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. There will be five stages of meaningful use over a five-year period. Stage 1 extends through the end of 2014. To meet the requirements of Stage 1, eligible providers must:

- Identify and purchase a certified EHR (ICANotes), and
- Use and capture specific criteria inside that EHR for 90 days for the 1st year of Stage 1.

**IMPORTANT DATES**

- **October 3, 2013**: For EPs whose first EHR payment year will be 2013, last day to start the 90-day reporting period and earn a $15,000 2013 incentive.
- **2013**: EPs who successfully demonstrate meaningful use in 2013 will not be subject to the 2015 payment adjustment.

**Getting Started – Registering for Meaningful Use**

You will need your vendor’s EHR certification number (ICANotes is 30000005PJPFEAM). 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 (30000005PJPFEAM). 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 19 specific criteria 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. Full details and
authoritative information are available on the CMS website. See the Meaningful Use Stage 1 attestation worksheets and specification sheets for EPs at the bottom of the CMS website.

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 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](http://www.cms.gov/EHRIncentivePrograms)
- **HHS Office of the National Coordinator for Health IT**: certified EHR technology list [http://healthit.hhs.gov/CHPL](http://healthit.hhs.gov/CHPL)
- **NPPES Help Desk**: Visit [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) (800) 465-3203 - TTY (800) 692-2326
- **PECOS Help Desk**: Visit [https://pecos.cms.hhs.gov/](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 14 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 2+)
9. Record smoking status for patients 13 years or older (> 50 % of unique patients 13+)
10. Report ambulatory clinical quality measures to CMS/States (successfully report clinical quality measures as specified by CMS)
11. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule
12. Provide patients with an electronic copy of their health information, upon request (>50 % of patients who request a copy are provided it within 3 business days)
13. Provide clinical summaries for patients for each office visit (provided to patients for > 50 % of all office visits within 3 business days)
14. Protect electronic health information (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 with your practice – not through ICANotes)
Menu Measures

You must also select any five of these additional “Menu” measures and report them as well. Of the 5 menu choices, one must be a public health menu measure (number 9 or 10). If you qualify for an exclusion for both 9 and 10, you can only take an exclusion for one and must choose 4 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. Provide patients with timely electronic access to their health information (At least 10 %)
6. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate (> 10% of unique patients are provided resources)
7. Medication reconciliation for patient received from another setting of care or provider or provider believes an encounter is relevant (> 50%)
8. Summary care record for each transition of care/referral (> 50%)
9. Capability to submit electronic data to immunization registries/systems (performed at least one test of EHR to submit data to immunization registry).
10. Capability to provide electronic syndromic surveillance data to public health agencies (performed at least one test of EHR to provide data to public health agencies).

Tracking Meaningful Use Measures in ICANotes

The first step is to request that ICANotes enables these reports for your group: the Meaningful Use Report and the Clinical Quality Measures Report. You can email this request to support@icanotes.com or call us at 443-569-8778.

After these reports have been enabled by Support, you can access them from the ICANotes Reports menu. You can only view or run these reports before 9 am or after 5 pm Eastern time.

The second step is to go to the Chart Room. Click on the button 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.

Now let’s describe how to document the information you will need to attest to the 14 core measures required for Meaningful Use including Clinical Quality Measures and 5 menu measures. Many items are easy to achieve by just doing what you normally do or by doing what is good practice.

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.

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" and you will easily meet the 30% requirement of this measure.

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

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.

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

Psych PN, part 1 – Drug Reactions
Fill out all the information in Part I under Drug Reactions.

Set up the ePrescribing Program Dr. First. To license this program contact sales@icanotes.com
Then click on > to ePrescribing PN Part 1 and fill out the appropriate Drug-Drug and Drug-Allergy reactions in Dr. First.

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 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.
The "Problem List" is the diagnosis you make for the patient. When you do an initial evaluation and arrive at one or more diagnoses in the Finish Initial section for more than 80% of your patients, you have achieved this meaningful use measure.

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.
Or go to the Chart Face-->Treatment Plan (Tab) on the top right-->
Then # 3--> "Add a new problem."

Once you've entered all 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
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%

**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).

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 and meeting this measure will be easy. To setup Dr First through ICANotes, contact sales@icanotes.com>

Generate and transmit eRx
E-Prescribe via DrFirst
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%
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.

This measure is also very simple. Either order medication for your patient or indicate "No Medication ordered". If you take either of these steps for more than 80% of your patients, you will achieve this measure.

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.

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%

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.

