

# Meaningful Use Stage 1 Implementation Guide



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## Get Ready

Meaningful Use Attestation can seem overwhelming, particularly if you are a first-time EHR user. However, don't panic! Kareo EHR is here to help you on this journey to incentive program payment.

We've created the Meaningful Use Boot Camp program to provide you with the necessary information, steps and organization to get you from preparation to attestation.

### Preparation

First things first: Depending on the stage and year for which you are attesting, there are specific guidelines to follow. Which stage and year are you working on?

This guide focuses on Stage 1, Year 1 and Year 2. We've outlined the specifics for Stage 1 to help you make the best decisions for your practice and to start your reporting period.

Because it's important to stay organized, Kareo EHR has created various progress checklists to keep you on track throughout the process.

### Create a Team

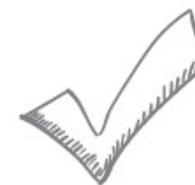
Achieving Meaningful Use takes the cooperation of the entire practice, so enlist the help of key personnel who are willing to meet weekly to check progress and make necessary workflow adjustments. The ideal team should include the provider(s), office manager, and a clinical assistant.



### How to use this guide

At ease recruits! Your Stage 1 Boot Camp begins on pages 2 and 3. For each year, a Task List is provided to ensure you don't miss a step and to help you easily monitor your progress from Enlistment to Graduation.

We recommend printing the appropriate checklist before getting started.



Next, each step provides details to aid in decision-making, with instructions and resources to help you complete the tasks.

# GO!

## Task List: Meaningful Use Stage 1, Year 1

Print this page and use it as your master task list.

Step 1: Enlistment	<ul style="list-style-type: none"><li><input type="checkbox"/> Confirm eligibility</li><li><input type="checkbox"/> Register with CMS</li><li><input type="checkbox"/> Complete all EHR training</li></ul>
Step 2: Basic Training	<ul style="list-style-type: none"><li><input type="checkbox"/> 17A - Meaningful Use Overview</li><li><input type="checkbox"/> 17B - Meaningful Use Stage 1 Core &amp; Menu Measures</li><li><input type="checkbox"/> 17C - Clinical Quality Measures</li></ul>
Step 3: Fitness Exercises	<ul style="list-style-type: none"><li><input type="checkbox"/> ePrescribing</li><li><input type="checkbox"/> eLabs (optional)</li><li><input type="checkbox"/> Purchase Rx paper (if not previously purchased)</li><li><input type="checkbox"/> Contact Immunization Registry for transmission process</li></ul>
Step 4: Survival Skills	<ul style="list-style-type: none"><li><input type="checkbox"/> Meaningful Use Dashboard</li><li><input type="checkbox"/> Kareo EHR Help Center</li><li><input type="checkbox"/> Kareo EHR Progress Checklist 2014</li><li><input type="checkbox"/> Kareo EHR CQM Checklist 2014</li></ul>
Step 5: Advanced Training	<ul style="list-style-type: none"><li><input type="checkbox"/> Select Menu Measures and CQMs</li><li><input type="checkbox"/> Discuss Practice Workflow Changes</li><li><input type="checkbox"/> Select Reporting Period</li><li><input type="checkbox"/> Reporting Triggers and Tips</li></ul>
Step 6: Field Drills	<ul style="list-style-type: none"><li><input type="checkbox"/> Meaningful Use Dashboard</li><li><input type="checkbox"/> Functional Measures Report</li><li><input type="checkbox"/> CQM Report</li><li><input type="checkbox"/> Progress Checklist</li><li><input type="checkbox"/> Audit Preparation</li></ul>
Step 7: Graduation	<ul style="list-style-type: none"><li><input type="checkbox"/> Start Your Reporting Period</li><li><input type="checkbox"/> Complete Attestation</li></ul>

## Task List: Meaningful Use Stage 1, Year 2

Print this page and use it as your master task list.

Step 1: Basic Training	<ul style="list-style-type: none"><li><input type="checkbox"/> 17B - Meaningful Use Stage 1 Core &amp; Menu Measures</li><li><input type="checkbox"/> 17C - Clinical Quality Measures</li></ul>
Step 2: Fitness Exercises	<ul style="list-style-type: none"><li><input type="checkbox"/> ePrescribing</li><li><input type="checkbox"/> eLabs (optional)</li><li><input type="checkbox"/> Purchase Rx paper (if not previously purchased)</li><li><input type="checkbox"/> Contact Immunization Registry for transmission process</li></ul>
Step 3: Survival Skills	<ul style="list-style-type: none"><li><input type="checkbox"/> Meaningful Use Dashboard</li><li><input type="checkbox"/> Kareo EHR Help Center</li><li><input type="checkbox"/> Kareo EHR Progress Checklist 2014</li><li><input type="checkbox"/> Kareo EHR CQM Checklist 2014</li></ul>
Step 4: Advanced Training	<ul style="list-style-type: none"><li><input type="checkbox"/> Select Menu Measures and CQMs</li><li><input type="checkbox"/> Discuss Practice Workflow Changes</li><li><input type="checkbox"/> Select Reporting Period</li><li><input type="checkbox"/> Reporting Triggers and Tips</li></ul>
Step 5: Field Drills	<ul style="list-style-type: none"><li><input type="checkbox"/> Meaningful Use Dashboard</li><li><input type="checkbox"/> Functional Measures Report</li><li><input type="checkbox"/> CQM Report</li><li><input type="checkbox"/> Progress Checklist</li><li><input type="checkbox"/> Audit Preparation</li></ul>
Step 6: Graduation	<ul style="list-style-type: none"><li><input type="checkbox"/> Start Your Reporting Period</li><li><input type="checkbox"/> Complete Attestation</li></ul>

# Enlistment



This step is typically only needed for practices that are in their first year of attestation (Stage 1, Year 1). If you are in Year 2, skip to Basic Training.

## 1. Eligibility

You must first determine if you are eligible to participate in the Meaningful Use program and if so, for which program (Medicare or Medicaid). Check out the [eHealth Eligibility Assessment Tool](#) to find out if you qualify for one of the programs.

## 2. Register

CMS recommends that you register as soon as possible. Registration is important because:

- It validates that you are an eligible professional.
- You can register but are not held to a timeline; that means you can register this year and attest the following year.

Prior to registration, each provider should have the following information available to expedite the registration process:

1. National Provider Number (NPI)
2. National Plan and Provider Enumeration System (NPPES) user ID and password
3. If you are reassigning your benefits, you will also need:
  - Your Payee Tax Identification Number (TIN)
  - Your Payee National Provider Identifier (NPI)

4. CMS EHR Certification ID. This ID identifies the EHR you are using during attestation. To locate Kareo EHR's unique ID, follow these steps:
  - Go to <http://healthit.hhs.gov/chpl>
  - Select the **2014 Edition** button.
  - In the "Search by Name or CHPL Product Number" box, select **Product Name** from the drop-down menu and type **Kareo** in the "Search for" field. Then click **Search**.
  - Under the Vendor column, you should see Kareo, Inc. Click **Add to Cart**.
  - Click **Get CMS EHR Certification ID**.

You are now ready to [register with CMS](#).

For additional assistance, see the CMS Registration User Guide listed on the next page.

