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.

How to Achieve Meaningful Use with ICANotes

Meaningful use involves using an EHR in a way that the government has defined as meaningful to collect incentive payments. To meet the requirements of Stage 1, eligible providers must:

- Identify and purchase a 2014 certified EHR (ICANotes), and
- Use and capture specific criteria inside that EHR for 90 days for the 1st year of Stage 1 and for 90 days in 2014 if you are in the 2nd year of Stage 1.

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.

Getting Started – Registering for Meaningful Use

You will need your vendor's EHR certification number (ICANotes is **1314E01P5LOTEAR**). Proceed to https://ehrincentives.cms.gov/hitech/login.action where you will register yourself and your EHR. Note that this can be done at any time before, during, or after your 90 days of EHR use.

You will first create a login and password, then log into the system. You will also need to have your NPI number handy. If you do not have an NPI number, you can use MPPES. Click on the Register tab and select the program type you are registering for, then confirm that you do have a certified EHR by clicking "yes." You will pick the type of provider you are and then enter the ICANotes certification number (**1314E01P5LOTEAR**). Next select what type of entity will be receiving the money.

You will be presented with a preview page to review the information you have entered. If it is correct, submit the information. You are now registered to receive incentive payments. Your next step is to attest to using your EHR in a meaningful way.

Meeting Meaningful Use Standards

You must use ICANotes for 90 consecutive days to collect your Stage 1 meaningful use payment. You will collect data for 18 specific criteria (13 core measures and 5 menu measures) and 9 Clinical Quality Measures during that period. You will then go back online and attest to what you have collected. 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 next to each of the following measures tells you how much information you need to collect.

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.

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.

Helpful Resources

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

Core Measures

These 13 Core Measures are all required:

1. Computerized provider order entry (CPOE) (> 30 % of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. Optional Alternate: >30 % of medication orders created by the EP during the reporting period are recorded using CPOE.)
2. Drug-drug and drug-allergy interaction checks (Enabled for the entire reporting period).
3. Maintain an up-to-date problem list of current and active diagnoses (> 80 % of all unique patients)
4. E-Prescribing (> 40% of all prescriptions written are transmitted electronically).
5. Maintain active medication list (> 80% of unique patients)
6. Maintain active medication allergy list (> 80 % of all unique patients)
7. Record demographics (> 50 % of all unique patients)
8. Record and chart changes in specific vital signs (> 50 % unique patients age 3+)
9. Record smoking status for patients 13 years or older (> 50 % of unique patients 13+)
10. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
11. Provide patients the ability to view online, download, and transmit information within 4 business days of the information being available to the EP.
12. Provide clinical summaries for patients for each office visit (provided to patients for > 50 % of all office visits within 3 business days.
13. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (Conduct or review a security risk analysis and follow through to make security updates and corrections to security deficiencies as necessary. (Note: This is something you must do separately for your practice. Compliance with this measure is not accomplished or documented in ICANotes)

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.

<mark>**Clinical Quality Measures**</mark>**: You must successfully report 9 ambulatory clinical quality measures as specified by CMS. No threshold is required for reporting but measures must be reported regardless. ICANotes will run the Clinical Quality Measures report for you at the end of the attestation period (after December 31, 2014). Please email ticket@icanotes.com to request your Clinical Quality Measures report.**

<mark>**Menu Measures**</mark>

You must select any <mark>five</mark> of these additional "Menu" measures and report them as well. <mark>**Of the 5 menu choices, one must be a public health menu measure (number 8 or 9).**</mark> If you qualify for an exclusion for both 8 and 9, you can only take an exclusion for one and must choose 4 other measures from the menu choices.

1. Drug-formulary checks (functionality enabled and access to at least one internal or external formulary for the entire reporting period)
2. Incorporate clinical lab test results as structured data (> 40% of tests ordered)
3. Generate lists of patients by specific conditions (generate at least one report listing patients with a specific condition)
4. Send reminders to patients per patient preference for preventive and follow-up care (> 20% who are 65 years or older or 5 years or younger)
5. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate (> 10% of unique patients are provided resources)
6. Medication reconciliation for patient received from another setting of care or provider or provider believes an encounter is relevant (> 50%)
7. Summary care record for each transition of care/referral (> 50%)
8. Capability to submit electronic data to immunization registries/systems (perform at least one test of EHR to submit data to immunization registry).
9. Capability to provide electronic syndromic surveillance data to public health agencies (perform at least one test of EHR to provide data to public health agencies).

