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McKesson Physician Practice Solutions Meaningful Use Quick Reference Guide Eligible Professional Objectives

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How To Use This Guide

The Meaningful Use Quick Reference Guide is intended to help you prepare for meeting the Meaningful Use requirements. Many of procedures in this guide are meant to be adapted after the installation of the ONC-ATCB* certified version of Practice Partner Patient Records (Release 9.5), Medisoft Clinical (version 17 sp1) and Lytec MD (version 2011) has been installed. Only those versions have all of the functionality you will need to meet the Meaningful Use requirements. This guide is organized by Core and then Menu Meaningful Use Objectives. Each Objective will be described using the following format:

Meaningful Use Objective	The description of the objective.
Measure	The measure for the objective. The measures are generally not retrospective.
Exclusion	The exclusion criteria, if applicable, for this objective.
Product Requirements	Features, functions, modules, etc. within the certified version of the EHR that will need to be implemented to meet the objective.
Reporting Capabilities Provided with Certified Release	The description of how the measure will be reported and calculated. – Most Measures require reporting of a statistic with a defined numerator and denominator. – Some require only a 'test' or 'proof.' Using the new EHR Performance Metrics reporting tool in the EHR you will be able to generate a report which includes the numerator and denominator totals and the percentage of the objective that was achieved for each of the objectives that must report a percentage.
Assumptions	The description of what specific features/functions in Patient Records that must be enabled to meet this objective.
Cross Product Implications	The description of implications when you are using a non-Practice Partner practice management system.
Workflow Considerations	Many of the objectives will require a review of current office workflow. This section will highlight areas that should be considered.
What to Do Now	A list of what you can begin doing prior to implementing the certified version of Patient Records.

Important Note: *This document is only intended to serve as a planning guide and should not be considered a final implementation plan. The information is based on McKesson's interpretation of the final meaningful use and certification rules published by the Department of Human Services and are subject to change. The information provided is "as is" and without any express or implied warranties. Using certified electronic health record (EHR) systems and other certified health IT to prove meaningful use is the responsibility of eligible providers and hospitals.*

*Glossary of terms:
ONC-ATCB: Office of the National Coordinator for Health Information Technology (ONC) - Authorized Testing and Certification Bodies (ATCB)

Considerations

Certain measures, such as Maintain Problem List and Medication List, require diligence to be sure that staff and providers are cleaning up past entered items as needed to meet the requirements. Fortunately, the denominator of these measures counts only those patients **who were seen during the reporting period**. Therefore, you don't need to clean up every chart at once but you **should** clean up every chart **as they are seen** to ensure maximum compliance.

For example, you do not need to go back into every chart in your clinic and make sure that you have an up to date codified Problem List or No Active Major Problems on all of your problem lists. You can do this each day for the patients that you see that day and those are the ones that will count in your reporting period. Similarly, you don't need to go back and enter the patient's preferred language for every patient ever seen in your clinic. You can do so as they come in for new appointments during the reporting period. So you should instill these procedures when you install the certified version and clean up charts and collect data properly going forward from that point.

Since the first year is any continuous 90 day period, running the reports after the first 90 day period to review potential problems and areas of concern may be of benefit. You may than make adjustments to your practice and run the report again at the end of the next month for the previous 90 days. Continue this process until you are compliant and submit that 90 day period of data. Continue to run the reports each month throughout the year to insure continued compliance. Year 2 requires compliance for the entire 12 month calendar year.

Certification

McKesson's Practice Partner 9.5, Medisoft Clinical v17 and Lytec 2011 are now 2011/2012 compliant and were certified as a Complete EHR on December 6, 2010, by the Certification Commission for Health Information Technology (CCHIT®), an ONC-ATCB, in accordance with the applicable certification criteria for eligible providers adopted by the Secretary of Health and Human Services. The certification number is CC-1112-589589-1. ONC-ATCB 2011/2012 certification conferred by CCHIT does not represent an endorsement of the certified EHR technology by the U.S. Department of Health and Human Services nor does it guarantee the receipt of incentive payments.

The clinical quality measures to which Practice Partner Version 9.5, Medisoft Clinical v17 and Lytec 2011 have been certified include: NQF 0421, NQF 0013, NQF 0028, NQF 0041, NQF 0024, NQF 0038, NQF 0059, NQF 0064, and NQF 0061.

The additional software that Practice Partner, Medisoft Clinical and Lytec MD relied upon to demonstrate compliance includes: Windows Server® 2008 Server which includes BitLocker® and IPSec for 170.302(u) & 170.302(v); SureScripts Messenger™ Services for 170.304(b) & 170.302(b); Medi-Span® for 170.302(e) & 170.302(a); AMA's CPT® codes for 170.302(d), 170.304(e) & 170.304(a); and RelayClinical™ Education for 170.302(m).

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Core Set Objectives

Core Set *(These objectives are to be achieved by all eligible professionals, hospitals, and critical access hospitals in order to qualify for incentive payments.)*	
Core Set Meaningful Use Objective #1	Use 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% of unique patients with at least one medication in their medication list seen by the eligible provider have at least one medication order entered using CPOE.
Exclusion	This objective and associated measure do not apply to any EP who writes fewer than one hundred prescriptions during the EHR reporting period.
Product Requirements	Patient Records, E-prescribing and optionally the Order Entry module (Order Entry is only needed for this objective if you enter medication orders through that module)
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of patients in the denominator that have at least one medication order entered using the Order Entry module or e-prescribing module. Patients "on no meds" will not be counted. – Denominator: The total number of unique patients with at least one medication in their medication list seen by the eligible professional (EP) during the electronic health record (EHR) reporting period.
Assumptions:	You must be live on the e-prescribing module and optionally Order Entry
Cross Product Implications	N/A
Workflow Considerations	– The majority, if not all, of your medication orders will be entered using electronic prescribing. – However, medication orders can also be placed using the Order Entry module. The most common use case for using order entry for a medication order instead of electronic prescribing would be if you are administering the medication in your office. Both medication orders entered using electronic prescribing and order entry will count toward the calculation of this measure. – For this measure, orders do not have to be transmitted electronically to the recipient; they can be printed as a requisition, faxed or completed in-office. As long as the order is placed in Patient Records, it will count towards this numerator.
What to Do Now	Refine practice workflow to make full use of the e-prescribing module and/or Order Entry.

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Core Set Objectives

Core Set Meaningful Use Objective #2	Implement drug-drug and drug-allergy interaction checks
Measure	The eligible provider has enabled this functionality for the entire EHR reporting period.
Product Requirements	Patient Records and Clinical Tools.
Reporting Capabilities Provided with Certified Release	Your organization must **attest** that this functionality is turned on.
Assumptions	– Drug database (Clinical Tools) is updated per the recommended schedule and maintained regularly. – After subscribing to the database and installing it, select the **Drug Interaction Check** check box on the **Drug Interactions** tab of the **Prescription Defaults** screen to activate this feature. Each medication is checked when entering the prescription. – After subscribing to the database and installing it with Patient Records, select the **Allergy Check** check box on the **Rx Defaults** tab of the **Prescription Defaults** screen to activate this feature. Each medication is checked when entering the prescription.
Cross Product Implications	N/A
Workflow Considerations	Note that this may result in more drug-drug interaction and drug-allergy interaction pop-up warnings.
What to Do Now	Review your set up to be sure you are subscribed to and are receiving regular Clinical Tools updates and that Drug-Drug Interaction and Drug-Allergy checking are activated as described above.