### 3. Complete all Kareo EHR training webinars

Kareo EHR is the tool that will help you to successfully participate in Meaningful Use. It is important that you complete all Kareo EHR core training to fully understand features and functionality. Register for live training # 10-17A or watch the recorded sessions.

## Resources



- CMS Registration User Guide
- eHealth Eligibility Assessment Tool



#### Live Training

- #10: EHR Administrator
- #11: PM & EHR Office Staff & Orientation or #12: EHR Only Office Staff & Orientation
- #13: EHR Clinical Staff
- #14: EHR Provider
- #17A: Meaningful Use Overview



#### Video

- EHR Administrator
- PM & EHR Office Staff & Orientation or EHR Only Office Staff & Orientation
- EHR Clinical Staff
- EHR Provider
- Meaningful Use Overview

# Basic Training

Now that you know you are eligible for the Meaningful Use program and have registered at CMS, it's time for basic training. Each course gives insight into requirements, understanding thresholds, and reporting. Live training gives you the opportunity to submit questions to a Meaningful Use expert.

## Stage 1, Year 1

- Complete Meaningful Use training
- Attend live virtual training or view a recording

Resources	
	<b>Live Training</b> <ul style="list-style-type: none"><li><input type="checkbox"/> #17A: Meaningful Use Overview</li><li><input type="checkbox"/> #17B: MU Stage 1 Core &amp; Menu Measures</li><li><input type="checkbox"/> #17C: Clinical Quality Measures</li></ul>
	<b>Video</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Meaningful Use Overview</li><li><input type="checkbox"/> MU Stage 1 Core &amp; Menu Measures</li><li><input type="checkbox"/> Clinical Quality Measures</li></ul>

## Stage 1, Year 2

- Complete Meaningful Use training
- Attend live virtual training or view a recording

Resources	
	<b>Live Training</b> <ul style="list-style-type: none"><li><input type="checkbox"/> #17B: MU Stage 1 Core &amp; Menu Measures</li><li><input type="checkbox"/> #17C: Clinical Quality Measures</li></ul>
	<b>Video</b> <ul style="list-style-type: none"><li><input type="checkbox"/> MU Stage 1 Core &amp; Menu Measures</li><li><input type="checkbox"/> Clinical Quality Measures</li></ul>

## Fitness Exercises



### ePrescribing

ePrescribing is required for Meaningful Use. If you have not done so, easily enroll with ePrescribing through Kareo EHR. This [help article](#) explains the various access points to enrolling for ePrescribing.

If you need assistance, contact Kareo EHR Support or your account manager.

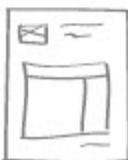


### eLabs

The use of eLabs in your EHR is optional in Stage 1 but required in Stage 2. Consider enrolling if it make sense for your practice.

#### **Start Process**

If you need assistance, contact Kareo EHR Support or your account manager.



### CQM Report

It is recommended that you run this report at the beginning of your reporting period and not wait until attestation. **Instructions**

The first-time run of this report is generated at 12am on the evening of your request because of the amount of data it must compile. After the initial run, this report can be generated immediately with updated data.



### Purchase Rx paper

If this is your first time prescribing through an EHR, you will need to replace your paper Rx pad with tamper-proof paper for printing prescriptions. Each state has specific requirements so make sure you order paper per your state's requirements.

Tip: To find Rx paper online, search using the term "tamper-proof Rx paper." Some of our customers use [www.rpaper.com](http://www.rpaper.com).



### Immunization State Registry Transmission Process

At the present time, a single patient's immunization record can be downloaded in a format that can be sent to the state registries. Not all states are able to receive electronic transmittal of immunization data.

Note that individual practices must arrange with the state registries to transmit a file. Kareo EHR has the ability to create an HL7 file format (version 2.5.1).

## Survival Skills

Before moving on to selecting your Menu Measures and CQMs, take a moment to note the Kareo EHR resources available to support you on your journey towards attestation.

### Meaningful Use Dashboard

The Meaningful Use Dashboard is an easy way for a provider to track his or her progress during a reporting period for Meaningful Use attestation. Use the dashboard for both quick insight and to drill down into measures that need attention. [Find out more...](#)

### Progress Checklists

The Kareo EHR Progress Checklist 2014 and Kareo EHR CQM Checklist 2014 are designed to assist eligible providers in tracking Stage 1 measures during a reporting period.

Tracking your progress on a weekly basis is important so that you can clearly see how your practice compares to the threshold of each measure and where improvement is needed. The checklists can also be used to track your progress in anticipation of your reporting period to monitor which areas of measurement indicate a weakness.

Resources	
	<a href="#">Kareo EHR Help Center</a>
	<a href="#">Meaningful Use Videos</a>
	<a href="#">Kareo EHR Progress Checklist 2014</a>
	<a href="#">Kareo EHR CQM Checklist 2014</a>
	<a href="#">Meaningful Use Resource Library</a>

## Advanced Training

You are now ready to review all required core measures and select which menu measures and CQMs you will use for attestation. For Stage 1, eligible providers must meet and report on the following criteria:

- All 13 core objectives
- 5 menu objectives from a list of 9
- 9 clinical quality measures from a list of 19

### How to Select Measures and CQMs for Attestation

The following pages provide tables listing each measure.

1. Print each table so you can mark your choices.
2. To view detailed information that will help you determine which measures or CQMs you want to attest to, click on a Requirement # to hyperlink to the details.
3. Mark on each table the measures and CQMs to which you are attesting.
4. Use the tables that you've marked as your master guide to attestation.



### Notes

#### Core Measures

- Thresholds must be met
- Some core measures require no further action because the functionality is built into Kareo EHR:
  1. Drug-drug, drug-allergy checks
  2. Clinical decision support
- Some core measures require that the defined action is completed only once:
  1. Protect electronic health information. [Find out more...](#)

#### Menu Measures

- Thresholds must be met
- Some menu measures require no further action because the functionality is built into Kareo EHR:
  1. Drug-formulary checks
  2. Lab test results, if eLab interface is active
- Some menu measures require that the defined action is completed only once:
  1. Patient lists
  2. Immunization registries
  3. Syndromic surveillance data

#### CQMs

- There are no minimum values to achieve
- You report the results as generated by the EHR
- All documentation needs to be completed before a note is signed
- An E&M code must be documented on the superbill before a note is signed

## Core Menu Measures

Print this table to mark your selections.

13 Core Measures: All are required			
Attest	Requirement #	MU Requirement	Threshold
<input type="checkbox"/> Yes <input type="checkbox"/> Yes	Core #1 OR Core #1 Alt	CPOE (Patients) CPOE (Meds)	> 30% > 30%
Yes	Core #2	Drug-drug, drug-allergy checks	Yes / No
Yes	Core #3	Problem lists	> 80%
Yes	Core #4	ePrescribing	> 40%
Yes	Core #5	Active medication list	> 80%
Yes	Core #6	Active medication allergy list	> 80%
Yes	Core #7	Demographics	> 50%
Yes	Core #8	Vital signs	> 50%
Yes	Core #9	Smoking status	> 50%
Yes	Core #10	Clinical decision support	Yes / No
Yes	Core #11	Patient electronic access	> 50%
Yes	Core #12	Clinical summaries	> 50%
Yes	Core #13	Protect electronic health information	Yes / No

## Select Menu Measures

Print this table to mark your selections.

