

EHR Meaningful Use Guide

Configuration and End User Training

Practice Partner[®], Medisoft[®] Clinical and Lytec[®] MD

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Table of Contents

Meaningful Use Configuration and End User Training Guide Updates8

Preface - Clinical Encounters9

- Configuration of Appointment Scheduling:.....9
- For Medisoft Clinical and Lytec MD:10
- Configuration of Patient Records:11
- Access Levels - Task Item Definitions for the Records Category.....12
- Clinical Encounters screen13
 - Fields and buttons on the Clinical Encounters screen.....13*
- Clinical Encounter New and Edit screen.....14
 - Fields and buttons on the Clinical Encounter screen.....15*

Core Objectives 1 and 3 – Orders and ePrescribing.....17

- Introduction:17
 - Core Objective 1:17*
 - Core Objective 3:17*
- Configuration Steps for Core Objective 1 and 3:17
 - Attaching Prescriptions to Order Names for In-House Orders18*
 - Configuration Notes:20*
- End User Workflow Training21
 - Core Objective 1:21*
 - Core Objective 3:22*
 - End User Notes:.....22*

Core Objective 2- Drug-Drug / Drug-Allergy Interactions24

- Objective:24
- Description:24
- Configuration:24
 - Configuration Notes:24*
- End User Training:24
 - End User Notes:.....25*

Core Objective 4 - Demographics26

- Introduction:26
- Objective:26
- Description:26
- Configuration:26
 - For Medisoft Clinical or Lytec MD:28
 - From.....28
 - To28
- End User Training:29

Core Objective 5 – Problem List31

Objective:31

Configuration:31

Configuration Notes:31

End User Training:32

End User Notes:.....33

Core Objective 6 – Medication List.....34

Objective:34

Description:34

Configuration:34

Configuration Notes:34

End User Training:34

End User Notes:.....35

Core Objective 7 – Medication Allergy List.....36

Objective:36

Description:36

Configuration:36

Configuration Notes:36

End User Training:36

End User Notes:.....38

Core Objective 8 - Vitals39

Objective:39

Access Level Configuration:39

Configuration Notes:39

End User Training:39

End User Notes:.....43

Core Objective 9 – Smoking Status44

Objective:44

Configuration:44

Configuration Notes:47

End User Training:47

Core Objective 10 – Clinical Decision Support Rule.....48

Objective:48

Configuration:48

Configuration Notes:48

End User Training:48

End User Notes:.....49

Core Objective 11 – Clinical Quality Measures50

Objective:50

Description:50

Installation: 50

Configuration: 51

End User Guidelines: 52

Reporting: 61

Core Objective 12 – Electronic Copy 63

 Introduction: 63

 Objective: 63

 Configuration: 63

 End User Training: 66

Core Objective 13 – Clinical Summary 70

 Introduction: 70

 Objective: 70

 Configuration: 70

Configuration Notes: 71

 End User Training: 72

End User Notes: 73

Core Objective 14 – Electronically Exchange Key Clinical Information 75

 Introduction: 75

 Description: 75

 Configuration: 75

 End User Training: 76

End User Notes: 78

Core Objective 15 - Security Administrator’s Application Guide 79

 Objective: 79

 Description: 79

 Access Control/Authentication: 79

Configuration: 79

Configuration Notes: 80

 Emergency Access: 80

Configuration: 80

End User Notes: 81

 Automatic Log-Off: 81

Configuration: 82

 Operator Audit Trail Report: 83

Configuration: 84

End User Functionality: 85

 System Security Events: 86

Configuration: 87

Menu Objective 1 - Implement Drug Formulary Checks 88

 Objective: 88

Description:	88
Configuration:	88
<i>Configuring Formulary Download Time</i>	89
<i>Configuring to download through Proxy Server</i>	89
<i>Patient Demographics Needed</i>	89
<i>Formulary Workflow</i>	90
Menu Objective 2 – Structured Lab Results	93
Description:	93
Objective:	93
Configuration:	93
<i>Configuration Notes:</i>	94
End User Training:	94
Menu Objective 3 - Generate Patient List by Problem	95
Description:	95
Configuration:	95
Patient Inquiry	95
<i>Entering values for Patient Inquiry report items</i>	96
<i>Using the Report Logic Keys</i>	96
<i>Completing the Patient Inquiry</i>	97
Patient Registries	98
Menu Objective 4 - Generate Patient Reminders	99
Description:	99
Configuration:	99
End User Training	99
<i>Patient Demographics</i>	99
<i>Patient Inquiry</i>	100
<i>Batch Communication</i>	100
Menu 5 Objective- Timely Access:	105
Objective:	105
Description:	105
Configuration:	105
<i>Configuration Notes:</i>	106
End User Training:	106
<i>End User Notes:</i>	106
Menu Objective 6 - Provide Patient-Specific Education	107
Objective:	107
Description:	107
Configuration:	107
<i>Configuration Notes:</i>	108
End User Training:	109
<i>External Source:</i>	109
<i>End User Notes:</i>	110

Menu Objective 7 – Medication Reconciliation111

 Introduction: 111

 Objective: 111

 Configuration: 111

 End User Training: 112

Menu Objective 8 – Summary of Care Record.....117

 Objective: 117

 Description: 117

 Configuration: 117

Configuration Notes: 119

 End User Training: 120

If a Summary of Care document is provided to another practice for purposes of referring a patient, you can document this through the Order Entry module..... 122

End User Notes:..... 123

Menu Objective 9 - Submit to Immunization Registries124

 Description: 124

 Exception: 124

 Configuration: 124

Health Maintenance Names:..... 124

Editing the Immunization Report..... 125

Entering Immunization Information in Health Maintenance..... 127

Menu Objective 10 – Submit Electronic Syndromic Surveillance Data to Public Health Agencies.....129

 Objective: 129

 Description: 129

 Configuration: 129

Configuration Notes: 129

 End User Training: 129

End User Notes:..... 130

EHR Performance Metrics Report.....131

 Configuration: 131

 End User Training: 131

End User Notes:..... 133

Meaningful Use Configuration and End User Training Guide Updates

Revision Date August 30, 2011

- [Clinical Encounters – page 10](#): Added a note about including the OUT appointment status code in the StatusCodes= PPART.INI setting to prevent deletion of Clinical Encounters when a patient is checked out.
- [Clinical Quality Measures – page 56](#): Clarified proper setup of health maintenance names for sites upgrading to certified version of the EHR.
- [Clinical Quality Measures – page 58](#): Fixed incorrect allergy name for Baker's Yeast.
- [Summary of Care - pages 117-123](#): Added configuration and end user training steps to allow for documenting of a Summary of Care record being provided for a referral.
- [EHR Performance Metrics Report – page 133](#): Added explanation of the two Summary of Care report options.

Preface - Clinical Encounters

The Clinical Encounters feature allows users to record details for each clinical encounter for patients. These details are used in reporting a provider's metrics. A clinical encounter is generally defined as an event where some kind of patient contact occurs.

Patient Records and Appointment Scheduler will automatically create clinical encounter records based on the presence of Type of Visit (TOV) codes, Status codes, and/or the .ENC Dot code. Users can manually add, edit, or delete clinical encounters that have been created.

Configuration of Appointment Scheduling:

The Appointment Scheduler will create Clinical Encounters during appointment entry based on Status codes and Type of Visit (TOV) codes. The setup for **Total Practice Partner** clinical encounters through the schedule is different than **Medisoft Clinical and Lytec MD**.

For Practice Partner:

System administrators can alter the PPart.ini (configuration) file to specify which codes create Clinical Encounters at the time of appointment entry. By default all of the built-in TOV and Status codes which come with Patient Records will generate a Clinical Encounter with the exception of the "CA", "NS", "BL" (blocked), "RS" Status codes or their equivalents. Users can modify settings to include the codes that their organization wants to use to create clinical encounters. If an organization uses custom codes, the system administrator can add these codes to the list.

The TOV Codes setting additionally specifies whether a TOV code will create encounters indicating that the transition of care is Outbound (O), Inbound (I), or Neither (N), and whether the clinical encounter is relevant to medication reconciliation (Y or N). For example, when an appointment is created for a single patient with the TOV Code, "AC", a clinical encounter will be created for the patient denoting that the Transition of Care was Inbound (I) and that Medication Reconciliation is not relevant (N). Your system administrator can change the defaults for these actions based on your organizations' preferences.

The default TOV Code settings are:

```
TOVCodes=AC:I:N,BCB:N:Y,CB:N:Y,CON:O:Y,CP:N:Y,NOB:I:N,NP:I:N,OB:N:Y,OV:I:Y,PE:N:Y,PRO:N:Y,SPE:I:Y
```

The default Status code settings are:

```
StatusCodes=DI,IN,LA,RM1,RM2,UR,WVC
```

To change the ppart.ini file settings:

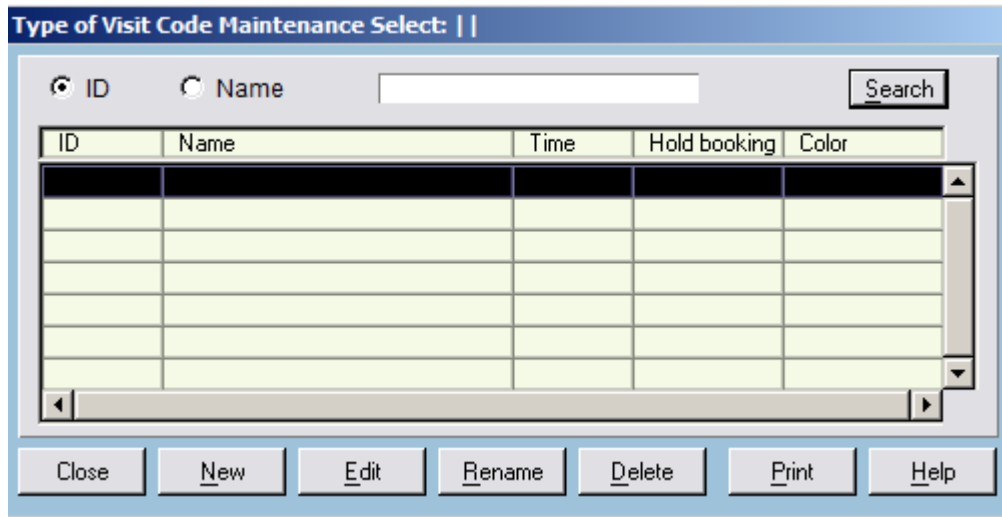
1. Open the PPart.ini file.
2. Find the **[ClinEncounters]** section.
3. To add a new **TOV code** to the TOVCodes= list; enter the new TOV code with no space after the comma. The TOV code must be immediately followed by a colon, then immediately followed by a I, O, or N to indicate whether you want the Transition of Care to be inbound, outbound, or neither. Another colon must follow, immediately followed by Y or N to indicate whether the code will create a clinical encounter that is marked relevant to Medication Reconciliation. For example, LB:I:N
4. To add a new **Status code** to the StatusCodes= list, enter the new Status code with no space after the comma (i.e., DI,IN).

5. Save the file when you are finished.
See the *PPart.ini* file topic in Patient Records Help for more information.

Note: The status code of OUT should be added to the StatusCodes= entry. Failure to do so can result in Clinical Encounters being improperly deleted when a patient is checked out.

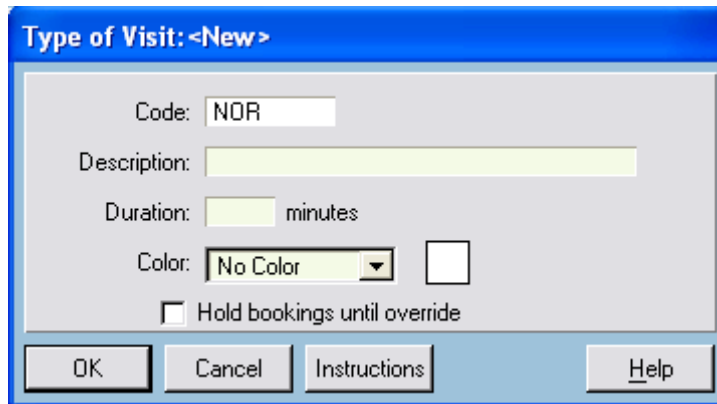
For Medisoft Clinical and Lytec MD:

1. Select Maintenance > Configuration > **Type of Visit Codes**. The Type of Visit Code Maintenance Select screen appears.



Type of Visit Code Maintenance Select screen

2. Click the **New** button. The Type of Visit <New> screen appears.



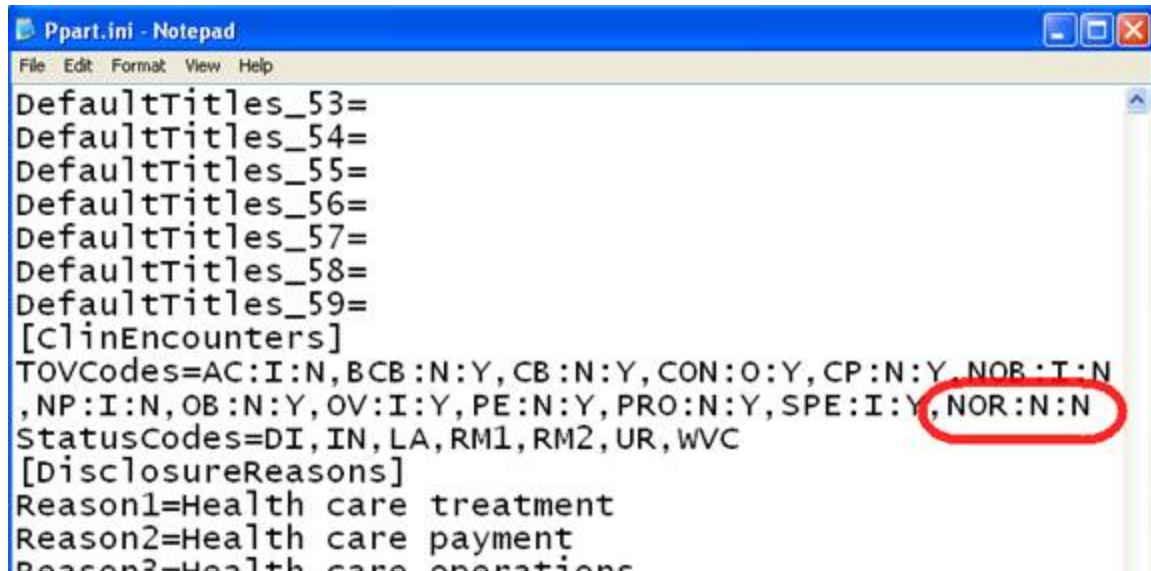
Type of Visit <New> screen

3. Type **NOR** in the **Code** field.

It is not necessary to complete the **Description** or **Duration** fields.

Next, it will be necessary to add the NOR code to the ppart.ini configuration file which is located in the PPART folder.

Open the file in notepad, then search for the word "clinencounters". Add the following to the end of the TOVCodes line (be sure to include the comma):



```

Ppart.ini - Notepad
File Edit Format View Help
DefaultTitles_53=
DefaultTitles_54=
DefaultTitles_55=
DefaultTitles_56=
DefaultTitles_57=
DefaultTitles_58=
DefaultTitles_59=
[ClinEncounters]
TOVCodes=AC:I:N,BCB:N:Y,CB:N:Y,CON:O:Y,CP:N:Y,NOR:T:N
,NP:I:N,OB:N:Y,OV:I:Y,PE:N:Y,PRO:N:Y,SPE:I:Y,NOR:N:N
StatusCodes=DI,IN,LA,RM1,RM2,UR,WVC
[DisclosureReasons]
Reason1=Health care treatment
Reason2=Health care payment
Reason3=Health care operations

```

If the practice wants all system created Clinical Encounters to default with either inbound or outbound transfer of care preselected, use an I or an O instead of the first N.

If the practice wants all system created Clinical Encounters to default with Relevant For Meds Reconciliation preselected, use a Y instead of the second N.

Note: In order to create a clinical encounter from a patient appointment both the TOV and Status code must be marked in the PPART.INI and be present on the appointment.

Note: Please note that Clinical Encounters are only created automatically at check-in for appointments added after completing this configuration. Any appointments that existed in the EHR prior to completing this setup will not create Clinical Encounters simply by checking in, so staff will want to either create them manually or utilize the .ENC: code for preexisting appointments.

Note: If you have a Medisoft or Lytec scheduling interface, Clinical Encounters will be created.

Configuration of Patient Records:

Users can use the .ENC Dot code to create clinical encounters from notes when a note is permanently saved, or when a note is loaded into Patient Records via Text Data Loader.

The note created for the clinical encounter will include the practice and provider who created the encounter, the date/time the encounter was created, the type of encounter (Office Visit, Transfer of Care, or Letter), whether the transfer of care was inbound (I) or outbound (O), or not recorded (blank), and whether the encounter is relevant to medication reconciliation (Y or N).

Note: Users can include multiple .ENC Dot codes in one note. This will result in the creation of multiple clinical encounter records.

Note: The system will not create a clinical encounter record from a Dot code if a matching clinical encounter exists for the patient (i.e., the patient, date, practice, and encounter type (Office Visit, Transfer of Care, or Letter) are the same).

If necessary, users can modify the clinical encounter after it has been created using Clinical Encounter maintenance.

If any dot code values are blank when the note is saved, the following will be specified for the clinical encounter:

- **Provider:** If there is current provider, the current provider will be specified as the provider for the clinical encounter.
- **Practice:** The current practice will be specified as the practice for the clinical encounter.
- **Type:** The type will be specified as "Office Visit" unless the note is a letter in which case the type will be "Letter".

Example of the .ENC code:

.ENC: provider : practice : date : time: type : transfer of care : relevant for medication reconciliation

For example:

.ENC: ABC: 1 : 09/15/10 : 10:00 am : Office Visit : I : Y

Access Levels - Task Item Definitions for the Records Category

In order to use the Clinical Encounters screen, the administrator must grant the user access to the Clinical Encounter Maintenance screen.

The task items for the Records category include:

Task item	Description
Clinical Encounters	
Clinical Encounter Maintenance	Indicate whether the operator can Add, Edit, View, or Delete clinical encounters using the Clinical Encounter Maintenance screen.

Clinical Encounters screen

The Clinical Encounters screen lists the clinical encounters that have been added for the current patient. Users can use this screen to add new clinical encounters for the current patient or change or delete existing clinical encounters for the patient.

To open the Clinical Encounters screen when the patient chart is open:

1. Open the Patient Chart for the patient that you want to add, edit, or delete Clinical Encounters for.
2. Select Show > **Clinical Encounters**. The Clinical Encounters screen appears.

To open the Clinical Encounters screen from the Patient Demographic screen:

1. Open the Patient screen for the patient you want to add, edit, or delete Clinical Encounters for.
2. On the **Dates** tab, click the **Clin. Encounters** button. The Clinical Encounters screen appears.

Fields and buttons on the Clinical Encounters screen

Field	Description
Search Encounters area	Allows you to search for a patient's clinical encounters by date, type, practice, provider, and the encounters relevancy to medication reconciliation. When you are finished entering all your search criteria, click the Search button. Clinical encounters matching all the criteria you entered are displayed in the Clinical Encounters list that includes the date, clinical encounter number, encounter type, practice, provider, and Transfer of Care (inbound, outbound, or neither).
Start Date/End Date	If you wish to search by date, type the beginning and ending dates to specify the period that the search is to cover. To search for a single date, enter the same date in both fields. Note: The start date is defaulted to one year prior to the current date and the end date is defaulted to the current date.
Encounter Type	If you wish to search by encounter type, select the encounter type from the drop-down list. Note: You can use List Maintenance to edit or add to the list of encounter types (ENCOUNTER LIST) that will be available from the drop-down list.
Practice	If you wish to search by practice, type the practice ID in this field, or click the drop-down arrow and select the practice from the Practice Select screen.
Provider	If you wish to search by provider, type the provider ID in this field, or click the drop-down arrow and select the provider from the Provider Select screen.
Relevant for medication reconciliation	Select this check box to only view clinical encounters that are relevant to medication reconciliation.

Field	Description
Clinical Encounters List	Lists the clinical encounters that have been added for the selected patient.
Close button	Click to close the screen.
New button	Click to add a new clinical encounter for the patient. The Clinical Encounter <New> screen appears. See the <i>Adding a clinical encounter</i> section in Patient Records Help for more information.
Edit button	Click to edit the currently selected clinical encounter. The Clinical Encounter <Edit> screen appears. See the <i>Editing a clinical encounter</i> section in Patient Records Help for more information.
Delete button	Click to delete the currently selected clinical encounter for the patient. A confirmation message appears. Click the OK button. Note: You can also delete more than one clinical encounter at a time from the list.
View button	Click to view the details of the currently selected clinical encounter for the patient. The Clinical Encounter <View> screen appears. Note: This button is only displayed when the Clinical Encounters screen for the patient is open in more than one Patient Records session. You will not be able to edit encounters until the operator of the other session has closed the screen.

Clinical Encounter New and Edit screen

The Clinical Encounter screen is used when adding or editing clinical encounters for a patient. You can use this screen to add new clinical encounters from the patient demographic screen, or edit existing clinical encounters.

To open the Clinical Encounter <New> or <Edit> screen:

1. Open the Clinical Encounters screen.
2. Click **New** to add a new clinical encounter, or click **Edit** to edit the currently selected clinical encounter. The **Clinical Encounter <New>** screen or **Clinical Encounter <Edit>** screen appears.

Fields and buttons on the Clinical Encounter screen

Field	Description
Encounter Number	<p>Displays the assigned encounter number on the <Edit> screen. When a new clinical encounter is created Patient Records automatically assigns the new encounter a number. The numbers assigned are in sequential order for all patients. For example, if the last encounter added was 100, the new encounter will be number 101.</p> <p>Note: The number will not be displayed for the encounter until after it has been added. The Clinical Encounter <New> screen will display "not yet assigned".</p>
Date/Time	<p>The current date and time are automatically displayed in these fields. You can change the date and/or time if necessary.</p>
Type	<p>Select the encounter type from the drop-down list. Your options include:</p> <ul style="list-style-type: none"> • Office Visit • Telephone Communication • Home Visit • Nursing Home Visit • Hospital Visit • Web Visit • Group Office Visit • Care Conference • Letter • Transfer of Care <p>Note: You can use List Maintenance to edit or add to the list of encounter types (ENCOUNTER LIST) that will be available from the drop-down list.</p> <p>IMPORTANT: If you edit the ENCOUNTER LIST, do not rename or delete Office Type or Transfer of Care. These encounter types are used for meaningful use.</p>
Provider	<p>The current provider is displayed. If you want to change the current provider, type the provider ID in this field, or click the drop-down arrow and select the provider from the Provider Select screen.</p>
Practice	<p>The current practice is displayed. If you want to change the current practice, type the practice ID in this field, or click the drop-down arrow and select the practice from the Practice Select screen.</p>

Field	Description
Transition of Care	Select a transition of care option: <ul style="list-style-type: none"> • Select the Outbound check box if the patient is transitioning out of your care setting to another health care organization or setting. • Select the Inbound check box if the patient is being received by the provider from another health care organization or setting. • Select the Neither check box, if the transition of care does not apply to the encounter.
Relevant for Medication Reconciliation	Select if the clinical encounter is relevant for medication reconciliation. If you select this option, you must link the clinical encounter to a medication reconciliation record. The Med Rec button on the Rx/Medications screen will be highlighted in red if there is a clinical encounter for the patient for the current day that is marked as relevant for medication reconciliation and there is no current medication reconciliation record linked to the clinical encounter. You can select the Document Med Rec option to link the clinical encounter to a medication reconciliation record.
Summary of Care Record provided for Care Coordination	Select if the Summary of Care record (i.e., Chart Summary report or the medical summary record (CCR or CCD)) was provided for care coordination.
Provided to Patient	
Printed Clinical Summary	Select if you provided the printed clinical summary (i.e., Patient Clinical Summary report) to the patient.
Electronic Clinical Summary	Select if you sent the clinical summary electronically to the patient (i.e., exported a clinical summary via CCR/CCD or an HIE).
Patient-Specific Education Materials	Select if patient education handouts or other educational materials were printed or e-mailed to the patient using the Patient Records Patient Education module or an external system, such as, WebMD.

Core Objectives 1 and 3 – Orders and ePrescribing

Introduction:

For the purposes of achieving Meaningful Use, core objectives 1 and 3 have been combined based on the workflow for achieving the measures in version 9.5. There are two distinct workflows outlined in this section: the first is for medications administered or distributed internally (such as Toradol) and the second workflow is for prescriptions sent electronically.

It is important to understand that if no medications are administered or distributed internally; prescribing electronically within version 9.5 will satisfy both Core Measure requirements.

Core Objective 1:

Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. More than 30% of unique patients with at least one medication in their medication list seen by the eligible provider must have at least one medication order entered using CPOE.

Core Objective 3:

Generate and transmit permissible prescriptions electronically (eRx).

More than 40% of all permissible prescriptions written by the eligible provider are transmitted electronically using certified EHR technology.

Configuration Steps for Core Objective 1 and 3:

To receive Meaningful Use credit for medication orders, those orders must be made by a licensed healthcare professional who can enter medications per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates drug or allergy interaction warnings. Each such user should be given appropriate Access Level settings that will allow them to add or edit medications, while users who are not licensed to enter medications should have their Access Level settings reviewed to ensure they are not able to enter medication orders.

To review or update Access Level settings pertaining to medication entry:

1. Select Maintenance > Setup > Access Levels
2. Enter your Practice Partner password when prompted
3. Select an Access Level entry and click the **Edit** button, or double-click an Access Level entry
4. Click on the **Records** tab
5. Use the navigation arrows to locate the **Rx/Medications** entry
6. Click on the boxes under the **New and Edit** columns to add or remove the ability to perform those actions for all users associated with the selected Access Level

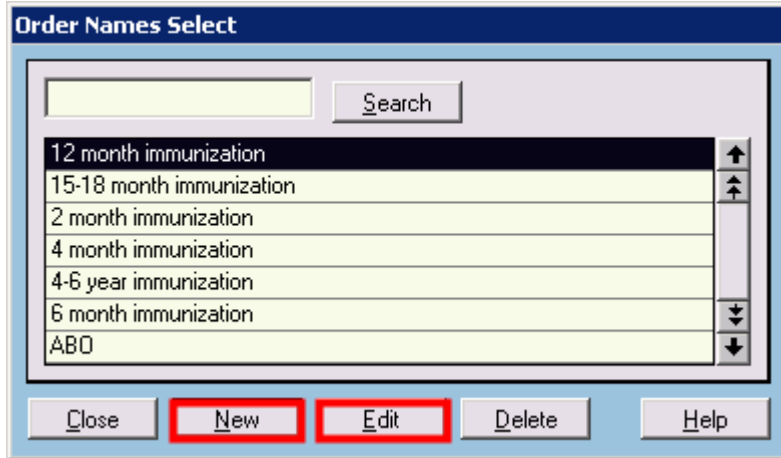
Attaching Prescriptions to Order Names for In-House Orders

Access levels and permissions associated with creating, editing, and signing orders and electronically transmitted prescriptions are unchanged from version 9.4.

There are no changes to how prescription templates are created in 9.5, however in order to tie medications to CPOE, prescriptions will need to be attached to orders.

In version 9.5, there are new configurations available as highlighted below which can be found in the Order Name Maintenance <New> and <Edit> screens (Maintenance > Templates > Order Templates > **Order Names**).

1. Select Maintenance > Templates > Order Templates > **Order Names**.
2. Click the **New** or **Edit** button depending on the desired action.



Order Names Select screen

3. If the order is new, type in the Order Name. In the Order Name Maintenance screen click the **Lookup** button to search for and navigate to the appropriate prescription template.

Order Name <New>

Order Type

Single Order Visible Order Set Hidden Order Set

Order Name: Torado

Order Description:

Order Workflow:

Order Cost: Order Facility:

Order Ext. Dialog: View Dialog

Order Type:

Order is for lab test with structured results

Order Rule:

Order Requirements:

Procedure code(s): Proc code modifiers:

Diagnosis required: Group Type:

Rx Template: Lookup Do not print View

Notes:

Routine Results Back Within: Hours Days

Stat Results Back Within: Hours Days

Initial Action:

Set Status as Pending

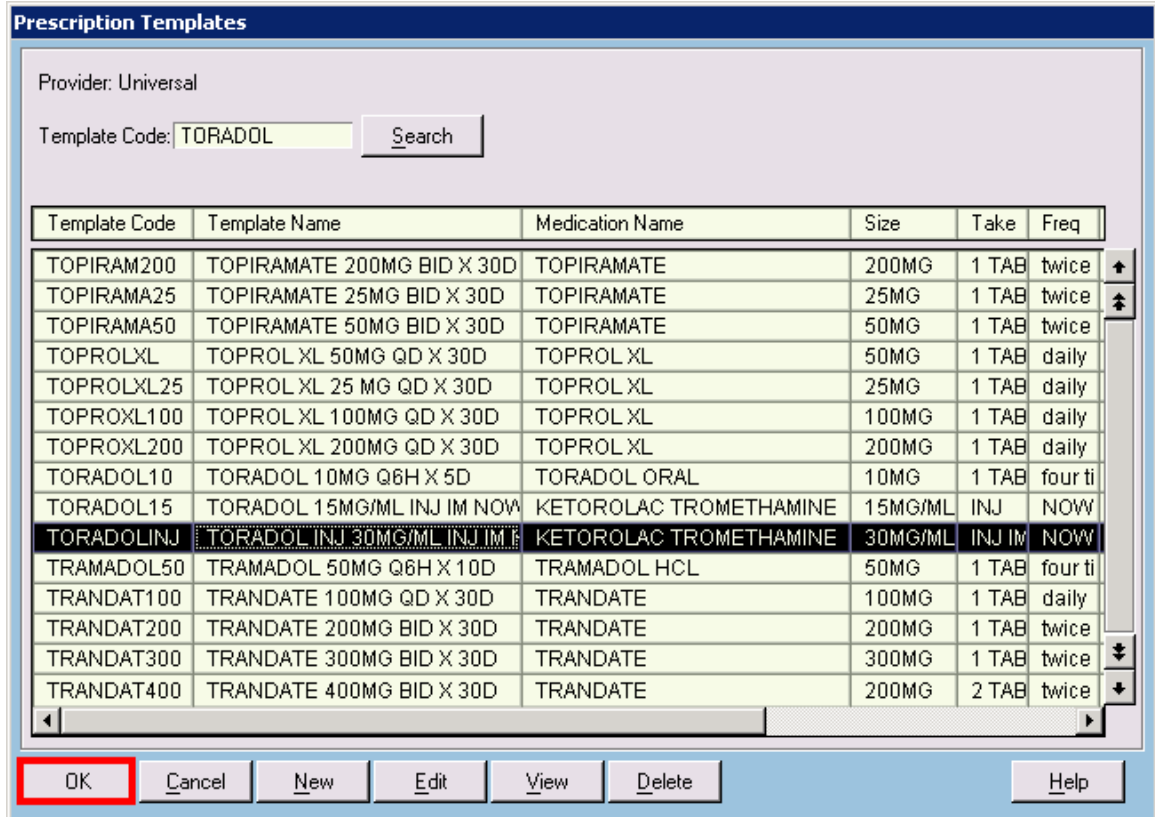
Print Immediately

Electronically Transmit Immediately

OK Cancel Apply Insurance Xref Order Set Instructions Help

Order Name <New> screen

4. Click the **New** or **Edit** button to create or modify a prescription template, otherwise select the appropriate template and click **OK**.



Prescription Templates screen

- To view the template in a read-only format, click the **View** button.
- Click **OK** to save.

