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Table of Contents

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IMPORTANT DATES

- **October 1, 2014**: Date providers will begin the 90-day attestation period for calendar year 2014.
- **December 31, 2014:** Last day to complete meaningful use reporting for 2014.
- **February 28, 2015:** Last day to submit your attestation data for the 2014 reporting period.

Helpful Resources

Specific details about measures can be answered via Centers for Medicare and Medicaid Services (CMS). Here are some direct links and phone numbers that may be helpful.

- **EHR Information Center Help Desk: (888) 734-6433 / TTY: (888) 734-6563** Hours of operation: Monday-Friday 8:30 am-4:30 pm in all time zones (except on Federal holidays)
- **CMS EHR Incentive Programs: www.cms.gov/EHRIncentivePrograms**
- **HHS Office of the National Coordinator for Health IT: certified EHR technology list http://healthit.hhs.gov/CHPL**
- **NPPES Help Desk:** Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do **(800) 465-3203 - TTY (800) 692-2326**
- **PECOS Help Desk:** Visit https://pecos.cms.hhs.gov/ **(866)484-8049 / TTY (866)523-4759**
- **Identification & Authentication System (I&A) Help Desk, PECOS External User Services (EUS) Help Desk:** Phone: 1-866-484-8049 – TTY 1-866-523-4759**|E-mail:** EUSSupport@cgi.com
- **State Medicaid Incentive help desks**

This document describes how to enter information into ICANotes so that the Meaningful Use Report will track the numerators and denominators needed to submit your attestation data.

Meeting Meaningful Use Standards

You must use ICANotes for 90 consecutive days to collect your Stage 2 meaningful use payment, beginning on October 1, 2014. You will collect data for 20 specific criteria (17 core measures and 3 menu measures) and 9 Clinical Quality Measures during that period. You will then go back online and attest to what you have collected. You must submit your attestation data by February 28, 2015.

To qualify for meaningful use, you do not have to collect the required information for every patient – just for the percentage of patients the government stipulates for each measure. The percentages specified in the threshold for each of the measures tells you how much information you need to collect.

To review the full text of the requirements for each measure, click on the hyperlink in the measure's section title in this document.

Disclaimer: ICANotes is not certified to instruct Eligible Providers on how to attest for Meaningful Use. Our Support Department is unable to provide any answers to questions regarding definitions or interpretation of the requirements outlined by CMS. For expert assistance including one-on-one guidance through the complexities of attestation we highly recommend contacting our consulting partner AttestEasy at 888-373-4778 x 3012.

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CORE MEASURES (all 17 required)

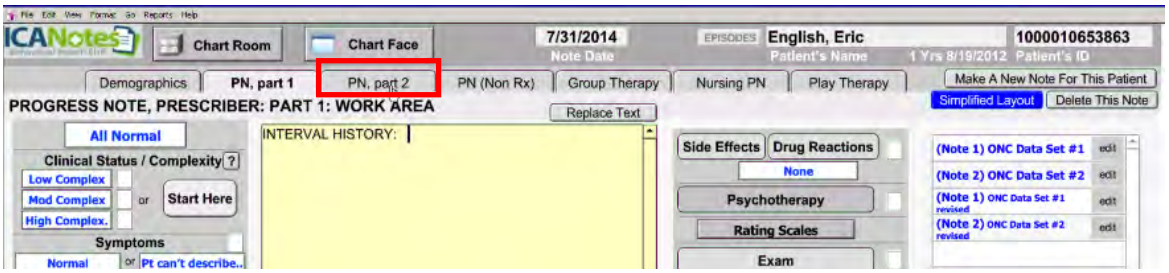
CORE MEASURE 1: CPOE

Measure: *More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.* **Objective:** Use CPOE for Medication, Laboratory and Radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

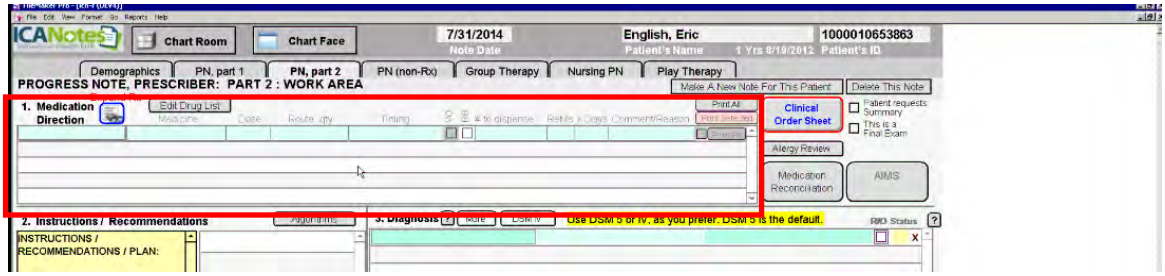
Measure 1: Medication

Denominator: Number of medication orders created by the EP during the EHR reporting period
Numerator: The number of orders in the denominator recorded using CPOE
Threshold: The resulting percentage must be more than 60% in order for an EP to meet this measure
Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period

- Select "PN, Part 2" tab



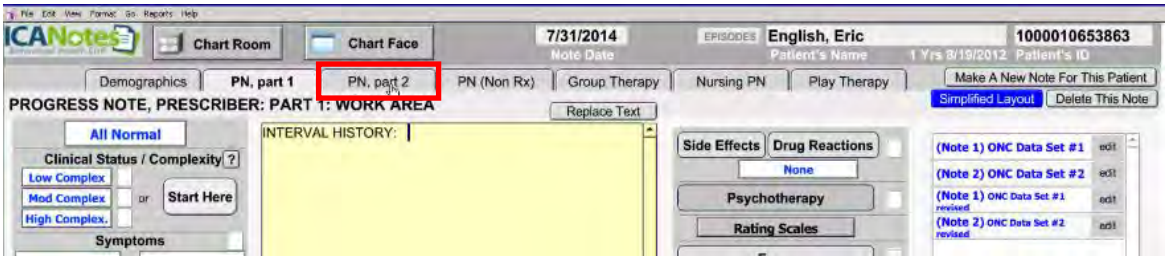
- Enter Medication orders; handled via e-prescribing



Measure 2: Radiology

Denominator: Number of radiology orders created by the EP during the EHR reporting period
Numerator: The number of orders in the denominator recorded using CPOE
Threshold: The resulting percentage must be more than 30% in order for an EP to meet this measure
Exclusion: Any EP who writes fewer than 100 radiology orders during the EHR reporting period

- Select "PN, Part 2" tab



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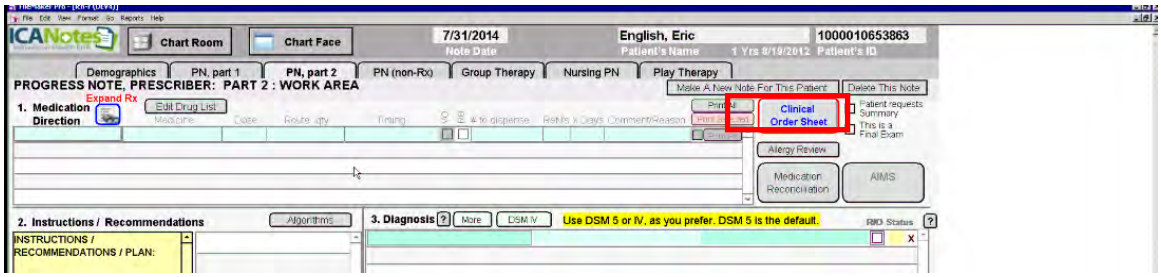
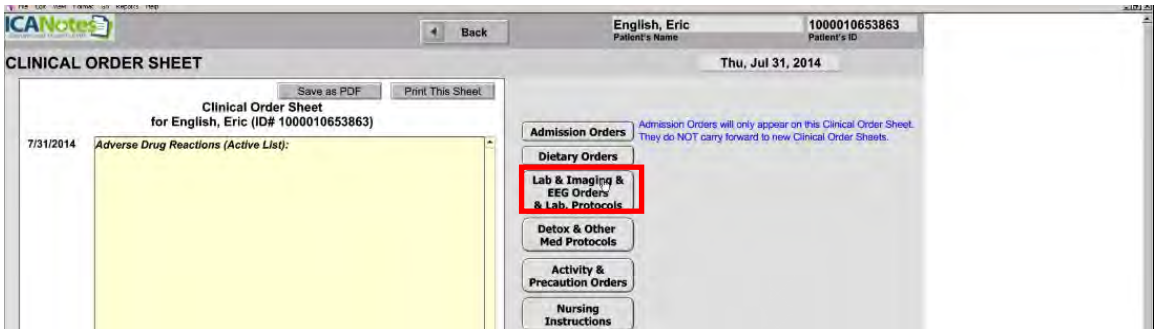
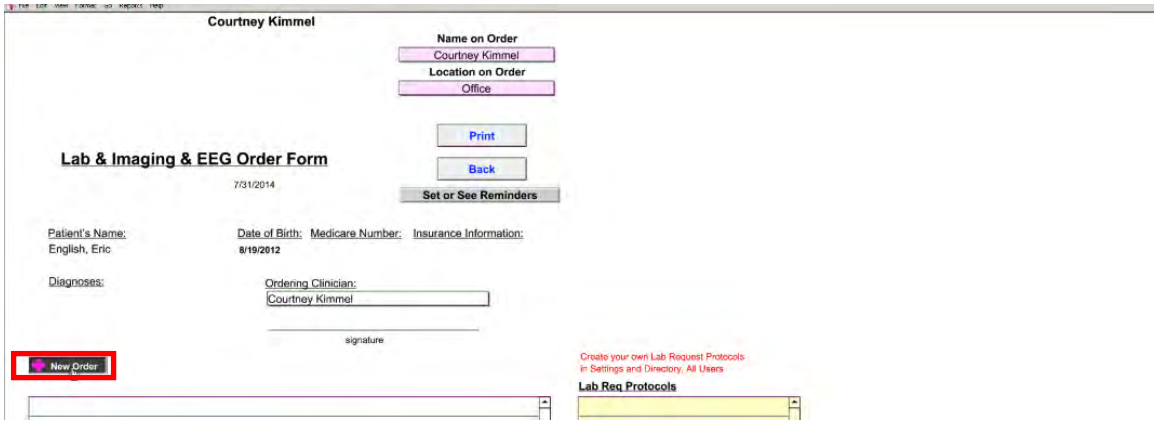
- Select “Clinical Order Sheet”



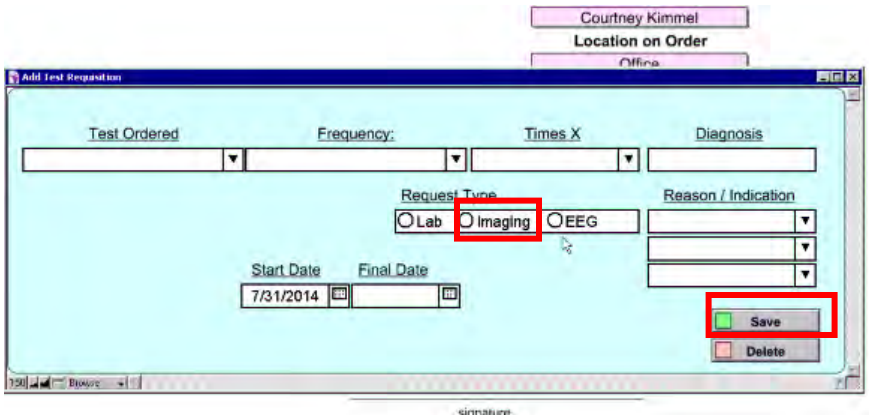
- Select “Lab & Imaging…” button



- Select the “New Order” button



- Enter information for radiology test being ordered
- Select the “Save” button



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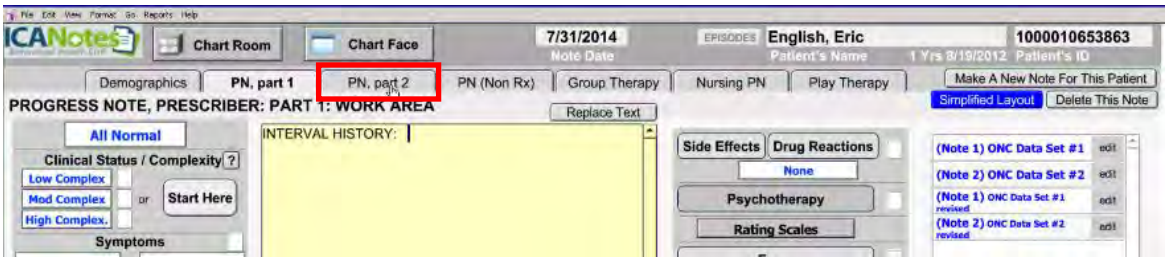
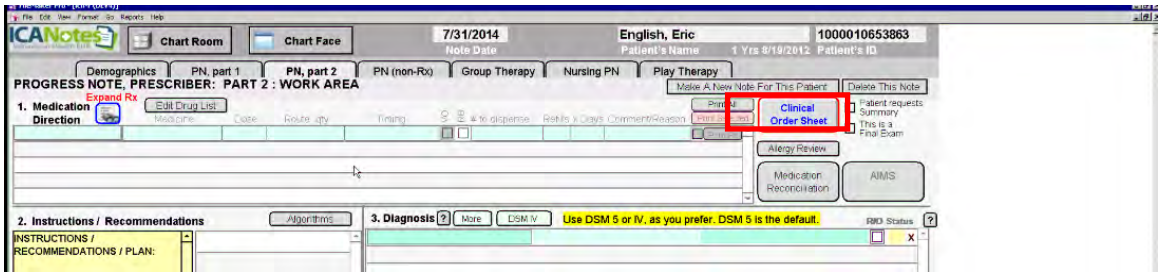
Measure 3: Laboratory

Denominator: Number of laboratory orders created by the EP during the EHR reporting period
Numerator: The number of orders in the denominator recorded using CPOE
Threshold: The resulting percentage must be more than 30% in order for an EP to meet this measure
Exclusion: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period

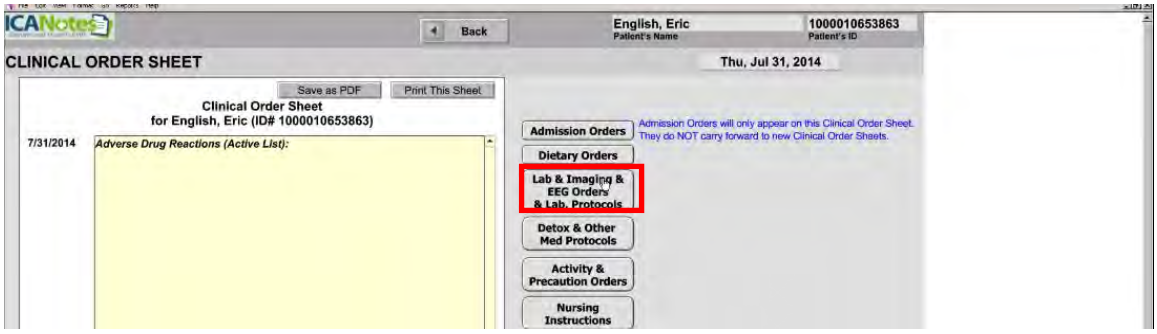
- Select "PN, Part 2" tab



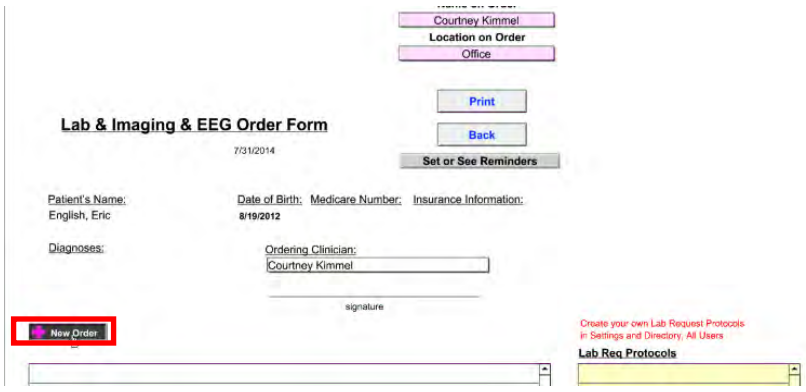
- Select "Clinical Order Sheet"



- Select "Lab & Imaging…" button



- Select the "New Order" button



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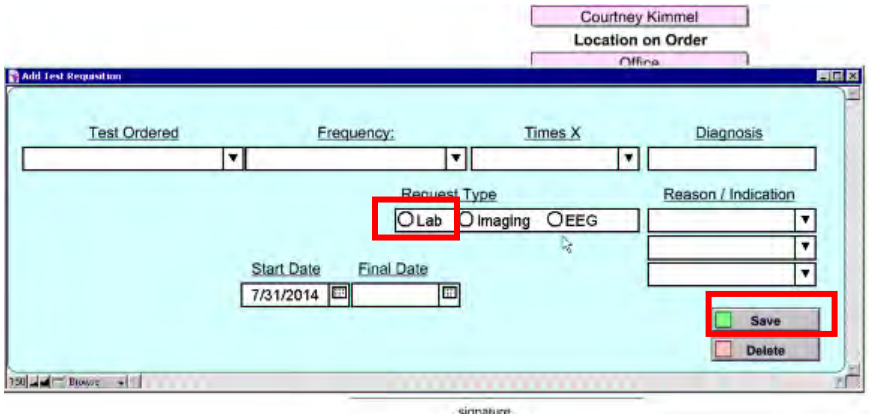
- Enter information for lab test being ordered
- Select the "Save" button



CORE MEASURE 2: eRx

Measure: *More than 50% of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.* **Objective:** Generate and transmit permissible prescriptions electronically

Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period
Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT
Threshold: The resulting percentage must be more than 50% in order for an EP to meet this measure
Exclusion: Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period; or Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period

Meaningful use requires that you use an e-prescription system and that 50% of your prescriptions be e-prescribed. If you use DrFirst e-Rx from within ICANotes to e-prescribe medications, this measure will be automatically calculated for you and meeting this measure will be easy. To set up Dr First through ICANotes, contact sales@icanotes.com.