Tracking Meaningful Use Measures in ICANotes

Step 1: Request that ICANotes enable these rules for your group: **Meaningful Use Measures, Patient Portal Sync, Direct Messaging, Always Generate CCDA, and Clinical Quality Measures**. You can email this request to ticket@icanotes.com or call us at 443-569-8778.

After the Meaningful Use Report has been enabled by Support, you can access it from the ICANotes Reports menu. **You can only view or run this report before 9 am or after 5 pm Eastern time.**

Step 2: Go to the Chart Room. Click on the drawer labeled Settings & Directories. Then click the Options Tab on the Specific to Individual tab. Check the following boxes to allow the program to automatically prompt you to print these items: **Clinical Decision Support Rules** and **Patient Education Material.** You will not comply with these measures unless you check these boxes.

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.
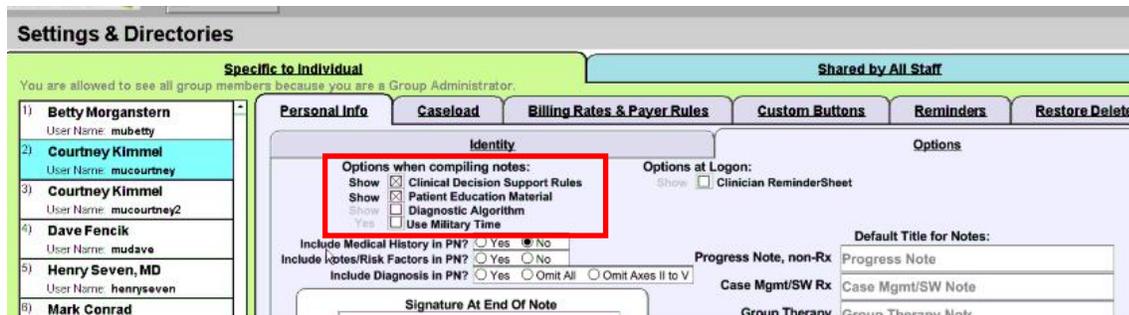
Now let's describe how to document the information you will need to attest to the 13 core measures required for Meaningful Use and the 5 menu measures.

Core Measure 1: CPOE for Medication Orders (> 30%)

Measure: *More than 30% of all 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.* **Objective:** Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

> **Numerator**: patients with a medication order entered using CPOE
> **Denominator**: all unique patients seen during the reporting period with at least one medication in their medication list
> **Threshold:** >30% unique patients

Computerized Physician Order Entry is what this acronym stands for. This measure is to ensure that you can use your EHR to order medications electronically. Either order medication for your patient using the DrFirst e-Rx program integrated with ICANotes or indicate "No Medication ordered."

> CPOE Rx
> Psych PN, part 2-->Section 1: Medication

Core Measure 2: Drug Interaction Checks

Measure: *Drug-drug and drug-allergy interaction checks are functionally enabled for the entire reporting period.* **Objective:** Implement drug-drug and drug-allergy interaction checks.

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.

Two actions must be taken. Patient's drug-drug and drug-allergy reactions must be completed in 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.

Core Measure 3: Maintain Problem List (> 80%)

Measure: More than 80% of all unique patients seen by the eligible provider have an up-to-date problem list of current and active diagnoses or an indication that no problems are known for the patient recorded as structured data. **Objective:** Maintain an up-to-date problem list of current and active diagnoses.

Numerator: patients with at least one problem list entry or an indication that no problems are known for the patient
Denominator: all unique patients seen during the reporting period
Threshold: > 80%

The "Problem List" is the diagnosis you make for the patient. Record the diagnosis for your patient as follows:

Patients with at least one diagnosis or problem
Psych PN, part 2 - # 3 Diagnosis (If no diagnoses, Column1=Additional Codes, Column2=No Diagnosis...)

Add, edit or remove diagnoses. Click Save.
OR

Go to the Chart Face-->Treatment Plan (Tab) on the top right-->and then # 3--> "Add a new problem."

After entering all of the information click on "Compile Comprehensive Treatment Plan."

Then Save to Progress Notes.

OR

You can add to diagnoses by going to the Chart Face and clicking on New Complete Evaluation.