Configuration Notes:

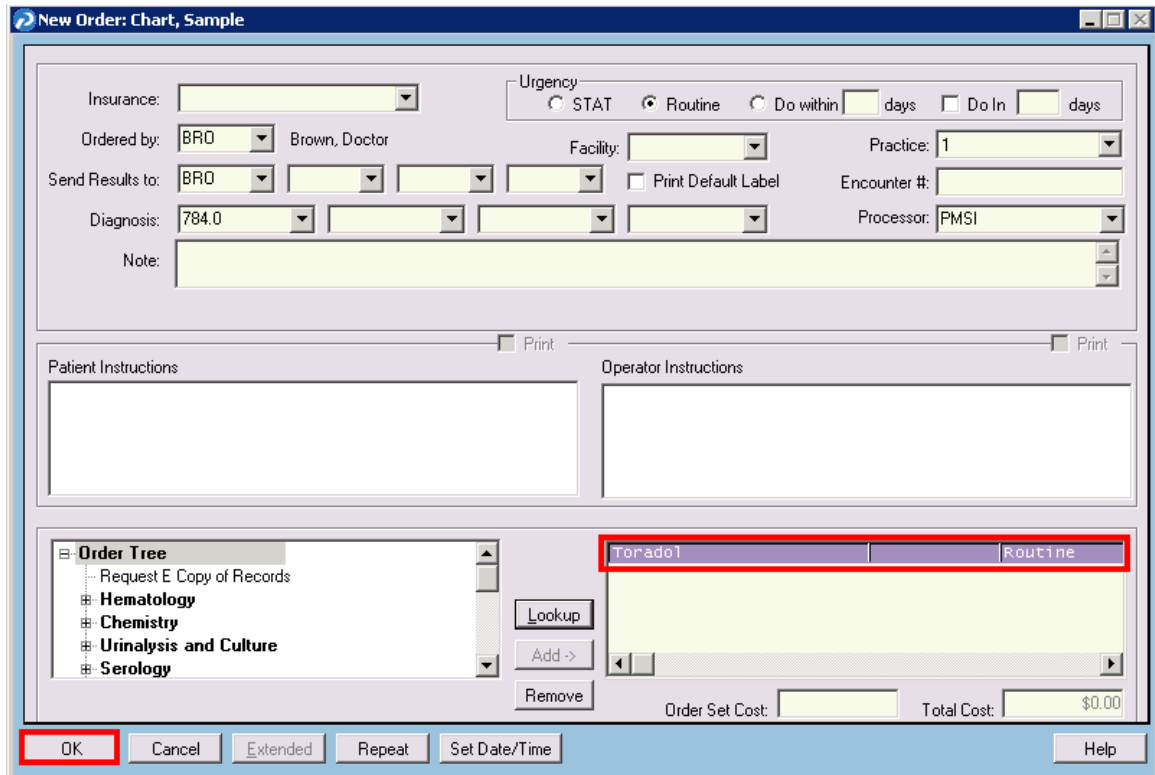
- If filling prescriptions in-house, it is recommended that prescription templates linked to orders have a Duration value of "1" so that they will drop off of the med list the following day, as well as have the print value set to "Do Not Print." Users also need to complete this order using their customary workflow.
- Prescription templates may only be associated with Single Orders, not Visible or Hidden Order Sets. Single orders which contain linked Prescriptions may be grouped into sets. Only one prescription template may be associated with each Single Order.
- When linking a prescription into an Order Name, the **Do Not Print** check box will be checked by default.
- Prescription templates may be created, edited, or deleted from the Rx Template Lookup window launched from the Order Name maintenance screen.
- Operators must have the appropriate access level to initiate new orders **and** to initiate new prescriptions.
- As of version 9.5, the application now records the identity of any Operator who creates a prescription, regardless of how Rx signatures or co-signatures are configured.

End User Workflow Training

Core Objective 1:

To create an order for an “in-house” medication:

1. Open a patient chart and open the orders screen using your existing workflow.
2. Create an order for a medication that will be dispensed in house.
3. Click **OK** to place the order.



New Order screen

4. The Prescription screen will appear allowing the user to make amendments to the prescription as needed. Any drug interactions that are indicated will also display at this time.
5. Click **OK** to place the order.

Prescription screen

- The medication attached to the order will appear in the patient’s medication list as well as the normal order processing screens.

Core Objective 3:

The end user workflows for electronically transmitting prescriptions have not changed from version 9.4. Providers are instructed to ePrescribe using their existing workflow.

End User Notes:

- It is permissible to create duplicate medication orders.
- If an end user **DOES** have access to create an order, but **DOES NOT** have access to write a new prescription, they will not be allowed to place an order with a linked prescription.
- If a user cancels out of a prescription resulting from an order, the prescription-linked order will not be placed, but any other orders issued at the same time will be processed.
- If a signature is required for either the order or the order with a linked prescription, the user will only have to enter in their pin once.
- If an order with a linked prescription is placed using a dot code, a warning will appear allowing the user to continue with the order or cancel it. Prescriptions associated with linked orders **CANNOT** be issued from a note.

- There is now a “Safety Warning” column on the following orders screens: Orders Placed in Patient Chart, Order Processing Select and Provider Orders. Any drug-related safety warnings will be highlighted in red.
- The Auto-Issue Order Utility will **NOT** process prescriptions associated with orders.
- Drug warnings will display for Rx Dot codes in notes.
- Drug warnings will **NOT** display for Rx Dot contained in notes processed by the Text Data Loader.
- If a user editing a prescription template attempts to modify the “Code” value, the system will display a warning and block the user from making the change.

Core Objective 2- Drug-Drug / Drug-Allergy Interactions

Objective:

Implement drug-drug and drug-allergy interaction checking.

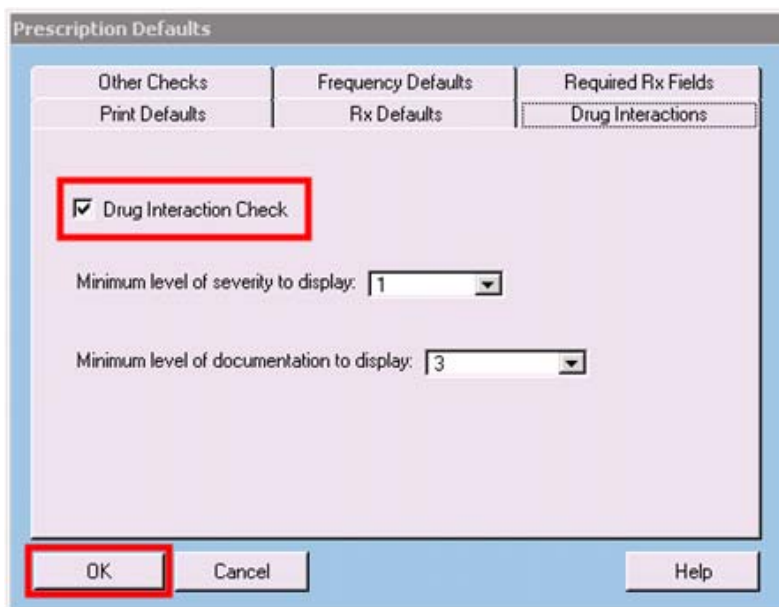
Description:

To meet this objective, eligible providers must have this functionality enabled for the entire EHR reporting period.

Configuration:

To enable drug-drug and drug-allergy interaction checking:

1. Select Maintenance > Configuration > **Prescription Defaults**.
2. Click on the **Drug Interactions** tab.
3. Click the check box labeled **Drug Interaction Check**.
4. Click **OK**.



Prescription Defaults screen

Configuration Notes:

None

End User Training:

There is no change to end user functionality from 9.4 with drug interactions enabled.

End User Notes:

None

Core Objective 4 - Demographics

Introduction:

This section provides details on what demographic information must be recorded to meet Core Objective 4.

Objective:

Record demographic data for the following fields: gender, date of birth, race, ethnicity, and preferred language.

Description:

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

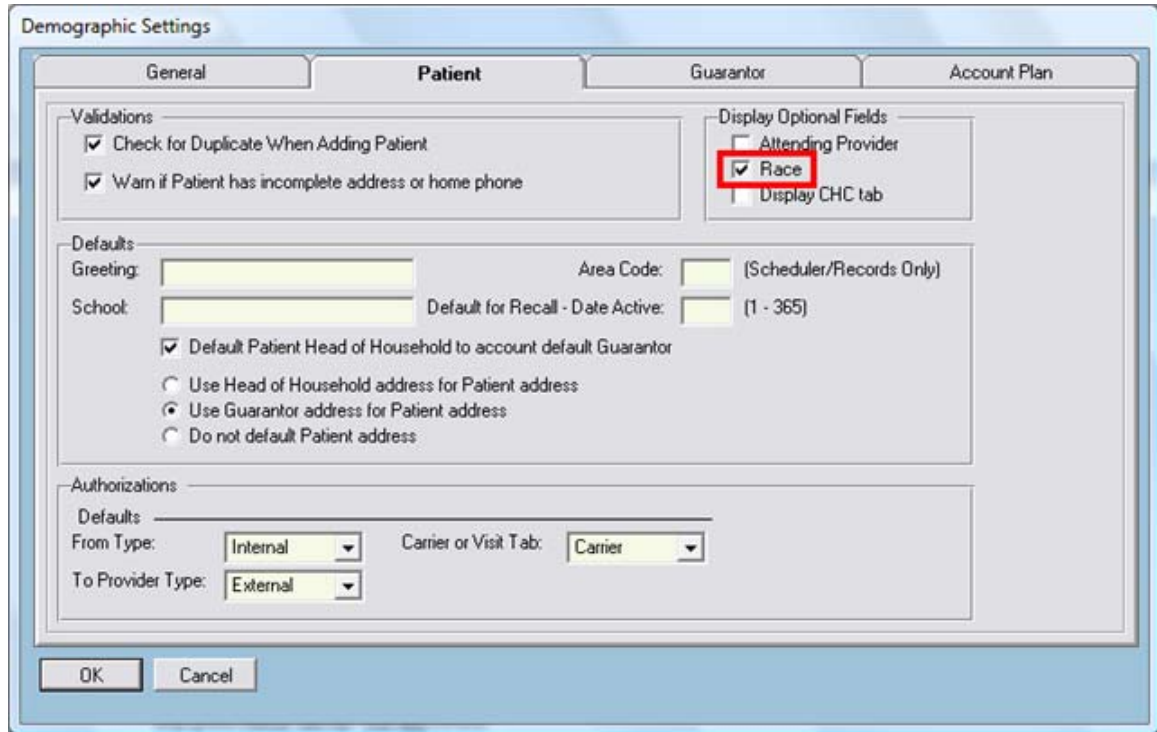
Configuration:

The ability to add or edit patient demographic data, through the appropriate access levels, is sufficient for end user functionality and has remained the same as in 9.4.

The **Race** and **Ethnicity** fields are available in the EHR, but must be enabled.

To enable the Race and Ethnicity fields, if they do not currently display on the General tab of patient demographics:

1. Select Maintenance > Configuration > **Demographic Settings**.
2. Click on the **Patient** tab.
3. Click the **Race** check box and click **OK**.
4. Log out of the EHR and then sign back in for the change to take effect.



Demographic Settings screen

In version 9.5 a new patient demographic “Other Data” field named **Language** will be needed to store the patient’s preferred language. New installations of version 9.5 will come with that field preconfigured. Existing customers that upgrade to version 9.5 will have an “Other Data” field named **Language** automatically added if it doesn’t already exist.

In addition, you will also need to add new Race and Ethnicity options to the ppart.ini file, using the following steps:

1. Navigate to your network drive that contains the \ppart folder.
2. Within the \ppart folder, search for the file titled ppart.ini
3. Open the ppart.ini file and search for the Race and Ethnicity lines by using ctrl+F to search.
4. Edit the ppart.ini file to reflect the example below. The new data also shows a declined option.
 RaceEnable=On
 RaceItems=Am Ind or AK Nat, Asian, Blk or Afr Amer, Nt HI or Ot Pa Is, White, Declined
 EthnicityItems01=His or Latino, Not His or Latino, Declined
5. Save and close upon completion.

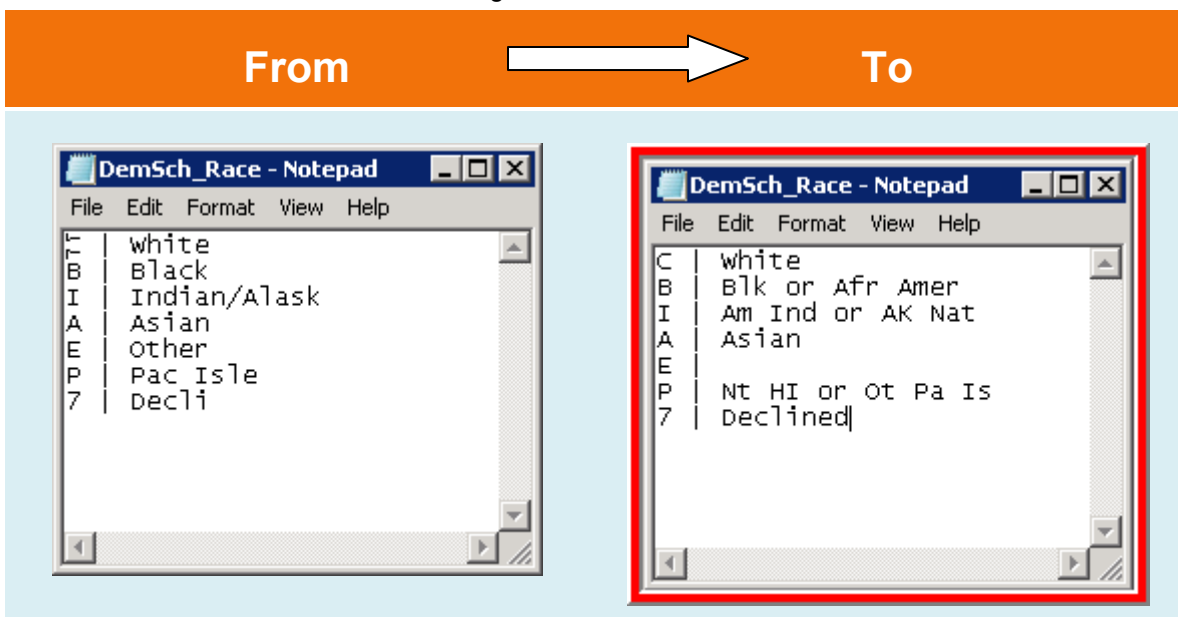
Note: At this time you must also leave in your legacy data in this field if you are an existing site with integrated Spirometry or have previously used these fields for other purposes.

Note: You should always make a back-up of the ppart.ini file before making or saving any modifications.

For Medisoft Clinical or Lytec MD:

When using Medisoft Clinical or Lytec MD, you will need to make additional changes to the cross-reference file “DemSch_Race.ref” within ppart. This will allow Communication Manager to synchronize with PPconnect to output the correct Race status. You can change the cross-reference file using the following steps:

1. Navigate to your network drive that contains the \ppart folder.
2. Within the \ppart folder, browse to the cross-reference file DemSch_Race.ref. The default directory for the file is:
 - For Medisoft Clinical - \ppart\Interface\Medisoft\Rcv\DemSch\Crossref
 - For Lytec MD - \ppart\Interface\Lytec\Rcv\DemSch\Crossref
3. Open the DemSch_Race.ref file and you will need to edit the cross-reference file to match the [Raceltems](#) you changed above in Step 4 from the ppart.ini.
4. Edit the file to match the “To” image below:



Note: Notice that the “Other (E)” race type is blank on the first image as this legacy ethnicity is no longer used with the Patient Records nor meets the Meaningful Use guidelines for Race.

End User Training:

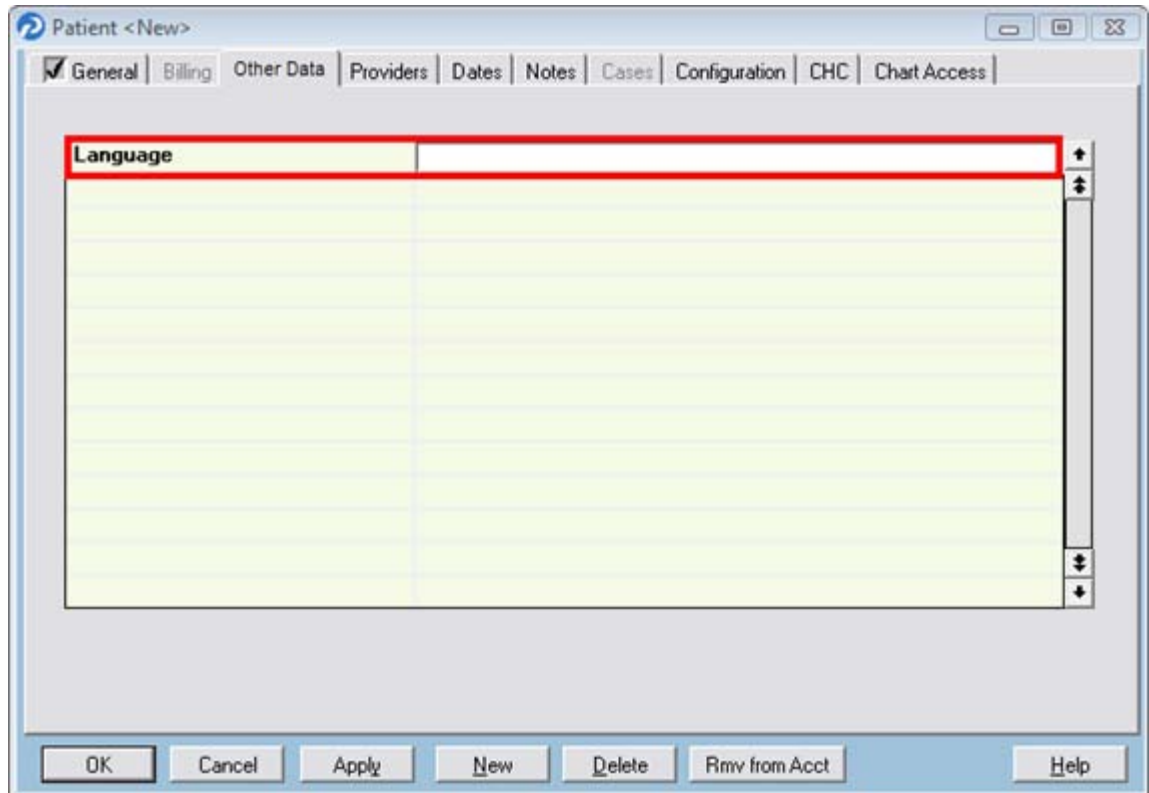
To enter the demographic data elements required for Meaningful Use:

1. On the **General** tab of a new or existing patient's Patient Demographic screen, record data in these four fields:
 - Date of Birth
 - Sex
 - Race
 - Ethnicity

The screenshot shows the 'Patient <New>' window with the 'General' tab selected. The form is divided into several sections. The top section contains personal and identification fields. The middle section contains demographic and contact information. The bottom section contains address and communication details. Four fields are highlighted with red boxes: 'Date of Birth' (mm/dd/yyyy), 'Sex', 'Race', and 'Ethnicity'. The 'Date of Birth' field is a date picker, while the others are dropdown menus. The 'Status' field is set to 'Active' and 'OK to Mail' is checked. The 'Photo' field is empty. The bottom of the window has buttons for 'OK', 'Cancel', 'Apply', 'New', 'Delete', 'Rmv from Acct', and 'Help'.

Patient <New> screen – General tab

2. On the **Other Data** tab, enter the patient's preferred language in the **Language** field. The field is a free-text field and will accept any value a user wishes to enter.



Patient <New> screen – Other Data tab

Core Objective 5 – Problem List

Objective:

Maintain an up-to-date problem list of current and active diagnoses.

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

Note: While it is possible to meet this requirement without having your problem list coded (ICD-9), we strongly encourage sites and providers to use ICD-9 for all problem list entries. This will ensure that you are capturing registry.

Configuration:

The ability to create, edit, and delete current problems and diagnoses, through the appropriate access levels, is sufficient for end user functionality.

In 9.5, there are new configurations available as highlighted below which can be found in the Diagnosis Code Maintenance <New> and <Edit> screens (Maintenance > Tables > **Diagnosis / Problem Codes**).

The screenshot shows a software window titled "Diagnosis Code Maintenance <Edit>: 001.9". At the top, there are several input fields: "Office Code: 001.9", "Standard Code: 001.9", and "Status: Active". Below these are "Coding System: ICD-9-CM" and "Coding System Version: 2009", both of which are highlighted with red rectangular boxes. The window is divided into two tabs: "General" (selected) and "Ledger Settings". Under the "General" tab, there are fields for "Short Description: CHOLERA UNSP" and "Long Description: CHOLERA UNSPEC". To the right of these are "Start Use:" and "Stop Use:" date pickers. Below the descriptions is a section for "Alternative Lookups:" with four empty text input fields. At the bottom of the window are three buttons: "OK", "Cancel", and "Help".

Diagnosis Code Maintenance <Edit> screen

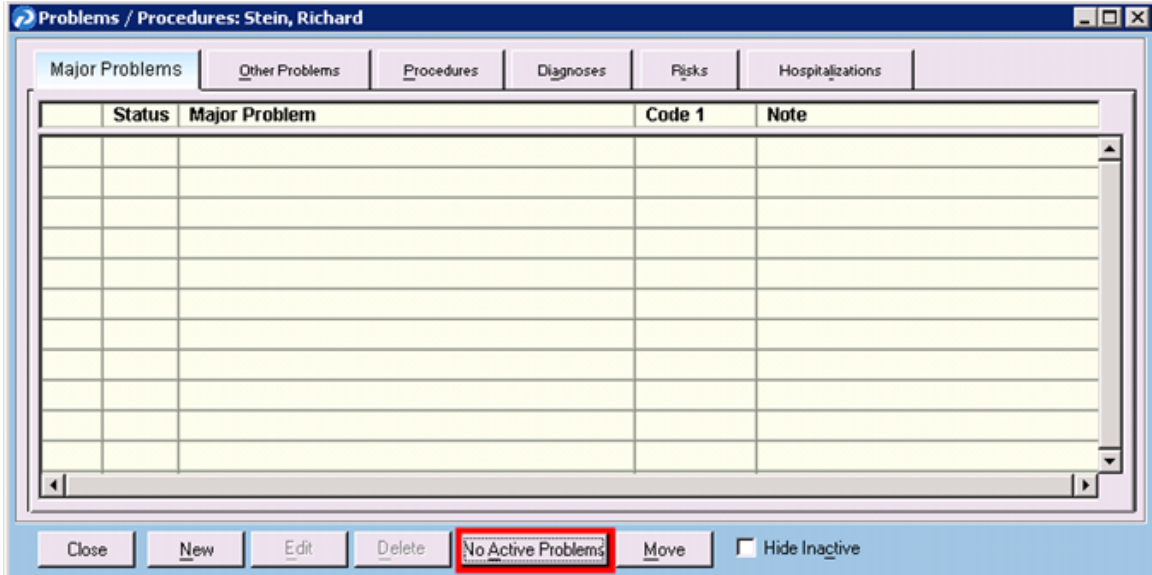
Configuration Notes:

- None

End User Training:

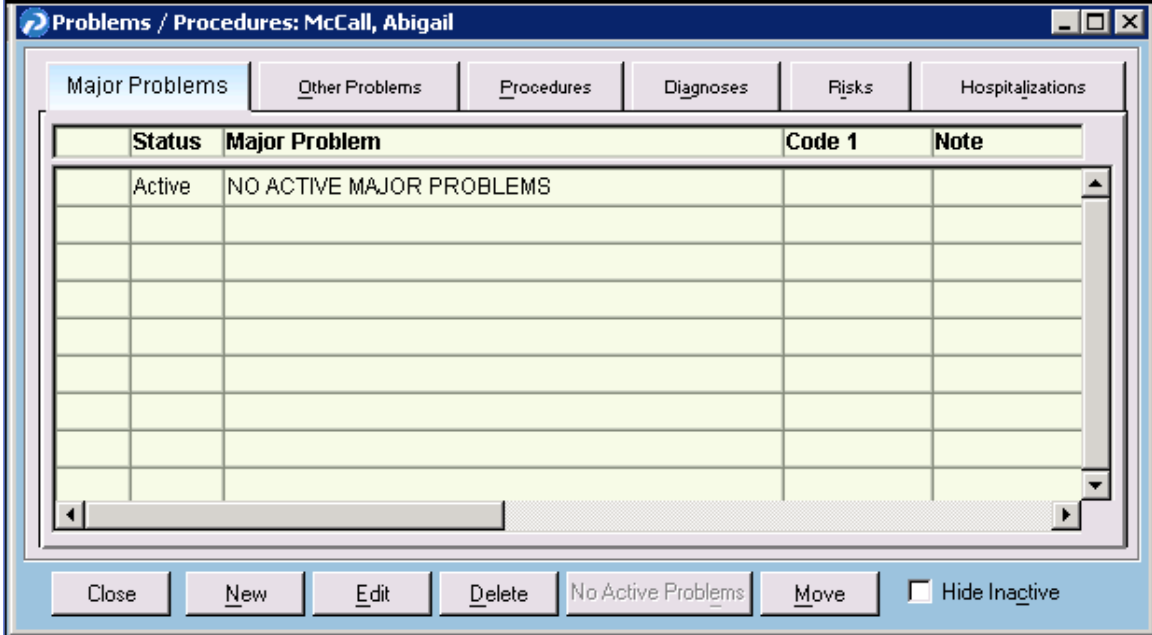
To create an entry on a patient’s problem list as structured data:

1. Open a patient chart, and click on the **Problem List** tab.
2. If the patient has no active major problems at the time of the visit, click the **No Active Problems** button.



Problems / Procedures screen

3. Click **OK** to document that the patient has no active problems, or **Cancel** to exit from the prompt.
4. Clicking **OK** will add the “No Active Major Problem” record to the patient’s problem list.



Problems/Procedures screen

To document a current problem on the patient's problem list:

1. Click the **New** button on the Problems/Procedures screen.
2. The Major Problem <New> screen appears.

Major Problem: <New>

Major Problem: DIABETES UNCOMPL TYPE II

Problem Number: 1 Date: 12/09/10

Provider: BRO Date Last: mm/dd/yy

External Provider: Date resolved: mm/dd/yy

Active/Inactive: Active Indent: 0

Lifecycle: Related to:

Note:

Code 1: 250.00 Code 2:

Coding System: ICD-9-CM Coding System:

Coding System Version: 2009 Coding System Version:

Major Problem <New> screen

3. Enter in the major problem in the **Major Problem** field as depicted above.
4. Using the **Lookup** button will result in the auto fill of the code, coding system, and version as highlighted above.
5. Click **OK** to save.

End User Notes:

- If a patient currently has “No Active Major Problems” listed in their problem list, clicking the **New** or **Edit** button to add a problem will result in replacing “No Active Major Problems” with the selected problem as structured data.
- If there is an existing problem in the problem list, the **No Active Problems** button will be grayed out.
- The .MP Dot code can be used to populate the problem list with “No Active Major Problems” from a saved progress note if used in the following format:
.MP: No Active Major Problems
- If any active Major Problem is entered or imported using this .MP Dot code and an active “No Known Major Problem” record exists, then the “No Active Major Problems” record will be automatically deleted.

Core Objective 6 – Medication List

Objective:

Maintain an active medication list.

Description:

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

Configuration:

There are no changes needed in configuration for this objective. Access levels remain the same as in 9.4.

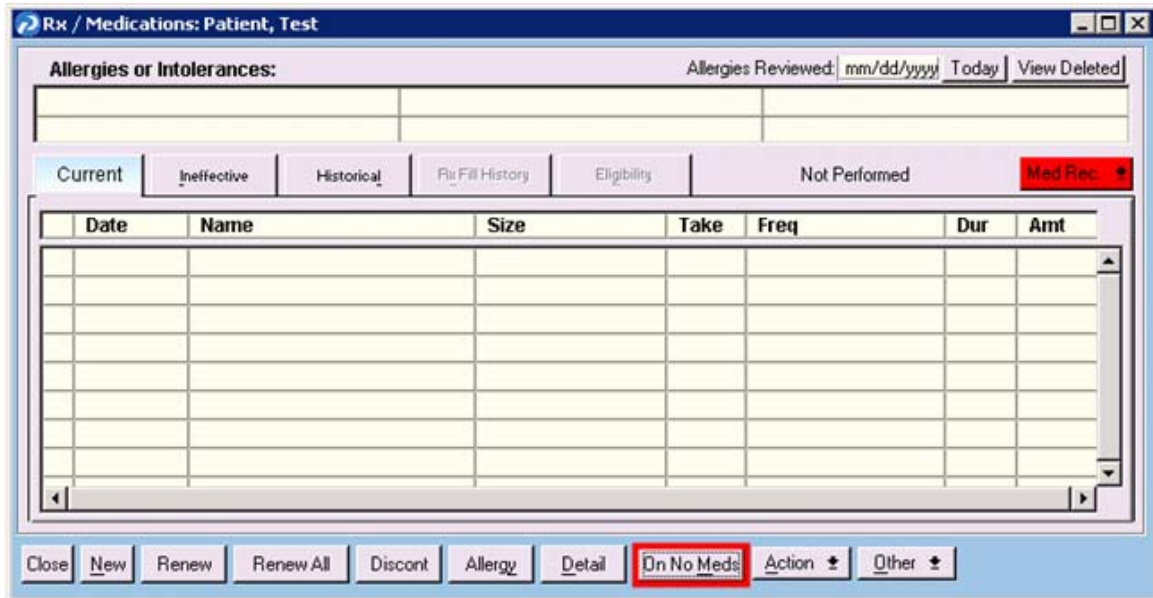
Configuration Notes:

None

End User Training:

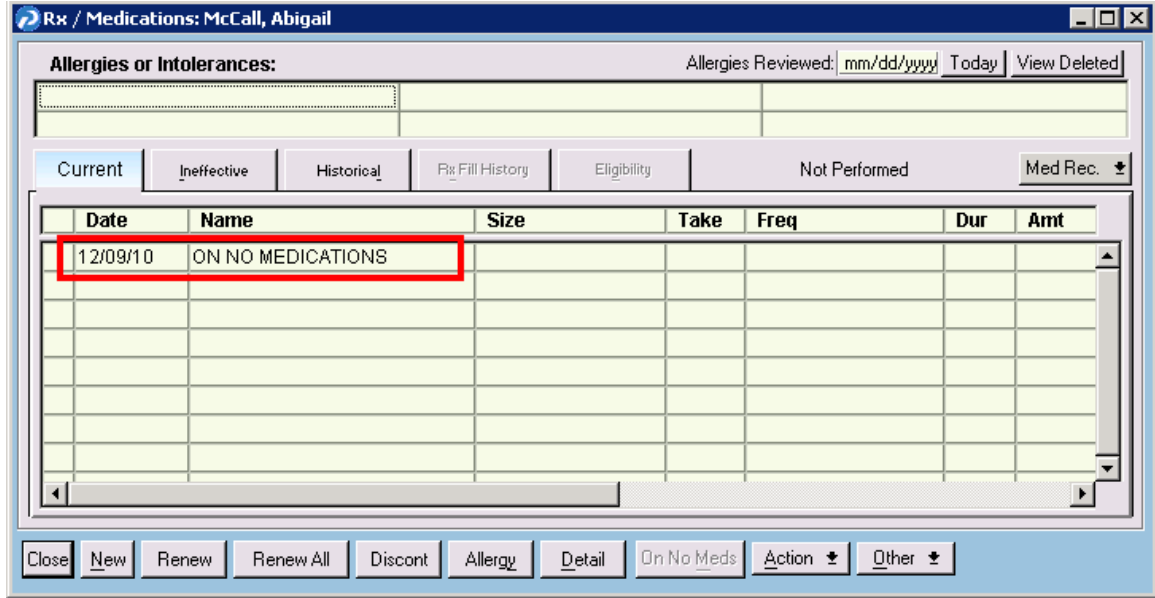
To create a new entry on a patient’s medication list:

1. Open a patient chart, and click on the **Rx/Medications** tab.
2. If the patient is not currently on any medications, click the **On No Meds** button.



