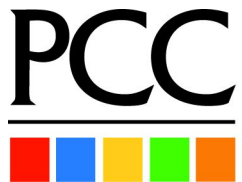


# Meaningful Use and PCC EHR

Tim Proctor (tim@pcc.com)  
Users Conference 2016

# Agenda

- MU basics and eligibility
- How to participate in MU
- Meeting MU measures in PCC EHR
- Understanding CQM reporting in PCC EHR



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# Takeaways

- An understanding of the eligibility requirements for participating in the MU program
- Identification of the areas at your practice that will need to be addressed to meet MU measures
- Understanding of PCC's CQM reports, how they are calculated, and the workflow / configuration changes you'll need to make before using those reports



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# Medicaid EHR Incentive Program

- Every state runs their own program
  - Application filed through your state
  - Deadlines can vary
  - States provide REC (Regional Extension Centers) for assistance
- 2016 is the last year to **start** participating
- No Medicaid payment reductions if you choose not to participate



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# How Much Will You Get Paid?

Medicaid Percent	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
<b>&gt;=30%</b>	<b>\$21,250</b>	<b>\$8,500</b>	<b>\$8,500</b>	<b>\$8,500</b>	<b>\$8,500</b>	<b>\$8,500</b>	<b>\$63,750</b>
<b>&gt;=20% &lt; 30%</b>	<b>\$14,167</b>	<b>\$5,667</b>	<b>\$5,667</b>	<b>\$5,667</b>	<b>\$5,667</b>	<b>\$5,667</b>	<b>\$42,500</b>

- Maximum 6 years of participation
- Program ends in 2021
- Big payment first year

# Eligibility

- Must be an “Eligible Professional” (EP)
  - Physicians (M.D., D.O.)
  - Nurse practitioners
- PAs not eligible
- Incentives are per-provider

# Determining Your Medicaid %

ARRA Medicaid Patient Volume Report

This report assists in determining eligibility for ARRA EHR Incentive program by calculating your Medicaid Patient Volume by provider.

Select a date range, stage, and your Medicaid Plans. A summary of patient volume with totals and Medicaid percentages will be calculated.

Select a Date Range:

☒ 90 Days from 04/02/15 to 06/30/15  
☐ Calendar Year 2014

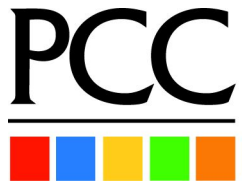
Select a stage to determine eligibility:

☐ Stage 1: Includes only visits with payments greater than \$0  
☒ Stage 2: Includes all visits

- Contact PCC support for assistance with using “arra” report
- Refer to your state for how to calculate Medicaid %
- CHIP patients do not count

# MU Timing

- First year of MU participation is “AIU Year” (Adopt, Implement, or Upgrade” to EHR Technology)
  - EP gets big chunk of MU \$ without any MU reporting
  - EP needs to be using certified EHR for 90 days and meet Medicaid % threshold



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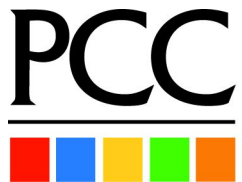


# MU Timing

- Second year of MU participation requires MU reporting
  - Use 90-day reporting period for this first year of MU reporting
  - EP may be eligible for “alternate exclusions”
- Third and subsequent years of MU participation require 365-day (calendar year) for reporting period. EP may still be eligible for some “alternate exclusions”

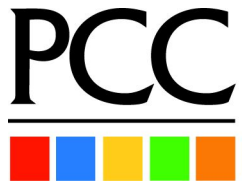
# No More Stage 1/Stage 2

- On 10/6/15, CMS released a final ruling including a new set of 10 “Modified Stage 2” objectives which replace stage 1 and stage 2 objectives
- Modified stage 2 will apply for 2015 through 2017 and shift to a single set of stage 3 objectives beginning in 2018
- Many objectives from stage 1 and stage 2 were removed



# CQM Reporting

- No changes were made with recent CMS final ruling. Still report on same 9 Pediatric CQMs
- Report on 90 day period. No threshold to meet.
- As with MU measures, CQMs are reported via your state application



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# Example 1

Example: Provider applied for Medicaid incentive in 2015 for the first time.

- 2015 – Attest for AIU
- 2016 – Modified stage 2 MU reporting based on **90 day** reporting period in 2016
- 2017 – Modified stage 2 MU reporting based on 365 day reporting period in 2017
- 2018 and beyond – stage 3 MU reporting based on 90 day reporting period

# Example 2

Example: Provider applied for Medicaid incentive in 2014 for the first time.

- 2014 – Attested for AIU
- 2015 – Modified stage 2 MU reporting (with alternate exclusions and specifications) based on 90 day reporting period in 2015
- 2016 and 2017 – Modified stage 2 MU reporting based on 365 day reporting period in respective year



# Example 3

Example: Provider applied for Medicaid incentive in 2013 for the first time.

- 2013 – Attested for AIU
- 2014 – Stage 1 MU reporting based on 90 day reporting period in 2014
- 2015 – Modified stage 2 MU reporting (with alternate exclusions and specifications) based on 90 day reporting period in 2015
- 2016 and 2017 – Modified stage 2 MU reporting based on 365 day reporting period in respective year

# Example 4

Example: Provider applied for Medicaid incentive in 2013 for the first time, but skipped 2014 and 2015

- 2013 – Attested for AIU
- 2014 and 2015 – skipped
- 2016 – Modified stage 2 MU reporting based on 90 day reporting period in 2016 (no alternate exclusions)
- 2017 – Modified stage 2 MU reporting based on 365 day reporting period in 2017



# Future of MU

- Is MU going away?
  - For Medicare providers, Yes.
  - For Medicaid providers, **NO**. CMS has not announced anything that will replace MU for Medicaid providers.
- CMS proposed new MACRA legislation in April which includes a completely new value-based reimbursement system **for Medicare providers**
- Stage 3 MU still scheduled to begin in 2018



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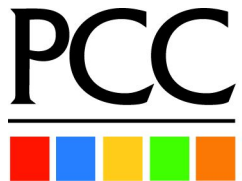
# How Do I Apply?

- Register with CMS <https://ehrincentives.cms.gov/>

- Registration User Guide:

[https://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicaidEP\\_RegistrationUserGuide.pdf](https://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicaidEP_RegistrationUserGuide.pdf)

- Then file application with your state
- PCC's CMS Certification ID#: 1314E01PRYOZEA5
- Contact support if you need our CHPL# (this may have recently changed)



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# 2016 MU Attestation

- Check your state MU website to determine if/when 2016 MU application is open
- If you have EPs who need to use full 2016 calendar year for MU reporting, the soonest you can apply will be early 2017
- MU Stage 3 begins in 2018

# MU Audits

- Audits are happening more often than they used to
- What may you be asked to provide?
  - Detail to prove your attested Medicaid % is accurate (support has custom scripts to help with this)
  - Explanations of MU report calculations (we can give you a letter to explain how PCC calculates certain measures)
  - Documentation of Security Risk Analysis
  - Verification of Software Use letter (contact PCC for this)

# MU Audits

- You should save everything in case of audit
  - 'arra' report output
  - Security Risk Analysis documentation
  - MU and CQM report output
  - Details of clinical decision support interventions

# Meeting Meaningful Use in PCC EHR

# PCC MU Reporting

Donut

PCC EHR

File Edit Reports Tools Help

Patient Lists  
Patient Reminders  
Health Information Summary  
Patient Education  
Patient Visit Summary  
Summary of Care Record  
Clinical Quality Measures  
Meaningful Use Measures  
Phone Encounter Performance

Visit Tasks (99+) E-lab Results (40) Messaging (11) Signing (99+)

Wed 08/26/15

Time	Last	First	DOB/Sex	Age	Visit Reason	Provider	Billed
7:00am	Mouse	Matilda	08/17/02 F	13y	12yr - 13yr Well Visit	Davidson	
7:30am	Mouse	Mookie	08/17/02 M	13y	12yr - 13yr Well Visit	Davidson	
8:00am	Mouse	Mickey	03/30/05 M	10y 4m	Sick Call	Casey	✓
9:00am	Blanchard	Rudy	02/09/14 F	1y 6m	18mo Well Visit	Casey	



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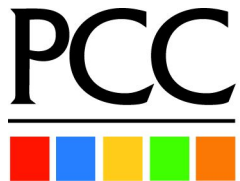
# Visit Reason Exclusions

## Visit Reasons (optional)

Edit

Excluding: Flu Vaccine, Immunizations Only, Lab Only, Wt Check

- You have ability to exclude certain visit reasons from MU report calculations
- Examples: lab or nurse-only visits and other “fake” visit reasons



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# Eligible Professional Selection(s)

## Eligible Professionals

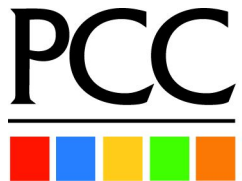
Edit

Including: Beverly Crusher, MD, Elizabeth Mary Casey, MD, Fred Jones, M.D.

