Stage 1

Meaningful Use
2014 Edition
User Manual

IMPORTANT: The Meaningful Use Dashboard provides statistical information for aiding healthcare providers in meeting Meaningful Use Objectives. Healthcare providers are cautioned that the denominators shown on the Meaningful Use Dashboard are based solely on information entered into the ChartMaker® Clinical Module. If a patient encounter was not entered into the Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Dashboard. In order to get accurate statistical information for the percentage calculation, to determine if you meet the Meaningful Use requirements, you may need to run additional reports. Please refer to the Center for Medicare and Medicaid Services (CMS) and this user manual for more information about calculating the correct percentage for each individual Meaningful Use Objective.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms
http://www.sticomputer.com/sticustomers.php

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Overview

Meaningful Use

The Medicare and Medicaid EHR Incentive Programs provide a financial incentive for the Meaningful Use of certified EHR technology to achieve health and efficiency goals. By implementing and meaningfully using an EHR system, providers will reap benefits beyond financial incentives – such as reduction in errors, availability of records and data, reminders and alerts, clinical decision support, and e-prescribing/refill automation.

WHAT IS MEANINGFUL USE

The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

The criteria for Meaningful Use will be staged in three steps over the course of five years.

- Stage 1 (2011 - 2014) sets the baseline for electronic data capture and information sharing.
- Stage 2 (implemented in 2014) and Stage 3 (expected to be implemented in 2017) will continue to expand on this baseline and be developed through future rule making.

To qualify for incentive payments, Meaningful Use requirements must be met in the following ways:

- Medicare EHR Incentive Program – Eligible Professionals (EPs), Eligible Hospitals (EHs), and Critical Access Hospitals (CAHs) must successfully demonstrate Meaningful Use of certified electronic health record technology every year they participate in the program.
- Medicaid EHR Incentive Program – Eligible Professionals and eligible hospitals may qualify for incentive payments if they adopt, implement, upgrade, or demonstrate Meaningful Use in their first year of participation. They must successfully demonstrate Meaningful Use for subsequent participation years.

Clinical Quality Measures:
To successfully demonstrate Meaningful Use, EPs are also required to report clinical quality measures (CQMs) that are specific to the EP. Beginning in 2014, all providers must use EHR technology that has been certified to the 2014 standards and capabilities that contains new CQM criteria. Providers will report using the 2014 criteria regardless of whether they are in Stage 1 or Stage 2 of Meaningful Use. CQMs may be reported electronically, or via attestation.

- The EP must report on 9 out of 64 available CQMs

  NOTE: You will only be able to select CQMs that are certified for ChartMaker® Medical Suite.

- The CQMs selected must cover at least 3 of the 6 available National Quality Strategy (NQS) domains. The domains include:

  1. Patient and Family Engagement
  2. Patient Safety
  3. Care Coordination
  4. Population/Public Health
  5. Efficient Use of Healthcare Resources
  6. Clinical Process/Effectiveness

- CMS has identified two recommended core sets of CQMs—one for adults and one for children—that focus on high-priority health conditions and best-practices for care delivery. These core sets can be used or you can pick your own list of 9 CQMs.

The following is a list of CQMs that ChartMaker Medical Suite is currently certified for:

Measure Title	NQF	NQS Domain	Recommended Set
Appropriate Testing for Children with Pharyngitis	0002	Efficient Use of Healthcare Resources	Pediatric
Controlling High Blood Pressure	0018	Clinical Process / Effectiveness	Adult
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	0024	Population / Public Health	Pediatric
Breast Cancer Screening*	0031	Clinical Process / Effectiveness	N/A
Cervical Cancer Screening	0032	Clinical Process / Effectiveness	N/A
Colorectal Cancer Screening	0034	Clinical Process / Effectiveness	N/A
Use of Appropriate Medications for Asthma*	0036	Clinical Process / Effectiveness	Pediatric
Pneumonia Vaccination Status for Older Adults*	0043	Clinical Process / Effectiveness	N/A
Use of Imaging Studies for Low Back Pain	0052	Efficient Use of Healthcare Resources	Adult
Diabetes: Eye Exam*	0055	Clinical Process / Effectiveness	N/A
Diabetes: Hemoglobin A1c Poor Control*	0059	Clinical Process / Effectiveness	N/A
Diabetes: Low Density Lipoprotein (LDL) Management*	0064	Clinical Process / Effectiveness	N/A
Documentation of Current Medications in the Medical Record*	0419	Patient Safety	Adult
HIV/AIDS: Medical Visit	0403	Clinical Process / Effectiveness	N/A
Children Who Have Dental Decay or Cavities	NULL	Clinical Process / Effectiveness	Pediatric
Functional Status Assessment for Complex Chronic Conditions*	NULL	Patient and Family Engagement	Adult

* SNOMED codes may be required in order to meet the requirements of this measure.

NOTE: **Please reference the "Clinical Quality Measures in 2014" user manual for more detailed information on Clinical Quality Measures.**

WHO IS ELIGIBLE TO PARTICIPATE

To participate in the Medicare and Medicaid EHR Incentive Programs, healthcare providers must meet the eligibility criteria defined by law. Eligibility groups are listed below.

Eligibility for Individual Providers - Eligible Professionals:

- The incentive payments for EPs are based on individual providers.
- If you are part of a practice, each EP may qualify for an incentive payment if each EP successfully demonstrates Meaningful Use of certified EHR technology.
- Each EP is only eligible for one incentive payment per year, regardless of how many practices or locations at which he or she provide services.
- Hospital-based EPs are not eligible for incentive payments. An EP is considered hospital-based if 90% or more of his or her services are performed in a hospital inpatient (POS 21) or emergency room (POS 23) setting.

Medicare: Under the Medicare EHR Incentive Program, EPs include the following:

- Doctor of medicine or osteopathy.
- Doctor of dental surgery or dental medicine.
- Doctor of podiatry
- Doctor of optometry.
- Chiropractor.

Medicaid: Under the Medicaid EHR Incentive Program, EPs include the following:

- Physicians (primarily doctors of medicine and doctors of osteopathy).
- Nurse practitioner.
- Certified nurse-midwife.
- Dentist.
- Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an EP must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume.*
- Have a minimum 20% Medicaid patient volume, and is a pediatrician.*
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals.

* Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.

Eligibility for Both Programs:

EPs who are eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register. Before 2015, an EP may switch programs only once after the first incentive payment is initiated. Most EPs will maximize their incentive payments by participating in the Medicaid EHR Incentive Program if they meet the Medicaid patient volume requirements as listed above.

Participating in the EHR Incentive Program and Other Current CMS Incentive Programs:

The Medicare and Medicaid EHR Incentive Programs are new and separate programs from other active CMS incentive programs, such as the Physicians Quality Reporting System (PQRS) formerly known as PQRI and the MIPPA E-Prescribing Incentive Program.

IMPORTANT DATES

Date	
January 1, 2011	First possible reporting year begins for Eligible Professionals (EPs)
December 31st	End of the reporting period for EPs for the current year
February 28th at 11:59 pm	Attestation deadline for EPs for the previous program year
July 1, 2014	First possible day (for ChartMaker® Clinical users) to begin 90-day reporting period for CY 2014. Providers in their first year of the program must start on this day in order to avoid penalties in future years.
October 1, 2014	Last day for year 1 EPs to attest to avoid future penalties
October 3, 2014	Last day for EPs to begin 90-day reporting period for CY 2014
2014	▪ Last year to initiate participation and avoid penalty in the Medicare EHR Incentive Program ▪ First year to begin Stage 2
2015	Medicare payment adjustments and penalties begin for EPs that are not meaningful users of EHR technology.
2016	▪ Last year to receive a Medicare EHR Incentive Payment ▪ Last year to initiate participation in Medicaid EHR Incentive Program
2017	First year to begin Stage 3
2021	Last year to receive Medicaid EHR Incentive Payment

REPORTING PERIODS

First Payment Year	Requirements for Each Payment Year					
	2011	**2012**	**2013**	**2014***	**2015**	**2016**
2011	Stage 1 (90 days)	Stage 1 (365 days)	Stage 1 (365 days)	Stage 2 (90 days)	Stage 2 (365 days)	--
2012	--	Stage 1 (90 days)	Stage 1 (365 days)	Stage 2 (90 days)	Stage 2 (365 days)	Stage 2 (365 days)
2013	--	--	Stage 1 (90 days)	Stage 1 (90 days)	Stage 2 (365 days)	Stage 2 (365 days)
2014	--	--	--	Stage 1 (90 days)	Stage 1 (365 days)	Stage 2 (365 days)
2015	--	--	--	--	Stage 1 (90 days)	Stage 1 (365 days)
2016	--	--	--	--	--	Stage 1 (90 days)

*** NOTE**: All providers, regardless of Stage or program, will attest to a 90-day reporting period in 2014. Providers participating in the Medicare program who are beyond their first year will need to select their reporting period based on the quarter of the calendar year. Medicare Providers in their first year of the program or Providers in the Medicaid program can select any 90-days.

INCENTIVE PAYMENTS

Incentive payments for the Medicare EHR Incentive Program will be made approximately four to six weeks after an Eligible Professional (EP) successfully attests that they have demonstrated Meaningful Use of certified EHR technology. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments. Incentive payments will be held until the EP meets the $24,000 threshold in allowed charges.

Medicaid incentives will be paid by the States. The timing will vary according to State.

INCENTIVE SCHEDULE

Medicare:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
CY 2011	$18,000	------	------	------	
CY 2012	$12,000	$18,000	------	------	
CY 2013	$ 7,840*	$11,760*	$14,700*	------	
CY 2014	$ 3,920*	$ 7,840*	$11,760*	$11,760*	
CY 2015	$ 1,960*	$ 3,920*	$ 7,840*	$ 7,840*	
CY 2016	------	$ 1,960*	$ 3,920*	$ 3,920*	
TOTAL	$43,720	$43,480	$38,220	$23,520	

* **NOTE**: Medicare EHR incentive payments made are subject to the mandatory reductions in federal spending known as sequestration. This 2% reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. If the final day of the reporting period occurs before April 1, 2013, those incentive payments will not be subject to the reduction.

Medicaid:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250	------	------	------	------	------
CY 2012	$ 8,500	$21,250	------	------	------	------
CY 2013	$ 8,500	$ 8,500	$21,250	------	------	------
CY 2014	$ 8,500	$ 8,500	$ 8,500	$21,250	------	------
CY 2015	$ 8,500	$ 8,500	$ 8,500	$ 8,500	$21,250	------
CY 2016	$ 8,500	$ 8,500	$ 8,500	$ 8,500	$ 8,500	$21,250
CY 2017	------	$ 8,500	$ 8,500	$ 8,500	$ 8,500	$ 8,500
CY 2018	------	------	$ 8,500	$ 8,500	$ 8,500	$ 8,500
CY 2019	------	------	------	$ 8,500	$ 8,500	$ 8,500
CY 2020	------	------	------	------	$ 8,500	$ 8,500
CY 2021	------	------	------	------	------	$ 8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

NOTE: **If 2015 or beyond is your first year in the Meaningful Use program (Stage 1, Year 1), your Provider will not receive any incentive payments.** Starting in 2015, payment adjustments will be applied every year that your Provider is not a "meaningful user". A payment adjustment of 1% per year (up to 5%) will be applied to the Medicare physician fee schedule (PFS) amount for covered professional services furnished by the Provider during the year if Meaningful Use is not achieved. A payment adjustment for the current year is based on successful attestation in the Meaningful Use program 2 years prior.

EHR INFORMATION CENTER

CMS has created a helpdesk to answer any questions related to Meaningful Use. Their hours of operation are 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays. The number is 1-888-734-6433 (TTY users: 1-888-734-6563).

PREPARING FOR MEANINGFUL USE

There are certain steps that need to be taken outside of and within the ChartMaker Medical Suite before you will be ready to start collecting information for Meaningful Use. Below are steps that should be taken in order to prepare you for this transition.

1. Review the STI Meaningful Use Manual

2. Recommend your office designate a staff member to be responsible for the coordination of your office's Meaningful Use requirements.

3. Register for Meaningful Use (see instructions below)

4. Upgrade your ChartMaker Medical Suite software to the latest version (must be a version of 5.1 or higher)
   NOTE: The upgrade package and instructions can be found under Software Downloads at www.sticomputer.com after logging into the "Customers" section.

5. Decide which measures you would like to attest to
   NOTE: You must complete all 13 Core measures, 5/9 Menu Set measures and 9/64 Clinical Quality Measures.

6. Run the Code Mapper Utility
   NOTE: Instructions can be found under STI University > Videos at www.sticomputer.com after logging into the "Customers" section or in the ChartMaker Clinical Help Files.

7. Add the appropriate new tools to your templates
   NOTE: New or updated functionality includes the following buttons: Chief Complaint, Education Materials, Family History, Medication Reconciliation, Smoking History, Recall/Physician Reminder, Referral and Vital Signs. Instructions can be found under STI University > Videos at www.sticomputer.com after logging into the "Customers" section or in the ChartMaker Clinical Help Files.

8. Add the appropriate CPT codes to your template(s)
   NOTE: If you do not have the ability to modify your templates, you can select CPT codes in the note through the "Other" option or contact STI to receive a quote on custom template editing time. Instructions can be found under STI University > Videos at www.sticomputer.com after logging into the "Customers" section or in the ChartMaker Clinical Help Files.

9. Add the appropriate Diagnosis codes to your template(s)
   NOTE: If you do not have the ability to modify your templates, you can select Diagnosis codes in the note through the "Search/Add Diagnosis" option or contact STI to receive a quote on custom template editing time. Instructions can be found under STI University > Videos at www.sticomputer.com after logging into the "Customers" section or in the ChartMaker Clinical Help Files.

10. Enroll for and incorporate the STI ChartMaker PatientPortal
    NOTE: Registration can be completed online at www.sticomputer.com by clicking "Enrollments", and then "PatientPortal Enrollment". Complete the online form and an STI Representative will contact you to complete the setup process.

11. Enroll for e-prescribing (SureScripts) and a Direct Messaging address
    NOTE: Registration can be completed online at www.sticomputer.com by clicking "Enrollments", and then "SureScripts /Direct Messaging Enrollment Form". Complete the online form and an STI Representative will contact you to complete the setup process, if necessary.

REGISTRATION INSTRUCTIONS

Each Eligible Provider (EP) in your practice will need to register if they are interested in obtaining Meaningful Use.

The steps to register are as follows:

1. Verify and or register each EP on PECOS: https://pecos.cms.hhs.gov

2. Obtain your unique certification number by going to ONC's website: http://onc-chpl.force.com/ehrcert

   NOTE: Click "**2014 Edition**". Then search by **Product Name** (middle box) by entering "ChartMaker" and clicking "**Search**". Click "**Add to Cart**" for each version you used during your reporting period and complete the remaining steps to receive your Certification ID.

3. Register on CMS website for Meaningful Use: https://ehrincentives.cms.gov

   NOTE: From the Meaningful Use page of the Customer's section on our website: please reference one of the following PDFs:
   - 01/04/2011: Meaningful Use - Medicare EHR Incentive Program Registration Guide
   - 01/04/2011: Meaningful Use - Medicaid EHR Incentive Program Registration Guide

4. After completing your reporting period, return to CMS website (https://ehrincentives.cms.gov) and fill out your attestation.

   NOTE: If you did not fill in your unique certification number during step 3 of this process you will need to do so now, prior to completing the attestation process.

If you have any questions regarding the registration process, please contact CMS' EHR Information Center at 888-734-6433.

Core Measures

Required: 13 objectives
Exclusions: Per objective

1. Computerized Provider Order Entry (CPOE)
2. Drug Interaction Checks
3. Maintain Problem List
4. Generate and Transmit Permissible Prescriptions Electronically (eRx)
5. Maintain Active Medication List
6. Maintain Medication Allergy List
7. Record Demographics
8. Record Vital Signs
9. Record Smoking Status
10. Clinical Decision Support Rule
11. View, Download and Transmit (Electronic Copy of Health Information)
12. Clinical Summaries
13. Protect Electronic Health Information

Attestation Requirements:
In order to receive credit for the following measures, your office must go through the attestation process. Some of the measures only look at whether you are using the functionality (Yes / No) while others are determined by meeting a minimum threshold for that objective (Numerator / Denominator).

- Yes / No: EPs must attest "Yes" to having the functionality enabled for the length of the reporting period in order to meet the requirement.

- Numerator / Denominator: The Denominator is typically the number of unique patients seen by the EP during the EHR reporting period. The Numerator is the number of patients in the denominator that meet the requirement.

  NOTE: Several of the measures have exclusions for Numerator / Denominator. If a provider is excluded from that measure, there will be a note about what he/she will need to do for attestation.

IMPORTANT: The Meaningful Use Dashboard provides statistical information for aiding healthcare providers in meeting Meaningful Use Objectives. Healthcare providers are cautioned that the denominators shown on the Meaningful Use Dashboard are based solely on information entered into the ChartMaker® Clinical Module. If a patient encounter was not entered into the Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Dashboard. In order to get accurate statistical information for the percentage calculation, to determine if you meet the Meaningful Use requirements, you may need to run additional reports. Please refer to the Center for Medicare and Medicaid Services (CMS) and this user manual for more information about calculating the correct percentage for each individual Meaningful Use Objective.

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http://www.sticomputer.com/sticustomers.php

(1) COMPUTERIZED PROVIDER ORDER ENTRY (CPOE)

Objective:	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.
Measure:	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. Optional Alternate: More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
Exclusion:	Any EP who writes fewer than 100 prescriptions during the EHR reporting period
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.*
Numerator:	The number of patients in the denominator that have at least one medication order entered using CPOE.
Denominator:	Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period with an office encounter.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must enter patient medications through ChartMaker Clinical and document an office visit code in the same note.

> **NOTE**: Entering medications through the "Add Medication" functionality on the Face Sheet will not qualify for this measure.

To enter medications for a patient:

1. In an office visit note, click the "Medication" button (

)
2. Choose "Add Medication"
3. Search for and select the medication
4. Enter all appropriate fields and click "Next"

   > **NOTE**: Designating the medication as "pre-existing" (un-checking the "Started" field) **WILL NOT** qualify for this measure. If the medication is a Schedule II controlled substance, a date must be entered in the Earliest Fill Date field.

5. Select a Location (if necessary) and the patient's Pharmacy

   > **NOTE**: If prescribing a controlled substance, you must have your IdenTrust token inserted into your computer and check the box for "Ready to sign" prior to completing Step 6.

6. Click "Confirm" or "Confirm and Send" (depending on the Transmission selected)
7. Enter an appropriate CPT code

   > **NOTE**: View the complete list in the Appendix on page 90.

ADDITIONAL INFORMATION:

- This measure will always be 100%. The query for the numerator is identical to the query for the denominator.
- CMS added an optional alternate measure in 2013 to this objective allowing CPOE to be based on the total number of medication orders created during the EHR reporting period instead of the number of unique patients. The Dashboard in ChartMaker® Clinical will display both options (CPOE based on the number of *unique patients* or the *total number of medication orders*) so that your practice may select the most appropriate measure for your situation.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

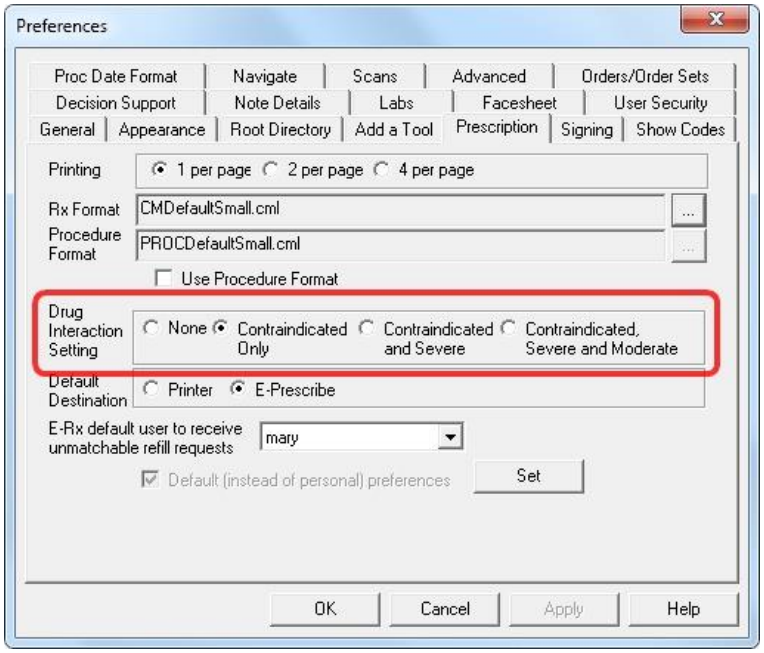
(2) DRUG INTERACTION CHECKS

Objective:	Implement drug-drug and drug-allergy interaction checks.
Measure:	The EP has enabled this functionality for the entire EHR reporting period.
Exclusion:	No exclusions.
Attestation Requirements:	Yes / No

In ChartMaker Clinical:
In order to qualify for this measure, the provider must enable the functionality for drug interaction checking. This setting is a user configuration and needs to be set up per user logging into the system.

To enable drug interaction checking:

1. Log into ChartMaker Clinical as the correct user
2. Go to Edit > Preferences
3. Click the "Prescription" tab
4. Select the level of interaction checking you prefer



NOTE: The Drug Interaction Setting has to be set to something other than "None" in order to meet this measure. This is a global setting for all patients, but set per user. Also, in order to be able to change this setting, the user must have the privilege to do so. Changing this user privilege is done through Edit > System Tables > Users. After selecting the user and clicking "Properties", change the Drug Interaction setting to "All".

5. Click "Set"
6. Click "OK"

(3) MAINTAIN PROBLEM LIST

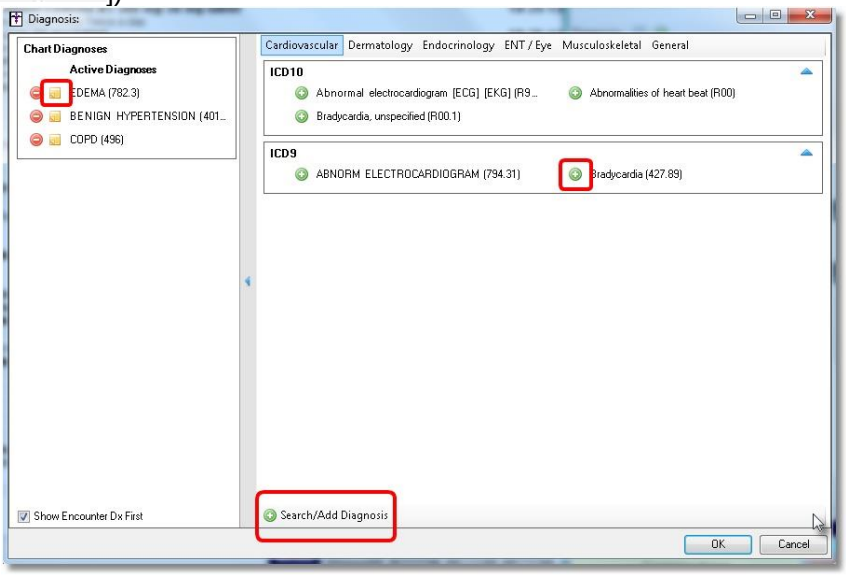
Objective:	Maintain an up-to-date problem list of current and active diagnoses.
Measure:	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Exclusion:	No exclusion.
Attestation Requirements:	Numerator / Denominator
Numerator:	Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
Denominator:	Number of unique patients seen by the EP during the EHR reporting period with an office encounter.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must enter diagnoses electronically on the patient's chart.

To enter diagnoses electronically:

1. In an office visit note, select a diagnosis (Diagnosis:)

   (Either by adding a new one [ ]; updating an existing one [ ]; or searching the database [Search/Add Diagnosis])



   NOTE: Marking a diagnosis as "Pre-existing" will count as well.

2. Enter an appropriate CPT code

   NOTE: View the complete list in the Appendix on page 90.

ADDITIONAL INFORMATION:

- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(4) GENERATE AND TRANSMIT PERMISSIBLE PRESCRIPTIONS ELECTRONICALLY (E-RX)

Objective:	Generate and transmit permissible prescriptions electronically (eRx).
Measure:	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Exclusion:	Any EP who writes fewer than 100 prescriptions during the EHR reporting period; or does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.*
Numerator:	Number of prescriptions in the denominator generated and transmitted electronically.
Denominator:	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must electronically prescribe medications (excluding controlled substances).

To electronically prescribe a medication:

1. In an office visit note, click the "Medication" button (

)
2. Choose "Add Medication" (or "Renew Medication")
3. Search for and select the medication
4. Enter all appropriate fields and click "Next"

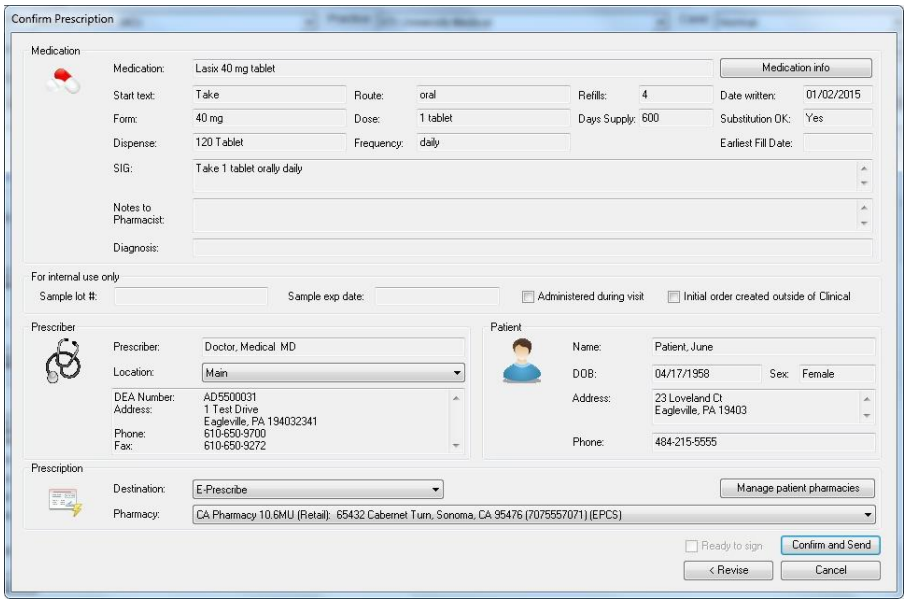
   NOTE: Select "E-Prescribe" in the Transmission field. If the medication is a Schedule II controlled substance, a date must be entered in the Earliest Fill Date field.

5. Select the Location (if necessary) and the patient's Pharmacy

   NOTE: If prescribing a controlled substance, you must have your IdenTrust token (see below) inserted into your computer and check the box for "Ready to sign" prior to completing Step 6.

Sample IdenTrust Token:

6. Click “Confirm and Send”



Alternative Method: Use the options available (to queue or renew) when you right-click on the medication from the Face Sheet.

ADDITIONAL INFORMATION:

- Medications entered as “pre-existing” or that are controlled substances do not count in the calculation.
- The statistical calculation for this measures does not include scripts for controlled substances.
- If the checkbox for “Initial order created outside of Clinical” is selected, you will not receive credit for this prescription for this measure.
- Medications that are refilled (as long as there was a patient encounter within the reporting period) will count in the denominator.
- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the numerator and the denominator of the measure.
- Instances where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the EHR reporting period.
- In order to have the ability to e-prescribe from Clinical, you must first enroll with Sure Scripts. If you have not done so, go to www.sticomputer.com, log into the “CUSTOMERS” section and go to ChartMaker Clinical > (SureScripts) New Provider Enrollment.
- To set your default transmission method in Clinical to “e-prescribe”, go to Edit > Preferences > Prescription tab.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(5) MAINTAIN ACTIVE MEDICATION LIST

Objective:	Maintain active medication list.
Measure:	More than 80 percent 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.
Exclusion:	No exclusion.
Attestation Requirements:	Numerator / Denominator
Numerator:	Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Denominator:	Number of unique patients seen by the EP during the EHR reporting period.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must enter the patient's medications or document that the patient is taking no medications electronically on the patient's chart.

To enter medications electronically:

1. In an office visit note, click the "Medication" button (

)

2. Choose "Add Medication"

   NOTE: If the patient is not taking any medications, select "No Active Medications" instead and skip to Step 7.

3. Search for and select the medication

4. Enter all appropriate fields and click "Next"

   NOTE: Designating the medication as "pre-existing" (un-checking the "Started" field) will qualify for this measure. If the medication is a Schedule II controlled substance, a date must be entered in the Earliest Fill Date field.

5. Select a Location (if necessary) and the patient's Pharmacy

   NOTE: If prescribing a controlled substance, you must have your IdenTrust token inserted into your computer and check the box for "Ready to sign" prior to completing Step 6.

6. Click "Confirm" or "Confirm and Send" (depending on the Transmission selected)

7. Enter a procedure code to indicate the patient had an encounter with this provider

   NOTE: Any CPT code is applicable.

ADDITIONAL INFORMATION:

- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(6) MAINTAIN ACTIVE MEDICATION ALLERGY LIST

Objective:	Maintain active medication allergy list.
Measure:	More than 80 percent 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.
Exclusion:	No exclusion.
Attestation Requirements:	Numerator / Denominator
Numerator:	Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
Denominator:	Number of unique patients seen by the EP during the EHR reporting period with an office encounter.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must enter allergies for the patient electronically. Entering "No Known Allergies" or "No Known Drug Allergies" counts as well.

To enter allergy information:

1. In an office visit note, click the "Allergies" button (

)
2. If the patient does not have any medication allergies, select "No Known Drug Allergies" and skip to Step 6. If the patient does have a medication allergy, select "Add/Modify Allergies".
3. Click "Add"
4. Search for and select the allergy
5. Click "OK" to close the Active Allergy dialog
6. Enter an appropriate CPT code

   NOTE: View the complete list in the Appendix on page 90.