Rx/Medications screen

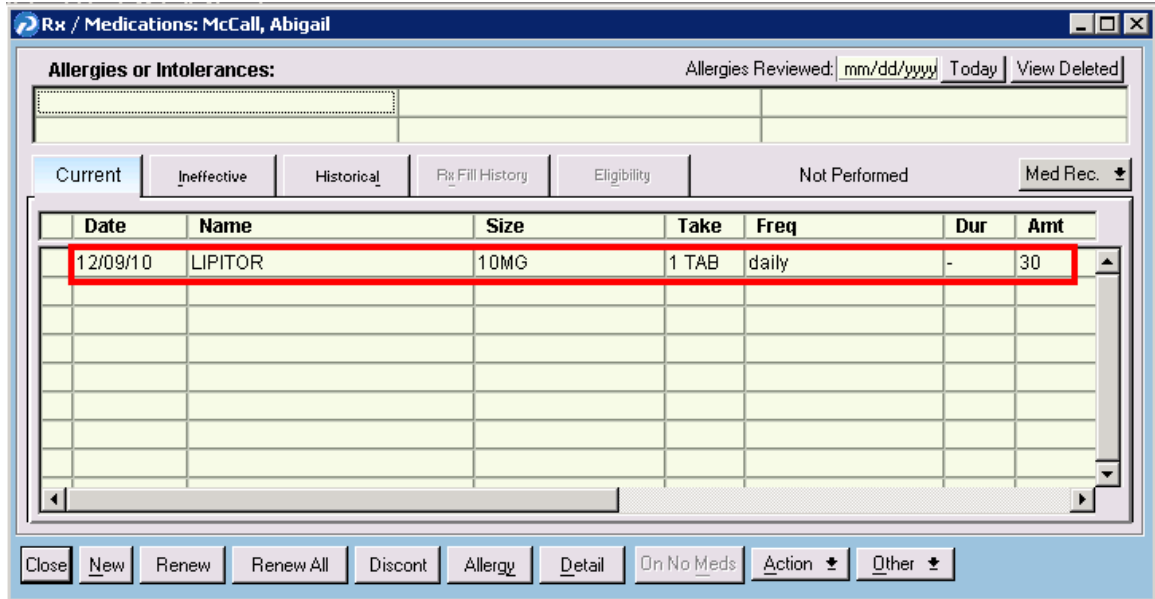
3. The system will then prompt you to confirm this choice. Click **OK** confirm or **Cancel** to exit from the prompt.
4. The system now shows that the patient is “On No Medications.”



Rx/Medications screen – “ON NO MEDICATIONS” entry

To manually place a medication on a patient’s medication list as structured data:

1. Open a patient chart, and click on the **Rx/Medications** tab.
2. Click the **New** button.
3. Complete the medication entry, and click **OK**.
4. The system will then list the patient’s medication as structured data.



Rx/Medications screen – Structured Data entry

End User Notes:

- Providers may also use this Dot code .RX:
For example: .RX: On No Medications

Core Objective 7 – Medication Allergy List

Objective:

Maintain an active medication allergy list.

Description:

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

Configuration:

There are no changes needed in configuration for this objective. Access levels involved in meeting this objective remain the same as in version 9.4.

Configuration Notes:

None

End User Training:

To create a new entry on a patient's allergy list:

1. Open a patient chart, and click on the **Rx/Medications** tab.
2. Click the **Allergy** button, or press **ALT+Y**.

Allergy: New screen

3. On the Allergy <New> screen, enter the following information:
 - **Medication/Allergy Name**
 - **Allergy Type:** food, drug allergy, miscellaneous
 - **Severity:** mild, moderate, severe

Notes:

- You can enter an unlimited number of allergies and intolerances for each patient.
- “NKA” and “NKDA” may also be entered. The system will disallow entry of “NKA” or “NKDA” if any other allergy is present.

4. When you are finished, click **OK**.

To edit an existing allergy:

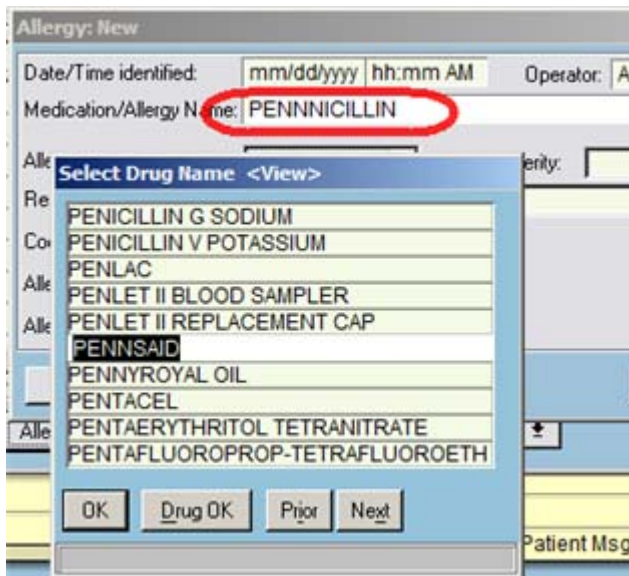
1. Double-click the allergy you want to change in the Allergies or Intolerances list. The Allergy: Edit screen appears.
2. Make the appropriate changes.
3. Click **OK**.

To delete an allergy:

1. Double-click the allergy you want to delete in the Allergies or Intolerances list. The Allergy: Edit screen appears.
2. Click the **Delete** button. A confirmation message is displayed. Click **Yes**.

Adding Allergies with Clinical Tools

With Clinical Tools installed and updated, the system will prevent mistypes and misspellings when inputting allergies and intolerances. If a user enters an allergy not found in the interaction database, the system will display a list of recognized medication names similar to what was typed.



Select Drug Name <View> screen

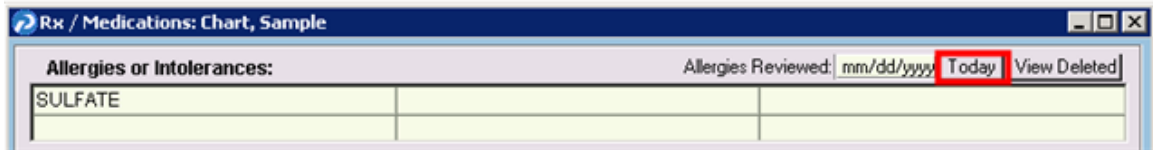
If you click the **Drug OK** button, the entry will be added as-is and will be used for future Allergy Interaction Checking. Since it will cause “Adverse reaction potential unknown” warnings each time a prescription is written for the patient, you should avoid using the **Drug OK** button when adding allergies.

Special Note regarding usage of the Allergy Dot Code (.AL:)

The allergy Dot code will push allergies from a note into the allergies section of the Rx/Meds section. It will **not** prevent mistypes or misspellings and will push **anything** over and use it for future checking. It will **not** bring up the Select Drug Name screen if the allergy is misspelled. **Users should use caution when using this code.**

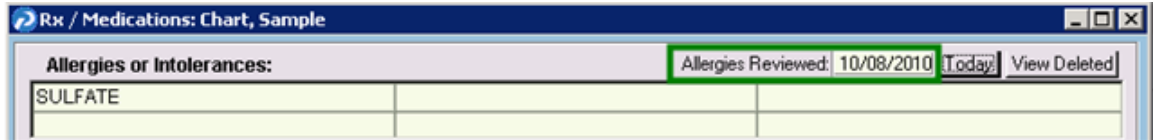
To denote that a patient’s allergies were reviewed:

1. On the Rx/Medications screen, click the **Today** button to the right of **Allergies Reviewed** field.



Rx/Medications screen – Today button

2. The system will then display the current date to denote that the patient’s allergies were reviewed.



Rx/Medications screen – Allergies Reviewed

End User Notes:

None

Core Objective 8 - Vitals

Objective:

For more than 50% of all unique patients age 2 and over seen by the eligible provider: Record and chart changes in vital signs including: Height, Weight and Blood Pressure. Calculate and display BMI. Plot and display growth charts for children 2-20 years, including BMI.

Access Level Configuration:

Access levels remain the same for this functionality from 9.4 and do not need to be changed.

Configuration Notes:

None

End User Training:

To record vital signs:

1. Open a patient's chart, and click on the **Vital Signs** tab.
2. Click the **New** button.
3. Enter in the appropriate vital signs as shown below.

Vital Signs <New> screen

4. Click **OK** to save.
5. On the Vital Signs screen, the BMI will be automatically calculated based on the patient's height and weight values, as shown below.

Template: Vitals		11/01/10
Height	5'5"	
Weight	150 lbs	
BMI	24.98 kg/m ²	
OFC		
Temperature		
Pulse		
Respirations		
Systolic	120	
Diastolic	80	
Oximetry		
Smoking		
Pain Level		
Peak Flow		
Other		

Vital Signs screen – BMI calculation

To plot weight and height growth charts for patients aged 2-20

To plot the height growth chart:

1. Click on Height to highlight it in black.
2. Click the **Graph** button to display the growth chart for height.

Vital Signs: <25> Test, Little Girl

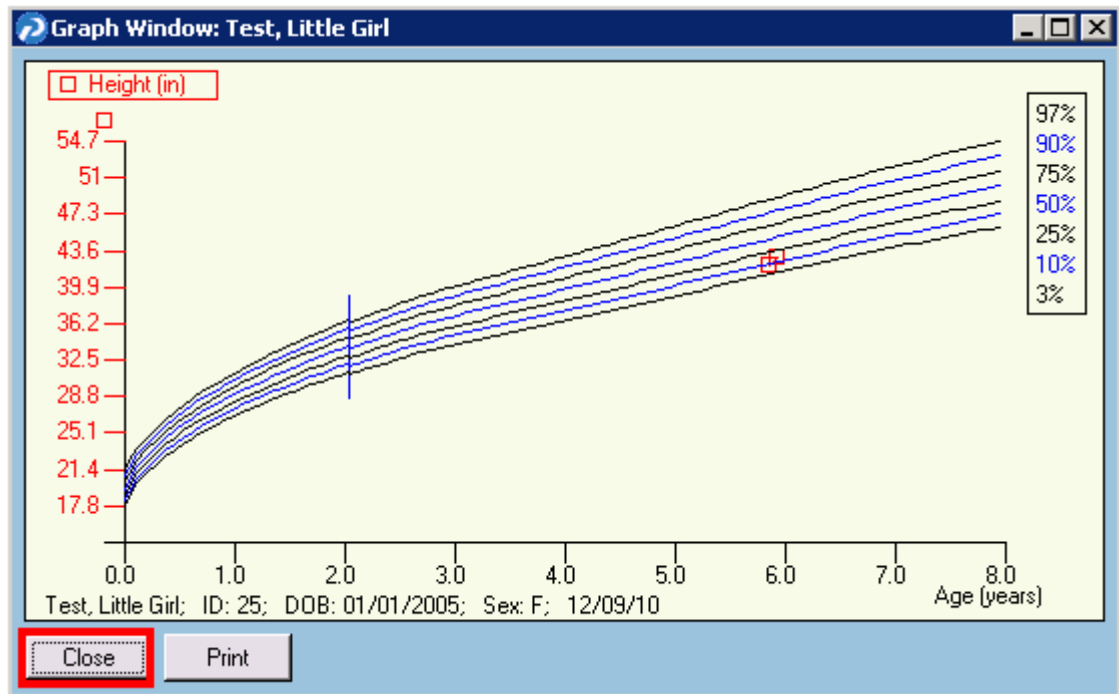
Template: Vitals

	11/08/10				
Height	3'6"				
Weight	45 lbs				
BMI	17.95 kg/m2				
OFC					
Temperature					
Pulse					
Respirations					
Systolic	70				
Diastolic	50				
Oximetry					
Smoking					

Close New Edit View Delete Newer Older Graph Print Detail

Vital Signs screen – Highlight Height

3. The growth chart will then appear on the screen.



Graph Window

4. You can print the growth chart by clicking the **Print** button, or close the screen by clicking the **Close** button.

To plot the weight growth chart:

1. Click on Weight to highlight it in black.
2. Click the **Graph** button to display the growth chart for weight.

	11/08/10			
Height	3'6"			
Weight	45 lbs			
BMI	17.95 kg/m2			
OFC				
Temperature				
Pulse				
Respirations				
Systolic	70			
Diastolic	50			
Oximetry				
Smoking				

Buttons: Close, New, Edit, View, Delete, Newer, Older, Graph, Print, Detail

Vital Signs screen – Highlight Weight

- The growth chart will then appear on the screen.
- You can print the growth chart by clicking the **Print** button, or close the screen by clicking the **Close** button.

End User Notes:

None

Note: Height may be self-reported

Note: All values must be obtained during the measurement period.

Core Objective 9 – Smoking Status

Objective:

Record smoking status as structured data for more than 50% of all unique patients 13 years old or older seen by the eligible provider.

Configuration:

Access levels remain the same as in 9.4.

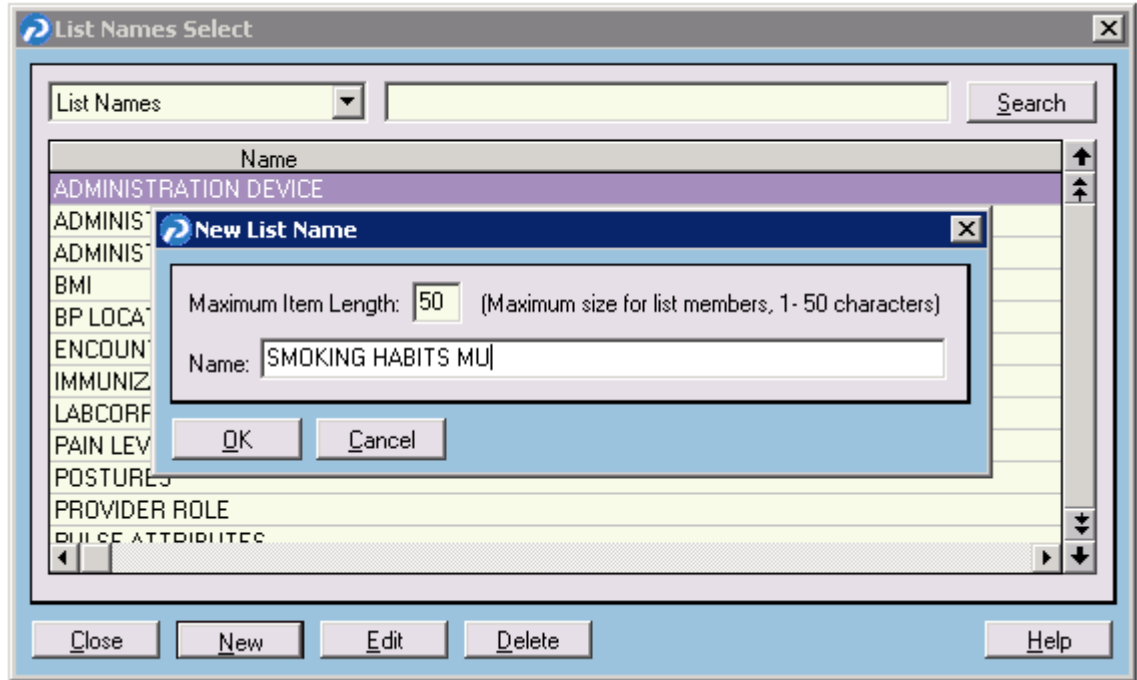
In order to meet the requirements for Meaningful Use, sites who are upgrading will need to add the following smoking statuses to the Smoking Habits list in List Maintenance:

- Current every day
- Current some day
- Former
- Never
- Cur status unknown
- Unknown if ever

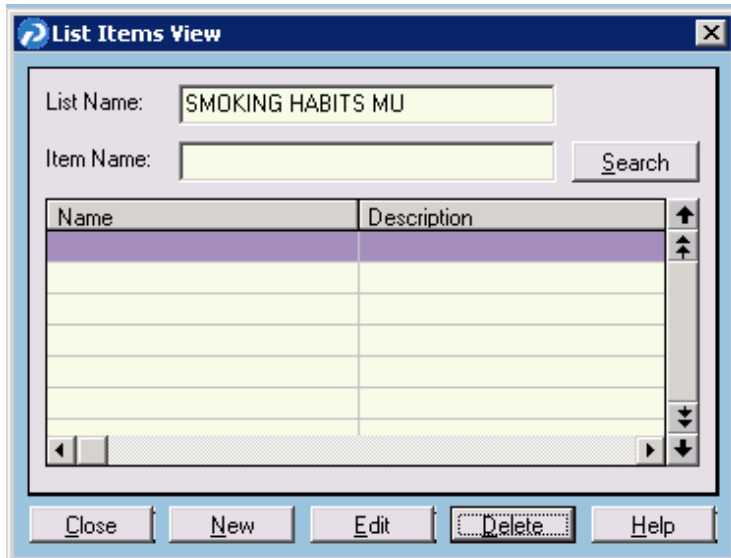
To ensure that past clinical data tied to the Smoking Habits List Maintenance is maintained it is best that a new List Maintenance is created.

To add a new item to List Maintenance:

1. Select Maintenance > Templates > **List Maintenance**. The List Names Select screen appears.
2. Click **New**, and a new list name screen will appear. Name the new list “SMOKING HABITS MU”, and click **OK**.

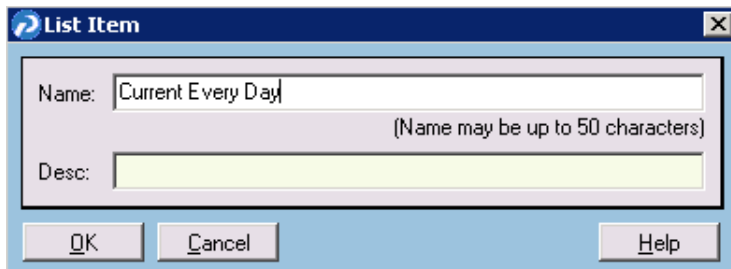


3. Select “SMOKING HABITS MU” from the list, and click the **Edit** button. The List Items View screen appears.



List Items View screen

4. Click the **New** button to add an element. The List Item screen appears.



List Item screen

5. Type the new element name in the **Name** field, and click **OK**.
6. Repeat this process until all new element names have been added to the list.

To add Smoking Habits MU the Smoking Vital Sign Name:

1. Maintenance > Templates > **Vital Sign Names**. The Vital Sign Names Select Screen will appear.
2. Select “Smoking” from the list and click the **Edit** button. The Vital Maintenance Screen for Smoking will appear.
3. In the Element List section, click the lookup button and select “**SMOKING HABITS MU**”. This will change to the appropriate drop down. Users can still keep the same Attribute Type “Packs Per Day” with its list “SMOKING ATTRIBUTES”.

The screenshot shows the 'Vitals Maintenance' dialog box. The 'Name' field is 'Smoking' and the 'Description' is 'Smoking habits'. The 'Vital Type' is set to 'User defined'. The 'Data Type' is 'Text' with a 'Data Length' of '20'. The 'Entry Type' is 'Drop-down'. The 'Element List' field is highlighted with a red box and contains 'SMOKING HABITS MU' with a 'Lookup' button. The 'Attribute Type' is 'Packs Per Day' and the 'Attribute List' is 'SMOKING ATTRIBUTES' with a 'Lookup' button. The 'Formulas' field is set to 'None'. At the bottom are buttons for 'OK', 'Cancel', 'Apply', 'Ranges', and 'Help'.

Vitals Maintenance screen

Configuration Notes:

- Do **NOT** delete any current items that exist in the Smoking Habits list, or delete the list in its entirety.

End User Training:

To enter a smoking status for a patient 13 years and older:

- Open a patient chart, and click on the **Vital Signs** tab.
- On the Vital Signs screen, click the **New** button.
- Select the patient's smoking status from the **Smoking** drop-down list.
- When you are finished, click the **OK** button.

The screenshot shows the 'Vital Signs <New>' window. At the top, there are fields for date (11/10/2010), time (08:59 AM), and Operator (PMSI). Below these are fields for Weight (lb/oz), Temperature (F), Height (ft/in), and OFC (cm). The next section contains Pulse, Systolic, Diastolic, and BP Location fields. Below that are Respirations (/min) and Oximetry (%). The 'Smoking' field is highlighted with a red box and shows 'Current Every Day'. To its right is the 'Packs Per Day' field. Below these are 'Pain Level', 'Peak Flow' (Liters/min), and 'Other' fields. At the bottom, there are 'OK', 'Cancel', 'Acquire', and 'Help' buttons. The 'OK' button is also highlighted with a red box.

Vital Signs <New> screen – Smoking drop-down list

Core Objective 10 – Clinical Decision Support Rule

Objective:

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

One way this can be accomplished is by enabling and using health maintenance protocols for medications or problems within Patient Records.

In order to achieve Meaningful Use the eligible provider must attest that this function is in use.

Configuration:

- Turn on the **Enable Active Health Maintenance reminders** option on the **Records 6** tab of the Special Features screen.

If this setting was not previously enabled you will have to exit Patient Records and log back in to enable this feature.

- Access levels remain the same as in 9.4.

Configuration Notes:

You must have Age/Sex, Medication, and Problem/Diagnosis Health Maintenance Templates available. These are all available upon standard installation.

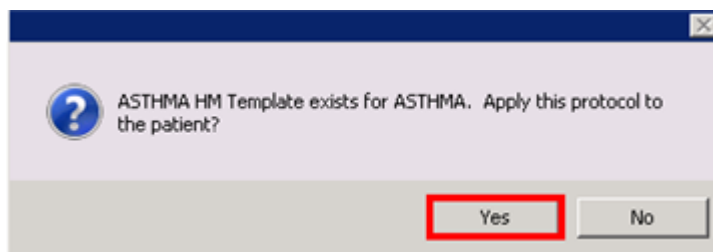
End User Training:

Age protocols are applied automatically as patients are entered if Age and Sex are entered.

Problem/Diagnosis and Medication specific protocols may be applied when prompted. Patient Records will prompt for the application of these protocols when there is a Health Maintenance template available for the specific medication that a patient is given, or if a Problem is added to a patient's Problem List that also has an existing Health Maintenance template.

To enable a protocol and view the new items added by the protocol:

1. Click **Yes** when prompted, as shown below:



2. Go to the patient's Health Maintenance list to see the new items that were added by the protocol (Select Show > **Health Maintenance**, or click the **Health Maintenance** tab on the Patient Chart).

Health Maintenance Summary: Randolph, Isabella		
	Recommend For	Due (seq.#)
Alcohol	19-39 YEAR FEMALE	11/02/2010
BP	19-39 YEAR FEMALE	11/02/2010
Chlamydia	19-39 YEAR FEMALE	02/02/1997
Cholesterol	19-39 YEAR FEMALE	11/02/2010
Depression	19-39 YEAR FEMALE	11/02/2010
Folate supplement	19-39 YEAR FEMALE	11/02/2010
Glucose,Fasting	19-39 YEAR FEMALE	
HDL Cholesterol	19-39 YEAR FEMALE	11/02/2010
Height	19-39 YEAR FEMALE	02/02/1996
HPV vaccine	19-39 YEAR FEMALE	
Influenza vaccine	ASTHMA	11/08/2010
LDL Cholesterol	19-39 YEAR FEMALE	11/02/2010
Pap Smear	19-39 YEAR FEMALE	02/02/1996
Pneumovax	ASTHMA	11/08/2010
Sexual Counseling	19-39 YEAR FEMALE	11/02/2010
Smoking Counseling	19-39 YEAR FEMALE	11/02/2010
Substance Abuse Co	19-39 YEAR FEMALE	11/02/2010

Health Maintenance Summary screen

End User Notes:

Age templates do not advance automatically as patients' age naturally. Templates should be adjusted to patients' ages monthly using the Age Health Maintenance Utility. See *Patient Records Help* for details on how to run this utility.

Core Objective 11 – Clinical Quality Measures

Objective:

Report ambulatory quality measures to CMS or the States

Description:

This section will describe and direct an eligible provider towards the steps to achieve meaningful use for the Clinical Quality Measures Objective.

This section contains the instructions for installing the Clinical Quality Reporting tool, as well as the requirements for the entry of clinical information that is necessary to populate the reports. The certified version of the EHR comes with the functionality to capture reports on the three core measures:

- NQF 0013 – Hypertension: Blood pressure measurement
- NQF 0028 – Preventive Care and Screening Pair: Tobacco Use Assessment and Tobacco Cessation intervention
- NQF 0421 (PQRI 128) – Adult weight screening and follow-up

You may choose any or all of the three alternate core measures, if the core measures do not apply to your practice:

- NQF 0041/PQRI 110 Preventative Care and screening: Influenza Immunization for Patients ≥ 50 Years Old
- NQF 0024 Weight Assessment and Counseling for Children and Adolescents
- NQF 0038 Childhood Immunization Status

There are also three additional measures that come with the certified EHR:

- NQF 0059/PQRI 1 Diabetes: Hemoglobin A1c Poor Control
- NQF 0064/PQRI 2 Diabetes: Low Density Lipoprotein (LDL) Management and Control
- NQF 0061/PQRI 3 Diabetes: Blood Pressure Management

Installation:

To install the Clinical Quality Reporting tool:

1. Double-click **Setup.exe**.
2. If Microsoft Access 2010 Runtime is not installed, it will install to a default location.
3. Click the **Close** button.
4. After Runtime is installed, the Clinical Quality Reporting tool will be installed. Click the “**I accept the terms of this license agreement**” check box and click the **Install** button to start the installation.
5. Files will be installed to a default location. Click the **Finish** button when the install is complete.

Configuration:

Immunizations

Immunizations are to be recorded as a Health Maintenance item using CVX Codes entered under the Health Maintenance Name (see below).

- **DTaP** Vaccine should be recorded under the HM Name of “DTaP”.
The provider should use one of the following CVX codes to codify the immunization data entry: 20, 106, 107, 110, 50, 120, 130, 132
- **IPV** should be recorded under the HM Name of “IPV”.
The provider should use one of the following CVX codes to codify the immunization data entry: 10
- **MMR** should be recorded under the HM Name of “MMR”.
The provider should use one of the following CVX codes to codify the immunization data entry: 03
- **HiB** should be recorded under the HM Name of “HIB”.
The provider should use one of the following CVX codes to codify the immunization data entry: 46, 47, 48, 49, 17, 51
- **Hep B** should be recorded under the HM Name of “HEPATITIS B”.
The provider should use one of the following CVX codes to codify the immunization data entry: 42, 43, 44, 45, 08
- **Hep A** should be recorded under the HM Name of “HEPATITIS A”.
The provider should use one of the following CVX codes to codify the immunization data entry: 52, 31, 83, 84, 85
- **VZV** should be recorded under the HM Name of “Varicella”.
The provider should use one of the following CVX codes to codify the immunization data entry: 21
- **Pneumococcal** should be recorded under the HM Name of “PNEUMOCOCCAL CONJ”.
The provider should use one of the following CVX codes to codify the immunization data entry: 133, 100, 109
- **Rota Virus** should be recorded under the HM Name of “Rotavirus”.
The provider should use one of the following CVX codes to codify the immunization data entry: 119, 122, 116, 74
- **Influenza** should be recorded under the HM Name of “Influenza”.
The provider should use one of the following CVX codes to codify the immunization data entry: 135, 111, 88, 15, 16

To Access Health Maintenance Names:

1. Navigate to Maintenance > Templates > **Health Maintenance Names**.
2. Click the **Edit** button.

Health Maintenance Procedure Name <Edit> screen

End User Guidelines:

An eligible provider’s workflow must be in compliance with the requirements necessary to capture data accurately for computation of the quality measures.

NQF 0013 – Hypertension: Blood pressure measurement

- It is recommended that users capture blood pressure readings at least once for each patient seen during the measurement period.
- Systolic blood pressure readings need to be captured under the Vitals name of “Systolic”.
- Diastolic blood pressure readings need to be captured under the Vitals name of “Diastolic”.

	11/09/10
Height	
Weight	
BMI	
OFC	
Temperature	
Pulse	
Respirations	
Systolic	100
Diastolic	80
Oximetry	

- Hypertension is identified by the specific list of ICD-9 codes provided below – the provider needs to ensure that at least one of the Code fields for the Hypertension problem is populated with a code from this list:

401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93

Major Problem: <New>

Major Problem: BENIGN ESSENTIAL HYPERTENSION

Problem Number: 4 Date: 11/10/10

Provider: BRO Date Last: mm/dd/yy

External Provider: Date resolved: mm/dd/yy

Active/Inactive: Active Indent: 0

Lifecycle: Related to:

Note:

Code 1: 401.1 Code 2:

Coding System: ICD-9-CM Coding System:

Coding System Version: 2009 Coding System Version:

Major Problem <New> screen

NQF 0028 – Preventive Care and Screening Pair: Tobacco Use Assessment and Tobacco Cessation intervention

- Providers must check smoking status in the vitals table, this is queried for reporting. The value for the Vitals record is used to determine the result of the query.
- It is recommended that smoking status be checked at each visit.
- Any value other than a BLANK value is considered to imply that a patient was asked about their smoking status.
- A patient is NOT considered a tobacco user if the latest value of the "Smoking" vital record is either "Never," or "Former".
- All other values are considered to imply that the patient IS a tobacco user.
- Providers are asked to record the delivery of Tobacco Cessation intervention as a clinical element under the name of "Tobacco Intervention".

Note: If you have upgraded to the certified version of the EHR, you would need to verify that this Clinical Element exists. In the event the upgrade did not automatically create it, you would need to create a clinical element with this specific name, and set up the result to be a check box.

Vital Signs <New>

11/10/2010 03:14 PM Operator: PMSI

Weight lb oz English Height ft in English

Temperature F OFC cm

Pulse

Systolic Diastolic Posturals

BP Location

Respirations /min Oximetry %

Smoking Current Every Day Packs Per Day

Pain Level

Peak Flow Liters/min

Other

OK Cancel Acquire Help

Vitals Signs <New> screen – Smoking drop-down list

Clinical Elements <New>

12/09/2010 02:41 PM Operator: PMSI

Tobacco Intervention

OK Cancel Help

Clinical Elements <New> screen – Tobacco Intervention check box

NQF 0421 (PQRI 128) – Adult weight screening and follow-up

- It is recommended that users enter a height and weight at every encounter, which will calculate the BMI.
- Users then need to view the BMI.
- For abnormal BMI values: “Check” the Clinical Element “BMI Plan” (under the Weight Screen Clinical Template) once the follow up plan has been discussed with the patient and recorded.

Note: If you have upgraded to the certified version of the EHR, you would need to verify that this Clinical Element exists. In the event the upgrade did not automatically create it, you would need to create a clinical element with this specific name, and setup the result to be a check box.

The following are the normal ranges [Ref: NQF Specs for 0421 and 0024] for BMI values based on age groups:

Age >=18 and <=64 NORMAL BMI is >=18.5 kg/m² and <25 kg/m²

Age >=65 NORMAL BMI is >=22 kg/m² and <30 kg/m²

Template: Vitals	
	11/10/10
Height	5'5"
Weight	150 lbs
BMI	24.98 kg/m ²

Clinical Elements <New>

12/09/2010 02:42 PM Operator: PMSI

BMI Plan

OK Cancel Help

Clinical Elements <New> screen – BMI Plan check box

NQF 0041/PQRI 110 Preventative Care and screening: Influenza Immunization for Patients ≥ 50 Years Old

- After the immunization is given, it will need to be documented in Health Maintenance.

Health Maintenance Procedure <New>: Randolph, Isabella

Date: 11/09/2010 Time: 12:28 PM

HM Procedure	Status	Comment
Height		
HPV vaccine		
Influenza vaccine	X	
LDL Cholesterol		
Pap Smear		
Pneumovax		
Sexual Counseling		

Influenza vaccine comments:

OK Cancel Less Help

Influenza vaccine More Data:

Dose: 0.5ml Route: Intramuscular Given By: PMSI
 Dose Number: 1 Location: Left Arm Facility:
 Lot: 3892302 Exp. Date: 01/01/2012
 Manufacturer: Merck & Co., Inc. Device: VFC Status: Not VFC eligible

Health Maintenance Procedure <New> screen

NQF 0024 Weight Assessment and Counseling for Children and Adolescents

- Providers are asked to record the delivery of counseling for nutrition as a Health Maintenance item under the name of “Nutrition Counsel.” New installations and upgrades of the certified version of the EHR will be set up with a Health Maintenance template of “Weight Screening” with Nutrition Counsel as a procedure in this template. The Nutrition Counsel health maintenance item should contain the following ICD.9 code in the “HM Code 1” field of the **Health Maintenance Procedure <Edit>** screen: V65.3

Note: If you have upgraded to the certified version of the EHR, you may need to create a Health Maintenance name with this specific name, codify the Health Maintenance name with the above ICD.9 code, and place the Health Maintenance name on a Health Maintenance template.

