Stage 1 and Stage 2

version 1.1

CREDIBLE
Behavioral Health Software

CREDIBLE

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Introduction

"It's not enough just to own a certified EHR. Providers have to demonstrate to CMS that they are using their EHRs in ways that can positively impact the care of their patients."

Eligible Professional's Guide to Stage 2 of the EHR Incentive Programs

This guide is for Credible Partners that have eligible professionals (EPs) pursuing meaningful use incentive payments through the Medicare or Medicaid EHR Incentive Programs. It provides the information necessary to use Credible in a meaningful way and capture the data needed for attestation. Credible successfully passed the 2011 Edition Meaningful Use EHR criteria on June 1, 2011 and is in the process of 2014 Edition Meaningful Use EHR certification.

While your Agency can currently configure and use Credible in a meaningful way for Program Year 2013, AIU, or Stage 1, Agency attestation for Program Year 2014 begins upon Credible's receipt of the 2014 Edition certification. Credible will notify Partners when 2014 Edition certification has been completed.

Two notes:

- Program Year refers to the actual year of participation (2011, 2012, 2013, and so on). While it is currently Program Year 2014, some Medicaid EPs may still be eligible to participate in Program Year 2013 since a few states have extended the attestation deadline beyond March 31, 2014. Please refer to your state's Medicaid EHR Incentive Program for information and deadlines related to Program Year 2013.
- AIU stands for Adopt/Implement/Upgrade of a certified EHR. Providers who are attesting to Medicaid can choose this option for their first year payment as opposed to Meaningful Use Stage 1. Under this option, EPs are not required to report on any of the Meaningful Use measures (core, menu, or clinical quality measures).

EPs always begin participating under Stage 1 requirements. Starting in 2014, EPs who have met Stage 1 for two or three years will need to demonstrate meaningful use under the Stage 2 requirements. All EPs, regardless of their stage of meaningful use, are only required to demonstrate meaningful use for a three-month (or 90-day) EHR reporting period in 2014.

To generate the CMS EHR Certification ID for Credible Behavioral Health software, go to the Certified Health IT Product List (CHPL) on the ONC website: http://healthit.hhs.gov/chpl. The ONC website provides a "certification bar" so you can review the criteria met by Credible software.

Disclaimer

The instructions in this guide are based on the steps Credible followed for certification purposes. Regardless of whether you follow these instructions or adjust them to suit the needs of your Agency, it is your responsibility to ensure that the steps you follow and the results you generate comply with all meaningful use requirements.

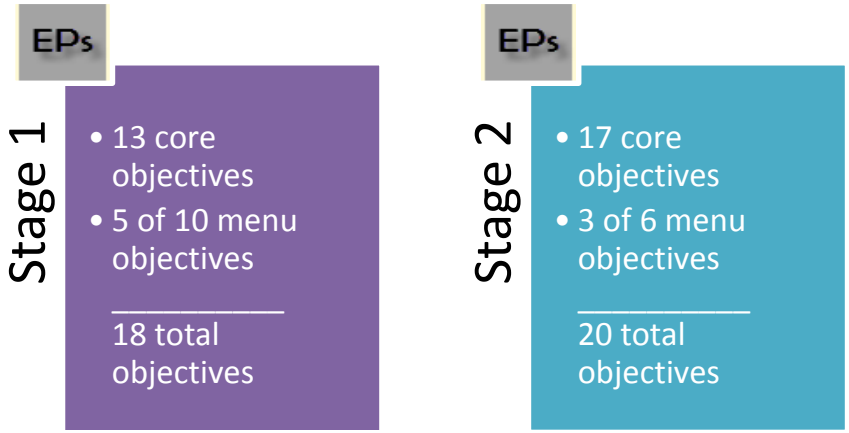
Resources

Stage 1 objectives, measures, exclusions, certification criteria, and attestation information in this guide are based on the specification (spec) sheets in the EP Stage 1 Specification Sheets 2013 08 20 zip file. Refer to the spec sheets for definition of terms, additional information, and related meaningful use FAQs. The Stage 1 content in this guide also reflects the information in the Stage 1 Changes Tipsheet.

The resource for the Stage 2 information in this guide is the EHR Incentive Programs Stage 2 Toolkit; it has links to the EP Stage 2 spec sheets.

Stage 1 vs Stage 2

Meaningful use includes core objectives (all are required) and menu objectives (a subset is required) that are specific to EPs. See below for the number of core and menu objectives required for Stage 1 and Stage 2.



In the EHR Incentive Programs Stage 2 Toolkit, CMS compares Stage 1 and Stage 2 as follows: “Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that EPs must meet for the objective has been raised.”

In addition to meeting the core and menu objectives, EPs have to report on 9 of the 64 approved clinical quality measures (CQMs). This requirement is the same for Stage 1 and Stage 2.

Stage 2 Navigation in this Guide

For EPs meeting Stage 2 meaningful use requirements, refer to the Stage 2 section of the guide. If a Stage 2 measure has the same configuration/use steps as a Stage 1 measure, a “click here” link will be provided to go to the corresponding section for the Stage 1 measure. Likewise, if a Stage 2 measure has the same denominator/numerator/stored procedure information as a Stage 1 measure. In both of these situations, a “Back to corresponding Stage 2 measure” link will be available so you can return to the Stage 2 measure you were working on.

Attestation for Objectives with Automated Measure Calculation §170.302(n)/§170.314(g)(2)

For each meaningful use objective with a percentage-based measure, you need to electronically record the numerator and denominator and generate a report that includes the numerator, denominator, and resulting percentage (numerator ÷ denominator). The resulting percentage must meet the specified measure requirement.

In Credible, the recording and reporting is done through summary stored procedures that you run via the Export tool (or optionally, the Reports tab). Your system also has detail versions of the stored procedures that you can use to see where corrections are needed (for example, which clients are missing allergies, problems, and so on). The summary stored procedure names are provided in the Attestation section for each percentage-based measure. To use a detail version, simply change “summary” to “detail” in the stored procedure name when creating the export (for example, spc_export_mu_cpoe_summary vs spc_export_mu_cpoe_detail).

Note: for the Record Demographics or Record Smoking Status measure, if you use a non-standard Client Profile field to capture the relevant information, the query behind the stored procedure will need to be modified. Please contact your Partner Services Coordinator (PSC) for more information.

For percentage-based measures, each client has to have an approved visit in Credible to meet the “seen by the EP” requirement. And to be considered an “office visit” (terminology used by CMS), the visit (service) has to have a clinical summary that uses the Consolidated Clinical Document Architecture (C-CDA) format (referred to as a CCD Summary in Credible). To meet this requirement, you need to set up a visit type to include a clinical summary (Admin tab > Visit Type > edit the visit type and select Include Summary setting) and select that visit type when adding/scheduling a visit for a client.

Clinical summary access is through the Visit Details screen and Credible Client Portal.

Settings

Security Matrix: FormBuilder, FormBuilderEdit, ClientFormsUpdate, ClientVisitSummaryView, ExportBuild, ExportRun

Your Implementation Manager (IM) or PSC needs to turn on the Client Portal for your system.

Steps to Configure

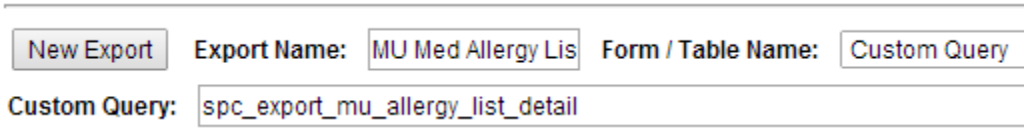
For the steps to set up the Client Portal and give a client user access to it, refer to Appendix A.

To configure a visit type to include a clinical summary and support time-of-visit clinical summary generation:

1. **Admin** tab > **Visit Type.**
2. Add a new service type or edit an existing one.
3. Select Include Summary checkbox.
4. If your organization uses the eMAR module, select Associate eMAR.
5. To include the visit information in the Procedures section in the clinical summary, select *Is Procedure for CDA documents*. When this setting is unchecked, the visit information will be in the Encounters section.
6. Click **Save.**

To create a “stored procedure export” for a meaningful use measure:

1. Reports tab > **Export Tool** on nav bar.
2. Enter the name of the measure in the Export Name field and select Custom Query from the Form/Table Name dropdown.
3. Copy and paste the stored procedure name into the Custom Query field and click **New Export.**



4. To set up the export so it can be run from the Reports tab, select the Show on Reports Tab checkbox and the desired report category from the Category dropdown.
5. Enter Start Date and End Date in the Custom Param 1 and Param 2 fields respectively so a date range can be entered when the export is run.
6. Select all custom columns displayed.
7. Click Next Step and then click Finish.
8. If you selected the Show on Reports Tab checkbox, give the appropriate profiles the right to run the export from the Reports tab: Admin tab > Report Security > select the export for the appropriate profiles > Save All.

Steps to Use

Add a visit for client, selecting a visit type that has been configured to include a clinical summary.

When running an MU export, select the Header Row checkbox and enter the appropriate dates in the Start Date and End Date fields. If no dates are entered, the export defaults to the previous year.

Stage 1

Core 1: CPOE for Medication Orders

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

Certification criteria: §170.304(a) Computerized provider order entry

§170.304(a) Computerized provider order	Enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types: (1) Medications; (2) Laboratory; and (3) Radiology/imaging.

In Credible, the Physicians Orders function lets you add an order to a client's record and view and manage current, pending, and completed orders. An order can be for medications, labs, consultations, therapy, psych evaluations, or radiology. There is also an "Other" category you can use if the order doesn't fall into one of the standard categories.

To add and manage orders, you need to be a doctor (specified via the is_doctor field in the Employee Profile) or have the appropriate rights (see below).

If a client has current orders, pending orders, or completed orders, you will see the details of those orders in the corresponding sections, as well as buttons for the actions that can be taken with the orders. Orders begin the cycle as current orders, become pending orders once they're signed, and move to Order History once they're completed. Nurses typically complete pending orders.

Settings

Security Matrix: PhysicianOrdersView, PhysicianOrdersAdd, and PhysicianOrderLineComplete or PhysicianOrdersSignAll

Partner Config: Physician Orders Hide Discontinue Button, Physician Order/Assigned Physician (both are optional)

Steps to Configure

1. Use the Data Dictionary to add is_doctor, is_nurse, is_mu_provider, and is_licensed_health_prof fields to the View and Update versions of the Employee table.
2. For employees who are doctors, nurses, eligible providers (professionals), and/or licensed health professionals:
   a. Profile button on Employee nav bar > Update button.
   b. Select the appropriate radio button for the fields above and click Update Employee.

Steps to Use

To add an order:

1. Client tab > Client's name > **Orders** on Client nav bar.
2. In the New Order section of the Physicians Orders screen, select the tab that corresponds to the order category.
3. Enter the order in the Order text box.
4. If you are entering the order after the actual Order Date, use the Order Date calendar picker to enter the correct date. If you don't enter a date, the current date will be the Order Date.
5. Click **Add Order** when done. The new order appears in the Current Orders section.

To edit a current order:

1. Click the **edit** button that corresponds with the order you want to modify. The Order text box displays with the existing order information.
2. Revise the order and click **Edit Order** to save the changes. The screen refreshes and the update appears in the Order column in the Current Orders section.

The Sign button will be enabled for current orders if you are a doctor (is_doctor is set to Yes in your employee profile) and you added the orders. If you are a doctor and have the PhysicianOrdersSignAll right, the Sign button will be enabled for all current orders regardless of whether you added them.

If necessary, you can use the Physician dropdown to change the assigned physician before signing a current order. The action will be recorded in your employee log as CHANGE ASSIGNED PHYSICIAN and the old and new employee IDs can be viewed via the details button.

- To sign all current orders, select the checkbox to the left of the Sign column header and click the Sign button.
- To sign one or more current orders, select the corresponding Sign checkboxes and click the Sign button.

The screen refreshes and the orders are now in the Pending Orders section instead of in the Current Orders section.

To complete a pending order, you must be logged into the system and have the appropriate credentials (typically a nurse). Click the **complete** button to complete the order. The screen refreshes and the order is now in the Order History section instead of in the Pending Orders section.

To discontinue an order:

1. Click **discont**.
2. In the popup that displays, enter the reason for the discontinuation and click **Save**.

To view discontinued orders, click **Show Discontinued**. After viewing the discontinued orders, click **Show Current** to return to the current orders.

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. Optional Alternate: More than 30 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

	CMS	Credible
Denominator	Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients having at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, visit type has Include Summary checked, and client has at least one medication (Credible eRx prescription or regular medication)
Numerator	Number of patients in the denominator that have at least one medication order entered using CPOE	Count of clients in Credible denominator that have at least one Physician's order of type 'Medications' OR at least one medication where the provider in an employee (automatic for Credible eRx) AND the entry of the order/medication was done by an employee that is a doctor, nurse, or licensed health professional. (A valid CPOE is NOT just based having the security right to add an order.) When you create a prescription in Credible, both requirements for the Credible numerator are automatically met. If you use the Add Medication function, you need to select the medication from the dropdown without editing and select an employee that is a doctor, nurse, or licensed health professional as the provider. A medication entered via free text or for an outside provider is excluded from the calculation for the Credible numerator. 💻 Stored procedure in Credible spc_export_mu_cpoe_summary

Optional Alternate Measure

	CMS	Credible
Optional Alternate Denominator	Number of medication orders created by the EP during the EHR reporting period	Meds Number of physician orders of type 'Medications' OR medication where the provider in an employee (automatic for Credible eRx)
Optional Alternate Numerator	Number of medication orders in the denominator entered using CPOE	Number of orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional Stored procedure in Credible spc_export_mu_cpoe_summary

Core 2: Drug Interaction Checks

Objective	Implement drug-drug and drug-allergy interaction checks.

Certification criteria: §170.302(a) Drug-drug, drug-allergy interaction checks

§170.302(a) **Drug-drug, drug-allergy interaction checks**	(1) Notifications. Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE). (2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.

(1) Notifications. When you create a prescription in Credible, the system automatically checks for interactions with existing medications and allergies in the client's record. If the existing medication was added through the Add Medication function, it has to have been selected from the autopopulated dropdown to be included in the check. The same is true for existing allergies. The matching required for an interaction notification will not occur if the medication or allergy was entered via free text. All existing medications added through Create Prescription will be included in the drug-drug check (free text is not an option).

Settings	Security Matrix: RxView or PhysicianOrdersView, PrescriptionCreate or PrescriptionCreateNonSPI if you are not a prescriber To create prescriptions, your agency needs the Credible eRx module and your IM/PSC needs to turn it on in your system.
Steps to Configure	Refer to the *Credible eRx Setup* guide in the Credible Library (reference ID 32908).

Steps to Use

1. Add a medication or create a prescription: Client tab > Client's name > **Medications** (or Orders) on nav bar.

Medication

a. Click the **Add Medication** button.

b. In the Medication field, enter the name of the medication or the first few letters in the name. *Select the appropriate medication from the dropdown that displays*.

c. Enter the dosage, frequency, rationale, quantity, and number of refills.

d. If applicable, select the provider from the dropdown.

e. If the medication is a prescription, select Yes from the Is Prescription dropdown and enter the name of the pharmacy.

f. Enter any instructions in the text box provided.

g. Enter the start date for the medication and click **Add Medication**.

Prescription

a. Click the **Create Prescription** button.

b. Search for and select the medication you want to prescribe in the Medication Search screen.

c. If you are not a prescriber, select the appropriate one from the Provider dropdown.

d. Fill out the rest of the Sig Builder tab and print, e-send, or e-fax the prescription.

2. Add an allergy:

   a. Client tab > Client's name > **Allergy** on nav bar > **Add Allergy** button.

   b. In the Allergy field, start typing the name of the allergy. *Select the appropriate entry from the dropdown that displays*.

   c. If necessary, enter additional text in the field provided.

   d. Use the Severe dropdown to indicate the severity of the allergy.

   e. Enter a description of the reaction in the field provided (required).

f. If you want to flag the allergy is a medical allergy for reporting purposes, select the Med Allergy checkbox. This flag has no impact on the drug-allergy interaction check that happens when creating a prescription.

g. Click **Add Allergy**.

3. Create a prescription *for a medication that you know will interact with the medication and allergy added in steps 1 and 2.* The Create Prescription screen will have a warning message about the interactions and a tab for each interaction (example).

   a. Review the interactions information and if necessary, change the medication you are prescribing.

   b. If you are not a prescriber, select the appropriate one from the Provider dropdown.

   c. Fill out the rest of the Sig Builder tab and print, e-send, or e-fax the prescription.

(2) Adjustments. In Credible, you can set up a custom severity level message for the interaction tab for the different type/severity level combinations. The custom message is not login (security) profile specific – all profiles that can see that security level's message will see the same message. Example: the standard message for a level 3/moderate drug-drug interaction is "SEVERITY LEVEL: 3-Moderate Interaction: Assess the risk to the patient and take action as needed." By adding a custom severity level message, you can change it to "SEVERITY LEVEL: 3-Moderate Interaction: Review client's medical history and document rationale for prescribing this medication in lieu of alternatives." Note that the remaining text of the interaction message (mechanism of action, clinical effects, and so on) is not changed.

Settings — Security Matrix: SeverityLevelAdmin

Steps to Configure — See steps to configure (1) Notifications above.

Steps to Use

1. Admin tab > **Med Severity Levels** (under Lookups and Code Tables).
2. Enter a custom message in the Description field for one or more of the type/severity level combinations.
3. Click **Save.**

Attestation: YES/NO

Measure	The EP has enabled this functionality for the entire EHR reporting period.
Exclusion	No exclusion.

EPs must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

In Credible, you will not be able to attest to meeting this objective without the Credible eRx module.

Core 3: Maintain Problem List

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

Certification criteria: §170.302(c) Maintain up-to-date problem list

§170.302(c) **Maintain up-to-date problem list**	Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care in accordance with: (1) The standard specified in §170.207(a)(1); or (2) At a minimum, the version of the standard specified in §170.207(a)(2).

The problem list is defined as a listing of ICD-9-CM codes for a client (Axes I, II, and III). In Credible, you can record Axis I - V diagnoses for a client and update them when necessary. For Axis I - III diagnoses, the system records the date each diagnosis is changed (directly or through mapping). Employees can keep the list up-to-date by entering a resolved date when a diagnosis has been resolved, adding new diagnoses as necessary, and removing diagnoses when they are no longer applicable. Resolved diagnoses will not be copied over when you start new diagnoses for the client.

When adding an Axis I – III diagnosis, you specify the SNOMED CT description that corresponds to the ICD-9 description.[1] If there is a one-to-one correspondence between the two codes, the SNOMED description dropdown will be preset with the appropriate SNOMED CT description. If the system cannot find any possible matches, you use the SNOMED Picker to search for the appropriate code. The mapping from ICD-9 to SNOMED CT is provided by data from the U.S. National Library of Medicine: www.nlm.nih.gov/research/umls/mapping_projects/icd9cm_to_snomedct.html.

Settings Security Matrix: DxView, DxAdd or DxFormsAdd, DxUpdate, DxAxisDelete

Partner Config: Use Axis IV Stressors, Show RO field in Diagnosis, Hide Previous GAF in Diagnosis, Shows Highest GAF in Diagnosis (all are optional)

[1] SNOMED CT stands for Systematized Nomenclature of Medicine – Clinical Terminology. "The Office of the National Coordinator for Health Information Technology (ONC) and CMS have adopted SNOMED CT as one of the key vocabularies for Meaningful Use Stage 2, EHR certification, and health information exchange" (click here for more information).

Steps to Configure

Add “No Diagnosis” entries for Axis I – III (Admin tab > Axis I/Axis 2/Axis 3) and code them as follows:

- No diagnosis on Axis I (finding) 1230003
- No diagnosis on Axis II (finding) 10125004
- No diagnosis on Axis III (finding) 51112002

Steps to Use

1. Diagnosis on Client nav bar.
2. For Axis I, II, or III diagnoses, use the Show All Detail/Hide All Detail button to display the detail for all diagnoses in the section. Use the plus/minus sign to show/hide the detail for an individual diagnosis.
3. If the screen does not default to add mode (“Adding new diagnoses” appears at the top), click the Update button.

To add an Axis I, II, or III diagnosis:

1. Select it from the New dropdown. An order dropdown and the detail fields for the diagnosis display. If the client doesn’t have a diagnosis, select the No Diagnosis option so he/she will be included in the measure.
2. If you need to change the order of the diagnosis, select a different number in the dropdown or select the > # option to manually enter the order number. For the latter scenario, click OK when the confirmation prompt displays and then enter the desired order number in the field.
3. For the SNOMED description:
   - If there is a one-to-one correspondence between the SNOMED CT code and ICD-9 code, the dropdown will be preset with the appropriate description and no action is necessary.
   - If the dropdown is enabled, it means there are multiple SNOMED CT codes that match the ICD-9 code. Select the appropriate description.
   - If there is a SNOMED Picker button, click it. When the picker popup displays, start entering the SNOMED CT code to view matching SNOMED CT descriptions. Click the appropriate code and click Done.
4. Fill out the remaining detail fields as appropriate.
5. Click Save.

To edit an Axis I, II, or III diagnosis, click the edit button, make the necessary changes, and click Save.

To delete an Axis I, II, or III diagnosis, click the delete button and click OK when the confirmation prompt displays.

To resequence the diagnoses in the Axis I, II, or III section, click the Resequence button and click OK when the confirmation prompt displays.

To add or edit an Axis IV or V diagnosis, click the Edit button for the corresponding section, enter/change the necessary information, and click Save.

To edit the effective date for the current diagnoses, click the Edit button to the right of the date field, change the date, and click Save.

Attestation: §170.302(n)

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

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list	Count of clients in Credible denominator that have current active list of diagnoses and at least one diagnosis with a SNOMED CT code Stored procedure in Credible spc_export_mu_problem_list_summary

Core 4: e-Prescribing (eRx)

Objective	Generate and transmit permissible prescriptions electronically (eRx).

Certification criteria: §170.304(b) Electronic prescribing

§170.304(b) Electronic prescribing	Enable a user to electronically generate and transmit prescriptions and prescription-related information in accordance with: (1) The standard specified in §170.205(b)(1) or §170.205(b)(2); and (2) The standard specified in §170.207(d).

With the Credible eRx module, prescribers -- employees with a Surescripts Provider Identifier (SPI) number set up in Credible -- and nonprescribers with the appropriate security rights can electronically create and send prescriptions. You can send a prescription to a pharmacy electronically as long as the medication is not a controlled substance II-V.

If you are not a prescriber but have the PrescriptionCreateNonSPI right, you can submit a prescription for a prescriber without approval.

Settings

For prescribers: Credible sends a prescriber's information to Surescripts and then enters the SPI number assigned into your Credible system; no additional security rights are necessary.

For non-prescribers: PrescriptionCreate or PrescriptionCreateNonSPI

Steps to Configure

Fill out the *Credible-defined* fields listed below for registered prescribers and other employees using Credible eRx and for clients receiving the prescriptions.

1. Employee profile fields: first_name, last_name, address1, city, state, zip, work_phone, fax_number, email, npi, dea (optional but recommended)
2. Client profile fields: first_name, last_name, sex, dob

If you are not sure which fields in the Employee or Client Profile screens correspond to the fields above, access the Employee or Clients table in the Data Dictionary, find the corresponding column names, and then see what the view labels are.

Steps to Use To create a prescription:

1. Client tab > Client's name (or **view** button) > **Medications** (or Orders) on Client nav bar.
2. Click **Create Prescription** on Client Medications screen (or Add Prescription on Physicians Orders screen).
3. Search for the drug by medication name, drug class, condition, or any combination of these three filters. In the Medication and Condition fields, you can enter the first few letters of the name and then select the appropriate option from the list provided. *Do not select* a controlled substance II-V.
4. Click the appropriate medication in the list to select it. The Create Prescription screen for the medication you selected displays.
5. If you are a nonprescriber, select the prescriber from the Provider dropdown.
6. Use the Sig Builder or Free Text Sig tab to enter the directions for how to use the medication.
   Note: if you switch between the Sig Builder and Free Text Sig tabs, the system will take the input from the active tab when you move to the next screen. Data is not shared between the two tabs.
7. Enter the quantity and select the quantity units (for example, capsules or drops) for the prescription.
8. Fill out any other fields as necessary.
9. Click **Send To Pharmacy**. The Pharmacy Search screen displays.
   - If this is your first time accessing the screen, there won't be any pharmacies in the list. Once you start electronically sending prescriptions to pharmacies, the system will populate the list based on your selections with the most recent selection at the top of the list.
   - To show only mail order pharmacies, click **Show Mail Order**.
     To include fax only pharmacies in the list, select the corresponding checkbox and click **Search.**
     Note that mail order only trumps fax only – if you select Include 'Fax Only' Pharmacies and click Show Mail Order, only mail order pharmacies will be returned in the search results.
10. If necessary, search for a pharmacy with the filtering fields and **Search** button.
11. Select a pharmacy from the list. A 'finalize prescription' screen displays.
12. If you need to change the dosage information or pharmacy, click the corresponding Edit button.
13. Use the radio buttons to specify whether the pharmacy can substitute a different medicine than the one you have prescribed.