Do you ask your patients if they have a history of Adverse Drug Reactions, or if they are "allergic" to any medications? Very likely you do. Their answer can be recorded in two places.
   a. Initial or Complete Examination: Medical History. Use the shrub button "Adverse Drug Reactions."
   b. Progress Note: Use the button at the top of column two, "Drug Reactions."

In either case, indicating what the adverse drug reaction is or indicating that there is no such history for 80% of your patients will achieve this measure.
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. OR a New Complete Evaluation allows you to record this information. Go to the Medical History tab and select Adverse Drug Reactions

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%

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. This measure is also very easy to achieve. 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. That's all there is to it.

Record Demographics
Name, DOB, sex, 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.
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%

Core Measure 8: Record Vital Signs (> 50%)
Measure: More than 50% of all unique patients age 2 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.
This may not be something you have been routinely doing. To meet this measure you are simply asked to record the Blood Pressure, Height, and Weight for 50% of your patients 2 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. That's all there is to this measure.

Vitals, BMI, Growth Charts
Patients 2 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’ve entered the information.

OR

Go to New Complete Evaluation – >Mental Status/Constitutional Vital Signs tab
Numerator: patients 2 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 2 years old and over seen during the reporting period
Threshold: > 50%

**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.

Do you routinely ask and record your patient's smoking status? It can be recorded in the Medical History using the shrub buttons "Health and Behavior" and "Tobacco." While making a progress note, it can be recorded in the "Behavior" section. If you record the smoking status of more than 50% of patients 13 years or older you will meet this meaningful use measure.

Record Smoking Status
Psych PN part 1, Behavior (lower left of PN part 1)--->tobacco use (lower right of Behavior tab)

Add the appropriate info. Hit Back button.

OR

Go to New Complete Evaluation. Medical History tab>Health & Behavior>Tobacco. Select an option.
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
Core Measure 10: 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. There is a separate Clinical Quality Measures report in the ICANotes Reports tab that must be enabled.

Providers must report on 6 CQM’s – 3 of these must be Core CQM’s or Alternate CQM’s if none of the Core are relevant to make 3.

There are 3 core CQM’s and 3 core alternate. First determine if any or all of the 3 Core are ones relevant to your practice. If any of the 3 Core CQM’s are not relevant to your practice, substitute one or more as needed from the Alternate Core to make a total of 3 even if there will be zeroes in the Alternate Core.

Finally choose 3 from the list additional CQMs to make that total of 6. This CMS list includes full explanation of the core, the alternate and the additional Clinical Quality Measures for Meaningful Use.

For specialties like psychiatry, providers may not find any measures relevant to their practice. It is ok for there to be 0 in the numerators and denominators for all or some of these if they are not relevant to a provider’s practice, however 6 measures must be reported as indicated above regardless and 3 must be Core or Alternate Core or a combination thereof.

Threshold: There is no threshold or percentages attached to CQM’s – just that there be 3 Core or Alternate Core and 3 from the other measures and that they be counted (even if 0) during the reporting period for Meaningful Use.

Core Measure 11: 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.

Core Measure 12: Electronic Copy of Health Information (> 50 % of patients who request this receive the information within 3 business days)
Measure: > 50 % of all patients who request an electronic copy of their health information are provided it within 3 business days. Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.
Electronic Copy of patient health information
Psych PN, part 2 --> "Patient Requests Summary" --> Compile Note (Can also be selected on Preview of Compiled Note)

(From Finished Note Screen) Click on “Create Clinical Summary” --> "Compile this Note" or "Compile this Note and Create CCR (Continuity of Care Record)" (only use if actually uploading CCR's to a patients health record - Not all Personal Health Records systems support CCR's), Download file from Upload site and provide to patient *

Enter Date in field “Date Summary Sent to Patient” (on the Finished Note Screen of the Note where the “Patient Requests Summary” was selected)

*Access of Microsoft HealthVault account or equivalent system required for both Provider and Patient (http://www.microsoft.com/en-us/healthvault/)

How to Create an Account with Microsoft's HealthVault: In order to electronically share Clinical Summaries with your patient, both you and your patient should go to the HealthVault web site and create accounts for yourselves. It’s easy to do. Go to http://www.healthvault.com and push the button "Create a Free Account."

**Important:** When your patients create a Microsoft HealthVault account they need to add you to the account. Alert your patient that during the sign up process they need to do the following: When they arrive at their HealthVault Home page they should push the "Sharing" tab. Then, push the "Share with Someone You Trust" button. The patient should enter you as a person they trust and must include your email address. When asked to select your sharing level, they should indicate "Custodian". This will give you full access to their account, including the ability to upload documents into the patient's HealthVault.

Numerator: Number of patients who receive and electronic copy of their electronic health information within 3 business days.