- Providers are asked to record the delivery of counseling for nutrition as a Health Maintenance item under the name of “Activity Counsel.” New installations and upgrades of the certified version of the EHR will be setup with a Health Maintenance template of “Weight Screening” with Activity Counsel as a procedure in this template. The Activity Counsel item should contain the following ICD.9 code in the “HM Code 1” field of the **Health Maintenance Procedure <Edit>** screen: V65.41

Note: If you have upgraded to the certified version of the EHR, you may need to create a Health Maintenance name with this specific name, codify the Health Maintenance

name with the above ICD.9 code, and place the Health Maintenance name on a Health Maintenance template.

NQF 0038 Childhood Immunization Status

Coding, Capture and Maintenance for specific Immunizations

- Immunizations are to be recorded as a Health Maintenance item using CVX Codes:
 - **DTaP** Vaccine should be recorded under the HM Name of “DTaP”
 - **IPV** should be recorded under the HM Name of “IPV”
 - **MMR** should be recorded under the HM Name of “MMR”
 - **HiB** should be recorded under the HM Name of “HIB”
 - **Hep B** should be recorded under the HM Name of “HEPATITIS B”
 - **Hep A** should be recorded under the HM Name of “HEPATITIS A”
 - **VZV** should be recorded under the HM Name of “Varicella
 - **Pneumococcal** should be recorded under the HM Name of “PNEUMOCOCCAL CONJ”
 - **Rota Virus** should be recorded under the HM Name of “Rotavirus”
 - **Influenza** should be recorded under the HM Name of “Influenza”

Health Maintenance Procedure <New>: Test, Little Girl

Date: 11/10/2010 Time: 04:05 PM

HM Procedure	Status	Comment
DTaP		
Height		
Influenza vaccine		
IPV	X	
MMR		
Passive Smoking		
Varicella		

IPV comments:

OK Cancel Less Help

IPV More Data:

Dose: 0.5 mL Route: Intramuscular Given By: PMSI

Dose Number: 1 Location: Right Thigh Facility:

Lot: 9309283908 Exp. Date: mm/dd/yyyy

Manufacturer: Abbott Laboratories Device: VFC Status: Not VFC eligible

Health Maintenance Procedure <New> screen

Coding, Capture and Maintenance for specific Allergies

Adverse reactions to food and other non medication substances are required to adhere to specified nomenclature, as specified in the detailed measure specifications.

- **Vaccine Allergies**

Medication allergies to any of the immunizations listed above should be recorded in the Allergies section of the patient chart with:

- **Allergy name** – identical to the vaccine name above
- **Code** – CVX codes – one on the list for the vaccine listed above
- **Neomycin**

Medication allergy to Neomycin should be recorded in the Allergies section of the patient chart with:

- **Allergy Name: “Neomycin”**
- **Code – RxNorm values – one of the following values:**
C0988018, C1123055, C1123343, C1123363, C1124224, C1127589, C1134215, C1140030, C1140542, C1186980, C1704126, C272305

- **Streptomycin**

Medication allergy to Streptomycin should be recorded in the Allergies section of the patient chart with:

- **Allergy Name: “Streptomycin”**
- **Code – RxNorm values – one of the following values:**
C1134151

- **Polymyxin**

Medication allergy to Polymyxin should be recorded in the Allergies section of the patient chart with:

- **Allergy Name: “Polymyxin”**
- **Code – RxNorm values – one of the following values:**
C0988924, C1123393, C1125567, C1133048, C272955

- **Baker’s Yeast**

Substance allergy to Baker’s Yeast should be recorded in the Allergies section of the patient chart with the Allergy Name: “Baker’s Yeast”

Allergy: New screen - Allergy example

NQF 0059/PQRI 1 Diabetes: Hemoglobin A1c Poor Control

- HbA1C is identified by the lab name HbA1C, or alternatively by one of the following LOINC codes: 17856-6, 4548-4, 4549-2
- It is recommended that providers ensure that the lab value for this result is recorded under the specific lab name listed above, or the lab result interface processes the result based on

LOINC codes (one of the codes listed above) and stores the result in the record accordingly.

Lab Data <New> :HEMOGLOBIN A1C

Date: 11/09/10 Time: 12:44 PM Save Time Status: F

Send To: BRO Doctor Brown

Name	Value	Units	Normal Range	Critical Range
HGB A1C	8	%		

HGB A1C comments:
Reported: N/A

OK Cancel Comment Help

Lab Data <New> screen

NQF 0064/PQRI 2 Diabetes: Low Density Lipoprotein (LDL) Management and Control

- LDL is identified by the lab name LDL, or alternatively by one of the following LOINC codes: 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 22748-8, 39469-2, 49132-4, 55440-2
- It is recommended that providers ensure that the lab value for this result is recorded under the specific lab name listed above, or the lab result interface processes the result based on LOINC codes (one of the codes listed above) and stores the result in the record accordingly.

NQF 0061/PQRI 3 Diabetes: Blood Pressure Management

- This measure is achieved by verifying that the systolic and diastolic values of the blood pressure were measured during the measurement period.

PQRI 1, 2, 3 Diabetes:

- Diabetes is identified by the provision of a medication indicative of diabetes within 2 years of the end of the reporting period OR encounters associated with one of the ICD.9 codes provided below. The provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list.
 - Diabetes:
 - 250, 250.0, 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82,

250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04

The following diagnoses represent exclusions in NQF 0059, 0061, 0064:

- Gestational Diabetes:
648.8, 648.80, 648.81, 648.82, 648.83, 648.84
- Polycystic Ovaries:
256.4
- Steroid induced diabetes:
249, 249.0, 249.00, 249.01, 249.1, 249.10, 249.11, 249.2, 249.20, 249.21, 249.3, 249.30, 249.31, 249.4, 249.40, 249.41, 249.5, 249.50, 249.51, 249.6, 249.60, 249.61, 249.7, 249.70, 249.71, 249.8, 249.80, 249.81, 249.9, 249.90, 249.91, 251.8, 962.0

Major Problem: <New>

Major Problem:

Problem Number: Date:

Provider: Date Last:

External Provider: Date resolved:

Active/Inactive: Indent:

Lifecycle: Related to:

Note:

Code 1: Code 2:

Coding System: Coding System:

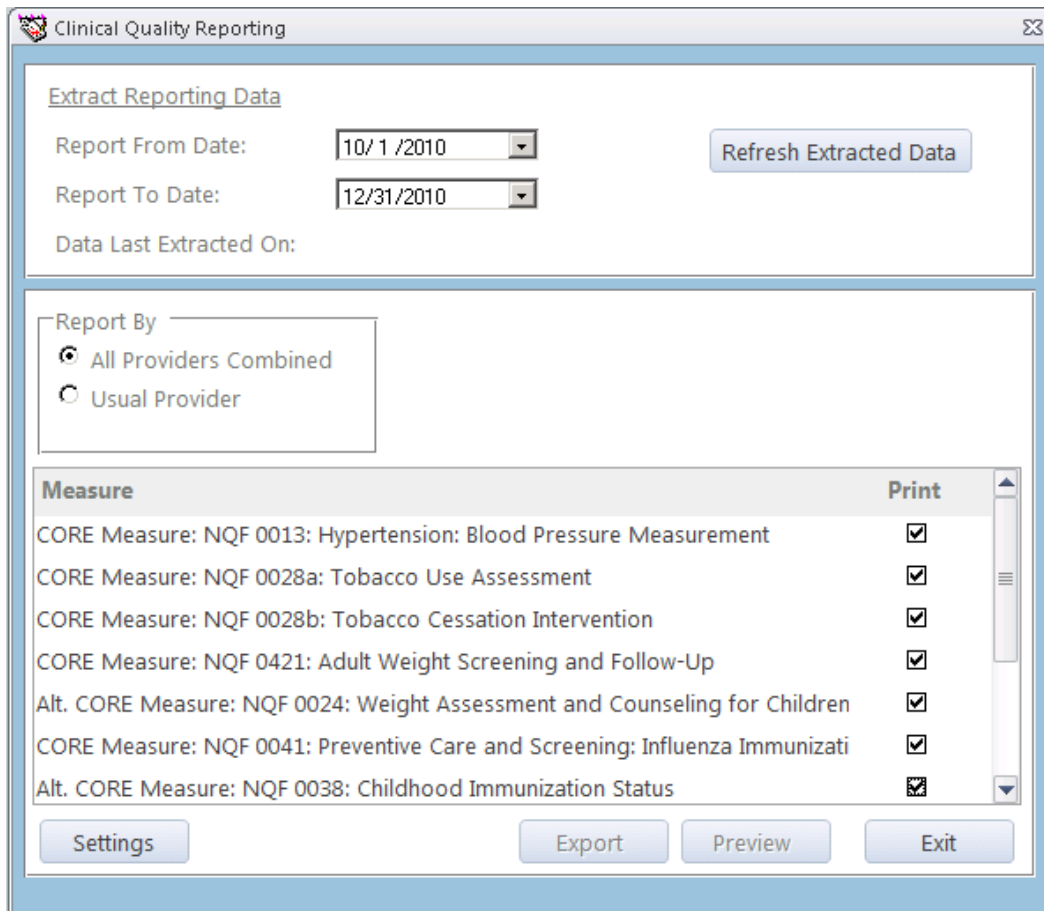
Coding System Version: Coding System Version:

Major Problem: <New> screen

Reporting:

To run the report for Clinical Quality Measures:

1. Navigate to your EHR database folder and locate the **PP Clinical Quality Reporting** access icon. It is recommended that you create a desktop shortcut to this file for future access.
2. Enter your user name and EHR password. The Clinical Quality Reporting screen appears.



Clinical Quality Reporting screen

3. Enter the date range for which you want to run the report.
4. Select if you'd like to sort the report output by **All Providers Combined** or **Usual Provider**.
5. Click the **Refresh Extracted Data** button.
6. Click the **Export** button to create a data file.
7. Click the **Preview** button to preview and subsequently print the output of the Clinical Quality Measures report.

Clinical Quality Measures Report			
Reporting Period: 10/1/2010 to 12/31/2010			
Printed: 12/9/2010 3:12:52 PM			
Provider: COMBINED - All Providers			
CORE Measure: NQF 0013: Hypertension: Blood Pressure Measurement			
Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.			
Numerator/Denominator #: 1	numerator:	1	
	denominator:	3	
	exclusions:	0	
	measure score:	33.33	
CORE Measure: NQF 0028a: Tobacco Use Assessment			
Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.			
Numerator/Denominator #: 1	numerator:	4	
	denominator:	7	
	exclusions:	0	
	measure score:	57.14	

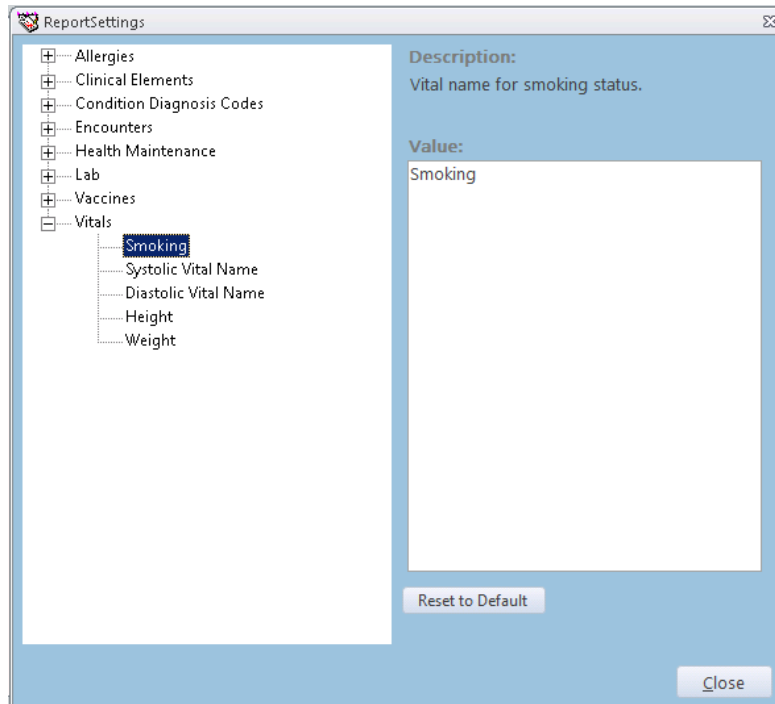
Clinical Quality Measures Report - Example

Note: This report is configurable by clicking the **Settings** button.

To configure the Clinical Quality Measures report:

1. Click the **Settings** button Clinical Quality Reporting screen. The ReportSettings screen appears.
2. Click on the plus symbol to the left of the item name. Click on the value you wish to change and type in the new value in the box on the right.

You can click the **Reset to Default** button to restore settings for the item that is currently displayed.



ReportSettings screen

Core Objective 12 – Electronic Copy

Introduction:

This section provides details on how to generate an electronic copy of a patient's record.

Objective:

Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and medication allergies) within 3 business days of a patient request.

Configuration:

Because the electronic copy of the patient's health information must be provided within 3 business days of a patient's request, it's necessary to track both when the patient makes the request for the electronic copy and when the record is generated. This is accomplished via an order in the Order Entry module.

To create an order to track patient requests for an electronic copy of their health information:

1. Select Maintenance > Templates > Order Templates > **Order Names**.
2. Click the **New** button.
3. Enter the following order name, exactly as listed: Request E Copy of Records

Note: If your order name does not exactly match what's listed above, the Meaningful Use report for this objective will not properly capture the data needed to report on the objective.

4. No further data is needed to create the Order Name, but it's recommended that you set the **Routine Results Back Within** value to aid in tracking requests that have not been completed. You may wish to enter a value of "2 days" to aid in identifying those requests that haven't been completed.

Order Name <New> screen

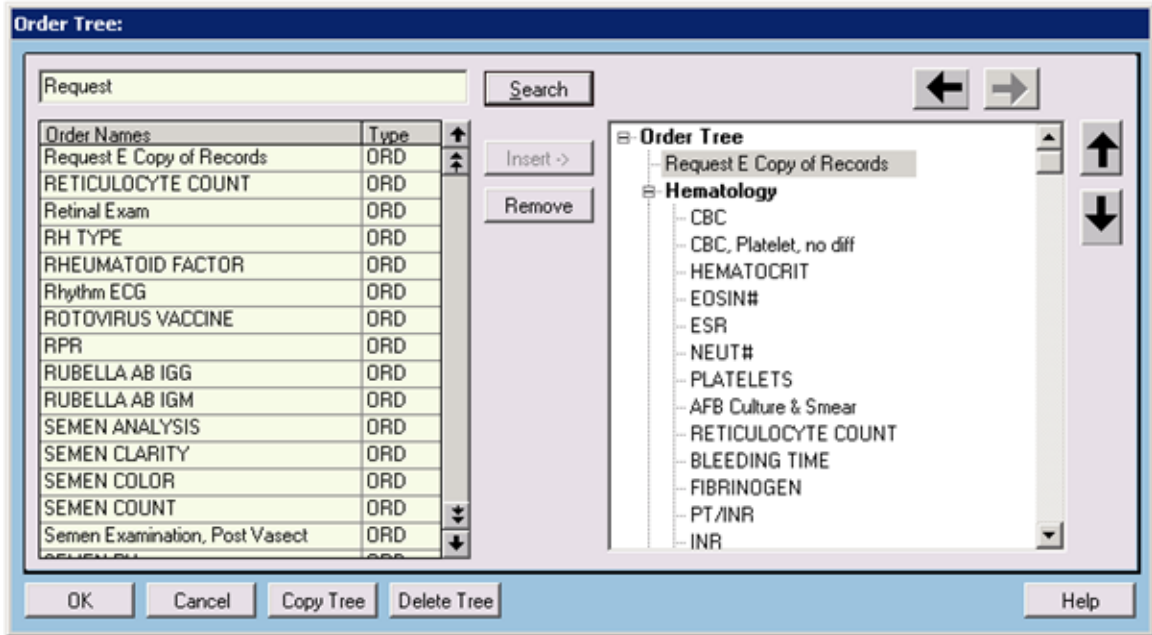
5. Click **OK** to save the Order Name.

For ease of ordering, it's recommended that you add this new Order Name to all appropriate Order Trees. You'll need to determine who in your office will place the order when the patient requests the electronic copy, and then ensure that they have access to the Order Entry module and that their Order Tree contains the order.

To add the order to an Order Tree:

1. Select Maintenance > Templates > Order Templates > **Order Trees**.
2. If your office uses a universal order tree (one that's not associated with a particular provider) click **OK** on the Provider/Practice Selection screen without entering any data. If individual providers have their own Order Trees, enter the Provider ID of a provider who will need access to the **Request E Copy of Records** order.
3. Enter "Request" in the **Search** field on the Order Tree screen, and click the **Search** button.
4. If the **Request E Copy of Records** order is not highlighted, select it once to highlight it.
5. On the right-side of the Order Tree, click on the Category you wish to add the order to. If you do not want the order to be listed within a category, click once on the "Order Tree" heading at the top of the tree to highlight it.
6. Click the **Insert** button to add the order to the tree. The order will be placed at the bottom of the chosen category, or it will be placed at the bottom of the order tree if you did not add it to a category.

- Use the up and down arrow buttons to move the order up or down within the chosen category, or to move it up or down the order tree if you did not add the order to a category.



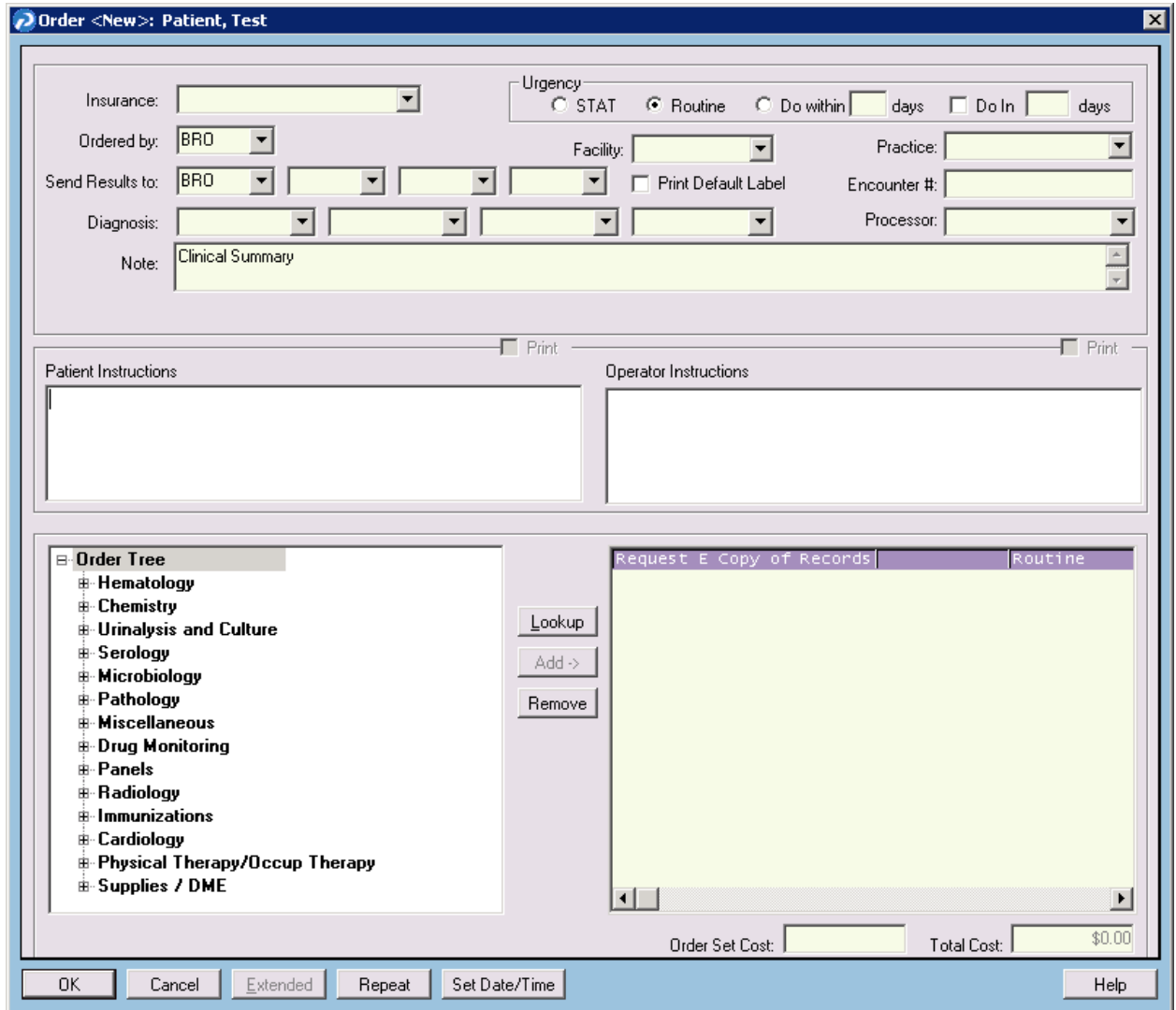
Order Tree screen

End User Training:

When a patient requests an electronic copy of their health information, how that copy is generated will depend on whether the copy is for the patient’s own record or if they are requesting it so it can be imported into another practice’s EHR.

The suggested workflow for completing a request for an electronic copy is as follows:

1. The patient requests an electronic copy of their health information. The user that will place the order should ask the patient if the copy is for their own records (i.e., if it needs to be human readable) or if the copy is needed so the patient’s data can be imported into another practice’s EHR.
2. The appropriate user places the order. In the **Note** field, they should enter text that will indicate whether the patient wants a human readable format (Clinical Summary) or a format that can be imported into an EHR (CCD). (Creation of an Extended Order Dialogue may be preferred to capture this output type.)



Order <New> screen

3. The appropriate user processes the order and creates the Electronic Copy file in the preferred format (see below for instructions for creating a Clinical Summary or CCD file.)
4. The user that generated the Electronic Copy file marks the order complete.

Note that the Electronic Copy file must be generated and the order marked complete within 3 business days of the patient’s initial request in order to successfully meet the Meaningful Use criteria for this objective.

How the file is provided to the patient is left to the discretion of each practice.

To create a human readable Clinical Summary file for the patient’s own records:

1. Select Reports > Patient Records > **Print Clinical Summary for Patient**.
2. Look up the appropriate patient.
3. Enter a date range that will capture all of the clinical data you wish to include on the Summary.
4. Where appropriate, check or uncheck boxes next to data types you wish to include or exclude from the Summary. Your system administrator can set a default configuration for the Patient Clinical Summary Report screen, if desired. In order to meet the Meaningful User objective, you must include at least problem data, medications and allergies, and lab data.
5. Click the **Print to File** check box.
6. Click **OK**.

Patient Clinical Summary Report screen

7. If the Clinical Encounter Not Found screen displays, click the **No** radio button and click **OK**.

Clinical Encounter Not Found screen

8. Select a file type for the Electronic Copy:
 - **RTF**: This type of file contains formatting and will display best in Microsoft Word or a similar word processing program.
 - **HTML**: This type of file contains formatting and will display best in a web browser.
 - **Text**: This type of file contains no formatting and will display best in a basic text editor such as Notepad or WordPad.

If you are unsure which option to choose, select HTML.

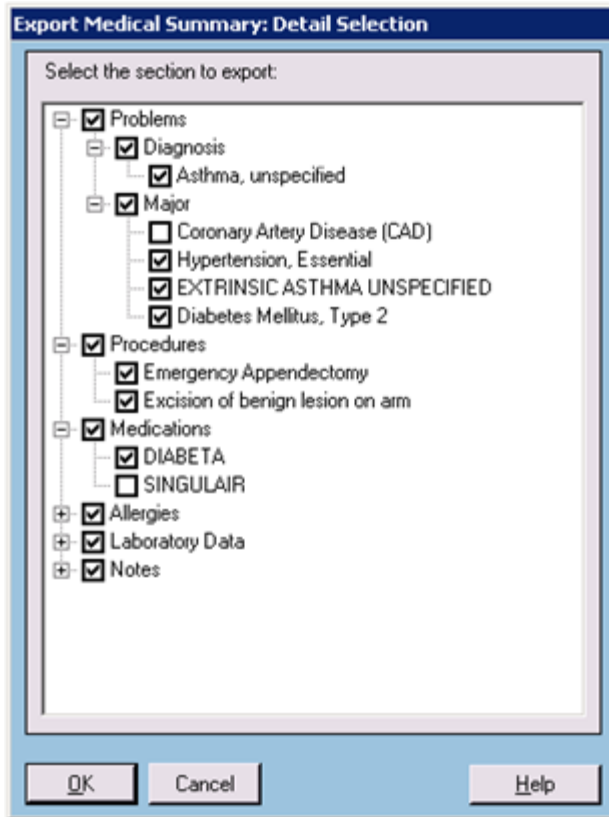
9. Enter a name for the Electronic Copy file. By default, the file will be saved to your EHR client directory. If you wish to save it to an alternate location, click the **Browse** button to browse your network and select a different location where the file will be saved.
10. Click **OK** to create the file.

Note: A Clinical Summary will only contain data that the user creating it is authorized to view, based on their Access Level settings. If any of the data types on the Patient Clinical Summary Report screen are not available, it's because the user creating the Summary does not have the Access Level settings to view that type of data.

To create a CCD file that the patient can provide to another practice for importation into an EHR:

1. Select Reports > Patient Records > **Export Medical Summary**.
2. Choose a purpose for the Summary from the **Purpose** drop-down list.
3. Click the **CCD** radio button.
4. Enter a date range if desired. If no dates are entered, all data for the patient will be exported.
5. Click **OK**.
6. Look up the appropriate patient.
7. If the **Clinical Encounter Not Found** screen displays, leave the **Yes** radio button selected if you know the patient will be providing the file to another practice as part of a transfer of care. Otherwise, click the **No** radio button.
8. If the **Yes** radio button is selected, ensure the appropriate provider and practice codes are selected, so that the appropriate information will appear in the transfer of care record.
9. Click **OK**.
10. In the **Save As** box, select a network location where the file will be created, and enter a name for the file.
11. On the **Export Medical Summary: Detail Selection** screen, review the data to be exported and uncheck any data types or individual data elements you do not wish to

include in the Summary. You can expand data types to see individual data elements by clicking on the + symbols to the left of the data type name.



Export Medical Summary screen

12. Click **OK** when you've finished reviewing or updating the data to be exported.
13. Click **OK** to close the confirmation screen.

Note: CCD files are not human readable. A Clinical Summary, printed to file, should be provided if the patient desires an Electronic Copy of their Health Information that they will be able to read themselves.

Also, CCDs exported from Patient Records versions older than 9.5 are not compatible with Patient Records version 9.5.

Core Objective 13 – Clinical Summary

Introduction:

This section provides details on how to generate a clinical summary of a patient’s office visit.

Objective:

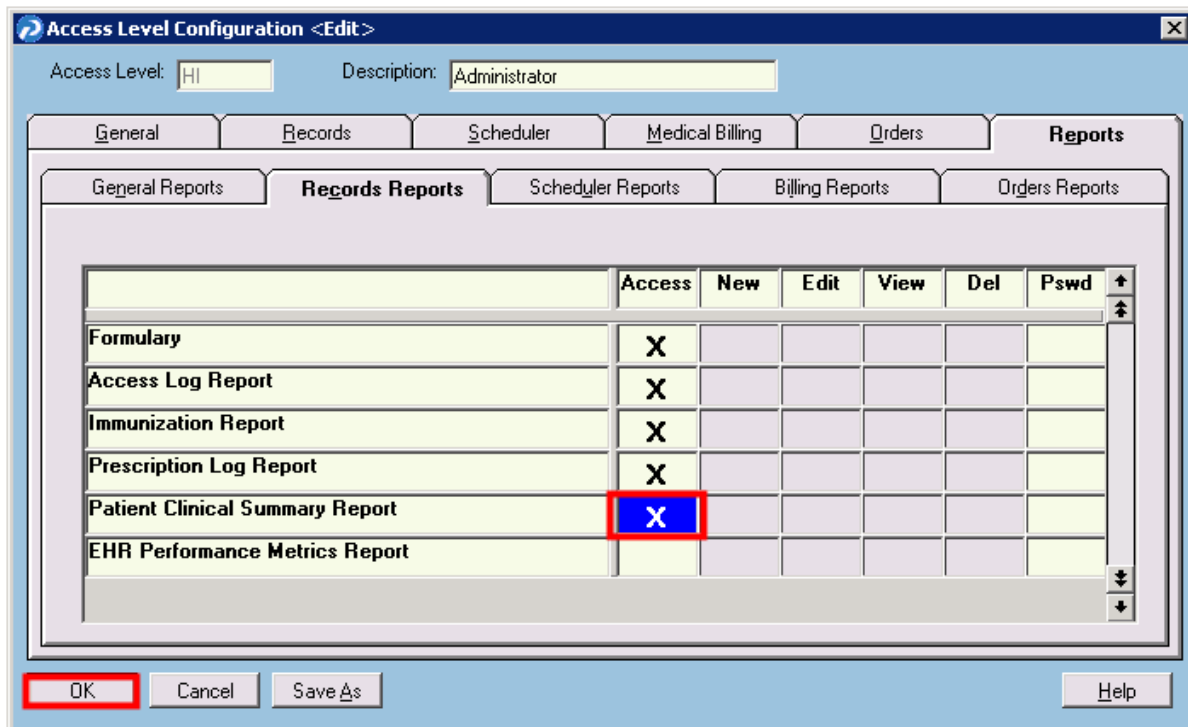
As part of achieving meaningful use, 50% of patients must be provided with a clinical summary within 3 business days of their office visit. The summary must contain: an updated medication list, laboratory and other diagnostic test orders, procedures and other instructions based on clinical discussions that took place during the office visit.

Configuration:

Access Levels:

Access needs to be given to operators who will be providing the Patient Clinical Summary report.

1. Select Maintenance > Set-Up > **Access Levels**.
2. Enter your EHR password.
3. Choose an Access Level associated with operators that will be providing the Patient Clinical Summary report, and click **Edit**.
4. Click on the **Reports** tab, and then click the **Records Reports** sub-tab.
5. Click the **Access** box next to **Patient Clinical Summary Report**.
6. Click **OK** to save the changes.
7. Repeat these steps for all appropriate Access Levels.



Access Level Configuration <Edit> screen

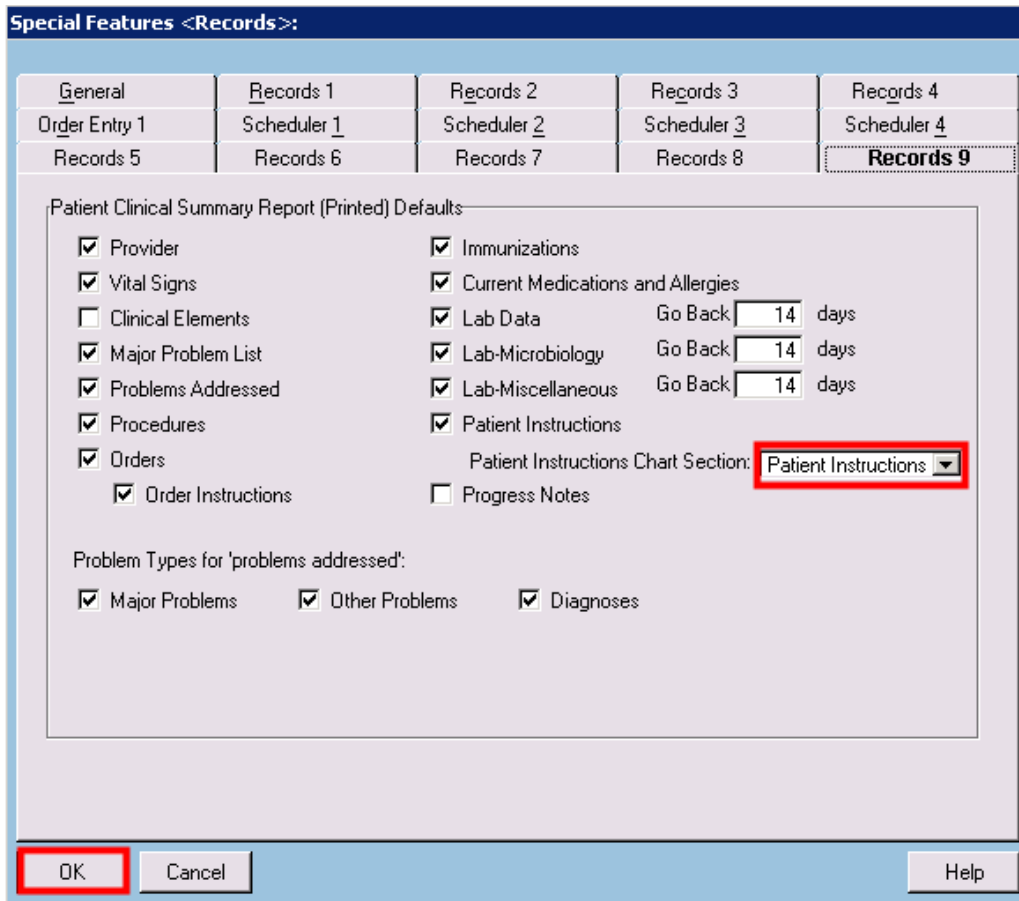
System Configuration:

Patient Clinical Summary Report defaults may be configured using the Special Features screen.