Go to Finish Initial tab on upper right

Go to Diagnosis

Core Measure 4: E-Prescribing (eRx) (> 40%)

Measure: More than 40% of all permissible prescriptions written by the eligible provider are transmitted electronically using certified EHR technology. **Objective:** Generate and transmit permissible prescriptions electronically (eRx).

Numerator: Number of permissible prescriptions generated and transmitted electronically
Denominator: Number of prescriptions written for drugs requiring a prescription (other than controlled substances) during the reporting period.
Threshold: >40%

Meaningful use requires that you use an e-prescription system and that 40% 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. To set up Dr First through ICANotes, contact sales@icanotes.com.

> Generate and transmit e-Rx
> e-Prescribe via DrFirst

Core Measure 5: Active Medication List (> 80%)

Measure: More than 80% of all unique patients seen by the eligible provider have at least one entry on an active medication list (or an indication that the patient is not currently prescribed any medication) recorded as structured data. **Objective:** Maintain active medication list.
Numerator: patients with at least one medication entry or an indication that the patient is not currently prescribed any medication
Denominator: all unique patients seen during the reporting period
Threshold: > 80%

Either order medication for your patient or indicate "No Medication ordered". Take either of these steps for more than 80% of your patients.

> Active medication list
> Patients with at least one medication or an indication that the patient is not currently prescribed any medication
> Psych PN, part 2 - Complete medication section

> Edit the patient's medication(s). Compile the note to save the information.

Core Measure 6 Medication Allergy List (> 80%)

Measure: More than 80% of all unique patients seen by the eligible provider have at least one entry on an active medication allergy list (or an indication that the patient has no known medication allergies) recorded as structured data. **Objective:** Maintain active medication allergy list.

Numerator: Unique patients with at least one medication allergy entry or an indication that the patient has no known medication allergies

Denominator: all unique patients seen during the reporting period

Threshold: > 80%

Do you ask your patients if they have a history of Adverse Drug Reactions, or if they are allergic to any medications? Record their answer in either of the following locations:

a. Initial or Complete Examination: Medical History. Use the shrub button "Adverse Drug Reactions"
b. Progress Note: Use the button at the top of the second column, "Drug Reactions"
    In either case, you must indicate what the adverse drug reaction is or indicate that there is no such history.

    Active Medication Allergy List
    Patients with either one or more medication allergies, or no known drug allergies
    Psych PN, part 1 tab - Click on "None" if patient has no medication allergies. Click Drug Reaction if they do have a medication allergy. Then follow steps 1 -5 to enter Medication allergy information. Hit Save. Then Compile the Note.

    OR a New Complete Evaluation allows you to record this information. Go to the Medical History tab and select Adverse Drug Reactions

Core Measure 7: Record Demographics (> 50%)
Measure: More than 50% of all unique patients seen by the eligible provider have demographics recorded as structured data (preferred language, gender, race, ethnicity, and date of birth).

Objective: Record all of the following demographics: Preferred language, gender, race, ethnicity, date of birth. When a new chart is begun and demographics are entered, just be sure to include the following for more than 50% of your patients: ethnicity, gender, race, date of birth, and preferred language.

Numerator: patients with all required demographic elements recorded (DOB, sex, ethnicity, race, and preferred language) or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law recorded as structured data.

Denominator: all unique patients seen during the reporting period

Threshold: > 50%

Record Demographics
Name, DOB, gender, ethnicity, race, and preferred language (+ At least 1 note in reporting period)
Chart Face -->Demographics Tab

Complete the required demographic fields **which all have asterisks** in ICANotes.

Video Tutorial

Core Measure 8: Record Vital Signs (> 50%)

Measure: More than 50% of all unique patients age 3 and over seen by the eligible provider have height, weight, blood pressure, and body mass index recorded as structured data. **Objective:** Record and chart changes in specific vital signs.

Numerator: patients 3 years old and over who have at least one entry of their with height, weight and blood pressure recorded during the reporting period.
Denominator: all unique patients age 3 years old and over seen during the reporting period
Threshold: > 50%

Record the Blood Pressure, Height, and Weight for 50% of your patients 3 years or older. ICANotes will automatically calculate the BMI and in the Patient Logs will create graphs of these vital signs if you wish to see them.