14. Click **Send**, **Send & Copy**, or **Submit for Approval** to finish the prescription. If you use Submit for Approval, have the prescriber approve and complete the prescription.

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology (CEHRT).
Exclusion	1. Any EP who writes fewer than 100 prescriptions during the EHR reporting period. 2. Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

In Credible, you will not be able to attest to meeting this objective without the Credible eRx module.

	CMS	Credible
Denominator	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period	Count of Credible eRx prescriptions for non-Schedule 2 drugs where creation date is in EHR reporting period, signature exists, and status is one of the following: • (EC) ELECTRONIC - CURRENT • (PC) PAPER - CURRENT • (FC) FAX - CURRENT • (ECU) ELECTRONIC - CURRENT UNAPPROVED • (PCU) PAPER - CURRENT UNAPPROVED
Numerator	Number of prescriptions in the denominator generated and transmitted electronically	Count of prescriptions in Credible denominator where status is (EC) ELECTRONIC – CURRENT or (ECU) ELECTRONIC - CURRENT UNAPPROVED Stored procedure in Credible spc_export_mu_erx_summary If your state regulations dictate that other Schedules should be excluded, the query behind the stored procedure will need to be modified. Contact your PSC for more information.

Core 5: Active Medication List

Objective	Maintain active medication list.

Certification criteria: §170.302(d) Maintain active medication list

§170.302(d) Maintain active medication list	Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care.

In Credible, you can add a medication to a client's record through the Add Medication or Create Prescription function (the latter requires the Credible eRx module). Both functions are available on the Client Medications and Physicians Orders screens. You use the Client Medications screen to manage a client's medications. While you can edit a current or concurrent medication at any time, you cannot edit a prescribed medication after it has been sent to a pharmacy or printed. If a prescription fails to send, you can edit it as part of the retry function. If appropriate, you can delete a medication or discontinue a prescribed medication. The system records all changes made to a medication or prescription – use the available history button to review the changes.

If a client has no active medications listed, there will be a "Client has reported no current medications" checkbox on the Client Medications screen. Selecting the checkbox affirms that you have reviewed the client's medication history and verified that he or she is not currently taking any medications. Behind the scenes, a no_med_flag field is set to true and can be used for reporting purposes. If a medication is added to the client's record, the system removes the checkbox and changes no_med_flag to false. If the last medication for a client is deleted or discontinued, the checkbox will become available again. However, you must manually select it to reaffirm that the client has reported no current medications – the system will not automatically reselect it.

Settings Security Matrix: RxView or PhysicianOrdersView, RxUpdate or PrescriptionCreate or PrescriptionCreateNonSPI if you are not a prescriber

Steps to Configure N/A

Steps to Use To add a concurrent medication:

1. Client tab > Client's name > **Medications** (or Orders) on nav bar > **Add Medication**.
2. In the Medication field, enter the name of the medication or the first few letters in the name. Select the appropriate medication from the dropdown that displays.
3. Enter the dosage, frequency, rationale, quantity, and number of refills.
4. If applicable, select the provider from the dropdown.
5. If the medication is a prescription, select Yes from the Is Prescription dropdown and enter the name of the pharmacy.
6. Enter any instructions in the text box provided.
7. Enter the start date for the medication and click **Add Medication**.

To prescribe a medication:

1. Client tab > Client's name > **Medications** (or Orders) on nav bar > **Create Prescription**.
2. Search for and select the medication you want to prescribe in the Medication Search screen.
3. If you are not a prescriber, select the appropriate one from the Provider dropdown.
4. Fill out the rest of the Sig Builder tab and print, e-send, or e-fax the prescription.

To edit a current or concurrent medication:

1. Client tab > Client's name > **Medications** on Client nav bar.
2. Click **edit**, make the necessary changes, and click **Update Medication**.

To discontinue or reject a prescribed medication:

1. Click **discont** or **reject** and click **OK** when the confirmation popup displays.
2. If a Reason popup displays, enter the reason you are discontinuing or rejecting the prescription and click **Save**.[2]

To delete a concurrent medication, click **delete** and click **OK** when the confirmation popup displays.

[2] Select *Use Med History Notes* in Partner Config to enable the Reason popup.

To view the history for a medication, click **history**. After viewing the history, click **Close History** to return to the active medication list.

If a client is not currently taking any medications and you have confirmed this fact with him or her, click the "Client has reported no current medications" checkbox.

Attestation: §170.302(n)

Measure	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Exclusion	No exclusion.

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data	Count of clients in Credible denominator that have active medication (Credible eRx prescription or regular medication) OR have "Client has reported no current medications" checked. The following are considered active statuses: • (C) CURRENT • (CC) CONCURRENT • (EC) ELECTRONIC - CURRENT • (PC) PAPER - CURRENT • (FC) FAX - CURRENT • (ECU) ELECTRONIC - CURRENT UNAPPROVED • (PCU) PAPER - CURRENT UNAPPROVED • (A) APPROVED

Stored procedure in Credible

spc_export_mu_medication_list_summary

Per the Federal Register: “As with the objective of maintaining a problem list, we clarify that the indication of ‘‘none’’ should distinguish between a blank list that is blank because a patient is not on any known medications and a blank list because no inquiry of the patient has been made.”[3]

By selecting the “Client has reported no medications” checkbox, your staff is affirming that the client is not on any known medications.

[3] Vol. 75, No. 144 /Wednesday, July 28, 2010 /Rules and Regulations, pages 44338-9

Core 6: Medication Allergy List

Objective	Maintain active medication allergy list.

Certification criteria: §170.302(e) Maintain active medication allergy list

§170.302(e) Maintain active medication allergy list	Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care.

In Credible, you can add an allergy to a client's record through the Add Allergy function and edit it if necessary. If appropriate, you can discontinue an allergy or delete it from the client's record.

If a client has no active allergies listed, there will be a "Client has reported no allergies" checkbox on the Client Allergies screen. Selecting the checkbox affirms that you have reviewed the client's medical history and verified that he or she has no current allergies. Behind the scenes, a no_allergy_flag field is set to true and can be used for reporting purposes. If an allergy is added to the client's record, the system removes the checkbox and changes no_allergy_flag to false. If the last allergy for a client is discontinued or deleted, the checkbox will become available again. However, you must manually select it to reaffirm that the client has reported no allergies – the system will not automatically reselect it.

Settings: Security Matrix: AllergyView, AllergyAdd, AllergyUpdate

Steps to Configure: N/A

Steps to Use: Add an allergy:

1. Client tab > Client's name > **Allergy** on nav bar > **Add Allergy** button.
2. In the Allergy field, start typing the name of the allergy. *Select the appropriate entry from the dropdown that displays*.
3. If necessary, enter additional text in the field provided.

4. Select the appropriate option from the Severity dropdown. The fatal severity is indicated with a skull and crossbones icon.
5. Enter a description of the reaction in the field provided (required).
6. If you want to flag the allergy is a medical allergy for reporting purposes, select the Med Allergy checkbox. *This flag has no impact on the drug-allergy interaction check that happens when creating a prescription*.
7. Click **Add Allergy**.

To edit an allergy, click the corresponding button. Make the necessary changes and click **Update Allergy**.

To delete an allergy, click the corresponding button and click **OK** when the confirmation popup displays.

To discontinue an allergy:

1. Click **discont**.
2. In the popup that displays, enter the reason you are discontinuing the allergy and click **Save**.

To view a client's active and discontinued allergy records on the same screen, select ALL from the status dropdown; active allergies will be listed at the top.

To view a list of discontinued allergies, select DISCONTINUED from the status dropdown. Mouse over the info icon to see the reason the allergy was discontinued.

If you have confirmed with the client that he or she does not have any allergies, click the "Client has reported no allergies" checkbox.

Attestation: §170.302(n)

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

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) in their medication allergy list	Count of clients in Credible denominator that have an active allergy OR have "Client has reported no allergies" checked. Stored procedure in Credible spc_export_mu_allergy_list_summary Per the Federal Register: "We agree that information on all allergies, including non medication allergies, provide relevant clinical quality data. However, while we agree that collecting all allergies would be an improvement, current medication allergy standards exists [*sic*] in a structured data format that may be implemented in Stage 1. We hope to expand this measurement to include all allergies as the standards evolve and expand to include non-medication allergies."[4] While you can flag an allergy as a medication allergy in Credible for reporting purposes, the presence of any allergy is evidence of having documented a client's medication allergies for the purpose of this measure. Likewise, selecting the "Client has reported no allergies" checkbox is evidence that your staff has documented (affirmed) that the client has no medication allergies.

[4] Vol. 75, No. 144 /Wednesday, July 28, 2010 /Rules and Regulations, page 44339

Core 7: Record Demographics

Objective	Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth

Certification criteria: §170.304(c) Record demographics

§170.304(c) Record demographics	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, gender, race, ethnicity, and date of birth. Enable race and ethnicity to be recorded in accordance with the standard specified at §170.207(f).

In the client profile in Credible, you need to add dropdowns for Preferred Contact Method, Preferred Language, Ethnicity, and Race. You also need to have a date of birth field in the client profile. To add the dropdowns, you set up the fields as lookups using existing custom lookup categories. For the Preferred Language lookup items, the Stage 1 best practice is to update the prepopulated 50 most widely spoken languages with the ISO 639.2 Language Code List required for Stage 2. The Ethnicity and Race lookup items are prepopulated with values from the CDC website that are accordance with Federal standards.[5]

To consolidate client profile updates, the configuration and use steps that follow include two fields necessary for the menu measure Immunization Registries Data Submission. With the Protection Indicator Effective Date field, you can specify the date the client (or guardian) indicated if his/her immunization information needs to be protected or can be shared. You use the Immunization Protection Indicator dropdown to indicate the client's wishes:

- N = No, it is not necessary to protect data from other clinicians
- Y = Protect the data

[5] www.whitehouse.gov/omb/fedreg_1997standards (OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, Statistical Policy Directive No. 15, October 30, 1997)

If the client has not indicated his/her wishes regarding the immunization information, the Immunization Protection Indicator dropdown should be left blank. Both of these fields are part of the Patient Demographic Segment in an HL7 immunization message.

Settings DataDictionary, AdminLookupUpdate, ClientUpdate

Steps to Configure

1. Admin tab > **Data Dictionary** > Table source = Clients | Type = View.
2. Insert the preferred_contact, preferred_language, ethnicity_omb, and race_omb fields into the Clients table and set them as Lookup fields (lookup parameters: Lookup Table = LookupDict, Lookup Description = lookup_desc or lookup_code, Lookup Category = category that corresponds to the field).
3. If your staff needs to be able to record more than one race for a client, insert race_omb2 and race_omb3 and set them as Lookup fields using the parameters above (lookup category will be race_omb).
4. Insert the pd113_pi_effectivedate and immunization_protection_indicator fields.
5. Set up immunization_protection_indicator as a lookup with the following parameters: Lookup Table: LookupDict, Lookup ID: lookup_code, External ID: hl7_code, Lookup Description: short_desc, Lookup SQL: lookup_code + ' ~ ' + short_desc, Lookup Category: immunization_protection.
6. Insert the dob and date_of_death fields and select the Is Date checkbox for both. While date_of_death is not required for meaningful use, your staff can use it to record when a client dies. The Age field calculates a deceased client's age based on the dob and date_of_death fields.
7. Make sure the User View checkbox is selected for first_name, last_name, sex, date_of_birth, preferred_language, ethnicity_omb, race_omb, race_omb2, and race_omb3.
8. Click **Match Update to View** or add the field to the Update screen manually.
9. Admin tab > **Custom Lookup Items**.
10. Configure the preferred_contact_method lookup:
    a. Select preferred_contact_method from the Category dropdown and click **Display.**
    b. Add different methods of contact to the category (for example, Email, Home Phone, Letter, or No Contact). For each entry except No Contact, enter the first letter of the description in the HL7 code field (for example, E for Email); this way you can link each one to a corresponding visit type for the Patient Reminders measure.

11. Add the languages in the ISO 639.2 Language Code List as preferred_language lookup items. For each preferred_language lookup item, enter the corresponding ISO 639-2/Alpha-3 code in the HL7 Code field; click here for the code list.
12. Add “Declined to Specify” as a lookup item to the preferred_language, ethnicity_omb, and race_omb categories. Enter “Declined” in the Code field and “ASKU” in the HL7 Code field.
13. If you use different Client Profile fields for race and ethnicity, make sure the lookup items are coded in accordance with Federal standards.
14. Configure the immunization_protection lookup:
    a. Add immunization_protection as a custom lookup category (Admin tab > Custom Lookup Categories > Add a New Lookup Categories Entry).
    b. Add the lookup items in the table below to the immunization_protection lookup category (Admin tab > Custom Lookup Items > Select immunization protection > Display button > Add a New immunization_protection Entry). Note that N and Y must be used as the codes (there are no other valid values) and must be uppercase.

Code	Description	Short Description
N	No, it is not necessary to protect data from other clinicians.	Sharing is OK
Y	Protect the data. Client (or guardian) has indicated that the information shall be protected.	Do not share data

Steps to Use

To record demographics for a new client: Client tab > **add client** > select the appropriate values for the demographic fields and save.

To record demographics for an existing client:

1. Click the Client tab > Client name or ID in Client List screen > **Profile** button on the Client nav bar.
2. In Client Profile screen: click **Update,** select the appropriate values for the demographic fields (do not leave a field blank), and then click **Update Client.**

If a new or existing client indicated if his/her immunization information needs to be protected or can be shared:

1. Select the appropriate option from the immunization_protection_indicator dropdown,
2. Enter the date the client conveyed his/her wishes regarding the immunization information in the pd113_pi_effectivedate field.

To view a client's demographics:

1. Click the Client tab > Client name or ID in the Client List screen.
2. Click the Profile button on the Client nav bar.

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
Exclusion	No exclusion.

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data	Count of clients in Credible denominator where the following Client Profile fields are not left blank (not null): sex, date_of_birth, preferred_language, ethnicity_omb, race_omb

Stored procedure in Credible
spc_export_mu_demographics_summary

If you use non-standard Client Profile fields to capture the demographic information, the query behind the stored procedure will need to be modified. Please contact your Partner Services Coordinator (PSC) for more information.

Back to corresponding Stage 2 measure

Core 8: Record Vital Signs

Objective	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI

Certification criteria: §170.302(f) Record and chart vital signs

§170.302(f) Record and chart vital signs	(1) Vital signs. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, height, weight, and blood pressure. (2) Calculate body mass index. Automatically calculate and display body mass index (BMI) based on a patient's height and weight. (3) Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients 2–20 years old.

(1) Vital Signs. In Credible, the Medical Profile screen has fields for height, weight, and blood pressure (resting and standing). For the blood pressure requirement, you only have to fill out the systolic and diastolic measurement fields for resting or standing blood pressure. Only height, weight, and blood pressure are counted towards meeting this objective – all other medical profile fields are optional.

Settings: Security Matrix: MedicalProfileView, MedicalProfileUpdate

Steps to Configure: N/A

Steps to Use: To record a client's vital signs in a medical profile:

1. Client tab > Client's name > **Medical Profile** on nav bar.
2. Enter the appropriate values in both height fields (enter 0 in the inches field if appropriate).
3. Enter the appropriate value in the Weight field.
4. Fill out the other fields as appropriate and click **Save Profile**.

To modify an existing medical profile:

1. Client tab > Client's name > **Medical Profile** on nav bar. The active profile is displayed.
2. Make the necessary changes or additions and click **Save Medical Profile**.

To create a new medical profile and view the old one:

1. Click **Start New Profile**. The system saves the old profile in history and clears the vital signs and check in notes in preparation for the new profile. The Profile Date defaults to the current date and time.
2. If necessary, change the profile date and/or time.
3. Enter the vital signs and any check in notes.
4. If appropriate, change the vision/hearing/mobility status and medical conditions of the client.
5. Click **Save Medical Profile**.
6. Click the **History** button and then the **view** button for the old medical profile. Click **Show Active Profile** to return to the new profile.

(2) Calculate body mass index. Credible automatically calculates the BMI for a client based on his or her height and weight. Note that the BMI calculation will only occur if you fill out both height fields (feet and inches) and the weight field.

Settings	Security Matrix: MedicalProfileView
Steps to Configure	N/A
Steps to Use	Client tab > Client's name > **Medical Profile** on nav bar. BMI is displayed in the upper right corner. Mouse over the info icon to see the corresponding weight status.

(2) Plot and display growth charts. Credible performs growth chart calculations for clients of all ages. Viewing growth charts for adults can be is useful if they are on medications that cause weight gain. To display the charts (weight/BMI and height) for a client, there must be a date of birth (DOB) in his or her client profile and the feet, inches, and weight fields in the medical profile must be filled out. To show progression in the growth charts, a client needs to have one or more historical medical profiles that have different values in the feet, inches, and weight fields (see above for the steps to create a new medical profile). The client's age at each data point is determined by the effective date of the medical profile.

Settings: Security Matrix: MedicalProfileView

Steps to Configure: N/A

Steps to Use:

1. Make sure the client has a DOB in his or her profile and that both height fields and the weight field are filled out in the medical profile.
2. Client tab > Client's name > **Medical Profile** on nav bar.
3. Click **View Height & Weight Charts**.

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
Exclusion	Any EP who 1. Sees no patients 3 years or older is excluded from recording blood pressure; 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

	CMS	Credible
Denominator	Number of unique patients age 2 or over seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, visit type has Include Summary checked, and client is 2 or older at time of being seen
Numerator	Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data	Count of clients in Credible denominator where across all medical profiles for a client: at least one medical profile has height in feet and inches, at least one medical profile has weight, AND at least one medical profile has blood pressure (top and bottom) Stored procedure in Credible spc_export_mu_vitalsigns_summary

New Denominator/Numerator optional 2013; required 2014 and beyond

	CMS	Credible
New Denominator	Number of unique patients (age 3 or over for blood pressure) seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, visit type has Include Summary checked, and client is 3 or older at time of being seen for blood pressure
New Numerator	Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data	Count of clients in Credible denominator where across all medical profiles for a client: at least one medical profile has height in feet and inches, at least one medical profile has weight, AND at least one medical profile has blood pressure (top and bottom) Stored procedure in Credible spc_export_mu_vitalsigns_summary

Core 9: Record Smoking Status

Objective	Record smoking status for patients 13 years old or older.

Certification criteria: §170.302(g) Smoking status

§170.302(g) Smoking status	Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; and unknown if ever smoked.

In Credible, you need to add a dropdown for Smoking Status to the client profile. Your system has the necessary custom lookup category and Stage 1 lookup items for setting up the dropdown. As a Stage 1 best practice, you should add the two additional smoking statuses and SNOMED CT codes required for Stage 2.

Settings Security Matrix: DataDictionary, ClientUpdate

Steps to Configure

1. Admin tab > **Data Dictionary** > Table source = Clients | Type = View.
2. Insert the smoking_status field and set it as a Lookup field (lookup parameters: Lookup Table = LookupDict, Lookup Description = lookup_desc, Lookup Category = smoking_ status).
3. Select the User View checkbox.
4. Click **Match Update to View** or add the field to the Update screen manually.
5. **Admin** tab > **Custom Lookup Items**.
6. Select smoking status from the Category dropdown and click **Display.**

7. Add “Heavy tobacco smoker” and “Light tobacco smoker” as lookup items, entering 1 in the Code field and the SNOMED CT code shown below in the Ext Code field.

Code	Description	Short Description	Ext Code
1	Current every day smoker		449868002
1	Heavy tobacco smoker		428071000124103
1	Light tobacco smoker		428061000124105
2	Current some day smoker		428041000124106
3	Former smoker		8517006
4	Never smoker		266919005
5	Smoker, current status unknown		77176002
9	Unknown if ever smoked		266927001

8. Edit each existing lookup item and enter the SNOMED CT code shown above in the Ext Code field.
9. Unless different codes are required for state reporting purposes, make sure the lookup items have the codes shown above. If your Agency uses different codes, the query behind the attestation stored procedure will need to be modified; please contact your PSC for more information.

Steps to Use

1. Client tab > Client’s name > **Profile** on nav bar.
2. Click **Update,** select the appropriate value from the smoking status dropdown, and then click **Update Client.**

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
Exclusion	Any EP who sees no patients 13 years or older.

	CMS	Credible
Denominator	Number of unique patients age 13 or older seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, visit type has Include Summary checked, and client is 13 or older at time of being seen
Numerator	Number of patients in the denominator with smoking status recorded as structured data	Count of clients in Credible denominator where the Client Profile field smoking_status is not left blank (not null)

Stored procedure in Credible
spc_export_mu_smoking_summary

Back to corresponding Stage 2 measure

Core 10: Clinical Quality Measures (CQMs)

Beginning in 2014, this objective has been incorporated directly into the definition of a meaningful EHR user and eliminated as an objective. Click here for the Stage 1 and Stage 2 CQM reporting information.

Core 11: Clinical Decision Support Rule

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

Certification criteria: §170.304(e) Clinical decision support

§170.304(e) Clinical decision support	(1) Implement rules. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) based on the data elements included in: problem list; medication list; demographics; and laboratory test results. (2) Notifications. Automatically and electronically generate and indicate in real-time, notifications and care suggestions based upon clinical decision support rules.

In Credible, you use the Clinical Support module to implement clinical decision support rules (referred to as “tools” in the software). You can set up clinical support tools based on any combination of medication, medication class, diagnosis, and lab test. If you select a combination of a single medication, medication class, diagnosis, and lab test, it creates an OR matching scenario. If you select multiple options within a category, it creates an AND matching scenario for that category.

You can further qualify the clinical support by entering a lab result range (entry must be numeric), gender, age range, or other client field. If you enter a lab result range and you selected multiple lab tests, the range will apply to all the tests.

A clinical support tool can include text, a URL, and a file. You can also set it up to be pushed out to the Credible Client Portal. When a client meets the conditions specified in the clinical support tool, it is added to his or her record. You can add a Clinical Support section to the Client Overview screen in your internal site and in the Client Portal.

When an employee adds a medication, diagnosis, or lab test to a client record, the system searches existing clinical support tools for a match. If a match is found, the additional clinical support criteria are analyzed. If all of it matches, the clinical support is added to the client record.

To track compliance with the clinical decision support rule, a provider would have to document that it was discussed with the client and then a “chart review” would be necessary to verify that the discussion occurred.

Settings

Security Matrix: ClinicalSupportAdmin, ClinicalSupportView

Client User Security Matrix: ClinicalSupportCU

Steps to Configure

To make the Clinical Support section available on the Client Overview screen in your internal site, use the Client Home Page Admin function. To make the section available on the Client Portal, use the Client User Home Page Admin function.

You need to add clinical support files to the system before you can add them to a clinical support tool.

To add a clinical support file to the system:

1. Admin tab > **Clinical Support** > **Clinical Support Files**.
2. Click **Attach New** (or Scan New if appropriate and if your Employee Config is set up for scanning).
3. Specify the folder you want to store the file in and enter a description of it.
4. Browse to select the file and click **Upload File**.

To set up a clinical support:

1. Admin tab > **Clinical Support** > **Add New Clinical Support Tool.**
2. In the Summary field, enter a description of the clinical support (required).
3. Enter at least one medication, medication class, diagnosis, or lab test. You can select multiple medications, medication classes, diagnoses, or lab tests or any combination of them.
   a. Click the corresponding field. A Clinical Support Picker popup displays.
   b. Type the first three letters of the medication, medication class, diagnosis, or lab test to display a list of possible matches. For a lab test, you can also enter the LOINC.
   c. Select the appropriate options. A total count is displayed at the top of the popup.
   d. Click the total count to view a list of all options selected so far. If you need to remove a selected option, click it.
   e. Click **Done.**
4. If applicable, enter additional clinical support criteria: lab test result, gender, age range, and/or a specific client field. If you select a client field, enter the appropriate value in the Other Client Field Value field.
5. If applicable, include a supporting URL (make sure you include http://) and/or file.

6. If you want to give users the option of pushing the clinical support to the Client Portal, select the Push To Client checkbox.
7. Click **Add Clinical Support Tool**.

Steps to Use

To view a client's clinical support:

1. Client tab > Client Overview screen > **Clinical Support** on Client nav bar (or All Clinical Support Tools link in the Clinical Support section). A list of all clinical supports that have not been accepted yet displays (All Active status).
2. To filter the clinical supports, select an option from the Status dropdown.

All Active	Default selection; all clinical supports that are new, have been flagged to keep active, or have not been accepted, rejected, or "PK deleted"
All	All clinical supports
New	Clinical supports that have not been accepted, rejected, or pushed to the Client Portal; new clinical supports are highlighted in green
Accepted	Clinical supports that have been reviewed and accepted by an employee or client user
Pushed to Portal	Clinical supports that have been made available to client users on the Client Portal by selecting Push to Portal checkbox in Client Clinical Support Details screen
All Closed	Clinical supports that have been accepted, rejected, or PK deleted
Rejected	Clinical supports that an employee decided were not appropriate for the client and flagged as Rejected
PK Deleted	Clinical supports that had the triggering record deleted

3. Click **select** to view the details of a clinical support.
4. Enter notes to record relevant information about the clinical support for this particular client. The notes will not display in the Client Portal.

