Aprima PRM 2014 EHR (electronic health record) and PM (practice management), version 14.0.1, has received Meaningful Use Stages 1 and 2 certification as a Complete EHR for use in ambulatory care settings from InfoGard (www.infogard.com), an accredited ONC-ACB certification body. This Complete EHR is 2014 Edition compliant and has been certified by an ONC-ACB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services or guarantee receipt of incentive payments. The application’s original certification was received on August 5, 2013, and the original InfoGuard certification number was IG-2999-13-0024. The application’s most recent certification was received on July 29, 2014. Current certification information is shown in the table below.

<table>
<thead>
<tr>
<th>Vendor Name:</th>
<th>Aprima Medical Software, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified EHR Name:</td>
<td>Aprima PRM 2014</td>
</tr>
<tr>
<td>Certified EHR Version:</td>
<td>14</td>
</tr>
<tr>
<td>InfoGard Certification #:</td>
<td>IG-2999-14-0051</td>
</tr>
<tr>
<td>CMS EHR Certification ID</td>
<td>1314E01PLXKGEAD</td>
</tr>
<tr>
<td>Certification Date:</td>
<td>7/29/2014</td>
</tr>
<tr>
<td>Classification:</td>
<td>Complete</td>
</tr>
<tr>
<td>Practice Setting:</td>
<td>Ambulatory</td>
</tr>
<tr>
<td>Requirements Edition:</td>
<td>2014</td>
</tr>
<tr>
<td>Clinical Quality Measures:</td>
<td>CMS2 v3, CMS22 v2, CMS50 v2, CMS52 v2, CMS56 v2, CMS61 v3, CMS62 v2, CMS64 v3, CMS65 v3, CMS66 v2, CMS68 v3, CMS69 v2, CMS74 v3, CMS75 v2, CMS77 v2, CMS82, v1, CMS90 v3, CMS117 v2, CMS122 v2, CMS123 v2, CMS124 v2, CMS125 v2, CMS126 v2, CMS127 v2, CMS128 v2, CMS129 v3, CMS130 v2, CMS131 v2, CMS132 v2, CMS133 v2, CMS134 v2, CMS135 v2, CMS136 v3, CMS137 v2, CMS138v2, CMS139 v2, CMS142 v2, CMS143 v2, CMS144 v2, CMS145 v2, CMS146 v2, CMS147 v2, CMS148 v2, CMS149 v2, CMS153 v2, CMS154 v2, CMS155 v2, CMS156 v2, CMS158 v2, CMS159 v2, CMS160 v2, CMS161 v2, CMS163 v2, CMS164 v2, CMS165 v2, CMS166 v2, CMS167 v2, CMS169 v2, CMS177 v2, CMS182 v3</td>
</tr>
<tr>
<td>Additional SW Required:</td>
<td>Microsoft Excel</td>
</tr>
</tbody>
</table>

Ref: 1111.06
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>7</td>
</tr>
<tr>
<td>Using This Guide</td>
<td>7</td>
</tr>
<tr>
<td>Participation in 2014</td>
<td>8</td>
</tr>
<tr>
<td>Stage 1 and Stage 2 Participation</td>
<td>8</td>
</tr>
<tr>
<td>Stage 2 Measures and Criteria</td>
<td>9</td>
</tr>
<tr>
<td>Menu Set Measure Exclusions</td>
<td>9</td>
</tr>
<tr>
<td>Additional Technology and Service Requirements</td>
<td>10</td>
</tr>
<tr>
<td>Registration and Attestation</td>
<td>11</td>
</tr>
<tr>
<td>Registration</td>
<td>11</td>
</tr>
<tr>
<td>Attestation</td>
<td>12</td>
</tr>
<tr>
<td>Supporting Documentation for Meaningful Use Attestation</td>
<td>12</td>
</tr>
<tr>
<td>Reporting Configuration</td>
<td>13</td>
</tr>
<tr>
<td>Defining Clinical Decision Support Rules</td>
<td>14</td>
</tr>
<tr>
<td>Define a Rule</td>
<td>14</td>
</tr>
<tr>
<td>Education Form Associations</td>
<td>16</td>
</tr>
<tr>
<td>Verify Procedure Codes for Orders</td>
<td>18</td>
</tr>
<tr>
<td>Verify Procedure Codes for E&amp;M Visits</td>
<td>19</td>
</tr>
<tr>
<td>Associate CVX Codes with Types of Vaccine Used for Measures</td>
<td>20</td>
</tr>
<tr>
<td>Define C-CDA Document Definitions</td>
<td>21</td>
</tr>
<tr>
<td>Configure the Patient URL Launcher for PACS System Access</td>
<td>22</td>
</tr>
<tr>
<td>Patient URL Launcher Setup</td>
<td>22</td>
</tr>
<tr>
<td>Associate the Patient URL Launcher with a User Settings Definition</td>
<td>25</td>
</tr>
<tr>
<td>Configure Syndromic Surveillance Reporting</td>
<td>26</td>
</tr>
<tr>
<td>Activate the Interface Message Jobs</td>
<td>27</td>
</tr>
<tr>
<td>Define Job Schedules</td>
<td>27</td>
</tr>
<tr>
<td>Modify the ExportPatientDiagnosisData HL7 Partner Record</td>
<td>28</td>
</tr>
<tr>
<td>Define Report Filters for the Export Patient Diagnosis Data Report</td>
<td>30</td>
</tr>
<tr>
<td>Defining Licensed Healthcare Professionals</td>
<td>31</td>
</tr>
<tr>
<td>Grant Clinical Delegate Security</td>
<td>32</td>
</tr>
<tr>
<td>Assign Clinical Delegate Security for a Provider</td>
<td>32</td>
</tr>
<tr>
<td>Drug Screening Configuration</td>
<td>33</td>
</tr>
</tbody>
</table>
Configure Drug Screening for the Practice ................................................... 33
Configure Drug Screening for a Provider ...................................................... 34
Enter Practice, Provider, Insurance Payer, and Patient Information ........... 34
Practice Information ................................................................. 35
Provider Information ................................................................. 35
Patient Information ................................................................. 35
Patient Status for Test Patient ....................................................... 36
Set Up the Patient Portal and Patient Accounts ........................................... 36
Configure the Patient Portal Error Message Recipients ............................ 36
Configure the Patient Portal .......................................................... 37
Create a Patient Account ............................................................ 39
Set Up the HISP and Direct Mail Addresses .......................................... 40
Set Up the Jobs and Job Schedules ..................................................... 40
Enable the Integration Partner Record for Nitor .................................. 42
Create an Internal Provider’s Direct Mail Email Address ....................... 44
Enter an External Provider’s Direct Communication Email Address .......... 45
Enter a Medical Service Provider’s Direct Communication Email Address .... 46
Assign Clinical Delegate Security for a Provider .................................. 48
Measure Charting Details .................................................................. 49
Core Measures .............................................................................. 50
Core Measure 1: CPOE (Computerized Provider Order Entry) for Medication, Laboratory and Radiology Orders ........................................... 50
Core Measure 2: e-Prescribing (eRx) ................................................... 52
Core Measure 3: Record Demographics .............................................. 53
Core Measure 4: Record Vital Signs .................................................. 54
Core Measure 5: Record Smoking Status .......................................... 57
Core Measure 6: Clinical Decision Support Rule ................................. 58
Core Measure 7: Patient Electronic Access ....................................... 59
Core Measure 8: Clinical Summaries ............................................... 63
Core Measure 9: Protect Electronic Health Information ....................... 64
Core Measure 10: Clinical Lab-Test Results ..................................... 65
Core Measure 11: Patient Lists ....................................................... 67
Core Measure 12: Preventive Care .................................................... 68
Core Measure 13: Patient-Specific Education Resources ....................... 69
Core Measure 14: Medication Reconciliation .................................... 70

Ref: 1111.06
Introduction

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, promotes the adoption and meaningful use of health information technology. One of its specific goals is to increase physician adoption of electronic health record (EHR) applications to 90 percent by 2019. To encourage physicians to adopt EHR software the HITECH and ARRA acts include incentive payments to physicians who demonstrate ‘meaningful use’ of a certified EHR application over the next six years. The Department of Health and Human Services’ (HHS) definition of meaningful use expands over three stages:

• Stage 1 - Data capturing and sharing
• Stage 2 - Advanced clinical processes
• Stage 3 - Improved outcomes

To receive incentive payments for EHR adoption, physicians must demonstrate that they are using a certified EHR in the manner proscribed by HHS as meaningful use.

Using This Guide

This guide is a general introduction to using Aprima PRM 2014 for Meaningful Use Stage 2 reporting in the 2014 calendar year.

If you are participating in Meaningful Use Stage 1, then please refer to the Aprima PRM 2014 Meaningful Use Stage 1 Guide for 2014 for the needed information.

This document:

• Explains the features and functions that you can use to meet the Meaningful Use requirements for core and menu set measures.
• Gives general information about the Meaningful Use core and menu set measures, and what you must do to meet the measures’ requirements.
• Describes the reports you use for Meaningful Use monitoring and reporting.

This guide does not include information on the clinical quality measures necessary for Meaningful Use. Clinical quality measures are applicable to Meaningful Use Stage 1 and Stage 2 and to PQRS. Please refer to the Clinical Quality Measures 2014 Edition guide for the needed information.
Participation in 2014

The original timeline would have required Medicare providers who first demonstrated meaningful use in 2011 to meet the Stage 2 criteria in 2013. HHS and the Centers for Medicare and Medicaid Services (CMS) changed the timeline so that the Stage 2 became effective in calendar year 2014. However, on August 29, 2014, the Centers for Medicare and Medicaid Services (CMS) announced the final rule changes for Meaningful Use participation in calendar year 2014. The final rule gives you the flexibility either to continue reporting for Stage 1, regardless of how many years you have participated in the past, or to report for Stage 2 in 2014.

The final rule also grants all providers a 3-month EHR reporting period for 2014, whether participating in Stage 1 or Stage 2. The requirements for this reporting period depend on whether you are eligible for the Medicare or Medicaid program and whether you have participated in the past.

- Medicare eligible professionals who have participated in Meaningful Use in the past must select a three-month reporting period fixed to a calendar year quarter of the calendar year for eligible professionals.
- Medicare eligible professionals in their first year of Meaningful Use may select any 90-day reporting period. However, this 90-day period must begin no later than July 1.
- Medicaid eligible professionals can select any 90-day reporting period that falls within the 2014 calendar year.


More information about Meaningful Use reporting for Stage 1 and Stage using a Stage 2 certified EHR is available from the CMS website at


Stage 1 and Stage 2 Participation

Participation in Meaningful Use is by provider, not by practice. A practice may have some providers who participate in Stage 1 and other providers who participate in Stage 2.

In calendar year 2014, all providers may participate in Stage 1. Providers who have participated in Stage 1 for at least two calendar years and who are able to meet all Stage 2 requirements may choose to participate in Stage 2.

It is important to know for which stage you are eligible, and then become familiar with the measures, measure criteria, and reports for that stage. Stage 1 and Stage 2 have similar
measures. But, even when a measure number and name are the same for Stage 1 and Stage 2, the measure objectives, criteria, and thresholds may be different for the different stages. Therefore, generating a Stage 1 report and Stage 2 report for the same measure and same provider may produce different results. The different results are valid. Which results are correct depends on whether that provider is eligible for Stage 1 or Stage 2. There is no need to generate Stage 1 reports for providers who must participate in Stage 2, and doing so may cause confusion since the results in the Stage 1 reports and Stage 2 reports may be different.

**Stage 2 Measures and Criteria**

Stage 2 measures and criteria are similar to, but different from, the Stage 1 measures and criteria. CMS expects providers who reach Stage 2 of the program to demonstrate Meaningful Use of their EHR for a larger portion of their patient population.

Stage 2 uses core measures and menu measures in the same way as Stage 1. However, some Stage 1 objectives have been eliminated or combined as core measures for Stage 2. Also, Stage 2 thresholds have been raised.

Meaningful Use measures must be reported for individual providers. Reporting cannot be done for the practice as a whole. To demonstrate meaningful use for Stage 2, you, as an individual provider, must report on:

- 17 core measure objectives, and
- 3 menu set measures, and

Aprima PRM 2014 is not certified for the cancer registry menu set measure. Therefore, you must choose three of the remaining five menu set measures.

**Menu Set Measure Exclusions**

Starting in 2014, exclusions no longer count towards the three menu set measures you need to successfully demonstrate meaningful use if there are other menu set measures that you can select. This means that you must either:

- Report on three menu set measures, or
- Report on as many measures as you can, and qualify for an exclusion to all of the remaining menu set measures.

It is important that you search for an electronic repository for syndromic surveillance or a specialized registry in your area, if you are not already aware of their existence. If a registry is available, then you must contact them to determine whether they can accept HL7 files. If a registry is available and can accept HL7 files, then you cannot claim an exclusion. You must enroll with the registry or repository. Then you must contact Aprima Support to set up an interface to the registry or repository.
Additional Technology and Service Requirements

Participation in Meaningful Use Stage 2 requires several technologies and services in addition to Aprima PRM. The table below lists the technologies and services required. In general, these technologies and services must be implemented before the start of your reporting period, and used throughout your reporting period. For some measures, there are requirements for beginning the registration process and testing the technology that may mean use of the technology does not have fully implemented for the entire reporting period.

