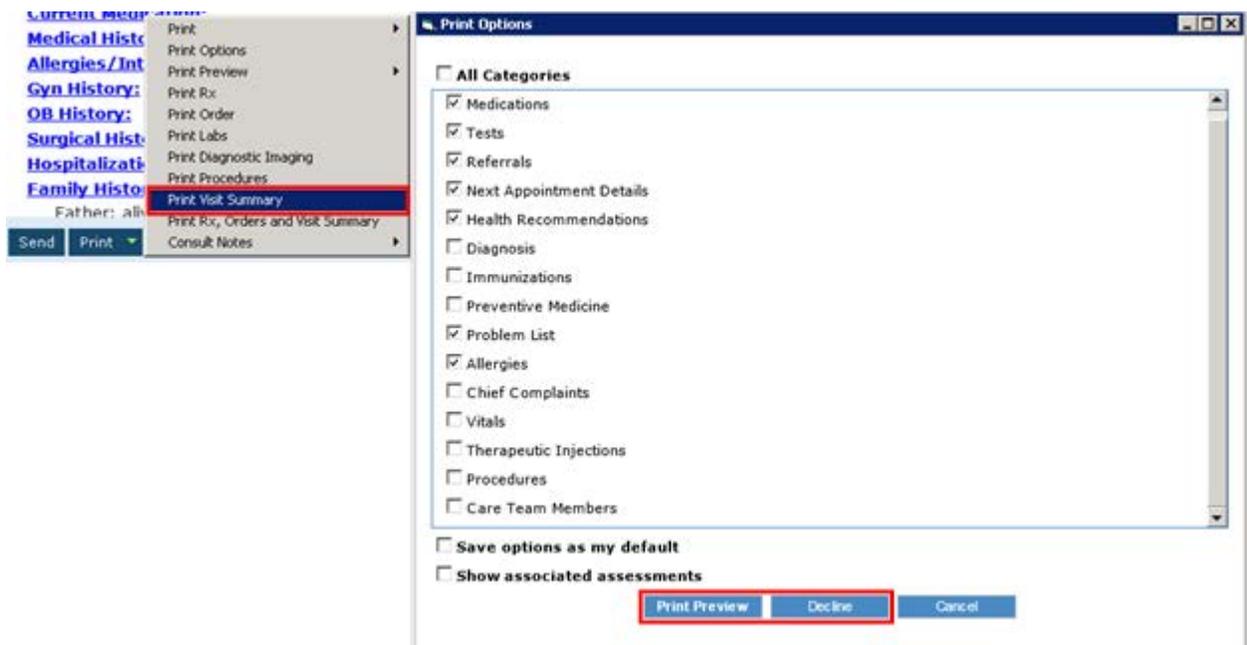
Recording E&M Codes

- Progress Notes > Visit Code > Add E&M

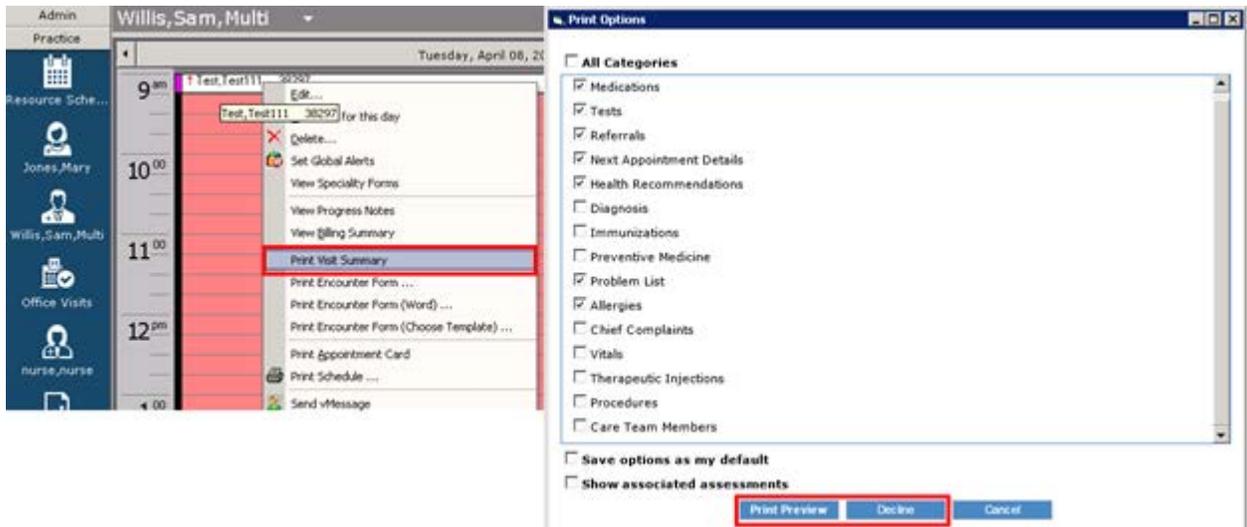


Printing a Visit Summary

- Progress Notes > arrow next to the Print button > Print Visit Summary > Print Options > *Print Preview* or *Decline*



- Practice band > Resource/Provider Scheduling icon > right-click on appointment > Print Visit Summary > *Print Preview* or *Decline*



- Progress Notes > Send



Enabling Visit Summaries on the Patient Portal

This is a one-time setup procedure:

- Admin > Patient Portal Settings > Feature Settings



The screenshot displays the 'Patient Portal Settings' interface. On the left is a vertical navigation menu with icons and labels for 'Admin', 'Providers', 'Staff', 'Referring Physi...', 'OB Flow Admin', 'OB Care Items', and 'Patient Portal S...'. The 'Patient Portal S...' menu item is highlighted with a red box. The main content area is titled 'Patient Portal Settings' and contains a list of settings categories: 'Message Settings', 'E-mail Message Settings', 'Appointment Settings', 'Labs Settings', 'Form(Quos &Imm) Settings', 'Menu Settings', 'Consent Form Settings', 'Welcome Message Setting', 'Medical Report Conf.', 'Visit Summary Conf.', 'Print Settings', and 'Feature Settings'. The 'Feature Settings' category is highlighted with a red box. Below this list, the 'Enable Visit Summary Feature:' label is followed by a dropdown menu set to 'Yes' and a 'More Info' link. The dropdown menu is also highlighted with a red box.

Web Enabling Patients

- Patient Information > Options > Web Enable

Patient Information (Smith, Bonnie)

Personal Info

Account No: P9337 Prefix: [] PCP: [] Clear

Last Name: Smith Suffix: [] Referring Provider: [] Clear

First Name: Bonnie MI: [] Rendering Provider/Primary Care Giver: []

Previous Name: [] Date Of Birth (mm/dd/yyyy): 06/22/1950 Age: 63Y

Address Line 1: 100 Main St Gestational Age: []

Address Line 2: [] Sex: Female Transgender

City: Westborough Validate Marital Status: []

State: MA ZIP: 01581 Country: US Social Security: 020-44-7894 Parent Info: []

Home Phone: 508-888-8888 Cell No: [] Ext: 9874 Employer Name: ECLINICALWORKS----- Clear

Work Phone: [] Emp Status: [] (None Selected)

(statements will be addressed to responsible party) Student Status: [] (None Selected)

Responsible Party Select Set Emergency Contact Family Hub Select Remove

Name: Smith, Bonnie Emergency Contact: []

Relation: 1 Self - patient is the insured Acct Balance: 1,548.50 Details Gr. Bal

Last Appt: 10/03/2013 11:00 AM Patient: -168.06 Acc Inquiry

Next Appt: []

Insurances IE New Case

Sliding Fee Schedule Fee Schedule New Test fee Self Pay Add Update Remove

	Name	State	Subscriber No	Rel	Insured	Co Pay	Group No
P	Medicare Part B	MA	77777777A	1	Smith, Bonnie		
	Workers Comp	NC	123456789	1	Smith, Bonnie		
PI	Medicare Part B	MA	123456789A	1	Smith, Bonnie		

Release of Information: Rx History Consent: Scan Signature Date: / / Advance Directive: []

Additional Info Alert Misc Info Options P.S.A.C OK Cancel

- Copy Demographics
- MediScan
- MediScan (with Photo)
- Web Enable**
- View Log
- View Fee Schedule Log
- Generate Log
- Registry Settings

- Appointment window > W check box

Appointment on Monday, October 06, 2014

Encounters Find Logs Referrals Orders Bubblesheet X Refresh

Facility: Internal - DEMO DASHBOARD (PM) Sel POS: 11

Date: 10/6/2014 Provider: Willis, Sam, Multi

Claim Providers Resource: Willis, Sam, Multi

Start Time: 10:00 AM End Time: 10:15 AM New Pt

Patient: Test, Document Sel Info Hub Elgib Sts

DOB: 03/02/1973 Tel: [] E-mail: test2@gmail.com W

Core 9: Protect Electronic Health Information

Objective

Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.

Measure

Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

Note: Regardless of whether a practice is locally hosted or hosted in the cloud, a Security Risk Assessment must be conducted by each practice at least once every year.

The following features are available to *assist* in protecting electronic health information:

Feature	Area to Document within eClinicalWorks
Security Attributes	File > Security Settings
Rx Security	File > Security Settings > Rx Security
P.S.A.C.	Access this feature from one of the following locations: <ul style="list-style-type: none"> ■ File > P.S.A.C. Settings > New ■ File > P.S.A.C. Settings > select group name > assign members > Save ■ File > P.S.A.C. Settings > select group name > Advanced Settings
Confidential Progress Notes	Progress Notes > Visit Code > Confidential Note
Confidential Patient Accounts	Patient Information > P.S.A.C.
Authentication Settings	File > Settings > Authentication Settings
Admin Logs	Admin band > Admin Logs icon

Note: For more information on how to use these features, refer to the *System Administration Users Guide* or the HelpHub.

Features Relating to Core 9

The following features are related to Core Measure 9:

- Using Security Settings
- Using Rx Security
- Using P.S.A.C.
- Making Progress Notes Confidential
- Making Patient Accounts Confidential
- Setting Up Authentication Settings
- Reviewing Administrative Logs

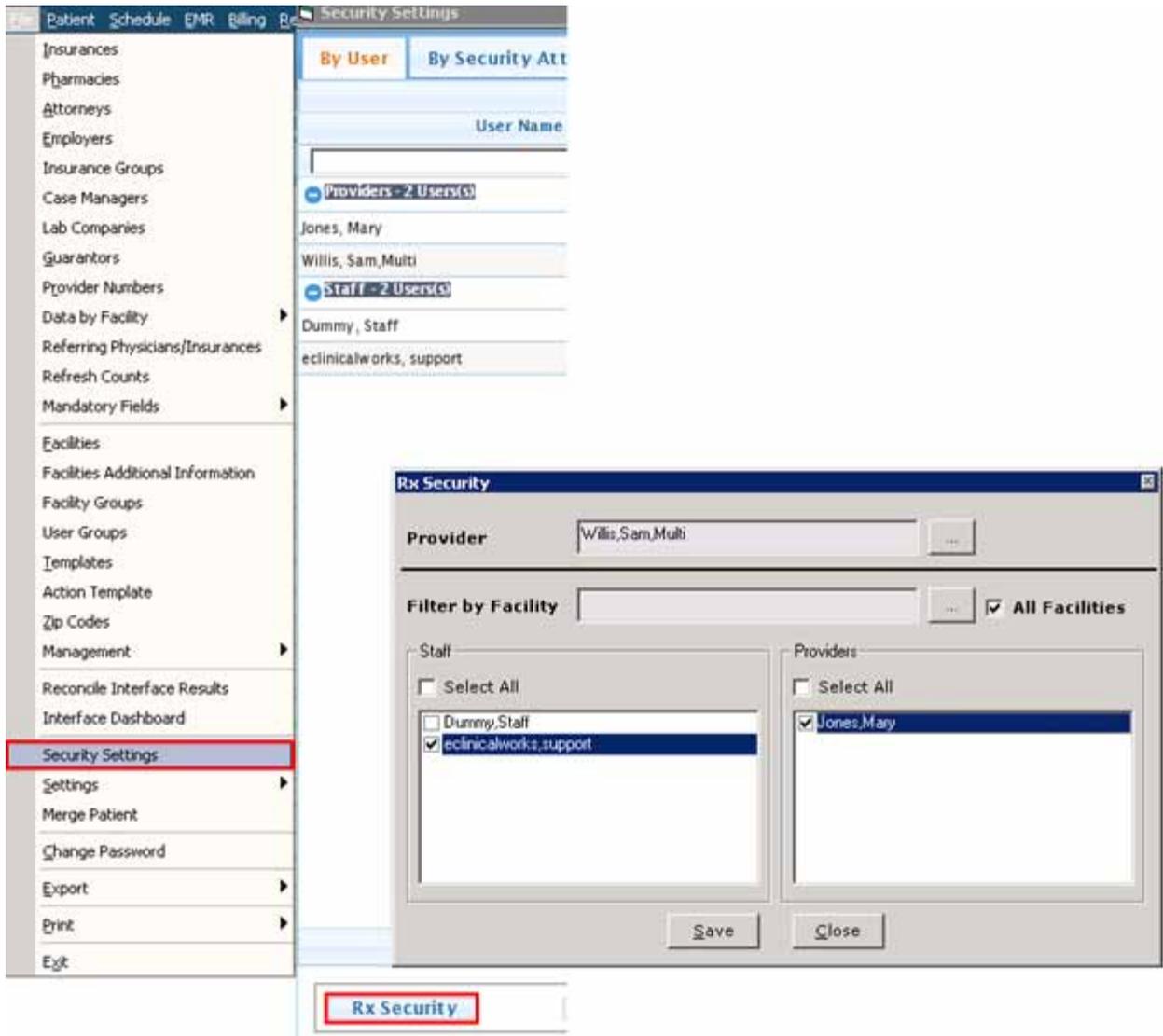
Using Security Settings

- File > Security Settings



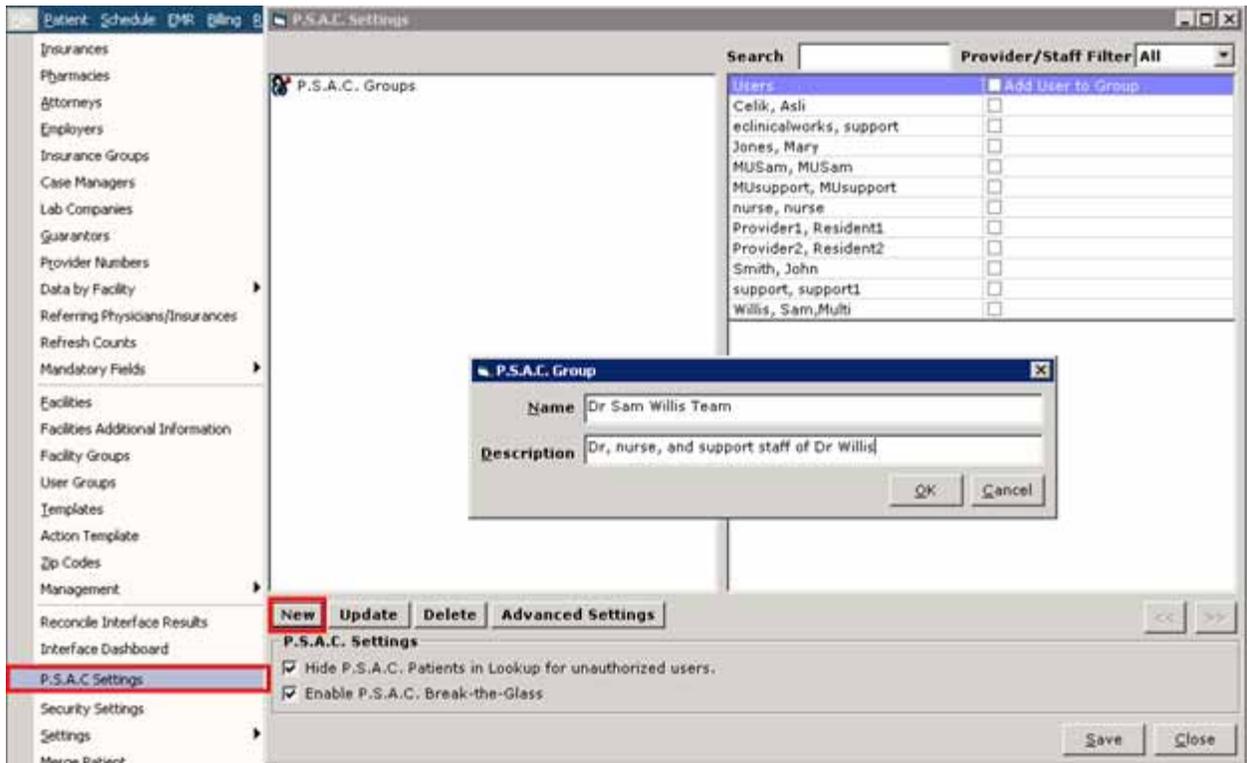
Using Rx Security

- File > Security Settings > Rx Security

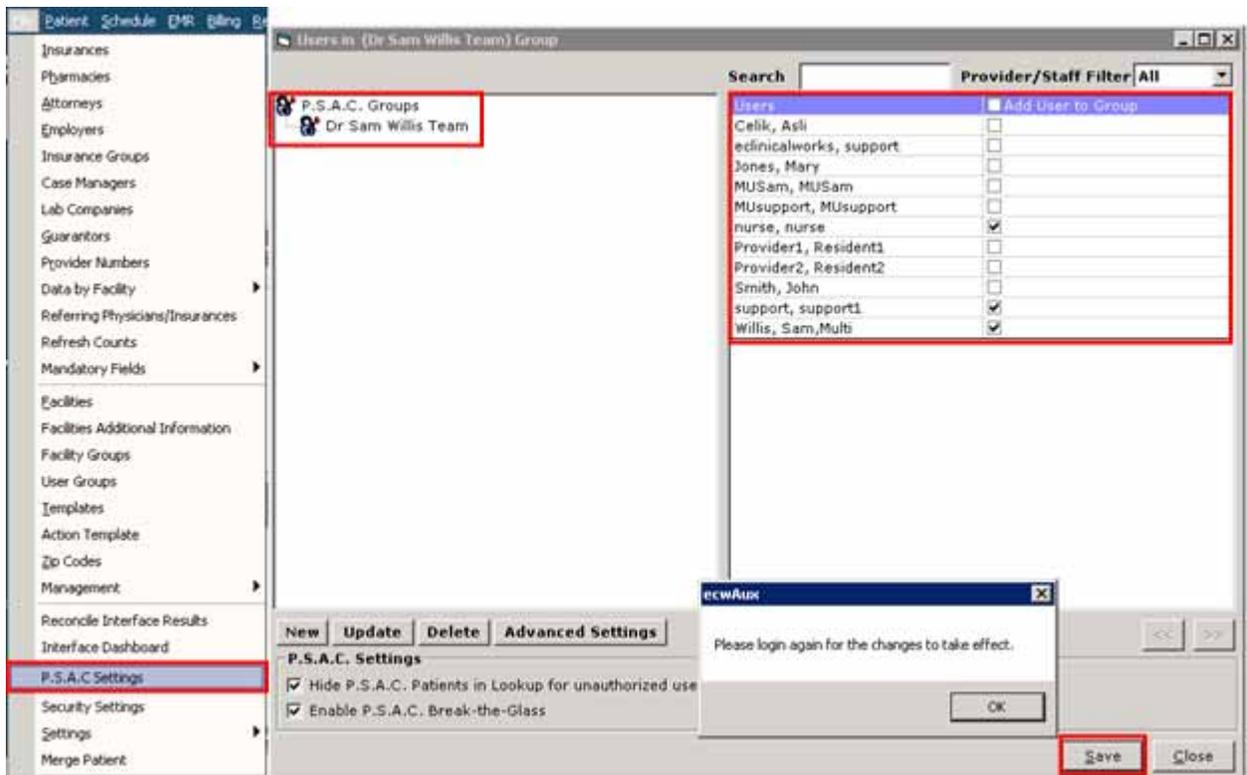


Using P.S.A.C.

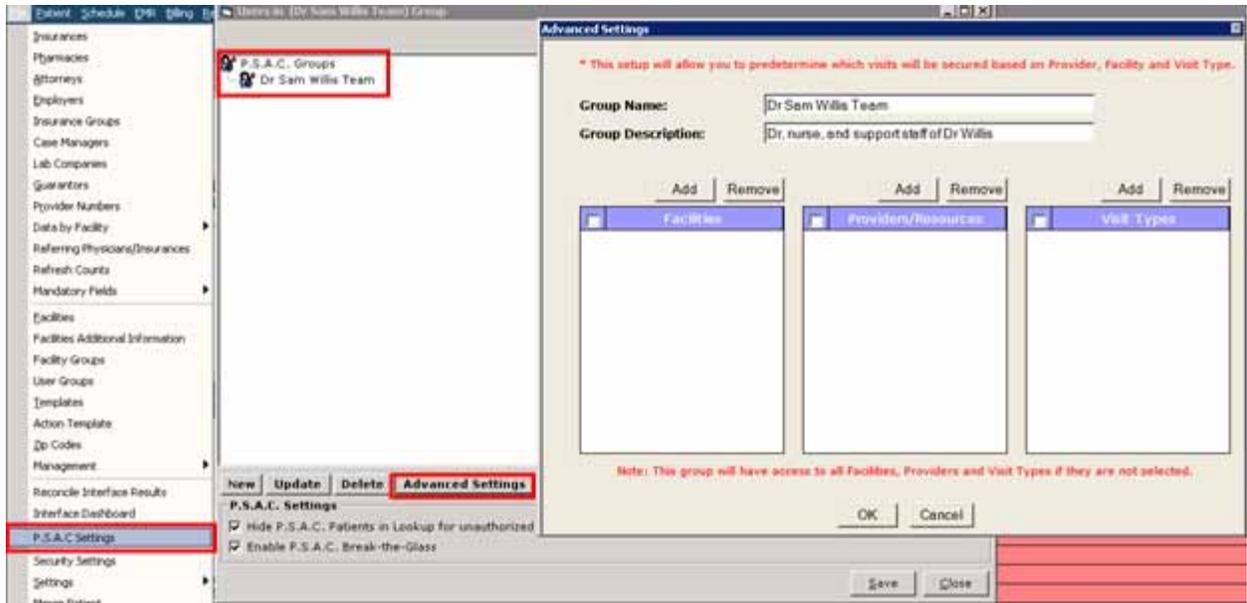
- File > P.S.A.C. Settings > New



- File > P.S.A.C. Settings > select group name > assign members > Save

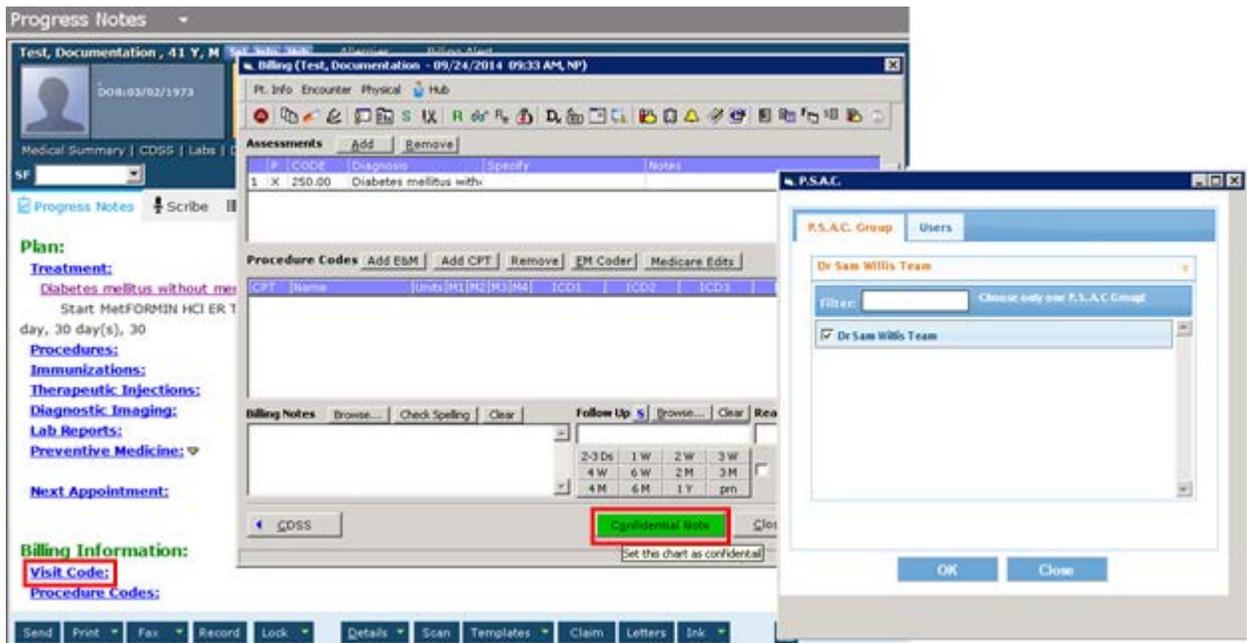


- File > P.S.A.C. Settings > select group name > Advanced Settings



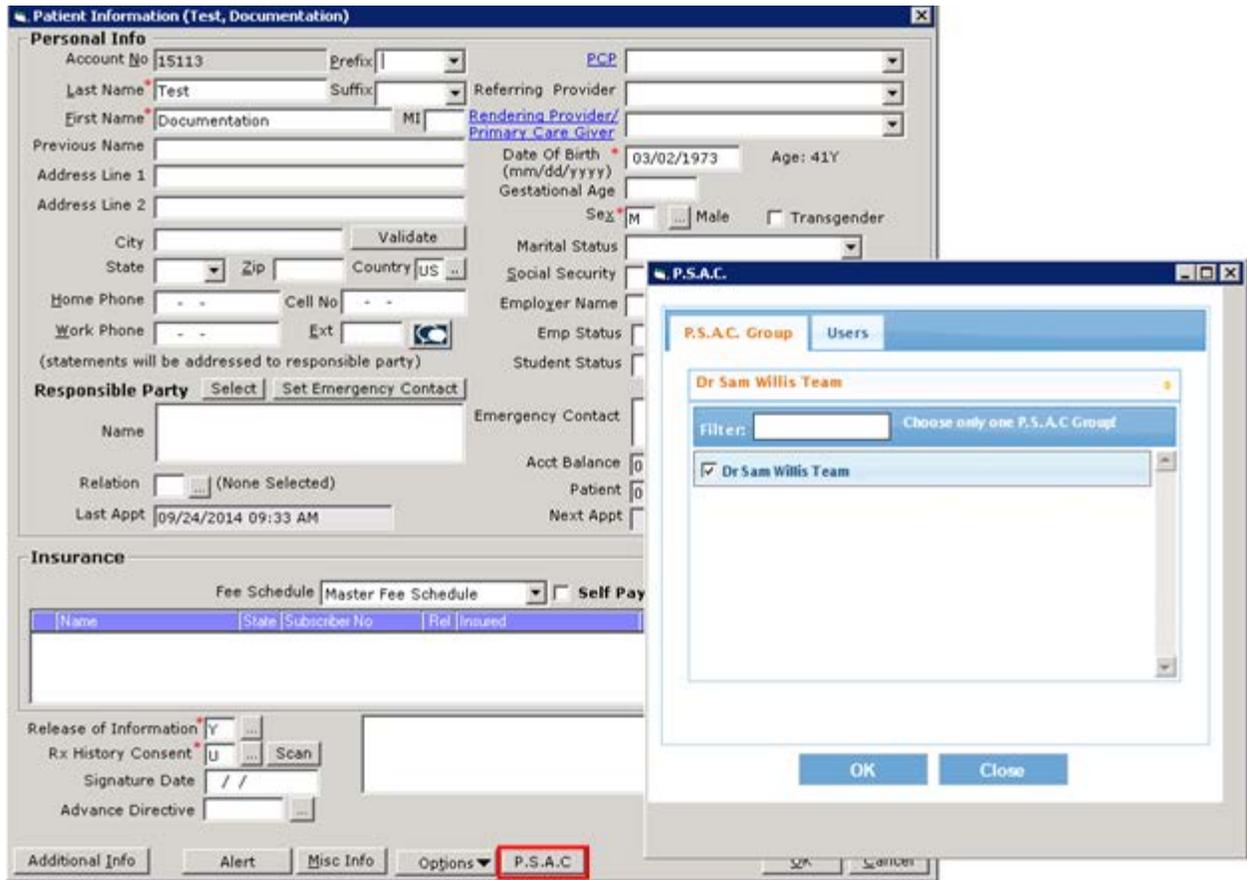
Making Progress Notes Confidential

- Progress Notes > Visit Code > Confidential Note



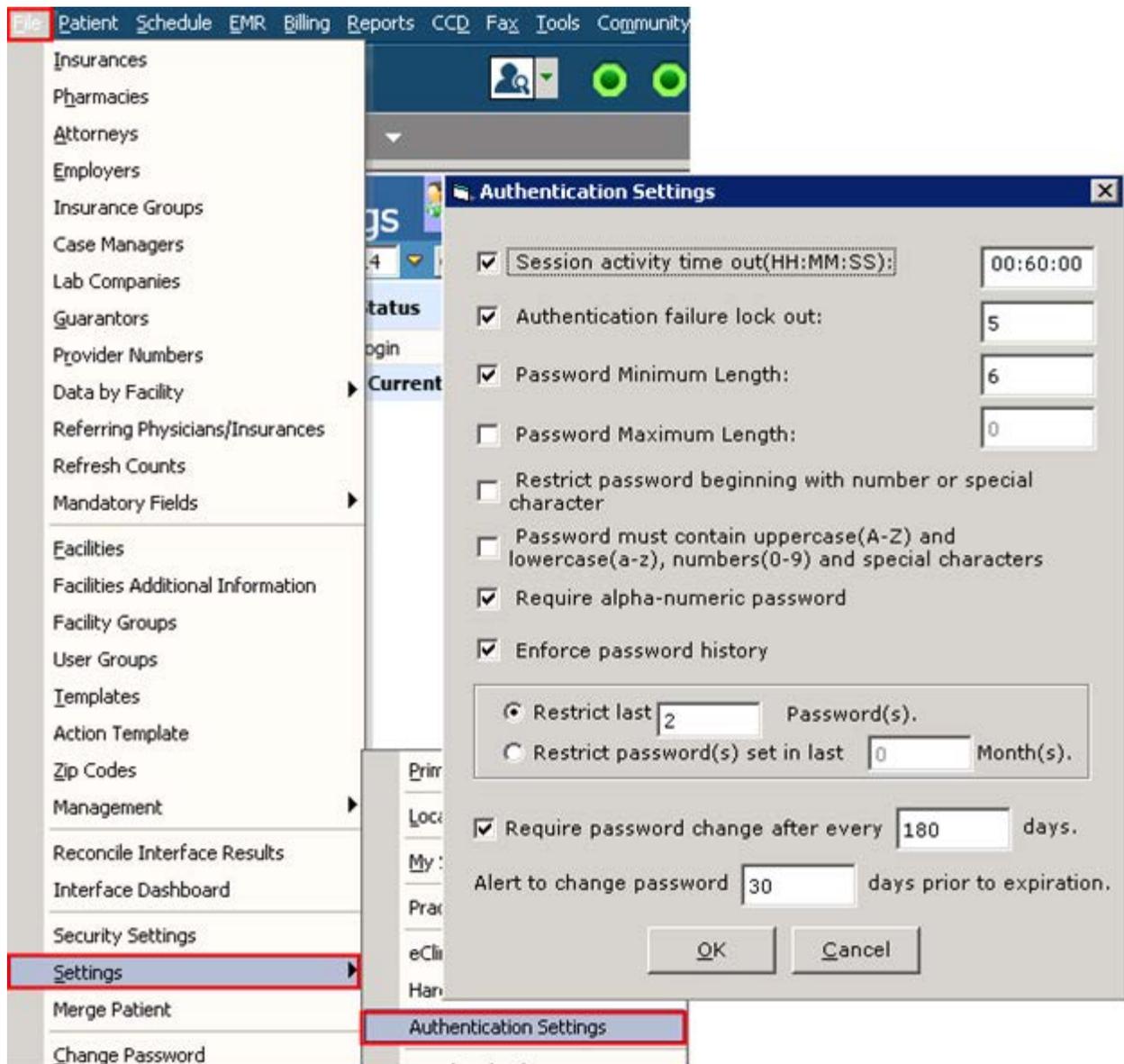
Making Patient Accounts Confidential

- Patient Information > P.S.A.C.



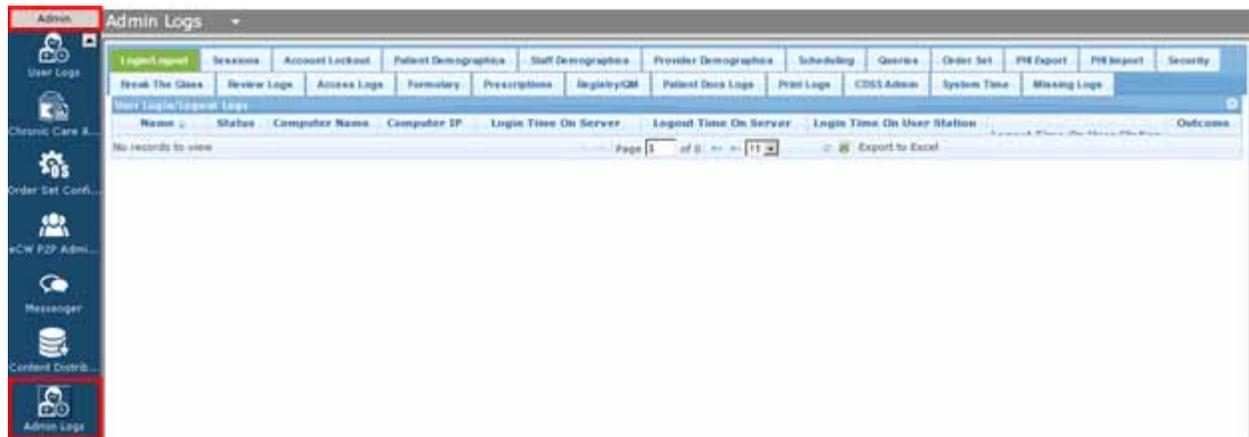
Setting Up Authentication Settings

- File > Settings > Authentication Settings



Reviewing Administrative Logs

- Admin band > Admin Logs icon



Core 10: Incorporating Lab Test Results as Structured Data

Objective

Incorporate clinical lab test results into Certified EHR Technology as structured data.

Measure

More than 55 percent of all clinical lab tests 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.

Denominator

Clinical labs are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have been ordered and had results recorded during the reporting period	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ L jellybean > New > Lab > Sel ■ Progress Notes > Treatment > Browse button in the Labs section > Lookup ■ Progress Notes > Lab Reports > Lookup ■ Patient Hub > Labs > New > Sel ■ Telephone/Web Encounter > Labs/DI tab > select Labs from drop-down list > New > Sel ■ Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse button in the Labs section > Lookup ■ Telephone/Web Encounter > Virtual Visit tab > Lab Reports > Lookup <p>IMPORTANT! A lab is only considered to be ordered for your patient if you are listed as the Ordering Provider.</p> <p>IMPORTANT! Labs in the Microbiology category are excluded from this calculation. Labs can be associated with categories from: EMR > Labs, DI & Procedures > Labs > search for and highlight a lab > green arrow next to the New button > Update > Associate Category</p>

Numerator

Clinical labs in the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have results entered and are marked as received from the Lab Results window.	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ L jellybean > click on lab ■ Progress Notes > Treatment > Lab link ■ Progress Notes > Lab Reports > Lab link ■ Progress Notes > right Chart Panel > Labs/DI tab > click on lab ■ Patient Hub > Labs > click on lab ■ Telephone/Web Encounter > Labs/DI tab > click on lab ■ Telephone/Wen Encounter > Virtual Visit tab > Treatment > Lab link ■ Telephone/Wen Encounter > Virtual Visit tab > Lab Reports > Lab link

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have not ordered any tests with results that are either in a positive/negative or numeric format during the reporting period.	This exclusion criteria is reported by self-attestation.

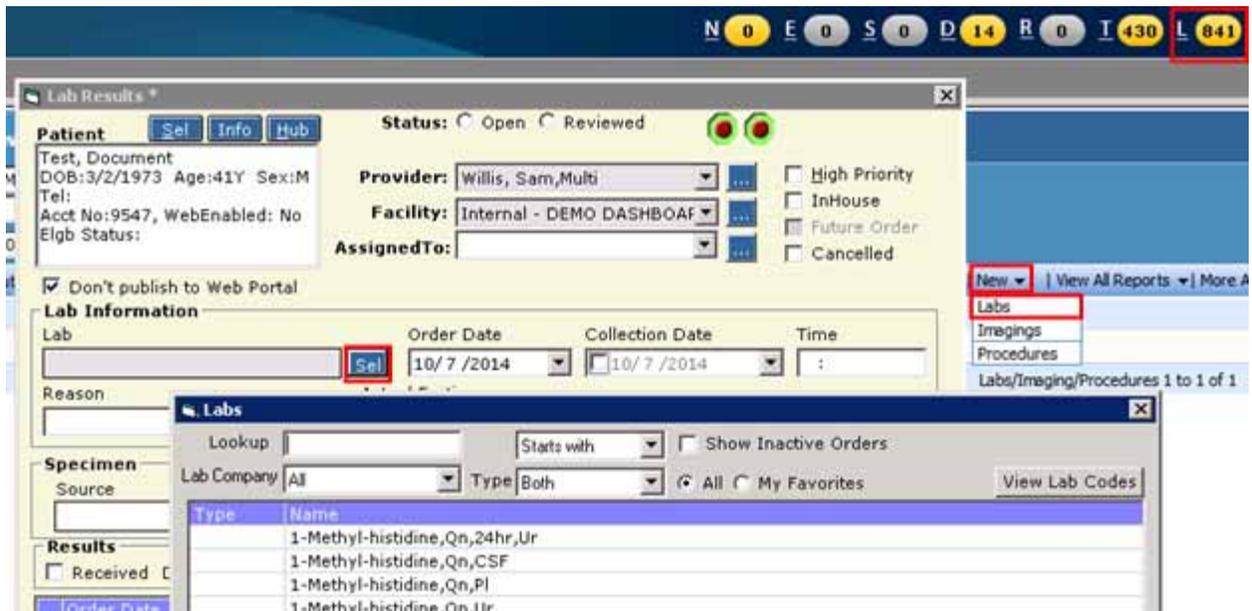
Features Related to Core 10

The following features are related to Core Measure 10:

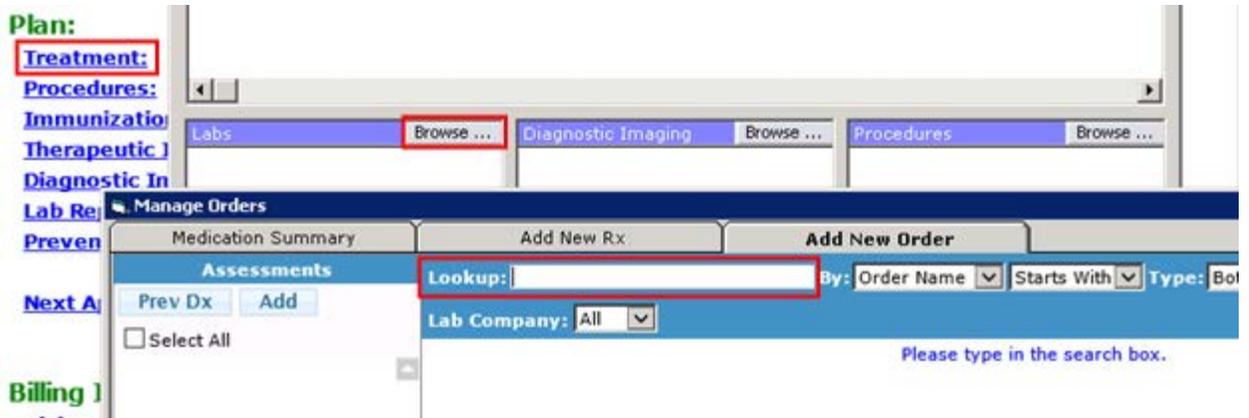
- Ordering Labs
- Associating Categories with Labs
- Recording Lab Results and Marking Labs as Received

Ordering Labs

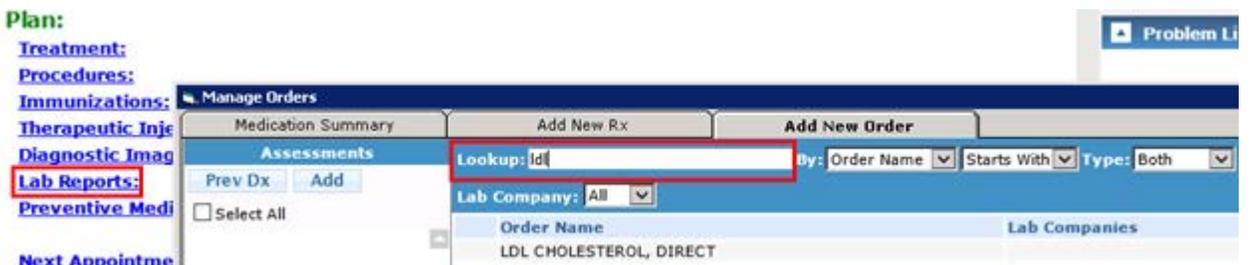
- L jellybean > New > Lab > Sel



- Progress Notes > Treatment > Browse button in the Labs section > Lookup



- Progress Notes > Lab Reports > Lookup



- Patient Hub > Labs > New > Sel



- Telephone/Web Encounter > Labs/DI tab > select Labs from drop-down list > New > Sel

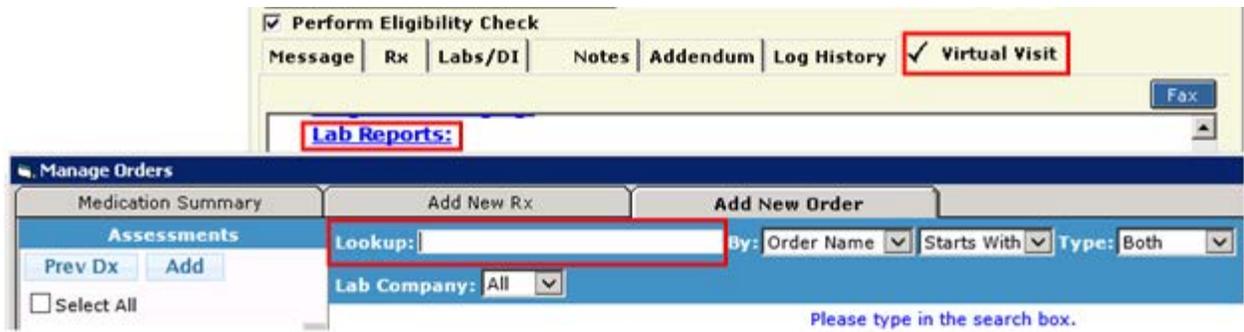
The screenshot displays two overlapping windows from a medical software application. The top window, titled "Telephone Encounter", contains several data entry fields. The "Answered by" field is populated with "Dummy, Staff". The "Date" is "4 / 4 / 2014" and the "Time" is "11:47 AM". The "Patient" section shows "Test, Test" with DOB: 9/9/2001, Age: 13Y, Sex: M, and other identifiers. The "Provider" is "Willis, Sam, Multi" and the "Facility" is "Internal - DEMO DASHBOARD (PM)". The "Status" is set to "Open". Below these fields are tabs for "Message", "Rx", "Labs/DI", "Notes", "Addendum", "Log History", and "Virtual Visit". The "Labs/DI" tab is selected, and a dropdown menu labeled "Labs" is open. To the right of the dropdown are "New", "Update", and "Delete" buttons. The bottom window, titled "Lab Results", shows patient information for "Test, Test" and lab details. The "Order Date" is "10/7/2014" and the "Collection Date" is "10/7/2014". A "Sel" button is highlighted in red in the "Lab" field.

- Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse button in the Labs section > Lookup

The screenshot displays three overlapping windows from a medical software application:

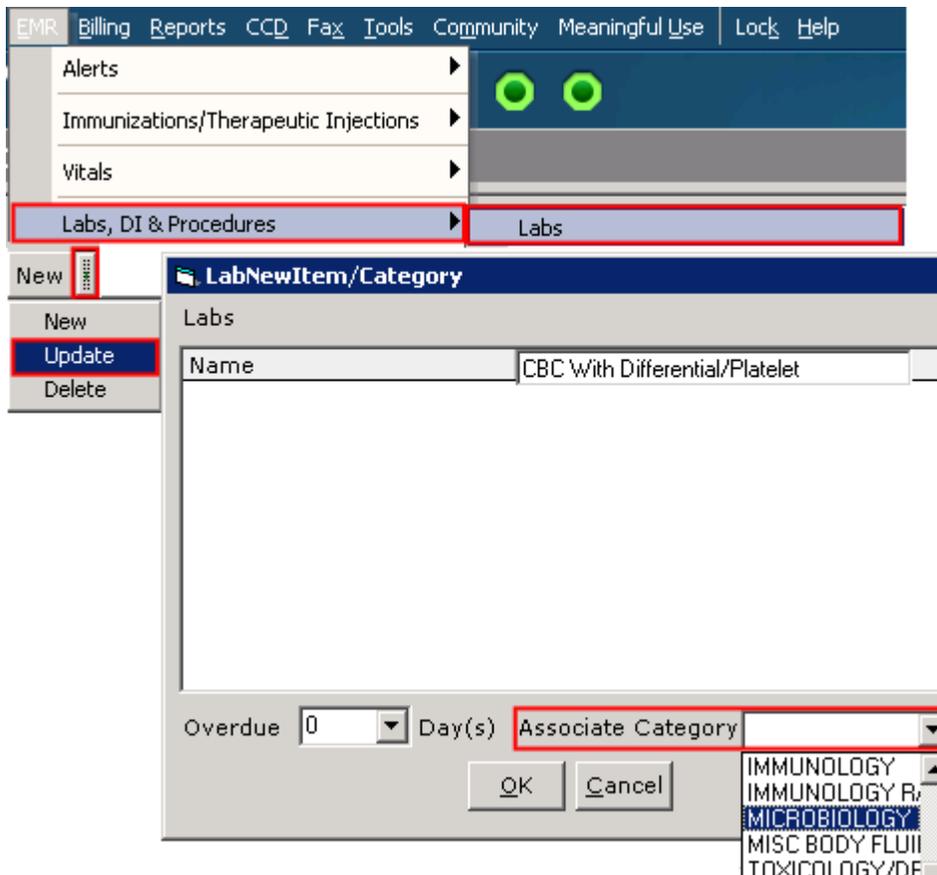
- Telephone Encounter Window:** Shows patient information (Test, Test, DOB: 9/9/2001, Age: 13Y, Sex: M), provider (Willis, Sam, Multi), and facility (Internal - DEMO DASHBOARD (PM)). The 'Virtual Visit' checkbox is checked and highlighted with a red box. Navigation tabs include Message, Rx, Labs/DI, Notes, Addendum, Log History, and Virtual Visit.
- Treatment Window:** Displays a medication list for Lisinopril 40 MG Tablet. The 'Browse...' button in the Labs section is highlighted with a red box.
- Manage Orders Window:** Features a search bar with the label 'Lookup:' and a dropdown menu for 'Lab Company' set to 'All'. The search bar is highlighted with a red box.