5. If there is a Push to Portal checkbox, select if if you want to push the clinical support to the Client Portal. If necessary, you can deselect this checkbox later on to remove the clinical support from the Client Portal.
6. If you didn't push the support to the Client Portal, accept or reject it by selecting the corresponding option from the Accepted dropdown.
7. To keep the clinical support active, select the corresponding checkbox.
8. Click **Save Clinical Support**.

Steps for a client user to accept a clinical support:

1. Log into the Credible Client Portal and click **Clinical Support** on the nav bar.
2. Click **select** to display clinical support details.
3. After reviewing the info, select Accepted checkbox and click **Save Clinical Support.**

Back to corresponding Stage 2 measure

Attestation: YES/NO

Measure	Implement one clinical decision support rule.
Exclusion	No exclusion.

EPs must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.

Core 12: Electronic Copy of Health Information

Beginning in 2014, this Stage 1 objective has been replaced with the Stage 2 Core objective Patient Electronic Access.

Core 13: Clinical Summaries

Objective	Provide clinical summaries for patients for each office visit.

Certification criteria: §170.304(h) Clinical summaries

§170.304(h) Clinical summaries	Enable a user to provide clinical summaries to patients for each office visit that include, at a minimum, diagnostic test results, problem list, medication list, and medication allergy list. If the clinical summary is provided electronically it must be: (1) Provided in human readable format; and (2) Provided on electronic media or through some other electronic means in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: (A) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); (B) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and (C) Medications. The standard specified in §170.207(d).

In Credible, the human readable format requirement is met through read-only access to clinical summaries for visits in the Credible Client Portal. The electronic media requirement is met by generating a client's Continuity of Care Document (CCD) that includes clinical summary information. A CCD automatically includes the common meaningful use dataset if the data is present in the client's record: Patient Name, Gender, and DOB; Race, Ethnicity, Preferred Language; Smoking Status; Problems (diagnoses); Medications; Medication Allergies; Lab Test Results; Vital Signs; Care Plans; Procedures; Care Team Members

You can generate a CCD that is based on the information that was current when a visit was signed and submitted – if the visit type was set up to include a summary. The information in a time-of-visit CCD will not change to reflect updates made to a client's record after the visit's Signed date/time. Note that time-of-visit CCDs will not be available for visits created in MobileForm or for visits created before the client summary feature was enabled (the functionality is not retroactive).

As a best practice, have the client sign an ROI for sending his or her CCD to another agency.

Settings

Security Matrix: FormBuilder, FormBuilderEdit, ClientFormsUpdate, ClientVisitSummaryView, ClientVisitViewExt, PatientSummaryGenerator

Client User Security Matrix: ClientUserSummaryView, ClientVisitListCU

Partner Config: Use Clinical Summary Features, CCD Author Address

Your IM/PSC needs to turn on the Client Portal for your system.

Steps to Configure

1. Configure the visit type to include a clinical summary and support time-of-visit clinical summary generation (click here for more information).
2. Set up questions in the form so they will be included in the clinical summary. To meet this objective, you must include injected lab results, diagnoses, medications, and allergies.
    a. Select the **Forms** tab and click the **new version** button for an existing form or add a new form.
    b. For any question that you want to include in the summary, select the Include in Summary checkbox. Minimally, you need to include questions that inject a client's current lab results, diagnoses, medications, and allergies.
    c. Make sure the category has one question that *doesn't inject data* that is *Category Required* to ensure the injected data is saved in the clinical summary.
    d. Build and activate the form and then link it to the visit type you updated above.
2. Give staff and client users the right to view clinical summaries.
3. If you want staff to populate Reason for Visit and Chief Complaint fields via form mapping, add the fields to the appropriate forms and set them up for mapping (ClientVisit:reason for visit and ClientVisit:chief complaint).

Steps to Use

To access a clinical summary:

1. Give client users access to the Client Portal (see Appendix A).
2. Once logged in: **Visit** button on the nav bar > **print** button in the Summary column in the Client Visit List screen.

If summary notes were entered, they will be in the header section of the clinical summary. The information below the header section corresponds to the questions in the form that you set up to include in the summary – for example, injected lab results, diagnoses, medications, and allergies.

To generate a time-of-visit CCD:

1. Complete a visit with the visit type you set up to include a summary.
2. Visit tab > **view** button for visit.
3. Click the **Create Clinical Summary** link in the Transfer XML CDA/CCR field.
4. If there are parts of the client's record you do not want to include in the CCD, uncheck the corresponding checkboxes.
5. If necessary, use the dropdown provided to change the number of visits that will be included.
6. Select the zip file output option and click Generate Summary. (You should only use the "Print summary to screen" option for review purposes.)
7. Save the file locally. The zip file contains the CCD in an XML document and the hash value in a text document.
8. Upload the zip file to the receiving agency – this process occurs outside of Credible.

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion	Any EP who has no office visits during the EHR reporting period.

	CMS	Credible
Denominator	Number of office visits by the EP for an office visit during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of office visits in the denominator for which the patient is provided a clinical summary within three business days	Count of clients in Credible denominator have clinical summary generated (not just print to screen) within 3 business days of visit start date/time OR visit has documentation that client declined (question SNOMED CT code = 422735006, answer SNOMED CT code = 436571000124108) Stored procedure in Credible spc_export_mu_clinical_smry_summary With the Client Portal, a client can obtain a clinical summary as soon as the visit is transferred to Credible or signed and submitted.

Core 14: Protect Electronic Health Information

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

Certification criteria: §170.302(o) Access control

§170.302(o) Access control	Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.

Logins

When you add an employee to your Credible system, he/she is automatically assigned a unique ID. To make the employee a "user," you need to create a login that consists of a unique username/password combination and a login profile to control what information and functions he or she has access to once logged in. Typically, a user login profile is based on a functional role such as Front Desk staff, Nurse, Billing Supervisor, or Administrator and has different Security Matrix rights assigned to it. There are Security Matrix rights for administrative functions, admin time, assignments, attachments, billing, clients, Credible eRx, eMAR, employees, forms, funds, MyCredible admin, physicians' orders, reports, and the scheduler.

The system will prevent you from adding a user with a username that already exists in the system. In addition, a login profile is required when setting up a user or client user. For security purposes, a password update is required the first time a user or client user logs in after having his/her password set up/changed by someone else.

For additional password security, you can enable one or more of the following Partner Config settings: Password Expiration, Block Dictionary Words in Passwords, and Use Strong Passwords. If you use the Password Expiration feature, you can set up a nightly notification trigger to alert employees when their passwords are about to expire.

You also use unique usernames/passwords and login profiles to control "client user" read-only access to the Credible Client Portal. Typically, a client user login profile is based on the role of the individual as it relates to the client – for example, ClientUser for the actual client and ClientParent for the client's mother and/or father. By assigning rights in the Client User Security Matrix, you control which parts of a client's record a client user can view when logged into the portal.

Assignments

In Credible, assignments – employee-program, client-program, and employee-client – are needed for employees to provide services and gain access to client records.

Settings

Security Matrix: SecurityUpdate, UserAdd, ClientUserView, UserUpdate, PasswordUpdate

Your IM/PSC needs to turn on the Client Portal for your system.

Steps to Configure

1. Set up user login profiles for your system: Admin tab > **Login Profiles**.
2. Assign the appropriate Security Matrix settings to each user login profile: Admin tab > **Security Matrix**.
3. Create a login for an employee:
   a. Employee tab > Employee's name > **Login**.
   b. If necessary, change the system-supplied username (the default is the first letter of the employee's first name and his/her last name). The system will let you know if the username is already taken when you try to add the user.
   c. Enter a password and then reenter it in the Password Again field (click here for password rules).
   d. Enter the employee's personal and office email.
   e. Select the appropriate login profile from the dropdown and click **Add User**.
4. Create assignments for an employee: Employee tab > Employee's name > **Program** and **Client** buttons on the nav bar.

Steps to Use

N/A

Back to corresponding Stage 2 measure

Certification criteria: §170.302(p) Emergency access

§170.302(p) Emergency access	Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.

If an emergency situation arises with a client and the assigned employee is not available, you can "take" emergency access to that client's record if you have the security right ClientEmergencyAccess. Note that you can only take emergency access for yourself – you cannot assign it to another employee. Emergency access only grants assignment to the client – what you can do once assigned will be determined by the Security Matrix rights assigned to your login profile. Assignment given through emergency access must be manually unassigned if needed.

With two notification triggers, the appropriate staff can be notified when emergency access has been taken. While the notifications are not required, they are highly recommended and should be set up before you enable the Emergency function.

Emergency client assignments are recorded in the client and employee HIPAA logs.

Settings

Security Matrix: ClientEmergencyAccess, ClientView, ClientViewLog, NotificationTriggers

Partner Config: Allow Emergency Access

Steps to Configure

Optional but recommended: set up the notification triggers (**Admin** tab > **Notification Triggers** > **Add a New Trigger Entry)**.

- Employee Granted Emergency Access – Occur = 0, Send To = Team Leaders & Supervisors
- Client Record Granted Emergency Access – Occur = 0, Send To = Specified Employee; select employee who is currently assigned to client

Steps to Use

1. Employee tab > **My Record** > **Emergency** on Employee nav bar.
2. Enter your password in the field provided and click **Continue**. The Emergency Client Assignment screen displays with filtering fields at the top. Searching for the client you need emergency access to minimizes inadvertent access to personal health information.
3. Use the filtering fields to search for the client you need emergency access to. Only clients that you are not already assigned to will be included in the results.

4. Find the client in the search results and click **assign**. The Client Overview screen for the client displays. (At this time, notification triggers will be sent and the emergency assignment will be logged.)
5. Once the emergency access is no longer needed, use the Client function on the Employee nav bar to unassign the client from your record.

Back to corresponding Stage 2 measure

Certification criteria: §170.302(q) Automatic log-off

§170.302(q) Automatic log-off	Terminate an electronic session after a predetermined time of inactivity.

You can configure your Credible system to automatically log off users that are inactive for a specified amount of time. If you prefer, you can have the system clear (blank) a user's screen instead of logging him or her off. Inactivity is defined as no clicks, key presses, or scrolls. If a user is inactive for the specified amount of time, a timeout warning popup displays: "Your session is about to expire. You will be redirected in X seconds. Do you want to Continue your session?"

The idle logout functionality applies to the following screens:

- Client List, Client Overview, Client Profile screens
- Treatment Plan screen
- Client Episodes
- Client Visit List screen
- Multiaxial Diagnoses screen
- Insurance Coverage screen
- Client Medical Profile screen
- Client Medications, Client Allergies, and Physicians Orders screens
- Client notes screen

The idle logout functionality is only one part of the security process to protect electronic health information. You should have other controls in place such as logging off when complete, using password-protected screen savers, not leaving passwords out, and locking the office and windows.

Settings Partner Config: Idle Logout, Idle Logout Redirect

Steps to Configure By default, Idle Logout is set to No Timeout. To configure, select a duration option from the Idle Logout dropdown and change the Idle Logout Redirect option if necessary.

Steps to Use If the timeout warning popup displays, do one of the following:

- Click **YES** to keep your session active.
- Click **NO, Log Off** to log off or clear (blank) your screen – the behavior depends on how your administrator has set up the redirect in Partner Config.

If your screen goes blank, click any tab to reactive your session.

The alternatives to clicking NO, Log Off are ignoring the popup or clicking the X in the upper right corner.

Back to corresponding Stage 2 measure

Certification criteria: §170.302(r) Audit log

§170.302(r) Audit log	(1) Record actions. Record actions related to electronic health information in accordance with the standard specified in §170.210(b). . (2) Generate audit log. Enable a user to generate an audit log for a specific time period and to sort entries in the audit log according to any of the elements specified in the standard at §170.210(b).

Credible automatically records actions related to clients, employees, and visits. With the Log function, you can view the actions related to a single client, employee, or visit. With the Global HIPAA report, you can report on an action for all clients, employees, or visits.

Settings Security Matrix: ClientVisitViewLog, ClientViewLog

Report Security: Global HIPAA Log

Steps to Configure N/A

Steps to Use To view the log for a single client or employee, navigate to his or her Overview screen and click **Log** on the nav bar. You can filter the log by action type and start date.

To view the log for a single visit: Visit tab > **log** button or use the Log button in the Visit Details screen.

To view the actions for all clients, employees, or visits:

1. Reports tab > **Admin** > **Global HIPAA Log**.
2. Select the entity and action you want to report on.
3. Change the date range if necessary and click **Run Report**.
4. To sort the log, click one of the column headers.

Back to corresponding Stage 2 measure

Certification criteria: §170.302(s) Integrity

§170.302(s) Integrity	(1) Create a message digest in accordance with the standard specified in §170.210(c). (2) Verify in accordance with the standard specified in §170.210(c) upon receipt of electronically exchanged health information that such information has not been altered. (3) Detection. Detect the alteration of audit logs.

To ensure the integrity of the electronic health information sent from your browser to the Credible Web server, our digital certificate uses the SHA-1 signature hash algorithm. Hash values are used to verify the integrity of files exchanged between different agencies. Credible generates a unique “File Hash” value for each CCR you generate and includes it in a text file when you use the ZIP file output option. Similarly, when you import a CCR or CCD, Credible generates a Received Hash value. For Meaningful Use attestation, you may need to generate a CCR and then import it to demonstrate that the hash values match.

Settings	Security Matrix: ClientFileView, ClientFileAdd, PatientSummaryGenerator Partner Config: Show Hashing, Use Clinical Summary Features, CCD Author Address
Steps to Configure	N/A

Steps to Use

To view Credible's digital certificate:

1. Click the padlock icon in Internet Explorer.
2. Click **View certificates** > **Details**. The Show field defaults to <All>. The Signature algorithm field = sha1RSA indicating it is a SHA-1 certificate.

To demonstrate the hash values match:

1. Generate a CCR from the client's profile (see §170.304(h) Clinical Summaries) and then import it into the client's record on your Test domain (see §170.304(i) Exchange Clinical Information and Patient Summary Record).
2. In the File Attachments screen, mouse over the Hash icon (a red circle icon next to Date Attached) and verify that the hash values match.

Back to corresponding Stage 2 measure

Certification criteria: §170.302(t) Authentication

§170.302(t) Authentication	Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.

Credible uses a unique username/password combination and domain name to authenticate an individual logging into your system. The domain name is typically an abbreviation or acronym of your Agency name. Once logged in, the user's login profile controls what information and functions he or she has access to. The system uses the same authentication process for a client user logging into the Credible Client Portal.

Settings

N/A

Steps to Configure

1. Set up login profiles for your system.
   a. Admin tab > **Login Profiles**.
   b. Add the different security profiles for your system.
2. Assign the appropriate Security Matrix settings to each user and client user login profile (Admin tab > **Security Matrix**).

Steps to Use To create a login for an employee:

1. Employee tab > Employee's name > **Login** on the nav bar.
2. If necessary, change the system-supplied username (the default is the first letter of the employee's first name and his/her last name). The system will let you know if the username is already taken when you try to add the user.
3. Enter a password and then reenter it in the Password Again field (click here for password rules).
4. Enter the employee's personal and office email.
5. Select the appropriate login profile from the dropdown and click **Add User**.

To remove a user:

1. Employee tab > Employee's name > **Login** on the nav bar > **Delete User** in the User Edit screen.
2. Click **Click Here to Delete This User Login.**
3. Edit the employee's profile and change the status to Inactive. This method is the best practice because it removes the user's access but retains his or her employee record.

Back to corresponding Stage 2 measure

Certification criteria: §170.302(u) General encryption

§170.302(u) General encryption	Encrypt and decrypt electronic health information in accordance with the standard specified in §170.210(a)(1), unless the Secretary determines that the use of such algorithm would pose a significant security risk for certified EHR technology.

Credible uses the Secure Sockets Layer (SSL) protocol and Advanced Encryption Standard (AES) 256-bit encryption to protect electronic health information that is sent from your browser to the Credible Web server. SSL provides authentication, data integrity, and data confidentiality through encryption. The padlock icon in your browser and the "https://" prefix in the URL indicate that your connection to the Credible Web server is secure.

SSL also protects electronic health information that is sent between the Credible Web server and Surescripts.

Settings N/A

Steps to Configure N/A

Steps to Use N/A

Certification criteria: §170.302(v) Encryption when exchanging electronic health information

§170.302(v) Encryption when exchanging electronic health information	Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in §170.210(a)(2).

In Credible, you have the option of encrypting a client's Continuity of Care Record (CCR) when you are generating it. Before you send the CCR and encryption key to another agency, make sure it has the ability to decrypt data protected with AES 256-bit. (You can also encrypt the syndromic surveillance data for a visit.)

Settings N/A

Steps to Configure N/A

Steps to Use Generate an encrypted CCR from the client's profile (for more information, see Stage 1 menu measure Transition of Care). To encrypt the CCR, you select the corresponding checkbox and enter an encryption key in the field that displays. Always use a mix of lowercase/uppercase letters, digits, and special characters. Uploading the encrypted file and encryption key to the receiving agency occurs outside of Credible.

To decrypt a CCR/CCD received from another provider or organization:

1. Save the CCR/CCD file locally.
2. Client tab > Client's name > **Attachments** > **Import Clinical Summary**.
3. Enter or select the folder you want to upload the file to.
4. Enter a description of the file.
5. If desired, select Public to make the file available in the Client Portal.
6. If the file is encrypted, select Decrypt File and enter the decryption password in the field that displays.
7. Browse for and select the ZIP or XML file.
8. Click **Upload File**.

If you uploaded a zip file, the system will automatically unzip it. You can access the file in the File Attachments screen.

Attestation: YES/NO

Measure	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Exclusion	No exclusion.

EPs must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.

Menu 1: Drug Formulary Checks

Objective	Implement drug formulary checks.

Certification criteria: §170.304(b) Drug-formulary checks

§170.302(b) Drug-formulary checks	Enable a user to electronically check if drugs are in a formulary or preferred drug list.

A formulary is a list of prescription drugs and non-drug items such as insulin test strips that are covered by a pharmacy benefit manager (PBM)/payer.[6] On a *weekly* basis, formulary data is automatically pulled from the PBMs and stored in your Credible system. When you create a prescription, Credible uses the medication code from the client's prescription (Rx) eligibility and the payer's formulary data to determine the formulary status. If a drug is on the list, it is considered "on-formulary." Each on-formulary drug is assigned a preferred level -- a PBM/payer rating of that drug's effectiveness and value compared to other drugs in the same therapeutic class. The higher the level, the greater the preference. Some on-formulary medications are designated as "non preferred."

The system displays the formulary status and supporting data in the Prescription tab above the Sig Builder/Free Text Sig tabs. If the medication is on-formulary, it will be in blue and the preferred level will be indicated. If the medication is off-formulary, unknown, or non-reimbursable, it will be in red. **Important:** the system does not block an employee from prescribing an off-formulary medication.

If the medication is non-preferred, has a low preferred level, or is off-formulary, you can:

- Switch to another plan if the client has multiple drug plans to see if the medication has a higher preferred level or is on-formulary for that plan
- Select a different medication from the On Formulary Alternatives list; the alternative medications in the list will have an equal or higher preferred level to the current medication selected

[6] A PBM is a third-party administrator contracted by a payer to manage its prescription drug program. A PBM processes and pays prescription drug claims and creates and maintains the drug formulary for a health plan.

Settings Security Matrix: RxView or PhysicianOrdersView, PrescriptionCreate or PrescriptionCreateNonSPI if you are not a prescriber

Steps to Configure Your IM/PSC needs to turn on Credible eRx and Credible eRx Formulary and Benefits in your system.

Steps to Use

1. Check the client's Rx eligibility:[7]
   a. Make sure the client has a service to associate the Rx eligibility request with. It must be a completed or incomplete service that was started in the past 24 hours or a service that is scheduled for any time today or tomorrow.
   b. Client tab > Client's name > **Medications** on nav bar > **Rx Eligibility** button.
   c. If you are not a prescriber, select the appropriate one from the Provider dropdown.
   d. Click **Run Rx Eligibility.**
   e. After reviewing the Rx eligibility information, click **Done.**

   You can click the Rx eligibility button at any time to review the information pulled during the last check.
2. Create a prescription for the client:
   a. Client tab > Client's name > **Medications** (or Orders) on nav bar > **Create Prescription** button.
   b. Search for and select the medication you want to prescribe in the Medication Search screen.
   c. Review the formulary data in the Create Prescription screen.
      - If the client has multiple drug plans and you want to check the medication against the formulary for another plan, select it from the list and click **Switch**. Note that there is no connection between a client's insurance providers listed in the system and the list of drug plans. The drug plans are returned through Rx Eligibility.
      - If the medication is off-formulary or on-formulary but you want a medication with a higher preferred level, select a different medication from the On Formulary Alternatives list and click **Choose Alt Med**.
   d. If you are not a prescriber, select the appropriate one from the Provider dropdown.
   e. Fill out the rest of the Sig Builder tab and print, e-send, or e-fax the prescription.

[7] You can only request Rx eligibility information for a client once every 72 hours (the information does not change that often) and there has to be a service to associate the request with. The following information is sent in the eligibility request: First Name, Last Name, Address, City, State, Zip DOB, and Gender.

Attestation: YES/NO

Measure	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

EPs must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure.

You will not be able to attest to meeting this objective without the Credible eRx and Credible eRx Formulary and Benefits modules.

Menu 2: Clinical Lab Test Results

Objective	Incorporate clinical lab test results into EHR as structured data.

Certification criteria: §170.304(a) Incorporate laboratory test results

§170.302(h) Incorporate laboratory test results	(1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. (2) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (3) Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record.

(1) Receive results. There are two different methods you can use in Credible to accomplish this objective.

- Method 1: use Credible eLabs to electronically import lab results into a client's record. When a lab sends results back, they are automatically imported into the client's record. Separate contracting is required for this module and the average lead time is 12 weeks. For more information, log into the Partner domain and submit an order form.
- Method 2: receive lab results in electronic form (for example, in an email or document) and manually enter them into Credible.

Method 2

Settings

Security Matrix: eLabs

Your IM/PSC needs to turn on the result entry feature in your system.

Steps to Configure

1. Employee tab > Employee's name > **Config** on Employee nav bar.
2. Select Insurance Card/Attachment Scanner and click **Save Employee Config**.

Steps to Use

1. Client tab > Client's name > **eLabs** on Client nav bar > **Add Result**.
2. In the Lab Results header screen:
   a. Enter the order number (required).
   b. Select the physician that ordered the lab test (employees with is_doctor = Yes are included in the list).
   c. Select the lab from the Facility dropdown. If the lab isn't in the list, enter its code and name in the fields provided. It will be added to the list the next time you access the Lab Results header screen. If a lab result doesn't have a facility, it will not be included in the client's CCD/CCR.
   d. Enter the collection and received dates (required; the dates cannot be in the future).
   e. Enter the specimen source, specimen condition, and test type and click **Save**.
3. In the Lab Results details screen, enter the results of the first lab test associated with the order.
   a. Click the Lab Picker button to search for and select the lab or enter the code and name of the test in the fields provided. To use lab results as a trigger for a clinical support or as criteria in Advanced Client Search, the test code and name entered must be valid.

      To work with the Labs Picker popup: enter the first few numbers of the LOINC code or part of the lab test name, select the appropriate test from the list provided, and click **done**. The Test Code and Test Name fields are autopopulated based on your selection.
   b. Use the Value, Abnormality, Units, and Range fields to record the details of the lab result.
   c. If the result is outside of the applicable range, select the Panic checkbox.
   d. Click the calendar picker icon to select the Result Date (required; you can also enter it manually).
   e. Click **Save Lab Result**.

4. Repeat step 3 for each lab test associated with the order.
    - To edit or remove test results from the client's record, use the corresponding button.
    - To add results for another order, click **Start New Result Header** and repeat steps 2 – 4.
    - To view the results entered, click **Return to Labs.** The Abnormal checkbox is automatically checked if the Abnormality is set to High or Low.

If you need to edit or remove manually entered test results from the client's record, use the corresponding button.

(2) Display test report information. With the eLabs function on the Client nav bar, you can view the lab results in a client's record.

Settings	Security Matrix: eLabs
Steps to Configure	N/A
Steps to Use	Client tab > Client's name > **eLabs** on nav bar. While can edit and delete manually entered lab results, you can only delete lab results received electronically through Credible eLabs.

(3) Incorporate results. In Credible, lab results – whether entered manually or received electronically through Credible eLabs – are automatically linked to a client's record.

Settings	N/A
Steps to Configure	N/A
Steps to Use	N/A

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

	CMS	Credible
Denominator	Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number	Number of physician orders where the type is 'Labs' and the Order Date in is the reporting period
Numerator	Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data	Number of orders in Credible denominator with eLabs results where the Test Type is blank or not 'Radiology'; the result is a number or the word/characters pos, positive, +, neg, negative, -; and the Order Date is in the reporting period Stored procedure in Credible spc_export_mu_labresult_summary

Back to corresponding Stage 2 measure

Menu 3: Patient Lists

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

Certification criteria: §170.302(i) Generate patient lists

§170.302(i) Generate patient lists	Enable a user to electronically select, sort, retrieve, and generate lists of patients according to, at a minimum, the data elements included in: (1) Problem list; (2) Medication list; (3) Demographics; and (4) Laboratory test results.