Please note that interfaces may take some time to develop, test, and implement in your database. Please contact Aprima immediately if you need an interface to ensure that your interface can be put in place prior to the start of your reporting period.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Stage 2 Measure</th>
<th>To Obtain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surescripts electronic pharmacy clearinghouse</td>
<td>Core Measure 2: e-Prescribing (eRx)</td>
<td>Contact your sales representative.</td>
</tr>
<tr>
<td>Aprima Patient Portal</td>
<td>Core Measure 7: Patient Electronic Access</td>
<td>Contact your sales representative.</td>
</tr>
<tr>
<td></td>
<td>Core Measure 17: Use of Electronic Messaging</td>
<td></td>
</tr>
<tr>
<td>Nitor HISP</td>
<td>Core Measure 15: Summary of Care</td>
<td>Setup instructions included in this guide.</td>
</tr>
<tr>
<td>Interface with an immunization registry or immunization information systems</td>
<td>Core Measure 16: Immunization Registries Data Submission</td>
<td>Contact your sales representative.</td>
</tr>
<tr>
<td>Interface with a public health agency</td>
<td>Menu Set Measure 1: Syndromic Surveillance Data Submission</td>
<td>If your public health agency accepts the standard file, then you can set up the standard interface. If your public health agency has additional requirements, then contact your sales representative to have a custom interface developed.</td>
</tr>
<tr>
<td>Interface with a specialized registry, other than for immunizations, syndromic surveillance, or cancer</td>
<td>Menu Set Measure 6: Report Specific Cases</td>
<td>Contact your sales representative.</td>
</tr>
</tbody>
</table>
For any registry or repository, you must identify your local registry or identify that one is not available. If a registry or repository is available, then you must obtain their requirements for receiving electronic data. To obtain an interface with the registry or repository, contact your sales representative with this information.

Please also note that Menu Set Measure 3: Imaging Results may use, but does not require, an external PACS (picture archiving and communication system), DICOM (digital imaging and communications in medicine) image system, or other imaging system. Direct access to a PACS or DICOM system may be through an optional interface. Or, depending on the imaging system, you may be able to access images in the PACS via a context-sensitive URL. Many imaging centers and hospitals provide ordering providers with online access to their PACS. For the context-sensitive URL access to the PACS to qualify for this measure, you must be able to configure access to it from Aprima PRM in such a way that you are able to directly access a particular patient’s images from the patient’s chart.

Core Measure 9: Protect Electronic Health Information requires a security risk analysis. This measure does not require that the security risk analysis be performed by a third party. However, your security risk analysis must meet all requirements, and must be able to pass a compliance review or audit. An experienced professional who is familiar with the requirements of the analysis and action plan may be helpful. Aprima cannot assist with this requirement.

Registration and Attestation

You must register with the Centers for Medicare and Medicaid Services (CMS) in order to apply for the Meaningful Use incentive. You must have registered before you can attest to your use of the application.

To register and to attest, you must have your NPI user ID and password. Your NPI user ID is not your NPI number. If you do not know your NPI user ID, you can call 1-800-465-3203 to get your NPI user ID and a temporary password. Please note that CMS only allows this information to be given to the doctor; they will not accept calls from or provide information to an administrative assistant or other staff member on your behalf.

The attestation deadline is February 28, 2015, regardless of your 90-day reporting period.

Registration

You may register at any time, but you must have registered prior to attestation. Use the following procedure to register.

2. Select the National Provider Identifier (NPI) link.
3. Select the Login link, and then go through the steps to create a new password. The password will be needed in step 4.
5. Select the Registration User Guide for Eligible Professionals, and save it to your desktop. That is your step by step guide to the registration process at CMS. You will need to use your NPPES Login and Password you obtained in step 1 to login into the EHR incentive site and then you are almost done.

6. When prompted about your Meaningful Use EMR, enter Aprima’s certification number: 1314E01PLXKGEAD

7. Print and save your Certificate.

**Attestation**

Once you have met the Meaningful Use requirements, you can attest to your use of the application. Use the following procedure to attest.


1. Print the Meaningful Use Stage 2 report and the other quality reports that show your use of the application. You will need information from these reports to enter your attestation data.


3. Select the Continue button.

4. Log in using your NPI user ID and password.

5. Follow the attestation process of the website to enter your meaningful data from the Meaningful Use and other quality reports.

**Supporting Documentation for Meaningful Use Attestation**

The Centers for Medicare and Medicaid Services (CMS) has announced that they will audit between 5 and 10 percent of providers who attest for Meaning Use. This document can help you identify the documentation you need to create and keep in order to support your attestation in the event of an audit. This information is for guidance only. As the provider or practice, you are responsible for any Meaningful Use audit and its results, including any monies that must be returned to CMS in the case of a failed audit.

CMS has provided the following information regarding the documentation needed to support attestation in the case of an audit. Additional information is available directly from CMS at:


CMS will not make the risk profiles for audits public. All documentation to support attestation should be retained for at least six years following the attestation.
The primary source document is the Meaningful Use Stage 2 report and the other quality reports that show your use of the application. You will need information from these reports to enter your attestation data, and you must retain them to support that attestation. If you request an exclusion for any measure, you must generate and retain the report for that measure showing a zero denominator for the measure.

Depending on the measures on which you report, you may also need one or more dated screen shots showing the use of functionality. For example:

- SIG Writer and drug-drug/drug-allergy interaction warning windows.
- SIG Writer window showing drug formulary check information.
- Clinical Decision Support Rule window with rules used for clinical decision support and the use of those rules in the Full Note Composer’s Clinical Decision Support slider.
- Reports window showing the filtering criteria for the Patient List Excel report used to generate a list of patients by condition (retain the actual report as well).
- Dated screen shots of the Interface Data Detail window confirming that the information was sent to and received by the vaccine registry. Evidence that the submission was generated from provider’s system (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.). This information must be displayed in your Interface Data Detail window screen shot.

For measures requiring the submission of data to a registry or public health agency, you may need a letter or email from registry or public health agency confirming the receipt (or failure of receipt) of the submitted data, including the date of the submission, name of parties involved, and whether the test was successful.

For Core Measure 9: Protect Electronic Health Information, you must perform a security analysis. For the security risk analysis, you need:

- A copy of the analysis report.
- Documentation of security updates implemented as a result of the analysis.

For Core Measure 15: Summary of Care, you must transmit, through a HISP, a summary of care document to an eligible provider external to your practice who uses an electronic health record (EHR) other than Aprima PRM. It is recommended that you obtain a letter from a provider with whom you exchange information using the HISP identifying the EHR application that provider uses.

**Reporting Configuration**

There are a number of tasks that you must perform in the application to configure it for Meaningful Use reporting. These tasks must be performed by an administrative super user or other user with the necessary security rights. Please refer to the *Administrative User’s Guide* or the online help for information and instructions on security.
Defining Clinical Decision Support Rules

Clinical decision support rules are needed for both Core Measure 6: Clinical Decision Support Rule and Core Measure 12: Preventive Care.

Core Measure 6: Clinical Decision Support Rule requires that you 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.

Core Measure 12: Preventive Care is the percentage of patients whom you remind of preventative care services. You can use clinical decision support rules to identify preventative care services, such as annual flu shots, mammograms, and PSA tests.

The clinical decision support rule must be flagged for preventative follow up, have an associated care team, and have recipients for messages regarding the rule in order for the rule to be used for reporting as preventive follow up.

Define a Rule

1. List Editor (临床) → Clinical → Clinical Decision Support
2. Either:
   - Select the New button to create a new rule.
   - Search for the select the desired rule, and select the Modify button to modify an existing rule.
3. Enter an ID, if desired.
4. Enter a Name for the rule.
5. Enter any Notes, if desired. If you will include a URL for the More Information functionality, then you must include bibliographic source information in the Notes field.

6. Select the checkbox for ‘Report as Preventative Followup’

7. Select the General tab.

8. Select the Procedures To Be Completed checkbox. This enables the other data fields needed.

9. Select the Procedures that will be provided or ordered when the rule is triggered. This is a multi-select field, so you can add one or more procedures that will satisfy the requirements of the rule.

   Note that the performance of any one of the procedures will satisfy the rule. If more than procedure must be performed then you must define a rule for each required procedure.

10. Define the rule recurrence and advance warning:
   a. Define the recurrence of the rule as a range, such as every 1 to 2 years or every 6 to 9 months. Qualifiers are Days, Months, Weeks, and Years.
   b. Select the Limit Recurrences checkbox to limit the number of times the rule will occur. Then enter the number of recurrences in Max Recurrences. The maximum number of recurrences is 180.
   c. Define the advance warning required. This is the amount of time in advance of the test being due that an alert is sent to recipients. Select the number and time period desired, such as 15 days, 2 weeks, or 1 month.

11. In the Reference URL field, enter the URL for information on the rule. This will enable the Info button in the Full Note Composer window so that the provider may access the information when reviewing the rule for a patient.

12. Select the Criteria tab.
   a. Define the age range for which the rule is applicable, such as 3 to 6 months or 40 to 65 years.
   b. Define Gender. This field is multi-select, so you can select Male and Female for any tests that are gender specific.
   c. Define Patient Medical History if appropriate. This field is multi-select, so you can add all medical problems to which the rule will apply.
   d. Define the drug or drug class if appropriate. These are multi-select fields, so you can add all the medications to which the rule will apply. However, you can only select by either drug or drug class; you cannot select by both drug and drug class.
   e. Define a Drug Allergy if appropriate. This field is multi-select, so you can add all the medications to which the rule will apply.

13. Define observation criteria if appropriate.
   a. Select the Edit Observation Criteria button. This accesses the Edit Observation Criteria window, where you can define an equation for observation values. You may want to write down your equation before you start to enter it.
   b. To enter a clause, select the open parentheses ( button.
   c. Select the desired Observation item.
d. Select the Not button if appropriate.
e. Select a comparison operator (=, <, >, Like, etc.).
f. Enter the literal value for the observation.
g. Select the Insert button to add the criteria to the equation. Your criteria will display in the Current Observation Criteria area.
h. To close a clause, select the close parentheses ) button.
i. If needed, select the And or Or buttons to begin another clause. Then repeat substeps b through g to enter the next clause.
j. To edit the equation, select the << button to backspace through the equation.
k. When finished, select the OK button to save the observation equation and return to the Clinical Decision Support window. Your equation displays in the Observation Criteria area.

14. Select the Care Team tab.
   a. Select the Care Teams with which the health maintenance rule will be associated.
   b. Select the Msg (message) Recipients for the care team. When a rule becomes due for a patient, a message is sent to the message recipients to alert them of the rule. The message recipients do not need to be members of the care team; they can, for example, be front desk or scheduling staff who will contact the patient to schedule an appointment.
   c. Select which providers, if any, in the care team wish to opt out of the health maintenance rule.
   d. Complete substeps a through c for each care team that will use the rule.

Education Form Associations

Core Measure 13: Patient-Specific Education Resources requires that you provide education resources to patients. Education form associations can make it easier to provide appropriate education forms to patients. You can associate education forms with age, gender, chief complaint, diagnosis, procedure, and/or observation item and results. Then when the specified conditions are met in a patient visit note, the application adds the associated education form to the Education Form slider so that the provider can easily give it to the patient.

1. List Editor (قن) → Clinical → Education Form Association
2. Select the New button.
3. Enter a Name for the set of education form associations.
4. Enter an ID or Notes if desired.
5. In the Patient Education Form field, search for and select the desired form.

6. Define the Demographic Factors for the education form.
   a. Define the age range by entering From and To ages and select the Units for the age (days, years, etc.).
   b. Select the Gender or genders.

7. If desired, enter the Recurrence period in which you want the form to be automatically available in the Education Form Slider. For example, Every 1 Years, or Every 6 Months.

8. Search for and select the item or items to which you want to associate the education form. You may associate the form with one or more:
   - CC Symptom
   - Diagnosis
   - Procedure

9. In the Other Factors section, select the checkboxes for the additional factors related to the form.
   - Smoker: If identified as a smoker in the patient history.
   - Overweight: For patients between the ages of 18 and 65, Medicare defines overweight as having a BMI over 25.
   - Underweight: For patients between the ages of 18 and 65, Medicare defines underweight as having a BMI under 18.5.

10. Define the Observation Items with which the education form is associated.
    a. Select the desired Observation Item.
    b. Select the operator for the Result.
    c. Enter the result Value.
    d. If an additional observation item is desired, select the radio button for ‘And’ or ‘Or’ and then repeat substeps a through c for the next observation item.

11. Repeat steps 5 through 10 for each education form.
Verify Procedure Codes for Orders

Procedure codes for laboratory and radiology orders must have the procedure code type of Lab or Radiology.

Laboratory and radiology procedure codes must also be defined to generate an order. The procedure code must be defined to generate an order at the time that the provider charts the procedure. If the procedure code is not set to generate an order, then the application will not generate an order when the provider charts the procedure. Orders cannot be generated retroactively.

If you have an interface with a DICOM (digital imaging and communications in medicine) image system or you access an external PACS (picture archiving and communication system) via a context-sensitive URL, then you must identify this on the procedure code for radiology procedures. This is necessary because the application cannot count the images, and you must attest to having access.

If you have an interface to an external PACS (picture archiving and communication system) that generates a results message with a hyperlink button that accesses the image, then you do not need to identify this on the procedure code. This is because the application actually receives a hyperlink to the image as a result, which can be counted.

1. List Editor (Clinical → Procedure Code
2. Search for and select the desired procedure code, and select the Modify button.
3. In the Code Type field, select either ‘Lab’ or ‘Radiology’ as appropriate.

[Image of procedure code interface]
4. Select the Default Laboratory. You must identify the lab or imaging center that has the PACS or DICOM system you are accessing.

5. Select the Generate Order checkbox.

6. If this is a radiology order, then:
   - If you have access to this type of image through a context-sensitive URL to an external PACS or through an interface to a DICOM imaging system, then select the Image Results Directly Accessible checkbox.
   - If you have an interface to a PACS and you receive a results message for image orders, then do not select the Image Results Directly Accessible checkbox.

   Note: This step is not needed for lab test orders.

7. Select the OK button to save the procedure code.

8. If you selected the Image Results Directly Accessible checkbox, then the application will display a popup message reminding you that you are attesting that you have a direct link to the image results.

   - Select the OK button if you do have access to the PACS, DICOM, or other imaging system.
   - Select Cancel if you do not have direct access to image results.

