CREDIBLE
Behavioral Health Software

Meaningful Use Modified Stage 2 Guide for Credible Software

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Guide for Credible Software

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Introduction

This guide is for Credible Partners that have Eligible Professionals (EPs) pursuing Meaningful Use incentive based payments through the Medicare or Medicaid EHR Incentive Based Programs. It provides the information necessary to use Credible in a meaningful way and capture the data needed for attestation. Credible Behavioral Health 10.1 successfully passed the meaningful use certification criteria for ONC HIT 2014 Edition certification on September 28, 2015.

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.

Obtaining CMS EHR Certification ID for Credible Behavioral Health[1]

1. Go to the Certified Health IT Product List on the ONC website: https://chpl.healthit.gov/
2. Enter the search criteria
3. Click the appropriate Edition and follow instructions provided

Resources

Security Risk Assessment Tool, Office of the National Coordinator for Health Information Technology (ONC), http://bit.ly/1WWwx62

Security Risk Analysis Tip Sheet: Protect Patient Health Information, a joint publication of CMS EHR Incentive Programs and HHS Office for Civil Rights, http://go.cms.gov/2erGPPr

Guide to Privacy and Security of Electronic Health Information, Office of the National Coordinator for Health Information Technology, http://bit.ly/2dw2n9y

EHR Incentive Programs: What's Changed for EHR Incentive Programs in 2015 through 2017 (Modified Stage 2), CMS EHR Incentive Programs, http://go.cms.gov/1XMLjRc

EHR Incentive Programs: 2015 through 2017 (Modified Stage 2) Overview, CMS EHR Incentive Programs, http://go.cms.gov/1PrQGkg

Eligible Professional Objectives and Measures, CMS EHR Incentive Programs, http://go.cms.gov/1pI2Hrs

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[1] **Credible Behavioral Health 10.1 attained 2014 Edition Complete Ambulatory EHR Certification from the ICSA Labs ONC Health IT Certification Program**. This Complete EHR is 2014 Edition compliant and has been certified by an ONC-ACB in accordance with the application certification criteria adopted by the Secretary of Health and Human Services.

Stage 1 and 2 vs Modified Stage 2

> **Key Concepts for the EHR Incentive Programs in 2015 through 2017**
>
> - Restructured Stage 1 and Stage 2 objectives and measures to align with Stage 3:
>   - 10 objectives for EPs, including one consolidated public health reporting objective with measure options
>   - 9 objectives for eligible hospitals and CAHs, including one consolidated public health reporting objective with measure options
> - Starting in 2015, the EHR reporting period aligns with the calendar year for all providers
> - Changed the EHR reporting period in 2015 to 90 days to accommodate modifications to meaningful use
> - Modified Stage 2 patient engagement objectives that require "patient action"
> - Streamlined the program by removing redundant, duplicative, and topped out measures
> - CQM reporting for both (EPs) and eligible hospitals/CAHs remains as previously finalized
>
> EHR Incentive Programs: 2015 through 2017 (Modified Stage 2) Overview | https://www.cms.gov/

Meaningful Use program requirements experienced a modification in October 2015 creating a final rule that specified criteria that Eligible Professionals (EPs), Eligible Hospitals (EHs) and critical access hospitals (CAHs) must meet in order to continue participation. These rules encompass EHR Incentive Programs in 2015 through 2017, as well as Stage 3 in 2018 and beyond.

The changes from Measures and Menu options in Stage 1 and 2 to Objectives and Measures in Modified Stage 2 reflect the move to align with Meaningful Use Stage 3 whose focus is on the advanced use of EHRs. Starting in 2015, all providers are required to attest to a single set of objectives and measures.

First year as a meaningful EHR user Stage of meaningful use	Stage of Meaningful Use		
	2015	2016	2017
2011	Modified Stage 2	Modified Stage 2	Modified Stage 2 Or Stage 3
2012	Modified Stage 2	Modified Stage 2	Modified Stage 2 Or Stage 3
2013	Modified Stage 2	Modified Stage 2	Modified Stage 2 Or Stage 3
2014	Modified Stage 2*	Modified Stage 2	Modified Stage 2 Or Stage 3
2015	Modified Stage 2*	Modified Stage 2	Modified Stage 2 Or Stage 3
2016	N/A	Modified Stage 2	Modified Stage 2 Or Stage 3

* The Modifications to Stage 2 include alternate exclusions and specifications for certain objectives and measures for providers that were scheduled to demonstrate Stage 1 of meaningful use in 2015. **Note:** Alternate exclusion reporting continues in 2016 for CPOE (all providers) and eRx (for eligible hospitals) only.

Required for All Providers in 2015 through 2017[2]

Single Set of Objectives and Measures

- **Change:** All providers attest to a single set of objectives and measures. Eligible hospitals and CAHs report on 9 objectives, which includes one consolidated public health reporting objective with four measure options. EPs report on 10 objectives, which includes one consolidated public health reporting objective with three measure options.