- Telephone/Web Encounter > Virtual Visit tab > Lab Reports > Lookup



Associating Categories with Labs

- EMR > Labs, DI & Procedures > Labs > search for and highlight a lab > green arrow next to the New button > Update > Associate Category



Recording Lab Results and Marking Labs as Received

- L jellybean > click on lab

Lab Results

Patient: Lamb2, Tracey
 DOB: 2/1/1984 Age: 30Y Sex: F
 Tel: 508-614-5849
 Acct No: 9361, WebEnabled: Yes
 Elg Status:

Status: Open Reviewed

Provider: Willis, Sam, Multi
 Facility: Internal - DEMO DASHBOAF
 AssignedTo: Willis, Sam, Multi

Don't publish to Web Portal

Lab Information

Lab	Order Date	Collection Date	Time
Hemoglobin A1c	2/26/2014	2/26/2014	:

Reason:
 Actual Fasting: Not Recorded Ordered Fasting

Specimen

Source	Description	Collection Volume	Units

Results

Received Date: 2/26/2014 Result:

Order Date	Coll. Date	Result	Hemoglob
02/26/2014	02/26/2014	11.5	

- Progress Notes > Treatment > Lab link

Diabetes mellitus without (Primary)
 Diabetes with ketoacidosis

Plan:
Treatment:
 Diabetes with ketoacidosis, ty
 Lab: CBC With Differential/P

Results

Received Date: 10/8/2014 Result:

Order Date	Coll. Date	WBC	RBC	Hemoglob	Hematocrit	MCV	MCH	MCHC
03/19/2014		25						

Assessments:
 250.01 Diabetes mellitus without mention of complication.
 250.12 Diabetes with ketoacidosis, type II or unspecified!

- Progress Notes > Lab Reports > Lab link

Diagnostic Imaging:
Lab Reports:
 Lab: LDL CHOLESTEROL

Results

Received Date: 10/8/2014 Result:

Order Date	Coll. Date	LDL CHOL	LDL CHOL
03/19/2014		99	

- Progress Notes > right Chart Panel > Labs/DI tab > click on lab

Specimen

Source	Description	Collection Volume	Units

Results

Received Date: 10/8/2014 Result:

Order Date	Coll. Date	LDL CHOL	LDL CHOL
03/19/2014		99	

Lab Reports:

Lab	Date
CBC With Differential/Platelet	03/19/2014
LDL CHOLESTEROL, DIRECT	03/19/2014

- Patient Hub > Labs > click on lab

The screenshot shows the 'Patient Hub (Test, Test)' interface. At the top, there are tabs for 'Labs', 'DI', 'Procedures', 'Imm/T/Inj', 'Referrals', 'Allergies', 'CDSS', 'Alerts', and 'Notes'. Below these are buttons for 'Overview', 'DRTLA', and 'History'. A table lists lab orders with columns for 'HM S O', 'W', 'Order Date', 'Coll Date', 'Result Date', 'Labs', 'Reason', 'Result', and 'Received Reviewed'. Two rows are visible, both with 'Labs' values 'CBC With Differentia...' and 'LDL CHOLESTEROL, DIRECT'. A 'Lab Results' window is open, showing patient information (Test, Test, DOB: 9/9/2001, Age: 13Y, Sex: M), provider (Willis, Sam, Multi), and facility (Internal - DEMO DASHBOAF). The 'Lab Information' section shows 'LDL CHOLESTEROL, DIRECT' with an order date of 3/19/2014 and a collection date of 10/8/2014. The 'Results' section shows a received date of 10/8/2014 and a result of 99. A table at the bottom of the results window shows 'Order Date' 03/19/2014 and 'Coll. Date' 10/8/2014 for 'LDL CHOL' with a result of 99.

- Telephone/Web Encounter > Labs/DI tab > click on lab

The screenshot shows the 'Telephone Encounter' interface. On the left, there are sections for 'Answered by' (Dummy, Staff), 'Patient' (Test, Test, DOB: 9/9/2001, Age: 13Y, Sex: M), and 'Caller'. A 'Reason' field is also present. Below these is a 'Perform Eligibility Check' section with a 'Message' field containing 'Labs/DI'. The 'Lab Results' window is open, showing patient information (Test, Test, DOB: 9/9/2001, Age: 13Y, Sex: M), provider (Willis, Sam, Multi), and facility (Internal - DEMO DASHBOAF). The 'Lab Information' section shows 'LDL CHOLESTEROL, DIRECT' with an order date of 3/19/2014 and a collection date of 10/8/2014. The 'Results' section shows a received date of 10/8/2014 and a result of 99. A table at the bottom of the results window shows 'Order Date' 03/19/2014 and 'Coll. Date' 10/8/2014 for 'LDL CHOL' with a result of 99.

- Telephone/Wen Encounter > Virtual Visit tab > Treatment > Lab link



- Telephone/Wen Encounter > Virtual Visit tab > Lab Reports > Lab link



Core 11: Patient Lists

Objective

Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

Measure

Generate at least one report listing patients of the EP with a specific condition.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

The following features are available to *assist* in generating lists:

Feature	Area to Document within eClinicalWorks
Registry	Access this information from the following locations: <ul style="list-style-type: none"> ■ Registry band > Registry icon > run a query > Save Queries ■ Registry band > Registry icon > Analyze Data > Copy

Note: For more information on how to use these features, refer to the *Electronic Medical Records Users Guide* or the HelpHub.

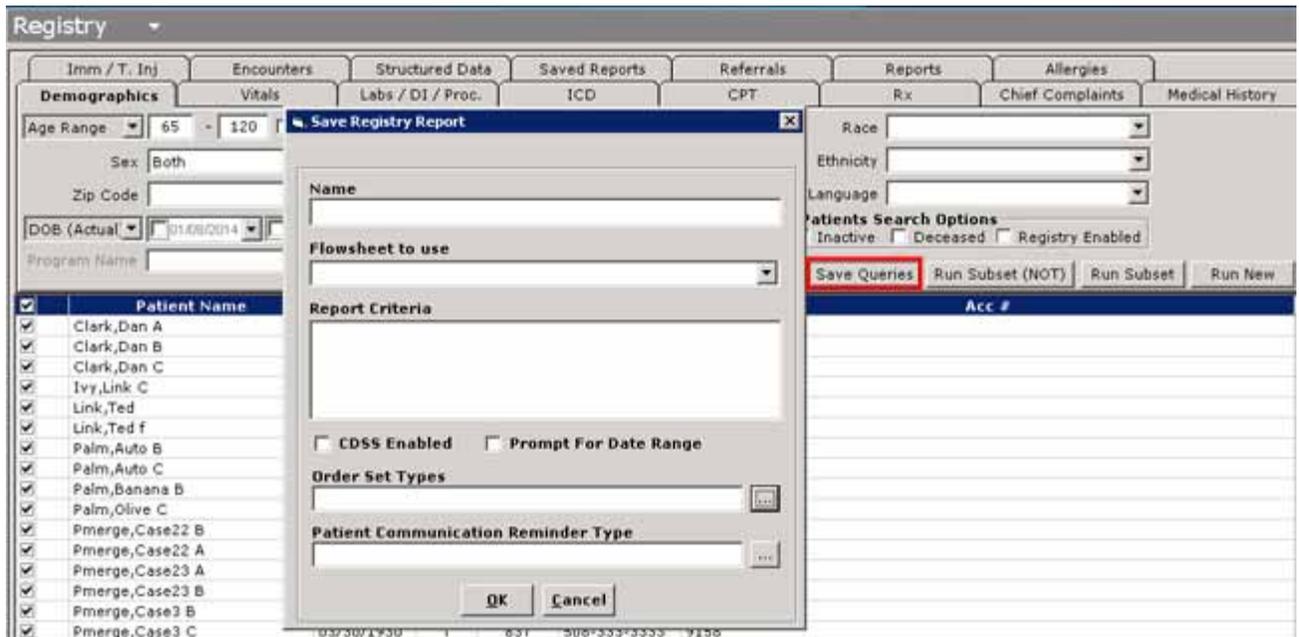
Features Related to Core 11

The following features are related to Core 11:

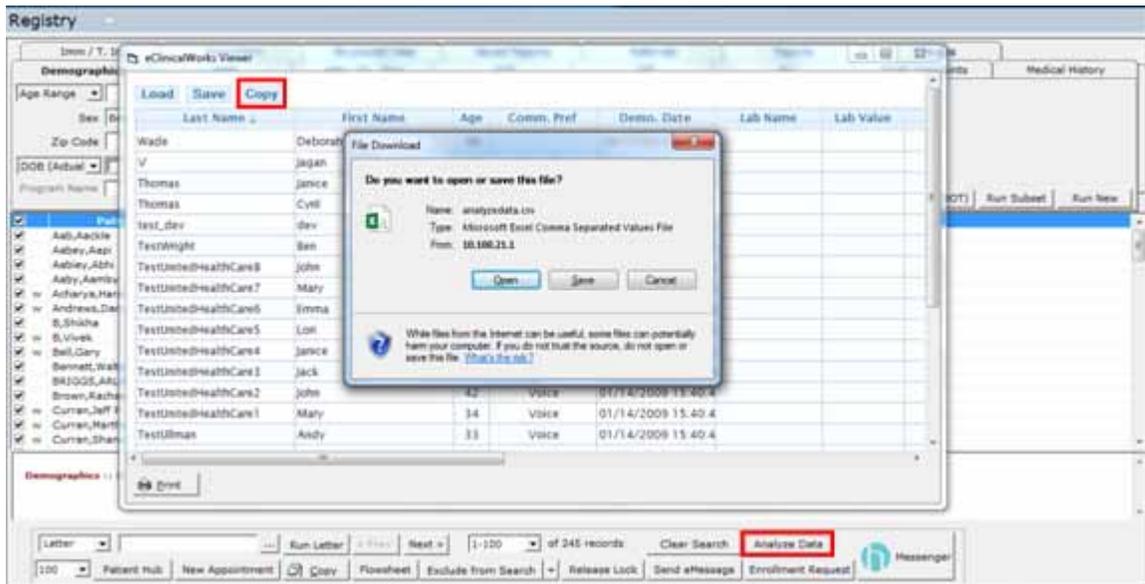
- Using the Registry

Using the Registry

- Registry band > Registry icon > run a query > Save Queries



- Registry band > Registry icon > Analyze Data > Copy



Core 12: Preventive Care

Objective

Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.

Measure

More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had at least two (2) outpatient appointment with a valid CPT* code created for them with an eligible professional within 24 months before the start of the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy at least ONE of the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
<p>They are sent a follow-up, health maintenance, or preventive care letter reminder.</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Patient Hub > Messenger > Messenger Configuration ■ Patient Information > Speaker icon ■ Registry band > Patient Recall icon > generate/select a list of patients > click More (...) next to the letter field > select a template > Run Letter > Print ■ Registry band > Lookup Encounter icon > generate/select a list of patients > click More (...) next to the letter field > select a template > Run Letter > Print ■ Registry band > Registry icon > generate/select a list of patients > click More (...) next to the letter field > select a template > Run Letter > Print ■ Patient Hub > Letters > generate/select a list of patients > click More (...) next to the letter field > select a letter > Run Letter > Print <p>IMPORTANT! Only letters using templates that have been configured as Follow-Up, Health Maintenance, or Preventive Care satisfy this measure. Letter template categories are configure from the following location: Registry band > Registry icon > click More (...) next to the letter field > select a letter > New or Update > Category</p>
<p>They are sent a health maintenance voice or text message.</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > Bump Appointment icon > Messenger ■ Patient Hub > Messenger > Send Message ■ Registry band > Patient Recall icon > Messenger ■ Registry band > Lookup Encounters icon > Messenger ■ Registry bad > Registry icon > Messenger ■ Practice band > Office Visits icon > Messenger ■ S jellybean > Messenger ■ Practice band > Resource Scheduling icon > right-click on an appointment > Messenger ■ Practice band > Telephone/Web Encounter icon > Messenger ■ T jellybean > Messenger ■ Practice Band > Labs/Imaging icon > Messenger ■ L jellybean > Messenger

Numerator Criteria	Area to Document within eClinicalWorks
	IMPORTANT! Messages must be Health Maintenance message types to satisfy this measure.
	IMPORTANT! eClinicalWorks Messenger must be enabled and configured to use this feature. For more information, refer to the <i>eClinicalWorks Messenger Users Guide</i> .
They are sent a preventive or follow-up care e-message.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Patient Hub > Send eMsg ■ Registry band > Patient Recall icon > eMsg ■ Registry band > Lookup Encounters icon > Send eMsg ■ Registry band > Lookup Encounters icon > Blast eMsgs ■ Registry band > Registry icon > Send eMessage
They are sent an alert reminder enabled for the Patient Portal.	Admin band > Patient Portal Settings icon > Feature Settings

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have had no office visits in the 24 months before the EHR reporting period.	This exclusion criteria is reported by self-attestation.

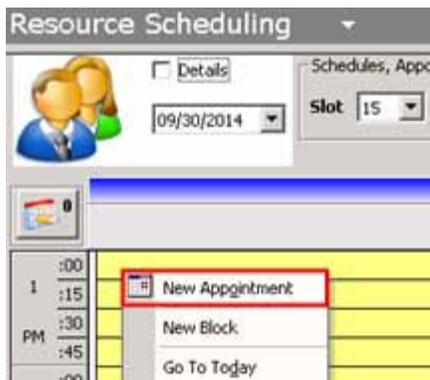
Features Related to Core 12

The following features are related to Core Measure 12:

- Recording Appointments
- Recording E&M Codes
- Recording Patients' Message Preferences
- Sending Letter Reminders
- Configuring Letter Categories
- Sending Voice or Text Message Reminders
- Sending eMessages
- Configuring Alert Reminders on the Patient Portal

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

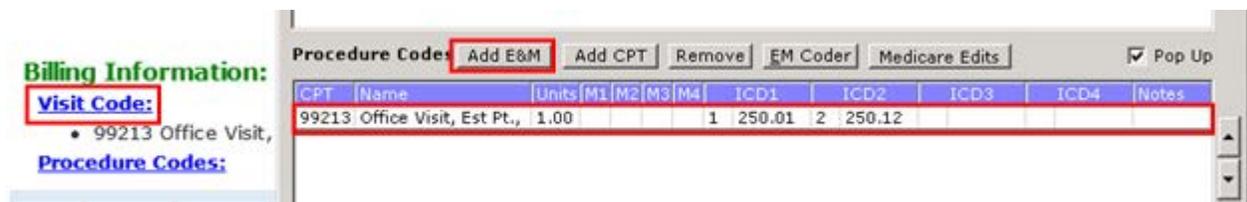


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



Recording E&M Codes

- Progress Notes > Visit Code > Add E&M

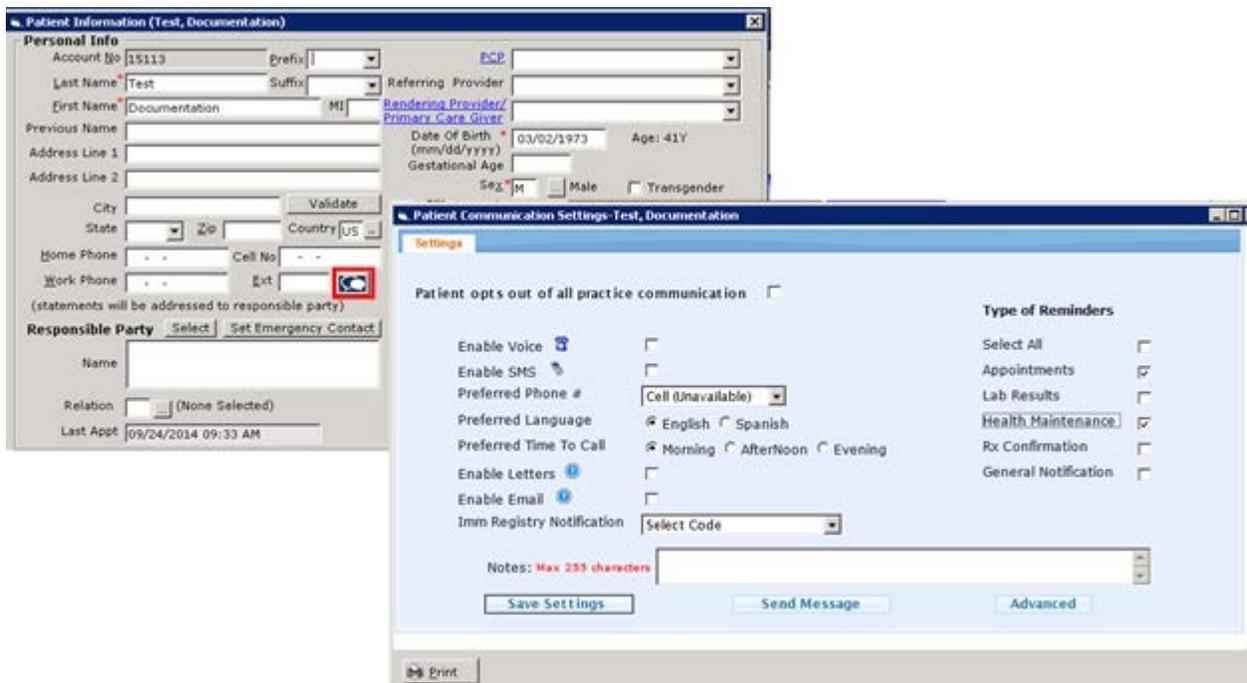


Recording Patients' Message Preferences

- Patient Hub > Messenger > Messenger Configuration



- Patient Information > Speaker icon



Sending Letter Reminders

- Registry band > Patient Recall icon > generate/select a list of patients > click More (...) next to the letter field > select a template > Run Letter > Print

Patient Recall ▾

Appointment Date | Patient | Protocol | All Labs/DI/Imm Alerts | Dx | Rx

Protocol ... Provider/Facility Filter

Report List Date(s)

Filter Patients

Age To Sex Deceased Only Inactive Only OverDue

Date of Service Filter To Search Criteria

Ignore Service Dates (Includes all the patients without encounters) Rendering Provider

Consolidated View Ignore Facility/Provider Status

<input checked="" type="checkbox"/>	Patient	Test	DOB	Sex	Age	Home Ph
<input checked="" type="checkbox"/>	166, Patient1	Influenza	02/02/1969	F	45Y	508-614-5
<input checked="" type="checkbox"/>	166, Patient2	Influenza	02/03/1969	F	45Y	508-614-5
<input checked="" type="checkbox"/>	Adkins, Christian	Influenza	02/01/2001	M	13Y	508-614-5
<input checked="" type="checkbox"/>	Adkins1, Christian	Influenza	02/01/2002	M	12Y	508-614-5
<input checked="" type="checkbox"/>	Adkins2, Christian	Influenza	02/01/2003	M	11Y 8M	508-614-5
<input checked="" type="checkbox"/>	Alcantar, Dale	Influenza	06/29/1976	M	38Y	508-614-5
<input checked="" type="checkbox"/>	Alcantar, John	Influenza	06/29/1976	M	38Y	781-271-3
<input checked="" type="checkbox"/>	Alcantar1, Dale	Influenza	06/29/1977	M	37Y	508-614-5
<input checked="" type="checkbox"/>	Alcantar1, John	Influenza	06/29/1977	M	37Y	781-271-3
<input checked="" type="checkbox"/>	Alvarez, Eddie	Influenza	02/01/1942	M	72Y	508-614-5
<input checked="" type="checkbox"/>	Alvarez1, Eddie	Influenza	02/01/1943	M	71Y	508-614-5
<input checked="" type="checkbox"/>	Alvarez2, Eddie	Influenza	02/01/1944	M	70Y	508-614-5
<input checked="" type="checkbox"/>	Barber, Andy	Influenza	08/01/1987	M	27Y	508-614-5
<input checked="" type="checkbox"/>	Barber1, Andy	Influenza	08/01/1988	M	26Y	508-614-5
<input checked="" type="checkbox"/>	Barber2, Andy	Influenza	08/01/1989	M	25Y	508-614-5
<input checked="" type="checkbox"/>	Barnett, Alfredo	Influenza	02/01/1942	M	72Y	508-614-5

Letter ▾ Letter/Tests Due ... Run Letter(s) ▾ Pt Hub New Appt Status

- Registry band > Lookup Encounter icon > generate/select a list of patients > click More (...) next to the letter field > select a template > Run Letter > Print

Lookup Encounters

Provider(s) Willis, Sam,Multi
 Service Date(s) 01/01/2013 to 10/08/2014
 Place of Service
 Date Of Birth 1 / 1 /1902 to 10/ 8 /2014
 Visit Status ALL
 Visit Types ALL

Rx
 Diagnosis (ICD) 401.9:Unspecified essential
 Procedure (CPT/HCPCS)
 Sort By DOB
 Show Unique Patients

	Patient	DOB	Sex	Age	Tel
<input checked="" type="checkbox"/>	Test, Test	09/09/2001	M	13	508-614-5849

View Progress Notes Patient Hub New Appointment Alerts Copy Messenger
Choose Letter Letter/Annual Physical Run Letter Send eMsg Blast eMsgs

- Registry band > Registry icon > generate/select a list of patients > click More (...) next to the letter field > select a template > Run Letter > Print

Registry

Imm / T. Inj Encounters Structured Data

Demographics Vitals Labs / DI / Proc.

Age Range: 13 - 100 M PCP: _____

Sex: Female Ren Provid: _____

Zip Code: _____ Facility: _____

DOB (Actual): 10/08/2014 - 10/08/2014 Insurance: _____

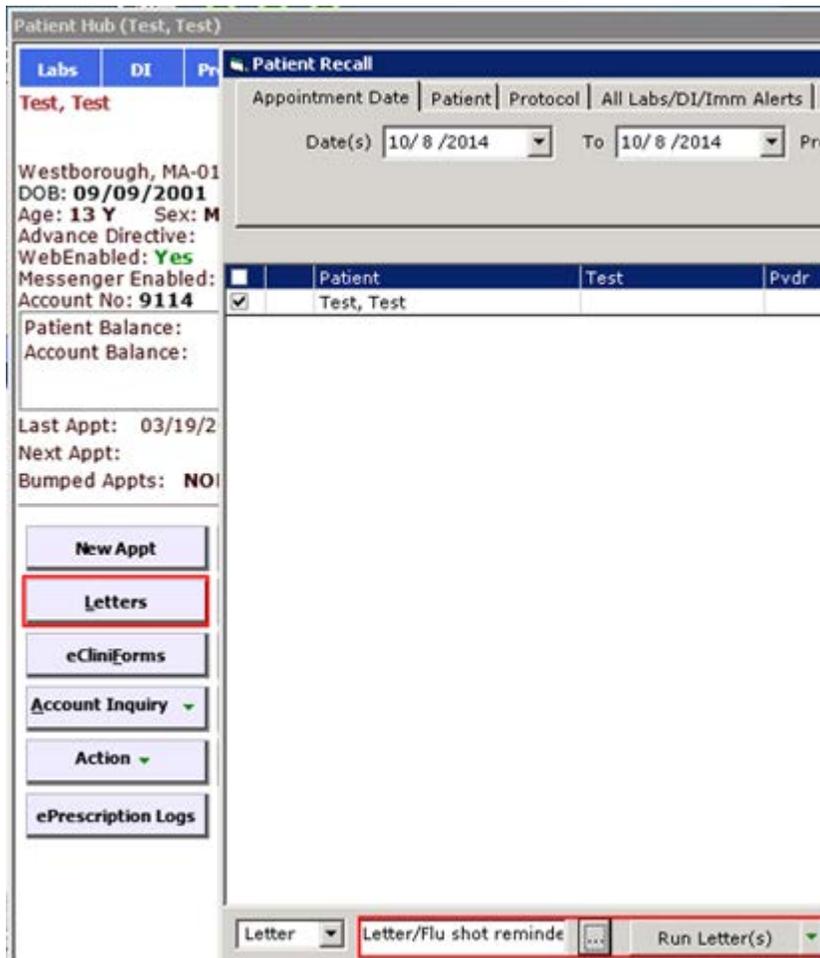
All ...

<input checked="" type="checkbox"/>	Patient Name	DOB	Sex	Age	T
<input checked="" type="checkbox"/>	166, Patient1	02/02/1969	f	45Y	508-I
<input checked="" type="checkbox"/>	166, Patient2	02/03/1969	f	45Y	508-I
<input type="checkbox"/>	w Benson2, Wanda	10/31/1999	f	14Y	508-I
<input type="checkbox"/>	w Brewer2, Kristen	12/01/1990	f	23Y	508-I
<input type="checkbox"/>	w Crawford2, Barbara	02/01/1984	f	30Y	508-I
<input checked="" type="checkbox"/>	Crawford2, Elizabeth	02/01/1984	f	30Y	781-I
<input type="checkbox"/>	w Criss1, Amanda	10/31/1994	f	19Y	781-I
<input type="checkbox"/>	w Criss1, Kristin	10/31/1994	f	19Y	508-I
<input type="checkbox"/>	w Curtis2, Anita	02/02/1939	f	75Y	508-I
<input type="checkbox"/>	w Edwards2, April	02/01/1997	f	17Y	508-I
<input type="checkbox"/>	w Evans2, Peggy	10/31/1999	f	14Y	508-I
<input type="checkbox"/>	w Evans2, Virginia	02/01/1997	f	17Y	508-I
<input type="checkbox"/>	w Farrell1, Amy	12/02/1950	f	63Y	781-I
<input type="checkbox"/>	w Farrell1, Ella	12/02/1950	f	63Y	508-I
<input type="checkbox"/>	w Fox2, Dolly	09/01/1964	f	50Y	781-I

Encounters :: From Date >= 01/01/2014 AND To Date <= 10/08/2014 AND
Demographics :: Sex=Female AND AND Show =All
Labs :: NOT [Mode=Labs AND Name=Pap Test AND Date >= 10/08/2014 AND AND Show =All
Demographics :: Age >= 12 AND Age <= 100 AND Sex=Female AND AND Show =All

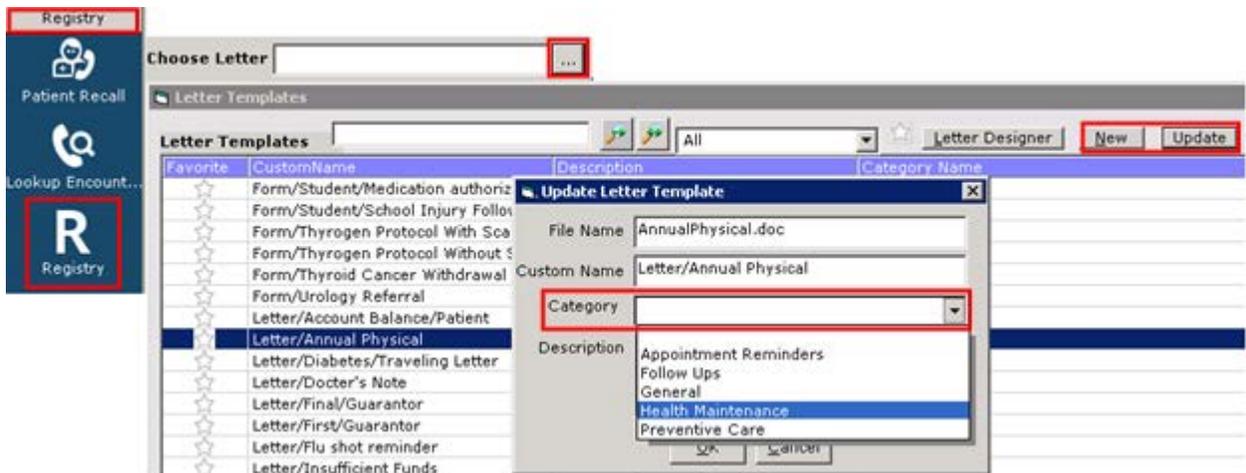
Letter Letter/Tests Due ... Run Letter < Prev Next

- Patient Hub > Letters > generate/select a list of patients > click More (...) next to the letter field > select a letter > Run Letter > Print



Configuring Letter Categories

- Registry band > Registry icon > click More (...) next to the letter field > select a letter > *New* or *Update* > Category



Sending Voice or Text Message Reminders

- Practice band > Resource Scheduling icon > Bump Appointment icon > Messenger

The screenshot displays the eClinicalWorks interface for sending reminders. The top window, titled 'Resource Scheduling', shows a 'Bump List' for provider 'Sant2, Stephen' with an appointment on 2014-10-01. The bottom window, titled 'Messenger Templates', shows a list of templates and a 'Voice' message editor. A red box highlights the 'Send' button in the messenger editor, which has a dropdown menu with 'Send voice' and 'Send SMS/Text' options.

Template	Msg Type	CreatedBy
Child Pneumonia (B)	healthMaintenance	lan
Child Pneumonia (A)	healthMaintenance	lan
Child MMR (B)	healthMaintenance	lan
Child MMR (A)	healthMaintenance	lan
Child Flu (B)	healthMaintenance	lan
Child Flu (A)	healthMaintenance	lan
Appointment Child (B)	appointment	lan
Appointment Child (A)	appointment	lan
Appointment Adult (B)	appointment	lan
Appointment Adult (A)	appointment	lan
Adult Pneumonia (B)	healthMaintenance	lan
Adult Pneumonia (A)	healthMaintenance	lan
Adult Flu (B)	healthMaintenance	lan
Adult Flu (A)	healthMaintenance	lan
New	appointment	lan
Lipids Control (B)	healthMaintenance	lan
Lipids Control (A)	healthMaintenance	lan
Hypertension Control (B)	healthMaintenance	lan
Hypertension Control (A)	healthMaintenance	lan
Child DTaP# (B)	healthMaintenance	lan

Message Editor Content:

Character: 0 child Appt Confirmation Send Message

Keywords: English Live English Machine Spanish Live Spanish Machine

Character: 64

Buttons: Call & Record, Record Now, Send, Cancel

- Patient Hub > Messenger > Send Message

The screenshot shows the Patient Hub interface for a patient named Test, Test. The patient's information includes: Home: 508-614-5849, Work: 508-614-5849, Email: test@gmail.com, Age: 13 Y, Sex: M, and Account No: 9314. The Patient Balance and Account Balance are both \$0.00. The last appointment was on 03/19/2014 at 01:00 PM. The facility is Internal - DEMO DASHBOARD. The Case Manager is Hc. The Messenger icon is highlighted in red in the bottom right of the patient details section.

The Patient Communication Settings window is open, showing that Test, Test is Web Enabled. The Username is TestTest2001. The Email field is set to test@gmail.com. The Voice Call and Text options are checked. The Text language is set to English. The Reminder Types section has Appointments and Clinical checked. The Notes field contains "Flu shot due". The Send Message button is highlighted in blue.

- Registry band > Patient Recall icon > Messenger

The screenshot shows the Patient Recall interface. The search filters include: Protocol: Influenza, Provider/Facility Filter: All Facilities/All Patients, Report List: (empty), Date(s): 10/08/2014, Due By: (empty). The Filter Patients section includes Age, Sex, Deceased Only, Inactive Only, OverDue, and Diagnosis (ICD-9). The Date of Service Filter is set from 01/01/2000 to 10/08/2014. The Search Criteria is Based on tests not ordered. The Rendering Provider is All Providers. The LookUp button is highlighted in blue.

The patient list shows two entries for Sanders, Gwendolyn. The second entry is highlighted in red. The Messenger icon is highlighted in red in the bottom right of the patient list section.

The Send Messages window is open, showing the Unified Patient Communication interface. The General Options section has the Reminder Type set to Health Maintenance. The Options For All Patients section has the Message Template set to select a template, and the Message Type set to Health Maintenance. The Send Message To All Patients button is highlighted in blue.

The patient list at the bottom shows the following information for Sanders, Gwendolyn: Name, Home Phone: 508-614-5849, Cell Phone: 774-275-0536, Work Phone, Preferred Phone: 774-275-0536 (cell), Text, vMessage, and PLINB.

- Registry band > Lookup Encounters icon > Messenger

Lookup Encounters

Provider(s): Wills, Sam, Mult
 Service Date(s): 01/01/2014 to 10/08/2014
 Diagnosis (ICD): 401.9:Unasp
 Procedure (CPT/HCPCS):
 Date Of Birth: 1 / 1 /1902 to 10 / 8 /2014
 Visit Status: ALL
 Visit Types: ALL

Patient	DOB	Sex	Age	Tel
Simpson, Olga	09/09/2003	F	11	508-614-5849

Buttons: Patient Hub, New Appointment, Alerts, Copy, **Messenger**

Unified Patient Communication

General Options: Reminder Type: Health Maintenance

Options For All Patients:
 Message Templates: [select a template]
 vMsg enabled patients only unique numbers
 Message Type: Health Maintenance
 Caller Id Number:
 Voice SMS/TEXT Patient Preference

Name	Home Phone	Cell Phone	Work Phone	Preferred Phone	Text	vMessage	PLHub
Simpson, Olga	508-614-5849	774-545-5654		774-545-5654 (cell)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

- Registry band > Registry icon > Messenger

Registry

Demographics | Vitals | Labs / DI / Proc | ICD | CPT | Rx | Chief Complaint

Encounters: Date Range: 1 / 1 /2014 to 10 / 8 /2014
 Appt. Provider: [text]
 Visit Type: ALL

Buttons: Run Letter, Copy, Messenger

Unified Patient Communication

General Options: Reminder Type: Health Maintenance

Options For All Patients:
 Message Templates: [select a template]
 vMsg enabled patients only unique numbers
 Message Type: Health Maintenance
 Caller Id Number:
 Voice SMS/TEXT Patient Preference

Name	Home Phone	Cell Phone	Work Phone	Preferred Phone	Text	vMessage	PLHub
Sanders, Gwendolyn	508-614-5849	774-275-0536		774-275-0536 (cell)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

- Practice band > Office Visits icon > Messenger

The screenshot displays the eClinicalWorks interface. At the top, the 'Office Visits' section is active, showing a list of visits for 'Wills, Sam Multi'. The 'Office Visits' icon in the left sidebar is highlighted with a red box. Below the list, the 'Messenger Templates' window is open, showing a table of templates and a message composition area. The 'Message' button in the top right corner of the window is also highlighted with a red box.

Visit Type	Appt. Time	Entered Name	P/R	No. Appt.	Sex / Age	Visit No.	Acc. Time	Duration	Room	Status	Index No.
IMIG	09:00 AM	Ralston2, Donna		010	F 23 Y	1	09:00				
Migrated	11:00 AM	Morris2, Tammy			F 23 Y						
Migrated	11:00 AM	Morris2, Bobbie			F 23 Y						

Template	Msg Type	Created By
Child Pneumonia (B)	healhhMaintenance	sam
Child Pneumonia (S)	healhhMaintenance	sam
Child IMR (B)	healhhMaintenance	sam
Child IMR (S)	healhhMaintenance	sam
Child Flu (B)	healhhMaintenance	sam
Child Flu (S)	healhhMaintenance	sam
Appointment Child (B)	appointment	sam
Appointment Child (S)	appointment	sam
Appointment Adult (B)	appointment	sam
Appointment Adult (S)	appointment	sam
Adult Pneumonia (B)	healhhMaintenance	sam
Adult Pneumonia (S)	healhhMaintenance	sam
Adult Flu (B)	healhhMaintenance	sam
Adult Flu (S)	healhhMaintenance	sam
New	appointment	sam
Lipids Control (B)	healhhMaintenance	sam
Lipids Control (S)	healhhMaintenance	sam
Hypertension Control (B)	healhhMaintenance	sam
Hypertension Control (S)	healhhMaintenance	sam
Child DTSP 4 (B)	healhhMaintenance	sam

Message Composition Area:

Keywords: English Live, English Machine, Spanish Live, Spanish Machine

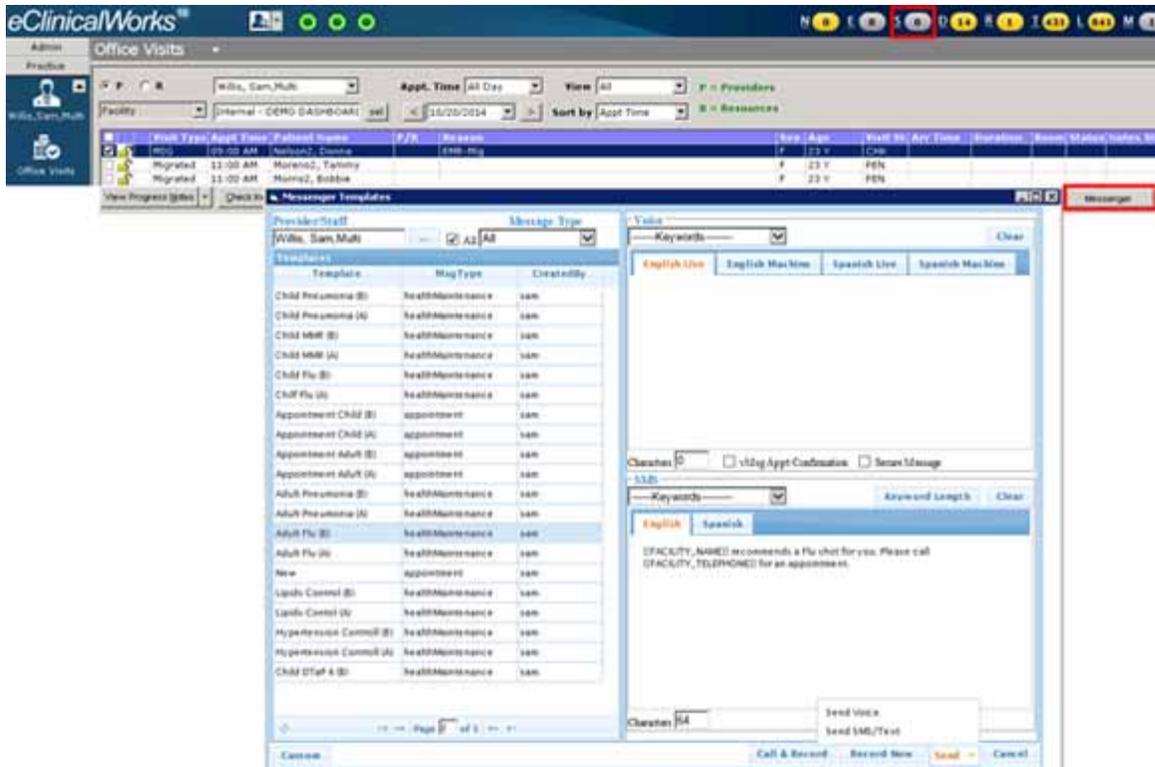
Characters: 0

Keywords: English, Spanish

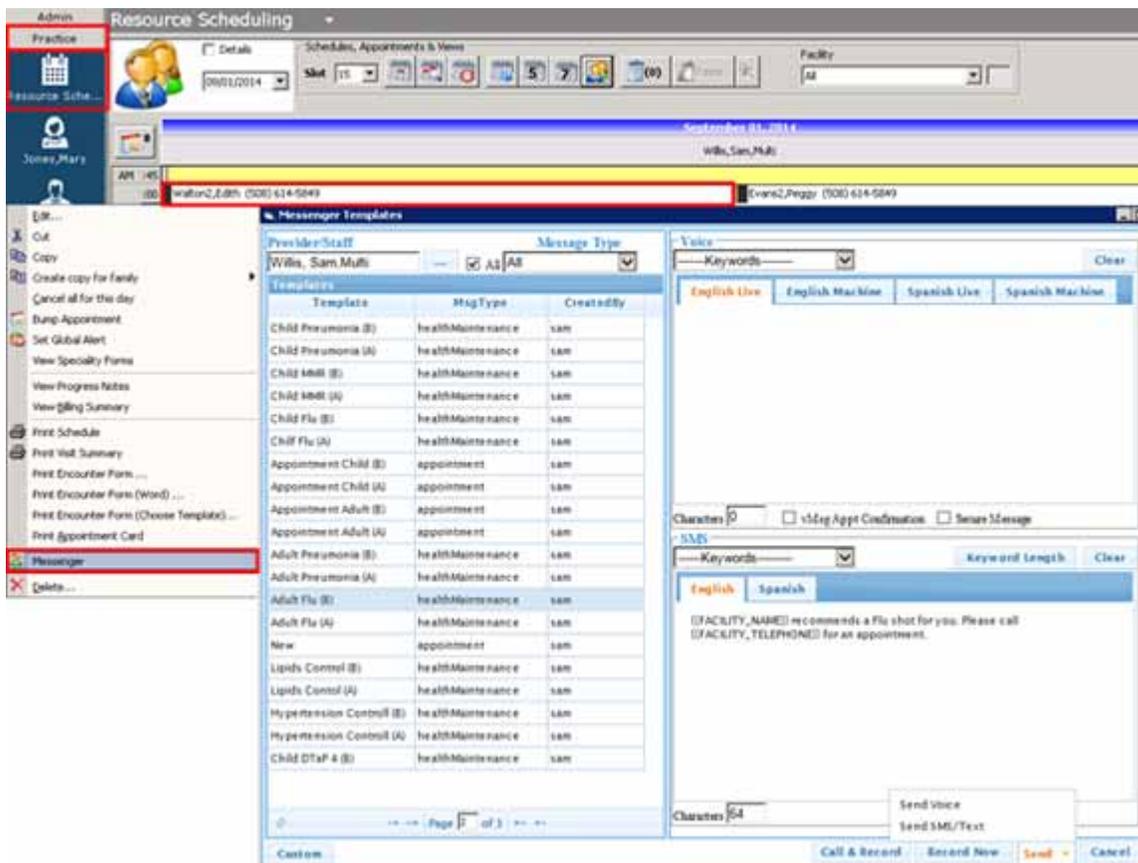
Message Content: {FACILITY_NAME} recommends a Flu shot for you. Please call {FACILITY_TELEPHONE} for an appointment.