In Credible, you can use Advanced Client Search (ACS) to generate lists of clients that meet specific search criteria. Examples:

- Under the age of 12 with asthma and are taking Advair: WEHRE statement = Age < 12 AND Medications Like advair
- Coronary artery disease, total cholesterol over 200, and are taking Lisinopril: Axis III condition = coronary artery disease and WEHRE statement = Age < 50 AND Medications Like lisinopril
- Allergic to penicillin: Allergy 1 in Advanced Search Filter (accessed via the Medical button) = penicillin
- Liver disease and an INR test result greater than 2.4: Axis III condition = liver disease and Lab Test 1 in Advanced Search Filter = 6301-6 > 2.4

Creating a saved report with your search criteria makes it easy to generate the client list again in the future.

Settings	Security Matrix: AdvSearch, AdvSearchExport
Steps to Configure	N/A

Steps to Use To generate a client list:

1. Client tab > **advanced search** button.
2. Enter and/or select the appropriate search criteria.

- Problem list – select an Axis I and/or Axis II diagnosis from the dropdowns and/or enter the ICD-9-CM code or name of the Axis III condition in the corresponding field. If appropriate, select Primary Only to search only the primary diagnoses for the selected Axis filters.

- Medication list – in the WEHRE statement, select the Medications or Med Class field from the Column dropdown. Select the appropriate operator and enter the name (full or partial) of the medication or med class in the Value field.

  Use the NOT = operator to find clients that are not taking the specified medication. Use = or LIKE to find clients that are taking the medication. If you select =, it automatically changes to LIKE and the system searches for clients taking a medication with a name that is like but not necessarily exactly the same as the one you entered. Note that the system only searches ACTIVE medications.

  Use the COUNTS (Period Start/Period End) fields to find clients who were taking the medication during a specific date range.
- Demographics – in the WEHRE statement, select a demographic field and the appropriate operator and enter the desired value. Example: to find all clients under the age of 18, select Age and less than (<) and enter 18 in the Value field.
- Medical profile, allergies, and laboratory test results: click the **Medical** button and use the fields provided to enter search criteria.

  The Any/All radio buttons only apply to a single section. *If multiple sections are filled in, the client must meet the criteria in all filled-in sections.* For example, assume the Medical Profile and Allergies sections are filled in and Medical Profile = Any and Allergies = All.

  (medical profile value 1 OR medical profile value 2) AND (allergy 1 AND allergy 2)

  Clients must meet either of the profile values AND both allergies.

If a client's allergy has been discontinued, he/she will not be returned in the search results.

For labs, click in a Lab Test field to display the Labs Picker popup. Enter the code or name of the lab test, select the appropriate test from the list provided, and click **Done**. To base the search on a specific result, select the appropriate operator and enter the desired value.

3. To include the information you are searching on in the search results, click **Custom Fields** and select the fields that correspond to your search criteria. For example, Medications, Medication Class, Allergies, and Axis III Conditions from the Special Fields section or a profile field that corresponds the demographic field specified in the WEHRE statement. Currently, a lab result sort field and custom field are not available.
4. To sort the search results by the information you are searching on, select the corresponding field from the Sort By dropdown.
5. Click **Filter.**

To create a saved report:

1. Click **Saved Reports** and enter a name for your saved report in the field to the right of the Save Report button.

   Tip: if you enter today's date in the Period Start (Start Date) and/or Period End (End Date) fields and create a saved report, the current date will be the default for those fields the next time anyone runs the report.

2. If you want to let other employees run the report (it will appear in the Saved Reports dropdown for other users), do one of the following:

   - Select a specific team (you do not have to be assigned to the team) from the **Save Team** dropdown. When a team is selected, only the employee who created the report and the employees on the specified team can run it.
   - Select the **Global View** checkbox. When Global View is selected, all employees can view it even if a team is selected.

     When there is no team assignment and Global View is not selected, only the employee who created the saved report can view it.

3. Click **Save Report.**

To generate a client list from a saved report, click **Saved Reports** and select the report from the Saved Reports dropdown.

Back to Stage 2 Patient Lists measure

Back to Stage 2 Preventative Care measure

Attestation: YES/NO

Measure	Generate at least one report listing patients of the EP with a specific condition.
Exclusion	No exclusion.

EPs must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

Menu 4: Patient Reminders

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

Certification criteria: §170.304(d) Patient reminders

§170.304(d) Patient reminders	Enable a user to electronically generate a patient reminder list for preventive or follow-up care according to patient preferences based on, at a minimum, the data elements included in: (1) Problem list; (2) Medication list; (3) Medication allergy list; (4) Demographics; and (5) Laboratory test results.

In Credible, you can use Advanced Client Search to generate a list of clients that need a reminder visit and then add the appropriate type of patient reminder visit for each client in the list via the Show Add Visit function.

Settings AdvSearch, VisitEntryMultiPerClient

Steps to Configure Add a Patient Reminder visit type for each contact method except for the No Contact method (Admin tab > Visit Type). In the External ID field for each one, enter the first letter of the contact method, for example E for Email. Note that the letters you use must match the ones used for the preferred_contact_method lookup items.

Steps to Use

1. Client tab > **advanced search**.
2. Enter the appropriate search criteria to find clients that need a reminder for preventive/follow-up care.
3. In the WHERE column: Preferred Contact Method = <one of the contact methods>.
4. Select the Show Add Visit checkbox and click **Filter.**
5. Uncheck the Add Visit checkbox for any clients you don't want to add a patient reminder visit for and then click **Select Options to Add Visits**.

6. In the Enter Visit screen, select the Patient Reminder visit type that corresponds to the contact method you entered in the WHERE clause.
7. Fill out the other fields as appropriate and click **Add All Visits**.
8. Repeat the process for the other contact methods.

Back to Stage 2 Preventative Care measure

Attestation: §170.302(n)

Measure	More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
Exclusion	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

	CMS	Credible
Denominator	Number of unique patients 65 years old or older or 5 years older or younger	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, visit type has Include Summary checked, and client is 65 or older OR 5 or younger at time of being seen
Numerator	Number of patients in the denominator who were sent the appropriate reminder	Count of clients in Credible denominator where reminder visit date is in the reporting period, reminder is identified via External ID on the visit type, and client has preferred contact method recorded in client profile Stored procedure in Credible spc_export_mu_patient_reminder_summary

Menu 5: Patient Electronic Access

Beginning in 2014, this Stage 1 objective has been replaced with the Stage 2 Core objective Patient Electronic Access.

Menu 6: Patient-Specific Education Resources

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

Certification criteria: §170.302(m) Patient-specific education resources

§170.302(m) Patient-specific education resources	Enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient's: problem list; medication list; and laboratory test results; as well as provide such resources to the patient.

In Credible, you use the Clinical Support tool and the Credible Client Portal to provide client-specific education resources. You can base a clinical support on any combination of medication, medication class, diagnosis, and lab test result. To further qualify a clinical support, you can specify a gender, age range, and/or another client field.

A clinical support tool can include text, a URL, and a file. When a client meets the conditions specified in the clinical support tool, it is added to his or her record and accessible to him or her via the Client Portal.

When an employee adds a medication, diagnosis, or lab result to a client record, the system searches existing clinical support tools for a match on medication, medication class, diagnosis, or lab result. *If a match is found,* the system then checks the client's profile for a match on the qualifying criteria – the demographic fields. If there is a match, the clinical support is added to the client record. Note that a clinical support item will not trigger just on a match of the demographic fields.

Notes:

- For the addition of a medication, addition/update of a diagnosis, and addition of a lab test result to trigger a clinical support, it must be made *after* the clinical support is set up.
- If a client record matches the same clinical support multiple times, the system will not add another instance of the support until the status of the initial one is no longer Active. If the medication, diagnosis, or lab result that triggered a clinical support is deleted, the support will be deleted from the client's record if the status is still set to New. For any other status, the system will delete the PK deleted flag in the clinical support, which will make the clinical support no longer active. If a client has an additional medication, diagnosis, or lab that is part of the clinical support *but did not trigger it,* deleting the medication/diagnosis/lab from the client record will not affect the clinical support.

- You need to add clinical support files to the system before you can add them to a clinical support tool.
- The system records employee and client actions related to clinical supports in the HIPAA logs

Settings

Security Matrix: ClinicalSupportAdmin, ClinicalSupportView, ClientUserView

Client User Security Matrix: ClinicalSupportCU

You need to have your IM/PSC turn on the Client Portal for your system. As an alternative to using the Client Portal for client access to education resources, you can print out the materials and give them to the client.

Steps to Configure

Optional: make the clinical support section available on the Client Portal home page: Admin tab > **Home Page Config** > **Client User Home Page Admin** and then select Clinical Support for left bar or center bar.

To add a clinical support file to the system:

1. Admin tab > **Clinical Support** > **Clinical Support Files.**
2. Click **Attach New** (or Scan New if appropriate and if your Employee Config is set up for scanning).
3. Specify the folder you want to store the file in and enter a description of it.
4. Browse to select the file and click **Upload File**.

To set up a clinical support:

1. Admin tab > **Clinical Support** > **Add New Clinical Support Tool.**
2. In the Summary field, enter a description of the clinical support (required).
3. Enter at least one medication, medication class, diagnosis, or lab test result. You can select multiple medications, medication classes, diagnoses, and/or lab test results. If you select a combination of medication, medication class, diagnosis, and lab test, it creates an OR matching scenario. If you select multiple options within a category, it creates an AND matching scenario for that category.
    a. Click the corresponding field. A Clinical Support Picker popup displays.
    b. For a medication or medication class, enter the first three letters in the Name field to display a list of possible matches. For a diagnosis or lab test, enter the first three digits of the code in the Axis Code/LOINC field or the first three letters of diagnosis or lab in the Diagnosis/Labs field.
    c. Select the appropriate options. A total count is displayed at the top of the popup.

d. Click the total count to view a list of all options selected so far. If you need to remove a selected option, click it.

e. Click **Done.**

4. Optional: if you entered a lab test and want to qualify the match further, enter the result range in the fields provided. If you selected multiple lab tests, the range will apply to all the tests.
5. If applicable, enter additional clinical support criteria: gender, age range, and/or a specific client field. If you select a client field, enter the appropriate value in the Other Client Field Value field.
6. Use the Clinical Support Text, URL (make sure you include http://), and File fields to provide educational resources.
7. Select the Push To Client checkbox. Note that this only makes the clinical support eligible to be pushed to the Client Portal by an employee – it will not automatically go out.
8. Click **Add Clinical Support Tool**.

Steps to Use

1. Add the appropriate medication, medication class, diagnosis, or lab test/result to the client's record to trigger the clinical support. Since a clinical support can only be accepted once, the clinician should decide if he or she is going to accept it or if it should be pushed to the portal for the client to accept it.
2. To accept the client's clinical support and/or push it to the Client Portal:
   a. Client tab > Client's name > **Clinical Support** on Client nav bar. A list of all clinical supports that have not been accepted yet displays (All Active status).
   b. Click **select** to view the details of a clinical support.
   c. Select Accepted from the Accepted dropdown and/or select the Push to Portal checkbox.
   d. To keep the clinical support active, select the corresponding checkbox.
   e. Click **Save Clinical Support**.

For a *client user* to view/accept education resources:

1. Log into the Credible Client Portal and click **Clinical Support** on the nav bar.
2. Click **select** to display clinical support details.
3. After reviewing info, select the Accepted checkbox and click **Save Clinical Support.**

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
Exclusion	No exclusion.

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients in the denominator who are provided patient-specific education resources	Count of clients in Credible denominator that have at least one clinical support item that was pushed to the Credible Client Portal (client user can access the resource on his/her own time frame) Stored procedure in Credible spc_export_mu_patient_education_summary

Back to corresponding Stage 2 measure

Menu 7: Medication Reconciliation

Objective	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Certification criteria: §170.302(j) Medication reconciliation

§170.302(j) Medication reconciliation	Enable a user to electronically compare two or more medication lists.

There are three different methods you can use in Credible to accomplish this objective.

- Method 1: electronically pull a client's medication history for the past two years from the PBMs. Review the list with the client and if appropriate, use the plus sign to add a medication from the list to the client's record.
- Method 2: scan and attach an externally sourced medication list to a client's record. Review the list with the client and if appropriate, use the Add Medication function to add a medication to the client's record.
- Method 3: import a clinical summary to the client's record and compare the medication information in it to the existing information in the client's record. If a matching record does not exist (matching is based on the RxNorm code), you can add (merge) the clinical summary record to the client's record. If a matching record exists, you can update (merge/consolidate) it with the data in the clinical summary record.

Method 1 is the recommended method and requires the Credible eRx and Credible eRx Formulary and Benefits modules.

Method 1 Notes

Important: the medications in the PBM Medication History list are for informational purposes only. They are not part of the client's record in Credible and therefore are not considered for the drug/drug interaction checks that happen when you create a prescription.

You do have the option of adding a medication in the medication history list to the client's record. Once added, it will be part of the drug/drug interaction checks. Note that adding a medication doesn't delete it from the medication history list; it will be reported every time you pull the medication history if it is within the two-year timeframe.

Every time you update the medication history for a client, the system replaces the old list with the new information. The medication history list will include medications prescribed via Credible.

You can enable the “Show PBM Med History” function at the client level.

Best practice:

1. Set up an ROI for showing medication history in Credible and have the client sign it before turning on the Show PBM Med History function.
2. Pull the medication history for a client and review the list with the client.
3. Add current medications from the medication history list to the client’s record.
4. Ask the client if he or she is taking other medications that aren’t on the list (such as self-pay or over-the-counter) and add them to the client’s record via the Add Medication function.

Method 1

Settings

Security Matrix: DataDictionary, ClientUpdate, RxView, RxUpdate

Your IM/PSC needs to turn on the Credible eRx and Credible eRx Formulary and Benefits modules in your system. Your organization must also be participating in electronic prescribing.

Steps to Configure

1. Admin tab > Data Dictionary > Table source = Clients, Type = View
2. Insert the show_pbm_medhistory field.
3. Click Match Update to View or add the field to the Update screen manually.

Steps to Use

The client must be enrolled in a drug plan to retrieve medication history.

Have the client sign a “Show Med History” ROI and then update his/her client profile so show_pbm_medhistory = YES (Client nav bar > **Profile** button > **Update**).

1. Client tab > Client’s name > **Medications** on Client nav bar. There is a PBM Medication History section at the bottom of the screen.

   If there isn’t a Last Updated date/time stamp on the Rx Eligibility button, click it to check Rx eligibility for the client (Rx eligibility information has to be pulled once before you can access a client’s medication history).

   If the client has medication history records, they are displayed in the PBM Medication History list. You can mouse over the source, prescriber name, and pharmacy name to view additional details.

2. Click the **Update History** button at any time to get the latest medication history for the client.
3. For the steps to add a medication in the PBM Medication History list to the client's medication list in Credible, click here.

Method 2

Settings

Security Matrix: ClientFileAdd, ClientFileView, RxView, RxUpdate

Your IM/PSC needs to turn on the Credible eRx and Credible eRx Formulary and Benefits modules in your system. Your organization must also be participating in electronic prescribing.

Steps to Configure

1. Employee tab > Employee's name > **Config** on Employee nav bar.
2. Select Insurance Card/Attachment Scanner, and click **Save Employee Config**.

Steps to Use

1. Scan (if needed) and attach the externally sourced medication list to the client's record (**Attachments** on Client nav bar > **Scan New** or **Attach New**).
2. Click **Medications** on Client nav bar to view the client's current medication list.
3. Right-click on **Attachments** on Client nav bar and select Open in New Window.
4. Click on the desired attachment. Depending on the file type, it may open in Internet Explorer or a separate application (such as Microsoft Word).
5. Compare the two lists and update the list in Credible as needed.

Method 3

Settings

Security Matrix: ClientFileAdd, ClientFileView, AllergyAdd, RxUpdate, DxAdd, RxDelete, RxDiscontinue (for nonprescribers), DxAxisDelete

Partner Config: Use Clinical Summary Features

Steps to Configure

N/A

Steps to Use

1. Attachments on Client nav bar > Import Clinical Summary button.
2. Enter a description for the clinical summary.

3. Click Choose file, select the file, click Open, and then click Upload File.
4. Open the folder the clinical summary was saved to and click the detail button. Headers for the different sections of the clinical summary display.
5. Expand the Medications category.
6. Review the Clinical Summary List and the Client Record List.
7. If you need to remove an existing client record, select the radio button and click the Remove button. *Note that this action cannot be undone.*
8. To merge a record from the clinical summary, select the radio button and click the Merge Record button. *Note that this action cannot be undone.*
9. When done removing and/or merging records, click Complete.

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Exclusion	An EP who was not the recipient of any transitions of care during the EHR reporting period.

	CMS	Credible
Denominator	Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition	Number of transitions into care; question has SNOMED CT code 1861000124105 for Transition of care (finding) and the question type is calendar control
Numerator	Number of transitions of care in the denominator where medication reconciliation was performed	Number of transitions into care in Credible denominator with Performed (SNOMED CT code 398166005) as the answer to the "Documentation of current medications (procedure) performed" question (SNOMED CT code 428191000124101) Date of the medication reconciliation is documented with a separate calendar control question that has SNOMED CT code 428191000124101 Stored procedure in Credible spc_export_mu_med_reconcile_summary You will need to edit an existing form or create a new one to capture the numerator information

Menu 8: Transition of Care Summary

Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Certification criteria: §170.304(i) Exchange clinical information and patient summary record

§170.304(i) Exchange clinical information and patient summary record	(1) Electronically receive and display. Electronically receive and display a patient's summary record, from other providers and organizations including, at a minimum, diagnostic tests results, problem list, medication list, medication allergy list in accordance with the standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2). Upon receipt of a patient summary record formatted according to the alternative standard, display it in human readable format. (2) Electronically transmit. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list in accordance with: (i) The standard (and applicable implementation specifications) specified in §170.205(a)(1) or §170.205(a)(2); and (ii) For the following data elements the applicable standard must be used: (A) Problems. The standard specified in §170.207(a)(1) or, at a minimum, the version of the standard specified in §170.207(a)(2); (B) Laboratory test results. At a minimum, the version of the standard specified in §170.207(c); and (C) Medications. The standard specified in §170.207(d).

In Credible, you use the Import Clinical Summary function to electronically receive a CCR or CCD from another provider or organization. If the file is encrypted, you will need the encryption/decryption key from the sending agency. The uploading action is logged in the HIPAA logs.

When the system imports the CCR/CCD, it creates a PDF version and attaches it to the client's record. Like any other attachment, you can make a CCR or CCD available to client users in the Credible Client Portal.

Through the client profile, you can generate a CCR/CCD that is based on the current information in the client's profile and then transmit it to a third party (happens outside of Credible).

Settings

Security Matrix: ClientVisitSummaryView, ClientFileView, ClientFileAdd, PatientSummaryGenerator

Client User Security Matrix: ClientFileViewCU

Partner Config: Use Clinical Summary Features, fill out CCD Author Address fields
Your IM/PSC needs to turn on the Client Portal in your system.

Steps to Configure

Refer to Appendix A for information on setting up the Client Portal.

Steps to Use

To upload a client's clinical summary received from a third party:

1. Save the CCR/CCD file from the external provider or organization locally.
2. Client tab > Client's name > **Attachments** > **Import Clinical Summary**.
3. Enter or select the folder you want to upload the file to.
4. Enter a description of the file.
5. If desired, select Public to make the file available in the Client Portal.
6. If the file is encrypted, select Decrypt File and enter the decryption password in the field that displays.
7. Browse for and select the ZIP or XML file.
8. Click **Upload File**.

If you uploaded a zip file, the system will automatically unzip it. You can access the file in the File Attachments screen.

Best practices for generating a CCD/CCR: have the client sign an ROI for sending his/her clinical summary to another agency and make sure the receiving organization has the ability to decrypt data protected with Advanced Encryption Standard (AES) 256-bit.

To generate a real-time CCD for a client:

1. Client tab > Client's name > **Profile** on Client nav bar > **Generate Clinical Summary**.
2. If there are parts of the client's record you do not want to include in the CCD, uncheck the corresponding checkboxes.
3. Make sure the Referral to other provider checkbox is selected.
4. From Provider dropdown, select External Care Provider that you are sending the clinical summary to.
5. Enter the reason for the referral in the corresponding field.
6. If necessary, use the dropdown provided to change the number of visits that will be included.
7. Select Encrypt Summary checkbox and enter an encryption key. Always use a mix of lowercase/uppercase letters, digits, and special characters. Jot down the key as you will need to send it to the receiving agency.
8. Select the zip file output option and click Generate Summary. (You should only use the "Print summary to screen" option for review purposes.)
9. Save the file locally. The zip file contains the CCD in an XML document and the hash value in a text document.
10. Upload the zip file to the receiving agency – this process occurs outside of Credible.

To generate a real-time CCR for a client:

1. Client tab > Client's name > **Profile** on Client nav bar > **Generate Clinical Summary**.
2. Select the CCR Summary checkbox.
3. Fill out the Summary detail section:
    a. In the From field, enter your name or the name of your agency (required).
    b. In the "from" Role field, enter your job title or information that further identifies your agency (required).
    c. Optional: use the To field and "to" Role field to identify the person and/or agency receiving the client summary.
    d. Optional: enter the reason the CCR is being sent.

4. Select Encrypt Summary checkbox and enter an encryption key. Always use a mix of lowercase/uppercase letters, digits, and special characters. Jot down the key as you will need to send it to the receiving agency.
5. Select the zip file output option and click **Generate Summary**. (You should only use the "Print summary to screen" option for review purposes.)
6. Save the file locally. The zip file contains the CCR in an XML document and the hash value in a text document.
7. Upload the zip file and encryption key to the receiving agency – this process occurs outside of Credible.

Back to corresponding Stage 2 measure

Attestation: §170.302(n)

Measure	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
Exclusion	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

	CMS	Credible
Denominator	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider	Number of approved visits with an answer coded to SNOMED CT for referral: • Clinical consultation report (record artifact) (SNOMED CT code 371530004) • Report of clinical encounter (record artifact) (SNOMED CT code 371531000) • Confirmatory consultation report (record artifact) (SNOMED CT code 371545006)
Numerator	Number of transitions of care and referrals in the denominator where a summary of care record was provided	Number of visits in Credible denominator that have CLINICAL SUMMARY GENERATED in its log Stored procedure in Credible spc_export_mu_transition_care_summary

Menu 9: Immunization Registries Data Submission

Objective	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

Certification criteria: §170.302(k) Submission to immunization registries

§170.302(k) Submission to immunization registries	Electronically record, modify, retrieve, and submit immunization information in accordance with: (1) The standard (and applicable implementation specifications) specified in §170.205(e)(1) or §170.205(e)(2); and (2) At a minimum, the version of the standard specified in §170.207(e).

In Credible, you can add immunizations to a client's record and then export that information to a file for submission to an immunization registry. To meet standards for interoperability, the immunization file is in Health Level Seven (HL7 v 2.5.1) format. When adding an immunization in Credible, the immunization and manufacturer dropdowns are populated with options from the CDC.

General information on immunization registries: www.cdc.gov/vaccines/programs/iis/default.htm

Vaccine list: www2a.cdc.gov/nip/IIS/IISStandards/vaccines.asp?rpt=cvx

Manufacturer list: www2a.cdc.gov/nip/IIS/IISStandards/vaccines.asp?rpt=mvx

Settings

Security Matrix: DataDictionary, ClientUpdate, MedicalProfileView, MedicalProfileUpdate, ImmunizationAdd, ImmunizationEdit

Partner Config: Use Immunizations, Immunization HL7 Exports

Steps to Configure

Add dropdowns for race_omb and ethnicity_omb to the Client table. Your system has the necessary custom lookup categories and lookup items – with the Office of Management and Budget's race and ethnicity descriptions and the CDC's HL7 codes – to set up the dropdowns.

1. Admin tab > **Data Dictionary** > Table source = Clients | Type = View.
2. Insert the race_omb field and set it as a Lookup field (Lookup Table = LookupDict, Lookup ID & External ID = lookup_id, Lookup Description = lookup_desc or lookup_code, Lookup Category = category that corresponds to field).

3. Select the User View checkbox.
4. Repeat steps 2 and 3 for ethnicity_omb.
5. Click **Match Update to View** or add the fields to the Update screen manually.

If you will be using Vaccine Information Statement (VIS) 2D barcodes, install a 2D barcode scanner app on your smartphone. There is not a direct scan-to-Credible capability.

Steps to Use

Make sure the client's profile has the following information: last name, first name, DOB, gender, race, ethnicity, address data (street address, city, state, zip code, country, address type), and home telephone number. It is included in the HL7 file and is necessary for the successful receipt of the file. To help capture the information, make the fields required in the client profile or intake form that maps to the profile.

Important: to capture race and ethnicity, you must use the race_omb and ethnicity_omb fields and lookups provided. Using any other fields will not work.

The following fields are hardcoded: Country = USA, Address type = M (for mailing), and Patient ID Number Type = PI.