Menu Measures: Choose a total of 5			
Attest	Requirement #	MU Requirement	Threshold
<b>Select 4 of the following 7 requirements:</b>			
<input type="checkbox"/> Yes	<a href="#">Menu #1</a>	Drug-formulary checks	Yes / No
<input type="checkbox"/> Yes	<a href="#">Menu #2</a>	Lab test results (must have eLabs)	> 40%
<input type="checkbox"/> Yes	<a href="#">Menu #3</a>	Patient lists	Yes / No
<input type="checkbox"/> Yes	<a href="#">Menu #4</a>	Patient reminders	> 20%
<input type="checkbox"/> Yes	<a href="#">Menu #5</a>	Patient education	> 10%
<input type="checkbox"/> Yes	<a href="#">Menu #6</a>	Medication reconciliation	> 50%
<input type="checkbox"/> Yes	<a href="#">Menu #7</a>	Summary of care record	> 50%
<b>Select 1 of the following 2 requirements:</b>			
<input type="checkbox"/> Yes	<a href="#">Menu #8</a>	Immunization registries	Yes / No
<input type="checkbox"/> Yes	<a href="#">Menu #9</a>	Syndromic surveillance data	Yes / No

## Select CQMs

Eligible providers must report on 9 out of the 19 CQMs for which Kareo is certified. CQMs are organized by CMS into recommended core sets:

- There are 9 CQMs for the adult population
- There are 9 CQMs for the pediatric population
- There are 2 additional measures that do not fall into the above two groups



You may select the 9 CQMs from either of the recommended sets but they must cover at least 3 of the National Quality Strategy domains. These are:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

As you make your selections, take a look at the domains in the CQM table on the next pages to ensure the 9 measures you end up with cover at least 3 domains.

### Notes about CQMs

- There are no minimum values to achieve
- You report the results as generated by the EHR
- All documentation needs to be completed before a note is signed
- An E&M code must be documented on the superbill before a note is signed

## Select CQMs

Print these tables to mark your selections.

CQMs: You must participate in reporting on 9 CQM measures				
Attest	Requirement #	MU Requirement	Threshold	Domain
<b>2014 CQMs Adult Recommended Core Measures</b>				
<input type="checkbox"/> Yes	<a href="#">CMS 2</a>	Preventive Care & Screening: Screening for Clinical Depression & Follow-up Plan	None	Population & Public Health
<input type="checkbox"/> Yes	<a href="#">CMS 50</a>	Closing the referral loop: Receipt of Specialist Report	None	Care Coordination
<input type="checkbox"/> Yes	<a href="#">CMS 68</a>	Documentation of Current Medications in the Medical Record	None	Patient Safety
<input type="checkbox"/> Yes	<a href="#">CMS 69*</a>	Preventive Care & Screening: BMI Screening & follow-up	None	Population/Public Health
<input type="checkbox"/> Yes	<a href="#">CMS 90</a>	Assessment for complex Chronic Conditions	None	Patient & Family Engagement
<input type="checkbox"/> Yes	<a href="#">CMS 138*</a>	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	None	Population & Public Health
<input type="checkbox"/> Yes	<a href="#">CMS 156</a>	Use of High-Risk Medication in the Elderly	None	Patient Safety
<input type="checkbox"/> Yes	<a href="#">CMS 165*</a>	Controlling High Blood Pressure	None	Clinical Process & Effectiveness
<input type="checkbox"/> Yes	<a href="#">CMS 166</a>	Use of Imaging Studies for Low Back Pain	None	Efficient Use of Healthcare Resources

<b>2014 CQMs Pediatric Recommended Core Measures</b>				
<input type="checkbox"/> Yes	<a href="#">CMS 2</a>	Preventive Care & Screening: Screening for Clinical Depression & Follow-up Plan	None	Population & Public Health
<input type="checkbox"/> Yes	<a href="#">CMS 75</a>	Children who have Dental Decay or Cavities	None	Clinical Process & Effectiveness
<input type="checkbox"/> Yes	<a href="#">CMS 117*</a>	Childhood Immunization Status	None	Population & Public Health
<input type="checkbox"/> Yes	<a href="#">CMS 126</a>	Use of Appropriate Medications for Asthma	None	Clinical Process & Effectiveness
<input type="checkbox"/> Yes	<a href="#">CMS 136</a>	ADHD: Follow-up Care for Children Prescribed ADHD Medication	None	Clinical Process & Effectiveness
<input type="checkbox"/> Yes	<a href="#">CMS 146</a>	Appropriate Testing for Children with Pharyngitis	None	Efficient Use of Healthcare Resources
<input type="checkbox"/> Yes	<a href="#">CMS 153</a>	Chlamydia Screening for Women	None	Population & Public Health
<input type="checkbox"/> Yes	<a href="#">CMS 154</a>	Appropriate Treatment for Children with Upper Respiratory Infection	None	Efficient Use of Healthcare Resources
<input type="checkbox"/> Yes	<a href="#">CMS 155*</a>	Nutrition & Physical Activity for Children and Adolescents	None	Population & Public Health
<b>2014 CQMs Alternate Core Measures</b>				
<input type="checkbox"/> Yes	<a href="#">CMS 127*</a>	Pneumonia Vaccination Status for Older Adults	None	Clinical Process & Effectiveness
<input type="checkbox"/> Yes	<a href="#">CMS 147*</a>	Preventive Care & Screening: Influenza Immunization	None	Population & Public Health

\*Indicates this measure was carried over from the 2011 Edition.

## Discuss Practice Workflow Changes

Now that you know what measures you are including in your attestation, review your current office workflows and decide whether you need to make any changes.



For example, if you have not been collecting patient email addresses so that you can invite them to the Patient Portal, you may need to modify the process in how you collect and confirm patient information.

Workflow	Change
Example: Patient email	Confirm or collect patient email at check-in. Add to intake form.

## Select Reporting Period

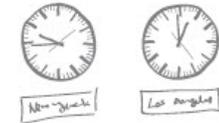
A reporting period is a period of time that you must gather data. This data is what you will use to attest for Meaningful Use with CMS.

The reporting period is dependent upon where you are in the Meaningful Use timeline. For example, if you are in your first year of attesting for Meaningful Use, your reporting period will be 90 consecutive days. With the exceptions below, the general timelines are as follows:

- First year (Stage 1, Year 1) = 90 consecutive days
- All subsequent years = 365 days
- Attest to each stage for a minimum of 2 years

### Exceptions for 2014

In 2014 only, a provider need only attest for 3 months, regardless of stage.



### Stage 1, Year 1

- Reporting period is any continuous 90 days
- Begin reporting period no later than July 1, 2014
- Attest by Oct 1, 2014 to avoid 2015 payment adjustment and to receive 2014 incentives

### Stage 1, Year 2

- Reporting period is 90 days fixed to calendar quarters for 2014
- Attest up to February 28, 2015
- The reporting period for all subsequent years is a calendar year

## Reporting Triggers & Tips

It is important to make sure that all necessary information is documented adequately. You must also take into consideration the fields that trigger items in the reports.