Verify Procedure Codes for E&M Visits

If you have user-defined procedure codes for valid E&M services, then you must verify that the procedure codes are defined as E&M visit procedures.

1. List Editor (Clinical) → Procedure Code
2. Search for and select the desired procedure code, and select the Modify button.
3. Select the E&M Code checkbox.
Associate CVX Codes with Types of Vaccine Used for Measures

Measures related to vaccinations require a CVX code associated with the type of vaccine. The CVX code is required for reporting and for submitting immunization records to registries.

1. List Editor (appen) → Vaccines → Types of Vaccine
2. Search for and select the desired type of vaccine, and select the Modify button.
3. Select the CVX Code used to submit immunization records to registries.
Define C-CDA Document Definitions

Core Measure 8: Clinical Summary requires that you provide patients with a clinical summary of each office visit within one business day of the visit. The clinical summary must include diagnostic test results, problem list, medication list, and medication allergy list, and may include other information as appropriate.

The consolidated clinical data architecture document (C-CDA) is by definition designated as a clinical summary document. Use this process to define the sections that you want to include in C-CDA documents. You may create different definitions for different purposes.

1. List Editor icon (🔗) → Integration → CDA Sections
2. Select the New button.
3. In the New CDA Sections window:

   a. Enter a Name for the C-CDA document definition.
   b. Enter an ID and Notes, if desired.
   c. Select the checkbox for each section that you want to include in the C-CDA document.
Configure the Patient URL Launcher for PACS System Access

To report on Menu Set Measure 3: Imaging Results, you must either store your images in the Aprima PRM database or have direct access to an external PACS (picture archiving and communication system), DICOM (digital imaging and communications in medicine) image system, or other imaging system. Direct access to a PACS or DICOM system may be through an optional interface. Or, depending on the imaging system, you may be able to access images in the PACS via a context-sensitive URL.

For the PACS to qualify for this measure, you must be able to configure access to it from Aprima PRM in such a way that you are able to directly access a particular patient’s images from the patient’s chart. This means that the PACS must allow Aprima PRM to pass parameter information to the system through the context-sensitive URL. You must contact the imaging center, hospital, or other owner of the PACS system to find out if the imaging system allows parameter information to be passed to it, and if so, what parameter information it requires.

To access an external PACS from Aprima PRM, you must configure the patient URL launcher functionality. Instructions for configuring the patient URL launcher are included here. However, it is recommended that you contact Support for assistance once you have the obtained the parameter information from the PACS owner.

After you have configured the patient URL launcher, you must configure the user settings definitions used by the providers reporting on this measure. This puts the patient URL launcher on the Patient toolbar, which enables the provider to access the PACS from Full Note Composer and other windows that use that toolbar.

Patient URL Launcher Setup

The Patient URL Launcher add-in application enables you to launch a URL in Windows Explorer (or other Internet browser) to pass the patient external ID to a PACS. You must modify the Patient URL Launcher to identify the URL that you want to launch.

If you have access to more than one PACS, then use these instructions to set up a Patient URL Launcher for each PACS.

1. List Editor icon (.route) → Integration → Add In
2. Highlight the Patient URL Launcher entry.
3. Make a copy for the PACS.
   a. Select the File menu, and the Save As option.
   b. Enter the New Name. Use a name that identifies the PACS. This appears as a tooltip for the user.
   c. Select the OK button.
4. Search for and select the copy of the Patient URL Launcher that you just made, and select the Modify button.
5. In the Data field, enter the desired URL and include any of the following parameters in the appropriate location in the URL string. Enclose the parameters in brackets as shown in the table below.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>{externalid}</td>
<td>Unique ID of the patient</td>
</tr>
<tr>
<td>{mrn}</td>
<td>Patient’s medical record number</td>
</tr>
<tr>
<td>{name}</td>
<td>Patient’s name in the format: First Name Last Name</td>
</tr>
<tr>
<td>{dob}</td>
<td>Patient’s date of birth in the standard short date format: m/d/yyyy</td>
</tr>
<tr>
<td></td>
<td>For example 8/7/1959 or 12/12/2014</td>
</tr>
<tr>
<td>{dob1}</td>
<td>Patient’s date of birth in the format: mmddyyyy</td>
</tr>
<tr>
<td>{phone}</td>
<td>Patient’s phone number in the format: (xxx)xxx-xxxx</td>
</tr>
<tr>
<td>{firstname}</td>
<td>First name</td>
</tr>
<tr>
<td>{middlename}</td>
<td>Middle name</td>
</tr>
<tr>
<td>{middleinitial}</td>
<td>Middle Initial</td>
</tr>
<tr>
<td>{username}</td>
<td>Name of the user in the format: Last name, First name</td>
</tr>
<tr>
<td>{userid}</td>
<td>Unique ID of the user</td>
</tr>
<tr>
<td>{providerid}</td>
<td>Unique ID of the provider. This is blank if the user is not a provider.</td>
</tr>
<tr>
<td>{servicesiteid}</td>
<td>Unique ID of the provider’s default service site. This is blank if the user is not a provider.</td>
</tr>
<tr>
<td>{practicesettingsuid}</td>
<td>Unique ID of the practice.</td>
</tr>
</tbody>
</table>
For example: \texttt{http://www.pm.com/test.asp?mrn=[externalid]}
Associate the Patient URL Launcher with a User Settings Definition

You must associate the copy of the Patient URL Launcher for the PACS with the user settings definitions used by the provider reporting on Menu Set Measure 3: Imaging Results.

1. List Editor icon (🔗) → System → User Setting
2. Select the Add Ins tab.
3. In the Patient Toolbars field, select the copy of the Patient URL Launcher that you made in the previous task. This enables users to launch a URL in Windows Explorer (or other Internet browser) to pass the parameters to the PACS.

If you have more than one PACS, you must select the copy of the Patient URL Launcher for each PACS that you set up.
Configure Syndromic Surveillance Reporting

Menu Set Measure 1: Syndromic Surveillance Data Submission requires ongoing submission of data to a public health agency. The application creates HL7 syndromic surveillance information messages that comply with the standard documented in the *PHIN Messaging Guide for Syndromic Surveillance and Conformance Clarification for EHR Certification of Electronic Syndromic Surveillance*, Addendum to *PHIN Messaging Guide for Syndromic Surveillance*.

To report on Menu Set Measure 1: Syndromic Surveillance Data Submission, you must first contact your state or local public health agency to determine whether they can accept HL7 syndromic surveillance message files, and if so, by what means they receive the files. For example, the agency may have an FTP site to which you may transmit files, or an IP address for receiving files through TCP sockets. Some agencies have their own application, which you must install, configure on your server, and use to transmit files saved on your server to the agency. An agency may also have a website to which you must upload files from your server.

Please note that after receiving your first syndromic surveillance message files, the public health agency may inform you that the files do not meet the agency’s requirements. The agency may, for example, require additional data be included. You must then contact your sales representative to request a custom interface with your public health agency. Since development and testing of the custom interface will take some time, it is recommended that you configure and test the standard syndromic surveillance reporting 60 days prior to the start of your Meaningful Use reporting period.

If your state or local public health agency does not accept HL7 files, then you cannot use this measure as part of your Meaningful Use reporting.

You must also determine the diagnoses that the agency wants reported, and the frequency at which you must report. For example, reporting may be required daily, monthly, annually, etc.

Once you have the information needed from the public health agency, you must perform several tasks to configure the application for syndromic surveillance reporting.

1. Activate and schedule the following interface message jobs. If you have an HL7 interface for another purpose, such as for a lab interface or a device, then these job schedules may already be active and scheduled.
   - Interface Message Listener
   - Interface Message Processor
   - Interface Message Sender

2. Configure the ExportPatientDiagnosisData HL7 partner to define the transmission method of the syndromic surveillance files. This may include simply generating and storing the files in specific folder on the server so they may be transmitted via another application or manually uploaded to a website by a user.
3. Create one or more report filters for generating the Export Patient Diagnosis Data report. This report generates the files used to report the syndromic surveillance information. The report filter defines the diagnoses to be reported and the time period for reporting.

To report syndromic surveillance information, a user must generate the Export Patient Diagnosis Data report in accordance with the agency’s reporting frequency requirements. The report generates a file for each patient with the selected diagnosis, and stores the file in the folder specified in your ExportPatientDiagnosisData HL7 partner record. Depending on the agency’s capabilities and your database configuration, the files are either transmitted automatically to the agency or a user must transmit the files via another application or upload process.

**Activate the Interface Message Jobs**

Activate the job schedules for the following jobs. If you have an HL7 interface for another purpose, such as for a lab interface or a device, then these job schedules may already be active.

- Interface Message Listener
- Interface Message Processor
- Interface Message Sender

You must also define the users or user groups to receive message when a job fails.

1. List Editor → System → Job Schedule
2. Search for and select the desired job (Listener, Processor, Creator, or Sender). Then select the Modify button.
3. Deselect the Inactive checkbox.
4. In the Notify Users field, select one or more users and/or user groups to notify.
5. Select the On Success checkbox, the On Failure checkbox, or both.

**Define Job Schedules**

You can define the schedules for jobs to run from List Editor.

**Note:** You should only change the time. When you have selected the job, do not edit any other information on the window because the other information is specific to the job.

1. List Editor → System → Job Schedule
2. Search for and select the desired job (Listener, Processor, Creator, or Sender). Then select the Modify button.
3. Update the Start Time as required. It is recommended that you leave the time interval at the default.
Modify the ExportPatientDiagnosisData HL7 Partner Record

Configure the ExportPatientDiagnosisData partner record to store or transmit the HL7 syndromic surveillance files. You must configure the record for the transmission method used by your public health agency. Transmission methods include TCP sockets, FTP, and web service. Or you may define a location on the server where files are created and stored so that later the files may be uploaded manually or are uploaded via another application.

1. List Editor → Interface Engine → HL7 Partner
2. Search for and select the ExportPatientDiagnosisData record, and select the Modify button.

![Modify HL7 Partner - ExportPatientDiagnosisData](image)

3. Select the Test Mode checkbox only if transactions to and from the HL7 partner are for testing only.

4. Do not change the following fields unless instructed to do so by Support.
   - Segment Separator
   - Ack Conn
   - Send Ack
   - Receive Ack
   - Start Message
   - Stop Message
   - HL7 Message Structure
5. If patients must consent before sending information to this HL7 partner:
   a. Select the Patient Consent Required checkbox.
   b. Select the appropriate radio button for the default consent setting for patients. The setting for patients may either default to ‘does not consent’ or to ‘does consent’. Selecting the ‘does not consent’ will prevent accidental disclosure of patient information.

6. Select the Files tab if the sending mechanism is a file system or FTP.
   a. The Send Msg Directory field should contain the full path to the location where the files will be sent by the application.
      • For a file system, the path should be in the format c:\folder1\FromAprima
      • For FTP, absolute paths are required. For example, /user/home/FTPUnder
   b. The Send File Prefix and Send File Suffix fields are used to differentiate file names when sending messages to different locations.
   c. The Recv Msg Directory field should contain the full path to the location where the files will be sent by the application.
      • For a file system, the path should be in the format c:\folder1\ToAprima
      • For FTP, absolute paths are required. For example, /user/home/FTPUnder
   d. The Receive File Prefix and Receive File Suffix fields are used to differentiate file names when receiving messages from different locations.

7. Select the TCP Sockets tab if the sending mechanism is TCP sockets.
   a. Enter the IP Address of the server where the Partner’s HL7 interface resides.
   b. The Send Port is the port on which the external system is expecting to receive messages from the application. This port is used when the sending method being used is TCP.
   c. The Receive Port is the port on which the external system is expecting to send messages to the application. This port is used when the receiving method being used is TCP.
   d. The Keep Alive field identifies the number of seconds the port is kept open.
   e. The Queue Length field identifies the size of the buffer for sending and receiving data. When the buffer is not large enough, the data will be written to it faster than data in it is removed, resulting in a lost data.

8. Select the FTP tab if the sending mechanism is FTP.
   a. The FTP Server Address is the IP address or name of the server that you are sending to or receiving from.
   b. The FTP Port is the port on the server that you are sending to or receiving from.
   c. The FTP Protocol is the protocol used for transmission.
   d. The FTP Server Username is the user name used to log into the FTP server.
   e. The FTP Server password is the password used to log into the FTP server.
   f. The FTP Download Path is the full path for downloading files from the FTP server.
g. The Recv File Prefix and Recv File Suffix fields are used to differentiate file names when there are multiple files in the download path.

9. Select the Web Service tab if the sending mechanism is a web service.
   a. The Order Service URL specifies the URL of the order service.
   b. The Result Service URL specifies the URL of the result service.
   c. The Username is the user name used to log into the web service.
   d. The Password is the password used to log into the web service.

Define Report Filters for the Export Patient Diagnosis Data Report

The Export Patient Diagnosis Data report generates the HL7 files used for syndromic surveillance reporting. It is recommended that you define one or more report filters identifying the diagnosis codes that must be reported and the reporting frequency. Users can generate the report without a filter, but a filter definition helps ensure that the generated files comply with the public health agency’s requirements.

Note: When creating a filter for this report, do not attempt to schedule the report. The schedule report functionality does not work for the Export Patient Diagnosis Data report since it generates files rather than producing a document for printing.

1. Reports ( ) icon
2. In the reports list, expand the General Reports folder.
3. Select the Export Patient Diagnosis Data report.

4. Select the Diagnosis code or codes that must be reported to the public health agency.
5. In the Visit Date field, select the time period for which you must report.
6. If desired, select the Set as My Default Filter checkbox to use the filter as your default for this report.
7. Select the appropriate radio button to make the filter available to you only or to Everyone.
   Note: The Everyone radio button will be enabled only if you have the security access needed to create filters for everyone’s use.

8. Select the Save As button.

9. Enter a name for the search filter.

Defining Licensed Healthcare Professionals

When a user qualifies as a licensed healthcare professional for Meaningful Use, PQRS, and other quality programs, then you must define this in the user record. The user must have a qualifying license issued by the state. Credentials issued by a hospital or other similar entity do not qualify as ‘licensed’.