CORE MEASURE 3: Demographics

Measure: *More than 80% of all unique patients seen by the EP have demographics recorded as structured data.* **Objective:** Record the following demographics: preferred language, sex, race, ethnicity, date of birth.

Denominator: Number of unique patients seen by the EP during the EHR reporting period
Numerator: The number of patients in the denominator who have all the elements of demographics recorded as structured data
Threshold: The resulting percentage must be more than 80% in order for an EP to meet this measure
Exclusion: None

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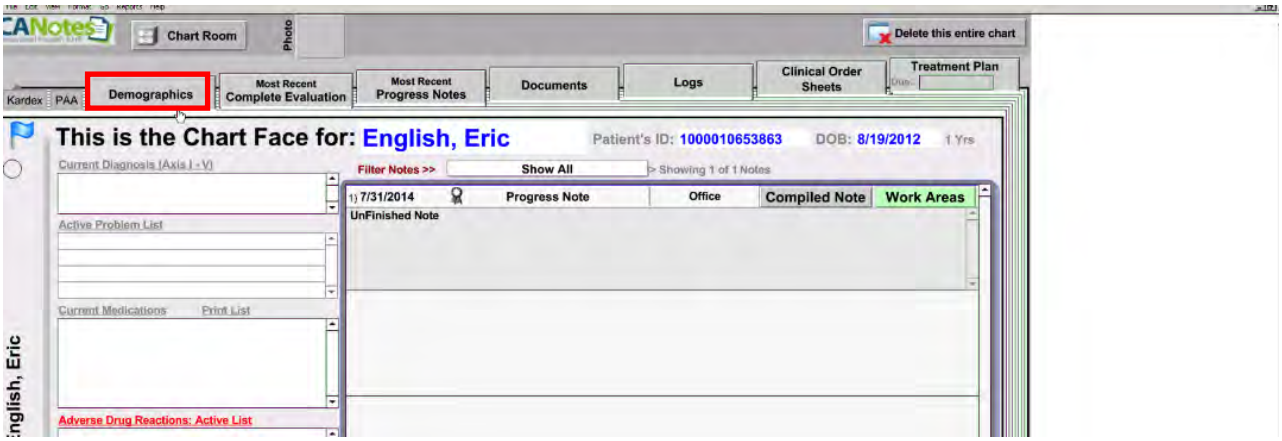
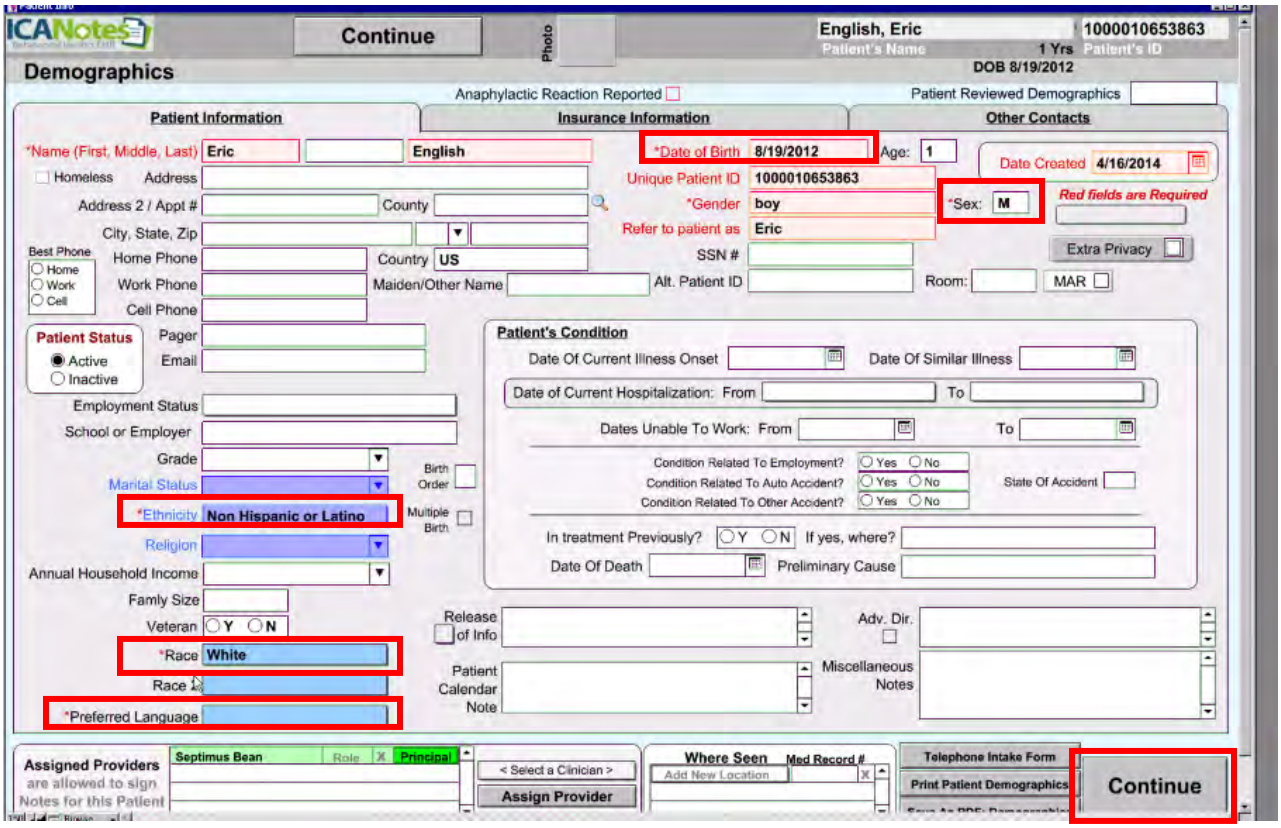
- From the patient's Chart Face, select the "Demographics" tab



- Enter required information (these fields are all asterisked to indicate they are required for MU)
  - Preferred Language
  - Sex
  - Race
  - Ethnicity
  - Date of Birth
- Click "Continue"



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CORE MEASURE 4: Vital Signs (This measure can be an exclusion)

Measure: More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data. **Objective:** Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20years, including BMI.

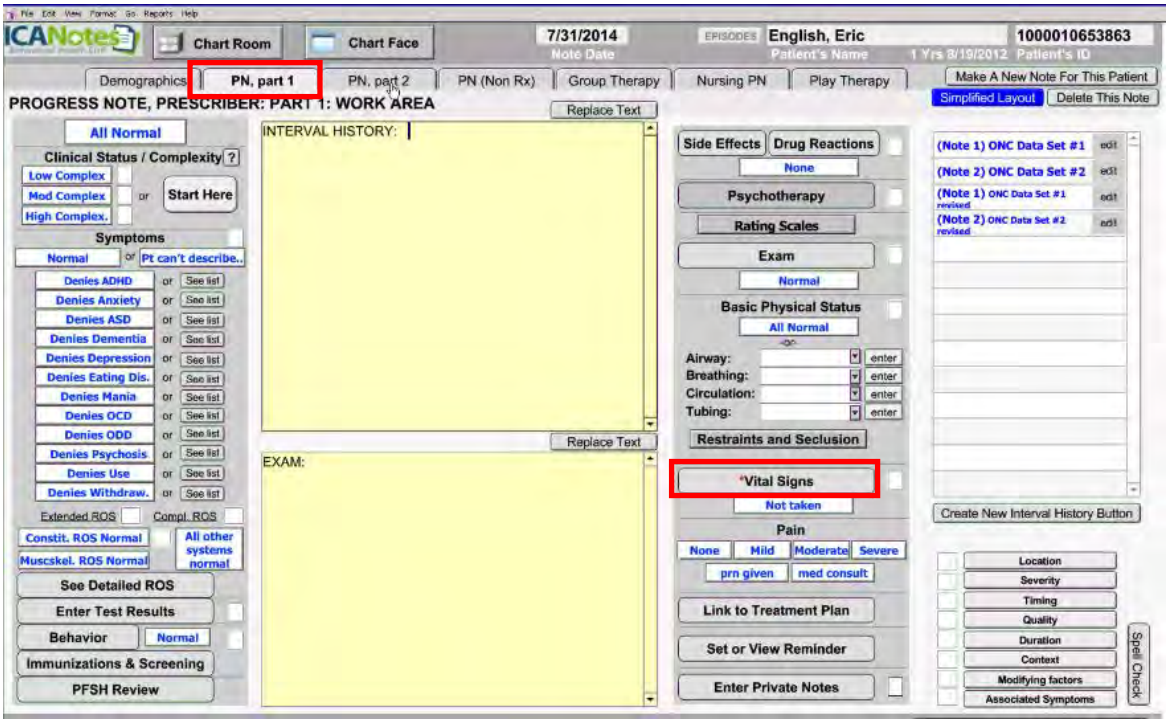
Denominator: Number of unique patients seen by the EP during the EHR reporting period
Numerator: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (age 3 and over) recorded as structured data
Threshold: The resulting percentage must be more than 80% in order for an EP to meet this measure
Exclusion: Any EP who sees no patients 3 years or older is excluded from recording blood pressure

Any EP who believes all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them

Any EP who believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure

Any EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight

- Select "PN, Part 1"
- Click on "Vital Signs"



- Enter vitals for patient
  - Height/Length
  - Weight
  - Blood Pressure

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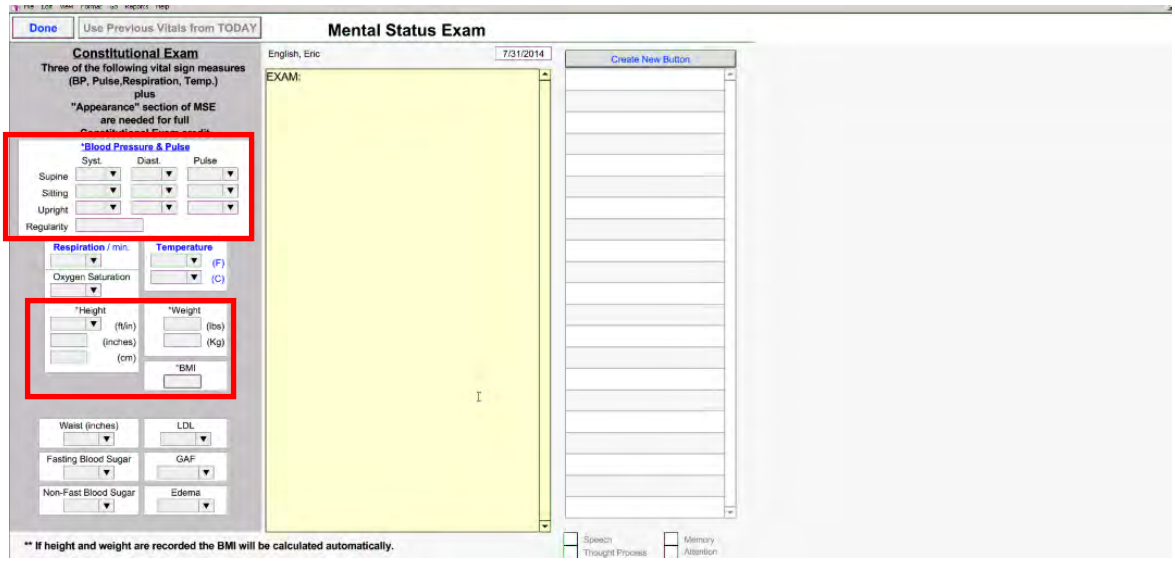
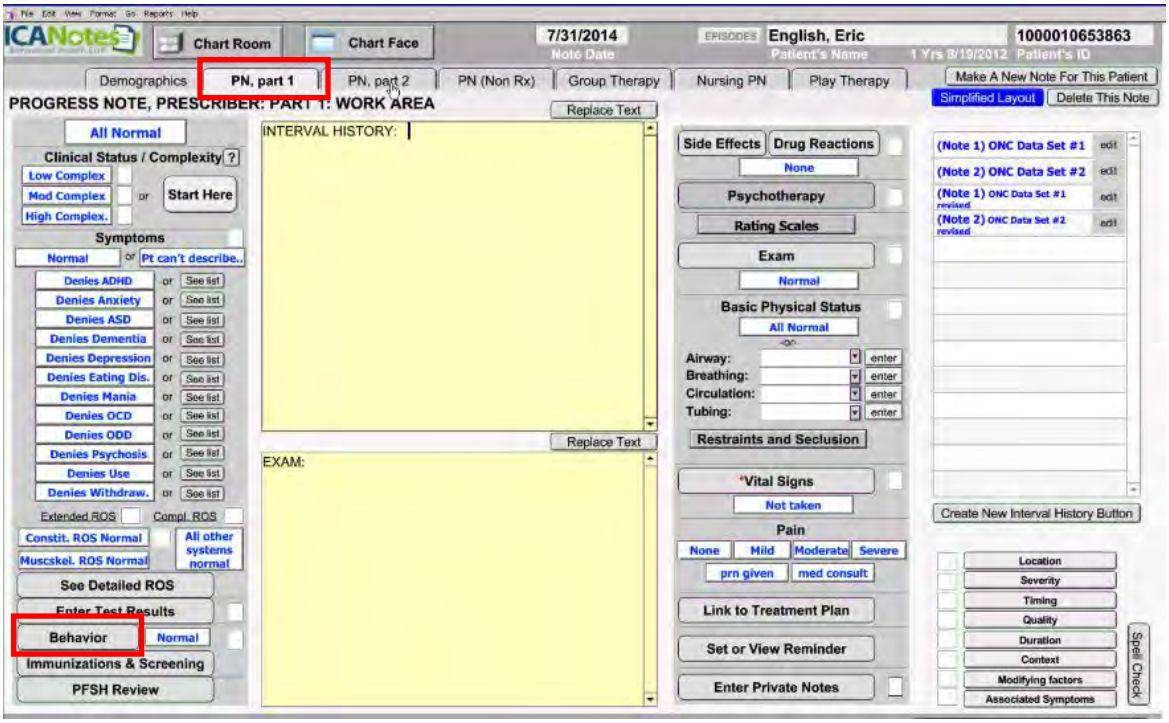


CORE MEASURE 5: Smoking Status

Measure: *More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.* **Objective:** Record smoking status for patients 13 years old or older.