Buttons: Call & Record, Record Now, Send, Cancel

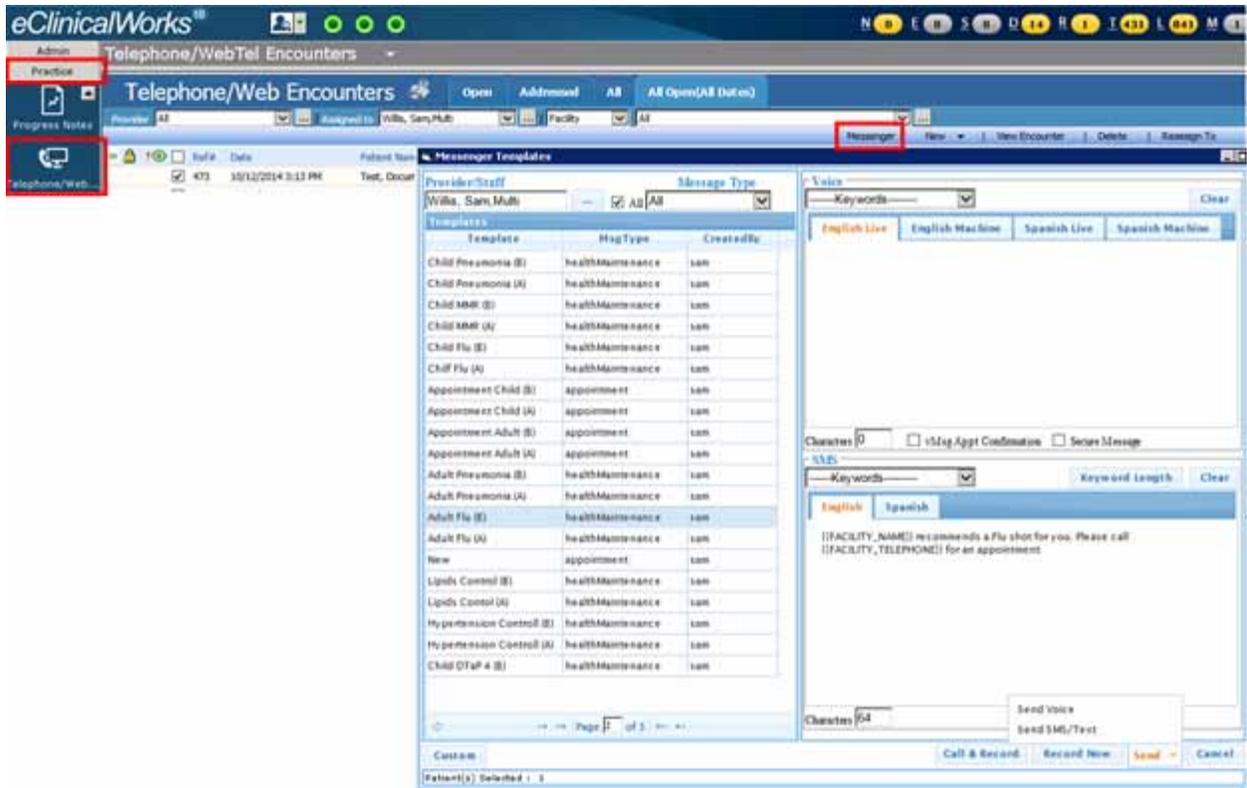
- S jellybean > Messenger



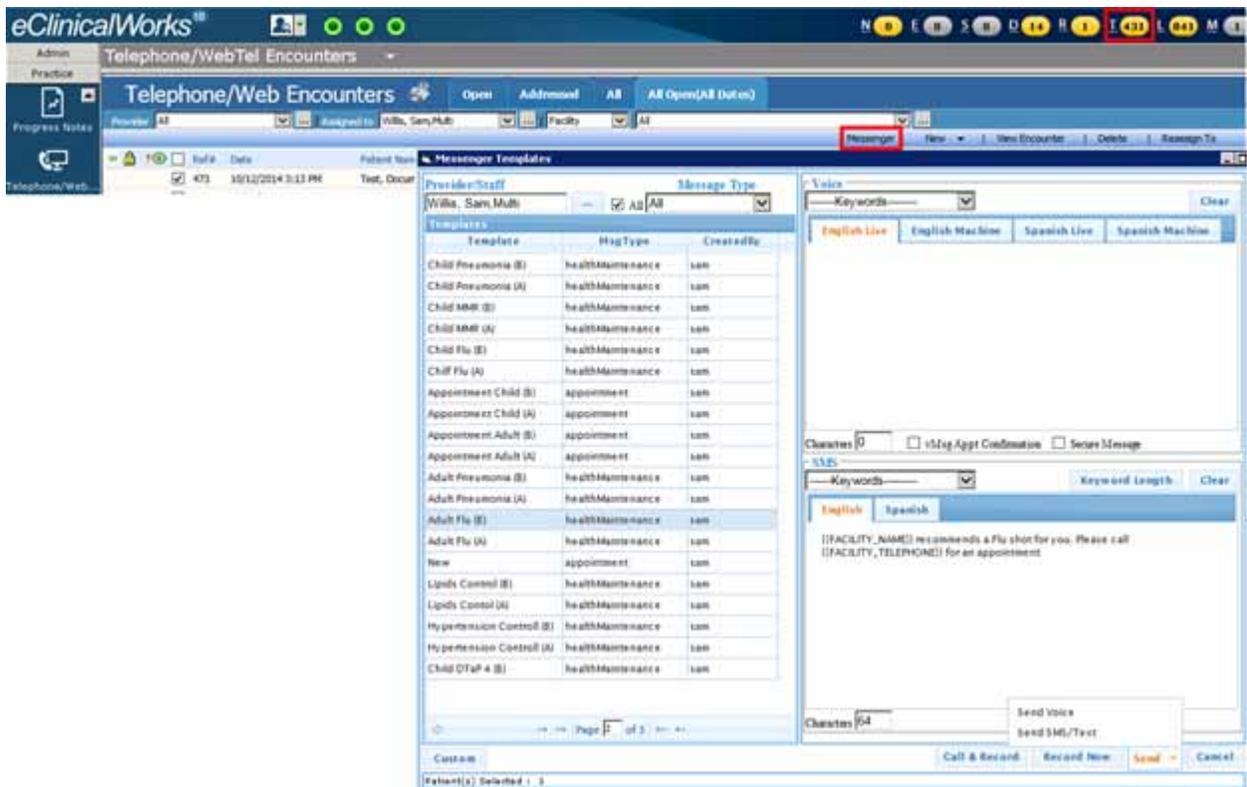
- Practice band > Resource Scheduling icon > right-click on an appointment > Messenger



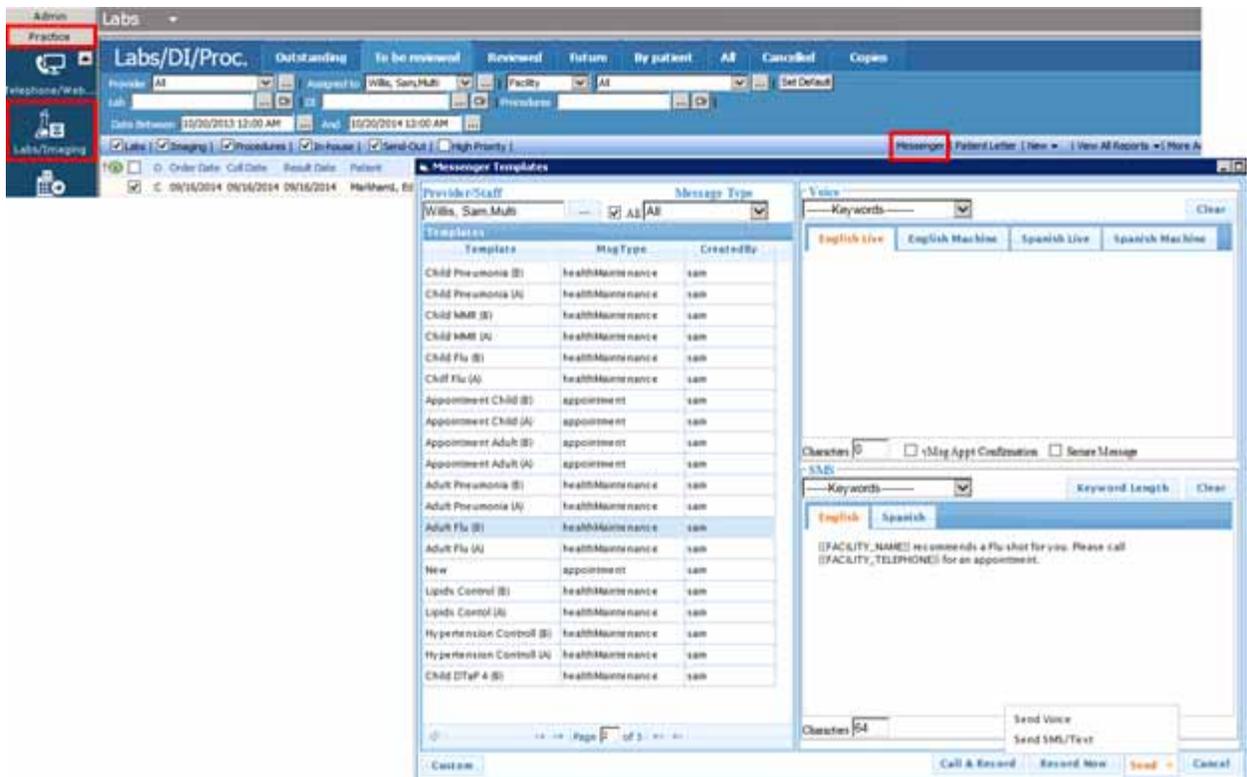
- Practice band > Telephone/Web Encounter icon > Messenger



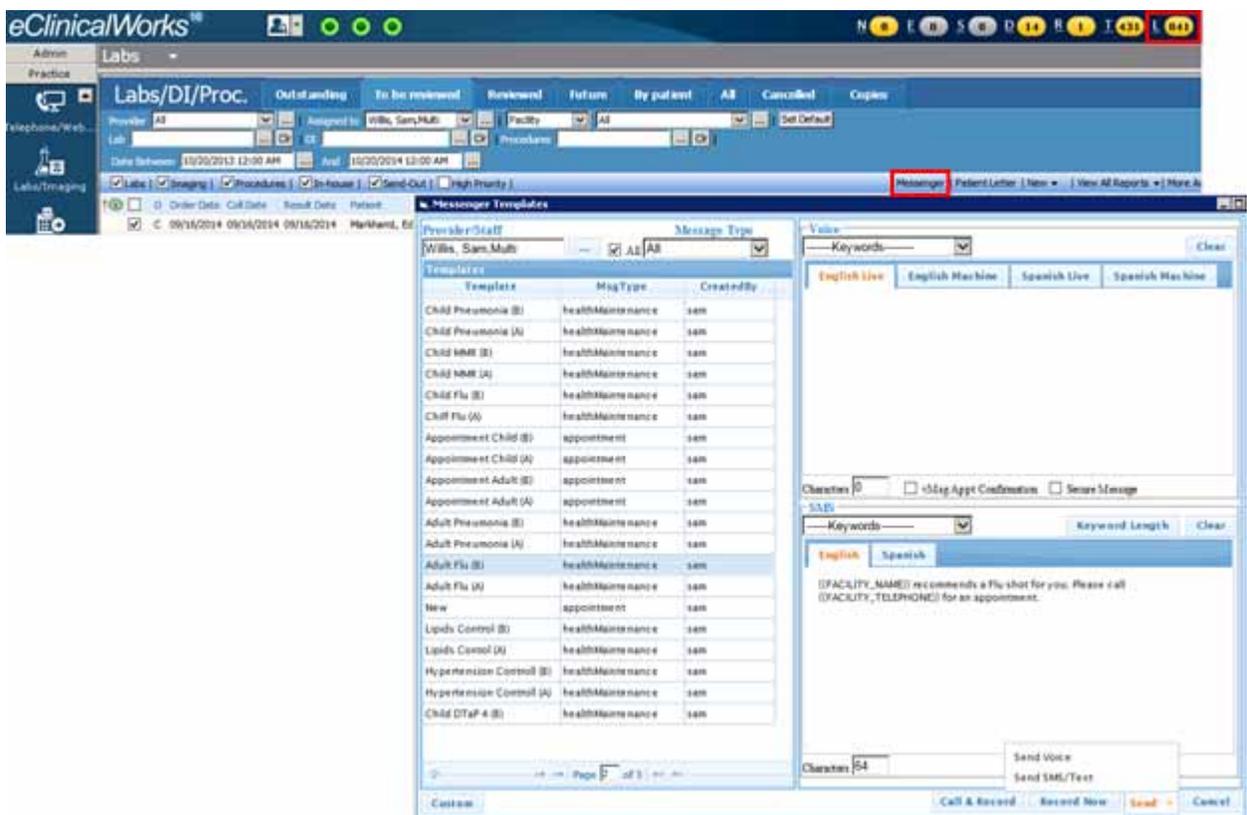
- T jellybean > Messenger



- Practice Band > Labs/Imaging icon > Messenger

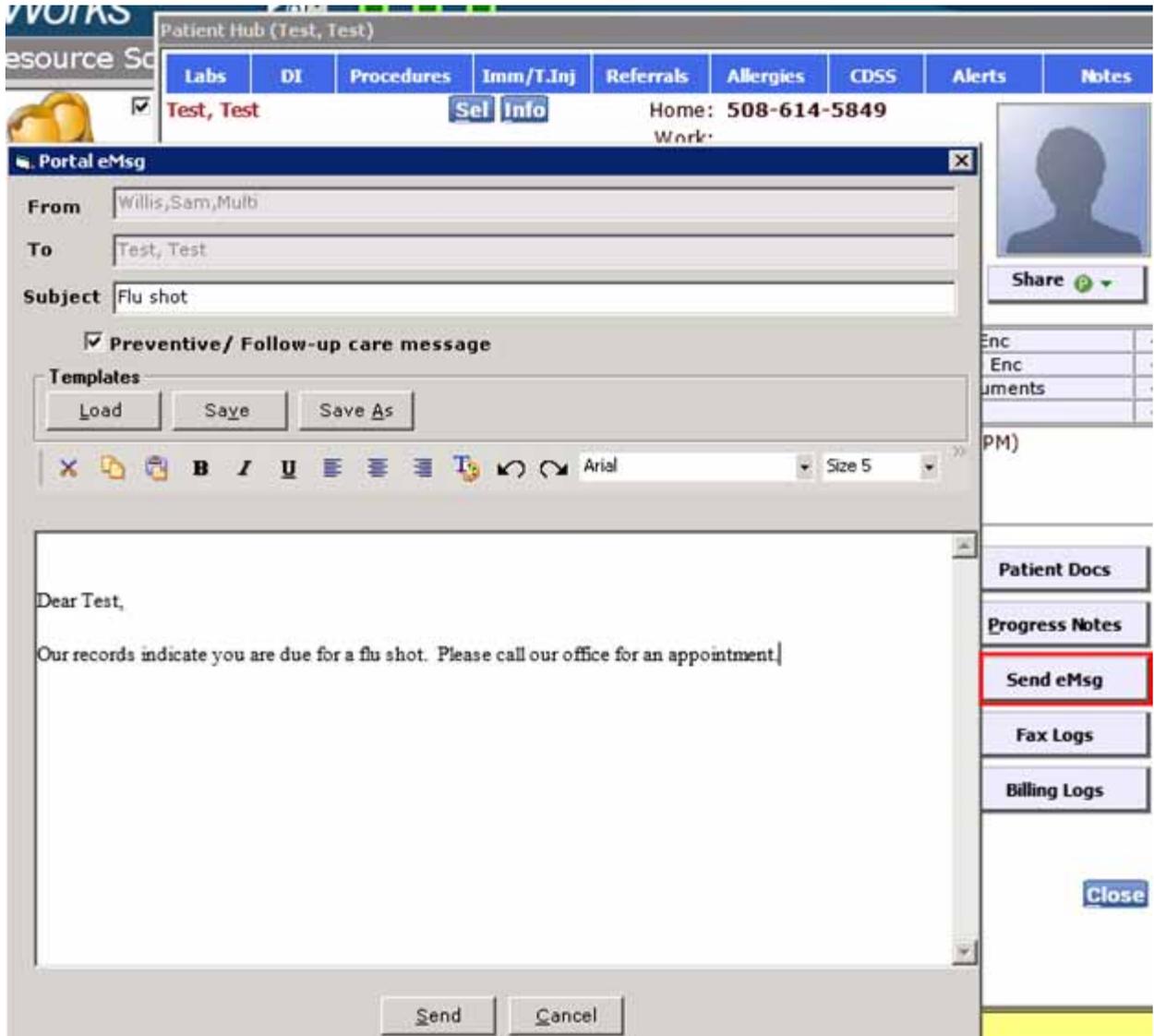


- L jellybean > Messenger



Sending eMessages

- Patient Hub > Send eMsg



- Registry band > Patient Recall icon > eMsg

The screenshot displays the 'Patient Recall' application window. At the top, there are tabs for 'Appointment Date', 'Patient', 'Protocol', 'All Labs/DI/Imm Alerts', 'Dx', and 'Rx'. The 'Protocol' dropdown is set to 'Influenza,' and the 'Provider/Facility Filter' is 'ALL Facilities/All Patients'. Below this, there are fields for 'Report List', 'Date(s)' (10/08/2014), and 'Due By'. A 'Filter Patients' section includes options for 'Age', 'Sex' (Both), 'Deceased Only', 'Inactive Only', 'OverDue', and 'Diagnosis (ICD-9)'. It also features a 'Date of Service Filter' (01/01/2002 to 10/08/2014), 'Search Criteria' (Based on tests not ordered), 'Rendering Provider' (All Providers), and checkboxes for 'Consolidated View' and 'Ignore Facility/Provider'. A 'LookUp' button is visible on the right.

Below the filters is a table of patient records. The first row is selected and shows: Sanders, Gwendolyn | Influenza | 02/01/1967 | F | 47Y | 508-614-5849 | No Record | Now | 06/25/2012. A 'Letter' dropdown is positioned to the left of the table.

An 'Portal eMsg' window is overlaid on the right side of the Patient Recall window. The 'eMsg' label in the window's title bar is highlighted with a red box. The message content is as follows:

From: Willis, Sam, Multi
To: Sanders, Gwendolyn
Subject: Flu shot

Preventive/ Follow-up care message

Templates: [Load] [Save] [Save As]

Dear Mrs Sanders,
 Our records indicate you are due for your Flu shot. Please call our office to set up an appointment.
 Thank you,
 Dr Office

[Send] [Cancel]

- Registry band > Lookup Encounters icon > Send eMsg

Lookup Encounters

Provider(s) Willis, Sam,Multi
 Service Date(s) 01/01/2014 to 10/08/2014
 Place of Service
 Date Of Birth 1 / 1 /1902 to 10/ 8 /2014
 Visit Status ALL
 Visit Types ALL

Rx
 Diagnosis (ICD) 401.9:Un:
 Procedure (CPT/HCPCS)
 Sort By DOB
 Show t

	Patient	DOB	Sex	Age	Tel
<input checked="" type="checkbox"/>	Test, Test	09/09/2001	M	13	508-614-5849

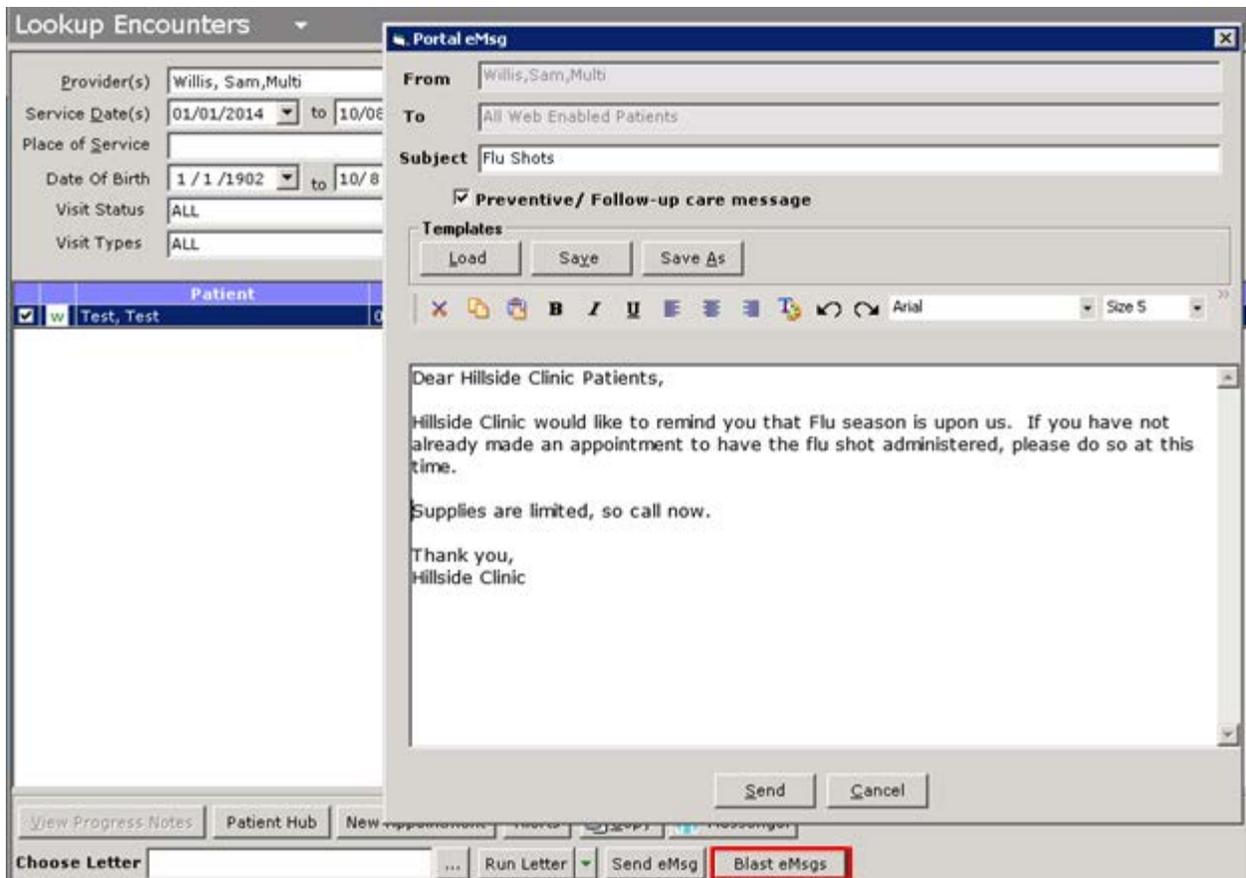
View Progress Notes Patient Hub New Appointment Alerts Copy Messenger

Choose Letter Run Letter **Send eMsg** Blast

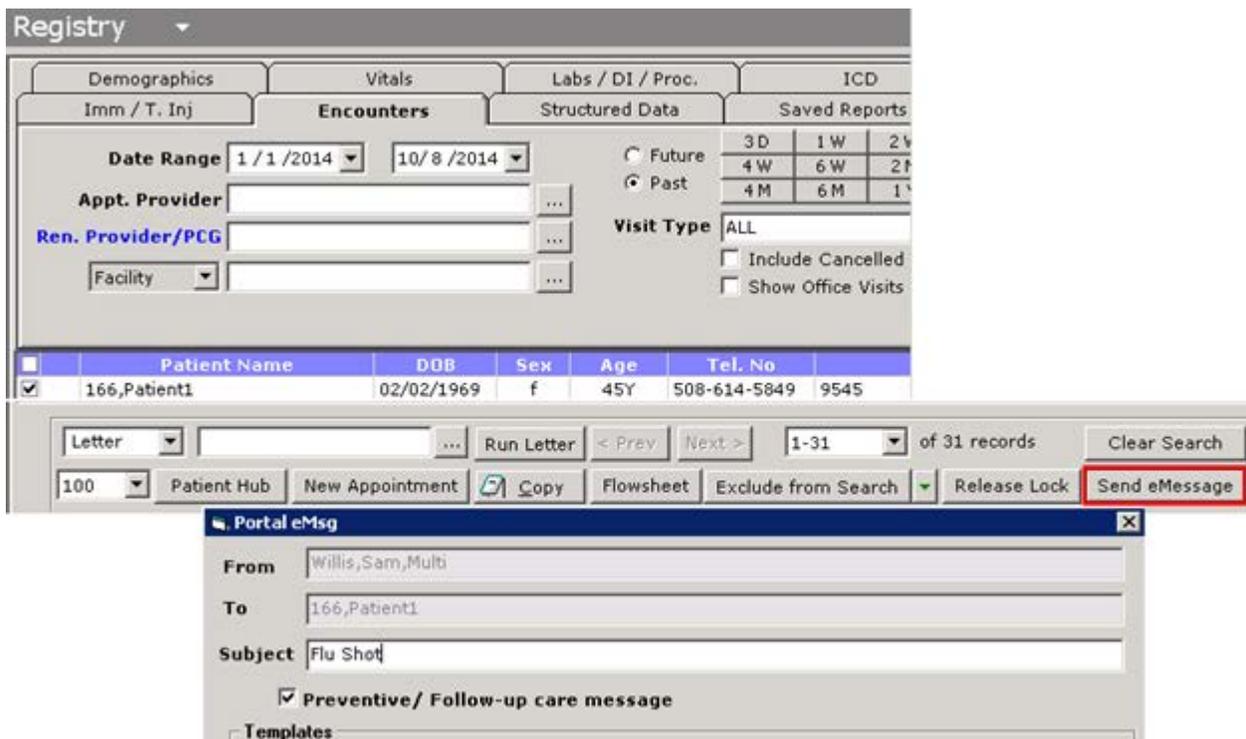
Portal eMsg

From Willis, Sam,Multi
 To Test, Test
 Subject Flu shot
 Preventive/ Follow-up care message

- Registry band > Lookup Encounters icon > Blast eMsgs

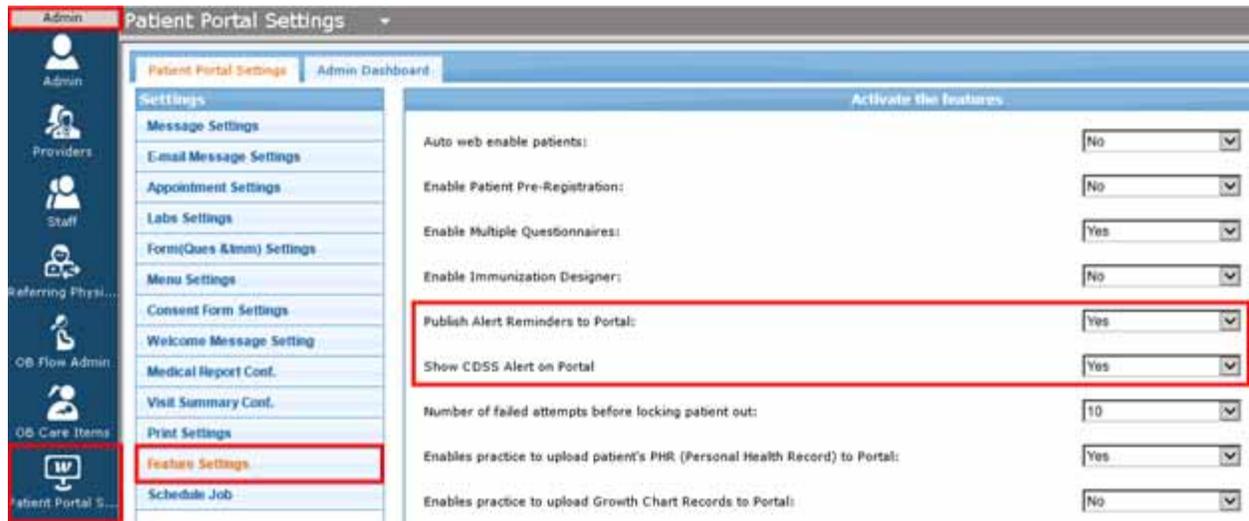


- Registry band > Registry icon > Send eMessage



Configuring Alert Reminders on the Patient Portal

- Admin band > Patient Portal Settings icon > Feature Settings



Core 13: Patient-Specific Education Resources



Enhanced Feature

Objective

Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

Measure

Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy at least ONE of the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have had at least one (1) piece of education printed or published	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Progress Notes > Treatment > Education > Rx Education > Medications (English) or Medications (Spanish) > View Rx Education > Print ■ Progress Notes > Treatment > Education > Patient Education > Print* ■ Progress Notes > Treatment > Education > Patient Education > Publish to Portal check box* ■ Progress Notes > Treatment > OS icon > Patient Education > PDF or Web Reference > Order ■ Progress Notes > Send > For Patients <p>IMPORTANT! Custom education given through Progress Notes > Treatment > Education > Custom Education does not count toward the numerator because it does not use patients' clinical information stored in the CEHRT to identify that resource.</p> <p>Note: In May 2015, per CMS FAQ 8231, this measure was modified to consider education material given in the year 2015 to receive credit for the numerator. Any material given prior to 2015 was not considered in the numerator calculations. CMS has revoked this FAQ until further notice, and as per CMS, the measure calculations must be reverted to the specifications prior to the FAQ 8231 release. The change now states that education material given any time prior to the attestation date satisfies this numerator. This change will be released in late July 2015. Please refer to my.eclinicalworks.com for updates as they become available.</p>

*. Users must be signed up with one of the education partners to have access to Patient Education * feature. For EPs attesting after Q2 2014, all of eClinicalWorks' education vendors (which includes Healthwise, ADAM, and Krames) are 2014-certified.

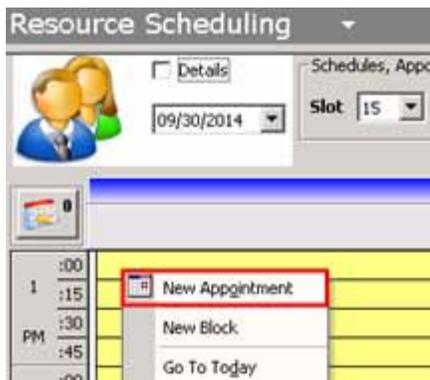
Features Related to Core 13

The following features are related to Core Measure 13:

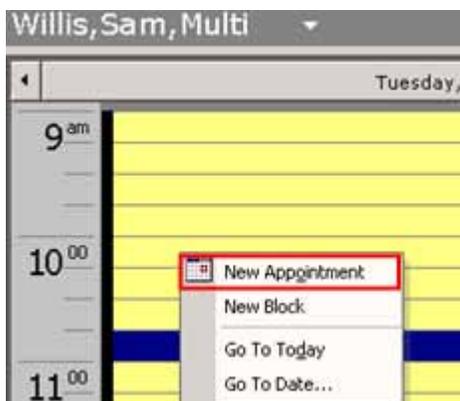
- [Recording Appointments](#)
- [Recording E&M Codes](#)
- [Printing and Ordering Education](#)

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

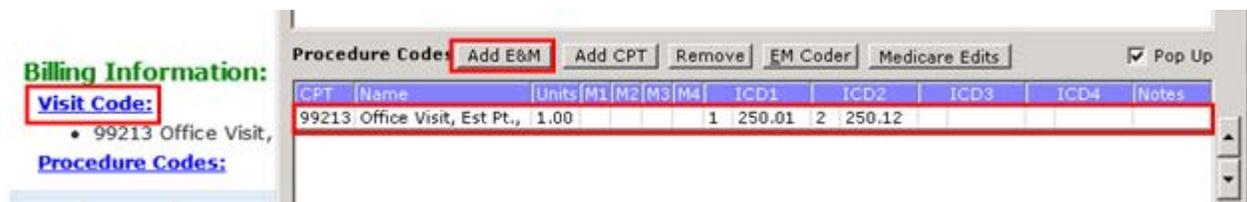


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment

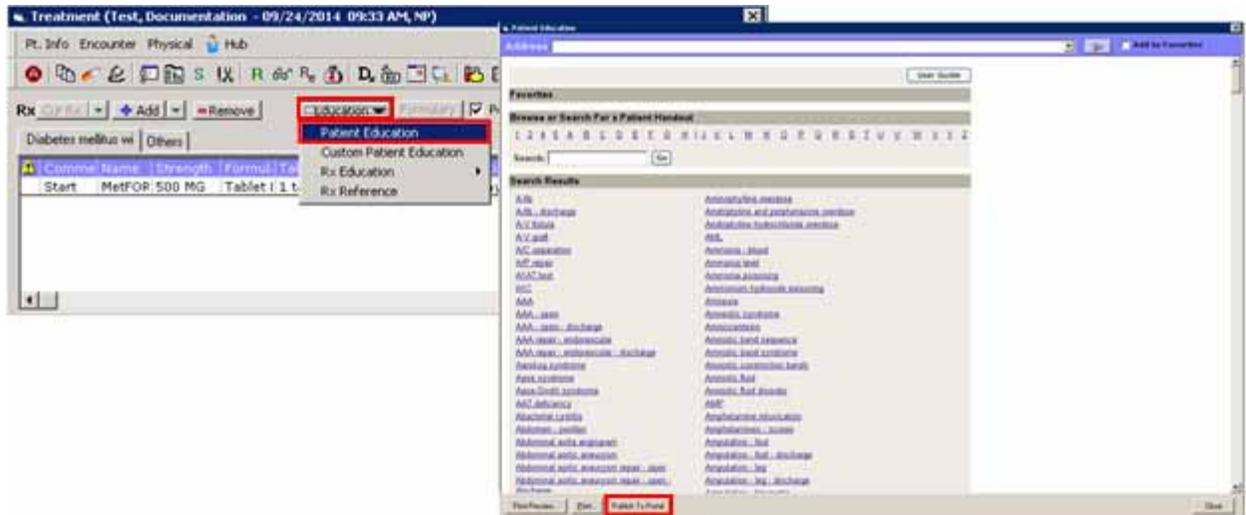


Recording E&M Codes

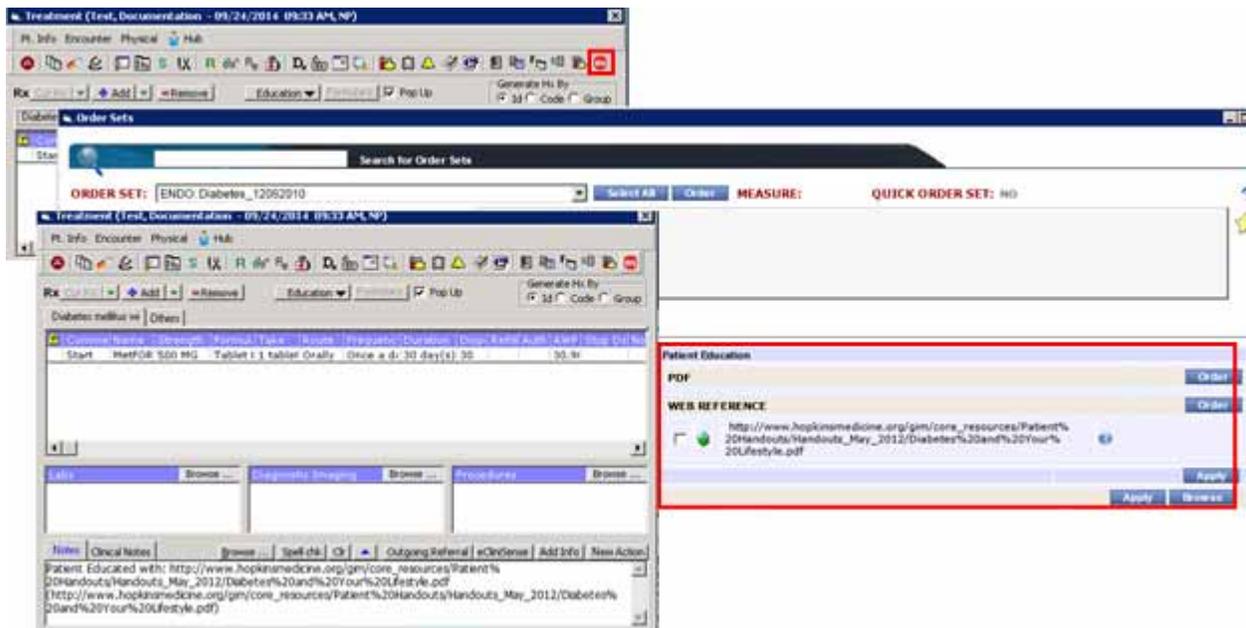
- Progress Notes > Visit Code > Add E&M



- Progress Notes > Treatment > Education > Patient Education > Publish to Portal check box



- Progress Notes > Treatment > OS icon > Patient Education > PDF or Web Reference > Order



- Progress Notes > Send > For Patients

Progress Notes

Test, Documentation, 41 Y, M **Sel Info Hub** Allergies Billing Alert

DOB: 03/02/1973 Appt(L): 09/24/14(SW) Ins: Self Pay
Language: Acc Bal: \$0.00
Translator: No Guar:

CLICK TO EDIT

Medical Summary | CDSS | Labs | DT | Procedures | Growth Chart | Imm/T.Ini | Encounters | Patient

SF

Common Send

Test, Documentation, 3/2/1973, M

Patient Orders **For Patients**

Patient Education Material

Patient Education Diabetes mellitus without

Visit Summary

Print Visit Summary

Immunization

Print Patient Vaccine Administration Record

Print State forms AL

Rx Rx Education

Print Rx Education Materials

Send Print

Plan:
Treatment
Diabetes
Start
day, 30 day
Procedure
Immunization
Therapeutic
Diagnostic
Lab Report
Preventive
Next Appointment

Billing Information
Visit Code
Procedure

Core 14: Medication Reconciliation

Objective

The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Measure

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

Denominator

Patients are included in the denominator if they satisfy ALL of the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an appointment created for them with the <i>Transition of care</i> box checked during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on time slot > New Appointment > Transition of Care check box ■ Practice band > Resource Scheduling icon > double-click on appointment > Transition of Care check box ■ Practice band > Provider Schedule icon > right-click on time slot > New Appointment > Transition of Care check box ■ Practice band > Provider Schedule icon > double-click on appointment > Transition of Care check box ■ Progress Notes > Chief Complaints > Transition of Care check box
They have a valid Outpatient CPT* code recorded for the <i>Transition of care</i> appointment.	Progress Notes > Visit Code > Add E&M

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Note: Telephone Encounters are not counted as appointments. Patients with only Telephone Encounters are not included in the denominator for this measure.

Numerator

Patients in the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
Their medications are reconciled and marked as verified.	Progress Notes > Current Medication > Verified check box

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They were not the recipient of any transitions of care during the reporting period.	This exclusion criteria is reported by self-attestation.

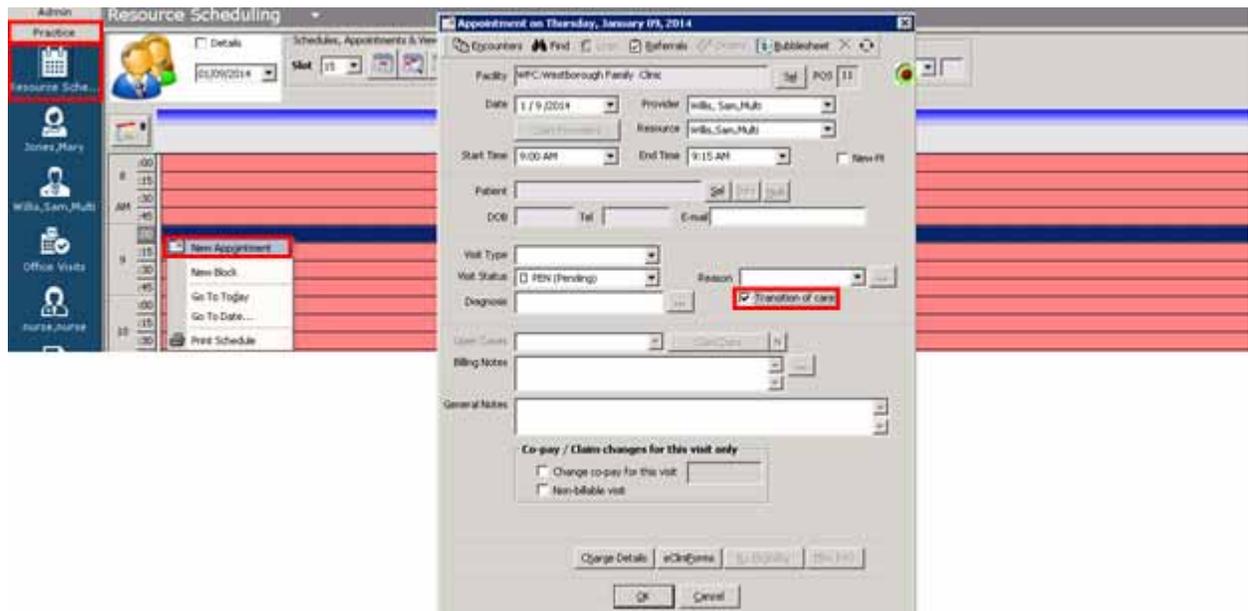
Features Related to Core 14

The following features are related to Core Measure 14:

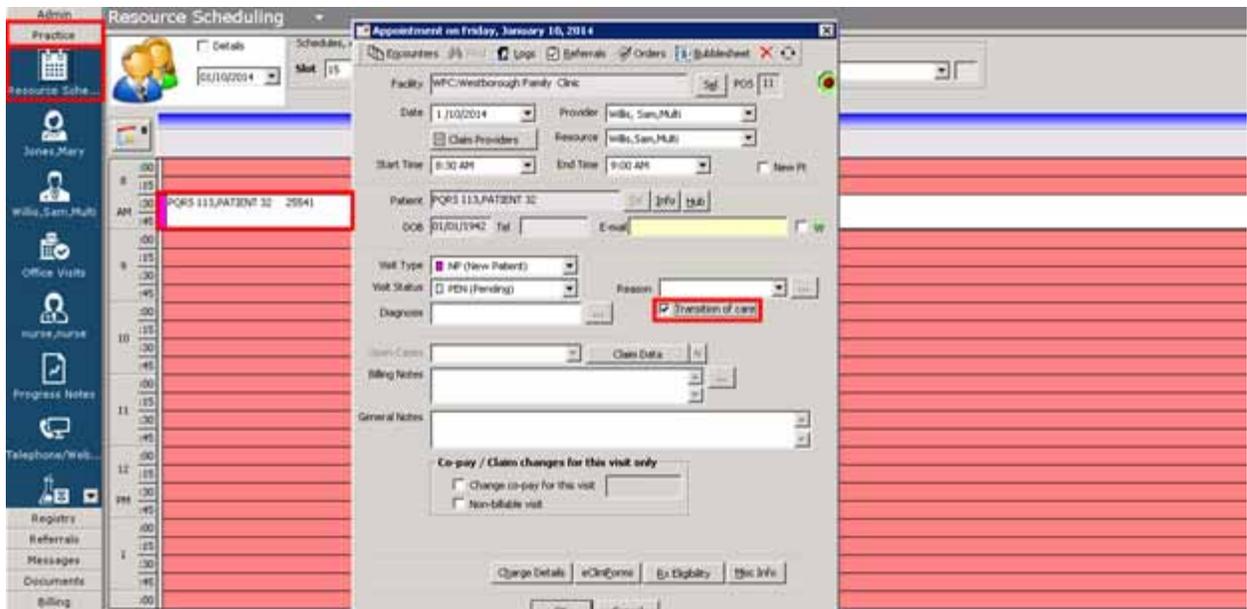
- Recording a Transition of Care
- Recording E&M Codes
- Recording Medication Reconciliation

Recording a Transition of Care

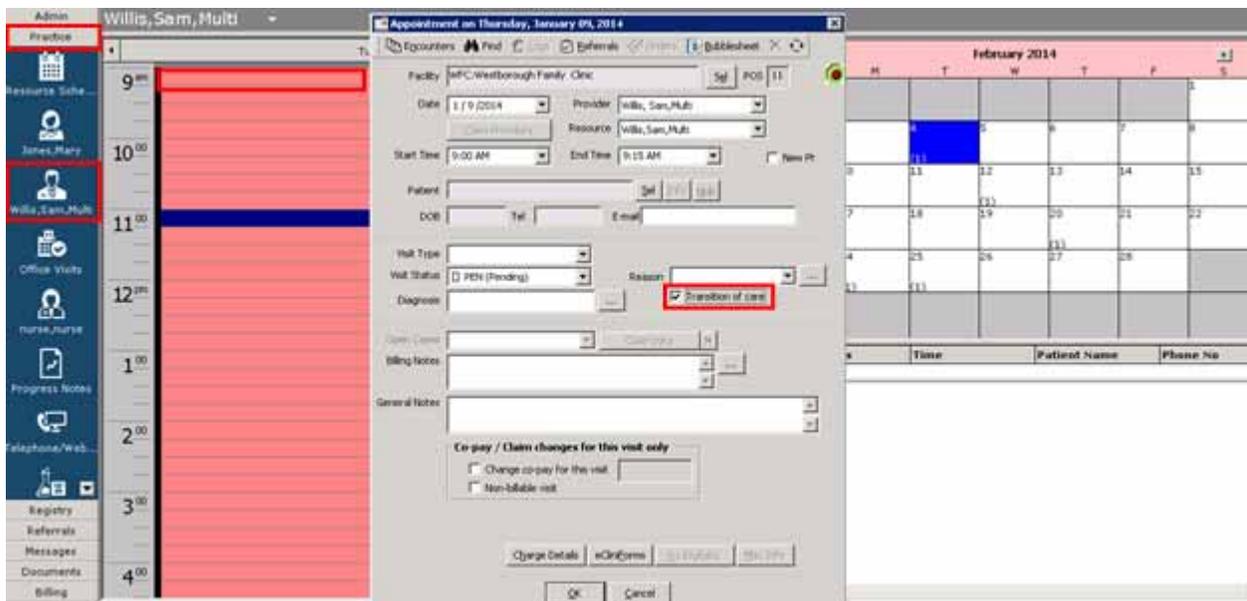
- Practice band > Resource Scheduling icon > right-click on time slot > New Appointment > Transition of Care check box



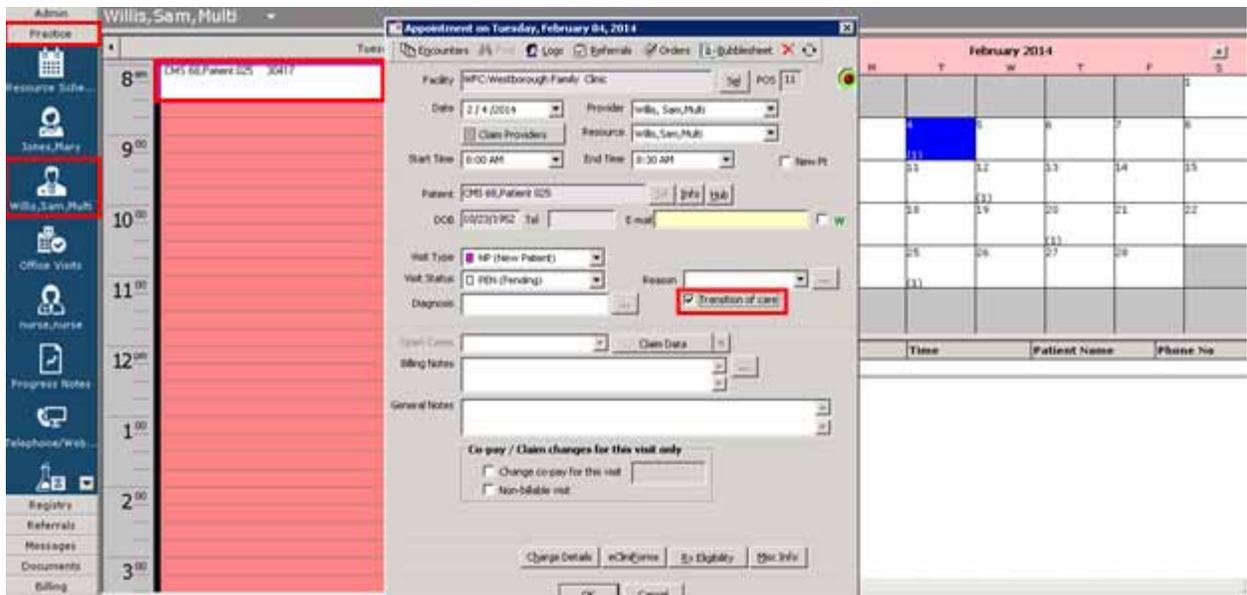
- Practice band > Resource Scheduling icon > double-click on appointment > Transition of Care check box



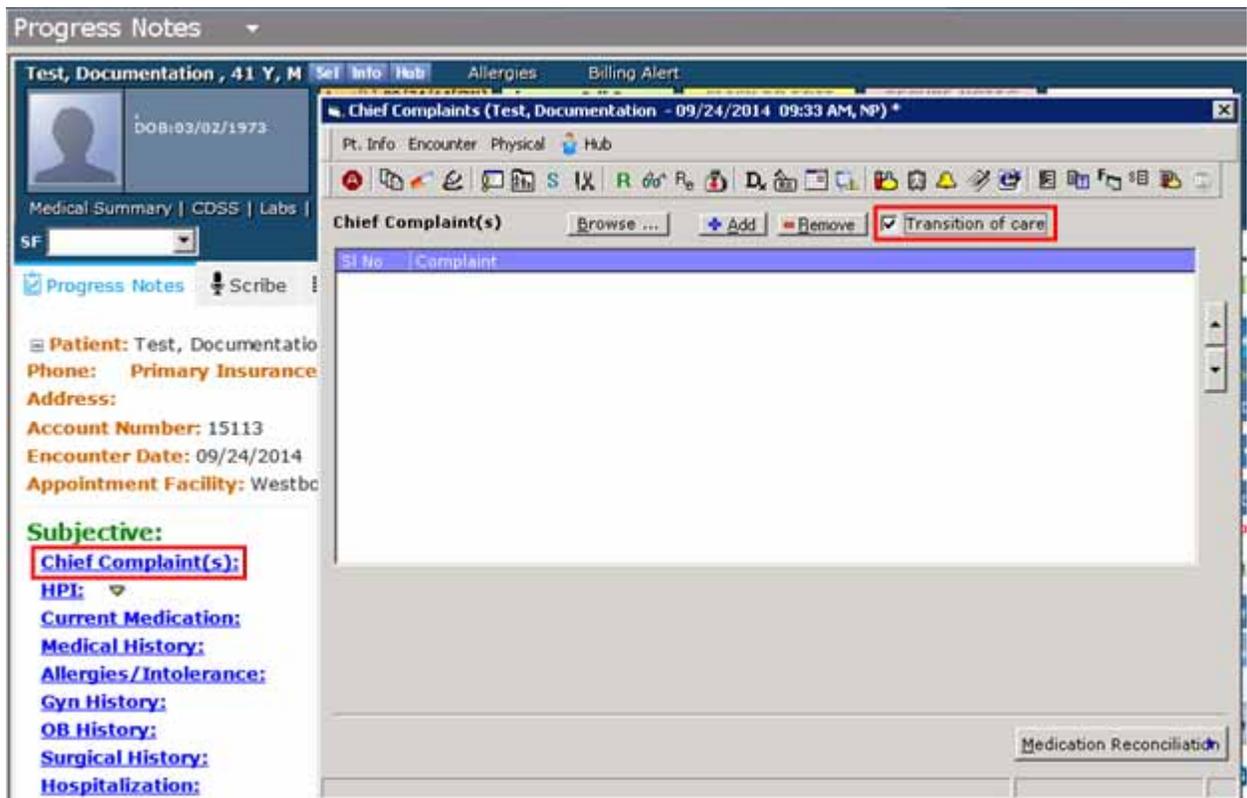
- Practice band > Provider Schedule icon > right-click on time slot > New Appointment > Transition of Care check box



- Practice band > Provider Schedule icon > double-click on appointment > Transition of Care check box



- Progress Notes > Chief Complaints > Transition of Care check box



Recording E&M Codes

- Progress Notes > Visit Code > Add E&M

Billing Information:

Visit Code:

- 99213 Office Visit,

Procedure Codes:

CPT	Name	Units	M1	M2	M3	M4	ICD1	ICD2	ICD3	ICD4	Notes
99213	Office Visit, Est Pt.,	1.00					1 250.01	2 250.12			

Recording Medication Reconciliation

- Progress Notes > Current Medication > Verified check box

Progress Notes

Test, Documentation, 41 Y, M

DOB: 03/02/1973

Appointment: 09/24/14 (W)

Language: English

Insurance: Self Pay \$5.00

Account Number: 15113

Encounter Date: 09/24/2014

Provider: Sam Willis, MD

Appointment Facility: Westborough Family Clinic

Subjective:

Chief Complaint(s): Medication Reconciliation

HPI:

Current Medication:

Medical History:

Allergies/Intolerance:

Gyn History:

OB History:

Surgical History:

Current Medication | Past Rx History | External Rx History

Add Medication

Verified

Rx Name Only

Drug Interaction

Cancel

Core 15: Summary of Care

Objective

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary care record for each transition of care or referral.