ADDITIONAL INFORMATION:

- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

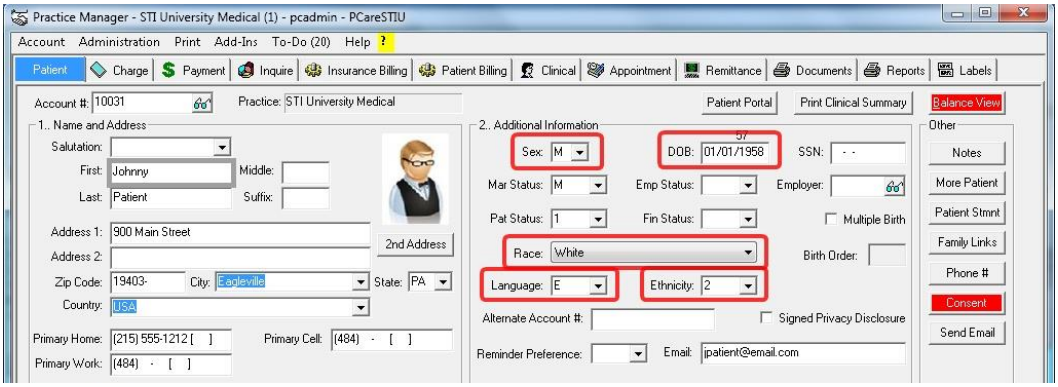
(7) RECORD DEMOGRAPHICS

Objective:	Record all of the following demographics: a) Preferred language b) Gender c) Race d) Ethnicity e) Date of birth
Measure:	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
Exclusion:	No exclusion.
Attestation Requirements:	Numerator / Denominator
Numerator:	Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.
Denominator:	Number of unique patients seen by the EP during the EHR reporting period with an office encounter.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must have a record of Preferred Language, Gender, Race, Ethnicity and Date of Birth for the patient. All of this information should be entered through Practice Manager, however it can be entered through ChartMaker Clinical, if necessary.

To enter demographic information:

1. In Practice Manager, enter data for Preferred Language, Gender, Race, Ethnicity & Date of Birth



2. Click “Save”

3. In the office visit note, enter an appropriate CPT code

   NOTE: View the complete list in the Appendix on page 90.

ADDITIONAL INFORMATION:

- If a patient declines to provide all or part of the demographic information, or if capturing a patient’s ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure.
- In regards to patients who do not know their ethnicity, EPs should treat these patients the same way as patients who decline to provide race or ethnicity— identify in the patient record that the patient declined to provide this information.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(8) RECORD VITAL SIGNS

Objective:	Record and chart changes in the following vital signs: a) Height b) Weight c) Blood pressure d) Calculate and display body mass index (BMI) e) Plot and display growth charts for children 3-20 years, including BMI
Measure:	More than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
Exclusion:	Any EP who either see no patients 3 years or older; or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice; or who believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or who believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must select "NO" next to the appropriate exclusion, then click the "APPLY" button in order to attest to the exclusion.*
Numerator:	Number of patients in the denominator who have at least one entry of their height, weight and blood pressure (ages 3 and over) recorded as structured data.
Denominator:	Number of unique patients (age 3 or over for blood pressure) seen by the EP during the EHR reporting period.

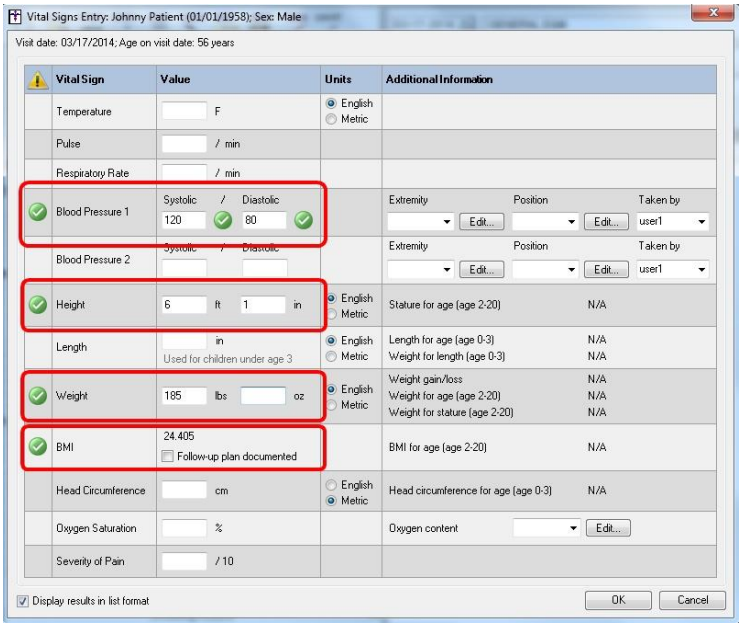
In ChartMaker Clinical:
In order to qualify for this measure, the provider must enter Height, Weight and Blood Pressure for each office visit. ChartMaker Clinical will automatically calculate BMI for you.

If you are a physician that sees patients between the ages of 3 – 20, you must also generate growth charts for them. By entering vital sign information, this information can automatically be generated.

To enter vital sign information:

1. In an office visit note, click on the "Vitals" button ()

2. Enter data for at least Blood Pressure, Height and Weight and click "OK"



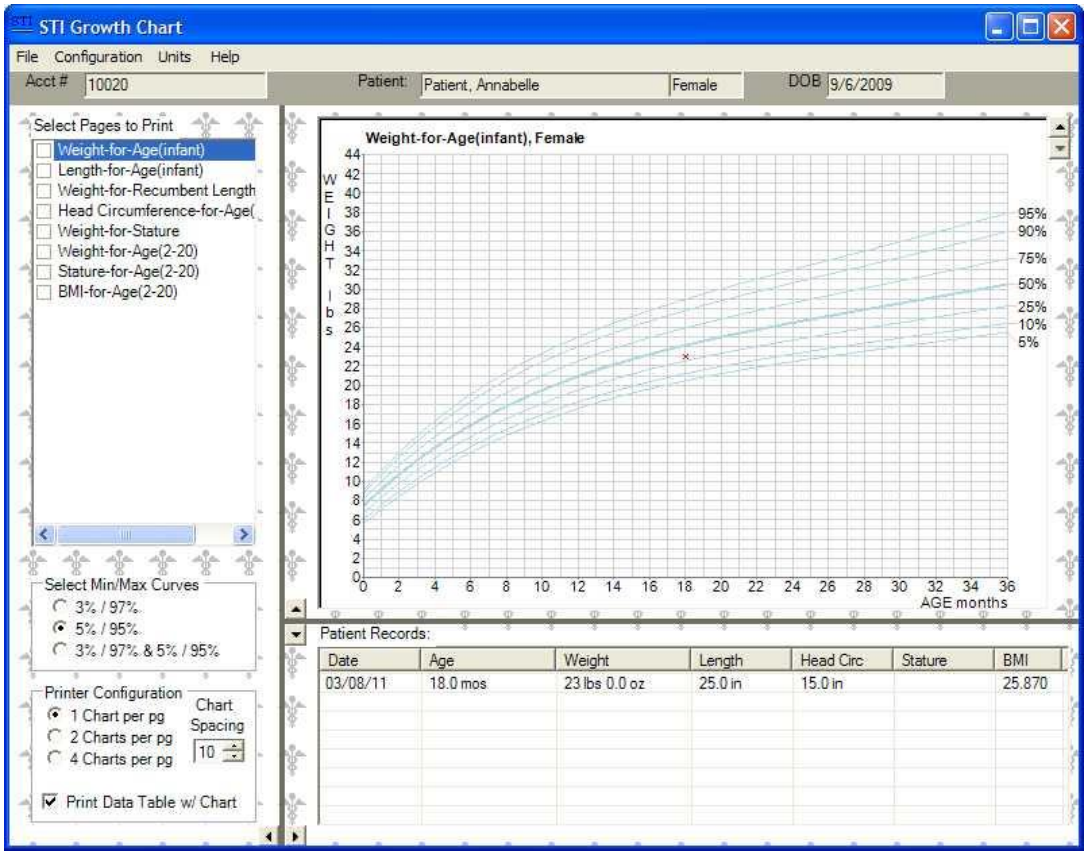
3. Enter an appropriate CPT code

   NOTE: View the complete list in the Appendix on page 90.

To generate a growth chart:

1. Open the patient's chart

2. Go to Tools > Growth Chart



ADDITIONAL INFORMATION:

- Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make the determination based on the patient's individual circumstances as to whether height, weight, and blood pressure need to be updated.
- In order for Clinical to recognize the correct "normal" ranges for each vital sign, the patient's date of birth must be recorded in the chart.
- The Dashboard in ChartMaker® Clinical will display all 3 options (All 3 vitals; BP only or Height and Weight only) so that your practice may select the most appropriate measure for your situation.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(9) RECORD SMOKING STATUS

Objective:	Record smoking status for patients 13 years old or older.
Measure:	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
Exclusion:	Any EP who sees no patients 13 years or older.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must enter "0" in the Exclusion box to attest to exclusion from this requirement.*
Numerator:	Number of patients in the denominator with smoking status recorded as structured data.
Denominator:	Number of unique patients age 13 or older seen by the EP during the EHR reporting period with an office encounter.

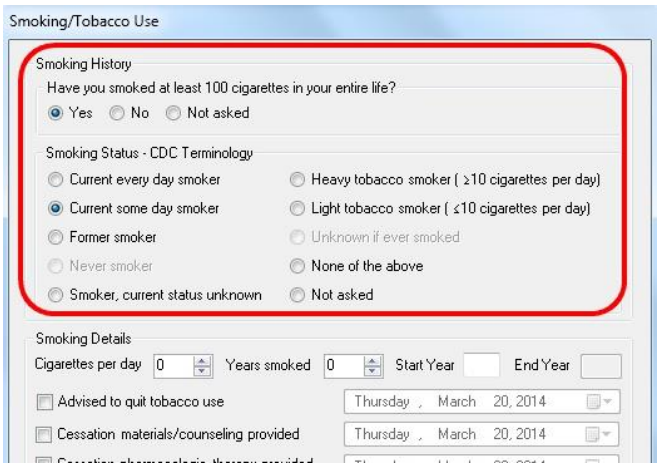
In ChartMaker Clinical:
In order to qualify for this measure, the provider must answer whether the patient has ever smoked at least 100 cigarettes in his/her lifetime and their current smoking status.

To enter smoking history information:

1. In an office visit note, click the "Smoking History" button (

)

2. Enter data for "Have you ever smoked at least 100 cigarettes in your entire life" and "Smoking Status"



3. Enter an appropriate CPT code

   NOTE: View the complete list in the Appendix on page 90.

ADDITIONAL INFORMATION:

- Only the first two questions ("Smoking History" and "Smoking Status") need to be answered to meet this measure.
- Patients with a Smoking History or Smoking Status of "Not asked" (or "None of the above" for Smoking Status) will not count in the Numerator.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(10) CLINICAL DECISION SUPPORT RULE

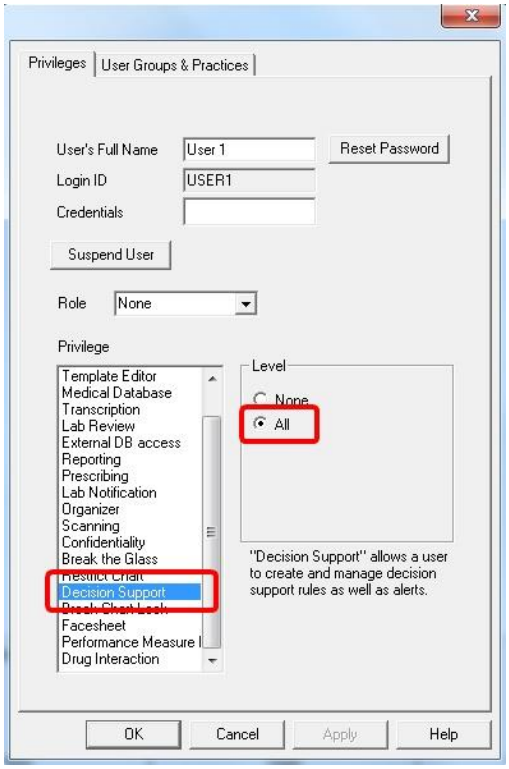
Objective:	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
Measure:	Implement one clinical decision support rule.
Exclusion:	No exclusion.
Attestation Requirements:	Yes / No

In ChartMaker Clinical:
In order to qualify for this measure, the provider must implement one clinical decision support rule relevant to their specialty.

In order to have the ability to create a decision support rule in ChartMaker Clinical, a user must have the privilege turned on.

To enable the privilege to create decision support rules:

1. Go to Edit > System Tables > Users
2. Highlight the user
3. Click “Properties”
4. Select “Decision Support” and change the Level to “All”



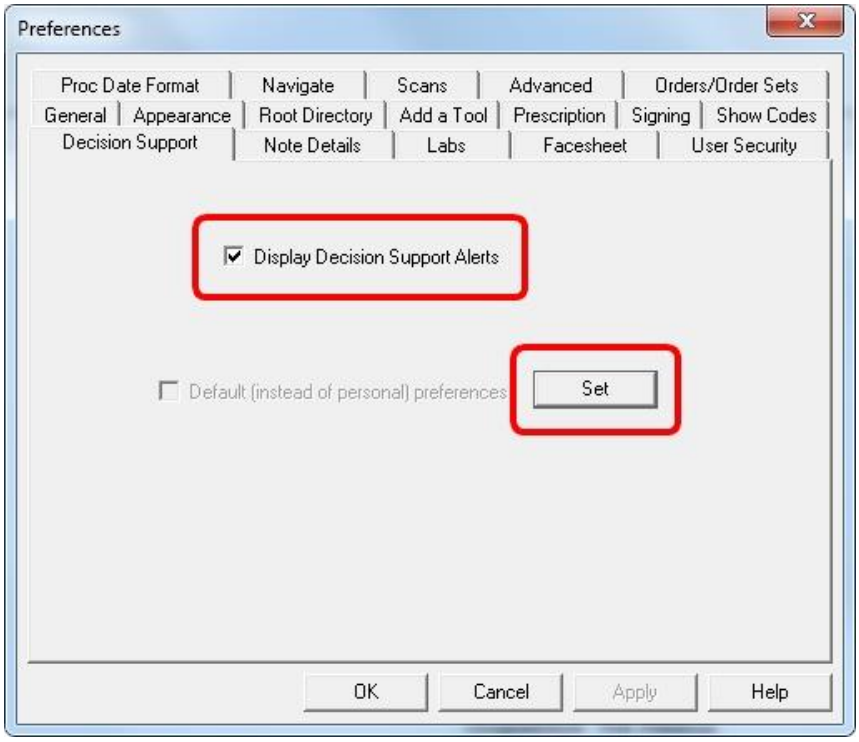
NOTE: This privilege only controls the ability to create, modify and delete rules. It does not control a user’s ability to see a Decision Support alert.

5. Click “OK”

ChartMaker Clinical also has the ability to enable the Decision Support pop-up alert per user. Your practice may decide that only the providers should receive the alerts (and not the office staff). This user preference is turned off by default.

To enable the Decision Support alerts:

1. Log into ChartMaker Clinical as the user you want to configure
2. Go to Edit > Preferences
3. Click the “Decision Support” tab
4. Check the box for “Display Decision Support Alerts”
5. Click “Set”

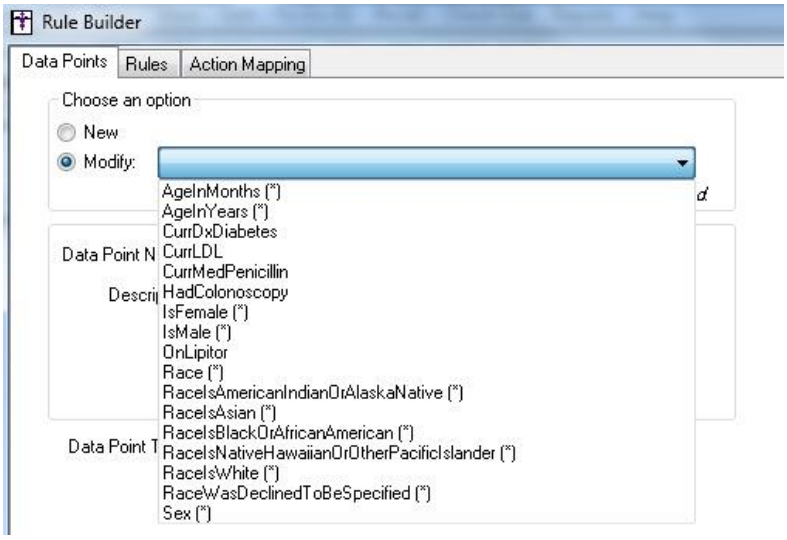


6. Click “OK”

To create a decision support rule:

1. Go to Edit > System Tables > DSS Rule Builder

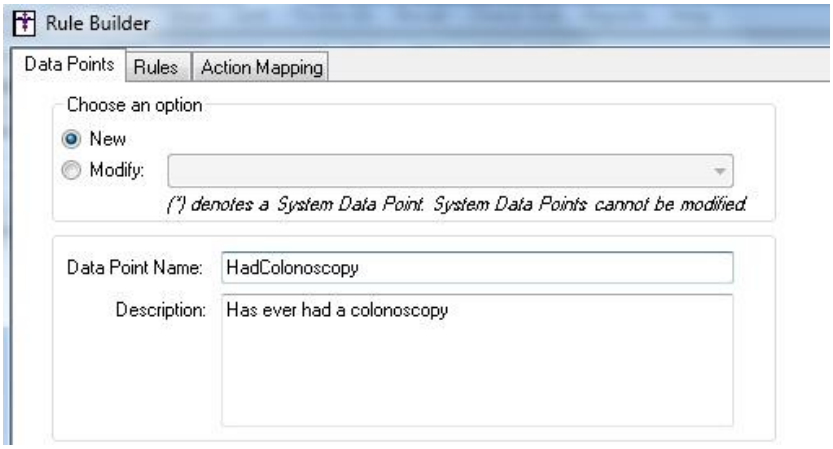
2. Click the “Data Points” tab



NOTE: All Data Points labeled with an asterisk (*) are system-defined Data Points and cannot be modified. They may be accessed by selecting “Modify” and then clicking the dropdown menu. If you would like to use an existing Data Point, select it from the Modify dropdown and then skip to Step 6 (if applicable).

3. To create a new office-defined data point, select “New”

4. Enter a Data Point Name and Description

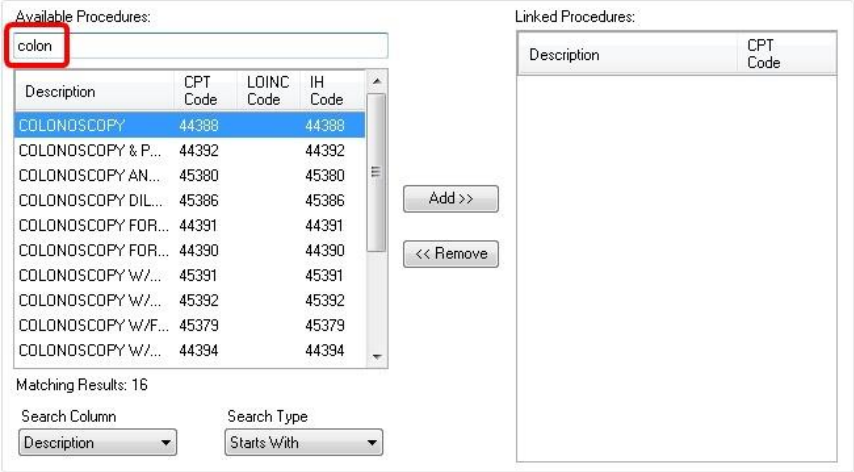


5. Select the “Data Point Type”

NOTE: The options are:

a) Current Dx – allows Data Points to be mapped to specific diagnosis codes (ICD-9)
b) Current Dx ICD10 – allows Data Points to be mapped to specific diagnosis codes (ICD-10)
c) Current Result – allows Data Points to be mapped to specific procedures in order to track results
d) Current Rx – allows Data Points to be mapped to specific medications
e) Current Rx Group – allows Data Points to be mapped to medication groups (Example: Cephalosporins)
f) Procedure Performed – allows Data Points to be mapped to specific procedures

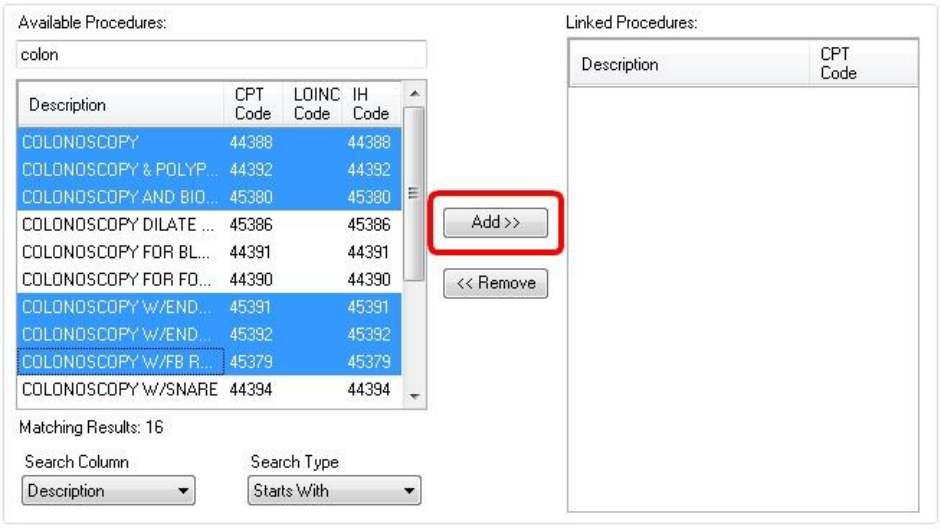
6. Search for the "Available" Diagnosis/Procedure/Medication/Medication Group (whichever is applicable)



7. Select the applicable items

TIP: Using the Shift or Ctrl key may be used to select multiple items.

8. Click "Add >>" to populate the Linked Procedures section



9. Click "Save"

NOTE: You cannot delete a Data Point once it is created. Repeat these steps for any additional Data Points that may need to be created.

10. Click the “Rules” tab

    NOTE: All Rules labeled with an asterisk (*) are system-defined Rules and cannot be modified. They may be accessed by selecting “Modify” and then clicking the dropdown menu. If you would like to use an existing (non system-defined) Rule, select it from the Modify dropdown and then skip to Step 15.

11. To create a new office-defined Rule, select “New”

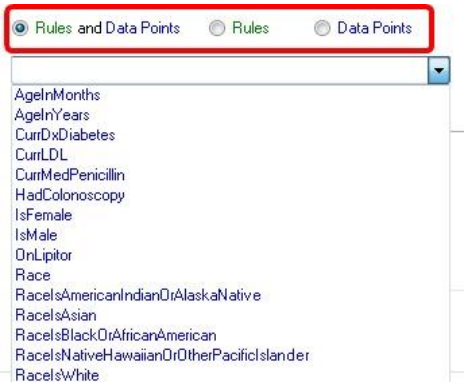
12. Enter a Name for the Rule

    NOTE: Spaces, punctuation and special characters are not permitted.

13. In the Rule Type dropdown, select “Decision Support”

14. Enter a Description for the Rule

15. Select the options you would like to view when building your Rule Logic



    NOTE: Rule Logic is built using existing Rules and Data Points. This will filter what you see in the dropdown directly below the Rule/Data Points radio buttons.

16. Add the Data Point you created in previous steps by selecting it from the dropdown

17. (Optional) Add any applicable Logic or Math by selecting it from the dropdown

NOTE: The example above was created by the following sequence of steps:

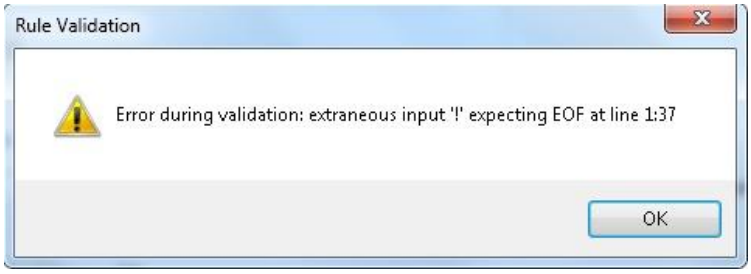
a) Select Rule of “HadColonoscopy”
b) Select Logic of “equal to (=)”
c) Type in “0”
d) Select Logic of “and (and)”
e) Select Data Point of “AgeInYears”
f) Select Math of “greater than (>)”
g) Select Logic of “equal to (=)”
h) Type in “50”

18. Click “Validate”

ALTERNATE METHOD: You could also use the “Rule Testing” section to test this rule on a real patient by entering a valid chart number in the box and clicking “Test”.

19. Click “OK”

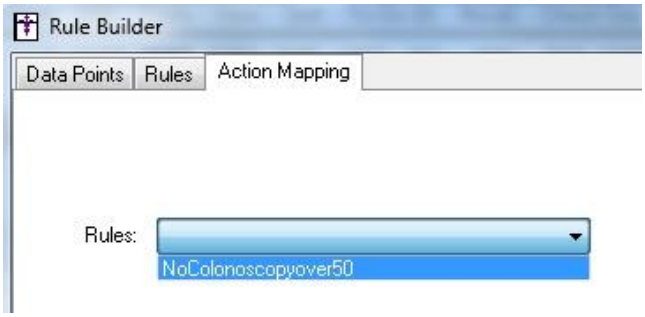
NOTE: If there is an input validation problem, the following message will appear. Click “OK” and make the appropriate changes to the Rule.



20. Click “Save”

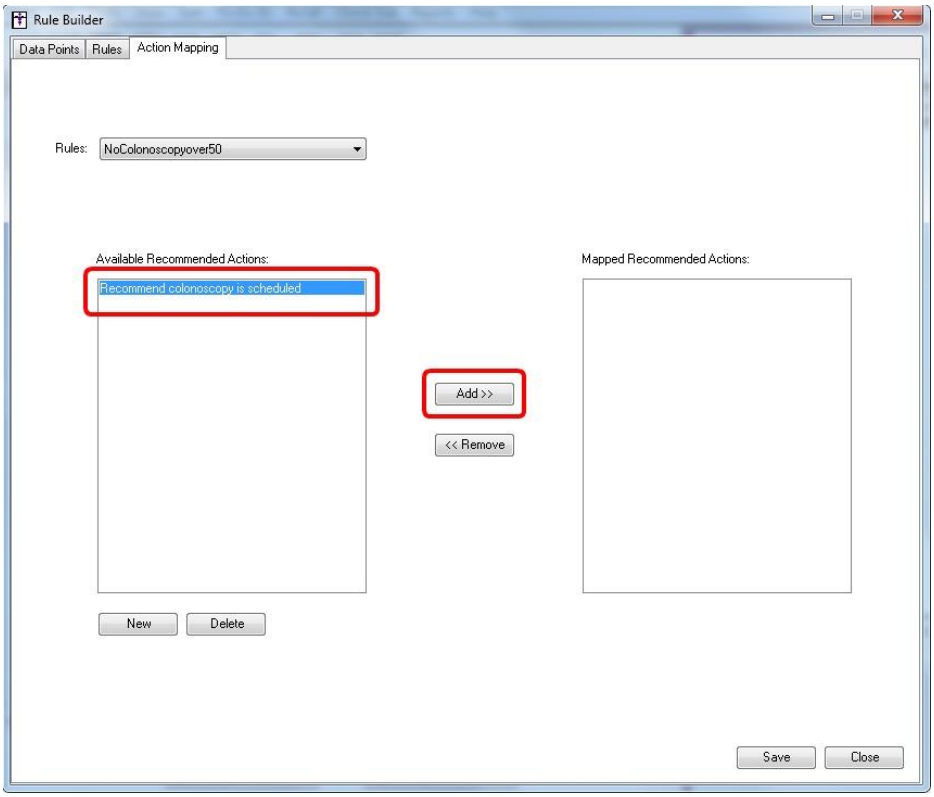
21. Click the “Action Mapping” tab

22. Select the appropriate Rule from the dropdown



23. Highlight the appropriate option from the “Available Recommended Actions” list and click “Add >>”

    NOTE: If the appropriate option is not listed, click “New” and type the Description. Then click “OK”.



24. Click “Save”

25. Click “Close”

Pre-Defined Decision Support Rules:

Starting in version 5.2, ChartMaker Clinical will come with pre-defined rules based on Clinical Quality Measures. These rules will greatly decrease the amount of work involved in configuring the rules as all you will need to do is define the Data Points and Action Mapping.

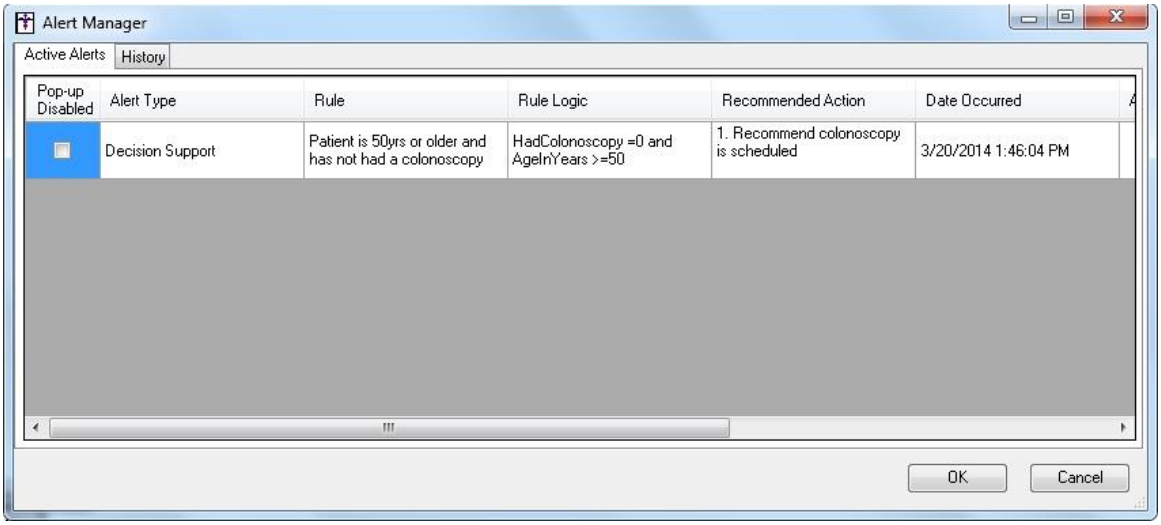
Listed below are the pre-defined rules along with which Data Points need to be mapped to conditions.