Denominator: Number of unique patients age 13 or older seen by the EP during the EHR reporting period
Numerator: The number of patients in the denominator with smoking status recorded as structured data
Threshold: The resulting percentage must be more than 80% in order for an EP to meet this measure
Exclusion: Any EP that neither sees nor admits any patients 13 years old or older

- Select "PN, Part 1"
- Click "Behavior"



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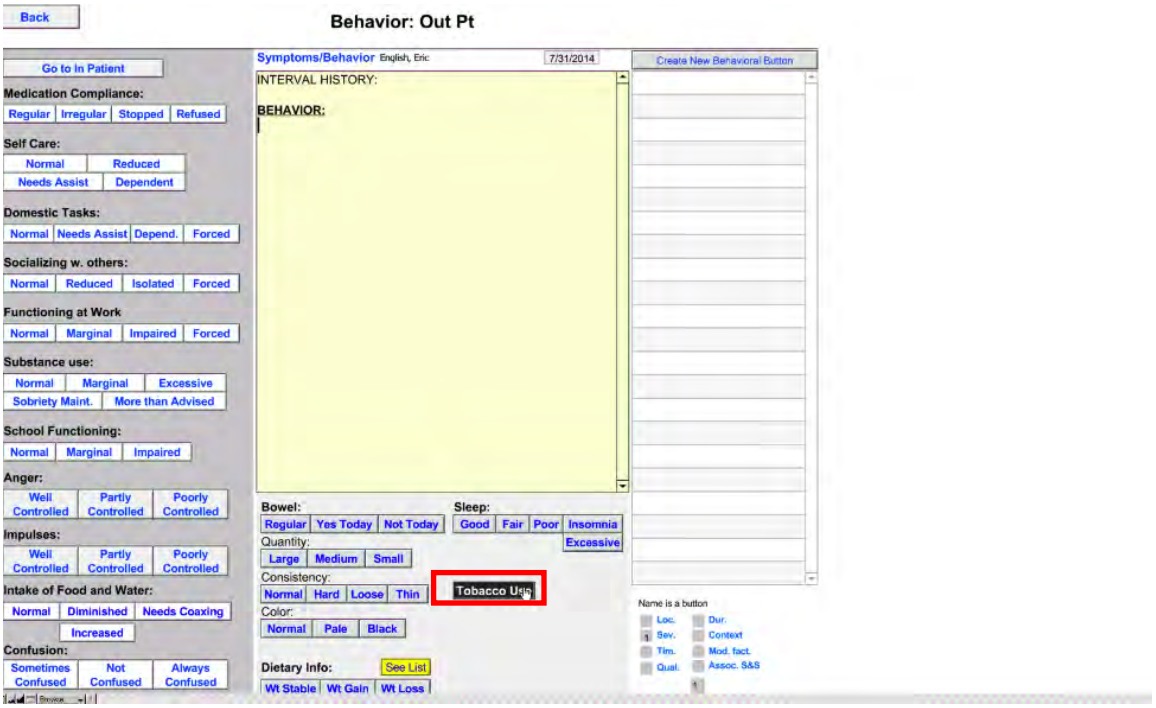
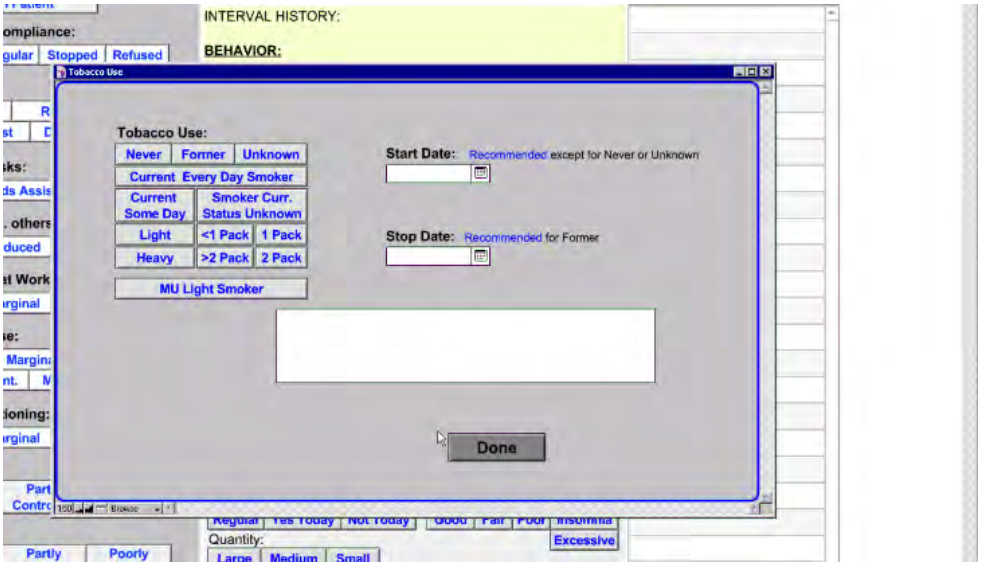
- Click “Tobacco Use”



- Enter current tobacco use status
- Select Start Date
    - Record End Date, if applicable
- Click “Done”



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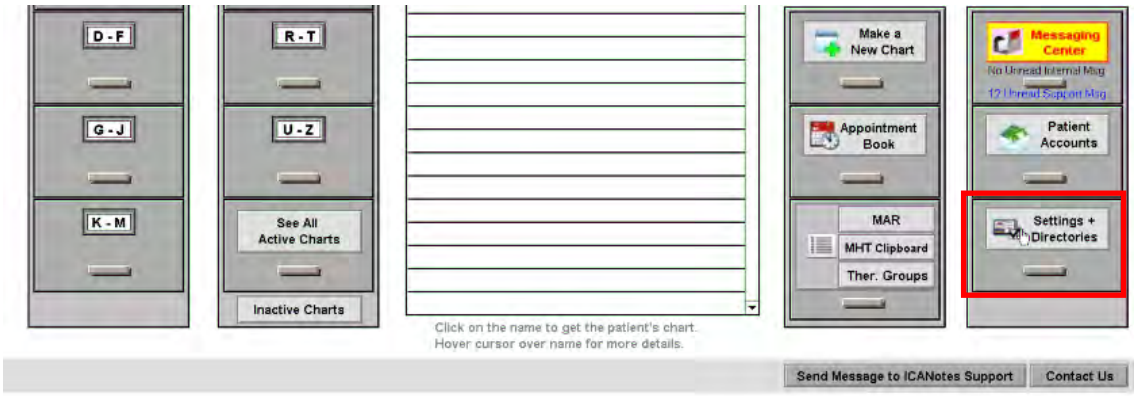
CORE MEASURE 6: Clinical Decision Support

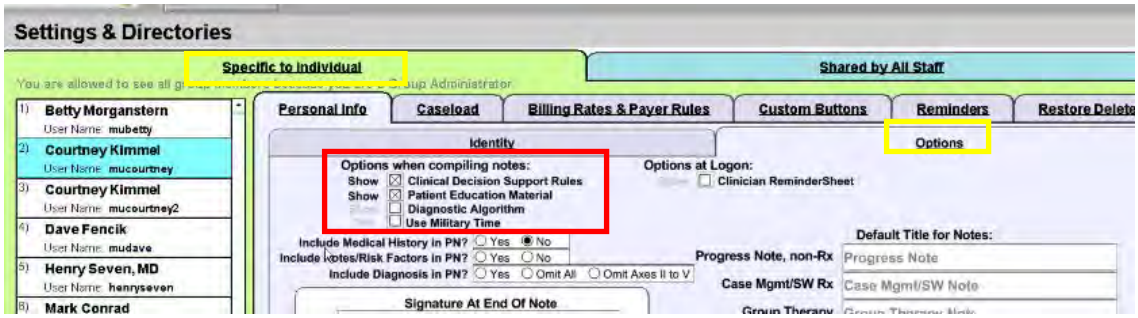
Measure 1: *Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.* ***Measure 2:*** *The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.* **Objective:** Use clinical decision support to improve performance on high-priority health conditions.

Measure 1

- From the Chart Room, select " **Settings & Directories**"



- Click the Options Tab on the Specific to Individual tab
- Check the box next to:
    - **Clinical Decision Support Rule**



EPs will attest YES to having enabled clinical decision support for the length of the reporting period to meet this measure.

Measure 2

Patient's drug-drug and drug-allergy reactions must be completed in **BOTH** ICANotes and in DrFirst.

Psych PN, part 1 – Drug Reactions
Fill out all the information in Part I under Drug Reactions. Fill out drug reactions or click None.

Add the DrFirst ePrescribing Program to your account. To license this program contact sales@icanotes.com. After activating, click on > to ePrescribing PN Part 1 and fill out the appropriate Drug-Drug and Drug-Allergy reactions in DrFirst.

Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.

Eligible professionals must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

CORE MEASURE 7: Provide patients the ability to view online health information
Measure 1: *More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, and transmit to a third party.* ***Measure 2:*** *More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.* **Objective:** Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.

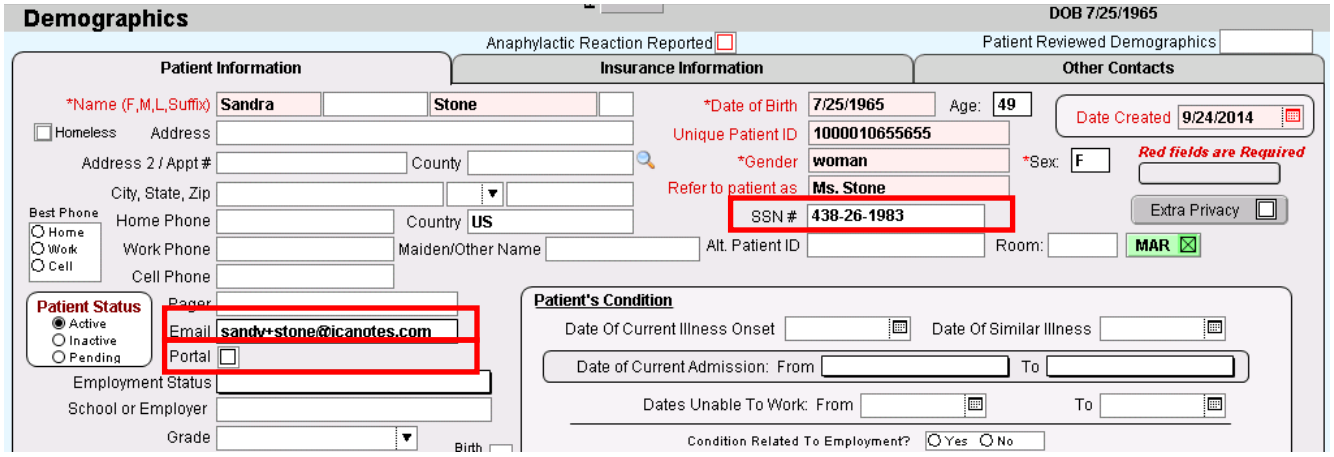
Measure 1:
Denominator: Number of unique patients seen by the EP during the EHR reporting period
Numerator: The number of patients in the denominator who have timely online access to their health information to view, download, and transmit to a third party
Threshold: The resulting percentage must be more than 50% in order for an EP to meet this measure

To comply with Measure 1, EPs must use the Patient Portal to make electronic CCDAs available to their patients. You must invite 50% of all patients seen during the reporting period to access their information from the Patient Portal.

First, you must ask ICANotes to enable the Patient Portal functionality on your account. Call Support at 443-569-8778 or email ticket@icanotes.com to request that these rules be enabled: **Patient Portal Sync, Always Generate CCDA, and Direct Messaging.**

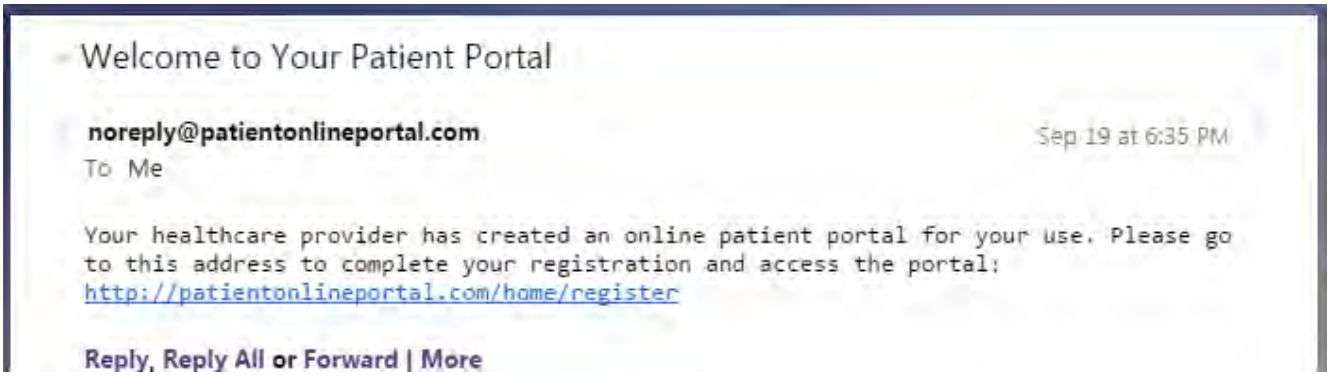
Second, for each patient seen, you will need to do the following:

- Enter the patient's **SSN#** and **Email** in Demographics (these fields are REQUIRED).
- Make sure you are listed as the Assigned Provider.
- Check the **Enable** box directly below the Email field to enable the patient's access to the portal.



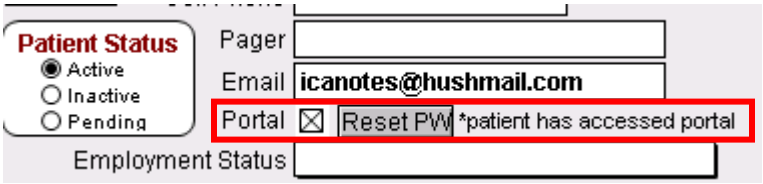
The patient will receive the following email invitation to register for an account on the patient portal:

Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.



Note that the email invitation does not identify the name of your practice. This is to protect the patient's privacy. You will want to make sure the patient is aware of the portal and how to use it. Please provide patients with these **Patient Portal Instructions** and encourage them to register and login.

You will be able to monitor whether or not a patient has accessed the portal from the Patient Information screen in Demographics. If the patient has registered and logged in successfully, these words will appear next to the Portal field: "***patient has accessed portal**." A **Reset PW** button will also appear. If the patient needs to have their portal password reset, you can do that for them by clicking the **Reset PW** button.



Measure 2:
Denominator: Number of unique patients seen by the EP during the EHR reporting period
Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information
Threshold: The resulting percentage must be more than 5 percent in order for an EP to meet this measure
Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient Name" and "Provider's name and office contact information," may exclude **both** measures. Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the **second** measure.

Complying with Measure 2 requires that 5% of all patients seen during the reporting period actually login and use the Patient Portal to view, download, or transmit their health information. These actions can also be taken by an authorized representative of the patient, but the patient will have to invite those representatives to register as an authorized user on the Portal. We recommend that you provide all patients the **Patient Portal Instructions** document to encourage them to use the Portal.

The Patient Portal Access log tracks which patients view, download, or transmit their information (see screenshot on next page). The only way you can monitor how many patients have performed these actions is to run the Meaningful Use Report for Measure 7.