Measure

This objective has multiple measure criteria and requires the provider to meet all thresholds for credit. For more information, refer to [Core 15-1](#), [Core 15-2](#), and [Core 15-3](#).

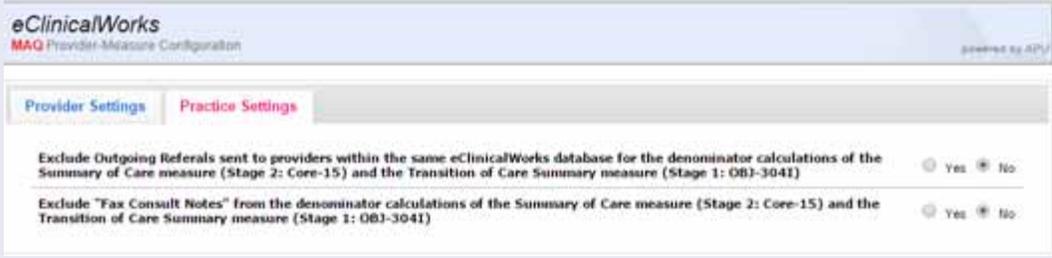
Core 15-1

Measure

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

Denominator

Referrals are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
<p>At least one outgoing referral has been printed, faxed, or transmitted electronically using JTN (Join the Network) during the reporting period.</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Progress Notes > Treatment > Outgoing Referral > Send Referral > Print, Print with attachment(s), Fax, or Fax with attachment(s) ■ Progress Notes > Treatment > Outgoing Referral > green arrow next to the Send Referral button > Send Electronically ■ Progress Notes > green arrow next to Fax button > Fax Consult Notes ■ T quick-launch link > Send eCW P2P Patient Record ■ T quick-launch link > Send eCW P2P Referral/Consult ■ Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Send Referral > Print, Print with attachment(s), Fax, Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically ■ Patient Hub > Referrals > Outgoing > New > Send Referral > Print, Print with attachment(s), Fax, Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically <p>Note: Fax consult notes and/or referrals sent from within the same database can be excluded from this denominator using settings on the MAQ Dashboard:</p>  <p>IMPORTANT! Referrals are only counted for a provider if they are listed as the <i>Referral From</i> provider on the referral.</p>

Numerator

Referrals that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
<p>At least one outgoing referral has been printed, faxed, or transmitted with attachments during the reporting period.</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Progress Notes > Treatment > Outgoing Referral > Send Referral > Print with attachment(s) or Fax with attachment(s) ■ Progress Notes > Treatment > Outgoing Referral > green arrow next to the Send Referral button > Send Electronically ■ T quick-launch link > Send eCW P2P Patient Record ■ T quick-launch link > Send eCW P2P Referral/Consult ■ Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Send Referral > Print with attachment(s), Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically ■ Patient Hub > Referrals > Outgoing > New > Send Referral > Print with attachment(s), Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically <p>IMPORTANT! For the electronic transmission of summary of care records (Core Measure 15), transactions must be sent to and from a Direct Address. For more information, refer to Requesting a Direct Address. Non-eCW providers can go to http://www.jointhenetwork.com to request an eClinicalWorks-issued Direct Address.</p>

Exclusions

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
<p>They transfer patients to another setting or refer patients to another provider less than 100 times during the reporting period.</p>	<p>This exclusion criteria is reported by self-attestation.</p>

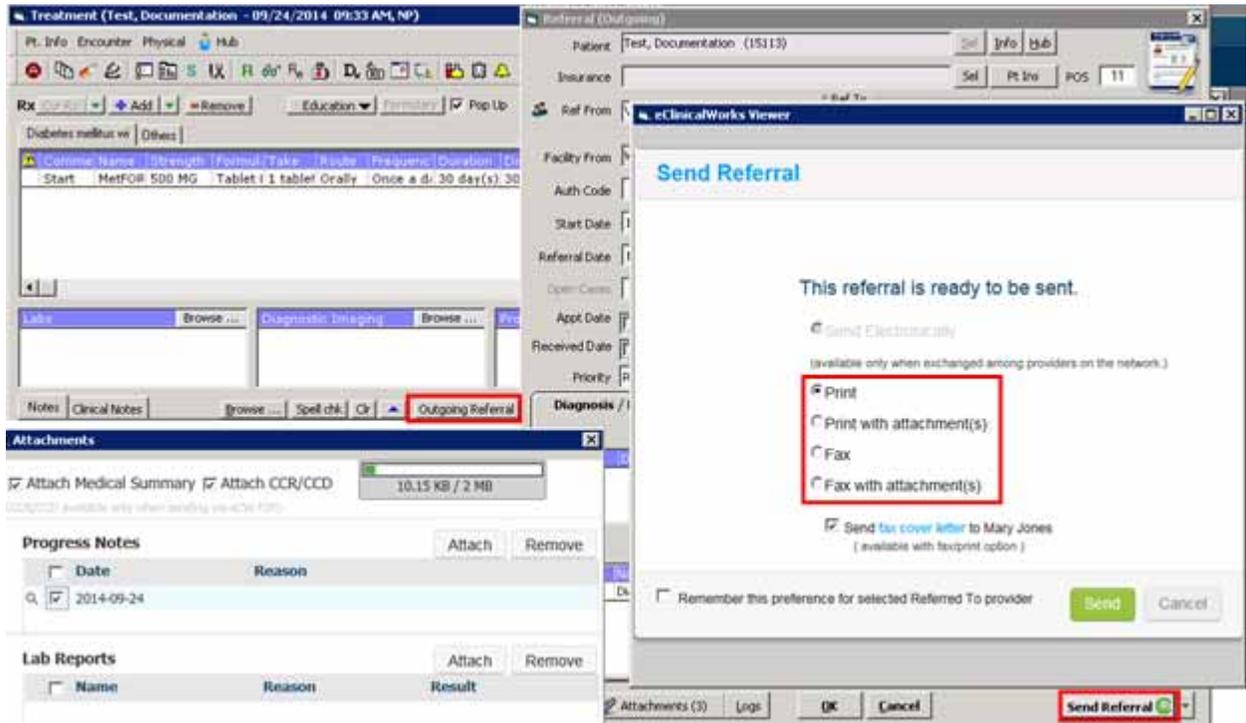
Features Related to Core 15-1

The following features are related to Core Measure 15-1:

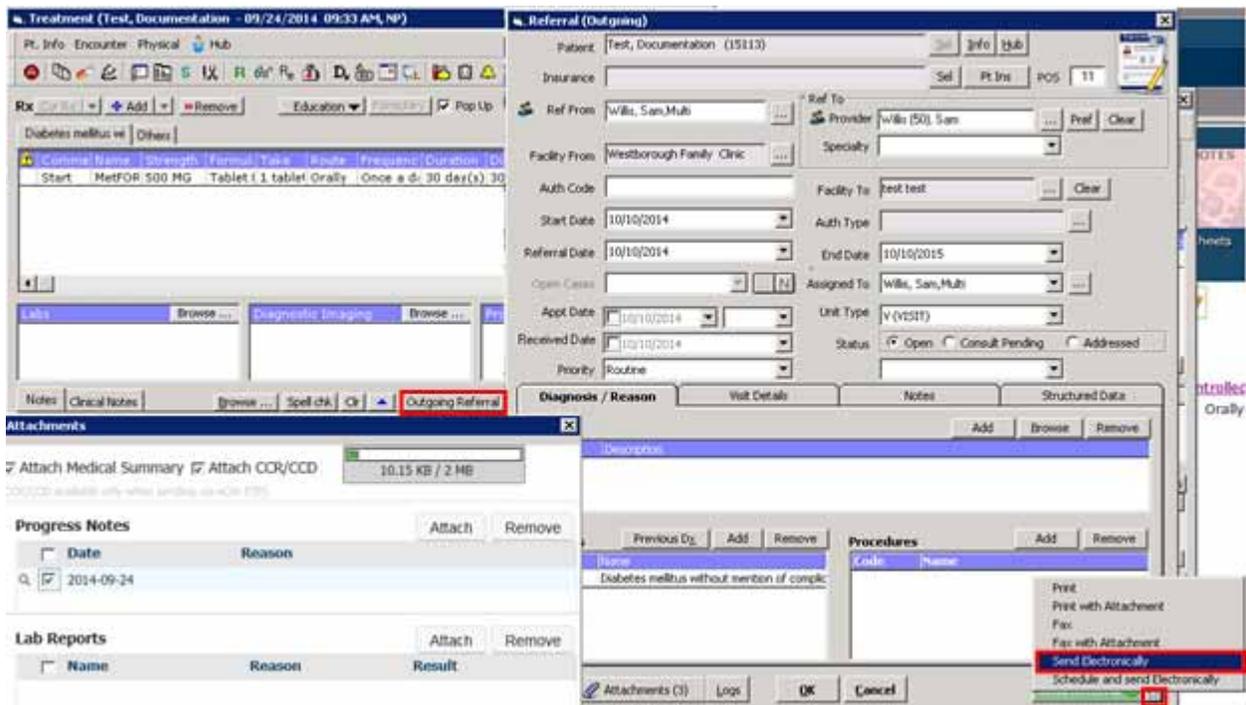
- Sending Referrals
- Sending Referrals with Attachments

Sending Referrals

- Progress Notes > Treatment > Outgoing Referral > Send Referral > *Print, Print with attachment(s), Fax, or Fax with attachment(s)*



- Progress Notes > Treatment > Outgoing Referral > green arrow next to the Send Referral button > Send Electronically



- Progress Notes > green arrow next to Fax button > Fax Consult Notes

Progress Notes

Test, Documentation, 41 Y, M | Set Info | Hub | Allergies | Billing Alert

DOB: 03/02/1973 | Appt(L): 09/24/14(SW) | Ins: Self Pay | Acc Bal: \$0.00 | Guan: | CLICK TO EDIT | SECURE NOTES | Enable | Not web mail

Language: | Translator: No

Medical Summary | CDSS | Labs | DI | Procedures | Growth Chart | Imm/T.Inj | Encounters | Patient Docs | Flowsheets | Notes

SF

Progress Notes | Scribe | Orders | Quick Search

Plan:

Treatment:

Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled

Start MetFORMIN HCl ER Tablet Extended Release 24 Hour, 500 MG, 1 tablet with evening meal, Orally, Once a day, 30 day(s), 30

Referral To: Sam Willis (50)

Reason:

Procedures:

Immunizations:

Therapeutic Injections:

Diagnostic Imaging:

Lab Reports:

Preventive Medicine:

Next Appoint

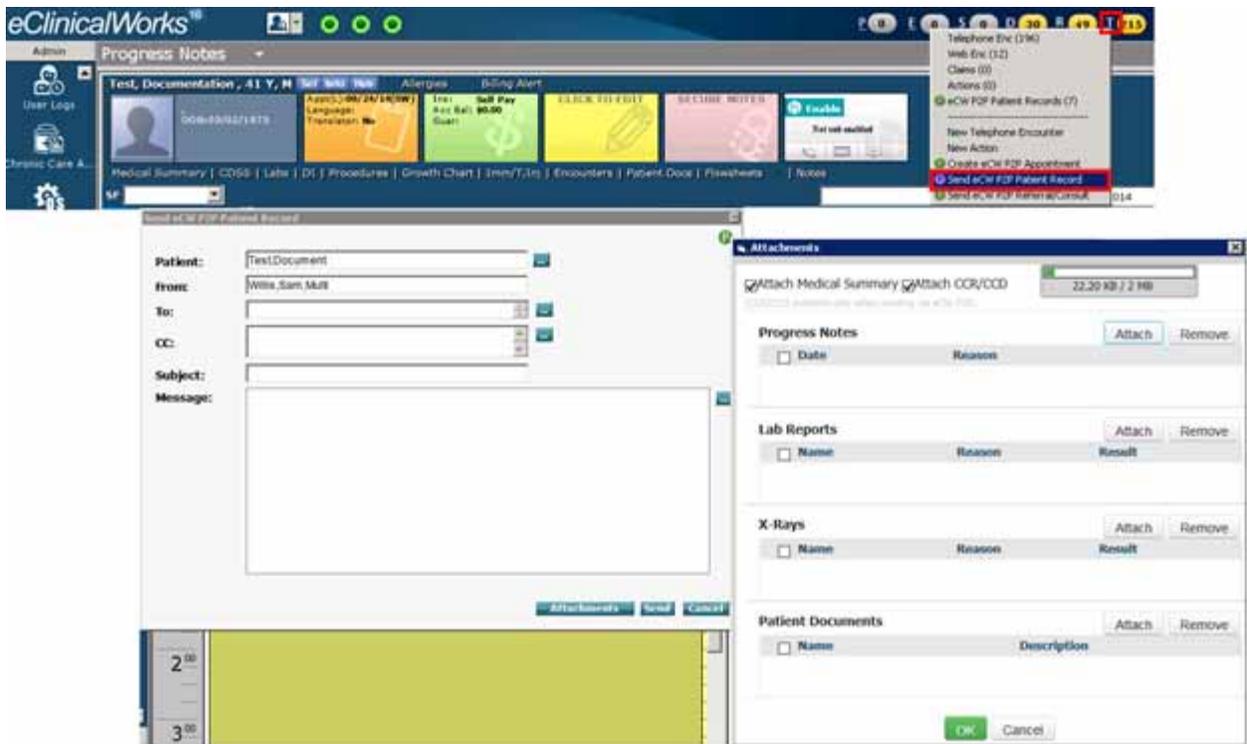
Billing Inform

Visit Code:

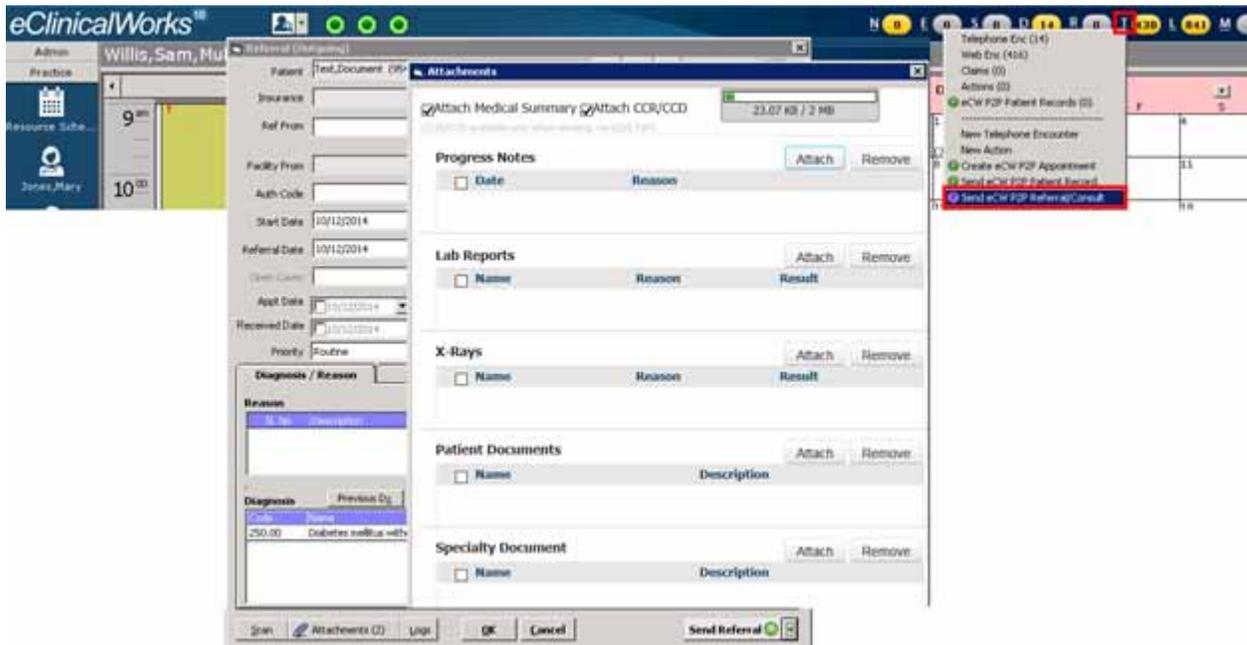
Fax
Fax Options
Fax Rx
Fax Order
Fax Labs
Fax Diagnostic Imaging
Fax Procedures
Fax ConsultNotes

Send | Print | Fax | Secure | Lock | Details | Scan | Templates | Claim | Letters | Ink

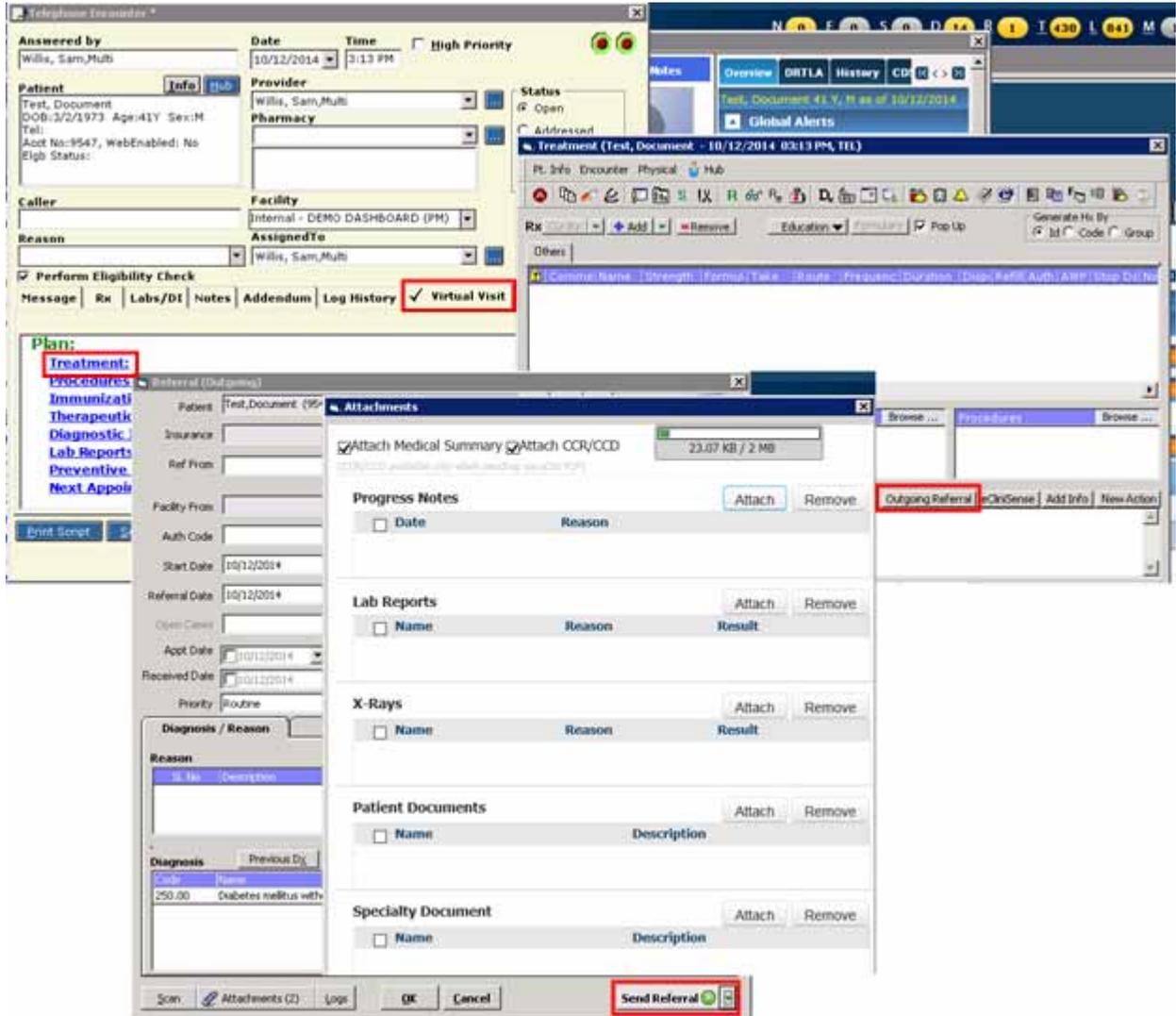
- T quick-launch link > Send eCW P2P Patient Record



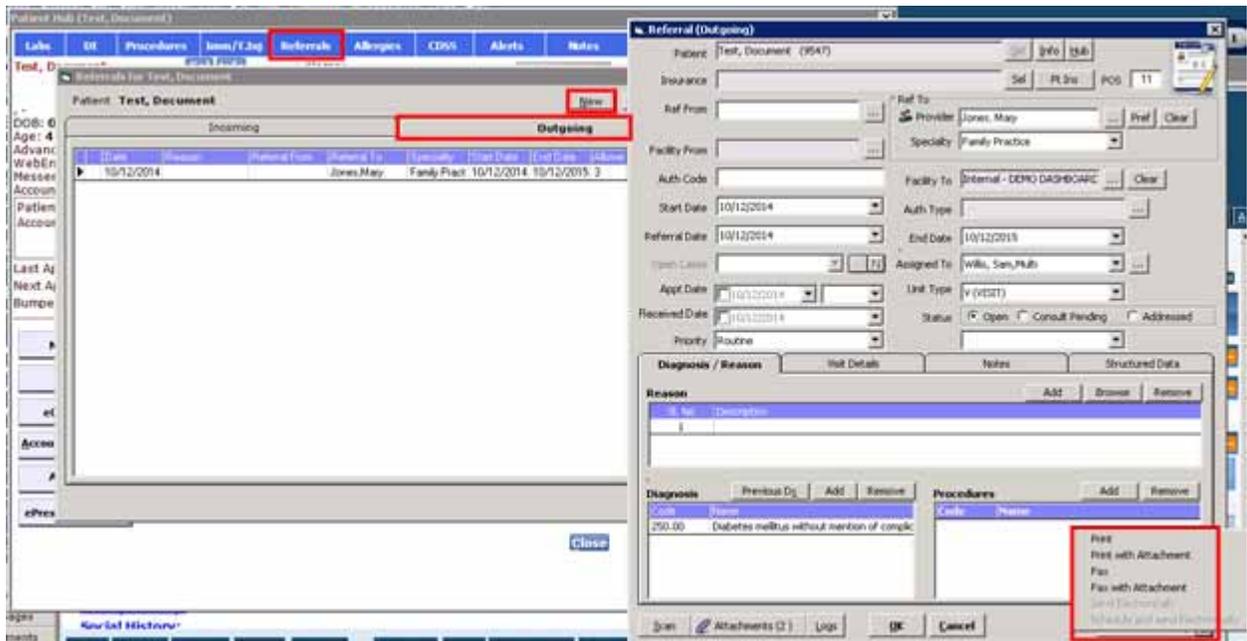
- T quick-launch link > Send eCW P2P Referral/Consult



- Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Send Referral > *Print, Print with attachment(s), Fax, Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically*

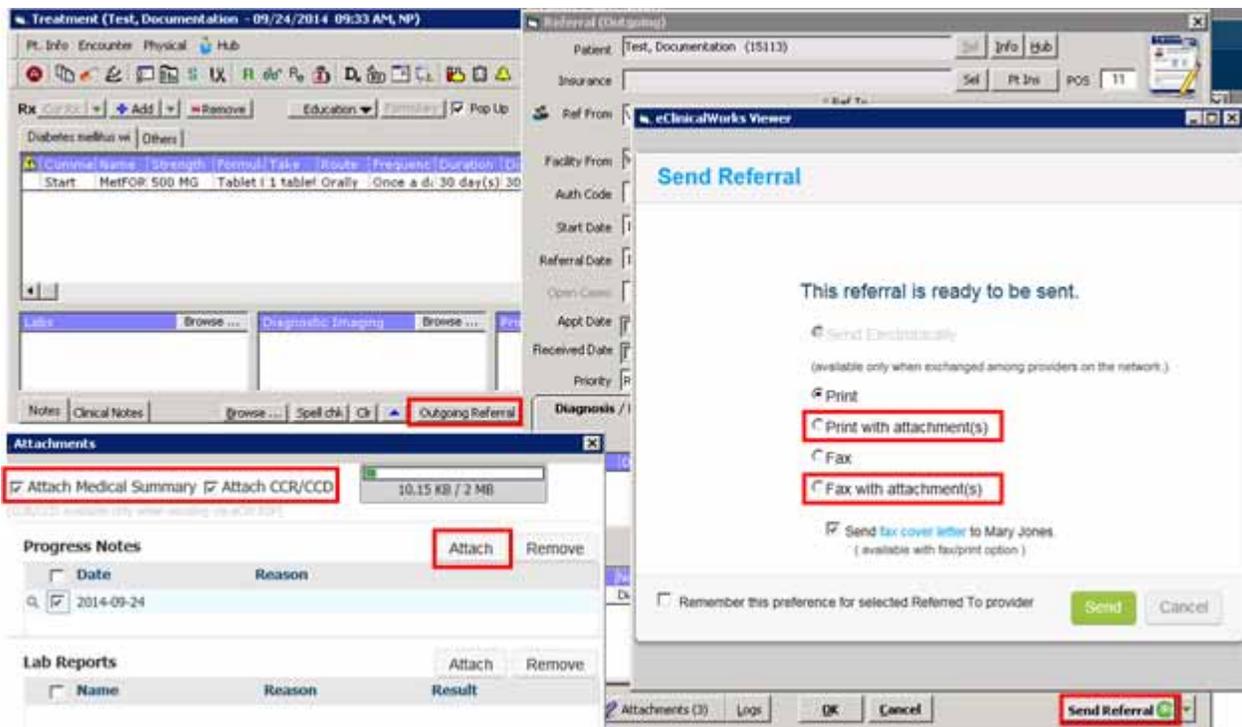


- Patient Hub > Referrals > Outgoing > New > Send Referral > *Print, Print with attachment(s), Fax, Fax with attachment(s),* or green arrow next to the Send Referral button and *Send Electronically*

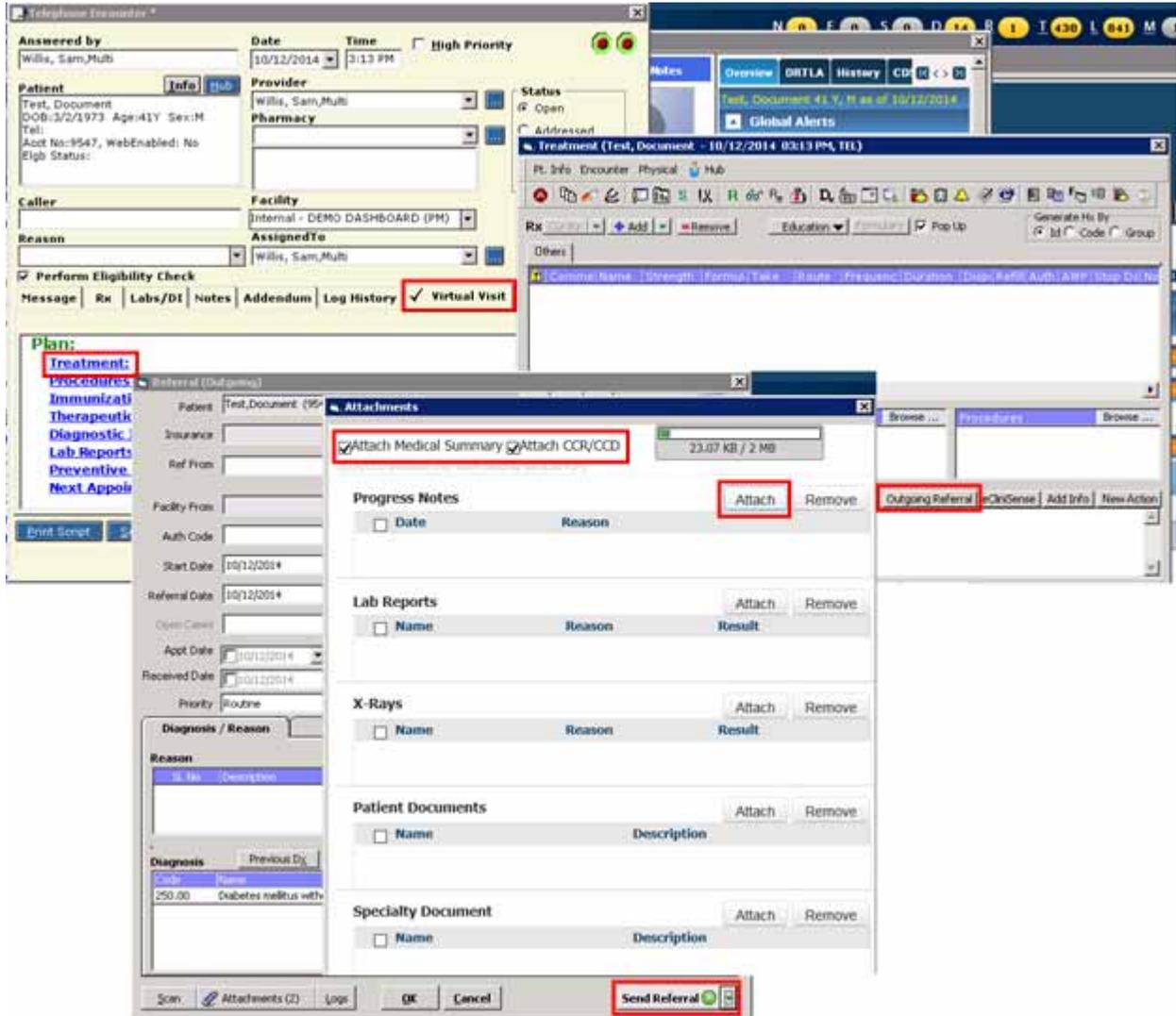


Sending Referrals with Attachments

- Progress Notes > Treatment > Outgoing Referral > Send Referral > *Print with attachment(s)* or *Fax with attachment(s)*



- Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Send Referral > *Print with attachment(s), Fax with attachment(s),* or green arrow next to the Send Referral button and *Send Electronically*



- Patient Hub > Referrals > Outgoing > New > Send Referral > *Print with attachment(s), Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically*

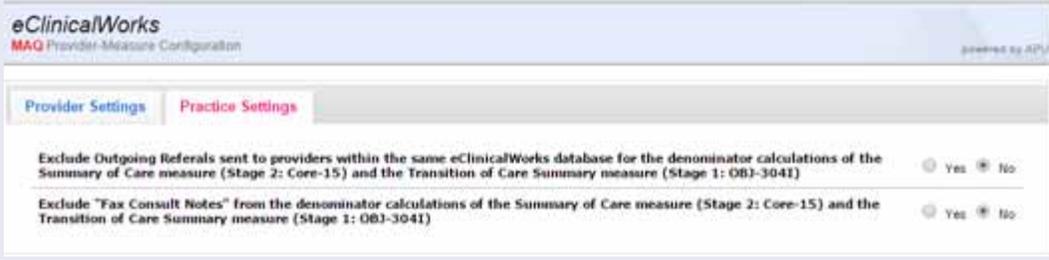
Core 15-2

Measure

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 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.

Denominator

Referrals are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
<p>At least one outgoing referral has been printed, faxed, or transmitted electronically using JTN (Join the Network) during the reporting period.</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ Progress Notes > Treatment > Outgoing Referral > Send Referral > Print, Print with attachment(s), Fax, or Fax with attachment(s) ■ Progress Notes > Treatment > Outgoing Referral > green arrow next to the Send Referral button > Send Electronically ■ Progress Notes > green arrow next to Fax button > Fax Consult Notes ■ T quick-launch link > Send eCW P2P Patient Record ■ T quick-launch link > Send eCW P2P Referral/Consult ■ Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Send Referral > Print, Print with attachment(s), Fax, Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically ■ Patient Hub > Referrals > Outgoing > New > Send Referral > Print, Print with attachment(s), Fax, Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically <p>Note: Fax consult notes and/or referrals sent from within the same database can be excluded from this denominator using settings on the MAQ Dashboard:</p>  <p>IMPORTANT! Referrals are only counted for a provider if they are listed as the <i>Referral From</i> provider on the referral.</p>

Numerator

Referrals that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They were transmitted through the P2P Portal with a medical summary, CCR/CCD, and Progress Notes attached	Record this information from the following locations: <ul style="list-style-type: none"> ■ T quick-launch link > Send eCW P2P Patient Record > Attachments > Send ■ T quick-launch link > Send eCW P2P Referral/Consult > Attachments or green arrow next to the Send Referral button and Send Electronically ■ Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Attachments > Send Referral or green arrow next to the Send Referral button and Send Electronically ■ Patient Hub > Referrals > Outgoing > New > Attachments > Send Referral or green arrow next to the Send Referral button and Send Electronically
	<p>IMPORTANT! For the electronic transmission of summary of care records (Core Measure 15), transactions must be sent to and from a Direct Address. For more information, refer to Requesting a Direct Address.</p> <p>Non-eCW providers can go to http://www.jointhenetwork.com to request an eClinicalWorks-issued Direct Address.</p>

Exclusions

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They transfer patients to another setting or refer patients to another provider less than 100 times during the reporting period.	This exclusion criteria is reported by self-attestation.

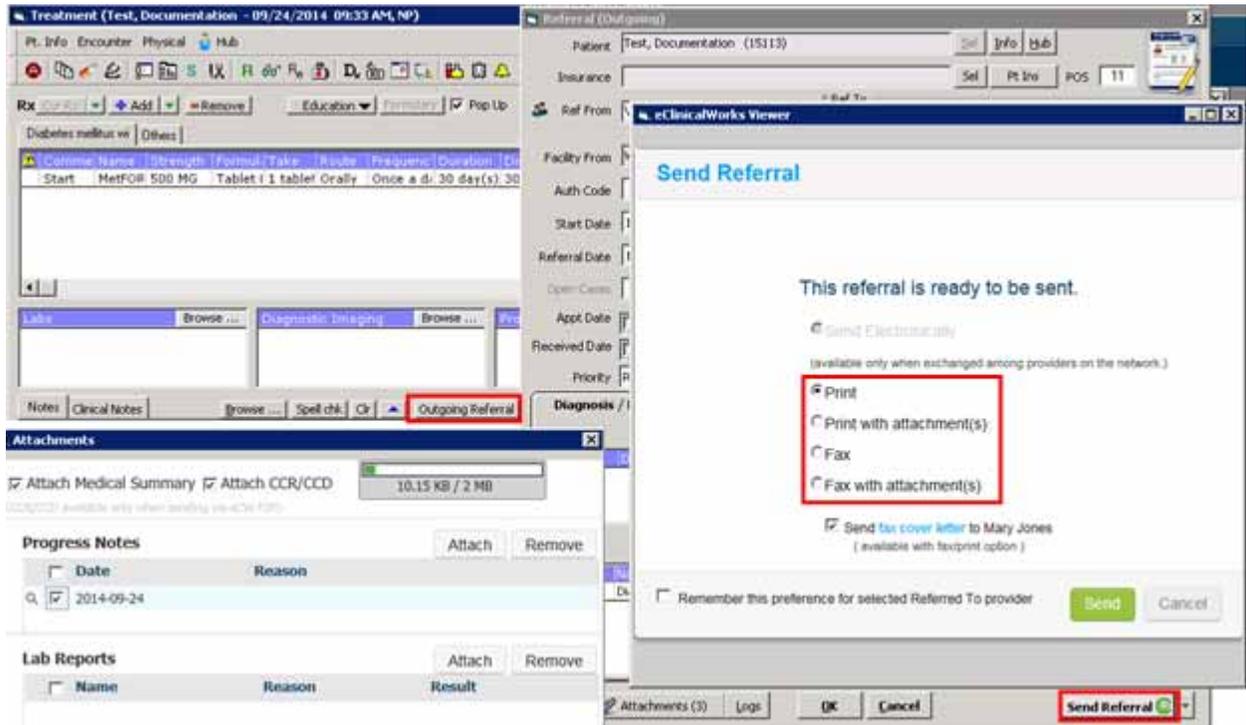
Features Related to Core 15-2

The following features are related to Core Measure 15-2:

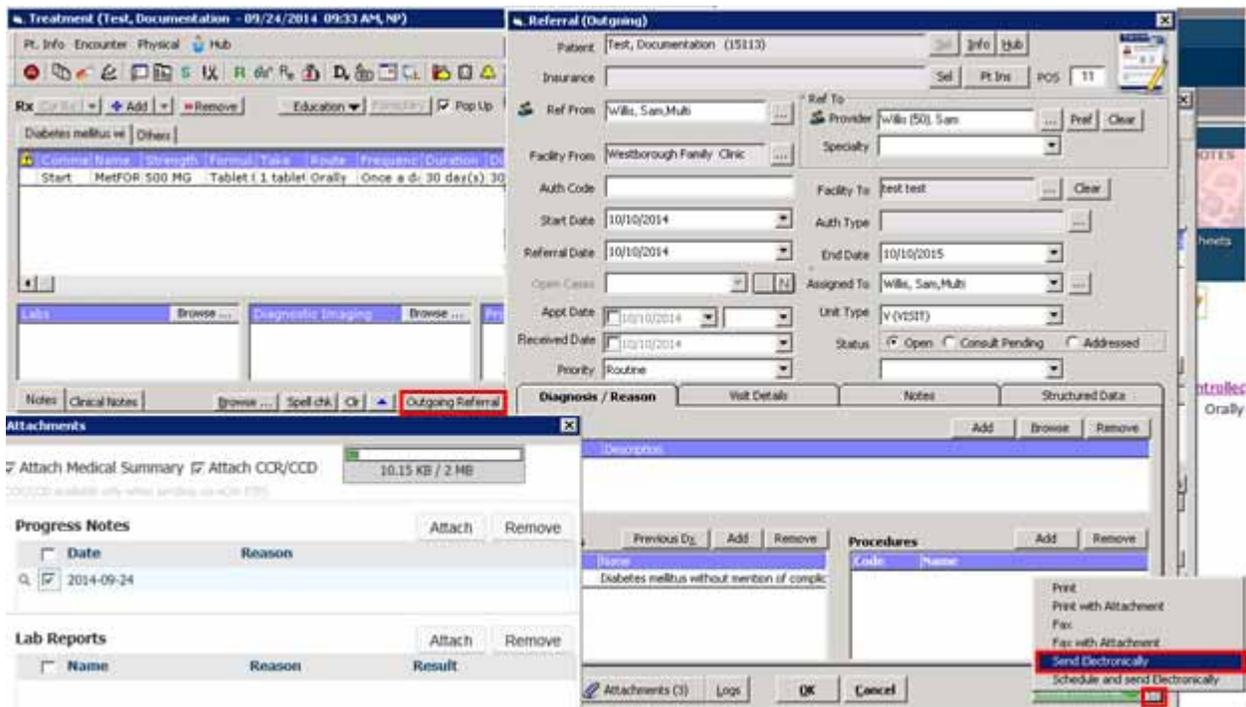
- [Sending Referrals](#)
- [Sending Referrals with Attachments](#)

Sending Referrals

- Progress Notes > Treatment > Outgoing Referral > Send Referral > *Print, Print with attachment(s), Fax, or Fax with attachment(s)*



- Progress Notes > Treatment > Outgoing Referral > green arrow next to the Send Referral button > Send Electronically



- Progress Notes > green arrow next to Fax button > Fax Consult Notes

Progress Notes

Test, Documentation, 41 Y, M | Set Info | Hub | Allergies | Billing Alert

DOB: 03/02/1973 | Appt(L): 09/24/14(SW) | Ins: Self Pay | Acc Bal: \$0.00 | Guan

Language: | Translator: No

CLICK TO EDIT | SECURE NOTES | Enable

Medical Summary | CDSS | Labs | DI | Procedures | Growth Chart | Imm/T.Inj | Encounters | Patient Docs | Flowsheets | Notes

SF

Progress Notes | Scribe | Orders | Quick Search

Plan:

Treatment:

Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled

Start MetFORMIN HCl ER Tablet Extended Release 24 Hour, 500 MG, 1 tablet with evening meal, Orally, Once a day, 30 day(s), 30

Referral To: Sam Willis (50)

Reason:

Procedures:

Immunizations:

Therapeutic Injections:

Diagnostic Imaging:

Lab Reports:

Preventive Medicine:

Next Appointment

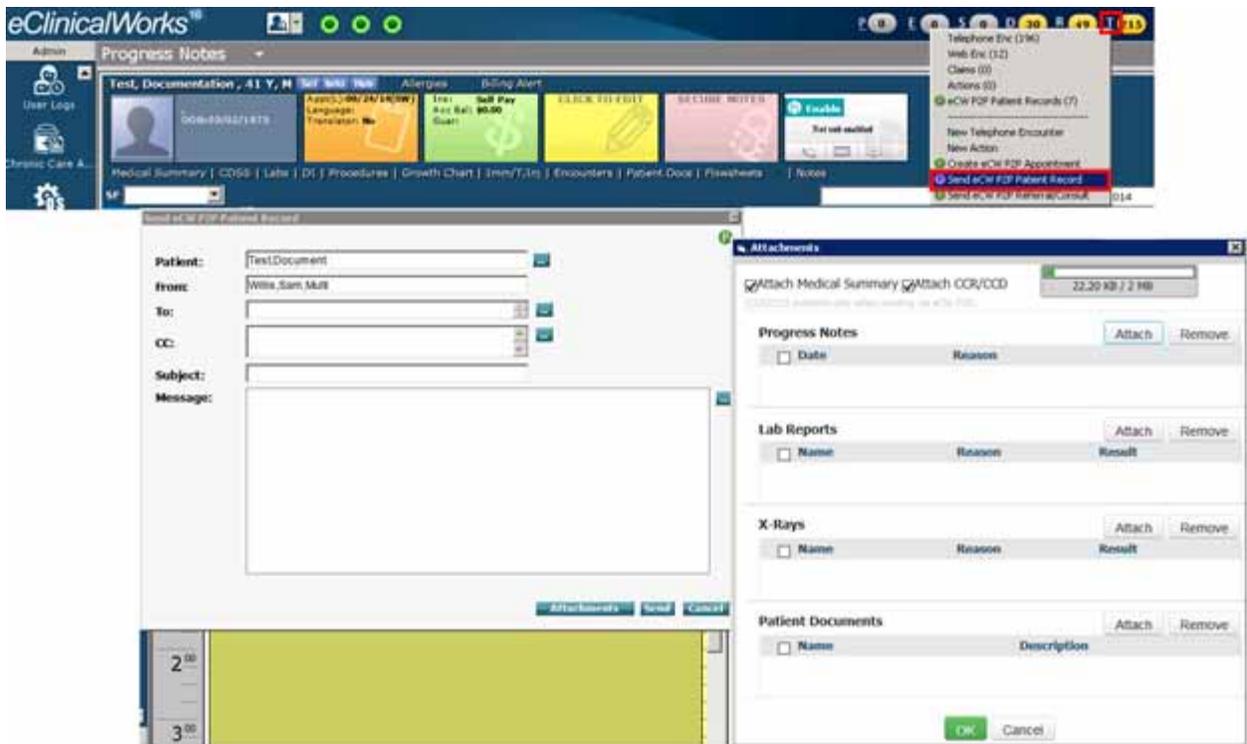
Billing Inform

Visit Code:

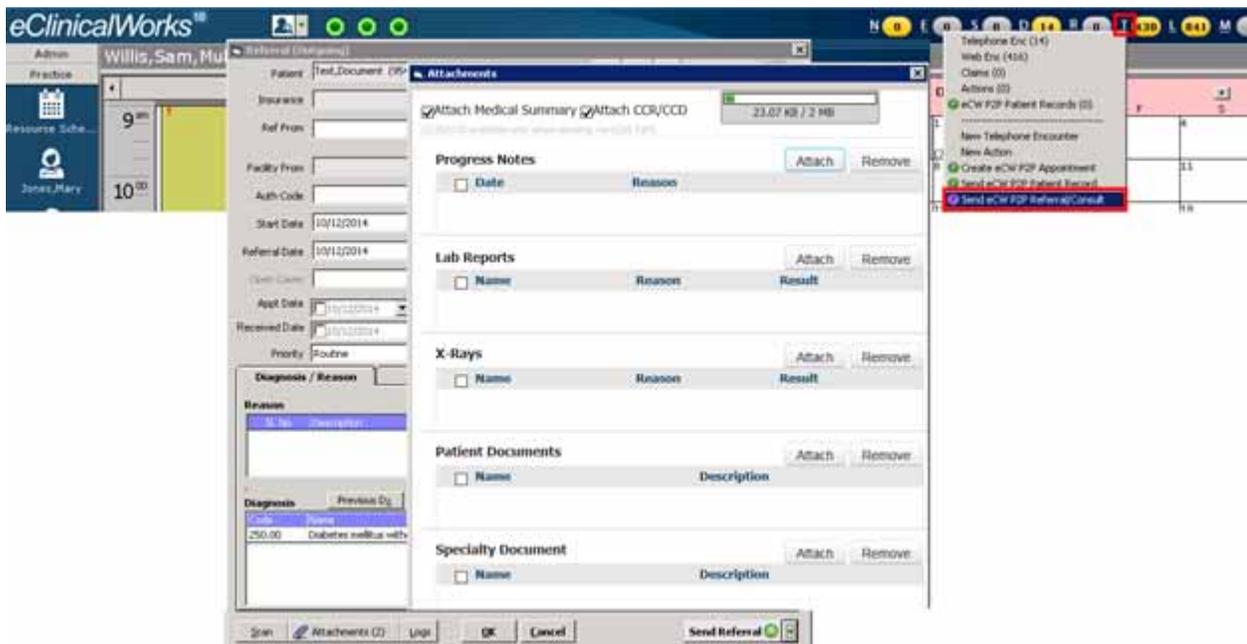
Fax
Fax Options
Fax Rx
Fax Order
Fax Labs
Fax Diagnostic Imaging
Fax Procedures
Fax Consult Notes

Send | Print | Fax | Secure | Lock | Details | Scan | Templates | Claim | Letters | Ink

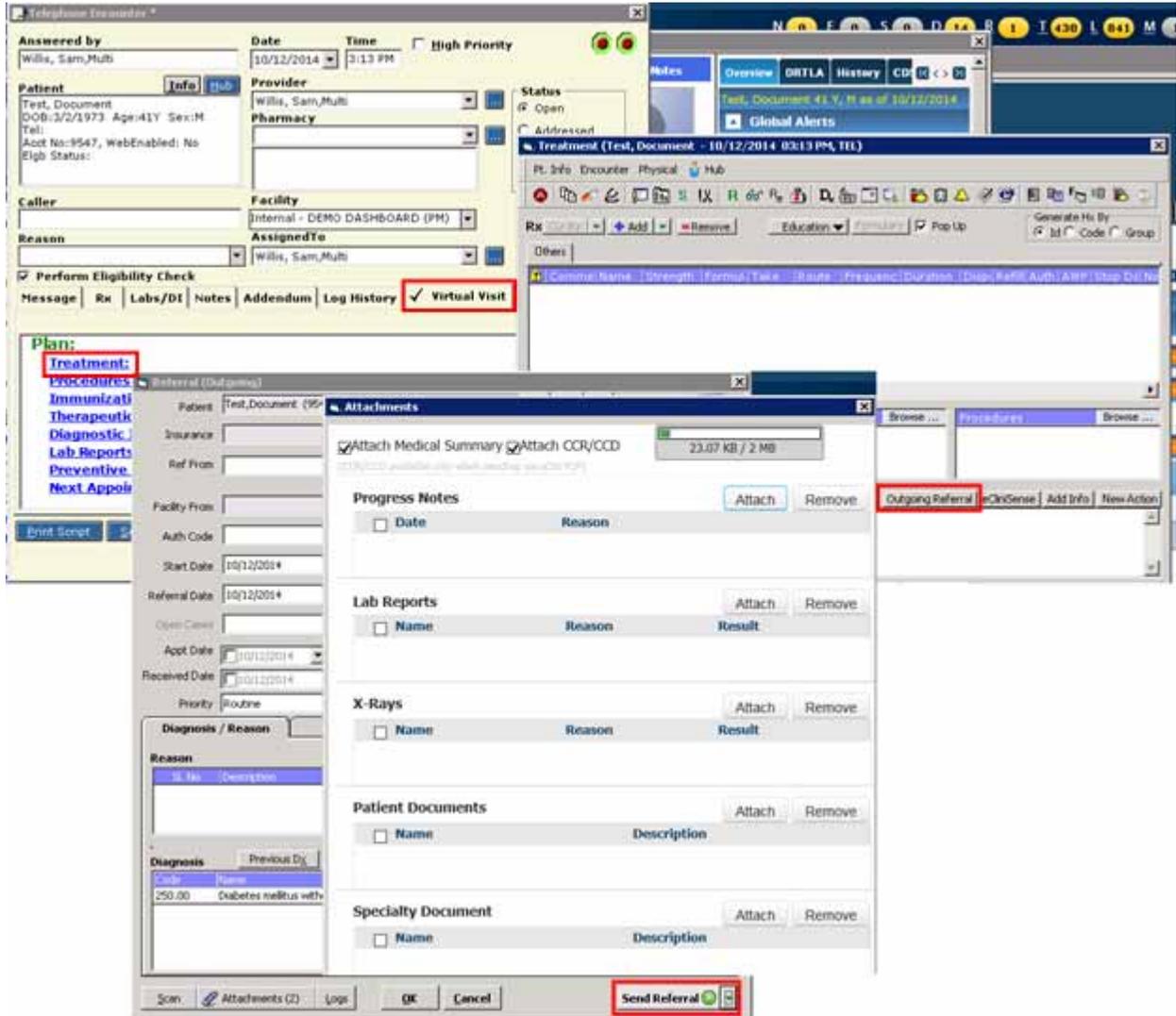
- T quick-launch link > Send eCW P2P Patient Record



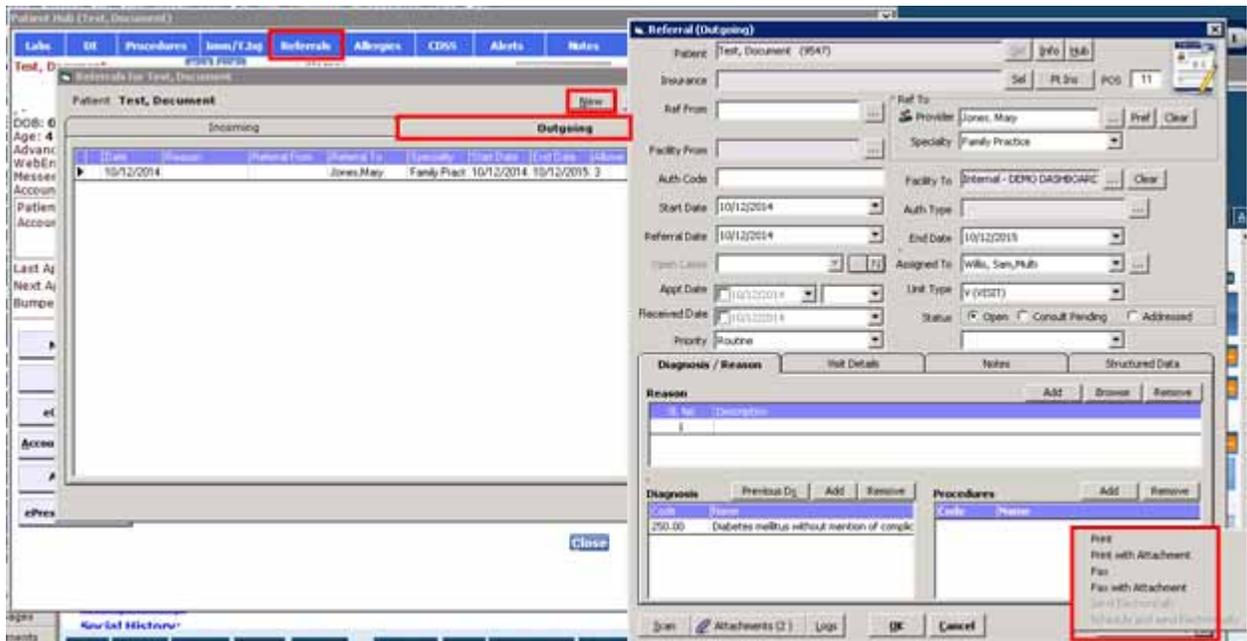
- T quick-launch link > Send eCW P2P Referral/Consult



- Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Send Referral > *Print, Print with attachment(s), Fax, Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically*

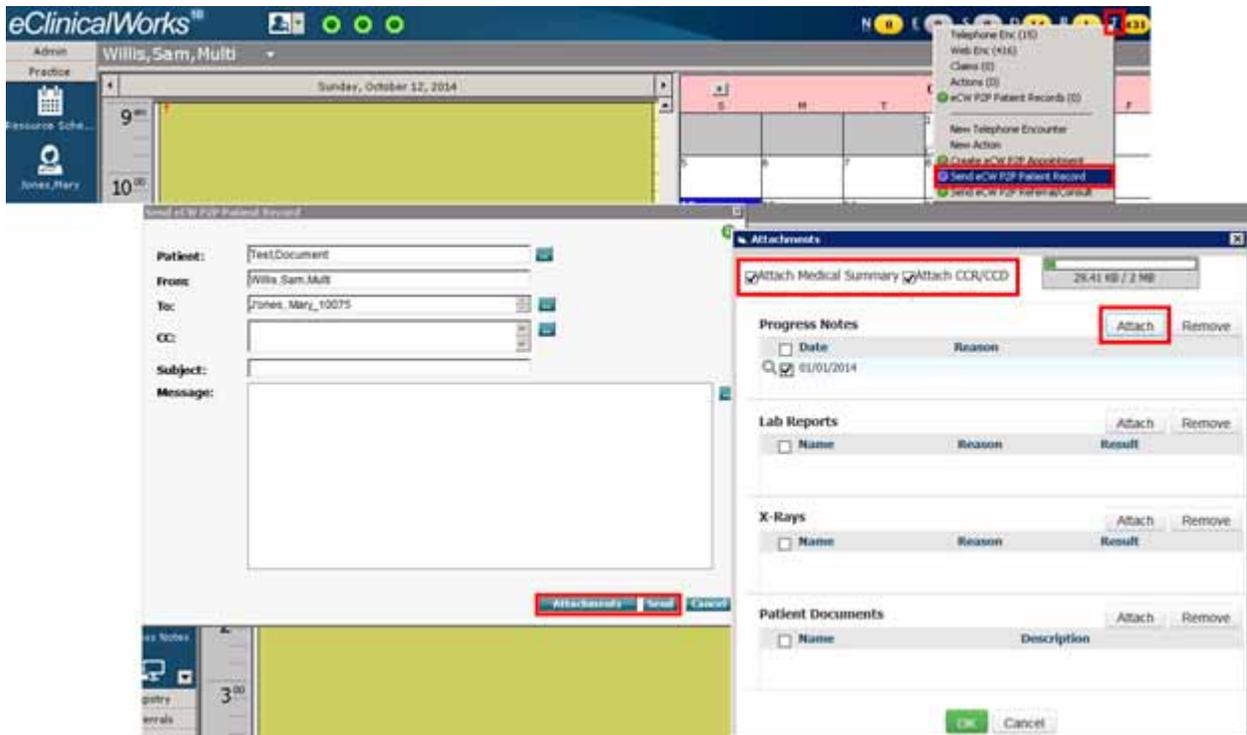


- Patient Hub > Referrals > Outgoing > New > Send Referral > *Print, Print with attachment(s), Fax, Fax with attachment(s), or green arrow next to the Send Referral button and Send Electronically*

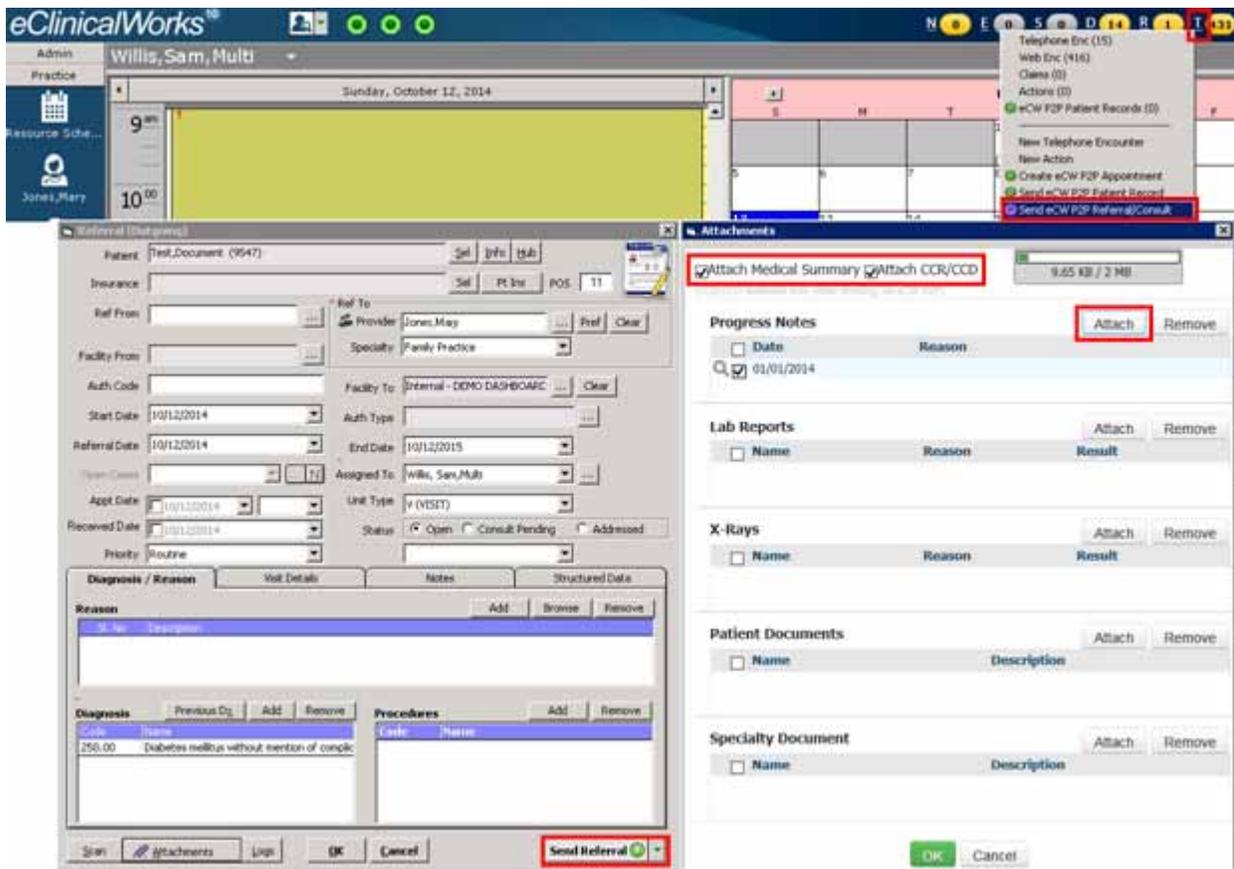


Sending Referrals with Attachments

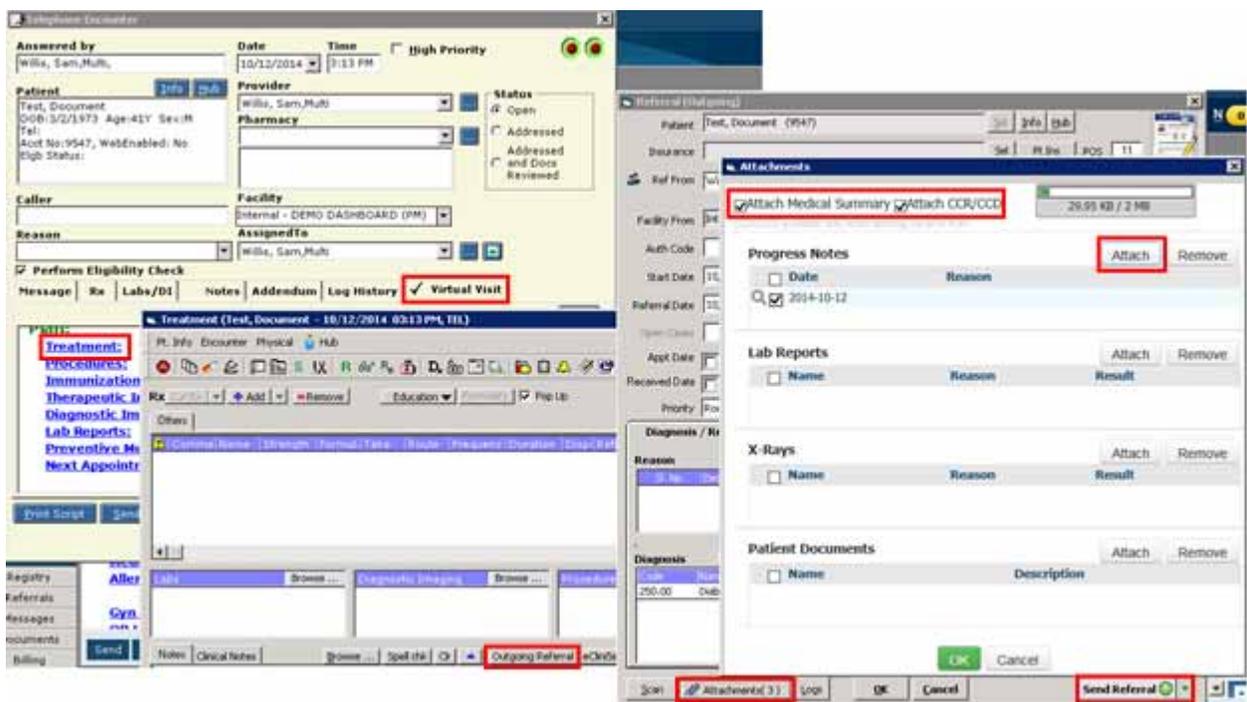
- T quick-launch link > Send eCW P2P Patient Record > Attachments > Send



- T quick-launch link > Send eCW P2P Referral/Consult > Attachments or green arrow next to the Send Referral button and *Send Electronically*



- Telephone/Web Encounter > Virtual Visit > Treatment > Outgoing Referral > Attachments > *Send Referral* or green arrow next to the Send Referral button and *Send Electronically*



- Patient Hub > Referrals > Outgoing > New > Attachments > *Send Referral* or green arrow next to the Send Referral button and *Send Electronically*

The screenshot displays the 'Patient Hub' interface for sending a referral. The main window shows the 'Referrals' tab with an 'Outgoing' section. A 'Send Referral' button is highlighted with a green arrow. An 'Attachments' window is open, showing options to attach a 'Medical Summary' and 'COR/CCD'. The 'Send Referral' button is highlighted with a green arrow.

Core 15-3

Measure

An EP must satisfy one of the following criteria:

- Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).
- Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

IMPORTANT! For the electronic transmission of summary of care records (Core Measure 15), transactions must be sent to and from a Direct Address. For more information, refer to [Requesting a Direct Address](#).

Non-eCW providers can go to <http://www.jointhenetwork.com> to request an eClinicalWorks-issued Direct Address.

To request a match to a CMS-designated test EHR:

1. Go to <https://ehr-randomizer.nist.gov>.
2. Click *Register*.

The Create Account page opens:

ehr-randomizer
Meaningful Use 2014 Edition

Home Register Reset Password

Create Account

Company ✓

First name ✓

Last name ✓

Username

Password ✓

Confirm Password

Email ✓

Create account

3. Fill out the fields here and click *Create account*.
4. Once your account is created, click *Login* in the top-right corner.
The Login pop-up window opens.
5. Enter your login information and click *Login*.
The EHR Randomizer Home Page opens.
6. Click *My CEHRTs* at the top of the page.

The Manage CEHRTs page opens:

My CEHRTs My Matches Vendors CEHRTs

Manage CEHRTs

eCW
Add CEHRT

Basic Information

CEHRT Label ✓

Direct Email Address ✓

Time Zone ✓

Developer ✓

Save Return to original state

Direct Trust Membership

Is your CEHRT member of Direct Trust?

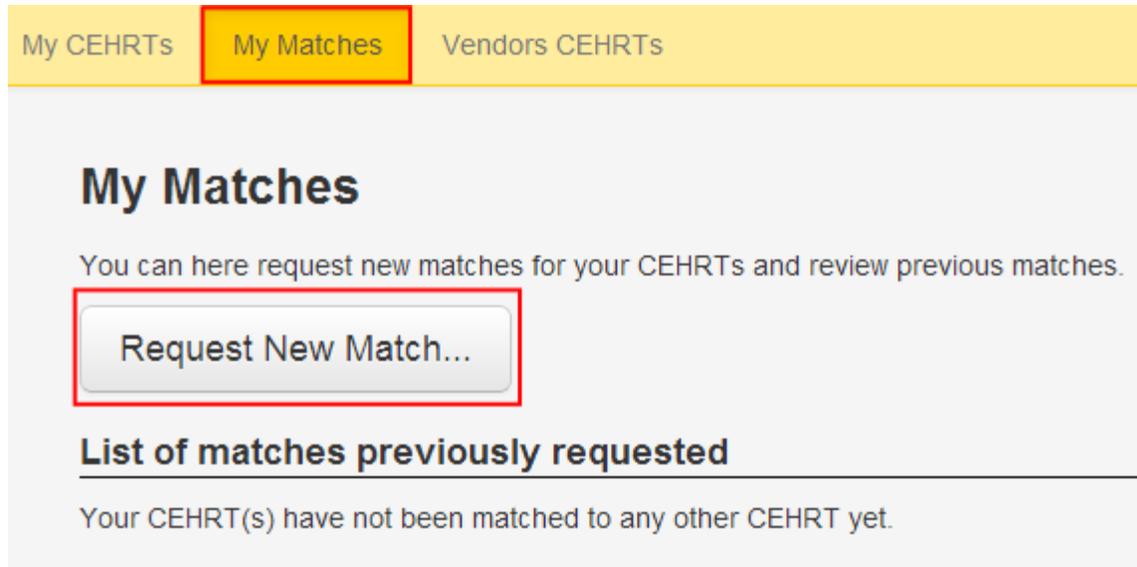
Yes

No

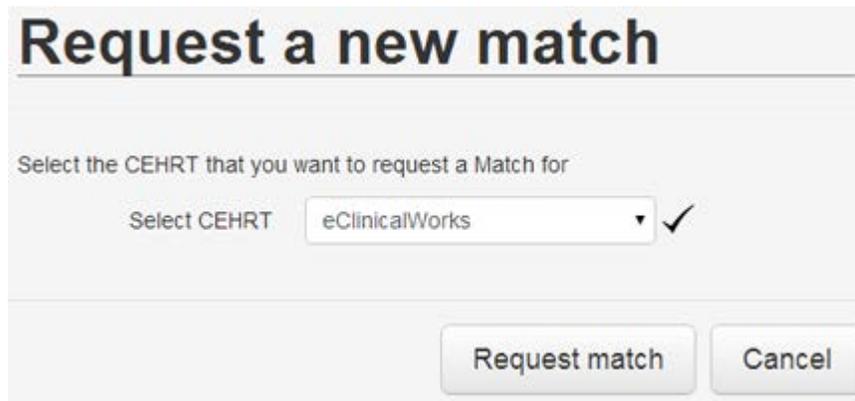
7. To create a CEHRT:
 - a. Enter a label of your choosing in the *CEHRT Label* field.
 - b. Enter the direct address issued to you by eClinicalWorks in the *Direct Email Address* field.
 - c. Select your time zone from the *Time Zone* pick list.
 - d. Select *eClinicalWorks* from the *Developer* pick list.
 - e. Click the *No* radio button in the *Is your CEHRT member of Direct Trust* section.
 - f. Click *Save*.
8. Click *My Matches* at the top of the page.

The My Matches page opens.

9. Click *Request New Match*:



The *Request a new match* pop-up window opens:



10. Select the CEHRT for which you want to create a match from the *Select CEHRT* pick list.
11. Click *Request match*.

Your match is generated:

My Matches

You can here request new matches for your CEHRTs and review previous matches.

Request New Match...

List of matches previously requested

Note: Click the EHR Product listed under "Matched Against" to see details about initiating the test process with this Test EHR

My CEHRT	Date	Matched Against	Comment
eCW	Jun 17, 2014	iPatientCare EHR	
eCW	Jun 17, 2014	Medical Information Technology Inc.	
eCW	Jun 17, 2014	McKesson Paragon with McKesson Quality eMeasures 12 & 2.0	
eCW	Jun 17, 2014	iPatientCare EHR	
eCW	Jun 11, 2014	Medical Information Technology Inc.	

You will receive an e-mail from your match with information on the next steps. eClinicalWorks has already exchanged the necessary trust anchors with these CMS-designated test EHRs.

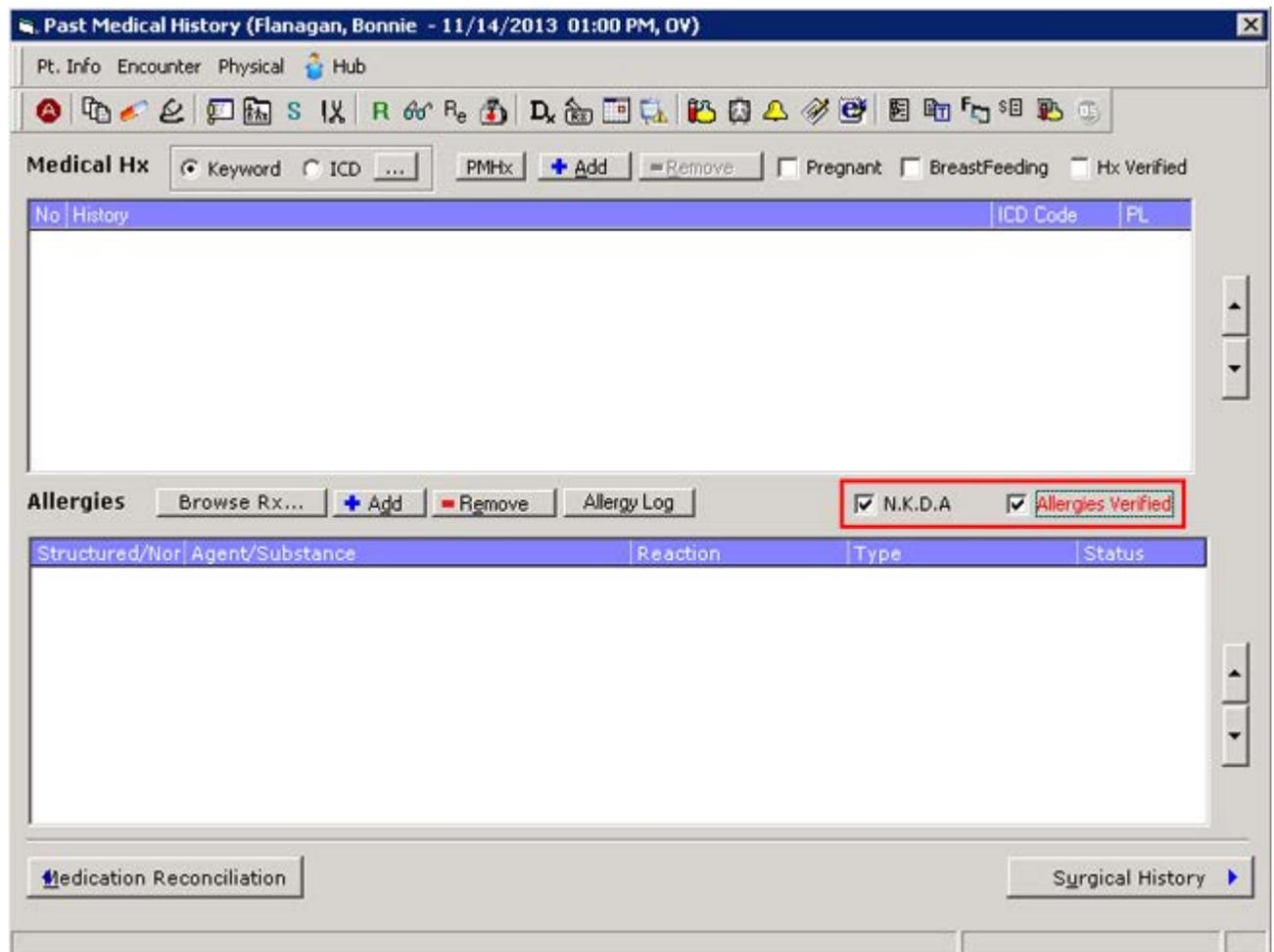
12. Send a test referral during the preferred times for the following CMS-designated test EHRs:

Vendor	Scheduling	Testing Window	Confirmation*
iPatientCare	Scheduling is not required, but iPatientCare prefers that providers wait for their initial communication by e-mail before sending a test.	<ul style="list-style-type: none"> ■ Monday 9:00 AM to 3:00 PM EST ■ Wednesday 9:00 AM to 3:00 PM EST 	Response is by e-mail and within the same day. Contact: Milan Kalola Interoperability@iPatientCare.com
Medical Information Technology (Meditech)	Scheduling is not required, but Meditech prefers that providers send them a follow-up e-mail notifying them that a test was sent.	<ul style="list-style-type: none"> ■ Monday 9:00 AM to 4:00 PM ■ Tuesday 9:00 AM to 4:00 PM ■ Wednesday 9:00 AM to 4:00 PM ■ Thursday 9:00 AM to 4:00 PM 	Response is by e-mail, with a screenshot if successful. If the test is unsuccessful Meditech will respond with the reasons why so that the issue can be addressed. Contact: Philip Alcainho onc-test-ehr-group@meditech.com

Vendor	Scheduling	Testing Window	Confirmation*
McKesson	Scheduling is not required, but McKesson prefers that the test is sent within the given testing window.	<ul style="list-style-type: none"> Monday 9:00 AM -to 4:00 PM EST Wednesday 9:00 AM to 4:00 PM EST Thursday 9:00 AM to 4:00 PM EST 	Response is by e-mail and usually within the hour if sent during the testing window. McKesson welcomes follow-up calls and e-mails from clients. Contact: Lori Fitzhugh CMSCrossVendorExchange@mckesson.com

- *. This is the information provided on <http://ehr-randomizer.nist.gov> when this document was published. Please refer to that website for the latest information.
- †. If you get McKesson when requesting a match, ensure you have selected *No* when you enter the information for *MyCEHRT*. Continue to request a match until you get iPatientcare or Meditech.

13. On the day of the test, create a test patient in the eClinicalWorks EMR and check the following boxes on the Past Medical History, Medication Reconciliation, and Problem List windows:



Medication Reconciliation

Pt. Info Encounter Physical Hub

Current Medication Past Rx History External Rx History Add Medication Verified Drug Interaction Cancel

T Taking N Not Taking D Discontinued U Unknown Status

Apply Status from Prior Visit

T Taking Mark all as: T N D U

Problem List

Patient :

Problem List

Dx Type All Dx Clinical Status All No known problems Add Remove Copy to Medical Hx

Type	Code	Name	Specify	Notes	Risk	Onset Date	W/U Status	Clinical Str	Added On	Modified On	Modified By	Resolved
------	------	------	---------	-------	------	------------	------------	--------------	----------	-------------	-------------	----------

Copy View Log OK Cancel

14. To create an outgoing referral for this test patient:
 - a. Click More (...) next to the Provider field:

Referral (Outgoing)

Patient: O'Test, Advocate (10858) [Sel] [Info] [Hub]

Insurance: BLUE CROSS OF ILLINOIS [Sel] [Pt Ins] POS: 11

*Ref From: [Redacted] ...

Ref To: Provider: [Redacted] ... [Pref] [Clear]

Specialty: Family Medicine

Facility From: [Redacted] ...

Facility To: [Redacted] ... [Clear]

Auth Code: [Redacted]

Auth Type: [Redacted] ...

Start Date: 04/18/2013

Referral Date: 04/18/2013

End Date: 04/18/2014

Open Cases: [Redacted] ... [N]

Assigned To: eclinicalworks, support ...

Appt Date: 05/20/2014

Unit Type: V (VISIT)

Received Date: 05/20/2014

Status: Open Consult Pending Addressed

Priority: Routine

Diagnosis / Reason [Add] [Browse] [Remove]

Sl. No	Description
1	Testing referral

Diagnosis [Previous Dx] [Add] [Remove]

Code	Name

Procedures [Add] [Remove]

Code	Name

[Scan] [Attachments (3)] [Logs] [OK] [Cancel] [Send Referral]

The Referring Physician Lookup window opens.

- b. Select MA from the state pick list.
- c. Enter Test in the *search Name* field.
Test names populate in the bottom pane.

- d. Click the radio button for your test referring physician (either *Test EHR, iPatientCare*; *Test EHR, Meditech*; or *Test EHR, Mckesson*):

Referring Physician Lookup

All Providers Preferred Providers By Facility

All Providers Specialty Search Accept Patient Insurance

Test search City MA search Zip search Aff

Name	Address	Specialty	Contact Details	Aff
Testing Labatori...	PO BOX 840 SOUTHBRIDGE MA 0...	Clinical Medical...	7744028111 7744028111	
Test Facility	123 Main Street Westborough...	Clinical, Clinic...		
Test Facility	800 Washintgon Street Bosto...			
Test EHR, iPatie...	Test drive Westborough MA 0...			
Test EHR, Medite...	Test drive Westborough MA 0...			
Test EHR, McKess...	Test drive Westborough MA 0...			
TEST - Wincheste...	41 Highland Ave Winchester ...			
Test, Test	MA 44333			

In address book Not in address book (from MA) Previous Next

- e. Click *Attachments* on the Referral (Outgoing) window.
The Attachments window opens.

- f. Check the *Attach Medical Summary* box, the *Attach CCR/CCD* box, and the box next to the applicable Progress Notes:

Attachments

Attach Medical Summary Attach CCR/CCD 

(CCR/CCD available only when sending via eCW P2P)

26.26 KB / 2 MB

Progress Notes Attach Remove

<input type="checkbox"/> Date	Reason
<input checked="" type="checkbox"/> 09/06/2013	

Lab Reports Attach Remove

<input type="checkbox"/> Name	Reason	Result

X-Rays Attach Remove

<input type="checkbox"/> Name	Reason	Result

Patient Documents Attach Remove

<input type="checkbox"/> Name	Description

Specialty Document Attach Remove

<input type="checkbox"/> Name	Description

OK Cancel

- g. Click OK.
15. Send the referral.
 16. Reply to the e-mail you received when you requested a match from the CMS-designated test EHR, indicating that you sent a referral from "your direct address" on the date and time on which you sent the referral.
 17. Receive a confirmation from the CMS-designated test EHR that they received the referral successfully. Save this confirmation for audit purposes.

Exclusions

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They transfer patients to another setting or refer patients to another provider less than 100 times during the reporting period.	This exclusion criteria is reported by self-attestation.

Note: Changes made in the Stage 2 Final Rule state that providers that use the same EHR technology and share a network for which their organization either has operational control of or license to use can conduct one test of the successful electronic exchange of a summary of care document with either a different EHR technology or the CMS-designated test EHR that covers all providers in their organization. For example, if a large group of EPs with multiple physical locations use the same EHR technology and those locations are connected using a network that the group has either operational control of or license to use, then a single test would cover all EPs in that group. For more information, refer to <https://questions.cms.gov/faq.php?faqId=7729>.

Core 16: Submitting Electronic Data to Immunization Registries

Objective

Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure

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

Note: At a minimum, you must register with your registry within the first 60 days of the start of the reporting period and follow their testing procedures.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

Feature	Area to Document within eClinicalWorks
Ongoing submissions originally achieved in a prior year using HL7 2.3.1 that are continuing.	EMR > Immunizations/Therapeutic Injections > Immunizations Registry > Export Immunizations
<p>A registration of intent within 60 days of the beginning of the reporting period and meet at least ONE of the following criteria:</p> <ul style="list-style-type: none"> ■ Awaiting an invitation to begin testing. ■ Engaged in testing. ■ Ongoing submissions using HL7 2.5.1. 	Contact your state immunization registry.
	<p>Note: eClinicalWorks provides registry interfaces to practices in many states. The process details vary slightly based on individual state requirements. Contact eCW Support for more information about immunization registry interface for a specific state.</p>

Exclusion

Providers may be excluded from this measure if they meet at least ONE of the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They do not administer any immunizations during the EHR reporting period.	This exclusion criteria is reported by self-attestation.
Their immunization registry does not provide timely information on their capacity to receive immunization data.	
Their registry is not able to accept the HL7 2.5.1 standard.	
Their registry is not enrolling new eligible providers on the HL7 2.5.1 standard.	

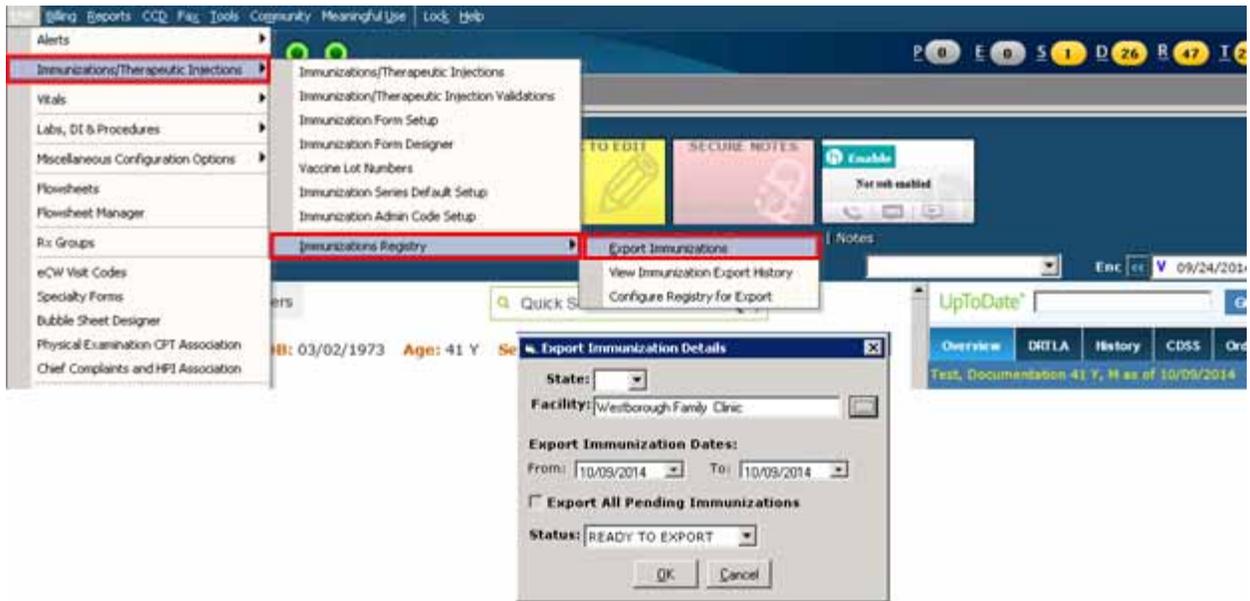
Features Related to Core 16

The following features are related to Core Measure 16:

- [Exporting Immunizations](#)

Exporting Immunizations

- EMR > Immunizations/Therapeutic Injections > Immunizations Registry > Export Immunizations



Core 17: Use Secure Electronic Messaging

Objective

Use secure electronic messaging to communicate with patients on relevant health information.

Measure

A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy at least ONE of the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
They have sent any message from the Patient Portal to the provider during the EHR reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Admin band > Patient Portal Settings icon > Menu Settings > select Show from drop-down lists ■ Patient Portal > Messages or Appointments
They have confirmed or canceled a voice appointment reminder message from the practice.	Configure options related to this measure from the following locations: <ul style="list-style-type: none"> ■ Admin band > Messenger icon > Visit Status Mapping ■ Admin band > Messenger icon > Voice Logs > select Appointment from the Message Type drop-down list Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > open an appointment > Visit Status ■ Practice band > Provider Schedule icon > open an appointment > Visit Status
	Note: For more information on how to use these features, refer to the <i>eClinicalWorks Messenger Guide</i> or the HelpHub.