To record an immunization:

1. Client tab > Client's name > **Immunizations** on Client nav bar.
2. Edit an existing immunization or add a new one.
3. Select/enter the appropriate information.
4. If using the barcode on the Vaccine Information Statement:
    a. Select the Use VIS 2D Barcode checkbox.
    b. Use your smartphone to scan the barcode and get the barcode number.
    c. Select the corresponding barcode number from VIS Barcode dropdown.
5. Click Update or Save.

To edit an immunization record, click the corresponding button on the Immunizations screen, make the necessary changes,and click Update.

To delete an immunization, click the corresponding button on the Immunizations screen and then click OK when the confirmation popup displays.

To generate an immunization file, click **Export Immunization HL7** on the Immunizations screen and save the file locally. Uploading the file to the desired immunization registry occurs outside of Credible.

Back to corresponding Stage 2 measure

Attestation: YES/NO

Measure	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful, (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically), except where prohibited.
Exclusion	An EP who administers no immunizations during the EHR reporting period, where no immunization registry has the capacity to receive the information electronically, or where it is prohibited.

EPs must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful, (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) except where prohibited, to meet this measure.§170.302(k) Submission to Immunization Registries

Menu 10: Syndromic Surveillance Data Submission

Objective	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

Certification criteria: §170.302(l) Public health surveillance

§170.302(l) Public health surveillance	Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard specified in §170.205(d)(1) or §170.205(d)(2).

In Credible, you can generate syndromic surveillance data for one or more visits associated with a client episode. The syndromic data is in HL7 format for interoperability and reflects the diagnosis at the time of service. After selecting the submitter and receiver, you have the option of encrypting the data and/or creating a zip file. Before you encrypt the data, make sure the receiving agency has the ability to decrypt Advanced Encryption Standard (AES) 256-bit encryption. You will need to provide the agency with the encryption key you specify.

As shown in the example below, a syndromic data file should have at least five segments: MSH, EVN, PID, PV1, and PV2. If multiple visits are included in the file, there will be PV1 and PV2 segments for each visit.

Example:

```
MSH|^~\&|Credible BH||CDC Software||20110608123531||ADT^A08|20110608123531|P|2.3.1|||||WINDOWS-1252
EVN||20110608123531
PID|||1010^^^CREDIBLEBH^PI||Doe^John||19520526|M||1002-5^American Indian/Alaskan^HL70005|123 Main Street^Apt
12B^Dover^NH^12345^USA^M||^PRN^^^^603^5551212|||||||||2186-5^Not Hispanic or Latino^HL70189
PV1|1|O||A||||||||||7|||||142|||||||||||||||||||||||||20110601091500
PV2|1||488.0^INFLUENZA DUE TO IDENTIFIED AVIAN INFLUENZA VIRUS^I9
```

Settings

Security Matrix: BillingConfig, DataDictionary, ClientEpisodeUpdate or ClientEpisodeFormsUpdate, VisitDataEntry or VisitEntryWeb

Partner Config: Ability to Create Syndromic HL7, Use Client Episodes

Steps to Configure

1. Set up a HIPAA config entry for each submitter/receiver pairing (Billing tab > Billing Office/Claim Config). The Receiver Application Name is the only piece of information from the HL7 Info section that is included in the HL7 file.
2. Add dropdowns for admission_type, admission source, and patient_class to the Client Episode table. Your system has the necessary custom lookup categories and lookup items – with HL7 codes – to set up the dropdowns.
   a. Admin tab > **Data Dictionary** > Table source = Clients | Type = View.
   b. Insert the admission_type field and set it as a Lookup field (Lookup Table = LookupDict, Lookup ID = hl7_code, External ID = lookup_id, Lookup Description = lookup_desc or lookup_code, Lookup Category = category that corresponds to field).
   c. Repeat steps above for admission_source and patient_class.
   d. Click **Match Update to View** or add the fields to the Update screen manually.

Steps to Use

1. Make sure the client has:
   a. Last name, first name, DOB, gender, race, ethnicity, address data (street address, city, state, zip code, country, address type), and home telephone number in his or her client profile. The following fields are hardcoded: Country = USA, Address type = M (for mailing), and Patient ID Number Type = PI.
   Important: to capture race and ethnicity, you must use the race_omb and ethnicity_omb fields and lookups provided. Using any other fields will not work.
   b. An active episode with values in the admission type, admission source, and patient class fields.
   c. One or more visits associated with the active episode that have a diagnosis directly associated with the visit – that is, the diagnosis was selected, not “defaulted in.” Often, public health surveillance data is associated with an Axis III diagnosis.
2. Client tab > Client’s name > **Episodes** on Client nav bar > **view** button for active episode > **Generate Syndromic HL7**.
3. In the Generate Syndromic HL7 screen, select the receiver/submitter pairing from the corresponding dropdown.
4. Select the type of trigger event that initiated the generation of the method and the processing type. The options for these dropdowns are specified by the CDC. The processing type indicates how to process the message as defined in HL7 processing rules.
5. If you want to encrypt the data, select the corresponding checkbox and enter an encryption key in the field that displays. Always use a mix of lowercase/uppercase letters, digits, and special characters.

6. To create a zip file with the data, select the corresponding checkbox.
7. Deselect any visits you do not want to generate syndromic data for and then click **Generate Syndromic HL7**. The syndromic data displays below the visit list unless you opted to create a zip file. For the zip file output, a File Download popup displays. Open or save the file. Sending the data or zip file to the desired agency occurs outside of Credible.

Back to corresponding Stage 2 measure

Attestation: YES/NO

Measure	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful, (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically) except where prohibited.
Exclusion	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or if it is prohibited.

EPs must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test was successful (unless none of the public health agencies to which the EP submits such information has the capacity to receive the information electronically), except where prohibited, to meet this measure.

Stage 2

Core 1: CPOE for Medication, Laboratory, and Radiology Orders

Objective	Use computerized provider order entry (CPOE) for medication, *laboratory, and radiology* orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Certification criteria: §170.314(a)(1) Computerized provider order entry

§170.314(a)(1) Computerized provider order	Enable a user to electronically record, change, and access the following order types, at a minimum: • Medications; • Laboratory; and • Radiology/imaging.

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

	CMS	Credible
Measure 1 Denominator	Number of medication orders created by the EP during the EHR reporting period	Meds Number of physician orders of type 'Medications' or OR medication where the provider is an employee (automatic for Credible eRx)
Measure 1 Numerator	Number of orders in the denominator recorded using CPOE	Number of med orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional Stored procedure in Credible spc_export_mu_cpoe_summary

	CMS	Credible
Measure 2 Denominator	Number of radiology orders created by the EP during the EHR reporting period	Radiology Number of physician orders of type 'Radiology'
Measure 2 Numerator	Number of orders in the denominator recorded using CPOE	Number of radiology orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional Stored procedure in Credible spc_export_mu_cpoe_summary

	CMS	Credible
Measure 3 Denominator	Number of laboratory orders created by the EP during the EHR reporting period	Labs Number of physician orders of type 'Labs'
Measure 3 Numerator	Number of orders in the denominator recorded using CPOE	Number of lab orders in Credible denominator where the entering employee is a doctor, nurse, or licensed health professional Stored procedure in Credible spc_export_mu_cpoe_summary

Core 2: e-Prescribing (eRx)

Objective	Generate and transmit permissible prescriptions electronically (eRx).

Certification criteria: §170.314(b)(3) Electronic prescribing

§170.314(b)(3) Electronic prescribing	Enable a user to electronically create prescriptions and prescription related information for electronic transmission in accordance with: • The standard specified in §170.205(b)(1); and • At a minimum, the version of the standard specified in §170.207(d)(2).

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	More than *50* percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
Exclusion	Any EP who: (1) Writes fewer than 100 permissible prescriptions during the EHR reporting period. (2) Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

In Credible, you will not be able to attest to meeting this objective without the Credible eRx and Credible eRx Formulary and Benefits modules.

	CMS	Credible
Denominator	Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period	Count of Credible eRx prescriptions for non-Schedule 2 drugs where the creation date is in the EHR reporting period, a signature exists, and status is one of the following: • (EC) ELECTRONIC - CURRENT • (PC) PAPER - CURRENT • (FC) FAX - CURRENT • (ECU) ELECTRONIC - CURRENT UNAPPROVED • (PCU) PAPER - CURRENT UNAPPROVED
Numerator	Number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.	Count of prescriptions in Credible denominator where status is (EC) ELECTRONIC - CURRENT or (ECU) ELECTRONIC - CURRENT UNAPPROVED Formulary checking is automatic *provided* med eligibility has been run for that client at least once. Stored procedure in Credible spc_export_mu_erx_summary If your state regulations dictate that other Schedules should be excluded, the query behind the stored procedure will need to be modified. Contact your PSC for more information.

Core 3: Record Demographics

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

Certification criteria: §170.314(a)(3) Record demographics

§170.314(a)(3) Record demographics	Enable a user to electronically record, change, and access patient demographic data including preferred language, sex, race, ethnicity, and date of birth. • Enable race and ethnicity to be recorded in accordance with the standard specified in §170.207(f) and whether a patient declines to specify race and/or ethnicity. • Enable preferred language to be recorded in accordance with the standard specified in §170.207(g) and whether a patient declines to specify a preferred language.

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.
Exclusion	No exclusion.

For denominator/numerator information and the stored procedure name, click here.

Core 4: Record Vital Signs

Objective	Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.

Certification criteria: §170.314(a)(4) Record and chart vital signs

§170.314(a)(4) Record and chart vital signs	(i) Vital signs. Enable a user to electronically record, change, and access, at a minimum, a patient's height/length, weight, and blood pressure. Height/length, weight, and blood pressure must be recorded in numerical values only. (ii) Calculate body mass index. Automatically calculate and electronically display body mass index based on a patient's height and weight. (iii) Optional—Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients.

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.
Exclusion	Any EP who: (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them. (3) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. (4) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height and weight.

	CMS	Credible
Denominator	Number of unique patients (age 3 or over for blood pressure) seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, visit type has Include Summary checked, and client is 3 or older at time of being seen for blood pressure
Numerator	Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data	Count of clients in Credible denominator where across all medical profiles for a client: at least one medical profile has height in feet and inches, at least one medical profile has weight, AND at least one medical profile has blood pressure (top and bottom) Stored procedure in Credible spc_export_mu_vitalsigns_summary

Core 5: Record Smoking Status

Objective	Record smoking status for patients 13 years old or older.

Certification criteria: §170.314(a)(11) Smoking status

§170.314(a)(11) Smoking status	Enable a user to electronically record, change, and access the smoking status of a patient in accordance with the standard specified at §170.207(h).

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
Exclusion	Any EP that neither sees nor admits any patients 13 years old or older.

For denominator/numerator information and the stored procedure name, click here.

Core 6: Clinical Decision Support Rule

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

Certification criteria: §170.314(a)(8) Clinical decision support & §170.314(a)(2) Drug-drug, drug-allergy interaction checks

§170.314(a)(8) Clinical decision support	(i) Evidence-based decision support interventions. Enable a limited set of identified users to select (i.e., activate) one or more electronic clinical decision support interventions (in addition to drug-drug and drug-allergy contraindication checking) based on each one and at least one combination of the following data: (A) Problem list; (B) Medication list; (C) Medication allergy list; (D) Demographics; (E) Laboratory tests and values/results; and (F) Vital signs. (ii) Linked referential clinical decision support. (A) EHR technology must be able to: a. Electronically identify for a user diagnostic and therapeutic reference information; or b. Electronically identify for a user diagnostic and therapeutic reference information in accordance with the standard specified at §170.204(b) and the implementation specifications at §170.204 (b)(1) or (2). (B) For paragraph (a)(8)(ii)(A) of this section, EHR technology must be able to electronically identify for a user diagnostic or therapeutic reference information based on each one and at least one combination of the following data referenced in paragraphs (a)(8)(i)(A) through (F) of this section: (iii) Clinical decision support configuration. (A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) of this section to be configured by a limited set of identified users (e.g., system administrator) based on a user's role.

	(B) EHR technology must enable interventions to be electronically triggered: a. Based on the data referenced in paragraphs (a)(8)(i)(A) through (F) of this section. b. When a patient's medications, medication allergies, and problems are incorporated from a transition of care/referral summary received pursuant to paragraph (b)(1)(iii) of this section. c. Ambulatory setting only. When a patient's laboratory tests and values/results are incorporated pursuant to paragraph (b)(5)(i)(A)(1) of this section. (iv) Automatically and electronically interact. Interventions triggered in accordance with paragraphs (a)(8)(i) through (iii) of this section must automatically and electronically occur when a user is interacting with EHR technology. (v) Source attributes. Enable a user to review the attributes as indicated for all clinical decision support resources: (A) For evidence-based decision support interventions under paragraph (a)(8)(i) of this section: a. Bibliographic citation of the intervention (clinical research/guideline); b. Developer of the intervention (translation from clinical research/guideline); c. Funding source of the intervention development technical implementation; and d. Release and, if applicable, revision date(s) of the intervention or reference source. (B) For linked referential clinical decision support in paragraph (a)(8)(ii) of this section and drug-drug, drug-allergy interaction checks in paragraph(a)(2) of this section, the developer of the intervention, and where clinically indicated, the bibliographic citation of the intervention (clinical research/guideline).
§170.314(a)(2) Drug-drug, drug-allergy interaction checks	(i) Interventions. Before a medication order is completed and acted upon during computerized provider order entry (CPOE), interventions must automatically and electronically indicate to a user drug-drug and drug-allergy contraindications based on a patient's medication list and medication allergy list. (ii) Adjustments. (A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted. (B) Limit the ability to adjust severity levels to an identified set of users or available as a system administrative function.

For Credible configuration and use information, click here.

Attestation: YES/NO

Measure	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
Exclusion	For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.

EPs must attest YES to implementing five clinical decision support interventions and enabling and implementing functionality for drug-drug and drug-allergy interaction to meet this measure.

Core 7: Patient Electronic Access

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

Certification criteria: §170.314(e)(1) View, download, and transmit (VDT) to third party

§170.314(e)(1) View, download, and transmit to third party	(i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at §170.210(f). (A) View - Electronically view in accordance with the standard adopted at §170.204(a), at a minimum, the following data: i. The Common MU Data Set (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set). ii. Provider's name and office contact information.

In Credible, this requirement is met by providing client users (the client, parent, guardian, and so on) read-only access to a client's health information through the Credible Client Portal. A client user can also generate a profile print view that includes the client's health information and if necessary, transmit the PDF to a third-party. The client user can transmit the summary from within the Client Portal using Direct Project support or download the file to his/her computer and transmit is manually outside of Credible.

Settings

Security Matrix: DataDictionary, ClientUserView, ClientView, ClientVisitView, ClientVisitViewExt

Client User Security Matrix: eLabsCU, AllergyViewCU, AssignmentsCU, AuthorizationsCU, ClientFileViewCU, ClientInsuranceViewCU, ClientNotesViewCU, ClientUserSummaryView, ClientVisitListCU, ClinicalSupportCU, ContactsViewCU, DxViewCU, eLabsCU, ExternalProviderViewCU, FamilyViewCU, FinancialsViewCU, ImmunizationViewCU, MedicalProfileViewCU, PlannerViewCU, RxViewCU, TxPlusView/TxViewCU, ViewPrivateFolderCU, WarningsCU

Your Implementation Manager (IM) or Partner Services Coordinator (PSC) needs to turn on the Client Portal in your system.

Steps to Configure

Refer to Appendix A for information on setting up the Client Portal.

Steps to Use

1. Give the login information and your domain name to each client user.
2. Give client users the Client Portal URL www.credibleportal.com and let them know they will need to enter a new password when they first log in.

Once logged into the Portal:

1. View the different parts of the client's record by clicking the corresponding buttons on the nav bar.
2. Generate a print view of the client's record by:
    a. Clicking Profile on nav bar > Print View button.
    b. Selecting the desired print options and click Print View. To generate a PDF of the print view for transmission purposes, click Print PDF.

Attestation: §170.302(n)

Measure	Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information. Measure 2: More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.
Exclusion	Any EP who: (1) Neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information, may exclude **both** measures. (2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude **only** the second measure.

	CMS	Credible
Measure 1 Denominator	Number of unique patients seen by the EP during the EHR reporting period.	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Measure 1 Numerator	Number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information.	Count of clients in Credible denominator where number of business days from visit start date to the visit sign & submit date (transfer_date) is 4 or less and the client has at least one client user account created within four business days of the visit 💻 Stored procedure in Credible spc_export_mu_vdt_summary If your organization is not using the Client Portal, you need to determine what you will provide electronically to clients and how this will be documented. A business day is defined as a date that is both a weekday (Monday to Friday) and is not marked as a holiday. To enable the Company Holidays function, select *Use Company Holidays* in Partner Config. To designate a day as a company holiday: Admin tab > **Company Holidays** > click the appropriate date.

	CMS	Credible
Measure 2 Denominator	Number of unique patients seen by the EP during the EHR reporting period.	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Measure 2 Numerator	The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information.	Count of clients in Credible denominator where there is at least one successful client user login into the Client Portal where the login date/time is in the reporting period 💻 Stored procedure in Credible spc_export_mu_vdt_summary

Core 8: Clinical Summaries

Objective	Provide clinical summaries for patients for each office visit.

Certification criteria: §170.314(e)(2) Clinical summaries (Ambulatory setting only)

§170.314(e)(2) Clinical summaries (Ambulatory setting only)	(i) Create - Enable a user to create a clinical summary for a patient in human readable format and formatted according to the standards adopted at §170.205(a)(3). (ii) Customization - Enable a user to customize the data included in the clinical summary. (iii) Minimum data from which to select - EHR technology must permit a user to select, at a minimum, the following data when creating a clinical summary: • Common MU Data Set (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set). • The provider's name and office contact information; date and location of visit; reason for visit; immunizations and/or medications administered during the visit; diagnostic tests pending; clinical instructions; future appointments; referrals to other providers; future scheduled tests; and recommended patient decision aids.

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits
Exclusion	Any EP who has no office visits during the EHR reporting period.

	CMS	Credible
Denominator	Number of office visits by the EP for an office visit during the EHR reporting period	Unduplicated/distinct count of clients with at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of office visits in the denominator for which the patient is provided a clinical summary within three business days	Count of clients in Credible denominator that have had a clinical summary generated (not just print to screen) within 1 business day of the visit start date/time OR the visit has documentation that the client declined (question SNOMED CT = 422735006, Answer SNOMED CT = 436571000124108) Stored procedure in Credible spc_export_mu_clinical_smry_summary With the Client Portal, a client can obtain a clinical summary as soon as the visit is transferred to Credible or signed and submitted.

Core 9: Protect Electronic Health Information

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

Certification criteria: §170.314(d)(4) Amendments

§170.314(d)(4) Amendments	Enable a user to electronically select the record affected by a patient's request for amendment and perform the capabilities specified in paragraphs (d)(4)(i) or (ii) of this section. (i) Accepted amendment - For an accepted amendment, append the amendment to the affected record or include a link that indicates the amendment's location. (ii) (ii) Denied amendment - For a denied amendment, at a minimum, append the request and denial of the request to the affected record or include a link that indicates this information's location.

In Credible, you use the Amendments function to record client requests to amend the information about a specific diagnosis, lab, medication, or completed visit.

Settings Security Matrix: ClientAmendmentView, ClientAmendmentAdd, ClientAmendmentDelete

Steps to Configure N/A

Steps to Use To add an amendment request:

1. Amendments on Client nav bar.
2. From the New dropdown, select the type of record (diagnosis, lab, medication, or visit) the amendment request is for.
3. From the diagnosis/lab/medication/visit list that displays, select the specific record the amendment request is for and click Create New.
4. From the Status dropdown, select Requested.
5. Enter information about the requestor and the date of the request in the Origin box.
6. Enter the specifics of the request in the Details box and click Save.

To edit, review, or accept/deny an amendment request:

1. Amendments on Client nav bar.
2. Click the amendment you need to edit/review/accept or deny and then click the Edit button.
    - If editing the request, add to the origin/detail information as necessary and click Save. Note that the system does not currently record change history for amendments.
    - If reviewing the request, select Review from the Status dropdown, add review notes to the Details section (including your name and date/time of the review), and click Save.
    - If accepting or denying the request, select the corresponding option from the Status dropdown, add notes about decision to the Details section (including your name and date/time of the acceptance/denial), and click Save.

Certification criteria: §170.314(d)(2) Auditable events and tamper-resistance

§170.314(d)(2) Auditable events and tamper-resistance	(i) Record actions. EHR technology must be able to: (A) Record actions related to electronic health information in accordance with the standard specified in §170.210(e)(1); (B) Record the audit log status (enabled or disabled) in accordance with the standard specified in §170.210(e)(2) unless it cannot be disabled by any user; and (C) Record the encryption status (enabled or disabled) of electronic health information locally stored on end-user devices by EHR technology in accordance with the standard specified in §170.210(e)(3) unless the EHR technology prevents electronic health information from being locally stored on end-user devices (see 170.314(d)(7) of this section). (ii) Default setting. EHR technology must be set by default to perform the capabilities specified in paragraph (d)(2)(i)(A) of this section and, where applicable, paragraphs (d)(2)(i)(B) or (C), or both paragraphs (d)(2)(i)(B) and (C). (iii) When disabling the audit log is permitted. For each capability specified in paragraphs (d)(2)(i)(A) through (C) of this section that EHR technology permits to be disabled, the ability to do so must be restricted to a limited set of identified users. (iv) Audit log protection. Actions and statuses recorded in accordance with paragraph (d)(2)(i) of this section must not be capable of being changed, overwritten, or deleted by the EHR technology. (v) Detection. EHR technology must be able to detect whether the audit log has been altered.

In Credible, there is no way for a user to turn off the logging. And if a change is made to the ChangeLog or ChangeLogDetail table, it will be recorded in the ChangeLog Changes Report.

Settings	Security Matrix: Report List Report Security: ChangeLog Changes Report
Steps to Configure	N/A
Steps to Use	Reports tab > Admin button on nav bar > ChangeLog Changes Report > Run Report.

Certification criteria: §170.314(d)(3) Audit report(s)

§170.314(d)(3) Audit report(s)	Enable a user to create an audit report for a specific time period and to sort entries in the audit log according to each of the data specified in the standards at §170.210(e).

For Credible configuration and use information, click here.

Certification criteria: §170.314(d)(7) End-user device encryption

§170.314(d)(7) End-user device encryption	Paragraph (d)(7)(i) or (ii) of this section must be met to satisfy this certification criterion. (i) EHR technology that is designed to locally store electronic health information on end-user devices must encrypt the electronic health information stored on such devices after use of EHR technology on those devices stops. (A) Electronic health information that is stored must be encrypted in accordance with the standard specified in §170.210(a)(1). (B) Default setting. EHR technology must be set by default to perform this capability and, unless this configuration cannot be disabled by any user, the ability to change the configuration must be restricted to a limited set of identified users. (ii) EHR technology is designed to prevent electronic health information from being locally stored on end-user devices after use of EHR technology on those devices stops.

Credible Mobile uses an AES encryption algorithm with a 256-bit key length. All electronic health information (EHI) stored on end-user devices is passed through the encryption algorithm prior to being stored in a local SQLite database. All EHI is then passed through a decryption algorithm prior to being displayed on screen. No EHI is stored on end-user devices in a non-encrypted manner.

Certification criteria: §170.314(d)(1) Authentication, access control, and authorization

§170.314(d)(1) Authentication, access control, and authorization	(i) Verify against a unique identifier(s) (e.g., username or number) that a person seeking access to electronic health information is the one claimed; and (ii) Establish the type of access to electronic health information a user is permitted based on the unique identifier(s) provided in paragraph (d)(1)(i) of this section, and the actions the user is permitted to perform with the EHR technology.

Authentication/authorization: for Credible configuration and use information, click here.

Access control: for Credible configuration and use information, click here.

Certification criteria: §170.314(d)(5) Automatic log-off

§170.314(d)(5) Automatic log-off	Prevent a user from gaining further access to an electronic session after a predetermined time of inactivity.

For Credible configuration and use information, click here.

Certification criteria: §170.314(d)(6) Emergency access

§170.314(d)(6) Emergency access	Permit an identified set of users to access electronic health information during an emergency.

For Credible configuration and use information, click here.

Certification criteria: §170.314(d)(8) Integrity

§170.314(d)(8) Integrity	(1) Create a message digest in accordance with the standard specified in §170.210(c). (2) Verify in accordance with the standard specified in §170.210(c) upon receipt of electronically exchanged health information that such information has not been altered.

For Credible configuration and use information, click here.

Core 10: Clinical Lab Test Results

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

Certification criteria: §170.314(b)(5) Incorporate laboratory test results

§170.314(b)(5) Incorporate laboratory test results	(i) Receive results – (A) Ambulatory setting only – a. Electronically receive and incorporate clinical laboratory tests and values/results in accordance with the standard specified in §170.205(j) and, at a minimum, the version of the standard specified in §170.207(c)(2). b. Electronically display the tests and values/results received in human readable format. (ii) Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). (iii) Electronically attribute, associate, or link a laboratory test and value/result with a laboratory order or patient record.

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	More than 55 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

For denominator/numerator information and the stored procedure name, click here.

