

MU2: Requirements & TouchWorks

11.4.1 Build Considerations

April 25, 2014

Enabling physician groups to realize the full potential of Electronic Health Records



vitalcenter





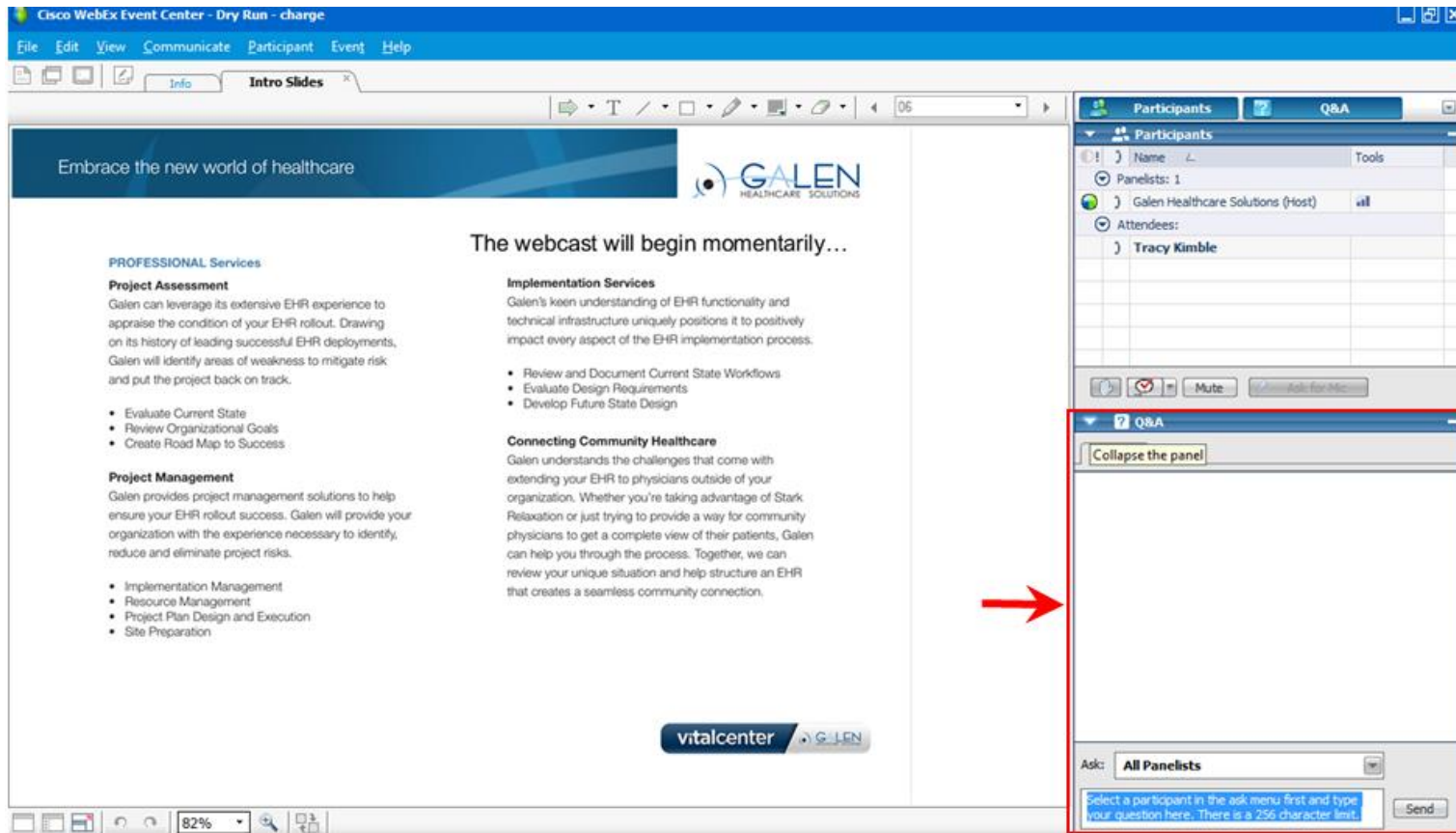
Elise



Cece



Your phone has been automatically muted. Please use the Q&A panel to ask questions during the presentation!