Notes	<ul style="list-style-type: none"><li>• Signing a note establishes the relationship with the provider.<ul style="list-style-type: none"><li>a. Reports scan the database for signed notes completed within the measurement period.</li><li>b. The provider who signed the note is considered the patient’s provider.</li></ul></li><li>• Signing a note accumulates the chart summary for a report. Note the following:<ul style="list-style-type: none"><li>a. For the Functional Measures report, most information added after the note is signed will be included.</li><li>b. For the CQM report, information added after a note is signed <u>will not</u> be included.</li></ul></li></ul>
Superbills	<ul style="list-style-type: none"><li>• A superbill must be completed with each note.<ul style="list-style-type: none"><li>a. The E&amp;M code establishes the type of visit.</li><li>b. The date of the superbill must be the same as the note.</li></ul></li></ul>
Patient Refusal	<ul style="list-style-type: none"><li>• Document a patient’s refusal by marking a response in each area:<ul style="list-style-type: none"><li>a. Demographics: For Language, Race or Ethnicity, select “Decline to specify.”</li><li>b. Vitals: When Height, Weight or Blood Pressure is blank, you will be prompted after saving to select a reason.</li><li>c. Immunizations: After selecting “Not administered”, mark the appropriate reason.</li></ul></li></ul>
Care Checklist	<ul style="list-style-type: none"><li>• The Care Checklist should be used to gather CQM information that is not gathered in other sections of the chart.<ul style="list-style-type: none"><li>a. Counseling</li><li>b. Terminal illness</li><li>c. Reminders</li></ul></li></ul>

<p>Problem/Issues</p>	<ul style="list-style-type: none"> <li>• Problems/Issues: <ul style="list-style-type: none"> <li>a. Must include a start date as some requirements measure the length of time that the patient has had the problem/issue.</li> <li>b. Not all variations of a problem (i.e. hypertension vs. essential hypertension) have been included in the definition of the CQMs.</li> <li>c. A provider should document based on clinically sound judgment and not based on whether the problem/issue is included in a measure.</li> <li>d. Pregnancy should be documented in Problems. Some CQM exceptions include pregnancy.</li> </ul> </li> </ul>
<p>Immunizations</p>	<ul style="list-style-type: none"> <li>• Immunizations must include an administration date as requirements account for the patient's age when administered.</li> </ul>
<p>Patient Portal</p>	<ul style="list-style-type: none"> <li>• Patient Portal <ul style="list-style-type: none"> <li>a. Measures are based on the number of patients invited; not on the number of patients that register.</li> <li>b. If the provider has an eLab interface, only signed labs will appear in the Patient Portal.</li> </ul> </li> </ul>

## Field Drills

You've now determined the measures you'll be reporting on and your reporting period. It's time to ramp up and practice! Below is a list of tools that Kareo EHR provides to help you track your progress.

### Meaningful Use Dashboard

- The dashboard is a real-time snapshot of how you're doing with your core and menu measures. It can be used throughout the day to track your progress and help you make adjustments to your office workflow.

### Functional Measures Report

- The Functional Measures report is useful to print and share with your team during a team meeting. This report identifies each core and menu measure and their results. At the end of your reporting period this is the report that you will need when you attest with CMS.

### CQM Report

- The CQM report is useful to print and share with your team during a team meeting. This report identifies each CQM measure and their results. At the end of your reporting period this is the report that you will need when you attest with CMS.

### Progress Checklist

- The [Kareo EHR Progress Checklist 2014](#) helps you track your progress for all measures week over week.

### Audit Preparation

- If you are audited, the specifics will vary, and cannot be determined by Kareo. However, here are a few things we suggest:
- Start a folder that you can store all relevant Meaningful Use items in.
- Keep your NPPES user ID and Password so they don't get lost.
- If you are attesting for Menu Measure # 3, Patient List: Print a report during your reporting period and save it in this folder.
- If your state's immunization registry or public health agency cannot accept your electronic submission, get that in writing and save in this folder.
- Save any documentation you have done to satisfy Core #13, Protected Health Information.

## Graduation

Congratulations! You are now ready to start your reporting period. Below are some final recommendations so you can hit the ground running.

### Start your Reporting Period

When you start your reporting period, it is recommended that you schedule weekly meetings. Meeting regularly helps address issues as they arise.



Best practices for each weekly meeting:

- Run the [Functional Measures report](#)
- Run the [CQM report](#) (Note that it is best to do an initial run of this report at the beginning of your reporting period. See section, Fitness Exercises.)
- Complete your [Progress Checklist 2014](#)
- Evaluate your progress: Identify areas that need attention
- Design workflow modifications
- Implement the modifications with your staff

### Complete Attestation

At the end of your reporting period you will need to:

- Run the [Functional Measures report](#) for the date range of your reporting period.
- Run the [CQM report](#) for the date range of your reporting period.
- You will also need Kareo EHR's CMS EHR Certification ID: **A014E01NDGFDEAD**

The Functional Measures and CQM reports will provide you with all the data you will need to attest with CMS.



[Attestation Site](#)



[Attestation User Guide](#)

## Core Measure Details

## Core Measure #1, CPOE



Use computer provider order entry (CPOE) for medication orders directly entered by a licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

# 30%

More than 30 percent of all unique patients with at least one medication in their medication list seen by the Eligible Professional (EP) have at least one medication order entered using CPOE.

Unique patient has at least one medication entered on his or her medication list during the Reporting Period.

= N

Unique patient has at least one medication entered on his or her medication list during the Reporting Period.

= D

Kareo EHR calculates the CPOE so that the numerator and denominator will always be identical. Therefore, the result will either be 0% or 100%.



### Exclusions

Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.

## Core Measure #1, Alternate CPOE



Use computer provider order entry (CPOE) for medication orders directly entered by a licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

30%

More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

Any medication added to the Medication List during the Reporting Period.

= N

Any medication added to the Medication List during the Reporting Period.

= D

Kareo EHR calculates the CPOE so that the numerator and denominator will always be identical. Therefore, the result will either be 0% or 100%.



### Exclusions

Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.

## Core Measure #2, DDI, DAI Checks



Implement drug-drug and drug-allergy interaction checks.

Yes/No

Have you enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

### YES!

This measure does not require any further action because this functionality is incorporated in the Kareo EHR.



### Exclusions

None

## Core Measure #3, Up-to-date Problem List



Maintain an up-to-date problem list of current and active diagnoses.

80%

More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.

- Has at least one active problem, OR
- “No Known Problems” checked

= N

- Unique patient with a signed note during the reporting period

= D



**Exclusions**  
None

## Core Measure #4, ePrescribing



Generate and transmit permissible prescriptions electronically (eRx).

# 40%

More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology

Any patient whose prescription was sent via ePrescribing.

= N

Any patient who has a new prescription or a refill prescribed by the provider during the Reporting Period.

= D



### Exclusions

1. Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.
2. Any EP who: does not have a pharmacy within their organization and there are no pharmacies that accept eRx within 10 miles of the EP's practice at start of Reporting Period.

## Core Measure #5, Active Medication List



Maintain active medication list.