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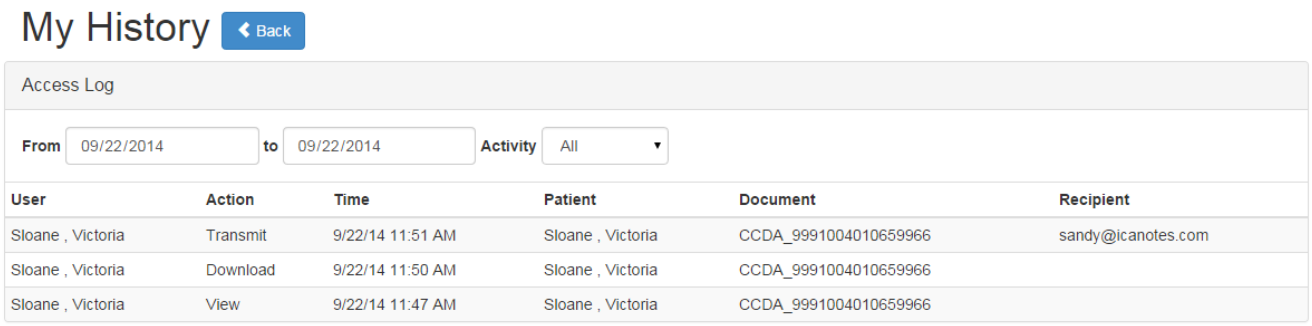


CORE MEASURE 8: Clinical Summaries
Measure: *Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50% of office visits.* **Objective:** Provide clinical summaries for patients for each office visit.

Denominator: Number of office visits conducted by the EP during the EHR reporting period
Numerator: Number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one business day
Threshold: The resulting percentage must be more than 50% in order for an EP to meet this measure
Exclusion: Any EP who has no office visits during the EHR reporting period

After requesting that the "Always Generate CCDA" and "Patient Portal Sync" rules be enabled for your ICANotes account, complying with Core Measure 8 requires you to invite your patients to access the patient portal within one business day of their office visit, following the steps outlined previously for Core Measure 7. Each time you create a note for the patient, a CCDA will be automatically generated and made available to the patient on the portal. **NOTE: CCDAs will only be generated for notes created AFTER you have enabled portal access for the patient in Demographics.**

CORE MEASURE 9: Protect electronic health information
Measure: *Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.* **Objective:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities

Security Risk Analysis Resources: A number of resources that may help you follow those steps and perform a Security Risk Analysis to meet Core Measure 9 include:

- MU Core Measure Stage 1 Protect Health Information
- Meaningful Use Core Objective for Security Risk Analysis from HITECH Answers
- ONC's Guide to Privacy and Security of Health Information
- Risk Analysis Tool for Meaningful Use from the Texas Medical Association – which includes a link to a spreadsheet with ONC's Risk Analysis tool.

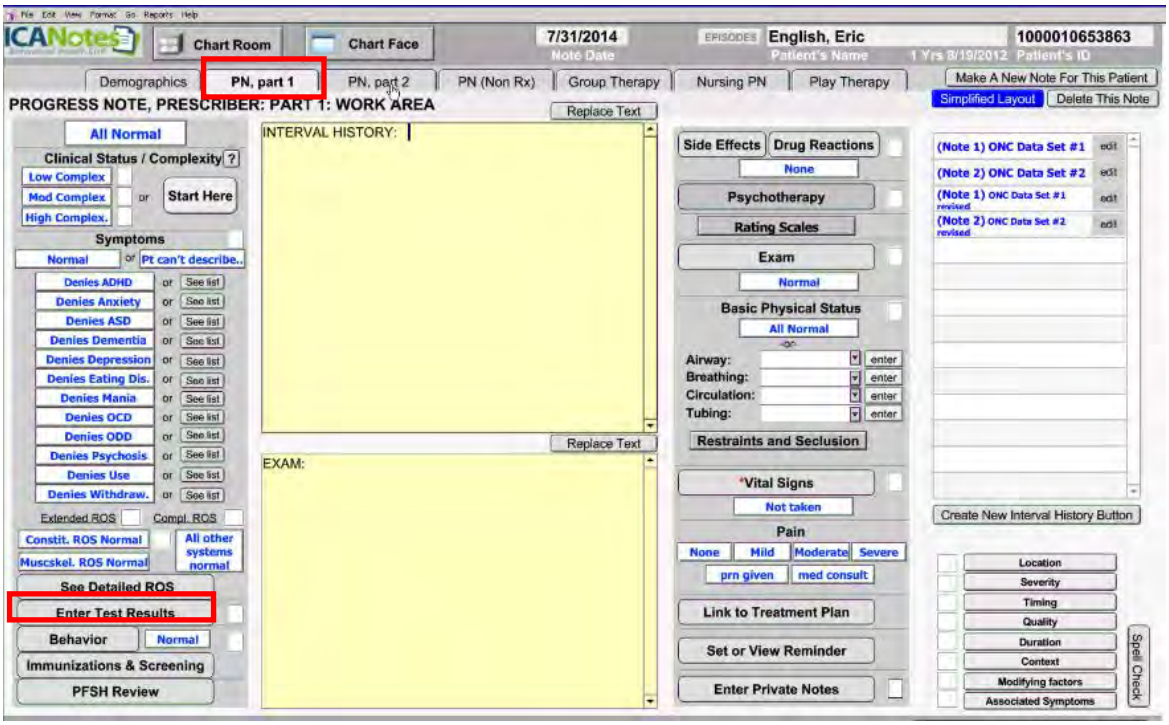
Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.

CORE MEASURE 10: Incorporate lab results

Measure: *More than 55% 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.* **Objective:** Incorporate clinical lab-test results into CEHRT as structured data

Denominator: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number
Numerator: Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data
Threshold: The resulting percentage must be more than 55% in order for an EP to meet this measure
Exclusion: Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the EHR reporting period

- **Enter Results:** Psych PN, part 1-->Enter Test Results



- Click on "New"
  - Select the type of test
  - Select the test name
  - Select the test result value
- Click "Save"

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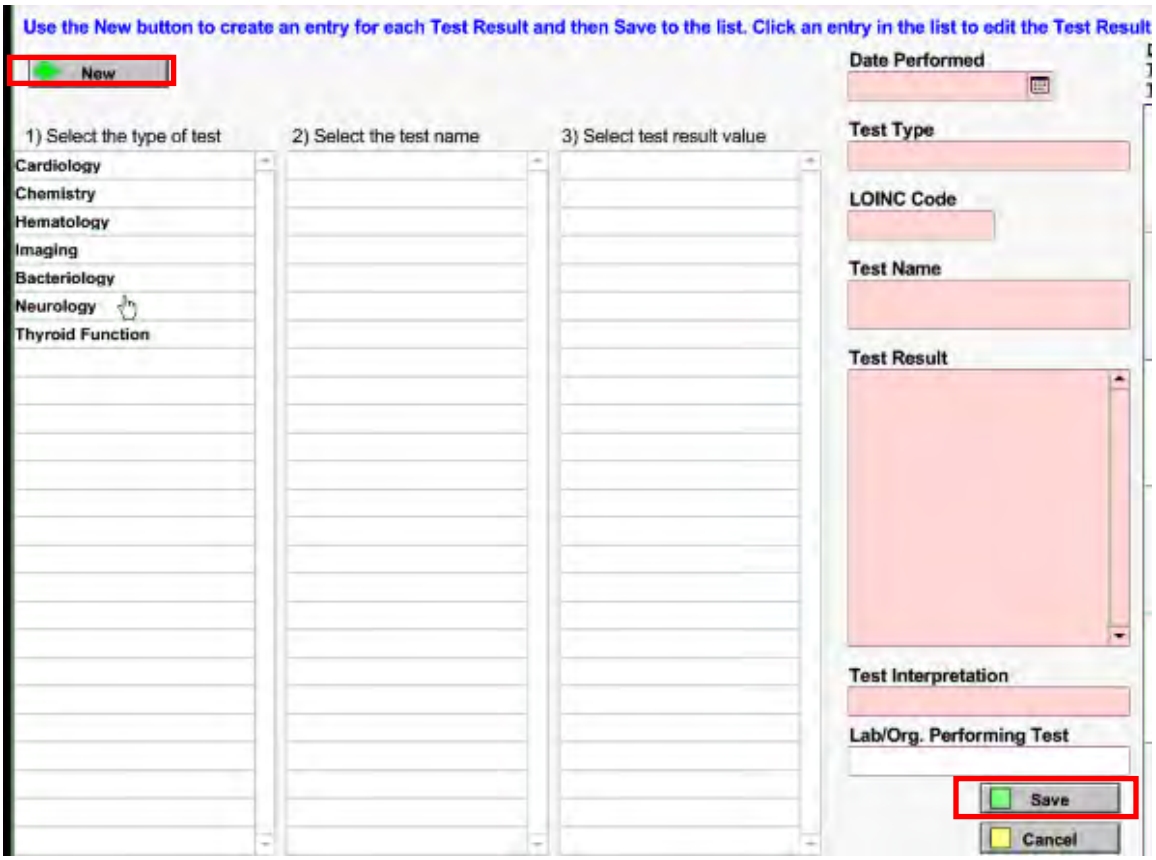
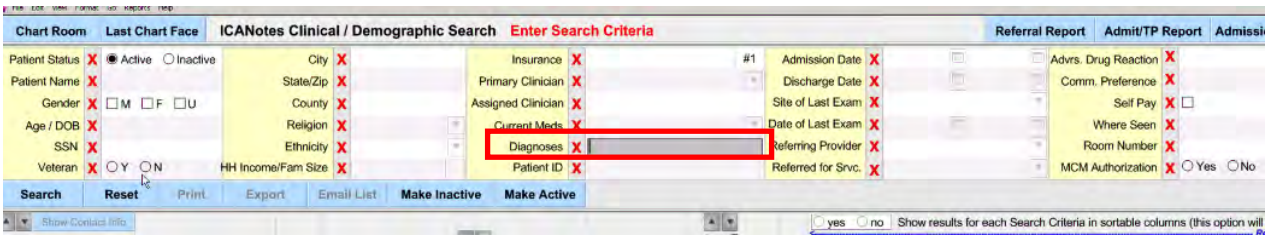


CORE MEASURE 11: Generate list of patients

Measure: *Generate at least one report listing patients of the EP with a specific condition.* **Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

- Go to "Reports" at top of screen
  - Select Clinical Demographics Search
  - Search by Diagnosis
    - Code or Description of condition



CORE MEASURE 12: Patient reminders

Measure: *More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.* **Objective:** Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.

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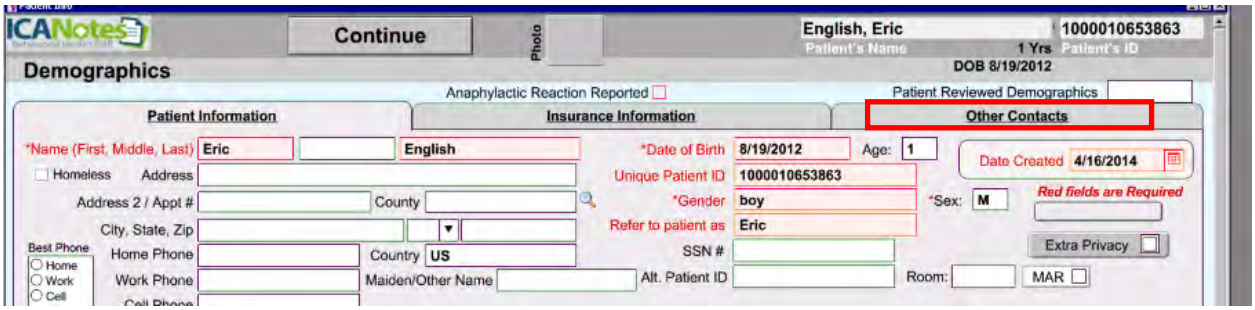
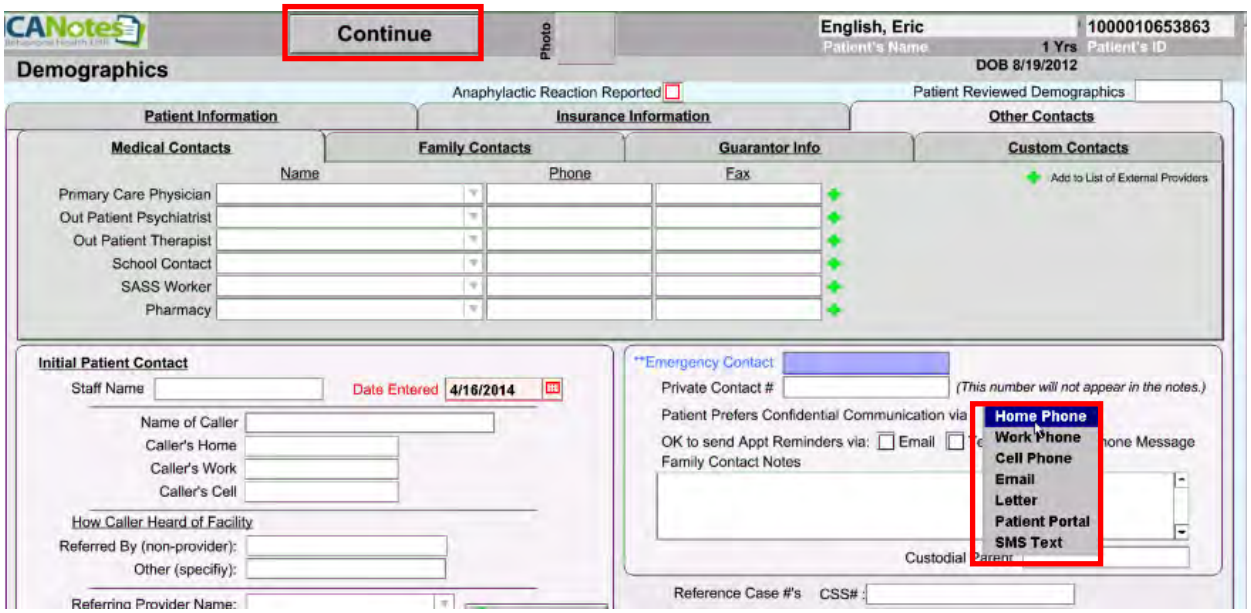
Denominator: Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period
Numerator: Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period
Threshold: The resulting percentage must be more than 10 percent in order for an EP to meet this measure
Exclusion: Any EP who has had no office visits in the 24 months before the EHR reporting period

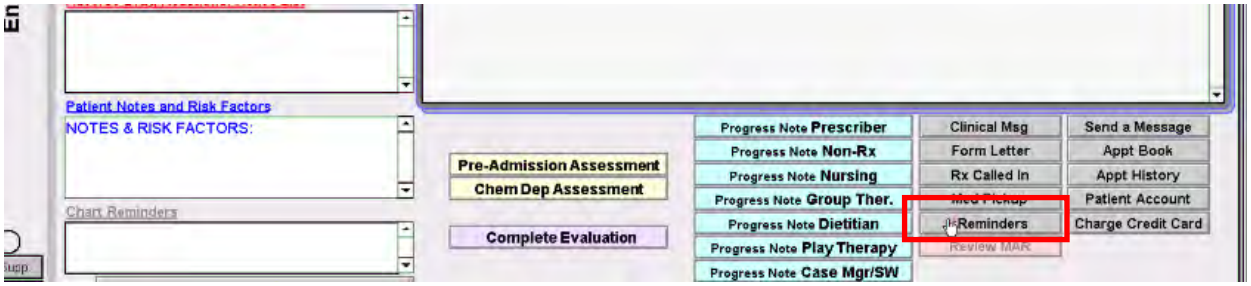
- Go to the patient's Demographics tab
    - Select "Other Contacts"



- Select the patient's preferred method of communication
- Click Continue



- From the patient's Chart Face, Select "Reminders"



