



Transforming Healthcare Delivery
With Physician's Solution 5.0®



"Designed FOR Doctors BY Doctors"®

Physician's Solution 5.0®

Meaningful Use 2011/2012

User's Guide

Universal EMR Solutions LLC - "Where Convenience Drives Acceptance"®

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Electronic Medical Records – When You Need Them, Where You Want Them®

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Introduction

In January 2011, the Centers for Medicare and Medicaid Services (CMS) launches its Electronic Health Record Incentive Programs. To qualify for the program, providers are required to use an ONC-ATCB certified EMR system **AND** to demonstrate "meaningful use" of their certified EMR. CMS has defined 15 Core and 10 Menu Set objectives that specify the requirements for meaningful use. In addition, providers are required to report on 6 Clinical Quality Measures that have been defined by the National Quality Forum (NQF). An overview of the program objectives can be found at <http://www.cms.gov/EHRIncentivePrograms>. For a more detailed discussion of the objectives, see: <http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>

Many of the Meaningful Use objectives are already supported by Physician's Solution 5.0[®] – for example, the EMR already supports e-prescribing, generating drug-drug and drug-allergy interaction warnings, and more. Other objectives require minor modifications to the structure and content of patient chart notes. Accordingly, your EMR has been upgraded to support you in meeting those requirements. This User's Guide will illustrate all the note modifications that have been installed on your system and explain their significance.

The following template items have been strategically placed in your notes in conformance with Federal requirements:

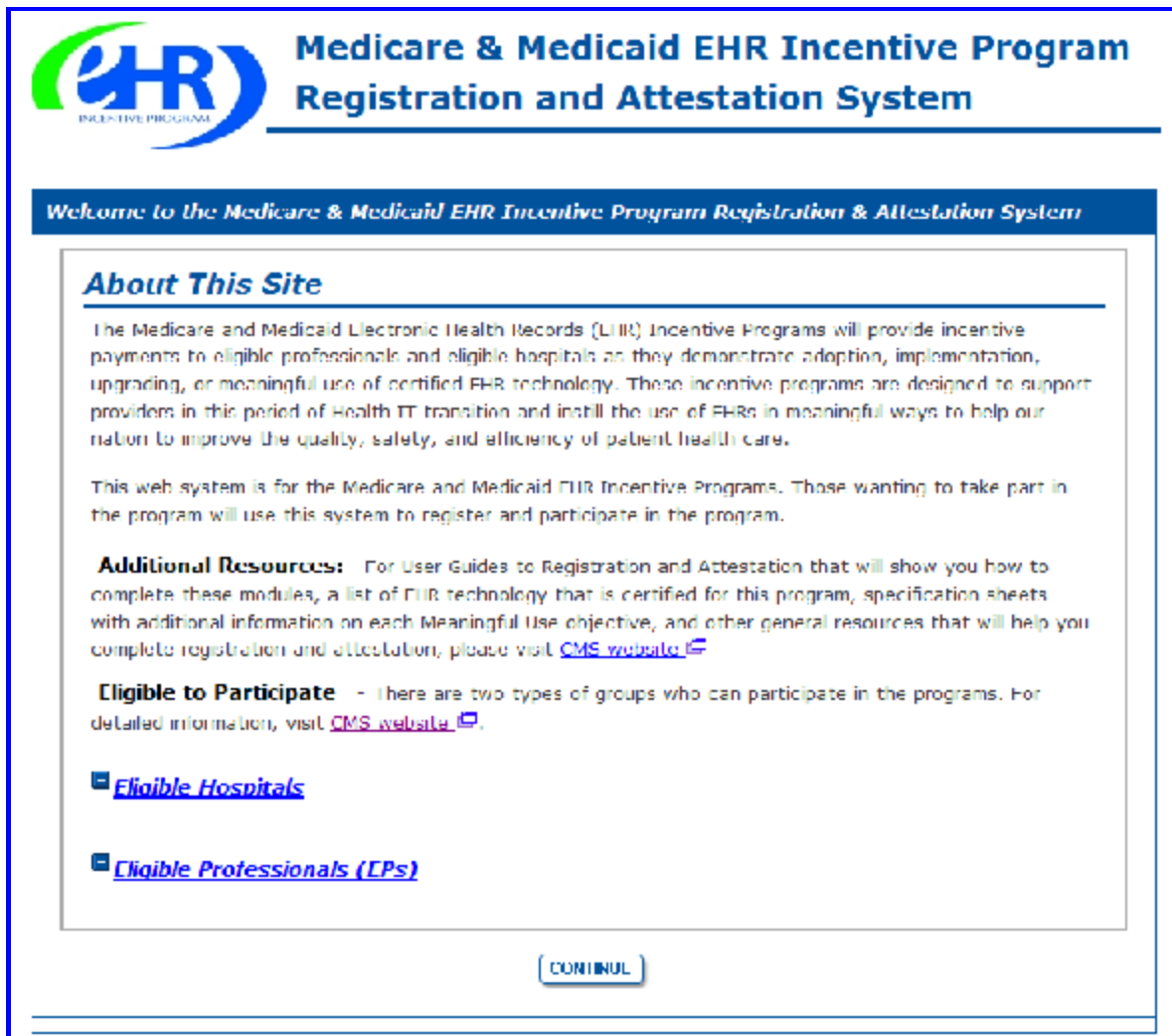
1. Patient demographic data – race, ethnicity, and preferred language
2. Tobacco use assessment and tobacco cessation intervention
3. BMI assessment and plan
4. Problem list
5. Allergy list
6. Vaccination information for Clinical Quality Measures
7. Creating an electronic copy of patient's EHR ("Write CCD File")