The screenshot shows a Cisco WebEx Event Center window titled "Cisco WebEx Event Center - Dry Run - charge". The main presentation area displays a slide with the title "Embrace the new world of healthcare" and the Galen Healthcare Solutions logo. The slide content is divided into three sections: "PROFESSIONAL Services", "Implementation Services", and "Connecting Community Healthcare".

PROFESSIONAL Services

Project Assessment

Galen can leverage its extensive EHR experience to appraise the condition of your EHR rollout. Drawing on its history of leading successful EHR deployments, Galen will identify areas of weakness to mitigate risk and put the project back on track.

- Evaluate Current State
- Review Organizational Goals
- Create Road Map to Success

Project Management

Galen provides project management solutions to help ensure your EHR rollout success. Galen will provide your organization with the experience necessary to identify, reduce and eliminate project risks.

- Implementation Management
- Resource Management
- Project Plan Design and Execution
- Site Preparation

Implementation Services

Galen's keen understanding of EHR functionality and technical infrastructure uniquely positions it to positively impact every aspect of the EHR implementation process.

- Review and Document Current State Workflows
- Evaluate Design Requirements
- Develop Future State Design

Connecting Community Healthcare

Galen understands the challenges that come with extending your EHR to physicians outside of your organization. Whether you're taking advantage of Stark Relaxation or just trying to provide a way for community physicians to get a complete view of their patients, Galen can help you through the process. Together, we can review your unique situation and help structure an EHR that creates a seamless community connection.

The webcast will begin momentarily...

Participants

Name	Tools
Panelists: 1	
Galen Healthcare Solutions (host)	
Attendees:	
Tracy Kimble	

Q&A

Collapse the panel

Ask: All Panelists

Select a participant in the ask menu first and type your question here. There is a 256 character limit.

Send

Meaningful Use 2 – Today's Outline:

- ✓ Functional Measures
- ✓ CQM
- ✓ TouchWorks Requirements
- ✓ TouchWorks Configuration
 - Core Measure 5 Record Smoking Status
 - PHQ 9/ Depression Screening
- ✓ Resources

Meaningful Use:

- ✓ Functional Measures
- ✓ Clinical Quality Measures

Meaningful Use:

- ✓ Functional Measures
- ✓ Clinical Quality Measures

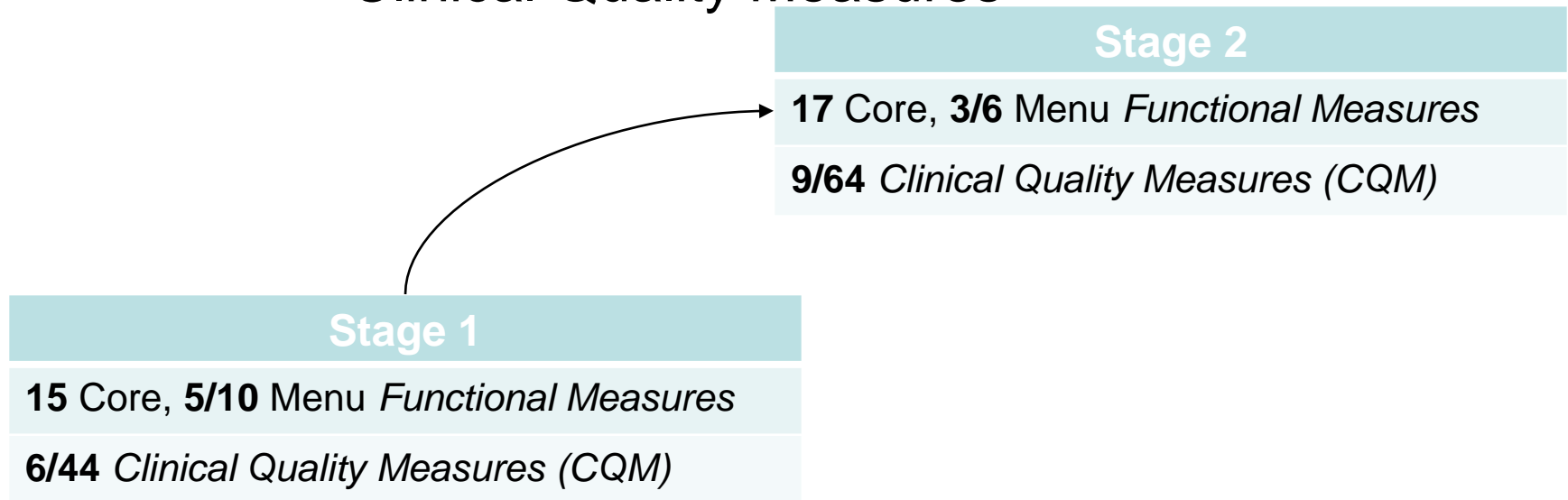
Stage 1

15 Core, **5/10** Menu *Functional Measures*

6/44 *Clinical Quality Measures (CQM)*

Meaningful Use:

- ✓ Functional Measures
- ✓ Clinical Quality Measures



MU2 Themes ...

- ✓ Higher Thresholds
- ✓ New/refined functional and clinical measures
- ✓ Emphasis on electronic communication and exchange of patient data
- ✓ Reporting to registries

MU2: Higher Thresholds...



Core #	Description	MU1	MU2
1	CPOE	> 30% unique patients have at least 1 medication ordered using CPOE.	> 60% medication, 30% labs, 30% radiology orders created by the EP using CPOE.
2	eRx	> 40% permissible Rx written by EP transmitted electronically.	> 50% permissible Rx written by EP transmitted electronically AND compared to at least 1 formulary.
3	Record Demographics	> 50% unique patients seen by EP have demographics recorded.	> 80% unique patients seen by EP have demographics recorded.
4	Capture & Record Vital Signs	> 50% unique patients age 2+ seen by EP have blood pressure, height and weight recorded.	> 80% unique patients age 3+ seen by EP have blood pressure, and height and weight recorded for all ages.
5	Record Smoking Status	> 50% unique patients age 13+ seen by EP have smoking status recorded.	> 80% unique patients age 13+ seen by EP have smoking status recorded.
8	Provide Clinical Summary	CS provided to patients for >50% office visits within 3 business days.	CS provided to patients for >50% office visits within 1 business day.
10	Lab Test Results	> 40% of all clinical lab test ordered by EP and resulted as +/- or numerical are incorporated into the EHR.	> 55% of all clinical lab test ordered by EP and resulted as +/- or numerical are incorporated into the EHR.
12	Send Patient Reminders	MENU	> 10% unique patients who have had 2+ office visits within 24 months prior to reporting period; sent a reminder, according to the patients preference.

MU2: Refined Criteria...

Core #	Description	MU1	MU2
6	Clinical Decision Support	Implement 1 CDS rule.	1. Implement 5 CDS interventions related to 4+ CQM's. 2. Enable functionality for drug-drug, drug-allergy interaction checks.
13	Provide Patient Education	> 10% unique patients seen by EP provided patient-specific educational resources.	> 10% unique patients with office visits seen by EP provided patient-specific educational resources identified by CEHRT .
15	Summary of Care	EP who transitions or refers patient to another setting of care provides a summary of care record > 50%.	1. EP who transitions or refers patient to another setting of care provides a summary of care record > 50%. 2. a) SOC is electronically transmitted –or– b) 10% exchanged via an eHealth Exchange 3. a) 1+ of the electronic exchanges must be completed with a recipient using different EHR technology than the EP. b) 1+ successful test during reporting period.
Menu 4	Patient Family Health History	NEW	> 20% of unique patients seen by the EP have structured data entered for 1+ first-degree relative or an indication that family health history has been reviewed.
Menu 5	Electronic Note	NEW	1+ electronic progress note created and signed by the EP for >30% of unique patients.
Menu 6	Imaging Results	NEW	> 10% of all scans and tests whose results is an imaged ordered by EP are incorporated into or accessible through EHR.