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Core Set Objectives

Core Set Meaningful Use Objective #3	Generate and transmit permissible prescriptions electronically (eRx).
Measure	More than 40% of all permissible prescriptions written by the eligible provider are transmitted electronically using certified EHR technology.
Exclusion	This objective and associated measure do not apply to any EP who writes fewer than one hundred prescriptions during the EHR reporting period.
Product Requirements	Patient Records and E-prescribing
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of prescriptions written by the eligible provider and transmitted electronically for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period. – Denominator: The total number of prescriptions in the denominator generated (printed and faxed) and transmitted electronically.
Assumptions	You are transmitting electronic prescriptions over the Surescripts Network using the E-prescribing module.
Cross Product Implications	N/A
Workflow Considerations	– This is a measure of prescription transactions. – Faxed and printed prescriptions do not count in the numerator value. – Both new and refill prescriptions count in the numerator. – All prescriptions, including those printed and faxed, are counted in the denominator. – Controlled substance prescriptions are excluded from the total since these were not yet "permissible" under the original Stage 1 requirements.
What to Do Now	– Refine workflow and encourage your providers to maximize the proportion of prescriptions that are sent electronically. – When refill requests arrive by fax or phone call, encourage your providers to refill prescriptions electronically using the e-prescribing module.

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Core Set Objectives

Core Set Meaningful Use Objective #4	Record demographics: preferred language; gender; race; ethnicity; date of birth
Measure	More than 50% of all unique patients seen by the eligible provider have demographics recorded as structured data
Exclusion	This objective and associated measure do not apply to any EP who writes fewer than one hundred prescriptions during the EHR reporting period.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of unique patients seen by the EP 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. "Declined" status for language and race and ethnicity are included in the numerator. – Denominator: The total number of unique patients seen by the EP during the EHR reporting period.
Assumptions	You must be live on: – A new field called "Language" has been added to the **Other Data** tab on the Patient screen for new and existing sites. Every patient must have an entry in each of the required demographic fields in order to be counted in the numerator value of this measure: – Preferred language – Gender – Race – Ethnicity – Date of Birth Note: The **Language** field is a free text field and does not have to correspond to any pre-defined list of languages. You can also enter "declined" if the patient declines to provide their preferred language. – The Race and Ethnicity drop-down lists in Patient Records are configurable. Your organization must include a "declined" option for patients that do not want to disclose those specific demographic elements. – The Race and Ethnicity standards used must comply with the current federal standards published by the Office of Management and Budget http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr). They are: – The revised standards will have five minimum categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. – There will be two categories for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino." Note: The **Race and Ethnicity** fields are a fixed set of characters in length so you will need to use abbreviations from some of these descriptions to fit in the field. We suggest that you use the following for race: Am Ind or AK Nat; Asian, Blk or Afr Amer; Nt HI or Ot Pa Is; and White. We suggest that you use the following for ethnicity: His or Latino; Not His or Latino.

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Core Set Objectives

Core Objective #4 continued from previous page.

Core Set Meaningful Use Objective #4	Record demographics: preferred language; gender; race; ethnicity; date of birth
Measure	More than 50% of all unique patients seen by the eligible provider have demographics recorded as structured data
Cross Product Implications	If your organization is using Horizon Practice Plus to pass demographics to Patient Records, version 12.5 will be required in order to pass required fields.
Workflow Considerations	– Update registration/intake procedures to ensure these additional data elements are recorded for each patient. You may need to be particularly sure reception is capturing Preferred Language consistently. – A patient may opt not to disclose preferred language, race, and ethnicity. Ensure that "declined" is selected or entered to ensure complete demographic information is provided and counted in the numerator.
What to Do Now	– Gain consensus on a standard list of "Preferred Language" (including "Declined") for your practice. You can find a recommended list of preferred languages in the Patients topic in Patient Records Help.

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Core Set Objectives

Core Set Meaningful Use Objective #5	Maintain an up-to-date problem list of current and active diagnoses.
Measure	More than 80% of all unique patients seen by the eligible provider have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Exclusion	This objective and associated measure do not apply to any EP who writes fewer than one hundred prescriptions during the EHR reporting period.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total 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: The total number of unique patients seen by the EP during the EHR reporting period.
Assumptions	– You must be populating the patient problem list. – The numerator will include entries that are considered "major problems" that have a status of active (status = "A") OR "No Active Major Problems." The ability to enter "No Active Major Problems" on the problem list as a distinct entry and new in the certified version. **Note:** While it is possible to meet this requirement without having your Problem List coded (ICD-9 for diagnoses), we strongly encourage sites and providers to use ICD-9 codes for all problem list entries. This will ensure that you are capturing registry data properly and also using a coding system may be required for future Meaningful Use stages.
Cross Product Implications	N/A
Workflow Considerations	– Clinicians should maintain an accurate coded and current major problem list or enter "No Active Major Problems" when appropriate to properly capture this measure. – Use ICD-9 codes when entering diagnoses.
What to Do Now	Clean up your problem lists and encourage all providers to attach ICD-9 codes to all entries on problem lists.

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Core Set Objectives

Core Set Meaningful Use Objective #6	Maintain active medication list
Measure	More than 80% of all unique patients seen by the eligible provider have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Product Requirements	Patient Records and Clinical Tools
Reporting Capabilities Provided with Certified Release	– Numerator: The total 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: The total number of unique patients seen by the EP during the EHR reporting period.
Assumptions	– You must be populating the patient medication list. – "On No Meds" will count in the numerator. – Only concerned with medications that are known to the provider through querying the patient, their own records and the transfer of records from other providers. Medications found on the patient's "current medication list" will be included in the numerator.
Cross Product Implications	N/A
Workflow Considerations	– Staff should be trained to ensure they are verifying medications at each patient visit. Users should enter "On No Meds" when applicable (i.e., use the **On No Meds** button at the bottom of the Rx/Medications screen). This ensures that these patients will be counted in the numerator value for this measure.
What to Do Now	– Ensure staff is trained on proper procedures per the Workflow Considerations above. Encourage providers to use the medication list in general and the **On No Meds** button where applicable.