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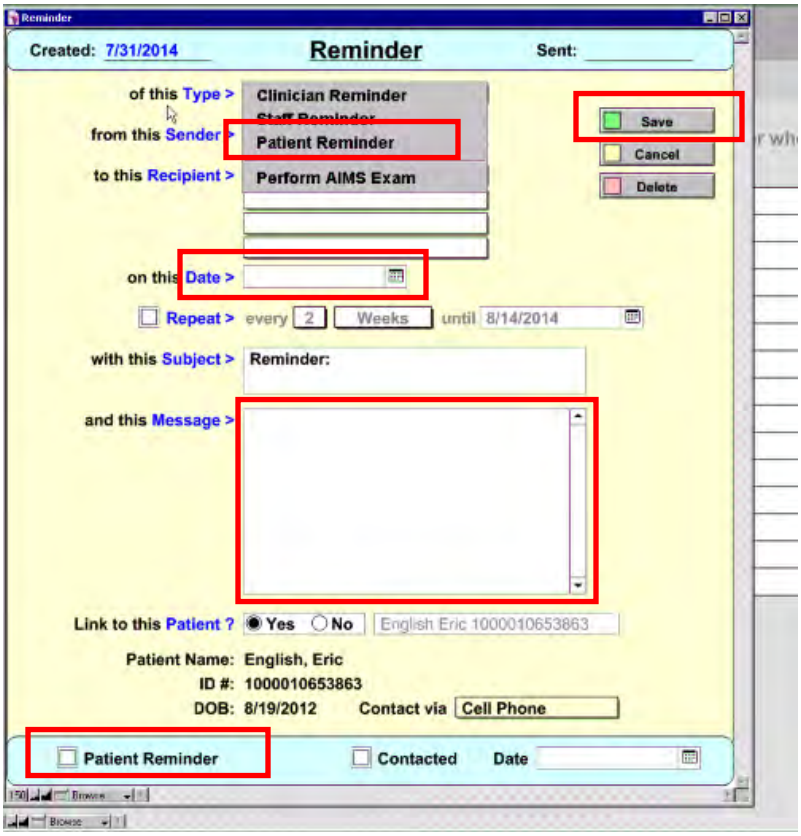
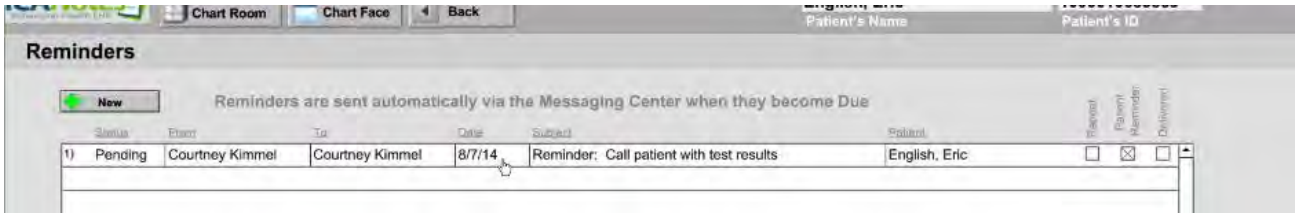
- Click on the "New" button

- Select "Patient Reminder" as the type
- Specify the date the reminder should be sent
- Complete a message
- Click the checkbox next to Patient Reminder at the bottom to count as a patient reminder for Meaningful Use
- Click "Save"



- Patient reminder is now pending



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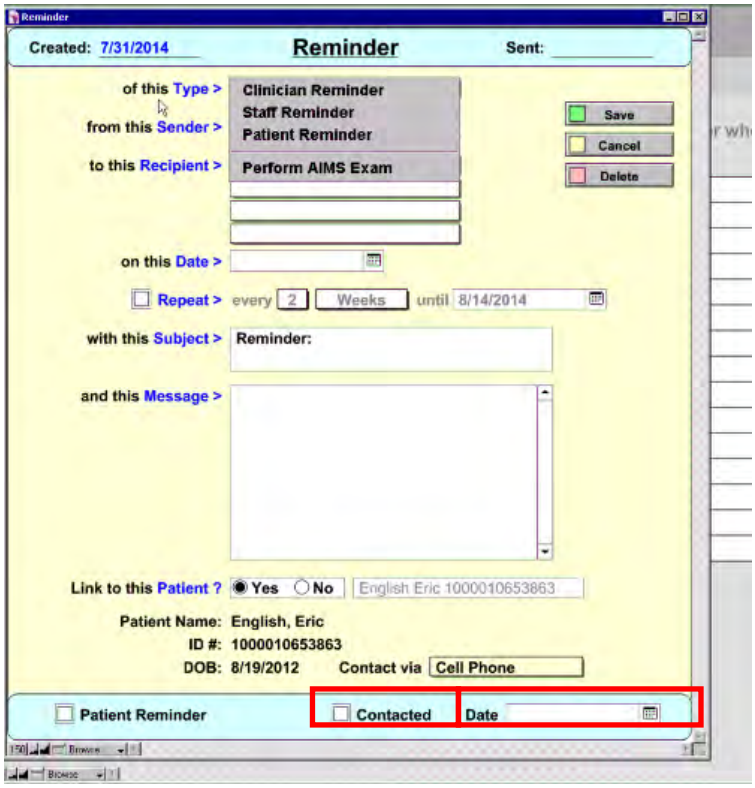
- On the specified date, the Provider will receive an alert via the Messaging Center
- Provider must complete the reminder by checking the box next to "Contacted," then populate the date the patient was contacted.



CORE MEASURE 13: Patient education

Measure: *Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.*

Objective: Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient

Denominator: Number of unique patients with office visits seen by the EP during the EHR reporting period

Numerator: Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT

Threshold: The resulting percentage must be more than 10 percent in order for an EP to meet this measure

Exclusion: Any EP who has no office visits during the EHR reporting period

- From the Chart Room, open the **Settings + Directories** file drawer.
- Click the Options Tab on the Specific to Individual tab
- Check the box next to:
    - **Patient Education Material**

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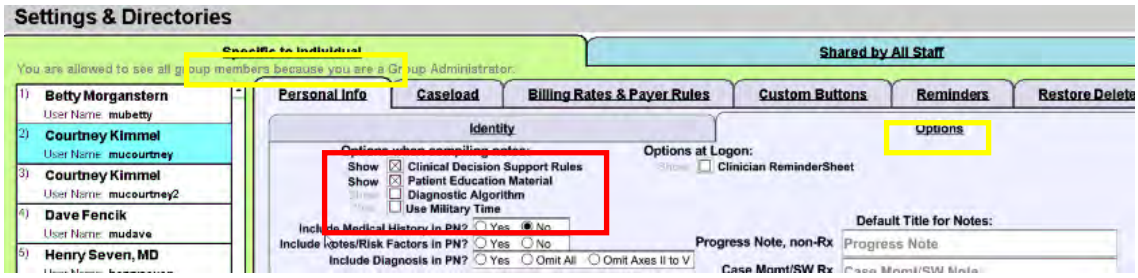


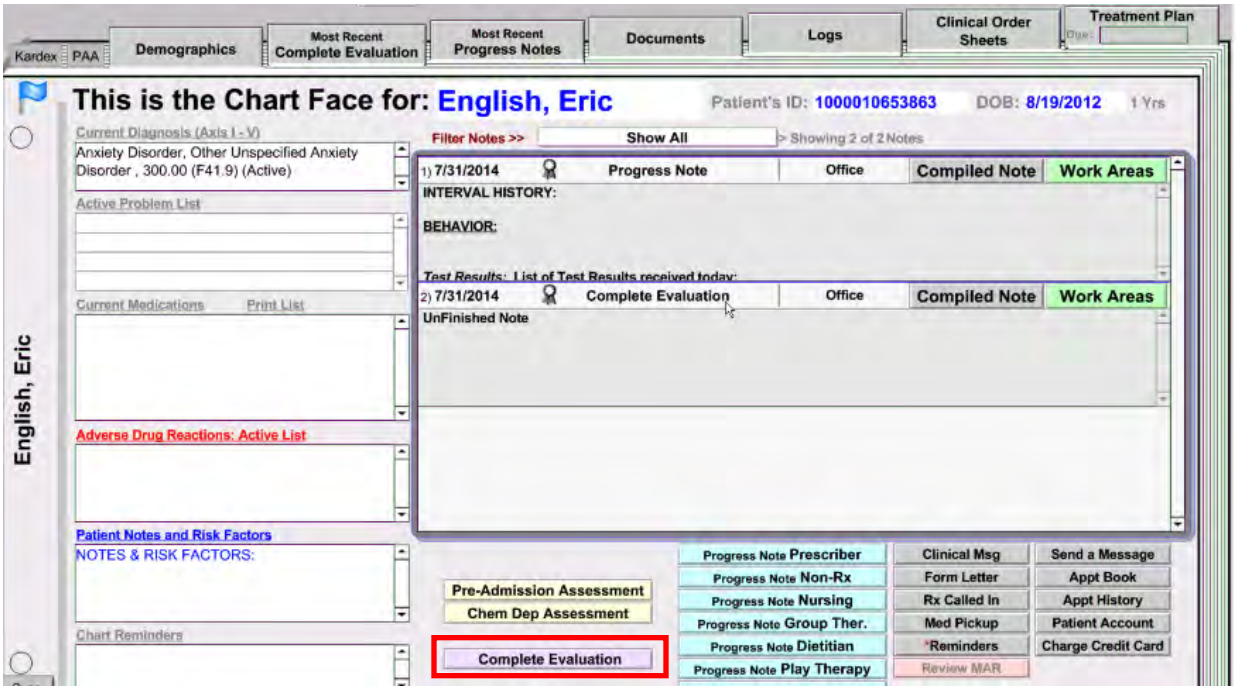
After enabling this setting, the option to print Patient Education Material will appear any time you make changes or additions to Test Results, Medications or Diagnoses. **To qualify for this measure, you must say yes and Print the document.**

CORE MEASURE 14: Medication Reconciliation

Measure: *The EP who performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.* **Objective:** The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

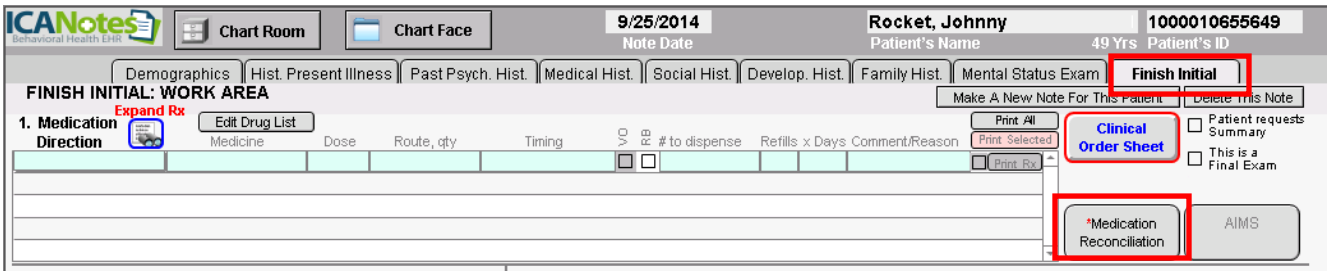
Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition
Numerator: The number of transitions of care in the denominator where medication reconciliation was performed
Threshold: The resulting percentage must be more than 50% in order for an EP to meet this measure
Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period.

- Go to the patient's Chart Face. Start a new **Complete Evaluation**.



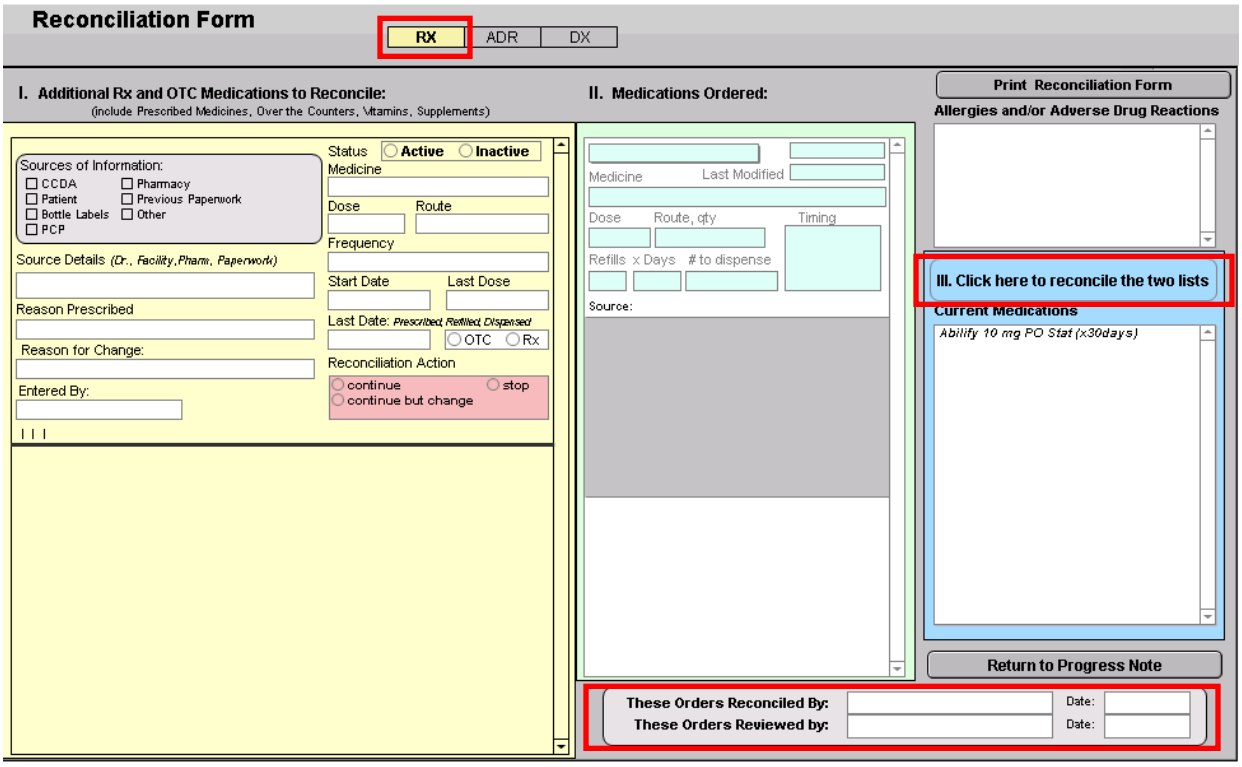
Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.

- Go to the **Finish Initial** tab and click the Medication Reconciliation Button.



There are three sections to be completed on the Reconciliation Form: RX, ADR, and DX.

On the first screen, RX, in section I enter all prescription and over-the-counter medications to be reconciled and whether those medications will be continued, continued but changed, or stopped. In section II, enter new medications being prescribed. Click the button in section III to reconcile the two medication lists. Enter the clinician's initials and date in the reconciled by and reviewed by fields at the bottom of the screen.



Next click on ADR at the top of the screen. Follow the same procedure to enter the patient's adverse drug reactions, click to transfer them into the record, click the button in Section III to reconcile and complete the initials and dates at the bottom.