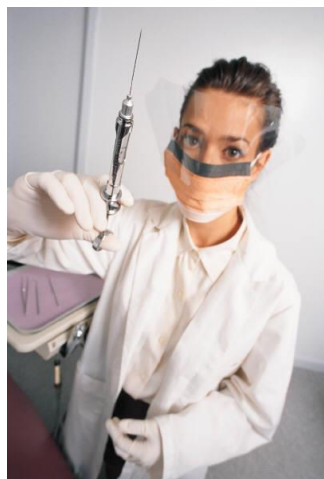
MU2: Electronic Access/Communication ...

Core #	Description	MU1	MU2
7	Patient Electronic Access	> 50% all patients who request an electronic copy of their health info are provided it within 3 business days.	1. > 50% unique patients provided with online access to their health info within 4 business days after the info is available to the EP. 2. > 5% unique patients (or authorized reps) view, download or transmit to a 3 rd party their health info.
17	Secure Electronic Messaging	NEW	For > 5% of unique patients seen by the EP, a secure message was sent using EHR technology.



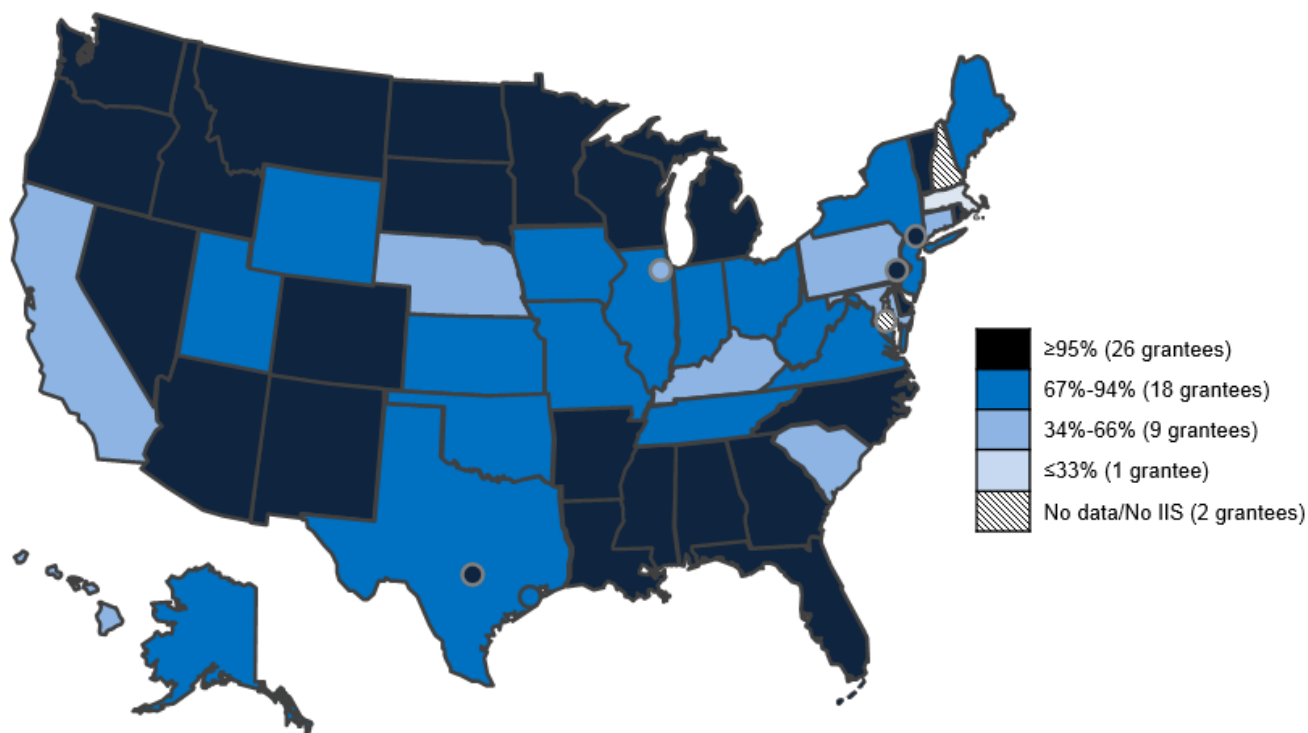
MU2: Reporting to Registries ...