## Report Layout

- ☒ Individual reports for each selected provider
- ☐ Aggregate data for selected providers into a single report

- Run individual MU reports for more than one provider at once
- Run MU reports aggregated for all providers (useful for PCMH)



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# Eligible Professional Selection(s)

- Most 2011 MU reports were based on **signing** provider
- Most 2014 MU reports are based on **visit/encounter** provider.



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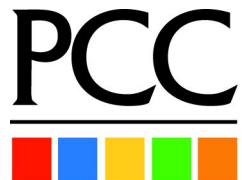
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# Eligible Professional Selection(s)

PROVIDER INFORMATION Entry 4 of 26

Provider Name:	James Davidson, Jr. M.D.	Type:	Real
Short Name:	Dr. Davidson		
Last Name:	Davidson		
Initials:	D		
Prov Group:	Davidson		
EHR User:	James Davidson, M.D. (james)		
Ins Name:	DAV	Blue Shield #:	
Ins Code:	DAV92391	Medicare #:	
Taxonomy Code:	298398747X	Medicaid #:	
Site ID #:		UPIN #:	
Tax ID #:	097284859	CHAMPUS #:	
S/S #:		Commercial #:	
NPI #:		Location #:	
License #:		Accident #:	

- Be sure to map Partner providers to EHR users
- Some MU reports are based on EHR user



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Meaningful Use Measures

2014 Edition 2011 Edition

### 2014 Edition Meaningful Use Measures - Details

**Stage:** Stage 2  
**Measure:** View, Download, Transmit  
**Reporting Period:** 07/16/2015 to 10/13/2015 (90 days)  
**Date Report Run:** 10/14/2015  
**Eligible Professional:** Beverly Crusher, MD

Find:  ◀ ▶

Numerator: 0  
Denominator: 6

In Numerator	Patient	DOB	PCC#
No	Canning, John	05/07/99	3314
No	Jenson, Astro	01/05/11	
No	Jenson, Elroy	04/12/04	
No	Jenson, Judy	07/31/15	
No	Stone, Michael Jay P.C	10/28/05	197
No	Thomas, Sophia	03/11/01	721

- See which patients are (or are not) included in the numerator



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# MU Objectives

- Refer to Modified Stage 2 Objectives Guide for summary of objectives and how to meet measures in PCC EHR

<http://learn.pcc.com/wp/wp-content/uploads/2015-10-ModifiedStage2MUChart.pdf>

MU Criteria	%	Denominator	Numerator	How to Meet the Measure in PCC EHR	Exclusions	Alternate Exclusions/ Specifications
Patient Specific Education Objective 6 of 10	>10%	The number of unique patients with at least one office visit, seen by the EP during the EHR reporting period.	Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology. The patient-specific education resources can be provided before, during or after the reporting period.	The patient education must be generated using the EHR. In the Patient Education report, you must select one of the patient's problems and diagnoses, medications, or lab tests from the drop down menu. After the initial selection you may search on a different term, if desired. User must print or save in order for the patient to meet the measure.	Any EP who has no office visits during the EHR reporting period.	Provider may claim an exclusion for the measure of the Stage 2 Patient Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective.  All providers must meet the measure threshold of >10% for 2016 and 2017.
Performed Medication Reconciliation for Transitions of Care Objective 7 of 10	>50%	The number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition. This includes both encounters for the EP they have identified as transitions of care (via component checkbox) and direct secure messages received by the EP	The number of transitions of care in the denominator where medication reconciliation was performed.	Use the Transition of Care (ARRA) component and click both the "Patient transitioned to my care" and "Medication Reconciliation was performed" checkbox. In addition, for all Direct Secure Messages received, press the "Reconcile" button. If you do not see the Reconcile button, you need a permission added.	Any EP who was not the recipient of any transitions of care during the EHR reporting period.	Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective.  All providers must meet the measure threshold of >50% for 2016 and 2017.

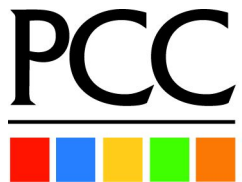


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# Objective 1: Protect Patient Health Information

- Attestation measure (yes/no)
- Conduct or review a security risk analysis of certified EHR technology and implement updates as necessary
- Needs to be done prior to end of reporting period
- If you've done this analysis before, you need to document that you've reviewed the analysis
- States can and will audit this



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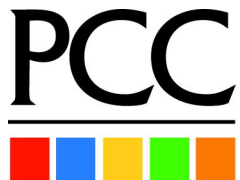
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# Security Risk Analysis

Refer to new online resources PCC has provided:

- [HIPAA and Security Risk Assessments](#)
- [CMS.gov Security Risk Analysis Tip Sheet](#)
- [ONC Tool to help with performing SRA](#)

For more on SRA, so to Paul Vanchiere's "Security Risk Assessment" class at 1:00pm!



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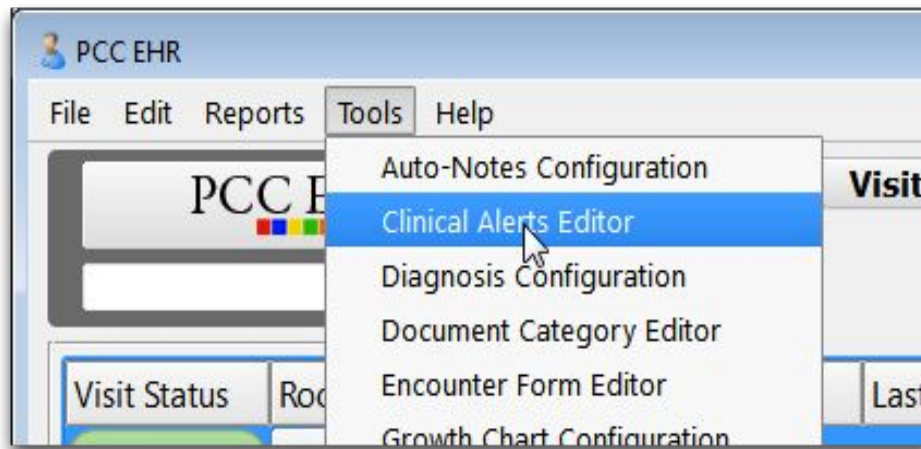
## Objective 2: Clinical Decision Support

- Attestation measure (yes/no)
- 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
- Measure 2: Enable and implement drug-drug and drug-allergy interaction checks for the entire EHR reporting period. (This is a built-in default for PCC eRx)