1. Select Maintenance > Configuration > **Special Features** and click on the **Records 9** tab.
2. Check the boxes for which items you would like to appear *by default* in the report.
3. Use the drop-down list to the right of “Patient Instructions Chart Section” to designate which chart tab will be used for patient instructions.

A new chart tab may be added for this purpose by clicking Maintenance > Configuration > **Customize Patient Chart for Site**. Click on any Undefined chart tab and name it “Patient Instructions”. **We strongly recommend that only Undefined chart tabs are changed. DO NOT change any existing chart tabs.**

4. Once you have finished configuring the **Records 9** tab, click **OK**.



Special Features screen – Records 9 tab

5. You must completely exit the program and re-enter for the settings to take effect.

Configuration Notes:

- To add patient instructions a user enters a note in that section during the patient visit, and includes it in the printed Patient Clinical Summary Report so the patient can have that to take home. The system will also allow the use of the .K: and .end codes to push information to the **Patient Instructions** tab from the progress note.
- The following items in the Special Features **Records 9** tab are defaulted to checked for new and upgrade sites: Provider, Vital Signs, Major Problem List, Problems addressed,

Procedures, Orders, Order Instructions, Immunizations, Current Medications and Allergies, Lab data, Lab-Microbiology, Lab-Miscellaneous, and Patient Instructions.

- For new and upgrade sites, the defaults for the three “go back” parameters are 14 days.
- For new sites, the default chart section is titled “Patient Instructions.”
- There will not be a default chart section for upgrade sites.

End User Training:

To print a Patient Clinical Summary Report:

1. Select Reports > Patient Records > **Print Clinical Summary for Patient**.
2. Select the appropriate parameters, including date range.
3. Click **OK** to print.

Patient Clinical Summary Report

Patient: **Sample Chart (ID: 001)**

From: 10/19/2010 To: 10/19/2010

Patient data to include in the report

<input checked="" type="checkbox"/> Provider: BR0 Doctor Brown	<input checked="" type="checkbox"/> Immunizations
<input checked="" type="checkbox"/> Vital Signs	<input checked="" type="checkbox"/> Current Medications and Allergies
<input type="checkbox"/> Clinical Elements	<input checked="" type="checkbox"/> Lab Data Go Back 14 days
<input checked="" type="checkbox"/> Major Problem List	<input checked="" type="checkbox"/> Lab-Microbiology Go Back 14 days
<input checked="" type="checkbox"/> Problems Addressed during date range above	<input checked="" type="checkbox"/> Lab-Miscellaneous Go Back 14 days
<input checked="" type="checkbox"/> Procedures	<input checked="" type="checkbox"/> Patient Instructions from chart section: Patient Instructions
<input checked="" type="checkbox"/> Orders	<input type="checkbox"/> Progress Notes
<input checked="" type="checkbox"/> Order Instructions	

Check All UnCheck All

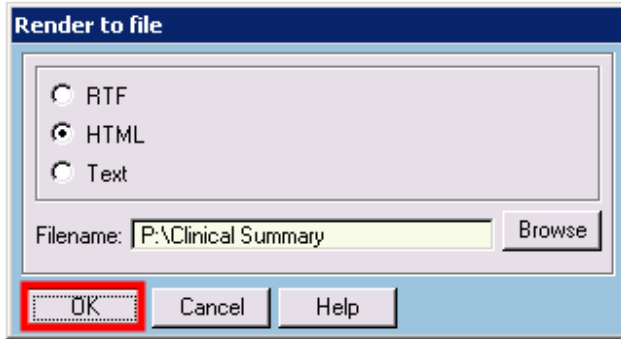
OK Cancel Print to File Help

Patient Clinical Summary Report screen

To create an electronic Patient Clinical Summary Report:

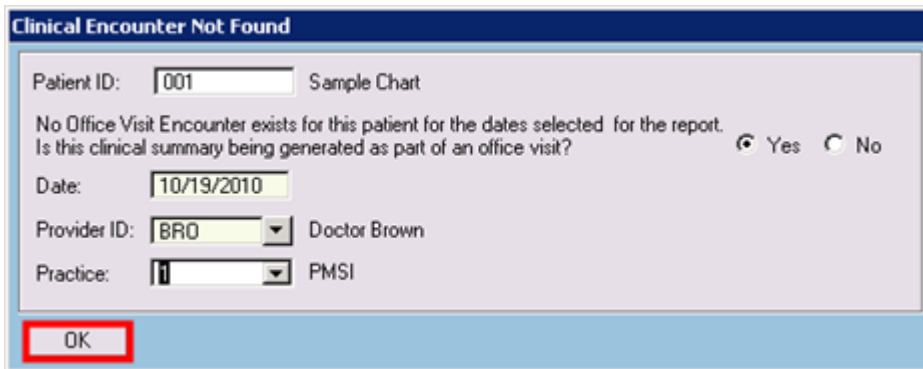
Note: These files are not encrypted. See HIPAA guidelines before transmitting electronically.

1. Select Reports > Patient Records > **Print Clinical Summary for Patient**.
2. Select the appropriate parameters, including date range.
3. Click the **Print to File** check box.
4. Click **OK**.
5. Click the radio button for the desired output format, **RTF**, **HTML**, or **Text**.
6. Click **Browse** and navigate to the location to which the report will be saved.
7. Type in the file name and click **Open**.
8. Click **OK** to run and save the report.



Render to file screen

Note: If there is no clinical encounter for a patient the system will ask the operator if they want to create a clinical encounter. If no clinical encounter is chosen the summary will still print.



Clinical Encounter Not Found screen

End User Notes:

- When an operator chooses to print the report the provider will default to the current provider, though it is possible to print for other providers.
- The **Print to Screen** option has no effect on this report.
- When an operator prints a Patient Clinical Summary report, the application will attempt to record this by marking the “Printed Clinical Summary Provided” flag and associated date/time set to the current date and time for a clinical encounter (see the **Clinical Encounters Appendix**). The application will look for an existing clinical encounter that is an appropriate match to the current situation, and if it doesn’t find one, a prompt will display to allow the operator the chance to create a clinical encounter.
- When printing a Patient Clinical Summary report, a “matching” clinical encounter means a clinical encounter where:
 - Encounter patient = the same patient for whom the report is being printed
 - Encounter date lies within the date range for which the report is being printed
 - Encounter type = “Office Visit”
- The Patient Clinical Summary report will not include any data that the current Operator would not normally have access to in the specific patient’s chart, from ANY level of blocking access to the data, including Practice-Access levels, Chart Access controls, Operator Access Levels, and Lab security levels.

- For ease of workflow providers may find it beneficial to use the .K: and .end: codes to send patient instructions from the progress note to the appropriate chart tab, rather than opening the chart tab and creating a separate note.

Core Objective 14 – Electronically Exchange Key Clinical Information

Introduction:

As part of achieving Meaningful Use you must perform at least one test of Patient Record's capacity to electronically exchange key clinical information with another practice utilizing an EHR.

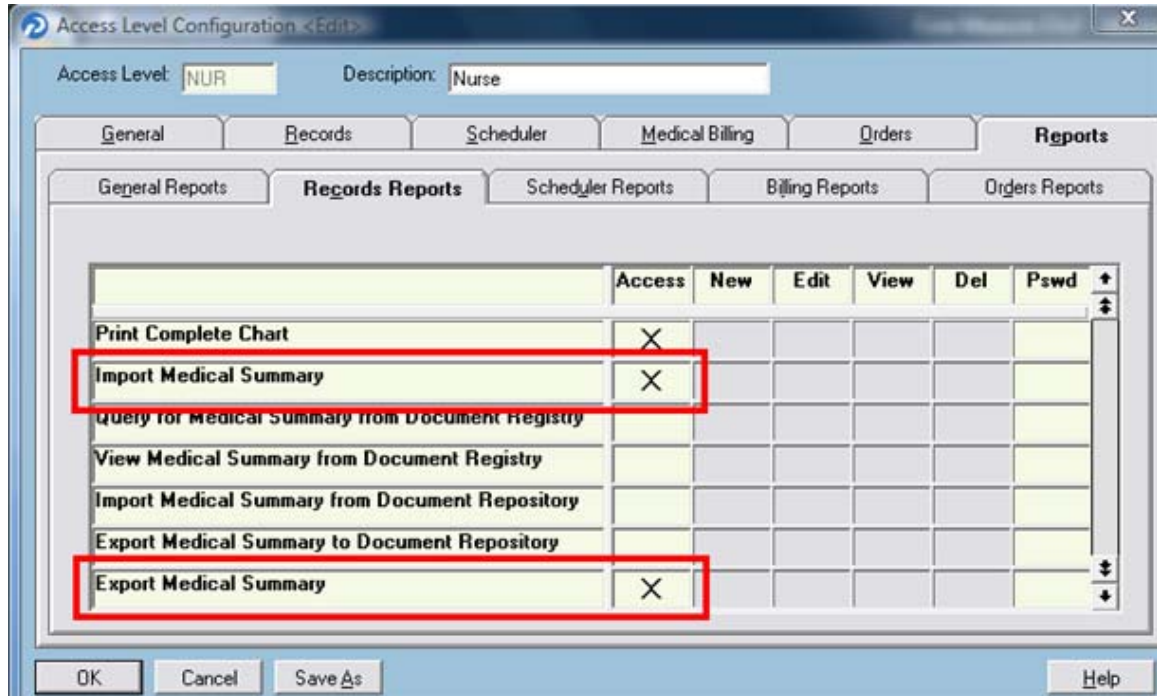
Description:

Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results). This can be done through importing or exporting patient data via CCR (Continuity of Care Record) or CCD (Continuity of Care Document) files. Both of those formats allow for the exchange of problem list data, medications, medication allergies, and diagnostic test results (laboratory data) with other systems.

Configuration:

To turn on the Access Level settings necessary to import and export CCR/CCD data:

1. Select Maintenance > Set-Up > **Access Levels**.
2. Enter your EHR password.
3. Choose an Access Level associated with operators that will need to be able to import or export CCR/CCD data, and click **Edit**.
4. Click on the **Reports** tab, and then click the **Records Reports** sub-tab.
5. Click the **Access** boxes next to **Import Medical Summary** and/or **Export Medical Summary**.
6. Click **OK** to save the changes.
7. Repeat these steps for all appropriate Access Levels.



Access Level Configuration <Edit> screen

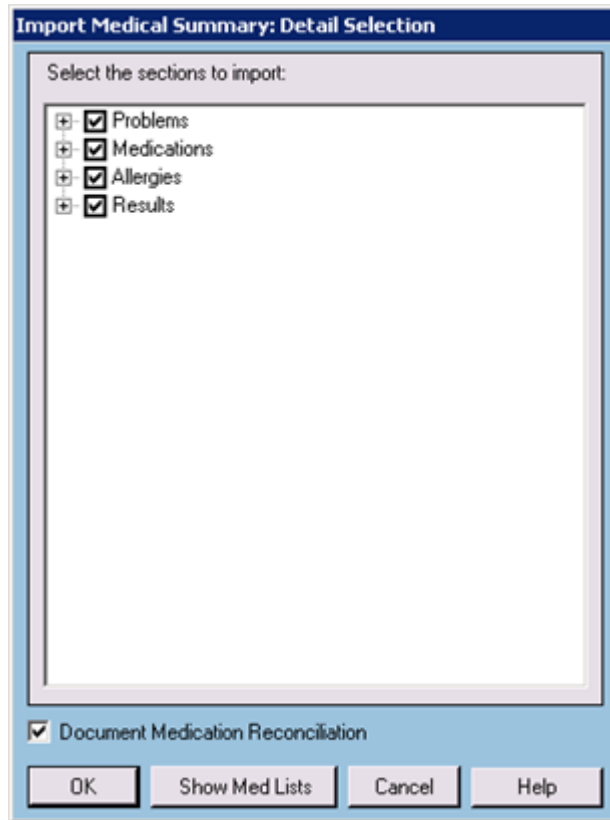
Configuration Notes:

- The CCR and CCD export formats cannot be modified.

End User Training:

To import a CCR or CCD file:

1. Ensure the CCR or CCD file to be imported is saved on your network in a location accessible from the computer where the import will be run.
2. Select Task > **Import Medical Summary**.
3. Click **Browse** to browse to the location of the CCR or CCD file and select it.
4. Click the **Show Detail Selection Screen** check box if you want to select what discrete data elements will be imported. If you do not click this check box, all data in the CCR or CCD will be imported.
5. On the Establish Patient Identity screen, the patient name and date of birth from the CCR or CCD file will display at the top of the screen. The lookup portion of the screen will display the closest patient matches found in the EHR. Select the appropriate patient, or refine the search if desired. If the file to be imported is for a patient not currently registered in the EHR, click the **New Patient** button.
6. If you selected the **Show Detail Selection Screen** check box, the **Import Medical Summary: Detail Selection** window displays. It will show each data type that will be imported. You can click on the + button next to each data type to view the discrete data elements for any given data type. If you wish to exclude a specific discrete data element, or an entire data type, remove the checkmark from the box next to that data element or data type.



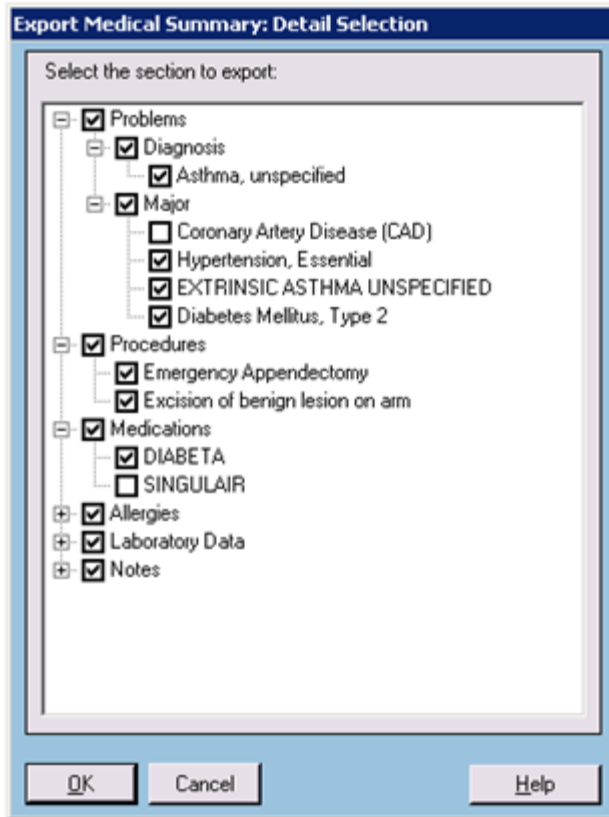
Import Medical Summary: Detail Selection screen

7. Click the **Show Med Lists** button to perform a Medication Reconciliation that will compare the patient's active medication list in the EHR to the medications contained in the CCR or CCD file.
8. Click **OK** to import all data with a check mark next to it.

To export a CCR or CCD file that can be loaded into another EHR that is capable of importing CCD data:

1. Select Reports > Patient Records > **Export Medical Summary**.
2. Choose a purpose for the Summary from the **Purpose** drop-down list.
3. Click the **CCR** or **CCD** radio button.
4. Enter a date range if desired. If no dates are entered, all data for the patient will be exported.
5. Click **OK**.
6. Look up the appropriate patient.
7. If the Clinical Encounter Not Found screen displays, leave the **Yes** radio button selected if the file is being provided to another practice for the purposes of a transfer of care. If the **Yes** radio button is selected, ensure the appropriate provider and practice codes are selected, so that the appropriate information will appear in CCD file. Otherwise, click the **No** radio button. Click **OK** when you are finished with the Clinical Encounter Not Found screen.
8. In the **Save As** box, select a network location where the file will be created, and enter a name for the file.
9. On the Export Medical Summary: Detail Selection screen, review the data to be exported and uncheck any data types or individual data elements you do not wish to include in the

Summary. You can expand data types to see individual data elements by clicking on the + symbols to the left of the data type name.



Export Medical Summary: Detail Selection screen

10. Click **OK** when you've finished reviewing or updating the data to be exported.
11. Click **OK** to close the confirmation screen.

End User Notes:

- It is left to the discretion of each practice to determine how to best obtain a CCR or CCD file from another practice, as well as how to best provide an exported CCR or CCD file to another practice.

Core Objective 15 - Security Administrator's Application Guide

Objective:

Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

Description:

This section will describe and direct the system administrator to the features within Patient Records that will assist an eligible provider in meeting this objective.

Access Control/Authentication:

This function allows the ability to assign a unique ID to track the identity of each Patient Records authorized user and to establish access controls for each authorized user to access electronic health information within the system.

Configuration:

This is achieved by creating a unique operator ID for each authorized user of the system as well as assigning the appropriate access level to that operator, using the following steps:

1. Select Maintenance > Set-Up > **Operators**.
2. Re-enter your password.
3. Click the **New** or **Edit** button.
4. Enter in the appropriate information and click **OK** to save.

Operator Maintenance screen

Configuration Notes:

None

Emergency Access:

This feature allows the capability to permit emergency access to restricted patients through the system's "break the glass" feature.

Chart Access

The access level for "Break the Glass-Chart" allows operators to temporarily open a patient's chart that they would not normally have access to because of Chart Access restrictions (e.g., not in the same practice or blocked on patient's list of allowed chart viewers). Chart tabs that are normally restricted from viewing based on access level will still be restricted when you access the patient's chart.

With this feature enabled, users can type the reason into the Reason for Access field and click the Proceed button to access a restricted patient's chart. Once a reason has been provided, an operator can view this patient's information with the same access level restrictions for the individual Chart tabs as any other patient that they normally have access to until the patient's chart is closed or the application is parked.

Complete

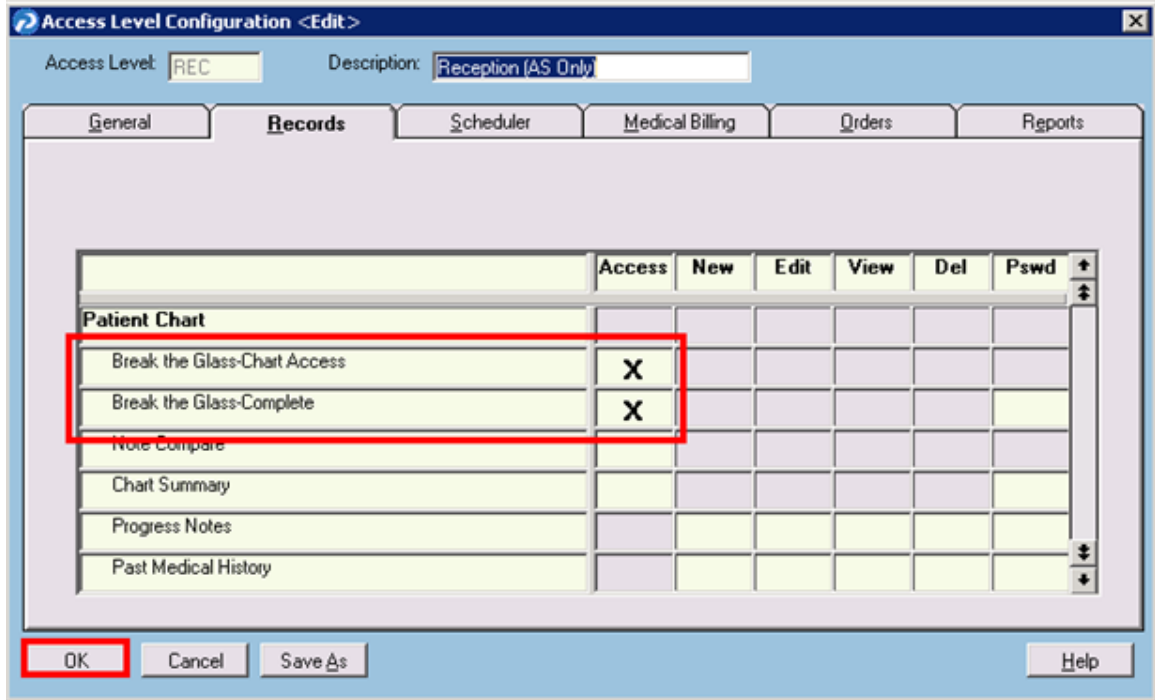
The access level for "Break the Glass-Complete" allows you to access a patient's chart that is restricted to you but you can temporarily view all chart information whether or not you normally have access to this information. The information you do not normally have access to will be displayed as view-only.

You can type the reason into the Reason for Access field and click the Proceed button to access this patient's chart. Once a reason has been provided, you can view all the patient's chart information until you close the patient's chart or park the application and sign in as another user.

Configuration:

To configure access to break the glass assign the access within the appropriate access level that is assigned to an authorized user. This can be accomplished by performing the following steps:

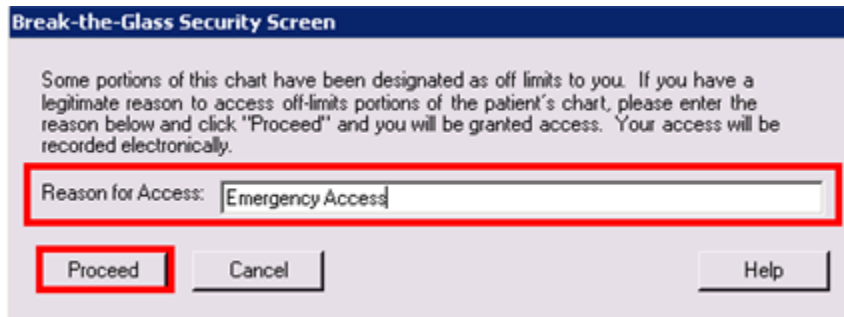
1. Select Maintenance > Set-Up > **Access Levels**.
2. Re-enter your password.
3. Select the access level that you wish to edit and click the **Edit** button.
4. Click on the **Records** tab.
5. Click the **Access** boxes next to the Break the Glass Access feature(s) you would like this access level to have permission to perform.
6. Click **OK** to save the changes.



Access Level Configuration <Edit> screen – Records tab

End User Notes:

End users will see the following screen if they have access to Break the Glass:



Break-the-Glass Security screen

As the Security Administrator, we recommend that you determine all possible appropriate responses and instruct users on proper usage of this feature. They can then click the **Proceed** button to gain temporary access to the patient’s chart.

Automatic Log-Off:

You may enable the autopark feature within PRUtils, the advanced securities system utility. With this feature, workstations and Patient Records can be automatically parked and/or locked after a designated period of inactivity.

Configuration:

To enable the autopark feature:

1. Ensure that all users are logged off of the system.
2. Log into PRUtils.
3. Click on the **Access 1** tab and click on the **Lock Workstation** check box to enable the lock workstation feature.
4. Enter in the amount of time after which you want the workstation to lock.
5. Click **OK** to save.

The screenshot shows the 'Electronic Security' configuration window with the 'Access 1' tab selected. The 'AutoPark' section is highlighted with a red box and contains the following settings:

- Lock Workstation
- Park Workstation
- Idle Interval (seconds):

Other sections visible in the window include:

- Password and PIN:**
 - User may set Password
 - User may set PIN
 - Password Interval (days):
- Track Access:**
 - Track access to individual patients
- Login Security:**
 - Inactivate user
 - Exit application
 - Number of incorrect logins:
- Rx Audit:**
 - Audit all Rx changes (even minor ones)

At the bottom of the window, the 'OK' button is highlighted with a red box, and the 'Cancel' button is also visible.

Electronic Security screen – Access 1 tab

Operator Audit Trail Report:

You may use this report to print all operator recorded events in Patient Records. This includes the adding, editing, deleting, and viewing of records. Patient Records also tracks and records the signing of patient notes and labs. Prescription printing, faxing, and transmitting will also be recorded.

If enabled, Patient Records automatically tracks and records operator activity for the following functions:

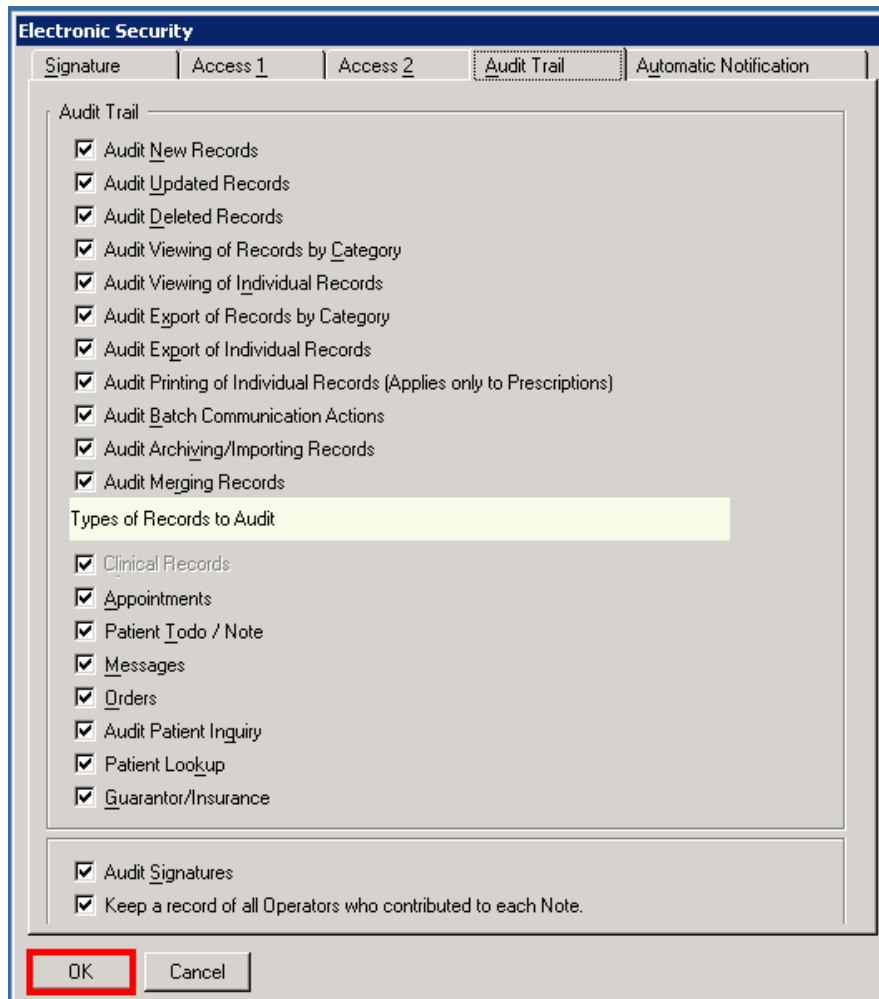
- Progress Notes
- Other Notes
- Health Maintenance
- Problems
- Labs
- Rx
- Allergies
- Vital Signs
- Clinical Elements
- Images
- Document Links
- Flow Charts
- Prenatal
- Patient
- Patient Chart
- Patient Lookup
- Guarantor/Insurance
- Messages
- To Do Notes: When to do notes are marked as "completed."
- Text Data Loader: When a note is imported, the user action Add TDL will be recorded.
- Lab Data Loader: When a result and/or lab note is imported, the user action Add LDL will be recorded.
- Zoom: When an operator imports or links to an external file (chart notes, patient photos, or patient attachments).
- Utilities: Any utility run from the Patient Records > Maintenance > Utilities menu will have the appropriate action recorded for every patient record that was added, edited, deleted, viewed, imported, or exported depending on what action the utility is performing.
- Reports: Any patient report that is run from the Patient Records > Reports menu will generate a View audit record for all patient's records that the report generated.
- Audit Trail Reports: When an operator successfully creates an audit trail report, and when an operator attempts to create an audit trail report and cannot generate the report because they do not have access level permission for the report.
- Operator Status: When an operator's status is changed from "active" to "inactive" the action will be recorded as "INACTIVATE", and when the operator's status is changed from "inactive" to "active" the action will be recorded as "ACTIVATE".
- Break-the-Glass events: When an operator opens a patient's chart when access to it has been restricted, the Operator ID, the Date/Time of the event, the Patient ID whose chart has been accessed, and the reason for "breaking the glass" as entered by the operator at the time of the event will print on the report.

Configuration:

You can enable the Audit Trail options within PRUtils.

To enable the Audit Trail options:

1. Ensure that all users are logged off of the system, and that all services and interfaces are shut down.
2. Log into PRUtils.
3. Click on the **Audit Trail** tab and click on the check boxes that correspond to the events that you wish to audit.
4. Click **OK** to save.



Electronic Security screen – Audit Trail tab

End User Functionality:

To run the Audit Trail Report:

1. Select Reports > **Audit Trail**.
2. Enter a valid operator ID in the **Operator** field (you can also click the down arrow button to access the Operator Select screen) or to print the report for all operators, leave this field blank.
3. Select a practice from the **Practice** drop-down list. To print the report for all practices, leave this field blank.
4. Enter a patient ID in the **Patient** field or a patient name in the **Patient Name** field. If a valid patient ID is entered, the patient's name will be displayed in the **Patient Name** field. To print the report for all patients, leave these fields blank.
5. Select the range of dates for which you want to print the report. When you select a starting and ending date, all audit trail data created between those dates that meet the other criteria you select will be included in the printed report.
If you leave the dates blank, all audit trail data up to the current system date and time that meet the other criteria you set will print.
6. Select the range of times for which you want to print the report. When you select a starting and ending date, all audit trail data created between those times that meet the other criteria you select will be included in the printed report.
7. In the **Sort by** frame, select the **Date/Time**, **Operator**, **Patient**, or **Action** radio button. The report will be sorted based on the selected option. The secondary sort is by date/time unless the **Patient** radio button is selected, then the secondary sort is by the patient's last name, first name, and middle initial.
8. To print the report to a file (instead of to a printer), select the **Print to file** check box.
9. Select the audit events you want to include in the report. Use the **Check All** or **Uncheck All** buttons to select or clear the selections.
10. Click the **OK** button to run the report.

Operator Audit Trail Report screen

System Security Events:

System alerts may be enabled to a specified Operator (e.g., a system administrator) when a significant auditable event occurs. This will allow the system administrator to be alerted right away to an event that might indicate a security issue for your organization, and to be able to respond promptly.

If a security event occurs, the operator assigned to receive the alert will receive a "System security event notification" in his or her operator message inbox. The message will include the event type, date/time, the operator's name and ID, workstation ID, user's Windows log on, patient name and ID, reason given for access, and the operator's name and ID whose record was modified. See the Messaging System Help section for a complete overview of the Messaging system.

The system will send a message to the specified Operator each time any of the following types of events occurs:

- Break-the-glass
- Inactivation of an Operator due to excessive failed logins
- Manual Inactivation of an Operator
- Manual Deletion of an Operator

If the operator is inactive the message will still be sent. Messages will not be sent if the operator is not found in the system.

Configuration:

1. Ensure that all users are logged off of the system.
2. Log into PRUtils.
3. On the **Automatic Notification** tab, type the ID of the Operator that you want to receive automatic notifications regarding security events in the **Select Operator to receive automatic notifications regarding security events** field, or click the **Lookup** button to select an operator from the Operator Select screen.
4. On the **Access 1** tab, select the **Inactive User** check box to track "Inactivation of Operator due to excessive failed logins" events. All other events are automatically tracked by the system's audit trail.
5. Click **OK** to save.

Menu Objective 1 - Implement Drug Formulary Checks

Objective:

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

Description:

Formulary Checks are an included feature with the implementation of the SureScripts electronic prescribing Add-On.

InfoScan Formularies (another optional Add-On) will also suffice for this menu item; however it is not required in addition to SureScripts. This section will only discuss SureScripts.