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Core Set Objectives

Core Set Meaningful Use Objective #7	Maintain active medication allergy list
Measure	More than 80% of all unique patients seen by the eligible provider have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Product Requirements	Patient Records and Clinical Tools
Reporting Capabilities Provided with Certified Release	– Numerator: The total 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: The total number of unique patients seen by the EP during the EHR reporting period.
Assumptions	The entries NKDA, NKA, or any medication allergy will count in the numerator. The measure is specifically measuring medication allergies, so food allergies will not count in the numerator.
Cross Product Implications	N/A
Workflow Considerations	– Staff should be trained to ensure they are verifying allergies at each patient visit. Users should mark the "Allergies reviewed" check box on the Intake window or the allergy window every time this information is reviewed and verified – this will assist in workflow compliance. – Staff should be trained to ensure they are verifying allergies at each patient visit. Users should use the **Today** button on the Rx/Medications screen every time this information is reviewed and verified; this will assist in workflow compliance. – If the patient reports no allergies, users should enter NKDA or NKA (from the Allergy screens), as appropriate. This will ensure these patients are counted in the numerator value.
What to Do Now	Ensure staff is trained on proper procedures.

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Core Set Objectives

Core Set Meaningful Use Objective #8	Record and chart changes in vital signs: – Height; weight; blood pressure – Calculate and display BMI for ages 2 and over – Plot and display growth charts for children 2-20 years, including BMI
Measure	For more than 50% of all unique patients age 2 and over seen by the eligible provider — height, weight and blood pressure are recorded as structured data
Exclusion	– EPs who do not see patients 2 years or older would be excluded from this requirement. – Any EP who believes that all 3 vital signs of height, weight and blood pressure of their patients has no relevance to their scope of practice.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of unique patients in the denominator who have at least one entry of their height, weight, and blood pressure recorded as structured data. – Denominator: The total number of unique patients age 2 and over seen by the EP during the EHR reporting period. **Note:** You do not need to report on BMI, you just need to be able to calculate and display it. McKesson anticipates that BMI will be a part of a Stage 2 Meaningful Use measure and it also may be used in CQM reporting.
Assumptions	– In order to count in the numerator, values must exist for ALL data elements (e.g., height, weight, systolic, and diastolic) for each unique patient 2 years and older within the reporting period. – Allow "height" information to be self-reported by the patient.
Cross Product Implications	N/A

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Core Set Objectives

Core Objective #8 continued from previous page.

Core Set Meaningful Use Objective #8	Record and chart changes in vital signs: – Height; weight; blood pressure – Calculate and display BMI for ages 2 and over – Plot and display growth charts for children 2-20 years, including BMI
Measure	For more than 50% of all unique patients age 2 and over seen by the eligible provider - height, weight and blood pressure are recorded as structured data
Workflow Considerations	– Train staff to utilize the Vitals Template to record patient height, weight, blood pressure, and other pertinent data as needed to calculate BMI and generate growth charts. – Train staff on how to access growth charts. – Train staff to record: – Height and weight at every visit for all patients up to and including age 20 – Record weight every visit and height at least once a year for all patients over 20 – Record blood pressure for all patients 3 years old and older at every visit **Note:** The certified version will plot growth charts to age 20 (previous versions only went to 18).
What to Do Now	See workflow considerations above.

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Core Set Meaningful Use Objective #9	Record smoking status for patients 13 years old or older
Measure	More than 50% of all unique patients 13 years old or older seen by the eligible provider have smoking status recorded as structured data.
Exclusion	EPs who see no patients 13 years or older would be excluded from this requirement.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of unique patients in the denominator with smoking status recorded as structured data. – Denominator: The total number of unique patients 13 years or older seen by the EP during the EHR reporting period.
Assumptions	– Smoking status must be captured as a vital sign. – Per the rule, Smoking status types must include: current every day, smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.
	Note: The Smoking Status field is a fixed character length so you will need to use abbreviations from some of these descriptions to fit in the field. We suggest that you use the following: Current every day, Current some day, Former, Never, Cur status unknown, Unknown if ever
	– Smoking status entered in free text format as part of social history or in a progress note will NOT count toward the numerator for this measure.
	Note: Historically captured data is adequate to meet this requirement. However, we suggest that you begin updating all patients with the required status values.
Cross Product Implications	N/A
Workflow Considerations	– Smoking status should be captured as a vital sign (on the Vitals > New template) and verified each visit. Also, see the clinical quality measure (CQM) described in the appendix for implications on recording smoking status. – If this information is already in the medical record available through certified EHR technology, the final rule does not intend that an inquiry be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community. – The information could be collected by any member of the medical staff.
What to Do Now	See the workflow considerations above. If your site is in the habit of entering smoking as social history or in progress notes, be sure it is also entered as a vital sign.

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Core Set Objectives

Core Set Meaningful Use Objective #10	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule
Measure	Implement one clinical decision support rule.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	Your organization must **attest** to the implementation of one clinical decision support rule relevant to specialty or high clinical priority with the ability to track compliance to that rule.
Assumptions	Clinical decision support rules can be provided through various functions within Patient Records including the Health Maintenance Rule feature and/or the use of specialized templates.
Cross Product Implications	N/A
Workflow Considerations	Build at least 1 health maintenance rule and train users to act upon prompts.
What to Do Now	Determine your organization's strategy for implementing at least one clinical decision support rule.

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Core Set Objectives

Core Set Meaningful Use Objective #11	Report ambulatory quality measures to CMS or the States.
Measure	For 2011, provide aggregate level data for the numerator, denominator, and exclusions through attestation as discussed in the final rule. For 2012, an EP would electronically submit the clinical quality measures as discussed in the final rule.
Product Requirements	Patient Records In addition, PPRNet, McKesson's partner for clinical quality reporting will support generation of clinical quality measures for Stage 1 of Meaningful Use — customers who presently use PPRNet can continue to work with PPRNet to meet the clinical quality reporting requirements for Meaningful Use.
Reporting Capabilities Provided with Certified Release	Your organization must **attest** to the correctness of the quality measures calculated results. Submission directly to the Centers for Medicare and Medicaid Services (CMS) is not required in your first year of participation, but may be required in your second year, pending availability by CMS to accept electronic submission. **Note:** For Certification, McKesson was required to show reporting on 9 CQMs. The nine that were tested are – NQF 0013 – Hypertension: Blood pressure measurement – NQF 0028 – Preventive Care and Screening Pair: Tobacco Use Assessment and Tobacco Cessation intervention – NQF 0041 – Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old – NQF 0024 – Weight Assessment and Counseling for Children and Adolescents – NQF 0038 – Childhood immunization Status – NQF 0059 – Diabetes: HbA1c Poor Control – NQF 0064 – Diabetes: LDL Management & Control – NQF 0061 – Diabetes: Blood Pressure Management They will be available in the certified release. McKesson will be enhancing the product's capability to calculate more measures and publish them as they are developed.
Assumptions	Your site must be in compliance with workflow requirements necessary to capture data for accurate computation of quality measures.
Cross Product Implications	N/A

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Core Set Objectives

Core Objective #11 continued from previous page.

Core Set Meaningful Use Objective #11	Report ambulatory quality measures to CMS or the States.
Measure	For 2011, provide aggregate level data for the numerator, denominator, and exclusions through attestation as discussed in the final rule. For 2012, an EP would electronically submit the clinical quality measures as discussed in the final rule.