By default, a user record that is associated with a provider record, is defined as a licensed healthcare professional.

When a user has been granted clinical delegate rights to create orders or write prescriptions for a provider, then they must be identified as a licensed healthcare professional to count for Core Measure 1: CPOE. It is important that users be properly defined to ensure your Meaningful Use and other quality program reporting is correct.

1. List Editor icon (損害) → System → User
2. Search for and select the desired user entry, and select the Modify button.
3. Select the Settings tab.
4. Select the Licensed Healthcare Professional checkbox. The checkbox will be selected and disabled if the user is a provider.

Ref: 1111.06
Grant Clinical Delegate Security

Any licensed healthcare professionals and credentialed medical assistants, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.

Clinical delegate security enables you to grant security rights to users to whom the provider may delegate certain activities. These activities include:

- Marking visit notes as complete.
- Sending direct emails through the HISP.
- Creating orders for lab tests and other medical services.
  Please note that if the user does not have delegate rights for the provider on the visit note, then the application will not allow the user to select a procedure code defined to generate an order when working in the SO tab of Full Note Composer or other clinical note type.
- Creating prescriptions.

A user must have security rights for clinical functions in order to be granted delegate rights for a provider.

Assign Clinical Delegate Security for a Provider

1. List Editor icon ( ) → System → Provider
2. Search for and select the desired provider entry, and select the Modify button.
4. Highlight the item to which you want to assign security rights.
5. Select the User or User Group to whom you want to assign rights, and select the Allow checkbox.

6. Select the Set Same Security for Like Items button if you want to assign the same users or user groups to all the items.

Drug Screening Configuration

Drug screening is required for core measures and for clinical quality measures. Ensure that the necessary screening is configured for both the practice and for each provider.

Configure Drug Screening for the Practice

1. Tools → Configure Practice Settings → Drug Screening tab

2. Select the Drug To Drug Interaction checkbox.

3. Select the desired Drug-To-Drug Severity level. The default setting is ‘Unknown, Contraindicated, and Severe’.

   There is no minimum setting based on the Meaningful Use requirements. You, as the provider, must determine the level appropriate for your practice.

4. Select the Allergies Precautions checkbox.

5. Select the desired Allergy Match items. All items are selected by default.

   There is no minimum setting based on the Meaningful Use requirements. You, as the provider, must determine the level appropriate for your practice.

6. Select the Geriatric Precautions checkbox. This is needed only if you see patients who are 65 years old or older.

Ref: 1111.06
7. In the Minimum Geriatric Age field, select 65. This is needed only if you see patients who are 65 years old or older.

8. Select other screening items as desired.

**Configure Drug Screening for a Provider**

1. List Editor → System → Provider

2. Search for and select the desired provider, and select the Modify button.

3. Select the Drug Screening tab.

4. Either:
   - Select the Use Practice Setting checkbox if drug screening is correctly set for the practice and if the provider does not need any modification to the practice settings. If selected, this task is complete.
   - Deselect the Use Practice Setting checkbox if the provider needs settings that are different from the practice settings. You must complete the remaining steps of this task.

5. Select the Drug To Drug Interaction checkbox.

6. Select the desired Drug-To-Drug Severity level. The default setting is ‘Unknown, Contraindicated, and Severe’.

   There is no minimum setting based on the Meaningful Use requirements. You, as the provider, must determine the level appropriate for your practice.

7. Select the Allergies Precautions checkbox.

8. Select the desired Allergy Match items. All items are selected by default.

   There is no minimum setting based on the Meaningful Use requirements. You, as the provider, must determine the level appropriate for your practice.

9. Select the Geriatric Precautions checkbox. This is needed only if you see patients who are 65 years old or older.

10. In the Minimum Geriatric Age field, select 65. This is needed only if you see patients who are 65 years old or older.

11. Select other screening items as desired.

**Enter Practice, Provider, Insurance Payer, and Patient Information**

The following information is required to calculate, monitor, and report on Meaningful Use compliance.
Practice Information

Practice information is entered in the Configure Practice Settings window. You must enter the following:

- Practice name
- Practice address, including state and ZIP code
- Service site addresses, including state and ZIP code

Provider Information

Provider information is entered in the Provider window. The following information must be entered in the provider record for each provider participating in the program. The provider’s employer tax identification number (ETIN) and NPI numbers must be correctly entered in the Provider window’s ID Values tab.

The ETIN and NPI numbers must be entered through the system-defined claim format value types. If these IDs are entered through user-defined claim format value types, then the ID numbers will not report properly.

- First and last name
- Specialty
- Primary phone number
- NPI number
- ETIN number

Patient Information

Patient information is entered in the Patient and Account windows. The Department of Health and Human Services’ (HHS) requirements for Meaningful Use of health information technology includes the following demographic information. If you are participating in the Meaningful Use program, you should enter this information for all patients.

- First and last name
- Gender
- Date of birth
- Race
- Ethnicity
  For both race and ethnicity, you may select the Not Provided option if the patient chooses not to provide specific information. If, however, you leave either of these fields empty, the patient will not meet the reporting requirements for any Meaningful Use measure that includes this demographic information.
- Language
You must make a selection for each required item of information even if a patient declines to give some information or if state law prohibits you from asking for some information. You may use the system-defined Not Provided entries for race and ethnicity. You may also create custom entries for gender, language, race, and ethnicity to indicate that the patient declined to give this information or that state law prohibits requesting it.

It is also recommended that you enter the patient’s preferred contact method. This is not necessary to include patients in measure denominators. However, Core Measure 12: Preventive Care requires that you contact patients using the patient’s preferred method of contact.

Patient Status for Test Patient

The application includes a system-defined patient status for Test Patient. Use this patient status to identify patient records that are used for application testing or training, and are not actual patients. Patient records with this status are not included in Meaningful Use reporting and may be excluded from other reports that filter on patient status.

Set Up the Patient Portal and Patient Accounts

Core Measure 7: Patient Electronic Access requires the use of the Aprima Patient Portal. To report on this menu set measure, you must purchase, implement, and setup the Patient Portal.

There are several other measures that are most easily satisfied by using the Patient Portal.

Configure the Patient Portal Error Message Recipients

1. Tools → Configure Practice Settings
2. Select the Message Routing tab.
3. In the Patient Portal Error Messages field, select the user group to receive error messages for the Portal.
Configure the Patient Portal

1. Tools → Configure Patient Portal Settings
2. Select the Consent tab.
3. In the Practice Consent Text field, enter your practice’s consent statement for using the Patient Portal. This statement will be presented to the patient at the first login, and must be accepted before the patient is allowed access to any functionality.
   This field limited to 1,000 characters. The following characters are not allowed: /, \, <, >, %, !, :,'#, ”
4. In the Chart Consent Text field, enter your practice’s consent statement for accessing information from the patient’s chart. This statement will be presented to the patient at login, and must be accepted before the patient is allowed access to those functions that display information from the patient’s chart.
   This field limited to 1,000 characters. The following characters are not allowed: /, \, <, >, %, !, :,'#, ”
5. Either:
   • Select the ‘Always Display Chart Consent’ checkbox if you want your chart consent statement presented to the patient every time the patient logs in for self-service functions.
   • Deselect the ‘Always Display Chart Consent’ checkbox if you want your chart consent statement presented to the patient only the first time that the patient logs in for self-service functions.
6. In the Patient Portal Tag Line field, enter a brief statement that will appear on the login window, if desired. This field limited to 100 characters. The following characters are not allowed: /, \, <, >, %, !, :,'#, ”
7. In the Patient Portal Internet URL field, enter your practice’s complete URL or website address (for example, www.aprima.com) This field is available for use in document formatting models used to generate emails generated for patients using the Patient Portal.
8. Select the Functions tab to enable patient self-service functions.
9. Select the checkboxes for the functionality that you want to enable for patients. or Meaningful Use, this must include the following items and the items specifically identified in the following steps.
   • Allow patients to send and receive messages
   • Allow patients to view educational material
   • Allow patients to view lab test results
   • Allow patients to view medical history
   • Allow patients to view medication allergies
   • Allow patients to view medication
10. When you select the checkbox for the ‘To View Clinical Summary’ option, a popup window will appear so that you can select the clinical summary document formatting model that you want to make available to patients.

   a. Select the desired Clinical Summary.
   b. Select the ‘Allow Patients to View Clinical Summary’ checkbox.
   c. Select the OK button.

11. When you select the checkbox for the ‘To View Complete Chart’ option, a popup window will appear so that you can select the complete chart document formatting model that you want to make available to patients.

   a. Select the desired Complete Chart.
   b. Select the ‘Allow Patients to View Complete Chart’ checkbox.
   c. Select the OK button.

12. When you select the checkbox for the ‘To View Immunizations’ option, a popup window will appear so that you can select the vaccine administration records that you want to make available to patients.

   a. Select the desired Pediatric vaccine administration record
   b. Select the desired Adult vaccine administration record.
   c. Select the ‘Allow Patients to View Immunizations’ checkbox.
   d. Select the OK button.
13. When you select the checkbox for the ‘Allow Patients to Request Assistance from the Login Page’ option, then you must also:
   a. In the Patient Message Routing area, scroll down to the Question - Login Assistance item.
   b. Select the user group to receive login assistance requests.
   c. Verify that the Send Email When Portal Password is Reset by Patient checkbox is selected.

14. Select the Message Routing tab to define the recipients for messages received from patients as a result of their self-service activities.
   a. Scroll through the list to find the desired type of patient message.
   b. Select the user group to receive this type of message.
   c. Select the ‘Allow Messages to be Sent from Portal to PRM’ checkbox.

15. Select the Email Notification tab to define the patient Internet email settings. These practice settings can be overwritten at the provider level if desired.
   a. Select the Enable Sending Internet Emails to Patients checkbox if you want to send welcome and notification emails to patients.
   b. In the Practice From Email field, enter the email address from which all welcome and notification emails are sent. A valid email address will allow patients to reply. If you do not want patients to reply, then enter ‘donotreply@youroffice.com’.
   c. Select the checkbox for each type of email message you want to send. You may send emails to patients:
      • When a new patient record is created and the patient record identifies the provider in your practice who is primarily responsible for the patient’s care.
      • When a new patient record is created, but the patient record does not identify a provider in your practice who is primarily responsible for the patient’s care.
      • When a web account is created for the patient enabling them to access the Patient Portal.
      • When the Portal password is reset by the patient.

Create a Patient Account

1. Patient Demographics → Questionnaire Tab
2. Select the Create Web Account button.
3. Enter a logon name for the patient or accept the default name. The default is the patient’s email address, if entered, or the patient’s first and last names.
4. Accept the randomly generated password, or select Reset Password to generate another password.
Set Up the HISP and Direct Mail Addresses

Core Measure 15: Summary of Care requires the use of a health information systems program (HISP) to satisfy the second and third parts of the measure. Aprima’s HISP is Nitor. Nitor is a member of DirectTrust and is in the DirectTrust Transitional Trust Anchor Bundle. Nitor is able to communicate with other HISPs in this bundle. A list of the HISPs in bundle is available from the DirectTrust website at http://www.directtrust.org/trust-bundles/

This optional functionality does not require enrollment or licensing. However, there is a fee for each provider direct mail email address that you set up with Nitor.

1. Set up the DirectCommunication job and job schedule.
2. You must also set up the AprimaVault Downloader, AprimaVault Outbound Queuing, and AprimaVault Sender jobs and job schedules. These jobs and job schedules will already be set up if you are using electronic prescribing or insurance eligibility processing.
3. Enable the integration partner record for Nitor.
4. Create your internal providers’ direct mail addresses in their provider records.
   Please note that you cannot use a standard email address (such as johndoe@yahoo.com or johndoe@medclinic.com) for direct mail through the HISP. You must create a HISP direct mail address.
5. Enter direct mail addresses for external providers and medical service providers to whom you want to be able to send documents.
   You must contact the provider to obtain their direct mail address. You cannot get provider direct mail addresses from Nitor or DirectTrust.
   Please note that you cannot use a standard email address (such as johndoe@yahoo.com or johndoe@medclinic.com) for direct mail through the HISP. You must use the recipient’s HISP direct mail address.
6. Define clinical delegate security for all internal providers who will use direct mail and for any users who will send documents on a provider’s behalf.

Set Up the Jobs and Job Schedules

You must configure the DirectCommunication job and its job schedule. The job communicates with the HISP to receive direct mail.

You must also set up the AprimaVault Downloader, AprimaVault Outbound Queuing, and AprimaVault Sender jobs and job schedules to send direct mail. These jobs and job schedules will already be set up if you are using electronic prescribing or insurance eligibility processing.
Define Notification Recipients for the DirectCommunication Job

You must define users or user groups to receive messages when a job fails. If desired, you can define users or user groups to receive messages when the job is successful.

1. List Editor icon (🔗) → Integration → Jobs
2. Search for and select the DirectCommunication job, and select the Modify button.
3. Add an ID and Notes, if desired.
4. In the Notify Users field, select one or more users and/or user groups to notify on the success or failure of the job when it runs.
5. Select the On Success checkbox, the On Failure checkbox, or both.
6. Select the OK button to save the job.
7. Select the Include Inactive Items checkbox, and search for the job names that begin with ‘AprimaVault’.
   - If any of these job names is shown in italics, then the job is inactive. Go to step 8 to activate the job.
   - If the job name is shown in regular text, then job is active. No further action is needed for the active jobs.
8. Highlight the inactive ‘AprimaVault’ job, and select the Modify button.
10. In the Notify Users field, select one or more users and/or user groups to notify on the success or failure of the job when it runs.
11. Select the On Success checkbox, the On Failure checkbox, or both.
12. Select the OK button to save the job.
13. Repeat steps 8 through 12 for each inactive ‘AprimaVault’ job.