# 80%

More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

- Who has at least one medication on his/her Active Medication List. OR
- “No known medications” checked

= N

- Unique patient with a signed note during the reporting period

= D



**Exclusions**  
None

## Core Measure #6, Active Medication Allergy List



Maintain active medication allergy list.

80%

More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

- Who has at least one medication allergy in their allergy list, OR
- “No known medications allergies” checked, OR
- “No known allergies” checked

= N

- Unique patient with a signed note during the reporting period

= D



**Exclusions**  
None

## Core Measure #7, Record Demographics



Record all of the following demographics:

- |                    |           |
|--------------------|-----------|
| Preferred language | Sex       |
| Race               | Ethnicity |
| Date of Birth      |           |

# 50%

More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.

- Patients who have all five (5) demographic fields completed OR
- “Decline to Specify” is selected for Language, Race or Ethnicity

= N

- Unique patient with a signed note during the reporting period

= D



**Exclusions**  
None

## Core Measure #8, Record Vitals



Record and chart changes in vital signs:

Height (No age limit)  
Blood pressure (Age 3 and over)  
Plot & display growth charts for children 2-20 years

Weight (No age limit)  
Calculate & display body mass index (BMI)

# 50%

More than 50 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height/length and weight (for all ages) recorded as structured data.



### Exclusions

1. Any EP who: Sees no patients 3 years or older is excluded from recording blood pressure.
2. Any EP who: 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.
3. Any EP who: Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
4. Any EP who: Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.

## Core Measure #8, Record Vitals continued...



If height/length, weight and blood pressure (all) within scope of practice.

Patients 3 yrs or older in the denominator for whom height/length, weight and blood pressure are recorded.

=  $N_1$

Patients younger than 3 yrs in the denominator for whom height/length and weight are recorded.

=  $N_2$

$\rangle$  =  $N_{\text{Sum}}$

- Unique patient with a signed note during the reporting period

=  $D$

Continued on next page...

## Core Measure #8, Record Vitals continued...



If height/length and weight (only) within scope of practice.

Patients in the denominator for whom height/length and weight are recorded.

= N

- Unique patient with a signed note during the reporting period

= D



If blood pressure (only) within scope of practice.

Patients in the denominator for whom blood pressure was recorded.

= N

- Unique patient 3 years of age or older with a signed note during the reporting period

= D

## Core Measure #9, Record Smoking Status



Record smoking status for patients 13 years and older.

50%

More than 50 percent of all unique patients 13 years or older seen by the EP have smoking status recorded as structured data.

Who has smoking status recorded under Social History.

= N

- Unique patient age 13 years or older with a signed note during the reporting period

= D



### Exclusions

Based on ALL patient records: Any EP who did not see patients 13 years or older would be excluded from this requirement.

## Core Measure #10, Clinical Decision Support



Implement one clinical decision support (CDS) rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.

Yes/No

Have you implemented one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule?

### YES!

This measure does not require any further action because this functionality is incorporated in the Kareo EHR.



#### Exclusions

None

## Core Measure #11, Patient Electronic Access



Provide patients the ability to view online, download and transmit their health information within four (4) business days of the information being available to the EP.

50%

More than 50 percent of all unique patients seen by the EP during the EHR Reporting Period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.

- Whose email has been entered into Demographics
- And invited to the Patient Portal

= N

- Unique patient with a signed note during the reporting period

= D



**Exclusions**  
None

## Core Measure #12, Clinical Summaries



Provide clinical summaries for patients for each office visit.

50%

Clinical summaries provided to patients for more than 50 percent of all office visits within three (3) business days.

- Number of office visits where a clinical summary was either
- Printed, OR
- Sent to the Patient Portal, OR
- “Patient Refused the Summary” box is checked.

= N

- Number of office visits conducted by the EP during the reporting period

= D



### Exclusions

Based on ALL patient records: Any EP who has no office visits during the EHR reporting period would be excluded from this requirement.

## Core Measure #13, Protect Electronic Health Information



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

Yes/No

Have you conducted or reviewed a security risk analysis per 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies as part of your risk management process?

This measure is independent of Kareo EHR. The security risk is completed by the EP. Refer to the CMS website for additional information or [find out more here...](#)



**Exclusions**  
None

## Menu Measure Details

## Menu Measure #1, Drug Formulary Checks



Implement drug formulary checks.

Yes/No

The EP has enabled this functionality and has access to at least one (1) internal or external drug formulary for the entire EHR Reporting Period. Have you met this measure?

### YES!

This measure does not require any further action because this functionality is incorporated in the Kareo EHR.

Drug formulary is available if a patient's formulary plan is documented in Demographics>Insurance.



### Exclusions

Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement.

## Menu Measure #2, Incorporate Lab Test Results

**Note: You must use eLabs within Kareo EHR to meet this measure!**



Incorporate clinical lab test results into certified EHR technology as structured data.

40%

More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are in either a positive/negative or numerical format are incorporated in certified EHR as structured data.

Number of lab tests results received via eLabs whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.

= N

Number of lab tests ordered using eLabs during the Reporting Period whose results are express in a positive or negative affirmation or as a number.

= D



### Exclusions

Based on ALL patient records: Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement.

## Menu Measure #3, Patient List



Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.

Yes/No

Generate at least one report listing patients of the EP with a specific condition. The final rule defines specific conditions as those conditions listed in the patient's active problem list.

- The ability to generate a patient list by condition (problem) is found on the Reports tab, under Patient List report.
- Only one report needs to be generated based on one condition. No further action is required. (Run this report sometime during your reporting period. Print and save it in case of an Audit)



**Exclusions**  
None

## Menu Measure #4, Patient Reminders



Send reminders to patients per patient preference for preventive/follow-up care.

20%

More than 20 percent of all unique patients 65 years or older OR 5 years or younger were sent an appropriate reminder during the EHR Reporting Period.

- Who was sent a reminder for preventive/follow-up care during the reporting period.
- Check "Follow-up" in Care Checklist.

= N

- Unique patient 65 years or older OR 5 years or younger with a signed note.

= D

**Note:** This measure requires a practice to document that a reminder has been sent using the Care Checklist. Kareo EHR does not have the capability of running patient reminders.



### Exclusions

Based on ALL patient records: Any EP who has no patients 65 years or older or 5 years old or younger with records maintained using certified EHR technology is excluded from this requirement.

## Menu Measure #5, Patient Specific Education



Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

10%

More than 10 percent of all unique patient seen by the EP during the EHR Reporting Period are provided patient-specific education resources.

Who has received printed patient education in Kareo EHR.

= N

- Unique patient with a signed note during the reporting period

= D



### Exclusions

None

## Menu Measure #6, 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.

# 50%

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

Who has the “Medication Reconciliation Performed” box checked under Medications.

= N

- Any patient with a signed note during the reporting period
- The signed note has the “Transition of Care-Receiving” box checked in the note.

= D



### Exclusions

Based on ALL patient records: Any EP who was not on the receiving end of any transition of care during the EHR reporting period would be excluded from this requirement.

## Menu Measure #7, Summary of Care Record



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 of care record information (including diagnostic lab results, problem list, medications list, medication allergies) for each transition of care or referral.

50%

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.

Any patient for whom a patient summary was created.