Workflow Considerations	– Train users on process and procedures specific to data capture requirements for clinical quality measures.
	– EPs must report on six total measures: three core measures (or alternate core measures where necessary) and three additional measures selected from Table 6. The three core measures required are:
	  – NQF 0013 — Hypertension: Blood pressure measurement
	  – NQF 0028 — Preventive Care and Screening Pair: Tobacco Use Assessment and Tobacco Cessation intervention
	  – NQF 0421 (PQRI 128) — Adult weight screening and follow-up
	– Providers must check smoking status.
	– Users need to enter height and weight at every encounter, and view BMI.
	– Consider required fields in ALL clinical templates that have REQUIRED fields to capture clinical elements:
	– If smoking + then need to capture CE that intervention there.
	– If BMI abnormal then need to capture CE on follow up plan.
	– An ICD.9 codified problem list must be maintained — list of code values that are considered to establish identity of a specific disease condition are listed in detailed measures specifications
	– Immunization events are expected to be recorded as a Health Maintenance event codified using CVX codes
	– Adverse reactions to food and other non medication substances are required to adhere to specified nomenclature — as specified in the detailed measure specifications
	– Structured result values such as HbA1C are expected to be stored and processed in compliance with pre-defined lab name values — defined in the detailed specification for each measure.

What to Do Now	– Review the final quality measures (reference Table 6 of the CMS Final Rule) and setup process/procedures to ensure compliance. This may include the use of Health Maintenance rules along with template changes to include use of observables to record/track specific criteria not available as discreet entry elsewhere in the application. – See the appendix for each of the following: 1. Description of CQMs 2. Nomenclature for Lab Names 3. ICD.9 codes for conditions 4. Nomenclature for Clinical Elements 5. Nomenclature for HM templates

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Core Set Objectives

Core Set Meaningful Use Objective #12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.
Measure	More than 50% of all patients of the eligible provider who request an electronic copy of their health information are provided it within 3 business days.
Product Requirements	Patient Records and the Order Entry Module
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of patients in the denominator who requested an electronic copy of their health information and received it within three business days. – Denominator: The total number of patients seen by the EP who requested an electronic copy of their health information four business days prior to the end of the EHR reporting period.
Assumptions	– To capture the metrics for this measure, you will need to create an ORDER for "Request E Copy of Records". When a patient requests the records, the order is entered. This creates a time and date stamp from which to measure 3 business days. The endpoint is when the order is marked "complete". – For the purposes of meaningful use criteria, a business day is defined as "Monday through Friday excluding Federal or State holidays on which the EP or their respective administrative staffs are unavailable". We realize that this may not cover the usual hours of care for each site but it is the definition given by CMS and so we are using that for the rule. – The denominator will be relatively small since a patient has to specifically **request** an electronic copy of their records to be in the measure. – The media could be any electronic form such as patient portal, PHR, CD, USB fob, etc.
Cross Product Implications	N/A
Workflow Considerations	You will need to identify the process and who will be responsible for entering this order name.
What to Do Now	– Review your existing policy and procedures for handling patient information requests and make sure you are able to accurately track and log all such requests. – Create a new order by selecting Maintenance > Templates > Order Templates > **Orders Names**. Select the **New** button and create a new order name template for, "Request E Copy of Records". We are recommending this name for uniformity. You could use a similar order "Request P Copy of Records" to track requests for paper records, etc., but the measure only requires tracking of requests for electronic copies. – Train staff to use the newly created order to track and process requests in a timely manner, since the time/date stamp is used for this measure.

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Core Set Objectives

Core Set Meaningful Use Objective #13	Provide clinical summaries for patients for each office visit
Measure	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.
Exclusions	EPs who have no office visits during the EHR reporting period would be excluded from this requirement.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of patients in the denominator who are provided a clinical summary of their office visit within 3 business days. – Denominator: The total number of unique patients seen by the EP during the EHR reporting period. **Note:** The Clinical Summary can be provided through a PHR, patient portal, secure email, electronic media such as CD or USB fob, or printed copy.
Assumptions	– A new Patient Clinical Summary report gives users the ability to create an electronic copy and/or print a clinical summary. When a summary is printed or generated electronically, a flag is marked that allows measurement for the numerator. – This applies to encounter type = "Office visits" only.
Cross Product Implications	N/A
Workflow Considerations	Establish workflow guidelines for staff to print out or electronically distribute a clinical summary as a standard part of as many office visits as possible.
What to Do Now	See workflow considerations above.

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Core Set Objectives

Core Set Meaningful Use Objective #14	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results) among providers of care and patient authorized entities electronically
Measure	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	Because this objective requires test demonstration only, there are no specified numerators and denominators to be used for reporting measures for this objective. This capability must involve the actual submission of information to another provider of care with distinct certified EHR technology or another system capable of receiving the information. The use of "test" or "dummy" data is permissible as long as the data is identical in form to what would be sent about an actual patient. CMS will accept a yes/no attestation to verify that the test has been successfully completed.
Assumptions	The ability to generate CCD/CCR documents is inherent to Patient Records – the provider would choose to export data for a patient or a group of patients to a CCD, and specifically select the set of clinical documents to include in the export, if necessary. They would also choose to save the CCD document at a local or shared file system location. A destination system (which can be another separate instance of Patient Records) can be used to import the saved CCD file. The patient information used here can be "test data," since the provider is required to only perform a test of the export and import of the CCD.
Cross Product Implications	N/A
Workflow Considerations	You should attempt to identify another entity with whom to conduct a test of the submission of electronic data. This test must include the transfer of either actual or "dummy" data to the chosen other entity. The testing could occur prior to the beginning of the EHR reporting period, but must occur prior to the end of the EHR reporting period and every payment year would require its own, unique test. To be considered an "exchange" for this objective and measure, the clinical information must be sent between different legal entities with distinct certified EHR technology or other system that can accept the information and not between organizations that share certified EHR technology.
What to Do Now	Evaluate your current support for the content of the Continuity of Care Document (CCD). – Document how the required data elements are currently being captured within your organization. – Identify where no product or workflow currently exists for required data elements. – Ensure the identified "key information" is captured as discrete data and included in the appropriate workflows in order to be available for exchange. – Familiarize your staff on importing, exporting, and transmitting CCDs.