Core #	Description	MU1	MU2
16	Immunization Registries	Perform 1+ test of ability to submit electronic data to immunization registries and a follow up submission if the test is successful.	Demonstrate successful ongoing submission of electronic immunization data to immunization registries or information systems.
Menu 1	Syndromic Surveillance	Perform 1+ test of ability to submit electronic syndromic surveillance data to public health agencies, and a follow-up submission if the test is successful.	Demonstrate successful ongoing submission of electronic syndromic surveillance data to public health agencies.
Menu 2	Cancer Registries	NEW	Successful ongoing submission of cancer case information to a cancer registry.
Menu 3	Specialized Registries	NEW	Successful ongoing submission of specific case information to a specialized registry.





Percentage of children aged < 6 years participating in an immunization information system -- United States, five cities[§], and D.C., 2012



National Participation: 86% (excluding Territories)

Source: CY2012 IISAR

MU2: Improved Security ...

Core #	Description	MU1	MU2
9	Protect Electronic Health Information	Conduct security risk analysis and implement security updates to correct deficiencies.	Conduct security risk analysis and implement security updates to correct deficiencies, and encrypt data at "rest" .



MU2: No Changes ...



Core #	Description	MU1	MU2
11	Generate Patient Lists	Generate 1+ report listing patients of the EP with a specific condition.	NO CHANGE
14	Medication Reconciliation	EP performs med rec for >50% of TOC in which the patient is transitioned into the care of the EP.	NO CHANGE

Clinical Quality Measures (CQM)

- ✓ Report 9 from a menu of 64
- ✓ Spanning at least 3 of 6 NQS domains
 1. Patient and Family Engagement
 2. Patient Safety
 3. Care Coordination
 4. Population/Public Health
 5. Efficient Use of Healthcare Resources
 6. Clinical Process/Effectiveness
- ✓ CMS Recommendations – 9 adult, 9 pediatric

Clinical Process/Effectiveness

- Initiation and Engagement of Alcohol and Other Drug Dependent Treatment
- Controlling High Blood Pressure
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Use of Appropriate Medications for Asthma
- Pneumonia Vaccination Status for Older Adults
- Diabetes: Eye Exam
- Diabetes: Foot Exam
- Diabetes: Hemoglobin A1c Poor Control
- Hemoglobin A1c Test for Pediatric Patients
- Diabetes: Urine Protein Screening
- Diabetes: Low Density Lipoprotein (LDL) Management
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- Coronary Artery Disease (CAD) Beta Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LWFE <40%)
- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
- Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Heart Failure (HF): Beta –Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Major Depressive Disorder (MDD): Suicide Risk Assessment
- Anti-depressant Medication Management
- ADHD: Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
- Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use
- Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
- Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
- HIV/AIDS: Medical Visit
- HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
- Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
- Pregnant Women that had HBsAg Testing
- Depression Remission at Twelve Months
- Depression Utilization of PHQ-9 Tool
- Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
- Children who have Dental Decay or Cavities
- Primary Care Prevention Intervention
- Preventive Care and Screening: Cholesterol- Fasting Low Density Lipoprotein (LDL-C) Test Performed
- Preventive Care and Screening: Risk Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)
- Dementia: Cognitive Assessment
- Hypertension: Improvement in Blood Pressure
- HIV/AIDS: RNA Control for Patients with HIV