= N

- Any patient with a signed note during the Reporting Period
- The signed Note has the "Transition of Care-Transferring" box checked in the note.

= D

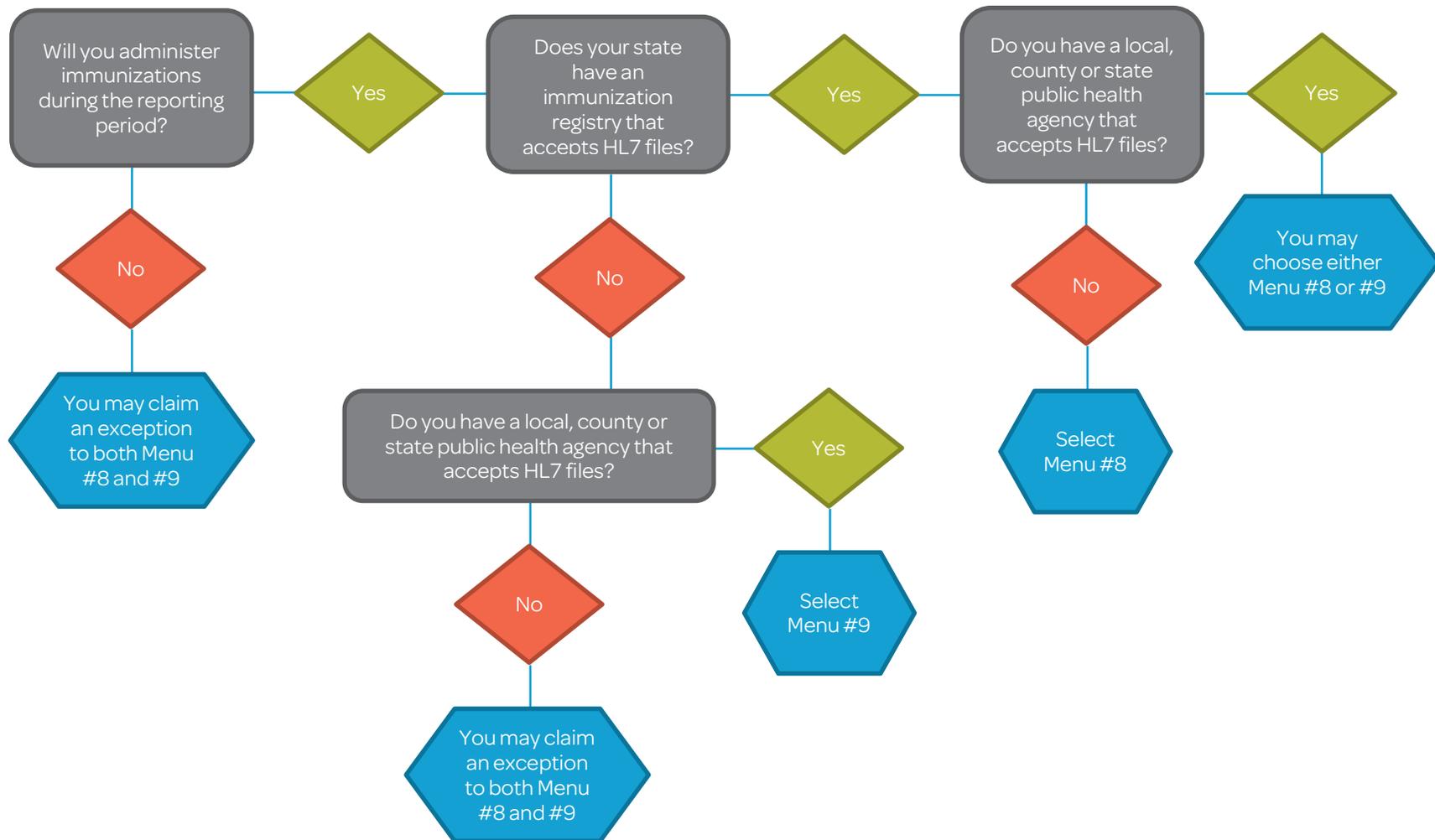


### Exclusions

None

## Menu Measures #8 and #9 Decision Tool

If you are eligible, you must select either Menu Measure #8 or #9. Answer the questions in the flow chart below to help you decide. Before you begin, contact your state or local immunization or public health agency to see if they accept the import of HL7 files: [Click here for registry information](#). Once you decide, continue on to the next pages for detailed information on Menu Measures #8 and #9.



## Immunization Registry Requirements

Fields that need to be completed if you plan to submit immunization:

Demographics Tab	<p>Additional Info</p> <ul style="list-style-type: none"><li>• Mother's first name</li><li>• Mother's Maiden name</li><li>• Birth Place</li><li>• Birth Order</li><li>• Multiple Birth Member</li></ul>
Immunizations Tab	<ul style="list-style-type: none"><li>• Vaccine settings</li><li>• Refuses all Immunization</li><li>• Immunization Registry settings<ul style="list-style-type: none"><li>○ Immunization Reminders</li><li>○ Consent to Share immunizations with Registries</li><li>○ Effective Date</li></ul></li></ul>

## Menu Measure #8, Immunization Registries



Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.

Yes/No

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

- Providers need to chart immunizations for one patient, either real or fake.
- Providers need to download the patient's immunization using Export Immunization Summary on the Exchange button.
- Providers will need to check with their state immunization registry to determine if they have the capacity to receive the downloaded summary electronically.



### Exclusions

1. Based on ALL patient records: Any EP who does not perform immunizations during the EHR Reporting Period would be excluded from this requirement.
2. Based on ALL patient records: If there is no immunization registry that has the capacity to receive the information electronically, an EP would be excluded from this requirement.

## Menu Measure #9, Syndromic Surveillance Data



Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

Yes/No

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

- Providers need to chart immunizations for one patient, either real or fake.
- Providers need to download the patient's immunization using Export Syndromic Surveillance on the Exchange button.
- Providers will need to check with their local public agency to determine if they have the capacity to receive the downloaded summary electronically.



### Exclusions

1. Based on ALL patient records: Any EP who does not perform immunizations during the EHR Reporting Period would be excluded from this requirement.
2. Based on ALL patient records: If there is no Public Health agency that has the capacity to receive the information electronically, an EP would be excluded from this requirement.

## CQM Details

## Adult Core Set

### CMS 2, Screening for Clinical Depression & Follow-up Plan

Percentage of patients aged 18 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.

- Document that depression screen was positive and a follow-plan was provided in the Care Checklist, or
- Document that depression screen was Negative in the Care Checklist, or
- Document that patient refuse treatment in the Care Checklist

= N

- All patients aged 18 years and older prior to the reporting period
- Signed note during the reporting period
- E & M code on the superbill
- Document in the Care Checklist "If patient screened for depression, was standardized tool used?"

= D

Domain: Population & Public Health

## CMS 50, Closing the Referral Loop: Receipt of Specialist Report

Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

- Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred
- Mark "consult received" in doc tab in patient chart

= N

- Number of patients, regardless of age
- Signed note during the reporting period
- E & M code on the superbill
- Select "Send a Referral" in the note

= D

Domain: Care Coordination

## CMS 68, Documentation of Current Medications in the Medical Record

Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

- Patients for whom Medications were reviewed during each visit
- Indicated by documenting "Medication Reconciliation" performed in the medication tab

= N

- Patients 18 years or older
- Signed note within the last 12 months
- E & M code on the superbill

= D

Domain: Patient Safety

## CMS 69, Body Mass Index (BMI) Screening and Follow-up

Percentage of patients ages 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. The guidelines for BMI are separated into two (2) age groups.

