Meaningful Use Measures:

Quick Reference Guide Stage 1 (2014 and Beyond)

Core Measures

Required: All 13 objectives

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
1. Computerized Provider Order Entry (CPOE)	More than 30% of medication orders created by the EP during the EHR reporting period are recorded using CPOE.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	Documenting medications through the Medication button	Add Medication button to your template(s).	☐
2. Drug Interaction Checks	The EP has enabled this functionality for the entire EHR reporting period.	None	Enabling interaction checks by going to Edit > Preferences > Prescription	Check Drug Interaction setting under each provider's login.	☐
3. Maintain Problem List	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	None	Documenting diagnoses through a Diagnosis checklist in a chart note, with applicable SNOMED codes attached	Add Diagnosis button to your template(s). Link SNOMED codes to all commonly used diagnoses.	☐
4. Generate and Transmit Permissible Prescriptions Electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using CEHRT.	Any EP who: (1) Writes fewer than 100 prescriptions during the EHR reporting period; or (2) Does not have a pharmacy within their organization and there is no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of the EHR reporting period.	Documenting medications through the Medication button and selecting the Transmission of "E-Prescribe" Note: You do not need an office code in the note for it to count as a permissible script. You could add the prescription via the Facesheet or through a chart note and Clinical will consider it 'permissible'.	Add Medication button to your template(s). If not yet e-prescribing, enroll at: www.sticomputer.com > Customers > ChartMaker Clinical > Surescripts Enrollment or http://tinyurl.com/lp56ewb	☐
5. Maintain Active Medication List	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	None	Documenting medications through the Medication button Note: If a patient is not taking any medications, "No Active Medications" should be documented using the Medication button.	Add Medication button to your template(s).	☐
6. Maintain Active Medication Allergy List	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	None	Documenting allergies through the Allergies button in a chart note	Add Allergy button to your template(s).	☐
7. Record Demographics	More than 50% of all unique patients seen by the EP have demographics (Preferred language, Gender, Race, Ethnicity and Date of birth) recorded as structured data.	None	Documenting applicable fields in Practice Manager (Patient tab) or in Clinical (ID tab)	(Optional) Set applicable fields as "required" in Practice Manager if desired. Go to Administration > Preferences > Screen Config > Patient.	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
8. Record Vital Signs	More than 50% of all unique patients seen by the EP have BP (for patients age 3+ only) and height/length and weight (for all ages) recorded as structured data.	Any EP who: (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	Documenting applicable vitals using the Vitals button in a chart note	Add Vitals button to your template(s). (Optional) For practices seeing patients age 3-20, setup Growth Charts. Call Clinical Support for assistance.	☐
9. Smoking Status	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Any EP who sees no patients 13 years or older.	Documenting smoking status ("Smoking History" and "Smoking Status") using the Smoking History button in a chart note	Add Smoking History button to your template(s). (Optional) Add section on Face Sheet to display last date documented.	☐
10. Clinical Decision Support Rule	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	None	Configuring 1 rule by going to Edit > System Tables > DSS Rule Builder	Create 1 Decision Support Rule in Clinical and mark as Active.	☐
11. View, Download and Transmit (Electronic Copy of Health Information)	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.	Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure, except for "Patient name" and "Provider's name" and office contact information.	- ChartMaker® PatientPortal usage (Authorize patient through PatientPortal button on Patient tab in Practice Manager) - Note signing within 4 business days - Attaching SNOMED codes to applicable Diagnoses	Enroll with STI PatientPortal (Log into www.sticomputer.com through the "Customer" link and then click PatientPortal). Enter the patient's Email address in Practice Manager on the Patient tab or in Clinical on the ID tab.	☐
12. Clinical Summaries	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.	Any EP who has no office visits during the EHR reporting period.	Using the "Export" button or Chart > Export Patient Data in Clinical Or Using the "Print Clinical Summary" option in Practice Manager Notes: A valid CPT code must be selected in the office note. Electronic lab results that arrive 24 hrs before or after the visit will be included. You will receive credit for generating the Clinical Summary for registered PatientPortal users without physically printing it as long as the progress note is signed within 3 business days.	Nothing to setup. (Optional) The option to exclude information on a Clinical Summary can be configured through Chart > Export > Patient Data.	☐
13. Protect Electronic Health Information	Conduct or review a security risk analysis in accordance with the requirements and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	None	This is not completed through the EMR.	Create a manual documenting the process your practice takes to secure patient data. Request STI or your IT Vendor conduct a Security Risk Analysis.	☐

Menu Set Measures

Required: 5 out of 9 objectives with one being a public health measure (#8 or #9)