Rule:	Data Points (to be mapped):
CQM_TBD_UpTo20YrsHasDentalDx	ActiveDxI9DentalCaries ActiveDxI10DentalCaries
CQM_0036_AsthmaWithRx5to64YrsOld	ActiveDxI9PersistentAsthma ActiveDxI10PersistentAsthma RxPreferredAsthmaTherapy ActiveDxI9AcuteRespiratoryFailure ActiveDxI10AcuteRespiratoryFailure ActiveDxI9COPD ActiveDxI10COPD ActiveDxI9CystricFibrosis ActiveDxI10CystricFibrosis ActiveDxI9Emphysema ActiveDxI10Emphysema
CQM_0002_2to18PharyngitisNoRX	ActiveDxI9Pharyngitis ActiveDxI10Pharyngitis ActiveDxI9Tonsillitis ActiveDxI10Tonsillitis RxAntibioticMedications RxGroupAntibioticMedications
CQM_0018_18to85GoodBP	ActiveDxI9Hypertension ActiveDxI10Hypertension ActiveDxI9Pregnancy ActiveDxI10Pregnancy ActiveDxI9EndStageRenalDisease ActiveDxI10EndStageRenalDisease ActiveDxI9ChronicKidneyDiseaseStage5 ActiveDxI10ChronicKidneyDiseaseStage5
CQM_0024_Under18HaveHtWtBMI	ActiveDxI9Pregnancy ActiveDxI10Pregnancy
CQM_0052_18to50BackPain	ActiveDxI9LowBackPain ActiveDxI10LowBackPain ActiveDxI9Cancer ActiveDxI10Cancer ActiveDxI9IVDrugAbuse ActiveDxI10IVDrugAbuse ActiveDxI9NeurologicImpairment ActiveDxI10NeurologicImpairment ActiveDxI9Trauma ActiveDxI10Trauma ProcCTScanOfLowerSpineGrouping ProcMRIofLowerSpineGrouping ProcXrayOfLowerSpineGrouping
CQM_TBD_Over65HeartFailure	ActiveDxI9HeartFailureGrouping ActiveDxI10HeartFailureGrouping ActiveDxI9Cancer ActiveDxI10Cancer ActiveDxI9SevereDementia ActiveDxI10SevereDementia
CQM_0419_ActiveMedList	No Data Points Need to be Mapped
CQM_0034_Colonoscopy	ProcColonoscopy ProcSigmoidoscopy ProcTotalColectomy

Using Decision Support:

Decision Support rules are activated when a patient's chart is opened or saved. If a Decision Support rule has been met, an alert will appear.

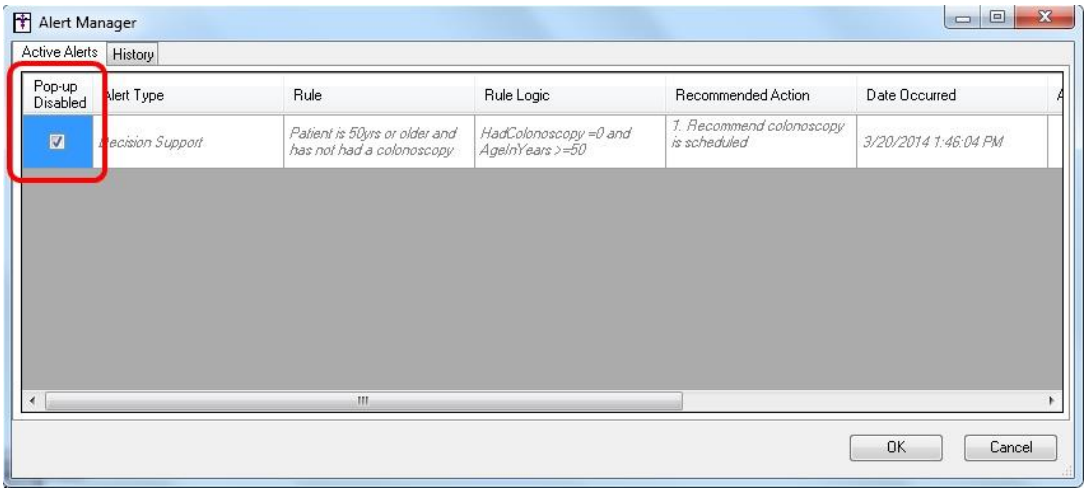
If the user preference to receive Decision Support alerts via a pop-up dialog is enabled, the Alert Manager dialog will appear as shown below.



If the user preference is disabled, no pop-up dialog will appear, however the DSS ALERT icon at the bottom of the Face Sheet will be red as shown below. Double-clicking on the "DSS ALERT" icon will open the Alert Manager dialog.

To disable the alert:

1. Click the “Pop-up Disabled” box for the appropriate Rule



2. Click “OK”

> **NOTE**: This does not remove, delete or mark the Rule as being addressed for this patient. This only indicates that you do not want a pop-up alert for this Rule. The DSS ALERT button will remain red, but a pop-up will no longer automatically appear for this Rule when opening the patient’s chart.

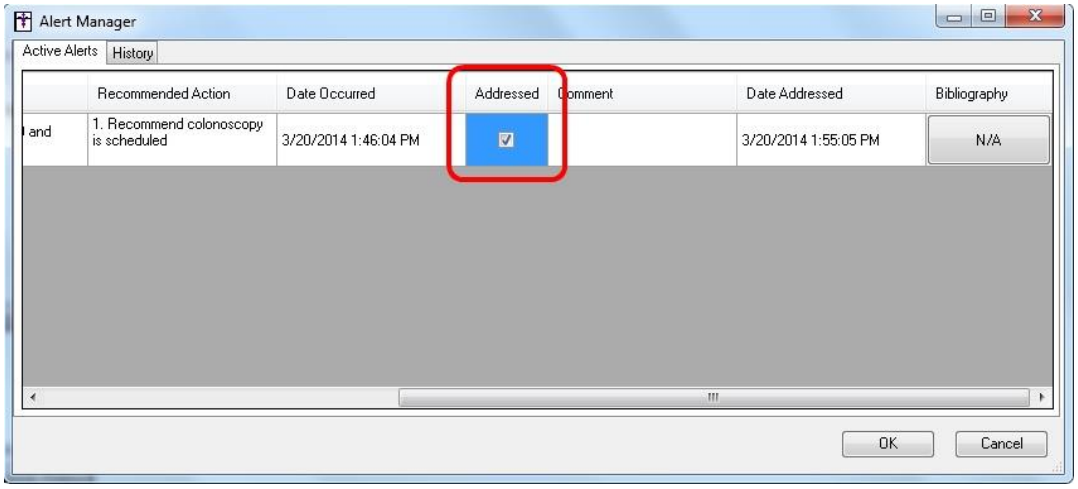
To re-enable the alert:

1. Open the patient’s chart
2. Double-click on “DSS Alert” (

)
3. Uncheck the “Pop-up Disabled” box for the appropriate Rule
4. Click “OK”

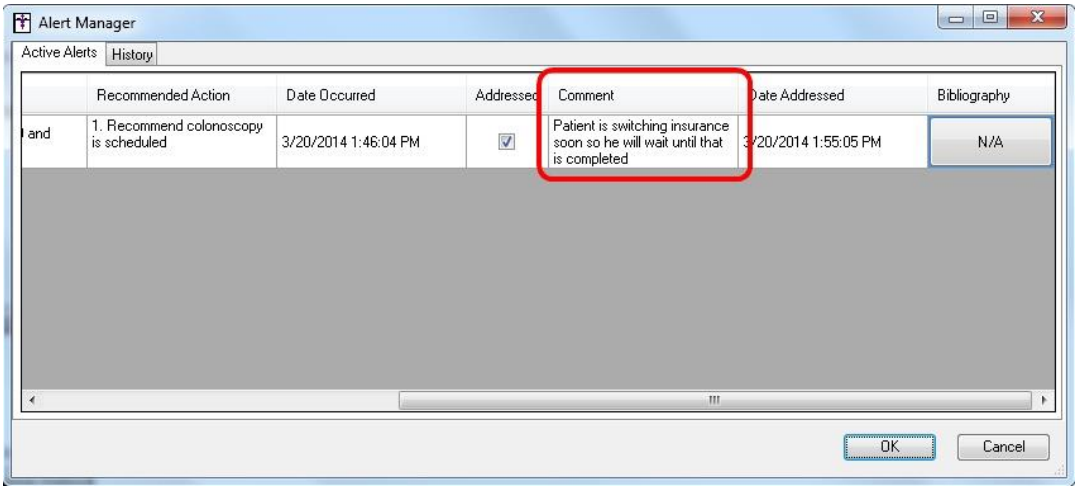
To address the DSS Alert:

1. Check the “Addressed” box for the appropriate Rule



NOTE: This will deactivate the alert for this patient. A pop-up will no longer appear for this Rule and the DSS ALERT icon will now appear blue, indicating there are no active alerts.

2. (Optional) Type your comments in the “Comment” box

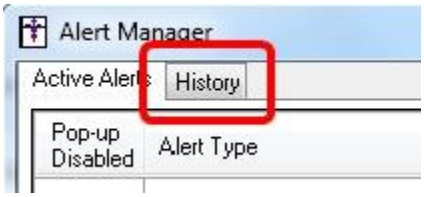


3. Click “OK”

To view the history for a DSS alert:

1. Double-click on the “DSS ALERT” icon

2. Click the “History” tab



ADDITIONAL INFORMATION:

- Drug-drug and drug-allergy interaction alerts cannot be used to meet this measure.

(11) VIEW, DOWNLOAD AND TRANSMIT (ELECTRONIC COPY OF HEALTH INFORMATION)

Objective:	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.
Measure:	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.
Exclusion:	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.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must enter "0" in the Exclusion box to attest to exclusion from this requirement.*
Numerator:	The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information.
Denominator:	Number of unique patients seen by the EP during the EHR reporting period.

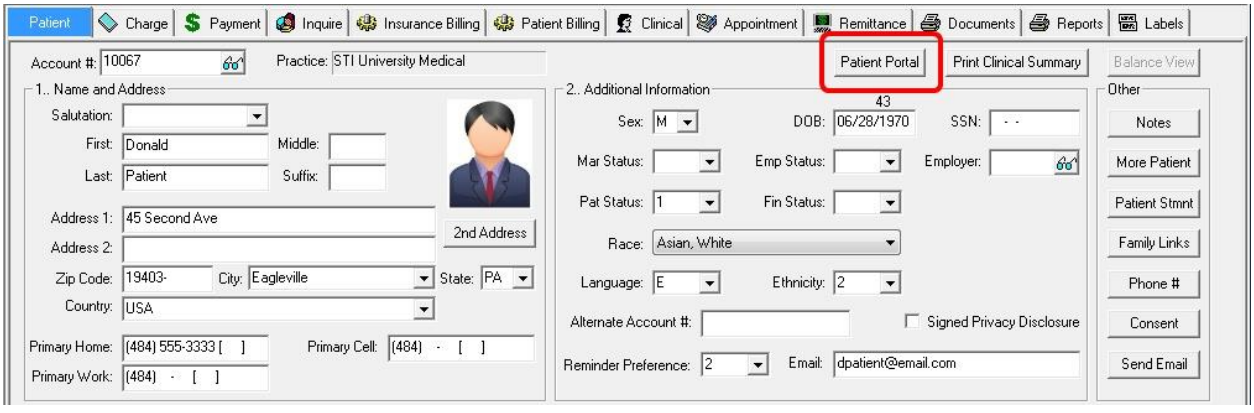
In ChartMaker Clinical:
In order to qualify for this measure, the provider must submit health information for their patients through the ChartMaker® PatientPortal. The provider will need to register the patient on the portal first through Practice Manager and then the patient must verify the registration before an exchange of information can occur. Once the registration is verified, ChartMaker Clinical will automatically send updates at a pre-configured amount of time.

> **NOTE**: The PatientPortal will need to be configured first before being able to use it. To request enrollment, visit www.sticomputer.com, click "Enrollments" and then "PatientPortal Enrollment". Fill out the form and click "Submit". Please contact STI Clinical Support if you need assistance with this process.

To enroll the patient for the PatientPortal (with an email address):

1. In Practice Manager, open the patient's account

2. On the Patient tab, click "Patient Portal"



> **NOTE**: You will need the patient's first name, last name and date of birth documented on their account in order to register the patient.

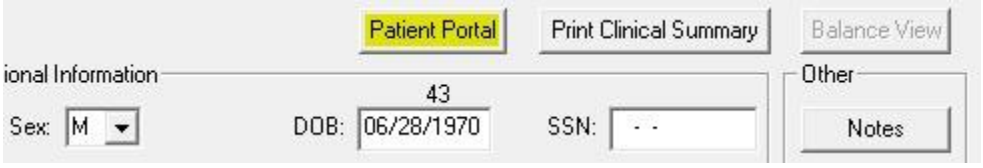
3. Click the first “Authorize” option

4. Click “Yes”

NOTE: The status of the registration will now display as “pending”.

5. Click “OK”

NOTE: The Patient Portal button will now show as yellow. Yellow indicates a pending registration. The button will turn green once the patient completes the registration process.



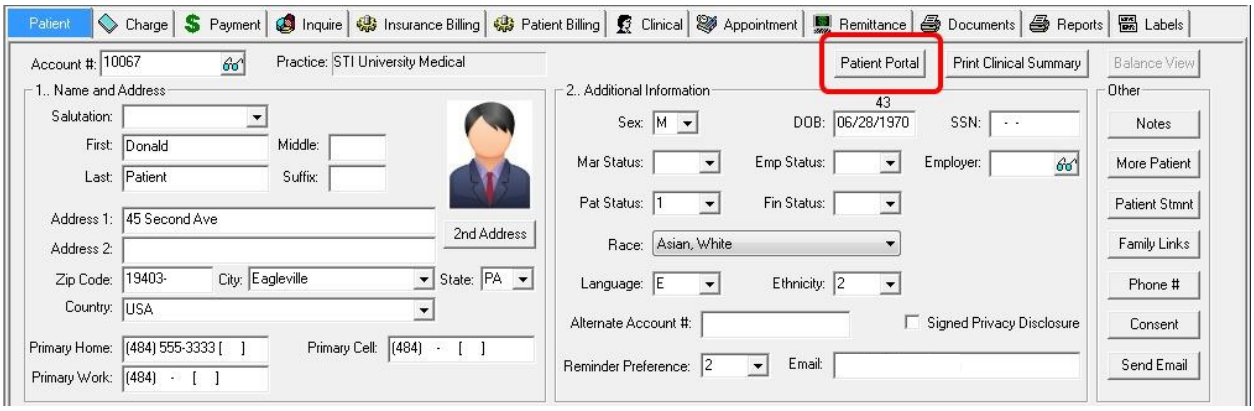
6. Click “Save” to close the patient’s account

NOTE: The denominator and numerator are not necessarily tied to the same event. To populate the denominator the provider must have completed an office visit note, with a valid CPT code included, for the patient encounter. View the complete list of valid CPT codes in the Appendix on page 90. To populate the numerator, the patient must be authorized for the PatientPortal through Practice Manager on the Patient tab and the provider must sign all information being sent to the portal (i.e. progress notes, labs, etc.) within 4 business days of receiving it.

To enroll the patient for the PatientPortal (without an email address):

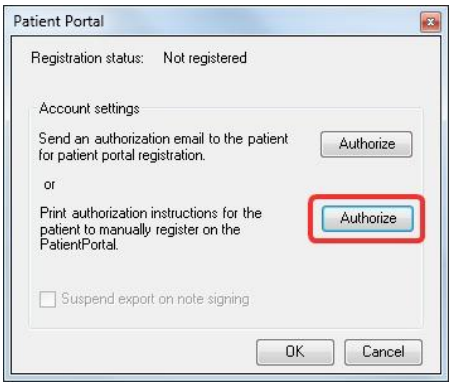
1. In Practice Manager, open the patient's account

2. On the Patient tab, click "Patient Portal"



NOTE: You will need the patient's first name, last name and date of birth documented on their account in order to register the patient.

3. Click the second "Authorize" option

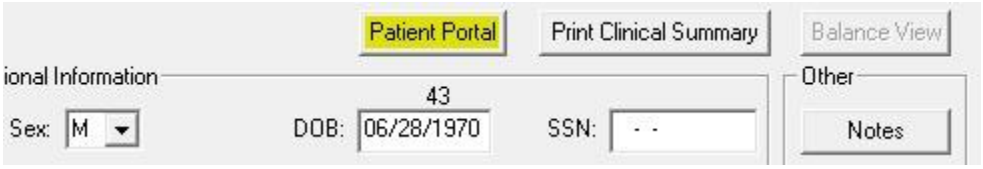


4. Click "Yes"

NOTE: The status of the registration will now display as “pending”.

5. Click “OK”

NOTE: The Patient Portal button will now show as yellow. Yellow indicates a pending registration. The button will turn green once the patient completes the registration process.



6. Click “Save” to close the patient’s account

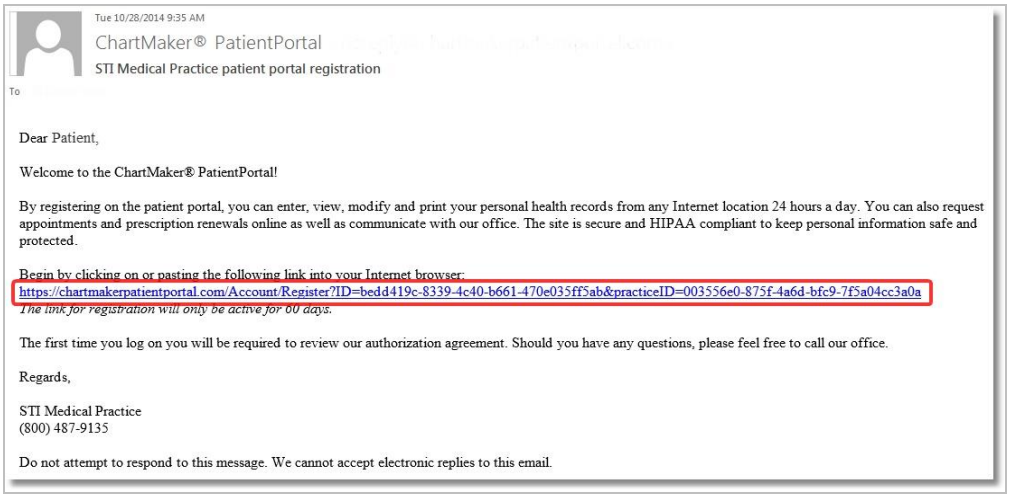
7. Give the printed instructions to the patient and encourage them to complete registration at a later time

NOTE: The denominator and numerator are not necessarily tied to the same event. To populate the denominator the provider must have completed an office visit note, with a valid CPT code included, for the patient encounter. View the complete list of valid CPT codes in the Appendix on page 90. To populate the numerator, the patient must be authorized for the PatientPortal through Practice Manager on the Patient tab and the provider must sign all information being sent to the portal (i.e. progress notes, labs, etc.) within 4 business days of receiving it.

Steps taken by the patient to complete registration and login to the PatientPortal:

1. Log into their email account and access the email regarding the PatientPortal registration

2. Click the link to access the PatientPortal to complete registration



Tue 10/28/2014 9:35 AM

ChartMaker® PatientPortal

STI Medical Practice patient portal registration

To

Dear Patient,

Welcome to the ChartMaker® PatientPortal!

By registering on the patient portal, you can enter, view, modify and print your personal health records from any Internet location 24 hours a day. You can also request appointments and prescription renewals online as well as communicate with our office. The site is secure and HIPAA compliant to keep personal information safe and protected.

Begin by clicking on or pasting the following link into your Internet browser:
https://chartmakerpatientportal.com/Account/Register?ID=bedd419c-8339-4c40-b661-470e035ff5ab&practiceID=003556e0-875f-4a6d-bfc9-7f5a04cc3a0a
The link for registration will only be active for 60 days.

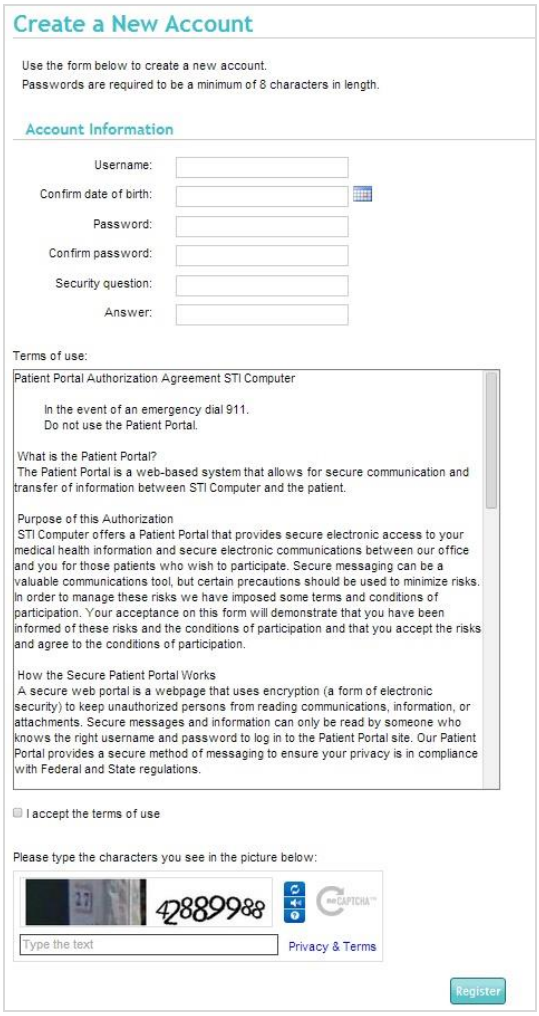
The first time you log on you will be required to review our authorization agreement. Should you have any questions, please feel free to call our office.

Regards,

STI Medical Practice
(800) 487-9135

Do not attempt to respond to this message. We cannot accept electronic replies to this email.

3. Fill out the required information (Username, Date of Birth, Password, Confirm Password, Security Question and Answer)



Create a New Account

Use the form below to create a new account.
Passwords are required to be a minimum of 8 characters in length.

Account Information

Username:
Confirm date of birth:
Password:
Confirm password:
Security question:
Answer:

Terms of use:

Patient Portal Authorization Agreement STI Computer

In the event of an emergency dial 911.
Do not use the Patient Portal.

What is the Patient Portal?
The Patient Portal is a web-based system that allows for secure communication and transfer of information between STI Computer and the patient.

Purpose of this Authorization
STI Computer offers a Patient Portal that provides secure electronic access to your medical health information and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your acceptance on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works
A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right username and password to log in to the Patient Portal site. Our Patient Portal provides a secure method of messaging to ensure your privacy is in compliance with Federal and State regulations.

I accept the terms of use

Please type the characters you see in the picture below:

Type the text

Privacy & Terms

Register

NOTE: Date of Birth must match what is documented in Practice Manager/Clinical.

4. Accept the Terms of Use along with typing the security characters that are displayed in the picture

5. Click “Register”

6. (Optional) Login using the credentials designated in Step 3

ADDITIONAL INFORMATION:

- The following information must be made available online: Patient name, provider's name and office contact information, current and past problem list, procedures. laboratory test results, current medication list and medication history, current medication allergy list and medication allergy history, vital signs (height, weight, blood pressure, BMI, growth charts), smoking status, demographic information (preferred language, sex, race, ethnicity, date of birth), care plan field(s), including goals and instructions, and any known care team members including the 3 primary care provider (PCP) of record unless the information is not available in certified EHR technology (CEHRT), is restricted from disclosure due to any federal, state or local law regarding the privacy of a person’s health information, including variations due to the age of the patient or the provider believes that substantial harm may arise from disclosing particular health information in this manner.
- Replaces the Stage 1 core objective for EPs of "Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request" and the Stage 1 menu objective for EPs of "Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP."
- This objective aligns with the Fair Information Practice Principles (FIPPs), in affording baseline privacy protections to individuals.
- In order for interoperability, applicable SNOMED codes should be attached to applicable data elements, such as Diagnoses.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.
- In order to receive credit for this measure, the patient needs to be authorized for the PatientPortal through Practice Manager (and progress notes must be signed within 4 business days). Please be aware that you will see the Dashboard calculate statistics based on this logic in versions 5.3.0.228 and higher. If you are using a lower version, the Dashboard will calculate statistics based on patient registration (not just authorization). Users are encouraged to be utilizing a version of 5.3.0.228 or higher.

(12) CLINICAL SUMMARIES

Objective:	Provide clinical summaries for patients for each office visit.
Measure:	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion:	Any EP who has no office visits during the EHR reporting period.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must enter "0" in the Exclusion box to attest to exclusion from this requirement.*
Numerator:	Number of patients in the denominator who are provided a clinical summary of their visit within three business days.
Denominator:	Number of unique patients seen by the EP for an office visit during the EHR reporting period with an office encounter.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must provide the patient with a clinical summary for each office visit. This information needs to be provided to the patient within 3 business days of the office visit.

To print an instant clinical summary:

1. Complete an office visit note for the patient encounter

   NOTE: A valid CPT code must be included in the office visit note. View the complete list in the Appendix on page 90.

2. Click "Save" (

)

3. Click "Export" (

)

   ALTERNATE METHOD: Go to Chart > Export > Patient Data and select "Office Visit Clinical Summary" from the Document to Export dropdown. You will also need to select the Encounter/Visit Date. This can be done inside or outside of a patient's chart. If it is done outside of the patient's chart, you will need to search for and select the patient, from the left.

NOTE: If you are printing a Clinical Summary on any day other than the date of service, you must use Chart > Export > Patient Data in order to receive credit for printing. The "Export" button (or "Print Clinical Summary" options in Practice Manager) should only be used on the date of the visit.

The *Patient Information Document Exclusions* dialog (which allows you to select information that you prefer to exclude from the Clinical Summary) will only be displayed when printing the Clinical Summary through Chart > Export > Patient Data (and not when using the Export icon).

To document a patient declined the clinical summary:

1. Complete an office visit note for the patient encounter

2. Go to Chart > Export > Patient Declined Clinical Summary

   NOTE: You will only receive credit for Meaningful Use using this option if it is selected within 3 business days of the office encounter.

To save a copy of a clinical summary:

1. Complete an office visit note for the patient encounter

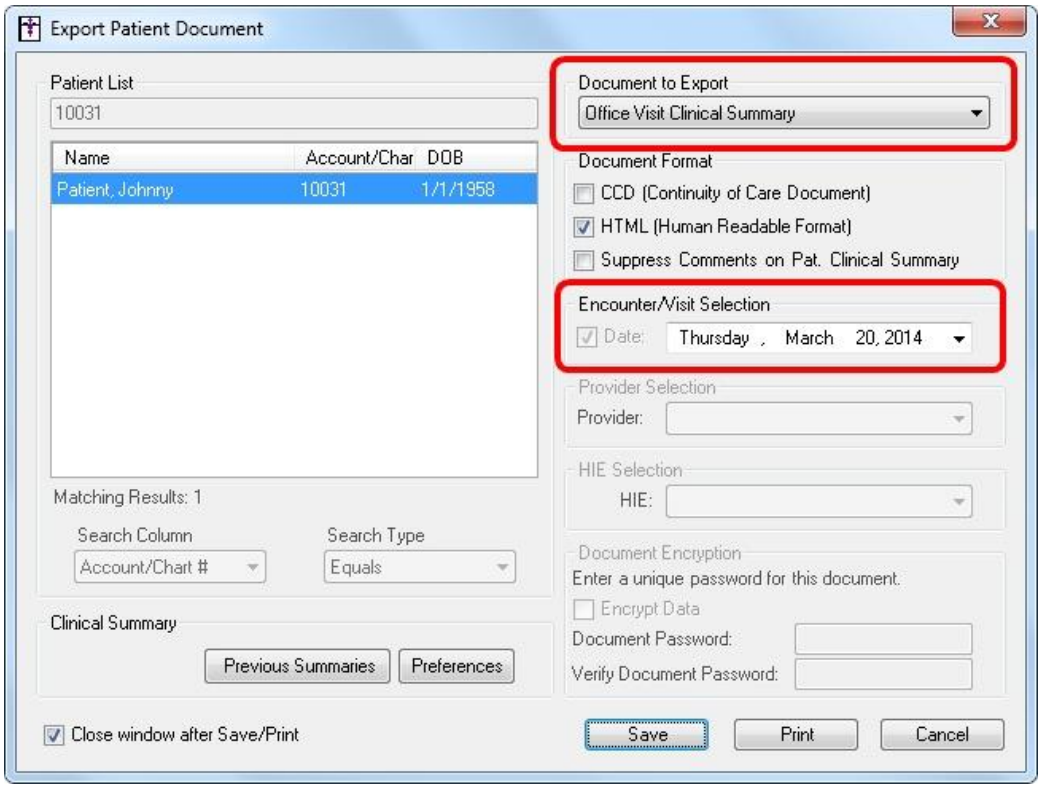
   NOTE: A valid CPT code must be included in the office visit note. View the complete list in the Appendix on page 90.

2. Click “Save” (

)

3. Go to Chart > Export > Patient Data

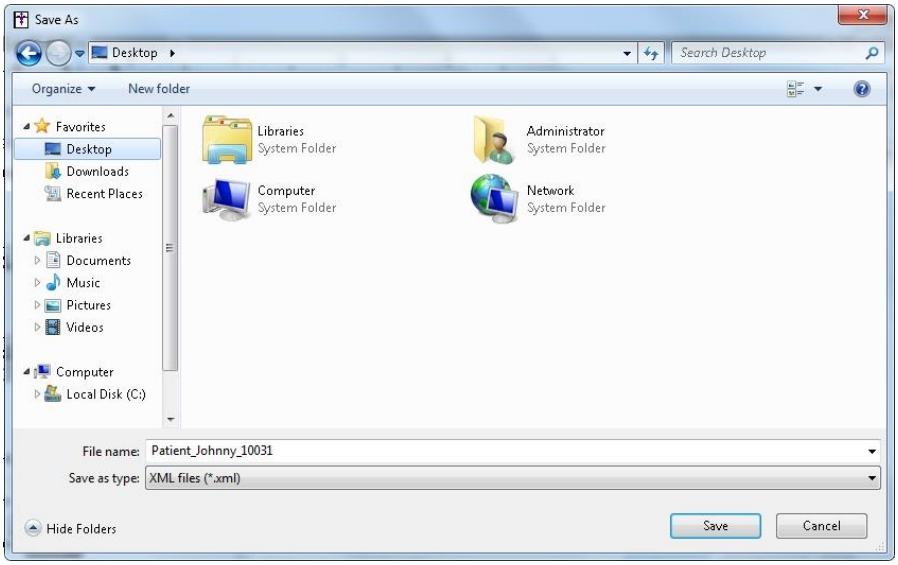
4. Select “Office Visit Clinical Summary” from the Document to Export dropdown and the Encounter/Visit Date.



   NOTE: If you are outside of a patient’s chart, you will need to search for and select the correct patient.

5. Click “Save”

6. Browse to where you would like to save the file and click “Save”



NOTE: The file will be named “LastName_FirstName_PatientID” by default. You can change the name of the file if you prefer. (The patient ID is not the same as their account number).

7. Click “OK”

To set clinical summary preferences:

You will have the option to exclude certain information from being displayed on the Clinical Summary – either in printed/saved format or on the PatientPortal (which is sent automatically when a note is signed). **The dialog to exclude information will only be displayed when printing the Clinical Summary through Chart > Export > Patient Data (and not when using the Export icon).**

1. Go to Chart > Export > Patient Data

2. Click “Preferences”

3. Select the box for “Display exclusions dialog when exporting Clinical Summary” and/or “Display exclusions dialog for all PatientPortal patients when note is signed” as appropriate

   NOTE: This is a per user configuration.