Denominator: Number of patients who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

Threshold: > 50% of patients who request an electronic copy are provided it within 3 business days to meet this measure.

**Core Measure 13: Clinical Summaries**

**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. This measure concerns itself with how quickly patients who request a copy of their Clinical Summary receive it electronically. You get credit for this measure if > 50% of the patients who request a clinical summary have electronic access to it within 3 days.

Clinical Summaries: This measure again involves making a Clinical Summary available to your patients. A Clinical Summary must be made available for 50% of every outpatient clinical contact, within four days. However, this summary does not require that the Clinical Summary be made available to your patient...
electronically. So, if you simply print a Clinical Summary and give it to your patient (perhaps on their way out, or mail or fax it to them) within four days of the contact, you will meet this measure.

**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 you created the clinical summary from.

Clinical Summaries
Psych PN Part 2-->Check box for "Patient Requests Summary"(upper righthand section)-->
>Compile Note
Click on “Create Clinical Summary”-->
>“Compile this Note and Create CCR” On Original Progress Note (Not the summary itself): Enter Date in field “Date Summary Sent to Patient"
All office Visits - Clinical Summaries: Number of office visits by the EP during the EHR reporting period.

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 %

How to Make a Clinical Summary: The ability to make a clinical summary of your patients’ conditions is an important and useful new feature in ICANotes. The summary contains information about your patients’ diagnoses, medications, drug allergies, recent test results, and medical conditions.

A number of meaningful use measures start by making a Clinical Summary. Here’s how to do it. After you compile a note push the button called, "Create Clinical Summary" on the Preview Screen. That's it.

If you wish to have the summary included as part of your chart, then push the button "Compile This Note." We’ll explain below when to push the button, "Compile This Note and Create a CCR."

This Clinical Summary can be sent to other providers when you request a consult or it can be put into a medical repository like Microsoft's HealthVault where it can, with the correct password, be accessed by other health professionals or by the patient. Giving the patient access to their Clinical Summary has proven to be good practice. Making this basic information available to other medical practitioners improves quality of care and helps avoid testing duplication.

How to Create an Account with Microsoft's HealthVault: In order to electronically share Clinical Summaries with your patient, both you and your patient should go to the HealthVault web site and create accounts for yourselves. It’s easy to do. Go to [http://www.healthvault.com](http://www.healthvault.com) and push the button "Create a Free Account."

**Important:** When your patients create a Microsoft HealthVault account they need to add you to the
Alert your patient that during the sign up process they need to do the following: When they arrive at their HealthVault Home page they should push the "Sharing" tab. Then, push the "Share with Someone You Trust" button. The patient should enter you as a person they trust and must include your email address. When asked to select your sharing level, they should indicate "Custodian". This will give you full access to their account, including the ability to upload documents into the patient's HealthVault.

Here's how to make a Clinical Summary electronically available to a patient: Make a Clinical Summary, as described above, and push the button, "Compile This Note and Create a CCR." CCR stands for Continuity of Care Record. It is your Clinical Summary in a standard format that can be electronically sent to HealthVault, other medical storage sites, or any location that has software set to receive and display it.

When you push the button "Compile This Note and Create a CCR", it puts a copy of your clinical summary, in CCR format, into the documents section of the patient's chart and into the patient's section of the upload site.

You will make a copy of the patient's Clinical Summary available to the patient by downloading it from the Upload site and then uploading it to the patient's HealthVault account.

To download the CCR from the upload site, go to the patients chart on the upload site (Mozilla Firefox works best), identify the CCR, right-click on its image, and choose "Save File." It will download to your Downloads folder (or, if you prefer, to your desktop.)

Then, sign in to your HealthVault account and switch to your patient's account (you have been made a Custodian of that account (see above), so the patient's name will appear in your HealthVault home page. Once you are in the patient's account, click on "Add, View, or Edit Information." Indicate that you want to add a CCR document to the account, locate the CCR on your desktop, and upload it. That's it. The patient's CCR document is now the latest entry in his or her HealthVault account.

There is one more thing to do. You need to let the ICANotes program know that a summary has been posted in the patient's HealthVault account. Please go to the Preview screen for the patient's note. On the right border, you will see a check box for "Patient Requests a Summary" and "Date Summary Sent to Patient." Check the box and select a date. The program now has all the information it needs to correctly calculate this measure for you.

