

Set up and Training for Meaningful Use Summary

This document is meant to be an over-view of the 2011 requirements for Meaningful Use. Detailed descriptions of the requirements can be found in the [MU Training Scenario Guide](#) which this document references.

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Most all Measure denominators are pulling from an Appointment on schedule, if there is an appointment type in which they should not be included in the Denominator a Visit type code should be created with the exclusion Flag enabled:

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

Core Objectives: (must meet all 15 Core Objectives) **on Meaningful Use Dashboard*

1. ***Record demographics:** 50%- DOB, Gender, Language, Race, Ethnicity (recommended to make mandatory)
 - A. No Set up Required
 - B. Action Required—Refer to page 93-98 of MU Training Scenario Guide
2. ***Active Medication list:** 80%-Record medications or click medications verified (if no meds)
 - A. No Set up Required
 - B. Action Required- Refer to page 106-108 of MU Training Scenario Guide
3. ***Active Medicaiton Allery list:** 80%-Record Allergy or mark Allergies verified
 - A. No Set up Required
 - B. Action Required-Refer to page 108-113 of MU Training Scenario Guide
4. ***Record vitals:** 50%-Height, Weight, Blood Pressure
 - A. Mapping of Vitals—Refer to page 114-116
 - B. Action Required-Refer to page 116-118 of MU Training Scenario Guide
5. **A. *Record Smoking Status for patients 13 and older:** 50%- Recommended Smart Form (Tobacco Control)
 - A. _Mapping of Structured Data—Refer to pages 37-40
 - B. Action Required-Refer to page 40-41 of MU Training Scenario Guide

B. ***Non Structured Smoking Status:** 50%---Not Recommended. We recommend using #5 above.

 - A. No Set Up Required
 - B. Action Required-Met if entering patient smoking status under the note field in Social History (Smoking Status)
6. ***Up to date problem list:** 80%- ICD's recorded in problem list or check box of No Known problems (Left Panel)
 - A. No Set Up Required (unless you want to make some ICD9 Codes Chronic-Refer to page 100 of MU Training Scenario Guide)
 - B. Action Required-Refer to page 99-104 of MU Training Scenario Guide

- 7. ***COPE (computerized Provider entry):** 30%-Documenting all **medications** in progress note (not telephone encounters)
 - A. No Set Up Required
 - B. Action Required-Refer to page 6-13 of MU Training Scenario Guide
 - C.
 - 8. ***Permissible electronic Prescription:** Must send RX electronically (denominator is all RX printed/faxed/send electronically)
 - A. Must have SureScripts (contact easeMD support to enroll)
 - B. Action Required-Refer to page 17-21 of MU Training Scenario Guide
 - 9. ***Clinical Visit Summaries for each visit:** 50%-Print Visit Summary at check out or from Progress note or Access from PP
 - A. No set up required (unless using Patient Portal-refer to patient portal set up guide-patient must be web-enabled)
 - B. Action Required-Refer to page 88-90 of MU Training Scenario Guide
 - 10. ***Electronic copy of Health Record:** 50%-Must enable Patient Portal, PHR's, satisfied by patient clicking on link in PP requesting a PHR. Exclusion: Providers with no request from patients
- Example of Dashboard (Score Card View)**
- A. Set Up Patient Portal—Refer to Patient Portal Guide
 - B. Action Required-Refer to page 76-87 of MU Training Scenario Guide

SAMPLE DASHBOARD

+	Record demographics	161	161	100 (50)	200	200	100 (50)
+	Active medication list.	161	160	99.38 (80)	200	196	98 (80)
+	Active medication allergy list.	161	159	98.76 (80)	200	194	97 (80)
+	Record Vital signs	160	148	92.5 (50)	199	180	90.45 (50)
+	Record smoking status	149	140	93.96 (50)	187	173	92.51 (50)
+	Non-structured smoking status	149	0	0 (0)	187	0	0 (0)
+	Up-to-date problem list	161	153	95.03 (80)	200	184	92 (80)
+	CPOE	147	126	85.71 (30)	180	154	85.56 (30)
+	Permissible e-prescriptions	404	381	94.31 (40)	494	454	91.9 (40)
+	Clinical visit summaries	161	123	76.4 (50)	200	134	67 (50)
+	Electronic copy of Health information	0	0	0 (50)	0	0	0 (50)