- **Timing/Compliance:** Required in 2015 through 2017

- **Affected Providers:** EPs, eligible hospitals, and CAHs

- **What It Means:** To reduce the complexity of Medicare and Medicaid EHR Incentive Programs and to align more closely with Stage 3, starting in 2015, all providers are required to meet a single set of objectives and measures. These changes remove the menu and core structure of Stages 1 and 2, decrease the overall number of objectives to which a provider must attest, and reduce the reporting burden on "topped out" measures. All providers are required to use EHR technology certified to the 2014 Edition for an EHR reporting period in 2015, 2016, and 2017. Providers may upgrade early to EHR technology certified to the 2015 Edition for an EHR reporting period prior to 2018.

Modified Stage 2 Objectives 2015 -2017	
Eligible Professionals	*Eligible Hospitals, CAHs*
1. Protect Patient Health Information	1. Protect Patient Health Information
2. Clinical Decision Support	2. Clinical Decision Support
3. Computerized Provider Order Entry	3. Computerized Provider Order Entry
4. Electronic Prescribing	4. Electronic Prescribing
5. Health Information Exchange	5. Health Information Exchange
6. Patient Specific Education	6. Patient Specific Education
7. Medication Reconciliation	7. Medication Reconciliation
8. Patient Electronic Access	8. Patient Electronic Access
9. Secure Electronic Messaging	9. Public Health Reporting
10. Public Health Reporting	

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[2] EHR Incentive Programs: 2015 through 2017 (Modified Stage 2) Overview | https://www.cms.gov/

Alternate Exclusions and Specifications

- **Change:** For certain objectives and measures where there is not a Stage 1 measure equivalent to the Modified Stage 2 (2015 through 2017) measure or where a menu measure is now a requirement providers may claim an alternate exclusion or meet an alternate specification.

- **Timing/Compliance:** Added to 2015 and 2016

- **Affected Providers:** EPs, eligible hospitals, and CAHs

- **What It Means:** There are several alternate exclusions and specifications for certain measures in 2015 and 2016, which some providers may not otherwise be able to meet for those years because they require the implementation of certified EHR technology beyond the functions required for Stage 1.

EHR Reporting Period

- **Change:** The EHR reporting period for all providers in 2015 is any continuous 90 days within the calendar year. Please note, for 2015, eligible hospitals and CAHs may use an EHR reporting period of any continuous 90 day period from the beginning of the federal fiscal year to the end of the calendar year (October 1, 2014 through December 31, 2015). For eligible professionals, the action may occur at any point during that time as long as it is no earlier than January 1, 2015 and no later than the date of attestation for their 2015 EHR reporting period. For eligible hospitals and CAHs, the action may occur at any point during that time so long as it is no earlier than October 1, 2014 and no later than the date of attestation for their 2015 EHR reporting period. In 2016 and 2017, first time participants as well as any provider moving to Stage 3 in 2017 may use an EHR reporting period of any continuous 90 days. All returning participants would use an EHR reporting period of a full calendar year.

- **Timing/Compliance:** Required in 2015 through 2017

- **Affected Providers:** EPs, eligible hospitals, and CAHs

- **What It Means:** Starting in 2015, the EHR reporting period will be based on the calendar year. To allow CMS and providers time to implement the modifications to the EHR Incentive Programs, the EHR reporting period in 2015 is any continuous 90 days' period. Maintaining the 90-day reporting period for new participants in 2016 and 2017 will assist new participants in demonstrating meaningful use in their first year of participation. Providing the 90-day reporting period for new Stage 3 participants in 2017 will help promote flexibility.
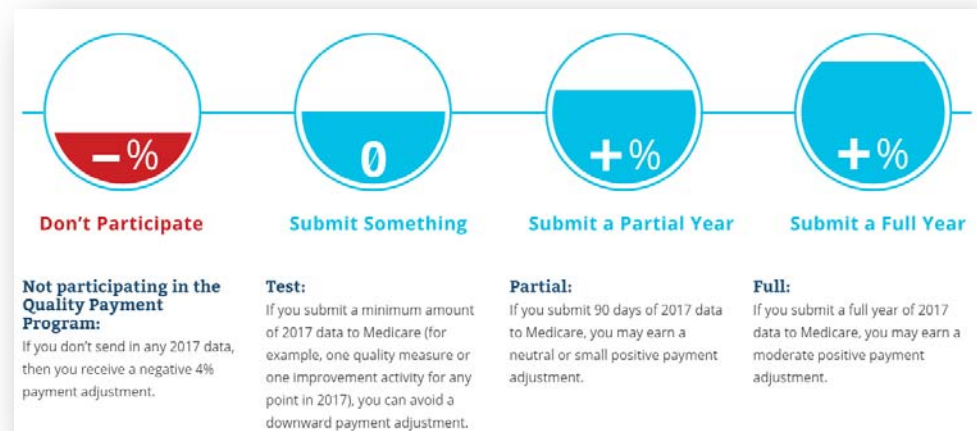
Removed Objectives and Measures for EPs

- **Change:** Removed the following objectives: Record Demographics, Record Vital Signs, Record Smoking Status, Clinical Summaries, Structured Lab Results, Patient List, Patient Reminders, Summary of Care – Measures 1 and 3, Electronic Notes, Imaging Results, and Family Health History.