Core Measure 14: 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.
A number of resources that may help you follow those steps and perform a Security Risk Analysis include:

- **MU Core Measure Stage 1 Protect Health Information**
- **Meaningful Use Core Objective for Security Risk Analysis** from HITECH Answers
- **Risk Analysis for Meaningful Use from VersaForm**
  VersaFrom’s **Small Practice Security Guide** designed for practices with 10 or fewer practitioners.
- **Risk Analysis Tool for Meaningful Use from the Texas Medical Association** – which includes a link to a spreadsheet with ONC’s Risk Analysis tool.
- **ONC’s Guide to Privacy and Security of Health Information**

### Menu Measures

**To attest to Meaningful Use, a provider must report on 5 of the Menu Measures listed below.** When selecting 5 objectives from the menu set, EPs must choose at least one option from the public health menu set (Menu Measures 9 & 10). See the [CMS details](#) about how to select menu objectives.

**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.

To attest to this, you should be able to electronically check if drugs are in a formulary or preferred drug list. Using ePrescribing should satisfy this measure.

**Menu Measure 2: Clinical Lab Test Results.** *Incorporate clinical lab test results into EHR as a structured data.* This measure is to determine that the tests (chemistries, imaging etc) you order with ICANotes have their results recorded in ICANotes. 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. If more than 40% of the tests you order have their results recorded, you will meet this measure.

Incorporate lab test results
Psych PN, part 2-->Clinical Order Sheet-->Lab & Imaging Orders & Order Protocols--> "+ New"
Psych PN, part 1-->Enter Test Results and Save
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.
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.

Menu Measure 4: Patient Reminders. Send reminders to patients per patient preference for preventive/follow-up care. This measure is odd because it only applies to patients who are younger than 5 or older than 65. In any case, it asks that you 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
OR
Reports--->Reminder Search
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 old or younger were sent an appropriate reminder during the EHR reporting period.

Menu Measure 5: Patient Electronic Access. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP This measure also involves making a Clinical Summary electronically available to your patient by posting it on his or her HealthVault account. The measure focuses on the availability of access within 4 business days (Monday – Friday, excluding holidays) not whether patients actually accessed the information.
Directions for creating HealthVault accounts and how to post a clinical summary are on page 10 of this document.

Once the Clinical Summary has been posted on the HealthVault account, you must fill out the "Date Summary Sent to Patient" field on the Preview screen of the Progress Note so that the ICANotes program can calculate this measure for you.

Timely Access
Psych PN, part 2 - Check Box for “patient request summary on upper right”, Compile Note (Can also be selected on Preview of Compiled Note)
On Preview of Compiled note - Enter date for “date summary sent to patient”
*Access of Microsoft HealthVault account or equivalent system required for both Provider and Patient (http://www.microsoft.com/en-us/healthvault/)
Numerator: number of patients in the denominator who have timely (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information online.

Denominator: all unique patients seen during the reporting period. If a patient is seen more than once during the reporting period, the patient is only counted once towards the denominator.
Threshold: 10%

Menu Measure 6: Patient-Specific Education Resources. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

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. By simply printing those sheets for more than 10% of your patients, you will achieve this meaningful use measure. The sheets contain links to web sites that we feel contain correct and useful information.

Patient-specific education - Must print when prompted to qualify.

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

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

Menu Measure 7: 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.

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.

ICANotes makes this process easy. First, create your medication orders as usual. Then, on Finish Initial upper-right, there is a button labeled "Medication Reconciliation". Use the Medication Reconciliation form to enter the medications, both OTC and prescribed, that the patient was taking prior to coming under your care. Indicate if you wish to continue, stop, or change the dosage of those medications. Then, push the button "Click Here to Reconcile the Two Lists." The resulting medication list, on both the Reconciliation form and on your clinical note will be the combined list of all medications being continued or newly ordered. Enter your initials in the "Reconciled By" field and record the Date.

Go to patient’s Chart Face. Start a New Complete Evaluation.
Complete Evaluation-->Finish Initial-->then Medication Reconciliation Button.
Fill out all information in Section I. Medications Being Taken at Time of Admission or Transfer.
Make any edits to Section II. Medications Ordered on Admission or Transfer. Then hit III. Click here to Create Reconciled, Current Medication List.
Add your initials and date to the bottom.
Hit return to initial button and Compile this Note.

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%
**Menu Measure 8: 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.* This measure asks a simple question: when you make a referral to another clinician do you send a Clinical Summary?

Patient Summary Record (Transition of Care/Referral)
In 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. Go Back. Compile your Note. 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.

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%

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**PUBLIC HEALTH MENU MEASURES – One of these must be chosen. 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 #’s 1 – 8.**

**Menu Measure 9: 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 10: 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.”

Further information is available at http://help.icanotes.com/.

If you have any questions about the instructions for one or more of these measures, please contact ICANotes Support at 443-569-8778 or via the Live Chat feature on our website. As always, thank you for choosing ICANotes as your EHR.