To re-print a clinical summary:

1. Go to Chart > Export > Patient Data
2. Select “Office Visit Clinical Summary” from the Document to Export dropdown
3. Click “Previous Summaries”
4. Highlight the applicable date / time
5. Click “Reprint”

ADDITIONAL INFORMATION:

- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(13) PROTECT ELECTRONIC HEALTH INFORMATION

Objective:	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
Measure:	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Exclusion:	No exclusion.
Attestation Requirements:	Yes / No

In ChartMaker Clinical:
In order to qualify for this measure, the provider must have a security management process in place to "implement policies and procedures to prevent, detect, contain and correct security violations." The specifications require the practice to conduct an analysis of potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic health information.

Some examples of this may include, but not limited to:

- Perform Security Risk Analysis / Assessment
- Implement Security Policies, such as providing passwords to computers and installing anti-virus software, screensaver for auto-log off, changing options in Preferences > User Security in ChartMaker Clinical
- Appoint a Security Official – Prepare and Implement Job Responsibilities
- Implement Audit Control Policies & Procedures
- Implement Automatic Log-off Processes
- Install Virus Protection Software
- Implement Firewall Technology
- Review and Implement Computer Backup Policies and Procedures
- Implement Facility Maintenance Log
- Develop Facility Security and Contingency Plans
- Create Computer Workstation Use Policies and Procedures
- Obtain Signed Workforce Confidentiality Agreements form all Physicians and Staff
- Create Workforce Termination Procedures
- Implement Sanction Policy

As part of the process in creating such a manual, STI Managed Services can perform a basic Security Risk Analysis on network and hardware vulnerability for your office by request. The practice is responsible for maintaining HIPAA compliance; however STI will work with you to assure the Information Technology portion of the Security Risk Analysis is complete. Upon completion of your analysis, you will be informed of STI findings whether positive or negative. The analysis will include some, but not all, of the examples listed above.

This service is provided free of charge for Platinum level maintenance clients and for a fee for all other clients. Contact STI Managed Services (800-487-9135; option 2) for more information.

Please keep in mind that the analysis completed by STI or another IT vendor is only a subset of this measure. There are other requirements that must be completed by the practice itself. If your practice would like a more thorough analysis, we can recommend a vendor to do so.

ADDITIONAL INFORMATION:

- More information regarding how to conduct a Risk Assessment can be found on www.sticomputer.com, the internet or www.healthit.gov (specifically, http://www.healthit.gov/providers-professionals/ehr-implementation-steps/step-2-plan-your-approach).

Menu Measures

Required: 5 out of 9 objectives **(One of the 5 must be #8 or #9)**
Exclusions: Per objective

1. Drug Formulary Checks
2. Clinical Lab Test Results
3. Patient Lists
4. Patient Reminders
5. Patient-Specific Education Resources
6. Medication Reconciliation
7. Transition of Care Summary
8. Immunization Registries Data Submission
9. Syndromic Surveillance Data Submission

NOTE: Starting in 2014, meeting the exclusion criteria will no longer count as reporting a Meaningful Use objective from the set of Menu measures. An EP must meet the measure criteria for 5 objectives in Stage 1 or report on all 9 of the Menu objectives, by attesting to meeting the exclusion or meeting the measure.

Attestation Requirements:
In order to receive credit for the following measures, your office must go through the attestation process. Some of the measures only look at whether you are using the functionality (Yes / No) while others are determined by meeting a minimum threshold for that objective (Numerator / Denominator).

- Yes / No: EPs must attest "Yes" to having the functionality enabled for the length of the reporting period in order to meet the requirement.

- Numerator / Denominator: The Denominator is typically the number of unique patients seen by the EP during the EHR reporting period. The Numerator is the number of patients in the denominator that meet the requirement.

  NOTE: Several of the measures have exclusions for Numerator / Denominator. If a provider is excluded from that measure, there will be a note about what he/she will need to do for attestation.

IMPORTANT: The Meaningful Use Dashboard provides statistical information for aiding healthcare providers in meeting Meaningful Use Objectives. Healthcare providers are cautioned that the denominators shown on the Meaningful Use Dashboard are based solely on information entered into the ChartMaker® Clinical Module. If a patient encounter was not entered into the Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Dashboard. In order to get accurate statistical information for the percentage calculation, to determine if you meet the Meaningful Use requirements, you may need to run additional reports. Please refer to the Center for Medicare and Medicaid Services (CMS) and this user manual for more information about calculating the correct percentage for each individual Meaningful Use Objective.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms
http://www.sticomputer.com/sticustomers.php

(1) DRUG FORMULARY CHECKS

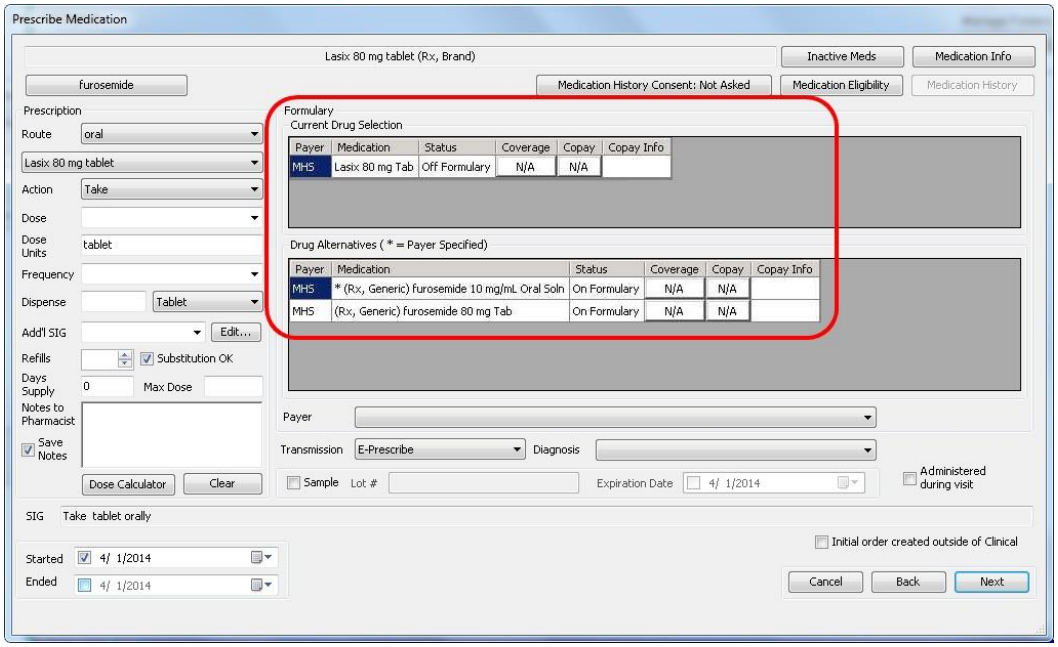
Objective:	Implement drug formulary checks.
Measure:	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
Exclusion:	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
Attestation Requirements:	Yes / No *Exclusions: EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.*

In ChartMaker Clinical:
In order to qualify for this measure, the provider must enroll with SureScripts. SureScripts is the vendor that handles e-prescribing but it also enables the formulary checks as well. Simply enrolling with SureScripts will qualify the provider to meet this measure. There is no other manual intervention on the provider's part.

To enroll in SureScripts:
1. Go to www.sticomputer.com
2. Click "Enrollments"
3. Click "SureScripts /Direct Messaging Enrollment Form"
4. Fill out the appropriate fields (including checking the box for "E-prescribing" and click "Submit"

ALTERNATE METHOD: If you do not have access to the internet, contact ChartMaker Clinical Support.

Example of Drug Formulary Information:



(2) CLINICAL LAB TEST RESULTS

Objective:	Incorporate clinical lab test results into EHR as structured data.
Measure:	More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion:	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must select "NO" next to the appropriate exclusion, then click the "APPLY" button in order to attest to the exclusion.*
Numerator:	Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
Denominator:	Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must document lab orders, track the status of that order and have documentation of the lab results(s) in the EMR. This can be accomplished by manually entering lab orders and results through a template or in conjunction with an electronic lab interface.

If you are not currently receiving electronic lab results, then you will want to contact ChartMaker Clinical Support or your trainer for more information on how to sign up for it. You will be required to contact your lab representative to initiate the interface proceedings.

AVAILABLE INTERFACES:

Labs:			
Accurate Diagnostic Labs	Clinical Laboratory Partners	Magview	SchuyLab by Schuyler House
Accu Reference Medical Lab	CNY Fertility	Main Street Radiology	Shiel Labs
Ameritox Laboratory	CSV Export	Manhattan Labs	SMA Medical Labs
Ameripath	Endo Choice	Medical Laboratory Diagnostics	Solstas Labs
Axis Diagnostics Inc.	Enzo Clinical Labs	Mercy Diagnostic	St Peters Health Care
Biodiagnostic Labs	GI Pathology	Millennium Labs	StrataDx Pathology Services
BioReference	Health Diagnostic Lab	Plus Diagnostics	Stryker Ortho
Caris Labs	Internist Associates of CNY IACNY	Practice First	Sunrise Labs
CBL Pathology	Kaleida Health	ProPath	Vascupro
Centrex	Lab Alliance	QDX Path Alliance	VitalAxis
Clearpath Diagnostics	LabCorp	Quest	

Hospitals:			
Adirondack Medical Center	Champlain Valley Physicians Hospital	Ellis Medicine	Samaritan Hospital
Albany Medical Center	Chester County Hospital	Holy Name Medical Center	South Jersey Health System
Brandywine Hospital	Crozer Keystone	INOVA Health System	St. Mary's Medical Center
Brooks Memorial Hospital	Danville Regional Medical Center	Main Line Health	Summit Health
Canton Potsdam	Dosher Memorial Hospital	Mather Hospital	
Cayuga Medical Center	Eastern Niagara Hospital	Oneida Healthcare Hospital	

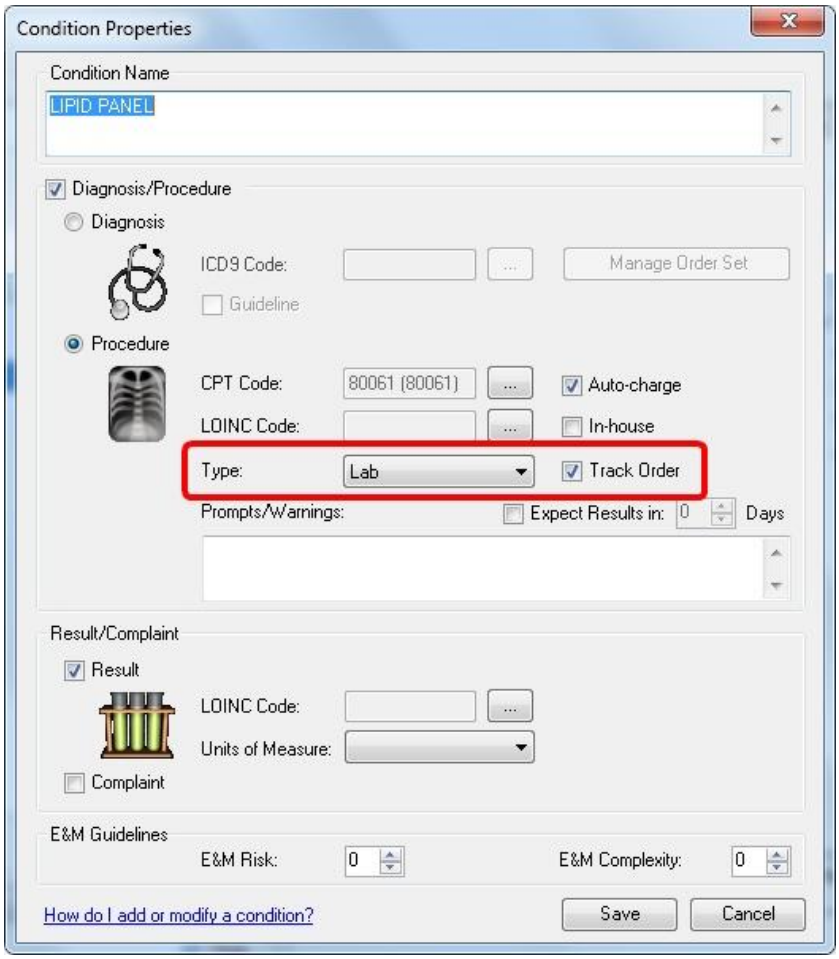
RHIOs:			
DHIN (Delaware RHIO)	HealtheConnections (Syracuse RHIO)	HIXNY (Albany RHIO)	
Greater Rochester RHIO	HealtheLink (Buffalo RHIO)		

NOTE: If you do not see a vendor that you use listed, please contact ChartMaker Clinical Support or your sales representative for information on initiating an interface.

To configure a lab procedure:

1. In Clinical, go to Edit > System Tables > Conditions > Procedures
2. Search for the lab procedure by typing the description or code
3. Highlight the procedure and click "Properties"
4. Change the "Type" field to Lab

5. Check the box for “Track Order”



NOTE: If the lab is performed at your office location, then you may want to select the checkbox for “In-house” as well.

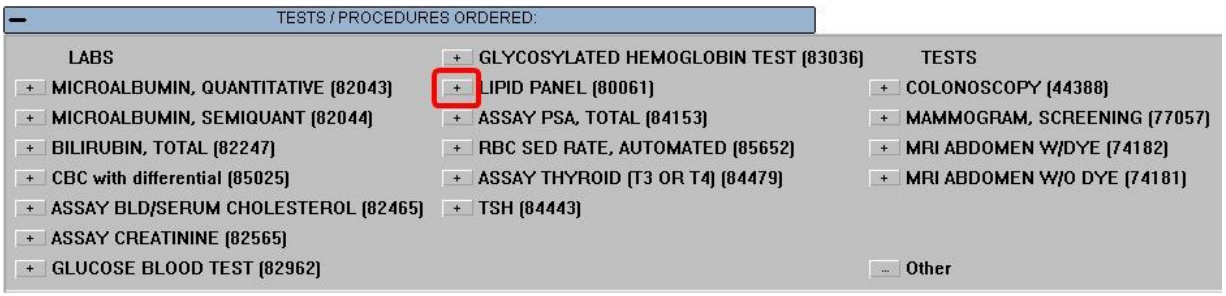
6. Click “Save”

7. Repeat steps 2 – 5 for each additional procedure

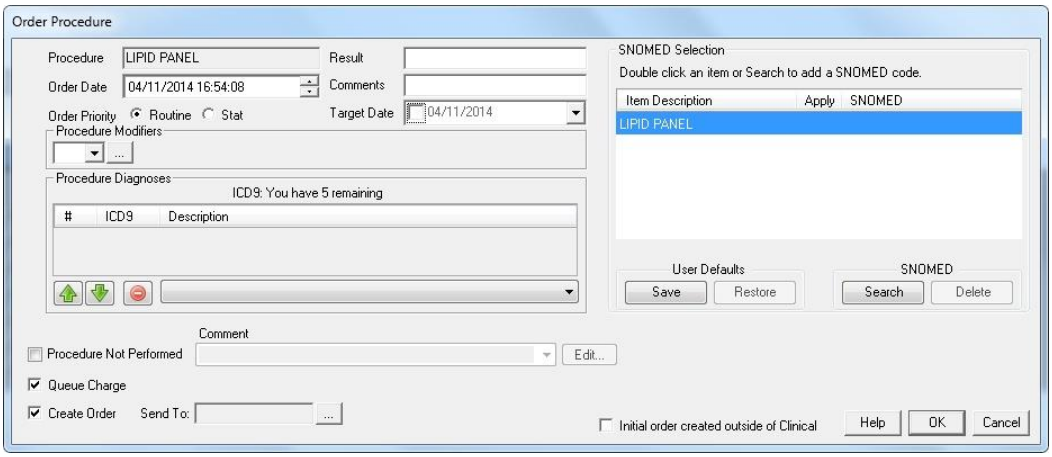
8. Click “Close” to close the Procedure Search dialog

To document/order a lab:

1. In a progress note, select the appropriate lab from within a procedure checklist



2. Select the appropriate information and click “OK”



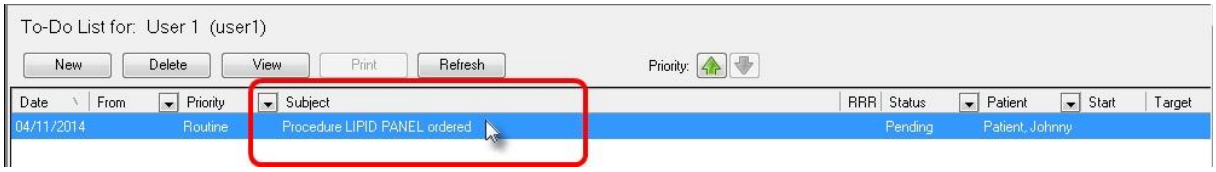
NOTE: Applicable information may include (but not limited to) Diagnosis and SNOMED codes. If you do not select a Diagnosis, you will be prompted to confirm that you would like to proceed without one by clicking “Yes” at the prompt. If the checkbox for “Initial order created outside of Clinical” is selected, you will not receive credit for this procedure for this measure.

3. Repeat steps 1 – 2 for each additional lab

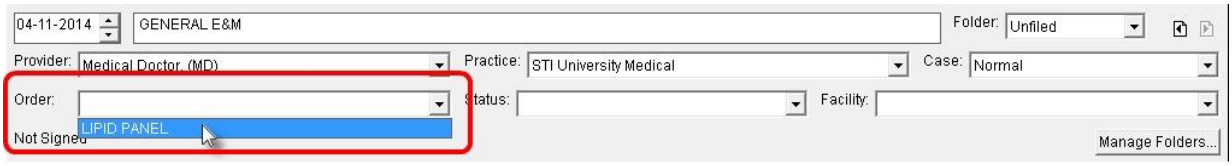
NOTE: The lab(s) will then output in the progress note, on the patient’s Face Sheet and on the ordering user’s To Do List on the Orders tab. To view a complete list of preferences related to Orders, view the Appendix on page 91.

To change the status of a lab (off-site):

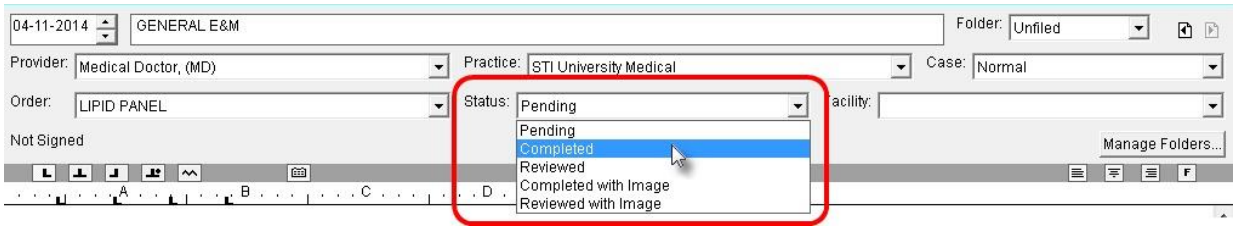
1. Open the patient’s chart or double-click on the Order from the To Do List



2. Select the applicable Order from the “Order” dropdown



3. Select the applicable Status from the “Status” dropdown

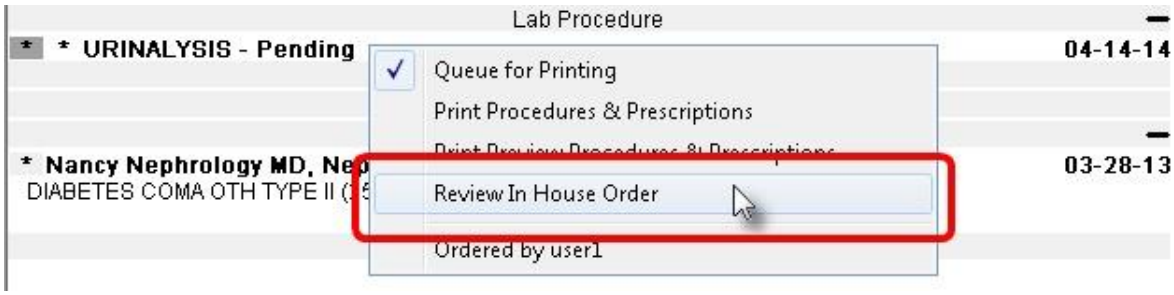


NOTE: Selecting a Status of “Completed” or “Reviewed” will give you credit for reviewing the lab for Meaningful Use purposes. Selecting a Status of “Reviewed” will remove the reminder from the Face Sheet and the To Do List.

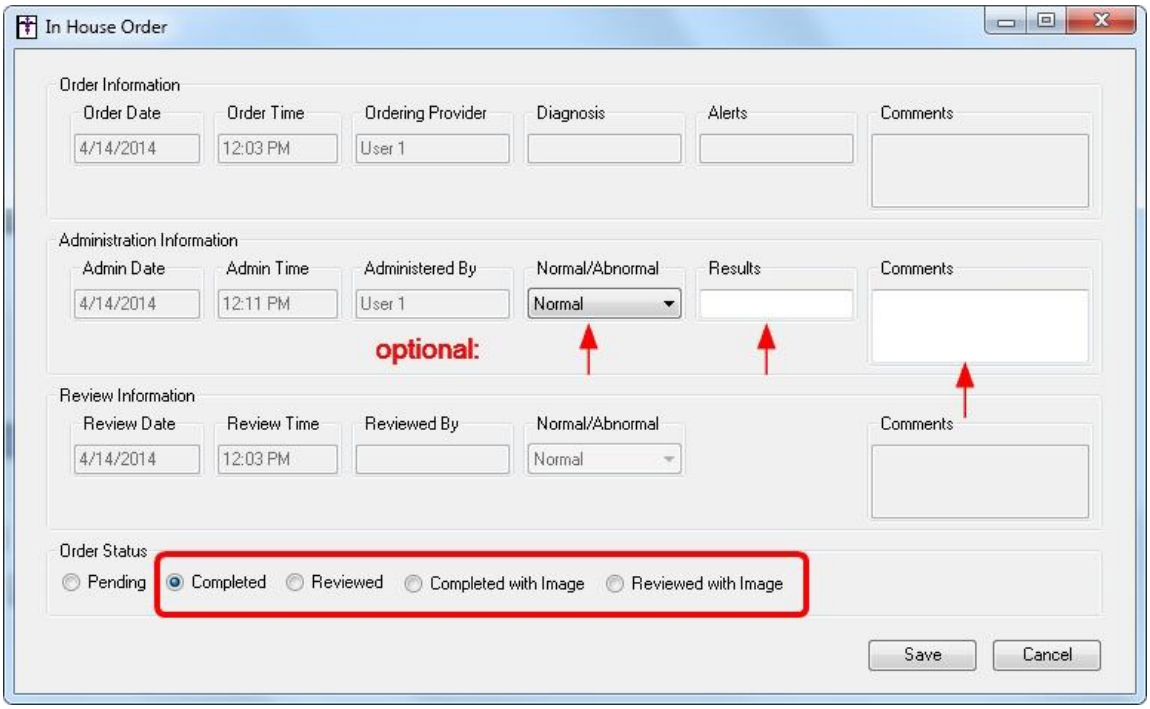
To change the status of a lab (in-house):

1. Open the patient's chart or double-click on the Order from the To Do List

2. Right-click on the Order from the Face Sheet and select "Review In House Order"



3. Select the appropriate Order Status



NOTE: Changing "Normal/Abnormal" and adding information for "Results" and "Comments" is optional. If this information is modified, it will be displayed in the auto generated note that will be created once the Order is reviewed. Selecting a Status of "Completed" or "Reviewed" will give you credit for reviewing the lab for Meaningful Use purposes. Selecting a Status of "Reviewed" will remove the reminder from the Face Sheet and the To Do List.

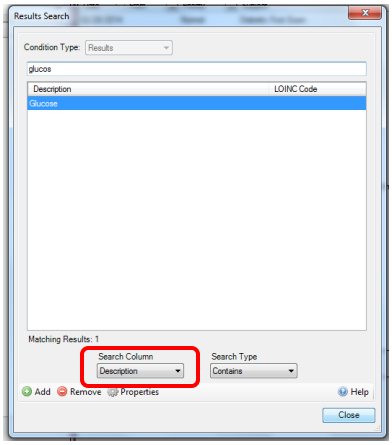
4. Click "Save"

In order to achieve this measure, the lab results also needs to be incorporated in the patient's chart as structured data. If you have an electronic lab interface(s) that accounts for 40% of your labs ordered then that will suffice. If you do not have an electronic lab interface and/or if the interface does not account for 40% of your labs ordered, you will need to manually document the lab results in the patient's chart. The following steps need to be taken if manually documenting lab results:

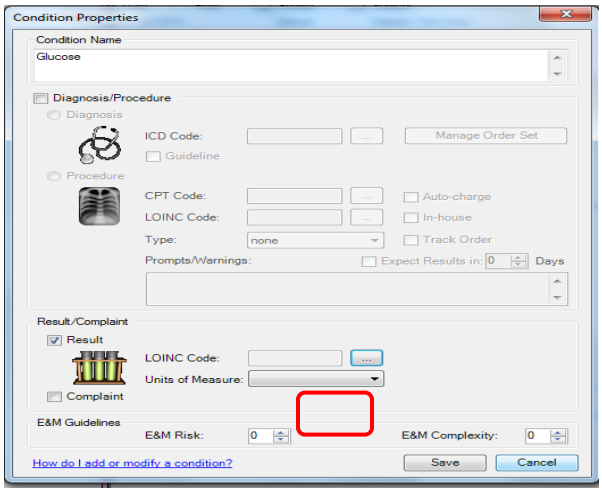
To link LOINC codes to lab conditions:

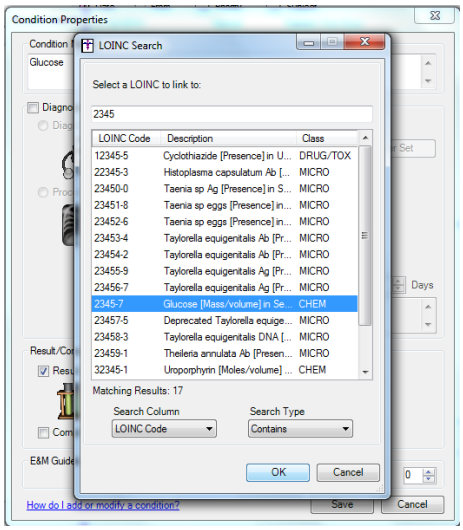
1. Go to Edit > System Tables > Conditions > Results

2. Search for the condition by Description, highlight it and click "Properties"



3. Click on the ellipsis to the right of LOINC code and search for the LOINC code that you found on the LOINC website. Highlight the applicable code.





NOTE: Information on LOINC codes can be found at www.loinc.org or by logging into the Customer's section on www.sticomputer.com and navigating to the PatientPortal page.

4. Click "OK" to select the LOINC code

5. Click "Save" to save the Properties dialog

6. "Close" to close the Results Search dialog

To modify a template to include a numeric field (with a condition mapped to a LOINC code):

NOTE: Instructions on Template Editing can be found under STI University > Videos at www.sticomputer.com after logging into the "Customers" section or in the ChartMaker Clinical Help Files.

1. Go to View > Template List

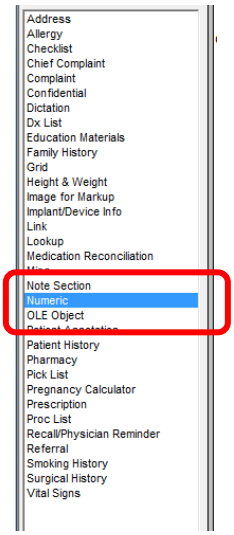
2. Open an existing template or create a new one by clicking "New" from the bottom

   NOTE: If you are creating a new template, you will need to name the template before proceeding.

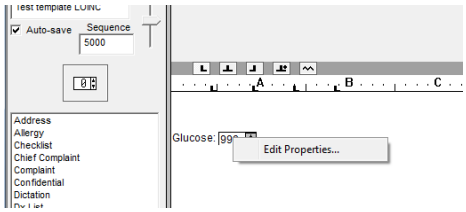
3. Place your cursor within the template where you would like your numeric field to go

   TIP: Do not place your cursor on the top line of the template as sometimes this causes information to get cut off when viewing a note. Hit the "enter" key at least once to add a hard return.

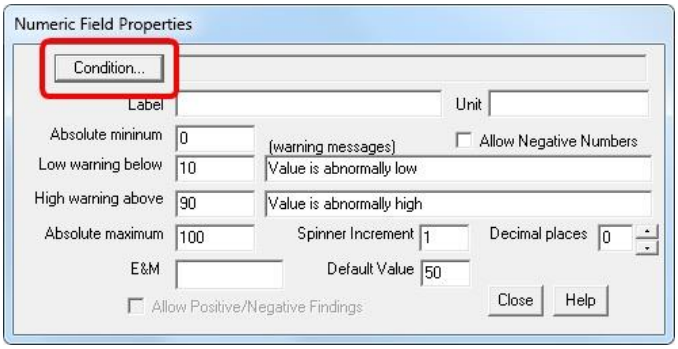
4. Double-click "Numeric" from the left pane



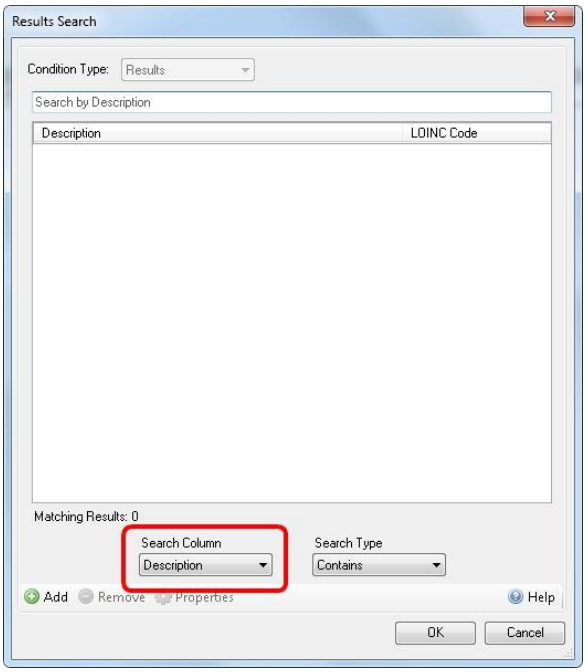
5. Right-click the Numeric field in the template and click "Edit Properties"



6. Click “Condition”



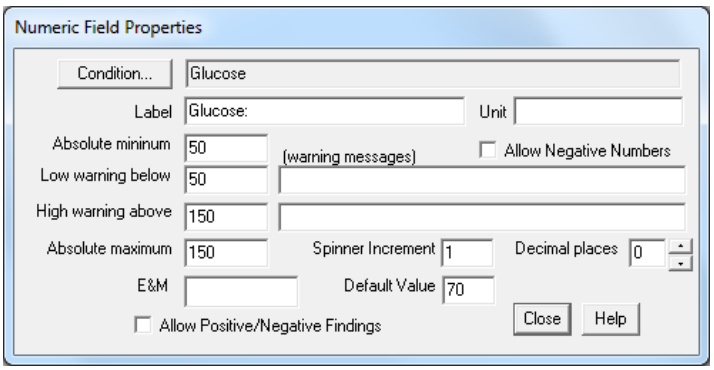
7. In the Search Column dropdown, select “LOINC Code”



8. Type in the LOINC Code

9. Highlight the appropriate result and click “OK”

10. Enter a “Label” (description that will print in front of the lab result value) and any other applicable information



11. Click “Close”

12. Repeat steps 3 through 11 for each additional result

To manually document lab results as structured data:

1. Open the patient’s chart
2. Open the applicable Lab Results template
3. Enter values in the numeric fields for the applicable labs
4. Sign the note
5. Close the chart

> **NOTE**: When a note is signed with a lab condition mapped to a LOINC code, the results for that lab condition will be added to the Clinical Summary and uploaded to the PatientPortal (if the patient is a registered PatientPortal user).