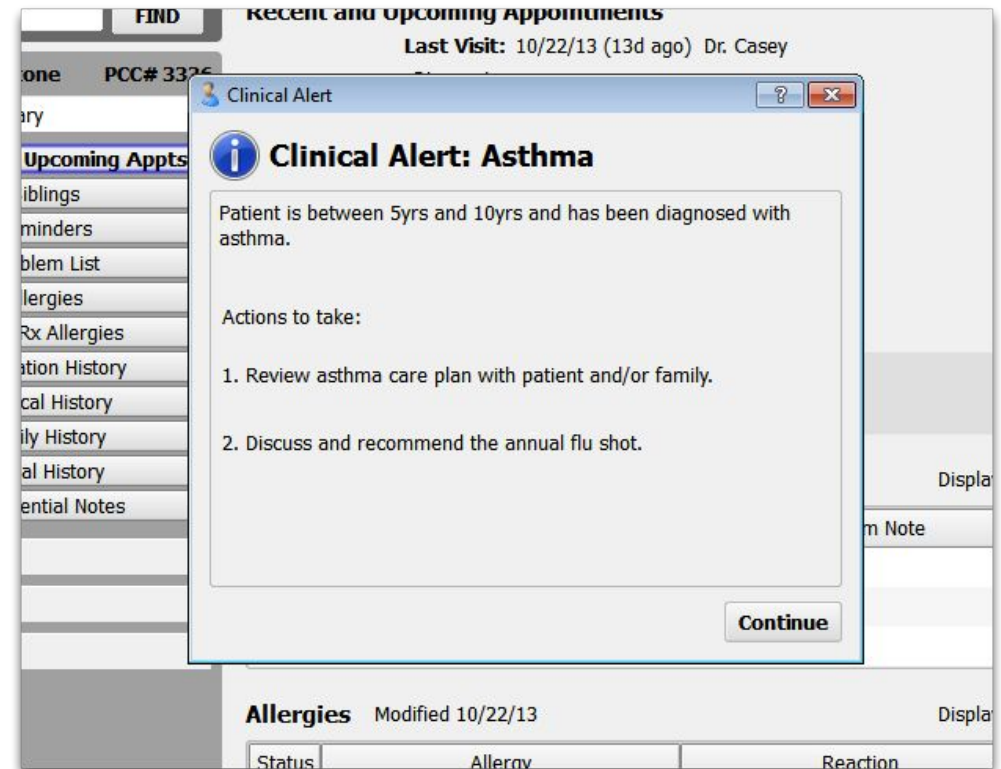
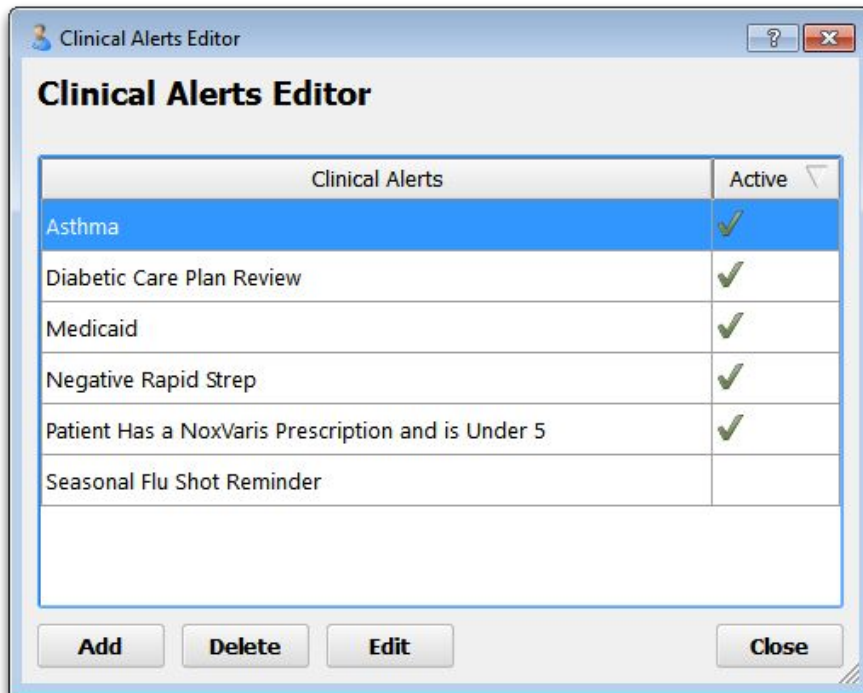
## Objective 2: Clinical Decision Support

- Attestation measure (yes/no)
- Use clinical alerts for clinical decision support





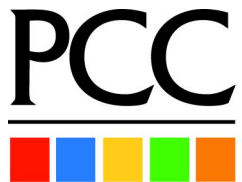
# Objective 2: Clinical Decision Support



## Objective 2: Clinical Decision Support

Other examples of “clinical decision support” according to CMS:

- Clinical guidelines (consider developmental or depression screening templates built into EHR)
- Condition-specific order sets
- Documentation templates
- Diagnostic support
- Contextually relevant reference information.



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# Objective 3: CPOE (Computerized Provider Order Entry)

3 sub-measures for this one MU objective

- Measure 1: >60% of medication orders created by EP must be ordered via CPOE (“CPOE Medication” measure on PCC MU report)
- Measure 2: >30% of laboratory orders created by EP must be ordered via CPOE (“CPOE Lab” measure on PCC MU report)
- Measure 3: >30% of radiology orders created by EP must be ordered via CPOE (“CPOE Radiology” measure on PCC MU report)

## Objective 3: CPOE (Computerized Provider Order Entry)

- Lab and radiology orders do not need to have discrete results to be counted toward this measure
- Since all medication, radiology, and lab orders are done electronically in PCC EHR, these will always report as 100%

## Objective 4: Electronic Prescribing

- >50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
- Report includes all Rxs signed by the EP within the reporting period
- PCC MU report can include or exclude Rxs for controlled substances
- Rxs generated through eRx but printed do not count in numerator



# Objective 4: Electronic Prescribing

PROVIDER INFORMATION Entry 4 of 26

Provider Name:	James Davidson, Jr. M.D.	Type:	Real
Short Name:	Dr. Davidson		
Last Name:	Davidson		
Initials:	D		
Prov Group:	Davidson		
EHR User:	James Davidson, M.D. (james)		
Ins Name:	DAV	Blue Shield #:	
Ins Code:	DAV92391	Medicare #:	
Taxonomy Code:	298398747X	Medicaid #:	
Site ID #:		UPIN #:	
Tax ID #:	097284859	CHAMPUS #:	
S/S #:		Commercial #:	
NPI #:		Location #:	
License #:		Accident #:	

- Be sure to map Partner providers to EHR users
- eRx MU report needs this mapping

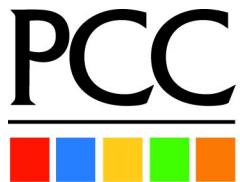


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# Objective 5: Health Information Exchange

- 2 sub-measures for this one MU objective:
  - Measure 1: EP uses PCC EHR to generate summary of care records for patients (Attestation yes/no)
  - Measure 2: EP electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
    - Refer to “Summary of Care (Transmitted)” measure on modified stage 2 PCC MU report



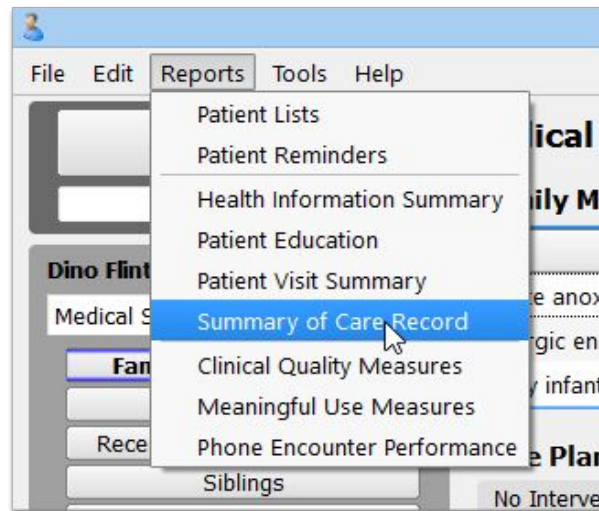
# Objective 5: Health Information Exchange

- Important Exclusion:
  - If you have less than 100 referrals or other transitions of care to another setting during the reporting period, you are excluded from this measure.



# Objective 5: Health Information Exchange

- The Summary of Care Record report produces a C-CDA-formatted chart summary for a patient.
- Use this report as a transition of care document. Can be printed, saved as .pdf or sent to another clinician or practice via Direct Secure Messaging



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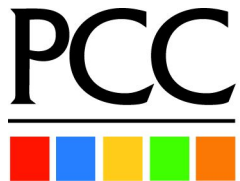
# Objective 5: Health Information Exchange

- Measure 2: EP electronically transmits summary of care to a receiving provider for more than 10% of transitions of care and referrals.
  - Denominator includes:
    - Referral orders during the reporting period where the EP was the Provider of Encounter for the visit where the referral was ordered
    - The number of Summary of Care Records generated whereby "Related to an outbound transition of care" is selected



# Objective 5: Health Information Exchange

- Measure 2: EP electronically transmits summary of care to a receiving provider for more than 10 percent of transitions of care and referrals.
  - Numerator Includes:
    - Transitions of care and referrals in the denominator that were sent electronically to another clinician or practice via Direct Secure Messaging



# Direct Secure Messaging

- First, choose the specific referral order or other transition of care from the selection pull-down menu:

**Summary of Care Record**

**Continuity of Care Document**

<b>Patient</b>	Pebbles Flintstone
<b>Date of birth</b>	September 20, 2005
<b>Sex</b>	Female
<b>Race</b>	White
<b>Ethnicity</b>	Not Hispanic or Latino
<b>Contact info</b>	Home: 15 Quarry Lane Winooski, VT 05404, US
<b>Patient IDs</b>	3336 2.16.840.1.113883.3.2402.400.100.2
<b>Document Id</b>	76655ae0-499d-4cf4-b4f7-060ea5828b17
<b>Document</b>	October 13, 2015, 12:14:17 -0400

Select a referral or outbound transition of care:

select referral or outbound transition of care

Related to an outbound transition of care

10/12/15 Referral: Audiology

07/11/09 Referral: Dermatology

Not related to a transition of care

☐ Save as a C-CDA file

Cancel Print

Select from the patient's referrals

# Direct Secure Messaging

- The Summary of Care report output includes the patient's insurance policy information, making it a good solution for referrals.