Core 11: Patient Lists

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

Certification criteria: 170.314(a)(14) Patient list creation

170.314(a)(14) Patient list creation	Enable a user to electronically and dynamically select, sort, access, and create patient lists by: date and time; and based on each one and at least one combination of the following data: (i) Problems; (ii) Medications; (iii) Medication allergies; (iv) Demographics; (v) Laboratory tests and values/results; and (vi) Ambulatory setting only - Patient communication preferences.

For Credible configuration and use information, click here.

Attestation: YES/NO

Measure	Generate at least one report listing patients of the EP with a specific condition.
Exclusion	No exclusion.

EPs must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

Core 12: Preventative Care

Objective	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.

Certification criteria: 170.314(a)(14) Patient list creation

170.314(a)(14) Patient list creation	Enable a user to electronically and dynamically select, sort, access, and create patient lists by: date and time; and based on each one and at least one combination of the following data: (i) Problems; (ii) Medications; (iii) Medication allergies; (iv) Demographics; (v) Laboratory tests and values/results; and (vi) Patient communication preferences.

For information on using Advanced Client Search to generate a list of clients that need a reminder visit and then add the appropriate type of patient reminder visit for each client in the list via the Show Add Visit function, click here.

For information on using Advanced Client Search to generate lists of clients that meet specific search criteria, click here.

Attestation: §170.302(n)

Measure	More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.
Exclusion	Any EP who has had no office visits in the 24 months before the EHR reporting period.

	CMS	Credible
Denominator	Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period	Unduplicated/distinct count of clients that have two approved visits in the 24 months prior to the reporting period start date where employee on visit is flagged as MU Provider and visit type has Include Summary checked
Numerator	Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period	Count of clients in Credible denominator where reminder visit date is in the reporting period, reminder is identified via External ID on the visit type, and client has preferred contact method recorded in client profile Stored procedure in Credible spc_export_mu_patient_reminder_summary

Core 13: Patient-Specific Education Resources

Objective	Use clinically relevant information from certified EHR technology to identify patient-specific education resources and provide those resources to the patient.

Certification criteria: §170.314(a)(15) Patient-specific education resources

§170.314(a)(15) Patient-specific education resources	EHR technology must be able to electronically identify for a user patient-specific education resources based on data included in the patient's problem list, medication list, and laboratory tests and values/results: (i) In accordance with the standard specified at §170.204(b) and the implementation specifications at §170.204(b)(1) or (2); and (ii) By any means other than the method specified in paragraph (a)(15)(i) of this section.

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.
Exclusion	Any EP who has no office visits during the EHR reporting period.

For denominator/numerator information and the stored procedure name, click here.

Core 14: Medication Reconciliation

Objective	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Certification criteria: §170.314(b)(4) Medication reconciliation

§170.314(b)(4) Clinical information reconciliation	Enable a user to electronically reconcile the data that represent a patient's active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically and simultaneously display (i.e., in a single view) the data from at least two list sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date. (ii) Enable a user to create a single reconciled list of medications, medication allergies, or problems. (iii) Enable a user to review and validate the accuracy of a final set of data and, upon a user's confirmation, automatically update the list.

For Credible configuration and use information, click here.

Attestation: §170.302(n)

Measure	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
Exclusion	An EP who was not the recipient of any transitions of care during the EHR reporting period.

	CMS	Credible
Denominator	Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition	Number of transitions into care; calendar control question has SNOMED CT code 1861000124105 for Transition of care (finding) First encounters with new patients: have a question asking if patient is new – answer is yes (SNOMED CT code 108220007 for Evaluation AND/OR management - new patient) or no (SNOMED CT code 108221006 for Evaluation AND/OR management - established patient) Encounter with existing patients with hard copy or scanned copy of summary of care document received or with an electronic CCD: uncoded question “Provision of Summary of Care Record to Provider?” with the following coded answers: • Clinical consultation report (record artifact) (SNOMED CT code 371530004) • Report of clinical encounter (record artifact) (SNOMED CT code 371531000) • Confirmatory consultation report (record artifact) (SNOMED CT code 371545006)

	CMS	Credible
Numerator	Number of transitions of care in the denominator where medication reconciliation was performed	Number of transitions into care in Credible denominator that have Performed (SNOMED CT code 398166005) as the answer to the "Documentation of current medications (procedure) performed" question (SNOMED CT code 428191000124101) AND have the date of the medication reconciliation documented via a separate calendar control question that has SNOMED CT code 428191000124101 Stored procedure in Credible spc_export_mu_med_reconcile_summary

Core 15: Summary of Care

Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Certification criteria: §170.314(b)(1)(2) Receive/display/incorporate & Create/transmit transition of care/referral summaries

§170.314(b)(1) Transitions of care – receive, display, and incorporate transition of care/referral summaries	(i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with: A. The standard specified in §170.202(a). B. Optional. The standards specified in §170.202(a) and (b). C. Optional. The standards specified in §170.202(b) and (c). (ii) Display. EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: §170.205(a)(1), §170.205(a)(2), and §170.205(a)(3). (iii) Incorporate. Upon receipt of a transition of care/referral summary formatted according to the standard adopted at §170.205(a)(3), EHR technology must be able to: A. Correct patient. Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient. B. Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s): • Medications. At a minimum, the version of the standard specified in §170.207(d)(2); • Problems. At a minimum, the version of the standard specified in §170.207(a)(3); • Medication allergies. At a minimum, the version of the standard specified in §170.207(d)(2). • Section views. Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at §170.205(a)(3).

§170.314(b)(2) Transitions of care – create and transmit transition of care/referral summaries	(i) Create. Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at §170.205(a)(3) that includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): A. Encounter diagnoses. The standard specified in §170.207(i) or, at a minimum, the version of the standard specified §170.207(a)(3); B. Immunizations. The standard specified in §170.207(e)(2); C. Cognitive status; D. Functional status; and E. The reason for referral; and referring or transitioning provider's name and office contact information. (ii) Transmit. Enable a user to electronically transmit the transition of care/referral summary created in paragraph (b)(2)(i) of this section in accordance with: A. The standard specified in §170.202(a). B. Optional. The standards specified in §170.202(a) and (b). C. Optional. The standards specified in §170.202(b) and (c).

With support for the Direct Project, Agency staff can securely send and receive clinical summaries (CCD format) directly to and from trusted third-party recipients from within Credible. The two-way trust relationship between your Agency and a third party is established by exchanging "credential" certificates and having Credible configure the third-party's certificate in your system. Credible will generate a Direct certificate for your Agency that you can then give to third parties you want to exchange clinical summaries with.

A Direct certificate can be for an individual (address-specific) or an organization (domain-specific). If a third party has a domain-specific certificate, the clinical summary can be sent to any individual at the organization. For security purposes, the address-specific certificate is the preferred type.

If your system is not currently configured for Direct Project support, use the configuration and use steps for the Stage 1 menu measure Transition of Care Summary.

Settings Security Matrix: PatientSummaryGenerator, ClientFileAdd

Partner Config: Use Clinical Summary Features; fill out CCD Author Address fields

Steps to Configure

1. Submit a Priority 4 Task requesting that Credible configure and enable Direct Project in your system.
    a. Attach certificates from third parties (in .der or .cer format) that you want to exchange clinical summaries with.
    b. For each third-party certificate, indicate if it is address-specific (preferred; allows just one address) or domain-specific (allows emails to be sent to entire domain).
    c. Specify the email address that your Agency wants to use for its address-specific certificate.
2. Once you are notified that your Agency's certificate is ready, download it from the Task and give it to the third parties that you want to exchange clinical summaries with.
3. Update existing external care provider records with the provider's first name and last name; these fields are new with this release (Admin tab > External Care Providers > edit > add first/last names > save).
4. Make sure there is an external provider record for each third party you are going to exchange clinical summaries with (Admin tab > External Care Providers > Add a New Provider Entry).
5. If appropriate, configure visit types so time-of-visit clinical summaries can be generated (Admin tab > Visit Type > edit > select Include Summary > Save).
6. Optional: add a file folder and name it Clinical Summaries (Admin tab > File Folders Admin > fill out Add Folder section).

Steps to Use

To upload a clinical summary received via Direct Project:

1. Client tab > Attachments on Client nav bar > Import Clinical Summary button > Direct Summaries radio button.
2. Fill out the File Categorization section.
3. Select appropriate clinical summary from Received Clinical Summaries list and click Upload File.
4. Close the "Summary successfully uploaded" popup and click the Attachments button on Client nav bar to view uploaded clinical summary.

Best practice for generating a CCD: have the client sign an ROI for sending his/her clinical summary to another agency.

To generate a clinical summary and send it to a trusted third party via Direct Project:

1. Client tab > Profile on Client nav bar > Generate Clinical Summary or Visit tab > view button for visit > Create Clinical Summary (in Transfer XML CDA/CCR field).
2. If necessary, uncheck one or more Summary detail checkboxes and adjust the number of visits. Make sure Referral to other provider is checked.
3. From Provider dropdown, select External Care Provider that you are sending the clinical summary to.
4. Enter the reason for the referral in the corresponding field.
5. Under Output options, select Send summary via Direct and then select the Direct Address that corresponds to the external provider you selected in step 3.
6. If you selected a domain address, enter the external provider's username in the Chosen Email Address field.
7. Click Generate Summary. A "Successful email send" message displays.

Attestation: §170.302(n) for Measures 1 and 2; YES/NO for Measure 3

Measure	EPs must satisfy both of the following measures in order to meet the objective: Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.

	Measure 3: An EP must satisfy one of the following criteria: • Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). • Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

	CMS	Credible
Measure 1 Denominator	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider	Number of approved visits with an answer coded to SNOMED CT for referral: • Clinical consultation report (record artifact) (SNOMED CT code 371530004) • Report of clinical encounter (record artifact) (SNOMED CT code 371531000) • Confirmatory consultation report (record artifact) (SNOMED CT code 371545006)
Measure 1 Numerator	Number of transitions of care and referrals in the denominator where a summary of care record was provided	Number of visits in Credible denominator that have CLINICAL SUMMARY GENERATED in the visit log Stored procedure in Credible spc_export_mu_messaging_summary

	CMS	Credible
Measure 2 Denominator	Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider	Same Credible denominator as Measure 1
Measure 2 Numerator	Number of transitions of care and referrals in the denominator where a summary of care record was 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. The organization can be a third-party or the sender's own organization	Number of visits in Credible denominator that have CLINICAL SUMMARY GENERATED or SEND CLINICAL SUMMARY VIA DIRECT in the visit log; the latter counts toward summary of care record provided and electronically transmitted Stored procedure in Credible spc_export_mu_messaging_summary

Measure 3: YES/NO

The EP attests YES to one of the two criteria:

1. Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).

   or

2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

Core 16: Immunization Registries

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

Certification criteria: §170.314(f)(1) Immunization information & §170.314(f)(2) Transmission to immunization registries

§170.314(f)(1) Immunization information	Enable a user to electronically record, change, and access immunization information.
§170.314(f)(2) Transmission to immunization registries	EHR technology must be able to electronically create immunization information for electronic transmission in accordance with: (i) The standard and applicable implementation specifications specified in §170.205(e)(3); and (ii) At a minimum, the version of the standard specified in §170.207(e)(2).

For Credible configuration and use information, click here.

Attestation: YES/NO

Measure	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.
Exclusion	Any EP that meets one or more of the following criteria may be excluded from this objective: (1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period; (2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or (4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

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

- Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period using either the current standard at 45 CFR 170.314(f)(1) and (f)(2) or the standards included in the 2011 Edition EHR certification criteria adopted by ONC during the prior EHR reporting period when ongoing submission was achieved.
- Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.

Core 17: Use Secure Electronic Messaging

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

Certification criteria: §170.314(e)(3) Secure messaging

§170.314(e)(3) Secure messaging	Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures: (i) Both the patient (or authorized representative) and EHR technology user are authenticated; and (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at §170.210(f).

To verify the integrity of public client notes (viewable in the Credible Client Portal) and client/employee messages, the system will generate a “Message Hash” each time a note or message is generated. When the note is viewed in the Client Portal or message is received, a “Received Hash” is generated. If the two hash values match, it means the content sent was the same as the content received. If they don’t match, an error message displays instead of the public note/message. Credible uses the SHA-1 algorithm.

Settings

Security Matrix: ClientNoteAdd, MessagingHubAnswerMessages

Partner Config: Show Hashing, Use Public Client Notes, Check Message Interval, Message Disclaimer Text for Client Portal

Your IM/PSC needs to turn on the Credible Client Portal for your system.

Steps to Configure

Refer to Appendix A for information on setting up the Client Portal.

Steps to Use

For public client notes:

1. Notes on Client nav bar.
2. Enter the note in the text box, select the Is Public checkbox, and click Add Note.
3. Hover over the hash symbol to view the message hash. When the client user views the note in the Client Portal, they can compare the message hash with the received hash.

For client/employee messages:

1. Click the envelope icon in the banner or the Messaging Hub button on Employee nav bar.
2. Click the Reply icon for the message you need to reply to.
3. Enter the reply and click Send Message.
4. Click the Subject to open the message/reply thread.
5. Hover over the hash symbol for your reply to view the matching message hash and received hash.

Attestation: §170.302(n)

Measure	A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.
Exclusion	Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients having at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period.	Count of clients in Credible denominator where client user has logged into the Client Portal and sent or responded to a message and the message date is in the date range Stored procedure in Credible spc_export_mu_messaging_summary

Menu 1: Syndromic Surveillance Data Submission

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

Certification criteria: §170.314(f)(3) Transmission to public health agencies – syndromic surveillance

§170.314(f)(3) Transmission to public health agencies – syndromic surveillance	EHR technology must be able to electronically create syndrome-based public health surveillance information for electronic transmission in accordance with: A. The standard specified in §170.205(d)(2). B. Optional. The standard (and applicable implementation specifications) specified in §170.205(d)(3).

For Credible configuration and use information, click here.

Attestation: YES/NO

Measure	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.
Exclusion	Any EP that meets one or more of the following criteria may be excluded from this objective: (1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period; (2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or (4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

EPs must attest YES to successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

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

Menu 2: Electronic Notes

Objective	Record electronic notes in patient records.

Certification criteria: §170.314(a)(9) Electronic notes

§170.314(a)(9) Electronic notes	Enable a user to electronically record, change, access, and search electronic notes.

In Credible, web forms are the vehicle for recording “electronic notes” (visit documentation) in a client’s record. You can edit the documentation of an incomplete or completed visit. Once a visit has been completed, you can search for a specific word or word sequence in the documentation. If there is a match, the word is highlighted in yellow. The system does not include headings (category names) or question text in the search.

Settings

Security Matrix: VisitEntryWeb, ClientVisitView (or variation such as ClientVisitViewTeam), ClientVisitViewForm, ClientVisitUpdateForm

Steps to Configure

Employee must have a signature on file (Signature button on Employee nav bar).

Steps to Use

For the steps to record and/or change visit documentation, refer to *Documenting a Visit with a Web Form* and/or *Viewing and Managing Incomplete Visits* in the online help.

To access and/or search the documentation of a completed visit:

1. Visit tab > Visit ID or view button.
2. Scroll down to the visit documentation section.
3. Enter the word or phrase you want to search for in the Enter search criteria box and click Search Answers.
4. Scroll down and look for matches highlighted in yellow.

Attestation: §170.314(g)(2)

Measure	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content
Exclusion	No exclusion.

	CMS	Credible
Denominator	Number of unique patients with at least one office visit during the EHR reporting period for EPs during the EHR reporting period	Unduplicated/distinct count of clients having at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data	Count of clients in Credible denominator where the visit has at least one question answered in a form, employee on the visit has a signature on file (via Employee nav bar), signature is attached to the visit, and employee on the visit entered it himself/herself Since text in the Visit Notes field for a data entry visit is not searchable, data entry visits are excluded from this measure. Stored procedure in Credible spc_export_mu_electronic_notes_summary

Menu 3: Imaging Results

Objective	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

Certification criteria: §170.314(a)(12) Image results

§170.314(a)(12) Image results	Electronically indicate to a user the availability of a patient's images and narrative interpretations (relating to the radiographic or other diagnostic test(s)) and enable electronic access to such images and narrative interpretations.

In Credible, when entering a manual lab result or editing an existing one, you can upload one or more attachments. Once an attachment is made, a blue paperclip is added to the lab results list for the order and the overall Results list; hovering over the paperclip displays the number of attachments. To count towards this measure, the lab attachment must be in one of the following formats: bmp, gif, jpg, jpeg, png, tif, tiff.

Settings

Security Matrix: eLabs

Your IM/PSC needs to turn on eLabs and the manual result entry function in your system.

Steps to Configure

See the *Setting Up eLabs* topic in the online help.

Steps to Use

1. eLabs button on Client nav bar.
2. Edit an existing lab result (click edit button > Save Result Header button) or add a new one (click Add Manual Result tab, fill out the Lab Results Header screen, and click Save Result Header.)
3. Edit an existing lab result or add a new one (make sure the required fields Test Code, Test Name, and Result Date are filled out).
4. In the Attachments section, click the Choose File button, select the file, and click Open.
5. Click the Attach File button.
6. If you need to delete an attachment, use the delete button in the Attachments section.
7. When done adding attachments, click Save Lab Result and then click Return to Labs.

Attestation: §170.302(n)

Measure	More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.
Exclusion	Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period.

	CMS	Credible
Denominator	Number of tests whose result is one or more images ordered by the EP during the EHR reporting period	Number of physician orders where type is 'Radiology' and the Order Date in is the reporting period
Numerator	Number of results in the denominator that are accessible through CEHRT	Number of orders in Credible denominator where eLab result has an image attached AND the test type specifically is the word 'Radiology' AND the ordered date is in the date range Image is defined as a bmp, gif, jpg, jpeg, png, tif, tiff file. Stored procedure in Credible spc_export_mu_imaging_summary

Menu 4: Family Health History

Objective	Record patient family health history as structured data.

Certification criteria: §170.314(a)(13) Family health history

§170.314(a)(13) Family health history	Enable a user to electronically record, change, and access a patient's family health history according to: (i) At a minimum, the version of the standard specified in §170.207(a)(3); or (ii) The standard specified in §170.207(j).

In Credible, the Diagnosis function is available for a client's family members.

- If a family member is an existing client, you use the Diagnosis button on that client's nav bar to add/update his/her health history. The ability to add/update diagnoses for an existing client family member is controlled by the corresponding Security Matrix rights.
- If a family member is not an existing client, a DX link will be available in the Family Members list screen.

Settings

Security Matrix: ClientUpdateContactsFamily

Partner Config: Use Client Family

Steps to Configure

Add external IDs shown below for first-degree relative relationship types and make sure Show on Family is set to True (Admin tab > Relationship Types).

Relationship	External ID
Brother	BRO
Child	CHD
Father	FTH
Mother	MTH
Parent	PAR
Sister	SIS
Sibling	SIB

Steps to Use

To record the health history of an “existing client” family member, use the Diagnosis button on his/her Client nav bar. Click here for more information.

To record the health history a family member who is not an existing client:

1. Family button on Client nav bar.
2. Click the DX link in the Diagnosis column.
3. Fill out the Multiaxial Diagnoses screen. Click here for more information.

Attestation: §170.302(n)

Measure	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.
Exclusion	Any EP who has no office visits during the EHR reporting period.

	CMS	Credible
Denominator	Number of unique patients seen by the EP during the EHR reporting period	Unduplicated/distinct count of clients having at least one approved visit where start date/time is in EHR reporting period, employee on visit is flagged as MU Provider, and visit type has Include Summary checked
Numerator	Number of patients in the denominator with a structured data entry for one or more first-degree relatives	Count of clients in Credible denominator that have a first-degree family member with at least one diagnosis record where the SNOMED CT description is not null. First-degree family member is represented by external ID of the relationship type: BRO, CHD, FTH, MTH, PAR, SIS, or SIB. Stored procedure in Credible spc_export_mu_family_hx_summary

Stage 1 and Stage 2: Reporting on Clinical Quality Measures (CQMs)

All eligible professionals (EPs) are required to report on CQMs to demonstrate meaningful use. Beginning in 2014, all EPs *regardless of their stage of meaningful use* will report on CQMs in the same way. In 2014, EPs must report on 9 of the 64 approved CQMs.

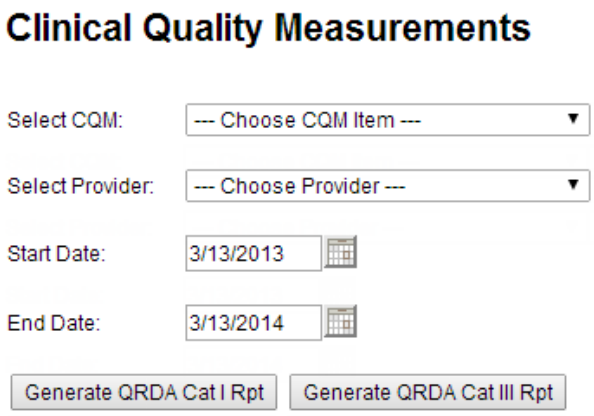
With the CQM module in Credible (accessed via the Reports tab), you can report on the following nine measures:

- CMS2v3 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- CMS50v2 Closing the Referral Loop: Receipt of Specialist Report
- CMS62v2 HIV/AIDS: Medical Visit
- CMS68v3 Documentation of Current Medications in the Medical Record
- CMS139v2 Falls: Screening for Future Fall Risk
- CMS149v2 Dementia: Cognitive Assessment
- CMS155v2 Weight Assessment
- CMS156v2 Use of High-Risk Medications in the Elderly
- CMS165v2 Controlling High Blood Pressure

The above measures meet the requirement of covering at least three of the National Quality Strategy domains.

The CQM reports are generated using the HL7 Quality Reporting Document Architecture (QRDA), a standard document format for exchanging electronic CQM data. The CQM module supports both QRDA Category I (individual patient) and QRDA Category III (aggregate) reports. A QRDA Category I report consists of multiple XML files – one for each client included in the measure results. **Important:** if transmitting a QRDA Category I report to a third-party, ensure that the file is encrypted since each XML file contains protected health information (PHI).

To report on a CQM, the system pulls data from visit records, form answers, client profile fields, medical profiles, diagnosis records, and/or medication records. For certain measures, you need to update existing forms with required questions and valid answers and/or make sure certain client profile fields exist and are set up as lookups with valid answers. This section provides generation configuration information and the configuration requirements for each measure.



Settings and General Configuration

Security Matrix settings: FormBuilder, FormBuilderEdit, ClientFormsUpdate, DataDictionary, ClientUpdate, ReportList, ClinicalQualityMeasurements. ExportBuild, ExportRun

General configuration steps:

1. Edit each payer record and select the appropriate Source of Payment Typology (Admin or Billing tab > Billing Payer). The Source of Payment Typology "is a payer type standard to allow for consistent reporting of payer data for health care services."
2. Copy the MU-CQM QUESTIONS form (ID 1981) from the Credible Library to your domain. You will refer to this form when configuring the CQMs that pull data from form answers. While the form includes all required questions, some questions will only have a subset of the possible answers; you need to review the value set and determine which ones are applicable for your Agency.

Understanding the Components of a CQM

CMS defines the five components of a CQM as follows:[8]

1. Initial Patient Population (IPP) -- group of patients the CQM is designed to address (may not be specified in non-EHR based measures)
2. Denominator – subset of the IPP; in some CQMs, the denominator may be the same as the IPP
3. Numerator – subset of the denominator for whom a process or outcome of care occurs
4. Exclusion – mechanism used to exclude patients from the denominator of a CQM when a therapy or service would not be appropriate in instances for which the patient otherwise meets the denominator criteria
5. Exception – allowable reason for nonperformance of a CQM for patients that meet the denominator criteria and do not meet the numerator criteria. Denominator exceptions are the valid reasons for patients who are included in the denominator population but for whom a process or outcome of care does not occur.

[8] http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/CQM_Webinar_Slides.pdf

In Credible:

- Any client that has been flagged as DUPLICATE (via Manage Client Duplicates) or DELETED will not be included in an IPP.
- If inclusion in an IPP is based on having received a service (encounter), a client must have had at least one *approved* visit where the visit date is in the measurement period AND the CPT or HCPCS code is in the "value set" (list of valid codes) for the measure. If there are multiple visits that meet this criteria, the most recent visit that occurs in the measurement period will be used to determine the Denominator and Numerator. This visit is referred to as the "IPP Visit."[9]
- If an IPP has an age requirement (for example, must be 12 or older), a client will only be included if he/she meets the requirement as of the measurement period Start Date AND his/her date_of_death field is blank (null) or has a date that is after the measurement period Start Date.

Viewing the Value Set for a CQM

The value set for a CQM will help you determine if your Agency is capturing the necessary data to report on the measure. For example, if inclusion in the IPP is based on having received a visit, the value set lists the visit/service CPT and HCPCS codes that will be pulled in when you report on the measure. If a measure pulls data from form answers, the value set can help you determine which forms need the required questions and what the valid answers are. If your Agency does not provide any of the services listed in the value set for a visit-based IPP, check with the appropriate authorities to see if you can still use this measure for CQM reporting.