ADDITIONAL INFORMATION:

- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

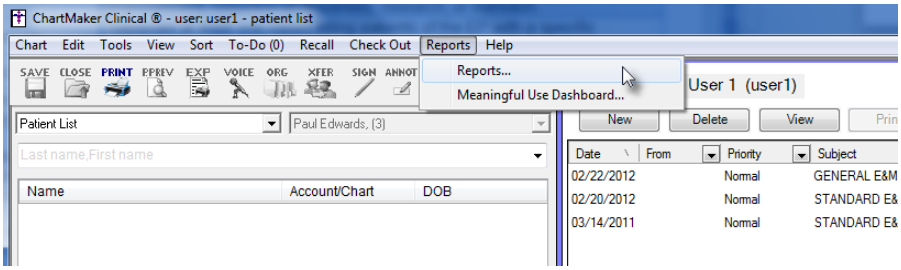
(3) PATIENT LISTS

Objective:	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
Measure:	Generate at least one report listing patients of the EP with a specific condition.
Exclusion:	No exclusion.
Attestation Requirements:	Yes / No

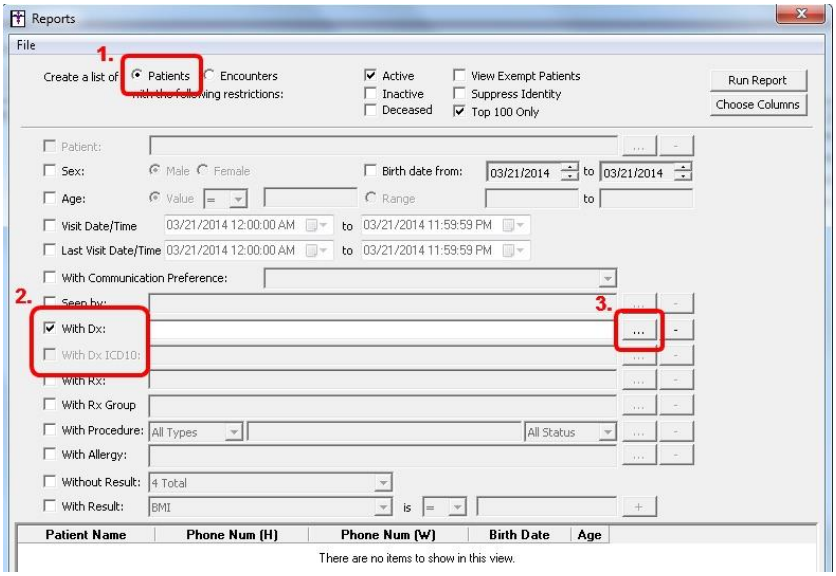
In ChartMaker Clinical:
In order to qualify for this measure, the provider must query the database for a list of patients with a specific condition (diagnosis). A copy of this report should be generated during the reporting period and kept for proof of completion.

To generate a list of patients:

1. From the main screen, go to Reports > Reports…



2. Select the criteria you would like to search for

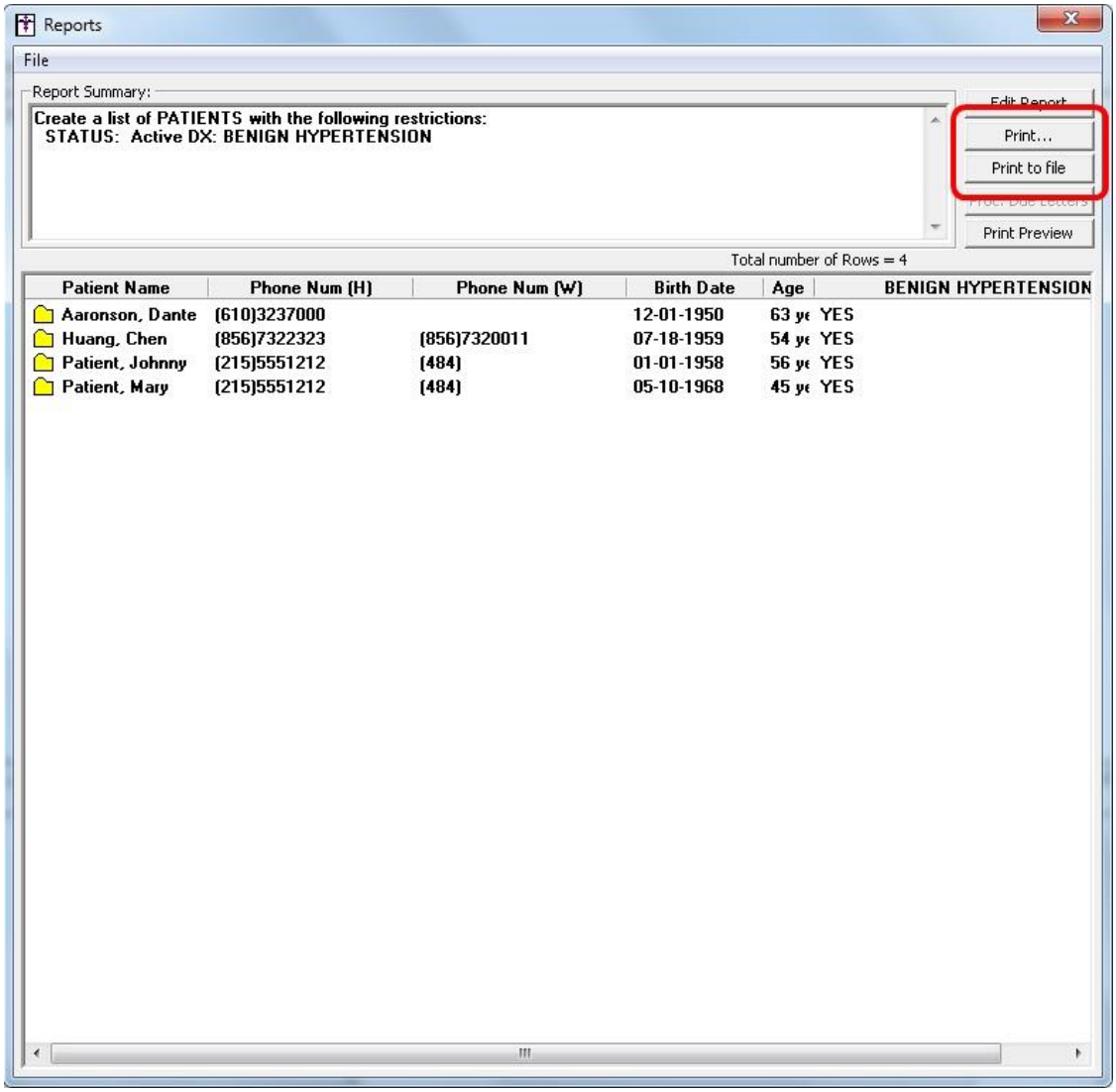


NOTE: If you want to anonymise the data, click “Suppress Identity”. You can select either “With Dx” or “With Dx ICD10”.

It is recommended to click “Choose Columns” and select “Provider Name”, or select the “Seen by” filter and then the applicable provider so that the provider associated with the patient prints on the report as well.

3. Click “Run Report”

4. Click “Print” or “Print to file”



NOTE: Selecting “Print to file” will prompt you to save the information in a text (.txt) file. A copy of this report should be kept for proof of completion for this measure.

ADDITIONAL INFORMATION:

- This report could also be run through Practice Manager as long as your practice is using Practice Manager to enter charges which include diagnosis information. The report can be run by going to the Reports tab > Managed Care tab > Charge Analysis Standard. On the 2. Select Criteria sub-tab, select the desired diagnosis (“Diagnosis 1 Code”) and time range (“Charge Start Date”, using the Operation of “Between”). The time range should be equivalent to your reporting period.

(4) PATIENT REMINDERS

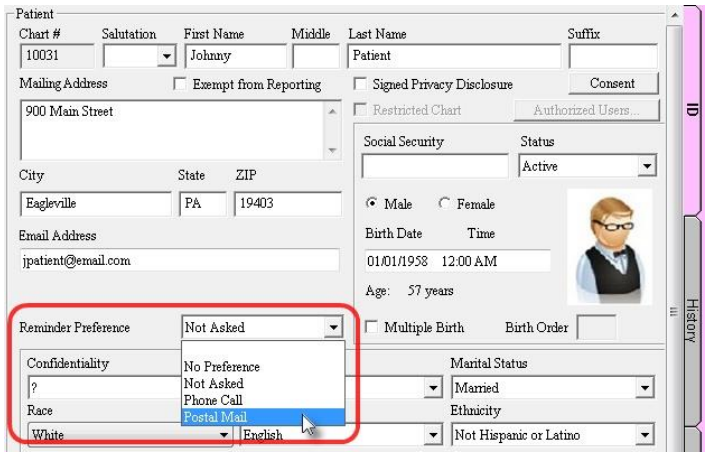
Objective:	Send reminders to patients per patient preference for preventive/follow-up care.
Measure:	More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
Exclusion:	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must select "NO" next to the appropriate exclusion, then click the "APPLY" button in order to attest to the exclusion.*
Numerator:	Number of patients in the denominator who were sent the appropriate reminder.
Denominator:	Number of unique patients 65 years old or older or 5 years old or younger, that are living, listed in the system as active patients, and for which the eligible provider is listed as the provider on at least one chart note in the 5 years prior to the start date of the reporting period.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must generate patient reminders for preventative or follow-up care per the patient's communication preference.

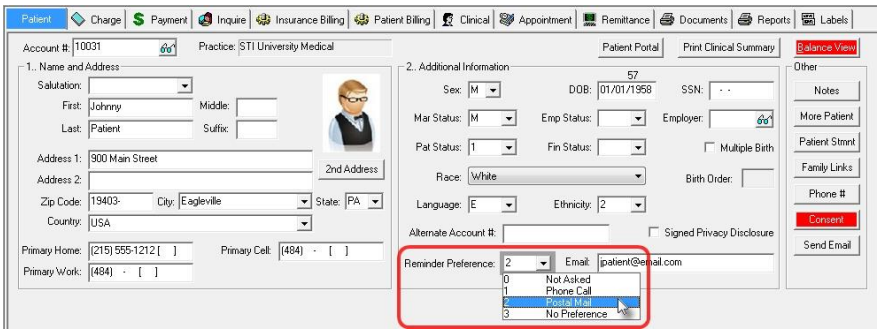
To set the patient's communication preference:

1. In the patient's chart, go to the ID tab

2. Select the preferred method from the "Reminder Preference" dropdown



ALTERNATE METHOD: The communication preference can also be set in Practice Manager on the Patient screen.



3. Click "Save" ( )

To create a patient reminder (Recall):

1. In Clinical, open a note in the appropriate patient's chart

   ALTERNATE METHOD: In Practice Manager, open the patient's account on the Charge tab and click the "3. Patient Recall" sub-tab. Click "New" to add a new Recall and continue with Step 4.

2. Click "Recall/Physician Reminder" (

)

3. Click "New" from the Recall List section

4. Enter the appropriate information and click "OK"

   NOTE: Recall Type and Recall Date are the only required fields.

5. Click "OK" to close the Patient Recalls and Physician Reminders dialog

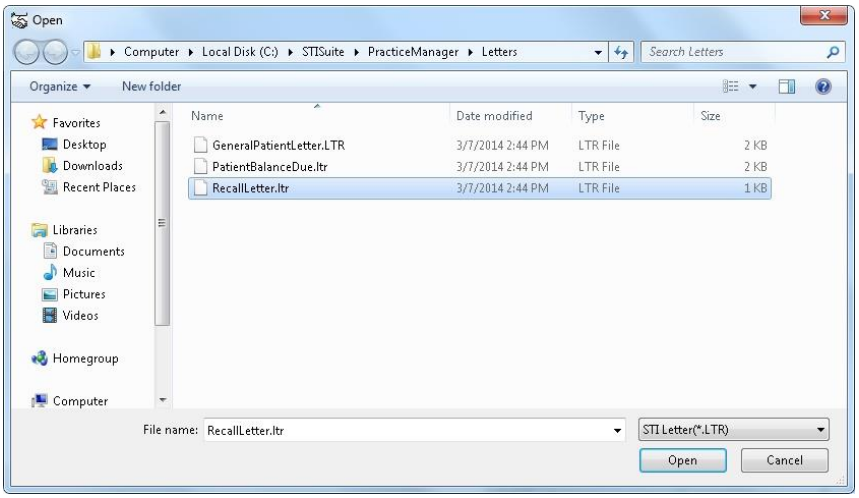
To generate patient reminder letters (Recall Letters):

NOTE: The patient's status (on the Patient tab) cannot be blank in order for Letters to generate properly.

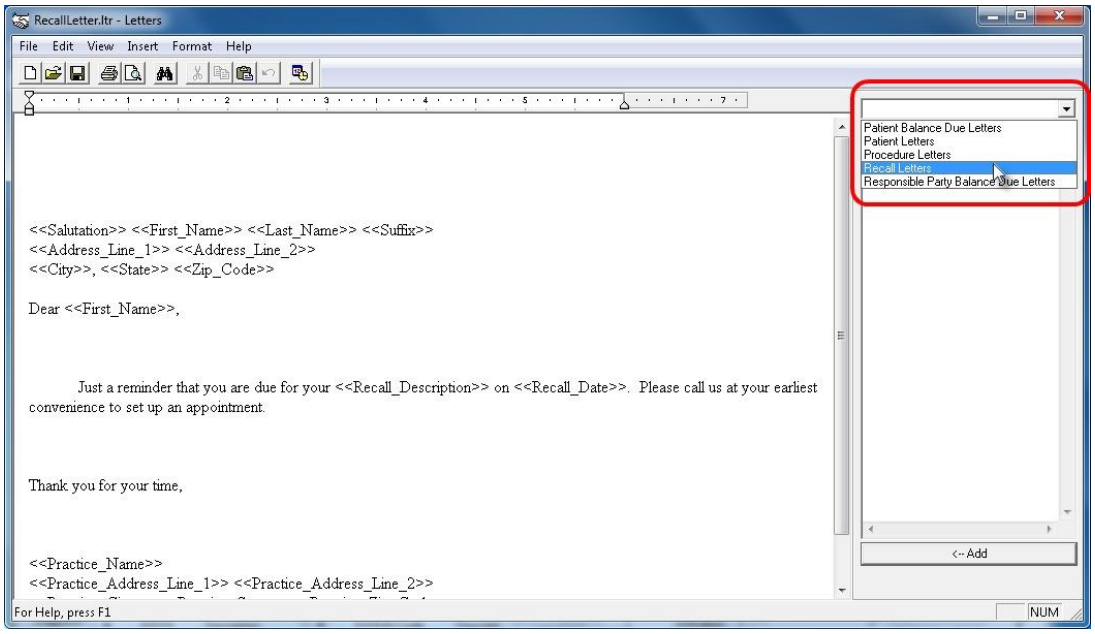
1. In Practice Manager, go to Add-Ins > Letters

2. Click "Open" ()

3. Highlight the appropriate letter and click "Open"



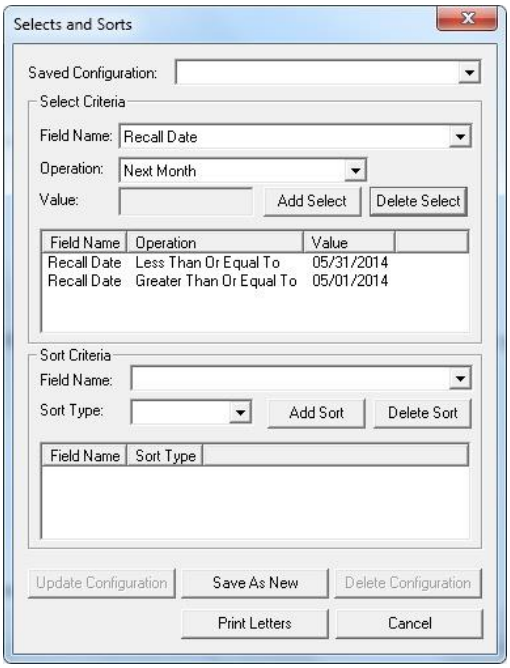
4. In the dropdown on the right, select the appropriate letter type



5. Adjust the letter contents as necessary
6. Click “Print” ()
7. Select “Recall Date” in the Field Name field
8. Select “Next Month” in the Operation field

   NOTE: You can select different criteria in this field, depending on the time range you would like to run this for. Selecting a different option may require you to also select information for “Value”.

9. Click “Add Select”



10. Click “Print Letters”

11. Click “Yes”

12. Type a name for this batch of letters and select “Update Recalls with Postal Mail notification”

NOTE: This information will then be displayed in the Inquire tab on the “9. Letters Sent” sub-tab.

13. Click “OK”

ADDITIONAL INFORMATION:

- The EP has the discretion to determine the frequency, means of transmission, and form of the reminder limited only by the requirements the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), and any other applicable federal, state or local regulations that apply to them.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.
- To receive full credit for this measure, you must enter a Recall and generate a Recall Letter.

(5) PATIENT-SPECIFIC EDUCATION RESOURCES

Objective:	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
Measure:	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
Exclusion:	No exclusion.
Attestation Requirements:	Numerator / Denominator
Numerator:	Number of patients in the denominator who are provided patient-specific education resources.
Denominator:	Number of unique patients seen by the EP during the EHR reporting period with an office encounter.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must provide the patient with educational materials specific to the patient. The provider can use the patient's problem list, medication list or laboratory test results to identify which educational materials are appropriate for the patient. The educational materials do not need to be stored within or generated by the EHR. However, if you are generating them through the steps listed below, ChartMaker Clinical will be able to calculate the numerator correctly without manual intervention. Educational material options can be added to the database, if desired. In a patient note, you will have the option to select from your pre-defined list or from information found on MedlinePlus.

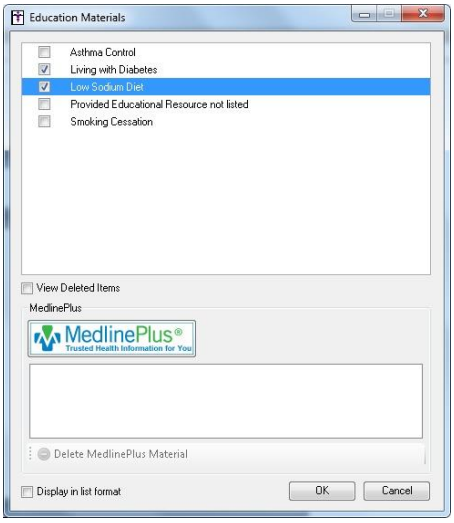
To add educational material options to the database:

1. Go to Edit > System Tables > Education Materials
2. Click "Add"
3. Type the description of the educational resource
4. Click "OK" to close the Education Materials System Table dialog

NOTE: Repeat steps 2-3 for any additional educational resource options before clicking "OK"

To document educational materials using the "Education Materials" button:

1. In an office visit note, click "Education Materials" (Education Materials)
2. Select the checkbox for the item(s) you would like to document in the current note from the box at the top



OR

Click “MedlinePlus” (

) and either search by selecting one of the patient’s Diagnoses, Medications or Labs from the boxes at the top:

Or by typing the subject you are looking for into the following box and clicking “Go”:

After selecting the appropriate item, click “Save” or “Save and Print”

3. Click “OK” to close the Education Materials dialog

4. Enter an appropriate CPT code

   NOTE: View the complete list in the Appendix on page 90.

To document educational materials using Clinical Decision Support

See the section on “(10) Clinical Decision Support Rule” on page 23. The only step that would be different is when setting up the Rule, the Rule Type should be set to “Education Materials”.

When possible, using Clinical Decision Support is the preferred method to generating educational materials as the final rule stated, “we agree with the HIT Policy Committee and others that the objective and associated measure should make clear that the EP should utilize certified EHR technology in a manner *where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology*.”

ADDITIONAL INFORMATION:

- While CEHRT must be used to identify patient-specific education resources, these resources or materials do not have to be stored within or generated by the CEHRT.
- The provider can use the patient’s problem list, medication list or laboratory test results to identify which educational materials are appropriate for the patient.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(6) MEDICATION RECONCILIATION

Objective:	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
Measure:	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Exclusion:	An EP who was not the recipient of any transitions of care during the EHR reporting period.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must select "NO" next to the appropriate exclusion, then click the "APPLY" button in order to attest to the exclusion.*
Numerator:	Number of transitions of care in the denominator where medication reconciliation was performed.
Denominator:	Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition for patients with an office encounter.

In ChartMaker Clinical:
In order to qualify for this measure, the provider must perform a medication reconciliation whenever a patient is transferred into their care from another setting (i.e. hospital or skilled nursing care), in the last 60 days. This means the provider must compare what the patient was taking while under the care of the outside provider versus what they are taking under your care.

To perform a medication reconciliation:

1. Obtain a list of medications the patient was on under the care of the transferring provider

2. Open the patient's chart and compare that list with what is in ChartMaker® Clinical

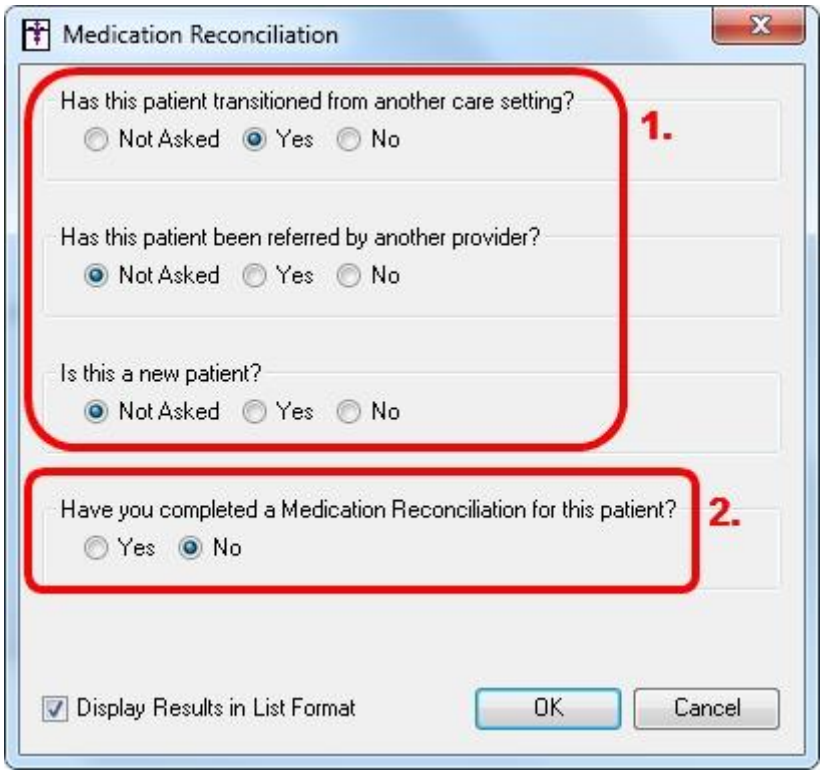
3. In a chart note, click "Medication Reconciliation" (

)

   ALTERNATE METHOD: Enter one of the following medication reconciliation codes from within a procedure checklist. If using this method, you can skip step 4.

   - 1110F – Medication Reconciled (from inpatient facility)
   - 1111F – Medication Reconciled (from outpatient facility)
   - 1111F with 8P - Medications not reconciled with the current medication list in outpatient medical record, reason not otherwise specified

4. Select “Yes” to the appropriate method of referral and/or if they are a new patient and “Yes” that Medication Reconciliation was performed and then click “OK”



5. In the same note, enter an appropriate CPT code for the office visit:

   NOTE: View the complete list in the Appendix on page 90.

ADDITIONAL INFORMATION:

- If you do not have the applicable medication reconciliation procedure codes (referenced in Step 3 – Alternate Method) in your database, they should be added through Practice Manager (Administration > Transaction Tables > Procedure).
- Selecting “Yes” to any of the top 3 questions (transitioned from another care setting; referred by another provider; is this a new patient) will put the patient in the denominator. Selecting “Yes’ to the last question (whether medication reconciliation was completed) will put the patient in the numerator.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(7) TRANSITION OF CARE SUMMARY

Objective:	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
Measure:	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
Exclusion:	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
Attestation Requirements:	Numerator / Denominator *Exclusions: EPs must select "NO" next to the appropriate exclusion, then click the "APPLY" button in order to attest to the exclusion.*
Numerator:	Number of transitions of care and referrals in the denominator where a summary of care record was provided.
Denominator:	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

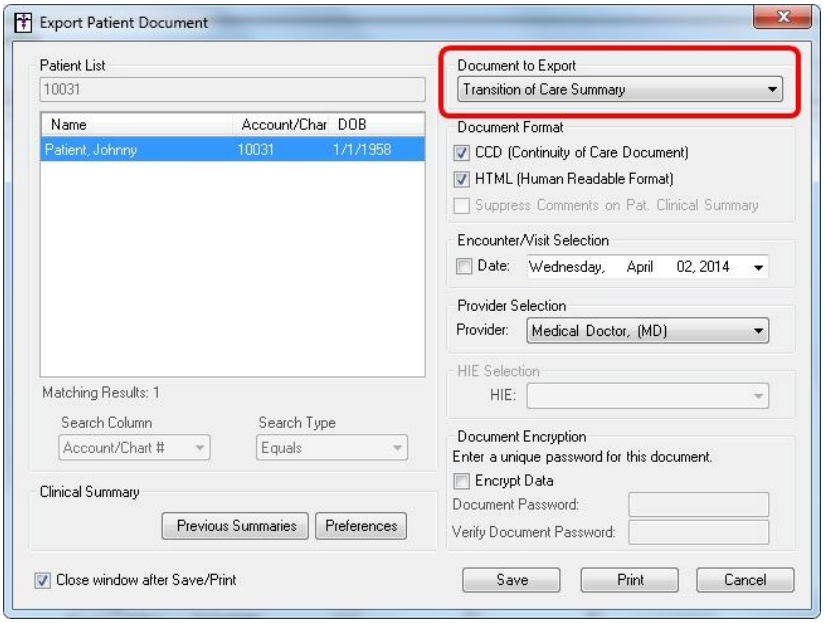
In ChartMaker Clinical:
In order to qualify for this measure, the provider must provide a summary of care record to the receiving provider when a patient is transitioning to a new provider, or has been referred to another provider and still remains under the referring provider's care.

To generate a Transition of Care Summary:

1. Go to Chart > Export > Patient Data

   ALTERNATE METHOD: If you are outside of a patient's chart, you will use the same steps to access the Transition of Care Summary, however you will need to search for the patient first after opening the Export Patient Document dialog.

2. Select "Transition of Care Summary" from the Document to Export dropdown

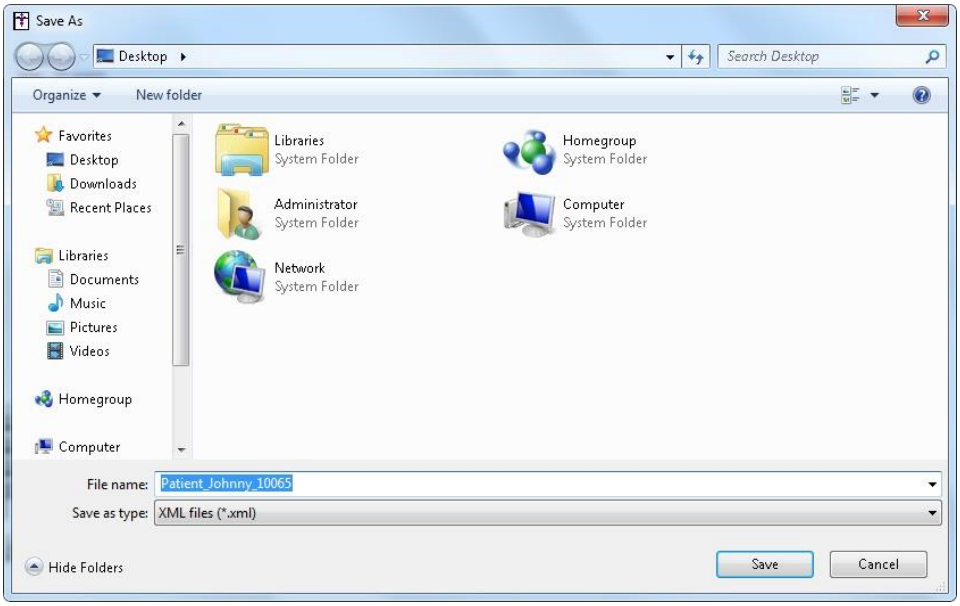


3. Select the appropriate Provider from the "Provider Selection" dropdown

4. Click “Save”

5. (Optional) If prompted with the Patient Information Document Exclusions dialog, select the information that you do not want to print on the Transition of Care Summary and click “OK”

6. Browse to where you would like to save the file and click “Save”



NOTE: The file will be named “LastName_FirstName_PatientID” by default. You can change the name of the file if you prefer. (The patient ID is not the same as their account number).