**Summary of Care Record**

Encounter Type	Performer	Location	Encounter Date	Diagnoses
Sick Call	Elizabeth Mary Casey, MD	Main - PCC Pediatrics	10/12/2015	

**REASON FOR REFERRAL**

Result Type	SNOMED Code	Description	Date	Status	Result
Audiology			10/13/2015	ORDERED	

**Functional status assessment**

No Cognitive or Functional Status.

**Payers**

Policies

**Primary Insurance**  
Ins. Policy: Aetna HDHP (Copay \$15.00)  
Certificate: 34DFJH  
Group:  
Ins. Phone:

**Secondary Insurance**  
Ins. Policy: Cigna PPO \$20 (Copay \$20.00)  
Certificate: 24958JD  
Group:  
Ins. Phone: 1-800-244-6224

Select a referral or outbound transition of care:  
10/12/15 Referral: Audiology

☒ Limited to the referral encounter



# Direct Secure Messaging

- Select “Send via Direct Secure Message” and fill out the fields for the message.

The screenshot displays a software interface for sending a Direct Secure Message. At the top, there are four radio button options: "Print", "Save as a PDF file", "Save as a C-CDA file", and "Send via Direct Secure Messaging:". The "Send via Direct Secure Messaging:" option is selected. Below these options are three input fields: "To:" with the value "test@testpeds.updox.test.com" and a "Search" button; "Subject:" with the value "Transition of Care C-CDA for Patient Dino Flintstone"; and "Message:" with the text "Dr. Test, Attached is the summary of care for patient Dino Flintstone. It includes all relevant patient data from the chart." At the bottom right, there are two buttons: "Cancel" and "Send". A mouse cursor is pointing at the "Send" button.

# Direct Secure Messaging

- Optionally, you can enter text and click “Search” to find a clinician by name or practice name.

Save as a C-CDA file

Send via Direct Secure Messaging:

To:

Subject: Transition of Care C-CDA for Patient Dino Flintstone

Message:

**Summary**

<b>Patient</b>	Hassan Fares Adult Medical Services, Pc 6645 Main Street, Williamsville, NY 14221 (716) 276-8730 (fax) john_williams_426537197@direct.myupdox.com
<b>Date of birth</b>	John Williams
<b>Sex</b>	Associates Of Medicine 608 S Hester, Stillwater, OK 74074 (405) 377-8040 (fax)
<b>Race</b>	simone_williamson@direct.myupdox.com
<b>Ethnicity</b>	Simone Williamson
<b>Contact info</b>	Simone Williamson 641 20th Street Sw, Vero Beach, FL 32962 drpaulwilliams@direct.practicefusion.com
<b>Patient ID:</b>	Paul Williams Prd.Ehr.Test drlwilliams@direct.practicefusion.com
Select a referral	Na Na Prd.Ehr.Test
Related to an	drleslie-annwilliams@direct.practicefusion.com
	Na Na Prd.Ehr.Test
	docwilliams@direct.practicefusion.com
	Na Na Prd.Ehr.Test
	swilliamson@metzgercare.eyefinitydirect.com
	Susan W. Julie Metzger, Od 6901 Dixie Hwy, Florence, KY 85952 (859) 525-1951 (fax)

To:

Subject: Transition of Care C-CDA for Patient Dino Flintstone



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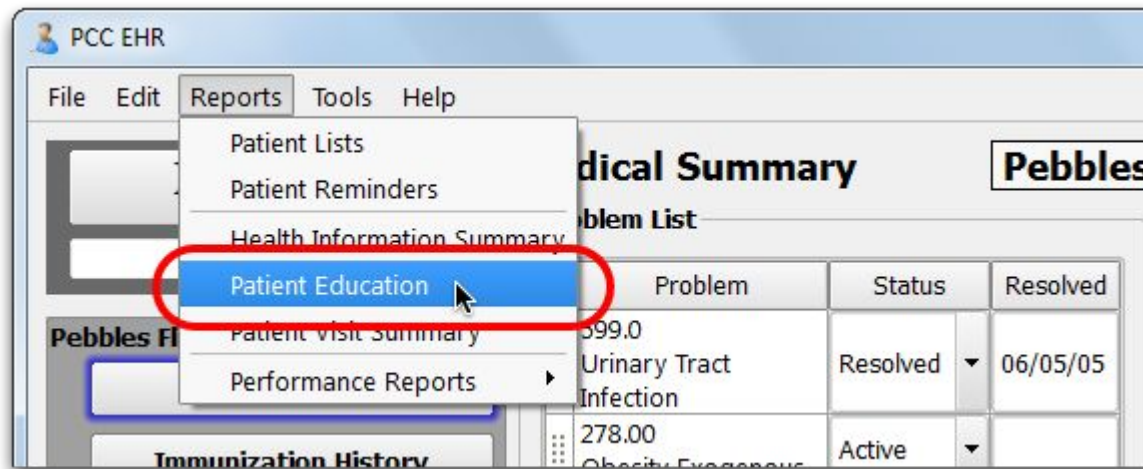
# Direct Secure Messaging

- Still in pilot testing, so not all clients have access to this yet
- Contact PCC support ASAP if you are doing 2016 MU and haven't already been contacted for training and configuration of this feature
- See [PCC 7.0.4 release documentation](#) for more details on how to activate direct secure messaging



# Objective 6: Patient Specific Education

- Patient specific education resources identified by PCC EHR are provided to patients for **>10% of all unique patients** with office visits seen by the EP during the EHR reporting period.