- **Timing/Compliance:** Removed from 2015 and beyond

- **Affected Providers:** EPs

- **What It Means:** These objectives and measures are identified as redundant, duplicative, or topped out, and therefore no longer required for the successful demonstration of meaningful use for EHR Incentive Programs in 2015 through 2017, or have been consolidated into other objectives.

Quality Payment Program in 2017: Pick Your Pace[3]

As addressed by Andy Slavitt, Acting Administrator of CMS on September 8, 2016, options for participation in 2017 shift to a "pick your pace" model for MIPS. These options are available for participants to specifically ensure you do not receive a negative payment adjustment in 2019.

- Option 1: Test the Quality Payment Program
- Option 2: Participate for part of the calendar year
- Option 3: Participate in the full calendar year
- Option 4: Participate in an Advanced Alternative Payment Model in 2017

The final Quality Payment Plan is available at https://qpp.cms.gov/ and details the two tracks providers can choose if they are a Medicare Part B provider:
- Advanced Alternative Payment Models (APMs) or
- The Merit-based Incentive Payment System (MIPS)

Don't Participate

Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Submit Something

Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Submit a Partial Year

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Submit a Full Year

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

Throughout this guide, the objectives that connect to the required MIPS Advancing Care Information measures are noted with the ▣ *icon.*

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[3] Plans for the Quality Payment Program in 2017: Pick Your Pace | https://blog.cms.gov/2016/09/08/qualitypaymentprogram-pickyourpace/

Attestation for Objectives with Automated Measure Calculation §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_problem_list_summary vs spc_export_mu_problem_list_detail). The Stage 2 CPOE measure is the one exception to this summary/detail naming "formula"; for this measure, the summary/detail stored procedures are spc_export_mu_cpoe_summary and spc_export_mu_cpoe_detail_stage2

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 Partner Services Coordinator (PSC) needs to turn on the Client Portal for your system.
Steps to Configure Configuration	For the steps to set up the Client Portal and give a client user access to it, refer to Appendix A: Credible Client Portal
	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 objective:

1. **Reports** tab > **Export Tool**
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**.

New Export	Export Name:	MU: CPOE Summ	Form / Table Name:	Custom Query	▼
	Custom Query:	spc_export_mu_cpoe_summary			

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

Meaningful Use stored procedure exports in the Credible Library

If you need to make Agency-specific changes to the queries behind the meaningful use stored procedures, they are available in text files in the Credible Library (reference ID 39088). For example, if you use a non-standard Client Profile field to capture demographic information and/or smoking status, you will need to modify the queries for the corresponding stored procedures.

MU Stored Procedure: SUMMARY	MU Stored Procedure: DETAIL
spc_export_mu_allergy_list_summary	spc_export_mu_allergy_list_detail
spc_export_mu_clinical_smry_summary	spc_export_mu_clinical_smry_detail
spc_export_mu_cpoe_summary	spc_export_mu_cpoe_detail
spc_export_mu_cpoe_detail_summary	spc_export_mu_cpoe_detail_stage2
spc_export_mu_demographics_summary	spc_export_mu_demographics_detail
	spc_export_mu_electronic_notes_detail
	spc_export_mu_erx_family_hx_detail
spc_export_mu_erx_summary	spc_export_mu_erx_detail
spc_export_mu_family_hx_summary	spc_export_mu_family_hx_detail
spc_export_mu_imaging_summary	spc_export_mu_imaging_detail
spc_export_mu_labresult_summary	spc_export_mu_labresult_detail
spc_export_mu_med_reconcile_summary	spc_export_mu_med_reconcile_detail
spc_export_mu_medication_list_summary	spc_export_mu_medication_list_detail
spc_export_mu_messaging_summary	spc_export_mu_messaging_detail
spc_export_mu_patient_education_summary	spc_export_mu_patient_education_detail
spc_export_mu_patient_reminder_summary	spc_export_mu_patient_reminder_detail
spc_export_mu_problem_list_summary	spc_export_mu_problem_list_detail
spc_export_mu_smoking_summary	spc_export_mu_smoking_detail
spc_export_mu_transition_care_summary	spc_export_mu_transition_care_detail
spc_export_mu_vdt_summary	spc_export_mu_vdt_detail
spc_export_mu_vitalsigns_summary	spc_export_mu_vitalsigns_detail

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Objectives and Measures for Modified Stage 2

1. **Protect Patient Health Information:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.
2. **Clinical Decision Support (CDS):** Use clinical decision support to improve performance on high priority health conditions.
3. **Computerized Provider Order Entry (CPOE):** Use computerized provider order entry 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.
4. **Electronic Prescribing:** (EPs) Generate and transmit permissible prescriptions electronically (eRx); (Eligible hospitals/CAHs) Generate and transmit permissible discharge prescriptions electronically (eRx).
5. **Health Information Exchange:** The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
6. **Patient Specific Education:** Use clinically relevant information from CEHRT to identify patient specific education resources and provide those resources to the patient.
7. **Medication Reconciliation:** The EP, eligible hospital, or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
8. **Patient Electronic Access:** (EPs) 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. (Eligible hospitals/CAHs) Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.
9. **Secure Electronic Messaging (EPs only):** Use secure electronic messaging to communicate with patients on relevant health information.
10. **Public Health Reporting:** The EP, eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT, except where prohibited and in accordance with applicable law and practice.