- For ages 65 and older, the BMI parameters are 1) less than (<) 22 kg/m<sup>2</sup> or 2) greater than (>) 30 kg/m<sup>2</sup>.
- For ages 18 to 64, the BMI parameters are 1) less than (<) 18.5 kg/m<sup>2</sup> or 2) greater than (>) 25 kg/m<sup>2</sup>.

The CQM Report will show these as two separate percentages but it considered one CQM measure.



### Exclusion (must be documented)

- Patient is terminally ill for six or less months from the encounter date;
- Patient is pregnant; diagnosis on Problems list
- Physical exam not done because of patient's refusal;
- Physical exam not done because of a medical reason;
- Physical exam not done because of a system reason.

## CMS 69, Body Mass Index (BMI) Screening and Follow-up continued...

- Any patient who has a BMI recorded; AND
- the BMI must be less than ( $<$ ) 18.5 kg/m<sup>2</sup> OR greater than ( $>$ ) 25 kg/m<sup>2</sup>; AND
- BMI Follow-up Plan or Dietary Consultation indicated on the Care Checklist

= N<sub>1</sub>

- Patients 18 years or older but younger than 65
- Seen once in the 6 months prior to the reporting period end date with a signed note
- E & M code on the superbill

= D<sub>1</sub>

- Any patient who has a BMI recorded; AND
- the BMI must be less than ( $<$ ) 22 kg/m<sup>2</sup> OR greater than ( $>$ ) 30 kg/m<sup>2</sup>; AND
- BMI Follow-up Plan or Dietary Consultation indicated on the Care Checklist

= N<sub>2</sub>

- Patients 65 years or older
- Seen once in the 6 months prior to the reporting period end date with a signed note
- E & M code on the superbill

= D<sub>2</sub>

## CMS 90, Functional Status Assessment for Complex Chronic Conditions

Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments.

- Patients with patient reported functional status assessment results
- Test was administered at least two weeks before or during each visit
- Documented in the Care Checklist

= N

- Adults aged 65 years and older who had two office visits within the last 12 months from the start of the reporting period with a signed note
- (The first visit was during the first 185 days of the measurement year)
- (The second visit was at least 30 days but no more than 180 days after first visit)
- An active diagnosis of heart failure
- E & M code on the superbill

= D

Domain: Patient & Family Engagement

## CMS 138, Tobacco Use: Screening and Cessation Intervention

Percentage of patients aged 18 years or older identified as tobacco user within the past 24 months who received cessation intervention.

- Was screened for smoking status AND
- IF has a smoking status of one of the following recorded in Social History: "Current every day smoker", "Current some day smoker", or "Smoker, current status unknown,"
- Received cessation counseling which has been recorded in Care Checklist
- Has at least one active smoking cessation agent on their Medications list

= N

- Any patient 18 years or older; AND
- Has been seen once in the 24 months prior to the reporting period end date with a signed note
- E&M code on superbill

= D

Domain: Population & Public Health

## CMS 156, Use of High-risk Medications in the Elderly

Percentage of patients 66 years of age and older who were ordered high-risk medication. Two rates are reported:

- Percent of patients who were ordered at least one (1) high-risk medication.
- Percent of patients who were ordered at least two (2) different high-risk medications

Patients with an order for at least one high-risk medication on Medication List

=  $N_1$

Patients with an order for at least two different high-risk medication on Medication List

=  $N_2$

- 
- Any patient 66 years or older
  - Signed note during the reporting period
  - E&M code on the superbill

=  $D$

Domain: Patient Safety

## CMS 165, Controlling High Blood Pressure

Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement.

- Any patient who has a diastolic blood pressure < 90 mmHg recorded at the recent visit; AND
- A systolic blood pressure < 140 mmHg recorded at the recent visit.

= N

- Any patient who is 18 years or older but 85 years or younger; AND
- Who has an active diagnosis of Essential Hypertension with a start date of  $\leq$  reporting period end date AND
- Seen at least once during the reporting period with a signed note
- E&M Code in the superbill

= D

Domain: Clinical Process & Effectiveness

## CMS 166, Use of Imaging Studies for Low Back Pain

Percentage of patients 18-49 years of age with a diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.

- Patients **without an imaging study** conducted on the date of the outpatient visit or in the 28 days following the outpatient visit
- High level order requested for image study

= N

- Patients 18-49 years of age
- With a problem of low back pain
- Signed note
- E & M code on the superbill

= D

Domain: Efficient Use of Healthcare Resources

## Pediatric Core Set

### CMS 2, Screening for Clinical Depression & Follow-up Plan

Percentage of patients aged 12 years and older but less than 18 years screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.

- Document that depression screen was positive and a follow-plan was provided in the Care Checklist, or
- Document that depression screen was Negative in the Care Checklist, or
- Document that patient refuse treatment in the Care Checklist

= N

- All patients aged 12-17 years prior to the reporting period
- Signed note during the reporting period.
- E & M code on the superbill
- Document in the Care Checklist "If patient screened for depression, was standardized tool used?"

= D

Domain: Population & Public Health

## CMS 75, Children Who Have Dental Decay or Cavities

Percentage of children, ages 0-19 years, who have had tooth decay or cavities during the reporting period.

Children who had cavities and/or tooth indicated under Problems.

= N

- Children, age 0-19 years,
- Signed note during the reporting period
- E & M code on the superbill

= D

Domain: Clinical Process & Effectiveness

## CMS 117, Childhood Immunizations Status

The percentage of children 2 years of age who had

- Four diphtheria, tetanus and acellular pertussis (DTaP);
  - Three polio (IPV);
  - One measles, mumps and rubella (MMR);
  - Two H influenza type B (HiB);
  - Three hepatitis B (Hep B);
  - One chicken pox (VZV);
  - Four pneumococcal conjugate (PCV);
  - Two hepatitis A (Hep A);
  - Two or three rotavirus (RV); and
  - Two influenza (flu) vaccines by their second birthday.
- The measure calculates a rate for each vaccine and two separate combination rates.

CMS 117, Childhood Immunizations Status continued...