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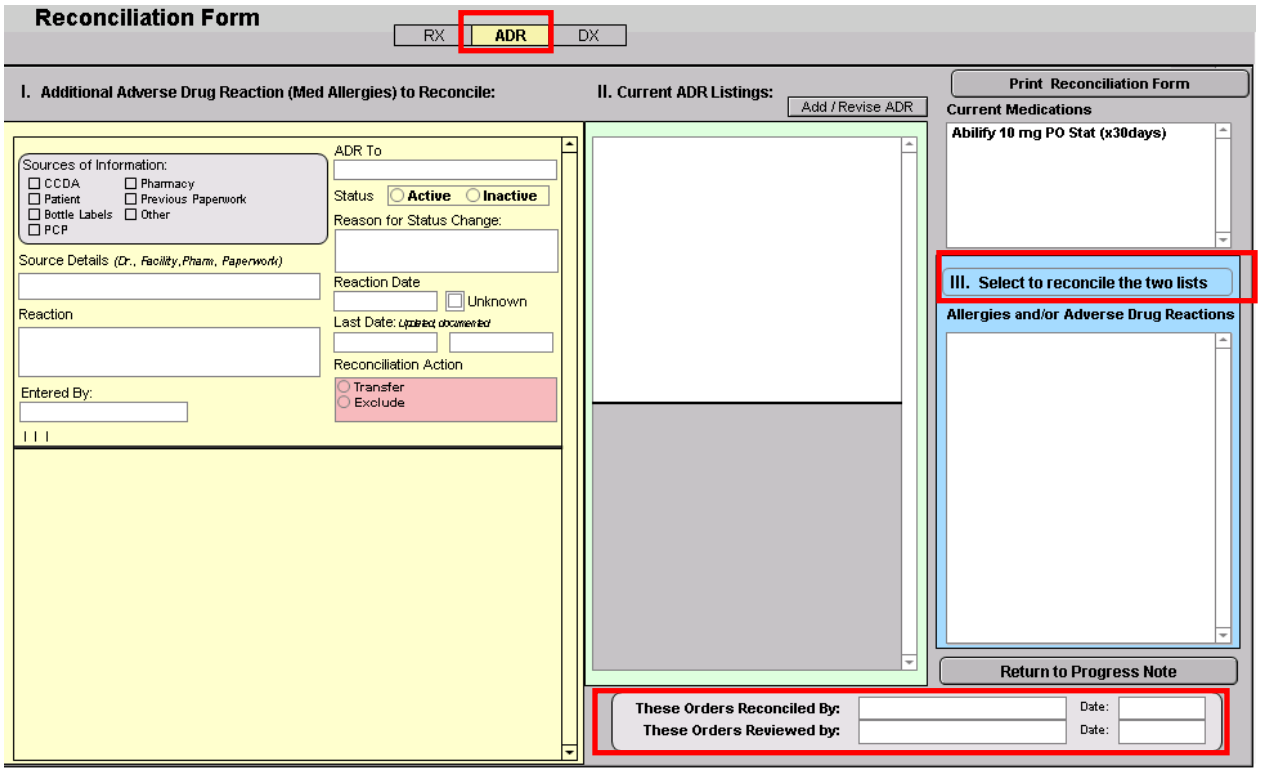
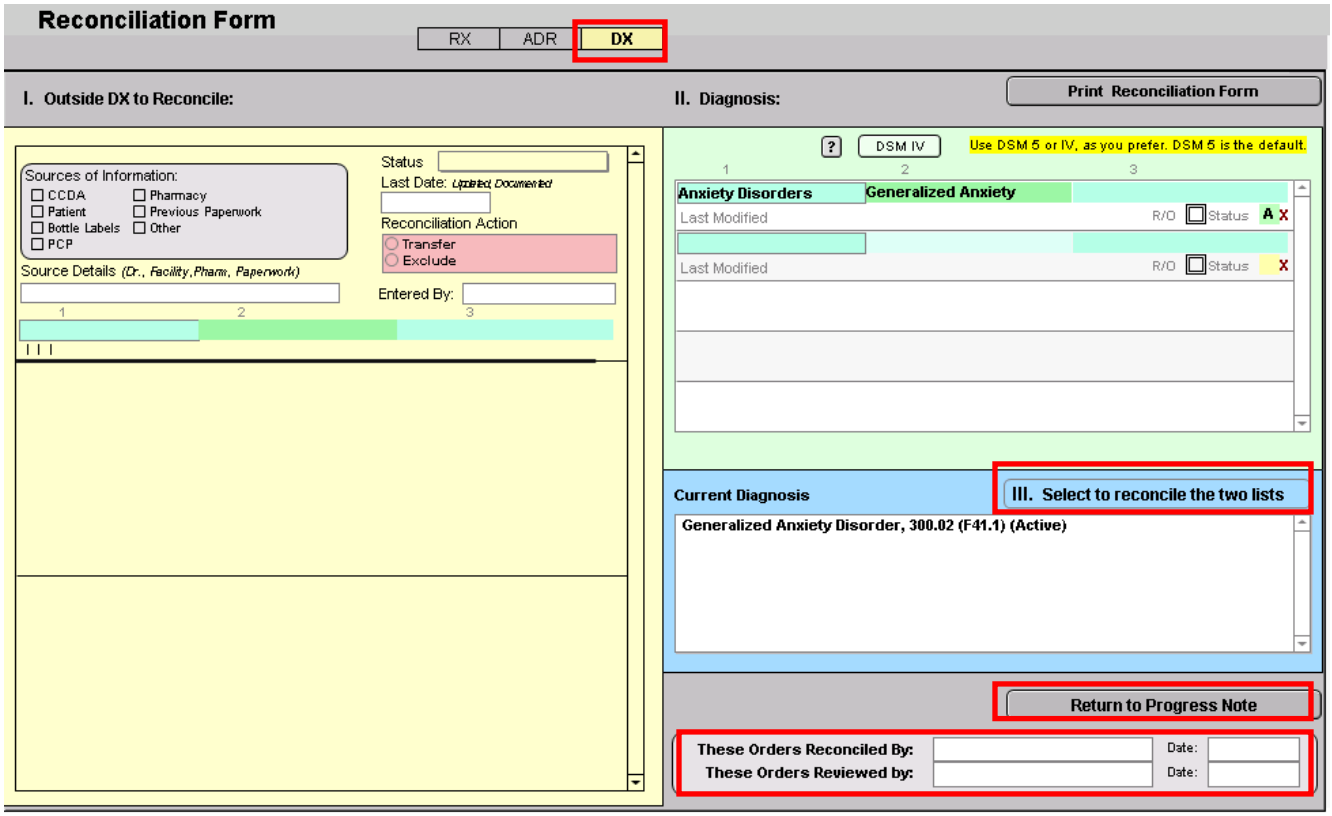


Next click on DX at the top of the screen. Follow the same procedure to enter the patient's diagnoses, click to transfer them into the record, click the button in Section III to reconcile and complete the initials and dates at the bottom.



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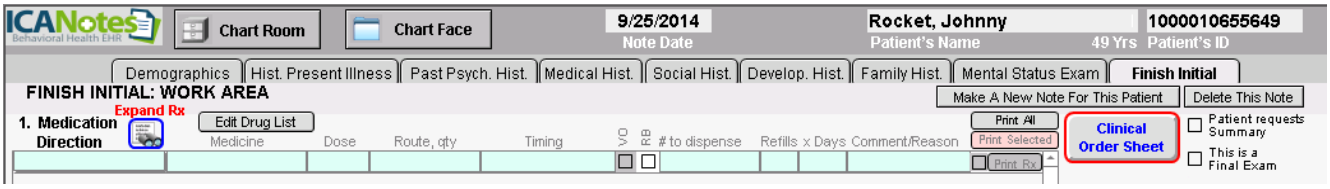
- Click on "Return to Progress Note", finish the complete evaluation, and compile the note.

CORE MEASURE 15: Summary of Care
Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

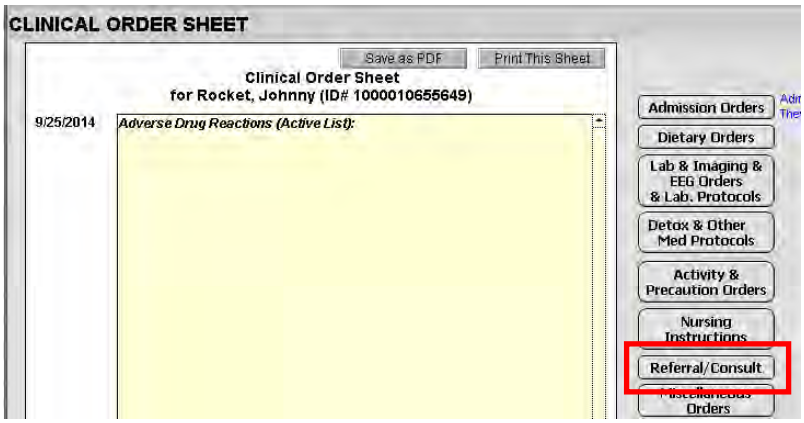
Measure 1: *The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.*
Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided.
Threshold: The percentage must be more than 50 percent in order for an EP to meet this measure
Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all 3 measures.

Go to Psych PN, part 2 or the Finish Initial tab of your Complete Evaluation.

Click on the Clinical Order Sheet button.

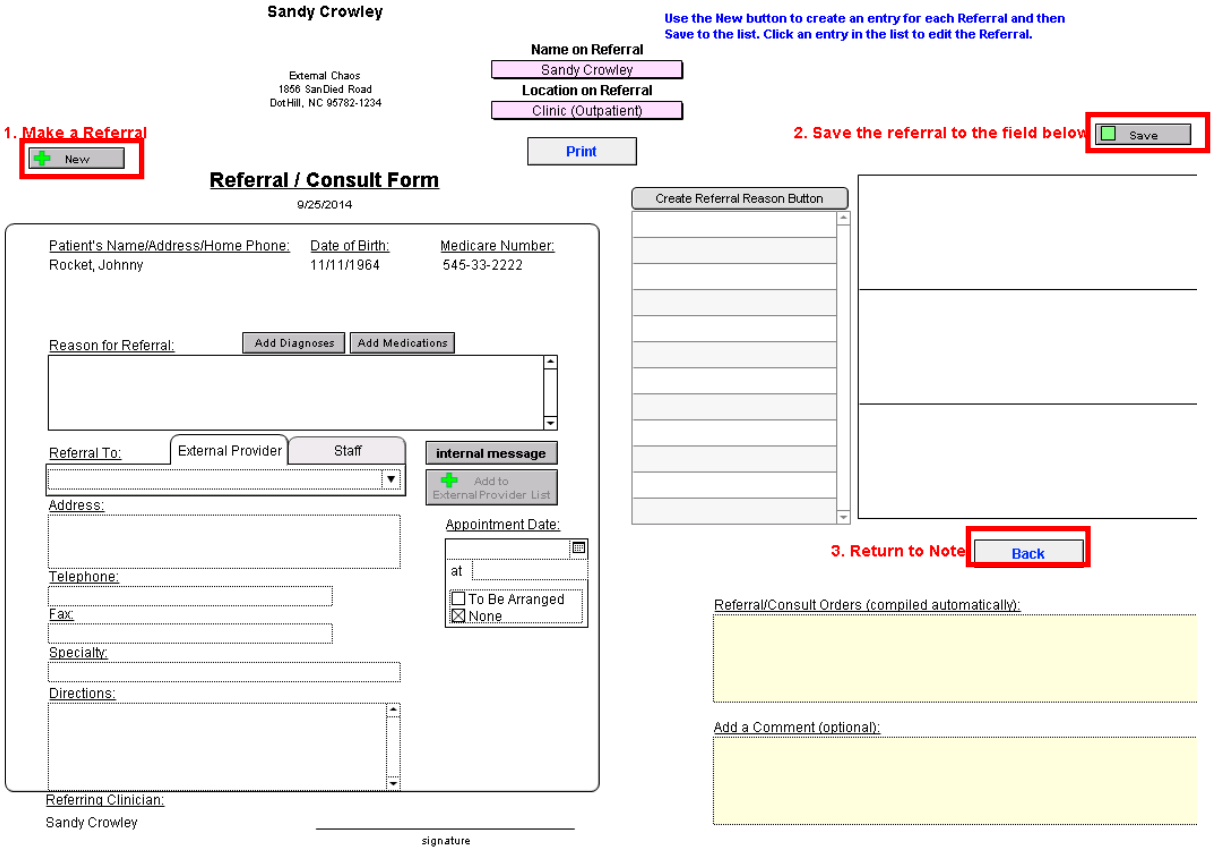


Click the "Referral/Consult" button.



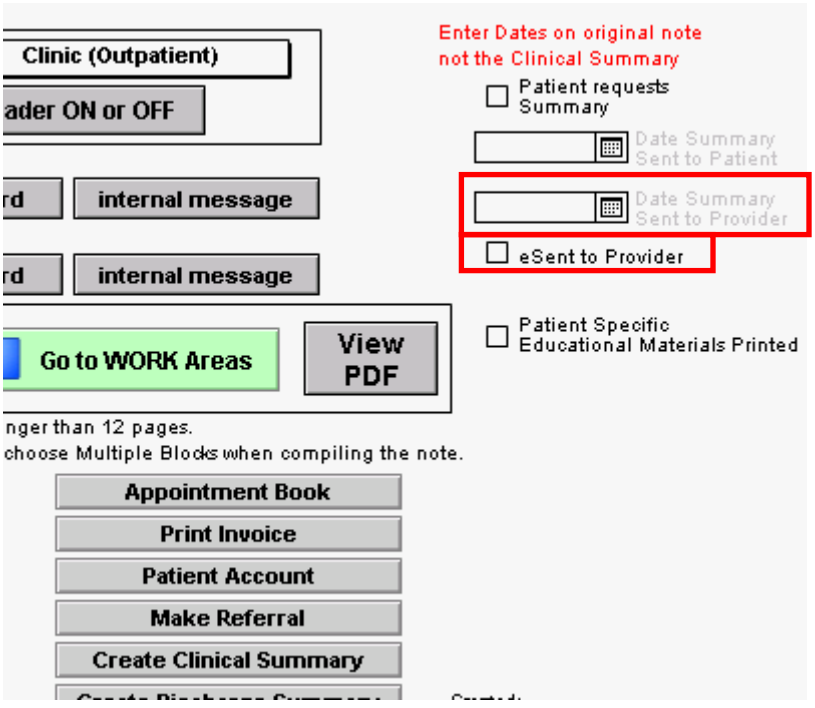
Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.

Click the **+New** button under **Make a Referral** at the upper left.



Fill out all appropriate information. Complete steps 1-3 on the referral page. Hit Save. Hit Back.

Compile the note. On the Preview screen for the compiled note, record the date you are sending the referral to the provider. If you are sending the information electronically, click the box "eSent to Provider."



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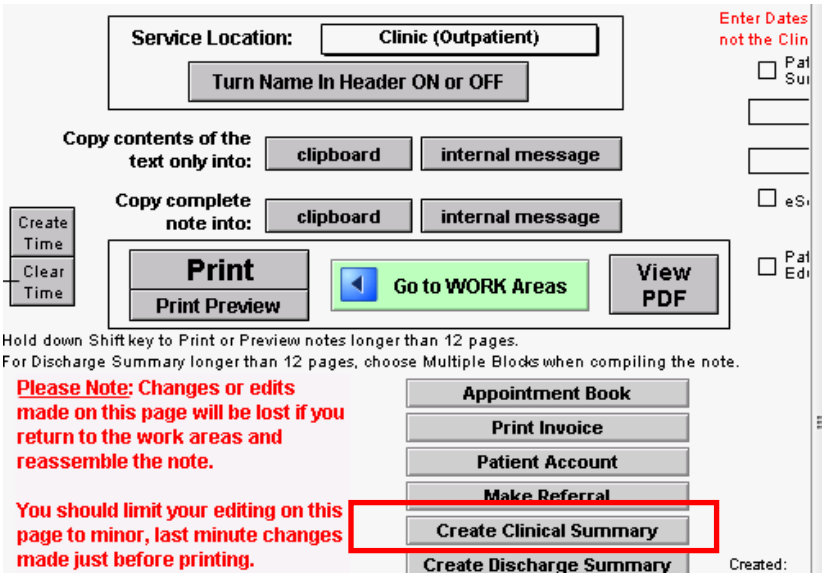
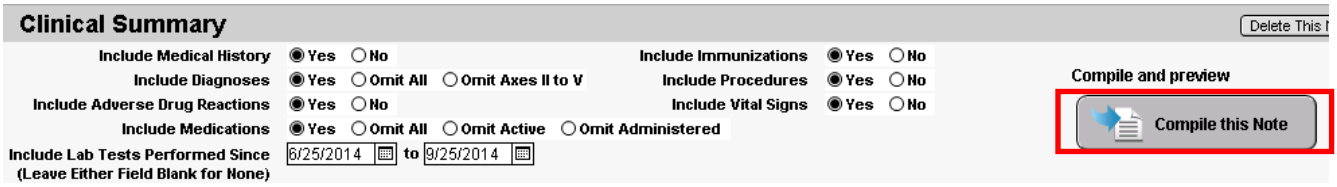
Next, click Create Clinical Summary.



On the next screen click "Compile this Note"



Print the Summary and send via fax to provider OR go to upload.icanotes.com site to retrieve the summary, save and send to the provider using secure methods to protect PHI.