Clinical Quality Measures (CQMs)

Clinical Quality Measures EPs, eligible hospitals, and CAHs must report on CQMs selected by CMS using certified EHR technology in order to successfully participate in the Medicare and Medicaid EHR Incentive Programs. There are no changes to CQM selection or reporting scheme from CQM requirements in Stage 2.

(The CQMs available for use in the EHR Incentive Programs beginning in 2014 have been outlined on the CMS EHR Incentive Programs website.)

For more information on Credible's CQM Tool, please visit the following resources in Credible's Help:

- Home > Help By Tab > Reports > Credible CQM Tool > CQM Tool User Guide
- Home > General Information > Meaningful Use Guide for Credible Software > Clinical Quality Measurements Guide v1.0

Objective 1: Protect Patient Health Information

Objective   Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

Measure   Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process

Exclusion   None

Attestation Requirements

YES/NO   Eligible professionals (EPs) must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary and correcting identified security deficiencies to meet this measure.

Additional Information:[4]
- EPs must conduct or review a security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once each calendar year and attest to conducting the analysis or review.
- An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each EHR reporting period. Any security updates and deficiencies that are identified should be included in the provider's risk management process and implemented or corrected as dictated by that process.
- It is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be unique for each EHR reporting period, the scope must include the full EHR reporting period, and the analysis or review must be conducted prior to the date of attestation.
- The parameters of the security risk analysis are defined 45 CFR 164.308(a)(1), which was created by the HIPAA Security Rule. Meaningful use does not impose new or expanded requirements on the HIPAA Security Rule nor does it require specific use of every certification and standard that
- is included in certification of EHR technology. More information on the HIPAA Security Rule can be found at http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/.
- HHS Office for Civil Rights (OCR) has issued guidance on conducting a security risk analysis in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule: http://www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html.

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[4] Eligible Professional EHR Incentive Program Objectives and Measures for 2016 Objective 1 of 10, Date updated: February 4, 2016

- Additional free tools and resources available to assist providers include a Security Risk Assessment (SRA) Tool developed by ONC and OCR: http://www.healthit.gov/providers-professionals/security-risk-assessment-tool.

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
Protect Electronic Health Information Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.	**Measure:** Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.	***Protect Patient Health Information*** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	**Measure:** Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EPs risk management process.

Objective 2: Clinical Decision Support

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

Measure   EPs must satisfy both of the following measures in order to meet the objective:

- **Measure 1:** Implement five clinical decision support interventions related to four Measures 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.

Definition of Terms

Clinical Decision Support – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

Attestation Requirements

YES/NO/EXCLUSION
- **MEASURE 1:** EPs must attest YES to implementing five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period.
- **MEASURE 2:** EPs must attest YES to enabling and implementing the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
- **EXCLUSION**: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

Certification Criteria

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.

With a Viewable By setting, you can limit which employees can view a clinical support when it is triggered. You can select one or more security profiles from the list provided. An employee with a selected profile also needs to have the ClinicalSupportView right.

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, medical profile details, 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 applicable, specify bibliographic citation, developer, funding source, and/or release.
7. To give users the option of pushing the clinical support to the Client Portal, select the Push To Client checkbox.
8. To limit which employees can view the clinical support when it is triggered, select one or more security profiles from Viewable By list (press and hold Shift/Ctrl and click to select range or multiple profiles).
   a. *Make sure the profiles selected have the ClinicalSupportView right.*
9. 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.

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
Clinical Decision Support Use clinical decision support to improve performance on high-priority health conditions.	**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.	*Clinical Decision Support* Use clinical decision support to improve performance on high-priority health conditions.	**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. **Measure 2 Exclusion**: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.

Objective 3: Computerized Provider Order Entry (CPOE)

Objective   Use computerized provider order entry 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.

Measure   An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective:

- **Measure 1:** More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.
- **Measure 2:** More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.
- **Measure 3:** More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Exclusion   **Measure 1:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.

Measure 2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

Measure 3: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

Alternate Exclusion

Alternate Exclusion for Measure 2: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

Alternate Exclusion for Measure 3: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

Definition of Terms

Computerized Provider Order Entry (CPOE) – A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Laboratory Order – An order for any service provided by a laboratory that could not be provided by a non-laboratory.

Laboratory – A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order – An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire EHR reporting period.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION/ALTERNATE EXCLUSION

Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Denominator	Numerator	Threshold	Exclusion
Number of medication orders created by the EP during the EHR reporting period.	The number of orders in the denominator recorded using CPOE.	The resulting percentage must be more than 60 percent in order for an EP to meet this measure.	Any EP who writes fewer than 100 medication orders during the EHR reporting period.

Measure 2: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Denominator	Numerator	Threshold	Exclusion	Alternate Exclusion
Number of laboratory orders created by the EP during the EHR reporting period.	The number of orders in the denominator recorded using CPOE.	The resulting percentage must be more than 30 percent in order for an EP to meet this measure.	Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.	Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Denominator	Numerator	Threshold	Exclusion	Alternate Exclusion
Number of radiology orders created by the EP during the EHR reporting period.	The number of orders in the denominator recorded using CPOE.	The resulting percentage must be more than 30 percent in order for an EP to meet this measure.	Any EP who writes fewer than 100 radiology orders during the EHR reporting period.	Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

Certification Criteria

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. 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.