This section will cover:

- SureScripts formulary configuration utility
- SureScripts formulary workflow for end users

Configuration:

Formulary updates are downloaded automatically on a weekly basis. It may be necessary to modify the formulary download schedule in order to avoid conflict with other automated services. In some environments, it may be necessary to direct the download through a proxy server.

In order to access the ePrescribing Formulary Download settings in Patient Records, launch the ePrescribing Configuration Utility. This utility should have been launched and configured when SureScripts was initially installed. It can be found in the \ppart folder which is external from the Patient Records application.

A patient's formulary information will automatically download into Patient Records if patient demographics are properly input.

To launch the ePrescribing Configuration Utility:

1. In the \ppart folder, locate PMSI.ePrescriptionConfiguration.exe.
2. Double-click to launch the utility.
3. Click on the **Formulary** tab to configure the Formulary download settings.

ePrescribing Configuration Utility - Formulary Download tab

Configuring Formulary Download Time

The default schedule for formulary downloads is on Friday nights. Perform the following if necessary to avoid conflicts with other scheduled services:

1. In the **Days** field, select which day you wish your weekly download to occur and click the **Add** button.
2. Make sure the **Download Files** check box is checked.
3. Click the **Hour** and **Minute** down arrows to scroll to the desired start time.

Configuring to download through Proxy Server

If the formulary is needed to download through a proxy server then fill out the **IP Address**, **Port**, the **User Name**, and **Password** fields.

Also please note that all users need to be logged out of Patient Records after the download has completed, or files will not be updated.

Users can be in the system when the ePrescribing Configuration Utility is accessed.

Patient Demographics Needed

SureScripts utilizes five demographic fields to match patient demographics between Patient Records and the SureScripts network. Ensure that all patients have the following demographic information entered accurately in order to receive Formulary checks.

1. First name
2. Last name
3. Date of Birth

4. Gender
5. Zip code

Formulary Workflow

In order for formulary checking to occur, ePrescribing needs to perform a query on the patient to match their demographic data. This occurs automatically when a user opens a patient's chart.

The formulary check query will return three results:

- Query was unsuccessful.
- Query was successful, but patient not found.
- Query was successful and pharmacy eligibility information is displayed. (This is the only query that will display patient formularies)

A query can be unsuccessful if incorrect demographic information was input into Patient Records or if the patient's Insurance's Pharmacy Benefits Manager does not participate with SureScripts.

Note: SureScripts' network holds over 300 million patients.

To see if the query was successful (this is not a required step), click on the **Eligibility** tab on the Rx/Medications screen. The patients Rx eligibility will display if successful.

When a provider is prescribing medications they will be able to see a color coded and numbered system that corresponds with the patient's coverage for that medication in the Select Rx Template screen.

The visual cues are similar to a traffic light:

- Red X (1): drug is not on formulary
- Yellow Triangle (2): drug is on formulary, but not preferred.
- Green Circle (3): drug is both on formulary and preferred

Select Rx Template

Template Code:

Search Template Code Indications

Insurance Formulary **General Formulary**

Code	Name	Prov	Rx/OTC	Generic	Formulary	Actual
ACEBUTO200	ACEBUTOLOL 200 MG BID X 30D		Rx	Y	3	(no price)
ACEBUTO400	ACEBUTOLOL 400MG BID X 30D		Rx	Y	3	(no price)
ACEON2	ACEON 2MG QD X 30D		Rx	N	2	(no price)
ACEON4	ACEON 4MG QD X 30D		Rx	N	2	(no price)
ACEON8	ACEON 8MG QD X 30D		Rx	N	2	(no price)
ACETACOD#2	ACET W/COD #2 2 TABS Q6H		Rx	Y	3	(no price)
ACETACOD#3	ACET W/COD #3 2TABS Q6H		Rx	Y	3	(no price)
ACETAM1GM	ACETAMINOPHEN 1GM QID X 30D		OTC	Y	1	(no price)
ACETAMI325	ACETAMINOPHEN 325MG 1-2 Q6H		OTC	N	1	(no price)
ACETAMI500	ACETAMINOPHEN 500MG 1-2T Q6H		OTC	Y	1	(no price)

OK Cancel Help

Select Rx Template screen (note the colors and numbers in the Formulary column)

Rx Template Code: ALPRAZXR2 by Template Code by Indication(s)
 Rx Template Name: ALPRAZOLAM XR 2MG QD X 10D

Date: 11/02/10 Medication: ALPRAZOLAM XR Size: 2MG

Take: 1 TAB Frequency: DAILY PRN Route: ORAL

Duration: 10 Amount: 10TAB Refills: 0

Print: Prov: JST John Smith Test Outside

Indication 1:
 Indication 2:
 Note:
 Pharmacy: RITE AID-1115 OLD TOWN ROAD

Formulary:
 Plan: CMX - UBS Painewebber
 On Formulary (preferred)
 Formulary status 3

Extended Sig: Code:
 Create Sig Template

Use Extended Sig Limit Refills Drug Interaction Check New Rx Template
 Use Extended Sig Only Substitution OK Allergy Check
 Use Patient Instructions Update Progress Note OTC

Wholesale: \$3.52 per unit. Total: \$35.20 Generic: (no price) per unit. Total: (no price)
 Insurance Total: (no price)

Prescription screen (note the Formulary box on the right-side with the Green Circle)

Clicking on the **Details** button in the formularies box of the new prescription screen will give more information such as alternative drugs that may have a “better” formulary status.

Clicking an alternative will alter the script.

Menu Objective 2 – Structured Lab Results

Description:

New to version 9.5 is the ability to indicate which orders store results as structured Lab Test data (in positive/negative or numeric format.) This Objective requires the use of the Order Entry module along with Lab Data Test Names. The measure can be met whether lab results are manually entered or loaded from an interface.

Objective:

More than 40% of all clinical lab tests results ordered by the eligible provider or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) 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.

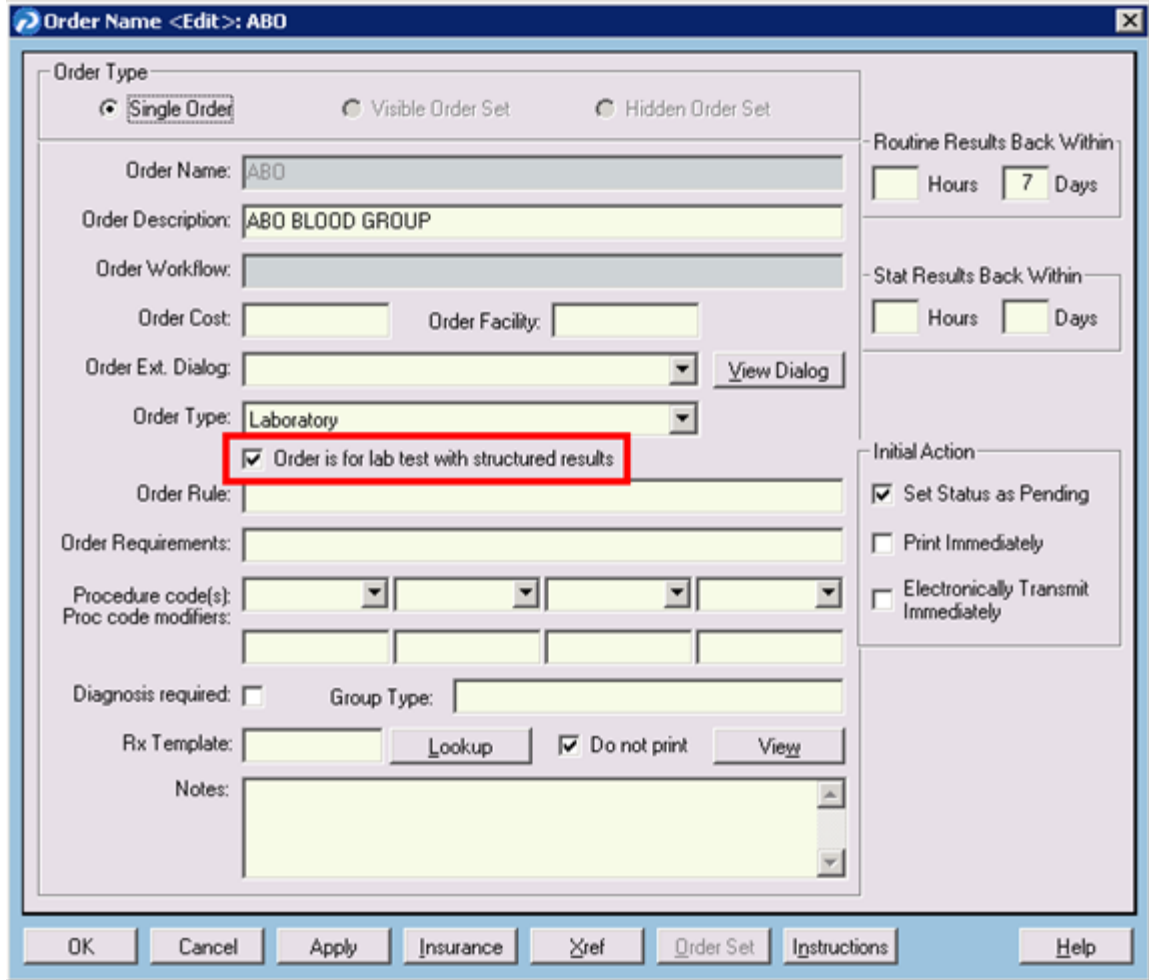
Configuration:

Order Names for lab tests with structured results will be pre-configured to comply with this objective on new 9.5 installations so users will only need to follow these instructions when adding additional Order Names of this type.

Customers upgrading to 9.5 will need to modify each Order Name that stores results as structured Lab Test data. No utility or tool is available for updating existing Order Names.

To indicate that an Order Name is a lab test with results that are stored as structured data:

1. Select Templates > Order Templates > **Order Names**.
2. Select an Order Name that is a lab test with structured results, and click the **Edit** button. If you are adding a new Order Name, click the **New** button and enter all appropriate data for the order.
3. Click the **Order is for lab test with structured results** check box.
4. When you are finished, click **OK**.



Order Name <Edit> screen

Configuration Notes:

- Only Single Orders can be configured as lab tests with structured results.

End User Training:

Once the EHR administrator has configured the appropriate Order Names to indicate that they are lab tests with structured data, nothing else is required from an end user perspective to meet this objective. Lab Results received for this type of Order will count towards this Meaningful Use objective.

Menu Objective 3 - Generate Patient List by Problem

Description:

Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach. This can be done through the use of Patient Inquiry.

Configuration:

No configuration is needed for the Patient Inquiry to be used.

Patient Inquiry

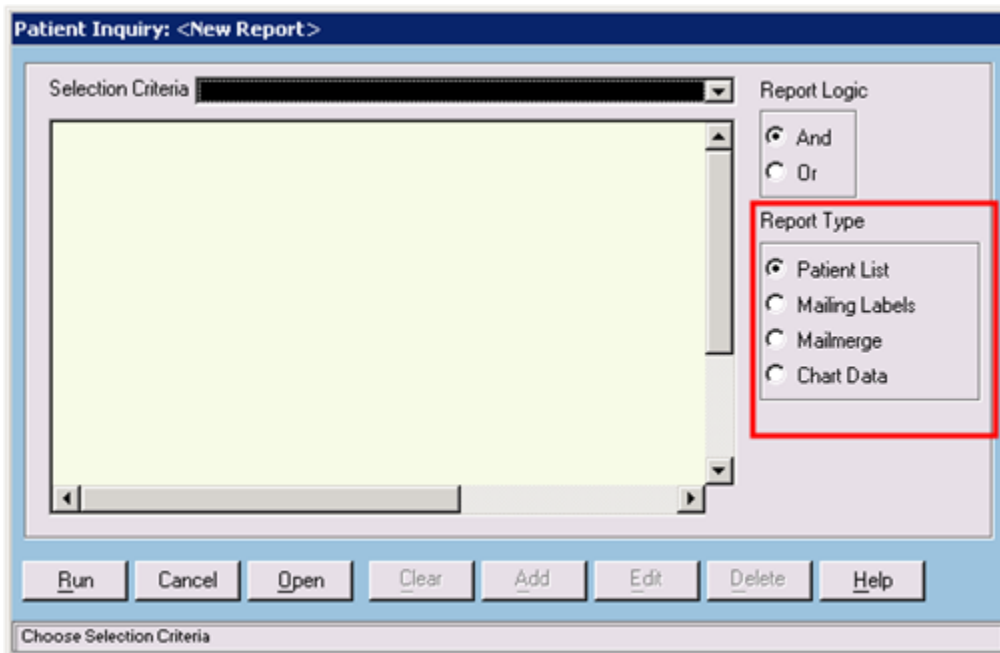
Patient Inquiry allows users to view, print, and store a list based on a relational inquiry of the information stored in Patient Records.

To access Patient Inquiry:

- Select Reports > **Patient Inquiry**.

Patient Inquiry Report types:

The only option needed to meet Meaningful Use is **Patient List**. This will produce a list of patients whose records fit your inquiry.



Patient Inquiry: <New Report> screen – Report Type radio buttons

Entering values for Patient Inquiry report items

A user can select numerous clinical and demographic data points to form an inquiry from the **Selection Criteria** drop-down list.

For example, to look for patients who have been diagnosed with Asthma, a user can choose "Problem" from the **Selection Criteria** drop-down list and enter the name of the problem and indicate whether the problem is active or inactive on the Values screen. Users can optionally enter a provider ID, although this is not required to meet the Meaningful Use objective.

To select report items:

1. Click the **Selection Criteria** drop-down list to display the item list.
2. Select an item. You can use the arrow keys, or the scroll bar and arrow buttons, to scroll down the list and display more items. Once an item is highlighted, you can click it or press ENTER.
3. In the Values screen, enter the appropriate values for the item. Click the **OK** button.
4. Click the **Add** button to repeat these steps with additional selection criteria.
5. Keep repeating these steps until you have selected all of the report items that you need. You can select up to 16 items.

The screenshot shows the 'Patient Inquiry: <New Report>' window. At the top, the 'Selection Criteria' dropdown is set to '38. Problem'. A dialog box titled 'Enter The Problem Name' is open, with 'Asthma' entered in the text field and 'Active (Y/N)?' checked. The 'OK' button is highlighted. On the right side, the 'Report Logic' section has 'And' selected, and the 'Report Type' section has 'Patient List' selected. At the bottom, there are buttons for 'Run', 'Cancel', 'Open', 'Clear', 'Add', 'Edit', 'Delete', and 'Help'. A status bar at the bottom left says 'Choose Selection Criteria'.

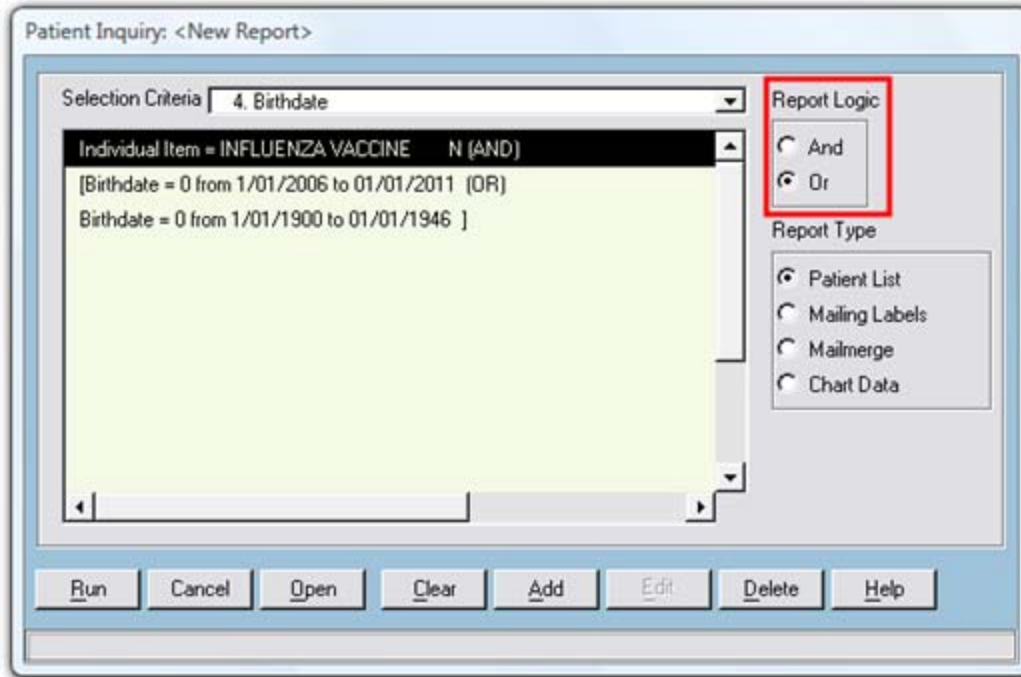
Patient Inquiry: <New Report> screen – Values screen

Using the Report Logic Keys

Users can do "AND" searches, "OR" searches, or combinations of "AND" and "OR" searches with patient inquiry. The default search is an "AND" search - that is, Patient Records only finds cases where all the items match. In an "OR" search, at least one item must match.

An example of using Report Logic Keys would be for users who are trying to meet Menu Objective 4 - Sending Patient Reminders. Sending Patient Reminders only requires that patients younger than five years or older than 65 years are sent reminders. If a practice is looking to print out a list of patients who are overdue for Influenza vaccines and are in the appropriate ages they would first select Health Maintenance in the selection criteria and search for Influenza vaccine.

The practice would ensure that “AND” was selected before selecting the first date of birth range. For the second date of birth range the logical operator needs to be switched to “OR”.



Patient Inquiry: <New Report> screen – Report Logic radio buttons

To switch to "OR" logic, select the "OR" Report Logic radio button. Users can combine one group of "AND" items and one group of "OR" items in a single search, by switching between "AND" and "OR" logic before choosing the next report item. Once a switch to "OR" has been made, users cannot switch back to using "AND". This will prompt the message, "Logical Operators cannot be mixed."

Completing the Patient Inquiry

1. In the **Selection Criteria** drop-down list, users can select the criteria they want to use. Up to 16 items can be selected.
2. After criteria have been chosen, click the **Run** button.
3. On the Enter File Name screen, enter a file name - without a file extension - that describes the inquiry and click **Open**.
 - Patient Records adds the extension ".sel" to the report selection criteria file and adds the extension ".inq" to the report results file. This file stores the information generated by the patient inquiry. Users can use the .inq file to generate patient reminders.
4. A message displays the number of patients (and the percentage) that matches the criteria selected. If there are no patients that match the criteria selected, a message displays, "No Data Matches Criteria." For either message, click the **OK** button.
5. The Print screen displays.
6. Click the **OK** button if it is desired to print the report.

By printing the report this will attest for Menu Item 3, but users can also additionally add this list to a patient registry to allow for further advanced tracking of these patients.

Patient Registries

Registries are custom lists of patients who have something in common, such as a particular chronic disease. For example, practices might set up a registry for patients with diabetes, patients over the age of 80 who live alone or patients who might be candidates for a particular clinical trial.

Administrators use the Registries Maintenance screens to set up and manage the different registries that are available in Patient Records. When patient registries have been set up, operators can access registries from the **Task** menu, view patient information, add or remove patients from the list, and quickly create flow charts, messages, notes, or letters for specific patients.

More detailed information about patient registries is available in Patient Records Help.

Menu Objective 4 - Generate Patient Reminders

Description:

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

Configuration:

Before Patient Records can retain data to report upon the metric for Generation of Patient Reminders, the PRUtils setting, "Audit Batch Communication actions" must be enabled.

To run PRUTILS:

1. All users must be out of the system, and interfaces (PPConnect) must be turned off.
2. Access PRUtils through the client folder.
3. Users with appropriate access will need to sign in to the initial login screen and then provide the PRUtils password.
4. Click on the **Audit Trail** tab and check the **Audit Batch Communication actions** check box, if unchecked.
5. Click **OK** to save changes and exit PRUTILS.

End User Training

In order to generate patient reminders in Patient Records, users need to:

1. Set the patient's reminder preference in Patient Demographics.
2. Generate a patient inquiry file.
3. Run Batch Communication using the file generated from the patient inquiry.

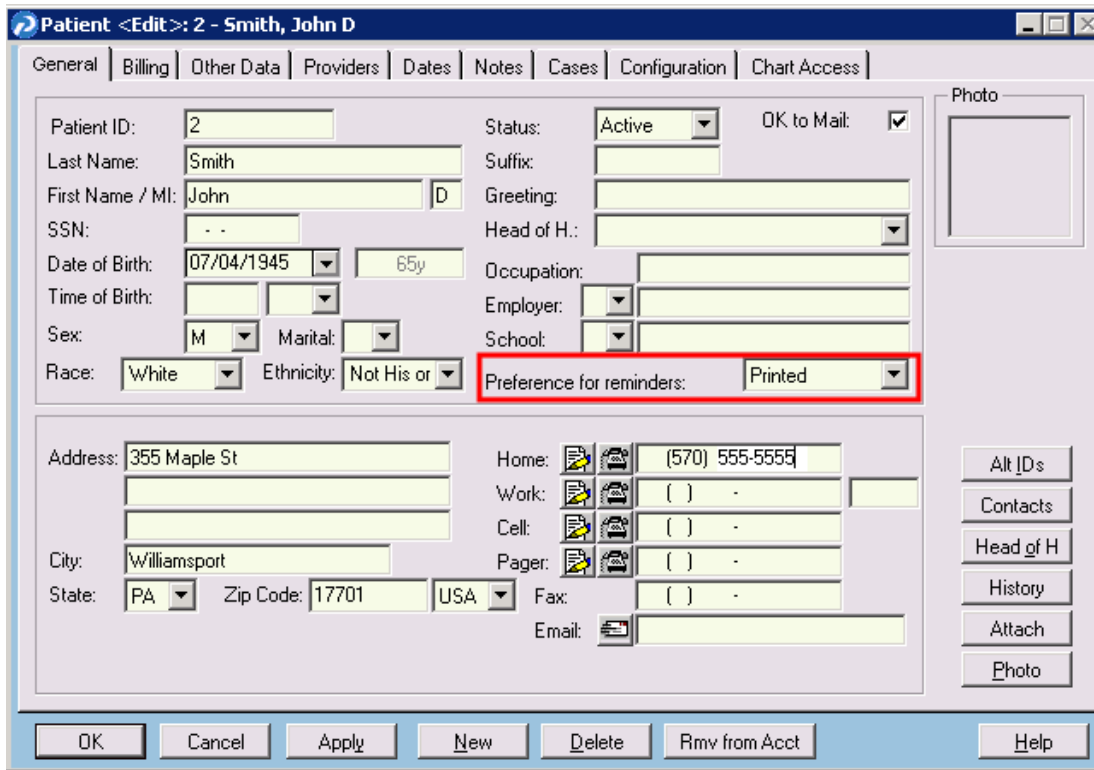
Patient Demographics

In Patient Records 9.5 a new field has been created in patient demographics to capture a patient's reminder type preference. The options available from the **Preference for reminders** drop-down list are **Printed**, **Electronic** or **Phone**.

Note: The **Electronic** option is only appropriate for patients who have been set up to receive electronic messages via RelayHealth or Web View.

To set a patient's reminder preference:

1. Click the **Patient** button in the toolbar. The Lookup screen appears.
2. Enter the search criteria and filters you want to use to narrow the search.
3. Click the **Lookup** button.
4. In the search results table, highlight the appropriate patient and click the **OK** button.
5. On the **General** tab, select an option from the **Preference for reminders** drop-down list.
6. When you are finished, click **OK**.
7. Repeat these steps for all patients that you want to set a preference for.



Patient <Edit> screen

Patient Inquiry

In order to send out patient reminders a list of patients who are to receive a reminder needs to be generated via Patient Record’s Patient Inquiry feature.

Detailed steps on how to run Patient Inquiry are located in the *Menu Objective 3 - Generate Patient List by Problem* section.

Batch Communication

This feature allows operators to automatically generate outbound communications in bulk (that is, multiple separate communications generated in one process), such as alerts to patients about the need for preventive services, or alerts to users about patients that need follow-up care in Patient Records.

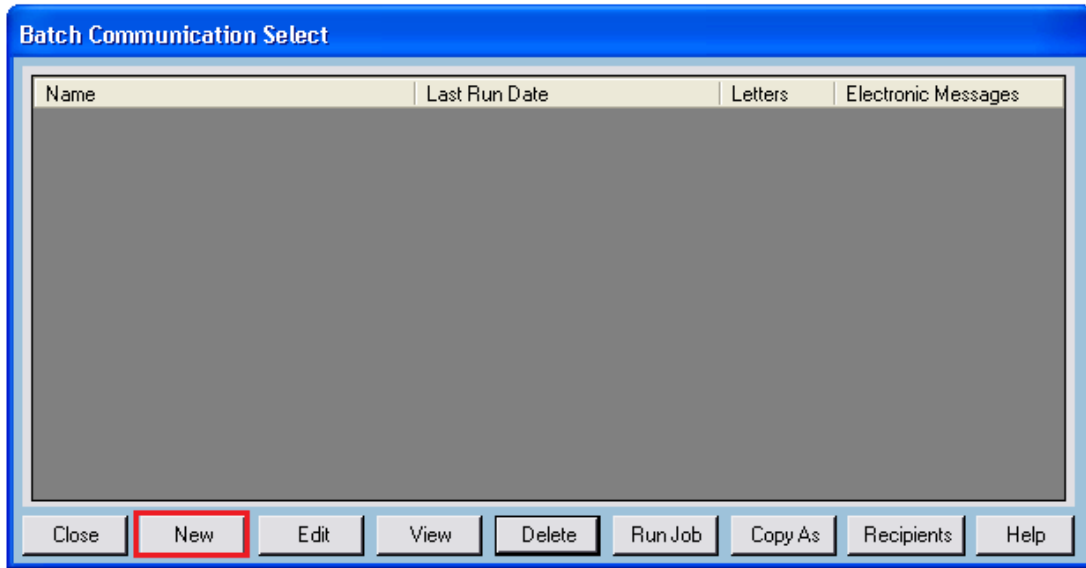
Operators can generate patient lists for batch communication jobs using Patient Inquiry and the Overdue HM List report. Operators can then create jobs using the lists and run batch communication to generate printed letters or send web messages via Web View or RelayHealth to the list of patients. After a job has been run, the letter will be saved in the Letter section of the Patient Chart for each patient whom it was printed for or transmitted to.

Adding Batch Communication Jobs

Operators can add batch communication jobs to generate printed letters or web messages to send to patients. When setting up a batch communication job, operators can specify the communication details and configure its output.

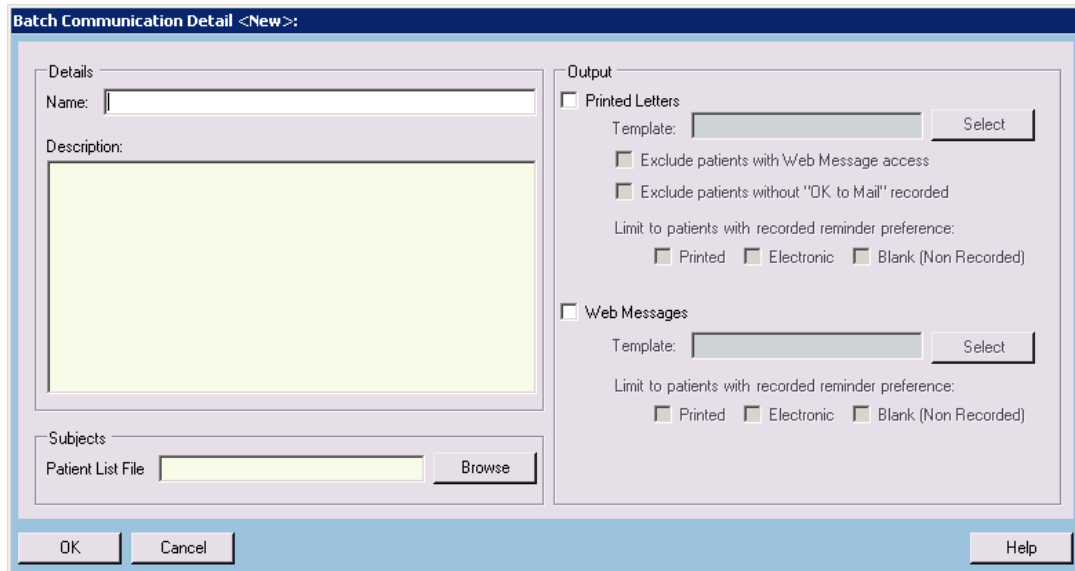
To add a job for printed letters:

1. Select Reports > **Batch Communication**. The Batch Communication Select screen appears.



Batch Communication Select screen

2. Click the **New** button. The Batch Communication Detail <New> screen appears.



Batch Communication Detail <New> screen

3. Type the name and description for the new job in the provided field.

4. Type the path and name of the file with an .inq extension desired for use to generate the job in the **Patient List File** field, or click the **Browse** button to navigate to a previously created inquiry file, and then click the **OK** button.
5. Select the **Printed Letters** check box. Type the name of the desired letter template or click the **Select** button to select from the list of templates at the Letter Template Select screen.
6. Select the **Exclude patients with Web Message access** option to exclude patients with access to Web View or RelayHealth.
7. Select the **Exclude patients without "OK to Mail" recorded** option to exclude patients that don't have the "OK to Mail" setting selected on their Patient Demographic screen.
8. Select one of the **Limit to patients with recorded reminder preference** options if operators want to exclude patients based on the "Preference for reminders" setting on the **General** tab of the Patient screen. For example, if operators select **Printed**, reminders will only be generated for patients with this selected preference.
9. When finished, click **OK**.
10. Run the job from the Batch Communication Select screen. (Shown below)

To add a job for web messages:

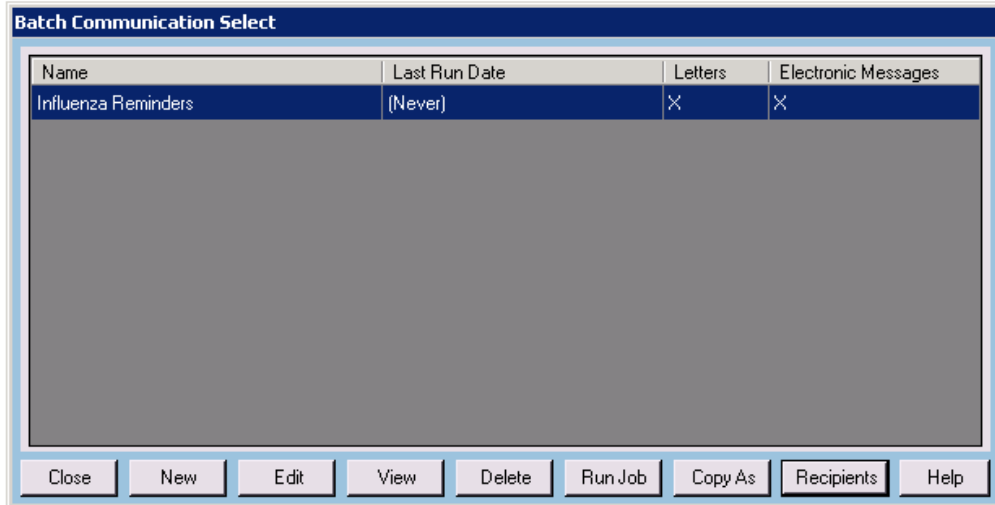
1. Select Reports > **Batch Communication**. The Batch Communication Select screen appears.
2. Click the **New** button. The Batch Communication Detail <New> screen appears.
3. Type the name and description for the new job in the provided field.
4. Type the path and name of the file with an .inq extension desired for use to generate the job in the **Patient List File** field, or click the **Browse** button to navigate to a previously created inquiry file, and then click the **OK** button.
5. Select the **Web Messages** check box. Type the name of the desired letter template or click the **Select** button to select from the list of templates at the Letter Template Select screen.
6. Select one of the **Limit to patients with recorded reminder preference** options if operators want to exclude patients based on the "Preference for reminders" setting on the General tab of the Patient screen. For example, if operators select **Printed**, reminders will only be generated for patients with this selected preference.
7. When operators are finished, click **OK**.
8. Run the job from the Batch Communication Select screen. (Shown below)

Running a Batch Communication Job

Batch communication jobs should be ran after a batch communication job has been set up from the Batch Communication Select screen.