7. Click “OK”

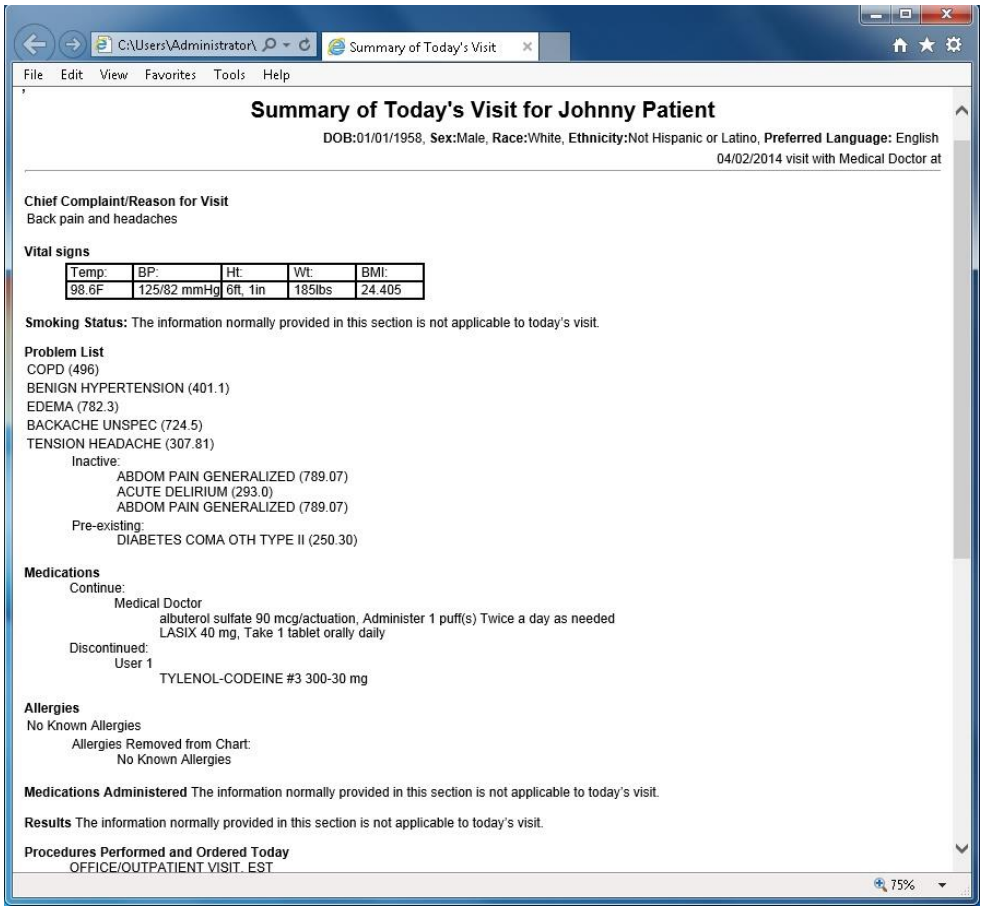
NOTE: The file(s) will now be saved to the specified location. The CCD file will be saved as an .xml file and the HTML file will be saved as a .html file.

CCD:

HTML:

The HTML file is a human readable formatted document that when opened is displayed in a web browser. The CCD file is a file format that can be imported into another EHR, therefore it is not in a human readable format. You may choose to unselect this file format when generating the file if you do not plan to send a copy to another practice.

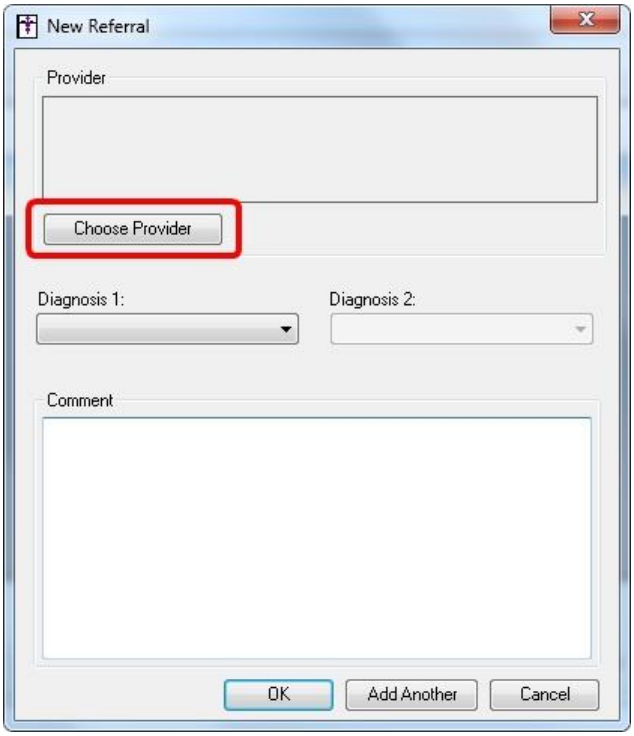
Example of HTML copy of Transition of Care Summary:



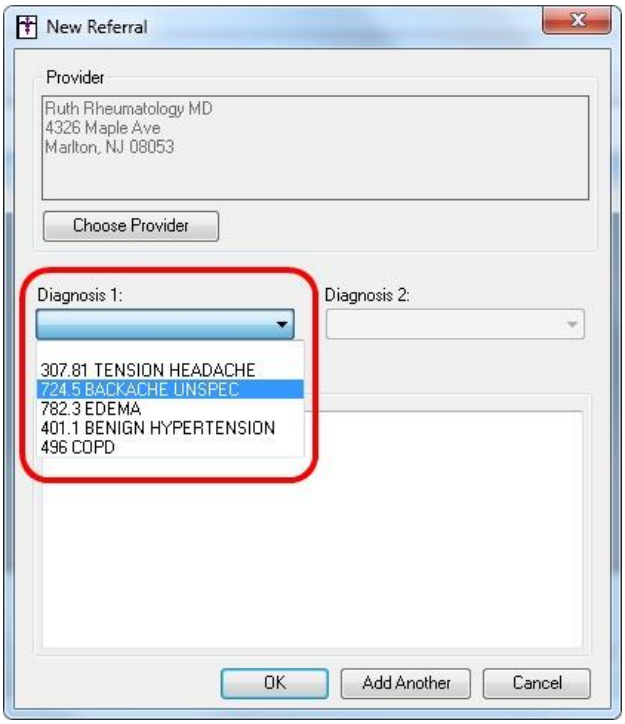
To document the transition of care (Optional):

1. In an office visit note, click the “Referral” button (

)
2. Click “New”
3. Click “Choose Provider”

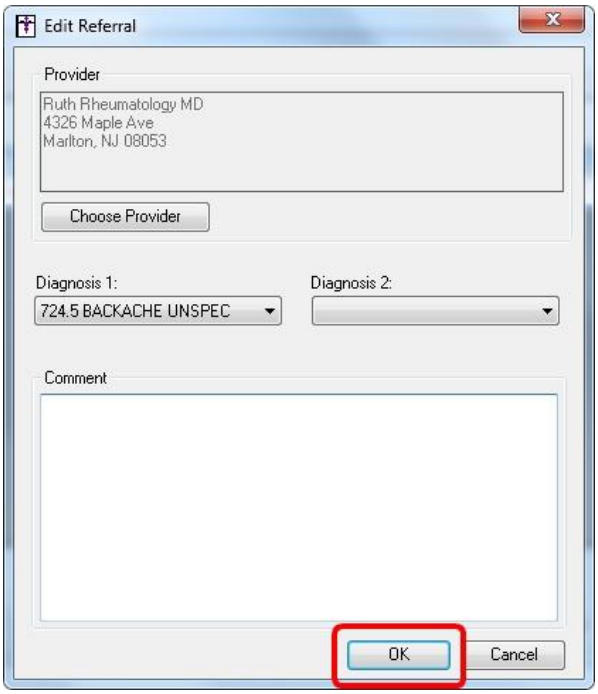


4. Search for and highlight the appropriate Provider. Click “OK”.
5. Select at least one diagnosis from the patient’s Problem List



6. Enter Comments, if applicable

7. Click “OK”



8. Click “OK” to close the Referral dialog

NOTE: Entering information into the office visit note through the “Referral” button will only contribute to the denominator. Generating the Transition of Care Summary report will contribute to the numerator. If you enter information through the “Referral” button but do not generate a Transition of Care Summary report, you will never contribute to the numerator (meaning you will only be at 50% for this measure).

In order to be at 100% for this measure, you either need to:

a) Enter information into the “Referral” button and generate a Transition of Care Summary report
   or
b) Generate a Transition of Care Summary report

ADDITIONAL INFORMATION:

- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably be expected to do so.
- If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient should not be included in the denominator for transitions of care.
- If the user creates an office note, the “Referral” button must be used in conjunction with generating the Transition of Care Summary in order to reach 100% for this measure. If an office note is not created, then simply generating the Transition of Care Summary will get you to 100%.
- The only data used to determine the denominator is data from the ChartMaker Clinical Module. If a patient encounter was not entered into the ChartMaker Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Meaningful Use Dashboard. Please add these additional patients to the denominator and recalculate the percentage for Attestation purposes.

(8) IMMUNIZATION REGISTRIES DATA SUBMISSION

Objective:	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
Measure:	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), except where prohibited.
Exclusion:	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.
Attestation Requirements:	Yes / No *Exclusions: EPs must select "NO" next to the appropriate exclusion, then click the "APPLY" button in order to attest to the exclusion.*

In ChartMaker Clinical:
In order to qualify for this measure, the provider must submit electronic immunization information to their local immunization registry for pediatric and adult patients. The state of DE, GA, NY, NJ, MD, PA, and VA, and the city of Philadelphia ("KIDS Plus") currently have immunization registries that accept electronic data. If the entity that you submit immunization information to does not accept them electronically, then you would meet the exclusion for this measure.

To send immunization information electronically from ChartMaker Clinical:

1. Go to www.sticomputer.com and click "Enrollments"

2. Under the "Immunization Registry Enrollment" section, find the applicable registry and download any applicable materials.

If you need assistance, please contact Clinical Support at 800-487-9135.

ADDITIONAL INFORMATION:

- Only sending the registry a test file is required in order to meet this measure however your practice could decide to send information on an ongoing basis, if so desired.
- It is recommended that the practice take a screenshot showing the process of sending the test submission as well as the file that was sent. Alternately, a letter or email from the registry or public health agency confirming the receipt (or failure of receipt) of the submitted data, including the date of the submission, name of parties involved, and whether the test was successful should be collected as well.

(9) SYNDROMIC SURVEILLANCE DATA SUBMISSION

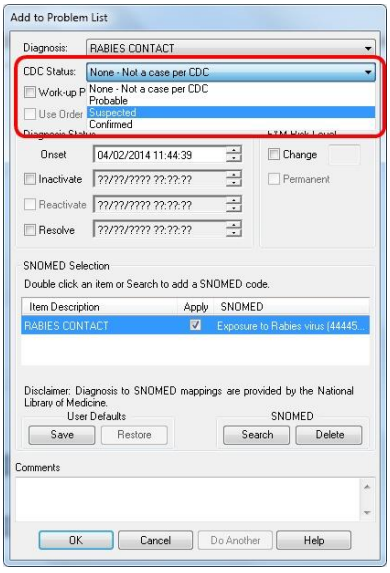
Objective:	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.
Measure:	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health 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), except where prohibited.
Exclusion:	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.
Attestation Requirements:	Yes / No *Exclusions: EPs must select "NO" next to the appropriate exclusion, then click the "APPLY" button in order to attest to the exclusion.*

In ChartMaker Clinical:
In order to qualify for this measure, the provider must submit syndromic information about infectious diseases (such as H1N1, Tuberculosis, Rabies, etc.) to the local CDC in an electronic format. If your local agency does not have the capacity to accept this information electronically, then you would meet the exclusion for this measure.

To document syndromic status:

1. In an office visit note, select a diagnosis

2. In the CDC Status dropdown, select the appropriate status



NOTE: The status options are:

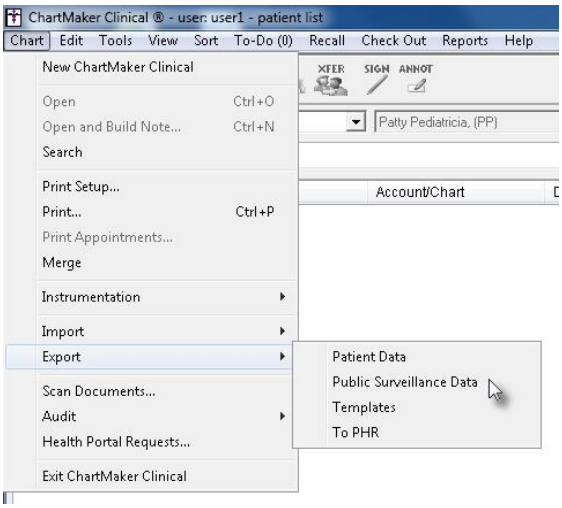
- Probable
- Suspected
- Confirmed

For complete definitions of these statuses, see the CDC's website or http://www.cdc.gov/ncphi/disss/nndss/casedef/index.htm

3. Click "OK"

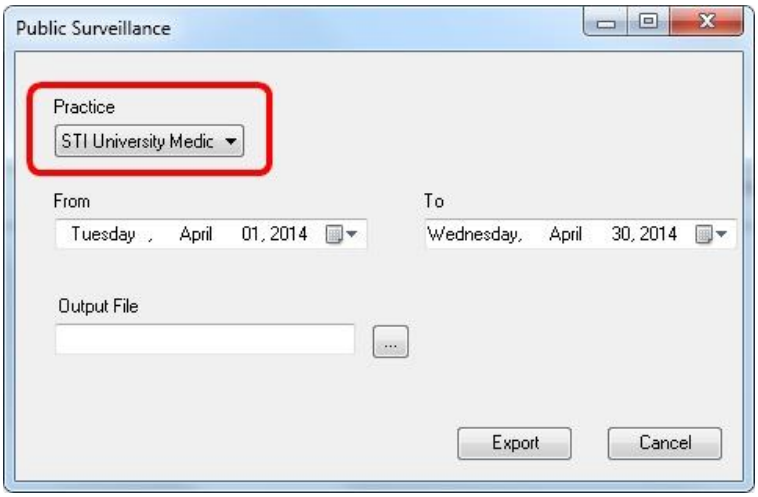
To export public surveillance data:

1. Go to Chart > Export > Public Surveillance Data

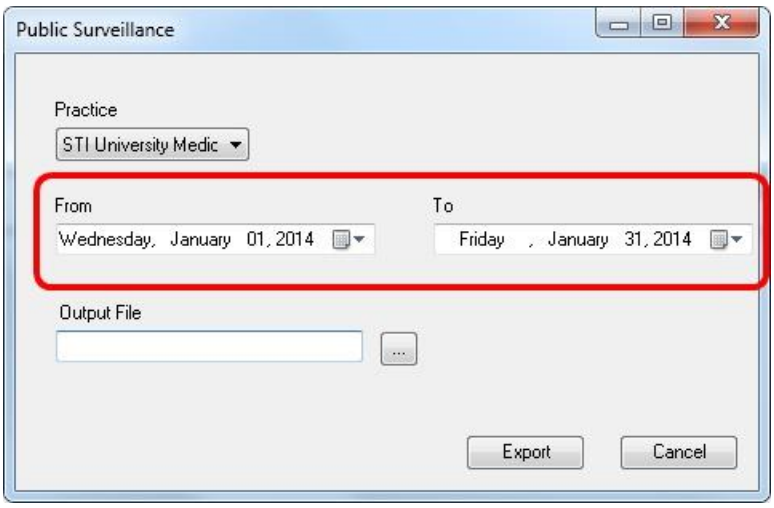


NOTE: This must be done outside of the patient's chart.

2. Select the appropriate practice from the dropdown

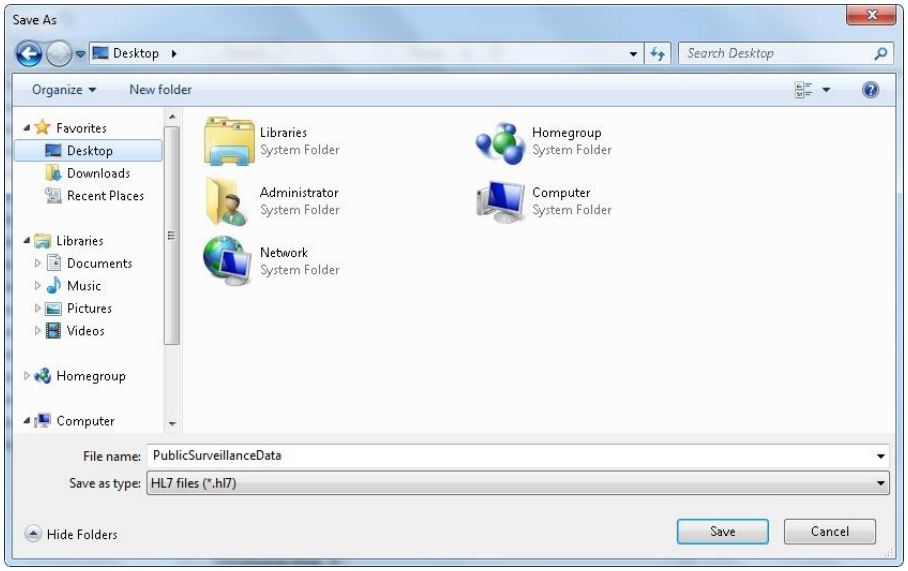


3. Select the appropriate data range



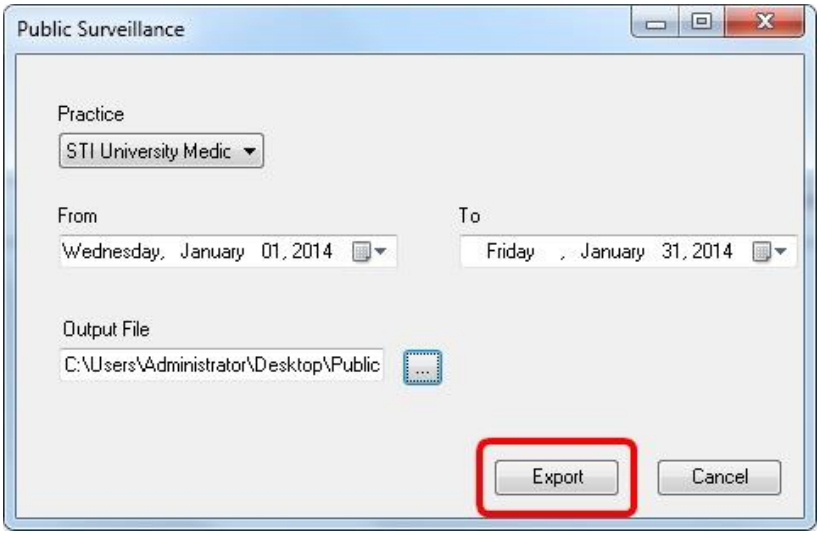
4. Click the () in the “Output File” field

5. Select where you would like to save the file and click “Save”

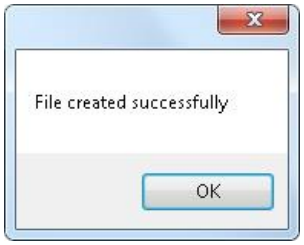


NOTE: The file will be saved in a HL7 format and will be named “PublicSurveillanceData” by default. You can change the file name if you want.

6. Click “Export”



7. Click “OK”



8. Click “Cancel” to close the Public Surveillance dialog

ADDITIONAL INFORMATION:

- As of 9/29/14, the current status for the following registries are as follows:

State Registry	Status
Delaware	Not accepting data electronically from EPs yet
Georgia	Currently accepting data electronically from EPs. More information can be found at: http://dph.georgia.gov/meaningful-use
Maryland	Not accepting data electronically from EPs yet
New Jersey	Not accepting data electronically from EPs yet
New York	Not accepting data electronically from EPs yet (outside of NYC)
Pennsylvania	Currently accepting data electronically from EPs through a third party called Health Monitoring Systems (HMS). HMS can only accept data via an interface which is currently not supported by STI.
Virginia	Currently accepting data electronically from Family Medicine, Internal Medicine, Pediatric, or Infectious Disease EPs. More information can be found at: https://www.vdh.virginia.gov/meaningfuluse/mu2/Login/Login.aspx

- It is recommended that the practice take a screenshot showing the process of sending the submission as well as the file that was sent. Alternately, a letter or email from the registry or public health agency confirming the receipt of the submitted data, including the date of the submission, name of parties involved, and whether the test was successful could be collected as well.
- Diseases that fall into the CDC reporting requirements are as follows:

Diagnosis	ICD-9 Code(s)
Acquired immunodeficiency syndrome (AIDS)	042, 073.93
Amebiasis	V02.2, 006.9, 006
Anthrax	V01.81, 022.3, 022.9, 022
Aseptic meningitis	100.81, 322.9, 047.9, 047.0, 047.1. 321.2, 348.2, 053.0, 072.9
Botulism, foodborne	005, 005.1
Botulism, infant	005.1, 040.41, 771, 005
Botulism, wound	005.1, 040, 040.42, 005
Botulism, unspecified	040, 005
Brucellosis	023.8, 023.9, 780.6, 023.1, 023.2, 277.31, 711.4, 716.9, 066.1, 695.9
Chancroid	099, 099.9, 289.3, 682.9
Cholera	001, 001.9, V06.0, V01, V03, 994.9
Congenital rubella syndrome	771.0, 136.9, 323.9, 760.2, 646.9, V22.2, V82.9, 716.9
Diphtheria	032.9, 032.89, V06.3, V06.1, V06.2, V06.5, V03.5, V05.9, V02.4, V07.2, 357.4, 344.9, 604.91, 478.30, 716.9, 580.81
Encephalitis, post chickenpox	052.9, V05.9, 136.9
Encephalitis, post mumps	072.2, 323.9, 072.9, 322.9
Encephalitis, post other	323.41, 064, 072.2, 056.01, 323.9, 323.82
Encephalitis, primary	326, 323.9, 136.29, 011.9, 094.1, 094.89
Gonorrhea	647, 647.1, V02.7, 098.2, 098.0, V01.6, 098.35, 098.11, V65.4
Granuloma inguinale	099.2. 099, 686.1, 099.1
Hansen disease	757.33, V74.2, V82.9, 030.9

Hepatitis A	070, 573.3, 573, 070.5, 570, 354.5, V02.61, V05.3, 155.0
Hepatitis B	070, 070.20, 070.21, 070.22, 070.23, 070.31, 070.32, 070.33
Hepatitis, non-A, non-B	
Hepatitis, unspecified	573.3, 070, 571, 573, 782.4, 070.30, 070.31, 711, 097.9, 646.9, 995.4, 711.90, 084.6, 573,9, 136.9, 155.0, V02.60
Legionellosis	
Leptospirosis	100.9, 100, 100.89, 100.81, 104.9, V82.9, 136.9, 100-104
Lyme disease	088.81
Lymphogranuloma venereum	099, 099.1, 078.8, 099.5, 799.89, 201.9, 569.2
Malaria	084.6, 084, 647, 771.2, 780.6, 581.81, 573.2, 323.2, 760.2
Measles	055.9, 055, V06.4, V04.2, 055.2, V05.9, 057.8
Meningococcal infections	036.3, 036.0, 036.42, 036.89, 036.2, 322.9, 038.9, 716.9, 038.8, 054.9, 429.89, 429.89, 255.8, 323.41, 729.2, 424.90, 255.5, 780.6, 424.9, 136.9, 423.9,
Mumps	072.9, 072.2, V06.4, 527.2, V05.9, 322.9, 711, 356.9
Pertussis	033, V06.1, V05.9, V03.6, V06.2, V06.5, 033.9, V03.1, V03.7, V04, 484.3
Plague	020.9, 020.8, 038.8, V03, 027.2, V05.9, 780.60, V82.9, 020-027
Poliomyelitis, paralytic	045, 045.9, 730.7, 730, 730.73, V06.3, 138, 344.9, 045.03, 045.92, 045.2, 344.1, 321.2,
Psittacosis	073.9, 486, 073, 136.9
Rabies, animal	071, 979.1, V01.5, V04.5, 312.0, 994.9, 136.9
Rabies, human	071, 979.1, V01.5, V04.5, 312.0, 994.9, 136.9
Rheumatic fever	391, 729.0, 391.1, 424.9. 398.91, 398.99, 393, 392
Rocky Mountain spotted fever	082.0, 066.1, 780.60, 082.9
Rubella	771.0, 056.09, 647, V06.4
Salmonellosis	003.0, 003.22, 484.8, 003.23, 558.9, 716.9, 486
Shigellosis	004.9, 004, 004.3, 004.1, 004.2,
Syphilis, all stages	097.1, 095.9, 090, 647, 090.49, 092, 094.9, 796.4, 453.9, 093.22, 091.4, 410.9, V01.6, 647.04, 759.82, 647.03, 095.5, 647.0, 647.01, 647.02,
Syphilis, primary	091.2, 091.1, 097.9, 093.9,
Syphilis, congenital	090, 090.7, 090.49, 090.40, 091.3, 097.3, 097.9, 759.82, 759.82, 379.32, 520.2, 095.5, 095.8, 760.2, 520.4, 738.0, 447.1, 363.13, 583.81
Tetanus	037, 771.3
Toxic shock syndrome	040.82, 040,
Trichinosis	124, 323.41, 323.9
Tuberculosis	017.2, 011, 012.8, 015.9,
Tularemia	021
Typhoid fever	002.0, 002
Varicella	052.9, 053, V01.79
Yellow fever	060.9, 060.1

Meaningful Use Dashboard

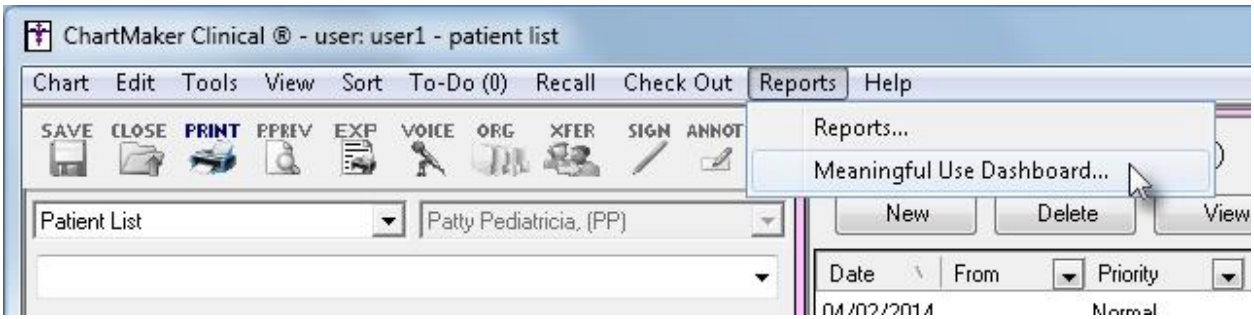
The Meaningful Use Dashboard allows you to select various Performance and Quality Measures to generate reports that providers can submit for reimbursement as part of the ARRA program. For each Meaningful Use objective with a percentage-based measure, the system will electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable Meaningful Use measure. The applicable reports can then be printed or exported to a text file to save a copy of the results.

IMPORTANT: The Meaningful Use Dashboard provides statistical information for aiding healthcare providers in meeting Meaningful Use Objectives. Healthcare providers are cautioned that the denominators shown on the Meaningful Use Dashboard are based solely on information entered into the ChartMaker® Clinical Module. If a patient encounter was not entered into the Clinical Module, that encounter is not included in the denominator for the statistical calculations on the Dashboard. In order to get accurate statistical information for the percentage calculation, to determine if you meet the Meaningful Use requirements, you may need to run additional reports. Please refer to the Center for Medicare and Medicaid Services (CMS) and this user manual for more information about calculating the correct percentage for each individual Meaningful Use Objective.

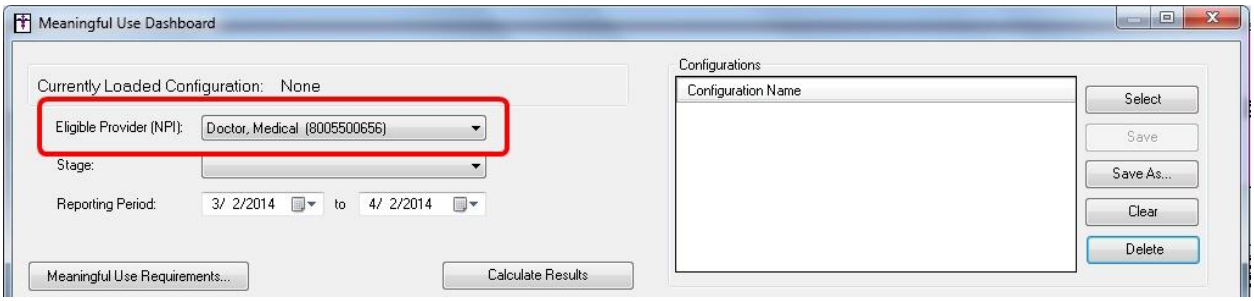
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms
http://www.sticomputer.com/sticustomers.php

To access the Dashboard:

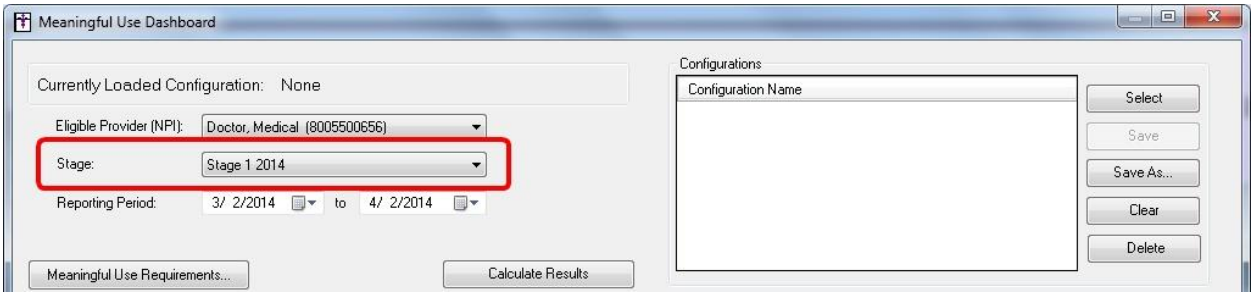
1. Go to Reports > Meaningful Use Dashboard…



2. Select the appropriate Provider

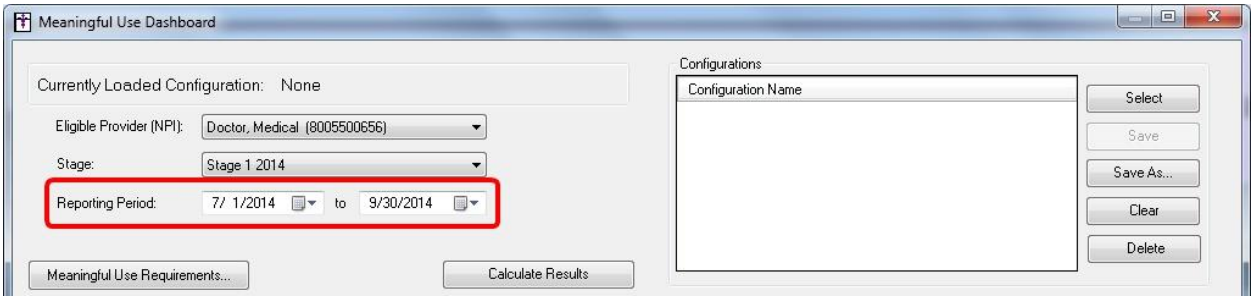


3. Select the appropriate Stage

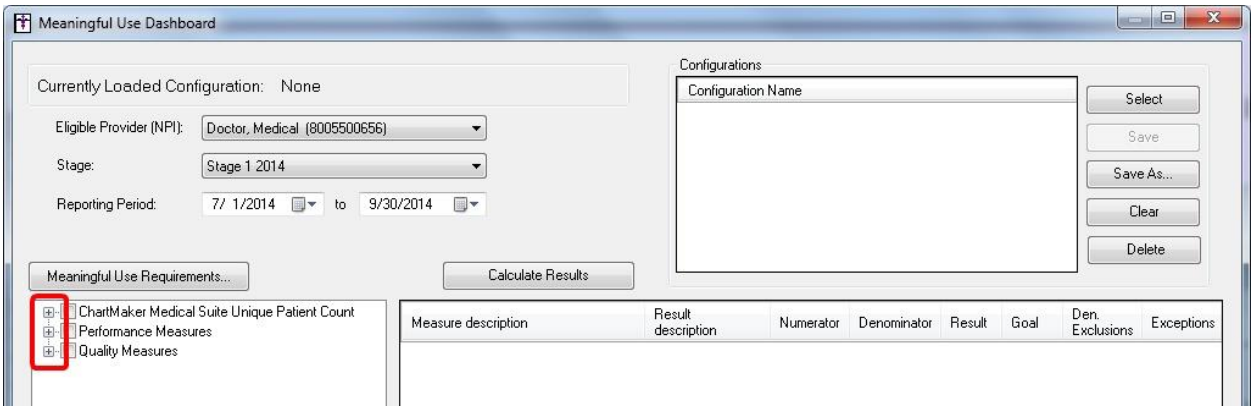


NOTE: Stage 1 2014 should be used for Providers attesting to Stage 1 in 2014 and beyond.