Attestation

Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Denominator	Numerator
CMS: Number of medication orders created by the EP during the EHR reporting period.	**CMS:** The number of orders in the denominator recorded using CPOE.
Credible: Number of physician orders of type 'Medications' or OR medication where the provider is an employee (automatic for Credible eRx)	**Credible:** 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

Measure 2: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Denominator	Numerator
CMS: Number of laboratory orders created by the EP during the EHR reporting period.	**CMS:** The number of orders in the denominator recorded using CPOE.
Credible: Number of physician orders of type 'Labs'	**Credible:** 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

Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Denominator	Numerator
CMS: Number of radiology orders created by the EP during the EHR reporting period.	**CMS:** The number of orders in the denominator recorded using CPOE.
Credible: Number of physician orders of type 'Radiology'	**Credible:** 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

Note that the detail stored procedure for this measure is *spc_export_mu_cpoe_detail_stage2.*

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
CPOE 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.	**Measure:** More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	*CPOE* Use computerized provider order entry 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.	**Measure 1**: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Measure 1 Exclusion:** Any EP who writes fewer than 100 medication orders during the EHR reporting period. **Measure 2:** More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Measure 2 Exclusion**:

			Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Measure 3**: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Measure 3 Exclusion:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

Objective 4: Electronic Prescribing (eRx)

Objective   Generate and transmit permissible prescriptions electronically (eRx).

Measure   More than 50 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

Exclusion   Any EP who:
- Writes fewer than 100 permissible prescriptions during the EHR reporting period; or
- Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

Definition of Terms

Prescription – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.

Permissible Prescriptions – "Permissible prescriptions" may include or not include controlled substances based on provider selection and where allowable by state and local law.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

Denominator	Numerator	Threshold	Exclusion
Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.	The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.	The resulting percentage must be more than 50 percent in order for an EP to meet this measure.	Any EP who: I. Writes fewer than 100 permissible prescriptions during the EHR reporting period; or II. Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

Certification Criteria

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

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.

Attestation

More than 50 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

Denominator	Numerator
CMS: Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.	**CMS:** The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.
Credible: 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	**Credible:** 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.*	

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
Electronic Prescribing (eRx) Generate and transmit permissible prescriptions electronically (eRx).	**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.	*Electronic Prescribing (eRx)* Generate and transmit permissible prescriptions electronically (eRx).	**Measure:** More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. **Exclusions:** Any EP who: - Writes fewer than 100 permissible prescriptions during the EHR reporting period; or - Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

Objective 5: Health Information Exchange

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 provides a summary care record for each transition of care or referral.

Measure   The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

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.

Definition of Terms

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record – All summary of care documents used to meet this objective must include the following information if the provider knows it:

- Patient name
- Referring or transitioning provider's name and office contact information (EP only)
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral (EP only)
- Current problem list (Providers may also include historical problems at their discretion)*
- Current medication list*

- Current medication allergy list*

Note: An EP must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.

Current problem lists – At a minimum a list of current and active diagnoses.

Active/current medication list – A list of medications that a given patient is currently taking.

Active/current medication allergy list – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan – The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

Denominator	Numerator	Threshold	Exclusion
Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.	The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.	The percentage must be more than 10 percent in order for an EP to meet this measure.	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.

Certification Criteria

In Credible, you use the Generate Clinical Summary and send the CCD via Direct Messaging in Credible. The Direct Messaging send action is logged in the HIPAA logs.

Settings	Security Matrix: ClientVisitViewExt, PatientSummaryGenerator
	Partner Config: Use Clinical Summary Features, CCD Author Address
	You need to contact your PRM to enable Direct Messaging in your system.

Steps to Configure	For each visit type that you want to include visit information for in a clinical summary:

1. Admin tab > Visit Type > edit.
2. Select Include Summary.
3. If your organization uses the eMAR module, select Associate eMAR.
4. 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.
5. Click Save.
6. When a visit type is flagged for Include Summary, two fields are available to support the C-CDA format: Reason for Visit and Chief Complaint. Staff can populate these fields via form mapping when documenting a visit, or by updating a completed visit.

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

You can generate a clinical summary that is based on the current information in the client's profile or 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 clinical summary will not change to reflect updates made to a client's record after the visit's Signed date/time. Note that time-of-visit clinical summaries will not be available for visits created before the clinical summary feature was enabled (the functionality is not retroactive).

Best practice: Have the client sign an ROI for sending his/her clinical summary to another agency.

To generate a real-time CCD for a client using Direct Messaging:

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. Click Generate Summary.

To generate a time-of-visit clinical summary:

1. Complete a visit with the visit type that has been set up to include a summary (Admin tab > Visit Type > select Include Summary > Save).
2. Visit tab > view button for visit.
3. Click the Create Clinical Summary link in the Transfer XML CDA/CCR field.
4. Follow steps above -- starting with step 2 -- for generating a real-time CCD or CCR.