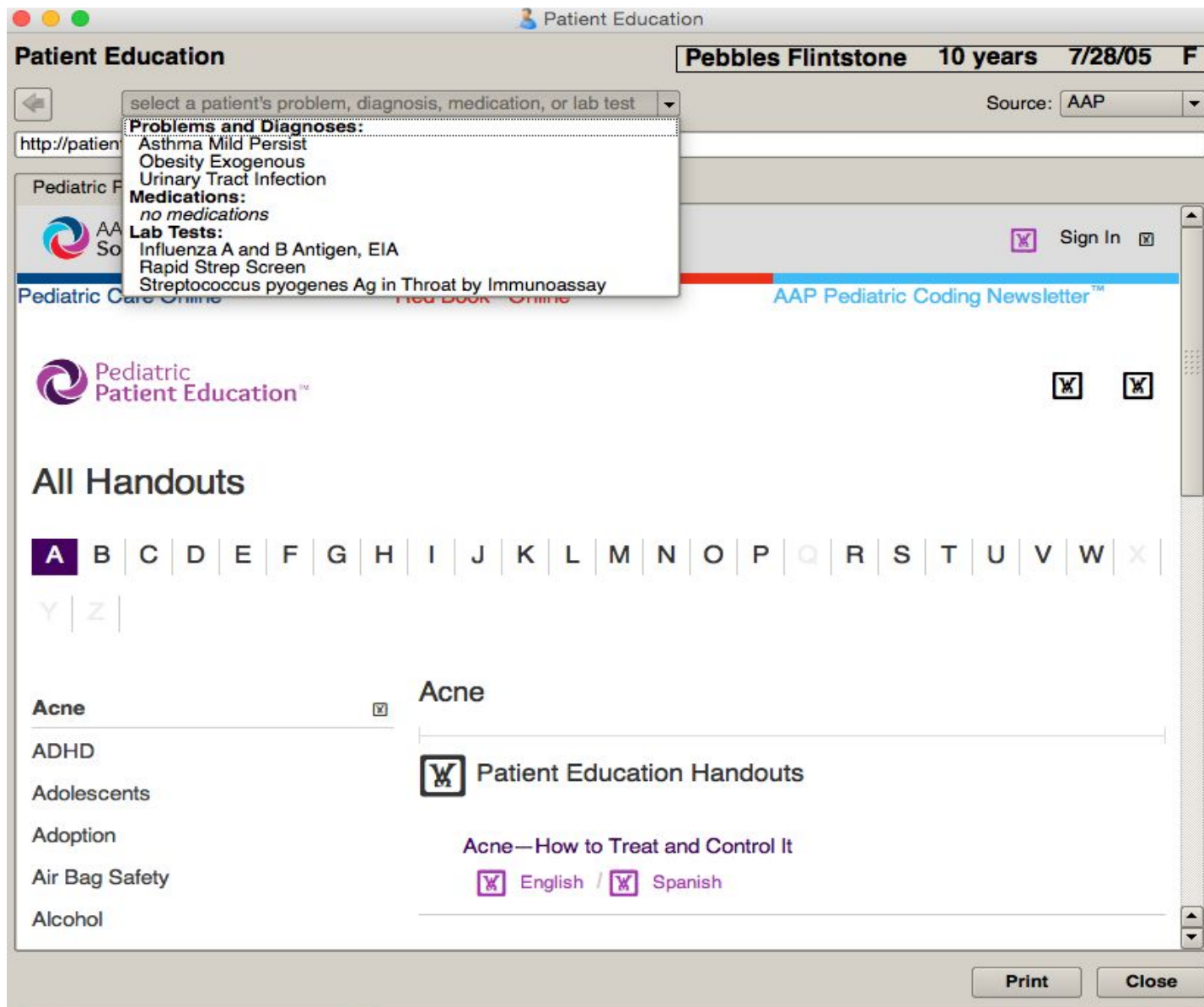


- Education can be provided before, during or after reporting period



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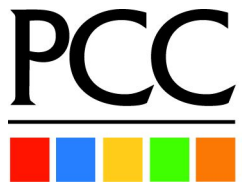
- Education sources now include AAP and Medline Plus
- Select problem, diagnosis, medication, or lab tests from single drop-down menu before printing
- Visit diagnoses now included

## Objective 6: Patient Specific Education

- Needs to actually be saved or printed to count

# Objective 7: Medication Reconciliation

- Measure: The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.
- This measure refers to *incoming* transitions of care, not outgoing.
- Use Transition of Care (ARRA ) component within protocols to indicate encounters that are transitions of care and medication reconciliation is performed
- Direct secure messages received by EP are also considered transitions of care



# Objective 7: Medication Reconciliation

- Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period.
- The denominator includes the following examples of incoming transitions of care:
  - Any visit for the EP that includes the “Transition of Care (ARRA)” component with checkbox labeled "Patient transitioned to my care" checked
  - Direct secure messages containing a C-CDA received by EP

# Objective 7: Medication Reconciliation

- Insert “Transition of Care (ARRA)” component in protocols used for new patient visits, hospital visit followups, or other incoming transition of care visits

## **Transition of Care (ARRA)**

- ☒ Patient transitioned to my care from another clinical setting
- ☒ Medication Reconciliation performed

- Check off “Medication Reconciliation Performed” to count in numerator for this measure



## Objective 7: Medication Reconciliation

- Other medical practices can send Direct Secure Messages to users at your practice. Those messages can include transition of care C-CDA attachments and other documents.

# Objective 7: Medication Reconciliation

**Direct Secure Message**

Message | Continuity of Care Document

**Patient Information from the Continuity of Care Document**  
Patient Name: Dino Flintstone  
DOB: 07/03/13  
Sex: Male

**Message**  
Date: 09/18/15  
From: mark@ehrdoc.qa.pcc-direct.com  
To: kathleen@ehrdoc.qa.pcc-direct.com  
Subject: Transition of Care records for Dino Flintstone  
Message: Dr. Gomez,  
Here's the records you requested.  
-Dr. Mark Williams

**Attachments**  
Continuity of Care Document: ccda\_3335.xml

Select the patient to receive the Direct Secure Message.

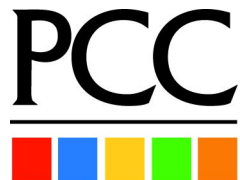
Best Matches for: Dino Flintstone 07/03/13 M

Last	First	DOB/Sex	Age	PCC #	PCP	Patier
Flintstone	Dino	07/03/13	M 2y 2m	3335	Casey	Billing
Warner	Graham E.	07/03/13	M 2y 2m	2225		New F
Flintstone	Pebbles	08/23/05	F 10y	3336	Williams	Adopti

Close Select

Review the message's  
details and attachments

Confirm or search for a patient  
chart to place the message



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# Objective 7: Medication Reconciliation

PCC EHR

**FIND**

Dino Flintstone PCC# 3335

Medical Summary

Demographics

History

Message: 09/18/15

Direct Secure Message

Direct Secure Message

Tasks

Direct Secure Message

Dino Flintstone 2 yrs, 2 mos 7/03/13 M

Direct Secure Message

Message

Date: 09/18/15  
From: mark@ehrdoc.qa.pcc-direct.com  
To: kathleen@ehrdoc.qa.pcc-direct.com  
Subject: Transition of Care records for Dino Flintstone  
Message: Dr. Gomez,  
Here's the records you requested.  
-Dr. Mark Williams

Attachments

View

Reconcile

Continuity of Care Document: ccda\_3335.xml

Tasks

TASK

TO

NOTE

☐ Task Completed AT   BY

Add Task

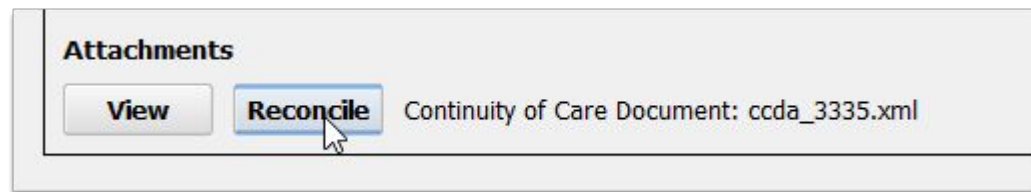


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## Objective 7: Medication Reconciliation

- When you see an incoming C-CDA in a Direct Secure Message, you can click “Reconcile” to review and import medication data (and also problems and allergies)
- Clicking “Reconcile” counts the transition of care in the numerator



# Objective 7: Medication Reconciliation

- See [PCC 7.0.4 release documentation](#) for more details on how to receive direct secure messaging and reconcile inbound C-CDAs for transitions of care

## Objective 8: Patient Electronic Access (View, Download, Transmit)

- Measure 1: **>50%** of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.
- Measure 2: **At least one patient** seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period.
  - Starting in 2017, the threshold increases to 5% for all EPs

## Objective 8: Patient Electronic Access (VDT)

- Need portal account for at least 50% of patients seen during reporting period
- Patient needs to be signed up for portal within 4 days of the visit
- If age-based privacy is enabled, patients that meet emancipation age are still included in denominator but won't be included in numerator unless portal access is individually enabled

## Objective 8: Patient Electronic Access (VDT)

- Exclusion: If EP is in county where >50% of patients do not have 3Mbps broadband availability, they are excluded from this measure
- For measure 2, portal user's action can take place before, during, or after reporting period to count

## Objective 9: Secure Messaging

- Measure: Use secure electronic messaging to communicate with patients on relevant health information.
  - For 2015, this was an attestation (yes/no) measure. The capability for patients to send and receive a secure electronic message with the EP needs to be fully enabled during the EHR reporting period
  - For 2016, need one secure message sent to patients by the practice
  - For 2017, threshold becomes 5%

## Objective 9: Secure Messaging

- Exclusion: If EP is in county where >50% of patients do not have 3Mbps broadband availability, they are excluded from this measure
- If you are doing MU attestation (and/or PCMH Recognition) you need portal and secure messaging enabled



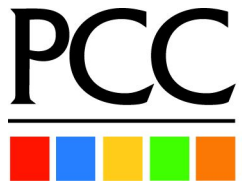


# Objective 10: Public Health Reporting

- An EP must be in *active engagement* with a public health agency for two of the following three measures:
  - Measure Option 1: Submit immunization data.
  - Measure Option 2: Submit syndromic surveillance data
  - Measure Option 3: Submit data to a specialized registry

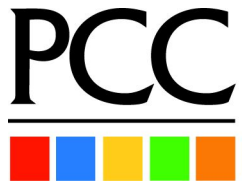
# Objective 10: Public Health Reporting

- For 2016, you can be excluded from having to be in active engagement with syndromic surveillance or specialized registry
- [Explanation of CMS alternate exclusion](#)
- Check with your state and specialty society (the AAP) to determine if a specialized registry exists that will accept pediatric-specific data. This action should be documented.



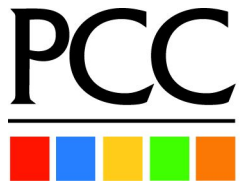
# Objective 10: Public Health Reporting

- Exclusions for syndromic surveillance data submission:
  - Is not in a *category of providers* from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system
  - Operates in a jurisdiction for which *no public health agency is capable of receiving* electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - Operates in a jurisdiction where *no public health agency has declared readiness* to receive syndromic surveillance data from EPs at the start of the EHR reporting period.