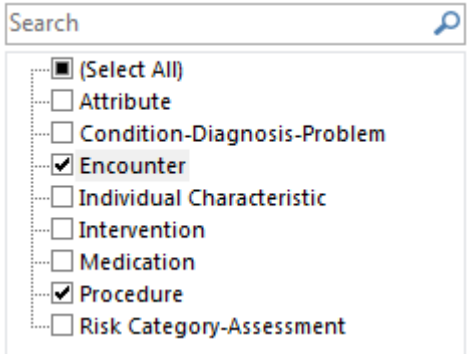
The procedure to view the value set for a CQM is as follows:

1. Create a custom query export (Reports tab > Export Tool) with the appropriate SELECT statement. For example, for CMS2v3, you would use `SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS2V3'`. Select all export fields displayed and use the default export details.
2. Run the export, selecting Excel (XLS or XLSX) for the format.
3. Open the Excel spreadsheet and select Data > Filter to add filtering dropdowns to each column.

A	B	C	D	
cms_id	measure_title	ecqm_domain	qdm_category	value_set_
CMS62v2	HIV/AIDS: Medical Visit	Clinical Processes/Effectiveness	Condition-Diagnosis-Problem	2.16.840.1.
CMS62v2	HIV/AIDS: Medical Visit	Clinical Processes/Effectiveness	Condition-Diagnosis-Problem	2.16.840.1.
CMS62v2	HIV/AIDS: Medical Visit	Clinical Processes/Effectiveness	Condition-Diagnosis-Problem	2.16.840.1

[9] CPT stands for Current Procedural Terminology and HCPCS stands for Healthcare Common Procedure Coding System.

Quality Data Model (QDM) categories are used to describe the different types of data in a value set; the standardized descriptions are necessary for exchanging electronic CQM data. To find specific values in a data set, it is helpful to filter by qdm_category. In a value set, “encounters” and “procedures” that have a CPT or HCPCS code correspond to the CPT codes on visits in Credible.

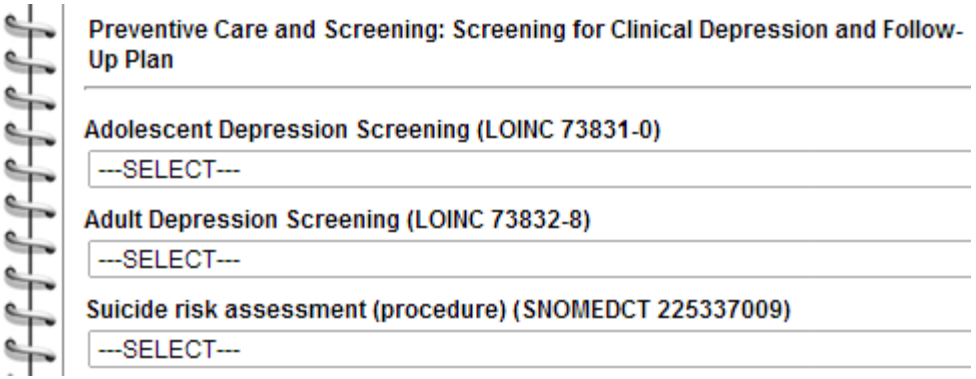


D	E	F	G	H
qdm_category	value_set_oid	value_set_name	code_system	code
Encounter	2.16.840.1.113883.3.464.1003.101.12.1047	HIV Visit	CPT	99201
Encounter	2.16.840.1.113883.3.464.1003.101.12.1047	HIV Visit	CPT	99202

If a qdm_category has multiple value sets, you may find it necessary to filter it by the value_set_name category to find specific values.

CMS2v3 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Description: 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.

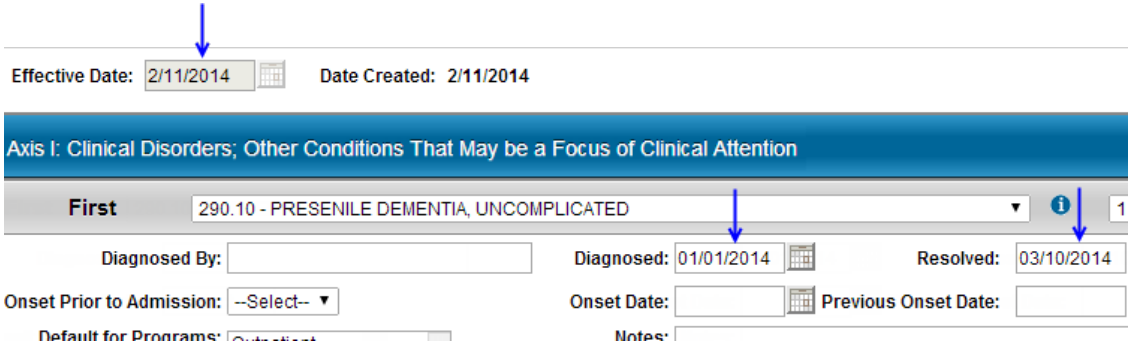


Note: in the form example above and the examples that follow, the required code has been included in the question "label"; this is for illustrative purposes only. When you update a web form, you only need to enter the code in the SNOMED Code or LOINC Code field.

CQM Component	In Credible
Initial Patient Population (IPP): all patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period	1. Click here for age requirement information. 2. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS2V3') and filter the qdm_category column by Encounter. Refer to the code_system, code, and description columns. 3. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides. 4. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with the required questions and answers.
Denominator: equals IPP	N/A

Denominator Exclusions: patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder

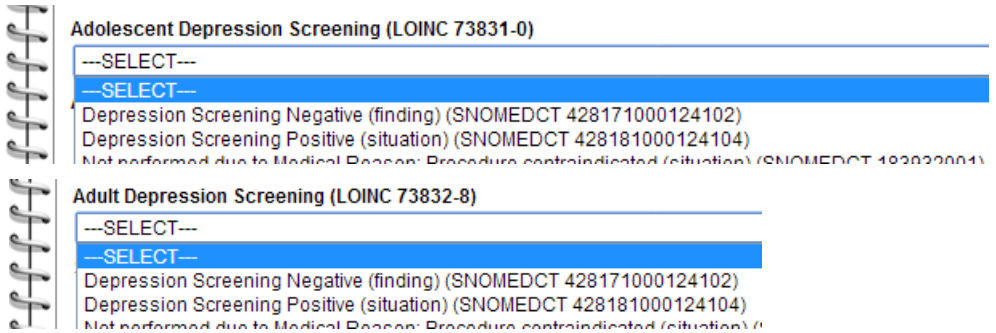
To be considered active, a Depression/Bipolar diagnosis must start prior to the IPP Visit AND end after the IPP Visit (or not end at all). The system compares the Diagnosed date and Resolved date (if applicable) to the IPP Visit date to determine if the diagnosis is active. If the Diagnosed date is blank, the Effective Date for the Multiaxial Diagnoses is used.



To see which Depression and Bipolar diagnoses are valid for the measure, filter the qdm_category column by Condition-Diagnosis-Problem; the valid diagnoses have ICD9CM or SNOMEDCT in the code_system column.

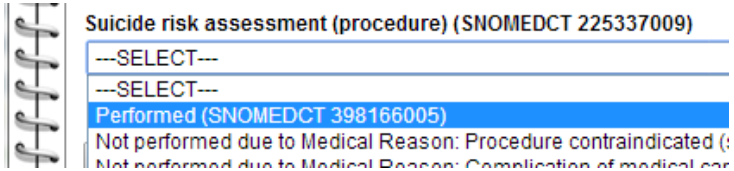
Numerator: patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

Screening for depression is indicated by an approved visit on the same date as the IPP Visit where form questions are coded for Adolescent and Adult Depression Screening. To count as having been performed, the selected answer is coded for Negative or Positive. The age of the client at the time of the visit determines whether the adolescent or adult (18+) screening is appropriate.



If the client has a Positive screening, staff must document the follow-up in at least one of the following ways for inclusion in the numerator:

- In the same visit, or another visit within one day, an "additional evaluation/follow-up/referral for depression" question has an answer that is coded to an Intervention in the value set.
- In the same visit, or another visit within one day, a suicide risk assessment is performed.



- Antidepressant prescription is created via Credible eRx AND the start date is within one day of the visit. To see the valid antidepressant medications for the measure, filter the qdm_category column by Medication; refer to the description column.

Numerator Exclusions: N/A

N/A

Denominator Exceptions:

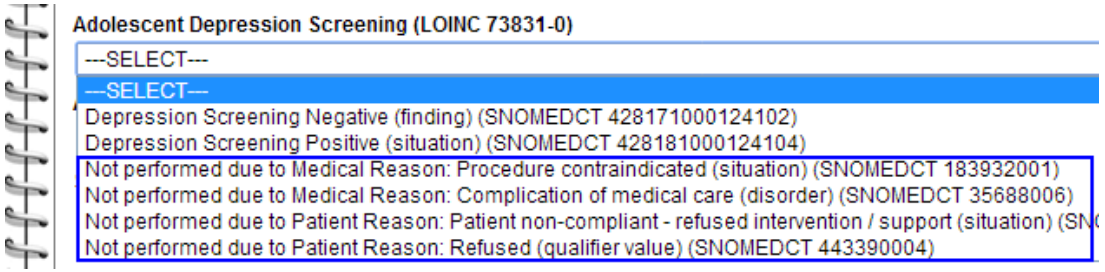
Patient Reason(s): Patient refuses to participate

OR

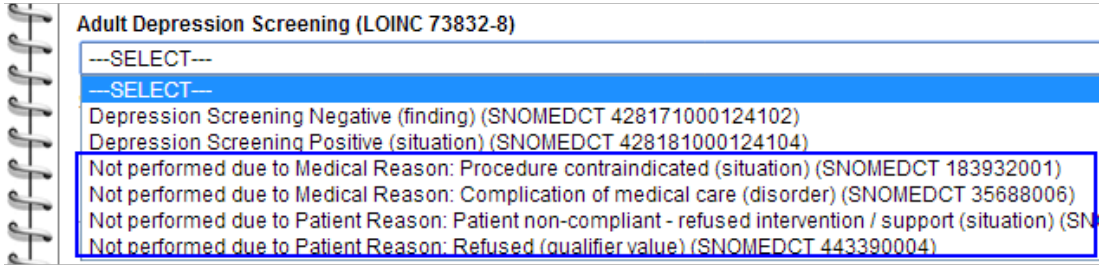
Medical Reason(s): Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

OR

Screening for depression is indicated by an approved visit on the same date as the IPP Visit where form questions are coded for Adolescent and Adult Depression Screening. To count as NOT having been performed for a specific reason, the selected answer is coded for a "Medical reason contraindicated" or "Patient Reason refused" value. The age of the client at the time of the visit determines whether the adolescent or adult (18+) screening is appropriate.



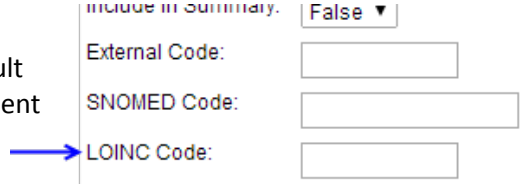
Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium



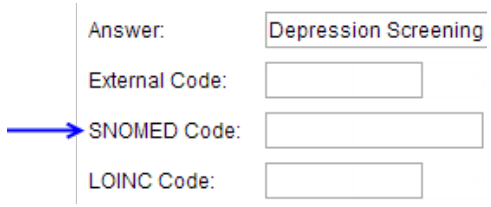
Form Configuration for the Numerator and the Denominator Exception

Update the appropriate form(s) as follows:

1. Optional: add a label only question that identifies the measure.
2. Add separate dropdown questions for Adolescent Depression Screening and Adult Depression Screening, coding the Adolescent one to LOINC 73831-0 and the Adult one to LOINC 73832-8.[10]



3. Add Negative and Positive answers to each depression screening question, coding the Negative one to SNOMED CT 428171000124102 and the Positive one to SNOMED CT 428181000124104.



4. Add "Not performed due to …" answers from the value set to each depression screening question, entering the appropriate code in the SNOMED Code field (qdm_category = Attribute; value_set_name = "Medical reason contraindicated" or "Patient Reason refused").

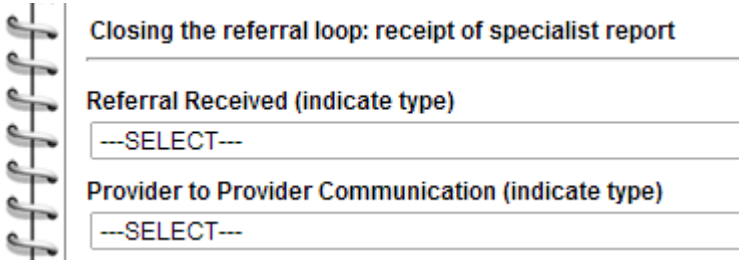
[10] LOINC stands for Logical Observation Identifiers Names and Codes, a standard for identifying medical laboratory observations.

5. For Positive screening follow-up, do one or both of the following:
    - Add an “additional evaluation/follow-up/referral for depression” dropdown question and then add coded answers from the value set (qdm_category = Intervention; refer to the description column and then the code column for SNOMED CT code).
    - Add a suicide risk assessment dropdown question, coding it to SNOMED CT 225337009; add a Performed answer to the question, coding it to SNOMED CT 398166005; and then add “Not performed due to …” answers from the value set to the question, entering the appropriate code in the SNOMED Code field (qdm_category = Attribute; value_set_name = “Medical reason contraindicated” or “Patient Reason refused”).

Note: if the Adolescent/Adult Depression Screening question is left unanswered or the answer does not match a SNOMED CT code in the Medical reason contraindicated/Patient Reason refused value set, the screening will be considered not performed and the client will not count towards the Numerator or the Denominator Exception.

CMS50v2 Closing the Referral Loop: Receipt of Specialist Report

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



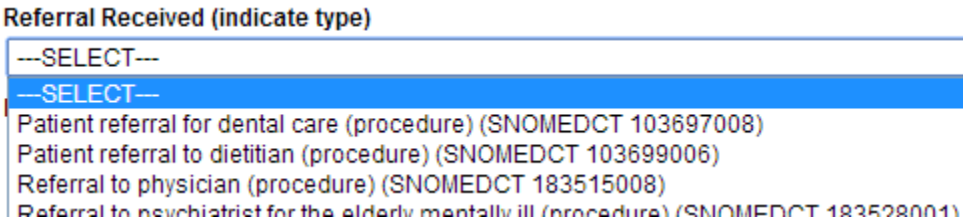
CQM Component	In Credible
Initial Patient Population (IPP): number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period	1. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS50V2') and filter the qdm_category column by Encounter. Refer to the code_system, code, and description columns. 2. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides. 3. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with the required questions and answers. To be included in the IPP, the client must also have a referral documented. In the same visit, or another approved visit in the measurement period, a question has an answer coded to an intervention in the value set. For example, the answer 'Referral to neurologist (procedure)' would be coded as 308474002. 4. To view valid referral answers, view the value set and filter the qdm_category column by Intervention. 5. Jot down the SNOMED CT codes that correspond to the referrals that your Agency makes.

Denominator: equals IPP	N/A
Denominator Exclusions: none	N/A
Numerator: number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred	Receiving the referral report is considered 'Communication from Provider to Provider' and is documented by having an approved visit with an answer coded to one the three Communications in the value set (see below). The visit documenting the communication must start after the referral visit ends.
Numerator Exclusions: N/A	N/A
Denominator Exceptions: none	N/A

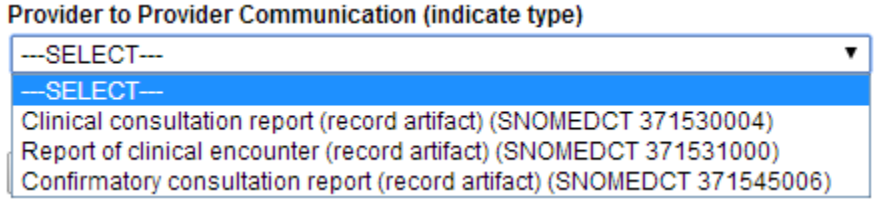
Form Configuration for the IPP and the Numerator

Update the appropriate form(s) as follows:

1. Optional: add a label only question that identifies the measure.
2. Add a dropdown question for Referral Received and add intervention answers that are applicable for your Agency; enter the appropriate SNOMED CT code for each answer in the SNOMED Code field. For example:



3. Add a dropdown question for Provider to Provider Communication and add the answers shown below; enter SNOMED CT codes in SNOMED Code field.



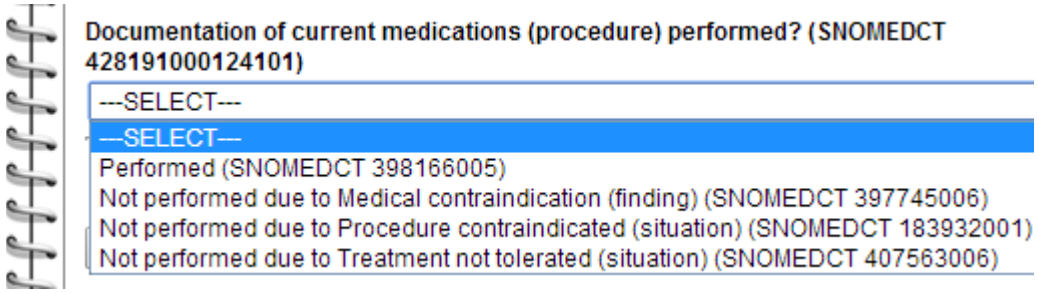
CMS62v2 HIV/AIDS: Medical Visit

Description: percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.

CQM Component	In Credible
Initial Patient Population (IPP): all patients, regardless of age, with a diagnosis of HIV/AIDS seen within a 12 month period	1. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS62V2') and filter the qdm_category column by Encounter. To be included in the IPP, the client must also have a diagnosis of HIV/AIDS starting on or before the end of the measurement period. The ICD9CM or SNOMEDCT code of the diagnosis must be in the value set. 2. To view the valid HIV/AIDS diagnoses and their codes, view the value set and filter the qdm_category column by Condition-Diagnosis-Problem.
Denominator: equals IPP	N/A
Denominator Exclusions: none	N/A
Numerator: patients with at least two medical visits during the measurement year with a minimum of 90 days between each visit	The system calculates a list of the client's approved visits that occurred during the measurement period and have a CPT/HCPCS code from the value set. For each visit, if the next approved visit is at least 90 days afterwards, the client will count towards the numerator. • Example 1: Visit A on 1/1/13 and Visit B on 1/15/13. Client has two visits but they are not 90 days apart. Client does not count towards the numerator. • Example 2: Visit A on 1/1/13, Visit B on 1/15/13, and Visit C on 6/20/13. Client has three visits and Visits B and C are more than 90 days apart. Client counts towards the numerator.
Numerator Exclusions: N/A	N/A
Denominator Exceptions: none	N/A

CMS68v3 Documentation of Current Medications in the Medical Record

Description: percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.



Measure Notes

This measure counts visits not clients; each visit is counted separately and medication reconciliation must occur to count towards the numerator.

CQM Component	In Credible
Initial Patient Population (IPP): all visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period	1. Click here for age requirement information. 2. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS68V3') and filter the qdm_category column by Encounter. 3. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides. 4. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with a required question and answers.

	The documentation for every visit identified in the IPP must contain a question asking whether Medication Reconciliation was performed. You need to code the question to SNOMED CT 428191000124101 for "Documentation of current medications (procedure)" and code the answers as specified below. The answer selected determines whether the visit counts toward the numerator or is a denominator exception (see below). If the completed form data for an IPP visit does not contain BOTH a Medication Reconciliation question and answer with the required SNOMED codes, medication reconciliation will be considered not performed.
Denominator: equals IPP	N/A
Denominator Exclusions: none	N/A
Numerator: eligible professional attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration	To count towards the numerator, the selected answer to the Medication Reconciliation question has to have a SNOMED code of 398166005 for "Performed (qualifier value)" – this indicates that the medication list was reviewed and found to be complete. *It is the responsibility of the employee completing the visit to review the list of medications at each visit and attest to its completeness.*
Numerator Exclusions: N/A	N/A

Denominator Exceptions:
Medical Reason: Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

To indicate a valid reason for NOT doing the medication reconciliation, the selected answer to the Medication Reconciliation question has to have one of the following SNOMED CT codes (in the value set, qdm_category = Attribute):

- 183932001 for Procedure contraindicated (situation)
- 397745006 for Medical contraindication (finding)
- 407563006 for Treatment not tolerated (situation)

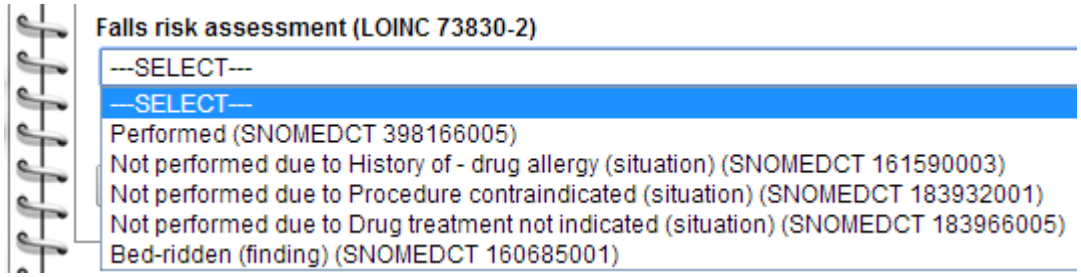
Form Configuration for the IPP, Numerator, and Denominator Exception

Update the appropriate form(s) as follows:

1. Optional: add a label only question that identifies the measure.
2. Add a dropdown question for "Documentation of current medications (procedure) performed?" and enter 428191000124101 in the SNOMED Code field.
3. Add the following answers to the question, entering the codes indicated in the SNOMED Code field:
    a. Performed (qualifier value) – 398166005
    b. Procedure contraindicated (situation) – 183932001
    c. Medical contraindication (finding) – 397745006
    d. Treatment not tolerated (situation) – 407563006

CMS139v2 Falls: Screening for Future Fall Risk

Description: percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.



CQM Component	In Credible
Initial Patient Population (IPP): patients aged 65 years and older with a visit during the measurement period	1. Click here for age requirement information. 2. To view the CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS139V2') and filter the qdm_category column by Encounter. 3. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides. 4. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with a required question and answers. The documentation for visits in the IPP must contain a question asking whether a Fall Risk Screening was performed. You need to code the question to LOINC for 73830-2 for "Falls risk assessment" and code the answers as specified below. The answer selected determines whether the visit counts toward the numerator or is a denominator exception (see below).
Denominator: equals IPP	N/A
Denominator Exclusions: none	N/A

Numerator: patients who were screened for future fall risk at least once within the measurement period	To count towards the numerator, the selected answer to the Fall Risk Screening question has to have a SNOMED CT code of 398166005 for "Performed (qualifier value)" – this indicates that the Fall Risk Screen was done. Clients will count towards the numerator when they have at least one visit where a fall risk screening was performed. Multiple fall risk screenings for the same client will not be counted.
Numerator Exclusions: N/A	N/A
Denominator Exceptions: documentation of medical reason(s) for not screening for fall risk (e.g., patient is not ambulatory)	To indicate a valid reason for NOT doing the fall risk screening, the selected answer to the Fall Risk Screening question has to have a SNOMED CT code from the value set OR the SNOMED CT code of 160685001 for "Bed-ridden (finding)."