Population/Public Health

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children & Adolescents
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Chlamydia Screening for Women
- Childhood Immunization Status
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- Maternal Depression Screening
- Preventive Care and Screening: Screening for High Blood Pressure and Follow Up Documented

Patient Safety

- Use of High Risk Medications in the Elderly
- Falls: Screening for Future Fall Risk
- Documentation of Current Medications in the Medical Record
- Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
- ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range

Patient and Family Engagement

- Oncology: Medical and Radiation – Pain Intensity Quantified
- Functional Status Assessment for Knee Replacement
- Functional Status Assessment for Hip Replacement
- Functional Status Assessment for Complex Chronic Condition

Efficient Use of Healthcare Resources

- Appropriate Testing for Children with Pharyngitis
- Use of Imaging Studies for Low Back Pain
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Care Coordination

- Closing the Referral Loop: Receipt of Specialist Report

Clinical Process/Effectiveness

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- Closing the Referral Loop: Receipt of Specialist Report

MU 2 Touchworks 11.4.1 Requirements

- Orders Adoption
- Meaningful Use Certified Solution
- Allscripts Patient Portal Adoption

- ✓ 11.4.1 Upgrade
- ✓ Full Patient Portal
- ✓ MU 2 Package

CPOE

Final Rule Requirements

1. More than 60% of medication orders created by the eligible provider (EP) during the reporting period were created using CPOE
2. More than 30% of lab orders created by the EP during the reporting period were created using CPOE
3. More than 30% of imaging orders created by the EP during the reporting period were created using CPOE

Core Objective: ☒ Menu Objective:

Dictionary: Orderable Item

- [-] Non-Medication
 - + Instructions
 - + Precautions
 - + Supplies
 - + Other Diagnostic Testing
 - + **Laboratory**
 - + Clinical Findings
 - + **Dx Imaging**
 - + Follow Up
 - + Referrals

Lab order
classification

Radiology
order
classification


eRx

Final Rule Requirements

More than 50% of all permissible prescriptions, or all prescriptions, written by the eligible professional (EP) are queried for a drug formulary and are submitted electronically.

Core Objective: ☒ Menu Objective:

⌵ Medication

Drug Name: 

NDC:

☐ Compound Medication

☐ Supply

[CVX Code](#)

[Manufacturer](#)

Route of Admin:

Dose Form:

Unit of Measure:

Package Sizes

Price Code:

Defines a
compound
medication

Record Demographics

Final Rule Requirements

More than 80% of all unique patients seen by the eligible professional (EP) have demographics recorded as structured data.

Core Objective:  Menu Objective:

⌵ **Race Standard**

OMB Standard: Native Hawaiian or Other Pacific Islander

⌵ **Ethnicity Standard**

OMB Standard: Non-Hispanic or Latino

⌵ **Language Code**

ISO Code: eng

☒ Show in MU Alert

Capture & Record Vital Signs

Final Rule Requirements

More than 80% of all unique patients seen by the EP during the EHR reporting period have blood pressures (for patients age 3 and over only) heights or lengths, and weights (for all ages) recorded as structured data.

Core Objective:  Menu Objective:

⌵ **Detail1**

Display Name: Height2

Answer Data Type: Numeric

Unit Picklist:

LOINC ID:

Precision: 0

Increments: 0

A custom height requires a LOINC code

Record Smoking Status

Final Rule Requirements

1. More than 60% of medication orders created by the eligible provider (EP) during the reporting period were created using CPOE
2. More than 30% of lab orders created by the EP during the reporting period were created using CPOE
3. More than 30% of imaging orders created by the EP during the reporting period were created using CPOE

Core Objective:  Menu Objective:

Problem Name:	Current Light Tobacco Smoker	Problem Name:	Current non-smoker
Primary ICD-9 Code:		Primary ICD-9 Code:	V49.89
Secondary ICD-9 Code:		Secondary ICD-9 Code:	
Primary ICD-10 Code:		Primary ICD-10 Code:	Z72.0
Secondary ICD-10 Code:		Secondary ICD-10 Code:	
SNOMED Code:	No SNOMED code	SNOMED Code:	SNOMED code 160618006
CPT-4 Code:		CPT-4 Code:	

Clinical Decision Support

Final Rule Requirements

More than 50% of all permissible prescriptions, or all prescriptions, written by the eligible professional (EP) are queried for a drug formulary and are submitted electronically.