> Vitals, BMI, Growth Charts
> Patients 3 years or older with Vitals recorded.
> Psych PN part 1-->Vital Signs (BP(Syst/Diast of Any: Upright, Sitting, Supine), height and weight)
>
> Record information under Blood Pressure & Pulse field as well as the Height & Weight field.
>
> ICANotes will automatically calculate BMI. Hit Done after you have entered the information. Compile the note to save the information.
>
> OR go to New Complete Evaluation – >Mental Status/Constitutional Vital Signs tab

Video Tutorial

Core Measure 9: Record Smoking Status (> 50%)

Measure: More than 50% of all unique patients age 13 and over seen by the eligible provider have smoking status recorded as structured data. **Objective:** Record smoking status for patients 13 years and older.

Numerator: all unique patients 13 years or older with smoking status recorded
Denominator: all unique patients age 13 or older seen during the reporting period
Threshold: > 50%

Record the patient's smoking status in the Medical History section of the Complete Evaluation using the shrub buttons "Health and Behavior" and "Tobacco." While making a progress note, smoking status can be recorded in the "Behavior" section.

> Record Smoking Status
> Psych PN part 1, Behavior (lower left of PN part 1)-->tobacco use (lower right of Behavior tab)
> Select the appropriate info. Hit Back button.

OR Go to New Complete Evaluation. Medical History tab>Health & Behavior>Tobacco. Select an option.

Core Measure 10: Implement one clinical decision support rule

Measure: Implement one clinical decision support rule. **Objective:** Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule. Drug-drug and drug-allergy interaction are not sufficient to meet this measure*.*

EPs must implement **one** clinical decision support rule in addition to drug-drug and drug-allergy interaction checks during the length of the reporting period.

Go to the Chart Room. Click on the drawer labeled Settings & Directories. Then click the Options Tab on the Specific to Individual tab. Check the boxes next to **Clinical Decision Support Rules** and **Patient Education Material** to allow the program to automatically prompt you.
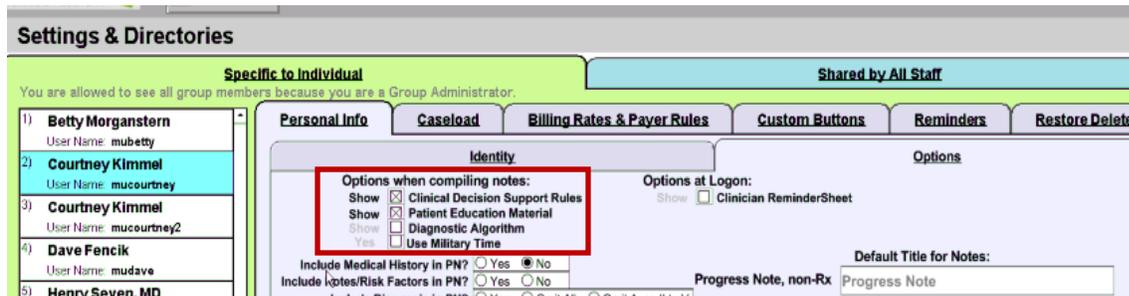
Core Measure 11: View online, download and transmit information

Measure: > 50% of all patients 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. **Objective**: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.

Numerator: The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information to view, download, and transmit to a third party.
 Denominator: Number of unique patients seen by the EP during the EHR reporting period.
Threshold: > 50%

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).

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.

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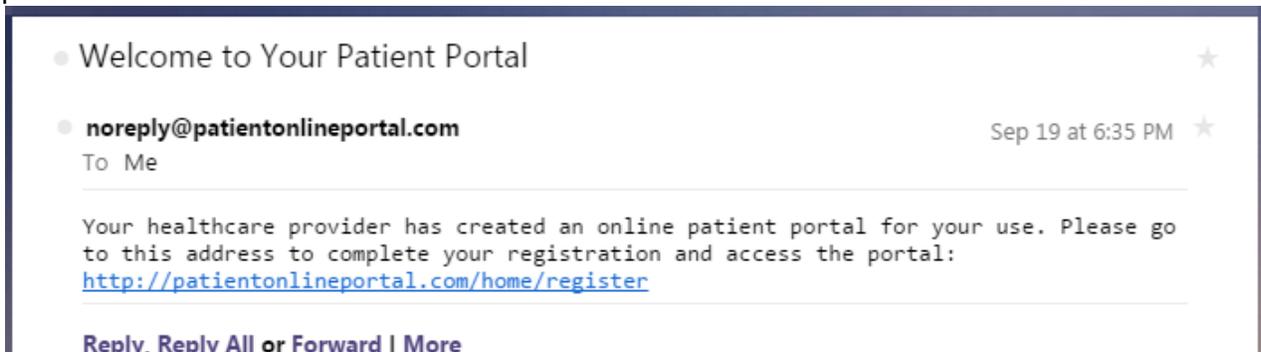
Note that the email invitation does not identify the name of your practice. This is to protect the patient's privacy. You will want to make sure the patient is aware of the portal and how to use it. Please provide patients with these **Patient Portal Instructions** and encourage them to register and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