Schedule the Jobs

You must activate the job schedule for the DirectCommunication job and the AprimaVault jobs. It is recommended that you accept the default repeat parameters for these jobs.

1. List Editor icon (🔗) → System → Job Schedule
2. Select the Include Inactive Items checkbox,
3. Search for and select the DirectCommunication job, and select the Modify button.
4. Unselect the Inactive checkbox.
5. Select the OK button to save and activate the job schedule.
6. With the Include Inactive Items checkbox selected, and search for the job schedule names that begin with ‘AprimaVault’.
   - If any of these job schedule name is shown in italics, then the job is inactive. Go to step 7 to activate the job schedule.
• If the job schedule name is shown in regular text, then job schedule is active. No further action is needed for the active jobs.

7. Highlight the inactive ‘AprimaVault’ job schedule, and select the Modify button.
8. Deselect the Inactive checkbox.
9. Select the OK button to save the change and activate the job schedule.
10. Repeat steps 7 through 9 for each inactive ‘AprimaVault’ job schedule.

**Enable the Integration Partner Record for Nitor**

Perform the following process to enable and configure the integration partner record. You must have set up the DirectCommunication and the AprimaVault jobs and jobs schedules before performing this task.

1. List Editor icon ( ) → Interface Engine → Integration Partner
2. Select the Include Inactive checkbox, and select the Search button.
3. Select the Nitor Direct Mail Service entry, and select the Modify button.
   
   **Note:** Do not select the Nitor TEST Direct Mail Service entry. This integration partner is used for Aprima testing purposes only. This cannot be used for end user testing or for actual direct mail.
4. Deselect the Inactive checkbox to activate the integration partner record.
5. In the Integration Partner window, select the Create Account button.

![Integration Partner Record](image)
6. When the Create Direct Mail Facility Account popup window appears, select the Create button.
   This creates the accounts needed to send and receive messages from the Nitor HISP. Then populates the necessary configuration fields.

7. Select the OK button to save the configuration information.
Create an Internal Provider’s Direct Mail Email Address

You must create a Nitor HISP direct mail address for each of your internal providers who will use direct mail through the HISP.

Please note that you cannot use a standard email address (such as johndoe@yahoo.com or johndoe@medclinic.com) for direct mail through the HISP. You must create a HISP email address.

1. List Editor icon (🔗) → System → Provider
2. Search for and select the desired provider, and select the Modify button.
3. Select the Direct Mail tab.

![Modify Provider Direct Mail Tab]

4. Select the From Address radio button. This is the address the provider will use to send and receive direct mail messages.
5. In the Integration Partner field, select the Nitor Direct Mail Service entry.
6. In the Address field, enter the direct mail address desired for the provider. The Nitor domain name portion of the address (following the @) is automatically populated.
   All direct mail addresses created within Aprima PRM for internal providers will be in the following format. The address does not identify Nitor.
   
   `<NameYouSelect>@direct.aprima.com`

7. Select the Available button to verify whether the desired mail address is available or already in use. If the address is available, then continue with the setup. If the address is already in use, then repeat steps 6 and 7 until you identify an available address.
8. If the provider has another direct mail address, then you may enter that address so that your practice can send direct mail to it. A provider may have another direct address if, for example, the provider has a direct mail address through a hospital EHR system.
   a. Select the To Address radio button.
   b. In the Address field, enter the complete direct mail address for the provider.
9. Select the OK button to save the direct mail addresses.
10. A popup message displays reminding you of the monthly charge for the Nitor direct mail address.

- To accept the charges and create the direct mail address, select the OK button.
- To refuse the charges and cancel the direct mail address, select the Cancel button.

**Enter an External Provider’s Direct Communication Email Address**

You must also enter the direct mail address for any external providers to whom your providers will send documents. You must contact the provider to obtain their direct mail address. You cannot get provider direct mail addresses from Nitor or DirectTrust.

You cannot use a standard email address (such as johndoe@yahoo.com or johndoe@medclinic.com) for direct mail through the HISP. This must be a HISP email address.

The following procedure assumes that a provider record for the external provider already exists. If a provider to whom you will send transition of care documents is not already defined in your database, then you must create an external provider record for that provider. Please refer to the *Administrative User’s Guide* or the online help for complete instructions.

1. List Editor icon (️) → System → Provider
2. Select the Include External Providers checkbox.
3. Search for and select the desired provider, and select the Modify button.
4. Select the Direct Mail tab.

![Direct Mail Tab Image]

5. The To Address radio button will be selected. The From Address radio button is disabled for external providers.

6. In the Address field, enter the complete direct mail address for the provider. You must contact the provider to obtain their direct mail address. You cannot get provider direct mail addresses from Nitor or DirectTrust.

   Remember that you cannot use a standard email address (such as johndoe@yahoo.com or johndoe@medclinic.com) to send direct mail through the HISp.

7. Repeat steps 5 and 6 for additional direct mail addresses for the provider, if desired.

8. If you enter multiple addresses for the provider, you must select the Default checkbox for one of the addresses. This is the address the application will default when sending direct mail to this provider.

Enter a Medical Service Provider’s Direct Communication Email Address

You may enter one or direct mail addresses for medical service providers to whom you send documents. You must contact the provider to obtain their direct mail address. You cannot get provider direct mail addresses from Nitor or DirectTrust.

You cannot use a standard email address (such as johndoe@yahoo.com or johndoe@medclinic.com) for direct mail through the HISp. This must be a HISp email address.

The following procedure assumes that a medical service provider record already exists for the entity. If a medical service provider to whom you will send direct mail is not already defined in your database, then you must create a medical service provider record for that entity. Please refer to the Administrative User’s Guide or the online help for complete instructions.
1. List Editor icon (🔗) → Demographics → Medical Service Provider
2. Search for and select the desired provider, and select the Modify button.
3. Select the Direct Mail tab.

![Direct Mail Tab Image]

4. The To Address radio button will be selected. The From Address radio button is disabled for medical service providers.

5. In the Address field, enter the complete direct mail address for the medical service provider. You must contact the provider to obtain their direct mail address. You cannot get provider direct mail addresses from Nitor or DirectTrust.

   Remember that you cannot use a standard email address (such as johndoe@yahoo.com or johndoe@medclinic.com) to send direct mail through the HISP.

6. Repeat steps 4 and 5 for additional direct mail addresses for the medical service provider, if desired.

7. If you enter multiple addresses for the medical service provider, you must select the Default checkbox for one of the addresses. This is the address the application will default when sending direct mail to this medical service provider.
Assign Clinical Delegate Security for a Provider

Define clinical delegate security for all providers who will use direct mail and for any users who will send documents on a provider’s behalf.

1. List Editor icon → System → Provider
2. Search for and select the desired provider entry, and select the Modify button.

![Diagram of Clinical Delegate Security settings]

4. Highlight the Can Send Direct Mail item.
5. In the User or User Group field, select the provider and select the Allow checkbox.
6. In the User or User Group field, select any other users to whom you want to assign rights, and select the Allow checkbox.
7. Select the Set Same Security for Like Items button if you want to assign the same users or user groups to all the items.
Measure Charting Details

The following sections summarize each core and menu set measure, and describe the charting or other tasks that you must perform for each measure. It is your responsibility to understand and comply with the measure requirements, including exclusions and exceptions. The CMS website provides information about the measures at the following link: 

Meaningful use measures are based on your total patient population, not just Medicare patients. Please note that to report on any measure, the patients’ demographic information must include the birth date, gender, race, and ethnicity.

Unless otherwise stated in the measure details, the patient must have at least one E&M visit with the provider during the reporting period to qualify for the denominator.

Patients with a status of Test and patients who have a death date prior to the start of the reporting period are not included in the denominator for any measure. The denominator does include patients with a status of Inactive and patients who have a death date during or after the reporting period.

Visit notes that have been struck out do not count for the denominator or numerator of any measure. Deleted or struck out items (such as, diagnosis codes, history answers, orders, etc.) do not count for the numerator of any measure.

Please note that individual measures may have additional qualifying and excluding characteristics that are not described in this document. Please refer to CMS for complete measure descriptions and information, including qualifying and excluding characteristics for each measure.

Meaningful use measures must be reported for individual providers. Reporting cannot be done for the practice as a whole. To demonstrate meaningful use for Stage 2, you, as an individual provider, must report on:

- All 17 of the core measures,
- Any 3 measures from menu set measures, and
Core Measures

Each participating provider must report all 17 of the core measures.

Core Measure 1: CPOE (Computerized Provider Order Entry) for Medication, Laboratory and Radiology Orders

Use computerized provider order entry (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.

More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the eligible professional (EP) during the EHR reporting period are recorded using CPOE.

Information about this measure is available from the CMS website at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_1_CPOE_MedicationOrders.pdf

Exclusion

Any EP who writes fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period.

Entering Data

An E&M visit during the reporting period is not necessary for a patient to be included for this measure. The prescription must be written or the order placed within the reporting period. This is determined by the date on the prescription or the order, not the date of the associated visit.

For medications, the user writing the prescription must be identified in the database as a licensed healthcare professional. Aprima PRM determines this by whether the user is marked as a licensed healthcare professional in the database (List Editor → System → User → Settings tab). If the user is not a provider, then the user must also have clinical delegate security for the provider (List Editor → System → Provider → Clinical Delegate Security tab).

You must write a prescription through the SIG Writer window or refill message, and either print it or submit it electronically through the Surescripts pharmacy clearinghouse.

To meet the measure’s medication goal, as the provider or licensed healthcare professional, you must enter the prescription in the SIG Writer window or refill message for more than 60 percent of your qualifying prescriptions during the reporting period. The prescription counts for the prescribing provider identified on the prescription.

You may use the Track Prescriptions window (Tools menu → Track Rx) to review and troubleshoot your prescriptions.
To report on this measure for laboratory and radiology orders, the eligible provider must chart a procedure with the procedure code type of Lab or Radiology. The procedure code must also be defined to generate an order. You may chart the procedure in either the SP or SO tab of Full Note Composer or other clinical note type window. To meet the measure’s laboratory and radiology goals, you must enter orders for more than 30 percent of your lab test and radiology orders. The order counts for the ordering provider identified in the order.

Radiology procedures with a CPT code in the 70000 range have the procedure code type Radiology. Laboratory procedures with a CPT code in the 80000 range have the procedure code type Lab. The 70000 and 80000 range procedure codes are also defined to generate an order. If you create custom procedure codes for lab or radiology orders, you must give them the correct procedure code type and define them to generate an order.

The procedure code must be defined to generate an order at the time that you chart the procedure. If the procedure code is not set to generate an order, then the application will not generate an order when you chart the procedure. Orders cannot be generated retroactively.

The Meaningful Use Stage 2 report includes three sub-measures for this measure. Sub-measure 1 is for prescriptions, sub-measure 2 is for radiology orders, and sub-measure 3 is for laboratory orders.

When considering your numbers, please be aware that:

- Prescriptions and orders that are deleted do not count for this measure.
- Procedures with a negation reason entered are not counted since they are not ordered.
- Future orders are counted if the future date on the order is included in your reporting period.

Please also remember that medication, laboratory, and radiology orders are calculated independently of each other.

**Troubleshooting**

Please note that sub-measure 1 includes administered medications and samples given as well as prescriptions. This measure includes prescriptions for controlled substances, and complex (stepped) prescriptions. Therefore, the denominator and numerator for this measure will be different from the denominator and numerator for Core Measure 2: e-Prescribing (eRx).

Prescriptions that are deleted do not count for this measure.

You may use the Track Prescriptions window (Tools menu → Track Rx) to review and troubleshoot your prescriptions. You can use this window to search for prescriptions printed or prescribed electronically. Administered medications and sample given prescriptions are included with printed prescriptions in this window. You may need to change the Maximum Items Returned in the filtering criteria to get an accurate count for a patient or time period.
For sub-measures 2 and 3, a procedure entered on the SP or SO tab that does not have a procedure type of Lab or Radiology will still be identified as an order and counted for this measure if results are associated with the order and those results have an attachment type of Lab Results or of Radiology Results.

Lab and radiology orders that have a negation reason or are deleted do not count for this measure.

Core Measure 2: e-Prescribing (eRx)

Generate and transmit permissible prescriptions electronically (eRx).

More than 50 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT (certified EHR technology).


Exclusion

Any EP who:

(1) Writes fewer than 100 permissible prescriptions during the EHR reporting period.

(2) 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.

Entering Data

An E&M visit during the reporting period is not necessary for a patient to be included for this measure. Prescriptions must be written during the reporting period. This is determined by the prescription date, not the visit date.

To report on this measure, you must obtain drug formulary information for 50 percent of permissible prescriptions within 30 days prior to writing the prescription. You must also then submit the prescription electronically.

Drug formulary information is obtained from the Surescripts pharmacy clearinghouse. The request may be done automatically by a job within the application. The job requests and obtains drug formulary information for patients with scheduled appointments for the following day. Requests are also automatically made when an electronic refill request is received and when a user creates a refill request message.

The request may also be made on demand by any user from the Appointment window or from Patient Demographics when a patient did not have an appointment scheduled in advance, such as a walk-in visit or a same day appointment.
The prescription counts for the prescribing provider on the prescription, even if another provider or user enters and submits the prescription.

Write the prescription through the SIG Writer window or refill a prescription from the prescription refill message, and then submit it electronically through the Surescripts pharmacy clearinghouse. Prescriptions sent through Surescripts to fax-only pharmacies meet the requirements for this measure. Prescriptions which are faxed to a pharmacy using a fax service do not meet the requirements for this measure.

This measure applies only to prescriptions for medications that may be electronically prescribed. Prescriptions that are not applicable for this measure include:

- Controlled substances
- Complex (stepped) prescriptions
- User-defined medications
- Non-dispensable medications, such as bulk aspirin
- Administered medications
- Samples given

The prescription status must be either Transmitted Successfully or Queued for Transmission.