Core Objective:  Menu Objective:

Provide Electronic Access

Final Rule Requirements

More than 50% of all unique patients seen by the eligible provider (EP) during the reporting period (RP) are provided timely (within 4 business days after the info is made available to EP) online access to their health info subject to the EP's discretion to withhold certain info

More than 5% of all unique patients seen by the EP during the RP (or authorized representatives) view, download or transmit to a third party their health info.

Core Objective: ☒ Menu Objective: ☐

^ Patient Preferred Communication

Clinical Summary:	<input type="text" value="Print"/>	Chart Update:	<input type="text" value="Not Enrolled in Portal"/>
Reminders:	<input type="text" value="Mail"/>	Result Notification	<input type="text" value="Mail - Not Enrolled in Portal"/>

Electronic access and communication requires the Patient Portal

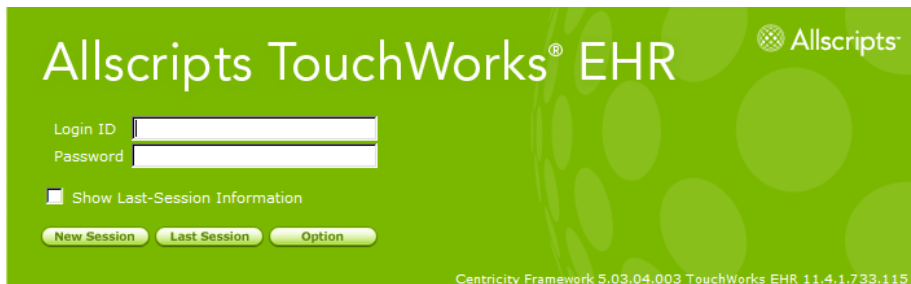
Provide Clinical Summary

Final Rule Requirements

Clinical summaries provided to patient or patient-authorized representatives within 1 business day for more than 50% of office visits.

Core Objective: ☒ Menu Objective: ☐ ☐ ☐ ☐

Protect Electronic Health Information



The image shows the login interface for Allscripts TouchWorks EHR. It features a green background with a pattern of overlapping circles. The text 'Allscripts TouchWorks® EHR' is prominently displayed at the top left, with the Allscripts logo to its right. Below this, there are input fields for 'Login ID' and 'Password'. A checkbox labeled 'Show Last-Session Information' is present, followed by three buttons: 'New Session', 'Last Session', and 'Option'. At the bottom right, a small text string reads 'Centricity Framework 5.03.04.003 TouchWorks EHR 11.4.1.733.115'.

Lab Test Results

Final Rule Requirements

More than 55% of all clinical lab test results ordered by the eligible professional (EP) during the EHR Reporting Period (RP) whose results are expressed in a positive/negative affirmation or numerical format are incorporated in the certified EHR technology (CEHRT) as structured data.

Core Objective:  Menu Objective:

Summary #1 - 21Apr2014 09:27PM

No summary entered. Document attached as result



[Results Document FoS \(Results Document FoS\) - Allscripts, Provider; Enc: 07Apr2014 - Chart Update - - \(Unassigned\)](#)

Generate Patient Lists

Final Rule Requirements

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

Core Objective:  Menu Objective:

Send Patient Reminders

Final Rule Requirements

More than 10% of all unique patients who have had 2 or more office visits with the eligible professional (EP) within the 24 months before the beginning of the EHR reporting period (RP) was sent a reminder, according to each patient's preference, when it has been recorded.