Details and illustrations for each of these template additions are provided on the following pages.

A note on Clinical Quality Measures: There are three Core measures: Tobacco Assessment and Intervention, BMI Assessment and Plan, and Influenza Immunization for Patients ≥ 50 . Templates for these measures have been added for ALL Physician's Solution 5.0 users. Three more alternate measures are required – these are more geared towards specific specialty types. More information on Clinical Quality Measures will be forthcoming.

CMS Registration

To register for CMS, go to: <https://ehrincentives.cms.gov/hitech/login.action> . On the first screen, simply hit "Continue" to progress to the second screen, where you will have to key in the provider's NPPES user ID and password to log into the system. **If you have any issues with the login or the registration process, contact the EHR Incentive Program Information Center at 888-734-6433.** The CMS Help Desk staffers that we have encountered are very knowledgeable and provide quick, efficient assistance. Should you have any difficulties navigating the registration process with the CMS Help Desk, feel free to call us at Universal EHR.



 **Medicare & Medicaid EHR Incentive Program
Registration and Attestation System**

Welcome to the Medicare & Medicaid EHR Incentive Program Registration & Attestation System

About This Site

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.

This web system is for the Medicare and Medicaid EHR Incentive Programs. Those wanting to take part in the program will use this system to register and participate in the program.

Additional Resources: For User Guides to Registration and Attestation that will show you how to complete these modules, a list of EHR technology that is certified for this program, specification sheets with additional information on each Meaningful Use objective, and other general resources that will help you complete registration and attestation, please visit [CMS website](#).

Eligible to Participate - There are two types of groups who can participate in the programs. For detailed information, visit [CMS website](#).

- [Eligible Hospitals](#)
- [Eligible Professionals \(EPs\)](#)

Record Patient Demographics

A core Meaningful Use objective is to "Record demographics: preferred language, gender, race, ethnicity, date of birth." Since Physician's Solution 5.0[®] already stores the patient's gender and date of birth, we have added textboxes within your notes for **Race, Ethnicity, and Preferred Language**. Like other demographic data, this information only needs to be entered **ONCE** per patient.

Both **Race** and **Ethnicity** text boxes are pre-populated with Favorites which are based on the standards for classification of federal data on race and ethnicity as determined by the Office of Management and Budget (OMB). We recommend that each practice create its own Favorites list for **Preferred Language**. The Federal guidelines for Race and Ethnicity categories are:

- **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American.** A person having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Race:

Ethnicity: **Preferred Language:**

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Patient declined information

Ethnicity:

- Not Hispanic or Latino
- Hispanic or Latino
- Patient declined information

Tobacco Use Assessment

A core Meaningful Use objective is to "Record smoking status for patients 13 years old or older." Accordingly, you will note a new **Tobacco Use** template item as illustrated below. These categories (Former smoker, Never smoker, etc.) have been determined by government health agencies.