Troubleshooting

Please note that the denominator and numerator for this measure will be different from the denominator and numerator for Core Measure 1: CPOE (Computerized Provider Order Entry) for Medication, Laboratory and Radiology Orders, sub-measure 1 for medications. Please see the troubleshooting section for that measure for more information.

You may use the Track Prescriptions window (Tools menu → Track Rx) to review and troubleshoot your prescriptions. You can use this window to search for electronically prescribed medications. You may need to change the Maximum Items Returned in the filtering criteria to get an accurate count for a patient or time period.

Core Measure 3: Record Demographics

Record the following demographics: preferred language, sex, race, ethnicity, date of birth.

More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.

Information about this measure is available from the CMS website at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_3_RecordingDemographics.pdf

Ref: 1111.06
Exclusion

No exclusion.

Entering Data

To report on this measure, you must enter the patient’s first and last name, date of birth, gender, language, race, and ethnicity in the Patient window.

To meet the measure’s goal, you must enter all the required demographics data for more than 80 percent of your qualifying patients seen during the reporting period.

You must make a selection for each required item of information even if a patient declines to give some information or if state law prohibits you from asking for some information. You may use the system-defined Not Provided entries for race and ethnicity. You may also create custom entries for gender, language, race, and ethnicity to indicate that the patient declined to give this information or that state law prohibits requesting it.

Note: If you are using a third-party practice management system and are entering patient information in that system, you must confirm that all the required demographic information is entered in the Aprima PRM Patient window. Some third-party practice management systems do not allow you to enter language, race, and ethnicity. Also, even if the third-party practice management systems does allow language, race, and ethnicity to be entered, the interface between your third-party practice management system and Aprima PRM may not include these items. In either of these cases, you will need to edit the patient record once it has been created in Aprima PRM.

Core Measure 4: Record Vital Signs

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 O-20 years, including BMI.

More than 80 percent 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.

Core Measure 4 Sub-Measure 1

- Denominator is all patients, of any age, seen by the provider in the reporting period
- Numerator is the total of:
  - Patients less than 3 years old who have height and weight entered, and
  - Patients 3 years old and greater who have height, weight, and blood pressure entered.

Core Measure 4 Sub-Measure 2

- Denominator is all patients, of any age, seen by the provider in the reporting period
- Numerator is patients, of any age, who have height and weight entered
Core Measure 4 Sub-Measure 3

- Denominator is patients 3 years old and older, seen by the provider in the reporting period
- Numerator is patients 3 years old and older, who have blood pressure entered


Exclusion

Any EP who:

(1) Sees no patients 3 years or older is excluded from recording blood pressure. (Use sub-measure 2 from the report.)

(2) Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them. (Use sub-measure 1 from the report.)

(3) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. (Use sub-measure 2 from the report.)

(4) 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. (Use sub-measure 3 from the report.)

If not claiming any exclusions, use sub-measure 1 from the report.
**Entering Data**

You must determine the sub-measure applicable to your practice. Please note that you only have to attest to one of the sub-measure options. Use the table below to determine the sub-measure you will use and the vitals you must enter.

<table>
<thead>
<tr>
<th>Vitals Relevant to Provider</th>
<th>Sub-Measure to Use</th>
<th>Vitals to Enter</th>
</tr>
</thead>
<tbody>
<tr>
<td>All three vitals are relevant to your practice.</td>
<td>Sub-measure 1</td>
<td>Enter height and weight all patients of any age, and enter blood pressure for all patients 3-years old and older.</td>
</tr>
<tr>
<td>All three vital signs are not relevant to your practice.</td>
<td>Sub-measure 1</td>
<td>Do not enter vitals. Your numerator will be 0.</td>
</tr>
<tr>
<td>Height and weight are relevant to your practice, but blood pressure is not.</td>
<td>Sub-measure 2</td>
<td>Enter height and weight all patients of any age.</td>
</tr>
<tr>
<td>Blood pressure is relevant to your practice, but height and weight are not.</td>
<td>Sub-measure 3</td>
<td>Enter blood pressure for all patients 3-years old and older.</td>
</tr>
</tbody>
</table>

Although the information is required per patient, not per visit, you must enter the vital signs in at least one visit note during the reporting period. Enter the patient’s vital signs in the Vitals tab of Full Note Composer or other clinical note type window. You must enter this information in the system-defined data fields. Entries in custom data fields do not count for this measure.

The application calculates and displays the patient’s BMI when both height and weight are entered. This is part of the measure goal and CMS encourages you to view the BMI, but it is not required for identifying patients in the numerator for the measure.

For patients 20 years old or younger, you must also plot and display the height, weight, and BMI growth charts. This is part of the measure goal and CMS encourages you to view the growth chart, but it is not required for identifying patients in the numerator for the measure.

Please note that deleted vitals entries are not used for this measure.
Core Measure 5: Record Smoking Status

Record smoking status for patients 13 years old or older.

More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Information about this measure is available from the CMS website at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_5_RecordSmokingStatus.pdf

Exclusion

Any EP that neither sees nor admits any patients 13 years old or older.

Entering Data

To report on this measure, you must enter the patient’s use or non-use of tobacco in the Hx tab, Social History category, in Full Note Composer or other clinical note type window. This entry must be active during the reporting period.

The tobacco history answer selected must be associated with a valid and appropriate SNOMED code in order to qualify. The following system-defined tobacco history answers are associated with the correct SNOMED codes.

- Current every day smoker (SNOMED code 449868002)
- Current some day smoker (SNOMED code 428041000124106)
- Former smoker (SNOMED code 8517006)
- Never smoker (SNOMED code 266919005)
- Smoker, current status unknown (SNOMED code 77176002)
- Unknown if ever smoked (SNOMED code 266927001)
- Heavy tobacco smoker (SNOMED code 428071000124103)
- Light tobacco smoker (SNOMED code 428061000124105)

The system-defined answer ‘Has never smoked or chewed tobacco’ is also associated with SNOMED code 266919005, and so is also counted.

To meet the measure’s goal, you must enter the tobacco use information for more than 80 percent of your qualifying patients seen during the reporting period.

It is strongly recommended that you use the system-defined tobacco history answers identified above. If you have charted tobacco use using custom history answers, you may merge your custom-defined answers with the appropriate system-defined answer or you may enter the appropriate SNOMED code (from the list above) in your custom-defined answer.
Please note:

- The system-defined tobacco history answer ‘Currently uses smokeless tobacco’ does not count for this measure since the measure is concerned only with smoking. Since you can only select one answer for the tobacco history question, you may want to define a custom question and answers to document the use of smokeless tobacco.

- The system defined Number of Years Using Tobacco and the Number of Cigarettes/Day questions and answers do not count toward this measure. They are available for you to add more detail to the patient’s history.

**Core Measure 6: Clinical Decision Support Rule**

Use clinical decision support to improve performance on high-priority health conditions.

- **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.


**Exclusion**

For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period

**Entering Data**

To attest Yes, you must properly use clinical decision support rules and use drug-drug and drug-allergy interaction checks.

For measure 1, you must create and activate at least five relevant clinical decision support rules for your providers or care teams. Your rules must be related to four or more of the clinical quality measures used by your providers. The rules must prompt you to perform a specific procedure (for example, annual exam) within the reporting period. To meet the measure’s goal, you must attest Yes to the use of the clinical decision support rules and to the relevance of the rules used.

All five of the clinical decision support rules must exist and be active on the first day of your reporting period and remain active throughout your reporting period. It is recommended that you print a screen capture of your clinical decision support rules, and keep the screen shot with your Meaningful Use documentation. Audit entries within the application also document the creation date of the rules.
For measure 2, the practice and individual providers must turn on drug-drug and drug-allergy screening. It is recommended that you print a screen capture of the Configure Practice Settings window’s and Provider window’s Drug Screening tab, and keep these screen shots with your Meaningful Use documentation. To meet the measure’s goal, you must attest Yes that drug interaction checks are performed by the application and that you review the interaction information provided by the check.

Core Measure 7: Patient Electronic Access

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.

- Sub-Measure 1: More than 50 percent 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.

- Sub-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.


Exclusion

Any EP who:

(1) 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.

(2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent 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.

Entering Data

To report on this measure, you must use the Aprima Patient Portal, which enables patients to access information through a secure website. You must also encourage your patients to use the Patient Portal. This is because CMS believes that providers are in a position to encourage patients to use health IT to further their own health care.

You must configure the Patient Portal to enable patients or their responsible parties to view their clinical summary, and you must associate a document formatting model that qualifies as a clinical summary to the Patient Portal.
You must meet both parts of this measure. For sub-measure 1, you must create web accounts for at least 50 percent of your patients. The patient’s user ID and password must exist and be active prior to or within four business days of the patient’s visit.

For sub-measure 2, at least 5 percent your patients or their responsible parties must view, download, or transmit to a third party a clinical summary of their health information through the Patient Portal during the reporting year. Transmission to third-party providers is done via your HIS/PH direct mail.

To meet this requirement, patients must one of the following procedures to view a visit summary or to access a continuity of care document.

To view a visit summary, the patient must:

1. Log into the Patient Portal.
2. Select the Patient Summary hyperlink.

3. On the Chart Consent page:
   a. Select the “I have read...” checkbox.
   b. Select the Agree button.
4. On the Patient Chart page, select the link for the desired visit date.

5. Select the option to view or save the visit summary. Please note that this action is dependent upon the browser being used.
To view, download, or transmit a clinical summary, the patient must:
1. Log into the Patient Portal.
2. Select the Continuity of Care Document hyperlink.

3. In the Continuity of Care Document window, the patient can:
   - Select the Display Document button to view the document.
   - Select the Download HTML Document button to download an HTML file of the document.
   - Select the Download CDA Document button to download a CDA file of the document.
   - Enter a Provider Email Address, and then select either the Transmit HTML Document button or the Transmit CDA button to send a file of the document to another provider. Please note that the provider email address entered must be the provider’s direct mail address from a HISP. The transmission will fail if a regular email address (such as DrJohn@Medclinic.com or DrJane@yahoo.com) is used.
Core Measure 8: Clinical Summaries

Provide clinical summaries for patients for each office visit.

Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.


Exclusion

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

Entering Data

To report on this measure, you must provide a clinical summary document using a document formatting model that is designated as a qualifying clinical summary, within one business day of the visit (whether or not the patient requests this information). To qualify as a clinical summary, the document must include diagnostic test results, problem list (diagnoses), medication list, and medication allergy list, and may include other information as appropriate.

There are several ways you can meet this measure’s requirement.

- Print the visit checkout plan at the conclusion of the visit, and give the document or file to the patient. The system-defined Checkout Plan formatting model is defined as a clinical summary, and is the default checkout plan document. You can select another formatting model for the checkout plan on the User Settings window.

- Use the document generation functionality to print a summary document or generate a file of the summary document within three days of the patient’s visit, and give the document or file to the patient. The consolidated clinical data architecture document (C-CDA) is by definition designated as clinical summary document. Your administrative super user may have defined formatting models for document generation that are designed as a clinical summary document.

- If your practice is using the Aprima Patient Portal, which enables patients to access information through a secure website, then you may use the Portal to meet this requirement. To do this, you must select the Allow Patients to View Clinical Summary option on the Configure Patient Portal Settings window. When you do this, you will select the document formatting model to be used for all clinical summaries made available to patients through the portal. Then you must create a user ID and password for the patient.

Ref: 1111.06
Please note:

- Selecting the Declined By Patient option on the appointment Checkout window meets the requirements for this measure.
- When using the Patient Portal for this measure, the patient’s user ID and password must be active prior to or within one business day of the patient’s visit.
- The patient does not have to access the document online to receive credit for this measure.

Troubleshooting

You can use the Document Management window to verify the checkout plan or clinical summary documents generated during a time period. You can search by attachment group name or file name. You can search for a word or phrase by enclosing them in percent signs (for example, %checkout%).

Core Measure 9: Protect Electronic Health Information

Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.

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 Measure CEHRT in accordance with requirements under 45 CER 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.

- EPs must conduct or review a security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.
- The parameters of the security risk analysis are defined 45 CFR 164.308(a)(1) which was created by the HIPAA Security Rule. Meaningful use does not impose new or expanded requirements on the HIPAA Security Rule nor does it require specific use of every certification and standard that is included in certification of EHR technology. More information on the HIPAA Security Rule can be found at http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/.


Exclusion

No exclusion.
**Entering Data**

No data entry is required to report on this measure.

To meet the measure’s goal, you must attest Yes to having conducted or reviewed an annual security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies as part of its risk management process.


The Office of the National Coordinator for Health Information Technology (ONC), the HHS Office for Civil Rights (OCR), and the HHS Office of the General Counsel (OGC) have developed a security risk assessment tool that you may use as part of your risk analysis process. You may download the security risk assessment tool from the HealthIT.gov website using the link below. Please note that this measure does not require the use of the security risk assessment tool. It is simply available to you for guidance and assistance.


Keep a copy of your security risk analysis report and documentation of security updates implemented as a result of the analysis with your Meaningful Use documentation. This may be needed in case of an audit.

**Core Measure 10: Clinical Lab-Test Results**

Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data.

More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.


**Exclusion**

Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the EHR reporting period.
**Entering Data**

An E&M visit during the reporting period is not necessary for a patient to be included for this measure. The order must be placed within the reporting period. This is determined by the date on the order, not the date of the associated visit.

To report on this measure, you must order the desired lab test using the appropriate procedure code, and then either enter the test results or receive them through an interface as structured data.

You must chart a procedure with the procedure code type of Lab or the results that are associated to the procedure must have an attachment type of Lab Results. The procedure code must also be defined to generate an order.

Laboratory procedures with a CPT code in the 80000 range have the procedure code type Lab, and are defined to generate an order. If you create custom procedure codes for lab orders, you must give them the correct procedure code type and define them to generate an order.

The procedure code must be defined to generate an order at the time that you chart the procedure. If the procedure code is not set to generate an order, then the application will not generate an order when you chart the procedure. Orders cannot be generated retroactively.