Exclusion

Providers may be excluded from this measure if they meet at least ONE of the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have no office visits during the EHR reporting period	This exclusion criteria is reported by self-attestation.
They conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability, according to the latest information available from the FCC on the first day of the EHR reporting period.	This exclusion criteria is reported by self-attestation. Information on broadband availability can be found at: http://www.broadbandmap.gov/

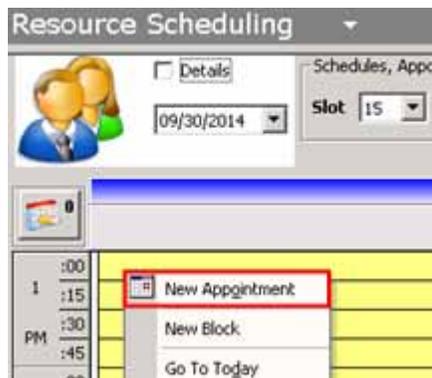
Features Related to Core 17

The following features are related to Core Measure 17:

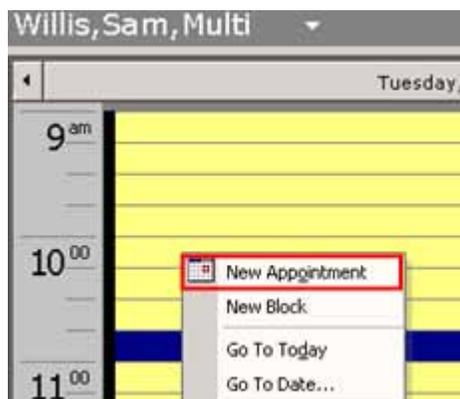
- Recording Appointments
- Recording E&M Codes
- Configuring Patient Portal Menu Settings
- Sending Messages for Patients
- Configuring eClinicalWorks Messenger
- Recording Visit Status

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

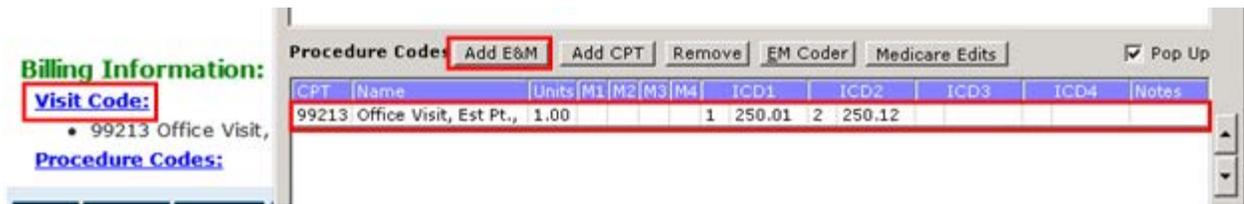


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



Recording E&M Codes

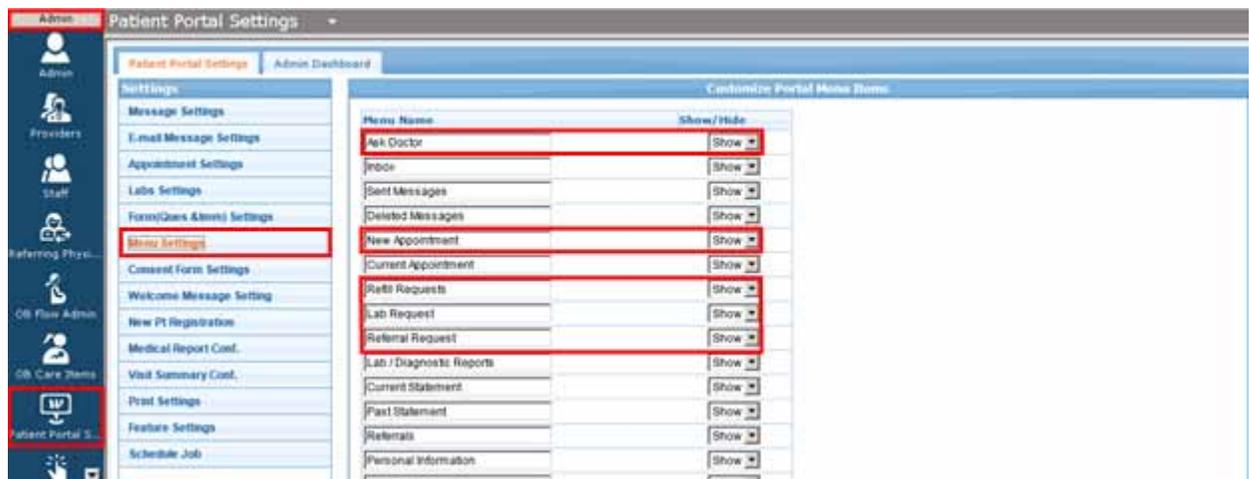
- Progress Notes > Visit Code > Add E&M



Configuring Patient Portal Menu Settings

This is a one-time setup process:

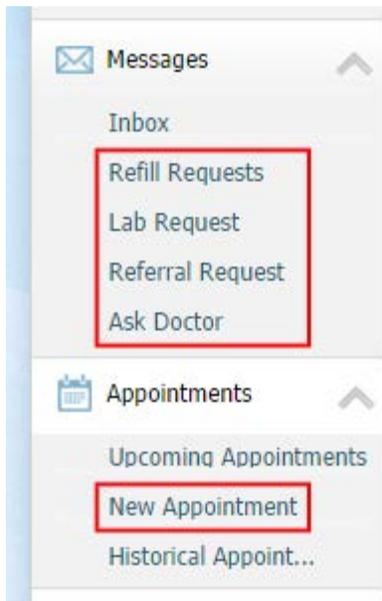
- Admin band > Patient Portal Settings icon > Menu Settings > select Show from drop-down lists



Sending Messages for Patients

Patients can send messages from the Patient Portal from the following location:

- Patient Portal > Messages or Appointments

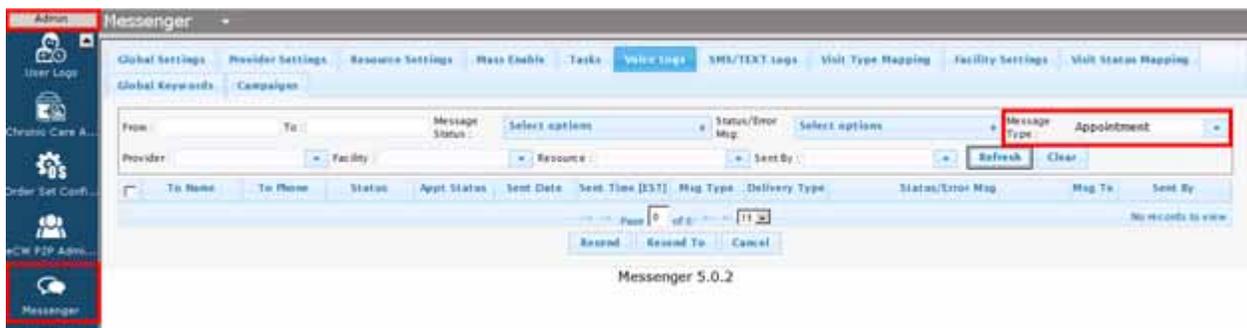


Configuring eClinicalWorks Messenger

- Admin band > Messenger icon > Visit Status Mapping

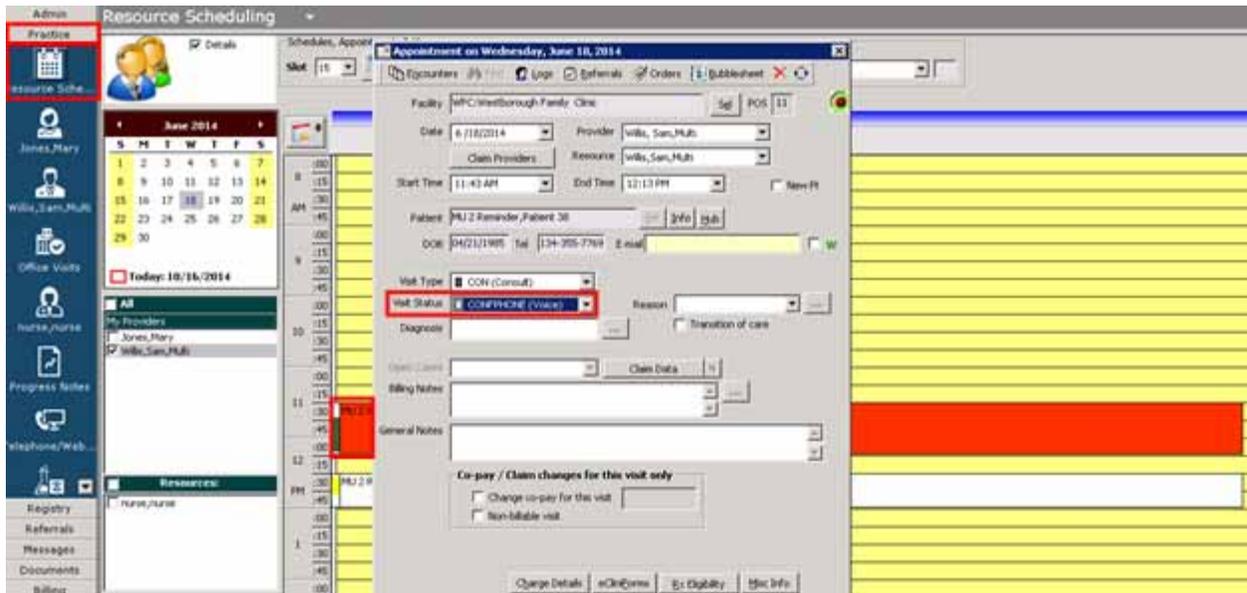


- Admin band > Messenger icon > Voice Logs > select Appointment from the Message Type drop-down list

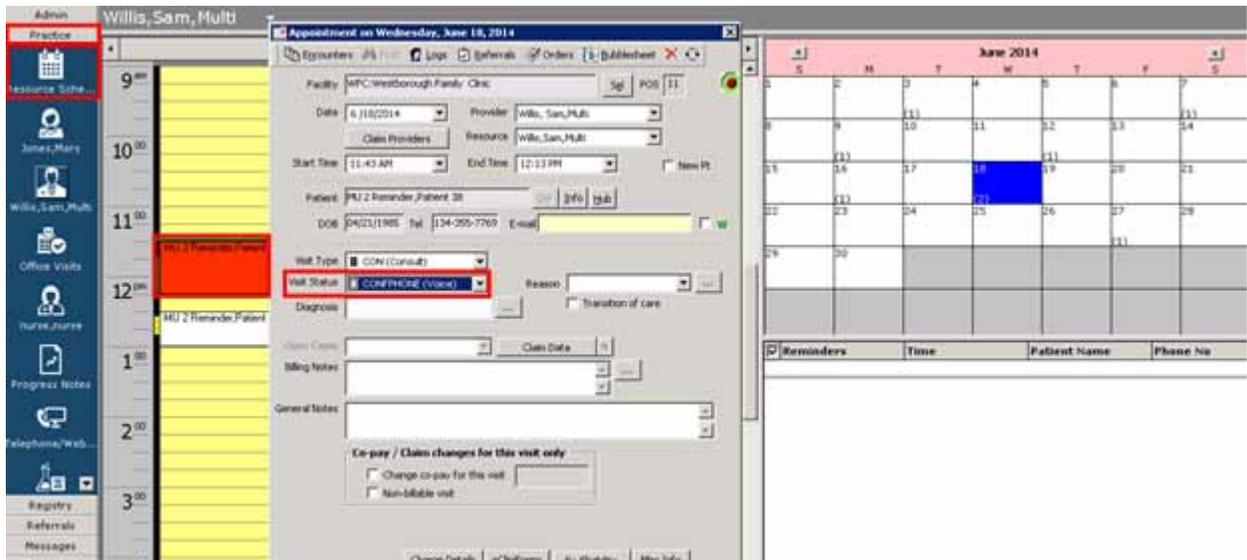


Recording Visit Status

- Practice band > Resource Scheduling icon > open an appointment > Visit Status



- Practice band > Provider Schedule icon > open an appointment > Visit Status



MENU SET MEASURES

3 of the following 6 objectives must be satisfied to fulfill the Meaningful Use requirements.

- [Menu 1: Submitting Electronic Syndromic Surveillance](#)
- [Menu 2: Electronic Notes](#)
- [Menu 3: Imaging Results](#)
- [Menu 4: Family Health History](#)
- [Menu 5: Identify and Report Cancer Cases](#)
- [Menu 6: Specialized Registry](#)

Note: While there are exclusions provided for some of the Menu Set objectives, users cannot select one of these objectives and claim the exclusion if there are other Menu Set objectives that they can report on instead.

Selection Suggestion

- The two measures that most providers find the easiest to meet are:
 - ◆ [Menu 2: Electronic Notes](#)
 - ◆ [Menu 4: Family Health History](#)
- Providers should first see if they can claim an exclusion for all four remaining measures. If so, attest with the two measures listed above and claim an exclusion for any other measure.
- If exclusions cannot be claimed for all remaining measures, start with [Menu 3: Imaging Results](#) to see if you can meet that measure. If not, check with your state to see if they accept Syndromic Surveillance data. If they do, attest for [Menu 1: Submitting Electronic Syndromic Surveillance](#). If they do not accept this data, attest for [Menu 6: Specialized Registry](#).
- In cases where you cannot claim an exclusion from other Menu Set Measures and you are not able to meet them (*e.g.*, you diagnose cancer and there is a cancer registry in your state but you cannot meet the measure as eCW is not supporting a cancer registry OR you have access to imaging results but are not able to meet the measure *i.e.*, access imaging results from CEHRT), then you should satisfy this measure by registering your intent for on-going submission within the first 60 days of the reporting period with Dartnet.info.

For more information on Dartnet.info, refer to [What is Dartnet.info?](#).

Menu 1: Submitting Electronic Syndromic Surveillance

Objective

Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Measure

Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

Note: At a minimum, you must register with your registry within the first 60 days of the start of the reporting period and follow their testing procedures.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

Feature	Area to Document within eClinicalWorks
Ongoing submissions originally achieved in a prior year using HL7 2.3.1 that are continuing.	Each state has its own rules for syndromic surveillance. Please contact your state's call center for more information. Open a support case to determine the scope and the cost of an interface with your chosen public health agency.
A registration of intent within 60 days of the beginning of the reporting period and meet at least ONE of the following criteria: <ul style="list-style-type: none"> ■ Awaiting an invitation to begin testing. ■ Engaged in testing. ■ Ongoing submissions using HL7 2.5.1. 	

Exclusions

Providers may be excluded from this measure if they meet at least ONE of the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They do not collect ambulatory syndromic surveillance information.	This exclusion criteria is reported by self-attestation.
Their public health agency does not provide timely information on their ability to accept electronic submissions.	

Exclusion Criteria	Area to Document within eClinicalWorks
Their public health agency is not capable of receiving electronic syndromic surveillance data.	
Their public health agency capable of receiving electronic submissions is not able to add any providers to their enrollment.	

Menu 2: Electronic Notes

Objective

Record electronic notes in patient records.

Measure

Enter at least one electronic Progress Notes created, edited, and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR Measure reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

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Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
Their data is entered in at least ONE of the following sections of the Progress Notes (HPI, ROS, Treatment, or Procedures).	Record this information from the following locations: <ul style="list-style-type: none"> ■ Progress Notes > HPI > select category > enter c/o, denies, duration, or notes ■ Progress Notes > ROS > select category > enter presence or notes ■ Progress Notes > Treatment > enter medications, labs, diagnostic imaging tests, procedures, outgoing referrals, or use eCliniSense ■ Progress Notes > Procedures > select category > enter notes

Features Related to Menu Set 2

The following features are related to Menu Set Measure 2:

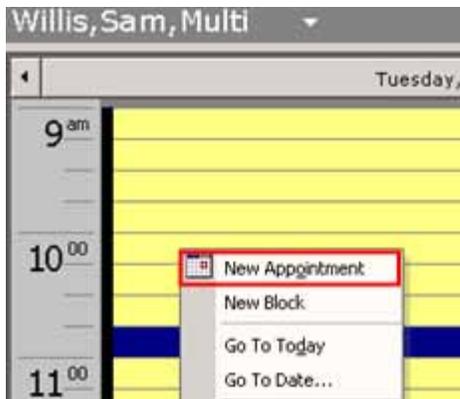
- Recording Appointments
- Recording E&M Codes
- Recording Information in Progress Notes

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

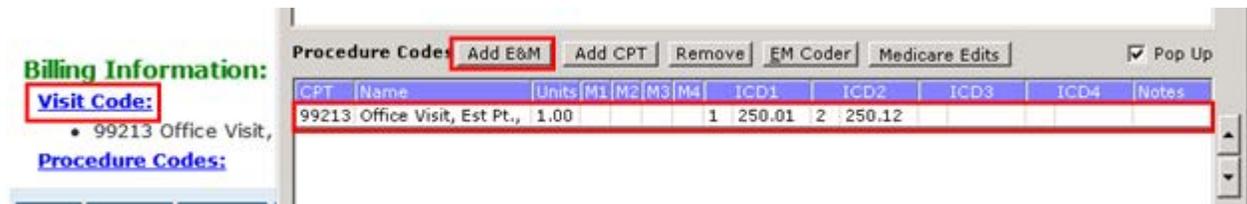


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



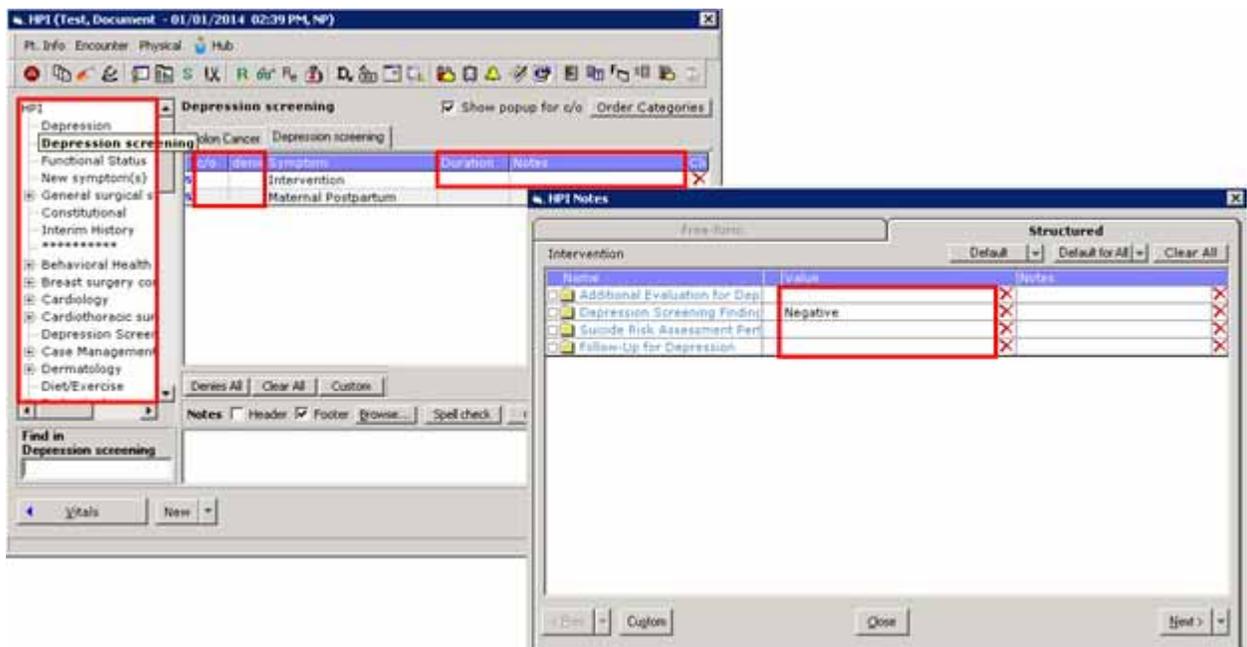
Recording E&M Codes

- Progress Notes > Visit Code > Add E&M

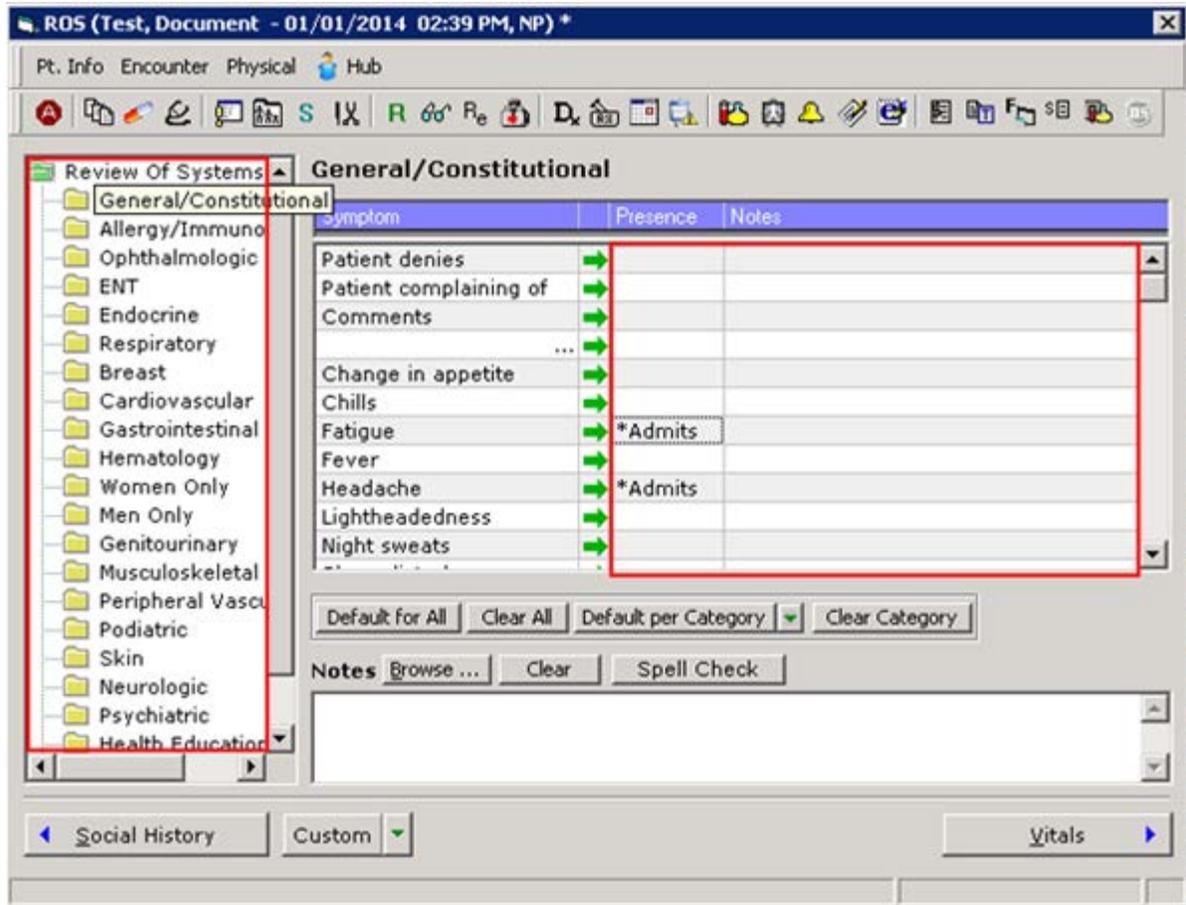


Recording Information in Progress Notes

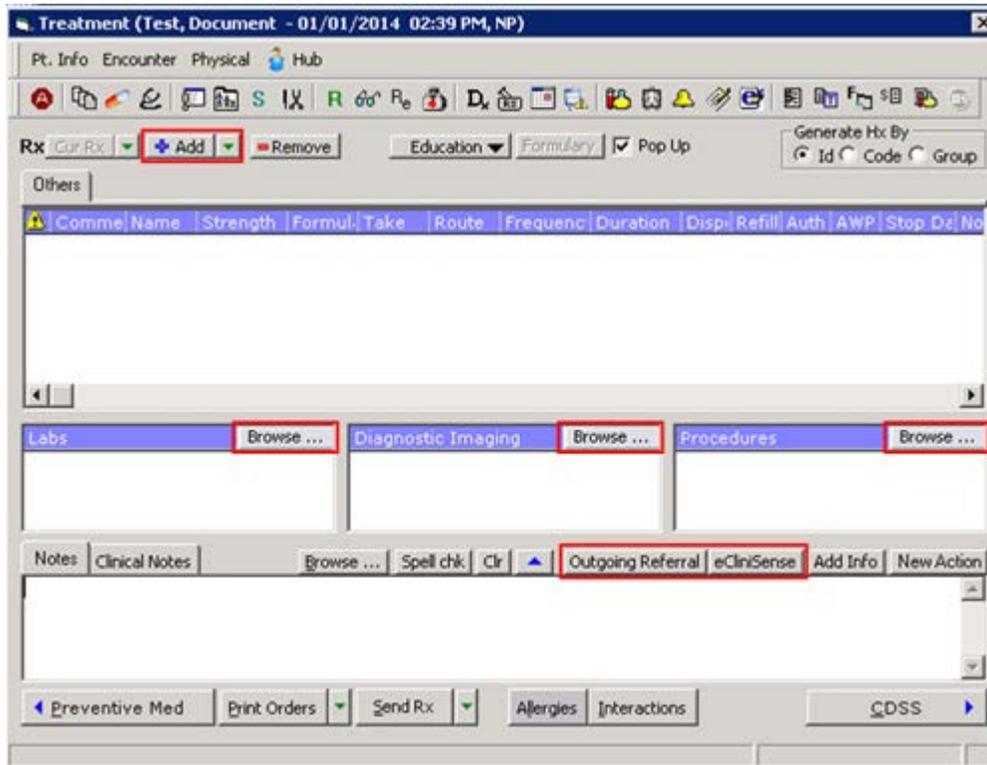
- Progress Notes > HPI > select category > enter c/o, denies, duration, or notes



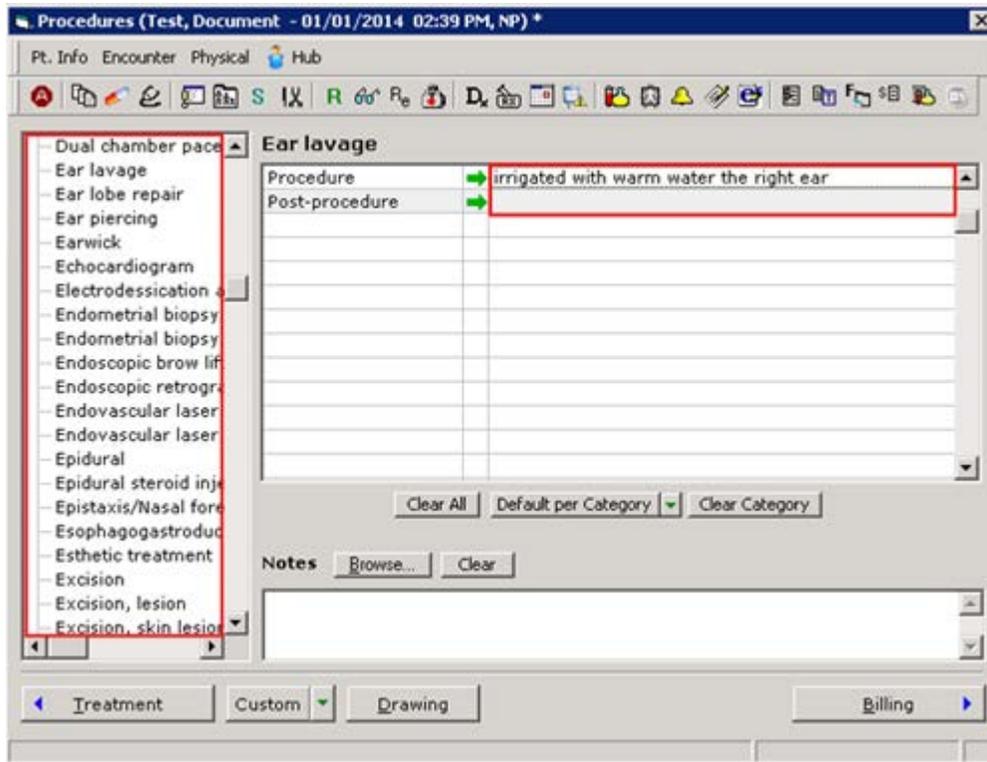
- Progress Notes > ROS > select category > enter presence or notes



- Progress Notes > Treatment > enter medications, labs, diagnostic imaging tests, procedures, outgoing referrals, or use eClniSense



- Progress Notes > Procedures > select category > enter notes



Menu 3: Imaging Results

Objective

Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

Measure

More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
Their order date and result date are during the reporting period and they are marked as Received from the Diagnostic Imaging window.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Progress Notes > Diagnostic Imaging ■ Progress Notes > Treatment > Browse in the Diagnostic Imaging section ■ Telephone/Web Encounter > Labs/DI tab > Imaging > New ■ Telephone/Web Encounter > Virtual Visit tab > Diagnostic Imaging ■ Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Diagnostic Imaging section ■ Patient Hub > DI > New

Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy at least ONE of the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
A diagnostic image is attached to the test from the Document Details window.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Documents > Document Details > select a patient > open a document > Attached To ■ Documents > Document Details > select a patient > open a document > Browse next to the Tag field > highlight the DI IMAGE tag > OK
	IMPORTANT! You must use DI IMAGE tag for this result to count in numerator for this measure.
	Note: There are no limitation on the resolution of the diagnostic image.
	Note: Diagnostic images and imaging results that are scanned into the CEHRT may be counted in the numerator for this measure.

Numerator Criteria	Area to Document within eClinicalWorks
<p>An indication that an image is accessible to the provider through the EHR is entered from the Diagnostic Imaging window</p>	<p>Record this information from the following locations:</p> <ul style="list-style-type: none"> ■ EMR > Labs/DI/Procedures > Diagnostic Imaging > highlight a DI and click Attribute Codes > New > Image Accessible ■ L jellybean > Imaging > click a DI order > enter Y or Yes in the yellow row in the Image Accessible column ■ Progress Notes > click a DI link under the Treatment heading > enter Y or Yes in the yellow row in the Image Accessible column ■ Progress Notes > Diagnostic Imaging > click a DI link under the Diagnostic Imaging heading > enter Y or Yes in the yellow row in the Image Accessible column ■ Progress Notes > right Chart Panel (ICW) > Labs/DI tab > click a DI > enter Y or Yes in the yellow row in the Image Accessible column ■ Patient Hub > DI > click a DI order > enter Y or Yes in the yellow row in the Image Accessible column ■ Telephone/Web Encounter > Labs/DI tab > Imaging > open a DI order > enter Y or Yes in the yellow row in the Image Accessible column ■ Telephone/Web Encounter > Virtual Visit tab > click a DI link under the Treatment heading > open a DI order enter Y or Yes in the yellow row in the Image Accessible column ■ Telephone/Web Encounter > Virtual Visit tab > click a DI link under the Diagnostic Imaging heading > enter Y or Yes in the yellow row in the Image Accessible column <p>IMPORTANT! To use the attribute workflow, the diagnostic image must be accessible through the EHR in some manner (scanned into documents, link to image within EHR, etc).</p> <p>IMPORTANT! The attribute code must be entered as <i>Image Accessible</i>. The entry into the yellow grid under <i>Image Accessible</i> must either be <i>Y</i> or <i>Yes</i> for this result to count in the numerator for this measure.</p>
<p>A diagnostic imaging result with a link to the image (PACS Interface) is attached.</p>	<p>Documents > Document Details > select a patient > open a document > paperclick link (PACS Interface)</p>

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have ordered less than 100 tests whose result is an image during the EHR reporting period.	This exclusion criteria is reported by self-attestation.
They have no access to electronic imaging results at the start of the EHR reporting period.	

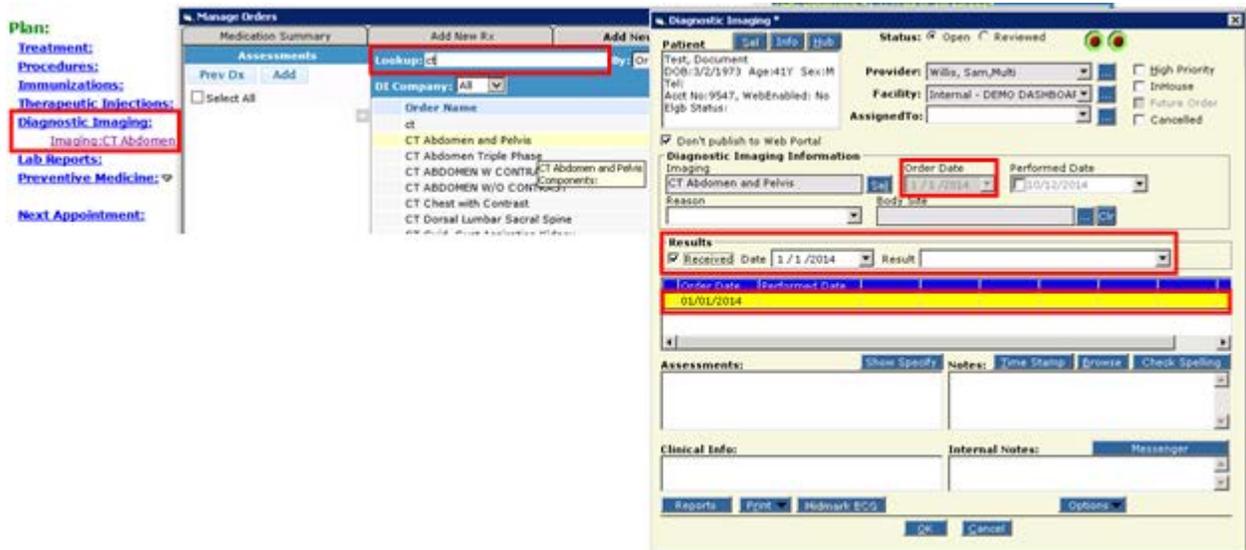
Features Related to Menu Set 3

The following features are related to Menu Set Measure 3:

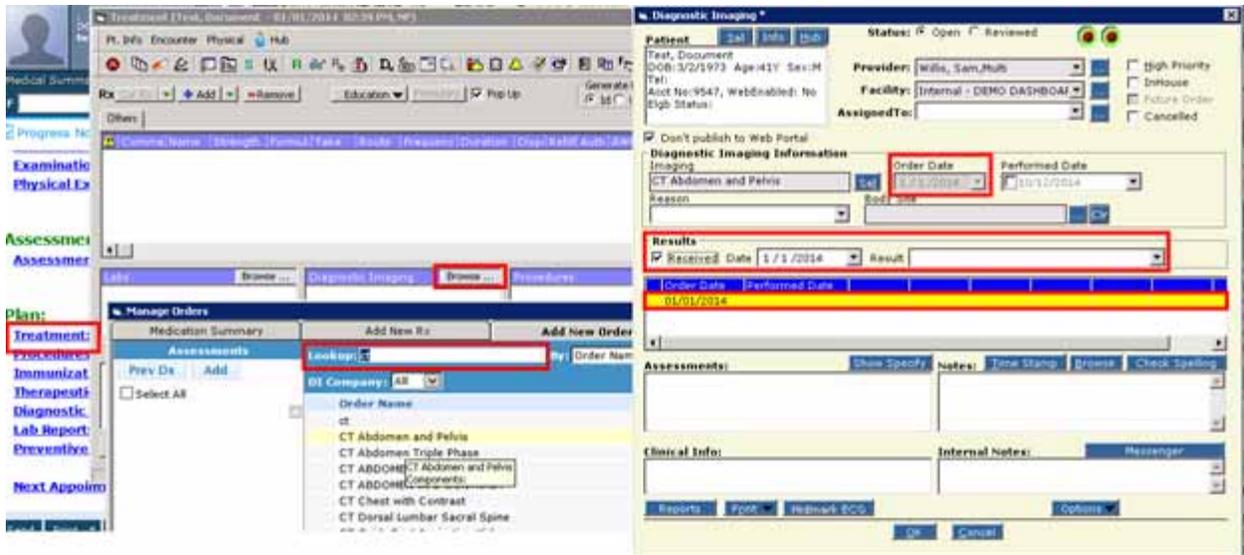
- Recording Diagnostic Imaging Tests
- Attaching Diagnostic Imaging Tests
- Configuring the Diagnostic Image Tag

Recording Diagnostic Imaging Tests

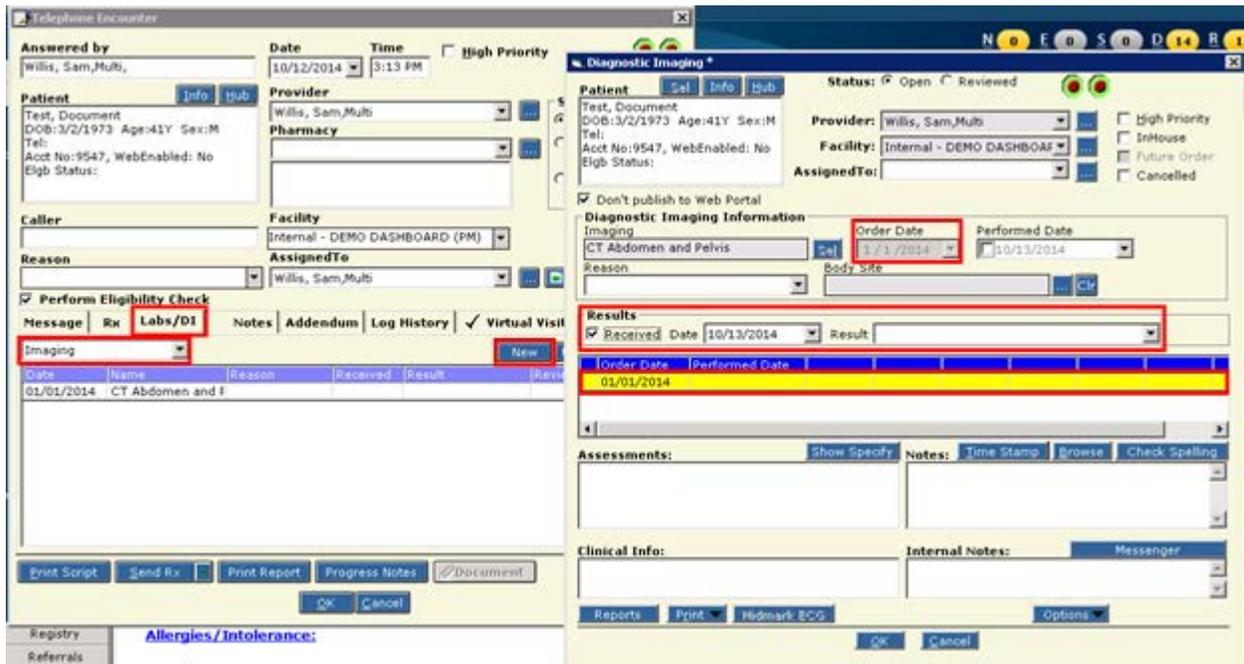
- Progress Notes > Diagnostic Imaging



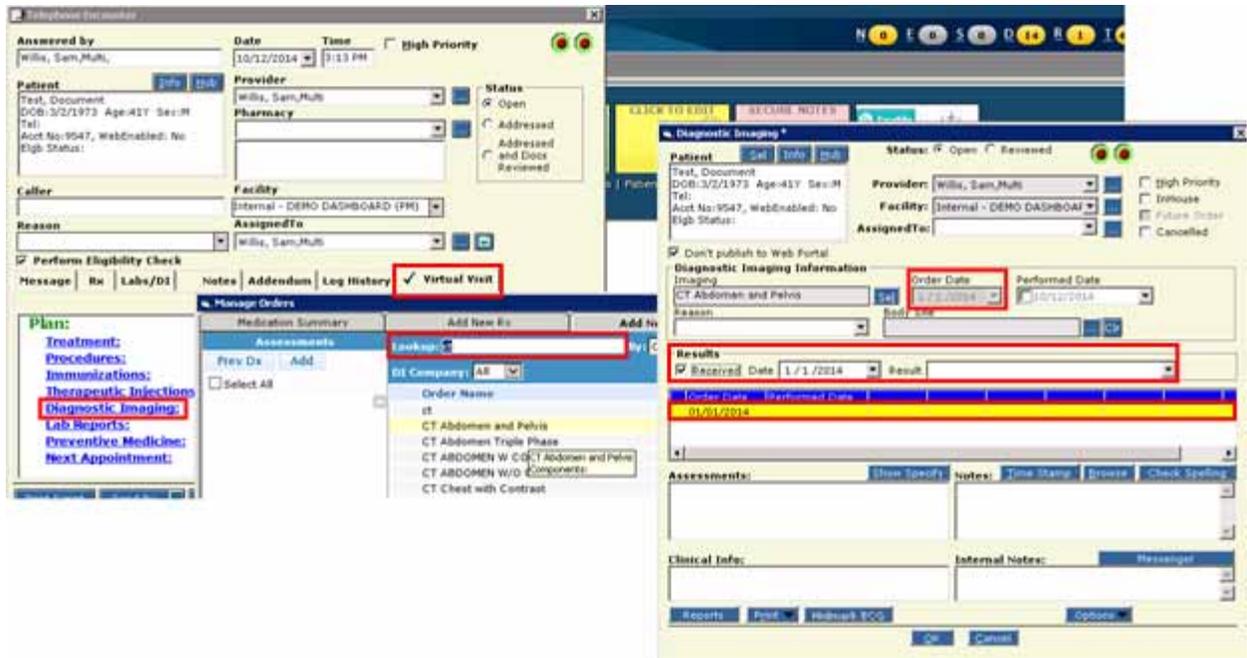
- Progress Notes > Treatment > Browse in the Diagnostic Imaging section



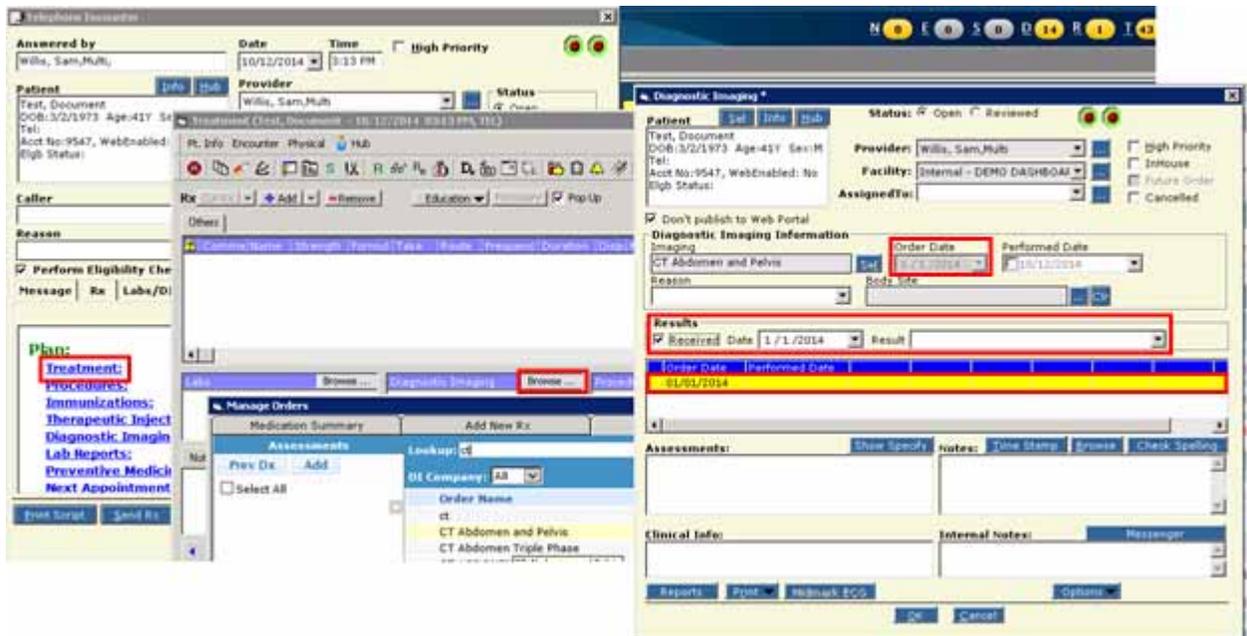
- Telephone/Web Encounter > Labs/DI tab > Imaging > New



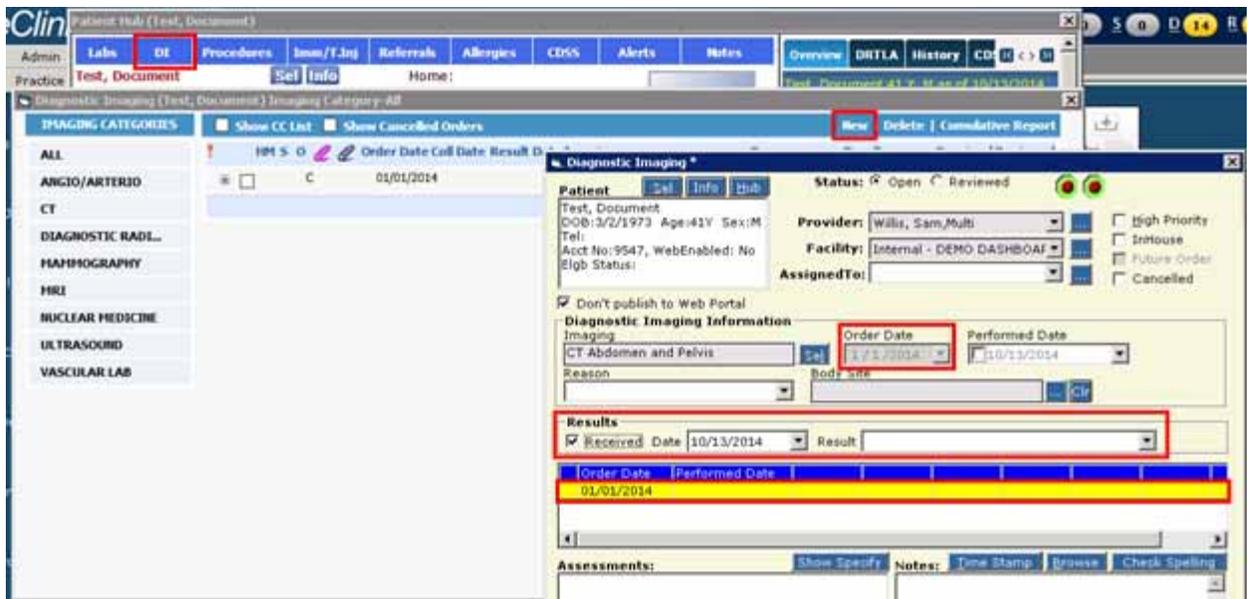
- Telephone/Web Encounter > Virtual Visit tab > Diagnostic Imaging



- Telephone/Web Encounter > Virtual Visit tab > Treatment > Browse in the Diagnostic Imaging section

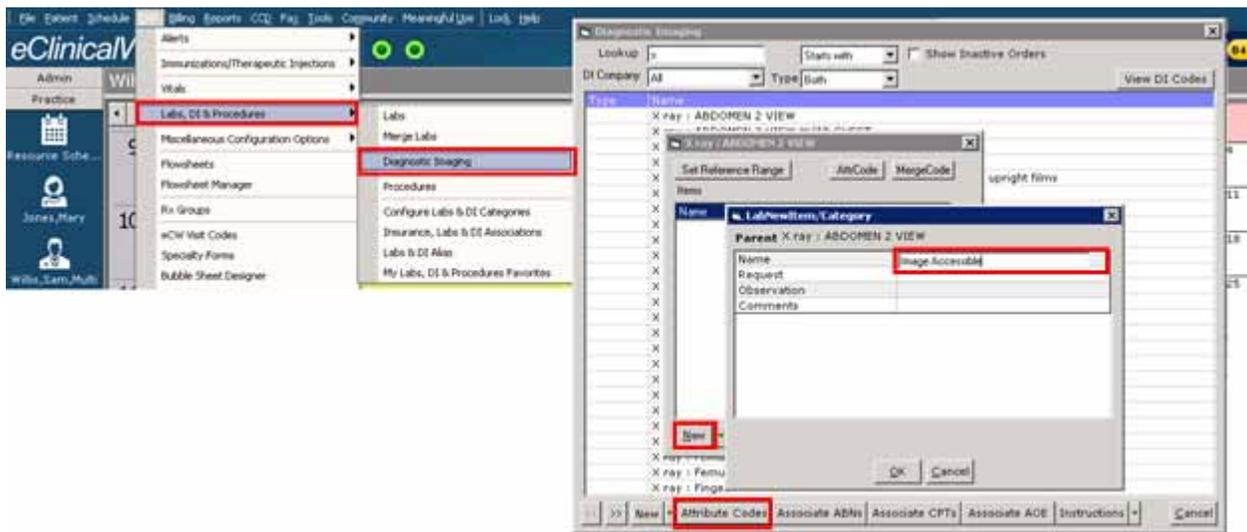


- Patient Hub > DI > New

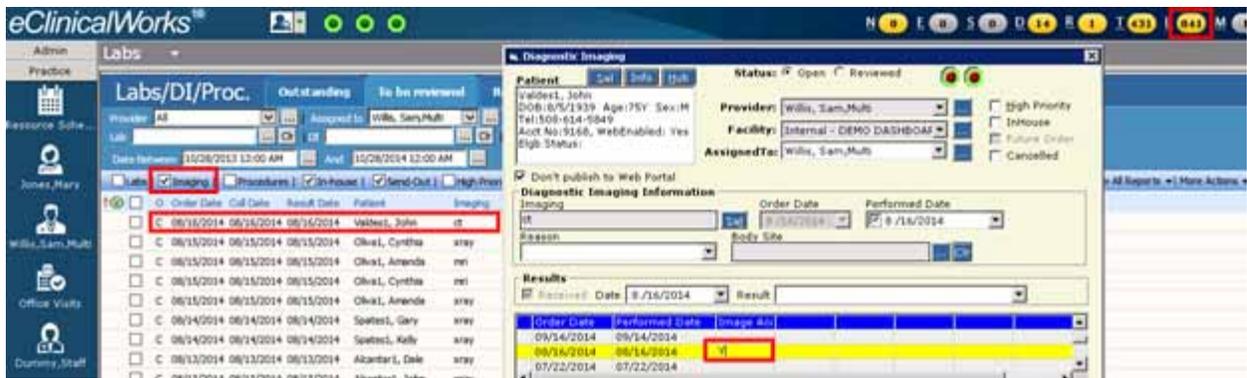


Recording That an Image is Accessible

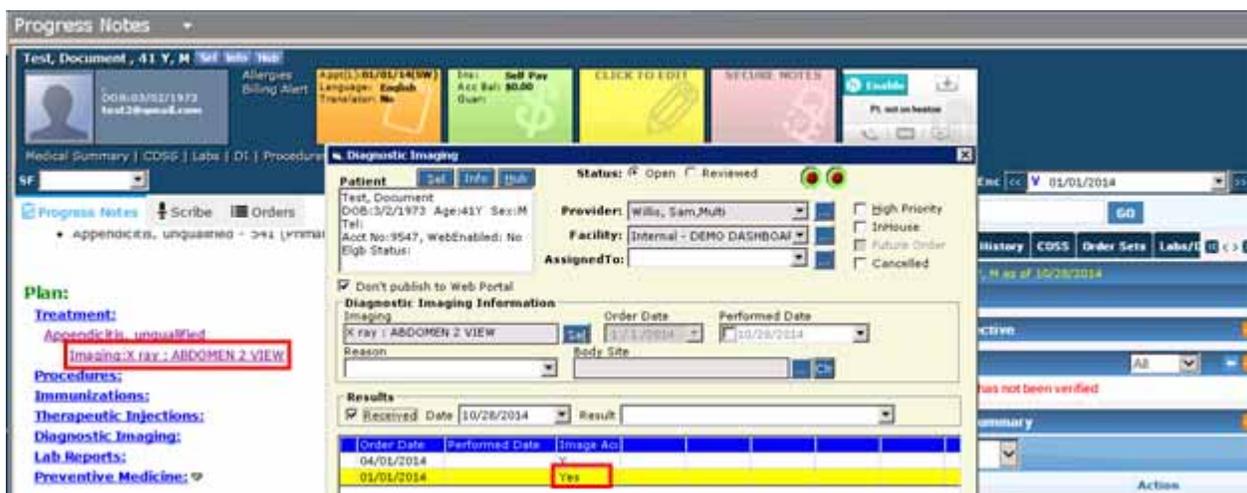
- EMR > Labs/DI/Procedures > Diagnostic Imaging > highlight a DI and click *Attribute Codes* > New > Image Accessible