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
1. Drug Formulary Checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire reporting period.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	Doing nothing. This functionality is turned on by default.	Nothing to setup.	☐
2. Clinical Lab Test Results	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in CEHRT.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.	- Documenting labs ordered in a chart note using a Procedure Checklist - Tracking incoming lab results using the Orders functionality (Status = "Completed" or "Reviewed") - Incorporating an electronic lab interface (if applicable) or manual entry of lab results	Configure lab procedures through Edit > System Tables > Conditions > Procedures ("Type" set to Lab; "Track Order" checked and "In-house" checked if applicable). Add Procedure Checklist(s) for documenting lab orders to your template(s). Map LOINC codes if manually entering lab results. (Optional) Sign up for an electronic lab interface and/or create a template for documenting lab results.	☐
3. Patient List	Generate at least one report listing patients of the EP with a specific condition.	None	Generating a list by going to Reports > Reports during your reporting period	Nothing to setup.	☐
4. Patient Reminders	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.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using the CEHRT.	- Using Recall button in Clinical or Practice Manager - Generating Letters from Practice Manager and/or updating the Reminder Method field on the Recall	Create a Recall Letter in Practice Manager to use during the reporting period. Add Recall button to Clinical template if provider intends to enter/view Recalls through the chart.	☐
5. Patient-Specific Education Resources	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.	None	Documenting educational materials given through the Education Materials button in a chart note	Setup handouts in Clinical by going to Edit > System Tables > Educational Materials.	☐
6. Medication Reconciliation	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	An EP who was not the recipient of any transitions of care during the EHR reporting period.	Documenting that reconciliation was performed through the Medication Reconciliation button in a chart note	Add Medication Reconciliation button to your template(s).	☐
7. Transition of Care Summary	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.	- Using the Referral button in a chart note - Attaching SNOMED codes to applicable information - Producing the Transition of Care Summary (printed and/or electronic) by going to Chart > Export Patient Data	Add Referral button to your template(s). (Optional) Enroll for a Direct Messaging address on sticomputer.com > Customers > ChartMaker Clinical > Surescripts	☐
8. Immunization Registries Data Submission	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	An EP who administers no immunizations during the EHR reporting period, where no immunization registry has the capacity to receive the information electronically, or where it is prohibited.	Registering with your state immunization registry and sending a test file. Note: Generating an immunization test file is completed from within Practice Manager.	Install PC Vaccine module (call Clinical Support for assistance). Add Procedure Checklist(s) for documenting immunization information to your template(s).	☐

Objective:	Requirement:	Exclusions:	Accomplish in Clinical by…	Setup to be Completed…	Setup Done
9. Syndromic Surveillance Data Submission	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 EP submits such information has the capacity to receive the information electronically – exclusion criteria)	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or if it is prohibited.	- Documenting the CDC Status field on the Diagnosis dialog - Registering with your state syndromic surveillance registry (if in existence) and submitting Syndromic Surveillance data - Generating syndromic surveillance batch information by going to Chart > Export > Public Surveillance Data	Add Diagnosis button to your template(s). Register with your state's registry.	☐

Additional Suggestions:

- ☐ Sign up for free STI University webinars on Meaningful Use Stage 1 – 2014 (on sticomputer.com)
- ☐ Sign up for free STI University webinars on PatientPortal and Patient Engagement
  - ☐ Collect email addresses for each patient (entered in Practice Manager on the Patient tab or Clinical on the ID tab)
  - ☐ Create in-house strategies for patient engagement/PatientPortal use
- ☐ Watch free videos available on STI website

  (Login by going to Customers and then clicking STI University > Videos)
- ☐ Save configurations for each provider in the Meaningful Use Dashboard

  (To facilitate running your statistics on a regular basis)
- ☐ Print and save a copy of your Dashboard statistics when collecting final numbers for attestation

  (To be kept in case of an audit.)

Clinical Quality Measures

Required: 9 out of 64 objectives, covering 3 of the 6 National Quality Strategy (NQS) Domains

To view a complete list of the 64 available CQMs, visit: http://tinyurl.com/nqd7orc

Listed below are the CQMs that ChartMaker® Clinical is currently certified for. You must select your 9 CQMs from this list:

NQF DOMAIN:	Efficient Use of Healthcare Resources
Measure Title	**NQF**
Appropriate Testing for Children with Pharyngitis	0002
Use of Imaging Studies for Low Back Pain	0052
Appropriate Treatment for Children with Upper Respiratory Infection (URI)*	0069

NQF DOMAIN:	Clinical Process / Effectiveness
Measure Title	**NQF**
Controlling High Blood Pressure	0018
Breast Cancer Screening*	0031
Cervical Cancer Screening	0032
Colorectal Cancer Screening	0034
Use of Appropriate Medications for Asthma*	0036
Pneumonia Vaccination Status for Older Adults*	0043
Diabetes: Eye Exam*	0055
Diabetes: Foot Exam*	0056
Diabetes: Hemoglobin A1c Poor Control*	0059
Hemoglobin A1c Test for Pediatric Patients*	0060
Diabetes: Urine Protein Screening*	0062
Diabetes: Low Density Lipoprotein (LDL) Management & Control*	0064
Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control*	0075
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*	0081
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*	0083
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy*	0088
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication*	0108
HIV/AIDS: Medical Visit	0403
Children Who Have Dental Decay or Cavities	NULL
Hypertension: Improvement in Blood Pressure*	NULL

NQF DOMAIN:	Patient Safety
Measure Title	**NQF**
Use of High-Risk Medications in the Elderly	0022
Documentation of Current Medications in the Medical Record*	0419

NQF DOMAIN:	Population / Public Health
Measure Title	**NQF**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*	0028
Chlamydia Screening for Women*	0033
Preventive Care and Screening: Influenza*	0041
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*	0421

NQF DOMAIN:	Patient and Family Engagement
Measure Title	**NQF**
Functional Status Assessment for Complex Chronic Conditions*	NULL

NQF DOMAIN:	Care Coordination
Measure Title	**NQF**
Closing the Referral Loop: Receipt of Specialist Report	NULL

* SNOMED codes may be required to be linked in order to meet the requirements of this measure. For details, see our Meaningful Use User Manual.