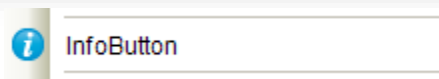
Core Objective:  Menu Objective:

Provide Patient Education

Final Rule Requirements

Patient-specific education resources identified by certified EHR technology (CEHRT) are provided to patients for more than 10% of all unique patients with office visits seen by an eligible professional during the EHR reporting period.

Core Objective:  Menu Objective:



Medication Reconciliation

Final Rule Requirements

The Eligible Professional (EP) who performs medication reconciliation for more than 50% of transitions of care (TOC) in which the patient is transitioned into the care of the EP.

Core Objective:  Menu Objective:

\$	N	TC	SOC	CS	A	Pt Loc
		<input type="checkbox"/>	<input type="checkbox"/>		Arr	

Summary of Care

Final Rule Requirements

The EP that transitions or refers their patient to another setting of care or provider or care provides a Summary of Care record for more than 50% of TOC and referrals

The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a Summary of Care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the Summary of Care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

Conducts one or more successful electronic exchanges of a Summary of Care document, which is counted in "measure 2" with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR OR Conducts one or more successful tests with the CMS designated test EHR during the EHR RP

Core Objective: ✓ Menu Objective:

Attachments

Questions

Referral Order
question for MU2

(MU) Care Summary provided.

Immunization Registries

Final Rule Requirements

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

Core Objective: ✓ Menu Objective:

Secure Electronic Messaging

Final Rule Requirements

A secure message was send using the electronic messaging function of certified EHR technology (CEHRT) by more than 5% of unique patients (or their authorized representatives) seen by the eligible professional (EP) during EHR reporting period (RP)

Core Objective: ✓

Menu Objective:

ePat Appt Request
ePat Med Ques
ePat Med Renew
ePat Message
ePat Message Failure
ePat Notification
ePat Registration
ePat Visit
eReferral Request
eReferral- Pt Match
eReply Portal Note

- SNOMED Code: 449868002 (current every day smoker)
- SNOMED Code: 428041000124106 (current some day smoker)
- SNOMED Code: 77176002 (smoker, current status unknown)
- SNOMED Code: 8517006 (former smoker)
- SNOMED Code: 266919005 (never a Smoker)
- SNOMED Code: 266927001 (unknown if ever smoked)
- SNOMED Code: 428071000124103 (heavy tobacco smoker)
- SNOMED Code: 428061000124105 (light tobacco smoker)



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2

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All Places > Ambulatory EHR > TouchWorks EHR > Documents

Meaningful Use Stage 2, Measure by Measure

created by Miranda Ladue on Nov 14, 2012 8:08 AM, last modified by Miranda Ladue on Apr 2, 2014 1:58 PM

Version 355

Webinar Series

Upcoming TouchWorks Webinar Series

- 4/8 Clinical Quality Measure Logic Measure Review Part 1 Register Now
- 4/15 Clinical Quality Measure Logic Measure Review Part 2 Register Now
- 4/22 Clinical Quality Measure Logic Measure Review Part 3 Register Now

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MU Regulatory Webinar Series

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MU 2014 Package Links	General Links
<ul style="list-style-type: none"> Welcome Letter For MU Package Deployment (Updated 3.6.14) Client Prepare Checklist (Updated 3.6.13) MU2 Clinical Quality Measure Configuration Workbook (Updated 3.2.14) MU1 Stimulus Reports vs MU1 MU Package Reports (NEW 2.27.14) Determining an MU Encounter for Eligible Professionals Link to Allscripts Learning Center 	<ul style="list-style-type: none"> CMS MU2 Measure Specifications CMS Stage 2 Home Page CMS MU Participation Timeline Meaningful Use Audit

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ACTIONS

- Edit
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- Enterprise EHR Webinar Summary - Sessions & Materials

Where to Find More about MU2?

http://internal-wiki.galenhealthcare.com/Meaningful_Use

<http://www.cms.gov/site-search/search-results.html.meaningfulusestage02>

Thank you for joining us today, for additional assistance....

You can contact us through our website at www.galenhealthcare.com