# Objective 10: Public Health Reporting

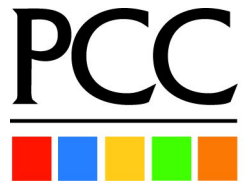
- Exclusions for specialized registry data submission:
  - *Does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the EHR reporting period;*
  - *Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or*
  - *Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.*



## Objective 10: Public Health Reporting

- If you are doing MU attestation, you need to be registered with your state to submit immunization data.
- Testing phase counts as “active engagement”. You don't need to be in production to meet this measure.

# CQM Reporting



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# CQM Reporting

- Report on 9 Pediatric CQMs.
- Report on 90 day period. No threshold to meet.
- Like most MU reports, based on provider of encounter
- As with MU measures, CQMs are reported via your state application
- [Documentation on learn.pcc.com](http://learn.pcc.com) on how to chart to meet each CQM



# CQM Reporting

Clinical Quality Measures - 2011 Edition

## Clinical Quality Measures

2014 Edition 2011 Edition

### 2014 Edition Clinical Quality Measures

**Measures**

**Edit** All Measures Included

**Reporting Period**

☒ 90 Day Reporting Period: from 05/29/15 to 08/26/2015

☐ Calendar Year Reporting Period: 2015

☐ From mm/dd/yy to mm/dd/yy

**Eligible Professionals**

**Edit** All Providers Included

**Report Layout**

☒ Individual reports for each selected provider

☐ Aggregate data for selected providers into a single report



# Screening for Clinical Depression and Follow-Up Plan

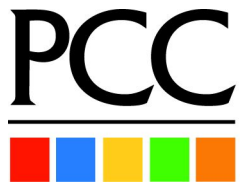
The percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate, standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

# Screening for Clinical Depression and Follow-Up Plan

Denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter\* with the EP during the measurement period

Numerator: Patients in the denominator screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

**\* The 2014 specs we used do not include well visits as an eligible encounter for this measure**



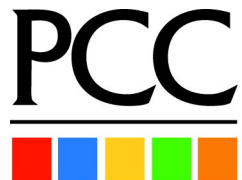
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# Screening for Clinical Depression and Follow-Up Plan

Component Name	Component Type	Attributes
Review of Systems	Generic Check	
Review of Systems by system	Generic Radio	Abn, NL, N/A
Risk Assessment	Generic Radio	Yes, No, N/A
Risk Assessment	Generic Check	
Risk Assessment (Adol Confidential)	Generic Radio	Yes, No, N/A
Risk Assessment for Severe RSV Disease	Generic Check	
ROS	Generic Radio	Abn, NL, NA
Safety	Generic Radio	Yes, No, May
<b>Screening Orders</b>	<b>Screening</b>	
Sensory Screening	Generic Header	
Smoking Status (ARRA)	Smoking Status	
Social/Family History	Generic Check	
Social Hx	Generic Radio	Yes, No, NA
Subjective Notes	Generic Text Edit	
Supply Orders	Supply	
Surgeries:	Generic Text Edit	
Surgical Procedure Orders	Surgical Procedure	
Teen Questionnaires	Generic QA	

Make sure the depression screening order is linked to an appropriate LOINC test

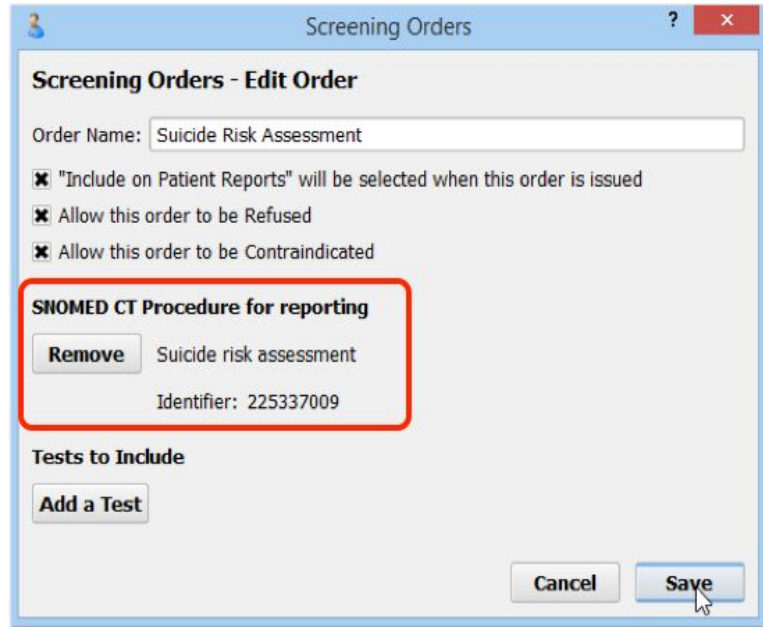


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# Screening for Clinical Depression and Follow-Up Plan

If screening is positive, a follow-up order mapped to a SNOMED-CT procedure is required to meet the measure



Screening Orders - Edit Order

Order Name: Suicide Risk Assessment

☒ "Include on Patient Reports" will be selected when this order is issued

☒ Allow this order to be Refused

☒ Allow this order to be Contraindicated

**SNOMED CT Procedure for reporting**

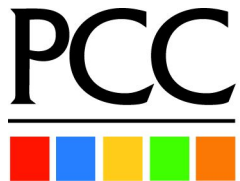
Suicide risk assessment

Identifier: 225337009

Tests to Include

Examples:

- Suicide risk assessment
- Follow-up for depression – (27 possible descriptions)
- Additional evaluation for depression (9 possible descriptions)
- Referral mapped to SNOMED-CT



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# Screening for Clinical Depression and Follow-Up Plan

Make sure that referral orders are mapped to an appropriate SNOMED-CT

Referral Orders

**Referral Orders - Edit Order**

Order Name: Psychiatry Referral

☒ "Include on Patient Reports" will be selected when this order is issued

☒ Allow this order to be Refused

☐ Allow this order to be Contraindicated

**SNOMED CT Procedure for reporting**

**Remove** Referral to psychiatry service

Identifier: 183524004

**Tests to Include**

**Add a Test**

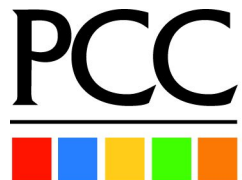
**Cancel** **Save**

# Screening for Clinical Depression and Follow-Up Plan

Make sure that depression screenings, followup, and/or referral orders are stored within protocols for adolescents

The screenshot displays a software interface with three main sections: Screening, Referral, and Followup. In the Screening section, there are buttons for 'Order' (Hearing Screen), 'Order' (Vision Screen), and 'Edit' (Depression Screen (Adolescent)). A table below the 'Edit' button shows a completed 'Adolescent depression screening assessment' with a 'Positive' result. The Referral section has an 'Order' button for 'Suicide Risk Assessment' and a dropdown menu for 'select a screening'. The Followup section has an 'Order' button for 'Psychiatry Referral' and a dropdown menu for 'select a referral'. Red boxes highlight the 'Order' buttons for 'Suicide Risk Assessment' and 'Psychiatry Referral'.

Test	Result	Units	Reference Range	Interpretation
Adolescent depression screening assessment	Positive		Negative	Abnormal



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# Children With Dental Decay/Cavities

Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.

Denominator: # patients ages 0-20 years with at least one eligible encounter with the EP during the measurement period

Numerator: # patients in the denominator who had an active diagnosis of dental decay or cavities during the measurement period

# Children With Dental Decay/Cavities

Update protocols to make it easier to record dental health and/or followup dental care

**Physical Exam**

Make All: **ABN** **NL** **N/E**

ABN NL N/E

☐ ☒ ☐ General Appearance  
Well developed and well nourished. Appropriate response for age.

☐ ☒ ☐ Head  
Normocephalic. Atraumatic.

☐ ☒ ☐ Teeth (caries, white spots, staining)  
Normal dentition for age. No caries.



# Children With Dental Decay/Cavities

If a patient has dental caries, enter an appropriate diagnosis code. Diagnosis can be entered in diagnosis component or as an active problem on problem list.

The screenshot shows a 'Diagnoses' panel with two entries. The first entry is 'Well child visit' with a checkbox, a dropdown to 'Refine the diagnosis of Well child visit', the ICD-10 code 'Z00.129 Encounter for routine child health examination without abnormal findings', a 'notes' dropdown, and an 'Add to Problem List' checkbox. The second entry, 'Dental caries', is highlighted with a red box. It also has a checkbox, a dropdown to 'Refine the diagnosis of Dental caries', the ICD-10 code 'K02.9 Dental caries, unspecified', a 'notes' dropdown, and an 'Add to Problem List' checkbox which is checked. Below these is an 'add diagnosis' section with a dropdown and a 'notes' dropdown.