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 12: Provide clinical summaries for patients for each office visit

Measure: *Clinical summaries provided to patients for > 50% of all office visits within 3 business days.*
Objective: Provide clinical summaries for patients for each office visit**.**

Numerator: Number of office visits for which the patient is provided a clinical summary within 3 business days.
Denominator: Number of office visits by the EP during the reporting period.
Threshold: > 50 %

The Clinical Summary does not have to be made available to your patient electronically. You just need to print a Clinical Summary and give it to your patient (perhaps on their way out, or mail or fax it to them within three days of the office visit.

Note: you need to let the program know when the Summary was given to the patient. You can do that by indicating the date in the "Date Summary Sent to Patient" field on the Preview screen of the Progress Note.

- Select "PN, part 2"
- Click on "Compile this Note" (see screenshot below)

- Check the "Patient Requests Summary" box
- Enter date given to patient

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.
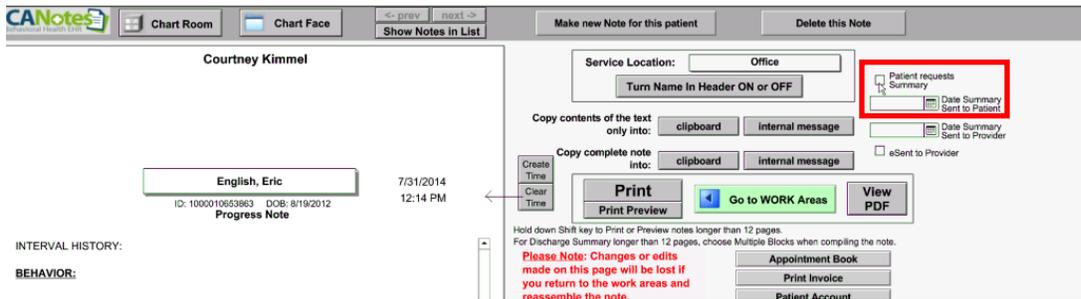
- Click on "Create Clinical Summary". If you wish to have the summary included as part of your chart, then push the button "Compile This Note."
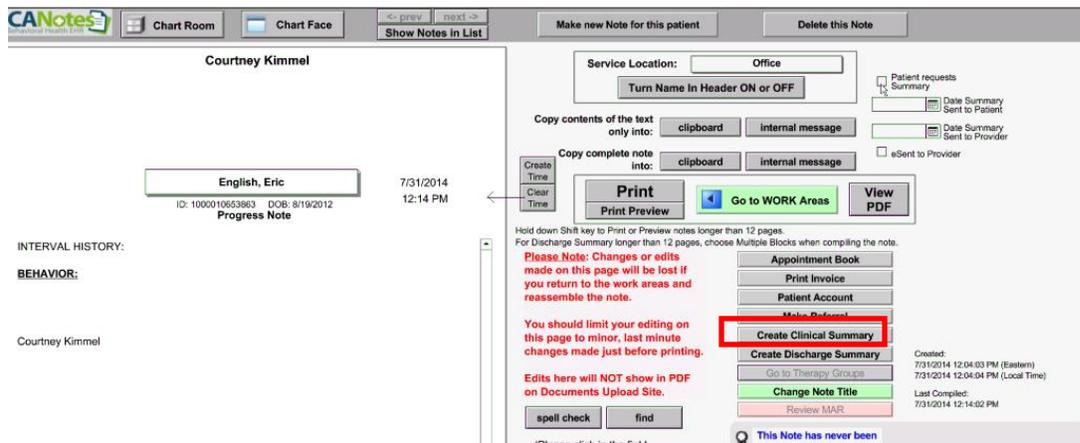
Core Measure 13: Protect electronic health information

Measure: The measure is to conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process. **Objective:** Protect electronic health information created or maintained by the certified EHR technology 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 13 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.