You may chart the procedure in either the SP or SO tab of Full Note Composer, Order Note, or other clinical note type window. The order counts for the ordering provider identified in the order.

All results, whether entered or received, must have a status of Resulted or Approved, and must have the attachment type of Lab Results.

The test results, whether entered by a user or received through an interface, must be entered in a lab template as discrete, quantifiable data. Enter the results in the Patients Results window using a lab template enabling you to enter the result values in a positive/negative or numerical format.

Results must be:

- Numeric, or
  - Numbers (e.g., 1, 0.1, -1, >1, <1, 1+, 1/2, etc.)
  - Reference range of numeric results (e.g., 2-6)
  - Numeric ratio (e.g., 1:2)
- The symbols “+” or “-“, or
- Text beginning with “Pos” or “Neg”

To meet the measure’s goal, you must receive through an interface or properly enter lab test results for more than 40 percent of the clinical lab test ordered for qualifying patients seen during the reporting period.
Please note:

• Simply attaching the scanned lab report does not meet this requirement. The results must be entered in a lab template.

• Only lab orders that are resulted with a positive/negative or a numeric value are counted for this measure.

• Orders that have been cancelled or deleted are not counted for this measure.

• Results may be received or entered after the reporting period, but must be available when the reporting data is generated for submission.

Core Measure 11: 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.


Exclusion

No exclusion.

Entering Data

No data entry is required to report on this measure. However, you must enter problems or diagnoses in patients’ medical history or in patient visit notes in order to have the data needed for the report.

To meet the measure’s goal, you must attest Yes that you have generated at least one report listing the eligible provider’s qualifying patients with a specific condition. The recommended report for this measure is Patient List Excel. However, this can be done using any system-defined or custom report that associates patients with a specific condition. Another system-defined report that can be used is the Patients by Diagnosis or Medication report.

As part of your records for possible auditing, it is recommended that you:

• Capture and print a screen shot of the Reports window showing the filtering criteria for the Patient List Excel or other report used to generate a list of patients by condition.

• Print the generated report.

• Keep the screen shot and the report with your Meaningful Use documentation.

In the event of an audit, information about printing these reports may be obtained from the application’s audit trail.
Core Measure 12: Preventive Care

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.

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.


Exclusion

Any EP who has had no office visits in the 24 months before the EHR reporting period.

Entering Data

This measure requires that patients have two or more visits with the provider within the two years prior to the start of the reporting period. An E&M visit during the reporting period is not necessary and does not qualify the patient for inclusion.

To report on this measure, you must create and activate clinical decision support rules, such as annual flu shots, vaccinations, mammograms, and PSA tests. Your rules must be defined in the following way when the rules are created. If you change rules to meet these requirements, the rules (and the patients the rules apply to) only count from that point forward.

- These clinical decision support rules must be defined as preventative follow up. This is done by selecting the “Report as Preventative Followup” checkbox on the Clinical Decision Support Rule window.

- These clinical decision support rules must also have defined recipients of messages notifying users that the rule is due for a particular patient. Message recipients are defined by care team on the Clinical Decision Support window’s Care Team tab.

It is important to recognize that for the notification to be included in the numerator, you must notify the patient in the manner the patient has identified as their preference. This is identified in the Patient window’s Preferred Contact Method field. If the patient declines to state a preferred contact method, then you may contact that patient by any method you choose.
There are several ways in which reminders may then be handled to satisfy this measure.

- You may use the CDS Reminders report, which generates reminder letters, and then print and mail the letters to patients. This counts only for patients whose preferred method is mail or is not identified. This does not count if the patient’s preferred contact method is phone or email.

- If you are using the Aprima Patient Portal, you may use the CDS Reminders report to generate reminder messages to patients with Portal accounts. This counts only for patients whose preferred method is email or is not identified. This does not count if the patient’s preferred contact method is phone or mail.

- You may contact the patient in some manner, and then complete the clinical decision support rule message for the patient. This counts regardless of the patient’s preferred method, because the message assumes that you notified the patient using the patient’s preferred method.

When using the CDS Reminders report, you should generate the report on a regular basis so that reminders are generated for patients who are due. The application uses the advance warning time period defined for a clinical decision support rule to determine the patients due for that rule.

When a patient meets the criteria for the rule, a message is sent to the defined recipient user. That user can then send a reminder to the patient. Once the user sends the reminder or contacts the patient, the user must complete the message in order for the reminder to be counted by the message.

Please note:

- All patients meeting the measure’s age criteria at the beginning of the measure period are counted in the denominator for this rule, whether or not you have defined a rule that is appropriate for them.

- The denominator includes active and inactive patient records, as long as the patient had at least two visits within the two years prior to the start of the reporting period.

- The denominator will be large since all active and inactive patients with two visits in the previous 24 months are included. However, the denominator is unlikely to be all patients. Therefore, you may send reminders to patients who are not in the denominator, and these reminders will not be counted in the numerator.

- Reminders must be sent during the reporting period.

- Contact must be by the patient’s preferred method, as described above.

**Core Measure 13: Patient-Specific Education Resources**

Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

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.

Exclusion

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

Entering Data

To report on this measure, you must attach an appropriate educational form to the visit note and print it for the patient. Selecting and attaching the education forms is done from the Education Form slider in Full Note Composer or other clinical note type window or during the checkout process. You may print the forms from the slider or the front desk staff may print them from the Checkout window when discharging the patient.

If you are using the Aprima Patient Portal and you have configured it to allow patients to view education materials, then any education form associated to a visit note is available to a patient with a Portal account. These education forms count toward this measure without being printed.

To meet the measure’s goal, you must provide educational forms to more than 10 percent of your qualifying patients seen during the reporting period.

Please note:

• The Patient Medication Summary report is not an education form, and so does not count as an education form, even though it appears in the Education Forms slider.

• When using the Patient Portal, the patient account should be created prior to or on the date of the patient visit and must be active.

Core Measure 14: Medication Reconciliation

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.

The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.


Exclusion

Any EP who was not the recipient of any transitions of care during the EHR reporting period.
**Entering Data**

To be included for this measure, the patient must have transitioned to you. This could include, but is not limited to:

- A first encounter with a new patient.
- A patient referred to you by another provider.
- A patient for whom you receive a C-CDA file for the patient.

To identify a patient as transitioning, you must select the “Patient has been seen by another provider” checkbox in the Medication History category of the Hx tab of Full Note Composer or other clinical note type window.

To report on this measure for the transitioning patients, you must perform the medication reconciliation. There are several ways that you can do this.

- You can reconcile that patient’s medication history in the application with a document listing the patient’s medication. You must then scan the document, and attach it to the visit note.
- You can download the patient’s electronic medication history, import the electronic medication history, and reconcile that medication history with the medication history in your patient record. To download the medication history, providers must be enrolled with the Surescripts pharmacy clearinghouse.
  
  Downloading the electronic medication history may be done automatically for appointments scheduled in advance, or may be done on demand from the Appointment window, Patient Demographics window, or Full Note Composer or other clinical note type window. Importing and reconciling the electronic medication history and the medication history in the patient record is done from the Import Medication History window.
- You can receive a C-CDA for the patient, and import the patient’s medication history from it, and reconcile that medication history with the medication history in your patient record.

Then in the Hx tab of Full Note Composer or other clinical note type window, select the checkbox for Medication History. This checkbox will be automatically selected if you made any changes while reconciling the electronic medication history within Full Note Composer or other clinical note type. If you do medication reconciliation from the Patient History window, then you must select this checkbox within Full Note Composer.

Please note that you must select the checkbox for Medication History in the Hx tab of Full Note Composer or other clinical note type window before you complete the visit note. Once you have marked the visit note as completed, you cannot select this checkbox.

To meet the measure’s goal, you must reconcile the medication history for more than 50 percent of the qualifying patients who transition into your care during the reporting period.
Core Measure 15: Summary of Care

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.

EPs must satisfy both of the following measures in order to meet the objective:

- **Sub-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 percent of transitions of care and referrals.

- **Sub-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 percent 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.

- **Sub-Measure 3:** An EP must satisfy one of the following criteria:
  - Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in “sub-measure 2” (for EPs the measure at §495.6(j)(14)(ii)(B) with 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 170.3 14(b)(2)).
  - Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.


*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 three measures.

*Entering Data*

To report on this measure, you must satisfy the objectives for both sub-measure 1 and 2, and you must satisfy the either the first or the second option for sub-measure 3.

This measure requires the use of a health information systems program (HISP) to satisfy sub-measures 2 and 3. Aprima’s HISP is Nitor. Instructions for setting up the HISP are included in this document.

An E&M visit during the reporting period is not necessary for a patient to be included for this measure.
For a patient to be included in the denominator, you must identify the patient as a transition-of-care patient by creating an active referral entry referring the patient to another provider during the reporting period.

There are several ways to create a referral entry.

- You can create a referral entry using the Create Referral dynamic procedure note from Full Note Composer or other clinical note type window. This is the recommended method.
- You can create a referral entry from the Patient/Provider Tracking window.
- You can create a referral entry from the Referral Tracking window.

There are several things to keep in mind when creating the patient/provider tracking entry and the referral entry associated to it.

- The patient/provider tracking entry must identify the referred to provider’s role as Specialist, Other, or a custom-defined provider role. (It cannot be Primary Care or Referring Provider.)
- The referral entry must be created during the reporting period.
- Referral entries with a status of Historical Reference or of Relationship are not included.

To report on this measure, you must generate a clinical summary document for a visit, a continuity of care document (CCD), or a consolidated clinical data architecture document (C-CDA) for the patient, and you must give the document or file to the referred to physician or medical services provider. You must generate this document within three days of creating the referral entry.

Please note that if you use the Create Referral dynamic procedure note to create the referral, you can select a document, generate it, and send it to the referred to physician as part of completing that procedure note.

The clinical summary, CCD, or C-CDA document that you generate must contain the patient’s diagnostic test results, problem list (diagnoses), medication list, and medication allergy list, and may include other information as appropriate. The formatting model for a clinical summary document must be defined as a clinical summary. CCD and C-CDA documents are, by definition, clinical summaries.

When you generate the document, you must:

- Select the referral entry with which the document is to be associated. You do this in the Generate Patient Document window.
- Select the disclosure reason ‘Referral’. You do this in the Send Documents window.
- Use direct mail through the HISP to send the document to the other provider or medical services provider. You do this in the Send Documents window.

These items are done automatically if you use the use the Create Referral dynamic procedure note to create the referral and to generate and send the document.
To meet the measure’s goal, you must generate clinical summary, CCD, or C-CDA documents for more than 50 percent of your qualifying patients who you transition to or refer to another physician or medical services provider during the reporting period. You must also send the clinical summary electronically using the HISP direct mail protocol for 10% of transition of care or referrals, and conduct one or more tests with a different EHR.

The Meaningful Use 2014 report shows the denominators and numerators for this measure in sub-measure 1 and sub measure 2. Sub-measure 3 is attestation only.

Please note:

• When using a clinical summary, the formatting model for the clinical summary document must be defined as a clinical summary before the document is generated. This setting is not retroactive, and does not apply to documents generated from the formatting model before the setting was selected.

• If you have an incoming referral that has associated referral entries, these will be included in the count. To remove them, change the referral entry status to ‘Relationship’.

Core Measure 16: Immunization Registries Data Submission

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

Successful ongoing submission of electronic immunization data from CEHRT (certified EHR technology) to an immunization registry or immunization information system for the entire EHR reporting period.

The EP must attest YES to meeting one of the following criteria under the umbrella of ongoing submission.

• Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period using either the current standard at 45 CFR 170.314(f)(1) and (f)(2) or the standards included in the 2011 Edition EHR certification criteria adopted by ONC during the prior EHR reporting period when ongoing submission was achieved.

• Registration with the PHA (public health agency) or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.

• Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission.

• Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.
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.

Information about this measure is available from the CMS website at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_16_ImmunizationRegistriesDataSubmission.pdf

Entering Data

You must enter information for administered immunizations in the Vaccine Administration Record (VAX) from Full Note Composer or other clinical note type.

To comply with this measure, you must:

1. Search for an immunization registry in your area, if you are not already aware of one’s existence.
   - If a registry does exist in your area, then go to step 2.
   - If there is no registry, you are excluded from this measure.

2. Contact your state or local immunization registry to determine whether they can accept HL7 immunization files.
   - If so, go to step 3.
   - If your local immunization registry cannot accept HL7 files through an interface, then you are excluded from this measure.

3. Contact Support to set up the interface to the registry.

4. Once the interface is in place, submit the data regularly throughout the reporting period.
Core Measure 17: Use of Electronic Messaging

Use secure electronic messaging to communicate with patients on relevant health information.

A secure message was sent using the electronic messaging function of CEHRT (certified EHR technology) by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3 Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.


Exclusion

Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent 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.

Entering Data

Reporting on this measure requires the use of the Aprima Patient Portal. You must create web accounts for your patients and/or responsible parties.

At least 5 percent of your patients and/or responsible parties must send a message to the provider through the Patient Portal. It is important to recognize that the message must be sent from the Portal. This can be a new message or a response to a message sent to the patient.

Please note that demographic changes made by patients on the Portal do not count as a message sent by the patient.

Menu Set Measures

Each participating provider must report three of the following five menu set measures. Please note that Aprima PRM 2014 is not certified for Menu Set Measure 5: Report Cancer Cases. Therefore, information about this measure is not included in this document.
Menu Set Measure Exclusions

Starting in 2014, exclusions no longer count towards the three menu set measures you need to successfully demonstrate meaningful use if there are other menu set measures that you can select. This means that you must either:

- Report on three menu set measures, or
- Report on as many measures as you can, and qualify for an exclusion to all of the remaining menu set measures.

It is important that you search for a syndromic surveillance or specialized registry in your area, if you are not already aware of their existence. If a registry is available, then you must contact them to determine whether they can accept HL7 files. If a registry is available and can accept HL7 files, then you cannot claim an exclusion. You must enroll with the registry or repository. Then you must contact Aprima Support to set up an interface to the registry or repository.