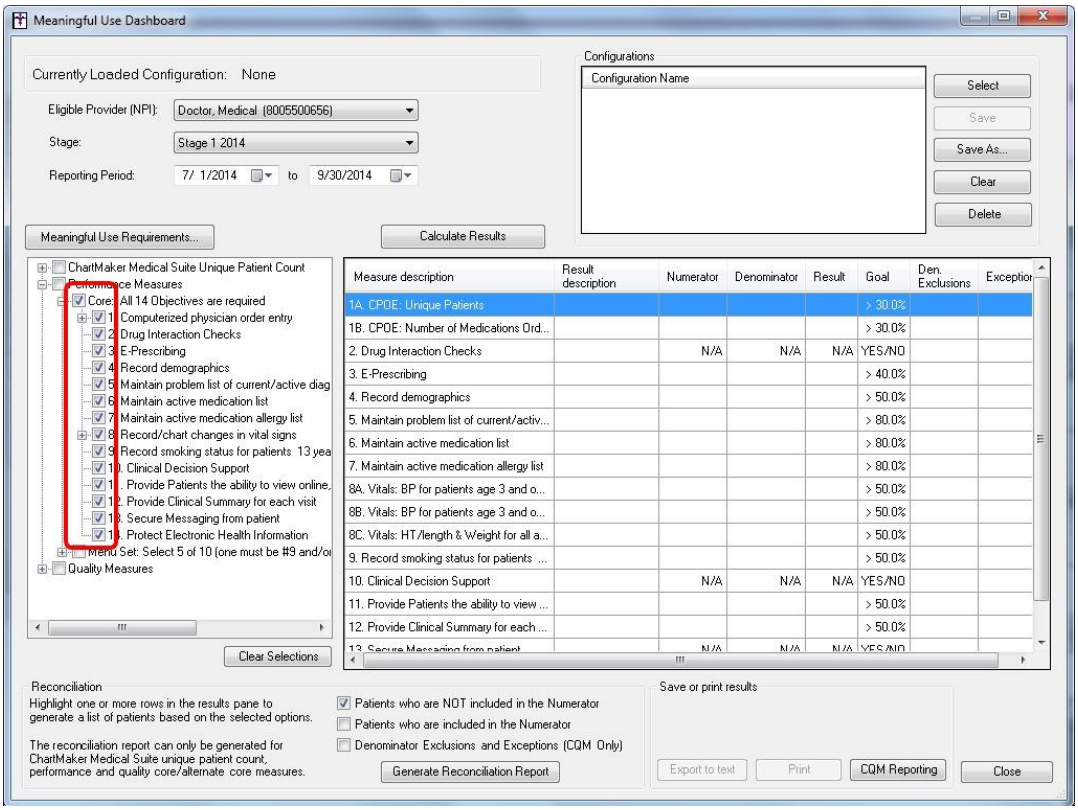
4. Select the Reporting Period



5. Click the + next to the appropriate item (Performance/Quality Measures or the Unique Patient Count) to expand the menu

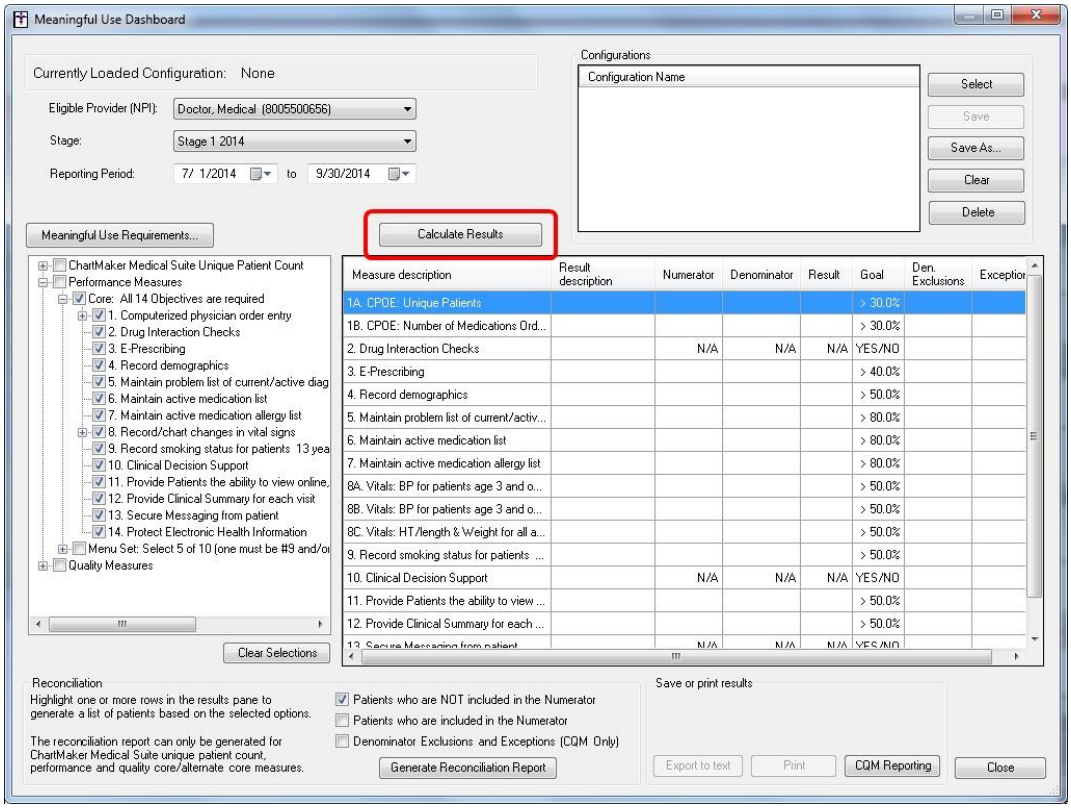


6. Select the box or boxes for the measure(s) you would like to view statistics for

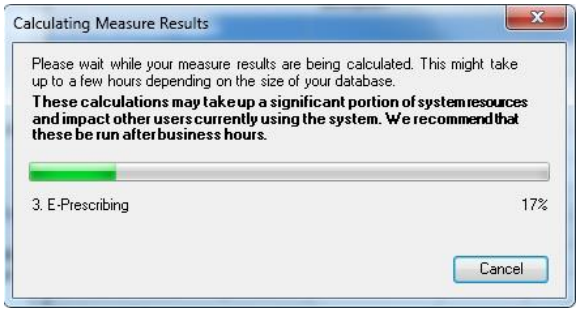


NOTE: Selecting the box for a higher level item will automatically select/deselect all the measures listed below it.

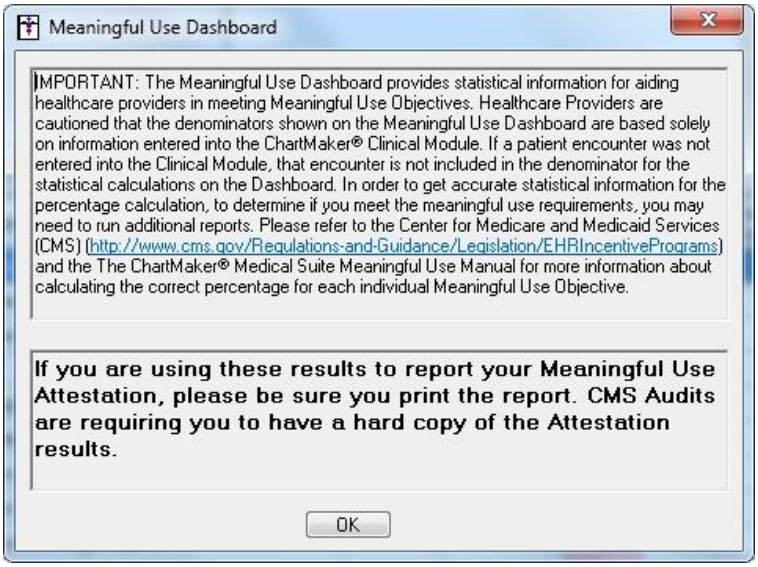
7. Click “Calculate Results”



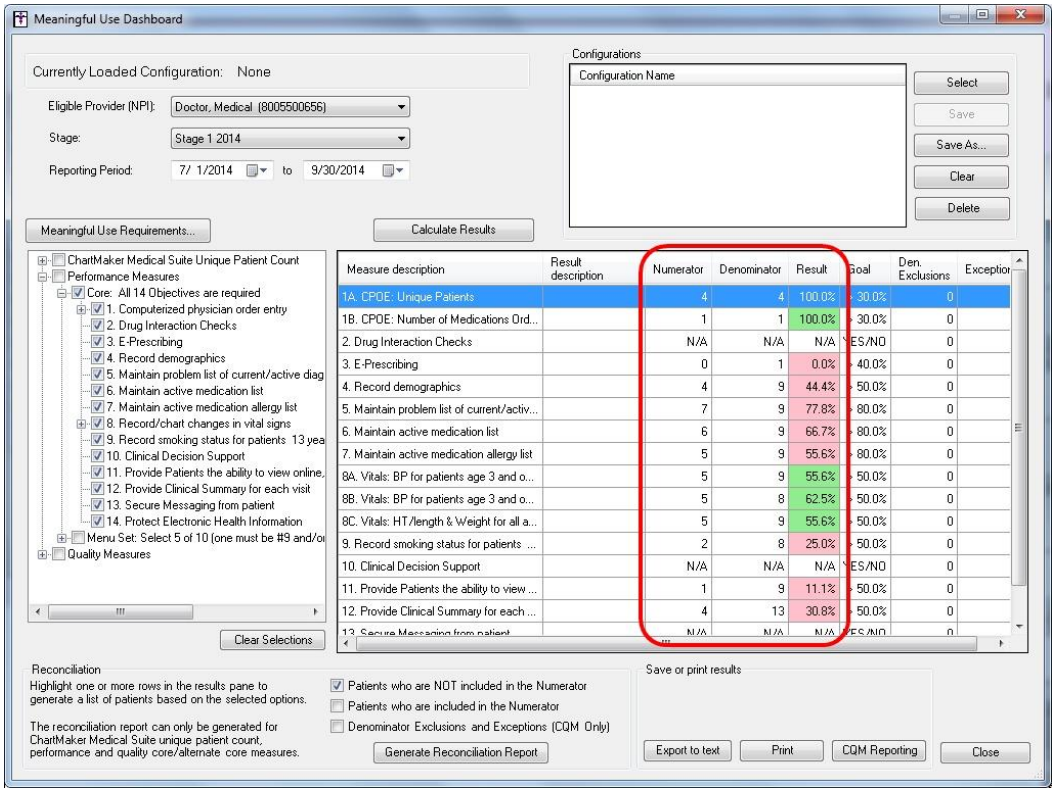
NOTE: **Depending on the size of your database, this could take several minutes to several hours**. You will receive the following progress dialog:



8. Read the disclaimer and click "OK"



Sample Results:



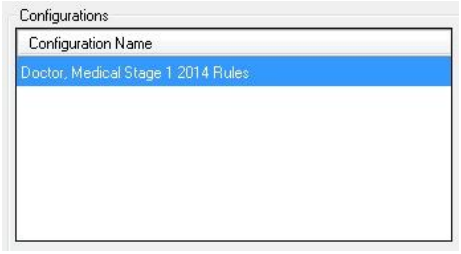
NOTE: If you would like a printed copy of this report, click “Print”. If you would like an electronic copy of this report, click “Export to text”.

TIP: It is recommended that you keep a printed copy of your Dashboard results as they were at the time of Attestation. CMS suggests that documentation to support the attestation should be retained for six years post-attestation.

9. To save this configuration for future use, click “Save as”

10. Name this configuration and click “OK”

TIP: It may be helpful to include the Stage and Provider for this configuration. The configuration will be available in the upper-right corner for future use.

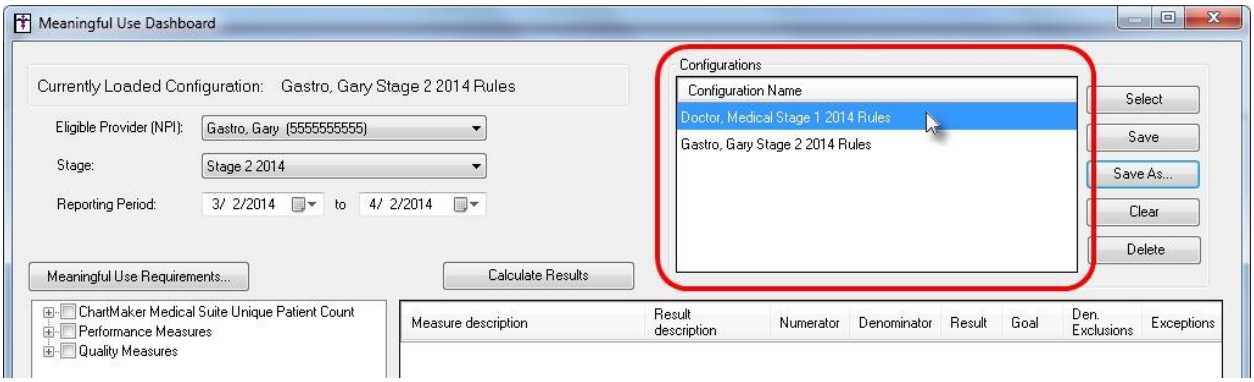


11. Click “Close” to close the Meaningful Use Dashboard dialog

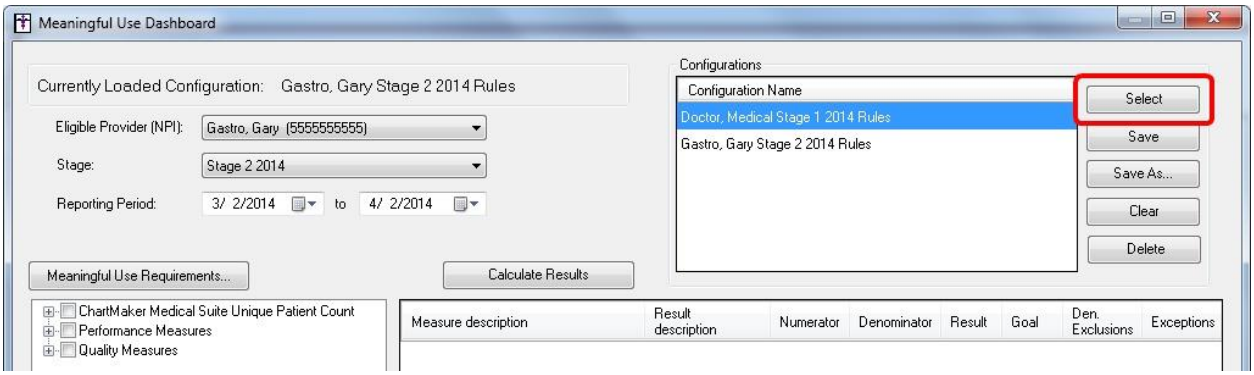
To use a saved configuration:

1. Go to Reports > Meaningful Use Dashboard…

2. Select the configuration you would like to view statistics for



3. Click “Select”



NOTE: The saved configurations will then load at the bottom of the screen

4. Modify any applicable search criteria and click “Calculate Results”

CQM REPORTING:

Starting in 2014, all providers beyond their first year of Meaningful Use will be required to submit Clinical Quality Measure (CQM) data to CMS electronically. Reference the "ChartMaker Clinical Meaningful Use Clinical Quality Measures 2014 Edition" user manual for more information on documenting CQM information. Below are steps to generate the electronic file that will be submitted to CMS upon attestation.

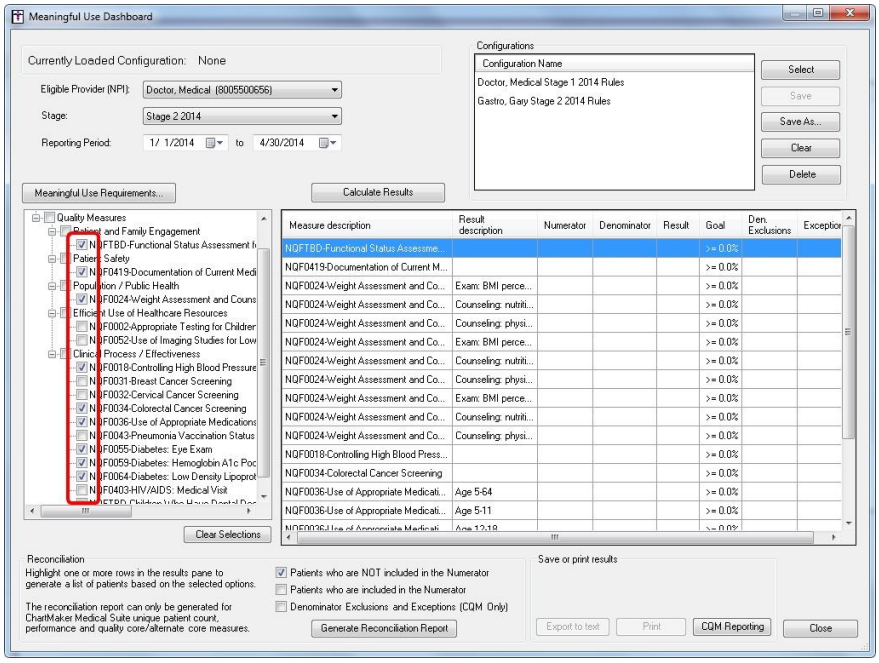
To generate a CQM batch file:

1. Go to Reports > Meaningful Use Dashboard

2. Select the applicable Eligible Provider, Stage and Reporting Period

   ALTERNATE METHOD: Select a saved configuration and click "Select" to load the configuration. If you are using a saved configuration, skip to Step 4.

3. Select the applicable Quality Measures

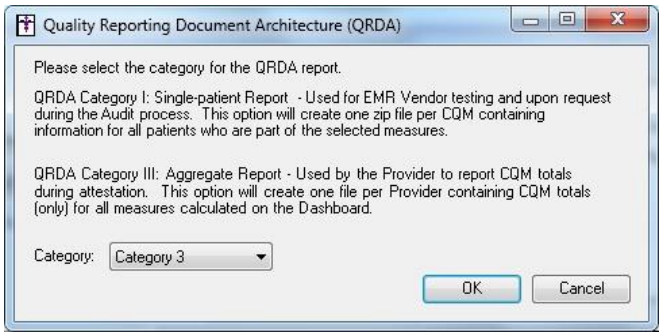


4. Click "Calculate Results"

   NOTE: If prompted with a Disclaimer, read the Disclaimer and click "OK".

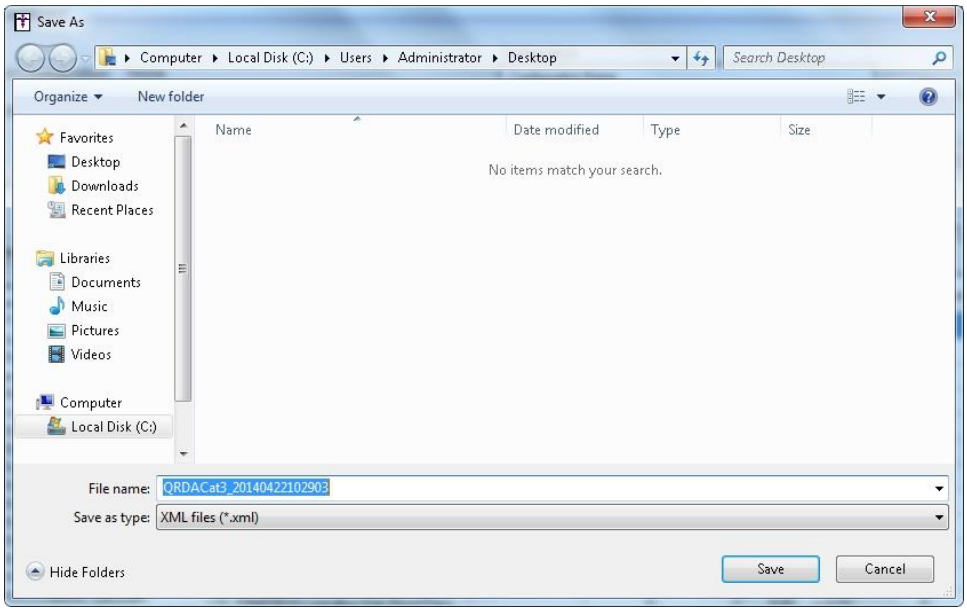
5. Click "CQM Reporting"

6. Select the appropriate Category and click “OK”



NOTE: If you are generating this file for attestation purposes, you should select Category 3.

7. Select a location and File Name and then click “Save”



NOTE: The File name will default to “QRDACategory_DateUniqueIdentifier”. You may change the File name if you chose to do so.

8. Click “OK”

NOTE: The file will then be saved to the location designated in Step 7. The file type will be an XML format, which is not human-readable.

9. Click “Close” to close the Meaningful Use Dashboard

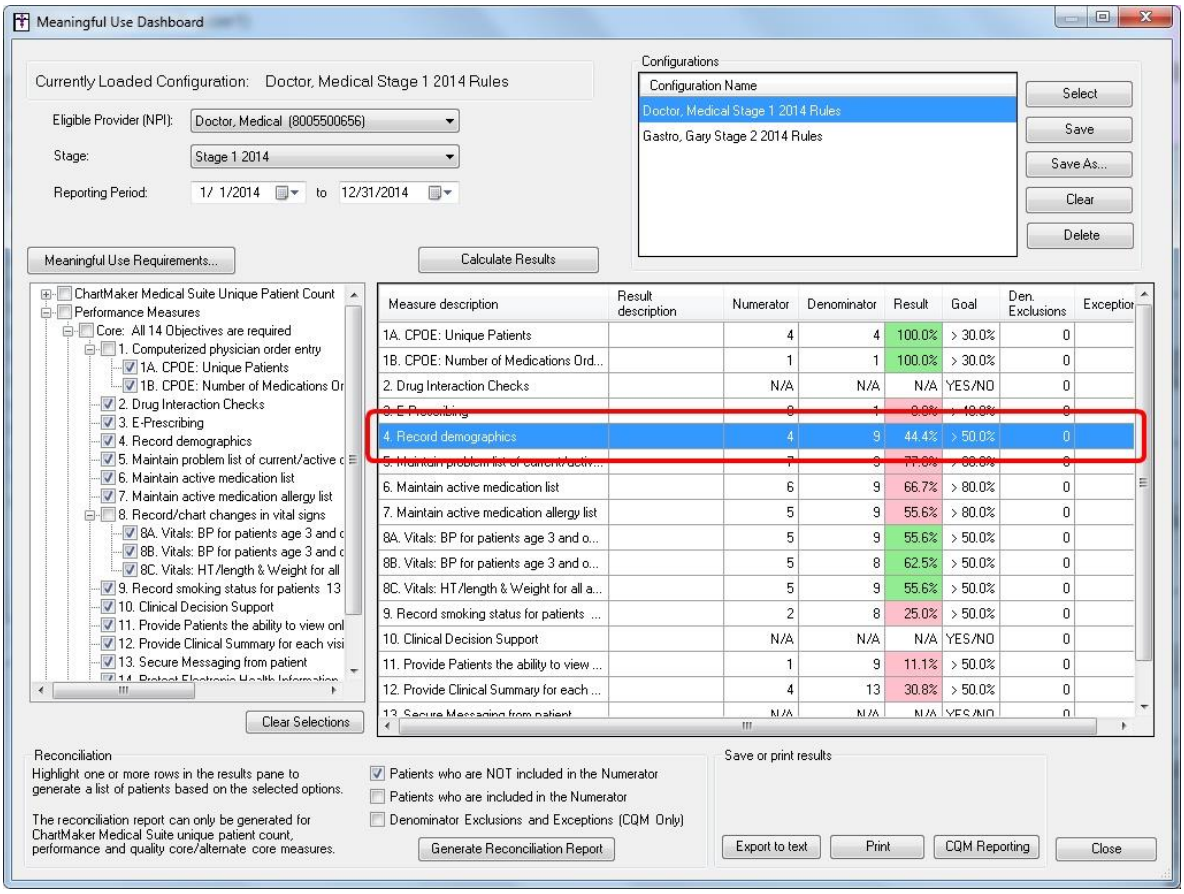
RECONCILIATION REPORT:

The Reconciliation Report will display additional information for individual measures that can be useful for troubleshooting purposes. It will be a helpful tool to figure out which patients you need to enter additional information for, if you are not meeting a certain measure's goal. The report can be run for Unique Patient Count, Performance and/or Quality measures for the selected provider and reporting period.

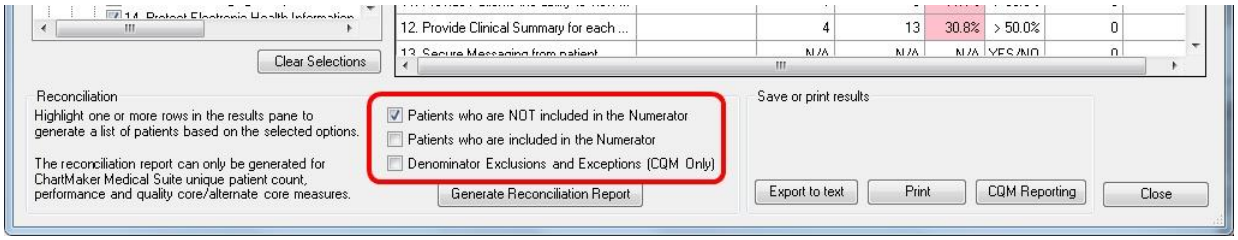
To generate a Reconciliation Report:

1. Calculate the results for the applicable measure

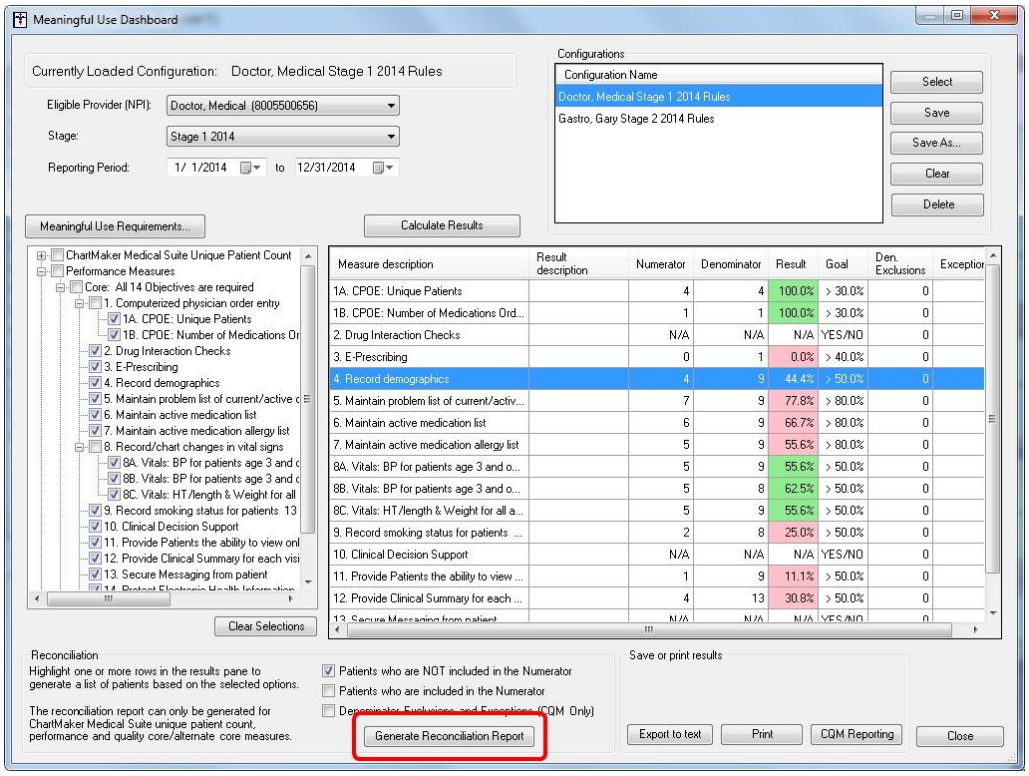
2. Highlight the measure you want to view the report for



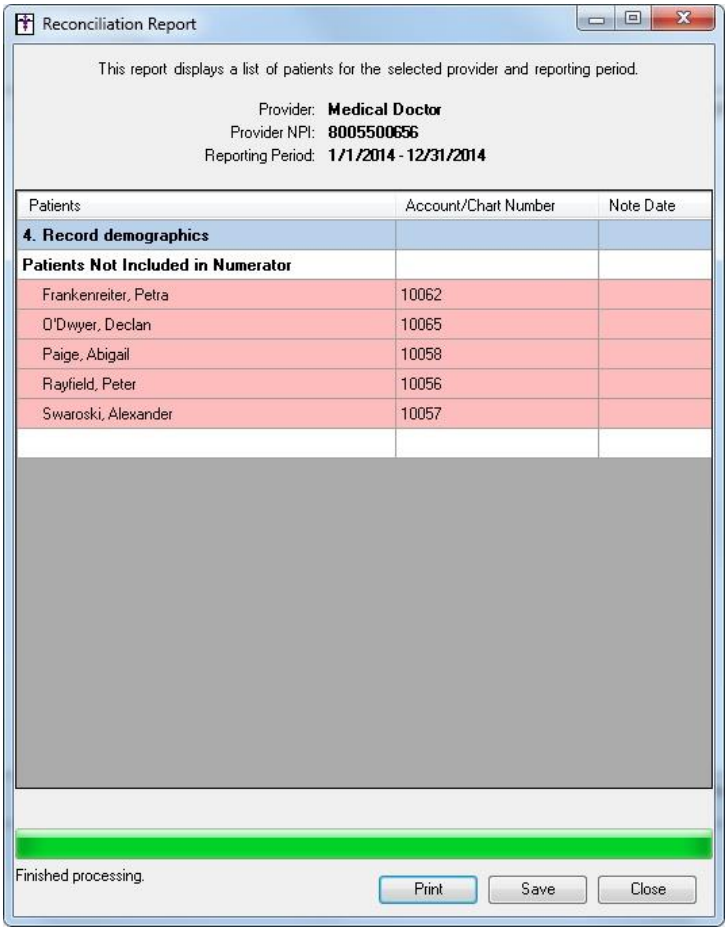
3. Select the desired display options



4. Click “Generate Reconciliation Report”



5. Click “Print”, “Save” or “Close”



Glossary of Terms

Term	Definition
Active medication allergy list	A list of medications to which a given patient has known allergies.
Active medication list	A list of medications that a given patient is currently taking.
Allergy	An exaggerated immune response or reaction to substances that are generally not harmful.
Appropriate technical capabilities	A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified HER technology or outside systems and programs that support the privacy and security of certified EHR technology.
Business Days	Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.
CAH	Critical access hospital
Clinical decision support	HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.
Clinical summary	An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.
CPOE	Computerized Provider Order Entry. CPOE entails the provider's use of computer assistance to directly enter medication orders from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization.
Diagnostic test results	All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.
Different legal entities	A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.