- A patient must have four (4) DTaP vaccines documented under Immunizations.
- All four DTaP vaccines must have been administered between  $\geq 42$  days of age and  $\leq 2$  years of age
- A patient may not have encephalopathy or progressive neurological disorder documented on the Problems List
- A patient may not have an allergy to DTaP vaccine documented on the Allergies List

=  $N_1$

- A patient must have three (3) IPV vaccines documented under Immunizations
- All three IPV vaccines must have been administered between  $\geq 42$  days of age and  $\leq 2$  years of age
- A patient may not have an allergy to IPV vaccine, neomycin, streptomycin or polymyxin documented on the Allergies List

=  $N_2$

- A patient must have four (4) DTaP vaccines documented under Immunizations
- All four DTaP vaccines must have been administered between  $\geq 42$  days of age and  $\leq 2$  years of age
- A patient may not have encephalopathy or progressive neurological disorder documented on the Problems List
- A patient may not have an allergy to DTaP vaccine documented on the Allergies List

=  $N_3$

## CMS 117, Childhood Immunizations Status continued...

- A patient must have four (4) pneumococcal vaccines documented under Immunizations
- All four pneumococcal vaccines must have been administered between  $\geq 42$  days of age and  $\leq 2$  years of age
- A patient may not have an allergy to pneumococcal vaccine documented on the Allergies List

= N<sub>7</sub>

- A patient must have two (2) hepatitis A vaccines documented under Immunizations
- Both hepatitis A vaccines must have been administered  $\leq 2$  years of age
- A patient may not have an allergy to hepatitis A vaccine documented on the Allergies List

= N<sub>8</sub>

- A patient must have two (2) rotavirus vaccines documented under Immunizations
- Both rotavirus vaccines must have been administered between  $\geq 42$  days of age and  $\leq 2$  years of age
- A patient may not have an allergy to rotavirus vaccine documented on the Allergies List

= N<sub>9</sub>

CMS 117, Childhood Immunizations Status continued...

- A patient must have two (2) influenza vaccines documented under Immunizations
- Both influenza vaccines must have been administered between  $\geq 180$  days of age and  $\leq 2$  years of age
- A patient may not have cancer of lymphoreticular or histiocytic tissue, asymptomatic HIV, multiple myeloma, leukemia or immunodeficiency documented on the Problems List
- A patient may not have an allergy to influenza vaccine documented on the Allergies List

=  $N_{10}$

All patients included in numerators 1, 2, 3, 5 and 6 above.

=  $N_{11}$

All patients included in numerators 1, 2, 3, 5, 6 and 7 above.

=  $N_{12}$

- 
- Any patient age 2, and
  - Seen at least once during the reporting period with a signed note
  - E & M Code on the superbill

=  $D_{1-12}$

## CMS 126, Use of Appropriate Medications for Asthma

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Patients who were dispensed at least one prescription for a preferred therapy during the reporting period.

= N

- 5-11 years of age
- Signed note during the reporting period
- Persistent asthma documented in the problems list with a start date
- E & M code on the superbill

= D

Domain: Clinical Process & Effectiveness

## CMS 126, Use of Appropriate Medications for Asthma continued...

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Patients who were dispensed at least one prescription for a preferred therapy during the reporting period.

= N

- 12-18 years of age
- Signed note during the reporting period
- Persistent asthma documented in the problems list with a start date
- E & M code on the superbill

= D

## CMS 126, Use of Appropriate Medications for Asthma continued...

Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Patients who were dispensed at least one prescription for a preferred therapy during the reporting period.

= N

- 19-50 years of age
- Signed note during the reporting period
- Persistent asthma documented in the problems list with a start date
- E & M code on the superbill

= D

## CMS 136 Follow-up Care for Children Prescribed ADHD Medication

Definitions	
Intake Period	5 month period starting 90 days prior to the start of the reporting period and ending 60 days after the start of the reporting period.
Index prescription start date (IPSD)	The earliest prescription dispensing date for an ADHD medication where the date is in the Intake period and an ADHD medication was not dispensed during the 120 days prior.
Continuation and Maintenance Phase	The 31-300 days following the IPSD.
Cumulative Medication Duration	Is an individuals total # of medication days over a specific period.

Domain: Clinical Process & Effectiveness

## CMS 136 Follow-up Care for Children Prescribed ADHD Medication continued...

### Measure A

Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.

Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSPD.

=  $N_a$

- Children 6-12 years of age
- Signed note during the reporting period
- Who were dispensed an ADHD medication during the intake period
- E & M code on the superbill

=  $D_a$

## CMS 136 Follow-up Care for Children Prescribed ADHD Medication continued...

### Measure B

Percentage of children who remained on ADHD medication for at least 210 days and who in addition to the visit in the initiation phase had at least 2 additional follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

- Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase
- And at least two follow-up visits during the Continuation and Maintenance Phase

=  $N_b$

- Children 6-12 years of age
- Signed note during the reporting period
- Who were dispensed an ADHD medication during the intake period and
- Who remained on the medication for at least 210 day out of the 300 days following the IPSPD
- E & M code on the superbill

=  $D_b$

## CMS 146, Appropriate Testing for Children with Pharyngitis

Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.

- Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis
- eLab request (**Requires elabs**)

= N

- Children age 2-18 years
- Signed note during the reporting period
- With a diagnosis of pharyngitis with a start date
- An antibiotic ordered on or within three days of the visit

= D

Domain: Efficient Use of Healthcare Resources

## CMS 153, Chlamydia Screening for Women

Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

- Women with at least one chlamydia test during the reporting period
- eLab test ordered (**must use eLab**)

= N

- Women 16-24 years of age
- Active problems that identify sexually active women would include: pregnancy, sexually transmitted infections, other reproductive conditions
- Signed note during the reporting period.
- E & M code on the superbill

= D

Domain: Population & Public Health

## CMS 154, Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.

Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection.

= N

- Children age 3 months to 18 years
- Signed note during the reporting period
- With a diagnosis of Upper Respiratory infection documented in the problems list with a start date during the reporting period
- E & M code on the superbill

= D

Domain: Efficient Use of Healthcare Resources

## CMS 155, Weight Assessment and Counseling for Children and Adolescents

The percentage of patients 3-17 years of age who had a visit with a PCP or OB/GYN and who had evidence height, weight and BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement period.

Patients who had a height, weight and BMI percentile recorded during the reporting period through Vitals.

=  $N_1$

Any patient who has Nutrition Counseling documented in Care Check list.

=  $N_2$

Any patient who has Physical Activity Counseling documented in Care Check list.

=  $N_3$

$\rangle$  =  $N_4$ Sum

- Any patient 3 years and older but younger than 18 years old
- Who does not have pregnancy on the active problem list
- Signed note during the reporting period
- E&M code on the superbill

=  $D$

Domain: Population & Public Health

## Additional Measures

### CMS 127, Pneumonia Vaccination for Older Adults

The percentage of patients 65 years of age and older prior to the reporting period who have ever received a pneumococcal vaccine.

Any patient who has a pneumococcal vaccine documented under Immunizations.

= N

- Any patient 65 years and older; AND
- Seen at least once during the reporting period with a signed note
- E&M code on the superbill

= D

Domain: Clinical Process & Effectiveness

## CMS 147, Influenza Immunizations

Percentage of patients ages > 6 months who received an influenza immunization during the flu season (Oct 1st through March 31st).

Any patient who has an influenza vaccine documented under Immunizations that was administered between Oct 1<sup>st</sup> through March 31<sup>st</sup>.

= N

- Any patient 6 months or older; AND
- Patient who does not have active influenza on the Problem list within the last four months; AND
- Seen at least once during the reporting period with a signed note
- E&M code on the superbill

= D



### Exclusion (must be documented)

- Influenza immunization contraindication (i.e. allergic to egg derived vaccine)
- Influenza immunization declined
- Influenza immunization not given due to patient reason
- Influenza immunization not given due to medical reason
- Influenza immunization not given due to system reason

Domain: Population & Public Health