Clinical Quality Measures (CQMs)

Measure: Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS. **Objective:** Report ambulatory clinical quality measures selected by CMS.

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. 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.).

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.

Menu Measures

==To attest to Meaningful Use, a provider must report on 5 of the Menu Measures listed below. When selecting 5 measures from the menu set, EPs must choose at least one option from the public health menu set (Menu Measures 8 and 9).==

Menu Measure 1: Implement drug formulary checks. *Implement drug formulary checks.* The provider enables this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. At a minimum an EP must have at least one formulary that can be queried which can be internally developed or an external formulary.

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.

To attest to this measure, you must be able to electronically check if drugs are in a formulary or preferred drug list.   Using e-Prescribing satisfies this measure.

Menu Measure 2: Clinical Lab Test Results. *Incorporate clinical lab test results into EHR as structured data.*

Numerator: Number of clinical lab tests with positive/negative or numeric format results
Denominator: All clinical lab tests requisitioned during the reporting period
Threshold: > 40% of all clinical lab results ordered during the reporting period are incorporated in the EHR as structured data.

This measure is to determine that the tests (chemistries, imaging, etc.) you order in ICANotes have their results recorded in ICANotes as structured data (uploading results via the Uploads site will *not* satisfy this measure). To order tests, use the "Lab & Imaging Orders & Order Protocols" button on Psych PN, Part 2. To enter test results, use the "Enter Test Results" button on Psych PN, Part 1.

> **Order Labs:** Psych PN, part 2-->Clinical Order Sheet-->Lab & Imaging Orders & Order Protocols-->"+ New Order"
> **Enter Results:** Psych PN, part 1-->Enter Test Results and Save
> Compile this note.

Menu Measure 3: Patient Lists. *Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.*
Generate at least one report listing patients of the EP with a specific condition.

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

Menu Measure 4: Patient Reminders. *Send reminders to patients per patient preference for preventive/follow-up care.*

Numerator: Number of patients in the denominator who were sent the appropriate reminder.
Denominator: All unique patients 65 years or older or 5 years old or younger
Threshold: > 20% of patients 65 years or older or 5 years or younger were sent an appropriate reminder during the EHR reporting period.

This measure only applies to patients who are younger than 5 or older than 65. You must provide "appropriate" reminders to 20% of those patients.

To create a patient reminder, use the "Set or See Reminder" button on the chart face. Use the "New" button to set a reminder and indicate that it is a patient reminder. Set the date of the reminder, who it is to be sent to and why.

For example, you might send a reminder in one week to an office staff person to remind Mr. Jones (who is 65+) to get a lithium level. The office staff person would use the patient's preferred means of communication (set in Demographics) to remind Mr. Jones.

Once the reminder to the patient has been made, the ICANotes program must be informed. Do that by returning to "Set or See Reminder", opening the reminder in question by clicking on it, and indicating in the appropriate fields that the reminder was done and when it was done.

> Patient Reminders
> Chart Face-->Set or View Reminder
> Click on checkmark next to "Patient Reminder" at bottom left. Click checkmark next to "Contacted" and enter Date. Click on Save.
> OR
> Reports-->Reminder Search

Menu Measure 5: Patient-Specific Education Resources. *Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.*

Numerator: Number of patients in the denominator provided patient-specific education resources
Denominator: All unique patients seen during the reporting period
Threshold: > 10%

When you make certain diagnoses for your patient, order certain medications, or record certain test results, you will automatically be offered the ability to print out a sheet providing educational resources for the patient. Print those sheets when prompted for more than 10% of your patients. The sheets contain links to web sites that contain correct and useful information.

> Chart Room >Settings and Directories >Specific to Individual > Find your Name on the list on the left >Personal Info >Options > check **Patient Education Material**

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.

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.**
> Psych PN, part 1-->Enter Test Results (chemistry - Any cholesterol)
> Psych PN, part 2-->Section 1: Medication, Section 3: Diagnosis

Menu Measure 6: Medication Reconciliation. *An EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.*

Numerator: Number of transitions of care in the denominator where medication reconciliation was performed.
Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
Threshold: > 50%

A medication reconciliation is identifying the most accurate list of medications the patient is taking including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. At the time of your initial evaluation, deciding whether those medications will be continued, stopped or have their dosage altered, writing additional orders now that the patient is under your care, and arriving at a combined list of the medications you have continued and the new orders you have written.