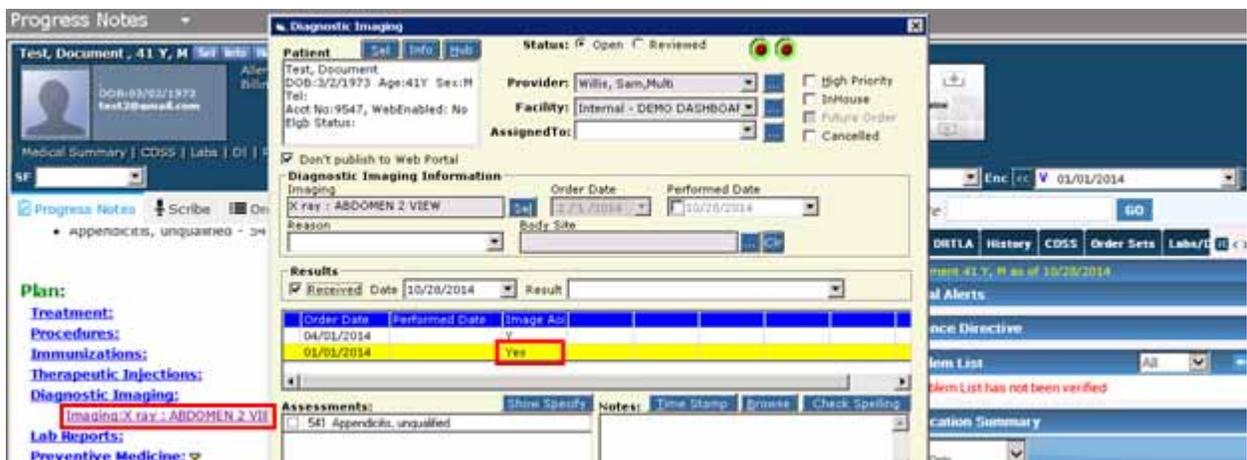
- L jellybean > Imaging > click a DI order > enter Y or Yes in the yellow row in the Image Accessible column



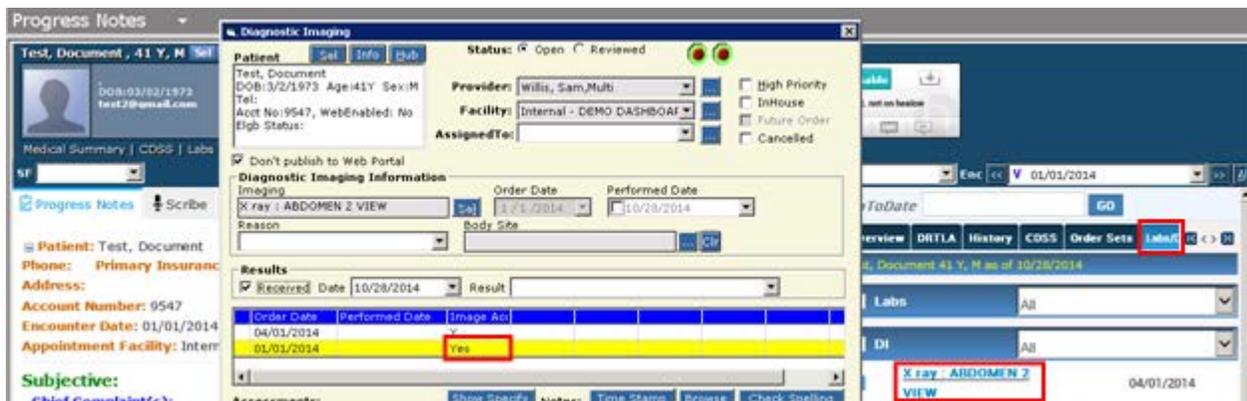
- Progress Notes > click a DI link under the Treatment heading > enter Y or Yes in the yellow row in the Image Accessible column



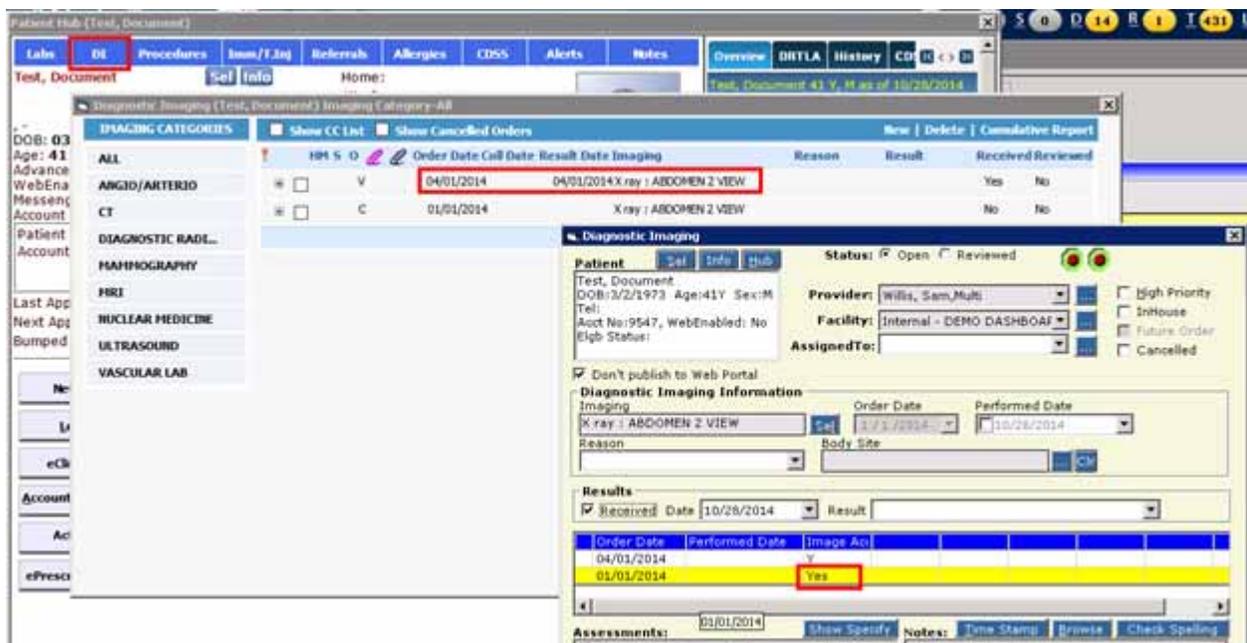
- Progress Notes > Diagnostic Imaging > click a DI link under the Diagnostic Imaging heading > enter Y or Yes in the yellow row in the Image Accessible column



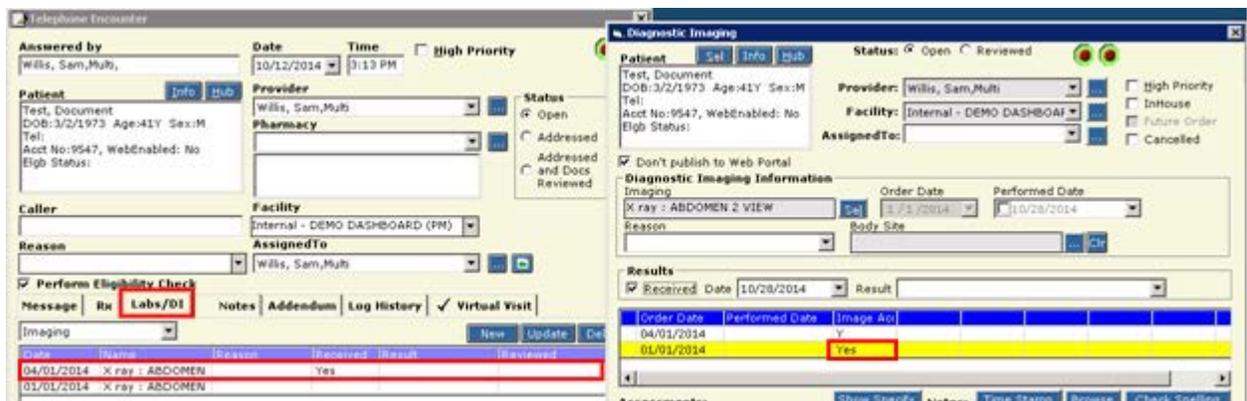
- Progress Notes > right Chart Panel (ICW) > Labs/DI tab > click a DI > enter Y or Yes in the yellow row in the Image Accessible column



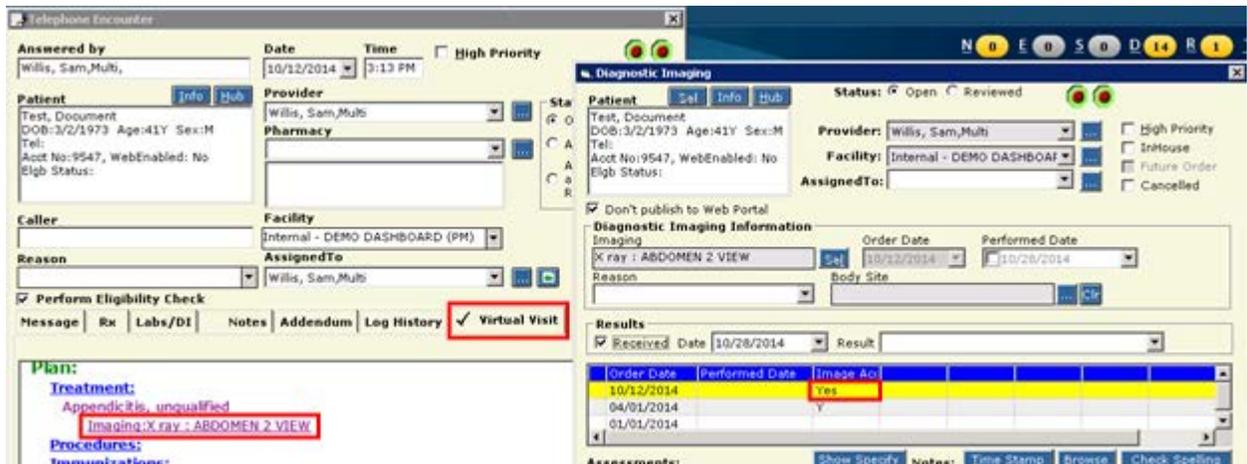
- Patient Hub > DI > click a DI order > enter Y or Yes in the yellow row in the Image Accessible column



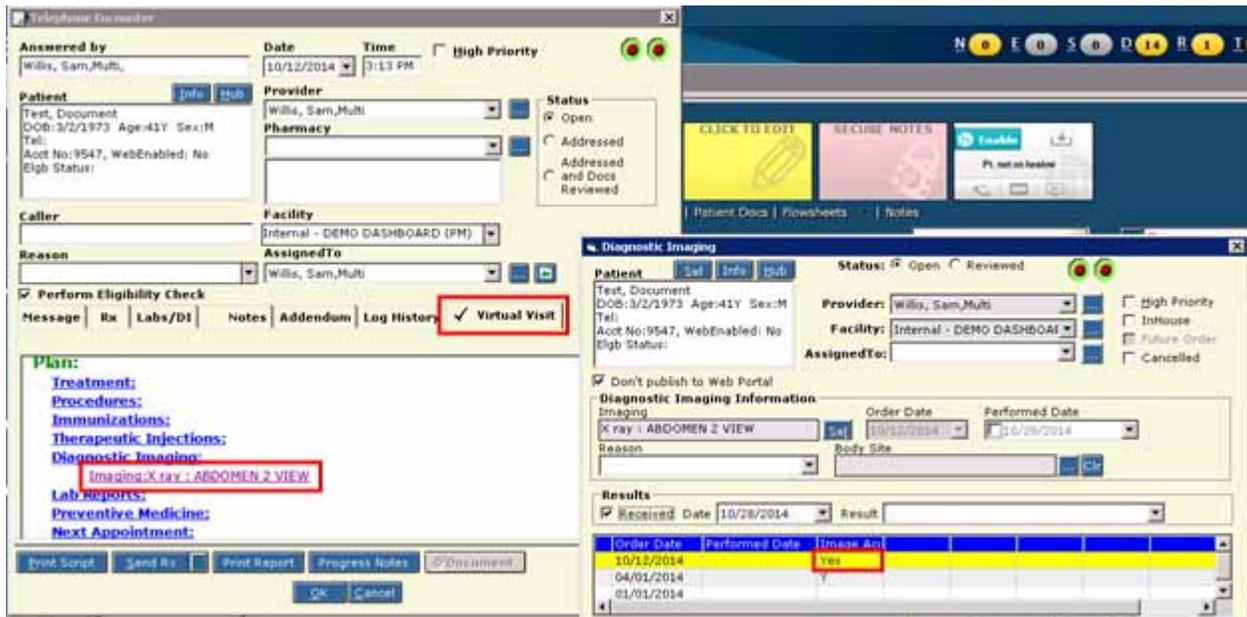
- Telephone/Web Encounter > Labs/DI tab > Imaging > open a DI order > enter Y or Yes in the yellow row in the Image Accessible column



- Telephone/Web Encounter > Virtual Visit tab > click a DI link under the Treatment heading > open a DI order enter Y or Yes in the yellow row in the Image Accessible column

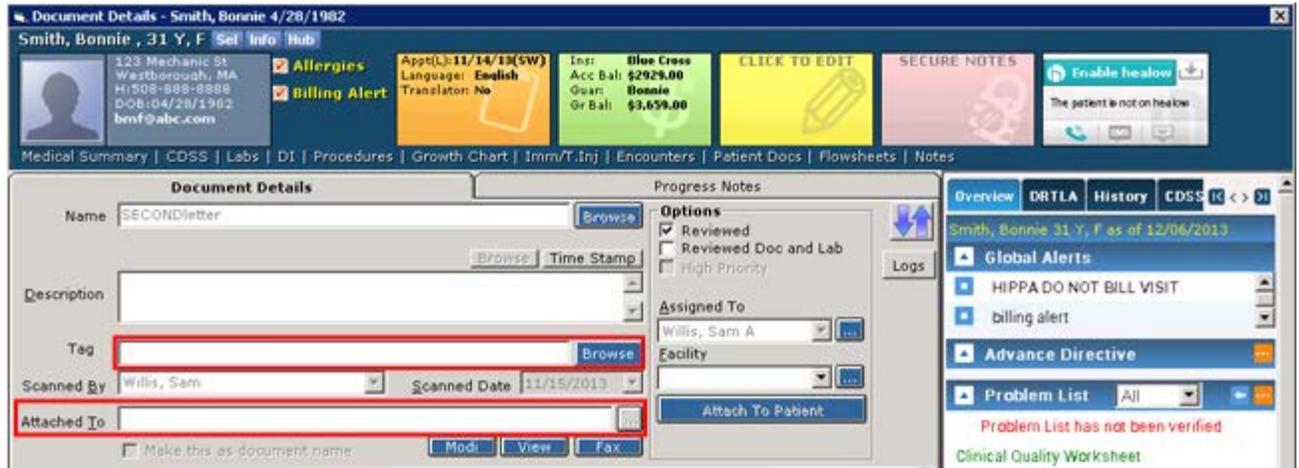


- Telephone/Web Encounter > Virtual Visit tab > click a DI link under the Diagnostic Imaging heading > enter Y or Yes in the yellow row in the Image Accessible column

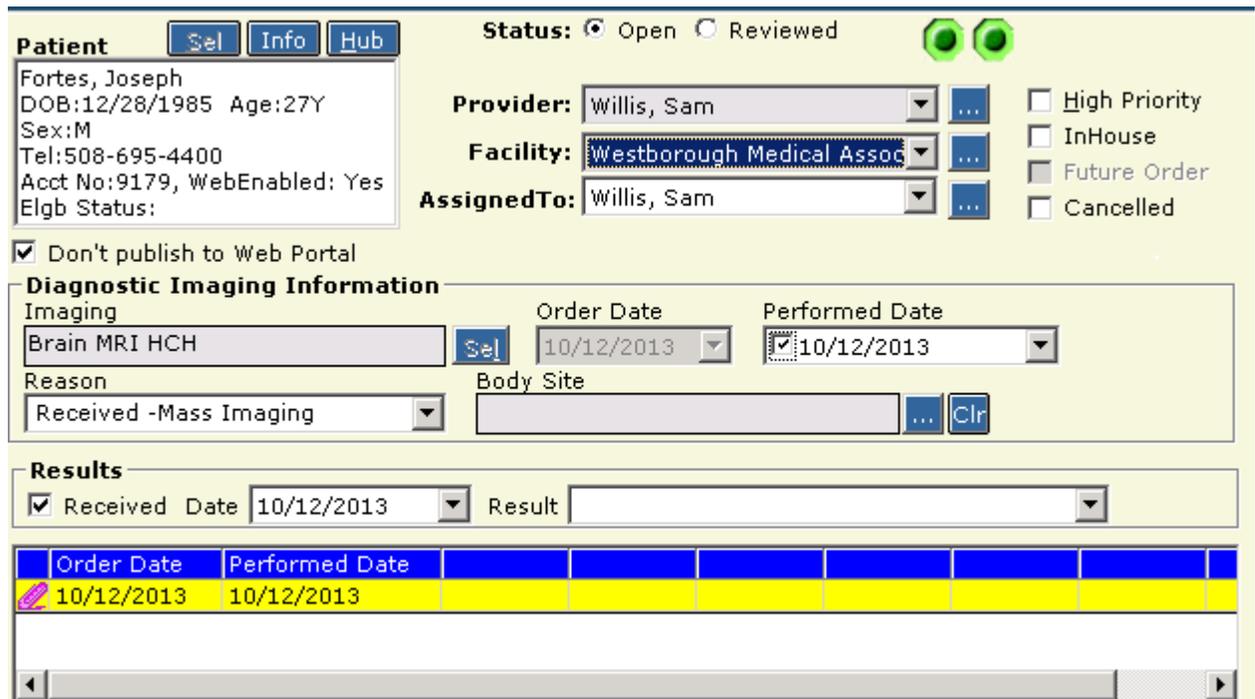


Attaching Diagnostic Imaging Tests

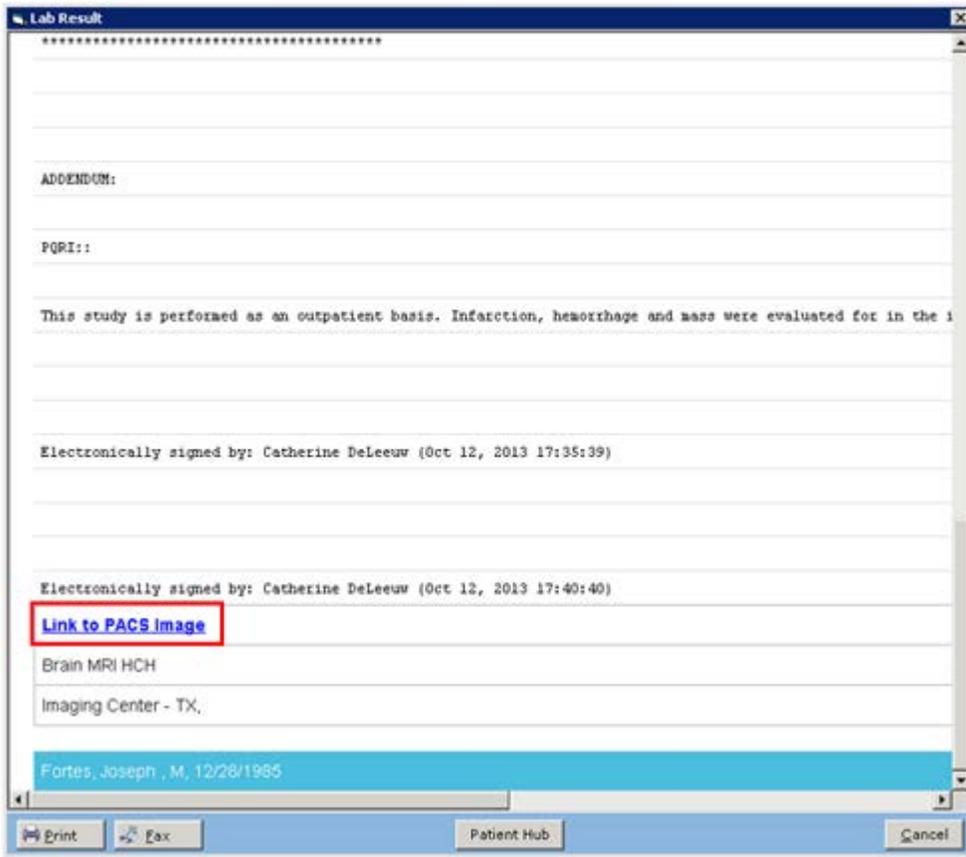
- Documents > Document Details > select a patient > open a document > Attached To



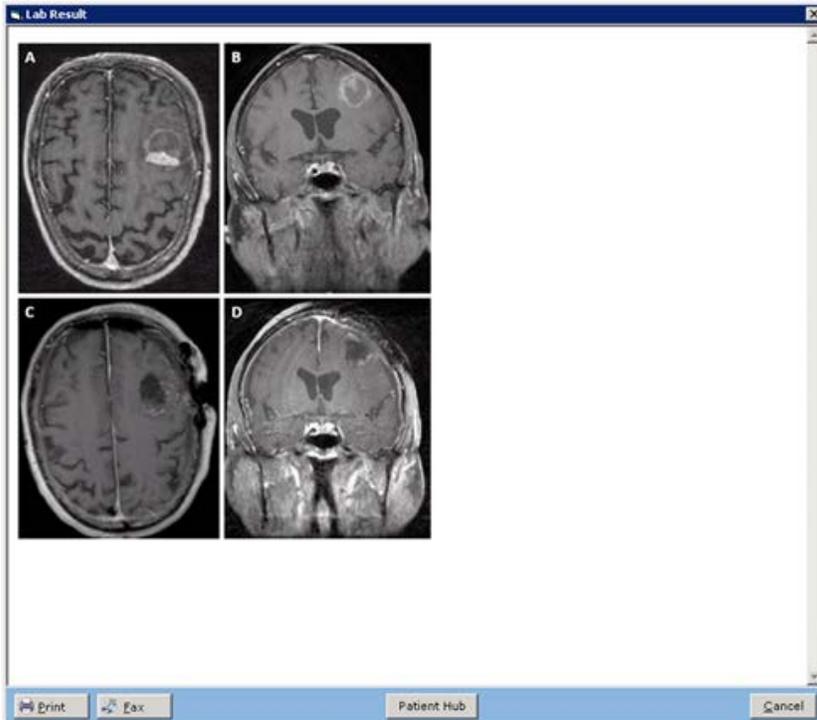
- Documents > Document Details > select a patient > open a document > paperclick link (PACS Interface)



AND

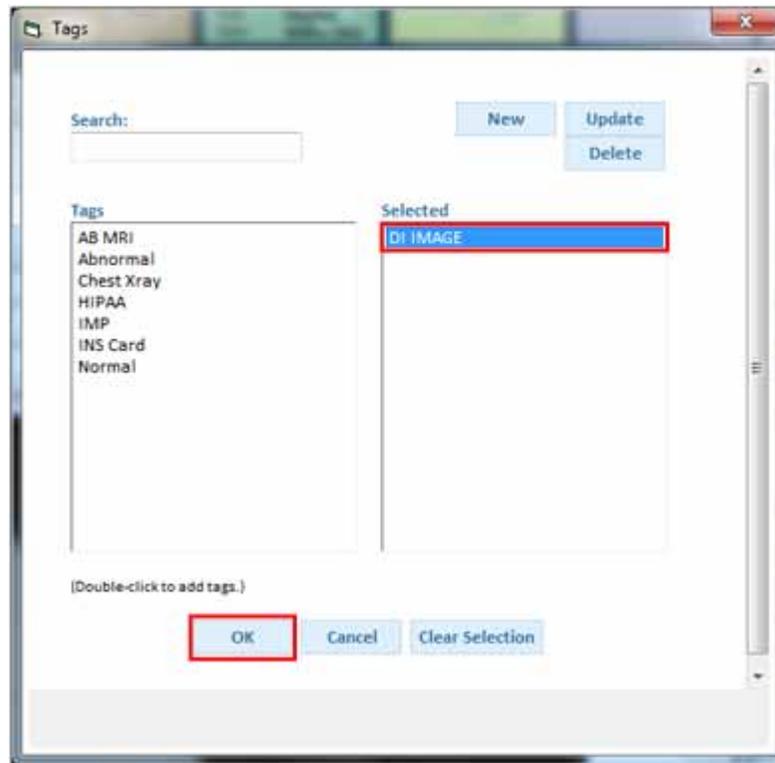


AND



Configuring the Diagnostic Image Tag

- Documents > Document Details > select a patient > open a document > Browse next to the Tag field > highlight the DI IMAGE tag > OK



Menu 4: Family Health History

Objective

Record patient family health history as structured data.

Measure

More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

Denominator

Patients are included in the denominator if they satisfy the following criteria:

Denominator Criteria	Area to Document within eClinicalWorks
They have had an outpatient appointment with a valid CPT* code created for them with an eligible professional during the reporting period.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment OR <ul style="list-style-type: none"> ■ Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment ■ Progress Notes > Visit Code > Add E&M

*. CPT copyright 2014 American Medical Association. All rights reserved.

Numerator

Patients that satisfy the denominator are included in the numerator if they satisfy the following criteria:

Numerator Criteria	Area to Document within eClinicalWorks
Family history for one or more of their first-degree relative is recorded as structured data from the Family History window.	Record this information from the following locations: <ul style="list-style-type: none"> ■ Progress Notes > Family History > Customize > Add ■ Progress Notes > Family History > select the statuses of family members and enter any applicable diagnoses <p>Note: A diagnosis for Unknown Family History also satisfies this measure and can be captured using the ICD code V49.89 or any dummy ICD code as long as it is mapped to SNOMED 407559004. If there is no known family history for a patient, you can use any dummy ICD code and map it to SNOMED 160266009.</p>
	<p>Note: The following ICD and SNOMED-CT codes are available by default on V 10:</p> <ul style="list-style-type: none"> ■ 250.00 (Diabetes) - 73211009 ■ 401.9 (Hypertension) - 59621000 ■ 429.9 (Heart Disease) - 56265001 ■ 434.91 (Stroke) - 432504007 ■ 310.9 (Mental Illness) - 192069009 ■ 199.1 (Cancer) - 363346000 SNOMED-CT codes for various diagnoses can be looked up from here: https://uts.nlm.nih.gov/snomedctBrowser.html To use this browser, you must first register from here: https://uts.nlm.nih.gov/license.html

Exclusion

Providers may be excluded from this measure if they meet the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They have no office visits during the EHR reporting period	This exclusion criteria is reported by self-attestation.

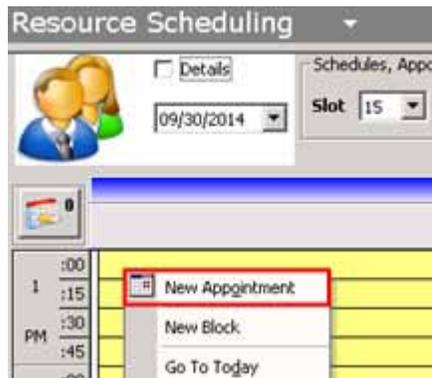
Features Related to Menu Set 4

The following features are related to Menu Set Measure 4:

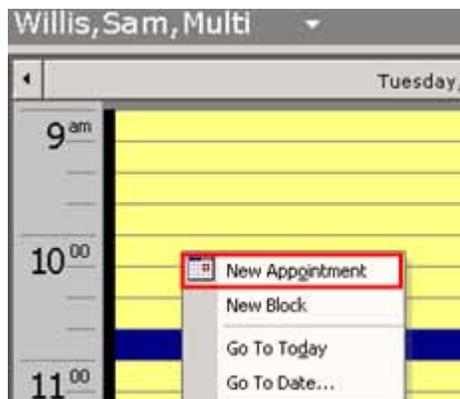
- Recording Appointments
- Recording E&M Codes
- Mapping ICD Codes with SNOMED Codes
- Recording Family History

Recording Appointments

- Practice band > Resource Scheduling icon > right-click on appointment slot > New Appointment

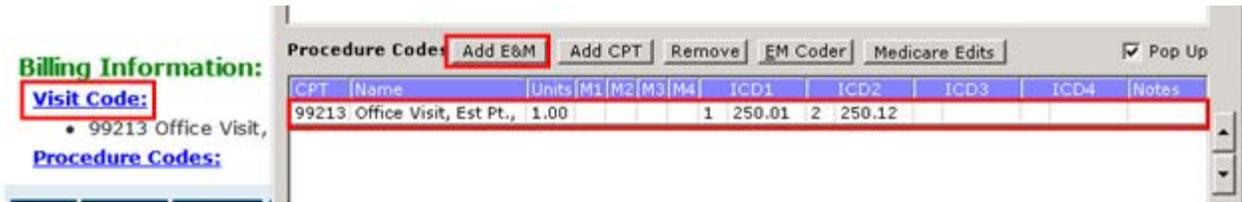


- Practice band > Provider's Schedule icon > right-click on appointment slot > New Appointment



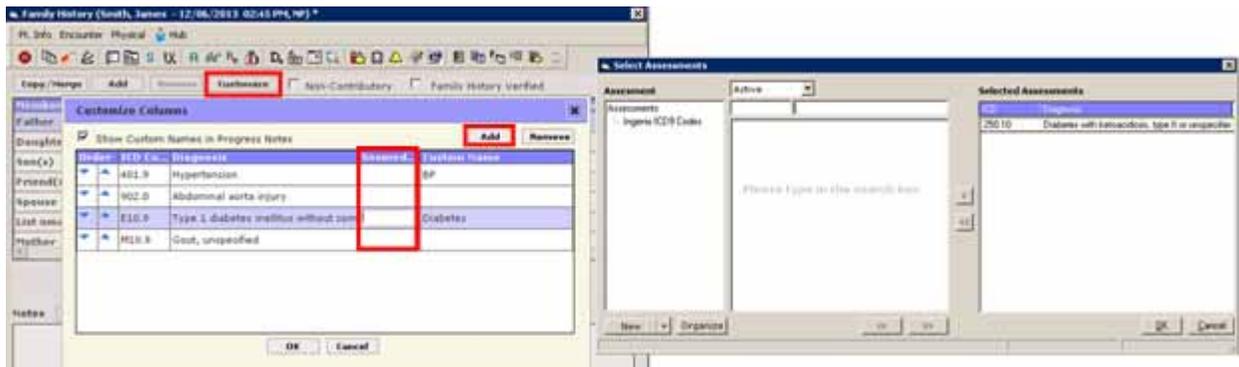
Recording E&M Codes

- Progress Notes > Visit Code > Add E&M



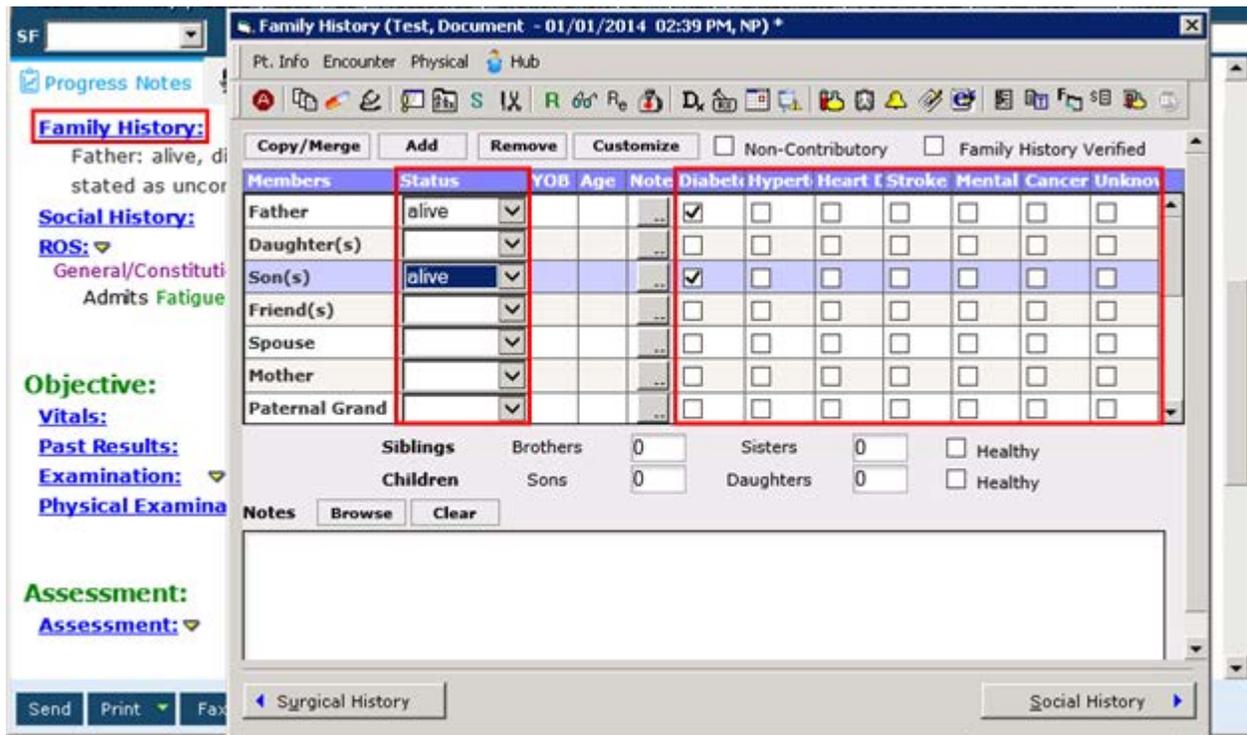
Mapping ICD Codes with SNOMED Codes

- Progress Notes > Family History > Customize > Add



Recording Family History

- Progress Notes > Family History > select the statuses of family members and enter any applicable diagnoses



Menu 5: Identify and Report Cancer Cases

Objective

Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.

Measure

Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

Note: eClinicalWorks Version 10 is a 2014 CEHRT complete EHR and has chosen not to certify for this Menu Set measure as it was optional for certification. Providers that diagnose cancer in a state that accepts cancer data, should report on one of the following measures:

- [Menu 1: Submitting Electronic Syndromic Surveillance](#)
- [Menu 3: Imaging Results](#)
- [Menu 6: Specialized Registry](#)

Feature	Area to Document within eClinicalWorks
Ongoing submissions originally achieved in a prior year that are continuing.	Contact your state registry.
A registration of intent within 60 days of the beginning of the reporting period and meet at least ONE of the following criteria: <ul style="list-style-type: none"> ■ Awaiting an invitation to begin testing. ■ Engaged in testing. ■ Ongoing submissions 	In cases where you cannot claim an exclusion from other Menu Set Measures and you are not able to meet them (<i>e.g.</i> , you diagnose cancer and there is a cancer registry in your state but you cannot meet the measure as eCW is not supporting a cancer registry OR you have access to imaging results but are not able to meet the measure <i>i.e.</i> , access imaging results from CEHRT), then you should satisfy this measure by registering your intent for on-going submission within the first 60 days of the reporting period with Dartnet.info. For more information on Dartnet.info, refer to What is Dartnet.info? Note: At a minimum, you must register with your registry within 60 days of the start of your reporting period and follow their testing procedures.

Exclusions

Providers may be excluded from this measure if they meet at least ONE of the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They do not diagnose or directly treat cancer.	This exclusion criteria is reported by self-attestation.
They operate in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period.	
They operate in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information.	
They operate in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.	

Menu 6: Specialized Registry

Objective

Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

Measure

Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.

IMPORTANT! No denominator/numerator calculations are required for this measure. This measure is reported through self-attestation.

Providers must attest Yes to successfully submitting specific case information from CEHRT to a specialized registry for the entire reporting period to meet this measure. In order to attest Yes, Providers must meet ONE of the following criteria:

Criteria	Action
An ongoing submission has already been achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.	<ul style="list-style-type: none"> ■ Identify if your state or national specialty society has a specialized registry. ■ If your state has a specialized registry, you must register your intent within the first 60 days of the reporting period.
A registration with the PHA (or other body to whom the information is being submitted) of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.	<ul style="list-style-type: none"> ■ If your state does not have a specialized registry, please verify with your national specialty society to see if they have or are sponsoring a specialized registry. If so, register your intent within the first 60 days of the reporting with Dartnet.info (as this is our preferred registry). ■ If neither your state nor your specialty society has a specialized registry, you can claim an exclusion.
A registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission.	<ul style="list-style-type: none"> ■ In cases where you cannot claim an exclusion from other Menu Set Measures and you are not able to meet them (<i>e.g.</i>, you diagnose cancer and there is a cancer registry in your state but you cannot meet the measure as eCW is not supporting a cancer registry OR you have access to imaging results but are not able to meet the measure <i>i.e.</i>, access imaging results from CEHRT), then you should satisfy this measure by registering your intent for on-going submission within the first 60 days of the reporting period with Dartnet.info.
A registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting an invitation to begin testing and validation.	<p>For more information on Dartnet.info, refer to What is Dartnet.info?</p>

Exclusions

Providers may be excluded from this measure if they meet at least ONE of the following criteria:

Exclusion Criteria	Area to Document within eClinicalWorks
They do not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction.	This exclusion criteria is reported by self-attestation.
They operate in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which they are eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period.	
They operate in a jurisdiction where no public health agency or national specialty society for which they are eligible provides information in a timely manner on their capability to receive information into their specialized registries.	
They operate in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which they are eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional providers.	

What is Dartnet.info?

The *DI Practice Performance Registry* compiles and processes EHR data in order to provide a graphical view of how organizations and practices are doing on specific measures and how they compare to other organizations/practices.

The DI Practice Performance Registry has been endorsed by the [American Academy of Family Physicians](#) as a *Quality Improvement Registry*. It also meets Stage 2 Meaningful Use Menu Set Measure 6 requirements, specifically: Successful ongoing submission of specific case information from a certified EHR technology to a specialized registry for the entire EHR reporting period.

Contact them by e-mail at DIRgistry@dartnet.info to register your intent.

For providers reporting for Q4, the deadline to register their intent is 26th Nov. The process takes several days to complete, so initiate them at the earliest.

MEANINGFUL USE STAGE 2 AUDIT TOOLKIT

This document provides suggestions for eClinicalWorks clients to prepare for a potential Meaningful Use audit. Auditors may need more information on a case-by-case basis. In such circumstances, contact eClinicalWorks Support for additional assistance.

Meaningful Use Audits

Providers who receive an EHR incentive payment for Stage 2 of the Medicare or Medicaid EHR Incentive Program may potentially be subject to an audit. Eligible professionals (EPs) and eligible hospitals should retain *all* relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses.

Documentation to support attestation data for Stage 2 Meaningful Use objectives and Clinical Quality Measures (COMs) should be retained for six years post-attestation.

Overview of Meaningful Use in 2015

Regardless of the stage/year of MU, EPs must demonstrate MU for a three-month period on 2015.

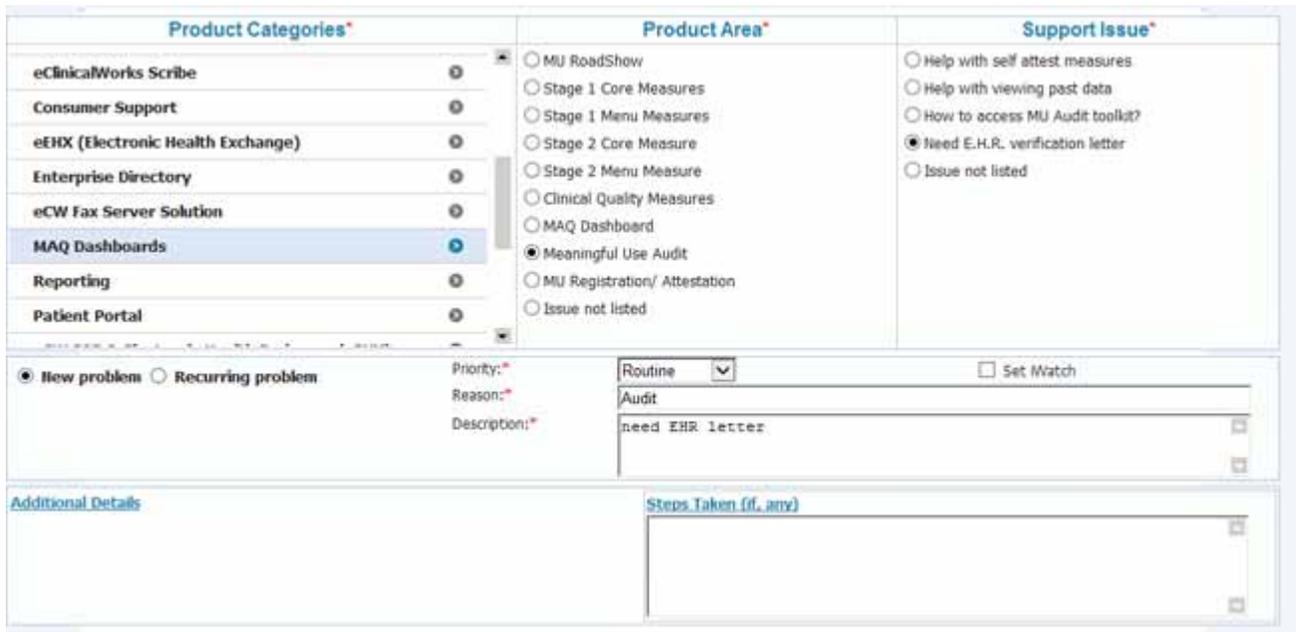
Medicare EPs beyond their first year must attest a Calendar Quarter- Q1, Q2, Q3, or Q4

Medicaid EPs must attest any 90 days in 2014.

To document proof of compliance for percentage-based measures:

1. As proof of use of a Certified Electronic Health Record Technology system, provide invoices or a copy of your licensing agreement with the vendor. Please ensure that the licensing agreements or invoices identify the vendor, product name, and product version number of the Certified Electronic Health Record Technology system utilized during your attestation period. If the version is not present on the invoice/contract, please supply a letter from your vendor attesting to the version number used during your attestation period.

Request an EHR verification letter by opening a case with eClinicalWorks Support. Indicate the reporting period, stage on which you are reporting, and the number of providers on which you are reporting:



2. Provide a response to the following questions:

- a. At how many offices or other outpatient facilities do you see your patients?
- b. List each office or other outpatient facility where you see patients and indicate whether or not you utilize Certified Electronic Health Record Technology in each office or other outpatients facility:

#	Office or Other Outpatient Facility	Utilize CEHRTS?
1		
2		
3		

- c. If you utilize more than one office or other outpatient facility, supply documentation which proves that 50% or more of your patient encounters during the EHR reporting period have been seen in offices or outpatient facilities where you utilize a CEHRT system.
- d. Do you maintain any patient records outside of your CEHRT system?

If yes, supply documentation which proves that more than 80% of the medical records of unique patients seen during the attestation period are maintained in a CEHRT system at each office or other outpatient facility where CEHRT system is being used.

Core Measures

Use the following workflow suggestions to document proof of compliance for self-attestation measures. All necessary screenshots should be taken three times: at the beginning, middle, and end of the reporting period.

The following self-attestation Core Measures are covered in this document:

- [Attesting to Core Set Objectives](#)
- [Protect Electronic Health Information](#)
- [Generate Lists of Patients by Specific Conditions](#)
- [Exchange Summary of Care Record at Each Transition of Care to EP on Another CEHRT or with a CMS-Designated EHR](#)
- [Capability to Submit Electronic Data to Immunization Registry](#)
- [Clinical Decision Support Rule](#)

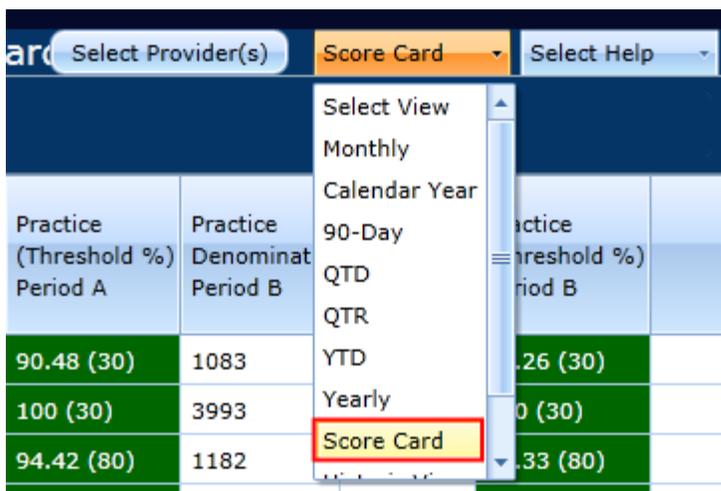
Attesting to Core Set Objectives

For Core Measures # 1, 2, 3, 4, 5, 7, 8, 10, 12, 13, 14, 15 (1 and 2), and 17 provide the supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses (*e.g.*, a report from your EHR system that ties to your attestation). This documentation should include the numerator and denominator for each measure, as well as the date range and the EP's name or NPI.