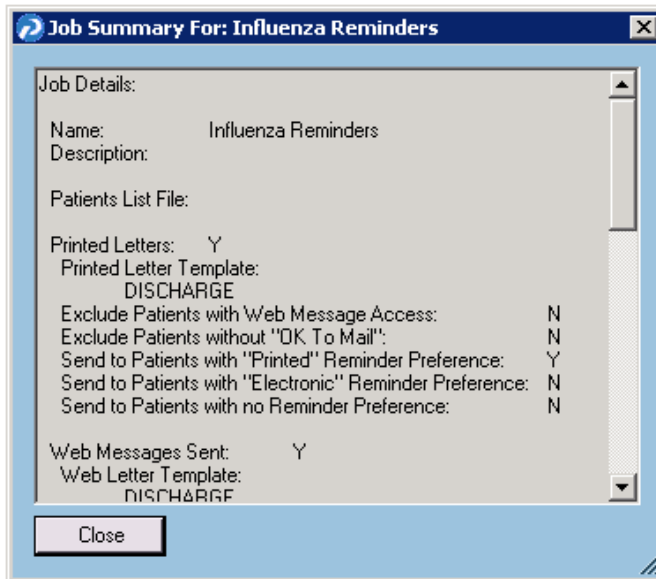
To run a batch communication job:

1. Select Reports > **Batch Communication**. The Batch Communication Select screen appears.
2. Highlight the batch communication job and click the **Run Now** button. Click the **OK** button at the confirmation message.



Batch Communication Select screen

3. The Batch Communication - Job Status screen displays the status of the job. If running a **printed letters** job, the Windows Print screen may appear. If it does, select a printer and then click **OK**.
4. When the job is complete, the Job Summary screen will display the job's details. To retain the contents of the Job Summary, users can highlight all of the text inside the box in order to copy and paste it into a Word document.



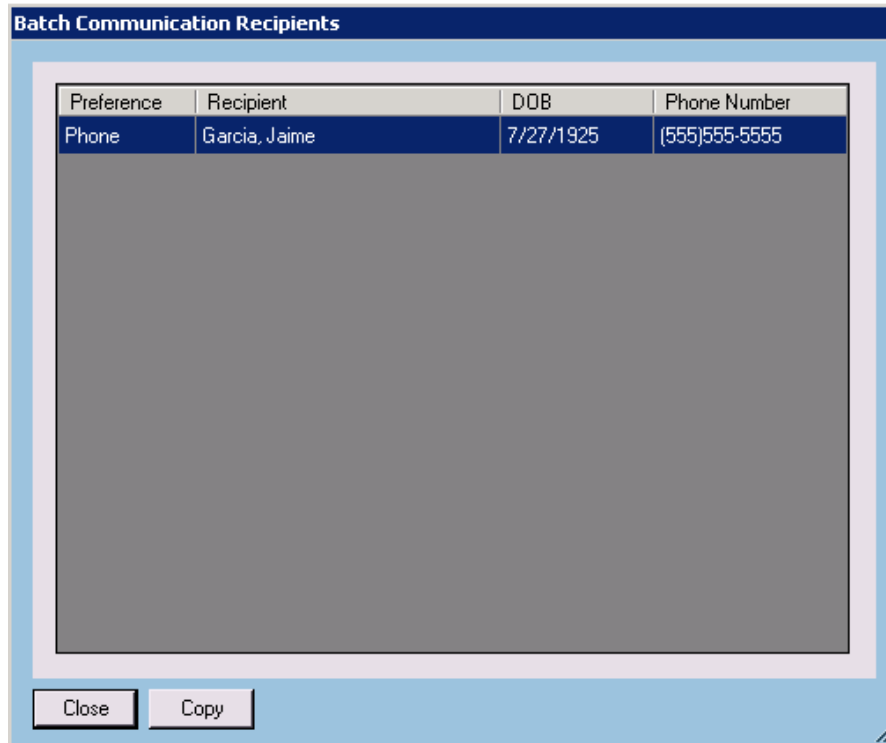
5. When finished, click the **Close** button.

Phone Reminders List

For patients that have a reminder preference set to “Phone”, a list can be generated containing patient names and their phone numbers.

1. On the Batch Communication Select screen a user should highlight the desired batch to create the phone list.
2. Click the **Recipients** button.

3. In the Batch Communication Recipients box, users can click on the column headings to reorganize the list of patients. Users should ensure the column is sorted by "Preference" and click **Copy**.



Batch Communication Recipients screen

4. Users should then paste the list contents into a Word document.

Menu 5 Objective- Timely Access:

Objective:

Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and medication allergies) within four business days of the information being available to the eligible provider.

Description:

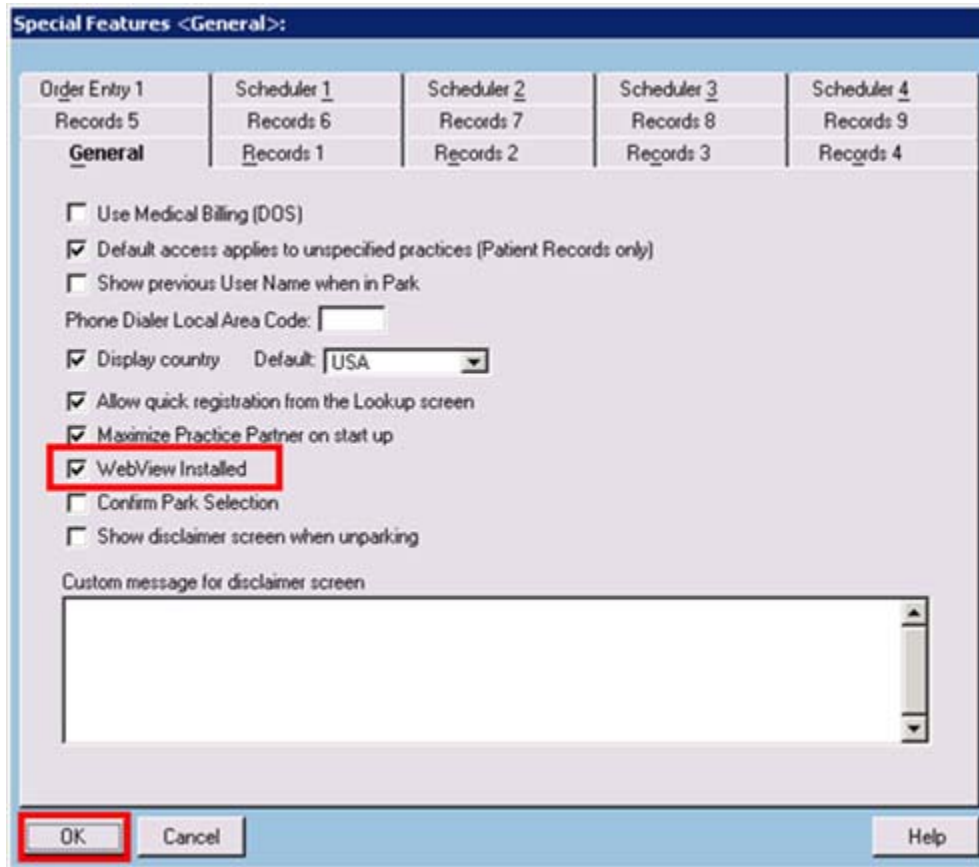
More than 10% of all unique patients seen by the Eligible Provider are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the Eligible Provider’s discretion to withhold certain information.

Configuration:

Web View must be installed prior to all configuration steps.

1. Select Maintenance > Configuration > **Special Features** and click on the **General** tab.
2. Select the **WebView Installed** check box.

Note: If this check box was not previously checked, you will need to exit the program and log back in.



Special Features screen – General tab

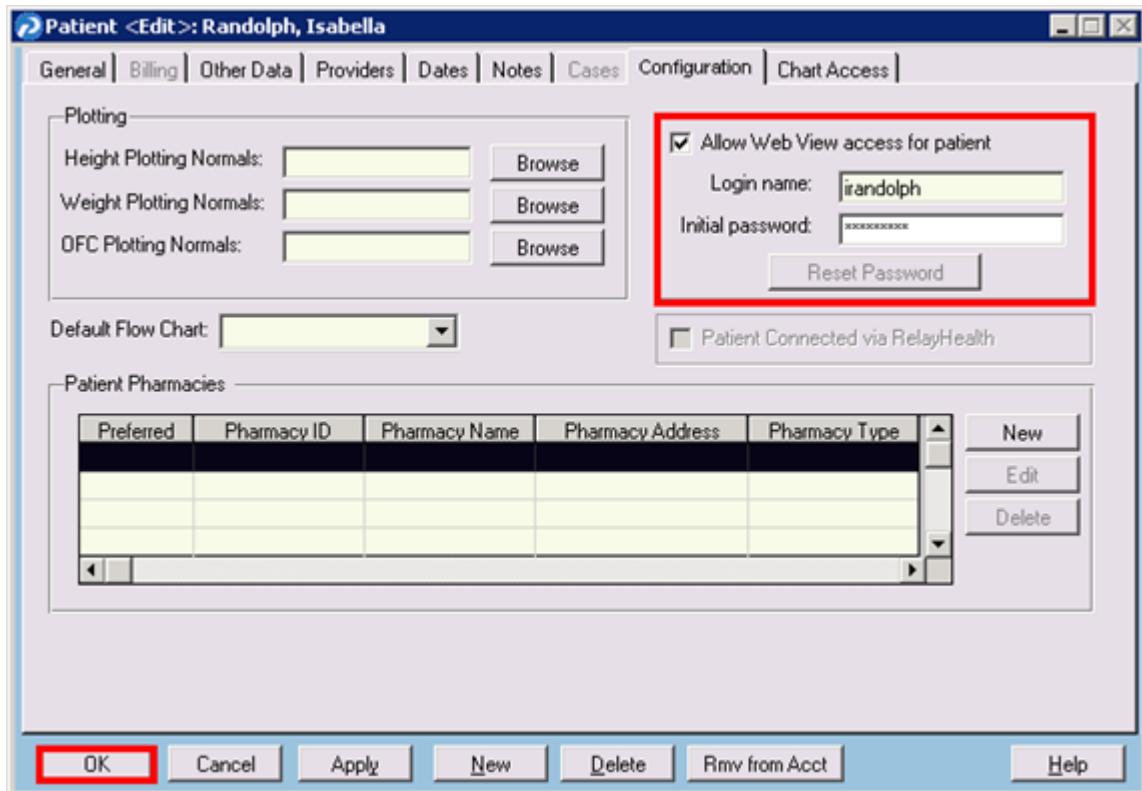
Configuration Notes:

- It is recommended that administrators predetermine a methodology for assigning user names and initial passwords to patients that best suits their workflow.

End User Training:

To enable Web View access for patients:

1. Open the patient’s demographics screen and click on the **Configuration** tab.
2. Click the **Allow Web View access for patient** check box.
3. Type the patient’s user name and password in the **Login name** and **Initial password** fields.
4. Click **OK** to save.



Patient <Edit> screen – Configuration tab

5. Provide the patient instructions as to how to access Web View.

End User Notes:

- When a patient logs in for the first time they will be required to reset their password.
- If a patient needs to reset their own password, you may assist them in doing so by clicking the **Reset Password** button and assigning a temporary new password.

Menu Objective 6 - Provide Patient-Specific Education

Objective:

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

Description:

This section covers:

- Access levels to External Systems
- Configuration of External Systems
- Embedding the education dot code into notes
- End User Training on how to use External Systems and the use of the Education Dot code

If you have McKesson's Patient Education module this guide can be used to supplement any other handouts not available in that module. Please refer to the Patient Education manual for more information on that specific module.

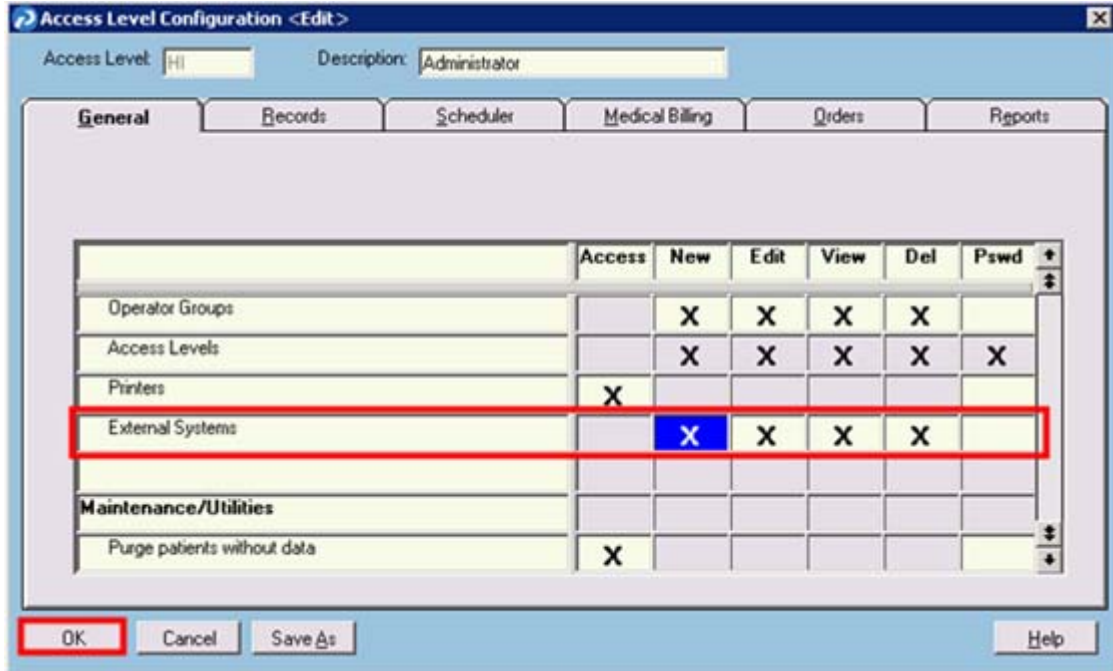
Configuration:

You can configure a new "Patient Education" category under External Systems Maintenance. External systems can be used to access internet web sites, or other patient education resources that are not located in Patient Records. This can be accessed through Labs, Problems, and Rx/Medications.

First, access needs to be given to create, edit, view or delete External Systems Maintenance.

To enable the access level for "External Systems":

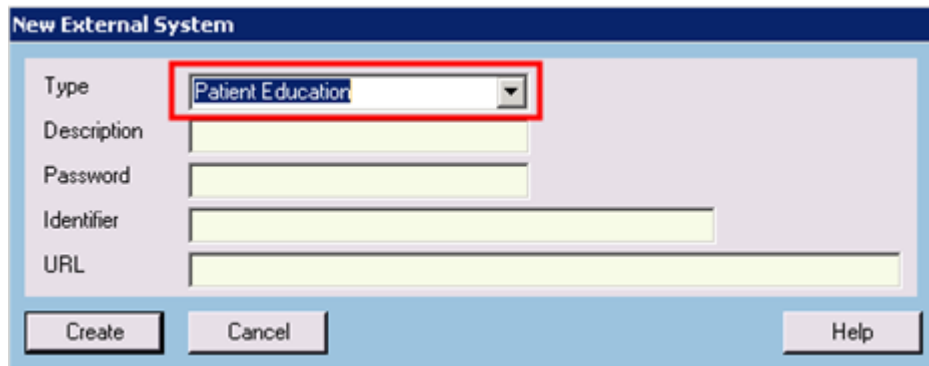
1. Select Maintenance > Configuration > **Access Levels**.
2. Under the **General** tab scroll to **Maintenance/Setup**.
3. Click the appropriate access for the specific level you are configuring.
4. Click **OK** to save.



Access Level Configuration <Edit> screen – General tab

To configure a new Patient Education Category:

1. Select Maintenance > Setup > **External Systems**.
2. Click the **New** button.
3. Select **Patient Education** from the **Type** drop-down list.
4. **Type** in the **Description** of this resource.
5. Type the **URL** you use to access the external system web site. You must include the web protocol in the web address (i.e., https://).
6. Click the **Create** button to save.



New External System screen

Configuration Notes:

It is recommended that the following Dot code and QuickText are added to all note templates that are regularly used by providers in order to reduce manual entry in the Clinical Encounter screen. The Dot code records that you have given the patient a Patient Education Resource.

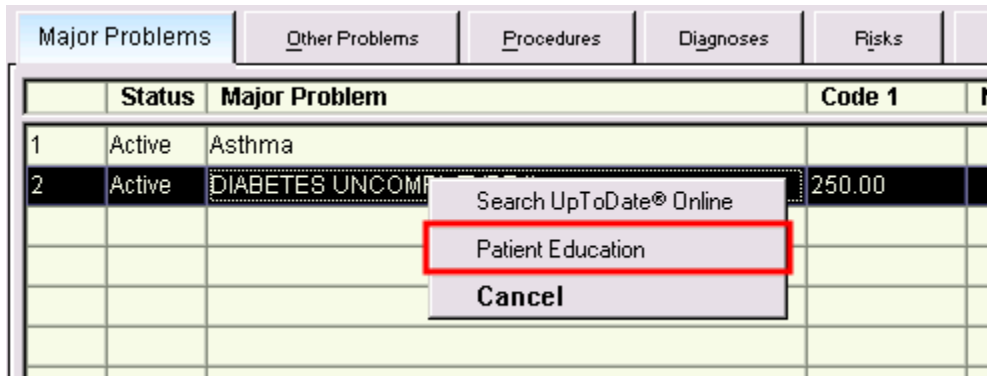
- .ED: <<Y>> <<N>>

End User Training:

McKesson’s Patient Education Module New Features:

To provide patient education the operator can right-click on any of the data in the following chart tabs and will be directly linked to Patient Record’s Patient Education Module:

- Lab Data Table
- Most Recent Labs
- Rx/Medications
- Problem Lists



Major Problem List screen – patient education right-click option

Once you have clicked on “Patient Education” the system will search the Patient Education Database for a matching document.

Note: Not all problems, medications, and labs have a corresponding document in Patient Education.

Also, if external systems are configured, the external systems option will first display upon right clicking as described above. You may cancel out of this which will result in the display of Patient Record’s Patient Education module.

External Source:

To provide patient education via an external source, the operator can right-click on any of the data in the following chart tabs:

- Lab Data Table
- Most Recent Labs
- Rx/Medications
- Problem Lists

Click on Patient Education and if an external site has been created, select the desired system to launch the education in a browser.

If an external education site is used there is a new Dot code, “.ED:” that can be used to denote a “yes” for the “Patient Education Resources Provided” flag within the clinical encounter.

Example:

.ED: Y

End User Notes:

Use of McKesson's Patient Education module, while the patient is "in context" will automatically enable setting of the "Patient Education Resources Provided" flag to "yes."

If the office uses external patient education resources, then an operator (either a provider or a nurse) can record the provision of education resources by checking the **Patient-Specific Education Materials** check box on the Clinical Encounter <New> or <Edit> screen.

Note: Only the printing of ELINKs automatically records the provision of patient specific education material. If patient specific education material is provided through LINKs or PLINKs, edit the encounter manually or use the .ED dot code to edit the encounter.

Menu Objective 7 – Medication Reconciliation

Introduction:

The new Medication Reconciliation feature allows users to review a patient’s active medication list while importing a CCR or CCD medical summary file that was obtained from another practice. If Medication Reconciliation is performed manually by comparing a paper list to the patient’s active medications in Patient Records, you can record that this reconciliation was done.

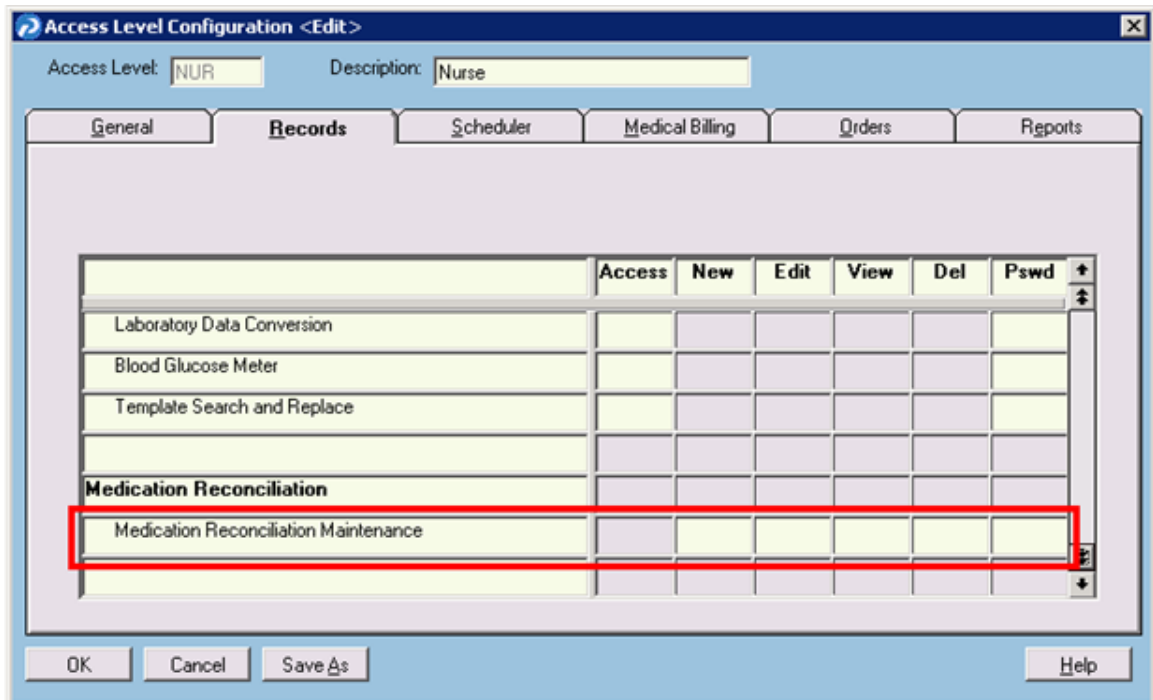
Objective:

The eligible provider must perform medication reconciliation for more than 50% patients transitioned into the care of the eligible provider.

Configuration:

To turn on the Access Level settings necessary to add, edit, view, or delete Medication Reconciliation details:

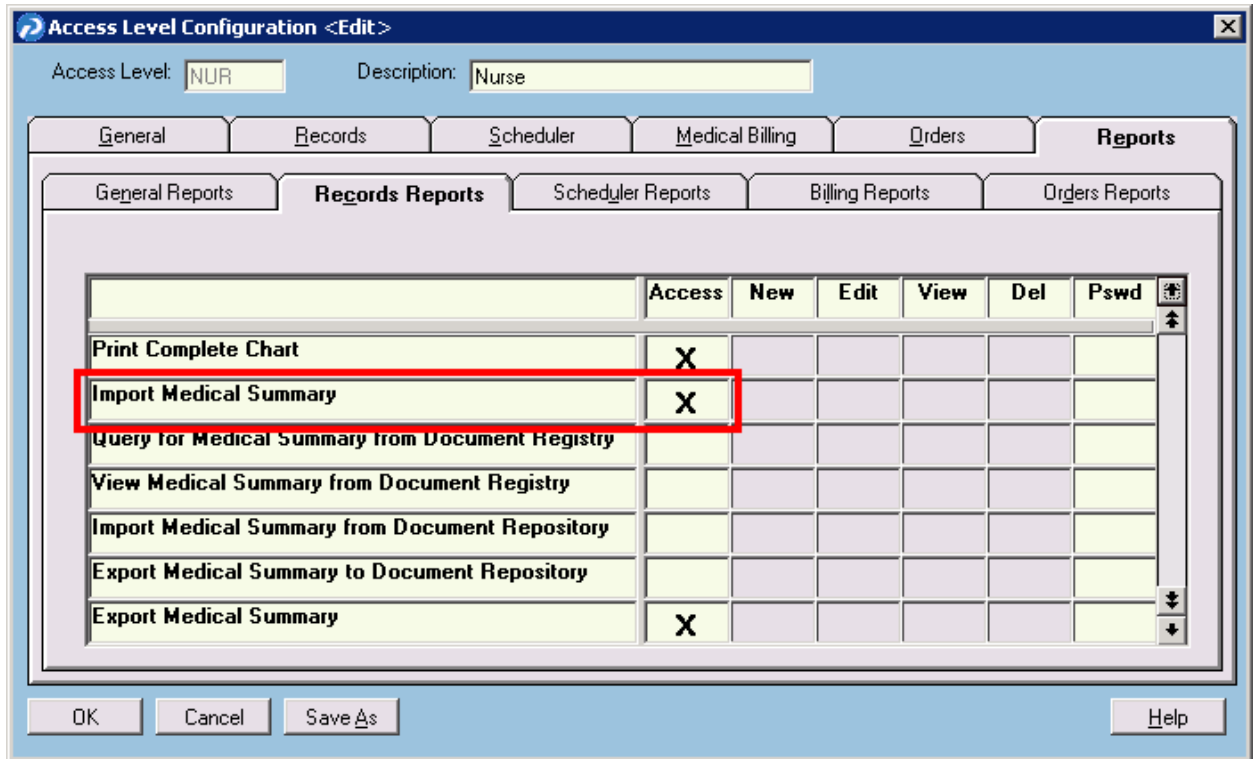
1. Select Maintenance > Set-Up > **Access Levels**.
2. Login with your EHR password, if prompted.
3. Choose an Access Level assigned to those operators who will need to be able to add, edit, view, or delete Medication Reconciliation details and click the **Edit** button.
4. Click on the **Records** tab.
5. Click the desired **Access** boxes next to Medication Reconciliation Maintenance.
6. Click **OK** to save the changes.
7. Repeat these steps for all appropriate Access Levels.



Access Level Configuration <Edit> screen – Records tab

To turn on the Access Level settings necessary to import CCR/CCD medical summary files, during which Medication Reconciliation can be accomplished:

1. Select Maintenance > Set-Up > **Access Levels**.
2. Enter your Operator password, if prompted.
3. Choose an Access Level assigned to those operators who will need to be able to import CCR/CCD medical summary files, and click the **Edit** button.
4. Click on the **Reports** tab, and then click the **Records Reports** sub-tab.
5. Click the desired **Access** boxes next to **Import Medical Summary**.
6. Click **OK** to save the changes.
7. Repeat these steps for all appropriate Access Levels.



Access Level Configuration <Edit> screen – Records Reports sub-tab

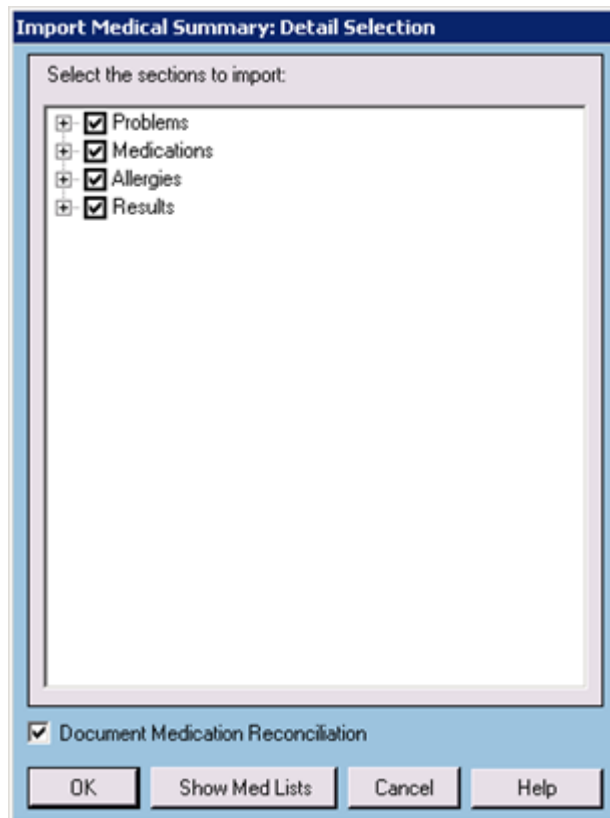
End User Training:

Medication Reconciliation can be done in several different ways within the EHR. However, in order to receive credit toward the Meaningful Use objective it is essential that a Clinical Encounter with a type of “Transfer of Care” is created in Patient Records and that the Clinical Encounter indicates that the Medication Reconciliation was performed. An appropriate Clinical Encounter can be created during a CCR or CCD import, when documenting Medication Reconciliation from the Rx/Medications section of a patient’s chart, or by utilizing the appropriate Dot code in a note. You can also link the Medication Reconciliation event to an existing Clinical Encounter.

To perform Medication Reconciliation when importing a CCR or CCD file:

1. Ensure the CCR or CCD file to be imported is saved on your network in a location accessible from the computer where the import will be run.
2. Select Task > **Import Medical Summary**.
3. Click **Browse** to browse to the location of the CCR or CCD file and select it.

4. Click the **Show Detail Selection Screen** check box.
5. Click **OK**.
6. On the **Establish Patient Identity** screen, the patient name and date of birth from the CCR or CCD file will display at the top of the screen. The lookup portion of the screen will display the closest patient matches found in the EHR. Select the appropriate patient, or refine the search if desired. If the file to be imported is for a patient who is not currently registered in Patient Records, click the **New Patient** button.
7. The **Import Medical Summary: Detail Selection** screen displays. It will show each data type that will be imported. You can click on the **+** button next to each data type to view the discrete data elements for any given data type. If you wish to exclude a specific discrete data element or an entire section, remove the check mark from the box next to that data element or section.



Import Medical Summary: Detail Selection screen

8. Click the **Show Med Lists** button to perform a Medication Reconciliation that will compare the patient's active medication list in the EHR to the medications contained in the CCR or CCD file.
9. After comparing the patient's medication lists from the CCR/CCD and the EHR, click the **Close** button.
10. Ensure the **Document Medication Reconciliation** check box is checked and then click **OK** to import all data with a check mark next to it.
11. The Medication Reconciliation Detail screen will appear. This screen will display any existing Clinical Encounters that have the **Relevant for medication reconciliation** check box checked. You can select an appropriate Clinical Encounter to link the Medication Reconciliation action to and click **OK**. If no appropriate Clinical Encounter is listed, you can create a new Clinical Encounter to link the Medication Reconciliation to by clicking the **New** button. Note that only those Clinical Encounters which are marked as an inbound **Transfer**

of Care and have the **Relevant for medication reconciliation** check box selected will count towards meeting this Meaningful Use objective.

- If you create a new Clinical Encounter, click the **Inbound** radio button in the Transition of Care section to ensure that the medication reconciliation that was done will count towards the Meaningful Use objective.

Clinical Encounter <New> screen

- When you are finished, click **OK** to save the Clinical Encounter.

If you review an outside medication list for a patient that was provided on paper or electronically in a non-CCR/CCD format, you can record that the reconciliation was done from the Rx/Medications section of the patient's chart or through a Dot code in a progress note.

To record Medication Reconciliation from the Rx/Medications tab of a patient's chart:

- Open the patient's chart and click on the **Rx/Medications** chart tab.
- Click on the **Med Rec** button in the upper right-hand corner of the screen. If an existing Clinical Encounter has the **Relevant For Medication Reconciliation** box checked but has not yet been linked to a Medication Reconciliation, the **Med Rec** button will be red. If no matching Clinical Encounter exists, you will be able to create it after clicking the **Med Rec** button.
- Choose **Document Medications Reconciliation** from the drop-down list.
- The Medication Reconciliation Detail screen will open. This screen will display any existing Clinical Encounters which have the **Relevant For Medication Reconciliation** box checked. You can select an appropriate Clinical Encounter to link to the Medication Reconciliation action and click **OK**. If no appropriate Clinical Encounter is listed, you can create a new Clinical Encounter to link to the medication reconciliation by clicking the **New** button. Note that only those Clinical Encounters which are marked as an inbound **Transfer of Care** and have the **Relevant For Medication Reconciliation** box checked will count towards meeting this Meaningful Use objective.

- If you create a new Clinical Encounter, click the **Inbound** radio button in the **Transition of Care** section to ensure the Medication Reconciliation that was done will count towards the Meaningful Use objective. Then click **OK** to save the Clinical Encounter.

To record a Medication Reconciliation through a Dot code in a progress note:

You can use the .MRC Dot code to document medication reconciliation actions within a progress note. The format for the .MRC Dot code is:

.MRC: Operator ID : Date : Time : Practice ID : Encounter Code

For example:

.MRC: ABC : 10/01/2010 : 10:00AM : 123 : 18

You can add the **Encounter Code** to link the Medication Reconciliation action to an existing clinical encounter for Meaningful Use reporting. To access a patient's Clinical Encounters, **Open** their chart and then select Show > **Clinical Encounters**. Select an appropriate Clinical Encounter and click **Edit** to display the Encounter details, including the Encounter Code.