Measure 2: *The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.*

Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or sender's own organization

Threshold: The percentage must be more than 10 percent in order for an EP to meet this measure

Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all 3 measures

To send a Summary of Care document electronically, you will need a Direct email address for the provider you wish to send the document to. After you have followed the steps in Measure 1 above to create the Clinical

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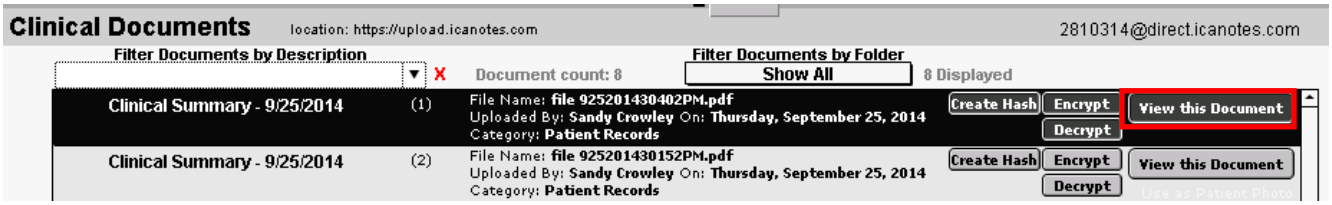
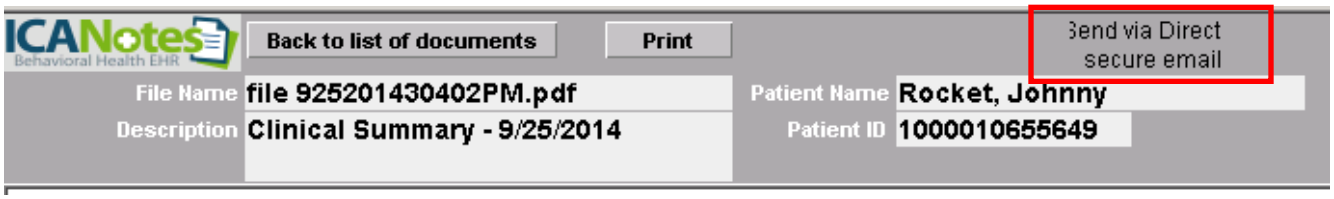
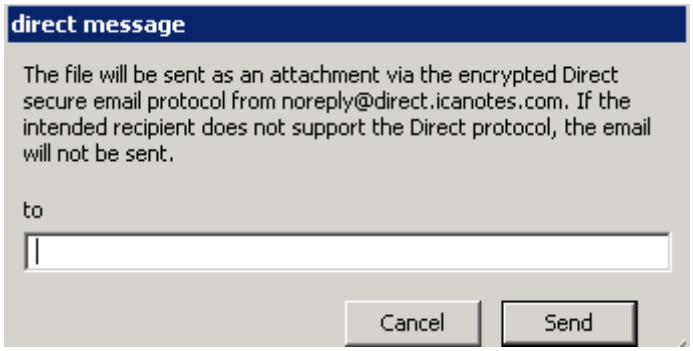
Summary, go to the Documents tab on the patient's Chart Face. Find the Clinical Summary you created on the list of documents, and click the **View this Document** button.



Click on the words "Send via Direct secure email"



Enter the Direct secure email address of the provider in the pop-up window (the email address must have the word "direct" in it after the @), then click Send.



NOTE: To receive credit on the Meaningful Use Report for sending this summary of care information electronically, you will need to check the box labeled "eSent to Provider" on the Clinical Summary Preview screen when you record the date sent as described above in Measure 1.

Alternately, you can sign up for a Kno2 account which can be used to electronically send patient information to other providers from directly within ICANotes. More information is available at: http://kno2.com/

Measure 3: *Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with (a) a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2) or (b) conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.*

EPs must attest YES to either part (a) or part (b) of Measure 3. This test can be performed by sending a CCDA document to the Direct email address of a provider using another Meaningful Use Stage 2 certified EHR. Just follow the steps for Measure 2 above to send the CCDA document electronically.

CORE MEASURE 16: Submit immunization information – Take Exclusion
Measure: *Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.* **Objective:** Capability to

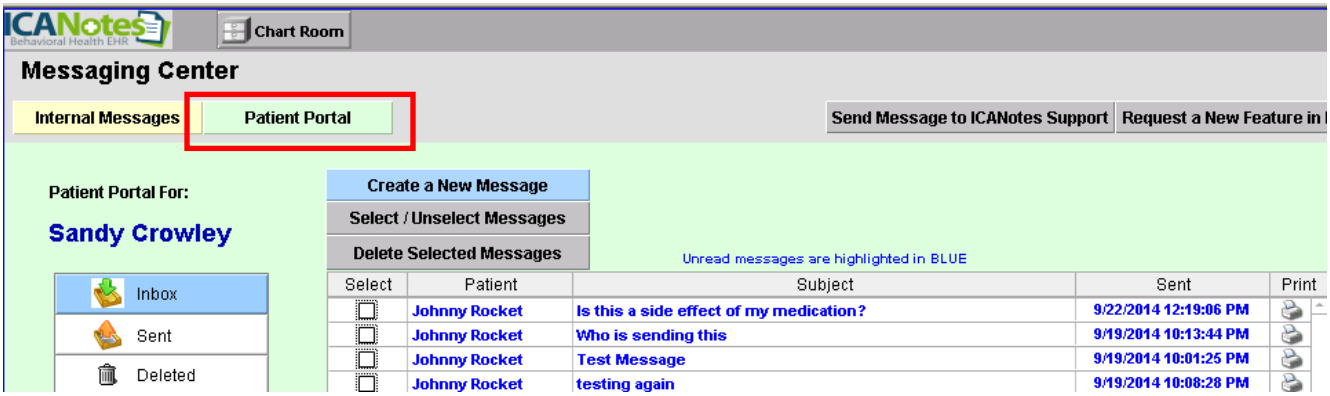
submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective:
(1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;
(2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period
(3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or
(4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

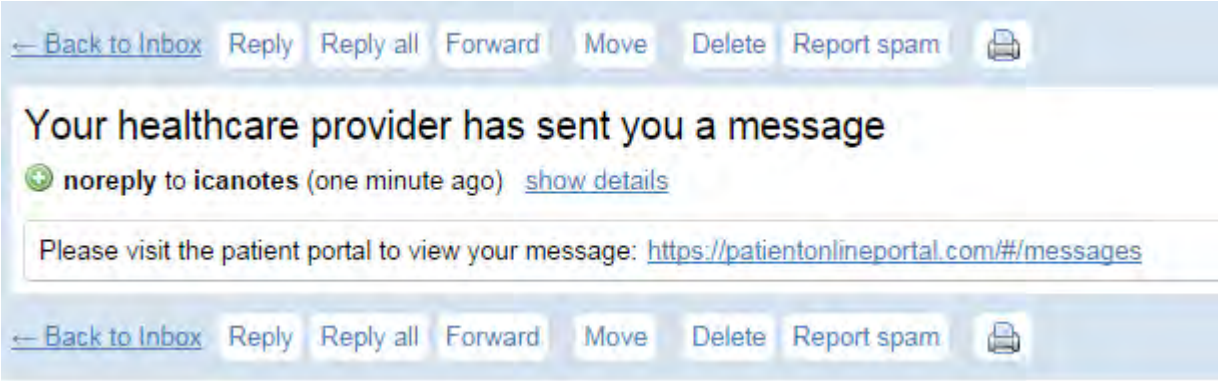
CORE MEASURE 17: Use secure electronic messaging
Measure: *A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.* **Objective:** Use secure electronic messaging to communicate with patients on relevant health information.

Denominator: Number of unique patients seen by the EP during the EHR reporting period
Numerator: The number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period.
Threshold: The resulting percentage must be more than 5% in order for an EP to meet this measure
Exclusion: Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

- Follow the steps for Core Measure 7 to:
  - Enable the Patient Portal for your practice
  - Invite patients to register for an account on the Patient Portal
  - Provide the patient with Patient Portal Instructions
- Regularly check the **Patient Portal** section of the Messaging Center for secure messages from your patients



- When you reply to a secure message from a patient, they will receive an email at their regular email address notifying them to check the portal for a secure message from their provider.



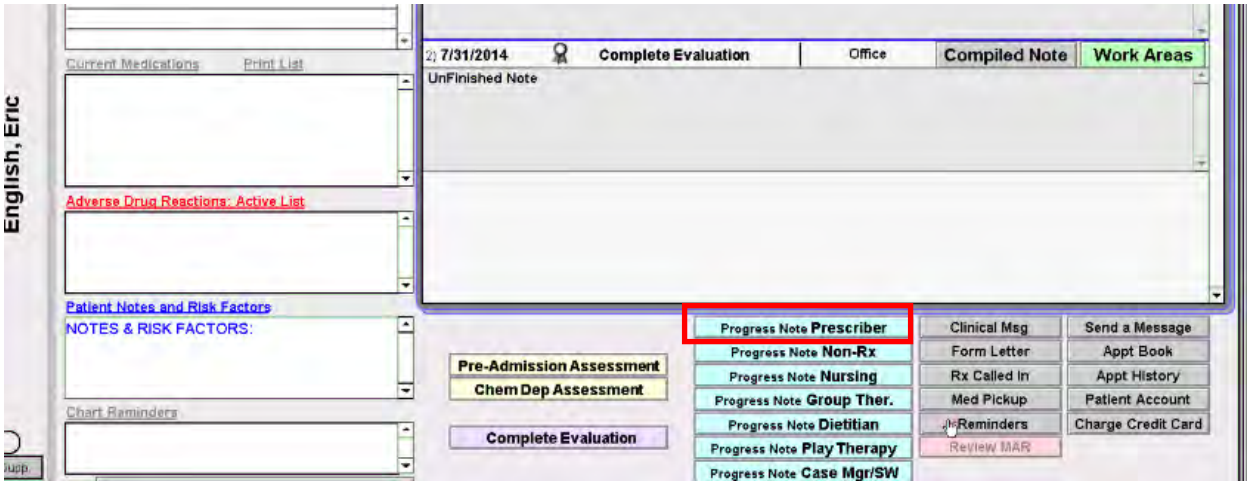
The Meaningful Use Report can be run periodically (before 9 am or after 5 pm Eastern time) to monitor your progress against the 5% threshold for this measure.

MENU MEASURES (3 required)

MENU MEASURE 2: Record electronic notes in patient record
Measure: *Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.* **Objective:** Record electronic notes in patient records.

Denominator: Number of unique patients with at least one office visit during the EHR reporting period for EPs during the EHR reporting period
Numerator: The number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data
Threshold: The resulting percentage must be more than 30% in order for an EP to meet this measure
Exclusion: Any EP who has no office visits during the EHR reporting period

- Go to the patient's Chart Face
- Click the **Progress Note Prescriber** button to create an electronic note for the patient



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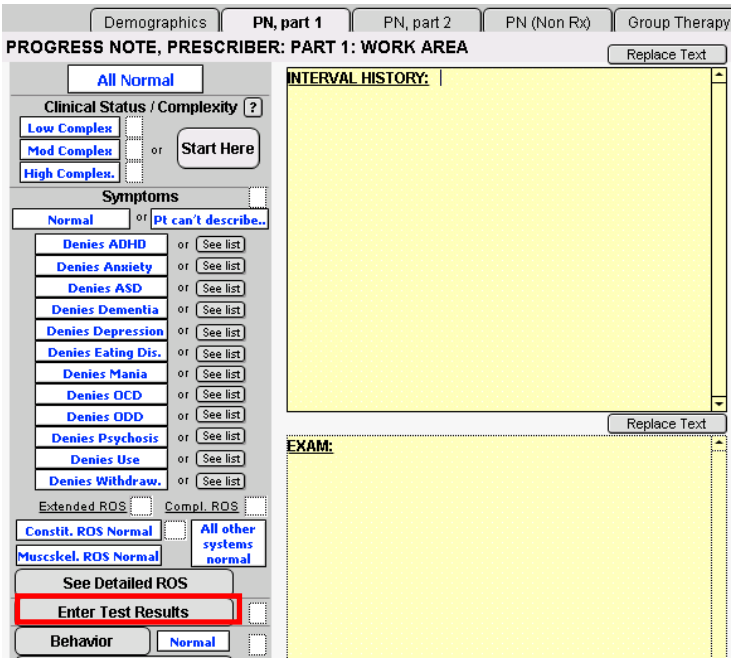
MENU MEASURE 3: Imaging results

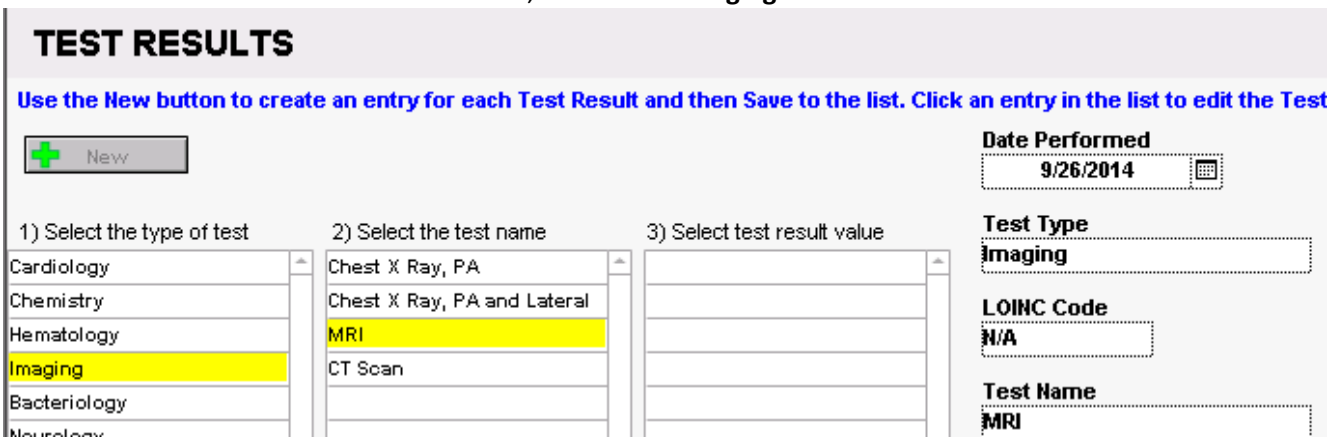
Measure: *More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT*. **Objective:** Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

Denominator: Number of tests whose result is one or more images ordered by the EP during the EHR reporting period
Numerator: The number of results in the denominator that are accessible through CEHRT
Threshold: The resulting percentage must be more than 10 percent in order to meet this measure
Exclusion: Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period

- To record the results for an imaging test that was ordered for the patient, go to the Progress Note Pt 1 screen and click on the **Enter Test Results** button;

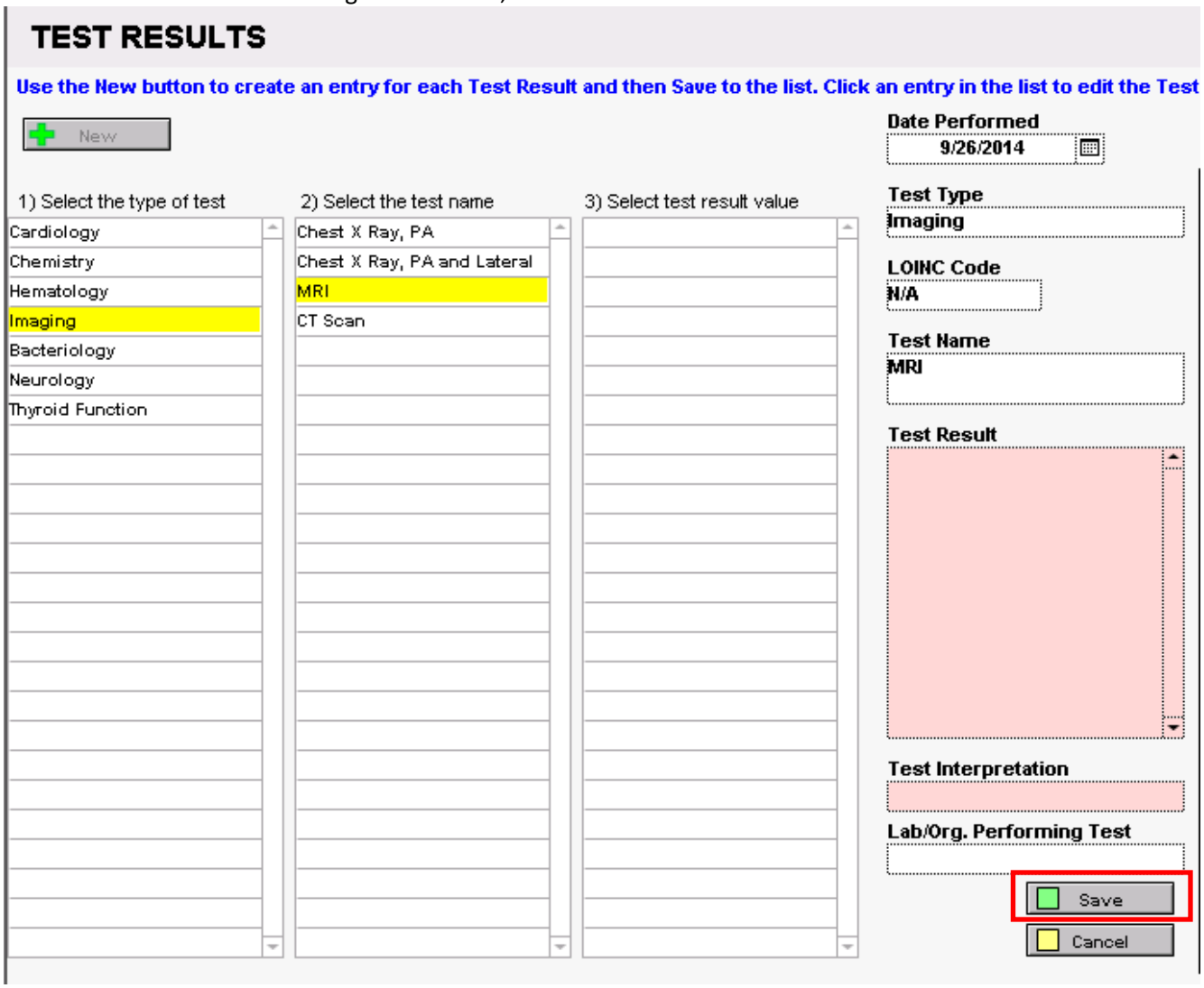


Click the **+New** button to create a test result, then select **Imaging** from the first shrub column.



Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.

Select the test name and test result value from the second and third shrub columns, then fill out the remaining fields in the column on the far right. Click **Save**, then **Back**.



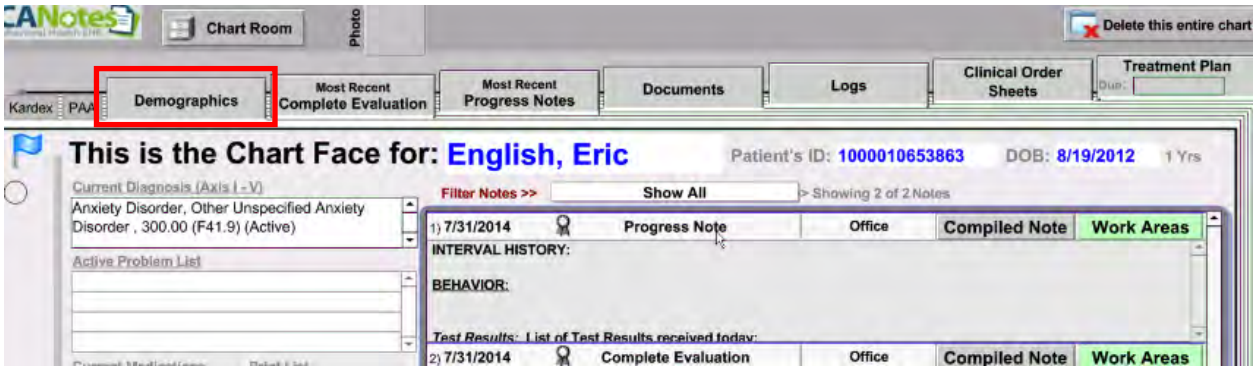
MENU MEASURE 4: Family Health History

Measure: *More than 20% of all unique patients seen by the EP during the EHR reportingperiod have a structured data entry for one or more first-degree relatives.* **Objective:** Record patient family health history as structured data.

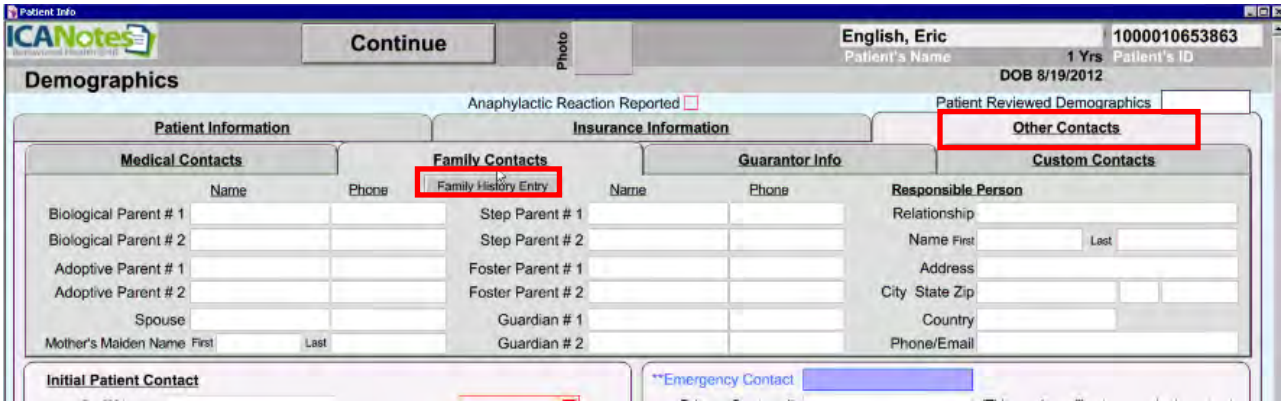
Denominator: Number of unique patients seen by the EP during the EHR reporting period
Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives
Threshold: The resulting percentage must be more than 20 percent in order to meet this measure
Exclusion: Any EP who has no office visits during the EHR reporting period

To record family health history as structured data in ICANotes, from the patient's Chart Face, click on the Demographics tab (**NOTE: entering family history in the Complete Evaluation will not count on the Meaningful Use Report**).

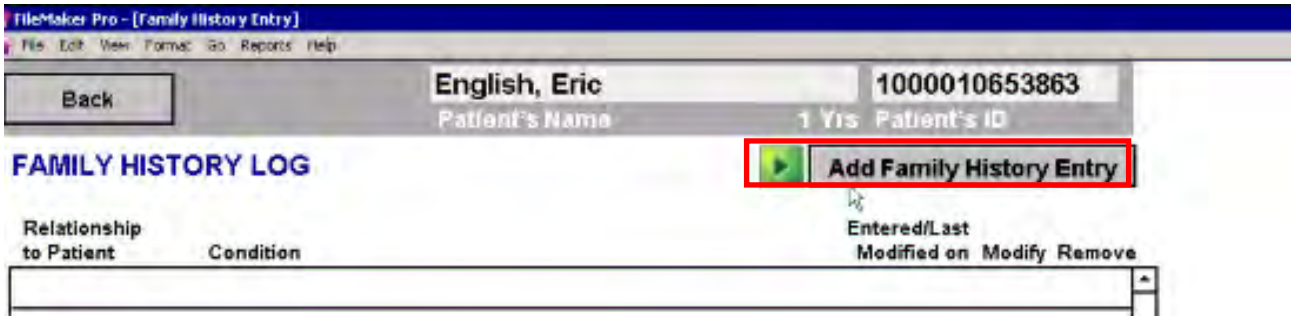
Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.



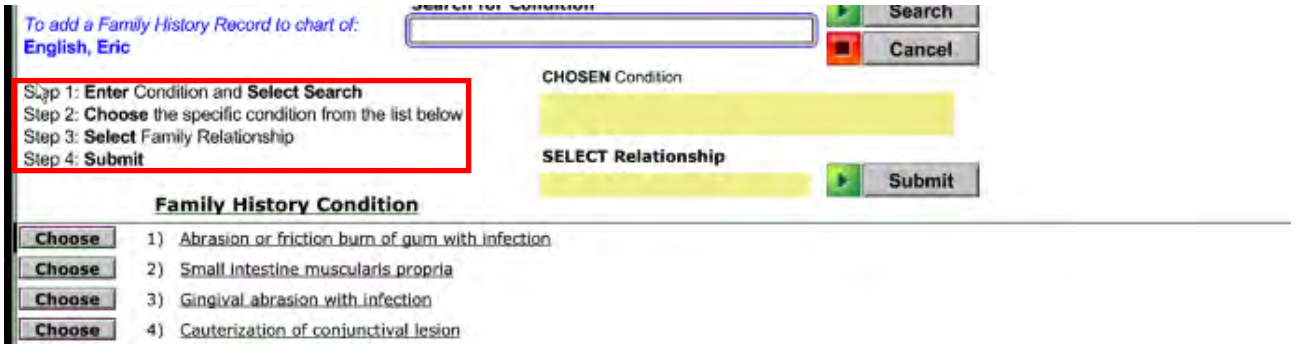
- Click on the "Other Contacts" tab
- Next select the "Family Contacts" tab
    - Click on the "Family History Entry" button



- Click on the "Add Family History Entry" button



- Follow the 4 steps to enter desired information.

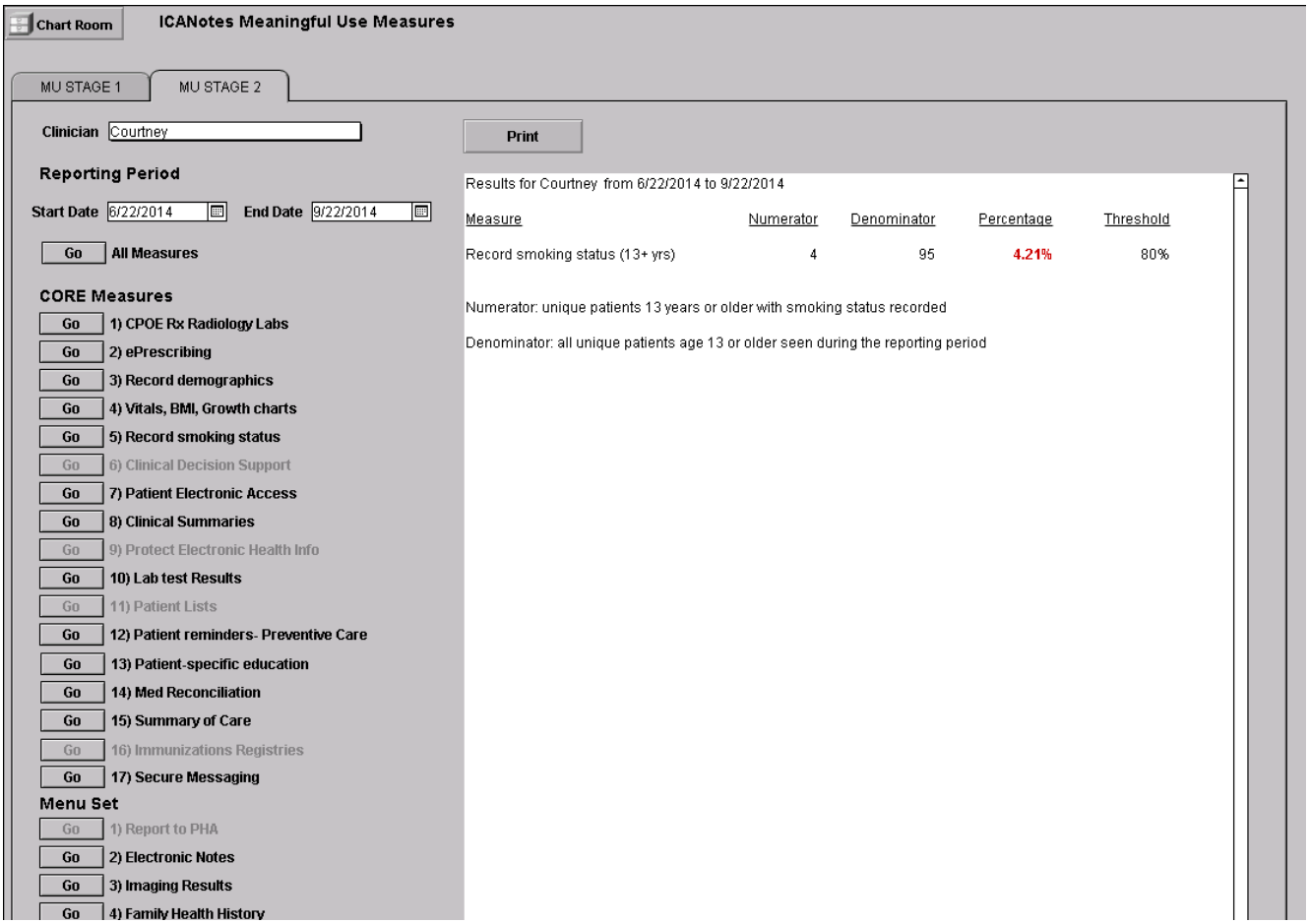


Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.

MEANINGFUL USE TRACKING REPORT

To run a report which will provide you with the numerators, denominators, and thresholds achieved for each of the meaningful use measures:

- Select "Reports" from the menu at the top of the screen
    - Select "Meaningful Use Measures"
        - Select MU Stage 2
            - Identify the clinician
            - Input the Start and End date for the reporting period
            - Click "Go"



Certified Clinical Quality Measures (CQMs):

ICANotes staff will run the Clinical Quality Measures Report for you at the end of your attestation period (after December 31, 2014). Since there are no thresholds for this measure, you don't need to monitor your progress against achieving the measure. Submit your request for this report to ticket@icanotes.com.

Providers must report on 9 CQMs, and they must cover 3 of the 6 domains. Each measure is assigned a domain by CMS (e.g., Population/Public Health, Patient Safety, etc.).

Note: ICANotes is not certified to instruct eligible providers on how to attest for meaningful use. For one-on-one assistance please contact our consulting partner AttestEasy at 888-373-4778, ext 3012.

Threshold: There is **no** threshold or percentages attached to CQMs –9 CQMs must be chosen and they must cover at least 3 of the available domains.

ICANotes is certified for the 9 CQMs listed below:

- CMS002v3 NQF 0418 Preventive Care and Screening: Clinical Depression Domain: Population/Public Health
- CMS68v3 NQF 0419 Documentation of Current Medications Domain: Patient Safety
- CMS69v2 NQF 0421 Preventive care and Screening: BMI Domain: Population/Public Health
- CMS50v2 Closing the referral loop: receipt of specialist report Domain: Care Coordination
- CMS 138v2 NQF 0028 Preventive Care and Screening: Tobacco Domain: Population/Public Health
- CMS165v2 NQF 0018 Controlling High Blood Pressure Domain: Clinical Process/Effectiveness
- CMS 127v2 NQF 0043 Pneumonia Vaccination Status for Older Adults Domain: Clinical Process/Effectiveness
- CMS 128v2 NQF 0105 Anti-Depressant Medication Management Domain: Clinical Process/Effectiveness
- CMS 130v2 NQF 0034 Colorectal Cancer Screening Domain: Clinical Process/Effectiveness

For specialties like psychiatry, providers may not find any measures relevant to their practice. It is acceptable for there to be 0 in the numerators and denominators for all or some of these measures if they are not relevant to a provider's practice; however, 9 measures must be reported on.

If you have any questions about the instructions for one or more of these measures, please contact AttestEasy at 888-373-4778, x3012. Identify yourself as an ICANotes user and leave a voicemail message. All messages will be answered promptly.

Disclaimer: ICANotes is not certified to instruct Eligible Providers on how to attest for Meaningful Use. Our Support Department is unable to provide any answers to questions regarding definitions or interpretation of the requirements outlined by CMS. For expert assistance including one-on-one guidance through the complexities of attestation we highly recommend contacting our consulting partner AttestEasy at 888-373-4778 x 3012.