- Go to the patient's Chart Face. Start a new **Complete Evaluation**.
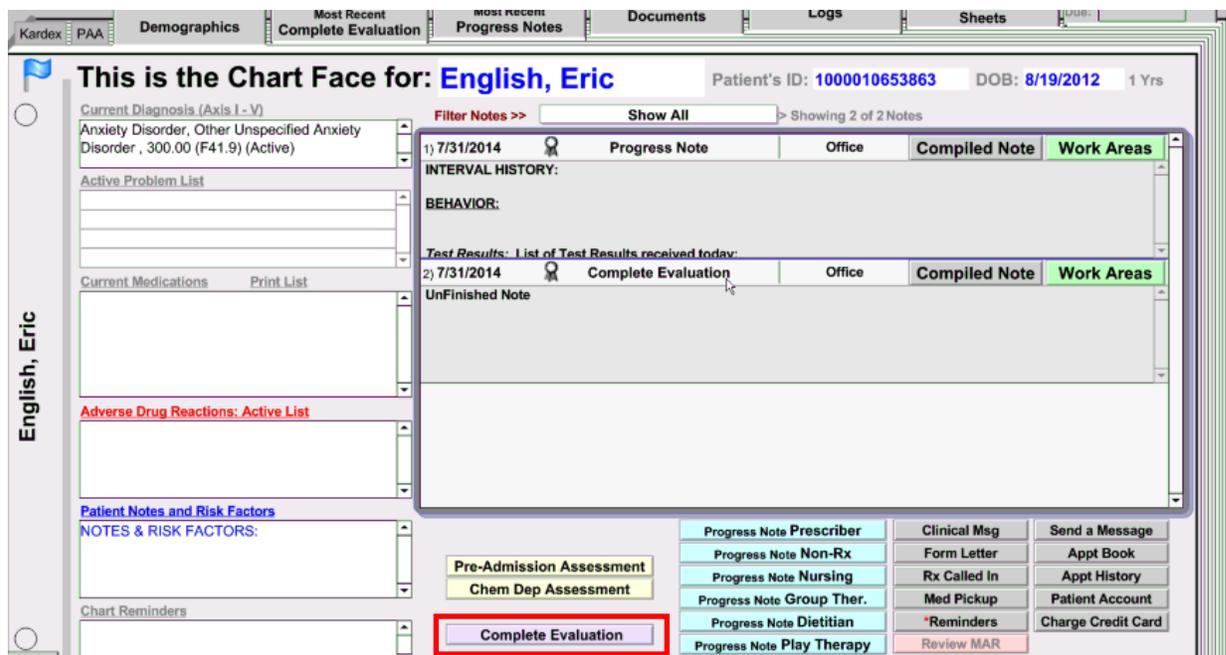
- Go to the **Finish Initial** tab and click the Medication Reconciliation Button.

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.

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.

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

Menu Measure 7: Transition of Care Summary. *EP who transitions a 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.*

Numerator: Number of transitions of care and referrals in the denominator where a summary of care record was provided.

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

Threshold: > 50%

Patient Summary Record (Transition of Care/Referral)

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

Click on the Clinical Order Sheet and click the "Referral/Consult" button.

Hit Make a Referral New button on upper left.

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

Hit Save. Hit Back. Compile your Note.

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Go to Create Clinical Summary button.

On Preview of Compiled note, enter the date for "Date Summary Sent to Provider"

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.

==PUBLIC HEALTH MENU MEASURES – One of these 2 menu measures must be chosen as one of your 5 menu measures. If you qualify for an exclusion, you can only take 1 of these as an exclusion. The other 4 menu measures you choose must come from numbers 1 – 7.==

Menu Measure 8: Immunization Registries Data Submission. *Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.*

Measure is "Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful, (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically), except where prohibited."

Menu Measure 9: Syndromic Surveillance Data Submission. *Capability to submit electronic surveillance data to public health agencies and actual submission according to applicable law and practice.*

Measure is "Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful, (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically) except where prohibited."

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 1
      - Identify the clinician
      - Input the Start and End date for the reporting period
      - Click "Go"

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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.