The following 4 have no Calculations and are met by Self Attestation

- 11. **Drug-Drug/Drug-Allergy Interaction:** No action required, reported by Self Attestation (Yes, No) Built into ECW
- 12. **Clinical Decision Support Rule:** No Calculations-Methods to assist using classic Alerts,Registry Alerts,CDSS Alerts (at least one)—Refer to page 58-75 for instructions on all methods
- 13. **Exchange Key Clinical information:** No Calculations- P2P with CCR or CCD, Self Attestation required— Refer to page 122-123 of MU Training Scenario Guide
- 14. **Protect Electronic Health Information:** No Calculations- Self Attestation, Authentication Settings and Security Settings— Refer to page 124-142 of MU Training Scenario Guide

15. Clinical Quality Measures: All reported on dashboard

- 3 Core Measures
 - ◆ If the denominator of one or more Core Measures is 0, Alternative Core Measures can be substituted
- 3 Additional Measures

NQF0421- Adult weight Screening and FU: 18 or older with a calculated BMI w/l past 6 months or during current visit—

- A. Setup during Vitals
- B. Action Required- Refer to page 29 of MU Training Scenario Guide

NQF0028a-Tobacco Use: Tobacco Control (Smart Forn or if linked to measure through order set)

- A. Mapping Previously done above
- B. Action Required- Refer to page 39 of MU Training Scenario Guide

NQF0028b-Tobacco Cessation: Preventive Medicine/Counseling/Smoking or thru RX of Chantix(make sure mapped in community mapping)

- A. Mapping Previously done above
- B. Action Required- Refer to page 41-46 of MU Training Scenario Guide

NQF 0013- HTN BP Measurement: 18 or older with at least two OV with BP recorded

- A. Previously mapped above
- B. Action Required- Refer to page 48 of MU Training Scenario Guide

SAMPLE DASHBOARD

Tobacco Use Assessment	17	16	94.12 (0)	24	22	91.67 (0)
Tobacco Use Intervention	10	2	20 (0)	12	2	16.67 (0)
Diabetes: BP Management	26	12	46.15 (0)	26	16	61.54 (0)
Hypertension: BP Measurement	4	4	100 (0)	6	6	100 (0)
Adult Wt Screen & Follow Up(>=65yrs)	11	5	45.45 (0)	13	6	46.15 (0)
Adult Wt Screen & Follow Up(18-64 yrs)	122	33	27.05 (0)	156	40	25.64 (0)

“Decide on additional Quality Measures in ECW toolbar EMR/CDSS/Measure Configuration—Only those that are certified in eCW should be selected. The certified measures are below”

Recommended Addt'l Measures:

- NQF 0041 Influenza Immunization –CVX Mapping-EMR/Immunization/Highlight Flu Injection/Update and link to:

NQF-0041	Influenza Immunization for Patients 50 Years Old	CVX or CPT mapping required	15, 16, 111, 125, 126, 127, 128, 135	90656, 90658, 90660, 90661, 90662, 90663, 90664, 90666, 90667, 90668	N/A	N/A	N/A
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- NQF 0024 Weight Assessment and Counseling –No set up—Enter BMI in eCW and communicate to patient weight counseling, nutrition counseling and activity counseling.
- NQF 0038 Childhood Immunization Status---CVX Mapping- EMR/Immunization/Highlight Immunization/Update and link to appropriate CVX Code. All Immunizations should be mapped.
- NQF 0059 Diabetes: Hemoglobin A1c Poor Control –Must have Lab Interface with LOINC code association

- NQF 0064 Diabetes: LDL Management and Control-- Must have Lab Interface with LOINC code association
- NQF 0061 Diabetes: BP Management :

NQF-0061	Diabetes: BP management	All patients 18-75 years of age with diabetes (type 1 or type 2) who had BP < 140/90 mmHg	Physical exam finding: diastolic blood pressure, minimum value < 90 mmHg during most recent encounter (encounter non-acute inpatient, outpatient, or ophthalmology)
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Menu Set Measures

(must meet 5 Menu set Objectives with at least 1 public health Objective)