**Diagnoses**

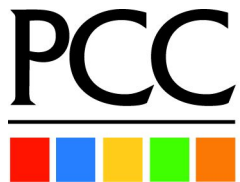
☒ Well child visit  
Refine the diagnosis of Well child visit  
ICD-10: Z00.129 Encounter for routine child health examination without abnormal findings  
notes  
☐ Add to Problem List    Onset: mm/dd/yy    Problem Note: problem note

☒ Dental caries  
Refine the diagnosis of Dental caries  
ICD-10: K02.9 Dental caries, unspecified  
notes  
☒ Add to Problem List    Onset: mm/dd/yy    Problem Note: problem note

☐ add diagnosis  
notes

# Childhood Immunization Status

The percentage of patients turning 2 years old during the reporting period who have a visit during the reporting period and have four DTaP; three IPV, one MMR; three HiB; three Hep B; one Varicella; four pneumococcal; one Hep A; two or three rotavirus; and two influenza vaccines by their second birthday, or had a documented history of the illness, seropositive result for the antigen, or a contraindication for a specific immunization



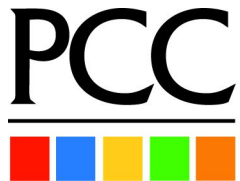
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# Childhood Immunization Status

Denominator: # children turning two years old during the measurement period with at least one eligible encounter with the EP during the measurement period

Numerator: # children in the denominator who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday

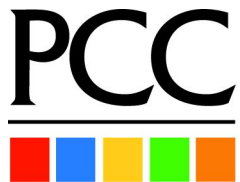


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# Childhood Immunization Status

- Verify CVX codes are stored properly for each immunization in Partner immunization and disease table
- When charting, review immunization history and forecasting results to make sure immunizations are up-to-date
- **The 2014 specs we used for this measure do not include quadrivalent flu vaccines as a valid immunization**
- Refer to new “Immunization Rates - Patients 2 Years Old” measure coming soon to Dashboard



# Use of Appropriate Meds For Asthma

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

A separate stratification is reported for each of the following ages:

- Patients 5-11
- Patients 12-18
- Patients 19-50
- Patients 51-64

# Use of Appropriate Meds For Asthma

Denominator: # patients 5-64 years of age who have an active, persistent asthma diagnosis during the measurement period and who have a visit with the Eligible Professional during the measurement period

Numerator: # patients in the denominator who were prescribed or had an active prescription for an appropriate medication during the measurement period

Exclusion: Patients will be excluded from the denominator if they have a diagnosis of emphysema, COPD, cystic fibrosis or acute respiratory failure during or prior to the measurement period.

# Use of Appropriate Meds For Asthma

- Diagnoses considered “persistent asthma”:
  - Persistent asthma
  - Mild persistent asthma
  - Moderate persistent asthma
  - Severe persistent asthma



# Use of Appropriate Meds For Asthma

Review medications with patients at every visit. Update medication history when patient is prescribed asthma med elsewhere

The screenshot displays two overlapping windows from the PCC Pediatric EHR system. The top window, titled "Prescribe a Medication", includes a "Select Medication for Prescription" section with a text input field for "Name:", a "Find" button, and a "Category Search" button. Below this is a "Favorites:" section with a dropdown menu showing "-Choose a Favorite-" and "Use" and "View/Edit" buttons. The bottom window, titled "Patient Medication Report", contains a section for "Add a Medication:" with a text input field containing "Fluticasone", a "Find" button, and a "Favorites:" dropdown menu. Both the "Find" buttons and the "Add a Medication:" input field are highlighted with red rectangles. The "Patient Medication Report" window also shows a "Medication List for Pebbles Flintstone (DOB: 09/10/2005)" with links for "Display Detailed Medication Report", "Mini Report", and "Medications Reviewed". It states "This patient has no active medications." and includes a link for "Show Medication History".

**Prescribe a Medication**  
Select Medication for Prescription  
Name:  Find Category Search  
-Choose a Favorite-  
Favorites: Use View/Edit

**Medication:** [\[Manage Medications\]](#)  
View: [Detail](#) [Mini](#) [Medication History](#) Actions: [\[Medications\]](#)  
Medication History is: ☐ Unknown or Incomplete ☐ Patient Takes No Medications [Reviewed](#)  
None.

**Patient Medication Report**  
This screen is for viewing and modifying the patient's medication list, and adding medications that have been prescribed previously or elsewhere.  
Add a Medication:  Find  
Favorites: -Choose a Favorite- Add View/Update

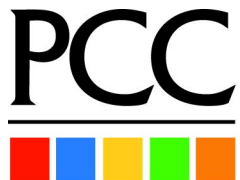
**Medication List for Pebbles Flintstone (DOB: 09/10/2005)**  
[Display Detailed Medication Report](#) [Mini Report](#) [Medications Reviewed](#)  
This patient has no active medications.  
[Show Medication History](#)



# ADHD Followup Care

The percentage of children 6-12 years of age, newly dispensed a medication for ADHD, who had appropriate follow-up care. Two rates are reported:

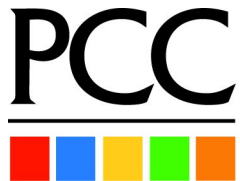
- Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.
- Percentage of children who remained on ADHD medication for at least 210 days, and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.



# ADHD Followup Care

## Exclusions:

- Patients who were actively on an ADHD medication in the 120 days prior to the newly dispensed ADHD prescription
- Patients diagnosed with narcolepsy at any point in their history or during the measurement period.
- Patients who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 30 days after the ADHD medication date



# ADHD Followup Care – Initiation Phase

Measure 1 Denominator: # children 6-12 years of age who had a visit with the EP during the reporting period and also who were dispensed an ADHD medication 90 days before the start of the reporting period through 60 days after the start date of the reporting period.

Measure 1 Numerator: # children in the denominator who had at least one face-to-face visit with the EP within 30 days after the ADHD Medication date

# ADHD Followup Care – Initiation Phase

- Measure is focused on **new** ADHD medications. Patients already on ADHD meds 120 days prior to new ADHD med are separated as exclusions and not reported in measure result
- Medication Initiation Phase: 90 days before start of reporting period to 60 days after start of reporting period
- To be counted in numerator, patient needs to have a visit **with any EP** within 30 days of ADHD medication date



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# ADHD Followup Care – Continuation Phase

Measure 2 Denominator: Same as measure 1 but only including patients who remained on the ADHD medication for at least 210 days out of the 300 days following initial medication date

Measure 2 Numerator: # children in the denominator who, in addition to the first visit during the Initiation Phase, had at least two additional follow-up visits with a clinician within 270 days (9 months)

# ADHD Followup Care – Continuation Phase

- Use the measure 1 details report as a recall tool to identify kids with newly prescribed ADHD meds that need followup

Measure#	NQF	Measure	Numerator	Denominator	Performance Rate	Exclusions	Exceptions	Details
CMS136v4	0108	ADHD: Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	N/A	N/A	N/A	N/A	N/A	N/A
		Initiation Phase	6	50	67%	41	N/A	<a href="#">Details</a>
		Continuation and Maintenance Phase	0	7	N/A	7	N/A	<a href="#">Details</a>

- Followup visits during continuation phase do not need to be with the same provider
- Review medications with patients at every visit. Update medication history when patient is prescribed ADHD med elsewhere

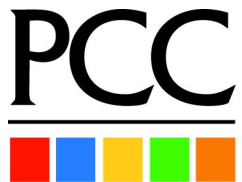


# Appropriate Testing For Children With Pharyngitis

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.

Denominator: # of episodes (visits) for patients 2-18 years of age who had an outpatient or ED visit with the EP with a active diagnosis of pharyngitis during the reporting period and an antibiotic ordered on or three days after the visit

Numerator: # episodes (visits) for patients in the denominator who had a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis

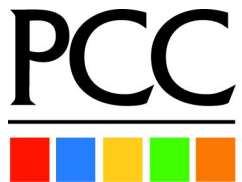


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# Appropriate Testing For Children With Pharyngitis

- Measure counts “episodes” (visits) not patients
- “Pharyngitis” includes various ICD-10 or SNOMED diagnoses including: Acute Pharyngitis, Acute Tonsillitis, Streptococcal Sore Throat, Viral Pharyngitis entered as active in diagnosis component or problem list
- To be included in the measure, antibiotic needs to be ordered on or three days after visit
- Strep test must be ordered from 3 days prior to 3 days after pharyngitis diagnosis





# 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

A separate stratification is reported for each of the following ages:

- Patients 16-20
- Patients 21-24

# Chlamydia Screening for Women

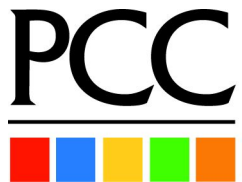
Denominator: # of women 16 to 24 years of age who are sexually active and who had a qualifying visit with the EP in the measurement period.