Distinct certified EHR technology	Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.
EHR	Electronic health record
EP	Eligible Professional
Exchange	Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. The exchange of information requires that the Eligible Professional must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.
Medication reconciliation	The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.
Office visit	Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.
Patient authorized entities	Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities.
Patient-Specific Education Resources	Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.
Permissible Prescriptions	The concept of only permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be permissible.
Preferred language	The language by which the patient prefers to communicate.
Prescription	The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.
Problem list	A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.
Public health agency	An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.

Relevant encounter	An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.)
Specific conditions	Those conditions listed in the active patient problem list.
Transition of care	The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Unique patient	If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term ‘‘unique patient’’ relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.
Up-to-date	The term ‘‘up-to-date’’ means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient.

Appendix

MEANINGFUL USE ENCOUNTER CODES

Below is a list of the system defined Meaningful Use Encounter Codes (CPT codes) for any of the Performance (Core or Menu) Measures that require a CPT code to be selected in the office visit note.

- 10060
- 10061
- 10140
- 11042
- 11043
- 11055
- 11056
- 11057
- 11400
- 11401
- 11402
- 11403
- 11420
- 11421
- 11422
- 11423
- 11440
- 11441
- 11442
- 11443
- 11600
- 11601
- 11602
- 11620
- 11621
- 11622
- 11641
- 11642
- 11643
- 11720
- 11721
- 11730
- 11750
- 17110
- 14000
- 14001
- 14020
- 14021
- 14040
- 14041
- 14060
- 14061
- 20550
- 21015
- 28008
- 28285
- 28292
- 29515
- 29540
- 29550
- 64640
- 90801
- 90802
- 90804
- 90805
- 90806
- 90807
- 90808
- 90809
- 90810
- 90811
- 90812
- 90813
- 90814
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- 90824
- 90826
- 90827
- 90828
- 90829
- 90845
- 90847
- 90849
- 90853
- 90857
- 90862
- 90875
- 90876
- 92002
- 92004
- 92012
- 92014
- 97597
- 98960
- 98961
- 98962
- 99024
- 99050
- 99058
- 99078
- 99090
- 99201
- 99202
- 99203
- 99204
- 99205
- 99211
- 99212
- 99213
- 99214
- 99215
- 99217
- 99218
- 99219
- 99220
- 99221
- 99222
- 99223
- 99231
- 99232
- 99233
- 99238
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- 99350
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- 99391
- 99392
- 99393
- 99394
- 99395
- 99396
- 99397
- 99401
- 99402
- 99403
- 99404
- 99408
- 99409
- 99411
- 99412
- 99420
- 99429
- 99455
- 99456
- 99510

NOTE: You may add additional Meaningful Use Encounter Codes by going to Edit > System Tables > Meaningful Use Encounter Codes. In order to access this area, you must have the user privilege (Edit > System Tables > Users) for "Performance Measure Mapping" set to "All". Any codes added to the Meaningful Use Encounter Codes list will be considered a code that you bill for as an encounter. If this is not consistent with what is billed to Medicare on a regular basis, this could raise a red flag for auditing.

ORDERS PREFERENCES

Below is an explanation and list of the preferences related to the Orders functionality.

In-House versus Off-Site Orders:

Orders can be configured as “In-House” or “Off-Site”. The difference between the two configurations is how you review them and whether the system creates a note or not. * This is only our terminology. If you prefer to set everything up as “In-house” because you like the system creating a note for you, then you can do so.

In House Orders:

- Orders are reviewed from the Face Sheet
- An auto-generated note is created once the order is “reviewed”

Off Site Orders:

- Orders are reviewed from the top of the chart (or through Scan Management)
- No note is created (we assume if a test is done offsite, a report will be sent back to you and scanned into the chart)

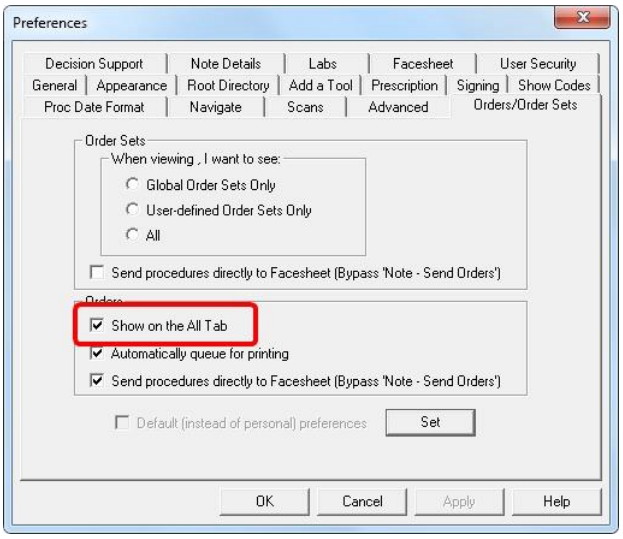
To configure procedures as Orders:

1. Go to Edit > System Tables > Conditions > Procedures
2. Search for the procedure
3. Highlight the procedure and click “Properties”
4. Change “Type” to the appropriate selection (Image, Lab or Test)
5. Select the box for “Track Order”
6. (Optional) Select the box for “In-house” if this procedure is performed at your location
7. (Optional) If you would like to set the number of days in which to expect the result back in, select “Expect Results in” and designate a number in the “Days” field.
8. Click “Save”
9. Repeat steps 2 – 8 for any additional procedures
10. Click “Close” to close the System Tables dialog

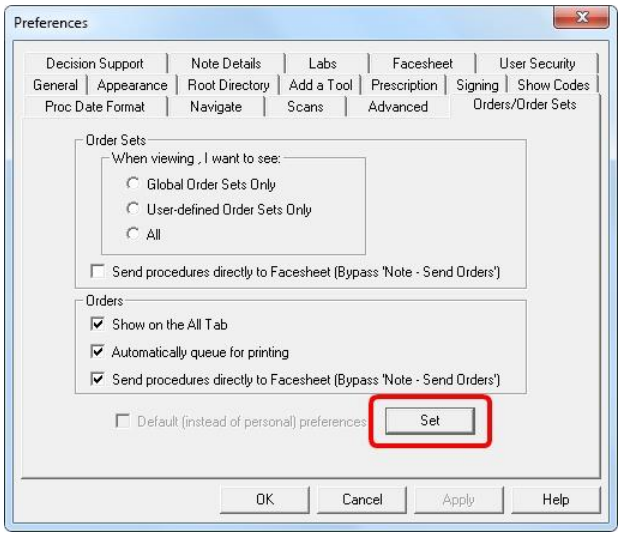
To Do List Display:

As of 5.2, by default Orders will only be displayed on the Orders tab of the main screen in ChartMaker Clinical. To see Orders on the All tab, follow the steps below:

1. Log into ChartMaker Clinical as the user you would like to set the preference for
2. Go to Edit > Preferences…
3. Click the “Orders / Order Sets” tab
4. Check the box for “Show on the All Tab” in the Orders section of the dialog



5. Click “Set”

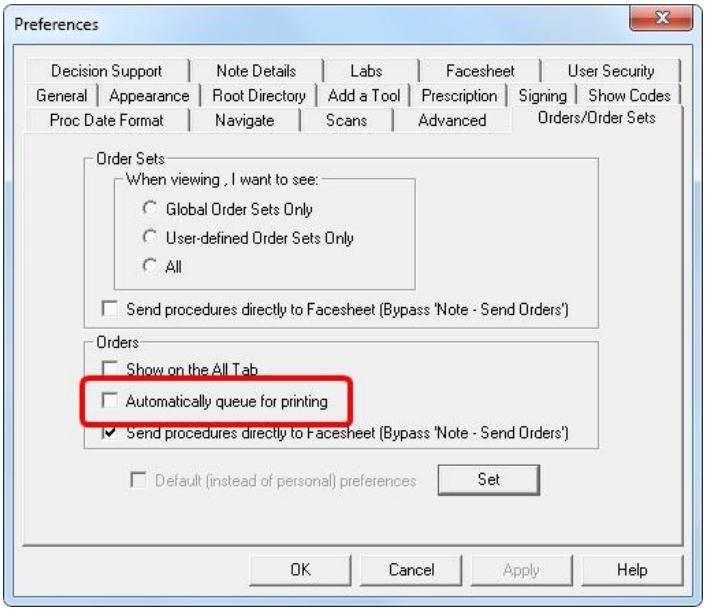


6. Click “OK” to close the Preferences dialog

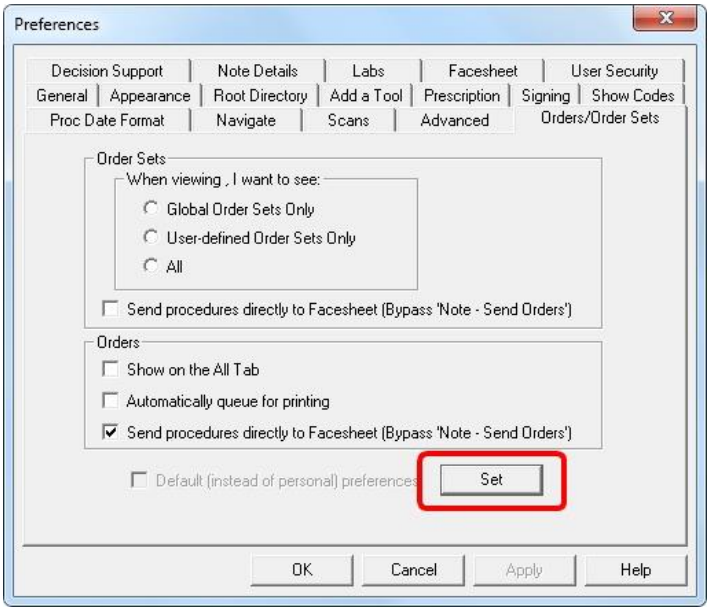
Queue for Printing:

As of 5.2, by default Orders will automatically be queued for printing eliminating additional steps to do so. If you do not want to print the order, you will not be required to and no additional steps will be required either. To turn off the option to automatically queue orders for printing, follow the steps below:

1. Log into ChartMaker Clinical as the user you would like to set the preference for
2. Go to Edit > Preferences…
3. Click the "Orders / Order Sets" tab
4. Uncheck the box for "Automatically queue for printing" in the Orders section of the dialog



5. Click "Set"

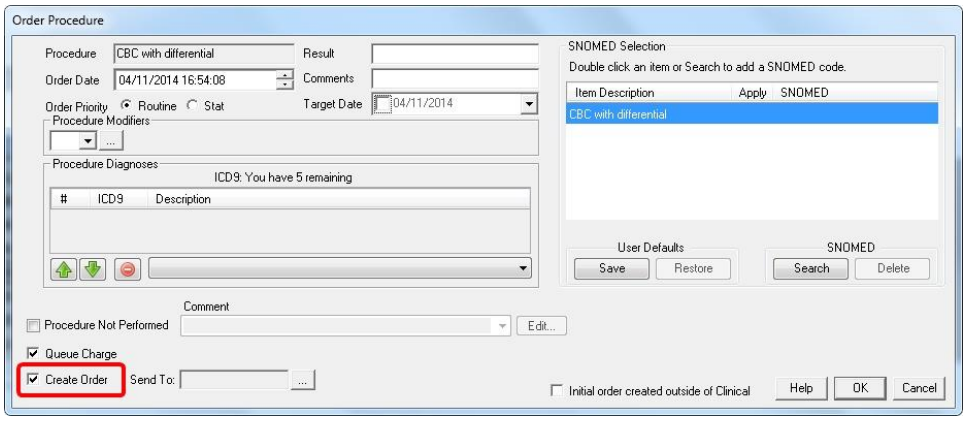


6. Click "OK" to close the Preferences dialog

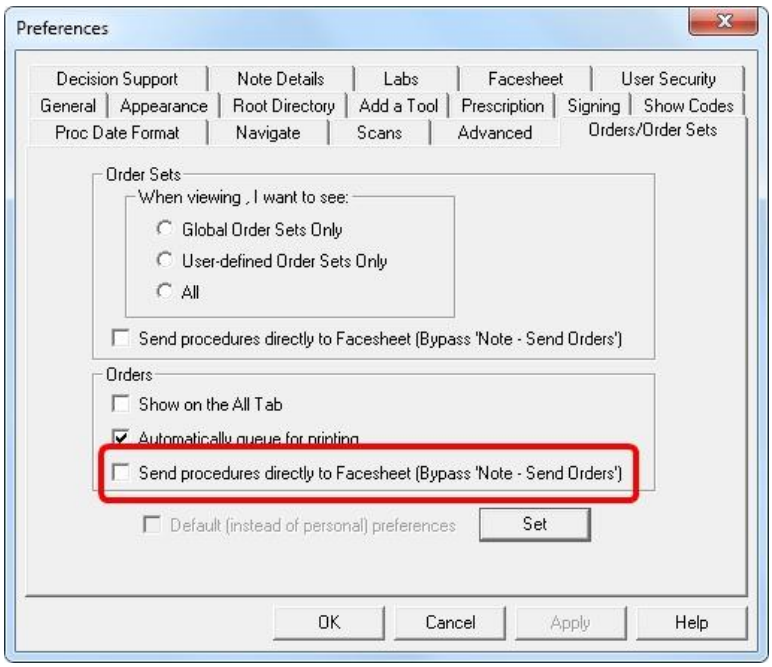
Sending Orders:

As of 5.2, by default Orders will automatically be sent to the Face Sheet and To Do List of the user ordering the Order eliminating additional steps to do so. To turn off the option to automatically send orders, follow the steps below:

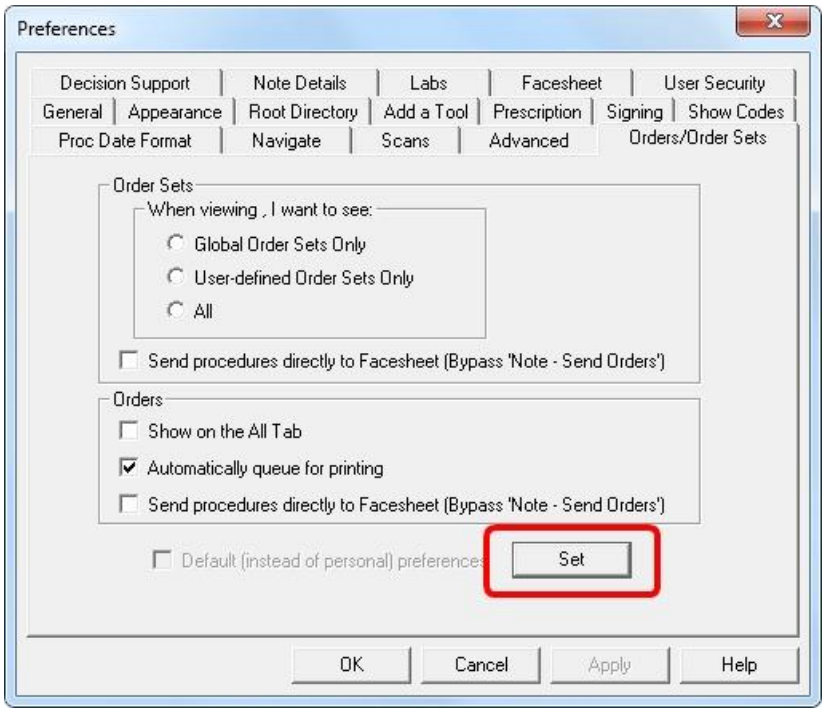
> **NOTE**: If you do not want to send an individual order, you can uncheck the box for "Create Order" in the Order Procedure dialog during the process of selecting the Order through your progress note.



1. Log into ChartMaker Clinical as the user you would like to set the preference for
2. Go to Edit > Preferences…
3. Click the "Orders / Order Sets" tab
4. Uncheck the box for "Send procedures directly to Facesheet (Bypass "Note – Send Orders")" in the Orders section of the dialog



5. Click “Set”



6. Click “OK” to close the Preferences dialog

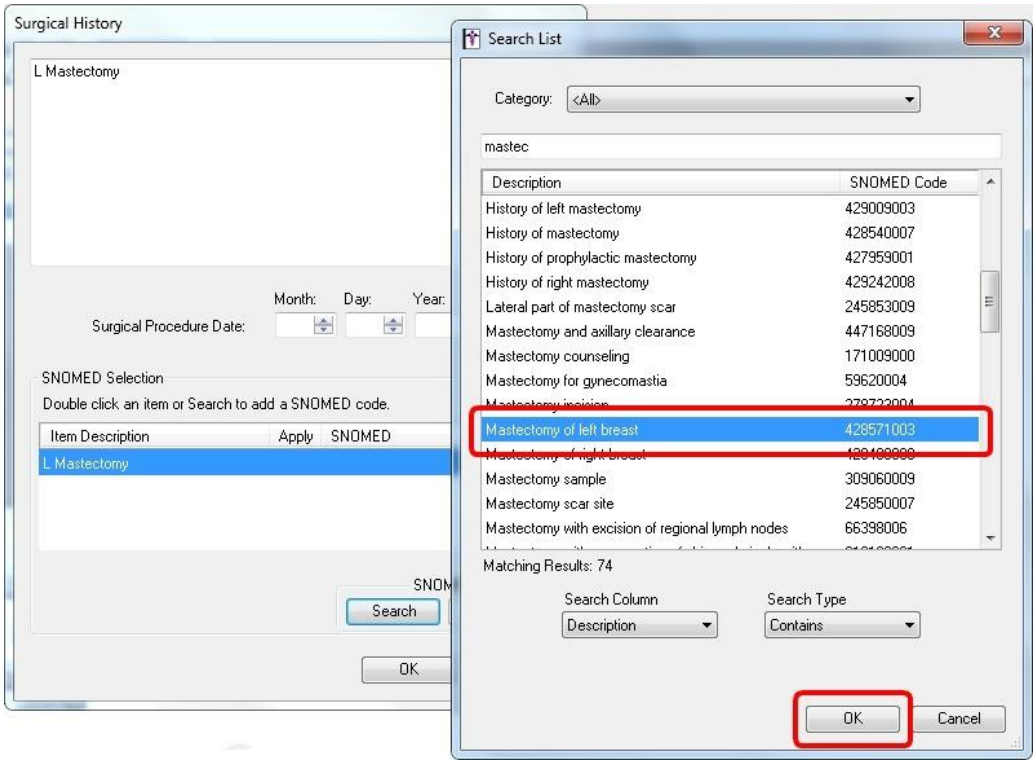
REMINDER: If “Send procedures directly to Facesheet (Bypass “Note – Send Orders”)” is turned off, the user will need to send the Order after selecting it in the progress note by going to Note > Send Orders… or else ChartMaker Clinical will not recognize it as an Order and you will not receive credit for Meaningful Use. Every time an Order is queued (i.e. sent to the Face Sheet), the denominator will be increased.

LINKING SNOMED TO SURGICAL HISTORY

Below are steps explaining how to attach a SNOMED code to a Surgical History item. This may be required for certain Meaningful Use requirements such as Clinical Quality Measures.

To link a SNOMED to surgical history:

3. In a progress note, click “Surgical History” (Surgical History)
4. Click “New”
5. Type the surgery description in the top box
6. (Optional) Select the date of the surgery
7. Click “Search”
8. Type a description of what you are looking for
9. Highlight the applicable SNOMED and click “OK”



10. Click “OK” to close the individual Surgical History item
11. Repeat steps 2 – 8 to add additional surgical history items
12. Click “OK” to close the Surgical History dialog

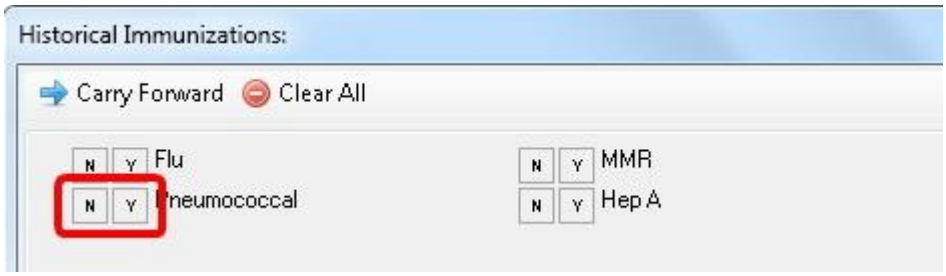
LINKING SNOMED TO CHECKLIST ITEMS

Below are steps explaining how to attach a SNOMED code to a Checklist item. This may be required for certain Meaningful Use requirements such as Clinical Quality Measures.

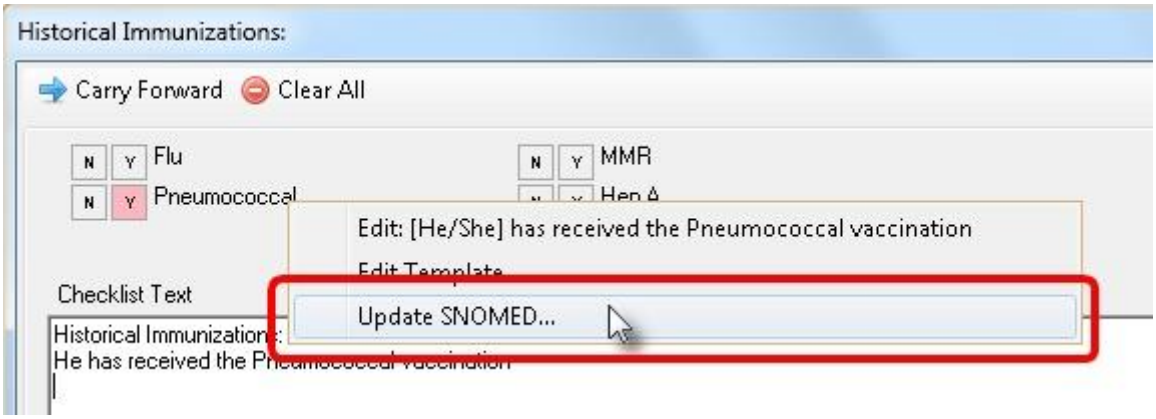
To link a SNOMED to a Checklist item:

1. In a progress note, click the open icon ( ) to open the applicable Checklist

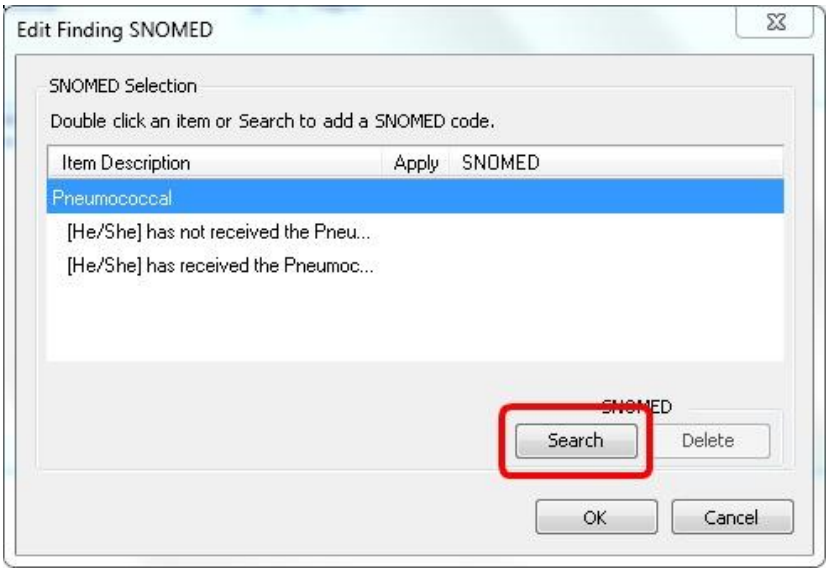
2. Select the Checklist finding



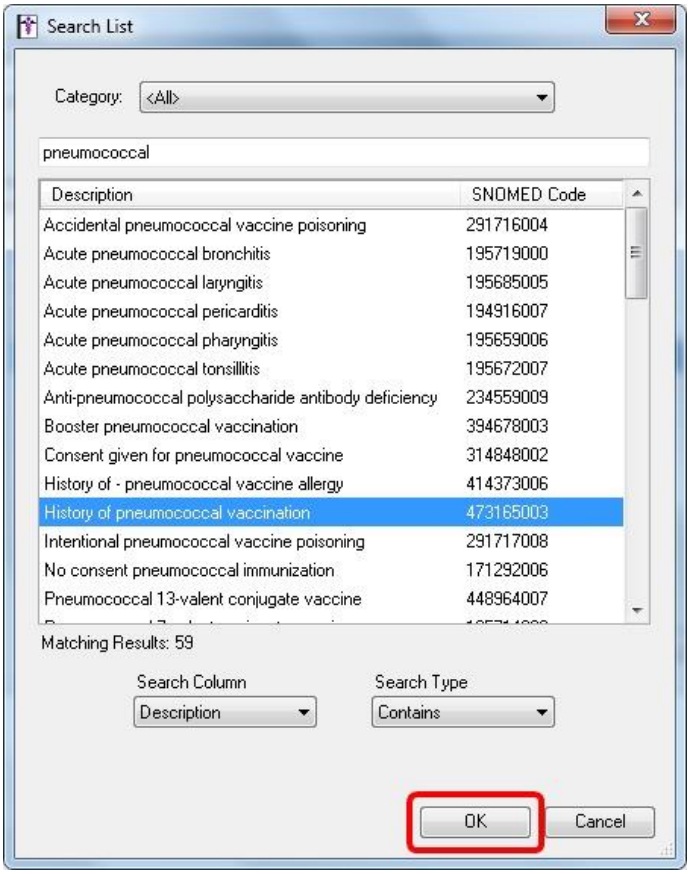
3. Right-click on the Checklist finding and select “Updated SNOMED…”



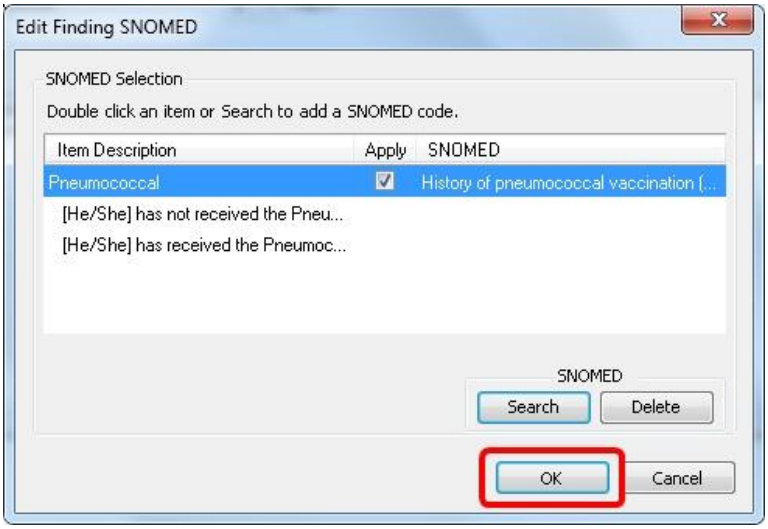
4. Click “Search”



5. Type a description of what you are looking for, highlight the correct SNOMED code and click "OK"



6. Click "OK"



7. Click "OK" to close the Checklist dialog

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Resources / Notes

Trainer: _____ **Phone:** _____

STI ChartMaker Clinical Support: **1-800-487-9135 (Option 1, then Option 2)**

NOTES:

Document Change Log

Date	Version	Changes
10/9/15	5.x	Added note for Patient Lists measure to select or filter by the provider name prior to performing the query.
2/6/15	5.x	Added clarification to the denominator calculation for Menu measure for Patient Reminders.
1/2/15	5.x	Updated information for 2015, added information regarding EPCS where applicable, and where to find immunization registry information online.
9/29/14	5.x	Updated status for state registries in regards to Syndromic Surveillance.
8/20/14	5.x	Included note about Menu measure exclusion rules changing in 2014.
8/19/14	5.x	Added additional description in the Notes area under the “Reporting Periods” section in regards to the 90-day reporting period.
8/15/14	5.x	Added note regarding Oct 1st deadline to “Important Dates” section.
7/3/14	5.x	Updated information regarding how the numerator is calculated for Core #11: View, Download, Transmit.
6/13/14	5.x	Modified SNOMED disclaimer for CQMs and added section on Linking SNOMEDs to Checklist items.
5/30/14	5.x	Added additional “Important Dates”, notes regarding reporting period, instructions for registering for Direct Messaging, notes about obtaining your certification number, instructions on registering for the PatientPortal for VDT, where to find LOINC codes, and additional report option for generating a Patient List.
4/25/14	5.x	Initial Release