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Core Set Objectives

Core Set Meaningful Use Objective #15	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 and implement security updates and correct identified security deficiencies as part of its risk management process.
Product Considerations	McKesson achieved certification using Windows Server® 2008 which includes BitLocker® and IPSec. BitLocker Drive Encryption is a full disk encryption feature included with the Ultimate and Enterprise editions of Microsoft's Windows 7 desktop operating systems, as well as the Windows Server 2008 and Windows Server 2008 R2 server platforms. To leverage this security feature, you will need to be running a Windows Server, running Windows 2008 operating system, Windows 2008 R2 is preferred. **Note:** this is not a requirement for you to meet this objective.
Reporting Capabilities Provided with Certified Release	You must conduct or review a security risk analysis of certified EHR technology and implement updates at least once prior to the end of the EHR reporting period and **attest** to the conduct or review. The testing could occur prior to the beginning of the EHR reporting period.
Assumptions	N/A
Cross Product Implications	N/A
Workflow Considerations	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
What to Do Now	Review the following and verify you are in compliance. This verbiage is taken directly from § 164.308 Administrative safeguards. (a) A covered entity must, in accordance with § 164.306: (1)(i) Standard: Security management process. Implement policies and procedures to prevent, detect, contain, and correct security violations. (ii) Implementation specifications: (A) Risk analysis (Required). Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity. (B) Risk management (Required). Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with § 164.306(a). (C) Sanction policy (Required). Apply appropriate sanctions against workforce members who fail to comply with the security policies and procedures of the covered entity. (D) Information system activity review (Required). Implement procedures to regularly review records of information system activity, such as audit logs, access reports, and security incident tracking reports. (2) Standard: Assigned security responsibility. Identify the security official who is responsible for the development and implementation of the policies and procedures required by this subpart for the entity. (3)(i) Standard: Workforce security. Implement policies and procedures to ensure that all members of its workforce have appropriate access to electronic protected health information, as provided under paragraph (a)(4) of this section, and to prevent those workforce members who do not have access under paragraph (a)(4) of this section from obtaining access to electronic protected health information.

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Menu Set Objectives

Menu Set *(Eligible professionals, eligible hospitals, and critical access hospitals may select any five choices from the menu set.)*	
Menu Set Meaningful Use Objective #1	Implement drug-formulary checks
Measure	The eligible provider has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
Exclusion	This objective and associated measure do not apply to any EP who writes fewer than one hundred prescriptions during the EHR reporting period.
Product Requirements	Patient Records and Surescripts Formulary or the optional Formulary (Infoscan) add-on.
Reporting Capabilities Provided with Certified Release	Your organization must **attest** that this functionality is turned on.
Assumptions	You must have access to an updated Drug Formulary and have formulary screening configurations turned on. This can be accomplished through either Surescripts or the optional Formulary add-on as part of Clinical Tools.
Cross Product Implications	N/A
Workflow Considerations	N/A
What to Do Now	If you are already using updated Clinical Tools or Surescripts and formulary screening, no additional action is needed. If not, you should review the functionality and turn it on.

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Menu Set Objectives

Menu Set Meaningful Use Objective #2	Incorporate clinical lab-test results into certified EHR technology as structured data.
Measure	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion	If an EP orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period they would be excluded from this requirement.
Product Requirements	Patient Records, Order Entry and an inbound lab results interface.
Reporting Capabilities Provided with Certified Release	– Numerator: The 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: The 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.
Assumptions	You must be live on a results interface(s) in production.
Cross Product Implications	N/A
Workflow Considerations	Results that are coming back as an electronic import (using integration) will be stored as structured data and counted in your measurement.
What to Do Now	Identify any sources of orders which are not providing a structured results import back into Patient Records and develop ways to automate.

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Menu Set Objectives

Menu Set Meaningful Use Objective #3	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 eligible provider with a specific condition
Product Requirements	Patient Records with Patient Inquiry (standard feature), or a 3rd Party Reporting Tool
Reporting Capabilities Provided with Certified Release	Your organization must **attest** to the ability to create a report listing patients by specific condition and to attest that you have actually done so at least once.
Assumptions	Patient Records will be able to generate lists according to certain data elements for which structured data will be available: medical problems; medications; demographics; and laboratory test results.
Cross Product Implications	N/A
Workflow Considerations	To facilitate this process, make sure your providers maintain coded problem lists.
What to Do Now	Practice the process by which you will generate such reports.

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Menu Set Objectives

Menu Set Meaningful Use Objective #4	Send reminders to patients per patient preference for preventive/follow up care.
Measure	More than 20% of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
Exclusion	Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of patients in the denominator who were sent the appropriate reminder. – Denominator: The total number of unique patients 65 years or older or 5 years old or younger seen by the EP regardless of the reporting period. – A new field has been added to the Demographics screen to capture patient preference called "Preference for Reminders." – Note that the Numerator is the number of patients in the denominator set for whom a printed letter, web message or phone message was generated using the Batch Communication feature during the reporting period.
Assumptions	N/A
Cross Product Implications	Web View or RelayHealth Platform will be supported.
Workflow Considerations	Determine a schedule for generating patient reminders for upcoming patient visits or follow-up care.
What to Do Now	Become familiar with the Batch Communications/Mail Merge

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Menu Set Objectives

Menu Set Meaningful Use Objective #5	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the eligible provider.
Measure	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
Exclusion	Any EP that neither orders nor creates any of the health information listed for this objective during the EHR reporting period.
Product Requirements	Patient Records and Web View (or a certified Patient Portal like RelayHealth)
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of unique patients seen by the EP who have timely, electronic access to their health information through Web View. – Denominator: The total number of unique patients seen by the EP during the EHR reporting period.
Assumptions	**Note:** If you are using a different patient portal service than Web View, McKesson will need to work with you to tailor/adjust this report.
Cross Product Implications	Web View
Workflow Considerations	If a different portal other than Web View is used, manual intervention is required to ensure that information is exported to the portal – there is no current automated means of exporting information. Manual intervention and self tracking of this metric is required if Web View is not the chosen patient connectivity solution.
What to Do Now	– Develop a strategy to provide electronic patient access to information and encourage patients to sign up for your web portal. – If you are using a different portal, ensure that you notify McKesson and your other vendor to ensure this measurement can be done.

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Menu Set Objectives

Menu Set Meaningful Use Objective #6	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
Measure	More than 10% of all unique patients seen by the eligible provider are provided patient-specific education resources.
Product Requirements	Patient Records and Patient Education (you can use either McKesson's Patient Education module or another external source)
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of patients in the denominator who were provided patient education specific resources. – Denominator: The total number of unique patients seen by the EP during the EHR reporting period. – The new Patient-Specific Education Materials feature for Patient Records will allow providers to give Patient-Specific Education Materials and document that such materials were given. **Note:** This new feature will allow you to link patient-specific education materials to any source.
Assumptions	This objective only applies to clinical encounters with the type "Office Visit".
Cross Product Implications	N/A
Workflow Considerations	– Train staff to document patient-specific education resources provided to patient as part of the visit using the new Patient-Specific Education Materials feature for 9.5. – A new field has been added "Patient Education Resources Provided" – If the Patient Education module is used while a patient is "in context," the system will automatically set this flag – If alternate Patient Education materials are used, the flag can be set by the user by going to the Encounter Summary Screen from the "show menu" and check "patient education resources have been provided to the patient." – A new dot code has also been added: – .ED: Patient-Specific Education Material Provided? <Yes/No>
What to Do Now	Encourage providers to use Patient-Specific Education Materials more often and document when they are used.