To send a clinical summary via Direct Messaging:

1. With Clinical Summary created, select the output option Send Summary via Direct
2. Select the Direct Address (to add to this list, please submit a PRM task ticket)
3. The chosen address will populate from the selected Direct Address
4. Subject is modifiable, if necessary
5. Click Generate Summary
6. System message verification will show at the bottom of the screen

Attestation

The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

Denominator	Numerator
CMS: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.	**CMS:** The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
Credible: **Measure 1:** 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 2:** Same Credible denominator as Measure 1	**Credible:** **Measure 1:** Number of visits in Credible denominator that have CLINICAL SUMMARY GENERATED in the visit log **Measure 2:** 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

Objective 6: Patient-Specific Education

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

Measure   Patient-specific education resources identified by CEHRT 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.

Definition of Terms

Patient-Specific Education Resources Identified by CEHRT – Resources or a topic area of resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.

Unique Patient – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

Denominator	Numerator	Threshold	Exclusion
Number of unique patients with office visits seen by the EP during the EHR reporting period.	Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.	The resulting percentage must be more than 10 percent in order for an EP to meet this measure.	Any EP who has no office visits during the EHR reporting period.

Certification Criteria

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**.

Attestation

Patient-specific education resources identified by CEHRT 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.

Denominator	Numerator
CMS: Number of unique patients with office visits seen by the EP during the EHR reporting period.	**CMS:** Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.
Credible: 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	**Credible:** 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	

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
Patient Specific Education Resources Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.	**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.	*Patient Specific Education* Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.	**Measure:** Patient-specific education resources identified by CEHRT 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.

Objective 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 performs medication reconciliation.

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   Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Definition of Terms

Medication Reconciliation – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

Transition of Care - The movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Referral - Cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well.

Denominator for Transitions of Care and Referrals: The denominator includes transitions of care and referrals (as finalized in the Stage 2 rule where the definition of transitions of care includes: "When the EP is the recipient of the transition or referral, first encounters with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving EP"(77 FR 53984).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

Denominator	Numerator	Threshold	Exclusion
Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.	The number of transitions of care in the denominator where medication reconciliation was performed.	The resulting percentage must be more than 50 percent in order for an EP to meet this measure.	Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Certification Criteria

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. If appropriate, add a medication in the PBM Medication History list to the client's active medication list. The steps to do this are available in Credible Help: http://help.crediblebh.com/CredibleHelp/default.aspx?pageid=pbm_medication_history.

Method 2 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. 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.

Attestation

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.

Denominator	Numerator
CMS: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.	**CMS:** The number of transitions of care in the denominator where medication reconciliation was performed.
Credible: 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)	**Credible:** 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

Sample Questions

Denominator

- **Date that the client transitioned into care:** [Calendar control]
  (question is coded with SNOMED 1861000124105)

- **Is this client a new patient?** [DropDown]
  - Yes (SNOMED CT code 108220007 for Evaluation AND/OR management - new patient)
  - No (SNOMED CT code 108221006 for Evaluation AND/OR management - established patient)

- **If client is established, Provision of Summary of Care Record to Provider?** [DropDown]
  Encounter with existing patients with hard copy or scanned copy of summary of care document received or with an electronic CCD
  - 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

- **Documentation of current medications (procedure) performed:** [DropDown]
  (question is coded with SNOMED 1861000124105)
  choices for drop down include:
  - Performed (SNOMEDCT 398166005)
  - other choices can be included as applicable to your agency, such as:
    183932001 for Procedure contraindicated (situation)
    397745006 for Medical contraindication (finding)
    407563006 for Treatment not tolerated (situation)

- **Date the medication reconciliation is documented:** [Calendar control]
  (question is coded with SNOMED 428191000124101)

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
Medication Reconciliation The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	**Measure:** The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	*Medication Reconciliation* The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.	**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:** Any EP who was not the recipient of any transitions of care during the EHR reporting period.

Objective 8: 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.

Measure   EPs must satisfy both measures in order to meet this objective:

- **Measure 1:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.
- **Measure 2:** For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.

Exclusion

Measure 1: Any EP who:

- Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and Provider's name and office contact information."

Measure 2: Any EP who:

- Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or
- 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 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Definition of Terms

Provide Access – When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

View – The patient (or authorized representative) accessing their health information online.

Download – The movement of information from online to physical electronic media.

Transmission – This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Business Days – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

Denominator	Numerator	Threshold	Exclusion
Number of unique patients seen by the EP during the EHR reporting period.	The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.	The resulting percentage must be more than 50 percent in order for an EP to meet this measure.	Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."

Measure 2: For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.

Denominator	Numerator	Threshold	Exclusion
Number of unique patients seen by the EP during the EHR reporting period.	The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.	The numerator and denominator must be reported, and the numerator must be equal to or greater than 1.	Any EP who— (a) Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or (b) 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 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Certification Criteria

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 IM/PSC needs to turn on the Client Portal in your system

Steps to Configure
    Refer to Appendix A: Credible Client Portal Configuration 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

Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

Denominator	Numerator
CMS: Number of unique patients seen by the EP during the EHR reporting period.	**CMS:** The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.
Credible: 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	**Credible:** 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 by the fourth business day after the visit
- 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.	🖥 Stored procedure in Credible spc_export_mu_vdt_summary

Measure 2: For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.