Form Configuration for Numerator and Denominator Exception

Update the appropriate form(s) as follows:

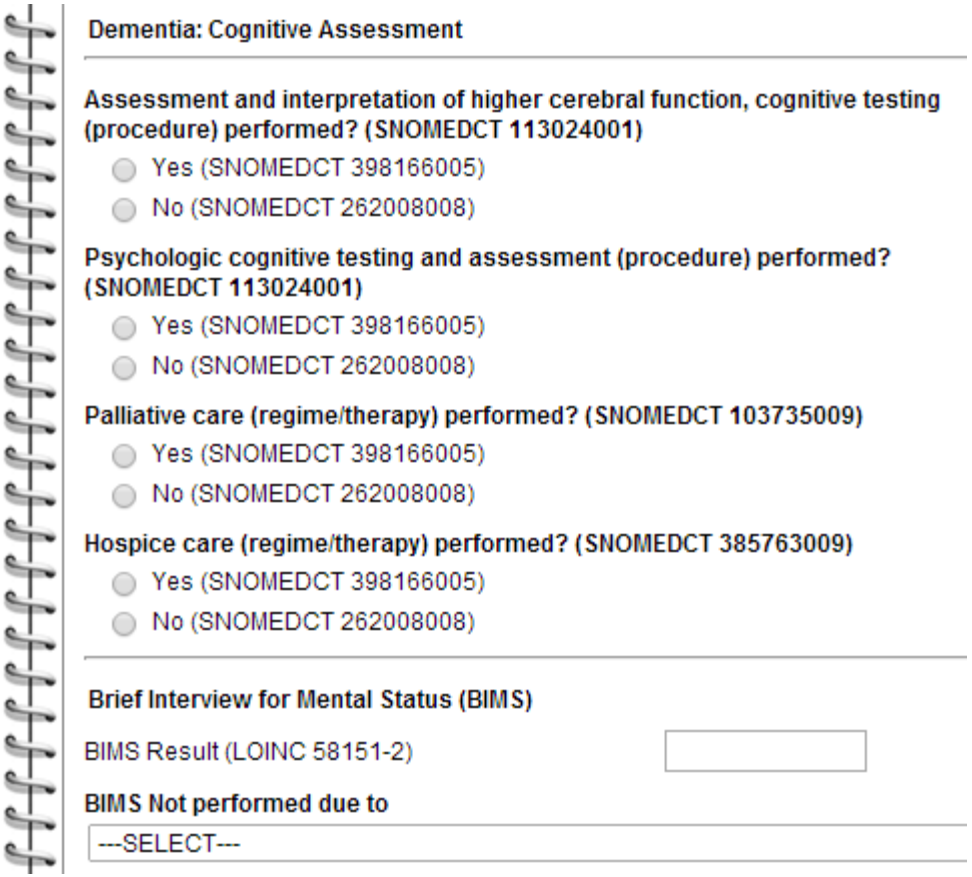
1. Optional: add a label only question that identifies the measure.
2. Add a dropdown question for "Falls Risk Assessment" and enter 73830-2 in the LOINC Code field.
3. Add the following answers to the question, entering the codes indicated in the SNOMED Code field:
   a. Performed (qualifier value) – 398166005
   b. Attributes from the value set; filter qdm_category by Attribute; refer to the code_system, code, and description columns

code	description
161590003	History of - drug allergy (situation)
183932001	Procedure contraindicated (situation)
183964008	Treatment not indicated (situation)

   c. Bed-ridden (finding) – 160685001

CMS149v2 Dementia: Cognitive Assessment

Description: percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period



Dementia: Cognitive Assessment

Assessment and interpretation of higher cerebral function, cognitive testing (procedure) performed? (SNOMEDCT 113024001)

- Yes (SNOMEDCT 398166005)
- No (SNOMEDCT 262008008)

Psychologic cognitive testing and assessment (procedure) performed? (SNOMEDCT 113024001)

- Yes (SNOMEDCT 398166005)
- No (SNOMEDCT 262008008)

Palliative care (regime/therapy) performed? (SNOMEDCT 103735009)

- Yes (SNOMEDCT 398166005)
- No (SNOMEDCT 262008008)

Hospice care (regime/therapy) performed? (SNOMEDCT 385763009)

- Yes (SNOMEDCT 398166005)
- No (SNOMEDCT 262008008)

Brief Interview for Mental Status (BIMS)

BIMS Result (LOINC 58151-2)

BIMS Not performed due to

---SELECT---

CQM Component	In Credible
Initial Patient Population (IPP): All patients, regardless of age, with a diagnosis of dementia	1. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS149V2') and filter the qdm_category column by Encounter. 2. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides. 3. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with required questions and answers. This measure uses two similar sets of Encounter codes (qdm_category = Encounter), one for determining the start of the Diagnosis and one for determining how many visits the client had. When the SNOMED CT-coded encounters are excluded, the two sets are the same. To be included in the IPP, the client must have at least two approved visits where the CPT code is in the value set and the visit date is in the measurement period. The client must also have a diagnosis of dementia starting on or before the approved visit. The diagnosis starts on the Diagnosed Date; if blank, the Effective Date for the assessment is used.
Denominator: equals IPP	N/A
Denominator Exclusions: none	N/A
Numerator: patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period	An assessment of cognition is documented in an approved visit via the form. The visit must occur within 12 months of the first IPP visit. There are two code sets that that can be used to document the cognitive assessment: • Cognitive Assessment which uses SNOMED CT codes • Standardized Tools for Assessment of Cognition which uses LOINC codes If using Cognitive Assessment, one of the answers should be “Performed,” coded to SNOMED CT as 398166005.

If using Standardized Tools for Assessment of Cognition, a separate question needs the LOINC code 58151-2. The answer can be free text OR a number for the score. Having any value in the answer will count as having performed the cognitive assessment.

See Denominator Exceptions for how to document NOT having the cognitive assessment performed.

Numerator Exclusions: N/A

N/A

Denominator Exceptions:

Documentation of medical reason(s) for not assessing cognition (e.g., patient with very advanced stage dementia, other medical reason)

Documentation of patient reason(s) for not assessing cognition

Severe Dementia is indicated by the client having a diagnosis with the SNOMED code 428351000124105 for “Severe dementia (disorder)” that starts on or before the end of the measurement period. In Credible, the SNOMED CT description (the code is behind the scenes) that corresponds to a diagnosis is selected in the detail section of the diagnosis record.

To document NOT performing the cognitive assessment:

1. If using Cognitive Assessment: a “Not Performed” answer coded to SNOMED CT 262008008 must be selected.
2. If using Standardized Tools for Assessment of Cognition: a SNOMED CT-coded answer to a “Not performed due to” question must be selected. The answers must be attributes from the value set.

This documentation can occur in any approved visit during the measurement period.
If a client has received Palliative Care during the measurement period, this also counts as a denominator exception. The documentation for this denominator exception is having an approved visit in the measurement period that has a “Performed” answer (coded to SNOMED CT 398166005) to a palliative or hospice care.

Form Configuration for the Numerator and the Denominator Exceptions

Update the appropriate form(s) as follows:

1. Optional: add a label only question that identifies the measure.
2. Add radio button questions for the Cognitive Assessment interventions in the value set (qdm_category = Intervention, value_set_name = Cognitive Assessment); enter the appropriate code in the SNOMED Code field.

code	description
113024001	Assessment and interpretation of higher cerebral function,
4719001	Psychologic cognitive testing and assessment (procedure)

   For each question, add a Performed answer (398166005 in SNOMED Code field) and Not Performed answer (262008008 in SNOMED Code field).

   OR

   Add a text box question for Brief Interview for Mental Status (BIMS) (qdm_category = Risk Category-Assessment) and a dropdown question for "BIMS Not performed due to"; enter LOINC code 58151-2 for both.

   For the dropdown question, add answers that correspond to attributes in the value set; enter appropriate code in the SNOMED Code field.

code	description
161590003	History of - drug allergy (situation)
183932001	Procedure contraindicated (situation)
183964008	Treatment not indicated (situation)

3. Add radio button questions for the Palliative Care interventions in the value set; enter the appropriate code in the SNOMED Code field (qdm_category = Intervention, value_set_name = Palliative Care).

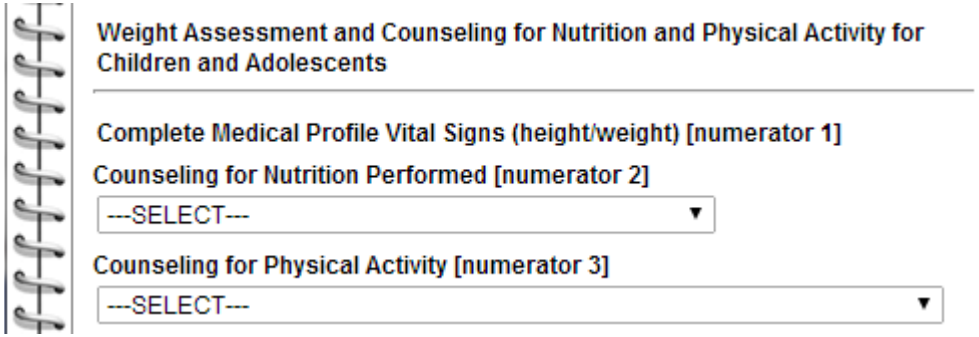
code	description
103735009	Palliative care (regime/therapy)
385763009	Hospice care (regime/therapy)

   For each question, add a Performed answer (398166005 in SNOMED Code field) and Not Performed answer (262008008 in SNOMED Code field).

CMS155v2 Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents

Description: percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.

a. Percentage of patients with height, weight, and body mass index (BMI) percentile documentation
b. Percentage of patients with counseling for nutrition
c. Percentage of patients with counseling for physical activity



Stratification: report a total score, and each of the following strata:

Stratum 1 – Patients age 3-11

Stratum 2 – Patients age 12-17

Stratification is based on the age of the client at the start of the measurement period

CQM Component	In Credible
Initial Patient Population (IPP): patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period	1. Click here for age requirement information. 2. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS155V2') and filter the qdm_category column by Encounter. 3. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides.

	4. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will need to update the forms linked to them with required questions and answers.
Denominator: equals IPP	N/A
Denominator Exclusion: patients who have a diagnosis of pregnancy during the measurement period	To be considered active, the diagnosis must start prior to the end of the measurement period and end after the start of the measurement period (or not end at all). The diagnosis of starts on the Diagnosed Date; if blank, the Effective Date for the assessment is used. The Resolved Date indicates when that diagnosis is no longer active. If you want to see which Pregnancy diagnoses are valid for the measure, view the value set and filter the qdm_category column by Condition-Diagnosis-Problem; the valid diagnoses have ICD9CM or SNOMEDCT in the code_system column.
Numerator 1: patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period	To count towards Numerator 1, the client must have a complete height and weight in the same medical profile and the effective date of the medical profile must be in the measurement period. BMI is automatically calculated. Height and weight must be recorded using the standard fields (ClientMedicalProfile.height_ft, ClientMedicalProfile.height_in, ClientMedicalProfile.weight); using any other fields will not calculate a BMI.
Numerator 2: patients who had counseling for nutrition during the measurement period	To count towards Numerator 2, the client needs at least one approved visit during the measurement period where Nutrition Counseling is documented. As there are multiple types of counseling, only the answers need to be coded with the SNOMED CT codes in the value set.
Numerator 3: patients who had counseling for physical activity during the measurement period	To count towards Numerator 3, the client needs at least one approved visit during the measurement period where Physical Activity Counseling is documented. As there are multiple types of counseling, only the answers need to be coded with the SNOMED CT codes in the value set.
Numerator Exclusion: N/A	N/A
Denominator Exceptions: none	N/A

Form Configuration for Numerators 2 and 3

Update the appropriate form(s) as follows:

1. Optional: add a label only question that identifies the measure.
2. Add check box/radio button/dropdown questions for Nutrition Counseling and Physical Activity Counseling.
3. For the Nutrition Counseling question, add answers that correspond to the value set (qdm_category = Intervention; value_set_name = Counseling for Nutrition); for each answer, enter the appropriate SNOMED CT code.

code	description
103699006	Patient referral to dietitian (procedure)
11816003	Diet education (procedure)
183059007	High fiber diet education (procedure)
183062006	Low cholesterol diet education (procedure)

4. For the Physical Activity Counseling question, add answers that Add (qdm_category = Intervention; value_set_name = Counseling for Physical Activity); for each answer, enter the appropriate SNOMED CT code.

code	description
103736005	History and physical examination, sports part
183073003	Patient advised about exercise (situation)
183075005	Recommendation to mobilize part (procedure)
223440006	Recommendation to undertake activity (proce

CMS156v2 Use of High-Risk Medications in the Elderly

Description: percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported.

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

Calculation Notes

This measure calculates a *Cumulative Medication Duration* – an individual's total number of medication days over a specific period; the period counts multiple prescriptions with gaps in between but does not count the gaps during which a medication was not dispensed.

Staff must use the Sig Builder tab in Credible eRx when creating the prescription (Free Text sigs cannot be calculated) and it must have one of the following statuses:

- (EC) ELECTRONIC - CURRENT
- (PC) PAPER - CURRENT
- (FC) FAX - CURRENT
- (ECU) ELECTRONIC - CURRENT UNAPPROVED
- (PCU) PAPER - CURRENT UNAPPROVED

The duration of the prescription is calculated by as follows:

(Quantity X Number of Refills) / (Dosage X Route Per X Route Time Multiplier)

Number of Refills = 1 + the number of refills entered. The 1 is for the original prescription so that if no refills are provided the +1 will make the 0 into 1. If PRN is selected, it will be considered the same as "no refills entered."

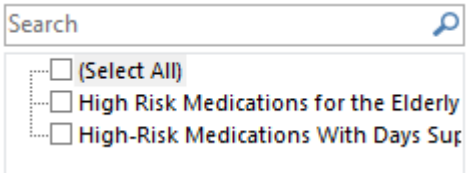
Route Time Multiplier = 1 or 3; see below

- 'daily', 'before breakfast', 'after breakfast', 'before dinner', 'after dinner', 'at bedtime', 'time per day', 'time(s) per day', and 'times per day' becomes 1
- 'before every meal' and 'after every meal' becomes 3
- All other selections are considered as zero and will not count towards the Cumulative Medication Duration

For example: **Take 2 Tablet(s) By Oral Route 3 times per day** where Quantity is 90 with 2 refills would result in the prescription being filled three times total, 90 tablets each time.

(90 X 3) / (2 X 3 X 1) = 270 total tablets prescribed DIVIDED BY taking 6 tablets per day = 270/6 for a cumulative medication duration 45 days

Note that the Cumulative Medication Duration is calculated based on the medication itself (RxNorm ID; this is a behind-the-scenes code in Credible). Creating a new prescription for Glyburide 2.5 MG Oral Tablet (RxNorm 310534) will create a new Meds record; subsequent refills of that prescription will retain the same Meds.med_id. If the prescription is discontinued and another new prescription is created for Glyburide 2.5 MG Oral Tablet (RxNorm 310534), a new Meds record with a new Meds.med_id will be created. The Cumulative Medication Duration will calculate the total days for all the prescriptions of Glyburide 2.5 MG Oral Tablet (RxNorm 310534) provided to the client.

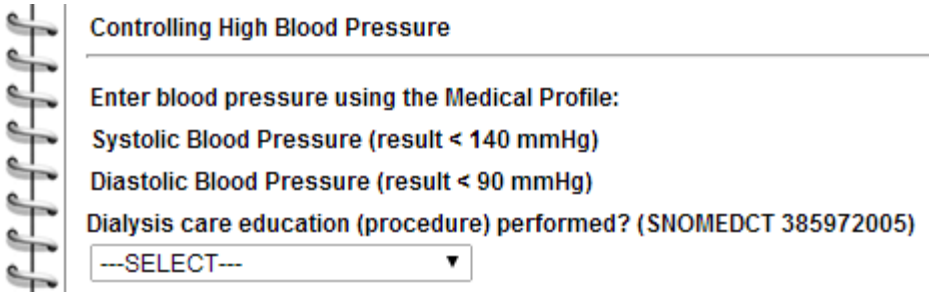
CQM Component	In Credible
Initial Patient Population (IPP): patients 66 years and older who had a visit during the measurement period	1. Click here for age requirement information. 2. To view CPT/HCPCS codes of IPP visits, export the value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS156V2') and filter the qdm_category column by Encounter.
Denominator: equals IPP	N/A
Denominator Exclusion: none	N/A
Numerators: Numerator 1: Patients with an order for at least one high-risk medication during the measurement period. Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period. There are two types of high-risk medications: • High Risk Medications for the Elderly -- these count towards the numerator when a prescription exists (simply having a prescription for this medication creates a high risk)	Use the Sig Builder tab in Credible eRx when creating a prescription. Status must be EC, PC, FC, ECU, or PCU and prescription start date must be in the measurement period. If you want to see which medications fall into the two different high-risk categories, view the value set, filter the qdm_category by Medication, and then filter the value_set_name category each category. 

- High-Risk Medications With Days Supply Criteria – these only count towards the numerator when the prescription exists AND the Cumulative Medication Duration is 90 days or greater (high risk for the client exists if 90 or more days worth of the medication has been ordered)

Numerator Exclusion: N/A	N/A
Denominator Exception: N/A	N/A

CMS165v2 Controlling High Blood Pressure

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



Measure Notes

This measure has four sets of diagnosis codes. Essential Hypertension is used to identify clients for the IPP. The three other sets -- Chronic Kidney Disease, Stage 5; End Stage Renal Disease; and Pregnancy – are used to identify clients for denominator exclusions.

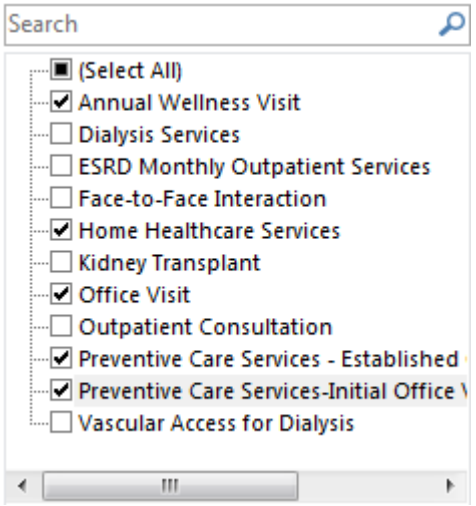
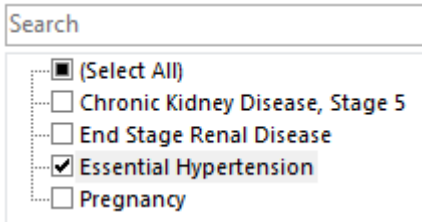
This measure also has 10 sets of CPT/HCPCS codes. The following are used for the IPP:

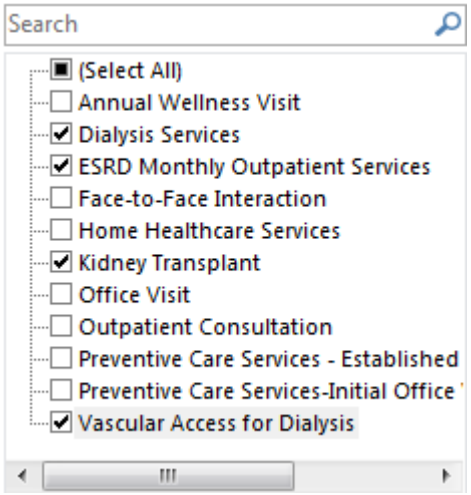
- Annual Wellness Visit
- Preventive Care Services - Established Office Visit, 18 and Up
- Preventive Care Services-Initial Office Visit, 18 and Up
- Home Healthcare Services
- Office Visit

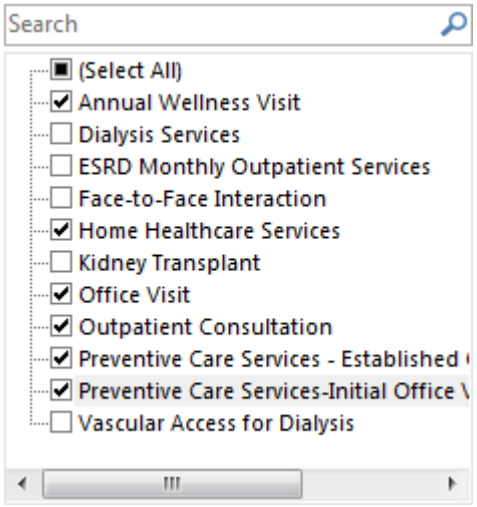
The numerator uses the five code sets above plus the Outpatient Consultation code set.

The following are used only for the denominator exclusions:

- Dialysis Services
- ESRD Monthly Outpatient Services
- Kidney Transplant
- Vascular Access for Dialysis

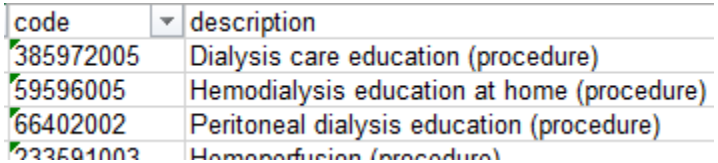
CQM Component	In Credible
Initial Patient Population (IPP): patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period	1. Click here for age requirement information. 2. To view CPT/HCPCS codes of IPP visits, export value set to a spreadsheet (SELECT * FROM CQMValueSetView WHERE cms_id = 'CMS165V2'), filter qdm_category column by Encounter, and then filter value_set_name by the names below.  To be included in the IPP, a client must have a diagnosis of Essential Hypertension that starts no later than 6 months after the start of the measurement period. If the diagnosis started prior to the start of the measurement period, the Resolved Date must be empty or after the start of the measurement period. In essence, the client has a diagnosis of hypertension during the first six months of the period. The ICD9CM or SNOMEDCT code of the diagnosis must be in the value set. To view the valid codes: view the value set, filter qdm_category by Condition-Diagnosis-Problem, and then filter value_set_name by Essential Hypertension. 

Denominator: equals IPP	N/A
Denominator Exclusions: patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.	Diagnosis-based exclusions are where the diagnosis code is in the value set AND the value_set_name is NOT Essential Hypertension. The diagnosis has to start on/before the end of the measurement period and either have no resolved date or be resolved during/after the measurement period. In essence, during the measurement period the client has to have that diagnosis. There are two approaches to documenting non-diagnosis-based exclusions: • The client has an approved visit where the CPT code is in the Denominator Exclusion value set (shown on right) and the visit date is before the end of the measurement period (this can include visits prior to the measurement period). • An intervention is performed as documented in a SNOMED CT-coded question/answer pair. The approved visit associated with the intervention has a visit date before the end of the measurement period (this can include visits prior to the measurement period). 

Numerator: patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.	To count towards the numerator, the date of the most recent numerator visit that occurs during the measurement period is obtained; see below for the different numerator visit types. The client must have a medical profile with an Effective Date matching this most recent date AND that profile must have a blood pressure pairing where the top (Systolic) value is less than 140 AND the bottom (Diastolic) value is less than 90.  There are three pairs of blood pressure fields in the medical profile: resting (bloodpressure_top and bloodpressure_bottom), standing (standing_bp_top and standing_bp_bottom), and lying (lying_bp_top and lying_bp_bottom). These are the only fields that can be used to record blood pressure. Both top (Systolic) and bottom (Diastolic) for the pair must be used.
Numerator Exclusions: N/A	N/A
Denominator Exceptions: N/A	N/A

Form Configuration for Denominator Exclusion Intervention Method

1. To view CPT/HCPCS codes of denominator exclusion visits, filter the qdm_category column by Encounter and then filter value_set_name by the names below:
    - Dialysis Services
    - ESRD Monthly Outpatient Services
    - Kidney Transplant
    - Vascular Access for Dialysis
2. Jot down the CPT and HCPCS codes that correspond to the services your Agency provides.
3. Using the CPT Code search field in the Billing Matrix, determine which visit type(s) is associated with each CPT/HCPCS code. Jot down the visit types as you will update them in the step below.
4. Update the appropriate form(s) as follows:
    a. Optional: add a label only question that identifies the measure.
    b. Add a dropdown question for one of the interventions in the value set (qdm_category = Intervention); enter the appropriate code in the SNOMED Code field.



code	description
385972005	Dialysis care education (procedure)
59596005	Hemodialysis education at home (procedure)
66402002	Peritoneal dialysis education (procedure)
233591003	Hemoperfusion (procedure)

    c. Add a Performed answer (398166005 in SNOMED Code field) and Not Performed answer (262008008 in SNOMED Code field) to the question.

Using the CQM Reporting Module

1. Reports tab > CQM button on nav bar.
2. Select the CQM you need to report on.
3. Select the provider you want to include in the header of the QRDA report. Select the provider you want to include in the header of the QRDA report. Since the report pulls data based on all clients meeting the criteria, the provider you select will have no bearing on the data pulled.
4. Enter the start and end date of the reporting period.
5. Click the button for the type of report you want to generate. As a reminder, a QRDA Category I report consists of multiple XML files – one for each client included in the measure results – and a QRDA Category III report is a single XML with aggregate data.

Appendix A: Credible Client Portal Configuration

Setting up the Credible Client Portal

1. Select the fields you want client users to view:
    a. **Admin** tab > **Data Dictionary**
    b. Make sure Table Source = Clients and Type = View and then click **Submit.**
    c. For each field that you want a client user to have view access to, select the User View checkbox and click **update.**
2. Add a client user login profile:
    a. **Admin** tab > **Login Profiles** > **Add a New Security Profile Entry.** You need to add at least one login profile where Is Client User = True.
    b. In the Profile Code field, enter the name of the profile.
    c. Enter a description, select True from the Is Client User dropdown, and click **Add Security Profile.**
3. Set up multiple client user login profiles if you want to vary the parts of a record client users have access to. For example, you can have one full access profile and several partial access profiles. You use the Client User Security Matrix to control the parts of a record profile has access to.
4. Set up the Client User Security Matrix:
    a. **Admin** tab > **Client User Security Matrix.**
    b. Select the options you want each client user profile to have access to and click **Save All.**
5. Give users the right to add client users by selecting *ClientUserView* for the appropriate profiles in the Security Matrix.
6. Configure the Client User Home Page:
    a. **Admin** tab > **Home Page Config** > **Client User Home Page Admin.**
    b. Select the options you want to display on the Client Portal home page and click **Save.**

Giving Client User Access to the Client Portal

1. Client tab > Client's name > **Users** on Client nav bar > **Add User**.
2. Enter a username for the client user.
3. Enter the first and last name of the client user and enter his or her email address.
4. Enter the date the client user requested access to an electronic copy of his/her health information (default is current date).
5. Select the client user profile from the dropdown and click **Add User.** The Password Update screen displays.
6. Enter a password for the client user in the New Password field and then enter it again in the second password field. Note that a client user will have to change his or her password during the initial login to the portal.
7. Click **Update Password.** The User Accounts screen displays with the user account you created.

   If a client user needs to access the records for more than one client, he or she will need separate logins as you can only access a single client's record when logged into the Client Portal.