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Menu Set Objectives

Menu Set Meaningful Use Objective #7	The eligible provider 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 eligible provider performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the eligible provider.
Exclusion	Any EP who was not the recipient of any transitions of care during the EHR reporting period.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total number of transitions of care in the denominator where medication reconciliation was performed. – Denominator: The total number of transitions of care marked as "Inbound" during the EHR reporting period for which the EP was the receiving party of the transition. – The new Medication Reconciliation and Clinical Encounter features will allow electronic medication reconciliation and also allow documentation of either electronic or non-electronic medication reconciliation. **Note:** Paper medication reconciliation also counts in the numerator.
Assumptions	N/A
Cross Product Implications	N/A
Workflow Considerations	– Be sure providers are familiar with the electronic medication reconciliation process and are documenting when medication reconciliation is performed. In particular, be sure to also document when medication reconciliation is performed using a paper medication list (paper medication reconciliation also counts in the numerator). For example, when a patient brings a paper list after discharge from the hospital and you update their medication list be sure to create a clinical encounter for the action and select the **Relevant for Medication Reconciliation** check box. – The certified version will allow the user to mark a new encounter as a transition of care. The encounter should also be marked as "Inbound" to be included in the denominator.
What to Do Now	Ensure staff is trained on proper procedures

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Menu Set Objectives

Menu Set Meaningful Use Objective #8	The eligible provider 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 of care record for each transition of care or referral
Measure	The eligible provider who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals
Exclusion	Any EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	– Numerator: The total the number of transitions of care and referrals in the denominator where a summary of care record was provided. – Denominator: The total number of transitions of care and referrals for which the EP was the referring or transferring provider. – The ability to designate an encounter as an Inbound or Outbound transfer of care is new to the certified version. – The new Patient Clinical Summary report will be used to meet the numerator requirement. – The clinical summary could send an electronic or paper copy of the summary care record directly to the next provider or could provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so.
Assumptions	N/A
Cross Product Implications	N/A
Workflow Considerations	– The term transition of care means a transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc) to another or from one EP, eligible hospital, or CAH (as defined by CMS Certification Number (CCN) to another.) – Encounters should now be designated as Inbound, Outbound, or Neither (no check box checked), to identify which encounters to include in the denominator of measures like these. – "Summary of Care Record provided for Care Coordination" flag must be marked and the encounter must be designated as "Outbound" in order to count in the numerator. – Encourage providers and train staff to document encounter types properly and to issue the Patient Clinical Summary as often as possible for transfers of care such as Referrals, Hospital Admissions, etc.
What to Do Now	See the Workflow considerations above.

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Menu Set Meaningful Use Objective #9	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with 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 eligible provider submits such information have the capacity to receive the information electronically)
Exclusion	Any EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically is excluded from this objective.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	Your organization must attempt to locate a registry or IIS with whom to conduct a test of the submission of electronic data. This test must include the transfer of either actual or "dummy" data. The testing could occur prior to the beginning of the EHR reporting period, but must occur prior to the end of the EHR reporting period. CMS will accept a yes/no attestation to verify this test was performed.
Assumptions	Immunization test orderables include "Requirement" prompts for specific data collection, such as Lot number, Manufacturer, units, etc.
Cross Product Implications	– Providers need to work with their local immunization registry to solicit their participation in this initiative. – The initiation of a test transaction is required between Patient Records and the registry – Providers need to Order the immunization interface – A successful/ or fully operational interface is not required for Meaningful Use – if the test transmission with the immunization registry fails, the failed test constitutes successful completion of this measure. If the test is successful, a production/operational interface is required.
Workflow Considerations	– Staff are trained how to complete immunization requirements – Immunization data must be codified using CVX codes
What to Do Now	If you plan to implement this into production with your specific state immunization registry, you should begin discussions with them now: – Share Immunization Registry interface specifications with state immunization registry to determine if any customization is required. Encourage them to adopt the "standard" as defined by CMS Final Rule specifications as this will eventually become an industry-wide standard. – If customization will be required, work with McKesson services team to plan and schedule interface development project(s). – Send test files to state immunization registries.

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Menu Set Meaningful Use Objective #10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with 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 eligible provider submits such information have the capacity to receive the information electronically)
Exclusion	Any 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.
Product Requirements	Patient Records
Reporting Capabilities Provided with Certified Release	Your organization must attempt to identify one public health agency with whom to conduct a test of the submission of electronic data. This test must include the transfer of either actual or "dummy" data. The testing could occur prior to the beginning of the EHR reporting period, but must occur prior to the end of the EHR reporting period. CMS will accept a yes/no attestation to verify this test was performed.
Assumptions	Providers need to work with their local public health agency to solicit their participation in this initiative.
Cross Product Implications	– The initiation of a test transaction is required between Patient Records and the PHA – Providers can use PR to enter a specific condition and export an HL7 file that conforms to the specified standard. – A successful/ or fully operational interface is not required for Meaningful Use – if the test transmission with the agency fails, the failed test constitutes successful completion of this measure.
Workflow Considerations	– Staff are trained how to document syndromic surveillance data. – Providers need to maintain an ICD.9 coded problem list.
What to Do Now	Obtain Syndromic Surveillance data specifications from state public health agencies to determine what needs to be reported.

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Appendix

1. Clinical Quality Care Descriptions

(Source: EP Measure Specifications: www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage)

Measure		Recommended Measure Title	Recommended Measure Description
Measure	Developer	Title	Description
0001	AMA	Asthma Assessment	Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
0002	NCQA	Appropriate Testing for Children with Pharyngitis	The percentage of children 2–18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
0012	AMA	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	Percentage of patients, regardless of age, who gave birth during a 12–month period who were screened for HIV infection during the first or second prenatal visit.
0013	AMA	Hypertension: Blood Pressure Measurement	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
0014	AMA	Prenatal Care: Anti-D Immune Globulin	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12–month period who received anti-D immune globulin at 26–30 weeks gestation.
0018	NCQA	Controlling High Blood Pressure	The percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
0024	AMA	Weight Assessment and Counseling for Children and Adolescents	The percentage of patients 2–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

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Appendix

Clinical Quality Care Descriptions continued from previous page.

Measure		Recommended Measure Title	Recommended Measure Description
Measure	**Developer**	**Title**	**Description**
0027	NCQA	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies	The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.
0028a	AMA	Preventive Care and Screening Measure Pair: a.Tobacco Use Assessment	Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.
0028b	AMA	Preventive Care and Screening Measure Pair: b.Tobacco Cessation Intervention	Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months who received cessation intervention.
0031	NCQA	Breast Cancer Screening	The percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.
0032	NCQA	Cervical Cancer Screening	The percentage of women 21–64 years of age who received one or more Pap tests to screen for cervical cancer.
0033	NCQA	Chlamydia Screening for Women	The percentage of women 15–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
0034	NCQA	Colorectal Cancer Screening	The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.
0036	NCQA	Use of Appropriate Medications for Asthma	The percentage of patients 5–50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5–11 years, 12–50 years, and total).

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Clinical Quality Care Descriptions continued from previous page.