Numerator: # women in the denominator with at least one chlamydia test during the measurement period

# Chlamydia Screening for Women

There are several methods to indicate sexually active women including:

- Sexually transmitted infections entered as a charted diagnosis, active problem on the problem list, or billed diagnoses
- Lab tests with results, such as pregnancy tests
- Medications, such as a contraceptive or infertility treatments

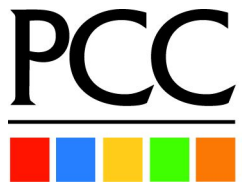


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# Chlamydia Screening for Women

- Measure exclusion: Women who received a pregnancy test solely as a safety precaution before ordering an x-ray or specified medications
- Chlamydia, pregnancy test, and radiology orders need to be mapped to LOINC test appropriately
- Update your practice's chart note protocols to make it easier to record sexual activity (by adding default diagnoses to age-appropriate chart notes, for example) and order and administer Chlamydia tests.



# Chlamydia Screening for Women

Lab Configuration

Lab Configuration

Lab Orders Common Tests Lab Facilities

Lab Orders

Name	Type	Default Lab Facility	Display on Patient Reports	Allow Refusal
▶ Chem 14 QUEST	Lab Order	Quest Diagnostics	✓	✓
▶ Childhood Allergy (Food-Environ)	Lab Order		✓	✓
▶ Chlamydia - GC, DNA, SDA	Lab Order			✓
▶ Chlamydia trachomatis DNA, SDA	Lab Order			✓
▶ Chlamydia/GC Amplification Labcorp	Lab Order	labcorp		✓

Lab Configuration

Lab Configuration

Lab Orders Common Tests Lab Facilities

Edit Lab Order

Lab Order Name: Chlamydia trachomatis DNA, SDA

Default Lab Facility: select a lab facility

☒ Enable recording of Specimen Collection user, date and time  
☐ \*Include on Patient Reports\* will be selected when this order is issued  
☒ Allow this order to be Refused  
☒ Allow this order to be Contraindicated

SNOMED CT Procedure for reporting

Add a Procedure

E-lab Vendor Order Mapping (for automated results)

LABCORP: select a LABCORP order

QUEST: CHLAMYDIA TRACHOMATIS DNA, SDA (17303)

Tests to Include (for manual result entry)

select a lab test

# Appropriate Testing For Children With 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.

Denominator: # episodes (visits) for children age 3 months to 18 years who had an outpatient visit with the Provider of Encounter (EP) with a diagnosis of upper respiratory infection (URI) during the measurement period

Numerator: # episodes (visits) in the denominator without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit

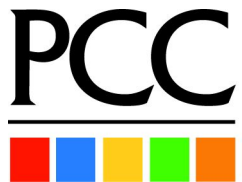
# Appropriate Testing For Children With URI

- This measure counts episodes (visits) for patients seen by the EP with active diagnosis of URI indicated on problem list or diagnosis component.
- Review medications with patients at every visit. Update medication history when patient was given antibiotic for URI elsewhere
- Prescribe antibiotics for URI only when appropriate
- Includes Rx made on or within 3 days after visit

# Weight Assessment and Counseling for Nutrition and Physical Activity

Percentage of patients 3-17 years of age who had an outpatient visit with the Provider of Encounter (EP) and who had evidence of the following during the measurement period (three rates are reported):

- Measure 1: Percentage of patients with height, weight, and body mass index (BMI) percentile documentation
- Measure 2: Percentage of patients with counseling for nutrition
- Measure 3: Percentage of patients with counseling for physical activity



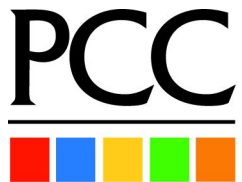
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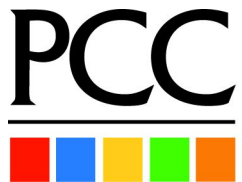
# Weight Assessment and Counseling for Nutrition and Physical Activity

- Two age stratifications for each measure:
  - Age 3-11
  - Age 12-17
- Denominator for each measure: # patients ages 3-17 who had at least one outpatient visit with the Provider of Encounter (EP) during the measurement period
- Denominator exclusion: Patients who have an active diagnosis of pregnancy during the measurement period (based on visit diagnosis, problem list, E-Rx problem, and EEF diagnosis)



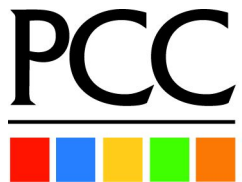
# Weight Assessment and Counseling for Nutrition and Physical Activity

- Numerator 1: # patients in the denominator who had a height, weight and body mass index (BMI) percentile recorded during the measurement period
- Sick, well, and counseling visits are included. Vaccine-only visits are not included
- The height, weight, and BMI can be recorded by any provider. It just has to be recorded during the measurement period



# Weight Assessment and Counseling for Nutrition and Physical Activity

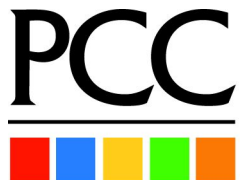
- Numerator 2: # patients in the denominator who had counseling for nutrition performed during a visit that occurs during the measurement period
- Numerator 3: # patients in the denominator who had counseling for physical activity performed during a visit that occurs during the measurement period
- Add medical procedure orders for nutrition and physical activity counseling and link to appropriate SNOMED procedures.



# Weight Assessment and Counseling for Nutrition and Physical Activity

Protocol Configuration		
Component Builder		
Visit Components    Chart-wide Components		
Component Name	Component Type	Attributes
Injection Orders	Injection	
Intake	Generic QA	
Intake	Generic Header	
M-Chat	Generic Radio	A, N, +/-
Medical Procedure Orders	Medical Procedure	
Medical Test Orders	Medical Test	
Medication	Generic Note	Multiple
Medication Effects	Generic Radio	G, F, P
Medication Review	Generic Check	

Medical Procedure Orders				
Medical Procedure Orders				
Medical Procedure Order Name	Display on Patient Reports	Allow Refusal	Allow Contraindication	Tests
Nebulizer, Repeat Tx	✓	✓	✓	0
Nursemaid Elbow-Reduction	✓	✓	✓	0
Nutrition Counseling	✓	✓	✓	0
Recommendation to Exercise	✓	✓	✓	0



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# Weight Assessment and Counseling for Nutrition and Physical Activity

**Medical Procedure Orders**

**Medical Procedure Orders - Edit Order**

Order Name:

☒ "Include on Patient Reports" will be selected when this order is issued

☒ Allow this order to be Refused

☒ Allow this order to be Contraindicated

**SNOMED CT Procedure for reporting**

Nutritionist education, guidance, and counseling

Identifier: 410270001

**Tests to Include**

**Medical Procedure Orders**

**Medical Procedure Orders - Edit Order**

Order Name:

☒ "Include on Patient Reports" will be selected when this order is issued

☒ Allow this order to be Refused

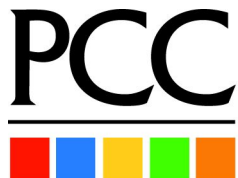
☒ Allow this order to be Contraindicated

**SNOMED CT Procedure for reporting**

Recommendation to exercise

Identifier: 281090004

**Tests to Include**



# Weight Assessment and Counseling for Nutrition and Physical Activity

- Add these “Nutrition Counseling” and “Recommendation to Exercise” medical procedures to chart protocols and order when appropriate

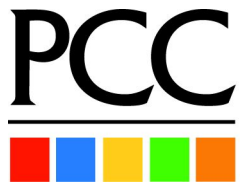
9-10 Yr Well - (client v. I) Bright Futures Tyler "Thomas" Danielle Ott J.R. 10 yrs, 9 mos 9/25/05 M

**Medical Test**

**Medical Procedure**

Nutrition Counseling

Recommendation to Exercise



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# CQM Documentation

[How to Chart for Each Clinical Quality Measure in PCC EHR](http://learn.pcc.com/help/meet-clinical-quality-measures-with-pcc-ehr)

<http://learn.pcc.com/help/meet-clinical-quality-measures-with-pcc-ehr>

Thank you!

Tim Proctor

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