Many providers have already been recording tobacco use information on the patient's chart. In these cases, your previous template items have been replaced with the new government-mandated language. You will have to re-enter the information for existing patients, using the new template.

Tobacco Cessation Intervention

One of the Clinical Quality Measures required for Meaningful Use is NQF (National Quality Forum) #0028. The clinical recommendation statement is:

The USPSTF [U.S. Preventive Services Task Force] strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003).

To this end, we have provided a space for the doctor to enter a **Tobacco Cessation Plan** for patients who are smokers. The pre-populated Favorites list offers a choice of two interventions recognized by the NQF.

Tobacco Use

Former smoker Never smoker Current every day smoker

Current some day smoker Unknown if ever smoked Smoker current status unknown

Tobacco Cessation Plan:

Tobacco Cessation Plan:

Tobacco use cessation counseling
Smoking cessation agents prescribed

Adult Weight Screening and Follow-Up

A core Meaningful Use requirement is to "Record and chart vital signs: height, weight, blood pressure; calculate and display BMI." While most EMR users are already calculating BMI, several systems have been updated with this function.

In addition, one of the Clinical Quality Measures required for Meaningful Use is NQF (National Quality Forum) #0421. The clinical recommendation statement is:

The USPSTF [U.S. Preventive Services Task Force] (2009) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. (Level of Evidence = B, USPSTF).

Accordingly, your EMR has been updated to provide BMI norms and a space to enter a follow-up plan for patients whose BMI falls outside the norms. The pre-populated Favorites for the **BMI Follow-up Plan** offer a choice of interventions recognized by the NQF.

Vitals

in/cm Lbs/kg **BMI:**

BMI Norms: Age: 18 - 64, BMI = 18.5 - 25; Age 65+, BMI = 22 - 30

BMI follow-up plan:

BMI exclusion:

BMI follow-up plan:

- Dietary surveillance and counseling
- Patient referral to dietitian

The NQF guidelines for the measure also provide for exclusions to BMI assessment and intervention. The Exclusions field is pre-populated with recognized medical and/or patient reasons explaining why the provider may not have performed the recommended clinical actions.

BMI exclusion:

- Active dx: Pregnancy
- Terminal illness
- Exam not done: Patient reason
- Exam not done: Medical reason

Problem List

A core Meaningful Use requirement is to "Maintain up-to-date problem list of current and active diagnoses ... or an indication that no problems are known for the patient." This means that providers will have to start entering diagnoses (i.e., problems) in the format required by the federal health agencies, as illustrated in the screen shot below. For patients with no current or active diagnoses, the provider must indicate this on the "No known problems" checkbox.

According to CMS, "An EP is not required to update the problem list at every contact with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances."

In order to support another core Meaningful Use objective – "to exchange key clinical information among providers of care and patient authorized entities electronically" – the Conditions (i.e., problems) must be entered using standardized diagnostic nomenclature that can be recognized across all healthcare IT platforms. To this end, the EMR will display your list of ICD-9 codes as choices for the **Condition** field.

Problem List (Persistent)

No known problems:

Status	Condition	Type	Active Date	
Active	272.4 (Hyperlipidemia)	Diagnosis	12/31/2010	✕
Active	250.0 (Diabetes Mellitus Type II)	Diagnosis	12/31/2010	✕

Status:

Condition:

Type:

Active Date:

Allergy List

A core Meaningful Use requirement is to "Maintain active medication allergy list ... or an indication that the patient has no known medication allergies." This means that providers will have to start entering allergies in the format required by the federal health agencies, as illustrated in the screen shot below.

In order to support another core Meaningful Use objective – "to exchange key clinical information among providers of care and patient authorized entities electronically" – the medication allergies should be entered using standardized nomenclature that can be recognized across all healthcare IT platforms.

The pre-populated Favorites for the **Allergy Reaction** offer reaction types recognized by commonly used medical nomenclature systems.