Measure		Recommended Measure Title	Recommended Measure Description
Measure	**Developer**	**Title**	**Description**
0038	NCQA	Childhood immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
0041	AMA	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
0043	NCQA	Pneumonia Vaccination Status for Older Adults	The percentage of patients 65 years of age and older as of January 1 of the measurement year who have ever received a pneumococcal vaccine.
0047	AMA	Asthma Pharmacologic Therapy	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long–term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
0052	NCQA	Low Back Pain: Use of Imaging Studies	The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.
0055	NCQA	Diabetes: Eye Exam	The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional .
0056	NCQA	Diabetes: Foot Exam	The percentage of patients aged 18–75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).
0059	NCQA	Diabetes: HbA1c Poor Control	The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%.

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Clinical Quality Care Descriptions continued from previous page.

Measure		Recommended Measure Title	Recommended Measure Description
Measure	**Developer**	**Title**	**Description**
0061	NCQA	Diabetes: Blood Pressure Management	The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.
0062	NCQA	Diabetes: Urine Screening	The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
0064	NCQA	Diabetes: LDL Management & Control	The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.
0067	AMA	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
0068	NCQA	Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic	The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.
0070	AMA	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.
0073	NCQA	Ischemic Vascular Disease (IVD): Blood Pressure Management	The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).

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Clinical Quality Care Descriptions continued from previous page.

Measure		Recommended Measure Title	Recommended Measure Description
Measure	**Developer**	**Title**	**Description**
0074	AMA	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
0075	NCQA	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL.
0081	AMA	Heart Failure (HF) : Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
0083	AMA	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
0084	AMA	Heart Failure (HF) : Warfarin Therapy Patients with Atrial Fibrillation	Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.
0086	AMA	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.
0088	AMA	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

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Clinical Quality Care Descriptions continued from previous page.

Measure		Recommended Measure Title	Recommended Measure Description
Measure	**Developer**	**Title**	**Description**
0089	AMA	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on–going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
0105	NCQA	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment	The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
0385	AMA	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12–month reporting period.
0387	AMA	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12–month reporting period.
0389	AMA	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer
0421	QIP	Adult Weight Screening and Follow-Up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
0575	NCQA	Diabetes: HbA1c Control (<8%)	The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.

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Appendix

2. Coding, Capture and Maintenance for specific Lab Results

Note: *Each of the Lab Name values indicated below is a default value setup for the clinical quality reporting tool. The customer can use configuration utilities available in the reporting tool to use a different lab name – based on their local configurations. The reporting tool will seek to identify a lab result on the basis of the lab name, or alternatively by using the LOINC code. The configuration settings can be adjusted to parse the EMR data for additional LOINC codes other than those codes identified in the NQF specification.*

#	Lab Result Name	Regulatory Requirement	Capture, Coding & Maintenance Instructions
1	Haemoglobin A1C (HbA1C)	CQM PQRI 1	HbA1C is identified by the lab name HbA1C, or alternatively by one of the following LOINC codes: 17856-6, 4548-4, 4549-2 It is recommended that providers ensure that the lab value for this result is recorded under the specific lab name listed above, or the lab result interface processes the result based on LOINC codes (one of the codes listed above) and stores the result in the record accordingly.
2	LDL - cholestrol	CQM PQRI 2	LDL is identified by the lab name LDL, or alternatively by one of the following LOINC codes: 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 22748-8, 39469-2, 49132-4, 55440-2 It is recommended that providers ensure that the lab value for this result is recorded under the specific lab name listed above, or the lab result interface processes the result based on LOINC codes (one of the codes listed above) and stores the result in the record accordingly.

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Appendix

3. Coding, Capture and Maintenance for specific Conditions

Note: *Each of the Conditions enumerated below represents a default setup for the clinical quality reporting tool. The reporting tool will seek to identify a condition based on the presence of one of the ICD.9 codes in the list below. Further, the customer can use configuration utilities available in the reporting tool to add/modify the ICD.9 codes used to identify a specific condition.*

#	Condition	Regulatory Requirement	Capture, Coding & Maintenance Instructions
1	Hypertension	CQM - NQF 0013	Hypertension is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Hypertension problem is populated with a code from this list: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93
2	Diabetes	CQM – PQRI 1, 2, 3	Diabetes is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list Diabetes: 250, 250.0, 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.4, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.7, 250.70, 250.71, 250.72, 250.73, 250.8, 250.80, 250.81, 250.82, 250.83, 250.9, 250.90, 250.91, 250.92, 250.93, 357.2, 362.0, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.0, 648.00, 648.01, 648.02, 648.03, 648.04 Gestational Diabetes: 648.8, 648.80, 648.81, 648.82, 648.83, 648.84 Polycystic Ovaries: 256.4 Steroid induced diabetes: 249, 249.0, 249.00, 249.01, 249.1, 249.10, 249.11, 249.2, 249.20, 249.21, 249.3, 249.30, 249.31, 249.4, 249.40, 249.41, 249.5, 249.50, 249.51, 249.6, 249.60, 249.61, 249.7, 249.70, 249.71, 249.8, 249.80, 249.81, 249.9, 249.90, 249.91, 251.8, 962.0

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Coding, Capture and Maintenance for specific Conditions continued from previous page.

#	Condition	Regulatory Requirement	Capture, Coding & Maintenance Instructions
3	Cancer of lymphoreticular or histiocytic tissue	CQM - NQF 0038	Cancer of lymphoreticular or histiocytic tissue is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list 201, 202, 203
4	asymptomatic HIV		asymptomatic HIV is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list 042, V08
5	multiple myeloma		multiple myeloma is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list 203
6	Leukemia		Leukemia is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list 200, 202, 204, 205, 206, 207, 208
7	immunodeficiency		immunodeficiency is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list 279
8	Encephalopathy		Encephalopathy is identified by a specific list of ICD.9 codes provided below — the provider needs to ensure that at least one of the Code fields for the Diabetes problem is populated with a code from this list 323.51

Appendix

4. Coding, Capture and Maintenance for specific Vital Signs

#	Vitals Name	Regulatory Requirement	Capture, Coding & Maintenance Instructions
1	Systolic & Diastolic: Blood Pressure	CQM - NQF 0013	– Recommend capture of blood pressure readings at least once for each patient seen during the measurement period – Systolic blood pressure readings need to be captured under the Vitals name of "Systolic" – Diastolic blood pressure readings need to be captured under the Vitals name of "Diastolic"
2	Smoking: Query and documentation of tobacco use	CQM - NQF 0028a	The "Smoking" Vitals record is used to document that a patient was queried regarding tobacco use. The value for the Vitals record is used to determine the result of the query. – Recommend recording of the Smoking vitals at each visit for each patient seen during the reporting period – Any value other than a BLANK value is considered to imply that a patient was queried – A patient is NOT considered a tobacco user if the latest value of the"Smoking" vital record is either "Never," or "Former" – All other values are considered to imply that the patient IS a Tobacco User.
3	Height and Weight: BMI	CQM - NQF 0421	The Height and Weight data capture is required to compute the BMI value which is displayed by Patient Records to the user when Height and Weight are entered — the quality measure requires tracking of the latest/current BMI value which implies capture/recording of height and weight data at each encounter – Capture of Height and Weight at each encounter of the patient is recommended – For abnormal BMI values: "Check" the Clinical Element "BMI Plan" (under the Weight Screen Clinical Template) once the follow up plan has been discussed with the patient and recorded