Note: If you are providing a summary report from your EHR system as support for your numerators/denominators, please ensure that we can identify that the report has actually been generated by your EHR (*e.g.*, your EHR logo is displayed on the report, or step-by-step screenshots which demonstrate how the report is generated by your EHR are provided).

To document proof of compliance for percentage-based measures:

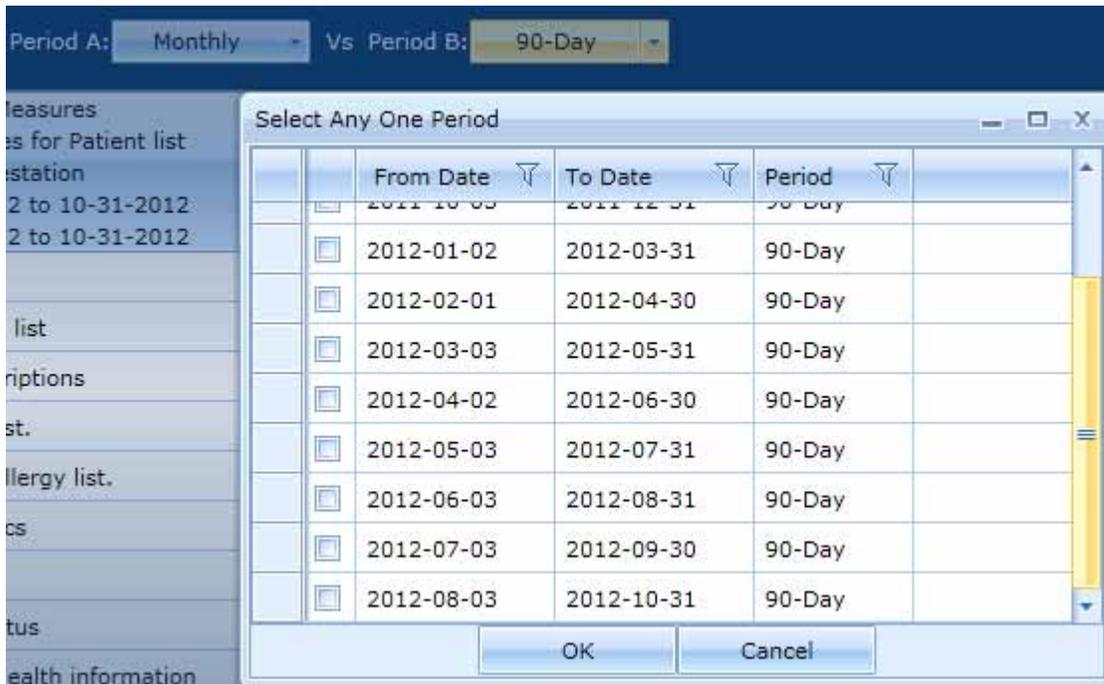
1. From the MAQ Dashboard, click *Stage 2* in the left pane, then click *Core*.
2. From the *Select View* pick list, click *Score Card*:



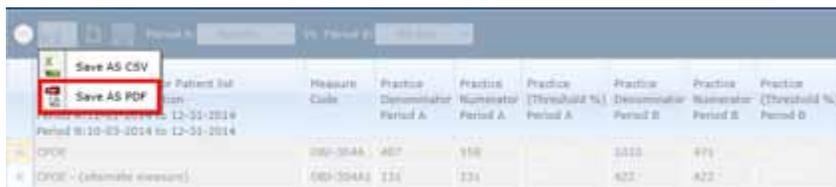
OR

If data for previous years is required, click *Historic View*.

3. Click *Period A* or *Period B* to open the *Select Any One Period* window and select a time period:



4. Export the data to a PDF by clicking the floppy disk icon to open a drop-down list, then clicking *Save as PDF*:



5. Save the file on your desktop.

A message displays confirming that the file was saved successfully:



In the file that is saved on your computer, pages 1 and 2 display the Core Measures for the practice:

eClinicalWorks

Practice Name : ██████████
 Provider Name : ██████████
 NPI :

		Report Start Date : 07/01/2014		Report End Date : 09/30/2014		
Measure ID	Measure Name	Denominator	Numerator	Exclusion	Performance Rate	Threshold
CORE-1-1	CPOE - Medication	398	398	0	100.00	60.00
CORE-1-2	CPOE - Radiology	789	738	0	93.54	30.00
CORE-1-3	CPOE - Laboratory	2165	1878	0	86.74	30.00
CORE-2	e-Prescribing (eRx)	517	0	0	0.00	50.00
CORE-3	Record Demographics	961	692	0	72.01	60.00
CORE-4-1	Record Vital Signs (HT, WL, BP>3 Yrs)	961	957	0	99.58	80.00
CORE-4-2	Record Vital Signs (HT, WL)	961	958	0	99.69	80.00
CORE-4-3	Record Vital Signs (BP > 3 Yrs)	961	959	0	99.79	80.00
CORE-5	Record smoking status	961	855	0	88.97	60.00
CORE-7-1	Patient Electronic Access (Timely)	961	52	0	5.41	50.00
CORE-7-2	Patient Electronic Access (VDT)	961	2	0	0.21	5.00

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March 11, 2015

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eClinicalWorks

Practice Name : ██████████
 Provider Name : ██████████
 NPI :

		Report Start Date : 07/01/2014		Report End Date : 09/30/2014		
Measure ID	Measure Name	Denominator	Numerator	Exclusion	Performance Rate	Threshold
CORE-8	Clinical Summaries	1166	986	0	84.56	50.00
CORE-10	Clinical Lab-Test Results	1435	1347	0	93.87	55.00
CORE-12	Preventive Care - Patient Reminders	1798	50	0	2.78	10.00
CORE-13	Patient-Specific Education Resources	961	89	0	9.26	10.00
CORE-14	Medication Reconciliation	1070	1009	0	94.30	50.00
CORE-15-1	Summary of Care	20	18	0	90.00	50.00
CORE-15-2	Summary of Care (Electronic)	20	0	0	0.00	10.00
CORE-17	Use Secure Electronic Messaging	961	0	0	0.00	5.00

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Pages 3 and 4 display the Core Measures for the selected provider:

eClinicalWorks

Practice Name :
 Provider Name :
 NPI :

		Report Start Date: 07/01/2014					
		Report End Date: 09/30/2014					
Measure Id	Measure Name	Denominator	Numerator	Exclusion	Performance Rate	Threshold	
CORE1-1	CPOE - Medication	398	398	0	100.00	60.00	
CORE1-2	CPOE - Radiology	789	738	0	93.54	30.00	
CORE1-3	CPOE - Laboratory	2165	1878	0	86.74	30.00	
CORE-2	e-Prescribing (eRx)	517	0	0	0.00	50.00	
CORE-3	Record Demographics	961	692	0	72.01	80.00	
CORE4-1	Record Vital Signs (HT, Wt, BP>3 Yrs)	961	957	0	99.58	80.00	
CORE4-2	Record Vital Signs (HT, Wt)	961	958	0	99.69	80.00	
CORE4-3	Record Vital Signs (BP > 3 Yrs)	961	959	0	99.79	80.00	
CORE-5	Record smoking status	961	855	0	88.97	80.00	
CORE7-1	Patient Electronic Access (Timely)	961	52	0	5.41	50.00	
CORE7-2	Patient Electronic Access (VDT)	961	2	0	0.21	5.00	

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March 11, 2015

3

eClinicalWorks

Practice Name :
 Provider Name :
 NPI :

		Report Start Date: 07/01/2014					
		Report End Date: 09/30/2014					
Measure Id	Measure Name	Denominator	Numerator	Exclusion	Performance Rate	Threshold	
CORE-8	Clinical Summaries	1166	986	0	84.56	50.00	
CORE-10	Clinical Lab-Test Results	1435	1347	0	93.87	55.00	
CORE-12	Preventive Care - Patient Reminders	1798	50	0	2.78	10.00	
CORE-13	Patient-Specific Education Resources	961	89	0	9.26	10.00	
CORE-14	Medication Reconciliation	1070	1069	0	99.91	50.00	
CORE15-1	Summary of Care	20	18	0	90.00	50.00	
CORE15-2	Summary of Care (Electronic)	20	0	0	0.00	10.00	
CORE-17	Use Secure Electronic Messaging	961	0	0	0.00	5.00	

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Protect Electronic Health Information

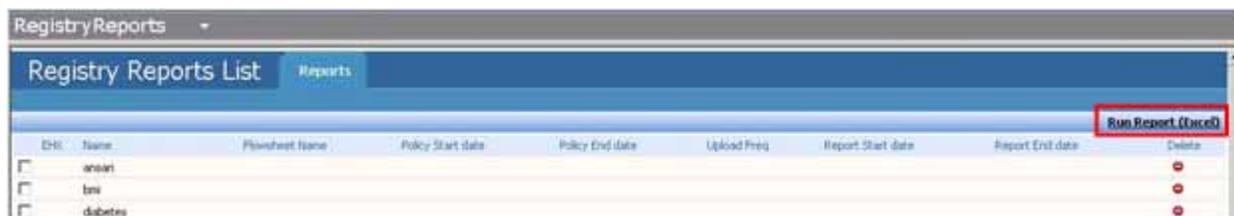
For this measure, you will need to provide documentation to CMS proving that you completed a security risk analysis (SRA). When you perform your SRA you should have a checklist of things to complete for it. Keep a copy of this checklist report.

Security attributes, Rx security, P.S.A.C. categories and permissions, authentication settings, admin logs, confidential Progress Notes, and confidential patient accounts are available from eClinicalWorks to satisfy this measure. For more information on how to use these features, refer to the *System Administration Users Guide* or the HelpHub.

Note: Regardless of whether a practice is locally hosted or hosted in the cloud, a Security Risk Assessment must be conducted

Generate Lists of Patients by Specific Conditions

1. From the *Registry* band, click *Registry Reports*.
The Registry Reports List window opens.
2. Check the box next to the saved report and click *Run Report (Excel)*:



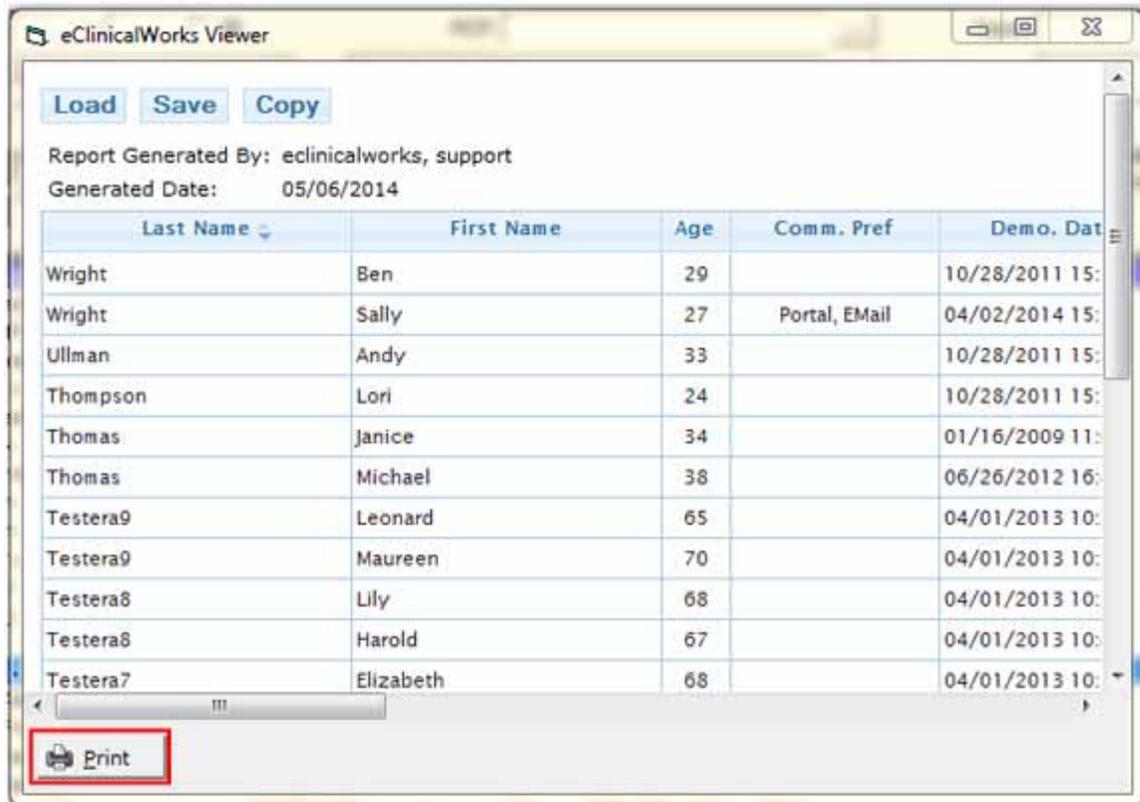
The report is exported to an Excel spreadsheet. Keep a copy of this report.

If you are using the Analyze Data button in the Registry dashboard:

1. When the report is run, click *Analyze Data*:



The eClinicalWorks Viewer window opens.

2. Click *Print*:

Exchange Summary of Care Record at Each Transition of Care to EP on Another CEHRT or with a CMS-Designated EHR

As part of Meaningful Use Stage 2's Transition of Care measure eligible professionals (EPs) and eligible hospitals/critical access hospitals (CAHs) are required to perform one of the following actions:

- Conduct one or more successful electronic exchanges of a summary of care document, with a recipient who has EHR technology designed by a different EHR technology developer than the sender's.
- Conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period

The EHR Randomizer supports the testing of exchanges with a designated test EHR. If you successfully exchanged a Summary of Care document with at least one provider with a different EHR than yours and documented that exchange, you do not need to use this website for the test exchange measure.

For support and assistance, post a message on the [ehr-randomizer](#) group.

Perform one of the following actions to collect the require documentation to demonstrate that you have met this requirement:

- Exchange a Summary of Care by a referral through P2P (including CCR/CCD):

The screenshot shows a 'Referral (Outgoing)' window with the following details:

- Patient:** John, Chris (AB11914)
- Insurance:** CCA
- Ref From:** Willis, Sam
- Facility From:** Reliant Medical Group
- Start Date:** 11/26/2013
- Referral Date:** 11/26/2013
- Open Cases:** 0
- Appt Date:** 11/26/2013
- Received Date:** 11/26/2013
- Priority:** Routine
- Ref To:** Provider and Specialty fields are empty.
- Facility To:** Empty
- Auth Type:** Pending
- End Date:** 11/26/2014
- Assigned To:** Billing, Billing
- Unit Type:** v (VISIT)
- Status:** Open (selected)

At the bottom of the window, the 'Attachments(2)' button and the 'Send Referral' button are highlighted with red boxes.

- Exchange a Summary of Care with a different EHR than the one they are using for Meaningful Use. Keep documentation for your records when you send a Summary of Care record to a provider that is using a different EHR. You should receive an e-mail within 24 hours after the registration process from the test EHR indicating that the test was successful. Once you receive confirmation that the CCDa was received, you have successfully completed your test.

Meaningful Use Stage 2 Core 15-3 Summary of Care – Randomizer Tool Unable to Find a Match – CMS.Gov

[EHR Incentive Programs] When reporting on the Summary of Care objective in the Electronic Health Records (EHR) Incentive Program, how can a provider meet measure 3 if they are unable to complete a test with the CMS designated test EHR (Randomizer)?

CMS is aware of difficulties providers are having in use of the CMS Designated Test EHRs (NIST EHR-Randomizer Application) to meet measure 3 of the Summary of Care objective. At this time the two CMS Designated Test EHRs can only exchange/match with an EP that is Direct Trust (DT) Accredited. There is not a non-DT Accredited Test EHR for providers to use to successfully complete the test.

The following actions are currently in place to meet the Summary of Care objective for measure 3:

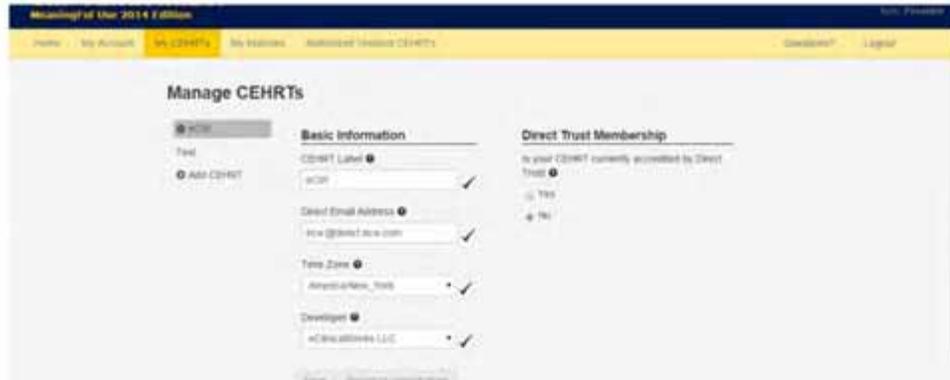
1. Exchange a summary of care with a provider or third party who has different CEHRT as the sending provider as part of the 10% threshold for measure #2. A successful exchange in measure #2 allows the provider to meet the criteria for measure #3 without the need to conduct a test with the Randomizer as outlined in measure #3, or
2. Conduct at least one successful test with the CMS designated test EHR (if the provider is Direct Trust Accredited).

If the provider does not exchange summary of care documents with recipients using a different CEHRT in common practice, and cannot use the CMS Designated Test EHR for the reasons outlined above, the provider may retain documentation on their circumstances and attest Yes to meeting measure #3 if they have and are using certified EHR which meets the standards required to send a CCDA (§ 170.202).

This exchange may be conducted outside of the EHR reporting period timeframe but must take place no earlier than the start of the year and no later than the end of the year or the provider attestation date whichever occurs first. For example, a EP who is reporting Meaningful Use for a 90-day EHR reporting period may conduct this exchange outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than December 31st of the EHR reporting year.

For more information on the NIST EHR-Randomizer Application, please visit:
<https://ehr-randomizer.nist.gov/ehr-randomizer-app/#/home>

Added on: 12/17/2014



Date: 12/19/2014

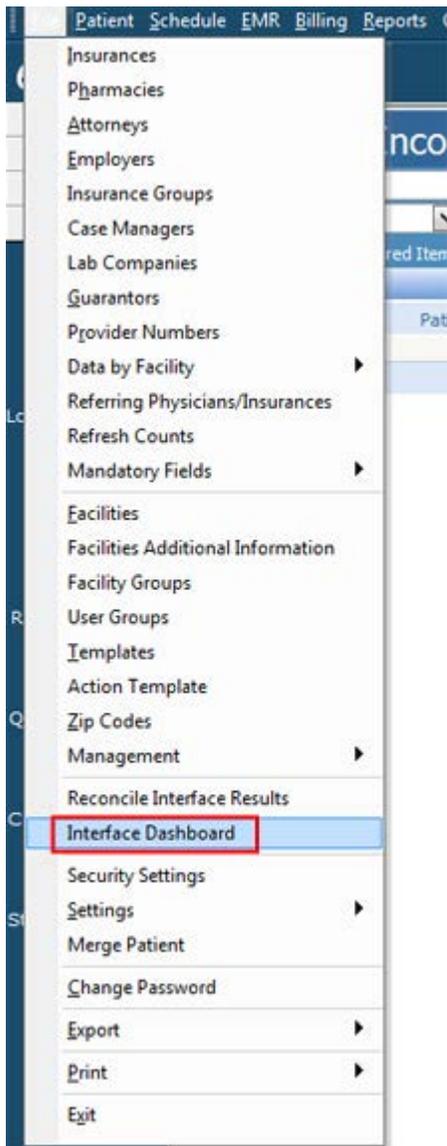
Source:
 CMS Website (www.cms.gov)
 FAQ # 11666
<https://questions.cms.gov/faq.php?isDept=0&search=11666&searchType=faq&submitSearch=1&id=5005>

Capability to Submit Electronic Data to Immunization Registry

Some practices may be exempt from this measure.

If your state has an immunization interface with eClinicalWorks:

1. From the *File* menu, click *Interface Dashboard*:



The Interface Dashboard window opens.

2. Click the *Immunizations* tab at the top of the window.
The Immunizations options display.
3. Click the *Outbound* tab on the left side of the window.
4. Information on immunizations sent from this system displays:



Note: If it is necessary to go back further than one month, please contact eClinicalWorks Support to obtain logs showing that data.

OR

- If the data submissions failed through the Immunization interface, take a screenshot of this failed submission.
- If you submitted a test HL7 file, provide documentation from your state that your test was successful or unsuccessful.
- If you were unable to submit an HL7 file due to a state unavailability discrepancy, request documentation for this from your state.
- If your state registry is on a different HL7 standard than eClinicalWorks' and you were not able to send a test file, contact eClinicalWorks Support and we will provide you a letter stating that we currently only offer HL7 version 2.5.1.

Note: Only the data for the last month is displayed on the Immunization Dashboard. Any immunization from one to six months old is archived, for which we do not have access.

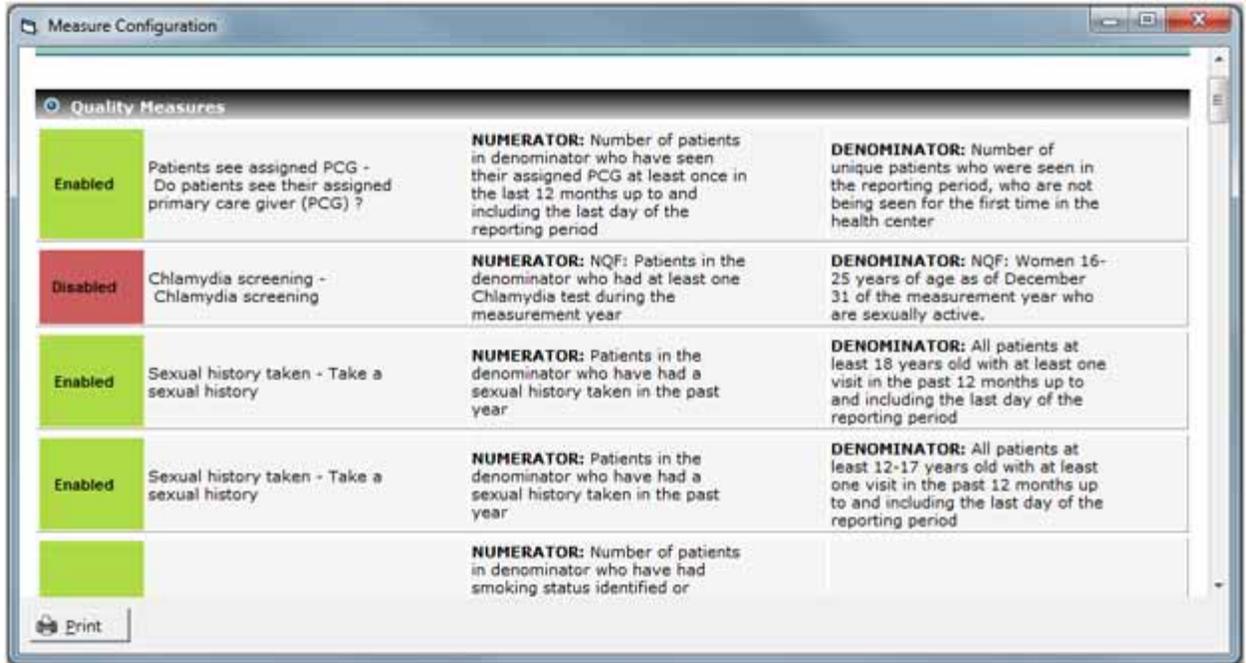
Clinical Decision Support Rule

Measure 1: CDSS Alerts

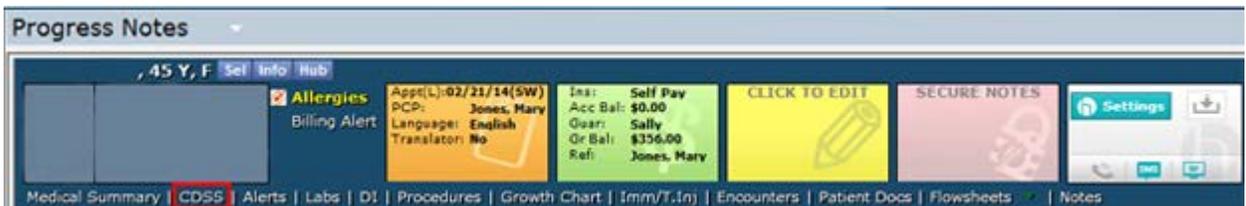
If you are meeting five (5) measures related to four (4) or more CDSS alerts:

1. To document how the CDSS alerts are set up:
 - a. From the EMR menu, hover over CDSS and click Measure Configuration.

The Measure Configuration window opens:



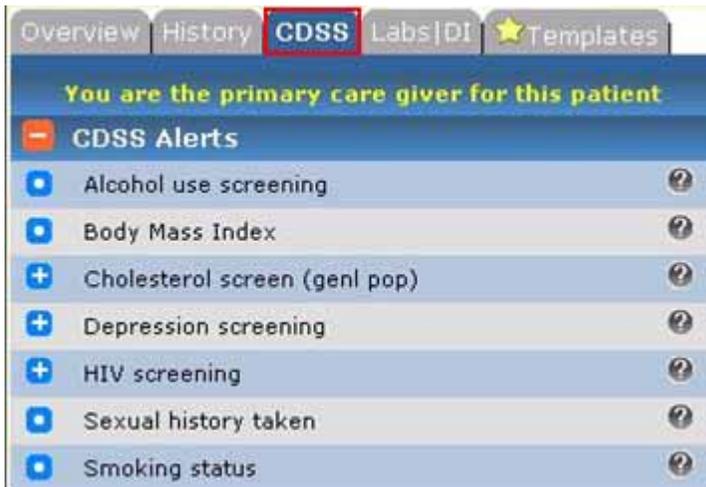
- b. Take a screenshot of this window.
- 2. To take screenshots of the CDSS alerts within the Patient Dashboard:
 - a. Open a patient's Progress Notes for an encounter taking place during the attestation period.
 - b. Click the CDSS link in the Patient Dashboard:



The CDSS Alerts window opens:

Measure Name	Last Done	Fq	Due Date	Status	Orders
A1C testing		6 M	04/10/2012		
Alcohol use screening		12 M	01/16/2013		
Antithrombic tx (IVD or DM)		12 M	01/16/2013		
BP control in DM (130/80)		12 M	01/16/2013		
Colorectal cancer screening		120 M	01/16/2013		
HIV screening		6 M	01/16/2013		
Influenza vaccine (over 50)		6 M	01/16/2013		
LDL testing (high risk)		12 M	02/10/2013		
Body Mass Index	02/08/2012	24 M	02/08/2014		
Patients see assigned PCP		12 M	02/10/2012		
Sexual history taken		12 M	02/10/2012		

- c. Take a screenshot of this window.
- 3. To document the CDSS alerts within the Office Visit:
 - a. Open a patient's Progress Notes for an encounter taking place during the attestation period.
 - b. Click the CDSS tab in the right Chart Panel (ICW):



- c. Take a screenshot of this tab.

Measure 2: Drug/Drug and Drug/Allergy Interaction Check

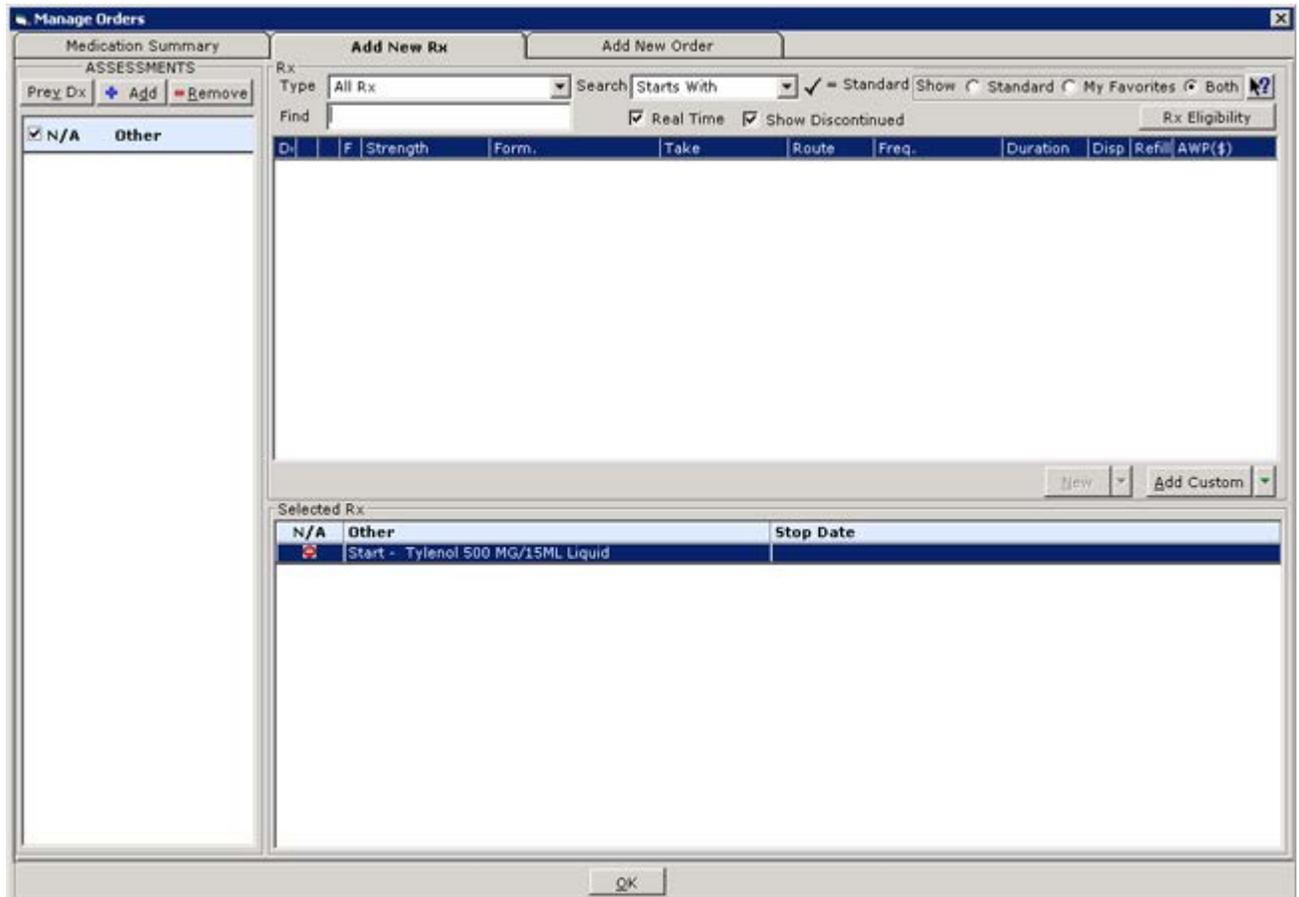
Documentation for Measure 170.304(a) is different for Multum® and Medi-Span® drug databases. First, determine which drug database the practice is using, and then use the appropriate procedure to document this measure.

To determine which drug database the practice is using:

1. From the Progress Note, and click *Treatment*.
The Treatment window opens.
2. Click *Add*:



The Manage Orders window opens:



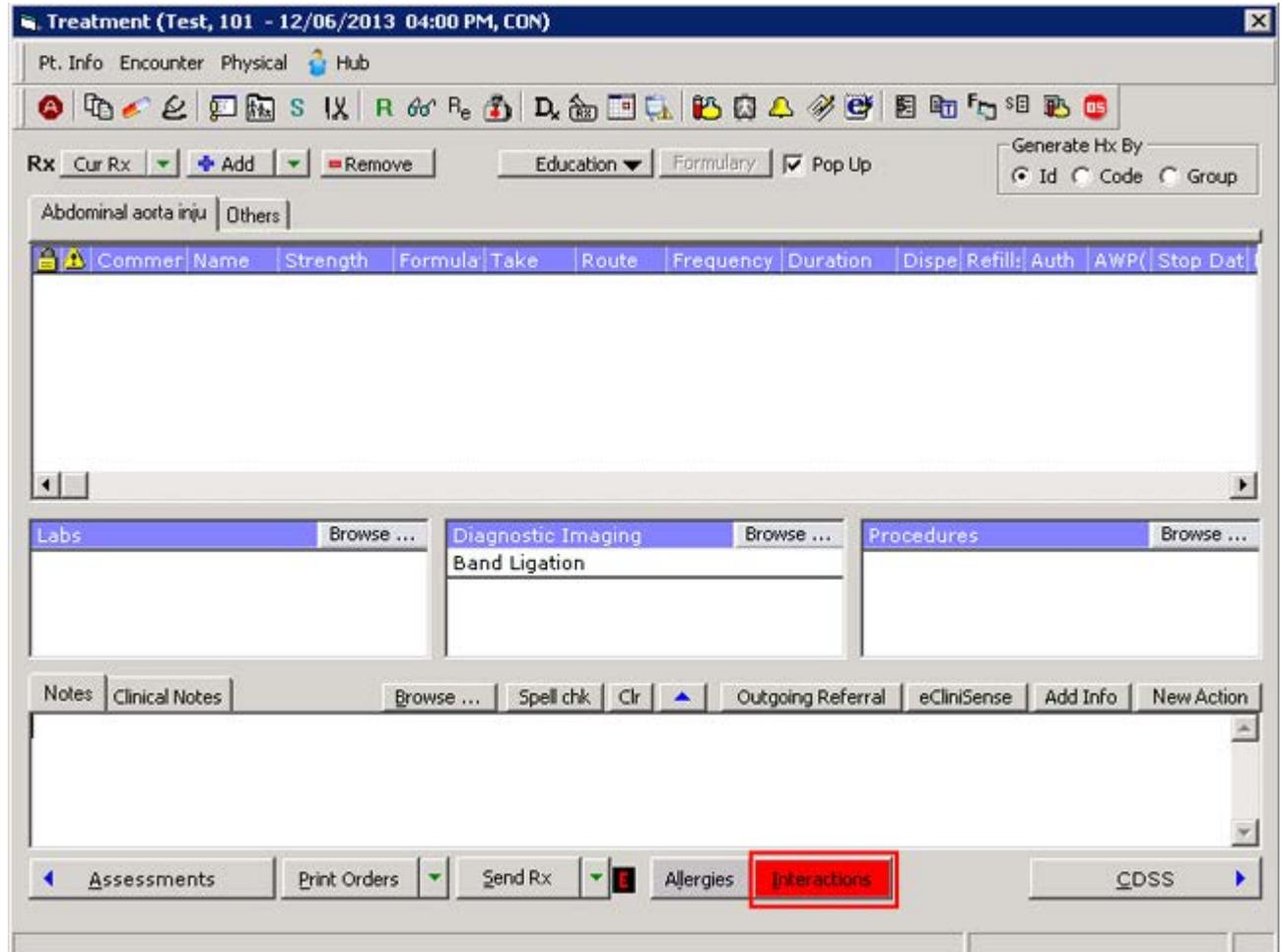
3. From the *Type* pick list, check for one of the following options:
 - ◆ Multum Rx
 - ◆ Medispan Rx

The option that displays is the drug database that the practice uses.

Multum Drug Database

To document 170.304(a) if the practice uses the Multum Drug Database:

1. From the Progress Note, click *Treatment*.
The Treatment window opens.
2. Click *Interactions*:



The Drug Interaction window opens:

The screenshot shows a 'Drug Interaction' window with two main sections. The top section lists drug-drug interactions, and the bottom section lists drug-allergy interactions.

Drug 1	Drug 2	Severity	Drug To Drug Interaction Description	Adjust Severity
Coumadin Oral Tablet 2.5 MG	Zocor Oral Tablet 10 MG	Major	Hypoprothrombinemic effects of Coumadin Oral Tablet 2.5 MG may be increased by Zocor Oral Tablet 10 MG. Hematuria, epistaxis and rectal bleeding may occur.	<input type="radio"/> Major <input type="radio"/> Moderate <input type="radio"/> Minor Reset
Coumadin Oral Tablet 2.5 MG	Aspirin Oral Tablet Chewable 81 MG	Major	The risk of bleeding, particularly gastrointestinal, may be increased by co-administration of Coumadin Oral Tablet 2.5 MG with Aspirin Oral Tablet Chewable 81 MG. However, use of low-dose aspirin with Coumadin Oral Tablet 2.5 MG may provide benefit that outweighs the risk of minor bleeding.	<input type="radio"/> Major <input type="radio"/> Moderate <input type="radio"/> Minor Reset
Coumadin Oral Tablet 2.5 MG	Minocycline HCl Oral Capsule 100 MG	Major	Hypoprothrombinemic effects of Coumadin Oral Tablet 2.5 MG may be increased by Minocycline HCl Oral Capsule 100 MG. Bleeding may occur.	<input type="radio"/> Major <input type="radio"/> Moderate <input type="radio"/> Minor Reset

----- Drug To Allergy Interaction - NONE -----

Drug	Condition	Severity	Precaution Description
MetFORMIN HCl Oral Tablet 500 MG	Chronic Renal Disease	Contraindicated	MetFORMIN HCl Oral Tablet 500 MG is contraindicated in Renal Disease. Since Chronic Renal Disease is a more specific form of Renal Disease, the same precaution may apply.
MetFORMIN HCl Oral Tablet 500 MG	Aggravation of Kidney Disease	Contraindicated	MetFORMIN HCl Oral Tablet 500 MG is contraindicated in Renal Disease. Since Aggravation of Kidney Disease is a more specific form of Renal Disease, the same precaution may apply.
Coumadin Oral Tablet 2.5 MG	Complications of Surgery	Not recommended	Coumadin Oral Tablet 2.5 MG is not recommended in Surgery. Since Complications of Surgery is related to Surgery, the same precaution may apply.
MetFORMIN HCl	Complications of		MetFORMIN HCl Oral Tablet 500 MG should be used with extreme

Notes: Time Stamp | Browse ... | Check Spelling | Action : [Dropdown]

Buttons: Print Preview | Print | Close

Take a screenshot of this window at the beginning, middle, and end of the reporting period.

Medi-Span Drug Database

To document 107.304(a) if the practice uses the Medi-Span Drug Database:

1. From the *Reports* menu, point to *EMR*, then click *Drug Interaction Logs*.

The Drug Interaction Log Report window opens:



2. Select the appropriate user from the *User* pick list.
3. Click More (...) next to the *From Date* and *To Date* fields to open pop-up calendars and select a date range. The report runs automatically when you make changes to these filter fields.

Menu Set Measures

In 2014, EPs cannot select a Menu Set Measure and claim exclusion for it if there are other Menu Set Measures they can meet. The following Menu Set Measures are covered in this document:

- Capability to Submit Electronic Syndromic Surveillance Data to Public Health Agencies
- Capability to Identify and Report Cancer Cases to a Public Health Central Cancer Registry
- Capability to Identify and Report Specific Cases to Specialized Registry (Other than a Cancer Registry)

Attesting to Measure Set Measures

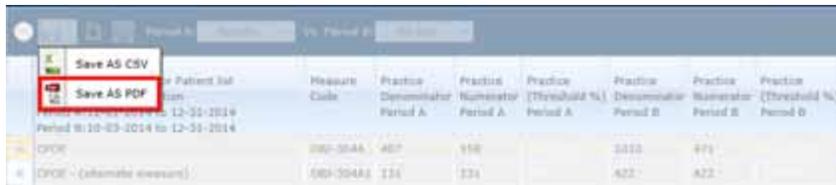
If attested to Menu Set Measures # 2, 3, or 4, provide the supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses (*e.g.*, a report from your EHR system that ties to your attestation). This documentation should include the numerator and denominator for each measure as well as a date range and the EP's name or NPI.

Note: If you are providing a summary report from your EHR system as support for your numerators/denominators, please ensure that we can identify that the report has actually been generated by your EHR (*e.g.*, your EHR logo is displayed on the report, or step-by-step screenshots which demonstrate how the report is generated by your EHR are provided).

To document proof of compliance for percentage-based measures:

1. From the MAQ Dashboard, click *Stage 2* in the left pane, then click *Menu*.

- Export the data to a PDF by clicking the floppy disk icon to open a drop-down list, then clicking *Save as PDF*:



- Save the file on your desktop.



A message displays confirming that the file was saved successfully.

In the file that is saved on your computer, page 1 displays all the Menu Set measures for your practice:

eClinicalWorks

Practice Name :
 Provider Name :
 NPI :

Report Start Date: 07/01/2014
 Report End Date: 09/30/2014

Measure Id	Measure Name	Denominator	Numerator	Exclusion	Performance Rate	Threshold
MENU-2	Electronic Notes	991	991	0	100.00	30.00
MENU-3	Imaging Results	419	0	0	0.00	10.00
MENU-4	Family Health History	991	54	0	5.42	20.00

Page 2 displays the Menu Set Measures for a specific provider:

eClinicalWorks

Practice Name :
 Provider Name :
 NPI :

		Report Start Date: 07/01/2014				
		Report End Date: 09/30/2014				
Measure Id	Measure Name	Denominator	Numerator	Exclusion	Performance Rate	Threshold
MENU-2	Electronic Notes	981	981	0	100.00	30.00
MENU-3	Imaging Results	419	0	0	0.00	10.00
MENU-4	Family Health History	981	54	0	5.62	20.00

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March 11, 2015

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Capability to Submit Electronic Syndromic Surveillance Data to Public Health Agencies

If you submitted a test HL7 file, provide documentation from your state that your test was successful or unsuccessful.

If you were unable to submit an HL7 file due to a state unavailability discrepancy, request documentation for this from your state.

If eClinicalWorks is on a different HL7 format than your state registry and you were not able to send your test file, contact eClinicalWorks Support and we will provide you a letter stating that we currently only offer HL7 version 2.5.1.

Capability to Identify and Report Cancer Cases to a Public Health Central Cancer Registry

eClinicalWorks Version 10 is a 2014 CEHRT complete EHR and has chosen not to certify for this measure as it was optional for certification.

Capability to Identify and Report Specific Cases to Specialized Registry (Other than a Cancer Registry)

eClinicalWorks Version 10 is a 2014 CEHRT complete EHR and has chosen not to certify for this measure as it was optional for certification.

CQMs

There are two recommended core sets of CQMs, one for adults, and one for children that focus on high-priority health conditions and best practices for care delivery.

Take a screenshot of the MAQ Dashboard with the CQM data displayed, ensuring that a zero is displayed in the denominator for each measure (or include documents for which the provider qualifies for an exclusion):

Measure Code	Practice Denominator Period A	Practice Numerator Period A	Practice (Threshold %) Period A	Practice Denominator Period B	Practice Numerator Period B	Practice (Threshold %) Period B
Controlling High Blood Pressure (CMS165)	0	0	0 (0)	1	0	0 (0)
Breast Cancer Screening (CMS125)	0	0	0 (0)	0	0	0 (0)
Colorectal Cancer Screening (CMS130)	0	0	0 (0)	0	0	0 (0)
Diabetes: Hemoglobin A1c Poor Control (CMS122)	0	0	0 (0)	0	0	0 (0)
Diabetes: LDL Management (CMS163)	0	0	0 (0)	0	0	0 (0)
EVD: Lipid Panel and LDL Performed (CMS182A)	0	0	0 (0)	0	0	0 (0)
EVD:Lipid Panel and LDL Control(< 100) (CMS182B)	0	0	0 (0)	0	0	0 (0)
HP: Beta-Blocker Therapy (CMS144)	0	0	0 (0)	0	0	0 (0)
Use of Appropriate Medications for Asthma (CMS126)	452	0	0 (0)	0	0	0 (0)
Use of Appropriate Meds for Asthma(5-11) (CMS126(5-11))	295	0	0 (0)	0	0	0 (0)
Use of Appropriate Meds for Asthma(12-18) (CMS126(12-18))	157	0	0 (0)	0	0	0 (0)
Use of Appropriate Meds for Asthma(19-50) (CMS126(19-50))	0	0	0 (0)	0	0	0 (0)

Medicaid Meaningful Use

In addition to all the aforementioned requirements, Medicaid attestation requires the Patient Encounter Report. Since eClinicalWorks can only generate the number of patients seen using the eClinicalWorks application, if any patient was seen using paper chart or at another facility, that number must be manually added to the denominator. If the practice has used the eClinicalWorks application only, the numerator would match the denominator for both of the following reports.

IMPORTANT! These are state-specific requirements. Practices should check with their states for specific Medicaid Meaningful Use requirements.

Patient Encounter Report

50% of All Patient Encounters Occurred at a Facility Using Certified EHR Technology

Use the denominator of the Clinical Visit Summaries (encounter - New MU Spec) to get the numerator of this report.

80% of All Unique Patient Encounters Occurred at a Facility Using Certified EHR Technology

Use the denominator of Record Demographics/Active Medication List/Active Medication Allergy List to get the numerator of this report.

Additional Tips

Throughout a Meaningful Use Stage 2 audit, keep the following tips in mind:

- If you have referred to any FAQ from <http://questions.cms.gov>, keep a copy of that FAQ document.
- Provide supporting documentation for all claimed exclusions.
- Print the PDF Summary at the end of attestation and keep it on file.
- When sending the screenshots to the auditors, black out any identifiable patient health information. If this is not possible, use secure messaging to send the screenshots. Ensure that all data sharing with the auditors is HIPAA compliant.

For more information about HIPAA compliance, visit: <http://www.hhs.gov/ocr/privacy/>

APPENDIX A: LIST OF OUTPATIENT CODES

The following is a list of codes that satisfy the objective measures that require a patient to be seen by the EP.

Outpatient

92004, 92002, 92014, 92012, 99024, 99211, 99212, 99213, 99214, 99215, 99201, 99202, 99203, 99204, 99205, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, 99420, 99429, 99455, 99456, 90846, 90847, 90853, 90857, 90801, 90804, 90805, 90806, 90807, 90808, 90809, 90802, 90810, 90811, 90812, 90813, 90862, 90960, 90961, 90962, 90966, 90970, G0438, G0439, G0402, D0120, D0140, D0150, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99391, 99392, 99393, 99356, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, D0120, D0140, D0145, D0150, D0160, D0170, D0180, D1110, D1120, 98940, 98941, 98942, 98943, MUOBV, MUREP, 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 99495, 99496

APPENDIX B: NOTICES

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