The screenshot shows a dialog box titled "Clinical Encounter <Edit>: Test, Patient". The "Encounter Number" field is highlighted with a red box and contains the value "18". Below this are fields for "Date" (11/9/2010), "Time" (12:25 PM), "Type" (Transfer of Care), "Provider" (BRD), and "Practice" (1). The "Transition of Care" section has three radio buttons: "Inbound" (selected), "Outbound", and "Neither". There are checkboxes for "Relevant For Medication Reconciliation" (checked), "Summary of Care Record Provided for Care Coordination", and "Provided to Patient" (Printed Clinical Summary, Electronic Clinical Summary, Patient-Specific Education Materials). Buttons for "OK", "Cancel", and "Help" are at the bottom.

Clinical Encounter <Edit> screen

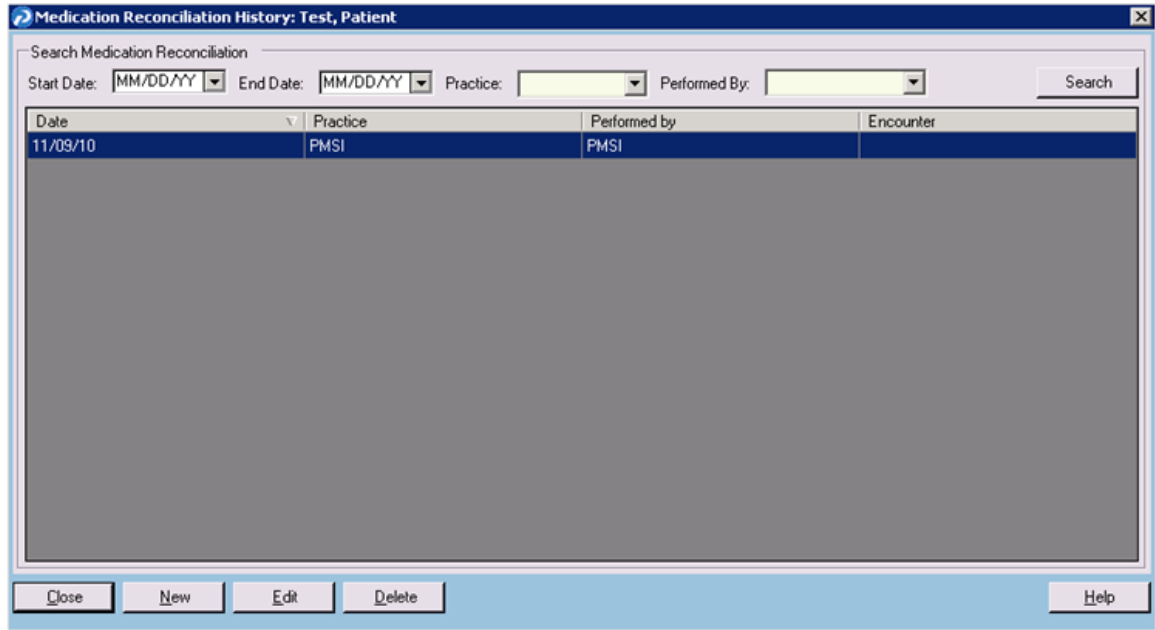
If an encounter code is not specified the system will try to match an existing Clinical Encounter that has the same date as the medication reconciliation action. If there is more than one Clinical Encounter with the same date, the system will match by operator ID.

The Operator ID field is the only field required in order for this Dot code to function. The remaining fields will default to the progress note's date and time and the current practice ID (if available). If an Encounter Code was entered, the practice ID will default to the practice ID for the matching Clinical Encounter.

The medication reconciliation record will include the operator and practice who performed the action and the date/time the action was performed (using the hh:mm am/pm and mm/dd/yy format).

To review a patient’s Medication Reconciliation history:

1. Open the patient’s chart.
2. Do one of the following:
 - Click Show > **Medication Rec. History**.
 - Open the patient’s **Rx/Medications** chart tab, click the **Med Rec** button, and select **View History**.



Medication Reconciliation History screen

The **Medication Reconciliation History** list can be filtered using the options at the top of the screen. Individual medication reconciliation events can be added, edited, or deleted using the buttons at the bottom of the screen.

Menu Objective 8 – Summary of Care Record

Objective:

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

Description:

When transferring or referring the care of a patient to another practice, a Medical Summary can be created that includes, at a minimum, problems, medications, allergies, and laboratory test results. The summary file can be printed or created electronically. Electronic summaries are created in either CCR (Continuity of Care Record) or CCD (Continuity of Care Document) format and an EHR capable of importing CCR or CCD documents would be able to load the patient's clinical data into their EHR.

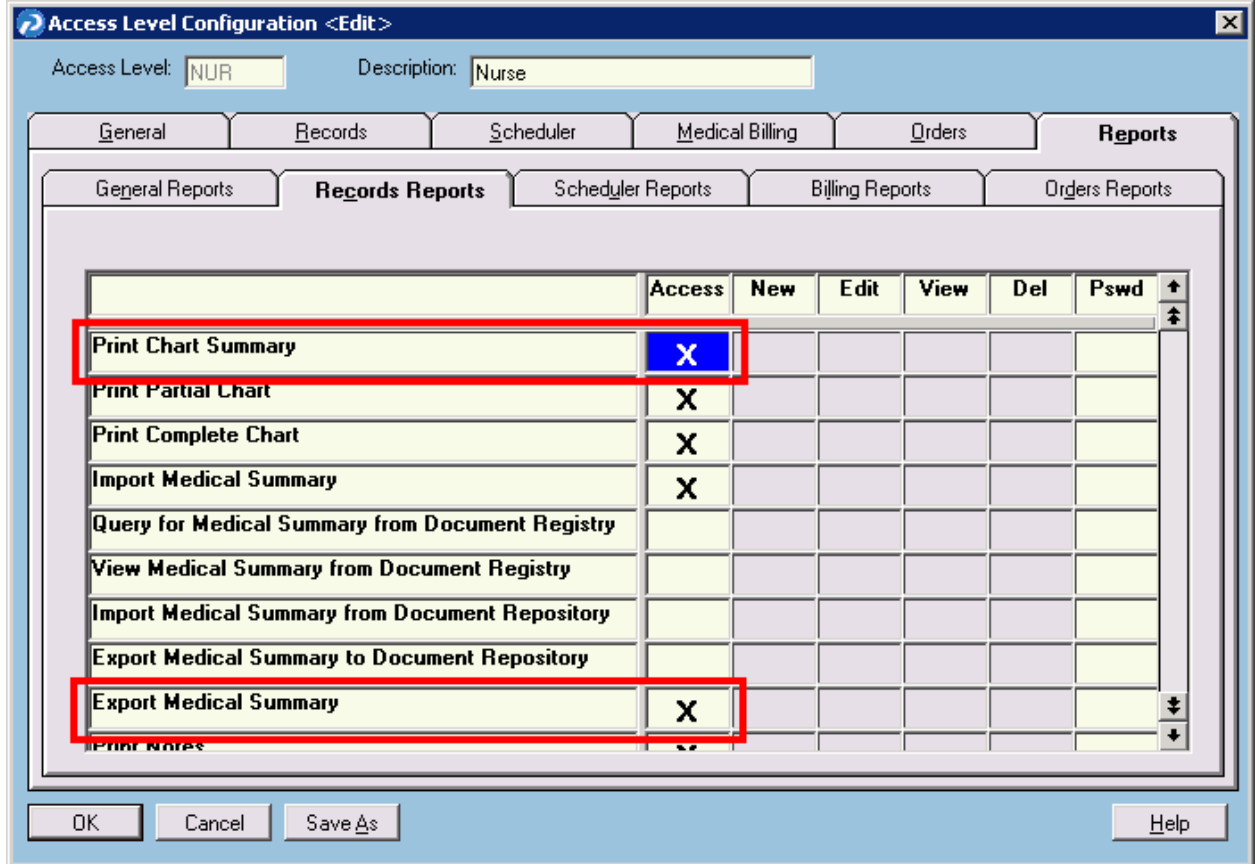
Configuration:

If Summary of Care records will be printed rather than generated electronically, the Chart Summary report is used. You'll need to ensure all appropriate users are associated with Access Levels that allow for the printing of the Chart Summary report.

If Summary of Care records will be generated electronically, users who will generate them must be associated with an Access Level that allows for CCR/CCD creation.

To turn on the Access Level settings necessary to print a Chart Summary report or export CCR/CCD data:

1. Select Maintenance > Set-Up > **Access Levels**.
2. Enter your EHR password.
3. Choose an Access Level associated with operators that will need to be able to print a Chart Summary report or export CCR/CCD data, and click the **Edit** button.
4. Click on the **Reports** tab, and then click the **Records Reports** sub-tab.
5. Click the **Access** boxes next to **Print Chart Summary** and/or **Export Medical Summary**.



Access Level Configuration <Edit> screen

6. Click **OK** to save the changes.
7. Repeat these steps for all appropriate Access Levels.

If Summary of Care records provided as part of a referral will be tracked through the Order Entry module, all Order Names used to order a referral must be assigned an Order Type that Practice Partner will recognize as a “referral” type.

To set up a referral order type:

1. Select Maintenance > Templates > Order Templates > **Order Types**
2. Click **New**
3. Enter a name for the referral order type. All other fields are options and can be entered if desired
4. Click **OK** to save the order type

This order type must be associated with all Order Names used for ordering a referral.

To assign the referral order type to an Order Name:

1. Select Maintenance > Templates > Order Templates > **Order Names**
2. Locate an order name used to order a referral, select it, and click **Edit**

3. Click the **Order Type** dropdown button and select the referral order type previously set up
4. Click **OK** to save the change
5. Repeat this process for all order names used for ordering referrals

Once the referral order type has been created and associated with all order names used for ordering referrals, a setting in the PPART.INI file must be reviewed or updated to ensure it contains the referral order type name.

To enter the referral order type name in the PPART.INI file:

1. Edit the PPART.INI file, found in the database directory (typically PPART), with Notepad, WordPad, or a similar text editor
2. Search for the setting **OrderTypeReferrals=**
3. After the equal sign, enter the name of the referral order type created in Practice Partner
4. Save the PPART.INI file

Configuration Notes:

- The Chart Summary report layout and contents cannot be modified.
- The CCR and CCD export formats cannot be modified.

End User Training:

There are two methods for documenting a Summary of Care record was provided for care coordination, and each method is reported separately in the EHR Performance Metrics Report.

Documenting a Summary of Care record was provided for a Transition of Care

If a Summary of Care document is provided to another practice for purposes of transitioning a patient's care, a Clinical Encounter noted as an **Outbound** transfer of care must be created and the **Summary of Care Record Provided for Care Coordination** check box must be checked. If you print a Chart Summary report, or export a Medical Summary, you will be prompted to create such a Clinical Encounter if an appropriate Encounter does not already exist.

Clinical Encounter <Edit> screen

To print a Chart Summary report:

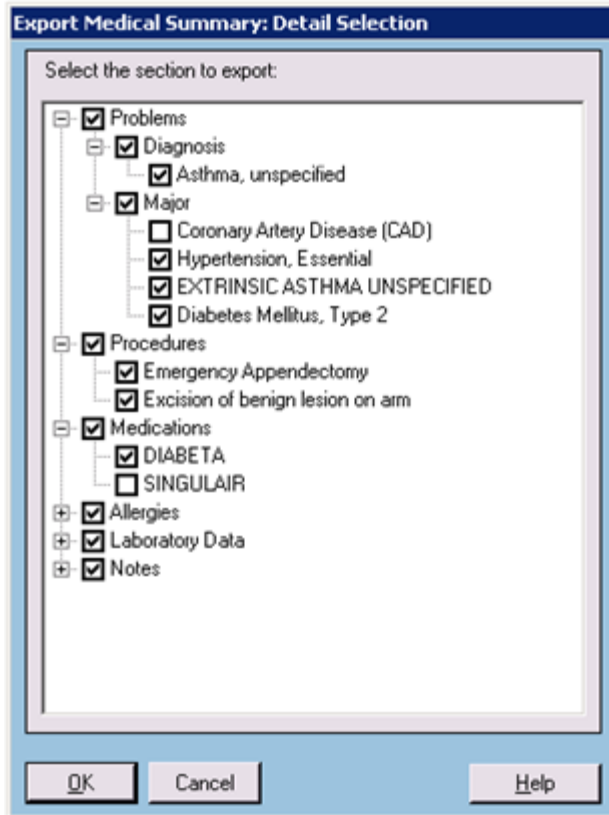
1. Select Reports > Patient Records > **Print Chart Summary**.
2. Leave the **Single Patient** radio button selected. Do not select the **Print first page data only** or **Limit first page data** options, as they may suppress the printing of clinical data required to be contained on the Summary. If your Patient Records system is configured to allow faxing from within the application and you wish to fax the Summary, click the **Fax** check box. If you wish to print the Summary to file, click the **Print to file** check box. Click **OK** when you've finished choosing your Chart Summary options.
3. If you chose to print the Summary to file, you will need to select a format and enter a name for the file.
4. Look up the appropriate patient and select them.
5. If the Clinical Encounter Not Found screen displays, the patient does not have an outbound transfer of care Clinical Encounter to link the summary to. Leave the **Yes** radio button

selected to create an outbound transfer of care Clinical Encounter. Ensure the **Provider ID** and **Practice** fields contain the appropriate values. Click **OK** when you are finished with the Clinical Encounter Not Found screen.

6. Indicate if you wish to print any images associated with the most recent progress note that will print as part of the Summary.
7. If you chose to fax the Summary, a Fax to box will display, allowing you to indicate who the Summary is being faxed to. See the *Fax To screen* topic in the Patient Records Help for additional information regarding faxing from within the application.

To export a CCD summary file that can be loaded into another EHR that is capable of importing CCD data:

1. Select Reports > Patient Records > **Export Medical Summary**.
2. Choose a purpose for the Summary from the **Purpose** drop-down list.
3. Click the **CCD** radio button.
4. Enter a date range if desired. If no dates are entered, all data for the patient will be exported.
5. Click **OK**.
6. Look up the appropriate patient and select them.
7. If the Clinical Encounter Not Found screen displays, the patient does not have an outbound transfer of care Clinical Encounter to link the summary to. Leave the **Yes** radio button selected to create an outbound transfer of care Clinical Encounter. Ensure the **Provider ID** and **Practice** fields contain the appropriate values. Click **OK** when you are finished with the Clinical Encounter Not Found screen.
8. In the **Save As** box, select a network location where the file will be created, and enter a name for the file.
9. On the Export Medical Summary: Detail Selection screen, review the data to be exported and uncheck any data types or individual data elements you do not wish to include in the Summary. You can expand data types to see individual data elements by clicking on the **+** symbols to the left of the data type name.



Export Medical Summary: Detail Selection screen

10. Click **OK** when you've finished reviewing or updating the data to be exported.
11. Click **OK** to close the confirmation screen that will display.

Documenting a Summary of Care record was provided as part of a referral

If a Summary of Care document is provided to another practice for purposes of referring a patient, you can document this through the Order Entry module.

To indicate a Summary of Care document was provided as part of a patient referral through Order Entry:

1. Through the **Orders** chart tab, or the **Orders** button on the toolbar, create a new order
2. From the order tree, or through the **Lookup** button, select a referral order
3. A **Summary of Care Record Provided** checkbox will display on the order screen. Check the box if a Summary of Care record was provided as part of the referral
4. Complete the order as normal
5. Generate the Summary of Care record by printing a Chart Summary or generating a CCD or CCR. On the **Clinical Encounter Not Found** prompt that displays, click **No** to ensure you do not create the clinical encounter. Clicking **Yes** would result in the Summary of Care record being documented as having been given twice.

End User Notes:

- It is left to the discretion of each practice to determine how to best provide an exported CCR or CCD file to another practice.
- The format and contents of a printed Chart Summary report cannot be modified

Menu Objective 9 - Submit to Immunization Registries

Description:

Attest to the capability of submitting electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.

Exception:

There is an exclusion if none of the immunization registries to which the eligible provider submits such information have the capacity to receive the information electronically.

Submission to immunization registries requires PPConnect for Immunizations, which allows you to extract and export immunization information. Please see the *PPConnect: Immunizations Installation Guide* and the *PPConnect: Immunizations Users Guide* for details.

PPConnect for Immunizations is currently available only for these four state registries: Washington, Georgia, Florida, and New York.

Configuration:

Health Maintenance Names:

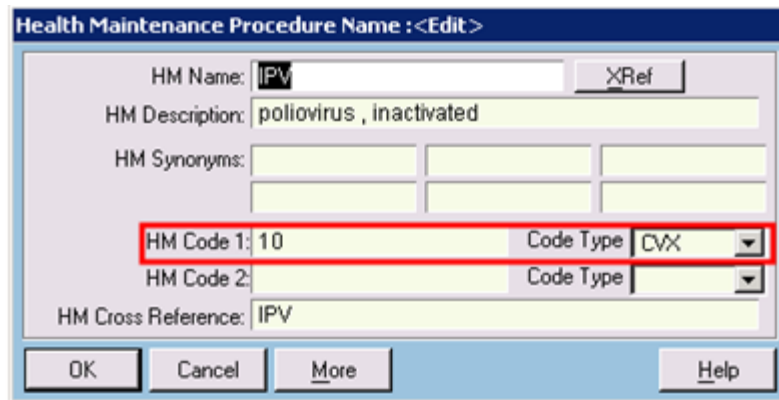
Immunizations are tracked in the Health Maintenance section. New to 9.5 is the ability to add universal immunization identifier (CVX) codes. CVX codes need to be entered on all immunizations that are intended to be sent through to an immunization registry.

A list of CVX codes can be found at:

<http://www2a.cdc.gov/nip/IIS/IISStandards/vaccines.asp?rpt=cvx>

To access Health Maintenance names:

1. Select Maintenance > Templates > **Health Maintenance Names**.
2. Select an Immunization Health Maintenance Name and click the **Edit** button.
3. Select **CVX** from the **Code Type** drop-down list.
4. In the **HM Code 1** field enter the corresponding CVX code (example below).
5. Click the **More** button to enter additional default immunization specific information like dose, lot number, etc. (for example, IM if the immunization is always given with an IM injection).
6. Click **OK** to save the changes.



The screenshot shows a dialog box titled "Health Maintenance Procedure Name : <Edit>". It contains the following fields and controls:

- HM Name: IPV (with an XRef button)
- HM Description: poliovirus , inactivated
- HM Synonyms: (empty text boxes)
- HM Code 1: 10 (highlighted with a red box) and Code Type: CVX (dropdown menu)
- HM Code 2: (empty) and Code Type: (dropdown menu)
- HM Cross Reference: IPV
- Buttons: OK, Cancel, More, Help

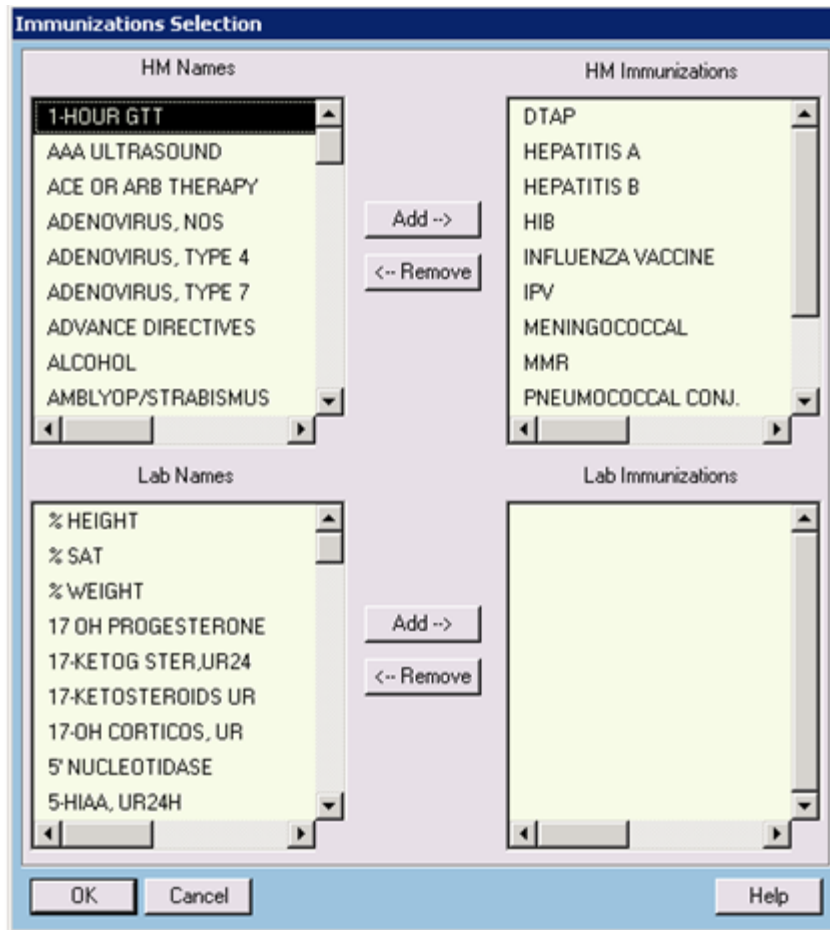
Health Maintenance Procedure Name: <Edit> screen

Editing the Immunization Report

In order to define a Health Maintenance immunization users need to use the Immunization Form Maintenance.

To define a Health Maintenance immunization:

1. Select Maintenance > Templates > Form Templates > **Immunization Form**.
2. Select the **HM Name** on the left and add it to the right in order for it to be considered an immunization. (shown below)
3. Click **OK** to close.



Immunizations Selection screen

Entering Immunization Information in Health Maintenance

To enter a patient's Immunization information:

1. Open a patient's chart.
2. Click on the **Health Maintenance** tab.
3. Click the **New** button.
4. Enter the date of the Immunization.
5. Find the procedure in the list and type **X** (for done within the organization) or an **E** (if it was done outside the organization).
6. Click the **More** button to enter additional information.
7. In the More section of the screen you can enter the **Dose**, **Route**, **Lot number**, and **Manufacturer**.
8. Click **OK** to save Immunization information.

Health Maintenance Procedure <New>: Test, Little Girl

Date: 11/01/2010 Time: 01:55 PM

HM Procedure	Status	Comment
DTaP	X	
Height		
Influenza vaccine		
IPV		
MMR		
Passive Smoking		
Varicella		

DTaP comments:

OK Cancel Less Help

DTaP More Data:

Dose: [] Route: [] Given By: []

Dose Number: [] Location: [] Facility: []

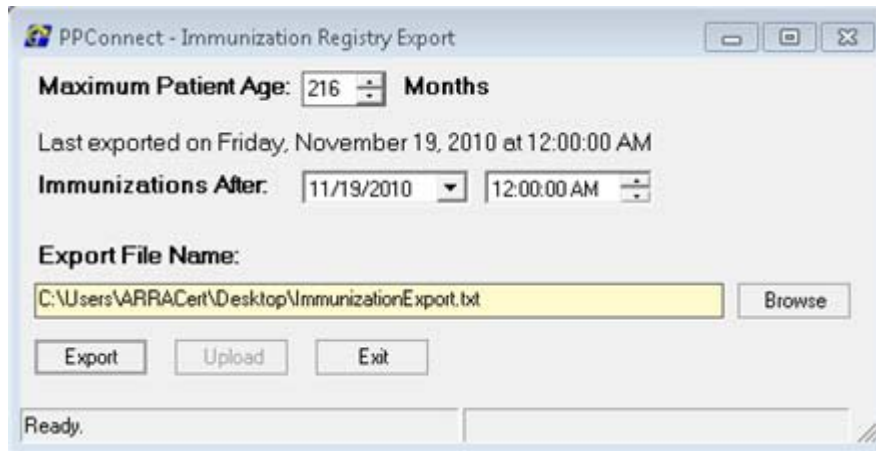
Lot: [] Exp. Date: mm/dd/yyyy

Manufacturer: [] Device: [] VFC Status: []

Health Maintenance Procedure <New> screen

To send Immunizations to the registry:

1. Open PPCConnect through your existing workflow.
2. Click the **Browse** button to the proper PPART export file.
3. Click the **Export** button to transmit the immunization records to the registry.



PPCConnect – Immunization Registry Export screen

Menu Objective 10 – Submit Electronic Syndromic Surveillance Data to Public Health Agencies

Objective:

Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

Description:

Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible provider submits such information have the capacity to receive the information electronically).

Configuration:

No configuration is required for this objective.

Configuration Notes:

None

End User Training:

To access this report through Patient Records:

- Select Reports > **Public Health Agency Surveillance**.

Enter the appropriate data (as depicted below) using the following steps:

1. Select the appropriate date ranges for which you want to run the report.
2. Click the **Load File** button or the **Lookup** button to load the appropriate diagnosis codes for which you would like to run the report.
See the *End User Notes* section below for a description of the **Load File** button.
3. Click the **Browse** button to select a file location or use the default of ppart\Interface\Reporting\Output\SyndromicSurveillance_YYYYMMDD.h17
4. Click **OK** to process and run the file.

Report Syndromic Surveillance

Diagnosis Date Range:
 From: 08/01/2011 To: 11/01/2011

Diagnoses:

Code	Description
488	AVIAN INFLUENZA

Location for Syndromic Surveillance Report:
 P:\ppart\Interface\Reporting\Output\SyndromicSurveillance\Syndr
 Browse

OK Cancel Help

Report Syndromic Surveillance screen

- Submit the file to the appropriate accepting agency.

End User Notes:

- Click the **Load File** button to select codes from a plain text list stored on your workstation. The Load Diagnosis File screen appears. Enter (or browse to) the file that you want to use to generate the report. Once selected, the list of ICD codes in the file will display in the Diagnoses list.
- If no codes are selected a warning will display:
"No diagnosis codes have been selected. This will generate a report of all active patients. Generation of this report may take a long time. Do you wish to continue?"
 Click **Yes** to generate the report, or click **No** to return to the report screen
- The report is a text message that conforms to the HL7 standard. This message needs to be transmitted to the public health agency.
- You may use the **Remove** button to remove any diagnosis codes from the list.

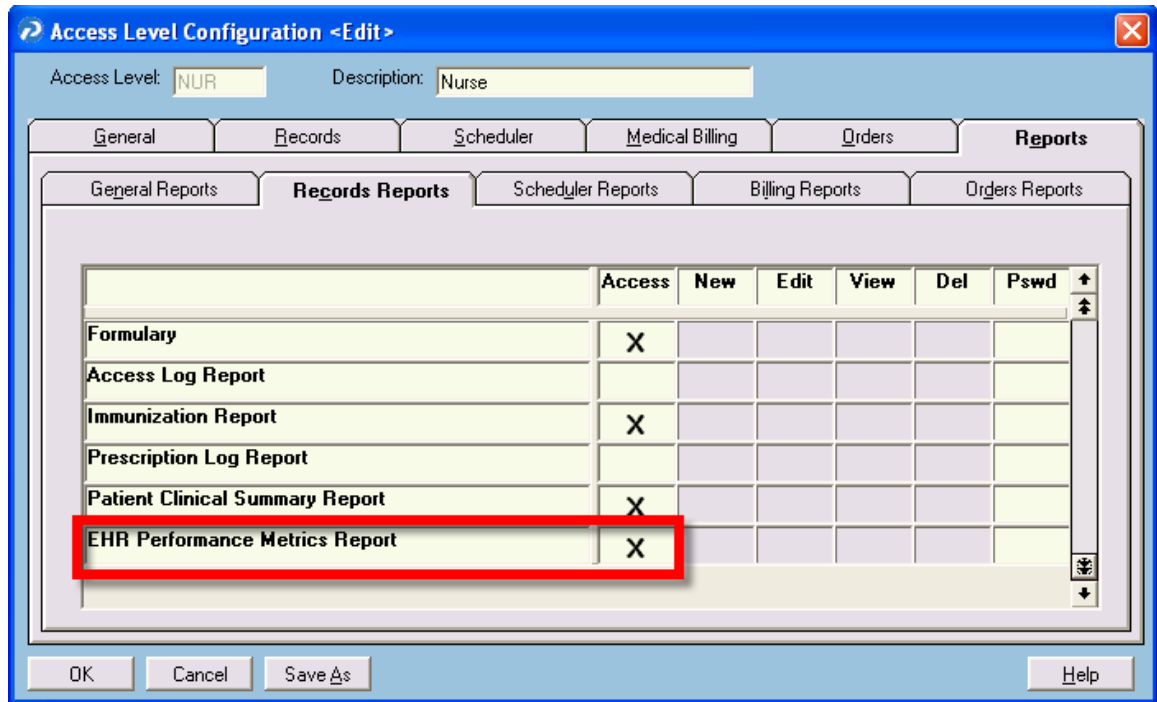
EHR Performance Metrics Report

The EHR Performance Metrics report was created to help eligible professionals (EP), hospitals, and critical access hospitals with their responses to particular measures required to qualify for meaningful use incentive payments.

Configuration:

To turn on the Access Level settings necessary to print a EHR Performance Metrics Report:

1. Select Maintenance > Set-Up > **Access Levels**.
2. Enter your EHR password.
3. Choose an Access Level associated with operators that will need to be able to print a Performance Metrics report and click the **Edit** button.
4. Click on the **Reports** tab, and then click the **Records Reports** sub-tab.
5. Click the **Access** box next to **EHR Performance Metrics Report**.



Access Level Configuration <Edit> screen

End User Training:

To run the EHR Performance Metrics report:

1. Navigate to the Practice Partner client folder (typically this is the Program Files > McKesson > Practice Partner folder) and double-click on the **PMSI.Reports.PerformanceMetrics.exe**. The EHR Performance Metrics Sign In screen appears.
2. Type your Practice Partner **User ID** and **Password**, and then click **OK**. The EHR Performance Metrics Report screen appears.

EHR Performance Metrics screen

3. In the **Provider To Report On** section of the screen, do one of the following:
 - a. Select the **All Providers** radio button to run the report for all providers.
 - b. Select the **Providers Affiliated with Practice** radio button to run the report for all providers affiliated with a specific practice. You can enter the Practice ID in the provided field, or select the practice from the drop-down list.
 - c. Select the **Specific Provider** radio button to run the report for a specific provider. You can enter the provider's ID in the provided field, or click the drop-down arrow and select the provider from the Provider Select screen.
4. Type the dates for which you want to run the report for in the **Report From Date** and **Report To** Date fields, or click the drop-down arrow to select the dates from the calendar.
5. In the **Report Options** section of the screen, select the appropriate check boxes for the measures you want to include in the report. To select the check boxes, click the box which will then display a check mark in the box. Use the **Check All** and **Uncheck All** buttons to select or deselect all measures.
6. If you want to print the report to a file, select the **Print to File** check box. The file will be generated as an Adobe Acrobat PDF (.pdf) file.
7. Click the **Run Report** button to generate the EHR Performance Metrics Report.
8. Once the report has been generated, the report is displayed in the Report Viewer.
9. To print the report from the Report Viewer click the **Print** button on the toolbar. The Print window appears. Select a printer and then click the **OK** button. The report is printed.
10. If you selected the **Print to File** check box, the Directory Path for Export Files screen appears. Navigate to the location in which you want to save the report. Then click **Save** to generate the report. Patient Records saves the report to the specified file. The name of the report is EHR Performance Metrics Report mmddyyyy_hhmmss. Where mmddyyyy is the date the report was generated and hhmmss is the time stamp. For example:
EHR Performance Metrics Report 10052010_105205.

End User Notes:

- There are two Performance Metrics reports, **Summary of care record provided for transitions of care** and **Summary of care record provided for referrals**, that both apply to the Menu 8 – Summary of Care objective. The performance metric for the **Summary of care record provided for transitions of care** report is generated through Clinical Encounters that have a type of “Transition of Care” and are marked as an “Outbound” transition of care. The performance metric for the **Summary of care record provided for referrals** report is generated through orders that have an order type that matches the **OrderTypeReferrals** setting in the PPART.INI file. If both methods are used to document the providing of summaries of care, the numerators and denominators for these reports should be added together to get the total numerator and denominator counts.