Because of the requirements for exclusions, Aprima recommends the following menu set measures:

- Menu Set Measure 2: Electronic Notes
- Menu Set Measure 3: Imaging Results
- Menu Set Measure 4: Family Health History

Menu Set Measure 1: Syndromic Surveillance Data Submission

Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Successful ongoing submission of electronic syndromic surveillance data from CEHRT (certified EHR technology) to a public health agency for the entire EHR reporting period.

Information about this measure is available from the CMS website at

Exclusion

Any EP that meets one or more of the following criteria may be excluded from this objective:

1. The EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period;

2. The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period;

3. The EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or
(4) The EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

**Entering Data**

To report on this measure, you must have determined how your public health agency receives syndromic surveillance data, and then configured the database appropriately. Please refer to the Configure Syndromic Surveillance Reporting section for instructions. You must also have determined the diagnosis codes that you must report to the public health agency, and the frequency of reporting required by the agency.

Please note that after receiving your first syndromic surveillance message files, the public health agency may inform you that the files do not meet the agency's requirements. The agency may, for example, require additional data be included. You must then contact your sales representative to request a custom interface with your public health agency. Since development and testing of the custom interface will take some time, it is recommended that you configure and test the standard syndromic surveillance reporting 60 days prior to the start of your Meaningful Use reporting period.

You must enter diagnoses in patient visit notes. Then generate the Export Patient Diagnosis Data report for the diagnosis or diagnoses of interest. You must generate the report at the frequency required by your public health agency. (Please note that you cannot schedule this report since it generates files rather than a document to be printed as a PDF.)

The Export Patient Diagnosis Data report generates a file for each patient with the selected diagnosis. Depending on your syndromic surveillance configuration, the files are either transmitted to the public health agency and or stored on your server. If files are stored on the server, then you must upload them to the public health agency.

To meet the measure’s goal, EPs must attest YES to successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

- Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.
- Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.
Menu Set Measure 2: Electronic Notes

Record electronic notes in patient records.

Enter at least one electronic progress note created, edited, or 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.

Information about this measure is available from the CMS website at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPMenu_2_ElectronicNotes.pdf

Exclusion

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

Entering Data

To report on this measure, you, the provider, must create, edit, or sign your patient visit notes within Aprima PRM 2014. To be counted toward this measure, the visit note must include an E&M code on the SP tab of Full Note Composer or other clinical note type window.

Visit notes that do not include an E&M code do not count toward this measure. Therefore, visit notes entered in clinical note type windows that do not include an SP tab are not counted toward this measure.

Electronic refill visit notes, order notes, and struck out visit notes also do not count toward this measure.

Please note:

- You, the provider, must make at least one entry in the visit note and save the visit note in order for the visit note to be counted.
- If another user, such a nurse or scribe, does all the entry, and you, the provider, never save the visit note, then that visit note will not be counted.

Menu Set Measure 3: Imaging Results

Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT (certified EHR technology).

More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.

**Definition of Terms**

The following definitions are quoted directly from the CMS definition of the measure. It is important to understand these terms and their definitions when determining how and whether you can meet the requirements of this measure. The full measure definition is available at [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPMenu_3_ImagingResults.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPMenu_3_ImagingResults.pdf)

**Imaging** - The description of radiology services from the Stage 2 CPOE objective is the minimum description of imaging. We [CMS] describe radiologic services as any imaging service that uses electronic product radiation. Electronic product radiation is defined at 21 CFR 1000.3 as: "any ionizing or nonionizing electromagnetic or particulate radiation, or any sonic, infrasonic, or ultrasonic wave that is emitted from an electronic product as the result of the operation of an electronic circuit in such product.” If the provider desires to include other types of imaging services that do not rely on electronic product radiation, they may do so as long as the policy is consistent across all patients and for the entire EHR reporting period.

**Accessible Through** - Either incorporation of the image and accompanying information into CEHRT or an indication in CEHRT that the image and accompanying information are available for a giving patient in another technology and a link to that image and accompanying information.

**Incorporation of the Image** - The image and accompanying information is stored by the CEHRT.

**A Link to the Image and Accompanying Information** - A link to where the image and accompanying information is stored is available in CEHRT. This link must conform to the certification requirements associated with this objective in the ONC final rule published elsewhere in this issue of the Federal Register.

**No Access** - None of the imaging providers used by the EP provide electronic images and any explanation or other accompanying information that are accessible through their CEHRT at the start of the EHR reporting period.

**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.

No access means that none of the imaging providers used by the EP provide electronic images and any explanation or other accompanying information that are accessible through their CEHRT at the start of the EHR reporting period.
Entering Data

An E&M visit during the reporting period is not necessary for a patient to be included for this measure. The order must be placed within the reporting period. This is determined by the date on the order, not the date of the visit in which the order is placed.

To report on this measure, you must order imaging procedures through the application using either the SP or SO tab in Full Note Composer, Order Note, or another clinical note type. The procedure code used to place the order must have the procedure code type of Radiology.

The procedure code must be defined to generate an order at the time that you chart the procedure. If the procedure code is not set to generate an order, then the application will not generate an order when you chart the procedure. Orders cannot be generated retroactively.

You can report on this measure in several ways.

- You can store the images in the database.
- You can have access to an external PACS (picture archiving and communication system) that enables you to access the images. Many imaging centers and hospitals provide ordering providers with online access to their PACS. For the PACS to qualify for this measure, you must be able to configure access to it from Aprima PRM in such a way that you are able to directly access a particular patient’s images from the patient’s chart. Please see the Configure the Patient URL Launcher for PACS System Access section of this document for instructions. Please contact Support if you need assistance.
- You can have an interface to an external PACS. The interface receives information about the image, and associates it with the image order as a result that is accessible through the Patient Results window. The Patient Results window then enables you to directly access the image for the order in the external PACS. An interface requires custom development and implementation. Please contact Support if you want an interface.
- You can have an interface to a DICOM (digital imaging and communications in medicine) image system. Some medical service providers send messages that include a link that enables you to access an image stored in their own repository. Others send messages that include the DICOM image file. You can then directly access the image in the DICOM system through an icon on the Patient toolbar in the Patient Demographics, Full Note Composer or other clinical note type window, or Review Past Notes window. An interface requires custom development and implementation. Please contact Support if you want an interface.

To store the images in the database, you must attach the result image to the order using the SP/SO association in the Document Linking window or through the order Results window. The image file must be one of the following file types: .bmp, .dcm, .dic, .dicom, .gif, .jpg, .jpeg, .tiff, .tif, .pdf, .htm, and .html.

If you have an interface with a DICOM (digital imaging and communications in medicine) image system or you access an external PACS (picture archiving and communication system) via a context-sensitive URL, then you must identify this in the procedure code for imaging procedures. This is defined using the Image Results Directly Accessible checkbox on the Procedure Code window. This is necessary because the application cannot count the images, and you must attest to having access.
If you have an interface to an external PACS (picture archiving and communication system) that generates a results message with a hyperlink button that accesses the image, then you do not need to identify this on the procedure code. This is because the application actually receives a hyperlink to the image as a result, which can be counted.

The DICOM interface or patient URL launcher functionality must also be configured in your user settings definition so that you can access the PACS or DICOM system from any window that includes the Patient toolbar. To access the DICOM or PACS, select the 🖼 icon from the toolbar.

To meet this measure’s goal, you must store in the database or have direct access to more than 10 percent of your image order results.

When considering your numbers, please be aware that:

- Orders that are cancelled or deleted do not count for this measure.
- Future orders are counted if the future date on the order is included in your reporting period.
- Results may be received or entered after the reporting period, but must be available when the reporting data is generated for submission.

Menu Set Measure 4: Family Health History

Record patient family health history as structured data.

More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.


Exclusion

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

Entering Data

To report on this measure, you must enter family health history information in either the Patient History window or the Hx tab of Full Note Composer or other clinical note type window using the Family History category.

Please note that measure counts history entered for first-degree relatives only. Therefore, for the patient’s history to count, you must enter information for at least one first-degree relative of the patient. The information for the relative may include entering one or more diseases or may include the No Known Diseases checkbox.
Menu Set Measure 5: Report Cancer Cases

Please note that Aprima PRM 2014 is not certified for Menu Set Measure 5: Report Cancer Cases. Therefore, information about this measure is not included in this document. This measure cannot be submitted through Aprima PRM.

Menu Set Measure 6: Report Specific Cases

Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

Successful ongoing submission of specific case information from CEHRT (certified EHR technology) to a specialized registry for the entire EHR reporting period.


Exclusion

Any EP that meets at least 1 of the following criteria may be excluded from this objective:

1. The EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction;

2. The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period;

3. The EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries; or

4. The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional EPs.
**Entering Data**

You must enter diagnosis or other data to be reported to the registry in Full Note Composer or other clinical note type.

To comply with this measure, you must:

1. Search for a specialized registry in your area, if you are not already aware of one’s existence.
   - If a registry does exist in your area, then go to step 2.
   - If there is no registry, you are excluded from this measure.

2. Contact your state or local specialized registry to determine whether they can accept HL7 immunization files.
   - If so, go to step 3.
   - If your local immunization registry cannot accept HL7 files through an interface, then you are excluded from this measure.

3. Contact Support to set up the interface to the registry.

4. Once the interface is in place, submit the data regularly throughout the reporting period.

**Monitoring and Reports**

**Meaningful Use Dashboard**

The Meaningful Use Dashboard enables you to monitor your practice’s or a single provider’s Meaningful Use of the EHR module of the application. Meaningful metrics are defined by the Department of Health and Human Services (HHS) as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

Please refer to the online help or the General User’s Guide for instructions on adding the Meaningful Use Dashboard to your Desktop.

The dashboard displays the summary information from the Meaningful Use Report. Metrics that have met the requirements for the selected date range are displayed in green text. Metrics that have not met the requirements for the selected date range are displayed in bold red text.

You can access the Meaningful Use Report by selecting the Display Meaning User Report link. From the report, you can access more detailed information.

Please note that the dashboard does not automatically refresh because of the amount of data used for Meaningful Use metrics.
Refresh the Meaningful Dashboard Report

1. Either:
   - Select the Provider you want to monitor.
   - Leave the Provider field empty to monitor the entire practice.
2. Select the Date Range that you want to monitor.
3. Select the Refresh Stage 2 Meaningful Use Data link to display Stage 2 metrics in the lower portion of the pane.

Amount Allowed Summary Report

The Amount Allowed Summary report can help you determine how long it will take for your providers to achieve the required billing in order to receive the maximum incentive payment from Medicare. The report lists the monthly average and monthly totals of each provider's allowed charges for the selected amount allowed schedule.

By running the report for the most recent 12 months, you can determine the total amount allowed billed for each provider. This enables you to estimate the number of months you will need to use Aprima PRM in the calendar year in order to have $24,000 in allowed charges per provider.

By running the report from the date you begin using this version of the application to the current date, you can see the total amount allowed billed for each provider for the incentive period. This will tell you what each provider is currently eligible for, and how close each provider is to the maximum incentive allowed.

It is important to remember that the report is only as accurate as your amount allowed schedule for Medicare. If allowed amounts entered in the amount allowed schedule are less than or greater than amounts actually allowed by Medicare, then the Amount Allowed Summary report will not accurately reflect the total amount allowed billed.

This report cannot be used to monitor fulfillment of Meaningful Use measures. This report only includes Medicare patients and charges. Meaningful use measures are based on your total patient population.

Patient List Excel

The Patient List Excel report is appropriate for fulfilling the requirements for Core Measure 11: Patient Lists. This report enables you to create a list of patients by diagnosis, medication, medication allergies, and/or laboratory tests and their result values. You may also filter the report by demographic information, including the patient’s preferred contact method.

This report generates as an Excel spreadsheet file. It does not produce a printed report. You may sort and manipulate the data in the spreadsheet file as desired.
Clinical Quality Reports

The quality reports meet the requirements for reporting to Centers for Medicare & Medicaid Services (CMS) on several types of care that should be provided under specific circumstances. For all of the quality reports, the number of patients meeting the selection requirements for a rule is the denominator of the rule. The number of qualified patients who received the required care for the rule is the numerator of the rule.

It is important to understand that all quality reports for Meaningful Use and other CMS program reporting are clinical reports. The data in the reports is pulled from patient visit notes only. Therefore, the reports may not be accurate, depending on the report criteria used, if you enter procedures directly into superbills or into a third-party billing system.

Meaningful Use Stage 2

The Meaningful Use Stage 2 report enables you to identify whether your practice or individual providers within your practice are meeting the HHS Meaningful Use requirements identified as ‘core’ and ‘menu’. These are some of the requirements that you must meet in order to receive incentive payments for implementing and using the application. You may generate the report for all providers within your practice or for an individual provider, and you may select date range for the reporting period.

Patient Volume for Meaningful Use

The Patient Volume for Meaningful Use report identifies your patient encounter volume by insurance payer or patient account type. This will help you determine whether your Medicaid patient encounter volume is sufficient for incentive payments for the "Meaningful Use" of a certified EHR application under the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

You may filter the report by billing or rendering provider, provider, financial center, service site, and visit date. You may group the report results by patient account type or insurance payer. When you group the report by patient account type, you may select one or more patient account types as additional filtering and insurance payers will be ignored if selected. When the report is grouped by insurance payer, you may select one or more insurance payers as additional filtering and patient account types will be ignored if selected.

The report displays the number of visits by patient account type or by insurance payer for the filtering criteria used. It also displays the percentage of the total visits. Visits are included in the report only once the patient visit note is marked as complete, and only when the patient visit note includes at least one procedure on the SP (services provided) tab of the visit note window.

You may select the account type or insurance payer hyperlink in the generated report to view details for the visits. The visit information includes the patient name, ID, and birth date; the visit date; and the provider.