Allergies

Status	Allergy	Reaction	Type	Active date	
Active	Latex	Hives,swelling	Allergy to substance	12/31/2010	X
Active	Penicillin	Anaphylaxis	Drug allergy	12/31/2010	X

Status:

Allergy:
Reaction:

Type:
Active Date:

Reaction:

- Anaphylaxis
- Chest pain
- Diarrhea
- Hives
- Headache
- Irregular heart rate
- Itching
- Nausea
- Photosensitivity
- Rash
- Respiratory distress
- Sneezing
- Swelling
- Vomiting
- Wheezing

Clinical Quality Measures: Vaccinations

Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old (NQF 0041)

The clinical recommendation statement for this core Clinical Quality Measure is:

Annual influenza immunization is recommended for all groups who are at increased risk for complications from influenza including persons aged ≥ 50 years. (CDC, USPSTF)

Note that "Date of last flu shot" is not limited to immunizations performed at the provider's office – i.e., patient may have received the immunization at a pharmacy, at another provider's office, etc.

The NQF guidelines for the measure also provide for exclusions to the requirement. The Exclusions field is pre-populated with recognized medical and patient reasons explaining why the patient may not have been vaccinated.

Influenza Vaccination (patients over 50)

Date of last flu shot:

Flu shot exclusion:

- Influenza immunization contraindicated
- Influenza immunization declined
- Allergy to eggs
- Patient reason
- Medical reason

Pneumonia Vaccination Status for Older Adults (NQF 0043)

The clinical recommendation statement for this alternate Clinical Quality Measure is (in part):

The U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services* recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease.

Since NQF 0043 is an alternate measure, it will appear in selected EMR's only, depending on the provider's specialty type.

Pneumonia Vaccination (patients over 65)

Has patient ever had a pneumonia vaccination? Yes No

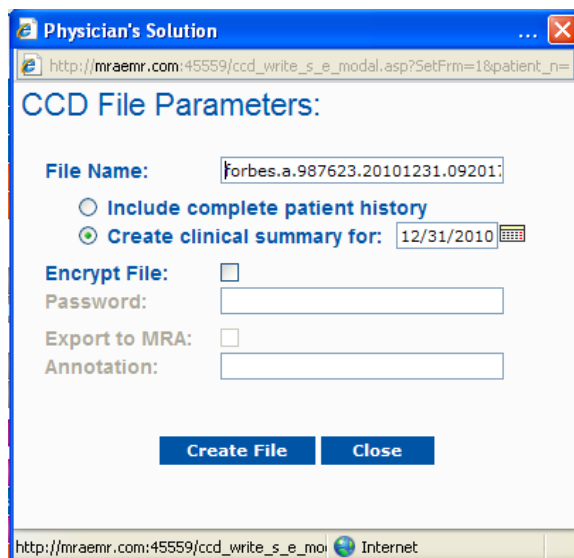
Create Electronic Copy of Patient's EHR

Meaningful Use objectives require that the provider produce an electronic copy of a patient's health record under the following circumstances:

- to exchange key clinical information among providers of care and patient authorized entities electronically
- to provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request
- to provide patients with a clinical summary of their office visit

The format and contents of an Electronic Health Record have been **strictly defined** by government healthcare IT agencies to ensure consistency when clinical information is exchanged. The standard for EHR exchange is known as the CCD file. Physician's Solution 5.0 enables the user to quickly and easily create a CCD file for a patient upon demand. The hyperlink to "Write CCD File" appears on the upper right-hand corner of the patient chart screen.

More details on this function will be forthcoming as Meaningful Use objectives become part of your everyday practice.

The screenshot shows a window titled "Physician's Solution" with a URL in the address bar: `http://mraemr.com:45559/ccd_write_s_e_modal.asp?SetFrm=18&patient_n=`. The main content area is titled "CCD File Parameters:" and contains the following fields and options:

- File Name:**
- Include complete patient history
- Create clinical summary for:
- Encrypt File:**
- Password:**
- Export to MRA:**
- Annotation:**

At the bottom of the dialog are two buttons: "Create File" and "Close". The status bar at the bottom of the window shows the URL `http://mraemr.com:45559/ccd_write_s_e_moi` and "Internet".