Denominator	Numerator
CMS: Number of unique patients seen by the EP during the EHR reporting period.	**CMS:** The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.

Credible:	Credible:
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	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

Required for All Providers in 2015 through 2017[5]

- **Change:** In 2015 and 2016, the threshold for the Patient Electronic Access objective, measure 2, is **equal to or greater than 1 patient**. (In 2017, the threshold is greater than **5%**.)

- **Timing/Compliance:** Added for 2015 and 2016

- **Affected Providers:** EPs, eligible hospitals, and CAHs

- **What It Means:** The change implements a phased approach for the Patient Electronic Access objective, measure 2. This modification assists providers to meet thresholds based on patient action, yet continues to promote patient access of their health information.

> **Patient Electronic Access, Measure 2 (Eligible Professionals):**
>
> **For 2015 and 2016**: For an EHR reporting period in 2015 and 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.
>
> **For 2017**: For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.

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[5] EHR Incentive Programs: 2015 through 2017 (Modified Stage 2) Overview | https://www.cms.gov/

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
Patient Electronic Access (VDT) Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.	**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.	*Patient Electronic Access* 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.	**Measure 1**: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. **Measure 2:** For an EHR reporting period in 2015 and 2016, at least one patient seen by the EP during the EHR reporting period (or patient authorized representative) views, downloads, or transmits his or her health information to a third party during the EHR reporting period. For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representative) view, download or transmit to a third party their health information during the EHR reporting period. **Exclusion for Measure 1**: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."

			Exclusion for Measure 2: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or 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 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Objective 9: Secure Electronic Messaging

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

Measure For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) 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 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Definition of Terms

Secure Message – Any electronic communication between a provider and patient that ensures only those parties can access the communication. This electronic message could be email or the electronic messaging function of a PHR, an online patient portal, or any other electronic means.

Fully Enabled - The function is fully installed, any security measures are fully enabled, and the function is readily available for patient use.

Attestation Requirements

YES/NO/EXCLUSION

Denominator	Numerator	Threshold	Exclusion
Number of unique patients seen by the EP during the EHR reporting period.	The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).	The numerator and denominator must be reported, and the numerator must be equal to or greater than 1.	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 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Additional Information

The thresholds for this measure increase over time between to allow providers to work incrementally toward a high goal. This is consistent with CMS's past policy in the program to establish incremental change from basic to advanced use and increased thresholds over time. The measure

threshold for this objective was "fully enabled" for 2015, and is at least one patient for 2016, and a threshold of 5 percent for 2017 to build toward the Stage 3 threshold.

Certification Criteria

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 Client User Security Matrix: MessagingCU 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	Assigned client must have at least one client user with MessagingCU right. Refer to

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. To reply to a message:
   a. Click the Reply icon.
   b. Enter the reply and click Send Message.
   c. Click the Subject to open the message/reply thread.
   d. Hover over the hash symbol for your reply to view the matching message hash and received hash.

3. To send the first message in an electronic conversation with client's authorized users:

a. New Message button.
b. Select the client from the Message Recipient dropdown and General Message as the message type.
c. Enter the subject and body of the message in the corresponding fields. You can format and spell check the message with the tools in the text box.
d. Click Send Message.
e. Click the envelope icon for the message and then hover over the hash symbol to view the matching message hash and received hash.

Attestation

For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

Denominator	Numerator
CMS: Number of unique patients seen by the EP during the EHR reporting period.	**CMS:** The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative)..
Credible: 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	**Credible:** 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	

Required for All Providers in 2015 through 2017[6]

- **Change:** For an EHR reporting period in 2015, the threshold for the Secure Messaging objective has been changed to functionality fully enabled (yes/no) during the EHR reporting period. In 2016, the threshold is functionality fully enabled (yes/no) and for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized

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[6] EHR Incentive Programs: 2015 through 2017 (Modified Stage 2) Overview | https://www.cms.gov/

representative; and in 2017, the threshold is functionality fully enabled (yes/no) and for more than 5% of unique patients seen by an EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative).

- **Timing/Compliance:** Required for 2015 through 2017

- **Affected Providers:** EPs

- **What It Means:** The change implements a phased approach for the Secure Messaging objective for EPs. This modification assists providers to meet thresholds based on patient action.

Secure Messaging (EPs):

For 2015: For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period.

For 2016: For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

For 2017: For an EHR reporting period in 2017, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
Secure Electronic Messaging Use secure electronic messaging to communicate with patients on relevant health information.	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.	*Secure Electronic Messaging* Use secure electronic messaging to communicate with patients on relevant health information.	Measure: For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period. For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period. For an EHR reporting period in 2017, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) 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 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period

Objective 10: Public Health Reporting

Objective   The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

Measure

- Measure 1 -Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.
- Measure 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.
- Measure 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry.