Stage 1 Objective Measures ** Click on % Scores for Patient list	Practice Denominator (Monthly)	Practice Numerator (Monthly)	Practice Monthly % (Threshold %)	Practice Denominator (90-Day)	Practice Numerator (90-Day)	Practice 90-Day % (Threshold %)
Medication reconciliation.	1	1	100 (50)	2	2	100 (50)
Patient education	161	0	0 (10)	200	0	0 (10)
Transition of Care Summary	30	15	50 (50)	32	16	50 (50)
Clinical lab-test results	12	1	8.33 (40)	44	6	13.64 (40)
Timely electronic access	161	0	0 (10)	200	0	0 (10)
Patient reminders	48	0	0 (20)	48	0	0 (20)

1. ***Medication Reconciliation:** Transition of Care must be checked on Appt Window and Medication Verified Box gets checked. **This is for NEW patients and patient’s that are returning to your care after any other receipt of medical care.**
 - A. No Setup
 - B. Action Required- Refer to page 169-170 of MU Training Scenario Guide
2. ***Patient Education Resources:** No graph, Rx Ed, Krames/Adam/healthwise, Custom PtED, Pt ED thru orderset, Publishing Pt Ed to PP
 - A. Setup—Activate Krames, Adam, Healthwise or link Pt ED in orderset—Page 166
 - B. Action—Use Krames, Adam, Healthwise or--- Refer to page 167-168 of MU Training Scenario Guide
3. ***Transision of Care Record:** Denominator: Referral is printed/faxed/transmitted thru P2P (provider must be listed in the From Provider in referral. Numerator: same as denominator with attachments
 - A. No Setup
 - B. Action Required- Refer to page 172-174 of MU Training Scenario Guide
4. ***Clinical Lab Test Results:** Denominator(Result date w/l reporting period, Numerator: Results entered in yellow grid and marked Received.
 - A. Set Up-- Refer to page 147-149 of MU Training Scenario Guide
 - B. Action Required- Refer to page 150-152 of MU Training Scenario Guide

Menu Set Measures : Continued.....

5. ***Timely Electronic Access:** No Graph, Web enabled patients
 - A. Set Up—Must enable Patient Portal
 - B. Action Required- Refer to page 164-165 of MU Training Scenario Guide
6. ***Patient Reminders:** No Graph, ages 5 or less and 65 and older, Letter (Category: Followup/HM/PC) or VM/Text with Health maintenance selected, eMessage from PP with Preventive/Followup care message box checked
 - A. Set Up Letters-- Refer to page 155 of MU Training Scenario Guide
 - B. Action Required- Refer to page 155-156 of MU Training Scenario Guide

The following 4 have no Calculations and done by Self Attestation

7. **Patient Lists:** No Calculations, Self Attestation (Registry)
 - A. No Set Up Required
 - B. Action Required- Refer to page 153-154 of MU Training Scenario Guide
8. **Implement Drug Formularies:** No Calculations, Self Attestation, Rx Formulary, Surescripts
 - A. Set Up-Activate SureScripts
 - B. Action—None required
9. **Submit Electronic Data to State Imm registry:** No Calculations, Self Attestation, perform at least one test
 - A. Set Up- Refer to page 175 of MU Training Scenario Guide
 - B. Action Required- Refer to page 175-176 of MU Training Scenario Guide
10. **Syndromic Surveillance Data:** No Calculations, Self Attestation, perform at least one test
 - A. Set Up- Refer to page 176 of MU Training Scenario Guide
 - B. Action Required- Refer to page 176-177 of MU Training Scenario Guide

*Reports on Dashboard

Product Activation:

Practices must enable the following services through product activation:

1. **ePrescriptions**- allowing physicians to sent electronic prescriptions and RX Formularies
2. **Patient Portal**-Web enable Patients and turn on PHR feature
3. **P2P**-Send at least one test of CCD/CCR to another practice
4. **eClinicalMessenger**- if wanting to send Health Maintenance Messages to patient to satisfy Patient Reminders

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<https://my.eclinicalworks.com/eManager/jsp/eCRM/login.jsp>

Go to your myeClinicalWorks for supporting HOW-TOS on Meaningful Use and other information