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Appendix

5. Coding, Capture and Maintenance for specific Immunizations

Note: *For each of the immunization items enumerated below, the names provided are default names used in the Patient Records product. The customer can use the configuration capability in the reporting tool to modify or add additional names as applicable to local practices, or can add additional CVX and RxNorm codes as necessary or required for identification of the administered vaccine.*

#	Immunization - HM Name	Regulatory Requirement	Capture, Coding & Maintenance Instructions
1	DTaP Vaccine	CQM NQF 0038	The administration of a DTaP vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "DTaP" 2. The provider should use either one of the following CVX codes to codify the immunization data entry: 20, 106, 107, 110, 50, 120, 130, 132
2	Polio (IPV) Vaccine		The administration of a IPV vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "IPV" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 10
3	MMR Vaccine		The administration of a MMR vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "MMR" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 03
4	HiB Vaccine		The administration of a HiB vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "HIB" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 46, 47, 48, 49, 17,51
5	Hep B Vaccine		The administration of a Hep B vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "HEPATITIS B" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 42. 43. 44. 45. 08

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Coding, Capture and Maintenance for specific Immunizations continued from previous page.

#	Immunization - HM Name	Regulatory Requirement	Capture, Coding & Maintenance Instructions
6	Hep A Vaccine	CQM NQF 0038	The administration of a Hep A vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "HEPATITIS A" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 52, 31, 83, 84, 85
7	Varicella (VZV) Vaccine		The administration of a Varicella vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "Varicella" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 21
8	Pneumococcal Vaccine		The administration of a Pneumococcal Conjugate vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "PNEUMOCOCCAL CONJ" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 133, 100,109
9	Rota Virus Vaccine		The administration of a Rotavirus vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "Rotavirus" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 119, 122, 116, 74
10	Influenza Vaccine		The administration of a Influenza vaccine should be recorded in Patient Records as a Health Maintenance item with the following specific attributes: 1. Administration event should be recorded under the HM Name of "Influenza" 2. The provider should use one of the following CVX codes to codify the immunization data entry: 135, 111, 88, 15, 16

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6. Coding, Capture and Maintenance for specific Allergies

Note: *For each of the Allergy items enumerated below, the names provided are default names used in the Patient Records reporting tool. The customer can use the configuration capability in the reporting tool to modify or add additional names as applicable to local practices.*

#	Allergy Name	Regulatory Requirement	Capture, Coding & Maintenance Instructions
1	Vaccine Allergies	CQM NQF 0038	Medication allergies to any of the immunizations listed above should be recorded in the Allergies section of the Patient Records patient chart with: 1. Allergy name – identical to the vaccine name above 2. Code – CVX codes – one on the list for the vaccine listed above
2	Neomycin		Medication allergy to Neomycin should be recorded in the Allergies section of the Patient Records patient chart with: 1. Allergy Name: "Neomycin" 2. Code – RxNorm values – one of the following values: C0988018, C1123055, C1123343, C1123363, C1124224, C1127589, C1134215, C1140030, C1140542, C1186980, C1704126, C272305
3	Streptomycin		Medication allergy to Streptomycin should be recorded in the Allergies section of the Patient Records patient chart with: 1. Allergy Name: "Streptomycin" 2. Code – RxNorm values – one of the following values: C1134151
4	Polymyxin		Medication allergy to Polymyxin should be recorded in the Allergies section of the Patient Records patient chart with: 1. Allergy Name: "Polymyxin" 2. Code – RxNorm values – one of the following values: C0988924, C1123393, C1125567, C1133048, C2729553
5	Bakers Yeast		Substance allergy to Bakers Yeast should be recorded in the Allergies section of the Patient Records patient chart with the Allergy Name: "Bakers Yeast"

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Appendix

7. Coding, Capture and Maintenance of Health Maintenance

Note: *A new Health Maintenance template would be created for new installations and upgrades of Patient Records with the name of "Weight Screening." Each of the following HM items is setup to be part of this template. Users can as alternatives use existing templates and add the HM items below to the existing template in use at your practice. Further, the configuration tools in the Patient Records reporting tool can be used to record the data under an alternate HM item.*

#	Health Maintenance Name	Regulatory Requirement	Capture, Coding & Maintenance Instructions
1	Counseling for nutrition	CQM NQF 0024	Providers are asked to record the delivery of counseling for nutrition as a Health Maintenance item under the name of "Nutrition Counsel." New installations and upgrades of Patient Records will be setup with a Health Maintenance template of "Weight Screening" with Nutrion Counsel as a procedure in this template. The Nutrition Counsel item should be coded in ICD.9 with the following value: V65.3 If you have upgraded to Patient Records, you would need to create a HM template with this specific name, and codify the result with the above ICD.9 code
2	Counseling for physical activity	CQM NQF 0024	Providers are asked to record the delivery of counseling for nutrition as a Health Maintenance item under the name of "Activity Counsel." New installations and upgrades of Patient Records will be setup with a Health Maintenance template of "Weight Screening" with Activity Counsel as a procedure in this template. The Activity Counsel item should be coded in ICD.9 with the following value: V65.41 If you have upgraded to Patient Records, you would need to create a HM template with this specific name, and codify the result with the above ICD.9 code

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8. Coding, Capture and Maintenance of Clinical Elements

Note: *New Clinical Elements template would be created for new installations and upgrades of Patient Records with the names of "Tob Cessation," and "Weight Screen." The Tob Cessation Clinical Element template will be setup with a Clinical Element with Name "Tobacco Intervention," and the Weight Screen template will be setup with a Clinical Element "BMI Plan. Each of these Clinical Elements is of the Checkbox type – where "checking" the checkbox is associated with a value of "Y." Users can as alternatives use existing templates and add the CE Names below to the existing template in use at your practice. Further, the configuration tools in the Patient Records reporting tool can be used to record the data under an alternate CE Name.*

#	Clinical Element Name	Regulatory Requirement	Capture, Coding & Maintenance Instructions
1	Tobacco Cessation Intervention	CQM - NQF 0028a	Providers are asked to record the delivery of Tobacco Cessation intervention as a clinical element under the name of "Tob Cessation." If you have upgraded to Patient Records, you would need to verify that this Clinical Element exists. In the event the upgrade did not automatically create it, you would need to create a clinical element with this specific name, and setup the result to be a checkbox.
2	Follow up plan for BMI documented	CQM - NQF 0421	Providers are asked to record the recoding of a follow up plan for abnormal BMI as a clinical element under the name of "BMI Plan." If you have upgraded to Patient Records, you would need to verify that this Clinical Element exists. In the event the upgrade did not automatically create it, you would need to create a clinical element with this specific name, and setup the result to be a checkbox. The following are the normal ranges [Ref: NQF Specs for 0421 and 0024] for BMI values based on age groups: 1. Age >=18 and <=64 NORMAL BMI is >=22 kg/m² and <30 kg/m² 2. Age >=65 NORMAL BMI is >=18.5 kg/m² and <25 kg/m²