Exclusion

- Measure 1 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP— Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period;
    - Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
    - Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

- Measure 2 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP--Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
    - Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
    - Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

- Measure 3 Exclusions: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP --Does not diagnose or treat any disease or condition associated with, or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;

- Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
- Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

Alternate Exclusions

- Alternate Exclusion for Measure 2: EPs may claim an alternate exclusion for measure 2 (syndromic surveillance reporting) for an EHR reporting period in 2016.
- Alternate Exclusion for Measure 3: EPs may claim an alternate exclusion for measure 3 (specialized registry reporting) for an EHR reporting period in 2016.

Definition of Terms

Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.

Active Engagement Option 1–Completed Registration to Submit Data:
The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

Active Engagement Option 2 -Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

Active Engagement Option 3 – Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

Production data refers to data generated through clinical processes involving patient care, and it is used to distinguish between data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers.

Attestation Requirements

YES/NO/EXCLUSIONS/ALTERNATE EXCLUSIONS

Measure 1 -Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.

YES/NO	Exclusion	Alternate Exclusion
The EP must attest YES to being in active engagement with a public health agency to submit immunization data.	Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP-- o Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period; o Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or o Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.	None

Measure 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.

YES/NO	Exclusion	Alternate Exclusion
The EP must attest YES to being in active engagement with a public health agency to submit syndromic surveillance data.	Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP— Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;	EPs may claim an alternate exclusion for measure 2 (syndromic surveillance reporting) for an EHR reporting period in 2016.

| | o Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
o Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. | |

Measure 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry.

YES/NO	Exclusion	Alternate Exclusion
The EP must attest YES to being in active engagement to submit data to a specialized registry.	Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP – Does not diagnose or treat any disease or condition associated with, or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period; o Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or o Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.	EPs may claim an alternate exclusion for measure 3 (specialized registry reporting) for an EHR reporting period in 2016.

Certification Criteria

Measure I: Immunization Registry Reporting

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.

CDC Meaningful Use and Immunization Information Systems: http://www.cdc.gov/vaccines/programs/iis/meaningful-use/index.html

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. For more information on VIS 2D Barcodes, visit the CDC VIS Home on Barcodes on Vaccine Information Statements at http://www.cdc.gov/vaccines/hcp/vis/barcodes.html.

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

Measure 2: Syndromic Surveillance Reporting

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.

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. A visit associated with the active episode that has 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. Select the visit you 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.

Required for All Providers in 2015 through 2017[7]

- **Change:** All the public health reporting objectives are consolidated into one objective with measure options. For 2015 only, eligible hospitals and CAHs previously scheduled to be in Stage 1 in 2015 may meet 2 measures while eligible hospitals and CAHs previously scheduled to be in Stage 2 must meet 3 measures. For 2015 only, EPs previously scheduled to be in Stage 1 in 2015 may meet 1 measure, while EPs previously scheduled to be in Stage 2 must meet 2 measures.

- **Timing/Compliance:** Added for 2015 through 2017

- **Affected Providers:** EPs, eligible hospitals, and CAHs

- **What It Means:** This aligns with the structure of public health reporting in Stage 3.

Public Health Reporting – Eligible Professionals (Must meet two measures. Alternate Specification for Eligible Professionals: An EP scheduled to be in Stage 1 in 2015 may meet one measure)

EPs scheduled to be in Stage 1: Must attest to at least 1 measure from the Public Health Reporting Objective Measures 1-3
- May claim an !lternate Exclusion for Measure 1, Measure 2 or Measure 3.
- !n !lternate Exclusion may only be claimed for up to two measures, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22 (e)(10)(i)(C).

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[7] EHR Incentive Programs: 2015 through 2017 (Modified Stage 2) Overview | https://www.cms.gov/

EPs scheduled to be in Stage 2: Must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3

May claim an !lternate Exclusion for Measure 2 or Measure 3 (Syndromic Surveillance Measure or Specialized Registry Reporting Measure)

Measure Option 1 – Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.

Measure Option 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.

Measure Option 3 – Specialized Registry Reporting. The EP is in active engagement to submit data to a specialized registry.

Note: An EP may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

Comparison between Stage 2 and Modified Stage 2

Stage 2 Objective	Stage 2 Measure	Modified Stage 2 Objective	Modified Stage 2 Measure
N/A	*N/A*	**Public Health Reporting** The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.	**Measure Option 1 – Immunization Registry Reporting**: The EP is in active engagement with a public health agency to submit immunization data. **Measure 1 Exclusions**: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP: • Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period; • Operates in a jurisdiction for which no immunization registry or immunization

			information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or • Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EPat the start of the EHR reporting period. **Measure Option 2 – Syndromic Surveillance Reporting**: The EP is in active engagement with a public health agency to submit syndromic surveillance data. **Measure 2 Exclusions**: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP: • Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; • Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the

| | | | start of the EHR reporting period; or
• Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

Measure Option 3 – Specialized Registry Reporting:
The EP is in active engagement to submit data to a specialized registry.
Measure 3 Exclusions:
Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP:
• Does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the EHR reporting period;
• Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
• Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to |

			receive electronic registry transactions at the beginning of the EHR reporting period. ***Note***: An EP may report to more than one specialized registry and may count specialized registry reporting more than once to meet the required number of measures for the objective.

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
7. will have to change his or her password during the initial login to the portal.
8. 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.